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

DISCIPLINARY HEARING

VOLUME 1

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 1, 2021

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

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September 1, 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 9:10 AM)

THE CHAIR: Good to see everyone here. We're just checking that we've got all the parties. Dr. Wall and counsel are here?

MR. KITCHEN: Yes, that's right, we are.
THE CHAIR: Okay, and you're together?
MR. KITCHEN: We are.
THE CHAIR: Okay. Hi, Dr. Wall.
DR. WALL: Hello there.
THE CHAIR: Good morning. Okay, we have our court reporter, Karoline Schumann. We have for the College, David Lawrence and Mr. Maxston, and we have one observer, Parker Hogan, and our court reporter, Karoline Schumann.

Opening Remarks

THE CHAIR: Okay, I think we're ready to start, so I'll call this Hearing Tribunal to order, and this is a hearing of the -- this is a hearing of a Hearing Tribunal of the Alberta College and Association of Chiropractors appointed pursuant to the Health Professions Act to consider allegations of unprofessional conduct against Dr. Curtis Wall, an active registered member of the ACAC.

My name is James Lees. I am a public member, and I will be acting as Chair of the hearing today and the other days scheduled.

I will now introduce the other members of the Hearing Tribunal sitting on this matter. First off, Dr. Leslie Aldcorn. Just stick your hand up and wave, Leslie. Dr. Dianna Martens. And they are both

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

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

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

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

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

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

MR. MAXSTON: None from the Complaints Director.

MR. KITCHEN: None from Dr. Wall.

THE CHAIR: Thank you. Are there any

objections to holding the hearing virtually or by electronic means?

MR. MAXSTON: None from the Complaints Director.

MR. KITCHEN: And none from Dr. Wall.

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

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

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

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

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

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

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

Discussion

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

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

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

THE CHAIR: Okay.

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

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

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

Hopefully we can complete the liability phase of

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

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

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

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

THE CHAIR: I'm aware of two.

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

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

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

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

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

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

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

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

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

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

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

Submissions by Mr. Maxston (First Preliminary Application)

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

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

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

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

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

relates to Mr. Kitchen's application.
THE CHAIR: In looking at this, I see on the second page, halfway down, there is some typed script in red; is that the change?
MR. MAXSTON: Yeah, I will get to that, Mr. Chair. I would like to make a few brief comments before I take you to that, but I just wanted to be sure everybody had access to this document.
THE CHAIR: I'm just wondering, if it's going to be the Notice of Hearing that is used that replaces the previous one, I would have thought it would have been entered as an exhibit.
MR. MAXSTON: Well, maybe we'll -- again, I invite Mr. Kitchen's comments. My experience in these types of situations is that you can certainly enter a revised Notice of Hearing as an exhibit, and I would intend that Part 1 of this document be that, but we're not quite there yet. I was wondering if you want to mark this as an exhibit for identification only or whether you don't need to mark it at all at this point. And, again, I'm fine either way.
THE CHAIR: Okay, let's not mark it yet, and let's proceed, and if it starts to get a little muddy, the waters get a little muddy, we might need to mark things. There's a lot of documents here, so ...
MR. MAXSTON: Mr. Chair, I'll --

THE CHAIR: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIR: Okay --

MR. MAXSTON: Mr. Chair --

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

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

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

MR. KITCHEN: Thank you.

(ADJOURNMENT)

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

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

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

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

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

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

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

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

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

THE CHAIR: I'm --

MR. MAXSTON: -- thinking we should wait.

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

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

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

MR. MAXSTON: Yeah, paragraph 20.

THE CHAIR: Okay, we're good.

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

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

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

Particulars enable the professional to identify the particular event that is said to amount to professional misconduct. Particulars also have the effect of limiting the scope of the charges so that the professional does not have to defend his or her entire career or general character during the hearing.

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

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

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

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

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

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

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

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

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

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

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

these charges and properly prepare for them.

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

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

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

Submissions by Mr. Kitchen (First Preliminary Application)

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

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

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

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

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

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

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

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

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

Reply Submissions by Mr. Maxston (First Preliminary Application)

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

THE CHAIR: Yes.

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

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

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

(ADJOURNMENT)

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

Ruling (First Preliminary Application)

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

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

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

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

but, again, I'm in Mr. Kitchen's hands on that.
MR. KITCHEN: I think that's fine, enter it as an exhibit. Yeah, we have a copy. It's part of the record.
THE CHAIR: Okay, just to be clear that, the Hearing Tribunal Members, your copies show in red the changes? So we don't need to reword it and reprint it. Okay, good.
EXHIBIT H-1 - Preliminary Application: Complaints Director's Reference Document Submissions by Mr. Maxston (Second Preliminary Application)
MR. MAXSTON: Mr. Chair --
THE CHAIR: Yeah, Mr. Maxston.
MR. MAXSTON: Thank you, I will proceed then with the Complaints Director's secondary preliminary application, which is to admit three Alberta Health Services or AHS documents as additional exhibits, and, as you know, Dr. Wall is objecting to that.
For your reference, I'll tell you I'm going to be making submissions in three areas, and I think, quite briefly, the first is to briefly review what the proposed exhibits are; secondly, I'm going to talk about what the HPA has to say about evidence and admissibility; and then I'm going to talk very briefly about what the courts have to say about evidence and

admissibility.

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

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

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

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

those around them.
And it talks about the importance of that for health care providers.
I could take you through these documents in detail, but I don't know that's appropriate, given the nature of the preliminary application, but I just wanted to give you a sense of the flavour of those documents and why the comments in them are important.
The next thing I want to turn to is to review Section 79(5) of the HPA, and that is actually in Part 2 of the reference document that had the changes to the charge wordings and the other HPA sections that you have. It's on the last page, the third page of that document, and it's under the heading "Section C", and then it says "Section 79(5)". I'll just ask all of you to go to that, and if you can let me know, Mr. Chair, when you'd like me to proceed.
THE CHAIR: Okay, just give me a moment, please. Okay. Everybody okay? Okay, Mr. Maxston.
MR. MAXSTON: Thank you. And, Mr. Chair, just for the balance of the hearing, if I start talking about a section, and there's a straggler who may be or a document someone hasn't gotten to yet, someone can raise their hands. I certainly want to make sure that everybody's on the same page, and I know it's a little cumbersome with the electronic documents. So, again,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. MAXSTON: But --

THE CHAIR: -- 'H'.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

comments in response.

THE CHAIR: Okay, Mr. Maxston.

Reply Submissions by Mr. Maxston (Second Preliminary Application)

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

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

Those are my submissions, thank you.

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

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

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

(ADJOURNMENT)

Ruling (Second Preliminary Application)

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

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

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

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

2018
EXHIBIT H-3 - R. v. Chikmaglur Mohan 1994 SCC 80
EXHIBIT H-4 - Genevieve Wright v. The College and Association of Registered Nurses of Alberta, 2012 ABCA 267

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

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

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

MR. KITCHEN: Yes.

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

MR. KITCHEN: Yes, unless Mr. Maxston has

any objections to doing that now.
MR. MAXSTON: No, I think that's actually the best way to go, and, of course, Mr. Chair, after Mr. Kitchen has made his comments, I'll, of course, have some response comments.
THE CHAIR: Yes, yeah.
Submissions by Mr. Kitchen (Third Preliminary Application)
MR. KITCHEN: All right, so you have in front of you this expert report from Chris Schaefer and his cv.

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

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

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

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

Could you just go over the tests again.

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

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

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

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

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

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

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

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

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

harmful.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE CHAIR: Thank you, Mr. Kitchen.

MR. KITCHEN: Thank you.

THE CHAIR: Mr. Maxston?

Submissions by Mr. Maxston (Third Preliminary Application)

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

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

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

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

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

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

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

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

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

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

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

rules; it breaks the rules.

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

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

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

as scheduled.

So, Mr. Chair, those are my comments. I'm happy to answer any questions, and Mr. Kitchen may have some response comments as well in fairness to him.

Reply Submissions by Mr. Kitchen (Third Preliminary Application)

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

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

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

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

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

That's my response.

THE CHAIR: Thank you.

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

THE CHAIR: Okay.

Reply Submissions by Mr. Maxston (Third Preliminary Application)

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

means to be a professional.

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

Thank you for allowing me that further comment.

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

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

(ADJOURNMENT)

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

Ruling (Third Preliminary Application)

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

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

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

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

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

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

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

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

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

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

Opening by Mr. Maxston

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

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

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

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

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

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

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

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

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

MR. KITCHEN: Yes, they have.

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

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

documents.

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

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

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

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

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

MR. KITCHEN: No.

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

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

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

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

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

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

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

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

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

EXHIBIT A-7 - ACAC Complaint Investigation Report

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

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

EXHIBIT A-10 - ACAC Code of Ethics

EXHIBIT A-11 - ACAC Standards of Practice

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

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

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

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

Masking
EXHIBIT E-3 - 9-page curriculum vitae for Dr. Bao Dang
EXHIBIT E-4 - Dr. Bao Dang - Expert Report Masking
EXHIBIT E-5 - 95-page curriculum vitae for Dr. Byram Bridle
EXHIBIT E-6 - Dr. Byram Bridle - Expert Report Masking
EXHIBIT E-7 - 5-page curriculum vitae for Dr. Thomas A. Warren
EXHIBIT E-8 - Dr. Thomas A. Warren - Expert Report Masking
EXHIBIT F-1 - GOA Albert's safely staged COVID-19 relaunch, dated April 30, 2020
EXHIBIT F-2 - CMOH Order 16-2020, dated May 3, 2020
EXHIBIT F-3 - ACAC Registrar's Report, dated July 5, 2021
EXHIBIT F-4 - ACAC Frequently Asked Questions, dated July 7, 2021

MR. MAXSTON: I do want to comment a little bit about some other aspects of the exhibits.

Typically, only evidentiary documents are entered as exhibits, those would be patient charts, CMOH orders, those types of things. Things like the Health

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

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

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

Each of the Complaints Director's witnesses would

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

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

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

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

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

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

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

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

MR. MAXSTON: I think they would --

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

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

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

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

THE CHAIR: Okay.

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

reconvene to deal with the matter of penalty orders.

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

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

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

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

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

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

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

The first one is item (i): (as read)

> Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

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

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

And then subsection (iii): (as read)

> Contravention of another enactment that

applies to this profession.

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

Conduct that harms the integrity of the regulated professional.

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

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

Regardless of whether the conduct is disgraceful or dishonourable.

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

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

Conduct is defined as meaning an act or an omission.

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

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

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

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

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

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

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

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

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

steps when it comes to evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Must maintain, must enforce standards for the profession.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discussion

THE CHAIR: Thank you, Mr. Maxston. Do

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

MR. KITCHEN: I'll say 10 minutes.

THE CHAIR: 10 minutes.

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

MR. MAXSTON: Yeah.

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

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

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

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

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

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

Chair, is that how you want to proceed?

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

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

Opening by Mr. Kitchen

MR. KITCHEN: All right, thank you.

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

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

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

That's the issue.

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

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

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

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

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

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

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

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

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

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

I note the word "overwhelming" was used to

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

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

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

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

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

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

That's my opening comments.

THE CHAIR: Thank you, Mr. Kitchen.

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

Discussion

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

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

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

I think we can simply break till 1:00.

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

THE CHAIR: Yeah, that's fine with me. It's just a couple of minutes after 12, so we'll reconvene at 1:00 with the College's first witness. The hearing will go into recess until then.

PROCEEDINGS ADJOURNED UNTIL 1:00 PM

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

Exhibits

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

DISCIPLINARY HEARING

VOLUME 2

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 2, 2021

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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

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

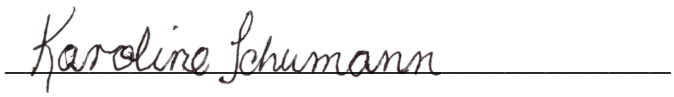
is that not an issue?
MR. PAVLIC: He should be provided the usual caution, but I think Mr. Maxston has already indicated that he will not be discussing any matters with him, so I think that will cover it off.
MR. KITCHEN: Okay, your comment, mine, and Mr. Maxston's.
THE CHAIR: Okay, that's great. Okay, 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

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

DISCIPLINARY HEARING

VOLUME 3

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 7, 2021

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

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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)

Discussion

THE CHAIR: Mr. Kitchen, we were just hearing from Mr. Maxston that Mr. Lawrence will require 5 minutes just to get himself set up computer-wise prior to his starting his direct, so if we could just ask people to hold. I think -- it's quarter to 11; is 5 minutes enough?

MR. MAXSTON: I think so, Mr. Chair, and, of course, Mr. Lawrence will be on the screen when he's ready to go, but I think that will be fine.

I'll just mention as well, I see that Dr. Halowski is no longer with us, but, of course, since his testimony is finished, he's free to listen in for the remainder of the hearing if he wants to. I don't see him here, but he may join us at some time.

THE CHAIR: Yes, I think, in fact, that might happen, but in any event. Okay, well, we'll just ask everybody to stay on mute and hold until David Lawrence is ready, and then we will continue with his direct examination.

MR. KITCHEN: Mr. Maxston, can I just ask you about timelines?

MR. MAXSTON: Yeah, that's a good question. I anticipate probably being about an hour-and-a-half with Mr. Lawrence. So I would think I'd be going maybe a little bit into the lunch hour, or we'd break at

noon, and then I resume after lunch and, of course, won't be talking to Mr. Lawrence about his testimony.

I don't know how long you anticipate being. And I should be candid, I may be longer with Mr. Lawrence, just depending on how things go.

I don't know, Mr. Kitchen, what your thoughts are about starting Dr. Wall's -- I believe that's your witness, as my case will be closed. I don't know what your thoughts are about starting with Dr. Wall today or whether you'd prefer to start with him tomorrow.

MR. KITCHEN: I'd prefer to start with him tomorrow just because I do think I'm going to be quite a while, I imagine you're going to be quite a while. And I know from experience the last couple days, particularly with Dr. Halowski, you went quite long, I have no issue with that, but you went on for a while, and then -- because I fully expected to do the cross, and then we just cut into the afternoon, and we ran out of time.

So, you know, I thought a realistic goal today was the direct of Mr. Lawrence, my cross, and then we'd probably be done 3, 3:30, 4, 4:30, somewhere around there. That was what I thought was realistic for today, so -- and I'm flexible about lunch, because I know if you don't want to break that up with him, and we're -- and we don't lunch till 12:30, 12:45, that's

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)

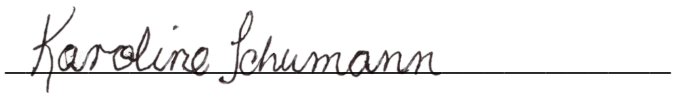
THE CHAIR: And we will, for the rest of those on the hearing call, we will see everybody 9:00 tomorrow morning.

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

D

Q

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 4

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 8, 2021

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September 8, 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: Good morning everybody. We will start this morning with Mr. Kitchen's examination of Dr. Wall, and before we do that, we will have

Dr. Wall sworn by Karoline.

Discussion

MR. MAXSTON: Chair, it's Blair Maxston. I have a quick housekeeping matter to attend to from yesterday. When we concluded our -- if I could just deal with that very briefly -- when we concluded our discussion yesterday, there was a discussion about whether the Complaints Director would seek to have the recording of the interview entered and placed before you. I have received instructions from Mr. Lawrence to not to do that, so that won't be placed then before you.

THE CHAIR: Okay, thank you for clarifying that.

DR. CURTIS WALL, Sworn, Examined by Mr. Kitchen

MR. KITCHEN: Just to confirm, everyone can hear me.

Q MR. KITCHEN: Dr. Wall, you can hear me?

A (NO VERBAL RESPONSE)

Q Good. Dr. Wall, just to confirm, can you give us your full name for the record?

A Curtis Wall.

MR. KITCHEN: My fault, I apologize. Like I said, I think we can make this work; I'm just going to have to be diligent.

Q MR. KITCHEN: Now, Dr. Wall, when did you

first become a chiropractor?
A I attended Palmer College of Chiropractic in Davenport, Iowa, and I graduated with a Doctor of Chiropractic in 1996.
MR. KITCHEN: Now, I apologize, I notice that produced some feedback as well, so if this continues, we might have to devise a separate way of doing this, but I'm going to just keep trying it a little bit longer. I had no way to really to test this prior to doing this.
THE CHAIR: Mr. Kitchen, would it help if there was maybe a couple of seconds pause between the end of your question and Dr. Wall's replying? I gather you're muting after you've spoken?
MR. KITCHEN: Yes, so that's what we're going to try to do is have more of a time lag in between each one. Just give me a second. Okay.
Q MR. KITCHEN: I'm just going to confirm, because of that issue, it was, in fact, Palmer College that you went to?
A That's correct.
Q All right, and, Dr. Wall, tell me why did you choose to go to that particular college amongst all the chiropractic colleges you could have gone to?
A That could be a long drawn-out answer. I'll give you a few of the salient points. I have a Bachelor of

Religious Education degree from a Canadian college, and in order to attend a Canadian chiropractic college, CMCC, I would have needed to take quite a few more credits in the social science end of things, and so I began looking at American colleges to attend because they did recognize my social science credits from the college I had attended in Canada.

And also I went to a chiropractor who had gone to Palmer College in Davenport, Iowa, and my wife attended a -- went to see a chiropractic who also went to Palmer College in Iowa. Another chiropractic friend, who -- whose practice I actually purchased, attended Palmer College in Iowa. And so all those recommendations to attend Palmer were the reasons why.

And Palmer College in Davenport is considered a fountainhead. It was the original college that was started by B.J. Palmer. And so it has a very strong reputation for academic excellence, strong in philosophy, the philosophy of chiropractic, so the science, philosophy, and art were very strong components of Palmer College. So those are some of the specific reasons why I attended Palmer.

Q Thank you. Now, I heard you mention the philosophy of chiropractic, which is interesting. I don't know that I would have expected to hear that word. Can you just elaborate a little bit on what the philosophy of

chiropractic was when you went there?

A Quite basically, I would say that the philosophy of chiropractic is based on the fact that the body has an innate ability to heal itself and that the nervous system is a very strong component in the body's healing capabilities.

At times, there are interferences to the nervous system through spinal misalignments, and so the chiropractic adjustment just removes those interferences and helps the body to heal itself in a manner.

And so those are some of the philosophical understandings. Innate intelligence, the body was created or made with an ability to heal itself, and so yeah.

Q Thank you. Were there any core principles of chiropractic that were taught to you when you were at Palmer?

A Yes, core principles, basically stated what I was just referring to, some of those principles being that the body has innate intelligence, that there is a science component to chiropractic. So that core understanding is that the body is physical, and that, at times, we do have spinal misalignments that interfere with the nervous system and that chiropractic, through an adjustment, can remove those interferences and help the

body to heal in a natural way.

Q Thank you. Now, let's back up a little bit. Why did you want to become a chiropractor in the first place?

A Excuse my long answer. My initial intention with a career path was to become a youth pastor. In the process of doing that, my wife and I spent four years in lay work in a church doing youth ministry work.

And in so doing, I was working at the University of Calgary in the phys. ed. department, and I played quite a bit of squash at the time. And at one point, I was playing squash, and I ruptured my achilles tendon. That put me in the hospital, and while I was in the hospital for surgery, a friend of mine, a very close friend of mine was in his first year at Palmer College of Chiropractic in Davenport, and he sent me a prospective student packet.

And I looked at that packet while I was in the hospital, and I said to myself I wish I could do that. I was very much interested in health, natural healing processes, lifestyle choices. And I looked at that packet, and I thought I would love to be a chiropractor.

And all I can say is that the pieces of the puzzle were being put together very specifically and amazingly, which I won't go into detail, but that unfolded the desire to pursue becoming a chiropractor,

and there's so much to the story, but, yeah, that's basically how I got into it.

Q Thank you. Do you feel like then that chiropractic is more than a mere occupation for you?

A Yes, I thoroughly enjoy what I do. I thoroughly enjoy the privilege of helping assist people in their health care goals. Yes, it is an occupation, but I love coming to work. I love coming to work to help people and to assist people in lifestyle choices, and the basic understanding of removing nervous system interference so that their bodies can carry out health in the best possible way, so, yes, it is more than an occupation, but that is one component of it.

Q Thank you. When did you first start practicing as a chiropractor in Alberta?

A I first started practicing in Alberta in 1996, shortly after graduation, perhaps early '97. I saw a few patients in a colleague's office, began that way, and then I started doing locums for a year or two, and then I purchased a practice in 1998.

I had a young family. I decided that perhaps that was a better way to go to have a patient base to start with, and so in 1998, I purchased a practice, and that's how I've practiced ever since.

Q When you started practicing in Alberta, did you think the chiropractic profession in Alberta held to the same

principles emphasized at Palmer College when you went to Palmer College?

A Yes, generally I would say so, yes.

Q When it comes to those principles, do you think things have changed here in Alberta since then?

A I have seen, over the last 20 years, a slow but steady change in chiropractic. I've seen a stronger role of governance from the College of less perhaps freedom to do some of the things that some chiropractors would prefer to do. I understand some of the reasoning that the College uses to create some of these restrictions perhaps or boundaries, but I have seen a steady decrease in the ability to do certain things that perhaps 20 years ago would not have been an issue.

Q Do you know roughly how many patients you've seen over the years that you've been a chiropractor?

A Very hard to tell, but several thousand for sure, multiple thousands, yeah.

Q Wow. Okay, do you have any patients that you have been treating for many years or even decades?

A Yes, yes, I have several patients that have started and stayed with me right from the beginning, so up to 25 years, yes.

Q Now, let's go to the spring of 2020. Were chiropractors ordered by the Alberta Government to stop practicing in March of 2020?

A There were, yes, restrictions on our ability to practice. We were told that we could only practice if the situation was an emergency, and so that was a regulation by the College to restrict only those people who had an emergency situation.
Q And did the restrictions only come from the College, or did they also come from any other sources?
A I believe the College placed that restriction in place due to Alberta Health Services. I'm sure they worked in collaboration with each other, so that's my understanding.
Q And what was it like for you during that time that you could only treat emergencies?
A Very challenging. My -- I support my family strictly through chiropractic, and I have a large family, many needs, and so when that happened, essentially my practice load went just about to zero, and I perhaps might see a patient in a day, maybe not. Some days were blank for sure, but, yeah, it was a stressful time.
Q Do you have any sense of what it was like for your patients during that time?
A I had several people say that it was difficult because they needed care, they needed to receive an adjustment to relieve their discomfort or their ailment. And so, yeah, many people were certainly -- had to wait, had to

wait it out or take painkillers or some other thing, but, yeah, it was challenging for everybody I think.

Q And were you permitted to -- or were chiropractors permitted to re-open and start practicing again?

A Yes, I believe -- I can't remember the exact date, but I believe it was sometime in May that that occurred.

Q And did the College implement a directive in May that imposed extra requirements for chiropractic practice related to practicing under COVID?

A Yes, they did.

Q And do you recall the name of the document, and this is in the record, but I'll ask you anyways, do you recall the name of the particular document that contained all these requirements and restrictions?

A It was called the Pandemic Practice Directive.

Q Thank you. And I'm just going to call it the Pandemic Directive. Did the Pandemic Directive contain a requirement that chiropractors wear a mask?

A Yes, it did.

Q And do you recall specifically what types of masks were mandated in the directive to be worn?

A Yes, it would have been a surgical style mask, so the blue type of mask, not a cloth mask, no homemade materials, a surgical mask.

Q Now, we've heard a lot about how the Pandemic Directive was not optional. Did you regard the Pandemic

Directive as optional?
A No, I did not.
Q Okay, thank you. Now, did you start wearing a mask while treating patients once you became aware of the mandatory mask requirement in the Pandemic Directive?
A Yes, I did off and on. It was very apparent to me right from the start when I put on a mask that I did experience mental concerns, and so -- but I did put the mask on to treat patients, again off and on. It was very quickly that I realized my mental concern.
Q And just to confirm, the Pandemic Directive at the time, so this is spring of 2020, May of 2020, did you have to wear the mask all the time, or was there only certain times that you had to wear it according to the directive?
A According to the directive, we were supposed to wear a mask at all times unless we kept the physical distance barrier of 2 metres.
Excuse us, sorry, we forgot to lock the door.
Q Now, I'm curious, did you have any prior experience to regularly wearing a mask?
A None whatsoever.
Q So you didn't have any prior experience with being required to wear a mask then, I take it?
A That's correct.
Q Now, did you eventually stop wearing a mask while

treating patients, and by that, I mean being within 2 metres of them?

A Yes, I did. Probably by the end of June, I made the decision that, with my mental concern and limitation, I decided that it was not productive for me to continue wearing a mask, and so I did stop by the end of June 2020.

Q And did you try wearing a face shield after you stopped wearing a mask?

A Yes, I actually went out and purchased a face shield to see if that was also a problem, and when I put the face shield on, I also experienced the same symptoms. And so, yes, I did purchase a face shield and tried that for several times.

Q Now, why was it that you decided to try that as opposed to just taking off the mask and leaving it at that?

A A face shield, I would think, provides a little more breathing room and space, and so that was my reasoning behind that, and so that's why I went to the face shield.

Q Did you attempt to -- at that time, did you attempt to obtain a doctor's note that would provide you with a medical exemption to wearing a mask?

A No, I did not.

Q Did you think there was any requirement that you do so?

A No, I didn't.

Q Did you understand the Pandemic Directive to include any direction about reaching out to the College if you were having problems with wearing a mask?
A No, I didn't see anything in the directive that stated that. I initially -- my thought was that my health information is private, between me and my doctor, and so I didn't decide that that was privy information to discuss with anybody at the time.
Q Did the College give you any reason to think that it would be supportive and work with you if you had reached out and told them your concerns about wearing a mask?
A No, they did not. Of course, the College is always of the stance that we should reach out if we have concerns and -- but on the same note, from my calls with Dr. Halowski and with Mr. Lawrence, it was apparent to me that, even as I expressed my concerns, there was no option with respect to the mask wearing.
Q Dr. Halowski mentioned an email that you had written to him I think just a few months before all this. Did you ever receive a response to that email?
A No, I did not.
Q Did that contribute to your apprehension about whether or not the College would be supportive?
A Yes, it did. In fact, in addition to sending an email to Dr. Halowski, I sent an email to a trusted, tenured

chiropractor, whom I've known for 30 years, and the response I received back was also very vague and disheartening when I expressed my concerns in that email. So I was reluctant that the College was going to have any, you know, understanding with my situation.

Q During this time, in the spring of 2020, did you have some doubts or fears about the College penalizing you or punishing you for what was going on?

A Yes, I did.

Q Did you think in the spring of 2020, so around this time, that the so-called surgical or blue or medical masks were effective at preventing the transmission of respiratory viruses such as the COVID virus?

A I had done my own research, and it's not -- again, I don't want to say that this is my word, this is research that I -- as doctors, we all look into various research, and so having researched this issue with respect to masks, yes, I did have some very strong concerns that they were effective at reducing the transmission of viral particles, specifically COVID in this situation, and I also had concerns about their health risks to the person wearing them.

Q So you started being concerned about what you just called the health risks right away then?

A Yes, I did.

Q And can you describe for me what some of those health

risks are?

A Specifically, when one wears a mask, there's decreased oxygen that you're taking in, and there is an increase in carbon dioxide intake. And whether perceptible or not, these physical facts are certain, and, at varying degrees, people will experience symptomatology, so, yes, I'm very aware of these physical issues.

Q Now, have you, since the spring of 2020, developed any other concerns or personal objections to wearing a mask?

A Yes, I have. I would say that I do have religiously, sincerely held religious beliefs that would preclude me from wearing a mask. Specifically, I'm a Christian, and that means that I am a born-again follower of Jesus Christ. And as such, I adhere to the teachings and requirements of the Holy Bible. And in Genesis 1:27, it states that: (as read)

> God created mankind in his own image, in the image of God he created them, male and female he created them.

So I believe that, number one, my face is sacred and sacred to me and sacred to God, because it is -- it's a manifestation of his image. So for me to cover up my face, essentially places a barrier between me and Jesus.

And for someone to require me to wear a mask,

who's in a position of authority, when there's no other reason to put that mask on other than the fact that they are telling me to, when I don't exhibit any symptoms or any upper respiratory issue, to me, is essentially fearing man and not God, and so that's one aspect of it.

Also, as a Christian, I believe that I am to live my life in the fullest measure and expression of faith. And just to clarify that, I just want to read a couple of, again, passages of the Bible that support my religious conviction. Hebrews 11:6 says: (as read)

> And without faith, it is impossible to please God: for whoever comes to God must believe that he exists and that he rewards those who diligently seek him.

The 2nd Corinthians 5:7 says: (as read)

> For we walk by faith and not by sight.

And Romans 14:23 says: (as read)

> For whatever does not proceed from faith is sin.

And so when I have to wear a mask, I am not living by faith; I am living because someone in a position of authority has told me, Put that mask on, whether it's fear-based or whether it's for some other reason, it violates my life of faith, and so that's one of the aspects of my religious convictions.

Also, I would have to clarify to say that the Canadian Charter of Rights and Freedoms and the Alberta Human Rights Act protect my expression of my religiously held beliefs, and it guards against anybody discriminating against those beliefs, and so that's kind of all wrapped up into that section.

Q Thank you. Why do you think it took you time to come to that conclusion instead of that being instantly apparent?

A Sometimes you don't know the significance of an issue until or the significance of a freedom until it is taken away, and this would apply in this situation. Until our freedoms have been -- our health freedoms have been slowly chipped away, you don't realize what it is that you have or the significance of it, and so that's how I would answer that question. It took some time to formulate that and to recognize, listen, this is going on.

Q Had you ever in your life before this thought about masking or mandatory masking in the context of your religious beliefs as a Christian?

A Never.

Q You just never had any reason to; is that it?

A That's correct.

Q Do you think mandatory masking interferes with bodily autonomy?

A Yes, I do when it's mandated. I believe that, as a chiropractor, I have been and we have all been trained to respect the principles of, first, do no harm and the principle of informed consent; extremely important principles that we are required to carry out in our profession every day.

So mandatory masking does violate those things. Specifically, the College has never performed informed consent to the issue of mask mandating, and this is a medical procedure, wearing a mask is a medical procedure because there is an imminent risk of mental or physical harm by putting the mask on. And so I believe that, essentially, the College has violated that aspect of informed consent and the right to bodily autonomy and, first, do no harm.

Putting on a mask harms me, and it harms my patients. And so as a doctor, which means teacher, I have to educate my patients; I have to tell them the specific harms of a treatment, risks of potential harms, and so that's all wrapped up in mandatory masking. It's not following informed consent, and it's not following, first, do no harm

Q Do you seek to obtain informed consent when you do your treatments with patients?

A From every patient at the outset of their becoming a patient, that is required, and if there's any changes

in treatment protocol or in their health picture, yes, we have to keep informed consent updated.

And informed consent is not implied; it has to be expressed, and so that's a very specific thing, it has to be communicated. We have to say here are the risks to this treatment, here are the benefits to this treatment, and here are some alternatives that you can do if you would like to investigate those. So these are core principles for sure.

Q And are there some treatments -- generally speaking, are there some treatments where the risks become quite high and the benefits become quite tenuous, and there's a difficult decision to make about whether you actually proceed with that treatment?

MR. MAXSTON: Mr. Kitchen, I'm sorry to interrupt, I've been a little bit liberal here; I think you're asking some fairly leading questions --

MR. KITCHEN: Okay --

MR. MAXSTON: -- so I'm a little concerned about that. Just thought I'd mention it.

MR. KITCHEN: That's fine. That one was ad hoc, and it was a little leading, I'll admit. That's fine.

Q MR. KITCHEN: Do you think wearing a mask also impacts psychological illness?

A Yes, I do. It can.

Q I'm going to take you to -- talk a little more about your patients. When you stopped wearing a mask, how did your patients react?
A Most of my patients never said a thing. They were very understanding. I would express to several patients, who did ask me if I would be wearing a mask, that I did have an exemption. And I would say 99 percent of those patients were very understanding and unconcerned, and there was the odd person who requested, you know, more information, and if I was at liberty to discuss that, I would. But, yes, 99 percent of my patients were unconcerned and were okay with my not wearing a mask.
Q So for those who wanted more information, was there any kind of discussion about why you weren't wearing one?
A Yeah, I -- for somebody that I felt in a trusted position, I would talk about my mental concern, but others, I would just, you know, give a very generalized answer.
Q Why do you think so many of your patients were so understanding?
A My patients know who I am. They know my character. They know who I am as a chiropractor, that I believe in their health. They trust me with their health. They trust me as somebody who understands the health process. And so I believe that it was a doctor/patient trust relationship that enabled people to feel

comfortable and to understand that they were coming into an office that was safe, and there was no risk of harm from them by me not wearing a mask.

Q Now, let's jump forward six, seven months to December of 2020. Did AHS close down your chiropractic office?

A Yes, it did.

Q Now, I'm going to take you and everybody else to that closure order, which is Exhibit D as in dog, D-1. Now, was there a CMOH order that was specified in that closure order?

A Yes, there is.

Q And which one was it?

A That is CMOH Order 38-2020.

Q Now, I'm going to come back to all the things that happened in December, but let's forward to early January; did AHS permit your chiropractic office to re-open?

A Yes, it did.

Q And was that done through another document that rescinded the closure order?

A Yes, it was. I had to complete a re-opening template and meet some of the requirements that were specified with that template.

Q Okay, so I'll bring you to that notice; it's Exhibit D-2. Now, did AHS permit you to continue treating patients in person without wearing a mask?

A Yes, they did.
Q Did you provide AHS with a doctor's note verifying your medical exemption from wearing a mask?
A I believe I did.
Q And why did -- looking at this rescind notice, why did AHS permit you to practice without wearing a mask?
A I believe they recognized the doctor's -- the medical doctor's note and decided that was sufficient grounds to permit me to treat patients.
Q You said earlier that it was CMOH Order 38-2020 that was mentioned in the closure order, so I'm going to take you to CMOH Order 38-2020. Just got to get the exhibit number. 38-2020 is Exhibit D-8. Now, I know we've been over this, but let me ask you is there anything in that order that provides for medical exemptions to wearing a mask?
A Yes, there is. Yes, there is.
Q All right, let's go back now to December. Did you hear from the College in early December?
A Yes, I did.
Q Did you receive a call from the Registrar, Todd Halowski?
A Yes, I did.
Q And did Dr. Halowski say anything in that call about how a decision may be made that you either wear a mask or sit out from practicing?

A Yes, he did.
Q Did you receive a call from the Complaints Director, David Lawrence?
A Yes, I did.
Q And did he say anything in that call about suspending your licence?
A Yes, he did.
Q Did you ask him any questions about accommodation?
A Yes, I did. I asked him, I said I knew the College was in a difficult place because of their desire to protect the public, and I also said but they also had a role in protecting its members; and so I discussed my mental concern, that I was exempt, and left that on the table and asked if there would be accommodation for that.
Q Did you mention anything about human rights?
A Yes, I did.
Q Did you say anything to him about how the literature does not support wearing a mask?
A Yes, I did.
Q What was Mr. Lawrence's response when you made that comment about the literature?
A I believe his response was that he didn't want to debate me on the issues. He felt he just had a responsibility to protect the public. He also said that he disagreed with me, and he said that I was a danger to the public and that he was going to initiate

this investigative process.
Q Did you say anything to Mr. Lawrence about the percentage of the COVID recovery rate?
A Yes, I did. I stated that there was a 99.97 percent recovery rate for people who were infected with COVID.
Q Did Mr. Lawrence say anything to you about making or not making you wear a mask?
A Yes, he said he couldn't make me wear a mask, but that if I was not going to wear a mask, he would have to initiate this practice suspension, suspending my licence.
Q And did Mr. Lawrence say anything to you about you being free to not wear a mask?
A Yes, yeah, he said I was free to wear a mask, but there would be the consequence, of course, of my licence being suspended.
Q Did you understand this comment about "free" from Mr. Lawrence to mean that the College's masking mandate was actually optional?
A No, this mandate was not optional.
Q Do you think "mandate" and "optional" are contradictory terms?
A I don't know the answer to that.
Q Did Mr. Lawrence say anything to you about your private life or what you do in your private time during that call?

A No, not to my knowledge. I can't remember him talking about me and my private life or what I do with that. No, I can't remember that. I don't think he did.
Q Now, after talking to Mr. Lawrence, did you feel like you were free to decide whether or not to wear a mask?
A No, I did not feel like I was free. I felt that there was a very strong arm of the College that was about to step in and stop my practice.
Q And was this call with Mr. Lawrence around December 3rd or 4th?
A That's correct.
Q Did Mr. Lawrence submit a request to suspend your licence?
A Yes, he did.
Q Now, you said earlier that you did not attempt, in the spring of 2020, to obtain a doctor's note in support of your inability to wear a mask. Did you now at this time, in December, attempt to obtain a doctor's note?
A Yes, I did. It seemed that there was an unspecified requirement from the College that verification of a mental or physical limitation or concern was required, and so I did try to obtain one at that time, yes.
Q When you first told Mr. Lawrence that you had a medical exemption, did you have doubts about whether or not he believed you?
A M-hm, yes, I did have doubts.

Q Did you end up receiving a medical note from a medical doctor regarding your inability to wear a mask?
A Yes, I did.
Q And do you recall when you received that?
A I can't remember the exact date in December, but sometime after December 5th.
Q It's an exhibit in the records, so I could give it to you to refresh your memory about when, but is it your recollection that you provided this note to him before Dr. Linford made a decision about Mr. Lawrence's request?
A I can't remember the exact timeline, but, yes, I believe it was before, but I'm unclear on the specific dates.
Q Were you at all surprised that Dr. Lawrence forged ahead with the request even though you gave him this medical note?
A No, I wasn't surprised. Dr. Lawrence was very clear that his role was to protect the public and that he needed to initiate this process, and so, yeah, he was going to do that, and so I wasn't surprised.
Q Did you feel like your medical concerns mattered at all to the College?
A No, I didn't feel like they mattered.
Q And what actually were your medical reasons for not being able to wear a mask?

A When I put on a mask, I experience feelings of anxiety and a sense of claustrophobia, like somebody's cutting off my air supply. And so what that does is it decreases my concentration level, and it makes it difficult for me when I am treating patients and note-taking to maintain proper concentration and provide the best possible care to my patients, and so that specifically is what my mental concern was.

Q And were those things reflected in the medical documentation you received from the doctor that you saw?

A Yes, that was reflected in that doctor's note.

Q Now, of course, there's this original note from Dr. Salem. Did the College ask -- I shouldn't say the College, forgive me. Did the Complaints Director, Mr. Lawrence, did he ask for further details from Dr. Salem?

A Yes, he did.

Q And did Dr. Salem provide those?

A Yes, he did.

Q Was a decision made regarding Mr. Lawrence's request to suspend your practice permit?

A Yes, a decision was made.

Q And who made that decision?

A I believe Dr. Linford had to make that decision.

Q And as part of Dr. Linford's written decision, did he

consider your medical note from Dr. Salem?
A Yes, he did.
Q So then were you permitted by Dr. Linford to continue practicing without wearing a mask?
A Yes, I was permitted. There were further conditions and restrictions placed on me at the time, but, yes, I was permitted.
Q Did the College ever raise the possibility of you practicing without a mask but with conditions?
A Yes, it did, after Dr. Linford's decision came out.
Q What about before?
A No, there -- no.
Q Let's just talk a little bit about your office. Have you had any staff at your office since the spring of 2020?
A Yes, I employ members of my family in my office occasionally, and so, yeah, my son was working in the spring of 2020 up until December of 2020.
Q How old was he at that time?
A He was 17.
Q And as of December, just before he stopped working with you in your office, was he wearing a mask when he was working in your office?
A No, he wasn't.
Q And why is that?
A He has religious concerns and beliefs that preclude him

from wearing a mask.
Q Are those similar to yours?
A Yes, they are.
Q Yesterday, Mr. Lawrence read into the record as part of his testimony that you did not tell him, during the January 25th, 2021 interview, that you had any other reasons that you did not mask. Did you tell Mr. Lawrence you had other reasons for not masking besides your issues with anxiety and claustrophobia in that interview?
A I don't believe I did. Yeah, I'm unclear, but I don't think I did.
Q And you had by now, by January 25th, you had made some conclusions about your religious beliefs around masking?
A Absolutely.
Q So why didn't you tell Mr. Lawrence about those beliefs during that interview?
A I believe that the primary issue was my mental concern and limitation. The religious beliefs are very strong, but I didn't believe that that was to come into play at the moment, so I left it at the mental concern, because it appears to me, from the CMOH order, that the only real exemptions that are provided are through physical or mental concerns or limitations.
Q Just want to ask you a few questions about the

treatments you provide your patients. What is the standard treatment you provide your patients when they come in to see you?

A The standard type of treatment that I provide is a chiropractic manual adjustment. And "chiropractic" is a term that means chiro, it means hand, and practice, which means work done by hand, and so that is my -- from day one, that's been my primary form of treating patients.

Q Forgive my ignorance as a non-chiropractor, but did you just tell me that "chiro" means hand, and the reason it's chiropractic is because "practic" is a reference to practice, is that what you just said?

A Yes.

Q So the name itself means using your hands to treat the body of another?

A That is correct.

Q What system of the body does this treatment intend to impact or improve?

A That's a loaded question. There are many aspects to a person's body, many different systems, and so essentially when you adjust a person, you're physically adjusting the skeletal structure, but there are far-reaching implications to that, because in the chiropractic philosophy and science aspect of it, you're also removing nervous system interference, and

you're also causing soft tissues to perhaps relax and come into better function.

So you're dealing with multiple systems of the body, but you're primarily adjusting, you know, the skeletal soft tissue component from an outward perspective.

Q This treatment, this physical manipulation, is this the primary form of care you provide?

A Yes, it is.

Q Can you provide this treatment from a distance?

A No, you cannot.

Q Can you provide it over the phone?

A I wish, but no.

Q Can your patients providing this treatment to themselves?

A No, they cannot.

Q Are there any treatments you can provide your patients that are as effective as manual manipulation that do not require you to be within 2 metres of your patients?

A No, there is not.

Q Do you think Telehealth is effective?

A It may have its place, but it doesn't -- it's not effective in my situation for what I do.

Q Do you think your patients find it effective?

A I haven't had a single patient tell me that they've had a Telehealth experience or treatment.

Q Do you think you'd be properly caring for your patients if you could only provide them with Telehealth?
A Absolutely not.
Q Do you think it likely that some of your patients would eventually have to seek care from a different chiropractor if you could only provide Telehealth to them?
MR. MAXSTON: Mr. Kitchen, I hate to interrupt, but the last two questions in particular aren't questions; they're leading questions in my view. I'm sorry to interrupt you, but I've raised this concern before, but those are loaded questions, they're not a regular question.
MR. KITCHEN: All right, I'll rephrase.
THE CHAIR: Mr. Kitchen, this might be an appropriate time to ask you how much longer you anticipate your examination will be in terms of a possible break. We've been going for an hour-and-a-quarter, and we'd just like to get an idea.
MR. KITCHEN: Well, I might be about halfway, so a break would make sense to me. I'm pretty sure I'm on track here to finish by the lunch hour, as you can see, Dr. Wall is not a big talker. So I -- yeah, I think now is fine for a break, and we should not be in any jeopardy of not finishing by the lunch hour.

THE CHAIR: Okay, I think that would be a good idea. So let's take a break. It's 10:14 by my watch. Let's come back at 10:30, and we'll continue with Dr. Wall's testimony. So we'll convene for now, and we'll see everybody in 15 minutes.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, we're back in session, and, Mr. Kitchen, the floor is yours.

MR. KITCHEN: Thank you. We're having some technical difficulties. Just bear with me. Let's turn your mic on.

(DISCUSSION OFF THE RECORD)

MR. KITCHEN: Sorry, my apologies.

Q MR. KITCHEN: Dr. Wall, before the break, I'd asked you if you think you were properly caring for your patients if you could only provide Telehealth, and you answered no, and then the next question was objected to.

So let me ask you this: Do you think your patients are receiving the care they need from you if you're only providing them with Telehealth?

A No, they would not.

Q Do you think your patients would need to seek manual adjustment treatment from another private chiropractor if they couldn't get it from you?

A Yes, I believe they would.
Q How do you think your ability to keep practicing and earning an income would be impacted if all you could do was provide Telehealth?
A I believe it would be severely impacted. Again, hands-on procedure for me is the primary form of care that I provide. Patients would go elsewhere, and so, yeah, it would be severely impacted.
Q Do you care about more than just the musculoskeletal health of your patients?
A Yes, I do. I believe that a person is not just physical, there is an emotional and spiritual component to it, so if that's what you're referring to, but -- so, yes.
Q Thank you. Do you feel like you owe any other duties to your patients other than a duty to provide good adjustments to their musculoskeletal system?
A That's a very good question. I'm sure there are other duties. I would have to give that some thought, but that would be a primary duty is to provide safe and effective chiropractic care to my patients, so yeah.
Q When it comes to treating your patients, are there any principles that come to mind that are important to you?
A Again, I touched on this earlier, but the principle of, first, do no harm is an oath that we take when we graduate, become chiropractors, and so that

encapsulates the principle of we are to very cautiously and carefully and thoughtfully examine what we are doing with our patients and teach and instruct them, you know, lifestyle issues, but -- so that's a primary principle. And, again, the principle of informed consent is also paramount when it comes to dealing with treating our patients.

Q Do you think those principles are engaged when it comes to masking or the masking of your patients?

A I believe they're engaged in my office, so, yes, I instruct my patients. If I see there's a potential for something to cause harm, many times I'll have to educate my patients on that, and so yes.

Q Do you permit your patients to not wear a mask in your office?

A Yes, I do.

Q Why?

A I believe everybody has the responsibility to make their own health choices. Health freedom is very important to me, and, again, that is a decision that has to be between that person and their personal health belief, personal bodily autonomy, and so that's an extremely important aspect of how I treat my patients. So, yes, everybody that comes in has the freedom to wear a mask or not to wear a mask based on their personal decision.

Q Do you feel like the College's stance regarding mandatory masking has placed you in a difficult position regarding your patients?
A A very difficult position, yes.
Q Do you feel AHS's stance on mandatory masking has put you in a difficult position?
A It appears that the Alberta Health Services has left some room for people who have physical or mental concerns to exercise those concerns and not wear a mask.

It appears that the College has no wiggle room for that expression. If somebody has a mental or physical concern or disability, yeah, there's no wiggle room for the College when it comes to that and the members of the College.

Q Does the College require patients to wear a mask?
A No, it does not.
Q And you've given some thoughts on masks, you gave some thoughts back in the spring of 2020, and, you know, you've given some religious objections, but have your thoughts changed at all regarding masks in the last 18 months?
A No, they have not.
Q Do you think, if you did require your patients to wear a mask while you treated them in your office, that you would be causing harm to them?

A Yes, I do. I believe that wearing a mask does decrease oxygen levels, increase CO2 levels, and that, again, whether perceptive to that person or not, the physical fact remains, and it's to the extent physically that it imposes a real imminent physical harm and danger.

Q Have you read or heard anything, whether in this hearing or before, that has caused you to change your mind on the ineffectiveness of masks?

A No, nothing I've heard would cause me to change my mind.

Q Let's just discuss your office a little more. Are you aware of any instance where COVID was transmitted in your office?

A No, I am not.

Q Do you think you ever put any of your patients at a higher risk of contracting COVID than they would otherwise regularly encounter by treating them without wearing a mask?

A No, I don't. I am asymptomatic. I come to work; I have to adhere to the very same prescreening questions that all patients must adhere to.

When it comes to treatment, I treat patients one on one. There is no one else in the office but that patient and myself. And so, no, I don't believe that there is an increased risk.

Q Have you ever treated patients while being symptomatic

with COVID symptoms?
A No, I have not.
Q Do you think you've done anything since COVID that has in any way threatened the health or safety of your patients?
A Absolutely not.
Q Do you think your actions since March of 2020 have caused any harm to any of your patients?
A No, I do not.
Q Just a quick side question here, did you ever receive a ticket for not wearing a mask, contrary to the Calgary mask bylaw?
A No, I did not.
Q Do you think you are a health care worker?
A Yes, I do.
Q Do you think there are different types of health care workers?
A Yes, I do.
Q Do you think health care workers fall on the spectrum?
A Can you explain that question?
MR. MAXSTON: Mr. Kitchen, I hate to keep interrupting, but that's a fairly leading question, a fairly leading couple of questions, "Do you think". I'd just ask you to rephrase that. I know where you're going, but I think the introduction presupposes an answer.

Q MR. KITCHEN: Now, Dr. Wall, you said that you do think there are different types of health care workers. Please explain, in as much detail as you can, what you think those differences are?
A I would say that there are emergency room doctors, there are paramedics, there are pathologists, all could be classified, there are chiropractors, naturopaths, all could be classed as health care workers, facing all kinds of different situations and treatments and patient needs. So, yes, there is a very wide spectrum of health care workers.
Q And how would you say, you as a chiropractor, how would you say that's different than, for example, being a doctor in an ER?
A Quite different in the sense that, number one, I'm seeing people one on one, I'm seeing people who have been prescreened in this last year-and-a-half, and I am seeing people who are asymptomatic obviously. And I would say that somebody in the ER, a doctor, is seeing more emergency types of situations with significant potential for bodily fluid contact and so on. So I would say it's a much different experience than what I'm doing in my office.
Q Do you think your chiropractic office is a health care setting?
A Yes, I do.

Q Do you think all health care settings are the same?
A No, I don't.
Q Could you describe for me how you think the health care setting in your office is different than the health care setting of a hospital?
A I believe the setting in my office is much more personable if you're looking at it from an emotional component perhaps, so it's much more welcoming; it's a homier feel; it's I would say much smaller; there's less fear involved in my office compared to perhaps a hospital or an ER setting.

So -- and I'm treating people with chiropractic care; I'm not treating people for cuts and stitches and broken bones and these types of situations, so I would say there's quite a big difference.

Q Is making your patients feel comfortable really important to you?
A Yes, it is; it establishes a sense of trust and, yes, so people want to come to my office. It's a very important part.
Q Do you directly treat infectious illnesses?
A No, I do not.
Q Do patients come to you for you to directly treat infectious illness?
A No, they do not.
Q Do you agree with Dr. Halowski that, generally, as a

chiropractor, you don't see people with infectious illnesses?

A No, people will have infectious illnesses. So I will see people with infectious illnesses, but I am not treating them for infectious illnesses. If I could clarify that also.

Q Go ahead.

A That's not a norm; that's a very rare thing. And, again, in the last year-and-a-half, we have to prescreen people. So if they are exhibiting any symptoms, we are not allowed to treat them; you have to reschedule them. And so in this last year-and-a-half, I have not seen anybody that has exhibited a symptomatic infectious illness.

Q You mentioned "prescreening" a lot; is it your understanding that prescreening is something that's quite important to the College?

A Yes, it is very important.

Q Have you received any communication from the College that indicates which is more important between prescreening and masking?

A No, I have not.

Q I'm going to shift gears a little bit here. Do you think it's possible to know the scientific truth about things like viruses?

A Yes, I do.

Q Including COVID?
A Yes.
Q Do you think there's a large amount of scientific information now available about COVID?
A Yes, a lot of information.
Q Do you think it's enough to actually make an informed determination on whether or not certain measures are effective at preventing the transmission of COVID?
A Yes, I do.
Q And would that include masking as a measure?
A Are you asking if masking is an effective measure at preventing COVID?
Q No, I'm just wondering if you think there's enough scientific knowledge to actually make an informed determination on whether or not masking is effective or not?
A Yes, I do believe that.
Q Do you think there's enough scientific information to make an informed determination on whether or not physical distancing is effective?
A Yes, I do.
Q Do you think there's enough scientific information available now to make an informed determination on whether or not masking as a restriction is harmful to the health of individuals?
A There is enough information, yes.

Q Would you agree with Dr. Hu that COVID Public Health restrictions have probably killed more people than COVID itself?
A Yes, I would agree with that. Yes, I would agree with that.
THE CHAIR: I'm sorry, Mr. Kitchen, I missed your question; would you mind repeating it, please.
MR. KITCHEN: Sure, yeah.
Q MR. KITCHEN: Dr. Wall, do you agree with Dr. Hu that COVID Public Health restrictions have probably killed more people than COVID itself?
A Yes, my answer is yes.
THE CHAIR: Thank you.
Q MR. KITCHEN: And just to confirm, do you agree with Dr. Hu that the COVID survival rate is 99 percent?
A Yes, I agree with that.
Q Do you think the College is making scientific knowledge the top priority when they make decisions about restricting the behaviour of chiropractors?
A I believe the College thinks they have. I think they have consulted with Alberta Health Services, and they believe that they are using information that is accurate, but I believe it is inaccurate. And there's too much conflicting scientific evidence that comes

from very credible, credible sources that would contradict the measures that have been put in place.

I am not a lone wolf stating some of those scientific issues. These scientific facts come from people much more knowledgeable and skilled to be able to represent that information in their fields of expertise, and so, yeah.

Q Well, in fact, some of those people are going to provide expert testimony.

Do you find it surprising that the College seems so unwilling to consider other viewpoints like yours?

A Not really, because I understand that our College is regulated by the Health Professions Act, which has a strong medical model, and there is a certain mindset about how legislation is formulated. So I can -- I'm not surprised by it, but I wish it were different.

Q Do you think Alberta Public Health has generally gotten it wrong when it comes to masking?

A Yes, I do.

Q Do you think Alberta Public Health has generally got it wrong when it comes to other COVID restrictions?

A Yes, I do, and I wouldn't say that's just my opinion. As we know, that will be backed up by our expert witness, and it is a testimony of so many others in so many different fields, not only health care, but emergency preparedness within the military, it's been

demonstrated that what has happened in the last year-and-a-half has not followed the methods that would be acceptable for an emergency situation such as COVID.

Q Do you think there is fear to challenge the perspective of Government Public Health?

A Yes, I do. Fear is a very big motivator in this situation, always has been. And in this situation, yes, if you stand up to the Public Health authority or your regulatory body, you risk -- you risk being censured, you risk your licence being suspended, and nobody wants that, nobody wants to experience what I'm experiencing right now. There are other chiropractors out there who believe as I do, but they are afraid of being in my situation.

I am the -- I would say one of the least likely people to be in this situation right now. From the standpoint that, if I can say, I am a very compliant person, generally speaking. I do not like to make waves. I do not like conflict. But a barrier was crossed, my health freedoms were crossed, and I have to say something, and I know I'm not the only one. I know there are many others out there, but they're afraid. And so, yes, that is a very accurate statement: Fear is a huge motivator to not step out.

Q Do you feel like, as a professional, you have an ethical obligation to speak the truth?

A Absolutely.
Q You described just a few minutes ago COVID being an emergency, did you think it was an emergency last spring?
A It was put out that way, but, no, I did not think it was an emergency.
Q Do you think it's an emergency now?
A No, I do not.
Q Is your integrity something that's really important to you?
A Extremely important.
Q If you were told that there was going to be an application to suspend your licence, why didn't you just put the mask on?
A Well, number one, as I've said, wearing a mask causes me anxiety and the inability to concentrate properly to do my -- the best work I can. So that's reason number one.

But I also understand it to affect my physical health. I know there's -- there are physical limitations and harms about putting a mask on, and so I had to -- I had to go with a personal health choice and freedom, bodily autonomy. No informed consent was provided to me by the College, and I had to stand up for those basic rights and freedoms.

Q Even though doing so might risk your licence?

A Yes, that's correct. I would emphasize character over reputation.
Q Do you think the College has violated your legal rights over the last year-and-a-half?
A Yes, I do.
Q Do you think the College's mandatory masking directive is unreasonable?
A Yes, I do insofar as other mandates, orders have allowed provisions for exemptions, and the Pandemic Directive has not allowed for any exemptions.
Q Do you think you've done anything unethical by permitting your patients to leave their faces uncovered when you treat them?
A No, I do not.
Q Who do you believe you owe your first loyalty to?
A First loyalty is to my patients. It's -- that's who I come to see every day, and they're my priority. And so, yeah, my ethical and moral responsibility is to my patients primarily, not to the College.
Q What about government?
A Well, the same would go for that. Ethically and morally, it's first to my patients, and if there's something I see from the government that violates that, I have to speak up, and I have to stick to treating my patients and treating them with the utmost respect first.

Q Do you think you've done any unethical by not wearing a mask yourself when treating your patients?
A No, I don't.
Q Do you have any concerns about the future of the chiropractic profession in Alberta?
A Yes. I have spoken about this to my wife. Over the last ten years, I have seen the steady increase in regulatory control, which has a veneer of protecting the public with decreased freedom for the chiropractor, and I've seen it occurring, and so, yes, I do have concerns for the chiropractic profession at this time, yes.
Q Do you think increased freedom for chiropractors to do lawful things is good for patients?
A Yes, I do.
Q Do you think if chiropractors were less constrained by the College that they would be more likely to engage in sexual impropriety with their patients?
A No, I don't. Somebody who's going to engage in sexual impropriety, whether there are restrictions or not, is likely going to commit that offence.
Q Why do you think the College has done all that it's done to you since December of 2020?
A I understand the College has a responsibility to protect the public, and that, again, is what they consider to be their highest mandate over protecting

the rights and freedoms of its members. And so I think, based on the legislation that has come down from the Public Health and the collaboration that has happened to create our Health Professions Act has created a difficult situation for the College whereby they cannot make this distinction between protecting the public and protecting the rights of its members.

And it's a very fine line. I think there needs to be some renegotiating that occurs to balance that out. I am not against rules and regulations, but I believe in this situation, there has been a line that has been crossed, so ...

Q Do you think mandating that chiropractors wear masks while treating patients is in any way actually protecting the public?

A No, I don't.

Q Do you think the College is trying to protect the public?

A Yes, I do.

Q Do you think the College is very concerned with pleasing the Chief Medical Officer of Health?

A Yes, I do. Again, I believe that much that has been collaborated with the Alberta Health Services and the College of chiropractic has created this dynamic, this relationship whereby the College does want to please authority, and so yeah.

Q Do you think when it comes to COVID, there is a tension between the desire to please government and the duty to protect patients?
A Are you referring to the College or to myself?
Q I'll ask it again. Do you think, in the context of COVID and when it comes to the College, there is a tension there between desiring to please the government and desiring to protect the interests of patients?
A I don't think I'd be able to speak to that because I'm not part of council, I'm not part of those people that make those decisions. That would be a tough decision for me to say. I don't think I could say that.
Q I asked you earlier if you ever received a ticket for not wearing a mask contrary to the Calgary bylaw; did you ever receive a ticket for not wearing a mask contrary to a CMOH order?
A No, I have not.
Q Do you think you've actually breached any CMOH orders?
A No, I don't.
Q Have your patients expressed any thoughts to you about the fact that you have -- that you're not wearing a mask?
A Did you ask have they expressed any concerns that I'm not wearing a mask?
Q No, I asked if your patients have expressed any thoughts about the fact that you're not wearing a mask

when you treat them?

A Yeah, I've had a few patients express their thoughts, so we have engaged in some discussion, and there are some people that believe in mask wearing, there are some people that don't believe in mask wearing, and so, yeah, I have definitely interacted with both sides of the fence with respect to that.

Q Do you think the fact that masks are mandated in spaces like chiropractic offices, do you think that interferes at all with that, an attempt by you to create an emotionally welcoming environment?

A Yes, I do. I believe when you cover the face with a mask, you are taking away a significant portion of communication ability. You're not able to read lips. You're not able to see facial expression as well. And not only that, your voice is muffled. So many times you can't hear or distinguish what the person is saying. So, yeah, it definitely creates a less welcoming environment, an environment for potential or greater misunderstanding between you and the patient, and, yeah.

MR. KITCHEN: Thank you, Dr. Wall. Those are my questions.

A Thank you.

MR. KITCHEN: Now, I note we're at 11:20, which is a little early for lunch, so, you know, I

guess we'll have to hear from Mr. Maxston what his thoughts are about his cross. I doubt he wants to break it up with a lunch break, so -- but I'm very flexible.

THE CHAIR: Okay, thank you, Dr. Wall, thanks, Mr. Kitchen.

Mr. Maxston, what are your thoughts on next steps?

MR. MAXSTON: Well, I'm going to propose this potentially: Maybe we take a break for 10 or 15 minutes. What I -- because I'd like to press on with Dr. Wall in just one respect.

I've been making notes of the direct examination, and I have questions arising from that. I wonder if it's a good idea for me to try and get through those questions now while Dr. Wall's testimony is fresh in everyone's mind, and then -- and I hope I can do that before lunch. And then at 1:00 or 1:15, whatever works, then I would start my planned questions if I can describe it that way.

I'm just a little reluctant to -- I think Mr. Kitchen's nodding his head -- I'm a little reluctant to start lunch at 11:30. Maybe I can make some headway at least with Dr. Wall in a good way in terms of asking those questions now. I just need a little bit of time to prep for that and consult with my client.

THE CHAIR: Okay, Mr. Kitchen, I'll take your nodding as agreement with that approach, so --
MR. KITCHEN: Yeah, if we could just have 10 minutes, because we've got to work on the technology on our end too, so ...
MR. MAXSTON: I think even 15 minutes to be honest, yeah.
THE CHAIR: It's 11:20, let's recess until 11:35. We'll reconvene then, and Mr. Maxston can start his cross-examination.
(ADJOURNMENT)
THE CHAIR: We're back in session, and, Mr. Maxston, the floor is yours.
MR. MAXSTON: I just want to be sure, is Mr. Dawson in attendance? I don't know if he's gone -- if he's activated his camera.
THE CHAIR: Okay, yeah, we were having a caucus during the break, so he might be a minute or two late. Thank you, I didn't notice that. Let's just wait for Mr. Dawson. He won't be long I'm sure.
(ADJOURNMENT)
THE CHAIR: Okay, not to interfere in the exchange, but Mr. Dawson is back, so we'll resume the session with Mr. Maxston and his cross-examination.
MR. MAXSTON: So again, Mr. Chair, what I'm going to do now is I'm going to go through my questions

that I noted during Mr. Kitchen's direct examination, and I'm going to stop at 12, regardless of where I'm at, whether I'm finished or not. I'll finish after 1:00, if need be, with those questions, and I'll then begin my more structured questions after that.

Mr. Maxston Cross-examines the Witness

Q MR. MAXSTON: Dr. Wall, in the beginning of your questions with Mr. Kitchen, you talked about the fact that, in your mind over 20 years, you've seen a -- I think you said a slow and steady decrease -- slow and steady change, pardon me, in the College and I think an increase in restrictions. Wouldn't it be fair to say though that professions evolve and grow, and we become better at regulating professionals over time?

A I would say we evolve and grow but not necessarily better.

Q You had a discussion with Mr. Kitchen, and in fairness to him, you talked about restrictions coming from the College, and you said, well, they also came from government; and you were talking there about the CMOH orders and I think the re-opening order, that type of thing. You're aware that all professions have to have a re-opening plan and have to have some type of restriction on masking; is that correct?

A Yes, I'm aware of that.

Q So it wasn't just this college or you as a

chiropractor?
A That's right.
MR. KITCHEN: Sorry, Mr. Maxston, I sincerely apologize. I have another headset, and I'm going to go quickly get that and put that on, because I just want to make sure that there's no feedback that's interfering with you; is that all right if I just run and do that?
MR. MAXSTON: Oh, I don't I can continue without that, Mr. Kitchen, so you've got to hear the question, so, yeah, sure thing.
(ADJOURNMENT)
THE CHAIR: All right, we're back on the record. Mr. Maxston.
Q MR. MAXSTON: Dr. Wall, you had a discussion where Mr. Kitchen asked you did the Pandemic Directive include direction to reach out to the College if there were problems with masking, and I think your answer was no.
Isn't it fair to say though that you can always reach out to the College? You don't need, a standard of practice, for example, doesn't have to say, Call us if you have a question or a policy on this or that; you can always reach out though, can't you?
A That's right.
Q You had an exchange with Mr. Kitchen about the

requirement to obtain a doctor's note, and you said there was nothing in the Pandemic Directive requiring that, and I think you also mentioned that your health information is private between you and your doctor. If you were to disclose that information to the College though, it wouldn't become public, would it?

A Insofar as addressing it to the College is addressing it to the public. The College is not my doctor, and so I believe that's public.

Q But I guess what I'm getting at is if you send that information to the College and you say, Look, I've got a medical condition, that information is not distributed to the public at large; it goes to the College; isn't that correct?

A That would be correct.

Q You had a discussion about your March 3 email to Dr. Halowski, and I believe you said you didn't receive a response. This isn't a gotcha question, I just want to say to you that Dr. Halowski, his recollection, is that there was, in fact, a response, and it was a March 4 email to you, where he essentially said, Thank you for your note, I'm going to send this to counsel. I'm just asking if that refreshes your memory about getting a response.

A Yes, that is very correct, but no further follow-up to that.

Q Just wanted to be clear that it wasn't unanswered.
You had a discussion about I think your apprehension with coming forward to the College, and you said you were reluctant to do so because you felt the College would not be supportive, but isn't it fair to say from June until December, you really didn't reach out to test the College's temperature, so to speak, on this?
A That is correct, but I also, as previously stated, did not believe that it was the College's position to hear my private health information, and so that is another reason why I didn't reach out to the College.
Q I think you'd agree with me though when you do your annual practice permit renewal, there are questions that go to your personal and private information. You have to disclose fitness to practice issues and those types of things, and you would routinely send that to the College, wouldn't you?
A Did you say "fitness practice issues"?
Q Sorry, fitness to practice is what I said.
A Yes.
Q You had a discussion with Mr. Kitchen at a number of points about consent and informed consent regarding masking, and I think you said that the College's mandatory masking requirement for you violated consent, and I'm going to suggest to you that that's the wrong

way about looking at consent, and that patient consent is the proper way to frame that phrase, and it's about getting consent from a patient to treatment. So the College doesn't have to get consent from members, do they, to Standards of Practice or things like the Pandemic Directive?

A I would disagree with that because my position would be the wearing of a mask is a medical procedure or a treatment, and, as such, it requires informed consent.

Q Aren't all of the College's requirements though, like infection control, those kinds of things, wouldn't it be a little unusual to say members have to consent to all those types of things?

A I'd have to say that mandating a mask poses an imminent risk to mental or physical harm, whereas infectious measures perhaps don't carry that imminent risk to harm, and so I would disagree with that.

Q Well, we'll agree to disagree on whether consent really applies here then.

One thing to be clear though, the College in the Pandemic Directive never said there must be masking for patients, correct?

A That is correct.

Q You had a discussion about what happened when you stopped masking and how patients reacted, and I think you said most never said a thing, 99 percent were

unconcerned, but, Dr. Wall, isn't it fair to say that patients don't vote on what standards apply to their health care provider?

MR. KITCHEN: I take an issue with that, because that's not a proper quote from what Dr. Wall said, he didn't say anything about 99 percent. So perhaps we need to go back to the record, but, Mr. Maxston, I only object to that question because you're putting words in Dr. Wall's mouth that aren't his.

MR. MAXSTON: You know, I think he did say 99 percent, but that's really not the point of my question, (INDISCERNIBLE) just forgetting than that (INDISCERNIBLE) --

Q MR. MAXSTON: But I think you had a -- made a comment that most of your patients never said a thing, but, again, my question is then patients don't vote on what you should or shouldn't apply as part of your practice when it comes to your college; they don't tell you what to do; is that not correct?

A That's correct.

Q You, in response to a question about why so many patients were understanding, you mentioned that there was patient trust and character, and you said that there was no risk of harm to your patients. And I'm going to suggest to you that that's, frankly, kind of

an astonishing statement to make. Are you absolutely confident that not masking poses absolutely no risk to your patients?

A Yes.

Q I want to turn to some of the questions you had with Mr. Kitchen about the phone discussion you had with Mr. Lawrence, and I think you mentioned that the College was in a difficult place, but their role is protecting the public. You've talked about literature not supporting masking and kind of talked about what I think you felt were Mr. Lawrence's -- the tone of his comments. But I just want to be clear, Mr. Lawrence, at that stage, is the Complaints Director; he's not making any findings of unprofessional conduct, is he?

A That's --

Q I don't mean to trick you, that's the Hearing Tribunal, isn't it?

A I would agree, yes.

Q So you talked to Mr. Kitchen about the commencement of an investigation, and that's a discretion that a Complaints Director has, correct?

A Yes.

Q And, again, this isn't a gotcha question, but Section 65 of the HPA allows a Complaints Director to seek a suspension; is that not accurate?

A Yes.

Q And I think you said in response to, again, one of the questions about Mr. Lawrence's interaction with you, you said that Mr. Lawrence advised you that he was fulfilling his public protection duty; is that accurate?
A Yes.
Q Mr. Kitchen asked you a question about what happened after your discussion with Mr. Lawrence. I think there was a question about whether Mr. Lawrence asked you anything about your private life, and you said no, and the question was something along the lines --
MR. MAXSTON: -- Mr. Kitchen, you can jump in --
Q MR. MAXSTON: -- did you then feel free to decide to wear or not wear a mask, and your answer was, no, you felt the strong arm of the College was about to step in and stop your practice. But it really wasn't the College that stepped in to stop your practice, it was AHS, wasn't it?
A Well, it was AHS that closed my practice in December, but it was the College that was ensuing the investigation further and looking into the suspension of my licence.
Q Again, what I think I was really getting at is your wording was that you were afraid the College was going to step in and stop you from practicing, but the

College never did that ultimately. Dr. Linford didn't do that, and it was AHS that did that?

A Yes, but this is still an ongoing investigation, and the College still has the possibility of shutting my practice down if they deem so at the end of the hearing.

Q And I guess I disagree with you a bit. I would say it would be a Hearing Tribunal not the College, because the Hearing Tribunal issues orders.

You talked about your son practicing at the clinic, and you indicated that he wasn't masking. Did he have a medical exemption note?

A No, he did not.

Q He didn't have a doctor's note then is what I'm getting at?

A That's correct.

Q You talked with Mr. Kitchen about the standard treatment you provide to patients, and you engaged in an interesting discussion about hand and practice and chiropractic, filling us all in on the nature of that, but I really want to stress, I think this is consistent with Dr. Halowski's testimony yesterday, you would agree there are other elements of practice, like educating patients?

A Absolutely.

Q And consulting them?

A Absolutely.
Q Yeah, and you can do that with social distancing?
A Absolutely.
Q Mr. Kitchen asked you questions about the principles that you employ in your practice, which ones are important to you, and I think you said the first one is do no harm to patients. Have you ever considered what the impact would be if you were wrong about masking?
A I'm confident in my understanding of masking to such an extent that I know it's not harmful.
Q Mr. Kitchen asked you a question, do you permit patients to not mask, and I believe you said yes, and he said why, and you said about freedom to make their own choices, something along those lines. I wonder if you can go back to Exhibit D-2, which is the AHS rescind order, which re-opened your clinic. And I'll just give you and the Tribunal Members a couple of minutes to go to that. Are you there, Dr. Wall?
A Yes, I am.
Q Okay. Order Number 4 says: (as read)

> Dr. Curtis Wall must ensure that all patients he treats continuously wear a mask that covers their mouth and nose for the duration of their time in the clinic, unless they are able to provide evidence that they have been granted a mask exemption.

I'm going to suggest to you that you're in breach of that order, aren't you, because you don't require a mask exemption order or letter?

MR. KITCHEN: Mr. Maxston, forgive me, I'm going to object to your question only on the basis that you just called this an order; it's not an order. If you call it what it is, then I have no issue with your question.

MR. MAXSTON: Well, you know what, it says "following conditions".

Q MR. MAXSTON: So you're not in compliance with Condition Number 4 then?

A That would be correct.

Q Yeah, and to be clear, the first line says: (as read)

> Notice is to inform you, on January 5, 2021, the undersigned Executive Officer of Alberta Health Services rescinded an order.

So they're rescinding an order, and they're placing new conditions on your practice; that's correct?

A Correct.

Q And, again, Order Number 4 -- sorry, Provision Number 4 is something you're not complying with? Correct?

A Correct.

Q You had a discussion --

MR. MAXSTON: I'm just mindful of time here; I think I can wrap this up in just another maybe 5

minutes.

Q MR. MAXSTON: You had a discussion about AHS, and you said that there was really no wiggle room from the College as a result of AHS's I guess pronouncements, but for seven months, you never inquired about whether there was any wiggle room, did you?

A No, I did not.

Q You had a discussion about requiring patients to mask and causing them harm and discussed your concerns about oxygen and carbon dioxide, and you said even -- I think you said even if it's imperceptible, that is, imminent physical harm and danger; isn't COVID also an imminent physical harm and danger?

A If you look at the statistics of people who are dying from COVID and the recovery rate, 99.97 percent of people recover, and this is no different than an average seasonal flu. And so if an average seasonal flu is also an imminent risk or harm, then, yes, we could say they're on the same level.

Q I think along the same lines a little later on, you made a comment that COVID-19 isn't an emergency; is that your recollection?

A Yes, it is.

MR. MAXSTON: This isn't in evidence, so, Mr. Kitchen, you can object if you want.

Q MR. MAXSTON: But we hear on TV about the fourth wave, you heard last year about the first, second, third wave, and high ICU numbers and hospitalizations. If COVID isn't an emergency, what is?

MR. KITCHEN: I'm going to have to object. It's a hypothetical, plus you're bringing in evidence that's just not --

MR. MAXSTON: Sure, I'll rephrase it.

Q MR. MAXSTON: Why isn't COVID an emergency?

MR. KITCHEN: Okay, hold on. Again, you're asking an opinion that's completely out of the scope to give.

MR. MAXSTON: Well, Mr. Kitchen, your client described COVID as not being an emergency, so he's offered that view. I'm certainly allowed to question him about that.

MR. KITCHEN: All right --

Q MR. MAXSTON: And I'll just base the question: Why isn't it an emergency?

A I'm basing that on the research that I have heard. I'm basing that on many people that are well beyond my knowledge level with respect to emergency -- emergencies and emergency preparedness, and so that is, again, an opinion based on other expert evidence, not my own.

MR. MAXSTON: Mr. Chair, can you give me 5 minutes. I think I can finish up a little bit into the lunch hour. Is that fair?

THE CHAIR: Yeah, that's fine.

MR. MAXSTON: Okay, I'll try to be quick.

Q MR. MAXSTON: You had an exchange with Mr. Kitchen about whether there was any comment from the College about which is more important, prescreening or masking, and I think you said no, but you'll recall when I took Dr. Halowski through Exhibits C-21 to C-22, don't those contain numerous statements where the College is inviting you to contact the College?

A Can you rephrase that question, please?

Q Yeah, you said that there was no comment from the College about which is more important, prescreening or masking. And I'm going to suggest to you that that really isn't the issue; that you could have reached out to the College and asked them what was more important.

A Yes.

Q You made some comments in response to a question that you believed that the College consulted with AHS and that it believes the information is accurate and that it's relying on that, so would it be fair to say that, in your view, the College is acting in good faith when it's carrying out these pandemic steps?

A According to their idea of good faith, yes.

Q There were a number of questions Mr. Kitchen asked you about were you surprised by the College doing this, or the College created this step, did these things, and I think my concern with that was isn't it fair that the College is made up of chiropractors?
A Yes, a majority of chiropractors, and I believe there are some public members.
Q Yeah, I think, in fairness, you're quite right on council and on Hearing Tribunals, there are public members, but I think my concern was that the way those questions were phrased and the way your answers were phrased, it made it sound like the College was sort of a third-party entity out there, kind of hovering around. The College is made up of chiropractors, and don't chiropractors vote on these, as councillors, vote on pandemic directives and standards of practice?
A I don't know if every individual chiropractor actually voted on the Pandemic Directive.
Q I should have been more precise, you're right, chiropractors on council.
A Yes.
Q So these are decisions, at least in part, where public members made by chiropractors to apply to the chiropractor profession?
A That's correct.
Q You talked about the Pandemic Directive being

unreasonable because there are no provisions for exemptions. Do you recall Dr. Halowski's testimony that, in his knowledge, no other college has exemptions for masking?

A Yes, I do.

Q I'm almost there. Mr. Kitchen asked you a question to the effect of is the College very concerned with pleasing the CMOH, and you said -- I think you said yes, and there's collaboration between CMOH and AHS and the College. That's really your opinion though; you don't -- haven't tendered any evidence to support that, have you?

A No evidence tendered, but it stands to reason that there has to be collaboration between the College and Alberta Health Services.

Q One of Mr. Kitchen's final comments, and this is my -- I think my final question was do you believe you've breached any CMOH orders, and you said no. But isn't it fair that when we look at the AHS closure order, they referred to CMOH orders being breached, and that's why they closed the clinic?

MR. KITCHEN: Mr. Maxston, I don't know that you're -- I think you're misleading here, because you are saying --

MR. MAXSTON: (INDISCERNIBLE)

MR. KITCHEN: -- well, you're saying in your

question that there's a breach of a CMOH order. Well, that's kind of an ultimate issue. If there was no doctor's note from Dr. Wall verifying that he fell into an exemption, I'd agree with you, but --

MR. MAXSTON: You know what I'm going to do, I'm going to -- it's a fair comment, Mr. Kitchen.

Q MR. MAXSTON: Just very briefly, Dr. Wall, can you go to the closure notice, which is Exhibit D-1. I'll get everybody to do that, and, I'm sorry, this is my last question.

And, Dr. Wall, let me know when you're there, and I'll start my question then.

A Yeah, go ahead.

Q So what I was really getting at is (a) and (b) are kind of mirror images, this is on page 1, but it says -- I'll just read item (a), and then there's a question: (as read)

> Practitioner does not wear a face mask while providing care within 2 metres distance from patients. This activity could contribute to the spread of COVID-19. This is a breach of Section 2(1) of the nuisance and general sanitation regulation, which states that [I won't read that out] and of Section 26 of the CMOH-38-2020, which states that ...

So on the face of it, this order says you're breaching

a CMOH order.

A Yes, on the face of it.

MR. MAXSTON: Okay, those are all my questions, Mr. Chair. Thank you for your indulgence in going a little bit into the lunch hour.

I welcome Mr. Kitchen's comments, we could reconvene at 1:00, we could reconvene at 1:15, whatever your decision is.

THE CHAIR: Before we decide that, can we get an idea of what the afternoon will look like?

MR. MAXSTON: I expect I will be a couple of hours in questioning Dr. Wall. I don't know how long of course Mr. Kitchen's cross-examination -- or, pardon me, redirect will be, and then, of course, there's your time for questions.

I'm hopeful we can get through Dr. Wall today but --

Q MR. MAXSTON: And, Dr. Wall, you've given me some very short answers at times, which is helpful for moving ahead, but at other times, I'm sure you're going to want to elaborate on some of my questions.

MR. MAXSTON: And, in fairness, I do have a lot of questions for Dr. Wall.

THE CHAIR: Okay, Mr. Kitchen, is that your vision of this afternoon? I don't see us calling any other witnesses today, unless we get --

MR. KITCHEN: I have --
THE CHAIR: -- through more quickly.
MR. KITCHEN: Well, I have one witness standing by, who is one of the four patient witnesses, so it will be quick. Each one of these four patient witnesses will be quick. Mr. Maxston and I have talked about this.

So as I see it, we're likely to be done with Dr. Wall by 3:30, 3:45. I'd like to use the entire day to get one more witness in, considering how slow we're moving and that -- you know, yesterday, we finished -- it's my fault, I understand this, but yesterday we didn't quite use the full time; I'd like to try to use the full time to get in that one extra witness, because I cannot see that taking more than an hour total.
MR. MAXSTON: I think maybe, Mr. Kitchen, I'd invite your comments, maybe just see where we're at by, you know, 3:00, 3:30, and then -- I know it's tough to have a witness hanging, but I'm going to be very brief with that witness if we get to him or her today.
MR. KITCHEN: Okay, well, I, yeah, that's important to me that we at least try to preserve that.
THE CHAIR: Okay, that's our objective. So we will recess for lunch. It's 10 after 12, so let's reconvene at 1:15, and we'll continue with Mr. Maxston's cross-examination at that time. Thank

you.

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 8, 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

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 1:15 PM)

THE CHAIR: Okay, it's 1:15. Mr. Kitchen, you're okay; your technology is okay?

MR. KITCHEN: I'm ready to go.

THE CHAIR: Okay.
MR. KITCHEN: Can you hear me? Good.
THE CHAIR: Yes, we can hear and see you.
So, Mr. Maxston, the floor is yours.
Discussion
MR. MAXSTON: Sure. Mr. Chair, during the break, I think about 12:15 or so, 12:20, I asked Ms. Nelson to send Mr. Kitchen a document I intend to rely on in cross-examination, and it is the email exchange, the March 4 response from Dr. Halowski and Dr. Wall's March 3 email to him.
I, frankly, don't intend to spend a lot of time with that, but I, of course, wanted to send it to Mr. Kitchen. I'm going to get to that probably 5 or 10 minutes into my examination. I wonder if Mr. Kitchen will consent to Ms. Nelson sending that to the Hearing Tribunal Members now.
MR. KITCHEN: Yeah, that's fine. Just forward it to Dr. Wall, so he has a copy.
MR. MAXSTON: And, again, I don't intend to spend a lot of time with that. I think it should probably be marked as an exhibit, and I think we might be up to H-4 or 5, if we are -- Mr. Chair, and Ms. Nelson can do that; she can put it into the Dropbox, and we'll ask the court reporter to mark that as part of her --

MR. KITCHEN: I do have an issue with -- okay, let me just pull up what you sent me here, because I think I might --

MS. NELSON: I also just want to hop on and let you know, Walter Pavlic is not currently on the call, so I'm just going to give him a call on his cell phone and try to get him in the meeting. It looks like he's dropped off.

THE CHAIR: Yeah, and my oversight. Thank you, Amber.

MR. MAXSTON: Mine as well. Maybe, Mr. Kitchen, we should not discuss this further until Mr. Pavlic comes online.

MR. KITCHEN: That's fine. Yeah, no, but I do want to discuss a point with you.

MR. MAXSTON: Yeah.

(ADJOURNMENT)

MR. MAXSTON: Mr. Pavlic, just before you came on, I mentioned to the Chair that, I think about 12:15 or 12:30, I asked Ms. Nelson to send Mr. Kitchen a document by email that I intend to rely on in cross-examination, and it is the March 3, 2020 email from Dr. Wall to Todd Halowski, and Dr. Halowski's March 4 response. I'm going to briefly refer to that in my cross-examination. I would like that to be entered as an exhibit, and I understand Mr. Kitchen

might have some questions about that, so I'll turn the floor over to him.

MR. KITCHEN: I received instructions from my client, and there's no objection to putting that in as is.

THE CHAIR: Okay, thanks, Mr. Kitchen. So if we could have that document shared to the members of the Hearing Tribunal and --

MS. NELSON: So what I'm going to do, I'm going to add it to the Dropbox file, you should all still have access to that file. I'm going to put it in File H, so you can find it there. Just give me about 2 minutes to add that in, and I'll let you know when it's there for your review.

THE CHAIR: Would it be possible to email it?

MS. NELSON: Sure, yeah, I can email it instead if that's easier for everyone.

THE CHAIR: It's certainly easier for me than having to go in and getting into the Dropbox again.

MS. NELSON: Okay, so what I'll do I'll send everyone an email now, all the Tribunal Members, so you have it, and then while the hearing's in session, I'll still upload it to Dropbox, so, Karoline, you'll be able to find it in File H.

EXHIBIT H-7 - Response to Curtis Wall Re - Vaccinations

THE CHAIR: Excellent, thank you, Amber. Mr. Maxston, are you going to start with this document?

MR. MAXSTON: No, I think in about 10 minutes I'll get to it, and it will be very brief, so I wonder if I might just start now, and when I get to that, I'll get to that document, I'll make sure everybody's been able to access it.

THE CHAIR: I think that's a wise idea. Let's use the time.

DR. CURTIS WALL, Previously Sworn, Cross-examined by Mr. Maxston

Q MR. MAXSTON: So, Dr. Wall, I'm just going to ask you a couple of questions about your educational background baed on what Mr. Kitchen said, and I understand you graduated from Palmer College in Davenport, Iowa, in 1996. Did you receive any public health education at Palmer?

A Yes.

Q And was that health education in relation to public disease management?

A No, it was not. It was a very basic course, going over basic microbiology and discussing infectious diseases, but not in management.

Q And do you have any advance training or degrees in public health?
A No, I do not.
Q When you graduated from Palmer, do you recall taking an oath that included, in part, an obligation to preserve the integrity of the profession?
A Yes, I do.
Q You came a licensed chiropractor in 1996 in Alberta I understand, and I believe you said this during your discussion with Mr. Kitchen, but would you agree that practicing in the profession of chiropractic is a privilege not a right?
A Yes, I would.
Q And would you also agree that the chiropractic profession is a self-regulating profession under the Health Professions Act in Alberta?
A Yes, it is.
Q I'm not going to ask you to go to this, but are you familiar with Section 3 of the Health Professions Act and the public protection mandate it establishes for colleges?
A I believe I've read through it, yes.
Q You're also, I'm assuming, familiar with the fact that the College, as a regulator, governs the conduct of chiropractors in their professional capacities?
A Yes, I'm aware of that.

Q Section 3 of the HPA, and, again I'm not asking you to go there, talks about the College establishing and enforcing requirements for the profession, and I just want to take you through a couple of things quickly here. You would agree that the College sets initial registration requirements?
A Yes.
Q For the profession?
A Yes.
Q And that's mandatory?
A That's correct.
Q And happily, you met those requirements a few years ago?
A Yes.
Q There are annual practice permit renewal requirements?
A Yes, there are.
Q And those are mandatory?
A Yes.
Q The College has a continuing competence program; is that correct?
A Yes, it does.
Q And is that mandatory in order to keep practicing?
A Yes, it is.
Q You're aware that the College creates Standards of Practice and Codes of Ethics?
A Yes, I am.

Q You're aware that the College creates practice visits?
A Yes.
Q For members?
A Yes.
Q And a participation and practice visit is mandatory, isn't it?
A Can you explain a practice visit?
Q If the College sends someone out to do a practice visit under the Health Professions Act, and they come to your clinic and assess what's occurring at the clinic, that's what I'm referring to.
A Yeah, I think there are definitely parameters surrounding that. It's -- I'm not sure that the College can just randomly come to a practice. I think there has to be some reason behind it, to my knowledge.
Q Yeah, and I think I'm referring to the practice visit program established under the HPA, and I think you're quite right, there are some parameters for how practice visits occur.

I'd like to ask you to go to the Standards of Practice -- I'm just going to digress for a moment -- the Standards of Practice are in Exhibit A-11, and I'm not going to be long on this, but once you're there on A-11 and Tribunal Members are there, I'm going to ask you to go to page 20 and the standard of practice for recordkeeping. And that's Standard of Practice 5.1.

A Yeah, I'm there.
MR. MAXSTON: Mr. Chair, I'll assume, unless someone waves their hand, everybody else is at Standard 5.1.
Q MR. MAXSTON: Dr. Wall, my purpose in taking you to this, number one, to flag that it addresses recordkeeping requirements, and it says: (as read)
Patient health records must be dated, accurate, legible, and comprehensive.
You'd agree that's mandatory?
A Yes, I would.
Q (as read)
All services provided by the chiropractor must be documented by the chiropractor and entries must be clearly identifiable as having been made by the chiropractor.
Again, a mandatory requirement, correct?
A Correct.
Q And if you skip down a couple of lines, there's a paragraph that says: (as read)
All patient health records must include the following information.
And there's some bullets, "Personal Information History", "Physical Exam", "Findings", "Written Diagnosis". You would agree that that's a mandatory set of contents for your records?

A Correct.
Q Is it fair to say that, until you independently decided that you weren't going to follow the Pandemic Directive, that you always follow ACAC requirements?
A That's correct.
Q I think you describe yourself as a fairly compliant person, and I'm not surprised to hear that. I'm wondering if I can get you to go to the notice of hearing, which is Exhibit A-1. It's the first document. I just want to take you through it.
A I'm good to go.
Q Okay. So I want to be careful, Mr. Kitchen can jump in here, but I don't think we ever heard -- we talked about this at the beginning of the hearing, but I don't think we ever heard from you whether you are denying or contesting the charges and are saying they don't constitute unprofessional conduct. I assume you're going to agree that that's what you're doing in the hearing?
A Can you repeat that, sorry?
Q Yeah, you're contesting the charges; you're arguing that you did not commit unprofessional conduct?
A That is correct.
Q Okay. I'm going to take you through each of the charges, and I want to be very clear, I'm not asking you to make admissions of unprofessional conduct; I'm

more interested in the facts in the charges are the factual foundation.

So Charge 1 says: (as read)

Beginning on or about June of 2020 and at the Wall Chiropractic Clinic: (a), [you] failed to use PPE, specifically failed to wear a mask; (b), failed to observe the required 2 metres of social distancing when unmasked; (c), until on or about December 2020, failed to have a plexiglass barrier at the clinic reception and/or did not require patients to mask; [and then] when he interacted with patients, members of the public, or both.

Do you dispute any of those facts?

A No, I do not.

Q And if we go to Charge Number 2: (as read)

Beginning on or about June of 2020 in the clinic, one or more staff members of the clinic, the staff, failed to use PPE, specifically staff failed to wear masks; (b), failed to observe the required 2 metres of social distancing when unmasked and/or, (c), did not require patients to be masked when they interacted with patients, members of the public, or both.

Again, I'm not asking you to make an admission of

unprofessional conduct, but do you accept those facts?
MR. KITCHEN: Mr. Maxston, I don't mind the question, but, in general, I'm going to ask that you break it up for each one of these pieces.
MR. MAXSTON: Sure, I'm happy to do that.
MR. KITCHEN: Okay, thank you.
MR. MAXSTON: Yeah.
Q MR. MAXSTON: Let's go to 2(a), do you dispute those facts, Dr. Wall?
A No, I do not.
Q And similarly for 2(b)?
A No, I do not.
Q And similarly for 2(c)?
A No, I do not.
Q Okay, we go to Charge Number 3: (as read)
Beginning on or about June 2020, Dr. Wall treated patients while not wearing a mask and/or did not require patients to be masked, and, (a), he did not advise patients of the increased risk of transmission of COVID-19 due to masks being worn.
Do you agree with that factually?
A Like "masks not being worn" I believe is --
Q Yeah.
A -- what you meant?
Q Yeah, sorry, yeah.

A That's correct.
Q And (b): (as read)
He advised patients that masks were not required.
Is that factually accurate?
A Correct.
Q And (c): (as read)
He advised patients that wearing masks had no effect concerning transmission of COVID-19.
Is that accurate factually?
A Correct.
Q So if we go to Charge Number 4: (as read)
Beginning on or about June of 2020, Dr. Wall failed to chart and/or failed to properly chart communications with his patients about, (a), him not wearing a mask.
Would you agree with that?
A Yes, I would.
Q (b): (as read)
His staff not wearing masks.
Would you agree with that?
A Yes, I would.
Q And (c): (as read)
His patients not wearing masks?
A Yes, I would.
Q And then, finally, Charge Number 5: (as read)

Beginning on or about June of 2020, Dr. Wall and/or the staff, (a), failed to follow CMOH orders regarding masking and COVID-19.

Do you accept that factually?

A Yes.

Q And (b): (as read)

Failed to follow the ACAC Pandemic Practice Directive.

Do you agree with that factually?

A Partially, but, yes, with respect to masking; is that what that (b) would be?

Q Yeah, I would -- yes, I think, in fairness to you, I'm thinking of masking, social distancing, and the plexiglass barrier.

A Correct, yeah.

Q Okay, thank you. So I think, Dr. Wall, it's fair to say that you're arguing that you have an exemption to masking, but you're also calling four experts who will dispute the science behind masking, they'll argue that masking causes harm, and argue that masking isn't necessary. Is that your position as well; it's not just that you have a medical exemption?

A That is correct.

Q And aside from any exemption for your anxiety disorder personally not masking, is it not fair to say you don't believe in masking generally in terms of COVID for a

number of reasons?
MR. KITCHEN: You're going to have to get a little more specific. I don't necessarily object to the question generally, but you're going to have to be a little more specific about what you mean about belief.
Q MR. MAXSTON: So I'll ask the question a little differently. You don't believe in masking generally in terms of COVID-19 as a preventative measure?
A Correct.
Q And just to be clear, you don't believe that chiropractors should have to mask or social distance or use plexiglass barriers; is that fair?
A Correct.
Q I'd like to take you to Exhibit A-11, another standard of practice, and specifically page 15, which is Standard of Practice 4.3. And I'm sorry, Dr. Wall, we're going to skip around a little bit with the documents this afternoon, but I'll let you and the Tribunal Members get to that document, and then I'll -- I've got a few questions for you.
THE CHAIR: Would you repeat that document number, again, please.
MR. MAXSTON: Yes, Mr. Chair, it's A-11, the Standards of Practice, and more specifically I'd like

you to go to page 15, which is 4.3, "Infection Prevention and Control".

THE CHAIR: Thank you.

Q MR. MAXSTON: So, Dr. Wall, we heard Dr. Halowski give some evidence about this standard, and you'd agree with me that this standard was in place before COVID?

A Yes, I would.

Q And you would agree that it was binding on you and is binding on you?

A Yes.

Q You'll see at the end of the first paragraph, just before the colon, it says "Chiropractors must", and then it sets out a number of duties that you have -- I shouldn't say "duties", I should say obligations. Would you agree with me that those bullets that follow are all musts, for lack of a better phrase?

A I'm sorry, are you still on 4.3?

Q Yeah, I'm just looking at that series of bullets. The first one says: (as read)

> Remain current and generally accepted routine practices.

And I'm just looking at the -- just before that, it says: (as read)

> In their clinical practice, chiropractors must ...

And my question was all those bullets are musts, if I read this correctly; would you agree with that?

A Yes, I would.

Q And is it your evidence that you've complied with this standard of practice at all times?

A Let me take a minute and just read those bullets, please. It would appear that the protective barrier, if that is referring to the plastic barrier, was something that I did not do. So that one bullet, there's --

Q You know, Dr. Wall, I'm not trying to sort of trick you here. I had a question specifically, frankly, about the second-last bullet. It says: (as read)

> Must utilize appropriate personal protective equipment in circumstances indicating such measures.

I think you'd agree you're not complying with that because you're not complying with the Pandemic Directive?

A Correct.

Q And, again, on its face, to be fair to you. I'd like to turn to the emails that were just entered as an exhibit, and we have your March 3, 2020 email, and as I asked you during my brief questions before, I asked you to just refresh your memory, and you would acknowledge now that Dr. Halowski did respond on March 4 to your

email?

A Yes, I would.

Q I'm looking at your email, and I just have a couple of quick questions about it. The second paragraph says: (as read)

> I fully recognize the position chiropractors are in with respect to being governed under the HPA, and I intend to follow any guidelines and rules put forth to our profession through Standards of Practice and bylaws.

Can you tell me why you said that?

MR. KITCHEN: Mr. Maxston, I understood that you were putting this document in so that you could discuss about whether or not there was a response. Now you're asking a question about the substance of the email.

MR. MAXSTON: I don't think I said I was confining my questions; I was putting it in to be used for cross-examination, and I only have a couple questions.

MR. KITCHEN: Well, I don't think the substance of the email is relevant. You and I have both seen the email. There's nothing in there about masking or the ACAC Pandemic Directive or any of that. The contents of the email aren't relevant. It's not a

relevant question.
MR. MAXSTON: Well, I would disagree. There's a comment in the second paragraph I'm taking your client to about compliance with future requirements of the College, so I guess we'll ask the Tribunal to let us know whether I can ask that question.
MR. KITCHEN: Well, I now admit I didn't ask you this, but you did not indicate when you asked for my consent to put this email in that you were going to ask substantive questions on the content of what Dr. Wall said in the email. I understood you to mean you were putting it in to show that it was sent and that Halowski -- Dr. Halowski sent a response, which I have no issue with.
MR. MAXSTON: Well, I --
MR. KITCHEN: So I'm going to object to questions on content, and I guess I'm going to have to object to you putting the document in for the purposes of asking substantive questions on the content of the email that Dr. Wall sent, which is irrelevant to these proceedings.
MR. MAXSTON: Well, I think it is, and when I mentioned my intention to have this entered, I said I intend to refer to it briefly during cross-examination. I didn't put any parameters on it, and I --

MR. KITCHEN: Well, I was trying to be -- you know, because I don't want to unduly contest things, okay? So that's why I didn't contest is because I didn't understand you to mean, and you didn't say you were going to ask questions on the contents.

MR. MAXSTON: Well, I'm just going to say that in my experience when you tender a document to be used in cross-examination, it's not limited. I don't have to say that I'm going to ask questions on 'X', 'Y', and 'Z'; I simply say I intend to refer to this.

So, again, I think it's relevant, my client thinks it's relevant, it talks about compliance issues, and it's in March of 2020 just before COVID hits and the directive comes out. I don't have a lot of questions, but I'd like to ask them, so I think we'll have to ask for the Tribunal to let us know what they --

MR. KITCHEN: Well, I'm going to object both to the questions, but I'm going to go back to object to the document being entered for substantive questions. This is similar to the issue we faced last week when I asked to have in the evidence that the studies that I questioned Dr. Hu about exist, and I was limited to asking procedural questions about their existence not on contents. That's what I'm going to ask -- that's how I ask this to be treated.

MR. MAXSTON: And I think the difference

from my perspective, Mr. Kitchen, is Dr. Hu is an expert, and he was being confronted with expert reports he didn't have any familiarity with, and I think, quite properly, the Tribunal put some parameters on what could be asked. This is an email exchange that your client knows about, and it's relevant to the issues. I'll let the Hearing Tribunal tell us what --

MR. KITCHEN: No, but if I had've known, if you had've made your intentions about questioning a little more clear, then I would have been in the position to object to it being entered for broad purposes as opposed to specific narrow purposes. I wasn't given that opportunity.

MR. MAXSTON: Yeah, I think I said I was going to refer to it. And, again, in my experience, in cross-examination, when you tender a document, you don't have to say what exactly you're going to ask about.

Anyhow, I've made my submissions on this point.

THE CHAIR: Yeah, I think we'll take a brief recess here so that the Tribunal can discuss this and consult with our independent legal counsel. So if we could be moved to a break-out room, please, and we'll be back with everybody shortly. Thank you.

(ADJOURNMENT)

THE CHAIR: We've discussed this amongst

ourselves and with independent legal counsel. Our decision is that the questioning can be allowed. We feel the document is relevant. Cross-examination is not limited in this regard. We don't feel that the situation with Dr. Hu and the medical -- or the studies is directly comparable. And, Mr. Kitchen, you have an opportunity to address anything raised in redirect examination of Dr. Wall. So on that basis, Mr. Maxston, subject to any further objections from Mr. Kitchen, please carry on.

MR. MAXSTON: Yeah, I'll be brief, Mr. Chair.

Q MR. MAXSTON: Dr. Wall, I've taken you to the second paragraph that says: (as read)

> I fully recognize the position chiropractors are in with respect to being governed under the HPA, and I intend to follow any guidelines and rules put forth to our profession through Standards of Practice and bylaws.

And my question to you was why did you make that statement?

A I made that statement because I'm a compliant chiropractor, and I, for the last 25 years, have upheld the Standards of Practice and bylaws and the Code of Ethics, but nobody could see what was coming around the

corner a month later, and here we are with different Standards of Practice and bylaws through the Pandemic Directive that have created the issue that's being contested right now.

Q So you've changed your view I think is what you're saying?

A Only to the point that it affects this particular hearing.

Q And just briefly, this is in March, early March of 2020, before the directive, but you've got Dr. Halowski's email address at that point, don't you?

A Yes, I do.

Q Dr. Wall, I'd like to take you to Exhibits D-8 and D-9, the two CMOH orders, CMOH Order 38-20 and 42-20. I am not going to take you through those in detail. I've got some questions for you about them generally, but if you want to have those in front of you, certainly that's fine.

A Okay.

Q So just putting aside the Pandemic Directive for the moment, was your understanding with CMOH Order 38-20 that you were required to mask when treating patients?

A That I was required to mask when treating patients?

Q M-hm.

A Yes, yes.

Q And in fairness to you, you also have taken the

position that there's an exemption or exception as well in this CMOH order; is that correct?
A That is correct.
Q And when we look at CMOH Order 42-20, and I, again, don't want you to go through that, I think it's also fair to say that it essentially mirrors 38-20, and would you agree there's an requirement for you to mask, and then there's an exemption as well?
A Yes.
Q So I think the question I have or the thing I want to explore with you is really timing. So in June of 2020, you decided to not mask and not social distance and not use barriers; that's fair to say?
A That's correct.
Q When we look at the CMOH orders, 38-20 is dated November 14, 2020, and 42-20 is dated December 11, 2020. So my question to you is there wasn't a CMOH order in force in June of 2020 that set out exemptions for masking; is that correct?
A Correct.
Q And, again, I'm not going to take you through this in detail, but Exhibit F-2 is CMOH Order 16-20, and you'll probably recall that 16-20, again, is from May 3 of 2020, and it's what we discussed previously in the hearing about requiring either adherence to the CMOH schedule, which required masking --

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

Q MR. MAXSTON: -- or opting into a College directive if they had one; is that your recollection?

A Yes, it is.

Q And would you agree that, when we look at that Exhibit F-2, and then there's F-1, the Government of Alberta safely staged COVID relaunch, that it was a requirement for the College to establish a Pandemic Directive?

A Yes.

Q Just bear with me for a moment, Dr. Wall. Don't mean to belabour this point, but on Exhibit F-1, which is the government relaunch document, if I can get you to go to that, it's Exhibit, again, F-1, "Alberta's safely staged COVID-19 relaunch".

A Okay.

Q Page 2, the second bullet talks about: (as read)

> Dental and other health care workers will be allowed to resume services starting May 4, as long as they are following approved guidelines set by their professional colleges.

You understand that that meant it was mandatory for you to comply with the Pandemic Directive if you wanted to re-open?

A Yes.

Q And when we look at CMOH Order 16-20, and, my apologies, that's F-2 if you want to look at it, I have a couple of quick questions for you.

Again, this is the CMOH order that talks about colleges creating their own Pandemic Directives. This CMOH order doesn't reference any exemptions, does it? And I mean exemptions from masking and social distancing.

A Not that I can see, yeah.

Q And you'd agree with me, of course, this is dated May 3, 2020, and it would have been in force in June of 2020 when you decided to not comply?

A Correct.

Q Dr. Wall, I'd like you to go to the Pandemic Directive itself, and we've been using I think Exhibit C-22, which is the, I'll call it, the most recent version, January 26th, 2021, although the contents of it relating to masking et cetera haven't changed. So I'll just ask you to go to that, please.

A Okay.

Q So I think you may have discussed this with Mr. Kitchen, but do you recall when you received the Pandemic Directive?

A Are you referring to the very first one or this most recent --

Q Thank you --

A -- one?
Q -- yes, thank you, the May 3, 2020 version, thank you.
A I believe it was in May, early May.
Q Yeah. And you would have received that as a regulated member getting like I guess as part of the normal communications from your college?
A Correct.
Q So I'd like you to go to page 1 of the -- pardon me, page 2 of the Pandemic Directive. Page 1 is kind of an introductory table of contents. Item number 1 in the middle of the page, numbered item 1, says "Follow all" -- I should go back, there's an opening sentence -- or opening statement: (as read)

> As regulated health professionals, chiropractors are required to, 1, follow all mandates and recommendations from Public Health and the Government of Alberta 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.

Would you agree with that statement?
A Yes, I would.
Q And the second one is a little more specific, number 2, it says, again chiropractors: (as read)

Read and adhere to all communications from the ACAC.

Would you agree that that's intended to be a binding direction from your college?

A Yes, I would.

Q Dr. Wall, I'm going to ask you to go to page 3 of the Pandemic Directive, and in kind of the middle of that page, there's a heading that says "Patient Screening", and there's some comments there about: (as read)

Chiropractors must assess and screen patients for symptoms of COVID-19 as per requirements of Public Health.

Were you doing patient screening?

A Yes, I was.

Q Okay. If you skip head to page 4 of the Pandemic Directive, and you go to the bottom of the page, there is a heading "Hand Hygiene", and if we go to the next page, there's a -- it's the first complete paragraph: (as read)

When hands are visibly soiled, they must be cleaned with soap and water, as opposed to using alcohol hand-rub.

Again, the word "must" is used. Were you adhering to the hand hygiene requirements in this Pandemic Directive?

A Yes, I was.

Q If we skip ahead a couple of pages to page 6, at the top of that page, Dr. Wall, there's a heading of "Environment Cleaning and Disinfection", and then there are some comments about proper disinfectant products and some requirements there. Were you adhering to the environment cleaning and disinfection part of the standard?

A Yes, I was.

Q And if we go to page 7, there's a heading that says "Required Clinic Environment Adaptions", and it's got some interesting comments about books, magazines, toys, et cetera. Were you adhering to that requirement?

A Yes, I was.

Q The next heading on that page is "Physical Distancing", and I'm going to ask you a question about the very next page, page 8, and that first black bullet on the top of that page says: (as read)

> Non-clinical employees and the public must be 2 metres from each other.

And then: (as read)

> Reception and payment area -- [and there's a question coming] -- if 2 metres cannot be maintained at reception/payment area, either staff must be continuously masked or the installation of a plexiglass/plastic barrier must occur to protect reception staff.

I'm assuming that you weren't following this part of the Pandemic Directive; the only exception being after December 20, you began using plexiglass; is that fair?

A That's correct.

Q So if we go to the next section on page 8, the heading "Personal Protective Equipment", and there's a heading "Staff and practitioner PPE", and it reads: (as read)

> On April 23, 2020, AHS announced, effective immediately, AHS is advising all health care workers providing direct patient care in both AHS and community settings to wear surgical/procedure masks continuously at all times and in all areas of the workplace if they are involved in direct patient contact or cannot maintain adequate physical distancing from patients and co-workers.

I'm assuming you would say you weren't following that?

A That's correct.

Q And if we go to the next heading, "PPE requirements", got three bullets: (as read)

> Surgical or procedure masks are the minimum acceptable standard; chiropractors and clinical staff must be masked at all times while providing patient care; [and then next] nonclinical staff must be masked when a physical distance of 2 metres cannot be

maintained.
I'm assuming you would agree that you weren't following that aspect of the Pandemic Directive?
A That's correct.
Q And if we go to the very next page, that's page 9, there are a series of steps for donning and doffing masks. I'm assuming you couldn't have been following those because you weren't masking; is that fair?
A That is correct.
Q Okay. Dr. Wall, I'd like you to go to the last page of the Pandemic Directive, page 12, and that's a heading "Resources". Do you recall whether you went through and reviewed any of these resources?
A Yes, I did. I did click on them. I'm unfamiliar with them now, but I did recall clicking on those at the time.
Q Yeah, and I wasn't going to take you through them, I just wondered if you'd accessed them.
Do you, in particular, remember whether you accessed the three AHS ones that are listed under "Personal Protective Equipment"?
A I'm positive that I looked at all of the resources, but, yeah, so I would have come across it, I'm sure.
Q And I take it, Dr. Wall, I'm going to ask you a question about what happens in a few weeks, but reading those resources or accessing them didn't change your

mind later on about whether to comply?
A That is correct.
Q And this is a little housekeeping on my part, I think I asked you this, but the Pandemic Directive does not contain an exemption for masking; is that correct?
A That's correct.
Q And there's -- I should have been a little more expansive -- there's no exemptions for social distancing or plexiglass barriers?
A Correct.
Q Okay, I'd like to take you to the AHS closure and rescind orders, and those are Exhibits D-1 and D-2. I'm just wait for you to get to those and get the Hearing Tribunal Members to those as well.
A I'm good.
Q So there's a couple "Whereas" paragraphs, and I went through these with you a little bit in my prior questions for you, but when we look at "Whereas" paragraph 8, it says: (as read)

> Practitioner does not wear a face mask while providing care within 2 metres distance from patients.

You'd agree with that, that's factually correct?
A Yes.
Q The next statement says: (as read)

> This activity could contribute to the spread

of COVID-19.

Would you agree with that statement?

A No, I would not.

Q And if we go to item (b), "Whereas" Section (b): (as read)

Practitioner does not implement continuous masking by all staff and patients.

That's correct, isn't it?

A Yes, it is.

Q And: (as read)

Physical barrier at front desk reception is also not available.

That was correct at that time?

A Correct, yeah.

Q And then we have another statement: (as read)

This activity could contribute to the spread of COVID-19.

And again notwithstanding that this is Alberta Health Services, you wouldn't agree with that, would you?

A No, I would not.

Q If we go to D-2, the rescind order -- oh, and I should go back, you did close your clinic after receiving D-1?

A Yes, I did.

Q So you chose to comply with the AHS order?

A Yes.

Q I think I know the answer to this question, but did you

agree with the closure order?
A No, I did not.
Q And would it be fair to say that you strongly disagreed with that order?
A Very strongly disagreed.
Q Would it be fair to say that, despite the references I took you through in (a) and (b), you don't believe there's a scientific basis for the conclusions in those "Whereas" paragraphs?
A Correct.
Q And I suppose, a little more broadly, it would be fair to say that you disagree with the CMOH orders and the science they're based on?
MR. KITCHEN: If you specify a section, he can answer, but --
MR. MAXSTON: Sure.
MR. KITCHEN: -- that's too broad.
MR. MAXSTON: Yeah, that's fair.
Q MR. MAXSTON: Do you agree with the CMOH orders not having a scientific basis for masking and social distancing and plexiglass barriers?
MR. KITCHEN: Again, when you went from all to three, why don't you try them one at a time.
Q MR. MAXSTON: Dr. Wall, consistent with Mr. Kitchen's advice, do you take issue with the CMOH -- any science the CMOH orders are based on in

terms of masking?
A Yes, I do.
Q And any science in terms of social distancing?
A Yes, I do.
Q And any science in terms of plexiglass barriers?
MR. KITCHEN: You're going to have to point us to what CMOH order requires plexiglass barriers?
MR. MAXSTON: I'll take that back; that may be the Pandemic Directive alone, Mr. Kitchen, so I'll leave that one.
Q MR. MAXSTON: I want to continue with looking at the rescind order, and I think you told me in some of the questions just before lunch you're not in compliance with Order Number 4; is that correct?
A Correct.
Q And this is Exhibit D-2.
A Yeah.
Q There was a discussion yesterday about Orders 1 and 3, Order 1 saying you must follow the Pandemic Directive, which would include masking, and Order Number 3 that says you can get consent to practice unmasked. Would you agree that there's an inconsistency between those two orders?
A Can you rephrase that or just --
Q Yeah, I'll break it down. Order number 1 says you have to comply with the ACAC's requirements, which is the

Pandemic Directive, and that includes masking, doesn't it?

A Yes, it does.

Q And if we look at Order Number 3, it says you must inform the patient you will be unmasked while providing services. And my question to you is there's an inconsistency between those two orders, isn't there?

A Yes, it -- yes.

Q Okay. When your clinic was shut down, you said you complied with the order, you didn't launch a court challenge to it, did you?

A No, I did not.

Q So you were prepared to respect the authority of the AHS? I'll rephrase it. Were you prepared to comply with their direction?

A Yes, I was.

Q In terms of the re-opening order and the four orders, was it your intention to comply with all of them?

A Are you referring to the four points under the rescind notice?

Q Yeah, that's what I'm looking at, and in fairness to you, we'll just call them the four points. Was it your intention to comply with all four of those?

A I can see point number 4 talks about: (as read)

> Ensuring all patients he treats continuously wear a mask that covers their mouth.

At that point, I would say that I believe patients have the need to exercise their own health freedom when it comes to that point, in the same way that I would exercise my own health freedom with respect to masking.

Q So would it be fair to say then that you re-opened, but you weren't in compliance with that fourth point when you re-opened?

A Yes.

Q I'd like you to go -- bear with me, Dr. Wall. I'd like to take you back to the Standards of Practice, which were Exhibit A-11 and specifically page 11. And, again, no surprises, I want to talk to you about the "Informed Consent", Standard 3.1.

A Go ahead.

Q Okay, there's under 3.1, we go to I think the third paragraph, it says: (as read)

> As part of the informed consent process, chiropractors are responsible for disclosing to each patient --

1 and 2 are diagnosis, purpose, nature of treatment, but I'm curious about number 3: (as read)

> The potential risks including those that may be of a special or unusual nature.

First, would you agree that's a requirement for you to do?

A Yes, I agree.

Q And when you talked to patients about masking, did you tell them about the risks of you not masking?
A No, I didn't, because I didn't believe that there was a risk to me not masking.
Q I take it then, when we go to the paragraph right after that: (as read)

> Chiropractors must private patients the opportunity to ask questions concerning risks [et cetera].

You really didn't engage in a Q-and-A then with patients about masking, your masking?
A That is correct. And my understanding of this informed consent process is that this is referring to chiropractic care. I'm not sure that this is getting into mask wearing per se. This looks like it's regarding the treatment that is being proposed to the patient. Wearing a mask in this situation seems extraneous, but I could be wrong.
Q I just have one other quick question for you, if we go to the final part of that page, it says: (as read)

> Informed consent must -- [and then item 6] -- be present on all existing patient files if verbal informed consent is noted from previous treatment.

Did you take the position that you had to get consent from a patient when you weren't masking?

A No, I did not.
Q And I'm going to skip around here a little bit. Order Number 3 in the Exhibit D-2, the AHS rescind order, says: (as read)

> Prior to booking an appointment, Dr. Curtis Wall must inform the patient he will be unmasked while providing services.

And I'll just stop there. Were you complying with that; prior to booking an appointment, were you informing the patient that you would be unmasked?
A Yes, I was.
Q And then the second part is prior to booking an -- oh, sorry, you: (as read)

> -- must obtain a patient's explicit consent to proceed with booking and undertaking said services.

I take it you weren't getting the patient's explicit consent based on what you were telling me before, because you didn't think you had to do that?
A Okay, I understand now. Yes, I was getting there consent, because I had to have them sign a form stating that they were okay to be treated by me while I was not wearing a mask. So perhaps I answered wrongly in the first place, but, yes, I was following all the conditions and restrictions on my practice, so that did require a consent, you're right.

Q Okay, so if we were to look at every one of your files after that rescind order, they'd have that patient consent form on them?
A No, it wouldn't be in a form on every file. I had two separate pieces of paper, each delineating -- one was the prescreening questions, that they were all negative to those questions, and the second form listed the exemption that I had to wearing a mask and that that patient was okay to be treated by me, so they would sign that one too, yeah.
Q So that was -- the rescind order was dated January 5, 2021. Did you have those kinds of consents on your charts before January 5, 2021?
A No, I did not.
Q And I don't want to put words in your mouth, is it fair to say, if we looked at your charts then from June onwards, we wouldn't see patient consent charted on, patient to masking, you or you being unmasked?
A That is correct.
MR. KITCHEN: Hold on, just to clarify, you mean June of 2020?
MR. MAXSTON: Did I say a different date? My apologies.
MR. KITCHEN: No, you just said June. If we had --
MR. MAXSTON: June of twenty --

MR. KITCHEN: -- (INDISCERNIBLE) to deal with.

Q MR. MAXSTON: So I'll go back. From June of 2020 onward, we would see charting about -- on your patient charts about you getting patient consent to you not being masked?

MR. KITCHEN: Well, hold on, you're getting confusing and misleading there, because he just said that he does do it after he's been asked to do it. So if you want to ask did he do it from June 2020 to when he had to start doing it, that's fine.

MR. MAXSTON: Yeah, I was really asking him --

MR. KITCHEN: But to try and -- okay.

MR. MAXSTON: Yeah, I was really asking that because you sort of objected, so my point, I think the answer was from June of 2020 onwards, there isn't charting about Dr. Wall's masking or not being masked, and I think Dr. Wall said that was correct.

A That is correct.

Q MR. MAXSTON: Dr. Wall, did you ever provide patients with views about masking that were in opposition to your own?

A I left it to the patient. If they were comfortable with masking and believed in it, that they were very willing to wear a mask, so we never engaged in strong

conversation about that.
Q Okay, and would that have applied to your decision to mask as well; you didn't have a dialogue with them about opposing views on that front?
A Only if a patient was really asking me questions about it, then perhaps we would dialogue further.
Q Okay, so it was up to the patient to raise that; that was your practice?
A Yeah, patients ask questions about all kinds of health issues, and so, you know, in this situation, that was no different.
Q Okay. I want to move now to your involvement with the College, or the College's involvement with you is more accurate, and I'd like you to go to Exhibits A-2 and A-3, and, frankly, you could probably just go to A-3, because A-3 includes A-2, which is Ms. Ho's email to Dr. Halowski. Maybe just ask you to get there, and you can let me know when you're ready to go.
A Okay, I'm on A-3.
Q And I'm going to refer to the email to Ms. Ho, even though it's a separate exhibit, but I'm just going to take you through it using A-3. I just have a couple of questions about it.
So this was an email from Ms. Ho to you dated December 1, 2020. Can you tell me if you have any information about how that email was sent to you?

A Yes, I do. The email came to me, initially I thought the email was spam quite honestly, and so I didn't answer the email, and then it was followed up by a telephone call, to which I took it.

Q I'm looking at the second paragraph, it says: (as read)

> As per our phone conversation, you indicated that you are [quote] mask exempt.

Is that a correct statement by Ms. Ho?

A Yes, it is.

Q And then: (as read)

> As per CMOH 38-2020, please indicate which exemption you would fall under; otherwise, you are required to be masking within 2 metres distance with a patient.

Did you ever get back to her about your exemption?

A Yes, I did.

Q Okay. The next paragraph says: (as read)

> As per your administrative staff, you indicated that there is no plexiglass barrier at reception and that staff are not masking.

Is that an accurate statement?

A Yes, it is.

Q If we go to the sort of tail end of that paragraph, it says: (as read)

> Your clinic must have control measures, eg., physical barrier, to promote physical

distancing at all times.
And you didn't have a physical barrier at that point, did you?
A No, I did not.
Q And then it says: (as read)
Otherwise, the administrative staff must be masked as per CMOH 38-2020.
Again, you'd agree with me that your administrative staff wasn't masked?
A That's correct.
Q I'm looking at the letter that Dr. Halowski sent to Mr. Lawrence, that's Exhibit A-3, and I just have one question about it. At the very tail end of the email, the second-last paragraph says: (as read)
Further to the email from Public Health, in conversation with Dr. Wall, he indicated that he does not mask and has provided for barriers in his clinic.
Is that an accurate statement; that's an accurate statement by Dr. Halowski of what you said?
A Yes.
MR. MAXSTON: Mr. Chair, I plan to go about another 10, 15 minutes and take a break at 2:45, if that works for everybody. And, Dr. Wall, if you need a break sooner, you let me know, but we've been chatting for about an hour and a bit now, so I'll just go about

another 10, 15 minutes, if that's okay.
THE CHAIR: That's okay, I believe, Mr. Maxston. Thanks.
Q MR. MAXSTON: I'd like you to go to Exhibit A-5, which is Mr. Lawrence's December 21, 2020 letter to you.
A Okay, I'm there.
Q And in paragraph 2, Mr. Lawrence is saying: (as read)
> You [meaning you, Dr. Wall] would not be taking steps to become compliant with these requirements.

And that was what you had communicated to him?
A In respect of masking, is that what you're referring to?
Q Yeah, I think so in the Pandemic Directive.
A Yeah, specifically to do with masking, yes.
Q And I guess, in fairness to you, and social distancing and plexiglass barrier.
A Yeah. Is that prior to me installing the plexiglass barrier or after?
Q Yeah, I think the plexiglass barrier is bit of a variable, because I agree that after December of -- I think it's December 20th, those came up, but my comment to you was he accurate in saying you weren't going to be taking steps then to become compliant?
MR. KITCHEN: Well, he's answered the

question; he said he's not going to be compliant with masking, so it's fine if you want to get a little more specific.

MR. MAXSTON: Well, I think I did.

Q MR. MAXSTON: Social distancing, you're not going to be compliant with that?

A Correct.

Q And the plexiglass barriers referenced in the Pandemic Directive, you're not going to be compliant with that?

MR. KITCHEN: Well, he's already answered --

A No, I've already put it --

MR. KITCHEN: -- that.

A Yeah, I've already put it up.

MR. MAXSTON: Okay. I was about to go on to my next set of questions, but they're actually probably going to be longer than 15 minutes. Mr. Chair, would you want to take a 10- or 15-minute break now? I think it would be --

THE CHAIR: Yeah, you know, if it makes sense in terms of fluidity for your questioning, that's fine. It's 2:30. Let's recess for 15 minutes and reconvene at 2:45, and we'll continue with the objective of meeting Mr. Kitchen's plans to have his witness around 3:45.

MR. MAXSTON: We're going to follow the accepted practice that, of course, Dr. Wall can't chat

about his testimony with Mr. Kitchen.
THE CHAIR: Yes, that's --
MR. MAXSTON: Thank you.
THE CHAIR: -- (INDISCERNIBLE). Okay, we'll see you at 2:45.
(ADJOURNMENT)
THE CHAIR: Okay, we're back in session.
MR. MAXSTON: Sure.
Q MR. MAXSTON: Dr. Wall, I was just taking you through your interactions with the College, and we talked about Mr. Lawrence's letter. I'd like you to go to Exhibit A-6, which is I think an undated, unless I missed something, letter from you in response to Mr. Lawrence, and I'd like to take you through that.
I think, in fairness, this document was received by the College I think on January 11, but I'll ask you to clarify when I start your questions, Dr. Wall, on this when it was sent. I don't think there's a date on it. So if you can let me know when you're at that document. Again, A-6.
A Yeah, I'm there, and it does appear January 11th.
Q Yeah, okay. So, Dr. Wall, some of this we've covered in some detail before, but I'm looking at the second paragraph, and that's a summary, I believe, of your comments about trying masking and trying a face shield, and your decision in June of 2020 to not wear either;

is that fair to say?
A Yes, it is.
Q The next paragraph says: (as read)
I considered this decision to be reasonable based on the information available to me and based on my conclusion that the ACAC pandemic practice directive could not be reasonably interpreted to demand the wearing of a mask if doing so was harmful to the member and negatively impacted the member's ability to provide the best possible patient care.
That's your interpretation without any consultation with the College, correct?
A That's correct.
Q There's another paragraph just below that, beginning: (as read)
The information available to me at the time was that the benefit of masks vis-à-vis reducing COVID-19 transmission was tenuous and that mask wearing was an additional precautionary measure, which was worth implementing only if doing so did not result in negative impacts that outweighed the potential marginal benefits.
And you then say: (as read)
This has been borne out over time.

I just want to be clear here, this is stating the obvious, but you're not a virologist or respirologist or an epidemiologist?

A That's correct, yeah.

Q So this is your conclusion?

A That's correct.

Q The next paragraph says: (as read)

> I did not think at the time that I should or needed to obtain any sort of exemption to wearing a mask or face shield from another health care practitioner such as a medical doctor.

And I'm going to suggest to you, Dr. Wall, that that's really kind of an astonishing statement that, as a health care provider, you would think you didn't need to go see another health care practitioner. Can you tell me why you would believe that, why you thought you could self-diagnosis?

A Well, my very obvious symptoms of anxiety and claustrophobia were very apparent to me. I didn't need somebody to diagnose that. It was extremely obvious, and so that would be my short answer.

Q The next paragraph you talk about a spring of 2020 AHS report, and you quote from it briefly I think, or you reference it. Do you recall Dr. Hu's testimony where he said that masking guidance has changed since the

beginning of the pandemic?
A Yes, I do.
Q And would it be fair to say that when we look at those three additional AHS documents, they do support masking?
A I'm sorry, which three initial documents?
Q We had an application at the beginning of the hearing where I asked three AHS documents be entered, and I took Dr. Hu through them. Would you agree with me, and I can take you through them, but I don't think I need to, would you agree with me that those three AHS documents are supportive of masking?
A I believe that's what they would believe, yes.
Q On the top of the next page, there's a closing sentence: (as read)

> Subsequent studies and reports have confirmed that the benefits of masks is tenuous at best.

Would you agree with me that there are other studies that are strongly in support of masking?
A I think there are probably multiple studies that would say that they are in strong support of masking. I question some of the design flaws with respect to that, but that is not my expertise, and so I'll leave it at that.
Q Okay. The next paragraph talks about, in part, the

CMOH orders, and to use your wording: (as read)

> Broadly worded exceptions and -- [sorry] -- broadly worded exceptions exempting individuals from wearing masks if they had mental concerns or limitations.

And then you talk about CMOH Order 38 and CMOH Order 42-2020, and we canvassed this before, but those orders weren't in force until November and December of 2020; isn't that correct?

A I believe so.

Q I'd like you to go to the -- I wish these pages were numbered, it might be easier for me, but the top of page 3 starts off with "Include exceptions for mental conditions or limitations". Are you there, Dr. Wall?

A Yes, I am.

Q Okay. There is a -- the first complete sentence says: (as read)

> I have legitimate mental concerns and limitations, and I'm, therefore, not bound by any order of the CMOH to wear a mask.

You would agree with me that those were, again, self-diagnosed mental concerns?

A Yes, I would. Initially.

Q If we go a little bit down, there's a paragraph beginning: (as read)

> As for the allegation I failed to comply with

the Pandemic Directive.

There's a closing statement, it says: (as read)

However, it appears the fact that I have not been wearing a mask is the content of the allegation I failed to comply with the ACAC Pandemic Practice Directive.

And that's still your understanding, at least in part? There's other issues, but ...

A That's correct.

Q You then say: (as read)

I acknowledge that, on its face, the Pandemic Directive states that mask wearing is a requirement of members. I further acknowledge the fact that I have been not wearing a mask, on its face, amounts to noncompliance with the practice directive.

And you maintain those acknowledgments today, I assume?

A Yes, I do.

Q Final sentence in that paragraph says: (as read)

Any policy or directive of the ACAC that imposes mandatory mask wearing upon members but does not permit necessary exceptions is unreasonable.

You never asked for an exception, did you?

A No, I did not.

Q The next paragraph: (as read)

I further submit it was reasonable of me to conclude that a reasonable reading of the ACAC Pandemic Directives requirement to wear masks implicitly permitted necessary exceptions such as for legitimate mental health conditions, concerns, or limitations. Again, that's your conclusion and your interpretation alone?

A Correct.

Q Thank you, Dr. Wall, I don't have any further -- any more questions on that document.

At this point or maybe it's happening already, Mr. Lawrence is conducting the investigation into your conduct under Part 4 of the HPA, and I'd like to take you to the investigation report, which is Exhibit A-7.

A Okay, I'm there.

Q Okay. I'm looking at page 1, and the second paragraph talks about a December 2, 2020 conversation with the Registrar and December 3, 2020 conversation during the -- with the Complaints Director. And we then have some comments about masking, et cetera. I'm skipping down to about the fourth-last line, there's a comment which Mr. Lawrence: (as read)

He indicated -- ["he" meaning you] -- indicated that he did not believe he was endangering the public, as the recovery rate

from COVID-19 is so high.

Is that your recollection of the statement you made as well?

A Yes, it is.

Q You'd agree with me though that even if the recovery rate is high, there are some individuals who have serious medical complications because of COVID-19?

A Yes, I would.

Q And that it's fatal for some people?

A Correct.

Q Going to ask you to go to page 4 of the investigation report, and this is a series of what Mr. Lawrence describes as key points of the interview. Just got a couple of questions for you about some of these, because I think you've answered a lot of the questions I was going to ask you. About the fifth bullet down deals with your son working at the clinic, and the second sentence says: (as read)

> Dr. Wall indicated that he also did not require his son to be masked and did not think it necessary to install any barriers.

Is that accurate?

A Yes, it is.

Q And if it wasn't your son, if it was anyone else there, would you take the same position?

MR. KITCHEN: That's a hypothetical. I

don't see the relevance.
Q MR. MAXSTON: Well, I'll ask you this: Did you have anybody other than your son working at the clinic during the time relating to the charges, working as a receptionist?
A No, I did not.
Q Okay, well, that answers that question. And the next arrow, there's a comment about Dr. Wall reiterated that your son is a healthy individual, and he did not want to wear a mask; that's accurate?
A That's correct.
Q I'm going to ask you, Dr. Wall, sort of a general question, but would you agree that a chiropractor is responsible for his staff members complying with the requirements of practice for a chiropractic clinic?
A With respect to the mask wearing, I would tend to take the same position that I've taken for myself. So if my staff member, being my son, had legitimate concerns, whether they were religious or physical or otherwise, then we'd have to walk through that.
Q Okay, I was trying to be a little more precise there. I'm thinking of things like the charting standard I took you through. If you delegate charting to a staff member, you're ultimately responsible, aren't you --
A That's correct.
Q -- for the charting?

A That's correct.
Q And the same would be true for Standards of Practice and other College requirements; if staff do things, you're ultimately responsible?
A Correct.
Q Dr. Wall, there's a bullet or an arrow about four from the bottom, it says: (as read)

> When asked if Dr. Wall ever alerted his patients to the dangers of not being masked, Dr. Wall replied that people are aware of the dangers, and he did not explain any of the dangers to patients of him not masking.

Is that sort of what you said to me before, that you let patients raise things with you?
A If the conversation came up, yes.
Q And you rely on the patient to raise that discussion?
A As it pertained to mask wearing; is that what you're --
Q Yeah.
A -- referring to? Yes.
Q When you had -- I'm sorry, when you had your interview with Mr. Lawrence, and I think it was a phone interview, Mr. Kitchen was present, participated, listened, I guess is maybe the best way, during the interview; is that correct?
A Are you referring to the interview with Dr. Halowski and Mr. Lawrence?

Q Yes, the one that would have occurred in -- oh, my apologies, Dr. Wall, January 25, 2021.
A Yes, that's correct. Mr. Kitchen was present on that call.
Q Okay, thank you. Would it be fair to say that when you had that discussion during the interview that you didn't mention the religious beliefs you talked about today?
A I didn't; I don't think I did mention the religious beliefs, yeah.
Q I'd like to turn to the Section 65 interim order matters, and as you know from Exhibit -- I'm not going to take you to this exhibit, but Exhibit D-1 was Mr. Lawrence's December 3, 2020 letter to Mr. Linford. I'd like to ask you though about the response letters that Mr. Kitchen sent on your behalf, and those appear as Exhibits B-3 and B-4. I'll take you to B-3 first, which is the December 10, 2020 letter from Mr. Kitchen.
A Okay, I'm there.
Q So this was a letter written by Mr. Kitchen in response to Mr. Lawrence's request for Section 65 suspension. I take it you adopt the contents of this letter; you instructed Mr. Kitchen to send this letter?
A Yes, I did.
Q Okay. I'm going to page 2, the second complete paragraph says: (as read)

Any risk to Dr. Wall's patients as a result of him not wearing a face covering is speculative at best.

That's your position as well?

A Yes, it is.

Q And notwithstanding hearing from Dr. Hu, that's your position still?

A Correct, yes.

Q And the next sentence, and I should go back, notwithstanding looking at those AHS documents, that's still your position?

MR. KITCHEN: You've asked that at least once if not a couple times already, Mr. Maxston.

Q MR. MAXSTON: The next sentence says: (as read)

There's a lack of scientific evidence that face coverings have any measurable effectiveness in preventing the transmission of COVID-19.

Is that your position?

MR. KITCHEN: Again, Mr. Maxston, you've asked that, and, obviously, his position, you've just established, that this was sent on behalf of Dr. Wall at his instructions, which means it is his position; you've just established that. So now --

MR. MAXSTON: Well (INDISCERNIBLE) --

MR. KITCHEN: -- you're asking does Dr. Wall agree that the sky is blue, does he agree that all the ski is blue, you know, you don't get to -- I don't see how you get to do that.

Q MR. MAXSTON: Well, I guess I could be more global and say do you agree with every statement in this letter that Mr. Kitchen has made about COVID and masking and related matters?

MR. KITCHEN: You've already asked that --

MR. MAXSTON: Well --

MR. KITCHEN: -- and he's already given you his answer.

MR. MAXSTON: I asked him whether he adopted it but --

MR. KITCHEN: Yes, you did. And that means that if he adopted it, he adopted all of it. And it's his statement, not mine, so once he adopts it, it's his, it's sent on his behalf by counsel.

MR. MAXSTON: I think even though he's adopted it, I'm allowed to ask questions, but I'll move on to something else.

Q MR. MAXSTON: I'm looking at the bottom of page 2 of the letter, it says: (as read)

> As a matter of factual clarity, Dr. Wall employees [or "employees" I think should be "employs"] no staff in his clinic that are

not members of his family.
You've confirmed that with me: (as read)
Dr. Wall reiterates that he has appropriately installed the required plexiglass barriers at his chiropractic office and will maintain such barriers as long as they are required.
Why did you install the, quote, required plexiglass barriers, Dr. Wall?
A I believe that was part of the re-opening process for Alberta Health Services, that my plexiglass barriers be up, so I did that.
Q So that was an aspect of the re-opening order that you did choose to comply with?
A That's correct.
Q Okay, let's go to Exhibit B-4. That's Mr. Kitchen's December 16, 2020 letter. I'll just ask you again, you adopt this as your response?
A Yes, I do.
Q Okay I was going to ask you about item number 1, but we've already dealt with why you installed the plexiglass barriers. I'm curious about item number 2. It says: (as read)
Attached to this letter as Appendix B is a medical certificate from an M.D. exempting Dr. Curtis Wall from being required to wear any sort of face covering on the basis of a

mental disability.
At the time of this letter, December 16, I think the only medical note we had was Exhibit A-8, Dr. Salem's December 12th, 2020 letter.
MR. MAXSTON: I can ask Mr. Kitchen to help out here, was that the enclosure you were referring to in this letter, Mr. Kitchen? I don't think it's attached as an exhibit. I think we probably didn't put it in because it was redundant, but I just want to be sure that --
MR. KITCHEN: It is (INDISCERNIBLE) Exhibit A-8.
MR. MAXSTON: Yeah. When you -- in item 2, when you --
MR. KITCHEN: You're asking this because it's not contained in this letter, I take it, which --
MR. MAXSTON: Yeah, I just want to be sure, in fairness to your client, I'm asking the right question about the right document and --
MR. KITCHEN: (INDISCERNIBLE)
Q MR. MAXSTON: -- and we're digressing a moment here, Dr. Wall --
MR. MAXSTON: --Mr. Kitchen, my sense is that because your letter is dated December 16, 2020, the only letter we can have from Dr. Salem is the one from December 12. He didn't do his other letter

until --
MR. KITCHEN: Yeah, I can't object to that as being factually inaccurate, so I'll let Dr. Wall answer, but everything's --
MR. MAXSTON: Yeah.
MR. KITCHEN: -- everything's in order so far.
MR. MAXSTON: Yeah, I think the other letter from Dr. Salem is January 8, 2021, so I just want to be clear I'm asking --
MR. KITCHEN: That's --
MR. MAXSTON: -- the right question.
MR. KITCHEN: That's right.
Q MR. MAXSTON: Okay, so if we're proceeding then that the Appendix B that is being referred to in this letter is Exhibit A-8, I'd just ask you to quickly go to Exhibit A-8, Dr. Wall.
A Okay, go ahead.
Q I'm going to read this to you, if you want to go back, but Exhibit B-4, the letter of December 16, 2020, item 2 says: (as read)

> Appended to this letter as Appendix B is a medical certificate from an M.D. exempting Dr. Curtis Wall from being required to wear any sort of face covering on the basis of a mental disability, which, as you know, is a

protected ground under Section 4 [and they have a reference to the Human Rights Act and the Charter].

When I go to Exhibit A-8, I don't see any reference to mental disability; would you agree with that?

A Yes, it is not included in that letter.

Q And it says "medical reasons" in Exhibit A-8; is that correct?

A That is correct.

Q I would like to take you to Exhibit B-5, which is Dr. Linford's decision on the Section 65 suspension.

A Sorry, can you clarify B dash what?

Q B dash 5, Bob dash 5, and it's the December 8th, 2020 decision letter from Dr. Linford, and specifically I'll be taking you to page 2 when you get to it, Dr. Wall.

A Yeah, go ahead.

Q You would agree with me, I'm looking at the second complete paragraph on page 2, Dr. Wall says: (as read)

> The impact of COVID-19 on the Public Health care system is undeniable.

That's correct?

A Correct.

Q At the end of that paragraph, the final two sentences say -- and he's talking about full vaccination occurring: (as read)

> Until that time arrives, the COVID-19 virus

remains a real and imminent public health threat.

You'd agree that's his statement?

A I'm sorry, where is that statement again?

Q Sorry, it's about two-thirds of the way down, it's the second-last full sentence, beginning "Until that time arrives", and it's in the same paragraph we were just chatting about.

THE CHAIR: I think it's a third of the way down the page, not two-thirds.

MR. MAXSTON: Yeah.

THE CHAIR: It's the third paragraph.

Q MR. MAXSTON: I don't know if it helps, Dr. Wall, but I've taken you to the statement: (as read)

The impact of COVID-19 on the public health care system is undeniable.

I'm about five lines below that in the sentence beginning "Until".

A Got it, yeah, I see that now.

Q Yeah, sorry, it's a little hard to follow, because it's -- there's some incomplete paragraphs.

So I'm just asking you to confirm, Dr. Linford is stating: (as read)

Until that time [I think he means full vaccination] arrives, the COVID-19 virus

remains a real and imminent public health threat.

Those are his words?

A Yes.

Q I take it you would disagree with that?

A Yes.

Q The next sentence is: (as read)

I find that the Complaints Director has a legitimate concern of risk to the public by Dr. Wall's decision to not wear a face mask or face shield when seeing and treating patients.

That's his statement?

A Yes, it is.

Q And you would disagree with it?

A Yes, I would.

Q We go to the next paragraph, there's a second sentence: (as read)

I have decided that 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.

So those are his words in identifying a risk to the public?

A Correct.

Q And, again, you would disagree with that?
A No, he is saying that the conditions were sufficient to address the risk to the public. That I agree, he believes that the conditions on my practice would be sufficient to meet -- to meet the risk to the public.
Q Okay, thanks for clarifying that. If we look at the balance of the letter, there are a series of directions on that page, and I'm using the word "directions" because Dr. Linford uses that, he says: (as read)

> Your practice permit will be subject to the following practice -- I direct that Dr. Wall's practice permit will be subject to the following practice conditions pending completion of this hearing.

There are, as I said, four directions from him then. Would you agree that those are binding on you?
A Yes, I would.
Q And would you agree that they're still binding on you, to be more clear?
A Yes.
Q And have you complied with those conditions or orders, and are you continuing to comply with them?
A Yes, I have.
Q So in this case, you've determined that you will follow a College requirement?
A Can you be more specific?

MR. KITCHEN: This isn't a College requirement, or maybe it is, then we have to establish that. It's obviously a requirement of Dr. Linford.

MR. MAXSTON: I'll rephrase my question.

Q MR. MAXSTON: This is a -- those are a series of directions ordered by Dr. Linford under Section 65 of the HPA; is that correct?

A Yes.

Q And Dr. Linford is appointed, pursuant to the HPA, to make these kinds of decisions; would you agree with that?

A Yes.

Q And my question was are you complying, are you continuing to comply with the directions, the conditions on your practice permit?

A Yes.

Q And my follow-up question was this is a situation where you are complying with a direction from a College I'll call him designate or officer?

A Correct.

Q And as you are likely aware, Section 65 of the HPA contains a right for you to appeal a Section 65 direction to the courts. Did you launch any kind of court deal concerning the Section 65 direction?

A No, I have not.

Q Dr. Wall, I want to switch gears now and talk about

your decisions you made, your decisions or independent decisions in June of 2020 about not masking and not social distancing, et cetera.

When you -- and I think we've covered this, but I want to be clear -- when you decided in June of 2020 that you weren't going to wear a face mask or use social distancing, you were aware that those choices would contravene the Pandemic Directive as written?

MR. KITCHEN: Mr. Maxston, I'd have to say that you've asked this and he's answered it, and the answer's not controversial.

MR. MAXSTON: Well, I won't re-ask the question on the basis that you're telling me your client has already agreed to that.

Q MR. MAXSTON: Can you tell me, Dr. Wall, when you started this review of, you know, the masking issue for you? And by "review", I mean the inquiries you made about efficacy of masking.

A Well, when the Pandemic Directive came into place for chiropractors, I believe that was specific to May with the Pandemic Directive, and so wearing a mask immediately had me asking questions because I experienced the symptoms that I was experiencing, so I would have to say in early May.

Q Okay. When you did that, did you look for any articles or studies that supported masking?

A I was looking, in general, at various articles, and so I don't think I was looking for articles in support of masking.
Q Did you consider any articles in support of masking when you made your decision?
A Yeah, I've seen articles floating around supporting masking, yes.
Q So I'm assuming then that you chose to discount those articles or studies?
A That's correct. I have seen articles that support masking, and then I've seen those particular articles debunked, and so, yeah.
Q Did you contact any other organizations to get their views on this masking efficacy question?
A No, I did not.
Q Specifically, did you contact the Canadian Chiropractic Association?
A No, I did not.
Q Did you -- I should go back. Are you insured for malpractice with the CCPA?
A Yes, I am.
Q Did you contact the CCPA about your decision?
A To not mask?
Q Yes.
A No.
Q Did you consult with any medical health care

professionals or specialists?
A Not until the time where I had to achieve a doctor's note.
Q And I suppose this is an obvious question, but when you made the decision in June of 2020, you didn't have the four expert reports that are being tendered in this hearing by you?
A That's correct.
Q Is it your position that it was professionally and ethically acceptable for you to decide when and how the Pandemic Directive applied to you?
A As it applied to masking, yes, and perhaps the social distancing, like you mentioned.
Q Okay. I'm going to ask you to go to Exhibit A-8, we went through this a little bit before, but I'm going to ask you a little bit more detailed questions. That's the letter from Dr. Salem, dated December 12th, 2020. And I'll just wait till everybody's there. When did you first contact Dr. Salem about an exemption letter?
A I believe I'd have to really look at my journal. It's probably sometime in early December.
Q Was that after you had received an indication from the College that there was a complaint?
A That is correct.
Q So it's fair to say that at least part of your motivation in getting this letter was to be able to

respond to the College's complaint?
A To be supportive, and, yes, because I wasn't under the understanding that there was a requirement to produce some type of exemption letter, yes.
Q Is Dr. -- was Dr. Salem your regular family doctor at the time?
A No.
Q So how did you choose him?
MR. KITCHEN: We're getting into something that's pretty personal and private, and I'm not sure that it's relevant.
MR. MAXSTON: Sure, I'll be a little more general.
Q MR. MAXSTON: If he wasn't your regular doctor -- I don't need any background -- did you sort of pick him out of the phone book, so to speak? And I remember when there were phone books or -- I'm just wondering how you made your way to Dr. Salem; that's what I'm really asking.
MR. KITCHEN: Again, personal, private, not relevant.
Q MR. MAXSTON: When you made an appointment with Dr. Salem and subsequently got this letter, were you aware that Dr. Salem had ever issued any other exemption letters?
A No, I'm not.

Q Was your attendance -- I think there were two attendances with Dr. Salem, the but the first time you saw Dr. Salem -- well, this is an obvious question, I guess -- you'd never seen him for anything before, anything other medical issues?

MR. KITCHEN: Again, this is personal, it's private, it's not relevant.

Q MR. MAXSTON: Isn't it fair to say, Dr. Wall, that you realized that your own self-diagnosis of an anxiety issue wasn't going to withstand scrutiny unless you had a doctor's letter?

A I would say that that's likely accurate, yes.

Q And you could have gone to a doctor like Dr. Salem in May or June of 2020?

A I could have, yes.

Q When you were seeing Dr. Salem the first time, which gave rise to the December 12th, 2020 letter, did he perform any tests in terms of your anxiety issues?

A It was a consultation, and so we discussed at length my issue.

Q Okay. Did he offer a prognosis to you?

A No.

Q Did he offer a treatment plan?

A No, he did not.

Q Did he recommend any steps to address the anxiety disorder: Relaxation, anything like that?

A No.
Q If we go to the next document, Exhibit A-9, that's the second letter, January 8, 2021 letter from Dr. Salem. Just let you get to that, and I've just got a couple of questions for you about it.
A Okay, go ahead.
MR. MAXSTON: Mr. Chair, I'm always just pressing on. If someone hasn't got a document, raise a hand or someone let me know if you're -- people haven't quite gotten to where I am, but I'll just continue here.
Q MR. MAXSTON: I'm looking at the first paragraph, and it's -- this is a letter to David Lawrence, and it says: (as read)

> I am in receipt of your request for information.

I think we've covered this, but this letter is coming about because Mr. Lawrence is asking for something further; is that correct?
A Yes.
Q Yeah, so you didn't ask for this letter is what I'm getting at?
A Correct.
Q Okay. About a third of the way through, Dr. Salem says: (as read)

> There are no other pertinent documents to

satisfy your requests for [quote] tests conducted or [quote] diagnostic information. These items are not applicable to the nature of Dr. Wall's medical issue. As you'll note from my charting, the primary driver for his inability to wear a mask is anxiety that is precipitated by wearing a mask.

Just, again, to confirm, Dr. Salem doesn't ever mention a medical disability in this letter, does he?

A Correct.

Q If we look at the following paragraphs, I'm going to suggest to you that they are a summary of Dr. Salem's views about the challenges that COVID presents and the concerns he has about the validity of COVID testing, and if we go to the next page, you'll see he talks about AHS saying there's limited research, et cetera. Would you agree with me that -- on masking -- would you agree with me that a large chunk of Dr. Salem's letter is dealing with his views on the efficacy of masking and the science behind it?

A He does share his views, yes.

Q And it's fair to say that you and he are literally and figuratively on the same page on those issues?

MR. KITCHEN: I think you're asking too much about the mind of Dr. Salem. You're going to have to get a little more specific here.

MR. MAXSTON: Sure, sure.
Q MR. MAXSTON: Dr. Wall, you agree with Dr. Salem's comments in his letter about COVID and masking, et cetera?
MR. KITCHEN: That's quite general. If you want to get a little more specific, I'm not going to take an issue.
MR. MAXSTON: Well, I don't think it's an unfair question.
MR. KITCHEN: Well, it's only unfair because it's so broad and vague. If you want to get more specific, that's fine. What's --
Q MR. MAXSTON: Do you -- Dr. Wall, do you agree with Dr. Salem's comments that mask wearing does not reduce the transmission of COVID?
MR. KITCHEN: Well, hold on. Can you point us to a specific comment, because --
MR. MAXSTON: Yeah.
MR. KITCHEN: -- is that supposed to be a quote, or is that --
MR. MAXSTON: Third paragraph, first line: (as read)

> There are numerous studies that refute the benefit of mask wearing in reducing the transmission of respirator illnesses.

Q MR. MAXSTON: What I'm getting at -- I don't

want to have a debate about this -- Dr. Wall, again, Dr. Salem's views, generally speaking, about masking are consistent with yours?

MR. KITCHEN: Again, if you're asking if he agrees with that statement that you just read, fair question, but you brought it back as a very general, vague question that I don't think is acceptable.

MR. MAXSTON: Well, I'm just going to move on. I tried to establish that your client agrees with Dr. Salem, but if you're going to object to that ...

Q MR. MAXSTON: In the second letter, would you agree that there are still no mention of a prognosis?

A I would agree.

Q And there is no mention of treatment options as next steps?

A Yes, I would agree.

Q So I asked you before, you could have gotten the letter from a doctor in May or June of 2020; why didn't you do that?

A Well, at the time, I did not think it was a requirement to get a doctor's note for a medical exemption. The CMOH order does not specifically state that, and so that's why I didn't get one.

Q I think that we've established though that those CMOH orders don't come out until November or December, later

in the year.
MR. KITCHEN: Yes, you asked that, and you've gotten the answer to it from before, nothing controversial there.
MR. MAXSTON: Mr. Kitchen, I'm going to ask a question, and unless you're going to object, I don't think you can help your client with his answers, so I'm moving along to a question.
MR. KITCHEN: I'm not trying to help; I'm just objecting to questions that have already been asked.
Q MR. MAXSTON: Wouldn't you agree, Dr. Wall, that something as serious as an exemption to masking would have required, from the very outset, some type of medical verification?
A Perhaps our opinion about the seriousness of a mask exemption is different. So, again, I, at the outset, I thought my health information was a private matter and that it was very specific to myself, and I didn't believe that I needed to disclose that information at the outset, so ...
Q So you don't have any training in anxiety disorders, do you?
A No, I don't.
Q And, nonetheless, you reached a diagnosis that you had an anxiety disorder sufficient to qualify you for some

type of exemption?
A Correct.
Q Do you believe it's appropriate for health care providers to self-diagnose medical issues?
A Potentially.
Q Like an anxiety disorder?
A Potentially.
Q Dr. Wall, we've been chatting now I think for about an hour and 15 minutes. I still have a fair number of questions, do you need a quick break, and or do you want to press on and just let me know when you need a break?
A We can press on.
MR. MAXSTON: Okay, Mr. Chair, you can feel free to jump in at any time if you need to direct a break.
Q MR. MAXSTON: Dr. Wall, I want to switch gears, and I want to go to the ACAC notices to you and the profession that are set out at Exhibits C-1 to C-22.

In my questioning of Dr. Halowski, I mentioned to him that Exhibit C1, C-10, and C-13 relate to the Telehealth option and the College council's ultimate approval of that. I think your evidence with Mr. Kitchen was you didn't feel that you could pursue Telehealth; is that correct?

A That is correct. I actually did look at it, but it did not fit my practice style. I'm a hands-on chiropractor, and that was not the way I chose to go as far as practicing.
Q I'm going to let your counsel decide if there is an objection here, but I can take you through Exhibits C-2 onward and ask you specific questions about the College saying you can contact them and asking for input, but my question to you, to be more general and more efficient, is would you agree that, throughout Exhibits C-1 to C-22, there are numerous references to the College asking for input and inviting members to contact the College about the Pandemic Directive?
A Yes, I would agree with that.
Q So is it fair to say that you would have received all of these documents?
A Yes, I did.
Q And you'd already had an email exchange with Dr. Halowski, and you could have emailed him?
A Regarding what?
Q Regarding masking and the social distancing and I guess your issues about the Pandemic Directive.
A Correct.
Q And just to be clear, you didn't participate in any of the platform discussions on the Pandemic Directive?
A How many platform discussions were there?

Q You know, I can't recall. I think there's reference to at least two in those exhibits. I'm just asking you if you can recall whether you participated in any of those exchanges.
A Yes, I believe I may have participated in the first one, because I do recall -- and I may be corrected here -- but I do recall the first draft included vaguely perhaps specific terms about vaccine issues, and that was a concern to me, and I think that's what potentially precipitated the letter to Dr. Halowski, but I may have participated in that first ThoughtExchange that was regarding the first draft.
Q Okay. But other than that, no communication or contact with the College?
A And then I also participated in a recent draft, several -- perhaps a month-and-a-half to several months ago.
Q Okay, I'm really concerned with the June to December 2020 time period. So just to be clear, other than your participation on that one platform or ThoughtExchange, you didn't have any communication with the College?
A That's correct.
Q Okay. I'm kind of switching gears a little bit here, I've sort of got some general questions.

There's been comments about your human rights being violated and Human Rights Act issues. You

haven't filed a complaint with the Alberta Human Rights Commission though, have you?

A No, I have not.

Q I want to ask you some questions about your decision to not comply with the Pandemic Directive, which I think it's fair to say you've been very candid in indicating that you haven't complied with certain parts of it. In fairness, you said you have complied with others, I don't want to be unfair. Is it your position that a health care professional such as you, a chiropractor, can decide when and if he'll follow a college's requirements?

MR. KITCHEN: That's been asked and answered.

MR. MAXSTON: Well, no, I don't think it has. I've asked him about compliance with certain specific things; that's a more general question, and it's an important one.

MR. KITCHEN: Well, I understand you think it's important, and I have no issue with you asking it once, but you already asked him, and it's already been answered. We've done a lot of that over the last few hours.

MR. MAXSTON: I disagree.

Q MR. MAXSTON: My question for you, Dr. Wall --

MR. MAXSTON: -- and I'll wait, Mr. Kitchen --

Q MR. MAXSTON: -- is it your position that a health care professional can decide when and if the requirements of a profession apply to him?

MR. KITCHEN: That's fine. I won't object to that, but we're going to have problems if you keep going down this road because you've already been down this road, but I won't object to this one.

MR. MAXSTON: Well, I --

MR. KITCHEN: (INDISCERNIBLE) ask it again.

MR. MAXSTON: I wonder if we can have the court reporter repeat that question so I don't mangle it and get an objection from you, Mr. Kitchen.

MR. KITCHEN: That's a good idea.

THE COURT REPORTER: (by reading)

Q Is it your position that a health care professional such as you, a chiropractor, can decide when and if he'll follow a college's requirements?

A I believe if those requirements cause harm to the member, then I do believe that the member has the right to make those decisions. We are doctors of chiropractic. We have spent a multitude of years learning and applying science, logic, and reason. And I believe that, in this situation regarding masks, if

there is harm being caused, yes, I do believe that a member should be able to make a decision.

Q MR. MAXSTON: So if you personally decide that a requirement of a college causes harm, your view is you don't have to follow it?

A That is correct.

Q And that's if you personally make that decision?

A Yes, and I'm basing that on multiple studies, not my own information only. It's based on other scientific studies that corroborate what I believe, so ...

Q I'm going to suggest to you, Dr. Wall -- and I'm not attacking your bona fides here, your sincerity -- but if this happens, we don't have a governable profession anymore, do we?

MR. KITCHEN: I think that's a hypothetical that he can't answer.

Q MR. MAXSTON: Well, how do you think your -- if a chiropractor like you makes an independent decision, how does that affect the College's role?

MR. KITCHEN: Well, I think that question's fine, but you need to be a little more specific.

Q MR. MAXSTON: Dr. Wall, what I'm getting at is would you agree or disagree with the statement that health care providers making their own decisions about requirements makes it challenging for a college to govern its members?

A Yes, it may make it challenging.
Q We've gone through a number of situations where you have chosen to follow and not follow certain requirements from various authorities, so -- and there's a question coming, but you've told me you comply with some aspects of the Pandemic Directive but not others; you've told me that you are complying with some aspects of the re-opening order but not others; do you think that's appropriate for a professional?
A To me, it always falls back to harm being done, the -- of course, the principle, first, do no harm applies primarily to patients but, in this situation, wearing a mask does harm. And in that situation, how can I follow the College directive if it's causing harm? So it makes it difficult for the College, but it doesn't make it right.
Q And just to be clear, you've also chosen to not follow the orders of -- the re-opening orders from AHS, certain of them?
A Are you referring to the masking of patients?
Q Yes.
A Yeah, well, that would fall under the same category as my understanding that wearing a mask causes harm.
Q You're going to be calling Dr. Gauthier as a lay witness; is that correct?
A That is correct.

Q Your counsel, Mr. Kitchen, sent me something called a will-say statement about what he anticipates Dr. Gauthier will testify to. Because of the order of witnesses that Mr. Kitchen has set out, we haven't heard from Dr. Gauthier, but is it your understanding that he has strong personal beliefs against masking?

MR. KITCHEN: Speaking to his mind and you said "personal beliefs", if we go to the will-say statement, you're going to see that Dr. Gauthier disagrees with the Pandemic Directive, follows it, disagrees with it. So if you want to question down those lines, I think that makes sense.

MR. MAXSTON: Sure, I'll --

MR. KITCHEN: (INDISCERNIBLE)

MR. MAXSTON: -- rephrase that question.

MR. KITCHEN: Okay.

Q MR. MAXSTON: Do you understand that Dr. Gauthier has concerns about complying with the masking and social distancing requirements of the Pandemic Directive?

A Yes, I believe so.

Q Is it your understanding that, nonetheless, he complied with the Pandemic Directive?

A I can't speak to that.

Q Okay, we'll ask Dr. Gauthier about that then.

When we talked about you researching your decision

in June of 2020 to not comply with certain aspects of the Pandemic Directive, wasn't it your obligation as a professional to notify the College of your concerns and your intention to breach parts of the Pandemic Directive?

A I didn't see that anywhere in the Pandemic Directive that stated I was supposed to consult the College regarding my exemptions, and so ...

Q I guess what I'm saying to you is I mean we have, for example, we have a standard of practice, and if you're not going to follow the standard of practice, there isn't anything in the standard of practice saying you should call the College, but I'm asking you wasn't it incumbent on you as a professional, a health care provider, to reach out to your college in June of 2020 and tell them what you were intending to do?

MR. KITCHEN: Unless I'm wrong, I don't think that is an allegation, and I may be wrong --

MR. MAXSTON: It's not an allegation; it's a question --

MR. KITCHEN: But it's not -- no, no, no, but it's not an allegation in the notice of hearing.

MR. MAXSTON: Mr. Kitchen --

MR. KITCHEN: So --

MR. MAXSTON: -- not every question I ask has to be framed in the context of the exact charges,

and you've been objecting a fair bit to my questions, and I'm going to ask for a ruling on this, because it's another important question. I'm entitled to ask Dr. Wall, as part of his views of his status as a professional, what he views his obligations were in that scenario.

MR. KITCHEN: But that's a question of the ultimate issue, right? Is it unprofessional conduct to not reach out. That's like an ultimate. You're asking him a question about the ultimate issue, and an ultimate issue that's not in the notice of hearing, so I question the relevance of it. That's why I've objected. I've objected because you've asked questions that are worth objecting to.

MR. MAXSTON: Well, Mr. Chair, my question is --

Q MR. MAXSTON: And, Dr. Wall, please don't answer this question. You won't hear me say that very often, but please don't answer this at this time, wasn't it your obligation as a professional to notify the College about your concerns with the Pandemic Directive and that you were going to not follow it in some respects?

MR. MAXSTON: So, Mr. Chair, I -- respectfully, the ultimate issue is whether not following the -- certain things is unprofessional

conduct, but I think this is a fair question to ask, because it goes to Dr. Wall's perception of what it means to be a professional. So I've made some comments about that question, and I'm going to ask for a ruling on that.

THE CHAIR: And, Mr. Maxston, is that not two questions? First question being the obligation to notify the College, and then the second question, the last part of your -- the last part of your statement, is that a second question?

MR. MAXSTON: I can break it down into two: wasn't it your obligation as a professional to notify the College of your concerns about the Pandemic Directive, and wasn't it your obligation as a professional to notify the College of your intention to ignore parts of it or not comply with parts of it.

MR. KITCHEN: So I'll just say two things: One, Dr. Wall did answer by saying, I didn't see an obligation in the Pandemic Directive, so he's provided that answer. Nothing controversial there.

Secondly, we do have a relevance issue because that's not about -- there is no allegation. And we've talked a lot, which is kind of odd, and I haven't objected much until this point, we've talked a lot about whether or not Dr. Wall reached out. And that's not really -- I don't know if that's a key issue until

now in this case, but that's not actually an allegation. There is no allegation in the notice of hearing that Dr. Wall engaged in professional misconduct by not reaching out to the College.

So there is, for me, I think there's a lack of relevance when we're making such a big deal out of this issue when there's actually no allegation. If the allegation was in there, that would make sense. There's no allegation of that. So why are we going down this road?

THE CHAIR: Okay, we will take a brief recess while the Hearing Tribunal discusses this with counsel, and we'll just ask you to give us a few minutes, and if we could be moved to a break-out room, thank you.

(ADJOURNMENT)

THE CHAIR: Thank you for your indulgence. We've discussed the question or questions amongst ourselves and with independent legal counsel. Our view is that the question as posed as an obligation pertaining to a health professional, so in a general sense, and that this goes to what it means to be a professional, what his obligations were.

We do feel that it's within the scope of relevance, so we do agree with asking Dr. Wall to respond to the question.

Q MR. MAXSTON: Well, I will try to be careful in my wording here to capture exactly what I said before, and it will be two questions, and those are my last two questions, Dr. Wall. Wasn't it your obligation as a professional to notify the College of your concerns about the Pandemic Directive?
A I wish I could answer that simply. I will say yes.
Q The second question, wasn't it your obligation as a professional to notify the College of your intention to not comply with the Pandemic Directive?
A It's --
Q Pardon me --
A I'm sorry, go ahead.
Q Yeah, I'm sorry, I want to be fair to you, wasn't it your obligation as a professional to notify the College of your intention to partly not comply with the Pandemic Directive, and I'm thinking of masking and social distancing?
A Yeah, I -- with respect to masking, again, this was an issue that was affecting my health, I believe it was harmful to me, and so I didn't think that it was necessary to respond to the College at the time.
MR. MAXSTON: Okay, those are my questions, Mr. Chair.
Discussion
MR. MAXSTON: In terms of the remainder of

the day, my client and I certainly are prepared to stay a little longer if we need time for Mr. Kitchen to do his redirect and answer your questions. I think probably about 4:30 or 5 is the latest we'd want to go, and I know that may mean we're not finished with Dr. Wall today, but my client's view and my view, frankly, is that going any longer than 4:30 or 5 is a little bit much for a Tribunal, even though we've got a healthy, robust Tribunal here.

MR. KITCHEN: I have some thoughts on that. One, my witness has arrived. He's Dr. Wall's witness. He's left for now, because we're obviously not quite there yet. I'm going to ask, because of the enormously slow pace, and that's to no one's fault, but the enormously slow pace at which we've moved that we press ahead today and get in this witness after we're done with Dr. Wall. I do have redirect, but I don't expect to be long. So if we could get going at 4:30 with this witness, I can't see that witness taking more than 45 minutes at most, which I understand that puts us past 5, but we've ended early quite a few days. We're making pretty slow progress on evidence.

This particular witness, like I said, the reason I wanted him here today is because he's the only witness I have who cannot do virtual testimony, so I would ask that the Tribunal to be gracious with Dr. Wall and I

and permit that witness today.

THE CHAIR: I think we'll make our best efforts to achieve that. I don't personally have any commitments that would prevent me from going to 5:15 if we needed to. I'm not sure if anybody else -- perhaps there are? One of the Tribunal Members --

DR. ALDCORN: Well, sorry, this is Leslie. I'm actually seeing patients after we're done here. If I knew we were done at 5:15, I could ask people to come at 5:15 instead of 5:00. I would just need to know.

THE CHAIR: I think in the best interests of not having to do this twice, let's decide that we will go until 5:15 so that Dr. Aldcorn can make her plans accordingly.

And I think it's a long time to go without a break, I suggest we take maybe 10 minutes now and come back at 5 after -- let's make it 10 after 4, and then we'll plow through with Mr. Kitchen's redirect and then any residual questions and then deal with Mr. Kitchen's witness. Okay?

MR. MAXSTON: Mr. Chair, I just want to make one comment, I'm very sensitive to Mr. Kitchen and his witness's availability, but I do want to be clear that I think -- in terms of chasing the clock, the Hearing Tribunal shouldn't feel constrained about asking questions of Dr. Wall and finishing quickly, and so I

really want to be -- I see Mr. Kitchen nodding, and I'm glad, because I'm very sensitive to his witness, but we've heard a lot from Dr. Wall today, and once he stops testifying, Mr. Chair, you know this, your colleagues know this, you can't ask him any other questions, and there was some pretty important stuff today. So I agree, let's press on and see where we're at, but I think completing Dr. Wall today is the priority, if we can.

THE CHAIR: Fair point, Mr. Maxston, and I will share with both you and Mr. Kitchen that, during our earlier breaks, we have discussed amongst ourselves some questions with respect to Dr. Wall, and we are holding back to determine which, if any, or all of them are covered either through direct or cross-examine or redirect. So, yes, the Hearing Tribunal may very well have some questions for Dr. Wall, but we will cross that bridge after we've dealt with the redirect.

So let's break now and come back at 10 after 4, and we'll do our best, Mr. Kitchen.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, I believe we are all here, so the session is that we are reconvened, and, Mr. Kitchen, you have the floor.

MR. KITCHEN: Thank you.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: Dr. Wall, that email that you sent to Dr. Halowski, we talked about this, you said earlier that Dr. Halowski sent you a response. Did you ever get a response from council to your email?

A No, I did not.

Q Did you ever get a further response from Dr. Halowski?

A No, I did not.

Q And what was -- the one response you got from Dr. Halowski, what did he say?

A I believe he was going to refer the matter to council, and that was about the extent of it.

Q Do you think that was a substantive response?

A Not substantive. I'm fine if he wanted to have council respond to it, but not a substantive response.

Q We've talked a lot about a risk from masking. I just want to make sure everybody knows your position. Do you think there is an increased risk beyond what anybody already encounters in their daily life from you not wearing a mask?

A No, I do not.

Q Did AHS close your office?

A Yes, they did.

Q Did AHS close -- did AHS take away your practice permit?

A No, they did not.

Q The closure order, I'm going to take you there, that's D-1, and Mr. Maxston can object to this if he wants to, but I'm going to ask you to pick up -- do you see the word "nuisance" in the middle of paragraph (a) there?
A Yes, I do.
Q Could you just read for me the rest of that sentence?
A I'll start: (as read)

> This is a breach of Section 2(1) of the Nuisance and General Sanitation Regulation, which states that no person shall create, commit, or maintain a nuisance, and of Section 26 of the CMOH 38-2020, which states that, subject to Section 27 of this order, 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 entity is operating.

Q Do you think that you fall under Section 27? I can take you to the Order 38 if you need me to. Do you want me to do that?
A Yes, please, let's review that.
MR. MAXSTON: Mr. Kitchen, I'm not sure I'm going to object to this question, but, with respect, isn't it irrelevant; doesn't AHS decide who's subject to it? It's not really your client.

MR. KITCHEN: Well, again, I don't know if there's any controversy here. I think there probably is going to be some controversy, because there's no mention of CMOH 38 in the re-opening.

Q MR. KITCHEN: So, Dr. Wall, let me just ask you this: We discussed that there's an exemption clause in CMOH Order 38-2020 -- well, okay, is there a general requirement to wear a mask in CMOH Order 38-2020?

A Yes, there is.

Q And there's an exemption, correct?

A That's correct.

Q Do you think you fell under the exemption?

A Yes, I do.

Q So do you think you breached the general requirement to wear a mask?

A No, I don't.

Q Now, while I'm on this point, this is important because -- so you just said now and you said earlier that the -- you never breached any of the CMOH orders, but when my learned friend asked you if you agreed factually to the statement at 5(a) of the hearing notice, that you failed to follow the Chief Medical Officer of Health orders regarding masking and COVID-19, you said, yes, that you agreed to that, so let me ask you: Do you think that you failed to follow

any Chief Medical Officer of Health orders?
A No, I don't.
Q Dr. Wall, was there a CMOH order in place requiring masking in June of 2020?
A I don't know the exact date of the CMOH order.
MR. MAXSTON: Mr. Kitchen, we have the re-opening order. Are you referring to that, the CMOH order that directed re-opening if guidelines were followed from AHS or from CMOH or from the College? Is that what you're referring to? I'm just asking because I don't think we have any other exhibits to that effect, and, clearly, the re-opening order would have been in force.
MR. KITCHEN: Not --
MR. MAXSTON: 16-2020 is the re-opening order.
MR. KITCHEN: Yes, right.
Q MR. KITCHEN: Well, Dr. Wall, you said to -- Mr. Maxston asked you, well, was there a CMOH order to require masking and specifying exemptions before November, and you said, no, there wasn't. We already know that. So merely just asking, was there a CMOH order in June of 2020 that generally required masking?
A No.
Q Do you think things like cleaning your office and washing your hands are harmful?

A No, I don't.
Q Do you think preventing people from being within 2 metres of each other violates their personal liberty of bodily autonomy?
A No, I don't.
Q So if you're told -- if your patients are told -- if your patients are told that they have to stay 2 metres away from you, do you think that violates their personal liberty to come within 2 metres of you?
A They can choose to come within 2 metres of me, so I'm not sure exactly of the -- maybe rephrase the question.
Q Well, let me ask you this -- and I'll leave it here, I don't want to belabour the point -- but do you think people's physical movements are restricted when they're told that they cannot come within 2 metres of other people?
A Yes, I do.
Q When -- and this goes back to a question Mr. Maxston asked you about Dr. Linford's statements on risk, do you agree with Dr. Linford that there is a risk to the public from you not wearing a mask?
A No, I don't agree.
Q Now, you answered a question of Mr. Maxston about the diagnosis or lack thereof in the December 12th note from Dr. Salem, and of course, ultimately, there was this note from January 11th. What was the ultimate

diagnosis in the January 11th letter?
MR. KITCHEN: While I'm here, I'll find it for everybody's benefit.
MR. MAXSTON: Is it A-9, Mr. Kitchen?
MR. KITCHEN: It is A-9. I was just about to say that.
Q MR. KITCHEN: So, yes, so this is the letter that -- Mr. Maxston was questioning you on this letter. This is the letter that Dr. Salem responds to Mr. Lawrence. Does Dr. Salem discuss in this letter the ultimate reason for why you couldn't wear a mask?
A Yes, he did.
Q And what was that reason?
A It was because of anxiety and dealing with claustrophobia.
Q And is that consistent with what you thought about yourself in June of 2020?
A Yes, it is.
Q Are the CMOH orders being challenged in court?
A I believe they are, yes.
Q Do you think a mandate from -- well, I'll ask you this: Do you think a mandate that mandates somebody wear a mask, do you think that violates that person's rights?
A Yes, I do.
Q Do you think if a mandate violates somebody's rights that it's unlawful?

A Yes, I do.
Q Okay, almost done here. In the rescind notice from the AHS, this is Exhibit D-2, we've talked about point 4, Mr. Maxston asked you about that, do you regard point 4 as violating the rights of the patients?
A Yes, I do.
Q And do you regard point 4 as unlawful?
A Yes, I do.
Q Do you think it is professional to not comply with requirements that are unlawful?
A Could you restate that, please, for me?
Q Sure. Do you think it is professional to not comply with requirements that are not lawful?
A That was a lot of nots, I'm sorry.
Q No, no, it's okay, it's okay. It's no problem.
A Sorry, it is getting late in the day --
Q Do you think it's professionally acceptable to disobey a requirement that is unlawful?
A Yes, I think that it is professionally (INDISCERNIBLE) to (INDISCERNIBLE) a law that is --
THE COURT REPORTER: Dr. Wall, you're going to have to speak up; you're not on speaker or something like that. I'm finding you very quiet. So, sorry, could you please restate your answer?
MR. KITCHEN: Madam Clerk, can you hear my just fine?

THE COURT REPORTER: I can hear you fine, yeah.
MR. KITCHEN: I think what happened is he turned the button, because he has to click it every time so we don't get the feedback.
A I'm sorry.
THE COURT REPORTER: That's okay. Do you want me to --
Q MR. KITCHEN: Do you want me to ask it again, or are you ready to go?
A Go ahead and ask.
Q Okay. Do you think it is professionally acceptable to disobey requirements that are unlawful?
A I think it is professionally (INDISCERNIBLE) --
THE CHAIR: We can't hear you, Dr. Wall. Can't hear you at all.
A Sorry about that, yeah, I don't know what happened there.
Q MR. KITCHEN: Well, I don't want to ask it a third time, but I'm going to ask it a third time, and I'm going to try to ask it exactly the same so that there's nothing unfair here.
Do you think it is professionally acceptable to disobey requirements that are unlawful?
A Yes, I do.
Q Do you think the masking mandate is unlawful?
A Yes, I do.

Q Last question, is it your understanding that Dr. Salem recommended, as a means of dealing with your anxiety, to not wear the mask?
A Yes, that's correct.
Q And I'm sorry, I have one more question. Do you think not wearing a mask around your patients is a form of treatment?
A No, it is not.
MR. KITCHEN: Okay, thank you, those are all my redirect.
MR. MAXSTON: Mr. Chair, I'm going to ask my friend's indulgence and yours, I do have one quick follow-up question, and it relates to the second or third-last question my friend asked because it was -- I think it was something a little bit new. And maybe I'll ask the question, if you're comfortable, Mr. Chair and Mr. Kitchen, you'll let me know if you've got any concerns.
MR. KITCHEN: Sure.
THE CHAIR: Okay.
MR. MAXSTON: And thank you for this indulgence.
Mr. Maxston Re-cross-examines the Witness
Q MR. MAXSTON: Dr. Wall, this goes back to the question that was repeated three times, so you're probably pretty familiar with it, and I believe the

wording from my friend was do you believe it's professionally acceptable to disobey requirements that are unlawful, and I just want to be clear, who determines whether they're unlawful?

A Well, I believe that -- sorry, I believe that there has to be a higher standard. For example, I believe that the Constitution, Charter of Rights and Freedoms, and Alberta Human Rights are specifically aspects of the law that would supersede, for example, a professional regulatory body's requirements.

Q Sorry, just quickly, just to be clear, it's not the professional who decides that though; it's the courts, if it's the Charter or human rights?

A Yeah, well, a person has to go through those measures for sure, and that's why I've obtained counsel, so, yeah.

Q Yeah, I just wanted to be clear, when you talked about "unlawful", I thought it was something I needed to kind of clarify.

MR. MAXSTON: Thank you for that indulgence, Mr. Chair and Mr. Kitchen.

MR. KITCHEN: You're welcome.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: I just want to ask one quick re-cross [sic], which is, Dr. Wall, do you think you'd ever be able to legally challenge these mandates if you

just went along with them and ignored them?
A No, I wouldn't be able to challenge them if I went along with them and ignored them.
MR. KITCHEN: Okay, well, I guess it's back to the Tribunal now.
THE CHAIR: Okay --
MR. KITCHEN: I just want to make a note, my witness is in the room, so I want to give anybody an opportunity to object if they -- I don't even know if he can hear anything because we all have headsets on, but I just -- I want to make a note of that if anybody has any objections to him being in the room while we're still doing this.
MR. MAXSTON: I don't, Mr. Kitchen, provided he's not going to be asked questions about what Dr. Wall is just testifying to.
MR. KITCHEN: I can't imagine. I have no intention.
MR. MAXSTON: Okay, yeah, thank you.
THE CHAIR: Well, at this point, we're going to take a brief recess so that we can discuss whether Members of the Tribunal have any further questions for Dr. Wall. So bear with us, we'll be back to you as quickly as possible, and if we could go to a break-out, please. Thank you.
(ADJOURNMENT)

THE CHAIR: We're back in session. Thank you for your indulgence. Members of the Hearing Tribunal do have a couple of questions they would like to ask Dr. Wall. So I would first ask Dr. Aldcorn to raise her questions.

The Tribunal Questions the Witness

Q DR. ALDCORN: Thank you. So, Dr. Wall, I'm just wondering in the time frame between June and December, if you had seen any new patients in your office or patients who had yet to have been to your office before?

A Yes, I have.

Q And my second question would be, because I don't know how your clinic is set up, but when you indicated that you saw one patient at a time, would that imply that there was only one patient in your clinic at a time, or could there be more than one patient in the clinic at the time, or are you seeing only one patient at a time?

A Yeah, so I only saw one person at a time, and so, yeah, no other people in the clinic.

DR. ALDCORN: Thank you.

THE CHAIR: Okay. Dr. Dawson -- Mr. Dawson, sorry.

Q MR. DAWSON: Dr. Wall, thank you. My question is in two parts. The first part is has a patient ever asked you to put on a mask, and if not,

how would you respond if a patient asked you to put on a mask?

A Yes, I have had a patient ask me to put on a mask, and at the time, I granted that request. They were a very nervous person, and so I did put on a mask. I told her that I did have an exemption and that I was -- experienced these symptoms that I've been discussing, but for that one person and one person only, I did it.

Q THE CHAIR: Just a quick follow-up, Dr. Wall. About what time period would that have happened?

A That would have been likely between June and -- I'd have to look back on my record, but, yeah, sometime between June and October, I would think.

THE CHAIR: Thank you. Those were the questions of the Hearing Tribunal for Dr. Wall.

If there's no other matters, Dr. Wall, we'll dismiss you as a witness, and thank you very much for your time and your testimony.

(WITNESS STANDS DOWN)

THE CHAIR: And, Mr. Kitchen, I believe we're at the point where you could call in your witness.

MR. KITCHEN: Thank you, which I'll do, and if we only get to the end of my direct, and we can't do the cross, obviously I don't want to rush Mr. Maxston's

cross, then so be it, we'll have to figure that out, but I think we should at least try to get through the direct and maybe even the whole thing.

THE CHAIR: It's quarter to 5. We've got 30 minutes. Mr. Maxston, are you okay with proceeding in the eventuality that you don't get an opportunity to cross-examine today?

MR. MAXSTON: Yeah. In fact, I think we've got a 5:15 hard stop, and for obvious reasons, I'm not going to want to rush through any cross-examination, and then, of course, there's redirect and then Hearing Tribunal questions. I think, regrettably, we're probably not going to finish with this witness today, but certainly if we go till 5:15 and see how far we get, I think that's a good idea.

THE CHAIR: Okay --

MR. KITCHEN: I think that's reasonable, so let's proceed on this basis. All right, so -- this is just a procedural note, he's -- Mr. Kosowan is going to be appearing on Dr. Curtis Wall's screen, so it has Dr. Curtis Wall's name, but, obviously, we all know it's not Dr. Wall; it's the witness I'm calling. So I'm just going to ask him to have a seat.

Madam Clerk, did you want to go ahead and swear him in.

JARVIS KOSOWAN, Affirmed, Examined by Mr. Kitchen

Q MR. KITCHEN: Mr. Kosowan, do you prefer I call you Jarvis or Mr. Kosowan?
A Jarvis.
Q All right, thank you, Jarvis. What do you do for a living?
A I own a (INDISCERNIBLE) agency for Alberta sales organization.
Q And just to confirm, are you a patient of Dr. Wall's?
A Yes, I have been for about 20 years.
Q Could you just briefly describe for us why you've stuck with Dr. Wall for your chiropractor for so long?
A I like the method that he uses. It's not the crunching and everything else. It's in the technique that I appreciate and enjoy, and Dr. Wall has become kind of a friend also over the years, so ...
Q Do you respect Dr. Wall?
A Absolutely.
Q Do you wear a mask when you see Dr. Wall for treatment?
A Sometimes. Sometimes not. It all depends when the mask mandate was invoked, I would bring it into the clinic, but then after that, inside, because it was only one on one, I had the respect to Dr. Wall to be able to take my mask off.
Q Are you grateful that Dr. Wall gives you a choice on whether or not to wear a mask, depending on whether or not you want to?

A Absolutely. I totally appreciate that.
Q Does Dr. Wall wear a mask when you come in for treatment?
A No, he does not.
Q Are you aware of the reasons for why Dr. Wall doesn't wear a mask?
A We had a conversation. He had alluded to the fact that he had a medical exemption for wearing a mask, and I respect that.
Q Now, do you feel comfortable with Dr. Wall not wearing a mask while he treats you?
A Absolutely, no qualms whatsoever.
Q Do you believe Dr. Wall puts you at any increased risk or in any way threatens your health by treating you without wearing a mask?
A No, I do not.
Q Are you at all concerned about catching COVID-19 from Dr. Wall because he treats you without wearing a mask?
A No, I'm not.
Q Do you think Dr. Wall could provide you with the treatment you want if all he could ever do is call you on the phone and talk with you?
A Absolutely not. That's not possible physically, I don't believe anyway, at least I haven't heard of a procedure, so I prefer the in-office procedure that he does.

Q So do you think Dr. Wall could provide you with the treatment you want if he could never come within 2 metres of you?
A It would be physically impossible.
Q Do you have an interest in seeing Dr. Wall continue to practice as a chiropractor?
A Absolutely. I believe he provides a worthwhile community function to a lot of people that are -- have the same issues I do.
Q Do you think it will harm your interests as a person if Dr. Wall is ordered to stop practicing or ordered to only practice over the phone?
A Definitely. I don't even know how he'd be able to operate over the phone, quite honestly, that -- it just escapes my imagination, quite honestly.
Q Do you want to keep Dr. Wall as your chiropractor?
A Absolutely.
Q Do you think your interests should be considered as part of any decision to restrict or not restrict Dr. Wall's ability to practice as a chiropractor?
A Absolutely. He's providing a service to me that makes me feel better physically and also that comes mentally also, and he provides a service that, without being able to touch me, he wouldn't be able to provide it at 2 metres of social distancing or over the phone, so I can't see how it would be possible.

Q If Dr. Wall is ordered to stop practicing or stop treating you except by calling you on the phone, do you think that would be the Chiropractic College's fault?
A Sorry, I didn't understand the question.
Q That's okay. I'll ask it again. If Dr. Wall is ordered to stop practicing or he's ordered to stop treating you except by calling you on the phone, whose fault do you think that will be?
A I imagine the College did prevent him from practicing as a chiropractor, because he provides an immense service to me.
Q Do you think Dr. Wall has done the right thing by letting you not wear a mask while he treats you?
A Yes, I do, absolutely. It gives me just -- it gives me more comfort, knowing that we're not -- I'm not concerned about getting COVID within the chiropractic office with Dr. Wall, so, therefore, it gives me the comfort of take the mask off, I feel better, and I'm comfortable with that.
Q Thank you.
Discussion
MR. KITCHEN: Now, those are all my questions, so I leave it to Mr. Maxston if he thinks he can do a cross as fast as I've done my direct, but I leave that up to him. I would suggest that that's the better way to go just because it's more convenient for

Jarvis, but -- that's 20 minutes.

MR. MAXSTON: Yeah, Mr. Kitchen, I think I'm, and this is no one's fault, but I think I'm put in a bit of a difficult position because I've got to think about my questions and then reconvene, and we've got the 5:15 hard stop. I don't know how long I'm going to be. I may be very short with this witness, but I don't know, and I, frankly, would prefer to, and I know this is an inconvenience, but I, frankly, would prefer to come back another day and not be racing against the clock.

MR. KITCHEN: You honestly think you're going to be -- you know, it's likely you're going to be more than 20 minutes?

MR. MAXSTON: I don't know. I'm just chatting with -- Mr. Lawrence and I were chatting just beforehand, and I don't know how long I'm going to be. I suppose I could ask some questions, and then we could see where we're at, but I might not be finished, but I do think I'm going to be pretty short.

THE CHAIR: May I just interject and say that don't discount the possibility that Members of the Tribunal may have questions for the witness.

MR. KITCHEN: Well, I'm in the Tribunal's hands. I prefer that we go ahead, so that's certainly what I want, but, you know, the Tribunal ultimately

directs its own proceeding, so I really have to leave it up to the Tribunal.

THE CHAIR: Okay, we do have 20 minutes. I think Mr. Maxston has expressed his desire to not have to interrupt his cross-examination, and I do believe that there may be questions from the Hearing Tribunal, so I'm -- I want to respect the hard deadline of 5:15, because, quite frankly, there have been patients booked based on that timeline.

So I think, unfortunately, for the witness, we will -- and it's up to Mr. Maxston, if he wants to start. If he wishes to defer until the next date that we can find to accommodate everybody, then I'm -- I would agree with that.

MR. MAXSTON: With a measure of reluctance, because I'm sympathetic to Mr. Kitchen and his witness. I would prefer to wait until we resume.

THE CHAIR: Okay. And, please, no disrespect, sir, if I call you Jarvis, I would just like to thank you for your testimony today and to advise you that, at a future date to be determined, there will be an opportunity for the College counsel to cross-examine you on your testimony, and I would ask your cooperation in that regard. We will be in touch and the College will be in touch with you regarding future dates. And I think on that basis, we can

dismiss you for today, and with our thanks once again, we appreciate your testimony.

A Thank you.

MR. KITCHEN: Thanks.

THE CHAIR: Okay. With that, I think it will be up to the College to solicit availability to determine when we can reconvene to continue on with this witness and the other witnesses that Mr. Kitchen has before we get to closing arguments. So I guess we're not going to go right till 5:15, which is, I'm sure, good for Dr. Aldcorn.

I would like to say thank you to everybody, and, Mr. Kitchen, I appreciate your comments and Mr. Maxston's. There has been a lot of testimony, a lot of documentation, a lot of information over the last four days, and we appreciate -- on behalf of the Tribunal, we appreciate everybody's, you know, cooperation and participation in this. So we'll -- we will --

MR. MAXSTON: Mr. Chair, I'm sorry, one quick question, I think in terms of next steps, Mr. Kitchen, I think it was earlier or later last week, was good enough a list of his witnesses, the order he's going to be calling them in, and I wonder if he's comfortable sending that list again to Ms. Nelson but with some estimated times for each witness, and that

would, I think, give us a sense of whether we need to reschedule two days, three days. It might be we can schedule two days and one day or something like that, but I think my cross-examinations of the lay witnesses will be brief. I'll be a little longer with the experts. But I guess if we have a sense from Mr. Kitchen about his timelines, I can jump in, and then we can get back to the Tribunal saying we need 'X' or 'Y' days, and then Ms. Nelson can canvass dates.

THE CHAIR: Okay. Is that okay with you, Mr. Kitchen?

MR. KITCHEN: Yeah, I think that's a great idea.

THE CHAIR: Okay, great. Okay, well, we will wait for that to unfold and look forward to hearing from the College about reconvening. So thank you once again, we'll call the hearing closed for today.

PROCEEDINGS ADJOURNED

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

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

DISCIPLINARY HEARING

VOLUME 5

VIA VIDEOCONFERENCE

Edmonton, Alberta

November 16, 2021

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

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November 16, 2021 Morning Session

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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 9:06 AM)

THE CHAIR: This Hearing Tribunal is reconvened. We are in session.

Mr. Kitchen?

Discussion

MR. KITCHEN: So the witness who was supposed to go first thing this morning to be cross-examined is Jarvis Kosowan, is who we ended with last time. He's feeling quite under the weather; he didn't sleep well. He's asked to go this afternoon.

I've just spoken with Mr. Maxston, because, obviously, the greatest concern there is any prejudice raised by the other side or -- by the College I should say.

So the plan at this point is to have him go this afternoon because he's unavailable this morning. So I guess what I'm doing is asking if the Tribunal will permit that.

THE CHAIR: Mr. Maxston, did you want to speak to that?

MR. MAXSTON: Yeah, thank you very much. Mr. Kitchen was really candid with me, and I really have no concern here. We can call the witnesses in whatever order will work for him.

THE CHAIR: Okay. Mr. Kitchen, with us not having Mr. Kosowan this morning, how did you plan to proceed from this point?

MR. KITCHEN: The first two witnesses after that I had scheduled are Charles Russell and Dave Hilsabeck, in that order, and then I want to go on to

Dr. Justin Gauthier after that. I had another witness planned for today, but he is unavailable due to urgent work requirements, and his name was Elvin Music. So at this point, I have three witnesses I want to do, and then circle back to Jarvis Kosowan for cross-examination this afternoon.

Now, unfortunately, Dr. Gauthier, because, of course, he's a practicing chiropractor, he has patients all this morning. He's blocked off the entire afternoon, so he can go immediately after lunch, even if we take an early lunch, but he cannot go this morning because he's with patients.

I had originally planned for the morning to be quite full with the four other witnesses I had. Now, I only have two. So that's where I'm at, which makes a little bit of a rocky day, I understand, but at least I don't think we'll be running out of time. If anything, it will be the opposite.

THE CHAIR: So you would start with either Russell, Hilsabeck, or Music?

MR. KITCHEN: I'll be starting with Charles Russell and then moving on to Hilsabeck. And at that point, I have no witnesses available until first thing in the afternoon, and that will be either Jarvis Kosowan, if he's available, or Dr. Justin Gauthier. He will be available right after lunch.

THE CHAIR: Okay, Mr. Maxston, any comment or thoughts?

MR. MAXSTON: No, I'm fine with that approach. Mr. Kitchen's been very candid, and I know we all have problems, from time to time, getting our witnesses to attend, so that's just fine.

THE CHAIR: Okay, thank you, Mr. Kitchen, Mr. Maxston, then we will proceed based on Mr. Kitchen's comments, and you can call your first witness this morning, Mr. Kitchen.

MR. KITCHEN: Okay, well, I see that, as far as I can see, Charles -- oh, there he is. Mr. Russell, can you hear us?

THE WITNESS: I can.

MR. KITCHEN: Excellent. Now, Madam Court Reporter is Karoline, her name is Karoline, she's going to swear you in --

THE WITNESS: Okay.

MR. KITCHEN: And then we'll get started.

CHARLES RUSSELL, Sworn, Examined by Mr. Kitchen

Q MR. KITCHEN: Well, good morning, Mr. Russell. I'm going to, unless you object, I'm going to call you by your first name, Charles?

A Fair enough.

Q For the record. Charles, can you tell us what you do for a living?

A I'm a commercial real estate agent.
Q And are you a patient of Dr. Wall?
A I am.
Q How long have you been a patient of Dr. Wall?
A At least 20 years, by my recollection.
Q And why have you stuck with Dr. Wall as your chiropractor for so long?
A Because he's effective. He does -- he fixes me when I need to be fixed.
Q How do you find that Dr. Wall's treatments help you?
A I come in in pain, and I leave without pain.
Q Thank you. Now, let me ask you, do you respect Dr. Wall?
A Absolutely.
Q Do you wear a mask when you come in to see Dr. Wall for treatment?
A I don't wear a mask for anything.
Q And so just to confirm, that includes when you're in Dr. Wall's office?
A Absolutely.
Q Are you grateful that Dr. Wall does not require you to wear a mask when you come in for treatment?
A Absolutely. I probably wouldn't come otherwise.
Q Does Dr. Wall wear a mask when you come in for treatment?
A No.

Q Are you aware of the reasons why Dr. Wall doesn't wear a mask?
A Yes.
Q Do you feel comfortable with Dr. Wall not wearing a mask while he treats you?
A Absolutely.
Q Now, let me ask you this: Do you prefer that Dr. Wall not wear a mask while he treats you?
A I wouldn't come if he wore -- if I had to wear a mask, if he was wearing a mask. I might sit still for him wearing a mask, but I sure won't wear one.
Q But if you had the choice, if you could choose, would you prefer to see Dr. Wall not wearing a mask or with wearing a mask?
A I'd prefer to see Dr. Wall not wearing a mask or anybody else.
Q Why is that?
A Because I believe they're ineffective, I believe they're dangerous, I believe they create more bad health than they do good health, and it's -- I just don't believe in that. I've studied it enough to know it's the wrong thing to do.
Q Do you believe Dr. Wall puts you at any increased risk or in any way threatens your health by treating you without a mask?
A Absolutely not.

Q Do you think Dr. Wall has done the right thing by letting you not wear a mask when you come in for treatment?
A Yes.
Q I'm going to shift gears a little bit. Let me ask you this: Do you think Dr. Wall could provide you --
MR. KITCHEN: -- oh, my apologies -- I had turned it off, and then I called Mr. Maxston, and I forgot to turn it off again. I apologize. I'll start again.
Q MR. KITCHEN: Do you think Dr. Wall could provide you with treatment that you want if he could not come within 2 metres of your body?
A I think it would be pretty much virtually impossible.
Q And do you think Dr. Wall could provide you with the treatment you want if all he could ever do is call you on the phone and talk with you?
A I don't think that would work.
Q And I know it might be a bit obvious, but could you tell me why?
A He needs to have the hands on.
Q And, again, I know it might be a bit obvious, but what is the treatment that Dr. Wall gives you when you come into the office?
A He adjusts my spine and my neck and whatever else might be out of line and checks to make sure I'm --

everything's lined up.
Q And what does he use to do that?
A His hands.
Q Do you want to keep Dr. Wall as your chiropractor?
A Absolutely.
Q Do you think it would be against your interests if Dr. Wall is ordered to stop practicing or to only practice over the telephone?
A Absolutely, I would be upset.
Q Do you think your interests should be considered as part of any decision to restrict or not restrict Dr. Wall's ability to practice?
A I would hope it would have some bearing.
Q If Dr. Wall is ordered to stop practicing or to stop treating you except by calling you on the phone, would you be upset with that order or that decision and the person or body that made it?
A Absolutely.
Q Could you explain why?
A It's not fair. It's not reasonable. It goes against the Hippocratic Oath. It goes against a lot of things.
Q Do you think the chiropractic profession has important core principles?
A Absolutely.
Q And what do you think some of those are?
A Promote natural health, to give people an alternative

to the pharmaceutical/medical establishment; to mainly promote natural health, just natural treatments.

Q Do you think those treatments are currently being adhered to -- sorry, let me say that again, I said it wrong. Do you think those principles are currently being adhered to?

A Well, I think they are by most of the practitioners. I'm not sure about the administrative side of it.

Q And why do you say that?

A Because we're having this hearing right now. I think it's a travesty that we're even having this hearing.

Q And as far as your knowledge, what is it that Dr. Wall has done wrong that brings us here today?

A I don't think he's done anything wrong, but I think one person out of hundreds was living in fear and thought they should do something about it.

Q How do you think the chiropractic profession should be acting in response to the Government COVID restrictions?

A I think they should be pushing back. I think they've got plenty of evidence that the Government's mandates are unreasonable and not in the interest of good health.

Q Forgive me for asking, Charles, but how old are you?

A I don't tell people how old I am. I'm 55 in my mind.

Q Do you regard yourself as being in the at-risk category

for COVID?
A No.
Q And why is that?
A Because I'm healthy, and I practice good health practices, and I do the things that make a difference, and I stay away from chemical drugs.
Q And just one more question, I just want to go back to what you said earlier, you talked a lot about natural health. So you -- would you say that chiropractic treatments, hands-on chiropractic treatments, that's a part of natural health?
A Absolutely.
MR. KITCHEN: Well, those are all my questions. Thank you, Charles.
A You're welcome.
THE CHAIR: Mr. Maxston?
MR. MAXSTON: Thank you, Mr. Chair.
Mr. Maxston Cross-examines the Witness
Q MR. MAXSTON: Mr. Russell, my name is Blair Maxston. I'm the lawyer for the College's Complaints Director, and I've just got a few questions for you, and I will not be asking you how old you are, so you cannot worry about that. I just have --
A I plead the fifth on it.
Q -- a few questions for you. Sorry?
A I plead the fifth on that one.

Q Yeah, well, I probably would too, so good for you. Would you agree with me, Mr. Russell, that practicing as a chiropractor is a privilege not a right?
MR. KITCHEN: Hold on, that's a legal opinion question.
MR. MAXSTON: Well, I'll rephrase it.
Q MR. MAXSTON: Would you agree with me that not everyone can be a chiropractor; you have to earn it?
A I think you should be qualified.
Q And you're aware that the Alberta College and Association of Chiropractors is the professional regulator for chiropractors in Alberta, correct?
A That's what I understand, yes.
Q Are you aware that that college has mandatory requirements for registration before someone can be a chiropractor, like going to a certain school, that type of thing?
A That would seem reasonable to me.
Q And are you also aware that the College has ongoing requirements for chiropractors so they can stay in good standing with the College, like continuing education and those kinds of things?
A Makes sense.
Q Would you agree that those requirements are important

in order to ensure that chiropractors are competent and can practice safely?

A I would say so.

Q Now, Mr. Kitchen sort of touched on this with you, but you're aware that, at times, the College, the College of Chiropractors, has had a directive requiring that its members, people like Dr. Wall, wear masks when they treat patients; is that your understanding?

A It's my understanding, yeah.

Q You've made comments today in support of Dr. Wall not following the requirement for masking; is that correct?

A Yes.

Q Would you agree with me, Mr. Russell, that you can only speak for yourself on those matters?

A Yes.

Q And would you agree with me that there might be other patients of Dr. Wall who don't share your views?

A Could be.

Q And would you agree that there could be other patients who might want Dr. Wall to comply with the College's pandemic masking directive?

A Could be.

MR. MAXSTON: Those are all my questions for you, Mr. Russell.

THE CHAIR: Thank you, Mr. Russell.

Mr. Kitchen, anything on redirect?

MR. KITCHEN: No, I do not have any redirect.

THE CHAIR: Okay, perhaps we can take a quick break just to see if -- or maybe I'll ask the Panel now, do any of the Panel Members have any questions that they would like to discuss in caucus before we dismiss Mr. Russell? Apparently not, Mr. Kitchen.

So thank you, Mr. Russell. I believe your testimony today is concluded.

A Okay.

MR. KITCHEN: Thank you, Charles. You're free to go in other words.

A Okay.

MR. KITCHEN: Take care.

(WITNESS STANDS DOWN)

Discussion

MR. KITCHEN: Chair, I guess I'm going to have to ask that we take a break, and I'm going to try to get my second witness here as fast as I can, and I'll also start putting in calls to the other witnesses I have, because we're moving at opposite of the speed we were last time.

THE CHAIR: It's 9:30 -- just about 9:30, Mr. Kitchen. How long would you like, and how long do you think you need?

MR. KITCHEN: Well --
THE CHAIR: If we check back in 15 minutes?
MR. KITCHEN: Yeah, we could check back. I don't know if I'll have my witness available. He was -- he preferred to come to the office because he didn't want to do the technology, so I'm going to have to call him and see how quickly he can get here. So --
THE CHAIR: Okay.
MR. KITCHEN: -- I can't say that he'll be ready in 15 minutes, but we can check in. Is that all right?
THE CHAIR: Okay. Yeah. I wonder if there's another way of doing this. Ms. Nelson, can Mr. Kitchen contact you when his witness is ready, and you can let us know. We'll shift to our break-out room.
MS. NELSON: Yeah, that works. Mr. Kitchen, you have my cell number, correct?
MR. KITCHEN: No, but I'd like it.
MS. NELSON: Okay, so 780-938-1666 is my cell number.
MR. KITCHEN: Okay, thank you.
MS. NELSON: What I'll do is I'll just open up all the break-out rooms, everyone can go into their

break-out room, and then, Mr. Kitchen, when you kind of have an idea of scheduling, just send me a text, and then I'll communicate to everybody through the rooms.

MR. KITCHEN: Excellent, thank you.

MS. NELSON: Okay, thank you.

THE CHAIR: Okay, we'll take a break. We'll head to our break-out rooms and reconvene at such time as we have another witness. Thank you.

(ADJOURNMENT)

THE CHAIR: Mr. Kitchen, could I ask, were you able to contact your witness or witnesses?

MR. KITCHEN: So Mr. Kosowan is available at 10:45 to be cross-examined, and he'll be appearing virtually, and what I mean by that is he won't be here in the office with me like he was the last time.

THE CHAIR: Okay.

MR. KITCHEN: Dr. Gauthier, the earliest he can be available is 12:45. He expects to be done with his last patient at 12:30. So wherever we're at with that means we have this witness now, we have Mr. Kosowan at 10:45. Then I would propose we have a lunch break, and then we come back, and we have Dr. Gauthier.

THE CHAIR: I'm sorry, when you say "we have this witness now", who is that?

MR. KITCHEN: That is Dave Hilsabeck. Now,

we had this issue last time, of course, because he's in the office with Dr. Wall and I, so he's appearing on Dr. Wall's screen, that's why it says "Dr. Curtis Wall", so just note that it's not Dr. Curtis Wall, it is, in fact, the witness, Dave Hilsabeck.

THE CHAIR: Okay, so I'm sorry, I should have asked this, are we prepared to resume then?

MR. KITCHEN: I am.

THE CHAIR: Okay, and Mr. Maxston?

MR. LAWRENCE: I don't think Mr. Pavlic is back, Mr. Chair.

MR. MAXSTON: Yeah, I was just going to say, on my screen, I'm not sure, but I don't think Mr. Pavlic is here.

THE CHAIR: Okay.

MR. PAVLIC: Can you hear me?

THE CHAIR: Yeah, can't see you; your camera's off.

MR. PAVLIC: Okay, I can put my camera on. Here we go. There I am. Yeah, sorry, my apologies, I didn't put my camera on, forgive me.

THE CHAIR: We will forgive you.

Okay, I think we're all here now. Mr. Maxston, you're okay to resume?

MR. MAXSTON: Yes, thank you for checking.

THE CHAIR: Okay. All right, Mr. Kitchen.

And just for the record, we are back in session, thank you.

MR. KITCHEN: All right, Madam Court Reporter, we're ready when you are.

DAVID WARREN HILSABECK, Sworn, Examined by Mr. Kitchen

Q MR. KITCHEN: All right, Dave, could you please just say your full name for the record?

A My name is David Warren Hilsabeck.

Q Thank you. Dave, could you tell me what you do for a living?

A At present, I'm a corporate pilot for an energy company here in Calgary, based out of Calgary.

Q Are you a patient of Dr. Wall's?

A Yes, I've been a patient for him for at least 15 years.

Q Okay, why have you stuck with Dr. Wall as your chiropractor for so long?

A I appreciate how he manages business with my body, let's put it that way, how he conducts business with me, his communication with me, and his responses to me and my needs, and that's why I've always come back to him. His gentle nature. I've been to other chiropractors before, and sometimes are definitely rougher, but I appreciate how his gentle nature looks after me.

Q Thank you. Now, I'm going to ask you a couple questions that might seem pretty obvious, so bear with

me. Can you describe for me in detail the treatment that Dr. Wall does on you when you come in to see him?

A The treatment in detail, so a lot of times what we'll do is discuss where -- the back issues that I'm having, for example, or hip issues or whatever the case may be. He will then examine me and to find out where the -- my problems lie and then will start to treat me step-by-step, let's say up and down my spine and into my hips or whatever that my problems are at the moment. Is that enough detail for what you need?

Q Yes, but let me ask you a question, what does he use to treat you?

A What does he use. Well, he uses his hands, we're using his workbench, uses different tools as far as vibrating massage therapy or the pressure point actuator, and we use a couple of different benches that he has here to figure out where my faults are and to help correct that.

Q Thank you. Dave, do you respect Dr. Wall?

A Greatly, yes, very much so. I appreciate what he has to say, and how he suggests going forward, what to do with my body, stretching exercises, strengthening exercises, those kind of things to get me back into shape and where I need to be.

Q Do you think Dr. Wall could provide you with the treatment you want if he could not come within 2 metres

of you?
A Oh, definitely not, no. Chiropractic is a hands on, and I mean hands on to my body to be able to adjust me correctly. If he was 2 feet away, there would be no sense in even coming here. Like I could not -- he could not do the adjustments that need to be done at a 2 foot mark -- or a 2 metre mark, so, no, he couldn't do that.
Q If he wasn't able to do that, what do you think you would do?
A I'd be in a world of hurt. First of all, to find other chiropractor that I trust and respect and have used for so many years; I've gone to a few other ones, you know, over the last 40 years, let's say, some with some success, some without success, and so I would be in a world of hurt. I wouldn't be able to keep going as often and, you know, do the things that I do without a proper chiropractor that can help me out.

And chiropractic I find is -- it's different for everybody -- sorry, it's different for every chiropractor, they do it in so many different ways. So one adjustment from one chiropractor doesn't necessarily mean that it's going to work for me. Dr. Wall has figured out my body, what I need and where my weak points are and has been able to fix me up with that.

So going to another one, I'd be in a -- I'd be in trouble, I think, in very short order, because I'd probably have to go to a number of them to even figure out if that style of chiropractic would work for me or not.

Q Thank you, and I know this may be obvious, do you think Dr. Wall could provide you with the treatment you want if all he could ever do was call you on the phone and talk with you?

A Oh, no way. It's physically impossible. Physically, because I have to be here, he has to be able to adjust my back, my spine, my hips, whatever the case may be, so definitely not.

Q We've already touched on this, but just to confirm, do you think it would be against your interests if Dr. Wall was ordered to stop practicing or to only practice over the phone?

A Yes, of course, it would be against my interests. If he wasn't available to do this, like I said, I'm in a world of hurt, and it would take me a long time, a lot of money just to find another chiropractor. Every time you go into a new chiropractor, you've got to start all over; you've got to do the whole process of an initial consultation and whatnot. So it would take a long time and a lot of money.

So, yes, it's -- your question was is it in my

best interest that he is here, most definitely, both physically and monetarily.

Q Do you think, as a member of the public, that your interests should be considered as part of any decision to restrict or not restrict Dr. Wall's ability to practice?

A Yes. And as a member of the public, I understand what he's doing, I appreciate what he's doing, and his thoughtful manner in how he manages me and my family, and so as a member of the public, yes, it affects me greatly, and it would -- I guess all I can say is yes. Can you say the question again for me, please?

Q I will, but I just want to confirm something, so your family comes to see Dr. Wall as well?

A Yes, over the last, you know, 15 years, both my wife and my kids have come numerous times, and so, yes, it would affect us greatly to have all of us be affected this way.

Q Now, let me ask you this: If Dr. Wall is ordered to stop practicing or to stop treating you except by calling you on the phone, would you and your family be upset with that order or decision and the person or body who made it?

A Most definitely. That affects us greatly. So we would not be able to -- Dr. Wall could not do what he does over the phone for us. You know, you can say, Oh, do

this exercise or that exercise; but if you need your spine, your hips, whatever, knees, actually manipulated, he can't do that over the phone. So, yes, it would affect us greatly. It would be a huge hindrance, a big disappointment that somebody would actually take away his ability to do that.

Q Thank you. Now, I'm going to take us to the -- to some of the deeper issues. Do you wear a mask when you come to see Dr. Wall for treatment?

A No, I don't, I don't wear a mask in the office here.

Q Are you grateful that Dr. Wall does not require you to wear a mask when you come in for treatment?

A Yes, most definitely. I am -- it's frustrating wearing masks. I find that so often people that are wearing a mask, if he was wearing a mask, and we're trying to converse and trying to figure out what's going on with me, if I can't read the lips sometimes or just see what's going on, facial expressions, I lose a lot of communication that way.

I find it a huge inconvenience to have to wear a mask. It doesn't matter where I go. You go into as simple as a -- into a restaurant, and you're trying to order, and you're trying to figure out what the specials are for the day, but you can't hear what they're saying; you go through a drive-through, for example, to get some food, and you go -- they're

mumbling, it's very, very, frustrating. You go to a hardwood store, and you're trying to figure out what you need for parts and pieces, and this guy is sitting there mumbling, and you can't see what he's talking about, or you can barely hear what he's talking about, so with my hearing diminished a little bit, it's very frustrating. I just don't appreciate it at all having to wear a mask everywhere.

Q Thank you. Does Dr. Wall wear a mask when you come in for treatment?

A No, he doesn't, and then, again, you know, in his office here, he's had the shields up and whatnot, so if the -- he is protected, but, you know, when he is working on me and my body, no, he's not wearing a mask. My -- you know, I want be able to hear him, I want to be able to see what he's got to say, so I appreciate that he doesn't wear a mask and that we're able to communicate properly without me asking, What did you say, what did you say, what did you say all the time. It's just so much better for me personally.

Q Do you believe Dr. Wall puts you at any increased risk in any way or threatens your health in any way when he treats you without wearing a mask?

A No, not at all. I feel very comfortable with him. I've known him and his family, a lot of his kids have been the receptionists and things like that, so over

the years, we've got to know each other, and I wouldn't say on a -- necessarily a personal level, but you understand where they're coming from. They are not the partying type of people that are out carousing all the time. You know, he's not exposing himself to any risk that I can see or have ever heard of even when he's not at work here.

So for him to -- I do not feel threatened at all coming in here, it's just a safe environment, and I haven't got a problem with it at all. It's like our work environment, you know, we know the people that we work with, and have we had any COVID problems at work? No, we haven't. But you know the people, you know what they're trying to do. So his threat level I think is next to zero.

And even with COVID, you know, we know that you look at the statistics, and for people that get COVID, we're sitting at 99.8 percent of the people that get it survive it. You know, that's huge. Even people, you know, that get the flu don't even have that kind of access -- or don't have that kind of, not access, but record of survival, so I don't feel threatened at all with what he does here.

Q You are, of course, aware that the Alberta College of Chiropractic has required, mandated that Dr. Wall wear a mask when he's treating you; would you agree with

that?

A That's what I've heard, that they are mandating it, but I find that that mandate -- how do I put it? I find that that mandate isn't necessarily based on strong data. I feel that a lot of this mandate is more on a political side of things, and that, you know, you look at the mask mandates around the world, and I fly around the world, I see all sorts of different things.

So you look at some place like Japan, for example, and Japan was masked-up, they were sitting in the high 98, 99 percent of people were masked-up, they still had huge outbreaks, so masks didn't necessarily fix the problem.

And I feel that the political side of things, you know, we're being forced to do this, but the data doesn't necessarily support it as far as I'm concerned.

Q You say you go around the world, and you see other places; are there any places where you don't encounter any mask mandates?

A Oh, sure. Like last week, I was down in Dallas, Texas, for the week. I went down there training, and everybody has a different way of doing things. So you get to the airport, for example, and you have to be masked-up because it's federally regulated in the airports. They sit there, and they say you've got to stand 6 feet apart when you're in the waiting area for

the airport. So everybody's 6 feet apart. Then all of a sudden, it's all okay because we can all go through a tunnel, hop on an airplane, sit side by side, and that's perfectly fine, and I'm rubbing shoulders with the person next to me, and that's perfectly fine.

So you look at the different ways of doing business, and you kind of go, well, okay, that makes sense, that doesn't make sense, that's just plain stupid. I get down to Texas, I get out of the airport, we take our mask off, and I didn't put a mask on for a week. I went to -- into the class, I went to the simulator, I went to restaurants, we went to hardware stores, nobody was wearing masks down there. And people say, Well, you know, that's because they've had a huge outbreak.

Actually it's not. If you look at the statistics, percentage-wise, we are at a higher percentage of infection than they do down there, and they don't have -- they're just not wearing masks. You do see masks in some of the restaurants, and some of the servers and whatnot were wearing masks, but none of the clientele.

So I hear, I haven't been to Arizona for a couple months now, and Florida have been for a while, but I hear that both those states are the same way: They have gone away from their masks, and it has not

affected them whatsoever.

Q I think I just have one more question for you. Do you think Dr. Wall has done the right thing by letting you not wear a mask when you don't want to?

A Yes, I do. I think he's done the right thing. First of all, he knows what I do and the risk. You know, I've had to take so many tests and whatnot traveling across the border, back and forth all the time, and so I know where I'm at, and I think he knows where I'm at.

So when I come in and he's not requiring a mask, it's -- there's a mutual agreement there that, yeah, we are both on the safe side of things. We're both very conscious that COVID is out there, both responsible with what we're doing and how we're acting and -- with our lives, but we both appreciate where we're at.

And so to come in here and not wear a mask, I appreciate that we do not have to, he's not requiring it. If he said I had to wear a mask to be treated, I wouldn't be happy about it, but would I do it? Yes, because I need the treatment. So if he's forced into it, it's not because of his doings, but because of somebody else is, you know, forcing him to go down this path.

Q Forgive me, one last question for you, do you think Dr. Wall prioritises your interests above his interests?

A That's a good question. I will say yes, because he's my doctor, my chiropractor, worrying about me. And so where I'm at, I believe that he's looking after me and not necessarily him. I don't know what else I can say about that, but I would agree with that, that he's looking after me and my best interests.

Q Do you think, by having this hearing, the Complaints Director for the College is acting in your best interests?

MR. MAXSTON: I'm going to object to that, Mr. Chair. There's no way this individual can comment on the motivations or intentions of the Complaints Director.

MR. KITCHEN: Well, I didn't ask about motivations of the Complaints Director. I asked if he thinks it's in his interest, and that's in his knowledge.

MR. MAXSTON: Well, I think this line of questioning is entirely subjective. I suppose I won't object further to it, but I don't see any value in this witness expressing personal opinions about the actions of the College.

THE CHAIR: Could you repeat the question, please, Mr. Kitchen?

MR. KITCHEN: The question I asked is if Mr. Hilsabeck thought that having this hearing was in

his best interests as a patient.

THE CHAIR: I'm going to sustain that objection.

A Okay, so I can answer it?

Q MR. KITCHEN: No. That means you can't.

Those are all my questions.

THE CHAIR: Thank you.

Mr. Maxston?

Mr. Maxston Cross-examines the Witness

Q MR. MAXSTON: Good morning, Mr. Hilsabeck, I just have a couple of quick questions I want to ask you based on some exchanges you had with Mr. Kitchen, and then I've got a few other questions I do want to ask you.

You made some comments earlier about survival rate and threat and those types of things, and I just to be clear, you're not a physician or an immunologist or a virologist; those are your personal views?

A That is correct; that would be my personal views on my research of those subjects.

Q You also talked about your belief that the College's pandemic masking and I should say required masking mandate wasn't based on strong data, but you, of course, don't have any knowledge of the process the College undertook to create that mandate, do you?

A No, that's correct, I do not know what the College has

done.
Q So I'll just ask you some questions then from a broader perspective. Would you agree with me that a person has to earn the right to practice as a chiropractor in Alberta?
A Earn the right? He has to take the training. So the right, I'm not sure what you're going with as far as the right is concerned.
Q I think --
A My knowledge --
Q Go ahead, sorry.
A Okay, my knowledge is for like a chiropractor, a doctor, they take the training, and then I'm assuming there is an application for that province or whatnot to be able to accept -- or to be able to license -- to get licensed in that province.
Q And that kind of ties into my next question, which is you're aware that the Alberta College and Association of Chiropractors is the professional regulator or licensing body for chiropractors in Alberta?
A Yes, I understand that, yes.
Q And based on your comments just now, I think you'd also agree with me that there are mandatory requirements to become registered with the College to be a chiropractor, like education?
A That's correct, yes.

Q And would you also agree with me that there are requirements the College has to keep a licence for a chiropractor, things like continuing education or payment of fees?
A Oh, sure, yes, I understand that completely. I'm a pilot; that's all we do.
Q I kind of thought you would, yeah. You probably get a lot of con ed from your regulators as well, so mandatory con ed.

Would you agree that those requirements to keep registration for a chiropractor are intended to ensure safe and competent practice?
A Would you say that again, please?
Q Yeah, those mandatory requirements to keep your licence, the mandatory requirements the College issues, would you agree that those are in place in order to ensure safe and competent practice?
A I would, yes.
Q Mr. Kitchen spoke with you about the College's directive, Pandemic Directive, requiring the wearing of masks when a chiropractor is treating, and I just want to be clear that, to this day, you're not wearing a mask, and Dr. Wall isn't wearing a mask when he performs treatment on you?
A That is correct.
Q I think it's fair to say you've made comments today in

support of Dr. Wall not masking when he treats you. Would you agree that you can only speak for yourself when you make those comments?

A I can speak for myself and for my family, yes.

Q Fair enough. Would you agree that there could be other patients of Dr. Wall who don't share your views?

A Oh, definitely.

Q And do you --

A Yes.

Q -- agree -- I'm sorry.

A No, go ahead.

Q Would you agree that there may be other patients of Dr. Wall who, in fact, want him to comply with the College's masking requirement?

A There is that possibility, sure.

MR. MAXSTON: Those are all my questions. Thank you, Mr. Hilsabeck.

A Thank you.

THE CHAIR: Mr. Kitchen, anything on redirect?

MR. KITCHEN: Just one question.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: Dave, my friend, my learned friend, Mr. Maxston, he asked you do you think the College's mandates are for the purposes of keeping the public safe. I don't know if those were his exact

words, but he can object if he thinks that's not reflective of the substance of what he said, do you have any actual knowledge yourself of what motivates the College when they have mandates for chiropractors?

A Do I have any knowledge? No, I don't have any knowledge of how they do their -- how they do that. What do I say there? A lot of this stuff, a lot of the mask wearing, a lot of our regulations, it seems like it's politically based.

Case in point, Calgary, we got a new mayor here in the last month, and her first response was basically whatever the Alberta Government says, we're going to add 28 days to it. Now, how does she become more knowledgeable than our head of our medical people, Dr. Hinshaw and her group of people with the AHS? How do they make those kind of claims after being elected and within 24 hours make a claim like that? This is why a lot of this stuff is so political and not necessarily scientific in my mind.

And it's not the same the world over. So I see, as I'm flying around different places in the world, or I see different countries and their requirements and whatnot, I see such a variety of mandates and requirements, and it's not on science, it's on personal belief or a political belief or whatever the case may be, but not necessarily science.

So why the difference between Alberta and Texas, for example? Why such a wide variety of understanding of what COVID is, what the requirements are, and you look at the percentage of COVID cases, there's really no difference. If you look at John Hopkins, and you look at what Texas has, and you look at Alberta, and you look at percentages, they are just about identical.

Q Why do you think the College is acting political?

MR. MAXSTON: Mr. Chair, I might ask my friend to rephrase that question. I think there's a premise in that question that the College is acting politically, and I don't know if this witness has any information in that regard, and, again, I think we're going very far from the core issues here.

MR. KITCHEN: Well, it wasn't a presumption because that's what he said, so I just asked him why he thought that. That's all. This is in the same line of questioning you asked him, Do you think the College is doing this for safety. Now, he has no knowledge of that, he said so, but you asked him anyways. I'm asking the same type of question, asking him why he thinks the College is acting in a political manner.

THE CHAIR: I'll allow that.

A I don't see -- you look from Alberta Health Care, for example, a lot of their decisions keep flip-flopping, and it doesn't seem to be on science, it seems to be

political. You look at each level of government, it seems to be political, not scientific.

Now, you say, Well, where are you getting your information from. Well, I get it from a lot of different sources. I read a lot of different -- and I'm not just talking the main media; I go to different places and do some analysis myself, and you start looking at, typical is, John Hopkins, which you would think would be a fairly reliable source with the data that they present, and you look at percentages.

So why does Alberta have one set of rules, Calgary have another set of rules, and you think that it's political. So I'm going down the road there, yes, I believe that everybody is doing it on a political side of things and not necessarily a scientific.

So do I think that the -- your Association is doing that? I feel that in a way, yes. I do not know that you are doing it purely scientific.

MR. KITCHEN: Thank you. That's it for my redirect.

THE CHAIR: Okay, I'll just quickly poll the Panel, are there any questions that the Panel wish to discuss before we release the witness?

Nothing further, okay. Okay, thank you very much. You are excused, sir, and we appreciate your coming in, and you can leave if you wish.

A Oh, good, thanks very much.

(WITNESS STANDS DOWN)

THE CHAIR: So, Mr. Kitchen, we have 15 minutes before your next witness; is that correct?

MR. KITCHEN: Yes, that's correct.

THE CHAIR: Okay, perhaps Ms. Nelson can put us in break-out rooms until 10:45, and then we'll reconvene. We'll adjourn for now and reconvene at 10:45 for the cross-examination of -- I'm sorry, I've forgotten his name -- Kosowan; is that right?

MR. KITCHEN: That's right.

THE CHAIR: Yeah, okay. Mr. Maxston, you're okay?

MR. MAXSTON: Yes, that's fine. Thank you for asking.

(ADJOURNMENT)

THE CHAIR: We'll reconvene, and Mr. Maxston will start his cross-examination of Mr. Kosowan.

JARVIS KOSOWAN, Previously affirmed, Cross-examined by Mr. Maxston

Q MR. MAXSTON: Good morning, Mr. Kosowan. Can you hear me?

A Yes, I can.

Q Thank you. Can you just confirm for me that you're still under oath when you're giving your testimony

today?
A Yes, I am.
Q I just have a few questions for you. The first question I have is are you aware that the Alberta College and Association of Chiropractors is the professional regulator and licensing body for chiropractors in Alberta?
A Yes, I am.
Q And are you also aware that the College has mandatory requirements such as education before someone can become licensed as a chiropractor?
A Not totally, no.
Q You'd agree with me though that, generally, that would be the case to become a member of a profession?
A I would believe that would be correct, yes.
Q Are you also aware, or if you're not, would you agree with me that the College of Chiropractors has ongoing requirements to keep registration as a chiropractor, things like continuing education or paying a yearly fee?
A Yes, I'm aware of that.
Q And would you agree that the College, having those requirements, is important to ensure chiropractors are competent and can practice safely?
A I agree with that.
Q You spoke with Mr. Kitchen, my friend Mr. Kitchen, a

little while ago, and you talked about the College's Pandemic Directive which required masking by chiropractors when they treated patients; do you recall that?

A Yes, I do.

Q And do you also recall that when you first testified, you made comments in support of Dr. Wall not following that requirement and not masking when he treated you?

A That is correct.

Q Would you agree that when you made those comments, you could only speak for yourself?

A That is correct.

Q And would you agree with me that there could be other patients of Dr. Wall who don't share your views?

A That's possible.

Q And would you agree with me that there could be other patients of Dr. Wall who want him to comply with the requirement to mask when he's treating patients?

A Obviously. I believe that's the way this whole thing got initiated, by one of the clients complaining about the mask not being worn, so I agree with that statement.

MR. MAXSTON: Those are all my questions for you, Mr. Kosowan. Thank you for making yourself available today.

A Thank you. Am I done or --

THE CHAIR: Mr. Kitchen, did you have anything on redirect?

MR. KITCHEN: No, I don't.

THE CHAIR: Well, Mr. Kosowan, thank you very much, once again, for finishing with your testimony. You are free to leave. We do appreciate your assistance in this.

A All right, thank you very much.

THE CHAIR: Thank you.

MR. KITCHEN: Thank you.

(WITNESS STANDS DOWN)

THE CHAIR: So I guess we are on an extended break, Mr. Kitchen, until 12:45; is that correct?

MR. KITCHEN: Yes, that's correct, my apologies, that's the earliest my next witness can be available.

THE CHAIR: Okay, we will have an early and extended lunch break I guess. Perhaps we can -- we'll reconvene at 12:45, and hopefully we'll -- and that will be the last witness of the day for today; is that correct?

MR. KITCHEN: Very likely. There is an unlikely chance that the witness, who I was hoping to call this morning but who's busy with work, may be able to make it this afternoon after Dr. Gauthier. It's

unlikely, but possible; I'm just going to check with him at lunch.

THE CHAIR: Okay, very good. Then we will recess for now and reconvene at 12:45. Did the Panel Members wish to caucus? I don't see a need to. Okay, we'll see everybody back at 12:45. Thank you.

MR. KITCHEN: Thank you.

PROCEEDINGS ADJOURNED UNTIL 12:45 PM

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

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November 16, 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

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 12:47 PM)

THE CHAIR: The Hearing Tribunal is back in session at 12:45, and Mr. Kitc1hen will be examining on direct Dr. Gauthier.

MR. KITCHEN: All right. Well, Mr. Maxston, you're ready to proceed?
MR. MAXSTON: Yes, I am, thank you.
MR. KITCHEN: All right, Madam Clerk, could you please proceed to swear in Dr. Gauthier.
DR. JUSTIN ROBERT GEZA GAUTHER, Sworn, Examined by Mr. Kitchen
Q MR. KITCHEN: Good afternoon, Dr. Gauthier. Could you just please tell us your full name so we have it for the record?
A Sure, Justin Robert Geza Gauthier.
Q Thank you. And, Dr. Gauthier, do you practice in Alberta?
A Yes, I practice in Medicine Hat, Alberta.
Q And how long have you been practicing?
A About two-and-a-half years. I started in practice in Medicine Hat in March of 2019.
Q Thank you. And where did you go to school?
A Palmer College of Chiropractic down in Davenport, Iowa.
Q And can you tell us anything that sticks out to you that you were taught at Palmer College?
A Can you repeat that?
Q Is there anything you learned at Palmer College that was particularly important to you?
A They had a good balance of teaching chiropractic, integrating it within the medical system. I thought it

was a good balance of learning both sides of health. So talked about the importance of keeping a body in a frame, a structure, a spine that is balanced and in line, while understanding there's other issues that chiropractic does not deal with, and that's where we kind of work as a team with the medical system, so I thought it was a good balance of learning the health system.

Q When you graduated and joined the profession here in Alberta, were there any principles that you thought were at the core of chiropractic?

A I think first and foremost our job is to take care of the spine. That is the core of most chiropractors, and manipulation or adjusting of the spine is I was taught quite vital to the profession. There's many other things that chiropractors will do in addition, but adjusting and the spine was always the core primary treatment that chiropractors would give.

Q And how do chiropractors administer that treatment?

A In their office, you've got to assess that person's spine based on what you see, based on what you feel, based on the feedback from the patient. Most chiropractors adjust with their hands, some use an instrument or a tool, but it's essentially always, always with contact I guess.

Q And what's the primary treatment that you provide your

patients?
A I practice an upper cervical technique, so I focus on correcting the neck as much as possible, so with my technique there won't be more cracking. If a patient needs that, I will have them go to another chiropractor, and so I adjust with the upper neck primarily, and it's a very low force technique without twisting or cracking.
Q Okay, and what do you use to do that?
A But -- it's all by hand, yeah, it's all using -- adjusting by hand.
Q Now, forgive me if some of these questions are a bit obvious, but can you provide that treatment from a distance?
A I might lose my licence if I tried. I don't think it's possible to do it without actually contacting the patient. You can't -- I would not be able to properly assess them. I wouldn't be able to properly adjust them. I wouldn't reasonably be able to walk anybody through treating themselves that way or having another person treating them in that way, so, no, it wouldn't be possible with what I do.
Q And forgive the redundancy, but you wouldn't be able to provide that type of treatment over the phone?
A No. I've had a couple phone calls with patients as follow-ups a few days later if they're from out of

town, and they can't -- just to ensure after their first appointment that things are going well, and they're not experiencing any issues, a checkup over the phone, very, very seldom, less than since I've started practicing, but the primary treatment is always in person.

Q So do you think Telehealth could be effective for you to help your patients?

A No, no, not with what I do and not with how the chiropractic that I learned, you know, adjusting by hand as your primary treatment, I would argue it's not, it's not possible to do.

Q Do you think your patients would find it effective?

A No, I don't think I'd have any patients if I tried doing that.

Q Do you believe you would be properly caring for your patients if you could only provide Telehealth over the phone?

A No, not at all. I wouldn't be able to properly assess them. I wouldn't be able to feel or see what's going on, and there's many intangibles that you get from patients after you've seen them several times that, over the phone, you simply don't get that you'll see and hear when the patient is with you. So, no, I don't think there's any way I would be able to take care of patients to the same level that I am now, not even

close. I don't know what it would look like.
Q And if you could only provide Telehealth, you said earlier that you don't think you'd have very many patients, so what do you think your patients would do if you could only provide Telehealth?
A I think they would go to another chiropractor, either somebody in town that does maybe a different style, or they would travel a couple hours to find someone that does. I mean, that's what we have. I have a lot of patients that come from Saskatchewan, Swift Current, Moose Jaw, Regina from up to three, four, five hours away, and they specifically come here because they can't get what they want in those places, so they would find somewhere else to go. I'd lose probably over 95 percent of my patients if I tried it. Maybe a hundred, I don't know. I would lose a very exceptionally high number of patients.
Q And forgive me if this question is a bit obvious, but if you did that, if you only did Telehealth, would you be able to earn enough income to keep practicing?
A I don't think so, not as I've learned to practice, not as I've learned to practice chiropractic, or as I've been practicing for the last two-and-a-half years. I mean if I lost 95 percent of my patients, I wouldn't have much income at all, so no.
Q I'm going take you in a slightly different direction

now.

A Sure.

Q Dr. Gauthier, are there different types of health care workers?

A Yeah. Yes.

Q Do you think there's a difference between yourself as a health care worker and so-called frontline health care workers like nurses and doctors at a hospital?

A Yeah, I think we have very different roles and fulfil different needs, yeah.

Q Do you regard your chiropractic office as a health care setting?

A Yeah, it's a health care setting.

Q Are there different types of health care settings?

A Yeah, absolutely.

Q Is there a difference between your office as a health care setting and a hospital as a health care setting?

A Having been a patient in a hospital and a chiropractor in an office, it's my experience, yeah, they're very different.

Q How so?

A Mainly just the types of patients and the types of complaints that we get are very different, but I think (INDISCERNIBLE) ER specific, it's very acute care or injuries or accidents, whereas I've never (INDISCERNIBLE) driven to my office in an ambulance,

right? That's not the role of my office is to take care of people with their acute injuries that are more serious, and that's in regards to, say, physical injuries or bleeding, that type of issue.

In my couple of years practicing, I've never had a patient come with a primary (INDISCERNIBLE) of a heart attack --

THE COURT REPORTER: Primary what? Primary what?

A -- or come to me saying, Do I have a heart attack, or I feel like I am, can you examine me? I've never had a patient come, wondering if they're in the middle of a stroke. I've never had a complaint of stroke or heart attack. You know, I've had patients that I've sent to be assessed for stroke, but that's never been the primary complaint.

Same thing with pneumonia, bronchitis, or anything like that, I've never had a patient come to me, saying, Hey, I think I have pneumonia, can you help? I've never had that type of complaint, whereas in the ER, from what I've seen, that's a -- those are some of the more common complaints that ERs get.

Q Thank you.

(DISCUSSION OFF THE RECORD)

Q MR. KITCHEN: So, Dr. Gauthier, let me ask you this: Do you care about more than just the spine of your patients?

A Yeah, of course.
Q Give me an example; what are some of the things that you tend to care about when it comes to your patients?
A So just one example, recently I had a patient who has a lot of pain and spine, like musculoskeletal issues, so we went through (INDISCERNIBLE). She's also been a smoker for 40 years and drinks, you know, five or six or seven drinks of alcohol per night. And so at our initial appointment, I said, Hey, like I can help you a certain amount I believe, but the reality is that if you continue, you know, smoking and drinking to this level, you're going to have a difficult time getting to your full potential, right; like there's a good chance you're always going to have some issues if you continue doing those things. It's not -- and I told her, it's not up to me to make you stop, it's not up to me to counsel you on how to stop, but to let you know it is going to prevent, you know, your energy levels, your fatigue, your immune system, your pain levels, all those things, and I said I'm happy to find, if you want, a counsellor to help with that, could be as simple as a health coach or something. But that was just somebody last week where I had to have that discussion with her; it was, you know, beyond what I could do, but I felt like if I didn't at least acknowledge those limitations for her, I wasn't doing

her justice by just saying, I'm going to help you with your spine and neck. So we had a discussion on that, and she was open to looking at other things, so that was one more recent example.

Q Do you care about the overall health of your patients then?

A Yeah. Yeah. Totally, because I mean -- I mean, you can see it in people when they're in physical pain, you can tell when people are in a stressful state. Another patient just last week was -- could tell was very -- in a lot of mental distress, and, you know, for a couple minutes, as I was treating her, she starts confessing to me about stress within her marriage and other issues that her concussion resulted in. You know, so I listened and said, Hey, like that's again more than what I do, and it's not my -- I'm not a marriage counsellor, but I'm happy to help you find somebody with that.

So, yeah, the emotional, the physical, the nutritional. Those are all important aspects of it that don't come up with every patient, but they do come up.

Q When it comes to treating your patients, are there any principles or ideals that guide you?

A Can you explain that a little bit or ...

Q Well, I can't too much or else Mr. Maxston will rightly

say that I'm leading you, so I'm just wondering if there's -- do you have any core ideas about the practice or core ideas about your approach to health or core principles when it comes to interacting with your patients that are really important to you as a practitioner?

A Sure, so I mean my primary view of patients is to view them as people, right, and to want to take care of them the best that I can, right, and that's not telling them what to do, not telling them what their treatment is, and allowing them to make that decision for themselves, and if they make a choice that I think is bad, that's their choice, but it doesn't mean I don't take care of them to the best of my ability, to treat those patients with respect regardless of whether I think what they're doing is good or not, they're still deserving that respect and love that I think we're supposed to have as health care providers.

So to me, that's kind of my core principle that guides me is to take care of people to the best of my ability without causing them harm and allowing them to make choices whether I think it's good or not.

Q So that allowing them to make choices then, is that, for you, is that the same idea as consent?

A Yeah, yeah, like they -- I can't force them to do something that has an impact on their health or

otherwise, and I can't do something to them that they don't want to. So if that day they came in, and they don't want me to adjust them for whatever reason, even if everything inside of me, everything that I'm seeing about them says they need to be adjusted, I don't adjust them, right, because that's their choice.

And if I think they shouldn't get a massage for the next day for whatever reason, but they choose to, that's their choice, and it's not going to affect how I take care of them. They've got to decide for themselves what they allow me to do and do at other times as well.

Q You mentioned something in your last answer to me about harm. Is it important to you to make sure you don't cause any harm to your patients?

A Oh, yeah, yeah, I mean if I'm causing more harm than good, (a), they're not going to come to me for very long, and (b), I'm not -- even if they did continue coming to me, I'm not doing my job as a health care provider to create an overall improvement in their health, right? So causing harm is a big part of that.

Q That's a good idea. All right, Dr. Gauthier, are you aware that the Alberta College of Chiropractors has mandated that all chiropractors must wear a mask when they're treating patients?

A Yes.

Q And have you worn a mask while treating patients when required to do so by the College?
A Yes.
Q Have you done so willingly?
A No, it's not been comfortable, but I still have done it.
Q And why do you do it even though you didn't want to?
A I mean, it was in our practice directive, right, so the way I understood it if I didn't, I wouldn't be able to take care of patients, so it was kind of a -- didn't really have a choice, a choice in that matter.
Q If you didn't have a choice for you, is that the same as saying you were coerced into doing it?
A Well, yeah, I mean if there's not (INDISCERNIBLE) choice for not doing something I'm supposed to do, then, yes, it's not a choice. It feels like that to a certain degree. Sorry, can you repeat that?
Q I think I said, to get it exactly right, for you -- is for you not having a choice in doing something, is that the same as coercion? And I believe your answer was yes, with some explanation, but you did break up so feel free to repeat it, if you can still hear me.
A I apologize James, I had a bad internet connection for a bit. Can you repeat that?
Q Yes.
THE COURT REPORTER: Did you want me to read it

back?
MR. KITCHEN: Madam Clerk, yes, because that way, I'm not slightly varying my question.
THE COURT REPORTER: (by reading)
Q If you didn't have a choice for you, is that the same as saying you were coerced into doing it?
A Sorry, can you repeat that, please?
THE COURT REPORTER: I'll give you more context if that helps. Is that okay, Mr. Kitchen?
MR. KITCHEN: That's fine, yeah.
THE COURT REPORTER: Okay, a series of questions and answers for you, Dr. Gauthier: (by reading)
Q And have you worn a mask while treating patients when required to do so by the College?
A Yes.
Q Have you done so willingly?
A Sorry, can we pause so I can try to (INDISCERNIBLE) different location?
MR. MAXSTON: Mr. Kitchen, this isn't my preference but -- because I'd like to see your witness when he testifies, but sometimes turning off the video can make it easier.
MR. KITCHEN: Yes, I was going to raise that, because I understand your position on that.

Q MR. KITCHEN: Dr. Gauthier, if you could turn off your video to see if that improves it, and then we can decide from there how we want to proceed, but we should just try it to see if it actually helps. Is that all right with you?

A Sure, so I've got my video off here. Is this sounding okay or not?

Q Sounding better so far. You let us know if you can hear us better.

MR. KITCHEN: Madam Court Reporter, do you mind reading my -- the first time I asked the question, if you could read it to Dr. Gauthier again and see if he's able to fully hear it and respond?

THE COURT REPORTER: (by reading)

Q If you didn't have a choice for you, is that the same as saying you were coerced into doing it?

A To me, it is, yeah, without a choice, it feels a certain amount like coercion, whether the consequences are severe or not. Yeah, when there isn't a choice, it feels like that, a certain amount, yeah.

MR. KITCHEN: Well, Mr. Maxston, it does seem to be a little better with his video off, but I'm sensitive to the fact that you want to able to see the witness. Do we want to go back to having his video on, and then as needed, we'll (INDISCERNIBLE) the question?

MR. MAXSTON: Well, I'll ask Mr. Lawrence if he has any concerns, but I'm prepared, frankly, to go ahead without the video.

MR. LAWRENCE: I have no concerns.

THE CHAIR: I think, Mr. Kitchen, we could try having his audio through a cell phone, but let's continue with this option to see if this solves it, because I know there's synchronization problems when you have different audio and video links.

MR. KITCHEN: Okay, thank you.

Q MR. KITCHEN: All right, Dr. Gauthier, we're going to try it with the video off, see if that improves the audio. It does typically, so we'll go on that basis for now.

A Okay.

Q So thank you for your answer to my last question.

So let me ask you this because you said you don't wear the mask willingly, can you tell me what's difficult about wearing the mask for you or why don't you willingly wear it?

A Sure. So, yeah, I've got asthma, and it's -- typically, it's pretty well controlled, I haven't really had issues with it over the years. I noticed shortly after needing to wear the mask, whenever it was in 2020, March or April, when we were supposed to wear them, not just at work, but, you know, in the hours and

days after working, I just noticed a lot more difficulty breathing. I just noticed, in general, my asthma flaring up considerably. It was hard to know first if it was the mask or whether -- there was a lot of variables, but that's kind of been the one constant was that.

And it definitely has been for me, the last year-and-a-half or so has been the worst -- the most difficulty I've had breathing in relation to, you know, asthmatic symptoms that I've had in, I don't know, at least ten years. I've gone through more inhalers than I had for a long time.

I notice especially at the initial appointment where there's more talking, because I spend a lot of time with patients, I was just getting short of breath much quicker. So I just had a lot of difficulty breathing, and I recognize not everybody feels that way, but, you know, with the way that my asthma has been, it's been difficult, yeah.

Q Speaking now just for yourself --

A Yeah.

Q -- do you regard your asthma as a medical -- as a form of a medical disability?

A Yeah, like I didn't really think of it like that, you know, until the last year or so when I recognized how limiting it's been, but, yeah, it's definitely caused

me some distress or dysfunction.
Q Are you aware that, due to human rights legislation in the Province, that there are sometimes obligations on parties to accommodate medical disabilities?
A Yes.
Q Have you ever asked the ACAC if they would accommodate you and your asthma medical disability?
A No, I haven't.
Q When the ACAC mandatory mask directive was issued to the Practice Pandemic Directive in the spring of 2020, did the College give you any reason to think that it would permit you to treat patients without wearing a mask if you told them about your medical disability and asked for accommodation?
A I honestly can't say I remember what I thought when I went through that first directive. For me, the reason I didn't ask I guess, from what I'm remembering, was that I got the impression that I just -- I wouldn't be able to treat patients whether I had an exemption or not, but, again, I can't -- I don't have that practice directive from that time memorized or remember it perfectly.
Q But what gave you the impression that the College wouldn't accommodate you?
A Well, in the directive, again from what I remember, it was very clear that wearing a mask was required no

matter what, so it didn't seem worth it to even try to get an exemption or ask about an exemption or, you know, go to a medical doctor over that.

Q Now, you've touched on this, but just to clarify --

A Yeah.

Q -- however small or however large, do you think wearing a mask the last year-and-a-half while treating patients has caused you any degree of harm?

A Yeah, I mean I think so. I've definitely noticed like just more restriction in general, having to wear the mask, you know, at work, because we're, you know, here lots of the time. Yeah, I find myself out of breath just talking to patients, which is not a normal experience for me. So I mean that combined with the fact that I've gone through more inhalers, you know, which I would much prefer not to do, yeah, it's definitely made -- just restricted my lung function.

Q Do you think informed consent should be obtained before someone requires somebody else to wear a mask?

A I do, because I think it has an impact on health. It doesn't necessarily impact everybody in health, but some people it does. I know many patients will say they hate wearing it because it restricts them; other patients say they don't care.

But I've seen that same principle at work in certain types of shoes, some people put on a pair of

shoes that cause them lots of foot and hip and knee pain, and other people put the same pair of shoes on, and it doesn't bother them whatsoever. So I've just -- I've kind of come to realize that because something does not cause one person harm or discomfort doesn't mean it doesn't do that to another.

So because it impacts health, I mean I've noticed impact to my energy levels and fatigue and breathing, if it's going to be mandated or examined or pushed, I think it should be -- it is -- the idea of informed consent should be applicable to it as well, yeah.

Q Was informed consent obtained from you by the College?

A No, there was no questions or answers or anything about it. It was just part of the practice directive that we had to wear it if we wanted to keep treating patients.

Q You mentioned your patients commenting on masks, so have you noticed that, in some of your patients, wearing a mask has negatively impacted their health?

A Yeah, I've had a lot of patients mention it, and it's hard to know because there's -- again, there's so many variables, but many, many patients have mentioned just their general like energy levels or if it's fatigue, some of them have noticed headaches when they're wearing it. Some of them it's very acutely, they have symptoms within minutes of wearing a mask. When you see it so many times, and it's so strongly correlated

with certain patients, it's hard to deny it. Yeah, it's definitely come up.

And like I said, some patients don't notice a change at all, whereas some patients really do, and I -- I mean, I've had some patients develop skin rashes and, you know, acne-type issues. I myself, about three months into wearing a mask, ended up with quite a significant boil on my nose that I never had before. Again, is it attributable to the mask? Maybe, maybe not but it was definitely a very noticeable change shortly after starting to wear them.

Q I'm going to ask you some different questions now. Do you think it's possible, Dr. Gauthier, to actually know the scientific truth about things like viruses?

MR. MAXSTON: I'm going to have to object to that, Mr. Kitchen. This is a lay witness not being called for expert opinion evidence, and I think I've been pretty generous in the types of questions you've asked. You've got four experts coming. I am going to object to this, because I think this goes far afield of what this witness can testify to as a lay witness.

MR. KITCHEN: Okay, I understand what you're saying, and I agree with you. I haven't in any way asked for an opinion, but I think maybe if you'll let me go, you'll see I'm not going to ask his opinion on COVID or the effectiveness of lockdowns; he isn't

qualified to give that. I'm asking him if he thinks it's possible to know the scientific truth, not what that truth is, but if he thinks it's possible to know that truth, and that's not an opinion question; that's a question that could be asked to anyone.

MR. MAXSTON: I suppose, frankly -- well, I guess you can ask your question. I'm not sure what the value of it is, because you're right, I guess it's a possibility for everyone to know the truth, but I'll let you know if I'm concerned you're kind of heading off in the wrong direction.

MR. KITCHEN: Okay, thank you.

Q MR. KITCHEN: So, Dr. Gauthier, let me ask you that again.

A Sure.

Q Is it possible -- speaking for yourself, right?

A M-hm.

Q From your perspective, is it possible to actually know the scientific truth about things like viruses?

A Given time and observation and enough people and study, I think it's possible, yeah.

Q Speaking for yourself, from your perspective, is there enough scientific information now available to you for you to determine if restrictions like masking and 2 metres distancing are effective or not effective in preventing the transmission of COVID?

A Can you repeat that?
Q Sure. Is there enough scientific information now available to you for you to be able to make an assessment if restrictions like masking and distancing are actually effective or not at preventing the transmission of COVID?
A Well, I think there's quite a bit of evidence about those things that have come out in the last year-and-a-half. I mean, I have opinions on it, but, yeah, I do think there's a lot of information that's available to tell us how likely it is that they're helping or not.
Q And as far as you're concerned -- and, again, I don't want you to give me your opinion -- but for you --
A M-hm.
Q -- is there enough scientific information available for you to be able to make an assessment whether masking is working and should be supported or is not working and should be opposed?
A I think, yeah, there is a decent amount of evidence -- there's a decent amount of evidence demonstrating -- I've seen a decent amount of evidence demonstrating that they may not be working as well as we want them to. To say with a hundred percent certainty, I can't do that, but I think the evidence is there.
Q Do you think the mask mandate of the College is 100

percent based on science?
A No.
Q And if it's not 100 percent based on science, what do you think of the other things that it's also based on?
A Do you mean what other -- what other ideas is it based on, or are you talking about like masking or -- like are you talking specifically of masking in that --
Q If mandating masking is not 100 percent based on science --
A M-hm.
Q -- then what else do you think it's based on?
A What is it based on, okay. So from my experience, a lot of the decision -- the decision especially with, say, patients and masks, they're not mandated to wear any particular kind, right? We know some masks are not very effective, some masks are a little more effective. So the masks that we're mandated to wear, the surgical or N95 have a little bit better use, still not great, but a little bit better.

Whereas patients, they don't have to wear the masks properly. There could be gaps in it. They could be wearing a mask that filters out an extremely miniscule amount of, you know, viral particles. We know that the virus is, in many ways, say largely airborne in addition to other modes of transmission. And so when patients are coming in with all these

different kinds of masks that don't work, I know that it is not doing the job that it is supposed to, that we want it to, but we do it a certain amount out of fear or to say we're doing something; it's better to do something than nothing. So I'm not entirely sure what -- you know, what's driving that.

But when I look at, you know, what I see in the clinic specifically, if I stick to the workplace, what patients wear and what they're allowed to wear as per the mandate, it's doing very little to prevent -- if they did have COVID, right, if they were symptomatic for COVID -- or not symptomatic but had COVID. So there's the science part of it, but there's also maybe the optics part of it. We don't want to be afraid of doing something that is wrong, so we err on the side of caution, but, again, that's not necessarily a scientific debate, that's a, you know, say, ethical or moral thing.

So I know that's a long-winded answer, but, yeah, it's hard to know what it's based on when it's not a hundred percent on science.

Q Thank you. You mentioned fear, what do you think the fear is of?

MR. MAXSTON: Mr. Kitchen, I do have to object here formally. There's been a lot of information from this witness, and I know he's

responding to your questions, we're talking about what is or isn't effective in masking, what does or doesn't prevent COVID. Again, I think we're now going far afield. He can't speculate on fear; I don't know how he can comment on that. He's not a psychologist; he's not a public health provider. I'm going to have to object to this line of questioning. I just don't think it's appropriate for a lay witness. And I'll ask the Chair to, in concert with the Tribunal Members if necessary, make a ruling on that.

MR. KITCHEN: Well, Chair, I'd like him to be able to answer the question, so I guess I'll put it to you to make a ruling on that.

THE CHAIR: Would you repeat the question, please, Ms. Schumann.

THE COURT REPORTER: (by reading)

Q You mentioned fear, what do you think the fear is of?

THE CHAIR: That's the question you wish a ruling on?

MR. KITCHEN: Yes, please.

THE CHAIR: Okay. We'll take a break for 5 or 10 minutes and caucus and come back with an answer for you.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, we're back in session.

The Hearing Tribunal has discussed the objection to the question, and we are going to sustain the objection. We feel this would be pure speculation on the part of this witness on what others fear, and we don't believe that's appropriate. We're also of the feeling that it's nonprobative, and it's not going to be helpful in terms of finding a ruling on this issue, so the objection is upheld.

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Dr. Gauthier, just a couple more questions. Does the phrase "First, do no harm" mean anything to you?

A Yeah, that's our primary directive. It doesn't matter how much good we're doing, if we're, at the same time, harming in a small way or maybe outweighing the benefits, so, yeah, it's, to me, one of the most important aspects of health care.

Q When you say, "we", you said something about that's our primary directive; when you say "we", who are you referring to?

A I mean, I'm referring to chiropractors primarily, but I would apply it to all health care providers.

Q Do you think it should apply to health care regulatory bodies like the College of Chiropractors or College of Physicians?

A If something that's being mandated affects something in regards to health, then yes.
Q Do you think mandating masks aligns with the principle of "First, do no harm"?
A No, no, I don't, because, as I said before, it may not affect Person A negatively, but it may affect Person B negatively, and until each individual person is assessed, it's really difficult to know how it's going to affect those people. So, you know, it may be not doing harm to someone, but it might be doing harm to another, and the mandate is kind of a blanket treatment, so to speak, so I'm not sure it was considered or should be.
MR. KITCHEN: Those are all my questions.
THE CHAIR: Thank you, Mr. Kitchen.
Mr. Maxston, did you want a short break before you start?
MR. MAXSTON: You know, I don't think I need a break, but I just want to double-check with Mr. Lawrence. Can we maybe have 10 minutes?
THE CHAIR: Yes. It's -- let's reconvene, we might as well take a break now, and then we'll push through for the afternoon, so let's come back at 2:00. We'll close the hearing for now and be back at 2.
(ADJOURNMENT)
THE CHAIR: I think we're back in session,

and the floor is Mr. Maxston's for his cross-examination of Dr. Gauthier.

Mr. Maxston Cross-examines the Witness

Q MR. MAXSTON: Good afternoon, Dr. Gauthier. I can't see you, but I'm assuming you can hear me and see me?

A Yeah, as long as you're okay without the video for now, I am here.

Q Yeah, that's just fine. So I want to start --

A Okay.

Q -- off, Dr. Gauthier, with just some basic questions. I'm sure you'd agree with me that the College is the licensing and regulatory body for chiropractic in Alberta?

A Yeah, that's correct.

Q And you'd also agree with me that for you to become a regulated member of the College, you had to go to an approved educational institution like Palmer; there was a requirement for you to become a chiropractor; is that correct?

A Correct.

Q And would you also agree with me that in order to keep your licence as a chiropractor, you have to meet ongoing requirements that the College issues, like continuing competence, for example?

A Yeah, those are all things that were laid out

beforehand, and, yeah, those were expectations I understood.

Q So I want to ask you some questions in that context about your comments with my friend about the fact that the Pandemic Directive was coercion and that you were -- you had no choice but to comply with it, and I'm going to suggest to you, Dr. Gauthier, that something like mandatory continuing competence, you don't have any choice in that, do you?

A Correct.

Q But that isn't coercion, is it?

A I think because it was something I knew, going into it, I do see it as a little different, but there is a difference between expectations and coercion; yeah, there is an expectation.

Q I guess you knew what it was when you were going into it, but continuing competence changes over time, doesn't it, or can change over time?

A Yeah, I can't comment on that. I imagine it can change a certain amount, but there is a limit to that change. I don't know what that would be.

Q So if the College sends you a bill each year for $250 for your yearly practice permit, you don't have any choice about paying that, do you?

A Correct.

Q And having said that though, that isn't coercion, is

it; it's just something you have to do to be a member of the profession?
A Yeah, that's correct.
Q So when it comes to something like the Code of Ethics or the Standards of Practice that the College issues, you don't have a choice about whether to comply with them, do you?
A No, there's -- no, there's not a choice in whether you comply with that, no.
Q And I would, again, suggest to you that complying with the Code of Ethics or the Standards of Practice isn't coercion, it's just part of the responsibility of being a professional; would you agree with that?
A Yes, yeah.
Q You talked about -- with my friend, Mr. Kitchen, about the College not getting informed consent with you. I'm going to suggest to you that the concept of informed consent applies to a caregiver and a patient; isn't that correct?
A I think it's correct with some caveats, I think. When there's -- when someone is doing something to you that has a direct impact on your health, I think they are, de facto, a care provider in that particular instance, so, yes, but I think there is a caveat in there.
Q Well, let me ask you this: You're aware of the Chief Medical Officer of Health orders that have come out

from time to time in the pandemic requiring masking, for example, not just chiropractors but the public?

A Yeah, correct.

Q When the Chief Medical Officer of Health issues those orders, there is no requirement to get consent from anyone, is there?

A I don't know if there is or isn't by law. I think there largely hasn't been, but I don't know if there is, or I don't know what the legality is on that.

Q Would you agree with me that the primary purpose of the College, if you look at the Health Professions Act or otherwise, the primary purpose of the College of Chiropractors, like other colleges, medical colleges, healthcare colleges, is public protection?

A The primary goal?

Q Yeah.

A Again, I don't have that memorized, but I was kind of under the impression that the primary goal is protection of individual patients not necessarily the public, and I think there is a distinction there. But --

Q Yeah, sorry, were you finished?

A Yes, yeah. I apologize.

Q Okay. You talked about, with my friend, Mr. Kitchen, you talked about the Do No Harm principle, and I think you said, when talking about masking, that it may not

affect Person A negatively, but it could affect Person B negatively, and it's difficult to know that. Would you agree with me, Dr. Gauthier, that regulators like the College can't assess individuals; they have to put in place general requirements for the profession?

A I guess from a -- from like a fundamental standpoint, it would be very difficult to assess each individual person, but I think that would be the correct way to go. Whether they could or not, I can't speak to that.

Q I'll just give you an example. You know, when we talk about the College's Standards of Practice for informed consent or charting, the College doesn't, of course, have to go out and poll patients and poll individual chiropractors when they create those kinds of directions, do they?

A I'm not sure I understood what your question was there.

Q Well, maybe I'll turn to a different aspect here. I take it your position is that where a college requirement, in your view, harms a patient, you can decide not to follow it; is that correct?

A No, that's a pretty broad statement, so, no, I can't say I would agree to that.

Q So is it fair to say then you think members of a profession can't selectively decide what requirements of their profession to follow and then not follow?

A So if I'm looking at letter of the law, like to --

yeah, to try to explain it as well as I can, if our Alberta Human Rights Act says one thing and the College mandates another, I'm kind of put at a crossroads, and I'm put in kind of a lose/lose situation as a practitioner. And what I would do in each individual circumstance, I can't say. I mean, that's theoretical and projecting and subjective based on that time.

If the Human Rights Act says one thing and the law says one thing and the College says another, yeah, it puts it in a very difficult position, and then you do have to choose whether you are going to do what the law says or do what the College says, and I don't like that that happens -- or if -- I don't like that that could happen, but it, you know, logically could occur.

Q Well, I guess, we'll leave the human rights legislation argument to a different day, but I think what I was driving at -- sorry, are you okay, can I continue?

A Sure.

Q What I was driving at is, in your discussions with Mr. Kitchen, you said that you don't believe the College's Pandemic Directive is valid; is that fair to say, and I should say masking?

A No, I didn't say valid. I didn't -- I said I didn't -- I wasn't convinced that it was based 100 percent on science. And I say that because science doesn't tell us what we should do; science tells us what will happen

or what most likely will happen with a given situation, but ethics and morals and politics look at what we should do in a given situation.

So to say it's a hundred percent based on science is not accurate, because science doesn't tell us what should happen; it tells us what might. I didn't say it wasn't valid; I said I didn't think it was a hundred percent based on science.

Q So is it fair to say that you do think it's valid?

MR. KITCHEN: Well, hold on, hold on. I mean, we can look at the record, but you didn't use that word or even a synonym for that word, so -- and, you know, he's already told you that -- he's already explained what he said, and it's totally different from his question, so I have an issue with that.

MR. MAXSTON: I guess, Mr. Kitchen, in his response, he said to me, I didn't say it was invalid, so I'd like to ask him whether he thinks it's valid. I think that's a reasonable question.

MR. KITCHEN: Well, okay, I guess my problem is is that's vague. That was relative to what? Valid legally, valid scientifically, valid (INDISCERNIBLE). If you could just qualify it, I think it would be okay.

MR. MAXSTON: Yeah, well, you know, fair enough, I guess it's his word, Mr. Kitchen, but, you know, I'll ask Dr. Gauthier.

Q MR. MAXSTON: Do you think the College's Pandemic Directive was valid in terms of you as a professional?
A Like valid like for what, what goals? Like do I think it was valid in terms was it like reasonable expectations for me, valid in terms of did it do the job of preventing infection? In what way do you mean?
Q Well, I'm going to take a different sort of approach on this, but I just want to go back and say, just to be clear, you didn't agree with the masking requirement the College issued; is that fair to say?
A For my particular situation, yeah, I found it pretty restricting, and I wish it was not a requirement for me, yeah.
Q And I think it went a little bit more than sort of, you know, you personally and your asthma condition, I think you said that you were concerned that there wasn't science that would support it; is that fair?
A Yeah, I think that's fair. I'm not -- I wasn't convinced that there was complete agreement as far as saying, Wear a mask, that the benefits were very obviously outweighing the risks for our particular setting. I'm not convinced that for our setting when there's other options like, you know -- not other options, but when there are other settings that can be more, say, an issue with this particular Coronavirus,

when I look at the type of patients, the screening that we do, I wasn't convinced that it was the best decision, yeah.

Q Yeah, and that's kind of what I was getting at when I was going back to my questions that Mr. Kitchen --

A Okay.

Q -- objected to. I just wanted to kind of establish here that you had a personal/medical/scientific objection, I guess, to the application of the directive. What I think is important here though is despite your concerns about the science or your medical condition, your personal views, you still chose to follow the masking directive; that's correct?

A Yeah, because for my situation, I didn't see any other option.

Q And you're aware that Dr. Wall did not follow the Pandemic Directive in terms of masking?

A I don't -- yeah, I don't know on the details, I don't know if he had an exemption or not, but -- or if that matters, but, yeah, it sounds like he wasn't doing it, and that was kind of how he chose to go about it, I guess.

THE CHAIR: Dr. Gauthier, are you moving away from your microphone, because your voice is fading and then coming back in.

A Okay, I apologize. No, I wasn't moving, but I'll try

to sit maybe closer, more still.
MR. MAXSTON: Mr. Kitchen, I hope you'll just allow me a little bit of latitude here, I'll just go back.
Q MR. MAXSTON: And my question to you, Dr. Gauthier, was you were aware that, unlike yourself, Dr. Wall did not comply with the masking Pandemic Directive requirements from the College; is that correct?
A I was aware he had -- he was not wearing the mask while treating patients, yes.
Q And I think it's fair to say, would you agree, that you ultimately concluded you could not disregard your regulatory bodies or your College's direction; is that correct?
A Yeah, because when I looked at the risk and the benefits, I was still able to function, albeit at a lower level; say, you know, as far as headaches and fatigue and breathing and energy, I was able to function. So my circumstance, it was not worth it to not comply even though I didn't want to. But, again, everybody has to weigh that themselves, and that was the conclusion that I ultimately came to for me.
Q I think this will be my final question. When you say so each person or everyone has to weigh that for themselves, do you think, again, a member of a

profession can decide what requirements of his or her college they have to follow and what ones they don't?

MR. KITCHEN: Hold on. My only issue with that is just it requires a qualification. I mean, are you asking legally, or are you asking practically, ethically?

MR. MAXSTON: I'll just say ethically, and I'll repeat the question.

Q MR. MAXSTON: But as a professional, do you think that members of a profession can decide what they will and won't follow from their college?

A So, I mean, since you qualified it as "ethically", I mean I would say no. If the College mandated that I could only -- and, again, this is very theoretical, because when you're dealing with ethics and morals, it is largely theoretical -- if the College mandated I was only allowed to care for males or only care for females or only care for a certain person, I would have to look at that ethically and say that's wrong. And I do believe it's up to the individuals to say, ethically, what is correct and incorrect, and if there's something they believe is wrong, then they should not be forced to go through with doing something they believe is incorrect.

Q If you think you have a concern or a problem with following one of your College's requirements, do you

think you have to talk to the College about that?
A Yeah, I mean especially depending -- in most circumstances, probably, yeah.
Q I'm going to go back to your example, but if you decided that, boy, my asthma is so bad or my objections to the directive are -- you know, my science-based objections are so significant, would it --
A M-hm.
Q -- be fair to say before you disregard the or not comply with the directive, you should reach out to your college and try and explore options?
A I think, again, that depends like on how -- like I'd have to go back to the mandate and look at it and compare that to what we are supposed to do or what is allowable, and from a human rights perspective, if my understanding -- like if I was in that situation and my understanding was that if there was an exemption, whether it had to be official or if my understanding was that an exemption was just a health condition, and I didn't require any sort of note, if I was under the -- under the -- if I was with the understanding that I had a legal exemption to following the mandate, I don't know that I would first think to ask the College about that if the mandate said to me exemptions are allowed or if the mandate said to me you have to wear a mask but then the law says you don't have to

with an exemption, it probably wouldn't be my first instinct to ask the College if it's seems clear that there are exceptions to that rule, so --

Q I just want to -- oh, sorry.

A No, no, that's okay, go ahead.

Q So I just want to understand that if you think you've got a legal exemption to a College requirement, you don't have to let the College know that you're not going to follow it?

A No, I don't know that. I'm saying so in this situation, if the mandate said that we have to wear -- again, I'd have to go back and look at that mandate from April 2020 or whatever it was, then if that mandate said that we had to wear masks, but then I also look at the law and the legality within the Human Rights Commission, as one example, and if the Alberta Human Rights Commission says you do not have to wear a mask with an exemption, then I would look at that and say that makes sense to me that I would not have to.

And if it was clear enough to me that I didn't have to, I don't know that it would be my first instinct to ask the College if the law seems very clear. I can't speak to every circumstance, and I can't speak to every issue, but on that particular issue, if my interpretation was the law, it was that -- was in that way, I don't know that I would ask for

permission --
Q So last year when the directive came out, and --
A M-hm.
Q -- I'm going to assume for the moment, you didn't have a Human Rights Commission ruling --
A M-hm.
Q -- you know, about your condition, you decided --
A M-hm.
Q -- to follow the Pandemic Directive with reluctance?
A Yeah, because in my case, again, it was -- you know, it takes effort if I want to go that route. Say, if I thought I needed an exemption, you hear through doctors and patients that doctors are not really writing exemptions, maybe I have to go see a specialist, fitting that into my schedule; there's just a lot of barriers to doing that, time being one of them.

And at that time, with the amount of negative I experienced with a mask, it wasn't worth it for me at that time. If it was worse, say I noticed significant headaches, or if I noticed I was having significant issues breathing, then it would have been worth it for me to go and get an exemption and deal with that in that way, but in my situation, it wasn't.

Q I just have one final question for you, Mr. Kitchen and you engaged in a discussion about how the Pandemic Directive was created and your concerns I think about

whether there were other elements that went into the creation of it other than perhaps science; you don't have any direct knowledge of how the Pandemic Directive was created or on what basis it was created, do you?

A No.

MR. MAXSTON: Those are all my questions. Thank you, Dr. Gauthier.

A Thank you.

THE CHAIR: Can I just remind everybody, we're picking up a lot of paper shuffling from the microphones, so if you're not involved in an exchange or a discussion, please mute. It's getting distracting.

Thank you, Mr. Maxston. Mr. Kitchen, anything on redirect?

MR. KITCHEN: No.

THE CHAIR: Okay, any of the Panel Members have a question? I would actually like to caucus with the Hearing Tribunal for a moment. There may be a question, so if you could bear with us. We would like to go into our break-out room, please, Ms. Nelson.

(ADJOURNMENT)

The Chair Questions the Witness

Q THE CHAIR: There's one question that came up, Dr. Gauthier, Mr. Maxston referred to getting an exemption, but the Hearing Tribunal wanted to ask you

if you did go to the trouble and time and effort to get an exemption, what would you do with it?

A What would I do with the exemption?

Q Yes.

A Well, I mean if my health was being compromised enough that I felt like it was wronging me and I couldn't practice, I would have that exemption, and I suppose I would use it as much as possible, as much as I felt was needed. Anything with health is -- I guess I'm not sure what you mean.

Q Would you feel the need to provide that exemption to anybody? How would people know if you had an exemption?

A I don't know that -- I mean -- by law, I don't know if they're required to know. I don't know that I would take it that far, because I'm not necessarily that kind of person that, you know, says, Oh, it's my freedom and my right, and this is the law, so I'm going to go by letter of the law. I think if patients ask, I would have no problem providing that exemption even if they're not -- even if I'm not obligated to do so.

THE CHAIR: Okay, that's fine. Thank you, Dr. Gauthier.

A Okay.

THE CHAIR: I believe that that's the end of your testimony with us this afternoon. Thank you

for coming in, and you are free to leave, sir.
A Thank you very much. Have a good afternoon.
THE CHAIR: You too.
(WITNESS STANDS DOWN)
Discussion
THE CHAIR: Mr. Kitchen, do we have another witness coming today or is --
MR. KITCHEN: I don't believe so. Like I said, I wanted to have -- yeah, no, Mr. Elvin Music has told me he's still stuck at work, so either we won't be calling that witness or we will try to fit him in during one of the days scheduled for the scientific experts.
THE CHAIR: Okay, with that in mind, perhaps I could ask you and Mr. Maxston what the agenda for Saturday will look like.
MR. KITCHEN: So I'm calling two witnesses, Chris Schaefer is first, Dr. Bao Dang is second. Based on history, I thought it was ambitious to even try to get those two in during that day. What I'm hoping is that we can get through Chris Schaefer in the morning. His report's pretty small. Obviously, that depends on how much he talks and Mr. Maxston crosses, but, ideally, we would get through that in the morning; that would leave the entire afternoon for Dr. Dang, and again, ideally, we would, you know, in

three-and-a-half, four hours, we would get through Dr. Dang. I think that's realistic, but based on history, we might not finish, but that's what I have set up is to have those two called that day with the idea that we actually fill the day but don't overflow.

THE CHAIR: Any comment, Mr. Maxston?

MR. MAXSTON: No, I think that's a fair assessment. I don't -- my sense is that I will not be as long with Dr. Dang or Mr. Schaefer as I was in my direct with Dr. Hu, so I think we'll just make as much progress as we can that day, and as Mr. Kitchen said, hopefully we can finish both of those witnesses on Saturday.

THE CHAIR: And that will be the closing of your case then; we can move on to arguments in January; is that correct?

MR. KITCHEN: No, so January 28th and 29th are reserved for Dr. Thomas Warren and Dr. Byram Bridle.

THE CHAIR: Okay.

MR. KITCHEN: Both of those reports are quite extensive. I do expect to be quite a long time with both of them. I know from experience that Dr. Bridle is a talker like Dr. Hu, so Dr. Hu took a whole day, spread out over two, but took a whole day, so what I've done is I've asked for those two days on

the basis that I doubt it would take less than a day to do either of those witnesses, so that's why I've scheduled those two days with those two witnesses. So after the 29th of January, then Dr. Wall's case is in, we're done with the evidence, and we would move on to closing statements.

THE CHAIR: Okay, so we will need to book some more time after the 28th and 29th?

MR. KITCHEN: Yes.

THE CHAIR: Perhaps we can give that some thought and maybe talk about that on Saturday if we have a few minutes. It's just getting so hard to accommodate people's schedules; if we can do it with a little notice, it would be helpful.

MR. KITCHEN: Well, closing statements are easy because it's only Mr. Maxston and I and probably Mr. Lawrence, so that should be -- I mean, I'm certainly very flexible. I actually don't have any commitments yet in February and March, so if we can do closing, you know, within three or four weeks of January 29th so that we have the transcripts, that seems to me to be a good way to move this forward.

THE CHAIR: Okay, well, we can talk more about that, the scheduling, on Saturday, but I guess, on that basis, that will conclude things for today, unless there's anything anybody else would like to

bring up at this time. Mr. Maxston, do you have anything?

MR. MAXSTON: No, I don't, thank you.

THE CHAIR: Okay. All right, then we will adjourn the hearing for today. We will reconvene at -- what time is your witness coming on Saturday, Mr. Kitchen?

MR. KITCHEN: 9 AM.

THE CHAIR: 9 AM, okay. We will reconvene on Saturday, November 20th, at 9 AM and plan to have a full day, I think.

MR. KITCHEN: Yes.

MR. MAXSTON: Mr. Chair, just before we break, I wonder if I can ask Amber to put Mr. Lawrence and I in a break-out room. I don't know if we have anything to chat about, but I wouldn't mind just a brief chance just to chat with him.

MS. NELSON: Yeah, I can do that for you.

THE CHAIR: And, Ms. Nelson, if you could do the same with the Hearing Tribunal and Mr. Pavlic, we would like to caucus for a few minutes.

Thank you everybody. We will see you on Saturday.

MR. KITCHEN: Thank you.

PROCEEDINGS ADJOURNED UNTIL 9:00 AM, NOVEMBER 20, 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 1st day of December, 2021.

Karoline Schumann

Karoline Schumann, CSR(A)
Official Court Reporter

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

DISCIPLINARY HEARING

VOLUME 6

VIA VIDEOCONFERENCE

Edmonton, Alberta

November 20, 2021

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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 9:16 AM)

THE CHAIR: This is continuation of the Hearing Tribunal for Dr. Wall is back in session.

And Ms. Nelson does have your witness in the

waiting room and is prepared to bring him into the meeting, Mr. Kitchen, so I'll turn the floor over to you.

MR. KITCHEN: Good morning, Mr. Schaefer, can you hear us?

THE WITNESS: Yes, good morning.

MR. KITCHEN: Excellent. Are you able at all to tip your camera down about -- yeah, perfect, there you go, excellent.

All right, so, Mr. Schaefer, the first thing we're going to do is we're going to swear you in, and Karoline, our court reporter, is going to do that, and once she does that, then we'll get into the questioning.

THE WITNESS: Sounds good.

CHRIS SCHAEFER, Sworn, Examined by Mr. Kitchen

(Qualification)

MR. KITCHEN: So, Mr. Chair, I'm going to start with some qualification questions. As you'll know from my end the other day, there was consent between the parties on the qualification of the next witness but not on this one, so I'm going to run through some questions and then propose a qualification to you, and then, of course, Mr. Maxston will have some opportunity to make some comments.

Q MR. KITCHEN: Mr. Schaefer, the first thing

I'll start with is what's your current occupation?
A My current occupation is as an Occupational Health and Safety consultant. I have been doing that now for quite a number of years. Since 2004, I've had my own company, but I've been working in Occupational Health and Safety as a consultant since 1994.
Q Okay, thank you. Now, you said "consulting", what are the types of things you consult on?
A Well, I consult on all aspects of Occupational Health and Safety training. Primarily what I do is one of my specialties is respirator fit testing and training. So respirator fit testing and training that I would consult on would be for any atmospheric hazard from anything that would require the most basic level of respiratory protection all the way up to and including respiratory protection for emergency responders like a self-contained breathing apparatus, both closed- and open-circuit systems.
Q And do you teach any courses on respirators or how they fit?
A Yes, I do. I do teach a course, a course on respirator fit testing and training, and I have been teaching that course as an advisor to the University of Alberta Faculties of Medicine and Dentistry for several years, as well as private clients.
Q I just want to -- on your résumé, you've got a long

list of certifications, I don't want to bring you through all of them, but I'll just ask you about a couple of them. One is a CSA respirator training and fit testing instructor. Can you tell me about that certification?

A Sure. CSA, if you're not already aware, is equipment certification, and they do have their own standards for equipment certification. So CSA stands for the Canadian Standards Association, and if you have ever worked in an industrial environment, from a very basic perspective, you would know that CSA does the approvals for basic safety equipment like steel-toed boots, hard hats, and safety glasses, among many others, but those would be probably basic ones that you would be aware of, and CSA is the certification body for the standards set for the safety of that equipment and others as well.

So as the course for CSA goes, it's a course that is within the standards of the use of that equipment through the Canadian Standards Association.

Q Thank you. I see also hazmat instructor. Now, I think I know what hazmat is, but could you please tell me what that's all about?

A Hazmat is hazards materials and training. So for people that go into high-risk situations like biohazardous environments, they need specialized

training and specialized equipment, because there is a lot of chemicals, vapours, and gases and even particulates that are very small, and those can penetrate through basically any part of your body.

So with hazmat training, it's all about, the basics are, is you've got to have full containment, you've got to have full encapsulation of workers or responders, and they have to be provided for any potential exposure through either inhalation or skin absorption of contaminants that could negatively affect their health.

Q Thank you. And just one more, right under that, you have "H2S alive instructor". Can you tell me what the H2S alive thing is?

A Yes, absolutely. H2S is the chemical formula for hydrogen sulphide gas. Hydrogen sulphide gas is a common detriment to oil and gas workers for -- primarily in Western Canada. We see our highest levels of hydrogen sulphide gas in Western Canada oil fields, so that is a course that is required for anybody that works in oil and gas situations that they have that course so that they know how to protect themselves and also respond to help others in the event of unintended or accidental hydrogen sulphide release or exposure.

Q All right, thank you. So if I understand this, I don't think I do, the 'S' stands for sulphide. I'm curious,

in your line of work, have you dealt with issues around carbon dioxide?

A Yes, absolutely.

Q Have you dealt with issues around oxygen in the air?

A Always, always. Yeah, you know, having a safe amount of oxygen in air is pretty essential to personal safety, so that's definitely a big part of my whole career.

Q And are you familiar with the Occupational Health and Safety legislation?

A M-hm, yes, I am.

Q Thank you. Is that something you commonly work with?

A You know, it depends on the course that I'm offering and the training that I'm offering, but, yeah, absolutely. Atmospheric hazards are a big, huge component of Occupational Health and Safety.

Q Have you done any testing on the cloth or nonmedical masks that have been commonly used to try and prevent the spread of COVID?

A Yes, I have.

Q Have you done any testing on the medical or procedural or surgical masks that have been commonly used to try and prevent the spread of COVID?

A Yes, I have.

Q Thank you.

MR. KITCHEN: Well, Mr. Chair, I'm going to

read out for you -- those are all my questions on qualification -- I'm going to read out what I'd like to have Mr. Schaefer qualified as. I'd like to have Mr. Schaefer qualified as an expert in the area of Occupational Health and Safety, in particular, all types of respirator masks, including the medical and nonmedical masks used to attempt to prevent the transmission of COVID-19. And, of course, I --

THE CHAIR: Can you just read that one more time, please?

MR. KITCHEN: Sure. I'd like to have Mr. Chris Schaefer qualified as an expert in the area of Occupational Health and Safety, in particular, all types of respirator masks, including the medical and nonmedical masks used to attempt to prevent the transmission of COVID-19.

THE CHAIR: Mr. Maxston, did you wish to comment before we --

MR. MAXSTON: I have I think two brief questions for Mr. Schaefer, and then my friend is aware of this, I've got a few comments about the qualification that's being tendered, so I'll just ask my questions briefly.

Mr. Maxston Cross-examines the Witness (Qualification)

Q MR. MAXSTON: Good morning, Mr. Schaefer.

A Good morning.

Q My two questions for you are this: I'm looking at the bottom of page 2 of your cv, and it talks about, you say, "Associations: Member of Alberta College of Paramedics"; are you still a regulated member of the Alberta College of Paramedics?
A No, I am not, but that is a -- that is a course that I had -- that is a -- sorry, that is a membership that I had a couple years ago. I had completed the Alberta College of Paramedic program as far as the emergency medical responder is concerned, and I did have that membership, yes.
Q Forgive me for not quite understanding this then, were you a regulated member of the Alberta College of Paramedics, so you could practice as a paramedic, or had --
A Yes --
Q -- just taken the --
A -- yes, I was --
Q -- courses --
A -- yes, I was. I was an actual member of the Alberta College of Paramedics, registered through the course that I had taken, so I had specific registration by completing exams with the Alberta College of Paramedics to practice as a medic within Alberta.
Q Sure, and I --
A So I was definitely registered.

Q And how long were you a regulated member of the Alberta College of Paramedics?
A One year.
Q And do you recall your designation, or were you an advanced care paramedic, primary care paramedic, EMT, EM -- you know, do you recall the designation that you were in?
A Of course. EMR, emergency medical responder.
Q And you can correct me if I'm wrong, but I think "EMR" is -- I think there's three designations; the first is advanced care paramedic, then there's primary care paramedic, and then there's the designation you were in, which is EMR; is that correct, to your understanding?
A That's absolutely correct, yes.
Q And, I'm sorry, you said you were an EMR for one year with the College?
A Yes.
Q Okay.
MR. MAXSTON: Those are all my questions, Mr. Chair, for the witness. I wonder if I might provide some responses to the qualification that Mr. Kitchen has tendered.
THE CHAIR: Okay.
Discussion
MR. MAXSTON: My friend will rightly point

out to you that I could make these same comments during my closing statement, and I made them during the opening statement, but I just want to reiterate the Complaints Director's position this is not a question of the efficacy of masking in this hearing, it's about compliance with regulatory responsibilities. We'll review that in greater detail. You can, of course, accept evidence in whatever manner you see fit. The Complaints Director maintains his position that this type of evidence should be given little weight in terms of the charges that are in front of you.

I do want to mention that the College anticipated that Mr. Schaefer's testimony would be confined or largely confined to the question of surgical or procedure masks that are set out in the Pandemic Directive, and, of course, the College does not have any ability to regulate or control the types of masks that members of the public wear. So I think the qualification that's been tendered is perhaps a little bit broad in terms of it referring to all types of respirator masks, so I have a little concern in that regard -- have a concern in that regard.

And I'll just, for reference sake, I just want to remind the Tribunal of some comments that were made by Mr. Kitchen during the qualification -- pardon me, the preliminary application that occurred in terms of

whether Mr. Schaefer could be called at all as an expert witness, and you'll recall we objected to that, and you made a ruling that you would allow Mr. Schaefer.

And just very briefly, this is on page 55 of the transcripts, this is my friend commenting on what Mr. Schaefer will be called to testify about: (as read)

> It should be quite obvious that this report [meaning Mr. Schaefer's] deals with a different subject than Dr. Wall's other three experts. The other three experts are various scientists and medical doctors ... They are all dealing with COVID-19; they're dealing with the SARS-CoV-2 virus. They're not dealing with whether or not masks are harmful. Certainly not in a specific sense that Chris Schaefer is doing, that being oxygen levels and carbon dioxide ... The effectiveness of masks is a different subject from the harms of masks.

And a few pages later, you made a ruling that Mr. Schaefer can testify. So my client's clear expectation is that Mr. Schaefer's testimony will be confined to, again, the harms of masks, not the science related to COVID or transmissibility or anything along

those lines.

So Mr. Kitchen has been scribbling, and I'm sure may want to made some response comments to what I said, but again I think it's important to remember the basis on which this witness was offered initially when we had our preliminary application on that, and I think it's very important for Mr. Schaefer's comments to be confined to the question of the harm of masks and nothing more. Thank you, Mr. Chair.

MR. KITCHEN: Mr. Chair, if I could, just a couple comments in response.

THE CHAIR: Yeah.

MR. KITCHEN: First, the reason I say all types of respirator masks is because, well, that's just the reality; that's what Mr. Schaefer has dealt with in his line of work. And I'm a little surprised to hear that the Complaints Director didn't anticipate evidence about nonmedical masks in addition to medical, as, of course, you'll see in the first paragraph of Mr. Schaefer's report, it talks about the different kinds of masks, and so it's a little surprising.

But the reason that I've asked inclusion of cloth masks is -- or nonmedical masks is because that's a reality of what we're dealing with, and that's what Mr. Schaefer has dealt with, and those aren't dramatically different, they're very similar, and so I

don't think that scope is too broad, I don't think it's inappropriately broad, I don't think it's irrelevantly broad. So I would ask that he not be limited to talk about medical masks but also be permitted to talk about nonmedical or cloth masks.

And, of course, I have no issue with my friend's comments about being limited to talk about the harms of masks and not the efficacy. We won't have any questions about that, so it's just the harms of masks, but when I say "masks", I mean medical and nonmedical. Those are all my submissions in response.

THE CHAIR: Thank you. I think we'll take a short break while the Hearing Tribunal caucuses to give you an answer to your request, Mr. Kitchen. So if we could be moved to a break-out room. Hopefully this won't take very long. Thank you.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, we're back in session, and the Hearing Tribunal discussed your request, Mr. Kitchen, and we have one question for Mr. Maxston, and we wanted a clarification on why Mr. Schaefer should be limited to medical masks.

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

THE CHAIR: Is it because of what's in the transcript? Is it because of what's in the CMOH

orders?

MR. MAXSTON: I think it's because primarily of what is in the Pandemic Directive that the College has, which refers to the requirement for chiropractors to wear surgical or procedure masks as being the minimum acceptable standard.

I think I said in my comments about this question, and I'll invite Mr. Lawrence to comment if he wants to, but we anticipated that the primary focus of Mr. Schaefer's testimony would be on those matters, because the College cannot -- I see Mr. Lawrence nodding his head -- the College cannot regulate what members of the public do, it can only regulate what chiropractors do. I'm not sure if that answers your question, but that was the concern. We didn't want this net to be cast too broadly.

THE CHAIR: Okay, I think we're just going to take that under advisement, Mr. Maxston. We'll go back into our cubbyhole, and we should have an answer here shortly, thank you. Just please bear with us, and we'll go to our break-out room.

(ADJOURNMENT)

Ruling (Qualification)

THE CHAIR: The hearing is back in session. The Hearing Tribunal has discussed the issues raised. We just want to clarify that the testimony

will be regarding the harm and not the efficacy associated with these masks, and we've also ruled that the testimony will relate to the medical masks not the nonmedical masks.

Having said that, we're aware that there are some issues here, and if Mr. Maxston feels that the line of questioning goes beyond the scope that we've discussed, then he certainly has the option to raise objections.

MR. KITCHEN: I wonder, and I invite comments on this, and I can be corrected if I'm off the mark on this, is it possible for me to receive written reasons for that decision, because that will likely be something that will end up being appealed, so -- and maybe that comes at the very, very end when we get written decisions -- written reasons on the whole decision, but that's something I would -- I'd ask for written reasons on it.

THE CHAIR: At the risk of taking us back to a break-out room, my thought would be that we can address it in the decision, once the decision is made, make a note to that effect. I don't think we want to interrupt this hearing to be doing that. I don't want to start writing parts of decisions, so --

MR. KITCHEN: No, no, I'm not asking you for it right now, I apologize. No, what I meant is I'm just asking whether it's, you know, tomorrow or a week

from now or a month from now or at the very end, that's -- I'm not asking for it right now. I'm just, in general, I'm making it known that, you know, likely that will be a source of appeal, so I think it best that there be reasons for that.

THE CHAIR: Duly noted, Mr. Kitchen.

MR. KITCHEN: Thank you.

CHRIS SCHAEFER, Previously sworn, Examined by Mr. Kitchen

Q MR. KITCHEN: All right, well, with that, Mr. Schaefer, you can hear me?

A Yes, I can.

Q Excellent, we'll jump right in. And I think you've already answered this, but just to clarify, you live and work in Alberta; is that correct?

A That is correct, yes.

Q Can you tell me what was the, generally speaking, what was the type of work you did prior to the onset of COVID?

A I had been doing safety training for my own company, but I had been doing safety training for a lot longer than that, but -- so safety courses in a variety of disciplines, as well as fit testing and training. So -- but fit testing and training has definitely been a significant portion of the work that I've done in clients that range from the military, to health care,

to educational institutions and private industry.
Q Has that work changed any since the onset of COVID?
A Absolutely, it's changed a lot. It's changed a lot primarily because there's so much -- there's no real -- there's no real requirement for many of the masks that are mandated for COVID, that they would be fit tested, there's no requirement to that.

So before the COVID thing, everything -- any type of mask whatsoever had to be fit tested on the wearer. They had to have approval fit test for safety. But since COVID, since this virus, there has been no requirement for the majority types of these devices to require a fit test to the user, which is really, really odd.

Q And why is that odd?
A It's odd, because in order to determine whether or not the wearer is suitable for wearing a mask, there are some screening processes that have be completed first.

So, for instance, if you have difficulty breathing without a mask, wearing a mask is going to make it much harder for you to breathe. It will increase breathing resistance for everybody. So if you're healthy, you breathe effortlessly right now, you will experience increased breathing effort by covering your mouth and nose, and so there's a screening process. Not everybody is capable of wearing a mask. Nobody -- like

there's a screening process that has to be completed.

So for people that have pre-existing medical conditions or identify pre-existing medical conditions within screening to wear a mask, they have to go to their doctor and get further testing done to determine their suitability or ability to be able to wear a mask and stay healthy. So that's one thing. The screening process, there's no screening to determine the suitability of masking for the general population and employment in general, right? So any workers, there's no screening anymore; it's just wear one or else, and that's never happened before.

The other thing is is that in order for any type of mask to protect the wearer, that mask has to make an airtight seal around the face. Without an airtight seal, there's no way that it can provide any respiratory protection. So a fit test determines that it is making an air-tight seal to your face so that it can verify that the contaminant is being filtered; it is having to flow through the filter into the wearer's mouth and then lungs.

But if you don't have an airtight seal, then the air that you inhale is -- a lot of it's going to follow the path of least resistance, which is through the openings, any openings, available openings, because it's harder to pull air through a filter than it is

just to breathe surrounding air. So if there's leaks, that's where you're going to be pulling the contaminant in from.

Q And so you talked about air coming in, and it coming in through what I'm going to call the path of least resistance, is that also true for air going out?

A Well, you know, there is some air coming in, but when you look at the volumes of breathing of inhalation and exhalation, it's going to cause an insufficient air supply. You're going to get a buildup of your own exhaled carbon dioxide in the cover, and if you're going to get -- see, in an actual respirator --

Let me explain in an actual respirator, actual respirators have an exhalation valve built into them, so that every time you exhale, your carbon dioxide gets pushed out the exhalation valve so you don't rebreathe it. If you just put a closed cover on your face, then it will capture some part of dioxide, and as you inhale, it will force you to rebreathe some air but also carbon dioxide that can be significant amounts above and beyond what is considered safe according to Occupational Health and Safety air quality standards.

Q Thank you. All right, well, you've already answered some questions, but just to go back to sort of a preliminary issue, let me ask you a couple different questions. Mr. Schaefer, do you know Dr. Curtis Wall

personally?
A I've never met him. I don't know what he looks like, and I really don't know much about him at all.
Q Do you have any personal interest or personal stake in the outcome of this case?
A Absolutely not. I've just been hired to give my expert opinion, and that's what I'm here for.
Q You don't have any financial interest or stake in the outcome of this case then?
A No, because I'm getting paid by the hour, and so it doesn't matter to me what the outcome is.
Q And just to confirm, do you understand your duty to provide this Tribunal with your expert knowledge and opinions in an objective and neutral manner?
A Absolutely.
Q Thank you. Now, just to give a bit of a road map, we've already got into the meat of it a little bit, but I'm going to be asking you about, you know, what masks really actually are, and then I'm going to ask you about carbon dioxide, about oxygen, a little bit about testing, and then, lastly, I'll ask you, from an Occupational Health and Safety perspective, a little bit about the harms or hazards involved.

So to start off, now -- and my friend may want to object to this, because we've got issues with different types of masks, but in the very first paragraph of your

report, you say -- we're talking about the masks that are being mandated to attempt to prevent the stop of COVID, you say: (as read)

These masks are the medical, nonmedical, and procedural masks.

Now, can you please explain for us what those terms and what those types of masks mean to you?

A Sure, absolutely. So a medical mask in a health care setting is referred to an N95. It's something that is -- what health care uses is a closed cover primarily, it is N95, which means that it's a filter, a filtration that's not resistant to oil, that's what the 'N' is. 95 refers to the best-case scenario protection that you could get with that device if it's properly fitted and used and disposed of and replaced as specified, as required, as the manufacturer requires. And that's what the medical is.

The nonmedical is any device that is really you put it on your mouth and nose. So you could take a plastic bag put it over your head; I mean, that's not a nonmedical mask, but, you know what, a nonmedical mask is anything that covers your mouth and nose. So if you want to put a bandana on your mouth and nose, you want to -- you want to -- anything literally that covers mouth and nose is classified as a nonmedical mask.

And a procedural mask is something that is -- is

something that they will typically use, and I won't say what they use it for because it's kind of -- you know, they use it for different things in health care settings, but it's a looser fitting -- it's a slightly looser fitting style, but it's still -- it's still enclosed enough that it typically -- it's like the blue mask, right? So a procedural mask is kind of -- it's a looser fitting than the N95, N95 is a tighter fitting and, depending on nonmedical, it can be anything from cloth to virtually anything anybody wants to do to cover their mouth and nose, because there's really no -- there's no rules on nonmedical masks; it's really just anything you put on your mouth and nose could be considered a nonmedical mask that covers your face.

And procedural mask, like I said, it's really just a -- it's a device. These are all -- they're all like the -- N95 and procedural would be considered temporary use only, to be replaced regularly, as needed when there's moisture buildup inside, and disposed of immediately. So the procedural and the medical in health care settings, both have to be used -- they're really only designed for short duration use and then to be immediately disposed of. They were never designed for hour upon hour use. It was never designed that way, and it's still not designed that way. So it's been used that way, but it's not designed that way.

So there are some dangers to that, but as far as procedural masks go, just -- it's a looser fitting mask that they use in the health care settings and disposable, just like N95. N95s are tighter fitting; procedurals are looser fitting.

Q Thank you, that's helpful. Would you say that when we use the word "surgical mask", in your experience, is that typically a reference to that category of procedural or blue masks?

A Yeah, you know, surgical masks, you know, in surgery, physicians and other health care practitioners, they may use N95, or they may use procedural. It's -- it depends on -- depends on what's going on, but both may be used.

Q So you're aware that what the Alberta College of Chiropractors has mandated that chiropractors must wear -- this mandate is found in the COVID-19 Pandemic Practice Directive, you're aware that the masks -- the type of masks that the Alberta College of Chiropractors is requiring chiropractors to wear are those procedural or blue masks?

A Yes, I am aware.

Q Okay. And you're aware that the CMOH orders that mandate masking for the general public mandates the nonmedical masks?

A Yes, I am aware.

Q All right, in the second paragraph of your report, you state that: (as read)

> Masks are required to have engineered breathing openings.

Can you explain what "engineered breathing openings" are, and why masks are required to have them?

A Okay, so if you are going to cover your mouth and nose with any device, it's important that you do not restrict your oxygen coming in, the air coming in, and your carbon dioxide and expelled toxic air leaving, and that is why we exhale outside of our bodies in the first place.

If we take a look at a mask, a mask has to have engineered openings. So, for instance, if you take a look at, say, here is a common Halloween-style mask, it's got engineered openings for nostrils for breathing, as well as mouth for breathing. It's important to be able to have easy, free breathing. When you restrict your breathing, then you get that accumulations of exhaled carbon dioxide that are then rebreathed because there's no exhalation valve to purge it, so you rebreathe your own exhaled waste toxic carbon dioxide, which is not going to be good for anybody, and for people over a longer period of time and if there's any pre-existing medical conditions could be a very serious situation.

Now, if you look at an actual respirator, like this, you can see that it is covered, there are two filters attached in the design. In the middle, there's an exhalation valve. That's to purge exhaled heat, moisture, and carbon dioxide, okay, for a reason, because we don't want to rebreathe it. So air comes in here, air can only enter through inhalation, air can only leave through exhalation.

And when I say "engineered openings" -- I say engineered opening and exhalation, but also engineered opening and inhalation. So if I unscrew the filter, you can see, if I just turn it like this, you can see it's a big hole, there's a big hole there. The reason the hole is there is so that air can flow in very easily and freely so that, you know, it can enter your lungs as unobstructed as possible, because anything that you put on your mouth or nose, it makes it harder to breathe. Depending upon the person, the length of exposure, the type of work or activity they're engaged in, and any pre-existing medical conditions could all change their ability to be able to wear that device at all.

Q I notice you used the word "device", just to clarify, you would say that these procedural or blue masks we're talking about, you would call that a device?

A Well, let me explain something, it's very difficult for

me to refer to any of the mandated masks for COVID as actual masks. It's really difficult. I struggle with it. It's hard, because they don't meet the actual definition of a mask from anything as simple as a Halloween mask, to a goalie mask, to a scuba mask, any kind of actual mask that's engineered, it's engineered for easy breathing.

If you look in a goalie mask, it looks full faced, it looks pretty encapsulated, but it does have breathing vents, so the air can flow in and out easily. Every type of mask, it's important that air flows in easily and air flows out easily.

Now, a goalie mask isn't going to offer anybody respiratory protection or a scuba mask, but they are devices that are engineered for breathing, but if you just close your -- take a piece of material or a paper and cover your mouth and nose with it, it will restrict breathing, it will restrict your ability to inhale, and it will restrict your ability to exhale.

Q So I know in your report, you use the term "breathing barriers" to describe these types of so-called masks that are mandated for COVID. Can you just explain to me why you use that term?

A Well, I coined that term actually, and the reason I use it is because I think it most accurately describes the situation -- what actually happens when you wear one of

these. If you've ever worn one, and, for most people, they probably have, they probably notice immediately that it does become increasingly difficult to breathe with one on. There's a reason that you're blocking your breathing. So when I call them breathing barriers, it's based upon the practicality that they block breathing, they block the normal flow of breathing.

Now, all respirators, even proper respirators, like the one I showed you, with the two filters and exhalation valve in the middle will increase breathing difficulty a little bit because you are going to pull air through the filter, so it's going to be a slight increase in inhalation effort but very minimal, and because it's designed for breathing, it's very minimal.

Let me remind you what I said earlier, anybody that wears any respirator before COVID needed -- or mask, for that matter -- needed any type of filtering mask needed to be fit tested. And before they could be fit tested, they had to be screened for their ability to wear it safely.

And without that screening, it's like Russian roulette, who's going to have to wear one and shouldn't be wearing one. Somebody with COPD, somebody with heart conditions, lung conditions of any type, high blood pressure, these are all people that need to be,

before COVID, needed to be examined by a physician to determine their ability to safely wear a respirator that's actually engineered for breathing, much less a closed cover over your mouth and nose that caps -- that makes it exponentially harder to breathe and captures carbon dioxide in significant amounts.

So that's why I call it a breathing barrier.

Q Thank you. Do you find it strange that we seem to be doing -- based on what you've said, we seem to be doing things very differently post-COVID than pre-COVID when it comes to things like fit testing? Do you find that strange?

A I think it's incredibly strange that there would be mandates for closed-cover barriers that aren't engineered -- aren't engineered for easy breathing, and I find it very strange that there is no requirement for a fit test for a filtering mask or respirator. That should be paramount; that should be primary.

Q Now, I know you've touched on this, but just to clarify, you say in the fourth paragraph in your report that wearing these what we're going to call breathing barriers are hazardous to the wearer.

A M-hm.

Q Why exactly are they hazardous?

A Well, think about it like this, if you take something, like if you take a piece of cloth or a piece of paper

towel or whatever it is, hold it closely to your mouth and nose, it becomes more difficult to breathe, right?

So we know that it's harder to breathe, which increases respiration effort. For people with pre-existing conditions, it's not going to be good. But even for people without pre-existing conditions, increased breathing effort, you increase the capture of carbon dioxide, and then you are re-inhaling that carbon dioxide, it's going to cause a variety of negative health effects, even if the person has no pre-existing medical conditions.

So common symptoms of blocking your flow of breathing and inhaling excess carbon dioxide can be things like experiencing a headache, nausea, dizziness, lack of coordination, maybe impaired hearing, impaired -- sometimes impaired vision. It can be a -- it can be feeling faint, overheating. And it can be worse than that, it could be people that have a very difficult time breathing, feel like they can't catch their breath, and it can go down from there. So anybody that inhales more than what the -- anybody that inhales above what the indoor Occupational Health and Safety standard is for carbon dioxide is at risk.

So if you were to look at my report, you would see the standards for carbon dioxide according to the Alberta standards for safety and see that the maximum

exposure for indoor carbon dioxide is a thousand parts per million. That's not very high. That's not very high. That's over a 24 period -- 24-hour period, but it's not very high. Because the normal oxygen that we have currently in our atmosphere is around 3 to 400 parts per million. So it doesn't have to go very high to get to a thousand.

And the testing that I've done inside these breathing barriers is very high levels of carbon dioxide. Even if somebody like -- here's the thing, if you wear a breathing barrier, and you are just sitting at a desk, looking at a computer, you're going to have hazardous levels of low oxygen just from having it on, any one of those three devices on it.

And if you are doing an activity like lots of speaking, those levels will drop dramatically, because your oxygen demand will increase dramatically.

And as well as, if you look at physical activity like, say, going for a run or something, and your oxygen demands go up significantly, then putting a closed cover on your face and blocking that ability to breathe can have a very severe negative impact of your ability to properly absorb oxygen or as much oxygen as your body needs and dispel -- disperse and dispel carbon dioxide away from you so you don't re-inhale it.

Q Thank you. I know you said that a thousand parts per

million is the sort of the safe limit for carbon dioxide. How long is too long to be exposed to that much carbon dioxide or more?

A Well, according to the -- the highest level that you can legally be exposed to in Alberta, according to Alberta standards -- and they revised their standards in the spring of this year, they actually -- it was actually higher, but they lowered it, instead it's lower, so -- is a thousand parts per million. That's based on a 24-hour exposure.

But I'll tell you based upon the testing that I've done and other research publications that I have as references, medical reports and research that I could -- I'm more than happy to submit a long list of certified medical scientific reports to show that levels of carbon dioxide in one of these devices exceed 5, 10,000 parts per million within a minute, anybody wearing any one of those three.

And oxygen levels -- here's -- carbon dioxide is only one part of the equation. The other immediately life-threatening condition is low oxygen. Hypoxemia is low oxygen in the blood; hypoxia is low oxygen in tissues. So what happens is is if you are not inhaling oxygen concentration, enough of an oxygen concentration in air, you're going to suffer -- you're going to suffer oxygen deficiency in your blood and in your

tissues.

And so the normal oxygen level in air is 19.5 -- 20.9 percent, 20.9 percent. Where it becomes dangerous to health becomes immediately dangerous, life and health, according to our regulations is 19.5 percent or lower.

So using instrumentation, you could see that the oxygen drop between the breathing barrier in the person's mouth or nose is significantly below 19.5 percent. Immediately, within the first 20 seconds, you'll see oxygen drop below 19.5 percent, which is safe levels. And if they're -- if they've got a tight-fitting cover, if their cover is very tight-fitting, especially like the N95 style or some of these cloth covers that are especially tight fitting, but even with a procedural-based mask, you're going to see unsafe levels of carbon dioxide and unsafe levels of oxygen. And even with the procedural-based what they call mask, which I call breathing barrier, is levels far in excess of a thousand parts per million, multiples higher, 10,000, 20,000 parts per million.

And I have done -- I've done testing. I've done video to show it. I am competent to operate testing equipment, and my testing equipment has been, you know, properly calibrated and properly tested to ensure that it's working properly as well, so I could verify it.

The readings that I take would hold up in a court of law.

Q What's the device that you use; what's the name of it?

A Well, there's -- I -- there's a number of devices that I could use. It's not -- it's not restricted to one type of device, because any device that has those appropriate sensors with those arrangers -- with those ranges of gas detection, as well as, you know, proper use and maintenance of the device would be suitable, but the one that I used was a MultiRAE Lite most recently.

Q And is that -- is that testing device, is it designed to test levels of carbon dioxide and oxygen in the atmosphere?

A Yes, it is.

Q Okay.

A So with these devices, you can get to a (INDISCERNIBLE) quick with any number of sensor configurations, because they're designed to test multiple types of gases, but carbon dioxide and oxygen is a very common configuration, and the sensors can be -- they can be in the monitor and installed in the monitor for that purpose, yes.

Q So we know the limit for carbon dioxide is a thousand parts per million, and I heard you say that you took readings inside these masks while they're being worn,

and some of those readings were 5 or 10,000 parts per million, but could you give me an idea of what an average would be inside the mask after it's been on for a bit?

A Okay, so let's say a couple minutes of wearing either a nonmedical, a medical, or a procedural based, you're looking at, a couple minutes of wearing, 20,000 parts per million carbon dioxide, oxygen levels as low as 18 percent, 18 to 18-and-a-half percent. The lowest oxygen can go legally is 19.5 before it becomes immediately dangerous to life and health.

So in Occupational Health and Safety standards, when we talk about IDLH, which stands for immediately dangerous to life and health, we're looking at device -- we're looking at levels that might not necessarily cause you to drop dead once they're reached, but certainly they're considered levels that now become -- those exposures become harmful without protection from those exposures.

Q And so now I've heard you use the number 20,000. So are these -- well, let me ask you this: The parts per million of carbon dioxide inside the mask while it's being worn, does it fluctuate, or is it steady?

A Well, it depends on a number of things. It depends upon what's the activity level of the person that's wearing it. The hard -- the more exertion, the higher

the carbon dioxide's going to go. It also depends upon what is the -- how tight-fitting is it around mouth and nose. If it's very tight-fitting, obviously it's going to trap more carbon dioxide than if it's a looser fitting.

So there's various factors. So, yes, it can fluctuate, or it can remain steady, depending upon the fit of it and depending upon the activity level of the person that's wearing it.

Q But in your experience with the loose-fitting ones, even though there are these leaky areas where air gets in and out, the parts per million of carbon dioxide stays above a thousand inside --

A Absolutely. It's still harmful to wear. It's still hazardous to wear for sure, because when you're exposed to levels that are levels that are far in excess, even with the looser -- even if it's not loose-fitting, it's a looser, slightly looser fitting, you're still going to find levels of oxygen that are lower than what is legislatively allowed and levels of carbon dioxide that are higher than what is legislatively allowed.

Q Now, you talked about some of the effects of this overexposure to carbon dioxide. Have you, in your line of work, have you ever encountered individuals suffering from these effects?

A You know, I am not a physician; I am an Occupational

Health and Safety specialist, so I primary measure the hazard. So I test people and equipment for their occupations to ensure that they are protected from respiratory hazards, but I do not evaluate the health conditions of people that may be affected by low carbon dioxide or high levels.

Q Okay.

MR. LAWRENCE: I'm sorry, to interrupt, Mr. Chair, I don't see Dr. Aldcorn on the screen. I'm just wondering, did we lose somebody? Excuse me, sorry, Mr. Kitchen.

MR. KITCHEN: That's okay. I don't see him either. He's --

MR. LAWRENCE: She.

MR. KITCHEN: I'm sorry, yes, she. Yeah, that's a concern.

MR. LAWRENCE: Oh, there she is, okay.

DR. ALDCORN: Sorry.

MR. LAWRENCE: So I'm not sure if we want to just read the last couple of minutes back for Dr. Aldcorn's benefit.

MR. MAXSTON: Maybe we can ask Dr. Aldcorn when she went offline --

DR. ALDCORN: Yeah.

MR. MAXSTON -- intentionally or not or when she came back.

DR. ALDCORN: Completely unintentionally. The last we were discussing was the fact that the numbers of the CO2 and O2 levels would depend on the nature of the tight-fittingness of the mask and the exercise level of the individual. And I apologize.

MR. KITCHEN: So that means you did miss one question --

DR. ALDCORN: I'm so sorry.

MR. KITCHEN: -- well, there's two ways we can handle this: One, there's going to be a transcript, of course, you'll get to read it; two, we could just give Miss -- Miss Karoline to read it. It doesn't matter to me, so I leave it to the Tribunal.

THE CHAIR: Let's have the court reporter read it back. That way, she'll get the same thing we all got.

THE COURT REPORTER: (by reading)

Q Now, you talked about some of the effects of this overexposure to carbon dioxide. Have you, in your line of work, have you ever encountered individuals suffering from these effects?

A You know, I am not a physician. I am an Occupational Health and Safety specialist, so I primary measure the hazard. So I test people and equipment for their occupations to

ensure that they are protected from respiratory hazards, but I do not evaluate the health conditions of people that may be affected by low carbon dioxide or high levels.

Q MR. KITCHEN: Mr. Schaefer -- I take it -- yes, everybody's here, good -- Mr. Schaefer, are you confident that if somebody else did the same tests that you've done on these masks or breathing barriers, are you confident they would come up with the same results that you have?

A If they're properly --

MR. MAXSTON: I'm a little concerned, that's a little speculative. I don't know if you want to consider rephrasing that, because I mean that -- what studies, who is conducting them? I think that's just a little bit broad, because there may well be studies which disagree with Mr. Schaefer. I'm just a little concerned about that type of question.

MR. KITCHEN: Well, I didn't use the word "studies", but let me try this.

Q MR. KITCHEN: Are you confident, Mr. Schaefer, that if somebody did the same testing you've done with the same device that you used that they would produce the same data regarding carbon dioxide and oxygen?

A Well, if they're following the proper procedure, as I

have, and they had done everything the same that I did as far as making sure that the equipment is -- has been properly calibrated, properly bump-tested, and making sure that everything is working as it should, then I would anticipate that the difference being them holding it versus you holding it should have no effect on the readings whatsoever.

Q And just to be clear, you used the same device to test the levels of oxygen and the levels of carbon dioxide?

A Yes, because the device was equipped with two sensors, one with oxygen and one with carbon dioxide, to measure these simultaneously, so I measured them both at the same time actually.

So there's a display on the monitor, there's a display for the readings of oxygen, and there's a separate display for the readings of carbon dioxide, so you can see both in realtime.

Q I see. Now, I notice you used the word "asphyxiation" at one point in your report; can you just, for those of us who do not know what that means, can you explain to me what asphyxiation is?

A Well, asphyxiation is when your body is suffering from insufficient oxygen, so whether it's, you know, accidental, intentional, whatever it may be, your body's not getting enough oxygen, that's asphyxiation.

And so there's various levels of it, but

asphyxiation may be fatal. It may cause injury. So these are the kinds of things that this is what -- and it's all due -- asphyxiation's due exclusively in this -- in this -- I guess how I should say -- view to insufficient oxygen.

Q Now, you say carbon dioxide is an asphyxiant, and it displaces oxygen.

A M-hm.

Q Can you explain why or how that happens?

A Well, carbon dioxide is used to -- carbon dioxide can displace oxygen, because it is considered an inert gas, so pure carbon dioxide is able to displace oxygen.

So, for instance, let me give you an example, carbon dioxide is often used in industrial situations to purge out hazardous atmospheres of, say, things like confined spaces and such to remove oxygen from those spaces. So we know carbon dioxide can cause displacement of oxygen. And it can do that in any closed container, it doesn't have to be a confined space like industrial, but any closed container where you've got accumulations of carbon dioxide, and it can affect how you can absorb and how you can be exposed to oxygen, how you can absorb oxygen basically.

Q Now, I know you've mentioned the 19.5 figure, but I'm just curious, what is the number that the Occupational Health and Safety code in Alberta describes as being

the point at which, if you go below it, it becomes hazardous?

A 19.5 percent. That's immediately dangerous to life and health. So you can't go below 19.5 percent for any reason.

And if you are exposed to air in Alberta, if you are exposed in air -- breathing air that has an oxygen concentration below 19.5 percent, you have to be equipped with a separate air source, like self-contained breathing apparatus, a supplied-air system, that will give you the correct oxygen requirement that you need.

Q That number of 19.5, is that fairly universal throughout jurisdictions?

A Yes, it is.

Q Okay. I know in your report, you mention the Occupational Health and Safety Administration [sic]; could you tell us what that is?

A Occupation Health and Safety Administration? What exactly is your question?

Q I'm just wondering what is the Occupational Health and Safety Administration, because that's not Occupational Health and Safety Alberta. I just want to know what that is.

A Okay, so Occupational Health and Safety Administration [sic] is the US standard of safety

requirements. So it's funny, because when you say it -- you said it full out; I'm more familiar with it in its abbreviated form, which is OSHA.

Q OSHA.

A If you would have said "OSHA", I'm like absolutely, but because I never hear it as Occupational Safety and Health Administration, that's why I kind of just hesitated for a second.

So anyhow, OSHA is the governing body for safety standards and exposures in the United States.

Q Okay, and is that -- are they similar to OHS here in Alberta?

A Yeah, many of the OSHA standards are accepted in various jurisdictions in Canada as well.

Q So in your report, you refer to a 2007 letter from OSHA. Can I just get you to turn to the first page of this letter, that's page 085 or 85 from your report, and for those who are following along, that's near the end of the report, and then the top left-hand corner is the page number, 085. Now, this letter, can I just ask you to read out the first sentence of the third paragraph there at the bottom of that page.

A (as read)

This letter constitutes OSHA's interpretation of the requirements discussed.

Q We must be on different pages. So I'm looking at the

first page of the letter --
A Okay, I'm looking at -- I'm on page 085.
Q Maybe you've got a different page 085. Well, can I get you to go to just the first page of this letter, where it says "April 2nd, 2007, Mr. William Costello"; do you see that?
A Oh, okay, okay, yes, I see that now, yeah.
Q Okay. And if we go down, the first paragraph starts with "Thank you", second paragraph --
A Yeah.
Q -- starts "Within your letter", if you could just read the first sentence of the third paragraph there.
A Okay, so the third sentence of the second paragraph -- third paragraph, okay, okay, I got you, okay. So it is -- is it the one "to ensure that employees", is that the second one?
Q No, it's starts with the word "Paragraph".
A Oh, "Paragraph", okay: (as read)

> Of paragraph (d)(2)(iii) of the respiratory protection standard considers any atmosphere with an oxygen level below 19.5 percent to be oxygen deficient and immediately dangerous to life or health.

Did you want me to continue?
Q No. That sounds a little dramatic to me. Can you help me understand, you know, from the perspective of an

Occupational Health and Safety expert, what does "immediately dangerous to life or health" actually mean?

A Well, I thought I actually explained that a little earlier, but I'll tell you what, I'll go over it again.

So "immediately dangerous to life and health" means that if you are exposed at that level or below that level especially, then you are going to be putting your health in harm's way. So that can have significantly dangerous impacts on your health. And the lower it goes, the lower it goes, like the more it differentiates, like if it's -- the lower it -- for oxygen, oxygen requirements here, the lower it goes below the minimum oxygen requirement, the 19.5 percent, the more dramatic and the more negative those effects are going to be. So it's bad.

You never are allowed to exceed -- you're never, ever allowed to breathe air less than 19.5 percent under any circumstance in Occupational Health and Safety settings. There's no -- there's no exceptions. This is the deadline. You can't go below 19.5.

If you do, if somebody is tested and they are exposed to levels of oxygen below 19.5 percent, the operation, the working operation, would have to be immediately shut down, and they would have to be evacuated from that space; even if it was 19.4, they'd

have to be immediately evacuated. There's nothing below 19.5 that's acceptable.

If somebody had to work in an atmosphere of 19.5 percent or lower, they would have to be equipped with a separate source of clean air with -- delivered via air line, supplied air-breathing apparatus. For those of you listening that might not necessarily be aware what that is, that is the same type of breathing apparatus that fire fighters wear when they go into smoking buildings, so they have a separate source of air. Why? Because they need it, because they go into oxygen-deficient atmospheres. And that's the type of equipment you need to be exposed to any oxygen concentration below 19.5 percent.

Q So when people are working with a procedural mask on, are they working in an environment that's immediately dangerous to life or health?

A The barrier, the breathing barriers create this environment. So if you are in your office or home or wherever it may be, and you are exposed to good breathing air without a breathing barrier, wearing a breathing barrier will create this hazardous environment for your body.

Q Could I get you to turn the page over on this letter, and you'll see there a box containing two paragraphs of text; do you see that?

A Yes, I do.
Q Can I just get you to read the first three sentences of text inside that box?
A (as read)

> Human beings must breathe oxygen to survive and begin to suffer adverse health effects when the oxygen level of their breathing air drops below 19.5 percent oxygen.

So for the person doing the documentation on this, I should probably say that -- I'll read it over again, just so that they can do their recording properly on it by hand. So: (as read)

> Human beings must breathe oxygen ... to survive, and begin to suffer adverse health effects when the oxygen level of their breathing air drops below (19.5 percent oxygen). Below 19.5 percent oxygen ..., air is considered oxygen deficient. At considerations of 16 to 19.5 percent, workers engaged in any form of exertion can rapidly become symptomatic as their tissues fail to obtain the oxygen necessary to function properly.

And do you want me to read what's in the brackets as well there as reference?
Q No, that's good, thank you. Now, this concentration of

16 to 19.5, that range, is that what you've discovered when you've tested the levels of oxygen between these breathing barriers and the faces of those wearing them?

A Absolutely. Every oxygen concentration, whether it's procedural they're wearing, and even at resting rate without any form of exertion, just resting rate, resting rate, we're seeing an oxygen drop of below 19.5 percent within 2 minutes of wearing it on either procedural, nonmedical, or medical masks. Within 2 minutes, and that's without, that's without speaking a lot or any other type of obvious exertion.

THE CHAIR: Mr. Kitchen --

MR. KITCHEN: Yes.

THE CHAIR: -- I'm just wondering, it's quarter to 11, we started at 9, and I don't want to interrupt the flow, but I'm wondering if people would like to take a 5- or 10-minute break just to stretch and whatever.

MR. KITCHEN: I'm fine with that. Can I just -- because I'm almost done with this area of questioning; can I just -- can I ask one question to tie that up?

THE CHAIR: Certainly, certainly.

Q MR. KITCHEN: Mr. Schaefer, I'll just get you to turn the next page over, can you just tell me who is it that wrote this letter, and what's his title?

A The person who wrote this letter is Richard E. Fairfax, F-A-I-R-F-A-X, Director, and his title is Directorate of Enforcement Programs. So he would be in charge of -- just for the record, this is somebody that's in charge of enforcement programs for all of OSHA, which is -- encompasses all of the United States, and in Canada, we have the same even, within our own individual provinces, we have the same standards for oxygen that nothing under 19.5 percent. Everything below 19.5 percent is immediately dangerous to life and health. It's universal throughout North America -- or I should say through the US and Canada.

Q One last question before we break, do you find it strange that the public has been mandated to wear, by various government bodies, devices that cause their oxygen to be below a level that's safe?

A Well, I don't know if "strange" is the right word, James. I'm not sure if "strange" is the right word. I think it's much more serious than "strange", because I know how serious it is, I know how serious the rules are regarding oxygen concentrations below 19.5 percent. In every one I've tested, every one, I've tested adults, I've tested children, everyone, within 2 minutes of wearing either a procedural, nonmedical, or the medical N95, even that's (INDISCERNIBLE) approved, within 2 minutes is having oxygen drops below 19.5

percent.
Q Thank you.
MR. KITCHEN: And that's it for me for now until we come back after our break.
THE CHAIR: Okay, well, let's reconvene at 11:00 then, and we'll continue on with Mr. Kitchen and Mr. Schaefer. Thank you.
MR. KITCHEN: Thank you.
(ADJOURNMENT)
THE CHAIR: We are back in session, and we'll have Mr. Kitchen continue with his direct exam of Mr. Schaefer.
MR. KITCHEN: All right, thank you.
Q MR. KITCHEN: Now, Mr. Schaefer, I think you touched on this, but just to clarify, in your experience, do some people tolerate wearing these breathing barriers better than others?
A Oh, absolutely, because some people have pre-existing medical conditions that make it difficult to breathe without any restriction. If you added a restriction on top of that, it could be life threatening for those people, and every bit of, you know -- depending upon -- there's levels, right? So if it's -- it depends on the level of pre-existing medical condition they have and the severity of it, but it could be life threatening, it could cause somebody a life-threatening medical

emergency to wear a breathing barrier, even a properly certified respirator, if they haven't -- if they don't have the health and they haven't been properly screened beforehand, before wearing it. It's important. It's important that we check out and people are health-assessed before we restrict our breathing. It's important.

Q Do you do screening and fit testing at workplaces for employees?

A Absolutely. Screening is a prerequisite for fit testing. I can't fit test anybody that hasn't completed screening protocol.

Q Can you tell me what are some of the things you look for when you're screening?

A Well, the screening is a document that the patient -- I shouldn't say "patient", but the client, the customer or client is going to complete in their own -- with their own privacy, so they're going to complete it completely themselves, and then I just look at the results.

The results that I'm looking for, there's a list of pre-existing medical conditions, and if they identify that they currently have any of those pre-existing medical conditions, then my obligation, as an Occupational Health and Safety fit testing professional, is that I have to refer them to their

physician for further testing and analysis to determine whether or not they have the physical fitness to be able to handle a restriction in their breathing.

Q Is asthma one of those conditions?

A Yes. Do you want me to mention some of the conditions?

Q Well, you can only do that if I ask you to do that. Well, let me ask you, just off the top of your head, you don't need to go through the whole list, but just give me some examples of some of these conditions just so we have an idea. We know one of them is asthma, but give us an idea.

A Allergies, high blood pressure, cardiac conditions, lung illnesses. I'm not reading; I'm just going off memory right now. Let's just see here, I can look up that form quickly here if you would like me to read them all, but, you know, those are included in that, so allergies, asthma, heart disease, high blood pressure.

Okay, I'm just going to open it up right now.

Q Well --

MR. MAXSTON: Mr. Kitchen, I'm not going to contest your client's view on different conditions. I'm not sure if we have to go down this road, to be honest with you. I don't --

MR. KITCHEN: Yeah --

MR. MAXSTON -- want to have to get him to read from something, if that's what you need him to do.

MR. KITCHEN: No, I don't.

Q MR. KITCHEN: And, you know, since what you're reading from, Mr. Schaefer, is not actually in the record. I think that's fine, that answers my question anyways.

Now, we've talked about this immediate danger, that life and health, but does it surprise you then that most people, when they wear these breathing barriers, even for hours on end, that they don't pass out from wearing them?

A Well, it doesn't surprise me, but just because they're not physically passing out does not mean that harm is not being done.

So here's the facts that I've been able to establish from my testing: People that wear breathing barriers are subjecting themselves to an oxygen deficient IDL -- IDLH inhalation atmosphere. And in many cases, they subject themselves to an IDLH level carbon dioxide as well.

If you subject yourself to IDLH levels of low oxygen, it will negatively impact your health whether you're aware of it or not, and that's why all the governing bodies that govern the rules of health and safety legislate what the minimum oxygen concentration in air that you can be exposed to, because you might not necessarily feel harm right away, you might not

necessarily have a headache right away or dizziness, you might not necessarily feel nausea right away, any of these other minor -- more minor types of symptoms of low oxygen.

But we know that if you are exposed to a hazard in a low enough concentration or a high enough concentration, depending on what the hazard is, harm will occur, and it might be something -- it might not necessarily be something that the wearer or user is aware of, at least not immediately.

Q In your experience, has Alberta Health Services or the Alberta Public Health authorities generally, have they acknowledged the risks and harms associated with these breathing barriers that you've been talking about?

A I've reached out to Dr. Hinshaw back in June of last year with a very detailed letter on pointing out -- at that time, it was -- nothing was mandated, it was just a recommendation that people wear, in Alberta, N95, nonmedical, or procedural what they call, you know, surgical mask for protection from COVID, and I had to point out a lot of the errors that she had stated.

I have read -- the only reply that I have received from Dr. Hinshaw's office to date is a read receipt. Actually it was CC'd to 23 other doctors in charge of public health in Alberta. So I have a lot of read receipts, no official response.

To also clarify, besides not having an official response, I have never -- there's been numerous attempts to contact Dr. Hinshaw's office for a response, and it has not been granted, it's been denied.

Q Do you have any thoughts on why Alberta Health Services or the Chief Medical Officer of Health hasn't been willing to discuss these risks and harms?

A I have thought --

MR. MAXSTON: I don't want to be difficult here, but I think that question really is asking your witness to talk about what's in the minds of the other people. I think if you rephrase it and ask him a different question, I might not object, but I don't think he can speak to why they're not doing or doing anything.

MR. KITCHEN: Right, I was asking him his thoughts, so I'll just ask it again with those words in there.

Q MR. KITCHEN: Mr. Schaefer, and, you know, maybe you just have no idea, and that's okay, but do you, from your perspective, can you think of any reason -- or what do you think the reason is that there hasn't been any discussion on this?

A I don't know. In all honesty, Mr. Kitchen, I have no clue, but I will tell you this, is that normally,

normally, before any types of mask mandates are -- would be even recommended in Occupational Health and Safety settings, professionals like myself would be consulted long in advance of any potential mandates that would occur, and that has not happened this time, in this instance.

Q Now, as an Occupational Health and Safety expert, as an Occupational Health and Safety consultant, do you work at all with Occupational Health and Safety Alberta?

A I'm always -- I don't work specifically for Occupational Health and Safety Alberta; they have their employees, their own government employees, but do I work in union with them, like in cooperation? Absolutely. Everything that is Occupational Health and Safety-related in Alberta works in cooperation with Occupational Health and Safety representatives in Alberta.

Q And in your experience, has Occupational Health and Safety, OHS, have they acknowledged any of these risks or harms associated with these breathing barriers?

A There hasn't been any -- there hasn't been any real willingness to discuss that on behalf of OH&S, and they're more than happy to back Provincial mandates without discussion and without discussion or any other opinion that's contrary to the AHS mandate.

Q Why do you think that is?

A I don't know. I don't know, Mr. Kitchen, but it is very strange, because in a normal time, before COVID, there was so much discussion about any new policy that could be implemented long in advance before it would become a mandate. There's planning, there's discussion, there's determination.

But I think what I find that's very interesting is that this is not just an Alberta situation; this is a worldwide thing. How strange is it that something like this type of breathing barrier could be mandated, rolled out so fast without any consulting of, you know, no one, no one trusted respirator professionals, by medical staff, who aren't experts in respiratory protection, they aren't qualified to -- medical doctors alone are not qualified to comment or give advice on various aspects of respiratory protection because they're not asked -- they don't deal in respirators professionally, they have very limited knowledge about respirators and masks and their protection levels and what they can do and what they can't do. And I find it strange that this has been implemented on a worldwide basis with virtually no contest, without official contesting of it, it's very strange.

Q In fact, earlier you said, it was more than strange, you said it was serious?

A Well, strange that it hasn't been documented, but when

I said serious, I said serious in relation to oxygen -- I said serious in response to your question for me on the effects on people being exposed to less than 19.5 percent oxygen. Yes, that is beyond strange. That is alarming. That is alarming that these devices could be mandated when they clearly -- when the testing that I am trained to perform clearly shows oxygen levels dropping below 19.5 percent with all three of these versions of mandated breathing barriers, whether it's an adult or a child even at resting rate, and we know that the drop is going to be even more significant for people that are engaged in any kind of activity.

Q And do you understand that we're here today because Dr. Wall has contested these breathing barriers and that, for doing so, he is facing professional discipline?

A Yes, I'm aware.

Q On page 8 of his report, Dr. Hu, I think his first name is Jia, but Dr. Hu says -- and just to clarify, he is the expert tendered by the Alberta College of Chiropractors -- on page 8 of his report, he says: (as read)

> There are no known harms associated with masking.

Now, maybe it's obvious, but do you disagree with his statement?

A Completely. I completely disagree with Dr. Hu's statement, because there are numerous scientific research papers and studies. I've looked through Dr. Hu's references, and I didn't see one registered scientific study in any one of his references, but I have references from registered scientific journals, medical journals. I have references from the -- published by the National Library of Medicine to show quite the opposite of what Dr. Hu's references claim.

Plus, in addition, my own -- obviously, my own testing, of course, but then as far as scientific references go, there's -- I can send a whole bunch of actual registered, published, scientific medical researchers that have shown quite the contrary to what Dr. Hu has stated.

Q A number of witnesses in this hearing, including Dr. Hu, have said that the issue of masking as it relates to COVID is a politicised issue. Do you think it's a politicised issue?

MR. MAXSTON: I am going to have to object to that, Mr. Chair, that runs afoul of commenting on the harm or lack thereof in terms of masking.

MR. KITCHEN: I think that's a fair question.

THE CHAIR: Can you restate it?

MR. KITCHEN: And this is part of the reason

why I raised the fact that this has been a constant issue in the hearing, the other expert, Dr. Hu, who Mr. Schaefer just responded to, said that masking is a politicised issue, and so have several other witnesses, so now I'm asking Mr. Schaefer if he thinks masking as it relates to COVID is a politicised issue.

MR. MAXSTON: I'll just again state, Mr. Chair, that I think this witness is being tendered for a very specific purpose, and that was harms, in his view, that are caused by masking, and I don't think this witness is anywhere near the -- is a very different type of witness from the other experts that have testified.

MR. KITCHEN: I don't see what entitles Dr. Hu to talk about the politicisation of the issue that doesn't also entitle Mr. Schaefer to talk about it.

THE CHAIR: Well, I don't want to go back and retroactively deal with Dr. Hu, but I do think this witness was qualified as an expert in a very specific area, and I do think the question extends beyond that.

Q MR. KITCHEN: Well, just one more question then, Mr. Schaefer, from your perspective, do you think Occupational Health and Safety is the primary consideration in forming these mask mandates?

A Well, Mr. Kitchen, Occupational Health and Safety has

not been a consideration at all in these mask mandates, as demonstrated, and I would contest any safety professional with qualifications equal to mine to prove otherwise, that oxygen deficiency is created by wearing a breathing barrier. That is why our parents taught us to never put a bag over our heads. It is pretty standard, you cover your mouth and nose with a random object, it limits your ability to breathe naturally, and anything that limits your ability to breathe naturally can potentially be harmful to health. That's why we have screening, and anybody with pre-existing medical conditions that has a limit on their breathing could cause a life threatening medical emergency.

MR. KITCHEN: Thank you. Those are all my questions.

MR. MAXSTON: Mr. Chair, if you're comfortable, I'll just continue on. I don't expect to be too long.

THE CHAIR: Yes, that's fine. Just before you start, Mr. Maxston, Mr. Schaefer, you're okay to continue with this cross-examination, or did you want a break?

A I'm fine. Thank you very much, Mr. Lees.

THE CHAIR: Okay.

Mr. Maxston Cross-examines the Witness

Q MR. MAXSTON: Mr. Schaefer, I've got some

questions I'm going to take you to in a couple of minutes that I had thought of in advance of the hearing, but I want to touch on a few things that are fresh in my mind now that you've just talked about with Mr. Kitchen, if you don't mind.

A Sure.

Q So a few minutes ago, you talked about the fact that some people tolerate masking better than others and that that was a function of pre-existing medical conditions and the severity of those medical conditions; do you remember that exchange you had?

A Yes, I do.

Q And I think you talked about properly screening individuals as well, and it's important that people are health-tested in terms of masking and medical preconditions; do you remember that?

A Well, at least as far as identifying pre-existing medical conditions that could make them not a good candidate for wearing any type of mask or respirator.

Q Sure. And you would agree with me that it's important to go to a doctor to determine whether they have any pre-existing medical conditions?

A That is correct.

Q I want to touch on a few things that you talked about with Mr. Kitchen. You talked about, in your view, that Dr. Hinshaw didn't contact OHS, I think that's the

Provincial OHS, but I think you'd agree with me that you don't have any direct knowledge of that, do you?

A I didn't say that Dr. Hinshaw didn't contact OH&S. What I had said was that Dr. Hinshaw has not been -- air testing on these masks has not been done, so they haven't -- the safety of people wearing them has not been properly determined, because there has been absolutely no air testing on oxygen deficiencies or carbon dioxide accumulations on these masks by --

Q Well, I don't want to belabour -- oh, sorry, so sorry, were you finished?

A Yeah.

Q I don't want to belabour this, but I think, Mr. Schaefer, it's fair to say though you haven't been involved in the development of the CMOH orders, have you?

A That is fair to say; I have not been involved in the development of those orders.

Q You made a comment I think it was a couple times during your testimony then, Mr. Kitchen had sort of a wrap-up question for you, and you were talking about the fact that it was strange that devices are mandated, that breathing devices are mandated. Would you agree with me that it is clear they are mandatory though?

A I would agree with you that it is clear that these breathing barriers are currently mandated, that's

correct.
Q And you've had a chance to look at the College's Pandemic Directive, I assume?
A I have not memorized it, but I have had exposure to it; I have looked at it, yes.
Q Yeah, and it's not a memory test for you. I'm just -- there's a phrase, and my friend and I talked about this when you were being qualified, there's a phrase in it that says "surgical or procedure masks are the minimum acceptable standard", and it goes on to say that chiropractors and staff must be masked. You'd agree with me that that's mandatory for chiropractors?
A You know, I can't agree with -- look, just because -- just because it's -- just because one of these or more of these breathing barriers is mandatory for chiropractors and other professions, doesn't mean they're safe.
Q Oh, I'm not asking you that. I'm asking you it's mandatory for chiropractors, question mark, full stop.
A Aware a procedural-based is what you're saying?
Q Yeah, I'm just saying that the Pandemic Directive, and I pointed you to the masking situation in particular, that's mandatory for chiropractors; aside from your views on the safety or harm, that's mandatory?
A That appears to be correct.
Q So, Mr. Schaefer, I'm going to turn you to now a couple

of, I guess, more generic questions, and I just wanted to be clear, and you kind of touched on this with Mr. Kitchen and I think with me a minute or 2 ago, you haven't been involved in the Government's response to COVID-19; that's correct?

A That is correct.

Q And you've been qualified today to provide your opinion about the harms that masking can cause for the wearer, and that's correct?

A That's correct.

Q And you're not here, of course, to provide any evidence about the benefits that might accrue from masking for people in the presence of the person being masked; is that correct?

MR. KITCHEN: Hold on, hold on --

A Well -- well --

MR. KITCHEN: -- that question --

THE CHAIR: Just (INDISCERNIBLE), Mr. Schaefer. Sorry, go ahead, James.

MR. KITCHEN: That question is premised on efficacy of masks, which my friend, my learned friend, went out of his way to make sure we were not going to talk about, and now he's trying to talk about it.

MR. MAXSTON: I'm trying to just make a comment that this witness isn't providing that evidence.

MR. KITCHEN: Well, that's been established time and over again, so I don't understand why we're just filling the record with repeats of what we've already established.

MR. MAXSTON: Well, I just wanted to be clear that this witness is not providing evidence about any potential benefits to persons in the presence of the wearer of a mask.

MR. KITCHEN: Well, I think we're --

MR. MAXSTON I'll move on, I'll move one, yeah. Mr. Kitchen, if you have a problem with this, you'll let me know.

Q MR. MAXSTON: You're not here to provide any evidence about the transmission of COVID for preventive measures for COVID?

A That's correct.

Q Would it be fair to say that your views about mandatory masking are inconsistent with most government Public Health agencies, in Canada I should say?

A In Canada, as far as the mandates that have come down provincially and nationally?

Q Yeah, that would be correct.

A Yeah, I would say that we definitely have a difference of opinion.

Q You talked with my friend, Mr. Kitchen, about the testing that you've done. None of that testing is

attached to your expert report, is it?
A That testing that I've done is not -- let me just take a look here.
MR. KITCHEN: Perhaps you could be a little more specific, Mr. Maxston --
MR. MAXSTON Yeah (INDISCERNIBLE) --
MR. KITCHEN: -- there's no exhibit that has a list of the readings. Is that what you're getting --
MR. MAXSTON: Yeah, that's kind of what I'm getting at.
Q MR. MAXSTON: And, Mr. Schaefer, this isn't a gotcha question, but I'm just looking at the second page of your report, and you talk about using the MultiRAE Lite, and you observed that upon commencement, and you have some comments then. I'm just saying there's no data or test results from those tests you performed which are part of your expert report, correct?
A I don't have it in the report, specific readings, but I have -- I've done lots of documentation on it and reports on it, so --
Q Yeah, I'm just -- I wasn't trying to take you down the road of what you did; I just wanted to be clear they're not attached.
A Yeah, the specific testing, I've done a lot of testing, so for me to have all of the different test subjects

and all of the different readings would be quite extensive as far as those testing results would be, so they're not attached, no.

Q Okay. I want to ask you some questions about your registration with the Alberta College of Paramedics, and I think you've told me that you were at EMS for one year, you were a regulated member of that college for one year. Did you have to meet any entry requirements to get your EMS registration with the ACP --

A Absolutely.

Q -- College of Paramedics?

A Yes, I did.

Q And that's a mandatory requirement to become an EMS with the College of paramedics?

A It's a mandatory requirement to be registered with the Alberta College of Paramedics to work in an occupational setting as a medic in Alberta.

Q And even though you were only a -- I shouldn't say "only" -- but it was a one-year period you were a regulated member, there were mandatory requirements you had to follow during that year like con ed or paying a licence fee; would you agree with that?

A Yes, in fact, the only requirements they registered with Alberta College of Paramedics, because I completed all of their requirements, the only requirement, moving forward from year to year, was to pay the fee to stay

registered. And that registration is required to work as a medic in Alberta, and I had no intention of working as a medic in Alberta as I was already fully employed as an Occupational Health and Safety specialist, so that's why I ended it.

Q Sure. And just to be clear, is it your understanding that if you don't follow those requirements, you can't be a member of the College?

A Yeah, you have to follow -- you have to work -- you have to practice your skills within a protocol as determined by Alberta College of Paramedics, yes, in an occupational setting.

Q Sure. I'm going to ask you a fairly specific question here, but would you comply with the paramedic equivalent of the College's pandemic requirement about mandatory masking if you were in the field?

A I would comply with wearing a mask, but I would not wear a breathing barrier. I have not worn a breathing barrier, and I won't. So, remember, there's a big difference between what's currently been mandated and what an engineered mask is.

A mask is safe to wear. A mask is engineered inhalation openings. A mask has an engineered exhalation opening. That's safe. It's established as safe. It's proven as safe over many decades.

So a closed cover is not something that I would

wear, no, but I would wear an actual mask.
Q So I just want to be clear, again, when we look at the Pandemic Directive for the College of Chiropractors, it says that the requirement is a surgical or a procedure mask; you would comply with that kind of directive from your regulatory body if that was applicable?
A I know that those aren't masks. Those are breathing barriers. I'm not going to jeopardize my health and safety through low oxygen and accumulations of carbon dioxide for any occupation, because that's my health, and my health is important to me. It's more important than anything else.
Q So you would choose to not comply with it?
A I would wear -- I would wear something that far exceeds the recommended protection, which is an actual certified respirator that actually is designed for easy and safe breathing, I would wear that, and it would far exceed any potential respiratory benefit that a breathing barrier could provide.
Q Those are all my questions --
A (INDISCERNIBLE)
Q Sorry, did you want to finish? I cut you off.
A Oh, sorry, I just wanted to say that -- so what I would wear would be far and above what has been currently mandated.
MR. MAXSTON: Those are all my questions,

Mr. Schaefer, thank you.

A Thank you very much, Mr. Maxston.

THE CHAIR: Mr. Kitchen, did you have anything on redirect?

MR. KITCHEN: Just a couple.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: Mr. Schaefer, you attest to the truth of what you said about the results of the testing you did?

A Well, I am under oath in this courtroom, so I believe I've already done that.

Q You just finished a discussion with my learned friend about whether or not you would wear a breathing barrier if your regulatory body told you you had to in order to practice, and if you didn't have access to the respirator, if all you had access to was the breathing barrier that they said you had to wear, would you wear it to keep your licence?

A No, I would not wear it to keep my licence because my health is more important than my job.

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Wait, hold on, forgive me. Mr. Maxston asked you about screening and pre-conditions. Just to clarify, you would say that masks -- well, would you say that masks are harmful to people who have no pre-existing conditions at all?

A Look, a mask is engineered for breathing. People without pre-existing conditions should be able to wear an actual engineered mask with engineered inhalation and exhalation valves no problem, provided -- you know, depend -- again, it depends like on previous -- if there's no pre-existing conditions, they're considered fit, then an actual mask is safe to wear for that person.

But if you're talking -- I'm not talking about a breathing barrier here. A breathing barrier with no inhalation valves, no exhalation valve, that's not safe for anybody.

MR. KITCHEN: Thank you. Those are actually all my redirect questions.

THE CHAIR: Thank you very much, Mr. Schaefer. I believe that concludes your testimony this morning, and we thank you for your attendance and for your testimony, and you're free to leave the hearing.

A Thank you very much, Mr. Lees.

THE CHAIR: It's 20 to 12, and we could start at 12:45. Mr. Maxston?

MR. MAXSTON: Yes, I wondered, do you have any questions? You didn't have any questions, I'm assuming, of Mr. Schaefer --

THE CHAIR: Oh, I'm sorry, I jumped the

gun there. Did the Members of the Tribunal want to caucus and discuss that? I think I'll have to take a lashing for that, probably ten lashes, but yeah.

So I suggest then that we break for lunch, and we reconvene at 12:45 with Mr. Kitchen's witness and go from there.

MR. MAXSTON: Just so I'm clear, Mr. Chair, my apologies, will you want Mr. Kitchen -- maybe this is a question Mr. Kitchen is going to ask, do you want him to have Mr. Schaefer available then at 12:45 if you have any further questions? And I'm just asking, I don't know exactly where we're heading at 12:45.

THE CHAIR: Okay, I'll touch base with the Tribunal Members when we break here, and if there are some follow-up issues from the Hearing Tribunal with respect to Mr. Schaefer, I'll get in touch with Mr. Kitchen, and we'll arrange to get him back.

MR. KITCHEN: Yeah, if you could just please let me know within 10, 15 minutes, just that way, I can release him or I can keep him around.

THE CHAIR: Yeah, thank you for bringing that up. That's my fault, I got ahead of myself. When we break now, we'll go into a break-out room first, the Panel Members and our legal counsel, and we'll just find out if there are any follow-up questions, and then I will let you know, Mr. Kitchen.

MR. KITCHEN: Okay, thank you.

PROCEEDINGS ADJOURNED UNTIL 12:45 PM

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

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November 20, 2021 Afternoon Session

HEARING TRIBUNAL

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 RECOMMENCED AT 12:46 PM)

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

MR. KITCHEN: All right, Dr. Dang, first

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

THE WITNESS: Okay.

DR. BAO DANG, Sworn, Examined by Mr. Kitchen

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

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

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

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

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

MR. KITCHEN: Thank you.

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

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

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

MR. KITCHEN: Okay.

THE CHAIR: -- let's proceed.

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

A I do.

Q And where?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A That is correct.

Q I just want to ask you a few questions about your impartiality. Dr. Dang, do you know Dr. Curtis Wall personally?
A No, I've never met him.
Q Do you have any personal interest or personal stake in the outcome of this case?
A I do not.
Q Do you have any financial interest or stake in the outcome of this case?
A No, I do not.
Q Do you understand your duty to provide this Tribunal with your expert knowledge and opinions in an objective manner?
A Yes.
Q Thank you. Dr. Dang, are there different types of health care settings?
A Yes.
Q Is there a big difference between, let's say, the hospital in Medicine Hat and your clinic?
A Yes, that is correct.
Q Is there a big difference between a hospital setting and a chiropractor's office?
A I would say so.
Q Based on your knowledge and the type of work you do at the hospital, would you say the type of the work you do is quite different than what a chiropractor does in a

chiropractic office?
A Yes, I would think so.
Q In a setting like the hospital in Medicine Hat, are a large number of the people there symptomatic?
A Generally, yes, that is usually one of the requirements of being hospitalized.
Q In a setting like a hospital, do nurses and doctors regularly interact with people that possibly have an infectious illness?
A Yes, potentially.
Q In settings like hospitals, are they designed to receive symptomatic patients potentially ill with infectious illnesses?
A Yes, absolutely.
Q What would you say are some of the big differences between a hospital setting and a setting like a chiropractic office?
A Well, I would think the acuity, patients are -- tend to be quite sick, sick enough certainly to go to the hospital and sometimes be admitted. They're symptomatic. There are lots of interventions that are offered to patients, some of them quite invasive.

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

Q Thank you. Now, I'm going to move into your report. In the second paragraph of your report, you state how ridiculous it would have been to mandate the entire public wear masks during past outbreaks of respiratory infections, such as H1N1 and SARS. Now, the first question I have for you on that is are those infections viral-based or bacterial-based?
A Both of them are viral-based.
Q And you said H1N1 was in 2009 and SARS was in 2003; that's correct, right?
A Yes, I actually, of course, took part in the medical care during those time periods as well.
Q Well, that was my next question, so you were practicing medicine during both of those?
A Well, in 2003, I was in medical school, and then in 2009, I was in my full practice at that time.
Q Okay.
A But in both cases, I had clinical exposures, of course, to them.
Q Right. Besides those, are there any other historical viral outbreaks that you've had experience dealing with?
A Not major ones that I can think of, to my knowledge, directly.
Q Now, forgive my ignorance, I can't help but notice that SARS must have something to do with what's going on

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

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

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

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

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

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

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

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

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

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

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

A Correct.

Q So not scientific reasons?

A Correct.

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

then?

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

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

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

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

A Yes, I would disagree with that assessment.

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

infections?
A No, I don't think so. Many of the studies that myself and he posted cited literature in the past, which is how you build up on scientific knowledge; you base your theories and evidence on previous evidence.
Q In order for masks to work now, would there have to be something fundamentally different about COVID?
A Well, just the virus itself would have to behave in an entirely different manner, I would think, and be an entirely different size. But, no, with regards to what the virus is currently, there would be no substantial difference.
Q Speaking of size, is SARS-CoV-2, the virus, is it larger in size than past viral respiratory infections like SARS or H1N1?
A I don't think so. I don't know the exact size off my memory, but viruses generally are of the order -- a different size compared to bacteria. So I think that -- I think I gave it in my report the size of the SARS virus, it was I think 100 microns, but I could be off by a decimal point or two. I just can't remember that.
Q Well, you have here, it's 0.1 micron.
A Oh, then that's the correct answer.
Q Okay, and then, in brackets, you say about a hundred times smaller than a bacteria.

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

molecule?
A It's very small molecule. Like a virus would be the size of an mRNA or a DNA, for example, so it would be extremely small. Probably one of the smallest forms of life forms possible.
Q So would it be smaller than, for example, a protein?
A Yes, I think it would be generally smaller than a protein.
Q Now, SARS-CoV-2, this tiny little molecule-sized virus, is it only transmitted through like large water droplets, or is it also transmitted through what's called aerosols?
A Well, I think in the early days, they thought it was more droplets, because that would be the typical nature of this infection, but I think there's more and more convincing evidence that aerosolized is possible and also a common route of transmission as well. The exact degree in terms of which one is more I don't think has been sorted out, but I think it is universally recognized now that it can be transmitted in both methods.
Q And can you just explain for us what's the difference between these large droplets and aerosols?
A Well, large droplets are, as the name implies, say you cough or you speak or sing or shout, you can spew droplets. Sometimes you see them, like if they're very

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

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

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

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

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

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

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

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

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

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

metres apart before boarding the plane.
Q Right. Is there any logical or scientific reason to think that masks are significantly more effective at preventing the transmission of COVID in a health care setting than in the general community?
A I don't think, from a scientific point of view, necessarily, because the masks are the same and the virus are the same theoretically, if you're talking about mask for mask.

The applications of the rules may be more vigorous in the hospital and under certain circumstances may be beneficial, but they would be, in my opinion, impossible to enforce and to make perfect in a community or a general population setting.
Q In your experience, is there any sort of significant difference in efficacy between nonmedical cloth masks or the medical blue procedural masks?
A Well, yes, they're quite different, and I would say the blue ones for certain things are certainly better than the cloth masks.
Q Are the blue procedural masks, are they better at stopping the large droplets than the cloth masks?
A They would be -- I think they would be superior at stopping anything compared to -- relatively compared to the cloth mask. I'm not saying that they're effective against viral transmission, but if you compare, of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Well, I guess it depends how high the plane is, but I would say, under normal circumstances, zero.
Q Right, okay. And what's the likelihood of surviving COVID if you contract it?
A Well, taking the general population, it would be more than 99 percent.
Q Taking the population of health care workers, would that number go up?
A It has more to do with health, age, and risk factors, so on the whole, in general, no, it would stay the same, over 99 percent survival rate.
Q And forgive me, I know this question is obvious, but what's the difference between 0 and 99?
A I think infinity, if you argue that way, mathematically, but obviously quite extreme opposite ends of each other.
Q It's not really a fair assessment to compare jumping out of a plane with a parachute with COVID, is it?
A I think not. May I just take a 1-minute pause?
MR. KITCHEN: Yeah, you know what, Chair, can we take just a little bit of a break; is that all right? Maybe until 1:30. Mr. Lees?
A I just need 2 minutes, but whatever you ...
THE CHAIR: That's fine. I was just going to ask, Mr. Maxston, you're okay?
MR. MAXSTON: Yes, I'm fine, thank you.

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

MR. KITCHEN: Thank you.

(ADJOURNMENT)

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

MR. KITCHEN: Thank you.

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

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

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

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

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

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

A No, they have not decreased.

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

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

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

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

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

A None that could support it conclusively.

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

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

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

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

A For various reasons, I do, yes.

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

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

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

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

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

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

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

statement likely to be true?
A I think it would be more than 100. I think there may be a degree of less than, say, in the community because of various factors, not just -- not primarily masking that may reduce the incidents to some extent, but I don't see that as being supported by evidence.
Q If we had to put a number on it, how many would you -- how many transmissions of COVID between patient and health care worker do you think has happened in Medicine Hat?
A Well, we're not a big facility, first of all, but I would say, I'm just estimating here, I would say in the hundreds.
Q Hundreds just in Medicine Hat?
A Yeah.
Q (INDISCERNIBLE)
A Over the last two years though, that's --
Q Right, but Dr. Hu has said that it's less than 100 for the whole province.
A Well, I don't think that's true.
Q Now, I want to ask you about the general community. From your perspective as a clinical respirologist in Medicine Hat, has mandatory masking noticeably reduced the transmission of COVID in the general community in Medicine Hat?
A No. Medicine Hat, up until the very first mandate,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

impact?
A Sorry, can you clarify that?
Q You said there's the domino effect of feeling like you have to follow what other jurisdictions are doing; is that effect a scientific effect?
A No, I think that's mainly a social political effect.
Q Dr. Hu has repeatedly stated that the evidence supporting the effectiveness of masks is, quote, overwhelming. Do you think that's a scientifically accurate statement?
A Well, I disagree with that statement is I think the best I can say. I think that there is not overwhelming evidence. I think it is still highly debatable at this point, and there have been studies in the past for and against his position.
Q Dr. Hu has also said that there's heaps and mounds of evidence supporting the effectiveness of masks.
A I would not say --
Q Do you -- I was just going to ask you, do think the statement is an exaggeration?
A I disagree with the statement.
Q Would you say he's -- you merely disagree with him, or would you say he's exaggerating?
A Well, I don't think what he said is true. I don't think there are heaps and mounds. Although heaps and mounds is a very subjective description, so maybe, in

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

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

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

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

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

Do you agree with that statement?

A I do not.

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

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

is not right.
Q Do you think there are some things about science or medicine that really aren't debatable because we know what the answer is?
A Yes, but very few things.
Q Okay. So does it surprise you then that Dr. Hu is so confident that he's absolutely right about the efficacy of masks?
A Well, really I can't speak for Dr. Hu or his intention, I presume they're honourable, but I think, as I say, in any scientific debate, especially on a question as this, that potentially it could affect civil society to such a broad extent, I think it should be open to debate, and I don't think that there is firm evidence saying conclusively that masking worked or that they justify the measures that have been in place.
Q Now, of course, to Dr. Hu's credit, he specifically said masks aren't perfect, nothing's perfect, masks aren't perfect.
A Correct.
Q Are you -- would you say that masks don't work at all ever?
A It -- no, I think that it depends on what the purpose of the mask is and the conditions that they're used. In some very limited settings, they might be useful to some extent. Even in the days, as I mentioned, the

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

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

Q So some masks could work sometimes for some things?

A Correct, yes.

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

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

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

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

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

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

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

A Correct.

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

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

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

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

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

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

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

Q So did Dr. Hu make a mistake when --

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

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

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

A I believe so --

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

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

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

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

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

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

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

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

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

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

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

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

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

Q To deal with the fear?

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

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

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

A Correct, I do.

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

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

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

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

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

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

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

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

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

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

A Yes, I would.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

might have, but, no, we wouldn't.
Q It's kind of like the parachute example?
A Correct.
Q Now, the types of masks that are mandated for COVID, how do those types of masks interfere with the normal breathing process as you've described it?
A Well, it could be something from very mild to very significant, depending on the type of mask, how it is worn, how much it has changed, et cetera, and also their condition of the patient -- or the person who wears the mask. If they have chronic lung disease, they may be impacted more severely than others.

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

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

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

scarves or anything to cover your face.

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

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

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

Q And what would some of these contaminants be?

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

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

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

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

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

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

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

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

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

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

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

Q Okay.

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

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

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

Q So you have patients with asthma?

A I have many patients with asthma.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. KITCHEN: Thank you.

THE CHAIR: And to our reporter too.

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

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

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

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

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

A Absolutely.

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

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

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

Q Do you find that surprising?

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

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

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

A I believe --

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

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

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

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

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

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

A About the masking pandemic worldwide or restrictions in general?

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

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

MR. KITCHEN: Those are all my questions.

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

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

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

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

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

A Okay, that's fine, thank you.

THE CHAIR: Okay, thank you.

Discussion

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

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

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

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

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

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

MR. KITCHEN: No, I appreciate that.

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

MR. MAXSTON: I'm hoping 20 minutes.

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

(ADJOURNMENT)

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

Mr. Maxston.

Mr. Maxston Cross-examines the Witness

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

A Good afternoon, Mr. Maxston.

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

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

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

A Yes, I agree that that is their intent.

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

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

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

A Not in that manner, no, correct.

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

A Correct.

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

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

yes.
Q Would you agree with me that it's appropriate to get a physician to make a proper assessment and diagnosis of whether asthma is a valid exemption for a particular patient?
A I think, most of the time, that would be a reasonable thing depending on access, of course.
Q You talked about with my friend, I think the question was, as a respirologist, are there medically valid exemptions from wearing a mask, and I think your answer was, yes, absolutely. This will be a little redundant, but, again, is the best course of action to get a physician to properly assess any medical exemption?
A Generally speaking, that would be the usual route, yes.
Q Okay. I'm going to ask you some general questions. Mr. Kitchen went through a great deal of your background in your practice, but I just want to ask you, you haven't had any experience working with the Chief Medical Officer of Health on COVID-19 measures?
A No, I have not.
Q Okay. Would it be fair to say that your views in your expert report are contrary to what AHS or the Chief Medical Officer of Health or the Public Health Agency of Canada say about requirements for masking?
A Yes, they are in opposition.
Q One of the reasons we're at this hearing is the Alberta

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

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

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

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

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

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

a professional to follow those requirements of their regulatory college?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Sure. Thank you.

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

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

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

THE CHAIR: Okay.

Mr. Kitchen Re-examines the Witness

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

A Well, I'm being coerced I believe, yes. If it were not for that rule, I would not be wearing it.
Q So you're not wearing it willingly?
A Correct.
MR. KITCHEN: Thank you. That's it.
THE CHAIR: Okay, Dr. Dang, if you could just bear with us for 2 or 3 minutes while we caucus to see if the Hearing Tribunal has any further questions of you, and we'll be right back.
A Okay.
THE CHAIR: Thank you.
(ADJOURNMENT)
THE CHAIR: We're back in session.
Dr. Dang, the Hearing Tribunal does not have any further questions for you. We'd like to thank you for taking the time to attend and to provide your testimony. You are free to leave and with our good wishes.
A All right, thank you, you as well, good night.
(WITNESS STANDS DOWN)
THE CHAIR: On that note, we will adjourn the hearing for today. We've got dates set for I think the end of January, if I remember. So unless either party has something they wish to raise at this time.
MR. MAXSTON: I think, Mr. Chair, Mr. Kitchen and I are to stay on to help out the court

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

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

MR. KITCHEN: Thanks, you too.

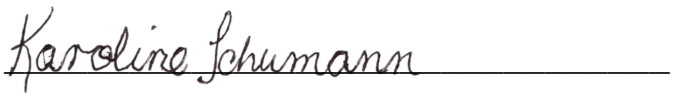
THE CHAIR: Thanks, bye-bye.

PROCEEDINGS ADJOURNED

CERTIFICATE OF TRANSCRIPT:

I, 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 1st day of December, 2021.



Karoline Schumann, CSR(A)
Official Court Reporter

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

DISCIPLINARY HEARING

VOLUME 7

VIA VIDEOCONFERENCE

Edmonton, Alberta

January 28, 2022

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

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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 9:18 AM)
THE CHAIR: Good morning, everybody. This is a continuation of the Hearing Tribunal for Dr. Wall, and we are back in session today, and I believe we left off on November 20th with witness testimony with Mr. Kitchen's witnesses. So that's the point at which we will pick up again.

I believe the transcript indicates that there's a Dr. Bridle that will be testifying today; is that correct, Mr. Kitchen?

MR. KITCHEN: Correct.

THE CHAIR: Okay, just a quick housekeeping item, I'd ask everybody to mute your cell phones. And good morning, Mr. Maxston, as well. Perhaps we'll start with you, if you have any comments you wish to make.

Discussion

MR. MAXSTON: Yes, thank you, Mr. Chair. Before we hear Dr. Bridle's evidence, I'd like to make some comments to you and your colleagues regarding process and scheduling matters. This isn't a preliminary application in the true sense, but to the extent you feel comfortable, my client will be asking for some advice and direction, for lack of a better phrase, I've advised him of my intention to raise these matters before the beginning of the hearing -- or

Dr. Bridle's evidence, and I understand he'll have a response.

Specifically the Complaints Director has asked me to make comments regarding the scheduling of the closing argument phase of the hearing and next steps, and this arises from Ms. Nelson's recent emails and Doodle poll to everyone, attempting to secure April 4 as the date for closing submissions. And the comments I'm making this morning also arise from the Complaints Director's ongoing and very serious concerns about the length of the hearing and the costs that continue to be incurred, and, as you know, I previously raised this with the Tribunal when we were objecting to Mr. Schaefer being called as a fourth expert witness.

My client was very, very supportive of proceeding on April 4 with closing submissions, given the considerable amount of time that has been spent on this hearing and I think our understanding that perhaps most people were available that day.

And by way of background, and recognizing the difficulties that can sometimes occur in terms of scheduling hearing dates and scheduling witnesses, my client remains concerned about the significant number of witnesses that Dr. Wall has called in terms of the lay witnesses and the expert witnesses. As you know, we've taken the position that the lay witnesses really

can't offer anything in terms of this hearing; it's about Dr. Wall's conduct and his regulator, and we've also indicated that we felt four experts was repetitious and was unnecessary.

The Complaints Director's concerns also arise from the number of days that have been scheduled for the hearing to receive Dr. Wall's evidence, and, in some cases, days where we haven't been able to utilize the full day, and that, in turn, has made the hearing that much longer.

So this leads me to my primary point today, and that is that the Complaints Director, again, is very strongly of the view that closing submissions should only need one day. They are a summary of the parties' positions and evidence, and scheduling closing submissions for one day should be more than sufficient, and, more specifically, April 4 should be sufficient in terms of the amount of time necessary to prepare. There's a lot of time coming now -- or that will occur between now and April 4.

So, again, my client is prepared to proceed with closing arguments on April 4, would like that to occur. I know Mr. Kitchen disagrees with that, but the -- and he has some comments he'll make, but the Complaints Director is asking for, again for lack of a better phrase, some advice and direction from the Tribunal

about how we're going to proceed and whether we can proceed on April 4, all with a view to maximizing the efficiency of the hearing.

I understand again that Mr. Kitchen has some comments in response.

THE CHAIR: Thank you, Mr. Maxston.

Mr. Kitchen?

MR. KITCHEN: Thank you. I have several comments.

We've heard a few times about the costs, and that's not relevant. I'm sure it is for the Complaints Director obviously but not for this hearing, not for the Tribunal. Quite frankly, if he doesn't like his costs, there's a way to remedy that, right? We don't have to keep going on this. Nobody is set in stone: Thou shalt, must continue this hearing. So I don't understand why we keep hearing that.

It's expensive to prosecute members of a regulatory body when those members put up a legitimate legal defence. Of course it is; that should come as no surprise.

So I say that because that can't be considered as a relevant component here. I mean, we could go down the road on how much Dr. Wall has suffered financially through all of this, you know, how much his family has suffered. He's had to hire legal counsel, right?

Enormous resources have been spent on his side. I haven't mentioned that because it's not relevant.

So a considerable amount of time, yeah, of course, of course it does, yes. This is a significant, significant issue, right? This is a scientific issue, it's a professional conduct issue, it's a matter of truth, it's a matter of integrity and professional regulation, and it's going to take some time. We haven't been at it for 20 days. It's not unusual for trials in the court to go for 20 or 40 days. My friend knows that. I think we've been at it for six or seven days. My friend took three days with his witnesses. I tried to utilize time as best I could. That's why I tried to fit in Mr. Jarvis [sic], and then, of course, we weren't able to continue that. I had witnesses standing by while we went through all of the Complaints Director's witnesses. I had no issue with that.

So again, it's not -- it's almost as if my friend's trying to say that Dr. Wall is doing a filibuster; that's not what's going on, okay? I didn't call 16 of his patients; he could have, he didn't. You know, I could call expert witness after expert witness after expert witness, and I could go, you know, go through all the more and -- arguments about why each witness should be allowed in, because there is no rule of court that applies here that caps the witnesses, but

I haven't done that. I've brought in four relevant witnesses, expert witnesses, and we're getting through them as fast as we can.

There is an enormous amount of evidence though, nonetheless, as you've seen. That evidence has to be synthesized, and it has to be discussed in closing argument. I'm not going to read to you line by line what Dr. Hu said or what Dr. Bridle says today out of the transcripts, but I'm going to have to go through the evidence, because the evidence is what matters. This case is about following the evidence to where it leads.

So -- and I've reviewed the evidence obviously for today, and there's a large amount of it, and we're not done yet, and part of the reason I submit there's a lot of evidence is because Dr. Wall's right, he's scientifically right, he's professionally right. That's why there's so much evidence to show that. I'm not going to ask this Tribunal, at the end of all this, to rule in his favour on a scant amount of evidence; I'm going to ask them to rule on his favour on a large amount of evidence. So I'm going to have to go through that evidence, and I'm not going to take four days to do it, but I'm not going to take 4 minutes to do it either.

And then I have to get into the legal argument,

which is complex, it's long, and this Tribunal deserves and Dr. Wall deserves for the Tribunal to hear a full explanation of how statutory human rights works, of how the Canadian Charter of Human Rights works, of how it applies to the College, of how Section 1 works, of how it's possible to justify these rights infringements. I have to go through a long list of rights infringements, because I have to establish that; it's Dr. Wall's burden.

This is not something that's going to be done in a couple hours. It's going to legitimately take me several hours to go through this, and then, of course, you may have questions, and we may have delays, like we had this morning, we started 20 minutes late. It's patently unreasonable to say we're going to get through it in one day.

Now, I understand that, you know, the Complaints Director is not a lawyer; I get that, I get that. But I think my friend, because my learned friend, because he is so reasonable, I think he can agree with me, that we're not going to get through a closing argument in five or six hours, which is typically what we have in one day. I could be the entire day before I get through mine, and then he deserves an opportunity to respond, and he might have a lot to respond to. Then I, of course, have an opportunity to rebut, and then we

have questions.

So it's not unreasonable, in any sense, to say there's got to be two days, and it's not unreasonable to say it's got to be two days in a row. We've broken up the evidence; that's fine. It's not ideal, but that's fine. But closing argument needs to be two days, two consecutive days in a row. And it's not fair to my friend, to be quite frank, if I go the whole day, and then he has to wait four weeks before he gets to respond to it because we've split it up.

The last thing I'll say is this: My client and I were available for days in February and March. It just so happens that the only day when everybody else was available is April 4th, and there's no option for April 5th, notwithstanding the fact that I have a trial I have to travel to for April 6th. I would have been willing to do April 4th and 5th if it had've been available. If we had've done those two days in a row, I would have done that, because we might only need a day-and-a-half, we might get through on the 5th, and then I could travel that evening. I don't like that, but I would have been willing to do that, but that option wasn't even presented --

THE CHAIR: Mr. Kitchen --

MR. KITCHEN: -- for whatever reason --

THE CHAIR: -- I'm --

MR. KITCHEN: Go ahead.
THE CHAIR: -- committed to another hearing with another college on the 5th.
MR. KITCHEN: No, and there we go. Now we know -- yeah, I understand that. So I don't -- but I don't know why it was always ever presented to Dr. Wall for only one day. I've made my position clear. I've explained to Ms. Nelson that the defence requires two days. So I don't know why it was only presented as one day; it should have been presented as two days, because that's our position.

So I can see why my friend is asking for direction here, because right now, as it is, we have a problem, because the Hearings Director is looking for one day when the defence has made it very clear there needs to be two days, which is perfectly reasonable, and he has a right to full answer in defence.

So I'm going to keep my calendar as open as I possibly can. I'm open all through May, I'm open almost all of June, I'm open all of July, so is my client. As soon as -- the soonest that everybody else can get two consecutive days, I'm going to be there, unless it happens to fall on the one or two days in May or June or July that I don't have available. So Dr. Wall is obviously not trying to delay this, okay?

I'll remind you that the initial delay was the

College's -- I won't say fault -- it was due to the College, okay? Dr. Wall filed his expert reports in April 2021, almost a year ago now, and we were gearing up, ready to go, and the College had to say, No, we're not ready.

And so here we are, you know, over a year later, after all this happened. That's not on Dr. Wall. He's keen to see this go through, he's ready to see it go through, but he has a right to full answer in the defence, and he's going to assert that, and he's going to require two days for closing argument. Those are my submissions.

THE CHAIR: I think before we caucus to consider a response, I will say that I can't speak for the two regulated members on the Panel, but I can speak for myself, and I think I can -- it's probably the same situation for Doug -- we're under significant demands these days. I'm booking 10 to 15 days a month for hearings, so it's difficult to find these periods of time. I know everybody has demands on their calendar.

We all just had a month off at -- some weeks off at Christmas, but fair enough, Mr. Kitchen, we will -- the Hearing Tribunal will caucus with counsel, and we'll take a -- and I hate to start doing this, but we'll take as short a break as possible, we'll be back in 10 minutes. If not, we'll let Amber know, and she

can advise everybody, and then hopefully we can move forward. So if you could -- thank you, Amber.

(ADJOURNMENT)

THE CHAIR: Well, the Hearing Tribunal and our counsel have considered the information we were presented with. I think our conclusion is that expecting to conclude final arguments and deliberations on the same day is probably not realistic. We also need time, and we also do not want a break following closing arguments until we're able to meet and deliberate on this matter. So I think it's realistic to ask for two days and to find two days that are consecutive. I'm not going to ask people to look at calenders now. Perhaps we can do that over lunch or at the end of the day.

I think we should get back on track and get this witness in, but I will say that the Hearing Tribunal has confirmed that they would be willing to meet on April 3rd. We're meeting on Saturday, tomorrow, so if Sunday, April 3rd, is an option, that could be two days in a row. Otherwise, Ms. Nelson will be back in the position of asking people if they could -- perhaps there's been changes to people's calenders, but, anyway, try and find two consecutive days.

It is a big -- I appreciate Mr. Kitchen's comments, there is a lot of evidence to cover, there's

also some complex legal arguments to be made, and I'm sure Mr. Maxston will have significant submissions to make as well, so we will try to find two days. I'm not going to cancel April 4th at the moment until we've found an option, but we will ask Amber to focus on doing that as soon as possible.

I understand that there's costs. These hearings are not cheap. That's the cost of doing justice, and that will be -- potentially it could be part and parcel of any final decision on this, but, in any event, we do not want to be in a position of telling either party, the College or Dr. Wall, how to present their final arguments. So we will look for two days. Hopefully everybody will be able to find something in their calendar that works without us incurring a further undue delay.

On that note, Mr. Maxston?

MR. MAXSTON: Yeah, Mr. Chair, I just had two comments, and I don't want to belabour this, I, unfortunately, am out of town for that weekend, so the 3rd would not work for me, and my second thought was I would suggest that we simply ask Ms. Nelson to send out a Doodle poll as soon as possible, that we not try not to compare schedules. I find that sometimes gets a little cumbersome, as everybody's flipping back and forth. Perhaps we could ask her to send out a Doodle

poll, you know, quite quickly with a two-day block.

The other comment I wanted to make was to my friend, Mr. Kitchen, and it might assist him in terms of Dr. Bridle, I've spoken with my client, and in terms of the qualification process and your questions, Mr. Kitchen, for Dr. Bridle; my client is prepared, subject to hearing from you in terms of, you know, the basis on which you're tendering your expert, my client is prepared to accept him as an expert witness without you having to go through, in any kind of detail, his qualifications, making again the same -- or submitting the same caveats we have before, that these issues are, you know, compliance issues and not scientific masking issues.

I don't know if that will assist you, Mr. Kitchen, or if you want to go through, I'll call it, a typical qualification process, but it might save you some time. I anticipate your -- the basis on which you're going to be tendering your expert witness is going to be, you know, fairly similar to what you've done before, and I -- if we can save some time that way, we're prepared to do that. I'll leave that with you.

MR. KITCHEN: Well, thank you, I appreciate that. I think that is probably an approach that I'll take for Dr. Warren tomorrow, and I will send you a proposed qualification today so that, you know, you

have notice about it tomorrow, and you can let me know if there's any issues.

Today I am going to run through qualification with Dr. Bridle, even though I don't anticipate a lot of objections, and it will be similar to what I've asked with Dr. Dang, but it's slightly different, and so I am going to establish the record for that.

THE CHAIR: Okay, well, thank you both. It's 8 minutes to 10, let's just take a quick break, and then we can plow through until lunch. We'll start at 10:00 with Dr. Bridle, okay?

MR. KITCHEN: Ms. Nelson, could you just -- because I haven't been able to communicate with Dr. Bridle. Could you just let him know that we're going to start at 10 so he has a heads-up?

MS. NELSON: Yes, I can do that for you.

MR. KITCHEN: Okay, thank you.

THE CHAIR: Thank you. And then, just to confirm, April 3rd is off the table.

(ADJOURNMENT)

THE CHAIR: We're back in session. Just two very quick items before I turn the floor over to Mr. Kitchen. I wanted to ask, Mr. Kitchen, do you have any documents that you plan to share with -- today or table?

MR. KITCHEN: No. Dr. Bridle's report and

his cv are part of the record, so you should have access to them.

THE CHAIR: Okay.

MR. KITCHEN: Please let us know if you don't, and that's all I intend. So I mean that could change if my friend brings something in, and then I need to bring something in in -- I don't anticipate that, but certainly for my direct, no documents.

THE CHAIR: Okay. And I just would like to tell people that during our first break to discuss your opening comments, one option we did look at very briefly and discarded was the option of having written closing arguments, and we decided that that was not an attractive option for this case, but we did -- we were trying to look at all options, and that was one that was brought up.

So with that note, I'll ask Mr. Kitchen to call your witness, and we can continue.

MR. KITCHEN: Sure, Ms. Nelson, if you could bring him in, and then we'll -- and then, Karoline, if you can swear him in.

(DISCUSSION OFF THE RECORD)

DR. BYRAM BRIDLE, Sworn, Examined by Mr. Kitchen

(Qualification)

Q MR. KITCHEN: So, Dr. Bridle, just to make sure that you know where we're going, I'm going to be

asking you what we call qualification questions, and then I'm going to be offering to the Tribunal the qualification I'm going to qualify you as, they'll make a ruling on that, my friend will have a chance to give some comments, and then I'll get into questioning you on substance, but this shouldn't take too long.

So to start with, Dr. Bridle, are you a doctor because you have a Ph.D.?

A Yes, that is correct.

Q What's your Ph.D. in?

A It's -- okay, so my training is -- well, I guess is to -- for -- to have a full understanding, I have a -- first, I obtained a Bachelor of Science degree in biomedical sciences, then a Masters of Science degree in immunology, and then a Ph.D. in immunology, and then I did a six-year post-doctoral fellowship to become certified as a viral immunologist, and I now hold, in a faculty position, as an associate professor of viral immunology at the University of Guelph.

Q Thank you. Your Ph.D., when did you get that and from what university?

A So it was from the University of Guelph, and I guess I would refer everybody to my cv, I -- it's been so long, I can't even recall the exact date.

Q That's okay. Are you a professor now currently?

A Yes, I'm an associate professor.

So just so everybody understands what that entails, the initial appointment for people for academics in a university setting is as an assistant professor. And then if we have progressed satisfactorily in our development as a faculty member, we then undergo usually about within, on average, about six years -- no, sorry, five, five to six years after being appointed as an assistant professor, we have to be -- we undergo a very rigorous review process where our performance is assessed independently by at least three world-renowned experts in the field.

And if our progress is deemed to have been satisfactory, then typically what happens is we are awarded tenure and promoted to the position of assistant professor.

And then the final stage would be full professorship, and that usually is about eight years later with a similar process involved.

So right now I am an associate professor of viral immunology.

Q Thank you. Have you received any awards or recognitions within the last two years?

A Yes. So you want to just limit it to the last two specifically --

Q Yes.

A -- or last --

Q Otherwise, we'd be here for a while.
A Okay. So, yes, so I've won several teaching awards. So one of the awards that I received was the equivalent of teacher-of-the-year within my college. It's the most -- like it's a prestigious award that's awarded within -- for, you know, the college that I -- for the college -- among the colleges that I'm involved in teaching in.

And what that entails is -- entails -- so I'm involved specifically with training or teaching veterinary students and -- in the field of immunology, general immunology. And so what happens is that, just like an M.D. program, it's a four-year -- it's four years of classes, four-year program.

And so for that award, what happens is all of the students in the second, third, and fourth year of the program vote on who they felt the top -- who the top professor is in that program. So that's one of the awards that I won recently.

Also what happens at the end of every academic year, the -- these professional students then vote on who they felt the top professor was for that given academic year, but I received that recognition, and that's -- so we get voted in basically as an honourary class president for that class.

I also recently received a research award for

outstanding research.

And I'm just trying to think, I think those are probably key highlights, you know, to highlight my -- yeah, the fact that I have been objectively assessed in terms of my teaching ability and research ability and have been recognized in those ways as being above average.

Q Thank you. Just give me one second, my phone was off, but my answering machine is on; I'm just going to turn it off.

THE CHAIR: I'll just mention, Mr. Kitchen, for everybody, Dr. Bridle's cv and other related information is in Folder E, and it's package number 5.

MR. KITCHEN: Yes, thank you.

Q MR. KITCHEN: Dr. Bridle, have you -- are you currently performing or overseeing research projects?

A Yes, a large number. So I'm known as what's called a research-intensive faculty member. So as faculty members at any university across Canada, our work is divided into three areas, and we all have -- we dealt [sic] on to have unique what we call distributions of effort.

So our work is divided among, again, three areas of focus, one is research, one is teaching, and one is

service. And so in my case, my distribution of effort is divided as such: 65 percent devoted to research, 25 percent devoted to teaching, and 15 percent devoted to service.

And just so there's some perspective with that, the sort of average dedication to research, like for the average faculty member across Canada, would be more in the range of 40 percent. So, therefore, I'm considered a research-intensive faculty member, and so that's an emphasis. And as such, I do have a fairly extensive research program and research team that I manage.

And so right now, active within my lab, there's sort of three areas of research that I'm focusing on. I do a lot of basic fundamental viral immunology research in which we look at the post-immune response to viruses and, you know, how we protect ourselves from viruses following infection.

And then the -- and then there's two more translational/applied areas of research. One is -- in both cases, they're using what we call immunotherapy, and the most common immunotherapy that I do research on are vaccines. And -- and for two purposes: So one arm of this program is focused on trying -- developing vaccines for the prevention of infectious diseases, and then the other one is for developing immunotherapies

for the treatment of cancers. Similar technologies can potentially apply to both, certainly scientific, the principles are fairly -- you know, overlap between the two. So I have those three areas of research is my emphasis right now.

And I guess I also, for full disclosure, just because it's probably most relevant to what's being discussed today, I did receive two grants to support my research program, infectious diseases, one from the Ontario Government and one from the Federal Government, and those are a specifically to conduct pre-clinical research in the area of SARS-Coronavirus-2 vaccines.

Q Thank you, you've answered some other questions I have.

And forgive me if this is not the right way to ask this, but are you currently a reviewer or an editor of any academic journals?

A I recently served as the guest editor for a special issue of a journal for -- and the journal is known as Vaccines, and that issue is now complete.

I do serve -- I'm active as a reviewer for many scientific journals, so that's a regular part of my job, and that comes under the service component that I was talking about. So that service component not only involves service to my institution, but it involves service to the -- well, to the public, but especially service to the larger scientific community.

And part of that is I serve as a reviewer on multiple grant review panels, including grant review panels for the Federal Government, and our -- that's our primary source of academic funding in Canada for medical research. So that organization is known as C-I-H-R for short or the Canadian Institutes of Health Research.

For that, I have served on multiple committees, including one that looks at grants that are being applied for in an area of cancer research, but probably my most -- definitely my most substantial contributions to that grant review agency has been serving on their virology and viral pathogenesis panel. In fact, I am currently serving a three-year term, invited term, as a reviewer.

And I guess, not that I usually like to tout, you know, things like accolades and awards, but, again, I understand that it's important to also -- you're trying to make considerations in this case about my potential to serve as an expert witness, so I'd have to point out that I have received three consecutive citations from -- and so I guess I forgot to mention this when you were asking about awards, because this is within the last two years -- and my service on the virology/viral pathogenesis panel, in which we determined which Canadian research -- researchers get

funding in that area. I have received three citations -- consecutive citations from CHR as being one of their most elite reviewers, which is an award given after the -- end of review competition, the chairs of the review panels, and the CHR staff that attended those panels identify the top 15 percent of reviewers for that particular review cycle across all of their panels, and then those top 15 percent receive these citations and try to set that standard for what the other reviewers should try and achieve in terms of the quality of the reviews that they provide.

And so as part of my job as well, yes, I routinely provide reviews, it can be to any scientific journal, and I do it for a large number of scientific journals. There's no limitation on that. Any scientific journal, if they feel that a faculty member anywhere in the world possesses expertise relevant to what that paper is about, then they can contact us and ask us if we would like to review. That's done on a voluntary basis; we're not required to do it, but it's done on a voluntary basis. And that is the foundation, the underpinning of how we establish the most rigorous scientific data.

So the top scientific data in the world of science is what we refer to as peer-reviewed scientific publications, and so those are -- that's scientific

data that has been compiled into what we call a manuscript, and that manuscript goes to what we call peer reviewers, that would be somebody like myself, who -- and we can have no conflict of interest, no connection with the authors of that paper. So that's important to make sure it's fully objective. And then -- in many phases, it's not even disclosed who the -- now with a lot of journals, not even disclosed who the authors are, to ensure that there can be no biases.

And then we give our feedback, either we recommend that the paper be rejected because the science is not of a sufficient quality, or we can recommend that it be accepted with different amounts of revision required to try and increase the quality of the science. And so, ultimately, if accepted, that means that -- so what we're talking about when we're talking about peer-reviewed scientific literature, that's the process that's followed. And so, yes, I participate in that and have done so for a large number of journals, and I do it on a regular basis and have throughout the duration of my independent academic career.

Q Thank you. When you do your research, you obviously do a lot of it, do you sometimes work with other scientists?

A Yes. Yes, my research team is highly collaborative.

So, again, if anybody would like to refer to my cv, you'll find that -- so the way authorship works in -- certainly in the area that I work in and so the academic realm, there is typically -- and it varies from research area to research area, there's sort of different conventions in the authorship of what typically happens. When you're looking at these papers, you'll often see a large number of names listed, and so those are all the people who contributed in some way to the sciences in that manuscript.

And the names that are at the beginning -- so this is the case for sure with all of my citations, the way it works, all the names at the beginning are typically the trainees that did most of the hands-on laboratory work, and then the names that are in the latter half of the authorship are what we call the senior authors. They're the ones that got the funding for the research, that often design the research project, and they oversee the management of the trainees that are working on that and provide feedback and troubleshooting, et cetera.

So -- and so when you're looking at sort of the level of collaborative-ness, you want to know who the senior authors are. And one of the -- and immediate ways to identify that is -- I mean, so, obviously, when I'm publishing something, my trainees are readily

identifiable typically because they're going to be from my institution. Although with that said, I have many trainees actually who have collaborated with mine from other institutions.

But so when you look at that latter part of the list, when you see people, especially from other institutions -- and I mean if there are any other faculty members as senior scientists, those are collaborators, official collaborators.

And so, yes, I've collaborated extensively. There's no way I could go through all of them, but I collaborate with researchers from around the world. I guess I can give you an example. So, for example, with a recent publication that we had on SARS-Coronavirus-2 vaccines, for example, that was a strategic collaboration with the National Microbiology Laboratory, which is part of the Public Health Agency of Canada, where they conducted part of our research. There were three separate research groups at the University of Guelph where -- that we came together strategically to do this work. So that's one type of example. So, yes, so I've collaborated with scientists in the Government and lots of scientists from other academic institutions, including others around the world.

So, yeah, my research team is highly

collaborative, so every one of my publications represents some type of formal scientific collaboration.

Q Thank you. Have you published any peer-reviewed articles or any other type of publications in the last two years either on your own or collaboratively with others?

A Yes. So I'm actually quite proud of that fact honestly, and this is why: So just to understand the setting, what happens is because of the lockdowns related to COVID-19 policy, a lot of research programs had to shut down and for substantial periods of time. And, indeed, my research was declared nonessential, and so the worst shutdown that we were facing originally was a -- it turned out to be six months of interruption to research, really nonessential research.

However, again, like I mentioned because I do -- because -- so this problem of COVID-19, specifically SARS-Coronavirus-2, the virus that causes COVID-19, because that's in my area of expertise and so many of the -- so much of the research and research tools that I work with were applicable, my group pivoted very rapidly to focus on COVID research, and like I said, we were successful in getting grants available to pursue that.

So we have continued our cancer research, we've

continued our basic virology research throughout this, but those two aspects have -- you know, we have experienced substantial interruptions to those components and -- but we focused our efforts on infectious diseases on the SARS-Coronavirus-2.

And so as a consequence, in fact, the last two years, remarkably despite that -- those, you know, impediments to research, the last two years have actually been my most productive in terms of publications. I -- again, you'd have to look at my cv to get the exact number. I -- what I can tell you, yeah, well -- oh, yeah, so, actually, I do have a fairly accurately grasp. We actually have so many papers that are currently under review that have been submitted that, you know --

What I can say for sure is that by the end -- by Christmas of last year, over the last two years, I had published 29 paper -- 29 peer-reviewed, scientific papers in scientific journals that are indexed in all the common databases and -- so 29 publications. And since then, I have had two or three more published. I have had two more accepted, and I have two or three more that are currently under review.

So, yeah, so it's been quite productive, and so the reality is -- so, for example, my institution, again, that has garnered attention because the average

publication record for faculty, in fact, dropped off substantially, to the point -- in fact, I should point out -- we actually normally have a performance review every two years, and because of this impact, our actual -- first performance review was supposed to occur very early on during the declared pandemic but was cancelled because of this impact at that time. And then we were supposed to have our last review very recently because this has been going on for two years now, and that's been cancelled.

So the next time we're going to have a review actually is going to have been -- at this point, it's going to have been a six-year gap, and that is to recognize the fact that it was unfair to evaluate the performance of faculty members who had had such massive interruptions to their research programs and their ability to be productive.

So, in fact, you can't expect the review committees to review six years of progress from every faculty member, so what's happening -- so, in fact, it's just been assumed that everybody -- at my institution, that everybody has performed reasonably well, because it actually gets linked to pay bonuses at the end of that two-year period, and so everybody will get the same pay bonus. And then when we have our next review, which will have been a six-year gap, it will --

we'll be starting from scratch again in terms of a review.

So, yeah, that's where I'm at with the publication record that I am particularly proud of, that my research team has been so incredibly productive throughout all of this, so that's kudos to them.

Q Thank you. And just to clarify some of those publications have been related to SARS-CoV-2 and/or COVID-19?

A Yes, that's true, yes, we have several peer-reviewed publications dealing with SARS-Coronavirus-2.

Q Have you been an expert witness in legal proceedings before today?

A I have. So, yeah, to disclose my involvement with those, I was in one that was ultimately not heard -- I was -- I -- so -- and the first one that I was involved with related to Corona -- SARS-Coronavirus-2. I served as an expert witness, was involved with various aspects of that case for many months leading up to it. I was cross-examined for 5 hours and 15 minutes for that case, but, ultimately, that case was thrown out. So I'm not a legal expert, but my understanding, therefore, is that I was not officially qualified as an expert in that case because the case ultimately was not heard, and my understanding is that's a requirement to be considered qualified, but I served as an expert

witness in that case.

I have -- I've served in an unofficial capacity for hearings that were run like court hearings for -- the most recent one was for a physician in Ottawa, an ear, nose, and throat specialist, who was -- and this was due to the vaccine mandates and whether or not they're privileged to serve into hospitals in Ottawa should be taken away because of not accepting, you know, the two jabs in that case, but that was not an official court proceeding, but it was run by lawyers.

And then I was also involved in a court case dealing with vaccine mandates that were -- that was -- this was for hospital workers in Toronto, and now that one is more complicated honestly. Again, I don't have the legal expertise, but it was my understanding and the understanding of the legal team that had recruited me to provide expert evidence to the people hearing the case that I had to qualify as an expert.

What I can tell you is that the -- one of the two experts on the -- serving on the other side, they were -- one was dismissed before the court hearing, their expert report, and then the other one was dismissed during the court hearing. Mine was discussed, and the lawyers accepted my expertise, and my report, my understanding was, had been admitted into court. There was a court hearing. My report was

discussed.

But then in the final report, what confused everybody is a -- the ruling ultimately was -- left only my report on the table, because the other two had been removed, and so, ultimately, the ruling was based on wording that the lawyers had used to, I guess, develop their case and not on the expert evidence. So the expert evidence ultimately was not considered in the ruling.

So, again -- so I was left with I had been told, on one hand, that I was qualified as an expert in that case, and then on the other hand, I was told that maybe not because the expert evidence, ultimately, was not considered. So that's just for full disclosure.

Because one of the things that I've got -- that I -- that was brought up is anytime I -- I didn't know from the first case, and I know it has to be disclosed, and I didn't want to get in trouble, so I disclosed that I was qualified as an expert witness in that -- the first case, and then I was accused of lying, but I just didn't know because I'm not a legal expert, and so that's been clarified.

So that's why, for your full disclosure, I want you to know what's happened. So in that last case, whether or not I was officially qualified, I'm actually uncertain of, but certainly my -- in both cases, nobody

disputed my -- the ability to serve as an expert. And in the last one, my expert report was actively discussed in court. That's for full disclosure.

Q Thank you. Now, Dr. Bridle, do you know Dr. Curtis Wall personally?

A I don't know him at all, no, and I -- so all I know is the name, and, in fact, I still know very little about him.

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

A No.

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

A Yes, yeah, and that's -- as a scientist, that's what I am expected to practice on a regular basis as I mentioned, otherwise, the entire peer-review process will be compromised, and I will endeavour to do that today as well.

Q Thank you.

MR. KITCHEN: Well, those are my qualification questions. Chair, I want to have Dr. Bridle qualified as the following -- I can read this a couple times -- but I want him to be qualified as an expert in the area of viral immunology and, in particular, SARS-CoV-2, COVID-19, and the efficacy of

masking, physical distancing, and other restrictions intended to prevent the transmission of SARS-CoV-2.

THE CHAIR: Mr. Maxston?

MR. MAXSTON: Mr. Kitchen, I'm going to ask you to read that back, I got part of it or most of it, but I just need to hear all of it again, if you could do that.

MR. KITCHEN: Yeah, no problem. I'd like to have Dr. Bridle qualified as an expert in the area of viral immunology and, in particular, SARS-CoV-2, COVID-19, and the efficacy of masking, physical distancing, and other restrictions intended to prevent the transmission of SARS-CoV-2.

MR. MAXSTON: Thank you, Mr. Kitchen.

Mr. Kitchen, I don't want to -- I may have a question or two for Dr. Bridle at this point, but can you clarify what other restrictions you're referring to? I don't want to be too difficult here, but that's a little bit open-ended; I just wonder if you can comment on that.

MR. KITCHEN: Sure. I'm going to ask Dr. -- what I anticipate asking Dr. Bridle specifically about specific other restrictions, right. I've identified masking and physical distance as specific restrictions, right? But the reality is, and I -- you know, I think we often hear this from the public health people is

that, Look, it's a whole, right? You can't talk about these things very well isolated; they need to be talked about as a whole. That's one reason I have that in there is I'm going to have generalized questions, and Dr. Bridle's going to have generalized answers, I anticipate, about COVID restrictions globally or generally. That's one.

And two, I'm following along the same lines that you established with Dr. Hu, which I didn't take issue with; you know, you had the catch-all other measures. You know, I figured that was appropriate, so I didn't object, and so I'm following along in the same vein so that we don't get into issues of, well, you know, you can only talk about masking or physical distancing. That doesn't really make any sense. It wouldn't make any sense for Dr. Hu, it wouldn't make any sense for Dr. Dang, it wouldn't make any sense for Dr. Bridle, so that's why I'm putting that in there; not because I'm going to go to specific other restrictions, but because I want to talk about them generally.

MR. MAXSTON: Okay, thank you for that. I just have a couple of quick question for Dr. Bridle.

Mr. Maxston Cross-examines the Witness (Qualification)

Q MR. MAXSTON: Good morning, Dr. Bridle. I wonder if you can answer a couple of quick things for me. You had a discussion with Mr. Kitchen about the

fact that you have your Ph.D., I think you're a viral immunologist. Is it correct that you're not a medical doctor then? I just want to be clear about that.

A Yes, that is correct. I do not hold an M.D. degree, nor a D.V.M. or any type of medical -- professional medical degree. I'm not a professional --

Q And similar to that --

A -- (INDISCERNIBLE) --

Q -- are you now a member of a regulated profession under, you know, the Ontario regulated Health Professions Act or something similar?

A No.

Q So you're not a member of a regulatory college like the College of Chiropractors of Alberta, for example, if you were in Alberta?

A That is correct.

Q Have you ever been a member of a regulatory college?

A No.

Q I think you touched on this with Mr. Kitchen, but have you advised any public health bodies concerning COVID-19; have you been asked to consult with them?

A Yes. So I have -- so, for example, I've had numerous interactions with the National Advisory Committee on Immunization, lots of back-and-forth emails, so, yeah, so that's a great question.

So I focus on research. I tend to focus more on

the pre-clinical side, feeding into the translational research arm. I have had some of my research go into clinical -- human clinical trials, but that gets passed off to those who work on the clinical research side.

So the type of research that I do helps inform public policy --

Q Yeah, I --

A -- public health policies but --

Q I think I --

MR. KITCHEN: Mr. Maxston, you need to let my witness finish.

MR. MAXSTON: Yeah, sorry, sorry.

Q MR. MAXSTON: I just wanted to -- I didn't want you to go down a certain road. I was more interested in whether you, for example, worked with the Ontario Chief Medical Officer of Health or anything along those lines.

MR. KITCHEN: And he'll --

A No, I haven't worked directly -- sorry.

MR. KITCHEN: Obviously, he's going to answer that question, but, Dr. Bridle, you are permitted to finish your answer to my friend's two questions ago.

A Okay, sure, yes. Yeah, so when it comes to public health, the type of research that I do and the science that I publish is what is used to inform public health

policy. So things like, for example, we've heard a lot about the epidemiological modelling, so what -- so -- and what happens is when these epidemiological models are made, there's a lot of assumptions that are plugged into those.

And so, for example, the type of research that I do would be important in terms of what kind of data gets plugged into these models when it comes to assumptions like naturally acquired immunity, for example, or vaccine-related efficacy, right, these assumptions that dictate how some of the measures right now are performing, and that then influences the output, which is when we're trying to predict what cases and severe outcomes like hospitalizations and intensive care unit admissions, for example, I get into, just so that the -- everybody has an understanding of sort of where I stand on that spectrum. So my data feeds into that, you know, basic science aspect that informs then these models and how they're run.

But to directly answer your question, Mr. Maxston, I have not worked directly with the medical -- with Ontario's Medical Officer of Health. With that said, I have provided letters to them, you know, with my input, but I have not been formally recruited by them to discuss, you know, scientific matters.

MR. MAXSTON: Thank you, Dr. Bridle, those are all my questions.

Mr. Kitchen, I don't have any concerns with the manner in which you're tendering this witness. I think you've told me you wanted to have a little flexibility in terms of the other restrictions phrased, and I'll object if I need to, but I don't anticipate I would have to do that.

MR. KITCHEN: Thank you. Well, Mr. Chair, it's over to you then to let us know if you accept that qualification. I can read it again --

THE CHAIR: Yeah, no, that's okay. I think we all got it. Do we need to caucus, Mr. Pavlic?

MR. KITCHEN: You're muted.

MR. PAVLIC: My apologies, I had a little bubble over my mute button. Yeah, maybe we should just take a very brief minute.

THE CHAIR: Okay.

MR. PAVLIC: Yeah.

THE CHAIR: Thank you.

MR. PAVLIC: Thank you.

(ADJOURNMENT)

Ruling (Qualification)

THE CHAIR: We're back in session, and, Mr. Kitchen, the Hearing Tribunal has no objection to your qualifying this witness as an expert in his stated

field.

MR. KITCHEN: Thank you. Well, then I propose we continue on with questioning, and then if we need to take a break, then I'm sure somebody will put their hand up.

DR. BYRAM BRIDLE, Previously sworn, examined by Mr. Kitchen

Q MR. KITCHEN: Dr. Bridle, you can hear us, right?

A Yes, I can.

Q Excellent, all right, well, I'm going to jump right in.

First, I want to start with a few basic questions, I know you touched on this in the qualification, but just to clarify, what is the virus that causes the disease of COVID-19?

A Yeah, so just to be clear, the virus in question here is known as the Severe Acute Respiratory Syndrome-Coronavirus-2. It's specifically been given that designation 2, because about 18, 19 years ago, there was an outbreak, including in Canada, of the original Severe Acute Respiratory Coronavirus, which is now either just called SARS-CoV or sometimes now referred to as SARS-CoV-1.

So this is dealing with the Severe Acute Respiratory Syndrome-Coronavirus-2, which was first identified and that information made public in the year

2019 now, late in the year 2019, and this is where we get this term "COVID-19" from. So what COVID-19 is, that's the Coronavirus disease, and then the 19 part refers to that was initially identified in 2019.

And, again, yeah, to differentiate -- and this is an important distinction for people to make -- SARS-Coronavirus-2 is the virus. COVID-19 is the disease. Being infected with the virus doesn't equate with having a disease. To have a disease, one must have signs for -- and/or symptoms of illness. So there's a clinical part to that diagnosis. So, again, one can be infected with the virus but not necessarily have disease, and, in fact, scientific literature right now shows that there's a much larger than previously anticipated and still unknown proportion of the population that has been or can be infected with SARS-Coronavirus-2 and not get COVID-19, the disease.

And so a way to kind of make sure that everybody understands that properly, we are all, all of us right now, I can guarantee, are infected, infected with all kinds of microorganisms, including lots of viruses. We think -- we hear a lot about our microbiome, and we often think about the bacteria that coat the outside and inside of our linings specifically, like the mucosal membranes throughout our body or gut, our respiratory tract, reproductive tracts, et cetera, and

then, of, of course, our skin.

But part of that microbiome is also what we know as the virome, so we actually have probably more viruses in and on our body than we actually do bacteria, and, interestingly, a lot of those viruses are actually -- have infected the bacteria that are in or on our body, and these are known as bacteriophage.

So I mean this just highlights that we can be infected with an agent but not have disease, and so that's the distinction here. SARS-CoV-2 is the virus that, in some people, can cause the disease known as COVID-19.

Q Thank you. Now, when it comes to the virus and the disease and everything that's been going on in the last two years, what would you say is the most important difference or some of the most important differences between scientists such as yourself and public health doctors such as Dr. Hu?

A Yeah, so I can't comment specifically on Dr. Hu, but I can provide some generic feedback, because, again -- so, for example, individuals like myself, again, so we train -- we train medical professionals. In my specific case, I've chosen to work with the University of Guelph. I've been offered a position at the University of Ottawa where I would have been teaching students in the M.D. program, but because I felt I

could do more sophisticated research at the University of Guelph, because there's more animal models available and the type of research I do, I teach students in the doctor veterinary program.

However with that said, I've also had many of my undergraduate and graduate students that I've trained and mentored have gone to medical school as well.

And so as a consequence because of this teaching, I'm routinely involved with communicating, for example, I've chaired for many years our department's seminar series committee, and so through that, I host other scientists through my collaborative network. I've been in contact with all kinds of faculty members who teach in these types of programs.

So what's important to note is when one has an advanced degree, so, for example, a Master -- so that would be like a Master's degree and especially a Ph.D., a Ph.D. takes it to a far greater extreme. What one is being educated in in that area is a very deep understanding of a particular area of expertise. So in my case, I have spent years studying in incredible detail the areas of virology and immunology, and although not relevant to today, but also cancer biology.

And so the key difference, what people have to understand -- and, again, this -- I mean no offence by

this in any way, but it's just to encourage understanding -- is if somebody holds an M.D., and the same would be for a D.V.M., any of these professional medical degrees, what you have to understand is when it comes to the medical doctorate programs, these are undergraduate programs -- they're undergraduate professional programs, right? So people when they get these degrees, they are declared professionals, but they are undergraduate degrees. So that is why, for example, if you see somebody who holds a graduate degree, the graduate degree will always, even if it's a Masters degree, it will always be listed after the undergraduate medical degree, and that's to recognize the fact that one is training at the undergraduate level, whereas the other one is more in-depth training at a graduate level. So literally -- so that's what you'll typically see. So if I were to list my credentials, I would be required to list my Bachelors of Science first, my Masters of Science second, and my Ph.D. last, and what we usually do is we just simply list the Ph.D. because it essentially trumps the others. So that's why you'll typically see -- not people won't list the Bachelors or Masters, and I don't like to do that because, you know, it's not about trying to garner, you know, praise from others, it's simply to recognize that, you know, ultimately we have

achieved -- we have -- we've got a Ph.D.

So that's why you see -- so the order in which degrees are listed actually is important in the scientific and medical community to recognize these distinctions, and so at the -- so, in other words, individuals like myself, who have deep expertise in immunology and virology, so I would teach in these programs in those areas that are under my expertise and try and get as much of that expertise conveyed to the people who are earning these undergraduate medical degrees.

One of the universal concerns actually -- so when I start my teaching -- and I mention this because it's important to understand the full scope of your question -- I -- so I -- one of the things I take pride in, as far as I know to date within the D.V.M. program, doctor veterinary medicine program that I teach, as far as we know to date, it involves the most extensive training in immunology in North America. I can't say for sure, because I don't know what every medical college in North America, what their programs entail, but so far, and has been recognized by my administration, we haven't seen one that's more intensive.

And by that I mean, we teach -- I have 30 lecture slots with my students to talk about -- you know, to

lecture them about immunology. Included with that is we have what we call independent learning sessions, where they also do some learning on their own about immunology. We also have -- I've incorporated what I call interactive learning sessions where we use a technology called iClickers, where I can put up questions and have the students then provide their feedback so I can gauge how well they are or are not understanding concepts, plus we have review sessions where they can openly ask me any questions that they want.

And then the other thing that we have is I run -- the class, because it's large, gets split into two, so I run two laboratories split across two halves of the class, so four laboratory sessions in total. So each student gets six hours of laboratory exposure to immunology, so hands-on learning.

So I just say that to put in perspective, because in Canada, in the M.D. program, the average M.D. program in Canada provides in the ballpark of ten lectures, only lectures and none of these other aspects, no laboratory, you know, hands-on learning, ten lectures on average in the first year of the M.D. program and less than that for virology.

So on the extreme end would be McMaster University. I have had several of my students go to

McMaster University and of course to collaborate -- I mean, I did my post-doctoral fellowship there, so I -- and I collaborate and still collaborate with people from McMaster, so I know this very well. They're on the extreme low end in Canada actually with five lectures in immunology in the first year of the program.

So I say that because when it comes to things like immunology and virology, therefore, if it's just an M.D., then somebody who just holds an M.D. and who has not taken advanced training in these areas would have only the most superficial understanding of these areas of science. And at an extreme, it is possible to get into these programs without completing an undergraduate program. I'd like to point that out because their undergraduate immunology training, for example, the University of Guelph involves about 35 lectures in immunology, so -- but those tend to be in third and fourth year. People can get admitted into medical -- and they're not often prerequisites as well. So even an undergraduate student with a Bachelor of Science degree who has taken an undergraduate immunology course, for example, from the University of Guelph would have a much more comprehensive understanding of immunology and virology than the average person at the point of completing their medical doctorate.

Q Thank you. Okay, now I've got some questions about your report. In Section 3 of your report, and just for those following along, that's page 2 of 18. So in Section 3, Dr. Bridle, you refer to the SARS-CoV-2 virus --

A Sorry, Mr. Kitchen, may I just ask a question; am I allowed to bring up my report to refer to it?

Q Yes, yes, you are.

A Okay, I'm going to be looking -- I'm going to bring it up on my -- I have a second screen here and that is what I'm looking at. So, sorry, which page?

Q So I'm on page 2 and 3 of 18 pages, and this is Section 3, where you say: (as read)

> SARS-CoV-2 is not a problem of pandemic proportions.

A Okay, just let me get there, page 2. Yes, okay, I'm there.

Q You discuss infection fatality rates in this. Well, let's start here: Could you just briefly explain for us, so we know, what is the infection fatality rate?

A Okay, yeah, so what -- infection fatality rate, what that tells you is if you have a population and you can confirm that an infection has occurred and how that -- and I want to point out how that is determined, what method is used is important, because if techniques are used improperly, one might be erroneously identified as

being infected. But so what infection fatality rate is supposed to be is if somebody is genuinely infected, it gives you an indication of what the chances are that that is going to be fatal for that individual.

So the best way to understand it is, again, because we're talking about percentages, it's best to put it, give the example of how having a population of 100 people, so if you know what -- if you have a group of people that you know for sure are infected with a pathogen, then the infection fatality rate would tell us how many, what proportion of those 100 people would be expected to die as a result of that infection.

Q Could you please describe the relative danger of SARS-CoV-2? And I say "relative" because, you know, obviously we're not working in a vacuum here. So if you could tell us the relative danger of SARS-CoV-2.

A Yes. So what I'd like to point out just before I start giving the full answer, and I'll come back to this at the end, there is -- what I want to point out is in my report -- just, again, to put it in perspective, my report was submitted I can't remember the exact date, but it was, you know, well -- it was quite some time back in 2021. So I'm going to talk about, because this has been admitted as evidence, I want to talk about what was available to me at that time, but it's important to note that things have also changed quite a

bit in the context of the Omicron variant, so I'd like to touch on that at the end.

So in terms of what I have in the report, what you'll see is that ultimately I cite a scientific paper, again, a peer-reviewed published paper that estimates -- that estimated at that time that the infection fatality rate for SARS-Coronavirus-2 was likely in the ballpark of 0.15 percent. So, again, to put that in perspective, if a hundred people were infected with SARS-Coronavirus-2, you'd expect 0.15 percent of them to die.

Now, this is important because when the pandemic was declared, many of us might recall or certainly you can look up the, you know, the headlines, it was declared -- there were concerns at the beginning, because we didn't know a lot about this virus at the very beginning, so what I'm referring to there is towards the end of 2019 when this virus was first identified, we didn't know, you know, what exactly the outcome of infection would be, and there were serious concerns that we might be looking at infection fatality rates as high as 10 percent. So that was stated by many health professionals including Anthony Fauci and many others.

Then as time progressed, and we started to realize that it was a relatively limited demographic that was

at high risk from this virus, that was rephrased, and the concerns were then that this might be in the ballpark of -- infection fatality rate might be in the ballpark of about 1 percent, and that would be serious if it was at 1 percent, definitely with 10 percent, also at 1 percent. I would argue as an expert in this area, a 1 percent infection fatality rate, that declaration of a pandemic would likely -- would be warranted at a 1 percent infection fatality rate.

But this is where it's important is what we soon realized because of the way that the testing was being done, and there'd certainly be flaws with the testing as it's been performed in Canada, what I'm referring to there are the reverse transcript-ase PCR tests or what we often refer to as just the PCR test. "PCR" meaning polymerase chain reaction test, which are -- the way we're using them, they're notorious for identifying a lot of false positives. So that's why you have to keep sort of mentioning and when I'm giving these statements that a lot of -- at its root is when you know somebody's infected.

So what we know is that there have been a lot of people who have been infected who never got sick, and so initially our estimates of infection fatality rate were based on people who actively had COVID. Now, we -- again -- so, again, we recognize now that

there -- that there -- a lot of people can be infected but for whom this is not even a pathogen. And what I mean by that is because it does not count as disease in those individuals.

For example, that's very common in children, and one of the reasons for that is children simply have physically expressed many fewer of the receptors the virus uses to grab onto our cells and infect it. So there's many children who get infected, but the infection is -- never becomes productive enough to cause disease.

And so as we've appreciated that, the way this is calculated is, like I said, you have to have -- in order to calculate infection fatality rate, you have to know the number of deaths, and you divide that by the denominator, which is the number of people who are infected. So early on in this pandemic, we -- the way this was being calculated, of course, we've always had quite accurate numbers of deaths, because that's -- I mean, you know, unfortunately, that is a very easy outcome to define and identify and document, and there's really -- there's no controversy about that outcome, that a death is black or white, either somebody's died or they have not. So we have very accurate data about deaths.

The problem is we still don't have fully accurate

data for the denominator, which is how many people have been infected. But as we have expanded the testing and looking for evidence of -- and, again, it's not even the virus but evidence that the virus is present in somebody's body by detecting portions of the genetic material that this virus would have, what we've been able to appreciate is that the denominator -- the denominators kept growing, in other words, right? We have found that more and more people have been infected.

So, for example, there's the great study that was published, actually a Canadian study, a high -- that was published in a very high-impact scientific journal, and it was a clinical trial that was being run out of British Columbia looking -- actually looking at healthy people for evidence of immunity acquired against SARS-Coronavirus-2, so, again, knowing that this was a novel virus. And what it found is that a majority of people who were not sick had evidence of having acquired, especially as time has gone on, so a year after the declaration of the pandemic, a large number of people who were unaware that they were sick with SARS-Coronavirus-2, you know, there was no sickness that they could identify, had evidence of what we call seroconversion, so the immune system having responded to the virus and produced antibodies against it.

So what this publication that I cited here did is it accounted for this ever increasing denominator, and so it corrected for the early massive overestimations of the infection fatality rate and came up with one that they felt at that time was more reasonable. And, again, I point out that this publication is from earlier in 2021, much earlier in 2021. And they estimated that the overall infection fatality rate was 0.15 percent.

So to put that into perspective for people, and this is largely agreed upon, I mean people like Dr. Fauci, for example, have publicly declared themself that, you know, the flu is often associate -- the annual flu is often associated with an infection fatality rate in the ballpark of 0.1 percent. So an infection fatality rate of 0.15 percent would be like a particularly bad flu season.

And the other thing to point out is when one looks at this publication, that's the overall infection fatality rate for the entire population. And in this case, we know that this virus is much more dangerous for a much more restricted subset of individuals, specifically the frail elderly and those who are immunosuppressed. And then we've come to identify some very key predictors of dangerous outcomes of infection: Obesity at the moment is the number one risk factor

associated with fatal outcomes, and alongside that are multiple comorbidities. So the average person who has died with SARS-Coronavirus-2 -- with the SARS-Coronavirus-2 infection has had, on average, more than three other comorbidities, meaning other illnesses, other health problems in addition to infection with the SARS-Coronavirus-2.

So why this is important is because if you were to remove those individuals from this analysis, you end up with an infection fatality rate for the rest of the population that is well below 0.1 percent, with the extreme being when you go into children. So if we go to the under 18-year-old demographic, the infection fatality rate would be well, well below 0.1 percent, and our own public health data show that, that there have been extremely few deaths. So, yeah, very few in that young demographic. So -- but this is the thing, so that's what I have in the report.

Now, what's important to note is that was dealing with data where we were dealing with the original variant and some of the variants that started to emerge, so, for example, the Alpha variant. Those variants we now know, certainly relative to the current Omicron variant -- and I think this is important because presumably I mean with this hearing happening today, I guess we're talking about the relevance of

certain COVID-19 policies as it exists today. If we ask somebody today to implement a certain policy, what's relevant is what the situation looks like today.

So the Omicron variant is far more infectious than the original variants -- actually I should restate that. It's more infectious than the original variants. The Delta variant was particularly infectious, that's when we first saw a change in the virus towards one that is more infectious and that can spread, therefore, easier, and this seems to have continued with the Omicron variant.

And this is very typical of viruses. What I'd like to highlight is -- and so this leads to what we call cases, right? Cases -- and, again, what I'd like to point out is the cases that we are identifying in our public health data are not actually cases of COVID-19; they're cases that were called -- although we often equate them to cases of COVID-19, what they are in reality is they are positive test results, again, for the presence of portions of the virus's genetic material in an individual. So people tested positive by the PCR test for -- and that provides some evidence that they may be infected with a potentially infectious form of SARS-Coronavirus-2. So that's important.

And what I'd like to point out is cases in and of themself are not dangerous. So if somebody were to

acquire any of the respiratory pathogens and develop mild to moderate signs or symptoms of illness like other common cold-causing viruses, including other types of cold-causing Coronaviruses, like Norwalk virus, like respiratory syncytial virus, and like influenza viruses as examples, they would be cases of respiratory illness. So that -- and all those cases, those viruses are highly transmissible, but in most cases do not cause -- well, I should -- I'll talk about the cold-causing viruses, in most cases do not cause severe disease.

So if we think about the common cold, highly contagious. I mean, we've all seen this, especially anybody who's been in -- volunteered in a school, worked in a school, or has children in school, and in also workplaces, schools especially, I mean, a cold will spread rampantly throughout the school population and in all the homes connected with the school. So the ability to spread rapidly is not in itself a concern if it's only causing, in most people, mild to moderate disease. The reason why I focused on cold viruses is they excluded things like respiratory syncytial virus and influenza viruses, for example, because they actually can be particularly dangerous, not only the same demographics that we're talking about with SARS-Coronavirus-2 but especially in young children,

which are quite -- actually protected because of that unique physical, you know, lack of expression of the receptor the virus uses to grab onto our cells that -- and it's not confined to SARS-Coronavirus-2, it's unique in that our very young are not susceptible in this case. But all these people are susceptible to potentially severe and fatal outcomes with influenza viruses and the young for sure with respiratory syncytial virus.

And so that -- so that's why -- so, yes, so I want people to understand Omicron is more -- because this relates to the infection fatality rate, -- it can spread easier, but it is definitely much less dangerous than any of the previous variants. That is clear. We're seeing that everywhere. I want to -- so what's important to understand this -- is because of the public health messaging, right, that's been out there, and personally as an expert -- I have contentions with this, but I'm just putting out what the public health messaging is right at the moment -- is that the vaccines being used for SARS-Coronavirus-2 have been purported to be -- I mean, originally, they purported to be very protective and protect people from infection and disease and very good at preventing transmission. That certainly has been downgraded, and I would argue that current data suggests that they are not reducing

the spread of the disease at all.

In fact, the remarkable phenomenon and of concern to me is that we're actually seeing cases occurring predominantly among the fully vaccinated, which might actually be evidence of vaccine-enhanced disease. But I raise this because in vaccinated individuals, this is the messaging, that it's supposed to be, supposed to be reducing their chances of getting infected and their chance of transmitting the virus to others. And yet in all of our school and work environments where it's almost completely people who are vaccinated, so there should be reduced transmission and they're masking, the viruses are still spreading rampantly. So this is the nature of Omicron.

But our data also show that while the cases of Omicron have skyrocketed across all of Canada, including Alberta, the most serious outcomes have steadily declined. So there's been a -- there's been, over time, a complete uncoupling of cases and the most severe outcomes. So as we've continued to have these -- and, remember, the first wave early on in the pandemic has been dwarfed by multiples -- recent waves, including the most recent with Omicron, has completely dwarfed the previous wave if you look on the graphs and the number of cases that are occurring. Yet, we have progressively gotten -- gone closer and closer to

baseline when it comes to hospitalizations and ICU admissions and deaths, and so that's clear evidence that Omicron is less dangerous.

Also biologically, I can explain why this is, and it -- there's two phenomenon that explain why Omicron now is much less dangerous than the previous variants. So -- and this goes hand-in-hand actually with the vaccines. The vaccines, unfortunately, we've delivered them into the muscle, which is called a parenteral route. That tricks the body, the immune system into thinking that there's a systemic infection, not a mucosal infection. Remember, the natural infection is through the airways. And so when the body thinks that there's a systemic infection, what it wants to do is it protects all of the key entry points into the body to protect from future systemic infections.

So when it comes to respiratory tract, the only place that these vaccines confer some protection is in the very lower airways, and that's because if a virus gets into our lower airways, there's not much physically to prevent that virus from getting into the blood, and that's because of gas exchange, right? We -- so in the alveolar space, we have blood vessels that come very, very close to the alveolar space to allow the gas exchange, oxygen to go into the blood and carbon dioxide to be released. So that also means that

if a virus gets there, there's only the ever so tiniest physical barrier to prevent it from getting into the blood. So our body produces antibodies in the lower airways.

So this is the thing -- and I say that because this is important -- the most severe outcomes of infection with SARS-Coronavirus-2 is when the virus goes down into the lungs. When it's in the upper airways, it's not particularly dangerous. When it gets dangerous is when it gets down into the lungs, and it causes a severe pneumonia, then you start getting inflammation in the lower lungs, and that can interfere with things like gas exchange, and it can cause a lot of damage to the physical architecture of the lower airways, which is where all the gas exchange has to occur.

And when it gets into those lower -- in the lower lungs, that's where the real problems are when the virus then starts entering the bloodstream, and we get what's called viraemia, and that means the virus can distribute all throughout the body using the blood, our blood, as highways of all the places -- all kinds of different places in our body. So that's where the severe outcome occurs.

And that's also why the vaccines with earlier variants were doing, you know, a somewhat decent job at

dampening the most severe aspects of the disease. But, as we've now recognized, they weren't preventing infection, and they weren't preventing transmission. And this is why they're having no impact on Omicron, the spread of Omicron, is because -- this is the other key biology you have to understand -- so if the virus doesn't go deep in the lungs, you tend not -- you're going to tend not to get severe disease. It's the difference between bronchitis and pneumonia, and many of us will know that pneumonia is -- has a much more severe prognosis than bronchitis, which is the upper airways. Pneumonia being in the lower airways.

So the interesting thing is Omicron now has accumulated a lot of mutations, a lot of mutations, and it has changed how this virus behaves. In one -- so one way it changed it is has become more infectious, but it's also become much less dangerous, because when we talk about viruses, we refer to something that's called tropism. Tropism is a scientific term that means where the virus likes to go in our body. So the original variants like to infect our upper airways and then migrate into our lower airways, and that's where they were dangerous.

The Omicron variant also infects through the nasal passages and the mouth and infects our upper airways, but it does not migrate down into the -- deeper into

the lower respiratory tract. It now has the more restrictive tropism, meaning it likes to stay in the upper airways. So this explains why the vaccines are now largely irrelevant in the context of the Omicron variant because the protection is in the lower airways and not in the upper airways. And so somebody -- and that also explains why the virus -- whether you have immunity or not is not particularly dangerous because it's restricted to the upper airways.

It also explains why everybody can equally transmit the virus, because nobody -- well, sorry, sorry, I -- that's untrue. I'm going with sort of the public messaging that's out there. So I'll tell you what the exception is to that. But it's thought right now that everybody, whether or not they have been vaccinated or not, can transmit at least the same quantity of the virus because it's in the upper respiratory tract.

But the reason why I want to point that out is I'm an immunologist and have found it profoundly frustrating that it's not recognized that our immune system actually does its job and functions naturally. The purpose of a vaccine is to simulate a natural infection, try and do the best that we can to simulate an actual infection as accurately as we can to confer immunity. As I mentioned that these -- we've made a --

you know, the vaccines going parenterally actually trick your immune system into thinking it's a systemic infection, so we're not getting proper protection of our airways.

Somebody who has been naturally infected will have mounted an immune response, and their immune response is going to be far more relevant, especially to the Omicron variant, because they've been infected the natural -- by the natural route. Our immune system when infected by the respiratory tract makes sure that it provides infector mechanisms that can protect all, all areas of the respiratory tract, upper and lower. So I want to point that out.

So we don't know a lot about natural immunity because we haven't been looking for it, but somebody who has natural immunity, we can't make any assumptions about their health status without knowing, because if somebody has natural immunity, they're actually going to be the most protected in the context of Omicron, and they're going to be the ones that spread the SARS-Coronavirus-2 to the least of anybody in Canada right now.

So I know that's a lot, but it's -- it's a lot of science, again, to understand the importance of the infection fatality rate, what it means, and why we have been seeing it declining, and why we can conclude that

the danger of SARS-Coronavirus-2 even more recently has continued to decline.

So, again, I'd just like to finish by, again, saying SARS-Coronavirus-2 with the dominant -- the variants out there right now, by far the dominant one is Omicron. It is more transmissible right now and much less dangerous right now.

And just to understand as well from the virology perspective, that's typical for a virus. Any pathogen -- so, again, you think about -- so if we think about viruses as organisms, right, if we just take that very like objective approach, and we think about this from the perspective of an organism and an organism trying to survive; it is never to an advantage to any microorganism to cause severe harm or kill its host, because if it does, it's going to render itself extinct.

So what happens over time is, arguably -- so we -- we often forget about this, as I mentioned, our bodies are loaded with viruses that causes no harm. The vast majority of viruses that we're exposed to in the world do not cause disease. That is where viruses want to get to and for the reason of survival. Because, again, like I said, if they were to infect the host and kill that host, they're rendering themself extinct.

So the natural progression for a virus is to

become -- so think about it, if you want to maximize survival, if you want to maximize the number of your kind, right, you can think about any organism, what you want to do is maximize your ability to propagate and minimize your ability to harm your host and especially not kill them. And so that's why viruses over time will naturally progress to ones that are more infectious, because the more hosts they can infect, the more they propagate, right, and the larger their numbers become, but they simultaneously become less dangerous, because if they were to kill all those hosts, they're going to render themselves extinct.

So that's what this virus is doing, has been doing. We have the evidence of this. This is the -- so this is a natural progression for this type of virus: It's reaching -- starting to approach a more ideal way to live with us by, you know, spread readily among people but not cause substantial harm to people, and it would probably -- likely continue to progress this way ideally, and so that's very important to understand.

So, again, just to highlight, being more infectious does not equal more dangerous. Again, I'd like to highlight the common cold is highly infectious, but for most people not dangerous. That seems to be where the Omicron variant is right now.

Sorry, Mr. Kitchen, it looks like you're muted.

Q Sorry, I muted, because I didn't want to cause any noise to interrupt you.

Okay, if I understand you correctly then, we have an infection fatality rate that has changed over time, so I want to ask you a couple of questions about that.

You've said it's much less dangerous now. Can you give me a rough number of what the IFR rate is now or in the last few months? And I understand that might be several decimal points, but if you could give us some idea just so we have a number.

A Well, actually I haven't seen a good, reliable peer-reviewed publication on that actually, and that's because the Omicron variant, you know, has -- it's quite recent, and, again, that would be the most relevant data. So all I can tell you is that, again, based on what I described for -- relative to the data that I highlighted -- that was highlighted in my report, which is dealing with older variants that unquestionably were more dangerous to the high-risk demographics, the Omicron is much less dangerous. So all I can say with certainty is that it would be well below the previously documented 0.15 percent, but I don't have a specific number that I could give you right now upon which I -- for which I could lean on a legitimate peer-reviewed scientific paper.

Q Let me ask you this: Is the survivability rate sort of the other side of the coin of the infectious fatality rate?
A Yes.
Q Okay, so, you know, the 99 percent --
A So sorry, could I just clarify that, Mr. Kitchen?
Q Go ahead.
A So, yeah, so, in other words, just to make sure that it's clear, yes, absolutely, infection fatality rate, I mean, so if you take the inverse of that, that's the survivability rate. So that infection fatality rate that was updated early in 2021 of 0.15 percent, the other way to put that is that 99.85 percent of those deemed to have been infected with the virus would be expected to survive, and, again, that was with the older, more dangerous variants.
Q Okay, so just to clarify, 99.85 survivability rate, that would have been the number in 2020?
A So, again, this is -- that publication was -- that I cited was in 2021. It would have taken into account data up until very early in 2021.
Q Okay, okay. So the survivability rate being 99.85 in 2020, that's gone up since 2020?
A Absolutely, yes, in the context of the Omicron variant. So like I said, so in terms of that data, yeah. What I've looking at, in particular, is the public health

data. And so, again, there -- so anybody can go to public health websites to see this for themself. But, for example, I'm in Ontario, but Ontario, I mean, there's nothing particularly unique about our demographic relative to most of the other provinces, especially Alberta, so a lot of our data are very similar.

So, for example, like I mentioned public health data, so I'm talking about this is not looking at anybody else's interpretation of the data; this is the public health data, the raw public health data that's available to every Canadian. So you could go right now onto the Public Health Ontario website or Public Health Alberta website and see these data to confirm.

This phenomenon, which I get has caused some of us to be worried about, that the vaccines in context of the Omicron variant have actually set up the immune system to respond suboptimally, meaning that there might actually be enhanced potential for infection of those who are vaccinated, right? What we see in terms of public health data is that the cases right now have been occurring for the past month. This happened -- this crossover happened at about -- at about -- well, in Ontario it happened on Christmas Eve. In Alberta, for example, the crossover happened a little bit later, up to a week later. But now the -- for the last month,

the -- with the Omicron wave, the number of cases have been occurring disproportionately among double-vaccinators.

So that then -- so that's the public health data that I'm relying on. So the same public health data, when you look at it -- and so because I know the -- I can -- I know the numbers much better off the top of my head for Ontario, that's what I'll use as my example. So keeping that in mind, simultaneously, the public health data has been looking at the most severe outcomes, and that includes data on hospitalizations. So the way in Ontario we show it is hospitalizations but not including admissions to ICU units, and then we also look at the proportion of people that are in -- have been to the ICU unit, and then we also have data on deaths. And so when we look at these outcomes, so as we've seen this huge spike in the -- massive spike in the cases of, again, I don't want to say COVID-19 but certainly infection, evidence of infection from SARS-Coronavirus-2, of which a proportion of those would have COVID-19, we have simultaneously seen, again, an uncoupling of the most severe outcome. The number of people admitted into the ICUs and hospitals has been lower, so despite record cases, it's been lower than the previous waves. All the more -- most severe outcomes have been reduced. Again, so I

highlight this shows an uncoupling of this idea of infectivity and the most severe outcomes of the disease.

And this is important as well because -- well, yeah, I guess I'll leave it at that, yeah. So using public health data, so, again, I can't use that to give you a specific infection fatality rate, current update of one, but all I -- what I can tell you is the same public health data that existed when this 0.15 percent infection fatality rate was estimated, right, compared to the public health data available now, the public health data is clearly showing this is less dangerous. So, again, I highlight that it -- the current rate would be less than .15 percent, but I can't definitively state what it would be.

Q I want to make sure we understand this, because I don't think any of us are mathematicians, with a 99.85 survivability rate, if 1,000 people were actually infected, statistically, how many of those would die?

A The -- so you're saying 1,000?

Q 1,000, yes.

A Okay, and this is with the assumption of .15 percent of infection fatality rate? Is that what you're --

Q Yeah, exactly.

A -- wanting me to do? So that would be -- so 1.5 [sic], and based on basic math, if we round up at a decimal

point of .52, two people. So I guess the more accurate number, therefore, would be you would have -- because rounding up actually has a substantial -- you're increasing the outcome by -- what is that -- by a third, so 2,000 people infected. In fact, in early 2021, you would have expected 1 to die.

Q Okay so if 10,000 people are known to be infected, statistically, 15 of those would be expected to die?

A Yes -- back in 2021, early 2021. Not --

Q Okay --

A -- now, not now. It would be -- it would be --

Q Right.

A -- likely be much lower, but how much lower I can't say definitively.

Q Now, you obviously touched on this, but the next thing I wanted to ask you is about the issue of endemic, because you touched on this in your report. Now, I'm now in Section 6 of your report. I'm not necessarily going chronologically through your report, but the issue of endemic, first, can you help us understand -- because I know you used that term -- can you help us understand what "endemic" actually means comparative to, let's say, "pandemic" or "epidemic"?

A Yeah, obviously with the timing. So an epidemic and a pandemic, you're dealing with an acute scenario, meaning short time frame, where an infection is

occurring and spreading, and the difference between an epidemic and a pandemic is the scope, the scope of the problem.

So with an epidemic, the scope is much -- on a much smaller geographical scale. So, for example, with the SARS -- the original SARS, Severe Acute Respiratory Syndrome by Coronavirus that caused the disease SARS, which we called, you know, at that time, the Severe Acute Respiratory Syndrome was the disease, that was -- because it was much more limited scope, that was declared in Canada to be an epidemic.

So a pandemic is all dealing with the scope. So if it's on a much broader scale, and in this case, you know, if that -- it's on a global scale, then it gets declared as a pandemic. If the dangerous, right, the most dangerous outcome -- because, again, I have to highlight, so, for example, if you have a common microbe that's part of the human microbiota, that's something that can readily be transmitted potentially around the globe, but if it has no dangers associated with it, although it has that same scale, it's not going to be defined as a pandemic.

So that's the two things, there has -- there's two things for -- to declare something a pandemic: There has -- it has to meet a certain threshold of danger and a scope, a very large scope of the problem. But, yeah,

so that's dealing with things in the acute or short-term.

When we talk about something being endemic, we're talking about something long-term. So the -- most of the Coronaviruses that we're used to, the ones that cause the common cold, like I would argue the Omicron variant is likely one that -- and the way it's behaving is starting to fit largely into this category. They're what we would call endemic; they're always with us, right? We're always interacting with them. They're always causing some form of mild disease.

So in that context, you know, we would not declare -- so a cold definitely, even in terms of the scope of a cold or the flu -- and the flu is a good example. The reason why the flu sometimes meets this threshold of an epidemic or pandemic is because the flu can be very dangerous, right? So we've heard of flu epidemics, and we -- you know, we -- many of us now have probably heard, in one form or another, of the Spanish flu outbreak in the early 1900s, right, which was declared a pandemic. And we have had a pandemic flu also declared as swine flu in the 2000s, back around 2009. So, you know, that's because they can spread on a large scale. But the flu gets called an epidemic or a pandemic because it is also associated with high fatality rates in those cases.

Now, when it comes to the common cold, again to differentiate, the common cold spreads at least as readily as the flu. So in terms of scope, it would fit into the definition of an epidemic or a pandemic, but it's never going to be declared as such because it never reached the threshold of danger.

So these viruses -- so what "endemic" means is if it is -- essentially in layman's terms, it would mean these are viruses that we basically have to learn to live with over the long term. So SARS-Coronavirus-2, we can see we've tried -- we've tried all kinds of things to stop it for two years. Not only have we failed, it's -- I mean, it's spread among people better than it ever has in the two years in the form of the Omicron variant, right? And that, we just have to show the number of cases. So that -- the virus has been very successful in bypassing all of our attempts to stop it.

The ideal, the ideal outcome, if you're dealing with something that causes disease and you identify it at the epidemic or pandemic stage, meaning short-term, the ideal outcome, right, and the goal that we would always have would be to eradicate that pathogen so we never have to deal with any risk of illness from it, again.

But an endemic agent is one in which we have

failed to eradicate it, and the virus now is able to bypass any and all the barriers that we put up to try and stop it. So there's no question, no question, in my professional opinion, this virus has all of the characteristics of an endemic pathogen now, including the fact that we can already define it as being with -- having been with us for long term, right? It has now existed, and we don't know how long it existed before it was identified, but if we go with the starting point being when it was first identified, it's now been with us for over two years. That alone suggests it's endemic.

The fact that our most recent wave was just completely out of control in terms of cases, not in terms of danger, again, show this is going to be endemic, and the reason -- there's several biological reasons. These are viruses that are amenable to mutation. The Coronaviruses will just constantly mutate. That's why we keep getting the cold.

Corona -- and to explain this, the reason is in order for a virus to propagate, it has to copy itself. When these viruses copy themselves, they actually -- so you think about this as -- literally if somebody is -- if you want to photocopy -- the way I like to explain this, say you have a report, a very large report of hundreds of pages that you want to copy, if you put it

on a modern state-of-the-art photocopier, almost all the time, you are going to get a complete, you know, 100 percent accurate replication of that document, right, the copy that you pull up; you're going to have all the pages copied. Many of us had familiarity with some of the, as we were developing this technology, of not having to put one page at a time on top of the glass and copy, many of us have had the experience of the early versions of doing the fully automated copying, and it would be very frustrating, because you would end up with, at the end, you would find out, as you take the document back to your office and you start going through it, you're missing page 7, and you're missing page 132, there was a paper jam, you know, that occurred or something.

So that's what these viruses are like, when they copy their genetic materials, they actually have built in to -- and this is a survival mechanism -- they have built in, so that copying process, and it's an error-prone process, intentionally error-prone. It incorporates mistakes into the copying the genome, and that's so you end up with different versions of the virus that can probe the environment that it's in, and if that change confers an advantage to the survival of the virus, that subspecies of the virus will start to dominate. That's how this happens. And so that's why

we're always going to -- we're never going to be able to stop these viruses from mutating, and that's why they become endemic.

So for the flu, for example, the flu is actually way better than Coronaviruses, including SARS-Coronavirus-2, at mutating. It mutates much more rapidly. That is why our flu vaccines are so ineffective from year-to-year, because if we were dealing with the same strains that we were dealing with the previous year, our vaccines would actually be much more effective, because they're based on last year's strains. The problem is we're using last year's strain to educate our immune system to deal with a much different-looking current strain.

So it's not as extreme as that with the Coronaviruses, but they do the same, just a -- slower, slower. And so that means that, almost certainly, we are going to be, whether vaccinated or not, no matter what we do, I can pretty much guarantee, and no matter whether we have been naturally infected or not, I pretty much guarantee we are all going to be infected, for the rest of our lifetimes, with the SARS-Coronavirus-2 repeatedly. It won't be as often as the flu, because, again, it takes longer to mutate, so I -- but we will all be infected and reinfected.

But, again, based on the course that it's been

following, that if it's like these other pathogens, they will be relatively mild to moderate infections, just like all of the other endemic respiratory pathogens.

And what we'll have to be diligent about is, like all these other respiratory pathogens, we will have to be diligent to look after the very high risk but limited demographics. So, for example, even the common cold can potentially be dangerous, for example, in babies and the frail elderly, right? So that's what we mean by endemic.

And in my professional opinion, this virus is now endemic, and it's going to be with us likely for the rest of our lives. I don't see how now we can possibly render it extinct from the globe.

Q So does that mean all of our measures right now to attempt to prevent the spread of SARS-CoV-2 are completely futile?

A There's one thing -- well, so I can tell you, the most dominant benefit -- beneficial, you know, strategy that anybody can use with any respiratory pathogen, including SARS-Coronavirus-2, is stay home when you're sick. That applies to any of the respiratory pathogens that we have, and so we -- well, that's the one thing that I really, really, really, really hope the global population will have learned from this declared

pandemic is just what I call is basic social hygiene. This has been the most frustrating thing for somebody who has expertise in this area.

I see it in my workplace, and, I will admit, I'm guilty as charged at times. As a faculty member, there are certain deadlines that we absolutely -- I mean, we can't push them off. So, for example, I have to get grants in order to pay my research team and run the research that I do. So if there is a grant deadline, a submission deadline, and I say, I'm sick, I'm -- so, therefore, I'm not going to go into work, and I'm not going to submit this grant; the granting agency is never going to give me an extension. I lose the ability to get that funding.

So there are times -- and some households, maybe both parents work, so it's very inconvenient if you wake up on a given morning and your child is quite sick. As long as I -- you know, I don't think most parents aren't going to send their kids in if they think it's literally going to be detrimental to their physical wellbeing, they're -- you know, they're going to collapse or something. But if they wake up sick, clearly sick with signs or symptoms, it can be very -- very difficult to -- you know, very inconvenient to try and find childcare or cancel your own work schedule so that you can stay home.

And so many of us have gone into the public with these -- with all of these pathogens that we're talking about, the flu and everything else. One of the reasons why it spreads so rapidly in all of our populations and workplaces and schools is because we don't acknowledge the fact that we are actively sick, that we're sneezing and coughing, or that we have our kids that are sneezing, coughing, and we send them into these areas, and, of course, that's going to spread the pathogens. Sick people spread pathogens. That's how it works.

So what I like to highlight as an immunologist is, for some reason, we've gotten into this mindset that somehow asystematic people are doing this, spreading. And this is there the -- I would say this is where the biggest disagreement -- this is the crux of the whole problem when it comes to some earlier interventions, like masking, is what is actually happening with asymptomatic individuals -- I can explain that, if you want, at another time, because it's not -- just so you're not -- directly relevant to this question, but keep that in mind, because prior to two years ago, the term that we used instead of asymptomatic is we used the term "healthy people". Right, if somebody didn't have signs or symptoms of illness, I mean, if you go -- so, you could be asymptomatic with anything, if you go to a physician and you're asymptomatic, and they say,

Okay, what are your signs, you know, what are your symptoms. And I mean, so they can assess signs, as what we mean by signs. Signs is something somebody else can see that provides evidence that you're sick. Symptoms are things that you feel that can provide indications that you're sick. So signs and symptoms are used.

So a physician cannot see a lot of your symptoms, you have to describe them. So, for example, if you're feeling pain, unless it's severe pain, a physician isn't going to be able to see that you're in pain, unless it's severe, and then we might need facial grimacing that let's them know. Otherwise, you can have a pain that they have no idea, they have no idea, you have to tell them that.

So that's why -- if you were traditionally to go to a physician and say, I have no symptoms, they're not going to investigate you for a disease, right, because, again, I'd like to highlight, people who are asymptomatic are healthy.

So what I would -- so this is the interesting thing, what I would say is the number one thing that we have done to prevent this has been to not allow sick people to go around others. So the one thing I would say has worked very well is the screening, the screening that ultimately got implemented, which

basically is asking, Are you sick, right? And if you're sick, don't go into work.

So I would agree, scientifically, rock solid data, because if you're not -- if you're coughing and sneezing, of course, you're going to be spreading a pathogen, and if you're not, you can likely go in -- go in to work.

So that's the only thing, that stay at home if you're sick that I would say -- and I would say this is going to be effective all over the place. What people don't realize is, this is fascinating, I would -- because I think most of you are in Alberta, so go to your Alberta public health website and start looking at the SARS-Coronavirus-2, look at the -- on the SARS-Coronavirus-2 data page, they actually have a link, the influenza page, go there, and I encourage you to look at the cases.

What you will see is huge waves of the flu. They only have the last five years currently showing publicly on your web page. 5, 4, and 3 years ago, they show the classic huge waves of the flu coming through Alberta. And you know what's happened in the last two years? No flu, no cases of the flu. It's not because the flu disappeared; it's because we have told people, If you're sick, stay home. Right? Because we have always left the flu, for some reason, and encouraged

people to go to work and go to school, or at least not discouraged them enough when they're sick, and the flu kills people, and the flu is dangerous.

So to me, I hope and pray that when this is all done, the people will remember, You know what, if nothing else, if I'm sick, don't go around other people. That is the simple -- that is the -- that is going to help public health enormously moving forward with all infectious agents that we've ever been living with. So, yeah, that's the number one thing.

And I know that those of you who are here today specifically are most interested in masking, so let me comment on the masking specifically. I am -- masks do quite a good job at preventing the spread of infectious diseases under a certain circumstance, when people are sick.

And (INDISCERNIBLE) so -- (INDISCERNIBLE) -- so I told you, I have to admit, myself, I am guilty as charged about going in to work sometimes when I'm sick. One of the things I try and do is I do try and isolate myself in my office. I do tell people, if they come to my office, I do tell people -- if they come to my office and knock on my door, I tell them, You might want to chat through the door, I'm sick. You know, and when I do have to go around people, I will wear a mask. I have done that, when I've gone in to sick -- and to

work sick previously, because these masks are reasonably well-designed to capture the large water droplets that come out of our respiratory system when we cough and sneeze.

The only way -- so if somebody's not sick, that means they're not coughing and sneezing, so the only theoretical way that a virus then could come out of our respiratory tract is through what we call aerosols, which are super tiny droplets that the cloth masks and surgical masks that we have been using, they're not designed to filter that out, and so this is an intuitively -- like we even know this intuitively.

If you've ever been really sick, so I know this because I have been respectful of those around me, and if I'm actively coughing and sneezing, I will wear a mask if I feel that I have had to go around people because I don't want to miss a critical deadline. And I'll also tell you from my own experience, those things end up slimy and disgusting inside the mask if you are doing a lot of coughing and sneezing. Why? Because they're very good at capturing those large water droplets, and so you have to change the mask quite quickly. I will also tell you that if I'm not coughing and sneezing, they don't get wet and slimy; they're not capturing robust amounts of the moisture that's coming out of our lungs.

There's a huge amount of moisture that comes out of our lungs during regular breathing throughout the day. We know -- just that's what happens. So in Alberta, you'll notice like in Ontario, especially during the winter, one of the phenomena are the humidity goes way down, right? Cold air humidity tends to be very low, and so if you don't have a humidifier in your home, typically what happens during the winter is you'll notice that when you wake up in the morning, you will tend to have a much dryer throat than at any other time of the year, and that's because there's so much moisture that's given off, and all night long, it's the air is wicking moisture as you breathe it out, and your body's actually having trouble replenishing it. You end up much more dehydrated in the morning than -- and during the winter than you do at any -- during any other seasons. So there's a lot of moisture, and the fact that it's not getting soaking wet tells you that. So, again, a long answer, but I want you to fully understand.

So to summarize, in terms of what's been implemented, I think the number one effective strategy has been keeping sick people away from others, and hopefully that continues, and the masking. So if people were to have to go around other people when they have SARS-Coronavirus-2, masks would definitely help

prevent the spread of SARS-Coronavirus-2.

But in healthy people, I have never been able to recommend masking of people who are not actively coughing, sneezing, you know, who are not sick. So, in other words, if you pass the screening that you're supposed to do every morning before you go in, in my professional opinion, there's nothing a mask is going to do to protect yourself or others around you at that point, because you are not -- you are not and nor are those around you expelling the type of infection-spreading water particles that spread disease.

Q So symptomatic masking is rational and effective?

A 100 percent. I believe -- again, I hope that that will be highly encouraged for everybody around the world moving forward, that if they are going to make the decision to send their child to school when sick or if they're going to go in to work when sick, for the respect of the health of others, yes, put on a mask, 100 percent.

Q But is asymptomatic irrational and ineffective?

A Yes, for the reasons that I said, because then you're not spreading those large droplets that masks are designed to stop.

Like -- so a lot of people don't realize, like when you think about even a surgical mask and you think

about a surgeon, right, there's been studies that have looked at this, this context, what people don't realize is what those surgical masks are designed to do. It doesn't sterilize your breath in any way, right? What it does is it stops any large droplets. When a surgeon is working over a surgical area, an open wound, it's making sure that -- now, this is the other thing, any surgeon who is doing surgery ideally should not be doing the surgery if they are sick. But literally what they're there for is to stop large water droplets.

It would be to -- and literally, for example, one of the reasons for wearing the mask is drops, spittle. Hey, we've all experienced that embarrassing time where we're talking, and then, all of a sudden, a little bit of spit comes out, and we're like, oh, I hope nobody saw that, right? That's literally one of the reasons why they wear the mask, to make sure large water droplets, including spittle, don't drop out into the surgical wound. So they're not designed, like I said, again to filter out with any kind of efficiency the aerosols, which are these super tiny water droplets that are far tinier than the pore sizes in these masks.

And so, again, to highlight this, there's something else that's important, because, again, this comes back to the idea of symptomatic versus asymptomatic or what I would call healthy people. Now,

what happens is in order for somebody to get sick, they have to initially be infected. As I pointed out, the infection does not necessarily equal sickness or disease. And the other thing that's important to note is infection certainly does not mean immediate disease. Because you have a pathogen in your body, so you might be -- so when people get sick, this is what happens, when we do get sick, this is the sequence of events: We have to be exposed to a certain threshold of the pathogen, which is not once. Our bodies, we have innate -- like we have physical barriers that immediately protect us from infection. For example, one of the things we have in our airways, our airways are lined with mucous. That's one of the reasons why I just said we have so much moisture coming out of them, we're constantly covering all of the membranes throughout our respiratory tract with mucous.

So if we have a pathogen come into our body, for example, one of the immediate lines of defence is that mucous, it will get buried in the mucous, and that mucous constantly gets removed from the body. Even if you're healthy, if you never clear your throat, you're eventually going to have to clear your throat because our airway is full of -- or your cells with these specialized hairs on them, we call them cilia, and their job is literally to, like fingers, to move this

mucous up. Because if you think about it, since our airways are constantly producing mucous, if we didn't have any way of getting that mucous out of the body, under gravity, the force of gravity that would migrate down into our lower airspaces, and we would literally drown. They would fill up our lower airways, and we would no longer be able to facilitate gas exchange. So these little hairs push the mucous up and out of our body. That's why, you know, it may end up getting -- accumulating in our throat so we can cough it out, or if it's in our nose, we'll end up, you know, with the mucous accumulating where you've got to blow it out of our nose.

Now, if it's a pathogen that has been able to bypass those barriers, our immune system has set up what are called sentinel cells. These are cells that are strategically located at critical entry points for pathogens into the body, so they're distributed all throughout our airways underneath the mucosal surface, below that -- you know, the mucous that's on the surface of our cells. And if a pathogen can get by that, these sentinel cells very quickly identify that there's a pathogen and start our immune response to start clearing this.

Now, there's two parts to an immune response. One is we call it the innate response. So, first of all,

we have to understand, actually there's three technically in terms of timing. The one is physical barriers that I just talked about like the mucous or cell barriers, right, that a virus would have to get by to get into the body. Those are always present. There is no immune response that has to be mounted. That's why, for example, burn victims, that they lose a large amount of their skin, are highly prone to infections because they've lost that physical barrier.

Now -- so in the lungs, these sentinel cells, if the pathogen gets past these initial physical barriers, and so that's why you have to have a certain threshold. One viral will not cause disease; you have to bombard these natural barriers with high numbers of the virus, so you have to have it delivered to you, you have to inhale a threshold dose, and that changes depending on the infectivity of the virus.

But so you have to -- if you get that threshold dose and your physical barriers can't deal with it, you have those sentinel cells that will immediately start detecting that virus and starts penetrating in -- and starts infecting cells past those physical barriers, and that they will start -- and trigger a whole series of events that lead to what we call innate immune responses, so those are very rapid, short-term responses. And then if they fail to clear the

pathogen, then we mount the types of responses that we're trying to get with these vaccines.

We call them acquired or adaptive immune responses, and the key effector mechanisms there, the key weapons are T cells, which could kill off virus-infected cells so they can't serve as virus replication factories and antibodies, which can block viruses from getting into other cells. Now, those latter things can take up to -- it takes about two weeks for those T cell and antibody responses to peak, so the innate response is very fast.

And so if you have an infection of the lungs, one of the first things these sentinel cells start to do in terms of communicating is they get these cells to produce the mucous, to start producing lots of it, because it -- we've got a virus that's bypassing this barrier, so let's make this barrier even more rigorous, a thicker mucous layer. And so that's why when we get an infection, as the virus starts replicating -- this is important -- so, in other words, early on in infection, yes, so if we were to take somebody who was infected early on, would we be able to detect the virus? Yes. Is that virus a replication-competent virus particle? Yes. Is it going to be able to infect and cause disease in other people? No, for two reasons: (a), a person has to reach a threshold level

in your own body such that you're delivering such a large enough quantity of the virus for another person to inhale that threshold dose to get them sick. The second reason is you could even have potentially a large amount of the virus in your body, but if you're not sending it out of your body, you're not going to be able to infect anybody else, and so this is the thing.

So our immune system -- so viruses take advantage of this early immune response for the transmission process. So because what happens is this mucous secretion starts increasing, and so that means we have a lot more mucous being brought up into our throat and into our -- and our nasal passages, right, producing a lot more of this. And so the body, to try -- you know, what it wants to do is get rid of as much of the viral particles as it can, because the fewer virus particles it has left in the body, the more easily it's going to be able to clear that infection.

And so the way our immune system gets it out of the body is it causes us to cough out all this mucous that's accumulating, all the liquid that's full of these viral particles, and we sneeze it out of our nose. That's literally -- we're trying to dump as much of the viral particles out of our body as we can. That is when we become an infection hazard to other people. And that's why I say these masks are awesome at

stopping the transmission when this transmission is -- when there's the high risk of this transmission, and that's when people are actively coughing and sneezing. As long as you have the virus contained in your own respiratory tract, you know, you're not doing that.

So in theory, you can -- so this is actually kind of interesting. Much more so than viruses like the influenza viruses that we live with, the SARS-Coronavirus-2, there's been a lot of literature suggesting, therefore, that one of the ways the virus might spread is through aerosols, right? And so that's -- because if you're not coughing, and you're not sneezing, then the only way the virus theoretically can get out of your body is being carried on the small water droplets that come out of our -- come out with our breath, right, with every exhalation we give.

So then that means that the masking, therefore, if somebody is not symptomatic, the only thing that it could potentially have to stop in terms of the virus leaving the body would be these aerosols. And like I said, while -- you know, I've got lots of figures and pictures to show that, you know, the pore sizes of these masks are not designed, they're not nearly small enough to stop these viral particles from getting through, that the water droplets that could potentially have the virus on them, the pores are way, way, way too

big to stop that.

Now, granted, so, for example, I noticed in Dr. Hu's report that he mentioned that -- actually maybe it wasn't even his report, but some have pointed out that it -- and I agree, it's not like it's one pore, if the virus gets past one pore, it's out of the mask. So, example, the surgical masks actually have three layers. So what it is more like is it's having pores all offset from one another. There's a whole bunch of pores that the virus would have to navigate. It would be like going through a maze.

So what these masks can do with aerosols is it can slow down the transit time it takes to navigate this maze of large pores that are all offset before it leaves the mask, but it doesn't stop it from leaving the mask. And, in fact, what ends up happening, this is the predominant thing, this is also in my figures is because it has to navigate this sort of complex maze to get through all the open doorways, that provides resistance, and any gas will follow the path of least resistance. And that's exactly why when we wear our masks, the vast majority of what we exhale never even, unfortunately, gets through the filtering material, again, which isn't designed to filter out these aerosols, but rather bypasses it.

And we've all seen that phenomenon; I mean, you

know, I wear glasses, especially now is not a great time, so I encourage anybody, put on a mask with their -- so what's especially -- what I especially recommend, if you -- so I have this every time I go to the grocery store, go outside for a little bit, let your glasses, you know, accommodate to the temperature around, right, so they get nice and cold; then go into a store, go into a warm location and put on your mask, right, put on your mask and step through the door into a warm location. Now your glasses are such that any moisture that's coming out is going to readily condense. I find it so frustrating because I can hardly shop. It takes me about 10 minutes before I can start shopping because I'm constantly taking my glasses off and wiping them because of all the fogginess happening. That's the aerosols, and that's, of course, because of the mask. Even with the pinch piece, if you have a good mask, a surgical mask that have the middle pinch piece, very difficult to get a seal properly around your nose. And so when you exhale, because we're slowing down the progress of the air through the filtering material, it'll just simply exit alongside the nose; that's where we see the fogging.

Now, the other place a lot of people don't realize is even the surgical masks are not designed to fit properly around -- by -- in front of the ears, and so

you almost always have these large, relatively large, triangular gaps at the back of the mask where it loops over the ears. And so literally when we exhale with these masks, the vast majority, when we exhale, fires up past the nose and out past the ears, and so there is no filter. And then, like I said, the limited amount that does come through the filter, it's not designed to stop these aerosols.

Like I said, if it did -- like, again, I can take off my glasses right now, and, for example, watch (UNREPORTABLE SOUND), I just breathed on my glasses, and you can probably see it's fogged quite a bit compared to my other lens, right? That's one exhale. So you can imagine if I was wearing a -- had been wearing a mask and go -- in some cases, I've had to, you know, because of these requirements, if I'm wearing a mask, there's not much aerosol coming out in just one breath. You can imagine how much liquid would accumulate in your mask if it is, in fact, filtering that out. If it's filtering it, it means it has to stop them from getting out in the air, from going through. If it's not getting into the air, then it's staying in the mask, the masking material. But I can wear these masks, if I'm not coughing and sneezing, I can wear them, and my mask will not get wet.

So, again, it's just intuitive to the point

where -- I like to use -- I'll just finish with this, an example which I think is helpful to consider this. Early on in the pandemic, in fact, every time I went to get my hair cut, and thankfully I was able to, you know, after quite some time, because my hair was horrible, like many of us, for the longest time, but, you know, when I actually first went and understanding this, out of respect for the hairdressers, I tried to explain this to them and actually asked them if they wanted me to take my mask off, because if they were worried about aerosolized transmission, right, the mask for filtering this stuff, I tried to point out to them, If it's my breath that you're worried about, do you want me to take my mask off. Because they always cut my hair from behind, right, and that way, if they're afraid of my breath, I'm directing it away from them. And they -- you know, but, no, because of the policy, said no, no, no, no, everybody has to be masked to keep -- you know, to keep us safe, and I tried to explain.

And so the best way is -- again, to envision this, again, if you go out in the winter time, cold air, and you put your mask on, you'll see exactly what I'm saying -- I put a picture of this in my report -- you'll -- because you can see these aerosols, because these tiny water droplets, when it's really cold, will

condense, right? Again, if water -- the gaseous water as -- when it's cool, it will turn into liquid. And so winter time is a great time because you can see the aerosols condensing in the cold air around you. And so when you breathe out in the winter, you'll see the -- it blasts up, you see this fog essentially as the aerosols are condensing, blasting up past your nose and out past your ears just like I said.

And I've shown people, if you're a hairdresser, what it does is it encases your head in this huge cloud of aerosol, all right. I've tried to point this out to my hairdressers is that if you are genuinely afraid of my breath, you know, as an asymptomatic individual, do you not realize that the whole time your hands are immersed in my aerosols by you forcing me to blow them around my hair instead of away from you.

So I'd just like to highlight that, because, again, that's kind of science meeting the reality that we currently have and how the two just simply don't align. So I'll --

THE CHAIR: Dr. --

A -- just stop there.

THE CHAIR: -- yeah, Dr. Bridle, I think it's now 10 after 12, Mr. Kitchen. I think it's time for a break.

MR. KITCHEN: Yes, I agree, however, I do

want to ask one question.

Q MR. KITCHEN: And, Dr. Bridle, I invite you to answer this in 5 minutes or less, and we can come back to it after the break, but I want to ask this question, because it's connected to the conversation we've had. Dr. Bridle, so you've said now that where we're really at is endemic, but I think the burning question we all have is was SARS-CoV-2 ever actually a pandemic? Right? You said declared pandemic, and you said that there was a (INDISCERNIBLE) severity for it to actually be really a scientifically a pandemic. So was SARS-CoV-2 ever a pandemic, and if so, when did it cease being a pandemic scientifically?

A Okay, yeah, that's an interesting question, but I can keep this short, yes. Sorry about that, you're getting the typical, you know, scientific, we like to make sure that all the details are relayed. But in this case, so -- this is -- the pandemic was declared again, assuming that the -- sorry, Karoline --

(AUDIO/VIDEO LOST)

MR. LAWRENCE: Sorry, can we just -- sorry to interrupt, Dr. Bridle -- I think we've lost a Tribunal Member --

A Oh, okay.

MR. LAWRENCE: -- Dr. Martens, I don't see her. Could we just --

MR. KITCHEN: Well --
MR. LAWRENCE: -- (INDISCERNIBLE) for a minute. Oh.
MR. KITCHEN: Dr. Martens, if you need us to break, we can, you know, we --
THE CHAIR: Dr. Martens is here.
DR. MARTENS: No, yeah, I came back, yeah, sorry.
A Okay, great --
THE CHAIR: Thank you, Mr. --
A -- I don't think I said anything --
THE CHAIR: -- Lawrence.
A -- that you missed, Dr. Martens. Did -- what was it -- yeah, I think I was just starting to answer, so I'll just start again --
THE CHAIR: Sure.
DR. MARTENS: Yeah, just when you were going to answer the question, yeah.
A Oh, okay, great.
DR. MARTENS: Thank you.
A Yeah, so this pandemic was declared with, again, on the initial concern that the infection fatality rate might be as high as 10 percent, and, again, as I've said, an infection fatality rate certainly between 1 and 10 percent. I don't think there's very many scientists around the world that would agree that that would be a

pandemic situation provided the pathogen is genuinely dangerous, because then you're, you know, talking about -- well, the infection fatality rate, that is an indication that it's going to be dangerous to far too many people.

But the reality is, just like I said, as we have come to appreciate the size of that denominator, which we didn't know at the beginning, we now know that the -- the real infection fatality rate is in the -- was in early 2021 in the ballpark -- and we're not even sure it's the full estimate because we don't have a full understanding of how big the denominator was. But at that time, it was estimated to be about .15 percent.

So to put that in perspective again, that was dealing with the earlier variants, which is when the pandemic was declared, in that context. And, again, at .15 percent, that is not a problem of pandemic proportions. It is -- it just simply is -- that's a fact.

And so it's not a case -- and then, again, that's for the entire population. And if we go to the demographics that we know, which is the vast majority of the people that are in the -- and the lower-risk demographics, it would be much lower. Again, I can't say exactly how much, but it would be lower.

So, again, to put that in perspective of .15

percent, that is in the same realm as a bad flu season and -- for which we never declare that to be a pandemic, despite the fact that, you know, the flu spreads around the world, nor is it declared an epidemic, even though it certainly meets that definition in terms of its spread throughout Canada.

Now -- so the thing to understand -- and now, as I point out, as far as Omicron, it would be even lower, but that's because there's been some biological changes as well to the virus, right, that's made it less deadly. So if I was going at .15 percent, because that's dealing with the earlier variants where -- which were relevant when the pandemic was declared, just to clarify, it's not that we went from an infection fatality rate of 1 to 10 percent to .15 percent, right, because that would require some kind of biological change or effective intervention that's completely stopping those deaths. And, no, it's the initial estimate was, the initial concern was that it was that high.

So what happened is the mathematics became more accurate by the time this paper was published. That same math applied to the beginning of the pandemic. So, in other words, if we knew by early 2021, you know, what the accurate -- if we had those same accurate numbers at the beginning of the pandemic, the pandemic

would not have been declared; it would not have been a problem of pandemic proportions. As I've pointed out, the flu is -- equals this, a bad flu season.

So, in my opinion, and based on our own policy, health policies in Canada, this would not have qualified as a pandemic. It qualified as a pandemic because we thought the infection fatality rate was much higher than what it really has been and what it has proven to be.

And the point that I'd like to make as well is, because a lot of people have probably heard of this term with the emergency use authorization in Canada for the vaccines, in Canada, we called it the authorization for interim use, but it means the same thing.

And the reason why that's important is because that's something -- and this whole -- actually, this whole concept actually we have right now of overriding constitutional freedoms, and we're hearing about this all the time, what a lot of people don't realize is, you know, this imposition where the Government can start dictating things and overriding potential individual, you know, constitutional policy rights is often -- is based on the perception -- like the impact of something on Canada. Technically it has to incapacitate the ability for Canada to operate in a certain way.

So a classic example would be if we were at war. At war, that's where you can have overriding executive decisions, right, and if Canada is at risk of being destroyed, being overtaken, right, being taken over.

So at a 10 percent or even 1 percent, that would have a dramatic impact on Canada, you know, death rate; that would have a dramatic impact on Canada to be able to function as a country. But at 0.15 percent, we've never done -- like I said, we have that for the flu routinely.

So, again, I hope that helps put it in some perspective. So, again, based on the science, the publications, my, you know, summarized answer to you, Mr. Kitchen, is that, with the math corrected, this has not been an issue of pandemic proportions, true pandemic proportions.

MR. KITCHEN: Thank you. We'll leave it there for lunch.

Mr. Lees, I'm fine if you want 45 minutes or an hour, an hour-and-15, I'm fine either way. As much as -- we'll definitely finish today. I think we're going to be a while yet, but we will finish today.

THE CHAIR: Okay. Let's take an hour; let's come back at 1:15. I think we all -- we went straight through from 10:00, so I think an hour is fine, and we'll see everybody at 1:15.

And do we need to caution the witness in any respect, Mr. Pavlic?

MR. KITCHEN: You're muted.

MR. PAVLIC: I've got it now.

Other than --

THE CHAIR: Okay.

MR. PAVLIC: -- he's not supposed to discuss his evidence with his counsel or anyone else --

THE CHAIR: Yeah.

MR. PAVLIC: And I'm sure --

THE CHAIR: Thank you.

MR. PAVLIC: -- Mr. Kitchen has given that warning in advance.

THE CHAIR: Okay, we'll see everybody at 1:15. Thank you.

PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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

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January 28, 2022 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

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 1:16 PM)

THE CHAIR: We will be back in session for the afternoon, and just before I ask Mr. Kitchen to continue, I just remind you, Dr. Bridle, that you are

still under oath.

A I understand, thank you.

THE CHAIR: Okay. All right, Mr. Kitchen.

DR. BYRAM BRIDLE, Previously sworn, Examined by Mr. Kitchen

MR. KITCHEN: Thank you. And, Chair, I'll try to be mindful of the time. If we get an hour or so into it, and we're still going, I'll try to find a good time for a break.

Q MR. KITCHEN: Dr. Bridle, thank you so much for all that information prior to the lunch break, but to continue where we left off, the question I had is we talked -- you talked about how isolation works, masking for asymptomatic doesn't work, and then we didn't get into any other restrictions yet, but I'm very curious, if isolation at home does work, and you said, intuitively, it does, can you give some insight as to why Omicron is still spreading the way it is unabated?

A Yeah, so, first of all, just to clarify, meaning isolating at home when symptomatic, right, when actually sick. I don't recommend that people have to stay away from others if they're not sick.

So, yeah, in terms of the Omicron, you know, so it's a multi-facetted answer, I guess. And so, first of all, I guess I'll start off with the, you know, the related topic of the vaccines, because that was

purported to be -- you know, we were hoping that was going to be the number one strategy for stopping the spread of this. And then the idea being, you know, the concept was that only those who were vaccinated would not be capable of transmitting the virus, and those who were unvaccinated would be capable of transmitting the virus, and, hence, you know, the isolation, kind of segregation that's been occurring in society.

But so one needs to understand a little bit about vaccines to understand that aspect because that's critical, because, again, like I said, that was supposed to be the number one strategy for stopping transmission.

So these COVID-19 vaccines -- so, again, I mean, I'd like to highlight and my record shows for itself, being a publication record, that I've been actively publishing in the area of vaccinology during the declared pandemic. I am a vaccinologist. So, again, you know, my expertise is in viral immunology, and specifically I focus heavily on vaccinology.

So I am actually strongly in support of the concept of vaccine mandates, but these COVID -- current COVID-19 injections look nothing like and they perform nothing like any historically mandated vaccines. And that helps to understand a large part of the question you're asking.

So what I mean by that is we're all probably familiar with the vaccines that are mandated during childhood, so the childhood -- what we call the childhood series of vaccines. So that's things like -- things like the mumps, measles, and Rubella vaccines, the ones we -- you know, we get for tetanus that get updated every 10 years and so on, chicken pox as of 2010.

And so all of these previously mandated vaccines have a quality that we refer to, as immunologists, as conferring sterilizing or near sterilizing immunity. And what that means is technically if somebody's vaccinated, they can still get infected because infected means you the get the pathogen in your body. But what sterilizing and non-sterilizing --

THE CHAIR: Dr. Bridle, Dr. Bridle --

A Yes.

THE CHAIR: -- you're frozen.

MR. KITCHEN: He's not frozen.

THE CHAIR: Yeah, he's back now.

A Okay, do I need to repeat anything?

THE CHAIR: Just the last sentence.

A Oh, okay, thanks. So previously mandated vaccines confer what we call sterilizing or near-sterilizing immunity. And so sterilizing immunity means like, in all cases, a pathogen can still get in your body. So a

respiratory pathogen like SARS-Coronavirus-2, obviously we can still inhale it. If we had sterilizing immunity, it would mean that we have the appropriate type and quantity of antibodies in our upper respiratory tract to be able to fully neutralize that virus, meaning the antibodies would bind to the virus.

And that's one of the reasons why we've been targeting the spike protein. The spike protein is the thing that sticks up on the surface of the virus that grabs onto the receptor on our cells, the same receptor I was telling you about earlier that children express at much lower concentrations, which is why they're inherently protected.

So if you have an antibody that binds to the spike protein, then that spike protein can't grab onto our cells. And if the virus can't get into our cells, there can be no replication whatsoever and, therefore, no risk of disease and no risk of transmission. That would be sterilizing immunity.

Near-sterilizing immunity means that the virus, probably there would be a lot of neutralization of the virus, but the virus might still be able to infect a limited number of cells that we would have sufficient additional immunological mechanisms to clear that virus from the infected cells, things like T cells, which are very good at this, and it would clear the virus again

before it would replicate to that -- to a quantity that would reach what I referred to previously as the threshold dose required to infect somebody else. So that would be what we call near-sterilizing immunity, meaning you can get some infection yourselves, limited replication, but you're not going to get sick because there hasn't been enough replication to cause illness, and you're not going to transmit, because, again, you haven't reached that threshold dose that needs to be delivered. So that's what all our historical mandated vaccines look like; they do this.

Oh, and the other thing they do is they -- they not only confer this type of immunity but for very long periods of time. So when you think about it, once we are done our childhood vaccination series, except for the, you know, update every 10 years for things like diphtheria and -- for example, the -- and tetanus, we never have to be vaccinated again, we don't have to get boosters. So we call that robust or long-lasting immunity. So that's the nature.

Now, we're all probably seeing -- you know, we're already, in Canada, rolling out -- well on our way to rolling out third doses. We've actually been implementing fourth doses in some long-term care facilities where there's been a complete inability to control the spread of the Omicron variant. Israel, you

know, of course, is large -- most of their population has got four doses.

So this highlights something, this is three to four doses in well under a year. So that -- so, clearly, they don't -- they don't have the duration of immunity; they don't provide the, you know -- a reasonable length of protection. That alone means these vaccines will never be able to stop the transmission of this virus, because there's no way we can get the whole world vaccinated and under three months, such that the people, you know, no longer -- we haven't reached the point where people have lost protection. Otherwise, if you get only -- if it's only through part of the population by three months, by the time you're vaccinating new people, the people who were vaccinated at the beginning are going to be susceptible again. So that's one of the problems.

The other problem is that -- I already explained this, that the immunity is -- just really protects the lower airways. And the Omicron variant, we're talking about a version of the virus now that preferentially stays in the upper airways, so there isn't that -- those aren't those neutralizing antibodies in the upper airways conferred by this vaccine that would confer that sterilizing protection.

So on that basis -- oh, and the other thing is

that there's been so many mutations in the spike protein of the Omicron variant that the immunity conferred by this, which is spike-protein specific, is largely irrelevant. A lot of those antibodies can't even physically bind to the spike protein anymore because it's changed too much.

So for all those reasons, that's one of the reasons why we're seeing the vaccine [sic] circulate freely, because it's largely then the unvaccinated that have been -- that have been -- or have continued to be asked to isolate and have been basically -- you know, segregated from society. So they are, you know, stay at home, not being able to go into the workplaces and so on.

So the fact -- and like I said, I've said this before as well, some of the -- for those in school settings or work locations, we're talking about people where almost everybody is vaccinated, but the virus -- like I said, despite that, we had this record peak for cases with the Omicron variant. So that's one of the reasons, because the vaccines, unfortunately, have failed to meet their goal.

If these conferred long-lasting sterilized or near-sterilizing immunity, I may have had to have retracted my earlier statement about this becoming endemic. We may actually have had a chance of

eradicating this virus. But, you know, because of these weaknesses in what an ideal vaccine should be -- I should even point out that even the very definition of a vaccine was altered about a year ago to accommodate these inoculations that we're providing, because, again, the definition of a vaccine was one that conferred sterilizing or near-sterilizing immunity. They were originally designed to not blunt the most severe forms of disease but actually prevent disease and prevent transmission to others. So that's why -- that's a primary reason why we're seeing this virus continue to circulate.

So now when you think about that, it's annoying that the vaccines are now largely irrelevant in terms of their ability to stop transmission; at the same time, we have kept -- we have remained -- keeping the vaccinated individuals from workplaces, we continue to require them to wear masks and do the physical distancing. So -- and, again, the fact that we've been doing this all along, but the waves of cases just keep getting progressively higher, although, like I said, the virus is progressively less -- that's the good news in all this. As that happens, the virus becomes -- has become less dangerous. So despite the spread, there is less potential harm to people. So I always want to remind people I don't want to be instilling unnecessary

fear.

But nevertheless ever increasing cases, and since the focus is on cases, that means that we've been trying to stop our cases. And, again, I won't say cases of COVID-19, that is what we ultimately want to prevent, but what we're actually measuring, again, are positive test results for potential infection with SARS-Coronavirus-2.

So what it tells us is that the masks and the physical distancing, despite the fact that we have not only maintained that all the way through but actually removed the vast majority of people from the population who are unvaccinated tells us that that combination of those critical three, which are supposed to be the three things to -- to end this pandemic, the vaccination, the masking, and the physical distancing, you know, that's real world evidence, you know, that we've all seen that really we can't -- argue doesn't exist, right, because we see it in our workplaces and schools. It clearly shows those aren't working. They can't be working while we're actually having, during this process of maintaining those three strategies, while removing most of those who are unvaccinated from those scenarios, when you actually see ever-increasing peaks in the, you know, recent waves, that clearly suggests that these are not working efficiently, right?

They're not -- they're certainly not efficient solutions to resolve the problem as we have it.

That's why many people are working right now on trying to develop vaccine strategies that ideally would be sterilizing or near-sterilizing because that would provide, potentially, an ideal way to prevent this. But then one even argues whether it's necessary if the virus isn't dangerous enough because -- this is something I teach my students -- one of the questions I get asked all the time, with all the vaccine technologies that we have, why don't we have a vaccine for the common cold. Well, the reason is simple, no medical intervention, no medical intervention comes with zero risk. So you always do a risk-benefit analysis.

And so the primary reason why we have never developed a vaccine against the cold that we try and implement is the cold in the vast majority of people again is not a major issue. And so if people aren't at substantial risk of harm from a pathogen, we're not going to introduce an unknown potential amount of harm from a novel medical intervention, and so that's why we'll never have vaccines for the common cold.

But, nevertheless, I just wanted to bring that up there, that that might be a viable strategy, if needed, if we were to get a future version of the -- you know,

future variant or strain of the virus that were to attain more dangerous characteristics again. But with the current tools that we have, we have seen the Omicron variant, the spread, the transmission go completely out of control. So, yeah, I'll end it there.

Q MR. KITCHEN: Well, thank you. But let's talk about prevaccine, let's talk about 2020. My understanding is, you know, the vaccine really didn't start to get up to -- until January of 2021, so about a year ago, you know, and the time that's really relevant, of course, for this case is, you know, from May 2020 till December 2020. That's when the chiropractors were allowed to work, that's when Dr. Wall was working, and that's when there was a mandatory mask requirement in place by the College.

So let's talk -- and as far as I can see, that's prevaccine. So let's talk back then. What's your take on why these measures, no vaccine, why measures like physical distancing and masking didn't work back then?

A Okay, so this leans heavily on what I already explained. So pathogens are a spread, there's risk of spreading it to somebody else when we're actively releasing large enough quantities from our body to meet the threshold dose needed to infect, bypass the initial physical barriers, and initiate disease -- or initiate,

sorry, what we would call a productive infection that would result in disease, because, again, disease is when there's the onset of signs and symptoms.

And so the reason why these largely haven't been -- weren't effective there, so outside of the scope of vaccines, is because we were keeping people out of the workplace who weren't sick. Again, I keep emphasizing that. If you're not around sick people, you tend not -- you're going to tend not to get sick.

And again -- so, again, these masks do a reasonable job at preventing the spread of illness when somebody's coughing and sneezing. That's what they're really designed to do, that's what the pore size is designed for in these masks.

And, otherwise, if -- so then the only argument that remains then for why these masks attempt to restrain the virus if somebody's not symptomatic would be, again, the concept that they have -- the assumption that they have a high enough dose of the virus in their respiratory tract but are not yet sick because of it and, therefore, exhaling large enough quantities, a threshold dose, through aerosols, right? That's the only physical way that a healthy person could, therefore, be spreading this, and as I've explained because of the pore size. And, more importantly, the pore -- really, the pore size is irrelevant if you

don't have a proper fitting mask, such as the vast majority is exiting the body unfiltered. You know, the virus isn't going to respect the masking, nor --

And then when it comes to the physical distancing, this is a complex process because some physical distancing theory can help if you can control, if you can control, because this is the thing, physical distancing was primarily implemented -- and, in fact, it's largely -- one can even argue what should be the appropriate distance. Many studies would suggest that an appropriate distance would only be 1 metre rather than 2. So it's a rather -- beyond 1 metre becomes rather arbitrary if you can -- if you pick a number beyond that.

But what people need to understand is that the reason this physical distancing was also selected was, in the context of sick people who were actively transmitting the virus by coughing and sneezing, it's this idea of large water droplets again. And the reason why 1 metre has always been recommended as the minimum distance to try and minimize your chance of getting infected -- so I would definitely recommend if somebody is around somebody who is coughing and sneezing, I would never recommend that you -- if you want to keep yourself healthy, I would recommend that you never go within 1 metre of their personal space,

and the further away you are, the less risk there is. And that's because people -- you know, when we cough and sneeze, the large droplets that we dispel land on the ground approximately a metre away from us, up to a metre away, so that's where that came from. But, again, that's for people who are symptomatic and meaning they're actively coughing and sneezing and projecting these large water droplets.

Otherwise, we're talking about aerosols. And when we're talking about aerosols, aerosols can travel very large distances, massive distances, in fact, depending on the environment. So, for example, there's very few indoor places anymore, like work environments, that have modern -- and even houses, you'll notice, most of the -- most modern buildings now have air circulating all the time, and so that creates currents, air currents, all the time in our homes. We're often unaware of these, but, you know, you know that you can get the test kits to look at smoke detectors or even smoke. If you ever put the smoke in a room, for example, in air vents and so on, you can often see that there are these air currents that are circulating. So we can't see that, so where these aerosols go is going to be dictated by the air currents that are around us.

So as an extreme example, and I've pointed this out to people, you know, kind of in a half-joking way,

only half-joking because it is actually serious, so, you know, I, from time to time, I've used -- you know, I use a bus. I've got a bus stop not far from my home, and again the best time -- the best time to see this, there's two ways to actually visualize this, one is observing smokers and the other one is observing people breathing but in the winter time, where you -- again, you can see the aerosols because of the condensation in the cold air.

And so one of the things that I always, always do, because I'm a nonsmoker myself, is if somebody's smoking, I always stand upwind from them, right? There is no defined distance at which smoke dissipates to -- and which it's safe, if there's a wind. If you can be 5 metres downwind of somebody at a bus stop, and you're going to be inhaling their smoke if the wind's taking it that way, because, yes, these aerosols dissipate, but if you have a wind that's moving quickly, you're going to be inhaling, you know, a reasonable amount of smoke, secondhand smoke. So many of us recognize that, and so if we don't want to inhale the smoke, we stay upwind, and that's what I'm talking about with these aerosols and air currents carrying this.

And so it's the same thing, if you have somebody that's, for example, let's say, unmasked and breathe out, if you -- if there's -- if the air is what we call

stale, is not moving, you're going to see a cloud that forms in front of their mouth, and it's going to dissipate as it moves out. In that case, the aerosol's probably going to dissipate, pretty low concentrations, right, per volume of air space at not too far a distance. But, again, if you're standing, you know, 3 metres downwind of the person and, you know there's a reasonable breeze, those vapours, you can see them coming right by, right by your face. And so you're actually inhaling, you know, reasonable concentrations of the air being expelled by that individual. So that's how, you know, is -- that's a good way to look at it.

And so it's the same thing, so -- and worse, this is the other thing, so I point out again that, in fact -- so you combine that, we're talking about aerosols with the masking, and the very frustrating thing there is -- again, I try to point out -- if I'm standing at a bus stop, and there's people sort of downwind of me, and I want -- and if I were to feel that I had to protect them from an aerosol, I would actually rather have to take my mask off so I'm projecting the aerosol ahead when then maybe it gets dissipated, you know, down in front of the crowd of people. By putting on the mask, I'm actually making sure that I'm blowing lots of unfiltered air out past

my ear and actually firing it basically in the direction of the people, right, or right beside me. So that's what I mean.

So this is the problem, this is the problem when it comes to the mask. We're not properly control -- and, in fact, it -- when you think about it, it's -- it's not logical, we don't think logically, because we think about -- we've all seen our breath in cold air, so we think if we're going to control our breath -- I'm going to use the example, bad breath. If you want to avoid somebody detecting bad breath, one of the things you do you don't breathe on them, right? So you find a way of making sure the breath goes some other way. Even if you're looking at them, some people will sort of breathe out the side of their mouth, change the shape so it kind of directs it away from the person. And this is inherently because we know that we can't alter the direction that it goes, but so we're always thinking of breath coming out from our mouths.

And so what the interesting thing is what people often do, out of reflex, is in order to -- when they have the masks on, in order to avoid having any of these aerosols hit them or their breath hit them, they tend to look away from them. And as I pointed out, because of the -- what the direction -- the air -- the air actually coming out, you know, by the ears, by

looking away from somebody, you actually redirect the unfiltered air in their direction.

So an example, in my workplace, we were actually told -- because it turns out that our hallways are less than 2 metres, so we were actually -- what we were actually asked to do was if we passed one another in the hallways, we'd go belly to belly or chest against the wall, like kind of inch our past one another with our backs turned. And all time we're do -- all I -- you know, all I'm doing by doing that is, you know, at least if I have the mask on and I'm looking at the person, I'm directing the air away from them. As soon as I turn my back on them, again, I'm directing air toward -- in their general direction.

So this is the problem, and this is why we've had trouble with the masking and controlling the spread of aerosols, and why distancing, why distancing is quite arbitrary in the context of aerosols. So, again, there have -- there was a published scientific study in a peer-reviewed journal that clearly showed with these aerosols, they can travel -- they can travel, again with the air currents, up to 30 metres, you know, if they're carried on an air current that's swift enough and going in a certain direction rather than swirling air.

So it's all dependent on air currents, it's

dependent on the direction that the unfiltered air is going. So we're talking about -- again, again, I would say -- you know, I saw Dr. Hu's report, I agree 100 percent with him on the efficacy of masking with symptomatic individuals, you know. But we're talking about -- but, again, what you asked is people who are going into the workplace who are asymptomatic, masking to prevent the spread of aerosols and control the direction in which they're going is not -- does not do the job, not in the context of aerosols. So that's why this virus has been spreading.

And I'd like to point out again, if you -- if we -- if that is true, if the masks -- if the virus, it could potentially spread on aerosols, and there's some -- lots of studies have suggested that maybe it can and -- but masks were doing their job, then we would expect that people would have been protected. But like I said, the actual -- in the study that was published looking at immunity in healthy individuals, people who never had any evidence that they were infected or knew they were infected with the SARS-Coronavirus-2, showed many healthy adults acquiring immunity for the virus, and so that's been occurring despite the masking.

Q Well, I need to ask you a couple questions about asymptomatic transmission, because -- and symptomatic

transmission for that matter. Let me ask you this: Of all the transmission of SARS-Coronavirus-2 or SARS-Coronavirus-2, roughly how much comes from asymptomatic people and roughly how much comes from symptomatic people?

A So the subtotal of scientific literature would suggest very little comes from asymptomatic individuals. It is not zero. There is some asymptomatic transmission that can occur.

One of the studies that often gets highlighted was a -- again, it was a peer-reviewed scientific paper published in an high-impact journal. It was actually studied in a huge population in China, about 10 million people, and the conclusion from that study was among a sample size of 10 million people. They found no substantial evidence of asymptomatic transmission.

And, again, it's not surprising, because, again, for all the reasons I already explained, so I won't go into them again in any detail, but just very quickly, you have to have the virus in your lungs at a sufficient quantity to be -- such that your body is releasing enough to exceed that threshold dose needed to cause illness in somebody else, and that almost always requires active expelling of the virus from the body through coughing and sneezing, but not always.

There is the theoretical scenario where you could

have somebody who's still not actively coughing and sneezing, so they don't know that they're sick, it might be a little bit threshold dose. When it comes to biology, anything is possible. I'll never say anything is impossible. So it is certainly theoretically possible, and, in fact, I would argue it is a real -- real thing, but it would be high -- it's highly improbable, meaning a rare event.

And there has been like a lot of agreement, generally speaking, including among major public health bodies, like the World Health Organization, there's many organizations that, after a while into the pandemic, we're starting to recommend just end the testing, testing for evidence of SARS-Coronavirus-2 and asymptomatic people for this very reason, because, you know, again, we recognize you're testing healthy people.

And what was being recognized though -- so although there's very few cases, documented cases of clear-cut transmission from asymptomatic people of infectious viruses that may be at a dose that can cause disease, it's definitely not a substantial driver of this pandemic in any way, shape, or form.

So even, I'd like to point out -- so I notice that -- you know, like Dr. Hu cited some peer-reviewed scientific articles, and that's great, because, again,

that's the, you know, best type of evidence for this, but even there, the important thing is looking at what was actually measured.

So when you actually look, when they were measuring some of the -- in some of those masking studies, it was -- they were looking at, again, doing genetic testing essentially, like PCR testing, to look for evidence of the genetic material from the virus, and so this -- you have to be very careful again because -- okay, so this requires a little bit of background in terms of measuring, measuring, how you measure whether a virus is being filtered.

So with this PCR test that we've all probably heard about, it's called polymerase chain reaction. What it is is this concept that we can use little pieces of genetic material that recognize sections of the genetic material from the virus, and so if the genetic material from the virus is present in a sample.

So, for example, if you put a mask on an individual like -- and you ask them to breathe, and you capture those samples, you can run this test to look for evidence, you can ask is there any evidence of the virus based on genetic material being present. And when you do that, this test can detect small segments of the genetic material from the virus, and then it -- this gets amplified, you run it for a number of cycles.

And if genetic material is present, you keep amplifying it with each cycle, somewhat exponentially, until you get enough of it, you can literally visualize it in a test. So you can ultimately amplify it to such an amount that you can visualize the genetic material, and then you say, okay, so that genetic material seems to have been present.

The problem with this is and the problem we've -- you know, I don't -- I can't comment on why this has happened, because it's -- it's against all historical standards, but we have relied on just the PCR test in Canada for some reason, and we have arbitrarily picked, in most cases, cycle cut-offs.

Because what happens, when you go to very high cycles, your amplify -- you can -- what can end up happening is you can end up amplifying background, you get background signals we call it. And so you think you see a causative result, but it's actually just background. And we've been calling, running these tests and calling -- so, for example, in Ontario, up to 38 cycles, if you can then detect a signal from this test, we're calling that a positive test result for SARS-Coronavirus-2.

But this is how it's supposed to work: We do actually -- PCR is not a gold-standard test for detecting it. Like it's a fabulous technology, but

like anything, all technology, it has limitations. It is able -- what it's not able to do is detect -- it's not able -- it's only going to tell you if a portion of the genetic material -- material is present. It can't tell you if there are replication-competent, intact virus particles, in other words, virus particles that have the potential to infect somebody.

But we do have a gold-standard test for that, a virology assay. Remarkably, we abandoned this early on in Canada. And specifically what's supposed to happen is in order to validate your test, in order -- in other words, in order to say, okay, my test, the results that I'm showing in this test are proving -- or are suggestive, highly suggestive that what I'm detecting is infect -- or are virus particles with the potential to infect somebody else. What you do is you take your sample, and you split it into two, and with one, you run your PCR test, and you determine at what cycle number you get a positive result.

And in the other one, you do -- that uses gold-standard virology test, which is actually a functional test. What you do is apply the sample to cells. You let these cells grow, you grow them on plates, and we grow them for what's called confluence, which means the entire bottom of the plate is covered with these cells; you can't see the plate at the bottom

of the plate anymore.

And then what you do is you add your sample. These are a special type of cell, we call them permissive cell lines, and what they are are they are cells that are stripped of all their anti-viral properties, they're not able to protect themselves from viruses, so that if there is a virus in your sample, it can very efficiently infect these cells, and it will start replicating and spreading, and it will kill the cells. We call this cytopathic effect.

So what you do is you look at your cells under a microscope, and you make sure, before you add your sample, that the entire bottom of the plate is covered with the cells, then you add your sample. If there's any replication-competent virus there, which also means, therefore, that it would have the potential to infect and cause disease in somebody else, when you look under the microscope later, you will see those cells removed from the -- those cells have been killed off, and now you'll be able to see the bottom of the plate. And what you do is you find the cycle number at which your samples no longer cause any damage to that cell layer, and then that is how you prove, objectively, the cutoff for your PCR.

And what's interesting is we actually did this -- I did. Our micro -- National Microbiology Laboratory,

which is part of the Public Health Agency of Canada. It's located -- it's one of our -- it's a Containment Level 3 and 4 facility in Winnipeg, Manitoba, they did this at the beginning of the pandemic, and -- which was the appropriate thing to do, and remarkably -- and this is published, this is a peer-reviewed published paper that they issued early on in the pandemic. And what's remarkable there is they set the cut-off at 24 cycles. Now, that doesn't mean anybody running a PCR test has to have their cut-off at 24 cycles. The -- the actual cycle cut-off, any person running this test should, first, establish what the cut-off is for themself, with their particular protocol, their set of reagents, and their particular technical expertise.

So the cycle number should act -- for the cut-off should change from laboratory to laboratory, but everybody should be able to show you that gold-standard virology assay and the results from it to provide the rationale as to why they picked that particular cut-off.

But nevertheless, it -- because it's not going to stray too far from that. And so my point is the National Microbiology Laboratory showed that the proper cut-off in their hands of the PCR assay was at 24 cycles. In other words, this paper, if you go and you read it, our own public health scientists that

published this, what they found is that if the PCR test came up positive at cycle numbers higher than 24, those samples, they were unable to infect the cells in that gold-standard virology assay with those samples. Meaning, there was no evidence of replication-competent or -- virus particles that had the potential to infect anybody else.

So if they were running the diagnostic tests, for example, to the PCR, therefore, they would set the cutoff at 24. They would say anybody with a positive test result up to 24 -- and they wouldn't have to run this assay again, you don't have to do it every time, and it makes no sense to do so -- they would then, with high confidence, be able to say anybody who tests positive up to a cycle number of 24 almost certainly has infection of -- replication-competent viruses in their body with the potential to infect others. But the reverse of that conclusion is anybody with the test result that is cycle number above 24, they would have to conclude that those people are not able to infect anybody else.

And so this is the problem, because a lot of the publications that relied on this genetic test, and, therefore, there is, without the gold-standard test being run in parallel, there's no way to tell whether their positive results were false positives, or even --

the thing I like to point out, there are genuine positive tests but that do not -- but -- in which those individuals, so they're genuinely detecting, they're truly detecting genetic material from the virus, but those people actually aren't infectious, and that's actually people who have mounted immune responses.

This is very important to understand, because what happens is one of the things our immune system does -- I didn't go into the details, but some of you may recall when I was explaining kind of line of defences, I mentioned that once the virus penetrates the physical barriers and starts affecting cells, we have these sentinel cells which will detect infection and trigger these subsequent immune responses.

Well, these sentinel cells, one -- and a couple other cell types, what they're designed to do very on [sic], in order to detect these viruses is they gobble them up, they actually consume them. We call this phagocytosis, right? So they actually basically eat, consume the virus, and then what they do is they take the virus, and they break it into pieces, and then they take these pieces, and they actually take it to the draining lymph node, and they show it to our B and T cells, to say, Look, here's a dangerous pathogen that you need to go and try and clear from the body.

And then we get our B cells and T cells activated.

The B cells are the ones that then produce the antibodies. And you know that this process is happening when your lymph node swells, because if those B and T cells are being activated, they start proliferating in large numbers, so we have an army, an army that's designed to go and recognize the pathogen.

So that's why if you're sick, like you have a throat infection, you can often palpate the lymph nodes, right, just behind your jaw, or your physician does that. That's what they're looking for for confirmation, because your lymph node is swelling; that means you're actively mounting an immune response against the pathogen, and it's clear evidence that you're infected.

But, so, this is what you have to understand, this is the key, to get to that process, we have to have cells that gobble up the virus and carry it to the lymph node and show pieces of it. These cells will hold on to that so that virus is no longer replication-competent. It's inside the phagocytic cells and -- but it -- they will hold onto this for up to weeks, even sometimes months, and that is to make sure that there is always a supply of the target that the immune system needs to respond to to protect the body.

So it can take -- usually it doesn't take months,

but certainly, for sure, at least two to three weeks, they'll be holding onto this material in case -- and that's the case, the immune system has to keep responding, in case they have to keep getting more effectors recruited, depending on how virulent the virus is.

And so in many cases, that -- then what you get is you get a true positive test result with the PCR. There's actually, you know, viral particles present -- or partial viral particles, at least pieces of the general genetic material present in the body, but as you can imagine, that's not ever going to infect anybody, right? It's inside the cells of our immune system that use that to educate the rest of our immune system.

So this is why it's important to understand how this works. Yeah, so I'll leave it at that.

Q Thank you. All right, so I need to go back to -- you established that SARS-CoV-2 spreads by aerosols; we've established that the masks don't stop aerosols; we've established that they do tend to stop the bigger droplets, we've established that asymptomatic spread is rare. And that leaves the question then, forgive me, but if I'm listening logically to what you're saying, then, when symptomatic people wear a mask, they'll end up spreading SARS-CoV-2 through aerosols; is that

correct?

A Yes. Again, there's evidence this virus can spread through aerosols. So one thing, just to clarify what you said just a moment ago, the -- so, yes, there's evidence that the virus spreads by aerosols, but I also want to make it clear, the virus is going to spread very efficiently through the large water droplets with the coughing and sneezing as well, as well as contact media transmissions.

So I notice in Dr. Hu's report, you know, he had mentioned that as well -- he had mentioned all three -- all three occur. He placed more emphasis on the large water droplets and the contact transmission, so I don't disagree. I just want to make that clear. But again, those are symptomatic individuals; we're talking about large water droplets and contact transmission, those are people who are actively -- you know, actively releasing large amounts of the virus.

And so with a contact transmission, actually I have additional concern there, because I agree that contact media transmission is an issue, and that's where I'm concerned when we -- when we're old -- when we're making people use these masks only in the context of aerosol media transmission, because, again, those who are actively sick are isolated, what we're doing with these masks, because of the contact -- or

potential contact is where we -- people are constantly handling their masks, right? So if there is any spread of virus, we're actually bringing their hands to their mask.

I have been -- I am unable -- I wear a mask on a regular basis, clearly for some of the, you know, surgical work that I do as part of my research program.

I -- when I'm doing the surgical stuff, I do tend to be very careful, you know, very mindful of that. And even there, it's very difficult not to touch a mask, but you're taught, you know, when you're doing surgical work not to touch it. But, otherwise, unless you're doing surgery, I'm not able to -- especially if I'm -- unless I'm focused on it all the time, I'm not able to avoid touching my mask. In fact, the average person cannot talk for any substantial period of time and not have to touch their mask because it causes bunching of the mask, you know, and it pulls off the chin or it pulls off the nose. So there's very few people who get through an eight-hour workday without handling their masks over and over and over and over again.

And worse, many people, unlike a surgery, where you would then discard your mask, and then if you have another surgery, you would put on a fresh one, there's a lot of people who keep reusing their masks over and

over. So that potentially enhances the contact media transmission. So I just want to be clear on that, that it's not just the aerosol, it's contact media transmission and large droplets. And wearing a mask for the large droplets can handle that, but you don't want to be handling the mask or else you're promoting the contact via transmission. But, again, I highlight that's symptomatic people, and we're screening those individuals out, so they're not supposed to be in the workplace, so that leaves, therefore, just the aerosol media transmission.

And so, yes, I agree with you that in the context of the aerosol transmission, an asymptomatic person leaving their home and then donning their mask to try and prevent the aerosol media transmission for all the reasons that I just cited prior to this is not going to be effective at preventing transmission by that route.

Q The question that I'm left with and I think many people are if they have the masking in place, and we have the screening in place, and yet what we've seen in the last year-and-a-half that we've had masks, because we didn't have it the first few months of the declared pandemic, the last year-and-a-half that we've had masks, we've just seen the spread increase and increase and increase and increase. And yet, what you're telling me is that it is effective with symptomatic people because it --

somewhat because it stops their droplets and spittle.

And I'm left with that question, right, of if masks are somewhat effective with symptomatic people, and symptomatic people are supposed to be removed, and it seems like they sometimes are, and yet we still have all this increase in spread, all right, so people -- nonscientific people like me are left scratching their head.

A Would you like me to address that point?

Q Yes.

A Yeah, so it's for the reason that we've been talking about is the aerosol media transmission.

Q Okay.

A So I've cited in my report, there's a large number in there. I mean, that's exactly what was looked at. So, again, just to make this clear, there's a big difference between SARS-Coronavirus-2 and the viruses that we're familiar with. This is why I took some time to investigate it.

So what seems to relatively unique about the SARS-Coronavirus-2 is this aerosol media transmission. That's something else they should clarify. Previous viruses historically -- because -- so this is again why, initially, the masking seemed to make sense, but only in the context of symptomatic individuals is because we assumed that the primary mode of spread was

the coughing and sneezing and contact media transmission. So that is pretty much what most of the previous viruses and our other viruses that we're used to causing respiratory infections, they usually fall into that category.

For the flu virus, for example, that is the primary way by which it is spread. It's not recognized. In fact, it's well recognized that the influenza viruses don't spread very efficiently via aerosols. So that's what's unique to this virus.

So, again, like all our historical studies and the masking studies, again, this is a strategy that is designed to stop those kind of respiratory pathogens, and that type of transmission, but not aerosol transmission, and so that's why we've been seeing this. And that's why I say when you take sick people away from other people, that's the most effective way, but the problem is with the aerosol transmission, people are still able to go out there, right, and transmit this virus.

And the issue here is with the -- yeah, the masking in particular. So this is something that I hadn't highlighted, which I think is important, because what it comes down to then is what would a protective mask look like or what would really protective masking look like in the context of aerosol media transmission.

So as a researcher, this is something that they deal with all the time. My entire laboratory is rated as a Containment Level 2 laboratory, so all of my entire research space. So this is because we work with what's called Containment Level 2 biosafety hazards. So -- and there's a certain amount of protection that -- that we implement to protect us. So these are not particularly -- these are not dangerous; these are not dangerous pathogens; these are not disease-causing agents, or, at most, if somebody were to get a large dose of them, it would cause mild disease at the most.

But so -- but what we have to do all the time when we are -- design a research program, I -- we're constantly policed in the sense that I have to get a biohazard permit in order to conduct my research. So I have to describe how I'm conducting my research and what protections are in place to make sure that people aren't put at unnecessary risk from the Containment Level 2 to agents that we work with.

The SARS-Coronavirus-2 -- and so I'm very familiar, therefore, with biosafety strategies, right, and personal protective equipment that one would use in these scenarios. And like I said, I've done collaborative research on the SARS-Coronavirus-2.

For the one publication that we published recently dealing with the novel vaccine, that involved a

challenge study with the SARS-Coronavirus-2, where animals were vaccinated and then challenged with the virus. So that work is done, and it can take -- what we call Containment Level 3. So SARS-Coronavirus-2 is considered a Containment Level 3 pathogen.

Now, this is interesting because this then says -- so we have -- the Public Health Agency of Canada has told us what the appropriate protection is against a Containment Level 3 pathogen, and I have that in my report. So, in fact -- not people to look at it, but if you want to take a note and look at it later, I would refer everybody to Figure 7 on page 13 of my report, because what I've done there -- what I've shown is a picture of a stereotypical personal protective gear that one would wear to protect themself against infection with a Containment Level 3 pathogen.

And so what I can tell you is -- I mean, it would be laughable if I ever put on a surgical mask or a cloth mask and then asked to go in and challenge our animals with a SARS-Coronavirus-2 wearing that. I mean, I would get myself in serious trouble. I'd probably have my biohazard permit revoked for showing such lack of understanding of personal protective equipment, because I'd be putting myself at incredible risk of being infected with the SARS-Coronavirus-2, because a lot of the procedures that we're doing create

aerosols. So if you're pipetting, which is a -- it's a scientific tool for allowing us to deliver precise quantities of fluid; that's known to create aerosols.

So a lot the work and manipulation we do -- and we're working with high doses of viruses as well, remember, in those kind of settings with lots of potential for aerosol production, so I'm very familiar with what it takes to protect one from a pathogen that's been aerosolized.

And if you can refer to this picture, the first thing you'll notice is the individual has the pathogen in a tube, a closed tube, and these tubes will only be opened inside this special unit that their arms are inserted into. It's called a biological safety cabinet. And if you can see the picture, you'll notice that just in front of the individual's elbows, there's a grate. There's a solid stainless steel surface inside the hood, and what's in the front of it is a grate.

And what happens is this has special air flow, and what happens is air actually blasts up from this grate and then up into the cabinet and then goes through a HEPA filter -- actually a number of HEPA filters. HEPA -- so unlike the masking material in the low-cost masks like the surgical masks and the cloth masks, which have very large pore sizes, HEPA filters have

extremely small pore sizes that are designed to filter out most pathogens. And so what that air, therefore, is -- so what it does is creates a wall of air in front of you that is basic -- essentially sterile air. So you actually run these things for 20 minutes, so if there's any contaminants in it, after 20 minutes, the air that's running is essentially sterile. So then when you put your arm -- you put your arms in slowly, because you don't want to disrupt the air flow too much. By doing so, you're literally going through an air barrier, so no aerosols can come out of that cabinet.

But in case any does, however, say for example, that individual were to make a mistake and insert the arm too quickly to disrupt that air flow excessively and allow a little bit, potentially, of aerosol to come out, that's why they have the rest of the personal protective equipment, the gloves and the gown, is to minimize the potential for contact media transmission. You don't want spills on your personal clothing, right, such that, you know, if you go home, you know, you might be touching your clothing, then touching other things, so that's to protect against that contact media transmission.

But you'll notice they don't -- they aren't wearing a cloth mask or a surgical mask; they're

wearing a mask -- and as you can see, very different -- this is actually a requirement interestingly. I would not be able to go into this facility with the mask that's in this picture. And so if you notice what the difference is between the individual wearing that mask and me, I've got a beard. And so this is very important to note. So if you look at their mask, you'll see it has elasticized material such that it provides a tight seal along the skin everywhere. And then around the hair, you'll see a headband. And then what you see is you see a tube coming out from the back of the -- the headpiece, and what it goes to is a little unit that mounts on the belt at the back of this individual, and this actually actively filters air.

So what that -- what that has is has a fan in it, and it has HEPA filters, and so it's actually drawing in air from the environment, from the room this individual is in, passing it through HEPA filters and then into that hood and specifically the face mask area so that what they're breathing is HEPA filtered air.

And like I said, so this individual -- so often, people working in these facilities are required to shave so that their mask can actually make proper contact, right? Because right now, I'm allowed to wear a cloth mask right now, and I'm not -- and I like to have a beard, and it's winter time, and I'm not

required, but I'll tell you the -- and because I know of the futility of masking in the context of aerosols, but the reality is, you know, if I were to wear a mask right now, I mentioned about how air would escape past the ears and the nose, well, also around my beard because the beard is holding the mask away from my skin, and I can guarantee that my beard has far larger pore sizes in it than the masking material.

So I just want to point that out, because that's our own government agency that's designed for telling us how we safely interact with Containment Level 3 pathogens, of which SARS-Coronavirus-2 is, that is how one would protect themself from aerosolized mediated transmission of a Containment Level 3 pathogen, and as I'm sure you can appreciate, it's not a cloth or a surgical mask.

Again, I can't emphasize enough that if I were to try to enter this facility and conduct this type of research with that, I would almost certainly have my biohazard permit rescinded and my ability to conduct that type of research removed, at least temporarily, until I underwent training to demonstrate that I understand how to truly protect myself from a Containment Level 3 pathogen.

And this isn't just for the individual of course. The key thing, in any of this strategy should be both

protecting the individual and also the people around them. You don't want a researcher coming out of a Containment Level 3 facility potentially spreading Containment Level 3 pathogens to the public.

Q Is there any logical or scientific reason to think that masks are more effective at preventing transmission of the virus by asymptomatic people in one place than another?

A No, no. They're physically -- they're operating based on the same physical principles. Now, I have seen the argument made that maybe the environment can potentially put an individual at greater risk. So, for example, in the health care environment, again, masking -- the physical protection conferred by a mask doesn't change based on the environment that they're in, but the potential risk of exposure does.

So a health care worker working with actively infected individuals certainly might be at increased risk of potentially being exposed. All the more reason why I would argue that they actually need proper protective equipment, so beyond the cloth mask, like something that would actually be designed to filter out this, and those are things that could not be worn for long durations of time. That would, for example, be like a rubber mask that could be fit-tested, again, to seal on the face; you wouldn't be allowed the beard,

and would have -- potentially the filters mounted to it. But you'll find that those devices, very difficult to breath with those devices for long periods of time. But that's the type of thing that might be appropriate in those settings. So, no, this type of masking isn't going to help in different settings.

But what I want to point out is -- so one of the things I noticed actually in Dr. Hu's report is that he brought this up in terms of health care workers. I mean, I'm no expert with chiropractors, but I agree with him that a health care worker working -- and he used the example of people who are -- were known to be actively infected and potentially infectious with diagnosed COVID-19. Where, I guess, I differ on this -- and, again, I'm not an expert in the world of practicing as a chiropractor, so I could be corrected -- but my understanding is that the average chiropractor is not being expected to work with a symptomatic COVID patient, diagnosed with COVID-19, so I would -- especially in that case, I wouldn't have a concern.

If -- so if a health care worker is working with -- is asymptomatic, and the patient they're working with is asymptomatic, having a mask just doesn't seem to make logical sense to me. A mask that is designed to effectively prevent transmission because

of lack of sickness doesn't make sense to me.

Q Forgive me, you've answered so many of my questions, I have to do a bit of a review here.

Okay, so I'm going to ask a couple questions here about aerosols and droplets, and then I think maybe we can leave that behind, because there seems to be contention on this. Would you say that the balance of the available academic literature supports aerosol transmission?

A So this is interesting, the -- it's debatable. This aspect is debatable about the aerosol-mediated transmission. Certainly without the act of coughing and sneezing, it would be difficult to get a, again, a threshold dose needed to infect somebody out with the aerosols, and there was -- earlier on, in order to explain this spread and the spread despite masking, that that's where a lot of the publications were geared towards were showing this aerosol-mediated transmission, that's been questioned now as well. So it's actually a little bit difficult to say definitively, based on the scientific literature, it's an active area of debate I would say.

And like I said, especially because, as we now have two years of experience and despite this strategy having been implemented throughout the duration, right from the beginning, but the ongoing spread of

increasingly --
(AUDIO/VIDEO FEED LOST)
MS. NELSON: Sorry, I don't mean to interrupt, but Dr. Martens has dropped off the call, so if we could just pause until I get her back, please --
A Yes.
MS. NELSON: -- that would be great.
Q MR. KITCHEN: Thanks, Dr. Bridle.
Dr. Bridle, I welcome you to continue.
A Okay.
Q But I just want to make sure I have this right, are there three potential or likely areas of methods of transmission: Droplet, aerosol, and contact; is that accurate?
A Yes.
Q Okay.
A Now, I guess, yeah, in the context of SARS-CoV-2. If we're talking about pathogens in general --
Q Right.
A -- (INDISCERNIBLE) like sexually transmitted diseases, but, yes, certainly SARS-CoV-2, for example --
Q Yes.
A -- those would be the three primary potential modes of transmission.
Q Okay, well, let me ask you this, and, again, you can continue going on about aerosols and droplets and all

that, but I -- what, if any effect on contact transmission do masks have?

A Potentially increasing it for the very reason that I said. I have -- I mean, I'm not going to excuse any individual, because there might be individuals who, miraculously, are able to wear a mask for very long periods of time and never touch it. I'm not going to say that's an impossibility, but I have watched hundreds of people throughout this pandemic, you know, because it's an area of interest of mine, because everybody's been instructed to not touch their masks because of the acknowledgment that there's contact-mediated transmission. I know it's in Dr. Hu's report that he -- you know, he mentioned that as a key potential way to transmit.

And I have yet -- I have yet to observe any individual who has not touched their mask multiple times within certainly let's say within an hour. I have not once seen anybody not touch their mask multiple times during a one-hour span. And, again, it's just natural with these masks. There are masks that are designed to stay in place. Again, if you refer to Figure 7 that I have in my report, that type of mask will stay in place; it's got very firm headbands, and it's designed to, you know, to seal. It's got -- you'll notice that the material, if you'll

notice the material, it's elasticized, and it's flexible. So, for example, this individual would be able to talk, you can envision his jaw moving up and down, and all the material that's attached to the plastic face shield, it is flexible -- or not flexible but loose enough that it allows that movement.

And see the differences with the mask, if I'm talking to you -- if I put on a mask right now, as I'm talking to you, within -- I don't exact time, but probably within 30 seconds, the mask, again, will have migrated off my nose or off my chin, and I'll have to do an adjustment. So unless you're sitting with these masks, never use -- never chewing, like not chewing on gum, not talking, it's going to be very difficult. And even at that, you know, people get itchy noses and so on. And depending on how they take their masks on or off, there's actually -- I mean, there's proper training procedures even for putting masks on and off.

Especially for surgery, right, you want to keep everything sterile, you want to keep your gloves sterile, you want to keep any masks that you put on sterile, right? So the proper thing would be just to handle the mask by the straps that go over the earpiece, right, and nothing else. But people, all the time, are grabbing their mask, you know, or taking their mask and grabbing it, you know, and stick in

their pockets or whatever. This is not the way these masks were designed to work.

Again, originally, remember, these masks came out of the concept of surgery and trying to make -- keep surgical fields as clean as possible. And if you watch how a surgeon dons and doffs their surgical equipment, including their mask, it's very different from what the average individual is right now, because we haven't trained, we haven't trained the general public in that kind of, you know, what we'll call sterile technique.

So, no, wearing a mask in an inappropriate environment can potentially cause more harm. Again, I'm not concerned. I'm not concerned about that contact media transmission if the person isn't symptomatic.

Q Right, so but, you know, I've heard you say, obviously, the masks don't work for asymptomatic, but I've heard you say they kind of work for symptomatic because they'll stop the droplets, but, in your opinion, do masks -- are they a net contributor to spread or a net inhibitor of spread when you balance out the contribution to contact spread with the reduction of droplet spread?

A Okay, so I would think that the net would be potentially enhancing for the -- again, for -- again -- and if it's an asymptomatic individual. And the reason

is if there is any --

Q Hold on, asymptomatic or symptomatic?

A The -- well, in both cases, right, they're going to do something for the -- well, again, if somebody's not sick, then I'm just not worried in general. If somebody is shedding the virus, if that's the scenario where somebody is shedding a virus, I think it's going to have a net negative result. And that's because, again, it's not designed to filter out the aerosols.

What happens when people put a mask on, there's well-established behavioural changes that occur, right? When we feel -- when we feel more protected, we tend to behave -- it's human nature to tend to behave in riskier ways.

So it's interesting, this is interesting: I play hockey, for example, I'm an ice hockey goaltender. Now, so one of the things is if you want to -- if you want a contact game -- or, sorry, a contact-free game of hockey, one of the general rules of thumb is you don't have people put on -- you put -- you have them put on the minimal amount of safety equipment. And what will often happen is because, following -- what often presents a very danger to the elbows is the elbow pads, but a lot of people will not wear the shoulder pads, because that's not a particularly risky area. And one of the reasons is is because it's

well-established behaviour, if you load yourself up with armour, you tend to be more risky in your behaviour, potentially more aggressive in a sport like that. And it's not different than everything.

And so what happens is when people -- when -- this is the problem, see if people mask, and they understand the limitations, they understand what they're designed for, where their strengths are and where their weaknesses are, you're fine. But the general messaging that people have received is that these masks are fabulous at preventing the spread of this. And so when you have that program in your mind, As long as I have my mask on, I'm not a risk now to anybody else, and they're not a risk to me; what you inevitably see is, on average, masked people will tend to interact closer than people who are unmasked, and that's just the reality.

And so if there is aerosol mediated transmission, if you're, on average, interacting in closer vicinity with somebody, there's the potential for greater aerosol mediated transmission than if you're not masked, you don't feel that, you know, (INDISCERNIBLE) extra protection.

And so that's what I argue, as a scientist, I mean, when I wear it, I know that it is -- you know, so I wear them because I have to when I go to the grocery

store and everything, but I recognize that they're not properly protecting against aerosol mediated transmission. And so if there can be aerosol mediated transmission, of which is active debate in the field, you know, I recognize -- I'll stay in my -- you know, far away from individuals. So that's one -- that's one potential harm.

So, yes, the net effect on average is the average person who is masked won't maintain as much distance, and so if they are transmitting, that could potentially be an issue. And then the other is that the contact that I just mentioned with the mask.

So, again, I simply -- I just am not concerned about asymptomatic or healthy people, period. But -- so -- but if anything, the net result of masking -- that's what I'm saying is especially if you're symptomatic, that's where the mask can stop the droplet -- the droplets, but there especially, you have to be very careful. Again, you know, if you're going to the workplace in, like I said, that I have, I have multiple masks that I change regularly, and, again, I'm mindful because I've been trained in this concept of, you know, sterile technique in the microbiological world and thinking from that perspective; because especially if you're symptomatic, you are spewing droplets into that mask, and it's getting soaked, and

it will soak through. This is material that's absorbant. You can think, especially with a cloth mask, it'll soak right through. And you can see that -- the wet stains. And so if you're grabbing that mask, you're going to dramatically enhance contact mediated transmission and -- and you have to be, again, mindful that when you have that mask on, although it's effective with the large water droplets, you don't want to go closer to people than necessary.

So, yes, you have to be very careful with masks: You have to recognize the strengths, their limitation, and you have to maintain other strategies that are independent from the mask. And by that, I mean, again, recognizing the inherent weaknesses of the masks and so, you know, not grabbing them, you know, not touching them and then, you know, touching others and that type of thing.

Q So in your opinion, is this part of the reason why, after a year-and-a-half of masking, the cases and the infections just keep going up?

A Yes, yeah. It's ineffective in the context of controlling the spread of SAR-Coronavirus-2. Again, I can't emphasize that enough. I use my own workplace as an example. We've prided ourselves on the fact that well over 99 percent are vaccinated, and I can tell you that the messaging both from the president of my

university and the Medical Officer of Health, who has presented in multiple town halls, have told us, although, again, it's -- this is -- it's often difficult to comment as a scientist, because there's the publicly acknowledged message, and then there's my message as a scientist, but --

So their message has been that the vaccines are excellent at protecting people, break-through infections are very rare, and it either prevents transmission or reduces that -- the number of viral particles that get transmitted, so excellent at overall trying to prevent transmission. So that's my campus community, more than 99 percent fall into that category.

And -- but everybody is still doing the exact same masking and the physical distancing, and yet SARS-Coronavirus-2 has ripped through our community. We recently had two -- two of our residences with outbreaks, declared outbreaks of -- so, you know -- and, again, I always find it difficult. So the public messaging was those are outbreaks of COVID-19. What they really were outbreaks of people identify -- who had positive test results for SARS-Coronavirus-2. I can tell you the majority of the students, you know, we had no deaths. The vast majority of the students had mild cold-like symptoms for a couple of days.

I can also give you the example at my son's high school, the same Medical Officer of Health recently declared an outbreak at his school. One of the cases was confirmed, where sequencing was done, to confirm that it was Omicron. And so the whole school was shut down, right, and everybody went home. In that case, the individuals both had -- they reported mild cold-like symptoms for three days and then recovered.

But the whole point being in that school again, this is high school, so they've been actively promoting vaccination. It's not nearly close to a hundred percent, like in the university, where it's been -- people are not allowed on campus if they're not vaccinated, but a large profession, and masking every day, right?

So this is all evidence -- and so that -- and again, I'll emphasize again, Omicron, that wave in terms of the number of people who tested positive for SARS-Coronavirus-2, it dwarfed, I mean, it shattered all previous records, you know, that we had in all previous waves, and this is despite not only the masking and the physical distancing that was there from the beginning but added to it what we hoped was this super strategy of vaccinating everybody. So even with that thrown on board, the masks have not stopped the spread.

So my professional opinion is and has been from the beginning that the way we're using these masks is not appropriate, it's not going to stop the spread, and worse, that there are harms. Again, I am not concerned in the context of symptomatic [sic] people, the masks necessarily promoting harm of spread because they're asymptomatic, they're not sick, but there are inherent harms to the mask itself, to individuals wearing them.

Would you like me to talk about that at all; is that something that's relevant?

Q Well --

A I have that in my report. I have it in my report if you're interested.

Q No, and I see that. Well, I mean, you seem to talk about -- well, let me ask you this: This fact that masking potentially actually increases the spread of SARS-Coronavirus-2, would you identify that as a harm?

A Yes.

Q Now, I know you identified the harm of low oxygen levels, but you also, which I found interesting, you mentioned the harm of muffling speech and inhibiting communication between individuals. Do you identify that as a significant harm?

A Yes, yeah. So I live in the world of special needs. I have two children with special needs, one of them does have speech difficulties. He has Down Syndrome, so I'm

around individuals with special needs all the time. I've interacted as a parent supporting work done by a speech therapist. And one of the things that I can tell you that has been particularly difficult, his speech through the speech therapy and also through sheer hard work, especially through my wife, his speech has dramatically improved, but this improvement has largely happened over the last couple of years. You know, he's in his formative years, he just turned 12.

It was exceptionally frustrating for him early on in the pandemic and frustrating us as parents to observe, because what a lot of people don't realize that when it comes to Down Syndrome, a lot of individuals have difficulty speaking. The best way to explain or for people to experience what it's like if an individual has Down Syndrome to try and speak is there's physical reasons for this. They tend to have smaller than average mouth cavities and larger than average tongues, size of tongues, often length. So I mean, my son, if he sticks out his tongue, a little bit like a snake, so long, but also very thick, and this combines to make it hard for them to speak like many of us. Again, it's difficult for him to physically get his tongue behind the teeth or the roof of the mouth, for example, because of the length and because of the size. So it's like if we were to stuff a couple of

marshmallows in our mouth and then try and talk, it muffles the speech.

So he had difficulty being understood at the best of times, and with the mask on, that further muffles the speech. So he went through a period where he progressed so well with his communication in school, and all of a sudden, for a long period of time, his teachers lost the ability to understand him for quite a while, and he had to learn with the mask to speak louder and to learn to annunciate even better to get that back.

So it was very hard for that -- to see that step backwards. You know, you have to understand for an individual, especially a young person, to lose the ability to communicate your thoughts and feelings becomes very difficult. So that's just an example on that side.

Even in terms of muffling the speech, so, again, I'll give an example to try -- you know, to try and convey, you know, an example of -- that we might be able to familiarize ourselves with. I personally like watching professional basketball. The Toronto Raptors are my favourite team. If anybody has watched the Toronto Raptors, one of the things that you'll know is that their coach, Nick Nurse, has got himself into trouble multiple times throughout the pandemic. He

always wears the mask, and he's always taking his mask off, and he gets in trouble for it, you know, people from the public complain that he's not wearing his mask or not wearing it properly. And the reason he gives every single time is he's the coach, he's trying to get critical instructions to his players, and they can't hear him or understand him. And you'll see it, it will be in the heat of the moment of a game, and he's trying to get instructions to his players, and that's when he pulls his mask off and is giving instructions to his players, and then he'll put it back on.

And that's the case, you know, we've all -- I'll tell you in the context of teaching, we've really had to adopt the whole concept of using microphones, because it's even very -- more difficult to project our voices to the back of the classroom. So, yeah, muffled speech definitely has that in impairing the ability to communicate.

MR. MAXSTON: Dr. Bridle and Mr. Kitchen, my apologies for interrupting, but I think we've gone a little far afield of the qualifications of this expert when we're talking about communication. We're here to talk and hear from him about transmission and efficacy and those kinds of things. I'm not trying to be unsympathetic to your comments, Dr. Bridle, but I think you haven't been called as an expert to talk about

those things.

A Can I comment about the specific comments I had in my report?

MR. MAXSTON: I'll leave that up to the Tribunal. It depends on what question Mr. Kitchen asks of you, but, again, I'm not trying to be difficult here, but you were qualified to speak about the transmission and efficacy of masking and physical distancing, and I don't think we're here today -- I'm not trying to be difficult, but I don't think we're here today to talk about communication problems --

A Okay --

MR. MAXSTON: -- and those types of things.

A -- and I respect that. I'll wrap up then with something that definitely is in my realm of expertise, so --

MR. MAXSTON: I'll let Mr. Kitchen decide what he wants to ask you next maybe, but I just wanted to be clear we shouldn't go too far off what you were called to testify about. So I might have an objection to what you're about to say too, if it's going to be in the same vein.

MR. KITCHEN: Well, let me jump in. I have two comments: One, Mr. Maxston, let me know if you're going to apply to strike that, because we'll have to deal with that. Two, it doesn't take expertise to do

what he's doing: He's observing reality as a scientist. You know, if he told me that clouds were made out of water droplets, it's the same as saying that masks muffle speech. So I don't think it requires any expertise, but, nonetheless, I take your point.

Q MR. KITCHEN: So, Dr. Bridle, let me ask you this: What would you identify as the three most severe harms of masking? Oh, hold on, you're muted.

A Okay, yeah, I listed quite a few. Let me just go to these points if you don't mind.

Q Yeah, I'm on page --

THE CHAIR: Excuse me, Dr. Bridle, what page are you on in your report?

A Actually, I'm looking for the page right at the moment. Okay, so page 8 would be one. So page -- I've listed my concerns about the masking and potential harms on page 8, and then also I would like you to refer to page 14, where I have some additional ones, and one that I would highlight perhaps is one of my biggest concerns, as Mr. Kitchen had indicated.

First of all, related to this, there's something that I was hoping to have the opportunity to say, it's directly related to this, in the expert report from Dr. Hu that I was able to look at, there was an accusation made against me actually with respect to these harms. Can I just address that for a moment?

Q MR. KITCHEN: Well, that's fine with me, but my friend might take issue with that, and I can understand why.

MR. KITCHEN So, Mr. Maxston, I was going to ask him a question on that. If you want me to hear him [sic] ask the question, I can do that if that's helpful to you.

MR. MAXSTON: Well, that might be helpful. I think it's fair for your client to comment on Dr. Hu's report, but I think it depends on the extent of your question or the type of your question.

A Okay, what I would like to do, if you don't mind, I'll just read something of the report and then see if you're okay with me just commenting on it. Just let me find this when it comes to the dangers.

Q MR. KITCHEN: Well --

A Okay, yeah, so the comment that I want -- the thing I want to comment on is in the -- Dr. Hu's report on page 8, the one, two, third paragraph down. He says: (as read)

> Lastly, both Dr. Dang and Dr. Bridle make unsubstantiated claims that there are numerous harms associated with masking.

And then states: (as read)

> There are no known harms associated with masking.

So that is what I was hoping to respond to.
Q Yes, well, I'll let you respond however you like, but -- well, let me ask you, I take it you would say that claim is inaccurate?
A Yes, and I provided scientific citations to demonstrate that that I'd like -- there is one in particular I'd like to highlight that is clearly within my realm of expertise, and it's a serious concern that I have.
Q And I want to hear your comments to that, and I --
A Okay.
Q -- invite you to, but I want to also ask you this: That claim coming from a public health doctor, is it merely inaccurate, or does it rise to the level of willful ignorance?
A Well, yeah, that's -- yes, that's why I wanted to comment on it, and also accusatory, indicating that we -- you know, that we -- suggesting that we have failed to -- or that I have somehow failed to demonstrate harms associated with masking.

And, yeah, because there's numerous -- there are numerous potential harms with masking. So I guess this -- yes, and so I'll highlight. So if you like, I can pick three. I can think of two right off the top of my head, and I can look through the list.

But I guess what I would do is bring people to the attention of those two pages, because I list numerous

potential harms on page 8, and I mention several more on page -- as I said, page --

Q 14?

A -- 14. So it isn't that I failed to identify, and these are substantiated, and I have peer-reviewed scientific publications to back them up, so this -- yeah, that's what I just wanted to mention is that is, I feel, a very untruthful statement and accusation against me.

So let me go on to some of the major concerns. I'll start with the hygiene hypothesis. So I just had been asked to comment on harms with the mask, so this one focuses on children. But what people need to understand, and I wrote an article about this early on -- after one year into the pandemic. I wasn't concerned when we were told it was two weeks, you know, and that was the original warning, even if it was a few months.

But after a year, I expressed this serious concern. It used to be called the hygiene hypothesis, but the concept is this is that we're designed to interact and interface with our microbial world. It's absolutely required for proper physiological development. For example, many people have shown -- and this has been shown with what we call gnotobiotically delivered animals, so animals that have

no microbiome whatsoever. Behaviours are fundamentally altered. They have the -- the development of the central nervous system is altered. But one of the key things is the immune system does not develop properly if we don't have proper interaction, as we are growing up with the microbial world.

So a lot of people don't realize when we're born -- so, first of all, when we're born, we are immunologically naive. Unless there was some kind of in-utero infection, meaning infection of the fetus while in the mother, then when born, the vast majority of us are immunologically naive: We have not been exposed to anything in the microbial world up to that point.

But further -- so that means that our immune system learns to interact with the immune system following birth. Further, and because of that -- and actually because of that and to have that opportunity to learn what is dangerous and what is not dangerous in the microbial world, our immune systems do not reach full maturity, they are not fully developed until about the age of 16, and the vast majority of that development occurs between birth and the age of 6

And what we know is that if and especially young people are not allowed to be exposed on a regular basis to the microbial world, their immune system does not

develop properly, specifically the ability to differentiate between the non-dangerous microbes that we encounter all the time and the genuinely dangerous pathogens. And it's only the latter we want to respond to, because if you can imagine if we -- if our immune system is what we call dysregulated, and it thinks that non-harmful microbes are worth responding to, that's very dangerous, because we have non-harmful microbes all over and inside our body.

An individual who responds inappropriately, for example, to -- and it's -- and it's many things, it's in our environment, it's even the food that we sample, the air that we breathe, the dust particles that we're exposed to in the environment. If we're not adequately exposed and our immune system learns to tolerate these things, not respond, then we can end up with problems like chronic inflammation in certain locations.

So, for example, if somebody were to develop a food allergy, right, that food is something we should be tolerized against, that you're going to have chronic inflammation in the gut when exposed to it, or if you haven't been properly exposed to the environment, so, for example, a lot of people who are mainly -- you know, grow up in urban areas might have more of a propensity towards things like hayfever, because when young and their immune system was learning to

differentiate the dangerous things in our environment from the non-dangerous things, they weren't exposed to some of these things that you're exposed to in a rural environment.

And so what -- and so this is very important, and the reason why this is important is because one of the things that masks are exceptionally good at filtering out are large particles, like I said, large water particles, that also includes dust particles, so environment -- things we are exposed to in the environment that are not dangerous and also bacteria, especially bacteria. And a lot of this development is not actually around the virome that populates the body, but it is, in fact, the bacterial.

So, for example, in these gnotobiotic animals that have no microbiome whatsoever, if you want to correct the behavioural deficits that they will develop and the immunological deficits, we can repopulate their gut, for example, with a lot of these what we call like probiotic bacteria, the same ones you would get in yogurt, like lactobacillus, for example, so it's largely these bacteria, these non-harmful bacteria that allow us to, you know, to educate our immune system.

Without that, what happens is a child's immune system tends to become dysregulated, never learns to differentiate properly, and individuals are at a much

enhanced risk of developing autoimmune disease -- anything that's disassociated with an improperly regulated immune response. So allergies, which is responding to non-dangerous things in our environment and causing inflammation against them; asthma is when you're responding to inert things in the air that you inhale and responding inappropriately to those, that cause asthma; and autoimmune diseases.

And so, and we know this is the case, because so, for example -- and this is largely looking at those who grew up largely in urban centres versus those who grew up on farms. Those who grew up on farms are much more exposed on a regular basis to a rich microbial environment. And so those who grew up in these urban area -- or, sorry, rural areas have a much lower incidence overall of allergies, asthma, and autoimmune diseases.

And so by -- so, again, by putting these masks on children, first of all, they're not at high risk of the most severe outcomes of SARS-Coronavirus-2, and I've already explained one of the physical reasons, they just don't -- simply don't express the receptors at nearly the concentration that adults do in their lungs that the virus uses to infect. But we have put masks that are effective at isolating their lungs from the microbial environment, and we, of course, isolated

them, kept them away from their friends, a lot of family members, and a lot of social interactions. Literally, for children, it's a good thing to get dirty, to get dirty, to have dogs lick their faces, to hug other people, that their immune systems need to interact with other microbiomes in order to develop properly. So that is an immunological concept that long-term masking -- and, again, nobody has any concern. I mean, kids get sick, and maybe they're at home, relatively isolated for a couple of weeks. It's not a problem if it's a couple of weeks or it's a couple of months. But once we start -- I wrote my article first about my serious concerns about that a year in. A year is getting too long. A year is a substantial amount of immunological development in a young person. And now we're at two years with no current end in sight. So that is a serious potential harm. By masking children, we are potentially, there's no question, we're going to have an unknown number of children with allergies, asthma, and autoimmune diseases in the future, and they're going to have those for the rest of their lives because we masked them for two-plus years. So that's one.

And then I guess another one that I would mention is this idea of carbon dioxide, because this is just intuitive, so, you know, fire fighters have the

equipment to do this. At my university, we have the ability to do this, look at CO2 levels, and we often do that when looking at how we adjust the air change rate in our rooms, especially the work rooms we work in a lot, like the laboratory space that we're in, the animal research rooms that we're in.

And so if you monitor the carbon dioxide level in front of your mouth without a mask and then with a mask on, it goes up. And this makes intuitive sense, because what you're doing by putting a mask on your face is you are restricting, you know, the free flow of oxygen. What you're doing is you're creating an additional dead space. When we exhale, when we exhale, there's always dead air. We cannot get all of the air out of our lungs, and we can't get all of the air out of our mouth. That's dead air. When we inhale, that dead air, when there's not been fresh air exchanged, gets inhaled back into the end of the lungs.

By -- so by putting on a mask, you're extending that dead air space a bit, and so it does increase the carbon dioxide level a little, not a lot, a little, and this creates a condition of very mild hypoxia, it's not severe hypoxia, but if you have high carbon dioxide, then the net result is you have slightly higher -- lower oxygen levels. But, again, slight changes in oxygen concentration we know can have profound

physiological consequences.

So, for example, on the positive side, endurance athletes, especially if they know they're going to have to compete at a higher elevation will often go to train in areas with a higher elevation. There's not a massive change in the oxygen concentration, but by going there for a long period of time, being exposed to that lower oxygen concentration and training in that environment, their body gets more efficient at the oxygen exchange. Then they can perform better in the sporting activity at a higher elevation.

But so we're kind of expecting this from individuals. So we're putting masks on -- again, I'd like to emphasize, masks make sense if you're going to wear it to go into work for, you know, a little bit of time because you have to meet a deadline, but you're sick. They make sense when you're doing surgical procedures. You're doing a limited procedure, you leave, you take the mask off. They're not designed to be left on for long periods of time and exposing people to chronic low levels of hypoxia.

And, again, I'd like to highlight this is just kind of intuitive in the sense that -- like I know for myself, if I wear -- and I wear masks all the time except for surgical intervention stuff, but if I wear a mask for several hours, I start developing a headache,

constant thing and consistently. I need to take a break; I need to get out in the fresh air.

And I would encourage anybody, if -- just focus, put on the mask and go outside, because often that's where the air, you know, seems the freshest and everything, keep your mask on and take several deep breaths, right, and pay attention to what it feels like. Then take that mask off and take in a big deep breath; it feels so refreshing. And that's why, because we are impacting, albeit to a small degree, our ability to gas-exchange, by taking off that mask, we're removing some of the dead air space that we've created; we're reducing the dead air space.

And this has -- because we've never done this for such a long period of time, we simply don't actually know the extent of harm that we might be causing, especially to developing children again, I'd like to highlight, right, this constant, prolonged exposure to low-level hypoxia it might be causing.

So I think I'll leave it at that, if that's okay, Mr. Kitchen. I -- I mean, I could look through and provide another one, but those are probably my two top concerns at this point in general.

Q Thank you. I am going to try to bring you through pretty quickly, I want to give my friend a chance to cross-examine, and we are down to, you know, roughly

only two hours left.
MR. KITCHEN Well, Mr. Maxston, let me ask you this because I want to be mindful of this. How much time do you think you're going to want for cross-examination?
MR. MAXSTON: Mr. Kitchen, I expect I'd be -- and this is not a criticism of Dr. Bridle, but he seems to give expansive answers -- so thank you, Dr. Bridle, for that -- I would anticipate 20 minutes, maybe a little longer just because of the nature of the answers, but I don't think I'll need terribly long.
I'll leave it up to you in terms of how much you think you'll want to be, but it may be time to take a break right now as well, given how long you've been asking questions.
MR. KITCHEN: Yeah, yeah, I agree.
THE CHAIR: Yeah, it's, by my watch, 5 to 3, so let's take 15 minutes, and we'll come back at 10 after 3 and resume then, okay?
MR. KITCHEN: Thank you.
THE CHAIR: Just a reminder, Dr. Bridle you're still under oath.
(ADJOURNMENT)
THE CHAIR: And, Mr. Kitchen, we'll turn it back to you.
MS. NELSON: Sorry, Mr. Kitchen, we can see

you talking, but we actually can't hear your audio.
MR. KITCHEN: Sorry, I have a mute button on my mic, so I apologize, so you missed --
MS. NELSON: No worries.
MR. KITCHEN -- the last 10 or 15 seconds, sorry.
Q MR. KITCHEN: Dr. Bridle, I just have some specific questions about comments that Dr. Hu has made both in his report and in questioning.

Dr. Hu has stated that every country that has imposed masking has experienced decreased transmission of COVID; do you disagree with him?
A Yes, I do. I'll point out again, you know, like -- you know, my expertise isn't epidemiological per se, but as a researcher, I certainly am qualified to look at the scientific literature and interpret some basic data.

I do know of numerous countries where the opposite is true. And, in fact, when we look at the United States, we see states where that trend is the opposite as well. I know that Dr. Hu did not like the example of Sweden, but I mean that is an example. He didn't seem to cite any science to -- he just said it's, you know, complex to interpret the reasons for observing differences, but, nevertheless -- and he didn't dispute either that Sweden is a classic example of, you know, a country where they went the natural immunity route, and

seem to have done just fine, and there's other examples. But, yeah, so, in other words, that all we need is one example to say that that is not true. So I do disagree with that overgeneralization.

Q You just called it an overgeneralization. So is that a fairly absolute statement?

A Could you remind me what page of that report is it on, just so I can look at it myself?

Q I'm quite sure he said that in questioning, not in his report.

A Oh, can you repeat --

Q I do know --

A -- (INDISCERNIBLE) --

Q -- that he said it --

A -- so could you repeat it again, please?

Q So he said that every country that has imposed mandatory masking has experienced decreased transmission of COVID.

A Okay, so, yeah, that's not an overgeneralization, that's incorrect. Again, when somebody has said "every", and all we need is one example where they didn't do it, and the -- you know, the outcome has been fine, like Sweden, so that makes it not just an overgeneralization, it makes it incorrect.

Q Do you find it unusual that he makes such an absolute statement?

A Yes. So in the sciences -- so I even mentioned this before when I was giving examples of -- when we were talking about asymptomatic and transmission, right, I -- there is asymptomatic transmission. It's not common, and it's not a driver in this. And when I mentioned, when I talked about that, is when you're dealing with biology, there are no absolutes. Biology is not an absolute science. It's not black and white. It's not like mathematics, it's not like chemistry, it's not like physics.

Biology, there are general ways that, you know, biological systems function, and there's almost always exceptions to the rule. So there's what the dominant biology is, and then there's always exceptions to the rule. So very rarely, if ever, can you make definitive statements like that when it comes to biology, especially when you're talking about fairly complex biology. Because here, we're talking about -- we're not even talking about one biological system, like people, like humans; we're talking about the biologic -- the biology of people interfacing with the biology of a virus in the context of a complex environment. So there's absolutely no way you can make absolute statements like that in the context of this current medical scenario.

That's -- so, again, that's the -- you know, so as

a scientist, that's not the appropriate scientific approach. One has to be open to the fact that there are exceptions. What we always have to do, and also to explain, the way science and medicine is supposed to function is we should -- we need to weigh the weight of the overall evidence.

Again, because there often are not absolutes, often things are not intuitive or common sense, what often happens is -- I mean, so it's very clear in science, if somebody put -- as soon as -- so the first time a paper is published, that's obviously the first report on a given scientific issue, so it sets the tone. At that point, that becomes what the scientific community agrees at that point in time, early point in time, seems to be the reality. If the subsequent scientific literature is all in agreement, that's something that usually then gets enshrined in science as a -- as, you know, sort of as a classic paradigm in science. But as soon as you have disagreement, say the second publication find -- finds something different, at that point, you automatically need additional research to be done to sort out the problem.

And so at the end of the day, it's never about -- and so especially one thing to keep in mind, you know, my advice to everybody with this is there's a lot of science that has accumulated over the past two years,

and, therefore, it's always about the weight of the science. They're not about citing one paper or, you know, two papers or selective papers. One has to look at the overall weight of the evidence, like on scales, and see what the balance of that evidence is. So, yeah, just by the very nature, we can't, in this scenario, make such conclusive statements.

Q To give Dr. Hu, to properly and fairly characterize his position -- and my friend can interject if he disagrees with me -- Dr. Hu has said the evidence for the effectiveness of masking in reducing the spread of COVID-19 in a heath care setting is overwhelming, and there's heaps and mounds of it. And then he says in a non-health care setting, well, it's less clear. He makes no distinction between asymptomatic or symptomatic; he simply says in a health care setting, it's guaranteed to work, we know absolutely it works, there's just no question, maybe there's a question about the community.

What I've heard you say is, Well, look, it doesn't work at all for asymptomatic people, it's just -- it just doesn't -- it's not even relevant, it's not even logical because they just don't spread it because they're asymptomatic, there's no asymptomatic spread. So, you know, you two, as experts, you're kind of talking at cross-purposes.

So I want to ask you about the health care setting, okay, and then the non-health care setting, because that's how he's done it, okay, to be fair to him.

So he says that the evidence for the effectiveness of masking in the health care setting is, quote, Overwhelming, and, quote, There's heaps and mounds of it. Would you agree with that or disagree?

A Yeah, we wouldn't be here today hearing this case if there was universal agreement and if it was overwhelming evidence. This is an area of active debate. It's an area of active research. I looked at Dr. Hu's report, because the other experts have provided that. Where the misunderstanding comes in is this concept of asymptomatic transmission and this misnomer, this concept.

Where it's been most exaggerated, for example, is children. We've mislabelled children as somehow being these individuals that rarely get sick but are overflowing with large quantities of this incredibly pathogenic virus, right, so they can spread it to others. That's simply not the case.

So, again, I highlight, Dr. Hu and I are not far off in our view of masking. We're in complete agreement that masking makes sense if you're symptomatic, and it can very much help as a tool to

curb the spread if you're symptomatic, and you're choosing to go around other individuals in that state. But not asymptomatic.

I mean, this is again, intuitively, I guess, you know, again, to put it in a perspective that maybe the average layperson could appreciate, knowing what I told you about the Omicron variant, where the reality is the average flu is more dangerous than the Omicron variant for the vast majority of the people, especially the very young, for which SARS-Coronavirus-2 is not particularly dangerous, but, you know, we've never implemented this, if this asymptomatic transmission was always such an issue, and we were to accept this now as a paradigm, we'd have to apply this to every -- every infection -- we would never -- we would never know if somebody is ever, quotes, healthier or unable to transmit to anybody else. There would be no way of me knowing of somebody else who has no signs or symptoms has, you know, in their lungs, respiratory syncytial virus or a flu virus or Norwalk virus or any of the viruses that we face. So just from that perspective, it's counterintuitive.

And this is definitely within the realm of immunology, and it comes largely from a misunderstanding -- and, again, you know, with all due respect, the average physician who has been in a

position of authority, you know, to implement policies, and this is one of the reasons why -- a lot of people don't realize it, and this is an area I have expertise in as well because we have an emergency preparedness plan in our university for responding to a pandemic. We were required to implement this by the Government following the 2009 flu, declared swine flu pandemic, where people realized that there was initially -- the response was one of panic and realizing that we really did not have a coordinated response, we hadn't really prepared for such a scenario. Now, that turned out -- that fizzled and that was not a true pandemic.

But so all the -- the Government made all publicly instituted -- institutions, including my university, come up with a pandemic preparedness plan. Our country came up with a pandemic preparedness plan. Every province and territory was required. We threw these out within the first week to two. At my institution, we threw it out within five days of the pandemic being declared, and we haven't been following any defined plan since.

And that applies at the Federal level as well. We -- like, if you look, we still don't know what the goalposts are. We don't know what the finish line is before we declare that we're out of this. In fact, the goalposts have kept moving.

And what I can tell you is that in those pandemic preparedness plans, none of them looked like this at all. They relied on the more traditional ways that we approach this kind of problem, which was you treat people who are sick as sick, and you keep them away, especially from the vulnerable populations, and you focus your protective efforts and your protective measures on the high-risk demographics if, if, and when a pathogen shows a predilection towards causing harm in limited demographics. And so, you know, we haven't reached that point here. You know, we didn't follow those kind of plans, and so this is where we've come in with these other approaches.

And what I do want to point out then is -- actually to get back on track, Mr. Kitchen, can you remind me what your core question was? I was just coming to it, and I wanted to find something in the report here.

Q Well, like I said, Dr. Hu says, end quote, heaps and mounds of evidence supporting the effectiveness of masks in --

A (INDISCERNIBLE)

Q -- a health care setting --

A -- yes, and so -- so, no, that is a point of contention, and so his report even highlights this. So one of the things -- I mean, he hasn't -- he hasn't

cited heaps and mounds of evidence. It's a limited number of citations.

And this is -- so this is something that I want to deal with head-on just so that people, when interpreting the two reports, can understand. He accused me of solely leaning on outdated documentation, or maybe not solely but certainly leaning on outdated documentation when it came to my report. People are free to look at my reference section. I have lots of updated citations in there.

I want to highlight that, in fact, after accusing me of using outdated literature, the two things that he most emphasized when talking about this -- when talking about this concept of masking, the first one was a citation from 2011. So he actually set the record for the oldest cited paper with respect to masking and citing the one from 2011, a Cochrane review. And so --

Oh, and the other thing he said is he accused me of using examples from other viruses. And I want to point out that this 2011 one is the oldest -- second oldest reference of all the reports about masking and dealt with influenza virus, not SARS-Coronavirus-2.

And one where he spent half of a paragraph highlighting it was actually to describe what he felt was, you know, sort of break-through work that was done, and it's a study that was done in the early

1900s, which shattered records in this in terms of the oldest citation, and that certainly wasn't dealing with the SARS-Coronavirus 2.

So he's got that aspect wrong in terms of arguing that he's got the updated literature. And, in fact, I just want to highlight this as well, because this is overstated again, he actually said in his report, on pages 1 -- at the very end of page 1, the final last few words, onto page 2, he said: (as read)

> A vast majority of literature [this means his literature] is from the years '20 to '21 with emphasis on literature published in 2021.

So I actually went to his reference section, because, again, I do lots of review of, you know, scientific and medical documentation, and I excluded some of these because they're not peer-reviewed articles. A couple of them are websites. One of them was a website where he -- that described the 2011 paper, the source of the 2011 paper that he got.

And so, in fact, it turns out that of his citations, 19 of his citations about masking, of those 19, 11 were from 2020 to 2021. That's 58 percent. So that's not a vast majority of the literature. And he then emphasized that most of it was from 2011. Well, in fact, only two of those is 11 -- sorry, two, the emphasis was on literature published in 2021, but only

two of those 11 papers were from 2021, 18 percent of the papers cited since 2020 were from 2021.

And so I think it's important, again, otherwise, it gives a misconception that somehow he's captured the recent, cutting-edge data, and I have -- again, people are free to look through -- I've got plenty of citations from 2020 to 2021, so that's not the case. It's not -- this isn't the case of somebody having -- understanding current literature, and somebody else, myself, not understanding the current literature and only focusing on historical literature. I want to point that out.

Further, he even states in this, if I can find it here, and this is important because this is a very important thing for us to understand, because we're all hearing public messaging, and we're all trying to sort through this information and understand, and there is lots of misinformation, there's genuine information, and there's been messaging that's been changing over the course of this. And so this is very important because one of his critical sources of information about this are public health officials, especially Dr. Theresa Tam, and that's why I'm hoping I can just find this here quickly. Where is it?

Q He mentions Theresa Tam on page 8. I don't think he mentions her anywhere else.

A Okay, thank you. Oh, Dr. -- sorry, I mean Dr. Tan, sorry. Do you see the reference to Dr. Tan?
Q T-A-N?
A Yes.
Q 'N' as in "nothing"? No.
A Medical Officer of Health. Give me one second, because this is an important point.
Q Okay.
A Let me just pull up the document here.
Q Do a search on it.
A Sorry for the extra time, but I just want to make sure, because this is important.
Q I don't find anything for T-A-N.
A Okay, sorry, yes, that's why, I meant Theresa Tam. I'm getting her Medical Officer of Health, her name messed up here, it's Theresa Tam, Dr. Theresa Tam --
Q Yeah, page 8.
A -- so this is on page 8 just before the summary, the subheading "Summary", and this is when talking about that that I made unsubstantiated claims, that there are numerous harms associated with masking, there are no harms, but we've already discussed that.

And then -- this is very important, because -- this is very important here, so what he states in that last sentence: (as read)

Indeed, public health experts, including

Dr. Theresa Tam, have walked back any statements alluding to the potential harms and increased infection risk of masking. There's no scientific documentation there, so peer-reviewed literature, and what this is -- so what he means, what he means, and if we're blunt about it, is that Dr. Theresa Tam has completely contradicted herself in the context of this pandemic.

And specifically what he's referring to when he talks about walking back in his statements, it was that a lot of top public health officials, including Dr. Tam, Dr. Fauci in the United States, and others and agencies like Health Canada were actually discouraging the use of masks and widespread use of masks earlier on in the pandemic and widespread use of masks earlier on in the pandemic, and that was because of the scientific evidence available at the time.

So, yes, they later walked back the statements, and I can tell you that I have yet to know what the scientific foundation is for Dr. Theresa Tam walking back that statement. And I point out, as you can see by the wording here, you can ask yourself, it's not scientific, I don't know what walking back a statement actually means. She never rescinded the statement. Yes, I will agree that she downgraded the -- I guess, the importance she placed on that, you know,

down-playing of masking as an effective protective strategy in the context of SARS-Coronavirus-2 early on, but she never rescinded it. She did, indeed, dampen it or walked it back to some degree. And, again, I have yet to see, she hasn't produced any peer-reviewed scientific literature that I've seen.

Now this -- so this becomes very critical, because I'm not going to say -- I can tell you there's lots of literature to suggest there's harms of masking, and it doesn't work, and, again, this comes down to the whole disagreement is about asymptomatic transmission. And, again, I highlight that in the studies that are cited to support this, the vast majority of those studies are defining transmission based on PCR positivity, not proof -- not demonstrating with using the functional virology assay that I said, that there is definitively replication-competent viral particles in the sample, especially at a concentration that would meet the threshold required to cause infection in other individuals.

So a lot of those studies actually agree, potentially, with the outcome that made -- where they measured what they did, but they didn't prove that there was transmissibility of the sample that they were collecting. And so that's what it comes down to is how we interpret asymptomatic transmission in this.

Because like I said, we are all in uniform agreement that if somebody is sick, this makes some sense.

And then the other thing is, which I was very surprised, because often scientists who have been speaking out in a way that's perceived to be against the narrative, one of the arguments that constantly comes up is, well, you haven't proven your point with the randomized controlled trials.

So I want to explain to everybody, a lot of people, when it comes to clinical medicine, consider a randomized controlled trial to be the be-all and end-all. It's where you actually look at a relevant clinical setting, and you have your treated group and your placebo group or untreated group. If you're talking about masking and SARS-Coronavirus-2, it would be a compilation in the context of SARS-Coronavirus-2 with the potential for it to be transmitted, and you would have a population that's masked and a population that is unmasked, that would be the negative control group, and then you actually see if there is an effect. So for everything that has not been accepted in the public health narrative, it's because there hasn't been a randomized controlled trial.

Let me give you an example. The same Dr. Theresa Tam told all of Canada that the concept of vitamin D reducing the potential for infection is fake science.

I can believe -- I'm an immunologist. I'm even left with -- I've actually sent a letter to my administration university telling me [sic] that am I going to get in trouble if I continue to teach immunology like I have during my whole career, because I can tell you vitamin D is a critical component of the immune system. There are -- it functions at such a basic fundamental level with so many aspects of the immune system.

Without it, it would be like if somebody is familiar with cars and a car engine, it would be like if you have a high-performing race car, say, a Formula One race car, there's no question, if you deactivate one of the cylinders in that engine, it is not going to perform as well as if it had that cylinder functioning. It's not going to be competitive in the race.

And that's the case with vitamin D. I mean, there's thousands and thousands of papers -- I can tell you -- I can give you 77 citations right now that show the benefit of vitamin D in the context of SARS-Coronavirus-2. That's why we have -- one of the reasons we have our annual cold and flu season. As an immunologist, I often don't refer to it as the cold and flu season, I refer to it as the low vitamin D season.

THE CHAIR: Dr. Bridle, I'm not sure that

vitamin D was really relevant --

A No --

THE CHAIR: -- to --

A -- no, I'll probably be back to it immediately, yes, thanks, I appreciate that. So my next comment immediately ties it in.

And the point being that it was declared that a randomized controlled trial, therefore, was needed to prove the effectiveness of vitamin D in the context of SARS-Coronavirus-2.

And so that's where this ties in. So when you have an area where there is definitely, clearly, far more debate going on and the science is -- it's why you have even more reason for a randomized clinical trial if you really want to sort out this issue.

Now, what I was honestly shocked by is in Dr. Hu's report, he acknowledged that but then went on to proceed to argue that a randomized controlled trial could not be done because this is such a cut-and-dry topic, because everybody is in such uniform agreement that masking works in the context of SARS-CoV-2. Well, clearly, that is not the case. If nothing else, my expert opinion disagrees with his expert opinion. There's evidence of nonuniform agreement right there. And when scientists disagree, we need further research to work it out.

Now, I want to highlight something, because this is very important to understand, randomized controlled trials has been -- that's been the basis for promoting anything to do with treating or protecting from COVID-19. So what we get to here, and I just want to go to this now -- I thought I'd have these better marked -- so I want to get to this where he talks about the randomized controlled trials, and I think this is in his rebuttal section. And it talks about -- he uses a -- an analogy there. Let me see here. Okay, yes, right here: (as read)

> With respect to the evidence for effectiveness of masking [this is on page 7], Dr. Warren states that in the absence of evidence for randomized controlled trials in meta-analyses ...

And then it continues on, and that's -- so that's what he's responding to, this idea of randomized controlled trials. So he admits it is correct that there are a few randomized controlled trials on masking, and there's none in the context of SARS-CoV-2 as -- so we're talking about a fundamentally different virus. Then he says: (as read)

> There is an overwhelming burden of evidence from other studies showing the benefits of masking. Furthermore, it's not ethical to do

RCTs on masking given its significant benefit.

Well, we've just talked about, there's potential harms, potentially even in the context of symptomatic -- asymptomatic people, maybe more harm than good. And it doesn't, for all the reasons I've explained, doesn't help spread SARS-CoV-2 by the aerosol route. So none of that fits into play here.

And then he goes on to give an analogy that this -- to say why the randomized controlled trials can't and should not be done with masking. He says this is like parachute-jumping out of an airplane. We wouldn't run a study right now, right, none of us would ask for a study to be run asking people to jump out of a plane with a control group that is not given a parachute, right, and to the test the idea that parachutes stop people from dying when jumping out of a plane.

Well, this is not a fair comparison whatsoever. Worse, he got upset about one of the other experts. He actually says here: (as read)

Notwithstanding the factual error on page 6, it is fallacious and unscientific to equate death rates by age in the context of a global pandemic with those of car accidents, with, at a minimum, it is a false dichotomy and

then [et cetera, et cetera].
So he was really upset with the use of an analogy to -- due to car accidents with deaths caused by an infectious agent in the context of a pandemic but then goes on and uses his own completely, arguably even far more inappropriate, analogy to argue that RCTs have no role to play when it comes to considering the benefits of masking.

And what do I mean by this? It's intuitive, I agree, we're not going to run a study to determine whether jumping out of a plane without a parachute increases the risk of dying upon impact with the ground, and we don't have to. That experiment has naturally been run multiple times. If people -- if somebody jumps from a large height, if they want to commit suicide, they know they can jump from a large height. Anybody who falls, plunges to the ground from a large height will experience death. We've had people with parachutes jump out of planes, and the parachutes failed to deploy, and they've died. So this is not a comparison.

The equivalent with -- the RC with masking would be that we know that, in the control group, if they do not wear the mask, they are going to die. Yes, that would be unethical. We do not know that. In fact, we're debating that very fact and whether it's actually

doing anything to protect these people from harm. And so I would actually propose that the precise thing that we do need scientifically to sort this out and especially if we're going to force people to follow this rule, we need to run a randomized controlled trial and sort out the science once and for all.

So again, you know -- I mean, I'm not going to apologize for the long answer, it's a thorough answer, and so, no, this is not a clear path. And I'm sorry, Dr. Hu has not cornered the market on, you know, the fact that, you know, being be able to state that everybody knows this, and everybody agrees on this fact.

Q MR. KITCHEN: Thank you, Dr. Bridle that answers several other questions that I had.

Since we're in that area on his report, on page 5 of your report in the last sentence of your section on asymptomatic transmission, you kind of make a summary statement, you say: (as read)

> There is no substantial evidence to suggest that people who are asymptomatic represent a substantial risk of causing COVID-19 related hospitalizations or deaths in others.

Now, as you know, Dr. Hu takes issue with this issue on page 7 of his report. He says that you have no scientific evidence for this statement. He also says

the fact that you would make such a statement, quote, proves a lack of understanding of asymptomatic transmission and its deadly effects on the community.

I have a couple questions on this. My first one is do you think there's any scientific evidence to support this statement that you made?

A Okay, that I think I can answer quickly. People, first of all, can read page 5 of my report, see the citations that I have there, and then refer to everything that I've explained today.

I understand the science -- so again, with all due respect, when it comes to asymptomatic transmission, what we're talking about is we were talking about fundamental, hard core immunology -- or, sorry, virology at the interface with immunology. That is precisely my area of expertise. I'm a viral immunologist. This has nothing to do with public health or anything like -- it has public health implications, but the science behind this, this is how a host immune system interacts with a virus that dictates whether or not the outcome is going to be potential transmission and infection and causing disease in others. And I mean people can take my expert, you know, commentary or not. Like I said, I have the citations there, and I've talked at length about the science, the precise mechanisms governing

this.

And just so that you understand, I don't know if people can see, but I actually appreciate being asked the question, because I've got that very thing marked up, so I'm glad I actually got to talk about this, because, again, I have been called upon to review lots of literature, grant applications, scientific publications, right, manuscripts people want to publish in peer-reviewed journals. And sorry to be blunt here, but this -- this report from Dr. Hu was and -- generally unprofessional, disrespectful in tone, very much highlighted here. That's why I have this actually underlined, because it's quite offensive. He uses language that is offensive, accusatory. He makes assumptions. He's hypocritical in areas of his report. And I can give examples of all of these so -- if I wish, and this is one of them. And he makes demonstrable -- you know, many claims that lack evidence, lacks citations or that are only backed up by hearsay evidence, and then makes these kind of statements, right, that as an expert in this area -- and I'm sorry, but looking at the expertise, I am quite confident that I have deeper expertise in the area directly relevant to understanding asymptomatic transmission or lack thereof. And he's actually arguing that I am provide -- that I have no scientific

evidence. That is a lie. That is a lie. I provided the scientific evidence today. I have all these citations. I'm looking at page 5 of -- and I see all kinds of citations listed here and a description of the science. And he says this proves -- somehow this proves a lack of understanding. Like this means me, that I do not understand this.

This is unprofessional. I don't do -- write this way in any of my reports, so I'm sorry, this group needs to understand this. I have been involved in a lot of court proceedings. I have been involved in a lot of scientific proceedings. This is not a scientifically or medically acceptable document for interacting with other scientists or medical professionals, and this highlights it.

So thank you, because I didn't know if I'd have the opportunity to share with the group, but this statement is -- there's several others, and I'm not going to take the time, but if anybody has a question, I can prove what I just -- my overview of his report, but that is, certainly I had listed, as the most egregious statement against myself.

We have to respect one another as scientists and physicians. I do respect Dr. Hu's perspective. Like I said, I agree with much of his science, and I've acknowledged the peer-reviewed publications that he's

used as valid, you know, acceptable scientific publications. I think we need to be very careful, and this stepped over the line, in my opinion, in terms professionalism in this kind of environment.

Q Thank you, Dr. Bridle. I am almost done. I know this might be obvious, is there an important difference between correlation and causation?

A Yeah, absolutely. A massive difference. The burden of proof is vastly higher for causations. Correlation can contribute to the overall determination of causation, but causation means that you know for sure that one thing influences the outcome of another thing, directly influences it, not, you know, has a direct impact on a certain outcome.

So, for example, we know that SARS-Coronavirus-2 is the causative agent of the disease we call COVID-19. If somebody is not infected with SARS-Coronavirus-2, they will not get COVID-19, and if we infect them with a different virus, they will not get COVID-19. It's a causative agent, right? So it's a cause-and-effect relationship.

A correlation means that something trends in the same direction as something else, you know. And a classic example -- and so I talk about this quite a bit, because when I teach actually my immunology students, because it is important to understand the

difference, so, for example, when it comes to -- you know, one of the correlations that does -- that is related and does have some link through causation, as we get older, people tend to have a greater risk of getting cancer. And there's two reasons: Scientifically one is we get exposed to more potential mutagens that can cause cells to turn cancerous; also our immunological function declines, and our immune system is very good at controlling cancers, right? But there's many other things that correlate with age as well, right?

So I don't know -- for example, as you get older, there's also a greater use, on average, of dental implants, right, as people lose their teeth, but that's not a causation to have cancer, for example. So that would be an example of a correlation, right, somebody getting older, where if something gets -- as they get older, there's an event that happens more frequently among that population, but that event doesn't necessarily mean that it's the cause of another event that increases in frequency in that older population. So, yeah, there's a huge difference.

Q Dr. Hu stated in his report that, quote: (as read)

> A very, very, very large number of health care workers in Italy contracted and died from COVID in early 2020.

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

A Do you have a page number for that so I can take a quick look?

Q That I think was in his examination. It's not in his report, but I can --

A Okay, I didn't recognize it --

Q -- invite my friend to --

A -- that's fine. So, yeah, I -- yeah, that's fine, I can comment on that. I heard the question.

So, no, that's clearly not. So, again, if -- in that case, when you're talking about a clinical scenario, a complicated clinical scenario where there's other things happened, so what I mean by this is it's very different from a lot of the, for example, preclinical experiments that I run. I can run experiments in very controlled environments.

So, for example, if I run a study in mice, these mice are all genetically identical. They are all the same sex. They are fed the same food. They're housed in the same environments. They -- and so we can divide them, and we can have one treatment differ between them, one thing. And so it's very easy then to

attribute an effect to that one thing because everything else is controlled.

So in the scenario that Dr. Hu was talking about, the only way that you could potentially allude strongly to causation is with a randomized controlled trial. That's the whole point. And so the reason it's so -- what randomized controlled trials are is they take account for these real life settings. So in the real world, when you're dealing with a clinical scenario where you're talking about an outbred population, you're talking about males and females, you're talking about old and young, you're talking about different lifestyles, different historical exposures to pathogens, et cetera, et cetera, and, therefore, different immunological programming and -- you know, and you're dealing with a pathogen and different potential exposures to that pathogen across that population, you're talking about many, many uncontrolled variables.

So what a randomized controlled trial is you try to account for all those variables by getting those variables equally distributed as much as possible among the two groups. That's why it's called a randomized trial: You literally random -- you can take two people, they randomly get associated to either the test arm or the control arm. And the idea of it's

totally -- if it is truly random, then at the end of the day, both arms of your trial should have people that represent the whole -- all those variables that exist in the real world should be --

THE CHAIR: Dr. Bridle, could -- I'm not --

A Yes.

THE CHAIR: -- sure that this is really relevant. Could we get back to the question, please?

A Oh, yeah, well, it is relevant because this is the way that Dr. Hu could have made his conclusion and should have.

And so with the relevant -- and so what I'm saying is with this randomized controlled trial, you equalize all those variables, it's very large because of all the variables, and then when you run those kind of studies, that is what allows you to draw strong conclusions about the potential causation of a variable, which, in this case, is masking.

In the scenario that you just posed, there's no way causation could be attributed to masking. There were far too many uncontrolled variables that were not accounted for.

Q MR. KITCHEN: I've only got one more question on this and then one final question, and then I'll be done.

Dr. Hu in his testimony, so in his questioning, he described the lockdown restrictions imposed in Alberta in November and December of 2020, so a little over a year ago now. He stated cases went up after the lockdown, but eventually later on cases went down. He then concluded that the lockdown did not cause the initial rise in cases, but that it did cause the eventual drop in cases. In your opinion, is this a logical or scientific conclusion?

A No. So actually he had the latter part of that argument in his report highlighting -- trying to highlight that these lockdown measures, including masking a key component, had contributed to the dramatic decline in cases.

So more recent history demonstrates that that is patently false, that that's just the reality. That was looking sort of -- taking a snapshot in time. So again, first of all, it's correlative at best. Secondly, I -- at least it was in the report. I didn't see any peer-reviewed scientific -- I didn't see any citations attributed to his comments there. That's one thing that I had noted. And further, it's one snapshot in time; it was looking at the tail end of one of major waves of the pandemic -- waves of positive test results for SARS-Coronavirus-2.

And what I would like to highlight is that since

he highlighted that snapshot in time, we have had a record-shattering wave of the Omicron variant, where all the historical stuff that was being I guess highlighted as the reason for that decline, right, it was still in place, coupled with the fact that the vast majority of people were then vaccinated to add additional -- an additional layer of protection, we had record-shattering cases of Omicron.

So clearly, like -- and so again -- and I mean, I'm a scientist and when I have the data, make certain statements when there's overstatements or things misstated. I don't think it's incorrect for me, as a scientist, to declare something like that as being patently false.

Q Thank you.

MR. KITCHEN Those are all my questions on direct examination. So, Mr. Maxston, I've managed -- (INDISCERNIBLE) --

THE CHAIR: Mr. Maxston (INDISCERNIBLE), would you like a few minutes?

MR. MAXSTON: I think, in fairness to Madam Court Reporter, we should take at least a 10-minute break. Again, I don't expect to be particularly long, but Mr. Kitchen may have some redirect, and I think we should take -- just take a 10-minute break if you're comfortable with that, Mr. Chair.

THE CHAIR: I'm fine with that. It's 3:55, so we'll come back at 10 after 4. Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, I think we're all back, so Mr. Kitchen has completed his direct, and we'll ask Mr. Maxston to continue.

MR. MAXSTON: Thank you, Mr. Chair.

Mr. Maxston Cross-examines the Witness

Q MR. MAXSTON: Good afternoon, Dr. Bridle. I wanted to begin by saying that I was very displeased to hear your expert testimony on the effects of aging. I, however, will not use that to attack your credibility, I tend to agree with it, I have to admit, but, nonetheless, I thought that was something we should all not take into account in today's hearing.

I have a couple of clarification questions for you, Dr. Bridle. When I looked at your cv, and then I Googled you at the University of Guelph, I just want to be clear that your position is at the University of Guelph in the pathobiology department at the Ontario Veterinary College; is that accurate?

A That is accurate.

Q And that's part of the Doctor of Veterinary Medicine program; is that correct?

A Yes, that's correct, yeah, as alluded to before, a lot of my teaching is actually of the students enrolled in

the Doctor of Veterinary Medicine program.
Q Right.
A Yeah.
Q You had some discussions with Mr. Kitchen where you talked about what was occurring at Guelph University. Over the course of the pandemic, have there been any requirements at Guelph University for you as staff or perhaps students to mask if there's in-class settings or teaching?
A So just -- so, yes, just to clarify, not just students and staff but faculty as well. So actually I'm technically not a staff member. So just so people understand, yeah, there's three categories of people at the university: Faculty, who are the professors is what we're referred to; the staff -- we're represented by the University of Guelph Faculty Association is kind of the best way to distinguish; then there's our staff, and many of them are affiliated with fundamentally different unions; and then there's the student population.

But all three populations, yes, there have been masking policies that were implemented at the University of Guelph, yes.
Q And did you comply with those masking policies, Dr. Bridle?
A I did. I respect the law, and I respect rules, and so

even though I -- you know, what I've shared with you today, I respect those rules and adhere to them, yes.

Q I think you mentioned as well that when you went for a hair cut, you or the barber or the hairdresser had to wear masks, and that, I'm assuming, was because of the Chief Medical Officer of Health order or something like that; would that be correct?

A That is correct, yes.

Q So you observed that as well, that masking requirement, I should say?

A Oh, yes, I acknowledged that masking requirements have been implemented in many places, yes, including my public health area, yes.

Q Yeah, and more to the point, when you went to see the barber or to get a hair cut, you complied with those?

A I did so I'd get my hair cut, yes.

Q I think you were very fair in saying, Dr. Bridle, that there were I think some fairly significant areas where you and Dr. Hu were, I think you'd even said, a hundred percent in agreement, and I think that was in the context of masking and persons who are symptomatic and the benefits of masking. I think that's what you said anyhow.

I think, isn't it fair to say, that for a chiropractor, that person treating a patient can't definitively know whether the patient is symptomatic or

asymptomatic; would you agree with that?
A Well, okay, so from a technical -- from a technical standpoint, nobody can know without screening or asking whether somebody is symptomatic. So again, as I explained earlier, but I can explain again because it's a common area where people don't quite understand the distinction, so a sign is something that somebody external to the individual can identify, can use to identify that somebody is sick. A symptom is something that a person experiences that's associated with sickness.

So specific -- so nobody -- so, in other words, by definition, nobody upfront can identify whether somebody has a particular symptom, but you can identify if somebody has a particular sign. And again, so -- and I can't comment beyond that in terms of chiropractors. I -- that's not my area of expertise. I'm not sure exactly how it works, but --

So, for example, in my field of expertise, that's why we've been using the prescreening, and again it's asking the questions. By asking the questions, if people have -- are experiencing any symptoms or showing any signs, then they are not to go in, you know, to the workplace, my workplace, for example. I can't comment on what happens in a chiropractor's office though.
Q Okay. I'm not going to take you through all the

exhibits that are in front of the hearing relating to mask mandates and mask requirements, but -- and I'll indulge -- hopefully my friend will indulge me a little bit, rather, I'll just tell you that there have been some exhibits from entities like Alberta Health Services and the Chief Medical Officer of Health in Alberta which set out mandatory masking and social distancing, and I'm talking about the typical blue medical masks, not N95s and things like that, and that you referred to Dr. Tam as well.

It's probably fair to say, isn't it, that you disagree with those type of mandates?

A In the context of asymptomatic individuals, yes. I agree with them in the context of symptomatic individuals for all the reasons that I've stated earlier.

Q I'm wondering -- and again you may not have had the chance to review this in detail, I'm not going to take you towards it -- but one of the key documents in this hearing is a Pandemic Directive that the College of Chiropractors created that, among other things, required social distancing and masking.

I'm assuming that, in your work, you do have contact with members of regulated professions, perhaps physicians, maybe lab techs, CLXTs, others. Are you familiar with generally the concept of self-regulation

for professionals?

A Yes, I have, yeah, multiple clinical colleagues, so, yes, through them, I understand this to a certain degree.

Q And I don't want to go into a lot of detail, but if you were to look at the Ontario Regulated Health Professions Act, which I understand is an omnibus legislation, it sets up a college like the College of Physicians and Surgeons, the CPSO, and is it your understanding that that organization sets up registration requirements for physicians that they have to meet before they can become registered as physicians?

Sorry, you're muted.

A So I -- honestly, I can't comment in much detail on that. I mean, I know that my clinical colleagues are licensed by a body, for example, in Ontario, like you said, like the College of Physician and Surgeons of Ontario, but the actual licensing process and the administrative structure and how that's managed, I -- I'm sorry, I don't have the expertise to comment on that.

Q Yeah, and fair enough. I didn't want to take you there; I was just trying to, you know, get your sense, I mean, in your work, that you're aware of the fact, for example, that a physician has to register with the

CPSO before they can practice as a physician.

Are you also generally aware that, again, a member of the CPSO has to have annual, continuing competence requirements, has to meet recordkeeping requirements, and those type of things established by the CPSO?

MR. KITCHEN: Mr. Maxston, look, we all know where you're going, and tomorrow I have a member of the CPSO up, and I'm not going to object. You're going to ask him these questions, I'm not going to object because he's a member of the CPSO. Dr. Bridle --

(AUDIO/VIDEO FEED LOST)

THE CHAIR: You've gone -- you're frozen, Mr. Kitchen.

MR. KITCHEN: -- have him talk about regulated members when he's not one.

MR. MAXSTON: Mr. Kitchen, you just froze there a bit, so I'm not going to proceed with that line of questioning then, that's fine.

Q MR. MAXSTON: In your -- as your job and in your area of expertise, I'm assuming you've looked at the Ontario equivalents to, broadly speaking, the Alberta Chief Medical Officer of Health masking and social distancing requirements; is that fair to say?

Oh, I think you're muted, sorry.

A It's not showing that -- can you hear me?

MR. KITCHEN Yeah.

Q MR. MAXSTON: Yeah.
A Okay, yeah, so I -- yes, yes, is my answer.
Q Would it, keeping in mind your comments to me about your visit to the barber and what happened at the university, your university in terms of the masking requirements, would you think that it's important to comply with CMOH orders?
A So could you clarify that question? What do you mean exactly, like in which context? I mean, if I want to get food from a grocery store to feed my family, of course, I think it's important to comply so that I can get food.

Do I think that I need to be masked in those scenarios? No. Do I take every opportunity to not wear my mask where it's allowed? Yes. You know, so I'm not quite clear. That's how I would answer that. Maybe a more specific form --

Q No, I was looking -- I'm sorry, I was looking to ask you some questions about the masking components of Medical Officer of Health orders, but I think you answered that before when we talked about the policies at the University of Guelph.

MR. MAXSTON: Those are all my questions for you, Dr. Bridle. Thank you very much.

A Okay, thank you.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: Dr. Bridle, I just have two questions in redirect. When you wear a mask because you have to to get groceries or work (INDISCERNIBLE), do you do so willingly or is it (INDISCERNIBLE)?
THE CHAIR: Mr. Kitchen, you're frozen, and you broke up with your question.
MR. KITCHEN Okay, I apologize, I'll ask it again.
A I did -- I heard the question, but did the rest of the members would like -- would you like them repeated?
MR. KITCHEN No, Karoline didn't hear it, so I'll have to ask it again. I apologize.
Q MR. KITCHEN: When you wear the mask, you just referred to wearing it to do groceries, you referred to wearing it at work, at the University of Guelph; when you wear it, do you wear it against your will?
A 100 percent, yes.
Q Do you think the prescreening questions that are pretty typical in your office and would be typical in Dr. Wall's office and any other chiropractor's office, do you think those questions are pretty effective at keeping symptomatic people out of the offices?
MR. MAXSTON: Mr. Kitchen, I'm going to have to object to that because Dr. Bridle has already said he knows nothing about chiropractic clinics, so I

really don't think he can answer that question, at least --

MR. KITCHEN Okay.

MR. MAXSTON: -- the second part of your question anyhow.

MR. KITCHEN: Point taken.

Q MR. KITCHEN: Dr. Bridle, let me ask you it this way: You have -- you said you have prescreening questions for your laboratory; do you think those prescreening questions are effective at keeping symptomatic people away from the laboratory?

A Yes, absolutely. So as I explained, symptoms are something that somebody experiences, and the only way to understand whether somebody's experiencing them is to ask questions.

So, for example, if you go to a physician, that's what they're designed to do, there are certain signs they can look for. So a sign, again, would be something -- so, example, when they take your temperature, they're looking for evidence of fever. That's something they can objectively assess themselves. You don't have to tell them that you have a fever, and then that's something that's a sign -- or, sorry, a -- yeah, a sign, therefore, of sickness.

Symptoms -- and symptoms can precede, can precede a lot of the signs. So that's the best way to actually

screen is for symptoms, which is something somebody is experiencing and an objective third party cannot directly observe. So the only way to get that out, whether you go to a physician or anything else is by asking the relevant questions.

And the -- so, for example, so the one that's used for my workplace was designed in consultation with physicians, who are experts at asking the relevant questions about symptomology, to assess whether somebody is sick -- and in my experience, that has been very effective. For the first time since those questions were implemented at the university, and it's the first time in the history of my laboratory that I have consistently not seen, not even once, one of my lab members come into work sick, whereas it was a relatively common occurrence prior to that.

Q Is there any logical reason to think that if Dr. Wall was to ask the same questions of his patients that it would be any less effective for him than it is for you?

MR. MAXSTON: I'm going to object to that too, Mr. Kitchen; it's just beyond his scope.

MR. KITCHEN: I disagree. I think it's perfectly legitimate. The way I asked it was is there any logical reason to think it would be any different, so that's not a scope question.

MR. MAXSTON: I don't think Dr. Bridle can

even comment on whether it's logical or not when he doesn't know what happens in a chiropractic office or what the specific requirements were for any screening that Dr. Wall carried out. I just think it's too far afield of what he can comment on.

MR. KITCHEN: Well, Chair, I put it to you; I think it's a perfectly legitimate question.

THE CHAIR: Okay, we will caucus and get back to you as quickly as we can.

(ADJOURNMENT)

THE CHAIR: The Hearing Tribunal has discussed the matter, and we've decided to allow the question.

Q MR. KITCHEN: So, Dr. Bridle, I'll just re-phrase it -- or not re-phrase it, re-ask it.

Is there any logical reason to think that if Dr. Wall, in his chiropractic office was using the same questions that you've been using that he would have different results?

A There would be no reason to expect different results. The expectation, what we were expected to do with ours is make sure -- let's put it this way: As long as the questions are comprehensive enough and thorough enough that a -- the average physician would be able to make a reasonable assessment as to whether or not somebody is or is not infected, that that's going to be an

appropriate questionnaire.

And just I guess maybe to help for you to interpret, one of the things that the -- well, yeah, let's just leave it at that. That's ultimately the litmus test: Physicians are the experts at diagnosing disease, and if they've designed a questionnaire that would allow them to get the same information that they would out of the individual, should they be a patient in their office, and they're screening for disease, yes, that questionnaire would be university applicable irrespective of the environment.

Q And my friend can object to this if he wants, but would you agree with me that those are administrative controls; is that an appropriate term to call those?

A Yes.

MR. KITCHEN: Those are my questions on redirect.

THE CHAIR: Okay, thank you, Mr. Kitchen. I think we'll just take a few brief minutes for a break just to see if the Panel has any questions for Dr. Bridle, so we'll be back with you as quickly as we can. If you could put us in our break-out, thank you.

MR. KITCHEN Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, I think we're all back. Thank you for your patience.

Dr. Aldcorn does have one question she would like to ask Dr. Bridle.

The Tribunal Questions the Witness

Q DR. ALDCORN: Hi, Dr. Bridle. Just regarding the IFR, you commented that in 2019, there was a prediction that the -- that there could be as much as 10 percent with regards to COVID-19 in terms of those who are infectious who get the disease, right? And then you mentioned, in early 2021, studies had shown that it was about .15 percent, and now even less. So I'm curious to know if there's any research or studies or -- to the best of your knowledge, if you knew that there was any percentage given in the time frame that we're concerned about, which would be from May to December 2020.

A Yeah, in that -- so that study that I cited in my report includes that time frame. So it would include everything from -- I was assessing everything from the beginning up until -- so the very earliest that it would have included data, and I'm not even certain -- I'd have to go back, and I have -- and double-check, but the earliest would have been, you know, like maybe January 2021, but the data would have been all from the start of the declared pandemic up until the end of December for sure.

It wouldn't have anything much newer than that,

because the way publications work, the publication process, just so you can understand the timing therefore, is normally what happens is when we have a manuscript ready, we submit it to a journal. And then what will happen is an editor will be assigned, then they'll try and recruit reviewers. Once they've identified reviewers for it, that paper gets sent to the reviewers. So there's a review process.

Normally reviewer -- so that process -- that process right there often takes a week, and then the review process always takes a minimum of two weeks, depends on the journal. Some like report back in two weeks, some three weeks, and sometimes they don't get them back when requested from reviewers, and they have to solicit them and try to remind the reviewers to get it in.

But so the point is, ideally then, they're going to get those initial reports after one month from the initial submission, and almost always, it's very, very rare for a manuscript to be accepted immediately with no revisions. So almost always, if a manuscript is going to be accepted, it is with revisions, and then, depending on how much revision they feel is necessary, that's going to dictate the -- dictate the time the authors have to go back and revise their manuscript. So for example, if they had to generate new data or run

new experiments, it's going to be -- it could be months they're given.

But for an article like this though, it would usually be a matter of weeks, and then that revised version goes back, and then, often, their reviewers have one final review, and then if they're satisfied with the changes, they'll approve it, the manuscript will be accepted. And then, at that point, it's called what we call in press, and then a short time thereafter it will be published. So --

Q So, sorry, so just -- so the question then, it was released or -- in some capacity in 2021. It --

A Exactly.

Q -- was based on the information from 2020 --

A Exactly because --

Q -- so the --

A -- even though it was several months into 2021, the data that they would have had available when they first submitted it would have been for -- mainly from that duration you're talking about.

Q Sure. So in the latter stages of 2020, would we have had -- would you or the population or whatever have any idea that 10 percent wasn't the number that we were looking at in the middle of 2020?

A Yes, yes. Yeah, that was very quickly obvious. So, again, what I mentioned is it wasn't a prediction that

the infection fatality rate would be 1 to 10 percent; it was that initial like immediate concern that it could potentially be that. It wasn't like any kind of modelling was done. This was high profile public health officials, like Fauci, like Theresa Tam, expressing this potential concern, but we very quickly -- it didn't take much time before we knew, we really started to narrow down the high-risk demographics.

And so we knew very early on, again, that the highest risk demographics were the frail elderly, those who are immunosuppressed, those who are obese, and those who have multiple comorbidities. And for the rest of the people, we knew, so very earlier on, that the risk of fatality from infection from this particular virus was quite low, yes.

DR. ALDCORN: Thank you.

A No problem.

MR. KITCHEN: I'm going to ask for permission to ask a follow-up question.

THE CHAIR: Okay.

Mr. Kitchen Re-examines the Witness

MR. KITCHEN: And I'll give you the question, and then you can let me know if you're okay with it.

Q MR. KITCHEN: Dr. Bridle, what do you mean

by "very early", right? Because it came in March 2020. So the Pandemic Directive came out in May of 2020, so it's important that we know what you mean by what's "very early", that we knew it wasn't going to be as high as 1 percent.

MR. KITCHEN And, Chair, is that okay that he answers that?

THE CHAIR: Mr. Maxston, do you have any objection?

MR. MAXSTON: I don't object.

A Yeah, so that's a good question. It was prior to the implementation of the policies that we knew that, in the low-risk demographics, it wasn't going to be anywhere close to 1 percent infection fatality rate. So prior to May, right? The virus was first identified in late 2019. It was only -- it only took a couple of months to start identifying that this was -- so basically what we refer to this as is this is a virus -- we talk a lot about discrimination, you don't want discrimination -- but this is a virus that very much discriminates. And we knew that within a couple of months, meaning, a potentially, a very dangerous virus that would have a high infection fatality rate, would indiscriminately kill people.

This virus is very discriminatory. We knew within a couple of months of the -- when it was -- after the

virus was first identified. So by "very early", I mean like by January, by the end of January 2020, we already had a good idea that there was a limited number of demographics that were at particularly high risk from this virus.

THE CHAIR: I think we should leave it at that. We're talking in generalities now.

MR. KITCHEN: I'm going to ask for permission for one more question.

Q MR. KITCHEN: Because I want to -- I want you to be able to answer Dr. Aldcorn's question.

At what month in 2020 did scientists know that the IFR was going to be below 1 percent?

MR. MAXSTON: Mr. Kitchen, I'm going to have to -- I don't want to be difficult here, but that is a very vague question. When we say scientists knew, which scientists, when, how did they know? I think we've explored this a little bit, but I'm reluctant to let it go much further than that, because it's just a broad topic to begin that -- and, of course, in fairness to Dr. Bridle, he can't speak to what other people thought.

So I think my request to you is that you've explored this enough, and I think you shouldn't go any further, and I hope you're comfortable with that.

MR. KITCHEN: I'm going to ask Dr. Bridle --

Q MR. KITCHEN: -- when did you know?
A I was quite confident that -- about that by the end of January 2020.
MR. KITCHEN: And I'll leave it there. I think that was helpful for answering everybody's questions.
THE CHAIR: Okay, I think that brings today to a conclusion. We'll being back at 9:00 tomorrow morning. Mr. Kitchen, you can discharge your witness, and thank you very much, Dr. Bridle, for a very long and informative day.
A Thank you. Take care.
THE CHAIR: So we're back on at 9 with your witness tomorrow morning, Mr. Kitchen, that's correct?
MR. KITCHEN: That's right.
THE CHAIR: Okay. Very good, well, we will recess until tomorrow morning. Thanks everybody, and we'll see you then.

PROCEEDINGS ADJOURNED UNTIL 9:00 AM, JANUARY 29, 2022

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 21st day of February, 2022.

Karoline Schumann

Karoline Schumann, CSR(A)
Official Court Reporter

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

DISCIPLINARY HEARING

VOLUME 8

VIA VIDEOCONFERENCE

Edmonton, Alberta

January 29, 2022

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

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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

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: Well, good morning, everybody. We've got one witness I believe to examine today, Mr. Kitchen, and just before we do that, Mr. Maxston, anything to raise?

MR. MAXSTON: No, thank you for asking, but I should mention, Mr. Kitchen, you'll probably speak to this, but he has sent Mr. Lawrence and I his proposed qualification for his expert witness, and I don't think there will be an issue.

Mr. Kitchen, I would have responded to you, but I needed to run that by my client, and I just saw it this morning, so I'll let you know that in advance.

MR. KITCHEN: Thanks.

THE CHAIR: Okay, let's turn the floor over then to Mr. Kitchen, and you can bring your witness in, and I just remind everybody to mute yourself, please, and hopefully we'll have enough bandwidth today that we don't have any interruptions.

MR. KITCHEN: All right. So, Dr. Warren, I'll just do some introductions because we have so many people, and I don't know if you can see everybody on the screen. I've got mine on gallery view so I can see everybody.

The four Tribunal Members are Dr. Dianna Martens, Dr. Leslie Aldcorn, those are chiropractic members of

the Tribunal; and then Mr. Jim Lees and Mr. Doug Dawson are public members of the Tribunal. So there's four in total.

Walter Pavlic is the lawyer for the Tribunal, probably won't hear anything from him, but he's the one that advises the Tribunal, so if they caucus, he goes caucusing with them, and don't wonder at that.

Mr. Maxston is the lawyer for the -- what I will refer to as the prosecutor in this case. So we have the College, we have the Tribunal, those are separate. The College is bringing the action against Dr. Wall, and that's happening through the Complaints Director, that's David Lawrence. His lawyer is Blair Maxston, so he'll be the one that cross-examines you.

And then, of course, there's the Hearings Director, you won't see her, but that's Ms. Nelson.

And then have our court reporter, Karoline.

And then of course, Dr. Wall is here. You won't see him or hear him, but he's listening. And that's everybody.

So with that, Karoline, could you please swear him in.

THE CHAIR: Dr. Warren, just before Karoline swears you in, I'll just -- we tell this to everybody, Karoline is a court reporter. She's making a verbatim record of the proceedings, and so we would

ask that you try not to speak real quickly. I have no idea whether that's your speech pattern or not, but if you could just keep that in mind, please.

THE WITNESS: Sure.

THE COURT REPORTER: And please wait for Mr. Kitchen and Mr. Maxston to finish their entire question before you answer. Do not interrupt them. It's just makes the audio very difficult for me, so ...

DR. THOMAS WARREN, Sworn, Examined by Mr. Kitchen

(Qualification)

Q MR. KITCHEN: Dr. Warren, I just have a few questions for you about your background, and then I'm going to tender your qualification, and then we'll go from there, so I don't imagine that it'll take too long.

A Sure.

Q Dr. Warren, do you have a medical degree?

A I do.

Q And what have you done for residencies and fellowships?

A Sure. So I did four years of medical school at the University of Western Ontario, graduated in 2005. Then I did three years of residency at the University of Ottawa in internal medicine. And then I did two fellowships in infectious diseases and medical microbiology from 2008 to 2011. So I'm Royal College certified in three different specialties.

Q Thank you. This may come up in your questioning, but I'll ask it now, can you give us an idea, just briefly, of what infectious disease, what that speciality is?
A Sure. So I'm an infectious disease specialist and a medical microbiologist. People can be one or the other or both.

So as an infectious diseases specialist, I treat patients with infections, so diseases caused by viruses, bacteria, parasites, fungus. So about two-thirds of my practice is clinical work, taking care of patients with infections, mostly in the hospital but some outpatient work as well. And then about a third of my practice is more administrative-type work. So as a medical microbiologist for ten weeks, I manage the microbiology laboratory in the hospital that I work in.

I also am responsible for covering the infection control service at the hospital I'm at for about ten weeks a year.

And then my primary administrative responsibility is something called antimicrobial stewardship, and so that's really just monitoring antimicrobial, antibiotic use within the hospital, ensuring that it's appropriate and controlling its use and intervening when needed.
Q Excellent, thank you. Are you currently enrolled in a graduate program?
A Yes, I'm doing a Masters in science and epidemiology at

the London School of Hygiene & Tropical Medicine, which is part of the University of London, England, and I'm in my fourth year, so I should finish later this year.

Q Thank you. Do you teach in any capacity?

A Yeah, I have an adjunct appointment at McMaster University as an assistant clinical professor, and so in my ten years of full-time practice and my eight years of my appointment with McMaster, I've had all levels of learners from medical students, first-, second-, third-year medical students, all the way up to infectious diseases fellows.

Q Now, I know you mentioned you work at the hospital, but could you tell us in more detail what your current occupation is?

A Like as an infectious diseases specialist?

Q Yes, yeah, exactly, we want to know --

A So --

Q -- about just what that actually looks like.

A Okay. So I have hospital privileges at Halton Healthcare Services, which is a medium-size hospital just west of Toronto. It has three campuses, an Oakville campus, a Milton, and a Georgetown campus. And so I am oncall for 17 weeks a year for infectious diseases, which is 24/7 call, can be quite busy.

And then other than that, as I said, I have a fair amount of administrative responsibilities, which is

basically the rest of my time, apart from vacation and being oncall. And then I have a small outpatient practice, which would involve things like hepatitis C, latent tuberculosis, HIV management.

Q Thank you. Are you a member of the CPSO?

A I am.

Q Have you been an expert witness in legal proceedings before today?

A Yes, I have.

Q And have you prepared other expert opinion reports regarding SARS-CoV-2 and/or COVID-19?

A Yes. I prepared I think nine expert reports in five provinces for -- regarding COVID-19 for SARS-CoV-2.

Q Thank you.

MR. KITCHEN Those are all my questions. Mr. Maxston, did you want to ask any questions before I tender the qualification I want?

MR. MAXSTON: I don't think so, Mr. Kitchen. Thank you.

MR. KITCHEN: Chair, I want to qualify Dr. Thomas Warren as an expert in the areas of infectious diseases and medical microbiology, in particular, SARS-CoV-2, COVID-19, and the efficacy of masking, physical distancing, and other restrictions intended to prevent transmission of SARS-CoV-2.

MR. MAXSTON: Mr. Chair, as I mentioned

before, Mr. Kitchen provided this to me and my client in advance, and we're not going to object to it.

I will repeat our prior comments with respect to Dr. Wall's expert witnesses that we, again, don't believe this is a hearing about mask efficacy and social distancing, et cetera. We've placed that same qualifier for all of Dr. Wall's witnesses as we have before.

MR. KITCHEN: And I'll provide the same response: It's borderline nonsensical to say such a thing when the Complaints Director has submitted an expert on the very issue of masking from a scientific and medical perspective, and that was in response to Dr. Wall's experts. So I understand my friend wants to continue to fill the record with that, but I guess I'm going to have continue to fill the record with saying that I don't understand how it makes any sense to say so.

THE CHAIR: You're both on the record on that point, so I don't think we need --

MR. MAXSTON: And, Mr. Chair, I'm sorry, I just want to make one comment, I've said this before and I'll say it again, we called an expert because Dr. Wall was calling experts, and we didn't introduce Dr. Hu at our own initiative. It was to respond to what we understood would be expert testimony, so I just

wanted to be clear about that. We didn't introduce Dr. Hu for anything other than to rebut the expert witness testimony from Dr. Wall. We've covered this, but I wanted to mention that.

THE CHAIR: Let's get back on track and deal with Dr. Warren. I just had one question I would like to ask Dr. Warren.

The Chair Questions the Witness (Qualification)

Q THE CHAIR: Good morning, sir, thank you for joining us.

A Morning. Thank you.

Q I was just looking at your résumé and your cv, and I noted that peer-reviewed publications, the last one is noted as 2015. Have you shifted your focus away from research in the last few years?

A Yeah, usually most people in academia have either one of two streams: One is research-based or teaching-based. And so my appointment with McMaster is a teaching-based appointment.

THE CHAIR: Thank you for clarifying that.

Ruling (Qualification)

THE CHAIR: Okay, I don't know that there's a need for us to caucus to consider approving Dr. Warren as an expert witness in the fields noted. The College has no objection.

So, Mr. Kitchen, I'll ask you to continue with

your direct examination of Dr. Warren.

MR. KITCHEN: Thank you.

DR. THOMAS WARREN, Previously sworn, Examined by Mr. Kitchen

Q MR. KITCHEN: Dr. Warren, just going to start with a couple standard questions. Do you know Dr. Curtis Wall personally?

A No.

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

A No.

Q And do you understand your duty today to provide this Tribunal with your expert knowledge and opinions in an objective and neutral manner?

A Yes.

Q And then the last thing is this: Do you understand that if and when, in the likely event we're going to have a break, you and I are not permitted to speak until your testimony is done?

A Yes.

Q All right, well, I'm going to start with your report. In the second section of your report, and that starts on page 1, you identified three factors that are driving SARS-CoV-2 transmission and mortality and state that those factors are, quote, non-modifiable. Now, I'm going to ask you about the factors, but, first,

could you please explain what "non-modifiable" means?
A "Non-modifiable" means that they can't be changed. For instance, I speak about a person -- or a person's age, you can't change someone's age or you can't change the age structure of a population. So non-modifiable means it cannot be changed by some sort of intervention.
Q The first non-modifiable factor you discuss is the timing of peak virus transmission or wave of transmission. You say the timing is primarily affected by seasonal patterns. First, I want to ask you, since your report is almost a year old now and we're two years in experiencing this with SARS-CoV-2, has your opinion in this regard changed in any way since drafting this report?
A It only changed in that I'm more certain of it. In the last nine or ten months since I wrote my report, there's been even much more accumulating evidence to show that SARS-CoV-2 is similar to essentially every other respiratory -- important respiratory infection in humans, in that it follows a seasonal pattern. We can just even see that in our Canadian data that -- and I mentioned it in my report, but other Coronaviruses have their peaks in January, and across Canada, this January, 2022, we have another peak of SARS-CoV-2.
Q Now, I know you cited to a lot of literature in your report, of course, and you just said that there's even

more literature since, but can you give us an idea of what is that literature that supports your position? Just a -- I know you can't go into every study, but please give us an idea of what that literature is.

A Specifically about seasonal patterns?

Q Yes.

A Yeah, so I quoted, I don't know, probably about a dozen studies or so, yeah, at least seven or eight, that talked about or showed that SARS-CoV-2 follows a seasonal pattern, which was fairly early, because by the time I wrote the report, it had only been around for just over a year, I think 15 months.

And so similar to those studies, there have been more studies looking at the timing of SARS-CoV-2 in different jurisdictions. So some of the studies I quoted were country-specific, others were global. And those similar types of studies, because we have one more year of data have continued to accumulate and been published in the peer-reviewed literature.

Q These are peer-reviewed academic articles, is that a good way to describe them?

A Correct.

Q And can you explain how or why these seasonal or cyclical patterns are, in fact, non-modifiable?

A Well, the weather is non-modifiable, and so we know, for instance, with influenza, that it kind of usually

starts in the southern hemisphere and moves to the northern hemisphere. Maybe potentially the time of year or the exact time in the winter, the colder season, when the peak occurs might be different, might be December one year, might be January the next or February, but it's always kind of in the winter months in the northern hemisphere.

And so the climate and the temperature is not something that can be changed, and that affects multiple things. It affects how often people are inside. It affects transmissibility, because the relative humidity in the air affects water droplets, which is, you know, aerosol droplets is one of the -- the primary way that SARS-CoV-2 and many other respiratory viruses are transmitted. So those type of factors can't be changed, but we're going to have a winter in the northern hemisphere every year around the same time, you know, between November and March, and so we can expect a peak of respiratory viruses to occur in that time frame.

Q So the theory that lockdowns or restrictions work based on the theory of being able to modify that or being able to work notwithstanding that?

A The main -- well, the main purpose, I guess, of lockdowns would be to reduce the frequency of contacts and then, therefore, infection, with the goal, you

know, it's usually the stated purpose of not overwhelming health care capacity.

But in my second point, I talk about population density. And the number of infections in a geographical location is primarily going to be influenced by population density, and I give an example of New York. Like in the first wave, there was a huge number of infections in New York City, because it's so population-dense, and you can't change that. You can't take 8 million people in New York City and put them in upstate New York, distribute them along upstate New York. So you're still going to have 8 million people in a small number of burrows in New York City, and even though there's a lockdown, you still have large apartment buildings with people in very close quarters. So you're not modifying the population density, which is the most important factor.

Q So the idea behind restrictions is not that restrictions can change that factor but that restrictions can work notwithstanding the presence of that factor?

A That's the idea. The idea would be by having a lockdown restriction, you're reducing the number of people that you would come in contact with and, therefore, the number of potential infectious contacts or the statistical risk of someone being infected.

What I'm arguing in this and what I think some of what the literature clearly shows in the studies that I quoted is that it has a negligible effect in a place that is already population-dense.

And so you have a rural location, those people already are going to come into contact with much fewer people. Let's just say, you know, give a number of 8 or something per day, whereas you have a population-dense place like New York City, I'm just throwing it out there, but you have people on a random day coming into contact with 80 people, you know what I mean.

And lockdown is modifying that slightly, like you're taking in a rural location, 8 down to 5, and then New York City, 80 down to 60. You still have a very population-dense area. When you go out to buy groceries in New York City, you're passing by lots of people, and so you can't modify that population density. And that, as I showed in the studies I quoted, is a very important factor to predict the number of infections in the current wave.

The timing is going to be predicted by season. The number of infections is going to be predicted by population density, and the mortality is going to be predicted by the age structure.

Q So is part of the reason why we keep getting wave after

wave after wave because the cyclical pattern just can't be stopped even by intense interventions?

A Yeah, SARS-CoV-2 is now the fifth seasonal Coronavirus. There have been four prior to SARS-CoV-2, and now it's the fifth. And it will continue to cause infections and waves in a seasonal pattern just like the other four do.

And so just like we can't prevent influenza or other seasonal Coronaviruses, we can't prevent the waves on a population level, we're not going to be able to prevent SARS-CoV-2 waves. We haven't been able to in the past two years, and we won't be able to going forward.

Q So at this point in time, are any attempts, any human attempts to try to stop SARS-CoV-2 from continuing as the fifth Coronavirus, are they just futile?

A Yeah, to stop it circulating within the community like globally, yeah. Like trying to stop it, the whole notion of zero COVID makes no sense. It can be done for short periods of time in places like New Zealand, which can -- are literally in the middle of the ocean and can hibernate themselves from the rest of the world. But even there, you see places like Australia that were able to maintain that for periods of time, but now it's circulating in Australia like anywhere else in the world.

And so, yeah, it would be utterly futile to say that we tried to stop the circulation of SARS-CoV-2 right now, like on a global level within the community.

Q So even if an entire nation went into, you know, a complete, you know, locked in your house kind of lockdown for a year on end, it wouldn't matter, because as soon as you lifted that, Coronavirus would come in; is that what you're saying?

MR. MAXSTON: Mr. Kitchen, I'm sorry, I don't want to interrupt, but I got the sense on the last three or four questions that there's a lot of lead-in, and I don't want to cramp your style here, but I think there's a lot of lead-in on some of these questions. I wonder if you could consider maybe rephrasing them a little bit.

MR. KITCHEN: That's fine.

Q MR. KITCHEN: Dr. Warren, just give me a second; you've already answered so many of my questions.

So let's talk about the -- I mean, you've already touched on this, but let's talk about the third factor. And I think I understand this better now, you say the third non-modifiable factor is just how old people are. But the first question I have for you to help us understand is what is infection fatality ratio?

A Okay, let me just bring that up here on my report.

Q Yeah, it's on page -- end of page 2, it's the third portion of that section.
A So the infection fatality ratio, so that's the number of people with the infection that died or the percentage. It's a ratio, so it would be a percentage.
Q And do you have any idea roughly what that is right now with COVID?
A It's unchanged from what I say in my report. So in my report, I say that persons over 80, the IFR is approximately a thousand times greater than the IFR in those under 20, and so the age of a patient is by far the most predictive measure of the risk of mortality.
Q In your opinion, is the IFR of people above 80 more relevant than the overall IFR?
A Well, I think the IFR in any age group is going to be important, so if we look at -- if we compare the mortality risk in persons under 20, I think that helps shape policy for that age group, so that's school-age people. And we know and it's clear from the literature now, it was when I wrote my report, but it's much clearer now, that the actual risk of death from SARS-CoV-2 infection is lower for that age group, persons under 20, than for seasonal influenza.

And so when you're considering policy in that age group, that's important to look at. It's also important to look at what the IFR is in other age

groups as well, but it's important to be able to break that down. And so, likewise, when we look at the IFR in persons over 80, that helps us form a policy for that age group, whether it's care homes, nursing homes, retirement homes. It matters what the IFR is in other populations, but it's very helpful to break it down, because each age group and demographic is going to have different policy implications, because policy implications for a school should be very different than a policy implication for a nursing home.

Q We've heard in the proceedings so far that the IFR overall for all age groups for COVID is about 0.15 or less now, but what we've heard, at least at one point, it was 0.15. Do you have any reason to agree with that number?

A No, that's roughly accurate. I would say it's probably lower now, having gone through the Omicron wave. Omicron has been much less severe with regards to mortality. There are various factors regarding that, but, yeah, that number is roughly accurate. Again, it really depends. When you talk about an IFR in a sub-Saharan African country, which has a much lower population, it's going to be quite different.

So in statistics, we use age -- like there's a way of age-standardizing when you compare different countries, and that would always have to be done when

you compare or when you discuss these things, because if you calculate an IFR of the Canadian population, without age-standardizing it and then comparing it to another country like say Nigeria, which is much younger, you're comparing apples to oranges. And so there's clear statistical methods if you want to do that comparison.

And so generally, when you talk about an IFR overall globally, well, then you have kind of standard -- well, what's your standard population scale, and then you normalize it to that. So it's not an easy answer, but that's a roughly good ballpark number, but I would say it's maybe slightly lower now.

Q Okay. So if I'm understanding you, in sort of nonscientific language, the more old people you have in your society, the higher the IFR in that society?

A Yeah, absolutely. If you're calculating it just based on your country, yeah.

Q And it's lower in Nigeria because they have less old people?

A Yeah, the age structure is different. So the proportion of, say, persons in over 70 in a younger country, and that would often be countries in sub-Saharan Africa or different places in Asia, it's going to be different, yeah.

And people discussed this with regard to the

Omicron wave in South Africa, because the South African population is quite a bit younger, and so people rightly said, okay, well, we need to compare apples to apples here, rather than apples to oranges. And there are standard statistical ways of kind of doing that comparison. There -- and I won't get into that, but you can still do it.

Q So when I look at your report, you say 95 percent -- we're in Canada -- 95 percent of deaths are in persons over 60. So do I understand correctly then that 95 percent of what contributes to that overall IFR of 0.15 is from people over 60?

A That's right.

Q So if we took those people out of the equation, instead of 0.15, we'd have something that might look like 0.00000 et cetera; is that accurate?

A Yeah, it would be -- if you look at the IFR of only persons 60 and under, it's substantially less, yes, that's right.

And again -- and then -- you know, it's affected -- there are other factors, right? There are comorbidities, and, you know, the CDC had a good study just recently that was published that just -- that looked at both age but then comorbidities as well. The risk of death increases significantly when you go from zero to one comorbidity and then to two and then to

three.

So you have someone who is over 80 with, you know, two or three comorbidities, their risk of death is very high and substantially higher than -- orders of magnitude higher than someone, you know, much younger with no comorbidities. And, you know, statistically, it's closer to zero once you get below a certain age with no comorbidities; it's for all intents and purposes zero.

Q Okay. So the IFR differs dramatically over age groups then?

A Yes.

Q Now, and this has been a big issue in this hearing, the overall IFR, was it ever much higher than this 0.15 figure even in the beginning?

A Well, it's changed, so if you -- it can be tracked over time, and what you'll see is that, very early on, it was very high because the number of infections detected was much lower very early on because testing was limited, but quite soon after the first wave, the IFR came down significantly.

So if you look at the very beginning when people were (INDISCERNIBLE) in the spring of 2020, it was quite high, but over time -- I mean, you could -- there are graphs of this, but over time, the IFR has been going down and down and down, and actually, you know,

quite significantly dropped in the Omicron wave, because you have a whole bunch of infections but relatively fewer deaths, and so it's been going down over time.

Q That IFR rate early on, so let's say early 2020, is that a highly reliable figure?

A No, because it was -- in statistics, you know, we talk about things like bias, like so that would be selection bias. And so early on, it was only the most evident, so symptomatic, the sickest who were being tested, and so you had a selection bias early on.

But as with -- in most things in statistics, the larger sample size, the more accurate it's going to be. And so now that we've got, you know, hundreds of millions of cases worldwide that we can reliably make a much better estimate as to what the true IFR is.

Q Is it possible that, in early 2020, a very large number of people were infected, but nobody really knew about it?

A Yes. It's hard to know that for sure, because there are a number of different factors, one of which just being limitations of testing, particularly in different places in the world.

Even in our institution, I remember for the first few weeks at least, if not longer, like we had quite significant limitations on who we could test, who we

could only run a certain number of tests per day. But, yeah, there have been other studies that have been done subsequently to say and estimate at least how many other infections are there apart from the ones that we've actually picked up with positive testing, for instance.

The estimates varied from, again, the country and various separate testing procedures or protocols, or, you know, who can be tested, who not. Because even here in Ontario, we've changed who's going to be tested. Our Chief Medical Officer of Health says that -- now said, you know, if you have minor symptoms and, you know, are otherwise healthy and stuff, you don't necessarily have to be tested, you just assume you have COVID and stay home. So over time there has been changes to testing protocols and stuff, and so that's going to change how many people are actually detecting.

So certainly very early on, there would have been a fair number of people who had the infection but were not detected, because we know the asymptomatic rate is about 10 to 20 percent as well, I said that as well. So at least early on, unless they were close contacts and similarly infected, they probably weren't being tested.

Q Now, obviously any IFR is, I guess, concerning or

upsetting, because that ultimately means people die, but can you help us understand, give us a figure of what would be considered in the medical community as a dangerously high IFR?

A Well, you know, that's a bit of a tricky question, but like I think what we're seeing now, I think one of the important things to say with regards to the IFR of SARS-CoV-2 is that, overall, what we're seeing is that the IFR is approaching seasonal influenza, and seasonal influenza varies quite a bit from year-to-year, and some years are very bad, other years aren't.

And actually they're related, because what happens is if you have a bad flu year, because many elderly people, no matter what, are -- in the end, are going to die of a respiratory tract infection. Canada's greatest physician, William Osler, kind of referred to it as -- respiratory infections, at least overall, as the old man's friend. It was just kind of something that just took off the elderly. So whether it's bacterial pneumonia, influenza, Coronaviruses, the frail elderly and, you know, with heart disease or cancer or other things that have debilitated them, it's the heart disease or the cancer that's debilitated them, but the thing in the very end, the last few days, that they might actually die of, is going to be a respiratory tract infection. And so it's very common

in that age group.

And so influenza, we know that if you have a bad influenza year, the next year is often going to be light, and one of the reasons is that the previous severe season has, unfortunately, killed many of the most vulnerable, and so you've now removed a good proportion of the most vulnerable from the population, and so the next year, the flu, at least in that population may be -- the IFR at least may be relatively low. And so there's multiple different factors going on here.

But what we're seeing is that now, overall, the IFR of SARS-CoV-2 is approaching and very similar to seasonal influenza.

Q So when you say a bad year, so the IFR for influenza fluctuates then?

A Absolutely from year-to-year. So you -- and during pandemic years, the IFR is going to be very high. So if we're just talking about 1919 to 1920, like the 18 months from late '17 to, you know -- or late 2018 to 2-thousand -- or, sorry, 1918 to 1920, during the Spanish the flu, the IFR would be huge, but there are other years when influenza IFR is quite low. And so you can talk about it on a yearly basis or a strain basis, or we can talk about it over years or decades. And if we kind of generally talk about it over years

and decades, then the IFR of SARS-CoV-2 is now approaching the IFR of influenza.

But, yes, the estimated mortality of influenza year-to-year can change by two or three times in a season even in Canada. And, again, that's affected by multiple factors. One of the factors, as I said, is the previous year and the proportion of vulnerable people, but it's also going to be the natural mutation, the strains of influenza. We would call them strains. Now, you know, we call them for SARS-CoV-2, it's variants, but it's the exact same process. It's natural mutation of a respiratory virus.

Q Right, but you used the word "pandemic" in describing a bad influenza year. Are you aware of what number, what -- you know, the IFR we know for low influenza must be somewhere around 0.15, but what's the number, roughly, for a bad influenza year or a pandemic influenza year? What's the IFR rate? I mean, you know, it could be 50 percent, it could be 25 percent. You know, we don't know because we don't look at this on a daily basis, and so I -- you know, it would be very helpful to have some sort of number to work with.

A Yeah, I don't know the exact number for Spanish flu, but the most kind of reasonable estimates for the Spanish flu is that between 50 and 75 million people died, so we're talking an IFR in the global population

was not that high, so we're talking an IFR of at least 1 percent in that case, if not higher.

Q Okay, so 1 percent is high?

A Well, it would be -- you know, I think the global population at that point was about 2 billion, so we're talking an IFR probably at that time of about 2 percent. Yeah, and these are just rough estimates. I know that the most conservative estimates of the mortality was about 50 million, so that's an example.

Q So has the IFR of COVID ever exceeded the IFR of a bad flu year?

A Yeah, certainly early on. And with different variants and as it starts to circulate, it's -- it doesn't happen all the time, but the general way a virus circulates is that it attenuates as it goes through a population. So SARS-CoV-2 was a new virus in the human population, and there's some cross-protection from seasonal Coronaviruses, there's some cross-immunity, but because it's a new virus, early on, it's going to be more severe.

But what we've seen, especially with the Omicron variant, and what happens with many new virus infections within a population is that they attenuate over time, because it's to the evolutionary advantage of that virus to do that, because it infects more people.

Just like one of the reasons we don't see massive Ebola outbreaks is because it kills too many people too quickly, and so it just burns itself out.

So we saw that with the Spanish flu. The flu we have now is a descendant of that flu. And what happened is, over time, the virus itself attenuated itself, so as it just started passing through just millions of people, it became less severe. And one of the reasons for that is that -- a virus -- the evolutionary advantage for a virus is to find kind of that balance between causing some disease but not killing the people too quickly, and so we've seen that with SARS-CoV-2 as well.

It would be expected. It's not unexpected at all for a variant like Omicron to occur, because Omicron, for a variety of reasons, but one of the primary ones it that it has less severity, infects way more people, and that's expected.

Q Okay, you said early on -- I need you, if you can, to try and give me months and years -- so what would be -- you said, you know, it was severe early on, well, when was that, and when did that period end?

A Well, we know, looking at the variants that there was a variant, even -- I don't know if I referenced it in my report, but there was a variant even just within the first few weeks of the pandemic that quickly switched.

I can look up the name. It wasn't given a name like Alpha, Beta, or Delta and stuff. It was given a name based on the base pair change. It was 'D' something, something, changed to 'G' something, I think. It was where the mutation was. So as the variants changed, they're going to have different IFRs, and we've kind of seen that. It does seem as though Delta was a little more severe than, say, Alpha. But that change started very early on, within weeks, and then we started seeing things like Alpha and then Delta and now Omicron.

And so very early on, the IFR is going to be high, because the most -- again, various reasons, but the most susceptible are going to be dying, and then once you eliminate those -- the most frail and -- who have been infected from the population, you also have a less frail population, and so that's one reason. I don't want to oversimplify it here. One is inherent to the virus itself. There's a difference between Delta and Omicron, and so the IFR is going to change between the variants, but the population itself is going to change. And so if you have a complete naive population early in the pandemic, that's going to change once the first wave goes through, because, all of a sudden, the frailest population are no -- are, unfortunately, no longer in the population because they've died, and so you have a population change. And these are just two

factors.

It's complicated. I think one of the risks, at any point, is oversimplifying, but those are two very important factors.

Q Thank you. When did the first wave end roughly in Canada?

A Well, would have been the late spring of 2020, and I don't have the graphs ahead of me, but I certainly think by May absolutely.

Q At what point did the data indicate that the IFR was no longer severe or high or whatever word you want to use? You used the word "severe"; at what point did the data indicate that the IFR was no longer severe?

A Well, it was within a couple months as we gathered more data. By the end of the first wave, the idea of the dramatic difference in mortality between the young and the old was evident, and by the end of that first wave, you know, within the first kind of three months, we had a rough estimate at that point of what the IFR would be, and then since then, it's been just trending down. Again, as more and more people get infected, and, unfortunately, the -- you know, the oldest, the frailest have already died, the IFR has been trending down.

Q Would you say the official definition of a pandemic is objective or subjective?

A Well, I think any definition, you know, you can get pedantic about it, but SARS-CoV-2 is clearly a pandemic. Some people define it as, you know, affecting multiple continents. Some people will argue the first pandemic was the Antonine plague in the '160s because it occurred in Africa, Europe, and Asia. And, at least based on the records we have, we don't know of any other infection before then that occurred on three different continents. So it depends on how you define your terms, but I think it's clear that SARS-CoV-2 is a pandemic; there's no doubt about it.

Q Is it pandemic because it's "pan" because it's global?

A Well, yeah. It comes from -- you know, "pandemic" just comes from the Latin root of "pan", which is all, and "demus", which is people, and so it's all people. We've seen that. Like it's even on Antarctica. I think this is the first pandemic in history that's been on all seven continents.

Q Is there no severability criteria for determining something is or is not a pandemic?

A Yeah, you know, I think for something like seasonal influenza, you have global infections every year, you have waves every year, and so you would talk about severity, so we would have a pandemic when -- in the scientific literature about influenza, we talk about antigenic drifts, which is the small changes that occur

year to year, and then antigenic shifts, which is the major changes.

And, generally, when there's an antigenic shift, we have a pandemic because we have a significant change in the virus, which then you have a large proportion of the population which don't have good cross-reactive immunity. And so whether it's swine flu in 2009 or previous pandemics in the 20th century, like 1968 and there's been others, but at least in influenza, yeah, it's not occurring on -- everywhere in the world, because that occurs every year, but it's a major change that increases the symptomatic infectivity, so morbidity as well as mortality.

Q So some years, influenza is severe enough to be pandemic and other years, it's not; do I have that right?

A Correct, yeah.

Q So you said that COVID was severe enough in the beginning to be, you know, at least as bad as a pandemic influenza, but is it now at the point of seasonal influenza? Is that a proper way to characterize it?

A Yeah, once it becomes endemic, that's a good question. Again, some of the definitions are going to be arbitrary. You'll talk to some experts now who will say, oh, COVID's already endemic, others will say no.

You know, a lot of people will say, okay, with Omicron, that's what we're seeing now, it's endemic, we have so many people infected. And others will say, well, no, we can't call it endemic.

There's essentially uniform agreement that it will be endemic, it's just kind of defining where that's going to be is somewhat arbitrary. But, yes, SARS-CoV-2 will be endemic, and whether you want to say that that's now or whether it's going to be three, six months from now, it's I think relatively arbitrary how you say it. It was pandemic; it's going to be endemic. Where you define that cutoff, I don't think it's easy to kind of say one particular --

How I would define is that we start seeing a different respiratory virus predominantly, because we haven't seen massive waves of influenza, and that's not unusual. So like in the hospital, we see different respiratory viruses at different times, and so we have a usual wave of influenza, say, in January, it's after influenza leaves that we're going to see some of the other important respiratory viruses in the waves of, say, parainfluenza or human metapneumovirus.

And how I would define the endemic state of SARS-CoV-2 is once we start seeing the return of waves of other important respiratory viruses, maybe it's in the spring with human metapneumovirus, I don't know,

but once that occurs, when we're having more cases of a different respiratory virus, I think we can safely -- to me, that's an objective criteria of how to kind of define the endemicity of SARS-CoV-2.

Q At what point in time did you become confident that SARS-CoV-2 was going to be endemic?

A Once you have community transmission on every continent, yeah. So it would have been within weeks of the pandemic.

Q Okay, but just to clarify then, that would place you in January 2020?

A No, no. Like early April 2020.

Q Okay, so just to clarify, by early April 2020, you looked at the data and thought this is going to be endemic?

A Yeah, absolutely.

Q So at that point, attempts to completely stop the virus are futile?

A Yeah, absolutely.

Q At that point, were attempts to slow it down theoretically possible to work?

A No. I think each different thing can be judged based on the evidence, and that's what I do in my report. I think most interventions had little or no effect, and the evidence is bearing that out. We know that from previous similar infections and -- but each different

intervention would have to be judged on its own merits, so whether it's masking or lockdown, kind of shelter-in-place, or, you know, testing in isolation, each of those factors can be judged on its different merits. But I think what we've clearly seen is that the interventions put in place have not had a significant effect.

Q And you do realize that many people say that they have had a positive effect?

A Yeah.

Q And you disagree with them; is --

A I do.

Q -- that fair to say?

A Yeah.

Q And now, generally speaking, correct me if I'm wrong, but at least in Canada, aren't the vast majority, if not all, you know, public health agencies and government bodies and medical officers of health saying that, look, these measures did work over the last two years; isn't that right?

A Yeah, there's lots of people claiming that, but it can be debated endlessly as to what actual effect they did or did not have.

Q Well, at least for you personally, is there a debate happening?

A Yeah, there's actually really starting to be a debate

both in society generally but in the academic literature as to what effect these different measures had or didn't have, and again each one needs to be judged based on the merits of each different intervention.

But, yeah, both in the general public, I think, globally, we're seeing an openness to debating and seeing what the actual risk and downsides have been to each individual intervention, but we're seeing that in the academic literature as well.

Q In your experience, have the public health agencies and medical officers of health in Canada been open to having that debate.

A You know, I think most of the public health agencies in Canada have had similar strategies and have not kind of differed too much from themselves. I think if you look at somewhere like Europe or the United States, which have similar numbers of jurisdictions, a few dozen jurisdictions in each of them and there's been wide differences, and so looking at different states and comparing them and looking at different countries in Europe and comparing them can be helpful. But, again, that has to be done carefully, because, as I mentioned in my report, just doing that is the lowest level of evidence, and it kind of commits the ecological fallacy in statistics.

But, anyway, I do see quite a change in, you know -- for instance, right now, a big debate, you're seeing it in all sorts of media, whether it's the New York Times or The Atlantic but also in the academic literature just this week about, you know, masking school age children. Like the New York Times and The Atlantic, you know, having articles this week, it's just been in the last few days, saying, yeah, the evidence just isn't there, you know, we don't need to be masking young school age children in schools. And we're seeing these kind of studies come out in the medical, the academic literature as well.

And I think what happened in the past is that, in the absence of a lot of that evidence, assumptions were made, and we -- you know, the term for that is called medical reversal, and it's very difficult, once assumptions are made, to reverse kind of course, and so you're gathering a lot more information now and seeing both the risks and benefits of various different interventions.

Q You just talked about how, once assumptions are in place, they're very difficult to reverse or change; does that help to explain why the public health agencies in Canada sort of refused to listen to experts like you and cease the restrictions?

A Yeah, you know, there are many different reasons for

why things occurred, yeah. You know, that's a whole other topic, why one group was listened to and one not. But that evidence is accumulating now, and so that's why you're seeing a lot of jurisdictions treat this very differently. Once that evidence is becoming more and more clear, more and more robust, you're seeing a lot less restrictions.

Q Those assumptions you mentioned, are they, for the most part, false or wrong or inaccurate?

A Well, again, it really depends on what you're talking about I think. If you talk about, say, again masking children, there's next to no studies in that. We can talk about studies in masking adults. The masking of healthy children, there was just no studies prior to the pandemic, but the assumption is, well, masks are good for health care workers in high-risk settings, they must be good for children.

And as evidence accumulates, there should have been more. There -- no randomized control trials of children were done in the pandemic when they should have been, they should have done cluster-randomized trials of different schools and classrooms, just like they did the cluster-randomized trial in Bangladesh, and then we could have quantitated. But the assumption was made, oh, they must be good, so we're going to do it, but then as the evidence accumulates, we learn more

that there is no benefit, and so we shouldn't be doing it.

In fact, there's lots of harms with regards, particularly, with emotional and cognitive learning in children if you mask both the children and the teachers.

Q Now, I'm going to ask you a little bit about one of those assumptions, and that's asymptomatic transmission. So this is on page 3 of your report, the third section. You say in your report that the rates of transmission from asymptomatic persons is substantially less than from symptomatic persons. So the first question I have for you, of course, is has the data or your opinion changed on that in the last year?

A No, it has not changed.

Q Now, what do you mean by "substantially less"? Give us an idea of how much less asymptomatic transmission is than symptomatic.

A Well, I note a number of studies, but I think the most important one would be study 53, because it's a meta-analysis of household transmission, and household transmission is, by far, the most important location of transmission. So some estimates are as high as 80 percent of all transmission occurs within the household, and that makes sense, this is where people

are in intimate contact with each other. So this study I think is very helpful and very reliable.

So it's looking at household transmission, which is the most important factor or place where transmission occurs. It had a large number of participants, close to 80,000, and the difference between -- and it can be controlled. Like a household is kind of like a unit, and so, again, I think this was a very good study and very representative of the literature and reliable, and it showed that the difference between symptomatic transmission and asymptomatic transmission was about 25 times. And so I think that would be where I would -- you know, get that word "substantial".

Q Thank you.

THE CHAIR: Mr. Kitchen --

MR. KITCHEN Yes.

THE CHAIR: -- I just wonder, is there a point, a logical point in your approach where we could take a short break?

MR. KITCHEN: Yes, I was planning to after I finished asymptomatic transmission, and I don't think I'm going to be on that very much longer --

THE CHAIR: Okay, thank you.

MR. KITCHEN -- so just a couple more minutes.

Q MR. KITCHEN: Dr. Warren, you further say that asymptomatic transmission does not warrant being considered a significant contributor to the overall transmission burden. Now, maybe that's obvious based on what you just said, but can you just explain why that's your opinion?

A So it can be -- my opinion can be considered in a number of domains. The first is just the number itself. So if we're talking about something that's 25 times less important, I think that's one domain. The other domain, you know, relates to the point we've already discussed, which is the fact that the virus is going to be around forever, and kind of related to that is the idea of treating an asymptomatic person as diseased. I think that has huge, kind of moral, philosophical, whatever implications. And so you have something that's going to be around forever, you can't treat the entire population, you know asymptomatic, as potentially infected with regards -- just on a moral -- in my opinion, of course, but on a philosophical level, you can't -- it's dangerous I think, societally, to be treating everybody who otherwise looks healthy as a potential germ carrier for an infection that's widely prevalent and going to be around forever.

Q But is it, nonetheless, scientifically accurate?

A What's scientifically accurate?

Q That there are a large number of asymptomatic healthy people going around that, you know, are harbouring something that can make people really sick, and they're likely to transmit it even though they're healthy?
A Well, I think it's just best to use numbers like I use in my report. Like I think the best evidence that we have is that asymptomatic transmission is 25 times less than symptomatic transmission, and to me, that -- you know, that's -- statistically that's a relatively large number. I'm happy to call that substantially different.
Q So it's not a good assumption that -- that most healthy people could transmit this thing?
A No, I don't think it's justified, based on the evidence, that we should be treating every healthy asymptomatic person as a potential -- potentially infected with SARS-CoV-2. You know, I think -- again, everything to be qualified, if you're talking about someone who is in very close contact, you know, of course. And so, of course, there's going to be exceptions to the rule, but it just proves the rule. But I think, generally, at a population level, I don't think the evidence warrants treating everybody in the population who is asymptomatic as a potential transmission risk for SARS-CoV-2.
Q Now, I'm going to come to masking after the break, but

just help me out, isn't that the assumption behind mandatory masking of all healthy people? Like (INDISCERNIBLE) --

A That's -- yeah, that's certainly one of the assumptions for masking the healthy general public, absolutely.

Q Almost done before we break. Now, as you know, Dr. Hu on page 6 of his report says your opinion regarding asymptomatic transmission is, quote, contradicted by a CDC report which says that 60 percent of COVID transmission is asymptomatic. Now, Dr. Hu does not provide the citation for this report, but are you aware of what report he is referring to?

A No, I'm not aware.

Q Do you find that strange that he didn't cite to the report?

A Well, I can't comment specifically on that, but generally if you're going to cite a number or a statistic or discuss a number or statistic in either the academic literature or a formal document such as this, you would provide a reference, like I did with all of mine.

Q Well, do you think the -- I guess you've already answered this, but, just to clarify, do you think the balance of the scientific literature that is available supports your opinion that symptomatic transmission is way more prevalent than asymptomatic?

A Yes, that's what I state in my report, and I don't -- my opinion has not changed, that symptomatic transmission is substantially more important than asymptomatic transmission.

MR. KITCHEN: So that's it for me for the -- you know, we can break now, and then I'll have some more when we come back. I'm, you know, probably halfway through, maybe a little less, but close to halfway through.

THE CHAIR: Okay. Thank you, Mr. Kitchen. And, Dr. Warren, we're going to take a 15-minute break, and you can put your connection -- you can mute and turn your camera off during this period, but please don't break the connection to the meeting and don't speak with Mr. Kitchen, and we will see everybody in 15 minutes. 25 to 11 I think.

(ADJOURNMENT)

THE CHAIR: Mr. Kitchen, the floor is yours once again; we'll resume your direct examination of Dr. Warren.

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Dr. Warren, from pages 3 to 5 of your report, you discuss the evidence for lockdown measures, generally speaking, including physical distancing. Prior to the year 2020, was there much scientific evidence or academic literature in support

of the effectiveness of physical distancing?

A No, there was essentially none, and that -- I think I gave a quote in -- yeah, there's a systematic review published in -- it was a Cochrane systematic review, and towards the end of page 4, I quote: (as read)

> There was only one randomized controlled trial of quarantine and no trials of screening and (INDISCERNIBLE) or for physical distancing.

So the highest level of evidence, as I discussed in other parts of my report, are randomized controlled trials or meta-analysis of randomized controlled trials, and there was just none of that evidence with regards to various lockdown measures prior to the pandemic.

I can discuss that one randomized trial that they discuss there, but -- in a quote. There was a randomized controlled trial in influenza in Japanese persons. What they basically randomized Japanese workers to is that home quarantine while they were symptomatic or not. And what it found is it had no significant difference on overall rates of influenza.

So what happened is these Japanese workers, who were quarantined at home, did -- their offices, their co-workers had lower rates of influenza, but it was counter-balanced by higher rates of influenza within

these quarantine workers' families. And so in the end, it made no overall difference, because it just shifted the number of infections from one place to the other.

And there are some interesting papers out there to suggest the same thing happened in COVID-19, because the household is already the highest -- or the most likely case -- a place of transmission, when you have a whole bunch of people sheltering in place, either you're just transferring infections from one place to the other, or, in fact, there's some people that would argue that infections may have been increased because of that.

Particularly in congregate settings, because you're -- places like nursing homes, group homes, other places where people are living but within close proximity to others that we have these shelter-in-place restrictions, it may actually increase the numbers of infection.

But, again, the evidence there isn't clear. There's lots of people kind of debating that, but prior to COVID-19, there was essentially no evidence for the positive effect of various different lockdown measures, including physical distancing, isolation -- or, you know, sheltering in place.

Q So is it basically there was a hypothesis that this could work, and then that hypothesis was implemented;

is that sort of what happened back in the -- you know, early 2020 in Canada?

A Yeah, there are a lot of different things going on here, I'm happy to talk about that, but, number one, a lot of the decisions were based on modelling. And as part of my Masters, I've done some modelling courses.

And one of the key metrics in modelling is this factor called Beta, which is just the average number of interactions a person in the model is going to have with other people. And by changing that one number in modelling, at least, you can change the size of waves or the number of infections and things like that.

So because a lot of decisions were based on modelling, and that one factor is so important in the modelling, the idea was if we can decrease the number of interactions people have with other people, then we're going to greatly decrease the number of infections. Again, I think there's various problems with that: Number one, the idea that most transmission occurs in households and kind of really isn't considered in that; number two, as I talked about in population density, in very population-dense areas, even sheltering at home, you're actually not reducing the number of -- significantly reducing the number of people, other people you are going to interact with, because you're still going out to walk your dog, you're

still going to the grocery store. You know, if I'm in downtown Toronto, and I'm walking two blocks to the nearest grocery store, I'm interacting with a lot of -- I'm going by a lot of people, and -- anyway. So that's one thing number one.

Then the other issue is that policies were going -- at least early on, very early on, were going to be heavily influenced by what happened with SARS-CoV-1. And what happened with that infection is that various different quarantine -- there were no lockdowns, but that infection was able to be controlled with various public health measures, mostly just the usual stuff: Sick patients are kind of quarantined to learn better; testing and tracing, so testing and tracing all of their contacts. But that infection, didn't last long, occurred -- recurred briefly in various places like Singapore and different cities in China and stuff.

But I think early on, because it wasn't that long ago, it was I think only 16 years previous, a lot of the policy was heavily influenced from that, and pandemics have a deep kind of social history, right? Like when you talk about things like the Black Death, in a lot of places in Europe, you know 50 percent of the population died from that pandemic and from plague, and there have been many others and stuff as well.

So deep within the societal consciousness, you know, there's fear of major infections. And in some cases, in different infections historically, lockdown or lockdown-like measures have worked, and you think of things like smallpox and quarantine. So you had, you know, a boat with -- you know, you think of 1720s Boston, and there's evidence, you know, of this, you have a -- and there's no smallpox in Boston, but you have a boat coming in over from England where there's people with smallpox on it, well, that boat is quarantined, it's locked down in the harbour for several weeks until there's no more transmission of smallpox. And I can give many other examples from history.

And so it's a complicated issue with regards to lockdown, quarantine, things like that, so I think those are kind of the three main ones that I just addressed.

Q Thank you. I mean, I guess you've touched on this, but just to be specific, has the evidence, you know, over the last two years substantiated the theory that physical distancing is effective?

A No, but, again, it's a hotly debated topic because we don't have the best evidence. The best evidence is randomized controlled trials, and those trials could have been done. And, in fact, in small instances, they

have.

So most of the evidence, what we're doing is ecological studies, so comparing one jurisdiction to the other. And as I mentioned with regards to masks, there's all sorts of statistical problems with that.

And, you know, debating various different lockdown measures kind of with the type of evidence we have is a whole other discussion, but the best evidence, randomized controlled trials, which should be done for everything, we just don't have that evidence.

But I give an example of one that was done, and it's something that should have been done more, so in Massachusetts, they did a randomized controlled trial of school children of 3-feet distancing versus 6-feet distancing, and there was no difference. Okay, so it was a cluster-randomized trial, much like the Bangladeshi mask study, so you randomized classrooms versus -- rather than people. That's the standard way of doing this type of intervention. And they showed that there's no difference between 3 feet and 6 feet.

And so that study kind of proved the point that that type of study can be done and should have been done everywhere throughout the pandemic, looking at a variety of different interventions. And when that type of study is done, what it will show, and what it showed prior to, as I talked about with that Japanese worker

study in influenza, which I think was 2010 or so, somewhere around there, when those types of studies are done prior to COVID and the very few that have been done during, they don't show much of an effect of these different lockdown-type procedures.

Q Thank you. Now, I want to ask you some questions about masks. On page 5 of your report, your section on the evidence regarding masks, you refer to, quote, healthy people, and I think we've touched on this, but just to be clear, for you is asymptomatic the same as healthy?

A Well, asymptomatic, I think you're -- yes, I guess. Again, it's depends on how you define your terms. If we're talking asymptomatic with regards to SARS-CoV-2, they could be unhealthy otherwise. They could have heart failure and diabetes and advanced-stage cancer; I wouldn't call them healthy, but they're asymptomatic with regards to respiratory symptoms.

Q So healthy in regards to not having cold flu symptoms?

A Right, yeah.

Q Okay. Is a mandate that all chiropractors wear a mask at all times in their office, is that effectively a mandate that all asymptomatic chiropractors wear a mask at all times in their office?

MR. MAXSTON: I'm going to have to object to that, Mr. Kitchen. I think that's a pretty central question for the Hearing Tribunal to decide.

MR. KITCHEN: Well, you're going to have to explain that.
MR. MAXSTON: Well, we can't ask this witness to comment on the College's mandate and its broader implications of it. I think your question is a little too broad, Mr. Kitchen.
MR. KITCHEN: Well, I'll rephrase it again, just -- not rephrase it, but say it again, because I'm struggling with that. I'm asking him is it logically accurate that a mandate that all chiropractors wear masks at all times in their office is a mandate that all asymptomatic chiropractors wear a mask at all times in their office? I'm asking if those two things are logically equitable. That's got nothing to do with any determination that the Tribunal has to make.
MR. MAXSTON: I guess you can take this witness to the Pandemic Directive, Mr. Kitchen, and you could ask him to comment on that, but I'm not sure I agree with you. I think that that's a broader question that goes to I think one of the conclusions the Tribunal is going to have to make based on the issues you are raising.
MR. KITCHEN: That being --
THE CHAIR: Mr. Kitchen, the first part of your question is all chiropractors, right?
MR. KITCHEN: Right. And I, you know -- I

thought this was not contentious. Maybe my friend can tell me. I mean, as far as I know, there's no disagreement here that the Pandemic Directive says that all chiropractors must wear a mask at all times while in their office.

Do you take issue with my characterization, Mr. Maxston?

MR. MAXSTON: The Pandemic Directive says what it says in terms of chiropractors having to wear masks when they treat patients. But I think, in fairness, you'd have to take this witness to the actual wording in the Pandemic Directive and ask him what his interpretation of it is, and I might have some objections I suppose to that. But I think your question, as it's framed, I just think is too general --

MR. KITCHEN Okay.

MR. MAXSTON: -- or relates to one of the issues this Tribunal's going to have to decide on.

I don't have a problem with you asking questions about masking and asymptomatic patients, you know, that's not -- I'm not going to object to that, of course.

MR. KITCHEN: Well, do you have any objections to me reading to him what the directive says in that portion?

MR. MAXSTON: I don't think I would. I think I would have objections to you asking him about the -- I want to say it, how that applies in the chiropractic office vis-à-vis a chiropractor and patients.

MR. KITCHEN: Well, at least for this question, I'm not asking.

MR. MAXSTON: Yeah. Well, as I said, I think it's probably better to take him to the Pandemic Directive if you want to ask questions about the meaning and intent of the Pandemic Directive. That's all I'm saying here is it just seems to me that this is a little bit of a bigger picture issue that the Tribunal's going to have to decide on.

THE CHAIR: Would it be possible to put that directive up on the screen?

MR. KITCHEN: I don't know if Ms. Nelson can do that quickly. The only reason I don't want to -- I'm just trying to save time.

MR. MAXSTON: And, Mr. Kitchen, you know, it says what it says --

MR. KITCHEN Yeah.

MR. MAXSTON: -- I'm not -- if you want to ask your client about whether he thinks that directive is, you know, scientifically supported, you've been doing that already, I suppose, indirectly; I'm just a

little concerned about saying -- you know, asking him to draw a conclusion about this specific directive in the context of, I guess, the charges that are in front of the Tribunal.

MR. KITCHEN: Well, let me ask a series of open-ended questions, and maybe we can resolve this.

Q MR. KITCHEN: Dr. Warren -- my friend can intervene if he thinks this is a problem -- but there are approximately 1150 regulated chiropractors in Alberta. That's somewhere in the record; I don't think that's contentious. Is it possible that -- well, is it possible that all of them are going to be symptomatic at exactly the same time?

A I don't totally understand the question, but obviously not; I don't think there would be 1100 people symptomatic at the same time.

Q And I can tell you this because it's in the record, I don't think it's contentious, chiropractors are not actually in the directive. I can't say precisely right now. Certainly in the relevant time period here which we're talking about, which is about May 2020 to December 2020, chiropractors weren't, in fact, allowed to be in their office if they were symptomatic, okay? So if there's a requirement -- and I'll read it to you if I have to, but, again, I don't think I'm mischaracterizing it -- if there's a requirement that

chiropractors wear a mask while in their office treating patients, and that requirement is static or universal, is that not a requirement that asymptomatic chiropractors wear a mask at all times in their office when they're treating their patients?

A So from what I understand from the question, I'm not again entirely sure, but it sounds like the directive says that chiropractors may not practice or be in their office if they're asymptomatic [sic], and presumably that's the same for their patients as well with regards to COVID symptoms; and so I think the question then is if they're not allowed to be in their office or practicing -- seeing patients, if they're symptomatic, then, by definition, they're wearing a mask as asymptomatic persons while performing the chiropractic. Is that correct? And so that's what you're asking?

Q That's what I'm asking, yes.

A Yes, okay.

Q I'm going to ask you a few questions about health care settings and non-health care settings, but let's first talk about non-health care settings. You say in your report that when limited to the strongest types of evidence, RCTs as we've discussed, there is no evidence in support of healthy or asymptomatic people wearing masks in non-health care settings. You've already explained all that.

Just to clarify, because I know that, you know, this is an issue with Dr. Hu, there are multiple peer-reviewed publications that support your position on that?

A Yes, so as I state in my report, pages -- and page 5 primarily, so prior to COVID, there was studies of randomized controlled trials of masking asymptomatic persons. Most of the studies were relatively small. Some showed marginal benefit, others didn't. And when those -- when randomized controlled trials are put together and all of the evidence and all of the patients are compared in one big group, it's called meta-analysis. And there's three meta-analyses, all of them done just prior to COVID, in fact, one of them, the Cochrane review, done during COVID but was only including studies done prior to COVID that showed there was no difference.

And so that's what happens, when you have randomized -- and the randomized controlled trials looking at masking healthy people primarily to prevent influenza were relatively small, and they're contradictory. Some would say, yeah, there's some marginal benefit, others no.

And so the standard way of kind of deciding the issue is a meta-analysis. And three meta-analyses said that the bottom line is that there is no evidence of

masking healthy persons in the community to prevent respiratory tract infection, and that was primarily influenza, but not -- see, that's tricky, it was primarily influenza, but it was influenza-like illness, ILI, which is a very standard, more or less symptomatic definition than a laboratory based definition, because never in history have we done such extensive testing on a respiratory virus than we've done on SARS-CoV-2, COVID-19.

Q Now, to your knowledge, have there been RCTs done since writing your report, you know, on masking in the context of COVID?

A Yeah, so in my report, I mention one randomized controlled trial done early in Denmark --

Q Yeah.

A -- with regards to masking, and it showed no significant difference. And since then, there has -- there's been two performed, one of -- so one was in Africa, I forget the exact country, that has -- even the preliminary results haven't been published, but it just finished I think in November, Guinea-Bissau I think is where it -- anyway, I don't want to say for sure -- but it was a -- I think a large cluster-randomized trial as well.

But there was a large study that's been discussed in the media for the last few months, done in

Bangladesh. It was a cluster-randomized trial of over 300,000 persons in Bangladesh. And so what they did is they randomized villages to wearing masks or not, rather than persons, but the number of -- total number of people was over 300,000.

It's interesting that study was finished last summer and published on the study investigator's website I think at least September 1st, but it hasn't, as far as I'm aware, even appeared in a preprint form, much less peer-reviewed literature, but it's widely discussed in the media, and there are certainly some conclusions that can be taken from the data that's available.

Q And what would those conclusions be?

A So the bottom-line conclusions were that -- so they cluster-randomized some villages to cloth masks and some villages to medical masks, and the overall benefit, if you include both those groups, was very small. So the absolute risk reduction -- I can just bring it up here -- the absolute risk reduction was from .76 percent down to .69 percent, so a 0.7 percent reduction. That's the absolute risk reduction.

So what that says is that -- and so there's some important features to consider when we're talking about this study. One of the most important things is what was the primary end point. So the primary end point

was not death, was not hospitalization -- at least in the initial report, they don't even mention that -- the primary end point was serologically confirmed symptoms, so people who had symptoms of COVID and then had a serology test indicating that they had the infection. Okay, so it's really produced -- it's really a study of where the end point is infection, okay?

And in the control group, no masks. The rate of infection was .76 percent, and in the treatment group, overall, it was .69. So relatively low rates of infection in both, but then we can compare them. So that's important.

But then when they broke that down into the treatment, and they broke it down into cloth masks versus medical masks, the cloth masks actually had no effect, no benefit whatsoever statistically. And then when they look at surgical masks only compared to control, which is no masks; in controls, again, it was .76 percent, in surgical mask villages, it was .67 percent. So for an absolute risk reduction of .9 percent.

And in randomized controlled trials, the absolute risk reduction is a very important number, because when we take the inverse of it, so we just 1 divided by the absolute risk reduction, we get what's called the number needed to treat; so if we did the same thing in

the study that they did, how many people would we need to treat without intervention to get one effect.

So if we take .09 percent and do the inverse of it, it's approximately 1100, just over 1100. And so what you need to do is take 0.009 and then take the inverse. So 1 divided by 0.009, you get 1100, okay? And so what that said -- and the study went on for eight weeks; you can find that in the "Methods".

So what that tells us is we need to -- in a general healthy population, we need to have 1100 people wear a mask for eight weeks to prevent one infection, not one death, not one hospitalization, but one infection. So 1100 people wearing a mask for eight weeks to prevent one infection, and that's a remarkably high number. Like if there's any sort of intervention that we're studying in cardiology or infectious diseases or, you know, in my -- like with antibiotics and bacteria or, you know, cardiology, that number is remarkably high. Generally something over -- between 50 to 100 is high, but anything over that -- like anything under 50 would be kind of low.

And it's not a hard outcome. It's always important to say what's the outcome. And maybe it is worth masking 1100 people for eight weeks to prevent one death, but it's not; it's masking 1100 for eight weeks to prevent one infection.

So that's the best evidence we have in SARS-CoV-2

Q Thank you. Now, on this vein, Dr. Hu compared conducting RCTs on masking in the context of COVID and health care workers to conducting RCTs on parachutes in the context of people jumping out of airplanes. You're aware of that, right?

A Yeah, I read that.

Q What's the likelihood that a person who jumps out of a plane without a parachute will live?

A Presumably zero.

Q What's the likelihood that a person who contracts COVID will live?

A Depends on the age group, but, overall, in all persons, it's probably over 99 percent.

Q Is it reasonable to compare the strength of evidence in support of the effectiveness of parachutes to the strength of the evidence in support of the effectiveness of masks?

A No, not at all. This is how we answer questions in medicine; we do randomized controlled trials, and those randomized controlled trials have been done with masks and health care workers in lots of other contexts, including other important infections like influenza.

Yeah, there have been randomized controlled trials looking at is a cloth mask similar to a medical mask in health care workers in influenza, and it showed cloth

masks -- and just that study too, I don't know, it was done 10, 15 years ago, showed cloth masks are -- yeah, cloth masks were useless for health care workers. The medical mask was better for the health care worker taking care of a patient with influenza.

We've looked at masks in a lot of surgical contexts. So there's lots of places in the hospital, especially -- like prior to COVID, there's a lot of places in the hospital, a lot of contexts, where masks were not indicated, and it was studied. Yeah, I think a lot of surgical indications, they've tried to prevent surgical site infections with wearing masks, and there was no benefit.

We've looked at a lot of -- some pretty good studies published in the New England Journal and JAMA I think, again prior to COVID, in the context of influenza or influenza-like illness, comparing N95s to surgical masks for health care workers taking care of persons with ILI, the most -- prime-most influenza, and there was no difference, and so --

And I know that one of the main authors of that study was at McMaster, Mark Loeb, and he tried to do a randomized controlled trial in COVID, but just there was such a default assumption that N95s would be better for treatment of COVID that, as far as I'm aware, that they were not able to actually do that study, because

the assumption was made, even though I think in the absence of evidence, what you do look at is similar context, and in this case, similar context done by the same authors, looking at N95s versus surgical masks in the context of influenza showed that there was no difference. And so I think it was very reasonable, from a clinical equipoise, statistical equipoise to ethics to do that study in SARS-CoV-2 as well.

So there's been lots of randomized controlled trials in health care workers to define who and who does not need to wear a mask, and who and who does not need to wear certain types of masks, lots of areas where masks are not needed for health care workers, including in infections, think of things like c. difficile or MRSA, we don't mask health care workers, but we make them gown and glove because of the route of transmission is not the respiratory tract.

Q Dr. Hu is adamant that mandatory masking in a health care setting prevents the spread of COVID, although he's less certain about community settings. You refer to a large body of evidence in your report that mandatory masking of healthy people does not work at all in community settings, we've been discussing that, but do you have any reason to think that although masking of healthy people is completely ineffective in community settings, it might, nonetheless, be highly

effective in health care settings as Dr. Hu says?
A Sorry, I was looking at my report. Can you just restate that?
Q Sure. So, you know, Dr. Hu says, look, they're really effective in health care settings, probably effective, but less effective in community settings. That's basically his position. Your position, in your report, is that, well, look, it's completely ineffective in the healthy community, in the non-health care setting. So even though that's your opinion, and you have all this scientific evidence to back it up, do you, nonetheless, think that Dr. Hu might be right in that, even though it's not effective at all in the community setting, it could be really effective in the health care setting?
A Well, yeah, masks are effective in the health care setting, if that's what you're asking. Masks are effective in a health care setting, yeah, because it's been studied, but, again, it's totally context-dependent. And everything is context-dependant and should be studied with regards to its context. So we know, because we did the studies, that for taking care of influenza patients, health care workers should wear a medical mask, which is a three-ply mask. It was compared in a randomized controlled trial to cloth masks, and it was superior, and it was control -- and it was compared in multiple randomized controlled

trials to N95s, and there was no difference. So an N95 was not needed, so a medical mask, no worse then an N95 medical mask, no -- certain better than cloth, and so that context is clearly established. Health care workers taking care of patients who have influenza-like illness should wear a medical mask.

And so -- and there is definitely context in the health care environment where masks have shown, through randomized controlled trials, which are the highest level there is, that they're helpful, they're beneficial, but that evidence just does not exist in a community setting.

And also prior to COVID, studies have been done in other health care settings within the hospital with other types of infections that show that masks aren't universally necessary all the time, and it's totally context dependent.

Q Right, so the effectiveness of the masks is dependent on the context of there being interactions between a symptomatic patient and a health care worker?

A That's correct.

Q Let me ask you a few questions about, you know, the issue with health care settings and non-health care settings, and I know we've touched on this, but in a health care setting like a hospital, are there a large number of symptomatic people expected to be present?

A Yeah, absolutely. That's -- hospitals are -- have lots, very high rates of symptomatic persons, and, again, it dependents on what you're talking about. Just unhealthy, yeah, they have all sorts of aches and pains, and, you know, heart attack, stroke, the -- but also symptoms from respiratory virus, and, again, it's going to depend on the season, because, in the middle of the summer, we don't really see much viral respiratory -- viral respiratory tract illness, but we do see that, you know, in the winter months. So, again, it's going to depend on those other factors that I talked about as well.

Q And that's been your experience working at the hospital you work at?

A Yeah.

Q And, forgive me, but hospitals are -- are they designed to receive patients symptomatic with a potentially infectious illness?

A Yeah, there are other factors other than masks, obviously, there's ventilation, there's how rooms and wards are designed, there's cleaning, so lots of evidence about different cleaning things. So, you know, we have three main types of cleaners: Ammonium-type cleaners and bleach-type cleaners and peroxide; we talk about each of the different pros and cons of those, so -- and then different types of

ventilation systems: You have negative-pressure ventilation for certain infections like tuberculosis that are not required for other important respiratory infections like influenza.

Yeah, you have kind of distance between patients, whether they're in their own room or whether they can be divided by, you know, just a screen; you have other personal protective equipment like gloves or gowns. Yeah, there's a variety of different factors that are built into kind of the design and how a hospital works.

Q Are there any important differences between a setting, a health care setting or any setting, where symptomatic people are regularly present and then a setting where symptomatic people are not present and only asymptomatic people are present?

A Yeah, I think so. Like, you know, there's -- I think of something like a hospital, even in that case, you know, there would be scenarios where it doesn't make sense to have everybody masked, even in the context of COVID. Like if you have an outpatient clinic, say a mental health clinic, where you have a psychiatrist, who is obviously healthy, he or she is not allowed to come to work if they have symptoms, and a healthy patient, you know, let's say with some anxiety issues, and there's cognitive behavioural therapy, which is -- you know, they're talking, you have a context like

that, it's occurring in a hospital, but really that context, from a transmission risk point of view, can be considered like any other context within the population; and so you have them sitting 3 feet apart, they're just talking, they're both healthy, the risk of transmission, I would say it's even less than, say, that patient after discussing anxiety issues with the psychiatrist, going and getting their hair cut, because the person trimming their hair or giving them a haircut is actually closer to them than the psychiatrist.

And so even within the hospital, it's completely context-dependent. Even in kind of health care settings, it can be a relatively arbitrary definition. Yeah, it occurs in a hospital, but what's the actual risk, like how are these people physically relating to each other, what are their symptoms, and what's the actual risk?

So I would argue that the actual risk for the scenario I provided, you know, would be the same as essentially a similar type of scenario within the general public. Whereas it's completely different if you have symptomatic people on a ward that then -- the benefit of masking is theoretically there but then also proven by previous randomized controlled trials and influenza disease.

Q Thank you. Dr. Warren, where you work, are you

currently required to where a mask because of COVID even when you're asymptomatic?

A Yes.

Q And are there any similar or extra requirements from the CPSO to wear a mask because of COVID even when you're asymptomatic?

A I'm not sure. I'm not sure entirely what you're asking, but I think most of the policies that I would follow, because I'm in infectious diseases, so I'm taking care of COVID patients and stuff, so I think most of the policies would be from my hospital rather than the CPSO. Yeah. Sorry, I'm just not entirely sure what you're asking there.

Q Well, I mean, certainly the general understanding is that most regulatory bodies, health professional regulatory bodies across the province have fairly sweeping requirements that their members wear masks regardless of their symptoms. You know, the College of Chiropractors has it, the College of Physicians and Surgeons of Alberta has it. So I'm just asking if you're aware if the College of Physicians and Surgeons of Ontario has a requirement like that.

A Oh, I'm sure they do, yeah. Yeah, and it probably doesn't really impact me because I'd be doing it anyway, taking care of patients with infections, so -- but, yes, I'm sure they do. I haven't read it in

detail, but it wouldn't impact me like it might impact some other people who wouldn't routinely be wearing a mask anyway in the course of their work.

Q Okay, so do you now wear a mask a whole lot more now than you used to prior to COVID just because of the type of work you do?

A Yeah, absolutely. Yeah, I have to wear a mask in all contexts now, whereas before, it was context-dependent.

Q And do you think the requirements now are equally rational or equally logical to what they were before when they were context-specific?

A Well, as I discussed earlier, the evidence base is not there. And as I discussed earlier prior to COVID, the requirement or need for masking, different types of masking was based on the context. And in many of those scenarios, it was actually studied, the most important scenarios, things like TB and influenza. So now there's a requirement for masking in every context, but it's not substantiated by evidence.

Q In the new context, where you are required to wear a mask, do you, in fact, wear a mask even though you didn't used to before COVID?

A Yes, I wear a mask at all times when I'm in the hospital. But the type of mask I wear is still different based on the context. So it can be a Level 1 mask in certain areas. When I'm actually in my office

with my door closed, I'm by myself, I don't wear a mask because I don't have to. But in other areas, if I'm just going to Tim Hortons to get a coffee, I just wear a Level 1 mask. In many clinical contexts, I can wear a Level 3 and then an N95 in certain clinical contexts.

Q When you wear a mask to go to Tim Hortons, do you do so because there's a law that requires you to do so?

A Yes.

Q Do you disagree with that law?

A I would say it's not based on evidence, universal masking. And so I would say when I'm standing in line at Tim Hortons, I would say that's similar to like a community setting. Presumably, you know -- well, yeah, people who have symptoms are not allowed to be in line at the Tim Hortons as you are at the hospital. If they're symptomatic patients, they need to, you know, reside in the rooms, and symptomatic staff are not allowed to come, not allowed to have symptomatic visitors, that kind of stuff. And so that would be considered community context, so as I've kind of argued in and out of places, the evidence base just is not there to say that that is required.

Q I'm nearing the end, believe it or not. I just have some more questions about Dr. Hu.

Now, from your observations, has the transmission of COVID decreased in jurisdictions of mandatory

masking as compared to jurisdictions with no masking? So, you know, the classic example would be California and Florida. Have you seen COVID transmissions decrease in California because of mandatory masking?

A Yeah, again, so this is a huge other wide body of literature and fraught with all sorts of methodological and statistical problems, but what work there is out there, there is no difference with regards to masking. You know, I think people can know that intuitively. Like we've had in Canada all of these mask mandates for 15 -- yeah, probably 15, 16 months before Omicron hit, and then, you know, it just blew through the society, didn't make any difference.

I think intuitively no, but when we do ecological studies, which, again, have all sorts of methodological problems, I would argue that the evidence shows that there is no effect on transmission. And the best ones are, you know, looking at the different states, because you have 50 different states or Europe, because you have a similar health care systems, relatively similar population, things like that. And, no, I would argue that it does not.

Q Dr. Hu has stated that every country that has imposed masking has experienced decreased transmission of COVID. Do you disagree with him?

A Yeah, I don't know what that assertion is based on.

I'd love to kind of know what study he's referring to in that.

Q Well, that's my next question. So you're not aware of any academic literature that would support such a claim?

A No. Again, there's a wide literature in that, but it's fraught with all types of problems, and so one of the kind of classic fallacies is the progression toward the mean, and we see this all the time where in the middle of a wave, stuff is done, and then the cases come down, and then it's attributed to whatever was done, but that's just statistically wrong because there's always going to be a regression toward the mean. A wave is going to go up, and then it's going to come down, and you have to have a control group to decide whether your intervention -- those are kind of before/after ecological studies, which are even lower than, you know, ecological studies with regards to the value of the evidence. It's essentially -- it's hypothesis-generating at most, but very low quality of evidence.

And whatever -- what evidence there is out there, can be -- because it's some very low methodological quality, it can often be twisted all sorts of different ways. And there is -- and there is hundreds of publications in that area with low methodological

qualities, so ecological studies or before/after studies, which, by definition, are low methodological quality, showing both sides.

So there's lots showing one side, lots showing the other, but the best evidence is randomized controlled trials and meta-analysis that there's no benefit in masking a healthy general population.

Q Well, I'm going to ask you if that's what Dr. Hu has done. I'm going to tell you what he said. He said that the lockdown restrictions imposed in Alberta in November and December of 2020, he said that those lockdown restrictions did not cause the initial rise in cases during the lockdown but did cause the eventual drop in cases. So did Dr. Hu do there what you just described?

A Yeah, there's no statistical epidemiologic way of making that conclusion, because there's all sorts of problems with it, but -- before/after, like you have all sorts of bias and confounding, especially confounding, and that conclusion just can't be made statistically, it's just not good practice, that that is not a high level of evidence because there's so many confounding factors.

And we just know, and we've seen this all over the world now for two years that you have waves that go up and waves that come down, in many cases no matter what

you do. We've seen that in different provinces in this wave. You know, provinces like Quebec who had the most extreme measures are having more per capita cases than places like Saskatchewan, which are having many fewer restrictions.

And I would argue I know exactly why Quebec is having more cases than Saskatchewan because the population weighted density in Quebec is much higher. You have a lot of people living in a relatively small area in Quebec. So it's predictable why they're going to have more cases than Saskatchewan. And every jurisdiction in Ontario follows the same pattern we're seeing in other places, which is that the most important factor for number of cases is population weighted density.

And it's not just overall area divided by the people. So you look at places like Ontario, most people don't live up in the north; it's population weighted density, which is a specific measure. So you take -- so the idea is you take any random person in that population, how many people live near them. It's not take the whole area of Ontario and divide it by the people. That's just population density. But the people of Ontario are not evenly spread over the entire province.

Population weighted density is a statistical

method of determining if you take a random Ontarian, how many, on average, people is that person near within like, say, a square kilometre. And that measure is, by far, the best predictor of how many cases you're going to have. And we see that -- you have provinces that have low population density have lower numbers of cases. Populations with high -- provinces with high population density, like Quebec, having very large -- Ontario as well, most people in Ontario live in the corridor between Windsor and Ottawa, and it's relatively population dense.

Q You said earlier something about reversal. You said it was very difficult to reverse (INDISCERNIBLE) trend. Does that help to explain that even though this data you're talking about is so obvious, does that help to explain why Quebec continues to do something that is very obvious doesn't work?

A Yeah. So it's difficult once there's an established practice, and we know this from thousands of years of history in medicine, it's very difficult once there's an assumed standard of practice to change practice. Now, I deal with that on a daily basis, and I have been for almost 11 years of practice now in antimicrobial stewardship, because my main role is to convince people, okay, we don't need to treat people with pneumonia with 14 days of antibiotics anymore. We've

had lots of randomized controlled trials that say three to five days is okay. But people are still practicing what they learned in med school 25, 30 years ago.

And so effecting that change is very challenging, and there's all sorts of books written about that and things like that. And so once a practice is assumed to be beneficial, even early on in the -- when there's clear evidence to the contrary, it's very difficult for medical practitioners, it's a psychological thing, you know, just part of humans and who we are as well, to change practice.

Q Is that what's going on generally with COVID now? We've got this practice in place, you know, revolving lockdowns must be effective because we thought they were going to be in the beginning, even though the data shows they're not, we must keep doing them because we thought they were effective. Is that -- you know, the example that you gave with treating pneumonia, is that what's going on with COVID?

A Well, you know, it's a very complicated topic. As I mentioned before, it needs to be looked at in the historical context as well, because as a -- you know, as human populations, we have gone through massive events that have decimated our populations that is still historically remembered in our social consciousness. And as I said, so you think of things

like the Black Death, as I said before, historically some sorts of quarantine, especially for things like smallpox and plague, frankly, have worked. Like when you kind of cut yourself off from the world, that actually saves a lot of lives with regards to smallpox and plague.

And so a lot of these things have very deep-rooted factors that come into play, but one of them is this medical reversal idea, and others kind of -- you know, the idea of some costs, like once you've invested billions or whatever dollars in something, you know, you really want that to work.

And it's political, right? Like it just comes down to politics, a philosophy of how things are done, whether you're interventionist or not, and people are interventionists in the economy, people are interventionists in the climate, people are interventionists in medicine, and to some degree, that's a political question as well. So there's many different factors.

I think there's a few problems that have occurred over the -- I think everybody will admit this that there's been some major problems that occurred over the last couple years. One is that, you know, we haven't subjected or made decisions based on enough evidence, and I think many people would agree on that, but I

think also that it's things are oversimplified. So I don't want to be one person that says, well, people do this because of one reason; I think it's very complex.

Q Right. Dr. Hu said quite a few times in his report and in questioning that the evidence supporting the effectiveness of masks is, quote, overwhelming and, quote, there's heaps and mounds of evidence. Do you find these statements to be reasonable?

A If he's referring to in the community, then, no, absolutely not, but I -- quite the opposite actually. So I don't have that direct quote in front of me, but if he's referring to masking healthy persons in the community, no, I would completely disagree with him.

Q Well, you know, to be fair, he's saying it in the context of health care settings --

A But, again, it's context-dependent, so, yes, for health care providers taking care of patients with influenza or influenza-like illness or tuberculosis or, you know, certain -- the context, then, yes, there is lots of evidence, but there's also lots of evidence for the fact that masks are not required in lots of health care contexts as well.

Q On page 7 of his report, Dr. Hu says that the issues of asymptomatic transmission, of symptomatic transmission, and the severity of COVID are not salient to the issue of the effectiveness of masking.

A Sorry, can you say that again?
Q Sure. And you might want to have it in front of you, on page 7 of his report, it's actually in the bold text in the third paragraph there of page 7, he says: (as read)

> The severity of COVID-19 right through transmission of --

A His report, sorry, Dr. Hu's report?
Q Yeah.
A Okay. Let me just bring it up. Page 7?
Q Page 7, yeah, there's the bold text.
A Okay, got it here.
Q So he says: (as read)

> The severity of COVID-19 rates of transmission amongst asymptomatic infected individuals, testing, et cetera, none are salient to the question at hand around whether or not masks provide benefit in a health care setting.

Do you disagree with him?
A I just have to look at this.
Q Now, mind you, we don't have a definition of "health care setting" of course, but ...
A No, I wouldn't agree at all. Like whenever we decide or whenever we're thinking conceptually about whether health care workers should wear masks, the severity of

the infection, the rates of transmission of the infection, whether asymptomatic persons can transmit, all of those are very important as to whether masks should be used in that context. I'm not arguing that masks shouldn't be used in a health care context. I would define that like as a hospital, you know, but health care providers should wear a mask when taking care of a patient who is symptomatic with COVID-19. I'm not disagreeing with that at all.

But this statement is not true, like whenever we think of, even in the health care environment, whether someone should be masked, we think of the severity of the infection, we think of the rates of transmission, we think of whether someone who is asymptomatic can transmit, absolutely.

Q I want to take you back to your comparison of a year of COVID death numbers to a year of vehicle fatality numbers. I think you do this on the bottom of page 2 and the top of page 3 of your report.

A Right.

Q Now, the first question I have for you is, and you may not know this, but when did COVID-related deaths in people under the age of 60 first start occurring in Canada in 2020?

A Oh, it would have started occurring very early, yeah.

Q "Very early" being?

A April.
Q So I'm going to ask you some obvious questions, bear with me. How many months are there between April 2020 and April 2021?
A 12.
Q And how many months were in the year 2019?
A 12.
Q Now, in your report, you say that there were 1,010 COVID-related deaths in people under 60 years of age as of April 16th, 2021, and that there were 1,191 motor vehicle fatalities in 2018 in people under 55 years of age. Do you still hold the opinion that the risk of death from COVID to people under the age of 60 between April 2020 and April 2021 was less than the risk of dying from a motor vehicle accident?
A Yeah, absolutely. And, in fact, the first -- when I kind of look at the number -- what you need to do is look at basically the average number of deaths per day, and in this analysis, I'm actually being generous, because the first death in Canada I think was around March 9th, 2020, and so what you're talking about is over 13 months of data until April 16th, 2021, and there were less deaths in that age group than just 12 months of persons -- and, again, it's under the age of 55. So not only am I doing it longer with regards to COVID deaths, I'm -- have a slightly larger age group.

So the number -- and if you continue that on, and you always have to -- the denominator is important, like you always have to divide it by the number of days, and I counted from the day of the first COVID death in Canada, and this holds today, so the number of deaths in Canada in persons under 60, if we divide it by almost two years, the number of deaths per day on average is less than what we would expect in that same age group, persons under 60, the number of deaths due to motor vehicle accidents.

Q Thank you. On page 6 of his report, Dr. Hu stated that you committed a, quote, factual error. He said your comparison was fallacious and unscientific. He went on to say that no scientist, doctor, or epidemiologist with a basic understanding of disease patterns would make this comparison.

Now, on cross-examination, Dr. Hu retracted his accusation that you have no basic understanding of disease patterns, but how do you respond to his claim that you made a factual error?

A Well, the mistake he made is he continued to accrue patient numbers without dividing -- without changing the denominator. So he changed the numerator without changing the denominator. What I was saying was that in a year, and it was actually more, the numerator was 1,000 -- what did I have -- 1,010, that was my

numerator, and my denominator would have been about a year, it was actually 13 months, but it was a year. In his report, he continues to increase the numerator, so 1,475 as of June 29th, but then he has to increase the denominator as well. And if you change the denominator to the June 29th, so approximately 16 months, you're finding the same thing: You're finding the average numbers of death per day in that age group is still less. So it's --

And, you know, saying it's fallacious and unscientific, well, it's very important, we do this all the time in medicine; like if we're talking to people that have a potential rare effect of a drug or, you know, a particular intervention, like my obligation is to provide the patient with informed consent, and part of that informed consent is providing a contextual risk. This is done all the time. It's done all the time at population health bubbles as well, because everything in life has a risk, you know. Me walking into my bathtub or shower has a risk, you know; there are certain numbers of people that die every year because of that. And getting struck by lightning or whatever and --

In fact, driving a car is one of the riskiest things in, you know, persons under a certain age that they can do in Canada. It's one of the major

preventable causes of death. And so it's always used -- not always, but often used as a way of contextualizing a risk of death, and I think it is very helpful in COVID-19. If you have people under 60, that's all persons under 60, all persons under 60, their risk of dying of COVID is actually lower than their historical risk of dying in a car accident.

And, again, you can talk about sub groups and things like that if you have -- if you're talking about healthy people under 40 with no risk factors, like you're talking about a phenomenally lower risk actually with no kind of comorbidities and lowering the age group and stuff. But it's routinely done in many areas of life, not only medicine, to contextualize a risk.

Q Just a couple more questions. In your experience as an infectious disease specialist, do government bodies tend to be more factually accurate than non-government bodies regarding scientific issues?

MR. MAXSTON: Mr. Kitchen, I'm sorry to interrupt, but I struggle with how that falls within the efficacy of masking and other qualifications. I think that's almost political, sociological. I know where you're going, but I wonder if you could think about rephrasing that, because that's awfully broad and really doesn't speak to efficacy of masking; that's governmental society.

MR. KITCHEN: No, I'm simply asking if the evidence he's seen for government bodies and the evidence he's seen from non-government bodies, if the scientific evidence -- if governments tend to be more right than non-government bodies.

MR. MAXSTON: Well, it's pretty open-ended, which governments, what evidence, provincial, federal, municipal. I mean, that's a pretty broad question, Mr. Kitchen. That's my concern.

MR. KITCHEN: I can narrow it down to specific governments, if you let me do that.

Q MR. KITCHEN: Well, Dr. Warren, I'm not going to ask you about the Alberta government because you're not in Alberta, but the Ontario government, generally speaking, in your -- and you've only be doing this for 11 years, so in your 11 years of infectious disease experience, do governments tend to be more factually or scientifically accurate in Ontario, the Ontario government, does the Ontario government tend to be more factually or scientifically accurate than non-government bodies?

A What do you mean by "non-government bodies"; like what would be the comparative group?

Q Independent scientists, private universities, people in bodies that are clearly unrelated to government.

A Yeah, again, that is a hard question to really answer,

because it all depends. Like I've seen it every single different way. Sometimes I've seen how the Government's just way behind the times. Other times, they're way more accurate than a different -- like, again, it's completely context-dependent, so I really can't answer that question, to be honest with you.

Q Do you think a scientific or medical proposition or theory is likely to be more accurate because it comes from a government source?

A I don't personally think that, no. I always look at the underlying data, so the primary evidence. So, you know, if you talk about historical analysis, the primary evidence is people who were there in that part of history or the archeological evidence or whatever.

You know, in scientific stuff, it's the studies, it's the bench research or the randomized controlled trials, yeah. So that's how I would form my opinion.

So what different bodies say, governments, whatnot, like that would be part of kind of how I think about things, but it's certainly not the most important, but I would want to look at the primary evidence, and that's what I did in my report.

Q So is the most important thing what the evidence and the data says?

A Absolutely.

Q What if government disagrees with that evidence and

data?

A Well, governments have, you know -- throughout the history of medicine, there's all sorts of examples of when governments got it wrong, different medical bodies got it wrong. You know, data is always accumulating, and so -- but, you know, lots of times they get it right, but, of course, they're going to get it wrong. Governments or any sort of political body or educational institution or even scientific community are not going to be infallible. Like there's lots of people that make mistakes, and evidence is going to change, you know, and they're influenced by a variety of factors. They are -- and things are influenced by cultural factors, things are influenced by political factors, so, yeah, it's a very complex thing.

(AUDIO/VIDEO FEED LOST)

THE CHAIR: Can we just --

MR. KITCHEN We've lost --

THE CHAIR: Yeah.

MR. KITCHEN I only have one more question, so if we get Dr. Martens back, then I'll be done.

THE CHAIR: Okay, we'll just wait a moment; I'm sure she'll be reconnecting.

(DISCUSSION OFF THE RECORD)

Q MR. KITCHEN: Dr. Warren, thank you, you've been very patient with me. My last question for you

is, as a medical professional working with infectious diseases, have you found the information or opinions regarding COVID restrictions coming from government sources such as the Public Health Agency of Canada to be well supported by real scientific evidence or not so well supported by real scientific evidence?

A So with regards to COVID-19?

Q With COVID restrictions.

A Yeah, I -- again, it's a complex question, but, in general, I would disagree with a fair amount of what my Provincial government has done. Like they've admitted -- you know, they were taping up children's playgrounds in two different waves, it just makes no sense.

But, again, it all depends on what we're talking about. Some things I do agree with, certain quarantine and testing and various treatment things I do agree with, other things I don't, but anything that I would have had issue with would have been found in my report.

Q So you don't agree with the masking and physical distancing, I take it?

A Yeah, my position is as it is in the report, and that would be quite different than what has occurred in my jurisdiction.

MR. KITCHEN: Well, those are all my questions.

Now, I know it's getting close to lunch, but I suspect Mr. Maxston's going to be quite brief, and so I propose that we go until lunch, but I leave that with Mr. Maxston.

THE CHAIR: I was just going to ask you, Mr. Maxston, if you have some idea of how long you might be.

MR. MAXSTON: I think I'll be 15 minutes, I don't know, depending on how, you know, again Dr. Warren might respond, I might have some follow-up questions. My sense is, and I leave this up to you to decide, but people would probably, and I invite Dr. Warren's comments and your colleagues', we probably want to plow through into the lunch hour and maybe try to finish any redirect and any questions from the Tribunal before we break for lunch. Now, that's -- I don't want to see us going till, you know, 1:25 and missing lunch for everybody, but my sense is maybe we should try to press ahead here for 15 or 20 minutes, see where we're at. Mr. Kitchen may have some follow-up. Let's just try to make as much progress as we can before maybe 12:30 or something like that.

THE CHAIR: I agree with you, and I see a very vigorous nod from Dr. Warren; I think he's supportive of that. I'm going to suggest that we just take a 5-minute stretch, bio break now, and we'll come

back, and we'll -- nose to the grindstone and try and see where that takes us, okay?

MR. LAWRENCE: Sorry, can I just -- Amber, can you stick us in a break-out room? I just want to chat with Blair for a few minutes.

THE CHAIR: Think we'll be back at 10 after 12, because I do anticipate there's going to be some discussion, so we'll see everybody in 15 minutes.

(ADJOURNMENT)

THE CHAIR: So we're back in session, and Mr. Maxston has some questions on cross-examination for you, Dr. Warren.

A Okay.

Mr. Maxston Cross-examines the Witness

Q MR. MAXSTON: Afternoon, Dr. Warren.

A Afternoon.

Q It's noon here now as well, so that's universal. Thank you for taking your time out of a Saturday. I don't have a lot of questions for you.

I just wanted to start off by confirming a few things you said to Mr. Kitchen, and the first was that the, I think, the infection fertility ratio varies over time; is that correct?

A Infection fatality ratio, yes, not fertility.

Q Thank you, not -- yes, thank you. And the IFR for COVID, I think you said exceeded a bad influenza year

when COVID-19 first began in Canada; is that correct?
A Yeah, so what I was saying is that very early on, because it was really only symptomatic cases being detected and tested for, and there was still a very vulnerable population, the IFR was quite high. But over time, as COVID has infected more and more people, there have been different strains, including especially Omicron, the IFR has continued to drop over the past 21 months or so --
Q Yeah.
A -- so --
Q I think that --
A -- I think it's graphed out in a number of places, and it's declining over time.
Q I think you might have said that in April or May of 2020, that was the first wave for COVID-19, and that's when the IFR would have been its highest; is that fair to say?
A Correct, yeah.
Q You had a discussion with Mr. Kitchen about the word "pandemic", and I think you said that COVID-19 is definitely a pandemic, and you supported that by saying that this is the first time we've seen a virus on all seven continents; is that correct?
A Correct.
Q You also said that there's going to be some debate

about when it's becomes endemic, and I think you said the decision about when it's going to become endemic is arbitrary, is that your evidence?

A Well, yeah, different people are -- you see some people saying now that it's endemic, others are going to say, well, there's these and these criteria. There's no established criteria. I gave kind of what I think is a reasonable thing, which is that once it's replaced with a different virus, not entirely, because COVID-19 or SARS-CoV-2 will continue to circulate indefinitely, but once the predominant virus is something else in most regions, I think that's a good place to say, well, it's now endemic.

Q You're kind of leading --

A There's no established -- sorry, there's just no established definition as to when the pandemic ends and when the endemic phase begins.

Q And you're kind of leading me to my next question, which was inasmuch as it's going to be arbitrary, it's probably going to be subjective as well, isn't it?

A Yeah, you can use whatever term you want, arbitrary, subjective, yeah.

Q You had, a number of times, interactions with Mr. Kitchen about how science has evolved with respect to each virus or pandemic, and that there is discussion and debate within the scientific community, and I think

you referred to different studies, and Mr. Kitchen took you through that. While that debate is occurring -- and I'll be more specific, while that debate was occurring in Canada when COVID-19 started and is still continuing, it's up to governments to make decisions though and orders in terms of how we respond to the pandemic; is that fair?

A Yeah, that's the role of government is to make decisions.

Q Yeah, and what I'm getting at there, I believe this is consistent with what you said, the CMOH, and I'll use Ontario, for example, but it's the same here, it's the CMOH that issues those public health orders that the public is required to follow; is that fair to say?

A Yes, the CMOH does have an important role -- or that's -- the CMOH has had an important role in Canada in different jurisdictions and provinces, but, yeah, it's still the government itself as well making certain things mandatory and usually will do so with consultation of the CMOH.

Q And I'm not trying to be cagey here, I'm just trying to -- I want to be clear that there's a distinction between the scientific debate, which has people on both sides or multiple sides of an issue, versus the decision-making, which is done by government and other government entities, I suppose. That's really what I'm

getting at.
A Yeah, I would agree with that. I would agree with that a hundred percent, because policy is always very different than scientific rationale, and so --
Q Right.
A -- there's lots of policy decisions that have been made that are not justified by science.
Q Yeah, and I think -- you know, I was talking with you about CMOH orders, but I'm thinking in Alberta, and I know -- I'm pretty sure they had these in Ontario, we had various re-opening requirements issued by government. If you wanted to open your gym, your salon, what have you, there were certain requirements that have to be followed, and I think you probably agree that, despite the scientific debate going on, businesses had to follow those requirements if they wanted to re-open?
A Yeah, that would be their decision, but, yeah. Absolutely.
Q You had a very I think fulsome discussion with Mr. Kitchen about you and wearing of masks, and I think you said to him that you are required to wear a mask at work when you're asymptomatic regardless of, you know, symptoms; that was your evidence, I think?
A Yeah, when I'm working in the hospital, I'm required to -- except when I'm in my own private office --

Q Right --
A -- with the door closed.
Q -- right. And in fairness --
A (INDISCERNIBLE)
Q -- I'm really concerned about the situation where you're treating patients, because that's what our hearing is talking about, and I think you were pretty candid about that. Mr. Kitchen mentioned to you CPSO, College of Physicians and Surgeons of Ontario, requirements for masking, and I think you said -- he asked you whether you knew whether they had any, and you said, I'm sure they do. And I think you indicated you would follow them if they applied to you, and in fact, I think you said you are following them when you wear a mask in the hospital. Is that fair to say?
A That's correct.
Q Would you agree that, as a member of the CPSO, you can't pick and choose which of their requirements for your practice applies or doesn't apply for you?
A I don't have a choice in the matter, no. The CPSO and various other regulatory bodies can make requirements, my hospital can make requirements of something that I don't agree with or I think is not based on evidence --
Q That was going to be my next -- sorry, were you finished?
A Yeah.

Q Yeah. That was going to be my next question was, you know, there's situations, and I think masking might be one of them, where you would disagree with your regulator or maybe a hospital policy where you're at, but your evidence I think is that you, nonetheless, would follow those requirements?
A That's correct.
Q Mr. Kitchen and you engaged in a discussion about government and non-government bodies, and he asked you some questions about that. I just want to be clear, you gave some answers about your knowledge of the Ontario experience, but you don't have any knowledge of the Alberta experience in terms of how CMOH orders were issued or weren't issued; that's correct?
A I have some knowledge of Alberta, but certainly nothing like I would have here in Ontario, because -- like you know, this case or whatever else, I've got some knowledge of Alberta, but not nearly as much as I would have of Ontario.
Q And I think, again, and I'm not trying to be critical here, I just think it's factual, Dr. Hu, in his testimony and his expert report, was directly involved in working with the CMOH office on certain aspects of their orders in Alberta; is that your understanding?
A I know nothing about Dr. Hu.
Q You had a discussion about, and Mr. Kitchen can correct

me if I'm paraphrasing his words incorrectly, but I think generally he asked you about whether government or non-government entities can be -- are more accurate, or less accurate, or more correct or less accurate, you know, when we compare them, and I think you were pretty candid in saying that it's fairly divergent, and lots of times government gets it right, and lots of times non-government entities get it right; is that fair to say?

A Yeah, it's a very complex issue, and it's such a broad question that I don't think any kind of sweeping statements can be made.

MR. MAXSTON: Those are all my questions, Dr. Warren. Thank you for your time.

A Thank you.

MR. KITCHEN And I --

THE CHAIR: Thank you.

MR. KITCHEN: -- just have two in redirect.

THE CHAIR: Okay.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: Dr. Warren, you said there's no established criteria for establishing an endemic. Is there any established criteria for establishing a pandemic?

A I think the -- yes, there would be, you know, established -- you know, the WHO, different

organizations would have definitions for a pandemic, however you want to define a pandemic. SARS-CoV-2 is a pandemic, and there are certainly more definitions or clearer definitions for when there is a pandemic and when it's been established than when an infection transitions from pandemic to endemic.

Q How come only some flu years are pandemic and some aren't? I don't want you to -- I don't want to rehash what we did earlier. You said something about -- something I didn't, frankly, understand. I think something about how the virus has changed. That's what I'm trying to get at. Is there --

A Yeah. So year to year, influenza changes, it mutates, we have different strains. It's equivalent to SARS-CoV-2, how we have different variants. They're both very -- they're similar viruses; they're RNA viruses; they mutate at approximately the same rate.

So in influenza, year to year, there's something called antigenic drift, which are minor changes that produce the seasonal yearly influenza. Every few decades, there's an antigenic shift, so not drift but shift, and that's a major reassortment of a virus, which generally causes more widespread illness, more severe illness, because many people in the population do not have sufficient immunity, and so that's, you know, swine flu 2009 would be kind of the last example

of that. The Spanish flu from a hundred years ago is another example. And there were I think three or so other pandemic influenza years in the 20th century.

Q When we go from variant to variant in COVID, is that a similar thing, or is that different?

A So that would be, if you want to make it analogous to influenza, that would be the antigenic drift part of influenza, and so that would be the -- kind of the yearly fluctuations, and we'll continue to have that, there'll be a new wave after Omicron, something of a new variant. In influenza, we called it the yearly strain. And so that's what the analogy would be with influenza. The variants are new -- are analogous to influenza antigenic drift.

Q And that's what we referred it to, COVID-19 or SARS-CoV-2, is one big long event, they don't -- we haven't chopped it up; we refer to it as one big long thing, that's -- because there's only drifting not shifting?

A That's correct.

Q Last question I think, if government has a role to impose measures to protect the public, do they also have a corresponding role to remove those measures once it's clear that they don't work or cause more harm than good?

A I think any policy decision needs to be based on

evidence, and I think the more significant a policy decision is, the more evidence should be behind it, because if you're going to make a policy decision that significantly impacts people's lives, there should be a lot of good evidence for that.

And so same with changing policy decisions, any time a policy decision is changed, it should be based on evidence. And again, I think the burden of proof, the more significant the policy decision, the more the higher burden of proof is on the evidence that that policy decision is based on.

Q And are you seeing that evidentiary burden being met for things like masking and distancing?

A Yeah, yeah, for sure. With regards to masking for sure. Like a lot of places -- a lot of places like Denmark, the UK, Ireland, many places in the States, a lot of jurisdictions are getting rid of masking because there's no -- like the evidence just isn't there. There was an assumption, and so the policy decision was based on an assumption, that I would argue flawed assumptions, but as evidence accumulates, jurisdictions are now starting to get rid of mask mandates, for example.

Q Logically speaking, if the virus is the same and the scientific evidence is the same between Florida and Alberta or between Canada and Denmark, then can it

logically be said that Canada's decision to keep masking in place is based on science, or is it based on something else?

A Well, I argue in my report I don't think that -- I would argue in my report that there was never a justification to mask healthy persons in the general public. That evidence base was never there. I argued that from the meta-analyses and studies in flu, and that evidence continues to be accumulating specifically for SARS-CoV-2.

Q So is it fair to say that places that are removing mask restrictions are following the science, and places that aren't are ignoring it?

A Yeah, I think the word "the science" has been way misused in --

Q (INDISCERNIBLE)

A -- this last two years, so I won't use that term, but I would say the --

Q How about the evidence?

A The evidence, I would say the evidence never has -- there has been no evidence that masking the general public is of any benefit, the healthy general public.

Q So at some level, isn't it required of governments that are continuing to impose mask mandates that they're ignoring the evidence?

A Again, policy and evidence-based decision-making are

often very different things. Policy is informed by many other factors other than evidence.

MR. KITCHEN: Thank you. Those are my questions in redirect.

THE CHAIR: Okay. Dr. Warren, the Members of the Tribunal may have questions for you. We're just going to take a 5-minute break while we discuss what questions, if any, we have for you. So if you can just bear with us for 5 minutes, I don't think we'll be any longer. Thank you.

(ADJOURNMENT)

THE CHAIR: The Hearing Tribunal is back in session. And, Dr. Warren, we'd like to thank you very much for your time and your expertise and your testimony today. Members of the Tribunal do not have any additional questions for you. We appreciate you participating in this process, and Mr. Kitchen will discharge you, unless there's anything else.

There's just one matter I would like to ask of the College. Ms. Nelson, we are concerned over finding two consecutive dates, and we would really appreciate seeing the Doodle poll go out as soon as possible, knowing how much pressure there is on various people's calenders, so we'll look forward to getting that in the near future.

And unless there's anything else, I'll declare the

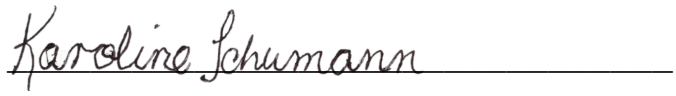
hearing closed until we meet again, and we will meet again sometime in the spring.

PROCEEDINGS ADJOURNED

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 22nd day of February, 2022.



Karoline Schumann, CSR(A)
Official Court Reporter

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