

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

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	September 1, 2021	Morning Session	10
6	Opening Remarks		11
7	Discussion		14
8	Submissions by Mr. Maxston (First Preliminary		18
9	Application)		
10	Submissions by Mr. Kitchen (First Preliminary		31
11	Application)		
12	Reply Submissions by Mr. Maxston (First		34
13	Preliminary Application)		
14	Ruling (First Preliminary Application)		35
15	Submissions by Mr. Maxston (Second Preliminary		36
16	Application)		
17	Submissions by Mr. Kitchen (Second Preliminary		43
18	Application)		
19	Reply Submissions by Mr. Maxston (Second		46
20	Preliminary Application)		
21	Ruling (Second Preliminary Application)		47
22	Submissions by Mr. Kitchen (Third Preliminary		49
23	Application)		
24	Submissions by Mr. Maxston (Third Preliminary		56
25	Application)		
26			

EXHIBITS	
Description	Page
EXHIBIT H-1 - Preliminary Application: Complaints Director's Reference Document	36
EXHIBIT H-2 - Karen MacLeod v. The Alberta College of Social Workers, dated January 12, 2018	47
EXHIBIT H-3 - R. v. Chikmaglur Mohan 1994 SCC 80	48
EXHIBIT H-4 - Genevieve Wright v. The College and Association of Registered Nurses of Alberta, 2012 ABCA 267	48
EXHIBIT G-4 - 2-page curriculum vitae of Chris Schaefer	63
EXHIBIT G-5 - 89-page document titled "Chris Schaefer Expert Witness Report"	63
EXHIBIT A-1 - Amended Notice of Hearing, Notice to Attend as Witness, and Notice to Produce, July 22, 2021	68
EXHIBIT A-2 - Email from AHS to Member re Complaint, dated December 1, 2020	68
EXHIBIT A-3 - Letter of Complaint Referral from Registrar, dated December 2, 2020	68

1	EXHIBIT A-4 - ACAC Statement on Alberta Health	68
2	Notice of Closure for a Calgary Chiropractic	
3	Clinic, December 15, 2020	
4	EXHIBIT A-5 - Letter to Member re s.56	68
5	Complaint, dated December 21, 2020	
6	EXHIBIT A-6 - Letter from Member in	68
7	Response to Complaint, January 11, 2021	
8	EXHIBIT A-7 - ACAC Complaint Investigation	68
9	Report	
10	EXHIBIT A-8 - Letter from Dr. Salem, dated	68
11	December 12, 2020	
12	EXHIBIT A-9 - Letter from Dr. Salem, dated	68
13	January 11, 2021	
14	EXHIBIT A-10 - ACAC Code of Ethics	68
15	EXHIBIT A-11 - ACAC Standards of Practice	68
16	EXHIBIT B-1 - Letter Requesting s.65 Review,	68
17	dated December 3, 2020	
18	EXHIBIT B-2 - Letter Requesting Extension,	69
19	dated December 9, 2020	
20	EXHIBIT B-3 - Response of Dr. Wall s.65 Request,	69
21	dated December 10, 2020	
22	EXHIBIT B-4 - Response of Dr. Wall s.65 Request	69
23	and Enclosures, dated December 16, 2020	
24	EXHIBIT B-5 - Letter of Decision re s.65 Review,	69
25	dated December 18, 2020	
26		

1	EXHIBIT C-1 - ACAC Notice to Members re	69
2	Telehealth Billing, dated March 26, 2020	
3	EXHIBIT C-2 - ACAC Notice to Members re	69
4	Consultation, dated April 21, 2020	
5	EXHIBIT C-3 - ACAC Notice to Members re	69
6	Consultation, April 22, 2020	
7	EXHIBIT C-4 - ACAC Website Update on COVID	69
8	Practices, April 29, 2020	
9	EXHIBIT C-5 - ACAC Notice to Members re Return	69
10	to Practice, dated April 30, 2020	
11	EXHIBIT C-6 - ACAC Notice to Members re Return	69
12	to Practice, dated May 1, 2020	
13	EXHIBIT C-7 - ACAC Notice to Members re Approval	69
14	of Plan, dated May 3, 2020	
15	EXHIBIT C-8 - ACAC Notice to Members about	69
16	Masking, May 25, 2020	
17	EXHIBIT C-9 - ACAC Notice to Members about	69
18	Masking, dated July 24, 2020	
19	EXHIBIT C-10 - ACAC Council Updates re	70
20	Telehealth, July 31, 2020	
21	EXHIBIT C-11 - ACAC Registrar's Report, August	70
22	4, 2020	
23	EXHIBIT C-12 - ACAC Notice to Members re COVID	70
24	Practices, dated August 11, 2020	
25	EXHIBIT C-13 - ACAC Website re Telehealth,	70
26	October 20, 2020	

1	EXHIBIT C-14 - ACAC Notice to Members re	70
2	Directive, dated November 23, 2020	
3	EXHIBIT C-15 - ACAC Notice to Members re	70
4	Restrictions, dated November 25, 2020	
5	EXHIBIT C-16 - ACAC Website COVID FAQs, dated	70
6	November 25, 2020	
7	EXHIBIT C-17 - ACAC Website Update on COVID	70
8	Practices, December 1, 2020	
9	EXHIBIT C-18 - Notice to Members about Masking,	70
10	dated December 9, 2020	
11	EXHIBIT C-19 - ACAC Notice to Members re PPE,	70
12	date December 10, 2020	
13	EXHIBIT C-20 - ACAC COVID-19 Pandemic Practice	70
14	Directive, May 5, 2020	
15	EXHIBIT C-21 - ACAC COVID-19 Pandemic Practice	70
16	Directive, May 25, 2020	
17	EXHIBIT C-22 - ACAC COVID-19 Pandemic Practice	70
18	Directive, January 6, 2021	
19	EXHIBIT D-1 - COVID-19 Business Closure Order	71
20	CMOH 25-2020, dated December 8, 2020	
21	EXHIBIT D-2 - Has Order to Rescind Closure	71
22	Notice, January 5, 2021	
23	EXHIBIT D-3 - CMOH Order 19-2021, dated May 6,	71
24	2021	
25	EXHIBIT D-4 - CMOH Order 20-2021, dated May 6,	71
26	2021	

1	EXHIBIT D-5 - CMOH Order 22-2021, dated May 13,	71
2	2021	
3	EXHIBIT D-6 - CMOH Order 26-2020, dated June 6,	71
4	2020	
5	EXHIBIT D-7 - CMOH Order 34-2021, dated June 30,	71
6	2021	
7	EXHIBIT D-8 - CMOH Order 38-2020, dated November	71
8	24, 2020	
9	EXHIBIT D-9 - CMOH Order 42-2020, dated December	71
10	11, 2020	
11	EXHIBIT D-10 - City of Calgary - Temporary	71
12	COVID-19 Face Covering Bylaw, March 11, 2020	
13	EXHIBIT D-11 - City of Calgary - Bylaw that	71
14	repeals Mask Bylaw, dated July 5, 2021	
15	EXHIBIT E-1 - 9-page curriculum vitae for	71
16	Dr. Jia Hu	
17	EXHIBIT E-2 - Dr. Jia Hu - Expert Report Masking	71
18	EXHIBIT E-3 - 9-page curriculum vitae for	72
19	Dr. Bao Dang	
20	EXHIBIT E-4 - Dr. Bao Dang - Expert Report	72
21	Masking	
22	EXHIBIT E-5 - 95-page curriculum vitae for	72
23	Dr. Byram Bridle	
24	EXHIBIT E-6 - Dr. Byram Bridle - Expert Report	72
25	Masking	
26		

1	EXHIBIT E-7 - 5-page curriculum vitae for	72
2	Dr. Thomas A. Warren	
3	EXHIBIT E-8 - Dr. Thomas A. Warren - Expert	72
4	Report Masking	
5	EXHIBIT F-1 - GOA Albert's safely staged	72
6	COVID-19 relaunch, dated April 30, 2020	
7	EXHIBIT F-2 - CMOH Order 16-2020, dated May 3,	72
8	2020	
9	EXHIBIT F-3 - ACAC Registrar's Report, dated	72
10	July 5, 2021	
11	EXHIBIT F-4 - ACAC Frequently Asked Questions,	72
12	dated July 7, 2021	
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		

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

4

5 September 1, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

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

22

23 (PROCEEDINGS COMMENCED AT 9:10 AM)

24 THE CHAIR: Good to see everyone here.

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

26 Dr. Wall and counsel are here?

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

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

3 MR. KITCHEN: We are.

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

5 DR. WALL: Hello there.

6 THE CHAIR: Good morning. Okay, we have
7 our court reporter, Karoline Schumann. We have for the
8 College, David Lawrence and Mr. Maxston, and we have
9 one observer, Parker Hogan, and our court reporter,
10 Karoline Schumann.

11 Opening Remarks

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

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

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

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

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

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

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

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

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

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

25 MR. KITCHEN: None from Dr. Wall.

26 THE CHAIR: Thank you. Are there any

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

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

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

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

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

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

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

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

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

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

7 Discussion

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

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

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

26 THE CHAIR: Okay.

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

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

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

26 Hopefully we can complete the liability phase of

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

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

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

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

18 THE CHAIR: I'm aware of two.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 relates to Mr. Kitchen's application.

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

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

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

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

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

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

1 THE CHAIR: Go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 THE CHAIR: Okay --

8 MR. MAXSTON: Mr. Chair --

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

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

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

25 MR. KITCHEN: Thank you.

26 (ADJOURNMENT)

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

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

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

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

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

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

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

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

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

10 THE CHAIR: I'm --

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

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

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

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

20 MR. MAXSTON: Yeah, paragraph 20.

21 THE CHAIR: Okay, we're good.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 these charges and properly prepare for them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 THE CHAIR: Yes.

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

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

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

24 (ADJOURNMENT)

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

1 Ruling (First Preliminary Application)

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

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

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

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

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

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

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

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

13 MR. MAXSTON: Mr. Chair --

14 THE CHAIR: Yeah, Mr. Maxston.

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

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

1 admissibility.

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

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

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

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

1 those around them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 MR. MAXSTON: But --

26 THE CHAIR: -- 'H'.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 comments in response.

2 THE CHAIR: Okay, Mr. Maxston.
3 Reply Submissions by Mr. Maxston (Second Preliminary
4 Application)

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

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

21 Those are my submissions, thank you.

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

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

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

3 (ADJOURNMENT)

4 Ruling (Second Preliminary Application)

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

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

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

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

1 2018

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

3 80

4 EXHIBIT H-4 - Genevieve Wright v. The College

5 and Association of Registered Nurses of

6 Alberta, 2012 ABCA 267

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

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

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

23 MR. KITCHEN: Yes.

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

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

1 any objections to doing that now.

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

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

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

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

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

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

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

1 Could you just go over the tests again.

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

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

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

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

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

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

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

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

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

1 harmful.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 THE CHAIR: Thank you, Mr. Kitchen.

17 MR. KITCHEN: Thank you.

18 THE CHAIR: Mr. Maxston?

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

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

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

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

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

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

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

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

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

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

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

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

1 rules; it breaks the rules.

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

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

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

1 as scheduled.

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

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

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

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

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

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

11 That's my response.

12 THE CHAIR: Thank you.

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

17 THE CHAIR: Okay.

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

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

1 means to be a professional.

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

14 Thank you for allowing me that further comment.

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

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

24 (ADJOURNMENT)

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

1 Ruling (Third Preliminary Application)

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

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

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

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

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

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

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

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

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

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

1 Opening by Mr. Maxston

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

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

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

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

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

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

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

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

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

15 MR. KITCHEN: Yes, they have.

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

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

1 documents.

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

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

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

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

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

22 MR. KITCHEN: No.

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

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

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

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

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

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

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

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

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

17 EXHIBIT A-7 - ACAC Complaint Investigation
18 Report

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

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

23 EXHIBIT A-10 - ACAC Code of Ethics

24 EXHIBIT A-11 - ACAC Standards of Practice

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

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

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

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

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

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

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

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

26 Each of the Complaints Director's witnesses would

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

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

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

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

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

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

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

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

8 MR. MAXSTON: I think they would --

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

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

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

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

21 THE CHAIR: Okay.

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

1 reconvene to deal with the matter of penalty orders.

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

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

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

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

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

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

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

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

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

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

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

26 Contravention of another enactment that

1 applies to this profession.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 steps when it comes to evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Discussion

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

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

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

6 THE CHAIR: 10 minutes.

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

12 MR. MAXSTON: Yeah.

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

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

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

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

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

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

7 Chair, is that how you want to proceed?

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

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

13 Opening by Mr. Kitchen

14 MR. KITCHEN: All right, thank you.

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

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

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

1 That's the issue.

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

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

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

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

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

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

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

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

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

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

26 I note the word "overwhelming" was used to

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

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

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

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

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

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

10 That's my opening comments.

11 THE CHAIR: Thank you, Mr. Kitchen.

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

14 Discussion

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

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

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

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

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

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

4 It's just a couple of minutes after 12, so we'll
5 reconvene at 1:00 with the College's first witness.

6 The hearing will go into recess until then.

7

8 PROCEEDINGS ADJOURNED UNTIL 1:00 PM

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

4

5 September 1, 2021

Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees

Tribunal Chair

9 W. Pavlic

Internal Legal Counsel

10 Dr. L. Aldcorn

ACAC Registered Member

11 Dr. D. Martens

ACAC Registered Member

12 D. Dawson

Public Member

13 A. Nelson

ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 D. Lawrence

ACAC Complaints Director

17 B.E. Maxston, QC

ACAC Legal Counsel

18

19 FOR DR. CURTIS WALL

20 J.S.M. Kitchen

Legal Counsel

21

22 K. Schumann, CSR(A)

Official Court Reporter

23

24 (PROCEEDINGS RECOMMENCED AT 1:03 PM)

25 THE CHAIR:

The Hearing Tribunal regarding

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

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

5 THE WITNESS: Sure.

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

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

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

24 A Yeah, Jia Hu.

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

1 A Yes.

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

4 A Yes.

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

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

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

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

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

16 Prepared by Jia Hu and Margaret Pateman.

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

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

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

1 expert report as your expert report?

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

4 Q Okay, thank you very much.

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

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

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

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

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

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

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

15 A I am.

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

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

23 Q And those would be COVID-related?

24 A Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 A Yeah.

9 Q -- was involved there?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 A Yeah.

13 Q -- two entries there?

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

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

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

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

10 Q Okay. Thank you very much.

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

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

19 MR. KITCHEN: Can you hear me?

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

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

23 THE CHAIR: Yeah.

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

1 to have some issues with how long that is?

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

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

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

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

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

15 MR. KITCHEN: And other preventative
16 measures.

17 MR. MAXSTON: Measures, yeah.

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

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

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

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

1 correct?

2 A M-hm.

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

6 A Yes.

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

9 A Yeah, I'll --

10 Q -- "yes" --

11 A -- say "yes" --

12 Q -- (INDISCERNIBLE) --

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

14 Q We all do it.

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

18 A That is correct.

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

23 A Yes.

24 Q You're not a virologist, correct?

25 A I am not a virologist.

26 Q You're not an immunologist, correct?

1 A No.

2 Q You're not a respirologist, correct?

3 A Correct.

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

5 A Correct.

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

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

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

17 A Yeah.

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

20 A M-hm.

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

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

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

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

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

19 A Oh, okay.

20 Q Do you dispute that?

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

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

25 A Yes. Absolutely.

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

1 manufacturers of COVID vaccines, do you not?

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

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

8 A Yeah, that's true.

9 Submissions by Mr. Kitchen (Qualification)

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

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

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

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

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

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

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

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

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

18 A Yes, for sure.

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

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

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

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

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

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

16 A M-hm.

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

20 A Okay.

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

23 A Okay, that's fine.

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

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

26 MR. KITCHEN: Yes, I am.

1 Discussion

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

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

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

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

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

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

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

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

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

14 A Thank you.

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

18 A Okay.

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

22 A Great, thank you.

23 (ADJOURNMENT)

24 Ruling (Qualification)

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

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

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

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

14 THE CHAIR: That's --

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

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

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

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

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

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

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

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

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

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

1 than --

2 Q Outbreaks?

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

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

12 A Yes.

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

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

15 Q And again --

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

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

22 A Yes.

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

25 A Yes.

26 Q Can you describe that?

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

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

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

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

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

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

13 A Yes.

14 Q Can you describe that to me?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 CMOH 38-2020.

2 A Yeah. This is CMOH 42?

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

5 A Okay.

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

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

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

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

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

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

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

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

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

1 includes the city of Calgary.

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

4 A Correct.

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

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

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

14 A Yes, yes, must, correct.

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

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

20 Are you familiar with that exemption?

21 A I am.

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

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

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

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

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

6 THE CHAIR: Okay.

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

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

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

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

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

1 Edmonton in particular.

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

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

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

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

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

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

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

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

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

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

3 A Could you repeat that question?

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

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

9 Q Provided that the CMOH orders were complied with?

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

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

4 A Okay, let me pull it up.

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

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

8 MR. KITCHEN: F-2.

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

11 MR. KITCHEN: Thank you.

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

15 (DISCUSSION OFF THE RECORD)

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

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

1 A Yeah.

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

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

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

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

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

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

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

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

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

17 A M-hm.

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

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

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

22 A Yeah: (as read)

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

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

4 Q So this is --

5 A (INDISCERNIBLE)

6 Q Oh, sorry.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 Is this a check and a balance?

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

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

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

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

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

18 A M-hm.

19 Q -- under this order?

20 A Yes.

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

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

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

3 A Yes, I believe so.

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

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

11 That's mandatory language?

12 A Yes, I think so.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 MR. MAXSTON: Yeah --

11 THE CHAIR: -- 'C' folder?

12 MR. MAXSTON: -- C-22.

13 THE CHAIR: C-22, thank you.

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

17 MR. MAXSTON: Yeah.

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

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

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

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

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

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

16 MR. MAXSTON: Yeah, okay.

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

19 A Yeah.

20 Q -- Pandemic Directive.

21 A Yeah, I'm there.

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

23 A M-hm.

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

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

3 A Yes.

4 Q Can you tell me why?

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

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

10 A Yes.

11 Q Can you tell me why?

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

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

26 You see more to another (INDISCERNIBLE)

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

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

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

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

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

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

4 A Yeah.

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

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

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

14 A I do.

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

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

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

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

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

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

7 Do you agree with the statements in this document?

8 A Definitely, yes.

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

12 A Yeah. I have that.

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

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

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

21 Do you agree with that statement?

22 A Yes.

23 Q Can you tell me why?

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

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

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

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

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

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

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

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

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

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

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

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

12 On page 1 of that document --

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

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

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

23 Can you describe this dual purpose of masking?

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

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

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

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

16 A Yes.

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

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

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

24 A M-hm.

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

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

3 A Yes.

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

6 A Yes.

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

9 A Yes.

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

13 A No.

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

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

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

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

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

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

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

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

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

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

17 A Extremely high.

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

23 A I did, yes.

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

26 A No.

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

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

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

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

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

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

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

25 A Oh --

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

1 A Yeah, sorry, sorry, I misunderstood. I'll stop --

2 Q No --

3 A -- (INDISCERNIBLE) --

4 Q -- that's fine. The next paragraph says: (as read)

5 Masks are a form of protective device
6 designed to protect the person wearing the
7 mask and protect those in their immediate
8 surroundings.

9 Is this is the dual affect we were just talking about
10 before?

11 A Yes.

12 Q The next paragraph talks about the use of masks and
13 other nonpharmaceutical interventions being recommended
14 by World Health Organization. Can you tell me about
15 the -- bear with me -- you talk about the use of masks,
16 sorry, in SARS and influenza. Can you talk about the,
17 briefly, the historical experience recently with the
18 use of masks?

19 A Yes. And I apologize, again, to Karoline, I keep on
20 talking over Blair, and I said I wouldn't, and I've
21 really sorry about that.

22 Look, I think that like our understanding of mask
23 efficacy has grown exponentially because of COVID.
24 Nothing in the history of medicine and probably in the
25 history of humanity has been researched as much as
26 COVID-19, right, like that's a fact.

1 And I would say, first of all, that we've learned
2 a heck of a lot more about mask use and how good it is,
3 where it works, where it doesn't work quite as well
4 over the last 18 months than we have in the history --
5 just the sum total of everything we've known before.

6 For example, one thing we did not use before was
7 continuous masking in health care centres, right? Like
8 that is not something that we did; that is something
9 that was new. And we -- you know, we began to do that
10 as we learned more about how COVID-19 transmitted
11 and (INDISCERNIBLE), a.k.a. a lot of the sort of
12 asymptomatic transmission. But when I think about --

13 Sorry, am I answering your question or sort of
14 going off on a tangent? Is that what you meant?

15 Q Yeah, I think you -- in the paragraph above, you talk
16 about the historical use of masks dating back to the
17 1600s, and then you've got some comments here about
18 some of the more recent experience, and I'm just asking
19 you to summarize that.

20 A Oh, yeah. I mean, masks have been used for a long
21 time, used in different health care settings. You
22 know, we know that they are an effective tool for
23 preventing the spread of respiratory viruses writ
24 large. And then (INDISCERNIBLE) what I've said before,
25 but we know far, far, far more about masking and its
26 effectiveness around COVID-19 than any -- than the sum

1 of everything we knew about masks in the history of all
2 masks that is going back, yeah.

3 Q In the middle of that paragraph we're talking about,
4 you mentioned on line 4 a Cochrane review, and it
5 included -- I'm skipping a couple lines -- 67
6 randomized control trials and observational studies.
7 What do those terms mean, "randomized control trials"
8 and "observational studies"?

9 A Yeah, so a randomized control trial is generally
10 considered like the gold standard of a type of a
11 medical study, right. Essentially in a randomized
12 control trial, what you do is there's a -- let's say
13 you split the population in half, and they actually
14 sort of split randomly, so the characteristics of those
15 two populations is the same. And then one group gets
16 assigned a treatment, let's say it's a medication, and
17 the other group gets assigned nontreatment, like a
18 placebo, for example.

19 And then you essentially use that to -- and then
20 you look at the treatment group to see if there's a
21 difference in effect, effect being, you know, your
22 outcome of interest, let's say, for a medication, you
23 know, how much it reduces your blood pressure.

24 And, you know, the reason why I randomized --
25 randomized part is when I say "randomized", that's when
26 I said you split these people in half randomly, so the

1 characteristics of the two groups should be sort of
2 random -- like largely similar, controlled in the sense
3 that you kind of control the study, you know, like
4 you've had very precise control over the study and
5 trial and that sort of randomized control trial.

6 Observational study is a more general term to
7 describe the type of study where you don't have sort of
8 much control over it, right. So an example of an
9 observational study would be some of the stuff that I,
10 you know, mentioned like around the COVID units of
11 Alberta. So like I'm observing that, you know, even
12 though we didn't have a vaccine, and there are hundreds
13 of thousands of interactions between COVID-positive
14 patients and COVID-negative health care workers, there
15 were very, very few COVID transmission events.

16 I will say that the issue with randomized control
17 trials is they cannot be generally used in the absence
18 when you have something called clinical equipoise.

19 So the best example of that is this: We generally
20 don't do randomized control trials on the effectiveness
21 of parachutes from jumping out of planes, right,
22 because, like, if you -- we could test them out that
23 way, but if we were to do that, the person -- we have a
24 hypothesis that the person with that parachute would
25 die.

26 And so like I say that because, when it came to

1 COVID, there aren't as many RCTs around COVID-19,
2 because it became pretty abundantly clear pretty early
3 that masking was good, and, therefore, depriving health
4 care workers of masks, like you can't do that, that
5 would be considered an unethical study; just like
6 depriving somebody of a parachute jumping out of a
7 plane would be considered unethical to study the
8 efficacy of parachutes for preventing death when you
9 jump out of a plane. So ...

10 Q Okay. I want to turn to the next page on your report,
11 and you talk there about "Methods", and on line number
12 2 -- oh, I should go back -- you talk E-2 about
13 databases such as PubMed, JSTOR, Cochrane Library,
14 high-quality peer reviewed. I think you've commented
15 on what peer reviewed means, but there's something
16 interesting in the -- at the end of your --
17 that sentence -- or that paragraph, it says: (as read)

18 The vast majority of literature is from the
19 years 2020 to 2021 with an emphasis on
20 literature published in 2021 as it is the
21 most up-to-date and evidence informed.

22 Why is that important, being up-to-date and evidence
23 informed?

24 A Well, specifically what we're really interested in,
25 right, is how good masks are at preventing COVID-19,
26 right? COVID-19 wasn't around, well, in 2019, really.

1 I guess it was maybe in China, the tail end of 2019.

2 And so when I, you know, look at past -- and, you
3 know, I comment on past studies around masking, but,
4 you know, it's less salient in the discussion because
5 different viruses like influenza or RSV have different
6 transmission dynamics than COVID-19, right, and so what
7 we want are studies to look at masking and COVID-19 in
8 specific, right, because every virus is different.
9 Yeah.

10 Q Okay. I'm going to go to the next section in your
11 expert report, which is entitled "Benefits of Masking".
12 Second sentence, I'll let you read -- or comment on,
13 the second sentence in that paragraph says: (as read)

14 Vast majority of evidence presented was by
15 credible academic sources indicating mask use
16 does reduce the rate of transmission in
17 clinical and lab settings.

18 And then: (as read)

19 Below are multiple studies detailing the
20 effectiveness of mask use in response to the
21 other expert reports.

22 What are you trying to communicate in that paragraph,
23 Dr. Hu?

24 A You know, in this paragraph, I guess what I'm basically
25 saying is that as the first (INDISCERNIBLE) says, like
26 as the pandemic progressed, there was more and more

1 evidence around what we wanted to specifically know
2 about, which is COVID-19 and masks, and this evidence
3 generally got published in very high quality, different
4 journals and different levels of, you know, quality.
5 They're all peer-reviewed.

6 So we began to build essentially more and more of
7 a robust case for masking, and, generally speaking,
8 that these studies show that masking is good at
9 reducing COVID-19 transmission in a clinical setting,
10 in a lab setting, various -- like all sorts of
11 different settings, so it's more I feel like what I've
12 been saying a lot over and over again, sorry.

13 Q Well, I'm asking you to do that, so you can -- you'll
14 have to bear with me.

15 The next paragraph talks about the
16 transmissibility of COVID-19. Can you describe that?

17 A Yeah, so COVID-19 is believed to be transmitted
18 through, you know, primarily through contact and
19 respiratory droplets, right, and to a lesser extent
20 through, you know, aerosols, right. And so basically,
21 you transmit it in a way I'll say that is like broadly
22 similar to the way like influenza is transmitted,
23 broadly similar I say, as opposed to something like
24 HIV, which is transmitted through sexual intercourse.

25 We now that COVID-19 is relatively infectious, you
26 know, in that, you know, we sort of thought the

1 original COVID-19 had a sort of R0 of 2.5. That
2 basically means, you know, one person would, on
3 average, infect 2-and-a-half people if everybody was
4 susceptible.

5 With the Delta variant, we think that R0's 4,
6 maybe even 5, and so COVID-19 is quite infectious, and
7 maybe -- a very good example of why COVID-19 is very
8 infectious, you know, every year we have a flu season,
9 right, and we can't really stop the flu season. But
10 this year, last year, we had no flu, and even though we
11 had no flu, there was a heck of a lot of COVID-19
12 still, and so our measures used to control COVID-19
13 were clearly sufficient to stop the spread of
14 influenza, but clearly insufficient to spread the
15 stop [sic] of COVID-19. So highly infectious
16 respiratory virus, but you all know that after tens of
17 millions of cases around the world. Hundreds, yes.

18 Q I'm looking at the next --

19 MR. MAXSTON: Mr. Chair, I should mention I
20 intend to take, if the Tribunal is willing or is
21 agreeable, I intend to take a break at 3:00, if that
22 will work for everybody, and then resume, and we maybe
23 go another hour after about a 15-minute break. I think
24 the intention is probably to try to finish each day by
25 about 4 or 4:30, somewhere in there, so just to give
26 you a heads-up on -- and, of course, if anybody on the

1 Tribunal needs a break at any time sooner, please let
2 me know, but I just thought I'd mention I thought I'd
3 go till 3:00.

4 MR. KITCHEN: Based on that, Mr. Maxston, it
5 sounds like we're not going to have time for
6 cross-examination today; is that you're thinking?

7 MR. MAXSTON: I'm thinking, and as I
8 mentioned to you, Mr. Kitchen, Dr. Hu is available to
9 come tomorrow morning at 9 AM to finish any examination
10 and cross-examination, so yes.

11 A Yeah.

12 MR. KITCHEN: Okay, that's fine.

13 Q MR. MAXSTON: The next paragraph in your
14 report, Dr. Hu, says: (as read)

15 To reduce transmission and spread to others,
16 studies indicate that physical distancing in
17 conjunction with such measures as mask
18 wearing can reduce the probability of droplet
19 spread.

20 Can you comment on why physical distancing is
21 important?

22 A Yeah, and, you know, again, this is me -- like I say,
23 in conjunction with things like vaccines as well, but,
24 you know, if you imagine that, you know, this virus is,
25 let's say, primarily spread through respiratory
26 droplets, I -- like I cough, there's little bits of

1 like spit with virus in them, and, you know, I cough
2 on -- like I cough on Mr. Maxston, and if he's 1
3 metre -- well, if he's right up to my face, then he'll
4 get all -- a big spray of COVID-19 spittle on his face,
5 which can cause infection.

6 If he is, let's say, a hundred metres away, my
7 little respiratory droplets probably won't go that far,
8 and, you know, we -- the further you are from
9 somebody -- and this is pretty obvious -- the less
10 likely you're going to get a virus sort of like this.
11 You know, I will say that it is known that COVID-19
12 does have some aerosol transmission.

13 And, you know, the line between -- here's how our
14 understanding evolved, right? Before, we were like
15 contacting droplet means if you're outside of the
16 2-metre range, you're probably not going to get the
17 virus, and if you're within the 2-metre range, you're
18 (INDISCERNIBLE). But conceptually, and this is where
19 like our understanding has really evolved over COVID,
20 if you coughed into a fan, and like clearly like your
21 little wet spray droplets can go more than 2 metres
22 presumably, right. And so when I say aerosol
23 transmission, you know, we can go further than 2
24 metres, and, you know, these droplets sometimes linger
25 in the air. And so it's less of like a -- you know,
26 it's airborne versus contacting droplet, like, you

1 know, like binary, like one, zero, on, off, it's more
2 of a continuous spectrum sort of transmission where the
3 further you are from somebody who is infectious, the
4 less likely you are to get it.

5 Q I'm going to go to the -- just carry on with your
6 report, and there's a comment about a large outbreak of
7 COVID-19 on the USS Theodore Roosevelt of an aircraft
8 carrier, I believe, and after that, there's a paragraph
9 that says: (as read)

10 The Public Health Agency of Canada produced a
11 COVID-19 brief titled "Does wearing a mask in
12 public decrease the transmission of
13 COVID-19".

14 You've already told me what the Public Health Agency of
15 Canada is, can you tell me -- and this I think is the
16 next couple of paragraphs in your report -- what the
17 Public Health Agency of Canada's brief found?

18 A Yeah, so, you know, it's this brief basically comments
19 on some of the evidence around masking and how it does
20 reduce the transmission of COVID-19. And, you know,
21 like you've got to remember, right, like -- and I'll
22 own this -- at the very start of this pandemic, we were
23 not recommending continuous masking, right? And the
24 Public Health Agency of Canada was saying you don't
25 have to wear a mask outside, you don't have to wear a
26 mask indoors, we weren't saying -- recommending mask

1 wear, like mask use in health care settings when the
2 pandemic started, right?

3 And over time, it didn't take too long, our
4 evidence sort of changed or the recommendations
5 changed, and that -- those recommendations changed on
6 the basis of evidence. And I say this because I think
7 it's really important to recognize that we've learned
8 lot about this, and organizations like the Public
9 Health Agency of Canada, like AHS, like CMOH office, we
10 take evidence, and we change our recommendations as new
11 evidence evolves, right? And so I'll just cap it at
12 that, because that did happen, initially we weren't
13 recommending mask use, and that was a mistake. And
14 I -- it wasn't me recommending that, but I'll like own
15 that mistake on behalf of Public Health.

16 But, you know, this little brief basically then
17 goes to cite a few different studies where, you know,
18 masking did reduce transmission, so, you know, one of
19 these is a longitudinal study in the US that it showed,
20 you know, essentially with an increased use in face
21 masks, you're going to have like lower cases.

22 There's a real interesting hairstylist study
23 actually, where basically, you know, if you imagine
24 somebody cutting somebody's hair, you're pretty like up
25 and cozy with them for a long period of time; and, you
26 know, essentially the COVID-positive hairstylist who

1 saw 139 people while infectious, and they were all
2 masked, and nobody became positive, right; and that's
3 reasonable evidence to show that masking may work, may
4 reduce the risk.

5 And, you know, there's something call an
6 ecological study here, right, and think of an
7 ecological study as a subset of an observational study
8 where, you know, you're not controlling the experiment,
9 you just sort of observe what happens over time, you
10 know, when masks are used, when they're not used, and
11 the vast majority, so 26 out of 27 studies showed that
12 face mask policies did decrease COVID-19 infections
13 and, naturally, that would decrease deaths.

14 If anything, like when I wrote this report,
15 there's like too many studies to talk about in favour
16 of masking, so I picked a few, right, but, you know,
17 I -- even this brief cites 27 studies at least that
18 show that, you know, masking is beneficial for reducing
19 transmission.

20 Q Just one quick question before we break, it's almost
21 3:00, you have a -- in the last paragraph on that
22 section, just about masking for health care workers:
23 (as read)

24 A recent systematic review with a high AMSTAR
25 rating concluded use of masks did reduce the
26 risk of contracting and transmitting

1 COVID-19. Overall, the Public Health Agency
2 of Canada brief, using evidence-informed
3 data, concludes that mask use decreases the
4 transmission in the community.

5 I take it that's still your conclusion?

6 A Yes.

7 Q And what's an AMSTAR rating?

8 A So, you know, with different type -- for most types of
9 studies, like whether you have a randomized control
10 trial study or systematic review type of study, they're
11 sort of like rating systems to, you know, kind of look
12 at how good -- within the -- within, let's say, the
13 universe of systematic reviews, like some are better
14 than others, and there are sort of rating systems where
15 you can sort of like assess the quality of the
16 systematic review by looking into a few factors, you
17 know, like did they include all the studies, did they
18 do the correct sort of like literature review, like
19 stuff like that. So it's a rating -- it's like rating
20 score for systematic reviews. So it means it's a good
21 systematic review.

22 Q Thank you.

23 MR. MAXSTON: Mr. Chair, I would propose to
24 take a 15-minute break now and then give everyone a
25 chance to take a bio break and then proceed from about
26 3:15 till about 4:15 if that works for everybody, and I

1 think I'll be able to be finished with Dr. Hu today on
2 that timeline.

3 THE CHAIR: Okay, that sounds good. I'm
4 not seeing any shaking heads, I'm seeing nodding heads,
5 so we'll do that. We will recess for now and reconvene
6 at 3:15. Thank you, Dr. Hu, and we'll see you in 15.

7 A Thank you. Sorry for being too long-winded. See you
8 soon.

9 (ADJOURNMENT)

10 THE CHAIR: It's 20 after 3. We
11 anticipate about another hour, and the plan will be to
12 finish the direct examination of Dr. -- by the way, the
13 hearing is back in session, and the plan is to finish
14 direct examination of Dr. Hu this afternoon, and
15 assuming that things go the way they are expected to,
16 we would adjourn for the day and pick up tomorrow
17 morning at 9:00 where we leave off today. Likely that
18 will be with Mr. Kitchen's cross-examination of Dr. Hu.

19 So I'll turn it back to you, Mr. Maxston.

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

21 Q MR. MAXSTON: Dr. Hu, I'm now taking you to
22 the heading in your expert report "Masking for
23 healthcare workers". In that paragraph, the first
24 paragraph, you talk about a three-fold increased risk
25 of reporting a positive COVID-19 test compared with the
26 general community, that's for health care workers. Can

1 you just explain what your comments here are about in
2 this paragraph?

3 A Yeah, so I mean basically this is saying that health
4 care workers are at potentially high risk of COVID than
5 non-health care workers, which stands to reason for a
6 number of possible reasons: One, if you think about
7 health care workers work in person, health care workers
8 work closely in person with people, and health care
9 workers interact with COVID-positive patients more
10 than, you know, the -- like your average person in
11 society, because your average person in society, you
12 know, over the last year-and-a-half has spent a lot of
13 time in some degree of lockdown or another, so, yeah.

14 Q Okay. You then have got some comments about
15 chiropractors falling into the category of HCWs or
16 health care workers. I'm looking at, you've got a
17 citation 13, and then there's a comment that starts:
18 (as read)

19 This statement indicates that chiropractors
20 are a health care worker and must adhere to
21 proper health and safety protocols.

22 What if they don't adhere to proper safety, health in
23 protocols in terms of COVID?

24 A Well, yeah, I mean, as with any sort of health care
25 worker, they're going to be at an increased risk of
26 getting COVID and/or giving COVID to their patients.

1 Q In the next paragraph, you talk about: (as read)

2 The evidence of the importance of mask use
3 among HCWs is very robust, and there is an
4 overwhelming body of evidence supporting the
5 use of masking in health care settings to
6 reduce COVID transmission.

7 Again, clinically, why did you choose the words
8 "robust" and "overwhelming body of evidence"?

9 A This is -- I like to use the word "robust" once in a
10 while. I could have used the word "strong". When I
11 say "overwhelming", I just mean there's like lots of
12 studies on it. You know, rarely do you have dozens and
13 dozens of studies on the same thing, reporting the
14 same, you know, benefit over and over again. I mean,
15 not all the studies show the exact same benefit, but,
16 yeah, like there's just like a ton of -- heaps, mounds
17 of evidence.

18 Q In the couple paragraphs down, you talk about a study
19 relating to the Massachusetts health care system that
20 was reported in the Journal of the American Medical
21 Association with -- I think involving 75,000 employees.
22 Can you talk about the importance of that study?

23 A Yeah, so I mean this is just one of the sort of many
24 studies. This is a fairly large study, right, I would
25 say, given the sample size of the health care workers.
26 But, you know, essentially this study looks at,

1 you know, the effect of implementing universal masking
2 and sort of how many health care workers became sort
3 of, you know, positive. And, you know, in the study,
4 you do see that there was a significant decline in like
5 risk of acquiring COVID-19 once, you know, universal
6 masking was in place.

7 Q The next couple of paragraphs down, you start with a
8 paragraph that says: (as read)

9 If we look closer to home in Alberta, there
10 is clear evidence of benefit to mask wearing
11 in the health care settings.

12 And then you go on to make some comments about -- I
13 guess in support of that statement. Can you summarize
14 what you're saying there?

15 A Yeah, yeah, this is back to sort of like what I said
16 earlier about the COVID ward example, and then so I
17 won't rehash that -- sorry, I jumped around a bit --
18 but COVID wards, no vaccine, masks only really, and it
19 worked pretty darn well.

20 Q And I think, in fact, you refer in that paragraph to
21 over tens of thousands of interactions between COVID-19
22 infectious patients and health care workers, and there
23 being only a handful of transmission events. Does that
24 support your opinion in this report?

25 A Yes.

26 Q I want to ask you in terms of your expert report and

1 your testimony, are using masks perfect?

2 A No. Nothing is perfect. Vaccines aren't perfect,
3 seatbelts aren't perfect. There's nothing that is
4 perfect, but it reduces transmission, and that's -- you
5 know, by a fairly substantial amount, so -- but they
6 aren't perfect.

7 Q I'm going to take you to the next part of your report,
8 which is your response to the statements by the other
9 experts, Drs. Warren, Dang, and Bridle, and I'm going
10 to ask you about Mr. Schaefer's expert report, but
11 that, of course, came in after you prepared this
12 document.

13 When I took you through your report, we talked
14 about a series of phrases, randomized control trials,
15 the AMSTAR rating, the quality peer-reviewed evidence,
16 systematic reviews, I think we talked about
17 meta-analysis. Bearing that in mind as a reference and
18 remembering the Journal of the American Medical
19 Association and Lancet, how would you characterize the
20 documents and studies cited by Drs. Warren, Dang, and
21 Bridle?

22 A Yeah, so I mean a few comments, and one is that, you
23 know, I -- when I read the reports, a lot of the
24 reports sort of aren't necessarily specifically about
25 masking in a health care setting and its effect on
26 COVID-19, right? It's about like how bad COVID is or

1 how not bad COVID is, and those things, right. And I
2 mean, I won't comment on that, I'm just saying that
3 stuff isn't directly salient to what we're talking
4 about today.

5 I think when it comes to some of the studies they
6 cite on masking, they -- you know, like they used
7 studies that were sort of before, the pre-COVID era,
8 and, again, I think that all I'm definitively saying is
9 that masking is very good for COVID-19, probably works
10 for other respiratory viruses, but like the
11 overwhelming body of evidence is for masking for
12 COVID-19. And I think these lot of older studies, you
13 know, I think they do comment on the lack of, one of
14 them, randomized control trials, but, again, I use my
15 example of sometimes we can't do RCTs, like, you know,
16 the parachute example. There's a lot of things we
17 can't do RCTs, randomized control trials, for.

18 And then they use kind of -- you know, they use
19 kind of like these -- like there's all sorts of lab
20 studies, that, you know, some of them show these
21 pictures of how masks are imperfect, and, you know,
22 even if you have a mask, there's sort of like leakage,
23 so to speak, right. And that's true, and masks are not
24 perfect, right. We know that, you know, how well you
25 put on your mask matters, how well the mask fits
26 matters, all these things matter.

1 But, you know, the type of evidence that I think
2 is the most compelling in this is what I call like an
3 epidemiological study, that is a type of observational
4 study that basically shows that, you know, in places
5 where we implement the masking, like transmissions
6 drop, right. And, you know, regardless of how
7 imperfect they are, the net end result, which we care
8 about, transmission or numbers of infections goes down.

9 And so I would, you know, essentially say that
10 what their reports, to summarize, one, a lot of them
11 don't talk about masking, so maybe not directly
12 salient. Two, they refer to some -- a few studies, but
13 they're pre-COVID, and so like it doesn't really
14 matter. Like, again, like I only care about COVID
15 studies and masks. And three, they comment on the
16 imperfection of masking, and I don't disagree with the
17 fact that masks are imperfect, but there's an update
18 that shows masks do reduce transmission, and that's
19 what we're interested in, that's what I'm interested in
20 when, you know, I'm going around telling people to
21 where masks in health care settings.

22 Q I asked you during my -- some questions a while ago
23 about your level of confidence in the studies and
24 reports that you had cited, and I think you said your
25 level of confidence was high, and you referred to
26 highly regarded institutions. Do you see those same

1 institutions in the citations from the three other
2 expert reports?

3 A No. I mean, like basically, as you probably all know,
4 like every Public Health organization recommends
5 masking in a health care setting, right? We talked
6 about some of them AHS, like PHAC, the Public Health
7 Agency of Canada, US CDC, like all the ministries do --
8 and so I don't because they all recommend masking.

9 Q You've got a statement that your first comment here is
10 in relation to Dr. Warren's statement about the risk of
11 death due to COVID-19 in persons under 60 is very
12 small, and you've got a response to that. Can you
13 please comment on that response, what it means?

14 A Yeah. I mean, I think that this is an example of the
15 statement is not directly salient to our discussion,
16 right, which is that, you know, he's saying that not a
17 lot of young people die from COVID. And it's true that
18 if you're over, let's say, 80, your risk of dying from
19 COVID is very, very, very high, but, you know, plenty
20 of people under 60 have died in Canada, 1475 since June
21 2021. I think about 3,000 people under 18 in the
22 United States have died of COVID. And so I acknowledge
23 that COVID is less likely to kill you if you're young,
24 I also acknowledge that COVID can kill you if you're
25 young, but, lastly, like this doesn't -- it's not
26 relevant.

1 Q Okay, I'm going to take you to your next comment where
2 you've quoted Dr. Warren's report by saying: (as read)
3 Asymptomatic transmission does occur, but the
4 rates of transmission from asymptomatic
5 persons is substantially less than from
6 symptomatic persons and does not warrant
7 being considered a significant contributor to
8 the overall transmission burden.

9 Can you comment on your thoughts to that statement?

10 A Yeah, so I mean I think that maybe what he's saying,
11 you know, asymptomatic transmission is not a big part
12 of, you know, overall COVID transmission, asymptomatic
13 or symptomatic. And I -- again, I acknowledge that
14 people who are symptomatic are at -- more likely to
15 transmit, you know, pound for pound than people who are
16 asymptomatic. But that being said, you know, viral
17 loads are actually the highest two days before symptom
18 onset than -- for what it's worth.

19 Actually nailing down the proportionate
20 transmission that's from asymptomatic versus
21 symptomatic is actually quite difficult to do, and so I
22 cite the CDC report saying it's about 60 percent. I
23 mean, other -- the lowest found estimate that I've seen
24 around asymptomatic transmission as a portion of total
25 transmission is probably around 20 percent, right. And
26 so whether it's 20 percent, whether it's 60 percent,

1 those are significant numbers, so, you know, it's not
2 like --

3 Q Okay.

4 A -- 1 percent.

5 Q There's another quotation here from Dr. Bridle's report
6 that begins with "Testing of asymptomatic people", and
7 there's a four or five-line quote there, and then
8 you've got another response there. Can you explain
9 your response to what Dr. Bridle is saying?

10 A Yeah, I mean, once again, like a comment that is isn't
11 salient to our discussion at all, but he's basically
12 saying is that testing asymptomatic people doesn't make
13 clinical or economic sense. I do know quite a lot
14 about testing, and I've actually published quite a lot
15 about testing, and I will say that asymptomatic testing
16 makes a lot of clinical sense.

17 You know, like, for example, in AHS, we
18 basically -- every patient who's admitted to hospital
19 during the -- you know, during the peaks, you get
20 tested whether you have symptoms or not, because we
21 can't rule out asymptomatic -- like asymptomatic
22 infection without testing. And so, yeah, like I
23 again -- I mean, so I do think we can test asymptomatic
24 and we can detect virus in meaningful ways when people
25 are asymptomatic, but it's not salient to the masking
26 discussion.

1 Q There is a bold type paragraph a little bit down in
2 your report, and it talks about the factual errors in
3 the above statements, and at the end, it says -- oh,
4 pardon me, you have a comment: (as read)

5 None are actually salient to the question at
6 hand around whether or not masks provide a
7 benefit in a health care setting.

8 Do their reports not relate to health care settings?

9 A Well, a large -- like much of the reports don't, but if
10 you read down, then I then comment on -- the above
11 statements just don't talk about masking at all, right;
12 one talks about how likely you are to die from COVID,
13 right; one talks about asymptomatic transmission of
14 COVID, like not just -- you know, one talks about
15 whether or not we should test people for COVID who
16 don't have symptoms.

17 Below that bold font section, I then respond to
18 the parts of the other expert witnesses that actually
19 talk about masking, for example.

20 So I guess what I'm saying is that above, they
21 make some statements that aren't necessarily true, but
22 like regardless if they're true or they're not true,
23 like it's not relevant.

24 Q I'm skipping down a little bit in your report now.
25 You've got a statement: (as read)

26 Dr. Bridle argues that masking is not helpful

1 given the aerosol route of transmission.

2 And then a quote, and then you've got a paragraph about
3 your response. Can you talk about your response in
4 aerosol transmission?

5 A Yeah, and I sort of spoke about aerosol transmission a
6 bit earlier, right, versus contact and droplet. I'll
7 rehash that, I mean I think that -- people I think are
8 perhaps under the impression that something that is
9 airborne or has an aerosol -- airborne and aerosol have
10 different -- just think of transmission occurring on a
11 spectrum, right, where most of it happens within 2
12 metres through the cough -- like respiratory droplets,
13 you know, like me talking on you, Mr. Maxston, and
14 sometimes it can like aerosolize, which is probably
15 defined as it staying in the air for an extended period
16 of time or going beyond 2 metres.

17 Now, again, very hard to pin down the proportion
18 of transmission due to aerosol spread versus contact
19 and droplet spread, but we think it's pretty low. And,
20 again, like it's just like none of those things matter
21 in the face of the hefty evidence that shows once
22 people start putting on masks in health care settings,
23 transmission goes down, right. Like that is the --
24 that's all you need.

25 Q You've got a paragraph that begins: (as read)

26 Dr. Bridle's critique of how well masks fit

1 and mask pore size being too large to screen
2 out SARS-CoV-2 in no way negate the huge body
3 of real-world ecological evidence that masks
4 reduce transmission as we describe in our
5 report.

6 And then you talk about masks not being a hundred
7 percent effective. You then go on to say that: (as
8 read)

9 It is clear they provide significant amounts
10 of protection and dramatically reduce
11 transmission.

12 Why do you say that?

13 A Well, I mean, I -- like there's a -- I think I do say
14 this somewhere in my report, but there's a big
15 meta-analysis in the Lancet, a highly reputable
16 journal, looked at -- I mean, I think they looked at
17 200-plus studies, and that study basically showed
18 there's about an 85 percent reduced odds of
19 transmission when people have masks on. And like
20 there's just so many studies like that over and over
21 again, right. And when I say "real-world ecological",
22 yes, masks are imperfect, yes, the pores might not be
23 perfect, yes, there's like air released. Like putting
24 on masks leads to reduced transmission, and we see that
25 in the real world over and over again, they probably
26 reduce transmission.

1 Q You've got a comment after a quote from Dr. Dang's
2 report about his statement being false and not backed
3 up by any evidence. Can you comment what you're
4 saying -- about what you're saying in that paragraph?

5 A Yeah, like this is kind of interesting, right, so I
6 mean this statement is basically like, how do I call
7 this, this is a fallacy, ecological -- whatever it's
8 called, so basically they're saying like if we
9 implement a mask bylaw, cases still go up, right, writ
10 large, but that just doesn't control for a bunch of
11 confounding factors, right.

12 When we implemented the lockdown, like CMOH Order
13 38, which was pretty aggressive, followed by CMOH Order
14 42, cases still went up for a while, and then they went
15 down, right. That doesn't mean the lockdown didn't
16 work. There's so many factors that lead to
17 transmission of COVID. Masks are one thing that
18 like -- that is protective, but, you know if people all
19 wear masks, but they then go around to basement parties
20 and kiss each other, you're still getting a lot of
21 transmission.

22 And so I think this is like what I call like --
23 it's called spurious causation, right. It's like a
24 correlation, not causation. So I talk about all the
25 things that can lead to like cases going up and cases
26 going down.

1 Q There's a paragraph in your expert report that begins:
2 (as read)

3 Lastly, both Dr. Dang and Dr. Bridle make
4 unsubstantiated claims that there are
5 "numerous harms associated with masking".

6 And then you say: (as read)

7 There are no known harms associated with
8 masking.

9 Can you explain that?

10 A Yeah, so medical harms, like I'm not a respirologist,
11 but like the Canadian Thoracic Society, which is the
12 group of like -- you know, has a statement that
13 basically says mask wearing is not known to exacerbate
14 any lung disease, right. That's their statement. They
15 are, I guess, the lung disease experts.

16 Probably the only harm that I'm aware of that
17 masking brings is, you know, in people with extreme
18 anxiety, right. It can make you anxious, right, but it
19 doesn't make your asthma worse or your COPD worse, and
20 that is from the, you know, the body that represents
21 the respirologists and the lung experts in Canada.

22 You know, I will say, you know, earlier the CMOH
23 orders, you know, they're like exemption clauses,
24 right. Like you put in these exemption clauses because
25 to like have a little way out, right. That exemption
26 clause caused great chaos, certainly in the medical

1 field, because there actually is not a reason to have
2 an exemption for a mask.

3 And so what ended up happening with a bunch of
4 patients went to the family doctors to try and seek
5 exemptions, and doctors were like, Is there a reason to
6 get an exemption; and the answer was no, and we were
7 caught in quite a bind. And that actually led to
8 Dr. Hinshaw apologizing to the Alberta Medical
9 Association for like not being clearer on, you know,
10 what qualified as an exemption and (INDISCERNIBLE).

11 Q Let me ask you this: Should a health care worker in
12 direct contact with patients be allowed to have an
13 exemption for mask wearing?

14 A No, I don't think so. Certainly not now with the case
15 counts where they're at, right? And like I mean --
16 I'll use a comparison, right, like I get why people
17 don't want to wear masks. Like I personally find
18 wearing masks quite uncomfortable and annoying, but
19 like when it comes to a matter of obviously patient
20 safety, then, you know, like you've got to do it
21 because you don't want to harm your patients.

22 If I was a surgeon, you know, surgeons they have
23 to operate in a sterile space, they have to scrub in,
24 you know, like I would not give an exemption to a
25 surgeon from scrubbing in and, you know, sterilizing
26 his or her hands for operating even if they were, you

1 know, like in -- if they were allergic to that, like,
2 you know, the particular sterilizers, and they use
3 something else. If they were allergic to everything,
4 they would not operate, because operating in a
5 non-sterile condition poses too great a risk to the
6 patient.

7 In the same way right now with COVID, you know,
8 not masking is not -- like is a risk to the patient,
9 and, again, and I will caveat this by saying if we had
10 five cases a day in the province of Alberta, we would
11 not need to do this probably I would say, right? Like,
12 you know, the extent to which we need COVID masks to
13 prevent COVID does depend on the risk of COVID. And
14 the baseline risk of COVID depends on how many cases we
15 have, right?

16 But like right now, Alberta a thousand cases a
17 day, north zone 33 percent positivity rate, that's like
18 as high as the highest US states ever were, right?
19 That's like we have a lot of risk and -- yeah, so, no,
20 like, you know, like you've got to wear a mask if
21 you're seeing patients.

22 Q I'm going to ask you a couple of very brief questions
23 about Mr. Schaefer's report, and I know you only
24 received that a little while ago.

25 MR. MAXSTON: And I just want to, Mr. Chair,
26 be clear to the Tribunal that in asking these questions

1 of Dr. Hu, I am again reserving my client's right to
2 call further rebuttal evidence on that point, but I
3 want to ask him about them.

4 Q MR. MAXSTON: You had a chance to read
5 Mr. Schaefer's report?

6 A M-hm, yeah.

7 Q Do you have any comments generally about its validity
8 and the opinions in it?

9 A Yeah, I mean, I think like the conclusion of -- in the
10 report is more or less that it's not safe to wear a
11 mask because it creates dangerously high levels of
12 carbon dioxide and dangerously low levels of oxygen.

13 Now, practically, if that were the case, a lot of
14 my friends would be really sick and/or unwell, because
15 a lot of my friends wear masks all day long because
16 they work in hospitals all day long, you know.

17 But, again, I -- again, I refer to the Canadian
18 Thoracic Society, these other sort of experts, you
19 know, basically said that like mask wearing is safe and
20 fine. There's so much evidence, and like we've been
21 wearing masks in hospitals every day for a
22 year-and-a-half, and if it was that bloody dangerous,
23 we'd have somebody passed out from low oxygen or too
24 high CO₂, and that has not happened to any health care
25 worker in Alberta in AHS that I'm aware of, right? And
26 so like that's -- that's about all I'll say about that.

1 Q Okay, I'm just going to go to the end of your report,
2 and you've got a "Summary" section, and you talk about
3 the vast majority of expert reports focus on trying to
4 downplay the seriousness of COVID-19 and various public
5 health approaches we have used to contain the pandemic.
6 You then talk about them not addressing the question at
7 hand, which is the evidence of masking and reducing
8 viral transmission.

9 Are you aware of -- and I'm going to apologize in
10 advance for me butchering this word -- are you aware of
11 any epidemiologically valid studies establishing that
12 masks should not be worn by health care providers?

13 A No. For COVID transmission, no.

14 Q Yeah, for COVID and --

15 A No, no.

16 Q I don't have any further questions for you. I'm
17 wondering if there's anything you want to add before I
18 ask Mr. Kitchen if he wants to begin his
19 cross-examination.

20 A Maybe I'll just say this, right, like I mean, like I've
21 clearly reiterated over and over again that I think
22 masking is very good for preventing transmission in a
23 health care setting and that there's a lot of evidence
24 for that, but, you know, I'll also say this: Like I'm
25 not like somebody who's like hyper-ideological. Like,
26 you know, when it comes to things like COVID, there's

1 lots of areas to debate, you know.

2 Like I think, oftentimes, people associate
3 people -- like, you know, pro-masking with like
4 pro-lockdown and all that stuff, and I guess what I'm
5 trying to say is -- like I try to read the evidence.
6 I'm fairly pro re-opening actually. You know, I was
7 the Calgary Stampeded medical director and like managed
8 to run that.

9 And so with that, you know, I do think what
10 happens with a lot of these debates, you know, whether
11 around masking or vaccine passports or lockdowns,
12 people get into a bit of an ideological bent, a bit of
13 a political bent, right; these issues have all been
14 highly politicised, and I really try to steer away from
15 those things and try to, you know, balance the benefits
16 and the harms of any particular intervention. And when
17 it comes to masking, like the benefits really, really,
18 really, really outweigh the harms. There aren't a
19 whole lot of harms other than them being a bit
20 uncomfortable to wear I think, so ...

21 Discussion

22 MR. MAXSTON: Okay, well, thank you, Dr. Hu.

23 Mr. Kitchen, I don't know if you want a quick
24 break before you start your cross-examination or
25 whether you'd prefer to start tomorrow morning; I leave
26 that up to you.

1 I think, and I should say in fairness I think just
2 to the Tribunal Members and everyone involved, I still
3 think we should shoot for shutting down today at maybe
4 4:15 or 4:30 just because people get a little saturated
5 at a certain point.

6 MR. KITCHEN: I don't want to start and not
7 finish, so if that's -- you know, we talked about this.
8 You know, my primary goal for pushing to go today, if I
9 was, was to try to get us ahead of the game. That's
10 not going to help anyways with I think where we're
11 going to go. So I have no interest in starting today,
12 because I don't want to go too long and not finish. It
13 should be done all at once. So I think tomorrow
14 morning, hopefully 9:00 right away we'll get going. I
15 think that's probably best for everybody.

16 MR. MAXSTON: Frankly, I would prefer that.
17 I don't think my redirect will be very long at all. I
18 anticipate the Tribunal might have questions, but I
19 think it's better to do that in one block so
20 everything's fresh in everyone's mind.

21 My intention would be, after the completion of
22 Dr. Hu, to have Dr. Halowski testify.

23 MR. KITCHEN: That's fine with me.

24 THE CHAIR: Okay, Dr. Hu, you are okay for
25 9:00 tomorrow morning to --

26 A Yes.

1 THE CHAIR: -- continue?

2 A Yes.

3 THE CHAIR: We appreciate that very much,
4 sir. Thanks, Mr. Maxston and Mr. Kitchen. It was a
5 pretty full day, as we expected, a lot of documents, so
6 I think we can adjourn for today with the expectation
7 we'll start at 9 sharp tomorrow morning, and we'll try
8 and have the site open a few minutes early so people
9 can log on, and we'll get off to a flying start in the
10 morning.

11 Okay, unless any of the Tribunal Members wish to
12 meet and chat, if you do, stick your hand up. No?
13 They're all heard enough of me for today, so we'll
14 declare this meeting in recess for now, and we will
15 reconvene tomorrow morning at 9. Thank you, everybody.

16 _____
17 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 2, 2021

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1 CERTIFICATE OF TRANSCRIPT:

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

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

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Karoline Schumann, CSR(A)

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Official Court Reporter

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Exhibits	Exhibit A-8 - Letter from Dr. Salem - December 12, 2020 5:10 68:19	Exhibit B-5 - Letter of Decision re s. 65 Review - December 18, 2020 5:24 69:8	Exhibit C-7 - ACAC Notice to Members re Approval of Plan - May 03, 2020 6:13 69:22	Exhibit C-14 - ACAC Notice to Members re Directive - November 23, 2020 7:1 70:10
Exhibit A-1 - Amended Notice of Hearing - July 22, 2021 4:18 19:4 68:3	Exhibit A-9 - Letter from Dr. Salem - January 11, 2021 5:12 68:21	Exhibit C-1 - ACAC Notice to Members re Telehealth Billing - March 26, 2020 6:1 69:10	Exhibit C-8 - ACAC Notice to Members about Masking - May 25, 2020 6:15 69:24	Exhibit C-15 - ACAC Notice to Members re Restrictions - November 25, 2020 7:3 70:12
Exhibit A-2 - Email from AHS to Member re Complaint - December 1, 2020 4:21 68:6	Exhibit A-10 - ACAC Code of Ethics 5:14 68:23	Exhibit C-2 - ACAC Notice to Members re Consultation - April 21, 2020 6:3 69:12	Exhibit C-9 - ACAC Notice to Member about Masking - July 24, 2020 6:17 69:26	Exhibit C-16 - ACAC Website COVID FAQs - December 01, 2020 7:5 70:14
Exhibit A-3 - Letter of Complaint Referral from Registrar - December 2, 2020 4:23 68:8	Exhibit A-11 - ACAC Standards of Practice 5:15 68:24	Exhibit C-3 - ACAC Notice to Members re Consultation - April 22, 2020 6:5 69:14	Exhibit C-10 - ACAC Council Updates re Telehealth - July 31, 2020 6:19 70:2	Exhibit C-17 - ACAC Website Update on COVID Practices - December 01, 2020 7:7 70:16
Exhibit A-4 - ACAC Website Statement on Notice of Clinic Closure - December 15, 2020 5:1 68:10	Exhibit B-1 - Letter Requesting s. 65 Review - December 03, 2020 5:16 68:25	Exhibit C-4 - ACAC Website Update on COVID Practices - April 29, 2020 6:7 69:16	Exhibit C-11 - ACAC Registrar's Report - August 04, 2020 6:21 70:4	Exhibit C-18 - ACAC Notice to Members about Masking - December 09, 2020 7:9 70:18
Exhibit A-5 - Letter to Member re s. 56 Complaint - December 21, 2020 5:4 68:13	Exhibit B-2 - Letter Requesting Extension - December 09, 2020 5:18 69:1	Exhibit C-5 - ACAC Notice to Members re Return to Practice - April 30, 2020 6:9 69:18	Exhibit C-12 - ACAC Notice to Members re COVID Practices - August 11, 2020 6:23 70:6	Exhibit C-19 - ACAC Notice to Members re PPE - December 10, 2020 7:11 70:20
Exhibit A-6 - Letter from Member in Response to Complaint - January 11, 2021 5:6 68:15	Exhibit B-3 - Response of Dr. Wall s. 65 Request - December 10, 2020 5:20 69:3	Exhibit C-6 - ACAC Notice to Members re Return to Practice - May 01, 2020 6:11 69:20	Exhibit C-13 - ACAC Website re Telehealth - October 20, 2020 6:25 70:8	Exhibit C-20 - ACAC COVID-19 Pandemic Practice Directive - May 05, 2020 7:13 70:22
Exhibit A-7 - ACAC Complaint Investigation Report 5:8 68:17, 18	Exhibit B-4 - Response of Dr. Wall s. 65 Request and Enclosures - December 16, 2020 5:22 69:5			

<p>Exhibit C-21 - ACAC COVID-19 Pandemic Practice Directive - May 25, 2020 7:15 70:24</p> <p>Exhibit C-22 - ACAC COVID-19 Pandemic Practice Directive - January 06, 2021 7:17 70:26 148:2,14,15</p> <p>Exhibit D-1 - AHS Closure Notice of Clinic - December 08, 2020 7:19 71:2</p> <p>Exhibit D-2 - AHS Order to Rescind Closure Notice - January 05, 2021 7:21 71:4</p> <p>Exhibit D-3 - CMOH Order - 19-2021 - May 06, 2021 7:23 71:6</p> <p>Exhibit D-4 - CMOH Order - 20-2021 - May 06, 2021 7:25 71:8</p> <p>Exhibit D-5 - CMOH Order - 22-2021 - May 13, 2021 8:1 71:10</p> <p>Exhibit D-6 - CMOH Order - 26-2020 - June 06, 2020 8:3 71:12</p>	<p>Exhibit D-7 - CMOH Order - 34-2021 - June 30, 2021 8:5 71:14</p> <p>Exhibit D-8 - CMOH Order - 38-2020 - November 24, 2020 8:7 71:16 133:23</p> <p>Exhibit D-9 - CMOH Order - 42-2020 - December 11, 2020 8:9 71:18 135:26 136:1,8</p> <p>Exhibit D-10 - City of Calgary - Temporary COVID-19 Face Coverings Bylaw - March 11, 2020 8:11 71:20</p> <p>Exhibit D-11 - City of Calgary - Bylaw that repeals Mask Bylaw - July 05, 2021 8:13 71:22</p> <p>Exhibit E-1 - Dr. Jia Hu - CV 8:15 71:24</p> <p>Exhibit E-2 - Dr. Jia Hu - Expert Report Masking 8:17 71:26 72:1 103:15 158:18</p>	<p>Exhibit E-3 - Dr. Bao Dang - CV 8:18 72:2</p> <p>Exhibit E-4 - Dr. Bao Dang - Expert Report Masking 8:20 72:4,5</p> <p>Exhibit E-5 - Dr. Byram Bridle - CV 8:22 72:6</p> <p>Exhibit E-6 - Dr. Byram Bridle - Expert Report Masking 8:24 72:8,9</p> <p>Exhibit E-7 - Dr. Thomas Warren - CV 9:1 72:10</p> <p>Exhibit E-8 - Dr. Thomas Warren - Expert Report Masking 9:3 72:12</p> <p>Exhibit F-1 - GOA Alberta's safely staged COVID-19 relaunch - April 30, 2020 9:5 72:14</p> <p>Exhibit F-2 - CMOH Order - 16-2020 - May 3, 2020 9:7 72:16 140:3,7</p> <p>Exhibit F-3 - ACAC Registrars Report - July 05, 2021 9:9 72:18</p>	<p>Exhibit F-4 - ACAC Frequently Asked Questions - July 07, 2021 9:11 72:20</p> <p>Exhibit G-4 - Chris Schaefer CV 4:14 63:9</p> <p>Exhibit G-5 - Chris Schaefer Expert Opinion Report 4:16 63:11</p> <p>Exhibit H-1 - Preliminary Applications - Complaints Director Reference Document 4:5 36:9</p> <p>Exhibit H-2 - MacLeod v. ACSW 4:7 47:25</p> <p>Exhibit H-3 - R v Mohan 199 4 SCC 80 4:10 48:2</p> <p>Exhibit H-4 - Wright v College and Assn of Registered Nurses of Alberta 2012 ABCA 267 4:11 48:4</p> <hr/> <p style="text-align: center;">\$</p> <hr/> <p>\$500,000 126:10</p> <hr/> <p style="text-align: center;">(</p> <hr/> <p>(i) 77:17,21</p>	<hr/> <p style="text-align: center;">1</p> <hr/> <p>1 2:5 3:11 4:22 6:12 7:8 10:5 15:2 20:17 29:5 31:19 37:10,14, 23 61:16 68:7 69:21 70:17 93:10 101:5 103:14 104:22,24 108:14 138:24 154:15 157:12,15 162:3 172:2 186:4</p> <p>1(1)(j) 78:26</p> <p>1(1)(pp) 31:24 77:7,9 78:2,18</p> <p>10 2:5 5:21 7:12 46:25 62:21 69:4 70:21 93:5,6,25 124:4</p> <p>101 3:11</p> <p>102 3:12</p> <p>10:30 47:1</p> <p>11 2:6 5:7,13 6:24 8:10,12 62:21 68:16,22 70:7 71:19,21 113:23 136:1</p> <p>11-page 27:15</p> <p>115 3:14</p> <p>11th 136:5</p> <p>12 4:8 5:11 27:13 47:26 68:20 78:3 93:13 94:2 100:4 119:17</p> <p>120 3:16</p> <p>121 3:17</p> <p>122 3:19</p> <p>123 3:21</p> <p>124 3:22</p> <p>125 3:23</p>
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13 8:1 71:11
178:17
139 175:1
14 2:7
14-present
107:21
1475 184:20
15 5:3 68:12
177:6
15-minute
170:23 176:24
16 5:23 69:6
149:3
16-20 140:17
16-2020 9:7
72:16 140:2,10
148:23
1600s 164:17
16th 149:5
17 50:3 112:12
18 2:8 5:25 69:9
110:22 128:8
164:4 184:21
19 104:14 109:7,9
19-2021 7:23
71:6
196 3:25
199 3:26
1994 4:10 48:2
49:21
1:00 93:20,23
94:3 99:23 100:1,
5,8
1:03 101:24

2

2 4:24 14:13 15:2
21:6 38:11 68:9
107:20 113:7
124:21 140:20,23
141:3,7 142:6
143:12,17 146:23
167:12 172:21,23

188:11,16 198:17
2,000 136:19
161:1,5
2-and-a-half
170:3
2-metre 172:16,
17
2-page 4:14 63:9
2.5 170:1
20 6:26 27:4,19,
20,22,24 46:25
70:9 118:7
124:21 134:20
160:21 177:10
185:25,26
20-2021 7:25
71:8
200-plus 189:17
2012 4:13 48:6
2018 4:9 48:1
127:14
2019 167:26
168:1
2020 4:22,24 5:3,
5,11,17,19,21,23,
25 6:2,4,6,8,10,
12,14,16,18,20,
22,24,26 7:2,4,6,
8,10,12,14,16,20
8:4,8,10,12 9:6,8
68:7,9,12,14,20,
26 69:2,4,7,9,11,
13,15,17,19,21,
23,25 70:1,3,5,7,
9,11,13,15,17,19,
21,23,25 71:3,13,
17,19,21 72:15,
17 87:19 88:21
95:22 118:6,8,14
119:18 120:6
130:1 133:23
134:22 136:1,5
140:3,10 148:7
155:8 167:19

2021 2:5 3:11
4:20 5:7,13 7:18,
22,24,26 8:2,6,14
9:10,12 10:5 19:5
21:24 29:13 68:5,
16,22 71:1,5,7,9,
11,15,23 72:19,
21 101:5 103:5
148:3,15,21
149:16 167:19,20
184:21 198:17
199:9
21 5:5 6:4 50:3
68:14 69:13
110:22 159:10
21(d) 134:26
22 4:20 6:6 19:5
21:24 68:5 69:15
22-2021 8:1
71:10
23 7:2 70:11
135:6 137:10
24 6:18 8:8 28:17
70:1 71:17
133:23 134:22
135:6 137:12
25 6:16 7:4,6,16
69:25 70:13,15,
25
25-2020 7:20
71:3
26 6:2 69:11
135:8,9 175:11
26(c) 135:16
26-2020 8:3
71:12
267 4:13 48:6
26th 148:3,15,21
27 135:15 143:26
175:11,17
27th 199:9
28 103:5
28(a) 138:22

28th 159:10
29 6:8 69:17

3

3 5:17 6:14 9:7
54:24 68:26
69:23 72:17
86:13 140:3,10,
20 141:12 143:14
144:23 145:11
146:26 147:5
152:25 177:10
3,000 184:21
30 6:10 8:5 9:6
23:7 69:19 71:15
72:15 86:11
31 2:10 6:20 70:3
33 193:17
34 2:12
34-2021 8:5
71:14
35 2:14
36 2:15 4:5
38 44:16,22
190:13
38-20 134:3
38-2020 8:7
71:16 133:22
134:1,6 136:13
3:00 74:25 170:21
171:3 175:21
3:15 176:26 177:6

4

4 6:22 70:5 74:25
118:15 134:16,17
140:20 144:20
152:25 165:4
170:5,25
42 134:2,4 136:17
137:2,6 190:14

42-20 135:26
136:8
42-2020 8:9
71:18 135:24
136:15
43 2:17
46 2:19
47 2:21 4:7 24:11
26:10
48 4:10,11
49 2:22
4:15 176:26 197:4
4:30 170:25 197:4

5

5 7:14,22 8:14
9:10 22:2 24:21
29:5 31:19 34:22
70:23 71:5,23
72:19 124:4
140:20 141:20
143:14 145:9
147:7 170:6
5-page 9:1 72:10
50.1 76:20
56 2:24

6

6 7:18,23,25 8:3
71:1,7,9,13
140:20,23 146:22
60 3:1 184:11,20
185:22,26
61 3:3
63 3:5 4:14,16
65 3:6
66(3) 22:19
67 165:5
68 4:18,21,23 5:1,
4,6,8,10,12,14,15,
16

69 5:18,20,22,24
6:1,3,5,7,9,11,13,
15,17

6th 149:5,6,16

7

7 9:12 51:5 72:21

70 6:19,21,23,25
7:1,3,5,7,9,11,13,
15,17

71 7:19,21,23,25
8:1,3,5,7,9,11,13,
15,17

72 8:18,20,22,24
9:1,3,5,7,9,11

75,000 179:21

77 28:6

77(a) 23:5

79(5) 38:10,15
39:4 80:17,22

8

8 7:20 71:3
150:18

8.16 55:5 57:24

8.16(1) 57:11

80 4:10 48:3
49:21 184:18

85 189:18

89-page 4:16
63:11

9

9 5:19 7:10 69:2
70:19 136:5
142:12,15 146:14
160:2 171:9
198:7,15

9-page 8:15,18
71:24 72:2

92 3:7

94 3:8

95-page 8:22
72:6

99 3:9

9:00 177:17
197:14,25 198:17

9:10 10:23

A

A-1 4:18 19:4
67:11 68:3

A-10 5:14 68:23

A-11 5:15 68:24

A-2 4:21 67:11
68:6

A-3 4:23 67:11
68:8

A-4 5:1 68:10

A-5 5:4 68:13

A-6 5:6 68:15

A-7 5:8 68:17

A-8 5:10 68:19

A-9 5:12 68:21

a.k.a. 164:11

ABCA 4:13 48:6

abiding 87:5

ability 59:10
63:22 199:7

absence 49:23
50:6 166:17

absolutely 90:2
119:25

abundantly
167:2

ACAC 5:1,8,14,
15 6:1,3,5,7,9,11,
13,15,17,19,21,
23,25 7:1,3,5,7,
11,13,15,17 9:9,
11 10:10,11,13,
16 11:19 12:7

32:1 43:24,26
50:13 51:3 61:3,9
68:10,17,23,24
69:10,12,14,16,
18,20,22,24,26
70:2,4,6,8,10,12,
14,16,20,22,24,26
72:18,20 97:3
101:10,11,13,16,
17 147:25 150:7

ACAC's 148:21

academia 109:14

academic 160:8
168:15

accept 35:15
92:15

acceptable 18:15
151:1,6

accepted 40:11
102:19 123:9

access 20:8 24:9
73:12

accommodate
75:2

accordance
144:22

accountable
111:4

accounts 89:16

accurate 116:26
117:21 125:7
126:15 199:4

achieved 43:9

acknowledge
184:22,24 185:13

acquiring 180:5

act 11:17 22:9
28:6 73:1 77:5,23
79:1 86:13 95:20
132:2,3,5 147:8

acted 98:12

acting 11:21 51:6

actions 15:7
78:23 92:12 97:3

98:12

active 11:19
107:24

activities 107:13
109:24 126:11
132:11

actual 15:11
73:25 97:20
122:4

acute 111:23

add 33:20 35:9
43:8 44:9 64:6
99:18 195:17

added 73:3

adding 21:18
30:6 44:11

addition 12:3
21:21 29:24 30:8
31:20

additional 16:3
31:10 35:5 36:18
66:18,26 144:4,
16

address 40:24

addressing 195:6

adequate 143:3

adhere 57:6
178:20,22

adhered 81:8

adhering 95:11

adjourn 177:16
198:6

adjourned 55:1
100:8 198:17

adjournment
25:26 34:24 47:3
54:10,16,18,23
55:1,2 59:13,23
62:24 64:13
124:23 177:9

adjournments
63:20

adjustment
82:16 92:10

administers

30:11

administrative

39:12

admissibility

36:25 37:1 41:20
62:19 63:7

admissible 52:11

admission 49:17

admit 13:19

36:17 41:18
46:18 47:18 63:8

admittance

49:14

admitted 47:24

48:11,16,17

49:17 88:20

131:7 152:18

186:18

admitting 49:19

advance 17:2

37:3 59:17 66:21
122:7 195:10

advent 112:7

advice 128:25

129:11 130:10

advise 127:23

131:25 133:14

147:17

advised 22:3

122:6 128:14

advising 128:22

advisory 110:10
112:22 128:2,4,8,
24 129:5

aerosol 172:12,
22 188:1,4,5,9,18

aerosolize

188:14

aerosols 169:20

affect 163:9

affirm 102:3

afternoon 3:11

42:22 101:5

177:14	air 172:25 188:15 189:23	allowing 62:14	84:12 85:10	97:19
Agency 37:16	airborne 172:26 188:9	alluded 21:3,24 97:23	93:22 177:11	applies 26:11
112:13,15,18	aircraft 173:7	amend 13:24	197:18	45:7 57:25 76:17
128:13,18	Albert's 9:5 72:14	19:20 21:5 22:4	anticipated 47:7	78:1,3 89:14 92:8
153:16,24 159:4	Alberta 4:7,12	145:10 146:8	anticipates 84:13	134:23
173:10,14,17,24	5:1 10:1,3,15	Amended 4:18	anxiety 191:18	apply 39:16
174:9 176:1	11:15 17:20	13:14 15:14	anxious 191:18	56:14 65:22
184:7	21:21 27:2 29:24	17:17 19:4,24	anybody's 51:2	77:15 78:8 80:24
aggressive	30:2,10,11 32:4	21:25 29:11	apologies 31:15	81:7 89:20 92:20
190:13	33:7 36:17 37:21	35:21,24 68:3	47:6 153:9	135:2 146:23
agree 14:22	46:10 47:25 48:6	amending 19:17	apologize 163:19	applying 13:24
21:20 40:5 54:6	55:5,10 68:10	amendment 33:2	195:9	appointed 11:16
63:19 67:18	86:10,12 88:9	amendments	apologizing	approach 99:1
81:17 98:11	94:23 95:20	26:25 34:12	192:8	approaches
116:14,19 117:21	101:1,3,15	American	appeal 29:8	195:5
119:23,26 154:7, 21	104:17 105:1,14	160:12 179:20	43:18,20 44:11	Approval 6:13
agreeable 170:21	106:15 108:23	181:18	46:6	69:23
agreed 14:4 17:3, 5 37:2 42:16	110:3,23 111:1,5, 9 128:1,5,6,17	amount 28:10	appears 77:6	April 6:4,6,8,10
48:15 65:16	130:6,15 131:15, 17,20 132:24	52:26 53:6,7,9	appellant 28:1	9:6 59:14 69:13, 15,17,19 72:15
66:17,20 102:25	137:23 139:14,15	58:8 108:10	Appendix 138:25	area 22:16 66:17
agreed-upon	147:20 157:6	162:18 181:5	applicable 24:7	76:2 80:13 84:15
66:13	159:2 166:11	amounts 189:9	39:9 40:4 52:2	112:11 113:19
ahead 21:1	180:9 192:8	ample 35:10	88:18 147:10	114:14 115:7
134:15 144:8	193:10,16 194:25	AMSTAR	application 2:9, 11,13,14,16,18,	123:10 125:11
197:9	199:8	175:24 176:7	20,21,23,25 3:2, 4,5 4:5 16:20	152:14
AHS 4:21 30:13, 15,18 33:11,14, 15,22 34:9 36:18	Alberta's 138:7	181:15	25 18:14,19,26	areas 22:7 36:21
37:5,13,18 41:2, 14 42:5,6,7,15	Albertans	analogous 26:15	17:10,12,19,24, 25 18:14,19,26	65:10,11 107:14
43:19 44:1,2	136:14	45:6	19:3,8,19,23 20:1	136:24,26 138:11
45:5,8,19 46:17	Aldcorn 10:10	analogy 32:24	21:3,4 22:7 24:2, 6,8,14 26:5 31:7,	142:25,26 196:1
60:14 68:6 71:4	11:25 101:10	analysis 45:7	14 34:2,8 35:1,6, 8,13,16 36:9,12,	argue 23:22 52:4
91:19 116:1,9	allegation 33:12	160:23	17 38:6 40:1	85:11
121:21 122:2	allegations 11:17	Anand 127:8	42:19 43:5 46:4	argues 28:1
128:16,21 130:13	13:17,19 28:20	and/or 79:4	47:4 48:16 49:8	187:26
131:6,23,25	29:6 33:11 48:12	130:24 141:14	56:20 60:6,13	argument 51:6
152:15 153:10,17	alleged 31:22	178:26 194:14	61:19 63:1 79:11	74:22
154:5,9 155:18, 21 156:19 157:6	76:10	announced	97:15,17 99:26	arguments 41:9
174:9 184:6	allergic 193:1,3	113:5	applications	91:7
186:17 194:25	allowed 141:21 192:12	annoying 192:18	14:12,14,20,24	arises 126:2
aimed 104:15		anoscopy 144:7	15:4 16:14,23	arm 30:10 46:10
109:10		answering	17:6,9,16 18:2,5, 13 64:2 93:17	113:23
		164:13		arranged 93:19
		anticipate 41:8 65:18 83:11		arrangement
				75:3

arrived 25:3
arrow 144:5
articles 106:20, 22,25,26 117:16
asks 13:7 95:16
aspects 72:23
assess 30:26 77:2 79:15,25 80:4 92:11 176:15
assessed 30:13
assessing 30:23
assign 47:21
assigned 165:16, 17
assist 40:17,26
assistance 40:14 41:26 63:3
assisting 49:22 50:5
associate 196:2
association 4:12 10:2,15 11:15 24:4 32:17 44:14 45:6 48:5 101:2, 15 106:12,16 160:12 179:21 181:19 192:9
associations 45:2
assume 158:20
assuming 67:17 75:14 103:9,26 157:25 177:15
asthma 191:19
Astrazeneca 116:18
asymptomatic 143:11 152:1,4,9, 13 153:20 164:12 185:3,4,11,12,16, 20,24 186:6,12, 15,21,23,25 187:13
attached 25:9,10 142:10,13 153:3

attachment 143:18
attainable 51:21
attempt 54:21
attend 4:19 23:9 68:4
attended 105:16
attending 137:14
audio 124:12
August 6:21,24 22:2 70:5,7
authority 22:8 23:13,19 43:18, 20,26 44:12 45:19 46:7 147:1
average 146:5 170:3 178:10,11
avoid 63:20
award 106:10,13, 17,19
awards 106:8,19
aware 16:18 161:18 191:16 194:25 195:9,10
awkward 18:7

B

B-1 5:16 21:18 68:25
B-2 5:18 69:1
B-3 5:20 69:3
B-4 5:22 69:5
B-5 5:24 69:8
B.E. 10:16 101:17
Bachelor's 104:26
back 18:14 26:2 34:22,26 47:2,5,8 59:14 62:22,26 94:3 101:26 106:3 107:3 108:14 120:6

124:20,25 125:9 136:18 140:25 143:12 155:8 161:18 164:16 165:2 167:12 177:13,19 180:15
backed 190:2
background 21:23 82:1 83:26 102:16 137:20 149:1 153:15,19
bad 133:11 160:22 181:26 182:1
balance 38:21 64:7 76:15,19,22 145:16 146:11 196:15
ban 137:2
Bank 113:18
Bao 8:19,20 72:3, 4
barrier 87:21
barriers 52:23 84:24 91:2
base 112:3 132:21
based 82:4,11 115:21 125:20 151:12 171:4
baseline 193:14
basement 190:19
basically 43:18 109:10,13 113:19 129:6,18 135:9 137:3 141:12,20, 24,26 142:4 145:17 146:8 153:19 156:1 160:20,23 168:24 169:20 170:2 173:18 174:16,23 178:3 183:4 184:3 186:11,18 189:17 190:6,8

191:13 194:19
basis 35:14 56:13,15 85:14 89:19 97:14,17 99:5 120:22 123:9,16 174:6
batch 19:10
bear 62:23 115:23 124:3 163:15 169:14
bearing 40:8 181:17
began 64:1 164:9 169:6
begin 19:2 21:10 64:5 102:13 140:16 195:18
beginning 16:10 78:18 126:21 154:15
begins 123:14 159:14 186:6 188:25 191:1
begun 65:4
behalf 55:7 57:16 73:19 74:12 85:19 89:16 90:10 174:15
belief 97:5
beliefs 86:5
believed 169:17
believes 66:6 84:17 91:10
bend 58:3
bends 58:26
beneficial 175:18
benefit 124:7 131:1,2 135:25 158:14 179:14,15 180:10 187:7
benefits 95:9 130:12 158:25 159:19 168:11 196:15,17

bent 196:12,13
biased 126:13
big 111:15,20 112:7 120:5 133:15 172:4 185:11 189:14
Billing 6:2 69:11
binary 173:1
bind 192:7
binding 39:23 55:11 132:9
bio 47:1 176:25
bit 12:15 18:7 23:25 30:7 34:7 47:6 58:16 65:19 72:23 73:24 91:6 96:9 107:12 123:4 127:9,17 129:1 131:10 134:20 137:20 141:25 144:11 155:5 157:1 180:17 187:1,24 188:6 196:12,19
bits 133:3 171:26
Blair 12:11 121:10 163:20
blaming 59:20
block 197:19
blocks 66:24
blood 165:23
bloody 194:22
board 113:9,24
boards 109:16
bodies 44:21 127:23 128:23
body 32:19 44:18,19 57:6 94:24 96:2 112:19 129:10 155:19 159:22 160:15 179:4,8 182:11 189:2 191:20

bold 187:1,17
bona 46:13
booked 63:19
border 153:11
Boston-based
 113:14
bottom 113:7
bound 39:8,15,
 21,26 55:9 57:19
 58:2 80:18
branches 40:22
breached 33:14
breaches 95:20
breaching 33:11,
 12
break 18:2,6,7,
 20,21 24:21
 25:22 31:5 46:25
 47:1 67:3,9 73:25
 94:2,9 99:25
 100:1 170:21,23
 171:1 175:20
 176:24,25 196:24
breakout 18:24
 124:17
breaks 58:5 59:1
breathing 52:23
bridge 12:19
Bridle 8:23,24
 72:7,8 81:10
 161:20 181:9,21
 186:9 187:26
 191:3
Bridle's 186:5
 188:26
briefly 34:6
 36:22,25 40:7
 50:20 53:1 60:8
 61:15 66:1 76:3
 78:25 104:23
 105:25 108:16
 110:6 120:11
 159:15 163:17

bright 89:13
bring 16:21 62:2
bringing 16:22
 17:24
brings 191:17
broad 30:18 56:1
 123:23
broader 119:16
 123:6
broadly 30:12
 46:11 52:22
 116:5 121:3
 169:21,23
broken 96:12
 162:17
brought 23:20
 61:14
build 169:6
bunch 77:13
 190:10 192:3
burden 76:14,18
 185:8
bureaucrat
 133:11,12
business 7:19
 71:2 138:24
busy 58:19 59:20
 93:22
butchering
 195:10
bylaw 8:12,13,14
 71:21,22,23
 122:8 130:7
 139:12 190:9
bylaws 130:4
 137:25 138:2
 139:17,22,23
Byram 8:23,24
 72:7,8

C

C-1 6:1 69:10

C-10 6:19 70:2
C-11 6:21 70:4
C-12 6:23 70:6
C-13 6:25 70:8
C-14 7:1 70:10
C-15 7:3 70:12
C-16 7:5 70:14
C-17 7:7 70:16
C-18 7:9 70:18
C-19 7:11 70:20
C-2 6:3 69:12
C-20 7:13 70:22
C-21 7:15 70:24
C-22 7:17 70:26
 148:2,15 149:12,
 13
C-3 6:5 69:14
C-4 6:7 69:16
C-5 6:9 69:18
C-6 6:11 69:20
C-7 6:13 69:22
C-8 6:15 69:24
C-9 6:17 69:26
C02 194:24
cabinet 111:4,8
 133:16,20 145:5
calculations
 160:25
Calgary 5:2 8:11,
 13 68:11 71:20,
 22 104:18 107:24
 108:1 110:24
 111:23 122:7
 127:13 128:21
 130:9,16,18
 134:23,25 135:1,
 3 136:26 138:3
 196:7 199:8
Calgary's 106:12
call 11:13 34:17,
 25 41:22 52:22
 64:20 83:10,15
 93:16 107:8,11,

25 109:24 110:11
 117:21 119:5
 130:1 131:6
 132:9 139:14,24
 148:20 152:15
 153:2 157:6
 175:5 183:2
 190:6,22 194:2
called 19:7 24:3
 27:2 40:3 57:23
 62:4,5,7 65:5
 75:15 76:15
 81:14 82:16
 102:14 104:14
 112:22 128:2
 166:18 190:8,23
calling 27:12
 73:20 81:13 82:5,
 6 84:5 91:5
camera 27:9
Canada 37:16
 91:20 112:14,15,
 18,22,26 113:10,
 23 128:13,18
 136:22 153:16,24
 159:5 173:10,15,
 24 174:9 176:2
 184:7,20 191:21
Canada's 173:17
Canadian
 110:10,12 191:11
 194:17
canvass 60:23
 76:6
canvassed 43:13
 45:15 105:12
cap 174:11
capita 136:21
carbon 50:23
 51:14,16,20
 52:16 55:22
 194:12
care 14:20 30:11
 37:9,11 38:3
 46:11 80:2,4

86:12 104:13
 106:12 108:4
 109:2,14 111:22,
 24 138:17,26
 139:8,16,19,25,
 26 140:21 141:7,
 10 142:11,14,24
 143:9 151:17
 153:25,26
 154:19,20 155:1,
 3,11 156:9,12,14,
 21 159:21,24
 162:20 164:7,21
 166:14 167:4
 174:1 175:22
 177:26 178:4,5,7,
 8,16,20,24 179:5,
 19,25 180:2,11,
 22 181:25 183:7,
 14,21 184:5
 187:7,8 188:22
 192:11 194:24
 195:12,23
career 28:14
 106:9
careful 127:16
carefully 80:9
 96:25
cares 128:20
carried 28:5
carrier 173:8
carry 65:7 74:1
 173:5
carve 114:1
case 12:22 13:16
 22:10,11 24:1,3,
 15 27:1,6,23
 28:22 29:7,21,23
 32:16,18,19,23,
 25 33:8 40:3,6
 43:13 44:13,17
 47:21 48:20
 49:20 50:25
 51:26 52:3 56:12
 60:15 62:12
 63:22 73:19

75:14 92:18
 94:16,18,19,21,
 23 95:2,5 133:6
 136:21,25 169:7
 192:14 194:13
cases 15:21 24:2,
 18,24 25:12,16,
 19,21,24 26:7
 74:19,21 136:19
 170:17 174:21
 190:9,14,25
 193:10,14,16
catch 49:26
 162:14
category 80:6
 81:24 113:8
 178:15
caucus 18:23
 34:19 62:17
caught 192:7
causation
 190:23,24
caused 191:26
cautious 41:24
caveat 193:9
CDC 112:26
 184:7 185:22
central 50:25
 51:25 130:17
Centre 108:1,9
centred 116:20
centres 164:7
Certificate 3:26
 199:1
certificates
 105:12
certifications
 52:12,19
certify 199:3
cetera 43:16
 67:11 74:19
 106:7 109:1,17
 112:9 114:9
 158:26

chair 10:8,24
 11:2,4,6,12,21
 12:11,18,26 13:6,
 7,10,16 14:1,8,26
 15:1 16:11,18
 18:3,17 19:11,17
 20:2,6,9,22,26
 21:1,23 23:12,25
 24:13,21,26 25:7,
 8,9,12,22 26:1,8
 27:10,12,18,21
 28:17 31:8 33:26
 34:3,5,19,25
 35:2,17 36:5,13,
 14 37:2 38:16,18,
 20 42:13,23,26
 43:3 45:23,25
 46:2,22 47:5
 48:7,14,21,24
 49:3,6,25 56:16,
 18,21 60:2 61:12,
 13,17 62:15,25
 63:2,13,26 64:8,
 17 66:10 67:10,
 20,23,26 75:11,
 17,21,22 76:26
 84:20 92:23,26
 93:6 94:7,8 99:11
 100:3 101:8,25
 102:8 103:8,10
 104:13 109:6
 114:12,17,20,23
 121:10 122:24
 123:3,20,21,26
 124:6,15,19,25
 125:14,17,24
 128:7 130:18
 134:9,12 136:2,4,
 6 147:26 149:8,
 11,13 152:17,23
 153:5 158:20
 170:19 176:23
 177:3,10,20
 193:25 197:24
 198:1,3
chaired 130:18

challenge 61:8
 85:2 95:15
 111:15
challenges 54:8
challenging
 32:23 44:18 51:4
 58:21 61:3 96:8,9
 99:3
chance 15:22
 176:25 194:4
change 20:4
 21:18,19 22:14
 67:15 79:21
 148:12,18 161:25
 162:13 174:10
changed 21:12
 29:23 93:9,21
 149:22 174:4,5
changing 29:19
chaos 191:26
character 28:14
characteristics
 165:14 166:1
characterize
 140:20 181:19
charge 21:11
 22:13 23:3,22,23
 27:25 28:25 29:4,
 26 30:4 38:12
charges 15:11,14
 22:10 23:2,14,20
 26:25,26 28:12,
 18 29:5,15,18,22
 30:9,21,24,25
 31:1,19,22 32:25
 33:5 83:5 84:23
 88:22
chart 89:5
Charter 45:9
 51:5 61:7 94:26
 95:19
charting 87:10
 89:4
charts 72:25

chat 65:11 198:12
chatted 65:19
check 24:22
 42:14 145:16
 146:11
checked 156:19
checking 10:25
checklist 64:4
chicken 34:7
Chief 94:24
 131:4,11,14
 159:7
Chikmaglur
 4:10 48:2
China 168:1
chiropractic 5:2
 68:12 86:10
 88:25 90:12
 94:20,23 95:8
chiropractor
 81:13 82:6,9 83:3
 97:2
chiropractor's
 90:4
chiropractors
 10:2,15 11:16
 80:1,10 83:18
 86:22 88:3,7,11,
 12 92:7 101:2,15
 139:2,5 140:25
 147:21 178:15,19
Chiropractors'
 73:1
choice 62:4 85:12
 88:4
choices 92:12
choose 75:13
 179:7
chose 90:19,20
chosen 62:2
Chris 4:14,16
 49:10 55:21
 63:10,11

Christmas 137:4
chronologically
 50:8
circle 58:10
circumstances
 59:8
citation 49:21
 178:17
citations 53:21
 159:26 184:1
cite 174:17 182:6
 185:22
cited 181:20
 183:24
cites 175:17
cities 138:2
city 8:11,13
 71:20,22 122:7
 130:9 135:1,2
 199:8
civil 76:13
claim 61:7
claims 61:10
 191:4
clarify 74:15
 93:8 140:18
clause 145:17
 146:7 191:26
clauses 191:23,24
cleanup 127:18
clear 23:12 29:4
 36:5 39:18 85:23
 87:23 90:10 94:9
 123:13 125:5
 126:5 128:22
 162:21 167:2
 180:10 189:9
 193:26
clearer 192:9
client 21:18
 59:13 66:14
 74:12 140:13
 142:23,24

client's 67:7 84:14 194:1	12,14,25 132:4, 14,17,19,25 133:6,7,21,22 134:1,2,3 135:2, 5,24,26 136:8,13, 15,17,23 137:2,6, 10 138:20,21 139:1,4,7,9,11,20 140:2,6,17,21 141:17,23 142:5 143:23 144:2,9, 14,20,21,25 145:4,10,12 146:1,8 147:23 148:22 150:2,3 151:13 174:9 190:12,13 191:22	42:22 44:14 46:8, 14 47:26 48:4 58:17 79:17 81:12 82:10,11, 19,20 83:10,20 84:5 86:15 87:8 88:5,15,21 89:6, 11 90:16,20 92:4 95:5 96:3 101:2, 15 105:13 125:1 131:8 141:12,13, 14 142:5,8 143:14,20 144:3, 21 145:11 146:9, 25 147:1,7,10,18, 20	commentary 29:25	communications 111:16 127:5
client/patient 143:2,9	co-founder 109:7	College's 44:25 73:21,23 79:9 83:18,24 84:6,12 85:12 87:20 89:4 90:8 91:17 95:16, 18 99:22 100:5	commented 167:14	community 141:10 142:9,11, 14 143:25 151:15 176:4 177:26
clients 89:16 97:22	co-investigators 119:5,16	colleges 140:24 141:16,21 143:26 144:10,15,16 145:7 147:17	commenting 27:7	companies 109:18 116:14
clinic 5:3 30:16 42:7,8 44:5 68:12 108:1,10	co-lead 118:9	combine 161:3	comments 12:12, 15 14:9,13,17,18, 21,25 15:3 17:22, 26 18:10 20:6,14 21:17 26:18 31:4, 17 34:4,18 35:3, 18,19 37:14,20, 23 38:8 41:3 42:12 46:1 49:4,5 56:22 60:2,4,8 64:1,16,23 65:20 84:17 92:23 99:10,19 102:18 121:6,11,13,15 123:19,22 150:7 162:22 164:17 173:18 178:1,14 180:12 181:22 194:7	compared 177:25
clinical 91:23 107:15,19,22 108:19 117:19 139:26 141:19 142:3 143:24 162:23 166:18 168:17 169:9 186:13,16	co-workers 154:2	comfortable 15:2 18:4,18 19:1 45:26 74:13	commit 15:13	comparing 53:1
clinically 179:7	coalition 104:14 109:10	COMMENCED 10:23	commitments 94:10	comparison 97:11 192:16
clinics 110:2	Cochrane 160:12 165:4 167:13	commend 59:15	committed 15:6	comparisons 97:25
close 110:19 125:16	Code 5:14 21:19 32:1 68:23 73:4 77:23 79:9 89:21	comment 24:17 32:14 46:6 48:8 56:23 60:9 61:20 62:14 65:24 66:5 72:22 84:7 91:1 124:7 125:10 140:17 148:1 153:17 168:3,12 171:20 173:6 178:17 182:2,13 183:15 184:9,13 185:1,9 186:10 187:4,10 190:1,3	committee 112:22 129:17 130:19,21	compelling 156:23 183:2
closed 30:16 33:10	Codes 87:5	COMMENCED 10:23	committees 121:22 130:14,22	competence 78:13 87:7,8 90:7
closely 113:24 130:8 178:8	coffee 47:1	commence 59:15	common 25:18 39:11 51:12 80:8 117:4	competently 52:14
closer 73:24 160:17 180:9	cohorting 130:24	comment 24:17 32:14 46:6 48:8 56:23 60:9 61:20 62:14 65:24 66:5 72:22 84:7 91:1 124:7 125:10 140:17 148:1 153:17 168:3,12 171:20 173:6 178:17 182:2,13 183:15 184:9,13 185:1,9 186:10 187:4,10 190:1,3	common-law 28:5	competes 54:8
closing 17:17 44:5 56:26 74:10, 11,16 75:5 79:12, 14 83:8 92:5,14 99:20 109:10	coin 56:3	comment 24:17 32:14 46:6 48:8 56:23 60:9 61:20 62:14 65:24 66:5 72:22 84:7 91:1 124:7 125:10 140:17 148:1 153:17 168:3,12 171:20 173:6 178:17 182:2,13 183:15 184:9,13 185:1,9 186:10 187:4,10 190:1,3	committed 15:6	complaint 4:22, 23 5:5,7,8 28:3 34:8 68:7,8,14, 16,17 82:15 83:22 84:10
closure 5:2 7:19, 21 42:7 68:11 71:2,4	colleagues 25:15 26:9 134:10 147:20	comment 24:17 32:14 46:6 48:8 56:23 60:9 61:20 62:14 65:24 66:5 72:22 84:7 91:1 124:7 125:10 140:17 148:1 153:17 168:3,12 171:20 173:6 178:17 182:2,13 183:15 184:9,13 185:1,9 186:10 187:4,10 190:1,3	committee 112:22 129:17 130:19,21	Complaints 4:6 12:23 13:3 17:8, 15 18:13 19:2,8 21:4,7 22:3,6,8, 23,25 23:1,13,19 24:7 26:22 28:24 29:1,26 30:8,12 31:6 33:19 34:15, 17 35:13 36:10, 16 41:10 43:13 45:12,17 46:15 49:12,15 53:10, 15,17,22 54:5,7, 11 56:10 57:3,9 58:12 59:2,7,9,22 60:10,13,15 61:1, 21,24 62:3,6 63:14 64:12,18
cloth 50:18	collecting 109:25 106:17	comment 24:17 32:14 46:6 48:8 56:23 60:9 61:20 62:14 65:24 66:5 72:22 84:7 91:1 124:7 125:10 140:17 148:1 153:17 168:3,12 171:20 173:6 178:17 182:2,13 183:15 184:9,13 185:1,9 186:10 187:4,10 190:1,3	communicable 112:1	
CMOH 7:20,23, 25 8:1,3,5,7,9 9:7 32:2,3 33:9,13, 16,18,23 43:26 44:1,6,8 71:3,6,8, 10,12,14,16,18 72:16,25 84:1,8 85:26 88:9 91:18 92:15 131:4,5,11,	collectively 106:17	comment 24:17 32:14 46:6 48:8 56:23 60:9 61:20 62:14 65:24 66:5 72:22 84:7 91:1 124:7 125:10 140:17 148:1 153:17 168:3,12 171:20 173:6 178:17 182:2,13 183:15 184:9,13 185:1,9 186:10 187:4,10 190:1,3	communicate 109:26 168:22	
	college 4:8,11 10:2,15 11:8,15 12:1 13:7 24:4 27:2,16 32:17	comment 24:17 32:14 46:6 48:8 56:23 60:9 61:20 62:14 65:24 66:5 72:22 84:7 91:1 124:7 125:10 140:17 148:1 153:17 168:3,12 171:20 173:6 178:17 182:2,13 183:15 184:9,13 185:1,9 186:10 187:4,10 190:1,3	communication 124:10	

66:2,5 73:19,23, 26 76:5,8,15,19, 22,24 77:14 78:6 82:20 83:24 84:6, 17 85:19 87:24 88:1,23 90:11 91:4,9,10,14,16, 21,25 92:14 95:2 96:15,21 97:16 98:3 101:16	concludes 176:3 conclusion 159:16 176:5 194:9 conclusions 43:16 52:15 86:5 159:12 161:25 condition 193:5 conduct 11:18 15:7,8,13,24 16:4 23:2 29:17 30:13, 23 52:14 75:26 76:10,26 77:2,3, 6,10 78:4,8,11, 14,16,20,24 79:1, 3,7,15,25 80:4,6, 12 83:4 85:17,18 87:12 92:12 95:12,24 97:13 99:5,9 105:19 conducted 105:16 confers 95:9 confidence 161:15 183:23,25 confident 91:16, 22 confines 111:11 confirm 12:7 66:13 67:6 102:25 103:3 conflate 55:25 confounding 190:11 confusing 53:4 conjunction 111:8 171:17,23 cons 130:12 consent 17:4 19:6 43:2 49:13 66:11, 19 67:8 87:10 89:6,8 122:17 consented 42:6	considered 47:11 165:10 167:5,7 185:7 considers 39:7 consistent 12:17 64:16,23 159:1,2, 4,7 constitute 78:24 constitutes 79:6 95:23 constitutional 94:26 98:23 consult 58:22 140:12 Consultant 112:13 Consultation 6:4,6 69:13,15 contact 88:20 90:20 127:3,20 143:2 169:18 188:6,18 192:12 contact-tracing 108:26 111:14 contacting 88:15 172:15,26 contained 43:10 content 23:14 50:24 contention 53:20 contentious 129:21 contents 2:1 13:26 150:8 contest 23:22 contested 14:3 15:11 42:19 65:6 context 123:5 126:3 contexts 23:16 continue 16:11 21:2 26:2 65:2 93:23 128:10 139:2,5 198:1	continuing 87:7, 8 90:7 105:17,19 continuous 37:25 139:16 153:11 154:6 155:6,7,17 156:1 157:18 164:7 173:2,23 continuously 142:26 151:16 contracting 175:26 contravened 30:1 32:11 95:4 Contravention 77:23,26 contributor 185:7 control 37:25 112:1 119:3 121:22 130:14, 19,21 157:19,21, 24 158:5 165:6,7, 9,12 166:3,4,5,8, 16,20 170:12 176:9 181:14 182:14,17 190:10 controlled 166:2 controlling 175:8 controversial 148:9 convene 16:5 convenient 60:17 conveniently 26:10 COPD 191:19 copies 36:6 37:3 copy 36:3 50:4 73:11 144:21 cornerstone 57:7 corporate 110:5 correct 42:17,18 103:3 116:12,22	117:1,18,24,26 118:2,3,4,5,8 125:8 135:4,13, 14 143:15 147:2 152:24 176:18 correlation 190:24 cough 171:26 172:1,2 188:12 coughed 172:20 Council 6:19 70:2 counsel 10:9,16, 19,26 12:4 34:21 35:3,5,9 47:9,12 63:3,15,19,24 81:16 101:9,17, 20 124:16 counsel's 63:22 count 119:17 136:21 countries 113:21 counts 136:25 192:15 couple 24:10 25:14 31:4 45:26 65:9,12 66:9 73:9 74:2 100:4 121:11 142:18 147:4 148:6 149:4 152:22 165:5 173:16 179:18 180:7 193:22 court 10:21 11:7, 9 12:5 19:26 27:26 28:5,18 29:8 39:16 44:21 55:5,10 56:14 57:12,14 67:2,8 101:22 102:2 117:3 125:7 199:15 courtesy 73:3
---	---	--	---	---

courts 26:20
29:19 36:26
57:25 80:21 81:4
90:23
cover 13:18
129:6
coverage 108:3
covered 12:6
covering 8:12
71:21 106:4
coverings 135:10
covers 78:17
COVID 6:7,23
7:5,7 37:19 69:16
70:7,14,16 82:9,
19 85:16 96:26
105:21 106:18
107:1,7 108:11
110:14,18
111:10,25 112:4
114:4 116:23,24,
26 119:24 120:1
126:4,9,11 129:7
132:15 133:18
137:19 138:8,15
145:3,10,22
146:6 152:10,12
155:9,12,22,23,
24,25,26 156:4,7,
8,10,15,20
157:22 158:3,4,7,
8,9,12,13 163:23
166:10,15 167:1
172:19 178:4,23,
26 179:6 180:16,
18 181:26 182:1
183:14 184:17,
19,22,23,24
185:12 187:12,
14,15 190:17
193:7,12,13,14
195:13,14,26
COVID-19 7:13,
15,17,19 8:12 9:6
37:22 55:18
70:22,24,26 71:2,

21 72:15 84:4
85:1 88:3 92:16
104:15 106:5
108:26 109:11,
12,23 111:12
114:15 115:8,9,
11 120:4,16,20,
25 123:11,12,14,
15,24 125:12
126:22,26 127:24
129:12 130:26
138:10 143:10
144:22 145:14,25
146:25 147:9
151:16,19 152:2
153:23 154:5,26
155:2 157:7,26
158:1 159:20,24
163:26 164:10,26
167:1,25,26
168:6,7 169:2,9,
16,17,25 170:1,6,
7,11,12,15 172:4,
11 173:7,11,13,
20 175:12 176:1
177:25 180:5,21
181:26 182:9,12
184:11 195:4
**COVID-
NEGATIVE**
166:14
**COVID-
POSITIVE**
155:4 156:14
166:13 174:26
178:9
**COVID-
RELATED**
104:20 105:23
114:6 128:15
cozy 174:25
CPPI 110:6
CPR 87:3
create 92:4
143:14,20 147:1

created 88:10
113:23 145:11
148:22
creates 132:3
194:11
creating 86:10
creation 132:6
credible 168:15
criminal 76:14,
17
criteria 30:22
40:10 49:19,22
50:2,5
critical 37:10
66:6 154:18
critique 188:26
cross 12:18
121:17
**cross-
application**
25:13
cross-cut 109:18
**cross-
examination**
74:2 171:6,10
177:18 195:19
196:24
cross-examine
53:10
Cross-examines
3:14 115:18
cross-examining
74:7
CSR(A) 10:21
101:22 199:14
cumbersome
38:26
current 53:23
104:9 149:24
curriculum 4:14
8:15,18,22 9:1
63:9 71:24 72:2,
6,10

Curtis 10:18
11:18 101:19
cuts 60:19
cutting 174:24
cv 48:16 49:11
52:17 62:19 63:4
103:2 104:6,23
107:15,20 108:14
112:11,17 113:7
115:24 119:21
121:23 122:22
127:10
cv's 58:7 161:19
CVS 107:6

D

D-1 7:19 71:2
D-10 8:11 71:20
D-11 8:13 71:22
D-2 7:21 71:4
D-3 7:23 71:6
D-4 7:25 71:8
D-5 8:1 71:10
D-6 8:3 71:12
D-7 8:5 71:14
D-8 8:7 71:16
133:23
D-9 8:9 71:18
135:26 136:1,3,8
daily 89:19
Dang 8:19,20
72:3,4 81:10
161:19 181:9,20
191:3
Dang's 190:1
dangerous
194:22
dangerously
194:11,12
darn 180:19
data 109:25
176:3

Database 160:13
databases 167:13
date 7:12 21:26
70:21 89:11
136:2
dated 4:8,22,24
5:5,10,12,17,19,
21,23,25 6:2,4,
10,12,14,18,24
7:2,4,5,10,20,23,
25 8:1,3,5,7,9,14
9:6,7,9,12 19:5
47:26 68:7,9,14,
19,21,26 69:2,4,
6,9,11,13,19,21,
23 70:1,7,11,13,
14,19 71:3,6,8,
10,12,14,16,18,23
72:15,16,18,21
103:5 133:23
136:1 148:2
159:10 199:8
dates 32:7 63:18
dating 164:16
David 11:8 73:22
84:6
Dawson 10:12
12:1 101:12
day 34:15 42:21
54:24 74:25 89:1,
3 106:3 107:4
136:19 156:10
162:16 170:24
177:16 193:10,17
194:15,16,21
198:5 199:9
days 11:22 15:19
16:1,3 23:7 54:19
65:19 73:16 75:1
94:11 185:17
dead 137:24
deal 13:10,13
14:23 47:14 52:6,
8 53:1 55:18 56:5
66:8 76:1 85:21
120:5 138:14

<p>dealing 14:12 52:9 54:2 55:17, 18,19 97:24 127:4</p> <p>deals 40:3 55:13</p> <p>dealt 45:11 66:10</p> <p>death 167:8 184:11</p> <p>deaths 175:13</p> <p>debate 84:25 196:1</p> <p>debates 196:10</p> <p>decades 52:21</p> <p>December 4:22, 24 5:3,5,11,17, 19,21,23,25 7:8, 10,12,20 8:9 68:7,9,12,14,20, 26 69:2,4,6,9 70:17,19,21 71:3, 19 88:21 136:1,5, 18 138:6</p> <p>decide 15:23 18:6 32:24 34:14 41:18,19 60:25 88:17 89:1,9,13, 20 90:24 92:20</p> <p>decided 88:5 120:4 125:19</p> <p>decides 23:1,19</p> <p>deciding 33:3 88:15,16 89:14</p> <p>decision 5:24 15:25 18:2,13,15 24:10,12,25 26:8 28:16 29:9 44:18 47:18 50:4 69:8 75:25 85:24 87:19 125:2</p> <p>decision-maker 40:13 57:26 81:19</p> <p>decision-making 17:7 133:15</p>	<p>decisions 26:17 86:2</p> <p>declare 95:17 198:14</p> <p>decline 180:4</p> <p>declined 90:20</p> <p>decrease 51:13, 17 173:12 175:12,13</p> <p>decreased 108:11</p> <p>decreases 176:3</p> <p>Deena 105:7</p> <p>defence 28:4 54:13 60:26 61:4</p> <p>defend 28:13</p> <p>defer 13:17</p> <p>deferring 144:9, 15</p> <p>define 108:18 116:1</p> <p>defined 79:1 188:15</p> <p>definition 77:6 78:2,7,18 107:10</p> <p>definitively 182:8</p> <p>degree 51:15,17 54:8 84:7 97:9 104:26 105:1,2 178:13</p> <p>degrees 105:11</p> <p>deliberate 62:19 66:22 75:24</p> <p>deliberately 87:19</p> <p>deliberations 41:19</p> <p>delineated 129:20</p> <p>Delta 170:5</p> <p>demarcation 131:24</p>	<p>demonstrable 97:20</p> <p>demonstrably 162:6,11</p> <p>denied 97:17</p> <p>denies 95:21</p> <p>dentists 86:22</p> <p>deny 13:19</p> <p>departing 12:15</p> <p>departure 80:5</p> <p>depend 193:13</p> <p>depending 119:7</p> <p>depends 90:2 193:14</p> <p>deprivation 50:23 51:19</p> <p>depriving 167:3, 6</p> <p>describe 98:1 107:22 108:15 109:7 127:26 129:14 131:12 157:23 159:15 161:15 166:7 169:16 189:4</p> <p>description 2:3 4:3 75:12</p> <p>designed 131:18 139:8 142:5 163:6</p> <p>desktop 25:1</p> <p>detail 38:5 104:22</p> <p>detailed 29:16</p> <p>detailing 168:19</p> <p>detect 186:24</p> <p>determination 51:22</p> <p>determine 15:6 23:14 31:9 34:20 46:23 51:15,25 62:18 77:2 91:23 99:2,4</p>	<p>determined 13:25 94:22 136:12</p> <p>determines 22:23 145:12</p> <p>determining 51:18 95:3</p> <p>develop 113:1,4</p> <p>development 83:20 122:1</p> <p>device 163:5</p> <p>devices 52:24</p> <p>devise 121:20</p> <p>Dianna 11:26</p> <p>die 166:25 184:17 187:12</p> <p>died 155:12 156:26 184:20,22</p> <p>difference 65:25 80:14 165:21</p> <p>difficult 185:21</p> <p>digital 50:4</p> <p>digression 26:5</p> <p>dioxide 50:23 51:14,16,20 52:16 55:22 194:12</p> <p>dire 138:7</p> <p>direct 81:20 87:18 124:10 142:23 143:2,9 147:16 177:12,14 192:12</p> <p>directed 37:22 141:13</p> <p>direction 17:7 21:8 54:3 114:1</p> <p>directions 21:22 29:25 30:3,14 32:5 33:11,22</p> <p>directive 7:2,14, 16,18 32:2 46:14 50:14 61:4 70:11, 23,25 71:1 79:17, 21,24 83:21 84:4, 8 85:13 87:20,25 88:2,10,17 90:9, 17,18,22 91:24 92:3,4,6,11,13,18 95:5,6 96:7,9 98:10 131:8 143:21 147:25 148:2,11,16,21, 22 150:8,20 154:6 157:7</p> <p>directives 87:10 95:13 98:19 148:6</p> <p>directly 33:6 108:19,20 111:3 182:3 183:11 184:15</p> <p>director 10:13 12:24 13:4 17:8, 15 19:6 21:5,8 22:3,9,18,23,25, 26 23:1,7,13,19 24:1,19 28:24 29:26 30:8 33:19 34:15 35:13,24 41:11 43:14 45:12,17 46:15 49:12,15 53:10, 15,17,22 54:5,7, 11 56:10 57:3,9 59:3,7,9,22 60:10,13,15 61:21 62:3,6 63:14 64:12 66:5 73:19,23 76:6,8, 15,19,22,25 82:20 83:24 84:7, 17 85:19 88:24 90:11 91:4,9,10, 14,16,22 92:14 95:3 96:15,21 97:16 98:3 101:13,16 110:5 113:25 196:7</p> <p>Director's 4:6 18:13 19:2,8 22:6</p>
---	---	--	---

24:7 26:22 29:1
30:12 31:6 34:8,
17 36:10,16
58:12 61:1,25
64:18 66:3 73:26
77:14 78:6 87:24
88:1 91:25
disadvantage
59:22
disagree 31:18
32:15,23 115:26
116:2 183:16
disagreement
94:17
disallow 54:12
disaster 126:12
discharge 86:15
87:1
discharged 29:2
disciplinary
26:15
discipline 76:4
78:9 84:9
disclose 29:5
discomfort 51:18
discovered 33:13
discretion 23:3,
16 26:16,19,21,
22 28:24 30:9
32:15,24 88:6
95:17
discuss 25:1
46:24 74:23
90:18
discussed 35:3
43:16 44:4 49:21
55:8 63:3 124:26
discussing 52:13
discussion 2:7
3:7,9,21,25 14:7
90:12,17 92:25
99:14 123:1
140:15 168:4
184:15 186:11,26

196:21
discussions
47:10
disease 132:12
133:1 191:14,15
diseases 112:2
disgraceful
77:12 78:21
dishonourable
77:12 78:21
disobeyed 61:2
Displaying 77:18
dispute 76:11,12
87:17 119:20
distance 146:16
distancing 84:24
85:8,25 86:4
87:21 90:14 91:2
96:13 128:25
143:3 148:12
150:26 158:26
162:5 171:16,20
distinct 16:6
distinction 81:3
distract 96:5
distracted 85:20
92:6
divided 130:16
diving 103:11
doctor 105:2
doctors 55:15
86:22 106:13
192:4,5
document 4:6,16
19:9,12,21 20:8,
17 21:7 22:18
23:6 27:13,16
35:20,26 36:10
37:7,14,21 38:11,
14,23 41:18
63:11 79:24
134:10 142:13
148:17,20 149:24
150:24 153:8,10

154:7,9,11 157:6,
9,11,12,15
158:21 181:12
document-basis
150:12
documents 16:17
17:20 19:10
20:25 34:9 36:18
37:3 38:4,8,26
40:4,8 41:2,14,
20,25 42:5,8,15
43:8 44:2,3,4,7
45:14,16,22
46:19 47:11,13,
23 48:8 60:14
61:23 63:6 66:25
67:1,17 72:24
90:15 91:19,20
131:6 149:2
152:15,17 153:3,
9 160:2,6 161:16
181:20 198:5
domain 127:8
double-back
42:13
doubt 76:16
Doug 12:1,2
downloaded
25:10
downplay 96:21
195:4
dozen 105:21
dozens 156:11
179:12,13
draft 103:24,25
drafted 132:20
drafters 39:12
drafting 133:4
147:16
dramatically
189:10
draw 160:18
drawing 161:14

drop 183:6
Dropbox 25:6
152:23
droplet 171:18
172:15,26 188:6,
19
droplets 169:19
171:26 172:7,21,
24 188:12
Drs 161:19 181:9,
20
dual 157:23
163:9
due 135:18
184:11 188:18
duties 86:15
110:24
dying 184:18
dynamics 145:25
168:6

E

E-1 8:15 71:24
103:2,9 104:6
E-2 8:17 71:26
103:2,9,15
158:18 167:12
E-3 8:18 72:2
E-4 8:20 72:4
E-5 8:22 72:6
E-6 8:24 72:8
E-7 9:1 72:10
E-8 9:3 72:12
ear 18:22
earlier 25:2
44:14,16 87:15
129:21 135:11
180:16 188:6
191:22
early 24:18
129:2,23 157:2
167:2 198:8

ease 19:21 73:6
easier 80:20
East 107:26
echo 56:24
echoed 23:4
ecological 175:6,
7 189:3,21 190:7
economic 186:13
Economics
104:26 105:10
ecosystem
132:26
edit 145:22
Edmonton 10:2
101:2 130:17
134:24 136:26
137:1 138:3,8
education 87:2
104:15,24,25
105:17,19
109:11,22 112:8
127:5
effect 28:11 41:4
53:2,15 54:4
61:20 82:25
95:18 125:15
137:6 140:18
165:21 180:1
181:25
effective 134:22
154:25 162:6
164:22 189:7
effectiveness
55:17,24 164:26
166:20 168:20
effects 159:19
efficacy 41:4
57:1 62:3 85:3
114:15 115:9,12
116:20 120:17,23
121:19 123:11
125:12 163:23
167:8
efforts 59:18

129:10	enforces 44:1	errors 187:2	60:17,18,20,21	Examined 3:12,
egg 34:7	engaged 52:2	essentially 19:24	61:9 62:9 63:8,16	23 102:6 125:25
egregious 97:12	98:24	23:15 110:13	64:19 65:7 74:17,	exception 95:16
elaborate 151:23	engages 51:4	111:23 129:19	21 75:1 80:19,23,	135:15
elect 107:6	engaging 15:17	132:10 137:2,5	24 81:1,21,23	excerpt 19:26
electronic 13:2	enormous 52:26	141:3,7,9,17	82:2,3,11,17,24	excerpts 19:25
38:26	53:6,7,9	142:1,5 151:13	83:1,19 87:18	exclude 53:5
element 30:22	enter 20:15 34:8	165:11,19 169:6	88:14,19 91:23	excluded 56:14
44:11	36:2	174:20,26 179:26	92:2 95:10 97:9	exclusionary
elements 40:10	entered 17:20	183:9	98:1,4,9 103:24	40:19 42:2 47:17
41:1	19:15 20:12	establish 46:13	122:5 129:4	49:23 50:6 52:2
eliminate 47:17	35:22 40:8 41:25	53:11	132:21 138:13,	excused 74:5
else's 26:23	49:13 67:7 72:24	established 81:5	14,17 149:23	excuses 85:15,16
email 4:21 22:2	73:2 122:17	142:8 147:8	151:22 153:19	Executive 113:25
25:10 68:6 153:2	entering 40:4	establishing	154:24 159:23	exempted 135:16
emergency 87:4	entire 28:14	195:11	160:15 161:9,11,	exemption
97:17	entities 115:26	estimate 185:23	12 162:18	135:20 191:23,
emphasis 167:19	139:2	ethical 78:14	167:21,22 168:14	24,25 192:2,6,10,
emphasize 88:18	entitled 27:16	98:25	169:1,2 173:19	13,24
employees	44:23 113:8	ethically 98:13	174:4,6,10,11	exemptions
179:21	154:10 168:11	ethics 5:14 21:19	175:3 179:2,4,8,	135:23 192:5
employees'	entity 116:1	32:1 68:23 73:4	17 180:10 181:15	exercise 95:17
110:17	138:24	77:23 79:10 87:5	182:11 183:1	exhibit 4:5,7,10,
employment	entries 107:21	89:21 94:21	188:21 189:3	11,14,16,18,21,23
107:14	113:13	event 28:9 55:11	190:3 194:2,20	5:1,4,6,8,10,12,
enable 28:8	entry 107:21	events 156:20	195:7,23 196:5	14,15,16,18,20,
enactment 77:26	109:6 110:5,22	166:15 180:23	evidence-	22,24 6:1,3,5,7,9,
encapsulate	112:12 113:9	eventual 51:6	gathering 133:3	11,13,15,17,19,
143:24	environment	everybody's	evidence-	21,23,25 7:1,3,5,
Enclosures 5:23	129:26 151:24	38:25 50:15	informed 176:2	7,9,11,13,15,17,
69:6	epidemiological	everyone's	evidentiary	19,21,23,25 8:1,
encourage 73:10	183:3	197:20	39:20 65:22	3,5,7,9,11,13,15,
end 29:25 34:15	epidemiological	everything's	72:24	17,18,20,22,24
159:17,26 162:16	y 195:11	197:20	evolved 172:14,	9:1,3,5,7,9,11
167:16 168:1	epidemiology	evidence 15:21,	19	13:9 19:4,15
183:7 187:3	106:6	22 16:8 34:16	evolves 174:11	20:12,16,19 25:6
195:1	equipment 37:13	35:7 36:24,26	191:13	35:22 36:3,9
ended 192:3	142:16 150:22	39:5,6,9,16,19,	exact 179:15	47:25 48:2,4
enforce 86:16,18	154:10 157:20	22,25,26 40:4,11,	examination	63:9,11 65:15
enforcement	equipoise 166:18	15,21 41:9 43:15	54:3 171:9	67:12 68:3,6,8,
44:6	equivalent	44:20,24 48:20	177:12,14	10,13,15,17,19,
enforcer 33:15	112:25	54:12,14,15,19,	examination/	21,23,24,25 69:1,
	era 182:7	21 55:3,7,9	cross-	3,5,8,10,12,14,16,
		57:16,19,21 58:3,	examination	18,20,22,24,26
		5,8,9 59:23	48:18	70:2,4,6,8,10,12,

14,16,18,20,22, 24,26 71:2,4,6,8, 10,12,14,16,18, 20,22,24,26 72:2, 4,6,8,10,12,14,16, 18,20 103:15 133:23 135:26 136:1,8 140:3,7 148:2,14 158:18	57:15,23 58:7,8, 10,19,22,24,25 59:16,23 60:11, 21 62:5,7,9,11,20 63:5,12,15 64:21 65:25 71:26 72:4, 8,12 73:22 80:16 81:3,9,25 83:25 85:5 91:5,11,15, 17 96:26 98:4 102:11,19,20 103:2,5,14 104:1 114:14 115:7 120:22 123:9,10, 17,18 125:1,2,11 131:9 158:17,20, 23,25 160:4 161:19,21,22,24 168:11,21 177:22 180:26 181:10 184:2 187:18 191:1 195:3	extent 73:10 169:19 193:12 extra 33:21 60:20 extreme 191:17 Extremely 161:17 eye 156:2,6 eyes 90:1 146:5	fair 14:1 41:14 58:16 107:6 144:9 fairly 137:24 179:24 181:5 196:6 fairness 60:4 149:21 197:1 fall 50:22 56:1 117:4 127:14 fallacy 43:21 190:7 falling 178:15 falls 80:6 133:8 150:8 false 190:2 familiar 102:9 110:26 132:14 135:20 family 104:10 106:13 107:23,26 192:4 fan 172:20 FAQS 7:5 70:14 Farmer 113:17 fault 93:18 favour 84:11 175:15 February 112:12 federal 112:19 113:4 126:24 127:7 feel 47:13,15,22 55:2 169:11 Felt 138:1 fides 46:13 field 91:5 106:21 162:26 192:1 file 13:8 25:6 66:26 152:24 filed 52:5 Files 42:19 66:25	final 66:4 78:2 79:22 80:7 84:5, 15 133:18 136:9 146:12,21 157:5 Finance 105:8 financial 119:11 find 25:16,18 30:5 41:25 47:16 50:3 58:21 59:24 92:17 99:6 133:26 192:17 finding 63:5 85:24 99:5 findings 16:4 32:11 75:26 finds 97:10 fine 18:11,12,20, 21 19:15 20:21 36:2 64:13,14 94:6 96:4 100:2,3 121:16 122:23 150:5 163:4 171:12 194:20 197:23 fine-tune 74:23 finish 14:11 29:21 54:24 74:25 93:24 170:24 171:9 177:12,13 197:7, 12 finished 64:2 122:25 177:1 Firstly 31:17 fit 30:9 94:9 188:26 fits 182:25 five-line 186:7 flag 133:5 flavour 38:7 flexibility 39:15 80:19 floor 94:12
exhibits 4:1 13:11,13 17:4,21 30:15 36:18,23 65:15,16 66:13, 18,19,20,24 67:4, 7,18 68:2 72:23, 25 73:2,5,6 79:20 88:8 91:21 102:25 103:2,9 152:18,21 expand 155:5 expect 93:3 124:20 expectation 198:6 expected 177:15 198:5 experience 17:1 20:14 52:12,26 80:2,3 102:17 107:16,17,18,19, 22 108:15 109:6 113:9 117:20 120:26 126:22 127:10 138:8 157:2 163:17 164:18 experiment 175:8 expert 4:17 8:17, 20,24 9:3 17:13, 14 40:2 43:14 45:11 48:19 49:10,14,16,20, 24 50:7 51:15,21 52:9,10 53:23 54:9,14,19 55:3,6	expertise 112:19 120:20 146:1 150:9 expertly 52:13 experts 54:23 55:14,15 58:6 59:2 98:8 181:9 191:15,21 194:18 explain 135:8 178:1 186:8 191:9 explained 133:16 explicit 98:26 explore 110:24 exponentially 163:23 exposure 51:14 extended 188:15 extension 5:18 69:1 130:2 extensive 83:25 115:22	face 8:12 71:21 96:1 97:3 99:17 135:7,10,13,18 137:13 172:3,4 174:20 175:12 188:21 faces 52:25 facilitate 39:13 fact 15:10 21:8,26 29:16 37:17 39:20 45:1 49:23 50:6 51:25,26 52:19 54:22 67:9 80:23 90:15 95:4, 24 96:24 98:4 116:9 142:13 147:22 148:5 150:3 163:26 180:20 183:17 factors 176:16 190:11,16 facts 14:4 21:23 27:23 40:12,25 53:12 76:9,11,22, 25 81:19 87:17 factual 81:20 87:16 187:2 failing 79:4	F F-1 9:5 72:14 F-2 9:7 72:16 140:3,7,8 F-3 9:9 72:18 F-4 9:11 72:20	

flu 170:8,9,10,11
flying 198:9
focus 117:16
 195:3
focused 61:25,26
focuses 50:9,20
folder 149:11
folks 111:2
follow 87:20
 88:12 89:2 98:16,
 19 142:4
follow-up 31:4
 74:2
font 187:17
force 95:18
foregoing 199:3
forgive 120:13
forgot 106:18
 112:17
form 53:26 54:2
 163:5
formal 32:22
 33:4 39:13,24,26
 57:19,20 80:18
formally 67:4,5
forms 132:22
forward 23:20
 28:6 31:6 158:12
found 35:7 49:20
 53:22 173:17
 185:23
foundation
 92:15
fourth 56:11
 65:21 76:2 79:26
 106:2
framework 46:7
frankly 14:16
 19:16 40:5 58:11
 59:23,25 64:24
 66:18 76:10 91:8
 121:14 150:12
 159:22 197:16

Fred 140:9
Frequently 9:11
 72:20
fresh 197:20
friend 31:18
 42:11 44:3 55:4
 57:12,18 58:14
 92:23 93:25
friend's 13:23
friends 52:3
 194:14,15
front 25:21 26:7
 35:21 49:10
 73:14 77:8 90:13,
 16 91:26 153:13
 158:21
full 54:12 102:23
 198:5
fully 45:15
fulsome 123:7
function 83:20
 157:18
fundamentally
 109:20 145:24
 151:17,23
funding 118:6,8
 119:24,26 120:7
fundraise 113:26

G

G-4 4:14 63:9
G-5 4:16 63:11
game 33:2 34:12
 139:11 197:9
gamut 106:4
 129:6
gap 109:11
gatherings 137:3
Gauthier 81:13
 83:2
gave 149:1
gears 107:12

147:24
general 28:14
 81:18 105:20
 107:26 126:20
 156:3 158:22
 160:2 166:6
 177:26
generally 22:13
 32:15 40:11,19
 104:19 105:5
 108:1,18 118:9
 119:2 121:2
 131:18 156:2
 159:20 160:6
 165:9 166:17,19
 169:3,7 194:7
generate 35:24
generating 144:6
Genevieve 4:11
 48:4
gentlemen
 123:26
geographically
 110:3
get all 74:26
 172:4
give 16:16 23:8,9
 24:10 38:7,18
 55:6 57:15 65:9
 66:2 76:9 80:25
 82:17 83:19
 84:11 93:4
 134:19 137:20
 140:14 155:20
 160:1 170:25
 176:24 192:24
giving 75:19
 102:4 155:1
 178:26
global 113:16,19
globally 13:11
GOA 9:5 72:14
goal 37:18 197:8
gold 165:10

good 10:24 11:6
 25:14 27:21
 31:16 36:8 39:22
 43:19,20 67:24
 89:22 97:1 104:3
 114:24 134:13
 141:24 145:6
 153:6 160:22
 164:2 167:3,25
 169:8 170:7
 176:12,20 177:3
 182:9 195:22
govern 87:12
governability
 61:26
governance 57:5
government
 86:9 88:2,9
 109:13 115:25
 116:1 130:6
 137:23
grab 47:1
grant 119:1,7
granted 97:19
grants 118:12,14,
 25 119:4,8,11,12,
 15,16,18 126:4,8
great 34:23 41:26
 85:21 124:22
 138:14 191:26
 193:5
grey 153:11,12
grounds 26:16
 44:20
group 104:13
 124:5 128:2,5,8,
 24 129:5,16,18
 133:7 146:3
 165:15,17,20
 191:12
groups 129:20
 132:23 166:1
grown 163:23
guess 94:16
 104:12 106:10,14

108:25 114:3
 115:10 118:13
 122:3 130:4,18
 150:11 168:1,24
 180:13 187:20
 191:15 196:4
guidance 39:22
 41:15 57:21
 80:25 111:18
 112:19 142:10,14
 144:2,4,17 146:8
guidances 141:9,
 22 143:16 145:21
guideline 143:13
guidelines 12:16
 37:5 113:2
 121:21 122:2
 141:13,15 142:4
 143:15 144:22,25
 145:10,12,23
 146:26 147:2,10
 153:10,17
guilty 85:17
guy 89:13 113:16,
 17

H

H' 42:26 152:24
H-1 4:5 19:9 36:9
H-2 4:7 47:25
 152:25
H-3 4:10 48:2
H-4 4:11 48:4
hair 174:24
hairstylist
 174:22,26
Haiti 113:21,22
half 133:10
 165:13,26
halfway 20:3
hallmark 108:21
Halowski 73:21
 83:15,16,17

93:16 148:4,16 197:22	he'll 83:19,21 84:2 172:3	154:18,19 155:1, 3,11,19 156:9,11, 14,21 157:6 159:2,4,21,24 162:20 163:14 164:7,21 166:14 167:3 173:10,14, 17,24 174:1,9,15 175:22 176:1 177:26 178:3,7,8, 16,20,21,22,24 179:5,19,25 180:2,11,22 181:25 183:21 184:4,5,6 187:7,8 188:22 192:11 194:24 195:5,12, 23	4,26 23:2,8,11 25:4,23 26:1 28:15 29:12,22 30:5,20 31:10 32:22,26 33:4 34:21,25 35:2,22, 24 36:6 38:21 39:6,14 41:6,12 44:23 46:23 47:8, 18 52:5 53:17 54:20 56:26 58:15,24,26 59:26 61:25 62:18,25 65:5,23 66:11,12,21 67:3, 4,15 68:3 73:7 74:3 75:23 76:4 77:16 79:12 81:7, 26 82:3 83:1 84:10,18,19,20, 21 85:6,10,22 86:3,6,20 87:13, 15 88:13 90:26 91:8,17 92:21 96:19 99:16 100:6 101:7,25 102:26 114:12 124:16,25 177:13	hesitancy 106:24 hierarchy 161:9 high 136:25 138:11 145:1 161:17 169:3 175:24 178:4 183:25 184:19 193:18 194:11,24 high-quality 167:14 higher 76:18 highest 185:17 193:18 highlighting 21:6 highly 61:10 161:11 170:15 183:26 189:15 196:14 Hinshaw 105:7 111:2 131:15 132:15 133:20 192:8 Hinshaw's 111:7 historical 163:17 164:16 history 107:14 138:7 163:24,25 164:4 165:1 hit 88:4 138:5 hitting 136:19 HIV 169:24 Hogan 11:9 hold 13:20 151:5 holding 13:1 home 111:18 180:9 hope 134:18 148:8 hopeless 32:10 Hopelessly 32:8 hospital 111:24 155:24 186:18
Halowski's 148:8 149:3,22	heading 28:18 38:14 109:5 134:17 142:15 150:22 153:12 154:15 177:22	Health's 159:8 healthcare 177:23	hearings 10:13 19:6 22:18,26 23:7,26 24:19 35:23 39:10 101:13 102:10 124:9	
hand 11:25 27:7 103:10 130:24 187:6 195:7 198:12	heads 177:4	heaps 179:16	hearsay 40:21	
handed 128:9	heads-up 170:26	hear 12:22 14:18 18:12,14 31:8 56:25 60:9 62:8 75:11 82:3 83:7, 12 85:21 87:18, 26 96:20 97:6,15 114:19 148:16	heavily 43:12	
handful 180:23	health 5:1 11:16 17:20 21:21 22:9 29:24 30:2,10,11 32:4 33:8 36:17 37:9,11,16,21 38:2 46:11 68:11 72:26 77:5 80:2,4 83:26 86:12,13 91:20 94:25 95:23 103:20,21 104:10,17,18 105:2,5,6,7 108:1,7,11,23 109:3,14 110:15, 17,23 111:1,5,9, 17 112:13,15,18, 20 113:10,14,16, 19,20 114:4 115:8 116:10 120:15,16 123:7, 11 125:12 127:11,23 128:1, 5,6,13,15,17,18, 23 129:10,19 130:15 131:4,12, 14,16,17,18,19, 20,21,25,26 132:1,2,3,5,7,13, 20,25 133:1,9 137:26 138:17,26 139:8,13,14,16, 18,19,25,26 140:21 141:7,8, 10 142:2,11,14 144:1,18 146:2 147:8 150:4 151:14,17 153:16,24,25	heard 15:10 29:14 44:20 46:20 82:13 94:15 115:5 120:25 121:3 198:13	heck 164:2 170:11	
handily 24:6	hands 18:16 27:5 36:1 38:24 192:26	hearing 4:18 10:7 11:13,14,15, 21,24 12:8,21,22 13:1,8,15,17,19, 24,26 14:4,17 15:5,11,14,16,18, 20,21 16:1,5,6, 11,26 17:2,17,18, 26 18:12 19:4,18, 20,25 20:10,16 21:5,13,25 22:1,	heft 40:16	
hands 18:16 27:5 36:1 38:24 192:26	handy 73:11 77:8	hearings 10:13 19:6 22:18,26 23:7,26 24:19 35:23 39:10 101:13 102:10 124:9	hefty 188:21	
happen 35:14 83:16 174:12	happen 35:14 83:16 174:12	hearing 4:18 10:7 11:13,14,15, 21,24 12:8,21,22 13:1,8,15,17,19, 24,26 14:4,17 15:5,11,14,16,18, 20,21 16:1,5,6, 11,26 17:2,17,18, 26 18:12 19:4,18, 20,25 20:10,16 21:5,13,25 22:1,	helpful 49:18 73:14 187:26	
happened 82:15 112:4 132:16 155:13 156:24 194:24	happening 51:16 111:25 152:6 192:3	heard 15:10 29:14 44:20 46:20 82:13 94:15 115:5 120:25 121:3 198:13	helpfully 66:10	
happening 51:16 111:25 152:6 192:3	happy 31:2 42:10 60:2 74:23 92:22	hearsay 40:21	helping 113:1 114:5	
hard 143:23 144:14 152:6 188:17	harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	heavily 43:12		
hard 143:23 144:14 152:6 188:17	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	heft 40:16		
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19	hefty 188:21		
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19	helpful 49:18 73:14 187:26		
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	helpfully 66:10		
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19	helping 113:1 114:5		
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14	harms 50:10,22 51:8 55:25 56:10 78:4 191:5,7,10 196:16,18,19			
harm 50:26 51:1 56:4 59:5 95:10, 26 97:20 191:16 192:21	harmful 22:15 51:18 52:1 55:20 56:8 61:6 95:8,14			
harmful 22:15 51:18 52:				

hospitalist 108:9	humanity 163:25	impacting 110:16	23:24	138:15
hospitals 128:20 155:22 194:16,21	hundred 156:20 160:16,17 172:6 189:6	impartial 126:6, 18	include 26:26 176:17	indoors 173:26
host 86:25 130:25	hundreds 156:13,16,22 161:7 166:12 170:17	imperfect 182:21 183:7,17 189:22	included 165:5	industries 109:17
hot 136:20	Hygiene 105:9	imperfection 183:16	includes 116:23 134:26 135:1	ineffectiveness 61:5
hour 170:23 177:11	hyper- ideological 195:25	implement 121:20 130:7 183:5 190:9	including 30:2 54:14 108:26 115:11 116:17 120:17,20 122:5, 7 123:14 129:7 133:26 141:6	infect 170:3
hours 65:3	hypothesis 166:24	implemented 190:12	incorrect 23:23	infection 121:21 130:13,19,20 152:3 172:5 186:22
housekeeping 35:23 65:13 66:9 93:3 103:6,13	hypothetically 44:25	implementing 122:8 155:17 180:1	increase 51:14 109:22,26 116:16	infections 175:12 183:8
HPA 15:7 19:25 22:16,20 23:4 31:24 36:24 38:10,12 73:9,11 77:7 78:16,23,26 79:6 80:17 86:9 142:9 146:24	I	implication 162:9	increased 95:22, 25 174:20 177:24 178:25	infectious 132:12 133:1 169:25 170:6,8,15 173:3 175:1 180:22
Hu 3:12,23 8:16, 17 58:19 59:24 71:25,26 73:21 81:10 83:24 91:17 93:10,19 99:23 102:2,6,13, 22,24 103:16 104:8 114:13 115:7,19 116:9 120:15,19,25 121:8,12 123:3 124:2,3,15 125:1, 2,11,20,23,25 126:3,4,5 133:21, 26 134:16 135:2 136:7 148:14,19 149:21 150:3,17 152:19,22 153:1, 13 158:23 168:23 171:8,14 177:1,6, 14,18,21 194:1 196:22 197:22,24	idea 25:14 48:14 93:4 115:3 145:6	importance 38:2 111:17 132:1 179:2,22	independent 12:3 43:25 44:8 59:6 81:16 85:12 124:16 126:6	influenza 163:16 168:5 169:22 170:14
Hu's 124:7	identification 20:19	important 25:13 26:6,20,24 27:24 37:6,7 38:8 39:4, 24 41:17 42:4 46:18 53:11,12 54:26 56:2 57:21 76:12 81:2 83:6 88:24 89:5 93:11 96:22 137:17 154:26 167:22 171:21 174:7	independently 92:12,19	informal 32:21
huge 189:2	identified 107:15	importantly 29:11,18 84:18 151:25	indicating 168:15	informally 25:17
human 44:19 45:1,8 61:7 94:25 95:20 98:23	identify 25:15 28:9	imposes 95:10	INDISCERNIB LE 81:6 83:19 105:3 106:16 109:21 116:7 117:12 122:21 127:3 129:17 130:3 136:21 139:15 142:3 143:5 145:5 151:26 156:25 161:2 162:10 163:3 164:11,24 168:25 172:18 192:10	information 29:7 47:12,20 51:11 58:17 63:16 66:22 82:4 85:21 97:5 160:3
	ideological 196:12	impossible 58:21	individual 58:20	informed 167:21, 23
	ignore 39:19 80:22	impression 188:8	individuals 143:11	initial 103:25 128:7 155:15
	ii 77:21	impugned 95:4	indoors 135:10 137:2,14,18	initially 174:12
	iii 77:25	impugning 61:3		institutions 183:26 184:1
	illegal 89:23	inadvertently 155:2		instructing 52:18
	illustrative 155:21	inapplicable		instruments 132:9
	imagine 53:9 171:24 174:23			insufficient 120:22 136:13 145:13 170:14
	immunization 112:23 129:17			integrity 78:4 89:26 96:1 98:13
	immunologist 117:26			
	immunologists 55:16			

intend 20:17 22:7 25:19 35:19 57:25 170:20,21	23:8 investigation 5:8 22:22,24 68:17 84:10	issues 17:1 32:18 40:12,25 42:11 43:14 44:19 47:15 50:25 56:1, 5 59:5 60:24 66:6 67:20 87:16 91:7 94:22 99:20 108:7 112:20 115:1 131:26 148:17 196:13	103:5 107:21 159:10	14:22 15:8 16:19 17:11 18:4,9,11 19:14 21:25 22:3 23:26 24:5,16 25:16,20,25 29:12 31:3,9,11, 13,15 34:14 36:2 39:1 40:1 42:11 43:3,4,6 48:9,13, 23,26 49:4,7,9,25 50:2 56:16,17 59:15,17 60:3,5,7 61:14 62:8 64:6, 9,11 65:12,20 66:9,12,15 67:6, 18,21,22 73:17 74:1,11,13,15 75:5,9,13,18 81:17 82:4 84:12 89:15 92:24 93:2, 5,7,13,15 94:4,6, 12,13,14 99:11, 16,26 100:2 101:20 102:11,17 114:12,17,18,19, 22,24 115:11,15, 18,19 120:9,10 121:13,16 122:12,14,25,26 123:13,21 125:18 126:2 127:17 134:18 136:10 140:5,8,11 148:24 149:1,5, 14,18,20,26 150:15 151:5 171:4,8,12 195:18 196:23 197:6,23 198:4
intended 75:16 83:15 93:16 139:5	investigator 118:10,18,19,23 119:2,10,17	Italy 155:10 156:24	June 8:3,5 71:12, 14 87:19 88:21 184:20	Kitchen's 14:9, 21 17:22 19:6 20:1,14 21:16 25:13 35:19 36:1 43:1 123:8 177:18
intense 112:5	investment 110:11	item 77:17 78:3	jurisdiction 12:21 66:10 136:22	Kitchens 126:14
intent 48:11	invite 12:14 14:8, 21 20:14 21:16 24:17 35:18 125:7 162:22	items 37:17 63:4	jurisdictions 135:11	
intention 139:1 170:24 197:21	invited 90:16		justice 28:2	
interact 178:9	invites 58:9		justification 98:25	
interactions 156:11,13,17,22 166:13 180:21	invoke 26:14		justifies 45:20	
intercourse 169:24	invoked 32:20	J		
interest 86:16 96:17 97:7 165:22 197:11	involved 30:17, 19 33:8 83:26 84:1 102:11,15 107:2 110:7,9,25 119:7 121:26 122:3 126:26 127:19 128:23 132:17 133:3 143:1 147:16 155:6 197:2	J.S.M. 10:19 101:20	key 29:19 61:4 94:22	
interested 167:24 183:19	involvement 83:22	James 11:20	kill 184:23,24	
interesting 167:16 174:22 190:5	involves 73:20	January 4:8 5:7, 13 7:18,22 47:26 68:16,22 71:1,5 79:23 148:3,8,15, 20 149:3,5,6,16	Kim 113:17	
interests 51:7 97:3	involving 179:21	Jia 3:12,23 8:16, 17 71:25,26 102:6,24 103:16 125:25	kind 32:20 59:5 64:12 97:12 105:6 109:14 121:12 139:20 140:18 153:11 155:9 166:3 176:11 182:18,19 190:5	
interfere 63:21	irrelevant 44:24 45:4,9 46:13	Jim 113:17	kinds 81:5 105:26	
interim 97:14,17	issue 15:24 18:23 29:17 46:5,16 51:26 56:1,9 57:4,22 61:5 63:17 64:17 75:25 83:4 85:6 90:13 91:13,18 95:1 150:15 166:16	job 111:7 131:19, 20	kiss 190:20	
interject 25:5	issued 54:17 79:18 131:8 132:14	journal 160:12 179:20 181:18 189:16	Kitchen 2:10,17, 22 3:1,8,14,16 10:19 11:1,3 12:14,25 13:5,22	
Internal 10:9 101:9		journals 160:11 169:4		
internet 128:4		JSTOR 167:13		
interrupt 49:26		judge 98:11,14		
intervention 196:16		judgment 77:19		
interventions 163:13		judicial 39:10		
introduce 11:23 102:1		July 4:20 6:18,20 8:14 9:10,12 19:5 21:24 68:5 70:1,3 71:23 72:19,21		
introduction 57:10 162:2				
inundated 57:26				
investigated				

knew 88:15 120:6
165:1

knife 60:19

knowing 90:2,3
152:19

knowledge 47:19
51:11,20,23
77:18 80:3 81:20
82:1 102:17
119:6 159:1
162:26

L

lab 106:26 107:3
168:17 169:10
182:19

lack 41:9 55:17
64:4 77:18 80:15
85:7 103:24
182:13

lacks 53:20

lady 89:13

Lancet 160:11
181:19 189:15

language 147:11
162:13

lapse 78:12,13

large 143:22
155:11 164:24
173:6 179:24
187:9 189:1
190:10

largely 76:12
166:2

larger 75:6

lastly 55:4 98:11
184:25 191:3

late 24:18 33:2
34:11 139:11

law 22:10,11
39:9,12 81:3 88:6
89:17

lawful 43:23 95:6

99:4

lawfulness 61:8
95:15 99:2

Lawrence 11:8
30:8 73:22 84:6
101:16

lawyer 89:14
114:12

lawyers 40:20
41:21 86:22

lay 32:25 54:21,
24 65:25 80:15
81:3,11,18,22
82:5,14,17,24,26
83:7

lead 104:12 114:5
118:9 119:15
133:4 190:16,25

leadership
107:17 113:8

leading 127:17

leads 189:24

leakage 182:22

learned 13:23
31:18 44:3 55:4
164:1,10 174:7

learning 87:6

leash 150:1

leave 123:20
124:17 135:23
138:18 177:17
196:25

lectures 105:17,
26

led 118:13 137:3
192:7

Lees 10:8 11:20
27:8 101:8

leeway 64:22

legal 10:9,16,19
12:4 13:7 14:19
22:12 23:13 29:1
61:10 63:3 65:22
74:18,22 76:3

81:16 92:3 101:9,
17,20 124:16
162:9,22

legally 51:3
132:9

legislation 39:12,
13 45:1 78:10

legislature 90:23

legitimate 61:10

Leslie 11:25,26

lesser 169:19

Letter 4:23 5:4,6,
10,12,16,18,24
68:8,13,15,19,21,
25 69:1,8

level 28:26 76:25
80:11 128:19
145:1 161:15
183:23,25

levels 52:16
55:22 169:4
194:11,12

liability 15:18,
20,26 16:7 65:5
75:23

liberty 134:19

Library 167:13

licence 97:16

licences 97:13

life 120:6

life-long 87:6

limit 132:10
155:23

limitation 135:19

limited 123:24

limiting 28:11

limits 95:19

lines 142:19
165:5

linger 172:24

link 25:6

list 65:15 67:13
68:1 159:26

listed 31:23 66:24
135:11 138:24

listen 63:23
96:23,24

literature 103:22
160:6 167:18,20
176:18

living 130:1

loads 185:17

lockdown 137:8
178:13 190:12,15

lockdowns
196:11

locum 108:3

log 198:9

London 105:8,9

long 53:19,21
58:16 62:21 93:3
108:5 114:25
115:1 121:16

136:22 139:17,19
150:1 164:20
174:3,25 194:15,
16 197:12,17

long-term 108:4
111:22 128:20

long-winded
157:1 177:7

longer 33:14 47:6
108:6

longitudinal
174:19

looked 47:11
99:12 189:16

losing 126:4

loss 59:25

lot 20:25 50:16
52:17,19 56:5
67:25 73:13
94:15 104:3
106:23,26 108:8
111:16 112:24
113:16,21 114:4
115:25 116:20

118:10 120:7
121:4,22 122:9
126:14 129:8
132:16,21,26
141:5,6 151:22
154:24 164:2,11
169:12 170:11
174:8 178:12
181:23 182:12,16
183:10 184:17
186:13,14,16
190:20 193:19
194:13,15 195:23
196:10,19 198:5

lots 104:19 119:6
120:25 152:8
179:11 196:1

Lougheed 108:9

low 114:21
156:18 188:19
194:12,23

low-income
113:21

lower 174:21

lowest 185:23

lunch 73:25 94:2,
9 99:25

lung 191:14,15,
21

M

M-A-H-O-N
24:25

M-HM 117:2
118:20 122:16
142:17 143:16
146:18 150:23
158:24 194:6

Macleod 4:7
24:15 27:2,16
29:9 47:25

made 16:5 21:9
26:17 29:13 49:4
51:22 59:17

87:19 90:26 104:3 121:14 123:19 148:10 main 155:19 maintain 86:16, 18 143:3 146:12 maintained 96:1 majority 167:18 168:14 175:11 195:3 make 13:22 14:14 17:16,25 18:2,13,14,19 20:6 22:7 23:16 34:4 38:24 42:14 48:15 52:14 67:24 74:10,11 75:13,26 85:6,24 86:1 87:23 96:3 104:2 120:11 121:14 124:7 130:22 133:25 141:24 148:1 154:13 180:12 186:12 187:21 191:3,18,19 makes 17:26 122:3 139:18 186:16 making 36:21 37:18 48:12 74:18,22 82:15 91:7 96:5,6 136:20 161:1 mall 138:16 man 82:18 manage 26:14 managed 111:22, 23 196:7 management 109:1 111:21 127:20 managing 108:25	mandate 51:4 61:9 95:11,16,18 110:20 138:11 mandated 95:9 136:24 mandates 96:10 99:7 139:23 mandatory 86:20 87:25 88:1 146:15 147:11 manner 39:7 62:4 manufacturers 120:1 map 65:9 131:3, 10 March 6:2 8:12 29:12,13 69:11 71:21 130:1 155:8 Margaret 103:16,19 marginalized 108:2 114:7 mark 20:19,20, 22,25 67:4,11 marked 67:5,19 73:5 marking 67:9 Martens 10:11 11:26 101:11 mask 8:14 51:4 61:3,9 71:23 95:9,16,18 96:11, 14 130:2 135:7, 13,18 136:23 137:13 139:19 142:25 144:13 151:18,19,21 152:11 153:26 156:5 157:24,26 158:3,4,7,8,9,11 159:19 162:4 163:7,22 164:2 168:15,20 171:17	173:11,25,26 174:1,13 175:12 176:3 179:2 180:10 182:22,25 189:1 190:9 191:13 192:2,13 193:20 194:11,19 masked 175:2 masking 6:16,18 7:9 8:17,21,25 9:4 37:6,15,17, 18,25 41:3,4,10, 12 43:15 46:12, 15 47:14 57:1 58:13 59:6 60:10, 12,14,15,20,21 61:23 62:2,3,10, 12 69:25 70:1,19 72:1,5,9,13 82:8 84:3,23,26 85:8, 15,24 86:3 87:20 90:14,26 91:11 92:16 95:26 96:10 98:2 103:23 106:1 114:15 115:9,12 117:16 120:23 121:1,19,21 122:2,8,10,19,21 123:4,12 125:13 126:17 127:3,21 128:25 129:3,22 130:4,7,11,24 135:16 136:15,24 137:16,18,24 138:2,15 139:12, 16,21,23 143:8, 15,19 146:15 148:11 150:25 153:11 154:6,25 155:6,7,18 156:1, 23 157:3,18,23 158:26 160:21 164:7,25 167:3 168:3,7,11 169:7, 8 173:19,23 174:18 175:3,16,	18,22 177:22 179:5 180:1,6 181:25 182:6,9, 11 183:5,11,16 184:5,8 186:25 187:11,19,26 191:5,8,17 193:8 195:7,22 196:11, 17 masks 37:22,26 43:12 45:8,10 50:10,11,12,13, 14,16,18,19,21,26 51:8,9,13,26 52:13,18,21 55:18,20,24,25 56:2,4 61:5 120:17 121:26 129:25 134:17 135:10 138:17 151:15 155:14 156:25 157:7 159:23 162:19 163:5,12,15,18 164:16,20 165:1, 2 167:4,25 169:2 174:21 175:10,25 180:18 181:1 182:21,23 183:15,17,18,21 187:6 188:22,26 189:3,6,19,22,24 190:17,19 192:17,18 193:12 194:15,21 195:12 Massachusetts 179:19 Masters 103:19 105:7 material 40:16, 25 43:11 44:1 47:16 materials 133:24 matter 11:24 13:11 15:3 22:25 23:10 33:18	35:23 45:19 46:24 47:15 60:23 76:1,11 103:13 108:5 128:6 137:8 182:26 183:14 188:20 192:19 matters 66:9 84:9 182:25,26 Maxston 2:8,12, 15,19,24 3:3,6, 12,17,19,24 10:16 11:8 12:11, 23 13:3,10 14:5,8 15:1 16:19 18:17, 25 19:1,17,19 20:5,13,26 21:2 24:13,16,23 25:8, 12 26:2,3 27:11, 15,20,22 31:11 34:1,3,6 35:16,17 36:11,13,14,15 38:19,20 42:18, 25 43:1 45:25 46:2,3,5 47:24 48:15,26 49:2 56:18,19,21 61:13,18,20 63:26 64:15 65:1, 2 66:16 67:10,12, 26 72:22 74:20 75:8,16,22 92:26 93:2,8,12,14 99:12,15 101:17 102:1,6,8,22 103:8,11,13 104:5,8 114:11, 24 115:2,4,13,17 120:13 121:9,10 122:24 123:2,16 124:6 125:3,4,6, 15,24,25,26 127:16,19 132:8 134:9,14,15,18 136:2,4,7,10,12 138:13 140:5,7,9, 12,16 147:26
--	--	--	--	--

148:19,24,26 149:6,8,10,12,17, 19 150:10,16,17 151:8 152:16 153:1,7 157:8,10, 13,15 158:19,22 170:19 171:4,7, 13 172:2 176:23 177:19,20,21 188:13 193:25 194:4 196:22 197:16 198:4 Maxston's 75:12 125:20 meaning 78:12, 14 79:1 meaningful 186:24 means 13:2 62:1 77:10 85:17 118:23 157:25 162:11 167:15 170:2 172:15 176:20 184:13 meant 116:3 130:25 131:25 147:22 164:14 measure 59:3 79:15 82:22 106:6 122:5 136:22 measures 84:4 85:3,16 92:16 114:16 115:9,10, 12,14,16,17 120:18,24 121:2 123:12 125:13 128:26 136:13,16 162:4 170:12 171:17 medical 50:10,12 55:15 94:24 104:17 105:1,6 106:15 108:22 110:5,10,23 111:1,5,9 116:9	118:4 127:11 131:4,11,14 159:7 160:11,12 165:11 179:20 181:18 191:10,26 192:8 196:7 medication 165:16,22 medicine 105:3,9 163:24 meet 28:23 41:15 42:1 45:8 63:6 90:3 198:12 meeting 124:17 198:14 meets 49:17 member 4:21 5:4,6 10:10,11,12 11:19,20 23:17, 18,21 68:6,13,15 86:8 95:4 101:10, 11,12 105:13 106:15 113:10 130:20 142:8 146:24 members 6:1,3,5, 9,11,13,15,17,23 7:1,3,9,11 11:23 12:1,2 16:25 23:12 25:4 35:2 36:6 51:12 63:2 69:10,12,14,18, 20,22,24,26 70:6, 10,12,18,20 77:1 80:2 84:20 87:26 88:25 89:18 90:2, 19 93:1 94:15,26 95:8 96:10,20 102:9 114:13 135:25 141:14 145:8 152:17 197:2 198:11 mental 108:7 110:15 135:18 mention 78:9,25 80:21 170:19	171:2 mentioned 15:5 41:2 53:14,21 58:14 78:17 109:21 121:23 127:21 128:12 129:7 130:8 133:7 137:21 165:4 166:10 171:8 mentioning 21:10 merit 53:20 merits 47:20 met 29:7,21,23 40:23 meta-analyses 160:19 161:10 meta-analysis 161:2 181:17 189:15 methodology 161:3 Methods 167:11 metre 172:3 metres 172:6,21, 24 188:12,16 metropolitan 134:23,24,26 mic 31:15 microbiologist 118:4 middle 165:3 millions 170:17 mind 40:9 181:17 197:20 mine 112:1 minimally 153:20 minimum 144:2, 12,13 146:17 Minister 127:8 129:19 133:8 137:26	ministries 184:7 Ministry 111:3 128:14,17 131:16,18,24,26 132:20 133:13 minor 30:20 148:10 minute 16:16 29:20 40:22 61:16 104:7 134:4 140:14 minutes 14:13 15:2 16:12 24:10, 22 25:15 34:20, 22 42:16 46:26 93:5,6,13,25 100:4 124:4 149:4 198:8 miscellaneous 104:19 misconduct 28:10,21 97:11, 22 mistake 174:13, 15 misunderstood 163:1 mitigate 138:9 Moderna 116:17 modification 123:14 MOH 150:5 Mohan 4:10 24:25 40:3,5 48:2 49:21 50:3 MOHS 111:26 moment 16:20 38:18 104:22 133:25 140:13 momentarily 52:7 moments 16:24 money 118:10 119:4 126:4,8,10,	18 monies 89:16 monthly 89:19 months 116:10 128:8 164:4 moot 139:20 moral 78:15 morning 2:5 10:5 11:6 16:14 24:18 25:2,4 93:18,24 131:7 152:18 171:9 177:17 196:25 197:14,25 198:7,10,15 motioning 121:12 mounds 179:16 mount 28:4 mounting 62:13 mouth 60:16 61:22 96:16 move 14:24 31:6 125:21 Moving 51:10 muddy 20:24 multi-sector 104:14 109:9 multiple 168:19 multisectoral 109:12 municipalities 137:26 mute 124:19 140:14 muted 31:12,15 114:18 115:2,5 myriad 87:9
<hr/> N <hr/>				
N95 50:18 NACI 112:22				

nailing 185:19	nonpharmaceuti	160:18 167:11	occupation	opened 33:14
named 113:17	cal 163:13	178:6	104:9	opening 2:6 3:6,8
narrow 26:17	nontreatment	numbering	occur 80:20 91:8	11:11 12:12
96:9	165:17	67:14,24 68:1	185:3	13:13 14:5,9
narrowly 50:20	north 130:17	numbers 161:2	occurred 15:24	16:12 42:7 44:5
national 112:22	193:17	183:8 186:1	74:24 77:3	56:24 61:24
Nationally 110:4	nose 153:22	numerous 191:5	156:18	62:16 64:5,7
natural 28:2	note 26:20 55:4	nurse 32:22	occurring 78:15	65:1,8 73:18
naturally 175:13	97:26 103:7,14	44:17	84:22 188:10	75:7,12,19 92:23,
nature 23:14	134:20	nurse's 44:19	October 6:26	24 94:13 99:10,
38:6 81:21	noted 28:20	nurses 4:12 24:4	70:9	19
necessarily 33:5	42:15	32:17 44:15 48:5	odds 189:18	operate 192:23
181:24 187:21	notes 199:6	86:22	offensive 97:10	193:4
necessity 49:22	notice 4:18,19		offered 156:3	operating 46:8
50:5 51:10	5:2 6:1,3,5,9,11,	O	office 33:10,14	192:26 193:4
needed 52:14	13,15,17,23 7:1,	object 21:18	90:4 131:4 146:1	operational
53:11 64:3 138:1	3,9,11,22 13:8,	82:12 150:11	159:8 174:9	128:19 130:22
negate 189:2	14,17,19,24,26	objected 82:21	Officer 94:24	operationalizati
negative 95:23	15:14,15 17:17,	objecting 22:5	104:17 105:6	on 122:4
156:15	18 19:4,18,20,25	36:19	108:22 110:23	operationalize
Nelson 10:13	20:10,16 21:5,13,	objections 12:20	116:10 127:11	131:21
25:5 101:13	24,25 22:1,4 23:9	13:1,7 49:1 59:4	131:4,11,14	opinion 49:20
net 183:7	29:11,22 30:20	objectives 114:2	159:7	52:9 54:19 55:6
NGO 109:16	35:21,24 58:22	obligation 29:2	officer's 33:23	57:15 81:23 82:2,
113:14,15	68:3,4,11 69:10,	92:3 98:26	officers 111:1,5,9	3,9,10,17 97:4
night 24:18	12,14,18,20,22,	obligations 45:9	offices 110:19	180:24
nitty-gritty	24,26 70:6,10,12,	86:20 89:1 90:3	141:6,7	opinions 82:8
110:1	18,20 71:5 79:12	92:7	Official 10:21	96:26 97:1 159:1,
no-exception	notion 51:13	observation	101:22 199:15	12 194:8
99:7	notwithstanding	81:19	oftentimes 196:2	opportunity
nodding 25:16	49:13 150:3	observational	older 182:12	35:10 121:17
177:4	November 7:2,4,	165:6,8 166:6,9	omission 79:2	oppose 33:21
nominated 119:1	6 8:7 70:11,13,15	175:7 183:3	omitted 75:17	60:17
non-clinical	71:17 133:23	observe 175:9	one's 93:17 161:1	opposed 32:22
107:16 108:15,	134:22 136:18	observer 11:9	one-on-one	169:23
17,20 109:5	137:23 138:6	observing 84:23	109:2	opposes 54:16
non-health 178:5	NPI 119:1	166:11	ongoing 111:21	59:13
non-sterile 193:5	number 23:14	obvious 55:12	onset 185:18	opposing 17:25
nonclinical	30:2 31:23 40:24	84:21 88:24	Ontario 110:4	opposition 62:5
108:22	57:8 79:11 81:9	89:23 129:15	128:14,18	123:22
nonetheless	91:1 99:20 107:7	133:6 161:24	onus 76:21,24	opt 88:16 89:17
103:26	119:5 122:6	172:9	open 153:8 198:8	90:24 92:12
	142:6 143:17			options 62:6
	145:9 155:11			optometrist
	156:7,8,17			

146:6
Optometrists
 146:9
optometry 146:5
order 7:19,21,23,
 25 8:1,3,5,7,9 9:7
 11:13 12:13
 14:17 16:21 21:9
 33:13,14,16
 37:18 42:6,7 44:1
 54:10 64:21
 65:18 71:2,4,6,8,
 10,12,14,16,18
 72:16 73:16,24,
 25 74:13 88:10
 132:8 134:22
 135:6,11,24,26
 136:8,13,15,17,
 23 137:5,10,13,
 16 138:20,21,23
 139:4 140:2,3,6,
 17,21 142:6
 143:13,17,23
 145:9 146:19,23
 148:23 154:1
 190:12,13
orders 16:9 32:2,
 4 33:9,18,24
 44:2,6,9 72:26
 76:1 84:1,8 85:26
 88:9 91:19 92:16
 98:19 131:5
 132:7,9,14,18,19,
 23,25 133:4,21
 139:1,4,7,9,11,20
 150:2 151:13
 191:23
ordinary 51:23
organization
 26:13 139:25
 163:14 184:4
organizations
 109:13,15 122:6
 128:16 130:10
 139:13 174:8

organizing 110:2
original 21:12
 22:1 59:16
 125:10 136:23
 155:6 170:1
originally 29:12
other's 85:4
outbreak 109:1
 111:22 127:20
 155:25 173:6
outbreaks
 111:21,24 112:6
 127:2,3
outcome 165:22
outcomes 95:23
outweigh 196:18
outweighed
 45:21
outweighs 54:4
overcomplicated
 53:4
overexposure
 50:23 51:16,20
overly 53:4
overstating 98:6
overwhelming
 91:23 92:2,17
 97:26 98:4,7
 159:22 160:15
 162:18 179:4,8,
 11 182:11
oxygen 50:22
 51:14,17,19
 52:15 55:22
 194:12,23

P

package 42:17
pages 27:14
 53:20 58:16
 199:4
pandemic 7:13,
 15,17 32:1 46:14

50:14 70:22,24,
 26 79:17,21,24
 83:21 84:4,8
 85:13 87:20,24
 88:2,10,16 90:8,
 17,18,21 91:24
 92:2,4,6,11,13,18
 96:7 122:3 131:8
 132:15 137:9
 141:4 143:20
 147:25 148:2,6,
 10,15,21,22
 150:8,20 157:3
 168:26 173:22
 174:2 195:5
paper 161:5,13
papers 103:23
 160:21
parachute
 166:24 167:6
 182:16
parachutes
 166:21 167:8
paragraph 24:11
 26:9,10,18 27:4,
 19,20,22,24
 28:17 44:15,22
 79:13 135:6,8,9
 136:9 137:10
 138:21 141:3,7,
 12 142:6 143:12
 144:20 147:5
 154:3 159:17
 162:3 163:4,12
 164:15 165:3
 167:17 168:13,
 22,24 169:15
 171:13 173:8
 175:21 177:23,24
 178:2 179:1
 180:8,20 187:1
 188:2,25 190:4
 191:1
paragraphs 50:3
 140:19,23 173:16
 179:18 180:7

pardon 149:6
 187:4
park 13:12
Parker 11:9
part 20:17 30:4
 36:3 38:10 40:23
 41:20 42:16 96:5
 98:14 134:17
 141:26 144:12
 155:13 157:20
 165:25 181:7
 185:11
part-time 112:13
participants
 161:6,7
particulars
 23:10 28:3,8,11
 29:5,14 31:18
 35:12
parties 10:25
 17:2,4,6 37:2
 46:20 99:18
 124:2 190:19
partner 118:21,
 22,24
partners 109:16
 113:10,14 114:3
parts 78:7 187:18
party 17:24,25
 30:18 55:7 57:17
pass 92:10
passed 194:23
passport 113:5
passports 128:14
 196:11
past 168:2,3
Pateman 103:16,
 17,19
patient 72:25
 82:15 87:10 89:6,
 8,11 109:2
 142:23,24 151:25
 156:4,10,14
 158:15 186:18

192:19 193:6,8
patients 37:11
 41:4 51:7 81:14
 82:7 83:1 86:7
 87:11 95:8,23,25
 96:11 98:22
 108:2,12,19,21
 146:15 153:21,26
 154:1,16,19
 155:2,4,24 156:7
 166:14 178:9,26
 180:22 192:4,12,
 21 193:21
pattern 119:13
Paul 113:17
pause 133:25
Pavlic 10:9 12:3
 18:24 73:3 76:6
 101:9 102:12
paying 87:2
PDF 67:13 68:2
peaks 186:19
peer 167:14,15
peer-reviewed
 107:9,10 169:5
 181:15
penalization
 96:12
penalizes 96:10
penalty 16:6,9
 76:1
Pension 110:11,
 12
people 37:26
 45:18 46:26
 51:22 80:15
 82:13,21 85:1,2
 108:7 110:1
 111:16,19 112:23
 118:13 119:9
 128:9 133:17
 135:9 137:4
 139:25 145:2
 151:20 152:8
 154:16 155:2,23

160:26 165:26 170:3 175:1 178:8 183:20 184:17,20,21 185:14,15 186:6, 12,24 187:15 188:7,22 189:19 190:18 191:17 192:16 196:2,3, 12 197:4 198:8	persons 184:11 185:5,6 perspective 29:1 58:12 64:18 77:14 87:24 91:26 150:25 162:24 Peter 108:9 Pfizer 116:17 PHAC 37:16 153:18 184:6 pharmaceutical 116:14 phase 15:18,20, 26 16:6,7 65:5,6 75:23 108:6 143:11 phonetic 144:6 phrase 21:21 34:17,18 64:4 80:16 147:13 phrases 181:14 physical 135:19 143:3 162:5 171:16,20 physician 89:10, 12 104:10,11 106:11,14,16 107:23,26 117:20,22 120:15,20 physicians 105:13 133:1 147:18 physicians' 141:6 PI 119:14 pick 146:3 177:16 picked 175:16 pictures 182:21 piece 112:7 pieces 39:11 133:3	pile 33:2 piling 34:13 pin 188:17 place 46:19 84:25 89:24 137:14,16 138:2,23 139:22 152:5 154:6 156:1 157:4 180:6 placebo 165:18 places 135:6,10 137:18 138:15,17 183:4 plan 6:14 62:21 69:23 110:11,13 177:11,13 plane 167:7,9 planes 166:21 planned 126:1 Planning 105:8 plans 141:17 play 18:22 41:6 76:4 plenty 155:17 184:19 plexiglass 84:24 87:21 91:2 150:26 PM 93:10 100:8 101:24 point 13:18 14:3, 9 15:25 16:25 20:20 33:6 39:25 47:22 48:14 74:16 93:2,8 118:15 130:5 143:7 194:2 197:5 policies 44:26 45:3 99:3 175:12 policy 105:8 111:8,11 131:19, 21 133:15 155:6, 8 156:3	political 137:22 196:13 politicisation 133:17 politicised 196:14 pop-up 110:2 population 160:26 165:13 populations 114:7 161:3 165:15 pore 189:1 pores 189:22 portfolio 111:26 112:3 portfolios 112:1 portion 17:18 24:7 185:24 portions 96:7 poses 193:5 position 15:12 30:12 53:18 61:1 74:7,26 103:21 117:21 133:8 positive 156:21 175:2 177:25 180:3 positivity 193:17 possibly 53:16 95:12 potential 30:1 144:16 potentially 16:8 63:14 130:5 178:4 pound 185:15 power 23:18 26:13 PPE 7:11 37:8, 10,13 70:20 129:26 130:1 142:16 154:10,18 155:14	practically 194:13 practice 5:15 6:10,12 7:13,15, 17 31:24,26 68:24 69:19,21 70:23,25 71:1 73:4 77:24 78:11, 12 79:9 87:3,5 88:3,7,11 90:6 97:14 107:26 139:2,6 140:21, 26 141:22 143:25 145:14 practices 6:8,24 7:8 44:26 45:3 69:17 70:7,17 practicing 86:23 87:13 90:24 92:9 142:9 151:15 practitioners 140:25 pre-covid 182:7 183:13 precise 29:4 166:4 precisely 52:12 prefer 196:25 197:16 prefers 18:12 prejudice 30:6, 25 44:11 45:21 52:4,6 54:7 prejudiced 35:8 prejudicial 22:14 53:2,15 54:4 58:15 59:7 preliminary 2:8, 10,13,14,15,17, 20,21,22,24 3:2, 4,5 4:5 14:12,14, 20,24 15:3,4 16:13 17:6,8,10, 15,19,23 18:5,25 19:3,7 24:2,14
---	--	--	--	---

26:5 31:7,13 34:1 35:1,13,16 36:9, 11,16 38:6 43:4 46:3 47:4 49:7 56:19 60:5 61:18 63:1 64:2 79:10 93:17 99:25 103:22 Premier 137:25 preparation 58:23,25 132:17, 19 prepare 23:3 31:1 53:25 58:23 63:22 prepared 22:22 35:14 103:16 159:11 161:22 181:11 preparing 67:15 103:18 160:3 present 15:20 63:23 65:6 73:19 presented 168:14 presents 52:12 president 113:18 press 160:9 pressure 165:23 prestigious 160:10 presymptomatic 153:20 pretty 113:15 125:16 127:6 132:26 137:21 139:24 145:6 167:2 172:9 174:24 180:19 188:19 190:13 198:5 prevent 42:2 106:7 130:25 132:11 138:15,23 154:1,5 155:1 157:21,26 193:13	preventative 105:3 115:15 prevented 54:13 preventing 37:19 145:1,2 154:25 164:23 167:8,25 195:22 prevention 115:10 121:21 127:24 130:14, 19,20 preventive 115:13 120:17,23 121:2 prevents 152:12 previous 20:11 previously 3:23 116:18 125:25 152:19 primarily 108:24 113:19 114:6 116:24 118:26 131:18 136:26 161:14 169:18 171:25 primary 104:13 106:12 111:25 131:20 136:17 197:8 principal 118:16, 19,21,22 119:2, 10,17 principle 28:19 37:23 40:5,18 principles 14:19 40:9 65:22 76:3 81:7 94:19 157:16 Printer 73:12 prior 53:17 78:9 102:3 108:8 111:25 137:23 139:10 priority 129:20	private 109:17 privilege 86:23, 24,25 87:14 92:9 pro 196:6 pro-lockdown 196:4 pro-masking 196:3 probabilities 76:16,20,23 probability 171:18 probative 41:22 45:21 53:2,13 54:3,9 problem 31:20 63:14 67:8 96:4 150:1 problems 67:16 134:13 procedure 144:5, 6 procedures 12:8, 10 144:17 proceed 20:23 27:8 32:25 33:4 36:15 38:17 47:7 48:17 54:20 59:26 64:7,14 94:7 134:11 176:25 proceedings 10:1,23 12:13 15:18 39:14,17 47:23 65:18 66:7 73:16 74:14 76:13,14,17 79:17 83:23 100:8 101:1,24 198:17 199:5 process 17:23 32:20 64:9 74:5 80:20 procurement 126:25 127:7	Produce 4:19 68:5 produced 34:16 173:10 profession 73:1 78:1 80:5 86:8,9, 10,17,19,23 87:2, 26 88:25,26 89:18 90:1,12 92:9,21 94:20 96:19 97:8 104:9 144:1,10 145:15, 19 professional 26:13,14 28:4,8, 10,13,20,22 29:20 45:2,5 57:7 62:1 77:20 78:5, 11,14 86:26 87:7 89:1 92:7,19 98:26 106:8 107:13 professionally 98:13 professionals 57:5 86:21 87:12 89:25,26 90:3 97:13 140:22 141:8 142:2 144:18 146:2 151:14 professions 11:17 22:9 73:1 77:5 86:12,13 92:8 147:8 program 87:8 progressed 168:26 prohibited 81:23 prohibits 40:20 proof 76:14,18 proper 28:4 52:8 54:9 178:21,22 properly 31:1 49:24 50:7 59:11, 15	proportion 188:17 proportionate 185:19 proposal 124:26 propose 67:11 176:23 proposed 12:13 36:23 proposes 54:18 pros 130:12 prosecutorial 23:15 26:16,19, 21 32:14,24 protect 52:25 95:25 136:14 155:3 157:19,21 163:6,7 protecting 51:7 96:18 154:16 protection 37:26 89:24 156:2,6 189:10 protective 37:13 142:16 150:22 154:10 157:20 163:5 190:18 protects 151:19 158:10,11 protocols 178:21, 23 prove 76:9,25 proven 30:4 provide 29:6 34:9 39:22 40:13 41:14,15 45:16 54:10 57:21 81:18 82:2 95:11 108:3 109:22 110:10 112:24 129:11 132:24 138:25 141:16 144:4,16,21,24
--	--	--	---	---

157:2 161:11 187:6 189:9 provided 21:13, 25 24:5 29:12 30:15 32:16 34:12 35:20 40:2 42:20 47:12 53:16 54:1 59:14 66:14,20 67:13 68:2 102:26 130:10 139:9 143:25 146:9 155:15 provider 80:4 providers 37:9 38:3 156:12 195:12 providing 73:18 74:21 81:23 82:8 91:14 104:15 109:11 128:24 139:26 142:21,23 143:8 145:21 153:26 155:19 province 46:12 88:4 107:3 110:2 136:25 139:25 193:10 199:8 province-wide 130:7 provincial 104:12 130:20 137:24 138:10 provincially 130:14 Proving 76:22 provision 39:11 77:19 132:3 139:8 provisions 85:3 public 10:12 11:20 12:2 37:15 80:2 83:26 86:6, 16 89:24,26 90:1, 2 96:17,18,20	97:7,21 101:12 103:20,21 104:10 105:2,4 108:11 109:3,13 111:17 112:13,15,18,20 114:14 115:8 120:15 123:7,10 125:11 127:5,23 128:13,18,23 129:10 131:26 132:2,3,5,7 133:1 135:6,10 137:18 138:15 139:17 150:4 153:16,24 159:4 173:10,12, 14,17,24 174:8, 15 176:1 184:4,6 195:4 publication 107:11 publications 107:6,8 121:1 160:8,9 publicly 128:3 publish 126:16 141:13 147:9 published 106:20 116:25 117:16 121:25 144:22 146:25 167:20 169:3 186:14 Pubmed 167:13 pull 134:7 140:4 purely 46:6 purpose 43:7,8,9, 17 131:13 137:15 144:23 153:13 157:23 159:14, 16,18 pursuant 11:16 148:22 purview 133:8 pushing 197:8 put 34:18,22 41:20 43:14	60:11,13,21,22 91:12 108:22 119:21 126:9 138:11 140:13 155:23 156:6 161:20 182:25 191:24 puts 48:19 59:21 putting 54:14 61:23 188:22 189:23 <hr/> Q <hr/> QC 10:16 101:17 qualification 3:13,15,16,18,20, 22 102:7 114:25 115:18 120:9,12 121:9 122:13 123:23 124:24 qualifications 52:8 121:7 qualified 49:24 50:7 52:10 81:26 120:15 150:9 192:10 qualifier 83:6 qualifies 105:5 qualify 103:6 120:22 125:1,2, 20 qualifying 102:15 quality 169:3,4 176:15 181:15 quarter 94:2 Queen's 73:12 question 39:23 40:15 41:13 58:9 61:26 63:4 85:7 93:1 103:6 112:10 125:26 127:18 136:11 139:3 146:21	148:14 150:6,10 151:8 154:4 157:11,17 158:22 161:24 164:13 175:20 187:5 195:6 questioned 74:1 questioning 123:5 questions 9:11 12:9 15:22 18:1 31:2,10 33:26 34:21 35:5,11 39:20 42:10 45:23 46:24 47:9 60:3 62:19 64:3 65:12 72:21 74:3, 4 92:22 102:13, 16 114:11 115:20 120:10 121:5 122:15,19 123:8, 22 125:23 126:3, 20 131:3 135:22 147:5 148:5,25 150:2 151:6 152:22 162:21,23 183:22 193:22,26 195:16 197:18 quick 31:4 65:10, 12 124:7 142:1 147:5 175:20 196:23 quickly 48:8 93:14 quotation 186:5 quote 186:7 188:2 190:1 quoted 57:11 185:2 <hr/> R <hr/> R0 170:1 R0's 170:5 raging 155:9	raise 38:24 103:10 raised 35:11 126:2 raising 41:9 59:4 ran 107:4 155:14 random 166:2 randomized 165:6,7,9,11,24, 25 166:5,16,20 176:9 181:14 182:14,17 randomly 165:14,26 range 109:24 172:16,17 rapid 107:5 127:6 rapidly 111:13 rarely 109:3 179:12 rate 168:16 193:17 rates 109:22 185:4 rating 175:25 176:7,11,14,19 181:15 rationale 57:24 137:15 143:8,22 155:15 RCTS 167:1 182:15,17 Re-cross- examines 3:19 122:12 re-enter 88:3,7 re-entry 140:21 Re-examines 3:17 121:9 re-opening 196:6 reach 159:16 read 13:21 22:20 23:6 26:12 27:26
---	--	--	---	---

28:7,19 37:24 39:5 44:22 57:13 77:8,9,17,22,25 78:3,19,26 86:14 103:15 112:12 134:21 135:17 138:22 140:19 141:2 142:7,18, 22 143:7 145:9 146:22 147:6 150:24 154:4,17 157:16,17 162:3 163:4 167:17 168:12,13,18 171:14 173:9 175:23 178:18 179:1 180:8 181:23 185:2 187:4,10,25 188:25 189:8 191:2,6 194:4 196:5	recall 129:2 recalled 75:18 receive 16:7 25:4 37:3 126:7 received 24:14 106:8,10,17,19 118:7 193:24 receiving 17:3 recent 47:9 79:23 116:26 149:16 164:18 175:24 recently 104:17 106:10 113:3 114:3 124:8 163:17 recess 25:23 46:23 100:6 124:1,4 177:5 198:14 recognition 106:9 recognize 63:13 145:18 174:7 recognized 26:21 RECOMMENC ED 101:24 recommend 184:8 recommendatio ns 112:24 128:5 129:11 130:11,23 174:4,5,10 recommended 139:22 163:13 recommending 139:15 145:8 173:23,26 174:13,14 recommends 153:25 184:4 reconvene 76:1 100:5 177:5 198:15	record 35:25 36:4 102:23 122:22 125:5 140:15 162:18 recourse 90:22 red 20:4 21:6,15 35:22 36:6 redirect 197:17 reduce 143:9 145:13,21 151:18 158:1 159:20,23 162:19 168:16 171:15,18 173:20 174:18 175:4,25 179:6 183:18 189:4,10,26 reduced 189:18, 24 reduces 137:19 151:16 158:12 165:23 181:4 reducing 169:9 175:18 195:7 refer 15:15 22:25 180:20 183:12 194:17 reference 4:6 19:8,21 21:7 22:18 35:20,26 36:10,20 38:11 73:6 134:25 153:15 181:17 referenced 79:11 references 32:7 46:8 91:20 referral 4:23 68:8 84:10 referred 16:13 21:19 32:16 183:25 referring 19:20 23:5 67:16 reflection 22:1 refuse 98:18	regard 15:25 16:17 22:11 40:14 59:12,18 64:26 regarded 183:26 regime 26:15 89:24 region 134:23,24, 26 registered 4:12 10:10,11 11:19 12:1 24:4 32:17 44:15 48:5 101:10,11 143:26 144:1,18 151:14 Registrar 4:24 68:9 73:21 81:12 83:18 Registrar's 6:21 9:9 70:4 72:18 regular 80:15 89:21 regularly 105:20 regulated 23:21 78:5 86:8 92:19 105:13 141:8 142:2,8 145:15 146:2,24 regulates 46:11 regulation 57:7 73:2 89:25 regulations 139:23 regulatory 32:19 44:18,19,21 57:6 94:23 96:2 rehash 180:17 188:7 reinforce 81:2 reiterated 195:21 reiterates 28:19 rejoin 124:5	relate 84:8,23 187:8 related 88:22 108:12 110:16 115:9 125:13 126:11 relates 17:12,19 19:3 20:1 relating 59:5 87:10 179:19 relation 30:13 184:10 relationships 87:11 89:12 relaunch 9:6 72:15 released 189:23 relevance 41:16 42:1 49:22 50:5,9 53:14 relevant 27:24 30:10 33:23 37:12 40:12,18, 24 42:8 45:10 47:14 50:24 51:3 53:12 54:14 61:10 184:26 187:23 reluctance 59:3 82:22 rely 39:24 79:22 relying 19:23 Remarks 2:6 11:11 remedy 54:10 remember 41:17 42:4 76:13 130:3 173:21 remembering 181:18 remind 124:11, 12 reminding 93:15 94:4
---	--	--	---	--

repeals 8:14
71:23
repeat 74:6 125:4
139:3
repetitive 115:21
rephrase 151:8
replaces 20:11
Reply 2:12,19
3:1,3 34:1 46:3
60:5 61:18
report 4:17 5:9
6:21 8:17,20,24
9:4,9 17:13
22:21,22 40:2
43:16 45:11
48:10,16 49:10,
16 50:9,20 51:10,
24 52:4,15 53:3,
6,8,16,19,26 54:9
55:13 56:9,11,12
57:10,26 58:1,15,
23 59:13 60:11
62:20 63:5,12
68:18 70:4 71:26
72:4,9,13,18
91:15,18 98:5
102:14,21 103:3,
5,14,18,25 104:1
118:11 122:17
126:5,18 131:9
158:17,20,23,25
159:10,11,14,18,
26 160:4 161:22
167:10 168:11
171:14 173:6,16
175:14 177:22
180:24,26 181:7,
10,13 185:2,22
186:5 187:2,24
189:5,14 190:2
191:1 193:23
194:5,10 195:1
report's 53:20
reported 129:23
179:20

reporter 10:21
11:7,9 12:5 67:2,
8 101:22 102:2
117:3 125:8
199:15
reporting 177:25
179:13
reports 43:10
49:14 58:7 59:16
128:3 129:5,18
160:3 161:19,21,
25 168:21
181:23,24
183:10,24 184:2
187:8,9 195:3
representative
13:8
representing
15:8
represents
191:20
reprint 36:7
reputable 189:15
request 5:20,22
17:19 29:14 69:4,
6
requested 21:16
requesting 5:16,
18 21:8 68:25
69:1
requests 54:17
63:23
require 17:7 28:2
80:26
required 51:24
63:25 86:26 87:6
146:26
requirement
87:25 88:2,10,11
98:15 143:19
150:25
requirements
21:22 22:13
29:25 30:3,14
32:5 33:12,22

37:8,15 57:6 63:7
87:4,22 89:4,11,
17 90:7,25
148:11,13 150:26
151:1
Rescind 7:21
71:4
research 106:24
109:25 116:13,
15,16,20 118:6,8,
25 119:23 120:7
126:8,10,15,19
researched
163:25
researchers
119:13
reserve 64:19,25
reserving 194:1
residency 105:2,
5
resolution 32:22
resolved 17:2
respect 35:12
47:12 64:18
94:10 121:19
146:24
respecting 39:9
respirators
52:18,23
respiratory
164:23 169:19
170:16 171:25
172:7 182:10
188:12
respirologist
118:2 191:10
respirologists
55:16 191:21
respond 29:10
53:19,23,24,25
54:11 58:18 59:9
62:4 91:14
187:17
responded 53:24

responding
111:10
response 5:7,20,
22 32:14 34:4
46:1 49:5 60:4,7
61:11 68:15 69:3,
5 91:9 93:26
108:25 121:11
126:23 133:18
168:20 181:8
184:12,13 186:8,
9 188:3
responses 31:3
129:11
responsibilities
76:5 86:21,26
responsibility
57:5 76:24
119:11 133:19
145:1,4
responsible
111:6,10 118:26
119:3 145:2,6
rest 14:25 133:19
restaurant
138:16
restrictions 7:4
70:13 84:26 85:1
restrictive 137:5,
7,8
rests 133:20
result 79:19
183:7
results 160:23
resume 170:22
return 6:9,11
69:19,21 141:10,
18,22 142:2
review 5:16,24
22:12 26:17
36:22 38:9 43:15
66:21 68:25 69:9
76:3 79:20 81:16
103:22 104:3
107:13 115:24

160:6,20 161:18,
21 165:4 175:24
176:10,16,18,21
reviewed 35:3
151:13 160:3,7
161:16 167:14,15
reviewing 22:21
74:17,21
reviews 43:10
122:5 129:2,23
160:13,19 161:10
176:13,20 181:16
revise 141:23
revised 19:24
20:16
revisions 104:2,3
revisit 125:9
reword 36:7
rights 44:20 45:1,
8 51:2 61:7 64:26
94:25,26 95:19,
20 98:21,22,23
99:8
rise 76:9,25 83:22
rises 80:11
risk 95:22,25
143:10 145:13,22
175:4,26 177:24
178:4,25 180:5
184:10,18 193:5,
8,13,14,19
rival 53:3
road 26:4 48:19
65:9 131:2,10
robust 169:7
179:3,8,9
role 33:16,17
49:23 50:6 58:11
66:7 84:19 86:2
92:6 103:18,21
108:24 110:13
113:1 131:15,16
132:1,4 133:6
roles 104:11

107:24
rollout 104:13
 109:1 112:9
 127:4
room 18:24 25:18
 34:23 124:17
 158:2,7
Roosevelt 173:7
roughly 138:3
route 188:1
RSV 168:5
rule 28:5 40:19
 42:2 47:17 52:2
 55:5 57:11,24
 58:1 81:18 96:13
 186:21
rules 19:26 28:1
 39:8,16,19,21,25,
 26 40:3 55:5,9,10
 56:14 57:12,19,
 20 58:3,4,5 59:1
 61:2,3 80:19,22,
 24 81:21 82:11
Ruling 2:14,21
 3:5,22 35:1 47:4
 63:1 124:24
run 196:8
runny 153:22
Rwanda 113:21
résumé 48:10

S

s.56 5:4 68:13
s.65 5:16,20,22,24
 68:25 69:3,5,8
safe 141:18
 151:25 194:10,19
safely 9:5 72:14
safety 37:11
 146:13 154:18
 178:21,22 192:20
SAG 128:2,23
 129:23 132:23

Salem 5:10,12
 68:19,21
salient 168:4
 182:3 183:12
 184:15 186:11,25
 187:5
sample 179:25
SARS 163:16
SARS-COV-2
 55:19 189:2
satisfy 34:16
satisfying 87:3
saturated 197:4
save 13:25 134:19
scale 111:13
SCC 4:10 48:2
 49:21
scenario 33:15
Schaefer 4:15,17
 48:10,18 49:10
 50:9 51:10 52:11
 53:3,8 55:21
 59:20 62:20 63:5,
 10,12
Schaefer's 40:2
 59:13 64:19
 181:10 193:23
 194:5
schedule 16:2
scheduled 11:22
 15:19 16:1 60:1
school 105:8,9
 109:16
Schumann 10:21
 11:7,10 12:5
 101:22 102:3
 199:3,14
science 43:12
 44:9 45:14 46:9
 57:2 84:3 85:7,
 11,14 86:2 91:3
 94:21 98:1 106:6
 127:24

scientific 41:9
 43:8,10,15,22
 45:10 46:9 85:2
 92:15 95:7 98:9
 128:2,4,7,24
 129:5
scientifically
 151:9
scientists 55:15
scope 28:12,18
 110:3 121:7
 123:23 150:9
score 176:20
scratching 59:23
screen 189:1
script 12:16 20:4
scrub 192:23
scrubbing
 192:25
season 170:8,9
seatbelts 181:3
sec 160:5
secondary 36:16
 112:21
seconds 104:7
section 21:19
 22:19,23 23:4,5
 28:6 31:21 37:24
 38:10,14,15,22
 39:4,18 51:5
 77:7,9 78:2,18,26
 80:17,21 86:13
 104:24 134:20
 135:15 137:12
 138:21 143:14
 144:23 145:11
 146:22,23,26
 147:7 149:20
 153:15 159:14
 162:2 168:10
 175:22 187:17
 195:2
sections 31:25,26
 32:6 38:12 73:9,
 14 79:8,12 132:6

141:2 149:21
sector 127:5
sectors 127:4
security 51:5
seek 35:12 64:12
 192:4
seeking 22:4
sees 30:9
selectively 92:20
seminars 105:17,
 19,26
send 22:19 24:1,
 19
sense 13:23 23:17
 30:17,18 38:7
 45:20 51:12
 55:10,21 66:2
 75:5 80:8 133:11
 139:18 144:15
 145:7 147:21
 162:8 166:2
 186:13,16
sentence 154:3
 167:17 168:12,13
separate 17:9
 81:24
September 2:5
 3:11 10:5 101:5
 110:22 198:17
 199:9
series 81:11 88:8
 181:14
seriousness
 195:4
serves 108:2,6
services 17:20
 21:21 29:24
 30:10 32:5 33:8
 36:18 37:21
 77:20 104:18
 108:23 110:23
 111:6,9 128:1,6
 130:16 131:17
 132:25 138:26

139:14,26 141:19
 157:7 159:2
Services' 30:2
 131:20
session 2:5 3:11
 10:5 26:2 34:26
 47:8 62:26 101:5,
 26 124:26 177:13
set 22:10 29:16
 59:8 119:16
 131:19 137:24
 145:21 150:12
 155:26 160:6
sets 27:24
setting 111:7
 138:18 139:18,20
 142:3 151:15,17
 159:21,25 162:20
 169:9,10 181:25
 184:5 187:7
 195:23
settings 139:17
 141:10 142:11,14
 164:21 168:17
 169:11 174:1
 179:5 180:11
 183:21 187:8
 188:22
seventh 66:4
 84:15
sexual 87:11
 89:12 97:11,21
 169:24
shaking 177:4
sharp 198:7
shingles 113:2
shoot 197:3
short 25:23 59:21
shorthand 199:5,
 6
shortly 21:26
show 19:22 27:5
 36:6 169:8 175:3,
 18 179:15 182:20

showed 174:19
175:11 189:17
showing 162:19
shows 95:11
154:24 183:4,18
188:21
shut 124:19 141:5
shutting 197:3
sic 24:25 44:15
91:20 126:14
134:3 135:16,26
147:21 148:3
149:3 170:15
sick 194:14
side 16:8 48:20
56:3 98:3
sides 15:20 16:15
60:16 61:22 65:6
74:9 96:16
signalling 137:26
significant 37:9
41:3 57:8,22 58:8
59:8,17 90:22
180:4 185:7
186:1 189:9
significantly
75:6
similar 37:17
110:18 128:25
166:2 169:22,23
similarly 37:14
simple 95:2
simplest 131:24
simply 15:15
35:26 40:17
43:17 59:10
62:11 74:17
100:1
sir 117:13 198:4
sit 129:16
site 198:8
sits 131:15
sitting 11:24

situation 58:5
138:7
situations 20:15
80:23 97:19
sixth 66:1 83:9
size 179:25 189:1
skill 77:19 199:7
skip 28:16 112:10
skipping 108:14
165:5 187:24
slide 144:6
slightly 115:21
small 26:4 132:26
184:12
sneaky 116:5
snuff 145:20
social 4:8 27:3,17
47:26 84:24 85:8,
25 86:4 87:21
90:14 91:2 114:8
128:25 137:3
148:12 150:26
158:26
socially 146:16
society 84:26
89:17 109:16,19
178:11 191:11
194:18
somebody's
174:24
sooner 171:1
sort 14:10 18:22
78:12 103:22
105:4 106:12,26
107:10,24,25
108:3,24 109:21
111:16,20 112:2,
18,20,21 113:20
119:10 122:10
126:20 128:9,10,
11,19 129:23
130:22 132:1,7
133:9,10 136:21,
23 137:7 138:9,

10 141:10,16,22
143:16 145:20
155:18,20 160:9
161:13 164:11,13
165:14 166:1,5,7
169:26 170:1
172:10 173:2
174:4 175:9
176:11,14,15,18
178:24 179:23
180:2,15 181:24
182:7,22 188:5
194:18
sorts 152:12
169:10 182:19
sought 60:13
95:25
sound 162:17
sounds 64:11
171:5 177:3
source 157:19,24,
25 158:5
sources 118:7
168:15
sourcing 127:6
south 130:17
space 192:23
span 129:6
speak 16:19,23
17:11 44:25
48:24 61:15,23
65:14 66:17 76:2
80:14 83:8 84:2,
9,16 99:13
122:10 141:18
161:9 182:23
speaking 27:26
32:16 52:22
60:16 84:13
96:16 105:25
169:7
specialist 106:11,
14 120:16 133:2
specific 26:6 27:4
28:21 31:25,26

50:10,22 55:21
129:23 144:5
147:17 168:8
specifically
17:17 31:23 76:5
81:4 121:2,3,4
132:20 135:15
159:21 167:24
169:1 181:24
specificity 26:26
28:26 34:10
specifics 17:11
spectrum 173:2
188:11
spent 178:12
spit 172:1
spittle 172:4
split 165:13,14,26
spoke 188:5
spray 172:4,21
spread 37:19
132:11 145:3
154:5 155:23
157:22 164:23
170:13,14
171:15,19,25
188:18,19
spring 95:22
spurious 190:23
staff 142:21,23
143:8
stage 33:20 99:19
150:12
staged 9:5 72:14
Stampeded
196:7
stand 103:26
standard 76:17
144:12,13 165:10
standards 5:15
31:24,26 68:24
73:4 77:24 79:9
86:17,18 87:5,9

stands 178:5
start 11:13 14:11
27:7 29:21 31:16
38:21 39:1 50:8
56:23 93:22
102:20 103:6
125:22 160:1
173:22 180:7
188:22 196:24,25
197:6 198:7,9
started 107:4
110:18 111:12
113:16 174:2
starting 16:25
39:25 197:11
starts 20:23 39:1
107:20 142:21
153:12 178:17
state 102:23
statement 5:1
14:4,6,10 16:12
26:11 37:10
56:25 64:5,7
68:10 74:11,12
75:12,19 92:24
93:3 137:12
154:17,21 157:17
178:19 180:13
184:9,10,15
185:9 187:25
190:2,6 191:12,
14
statements 56:26
73:18 74:16 75:6,
7 153:17 154:7
181:8 187:3,11,
21
states 114:5
184:22 193:18
statistics 160:25
statutory 94:25
stay 25:17 99:26
staying 111:18
188:15

talking 38:21 42:15 50:15,17, 18 61:22 78:22, 23 79:3 98:8 140:6 148:17 156:12 163:9,20 165:3 182:3 188:13	65:7 78:10 89:20 102:16 104:25 107:13 130:11 131:2 159:12 160:2 162:7 165:7 178:23 180:26	105:18 111:13,20 112:21 126:19 130:3,5 133:5 138:12 158:6 164:6 179:13 190:17	three-fold 177:24	told 87:15 173:14
talks 37:15,17 38:2 138:22 163:12 169:15 187:2,12,13,14	test 15:22 22:12 26:26 27:25 40:23 41:1,16 42:1 47:13 49:17, 18 53:10 166:22 177:25 186:23 187:15	things 17:5 19:23 20:25 30:2 31:23 32:12 40:21 43:25 52:25 58:24 72:26 73:13 79:13 81:19 84:22 85:9 87:1,2,4,6,9,11 96:26 103:21 104:19,20 106:1 108:25,26 109:25 110:1,12,14,15, 16 127:21 128:13,15 129:7, 24 130:23,25 133:19 137:21 144:7,14,18 147:23 171:23 177:15 182:1,16, 26 188:20 190:25 195:26 196:15	three-page 53:6, 25	tomorrow 54:20 83:17 93:24 120:4 171:9 177:16 196:25 197:13,25 198:7, 15
tangent 164:14	tested 186:20	thinking 27:11 171:6,7	three-week 58:22	ton 179:16
target 93:20	testified 84:1 124:8	thinks 19:14 83:3	throw 162:12	tool 77:5 79:5,8, 16,26 80:7 164:22
team 118:13	testify 17:14 57:23 59:24 66:3 83:17 148:4 149:4 197:22	Thomas 9:2,3 72:11,12	till 100:1 104:7 171:3 176:26	tools 77:1,4
technical 35:15 78:12	testifying 58:6 59:4 81:6 82:21 84:14 93:23 124:9	Thoracic 191:11 194:18	time 13:15 18:23 22:2 25:24 30:26 47:21 53:6,7,9,25 54:11,22 58:21 59:10,24 63:21, 24 73:7 75:2 86:11 94:11 99:17 111:18 114:13 127:13 130:6 134:20 136:20 137:20,25 138:5,9 147:23 148:11 155:9,26 156:19 164:21 171:1,5 174:3,25 175:9 178:13 188:16	top 126:1
technically 51:19	testimony 74:10 80:15 83:7 102:4 148:8 181:1	thought 20:11 74:20 75:4 169:26 171:2	timeline 177:2	topic 126:25 129:21
Telehealth 6:2, 20,25 69:11 70:3, 8	testing 52:14,18 107:3 114:8 186:6,12,14,15, 22	thoughts 18:9 19:14 74:26 185:9	times 84:25 91:1 98:5 137:13 142:26	topics 129:6
telling 65:4 183:20	tests 50:1 107:5 127:6	thousand 160:26 161:4,5 193:16	title 13:15 18:23 22:2 25:24 30:26 47:21 53:6,7,9,25 54:11,22 58:21 59:10,24 63:21, 24 73:7 75:2 86:11 94:11 99:17 111:18 114:13 127:13 130:6 134:20 136:20 137:20,25 138:5,9 147:23 148:11 155:9,26 156:19 164:21 171:1,5 174:3,25 175:9 178:13 188:16	Toronto 105:4
Temporary 8:11 71:20	thankfully 37:2	thousands 156:13,16,22 161:7 166:13 180:21	timed 13:15 18:23 22:2 25:24 30:26 47:21 53:6,7,9,25 54:11,22 58:21 59:10,24 63:21, 24 73:7 75:2 86:11 94:11 99:17 111:18 114:13 127:13 130:6 134:20 136:20 137:20,25 138:5,9 147:23 148:11 155:9,26 156:19 164:21 171:1,5 174:3,25 175:9 178:13 188:16	total 164:5 185:24
ten 94:2 160:16	Theodore 173:7		timing 63:24	totally 56:9
tend 118:11,12 119:4,14,15 160:7,8	therapy 108:6		title 117:20	touch 104:21 106:5
tendency 117:4	thereof 55:17 85:7 103:24		titled 4:16 63:11 173:11	touched 91:5 127:9
tender 102:19 114:13	thing 14:2,19,23 32:9 33:7,21 38:9 57:10 59:12 61:14 65:11,14, 17,21,24 66:1,4,8 73:15 83:9 86:1		today 11:21 15:16 17:4 23:21 24:8 54:20 78:8 83:15 93:24 122:22 136:20 171:6 177:1,17 182:4 197:3,8,11 198:6,13	toxic 50:23
tendering 17:13 115:7 123:17 125:11			today's 15:5 89:3	tracing 127:4,20
tens 156:12,16 170:16 180:21			Todd 73:20 83:15	track 25:24
term 50:16 78:16 166:6				traditionally 119:8
terminology 119:6 162:23				trained 107:23
terms 30:23,25 31:4 37:6,7,18 39:4 41:1 63:15				training 80:3 82:1 87:4 90:5 102:17 162:26

151:16,18 152:1 154:1,26 156:20 158:1,12 159:20, 24 162:19 164:12 166:15 168:6,16 169:9 171:15 172:12,23 173:2, 12,20 174:18 175:19 176:4 179:6 180:23 181:4 183:8,18 185:3,4,8,11,12, 20,24,25 187:13 188:1,4,5,10,18, 23 189:4,11,19, 24,26 190:17,21 195:8,13,22	25:4,23 26:1 31:10 34:21,26 35:2 36:6 39:7 43:7 44:23 46:23 47:8 51:12,25 54:2,6 55:8 59:26 62:18,25 63:2 66:11 74:3 75:9, 24 77:1 80:1 84:20 93:1 94:15 95:17 97:6 101:7, 8,25 102:8 114:13 120:19 121:5 124:16,25 131:12 133:24 135:25 152:17, 20,21 154:14 161:20 170:20 171:1 193:26 197:2,18 198:11	type 14:19 22:14 23:18 52:14 78:14 85:13 91:9 97:24 105:17 107:2 109:3 119:7 144:5 160:20 165:10 166:7 176:8,10 183:1,3 187:1 typed 20:3 types 20:15 50:11,14,19 52:21,24 72:26 85:9 143:24 144:17 176:8 Typically 72:24	underwhelming 98:9 unethical 167:5,7 unhelpful 97:25 United 114:4 184:22 units 155:22,26 156:8 166:10 universal 180:1,5 universe 176:13 University 104:26 105:1,4 unjustifiably 95:19 unlawful 61:4 98:16,17,19 99:8 unlawfulness 96:7 unopposed 62:9 unprofessional 11:18 15:6,13,23 16:4 75:26 76:10, 26 77:2,6,10 78:7,16,24 79:3,7 80:6,11 83:4 85:18 95:12,13, 24 98:17,18,20 99:5,9 unskilled 78:10, 11 unspecific 29:15 unsubstantiated 191:4 unusual 61:14 unwell 194:14 up-to-date 167:21,22 update 6:7 7:7 69:16 70:16 183:17 Updates 6:19 70:2 upstream 109:24	uptake 106:24 109:26 116:16 urban 136:26 urge 85:20 92:5 urges 92:14 user 151:19 users 119:6 USS 173:7 usual 109:15
transmissioned 164:10 transmissions 152:12 156:17 183:5 transmit 152:2,8 153:22 169:21 185:15 transmitted 169:17,22,24 transmitting 143:10 175:26 treat 89:15 96:11 156:3 treated 96:13 treating 146:15 treatment 165:16,20 trial 165:9,12 166:5 176:10 trials 165:6,7 166:17,20 181:14 182:14,17 tribunal 10:7,8 11:13,15,24 12:4, 8,21,22 15:21 16:5,26 17:26 18:12 23:2,12	25:4,23 26:1 31:10 34:21,26 35:2 36:6 39:7 43:7 44:23 46:23 47:8 51:12,25 54:2,6 55:8 59:26 62:18,25 63:2 66:11 74:3 75:9, 24 77:1 80:1 84:20 93:1 94:15 95:17 97:6 101:7, 8,25 102:8 114:13 120:19 121:5 124:16,25 131:12 133:24 135:25 152:17, 20,21 154:14 161:20 170:20 171:1 193:26 197:2,18 198:11 Tribunal's 18:16 47:18 131:2 tribunals 39:14 trier 49:23 50:6 51:24 triggered 77:15 tripped 124:13 Tropical 105:9 Trudeau 113:5 true 120:8 145:19 182:23 184:17 187:21,22 trust 89:15,26 truth 60:23 94:21 turn 14:14 15:3 27:3 38:9 66:16 80:13 84:15 124:11 134:16 142:12 150:18 152:14 158:17 167:10 177:19 turning 131:11 turns 41:12 turpitude 78:15	U ultimate 145:4 ultimately 15:23 91:22 99:2 unable 96:10 135:18 unbeneficial 95:14 uncalled 97:12, 25 uncomfortable 192:18 196:20 underlie 76:9 94:19 underneath 31:21 understand 60:26 82:7 120:14 150:6,24 understanding 47:19 53:13 93:9 136:14 145:25 149:14,16 163:22 172:14,19 understood 25:11 125:18	vaccinated 114:8 vaccination 106:2 109:10,22 vaccinations 104:16 109:12 112:2,25 123:15, 18,25 vaccine 104:12 106:23,24 109:1, 26 112:7,8 113:2, 5 116:18 126:24 127:4,7 128:14 129:20 166:12 180:18 196:11 vaccines 110:20 116:16,21,23,24 120:1,21,26 121:4 126:15 171:23 181:2 vacuum 84:22 vague 31:21 32:4, 7,8 131:23 valid 90:6 195:11 validation 107:2 validity 84:2 194:7 valuable 94:11 96:23 97:5,9 variant 170:5 variations 131:22	

vast 160:5 167:18
168:14 175:11
195:3
veer 23:25
verify 121:24
version 19:24
149:25 150:13
versions 79:20
149:2,15
versus 131:16
156:24 172:26
185:20 188:6,18
veto 23:17
video 124:11,20
Videoconference
10:1 101:1
view 57:3 61:25
85:4 146:11
viewed 22:14
161:10
views 37:16
vigorous 84:25
90:11
vigorously 23:22
violate 51:2 99:8
violated 94:25
98:24
violation 98:21
violations 61:7
viral 185:16
195:8
virologist
117:24,25
virologists 55:16
virtual 66:12
virtually 13:1
virus 55:19 168:8
170:16 171:24
172:1,10,17
186:24
viruses 164:23
168:5 182:10

vitae 4:14 8:15,
18,22 9:1 63:9
71:24 72:2,6,10
volume 114:21
VU 50:12

W

W-R-I-G-H-T

24:3
wait 27:5,11
29:20 40:22
104:6,7 154:13
157:13
waiting 34:23
walk 49:18 90:4
Wall 5:20,22
10:18,26 11:4,5,
18 12:25 13:5,18
15:6,9,10,12 17:9
21:20 22:15
23:21 29:7,9,13,
23 30:1,6,25,26
32:11 33:20 35:8,
9 36:19 41:8 42:5
44:11 48:19
49:15 51:4 54:1,
12,16,17,26
56:26 58:4,6
60:25 62:2,8,13
64:14 66:20 69:3,
5 80:9 81:12,13
82:5,9 83:2 84:23
85:5 87:18 88:13,
20 89:3 90:19,21
91:6,12 95:10,15,
21 96:3,4,8 97:1,
10 98:8,12 99:1,6
101:19,26
Wall's 30:13,16,
23 33:10 44:5
55:14 60:17 74:5
79:15,25 80:4
85:11 86:4 92:11
95:19 97:16
114:12

Walter 12:3
wanted 20:7 38:7
66:17 93:9 94:8
150:12 157:2
169:1
ward 180:16
wards 180:18
Warner 81:10
warrant 185:6
warranted
85:25,26 151:2,7
Warren 9:2,3
72:11,12 161:20
181:9,20
Warren's 184:10
185:2
washing 130:24
waste 54:22
waters 20:24
wave 11:25
106:3,4 141:4,5
ways 60:19 61:21
62:11 79:14
123:6 186:24
wear 51:9 96:11
135:10,18 142:25
144:13 151:15
153:26 156:5
173:25 174:1
190:19 192:17
193:20 194:10,15
196:20
wearer 157:21
158:14,15
wearing 37:26
95:9 139:19
151:18,20 152:11
157:26 159:19,23
162:4 163:6
171:18 173:11
180:10 191:13
192:13,18
194:19,21
Website 6:7,25

7:5,7 69:16 70:8,
14,16
week 54:24
147:19
weekly 89:19
weeks 34:12
35:10 52:5 53:17,
18,24 58:15
59:21 113:5
weigh 59:5
weight 40:16
41:19,21 46:19
47:21 82:26
well-being 86:7
well-known
160:9
well-regarded
160:11
wet 172:21
whack 119:9
wholesome
90:12
win 118:12
wind 136:18
witnesses 14:18
54:25 65:25,26
66:3 73:20,24,26
74:4,5,9 75:14
80:15,16 81:3,4,
5,10,11,18,22,24,
25 82:5,14 83:10,
13 84:12,14 85:5
88:1 90:16 91:11
94:10 102:11
187:18
woman 82:18
wondering 20:9,
18 195:17
word 30:9 35:15
97:26 98:5 119:3
133:11 146:12
153:12 160:10
179:9,10 195:10

wording 22:10
23:3 29:18 34:10
125:19
wordings 21:11
22:13 23:22,23
27:25 28:25 29:4
38:12
words 34:13,14
125:15 162:8,14
179:7
work 63:18 64:9
107:16,19,22
108:2,4,8,10,12,
15 109:4 110:3,
25 111:2 113:16,
22,24 114:4,6
115:25 116:14,20
117:19 118:25
128:10,12 141:11
142:2 152:5
156:24 164:3
170:22 175:3
178:7,8 190:16
194:16
worked 103:20
116:9 130:8
180:19
worker 156:15,
21 162:20
178:20,25 192:11
194:25
workers 4:8
27:3,17 37:11
47:26 153:25
154:19 155:1,3,
11 156:9 166:14
167:4 175:22
177:23,26 178:4,
5,7,9,16 179:25
180:2,22
working 107:26
113:4 126:22
127:10 142:24
workplace
142:10,13 143:1

works 31:16
 133:12 164:3
 176:26 182:9
world 78:23
 113:18 163:14
 170:17 189:25
worn 157:19
 195:12
worse 191:19
worth 185:18
Wright 4:11
 24:3,9,11,24 26:8
 32:16 44:14 48:4
writ 143:22
 164:23 190:9
write 150:4
writes 132:25
writing 49:26
written 15:24
 54:1 75:25
 122:21 149:7
wrong 86:1 149:7
 152:25
wrote 175:14

X

xii 78:3

Y

year 21:14 79:23
 87:3,4 105:22
 106:11,15,17
 118:8 127:14
 129:21 136:19
 138:6 170:8,10
year-and-a-half
 97:4 178:12
 194:22
years 113:23
 167:19
yesterday 16:21
 19:7 22:19 24:1

27:1 42:21,22
York 155:10
young 184:17,23,
 25

Z

zeal 94:24
zonally 130:15
zone 104:18
 111:23 128:21
 130:16,18 193:17
zones 130:16

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

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	September 2, 2021	Morning Session	203
6	Discussion		204
7	Submissions by Mr. Kitchen (Application)		206
8	Submissions by Mr. Maxston (Application)		207
9	Reply Submissions by Mr. Kitchen (Application)		211
10	Reply Submissions by Mr. Maxston (Application)		213
11	Reply Submissions by Mr. Kitchen (Application)		214
12	Ruling (Application)		215
13	Discussion		216
14	DR. JIA HU, Previously sworn, Cross-examined		221
15	Mr. Kitchen		
16	Mr. Maxston Re-examines the Witness		286
17	Mr. Kitchen Re-cross-examines the Witness		292
18	Discussion		299
19			
20	September 2, 2021	Afternoon Session	302
21	DR. TODD HALOWSKI, Affirmed, Examined by		303
22	Mr. Maxston		
23	The Chair Questions the Witness		403
24	Certificate of Transcript		406
25			
26			

1	EXHIBITS	
2		
3	Description	Page
4		
5	EXHIBIT H-5 - Face Masks to reduce COVID-19 in	216
6	Bangladesh RCT	
7	EXHIBIT H-6 - Locally Produced Cloth Face Mask	216
8	and COVID-19 Like Illness Prevention RCT	
9	EXHIBIT G-1 - AHS - Directive Use of Masks	352
10	During COVID-19	
11	EXHIBIT G-2 - AHS - Guidelines for Continuous	352
12	Masking	
13	EXHIBIT G-3 - AHS - Personal Protective	352
14	Equipment (PPE)	
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		

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

4

5 September 2, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

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

22

23 (PROCEEDINGS COMMENCED AT 9:03 AM)

24 THE CHAIR: I think the point we were at

25 yesterday was that Mr. Maxston had presented or had

26 direct examination of his expert witness, and we

1 adjourned for the day to enable Mr. Kitchen to start
2 his cross-examination of the expert witness this
3 morning. Is that where we're at?

4 Discussion

5 MR. MAXSTON: Mr. Chair, it's Mr. Maxston.
6 I think that's accurate. I do have one quick
7 housekeeping comment I need to make based on a
8 discussion I had with the court reporter about
9 exhibits. I also believe Mr. Kitchen has I'll call it
10 something in the nature of a preliminary application to
11 make concerning some documents he wants to place before
12 Dr. Hu, which my client is objecting, and we'll have to
13 ask Dr. Hu to be excused and put in a breakout room
14 while we deal with that.

15 I wonder if I can just very quickly make my
16 comment about exhibits, and then I'll let Mr. Kitchen
17 speak about his application.

18 THE CHAIR: Okay.

19 MR. MAXSTON: Madam Court Reporter made a
20 comment to me that yesterday when I was introducing
21 documents to a witness, I did not stop and ask for each
22 one of them to be formally marked as an exhibit, and
23 the reason I didn't do that was because of the
24 agreement between Mr. Kitchen and myself, that the
25 exhibits were agreed on. I'm happy to do that if you
26 prefer. I, frankly, don't think it's necessary, given

1 the agreement between Mr. Kitchen and myself. I see
2 him nodding, so I'm hoping that perhaps we can dispense
3 with that, all on the understanding that all of the
4 documents when they're referred to are formally entered
5 by agreement as exhibits. Mr. Kitchen, do you have any
6 thoughts on that?

7 MR. KITCHEN: I have no objections to that.
8 I think that's fine. We've already identified them in
9 the files with letters and numbers, so ...

10 THE CHAIR: Okay, and just for Karoline's
11 clarification, those are in the folders that are marked
12 'A' to 'F', and then we have Folder 'H', which we dealt
13 with, and I don't know that there ever was a Folder
14 G. So, okay, that's -- you're okay with that,
15 Karoline?

16 THE COURT REPORTER: (NO VERBAL RESPONSE)

17 THE CHAIR: Good. So then --

18 MR. MAXSTON: Mr. Chair, my apologies, I
19 think it's time to turn this over to Mr. Kitchen, but
20 we are going to have to ask Ms. Nelson to move Dr. Hu
21 into a breakout room I think for a relatively brief
22 period of time, but I think we need to do that first.

23 THE CHAIR: Okay. And just before Mr. Hu
24 departs, I will just remind him that he is -- well,
25 he's gone. Okay. We have to remind him that he's
26 still under oath from yesterday.

1 Okay, Mr. Kitchen.

2 Submissions by Mr. Kitchen (Application)

3 MR. KITCHEN: So, The Chair, the purpose of
4 this is I have two documents. They are PDF screenshots
5 of web pages, and obviously I'm going to have to
6 provide them to you, but I approached Mr. Maxston about
7 providing these to the witness, and I take it from his
8 comments, and this reflects something I had proposed to
9 him, that the best way to do this is for me to make an
10 application, he will oppose it, and then you'll be
11 provided with the documents. I can send those to
12 Ms. Nelson, and then you can make a ruling whether or
13 not to admit them.

14 What these two documents are, very briefly,
15 they're simply evidence of the existence of one
16 randomized -- well, RTC, they're clinical trials,
17 randomized clinical trials. One ended in June, one is
18 ongoing; that's what these two documents are. They
19 simply show the existence of these trials, simply what
20 they are, where they are, what they're called, who is
21 doing them, et cetera. That's what they are.

22 The purpose for my putting them in is to give them
23 to Dr. Hu and give him a chance, an opportunity, to
24 respond before I ask him any questions about those or
25 before I would ask any questions to my experts, as, of
26 course, that wouldn't be fair if he hasn't had a chance

1 to see them and comment on them.

2 Again, the only purpose I'm putting it in is not
3 substantively for anything to do in the trial; it's
4 simply that the trials exist. He had said that it
5 would be unethical to do so. I'm simply putting those
6 in to show on the record that those trials are being
7 done currently and have been done.

8 THE CHAIR: Mr. Maxston?

9 MR. MAXSTON: Just so I'm clear enough, I
10 didn't understand you correctly, Mr. Kitchen, were you
11 proposing that those documents be provided to the
12 Hearing Tribunal as they consider this issue or only
13 after they hear submissions from us?

14 MR. KITCHEN: After they hear submissions,
15 I'll provide -- I propose that I provide them to
16 Ms. Nelson so that she can provide them to the
17 Tribunal, and they can have those documents in front of
18 them to make a decision on whether or not they should
19 be admitted as exhibits.

20 Submissions by Mr. Maxston (Application)

21 MR. MAXSTON: Okay, well, then I will make
22 my submissions.

23 Mr. Chair and Hearing Tribunal Members, the
24 Complaints Director strongly objects to these documents
25 being provided. I will speak about this in a few
26 minutes in greater detail, but there is an element of

1 fairness that has to be a core element of this hearing,
2 fairness not only to the member but fairness to the
3 Complaints Director.

4 Just by way of background, I received -- or I
5 opened my emails this morning and saw an email from
6 12:11 AM from Mr. Kitchen attaching these two studies.
7 Again, my client strongly objects to these going in;
8 it's highly prejudicial. I haven't been able to print,
9 much less read, these studies. Mr. Lawrence hasn't
10 been able to read them, and certainly Dr. Hu hasn't
11 been able to read them.

12 Mr. Kitchen has had Dr. Hu's expert report since
13 July 28 of this year and has had more than enough time
14 to prepare any rebuttal documents or any type of
15 exhibit package he wanted to enter. He has not three
16 but now four experts to present his client's case, and
17 providing these studies immediately before
18 cross-examination gives Dr. Hu no ability to properly
19 read them, to engage in an informed analysis of them,
20 and to responsibly engage in any kind of discussion
21 about them.

22 I know Mr. Kitchen says they're only being
23 tendered to reflect the existence of these studies, and
24 I have no idea about the history or background of
25 these, but Dr. Hu may have very strong comments about
26 the validity of the studies or the status of them, any

1 myriad of elements of those studies, he might have
2 very, very considerable questions and thoughts on
3 those.

4 So, again, no time for Mr. Lawrence or I to read
5 and review these, certainly no time to consult with
6 Dr. Hu to allow him to provide a fulsome and informed
7 response.

8 The answer is not to say, Well, let's take an hour
9 break and let Dr. Hu review them. I think that is not
10 the answer for a number of reasons. First of all, it's
11 just not fair. Dr. Hu is under the gun. He's looking
12 at these, trying to formulate a response on very, very
13 short notice. It takes up valuable time which we could
14 be using on other things. Frankly, the witness's, his
15 order is potentially disrupted. He's only available
16 till noon today. It just is a very, very troubling
17 development.

18 Again, there are four expert reports that have
19 been tendered with citations and documents in support
20 of them, and I would say to you that the Complaints
21 Director has been very, very accommodating and very
22 generous in terms of not objecting to three experts and
23 not objecting to other documents and information that
24 have been provided in support of those documents.

25 I think, Mr. Chair and Hearing Tribunal, this also
26 speaks to the larger question of how this hearing is

1 going to be conducted, and as I said before, there
2 certainly has to be fairness to the member, to
3 Dr. Wall, but there also has to be fairness to the
4 Complaints Director. A phrase I like to use, and I
5 can't remember where it came from, but I used it over
6 the years is these types of hearings are not argument
7 by ambush. It's not a surprise gotcha moment that
8 we're looking for, and we need to avoid that.

9 We had the Schaefer report come in I would say
10 very, very briefly before the hearing, which was of
11 concern to my client. You've made your decision; we've
12 got some remedies to call rebuttal evidence, but that
13 was concerning. I know that the cases I received from
14 Mr. Kitchen in support of his preliminary application
15 were sent to me at 12:44 AM on Wednesday. I sent my
16 cases about my preliminary application, my supporting
17 document to him the day before. I don't think it's
18 fair to expect Mr. Lawrence and I to check emails at
19 all hours and to be on-the-fly and be ready to accept
20 documents and information in that manner. Mr. Kitchen
21 is obviously trying to be an advocate for his client,
22 and that's certainly his role, but this goes beyond
23 that.

24 We need, Mr. Chair and Tribunal Members, we need
25 direction from you, not just to refuse to allow this
26 document to go in but to set parameters about how

1 documents and case law are going to be provided,
2 because, again, this isn't argument by ambush.

3 So my client strongly objects to these being
4 provided. If they have any probative value, it's
5 minimal, and it's highly prejudicial to the Complaints
6 Director. Those are my submissions.

7 Reply Submissions by Mr. Kitchen (Application)

8 MR. KITCHEN: Chair, if I may respond.
9 These have been provided to my friend, he knows that
10 I'm not tendering studies. There's no content here.
11 He knows that all I've provided is a record that's a
12 couple pages long that such studies are being done.
13 They haven't been written out yet. There is no report.
14 There's no peer-reviewed article. They're simply at
15 the clinical phase of being done. We're simply
16 tendering them for the evidence that these studies are
17 being conducted. So there's nothing to read.

18 You know I'm literally going to -- if these are
19 admitted, I'm literally going to take Dr. Hu to the
20 point in which it describes what the study is, and I'm
21 going to ask him that. That's it.

22 So all of this argument about the time it's going
23 to take is completely without merit. There is no time
24 involved. There is no actual study to read. There is
25 simply a document showing that such clinical trials are
26 ongoing or have been conducted a few months ago.

1 That's it.

2 I have no disagreement with my learned friend
3 about fairness or avoiding a trial by ambush, which is
4 why I provided it to them, I asked him his position.
5 It's almost as if he thinks this is unusual; it's
6 unusual to put documents to a witness in
7 cross-examination after his examination-in-chief
8 reveals that there are certain things that would be
9 useful. That's not unusual. It's not unusual to
10 provide cases. In fact, if it were in person, it would
11 not be unusual to hand the cases up at the beginning of
12 a hearing. That they're provided the night before is
13 not unusual.

14 I don't think it's appropriate to be commenting on
15 what time of the day my emails come in, as if I expect
16 everybody to be awake at all hours of the day to read
17 my emails and immediately comment on them. I think
18 that's a red herring.

19 You're going to see these documents I have, and
20 you're going to see that they are as I've described
21 them, and they are not actual articles that need to be
22 read. I think that's very important to understand, and
23 I think any description of that is completely missing
24 the point. Those are my submissions, Chair.

25 THE CHAIR: Can I ask you, Mr. Kitchen,
26 you said there's one study that's been completed?

1 MR. KITCHEN: Yes.

2 THE CHAIR: Has it been published?

3 MR. KITCHEN: Not that I know of.

4 THE CHAIR: And the other study is
5 ongoing.

6 MR. KITCHEN: The other study is ongoing to
7 be completed I think in October.

8 THE CHAIR: Okay --

9 Reply Submissions by Mr. Maxston (Application)

10 MR. MAXSTON: Mr. Chair, I wonder if I might
11 just have an opportunity to make one or two very brief
12 comments in response to what Mr. Kitchen said.

13 I have looked at these document very, very
14 briefly. They may well be not in-depth studies. They
15 may not have a lot of meat on the bone, but it's the
16 larger principle. Again, Dr. Hu is at a complete
17 disadvantage. He has seen these on-the-fly. He is not
18 able to go and make his own inquiries about them. It
19 doesn't matter that Mr. Kitchen is going to be very
20 brief with them he says. It simply puts Dr. Hu in an
21 awful position, because he can't respond properly
22 whatsoever.

23 And I would suggest, I'm not a fan of this, but --
24 or I can't tell Mr. Kitchen how to run his case, but
25 certainly he's got his own experts, he's got four of
26 them. There is ample opportunity for him to have his

1 experts testify to these matters. I don't see that
2 putting Dr. Hu in this position is at all fair to my
3 client.

4 Reply Submissions by Mr. Kitchen (Application)

5 MR. KITCHEN: Sir, I just want to make a
6 comment. Fairness seems to be an issue here, and as
7 I've said I have no issue with that.

8 I will say, out of fairness, it's typically,
9 procedurally the way we do things is if somebody makes
10 an application, they make the application, the other
11 side has a chance to respond, and then the person
12 who -- the party who made the application has a chance
13 at rebuttal, and then that's the end of things.

14 And twice now in these proceedings, Mr. Maxston
15 has come in after I've given a rebuttal, and he's made
16 comments, and I haven't objected to that out of
17 fairness, but since fairness is becoming a real issue
18 here, I note that that's not normally how things are
19 done.

20 And if we're going to get really about the book
21 about this, which seems the Complaints Director is
22 going in that direction, I'm going to find myself
23 objecting any time Mr. Maxston is coming in after I've
24 given a rebuttal and is trying to make comments,
25 because that's not actually normally how things are
26 done.

1 THE CHAIR: Your comments are noted,
2 Mr. Kitchen. That's -- I will take responsibility for
3 that. I know the rule of three is the generally
4 accepted process, and I will do my best to adhere -- or
5 to follow that.

6 I think at this point, we'll caucus while we
7 discuss -- can I just ask one more question? Is Dr. Hu
8 involved in these studies? Is he an author or a ...

9 MR. KITCHEN: No, he is not.

10 THE CHAIR: He is not, okay, thank you.

11 MR. KITCHEN: And what I'm doing is I'm
12 just -- I haven't provided these documents yet, so I'm
13 just providing them to Ms. Nelson so that she can
14 provide them to you.

15 THE CHAIR: I think what we were talking
16 about is that -- okay, we will caucus now, and we'll be
17 back to you shortly. Please bear with us, thank you.

18 MR. KITCHEN: Thank you.

19 (ADJOURNMENT)

20 Ruling (Application)

21 THE CHAIR: Okay, we'll reconvene. The
22 Hearing Tribunal with the advice of counsel has
23 considered the two documents in question. I will give
24 you our decision and then some comments before we move
25 any further.

26 We have decided to allow these within certain

1 limitations, and we've noted that these are overseas
2 trials, that these are in progress or just recently
3 completed. Neither of the two documents contains any
4 results, and they've not been published.

5 So our view is that, Mr. Kitchen, if your desire
6 is just to establish that these trials exist, that's
7 the direction we're prepared to allow. If the
8 questioning or the discussion goes into any depth
9 regarding the trials themselves, I'm sure we will hear
10 objections at that time.

11 MR. KITCHEN: Thank you, Mr. Chair. I
12 appreciate that. That makes perfect sense to me.

13 EXHIBIT H-5 - Face Masks to reduce COVID-19
14 in Bangladesh RCT

15 EXHIBIT H-6 - Locally Produced Cloth Face
16 Mask and COVID-19 Like Illness Prevention RCT

17 Discussion

18 MR. MAXSTON: Mr. Chair, in light of your
19 decision, and I hope Mr. Kitchen will be comfortable
20 with this, we're going to bring Dr. Hu back in. I
21 think he needs to have a little bit of time to look at
22 these documents, and I don't mean 2 minutes on-the-fly,
23 and I don't mean two hours, but I think he's got to be
24 given a reasonable opportunity to see these documents
25 and be able to read through them.

26 I understand the narrow parameters you've placed

1 on the questioning, but I'll be candid, I think all
2 that he can say is, Well, I guess these are documents
3 that shows studies being done. I'm still kind of
4 puzzled why Mr. Kitchen can't do that with one of his
5 experts, but, again, I think he has to be given the
6 opportunity to at least read these.

7 THE CHAIR: I agree, and I suggest that we
8 take -- it's 20 to 10, one's a six-page, one's a
9 seven-page document, there's not a lot of information
10 in them; I think if we said we'll reconvene at 10:00,
11 people can take an early coffee break now, stretch,
12 grab a coffee, and we'll give Dr. Hu 15 minutes to
13 review them, if that --

14 MR. MAXSTON: Can I --

15 THE CHAIR: Yeah?

16 MR. MAXSTON: I welcome Mr. Kitchen's
17 comments on this, but I wonder if we could bring Dr. Hu
18 back in and let him know exactly what they're being
19 tendered for, because if we simply give them to him,
20 and he's thinking I've got to go off and check sites,
21 I've got to research these, I've got to -- it's
22 entirely different to say he's being -- You're going to
23 be asked about whether these are ongoing or not. And I
24 don't want to spoil Mr. Kitchen's questions, and he may
25 have a few more questions than that, but I mean if I
26 send these to him and say you're going to be examined

1 on these, he's going to say, Well, to what end and in
2 what nature.

3 MR. KITCHEN: So, again, all I'm -- well, if
4 I had have asked him, you know, these studies exist,
5 don't they, that would have been improper, because
6 they're not before him. I'm literally going to ask
7 him, Do you deny that these studies exist. And now
8 that he's had an opportunity to see them, he can
9 actually make an informed answer on that, it's not
10 ambush, and then that's only fair.

11 And, you know, that's why I can't bring it in with
12 my experts, that's not fair to do that because then the
13 Complaints Director's expert hasn't seen it. We're
14 probably talking about, you know, 90 to 120 seconds of
15 questioning at most on that, and that's it.

16 So -- and I'm fine, you know, with giving him the
17 time to break until 10, but I'll say that if we do
18 that, and we come back at 10, I would ask that we just
19 go straight through until noon, if I take that long
20 without any breaks, because I want to have the time I
21 need for cross-examination, and I understand Dr. Hu has
22 to get going as well.

23 MR. MAXSTON: And, Mr. Kitchen, of course, I
24 may have redirect and the Tribunal may have questions
25 as well, so, again, I can't tell you how to run your
26 cross-examination, but we have some timelines here that

1 are tight.

2 THE CHAIR: Yeah, we --

3 MR. KITCHEN: I don't expect to go beyond an
4 hour-and-a-half, I really don't.

5 THE CHAIR: Okay, let's bring Dr. Hu in
6 please then, and I'll give him an explanation. Do we
7 have a copy of the documents for him?

8 MS. NELSON: I can send those to him via
9 email right now.

10 THE CHAIR: Could you send them, please.

11 Dr. Hu, we're back. Dr. Hu, can you hear me? Can
12 you hear me?

13 A Oh, yeah, now I can, sorry. I was just -- yeah.

14 THE CHAIR: Yeah, okay, thanks, Dr. Hu,
15 sorry to keep you waiting.

16 A That's okay.

17 THE CHAIR: We're very respectful of your
18 time and our commitment to get you out of here at noon.
19 An issue --

20 A (INDISCERNIBLE) all good.

21 THE CHAIR: -- an issue has come up, and
22 we're going to be breaking here momentarily, and we're
23 providing you with summaries of -- well, two documents
24 that contain summaries of clinical trials. It's a
25 six-page summary put out by the NIH US National Library
26 of Medicine. So --

1 A Yeah.

2 THE CHAIR: -- we have allowed these
3 documents to be entered by Mr. Kitchen. Neither of
4 these studies have been published, one has just been
5 completed, the other is still in the data collection.

6 A Okay.

7 THE CHAIR: We are only allowing
8 Mr. Kitchen to question on the actual existence of
9 these. Because there are no results, there's no
10 findings, there's no publication, there's nothing to
11 discuss there, but Mr. Kitchen will deal just with the
12 actual existence of these.

13 We're going to give you until 10:00 to read
14 through them --

15 A Sure.

16 THE CHAIR: -- so that you're familiar
17 with it. I don't anticipate there will be very many
18 questions on this, but we don't want you having to
19 respond to something you haven't read.

20 A Yeah, yeah, I'm all good. I always like more, more
21 science, so happy to -- yeah, that's good, cool.

22 THE CHAIR: Have you got them; have you
23 checked your email?

24 A Let me just hit "refresh" again. Oh, yes, I just got
25 them, okay. Cloth masks and face masks reduce COVID-19
26 (INDISCERNIBLE).

1 THE CHAIR: Okay, we will recess now, and
2 we will reconvene at 10:00 with Dr. Hu and Mr. Kitchen.

3 A Thank you.

4 THE CHAIR: Thank you.

5 (ADJOURNMENT)

6 THE CHAIR: Okay, the session is --
7 obviously, we've reconvened, just to remind everybody,
8 and the floor is Mr. Kitchen's to cross-examine Dr. Hu.

9 MR. KITCHEN: Thank you, Chair.

10 DR. JIA HU, Previously sworn, Cross-examined by
11 Mr. Kitchen

12 Q MR. KITCHEN: Dr. Hu, I'm mostly going to be
13 questioning you on your report, so I'll be taking you
14 to various portions of it at times.

15 Just to start off on your first page of the
16 report, you refer to the Manchurian plague. I note
17 that you neglected to mention that plague is caused by
18 bacteria. The Manchurian plague was caused by a
19 bacteria; isn't that right?

20 A Yeah. Yes.

21 Q And bacteria are hundreds of times larger than viruses;
22 isn't that right?

23 A Yes.

24 Q In your report, you regularly refer to masks without
25 any qualifiers, and I think twice to what you call
26 medical-grade masks, and by either of these terms, you

1 are referring to the so-called surgical or blue masks
2 that are specified in the ACAC Pandemic Directive;
3 isn't that right?

4 A Correct -- well, it depends. I mean, the report talks
5 about a number of different things, right, and like,
6 first of all, that introduction around Manchurian
7 plague, think of that as like a fun introduction.
8 Like, once again, I only care about COVID and masks; I
9 don't care about anything else in masks.

10 There's some studies that I talk about which
11 are -- which talk about sort of masks in the community,
12 right. And when I talk about masks in the community,
13 it's a mishmash of like surgical-grade masks, but
14 primarily probably cloth masks and sort of that mix of
15 masks changes based on where you are and access to
16 medical-grade masks.

17 Very early on, people didn't really have access to
18 medical-grade masks. Now, probably people have more
19 access to those. But within the health care setting, I
20 think we can broadly assume that, in Alberta, like, you
21 know, we have medical-grade masks, so yes.

22 Q Okay, now that was a bit long, I just -- and, again,
23 I'm not trying to trick anybody, I want to make sure
24 we're all on the same page about what is a
25 medical-grade mask. Now, would you agree that a
26 medical-grade mask is the same as a surgical or blue

1 mask?

2 A Yes, so I would say a medical-grade -- like, when it
3 comes to mask terminology, you know, we often say
4 surgical mask, procedure mask, or medical-grade mask.
5 Within the categories of medical-grade masks, there's
6 sort of different levels, like, you know, like tier 1,
7 tier 2, tier 3 masks, and these are not the same as N95
8 masks, which are different.

9 Though to your question about like what I talked
10 in my report, you know, like I report about types of
11 like community type studies, and those are more going
12 to be like a mishmash of mask types that just ...

13 Q Right, but a lot of times in your report, you use the
14 term "masks", and when you use the term "masks", you're
15 not referring to cloth masks; you are referring to --

16 A No --

17 Q -- let's call them surgical masks?

18 A No, it -- no, and I should have probably applied more
19 specificity in the report, but like -- I mean, we can
20 go by study by study, and we talk about the types of
21 masks being used in those studies, but like I -- it
22 depends on the study in question, right.

23 So, for example, by and by, if I refer to a study
24 around, you know, like some of the studies around this
25 reduces community transmission, so masks used -- any
26 study that describes mask wearing and its ability to

1 prevent COVID outside of a health care setting, you
2 know, we don't necessarily know what masks are being
3 used, but I would broadly assume, in that setting,
4 we're not using medical-grade masks. Like, you know,
5 some people might have them, like I would, you might
6 not. But when we begin to talk about the studies in
7 health care settings, those are almost all
8 medical-grade masks, but -- so I use the term "masks"
9 like generally, but it would depend on the study in
10 specific.

11 Q Now, just to confirm --

12 A M-hm.

13 Q -- I think, I believe you said this, when you use the
14 term "masks", you are not referring to N95s?

15 A That is correct.

16 Q Okay, thank you. Now, would you agree that the
17 surgical or blue masks, and those are the ones that are
18 specified as being -- or medical masks --

19 A M-hm.

20 Q -- (INDISCERNIBLE) as being specified in the ACAC
21 pandemic [sic], and the reason I'm mentioning this is
22 the ACAC pandemic says cloth masks are unacceptable,
23 all right, and --

24 A Yes.

25 Q -- there's no trickery here, right? We're talking
26 about --

1 A Yeah.

2 Q -- a classification of masks between N95 and cloth.
3 Would you agree that's what we're talking about, when
4 we're talking about what's acceptable for the ACAC
5 Pandemic Directive, we're talking about masks that are
6 not cloth and not N95 but in that surgical category in
7 between? Would you agree with me on --

8 A Yes.

9 Q -- that? Okay.

10 A Yes. Although, I'm not entirely -- like I think that
11 like if somebody wanted to wear an N95 mask like in
12 the, you know, clinical setting, like ACAC in a
13 chiropractor's office, I mean you could mask, I would
14 say an N95 is better than a cloth mask -- like, sorry,
15 than a medical-grade mask, which serves different
16 purposes, but it's not inferior, I'll say, to a medical
17 blue mask.

18 Yeah, so -- and I don't think there's trickery,
19 I'm trying to explain, because I wasn't specific in my
20 report around what I mean by "masks", so yeah.

21 Q Well, and that's just it, I don't want us to talk at
22 cross-purposes.

23 Now, would you agree that these medical or
24 surgical or blue masks are of low cost?

25 A What do you mean by "low cost"?

26 Q I mean that they are not expensive; would you agree?

1 A I don't know. I mean -- so the price of a
2 medical-grade mask before the pandemic started was
3 around, I think in bulk procurement prices, 6 cents a
4 mask. In the midst of the first wave, that price went
5 up to 60 cents to \$1 a mask, given our shortage of
6 masks, right? And so I mean -- and then I think it's
7 gone down again, but I would say that 6 cents a mask is
8 pretty cheap. I would say that during the pandemic, a
9 10X increase in price is not insignificant, but, yeah,
10 those are the prices. So now you know what the prices
11 are.

12 Q Thank you, and, you know, that's -- I wasn't asking you
13 about supply and demand. So let me ask you again,
14 would you agree that surgical blue medical, would you
15 agree that those are low-cost masks?

16 A I would, relative, yeah, sure. If we think that 50
17 cents a mask is low cost, then that's low cost.

18 Q Thank you. And, Dr. Hu, you're proud of the work
19 you've done for AHS during COVID, aren't you?

20 A Generally, I mean, I think I've made mistakes, but I
21 think I've done some good things hopefully as well.

22 Q You're glad to defend the COVID public health
23 restrictions in the CMOH orders, aren't you?

24 A Which restrictions are you referring to specifically,
25 like in which CMOH orders? And not being at
26 cross-purposes, there's things I agree with and things

1 that I don't. I would defend the masking one for sure.

2 Q And you would defend the distancing one?

3 A Yes.

4 Q When it comes to COVID, you think information is more
5 likely to be scientifically accurate if it comes from a
6 government public health source than if it comes from
7 some other source, don't you?

8 A What is the "other source" referring to?

9 Q Exactly that, an other source, other than government
10 public health source.

11 A Yeah, I mean, I would say that I -- yes, with the
12 caveat that I think government and public health
13 sources tend to aggregate the, you know, hopefully the
14 studies and what we know about COVID sort of at the
15 time, and so I would say stuff like that, or, you know,
16 things published in high quality peer-reviewed journals
17 are good, but, yes, I would agree broadly with the
18 statement that I trust those sources a fair amount, but
19 we've also been wrong, right? So ...

20 Q What I'm asking you is do you trust government public
21 health sources more than any other source?

22 A I mean not -- like it depends, right? And so like
23 here, I'll give you an idea of things that I trust,
24 right? So I generally trust things that AHS comes out
25 with, right? I generally trust things like the
26 meta-analysis and the Lancet, you know, that I refer to

1 in my expert report.

2 I generally trust less, you know, any one-off
3 study, right? Like, you know, I tend to trust like
4 conglomerate-like aggregation studies, but, yeah, that
5 would be sort of what I trust and don't trust.

6 And then what I'm looking for is like a
7 convergence of evidence, right? Like when I say what
8 governments do is we try to -- I'll say what public
9 health bodies do is they try to synthesize the
10 evidence, right, and so what they're drawing on -- like
11 the data they draw from are published studies, right,
12 and one -- you know, I would say that you can look at
13 the quality of any one published study, and, you know,
14 some are better than others, but, you know, I -- you
15 know, because there are so many studies, you try to
16 look at like what do the majority of those studies say,
17 but they -- yeah, but, yes.

18 For example, I'll give you a counter example,
19 right? So, you know, I could argue that, you know, in
20 a lot of US states, the governments have been very
21 anti-mask, right, and so, you know, like the State of
22 Texas, like no masking, right, State of Florida, no
23 masking. So I don't necessarily trust that, right,
24 just because it's coming from a government.

25 I trust more I think if that's -- the source is
26 sort of informed primarily by the available scientific

1 evidence, because, again, governments can say lots of
2 different things because they have other
3 considerations, like political ones.

4 Q Anyone who disagrees with your position on masks is
5 anti-mask; is that correct?

6 A No, I mean -- I think I'm actually quite -- what's the
7 word -- I'm quite open to chatting with people about
8 these things. You know, like I said at the end of the
9 last testimony, I'm quite un-ideological, right? Like
10 I have lots of chats with people about things like
11 Ivermectin, which Public Health doesn't really agree
12 with. You know, I have chats -- and so I --

13 And the word "anti-mask", I think, carries with it
14 like a certain -- like I don't like it, just like I
15 don't like the word "anti-vaxxer", right? Like, you
16 know, I think people are generally trying to do the
17 best thing for themselves and their patients. I may
18 disagree with what the best thing for themselves and
19 the patients are, but like I like -- you know, like I'm
20 always down, game for discussion about these things.

21 Q You just said you don't like the term "anti-masker",
22 and yet you just used that term to describe two states
23 in the United States of America; isn't that right?

24 A Sure, well, my bad then, but I -- I mean, maybe what
25 I'm saying is like -- I think right now when we call
26 somebody anti-mask or anti-vax, I think it carries with

1 it an implication that they're like a bad person in
2 some ways, right? And I don't want that -- I don't
3 want that to be implied, right?

4 I think, you know, people are trying to do the
5 best, like, with the knowledge they have. I may
6 disagree with their perspective, but I don't want to
7 be, what's the word, judgy, right? So anyways.

8 Q You would agree that the term "anti-mask" is a
9 pejorative term, would you not?

10 A Yeah, it is pejorative, yes. I mean, it's -- it's both
11 pejorative -- like it's an interesting -- because --
12 you know, like being anti-something does not
13 necessarily, in and of itself, make a term pejorative.
14 But being, you know, in the current environment, I
15 would say being anit-vaxxer can be pejorative, being
16 anit-masker can be pejorative. Anyways, I don't know
17 if I want to talk about sort of these like linguistic
18 interpretations.

19 I guess what I'm saying is that, I mean if you use
20 the statement, people who are against wearing masks,
21 right, that sounds less pejorative than anti-mask, and
22 it sort of defines like, characterizes what they
23 like -- you know, a position is. And so I just don't
24 want to be too judgy, you know.

25 I think it's very important that we always sort of
26 listen for new evidence, right? Like -- and not like

1 judge people or malign people like for not -- like the
2 nature of people for having these different
3 perspectives, even though I may disagree with them.

4 Q You said argument "against masking", in the very last
5 sentence of your report, you say that: (as read)

6 Nobody would argue against masking in a
7 health care setting.

8 That seems to me a curious thing to say. Nobody is
9 arguing against masking in any context, are they?

10 A Well, I would say it's an inaccurate statement, because
11 clearly people are arguing against masking in a health
12 care setting, and so, again, the precision of my
13 language is not there. I would say the vast majority
14 of people in the health care sector would not be
15 against masking in a health care setting.

16 Q Can you identify for me somebody that's arguing against
17 masking?

18 A I mean, I sometimes see protesters that say like "no
19 masks", right? I -- you know, I've received a lot of
20 emails around, you know, may have -- you know, the
21 Calgary school boards are implementing masking,
22 mandatory masking for school-age children, that's where
23 it starts, and, you know, I've commented on it, and
24 I've gotten lots of emails saying that, like, kids
25 shouldn't be masked. I would say that's an example of
26 arguing against masking. I don't know if it's many

1 people arguing against masking in the health care
2 setting, but I'm sure there's more than one somewhere
3 in the world.

4 Q Let me narrow that, and I apologize that I didn't,
5 nobody's arguing against masking in any context in this
6 case, are they?

7 A Not -- I'm -- I thought that we were talking about not
8 wearing masks in like the chiropractic setting, but if
9 I'm -- yeah. Is that not what we're talking about?

10 Q There are individuals in this case that are arguing
11 against the case for mandatory masking; isn't that
12 right?

13 A Can I ask the ACAC for like -- like what is the actual
14 argument here?

15 Q Well, "argument" isn't really the right word. I
16 guess -- and I've only used that word because you have.
17 What I'm getting at is you said in your report that
18 people are arguing against masking.

19 A M-hm.

20 Q You haven't identified anybody, other than some
21 unspecified anti-masking groups. It just strikes me as
22 a strange thing to say. I guess what I'm asking is
23 would you agree with me that, from your perspective,
24 from your perspective --

25 A M-hm.

26 Q -- is it not true that what anybody in this case is

- 1 arguing about is against mandatory masking?
- 2 A If that's the case, like I'm not sure actually, but if,
3 it's helpful to note, so the issue is against the
4 policy of mandatory masking, good to know, we can talk
5 about that, but pardon my ignorance, yeah.
- 6 Q No, I know. I'm asking you, the question is to you --
- 7 A Well, I don't know.
- 8 Q -- would you agree with me that what individuals in
9 this case are arguing --
- 10 A M-hm.
- 11 Q -- against mandatory masking? You can disagree or
12 agree. It's up to you. Please --
- 13 A No, I'm not -- like I'm -- sorry, I talked over you
14 again, I'm not sure, but it sounds like that's the case
15 based on what you're asking, so that's good for me to
16 know, and we can talk about that.
- 17 Q The experts adduced by Dr. Wall, if they're arguing for
18 anything, they're arguing against the efficacy of masks
19 and the supposed harmlessness of masks.
- 20 A M-hm, yes, I agree with that, yeah.
- 21 Q Nobody is arguing that people shouldn't wear masks if
22 they want to, are they?
- 23 A Correct, I agree with that.
- 24 Q And, again, do you have a copy of your report in front
25 of you?
- 26 A Yeah.

1 Q Okay, excellent. I'm at the end here -- or I should
2 say the end of the main section, so this is page 5.

3 A Okay.

4 Q And you say: (as read)

5 While there does exist [in quotation marks]
6 anti-masking movements in Alberta and Canada
7 and all across the world [et cetera].

8 You provide no independent source to verify your claim
9 about these so-called anti-masking movements, do you?

10 A No, but I can just pull up an article from, you know,
11 like the news. There was a group called Masks not --
12 Hugs Not Masks [sic] as I recall. I thought they had
13 quite a catchy name, and -- but I mean -- and I think
14 the point of that line was to say that when I look at
15 the masking debate, so to speak, let's say the debate
16 around mandatory masking, right, I think there's a lot
17 more contention around mandatory masking in, say,
18 public spaces, indoor public spaces, versus the debate
19 around masking in health care settings, generally
20 speaking, right? So, yeah, I can give you sources if
21 you like.

22 Q You said yesterday that the final decision on the
23 content of the CMOH orders lies with the Cabinet of the
24 Alberta Government; isn't that right?

25 A Yes, I would say so.

26 Q You agree that cabinet is a political body, do you not?

1 A I do, yes.

2 Q Yesterday, you said that COVID public health
3 restrictions, including mandatory masking, have become
4 politicised; isn't that right?

5 A Correct.

6 Q Now, Dr. Hu, chiropractic offices are not true health
7 care settings; isn't that right?

8 A I mean, I think they're health care settings. You're
9 providing treatment to a person. You spend like a --
10 you know, I'm a -- sometimes a family doctor, right,
11 you know, what I do is, you know, talk to patients, do
12 a physical exam once in a while, prescribe medications.
13 Yeah, I think chiropractors, you know, do much of the
14 same, but I think they spend probably more time with a
15 patient than I normally would, like, you know, so I
16 think that they're a health care setting.

17 Q Chiropractic offices really are community settings;
18 isn't that right?

19 A I mean, I believe I call it a community health care
20 setting in the same way that a family doctor's office
21 is a community setting, as opposed to a hospital
22 setting, right, but health care is provided in a
23 community setting. A dialysis clinic is a community
24 setting if it's outside of the hospital, right, like --
25 but, yeah, health care is provided, and sometimes it's
26 provided in the community, as in not in the hospital,

1 and sometimes it's in the hospital, but they're all
2 health care settings.

3 Q Chiropractors are more like office-based professionals
4 than front-line health care workers, aren't they?

5 A No. I disagree completely. I mean, if you're saying
6 chiropractors aren't front-line health care
7 professionals, like, that see patients, then family
8 doctors aren't either. Are you -- sorry.

9 Q In a health care setting such as a hospital, a large
10 number of symptomatic people are regularly and
11 predictably present; isn't that right?

12 A Yes.

13 Q In fact, in a health care setting such as an emergency
14 room or hospital ward, most patients could not
15 accurately be described as healthy, could they?

16 A Correct.

17 Q In a health care setting, such as a hospital or a
18 drop-in clinic, workers such as nurses and doctors will
19 regularly interact with symptomatic people that
20 possibly have an infectious illness; isn't that right?

21 A Yes.

22 Q Front-line health care workers like nurses and doctors
23 actively and knowingly treat many symptomatic people
24 that are possibly ill with an infectious illness; isn't
25 that right?

26 A Yes.

1 Q On a daily basis --

2 A (INDISCERNIBLE) --

3 Q -- isn't that right?

4 A Oh, no, it's true, yeah. I mean, I -- although I mean
5 I kind of see your questioning, but I'll just say that,
6 you know, family doctors often -- like I would say when
7 it comes to, you know, let's -- I'll talk about a
8 community family doctor practice, right. You know, you
9 see patients that are actively ill; you take those
10 precautions that you can. You also see people who
11 don't have symptoms, right, or don't have respiratory
12 symptoms, and you see them for other things, as a
13 chiropractor would, right? Like it's a family doctor
14 who sees somebody for lower back pain, a chiropractor
15 sees somebody for lower back pain, no symptoms, no
16 respiratory symptoms.

17 But this is where the whole asymptomatic
18 transmission of COVID comes into play, right? And so I
19 have definitely seen examples in a family doctor
20 setting where patients did not have symptoms when they
21 presented, no respiratory symptoms, ended up having
22 COVID and ended up, you know, infecting health care
23 workers, right. And that just shows that, you know,
24 the absence of symptoms, in and of itself, does not
25 mean that you do not have COVID, which you know.

26 I will agree that there are higher risk settings

1 than a chiropractor's office or a family doctor's
2 office. I think a long-term care is probably the
3 highest risk setting possible, right, based on what
4 we've seen.

5 But you know I would still say that the risk of,
6 you know, getting COVID or like the risk of seeing a
7 COVID patient in a family doctor's office or even a
8 chiropractic office is higher than, you know, walking
9 around a mall, and that is for a few reasons, right?
10 Like let's assume everybody who comes in is, you know,
11 asymptomatic, you know, and you do your best to do
12 symptom screening ahead of time. But even with that,
13 you know, the duration of contact with a person matters
14 quite a lot. And for much of this pandemic, we have
15 been in lockdown, you know, I don't think we've been
16 generally close with lots of different people for an
17 hour at a time, right? Most people haven't enjoyed
18 that, like (INDISCERNIBLE) to be hearing that. And
19 when you have that intensity of -- like when you see a
20 bunch of people, patients, and we see a bunch of people
21 for long periods of time in close proximity, you're
22 naturally at higher risk of getting COVID-19.

23 Q Health care settings like hospital emergency rooms and
24 drop-in clinics are designed to receive symptomatic
25 patients potentially ill with an infectious illness;
26 wouldn't you agree?

1 A Yes.

2 Q In fact, people, who think they might be ill with an
3 infectious illness, intentionally set out health care
4 settings like hospital ER rooms and walk-in clinics to
5 get the medical health care they need; isn't that
6 right?

7 A Yes. And you're talking about "symptomatic" as in
8 respiratory symptoms, right, like COVID symptoms
9 that -- correct? As opposed to, say, what I might see
10 a chiropractor for or a family doctor for, right, so --
11 but you're -- I assume you're talking about respiratory
12 symptoms here?

13 Q Yes --

14 A Okay.

15 Q -- and just so it's fair to you, I wasn't trying to
16 name symptomatics, as in any symptoms, what I meant was
17 visibly symptomatic with a cold, flu, respiratory type,
18 runny nose, coughing, et cetera.

19 A Okay.

20 Q In health care setting such as hospitals or medical
21 doctors' offices, a wide range of interventions,
22 treatments, and tests are likely to occur on a regular
23 basis; isn't that right?

24 A Yes.

25 Q Now, community office settings, such as the types of
26 offices where chiropractors typically work, it's quite

1 rare that a symptomatic person is regularly present;
2 isn't that right?

3 A Yes. However, I will say this, you know, one of the
4 most difficult things -- and this, like, and I would
5 say is quite rare actually for symptomatic patients,
6 and at various points, for them to even go to a family
7 doctor's office, right, because we try to like screen
8 that quite a lot.

9 But, you know, and this is actually a cause of a
10 lot of transmission actually, because what is a
11 symptom, right? And this is why COVID is tricky. You
12 know, if you've been having a, you know, a headache for
13 much of your life on and off, right, and then you have
14 a headache again, that could be your old headache, that
15 could be COVID, right, and that's, you know, a type of
16 symptom that's hard to sort of assess.

17 If you're tired, right, you're fatigued, another
18 COVID symptom non-specific, you know, you come in,
19 you're kind of tired, you know, do you think that --
20 like, and you're a bit more tired today than yesterday.
21 Was that because you, like, didn't get enough sleep, or
22 could it be COVID.

23 And then you have like what I call like very like
24 possi [phonetic] low-grade symptomatic people, and so
25 really -- and this happens a lot in real life and kind
26 of makes it difficult, right? So you have a runny nose

1 for 5 minutes this morning, right, so you had a
2 symptom, and then it goes away. You probably think
3 it's nothing, and it most likely is nothing, but that
4 could actually herald, you know, COVID-19.

5 And this is -- you know, these are the things
6 where, you know, it's not like always -- like obviously
7 if you have like a raging fever and shortness of
8 breath, you know, it's very clear, you're very
9 symptomatic. But it's a lot of these sort of like --
10 well, I've talked about asymptomatics already but these
11 like sort of low-grade symptoms and/or, you know, you
12 just think it's something you've always had, these
13 people have symptoms at the baseline that become very
14 tricky.

15 And those types of events have led to actually,
16 you know, transmission events actually in hospitals,
17 oh, for sure, yeah.

18 Anyways, keep going.

19 Q Symptomatic people who expect they are ill with an
20 infectious illness usually avoid community settings
21 like chiropractic offices; wouldn't you agree?

22 A Yes, you're right, if they suspect they have an
23 illness. But here's my example, and I'll say it again,
24 right, like, you know, let's say you're going to see
25 your chiropractor, right, tomorrow, and then tomorrow
26 morning, you have a runny nose for about 5 minutes,

1 right. Like, you know, are you like, oh -- and you
2 feel well otherwise; is that a symptom? It is
3 technically, but, you know, you might not think it's a
4 big deal.

5 I can tell you for sure that like this happened
6 at, you know, the Peter Lougheed Hospital. We have
7 staff coming in. To like have that type of symptom,
8 you don't think it's a big deal, and then you end up
9 having COVID, you end up inadvertently like maybe
10 infecting some other people.

11 But you're right, that, by and large, if you have
12 like very clear overt symptoms, you will avoid,
13 correct, but there's all these like low-grade-type
14 symptoms and/or, you know, like if you have chronic
15 symptoms actually, you know, let's say you have like
16 chronic allergies, right, like, and then your allergies
17 start up again; you know, like you may not think that's
18 a symptom of COVID, and you can't really actually
19 differentiate by the symptoms alone whether it's your
20 allergies or COVID, and this has actually been very,
21 very tricky. And it's a cause of -- yeah.

22 Q You said yesterday that sick people generally avoid
23 community settings; isn't that right?

24 A Yes, but we need to like get deeper into the word
25 "sick", right? But you're right. So here's what
26 I'll -- and thank you for questioning me on the sort of

1 specificities of my language. I would say people who
2 clearly have like what I call overtly obvious
3 respiratory symptoms will not go to, I imagine, a
4 chiropractor, will tell them ahead of time, right? So
5 totally agree with that. You know, if you have trouble
6 breathing, you have a fever, you have like a day of
7 runny nose, day of sore throat, yeah, I imagine you
8 would not go see your chiropractor. I imagine, you
9 know, when you book in, there's some screening that
10 happens to try to like, you know, suss out, you know,
11 like you don't have those symptoms.

12 But it becomes a bit trickier when like what is
13 sick is kind of what I'm saying, right? Like this
14 happened to me a number of times during this pandemic,
15 right, like in the sense of, like, I had for like 30
16 minutes, and then I go get tested. And, you know,
17 like -- and then the runny nose goes away. But like
18 ten times this happened, ten times I've been tested,
19 but, you know, they've all been negative, but like I
20 know people where you have that, and you test, and it's
21 positive. So it's not quite so black and white,
22 unfortunately.

23 And I wish it was, because if it was -- we --
24 anyways, keep going. Sorry, I am long-winded, but I
25 think it's important to impress, you know, the like --
26 there's a difference between like really, really

1 like -- it's a spectrum of what sick is and what people
2 perceive as sick.

3 Q Would you agree with me that it's accurate to call
4 someone who is asymptomatic healthy?

5 A Are you, again, talking about asymptomatic with
6 respiratory symptoms not having or cold-like, flu-like
7 symptoms being -- not having cold or flu-like -- like
8 not having like a viral infection?

9 Q Let me ask you again. Would you agree with me that
10 it's accurate to call somebody healthy if they do not
11 have any visible cold-, flu-type symptoms?

12 A What do you mean by "healthy"? They could still have
13 COVID. Right now you know can be asymptomatic of
14 COVID. We know you can be asymptomatic of COVID and
15 get pretty sick tomorrow.

16 Q You would agree with me though that it would be
17 accurate to describe most people at a chiropractor's
18 office as asymptomatic?

19 A Yes. I would, most. Yes, I would agree.

20 Q Chiropractors don't actually interact with people
21 infected with COVID any more than in a typical day than
22 members of the public, do they?

23 A This I disagree with. I mean, I don't know how many
24 patients the average chiropractor sees in a day, but
25 like, yeah, I'm going to assume your appointment's an
26 hour long, half an hour.

1 Am I allowed to ask the chiropractor people how
2 many people they see in a day? If I'm not, I'm just
3 going to speculate, sure.

4 So, let's say, you see eight people a day, right,
5 like it could probably be more sometimes than that. I
6 would say during the course of the pandemic, most
7 people did not see eight new people every day, right,
8 like that would be really bad, and so you are at high
9 risk. And they also didn't see eight people in such
10 close indoor settings, right? Like how many people
11 did -- well, you've see during the pandemic when we
12 were like in lockdown, right; I doubt you were close in
13 a room with eight new people every day.

14 Q No front-line treatment of suspected infectious
15 illnesses occur at chiropractor offices, does it?

16 A I don't think so, but I imagine not.

17 Q A chiropractic office is actually much more akin to any
18 other office where a professional service is provided
19 than it is to a true health care setting like a
20 hospital or a walk-in clinic; isn't that right?

21 A What do you mean by other professional services? Like
22 a retail bank or something?

23 Q Let me ask you --

24 MR. MAXSTON: Mr. Chair, Mr. Chair, it's
25 Mr. Maxston, and I apologize for interrupting my
26 friend's questions here, but I'm going to have to

1 object to this line of questioning. Dr. Hu is not a
2 chiropractor. He can't characterize what a
3 chiropractic office is or isn't. He can't have any
4 understanding of what the patient load is for a
5 chiropractic office. These are questions that are far
6 afield from his expert report, and I've given my friend
7 some leeway here, but I have to put on the record that
8 we object to these questions.

9 THE CHAIR: I think I have to agree,
10 Mr. Maxston. Dr. Hu is qualified as a public health
11 expert and not a chiropractor, so if we could focus the
12 questioning.

13 Q MR. KITCHEN: A chiropractic office is a
14 public place under the Public Health Act, is it not?

15 A I would say it's a health care setting under the Public
16 Health Act. Well -- yeah.

17 Q Pursuant to the CMOH orders, a chiropractic office is a
18 public place, is it not?

19 A I mean. It is a public place, as is in a family
20 doctor's office, it's public, like people can go in,
21 but it's also a health care setting, yeah.

22 I mean, like I actually have a -- like I don't
23 know that much about the specifics of chiropractor, but
24 what I need to be able to do in my line of work is like
25 try to assess risk, right? And so I will tell you this
26 right now your risk of COVID increases the more people

1 you interact with, right, and your risk of COVID
2 increases the longer you interact with those people,
3 right, and the closer you are with those people, right?
4 Like I think we can all sort of agree with that.

5 The average person in society during this pandemic
6 was not interacting with a whole lot of people, new
7 people, I imagine. They weren't interacting with a
8 whole lot of people in very close quarters indoors as
9 well. And so, you know, I get the sense what you're
10 asking, you're trying to sort of like say that a
11 chiropractic setting is closer to a public setting like
12 you said professional services than a health care
13 setting.

14 Whereas what I'm arguing is that, no, I would say
15 a chiropractor's office is more akin to a health care
16 setting or any community family practice than that --
17 than, you know, like a retail bank or something.
18 Where, you know, in a retail bank, what do you do,
19 right, you go, you see teller for like 15 minutes,
20 there's like a big like plexiglass barricade, and
21 you'll -- yeah, and so I mean there's other sort of
22 measures, so anyways.

23 Q You would agree that in CMOH Order 16-2020,
24 chiropractic offices are called "community health care
25 settings"; isn't that right?

26 A Yes.

1 Q Going to go back to your report, I note in your report
2 that you did not respond -- actually, and I'm going to
3 refer to Dr. Dang's report. Do you want me to give you
4 a moment to get that up?

5 A Yeah, let me just pull it up. Yeah, I have it up.

6 Q Thank you. Now, I note, in your report, that you did
7 not respond to the 2015 study and 2014 Cochrane review
8 that were cited by Dr. Bao Dang on the first page of
9 his report, and these -- both of these conclude that
10 there's a lack of evidence to support the effectiveness
11 of masks even in a health care setting like an
12 operating room. You don't contest the existence of
13 these studies, do you?

14 A No, but what I will say is that 2014, 2015, COVID did
15 not exist, and I think what I care about is masks in a
16 COVID setting, right? So I abide what's in those
17 studies, right, but we live in a different world with
18 COVID.

19 And so earlier, I did comment on the fact that,
20 you know, like whatever studies we had pre-COVID are
21 not as salient as studies around masking and COVID,
22 because COVID is its -- is a unique novel virus with
23 its own transmission dynamics.

24 Q Now, you just said that you only care about masks in a
25 COVID setting; is that right?

26 A I -- yes.

1 Q And yet, you specifically put in your report a
2 reference to masks during the Manchurian plague?

3 A Yeah, that was like a -- think of that as like fun
4 introduction, I mean, you know, a historical preamble.

5 You'll see that, in my report, most of it is
6 around masking during COVID, whereas in the expert
7 reports, I don't think many of them comment around
8 masking during COVID at all. My report is full of
9 citations around masking during COVID. I'm providing
10 some historical background. It's not salient as well,
11 I agree.

12 Q You don't think it's fun that bacteria are hundreds of
13 times bigger than viruses, do you?

14 A Say that again?

15 Q You don't think it's fun; you used the word "fun", did
16 you not?

17 A Yeah, I'm sorry. Yeah, I shouldn't have used that, my
18 bad. Very casual.

19 I think that if you want to disregard that section
20 of my report entirely, feel free to do so. It is --
21 you know how I was critiquing the other expert reports
22 for having a lot of sections that were not relevant to
23 the question at hand, I have some sections in my report
24 that are not relevant to the question at hand, and this
25 is one of them.

26 Q You would agree with me then that it's not relevant to

1 talk about infectious illnesses that are caused by
2 bacteria when it comes to --

3 A Correct, a hundred percent, I would agree with that.

4 Q You said yesterday that there's no good reason to have
5 any exemptions to mandatory masking except maybe severe
6 mental health reasons such as anxiety; do I have that
7 right?

8 A Yes, correct, and that is based on a Canadian Thoracic
9 Society statement. Again, I'm not a respirologist,
10 but, you know, they basically say that, you know, it
11 doesn't really exacerbate any underlying lung disease,
12 so, yes.

13 Q You said yesterday that nobody should be exempt from
14 wearing a mask except maybe those few people with
15 anxiety; do I have your position right?

16 A Are we talking about in a health care setting? Because
17 I think I've been referring to a health care setting.

18 Let me put it this way: I think that like if
19 you're going to work in a health care setting, right,
20 like you generally have to wear a mask, right. And by
21 "generally", I mean I can think of almost no exceptions
22 to, you know, wearing a mask in a health care setting
23 where you're providing care to patients and you see
24 more patients, and, you know, you're at risk of getting
25 COVID more, and patients are at risk of getting COVID
26 more.

1 Q I'm going to ask you the question again, because this
2 is my memory of what was said yesterday.

3 A M-hm.

4 Q And if you disagree with me you tell me. You said
5 yesterday that nobody should be exempt from wearing a
6 mask except maybe those few people with anxiety.

7 A Yeah, and I'll add in like in a health care setting
8 especially.

9 Q Okay, especially.

10 A M-hm.

11 Q But help me out here --

12 A Yeah, that's fine.

13 Q -- I'm not trying to trick you, I just -- I want to
14 know --

15 A Yeah.

16 Q -- did you say yesterday, because that's what I have
17 written down, you said yesterday that nobody should be
18 exempt from wearing a mask except maybe those few
19 people with anxiety?

20 A I did say that, and I -- like what I was referring to
21 in a health care setting. And like, let me explain
22 that, right, like -- the riskier the setting, the more
23 important it is to wear a mask, right? And so do I
24 care if you're wearing a mask outside in public, you
25 know, in a park? No, I don't really care if you wear a
26 mask there or not, because the risk of transmission is

1 very low.

2 In a health care setting during COVID, and -- your
3 risk is much higher, so there should be -- like, yeah,
4 I would agree, like basically like no exemptions or
5 almost no exemptions. I'm sure -- yeah.

6 Q So you would agree that there should be no exemptions
7 in what you call to be -- in what you say is a health
8 care setting?

9 A Yes.

10 Q And would you agree -- well, would you agree with me
11 that your position is that no one should be exempt from
12 wearing a mask, except maybe the anxiety people, in a
13 community setting, community indoor setting?

14 A More flex there. Community indoor, non-health care
15 setting is what you're talking about, right?

16 Q Well, let me ask you again.

17 A Okay.

18 Q Is it your position that there -- you said flex, so let
19 me ask it this way --

20 A M-hm.

21 Q -- you said -- or, sorry, your position is that there
22 should be exemptions for people to not wear a mask
23 beyond just anxiety in an indoor community setting, yes
24 or no?

25 A I mean, I -- I would say that in certain indoor
26 community settings, you don't need to wear a mask at

1 all.

2 Q Okay.

3 A Now, I'm defining community indoor like as separate
4 from community health care. Community indoor would be
5 a mall, a restaurant, you know just not a place where
6 you receive health services.

7 Q So is it your position then that in a place where
8 health services are received, regardless of what the
9 health service is, nobody should be exempt from wearing
10 a mask?

11 A Yes, while they're providing care to a clinic -- you
12 know, while they're providing, you know, like patient
13 care, I mean, that's also in all the orders, right?

14 Yes.

15 Q And that includes --

16 A (INDISCERNIBLE)

17 Q And that includes --

18 A Pardon?

19 Q -- and that includes the patients, correct?

20 A Well, I'm focused more on the health care worker side
21 right now, but, again, I would say patients sort of
22 should wear like a mask in those settings, and, yeah,
23 but like, sure, yes.

24 Q Just to clarify, because I asked you, in fairness --

25 A Yes.

26 Q -- to you, I asked you in a setting where health care

1 services are being received, I asked you if anybody
2 should be exempt, and you said no, and then I asked you
3 does that include patients, and you changed your
4 answer. So let me give you an opportunity -- listen --

5 A Yeah, I mean --

6 Q -- listen carefully to the words that I use -- when I
7 say "nobody" --

8 A Okay.

9 Q -- okay -- you know, I'm really not trying to trick
10 you, okay?

11 A Okay, no, I know, I'm just, yeah --

12 Q Let me ask you again: Your -- look, you want your
13 position to be understood, so do we.

14 A Yes.

15 Q In a setting where health care services are being
16 received, it's your position that nobody should be
17 exempt from wearing a mask except for those few with
18 severe anxiety?

19 A And thank you for clarifying that. I mean, I will say
20 there are like times, as a patient, you would take off
21 your mask in a health care setting. If I needed to,
22 for example, look at the back of your throat, I don't
23 know if that's considered an exemption, but you would
24 take your mask off to receive certain medical
25 treatments, right?

26 And, again, I think the focus is on what health

1 care workers should do, right? There are very few --
2 you know, like, and I think there -- I'll say this: In
3 a community health care setting, I think that health
4 care workers should always wear a mask. In a community
5 health care setting, I think patients should almost
6 always wear a mask, but there are times when they --
7 you know, you've got to take that mask off for the
8 patient.

9 Q Is it your position that patients should not be
10 allowed -- is it your position that in a setting where
11 health services are being provided --

12 A M-hm.

13 Q -- regardless of the health services, is it your
14 position that patients should not be exempt such that
15 they're allowed to never wear the mask?

16 A Such that they're exempt that they're never allowed to
17 wear a mask. I mean, it is more complex with patients
18 I think, right, for a few reasons.

19 Number one, if I had a patient coming in, and
20 they're having a heart attack, and they don't want to
21 wear a mask, like would I turn that patient away? No,
22 right, because it's sort of our duty as health
23 providers to like treat the patient for what they have.
24 This is actually why it's all the more important for
25 health care workers to wear masks so they can sort of
26 take that extra layer of protection for themselves and

1 for those, you know, patients.

2 You know, another type of patient, you know,
3 somebody with some, you know, psychosis, right; they
4 may not like walk -- people walk in the emerg, you
5 know, they may not have a mask on, they may like be
6 agitated and not want to wear a mask, we should not at
7 all like deny care for those patients, I don't think,
8 right?

9 And so there's, yeah, the patient side is a little
10 more complex, but I think if you are able to wear a
11 mask, you should wear a mask as a patient. Most
12 community health care settings have these policies
13 where if you come in, you should wear a mask. But,
14 again, you know, I don't think -- and this is where
15 there's more of a, you know, a balance. I know some
16 physicians, who, you know, like won't see patients
17 unless their patients are wearing a mask, right, and I
18 know some, you know, who are more flexible on it,
19 right? It just -- you know, like but, generally
20 speaking, the rule is patients should wear a mask if
21 they can, right, if they're able to.

22 Q You said "able to". Do you think religious beliefs are
23 a good enough reason for a person to not be able to
24 wear a mask?

25 MR. MAXSTON: Mr. Chair, I have to object to
26 that question. This is far beyond the purview of what

1 Dr. Hu has been called to testify on. That's -- if
2 anything, that's a legal issue. It's certainly not for
3 an expert, like Dr. Hu, to comment on.

4 MR. KITCHEN: Chair, Dr. Hu, yesterday, gave
5 a lot of opinions on the CMOH orders. He gave a lot of
6 opinions on mandatory masking; okay, mandatory masking
7 he gave opinions on.

8 A M-hm.

9 MR. KITCHEN: So we're not just talking
10 about masking itself; we're talking about mandatory
11 masking. So I am exploring his positions on mandatory
12 masking. It's relevant, and it goes to what he said
13 yesterday.

14 MR. MAXSTON: You're not exploring,
15 Mr. Kitchen, clinical positions, you're exploring
16 religious beliefs. I'm going to strongly object to
17 that.

18 THE CHAIR: I have to agree with
19 Mr. Maxston, that's a protected ground. I don't think
20 we need to get into that.

21 Q MR. KITCHEN: Dr. Hu, you think that the
22 CMOH orders would have been better if they did not
23 allow for exemptions to mandatory masking, correct?

24 A What do you mean by "better"?

25 Q Well, that's the word I heard you use yesterday.

26 Yesterday, did you not say that it would have been

1 better if those exemptions were not in there that
2 Dr. Dean Hinshaw had in her orders?

3 A Well, no, I mean actually -- from a policy perspective,
4 I think what I said -- I may not remember, but here,
5 I'll -- my position on this looks, like, looks like
6 this, right: Normally when governments like make these
7 recommendations, they tend to like have a carve-out for
8 exemptions, because, it's just -- you know, you can't
9 necessarily think of all the million things that
10 somebody could have an exemption for, right, and so you
11 tend to want to be a little bit flexible.

12 The issue that -- you know, when you say there's
13 some exemptions to this is the CMOH order cannot
14 provide guidance on what those exemptions -- like what
15 would qualify as an appropriate exemption, and they --
16 I think they added that intentionally a bit. And that
17 let to a lot of confusion, you know, with family
18 doctors being like, okay, so people are asking for
19 exceptions, like what qualifies as an exemption, right?

20 And so it would have been better if they probably
21 qualified what would -- if they sort of described what
22 an exemption would actually -- what would qualify for
23 an exemption.

24 Q From a Public Health policy perspective, you support
25 mandatory masking policies, correct?

26 A Yes. M-hm, yes.

1 Q From a Public Health policy perspective, you support
2 the Alberta Chiropractic College's mask mandate,
3 correct?

4 A Yes.

5 Q You think the Alberta Chiropractic College got it right
6 by not permitting exemptions; isn't that right?

7 A This is for health care workers, right?

8 Q Yes. From a policy perspective, you support mandatory
9 vaccination, don't you?

10 A Define "mandatory vaccination". I mean, this is a
11 very, yeah, complex topic, right?

12 Q I define it exactly the same as I define mandatory
13 masking.

14 A Sorry, you're talking about do I support mandatory
15 vaccination of health care workers who work in health
16 care settings? Is that what you mean by mandatory
17 vaccination?

18 Q Well, I'll ask you again. From a Public Health policy
19 perspective, do you support mandatory vaccination of
20 all health care workers?

21 A I do, yes. But as somebody who also like works a lot
22 in like trying to create having this policy, you know,
23 you can't -- I think it would be wonderful if all
24 health care workers were immunized. I think that what
25 you want to do is not use a mandate if you can convince
26 people to be immunized without a mandate, right? You

1 always want to be as non-coercive as possible
2 initially, right?

3 I think that when it comes to, you know, like when
4 it comes to mandatory vaccination policy, for example,
5 right, there will be exemptions, right, there's
6 carve-outs for exemptions. But I think, broadly
7 speaking, I view mandatory vaccinations, like a policy
8 like that, is something you do once you find that,
9 through other means, you cannot get a sufficiently high
10 number of people immunized in health care, like, for
11 example, health care workers immunized.

12 And, you know, I -- the mandatory vaccination
13 thing is really interesting because I think that a lot
14 of people like view it as a way to increase vaccine
15 uptake, which, you know, is obviously an effect of
16 mandatory vaccination.

17 You know, the primary reason for a vaccine mandate
18 in a particular setting is to keep that setting safer,
19 I think, right? So I almost definitely support
20 mandatory vaccination in a long-term care setting,
21 right, because, again, that's the -- by far, the
22 highest risk. You know, I think hospital settings are
23 also, you know, pretty high risk.

24 But, you know, you want to -- yeah, like, and so
25 I'm like shading this a little bit, because it's not
26 like just like "yes", "no", right? Like, and we go

1 down this road because it's a complex topic for a
2 mandatory vaccination: When you should do it, like
3 when's best, who should apply for it, what exemptions
4 you should have, et cetera, et cetera.

5 Q I'm going to move on to something different. You said
6 yesterday that more health care workers died in Italy
7 in the spring of 2020 because they weren't wearing
8 masks; do I have that right?

9 A No, I think what I said was they ran out of like --
10 sorry, what happened is they didn't have enough like
11 good PPE, and, sorry, if I meant that, right? I think
12 they were reusing masks. They like were -- and these
13 masks were -- like their masks were not providing
14 sufficient protection -- or the PPE was not providing
15 sufficient protection. That can happen by not wearing
16 masks, so I think they were wearing masks, or just by
17 using the same mask over and over and over again for
18 days. Right?

19 Q You don't have any scientific reports or peer-reviewed
20 studies to support that conclusion, do you?

21 A I don't, but I can find some.

22 Q You didn't include them in your report, did you?

23 A Correct, there's lots of things I didn't include in my
24 report that I've been talking about.

25 Q You weren't a health care worker in Italy in the spring
26 of 2020, were you?

1 A No, I was not.

2 Q I'm looking now at the second-to-last paragraph on page
3 4 of your report where you discuss health care workers
4 in Alberta.

5 A M-hm.

6 Q That paragraph starts with "If we look closer to home".
7 You cite no scientific reports or peer-reviewed studies
8 in that entire paragraph, do you?

9 A Yeah, because nothing has been like peer-reviewed yet
10 on this, yeah, but you're right.

11 Q You provide no independent sources to verify your
12 claims regarding the number of infections between
13 COVID-19 infectious patients and health care workers in
14 Alberta, did you?

15 A No, but I can provide them.

16 Q You provided no independent sources to verify your
17 claims regarding the number of transmission events, did
18 you?

19 A No, I did not.

20 Q Everything discussed in this paragraph is simply your
21 assessment of what happened, is it not?

22 A My assessment in discussion with a bunch of other
23 people, like Workplace health and safety, Alberta
24 Health Services, you know, hospital management,
25 leadership, and all that, but, yes, you're right, I do
26 not cite anything, that is true.

1 Q You've not worked as a doctor in an emergency room or
2 hospital ward treating COVID patients, have you?

3 A No -- I'm trying to think, because like I spent a fair
4 amount of time in the hospitals to manage some of these
5 outbreaks, but you're right I wasn't providing direct
6 clinical care to patients in the COVID wards or the
7 emerges, but I was extremely involved in developing,
8 one, policies around preventing transmission of
9 COVID-19, and, two, managing any outbreaks that emerged
10 in hospitals and emerges.

11 Q Now, I note it's 10:58, which means you've got to leave
12 in 2 minutes.

13 A M-hm, yes, thank you for reminding me.

14 MR. KITCHEN: Mr. Maxston, I can tell you
15 I'm at least half way through.

16 MR. MAXSTON: I think we should let Dr. Hu
17 go, and maybe we can chat about, after he's gone, just
18 take 5 minutes of that 15-minute break to chat about
19 the balance of the day.

20 MR. KITCHEN: Sure.

21 THE CHAIR: Before we do that, Dr. Hu, you
22 mentioned that you might be a little more flexible on
23 the noontime if you're able --

24 A Yeah --

25 THE CHAIR: -- to deal with it.

26 A -- yeah. Yes, I can be. I like jiggled things around a

1 little bit, so ...

2 THE CHAIR: Could we take 1:00 as a
3 target --

4 A Yes.

5 THE CHAIR: -- time to be done? Does that
6 work for you, Mr. Maxston, Mr. Kitchen, if needed?

7 MR. MAXSTON: Yeah, I have a -- I think that
8 would be as far as I would want to go without having
9 people take a lunch break, frankly.

10 I am concerned we're not going to finish with
11 Dr. Hu today though if we -- just nothing critical of
12 anybody, but I have a fair number of questions, and the
13 Tribunal should be able to ask questions too, and that
14 shouldn't be rushed, so I think we should just press on
15 here and try and get done as much as we can.

16 THE CHAIR: Okay, let's break, we'll
17 reconvene we'll go into recess now, and we'll reconvene
18 at 11:15, when Dr. Hu returns, and we'll press forward.
19 If it looks like we can wind up somewhere around 1:00,
20 we'll press through. If not, Mr. Maxston, I take your
21 comments to heart; we will find time in there for a
22 proper lunch break for people to replenish, and we'll
23 go from there. So, thank you, we'll see you in 15.

24 (ADJOURNMENT)

25 THE CHAIR: So we will reconvene, and
26 Mr. Kitchen is continuing with his cross-examination of

1 Dr. Hu.

2 MR. KITCHEN: Thank you.

3 Q MR. KITCHEN: Now, Dr. Hu, you said
4 yesterday that it would be unethical to perform RCTs on
5 people jumping out of planes without parachutes as a
6 part of a scientific investigation to determine the
7 effectiveness of parachutes; is that right?

8 A Yes.

9 Q The overall survivability rate of jumping out of an
10 airplane is zero, is it not?

11 A Well, it's close to zero, but -- very close to zero,
12 but you're right, it's like basically near zero, yes.
13 I think a --

14 Q (INDISCERNIBLE)

15 A -- I think a few people have survived in the history of
16 it, but it is very close to zero, I agree.

17 Q The overall survivability rate of COVID is 99 percent;
18 isn't that right?

19 A Yes.

20 Q RCTs --

21 A (INDISCERNIBLE) -- oh, sorry.

22 Q -- RCTs regarding the efficacy of masks have been
23 conducted and are currently being conducted, are they
24 not?

25 A In the community setting, yes, not in the health care
26 setting really.

1 And maybe I'll just explain, so, I mean, I used
2 the parachute example just like -- just to describe
3 certain situations where you can't do an RCT, but I
4 believe I -- I used a term yesterday called "clinical
5 equipoise", and that basically means that when you do
6 an RCT for anything, medication, intervention, right,
7 like, you can't do it if you think that like one --
8 like the placebo, if the treatment is like -- you think
9 is like definitely better than the non-treatment
10 placebo group, right?

11 And I think right now it would be probably not
12 ethical to do an RCT of mask wearing in a health care
13 setting, because there's so much evidence supporting
14 masking in health care setting. Now, in a community
15 indoor setting, it's a bit different, right? There's a
16 lot more sort of debate around that one.

17 Q So RCTs regarding the efficacy of mask and mask wearing
18 in community settings --

19 A Yes.

20 Q -- are being conducted and has been conducted?

21 A Yes.

22 Q Thank you. Now, on the top of page 3 of your report --
23 forgive me, I put it down -- the top of page 3 of your
24 report --

25 A Yeah.

26 Q -- you cite to a study sponsored by the World Health

1 Organization that is authored by Chu et al., so I'm
2 going to call that the Chu study.

3 A Sure.

4 Q You know what I mean by that?

5 A Yeah.

6 Q And you discuss this same study in the second paragraph
7 of page 4. This study was published in June 2020,
8 correct?

9 A Yeah.

10 Q Now, this study is also discussed by Dr. Thomas Warren
11 on page 6 of his report in the second-to-last paragraph
12 of his report. Dr. Warren --

13 A Okay (INDISCERNIBLE) --

14 Q (INDISCERNIBLE)

15 (INDISCERNIBLE - OVERLAPPING SPEAKERS)

16 Q MR. KITCHEN: Let me know when you've got
17 it.

18 A Yeah. This is page 6 of his report.

19 Q Right, that's these -- the paragraph there at the
20 bottom that starts with: (as read)

21 Finally, a comment should be made.

22 Dr. Warren refers to a Cochrane review that was
23 evidently published after the Chu study. This Cochrane
24 review is found at footnote -- or I should say, sorry,
25 end note 62 of Dr. Warren's report. The first author
26 listed for this report is Jefferson.

1 A Okay.

2 Q Jefferson/Cochrane review.

3 A M-hm.

4 Q Dr. Warren quotes directly from this Jefferson/Cochrane
5 review, in which it is stated that the Chu study,
6 quote: (as read)

7 Has been criticized for several weeks. Use
8 of an outdated risk of bias tool, inaccuracy
9 of distance measures, and not adequately
10 addressing multiple sources of bias,
11 including recall and classification bias and,
12 in particular, confounding.

13 My question is you don't deny the existence of this
14 Jefferson/Cochrane review cited by Dr. Warren, do you?

15 A No.

16 Q You don't contest that the portion of the
17 Jefferson/Cochrane review quoted by Dr. Warren was
18 quoted accurately, do you?

19 A No.

20 Q And you don't disagree with Dr. Warren that Cochrane
21 systemic reviews are widely recognized in the medical
22 community as authoritative, do you?

23 A Yeah, they are. I agree.

24 Q I note --

25 A I'm trying to download this Cochrane review; is that
26 okay? Can I like crack it open?

1 Q Well, yes, because it's part of the record, it's --

2 A Yeah, just trying to --

3 Q It's in Dr. Warren's report.

4 A Is it one of the -- it's not one of the exhibits,
5 right? I'm just trying to download the PDF of it right
6 now.

7 THE CHAIR: It's in E-7.

8 A Oh, it's in E-7, okay, thank you. (INDISCERNIBLE)

9 (INDISCERNIBLE - OVERLAPPING SPEAKERS)

10 Q MR. KITCHEN: (INDISCERNIBLE)

11 A The paper itself, the Cochrane review itself.

12 Q So just so you know, Dr. Hu, I'm not going to question
13 you any further on the report, so ...

14 A I'm just reading that study right now, the Cochrane one
15 where -- I mean, so they talk about medical surgical
16 masks compared to no masks, but I think that what
17 they're looking -- and they basically in that study say
18 that wearing a mask may make little or no difference to
19 the outcome of influenza-like illness if not wearing a
20 mask. And so what we're trying to look at is if like
21 what they're looking at is general influenza-like
22 illness for COVID specifically.

23 So, now, this Cochrane review was published
24 initially in 2007, and then -- as Cochrane reviews
25 often are, right; you have an initial one on masking,
26 and then updated in 2009, '11, '17. And so I mean I --

1 again, I kind of wanted to look at it just to see if
2 the studies this Cochrane review talks about, which --
3 Cochrane reviews are very good -- refer directly to the
4 transmission of COVID and masking to prevent that.

5 The comments around criticizing, you know -- you
6 know, with the Lancet paper, I mean, yes, you can
7 always critique these meta-analyses, but it really is
8 seen as like a, you know, a fairly good study. No
9 study is perfect, but -- oh, thanks for flagging the --
10 the -- yeah, yeah, I'm just reading this document right
11 now. I'm going to -- keep going though.

12 Q I note that in your report, you state no less than six
13 times that the evidence in support of masking is,
14 quote, overwhelming. Do you --

15 A Yes.

16 Q Do you today remain of that opinion?

17 A Yes, for health care -- for prevention of COVID in a
18 health care setting, yes. I do.

19 Q You state on page 8 of your report that the efficacy of
20 mask wearing is beyond doubt; do you stand --

21 A (INDISCERNIBLE)

22 Q -- by that statement?

23 A Yes, in a health care worker setting, yes.

24 Q So it's not beyond doubt in a community setting; do I
25 have your position right?

26 A Yes. I mean, I will say the other thing that like

1 affects this is like the number of cases you have,
2 right, of COVID.

3 And so, for example, like -- and this is quite --
4 I think I may have talked about this yesterday, but if
5 we had zero COVID, we wouldn't need to wear masks,
6 right; like I fully support that, right. And so, like,
7 a lot of what I'm trying to say is that, you know, when
8 you wear -- like -- and zero COVID is a type of, you
9 know, like if there's no COVID cases, your risk is very
10 low of getting COVID. I think that, you know, your
11 risk is sort of determined by a number of factors,
12 including, you know, the prevalence of COVID but also
13 what you're doing exactly.

14 But I will stand by my fact that right now, like,
15 yeah, like, beyond doubt people should wear masks to
16 prevent COVID-19 in health care settings. If there was
17 no COVID for ten years, I would take that back, right?
18 But, you know, that's -- these are all important things
19 that I, you know, actually even think about. The
20 community setting is very, very different.

21 For example, do I think people should engage in
22 indoor masking in -- let me pick an area with very few
23 COVID cases -- in, I don't know, there's a big outbreak
24 in the Northwest Territories -- like in Nunavut, right,
25 where I don't really think they have many cases right
26 now. Like, no, not in, you know, a community setting.

1 It's really important to make a difference between
2 a health care setting and a community setting. They're
3 completely different.

4 Q When -- well, I want to make sure I have your position
5 correct --

6 A M-hm.

7 Q -- so you --

8 A (INDISCERNIBLE) again?

9 Q Sorry?

10 A Do you want me to say my position again --

11 Q No, no, sorry, I'm going to ask you a question, I
12 apologize.

13 A Okay, yeah, no problem.

14 Q So you would say that the evidence of the effectiveness
15 of masking in what you call a health care setting is
16 overwhelming, correct?

17 A Yes.

18 Q It's not overwhelming in what you would call a
19 non-health care setting?

20 A Correct. I think there's lots of evidence for it; it's
21 just not as overwhelming, right, like -- but yes.

22 Q And, again, embellish me, you would say that the
23 evidence for the efficacy of mask wearing in what you
24 would call a health care setting --

25 A M-hm.

26 Q -- beyond doubt --

1 A Yes.

2 Q -- (INDISCERNIBLE)

3 A And I will --

4 Q -- and you would say it's not beyond doubt in what you
5 would call a non-health care setting?

6 A I would say that -- and, you know, these terms are not
7 very specific, right, beyond doubt, overwhelming. So
8 let me try to describe these terms.

9 When I say "overwhelming", what I mean is that in
10 a health care setting, basically every study on --
11 pretty much every study or the vast majority, let's say
12 95 percent plus studies have been done on masking in a
13 health care setting during COVID which show that it
14 provides benefit, right, and so that's pretty
15 overwhelming, I think.

16 And now when I talk about studies around masking
17 in a community setting, again, there's a lot of studies
18 that show, you know, masking previously, like in a
19 classroom, for example. That's probably one of most
20 interesting ones right now. Like it's also strong, but
21 like the effect size is not as strong. By "effect
22 size", I mean the extent to which like the proportion
23 of like -- the risk reduction of transmission is not as
24 high in the community settings as in a health care
25 worker setting. And so while there's lots of studies
26 supporting it, like the magnitude of the risk reduction

1 does matter as well, so, yeah.

2 Q Going to take you to page 8 --

3 A M-hm.

4 Q -- of this report, now we're in the response
5 sections --

6 A Yeah.

7 Q -- I guess this is the last page. You make a comment
8 on this page, page 8 --

9 A Yeah.

10 Q -- in response to Dr. Bao Dang's statement regarding
11 mask mandates in other countries. You say that
12 Dr. Dang's remark about Sweden is, quote, false and not
13 backed by any evidence. However, you do not refer to
14 any study or other evidence that supports your claim
15 that Dr. Dang's Sweden remark is, in fact, false, do
16 you?

17 A You're right. And let me explain that, maybe I didn't
18 use my words, like language correctly, but Dr. Dang's
19 real-world data from various countries shows that cases
20 increased after masked mandates were enacted, and
21 countries that had no mask mandates did just as well or
22 better than other countries with masked mandates.

23 You know what, my -- like I will -- I like -- my
24 main critique with that is, you know, I'll give you an
25 example, right, like China after the first wave as of,
26 let's say, June of 2020, no longer had any

1 restrictions, right, because they had no COVID anymore,
2 because they managed to suppress it completely. You
3 know does that mean masking doesn't work? No, because
4 there's no COVID, so you don't like necessarily need to
5 mask.

6 I think that when we're looking -- and this is
7 what I was talking about like a -- like spurious, you
8 know, causation, a lot of factors drive up cases.
9 Masking can reduce transmission, but like a lot of
10 things can reduce transmission and a lot of things can
11 increase transmission as well, right? And I would say
12 the biggest predictor overall case counts in a
13 particular country, you know, is just the total number
14 of -- you know, actively interaction between people.

15 And so, you know, you can't just like make like --
16 it's kind of like -- yeah, you know what I'm talking
17 about when you have like a -- like a spurious like, you
18 know, causation like -- correlation versus causation
19 are very different.

20 I think the example I used yesterday was -- and,
21 you know, November -- like late November, we
22 implemented some strict measures, and then in December,
23 in Alberta, we implemented stricter measures, but cases
24 kept on going up. They eventually started falling, but
25 I can say that, you know, the implementation of
26 measures in November, December, like initially led to a

1 rise in cases, right, and like -- and so you'd be like,
2 oh, so maybe your like lockdowns don't work.

3 But, you know, it's factually true, the cases went
4 up after we implemented lockdowns, right, for a bit.
5 That doesn't mean lockdowns don't work. I'm just
6 saying lots of other factors determined, you know, what
7 our case counts are.

8 Q So you would say that when cases went up after what you
9 called the lockdown --

10 A M-hm.

11 Q -- you would say it's just correlation; it's not
12 causation?

13 A Yeah, I mean, like, sorry, like if you're like
14 correlation like, you know, like mathematically,
15 statistically is like there's a -- like something
16 happens, and something goes up or down, right? It's
17 just like a direct -- this immediately -- how do I
18 define correlation? Like correlation just describes
19 the relationship between sort of like two variables,
20 right?

21 And so whereas causation is more like, okay, so
22 what our action -- what is driving, you know did
23 lockdowns lead to lower cases in the end? Yeah, they
24 did, but it took some time for that to happen, right;
25 but if I took a slice of time, like a week after, cases
26 were still high. Anyways --

1 Q So you --

2 A -- (INDISCERNIBLE) say.

3 Q You would say the relationship between cases going down
4 after what you call the lockdown is causation not
5 correlation?

6 A Yes.

7 Q So you would agree that the lockdown caused those cases
8 to go down?

9 A Yes. And then let me like -- and we have to like get
10 into more specifics like because many, many things like
11 lead to a decrease in cases, right?

12 What did the lockdown actual -- okay, for just a
13 fun public health discussion, right? So, again, you
14 know, just illustratively, what was causing our cases
15 to be very high in the late fall was indoor private
16 social gatherings, right? The lockdown really said you
17 couldn't do those things, and, you know, that led to a
18 decrease in the number of indoor private social
19 gatherings that occurred, as in people going to
20 people's houses, or we think it did.

21 And that is sort of like the causal link, because,
22 you know, when you say "causation" -- like establishing
23 causation, as you know, can be very difficult, but, you
24 know, the reason why I think lockdowns generally -- and
25 there's a whole set of criteria and epidemiology to,
26 like, try to determine causation.

1 But I would say that I guess point one is you
2 can't just look at correlation; point two when you're
3 trying to assert causation, you know, you have to
4 consider a number of factors, you have to have an
5 understanding of like, you know, the sort of like the
6 drivers of transmission, the things that make it worse,
7 the things that make it better.

8 Q Now, I'm going take you back to -- I know you just
9 talked about a lot of stuff, but I'm going to take you
10 back to exactly what we were talking about before,
11 okay --

12 A Yeah.

13 Q -- we're talking about this Sweden reference here.

14 A Yeah.

15 Q Okay, so you've got your sentence here where you say,
16 And this statement is false and has not been backed up
17 by any evidence.

18 Now, in the very next sentence, you state in your
19 report: (as read)

20 The use of masks has decreased the
21 transmission of COVID-19 across every country
22 that has imposed them.

23 Q That's what you state in your report. You do not cite
24 or refer to any study or other evidence at the end of
25 that sentence to back up that claim, do you?

26 A No. But I can give you some citation.

1 Q On page 6 of your report, you accuse Dr. Warren of
2 committing a factual error in stating that 1,010
3 COVID-related dates says, as of April 16th, 2021, our
4 last deaths than the 1,191 motor vehicle accident
5 deaths in the year 2018. Do you today stand by that
6 accusation?

7 A I do. Sorry, like -- like I think what Dr. Warren put
8 in is accurate, right? Like I'm not arguing that.
9 Like I think what I'm trying to articulate is that,
10 one, it doesn't really matter for the purposes of our
11 discussion to talk about again, which is, you know,
12 whether or not which of these masks can be in a health
13 care setting, right, and whether or not that reduces,
14 you know, transmission.

15 You know, the spirit of I think what, you know,
16 Dr. Warren is talking about is basically like COVID
17 isn't that serious, and, you know, whether or not you
18 think COVID is serious or not, right, like -- like,
19 again, like the focus of this is, you know, health
20 care -- like use of masking in a health care setting to
21 reduce transmission, right?

22 And I think one of the issues that I have with a
23 lot of the expert reports -- and, you know, like I can
24 actually chat at length actually about how serious or
25 not serious I think COVID is. You know, there's a lot
26 of room for discussion, I think, frankly, right? Like,

1 lockdown I think is actually -- you know, more people
2 have died from non-COVID causes than COVID, you know,
3 during like our -- the last 18 months in terms of
4 excess mortality.

5 But, you know, at the end of the day, it's just
6 not relevant, and, you know, I think with a lot of the
7 expert reports, like a lot of their reports are spent
8 like just talking around the issue -- or like around
9 COVID, but not around masking. There's very little in
10 the reports about masking as a portion of the total
11 report.

12 And I made that error too, I talked about the
13 Manchurian plague thing, which is also not relevant, so
14 point taken.

15 Q Now, that was a long answer, and I want to make sure I
16 have your answer, okay?

17 A Okay.

18 Q You stand by the accusation that Dr. Warren made a
19 factual error in stating that 1,010 COVID deaths as of
20 April are less than the 1,191 motor vehicle accident
21 deaths in the year 2018?

22 A Yeah -- no, I don't. Like his statement is accurate --

23 Q No, you don't -- hold on, like I don't want to
24 interrupt you, but, no, you --

25 A Okay.

26 Q -- don't stand by your accusation?

1 A Sorry, what I'm saying -- okay, like what he says is
2 that, in Canada, there have been a thousand COVID
3 deaths in people under 60 as of April 2021. In Canada,
4 in 2018, there were 1191 motor vehicle fatalities. And
5 what I say is that as of June, so like two months
6 later --

7 Q But I didn't ask you what you said --

8 A Okay.

9 MR. MAXSTON: Mr. Chair, Mr. Chair,
10 Mr. Kitchen may not like the answer Dr. Hu is giving,
11 but he's got to let him finish, and he should be
12 allowed to finish his answer.

13 Q MR. KITCHEN: Okay, you go ahead, Dr. Hu.

14 A So I mean, I think that Dr. -- that is what Dr. Warren
15 said, right, and he's basically saying there were fewer
16 COVID deaths than motor vehicle deaths, you know, as of
17 April 2021. What I say is, as of June 29, there were
18 more COVID deaths than motor vehicle deaths, right, and
19 so that's it, and both are factually correct
20 statements, right?

21 And, yeah, so you're right, the point where I say,
22 notwithstanding the factual error, I mean, like it's
23 not his fault, because like at the point he cited it,
24 there were more motor vehicle deaths than like there --
25 than COVID deaths, and two months later, there are more
26 COVID deaths than motor vehicle deaths, but like --

1 but -- and when you like pick a point in time for
2 looking at COVID deaths, right?

3 Q Now, I feel like I've gotten two answers from you, and
4 I want to make sure everybody's got this right, because
5 you just said -- you just said that there is a factual
6 error --

7 A Yes, the factual error is that --

8 Q -- you stand by the claim that Dr. Warren made a
9 factual error?

10 A Okay, let me be precise here. So at the time of him
11 citing, you know -- picking April -- like so he says
12 two things really, right? He says as of April 16th,
13 there were more motor vehicle deaths than COVID deaths,
14 right? And that's true. And then he goes on to say so
15 the risk of death due to COVID in persons under 60 is
16 less than the risk of death due to a motor vehicle
17 fatality. So, I mean, I think that part is not true
18 based on, you know, by June 2021, you know. There have
19 been 1400 COVID-related deaths under 60, right?

20 And so what I'm saying is like the first part of
21 his statement is accurate, right, like numbers of
22 deaths at this point versus number of motor vehicle
23 fatalities, but the second part, the risk due to COVID
24 in a person under 60 is less than death to a motor
25 vehicle fatality, because like if you go like two
26 months later, you see that the number of COVID deaths

1 is quite a bit higher than the number of motor vehicle
2 deaths, right?

3 Q So what he said was accurate on April 16th?

4 A Yes. But --

5 Q (INDISCERNIBLE)

6 A -- as of June, it is no longer accurate, right, and so
7 there's a factual error there, right?

8 Q But Dr. Warren didn't say June, he said April; isn't
9 that correct?

10 A That's true. Yeah, but like he did, so you're right,
11 at that time, he was correct, but like two months
12 later, he was no longer correct, right?

13 Q There are --

14 THE CHAIR: Please --

15 Q MR. KITCHEN: -- (INDISCERNIBLE)

16 THE CHAIR: -- Mr. Kitchen, I'm wondering
17 if Dr. Hu is referring to the second -- he said there
18 were two parts to the answer, one, what happened in
19 April, and then a broader generalization. I think,
20 Dr. Hu, were you not saying that it's the broader
21 generalization that's not true?

22 A Yeah, so the generalization he makes is -- I mean, and
23 like we can move off this, like I -- is like so the
24 risk of death due to COVID in persons under 60 is less
25 than the risk of death due to a motor vehicle fatality.
26 And while that was true in April, it is not true now,

1 because we had a lot more COVID deaths, right? And so
2 that is like the sort of factual error. I mean,
3 regardless, I will -- yeah.

4 Q MR. KITCHEN: Let me ask you this, Dr. Hu:
5 There are 12 months between April 16th, 2020, and April
6 16th, 2021, are there not?

7 A Yeah.

8 Q And there were 12 months in the year 2018, were there
9 not?

10 A M-hm. Would you like me to calculate like a death by
11 month rate because -- okay, so, here, let's do this --

12 Q Now, Dr. Hu, look, I didn't ask, and Mr. Maxston can
13 chime in here, I didn't ask you a question.

14 A Sorry, my bad.

15 Q You're asking me, Can I do this, and then you're
16 talking, and, you know, I've let you do that a lot, I
17 don't generally have an issue with that, but --

18 A Sorry, but --

19 Q -- the idea is that you --

20 A -- (INDISCERNIBLE) --

21 Q -- I ask a question and you answer it. And that's
22 exactly why Mr. Maxston rightfully stepped in and said,
23 Well, you know, look, my witness --

24 A Yeah.

25 Q -- is answering a question that you asked.

26 A Right, that's fair.

1 Q Now, in the next sentence, you accuse Dr. Warren of
2 lacking, quote, a basic understanding of disease
3 patterns. Do you today stand by that accusation?

4 A Well, it's a little bit general accusation. I don't
5 know, like I -- maybe I won't say that anymore, right?
6 Like I don't know Dr. Warren well enough.

7 Q So you don't stand by that accusation; do I have that
8 right?

9 A Yes. I don't anymore. It's too general. It's too
10 like general in my writing.

11 Q It must surprise you that someone who you up until just
12 now said has no basic understanding of disease patterns
13 has written a seven-page report about COVID that
14 contains 98 citations to academic literature, doesn't
15 it?

16 A No, I mean, like -- like I said, like I -- I will
17 retract my statement as I think he has no understanding
18 of disease patterns, and, fair. I mean I think he has
19 a lot of citations, but I think, yeah, when it comes to
20 the whole masking thing, which is the thing we should
21 be focusing on, which is the purpose of this
22 discussion, right, I disagree with, you know, his
23 findings.

24 Q So it doesn't surprise you that he's created a
25 seven-page report with 98 citations to academic
26 literature about COVID?

- 1 A No. Does it surprise me? No, because -- yeah.
- 2 Q Your report contains 22 citations to academic
3 literature; isn't that right?
- 4 A M-hm. Yes.
- 5 MR. KITCHEN: Those are my questions.
- 6 A Thank you. Sorry, for being so long-winded again,
7 Mr. Kitchen.
- 8 THE CHAIR: Thank you, Dr. Hu. We will
9 now turn the floor back to Mr. Maxston for his -- any
10 redirect.
- 11 MR. MAXSTON: Thank you.
- 12 Mr. Maxston Re-examines the Witness
- 13 Q MR. MAXSTON: I'm just going to start with a
14 question, Dr. Hu, about the Pandemic Directive, which
15 is Exhibit C-22 --
- 16 A Okay.
- 17 Q I'll let you just get to that, and I'm looking at -- in
18 specific, I'm looking at page 8. While --
- 19 A Yeah.
- 20 Q -- you're getting to that, there was a discussion
21 between you and Mr. Kitchen about the type of masks
22 that are -- really, you're referring to, and I think a
23 discussion about the blue medical clinical mask. I'll
24 just take you to the heading "PPE Requirements" and --
- 25 A Yeah.
- 26 Q -- the first black dot says: (as read)

1 Surgical or procedure masks are the minimum
2 acceptable standard.

3 And you'd agree that's appropriate?

4 A Yes.

5 Q There was a discussion between you and Mr. Kitchen
6 about how the CMOH orders come about and Cabinet and
7 other considerations, regardless of the development
8 process of CMOH orders, they're to be followed, aren't
9 they?

10 A Yes. They are legally binding, I believe, so ...

11 Q There was, I found, a surprising comment, a surprising
12 question from Mr. Kitchen that chiropractic offices
13 aren't true health care settings, and I think you
14 responded pretty vigorously to that, but I just want to
15 be clear, is there any doubt in your mind that
16 chiropractic offices are health care settings?

17 A No.

18 Q Patients are treated, diagnoses --

19 A Yes.

20 Q -- diagnoses are made, and that, in fact --

21 MR. KITCHEN: Chair, hold on a second, I --
22 this was the same line of questioning that I was doing
23 that Mr. Maxston objected to on the basis that,
24 ultimately, Dr. Hu doesn't know what goes on in a
25 chiropractic office, and he's not qualified as an
26 expert to comment on what goes on in --

1 MR. MAXSTON: I'll skip on, I'll skip on.

2 Q MR. MAXSTON: You made comments about there
3 being a higher risk -- pardon me, that there are higher
4 risk settings in the health care world that -- than
5 there are in the community setting; is that correct?

6 A Yes.

7 Q You talked about things like duration of contact is
8 important, the number of patients you might see, and
9 although you're not a chiropractor, you used an example
10 of eight people a day as a patient load. If any health
11 care professional, whether it's a chiropractor or a
12 dentist or whoever, sees 16 or 32 patients, the risk
13 would go up for COVID transmission, wouldn't it?

14 A Yes.

15 Q So if someone like Dr. Wall was seeing 32 patients a
16 day would be different -- more risky than if he was
17 seeing 8 patients, just to use your hypothetical?

18 A Yes.

19 Q You talked about there is a spectrum about what sick
20 is, and I think, very importantly, you said, And what
21 people perceive as sick. And I'm going to suggest to
22 you that people may not know when they're sick; that's
23 the whole concept of asymptomatic?

24 A Yes, definitely.

25 Q And isn't that why we have things like what are called
26 universal precautions, so that when someone comes into

1 a dentist's office, the dentist says, I'm going to
2 assume you've got Hep B, Hep C, or whatever, we always
3 use universal precautions?

4 A Yes, yeah, that is a term used in infection prevention
5 and control, just the basics for everybody.

6 Q You made a statement, and I'm going to paraphrase here,
7 but I think I've got the wording right, the more people
8 you interact with and the longer you interact with them
9 and the closer you are, the greater the risk of COVID
10 transmission; is that correct?

11 A That's correct.

12 Q So if I'm a dentist or a physician or a chiropractor,
13 and I have closer contact, see more people, have a
14 longer duration with them, the risk of COVID is going
15 to increase?

16 A Yes.

17 Q Or transmission, okay.

18 A Yeah.

19 Q There was a discussion you had with Mr. Kitchen about
20 bacterial infection references and some historical
21 references in your paper, but I want to be clear, your
22 paper focuses on masking and COVID and efficacy of
23 masking?

24 A Yes.

25 Q There was another lengthy exchange between you and
26 Mr. Kitchen about exemptions to masking, and I just

1 want to be absolutely clear on this point, because I
2 think the discussion boiled down to one comment on your
3 part -- or one theme on your part, there should not be
4 exemptions to masking in health care settings in the
5 overwhelming majority of situations?

6 A Yeah, but I will take -- Dr. -- that Mr. Kitchen's
7 projective for health care workers, right, like a lot
8 of patients can't wear masks or, you know, their
9 mental -- like, you know, so I'm not going to deny
10 treatment to an acutely psychotic person coming into
11 the emerg without a mask on, right?

12 Q Yeah, and let me be more clear, there should be no
13 exemptions for health care workers in health care
14 settings?

15 A Yes.

16 Q You had a discussion with Mr. Kitchen about -- and,
17 again, I'm going to paraphrase -- it would have been
18 better if the CMOH orders had provided more detail
19 about exemptions; is that your recollection?

20 A Yes.

21 Q Ideally, you would want, I'm assuming, some criteria
22 for what a medical exemption is?

23 A Yes.

24 Q And a process for getting it, who you get it from, and
25 who that person is and how qualified they are?

26 A Yes.

1 Q I think you, would it be fair to say that when you get
2 a medical exemption, you would want some rigour
3 involved in that exemption process?

4 A Yes, ideally.

5 Q You would want testing, diagnosis, interaction with the
6 patient?

7 A Yes, ideally.

8 Q You'd want to avoid quickie, one-line diagnoses or
9 exemptions?

10 A Yes.

11 Q Would it be fair to say that a physician, for example,
12 shouldn't self-diagnosis his own or her own exemption
13 from COVID?

14 A Yes, for various reasons, but yes.

15 Q Okay. And, particularly, let's say if it was a
16 physiotherapist, a nonphysician, that person shouldn't
17 be self-diagnosing their medical exemption for COVID?

18 A No.

19 Q And can you tell me why?

20 A Well, I mean, I -- in the same way that I, you know,
21 generally do not know very much about the practice
22 of -- you know, like the skill set, knowledge of being
23 a physiotherapist or a chiropractor, you know, so too I
24 imagine most physiotherapists don't know as much about,
25 let's say, providing medical exemptions for masks,
26 respiratory illness, all those things as compared to at

1 the doctor or a physician, it's just how you're trained
2 and what you do.

3 Q So if you had someone who thought they might have an
4 anxiety disorder, they should get that diagnosed by
5 someone who has knowledge and training and experience
6 in anxiety disorders?

7 A Yes.

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

10 MR. KITCHEN: Mr. Chair, there were some new
11 questions there that weren't in response to my
12 questions. I'd like a chance, and this is what I'm
13 going to ask you, I'd like a chance just to ask one or
14 two questions based on what I saw as new questions that
15 were not in response to my questions.

16 MR. MAXSTON: I wouldn't have a problem with
17 that, Mr. Kitchen.

18 THE CHAIR: Okay.

19 Mr. Kitchen Re-cross-examines the Witness

20 Q MR. KITCHEN: Prior to May 14th, 2021,
21 nothing in the CMOH orders said that a third-party
22 diagnosis was required for those who felt that they
23 fell within the exemption clauses in the CMOH orders as
24 far as masking is concerned; is that correct?

25 A I believe you. I'd have to go into the CMOH orders and
26 just double-check, but I think you're right from my

1 experience.

2 Q Why don't I put one to you.

3 A Sure.

4 Q I've got to find one here, that's only fair, and I
5 think May 14th is the right date upon which the CMOH
6 issued a new order specifying who can grant exemptions
7 and the criteria for granting them and all of that.
8 Would you agree with me that it was on or around May
9 14th that happened?

10 A Do you have the CMOH order that did that?

11 Q No, I don't.

12 A Oh, well, I (INDISCERNIBLE) --

13 Q But what I have -- but what I do have is CMOH orders
14 prior to May 14th, 2021. Find one here. So, for
15 example, CMOH Order 38-2020; are you familiar with that
16 one?

17 A Yes, we talked about that one yesterday, I believe.

18 MR. MAXSTON: Mr. Kitchen, that's actually
19 an exhibit, if you want to go to that, it's D-8.

20 MR. KITCHEN: It is? Thank you. It's D-8.

21 Q MR. KITCHEN: Yes, we talked --

22 THE CHAIR: 'D' or 'E'?

23 MR. KITCHEN: 'D', it should be 'D', should
24 be D-8, that sounds familiar. I've got my exhibit book
25 over here. Yeah, it's D-8.

26 Q MR. KITCHEN: Okay, so this is the first

1 CMOH order that brings in province-wide mandated
2 masking, and Dr. Hu, if I could just take you to, and
3 you were here yesterday, I believe --

4 A M-hm.

5 Q -- Part 4 says "Masks", if we go down to Section 27, it
6 says: (as read)

7 A person must wear a mask at all times.

8 Do you see that there?

9 A Yeah, section -- this is on page 6 of 8 of the --

10 Q That's on page 6, and we're at Section 26, it says:
11 (as read)

12 Subject to Section 27, a person must wear a
13 mask.

14 And then Section 27 says: (as read)

15 Section 26 does not apply to a person
16 attending an indoor public place if the
17 person ...

18 And then there's above, I don't know what, about ten --
19 eight or ten different exemptions there, one of which
20 is 'C', it says: (as read)

21 Is unable to wear a face mask due to a mental
22 or physical concern or limitation.

23 You see that there, correct?

24 A Yeah.

25 Q Now, would you agree with me that in this order and
26 subsequent orders up until around -- on or around May

1 14th, 2021, there was no requirement in the CMOH that
2 anybody who is unable, pursuant to Section 27(c),
3 "unable to wear a face mask due to a mental or physical
4 concern or limitation" get third-party authorization
5 for that inability?

6 A Can I ask you a question about this actually? So my
7 read of Section 27, like this is a broader thing to
8 sort of indoor public places, right? I think we should
9 look at the CMOH orders that talk about community
10 health settings as opposed to general --

11 Q Yes, that's right.

12 A Yeah, and so 27 is indoor public places, which is not
13 the same.

14 Q That's right, that's right. And so what I'm asking you
15 about is 38; I'm not asking you about 16.

16 A Okay.

17 Q I'm asking you about 38-2020. So you would agree with
18 me in 38-2020 and in 40 -- I think it's 40-2020,
19 42-2020, 02-2021, et cetera, all the way up until May
20 14th, 2021, you would agree with me that there was no
21 requirement in the CMOH orders for a person saying
22 they're unable to wear a mask to get any type of
23 third-party medical verification of that inability?

24 A I trust you. Like, I mean, I -- like I don't -- I
25 would have to read in greater detail all these orders,
26 but let's assume I agree with you. I mean, I -- yeah.

1 Q Well, you did speak at length yesterday about the CMOH
2 orders, correct?

3 A I did, yes, but they're quite long, and I don't
4 remember every single clause in the CMOH order.

5 Q I understand, but you did say you are fairly familiar
6 with them, generally speak --

7 A Yes.

8 Q And you're familiar with the mandatory mask portions of
9 the CMOH orders?

10 A Yes, and I'm familiar, in particular, with actually the
11 problems that were caused by not providing guidance
12 around what constitutes an exemption and how to get
13 one. I'm more familiar (INDISCERNIBLE) --

14 Q And that's (INDISCERNIBLE) --

15 (INDISCERNIBLE - OVERLAPPING SPEAKERS)

16 A -- yeah.

17 Q Go ahead.

18 A I just don't remember what date, like, that was
19 changed, but you're right, I'm familiar with the fact
20 that like in -- on the series -- I agree with you, in
21 the series of initial CMOH orders, they talk about the
22 exemption, they didn't provide like criteria for an
23 exemption or like who to get an exemption from. It was
24 broadly assumed that people would have to go to their
25 family doctor to get an exemption. Family doctors were
26 getting lots of questions about exemptions, and they

1 were confused about what to do, and that caused a bit
2 of chaos.

3 Q And by the way, it's okay to answer my questions with,
4 I don't know. If you --

5 A Yeah, okay.

6 Q -- do, I'll leave you alone, if you give me that
7 answer --

8 A Yeah, yeah, yeah.

9 Q -- (INDISCERNIBLE) with you because you know a lot, but
10 if you do --

11 A Yeah, no, but I don't know, you're right, I don't know,
12 so there you go --

13 Q Okay, so your answer is to -- my question was is there
14 a requirement in CMOH Order 38-2020 to get the
15 third-party authorization of that inability to wear a
16 mask, is your answer yes, no, or I don't know?

17 A I don't know, but I'm flipping through this, and I'm
18 going to assume -- like I trust you that I -- I don't
19 know, but I believe that you -- like I trust you that I
20 don't think there is one based -- because you're saying
21 there isn't.

22 Q Well, no, I'm asking you.

23 A Well, I don't know, but now I'm just --

24 Q If your answer is, I don't know, that's okay, but your
25 answer shouldn't be you trust me.

26 A Oh, really? Okay, well, I don't know then. But now

1 I'm reading it. Okay, I mean, now I would say, yes,
2 there's no like specific criteria. I just like
3 scrolled through the whole order again.

4 Q And you would agree with me that it was in the month of
5 May 2021 that that new criteria came in?

6 A I don't know. I'm trying to look through the actual
7 CMOH order that led to that one, but I don't know, and
8 I'm trying to find the CMOH order specifically.

9 Q I don't know if it's an exhibit in this case. It
10 wouldn't -- I don't think it would be difficult to make
11 it one; it's a CMOH order.

12 A Yeah, yeah, it's not. I'm just looking for it in the
13 list of CMOH orders.

14 Q Well, if you have -- I have a list, but you might have
15 a better one.

16 A This is from the Alberta Health website.

17 Q I remember the date, but not the number of the CMOH
18 order.

19 A They're hard to track, just so many of them.

20 Anyways --

21 MR. MAXSTON: Mr. Kitchen, it's Mr. Maxston,
22 I'm not going to take issue with this point, the CMOH
23 orders are the CMOH orders. If I can respectfully
24 suggest, you can go on with your questions, you're not
25 going to hear from me later on there wasn't a CMOH
26 order that spoke at some time, at some date with some

1 type of criteria if you produce that order, so I --
2 just in the interest of time, I thought I'd make that
3 comment.

4 MR. KITCHEN: Well, maybe I'll produce it,
5 because it seems like it's probably going to be good
6 to. No, that was it. That's all I wanted to ask.

7 A Thank you.

8 THE CHAIR: Okay, Dr. Hu, thank you very
9 much. I would ask you to just bear with us; we're
10 going to have a brief recess while the Hearing Tribunal
11 Members caucus to see if we have any questions of you,
12 so --

13 A Sure.

14 THE CHAIR: -- just give us a couple
15 minutes here, and we will be back. Get up and have a
16 stretch if you want. We'll be back before long. Thank
17 you.

18 A Thank you.

19 (ADJOURNMENT)

20 Discussion

21 THE CHAIR: Dr. Hu, the Hearing Tribunal
22 has met, and we do not have any further questions for
23 you, so I will take this opportunity to thank you very
24 much for your time and your testimony. I'm sure you're
25 a busy man, and I'm sure we all wish you continued
26 success in dealing with this particular problem at this

1 time. And I will also apologize if I mispronounced
2 your name. I apparently called you Dr. Ho, which is
3 unforgivable. But anyway, thank you, and you're free
4 to go, and hopefully we won't need to call you back.

5 A Yeah, no, no, thank you so much for having me, and I'm
6 sorry for talking over people, Karoline, and it was a
7 pleasure to meet you all, and sorry for being
8 long-winded and all that jazz, but have a good day.

9 THE CHAIR: Thank you, take care.

10 A Bye.

11 THE CHAIR: Bye.

12 (WITNESS STANDS DOWN)

13 THE CHAIR: So it's 12:15. Mr. Maxston,
14 is your next witness available for 1:00, or do we know
15 that?

16 MR. MAXSTON: He is. I can certainly make
17 him available for 1, and that would be Dr. Halowski.

18 THE CHAIR: Yes, I think that's the next
19 step; is that correct? So why --

20 MR. MAXSTON: Yes.

21 THE CHAIR: -- don't we meet -- did you
22 have any thoughts, Mr. Kitchen?

23 MR. KITCHEN: Well, I prefer an hour for
24 lunch, but I think most people prefer to have a quick
25 lunch and get out of here sooner, so I'm fine with
26 that.

1 THE CHAIR: If we want to take an hour, we
2 can take an hour, that's ...

3 MR. MAXSTON: I have no problem, neither
4 does my client with taking an hour break. We had a
5 pretty intense morning, so we're in your hands,
6 Mr. Chair.

7 THE CHAIR: Okay, well, let's reconvene at
8 1:15 with Dr. Halowski. I think you're right, it was a
9 fairly full morning, and it would be good to get away
10 from the computer screen and the pen and paper for a
11 little while. So thanks everybody, we'll see you at
12 1:15, and we are now in recess until 1:15 for the
13 record.

14

15 PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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

4

5 September 2, 2021

Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees

Tribunal Chair

9 W. Pavlic

Internal Legal Counsel

10 Dr. L. Aldcorn

ACAC Registered Member

11 Dr. D. Martens

ACAC Registered Member

12 D. Dawson

Public Member

13 A. Nelson

ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 D. Lawrence

ACAC Complaints Director

17 B.E. Maxston, QC

ACAC Legal Counsel

18

19 FOR DR. CURTIS WALL

20 J.S.M. Kitchen

Legal Counsel

21

22 K. Schumann, CSR(A)

Official Court Reporter

23

24 (PROCEEDINGS RECOMMENCED AT 1:18 PM)

25 THE CHAIR:

This Hearing Tribunal is back

26 in session. It's 1:15, and I believe we are at the

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

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

7 A I'm happy to affirm.

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

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

10 MR. MAXSTON: Just for the Tribunal's
11 benefit, I'm going to be asking Dr. Halowski questions
12 in six areas. The first is some -- the first area is
13 some very brief questions about his background. The
14 second area is going to be some questions, again
15 relatively brief, about his role as Registrar at the
16 College. Third area I will be asking questions about
17 is generally the functions of the College. The fourth
18 area I'm going to ask questions about are the
19 educational background for chiropractors and to ask
20 Dr. Halowski to discuss briefly the educational
21 information the College has on its registration file
22 for Dr. Wall. The fifth area I'm going to take
23 Dr. Halowski to are the CMOH orders and the Pandemic
24 Directive and what I will call the ACAC notices and web
25 blasts and things that were sent out to the members,
26 which are Exhibits C-1 to C-22. And then the final

1 sixth area I'll be asking questions of Dr. Halowski
2 about is his specific involvement in the Wall
3 complaint.

4 So skipping to the first area then, Dr. Halowski,
5 I understand that you are the Registrar for the
6 College. Are you also a licensed practicing
7 chiropractor?

8 A I am.

9 Q Can you tell me about what your chiropractic education
10 is and your employment history in the profession?

11 A Yeah, I graduated from Palmer College of Chiropractic
12 in 2005. Since then, I entered private practice in
13 September of 2005 and have been a practicing
14 chiropractor until 2019, when I left full-time practice
15 and became the Registrar of the College.

16 I am still currently practicing in a part-time
17 capacity, with my role as Registrar demanding the
18 majority of my time, and right now I'm practicing part
19 time in Sherwood Park as an associate in a clinic.

20 Q Thank you. Going to the secondary, I think you
21 mentioned you became Registrar in 2019 then?

22 A M-hm, yes.

23 Q Okay, can you tell me before you became Registrar, did
24 you have any positions or other involvement with the
25 College?

26 A Yeah. I had started volunteering with the College I

1 think in 2007 or 2008 -- or with the ACAC. At that
2 time, I was on a fee negotiating committee, which is an
3 association activity versus the College.

4 In 2014, I was asked to become an investigator for
5 the ACAC, which is a College activity. I received
6 investigator training with Field Law at the time, and I
7 think I started into investigations shortly thereafter,
8 where we would participate as an investigator under
9 Part 4 of the HPA. In 2015, I was trained also as a
10 member of a -- to be a member of a hearing tribunal.
11 During that time, I actively participated in
12 investigations but never served as a member of the
13 hearing tribunal.

14 Q Now, I understand you have the title of Registrar and
15 you carry out Registrar duties, but there is also a,
16 I'll call it a management or administration function
17 you carry out as well. Can you tell me what -- first
18 of all, what your duties are as Registrar?

19 A Yeah, the Registrar, we primarily focus -- that role
20 primarily focuses on registration and registration
21 decisions and also membership renewal in a year, so
22 we're making sure that those people that are joining
23 the profession meet the requirements that are set out
24 by council or under the Health Professions Act, and
25 then we also, for renewal, we perform that same duty,
26 and that would be very specific to the Registrar role.

1 Beyond that, I'm also the director of regulatory,
2 and in that capacity, I oversee the regulatory programs
3 administered by the College. Specifically, I look
4 at -- I work with the complaints, and I am aware of
5 what's going on in the complaints department, I work in
6 the continuing competence. I also oversee things like
7 professional corporation and some of the other duties
8 that go on on an ongoing basis like professional
9 corporation renewal and membership renewal and the
10 other things that go on in a year that the College
11 administers on behalf of the members.

12 Q You've helpfully gone to my second area of questioning
13 here, which is what your other duties are over and
14 above Registrar. In your -- I'll call it your
15 management or administration duties you described, do
16 you work with council at all?

17 A Yes, I attend all council meetings, and one of the
18 roles that I have is, because I am a clinician, I
19 advise council on clinical matters as well, so for
20 consideration. Our council is composed right now of
21 six chiropractors and two public members. We are
22 waiting for more public members to be appointed so that
23 that does go to an equal representation.

24 So my role is also in providing practice
25 information and being a consultant to council on areas
26 of that and advising council on policy -- recommending

1 policy to support the safe practice of chiropractic in
2 the Province of Alberta.

3 Q And I take it -- I'm going to take you to Pandemic
4 Directive in a few minutes, but I take it you were
5 given assignments from time to time to become involved
6 on certain projects and things like that?

7 A That is a hundred percent correct.

8 Q Okay, I'm going to go to my third area of questioning,
9 which is just to talk a little bit about the College.
10 Can you explain the role of the College and what its
11 mandate is?

12 A Absolutely. The best -- you know, if we look at it
13 very high level, a college, a regulatory college has
14 two duties: Protection of the public and professional
15 competence. And at a high level, protection of the
16 public comes down to setting standards, Codes of Ethics
17 and bylaws that set the guidelines and direction that
18 members must follow when they're practicing.

19 And then there's the whole aspect of complaints
20 that a college oversees. So when a complaint or
21 concern comes from the public, how we address it and
22 how we respond is one of the primary functions that is
23 in the Health Professions Act.

24 And then the other is the competence component, is
25 identifying the competence programs that are there, how
26 they're operating, is it meeting the intended goals,

1 highlighting what competencies may need extra attention
2 from members due to -- our practice visit program will
3 observe patterns or trends in practice, and that may
4 result in recommendations to counsel on ways that we
5 can improve the competence requirements that the
6 profession meets as part of being a regulated member.

7 Q In keeping with your comment about sort of a high-level
8 view of the College and its role, I don't need you to
9 go to this section of the HPA, the Health Professions
10 Act; are you familiar with Section 3 of the HPA?

11 A That is -- that defines specifically the roles that a
12 college must fulfil or the reason that we exist.

13 Q Is public protection part of the College's role?

14 A That is -- absolutely. That's -- when we talk about
15 that public protection is our -- the primary mandate
16 that we have is making sure that we are producing -- or
17 protecting the public in -- is our primary
18 consideration.

19 Q You talked a few minutes ago about the College creating
20 bylaws and Standards of Practice and Codes of Ethics,
21 is the creation of a Code of Ethics and a Standard of
22 Practice is that a mandatory duty under the HPA?

23 A Yes, it is. It's mandatory, and they need to be
24 consulted with members but adopted by council, and once
25 they are adopted, they do become binding upon the
26 membership. And it's the standard under which, when we

1 look at it, that we enforce conduct based on the
2 Standards of Practice. And some people look at
3 standards are -- you know, really, one of the
4 considerations there that's really important, and it's
5 a discussion often is that they're meant to be the
6 minimal acceptable level of performance that our
7 members must meet.

8 Q Okay. I'll get to this later in some more detail,
9 questioning with you on the Pandemic Directive and some
10 other things, but are some of those Standards of
11 Practice, are they mandatory in nature?

12 A That's a great question. I would say all Standards of
13 Practice are meant to be mandatory. There is specific
14 languaging in them that highlights -- when we see the
15 word "must", they are mandatory; that is an absolute
16 that must be followed.

17 Sometimes you'll see the word "may", which is
18 meant to leave that to the professional judgment of the
19 member, and so -- but they are meant to define
20 practice.

21 Q I'm going to move to then the fourth area of questions
22 I wanted to chat with you about, and that is, again,
23 the educational background for chiropractors generally
24 and what Dr. Wall's education is reflected in the
25 College's records. So I'll just start off with a
26 general question, are you familiar with the education

1 generally required to become licensed as a
2 chiropractor?

3 A Absolutely. Yeah, would you like me to describe that
4 for you?

5 Q Yeah, if you could.

6 A Absolutely. So the majority of chiropractors are
7 trained here in North America. Most, who are in the
8 entry school, have some form of undergrad education
9 with -- meaning they'll have a Bachelor's degree or
10 some have advanced degrees in Masters of Science or
11 other components.

12 A chiropractic program has very set requirements
13 to go through that are defined by the council -- well,
14 they're defined by the regulators, but they're put
15 forward by the council on chiropractic education, and
16 chiropractic colleges are -- must be accredited, or a
17 chiropractor that practices must be accredited and
18 leave an institution that's accredited in order to be
19 eligible to licence in Alberta.

20 A And so -- but those requirements cover over
21 aspects of delivery of health care and broad ranges of
22 topics that prepare us to be clinicians.

23 Q As part of the education that chiropractors receive to
24 get their degree, is there a required component for
25 public health education?

26 A There is, yeah. So we do have a very, very -- we do

1 have two courses that may apply. We have one in kind
2 of microbiology, which is a component that is
3 considered. And then we actually have specific courses
4 in public health, and more of an introductory -- I
5 would call an introductory course. They are not meant
6 for chiropractors to be prepared to manage public
7 health situations; it's meant to understand kind of the
8 implications of public health and to understand how our
9 role is relative to public health.

10 Q Are there any specific training or educational
11 requirements then in any of these approved programs
12 relating to infection prevention and control, for
13 example?

14 A There would be, relative to practice, there would be
15 things like hand hygiene and so on like this. Never
16 during our training initially would we have been
17 exposed to things like PPE or personal protective
18 equipment. It wasn't a consideration because
19 chiropractors are not typically working with an
20 infectious population; you know, we're not having
21 people come in that could be highly infectious or
22 contagious with different things. So we tend to run
23 and work from that point of view of -- around
24 neuromusculoskeletal conditions.

25 And so with that, PPE isn't typically used, nor do
26 we work with body fluids typically. Gloves may be

1 another thing we're exposed to; i.e., if we're working
2 in or around the mouth or on the face in treating,
3 chiropractors may use gloves to work with in the mouth
4 or in intraoral situations.

5 Q Is there any required training then in these programs
6 for how to address viral outbreaks or pandemics?

7 A I -- so I'll speak personally, I graduated in 2005. I
8 took my public health training in 2003 or 2004, and we
9 were not advised to any such learning during education.
10 It is something that is, I would say, has been a gap in
11 our education up to now, and given the current
12 environment that may adapt, but I can't speak to that.

13 Q I'm going to ask you a question about the chiropractic
14 profession sort of generally, but are there
15 chiropractors who take the position that chiropractic
16 care can strengthen the immune system?

17 A There is. That is an issue within the profession where
18 some chiropractors do believe that by providing
19 chiropractic care that they may prevent illness or
20 prevent infections. We do know that there has been
21 research focused on that in the last couple of years
22 that has come out and said that there isn't evidence to
23 support the position that chiropractic care is an
24 effective treatment for many immune-based disorders
25 such as infections or common colds or flus.

26 Q Okay, I'm going to switch gears a little bit here in

1 this fourth area I'm asking you questions about. Have
2 you been able to review Dr. Wall's registration file
3 with the College?

4 A I did go through and look at that just to confirm the
5 details for this file, yeah.

6 Q Can you tell me where Dr. Wall was educated?

7 A Yeah, Dr. Wall was educated at Palmer College of
8 Chiropractic in Iowa, the same place I was.

9 Q And do you know when he graduated?

10 A On his transcripts, it identifies October 18th, 1996.

11 Q And do you know when he became licensed with the
12 Alberta College?

13 A Yeah, that, in our records, indicates that he was
14 originally -- his initial joining with the College was
15 December 2nd of 1996.

16 Q Now, you mentioned before that you were involved in
17 managing the required continuing competence program for
18 chiropractors, and I should say that's a mandatory
19 requirement, to maintain your continuing competence?

20 A M-hm.

21 Q And to meet the College's requirements for continued
22 competence?

23 A That's correct. Yes, we have set requirements on an
24 annual basis, and so annually all chiropractors are
25 required to complete a minimum of 24 continuing
26 competence credits. That's usually obtained through

1 seeking further development in courses, seminars, or
2 different things. Those could focus on anywhere from
3 assessment right through to treatment in that, or they
4 could be more informationally based in their
5 presentation.

6 And further, that we also currently have required
7 recordkeeping, we have a required -- all members must
8 demonstrate competence in first aid, right? And then
9 we -- since the introduction of Bill 21, all members
10 must annually demonstrate that they've taken trauma
11 informed training.

12 Q When you look through Dr. Wall's continuing -- well, I
13 should go back, did you look through Dr. Wall's
14 continuing competence history with the College?

15 A I have reviewed Dr. Wall's continuing competence
16 history in his profile, and in reviewing that, I did
17 look back to see what kind of continuing competence,
18 and there is no record of Dr. Wall completing any
19 continuing competence around the treatment of
20 infection, nor anything to do with practicing during a
21 pandemic or any kind of public health training.

22 Q Okay. I want to go to the next area of my questions
23 for you, which is the CMOH orders and the Pandemic
24 Directive. I'm going to take you to the CMOH orders
25 specifically and the Pandemic Directive specifically,
26 but I'd just like you to begin with some -- giving me

1 some background, some history about what was happening
2 with the College in I believe late March of '20, 2020,
3 and the CMOH orders that were coming out and what the
4 status of the profession was at that point.

5 A Absolutely I can talk to that. So in -- I think it was
6 right around the middle of March where there -- you
7 know, there was -- we started to see some notices
8 coming from Dr. Hinshaw about the presence of the novel
9 Coronavirus here in Alberta. As that escalated, we
10 kind of watched -- on March 27th, CMOH order I think it
11 was 7 was issued that effectively closed all health
12 care except to urgent care.

13 Once that came down, that was I think both a very
14 psychological blow to Albertans but also, speaking to
15 our profession, was a psychological blow to many of my
16 colleagues, right? It was a very tough time to see us
17 shut down. You know, it wasn't something that we
18 planned for, prepared for, would have expected in our
19 lifetime.

20 One of the things that became very acutely aware
21 is that our members didn't have any skill set around
22 practicing in a pandemic, and there was a lot of
23 confusion. This was novel. There was a lot of
24 discussion around how it -- you know, the risk, the
25 severity, all those things like this, but one of the
26 things we set about doing as a college right away, and

1 we advised council and were given direction to go in
2 that direction is to prepare a guide or directive for
3 members to follow during the pandemic so that they
4 would know how to practice safely and have kind of a
5 guideline to practice during a pandemic.

6 And so we set about doing the research, reviewing
7 the documents that Alberta Health was publishing, other
8 information that was available at that time.
9 Ultimately though, we did look at Alberta Health as a
10 guide, because they were advising practice and health
11 care workers in the province on how to practice safely
12 during a pandemic.

13 Q So that's late -- I think you said March 27, that's
14 late March where you're starting this effort or looking
15 at this question, this issue. Did you consult with any
16 other regulators in the province or outside the
17 province about what they were doing for the -- their
18 response to pandemic issues?

19 A Absolutely. During that time, in Alberta, there's
20 something called the Alberta Federation of Regulated
21 Health Professions, and that would be kind of like --
22 it's like a -- I don't want to call it a working group,
23 but it's a federation, we actually work together and
24 address issues together. And many regulators face
25 common issues, and so I know there was discussions
26 going on amongst Alberta regulators in that group on

1 exactly the impact to the environment introduced by the
2 novel Coronavirus.

3 Also at that time, the ACAC as a member of the
4 FCC, which is the Federation of Chiropractic Colleges,
5 which is all the Canadian chiropractic regulators
6 across the country. And all provinces were shut down
7 at that time as a result of Coronavirus, and so why
8 was -- one of the things that we were doing was sharing
9 what we were looking at in developing.

10 And during that time, in Alberta, we're really
11 lucky, we actually have one of our members, who is a
12 published microbiologist who we were able to consult
13 with, we consulted with our competence committee,
14 because we really wanted to contextualize how to
15 practice safely during the pandemic to chiropractors
16 and make those considerations.

17 So we consulted with regulators to understand kind
18 of the environment, the Alberta regulators, which are
19 not chiropractors, but every other profession, on
20 practicing safely, and then we consulted with
21 chiropractic regulators from across the country and
22 were very proactive in developing kind of a plan and a
23 guide. And, you know, it took us a lot.

24 What we ended up with is what I would call a
25 summit of documents. So there was a lot of
26 information, and we kind of compiled it into different

1 areas, things like hand hygiene, we compiled it into
2 areas on physical distancing, we compiled it into areas
3 on personal protective equipment, and, you know,
4 infection prevention and control. And what would we
5 require, what would we not require.

6 And then once we developed all of that, we
7 actually initiated a member consultation where all
8 members had an opportunity to review what we developed
9 and provide comments.

10 In addition to that, that was conducted via two
11 things, we had town halls where we could talk and
12 listen; we also had a digital consultation, where
13 members were able to provide responses. And then once
14 we had those consultations, we took the information
15 back and prepared revisions to what we put forward. We
16 listened to the membership, and we had a lot of
17 information to contextualize, how to inform safe
18 practice during a pandemic.

19 And then -- so that's kind of where we went to.
20 That was April 22nd, 23rd, we were consulting. The
21 next week, by April 29th, we were meeting with council
22 with what was a plan, which we do call the Pandemic
23 Practice Directive. And so that was by -- and then
24 that was published, we reviewed that, council had some
25 corrections. We came back to them a day later, and
26 they adopted that, which we were then able to prepare

1 and publish to the membership.

2 Q Okay, I want to skip back to something you said before
3 that -- and I think you used the word "direction", that
4 you felt it was important to give clear direction to
5 chiropractors. Why was it important to do that?

6 A Well, one of the things that we experienced and we had
7 to be really clear with the membership, and I think
8 some of that goes back to, one, we're not trained to
9 practice; we were never trained to originally practice
10 in that environment. It wasn't a consideration of our
11 training.

12 The second one is that within the profession, we
13 do see a diversity in membership, where, you know, some
14 members, even to this day, I think really struggle with
15 the idea that they shouldn't be offering adjustments to
16 treat COVID. And so when I look at that, like that
17 direction was required in order to provide -- and for
18 us, our primary concern was making sure that what we
19 were doing was going to be safe for the public to meet
20 our mandate as a College. We have that obligation to
21 protect the public, and so we needed to provide a way
22 for our members to practice as safe as possible for the
23 public during a pandemic.

24 Q So before the Pandemic Directive was created, was there
25 any type of significant training or exposure in PPE
26 that chiropractors would have had?

1 A I don't -- not to the degree that was required during
2 the pandemic. I would say, you know, some
3 chiropractors were very aware of when to use gloves,
4 but as far as things like face masks, face shields,
5 gowns, or other PPE, there was a low level of uptick in
6 consumption amongst members.

7 Even now, I can speak to members, and some of
8 them, you know, around some of -- they kind of go, Oh,
9 this has actually been really helpful. It's really
10 helped me reframe how I'm going to practice and how to
11 make considerations for safe practice going forward.

12 And one thing too, Mr. Maxston, that we have to
13 consider is that a lot of the information we present
14 here is actually in our standard of practice. Like
15 there's nothing that we presented that was new. We
16 just provided direction per the Health Professions Act
17 on informing practice according to the standard of
18 practice.

19 Q I want to skip back. You talked about two
20 communication modes you used. I think, I'll let you
21 clarify the time period, but I think it's March and
22 April of last year being town halls and digital
23 consultations. What was the purpose of having that
24 communication?

25 A We wanted to -- you know, it's really important for us,
26 like we are a very transparent organization, and you

1 know, like just like our members, this was novel for
2 us, and so we were doing our absolute best to make sure
3 we provided a safe environment for the public, but we
4 also needed to make sure that it's enforceable.

5 Remember, when we talk about Standards of Practice
6 or practice direction has to meet a minimally
7 acceptable level. It's not about ideal or being
8 aspirational; it's a minimal acceptable level of
9 performance and in the context of practicing safely.
10 And so, you know, well, we go there, we want that
11 perspective from all of our membership.

12 And so we did conduct two consultations. We had
13 town halls that, you know -- where they could actually
14 ask questions, provide feedback in a live way. We
15 could go through, listen to them, respond, and all
16 those kinds of communications.

17 And the second is we used a platform called
18 ThoughtExchange, which allowed us -- you know, they
19 could read the whole practice directive and then
20 provide any feedback they chose to anonymously. We had
21 a high uptick, we had over 356 unique IP addresses
22 provide feedback to that. I'd like to think that that
23 was significant, considering our membership at the time
24 was probably around between 1150, 1200 members. You
25 know, so I think that that's at 25 percent of our
26 membership were actively providing feedback.

1 And it came on a spectrum at that time as well.
2 It wasn't all like, This is great. Some people really
3 challenged and helped to inform, you know, and maybe
4 some of the things, hey, this shouldn't be used now, or
5 we should do this now.

6 So where we got to after consultation was a place
7 that really represented -- it was a great way for us to
8 understand the climate of the membership and also to
9 advise council on how to adopt a directive that was
10 going to keep the public safe.

11 Q I think I want to skip back again, was there a
12 particularly -- was there a large or significant risk
13 that you identified when you were putting together the
14 pandemic derivative?

15 A The risk for our membership, there was a couple. One
16 is that, you know, if I speak about it, there's kind of
17 two ways I can look at this, so even during the
18 development of it, we would have -- we receive emails
19 from people going, Oh, this is -- you know, why are we
20 doing this, we shouldn't be shut down. One of the
21 biggest concerns for chiropractors, we should be
22 considered essential services, and essential services
23 didn't have to shut down during COVID, right? And so
24 that was -- we got a lot of communication around that.

25 When we started looking at it and asking, well,
26 what do you mean; you know, a lot of our membership

1 wanted to understand, well, we want to be safe, how do
2 we practice safe, why weren't we considered to be safe
3 at this time. And so there was obviously some
4 questions around that that came in, but a lot of it was
5 also around things like, you know, like hand hygiene.

6 You know, one of the practices we identified is
7 that chiropractors really need to be consistent in
8 their hand hygiene, when they apply it, how to apply
9 it. PPE was one that we recognized that the membership
10 really needed to -- we needed to be able to advise a
11 member on the safe and effective use of PPE according
12 to the evidence that was available.

13 And so the -- we really went through the stuff
14 that the Medical Officer of Health was instructing, who
15 was obviously the lead -- leading the response to the
16 public health crisis or pandemic that we were
17 experiencing, so we looked at that kind of feedback.

18 Q Was close body contact a concern?

19 A It was for us, because we do work very close -- I mean,
20 when we're actually delivering care to a patient, the
21 hands-on care that chiropractic is known for, we're
22 right over top. We stand and breathe on a patient,
23 sometimes like less than a foot away from their face.

24 Similar like -- to contextualize it, some members
25 on the Hearing Tribunal may have been to a
26 chiropractor, some, they haven't, but think of like

1 when a dental hygienist or a dentist is working on you,
2 where they're leaning over top, when we're caring for
3 patients, we're right there, and so that close contact
4 is there. There's other things where we do work are
5 maybe not as close or our faces aren't in close
6 proximity. Sometimes when we do assessments, like
7 ophthalmological assessments or doing some of the other
8 things, we're like face to face and mouth to mouth --
9 well, close to mouth to mouth with patients. So that
10 was an important consideration we had to make.

11 Q I should go back, was masking intended to address that
12 risk?

13 A Absolutely. Masking was identified in what we were
14 looking to be a measure that would ensure that we
15 reduce the risk of transmission of COVID.

16 Q I'm going to take you to CMOH Order 16-20 [sic] in a
17 little while, but I'll just stay in this area of the
18 Pandemic Directive and how it was developed. I
19 understand that under Order 16-2020, you are required
20 to or were required to send your directive to
21 government for review; did that occur?

22 A That did. We sent that and submitted that to
23 government on May 1st. So prior to the releasing of
24 that, we had some opportunities to have phone calls
25 with Dr. Hinshaw and a couple other representatives. I
26 believe Martin Tyre [phonetic] was one of them as well,

1 who was head of the emergency operations centre at that
2 time. And they were very specific to us in the
3 guidelines that they were looking for, and that we
4 would need to submit that in order for our
5 practitioners to be able to return to practice when
6 things opened back up.

7 Q Give me a moment, Dr. Halowski.

8 A Okay.

9 Q Did you receive any feedback from the CMOH about the
10 Pandemic Directive before you adopted it then?

11 A No. We were able to adopt it and advised our
12 membership that they could return to practice right
13 away.

14 We did have one follow-up inquiry specific to what
15 we were advising employers, but we did point them to
16 the section of the practice directive that covered
17 that, and they were satisfied.

18 Q In your consultation with CMOH, did they ever ask about
19 an exemption for members under the masking requirements
20 of the Pandemic Directive?

21 A There was no expectation in any of the Alberta Health
22 literature we reviewed in developing that us in the
23 proximity, because we're always going to be breaching
24 that 2 metre physical distance that has been identified
25 very early on, that there would be exemptions for that
26 close of practice.

1 We did recognize, like -- yeah, so there was never
2 any thought of an exemption, because we are always
3 going to breach when delivering physical care to a
4 patient, that 2 metres.

5 Q I'm going to skip ahead. I'll ask you some more
6 questions in a little about this, but did the College
7 recognize or identify in any way that treatment could
8 be provided outside of that 2 metre space?

9 A Yeah. So one of the things that we did do in very
10 early March -- I was so focused on the practice
11 directive, I forgot to mention it, but we had developed
12 and council had adopted Telehealth, and so Telehealth
13 and Telerehabilitation is a practice. It's not
14 obviously the same as providing physical care, but it
15 was a way for us to consult with patients, it is a way
16 for us to instruct patients on movement, exercises, and
17 shown to be effective for mitigating many common MSK
18 conditions through education and instruction.

19 Q And "MSK" means, just for those of us --

20 A Oh, yeah --

21 Q -- who aren't chiropractors?

22 A -- fair enough, I apologize. So "MSK" or NMSK means
23 neuromusculoskeletal, so the common conditions that
24 chiropractors do see patients for.

25 MR. MAXSTON: Mr. Chair, I'm going to ask
26 you and your colleagues to turn to Exhibit F-1, which

1 is the government relaunch document. Just wait a
2 little bit to make sure everybody's literally and
3 figuratively on the same page, and I'm going to be
4 looking at the top of page 2 of that 5-page document.

5 Q MR. MAXSTON: Dr. Halowski, are you familiar
6 with this document?

7 A I am. This document actually -- I'm very familiar with
8 it, because when they first announced, it was very
9 contentious because they did not specifically list
10 chiropractors to be able to return to work on May 4th,
11 and so we had to seek clarification to provide that for
12 our members.

13 Q Well, that's right where I was leading you. On the top
14 of page 2, there's a second bullet. Maybe I'll just
15 ask you to read that.

16 A (as read)

17 Dental and other health care workers, such as
18 physiotherapist, speech-language
19 pathologists, respiratory therapists,
20 audiologists, social workers, occupational
21 therapists, dieticians, and more will be
22 allowed to resume services starting May 4th
23 as long as they are following approved
24 guidelines set by their professional
25 colleges.

26 Q So just two questions. We talked about "and more", I

1 take it you received confirmation that chiropractors
2 were in the "and more" category?

3 A We did, yes.

4 Q And as long as they were following approved guidelines,
5 did they tell you that was mandatory then, the CMOH?

6 A Yes, that we had to actually submit that before our
7 membership could return to practice.

8 MR. MAXSTON: So, Mr. Chair and Tribunal
9 Members, I'm going to ask you to go to CMOH Order
10 16-2020, which is Exhibit F-2.

11 Q MR. MAXSTON: Dr. Halowski, you weren't
12 present for Dr. Hu's testimony, but I took him through
13 this, but I'm going to ask you some specific questions
14 about it, given your direct role in the College in this
15 regard.

16 Are you familiar with this document?

17 A Yes, I am.

18 Q Can you tell me what the second numbered paragraph,
19 number 2, says?

20 A Would you like me to read it?

21 Q Sure.

22 A (as read)

23 Effective May 4th, 2020, and subject to
24 Section 6 of this order, a regulated member
25 of a college established under the Health
26 Professions Act practicing in the community

1 must comply with the attached workplace
2 guidance for community health care settings
3 to the extent possible when providing a
4 professional service.

5 Q Does that attached guideline that's attached to this
6 order, does it require masking?

7 A It does. There's two references to it in there, and
8 specifically, I'll just find them and share them with
9 the Tribunal. On page 3 of Appendix A for that, for
10 prevention, it does highlight personal protective
11 equipment. And then on page 9, it does go further into
12 defining that: (as read)

13 All staff providing direct client/patient
14 care or working in client/patient care areas
15 must wear a surgical/procedure mask
16 continuously at all times and in all areas of
17 the workplace if they are either involved in
18 direct client/patient contact or cannot
19 maintain adequate physical distancing [which
20 they defined as 2 metres] from
21 client/patients and co-workers.

22 Q I'm going to ask you to skip ahead to paragraph 6. Can
23 you tell me what that says in this CMOH order?

24 A Yes: (as read)

25 Section 2 of this order [meaning the section
26 that we just read] does not apply in respect

1 of a regulated member under the Health
2 Professions Act whose college has published
3 COVID-19 guidelines as required by Section 3
4 of this order.

5 Q So let's go to Section 3 then. I'll ask you to look at
6 that, read that in, and tell us what that means to you.

7 A Yeah: (as read)

8 Subject to Section 5 of this order, each
9 college established under the Health
10 Professions Act must as soon as possible
11 publish COVID guidelines applicable to the
12 regulated members of the college that are
13 substantially equivalent to the guidance set
14 out in the workplace guidance for community
15 health care settings developed by Alberta
16 Health along with any additional guidelines
17 to the usual practices of the regulated
18 profession.

19 Q So the option here was, under item 2, you could use the
20 guidance document that they have with mandatory
21 masking, or the College could create its own?

22 A Yes.

23 Q And was this a condition to re-opening?

24 A That was what was indicated to us, and that is the
25 information we had from the Medical Officer of Health,
26 so the -- so that was our exact understanding that this

1 was a condition.

2 Q So was it a requirement to practice then?

3 A Yes, and it was adopted by council motion.

4 Q Can you tell me what paragraph 4 -- paragraphs 4 and 5
5 say?

6 A Yeah: (as read)

7 Each college must provide the Chief Medical
8 Officer of Health with a copy of any COVID-19
9 guidelines published in accordance with
10 Section 3 of this order.

11 And then Section 5 says: (as read)

12 The Chief Medical Officer of Health may amend
13 any COVID-19 guidelines created by a college
14 under Section 3 if the Chief Medical Officer
15 of Health determines that the guidelines are
16 insufficient to reduce the risk of
17 transmission of COVID-19 in the practice of
18 the regulated profession.

19 Q I think a few minutes ago, you told me that you
20 complied with Order Number 4, you provided to the
21 Minister of Health, and just to be clear, did you
22 receive amendments from the CMOH; did you get any
23 amendments from them?

24 A We did not amend our practice directive due to any
25 feedback from the CMOH. There was no feedback provided
26 that we needed to amend anything or make further

1 considerations to reduce the risk of COVID-19 in
2 chiropractic practice.

3 Q I'm going to ask you to go to CMOH Order 38-20, which
4 is Exhibit D-8. This is a November 24, 2020 CMOH
5 order. I'm going to ask, Dr. Halowski, you and
6 everyone to go to part 4 on page 4.

7 THE CHAIR: Sorry, which number was this?

8 D --

9 MR. MAXSTON: Sorry, Mr. Chair, this is
10 Exhibit D-8.

11 THE CHAIR: Okay.

12 MR. MAXSTON: And it's CMOH Order 38-20.

13 Q MR. MAXSTON: So, Dr. Halowski, I'm just
14 going to ask you to go to paragraphs -- well, I've
15 taken you to page 4, which talks about masks and the
16 geographic application of this order, but I'm going to
17 ask you to go to paragraphs 23 and 24, and can you tell
18 me what those two sections mean or what you interpreted
19 them to mean?

20 A Yeah. So we took a very literal look at this: (as
21 read)

22 For the purpose of part 4 of this order, a
23 "public place" has the same meaning given to
24 it in the Public Health Act but does not
25 include a rental accommodation used solely
26 for the purpose of a private residence.

1 And then 24 says: (as read)

2 For the purpose of this order, a "face mask"
3 means a medical or nonmedical face mask or
4 other face coverings that cover a person's
5 nose, mouth, and chin.

6 When we saw this and had an opportunity to read this,
7 one of the things that we did look at is is a
8 chiropractic office a public space. And at that time,
9 we were under direction that appointments were by -- or
10 if we were to control our environment, so who was
11 coming into the office was by schedule. And we
12 interpreted this, and the interpretation was that
13 chiropractic offices are, for the intent of this, a
14 private space, meaning that we control who's in the
15 office or can control who receives care at the time.

16 And then face masks under this order, one of the
17 things when we looked at this, we reviewed and
18 recognized that, you know, when they start talking
19 about cloth face masks and the other, we knew that this
20 didn't specifically apply to chiropractors as the
21 requirement was that we had to wear at least a Level 1
22 surgical procedural mask as identified in the practice
23 directive.

24 So when we saw this section, we saw it as applying
25 not to our profession but to the public and more of a
26 guidance for the public on what they should be doing.

1 And I think this is when the Province started to
2 institute their provincial face mask guidelines and
3 requirements.

4 Q So let's go to paragraph 26 of this order, and we there
5 have a -- I'm going to ask a question -- but it says:
6 (as read)

7 Subject to Section 27, a person must wear a
8 face mask at all times while attending an
9 indoor public place. For greater certainty,
10 an indoor public place includes any indoor
11 location where a business or an entity is
12 operating.

13 Chiropractic clinics would be covered by that?

14 A Correct.

15 Q There's an exemption in paragraph 27(c) of this order.
16 You're aware of that exemption?

17 A I did read that, yeah. We had read that when it was
18 published.

19 Q Okay, I'll have some questions for you later on about
20 the exemption and the Pandemic Directive ultimately.

21 I'll get you to now go to and everyone to go to
22 Exhibit D-9, which is CMOH Order 42-20, and the date of
23 that order is December 11th, 2020. And, Dr. Halowski,
24 I will get you to go to paragraphs 23 and 24, which are
25 on page 5 of that CMOH order.

26 A M-hm. Yeah, I'm there.

1 Q I could ask you to read these in, but are these
2 substantially similar, if not identical, to the
3 equivalent provisions in the last CMOH order we looked
4 at?

5 A Yes, they are, on a quick reading, yes.

6 Q And there's the same exemption there in 24(c)?

7 A Correct.

8 Q So we have these two exemptions then or two references
9 to exemptions. Was there ever any consideration about
10 whether those exemptions should apply to chiropractors?

11 A We did look at that in consideration. Based on the
12 guidance that Public Health had provided, that we could
13 not maintain a physical distance of 2 metres, the
14 consideration was made that this wouldn't apply because
15 we can't maintain a physical distance of 2 metres when
16 providing in-person or close contact care.

17 And I remember communicating this to our members
18 and using the example that this is probably more meant
19 for situations like in the public, like if you were
20 going to a grocery store where you could maintain a
21 physical distance, or in the public where you can space
22 yourself appropriately from somebody. But when
23 we're -- as a practitioner, when we're face to face, we
24 are not maintaining that distance of 2 metres, which
25 was identified as one of the risks for transmission
26 during COVID.

1 Q I'm going to ask you to go to the Exhibits C-20, 21,
2 and 22, which are the three versions of the Pandemic
3 Directive. They are dated I believe May 5, 2020, May
4 25, 2020, and January 6th, 2021. Just broadly
5 speaking, can you tell me why there are three
6 directives?

7 A That's a great question. So obviously the first one
8 was published, this is the one we had originally
9 submitted to government when they had alerted us that
10 we would have to provide this for our members to be
11 able to return to practice on May 4th, and so that was
12 published and sent to them for review.

13 On May 25th, we had done some review and revisions
14 and included the practice of mobile chiropractic for
15 chiropractors to be able to provide chiropractic care
16 in mobile settings. And for a percentage of our
17 population, our members, they do provide mobile care,
18 where they go and provide care in different settings
19 outside of their office. And, originally, we had not
20 allowed it, and so council had made the decision that
21 this would be allowed as long as they were following
22 the Pandemic Practice Directive. And then --

23 Q Then --

24 A Sorry, yeah, I'll stop.

25 Q No, you go ahead. I was just going to say January 6th.

26 A Yeah, oh, yeah, January 6th, that one was published,

1 that was right in the middle of the second wave of
2 COVID or the one that was identified as being
3 significant, and there had been a significant number of
4 cases. And so we did continue to regularly review the
5 Pandemic Practice Directive with council.

6 And one of the recommendations we made on this one
7 was to include the requirements -- or, sorry, include
8 the recommendation of PPE to include a face shield or
9 eye protection. And that specifically -- and one of
10 the unique things about that is this is one of the
11 first considerations we specifically made for members
12 to be protected, because it was -- some of the
13 information that was published in an advisement that we
14 had had was that eye protection was seen as protective
15 against the Coronavirus.

16 Up until this time, the practice directive was
17 focused on public protection. With the introduction of
18 the eye protection, that was one of the pieces that and
19 one of the few that we actually specifically put --
20 meant for the protection of the member only, and that
21 was to consider the use of eye protection.

22 Q I'm going to take you through the portions of the
23 Pandemic Directive in a couple of minutes when we deal
24 with masking and social distancing and plexiglass
25 barriers. Through those three versions of the Pandemic
26 Directive, were there changes about masking and social

1 distancing and the plexiglass barrier requirements?

2 A There was slight -- I believe there were some slight
3 changes, nothing significant. Some of it may have been
4 wording.

5 Specifically when we got the last one in January,
6 we introduced the requirement that patients must be
7 masked in the clinic as well. And that was in response
8 to, one, the orders that we received, there was a lot
9 of confusion from membership, going, well, do my
10 patients have to mask, the practice directive doesn't
11 say they have to mask. And so we implemented that
12 patients are required to mask in that January 6th one,
13 and then that has -- that persisted through to this
14 summer.

15 MR. MAXSTON: Mr. Chair, I think as I
16 mentioned earlier, I'm going to simply use the January
17 6th, 2021 Pandemic Directive in my questions for
18 Dr. Halowski and other witnesses, so I'm going to
19 continue that here.

20 THE CHAIR: Can you give us a reference
21 number for that?

22 MR. MAXSTON: Yeah, it's C-22.

23 THE CHAIR: Great, thank you.

24 Q MR. MAXSTON: So I'd just like to summarize
25 I think what are the more -- ask you questions about
26 what are the more relevant elements of the personal

1 directive -- sorry, Pandemic Directive for today's
2 hearing in the questions for you.

3 I'd like you to go to page 7 of the Pandemic
4 Directive. And there's a heading "Physical
5 Distancing", and I think the comments on this actually
6 go over to page 8, but can you tell me what the
7 requirements were in that regard in the Pandemic
8 Directive?

9 A Yeah, that we were to, as much as possible, in this
10 space ensure that physical distancing was provided for
11 in treatment areas.

12 And one of the things that some of our members do
13 operate is more an open-concept style where they'll
14 have multiple tables in one area, so we wanted to make
15 sure that patients receiving care were at least 2
16 metres apart in those spaces. In waiting areas, that
17 the patients were provided a place, if they were
18 waiting indoors, to be 2 metres from the next closest
19 patient, right; or from staff that may be working
20 behind the desk, right; in transition areas, i.e., you
21 know, like hallways or there might be areas where
22 patients are moving in and out of treatment rooms.

23 Then we did provide an exemption for people who
24 lived together to be 2 metres, because they're
25 obviously within the same cohort already, and there are
26 patients that may present to the office who have care

1 givers or companions with them, and so they were
2 exempted from that requirement as well. You know, we
3 didn't feel that it was our place to separate,
4 especially if somebody that needed a care giver, in the
5 office environment.

6 And then we did talk about non-clinical employees
7 in the public, right? So that would be the reception
8 area. And if 2 metres cannot be maintained, that staff
9 must be continuously masked, or the installation of a
10 plexiglass or plastic barrier must occur to protect
11 reception staff.

12 Q So, again, the word "must" is used, that's mandatory?

13 A Yeah, that's correct, "must" is a mandatory
14 requirement.

15 Q Okay. I'm going to take you to the heading that says
16 "Personal Protective Equipment", and I wonder if you
17 can tell me about the opening paragraph, what it means.

18 A Yeah. So one is that we -- personal protective
19 equipment is an essential element for the disease.
20 Like that was identified early on that it was being
21 novel and without an effective treatment, personal
22 protective equipment would be essential in order to
23 provide as safe an environment as possible.

24 We also wanted to alert members that if they were
25 not using PPE appropriately, it could fail to prevent
26 transmission and may facilitate the spread of the

1 disease.

2 Q So the next heading is "Staff and Practitioner PPE",
3 and there's a quote from an AHS announcement. Can you
4 tell us what that quote says, what it means?

5 A Yeah. So one of the things we were looking at in the
6 development stage is what is the requirement or what
7 are we going to look at around the use of personal
8 protective equipment. And so this was very clear, it
9 says: (as read)

10 Effective immediately, AHS is advising all
11 health care workers [which chiropractors are
12 considered a health care worker] providing
13 direct patient care in both AHS and community
14 settings [chiropractors are in a community
15 setting] to wear a surgical procedural mask
16 continuously at all times and in all areas of
17 their workplace if they are involved in
18 direct patient contact or cannot maintain
19 adequate physical distancing from patients
20 and co-workers.

21 Q Can you take me to the next section "PPE Requirements"
22 and tell me what those first three bullets say?

23 A Yeah: (as read)

24 Surgical or procedural masks are the minimal
25 acceptable standard.

26 And that's identified, because there's -- you know, one

1 of the questions that we had during the development is
2 like do I need an N95 mask, which is a fitted mask
3 meant for aerosol producing procedures. We wanted to
4 be very clear that that was not a requirement.

5 Again, we always set minimally acceptable
6 standards. So a minimal acceptable standard in this
7 would be a surgical mask.

8 Q Okay.

9 A And then the next one: (as read)

10 Chiropractors and clinical staff must be
11 masked at all times while providing patient
12 care.

13 That was very clear. Like if you're providing patient
14 care, you must wear a mask. It wasn't a suggestion; it
15 was a requirement.

16 And then the last one is: (as read)

17 Nonclinical staff must be masked when a
18 physical distance of 2 metres cannot be
19 maintained.

20 And that would be like some offices are smaller, the
21 reception desk may not be able to be isolated, the --
22 you know, or the receptionist is in and out from behind
23 the desk because they have double duty in bringing
24 patients to rooms or to cleaning or other aspects. We
25 wanted to make sure that there was a safety provided
26 for that person as well.

1 Q So I'm going to ask you to go ahead to page 9.

2 A Okay.

3 Q And at the top of that page, there's some requirements
4 for donning and doffing masks. But there's a paragraph
5 right after number 7 under "Doffing of Masks", and it
6 starts off with: (as read)

7 It is essential that all chiropractors and
8 staff providing services in a clinic area are
9 aware of the proper donning and doffing of
10 PPE.

11 I just want to be clear here, who is responsible for,
12 in a chiropractic clinic, for ensuring that staff
13 complies with the Pandemic Directive requirements?

14 A That would be anybody, the chiropractor as a regulated
15 member has a requirement to provide a safe environment
16 for themselves and those that work at their direction.

17 Q Okay. I'm going to ask you when the masking
18 requirement was developed, were you focusing only on
19 the protection to patients, or were you also
20 considering your members' protection?

21 A Obviously, there was member protection, but as a
22 College, our first consideration is always the public
23 as well. And so anything we could do to reduce the
24 risk of transmission from a chiropractor who had
25 acquired a COVID infection was our first consideration,
26 followed by the safety of the member.

1 And I would say, you know, followed by, it's not
2 like it was a large gap. You know, both were very,
3 very important, but as a College, we had a requirement
4 to definitely consider the needs of the public first.

5 Q Okay, we talked before about CMOH Order 16-2020 and the
6 use of the guideline or opting into the Pandemic
7 Directive and the mandatory guideline on masking or
8 creating your own Pandemic Directive, in terms of
9 masking and what you developed for your Pandemic
10 Directive here, were less restrictive directives than
11 requiring masking considered?

12 A We did look at all sorts of things. And I do remember
13 the final meeting, the second -- on April 29th, when we
14 met with council, I believe that was the Wednesday,
15 they had -- that was one of their considerations. Like
16 they had a question: Should masking be a
17 recommendation or a requirement.

18 And after discussion, council felt strongly that
19 masking was and should be a requirement of practice at
20 that time. So it was discussed, but given the climate,
21 given that this was novel, and given the risk of being
22 close contact body workers, council ultimately did
23 adopt the position that masking is required.

24 Q I note that -- well, I should ask you, does the
25 Pandemic Directive contain an exemption for masking,
26 social distancing, or plexiglass barriers?

1 A There -- let me see if I understand the question, so
2 there is no exemption for masking at any time when
3 we're providing care within 2 metres. The original one
4 did allow -- the original one introduced did allow for
5 them to not have a mask on if they were conversing over
6 2 metres apart, so i.e., on the other side of the room.

7 And the other exemption that was provided is that
8 if you can't -- if you need to, you could use
9 Telehealth as a form of care for patients to lessen the
10 risk of spread for COVID-19.

11 Q Ultimately, why wasn't there an exemption for masking
12 like we saw in the CMOH orders?

13 A You mean in the CMOH 38 and 42?

14 Q Yeah.

15 A Yeah, so the reason that we didn't ever consider an
16 exemption is because we work face to face with a
17 patient. We're not walking around in parks or open
18 spaces; we're in closed rooms, sometime poorly
19 ventilated, and we are breathing right on a patient,
20 and patients are breathing right on us as well, but
21 having a mask was meant to be protective for the
22 patient as well as for the practitioner.

23 Q Are you aware of any other HPA colleges and their
24 pandemic directives?

25 A Yeah. So one of the things that we did do after is we
26 had an opportunity to read and review other colleges

1 and what they were directing. And to my knowledge,
2 every college adopted a position of masking is a
3 requirement.

4 I know recently that, talking to one of the
5 registrars, who -- for I think it was ACSLPA, which is
6 the Alberta College of Speech-Language Pathology [sic]
7 and Audiologists. They had indicated that that had
8 been very stressful for their members to practice
9 during the pandemic when masking was required, because
10 they need to observe the mouth and visualize it in
11 order to respond or appropriately teach or provide
12 interventions, but they also, in some of their
13 interventions, identified that they produced more
14 aerosols because they're -- of speaking and causing
15 that, and so they had to maintain masking. And then up
16 until the end of June or beginning of July this year,
17 they amended it to become a recommendation. And that
18 was one that had indicated it was stressful.

19 Physiotherapists from when I reviewed, the
20 physicians when I reviewed, everybody else was
21 requiring masking for providing that close care.

22 Q So I'm going to ask you to go a little bit backwards in
23 this document. I'd like to go to page 1 -- actually
24 page 2 of the Pandemic Directive.

25 A Okay.

26 Q And right after the introduction, the first paragraph,

1 there's a second paragraph that says -- actually it's
2 an indent after the second paragraph: (as read)

3 Note to chiropractors, this directive is
4 current as of the date of publication and
5 reflects the rules and requirements for
6 chiropractors. In the event of a discrepancy
7 between this information and the directives
8 of Provincial Public Health authorities, the
9 directions of the Provincial Public Health
10 authorities take precedence.

11 Can you tell me what you meant by that language and --

12 A Absolutely.

13 Q -- what would or wouldn't take precedence, I guess?

14 A Absolutely. So when we look at that, one of the things
15 that -- I think the word we could describe around COVID
16 is it was a very fluid environment, and it seemed that
17 information was consistently and constantly shifting or
18 changing, or new information would come to light.

19 And so one of the things we wanted to make sure
20 that our members were aware that, say, this was in
21 place, and something came out from the Chief Medical
22 Officer of Health that had a more stringent
23 requirement, i.e., that maybe all practitioners were
24 required to wear an N95 mask or were required to wear a
25 face shield, that our members would know that they
26 should follow that direction, that they should wear

1 something more stringent.

2 Q So -- sorry.

3 A No, go ahead.

4 Q So that comment is directed to chiropractors then?

5 A Yes.

6 Q Health care professionals?

7 A Yeah.

8 Q If we go a little further down, it says: (as read)

9 As regulated health professionals,
10 chiropractors are required to: 1. Follow all
11 mandates and recommendations from Public
12 Health and Government of Alberta regarding
13 your personal and professional conduct. As a
14 regulated -- [Mr. Kitchen, there is a
15 question coming] -- regarding your personal
16 and professional conduct. As a regulated
17 health professional, you have a fiduciary
18 responsibility to follow all civil orders
19 that originate from any level of government.

20 And then number 2: (as read)

21 Read to and adhere to all communication from
22 the ACAC.

23 So what message are you sending to chiropractors there?

24 A Yeah, that's a great question. This was introduced for
25 our regulated members, because, at one time, we were
26 getting a lot of members calling in and going, hey, you

1 know, the City of Calgary has a masking mandate, or
2 this city has a masking mandate; and what we were
3 finding is people were calling us to interpret local
4 legislation, so we wanted to inform them that they
5 actually also have a responsibility to be aware of and
6 follow legislation or requirements or orders, civil
7 orders, that are introduced in the location where they
8 practice.

9 You know, one of the ones I remember dealing with
10 specifically was the City of Chestermere had ordered
11 all clinics closed at one time, and our members that
12 were there were calling and saying, But we're
13 regulated. I said, You need to follow the civic orders
14 that are introduced by your local government.

15 And so that was the intent of that, because those
16 may change or have a crossover, an impact for the
17 direction that we're providing. And we continually
18 also informed members that we wanted them to follow the
19 more stringent requirements. So that would be the part
20 of it as well.

21 Q Okay, so I want to just explore that a little bit with,
22 so if a local bylaw, for example, was more stringent,
23 you were required to follow that?

24 A Correct.

25 Q If a Pandemic Directive was more stringent, you were
26 required to follow that?

1 A Correct.

2 Q Dr. Halowski, you were not part of the discussion or
3 not present when we talked about entering some new
4 exhibits relating to Alberta Health Services, but I
5 have provided those to you, and I'm just going to ask
6 you to go through them briefly. They are again three
7 documents.

8 MR. MAXSTON: And, Mr. Chair, you'll have
9 those I believe in your File H [sic], and they're the
10 AHS Guidelines for Continuous Masking, the AHS Personal
11 Protective Equipment document, and the Alberta Health
12 Services Directive Use of Masks During COVID-19.

13 A Mr. Maxston, I don't have those documents available
14 right now. Can I obtain them? I apologize, I just
15 don't have them here.

16 Q I wonder if Ms. Nelson can send those to you in the
17 Dropbox, or we can have her forward them to you by
18 email.

19 A Okay, I'll wait for her to provide those.

20 MS. NELSON: Yeah, I will email those out
21 right now. Just the three AHS docs?

22 MR. MAXSTON: Mr. Chair, I wonder if this
23 isn't a good time to just take a 5- or 10-minute break,
24 just to allow some time for those documents to make
25 their way to Dr. Halowski, and we'll make sure he's got
26 them, and then we'll resume.

1 THE CHAIR: I was about to suggest the
2 same thing. It's 25 after 2, so let's take a 10-minute
3 break, and we'll come back at 25 to 3 and resume, and
4 hopefully by then, Dr. Halowski, you'll have received
5 and had a chance to look at the three documents.
6 They're not lengthy.

7 MR. MAXSTON: And, Mr. Kitchen, I'm aware of
8 the fact that I can't speak with Dr. Halowski about his
9 testimony, but I am going to chat with him just briefly
10 to make sure he's got the right documents if you're
11 okay with that.

12 THE CHAIR: Okay, I'm okay with that.
13 Mr. Kitchen, any comment?

14 MR. KITCHEN: I was muted, I'm sorry.
15 Blair, it looks like we're going to have time for me to
16 do my whole cross, and that's probably going to be it
17 for the day. Is that what you're thinking?

18 MR. MAXSTON: Yeah, I'll see how far I've
19 got to go. I still have to go through Exhibits C-1 to
20 C-22 with Dr. Halowski. I'm not going to through every
21 line of them; I'm going to highlight some things, but,
22 yeah, I think we're making some good progress. So I'm
23 just going to make sure he's got these documents,
24 James. I won't talk to him about his testimony, but I
25 want to make sure he's on the literally the same page,
26 so --

1 MR. KITCHEN: That's fine, yeah.

2 MR. MAXSTON: -- okay, thanks, yeah.

3 THE CHAIR: Okay, we're in recess now, and
4 we'll reconvene in 10 minutes, thank you.

5 (ADJOURNMENT)

6 THE CHAIR: The Hearing Tribunal is back
7 in session, and Mr. Maxston is continuing with his
8 direct examination of Dr. Halowski.

9 EXHIBIT G-1 - AHS - Directive Use of Masks
10 During COVID-19

11 EXHIBIT G-2 - AHS - Guidelines for Continuous
12 Masking

13 EXHIBIT G-3 - AHS - Personal Protective
14 Equipment (PPE)

15 Q MR. MAXSTON: So, Dr. Halowski, you've got
16 these three AHS documents in front of you?

17 A Yes, I do.

18 Q I'm not going to be very long with these with you. You
19 talked before about the fact that council was
20 monitoring the situation in terms of the Pandemic
21 Directive. Were you and council considering AHS
22 documents?

23 A We were considering them. That was one of the
24 resources, one of the primary resources we used when
25 evaluating the practice directive.

26 Q So I'm just looking at the first document, which is AHS

1 Guidelines for Continuous Masking, and the middle of
2 the page, it says: (as read)

3 To prevent the spread of COVID-19, AHS has a
4 continuous masking directive in place.

5 I take it that supports the Pandemic Directive from
6 your perspective?

7 A It does, and it -- one of the things in reading this,
8 and I remember having conversations with council about
9 it is we would see these documents, and, you know,
10 obviously these were developed specifically for the AHS
11 environment, but we did pay close attention to them
12 because they're advising how to keep their staff safe
13 and how to limit the risk of spread between patients
14 and between patients and staff.

15 Q The next document is the Personal Protective (PPE)
16 document, and really I'm just going to take you to page
17 2, under the heading "AHS Guidelines For Continuous
18 Masking and Use of Eye Protection". Again, there's a
19 statement about AHS has a continuous masking directive
20 in place, and, again, that would have been consistent
21 with the directive?

22 A Correct.

23 Q The final document is the AHS directive on use of
24 masks, and I'll take you to the principle section, and
25 the first sentence there, I wonder if you can just read
26 that, the one beginning with "Continuous".

1 A Yeah: (as read)

2 Continuous masking can function either as a
3 source control, being worn to protect others,
4 or part of personal protective equipment to
5 protect the wearer to prevent or control the
6 spread of COVID-19. Working collaboratively,
7 we shall ask all individuals to assist us in
8 limiting the spread of COVID-19 through the
9 use of procedure masks in AHS
10 facilities/settings.

11 Q So we talked --

12 A Okay, next paragraph? Okay, sorry.

13 Q No, that's fine. So we talked a little bit about this
14 before. They're talking here about two things, source
15 control protecting others and protecting the wearer;
16 was that a consideration for the development of the
17 Pandemic Directive?

18 A That is the consideration that we made to protect our
19 patients and also to provide that protection for our
20 members as well.

21 Q To your knowledge, has AHS ever granted an exemption
22 from masking for the health care workers they regulate?

23 A No, and specifically during the pandemic, I did speak
24 to members who raised concerns, i.e., one had a severe
25 allergy to latex and was reacting to the mask. And I
26 did reach out to AHS and had a conversation with them

1 about that, and they indicated that there was no
2 substitution for a procedural mask available. And so
3 even in the case of somebody that was having that
4 reaction and actually having a like constant contact
5 dermatitis reaction, there was no exception provided to
6 masking.

7 Q I'm going to talk now about the manner in which the
8 Pandemic Directive was communicated or distributed to
9 members, and I'm going to, in a couple of minutes, I'm
10 just going to ask you to go through some of the
11 highlights of the documents C-1 to C-22, but I'll
12 just -- I'll ask you to call those up.

13 When we look at C-1 to C-22, they are a series
14 of -- they're entitled "Notice to Member", "Registrar's
15 Report", "Council Updates". Can you tell me generally
16 how the Pandemic Directive was communicated and what
17 the purpose of these notices was?

18 A Yeah, no, and that's great. So a lot of -- I looked
19 back, during COVID, we were highly communicative with
20 our members, right from the time there was an
21 identified pandemic declared, all the way up and to --
22 including the provision of the Pandemic Practice
23 Directive, we were sending communications to members or
24 notices to members once, sometimes twice a day, to make
25 sure they had the most current information for their
26 consideration.

1 And that would have been a blend of -- because we
2 are a dual-mandate organization currently, that would
3 have been a blend of both Association communications
4 and College communications. And often they may -- that
5 communication may have come from one, like clearly the
6 Association or the College, or made a blended
7 communication where we would have covered topics of
8 both in that communication.

9 Q Okay, so when we look at these notices and the, again,
10 Registrar's report, who sends them; how do they go out
11 to chiropractors?

12 A Yeah, so those are sent specifically out of our
13 patient -- or not our patient but our member database.
14 So those are in there. We have -- we can see who we're
15 sending to. They would have distributed to all of the
16 regulated members at the same time.

17 One of the requirements of the College, of the
18 ACAC is that members must receive our electronic
19 communications because we're an electronic
20 communicator.

21 Q So are you confident that Dr. Wall would have received
22 all of these notices and updates?

23 A I am confident. It is our members' responsibility to
24 ensure that their email address is up to date and on
25 the College database. And I am confident, because when
26 I did contact Dr. Wall, I did so using the email

1 address that's provided to the College when I first
2 reached out to Dr. Wall in December of 2020.

3 Q We talked about the -- I'm going to take you through
4 some of these, of course -- or take you through them in
5 a minute. We talked about the fact that the Pandemic
6 Directive had mandatory language for masking. Do these
7 notices all have mandatory language in terms of
8 masking?

9 A I would say that it depends on each notice. Some will
10 say "must", some will say "may", but whenever we were
11 being direct with members of what they were required to
12 do, we always used the word "must". If they were
13 allowed to -- professional discretion in a situation,
14 then we used the word "may".

15 Q So I'm going to (INDISCERNIBLE) --

16 THE COURT REPORTER: That was all -- you were
17 turned away from the camera. I did not hear a word of
18 that, sorry.

19 MR. MAXSTON: I'm sorry, Madam Court
20 Reporter.

21 Q MR. MAXSTON: Dr. Halowski, I'm going to
22 take you or ask you questions about Notices C-1, C-10,
23 and C-13, and they are the Telehealth notices.

24 MR. MAXSTON: I don't need, Mr. Chair, you,
25 and the Tribunal Members, to go to all of them.

26 Q MR. MAXSTON: But I just wonder if you can

1 tell me what these Telehealth notices to members are,
2 when they came out, and what they were intended to
3 achieve.

4 A Absolutely. So C-1 specifically we sent to members.
5 We had developed a framework for our members to be able
6 to provide Telehealth, but one of the things that we
7 were getting questions on was billing. And I say "we",
8 often they would call me in looking to do that. The
9 College cannot advise on billing matters, so then this
10 would have been a communication that came from the
11 Association but specific to needs identified, where
12 they were asking, well, how do I bill for Telehealth,
13 how do I, you know. And so they were looking for a
14 way. So this was our advisement provided to members on
15 how to bill when they're providing Telehealth services.

16 Q Okay. Was this something new for the profession, to be
17 allowed to do Telehealth?

18 A Absolutely. This -- we had never provided Telehealth
19 as a profession before, and so this was something that
20 we developed as soon as -- we started working on this
21 right away when things were -- when we saw where this
22 was going so that we could offload or offset the risk
23 for in-person care at that time. And so this was
24 developed and adopted by a motion from council as a
25 temporary Telehealth solution, which was intended to be
26 reviewed in June of that same year.

1 Q Is Telehealth now a permanent allowed modality for
2 treatment for chiropractors?

3 A It is a permanent allowed modality, and it's the
4 intention of the ACAC to take and turn that into a
5 standard of practice as time permits. Some of that's
6 been restricted due to other legislative challenges
7 within the system and introduction of other bills. So
8 that is our intention to make that a standard of
9 practice down the road.

10 Q Okay, I'm going to be mindful of the court reporter's
11 caution to me, I'm going to keep looking at the camera
12 here when I go to the next documents. I'd like to take
13 you to C-2, which is an April 21, 2020 Notice to
14 Members.

15 A Yeah.

16 Q Broadly speaking, when I look at paragraph 2, this
17 addresses, at least in part, the return to practice
18 plan. Can you tell me what paragraph 2 is talking
19 about in terms of consultation or feedback?

20 A Yeah. So when we developed this, you know, we had done
21 a lot of work to develop, but we wanted to inform
22 members how we developed it, that we weren't pulling it
23 out of a hat, we had spoken to other regulators, we had
24 spoken to members of the competence committee, to
25 specialists within the profession, and other regulators
26 across Canada so that we had a framework for

1 chiropractors to reasonably practice during a pandemic.

2 And then what we did is that we were advising
3 members that as -- we've done the work, but we're not
4 just going to say here it is, we wanted consultation,
5 we wanted their feedback.

6 Q The second paragraph talks about the platform you
7 referred to before as ThoughtExchange, and there's a
8 final sentence in that paragraph: (as read)

9 This is your opportunity to engage in the
10 development of this plan, so please
11 participate.

12 Were you hoping for participation?

13 A Absolutely. We wanted feedback, and I believe we
14 received robust feedback from members in the form of
15 participation in the ThoughtExchange, during the town
16 halls, and then also with direct communication from
17 members to myself or to council during the time that we
18 were developing that.

19 Q If you go to paragraph 3 in this notice, it talks about
20 virtual member meetings on COVID-19 to be held next
21 week, and the final sentence: (as read)

22 There will be an opportunity for members to
23 submit questions related to COVID-19 during
24 the meeting.

25 Did you receive questions?

26 A I do, we did receive questions. During that, there was

1 a lot of questions ranging from like everything in the
2 practice directive and other questions that were also
3 other than College questions, there was Association
4 questions, people worried about different aspects of
5 practice and when could we go back.

6 As indicated when I spoke earlier, one of the
7 concerns that chiropractors continued to voice was
8 around the idea of why aren't we considered an
9 essential worker, and so that was a question that was
10 also raised during that meeting.

11 Q When we go to document C-3, which is a Notice to
12 Members, the first line after that says: (as read)

13 Participate in the member consultation on the
14 draft return to practice plan.

15 Is this the mechanics of getting that access we were
16 just talking about?

17 A Yeah, absolutely. We published it, which is what
18 step 1 was so they could review the draft return to
19 practice plan, and step 2 was to provide anonymous
20 feedback to that draft practice plan.

21 Q There is a statement just above the heading
22 "Registration for ACAC", and it says: (as read)

23 If you have any questions or concerns about
24 the plan or survey, please email Dr. Todd
25 Halowski.

26 Were you available to take questions then about the

1 plan for re-entry?

2 A Absolutely. In addition to that, I received I would
3 say upwards of a hundred emails from members, ranging
4 and weighing in of topics of concern or consideration
5 in regard to the Pandemic Practice Directive as
6 presented -- as the draft was presented.

7 Q I'm going to ask you more about this in a moment, but
8 do you recall if you received any communications or
9 questions from Dr. Wall?

10 A I did review my email to see if Dr. Wall had submitted
11 any feedback to the practice directive, and in all the
12 emails that I reviewed, I did not see any feedback
13 received from Dr. Wall.

14 Q I'm going to ask you to go to document C-4, "Our
15 Clinics are Adjusting to Keep You Safe". What is that
16 document?

17 A Yeah, so this is one of the things, this would be an
18 Association style communication that was produced, and,
19 again, this is more meant for marketing to patients,
20 but it's also highlighting what chiropractors are going
21 to be doing to keep them safe when patients return to
22 practice.

23 And so this was developed and prepared, and you'll
24 see the date on it was April 29th. That's when we knew
25 that we were going to be going ahead, and this had been
26 approved for distribution, so members could get these

1 posters prepared for use in their clinics when we had
2 the opportunity to re-open.

3 Q Did this also go to chiropractors then, just so I'm
4 clear?

5 A Yeah, yes, that was distributed to all members of the
6 Alberta College and Association of Chiropractors.

7 Q Okay. I'm looking at the next document, C-5, it's a
8 Notice to Members, and item 1, numbered paragraph 1,
9 the last paragraph says: (as read)

10 Chiropractors will not be able to open until
11 the ACAC has received Public Health approval
12 of the return to practice plan.

13 This is referring to the Pandemic Directive approval
14 process we talked about before?

15 A That is correct, we wanted to make members very aware
16 that that was a part of that.

17 Q If you go to number 5 on the next page, it's dealing
18 with PPE, and can you tell me what the first sentence
19 says and what it means?

20 A Yeah: (as read)

21 The initial information from Alberta Health
22 Services is that the appropriate use of PPE
23 will be a requirement of return to practice
24 for close contact practitioners. As
25 mentioned in the --

26 Oh, sorry, I'll stop.

1 Q Sorry. This would have gone to all chiropractors?

2 A This was distributed to all chiropractors of the
3 Alberta College and Association of Chiropractors.

4 Q Okay, I'll go to document C-6, which is a May 1, 2020
5 Notice to Members. And I'll just ask you to tell me
6 what the first paragraph -- first couple sentences in
7 paragraph 1 say.

8 A Is that starting with "Yesterday"?

9 Q No, numbered paragraph 1, I'm sorry --

10 A Oh, sorry.

11 Q -- "Status on".

12 A Yes: (as read)

13 Status on the return to practice plan.
14 Council approved the ACAC COVID-19 Pandemic
15 Practice Directive today, which can be
16 accessed here. This directive has been
17 submitted to Public Health for review and
18 approval as required by the Government of
19 Alberta.

20 And then: (as read)

21 Public Health must approve the directive
22 before chiropractors can proceed with
23 re-opening, and chiropractors can remain
24 limited to urgent, critical, and emergency
25 care until otherwise notified by the ACAC.

26 Q So was this the first communication of the Pandemic

1 Directive to members?

2 A It absolutely was, yes. And we did that because we
3 wanted members to be able to review it so they could be
4 prepared to implement it, because they weren't allowed
5 to return to practice till they could implement it.

6 Q So that sort of takes us to the next document, C-7,
7 which is a May 3, 2020 notice.

8 A Yeah.

9 Q And I wonder if you can just read the first three
10 paragraphs, it begins with "We are", and tell me what
11 this means.

12 A Yeah: (as read)

13 We are excited to report that Alberta Health
14 notified all regulated health professions
15 today that effective May 4th, 2020, regulated
16 health professions who are ready to execute
17 all requirements of their respective
18 regulatory college pandemic practice
19 directives can return to practice.

20 Q And the next, I've got a question, tell me about the
21 next two paragraphs, if you can read those.

22 A Yeah: (as read)

23 The ACAC COVID-19 Pandemic Practice Directive
24 is approved. Chiropractors who can
25 completely implement the directive may
26 re-open. Chiropractors who are unable to

1 fully implement the ACAC Pandemic Practice
2 Directive may not proceed with re-opening
3 until all measures are in place.

4 Q So compliance was a condition to re-opening?

5 A Absolutely.

6 Q And was that mandatory compliance, just to be clear?

7 A Mandatory, yes.

8 Q I'll go to the next document C-8, which is a May 25,
9 2020 Notice to Members.

10 A Yeah.

11 Q And in specific, I'll get you to go to page 2, and
12 there is a heading "Why do Chiropractors need to wear
13 masks". I'm wondering if you can just explain why this
14 is being sent to members?

15 A Yeah, and so we did have some questions from members
16 once we originally returned to practice who were
17 wondering why we were required to wear masks, and so we
18 wanted to make sure that we were answering that for
19 members, and that that was that proper -- the observing
20 PPE requirements protects chiropractors from mandatory
21 self-isolation if they treat an asymptomatic patient
22 who later tests positive for COVID-19.

23 So when we returned to practice, what we did start
24 to see is that members that were being deemed close
25 contacts would have to isolate, and it was communicated
26 via Public Health that chiropractors that were wearing

1 masks at the time would not be required to self-isolate
2 if they were masked when exposed to a pre -- what
3 Alberta Health termed a presymptomatic patient.

4 Q Okay, if we go to Notice C-9, it's July 24, 2020 Notice
5 to Members, there's a reference on page 1 to the City
6 of Calgary's mandatory face bylaw, but I'd like to take
7 you to the top of page 2, and there's a bullet that
8 starts off with "Exemptions", I wonder if you can just
9 read that.

10 A Yeah. So: (as read)

11 Exemptions to any bylaw are designated by
12 each municipality.

13 And I should give context to that, at that time, only
14 the cities were providing exemptions; there was no
15 provincial exception -- our provincial bylaw requiring
16 masking, sorry, not exemptions: (as read)

17 A medical diagnosis that leads to an
18 exemption may only be provided by
19 practitioners who have the authority to grant
20 exemptions.

21 So currently, chiropractors are not entitled to offer
22 exemption from face covering to their patients.

23 Q So I'm going to stop you. Are you telling
24 chiropractors there that they can't grant exemptions?

25 A Absolutely correct. One of our concerns was that
26 chiropractors may attempt to write exemptions once

1 these were introduced, and so we wanted to be very
2 clear that that is not in our scope of practice to
3 exempt patients from a face covering when required by a
4 bylaw.

5 Q And there's a sentence you read: (as read)

6 A medical diagnosis that leads to an
7 exemption may only be provided by
8 practitioners who have the authority to grant
9 exemptions.

10 The College was requiring a medical diagnosis then?

11 A No, so I think in the initial stages of the bylaw
12 introduction, one of the things we were trying to be
13 clear to our members is if a medical -- "that leads to
14 an exemption may only be" -- so if there was a medical
15 diagnosis, i.e., that somebody was -- because I -- like
16 Edmonton required an exemption card, Calgary had a
17 different way, but we wanted our members to know that
18 they weren't authorized to provide any sort of --
19 exemption for a member of the public from a masking
20 bylaw.

21 Q I'm going to ask you a question, but was -- did you
22 ever -- that's okay.

23 I'll go to the next notice, C-10 -- sorry, we've
24 talked about C-10, that's the Telehealth notice, my
25 apologies.

26 I'd like to go to C-11, which is your August 2020

1 Registrar's report.

2 A Yeah.

3 Q And more specifically, I'm going to ask you to go to
4 page 9.

5 A Okay.

6 Q And under the heading "Return to Practice Feedback
7 Survey, I wonder if you could read that sentence.

8 A Yeah: (as read)

9 We want to hear how implementation of the
10 return to practice plan is going in your
11 clinic. Please submit your feedback to us
12 using this survey.

13 And that was another ThoughtExchange survey that was
14 sent out for members to be able to make comments on.

15 Q So you had a line of communication for positive
16 comments or negative comments?

17 A For any comment, and comments received could have been
18 both positive or negative.

19 I can take a second and explain how
20 ThoughtExchange works. So in ThoughtExchange, what
21 happens is somebody gets to make a comment, and they
22 could say, I love masking, or they could say, I hate
23 masking. And when then they do that, then what happens
24 is, once you get enough thoughts in there, people get
25 to go and read the thoughts that are currently in it,
26 and they can rank them; they can go this is actually

1 really important, or, oh, this is garbage, or they may
2 flag inappropriate comments. So ThoughtExchange is
3 meant for a much more interactive response than, say,
4 the idea of a yes/no survey.

5 Q Okay. Let's go to document C-12, which is an August
6 11, 2020 Notice to Members.

7 A Okay.

8 MR. MAXSTON: Mr. Chair and Tribunal
9 Members, I'm planning on going through these quickly.
10 I'm assuming that once you're in that C file, you're
11 able to click ahead fairly easily too. If any of you
12 are not at a document, please let me know.

13 Q MR. MAXSTON: So, Dr. Halowski, I'm looking
14 at C-12 again, and numbered paragraph 1 says: (as
15 read)

16 Chiropractors must adhere to the ACAC
17 COVID-19 Pandemic Directive regardless of
18 local bylaws.

19 What are you intending to communicate there?

20 A Yeah. So one of the questions that members were going,
21 say -- they were asking what's the interplay between
22 bylaws and what's the interplay between this. And so
23 when we said this, that "Chiropractors must adhere to
24 the ACAC COVID" ... "regardless of local bylaws", local
25 bylaws only expand practice requirements. They do not
26 remove the requirements of the practice directive.

1 And so we're saying like they may add things in,
2 but they can't diminish the minimally acceptable level
3 of performance that's put out by the practice
4 directive.

5 Q Okay. We've already talked about C-13, that's one of
6 the Telehealth directives, so I'm going to go ahead to
7 C-14, which is a November 23, 2020 Notice to Members,
8 and I'd just like you to, I'm on page 1, if you could
9 read the last couple of sentences on that page, "As
10 always".

11 A (as read)

12 As always, as soon as we know more, we will
13 advise you. If you have questions, please
14 contact us at the ACAC office.

15 So we -- again, we were always very open and
16 communicative with members, especially when questions
17 were coming up. You know, speaking as a -- as the
18 Registrar, I was often communicated to with questions.
19 And speaking as a practitioner, this time, I think this
20 is when we started to see kind of the development of
21 that second wave, and practitioners were getting
22 nervous, that, hey, we're going to get shut down again
23 like we did when the first wave happened. And so they
24 were often seeking clarification. We wanted to make
25 them very aware that they could reach out and speak to
26 us at any time.

1 Q Okay. So C-15 is a November 25, 2020 document.

2 A Yeah.

3 Q I'd like you to read the last sentence on the bottom of
4 that page "As a health professional", that's what it
5 begins with.

6 A Oh: (as read)

7 As a health professional, it is your
8 obligation to be informed of and to uphold
9 all restrictions, bylaws, or other decisions
10 that impact your clinic and the health and
11 well-being of staff, patients, and visitors.

12 Q And then if you go to the next page, can you read the
13 last sentence, "If you have"?

14 A Yeah: (as read)

15 If you have questions, please contact the
16 ACAC office.

17 Q So this is an opportunity for members to contact you
18 again?

19 A Yes, it is.

20 Q Again, these would go to all members?

21 A Yes.

22 Q If we go to the next document, C-16, which is a
23 November 25, '20 FAQ or frequently asked questions, I'm
24 going to ask you to go to page 7.

25 A Okay.

26 Q And there's a heading "Do we need barriers for our

1 reception desks", and can you tell me what it talks
2 about in that next paragraph?

3 A Yeah, I will read it, and then interpret it, if that's
4 okay: (as read)

5 Employees in the public should be 2 metres
6 from each other. If 2 metres cannot be
7 maintained at reception/payment area, other
8 noncontact electronic payment means can be
9 used or installed, or installation of a
10 plexiglass or plastic barrier can be used to
11 protect reception staff. Many local
12 companies are retooling to do installations
13 of barriers in local businesses.

14 One of the things that we wanted to make sure is that
15 members knew how to obtain and provide for barriers for
16 their staff, especially with the uptick in cases, that
17 that was made available for members as a resource and
18 also just to remind them that they have a duty to keep
19 barriers in place when the physical distance of 2
20 metres can't be maintained or to separate them from the
21 general public that was receiving care.

22 Q Just below that, there's a heading "Personal Protective
23 Equipment (PPE), and it has some Q and As again about
24 wearing masks, et cetera. Is this a reminder to
25 members of your profession?

26 A Yeah, absolutely, because we were getting not only

1 questions about that but questions around things like,
2 Do I have to wear a mask, or, Do I have to wear gloves
3 or gowns when treating. So we wanted to just be very
4 mindful and remind them of the duty that a
5 surgical/procedure mask must be worn by the member when
6 treating patients and a physical distance of 2 metres
7 cannot be maintained.

8 Q If we go to page 10 of that document, there is a
9 heading "Who should I contact if I have questions", I
10 wonder if you can read that paragraph?

11 A (as read)

12 If you have questions, please contact the
13 ACAC at office@albertachiro.com, and we will
14 respond to you as quickly as possible. If
15 you have a question, it's likely that other
16 chiropractors are having the same question.
17 We'll answer your question if we can. Follow
18 up with the Government on anything that
19 requires further investigation, and continue
20 to update you on any news.

21 And that's one of the patterns that we saw, like if we
22 started to get one member asking a question, usually
23 we'd get three or four questions. That's one of the
24 ways we identified some of our FAQs, because if
25 somebody was asking it, we'd get multiple questions
26 along the same line around topics like that.

1 Q And there's a reference here to an email address so
2 members could communicate with you by email as well
3 then?

4 A That's correct.

5 Q I'd just like to go to the next document very briefly,
6 C-17, which is I think an ACAC website update, and it's
7 entitled "Adjusting for you". I'm assuming this is
8 something that was intended to go to the public or more
9 for public consumption?

10 A Yes, yeah, this is more of an Association style
11 communication relative versus a College style.

12 Q And the second page has a heading called "Wearing
13 Masks", can you tell me what that is telling the
14 public, members of the public who might read this?

15 A Yeah, so if you look like -- like if we -- and for a
16 second, if you juxtapose this to the practice
17 directive, this language is meant to be clear, like
18 everyday language so that chiropractors are wearing
19 personal protective equipment such as masks during
20 treatments.

21 We're letting the public know that that's what
22 chiropractors are doing, because in the directive,
23 we're very clear that that's a requirement, and we
24 thought it was reasonable to alert the public that
25 chiropractors are wearing masks.

26 Q I'd like to go to the next document, which is C-18, a

1 Notice to Members dated December 9, 2020.

2 A Yeah.

3 Q And about halfway down the page, maybe two-thirds of
4 the way down the page, there's a paragraph that begins
5 with "Masking is mandatory", and there is a sentence
6 sort of about a third of the way down or half of the
7 down that paragraph that says: (as read)

8 There are no exemptions to chiropractors and
9 staff masking.

10 Was that consistent with the Pandemic Directive?

11 A That was a hundred percent consistent with what we had
12 indicated to our members.

13 Q So this is another reminder to members?

14 A Yes.

15 Q If you go to page 2, there's an impacts -- sorry,
16 "Impacts on ACAC operations", and there's a paragraph
17 that begins, it's the third one: (as read)

18 If you experience a COVID-19 emergency.
19 Can you tell me what that paragraph says?

20 A Yeah, so at that time, with the -- right now, the
21 province was in the full, like kind of a ramp-up up to
22 that second wave of COVID-19, and we were shutting down
23 operations, and so we wouldn't be answering the phones
24 live, so we wanted to make sure that our members knew
25 how to reach us and how to contact us and that we were
26 there to receive their communications.

1 And so when you look at that, they could email the
2 Registrar, email directly. Under that, this contact
3 information, where you see the underlined in blue,
4 where it says "Dr. Todd Halowski" or "Sheila Steger",
5 those lines, that provided a direct link to our
6 personal emails. And then also that was the extension
7 of the phone number, if they called the College office,
8 it would come to us, and we received all voice mails
9 electronically at that time.

10 Q So they can communicate by email or by phone?

11 A We were available to be communicated to at all times.

12 Q C-19 is a Notice to Members, and I'm just going to get
13 you to go to the third page of that three-page
14 document, and I'd like you to read the last sentence
15 literally above your signature. It says "We are here
16 to support you: Can you read that sentence?"

17 A Yeah: (as read)

18 We are here to support you. If there are
19 COVID topics that will benefit the profession
20 that you believe the ACAC should cover,
21 contact me.

22 Q So this is another opportunity for members to contact
23 you?

24 A Yes.

25 Q I just have to grab a binder, just bear with me for one
26 moment.

1 I'm looking -- I'd like to take you to File F,
2 File Folder F and, in specific, F-3, the ACAC Registrar
3 report from July 5 of 2020, and more specifically, I'll
4 just get you to go to page 5 -- sorry, 2021, thank you.
5 Mr. Lawrence just reminded me.

6 And on page 5, there's a reference to a simple
7 rule. Can you read that sentence?

8 A I'm just going to pull it up on the 'K' drive here.

9 Q And, again, that's the --

10 A Registrar's report.

11 Q -- yeah, July 2021, yeah.

12 A Yeah, okay.

13 Q So I've asked you to go to page 5, and the second
14 complete paragraph has a sentence about the "simple
15 rule". Can you just tell me what the "simple rule" is?

16 A Yeah: (as read)

17 The simple rule to follow to maintain
18 compliance is that the more stringent
19 requirement applies to chiropractic practice
20 in Alberta.

21 And that's -- we communicated that: (as read)

22 For example, if Public Health relaxed a
23 restriction, but your local municipality
24 maintained their bylaw, then the bylaw would
25 be considered more stringent and would need
26 to be followed. If your local --

1 Q Okay -- yeah, I'm sorry.

2 A Oh, so, yeah, this is part of that line of
3 communication. Like it's the more strict. The
4 baseline, the minimal accepted level is the practice
5 directive. If there was a more strict requirement
6 introduced, it was the requirement of the member to
7 follow the more strict requirement.

8 Q And just finally, very quickly, the next document, F-4,
9 is an FAQ from July 7. I'll just let you get to that.
10 I'm not sure if you have it handy or have to go through
11 your computer to --

12 A I have it, I have it handy.

13 Q Okay. There's a question on the first page: (as read)

14 Why are we still required to do all this when
15 the rest of the province is back to normal.
16 Can you tell me what the answer is?

17 A Yeah, we are a regulated health profession. We're
18 not -- not to diminish the work or role that anybody
19 else plays, but we have a responsibility as a health
20 care provider to act first for the safety and
21 protection of our patients and to consider their health
22 needs.

23 And so when we're looking at that, we have a duty
24 to maintain the privilege that we're offered as a
25 regulated health profession, and part of that is to
26 make sure that we're following the highest standard in

1 ensuring public health and safety.

2 Q So I've taken you through a number of documents --

3 MR. MAXSTON: Thank you, Mr. Chair, for your
4 patience, and Tribunal Members --

5 Q MR. MAXSTON: -- that have talked about the
6 communication efforts and the feedback efforts from the
7 College.

8 I asked you this question before, but I'm just
9 going to confirm, you did receive feedback from the
10 membership?

11 A I did receive feedback from the membership.

12 Q I'm going to talk with you in a couple of minutes about
13 your communications with a lady named Ms. Ho and how
14 the Dr. Wall complaint arose.

15 After -- or in April and May, when the Pandemic
16 Directive was being created and thereafter, did you
17 receive any communication from Dr. Wall?

18 A I received -- in preparing for this, I was reviewing
19 and I didn't see any communication via email directly
20 to myself or the College from Dr. Wall. And all
21 communication around COVID was always forwarded to me
22 for a response and -- and review and response of the
23 College, and I have no record of Dr. Wall emailing the
24 College.

25 Q Just so I'm clear, no emails or phone calls?

26 A No phone calls either.

1 Q Before the introduction of the Pandemic Directive, did
2 Dr. Wall contact you about pandemic concerns?

3 A I didn't -- prior to this, I didn't have any
4 communication from Dr. Wall about the pandemic.

5 You have one communication in my record that I had
6 received from Dr. Wall in early March, just when the
7 thought of the pandemic was coming.

8 Council had recently introduced some direction on
9 discussion of vaccines and that -- chiropractors, we
10 wanted to be very clear with our members that, you
11 know, we don't have it in our scope of practice to
12 administer, educate on vaccinations, and so we had
13 tightened up a position statement that directed our
14 regulated members to send questions direct -- send
15 patients with questions directly to Public Health or
16 their medical doctor in order to receive the
17 appropriate answer and education.

18 One of the things that we know is that vaccine
19 misinformation or -- can elevate vaccine hesitancy and
20 put the public at risk especially in the times of
21 communicable disease. And Dr. Wall had written a
22 letter saying that, you know, that he was -- he said
23 that he recognizes that chiropractors are governed
24 under the Health Professions Act, and he intends to
25 follow any guidelines and rules put forth to our
26 profession through Standards of Practice and bylaws.

1 But then he was also expressing frustration that
2 chiropractors couldn't speak up about vaccines, that he
3 indicated that he doesn't believe in vaccines to the
4 same extent that Public Health does and that he thinks
5 that, you know, it's a shame that we were being limited
6 in our ability to communicate about vaccination. So he
7 provided feedback to a policy that council had put
8 forward that he disagreed with.

9 Q And that was before the Pandemic Directive though?

10 A Absolutely.

11 Q I'm not going to take you to these documents to look
12 at, but Exhibits D-3 to D-7 are a series of CMOH
13 orders, and I'll just ask you, are you generally
14 familiar with those?

15 A I believe so, yes.

16 Q And just to close off a discussion on the Pandemic
17 Directive, did the College review CMOH orders as they
18 came out?

19 A We did, we did review them and consider them in our
20 policies that we were maintaining and the direction
21 that council was providing.

22 CMOH orders were an essential part in looking at,
23 reviewing, and advising council so that council had the
24 best information when they were making their decisions.

25 Q Was the Pandemic Directive a fluid document?

26 A It was fluid in the sense that when a change was

1 required, we would make a change. As we reviewed that,
2 there was no need to change the directive relatively --
3 when it first came out, we were very -- we wanted to
4 think big picture with it, so we wanted to have a
5 document that would stand during a pandemic. I didn't
6 want the idea of tinkering it. It's difficult for
7 members to have to adapt if we were reviewing it every
8 two weeks and going, What about this and what about
9 that.

10 So we really did develop a document that was able
11 to stand during a pandemic and provide and inform
12 members' practice relative to the standard of practice.

13 Q I understand that there was change to the Pandemic
14 Directive in early July of 2021; is that correct?

15 A I think -- oh, this year, yeah, sorry. There was.
16 That was changed -- sorry, I was thinking back to last
17 year. I don't think anything happened in 2020, but
18 2021, that's correct, we did introduce new direction
19 for the members based on the current environment and
20 current information and the medical orders that were in
21 place from the Medical Officer of Health at that time,
22 so ...

23 Q So mask --

24 A Yeah, we amended specifically, we changed and we
25 maintained requirements around infection prevention and
26 control in the office, but specifically, you know, hand

1 washing and some of the other measures in around
2 screening as well.

3 We did remove the requirement for masking and eye
4 protection but did maintain a strong recommendation
5 that members consider to continue to use the masking
6 for themselves and the eye protection for themselves as
7 well.

8 Q So, Dr. Halowski, a while ago when we were first
9 talking, I think you mentioned to me that the Pandemic
10 Directive, at least in part, was based on Standard
11 4.3 --

12 A Yes.

13 Q -- that was already in place. I'd like you to go to
14 and the Tribunal Members to go to Exhibit A-11, which
15 is an excerpt from the -- or, pardon me, it is the
16 Standards of Practice for the College, and I'd like
17 everyone specifically to go to page 15 and Standard
18 4.3, which is "Infection Prevention and Control". So,
19 again, that's Exhibit A-11, and I'd ask all of you to
20 go to page 15.

21 Dr. Halowski, this is a bit of a lengthy standard.
22 I'm more interested in -- most interested in the
23 opening statement and then the bullets that appear on
24 page 16. I'm wondering if you can take me through this
25 with as much detail as you need to. Can you tell me
26 what the standard of practice says?

1 A Yeah, so this is our infection, prevention, and control
2 standard. It was adopted in 2010 and revised in 2014
3 specifically.

4 And, again, one of the things that, Mr. Maxston
5 and the Hearing Tribunal, is that I cannot stress
6 enough that Standards of Practice represent our
7 minimally acceptable level of performance. These are
8 not aspirational; they're meant to designate the low
9 bar for practice.

10 And so when we look at that -- and that's the same
11 in every profession, that's not unique to us as
12 chiropractors or unique to physicians or
13 physiotherapists, dentists, or anybody; Standards of
14 Practice are the minimal acceptable level of
15 performance, and it's kind of how we measure if
16 somebody has met the threshold of professional conduct.
17 And if they're at or exceed the standards, then that's
18 one of the considerations.

19 So when we look at that and go through this, the
20 standard does lay out specifically what the
21 requirements are for our members to be minimally
22 acceptable, to: (as read)

23 Remain current in generally accepted routine
24 practices and infection control protocols
25 relative to their current practice context.

26 And practice context can be what's internal in the

1 environment and what's external to the environment.

2 In the case of something like a novel Coronavirus,
3 none of us have practiced that in that environment, and
4 so that's where we saw a need that we would have to
5 provide direction for membership, right?

6 The next one: (as read)

7 Develop, incorporate, and keep up to date
8 infection control policies to promote the use
9 of infection control measures, which may be
10 unique to their personal professional
11 practice style.

12 That's a -- so that's incorporating that they need or
13 are required to have an infection prevention control
14 policy in their office that highlights how they execute
15 and practice to keep in consideration of infection and
16 infectious disease, right?

17 (as read):

18 Ensure that their clinic is fully equipped,
19 operated, and maintained to meet generally
20 accepted infection control guidelines.

21 And that's a really important one is the "generally
22 accepted". You know, it's not -- we're not looking to
23 set a bar higher for the chiropractic profession than
24 any other profession; these are measures that are
25 generally accepted.

26 Like, you know, hand washing is a great example.

1 The World Health Organization continues to identify
2 that hand washing is the single most effective way to
3 break the transmission of disease. Every standard of
4 practice I review from other professions highlights the
5 importance of hand hygiene before and after care.

6 And so that's -- and you look at that in our
7 practice directive: (as read)

8 Hand hygiene, which must include the use of
9 hand cleaner or a hand washing -- or hand
10 washing before and after each patient
11 contact.

12 We're very consistent as a generally accepted measure:
13 (as read)

14 Use of protective barriers as standard
15 practice whenever contact with blood and body
16 fluids is likely to occur during patient
17 contact. Barriers must also be used when a
18 patient's personal care equipment is likely
19 to have been contaminated with potentially
20 infected fluids, like wheel chairs or
21 walkers.

22 So protective barriers, and that's defined specifically
23 in here as personal protective equipment: (as read)

24 Specialized equipment or clothing used by
25 health care workers to protect themselves
26 from direct exposure to client's blood,

1 tissue, or body fluids. Personal protective
2 equipment [and here's where we leave it to
3 practitioner discretion in the standard of
4 practice] may include gloves, gowns,
5 fluid-resistant aprons, head and foot
6 coverings, face shields or masks, eye
7 protection, and ventilation devices, for
8 example, mouth pieces, respirator bags,
9 pocket masks.

10 And the reason that it's left to practitioner
11 discretion in a standard of practice is -- and if we
12 required our practitioners to wear gloves, to wear a
13 gown, fluid-resistant aprons, and head and foot
14 coverings for every patient interaction would be
15 significantly oppressive to practice and to the
16 practice style that we practice in. You know,
17 chiropractors tend to work with non-infectious
18 patients, we tend to work with patients that are coming
19 in with neuromusculoskeletal conditions or NMSK as I
20 indicated earlier.

21 We go on to talk about: (as read)
22 Internal environmental cleaning, disinfecting
23 and sterilizing equipment and facilities, and
24 managing waste and materials contaminated by
25 body fluids [which we use Appendix A to
26 define all of that].

1 And I'm happy to review that as part of this, right?

2 And highlights of that is measures practiced in
3 appendix -- I'm going to jump over to that, and then
4 I'll come back to the bullets. But: (as read)

5 Measures practiced by health care
6 practitioners intended to prevent spread,
7 transmission, and acquisition of agents or
8 pathogens between patients, from health care
9 practitioners to patients, from patients to
10 health care practitioners in the health care
11 setting. Infection control measures
12 instituted are based on how an infectious
13 agent is transmitted and includes standard,
14 contact, droplet, and airborne precautions.

15 Cleaning is really the physical cleaning of a space,
16 right? Disinfection is using different things that we
17 know are -- during contact time are meant to kill or --
18 kill the pathogen, right? Sterilization is a two-step
19 process not typically applied in practice, but there
20 may be some practitioners who use metallic pinwheels,
21 and those require sterilization versus, say, a disposal
22 one.

23 And then we really highlight as well as part of
24 Appendix A that we have to consider our policies in
25 light of both external and internal practice
26 environments. External would be: (as read)

1 Any locale beyond the internal practice
2 environment and may extend to municipal,
3 provincial, national, or international
4 borders, depending on the nature of the
5 infection risk being considered.

6 Specifically when I look at that, that just
7 specifically speaks about a novel infection. There was
8 so much information that was lacking at the onset of
9 the pandemic that we -- this is where we again
10 identified that we really need to be -- get the
11 information and provide the information that's relevant
12 to practice.

13 And then when you come back, we are adamant that
14 our members must: (as read)

15 Adopt appropriate -- [and this is a minimal
16 level] -- but adopt appropriate infection
17 control measures, including contact
18 management protocols and monitor their use
19 and effectiveness to identify problems,
20 outcomes, and trends; provide infection
21 prevention and control training for clinical
22 staff and monitor implementation of that.

23 So, again, they are highlighting, to a question you had
24 asked earlier, Mr. Maxston, part of this standard is
25 that our members have a responsibility to make sure
26 their staff are trained and monitored in their use of

1 infection prevention and control procedures, which --
2 excuse me for a sec -- which does include the use of
3 personal protective equipment.

4 And then to: (as read)

5 Conduct ongoing assessments of current risk
6 of infections and transmissions to patients,
7 staff, colleagues, and other health
8 professionals, and take appropriate remedial
9 action in a timely manner consistent with
10 professional requirements --

11 Right? And when I look at that word "professional
12 requirements", you know, that is the Pandemic Practice
13 Directive, that was the professional requirement that
14 council put in place in respect of the novel
15 Coronavirus that -- pandemic: (as read)

16 -- and the applicable law based on
17 consideration of the following: The
18 assessment of the treatment [so this is
19 speaking to, you know, assessing what's going
20 on]; the health condition of the patients;
21 the degree of infection and risk currently
22 present in the internal practice environment;
23 the degree of risk presently in the external
24 practice environment; and current best
25 practice infection prevention control
26 protocols relative to his or her practice.

1 Again, going back to, you know, if -- what they're
2 doing with patients.

3 For instance, we have some practitioners that work
4 intraoral or do work inside of somebody's mouth,
5 they're going to wear gloves. There's a risk that they
6 could be closer or developing aspirations or -- from
7 the patient or where they would need face shields. So
8 that was a significant portion of that.

9 And then, you know, so this standard of practice
10 is there -- there isn't a requirement in our Pandemic
11 Practice Directive that isn't already considered in our
12 standard of practice, but the Pandemic Practice
13 Directive was contextualized to the information
14 provided by Alberta Health and Public Health to
15 practicing during the novel Coronavirus outbreak and
16 was meant to -- as a requirement for our members to
17 follow. Hence, why we use the word "directive" instead
18 of "suggestions".

19 Q Okay.

20 MR. MAXSTON: Mr. Chair, it's about 3:30.
21 The -- I have my last section of questions for
22 Dr. Halowski is about his involvement in the complaint
23 concerning Dr. Wall and a couple of I guess
24 housekeeping questions after that, not many.

25 I understand from the College that the Hearings
26 Director at 4:00 would need to hand over control of the

1 meeting hosting to someone else. I think I would
2 propose to go another half an hour unless you need a
3 break, and I don't think, unfortunately, we're going to
4 get to cross-examination today by Mr. Kitchen, but I
5 think I can finish with Dr. Halowski today. And then
6 next Tuesday, we would resume with Mr. Kitchen. I, of
7 course, wouldn't talk to Dr. Halowski about his
8 testimony during that break.

9 Do you want to take a quick break now though for 5
10 or 10 minutes, or do you want me to just go ahead, and
11 I'm fine either way?

12 THE CHAIR: No, I think my body doesn't
13 like sitting in front of a computer screen eight hours
14 a day, so I'd like to get up and stretch. So let's
15 just -- I mean 5 minutes is fine, and then we'll --

16 Mr. Kitchen, does that sound fair to you in terms
17 of a plan for the rest of today and for next week?

18 MR. KITCHEN: That's fine, yeah. We're not
19 going to have time to do my cross, so that's fine.

20 THE CHAIR: Okay, very good. All right,
21 well, if that's the case, let's break for -- come back
22 at 20 to 4, and then we'll plow through the rest of the
23 direct examination. So we're in -- session is in
24 recess for now, reconvene at 3:40. Thank you.

25 (ADJOURNMENT)

26 THE CHAIR: The hearing is back in

1 session, and, Mr. Maxston, it's your floor to continue
2 with Dr. Halowski.

3 MR. MAXSTON: Thank you, Mr. Chair.

4 I'm now going to turn to the sixth and final area
5 that I wanted to have questions for Dr. Halowski on,
6 and that is his involvement in the complaint concerning
7 Dr. Wall. I'm going to ask you, Mr. Chair and your
8 colleagues, to go to Exhibit A-2, which is a December
9 1, 2020 email from a lady named Heidi Ho at Alberta
10 Health Services that was sent to Dr. Wall and was
11 copied to Dr. Halowski, so I'll just let everybody get
12 to that document, and then I'll -- I've got a few
13 questions on that.

14 THE CHAIR: And, Dr. Halowski, do you have
15 a copy?

16 A Yes, I do, thank you.

17 Q MR. MAXSTON: So, Dr. Halowski, I really, as
18 I said, going to want to talk to you here about your
19 involvement with this complaint and how things started.
20 Can you tell me who Heidi Ho is at Alberta Health
21 Services?

22 A Yeah. Heidi Ho is a community medical specialist, so
23 she's like a ground-worker for Public Health, and so
24 when Public Health complaints are received, then she
25 would go out and investigate.

26 During the pandemic in the initial phase, we

1 received many contacts specifically from Public Health
2 about the conduct of our membership, where we would
3 investigate. That was something that I would often
4 receive, initiate, and then follow up and let me them
5 know that we'd investigated and any action taken.

6 So for Heidi Ho to reach out and communicate to me
7 directly was an occurrence that wouldn't have raised on
8 my radar from time to time, but it was a signal that
9 Public Health had something that they wanted us to look
10 into and be able to respond to them that our member
11 was, in fact, doing what they should do, or if there
12 was concerns, then we would raise them back to Public
13 Health as well.

14 Q So the December 1, 2020 email, you're copied with it,
15 it's going to Dr. Wall. Can you tell me what Ms. Ho is
16 communicating to you in this email?

17 A Yeah. So she says: (as read)

18 Alberta Health Services received a complaint
19 indicating that the administration staff and
20 yourself are not masking even when within 2
21 metres distance with patients. As per our
22 phone conversation, you indicated you were
23 mask-exempted as per CMOH 38-2020. Please
24 indicate which exemption you would fall
25 under; otherwise, you are required to be
26 masking when within 2 metres distance with a

1 patient. As for your administrative staff,
2 you indicated that there is no plexiglass
3 barrier at the reception and that staff are
4 not masking. Patients could be within 2
5 metres' distance when making payments. This
6 is in violation of the CMOH Order 26-2020,
7 where every person attending an indoor or an
8 outdoor location must maintain a minimum of 2
9 metres distance from every other person.
10 Your clinic must have control measures,
11 physical barriers -- for example, physical
12 barriers to promote physical distancing at
13 all times; otherwise, the administrative
14 staff must be masked as per CMOH Order
15 38-2020.

16 And then she just informs that she's copied me, and
17 when I received this email, I was quite concerned that
18 Dr. Wall was not following the practice directive,
19 because we were very clear about what the requirements
20 are, and masking was one of them, and Ms. Ho was also
21 aware of that.

22 Q Okay. I'll ask you to go and everyone else to go to
23 Exhibit A-3, which is your December 2, 2020 letter to
24 Mr. Lawrence, in his capacity as Complaints Director.
25 And I'll just -- you quote Ms. Ho's email in there in
26 your letter, I'll just ask you to read the first

1 paragraph in your letter to Mr. Lawrence.

2 A (as read)

3 It has come to the attention of the Registrar
4 through Public Health on December 1st, 2020,
5 at 4:17 PM that Dr. Curtis Wall is not
6 following the ACAC Pandemic Directive and the
7 CMOH orders regarding masking and the
8 requirements to maintain 6 feet of social
9 distance.

10 And I included that body of the email just for
11 Mr. Lawrence's consideration.

12 Q Okay, and can you read the last two paragraphs -- I'm
13 going to have questions for you on these, but can you
14 read the last two paragraphs in your letter,
15 beginning --

16 A Yeah.

17 Q -- with "Further to"?

18 A (as read)

19 Further to the email from Public Health, in
20 conversation with Dr. Wall, he indicated that
21 he does not mask, and he has not provided
22 for barriers in his clinic.

23 So I did, once I had this, send an email to Dr. Wall,
24 letting him know I would need to speak with him. We
25 did have a conversation on December 2nd.

26 And so that's what that's referencing, that, in

1 conversation, he had communicated that he wasn't doing
2 it and nor do he have intention to: (as read)

3 I have serious concern for public safety as
4 Dr. Wall refuses to mask when he breaches the
5 physically distance of 6 feet with the
6 public. He is not providing for or requiring
7 his staff to mask when they are within 6 feet
8 of distance.

9 Q Okay, so I want to turn back to this phone conversation
10 you had with Dr. Wall, and can you just refresh my
11 memory, what day did that happen?

12 A December 2nd.

13 Q And did he call you?

14 A I can't remember the exact -- I did imply that we would
15 need to converse, and I believe that I did call him at
16 his clinic, but I don't know off the top of my head.

17 Q Okay, I want to just be very clear about your
18 conversation with him and what he said to you. You
19 said in your letter he indicated that he does not mask?

20 A Yeah.

21 Q And that's accurate?

22 A That's what he indicated at the time, that he was not
23 masking, and I also remembered he indicated he had no
24 intention to mask because -- yeah, well, he did, for a
25 brief moment in that conversation, describe how he
26 didn't think that COVID was serious, and that it was --

1 we were overreacting with the Pandemic Practice
2 Directive. And so he was indicating that he was not
3 going to because he did not believe that he needed to
4 follow this, that he would be just fine.

5 And somewhat at -- somewhat at the time, I think
6 they've come to be known as COVID deniers in the
7 public, that there was rhetoric, there was speech about
8 how COVID's not real, how it's not serious, that it's
9 no more than a mild flu, and some of that language that
10 was common and has continued to be common about COVID
11 during the pandemic.

12 Q Did he talk to you about his exemption from masking or
13 his alleged exemption?

14 A He had talked about how he had originally worn a mask
15 but then decided that he didn't like to wear it and
16 that he -- you know, I think he said, you know, he just
17 didn't feel comfortable wearing it, so he had been
18 wearing it since May. And so at the end of May, I
19 think, is when he indicated that he had removed the
20 mask from what I recall of that conversation.

21 Q And, I'm sorry, what did he identify as the reason for
22 not masking?

23 A He said he didn't like how he felt when he wore it, you
24 know, he just didn't feel comfortable wearing it, which
25 I believe were the words he used in that conversation.

26 Q Okay. Did he identify any other reasons for not

1 wanting to wear the mask?

2 A Other than, you know, I asked why, and I think that's
3 when some of the conversation around COVID not being
4 real and that this is, you know, we're just
5 overreacting, and, in this environment, to have to wear
6 a mask and that he wasn't comfortable doing that.

7 Q Did he mention any religious objections?

8 A I don't believe he did at that time; not that I can
9 recall.

10 Q Did he argue that he couldn't practice because of the
11 Pandemic Directive then?

12 A No, he didn't raise anything. You know, I tried to
13 encourage him that masking is required, and he said
14 that he wouldn't be masking, that he -- I think he then
15 was -- yeah, I think, you know, part of it he was
16 claiming he was now exempt from masking because of the
17 City bylaws allowed him to be exempt. And I do
18 remember having a conversation that that's not the
19 intent of the bylaws, and the practice directive
20 applies to you.

21 Hence, the follow-up communication to
22 Mr. Lawrence, that we have a member that's not
23 following the Pandemic Practice Directive.

24 Q We talked before about the Telehealth directives; were
25 there some options for practice available to Dr. Wall
26 if he didn't want to mask?

1 A Dr. Wall could have practiced Telehealth. Dr. Wall
2 could have -- at that time, he could have had
3 conversations with his patients to only mask when he
4 was going to be within 6 feet, but Dr. Wall indicated
5 that he wouldn't do that either.

6 Q I'm going to ask you some closing questions here just
7 about I guess the regulatory function of the College
8 and, more specifically, the regulatory roles that you
9 occupy or have involvement with as Registrar.

10 Does the College have mandatory practice visits?

11 A Yes, that is a part of our practice. That's part of
12 the rights given in our regulations that our competence
13 committee has mandatory practice visits.

14 Q And can a chiropractor choose to opt out of practice
15 visits?

16 A They cannot.

17 Q Does the College have a required continuing competence
18 program?

19 A We do have a continuing competence program that
20 requires a certain number of CC hours. Council has
21 also directed that members have to maintain currency in
22 first aid, that right now we have a requirement for a
23 recordkeeping course that must be completed annually,
24 and that members also must complete trauma-informed
25 training on an annual basis.

26 Q Can a member choose to opt out of those requirements?

1 A Not if they would like to renew their practice permit.

2 Q So I take it that means, no, if they want to practice?

3 A That's correct, yes.

4 Q In his questions with a prior witness, Mr. Kitchen
5 asked a question about whether chiropractic clinics are
6 or are not health care settings; how would you respond
7 to that?

8 A The way I would look at that is we're a regulated
9 profession underneath the Health Professions Act, and
10 we are health professionals, health care workers.
11 We're regulated members of a health care profession,
12 and that's what the Health Professions Act establishes.
13 That's the level of expertise.

14 When people come to us, they're coming to us for
15 health care problems. They're coming to us because
16 they're seeking our care for conditions that impact
17 their health. So I would say, in every sense of the
18 word, we are health care workers.

19 Q Dr. Halowski, since the COVID-19 pandemic began, have
20 any chiropractors died from COVID-19, to your
21 knowledge?

22 A Yes. We've had two of our members that passed away as
23 a result of COVID-19. We had one practitioner in his
24 early 50s in Calgary that passed way as a result of it.
25 We had one of our members in their early 60s passed
26 away as a result of it. And during that time, I've had

1 an opportunity to speak to many of our members who
2 acquired COVID as well.

3 MR. MAXSTON: Dr. Halowski, those are all my
4 questions for you.

5 I see we're just coming to 4:00, so Ms. Nelson is
6 still involved. I take it, based on our previous
7 discussion, Mr. Chair and Mr. Kitchen, that what the
8 intention will be is that next Tuesday, when we resume,
9 Dr. Halowski's testimony would continue, and
10 Mr. Kitchen would commence his cross-examination, I
11 would do my redirect, if any, and the Tribunal would
12 ask any questions of Dr. Halowski?

13 THE CHAIR: That's my understanding. I
14 think that's the path that we shall follow.

15 The Chair Questions the Witness

16 THE CHAIR: But before we break for today,
17 I had one quick question that I would like to ask
18 Dr. Halowski, and this goes to the complaint that was
19 received.

20 Q THE CHAIR: So the complaint was made by a
21 patient to Alberta Health?

22 A It was made by one of Dr. Wall's patients specifically
23 to Alberta Health, but Alberta Health communicated it
24 back to us. They indicated that that patient would
25 like to stay anonymous, as they had a -- often
26 patients -- and that's very standard for a patient not

1 to want to be identified -- but when they made that
2 complaint and with that follow-up conversation to
3 Dr. Wall where I became aware of it, that's when we
4 decided to action further.

5 Q Okay, so there was no further communication with the
6 patient?

7 A No, at no time did we communicate with the patient;
8 that came to Alberta Health from a patient.

9 Q Okay, I just was curious as to how -- what the path was
10 for that complaint to end up where it did.

11 THE CHAIR: Did any other Members of the
12 Tribunal have questions they wanted to talk about
13 today? We can caucus and discuss those, or we can --
14 you have a chance to think about this and certainly
15 raise them next week when we meet.

16 Okay, I think the Hearing Tribunal Members are
17 fine; I'm fine.

18 So thank you very much, Dr. Halowski, for your
19 time and your testimony today. Much appreciated.

20 Thank you, counsel, both counsel for your efforts.
21 They are long days, but there's a lot to cover, and we
22 shall pick this up at 9:00 on September 7th and
23 continue, at that point, with Mr. Kitchen's
24 cross-examination of Dr. Halowski.

25 And I would just ask, Mr. Pavlic, do we need to
26 caution Dr. Halowski not to discuss his testimony, or

1 is that not an issue?

2 MR. PAVLIC: He should be provided the
3 usual caution, but I think Mr. Maxston has already
4 indicated that he will not be discussing any matters
5 with him, so I think that will cover it off.

6 MR. KITCHEN: Okay, your comment, mine, and
7 Mr. Maxston's.

8 THE CHAIR: Okay, that's great. Okay,
9 thanks everybody. We will call this hearing to close
10 for today, and we'll see everybody on the 7th. Have a
11 good long weekend.

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13 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, SEPTEMBER 7, 2021

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1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing
4 pages are a complete and accurate transcript of the
5 proceedings, taken down by me in shorthand and
6 transcribed from my shorthand notes to the best of my
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,
9 this 27th day of September, 2021.

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Karoline Schumann, CSR(A)

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Official Court Reporter

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Exhibits	1		
Exhibit G-1 - AHS - Directive Use of Masks During COVID-19 202:9 352:9,10	1 223:6 300:17 333:21 346:23 348:10 361:18 363:8 364:4,7,9 367:5 370:14 371:8 394:9 395:14	16 288:12 295:15 384:24 16-20 324:16 16-2020 247:23 324:19 328:10 344:5 16th 279:3 282:12 283:3 284:5,6 17 269:26 18 280:3 18th 313:10 1996 313:10,15 1:00 264:2,19 300:14 1:15 301:8,12,15 302:26 1:18 302:24 1st 324:23 397:4	2007 269:24 305:1 2008 305:1 2009 269:26 2010 385:2 2014 248:7,14 305:4 385:2 2015 248:7,14 305:9 2018 279:5 280:21 281:4 284:8 2019 304:14,21 2020 261:7,26 267:7 274:26 284:5 315:2 328:23 332:4 334:23 336:3,4 357:2 359:13 364:4 365:7,15 366:9 367:4 368:26 370:6 371:7 372:1 376:1 378:3 383:17 394:9 395:14 396:23 397:4 2021 201:5,20 203:5 279:3 281:3,17 282:18 284:6 292:20 293:14 295:1,20 298:5 302:5 336:4 338:17 378:4,11 383:14, 18 405:13 406:9 203 201:5 204 201:6 206 201:7 207 201:8 21 314:9 336:1 359:13 211 201:9 213 201:10
Exhibit G-2 - AHS - Guidelines for Continuous Masking 202:11 352:11,12	1,010 279:2 280:19 1,191 279:4 280:20 10 217:8 218:17, 18 352:4 374:8 393:10 10-minute 350:23 351:2 10:00 217:10 220:13 221:2 10:58 263:11 10X 226:9	2 201:5,20 203:5 216:22 223:7 263:12 302:5 325:24 326:4,8 327:4,14 328:19 329:20,25 330:19 335:13,15,24 339:15,18,24 340:8 342:18 345:3,6 346:24 348:20 351:2 353:17 359:16,18 361:19 366:11 367:7 373:5,6,19 374:6 376:15 395:20,26 396:4, 8,23 20 217:8 315:2 372:23 393:22 2003 312:8 2004 312:8 2005 304:12,13 312:7	214 201:11 215 201:12 216 201:13 202:5, 7 22 286:2 336:2 221 201:14 22nd 318:20 23 332:17 334:24 371:7 23rd 318:20 24 313:25 332:4, 17 333:1 334:24 367:4 24(c) 335:6 25 321:25 336:4 351:2,3 366:8 372:1,23 25th 336:13 26 294:10,15 334:4 26-2020 396:6 27 294:5,12,14 295:7,12 316:13 334:7 27(c) 295:2 334:15 27th 315:10 406:9 28 208:13 286 201:16 29 281:17 292 201:17 299 201:18 29th 318:21 344:13 362:24 2nd 313:15 397:25 398:12
Exhibit G-3 - AHS - Personal Protective Equipment (PPE) 202:13 352:13,14	11 269:26 370:6 1150 321:24 1191 281:4 11:15 264:18 11th 334:23 12 284:5,8 120 218:14 1200 321:24 12:11 208:6 12:15 300:13 12:44 210:15 1400 282:19 14th 292:20 293:5,9,14 295:1, 20 15 217:12 247:19 264:23 384:17,20 15-minute 263:18	2 201:5,20 203:5 216:22 223:7 263:12 302:5 325:24 326:4,8 327:4,14 328:19 329:20,25 330:19 335:13,15,24 339:15,18,24 340:8 342:18 345:3,6 346:24 348:20 351:2 353:17 359:16,18 361:19 366:11 367:7 373:5,6,19 374:6 376:15 395:20,26 396:4, 8,23 20 217:8 315:2 372:23 393:22 2003 312:8 2004 312:8 2005 304:12,13 312:7	28 208:13 286 201:16 29 281:17 292 201:17 299 201:18 29th 318:21 344:13 362:24 2nd 313:15 397:25 398:12
Exhibit H-5 - Face Masks to Reduce COVID-19 in Bangladesh RCT 202:5 216:13,14	19 Like Illness Prevention RCT 202:7 216:15,16	2 201:5,20 203:5 216:22 223:7 263:12 302:5 325:24 326:4,8 327:4,14 328:19 329:20,25 330:19 335:13,15,24 339:15,18,24 340:8 342:18 345:3,6 346:24 348:20 351:2 353:17 359:16,18 361:19 366:11 367:7 373:5,6,19 374:6 376:15 395:20,26 396:4, 8,23 20 217:8 315:2 372:23 393:22 2003 312:8 2004 312:8 2005 304:12,13 312:7	203 201:5 204 201:6 206 201:7 207 201:8 21 314:9 336:1 359:13 211 201:9 213 201:10
Exhibit H-6 - Locally Produced Cloth Face Mask and COVID-19 Like Illness Prevention RCT 202:7 216:15,16	19 Like Illness Prevention RCT 202:7 216:15,16	2 201:5,20 203:5 216:22 223:7 263:12 302:5 325:24 326:4,8 327:4,14 328:19 329:20,25 330:19 335:13,15,24 339:15,18,24 340:8 342:18 345:3,6 346:24 348:20 351:2 353:17 359:16,18 361:19 366:11 367:7 373:5,6,19 374:6 376:15 395:20,26 396:4, 8,23 20 217:8 315:2 372:23 393:22 2003 312:8 2004 312:8 2005 304:12,13 312:7	203 201:5 204 201:6 206 201:7 207 201:8 21 314:9 336:1 359:13 211 201:9 213 201:10
\$			
\$1 226:5			
0			
02-2021 295:19			
			3
			3 223:7 266:22,23 308:10 329:9 330:3,5 331:10,

14 351:3 360:19 365:7	393:9,15	9:03 203:23	385:7,14,22	404:4
30 243:15	5- 350:23		accepted 215:4	actively 236:23
302 201:20	5-page 327:4	<hr/> A <hr/>	379:4 385:23	237:9 275:14
303 201:21	50 226:16		386:20,22,25	305:11 321:26
32 288:12,15	50s 402:24	A-11 384:14,19	387:12	activity 305:3,5
352 202:9,11,13		A-2 394:8	access 222:15,17, 19 361:15	actual 211:24
356 321:21	<hr/> 6 <hr/>	A-3 396:23	accessed 364:16	212:21 220:8,12
38 295:15 345:13	6 226:3,7 267:11, 18 279:1 294:9, 10 328:24 329:22	abide 248:16	accident 279:4	232:13 277:12
38-20 332:3,12	397:8 398:5,7	ability 208:18	280:20	298:6
38-2020 293:15	401:4	223:26 382:6	accommodating	acutely 290:10
295:17,18 297:14	60 226:5 281:3	406:7	209:21	315:20
395:23 396:15	282:15,19,24	absence 237:24	accommodation	adamant 390:13
3:30 392:20	283:24	absolute 309:15	332:25	adapt 312:12
3:40 393:24	60s 402:25	321:2	accordance	383:7
	62 267:25	absolutely 290:1	331:9	add 251:7 371:1
<hr/> 4 <hr/>	6th 336:4,25,26	307:12 308:14	accredited	added 258:16
4 262:3 267:7	338:12,17	310:3,6 315:5	310:16,17,18	addition 318:10
294:5 305:9		316:19 324:13	accurate 204:6	362:2
331:4,20 332:6,	<hr/> 7 <hr/>	347:12,14 358:4,	227:5 244:3,10,	additional
15,22 393:22	7 315:11 339:3	18 360:13 361:17	17 279:8 280:22	330:16
4.3 384:11,18	343:5 372:24	362:2 365:2	282:21 283:3,6	address 307:21
40 295:18	379:9 405:13	366:5 367:25	398:21 406:4	312:6 316:24
40-2020 295:18		373:26 382:10	accurately	324:11 356:24
403 201:23	7th 404:22 405:10	ACAC 203:10,	236:15 268:18	357:1 375:1
406 201:24		11,13,16 222:2	accusation 279:6	addresses 321:21
42 345:13	<hr/> 8 <hr/>	224:20,22 225:4,	280:18,26 285:3,	359:17
42-20 334:22	8 270:19 274:2,8	12 232:13	4,7	addressing
42-2020 295:19	286:18 288:17	302:10,11,13,16,	accuse 279:1	268:10
4:00 392:26 403:5	294:9 339:6	17 303:24 305:1,	285:1	adduced 233:17
4:17 397:5		5 317:3 348:22	achieve 358:3	adequate 329:19
4th 327:10,22	<hr/> 9 <hr/>	356:18 359:4	acquired 343:25	341:19
328:23 336:11	9 329:11 343:1	361:22 363:11	403:2	adequately
365:15	369:4 376:1	364:14,25 365:23	acquisition	268:9
<hr/> 5 <hr/>	90 218:14	366:1 370:16,24	389:7	adhere 215:4
5 234:2 241:1,26	95 273:12	371:14 372:16	ACSLPA 346:5	348:21 370:16,23
263:18 330:8	98 285:14,25	374:13 375:6	act 246:14,16	adjourned 204:1
331:4,11 334:25	99 265:17	376:16 377:20	305:24 307:23	301:15 405:13
336:3 363:17	9:00 404:22	378:2 397:6	308:10 320:16	ADJOURNME
378:3,4,6,13	405:13	academic	328:26 330:2,10	NT 215:19 221:5
		285:14,25 286:2	332:24 379:20	264:24 299:19
		accept 210:19	381:24 402:9,12	352:5 393:25
		acceptable 225:4	action 276:22	Adjusting
		287:2 309:6	391:9 395:5	362:15 375:7
		321:7,8 341:25		
		342:5,6 371:2		

adjustments 319:15	Affirmed 201:21 303:8	353:3,10,17,19, 23 354:9,21,26	218:10	anti-vax 229:26
administer 381:12	afield 246:6	aid 314:8 401:22	amend 331:12, 24,26	anti-vaxxer 229:15
administered 306:3	afternoon 201:20 302:5 303:9	airborne 389:14	amended 346:17 383:24	anticipate 220:17
administers 306:11	agent 389:13	airplane 265:10	amendments 331:22,23	anxiety 250:6,15 251:6,19 252:12, 23 254:18 292:4, 6
administration 305:16 306:15 395:19	agents 389:7	akin 245:17 247:15	America 229:23 310:7	anymore 275:1 285:5,9
administrative 396:1,13	aggregate 227:13	Alberta 203:1,3, 15 222:20 234:6, 24 259:2,5 262:4, 14,23 275:23	amount 227:18 263:4	apologies 205:18 368:25
admit 206:13	aggregation 228:4	298:16 302:1,3, 15 307:2 310:19	ample 213:26	apologize 232:4 245:25 272:12 300:1 326:22 350:14
admitted 207:19 211:19	agitated 256:6	313:12 315:9	analysis 208:19	apparently 300:2
adopt 322:9 325:11 344:23 390:15,16	agree 217:7 222:25 224:16 225:3,7,23,26 226:14,15,26 227:17 229:11 230:8 232:23 233:8,12,20,23 234:26 237:26 238:26 241:21 243:5 244:3,9,16, 19 246:9 247:4, 23 249:11,26 250:3 252:4,6,10 257:18 265:16 268:23 277:7 287:3 293:8 294:25 295:17, 20,26 296:20 298:4	316:7,9,19,20,26 317:10,18 325:21 330:15 346:6 348:12 350:4,11 363:6,21 364:3, 19 365:13 367:3 378:20 392:14 394:9,20 395:18 403:21,23 404:8 406:8	and/or 241:11 242:14	appendix 329:9 388:25 389:3,24
adopted 308:24, 25 318:26 325:10 326:12 331:3 346:2 358:24 385:2	agreed 204:25	Albertans 315:14	anit-masker 230:16	applicable 330:11 391:16
advanced 310:10	agreement 204:24 205:1,5	Aldcorn 203:10 302:10	anit-vaxxer 230:15	application 201:7,8,9,10,11, 12 204:10,17 206:2,10 207:20 210:14,16 211:7 213:9 214:4,10, 12 215:20 332:16
advice 215:22 306:19	ahead 238:12 243:4 281:13 296:17 326:5 329:22 336:25 343:1 348:3 362:25 370:11 371:6 393:10	alert 340:24 375:24	announced 327:8	apologize 232:4 245:25 272:12 300:1 326:22 350:14
advise 322:9 323:10 358:9 371:13	AHS 202:9,11,13 226:19 227:24 341:3,10,13 350:10,21 352:9, 11,13,16,21,26	alerted 336:9	announcement 341:3	apparently 300:2
advised 312:9 316:1 325:11		alleged 399:13	annual 313:24 401:25	appendix 329:9 388:25 389:3,24
advisement 337:13 358:14		allergies 242:16, 20	annually 313:24 314:10 401:23	applicable 330:11 391:16
advising 306:26 316:10 325:15 341:10 353:12 360:2 382:23		allergy 354:25	anonymous 361:19 403:25	application 201:7,8,9,10,11, 12 204:10,17 206:2,10 207:20 210:14,16 211:7 213:9 214:4,10, 12 215:20 332:16
advocate 210:21		allowed 220:2 245:1 255:10,15, 16 281:12 321:18 327:22 336:20,21 357:13 358:17 359:1,3 365:4 400:17	anonymously 321:20	applied 223:18 389:19
aerosol 342:3		allowing 220:7	answering 284:25 366:18 376:23	applies 378:19 400:20
aerosols 346:14		ambush 210:7 211:2 212:3	answers 282:3	apply 261:3 294:15 311:1 323:8 329:26 333:20 335:10,14
affects 271:1			anti-mask 228:21 229:5,13, 26 230:8,21	applying 333:24
affirm 303:5,7			anti-masker 229:21	appointed 306:22
			anti-masking 232:21 234:6,9	appointment's 244:25
			anti-something 230:12	appointments

333:9	argument 210:6 211:2,22 231:4 232:14,15	244:4,5,13,14,18 288:23 366:21	awful 213:21	Bangladesh 202:6 216:14
appreciated 404:19	arose 380:14	asymptomatics 241:10	<hr/> B <hr/>	bank 245:22 247:17,18
approached 206:6	article 211:14 234:10	attached 329:1,5	B.E. 203:16 302:17	Bao 248:8 274:10
appropriately 335:22 340:25 346:11	articles 212:21	attaching 208:6	Bachelor's 310:9	bar 385:9 386:23
approval 363:11, 13 364:18	articulate 279:9	attack 255:20	back 215:17 216:20 217:18 218:18 219:11 237:14,15 248:1 254:22 271:17 278:8,10,25 286:9 299:15,16 300:4 302:25 314:13,17 318:15,25 319:2, 8 320:19 322:11 324:11 325:6 351:3 352:6 355:19 361:5 379:15 383:16 389:4 390:13 392:1 393:21,26 395:12 398:9 403:24	barricade 247:20
approve 364:21	aspect 307:19	attempt 367:26	backed 274:13 278:16	barrier 338:1 340:10 373:10 396:3
approved 311:11 327:23 328:4 362:26 364:14 365:24	aspects 310:21 342:24 361:4	attend 306:17	background 208:4,24 249:10 303:13,19 309:23 315:1	barriers 337:25 344:26 372:26 373:13,15,19 387:14,17,22 396:11,12 397:22
April 279:3 280:20 281:3,17 282:11,12 283:3, 8,19,26 284:5 318:20,21 320:22 344:13 359:13 362:24 380:15	aspirational 321:8 385:8	attending 294:16 334:8 396:7	backwards 346:22	based 204:7 222:15 233:15 238:3 250:8 282:18 292:14 297:20 309:1 314:4 335:11 383:19 384:10 389:12 391:16 403:6
aprons 388:5,13	aspirations 392:6	attention 308:1 353:11 397:3	backed 274:13 278:16	baseline 241:13 379:4
area 271:22 303:12,14,16,18, 22 304:1,4 306:12 307:8 309:21 313:1 314:22 324:17 339:14 340:8 343:8 373:7 394:4	assert 278:3	audiologists 327:20 346:7	basic 285:2,12	basically 250:10 252:4 265:12 266:5 269:17 273:10 279:16 281:15
areas 303:12 306:25 318:1,2 329:14,16 339:11,16,20,21 341:16	assess 240:16 246:25	August 368:26 370:5	backward 289:20	basics 289:5
argue 228:19 231:6 400:10	assessing 391:19	author 215:8 267:25	bacteria 221:18, 19,21 249:12 250:2	basis 237:1 239:23 287:23 306:8 313:24 401:25
arguing 231:9, 11,16,26 232:1,5, 10,18 233:1,9,17, 18,21 247:14 279:8	assessment 262:21,22 314:3 391:18	authored 267:1	bad 229:24 230:1 245:8 249:18 284:14	bear 215:17 299:9 377:25
	assessments 324:6,7 391:5	authoritative 268:22	balance 256:15 263:19	began 402:19
	assignments 307:5	authorities 347:8,10		begin 224:6 314:26
	assist 354:7	authority 367:19 368:8		beginning 212:11 346:16 353:26 397:15
	associate 304:19	authorization 295:4 297:15		
	association 203:2,15 302:2, 15 305:3 356:3,6 358:11 361:3 362:18 363:6 364:3 375:10	authorized 368:18		
	assume 222:20 224:3 238:10 239:11 244:25 289:2 295:26 297:18	average 244:24 247:5		
	assumed 296:24	avoid 210:8 241:20 242:12,22 291:8		
	assuming 290:21 370:10 375:7	avoiding 212:3		
	asymptomatic 237:17 238:11	awake 212:16		
		aware 306:4 315:20 320:3 334:16 343:9 345:23 347:20 349:5 351:7 363:15 371:25 396:21 404:3		

begins 365:10
372:5 376:4,17
behalf 303:1
306:11
beliefs 256:22
257:16
benefit 273:14
303:11 377:19
bias 268:8,10,11
big 242:4,8
247:20 271:23
383:4
bigger 249:13
biggest 275:12
322:21
bill 314:9 358:12,
15
billing 358:7,9
bills 359:7
binder 377:25
binding 287:10
308:25
bit 216:21 222:22
240:20 243:12
258:11,16 260:25
264:1 266:15
276:4 283:1
285:4 297:1
307:9 312:26
327:2 346:22
349:21 354:13
384:21
black 243:21
286:26
Blair 351:15
blasts 303:25
blend 356:1,3
blended 356:6
blood 387:15,26
blow 315:14,15
blue 222:1,26
224:17 225:17,24
226:14 286:23
377:3

boards 231:21
bodies 228:9
body 234:26
311:26 323:18
344:22 387:15
388:1,25 393:12
397:10
boiled 290:2
bone 213:15
book 214:20
243:9 293:24
borders 390:4
bottom 267:20
372:3
breach 326:3
breaches 398:4
breaching
325:23
break 209:9
217:11 218:17
263:18 264:9,16,
22 301:4 350:23
351:3 387:3
393:3,8,9,21
403:16
breaking 219:22
breakout 204:13
205:21
breaks 218:20
breath 241:8
breathe 323:22
breathing 243:6
345:19,20
briefly 206:14
210:10 213:14
303:20 350:6
351:9 375:5
bring 216:20
217:17 218:11
219:5
bringing 342:23
brings 294:1
broad 310:21

broader 283:19,
20 295:7
broadly 222:20
224:3 227:17
260:6 296:24
336:4 359:16
bulk 226:3
bullet 327:14
367:7
bullets 341:22
384:23 389:4
bunch 238:20
262:22
business 334:11
businesses
373:13
busy 299:25
Bye 300:10,11
bylaw 349:22
367:6,11,15
368:4,11,20
378:24
bylaws 307:17
308:20 370:18,
22,24,25 372:9
381:26 400:17,19

C

C' 294:20
C-1 303:26
351:19 355:11,13
357:22 358:4
C-10 357:22
368:23,24
C-11 368:26
C-12 370:5,14
C-13 357:23
371:5
C-14 371:7
C-15 372:1
C-16 372:22
C-17 375:6
C-18 375:26
C-19 377:12
C-2 359:13
C-20 336:1
C-22 286:15
303:26 338:22
351:20 355:11,13
C-3 361:11
C-4 362:14
C-5 363:7
C-6 364:4
C-7 365:6
C-8 366:8
C-9 367:4
cabinet 234:23,
26 287:6
calculate 284:10
Calgary 231:21
349:1 368:16
402:24 406:8
Calgary's 367:6
call 204:9 210:12
221:25 223:17
229:25 235:19
240:23 243:2
244:3,10 252:7
267:2 272:15,18,
24 273:5 277:4
300:4 303:24
305:16 306:14
311:5 316:22
317:24 318:22
355:12 358:8
398:13,15 405:9
called 206:20
234:11 247:24
257:1 266:4
276:9 288:25
300:2 316:20
321:17 375:12
377:7
calling 348:26
349:3,12

calls 324:24
380:25,26
camera 357:17
359:11
Canada 234:6
281:2,3 359:26
Canadian 250:8
317:5
candid 217:1
capacity 304:17
306:2 396:24
card 368:16
care 222:8,9,19
224:1,7 231:7,12,
14,15 232:1
234:19 235:7,8,
16,19,22,25
236:2,4,6,9,13,
17,22 237:22
238:2,23 239:3,5,
20 245:19
246:15,21
247:12,15,24
248:11,15,24
250:16,17,19,22,
23 251:7,21,24,
25 252:2,8,14
253:4,11,13,20,
26 254:15,21
255:1,3,4,5,25
256:7,12 259:7,
15,16,20,24
260:10,11,20
261:6,25 262:3,
13 263:6 265:25
266:12,14
270:17,18,23
271:16 272:2,15,
19,24 273:5,10,
13,24 279:13,20
287:13,16 288:4,
11 290:4,7,13
300:9 310:21
312:16,19,23
315:12 316:11
323:20,21 326:3,

14 327:17 329:2, 14 330:15 333:15 335:16 336:15, 17,18 339:15,26 340:4 341:11,12, 13 342:12,14 345:3,9 346:21 348:6 354:22 358:23 364:25 373:21 379:20 387:5,18,25 389:5,8,10 402:6, 10,11,15,16,18 carefully 254:6 caring 324:2 carries 229:13,26 carry 305:15,17 carve-out 258:7 carve-outs 260:6 case 208:16 211:1 213:24 232:6,10, 11,26 233:2,9,14 275:12 276:7 298:9 355:3 386:2 393:21 cases 210:13,16 212:10,11 271:1, 9,23,25 274:19 275:8,23 276:1,3, 8,23,25 277:3,7, 11,14 337:4 373:16 casual 249:18 catchy 234:13 categories 223:5 category 225:6 328:2 caucus 215:6,16 299:11 404:13 causal 277:21 causation 275:8, 18 276:12,21 277:4,22,23,26 278:3	caused 221:17,18 250:1 277:7 296:11 297:1 causing 277:14 346:14 caution 359:11 404:26 405:3 caveat 227:12 centre 325:1 cents 226:3,5,7, 17 certainty 334:9 Certificate 201:24 406:1 certify 406:3 cetera 206:21 234:7 239:18 261:4 295:19 373:24 Chair 201:23 203:8,24 204:5, 18 205:10,17,18, 23 206:3 207:8, 23 209:25 210:24 211:8 212:24,25 213:2,4,8,10 215:1,10,15,21 216:11,18 217:7, 15 219:2,5,10,14, 17,21 220:2,7,16, 22 221:1,4,6,9 245:24 246:9 256:25 257:4,18 263:21,25 264:2, 5,16,25 269:7 281:9 283:14,16 286:8 287:21 292:9,10,18 293:22 299:8,14, 21 300:9,11,13, 18,21 301:1,6,7 302:8,25 326:25 328:8 332:7,9,11 338:15,20,23 350:8,22 351:1, 12 352:3,6	357:24 370:8 380:3 392:20 393:12,20,26 394:3,7,14 403:7, 13,15,16,20 404:11 405:8 chairs 387:20 challenged 322:3 challenges 359:6 chance 206:23,26 214:11,12 292:12,13 351:5 404:14 change 349:16 382:26 383:1,2, 13 changed 254:3 296:19 383:16,24 changing 347:18 chaos 297:2 characterize 246:2 characterizes 230:22 chat 263:17,18 279:24 309:22 351:9 chats 229:10,12 chatting 229:7 cheap 226:8 check 210:18 217:20 checked 220:23 Chestermere 349:10 Chief 331:7,12,14 347:21 children 231:22 chime 284:13 chin 333:5 China 274:25 chiropractic 232:8 235:6,17	238:8 241:21 245:17 246:3,5, 13,17 247:11,24 259:2,5 287:12, 16,25 304:9,11 307:1 310:12,15, 16 312:13,15,19, 23 313:8 317:4,5, 21 323:21 332:2 333:8,13 334:13 336:14,15 343:12 378:19 386:23 402:5 chiropractor 237:13,14 239:10 241:25 243:4,8 244:24 245:1,15 246:2,11,23 288:9,11 289:12 291:23 304:7,14 310:2,17 323:26 343:14,24 401:14 chiropractor's 225:13 238:1 244:17 247:15 chiropractors 203:2,15 235:13 236:3,6 239:26 244:20 302:2,15 303:19 306:21 309:23 310:6,23 311:6,19 312:3, 15,18 313:18,24 317:15,19 319:5, 26 320:3 322:21 323:7 326:21,24 327:10 328:1 333:20 335:10 336:15 341:11,14 342:10 343:7 347:3,6 348:4,10, 23 356:11 359:2 360:1 361:7 362:20 363:3,6, 10 364:1,2,3,22, 23 365:24,26 366:12,20,26	367:21,24,26 370:16,23 374:16 375:18,22,25 376:8 381:9,23 382:2 385:12 388:17 402:20 choose 401:14,26 chose 321:20 chronic 242:14, 16 Chu 267:1,2,23 268:5 citation 278:26 citations 209:19 249:9 285:14,19, 25 286:2 cite 262:7,26 266:26 278:23 cited 248:8 268:14 281:23 cities 367:14 citing 282:11 city 349:1,2,10 367:5 400:17 406:8 civic 349:13 civil 348:18 349:6 claim 234:8 274:14 278:25 282:8 claiming 400:16 claims 262:12,17 clarification 205:11 327:11 371:24 clarify 253:24 320:21 clarifying 254:19 classification 225:2 268:11 classroom 273:19 clause 296:4
--	--	--	---	--

clauses 292:23	349:11 362:15	co-workers	College's 259:2	communicable
cleaner 387:9	363:1 402:5	329:21 341:20	308:13 309:25	381:21
cleaning 342:24	close 238:16,21	Cochrane 248:7	313:21	communicate
388:22 389:15	245:10,12 247:8	267:22,23	colleges 310:16	370:19 375:2
clear 207:9 241:8	265:11,16	268:20,25	317:4 327:25	377:10 382:6
242:12 287:15	323:18,19 324:3,	269:11,14,23,24	345:23,26	395:6 404:7
289:21 290:1,12	5,9 325:26	270:2,3	comfortable	communicated
319:4,7 331:21	335:16 344:22	Code 308:21	216:19 399:17,24	355:8,16 366:25
341:8 342:4,13	346:21 353:11	Codes 307:16	400:6	371:18 377:11
343:11 363:4	363:24 366:24	308:20	commence	378:21 398:1
366:6 368:2,13	382:16 405:9	coffee 217:11,12	403:10	403:23
375:17,23 380:25	closed 315:11	cohort 339:25	COMMENCED	communicating
381:10 396:19	345:18 349:11	cold 239:17 244:7	203:23	335:17 395:16
398:17	closer 247:3,11	cold- 244:11	comment 204:7,	communication
click 370:11	262:6 289:9,13	cold-like 244:6	16,20 207:1	320:20,24 322:24
client 204:12	392:6	colds 312:25	212:17 214:6	348:21 356:5,7,8
208:7 210:11,21	closest 339:18	collaboratively	248:19 249:7	358:10 360:16
211:3 214:3	closing 401:6	354:6	257:3 267:21	362:18 364:26
301:4	cloth 202:7	colleagues	274:7 287:11,26	369:15 375:11
client's 208:16	216:15 220:25	315:16 326:26	290:2 299:3	379:3 380:6,17,
387:26	222:14 223:15	391:7 394:8	308:7 348:4	19,21 381:4,5
client/patient	224:22 225:2,6,	collection 220:5	351:13 369:17,21	400:21 404:5
329:13,14,18	14 333:19	college 203:2,15	405:6	communications
client/patients	clothing 387:24	259:5 302:2,15	commented	321:16 355:23
329:21	CMOH 226:23,	303:1,16,17,21	231:23	356:3,4,19 362:8
climate 322:8	25 234:23 246:17	304:6,11,15,25,	commenting	376:26 380:13
344:20	247:23 257:5,22	26 305:3,5 306:3,	212:14	communicative
clinic 235:23	258:13 287:6,8	10 307:9,10,13,	comments 206:8	355:19 371:16
236:18 245:20	290:18 292:21,	20 308:8,12,19	208:25 213:12	communicator
253:11 304:19	23,25 293:5,10,	313:3,7,12,14	214:16,24 215:1,	356:20
338:7 343:8,12	13,15 294:1	314:14 315:2,26	24 217:17 264:21	community
369:11 372:10	295:1,9,21 296:1,	319:20 326:6	270:5 288:2	222:11,12
386:18 396:10	4,9,21 297:14	328:14,25 330:2,	318:9 339:5	223:11,25
397:22 398:16	298:7,8,11,13,17,	9,12,21 331:7,13	369:14,16,17	235:17,19,21,23,
clinical 206:16,	22,23,25 303:23	343:22 344:3	370:2	26 237:8 239:25
17 211:15,25	314:23,24 315:3,	346:2,6 356:4,6,	commitment	241:20 242:23
219:24 225:12	10 324:16 325:9,	17,25 357:1	219:18	247:16,24
257:15 263:6	18 328:5,9	358:9 361:3	committee 305:2	252:13,14,23,26
266:4 286:23	329:23 331:22,25	363:6 364:3	317:13 359:24	253:3,4 255:3,4
306:19 342:10	332:3,4,12	365:18 368:10	401:13	256:12 265:25
390:21	334:22,25 335:3	375:11 377:7	committing	266:14,18 268:22
clinician 306:18	344:5 345:12,13	380:7,20,23,24	279:2	270:24 271:20,26
clinicians 310:22	382:12,17,22	382:17 384:16	common 312:25	272:2 273:17,24
clinics 238:24	395:23 396:6,14	392:25 401:7,10,	316:25 326:17,23	288:5 295:9
239:4 334:13	397:7	17	399:10	328:26 329:2

394:22	complex 255:17 256:10 259:11 261:1	conducted 210:1 211:17,26 265:23 266:20 318:10	constant 355:4	contentious 327:9
companies 373:12	compliance 366:4,6 378:18	confident 356:21,23,25	constantly 347:17	CONTENTS 201:1
companions 340:1	complied 331:20	confirm 224:11 313:4 380:9	constitutes 296:12	contest 248:12 268:16
compared 269:16 291:26	complies 343:13	confirmation 328:1	consult 209:5 316:15 317:12 326:15	context 231:9 232:5 321:9 367:13 385:25,26
competence 306:6 307:15,24, 25 308:5 313:17, 19,22,26 314:8, 14,15,17,19 317:13 359:24 401:12,17,19	comply 329:1	confounding 268:12	consultant 306:25	contextualize 317:14 318:17 323:24
competencies 308:1	component 307:24 310:24 311:2	confused 297:1	consultation 318:7,12 322:6 325:18 359:19 360:4 361:13	contextualized 392:13
compiled 317:26 318:1,2	components 310:11	confusion 258:17 315:23 338:9	consultations 318:14 320:23 321:12	continually 349:17
complaint 304:3 307:20 380:14 392:22 394:6,19 395:18 403:18,20 404:2,10	composed 306:20	conglomerate- like 228:4	consulted 308:24 317:13,17,20	continue 337:4 338:19 374:19 384:5 394:1 403:9 404:23
complaints 207:24 208:3 209:20 210:4 211:5 214:21 218:13 302:16 303:2 306:4,5 307:19 394:24 396:24	computer 301:10 379:11 393:13	considerable 209:2	consulting 318:20	continued 299:25 313:21 361:7 399:10
complaints 207:24 208:3 209:20 210:4 211:5 214:21 218:13 302:16 303:2 306:4,5 307:19 394:24 396:24	concept 288:23	consideration 306:20 308:18 311:18 319:10 324:10 335:9,11, 14 343:22,25 354:16,18 355:26 362:4 386:15 391:17 397:11	consumption 320:6 375:9	continues 387:1
complete 213:16 313:25 378:14 401:24 406:4	concern 210:11 294:22 295:4 307:21 319:18 323:18 362:4 398:3	considerations 229:3 287:7 309:4 317:16 320:11 332:1 337:11 344:15 385:18	contact 238:13 288:7 289:13 323:18 324:3 329:18 335:16 341:18 344:22 355:4 356:26 363:24 371:14 372:15,17 374:9, 12 376:25 377:2, 21,22 381:2 387:11,15,17 389:14,17 390:17	continuing 264:26 306:6 313:17,19,25 314:12,14,15,17, 19 352:7 401:17, 19
completed 212:26 213:7 216:3 220:5 401:23	concerned 264:10 292:24 396:17	considered 215:23 254:23 311:3 322:22 323:2 341:12 344:11 361:8 378:25 390:5 392:11	contacts 366:25 395:1	continuous 202:11 350:10 352:11 353:1,4, 17,19,26 354:2
completely 211:23 212:23 236:5 272:3 275:2 365:25	concerns 322:21 354:24 361:7,23 367:25 381:2 395:12	consistent 323:7 353:20 376:10,11 387:12 391:9	contagious 311:22	continuously 329:16 340:9 341:16
completing 314:18	conclude 248:9	consistently 347:17	contaminated 387:19 388:24	control 289:5 311:12 318:4 333:10,14,15 354:3,5,15 383:26 384:18 385:1,24 386:8,9, 13,20 389:11 390:17,21 391:1,
	conclusion 261:20		content 211:10 234:23	
	condition 330:23 331:1 366:4 391:20		contention 234:17	
	conditions 311:24 326:18,23 388:19 402:16			
	conduct 309:1 321:12 348:13,16 385:16 391:5 395:2			

25 392:26 396:10
convergence
 228:7
conversation
 354:26 395:22
 397:20,25 398:1,
 9,18,25 399:20,
 25 400:3,18
 404:2
conversations
 353:8 401:3
converse 398:15
conversing 345:5
convince 259:25
cool 220:21
copied 394:11
 395:14 396:16
copy 219:7
 233:24 331:8
 394:15
core 208:1
Coronavirus
 315:9 317:2,7
 337:15 386:2
 391:15 392:15
corporation
 306:7,9
correct 222:4
 224:15 229:5
 233:23 235:5
 236:16 239:9
 242:13 250:3,8
 253:19 257:23
 258:25 259:3
 261:23 267:8
 272:5,16,20
 281:19 283:9,11,
 12 288:5 289:10,
 11 292:24 294:23
 296:2 300:19
 307:7 313:23
 334:14 335:7
 340:13 349:24
 350:1 353:22
 363:15 367:25

375:4 383:14,18
 402:3
corrections
 318:25
correctly 207:10
 274:18
correlation
 275:18 276:11,
 14,18 277:5
 278:2
cost 225:24,25
 226:17
coughing 239:18
council 305:24
 306:16,17,19,20,
 25,26 308:24
 310:13,15 316:1
 318:21,24 322:9
 326:12 331:3
 336:20 337:5
 344:14,18,22
 352:19,21 353:8
 355:15 358:24
 360:17 364:14
 381:8 382:7,21,
 23 391:14 401:20
counsel 203:9,16,
 19 215:22 302:9,
 17,20 308:4
 404:20
counter 228:18
countries 274:11,
 19,21,22
country 275:13
 278:21 317:6,21
counts 275:12
 276:7
couple 211:12
 299:14 312:21
 322:15 324:25
 337:23 355:9
 364:6 371:9
 380:12 392:23
courses 311:1,3
 314:1

court 203:21
 204:8,19 205:16
 302:22 303:4
 357:16,19 359:10
 406:15
cover 310:20
 333:4 377:20
 404:21 405:5
covered 325:16
 334:13 356:7
covering 367:22
 368:3
coverings 333:4
 388:6,14
COVID 222:8
 224:1 226:19,22
 227:4,14 235:2
 237:18,22,25
 238:6,7 239:8
 240:11,15,18,22
 242:9,18,20
 244:13,14,21
 246:26 247:1
 248:14,16,18,21,
 22,25 249:6,8,9
 250:25 252:2
 263:2,6 265:17
 269:22 270:4,17
 271:2,5,8,9,10,
 12,17,23 273:13
 275:1,4 279:16,
 18,25 280:2,9,19
 281:2,16,18,25,
 26 282:2,13,15,
 23,26 283:24
 284:1 285:13,26
 288:13 289:9,14,
 22 291:13,17
 319:16 322:23
 324:15 330:11
 335:26 337:2
 343:25 347:15
 355:19 370:24
 377:19 380:21
 398:26 399:6,10
 400:3 403:2

COVID's 399:8
COVID-19
 202:5,8,10
 216:13,16 220:25
 238:22 241:4
 262:13 263:9
 271:16 278:21
 330:3 331:8,13,
 17 332:1 345:10
 350:12 352:10
 353:3 354:6,8
 360:20,23 364:14
 365:23 366:22
 370:17 376:18,22
 402:19,20,23
COVID-RELATED
 279:3 282:19
crack 268:26
create 259:22
 330:21
created 285:24
 319:24 331:13
 380:16
creating 308:19
 344:8
creation 308:21
credits 313:26
crisis 323:16
criteria 277:25
 290:21 293:7
 296:22 298:2,5
 299:1
critical 264:11
 364:24
criticized 268:7
criticizing 270:5
critique 270:7
 274:24
critiquing
 249:21
cross 351:16
 393:19

cross-examination
 204:2 208:18
 212:7 218:21,26
 264:26 393:4
 403:10 404:24
cross-examine
 221:8
Cross-examined
 201:14 221:10
cross-purposes
 225:22 226:26
crossover 349:16
CSR(A) 203:21
 302:22 406:14
curious 231:8
 404:9
currency 401:21
current 230:14
 312:11 347:4
 355:25 383:19,20
 385:23,25 391:5,
 24
Curtis 203:18
 302:19 397:5

D

D' 293:23
D-3 382:12
D-7 382:12
D-8 293:19,20,24,
 25 332:4,10
D-9 334:22
daily 237:1
Dang 248:8
Dang's 248:3
 274:10,12,15,18
data 220:5
 228:11 274:19
database 356:13,
 25
date 293:5 296:18
 298:17,26 334:22

347:4 356:24 362:24 386:7	decision 207:18 210:11 215:24 216:19 234:22 336:20	deny 218:7 256:7 268:13 290:9	developed 318:6, 8 324:18 326:11 330:15 343:18 344:9 353:10 358:5,20,24 359:20,22 362:23	directed 348:4 381:13 401:21
dated 336:3 376:1 406:8	decisions 305:21 372:9 382:24	department 306:5	developing 263:7 317:9,22 325:22 360:18 392:6	directing 346:1
dates 279:3	declared 355:21	departs 205:24	development 263:7 317:9,22 325:22 360:18 392:6	direction 210:25 214:22 216:7 307:17 316:1,2 319:3,4,17 320:16 321:6 333:9 343:16 347:26 349:17 381:8 382:20 383:18 386:5
Dawson 203:12 302:12	decrease 277:11, 18	depend 224:9	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
day 204:1 210:17 212:15,16 243:6, 7 244:21,24 245:2,4,7,13 263:19 280:5 288:10,16 300:8 318:25 319:14 351:17 355:24 393:14 398:11 406:9	decreased 278:20	depending 390:4	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directive 202:9 222:2 225:5 286:14 303:24 307:4 309:9 314:24,25 316:2 318:23 319:24 321:19 322:9 324:18,20 325:10,16,20 326:11 331:24 333:23 334:20 336:3,22 337:5, 16,23,26 338:10, 17 339:1,4,8 343:13 344:7,8, 10,25 346:24 347:3 349:25 350:12 352:9,21, 25 353:4,5,19,21, 23 354:17 355:8, 16,23 357:6 361:2 362:5,11 363:13 364:15, 16,21 365:1,23, 25 366:2 370:17, 26 371:4 375:17, 22 376:10 379:5 380:16 381:1 382:9,17,25 383:2,14 384:10 387:7 391:13 392:11,13,17 396:18 397:6 399:2 400:11,19,
days 261:18 404:21	defined 310:13, 14 329:20 387:22	derivative 322:14	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
deal 204:14 220:11 242:4,8 263:25 337:23	defend 226:22 227:1,2	dermatitis 355:5	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
dealing 299:26 349:9 363:17	define 259:10,12 276:18 309:19 388:26	describe 229:22 244:17 266:2 273:8 310:3 347:15 398:25	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
dealt 205:12	defines 230:22 308:11	describes 211:20 223:26 276:18	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
Dean 258:2	defining 253:3 329:12	description 201:3 202:3 212:23	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
death 282:15,16, 24 283:24,25 284:10	degree 310:9,24 320:1 391:21,23	designate 385:8	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
deaths 279:4,5 280:19,21 281:3, 16,18,24,25,26 282:2,13,19,22, 26 283:2 284:1	degrees 310:10	designated 367:11	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
debate 234:15,18 266:16	delivering 323:20 326:3	designed 238:24	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
December 275:22,26 313:15 334:23 357:2 376:1 394:8 395:14 396:23 397:4,25 398:12	delivery 310:21	desire 216:5	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
decided 215:26 399:15 404:4	demand 226:13	desks 373:1	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
	demanding 304:17	detail 207:26 290:18 295:25 309:8 384:25	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
	demonstrate 314:8,10	details 313:5	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
	deniers 399:6	determine 265:6 277:26	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
	dental 324:1 327:17	determined 271:11 276:6	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
	dentist 288:12 289:1,12 324:1	determines 331:15	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
	dentist's 289:1	develop 359:21 383:10 386:7	development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9
	dentists 385:13		development 209:17 287:7 314:1 322:18 341:6 342:1 354:16 360:10 371:20	directions 347:9

23	285:22 286:20,23	237:8,13,19	double 342:23	early 217:11
directives 336:6	287:5 289:19	239:10 263:1	double-check	222:17 325:25
344:10 345:24	290:2,16 299:20	292:1 296:25	292:26	326:10 340:20
347:7 365:19	309:5 315:24	381:16	doubt 245:12	381:6 383:14
371:6 400:24	344:18 350:2	doctor's 235:20	270:20,24 271:15	402:24,25
directly 268:4	381:9 382:16	238:1,7 240:7	272:26 273:4,7	easily 370:11
270:3 377:2	403:7	246:20	287:15	Edmonton 203:2
380:19 381:15	discussions	doctors 236:8,18,	download 268:25	302:2 368:16
395:7	316:25	22 237:6 258:18	269:5	educate 381:12
director 203:13	disease 250:11	296:25	draft 361:14,18,	educated 313:6,7
207:24 208:3	285:2,12,18	doctors' 239:21	20 362:6	education 304:9
209:21 210:4	340:19 341:1	document	draw 228:11	309:24,26 310:8,
211:6 214:21	381:21 386:16	210:17,26 211:25	drawing 228:10	15,23,25 312:9,
302:13,16 303:2	387:3	213:13 217:9	drive 275:8 378:8	11 326:18 381:17
306:1 392:26	disinfecting	270:10 327:1,4,6,	drivers 278:6	educational
396:24	388:22	7 328:16 330:20	driving 276:22	303:19,20 309:23
Director's	Disinfection	346:23 350:11	drop-in 236:18	311:10
218:13	389:16	352:26 353:15,	238:24	effect 260:15
disadvantage	disorder 292:4	16,23 361:11	Dropbox 350:17	273:21
213:17	disorders 292:6	362:14,16 363:7	droplet 389:14	effective 312:24
disagree 229:18	312:24	364:4 365:6	dual-mandate	323:11 326:17
230:6 231:3	dispense 205:2	366:8 370:5,12	356:2	328:23 340:21
233:11 236:5	disposal 389:21	372:1,22 374:8	due 282:15,16,23	341:10 365:15
244:23 251:4	disregard 249:19	375:5,26 377:14	283:24,25 294:21	387:2
268:20 285:22	disrupted 209:15	379:8 382:25	295:3 308:2	effectively
disagreed 382:8	distance 268:9	383:5,10 394:12	331:24 359:6	315:11
disagreement	325:24 335:13,	documents	duration 238:13	effectiveness
212:2	15,21,24 342:18	204:11,21 205:4	288:7 289:14	248:10 265:7
disagrees 229:4	373:19 374:6	206:4,11,14,18	duties 305:15,18	272:14 390:19
discrepancy	395:21,26 396:5,	207:11,17,24	306:7,13,15	efficacy 233:18
347:6	9 397:9 398:5,8	208:14 209:19,	307:14	265:22 266:17
discretion	distancing 227:2	23,24 210:20	duty 255:22	270:19 272:23
357:13 388:3,11	318:2 329:19	211:1 212:6,19	305:25 308:22	289:22
discuss 215:7	337:24 338:1	215:12,23 216:3,	342:23 373:18	effort 316:14
220:11 262:3	339:5,10 341:19	22,24 217:2	374:4 379:23	efforts 380:6
267:6 303:20	344:26 396:12	219:7,23 220:3	dynamics 248:23	404:20
404:13,26	distributed	316:7 317:25	<hr/>	electronic
discussed 262:20	355:8 356:15	350:7,13,24	E	356:18,19 373:8
267:10 344:20	363:5 364:2	351:5,10,23	<hr/>	electronically
discussing 405:4	distribution	352:16,22 353:9	E' 293:22	377:9
discussion 201:6,	362:26	355:11 359:12	E-7 269:7,8	element 207:26
13,18 204:4,8	diversity 319:13	380:2 382:11	earlier 248:19	208:1 340:19
208:20 216:8,17	docs 350:21	doffing 343:4,5,9	338:16 361:6	elements 209:1
229:20 262:22	doctor 235:10	donning 343:4,9	388:20 390:24	338:26
277:13 279:11,26		dot 286:26		

elevate 381:19	ended 206:17 237:21,22 317:24	373:23 375:19 387:18,23,24 388:2,23 391:3	278:17,24 312:22 323:12	335:6 339:23 344:25 345:2,7, 11,16 354:21 367:18,22 368:7, 14,16,19 395:24 399:12,13
eligible 310:19	enforce 309:1	equipoise 266:5	evidently 267:23	exemptions 250:5 252:4,5,6, 22 257:23 258:1, 8,13,14 259:6 260:5,6 261:3 289:26 290:4,13, 19 291:9,25 293:6 294:19 296:26 325:25 335:8,9,10 367:8, 11,14,16,20,24,26 368:9 376:8
email 208:5 219:9 220:23 350:18,20 356:24,26 361:24 362:10 375:1,2 377:1,2,10 380:19 394:9 395:14,16 396:17,25 397:10,19,23	enforceable 321:4	equipped 386:18	exacerbate 250:11	
emailing 380:23	engage 208:19,20 271:21 360:9	equivalent 330:13 335:3	exact 330:26 398:14	
emails 208:5 210:18 212:15,17 231:20,24 322:18 362:3,12 377:6 380:25	enjoyed 238:17	ER 239:4	exam 235:12	
embellish 272:22	ensure 324:14 339:10 356:24 386:18	error 279:2 280:12,19 281:22 282:6,7,9 283:7 284:2	examination 203:26 352:8 393:23	
emerg 256:4 290:11	ensuring 343:12 380:1	escalated 315:9	examination-in- chief 212:7	
emerged 263:9	enter 208:15	essential 322:22 340:19,22 343:7 361:9 382:22	examined 201:21 217:26 303:8	
emergency 236:13 238:23 263:1 325:1 364:24 376:18	entered 205:4 220:3 304:12	establish 216:6	examples 237:19	
emerges 263:7, 10	entering 350:3	established 328:25 330:9	exceed 385:17	
employees 340:6 373:5	entire 262:8	establishes 402:12	excellent 234:1	
employers 325:15	entitled 355:14 367:21 375:7	establishing 277:22	exception 355:5 367:15	
employment 304:10	entity 334:11	et al 267:1	exceptions 250:21 258:19	
enable 204:1	entry 310:8	ethical 266:12	excerpt 384:15	
enacted 274:20	environment 230:14 312:12 317:1,18 319:10 321:3 333:10 340:5,23 343:15 347:16 353:11 383:19 386:1,3 390:2 391:22,24 400:5	Ethics 307:16 308:20,21	excess 280:4	
encourage 400:13	environmental 388:22	evaluating 352:25	exchange 289:25	
end 214:13 218:1 229:8 234:1,2 242:8,9 267:25 276:23 278:24 280:5 346:16 399:18 404:10	environments 389:26	event 347:6	excited 365:13	
	epidemiology 277:25	events 241:15,16 262:17	excuse 391:2	
	equal 306:23	eventually 275:24	excused 204:13	
	equipment 202:14 311:18 318:3 329:11 340:16,19,22 341:8 350:11 352:14 354:4	everybody's 282:4 327:2	execute 365:16 386:14	
		everyday 375:18	execute 365:16 386:14	
		evidence 206:15 210:12 211:16 228:7,10 229:1 230:26 248:10 266:13 270:13 272:14,20,23 274:13,14	exempt 250:13 251:5,18 252:11 253:9 254:2,17 255:14,16 368:3 400:16,17	
			exempted 340:2	
			exemption 254:23 258:10, 15,19,22,23 290:22 291:2,3, 12,17 292:23 296:12,22,23,25 325:19 326:2 334:15,16,20	
			exist 207:4 216:6 218:4,7 234:5 248:15 308:12	
			existence 206:15, 19 208:23 220:8, 12 248:12 268:13	
			expand 370:25	
			expect 210:18 212:15 219:3 241:19	
			expectation 325:21	

expected 315:18	extremely 263:7	fail 340:25	316:20,23 317:4	393:11,15,18,19
expensive 225:26	eye 337:9,14,18, 21 353:18 384:3, 6 388:6	fair 206:26	fee 305:2	399:4 404:17
experience 292:5 293:1 376:18		209:11 210:18	feedback 321:14, 20,22,26 323:17	finish 264:10 281:11,12 393:5
experienced 319:6	F	214:2 218:10,12	325:9 331:25	fitted 342:2
experiencing 323:17	F' 205:12	227:18 239:15	359:19 360:5,13, 14 361:20	flag 370:2
expert 203:26	F-1 326:26	263:3 264:12	362:11,12 369:6, 11 380:6,9,11	flagging 270:9
204:2 208:12	F-2 328:10	284:26 285:18	382:7	flex 252:14,18
209:18 218:13	F-3 378:2	291:1,11 293:4	feel 242:2 249:20	flexible 256:18 258:11 263:22
228:1 246:6,11	F-4 379:8	326:22 393:16	282:3 340:3	flipping 297:17
249:6,21 257:3	face 202:5,7	fairly 270:8	399:17,24	floor 221:8 286:9 394:1
279:23 280:7	216:13,15 220:25	296:5 301:9	feet 397:8 398:5,7	Florida 228:22
287:26	294:21 295:3	370:11	401:4	flu 239:17 399:9
expertise 402:13	312:2 316:24	fairness 208:1,2	fell 292:23	flu-like 244:6,7
experts 206:25	320:4 323:23	210:2,3 212:3	felt 292:22 319:4	flu-type 244:11
208:16 209:22	324:8 333:2,3,4, 16,19 334:2,8	214:6,8,17	344:18 399:23	fluid 347:16
213:25 214:1	335:23 337:8	253:24	fever 241:7 243:6	382:25,26
217:5 218:12	345:16 347:25	fall 277:15 395:24	fewer 281:15	fluid-resistant 388:5,13
233:17	367:6,22 368:3	falling 275:24	fiduciary 348:17	fluids 311:26 387:16,20 388:1, 25
explain 225:19	388:6 392:7	false 274:12,15 278:16	Field 305:6	flus 312:25
251:21 266:1	faces 324:5	familiar 220:16	figuratively 327:3	focus 246:11 254:26 279:19
274:17 307:10	facilitate 340:26	293:15,24 296:5, 8,10,13,19	file 303:21 313:2, 5 350:9 370:10	305:19 314:2
366:13 369:19	facilities 388:23	308:10 309:26	378:1,2	focused 253:20 312:21 326:10
explanation 219:6	facilities/settings 354:10	327:5,7 328:16	files 205:9	337:17
explore 349:21	fact 212:10	382:14	final 234:22	focuses 289:22 305:20
exploring 257:11,14,15	236:13 239:2	family 235:10,20	303:26 344:13	focusing 285:21 343:18
exposed 311:17	248:19 271:14	236:7 237:6,8,13, 19 238:1,7	353:23 360:8,21	Folder 205:12,13 378:2
312:1 367:2	274:15 287:20	239:10 240:6	394:4	folders 205:11
exposure 319:25	296:19 351:8	246:19 247:16	finally 267:21	follow 215:5 307:18 316:3
387:26	352:19 357:5	258:17 296:25	379:8	347:26 348:10,18
expressing 382:1	395:11	fan 213:23	find 214:22 260:8	349:6,13,18,23, 26 374:17 378:17
extend 390:2	factors 271:11	FAQ 372:23 379:9	261:21 264:21	
extension 377:6	275:8 276:6	FAQS 374:24	293:4,14 298:8	
extent 273:22	278:4	fatalities 281:4 282:23	329:8	
329:3 382:4	factual 279:2	fatality 282:17, 25 283:25	finding 349:3	
external 386:1	280:19 281:22	fatigued 240:17	findings 220:10	
389:25,26 391:23	282:5,7,9 283:7	fault 281:23	285:23	
extra 255:26	284:2	FCC 317:4	fine 205:8 218:16	
308:1	factually 276:3 281:19	federation	251:12 300:25	
			352:1 354:13	

379:7 381:25
 392:17 395:4
 399:4 403:14
follow-up 325:14
 400:21 404:2
foot 323:23
 388:5,13
footnote 267:24
foregoing 406:3
forgive 266:23
forgot 326:11
form 310:8 345:9
 360:14
formally 204:22
 205:4
formulate
 209:12
forward 264:18
 310:15 318:15
 320:11 350:17
 382:8
forwarded
 380:21
found 267:24
 287:11
fourth 303:17
 309:21 313:1
framework
 358:5 359:26
frankly 204:26
 209:14 264:9
 279:26
free 249:20 300:3
frequently
 372:23
friend 211:9
 212:2 246:6
friend's 245:26
front 207:17
 233:24 352:16
 393:13
front-line 236:4,
 6,22 245:14

frustration
 382:1
fulfil 308:12
full 249:8 301:9
 376:21
full-time 304:14
fully 271:6 366:1
 386:18
fulsome 209:6
fun 222:7 249:3,
 12,15 277:13
function 305:16
 354:2 401:7
functions 303:17
 307:22

G

G-1 202:9 352:9
G-2 202:11
 352:11
G-3 202:13
 352:13
game 229:20
gap 312:10 344:2
garbage 370:1
gatherings
 277:16,19
gave 257:4,5,7
gears 312:26
general 269:21
 285:4,9,10
 295:10 309:26
 373:21
generalization
 283:19,21,22
generally 215:3
 224:9 226:20
 227:24,25 228:2
 229:16 234:19
 238:16 242:22
 250:20,21 256:19
 277:24 284:17
 291:21 296:6

303:17 309:23
 310:1 312:14
 355:15 382:13
 385:23 386:19,
 21,25 387:12
generous 209:22
geographic
 332:16
give 206:22,23
 215:23 217:12,19
 219:6 220:13
 227:23 228:18
 234:20 248:3
 254:4 274:24
 278:26 297:6
 299:14 319:4
 325:7 338:20
 367:13
giver 340:4
givers 340:1
giving 218:16
 281:10 314:26
glad 226:22
gloves 311:26
 312:3 320:3
 374:2 388:4,12
 392:5
goals 307:26
good 205:17
 219:20 220:20,21
 226:21 227:17
 233:4,15 250:4
 256:23 261:11
 270:3,8 299:5
 300:8 301:9
 303:9 350:23
 351:22 393:20
 405:11
gotcha 210:7
governed 381:23
government
 227:6,9,12,20
 228:24 234:24
 324:21,23 327:1
 336:9 348:12,19

349:14 364:18
 374:18
governments
 228:8,20 229:1
 258:6
gown 388:13
gowns 320:5
 374:3 388:4
grab 217:12
 377:25
graduated
 304:11 312:7
 313:9
grant 293:6
 367:19,24 368:8
granted 354:21
granting 293:7
great 309:12
 322:2,7 336:7
 338:23 348:24
 355:18 386:26
 405:8
greater 207:26
 289:9 295:25
 334:9
grocery 335:20
ground 257:19
ground-worker
 394:23
group 234:11
 266:10 316:22,26
groups 232:21
guess 217:2
 230:19 232:16,22
 274:7 278:1
 347:13 392:23
 401:7
guidance 258:14
 296:11 329:2
 330:13,14,20
 333:26 335:12
guide 316:2,10
 317:23

guideline 316:5
 329:5 344:6,7
guidelines
 202:11 307:17
 325:3 327:24
 328:4 330:3,11,
 16 331:9,13,15
 334:2 350:10
 352:11 353:1,17
 381:25 386:20
gun 209:11

H

H' 205:12
H-5 202:5 216:13
H-6 202:7 216:15
half 244:26
 263:15 376:6
 393:2
halfway 376:3
halls 318:11
 320:22 321:13
 360:16
hallways 339:21
Halowski 201:21
 300:17 301:8
 303:2,4,8,9,11,
 20,23 304:1,4
 325:7 327:5
 328:11 332:5,13
 334:23 338:18
 350:2,25 351:4,8,
 20 352:8,15
 357:21 361:25
 370:13 377:4
 384:8,21 392:22
 393:5,7 394:2,5,
 11,14,17 402:19
 403:3,12,18
 404:18,24,26
Halowski's
 403:9
hand 212:11
 249:23,24 311:15

318:1 323:5,8 383:26 386:26 387:2,5,8,9 392:26 hands 301:5 hands-on 323:21 handy 379:10,12 happen 261:15 276:24 398:11 happened 242:5 243:14,18 261:10 262:21 283:18 293:9 371:23 383:17 happening 315:1 happy 204:25 220:21 303:7 389:1 hard 240:16 298:19 harmlessness 233:19 hat 359:23 hate 369:22 head 325:1 388:5, 13 398:16 headache 240:12,14 heading 286:24 339:4 340:15 341:2 353:17 361:21 366:12 369:6 372:26 373:22 374:9 375:12 health 222:19 224:1,7 226:22 227:6,10,12,21 228:9 229:11 231:7,11,14,15 232:1 234:19 235:2,6,8,16,19, 22,25 236:2,4,6, 9,13,17,22 237:22 238:23	239:3,5,20 245:19 246:10, 14,15,16,21 247:12,15,24 248:11 250:6,16, 17,19,22 251:7, 21 252:2,7 253:4, 6,8,9,20,26 254:15,21,26 255:3,5,11,13,22, 25 256:12 258:24 259:1,7,15,18,20, 24 260:10,11 261:6,25 262:3, 13,23,24 265:25 266:12,14,26 270:17,18,23 271:16 272:2,15, 24 273:10,13,24 277:13 279:12, 19,20 287:13,16 288:4,10 290:4,7, 13 295:10 298:16 305:24 307:23 308:9 310:21,25 311:4,7,8,9 312:8 314:21 315:11 316:7,9,10,21 320:16 323:14,16 325:21 327:17 328:25 329:2 330:1,9,15,16,25 331:8,12,15,21 332:24 335:12 341:11,12 347:8, 9,22 348:6,9,12, 17 350:4,11 354:22 363:11,21 364:17,21 365:13,14,16 366:26 367:3 372:4,7,10 378:22 379:17, 19,21,25 380:1 381:15,24 382:4 383:21 387:1,25 389:5,8,10 391:7, 20 392:14	394:10,20,23,24 395:1,9,13,18 397:4,19 402:6,9, 10,11,12,15,17,18 403:21,23 404:8 healthy 236:15 244:4,10,12 hear 207:13,14 216:9 219:11,12 298:25 357:17 369:9 heard 257:25 hearing 203:7 207:12,23 208:1 209:25,26 210:10 212:12 215:22 238:18 299:10,21 302:7,25 305:10, 13 323:25 339:2 352:6 385:5 393:26 404:16 405:9 hearings 203:13 210:6 302:13 392:25 heart 255:20 264:21 Heidi 394:9,20,22 395:6 held 360:20 helped 320:10 322:3 helpful 233:3 320:9 helpfully 306:12 Hep 289:2 herald 241:4 herring 212:18 hesitancy 381:19 hey 322:4 348:26 371:22 high 227:16 245:8 260:9,23 273:24 276:26	277:15 307:13,15 321:21 high-level 308:7 higher 237:26 238:8,22 252:3 283:1 288:3 386:23 highest 238:3 260:22 379:26 highlight 329:10 351:21 389:23 highlighting 308:1 362:20 390:23 highlights 309:14 355:11 386:14 387:4 389:2 highly 208:8 211:5 311:21 355:19 Hinshaw 258:2 315:8 324:25 historical 249:4, 10 289:20 history 208:24 265:15 304:10 314:14,16 315:1 hit 220:24 Ho 300:2 380:13 394:9,20,22 395:6,15 396:20 Ho's 396:25 hold 280:23 287:21 home 262:6 hope 216:19 hoping 205:2 360:12 hospital 235:21, 24,26 236:1,9,14, 17 238:23 239:4 242:6 245:20 260:22 262:24	263:2 hospitals 239:20 241:16 263:4,10 hosting 393:1 hour 209:8 238:17 244:26 300:23 301:1,2,4 393:2 hour-and-a-half 219:4 hours 210:19 212:16 216:23 393:13 401:20 housekeeping 204:7 392:24 houses 277:20 HPA 305:9 308:9,10,22 345:23 Hu 201:14 204:12,13 205:20,23 206:23 208:10,18,25 209:6,9,11 211:19 213:16,20 214:2 215:7 216:20 217:12,17 218:21 219:5,11, 14 221:2,8,10,12 226:18 235:6 246:1,10 257:1,3, 4,21 263:16,21 264:11,18 265:1, 3 269:12 281:10, 13 283:17,20 284:4,12 286:8, 14 287:24 294:2 299:8,21 Hu's 208:12 328:12 Hugs 234:12 hundred 250:3 307:7 362:3 376:11
--	--	--	---	--

hundreds 221:21 249:12	269:19,22 291:26 312:19	255:24 271:18 272:1 288:8 309:4 319:4,5 320:25 324:10 344:3 370:1 386:21	increased 274:20	25
hygiene 311:15 318:1 323:5,8 387:5,8	illnesses 245:15 250:1	importantly 288:20	increases 246:26 247:2	infections 262:12 312:20,25 391:6
hygienist 324:1	illustratively 277:14	imposed 278:22	indent 347:2	infectious 236:20,24 238:25 239:3 241:20 245:14 250:1 262:13 311:20,21 386:16 389:12
hypothetical 288:17	imagine 243:3,7, 8 245:16 247:7 291:24	impress 243:25	independent 234:8 262:11,16	inferior 225:16
I	immediately 208:17 212:17 276:17 341:10	improper 218:5	indicating 395:19 399:2	influenza-like 269:19,21
i.e. 312:1 339:20 345:6 347:23 354:24 368:15	immune 312:16	improve 308:5	INDISCERNIB LE 219:20 220:26 224:20 237:2 238:18 253:16 265:14,21 267:13,14,15 269:8,9,10 270:21 272:8 273:2 277:2 283:5,15 284:20 293:12 296:13, 14,15 297:9 357:15	inform 318:17 322:3 349:4 359:21 383:11
idea 208:24 227:23 284:19 319:15 361:8 370:4 383:6	immune-based 312:24	in-depth 213:14	individuals 232:10 233:8 354:7	information 209:23 210:20 217:9 227:4 303:21 306:25 316:8 317:26 318:14,17 320:13 330:25 337:13 347:7,17,18 355:25 363:21 377:3 382:24 383:20 390:8,11 392:13
ideal 321:7	immunized 259:24,26 260:10,11	in-person 335:16 358:23	indoor 234:18 245:10 252:13, 14,23,25 253:3,4 266:15 271:22 277:15,18 294:16 295:8,12 334:9, 10 396:7	informationally 314:4
ideally 290:21 291:4,7	impact 317:1 349:16 372:10 402:16	inability 295:5, 23 297:15	indoors 247:8 339:18	informed 208:19 209:6 218:9 228:26 314:11 349:18 372:8
identical 335:2	impacts 376:15, 16	inaccuracy 268:8	infected 244:21 387:20	informing 320:17
identified 205:8 232:20 322:13 323:6 324:13 325:24 333:22 335:25 337:2 340:20 341:26 346:13 355:21 358:11 374:24 390:10 404:1	implement 365:4,5,25 366:1	inaccurate 231:10	infecting 237:22 242:10	informs 396:16
identifies 313:10	implementation 275:25 369:9 390:22	inadvertently 242:9	infection 244:8 289:4,20 311:12 314:20 318:4 343:25 383:25 384:18 385:1,24 386:8,9,13,15,20 389:11 390:5,7, 16,20 391:1,21,	initial 269:25 296:21 313:14 363:21 368:11 394:26
identify 231:16 326:7 387:1 390:19 399:21,26	implemented 275:22,23 276:4 338:11	inappropriate 370:2	initiate 395:4	
identifying 307:25	implementing 231:21	include 254:3 261:22,23 332:25 337:7,8 387:8 388:4 391:2		
ignorance 233:5	implication 230:1	included 336:14 397:10		
ill 236:24 237:9 238:25 239:2 241:19	implications 311:8	includes 253:15, 17,19 334:10 389:13		
illness 202:8 216:16 236:20,24 238:25 239:3 241:20,23	implied 230:3	including 235:3 268:11 271:12 355:22 390:17		
	imply 398:14	incorporate 386:7		
	importance 387:5	incorporating 386:12		
	important 212:22 230:25 243:25 251:23	increase 226:9 260:14 275:11 289:15		

initiated 318:7	388:14	346:26 359:7		kids 231:24
inquiries 213:18	interactive 370:3	368:12 381:1		kill 389:17,18
inquiry 325:14	interest 299:2	introductory	J	kind 208:20
inside 392:4	interested	311:4,5		217:3 237:5
insignificant	384:22	investigate	J.S.M. 203:19	240:19,25 243:13
226:9	interesting	394:25 395:3	302:20	270:1 275:16
installation	230:11 260:13	investigated	James 351:24	311:1,7 314:17,
340:9 373:9	273:20	395:5	January 336:4,	21 315:10 316:4,
installations	internal 203:9	investigation	25,26 338:5,12,	21 317:17,22,26
373:12	302:9 385:26	265:6 374:19	16	318:19 320:8
installed 373:9	388:22 389:25	investigations	jazz 300:8	322:16 323:17
instance 392:3	390:1 391:22	305:7,12	Jefferson 267:26	371:20 376:21
institute 334:2	international	investigator	Jefferson/	385:15
instituted 389:12	390:3	305:4,6,8	cochrane 268:2,	kinds 321:16
institution	interplay 370:21,	involved 211:24	4,14,17	Kitchen 201:7,9,
310:18	22	215:8 263:7	JIA 201:14	11,15,17 203:19
instruct 326:16	interpret 349:3	291:3 307:5	221:10	204:1,9,16,24
instructing	373:3	313:16 329:17	jigged 263:26	205:1,5,7,19
323:14	interpretation	341:17 403:6	joining 305:22	206:1,2,3 207:10,
instruction	333:12	involvement	313:14	14 208:6,12,22
326:18	interpretations	304:2,24 392:22	journals 227:16	210:14,20 211:7,
insufficient	230:18	394:6,19 401:9	judge 231:1	8 212:25 213:1,3,
331:16	interpreted	Iowa 313:8	judgment 309:18	6,12,19,24 214:4,
intended 307:26	332:18 333:12	IP 321:21	judgy 230:7,24	5 215:2,9,11,18
324:11 358:2,25	interrupt 280:24	isolate 366:25	July 208:13	216:5,11,19
375:8 389:6	interrupting	isolated 342:21	346:16 367:4	217:4 218:3,23
intending 370:19	245:25	issue 207:12	378:3,11 379:9	219:3 220:3,8,11
intends 381:24	intervention	214:6,7,17	383:14	221:2,9,11,12
intense 301:5	266:6	219:19,21 233:3	jump 389:3	246:13 257:4,9,
intensity 238:19	interventions	257:2 258:12	jumping 265:5,9	15,21 263:14,20
intent 333:13	239:21 346:12,13	280:8 284:17	June 206:17	264:6,26 265:2,3
349:15 400:19	intraoral 312:4	298:22 312:17	267:7 274:26	267:16 269:10
intention 359:4,8	392:4	316:15 405:1	281:5,17 282:18	281:10,13
398:2,24 403:8	introduce 383:18	issued 293:6	283:6,8 346:16	283:15,16 284:4
intentionally	introduced	315:11	358:26	286:5,7,21 287:5,
239:3 258:16	317:1 338:6	issues 279:22	juxtapose 375:16	12,21 289:19,26
interact 236:19	345:4 348:24	316:18,24,25		290:16 292:10,
244:20 247:1,2	349:7,14 368:1	Italy 261:6,25	K	17,19,20 293:18,
289:8	379:6 381:8	item 330:19		20,21,23,26
interacting	introducing	363:8	Karoline 205:15	298:21 299:4
247:6,7	204:20	Ivermectin	300:6 406:3,14	300:22,23 302:20
interaction	introduction	229:11	Karoline's	348:14 351:7,13,
275:14 291:5	222:6,7 249:4		205:10	14 352:1 393:4,6,
	314:9 337:17		keeping 308:7	16,18 402:4
				403:7,10 405:6
				Kitchen's
				217:16,24 221:8

290:6 404:23
knew 333:19
 362:24 373:15
 376:24

knowingly
 236:23

knowledge 230:5
 291:22 292:5
 346:1 354:21
 402:21

L

lack 248:10

lacking 285:2
 390:8

lady 380:13 394:9

Lancet 227:26
 270:6

language 231:13
 243:1 274:18
 347:11 357:6,7
 375:17,18 399:9

linguaging
 309:14

large 236:9
 242:11 322:12
 344:2

larger 209:26
 213:16 221:21

late 275:21
 277:15 315:2
 316:13,14

latex 354:25

law 211:1 305:6
 391:16

Lawrence 208:9
 209:4 210:18
 302:16 378:5
 396:24 397:1
 400:22

Lawrence's
 397:11

lay 385:20

layer 255:26

lead 276:23
 277:11 323:15

leadership
 262:25

leading 323:15
 327:13

leads 367:17
 368:6,13

leaning 324:2

learned 212:2

learning 312:9

leave 263:11
 297:6 309:18
 310:18 388:2

led 241:15 275:26
 277:17 298:7

Lees 203:8 302:8

leeway 246:7

left 304:14 388:10

legal 203:9,16,19
 257:2 302:9,17,
 20

legally 287:10

legislation 349:4,
 6

legislative 359:6

length 279:24
 296:1

lengthy 289:25
 351:6 384:21

lessen 345:9

letter 381:22
 396:23,26 397:1,
 14 398:19

letters 205:9

letting 375:21
 397:24

level 307:13,15
 309:6 320:5
 321:7,8 333:21
 348:19 371:2
 379:4 385:7,14

390:16 402:13

levels 223:6

Library 219:25

licence 310:19

licensed 304:6
 310:1 313:11

lies 234:23

life 240:13,25

lifetime 315:19

light 216:18
 347:18 389:25

limit 353:13

limitation 294:22
 295:4

limitations 216:1

limited 364:24
 382:5

limiting 354:8

lines 377:5

linguistic 230:17

link 277:21 377:5

list 298:13,14
 327:9

listed 267:26

listen 230:26
 254:4,6 318:12
 321:15

listened 318:16

literal 332:20

literally 211:18,
 19 218:6 327:2
 351:25 377:15

literature
 285:14,26 286:3
 325:22

live 248:17
 321:14 376:24

lived 339:24

load 246:4 288:10

local 349:3,14,22
 370:18,24
 373:11,13
 378:23,26

locale 390:1

Locally 202:7
 216:15

location 334:11
 349:7 396:8

lockdown 238:15
 245:12 276:9
 277:4,7,12,16
 280:1

lockdowns

276:2,4,5,23
 277:24

long 211:12
 218:19 222:22
 238:21 244:26

280:15 296:3

299:16 327:23

328:4 336:21

352:18 404:21

405:11

long-term 238:2

260:20

long-winded
 243:24 286:6
 300:8

longer 247:2
 274:26 283:6,12
 289:8,14

looked 213:13
 323:17 333:17
 335:3 355:18

lot 213:15 217:9
 223:13 228:20
 231:19 234:16
 238:14 240:8,10,
 25 241:9 247:6,8
 249:22 257:5
 258:17 259:21
 260:13 266:16
 271:7 273:17
 275:8,9,10 278:9
 279:23,25 280:6,
 7 284:1,16
 285:19 290:7
 297:9 315:22,23
 317:23,25 318:16

320:13 322:24,26
 323:4 338:8
 348:26 355:18
 359:21 361:1
 404:21

lots 229:1,10
 231:24 238:16
 261:23 272:20
 273:25 276:6
 296:26

Lougheed 242:6

love 369:22

low 225:24,25
 226:17 252:1
 271:10 320:5
 385:8

low-cost 226:15

low-grade
 240:24 241:11

low-grade-type
 242:13

lower 237:14,15
 276:23

lucky 317:11

lunch 264:9,22
 300:24,25

lung 250:11

M

M-HM 224:12,19
 232:19,25
 233:10,20 251:3,
 10 252:20 255:12
 257:8 258:26
 262:5 263:13
 268:3 272:6,25
 274:3 276:10
 284:10 286:4
 294:4 304:22
 313:20 334:26

Madam 204:19
 357:19

made 204:19
 210:11 214:12,15

226:20 267:21 280:12,18 282:8 287:20 288:2 289:6 335:14 336:20 337:6,11 354:18 356:6 373:17 403:20,22 404:1	347:19 350:24,25 351:10,23,25 355:24 359:8 363:15 366:18 369:14,21 371:24 373:14 376:24 379:26 383:1 390:25	16,20 261:2 296:8 308:22,23 309:11,13,15 313:18 328:5 330:20 340:12,13 344:7 357:6,7 366:6,7,20 367:6 376:5 401:10,13	14 345:5,21 347:24 354:25 355:2 374:2,5 383:23 397:21 398:4,7,19,24 399:14,20 400:1, 6,26 401:3	399:12,22 400:13,14,16
magnitude 273:26	makes 214:9 216:12 240:26 283:22	manner 210:20 355:7 391:9	mask-exempted 395:23	masks 202:5,9 216:13 220:25 221:24,26 222:1, 8,9,11,12,13,14, 15,16,18,21 223:5,7,8,14,15, 17,21,25 224:2,4, 8,14,17,18,22 225:2,5,20,24 226:6,15 229:4 230:20 231:19 232:8 233:18,19, 21 234:11,12 248:11,15,24 249:2 255:25 261:8,12,13,16 265:22 269:16 271:5,15 278:20 279:12 286:21 287:1 290:8 291:25 294:5 320:4 332:15 333:16,19 341:24 343:4,5 350:12 352:9 353:24 354:9 366:13,17 367:1 373:24 375:13,19,25 388:6,9
mails 377:8	making 305:22 308:16 319:18 351:22 382:24 396:5	March 315:2,6, 10 316:13,14 320:21 326:10 381:6	masked 231:25 274:20,22 338:7 340:9 342:11,17 367:2 396:14	
main 234:2 274:24	manage 263:4 311:6	marked 204:22 205:11	masking 202:12 227:1 228:22,23 231:4,6,9,11,15, 17,21,22,26 232:1,5,11,18 233:1,4,11 234:15,16,17,19 235:3 248:21 249:6,8,9 250:5 257:6,10,11,12, 23 258:25 259:13 266:14 269:25 270:4,13 271:22 272:15 273:12, 16,18 275:3,9 279:20 280:9,10 285:20 289:22, 23,26 290:4 292:24 294:2 324:11,13 325:19 329:6 330:21 337:24,26 343:17 344:7,9,11,16,19, 23,25 345:2,11 346:2,9,15,21 349:1,2 350:10 352:12 353:1,4, 18,19 354:2,22 355:6 357:6,8 367:16 368:19 369:22,23 376:5, 9 384:3,5 395:20, 26 396:4,20 397:7 398:23	
maintain 313:19 329:19 335:13, 15,20 341:18 346:15 378:17 379:24 384:4 396:8 397:8 401:21	mall 238:9 253:5	marketing 362:19		
maintained 340:8 342:19 373:7,20 374:7 378:24 383:25 386:19	man 299:25	marks 234:5		
maintaining 335:24 382:20	managed 275:2	Martens 203:11 302:11		
majority 228:16 231:13 273:11 290:5 304:18 310:6	management 262:24 305:16 306:15 390:18	Martin 324:26		
make 204:7,11,15 206:9,12 207:18, 21 213:11,18 214:5,10,24 218:9 222:23 230:13 258:6 269:18 272:1,4 274:7 275:15 278:6,7 280:15 282:4 298:10 299:2 300:16 317:16 320:11 321:2,4 324:10 327:2 331:26 339:14 342:25	managing 263:9 313:17 388:24	mask 202:7 216:16 222:25,26 223:1,3,4,12,26 225:11,13,14,15, 17 226:2,4,5,7,17 250:14,20,22 251:6,18,23,24, 26 252:12,22,26 253:10,22 254:17,21,24 255:4,6,7,15,17, 21 256:5,6,11,13, 17,20,24 259:2 261:17 266:12,17 269:18,20 270:20 272:23 274:11,21 275:5 286:23 290:11 294:7,13, 21 295:3,22 296:8 297:16 329:15 333:2,3, 22 334:2,8 338:10,11,12 341:15 342:2,7,		
	mandate 259:2, 25,26 260:17 307:11 308:15 319:20 349:1,2			
	mandated 294:1			
	mandates 274:11,20,21,22 348:11			
	mandatory 231:22 232:11 233:1,4,11 234:16,17 235:3 250:5 257:6,10, 11,23 258:25 259:8,10,12,14, 16,19 260:4,7,12,			
				Masters 310:10
				materials 388:24
				mathematically 276:14
				matter 213:19 274:1 279:10
				matters 214:1 238:13 306:19 358:9 405:4
				Maxston 201:8, 10,16,22 203:16, 25 204:5,19 205:18 206:6 207:8,9,20,21 213:9,10 214:14,

23 216:18	measures 247:22	12 305:10,12	384:5,14 385:21	24 340:8 342:18
217:14,16 218:23	268:9 275:22,23,	308:6 309:19	390:14,25 392:16	345:3,6 373:5,6,
245:24,25 246:10	26 366:3 384:1	317:3 318:7	401:21,24	20 374:6 395:21,
256:25 257:14,19	386:9,24 389:2,5,	323:11 328:24	402:11,22,25	26 396:9
263:14,16 264:6,	11 390:17 396:10	330:1 337:20	403:1 404:11,16	metres' 396:5
7,20 281:9	meat 213:15	343:15,21,26	members'	microbiologist
284:12,22 286:9,	mechanics	355:14 356:13	343:20 356:23	317:12
11,12,13 287:23	361:15	360:20 361:13	383:12	microbiology
288:1,2 292:8,16	medical 224:18	368:19 374:5,22	membership	311:2
293:18 298:21	225:16,23 226:14	379:6 395:10	305:21 306:9	middle 315:6
300:13,16,20	239:5,20 254:24	400:22 401:26	308:26 318:16	337:1 353:1
301:3 302:17	268:21 269:15	members 207:23	319:1,7,13	midst 226:4
303:1,8,9,10	286:23 290:22	210:24 244:22	321:11,23,26	mild 399:9
320:12 326:25	291:2,17,25	299:11 303:25	322:8,15,26	million 258:9
327:5 328:8,11	295:23 323:14	306:11,21,22	323:9 325:12	mind 287:15
332:9,12,13	330:25 331:7,12,	307:18 308:2,24	328:7 338:9	mindful 359:10
338:15,22,24	14 333:3 347:21	309:7 314:7,9	380:10,11 386:5	374:4
350:8,13,22	367:17 368:6,10,	315:21 316:3	395:2	mine 405:6
351:7,18 352:2,7,	13,14 381:16	317:11 318:8,13	memory 251:2	minimal 211:5
15 357:19,21,24,	383:20,21 394:22	319:14,22 320:6,	398:11	309:6 321:8
26 370:8,13	medical-grade	7 321:1,24	mental 250:6	341:24 342:6
380:3,5 385:4	221:26 222:16,	323:24 325:19	290:9 294:21	379:4 385:14
390:24 392:20	18,21,25,26	327:12 328:9	295:3	390:15
394:1,3,17 403:3	223:2,4,5 224:4,8	330:12 335:17	mention 221:17	minimally 321:6
405:3	225:15 226:2	336:10,17 337:11	326:11 400:7	342:5 371:2
Maxston's 405:7	medication	339:12 340:24	mentioned	385:7,21
meaning 310:9	266:6	346:8 347:20,25	263:22 304:21	minimum 287:1
329:25 332:23	medications	348:25,26	313:16 338:16	313:25 396:8
333:14	235:12	349:11,18	363:25 384:9	Minister 331:21
means 260:9	Medicine 219:26	354:20,24 355:9,	mentioning	minute 357:5
263:11 266:5	meet 300:7,21	20,23,24 356:16,	224:21	minutes 207:26
326:19,22 330:6	305:23 309:7	18 357:11,25	merit 211:23	216:22 217:12
333:3 340:17	313:21 319:19	358:1,4,5,14	message 348:23	241:1,26 243:16
341:4 363:19	321:6 386:19	359:14,22,24	met 299:22	247:19 263:12,18
365:11 373:8	404:15	360:3,14,17,22	344:14 385:16	299:15 307:4
402:2	meeting 307:26	361:12 362:3,26	meta-analyses	308:19 331:19
meant 239:16	318:21 344:13	363:5,8,15 364:5	270:7	337:23 352:4
261:11 309:5,13,	360:24 361:10	365:1,3 366:9,14,	meta-analysis	355:9 380:12
18,19 311:5,7	393:1	15,19,24 367:5	227:26	393:10,15
335:18 337:20	meetings 306:17	368:13,17 369:14	metallic 389:20	mishmash
342:3 345:21	360:20	370:6,9,20 371:7,	326:8	222:13 223:12
347:11 362:19	meets 308:6	16 372:17,20	metre 325:24	misinformation
370:3 375:17	member 203:10,	373:15,17,25	326:8	381:19
385:8 389:17	11,12 208:2	375:2,14 376:1,	metres 326:4	
392:16	210:2 302:10,11,	12,13,24 377:12,	329:20 335:13,	
measure 324:14		22 380:4 381:10,	15,24 339:16,18,	
385:15 387:12		14 383:7,19		

mispronounced 300:1	392:4	negative 243:19 369:16,18	noon 209:16 218:19 219:18	278:4 282:22,26 283:1 288:8
missing 212:23	move 205:20 215:24 261:5	neglected 221:17	noontime 263:23	298:17 328:19
mistakes 226:20	283:23 309:21	negotiating 305:2	normal 379:15	331:20 332:7
mitigating 326:17	movement 326:16	Nelson 203:13	North 310:7	337:3 338:21
mix 222:14	movements 234:6,9	205:20 206:12	Northwest 271:24	343:5 348:20
mobile 336:14, 16,17	moving 339:22	207:16 215:13	nose 239:18 240:26 241:26	363:17 377:7
modality 359:1,3	MSK 326:17,19, 22	219:8 302:13	243:7,17 333:5	380:2 401:20
modes 320:20	multiple 268:10 339:14 374:25	350:16,20 403:5	note 214:18 221:16 233:3	numbered 328:18 363:8 364:9 370:14
moment 210:7 248:4 325:7	municipal 390:2	neuromusculoskeletal 311:24 326:23 388:19	248:1,6 263:11	numbers 205:9 282:21
362:7 377:26	municipality 367:12 378:23	news 234:11 374:20	267:25 268:24	Nunavut 271:24
398:25	muted 351:14	night 212:12	270:12 344:24	nurses 236:18,22
momentarily 219:22	myriad 209:1	NIH 219:25	347:3	
monitor 390:18, 22		NMSK 326:22 388:19	noted 215:1 216:1	
monitored 390:26	N	nobody's 232:5	notes 406:6	O
monitoring 352:20	N95 223:7 225:2, 6,11,14 342:2	nodding 205:2	notice 209:13 355:14 357:9	oath 205:26
month 284:11 298:4	347:24	non-clinical 340:6	359:13 360:19	object 246:1,8 256:25 257:16
months 211:26 280:3 281:5,25	N95s 224:14	non-coercive 260:1	361:11 363:8	objected 214:16 287:23
282:26 283:11	named 380:13 394:9	non-covid 280:2	364:5 365:7	objecting 204:12 209:22,23 214:23
284:5,8	narrow 216:26 232:4	non-health 252:14 272:19 273:5	366:9 367:4	objections 205:7 216:10 400:7
morning 201:5 203:5 204:3	national 219:25 390:3	non-infectious 388:17	368:23,24 370:6	objects 207:24 208:7 211:3
208:5 241:1,26	naturally 238:22	non-specific 240:18	371:7 376:1	obligation 319:20 372:8
301:5,9	nature 204:10 218:2 231:2	non-treatment 266:9	377:12	observe 308:3 346:10
mortality 280:4	309:11 390:4	Nonclinical 342:17	notices 303:24 315:7 355:17,24	observing 366:19
motion 331:3 358:24	necessarily 224:2 228:23 230:13 258:9	noncontact 373:8	356:9,22 357:7, 22,23 358:1	obtain 350:14 373:15
motor 279:4 280:20 281:4,16, 18,24,26 282:13, 16,22,24 283:1, 25	275:4	nonmedical 333:3	22,23 358:1	obtained 313:26
mouth 312:2,3 324:8,9 333:5 346:10 388:8	needed 254:21 264:6 319:21	nonphysician 291:16	notified 364:25 365:14	obvious 243:2
	321:4 323:10		notwithstanding 281:22	occupational 327:20
	331:26 340:4		November 275:21,26 332:4 371:7 372:1,23	occupy 401:9
	399:3		number 209:10 222:5 236:10	occur 239:22 245:15 324:21
			243:14 255:19	340:10 387:16
			260:10 262:12,17	
			264:12 271:1,11	
			275:13 277:18	

occurred 277:19
occurrence
 395:7
October 213:7
 313:10
offer 367:21
offered 379:24
offering 319:15
office 225:13
 235:20 238:1,2,7,
 8 239:25 240:7
 244:18 245:17,18
 246:3,5,13,17,20
 247:15 287:25
 289:1 333:8,11,
 15 336:19 339:26
 340:5 371:14
 372:16 377:7
 383:26 386:14
office-based
 236:3
office@
albertachiro.
com 374:13
Officer 323:14
 330:25 331:8,12,
 14 347:22 383:21
offices 235:6,17
 239:21,26 241:21
 245:15 247:24
 287:12,16 333:13
 342:20
Official 203:21
 302:22 406:15
offload 358:22
offset 358:22
on-the-fly 210:19
 213:17 216:22
one's 217:8
one-line 291:8
one-off 228:2
ongoing 206:18
 211:26 213:5,6
 217:23 306:8

391:5
onset 390:8
open 229:7
 268:26 345:17
 363:10 371:15
open-concept
 339:13
opened 208:5
 325:6
opening 340:17
 384:23
operate 339:13
operated 386:19
operating 248:12
 307:26 334:12
operations 325:1
 376:16,23
ophthalmologica
l 324:7
opinion 270:16
opinions 257:5,6,
 7
opportunities
 324:24
opportunity
 206:23 213:11,26
 216:24 217:6
 218:8 254:4
 299:23 318:8
 333:6 345:26
 360:9,22 363:2
 372:17 377:22
 403:1
oppose 206:10
opposed 235:21
 239:9 295:10
oppressive
 388:15
opt 401:14,26
opting 344:6
option 330:19
options 400:25
order 209:15
 247:23 258:13

293:6,10,15
 294:1,25 296:4
 297:14 298:3,7,8,
 11,18,26 299:1
 310:18 315:10
 319:17 324:16,19
 325:4 328:9,24
 329:6,23,25
 330:4,8 331:10,
 20 332:3,5,12,16,
 22 333:2,16
 334:4,15,22,23,
 25 335:3 340:22
 344:5 346:11
 381:16 396:6,14
ordered 349:10
orders 226:23,25
 234:23 246:17
 253:13 257:5,22
 258:2 287:6,8
 290:18 292:21,
 23,25 293:13
 294:26 295:9,21,
 25 296:2,9,21
 298:13,23 303:23
 314:23,24 315:3
 338:8 345:12
 348:18 349:6,7,
 13 382:13,17,22
 383:20 397:7
organization
 267:1 320:26
 356:2 387:1
original 345:3,4
originally 313:14
 319:9 336:8,19
 366:16 399:14
originate 348:19
outbreak 271:23
 392:15
outbreaks 263:5,
 9 312:6
outcome 269:19
outcomes 390:20
outdated 268:8

outdoor 396:8
OVERLAPPING
G 267:15 269:9
 296:15
overreacting
 399:1 400:5
overseas 216:1
oversee 306:2,6
oversees 307:20
overt 242:12
overtly 243:2
overwhelming
 270:14 272:16,
 18,21 273:7,9,15
 290:5

P

package 208:15
pages 206:5
 211:12 406:4
pain 237:14,15
Palmer 304:11
 313:7
pandemic 222:2
 224:21,22 225:5
 226:2,8 238:14
 243:14 245:6,11
 247:5 286:14
 303:23 307:3
 309:9 314:21,23,
 25 315:22 316:3,
 5,12,18 317:15
 318:18,22
 319:23,24 320:2
 322:14 323:16
 324:18 325:10,20
 334:20 336:2,22
 337:5,23,25
 338:17 339:1,3,7
 343:13 344:6,8,9,
 25 345:24 346:9,
 24 349:25 352:20
 353:5 354:17,23
 355:8,16,21,22

357:5 360:1
 362:5 363:13
 364:14,26
 365:18,23 366:1
 370:17 376:10
 380:15 381:1,2,4,
 7 382:9,16,25
 383:5,11,13
 384:9 390:9
 391:12,15
 392:10,12 394:26
 397:6 399:1,11
 400:11,23 402:19
pandemics 312:6
paper 269:11
 270:6 289:21,22
 301:10
parachute 266:2
parachutes
 265:5,7
paragraph
 262:2,6,8,20
 267:6,11,19
 328:18 329:22
 331:4 334:4,15
 340:17 343:4
 346:26 347:1,2
 354:12 359:16,18
 360:6,8,19 363:8,
 9 364:6,7,9
 370:14 373:2
 374:10 376:4,7,
 16,19 378:14
 397:1
paragraphs
 331:4 332:14,17
 334:24 365:10,21
 397:12,14
parameters
 210:26 216:26
paraphrase
 289:6 290:17
pardon 233:5
 253:18 288:3
 384:15

park 251:25
304:19
parks 345:17
part 265:6 269:1
282:17,20,23
290:3 294:5
304:18 305:9
308:6,13 310:23
332:6,22 349:19
350:2 354:4
359:17 363:16
379:2,25 382:22
384:10 389:1,23
390:24 400:15
401:11
part-time 304:16
participate
305:8 360:11
361:13
participated
305:11
participation
360:12,15
parts 283:18
party 214:12
passed 402:22,
24,25
path 403:14
404:9
pathogen 389:18
pathogens 389:8
pathologists
327:19
Pathology 346:6
patience 380:4
patient 235:15
238:7 246:4
253:12 254:20
255:8,19,21,23
256:2,9,11
288:10 291:6
323:20,22 326:4
339:19 341:13,18
342:11,13
345:17,19,22

356:13 366:21
367:3 387:10,16
388:14 392:7
396:1 403:21,24,
26 404:6,7,8
patient's 387:18
patients 229:17,
19 235:11 236:7,
14 237:9,20
238:20,25 240:5
244:24 250:23,
24,25 253:19,21
254:3 255:5,9,14,
17 256:1,7,16,17,
20 262:13 263:2,
6 287:18 288:8,
12,15,17 290:8
324:3,9 326:15,
16,24 338:6,10,
12 339:15,17,22,
26 341:19 342:24
343:19 345:9,20
353:13,14 354:19
362:19,21 367:22
368:3 372:11
374:6 379:21
381:15 388:18
389:8,9 391:6,20
392:2 395:21
396:4 401:3
403:22,26
patterns 285:3,
12,18 308:3
374:21
Pavlic 203:9
302:9 404:25
405:2
pay 353:11
payment 373:8
payments 396:5
PDF 206:4 269:5
peer-reviewed
211:14 227:16
261:19 262:7,9
pejorative 230:9,
10,11,13,15,16,21

pen 301:10
people 217:11
222:17,18 224:5
229:7,10,16
230:4,20 231:1,2,
11,14 232:1,18
233:21 236:10,
19,23 237:10
238:16,17,20
239:2 240:24
241:13,19
242:10,22 243:1,
20 244:1,17,20
245:1,2,4,7,9,10,
13 246:20,26
247:2,3,6,7,8
250:14 251:6,19
252:12,22 256:4
258:18 259:26
260:10,14 262:23
264:9,22 265:5,
15 271:15,21
275:14 277:19
280:1 281:3
288:10,21,22
289:7,13 296:24
300:6,24 305:22
309:2 311:21
322:2,19 339:23
349:3 361:4
369:24 402:14
people's 277:20
perceive 244:2
288:21
percent 250:3
265:17 273:12
307:7 321:25
376:11
percentage
336:16
perfect 216:12
270:9
perform 265:4
305:25
performance
309:6 321:9

371:3 385:7,15
period 205:22
320:21
periods 238:21
permanent
359:1,3
permit 402:1
permits 359:5
permitting 259:6
persisted 338:13
person 212:10
214:11 230:1
235:9 238:13
240:1 247:5
256:23 282:24
290:10,25 291:16
294:7,12,15,17
295:21 334:7
342:26 396:7,9
person's 333:4
personal 202:13
311:17 318:3
329:10 338:26
340:16,18,21
341:7 348:13,15
350:10 352:13
353:15 354:4
373:22 375:19
377:6 386:10
387:18,23 388:1
391:3
personally 312:7
persons 282:15
283:24
perspective
230:6 232:23,24
258:3,24 259:1,8,
19 321:11 353:6
perspectives
231:3
Peter 242:6
phase 211:15
394:26
phone 324:24

377:7,10 380:25,
26 395:22 398:9
phones 376:23
phonetic 240:24
324:26
phrase 210:4
physical 235:12
294:22 295:3
318:2 325:24
326:3,14 329:19
335:13,15,21
339:4,10 341:19
342:18 373:19
374:6 389:15
396:11,12
physically 398:5
physician 289:12
291:11 292:1
physicians
256:16 346:20
385:12
physiotherapist
291:16,23 327:18
physiotherapists
291:24 346:19
385:13
pick 271:22 282:1
404:22
picking 282:11
picture 383:4
pieces 337:18
388:8
pinwheels
389:20
place 204:11
246:14,18,19
253:5,7 294:16
313:8 322:6
332:23 334:9,10
339:17 340:3
347:21 353:4,20
366:3 373:19
383:21 384:13
391:14

placebo 266:8,10
places 295:8,12
plague 221:16,
 17,18 222:7
 249:2 280:13
plan 317:22
 318:22 359:18
 360:10 361:14,
 19,20,24 362:1
 363:12 364:13
 369:10 393:17
planes 265:5
planned 315:18
planning 370:9
plastic 340:10
 373:10
platform 321:17
 360:6
play 237:18
plays 379:19
pleasure 300:7
plexiglass 247:20
 337:24 338:1
 340:10 344:26
 373:10 396:2
plow 393:22
PM 301:15
 302:24 397:5
pocket 388:9
point 203:24
 211:20 212:24
 215:6 234:14
 278:1,2 280:14
 281:21,23 282:1,
 22 290:1 298:22
 303:1 311:23
 315:4 325:15
 404:23
points 240:6
policies 256:12
 258:25 263:8
 382:20 386:8
 389:24

policy 233:4
 258:3,24 259:1,8,
 18,22 260:4,7
 306:26 307:1
 382:7 386:14
political 229:3
 234:26
politicised 235:4
poorly 345:18
population
 311:20 336:17
portion 268:16
 280:10 392:8
portions 221:14
 296:8 337:22
position 212:4
 213:21 214:2
 229:4 230:23
 250:15 252:11,
 18,21 253:7
 254:13,16 255:9,
 10,14 258:5
 270:25 272:4,10
 312:15,23 344:23
 346:2 366:22
 381:13
positions 257:11,
 15 304:24
positive 243:21
 369:15,18
possi 240:24
possibly 236:20,
 24
posters 363:1
potentially
 209:15 238:25
 387:19
PPE 202:14
 261:11,14 286:24
 311:17,25 319:25
 320:5 323:9,11
 337:8 340:25
 341:2,21 343:10
 352:14 353:15
 363:18,22 366:20

373:23
practice 237:8
 247:16 291:21
 304:12,14 306:24
 307:1 308:2,3,20,
 22 309:2,11,13,
 20 311:14 316:4,
 5,10,11 317:15
 318:18,23 319:9,
 22 320:10,11,14,
 17,18 321:5,6,19
 323:2 325:5,12,
 16,26 326:10,13
 328:7 331:2,17,
 24 332:2 333:22
 336:11,14,22
 337:5,16 338:10
 344:19 346:8
 349:8 352:25
 355:22 359:5,9,
 17 360:1 361:2,5,
 14,19,20 362:5,
 11,22 363:12,23
 364:13,15 365:5,
 18,19,23 366:1,
 16,23 368:2
 369:6,10 370:25,
 26 371:3 375:16
 378:19 379:4
 381:11,26 383:12
 384:16,26 385:6,
 9,14,25,26
 386:11,15 387:4,
 7,15 388:4,11,15,
 16 389:19,25
 390:1,12 391:12,
 22,24,25,26
 392:9,11,12
 396:18 399:1
 400:10,19,23,25
 401:10,11,13,14
 402:1,2
practiced 386:3
 389:2,5 401:1
practices 310:17
 323:6 330:17
 385:24

practicing 304:6,
 13,16,18 307:18
 314:20 315:22
 317:20 321:9
 328:26 392:15
practitioner
 335:23 341:2
 345:22 371:19
 388:3,10 402:23
practitioners
 325:5 347:23
 363:24 367:19
 368:8 371:21
 388:12 389:6,9,
 10,20 392:3
pre 367:2
pre-covid 248:20
preamble 249:4
precautions
 237:10 288:26
 289:3 389:14
precedence
 347:10,13
precise 282:10
precision 231:12
predictably
 236:11
predictor 275:12
prefer 204:26
 300:23,24
preference 303:6
prejudicial
 208:8 211:5
preliminary
 204:10 210:14,16
prepare 208:14
 310:22 316:2
 318:26
prepared 216:7
 311:6 315:18
 318:15 362:23
 363:1 365:4
preparing
 380:18

prescribe 235:12
presence 315:8
present 208:16
 236:11 240:1
 320:13 328:12
 339:26 350:3
 391:22
presentation
 314:5
presented 203:25
 237:21 320:15
 362:6
presently 391:23
press 264:14,18,
 20
presymptomatic
 367:3
pretty 226:8
 244:15 260:23
 273:11,14 287:14
 301:5
prevalence
 271:12
prevent 224:1
 270:4 271:16
 312:19,20 340:25
 353:3 354:5
 389:6
preventing 263:8
prevention 202:8
 216:16 270:17
 289:4 311:12
 318:4 329:10
 383:25 384:18
 385:1 386:13
 390:21 391:1,25
previous 403:6
previously
 201:14 221:10
 273:18
price 226:1,4,9
prices 226:3,10
primarily 222:14
 228:26 305:19,20

primary 260:17 307:22 308:15,17 319:18 352:24	362:18	396:12	proud 226:18	341:12 342:11,13 343:8 345:3 346:21 349:17 358:15 367:14 382:21 398:6
principle 213:16 353:24	producing 308:16 342:3	proper 264:22 343:9 366:19	provide 206:6 207:15,16 209:6 212:10 215:14 234:8 258:14 262:11,15 296:22 303:3 318:9,13 319:17,21 321:14,20,22 327:11 331:7 336:10,15,17,18 339:23 340:23 343:15 346:11 350:19 354:19 358:6 361:19 368:18 373:15 383:11 386:5 390:11,20	province 307:2 316:11,16,17 334:1 376:21 379:15 406:8
print 208:8	profession 304:10 305:23 308:6 312:14,17 315:4,15 317:19 319:12 330:18 331:18 333:25 358:16,19 359:25 373:25 377:19 379:17,25 381:26 385:11 386:23,24 402:9,11	properly 208:18 213:21	provided 206:11 207:11,25 209:24 211:1,4,9,11 212:4,12 215:12 235:22,25,26 245:18 255:11 262:16 290:18 320:16 321:3 326:8 331:20,25 335:12 339:10,17 342:25 345:7 350:5 355:5 357:1 358:14,18 367:18 368:7 377:5 382:7 392:14 397:21 405:2	province-wide 294:1
prior 292:20 293:14 324:23 381:3 402:4	professional 245:18,21 247:12 288:11 306:7,8 307:14 309:18 327:24 329:4 348:13,16,17 357:13 372:4,7 385:16 386:10 391:10,11,13	propose 207:15 393:2	provinces 317:6	provinces 317:6
private 277:15, 18 304:12 332:26 333:14	professionals 236:3,7 348:6,9 391:8 402:10	proposed 206:8	provision 355:22	provincial 334:2 347:8,9 367:15 390:3
privilege 379:24	professions 305:24 307:23 308:9 316:21 320:16 328:26 330:2,10 365:14, 16 381:24 387:4 402:9,12	proposing 207:11	provisions 335:3	proximity 238:21 324:6 325:23
proactive 317:22	profiles 314:16	protect 319:21 340:10 354:3,5, 18 373:11 387:25	psychological 315:14,15	psychosis 256:3
probative 211:4	programs 306:2 307:25 311:11 312:5	protected 257:19 337:12	psychotic 290:10	public 203:12 226:22 227:6,10, 12,20 228:8 229:11 234:18 235:2 244:22 246:10,14,15,18, 19,20 247:11 251:24 258:24 259:1,18 277:13 294:16 295:8,12 302:12 306:21,22 307:14,16,21 308:13,15,17 310:25 311:4,6,8, 9 312:8 314:21 319:19,21,23 321:3 322:10 323:16 332:23,24 333:8,25,26 334:9,10 335:12, 19,21 337:17 340:7 343:22
problem 272:13 292:16 299:26 301:3		protecting 308:17 354:15		
problems 296:11 390:19 402:15		protection 255:26 261:14,15 307:14,15 308:13,15 337:9, 14,17,18,20,21 343:19,20,21 353:18 354:19 379:21 384:4,6 388:7		
procedural 333:22 341:15,24 355:2		protective 202:13 311:17 318:3 329:10 337:14 340:16, 18,22 341:8 345:21 350:11 352:13 353:15 354:4 373:22 375:19 387:14, 22,23 388:1 391:3		
procedurally 214:9		protects 366:20		
procedure 223:4 287:1 354:9		protesters 231:18		
procedures 342:3 391:1		protocols 385:24 390:18 391:26		
proceed 364:22 366:2				
proceedings 203:1,23 214:14 301:15 302:1,24 405:13 406:5				
process 215:4 287:8 290:24 291:3 363:14 389:19				
procurement 226:3				
produce 299:1,4				
produced 202:7 216:15 346:13				

344:4 347:8,9
 348:11 363:11
 364:17,21 366:26
 368:19 373:5,21
 375:8,9,14,21,24
 378:22 380:1
 381:15,20 382:4
 392:14 394:23,24
 395:1,9,12 397:4,
 19 398:3,6 399:7

publication

220:10 347:4

publish

319:1

330:11

published

213:2
 216:4 220:4
 227:16 228:11,13
 267:7,23 269:23
 317:12 318:24
 330:2 331:9
 334:18 336:8,12,
 26 337:13 361:17

publishing

316:7

pull

234:10 248:5

378:8

pulling

359:22

purpose

206:3,22
 207:2 285:21
 320:23 332:22,26
 333:2 355:17

purposes

225:16

279:10

pursuant

246:17

295:2

purview

256:26

put

204:13 212:6
 219:25 246:7
 249:1 250:18
 266:23 279:7
 293:2 310:14
 318:15 337:19
 371:3 381:20,25
 382:7 391:14

puts

213:20

putting

206:22
 207:2,5 214:2
 322:13

puzzled

217:4

Q

QC

203:16
 302:17

qualified

246:10
 258:21 287:25
 290:25

qualifiers

221:25

qualifies

258:19

qualify

258:15,22

quality

227:16
 228:13

quarters

247:8

question

209:26
 215:7,23 220:8
 223:9,22 233:6
 249:23,24 251:1
 256:26 268:13
 269:12 272:11
 284:13,21,25
 286:14 287:12
 295:6 297:13
 309:12,26 312:13
 316:15 334:5
 336:7 344:16
 345:1 348:15,24
 361:9 365:20
 368:21 374:15,
 16,17,22 379:13
 380:8 390:23
 402:5 403:17

questioning

216:8 217:1
 218:15 221:13
 237:5 242:26
 246:1,12 287:22
 306:12 307:8
 309:9

questions

201:23
 206:24,25 209:2

217:24,25 218:24
 220:18 245:26
 246:5,8 264:12,
 13 286:5 292:8,
 11,12,14,15
 296:26 297:3
 298:24 299:11,22
 303:11,13,14,16,
 18 304:1 309:21
 313:1 314:22
 321:14 323:4
 326:6 327:26
 328:13 334:19
 338:17,25 339:2
 342:1 357:22
 358:7 360:23,25,
 26 361:1,2,3,4,
 23,26 362:9
 366:15 370:20
 371:13,16,18
 372:15,23 374:1,
 9,12,23,25
 381:14,15
 392:21,24 394:5,
 13 397:13 401:6
 402:4 403:4,12,
 15 404:12

quick

204:6
 300:24 335:5
 393:9 403:17

quickie

291:8

quickly

204:15
 370:9 374:14
 379:8

quotation

234:5

quote

268:6
 270:14 274:12
 285:2 341:3,4
 396:25

quoted

268:17,18

quotes

268:4

R

radar

395:8

raging

241:7

raise

395:12

400:12 404:15

raised

354:24

361:10 395:7

ramp-up

376:21

ran

261:9

randomized

206:16,17

range

239:21

ranges

310:21

ranging

361:1

362:3

rank

369:26

rare

240:1,5

rate

265:9,17

284:11

RCT

202:6,8

216:14,16 266:3,
 6,12

RCTS

265:4,20,
 22 266:17

Re-cross-

examines

201:17

292:19

re-entry

362:1

Re-examines

201:16 286:12

re-open

363:2

365:26

re-opening

330:23 364:23

366:2,4

reach

354:26

371:25 376:25

395:6

reached

357:2

reacting

354:25

reaction

355:4,5

read

208:9,10,11,
 19 209:4 211:17,
 24 212:16,22
 216:25 217:6

220:13,19 231:5

234:4 267:20

268:6 278:19

286:26 294:6,11,
 14,20 295:7,25

321:19 327:15,16

328:20,22

329:12,24,26

330:6,7 331:6,11

332:21 333:1,6

334:6,17 335:1

341:9,23 342:9,
 16 343:6 345:26

347:2 348:8,20,
 21 353:2,25

354:1 360:8,21

361:12,22 363:9,
 20 364:12,20

365:9,12,21,22

367:9,10,16

368:5 369:7,8,25

370:15 371:9,11

372:3,6,12,14

373:3,4 374:10,
 11 375:14 376:7,
 17 377:14,16,17

378:7,16,21

379:13 385:22

386:6,17 387:7,
 13,23 388:21

389:4,26 390:14

391:4,15 395:17

396:26 397:2,12,
 14,18 398:2

reading

269:14

270:10 298:1

335:5 353:7

ready

210:19

365:16

real

214:17

240:25 399:8

400:4

real-world

274:19

reason

204:23

224:21 250:4

256:23 260:17

277:24 308:12 345:15 388:10 399:21 reasonable 216:24 375:24 reasons 209:10 238:9 250:6 255:18 291:14 399:26 rebuttal 208:14 210:12 214:13, 15,24 recall 234:12 268:11 362:8 399:20 400:9 receive 238:24 253:6 254:24 310:23 322:18 325:9 331:22 356:18 360:25,26 376:26 380:9,11, 17 381:16 395:4 received 208:4 210:13 231:19 253:8 254:1,16 305:5 328:1 338:8 351:4 356:21 360:14 362:2,8,13 363:11 369:17 377:8 380:18 381:6 394:24 395:1,18 396:17 403:19 receives 333:15 receiving 339:15 373:21 recently 216:2 346:4 381:8 reception 340:7, 11 342:21 373:1, 11 396:3 reception/ payment 373:7	receptionist 342:22 recess 221:1 264:17 299:10 301:12 352:3 393:24 recognize 326:1, 7 recognized 268:21 323:9 333:18 recognizes 381:23 recollection 290:19 RECOMMENC ED 302:24 recommendatio n 337:8 344:17 346:17 384:4 recommendatio ns 258:7 308:4 337:6 348:11 recommending 306:26 reconvene 215:21 217:10 221:2 264:17,25 301:7 352:4 393:24 reconvened 221:7 record 207:6 211:11 246:7 269:1 301:13 314:18 380:23 381:5 recordkeeping 314:7 401:23 records 309:25 313:13 red 212:18 redirect 218:24 286:10 403:11	reduce 202:5 216:13 220:25 275:9,10 279:21 324:15 331:16 332:1 343:23 reduces 223:25 279:13 reduction 273:23,26 refer 221:16,24 223:23 227:26 248:3 270:3 274:13 278:24 reference 249:2 278:13 338:20 367:5 375:1 378:6 references 289:20,21 329:7 335:8 referencing 397:26 referred 205:4 360:7 referring 222:1 223:15 224:14 226:24 227:8 250:17 251:20 283:17 286:22 363:13 refers 267:22 reflect 208:23 reflected 309:24 reflects 206:8 347:5 reframe 320:10 refresh 220:24 398:10 refuse 210:25 refuses 398:4 regard 328:15 339:7 362:5 Registered 203:10,11	302:10,11 Registrar 303:15 304:5,15,17,21, 23 305:14,15,18, 19,26 306:14 371:18 377:2 378:2 397:3 401:9 Registrar's 355:14 356:10 369:1 378:10 registrars 346:5 registration 303:21 305:20 313:2 361:22 regular 239:22 regularly 221:24 236:10,19 240:1 337:4 regulate 354:22 regulated 308:6 316:20 328:24 330:1,12,17 331:18 343:14 348:9,14,16,25 349:13 356:16 365:14,15 379:17,25 381:14 402:8,11 regulations 401:12 regulators 310:14 316:16, 24,26 317:5,17, 18,21 359:23,25 regulatory 306:1,2 307:13 365:18 401:7,8 related 360:23 relating 311:12 350:4 relationship 276:19 277:3 relative 226:16 311:9,14 375:11	383:12 385:25 391:26 relaunch 327:1 relaxed 378:22 releasing 324:23 relevant 249:22, 24,26 257:12 280:6,13 338:26 390:11 religious 256:22 257:16 400:7 remain 270:16 364:23 385:23 remark 274:12, 15 remedial 391:8 remedies 210:12 remember 210:5 258:4 296:4,18 298:17 321:5 335:17 344:12 349:9 353:8 398:14 400:18 remembered 398:23 remind 205:24, 25 221:7 373:18 374:4 reminded 378:5 reminder 373:24 376:13 reminding 263:13 remove 370:26 384:3 removed 399:19 renew 402:1 renewal 305:21, 25 306:9 rental 332:25 replenish 264:22 Reply 201:9,10, 11 211:7 213:9 214:4
---	--	---	--	---

report 208:12 210:9 211:13 221:13,16,24 222:4 223:10,13, 19 225:20 228:1 231:5 232:17 233:24 246:6 248:1,3,6,9 249:1,5,8,20,23 261:22,24 262:3 266:22,24 267:11,12,18,25, 26 269:3,13 270:12,19 274:4 278:19,23 279:1 280:11 285:13,25 286:2 355:15 356:10 365:13 369:1 378:3,10	357:11 364:18 366:17 367:1 368:3,16 379:14 383:1 386:13 388:12 395:25 400:13 401:17	respectfully 298:23	restrictive 344:10	382:23 383:7
reporter 203:21 204:8,19 205:16 302:22 303:4 357:16,20 406:15	requirement 295:1,21 297:14 313:19 331:2 333:21 338:6 340:2,14 341:6 342:4,15 343:15, 18 344:3,17,19 346:3 347:23 363:23 375:23 378:19 379:5,6,7 384:3 391:13 392:10,16 401:22	respective 365:17	result 308:4 317:7 402:23,24, 26	reviews 268:21 269:24 270:3
reporter's 359:10	requirements 286:24 305:23 308:5 310:12,20 311:11 313:21,23 325:19 334:3 337:7 338:1 339:7 341:21 343:3,13 347:5 349:6,19 356:17 365:17 366:20 370:25,26 383:25 385:21 391:10,12 396:19 397:8 401:26	respirator 388:8	results 216:4 220:9	revised 385:2
reports 209:18 249:7,21 261:19 262:7 279:23 280:7,10	requires 374:19 401:20	respiratory 237:11,16,21 239:8,11,17 243:3 244:6 291:26 327:19	resume 327:22 350:26 351:3 393:6 403:8	revisions 318:15 336:13
represent 385:6	requiring 344:11 346:21 367:15 368:10 398:6	respirologist 250:9	retail 245:22 247:17,18	rhetoric 399:7
representation 306:23	research 217:21 312:21 316:6	respond 206:24 211:8 213:21 214:11 220:19 248:2,7 307:22 321:15 346:11 374:14 395:10 402:6	retooling 373:12	rightfully 284:22
representatives 324:25	residence 332:26	responded 287:14	retract 285:17	rights 401:12
represented 322:7	resource 373:17	response 205:16 209:7,12 213:12 274:4,10 292:11, 15 316:18 323:15 338:7 370:3 380:22	return 325:5,12 327:10 328:7 336:11 359:17 361:14,18 362:21 363:12,23 364:13 365:5,19 369:6, 10	rigour 291:2
require 318:5 329:6 389:21	requires 374:19 401:20	responses 318:13	returned 366:16, 23	rise 276:1
required 292:22 310:1,24 312:5 313:17,25 314:6, 7 319:17 320:1 324:19,20 330:3 338:12 344:23 346:9 347:24 348:10 349:23,26	requiring 344:11 346:21 367:15 368:10 398:6	responsibility 215:2 348:18 349:5 356:23 379:19 390:25	returns 264:18	risk 237:26 238:3,5,6,22 245:9 246:25,26 247:1 250:24,25 251:26 252:3 260:22,23 268:8 271:9,11 273:23, 26 282:15,16,23 283:24,25 288:3, 4,12 289:9,14 315:24 322:12,15 324:12,15 331:16 332:1 343:24 344:21 345:10 353:13 358:22 381:20 390:5 391:5,21,23 392:5
	research 217:21 312:21 316:6	responsible 343:11	reveals 212:8	riskier 251:22
	residence 332:26	responsibly 208:20	review 209:5,9 217:13 248:7 267:22,24 268:2, 5,14,17,25 269:11,23 270:2 313:2 318:8 324:21 336:12,13 337:4 345:26 361:18 362:10 364:17 365:3 380:22 382:17,19 387:4 389:1	risks 335:25
	resource 373:17	rest 379:15 393:17,22	reviewed 314:15 318:24 325:22 333:17 346:19,20 358:26 362:12 383:1	risky 288:16
	resources 352:24	restaurant 253:5	revising 314:16 316:6 380:18	road 261:1 359:9
	respect 329:26 391:14	restricted 359:6		robust 360:14
	respectful 219:17	restriction 378:23		role 210:22 303:15 304:17 305:19,26 306:24 307:10 308:8,13 311:9 328:14 379:18
		restrictions 226:23,24 235:3 275:1 372:9		roles 306:18 308:11 401:8
				room 204:13 205:21 236:14

245:13 248:12
263:1 279:26
345:6
rooms 238:23
239:4 339:22
342:24 345:18
routine 385:23
RTC 206:16
rule 215:3 256:20
378:7,15,17
rules 347:5
381:25
ruling 201:12
206:12 215:20
run 213:24
218:25 311:22
runny 239:18
240:26 241:26
243:7,17
rushed 264:14

S

safe 307:1 318:17
319:19,22 320:11
321:3 322:10
323:1,2,11
340:23 343:15
353:12 362:15,21
safely 316:4,11
317:15,20 321:9
safer 260:18
safety 262:23
342:25 343:26
379:20 380:1
398:3
salient 248:21
249:10
satisfied 325:17
Schaefer 210:9
schedule 333:11
school 231:21
310:8

school-age
231:22
Schumann
203:21 302:22
406:3,14
science 220:21
310:10
scientific 228:26
261:19 262:7
265:6
scientifically
227:5
scope 368:2
381:11
screen 240:7
301:10 393:13
screening 238:12
243:9 384:2
screenshots
206:4
scrolled 298:3
sec 391:2
second-to-last
262:2 267:11
secondary
304:20
seconds 218:14
section 234:2
249:19 294:5,9,
10,12,14,15
295:2,7 308:9,10
325:16 328:24
329:25 330:3,5,8
331:10,11,14
333:24 334:7
341:21 353:24
392:21
sections 249:22,
23 274:5 332:18
sector 231:14
seek 327:11
seeking 314:1
371:24 402:16

sees 237:14,15
244:24 288:12
self-diagnosing
291:17
self-diagnosis
291:12
self-isolate 367:1
self-isolation
366:21
seminars 314:1
send 206:11
217:26 219:8,10
324:20 350:16
381:14 397:23
sending 348:23
355:23 356:15
sends 356:10
sense 216:12
243:15 247:9
382:26 402:17
sentence 231:5
278:15,18,25
285:1 353:25
360:8,21 363:18
368:5 369:7
372:3,13 376:5
377:14,16 378:7,
14
sentences 364:6
371:9
separate 253:3
340:3 373:20
September
201:5,20 203:5
302:5 304:13
404:22 405:13
406:9
series 296:20,21
355:13 382:12
served 305:12
serves 225:15
service 245:18
253:9 329:4

services 245:21
247:12 253:6,8
254:1,15 255:11,
13 262:24 322:22
327:22 343:8
350:4,12 358:15
363:22 394:10,21
395:18
session 201:5,20
203:5 221:6
302:5,26 352:7
393:23 394:1
set 210:26 239:3
277:25 291:22
305:23 307:17
310:12 313:23
315:21,26 316:6
327:24 330:13
342:5 386:23
setting 222:19
224:1,3 225:12
231:7,12,15
232:2,8 235:16,
20,21,22,23,24
236:9,13,17
237:20 238:3
239:20 245:19
246:15,21
247:11,13,16
248:11,16,25
250:16,17,19,22
251:7,21,22
252:2,8,13,15,23
253:26 254:15,21
255:3,5,10
260:18,20
265:25,26
266:13,14,15
270:18,23,24
271:20,26 272:2,
15,19,24 273:5,
10,13,17,25
279:13,20 288:5
307:16 341:15
389:11
settings 224:7
234:19 235:7,8,

17 236:2 237:26
238:23 239:4,25
241:20 242:23
245:10 247:25
252:26 253:22
256:12 259:16
260:22 266:18
271:16 273:24
287:13,16 288:4
290:4,14 295:10
329:2 330:15
336:16,18 341:14
402:6
seven-page
217:9 285:13,25
severe 250:5
254:18 354:24
severity 315:25
shading 260:25
shame 382:5
share 329:8
sharing 317:8
Sheila 377:4
Sherwood
304:19
shield 337:8
347:25
shields 320:4
388:6 392:7
shifting 347:17
short 209:13
shortage 226:5
shorthand 406:5,
6
shortly 215:17
305:7
shortness 241:7
show 206:19
207:6 273:13,18
showing 211:25
shown 326:17
shows 217:3
237:23 274:19

shut 315:17 317:6 322:20,23 371:22	skill 291:22 315:21 406:7	sources 227:13, 18,21 234:20 262:11,16 268:10	353:10 354:23 356:12 358:4 369:3 378:3 383:24,26 384:17 385:3,20 387:22 390:6,7 395:1 401:8 403:22	stage 341:6 stages 368:11
shutting 376:22	skip 288:1 319:2 320:19 322:11 326:5 329:22	space 326:8 333:8,14 335:21 339:10 389:15	specificities 243:1	stand 270:20 271:14 279:5 280:18,26 282:8 285:3,7 303:3 323:22 383:5,11
sic 224:21 234:12 324:16 346:6 350:9	skipping 304:4	spaces 234:18 339:16 345:18	specificity 223:19	standard 287:2 308:21,26 320:14,17 341:25 342:6 359:5,8 379:26 383:12 384:10,17,21,26 385:2,20 387:3, 14 388:3,11 389:13 390:24 392:9,12 403:26
sick 242:22,25 243:13 244:1,2, 15 288:19,21,22	sleep 240:21	speak 204:17 207:25 234:15 296:1,6 312:7,12 320:7 322:16 351:8 354:23 371:25 382:2 397:24 403:1	specifics 246:23 277:10	standards 307:16 308:20 309:2,3,10,12 321:5 342:6 381:26 384:16 385:6,13,17
side 214:11 253:20 256:9 345:6	slice 276:25	SPEAKERS 267:15 269:9 296:15	spectrum 244:1 288:19 322:1	STANDS 300:12
signal 395:8	slight 338:2	speaking 234:20 256:20 260:7 315:14 336:5 346:14 359:16 371:17,19 391:19	speculate 245:3	start 204:1 221:15 242:17 286:13 309:25 333:18 366:23
signature 377:15	smaller 342:20	speaks 209:26 390:7	speech 399:7	started 226:2 275:24 304:26 305:7 315:7 322:25 334:1 358:20 371:20 374:22 394:19
significant 319:25 321:23 322:12 337:3 338:3 392:8	so-called 222:1 234:9	specialist 394:22	speech-language 327:18 346:6	starting 316:14 327:22 364:8
significantly 388:15	social 277:16,18 327:20 337:24,26 344:26 397:8	specialists 359:25	spend 235:9,14	starts 231:23 262:6 267:20 343:6 367:8
similar 323:24 335:2	society 247:5 250:9	Specialized 387:24	spent 263:3 280:7	state 228:21,22 270:12,19 278:18,23
simple 378:6,14, 15,17	solely 332:25	specific 224:10 225:19 273:7 286:18 298:2 304:2 305:26 309:13 311:3,10 325:2,14 328:13 358:11 366:11 378:2	spirit 279:15	stated 268:5
simply 206:15,19 207:4,5 211:14, 15,25 213:20 217:19 262:20 338:16	solution 358:25	specifically 226:24 249:1 269:22 298:8 306:3 308:11 314:25 327:9 329:8 333:20 337:9,11,19 338:5 349:10	spoil 217:24	statement 227:18 230:20 231:10
single 296:4 387:2	somebody's 392:4		spoke 298:26 361:6	
Sir 214:5	sooner 300:25		spoken 359:23,24	
sites 217:20	sore 243:7		sponsored 266:26	
sitting 393:13	sort 222:11,14 223:6 227:14 228:5,26 230:17, 22,25 240:16 241:9,11 242:26 247:4,10,21 253:21 255:22,25 258:21 266:16 271:11 276:19 277:21 278:5 284:2 295:8 308:7 312:14 365:6 368:18 376:6		spread 340:26 345:10 353:3,13 354:6,8 389:6	
situation 352:20 357:13	sorts 344:12		spring 261:7,25	
situations 266:3 290:5 311:7 312:4 335:19	sound 393:16		spurious 275:7, 17	
six-page 217:8 219:25	sounds 230:21 233:14 293:24		staff 242:7 329:13 339:19 340:8,11 341:2 342:10,17 343:8, 12 353:12,14 372:11 373:11,16 376:9 390:22,26 391:7 395:19 396:1,3,14 398:7	
sixth 304:1 394:4	source 227:6,7,8, 9,10,21 228:25 234:8 354:3,14			
size 273:21,22				

250:9 270:22
274:10 278:16
280:22 282:21
285:17 289:6
353:19 361:21
381:13 384:23
statements
281:20
states 228:20
229:22,23
stating 279:2
280:19
statistically
276:15
status 208:26
315:4 364:11,13
stay 324:17
403:25
Steger 377:4
step 300:19
361:18,19
stepped 284:22
sterilization
389:18,21
sterilizing
388:23
stop 204:21
336:24 363:26
367:23
store 335:20
straight 218:19
strange 232:22
strengthen
312:16
stress 385:5
stressful 346:8,
18
stretch 217:11
299:16 393:14
strict 275:22
379:3,5,7
stricter 275:23
strikes 232:21

stringent 347:22
348:1 349:19,22,
25 378:18,25
strong 208:25
273:20,21 384:4
strongly 207:24
208:7 211:3
257:16 344:18
struggle 319:14
studies 208:6,9,
17,23,26 209:1
211:10,12,16
213:14 215:8
217:3 218:4,7
220:4 222:10
223:11,21,24
224:6 227:14
228:4,11,15,16
248:13,17,20,21
261:20 262:7
270:2 273:12,16,
17,25
study 211:20,24
212:26 213:4,6
223:20,22,23,26
224:9 228:3,13
248:7 266:26
267:2,6,7,10,23
268:5 269:14,17
270:8,9 273:10,
11 274:14 278:24
stuff 227:15
278:9 323:13
style 339:13
362:18 375:10,11
386:11 388:16
subject 294:12
328:23 330:8
334:7
submissions
201:7,8,9,10,11
206:2 207:13,14,
20,22 211:6,7
212:24 213:9
214:4

submit 325:4
328:6 360:23
369:11
submitted
324:22 336:9
362:10 364:17
subsequent
294:26
substantially
330:13 335:2
substantively
207:3
substitution
355:2
success 299:26
sufficient 261:14,
15
sufficiently
260:9
suggest 213:23
217:7 288:21
298:24 351:1
suggestion
342:14
suggestions
392:18
summaries
219:23,24
summarize
338:24
summary 219:25
summer 338:14
summit 317:25
supply 226:13
support 209:19,
24 210:14 248:10
258:24 259:1,8,
14,19 260:19
261:20 270:13
271:6 307:1
312:23 377:16,18
supporting
210:16 266:13
273:26

supports 274:14
353:5
supposed 233:19
suppress 275:2
surgical 222:1,26
223:4,17 224:17
225:6,24 226:14
269:15 287:1
333:22 341:15,24
342:7
surgical-grade
222:13
**surgical/
procedure**
329:15 374:5
surprise 210:7
285:11,24 286:1
surprising
287:11
survey 361:24
369:7,12,13
370:4
survivability
265:9,17
survived 265:15
suspect 241:22
suspected 245:14
suss 243:10
swear 303:5
Sweden 274:12,
15 278:13
switch 312:26
sworn 201:14
221:10
symptom 238:12
240:11,16,18
241:2 242:2,7
symptomatic
236:10,19,23
238:24 239:7,17
240:1,5,24 241:9,
19
symptomatics
239:16

symptoms
237:11,12,15,16,
20,21,24 239:8,
12,16 241:11,13
242:12,14,15,19
243:3,11 244:6,7,
11
symptom 242:18
synthesize 228:9
system 312:16
359:7
systemic 268:21

T

TABLE 201:1
tables 339:14
takes 209:13
365:6
taking 221:13
301:4
talk 222:10,11,12
223:20 224:6
225:21 230:17
233:4,16 235:11
237:7 250:1
269:15 273:16
279:11 295:9
296:21 307:9
308:14 315:5
318:11 321:5
340:6 351:24
355:7 380:12
388:21 393:7
394:18 399:12
404:12
talked 223:9
233:13 241:10
271:4 278:9
280:12 288:7,19
293:17,21 308:19
320:19 327:26
344:5 350:3
352:19 354:11,13
357:3,5 363:14
368:24 371:5

380:5 399:14
400:24
talking 215:15
218:14 224:25
225:3,4,5 232:7,9
239:7,11 244:5
250:16 252:15
257:9,10 259:14
261:24 275:7,16
278:10,13 279:16
280:8 284:16
300:6 333:18
346:4 354:14
359:18 361:16
384:9
talks 222:4 270:2
332:15 360:6,19
373:1
target 264:3
teach 346:11
technically 242:3
Telehealth
326:12 345:9
357:23 358:1,6,
12,15,17,18,25
359:1 368:24
371:6 400:24
401:1
Telerehabilitation
326:13
teller 247:19
telling 367:23
375:13
temporary
358:25
ten 243:18 271:17
294:18,19
tend 227:13
228:3 258:7,11
311:22 388:17,18
tendered 208:23
209:19 217:19
tendering
211:10,16

term 223:14
224:8,14 229:21,
22 230:8,9,13
266:4 289:4
termed 367:3
terminology
223:3
terms 209:22
221:26 273:6,8
280:3 344:8
352:20 357:7
359:19 393:16
Territories
271:24
test 243:20
tested 243:16,18
testify 214:1
257:1
testimony 229:9
299:24 303:3
328:12 351:9,24
393:8 403:9
404:19,26
testing 291:5
tests 239:22
366:22
Texas 228:22
theme 290:3
therapists
327:19,21
thing 229:17,18
231:8 232:22
260:13 270:26
280:13 285:20
295:7 312:1
320:12 351:2
things 209:14
212:8 214:9,13,
18,25 222:5
226:21,26
227:16,23,24,25
229:2,8,10,20
237:12 240:4
241:5 258:9
261:23 263:26

271:18 275:10
277:10,17 278:6,
7 282:12 288:7,
25 291:26 303:25
306:6,10 307:6
309:10 311:15,
17,22 314:2
315:20,25,26
317:8 318:1,11
319:6 320:4
322:4 323:5
324:4,8 325:6
326:9 333:7,17
337:10 339:12
341:5 344:12
345:25 347:14,19
351:21 353:7
354:14 358:6,21
362:17 368:12
371:1 373:14
374:1 381:18
385:4 389:16
394:19
thinking 217:20
351:17 383:16
thinks 212:5
382:4
third-party
292:21 295:4,23
297:15
Thomas 267:10
Thoracic 250:8
thought 232:7
234:12 292:3
299:2 326:2
375:24 381:7
Thoughtexchange
321:18 360:7,15
369:13,20 370:2
thoughts 205:6
209:2 300:22
369:24,25
thousand 281:2
three-page
377:13

threshold 385:16
throat 243:7
254:22
tier 223:6,7
tight 219:1
tightened 381:13
till 209:16 365:5
time 205:19,22
208:13 209:4,5,
13 211:22,23
212:15 214:23
216:10,21
218:17,20 219:18
227:15 235:14
238:12,17,21
243:4 263:4
264:5,21 276:24,
25 282:1,10
283:11 298:26
299:2,24 300:1
304:18,19 305:2,
6,11 307:5
315:16 316:8,19
317:3,7,10
320:21 321:23
322:1 323:3
325:2 333:8,15
337:16 344:20
345:2 348:25
349:11 350:23,24
351:15 355:20
356:16 358:23
359:5 360:17
367:1,13 371:19,
26 376:20 377:9
383:21 389:17
393:19 395:8
398:22 399:5
400:8 401:2
402:26 404:7,19
timelines 218:26
timely 391:9
times 221:14,21
223:13 243:14,18
249:13 254:20
255:6 270:13

294:7 329:16
334:8 341:16
342:11 377:11
381:20 396:13
tinkering 383:6
tired 240:17,19,
20
tissue 388:1
title 305:14
today 209:16
240:20 264:11
270:16 279:5
285:3 364:15
365:15 393:4,5,
17 403:16
404:13,19 405:10
today's 339:1
Todd 201:21
303:2,8 361:24
377:4
told 331:19
tomorrow
241:25 244:15
tool 268:8
top 266:22,23
323:22 324:2
327:4,13 343:3
367:7 398:16
topic 259:11
261:1
topics 310:22
356:7 362:4
374:26 377:19
total 275:13
280:10
totally 243:5
tough 315:16
town 318:11
320:22 321:13
360:15
track 298:19
trained 292:1
305:9 310:7
319:8,9 390:26

training 292:5
305:6 311:10,16
312:5,8 314:11,
21 319:11,25
390:21 401:25

transcribed
406:6

transcript
201:24 406:1,4

transcripts
313:10

transition 339:20

transmission
223:25 237:18
240:10 241:16
248:23 251:26
262:17 263:8
270:4 273:23
275:9,10,11
278:6,21 279:14,
21 288:13
289:10,17 324:15
331:17 335:25
340:26 343:24
387:3 389:7

transmissions
391:6

transmitted
389:13

transparent
320:26

trauma 314:10

**trauma-
informed** 401:24

treat 236:23
255:23 319:16
366:21

treated 287:18

treating 263:2
312:2 374:3,6

treatment 235:9
245:14 266:8
290:10 312:24
314:3,19 326:7
339:11,22 340:21

359:2 391:18

treatments
239:22 254:25
375:20

trends 308:3
390:20

trial 207:3 212:3

trials 206:16,17,
19 207:4,6
211:25 216:2,6,9
219:24

tribunal 203:7,8
207:12,17,23
209:25 210:24
215:22 218:24
264:13 299:10,21
302:7,8,25
305:10,13 323:25
328:8 329:9
352:6 357:25
370:8 380:4
384:14 385:5
403:11 404:12,16

Tribunal's
303:10

trick 222:23
251:13 254:9

trickery 224:25
225:18

trickier 243:12

tricky 240:11
241:14 242:21

trouble 243:5

troubling 209:16

true 232:26 235:6
237:4 245:19
262:26 276:3
282:14,17
283:10,21,26
287:13

trust 227:18,20,
23,24,25 228:2,3,
5,23,25 295:24
297:18,19,25

Tuesday 393:6
403:8

turn 205:19
255:21 286:9
326:26 359:4
394:4 398:9

turned 357:17

two-step 389:18

two-thirds 376:3

type 208:14
223:11 239:17
240:15 242:7
256:2 271:8
286:21 295:22
299:1 319:25

types 210:6
223:10,12,20
239:25 241:15

typical 244:21

typically 214:8
239:26 311:19,
25,26 389:19

Tyre 324:26

U

ultimately
287:24 316:9
334:20 344:22
345:11

un-ideological
229:9

unable 294:21
295:2,3,22
365:26

unacceptable
224:22

undergrad 310:8

underlined
377:3

underlying
250:11

underneath
402:9

understand
207:10 212:22
216:26 218:21
296:5 304:5
305:14 311:7,8
317:17 322:8
323:1 324:19
345:1 383:13
392:25

understanding
205:3 246:4
278:5 285:2,12,
17 330:26 403:13

understood
254:13

unethical 207:5
265:4

unforgivable
300:3

unique 248:22
321:21 337:10
385:11,12 386:10

United 229:23

universal 288:26
289:3

unspecified
232:21

unusual 212:5,6,
9,11,13

update 374:20
375:6

updated 269:26

updates 355:15
356:22

uphold 372:8

uptake 260:15

uptick 320:5
321:21 373:16

upwards 362:3

urgent 315:12
364:24

usual 330:17
405:3

V

vaccination
259:9,10,15,17,
19 260:4,12,16,
20 261:2 382:6

vaccinations
260:7 381:12

vaccine 260:14,
17 381:18,19

vaccines 381:9
382:2,3

validity 208:26

valuable 209:13

variables 276:19

vast 231:13
273:11

vehicle 279:4
280:20 281:4,16,
18,24,26 282:13,
16,22,25 283:1,
25

ventilated
345:19

ventilation 388:7

VERBAL 205:16

verification
295:23

verify 234:8
262:11,16

versions 336:2
337:25

versus 234:18
275:18 282:22
305:3 375:11
389:21

Videoconference
203:1 302:1

view 216:5 260:7,
14 308:8 311:23

vigorously
287:14

violation 396:6
viral 244:8 312:6
virtual 360:20
virus 248:22
viruses 221:21
 249:13
visible 244:11
visibly 239:17
visit 308:2
visitors 372:11
visits 401:10,13,
 15
visualize 346:10
voice 361:7 377:8
volunteering
 304:26

W

wait 327:1 350:19
waiting 219:15
 306:22 339:16,18
walk 256:4
walk-in 239:4
 245:20
walkers 387:21
walking 238:8
 345:17
Wall 203:18
 210:3 233:17
 288:15 302:19
 303:22 304:2
 313:6,7 314:18
 356:21,26 357:2
 362:9,10,13
 380:14,17,20,23
 381:2,4,6,21
 392:23 394:7,10
 395:15 396:18
 397:5,20,23
 398:4,10 400:25
 401:1,4 404:3
Wall's 309:24
 313:2 314:12,13,
 15 403:22
wanted 208:15
 225:11 270:1
 299:6 309:22
 317:14 320:25
 323:1 339:14
 340:24 342:3,25
 347:19 349:4,18
 359:21 360:4,5,
 13 363:15 365:3
 366:18 368:1,17
 371:24 373:14
 374:3 376:24
 381:10 383:3,4
 394:5 395:9
 404:12
wanting 400:1
ward 236:14
 263:2
wards 263:6
Warren 267:10,
 12,22 268:4,14,
 17,20 279:1,7,16
 280:18 281:14
 282:8 283:8
 285:1,6
Warren's 267:25
 269:3
washing 384:1
 386:26 387:2,9,
 10
waste 388:24
watched 315:10
wave 226:4
 274:25 337:1
 371:21,23 376:22
ways 230:2 308:4
 322:17 374:24
wear 225:11
 233:21 250:20
 251:23,25
 252:22,26 253:22
 255:4,6,15,17,21,
 25 256:6,10,11,
 13,20,24 271:5,8,

15 290:8 294:7,
 12,21 295:3,22
 297:15 329:15
 333:21 334:7
 341:15 342:14
 347:24,26
 366:12,17 374:2
 388:12 392:5
 399:15 400:1,5
wearer 354:5,15
wearing 223:26
 230:20 232:8
 250:14,22 251:5,
 18,24 252:12
 253:9 254:17
 256:17 261:7,15,
 16 266:12,17
 269:18,19 270:20
 272:23 366:26
 373:24 375:12,
 18,25 399:17,18,
 24
web 206:5 303:24
website 298:16
 375:6
Wednesday
 210:15 344:14
week 276:25
 318:21 360:21
 393:17 404:15
weekend 405:11
weeks 268:7
 383:8
weighing 362:4
well-being
 372:11
whatsoever
 213:22
wheel 387:20
when's 261:3
whichever 303:5
white 243:21
wide 239:21
widely 268:21

wind 264:19
witness's 209:14
witnesses 338:18
wonderful
 259:23
wondering
 283:16 366:13,17
 384:24
word 229:7,13,15
 230:7 232:15,16
 242:24 249:15
 257:25 309:15,17
 319:3 340:12
 347:15 357:12,
 14,17 391:11
 392:17 402:18
wording 289:7
 338:4
words 254:6
 274:18 399:25
wore 399:23
work 226:18
 239:26 246:24
 250:19 259:15
 264:6 275:3
 276:2,5 306:4,5,
 16 311:23,26
 312:3 316:23
 323:19 324:4
 327:10 343:16
 345:16 359:21
 360:3 379:18
 388:17,18 392:3,
 4
worked 263:1
worker 253:20
 261:25 270:23
 273:25 341:12
 361:9
workers 236:4,
 18,22 237:23
 255:1,4,25 259:7,
 15,20,24 260:11
 261:6 262:3,13
 290:7,13 316:11

327:17,20 341:11
 344:22 354:22
 387:25 402:10,18
working 311:19
 312:1 316:22
 324:1 329:14
 339:19 354:6
 358:20
workplace
 262:23 329:1,17
 330:14 341:17
works 259:21
 369:20
world 232:3
 234:7 248:17
 266:26 288:4
 387:1
worn 354:3 374:5
 399:14
worried 361:4
worse 278:6
write 367:26
writing 285:10
written 211:13
 251:17 285:13
 381:21
wrong 227:19

Y

year 208:13
 279:5 280:21
 284:8 305:21
 306:10 320:22
 346:16 358:26
 383:15,17
years 210:6
 271:17 312:21
yes/no 370:4
yesterday 203:25
 204:20 205:26
 234:22 235:2
 240:20 242:22
 250:4,13 251:2,5,
 16,17 257:4,13,

25,26 261:6
265:4 266:4
271:4 275:20
293:17 294:3
296:1 364:8

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

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	September 7, 2021	Morning Session	409
6	DR. TODD HALOWSKI, Previously affirmed,		410
7	Cross-examined by Mr. Kitchen		
8	Mr. Maxston Re-examines the Witness		441
9	The Tribunal Questions the Witness		450
10	Discussion		453
11	DAVID LAWRENCE, Affirmed, Examined by		455
12	Mr. Maxston		
13	Discussion		490
14			
15	September 7, 2021	Afternoon Session	493
16	DAVID LAWRENCE, Previously affirmed,		494
17	Cross-examined by Mr. Kitchen		
18	Mr. Maxston Re-examines the Witness		526
19	Mr. Kitchen Re-cross-examines the Witness		547
20	Discussion		551
21	Certificate of Transcript		554
22			
23			
24			
25			
26			

1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 September 7, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees	Tribunal Chair
9 W. Pavlic	Internal Legal Counsel
10 Dr. L. Aldcorn	ACAC Registered Member
11 Dr. D. Martens	ACAC Registered Member
12 D. Dawson	Public Member
13 A. Nelson	ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:08 AM)

24 THE CHAIR: Good morning, everybody.

25 Thank you, Dr. Halowski, for coming back this morning.

26 A Thank you for having me back.

1 THE CHAIR: Just to remind everybody, we
2 concluded on September 2nd with the direct examination
3 of Dr. Halowski, and we will start this morning -- I
4 should, first of all, remind everybody that the Hearing
5 Tribunal is back in session, and we will start this
6 morning with the cross-examination of Dr. Halowski.

7 And, Dr. Halowski, I would just remind you that
8 you are still under oath. Very good.

9 Mr. Kitchen, I'll turn the floor over to you.

10 MR. KITCHEN: Thank you, Chair.

11 DR. TODD HALOWSKI, Previously affirmed, Cross-examined
12 by Mr. Kitchen

13 Q MR. KITCHEN: Good morning, Dr. Halowski.

14 Is it all right, if I call you Dr. Halowski?

15 A Yeah, that works for me.

16 Q Thank you. Well, I'm going to start with just a few
17 questions about some of the things you had to say on
18 Thursday, and I might refer to last Thursday, and
19 that's just a reference to your direct examination with
20 Mr. Maxston.

21 Now, Dr. Halowski, the primary form of care
22 provided by chiropractors is physical manipulation of
23 the musculoskeletal system of their patients; isn't
24 that right?

25 A That is one form of treatment provided. There's also
26 consultation. There's education. There's also soft

1 tissue immobilization. There's exercise instruction.
2 And so one of the modalities of treatment that is used
3 is physical manipulation as well as many others.

4 Q So you disagree that the primary form of care is
5 manipulation?

6 A That is one of the modalities of treatment that we are
7 taught. It may be that many chiropractors employ it.
8 There are chiropractors that don't use that. So for me
9 to speak for every chiropractor and the treatment plan
10 they provide would be inappropriate in this setting,
11 but it is one of the treatment forms that chiropractors
12 utilize and are trained to utilize and recognized as a
13 restricted activity that we are able to perform under
14 the Health Professions Act.

15 Q Okay, and I appreciate that answer, but can you just
16 confirm for me that you disagree that it's the primary;
17 in other words, you would say it is only one form of
18 treatment, it is not the primary; would you agree with
19 that statement?

20 A I would say that historically, manipulation was the
21 primary means of treatment. I would say in today's
22 chiropractic. There are many approaches; chiropractors
23 also provide acupuncture, they provide all sorts of
24 different treatments that are physical or meant as for
25 intervention. So I think that having me agreed to that
26 statement or disagree to that statement, doesn't

1 provide the full context of care provided by
2 chiropractors.

3 Q And I appreciate that you feel that way --

4 A No, that's the truth; it's not my feeling.

5 Q Okay, and I appreciate that you think that's the truth,
6 but you are required to answer my question, and my
7 question is do you agree that physical manipulation of
8 the musculoskeletal system is the primary form of care?
9 If you disagree, I'd ask that you tell me.

10 A I think I have answered that that is one of the forms
11 of care, and it may be the most --

12 Q I didn't --

13 A -- commonly --

14 Q -- ask you if it's one form of care; I asked you if
15 it's the primary.

16 A Again, then --

17 Q Do you agree it's the primary, or do you disagree?

18 A I would say I can't answer that question the way you're
19 asking it.

20 Q So do you agree that you don't know the answer to that
21 question?

22 A No, I think I do understand that that applies, and I
23 did inform you as well as the Hearing Tribunal of the
24 many different options that are available for treatment
25 as offered by chiropractors.

26 Q I didn't ask you if you understood. I asked you if you

1 don't know. So is your answer to the question whether
2 you agree that musculoskeletal manipulation is the
3 primary form, is your answer I don't know?

4 A The answer is that would depend on each practitioner,
5 and while that is we are trained and experts in
6 providing manipulation as you're describing, or if we
7 talked about osseous manipulation, then, yes, that is a
8 primary treatment that we're trained to offer.

9 Q So you would agree that physical manipulation is a
10 primary form but not the primary form?

11 A That's correct.

12 Q Well, do you agree that the physical manipulation of
13 the musculoskeletal system is called an adjustment?

14 A That is one word that's used for it. Adjustment and
15 manipulation are used interchangeably by practitioners,
16 often recognizing that, you know, manipulation is what
17 would be recognized by the majority of health
18 professions. Adjustment is the term used by some
19 chiropractors when they're describing manipulation.

20 Q Well, I'll use the word "manipulation" because it seems
21 to be the one favoured by you. Now, manipulation is
22 done by chiropractors by either touching patients with
23 their hands or with small manipulation devices; isn't
24 that right?

25 A That are -- yes, that would be the two, typically
26 either instrument-assisted or hand-based adjustment or

1 manipulation as you call it.

2 Q Well, I'm calling it that, because you called it that.
3 Adjustments cannot be done -- okay, sorry, let's call
4 them manipulation. Manipulation cannot be done over
5 the phone, can it?

6 A That is correct.

7 Q Manipulation cannot be done if a chiropractor is
8 physically distanced from their patients by 2 metres;
9 isn't that correct?

10 A That's correct.

11 Q You stated last Thursday that Telehealth is not the
12 same as physical care, did you not?

13 A It is not the same.

14 Q I don't think you said last Thursday that Telehealth is
15 shown to be effective, but you have produced no
16 independent evidence of this effectiveness in the form
17 of studies or reports, have you?

18 A I think I did report on a study that's forthcoming
19 that's not yet published, but there is evidence and
20 there is published evidence that treating
21 musculoskeletal conditions with Telehealth has been
22 shown for specific conditions to be effective, that
23 depends on the condition.

24 Q You haven't produced that evidence for the purposes of
25 this hearing, have you?

26 A I didn't -- no, we didn't produce that evidence. It's

1 not submitted as one of the articles.

2 Q Chiropractors don't generally work with people that
3 have infectious illnesses, do they?

4 A They -- not typically, we don't. We don't seek out to
5 treat patients with infections. Some patients may show
6 up because they have an infection -- well, with an
7 infection as a comorbidity.

8 Q But you said last Thursday, did you not, that
9 chiropractors don't generally work with people that
10 have infectious illnesses, didn't you?

11 A Yeah, we're not a primary treatment for those patients.

12 Q When the ACAC decided to include mandatory masking for
13 chiropractors in the Pandemic Directive in May of 2020,
14 it did not consider the statutory human rights and
15 constitutional rights of chiropractors regarding
16 mandatory masking, did it?

17 A We were taking the direction of Public Health around
18 the requirements to protect patients. So if you're
19 asking about it in that situation, it was one of the
20 discussions; however, the primary decider was that we
21 have a responsibility to practice in the safest way
22 possible for our patients.

23 Q Thank you for that answer, but you didn't answer my
24 question. My question was when you were deciding what
25 to put in the Pandemic Directive, and you decided to
26 include mandatory masking, this is in May of 2020, you

1 did not consider the human rights and constitutional
2 rights of chiropractors, did you?

3 A I would say that the rights of the patient and our
4 responsibility to provide a safe environment were
5 considered above those rights. So it's not that it was
6 not considered, the consideration was specifically that
7 the patient's safety in a situation like that should
8 come first at this time.

9 Q Sir, you agree that the human rights and constitutional
10 rights of patients are very important?

11 A I do agree that we have a responsibility. I don't know
12 if I'm an expert -- able to speak about constitutional
13 and human rights. I do know that we had a
14 responsibility to provide a way for our practitioners
15 to deliver safe care. So while you're asking me about
16 that, I don't feel that I'm qualified to speak about
17 the human rights here in the aspect that you're
18 pursuing. And what you're seeking is my opinion, and I
19 don't know if my opinion really matters in the regard
20 of making a decision of what's best and safest for a
21 patient.

22 Q But you would agree, just to confirm what you just
23 said, you would agree that the rights of patients are
24 paramount over the rights of chiropractors?

25 A That the safety of patients is paramount in making a
26 decision about how to provide for safe practice.

1 Q Right, but what you just said is that the rights of
2 chiropractors are less important than the rights of
3 patients; is that not what you just said?

4 A I don't believe it is.

5 MR. KITCHEN: Well, Madam --

6 A I think I spoke about the safety of the patient.

7 MR. KITCHEN: Madam Reporter, can you help
8 us out with that? Can we just go back to what
9 Dr. Halowski said there just a moment ago?

10 COURT REPORTER: (by reading)

11 A I would say that the rights of the
12 patient and our responsibility to provide
13 a safe environment were considered above
14 those rights. So it's not that it was
15 not considered, the consideration was
16 specifically that the patient's safety in
17 a situation like that should come first
18 at this time.

19 MR. KITCHEN: Thank you.

20 Q MR. KITCHEN: So, Dr. Halowski --

21 A Yeah.

22 Q -- you would agree can with me that, from your
23 perspective, the rights of the patients are paramount
24 to the rights of chiropractors?

25 A When you say "paramount", can you give me the
26 definition of how you're describing "paramount"?

1 Q You would agree with me that you just said that the
2 rights of patients are more important to you in your
3 role as the Registrar than the rights of chiropractors?

4 A I would say that the rights -- if you're going to use
5 those words, the right or the responsibility of the
6 College is to ensure public protection, public safety,
7 and practitioner competence, and I believe we met those
8 requirements by the decisions that were made in May
9 last year.

10 So we did say that paid practitioners must be
11 masked to provide care, because the evidence at that
12 time was that masking was an effective way to limit the
13 transmission of COVID-19 to patients that were
14 receiving care.

15 Q So you would agree with me that the Pandemic Directive
16 does a good job of prioritizing the rights of patients
17 over the rights of chiropractors?

18 A I would agree with that.

19 Q When the ACAC decided to include mandatory masking for
20 chiropractors in its Pandemic Directive in May of 2020,
21 it did not consult a scientist who was independent of
22 the Alberta Government, did it?

23 A We were -- we did not, other than the advice and
24 recommendations of Public Health, consult anybody
25 outside of that organization.

26 Q And by "Public Health", you mean the Public Health of

1 the Government of Alberta?

2 A Correct, and also the recommendations of the Public
3 Health Agency of Canada.

4 Q Now, when the ACAC reviewed and revised the Pandemic
5 Directive in January of 2021, it didn't then consult a
6 scientist who was independent of Government Public
7 Health to review the mandatory masking, did it?

8 A No, we continued to put our trust in the
9 recommendations and direction received from Public
10 Health in Alberta as well as that from Public Health of
11 Canada.

12 Q Exclusively, correct?

13 A Yes, correct.

14 Q You said last Thursday, that it would be, quote,
15 oppressive for the ACAC to mandate too much PPE too
16 often; isn't that right?

17 A In the context of reviewing the standard of practice, I
18 believe that is correct. When we talked about all of
19 the different things, i.e., having to wear gowns,
20 having to wear gloves, having to wear splash shields,
21 all those different things would have been an excessive
22 amount of PPE in the context of what we knew about
23 COVID at the time.

24 Q Now, I'm going to take you and the Tribunal to Exhibit
25 F-2. If you could just let me know when you have that
26 in front of you. This is CMOH Order 16-2020.

1 A I will let you know as soon as I have it. Okay.

2 THE CHAIR: Does everybody have it?

3 MR. KITCHEN: Thank you.

4 Q MR. KITCHEN: Dr. Halowski, you're there?

5 A Yeah.

6 Q Now, Section 2 of this order, CMOH Order 16-2020,
7 Section 2 never applied to Dr. Wall, did it?

8 A You're saying Section 2 of the actual order or Section
9 2 of Appendix A? Because when I read Section 2 of the
10 order: (as read)

11 Effective May 4th and subject to Section 6 of
12 this order, a regulated member of a college
13 established -- [so Dr. Wall is a regulated
14 member of a college] -- established under the
15 Health Professions Act practicing in the
16 community must comply with the attached
17 Workplace Guidance for Community Health Care
18 Settings to the extent possible when
19 providing a professional service.

20 I would say that does apply to Dr. Wall.

21 Q Let me take you over to the next page then. You see
22 Section 6 there?

23 A Yeah.

24 Q Now, I'm going to read it to you, and then I'm going to
25 ask you a question: (as read)

26 Section 2 of this order does not apply in

1 respect of a regulated member under the
2 Health Professions Act whose college has
3 published COVID-19 guidelines as required by
4 Section 3 of this order.

5 A Yeah.

6 Q You would agree that the ACAC Pandemic Directive was
7 implemented on May 4th?

8 A It was -- that's when members could return to practice
9 under the CMOH order. It was -- that's when it was
10 effected. It was provided to members before that.

11 Q All right. Okay, so let me ask you again -- let's go
12 back to Section 2 --

13 A Okay.

14 Q You would agree with me then that Section 2 never
15 applied to Dr. Wall?

16 A Section -- the way you're reading it, yes.

17 Q And that's because of Section 6 and the fact that the
18 ACAC implemented the Pandemic Directive on May 4th,
19 correct?

20 A Correct.

21 Q So at no time did Dr. Wall ever contravene Section 2 of
22 CMOH Order 16-2020, did he?

23 A I am answering; I'm just reading to make sure my answer
24 is consistent with what I'm reading right now.

25 Q That's fine.

26 A Yeah, at that time, he would be under the direction of

1 the College. So your answer -- I think the way you --
2 can you restate your question, and then I will answer
3 it specifically?

4 Q At no time did Dr. Wall ever contravene Section 2 of
5 CMOH Order 16-2020; isn't that correct?

6 A He would have been -- so, yes, he would have been under
7 Section 6 of the CMOH -- of this order at 16-2020,
8 because the College had its own guide, but the answer
9 is, yes, that said that.

10 Q Thank you. I'll take you to Exhibit D-8, please. D-8,
11 and that is CMOH Order 38-2020.

12 A Okay.

13 Q You're familiar with this? I believe we discussed this
14 last Thursday.

15 A Yes.

16 Q And I'll take you over to page 6. Now, Section 27(c)
17 of this CMOH Order 38-2020 orders that individuals are
18 exempt from wearing a mask if they are: (as read)

19 Unable to due to a mental or physical concern
20 or limitation.

21 Isn't that right?

22 A That's what that says right there.

23 Q Just going to go back to the Pandemic Directive, and
24 just so everybody knows, there's three versions of the
25 directive, of course, I think it's C-20, C-21, and
26 C-22. C-22 being the January 6th version.

1 Now, Dr. Halowski, none of these three versions of
2 the Pandemic Directive requires that patients wear a
3 mask, do they?

4 A I think the first and second did not. I believe in the
5 third version, we did start speaking to the direction
6 that was provided in the CMOH orders. I would have to
7 confirm that.

8 Q Well, why don't you do that.

9 A In here, we did not speak to patients. I do know we
10 did -- and so that's why I had to review. I do know we
11 communicated to the ACAC around patients and how to
12 manage and handle patients that were not masking
13 because those were at the time Provincial or Municipal
14 orders.

15 Q I appreciate that, but you'll confirm for me that never
16 in the directive, in the Pandemic Directive, did you
17 mandate that patients must wear a mask?

18 A No, we don't regulate patients. We did not mandate it
19 in there.

20 Q And none of the three versions of the directive
21 required chiropractors to enforce that their patients
22 wear a mask, does it?

23 A That was -- no, we don't have anything in the Pandemic
24 Practice Directive around enforcement for chiropractors
25 to make their patients mask in the clinic.

26 Q Now, I'm at that Personal Protective Equipment section,

1 okay, which stays largely the same for the three
2 versions. Now, you would agree with me that nowhere in
3 the PPE or the Personal Protective Equipment section in
4 the directive, you would agree with me that nowhere
5 does it say anything about chiropractors contacting the
6 ACAC regarding masking if they think they have a human
7 rights concern regarding mandatory masking?

8 A We don't have anything in there about our practitioners
9 contacting us. We do -- and this directive didn't
10 include anything about them contacting, because the
11 expectation was that they would always mask when
12 providing close contact care.

13 Q I heard you say quite a few times in your answers to
14 Mr. Maxston on Thursday that the protection of the
15 public is the top priority and primary consideration
16 for the ACAC?

17 A That is what directs our policy decisions, yes, that
18 is -- when council meets and council makes decisions,
19 that is the consideration that's made is what is best
20 for the public. That is that council -- both
21 between -- so I would say, yes, that is an appropriate
22 assessment that we do speak to the need for regulating
23 members with the perspective of public safety first.

24 Q You agree that a key aspect of protecting the public is
25 protecting their health, do you not?

26 A Yes.

1 Q You agree that the principle of, first, do no harm is a
2 vital part of protecting the health of members of the
3 public; do you not?

4 A That would be part of what we do and aim to do with the
5 provision of care as chiropractors.

6 Q You agree that each patient of every chiropractor is a
7 member of the public, do you not?

8 A Yes.

9 Q You agree that the interests of each patient, each
10 forms a part of the broader public interest; do you
11 not?

12 A I would say I guess so if we're going down this --
13 where you're going is that each patient's, you know --
14 but again there, I'm trying to understand the reason of
15 the question, other than, yeah, we have that each
16 patient's safety is paramount, but we only interact
17 with a patient that's in the office.

18 Q You agree from the perspective of the ACAC, because
19 that's -- I'm not asking this question, I'm not asking
20 any of these questions about you as a chiropractor. I
21 know you've practiced; you mentioned that on Thursday.

22 A Yeah.

23 Q But you're here in your role as Registrar.

24 A Yeah.

25 Q Okay, so that's what I'm talking about.

26 A Okay.

1 Q So you would agree from the perspective of the ACAC
2 that the interests of each patient, each chiropractor,
3 each forms a small part of the broader public interest,
4 correct?

5 A Yes. I would say the public as a whole, yes.

6 Q Do you think -- would you agree that if the interests
7 of one individual patient were impacted, that in some
8 small way the broader public interest as a whole is
9 impacted?

10 A Perhaps. I mean, can you give me an example of a
11 situation that you're thinking of? Because I can think
12 there would be positive and negative for impact, I
13 think that's a consideration.

14 Q If I did that, Mr. Maxston would tell me I can't ask
15 you a hypothetical, so I'm not going to do that.

16 A Okay.

17 Q You would agree that the public interest is not merely
18 an ideal, correct?

19 A The public interest, I think that's the
20 decision-making, it's not -- it's meant to be realistic
21 for the public and how they receive care or how we
22 interact or how we provision for the -- it's meant to
23 be realistic, yes.

24 Q Exactly, and the public is made up of many individuals,
25 correct?

26 A It would be, yeah, everybody, like I said, the --

1 society in its entirety.

2 Q So the interests of each individual chiropractic
3 patient, a conglomeration of those interests make up
4 the public interest, correct?

5 A Perhaps, yes, that would be -- I guess so, yes.

6 Q The ACAC expects chiropractors to prioritize the
7 protection of the health of their patients above all
8 other priorities; isn't that right?

9 A That we do expect that they practice with safety as
10 their primary concern, whether it's safety to deliver
11 the care at that time, whether it's safe to -- safer to
12 not provide care, whether it's safer to refer the
13 patient. All of those are considerations that an
14 individual chiropractor must make based on the
15 presentation of the patient. So in the full context,
16 yes.

17 Q Okay, thank you, but I didn't ask you about safety, so
18 please try to listen to the words that I use.

19 A Okay.

20 Q And if you don't agree with me, that's okay, just say
21 so, say, I don't agree with that, or just say, That's
22 not right. You can give whatever answer you want, but
23 I am asking you, and you are required to answer the
24 question that I ask you.

25 A Okay.

26 Q The ACAC expects chiropractors to prioritize the

1 protection of the health of their patients above all
2 other priorities; is that right or is that wrong?

3 A Yes, that's right.

4 Q Even above their own interests, correct?

5 A That would be -- I'm going to say there is context --
6 no, yes, that would be true.

7 Q You agree that the principle -- again I'm asking you in
8 your capacity as the Complaints Director, okay? I'm
9 not asking your personal opinion --

10 A I'm not the Complaints Director, but I'm the --

11 Q Sorry.

12 A -- Registrar, yeah.

13 Q Forgive me. That's exactly --

14 A That's okay. No, that's okay, I just wanted to make
15 sure that that was clear that I'm not pretending to be
16 the Complaints Director.

17 Q So you agree, from your perspective as the Registrar of
18 the ACAC, that the principle of chiropractors
19 protecting the public from harm is more important than
20 the principle of protecting the reputation of the
21 chiropractic profession, do you not?

22 A Public safety is what is the key and essential in the
23 decision-making, so I don't know if I would separate
24 the two because I do believe that protecting the
25 patients protects the reputation of the profession. So
26 that would be I disagree with the way you stated the

1 question.

2 Q Okay. As far as you're concerned, those two things
3 could never come in conflict?

4 A So when you say "those two things", you're talking
5 about patient safety and the public reputation. They,
6 at times, they do come in conflict, and patient safety
7 would be above the professional reputation at the time
8 in the sense that, you know, we actually -- when we
9 govern or when council governs under the Health
10 Professions Act, their consideration is the public
11 above the profession.

12 Q So you've agreed that public safety is above the
13 reputation -- or above the interest of protecting the
14 reputation of the profession. Do you agree that
15 protecting the public from harm is also above
16 protecting the reputation of the profession?

17 A I think that, in my mind, the protecting the public and
18 protecting them from harm is very similar. I don't
19 know if I understand the distinction you're trying to
20 make there.

21 Q Well, again, I asked the question, and I didn't use the
22 word "safety", but you used the word "safety" in
23 answering, which --

24 A Okay, you said public -- versus public, protecting the
25 public and protecting the public from harm, is that
26 what you used?

1 Q That's exactly what I used.

2 A And so what's the distinction? To me, I see them as
3 the same.

4 Q You see safety and protection from harm as the same
5 things?

6 A Again, you put the word "safety" in there, I didn't.
7 When I was restating your question, I said public and
8 public harm. And so when you're saying protecting the
9 public, I think that encompasses protecting them from
10 harm as one of the components. So I guess I would say,
11 yes, in that aspect.

12 Q You agree that there are other threats to the overall
13 health and safety, health and well being of
14 chiropractic patients besides COVID-19, do you not?

15 A Absolutely, yeah. You know, that is -- I would a
16 hundred percent agree that COVID-19 is not the only
17 health threat that our patients face at this time or
18 the public faces, because I'm not speaking about my
19 years as a practitioner.

20 Q You agree that chiropractors are obligated to comply
21 with the ACAC's requirements of practice even if those
22 requirements are harmful to the chiropractor, do you
23 not?

24 A I would say that the -- that the chiropractor must
25 deliver care in a safe way, which is that to reduce the
26 risk of harm.

1 Q I appreciate that, but that's not what I asked you.

2 A Okay.

3 Q You agree, do you not, that chiropractors are obligated
4 to comply with the ACAC's requirements of practice even
5 if those requirements are harmful to the chiropractor?

6 A I disagree with the way you've asked the question, and
7 I know you're going to tell me I have to answer the
8 question, and so I would agree that the patient's
9 safety comes -- is paramount in the delivery of
10 chiropractic care, and we would not set it up so that
11 our chiropractors were in a position to be in physical
12 danger when providing the care.

13 Q Dr. Halowski, if you don't agree with my questions,
14 it's perfectly acceptable for you to answer and say you
15 don't agree.

16 A Okay.

17 Q But you don't get to ask yourself a different question.
18 I'm the one asking questions. I'm asking you
19 questions, and if you disagree with the question that I
20 have asked you, if I ask you if you agree with
21 something, I'm asking you to tell me whether or not you
22 agree. I'm not asking for you to ask yourself a new
23 question.

24 A Okay.

25 MR. MAXSTON: Mr. Chair, I've got to make a
26 comment. Mr. Kitchen is phrasing his responses to

1 Dr. Wall's [sic] answer in the format of, You're not
2 answering a question. He may not like the answer that
3 Dr. Halowski has given, but this constant repeating of
4 you have to answer my question, Dr. Halowski is
5 answering. It's not a question of does Mr. Kitchen
6 like the answers. Dr. Halowski is providing his
7 answer, and I just -- I would ask Mr. Kitchen to
8 refrain from the repeated rephrasing of a question when
9 the answer has been given.

10 MR. KITCHEN: And I appreciate that. The
11 problem is that what we're seeing is the witness is
12 making up his own questions and answering them; he's
13 not even attempting to answer my questions.

14 MR. MAXSTON: Mr. Kitchen, you and I
15 disagree, but when I think when Dr. Halowski gives an
16 answer, he gives an answer, and you don't have to like
17 it. You can press him on it. But I think you're going
18 beyond that in reminding him repeatedly about what his
19 obligations are. He's answering questions.

20 MR. KITCHEN: Well, I'll refrain from that,
21 and I won't give that reminder again.

22 THE CHAIR: I think, Mr. Kitchen, that
23 and, Mr. Maxston, that Mr. Kitchen's questions are
24 being asked to solicit a certain answer from
25 Dr. Halowski, which -- and Dr. Halowski, from my
26 perspective anyway, is trying to provide the

1 information in his answer the best way he can, and I
2 think perhaps there is disagreement on how the answer
3 should be worded between Mr. Kitchen and Dr. Halowski.

4 But I agree, let's try and move forward with this.
5 We seem to be hung up on splitting hairs about the use
6 of a particular word. Thank you.

7 MR. KITCHEN: Thank you.

8 Q MR. KITCHEN: Dr. Halowski, I'm just going
9 to ask this question one more time, and whatever answer
10 you give, we're going to move on.

11 I'm simply asking you whether or not you agree, do
12 you agree that chiropractors are obligated to comply
13 with the ACAC's requirements of practice even if those
14 requirements are harmful to the chiropractor? Do you
15 agree with that, or do you not?

16 A Patient safety comes first in the delivery of care, so
17 I would say that if there's the risk for harm for a
18 practitioner in providing care, they shouldn't be
19 providing care at that time. If providing safe patient
20 care is going to harm the practitioner, that
21 practitioner should not be providing that care at that
22 time.

23 Q And you would agree that it's impossible for the ACAC
24 requirements of practice to ever result in a lack of
25 safety to the patients?

26 A Can you repeat the question once more?

1 Q You would agree it's impossible that the ACAC's
2 requirements of practice would be or would result in a
3 lack of safety to patients?

4 A Can I -- I'm going to say how I heard your question,
5 and so that the way we require care may result in an
6 unsafe environment for patients?

7 Q No, I'm asking you, you in your role as the Registrar,
8 you regard it as impossible that the requirements of
9 practice from the ACAC could ever result in a lack of
10 safety for patients?

11 A I think the Standards of Practice -- so I'm going to
12 contextualize this, the way the Standards of Practice
13 are established and direction is meant to provide the
14 safest way for a patient to receive care. If
15 somebody's not following that, it may introduce an
16 environment where the patient is not safe in receiving
17 care.

18 Q The ACAC is obligated by law to only impose
19 requirements of practice that are lawful; isn't that
20 right?

21 A So I would, listening to that, I think that there's
22 more meaning behind the words than I would be able to
23 speak to. I do know our responsibility is to set
24 Standards of Practice and to govern the profession --
25 and Codes of Ethics and govern the profession according
26 to the mandate that the legislation provides.

1 So when we do that, the consideration is to be
2 lawful in how we set up our direction as well as
3 Standards of Practice and Code of Ethics.

4 Q Well, since you take objection to the words, let me get
5 a little more specific.

6 A Okay.

7 Q You would agree with me that the ACAC is obligated to
8 only impose requirements of practice that are
9 consistent with the Alberta Human Rights Act, correct?

10 MR. MAXSTON: Mr. Chair, I'm going to object
11 to that. Dr. Halowski has no knowledge of Alberta
12 human rights legislation or requirements. This may be
13 a question for another witness but not Dr. Halowski.

14 And, I'm sorry, and I might add that's the
15 ultimate question that may be before -- or one of the
16 questions that may be before the Tribunal.

17 THE CHAIR: I think Mr. Maxston makes a
18 good point. Dr. Halowski is an expert on the College's
19 work; however, I don't think he should be held to be an
20 expert on human rights legislation.

21 MR. KITCHEN: And I would agree, and I
22 wasn't asking about the content.

23 Q MR. KITCHEN: I was merely asking do you
24 agree, Dr. Halowski, that the ACAC is bound by the
25 statutes of Alberta?

26 A To the extent that we have authority under the

1 legislation, we have a responsibility to -- council has
2 a responsibility to govern, given the -- what the
3 legislation provides for us to govern.

4 So I think that, yes, but there's context there
5 that's really important to consider. Like I don't get
6 to decide what happens in somebody's personal life
7 but -- or our director or -- I say "us", the ACAC
8 doesn't get to.

9 What we actually have to specifically consider is
10 how the legislation should be applied for chiropractors
11 that are practicing in Alberta, and "legislation" being
12 specifically the Health Professions Act.

13 Q The ACAC is bound to act according to the Constitution
14 of Canada; isn't that correct?

15 A Again, there I wouldn't be an expert in that. I think
16 we are bound -- we are entitled with the legislation
17 under the Health Professions Act and act according to
18 the direction provided in that document.

19 Q So would you agree with me that the ACAC is bound by
20 other pieces of legislation besides the Health
21 Professions Act?

22 A There are other pieces of legislation that do speak to
23 the chiropractic profession, specifically things like
24 the Health Information Act. We also are responsible
25 for PIPA in our own conduct. Our members are
26 responsible PIPA in their own conduct. So there are

1 other pieces of legislation that direct the conduct of
2 what we have an opportunity to provide guidance,
3 direction, or regulation on.

4 Q Thank you. Now, last Thursday, in response to
5 questions from Mr. Maxston, you discussed what was said
6 in an initial call between yourself and Dr. Wall. This
7 occurred in early December; you would agree?

8 A December 2nd from my records.

9 Q Thank you. Now, you told Dr. Wall, during that call,
10 that a decision may be made that he either wear a mask
11 or sit out from practicing for the rest of the
12 pandemic, didn't you?

13 A I don't believe I made that. I said that we would have
14 to go further in inquiry at that time. I don't
15 actually get to make the decisions, but that would be
16 one of the decisions that would have been possible to
17 be raised, so -- I don't have the transcript nor a
18 memory of every word that was said in that
19 conversation.

20 Q Well, Dr. Wall remembers the conversation, and I'm just
21 going to put it to you that he is going to say that you
22 said to him in that phone call that he either wear a
23 mask or sit out from practicing?

24 A I think that if it was prefaced that way, it would have
25 been an ask not a demand: So would you consider not
26 practicing at this time if you're not willing to mask.

1 Q Well, I'm going to put it to you, Dr. Wall is going to
2 say that you made that as a statement.

3 A All right.

4 Q So let me ask you: Do you confirm or deny that you
5 said to him on that phone call that he either wear a
6 mask or sit out from practicing?

7 A I don't -- I would disagree that I said it that way.

8 Q And, Dr. Halowski, you said that COVID killed two
9 Alberta chiropractors; you said that, correct?

10 A That is what was reported to us from their families,
11 so, yes, I did report what was communicated from my
12 family out to our colleagues, so that our colleagues
13 were aware of the impact of COVID on these families and
14 fellow colleagues.

15 Q So you haven't viewed the death certificates of these
16 two individuals, have you?

17 A I did view the death certificate of one; the other, I
18 received the obituary from the -- and it wasn't a death
19 certificate, like the Government death certificate; it
20 was the one, like a -- I don't know what it's called,
21 but a certificate of death, but like the notice that a
22 funeral home or a mortuary would provide, confirming
23 that they are in possession of this body is what we
24 received, and we require that for some form of
25 confirmation -- or we require some form of
26 confirmation, and that is what we received in that

1 case, and the other was the obituary.

2 Q That document that you viewed, you haven't produced
3 that as an exhibit in this case, have you?

4 A No.

5 Q You have no evidence of what comorbidities these two
6 chiropractors had at the time of their death, do you?

7 A I don't. I didn't. It wasn't my place to ask these
8 families specifically what comorbidities or health,
9 that's their personal health information. They just
10 informed me that COVID had killed their -- one was
11 their husband, and the other was their father.

12 Q So you don't have personal knowledge that COVID was the
13 primary cause of death in these two people, do you?

14 A I have what was reported to me. Is that not considered
15 personal knowledge before the -- like I don't know what
16 your -- is "personal knowledge" is a legal word or not?
17 Like I would call that personal when I spoke to the
18 wife and said that her husband was in the hospital for
19 close to six -- I think four weeks, six weeks, received
20 care at both the Rockyview and the Foothills, but
21 eventually succumbed to complications due to COVID.

22 And the other, there was reports that there was --
23 from them, not from that person directly, somebody else
24 who knew them, indicated that they may have had
25 comorbidities and -- but the son said, Yeah, no, COVID
26 is what killed my father.

1 So I mean, that's information. I didn't enter
2 that as exhibits, other than the fact that both those
3 families declared to me, in different ways, that their
4 loved ones had been killed by COVID or as a result of
5 COVID-acquired infection.

6 Q The basis of your belief that these two individuals
7 died of COVID is based on what you were told by other
8 people, correct?

9 A Correct.

10 Q And you don't know how these two people contracted
11 COVID if they did; isn't that correct?

12 A I didn't ask. It was moot to the conversation, and I
13 didn't feel it was my place to ask that question, so
14 that is correct.

15 Q But you did feel it was your place to say, as part of
16 your testimony, that you believe that two Alberta
17 chiropractors died of COVID?

18 A I believe the reports that were provided by those
19 people, so, yes, I did. And I think, again, for our
20 profession, it only illustrated to me, as well as to
21 our colleagues, the severity of COVID in our community.

22 Q Dr. Halowski, how many chiropractors are there in
23 Alberta?

24 A It -- that goes up or down. Do you want an exact
25 number today or just an estimate?

26 Q Is it greater than 1100?

1 A Yes, it is, and it would have been, at the time, it
2 would have been 1150 to 1180.

3 MR. KITCHEN: Those are all my questions.

4 THE CHAIR: Thank you, Mr. Kitchen. I'll
5 ask, Mr. Maxston, if you have any questions in redirect
6 for Dr. Halowski?

7 MR. MAXSTON: Mr. Chair, I do, I have a few,
8 but I wonder if we could just take maybe a 10-minute
9 break; I just need to go through my notes and organize
10 my questions a little bit.

11 THE CHAIR: Okay, it's 10:00. I think
12 that's a good idea. Let's come back, we'll give you 15
13 minutes, Mr. Maxston, so we'll reconvene at 10:15.
14 We'll take a recess for now and see everybody in 15
15 minutes.

16 (ADJOURNMENT)

17 THE CHAIR: The hearing is back in
18 session, and, Mr. Maxston, it's your opportunity for
19 any redirect with respect to Dr. Halowski.

20 MR. MAXSTON: Yeah, I have about maybe five
21 or six questions for Dr. Halowski. It will be pretty
22 brief.

23 Mr. Maxston Re-examines the Witness

24 Q MR. MAXSTON: Mr. Kitchen engaged you in a
25 discussion about chiropractors, and his statement to
26 you was chiropractors don't generally work with

1 patients with infectious illnesses, and your response
2 was I believe that chiropractors are not a primary
3 treatment for those types of patients.

4 When it comes to COVID though, chiropractors don't
5 know whether a patient is or isn't infectious, even if
6 they're coming to you for an adjustment for their back;
7 is that correct?

8 A That is correct. We do have the screening questions as
9 part of our thing, because we were concerned, right
10 from the get-go, with chiropractors trying to triage
11 patients coming in with infections that they shouldn't
12 be in the clinic in the first place, and then we were
13 concerned that practitioners may try and triage their
14 symptoms and go, Well, this sounds like a cold or this
15 sounds like something else.

16 So we were very prescript to begin with and had
17 maintained that for the duration of the pandemic that
18 those screening questions are important in part of the
19 consideration of whether it would be safe to provide
20 care at that time and --

21 Q And -- sorry.

22 A Sorry. Or have that patient in the clinic environment.

23 Q Is it fair to say --

24 MR. KITCHEN: Mr. Maxston, that was a
25 leading question, and this is a redirect. So if
26 there's any more leading questions, I am going to

1 object.

2 MR. MAXSTON: Sure.

3 Q MR. MAXSTON: Dr. Halowski, patients can be
4 asymptomatic when they attend, asymptomatic for COVID
5 when they attend at a chiropractor's clinic?

6 A That is correct.

7 Q I'll take you to a discussion you had with Mr. Kitchen
8 where he commented that the Pandemic Directive contains
9 no requirements for patients to mask. You don't have
10 jurisdiction over patients, do you?

11 A Correct.

12 MR. KITCHEN: I object to that; it's
13 leading.

14 Q MR. MAXSTON: Oh, I'm sorry, I'll rephrase
15 that. Does the College have jurisdiction over
16 patients?

17 MR. MAXSTON: You're quite right,
18 Mr. Kitchen.

19 A We have no jurisdiction over patients. We regulate
20 chiropractors.

21 Q MR. MAXSTON: Would the CMOH orders enforce
22 a time that required patients to mask?

23 A Yes, there was times where either municipalities and
24 CMOH orders required masking.

25 Q For patients?

26 A For patients, for the public, which patients are a part

1 of.

2 Q Including Dr. Wall's patients?

3 A Including Dr. Wall's patients.

4 Q Mr. Kitchen took you through a part of the PPE section
5 of the Pandemic Directive and mentioned that it said
6 nothing about the chiropractor having a human rights
7 concern. Do you recall last week, last Thursday, when
8 I took you through the Chiropractic College notices,
9 Exhibits C-1 to C-22?

10 A I do remember.

11 Q Are there comments in those notices --

12 A I could review and look off the top of my head. I am
13 not sure. I do know, if that's what I -- you would
14 like me to do, I can definitely look through and give a
15 quick look about that.

16 Q My question was going to be --

17 MR. KITCHEN: Mr. Maxston --

18 Q MR. MAXSTON: -- were chiropractors invited
19 to contact the College if they had questions or
20 concerns?

21 MR. KITCHEN: Mr. Maxston --

22 A Oh, yes.

23 MR. KITCHEN: -- you asked that in direct,
24 okay, last Thursday, okay? So this is not new, and
25 redirect is for new issues and --

26 MR. MAXSTON: Well, you raised the human

1 rights concern, Mr. Kitchen, and I'm responding to
2 that.

3 MR. KITCHEN: Okay, but then the question's
4 going to have to be phrased to be specifically dealing
5 with the human rights concern that I raised in cross,
6 not going back and re-asking the same question you
7 asked last Thursday.

8 Q MR. MAXSTON: Well, I'll ask another
9 question. Dr. Halowski, could a chiropractor contact
10 the College about a human rights concern?

11 A At all times, chiropractors were able to contact the
12 ACAC.

13 Q Dr. Halowski, you engaged in a discussion with
14 Mr. Kitchen and his reference to I think a generally
15 accepted principle of, first, do no harm; do you recall
16 that?

17 A I remember that.

18 Q Who does the "harm" refer to in that, first, do no
19 harm?

20 A That would be in consideration of the patient, that our
21 plans and our treatment is specifically around ensuring
22 that the care we're providing is safe, that our -- how
23 we're providing that we're making those considerations
24 that patients can, one, in our treatment be safe but
25 also in the environment we provide that they're safe.

26 Q And what was the College's determination about

1 practitioners not masking?

2 A The determination, based on the guidance from Public
3 Health and the evidence that we had in making those
4 decisions, was that masking posed a risk to the public
5 because there was the risk for transmission from the
6 practitioner to the patient if the practitioner was not
7 masked inside of that 2 metres distance.

8 Q Okay. Thank you for that. Mr. Kitchen asked you a
9 question, and I'll paraphrase here, does the College
10 expect chiropractors to prioritize the health of
11 patients above all other priorities. Why does the
12 College create Standards of Practice or Code of Ethics?

13 A Standards of Practice and Codes of Ethics, look, the
14 Standards of Practice represent the minimal acceptable
15 level of performance for our practitioners in
16 delivering care. It's meant to provide that framework
17 so that the obligations for the practitioner is spelled
18 out that the public knows what they're reasonably going
19 to receive when they receive care. It makes
20 considerations for public and patient safety in the
21 provision of care.

22 And Code of Ethics represents the conduct or the
23 ethical conduct that's expected out of regulated
24 members of the chiropractic profession in Alberta.

25 Q You engaged in a discussion with Mr. Kitchen about his
26 comment or question that preventing public harm is

1 above the reputation of the profession. I just want to
2 be clear, where does the reputation of the profession
3 come into the College's functions?

4 A The way that -- the reputation of the profession is
5 paramount. Practicing in a safe way is how we protect
6 that. If we made decisions that put the public at
7 risk, that would damage the reputation of the
8 profession.

9 And that also comes in in the reputation of the
10 profession in the way that council deliberates and
11 discusses. Our council currently is comprised of 25
12 percent public members, 75 percent practitioners. That
13 is going to be expanding to 50/50 representation once
14 the Government's provided enough public members of
15 council.

16 But that reputation -- and reputation is based on
17 the idea that, you know, the College is providing a
18 safe way, and we've spent a considerable amount of
19 effort to ensure that things like advertising have been
20 in line -- you know, and that's significant because
21 some of the things that members of our profession say
22 publicly have and potentially damaged the profession in
23 Alberta, have damaged it in other provinces, and so the
24 reputation is really, really key, and we do that by
25 regulating the members to practice safely and practice
26 within the guidelines of what we're given to do under

1 the Health Professions Act.

2 Q I just have one final question. You talked with
3 Mr. Kitchen about the initial phone discussion you had
4 with Dr. Wall I think in early March of last year, I
5 might have the date wrong, my apologies, but it was --

6 A December last year.

7 Q Pardon me, thank you --

8 A Oh, sorry, March was the one that I had with you,
9 Mr. Maxston, but December was the one I had with Mr. --
10 or was the email that I had with, prior to the
11 pandemic, with Dr. Wall, and December 2nd was the
12 conversation after we became aware that he was not
13 masking in his practice.

14 Q Yeah, and I'm referring to that December 2 --

15 A Yeah.

16 Q -- conversation, and I think a difference of opinion or
17 a different recollection that Mr. Kitchen explored with
18 you between your recollection of that conversation and
19 what Dr. Wall's anticipated testimony is. During your
20 phone conversation with Dr. Wall, did you explain the
21 risks to him of not complying with the Pandemic
22 Directive?

23 A I did. I said, realistically, if he's not willing to
24 comply, I would have to refer him to -- on to the
25 Complaints Director and make the Complaints Director
26 aware, and the Complaints Director would -- may

1 proceed.

2 And we -- I am very specific with that in my
3 language, and we don't use -- I can't determine the
4 outcome of something ahead of time, but I do inform
5 members that this may happen. So, for instance, you
6 may be suspended, you may not be able to practice, you
7 may -- all of those would be the language. So those
8 would have been the warnings provided to Dr. Wall in
9 that phone conversation, that if we proceeded down this
10 path, those are things that may happen or could happen
11 as a result of his decision to not wear a mask.

12 MR. MAXSTON: Those are all my questions,
13 Mr. Chair.

14 THE CHAIR: Okay, do Members of the
15 Tribunal have any questions for Dr. Halowski?

16 MR. MAXSTON: Mr. Chair, I don't mean to
17 tell you what to do, but do you need a break to canvass
18 that? I don't know if you had done that before.

19 THE CHAIR: I am going to see if we do
20 need a break. I actually may have a question, so I
21 think we will recess for a couple of quick minutes just
22 to check on if there's any further questions for you,
23 Dr. Halowski, so please bear with us. If we could put
24 the members of the Hearing Tribunal into a break-out
25 room. Thank you.

26 (ADJOURNMENT)

1 THE CHAIR: We're back in session. The
2 Hearing Tribunal has discussed the testimony of
3 Dr. Halowski, and a couple of questions have come to
4 mind, and I will ask Dr. Aldcorn to present these
5 questions to Dr. Halowski.

6 The Tribunal Questions the Witness

7 Q DR. ALDCORN: Thank you. Dr. Halowski, you
8 referred to the ThoughtExchange as an opportunity for
9 members to perhaps share, discuss concerns that they
10 had. My question for you is that ThoughtExchange
11 anonymous?

12 A It is anonymous, yeah, we don't keep a record of
13 anybody. The only thing that shows up in a
14 ThoughtExchange is IP addresses, but we don't keep a
15 record of anybody's personal IP address, and so we
16 don't know who is there or who is commenting. We
17 assume, because it's distributed to members, that it's
18 regulated members of the profession in Alberta.

19 Q Thank you. And the second question I have is just a
20 quick comment that was made by you on Thursday, and you
21 had commented, we were going through the Alberta Health
22 Services G-3 personal protection report, and you had
23 commented that, at some point, you had reached out to
24 Alberta Health Services to find out if there was any
25 exceptions, but my question to you is just when did
26 that happen?

1 A That would have been in and around the fall. Actually
2 we started speaking about PPE with Alberta Health I
3 would say in August, and part of that was driven at the
4 time because we started hearing reports of members that
5 didn't have eye protection being required to isolate,
6 which wasn't in our practice directive.

7 And when they had originally issued the practice
8 directive, they said masking would be adequate, and
9 then we saw this shift in what was being communicated.
10 So I continually tried to inquire around there and
11 looking for guidance and, specifically, was eye
12 protection required for our profession.

13 And then we did have one member of our profession
14 last -- who's on mat. leave and, last summer, inquiring
15 about, you know, they were finding it increasingly
16 difficult to practice while pregnant and wearing a
17 mask. And so, you know, we were looking for ways, and
18 the same guidance was given, that there isn't a safe
19 way for you to provide care to a patient without a mask
20 within 2 metres.

21 Q So that was August approximately you would say?

22 A That member, I would say about August, because I think
23 they're just getting ready to come back to practice
24 now.

25 DR. ALDCORN: Thank you, that's all I have.

26 Q THE CHAIR: And just to follow up,

1 Dr. Halowski. You said it started in August. This was
2 an exchange of consultation?

3 A Yeah, we continued consultation until December, when
4 Alberta Health said that they wouldn't provide any
5 guidance on the requirement for the eyewear, so we did
6 make the -- and that's why we only ever made the
7 recommendation; there was no indication it would be a
8 requirement for practitioners to wear eyewear.

9 And for context, other professions had at the
10 time, but we had not.

11 THE CHAIR: Thank you. Thanks,
12 Dr. Halowski.

13 I would ask counsel, are there any questions
14 arising from these most recent responses? None.

15 Okay, Dr. Halowski, thank you very much for your
16 testimony over the past two days. Your presence here
17 is no longer required, and we very much appreciate your
18 expertise, and you can leave at this time.

19 A Thank you very much, Mr. Chair. I do appreciate the
20 opportunity to have spoken, and for the care and
21 concern and attentiveness of the Hearing Tribunal, as
22 well as Mr. Maxston and Mr. Kitchen in their
23 questioning as well. So thank you for the opportunity
24 to be here as a witness for this Tribunal.

25 THE CHAIR: Okay.

26 (WITNESS STANDS DOWN)

1 Discussion

2 THE CHAIR: Mr. Kitchen, we were just
3 hearing from Mr. Maxston that Mr. Lawrence will require
4 5 minutes just to get himself set up computer-wise
5 prior to his starting his direct, so if we could just
6 ask people to hold. I think -- it's quarter to 11; is
7 5 minutes enough?

8 MR. MAXSTON: I think so, Mr. Chair, and, of
9 course, Mr. Lawrence will be on the screen when he's
10 ready to go, but I think that will be fine.

11 I'll just mention as well, I see that Dr. Halowski
12 is no longer with us, but, of course, since his
13 testimony is finished, he's free to listen in for the
14 remainder of the hearing if he wants to. I don't see
15 him here, but he may join us at some time.

16 THE CHAIR: Yes, I think, in fact, that
17 might happen, but in any event. Okay, well, we'll just
18 ask everybody to stay on mute and hold until David
19 Lawrence is ready, and then we will continue with his
20 direct examination.

21 MR. KITCHEN: Mr. Maxston, can I just ask
22 you about timelines?

23 MR. MAXSTON: Yeah, that's a good question.
24 I anticipate probably being about an hour-and-a-half
25 with Mr. Lawrence. So I would think I'd be going maybe
26 a little bit into the lunch hour, or we'd break at

1 noon, and then I resume after lunch and, of course,
2 won't be talking to Mr. Lawrence about his testimony.

3 I don't know how long you anticipate being. And I
4 should be candid, I may be longer with Mr. Lawrence,
5 just depending on how things go.

6 I don't know, Mr. Kitchen, what your thoughts are
7 about starting Dr. Wall's -- I believe that's your
8 witness, as my case will be closed. I don't know what
9 your thoughts are about starting with Dr. Wall today or
10 whether you'd prefer to start with him tomorrow.

11 MR. KITCHEN: I'd prefer to start with him
12 tomorrow just because I do think I'm going to be quite
13 a while, I imagine you're going to be quite a while.
14 And I know from experience the last couple days,
15 particularly with Dr. Halowski, you went quite long, I
16 have no issue with that, but you went on for a while,
17 and then -- because I fully expected to do the cross,
18 and then we just cut into the afternoon, and we ran out
19 of time.

20 So, you know, I thought a realistic goal today was
21 the direct of Mr. Lawrence, my cross, and then we'd
22 probably be done 3, 3:30, 4, 4:30, somewhere around
23 there. That was what I thought was realistic for
24 today, so -- and I'm flexible about lunch, because I
25 know if you don't want to break that up with him, and
26 we're -- and we don't lunch till 12:30, 12:45, that's

1 fine with me.

2 MR. MAXSTON: Maybe we can just see where we
3 get and invite comments from the Chair and the Tribunal
4 Members. Oh, and Mr. Lawrence is just going into
5 another room now.

6 I'm thinking as well, and I'm not going to, of
7 course, hold you to this, Mr. Kitchen, do you have any
8 sense about how long you'll be with Dr. Wall? Because
9 I'm going to be a while with him, and I don't know if I
10 want to start my cross-examination, let's say, at 2:00
11 tomorrow and leave it hanging. I want to use our time
12 as effectively as possible. Having said that, maybe
13 you can just give me a sense of what you think our day
14 might look like tomorrow while we're on a break here.

15 And maybe we can ask -- we can go off the record,
16 so Madam Court Reporter doesn't have to be --

17 MR. KITCHEN: I -- yes --

18 MR. MAXSTON: -- taking this down.

19 MR. KITCHEN: -- let's do that.

20 (DISCUSSION OFF THE RECORD)

21 THE CHAIR: Thank you very much.

22 Mr. Lawrence, we will turn you over to
23 Mr. Maxston, but, first, I would ask that you be sworn
24 in as a witness, and our court reporter will take you
25 through that process.

26 DAVID LAWRENCE, Affirmed, Examined by Mr. Maxston

1 MR. MAXSTON: Give me one minute, Mr. Chair,
2 I just have to locate a document. Thank you,
3 Mr. Chair.

4 Q MR. MAXSTON: Good morning, Mr. Lawrence. I
5 understand that you're the Complaints Director for the
6 College. Can you tell me since when you've occupied
7 that position?

8 A I am the Complaints Director since March of 2020.

9 Q And can you briefly describe your employment history or
10 professional background before coming to the College?

11 A So educationally, I hold a Masters in Business
12 Administration from Athabasca University, I have
13 certification in Business and Human Resources from the
14 University of Alberta, and I've spent 25 to 30 years in
15 the management field in both public and private
16 businesses.

17 Q Thank you, Mr. Lawrence.

18 MR. MAXSTON: Mr. Chair and Hearing Tribunal
19 Members, for your benefit, I'm going to be asking
20 Mr. Lawrence questions in three areas. The first area
21 will be general questions about the College and its
22 regulatory functions in the context of the Complaints
23 Director's duties. The second area will be to, very
24 briefly, review the two primary CMOH orders we've been
25 talking about and, very briefly, review the Pandemic
26 Directive. The third area I'll be asking questions on

1 is his involvement in terms of the Section 56 complaint
2 that he made, the investigation, and the referral to
3 hearing.

4 Q MR. MAXSTON: So I'll just go to the first
5 area of my questions then, Mr. Lawrence, can you
6 generally describe the College's regulatory function?

7 A Certainly. So under the Health Professions Act, the
8 College duties set out by council is to establish Codes
9 of Ethics, Standards of Practice, policies, directives
10 for members to follow. And as part of the Complaints
11 Director, my role is to hold members accountable when
12 there are breaches of compliance.

13 So when standards, Codes of Ethics, or the HPA is
14 not complied with, then my role is to, under Part 4 of
15 the HPA, is to take appropriate action and -- rather,
16 open, and if that is a complaint, an investigation,
17 referral to hearing, whatever action that's required
18 under the HPA.

19 Q Okay, thank you for that. I'll just get back and go
20 back to the College's regulatory function. Are you
21 familiar with Section 3 of the Health Professions Act?

22 A I am.

23 Q Can you tell me what that says, and I'll just ask you
24 to tell me what that says?

25 A So under Section 3, it talks about the regulation of
26 health professions; they're governed by legislation by

1 Codes of Ethics, by Standards of Practice, the
2 directives that are set by government or the governing
3 bodies; and in the ACAC's case, that's the ACAC
4 council.

5 Regulated health professionals are mandated to
6 comply with the section when delivering health services
7 to patients. And certainly for any medical
8 professional, it is about compliance and protecting the
9 public from harm. And, you know, the most important
10 thing is there is mandated compliance; it is not a
11 question for members whether they do comply or not.

12 Q You spoke a little bit before about your role as
13 Complaints Director and the handling of complaints.
14 Are you familiar with Section 55 of the Health
15 Professions Act?

16 A I am.

17 Q Can you tell me what that says in terms of your role as
18 Complaints Director?

19 A Under Section 55 of the HPA, it lays out the
20 responsibilities of what can and can't be acted on when
21 a complaint is opened. So it talks about, you know,
22 after you treat something as a complaint, there's a
23 30-day window in which to notify the members, notify
24 the member of the action being taken, and then lays out
25 the options available to the Complaints Director in
26 managing a complaint.

1 Q I'm going to turn now to the second area of my
2 questions for you, and I'm going to just very briefly
3 take you through the CMOH orders. Are you generally
4 familiar with Exhibits D-8 and D-9, which are CMOH
5 Orders 38-20 and 42-20?

6 A I am.

7 Q Can you tell me, generally, what your understanding is
8 of those CMOH orders?

9 A So in the -- the CMOH Order 38-2020 talked about the
10 private social gatherings, talked about the masking,
11 and talked about the areas of the province in Section
12 21, which was the Calgary metropolitan area, and the
13 requirements for masking. It went on to the Edmonton
14 area and talked about face masking.

15 Q And I'll talk with you about this in a little more
16 detail in a few minutes, but you're aware of an
17 exemption under paragraph 27(c)?

18 A I am.

19 Q When it comes to CMOH Order 42-20, can you tell me what
20 your understanding of that order is? And that's
21 Exhibit D-9.

22 A So under 42-20, Section 5 is appropriate to this, talks
23 about masking as well, and the requirement for masking,
24 as the previous order did.

25 Q So we talked about the exemption in CMOH Order 38-2020.
26 There's a similar exemption, it might be word for word,

1 in paragraph 24(c) of CMOH Order 42-20, and it speaks
2 of medical conditions.

3 When you were determining -- I'll get to this in
4 greater detail in a few minutes -- but when you were
5 determining what action to take concerning this
6 complaint, did that exemption apply to Dr. Wall?

7 A I didn't feel so at the time. The -- I didn't -- I
8 didn't believe Dr. Wall had an exemption, at least none
9 was provided to the College. And also I do think that
10 there was never an expectation for exemptions for
11 medical health professionals, especially in close
12 contact with patients. And the chiropractors are in
13 very close contact with them during treatment, and so I
14 don't think this exemption would apply in this case.

15 Q Mr. Lawrence, I'm going to take you, again very
16 briefly, to the College's Pandemic Directive, and,
17 again, I'm going to use the January 6, 2021 one as the
18 reference document.

19 Can you tell me what your understanding was of the
20 Pandemic Directive in terms of requirements on relating
21 to chiropractors and how they would practice?

22 A So when the Pandemic Directive was initiated, the
23 profession was closed -- or, sorry, shut down for
24 practice except for emergency situations only. And
25 when Public Health enabled chiropractors to return to
26 practice, part of the expectation was that there would

1 a Pandemic Directive in place approved by Public
2 Health, and so the Pandemic Directive was established
3 so that chiropractors could return to practice in a
4 safe manner to protect the public.

5 In regards to the masking, the PPE requirements
6 were clear that chiropractors and clinic staff must be
7 masked at all times while providing patient care, and
8 so the masking requirement was very clear as part of
9 the re-opening strategy to allow chiropractors to
10 return to practice.

11 Q Dr. Halowski commented on the Pandemic Directive
12 extensively, so I'm not going to take you through this
13 in any great detail, but were there requirements for
14 social distancing and plexiglass barriers?

15 A There were. And I should say for plexiglass barriers
16 that was for, you know, clinic staff if they weren't
17 masking.

18 Q Did the Pandemic Directive contain an exemption for
19 masking when a chiropractor was providing patient care
20 and was within 2 metres?

21 A It didn't provide any exemption for there. It gave
22 some options for other modalities of care but not a
23 direct exemption when you're within the 2 metres, no.

24 Q And to your understanding, why was there no exemption?

25 A The close proximity that chiropractors have with their
26 patients at times is -- puts them in close contact and

1 can be a -- can cause transmission of the COVID-19
2 pandemic.

3 So similar to, you know, your dentist working
4 around your mouth, chiropractors are very close, face
5 to face. They can be very close to their patients, and
6 so for patient safety, the masking was required.

7 Q So I'll go to the third area now that I want to ask you
8 questions about, and that is your involvement in terms
9 of the complaint relating to Dr. Wall, and I'll ask you
10 to go to Exhibit A-3, which is a December 2, 2020
11 letter to you from Dr. Halowski.

12 A Okay.

13 Q I'll just wait a minute to make sure all the Tribunal
14 Members have located that, and it's Exhibit A-3.

15 MR. MAXSTON: So, Mr. Chair, I'll just
16 continue then.

17 Q MR. MAXSTON: Mr. Lawrence, can you tell me
18 when you received this letter?

19 A So this was referred to me from the Registrar, dated
20 December 2nd, and the Registrar said sent this to me as
21 the Complaints Director.

22 Q And I'd like to ask you to go to Exhibit A-5, which is
23 your December 21, 2020 letter to Dr. Wall.

24 A Okay.

25 MR. MAXSTON: Let everyone catch up and make
26 sure we're there, that we're all on that same document.

1 Q MR. MAXSTON: So, Mr. Lawrence, the opening
2 paragraph refers to Section 56 of the HPA. Can you
3 tell me what that paragraph means?

4 A So under Section 56 of the HPA, if information is
5 received by the Complaints Director that is deemed to
6 be a complaint when there is no -- if there is no
7 complainant, the Complaints Director can open a
8 complaint and become the de facto complainant under
9 this section.

10 Q And is that what happened here?

11 A It is.

12 Q If you look at paragraph 2, can you just explain the
13 first sentence?

14 A So on the referral from the ACAC Registrar, so the
15 Registrar sent me the December the 2nd letter. We
16 received information that Dr. Wall was in breach of
17 CMOH orders and the Standards of Practice, as well as
18 the COVID-19 Pandemic Practice Directive, and that
19 Dr. Wall would not be taking steps to come into
20 compliance, so I had treated that as a complaint and
21 opened the Complaint Number 20-20 under Section 56 of
22 the HPA.

23 Q The second sentence in that paragraph says, and there's
24 a question coming: (as read)

25 On December 2, 2020, you advised the
26 Registrar, and on December 3, 2020, advised

1 the Complaints Director that you would not be
2 taking steps to become compliant with these
3 requirements.

4 And those requirements are the COMH orders and
5 Standards of Practice as mentioned above.

6 There's a reference to a December 3, 2020
7 communication or interaction between you and Dr. Wall;
8 can you tell me what happened there?

9 A So after I received a referral from the Registrar, I
10 called Dr. Wall to discuss the issue with him, and I
11 let him know that this would be proceeding to a
12 complaint and certainly, I'm sure we'll get to it, a
13 request under Section 65.

14 And Dr. Wall had asked me if there was sort of any
15 alternatives to that, which I let him know that he
16 certainly, you know, could start complying and begin
17 masking. And we had discussed the information that was
18 received from Alberta Health about the discussion he
19 had had with Heidi Ho.

20 Q What did he say about any steps he was taking to comply
21 with the CMOH orders?

22 A He said, at that time, that he had an exemption, and he
23 also said that, you know, the -- it's just -- it's like
24 the flu or words to that effect, and either the
25 recovery rate or the survival rate was I think he said
26 99 percent, but I'm not quoting directly.

1 Q Did he indicate whether he was masking?

2 A He said he was not.

3 Q Did he --

4 A And --

5 Q -- indicate whether -- oh, I'm sorry, go ahead.

6 A Yeah, he said he had tried originally and had feelings
7 of anxiety and claustrophobia, and that he felt he was
8 exempt from it.

9 Q Did he mention any other reasons for not masking at
10 that time?

11 A I don't believe he did. I think he might have
12 mentioned about human rights in that call, but like it
13 was more about the low risk of COVID and that he was
14 exempt.

15 Q Did he say anything about his staff masking?

16 A I think he had said -- no, I don't have a recollection
17 of that, sorry, no.

18 Q Did he say anything about observing social distancing,
19 the 2 metre requirement?

20 A He did not.

21 Q Did he say anything about his use of plexiglass
22 barriers?

23 A Not that I recall, no.

24 Q I'm going to stop here, because you are -- pause for a
25 second, because, as you alluded to, there's a bunch of
26 things that are happening now in conjunction with the

1 complaint itself. We've talked about your choice to
2 rely on Section 56 to initiate a complaint.

3 The second thing that was happening was also the
4 Section 65 interim suspension request. Can you explain
5 what Section 65 is, what it's designed for?

6 A So under Section 65 of the HPA, if there is a -- if the
7 Complaints Director believes that there is a risk to
8 the public, they can make application for a suspension
9 of practice permit or restrictions placed on the
10 practice of the member.

11 Q Sorry, Mr. Lawrence, I was just reaching for a document
12 there.

13 I'll ask you to go to Exhibit B-1, as in Bob dash
14 one, and that is a December 3, 2020 letter to a
15 Dr. Linford.

16 A Yes.

17 Q And I'll just make sure everybody on the Tribunal has
18 skipped ahead to B-1.

19 So can you explain to me who Dr. Linford is?

20 A So part of council's role is to identify and nominate
21 people who can hear -- or members of the profession who
22 can hear these types of requests and make decisions
23 with legal counsel when these are provided, so
24 Dr. Linford was one of the members that had been
25 appointed by council to hear these requests.

26 Q Okay, and what are you asking for from Dr. Linford?

1 A So in the Section 65 request, I asked for an interim
2 suspension of the practice permit until the completion
3 of the complaint process.

4 Q And why were you asking for an interim suspension?

5 A Because I believed that there was a danger to the
6 public for members to practice in close proximity
7 without a mask as outlined by Public Health at that
8 time.

9 Q I'll take you to the second page of the letter, and
10 there's a Section entitled "Background".

11 A Yes.

12 Q And there's a couple of arrows that are indented. Can
13 you explain what the background information is in those
14 arrows?

15 A So at the time, there was no plexiglass barrier at the
16 reception area, and the staff were not masking. And so
17 in the Pandemic Directive, if people come in that if
18 they breach the 2 metre distance, other clinical staff,
19 they are to be masked or have a barrier protecting or
20 separating them from the patients.

21 And the other point is that Dr. Wall was not
22 masking during patient treatment even though he's in
23 close proximity to his patients.

24 Q There's a paragraph a couple of -- well, I'll skip a
25 paragraph and go to the next one, it says: (as read)

26 In my view, Dr. Wall was in violation.

1 Can you tell me what violation you were concerned about
2 there?

3 A So in regards to the Pandemic Directive, when --
4 without masking, there were I believe Standards of
5 Practice and Codes of Ethics that were being breached,
6 as along with the Pandemic Directive, and so that's
7 what that refers to.

8 Q There's a second sentence in that paragraph that
9 begins: (as read)

10 If there is a medical exemption applicable to
11 Dr. Wall.

12 Can you tell me what you're saying there?

13 A It says: (as read)

14 If there is a medical exemption applicable to
15 Dr. Wall, there is no requirement for him to
16 mask in his personal activities. However, to
17 continue in his chiropractic treatment, the
18 pandemic protocols of the ACAC and AHS must
19 be followed.

20 And what I meant there was, you know, in a regulated
21 member's personal life, that's their own business and
22 their own decisions. The compliance in my role has
23 just to do with practice and interaction with patients.
24 So where I don't regulate, nor where the College
25 doesn't regulate anything outside of practice while
26 you're practicing chiropractic, you are responsible for

1 the mandates.

2 Q There are a couple of other exhibits after that, B-3
3 and B-4; I'll just ask you to identify those. Those
4 are Mr. Kitchen's letters in relation to the Section 65
5 request you made?

6 A Correct.

7 Q If we go to Exhibit B-5, there's a December 18, 2020
8 letter to Dr. Wall from Dr. Linford. I'll just let
9 everybody get caught up and be at B-5, and then I've
10 got a couple of questions for you about that document.

11 So is this Dr. Linford's decision letter
12 concerning your Section 65 request?

13 A It is.

14 Q On page 2, it's the third complete paragraph, it begins
15 with "I have decided"; can you tell me what
16 Dr. Linford's decision was ultimately?

17 A So Dr. Linford decided that, at that time, the
18 suspension wasn't justified, and he instead decided to
19 put conditions on Dr. Wall's practice permit to try to
20 address the risk to the public.

21 Q Can you tell me what the -- I think there are four
22 numbered orders, can you tell me what those orders were
23 that Dr. Linford made?

24 A So number 1 was that Dr. Wall was to inform each client
25 or patient that he sees that Dr. Wall has a medical
26 exemption from the Public Health order that all persons

1 in a public place must wear a face mask.

2 He also ordered that Dr. Wall should obtain
3 written confirmation that each patient would sign and
4 the patient agrees to be seen and treated by Dr. Wall
5 without wearing a face mask or a face shield, and that
6 copies of those would be sent to the Complaints
7 Director, to me, by 5 PM on Friday of each week, and
8 that this stays in effect until the public order and
9 face masks are in effect.

10 Number 2 talked about Dr. Wall directing any staff
11 person assisting in his office, whether that's a
12 volunteer, paid or unpaid, that they also comply with
13 the current orders and that physical barriers must be
14 up, social distancing must be adhered to, or they wear
15 a face mask. The -- and then if anybody brings in an
16 exemption for that, Dr. Wall was to consult with
17 Alberta Health.

18 Dr. Wall was to maintain a log of screening
19 questions asked and answered by all patients and daily
20 screening of his staff and himself. And in the event
21 that Dr. Wall has any symptoms or answers positively to
22 screening questions, he would not see patients.

23 Q To your knowledge, did Dr. Wall comply with those
24 orders?

25 A To my knowledge, he did.

26 Q So I'm going to ask you specifically, he was to send

1 you written confirmation by 5 PM on Friday of each week
2 about certain matters. Did you receive written
3 confirmations weekly?

4 A I did by email.

5 Q In terms of your statement, that you believe he
6 complied with the other aspects of the order, on what
7 information are you basing that?

8 A So the -- Dr. Wall had provided pictures that,
9 following the request from Alberta Health, the barriers
10 were put in place in the clinic, the protective
11 barriers. And based on the screening questions that
12 they were -- that was also part of the information he
13 sent to me. And as I don't have any evidence that
14 Dr. Wall had any symptoms or was answering positively
15 on the screening questions, then I believe he was
16 compliant with that one as well.

17 Q So the -- I talked with you about the fact that you
18 initiated this Section 65 complaint. We talked about
19 the Section 65 interim suspension request. As for the
20 same time, there was a third thing going on, and
21 Alberta Health Services became involved in terms of the
22 operation of Dr. Wall's clinic; is that correct?

23 A It is.

24 MR. MAXSTON: Bear with me, Mr. Chair. I'm
25 going to ask everyone to go to Exhibit D-1, which is an
26 AHS Order of an Executive Officer Notice of Public

1 Access Closure.

2 Q MR. MAXSTON: So, Mr. Lawrence, are you able
3 to tell me how this came into the possession of the
4 College?

5 A So following the information provided to Alberta
6 Health, they also do site visits and also the Alberta
7 Health had discussion with Dr. Wall as well and had
8 decided that, as the practitioner at that time was not
9 wearing a face mask and was well within 2 metre
10 distance from the patient and that could contribute to
11 the spread of COVID-19, they also found that staff
12 worked at the clinic were not continuous masking, and
13 no barriers were up, they initiated a closure order
14 against the clinic, and shut the clinic down under
15 the -- from the Executive Officer of Public Health.

16 Q And if we go to page 2 of that document, paragraph 2
17 talks about: (as read)

18 The owner [meaning Dr. Wall] immediately
19 undertake to diligently pursue completion of
20 the following work.

21 Can you describe what Dr. Wall was supposed to do?

22 A So Dr. Wall was the practitioner, which is Dr. Wall:
23 (as read)

24 ... must be masked when treating patients
25 within 2 metre proximity to help prevent the
26 spread of COVID-19; patients must be masked

1 when receiving a treatment from the
2 practitioner; staff not working alone at the
3 station must be masked at all times while
4 working an indoor public space; staff working
5 alone at a work station must also be
6 observing physical distance, the 2 metre
7 distance, from all other persons, otherwise,
8 they must mask or a barrier must be up; and
9 the complete the relaunch plan template
10 [which is an Alberta Health document].

11 Q And I'm just going to digress for a moment.
12 Exhibit A-4, I don't need you to go to this, is an ACAC
13 Notice of Closure of Clinic. Can you tell me what that
14 document is just very briefly?

15 A So once we received the closure order from Alberta
16 Health, there was a statement put out to the rest of
17 the membership about the closure of the clinic.

18 Q So I said before, a few minutes, ago I was going to
19 pause because there was a lot happening, and I went
20 through three areas with you, the complaint, the
21 Section 65 request, and AHS's involvement.

22 I'm now going to take you back to your direct
23 involvement and specifically the investigation that was
24 conducted under Part 4 of the HPA. Did you act as the
25 investigator?

26 A I did.

1 Q I'd ask you to go to and the Tribunal Members to go to
2 Exhibit A-7, which is your investigation report.

3 MR. MAXSTON: Mr. Chair, I'll just assume
4 that everybody is at document A-7 or is getting there
5 very, very quickly.

6 Q MR. MAXSTON: Mr. Lawrence, did you write
7 this report?

8 A I did.

9 Q Can you tell me when you wrote it?

10 A I'm going to say late January. I don't know the exact
11 date, I'm sorry.

12 Q And is it your belief that it's an accurate reflection
13 of your investigation?

14 A It is.

15 Q Okay, I'm going to ask you some questions about it. In
16 the second paragraph of your investigation report,
17 beginning with the phrase "On December 2, 2020",
18 there's a reference to the discussions between the
19 Registrar and you with Dr. Wall on December 2 and
20 December 3, 2020. I'm not going to go through that in
21 any greater detail, except the tail end of the
22 paragraph. There's, about the fifth line down, there's
23 a sentence beginning with: (as read)

24 He indicated that he thought this was a human
25 rights violation and that he was exempt from
26 wearing a mask.

1 Does that refresh your memory in terms of your
2 conversation with him?

3 A Yes.

4 Q And can you tell me what he might have told you then
5 about a human rights violation?

6 A So when he had an exemption, the -- and I had talked
7 about initiating the Section 65 and the following
8 complaint, he thought his -- it was his -- under the
9 human rights that he would be allowed to continue to
10 practice and that the College was violating this right
11 by taking these actions.

12 Q The next sentence says: (as read)

13 He was informed that, as this was unsafe
14 practice, it was the responsibility of the
15 College to take action to protect the public.

16 Was it you who informed him?

17 A Yes.

18 Q The next --

19 A Oh, sorry.

20 Q I'm sorry.

21 A I think the Registrar had that discussion as well, but
22 certainly I did, yes.

23 Q The next sentence begins: (as read)

24 He indicated that he did not believe ...

25 Can you just read that sentence, read to the end of the
26 paragraph and then tell me what you're conveying here?

1 A (as read)

2 He indicated that he did not believe he was
3 endangering the public as the recovery rate
4 from COVID is so high and asked if there
5 could be any discussion on alternatives. He
6 was informed that public safety is not for
7 debate and that if he would not mask, we
8 would proceed with a Section 65 request.

9 So as I said before, during the discussion, Dr. Wall
10 had talked about the recovery rate from COVID, and I
11 seem to remember it was 90, he might have even said 99
12 percent, I can't remember exactly, but very high, and
13 that, you know, because the recovery rate was so high,
14 he didn't think he was endangering people.

15 And the -- in my comment was that, you know,
16 public safety is a requirement of the College, we're
17 mandated to follow the legislation, and that we would
18 need to proceed to a Section 65, which is the
19 suspension request if he didn't mask.

20 Q The next couple of paragraphs talk about the --
21 Dr. Salem's letter and those types of things, and I'll
22 get to those in a few minutes, but there's a paragraph
23 that begins: (as read)

24 On December 16th, 2020, Dr. Wall provided a
25 follow-up letter to David Linford indicating
26 plexiglass barriers had been installed at the

1 front counter of the clinic.

2 How did you get that information?

3 A That was sent over by Mr. Kitchen, and Dr. Wall had
4 provided pictures of the installed plexiglass barriers.

5 Q After you had initiated the complaint, I believe you
6 received an undated response letter from Dr. Wall, and
7 I'm going to ask you to go to Exhibit A-6.

8 A Okay.

9 Q And I'll ask the Tribunal Members to go to A-6 as well.
10 This is a four-page letter, so I'm not going to ask you
11 to go through it line by line, but could you summarize,
12 to the best of your ability, what Dr. Wall was saying
13 to you in this letter?

14 A So it starts out where that Dr. Wall had originally put
15 on a face mask, and he believed that it was causing him
16 anxiety and symptoms of claustrophobia, he said he
17 decided to wear -- or to try a face shield, and he
18 found that the same symptoms persisted and thought that
19 this negatively impacted his dialogue with patients,
20 and that he had decreased concentration levels.

21 So he said: (as read)

22 After enduring this for several weeks, I
23 decided in late June of 2020 to not wear a
24 mask or a face shield.

25 He went on to say that in his conclusion, the Pandemic
26 Directive could not reasonably be interpreted to demand

1 the wearing of a face mask if doing so was harmful to a
2 member, and it negatively impacted the member's ability
3 to provide the best patient care.

4 So he said that patients had asked him about, you
5 know, why he wasn't masking, and he said because he had
6 mental concerns and limitations and said that the
7 patients were understanding.

8 He said: (as read)

9 At the time I did not think that I should or
10 needed to obtain any sort of exemption to
11 wearing a mask or shield such as -- from
12 another health care practitioner such as a
13 medical doctor.

14 He said: (as read)

15 As time progressed, it seemed to me that my
16 decision was reasonable in the circumstance.
17 So I think as we go through, what he's saying is that
18 he has concerns of concentration levels, he has
19 concerns of anxiety and feelings of claustrophobia, and
20 thought that the Pandemic Directive wasn't accurate in
21 mandating face masks, so he made the decision to
22 discontinue wearing one.

23 Q When you received this letter from Dr. Wall, did it
24 cause you to change your decision about referring the
25 matter to investigation?

26 A It did not.

1 Q Can you tell me why?

2 A I think that when I look at the requirements of the
3 legislation, the mandates or the compliance is not a --
4 it's not really an optional what you choose to comply
5 with and what you choose not to comply with.

6 The legislation, the Standards of Practice, Codes
7 of Ethics, whatever mandates under that, the
8 chiropractors that are members of the profession are
9 mandated to comply with them. And so what I saw here
10 was the member deciding that he wouldn't comply, and so
11 I didn't see anything that would prevent -- would
12 change my mind on proceeding with the investigation.

13 Q On page 2 of your investigation report, there is a
14 statement, it's the third complete paragraph: (as
15 read)

16 On January 25, 2021, Dr. Wall was interviewed
17 by David Lawrence. ACAC Complaints Director,
18 Dr. Todd Halowski, ACAC Registrar, Dr. Wall
19 and his legal counsel were present for this
20 interview.

21 I'm going ask you to skip a couple pages ahead here to
22 page 4 of your investigation report, there's a
23 statement at the top of that page that says: (as read)

24 The key points of the interview.

25 And I'll just let everyone get to that page, again page
26 4 of the investigation report. So when you say "The

1 key points of the interview", was that your interview
2 of Dr. Wall that occurred on January 25?

3 A It is.

4 Q And again, during that interview, Dr. Wall had legal
5 counsel present?

6 A He did.

7 Q Okay, I'm going to ask you to go through each of these
8 arrows or bullets and just tell me what occurred during
9 the interview. And I know this may be a little bit
10 lengthy but I think it's important to get a flavour for
11 what was going on during the interview.

12 A Certainly. So as it indicates, the interview was done
13 on January 25th, 2021. It was myself, Dr. Halowski,
14 Mr. Kitchen, and Dr. Wall.

15 So we talked about that Dr. Wall said he had
16 originally tried masking and that he had feelings of
17 anxiety or claustrophobia and that he had also tried
18 using a face shield but had the same feelings, and so
19 at the end of June, he made the decision to stop
20 masking. He said he felt the mask interfered with his
21 concentration and his ability to interact with
22 patients.

23 He's indicated that he felt the risk to him in
24 wearing a mask was greater than not wearing one, as his
25 feelings of claustrophobia and anxiety were something
26 that he didn't want to deal with.

1 We asked him about if he had had these feelings
2 previously, and he said he had not experienced these
3 feelings prior to masking, he had no diagnosis of any
4 condition, and the decision to not mask was made by
5 Dr. Wall on how he felt and his comfort.

6 He indicated the ACAC Pandemic Directive does not
7 give any room for exceptions, and so he made the
8 decision to stop masking based on the feelings he was
9 having. As he was -- as there was no exemptions in the
10 Pandemic Directive, he talked about the CMOH orders
11 that he was using for exemption.

12 His -- he indicated that his son was the only
13 other person that was working at the clinic at the
14 time, he had no other employees, and that -- yeah,
15 since March of 2020, so during the COVID pandemic. He
16 also indicated that he did not require his son to be
17 masked and did not think it necessary to install any
18 barriers. He said his son was -- completed
19 transactions, he did not mingle with anyone and so did
20 not think it necessary, and that his son was 17, he's
21 young, healthy, and so he didn't think his son was at
22 risk from COVID. He also responded that his son was
23 not able to maintain physical distance at all times.

24 Dr. Halowski asked Dr. Wall if his son was
25 provided the opportunity to mask, and Dr. Wall
26 reiterated that he was a healthy individual and that he

1 did not want to wear one. When asked if he was
2 presented with the facts and varying points about
3 COVID, Dr. Wall indicated he was aware that he told his
4 son about the Pandemic Directive.

5 When talking about compliance with the Standards
6 of Practice or the Codes of Ethics, Dr. Wall indicated
7 that the only area he believes he did not comply with
8 was the ACAC Pandemic Directive. He believes it is
9 unreasonable not to provide exceptions to allow him not
10 to mask with his patients, and he indicated that he had
11 a medical note regarding his mental limitation and
12 concern.

13 Dr. Wall further indicated that under CMOH Order
14 38-2020, there is an exemption to mask wearing that he
15 used to discontinue wearing a mask. Dr. Wall had
16 indicated he stopped masking in June, and his medical
17 exemption he did not get till December of 2020 from
18 Dr. Salem.

19 The same order also indicates that physical
20 distance must be maintained, so further down in the
21 "Exceptions to masking", it does indicate that the 2
22 metre barrier must be maintained.

23 When we talked if Dr. Wall had talked to his
24 patients about the dangers of him not being masked, he
25 replied that people are aware of the dangers, and he
26 did not need to explain any of the dangers to the

1 patients from him not masking. And Dr. Wall said that
2 the people he sees, they either understand they are at
3 high risk of getting COVID or they are not at risk. He
4 said people fill out the screening questions, and if
5 they answered "no" were considered low risk.

6 Dr. Wall stated that the feelings of anxiety he
7 experienced were the only reasons that he chose not to
8 mask, and there are no other reasons that he does not
9 mask.

10 Dr. Wall discontinued masking in June, however,
11 did not get a medical exemption until December 2020
12 when the public closure order was given. During that
13 time, he sought no treatment for his condition,
14 provided no communication to the ACAC and has no
15 charting to show that he was advising patients of the
16 risk they were facing by seeing an unmasked doctor.
17 Dr. Wall indicated that he made the decision to stop
18 masking due to the feelings of anxiety he was having.

19 Q I'll just ask you a couple of questions. During this
20 interview with Dr. Wall, did he mention any objections
21 to masking about his religious beliefs?

22 A He did not.

23 Q Did he mention anything, and we may have covered this,
24 did he mention any about whether he thought masks
25 weren't medically effective against spreading COVID?

26 A No.

1 Q Did he discuss whether he thought masks were or weren't
2 necessary?

3 A He said that -- he said that he thought that they
4 interfered with his ability to concentrate, and that he
5 felt that it was giving him anxiety and claustrophobia
6 but not unnecessary, no.

7 Q Okay, I'm going to switch gears a little bit here, and
8 ask you about the letters from Dr. Wesam Salem. They
9 are referenced -- this is referenced in your
10 investigation report on page 3. So again the
11 investigation report is Exhibit A-7, and page 3 has a
12 heading "Dr. Wesam Salem".

13 MR. MAXSTON: And I'll just get everybody to
14 turn to that.

15 Q MR. MAXSTON: At the same time, I'm going to
16 ask you a question about Exhibit A-8, which is
17 Dr. Salem's December 12, 2020 letter to Dr. Wall. So
18 I'll just ask you, how did you get Exhibit A-8, the
19 letter from Dr. Salem?

20 A So this was provided by Dr. Wall.

21 Q And do you remember roughly when it was provided to
22 you?

23 A I think it was shortly after the date that it was dated
24 on the letter.

25 Q And it's quite brief, so I'll ask you what does the
26 letter say?

1 A The letter is dated December 12, 2020, and it says:
2 (as read)

3 To whom it may concern, this letter serves to
4 confirm that I have assessed Mr. Curtis Wall
5 in my office today. Please be advised that
6 due to medical reasons, he has been deemed to
7 be exempt from mask wear and the use of a
8 face shield.

9 Q When you saw that letter, how did you respond to it?

10 A I sent a follow-up request to Dr. Salem's office for
11 more information.

12 Q And why did you do that?

13 A I found that it was a very just a general note that
14 didn't really have a lot of detail to it, and I was
15 looking for more information.

16 Q And if we go to Exhibit A-9, there's a January 8, 2021
17 letter on Dr. Salem's letterhead. Just let everybody
18 get to document A-8.

19 THE CHAIR: A-8 or A-9, Mr. Maxston?

20 MR. MAXSTON: Oh, I'm sorry, A-9. Thank
21 you, Mr. Chair.

22 Q MR. MAXSTON: So, Mr. Lawrence, was this the
23 response you got from Dr. Salem?

24 A It is.

25 Q And if we look -- I'm sorry, I'm skipping around a
26 little bit here, if we go back to page 3 of your

1 investigation report, it says: (as read)

2 Dr. Salem provided a written response related
3 to the medical exemption. The following
4 outlined the key points in the information
5 from Dr. Salem.

6 MR. MAXSTON: And forgive me, Mr. Kitchen,
7 here, I'm going to ask a bit of a leading question.

8 Q MR. MAXSTON: I'm assuming the outline of
9 the key points you referred to are the key points from
10 this January 8, 2021 letter?

11 A That's right.

12 Q Okay, I'll just ask you then to go through your
13 investigation report on page 3, and those four stars,
14 and there's a little bullet point at the bottom that
15 says "Note", and if you can tell me what the key points
16 were.

17 A So the -- Dr. Salem had provided the written responses
18 we went through, so he indicated that, at his
19 appointment on December 29th, that Dr. Wall harboured
20 significant anxiety about masking and his inability to
21 breathe. Then in his letter, he indicates that there
22 were no other documents or tests conducted or any
23 diagnostic information.

24 In my letter to him, I had asked for, you know,
25 how did he confirm the diagnosis? Was there tests or
26 any diagnostic information, of which he said there's

1 not.

2 Dr. Salem provided some medical history regarding
3 Dr. Wall, which included that Dr. Wall takes no
4 medication and is in good health. He indicated
5 Dr. Wall tried to wear a mask and developed a tickle in
6 his throat and felt anxiety and claustrophobia after
7 wearing a mask. Dr. Salem further cites that Dr. Wall
8 is pushing for exemption given his mental health
9 impact.

10 Q You also have a note at the bottom, can you tell me
11 what you're saying there?

12 A I'm sorry, where are you looking?

13 Q Just on your investigation report after those four
14 bullets, there's an indented note, literally N-O-T-E:
15 (as read)

16 It should be noted that.

17 I'm just wondering what you're saying there.

18 THE CHAIR: I'm not following. This is
19 after the four bullet points regarding Dr. Salem?

20 MR. MAXSTON: Yes, that's -- oh, I'm sorry,
21 that's my mistake, Mr. Chair. Yes, I'm sorry, that's
22 my mistake.

23 Q MR. MAXSTON: After your investigation was
24 completed, did you decide to refer this to a hearing?

25 A I did.

26 Q And can you tell me why?

1 A I do think there was significant breach of both the
2 Standards of Practice and the Codes of Ethics, and
3 these were I think most appropriate to be presented to
4 a Hearing Tribunal for a decision on the disposition of
5 the complaint, and so for that reason, I referred it to
6 the hearing on the 4th of February.

7 Q We talked a little bit about this before at the
8 beginning of your testimony, and I believe you
9 indicated that when you talked with Dr. Wall on I think
10 it was December 3, you said that compliance wasn't
11 optional. What was your expectation if a member
12 couldn't comply or was thinking of not complying with
13 the Pandemic Directive?

14 A So if there's questions about compliance, I would
15 expect that they would -- usually what members do is
16 they reach out to the Registrar, and they talk about,
17 you know, what the -- what options may be available or,
18 you know, a question about, you know, if they're not
19 sure about something, usually the Registrar fields
20 those types of questions, and they reach out about
21 that.

22 In my role, it's -- you know, compliance is
23 mandatory, and so that -- usually the -- when there is
24 questions about that, whether it's, you know, sometimes
25 they'll reach out about is this advertising compliant,
26 is this compliant, can I do this or can I do that, so

1 we get those questions quite frequently. And so my
2 expectation would be that you usually contact the
3 Registrar or that you comply until you question, or you
4 step back from practice until you resolve the issue
5 Q So I'm just about finished with my questions for you,
6 Mr. Lawrence. I just want to ask you about some other
7 obligations at the College.

8 If there is a complaint sent to you, and you
9 choose to investigate it, is a member required to
10 cooperate with your investigation?

11 A They are.

12 Q And can a chiropractor choose to not cooperate?

13 A Well, they could choose to, but that is actually --
14 that would be an example of unprofessional conduct
15 defined in the Health Professions Act.

16 Q Dr. Wall's conduct doesn't involve any sexual
17 misconduct. This is a theoretical question I'm going
18 to pose to you. Are you aware of Bill 21 Standards of
19 Practice that the College has about prohibiting sexual
20 relationships with patients?

21 A I am.

22 Q Is that part of your role, or enforcing that part of
23 your role as Complaints Director?

24 A It is.

25 Q Are those standards mandatory?

26 A They are.

1 Q Are there any exemptions to them?

2 A No. There are -- there are guidelines provided about
3 how to discharge from a patient care to enable a
4 relationship to begin, but they are not -- they're not
5 optional while a patient is under doctor care.

6 Q Are you familiar with the phrase "ungovernability" or
7 "ungovernable professional"?

8 A I am.

9 Q Can you tell me what that means to you?

10 A So the mandate of the College is to hold regulated
11 members in compliance with the mandates of practice and
12 the self-regulation. Council is the deciding body on
13 the conduct that members must adhere to in practice.

14 And so the role of the College or my role is to
15 hold members accountable when they're not compliant,
16 and when they are what's termed "ungovernable", it is
17 when they are purposefully or deciding not to comply
18 with the requirements of their practice.

19 Q How would ungovernability affect the profession?

20 A Well, I think if members are picking and choosing about
21 what they comply with and what they won't, it doesn't
22 really become compliance then; it's -- everything's
23 just becoming a recommendation or a suggestion, so the
24 profession basically isn't self-regulating at that
25 point.

26 Discussion

1 MR. MAXSTON: Mr. Chair, those are all my
2 questions for Mr. Lawrence.

3 I welcome Mr. Kitchen's comments, but I doubt he
4 wants to start his cross-examination at 10 to 12. I
5 wonder if this might be a good time to take a break for
6 lunch, and come back perhaps at 10 to 1 or 1:00, and
7 then Mr. Kitchen could conduct his cross-examination, I
8 can do my redirect, and you can ask any questions that
9 you have.

10 MR. KITCHEN: I prefer a slightly longer
11 break for lunch. I'd like to come back at 1:15, one of
12 the reasons being I don't think we are in jeopardy of
13 not finishing today at a very reasonable hour. If we
14 come back at 1:15, I suspect we'll still be out of here
15 at 3:30 at the latest. So if that's acceptable to the
16 Chair, that's what I would propose.

17 THE CHAIR: Mr. Maxston, any ...

18 MR. MAXSTON: Sorry, that's fine, and I
19 think, Mr. Kitchen, we'd be moving ahead on the
20 understanding we wouldn't start with your evidence then
21 until tomorrow morning?

22 MR. KITCHEN: That's right.

23 MR. MAXSTON: Yeah, I'm fine with that
24 approach.

25 THE CHAIR: Okay, if both parties are okay
26 with that plan, we will now break until 1:15, so see

1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 September 7, 2021 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 D. Lawrence ACAC Complaints Director

17 B.E. Maxston, QC ACAC Legal Counsel

18

19 FOR DR. CURTIS WALL

20 J.S.M Kitchen Legal Counsel

21

22 K. Schumann, CSR(A) Official Court Reporter

23

24 (PROCEEDINGS RECOMMENCED AT 1:21 PM)

25 THE CHAIR: We are now back in session,

26 and we will ask Mr. Kitchen to start with his

1 cross-examination of Mr. Lawrence.

2 MR. KITCHEN: Thank you, Chair.

3 DAVID LAWRENCE, Previously affirmed, Cross-examined by
4 Mr. Kitchen

5 Q MR. KITCHEN: Good afternoon, Mr. Lawrence.

6 A Hello.

7 Q You are not a chiropractor, correct?

8 A I am not.

9 Q And I have it right that you started in this position
10 as Complaints Director in March of 2020, correct?

11 A That's correct.

12 Q So you did not do this job prior to the onset of COVID?
13 Is that --

14 A I did not.

15 Q -- (INDISCERNIBLE)? You agree that the most important
16 principle for chiropractors to adhere to is the
17 principle of protecting the public from harm, do you
18 not?

19 A I do.

20 Q You agree that each patient of a chiropractor is a
21 member of the public, do you not?

22 A I do.

23 Q You agree that each patient of every chiropractor is --
24 sorry, let me start again. You agree that the
25 interests of each patient, each forms a part of the
26 broader public interest, do you not?

1 A I'm not sure about public interest, but public safety,
2 yes.

3 Q So you agree that the safety interests of each patient
4 forms a part of the broader public safety interest,
5 correct?

6 A That would follow, yes.

7 Q So then would you agree that the interests of each
8 individual patient make up together the broader public
9 interest?

10 A As it applies to the practice of chiropractic, each
11 patient is part of the public.

12 Q You agree that chiropractors should protect members of
13 the public from harm no matter what, do you not?

14 A Yes.

15 Q You agree, do you not, that the principle of
16 chiropractors protecting the public from harm is more
17 important than the principle of protecting the
18 reputation of the chiropractic profession, do you not?

19 A More important. It's difficult I think from a
20 compliance perspective. I think the priority of the
21 College is the protection of the public, and so in that
22 regard, yes.

23 Q You agree that there are other threats to the overall
24 health and well being of chiropractic patients besides
25 COVID-19, do you not?

26 A Yes.

1 Q You agree that there are other threats to the overall
2 health and well being besides COVID-19 that are more
3 severe than COVID-19, that are a greater threat, do you
4 not?

5 A I'm not sure. It probably would be per threat, but,
6 you know, a threat's a threat.

7 Q Do you think all threats are the same?

8 A I would think that there's many different kinds of
9 threats, so I don't know where COVID would be in
10 compared to a threat of something else. So in regards
11 to legislation and compliance, public safety threats
12 are public safety threats.

13 Q But you would agree some threats are more serious than
14 others?

15 A If you could give me an example of what threats you're
16 talking about.

17 Q Well, I don't want to give you a hypothetical, but let
18 me ask you this: You believe that the threat of
19 COVID-19 is more of a threat than the threat posed by
20 wearing a mask; is that correct?

21 A I think the legislation in regards to COVID-19 is clear
22 on the expectation of masking.

23 Q Okay, I didn't ask that, so I'll try again. You would
24 agree with me -- sorry, you believe, do you not, that
25 the threat of COVID-19 is greater -- that the threat of
26 COVID-19 to a person's health is greater than the

1 threat to a person's health posed by a mask?

2 A I think, you know, my personal beliefs on --

3 Q I didn't ask you your personal beliefs.

4 A You did you asked me what -- if I believe that.

5 Q Right, but you are here as the Complaints Director.

6 A Correct, so my response is is that the legislation is
7 what guides, not my personal beliefs.

8 Q You have discretion as the Complaints Director, do you
9 not?

10 A I do.

11 Q You used the word "danger" to describe Dr. Wall not
12 wearing a mask while treating his patients earlier
13 today; is that correct?

14 A I believe so, yes.

15 Q So let's use the word "assessment", okay? Let's not
16 use the word "belief", because you didn't use the word
17 "belief". In your assessment, COVID-19 is more of a
18 threat to a patient's health than wearing a mask,
19 correct?

20 A In my assessment, the legislation and guidelines
21 indicate it is more of a threat than wearing a mask.

22 Q So I want to make sure I have your position correct.
23 You're saying that the legislation -- well, let me ask
24 you this: By "legislation", do you mean the Health
25 Professions Act?

26 A I mean all the mandates of practice.

1 Q And you would say the mandates of practice are
2 legislation?

3 A I would refer to them -- and I use the term broadly,
4 but I'm referring to whether the Code of Ethics, the
5 Standards of Practice, directives, policies,
6 legislation, and perhaps mandates would have been a
7 more appropriate word than "legislation" to use in that
8 context.

9 Q So you believe that the ACAC mandates state that
10 COVID-19 is a greater threat to a patient's health than
11 masks?

12 A I think the Pandemic Directive states that wearing a
13 mask can reduce the risk of transmission between doctor
14 and patient.

15 THE CHAIR: Mr. Kitchen, I was just going
16 to say Mr. Lawrence is not a medically trained
17 individual, so I'm wondering if we're asking him for
18 medical opinions or medical --

19 MR. KITCHEN: I'm not. I'm not searching
20 for a medical opinion.

21 THE CHAIR: Okay.

22 MR. KITCHEN: But I'm -- this question is --
23 he has said -- and I don't think he's trying to claim a
24 medical opinion, and I'm not claiming that he is, he
25 has said, I think Dr. Wall not wearing a mask and
26 treating patients was dangerous to the public, that's

1 why I took action. That's what he said.

2 So what I'm trying to figure out -- and that
3 wasn't a medical determination, that was a Complaints
4 Director determination about public safety, which he
5 has to make. So I'm asking him if he thinks one danger
6 is more than another danger, and I think that's within
7 his purview, not as an expert, not as an opinion, but
8 simply he has to assess that, and he has been assessing
9 that.

10 And I've asked the question four times, and he's
11 refused to answer, so I don't see any point in asking
12 it again; however, I will ask you, Mr. Chair, to either
13 direct that he answer the question, or that he not, and
14 I continue on because --

15 THE CHAIR: Well --

16 MR. KITCHEN: -- (INDISCERNIBLE) again.

17 THE CHAIR: Well, I think he did reply
18 that he couldn't compare one to the other without
19 knowing what they were and asking for examples, and I
20 know you won't provide hypotheticals. Is there a
21 possibility you could reword your question?

22 MR. KITCHEN: Sure. No, I did -- the
23 example I provided was masking. I asked if he thought
24 COVID was more of a danger to the health of patients
25 than wearing a mask, and he has refused to answer.

26 THE CHAIR: I don't know. To me, that

1 would require some medical knowledge.

2 MR. KITCHEN: Okay.

3 THE CHAIR: I mean, in some cases, COVID
4 is fatal, so there's all kinds of different ways to
5 assess how dangerous COVID is. I don't want to get
6 into your direct -- your cross-examination,
7 Mr. Kitchen, I just wanted to just clarify that
8 Mr. Lawrence is there in an administrative rather than
9 a medical position.

10 Q MR. KITCHEN: Mr. Lawrence --

11 THE CHAIR: (INDISCERNIBLE)

12 MR. KITCHEN: Oh, sorry.

13 Q MR. KITCHEN: Mr. Lawrence, in assessing
14 Dr. Wall as a danger to the public and not wearing a
15 mask, are you not making something of a medical or
16 scientific determination?

17 A The comment there is in regards to the Standards of
18 Practice that apply by not masking that -- when you are
19 not compliant, that is the danger. So when I look at
20 the practice directive, and it says chiropractors and
21 clinic staff must be masked at all times while
22 providing patient care, when a member of the profession
23 does not comply with that, then they are a risk.

24 Q All right, so if I have your position correct then,
25 what you're saying -- and if you don't agree with me,
26 tell me -- the source of the danger to the public in

1 Dr. Wall's actions are simply that he wasn't complying
2 with what the ACAC said to do?

3 A In my position as Complaints Director, when members are
4 not compliant with what they're supposed to do, my role
5 is to hold them accountable to comply.

6 Q Okay. I didn't ask you what your role is. I thought I
7 was asking a simple question because I was trying to
8 repeat what you had said, I was just trying to clarify.
9 Wasn't trying to trick, I was trying to clarify what
10 you had just said just so I understood your position.

11 I thought you just said that the source of the
12 danger to the public from Dr. Wall was that he was not
13 complying with what the ACAC said to do; do you agree
14 with that?

15 A I would say not complying with the ACAC and Public
16 Health, yes.

17 Q So the noncompliance is the source of the danger,
18 correct or not correct?

19 A Noncompliance -- noncompliance is the -- what's the
20 term -- the noncompliance is the issue in the
21 complaint. The actions are the danger.

22 Q And so and the action --

23 A Dr. Wall's actions, yes.

24 Q You would agree that by referring to Dr. Wall's
25 actions, you mean his actions in not wearing a mask
26 while treating patients?

1 A Correct.

2 Q You agree that chiropractors are obligated to comply
3 with the ACAC's requirements of practice even if those
4 requirements are harmful to the chiropractor, do you
5 not?

6 A I wouldn't say that, no.

7 Q Okay. The ACAC is obligated to comply with the
8 statutes of Alberta; isn't that correct?

9 A The statutes that apply to the profession, yes.

10 Q The ACAC is obligated to only impose restrictions on
11 chiropractors that are consistent with the Canadian
12 Constitution; isn't that right?

13 MR. MAXSTON: Mr. Chairman, I'm going to
14 object there. We don't have a constitutional law
15 expert. Mr. Lawrence is the Complaints Director, and I
16 objected this question or line of questioning with
17 Dr. Halowski, and I'll object again.

18 MR. KITCHEN: Sure. If I was asking whether
19 or not Dr. Lawrence [sic] thought, in his opinion, that
20 wearing a mask could possibly be a violation of Section
21 2(a) of the Canadian Charter of Rights and Freedoms,
22 I'd be asking for his legal opinion. I'm not asking
23 for his legal opinion. I'm asking for his
24 confirmation, as Complaints Director, whether or not
25 the Canadian Constitution applies to the body that he
26 is the Complaints Director of. That is requisite

1 knowledge to do his job. It's not an opinion. That
2 either does or doesn't, and he, by virtue of his
3 position, must have that knowledge. I'm asking for him
4 to confirm that knowledge, not to provide me a legal
5 opinion.

6 MR. MAXSTON: I'm only going to make one
7 other comment, and then you'll decide whether the
8 question can be asked. That again is one of the
9 ultimate questions that this Tribunal is going to be
10 deciding on, what does and doesn't apply to the
11 College's Pandemic Directive and other mandates, so ...

12 MR. KITCHEN: So, Chair, my question is I'm
13 asking Mr. Lawrence to confirm that the Canadian
14 Charter of Rights and Freedoms, being part of the
15 Canadian Constitution, applies to the College; so I'm
16 asking you to let me know if you're going to allow the
17 question.

18 THE CHAIR: My thoughts on this are that
19 we could recess and take advice from independent legal
20 counsel, and I think Mr. Maxston's indicated his
21 concern that this could be a central issue, so I think,
22 as much as I'd like to keep things moving, we will take
23 a brief recess so that the Hearing Tribunal and myself
24 can take advice from counsel, so please bear with us
25 for a few minutes. Thank you.

26 MR. KITCHEN: Okay, thank you.

1 (ADJOURNMENT)

2 THE CHAIR: Okay, we are back. We are
3 still in session. We've had a couple of internet
4 hiccups, a couple of freezing screens, so we'll just
5 hope that this doesn't re-occur.

6 We have discussed the question you've proposed,
7 Mr. Kitchen, and spoken to our independent legal
8 counsel, and our decision is that we do not allow you
9 to ask this question. We believe you're asking for an
10 opinion from this witness, and as you've pointed out,
11 this is likely -- or Mr. Maxston has pointed out it's
12 likely to be a central issue in this hearing, so that
13 question is not allowed.

14 MR. KITCHEN: Thank you, Chair.

15 Q MR. KITCHEN: Now, Mr. Lawrence, I'm going
16 to take you to the Pandemic Directive.

17 A Okay.

18 Q Once again, there's three versions, so it's Exhibits
19 C-20, C-21, and C-22, C-22 being the January 6th
20 version.

21 Now, there's a Personal Protective Equipment
22 section in the directive. Of course, that's what we've
23 been talking about. Now, in that section, there is
24 nothing discussing chiropractors contacting the ACAC if
25 they have human rights concerns regarding the mandatory
26 masking directive, is there?

1 A There is not.

2 Q And the ACAC has never had in place a process in which
3 to reach a possible resolution whereby a chiropractor
4 could practice without a mask; isn't that right?

5 A I think depending on the modality. So certainly I know
6 when council had decided to make Telehealth a permanent
7 modality for chiropractors going forward, and we
8 received communication from I believe it was Green
9 Shield and Blue Cross about how to bill for it. There
10 certainly is practice under that which wouldn't require
11 masking.

12 And in the earlier pandemic, there was if you can
13 maintain 2 metres of distance while conversing with a
14 patient, there was exception -- or there wouldn't be a
15 required to mask.

16 Q The ACAC has never had in place a process by which
17 there's a possible resolution that would allow a
18 chiropractor to physically treat patients without a
19 mask; isn't that right?

20 A In close contact, that's correct.

21 Q You called Dr. Wall December 4th, 2020, to inform him
22 you were making a request to suspend his practice
23 permit, did you not?

24 A I think it was December 3rd.

25 Q Okay.

26 A But yes.

1 Q Thank you for that. Dr. Wall asked you during that
2 call about human rights accommodations, didn't he?

3 A I think he said something to the effect of, Isn't there
4 a human rights part of this. I don't know exact words,
5 but something to that effect, yes.

6 Q Okay. Dr. Wall said to you that the literature doesn't
7 support mandatory masking, didn't he?

8 A I think he said that in his response letter. I don't
9 know if it was during our call, but something to that
10 degree, yes.

11 Q And you responded to him by saying that you were not
12 going to debate the issues, didn't you?

13 A I said the patient's safety isn't up for debate, yes,
14 and that compliance wasn't up for discussion -- or
15 compliance wasn't up for debate, and that if he wasn't
16 going to comply, I was going to initiate the Section 65
17 request.

18 Q But it wasn't public safety that you refused to debate,
19 was it?

20 A Well, it's compliance.

21 Q It was the scientific efficacy of masks that you
22 refused to debate, wasn't it?

23 A No, that's sort of beyond my purview. It's, you know,
24 this is a compliance issue, so the mandates of practice
25 were masking, and if Dr. Wall wasn't going to comply
26 with the requirements, then I initiated the request.

1 Q Now, I'm going to put it to you that Dr. Wall is going
2 to say that what you refused to debate was the
3 scientific efficacy of masks; that's what he's going to
4 say.

5 A Okay, I disagree with that, but okay.

6 Q And I'm talking in the context of this call, not
7 talking anywhere else. In the context of this call,
8 Dr. Wall's going to say that you said to him that you
9 refused to debate the efficacy of masks.

10 A I don't believe -- "efficacy" isn't a word I would
11 usually use. I think I probably talked more in
12 compliance. I note he did talk about the recovery rate
13 of COVID, and like I said before, I think he said
14 something to the effect of it's 99 percent recovery or
15 something to that regard, but it's not -- this was
16 about compliance.

17 Q Do you disagree that Dr. Hu said that the recovery rate
18 is 99 percent?

19 A I don't remember specifically, but I wouldn't disagree
20 with that.

21 Q So you don't disagree that what Dr. Wall said when he
22 told you the recovery rate is 99 percent is truthful?

23 A I don't know either way, so, no, I wouldn't disagree
24 with that.

25 Q So you don't know if the recovery rate is 99 percent or
26 not?

1 A I know it's quite high. I don't know what the exact
2 percentage is, so -- but I know it's quite high.

3 Q But you did just say -- so you don't remember what
4 Dr. Hu said; is that correct?

5 A I'm -- what I said was I believe he said something like
6 that, and I have no reason to disagree with that
7 comment.

8 Q So you have no reason to disagree with Dr. Wall when he
9 said that the recovery rate's 99 percent?

10 A I don't.

11 Q You said in that call that you cannot make Dr. Wall
12 wear a mask and that he was free to not wear a mask,
13 didn't you?

14 A I think I was talking about in regards to, you know, in
15 both his public life and in work. I can't, you know,
16 make him do anything; all I can do is hold
17 chiropractors compliant when their mandates of practice
18 are not complied with and proceed in that way.

19 Q You said he was free to not wear a mask, didn't you?

20 A I think I was talking about in his private life.

21 Q Dr. Wall is going to say that there was no discussion
22 in that call about anything to do with his private life
23 but that the discussion was focused on his professional
24 life.

25 A Okay.

26 Q So let me ask you again: You said in that call to

1 Dr. Wall that he was free to not wear a mask; isn't
2 that correct?

3 A I think what I said was in regards to his private life.
4 If we -- if I interpreted it differently, or he
5 interpreted it difficulty, or there's misunderstanding
6 there, or I don't know, I think what I was talking
7 about was like I can't -- you know, I can't put a mask
8 on him; all I can do is if he won't comply, I can take
9 an action.

10 Q So you disagree with me that you said in that call that
11 Dr. Wall --

12 A I don't have the transcript here, so I wouldn't
13 disagree or agree at all because I'm not -- I don't
14 know exactly the wording that was used.

15 Q So is your answer that you don't remember?

16 A No, my answer is that I believe what we were saying was
17 in his personal life, and also that I can't make him do
18 anything. My job is if he refuses to comply, then I
19 take an action in regards to noncompliance.

20 Q So when Dr. Wall says that there was no mention of
21 private life in that conversation, you're going to
22 disagree with him?

23 A I don't have an answer to that. Like I said, I don't
24 have a transcript. I don't have the call transcript
25 here. I don't have a record of it, so, you know, it's
26 based on what I remember, and that's it.

1 Q But you are convinced, are you not, that you --

2 THE CHAIR: Mr. Kitchen, if I could just
3 interrupt, I believe Mr. Lawrence has indicated what he
4 believes the conversation was about, and you've
5 indicated that you have a witness that will testify
6 differently. I don't know that we can get any more
7 clarification than that.

8 MR. KITCHEN: Thank you, Chair. The only
9 reason I continue to keep going is I keep getting
10 contradictory answers, so I'm just trying to give the
11 witness an opportunity to remove the contradictory
12 answers.

13 THE CHAIR: I think he's been consistent
14 in saying what he recalls the conversation was about.
15 Thank you.

16 MR. KITCHEN: Thank you.

17 Q MR. KITCHEN: Mr. Lawrence, when Dr. Wall
18 was faced with a choice of either wearing a mask or
19 sacrificing his ability to earn an income as a
20 chiropractor, his choice was not a free choice absent
21 of a coercion, was it?

22 A I think there were alternatives he could have followed.
23 He could have practiced Telehealth and -- which would
24 have enabled him to continue practice and not wear a
25 mask.

26 Q When Dr. Wall was faced with a choice of either wearing

1 a mask or treating his patients in a way that he
2 thought was the only good way to treat them, his choice
3 between those two things was not a free choice absent
4 of coercion, was it?

5 A I don't agree with the way you're stating that. I
6 think there's, in any mandate of practice, the
7 compliance is obligatory. I think that in probably
8 most cases in the legislation and in all the standards,
9 there may be chiropractors that agree with some and
10 disagree with others, but the obligation is to comply.

11 Q So that obligation imposes no coercion?

12 A That would be up to the drafters of the legislation. I
13 think, you know, the compliance is not an option, so if
14 non-optional compliance is coercion, then it's
15 coercion.

16 Q By requesting the suspension of Dr. Wall's practice
17 permit, you were, in fact, attempting to make Dr. Wall
18 either wear a mask or stop treating patients in person,
19 were you not?

20 A I think the purpose of that was to safeguard the public
21 and protect the public from harm.

22 Q And the way that you protect the public from harm in
23 that scenario is by making Dr. Wall either wear a mask
24 when he's treating patients or stop treating patients
25 in person?

26 A Correct.

1 Q Now, it was on December 3rd, 2020, that you submitted a
2 request to suspend the practice permit of Dr. Wall;
3 isn't that right?

4 A Correct.

5 Q Now, you said earlier it was on the same day, December
6 3rd, that you called him, correct?

7 A Yes.

8 Q So when Dr. Wall told you on that call that he was
9 exempt from wearing a mask on medical -- he was
10 medically exempt, you didn't believe him, did you?

11 A No, I don't believe that -- under the regulations, the
12 health care workers aren't exempt from masking.

13 Q You didn't believe that he had a medical condition that
14 exempted him, did you?

15 A I think that in regards -- from Public Health and the
16 Pandemic Directive, I think that he was noncompliant
17 with his requirements, and there was never an
18 expectation for exemptions for medical health
19 professionals.

20 Q Didn't ask you that. You didn't believe that he had a
21 medical condition that exempted him from wearing a
22 mask, did you?

23 A "Believe" is not really an appropriate term. It's
24 compliance with or noncompliance with, and that's what
25 guides the direction.

26 Q In your assessment, he wasn't being truthful with you?

1 A That's not what I said, no.

2 Q So you did believe him; you thought he was being
3 truthful?

4 A I believe that there was never an expectation for
5 medical health professionals to be exempt, and I
6 believe Dr. Wall was noncompliant with his mandates of
7 practice. You know, truth and not truth, that's not
8 really appropriate I think.

9 Q Isn't it your job as Complaints Director to assess
10 whether or not chiropractors are telling the truth?

11 A My job is to apply the legislation and the mandates of
12 practice and hold them accountable when they've been
13 breached.

14 Q And when you do that, you have to make assessments of
15 whether or not chiropractors are telling you the truth
16 about something; isn't that right?

17 A I have to look at their actions about what they're
18 doing and whether their actions are compliant or
19 noncompliant with the standards. Whether they lied to
20 me or not, I -- you know, it's more on the actions
21 towards compliance.

22 Q Isn't lying to the -- isn't lying to you in your
23 capacity as Complaints Director in and of itself
24 something worthy of investigation?

25 A Potentially, yes.

26 Q So in your work, you have to make determinations

1 occasionally on whether or not somebody's telling you
2 the truth, correct?

3 A Yes.

4 Q So you made an assessment on December 4th, when
5 Dr. Wall and you had that conversation on the phone,
6 you made an assessment of whether or not he was telling
7 you the truth about his medical exemption?

8 A No. And I think you're misquoting that. It's not
9 about truth or lying or -- it's about compliance, and
10 so the mandates of practice say, you know, this should
11 happen, and if the actions don't follow those mandates,
12 then that's the direction or the actions they take
13 accordingly. It's not whether Dr. Wall was telling the
14 truth or not. It's about whether he was compliant or
15 not.

16 Q Well, and he clearly wasn't.

17 A Wasn't compliant? I agree.

18 Q Right.

19 A I agree he was not compliant.

20 Q So you don't think he had a medical condition that made
21 him medically unable to wear a mask, did you?

22 A I think the question about the -- whether that is an
23 exemption or not, it will be up to the Tribunal to
24 decide. My position is he was not compliant, and as
25 the Complaints Director, my job is to act when members
26 are not compliant.

1 Q And I appreciate that, but I didn't (INDISCERNIBLE) --

2 A I understand what --

3 Q -- (INDISCERNIBLE) about --

4 A I understand what you wanted to say was Dr. Wall
5 telling the truth or not, and it's compliance, so it's
6 about whether he was compliant or not.

7 Q So you believed he was not compliant?

8 A I believe he was not compliant with his mandates of
9 practice, correct.

10 Q And you believed he had no medical condition that made
11 him unable to wear a mask?

12 A I don't know the answer to that.

13 Q Okay. You thought he was just saying that he was
14 exempt because he didn't want to wear a mask, and he
15 was being ungovernable, didn't you?

16 A I believe that he was not being compliant because what
17 he was supposed to be doing, and when they're not
18 compliant, members of every regulated health profession
19 are to be held accountable. So this is a compliance
20 question.

21 Q And you thought he had no medical basis for
22 noncompliance?

23 A I believe there is no -- there wasn't an expectation
24 for medical health professionals to have an exemption,
25 and he was noncompliant with his expectations of
26 practice.

1 Q Which is fine, I didn't ask you anything about
2 exemptions.

3 Now, you received a letter from Dr. Salem, a
4 Calgary medical doctor, stating that Dr. Wall was
5 deemed by that doctor to be medically exempt from
6 wearing a mask; isn't that right?

7 A Yes.

8 Q And you would have received that by December 14th;
9 isn't that right?

10 A Do you mean the letter in follow-up or his December the
11 12th note?

12 Q The December the 12th note, you received that by
13 December 14th, did you not?

14 A Correct.

15 Q And upon receiving that letter, you decided not to
16 withdraw your request to suspend Dr. Wall's licence;
17 isn't that right?

18 A Correct.

19 Q You doubted the accuracy of Dr. Salem's December 12th
20 medical note, didn't you?

21 A I asked for more information about the condition in a
22 follow-up letter to Dr. Salem.

23 Q That's not what I asked. So you didn't doubt the
24 accuracy of that note?

25 A I don't know what you mean by "accuracy". Dr. Salem
26 sent me this note, so I have no doubt to believe it

1 came from Dr. Salem, and he meant what he said.

2 Q So you don't doubt the accuracy of that note?

3 A I think that's accurate.

4 Q So when you received that note, you just said you
5 decided not to withdraw your request to suspend, it
6 didn't matter to you that Dr. Wall was medically unable
7 to wear a mask, did it?

8 A At the time, I, as I said before, I don't think there
9 was an expectation for exemptions for people in
10 front-line medical health workers, and Dr. Wall was
11 still not compliant with the Pandemic Directive and the
12 Standards of Practice, so I continued, yes.

13 Q It didn't matter to you that Dr. Wall had a medical
14 disability that potentially triggered the duty to
15 accommodate in the human rights legislation, did it?

16 A I'm not familiar enough with human rights legislation
17 to answer that.

18 Q So you didn't think about potential human rights
19 accommodation after you received that letter?

20 A I think that in regards to proceeding with the
21 investigation and the complaint, there was still
22 concern about the risk to the public, so I continued
23 with the complaint.

24 Q Great, that's greet. I didn't ask you that. I asked
25 you if you thought about human rights --

26 A I --

- 1 Q -- (INDISCERNIBLE) --
- 2 A -- you -- this is --
- 3 Q -- either you did or you didn't.
- 4 A This is nine months ago. I don't know what -- every
5 thought that went through my head then.
- 6 Q That wasn't important then; must not have been, you
7 forgot about it. So was it important to you to
8 consider human rights at that time or no?
- 9 A The consideration was in the protection of the public
10 and the compliance of a regulated member to the
11 mandates of the legislation. So, you know, that's what
12 led to the complaint, that's what led to the Section 65
13 request, and that's what led to the continuation of the
14 complaint.
- 15 Q And nothing else matters, right?
- 16 A Well, that's not what I said either, but ...
- 17 Q Okay.
- 18 A I'll agree with you. How about that?
- 19 Q When your December 3rd request for an interim
20 suspension of Dr. Wall's practice permit was denied by
21 Dr. Linford on December 18th, Dr. Linford relied upon
22 Dr. Salem's December 12th doctor note, didn't he?
- 23 A You would have to ask Dr. Linford, but that would be a
24 good assumption I think.
- 25 Q It's not an assumption. Let's take you over to the
26 December 18th decision of Dr. Linford. That's Exhibit

1 B-5. I'll give you a chance to pull it up.

2 MR. MAXSTON: Mr. Kitchen, while
3 Mr. Lawrence is looking for that, I'm going to tell you
4 that I'll object to any questions about what
5 Dr. Linford was thinking. I don't expect you're going
6 to ask those questions because that's not within this
7 witness's knowledge.

8 MR. KITCHEN: Right, you and I are on the
9 same page there.

10 THE CHAIR: You said E-5, Mr. Kitchen?

11 MR. KITCHEN: B-5, 'B' as in Bob.

12 Q MR. KITCHEN: Now, Mr. Lawrence, do you have
13 that in front of you?

14 A I do.

15 Q Now, do you see there, this is the very first
16 paragraph, do you see where Dr. Linford says: (as
17 read)

18 I have also considered the following?

19 A Yes.

20 Q And there's a list there of six things, okay? Then
21 there's a paragraph that starts "I have also
22 considered". Now, so at the very bottom of the page
23 there, it says "Dr. Wall has provided". Do you see
24 that there?

25 A Yes.

26 Q Now, this thing that Dr. Wall provided, was it a letter

1 from a physician, Dr. Salem?

2 A Yes.

3 Q And does Dr. Linford describe there what that note was
4 about?

5 A Yes.

6 Q Dr. Linford states, I'm reading it here: (as read)

7 Dr. Wall has a medical condition that
8 prevents him from wearing a mask or a face
9 shield as required under the CMOH orders.

10 A Yes.

11 Q You would agree that I've just read that accurately,
12 correct?

13 A Yes.

14 Q So Dr. Linford referred to that note in making his
15 decision; is that correct?

16 A Yes.

17 Q Now, in this December 18th decision, I guess we can
18 call it Section 55 request for interim suspension of
19 Dr. Wall's practice permit. So Dr. Linford didn't call
20 it anything in particular, but, it's you would agree
21 with me, that this December 18th document from
22 Dr. Linford is Dr. Linford's written decision on your
23 request, right?

24 A Yes.

25 Q So Dr. Linford decided December 18th to permit Dr. Wall
26 to continue to practice in a manner that was

1 noncompliant with the ACAC Pandemic Directive, didn't
2 he?

3 A He did until the completion of the complaint under Part
4 4 of the HPA, so until the complaint is completed, and
5 that, in this case, will be the decision of the
6 Tribunal, so once that is completed, he provided him an
7 avenue to continue to practice.

8 Q So because of Dr. Linford's decision, Dr. Wall has
9 practiced in a manner noncompliant with the ACAC
10 Pandemic Directive for the last eight months since
11 Dr. Linford's decision; isn't that right?

12 A Correct.

13 Q Now, the only two CMOH orders referred by Dr. Linford
14 in his written decision on December 18th are CMOH
15 Orders 38-2020 and 42-2020; isn't that right?

16 A That's correct.

17 Q Now, you would agree with me that in early December,
18 December 7th, AHS issued a closure order to Dr. Wall's
19 office, correct?

20 A That's correct.

21 Q And that was an oral order, it was followed up by a
22 written order on December 8th; you wouldn't contest
23 that, would you?

24 A No.

25 Q Now, you would agree with me that the only CMOH order
26 referred to in that closure order is CMOH Order

1 38-2020; isn't that right?

2 A That's correct.

3 Q You might not have it in front of you, so I'll take you
4 to Exhibit D-2, 'D' as in Deborah, D-2. This is the
5 rescind notice, and I don't know that it has a date on
6 it. It was issued on January 5th. Here it is, January
7 5th, it's right in the first paragraph.

8 Now, in that notice re-opening Dr. Wall's office,
9 Dr. Wall was permitted by AHS to practice, to treat
10 patients in person without a mask; isn't that correct?

11 A That's correct.

12 Q That January 25th interview that was conducted by
13 phone, you questioned Dr. Wall, was there a transcript
14 or recording of that interview?

15 A There is.

16 Q But it hasn't been entered as an exhibit as part of
17 this case though, has it?

18 A No.

19 Q So in your investigation report, you discuss at length
20 what Dr. Wall said to you. Those are your own words to
21 describe what Dr. Wall said; isn't that right?

22 A I lot of it, yes.

23 Q Forgive me, I'm going to take you back to Dr. Linford's
24 decision just one last time. I don't think you'll have
25 to go there, but we can if we need to. Dr. Linford, in
26 his written decision of December 18th, he did not order

1 that patients of Dr. Wall must be masked, did he?

2 A He did not.

3 Q Mr. Lawrence, you are the de facto complainant in this
4 case; isn't that right?

5 A That's correct.

6 Q You appointed yourself as the lead investigator in this
7 case; isn't that right?

8 A It's correct. Under the Health Professions Act, the
9 Complaints Director becomes the lead investigator, and
10 when other investigators are used, they are assistant
11 investigators, but for this case, yes, I was lead
12 investigator.

13 Q There's no assistant investigators in this case, is
14 there?

15 A There is not, no.

16 Q And just to be clear, you made that appointment,
17 appointing yourself as lead investigator, after opening
18 the complaint and becoming the de facto complainant;
19 isn't that right?

20 A Yes.

21 Q Dr. Wall has not harmed any member of the public or any
22 one of his patients by treating them in person without
23 wearing a mask, has he?

24 MR. MAXSTON: I'm going to object to that,
25 Mr. Chair, that's beyond Mr. Lawrence's knowledge.

26 THE CHAIR: Agreed.

- 1 Q MR. KITCHEN: Mr. Lawrence, do you have any
2 evidence that Dr. Wall has harmed any of his patients?
- 3 A I do not.
- 4 Q Do you have any evidence that Dr. Wall has harmed a
5 member of the public by not erecting a plexiglass
6 barrier in his office?
- 7 A I do not.
- 8 Q And just to be clear, you don't have any evidence that
9 any of his patients have been harmed by him treating
10 his patients in person, up close without wearing a
11 mask, do you?
- 12 A I do not.
- 13 Q No member of the public has complained to the ACAC
14 regarding the conduct of Dr. Wall in the period of time
15 between March 2020 and today; isn't that correct?
- 16 A I believe the original concern that came from Public
17 Health was initiated by a patient of Dr. Wall, but the
18 ACAC has not received any, no.
- 19 Q The complaint you just referenced went to AHS, correct?
- 20 A Correct.
- 21 Q Not to the ACAC, correct?
- 22 A Correct.
- 23 Q And you've received no other complaints to the ACAC
24 about Dr. Wall in the last 18 months, correct?
- 25 A Correct.
- 26 Q In fact, as far as you're aware, there had never been

1 any complaints to the ACAC about the conduct of
2 Dr. Wall; is that correct?

3 A Not that I know of, that's correct.

4 MR. KITCHEN: Just give me one second.
5 Those are all my questions.

6 A Thank you.

7 THE CHAIR: Okay, Mr. Maxston, any
8 redirect, or would you like a few minutes? We can
9 break for 5 or 10 minutes.

10 MR. MAXSTON: You know, I think I'm okay.
11 I've got a pretty good idea of what I'm going to ask
12 Mr. Lawrence, but I don't know if Mr. Lawrence needs a
13 break or if the Tribunal needs a break. We've been
14 going for just about an hour, so I'm in your hands. I
15 think I will be 15 or 20 minutes, but, again, I'm in
16 your hands.

17 THE CHAIR: I think that why don't we just
18 break for 10 minutes, and then we can check to see if
19 the Tribunal has any questions arising from the direct
20 and the cross-exam, and we can do both those things
21 while you prepare for your follow-ups, okay?

22 So it's 20 after. Let's take a brief recess, and
23 we'll reconvene at 2:30, and Members of the Tribunal,
24 let's go to a break-out room with our esteemed counsel,
25 and we'll just see if there's any questions arising
26 that we can discuss. Thanks.

1 (ADJOURNMENT)

2 THE CHAIR: Okay, we're all back. Just a
3 reminder everybody, the hearing is in session, and
4 Mr. Maxston has some follow-up on the -- following the
5 cross-examination of Mr. Lawrence by Mr. Kitchen.

6 MR. MAXSTON: Thank you, Mr. Chair.

7 Mr. Maxston Re-examines the Witness

8 Q MR. MAXSTON: Mr. Lawrence, you had a
9 discussion with Mr. Kitchen, and his question was would
10 you agree that chiropractors should protect patients
11 from harm no matter what, and I believe your answer was
12 yes. In your role as Complaints Director, do you
13 decide those kinds of issues?

14 A No.

15 Q Who does?

16 A It's the legislation governs what our actions is, and
17 so I'm led by the regulations or mandates of practice.
18 So the drafters of the legislation, and then council
19 also directs the Standards of Practice, Codes of
20 Ethics, the Pandemic Practice Directive, any policies.
21 The council of the ACAC determines how chiropractors
22 will conduct themselves.

23 Q And a similar question, Mr. Kitchen asked you would you
24 agree that the threat of COVID-19 is more than the
25 threat posed by wearing a mask. Again, as Complaints
26 Director, in your role under Section 55 of the HPA, do

1 you decide that?

2 A No.

3 Q And, again, who does?

4 A Again, that would be, in this case, I would assume
5 Public Health, and they would set the direction for
6 managing the pandemic during -- or managing COVID
7 during the pandemic, and then council would apply
8 practice directives or practice mandates to the
9 members.

10 Q Mr. Kitchen asked you a question about when you are
11 assessing whether Dr. Wall was a danger to the public,
12 aren't you making a medical or scientific judgment. Is
13 that the Complaints Director's role, to make a
14 judgment?

15 A The judgment really is whether the mandates of practice
16 have been complied with or not, and the -- apply the
17 appropriate actions if noncompliance occurs.

18 Q Do you as Complaints Director make findings of
19 unprofessional conduct?

20 A I do not.

21 Q Is that prohibited under the HPA?

22 A So the -- in this case, the Hearing Tribunal makes the
23 determination of that. I don't assign guilt or
24 innocence. That would be the purview of the Hearing
25 Tribunal.

26 Q Does a Complaints Director assess a threshold of

1 evidence?

2 A No. I think really the role of the investigation is to
3 gather evidence and then present the evidence to the
4 Tribunal, and the Tribunal will determine its value and
5 weight.

6 Q Okay. Mr. Kitchen asked you or stated there was --
7 asked you a question about there was no process for a
8 chiropractor to practice without a mask. Were you ever
9 asked by Dr. Wall as Complaints Director about that by
10 Dr. Wall?

11 MR. KITCHEN: Hold on, hold on.

12 Mr. Maxston, you asked that exact question in direct,
13 and now you're asking it again. That's not a new
14 issue. You're just re-going through your direct when
15 you're asking that question.

16 MR. MAXSTON: Well, I think you asked
17 whether there was a process for a chiropractor to
18 practice without a mask --

19 MR. KITCHEN: Yes.

20 MR. MAXSTON: -- and I'm asking Mr. Lawrence
21 whether he was ever asked --

22 MR. KITCHEN: Right.

23 MR. MAXSTON: -- about that process.

24 MR. KITCHEN: But you've already asked that
25 question. Now you're just asking it again.

26 MR. MAXSTON: Well, I'm asking whether

1 Mr. Lawrence was ever asked about that. I'm not asking
2 whether there was one or wasn't. I'm asking was
3 Mr. Lawrence ever asked about the process.

4 MR. KITCHEN: You're asking if Mr. Lawrence
5 was ever asked by Dr. Wall if there was a process?

6 MR. MAXSTON: I'll be even -- yeah, I'll be
7 even more precise then.

8 Q MR. MAXSTON: Were you ever asked by
9 Dr. Wall if there was a process?

10 MR. KITCHEN: Right, but you asked that in
11 direct. This isn't new. This is redirect; it's new
12 only. That's not --

13 MR. MAXSTON: Well --

14 MR. KITCHEN: -- new. You asked him; we
15 have the answer to it.

16 MR. MAXSTON: Well --

17 MR. KITCHEN: You're going to get the same
18 answer now, I don't dispute that, but I have an issue
19 with you using redirect as Direct 2.0.

20 MR. MAXSTON: Well, your question was in the
21 context of a human rights concern, and you then asked
22 whether there was a process to address human rights
23 concerns, and I'm going to ask Mr. Lawrence whether he
24 was ever asked by Dr. Wall if there was a process to
25 address human rights concerns, and that's new.

26 MR. KITCHEN: Well, I guess -- I don't think

1 it is. I think you asked something almost identical to
2 that, maybe the exact words were different, but you, in
3 substance, asked that question on the record.

4 MR. MAXSTON: Yeah, I asked him -- I asked
5 him, Mr. Kitchen, about whether there was an exemption
6 process. I didn't ask him whether someone had raised a
7 human rights concern and asked about an exemption
8 process.

9 THE CHAIR: I think we've been allowing
10 some latitude in terms of these questions. I think I
11 will allow this question with the inclusion of the
12 specific reference to human rights, if that wording was
13 not part of the first time this was raised.

14 MR. MAXSTON: So I'll ask a very precise
15 question then.

16 Q MR. MAXSTON: Mr. Lawrence, did Dr. Wall
17 ever ask you about whether there was a process to
18 address any human rights concerns he had?

19 A No.

20 Q In fairness to Mr. Kitchen and his last comment, I'm
21 going to ask a question, but if he thinks it was asked
22 and answered, I'll invite him to refresh my memory.

23 Did Dr. Wall ever ask you for an exemption?

24 A No.

25 MR. KITCHEN: Again, we know the answer to
26 that, but I --

1 MR. MAXSTON: I'm content to move on,
2 Mr. Kitchen. I'm not going to pursue that any further.

3 MR. KITCHEN: Okay. Well, I have no issue
4 with new questions, but you're asking the same
5 questions you asked in direct. So regardless of
6 whether we know the answer, whether it's controversial,
7 I take issue with simply asking the same questions.

8 Q MR. MAXSTON: Mr. Lawrence, Mr. Kitchen
9 asked you whether you refused to debate scientific
10 efficacy of masking with Dr. Wall. Is debating that
11 part of your role under the HPA as Complaints Director?

12 A It is not.

13 Q Mr. Kitchen asked you about the 99 percent recovery
14 rate. Is recovery rates part of a charge in the notice
15 of hearing?

16 A It is not.

17 Q Mr. Kitchen and you engaged in a discussion about your
18 comment, alleged comment, to Dr. Wall during your
19 telephone conversation where you allegedly said that
20 Dr. Wall was not free to mask, and I believe you
21 responded couldn't comment about his private life.
22 Does the College have jurisdiction over a regulated
23 member's private life in masking?

24 A It does not.

25 Q Were you concerned about Dr. Wall's private life and
26 masking?

1 A No.

2 Q Mr. Kitchen made some comments to you about Dr. Wall
3 being placed in a position where he could either choose
4 between masking or earning an income, and that wasn't a
5 free choice. Order 16-2020, about the relaunch of the
6 profession, had required masking; is that correct?

7 A Yes.

8 Q Was this about a free choice for you as Complaints
9 Director, Dr. Wall's alleged free choice?

10 A As the Complaints Director, compliance is a necessity
11 or an obligation.

12 Q Mr. Kitchen engaged in a discussion with you about
13 Section 65, and his words were that you were attempting
14 to require masking or requiring Dr. Wall to force
15 practice -- to stop practicing. Does Section 65 allow
16 for interim suspensions for a member to stop
17 practicing?

18 A Section 65 allows for an interim suspension, yes.

19 Q Mr. Kitchen talked about you coercing Dr. Wall into
20 masking or, I guess his alternative, he did not
21 practice; who made the Section 65 decision?

22 A Dr. Linford.

23 Q Did you have any involvement in Dr. Linford -- direct
24 involvement talking to Dr. Linford about this decision?

25 A No.

26 Q You had a discussion with Mr. Kitchen about whether you

1 believed that Dr. Wall had a medical exemption. Was
2 your belief relevant?

3 A No.

4 Q Can you tell me why?

5 A The -- my beliefs aren't relevant. The legislation is
6 what's relevant, and so the -- and, sorry, I should
7 clarify, when I say "legislation", what I'm talking
8 about is the mandates of practice, and I just use that
9 term as a catch-all, I guess. So I'm referring to the
10 Standards of Practice, the Code of Ethics, directions
11 that are provided by council for the members to adhere
12 to, and my role is to ensure there is compliance to
13 those requirements.

14 Q Mr. Kitchen brought you back to the Linford decision
15 after leaving it for a few minutes, and he brought you
16 back to it, do you ultimately decide whether a member's
17 noncompliance is unprofessional conduct?

18 A I do not.

19 Q Who does that?

20 A In this case, it would be the Hearing Tribunal.

21 Q Did you have to make a determination about exemptions
22 to refer this to hearing?

23 A No.

24 Q I'll ask you to go to Dr. Linford's decision letter and
25 specifically page 2. And that again is Exhibit B-5,
26 'B' as in Bob, dash 5.

1 A Okay.

2 Q Just while you're finding that, Mr. Kitchen asked you
3 to confirm a number of statements in this letter by
4 reading them out to you and asking is that
5 Dr. Linford's statement, and I'm going to ask you to go
6 to the paragraph in the middle of page 2 that begins:
7 (as read)

8 I have decided that the interim suspension of
9 Dr. Wall's practice permit is not justified
10 at this point in time.

11 I'm going to read the next sentence to you, and there's
12 a question coming: (as read)

13 I have decided the conditions on Dr. Wall's
14 practice permit will be sufficient to address
15 the risk to the public by Dr. Wall not
16 wearing a face mask or face shield when
17 seeing and treating patients.

18 Is that Dr. Linford's statement?

19 A Yes.

20 Q Does he mention a risk to the public?

21 A Yes.

22 Q I'm going to ask you to go to the AHS rescind notice,
23 that's the rescinding of the closure of
24 (INDISCERNIBLE), and that is Exhibit D-2, 'D' as in
25 dog.

26 A Okay.

1 Q So while everyone is finding that, Mr. Kitchen took
2 you, I believe, to paragraph 3 of the rescind notice.
3 There is a question coming, but paragraph 3 says: (as
4 read)

5 Prior to booking an appointment, Dr. Wall
6 must inform the patient he will be unmasked
7 [and so forth].

8 I'm going to ask you to read Order Number 1 in the
9 rescind notice.

10 A (as read)

11 Dr. Curtis Wall must follow the current
12 re-opening practice guidance as set out by
13 the Alberta College and Association of
14 Chiropractors, as well as all future
15 iterations of this guidance.

16 Q So the Pandemic Directive, the guidance, did it require
17 masking?

18 A It did.

19 Q Is there a contradiction between Order 1 and Order 3 in
20 your mind?

21 A I believe there is, yes.

22 MR. MAXSTON: Mr. Chair, this isn't a
23 question, but I'll leave this as a final comment, I
24 want to come back to something about the transcript and
25 discuss that.

26 Q MR. MAXSTON: Mr. Lawrence, Mr. Kitchen

1 discussed with you how you decided to, after utilizing
2 Section 56 to create a complaint, that you also acted
3 as investigator. Do you have Section 55(2) of the HPA
4 handy? And it's not crucial that you do, but if you
5 do --

6 A 55(2)?

7 Q Yeah.

8 A Yes.

9 Q And I'm really looking -- I'm sorry?

10 A I do, yes.

11 Q And can you tell me what Section 55(2)(d) as in dog
12 says? And I think you'll have to read the opening line
13 on 55(2) for it to make grammatical sense.

14 A So 55(2) says: (as read)

15 The Complaints Director may ...

16 And (d) of that says: (as read)

17 May conduct or appoint an investigator to
18 conduct an investigation.

19 Q Did you rely on this section when you conducted the
20 investigation yourself?

21 A Yes.

22 Q Is that allowed under the HPA?

23 A It is.

24 Q Mr. Kitchen asked you whether you were aware of any
25 other complaints about Dr. Wall's conduct in terms of
26 masking.

1 MR. KITCHEN: Hold on, that's not what I
2 asked. I did not qualify it in terms of masking.

3 MR. MAXSTON: Okay, well --

4 MR. KITCHEN: I left it unqualified.

5 MR. MAXSTON: Fair enough, well, I'm going
6 to ask the question then a little bit differently.

7 Q MR. MAXSTON: Mr. Kitchen asked you about
8 whether there were any complaints against -- other
9 complaints against Dr. Wall; is that correct?

10 A Yes.

11 Q And I think your response was that you relied on
12 Section 56. Do you need more than one complaint to
13 direct that an investigation occurs?

14 A I do not.

15 Q Mr. Kitchen asked you a series of questions about
16 whether you have any evidence of Dr. Wall harming
17 patients because of not masking or social distancing or
18 using plexiglass barriers; is that relevant?

19 A I don't believe so. I think in a -- when we're looking
20 at compliance, it's not about the outcome, it's the
21 action.

22 Q When you look at the Notice of Hearing -- the Amended
23 Notice of Hearing, are there any charges about causing
24 harm to patients?

25 A There is not.

26 MR. MAXSTON: So, Mr. Chair, I want to go

1 back to something I was going to address sort of in the
2 tail end of my questions, in the middle of my tail end
3 of my questions.

4 Q MR. MAXSTON: Mr. Kitchen asked questions
5 about a transcript or a recording of the I believe it's
6 the December 3 telephone conversation and --

7 A Sorry, I think it was about the interview that
8 Dr. Halowski and I conducted with him.

9 Q Pardon me, thank you.

10 MR. MAXSTON: I think, and this is open to
11 the Tribunal more than anything, but -- well, first,
12 you're not bound by the formal Rules of Evidence. If
13 Mr. Lawrence has a recording or a transcript, I think
14 it's open to this Tribunal to ask that he produce it,
15 and that we finish his testimony tomorrow by reviewing
16 that with him.

17 And I don't think that's unusual or extraordinary.
18 My friend brought up the matter of the transcript. And
19 if you're concerned about what was or wasn't said, and
20 I think Mr. Kitchen is, I think it's fair to ask that
21 that transcript be or recording, whatever it is, be
22 entered as an exhibit, and we finish with Mr. Lawrence
23 tomorrow morning.

24 So I'm going to ask Mr. Kitchen if he has any
25 comments on that, but my sense is it might clear up a
26 lot of questions.

1 MR. KITCHEN: I disagree. I don't think it
2 would clear up hardly any questions. I don't object to
3 it coming in as an exhibit. I do object to Mr. Maxston
4 having another opportunity to do a direct examination.
5 That ship has sailed. He's had his opportunity. He's
6 done it. He did not introduce that as an exhibit as
7 part of that or inquire to that. He should not be
8 permitted, it's procedurally unfair to permit him to
9 have another chance to have a direct examination of
10 this witness. We've had a direct, we've had a cross,
11 we've had a re-direct, let's put in the transcript and
12 leave it there.

13 MR. MAXSTON: I'm not really -- I don't
14 think my re-re-direct, if I was to ask Mr. Lawrence
15 questions about it tomorrow, would be anything other
16 than, Is this a recording, did you make it, or is this
17 a transcript, did you type it up or have someone
18 prepare it. That's all I would want to do. If you're
19 consenting to it being entered as an exhibit,
20 Mr. Kitchen, then I don't intend to ask any further
21 questions about it because I've asked those questions.
22 But it occurred to me that if it's a concern for the
23 Tribunal, they can certainly have it as an exhibit.

24 MR. KITCHEN: Yeah, I'm fine with it being
25 an exhibit, just not with any further questioning.

26 MR. MAXSTON: I think what I would -- again,

1 what I would suggest is that I ask Mr. Lawrence, if
2 that transcript or recording is provided, you know, Is
3 it something you created. And I'd leave that today. I
4 just don't want there to be any question about the
5 bona fides or source of that exhibit. I don't intend
6 to ask him any questions about it other than that.

7 MR. KITCHEN: Well, you can ask him that
8 question now I mean. If there is a transcript, if
9 one's produced, you can ask him how it was produced,
10 who produced it. I've got no issue to go ahead and ask
11 it now.

12 MR. MAXSTON: Yeah, and I think I'm only
13 going to do that if we have, (a), the consent from you,
14 Mr. Kitchen, that this can go in and, (b), the Tribunal
15 wanting it to go in. It just struck me, as I was
16 listening to your questions about, you know, what said
17 and what wasn't said, and I heard Mr. Lawrence indicate
18 that there was either a transcript or a recording, I
19 thought, well, why wouldn't we put that to the
20 Tribunal. Not intending to re-examine, that's why I
21 stopped right there and didn't ask a question.

22 MR. KITCHEN: Well, I tell you what, if
23 there's a transcript, there's a recording. I think the
24 fair thing to do, if the Tribunal agrees, is we put in
25 the transcript as an exhibit but that you provide to me
26 a copy of the audio recording. That sounds fair to me.

1 MR. MAXSTON: Why don't we do this: I'm
2 going to --

3 Q MR. MAXSTON: We're digressing here,
4 Mr. Lawrence, with some legalese questions, and they're
5 good questions, but maybe I can ask you a couple of
6 questions, with my friend's consent, about the
7 transcript and the recording, and then we can see how
8 that might or might not go in.

9 MR. MAXSTON: Would that be fair,
10 Mr. Kitchen?

11 MR. KITCHEN: Yeah, I think that's okay.

12 A Can I make one comment about --

13 Q MR. MAXSTON: Sure.

14 A -- that? It is a recording not a transcript.

15 Q Okay. Well, I'll ask you a couple of quick questions
16 about it. Did you make that recording when you had the
17 conversation?

18 A I did.

19 Q Has it been altered in any way, to your knowledge?

20 A It has not.

21 MR. MAXSTON: Okay, subject to Mr. Kitchen,
22 and I think, in fairness, he should have a chance to
23 ask you some very basic questions about it as well, I
24 think we should provide the recording to the Tribunal
25 and go from there.

26 THE CHAIR: Can I ask -- and I'll be

1 frank, we discussed this at our last break and the
2 question as to why it wasn't entered. If it's a
3 recording, is it -- are you proposing, Mr. Maxston,
4 that it be played, or are you proposing that it be
5 transcribed?

6 MR. MAXSTON: Well, I'm in Mr. Kitchen's
7 hands because I really want to be fair to him. To be
8 honest with you, I think it might be better to have it
9 transcribed and put the recording in so everybody has a
10 chance to look at, you know, both versions of it.

11 I'm really concerned here with getting this
12 information into your hands. There's nothing devious
13 here. I'm not -- again, in fairness to Mr. Kitchen,
14 I'm not going to ask questions about it. I've asked
15 questions about the discussion before. It just
16 occurred to me that, particularly when I heard his
17 cross-examination, and there were questions about what
18 was said and what wasn't said in this particular
19 conversation, I thought, well, let's just put it in
20 front of you.

21 And to the extent that helps or hurts my case or
22 helps or hurts Mr. Kitchen's case, well, so be it.

23 THE CHAIR: It's kind of out of order in
24 terms of normally we get that, and then there's
25 questioning direct and cross. So --

26 MR. MAXSTON: Well, again, Mr. --

1 THE CHAIR: Are --

2 MR. MAXSTON: Oh, I'm sorry.

3 THE CHAIR: -- we at the point where we've

4 agreed that it could be entered tomorrow morning and

5 that Mr. Maxston and Mr. Kitchen can ask a very -- very

6 pointed questions to establish what it is, it's

7 provenance, and then -- but not its subject?

8 MR. MAXSTON: I think I probably already did

9 that with Mr. Lawrence. I'm not sure I need to redo

10 that again.

11 MR. KITCHEN: What about this? We're going

12 to have to come back to hear more evidence at some

13 point, we don't know when, but that's -- we're probably

14 looking at at least a few weeks I'd imagine, unless we

15 can get ourselves all together again soon. Why not --

16 Mr. Maxston, let me know what you think of this -- why

17 not, in that span of time, because it should be quite a

18 bit of time, the recording is transcribed, and then

19 when that transcription is ready, it gets -- you know,

20 you can send it to me for me to have a look.

21 Presumably, I won't object to it, I don't intend to,

22 unless I see something fishy, which I don't expect to

23 see. It can go in by consent -- well, it can go in by

24 consent from counsel. We can, by consent, suggest that

25 the Tribunal accept it when we reconvene a few weeks

26 down the road to hear the rest of the evidence.

1 THE CHAIR: I would prefer that. I would
2 much prefer to see a transcription. Then there is
3 no -- since it's not going to be directly the topic of
4 questioning at this point, then there's no panic to get
5 it in tomorrow. Is that fair?

6 MR. MAXSTON: I didn't think it was
7 providable tomorrow, if that's a word. I'm just
8 suggesting that, you know, it's something that you
9 might be interested in. And I'll be --

10 THE CHAIR: Who would transcribe it?

11 MR. MAXSTON: We could send it to a court
12 reporter. We could ask someone internally at the
13 College to do it. I'm a -- I want to make sure that
14 Mr. Kitchen is comfortable with that process. Again --

15 THE CHAIR: I don't know --

16 MR. MAXSTON: -- I'm in your hands.

17 THE CHAIR: -- who has -- who has
18 possession? The College?

19 A The College.

20 MR. MAXSTON: I don't --

21 THE CHAIR: Yeah. Okay, can we leave it
22 with the College to make arrangements to have a
23 transcription prepared?

24 MR. MAXSTON: (NO VERBAL RESPONSE)

25 THE CHAIR: Okay.

26 A Yes.

1 MR. KITCHEN: Now, I have to raise
2 something. This was Mr. Maxston's idea, I've consented
3 to it. In the event months from now, we get to a point
4 where we're discussing costs, I'm going to object now,
5 make it known, that I will object to the College
6 claiming any costs for this transcription. Because as
7 much as I'm consenting to it going in, it was not my
8 proposal, it was not my idea, it was the College's idea
9 to put it in.

10 So in the event the Tribunal rules against
11 Dr. Wall, and the College, the Complaints Director
12 seeks costs, I don't consent to the cost of this
13 transcription being added --

14 THE CHAIR: Okay, that --

15 MR. KITCHEN: -- to those costs.

16 THE CHAIR: -- that's a -- your point's
17 made. I think we're getting ahead of ourselves.

18 MR. MAXSTON: Yeah, and, Mr. Kitchen, let me
19 be honest with you, if you don't think you want this
20 in, then -- I mean it's really for your benefit in a
21 sense, because you haven't questioned your client yet.
22 I'm content to leave it out. I wanted to raise it.
23 You seemed to, rightly so, have some questions about
24 the interaction. If you don't want it to go in for
25 either cost reasons or other reasons, I'm content to
26 just leave things as is.

1 MR. KITCHEN: I'm indifferent. I'm content
2 to leave it out as well. It sounded like it was your
3 idea to bring it in.

4 MR. MAXSTON: Well, can I suggest this?
5 Mr. Lawrence is in the sort of awkward position of
6 being both witness and the client who gives me
7 directions. Without discussing the contents of that
8 tape at all or any questions about the discussion,
9 because I can't do that, can I get instructions from
10 him and let you know tomorrow what his preference is?

11 MR. KITCHEN: That's fine, yeah.

12 THE CHAIR: Okay, we'll table it till
13 tomorrow.

14 MR. MAXSTON: Sure.

15 THE CHAIR: Mr. Maxston, were you finished
16 with your examination -- your redirect?

17 MR. MAXSTON: Yes, I am. So I don't know if
18 you want to take a break, Mr. Chair, and decide whether
19 you have questions for Mr. Lawrence or you want to go
20 ahead right now, but fine either way.

21 MR. KITCHEN: Mr. Chair, I propose I have a
22 couple questions for recross. That was a pretty
23 extensive redirect. That was a pretty extensive
24 redirect that I think raised some new issues that I
25 should be entitled to cross on.

26 MR. MAXSTON: I'm not going to object to

1 that, Mr. Chair, provided that I get the same courtesy
2 if I have a couple of quick follow-ups on something
3 down the road with my friend's witnesses.

4 THE CHAIR: Okay, let's proceed.

5 Mr. Kitchen.

6 Mr. Kitchen Re-cross-examines the Witness

7 Q MR. KITCHEN: Mr. Lawrence, just to confirm,
8 you would not initiate an investigation unless there
9 was at least a possibility of professional misconduct;
10 isn't that correct?

11 A Yes.

12 Q In your discretion, before you initiate a complaint,
13 you decide if there's actually any likelihood of a
14 finding at the end of professional misconduct; do you
15 not?

16 A I don't know about if there's a finding, but if --
17 because there might be what I would consider evidence
18 of professional misconduct and then not a finding, but
19 generally that's correct, yes.

20 Q You said in answer to Mr. Maxston that you're not
21 concerned about the private life of Dr. Wall; is that
22 correct?

23 A That's correct.

24 Q Then it's not likely, given that lack of concern, it's
25 not likely that your comments in the call to Dr. Wall
26 about being free to wear a mask were actually about his

1 private life?

2 A What I meant by that when I said that is the concern
3 is, because I don't have any legislative authority over
4 his private life, so that's what I mean, in his private
5 life, he's free to do whatever he chooses; my concern
6 is only as a member of the College.

7 Q Right, so considering you're only concerned with the
8 professional life of Dr. Wall, it's not likely you
9 would have made that comment about being free to wear a
10 mask only in the context of his private life; it's not
11 likely you discussed his private life at all, correct?

12 A I don't agree with that, but I believe what I was
13 talking about was, you know, in his private life, he's
14 free to do whatever he decides he wants to do.

15 Q Dr. Linford disagrees with the ACAC on how to respond
16 to the alleged risk to the public of not wearing a
17 mask, correct?

18 A I think Dr. Linford's decision was to allow practice
19 with restrictions until the completion of the complaint
20 so that the Tribunal could make a decision on how best
21 to proceed.

22 Q That's not what he said in his December 18th decision
23 though, is it?

24 A Well, he said that he directs Dr. Wall's practice
25 permit is subject to the following conditions pending
26 the completion of the process under Part 4 of the

1 Health Professions Act, and Part 4 is dealing with
2 complaints.

3 MR. MAXSTON: Mr. Kitchen, I wasn't going to
4 object before, but we are now going back to things you
5 directly asked my client about. This isn't anything
6 new, so --

7 THE CHAIR: Yeah, I agree.

8 MR. KITCHEN: I think I just have one more.

9 Q MR. KITCHEN: So I'm going to the rescind
10 notice. My learned friend asked you a question
11 about -- a redirect question about a contradiction
12 between 1 and 3, between paragraph 1 and paragraph 3 of
13 that rescind notice. Do you recall him asking you that
14 just a few minutes ago?

15 A Yes.

16 Q Contradiction being, paragraph 1 says: (as read)

17 Dr. Wall must follow the current reopening
18 practice guidance as set out by the ACAC.

19 And then Section 3 says: (as read)

20 Prior to booking an appointment, Dr. Wall
21 must inform the patient he will be unmasked
22 while providing services.

23 So just to confirm, you think there's a contradiction
24 there, correct?

25 A Yes.

26 Q Would you agree that, at least in the short-term, at

1 least for the last eight months, Dr. Linford does not
2 see a distinction there? That's based on his written
3 decision. I'm not asking about his thought process.
4 Based on his written decision, Dr. Linford doesn't see
5 a distinction there?

6 MR. MAXSTON: I'm not sure that question can
7 be asked, because that's not something that is even
8 addressed in the Linford decision. So, Mr. Kitchen, I
9 think we've gone about as far as we can here with your
10 recross-examination. I think that goes beyond
11 Dr. Linford -- what Dr. Linford was even talking about,
12 so I'm going to object to that.

13 MR. KITCHEN: That's fine. That's fine.

14 Q MR. KITCHEN: Last question, and I only
15 raise this because there seems to be some confusion
16 about how many complaints to the ACAC that have been
17 submitted on behalf of -- or about Dr. Wall.

18 Mr. Maxston said it doesn't take any more than one
19 complaint against Dr. Wall for there to be a finding of
20 professional misconduct, but just to be clear, there
21 are zero complaints to the ACAC about Dr. Wall's
22 conduct; is that correct?

23 A Except the one presently opened, that's correct.

24 Q So the only complaint is the one from yourself,
25 correct?

26 A That's correct.

1 Q Okay, good, we're on the same page.

2 MR. KITCHEN: All right, that's it for me.

3 Discussion

4 THE CHAIR: Okay, then that will conclude
5 our session for today. We will resume, we'll convene
6 for today and resume 9:00 tomorrow morning.

7 And I believe Mr. Maxston is finished with his
8 witnesses, so you will have your at least one witness
9 tomorrow morning, Mr. Kitchen?

10 MR. KITCHEN: I'm going to be calling
11 Dr. Wall tomorrow morning, yes.

12 THE CHAIR: Okay.

13 MR. KITCHEN: Just to go back, so maybe I
14 misheard, you don't have any questions then for
15 Mr. Lawrence as the Chair, as the Tribunal?

16 MR. MAXSTON: I was just going to ask that
17 actually.

18 THE CHAIR: We have -- we discussed that
19 in the 15-minute break, and, at this point, I will say
20 no.

21 MR. MAXSTON: Mr. Chair, I just want to make
22 one other comment, Mr. Lawrence was the College's final
23 witness, but you will recall, and I think this is --
24 there's an understanding amongst everyone here, but I
25 want to just put it on the record again, I believe the
26 Hearing Tribunal gave my client the ability to call a

1 response witness or response evidence to Mr. Schaefer's
2 expert report. I don't know if that will happen,
3 frankly, but I just want to put on the record that,
4 although the College's -- the Complaints Director's
5 case is closed, there's that one caveat. I don't know
6 if we'll be calling anyone, but I wanted to remind
7 everyone of that.

8 THE CHAIR: I don't think we'll be doing
9 that tomorrow.

10 MR. MAXSTON: No, I'm not in a position to
11 do that tomorrow. It would be, frankly, out of order.
12 To use a phrase my friend and I are familiar with, at
13 some point, I might say, Well, before we go on to the
14 next witness, we have to finish up with a Complaints
15 Director witness concerning Mr. Schaefer. Again, I'll
16 let Mr. Kitchen know as soon as we've made any
17 determination on that, but, typically, I'd be saying
18 now, well, the Complaints Director's case is closed,
19 that's accurate with that one caveat.

20 THE CHAIR: Okay --

21 MR. KITCHEN: That's fine.

22 THE CHAIR: -- fair enough. Okay, on
23 behalf of all of us, Mr. Lawrence, thank you very much
24 for your attendance and your testimony today.

25 A Thank you.

26 THE CHAIR: You are discharged or

1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing
4 pages are a complete and accurate transcript of the
5 proceedings, taken down by me in shorthand and
6 transcribed from my shorthand notes to the best of my
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,
9 this 27th day of September, 2021.

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Karoline Schumann, CSR(A)

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Official Court Reporter

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(1:00 491:6	25th 480:13 522:12	42-2020 521:15	518:12 532:13, 15,18,21
(a) 540:13	1:15 491:11,14,26 492:1,5,7	27(c) 422:16 459:17	441 408:8	6th 422:26 504:19
(b) 540:14	1:21 493:24	27th 554:9	450 408:9	<hr/> 7 <hr/>
(d) 536:16	<hr/> 2 <hr/>	29th 486:19	453 408:10	<hr/> 7 408:5,15 409:5 493:5
<hr/> 1 <hr/>	2 414:8 420:6,7,8, 9,26 421:12,14, 21 422:4 446:7 448:14 451:20 461:20,23 462:10 463:12,25 465:19 467:18 469:14 470:10 472:9,16, 25 473:6 474:17, 19 479:13 482:21 505:13 533:25 534:6	2:00 455:10	455 408:11	75 447:12
1 469:24 491:6 535:8,19 549:12, 16	2(a) 502:21	2:30 525:23	490 408:13	7th 521:18
10 491:4,6 525:9, 18	2.0 529:19	2nd 410:2 437:8 448:11 462:20 463:15	493 408:15	<hr/> 8 <hr/>
10-minute 441:8	20 525:15,22	<hr/> 3 <hr/>	494 408:16	8 485:16 486:10 553:7
10:00 441:11	20-20 463:21	3 421:4 454:22 457:21,25 463:26 464:6 466:14 474:20 484:10,11 485:26 486:13 488:10 535:2,3, 19 538:6 549:12, 19	4:30 454:22	8th 521:22
10:15 441:13	2020 415:13,26 418:20 456:8 462:10,23 463:25,26 464:6 466:14 469:7 474:17,20 476:24 477:23 481:15 482:17 483:11 484:17 485:1 494:10 505:21 512:1 524:15	30 456:14	4th 420:11 421:7, 18 488:6 505:21 514:4	<hr/> 9 <hr/>
11 453:6	2021 408:5,15 409:5 419:5 460:17 479:16 480:13 485:16 486:10 493:5 553:7 554:9	30-day 458:23	<hr/> 5 <hr/>	90 476:11
1100 440:26	21 459:12 462:23 489:18	38-20 459:5	5 453:4,7 459:22 470:7 471:1 525:9 533:26	99 464:26 476:11 507:14,18,22,25 508:9 531:13
1150 441:2	24(c) 460:1	38-2020 422:11, 17 459:9,25 482:14 521:15 522:1	50/50 447:13	9:00 551:6 553:4, 7
1180 441:2	25 447:11 456:14 479:16 480:2	3:30 454:22 491:15	526 408:18	9:08 409:23
12 484:17 485:1 491:4		3rd 505:24 512:1, 6 518:19	547 408:19	<hr/> A <hr/>
12:30 454:26		<hr/> 4 <hr/>	55 458:14,19 520:18 526:26	A-3 462:10,14
12:45 454:26		4 454:22 457:14 473:24 479:22,26 521:4 548:26 549:1	55(2) 536:3,6,13, 14	A-4 473:12
12th 516:11,12, 19 518:22		42-20 459:5,19,22 460:1	55(2)(d) 536:11	A-5 462:22
14th 516:8,13			551 408:20	A-6 477:7,9
15 441:12,14 525:15			554 408:21	A-7 474:2,4 484:11
15-minute 551:19			56 457:1 463:2,4, 21 466:2 536:2 537:12	A-8 484:16,18 485:18,19
16-2020 419:26 420:6 421:22 422:5,7 532:5			5th 522:6,7	A-9 485:16,19,20
16th 476:24			<hr/> 6 <hr/>	ability 477:12 478:2 480:21 484:4 510:19 551:26 554:7
17 481:20			6 420:11,22 421:17 422:7,16 460:17	absent 510:20 511:3
18 469:7 524:24			65 464:13 466:4, 5,6 467:1 469:4, 12 471:18,19 473:21 475:7 476:8,18 506:16	
18th 518:21,26 520:17,21,25 521:14 522:26 548:22				

Absolutely 430:15	accurate 474:12 478:20 517:3 552:19 554:4	ADJOURNME NT 441:16 449:26 504:1 526:1	496:1,13,24 500:25 501:13,24 502:2 509:13 511:5,9 514:17, 19 518:18 520:11,20 521:17,25 526:10,24 548:12 549:7,26	allowing 530:9 alluded 465:25 altered 541:19 alternative 532:20 alternatives 464:15 476:5 510:22 Amended 537:22 amount 419:22 447:18 anonymous 450:11,12 answering 421:23 429:23 432:2,5,12,19 471:14 answers 424:13 432:6 470:21 510:10,12 anticipate 453:24 454:3 anticipated 448:19 anxiety 465:7 477:16 478:19 480:17,25 483:6, 18 484:5 486:20 487:6 anybody's 450:15 apologies 448:5 Appendix 420:9 applicable 468:10,14 application 466:8 applied 420:7 421:15 436:10 applies 412:22 495:10 502:25 503:15 apply 420:20,26 460:6,14 500:18
ACAC 409:10, 11,13,16 415:12 418:19 419:4,15 421:6,18 423:11 424:6,16 425:18 426:1 427:6,26 428:18 433:23 434:9,18 435:7, 24 436:7,13,19 445:12 458:3 463:14 468:18 473:12 479:17,18 481:6 482:8 483:14 493:10, 11,13,16,17 498:9 501:2,13, 15 502:7,10 504:24 505:2,16 521:1,9 524:13, 18,21,23 525:1 526:21 548:15 549:18 550:16,21	acted 458:20 536:2 action 457:15,17 458:24 460:5 475:15 499:1 501:22 509:9,19 537:21 actions 475:11 501:1,21,23,25 513:17,18,20 514:11,12 526:16 527:17 activities 468:16 activity 411:13 actual 420:8 acupuncture 411:23 add 435:14 added 545:13 address 450:15 469:20 529:22,25 530:18 534:14 538:1 addressed 550:8 addresses 450:14 adequate 451:8 adhere 490:13 494:16 533:11 adhered 470:14 ADJOURNED 492:7 553:7	adjustment 413:13,14,18,26 442:6 Adjustments 414:3 Administration 456:12 administrative 500:8 advertising 447:19 488:25 advice 418:23 503:19,24 advised 463:25, 26 485:5 advising 483:15 affect 490:19 affirmed 408:6, 11,16 410:11 455:26 494:3 afternoon 408:15 454:18 493:5 494:5 Agency 419:3 agree 411:18 412:7,17,20 413:2,9,12 416:9, 11,22,23 417:22 418:1,15,18 421:6,14 424:2,4, 24 425:1,6,9,18 426:1,6,17 427:20,21 428:7, 17 429:14 430:12,16,20 431:3,8,13,15,20, 22 433:4,11,12, 15,23 434:1 435:7,21,24 436:19 437:7 494:15,20,23,24 495:3,7,12,15,23	agreed 411:25 429:12 523:26 543:4 agrees 470:4 540:24 ahead 449:4 465:5 466:18 479:21 491:19 540:10 545:17 546:20 AHS 468:18 471:26 521:18 522:9 524:19 534:22 AHS's 473:21 aim 425:4 Alberta 409:1,3, 15 418:22 419:1, 10 435:9,11,25 436:11 438:9 440:16,23 446:24 447:23 450:18, 21,24 451:2 452:4 456:14 464:18 470:17 471:9,21 472:5,6 473:10,15 493:1, 3,15 502:8 535:13 554:8 Aldcorn 409:10 450:4,7 451:25 493:10 alleged 531:18 532:9 548:16 allegedly 531:19 allowed 475:9 504:13 536:22	

502:9 503:10
513:11 527:7,16
appoint 536:17
appointed
466:25 523:6
appointing
523:17
appointment
486:19 523:16
535:5 549:20
approach 491:24
approaches
411:22
approved 461:1
approximately
451:21
area 456:20,23,
26 457:5 459:1,
12,14 462:7
467:16 482:7
areas 456:20
459:11 473:20
arising 452:14
525:19,25
arrangements
544:22
arrows 467:12,14
480:8
articles 415:1
aspect 416:17
424:24 430:11
aspects 471:6
assess 499:8
500:5 513:9
527:26
assessed 485:4
assessing 499:8
500:13 527:11
assessment
424:22 497:15,
17,20 512:26
514:4,6
assessments
513:14

assign 527:23
assistant 523:10,
13
assisting 470:11
Association
409:2,15 493:2,
15 535:13
assume 450:17
474:3 527:4
assuming 486:8
assumption
518:24,25
asymptomatic
443:4
Athabasca
456:12
attached 420:16
attempting
432:13 511:17
532:13
attend 443:4,5
attendance
552:24
attentiveness
452:21
audio 540:26
August 451:3,21,
22 452:1
authority 435:26
548:3
avenue 521:7
aware 438:13
448:12,26 459:16
482:3,25 489:18
524:26 536:24
awkward 546:5

B

B-1 466:13,18
B-3 469:2
B-4 469:3

B-5 469:7,9
519:1,11 533:25
B.E. 409:16
493:17
back 409:25,26
410:5 417:8
421:12 422:23
441:12,17 442:6
445:6 450:1
451:23 457:19,20
473:22 485:26
489:4 491:6,11,
14 492:1 493:25
504:2 522:23
526:2 533:14,16
535:24 538:1
543:12 549:4
551:13
background
456:10 467:10,13
barrier 467:15,
19 473:8 482:22
524:6
barriers 461:14,
15 465:22 470:13
471:9,11 472:13
476:26 477:4
481:18 537:18
based 427:14
440:7 446:2
447:16 471:11
481:8 509:26
550:2,4
basic 541:23
basically 490:24
basing 471:7
basis 440:6
515:21
bear 449:23
471:24 503:24
begin 442:16
464:16 490:4
beginning
474:17,23 488:8

begins 468:9
469:14 475:23
476:23 534:6
behalf 550:17
552:23
belief 440:6
474:12 497:16,17
533:2
beliefs 483:21
497:2,3,7 533:5
believed 467:5
477:15 515:7,10
533:1
believes 466:7
482:7,8 510:4
benefit 456:19
545:20
bill 489:18 505:9
bit 441:10 453:26
458:12 480:9
484:7 485:26
486:7 488:7
537:6 543:18
Blue 505:9
Bob 466:13
519:11 533:26
bodies 458:3
body 438:23
490:12 502:25
bona 540:5
booking 535:5
549:20
bottom 486:14
487:10 519:22
bound 435:24
436:13,16,19
538:12
breach 463:16
467:18 488:1
breached 468:5
513:13
breaches 457:12
break 441:9
449:17,20 453:26

454:25 455:14
491:5,11,26
525:9,13,18
542:1 546:18
551:19
break-out
449:24 525:24
breathe 486:21
briefly 456:9,24,
25 459:2 460:16
473:14
bring 546:3
brings 470:15
broader 425:10
426:3,8 494:26
495:4,8
broadly 498:3
brought 533:14,
15 538:18
bullet 486:14
487:19
bullets 480:8
487:14
bunch 465:25
business 456:11,
13 468:21
businesses
456:16

C

C-1 444:9
C-20 422:25
504:19
C-21 422:25
504:19
C-22 422:26
444:9 504:19
Calgary 459:12
516:4 554:8
call 410:14 414:1,
3 437:6,9,22
438:5 439:17
465:12 506:2,9

507:6,7 508:11, 22,26 509:10,24 512:8 520:18,19 547:25 551:26 553:4	catch 462:25 catch-all 533:9 caught 469:9 causing 477:15 537:23 caution 492:2 caveat 552:5,19 central 503:21 504:12 certificate 408:21 438:17, 19,21 554:1 certificates 438:15 certification 456:13 certify 554:3 Chair 409:8,24 410:1,10 420:2 431:25 432:22 435:10,17 441:4, 7,11,17 449:13, 14,16,19 450:1 451:26 452:11, 19,25 453:2,8,16 455:3,21 456:1,3, 18 462:15 471:24 474:3 485:19,21 487:18,21 491:1, 16,17,25 492:5 493:8,25 494:2 498:15,21 499:12,15,17,26 500:3,11 503:12, 18 504:2,14 510:2,8,13 519:10 523:25,26 525:7,17 526:2,6 530:9 535:22 537:26 541:26 542:23 543:1,3 544:1,10,15,17, 21,25 545:14,16 546:12,15,18,21 547:1,4 549:7 551:4,12,15,18,	21 552:8,20,22, 26 553:3 Chairman 502:13 chance 519:1 539:9 541:22 542:10 change 478:24 479:12 charge 531:14 charges 537:23 Charter 502:21 503:14 charting 483:15 check 449:22 525:18 chiropractic 411:22 427:2 428:21 430:14 431:10 436:23 444:8 446:24 468:17,26 495:10,18,24 chiropractor 411:9 414:7 425:6,20 426:2 427:14 430:22,24 431:5 433:14 444:6 445:9 461:19 489:12 494:7,20,23 502:4 505:3,18 510:20 528:8,17 chiropractor's 443:5 chiropractors 409:2,15 410:22 411:7,8,11,22 412:2,25 413:19, 22 415:2,9,13,15 416:2,24 417:2, 24 418:3,17,20 423:21,24 424:5 425:5 427:6,26 428:18 430:20	431:3,11 433:12 436:10 438:9 439:6 440:17,22 441:25,26 442:2, 4,10 443:20 444:18 445:11 446:10 460:12, 21,25 461:3,6,9, 25 462:4 479:8 493:2,15 494:16 495:12,16 500:20 502:2,11 504:24 505:7 508:17 511:9 513:10,15 526:10,21 535:14 choice 466:1 510:18,20,26 511:2,3 532:5,8,9 choose 479:4,5 489:9,12,13 532:3 chooses 548:5 choosing 490:20 chose 483:7 circumstance 478:16 cites 487:7 City 554:8 claim 498:23 claiming 498:24 545:6 clarification 510:7 clarify 500:7 501:8,9 533:7 claustrophobia 465:7 477:16 478:19 480:17,25 484:5 487:6 clear 428:15 447:2 461:6,8 496:21 523:16 524:8 538:25 539:2 550:20	client 469:24 545:21 546:6 549:5 551:26 clinic 423:25 442:12,22 443:5 461:6,16 471:10, 22 472:12,14 473:13,17 477:1 481:13 500:21 clinical 467:18 close 424:12 439:19 460:11,13 461:25,26 462:4, 5 467:6,23 505:20 524:10 closed 454:8 460:23 552:5,18 closure 472:1,13 473:13,15,17 483:12 521:18,26 534:23 CMOH 419:26 420:6 421:9,22 422:5,7,11,17 423:6 443:21,24 456:24 459:3,4,8, 9,19,25 460:1 463:17 464:21 481:10 482:13 520:9 521:13,14, 25,26 Code 435:3 446:12,22 498:4 533:10 Codes 434:25 446:13 457:8,13 458:1 468:5 479:6 482:6 488:2 526:19 coercing 532:19 coercion 510:21 511:4,11,14,15 cold 442:14 colleagues 438:12,14 440:21
---	--	---	---	--

college 409:2,15
418:6 420:12,14
421:2 422:1,8
443:15 444:8,19
445:10 446:9,12
447:17 456:6,10,
21 457:8 460:9
468:24 472:4
475:10,15 476:16
489:7,19 490:10,
14 493:2,15
495:21 503:15
531:22 535:13
544:13,18,19,22
545:5,11 548:6
College's 435:18
445:26 447:3
457:6,20 460:16
503:11 545:8
551:22 552:4
comfort 481:5
comfortable
544:14
COMH 464:4
COMMENCED
409:23
comment 431:26
446:26 450:20
476:15 500:17
503:7 508:7
530:20 531:18,21
535:23 541:12
548:9 551:22
commented
443:8 450:21,23
461:11
commenting
450:16
comments
444:11 455:3
491:3 532:2
538:25 547:25
commonly
412:13
communicated
423:11 438:11

451:9
communication
464:7 483:14
505:8
community
420:16,17 440:21
comorbidities
439:5,8,25
comorbidity
415:7
compare 499:18
compared
496:10
competence
418:7
complainant
463:7,8 523:3,18
complained
524:13
complaint 457:1,
16 458:21,22,26
460:6 462:9
463:6,8,20,21
464:12 466:1,2
467:3 471:18
473:20 475:8
477:5 488:5
489:8 501:21
517:21,23
518:12,14 521:3,
4 523:18 524:19
536:2 537:12
547:12 548:19
550:19,24
complaints
428:8,10,16
448:25,26 456:5,
8,22 457:10
458:13,18,25
462:21 463:5,7
464:1 466:7
470:6 479:17
489:23 493:16
494:10 497:5,8
499:3 501:3
502:15,24,26

513:9,23 514:25
523:9 524:23
525:1 526:12,25
527:13,18,26
528:9 531:11
532:8,10 536:15,
25 537:8,9
545:11 549:2
550:16,21 552:4,
14,18
complete 469:14
473:9 479:14
554:4
completed
481:18 487:24
521:4,6
completion
467:2 472:19
521:3 548:19,26
compliance
457:12 458:8,10
463:20 468:22
479:3 482:5
488:10,14,22
490:11,22 495:20
496:11 506:14,
15,20,24 507:12,
16 511:7,13,14
512:24 513:21
514:9 515:5,19
518:10 532:10
533:12 537:20
compliant 464:2
471:16 488:25,26
490:15 500:19
501:4 508:17
513:18 514:14,
17,19,24,26
515:6,7,8,16,18
517:11
complications
439:21
complied 457:14
471:6 508:18
527:16

comply 420:16
430:20 431:4
433:12 448:24
458:6,11 464:20
470:12,23 479:4,
5,9,10 482:7
488:12 489:3
490:17,21 500:23
501:5 502:2,7
506:16,25 509:8,
18 511:10
complying
448:21 464:16
488:12 501:1,13,
15
components
430:10
comprised
447:11
computer-wise
453:4
concentrate
484:4
concentration
477:20 478:18
480:21
concern 422:19
424:7 427:10
444:7 445:1,5,10
452:21 482:12
485:3 503:21
517:22 524:16
529:21 530:7
539:22 547:24
548:2,5
concerned 429:2
442:9,13 468:1
531:25 538:19
542:11 547:21
548:7
concerns 444:20
450:9 478:6,18,
19 504:25
529:23,25 530:18
conclude 551:4

concluded 410:2
conclusion
477:25
condition 414:23
481:4 483:13
512:13,21 514:20
515:10 516:21
520:7
conditions
414:21,22 460:2
469:19 534:13
548:25
conduct 436:25,
26 437:1 446:22,
23 489:14,16
490:13 491:7
524:14 525:1
526:22 527:19
533:17 536:17,
18,25 550:22
conducted
473:24 486:22
522:12 536:19
538:8
confirm 411:16
416:22 423:7,15
438:4 485:4
486:25 503:4,13
534:3 547:7
549:23
confirmation
438:25,26 470:3
471:1 502:24
confirmations
471:3
confirming
438:22
conflict 429:3,6
confusion 550:15
conglomeration
427:3
conjunction
465:26
consent 540:13
541:6 543:23,24

545:12	contest 521:22	conversing 505:13	505:6 526:18,21 527:7 533:11	536:2
consented 545:2	context 412:1 419:17,22 427:15 428:5 436:4 452:9 456:22 498:8 507:6,7 529:21 548:10	conveying 475:26	council's 466:20	created 540:3
consenting 539:19 545:7	contextualize 434:12	convinced 510:1	counsel 409:9,16, 19 452:13 466:23 479:19 480:5 493:9,17,20 503:20,24 504:8 525:24 543:24	cross 445:5 454:17,21 505:9 539:10 542:25 546:25
considerable 447:18	continually 451:10	cooperate 489:10,12	counter 477:1	cross-exam 525:20
consideration 416:6 417:15 424:15,19 426:13 429:10 435:1 442:19 445:20 518:9	continuation 518:13	copies 470:6	couple 449:21 450:3 454:14 467:12,24 469:2, 10 476:20 479:21 483:19 504:3,4 541:5,15 546:22 547:2	cross- examination 410:6 455:10 491:4,7 494:1 500:6 526:5 542:17
considerations 427:13 445:23 446:20	continue 453:19 462:16 468:17 475:9 499:14 510:9,24 520:26 521:7	correct 413:11 414:6,9,10 419:2, 12,13,18 421:19, 20 422:5 426:4, 18,25 427:4 428:4 435:9 436:14 438:9 440:8,9,11,14 442:7,8 443:6,11 469:6 471:22 494:7,10,11 495:5 496:20 497:6,13,19,22 500:24 501:18 502:1,8 505:20 508:4 509:2 511:26 512:4,6 514:2 515:9 516:14,18 520:12,15 521:12,16,19,20 522:2,10,11 523:5,8 524:15, 19,20,21,22,24,25 525:2,3 532:6 537:9 547:10,19, 22,23 548:11,17 549:24 550:22, 23,25,26	court 409:21 417:10 455:16,24 493:22 544:11 554:15	Cross-examined 408:7,17 410:11 494:3
considered 416:5,6 417:13, 15 439:14 483:5 519:18,22	continued 419:8 452:3 517:12,22	copy 540:26	courtesy 547:1	Crucial 536:4
consistent 421:24 435:9 502:11 510:13	continuous 472:12	covered 483:23	COVID 419:23 438:8,13 439:10, 12,21,25 440:4,7, 11,17,21 442:4 443:4 465:13 476:4,10 481:15, 22 482:3 483:3, 25 494:12 496:9 499:24 500:3,5 507:13 527:6	CSR(A) 409:21 493:22 554:14
constant 432:3	contracted 440:10	COVID-19 418:13 421:3 430:14,16 462:1 463:18 472:11,26 495:25 496:2,3, 19,21,25,26 497:17 498:10 526:24	current 470:13 535:11 549:17	Curtis 409:18 485:4 493:19 535:11
Constitution 436:13 502:12,25 503:15	contradiction 535:19 549:11, 16,23	COVID-19 418:13 421:3 430:14,16 462:1 463:18 472:11,26 495:25 496:2,3, 19,21,25,26 497:17 498:10 526:24	cut 454:18	
constitutional 415:15 416:1,9, 12 502:14	contradictory 510:10,11	create 446:12		
consult 418:21, 24 419:5 470:16	contravene 421:21 422:4			
consultation 410:26 452:2,3	contribute 472:10			
contact 424:12 444:19 445:9,11 460:12,13 461:26 489:2 505:20	controversial 531:6			
contacting 424:5,9,10 504:24	convene 551:5			
content 435:22 531:1 545:22,25 546:1	conversation 437:19,20 440:12 448:12,16,18,20 449:9 475:2 509:21 510:4,14 514:5 531:19 538:6 541:17 542:19	cost 545:12,25		
contents 408:1 546:7		costs 545:4,6,12, 15		
		council 424:18, 20 429:9 436:1 447:10,11,15 457:8 458:4 466:25 490:12		
				D
				D-1 471:25
				D-2 522:4 534:24
				D-8 422:10 459:4
				D-9 459:4,21
				daily 470:19
				damage 447:7
				damaged 447:22, 23
				danger 431:12 467:5 497:11 499:5,6,24 500:14,19,26 501:12,17,21 527:11

dangerous 498:26 500:5	19 518:19,21,22, 26 520:17,21,25 521:14,17,18,22 522:26 538:6 548:22	deemed 463:5 485:6 516:5	determines 526:21	419:5 421:6,18 422:23,25 423:2, 16,20,24 424:4,9 443:8 444:5 448:22 451:6,8 456:26 460:16, 20,22 461:1,2,11, 18 463:18 467:17 468:3,6 477:26 478:20 481:6,10 482:4,8 488:13 498:12 500:20 503:11 504:16, 22,26 512:16 517:11 521:1,10 526:20 535:16
dangers 482:24, 25,26	decide 436:6 487:24 503:7 514:24 526:13 527:1 533:16 546:18 547:13	defined 489:15	determining 460:3,5	directives 457:9 458:2 498:5 527:8
dash 466:13 533:26	decided 415:12, 25 418:19 469:15,17,18 472:8 477:17,23 505:6 516:15 517:5 520:25 534:8,13 536:1	definition 417:26	developed 487:5	directly 439:23 464:26 544:3 549:5
date 448:5 474:11 484:23 522:5	decider 415:20	degree 506:10	devices 413:23	director 409:13 428:8,10,16 436:7 448:25,26 456:5,8 457:11 458:13,18,25 462:21 463:5,7 464:1 466:7 470:7 479:17 489:23 493:13,16 494:10 497:5,8 499:4 501:3 502:15,24,26 513:9,23 514:25 523:9 526:12,26 527:18,26 528:9 531:11 532:9,10 536:15 545:11 552:15
dated 462:19 484:23 485:1 554:8	decides 548:14	deliberates 447:10	devious 542:12	Director's 456:23 527:13 552:4,18
David 408:11,16 453:18 455:26 476:25 479:17 494:3	deciding 415:24 479:10 490:12,17 503:10	deliver 416:15 427:10 430:25	diagnosis 481:3 486:25	directs 424:17 526:19 548:24
Dawson 409:12 493:12	decision 416:20, 26 437:10 449:11 469:11,16 478:16,21,24 480:19 481:4,8 483:17 488:4 504:8 518:26 520:15,17,22 521:5,8,11,14 522:24,26 532:21,24 533:14,24 548:18,20,22 550:3,4,8	delivering 446:16 458:6	diagnostic 486:23,26	disability 517:14
day 455:13 512:5 554:9	decision-making 426:20 428:23	delivery 431:9 433:16	dialogue 477:19	
days 452:16 454:14	decisions 418:8 424:17,18 437:15,16 446:4 447:6 466:22 468:22	demand 437:25 477:26	died 440:7,17	
de 463:8 523:3,18	declared 440:3	denied 518:20	difference 448:16	
deal 480:26	decreased 477:20	dentist 462:3	differently 509:4 510:6 537:6	
dealing 445:4 549:1		deny 438:4	difficult 451:16 495:19	
death 438:15,17, 18,19,21 439:6, 13		depend 413:4	difficulty 509:5	
debate 476:7 506:12,13,15,18, 22 507:2,9 531:9		depending 454:5 505:5	digress 473:11	
debating 531:10		depends 414:23	digressing 541:3	
Deborah 522:4		describe 456:9 457:6 472:21 497:11 520:3 522:21	diligently 472:19	
December 437:7, 8 448:6,9,11,14 452:3 462:10,20, 23 463:15,25,26 464:6 466:14 469:7 474:17,19, 20 476:24 482:17 483:11 484:17 485:1 486:19 488:10 505:21,24 512:1,5 514:4 516:8,10,12,13,		describing 413:6,19 417:26	direct 410:2,19 437:1 444:23 453:5,20 454:21 461:23 473:22 499:13 500:6 525:19 528:12,14 529:11,19 531:5 532:23 537:13 539:4,9,10 542:25	

disagree 411:4,
16,26 412:9,17
428:26 431:6,19
432:15 438:7
507:5,17,19,21,
23 508:6,8
509:10,13,22
511:10 539:1

disagreement
433:2

disagrees 548:15

discharge 490:3

discharged
552:26

discontinue
478:22 482:15

discontinued
483:10

discretion 497:8
547:12

discuss 450:9
464:10 484:1
492:2 522:19
525:26 535:25

discussed 422:13
437:5 450:2
464:17 504:6
536:1 542:1
548:11 551:18

discusses 447:11

discussing
504:24 545:4
546:7

discussion
408:10,13,20
441:25 443:7
445:13 446:25
448:3 453:1
455:20 464:18
472:7 475:21
476:5,9 490:26
506:14 508:21,23
526:9 531:17
532:12,26 542:15
546:8 551:3

discussions
415:20 474:18

dismissed 553:1

disposition 488:4

dispute 529:18

distance 446:7
467:18 472:10
473:6,7 481:23
482:20 505:13

distanced 414:8

distancing
461:14 465:18
470:14 537:17

distinction
429:19 430:2
550:2,5

distributed
450:17

doctor 478:13
483:16 490:5
498:13 516:4,5
518:22

document
436:18 439:2
456:2 460:18
462:26 466:11
469:10 472:16
473:10,14 474:4
485:18 520:21

documents
486:22

dog 534:25
536:11

doubt 491:3
516:23,26 517:2

doubted 516:19

drafters 511:12
526:18

driven 451:3

due 422:19
439:21 483:18
485:6

duration 442:17

duties 456:23
457:8

duty 517:14

E

E-5 519:10

earlier 497:12
505:12 512:5

early 437:7 448:4
521:17

earn 510:19

earning 532:4

Edmonton 409:2
459:13 493:2

education 410:26

educationally
456:11

effect 464:24
470:8,9 506:3,5
507:14

effected 421:10

effective 414:15,
22 418:12 420:11
483:25

effectively
455:12

effectiveness
414:16

efficacy 506:21
507:3,9,10
531:10

effort 447:19

email 448:10
471:4

emergency
460:24

employ 411:7

employees
481:14

employment
456:9

enable 490:3

enabled 460:25
510:24

encompasses
430:9

end 474:21
475:25 480:19
538:2 547:14

endangering
476:3,14

enduring 477:22

enforce 423:21
443:21

enforcement
423:24

enforcing 489:22

engaged 441:24
445:13 446:25
531:17 532:12

ensure 418:6
447:19 533:12

ensuring 445:21

enter 440:1

entered 522:16
538:22 539:19
542:2 543:4

entirety 427:1

entitled 436:16
467:10 546:25

environment
416:4 417:13
434:6,16 442:22
445:25

Equipment
423:26 424:3
504:21

erecting 524:5

essential 428:22

establish 457:8
543:6

established
420:13,14 434:13
461:2

esteemed 525:24

estimate 440:25

ethical 446:23

Ethics 434:25
435:3 446:12,13,
22 457:9,13
458:1 468:5
479:7 482:6
488:2 498:4
526:20 533:10

event 453:17
470:20 545:3,10

eventually
439:21

everything's
490:22

evidence 414:16,
19,20,24,26
418:11 439:5
446:3 471:13
491:20 524:2,4,8
528:1,3 537:16
538:12 543:12,26
547:17 552:1

exact 440:24
474:10 506:4
508:1 528:12
530:2

examination
410:2,19 453:20
539:4,9 546:16

Examined
408:11 455:26

examples 499:19

exception 505:14

exceptions
450:25 481:7
482:9,21

excessive 419:21

exchange 452:2

Exclusively
419:12

Executive 471:26
472:15

exempt 422:18

465:8,14 474:25
485:7 512:9,10,
12 513:5 515:14
516:5

exempted
512:14,21

exemption
459:17,25,26
460:6,8,14
461:18,21,23,24
464:22 468:10,14
469:26 470:16
475:6 478:10
481:11 482:14,17
483:11 486:3
487:8 514:7,23
515:24 530:5,7,
23 533:1

exemptions
460:10 481:9
490:1 512:18
516:2 517:9
533:21

exercise 411:1

exhibit 419:24
422:10 439:3
459:21 462:10,
14,22 466:13
469:7 471:25
473:12 474:2
477:7 484:11,16,
18 485:16 518:26
522:4,16 533:25
534:24 538:22
539:3,6,19,23,25
540:5,25

exhibits 440:2
444:9 459:4
469:2 504:18

expanding
447:13

expect 427:9
446:10 488:15
519:5 543:22

expectation
424:11 460:10,26

488:11 489:2
496:22 512:18
513:4 515:23
517:9

expectations
515:25

expected 446:23
454:17

expects 427:6,26

experience
454:14

experienced
481:2 483:7

expert 416:12
435:18,20 436:15
499:7 502:15
552:2

expertise 452:18

experts 413:5

explain 448:20
463:12 466:4,19
467:13 482:26

explored 448:17

extensive 546:23

extensively
461:12

extent 420:18
435:26 542:21

extraordinary
538:17

eye 451:5,11

eyewear 452:5,8

F

F-2 419:25

face 430:17
459:14 462:4,5
470:1,5,9,15
472:9 477:15,17,
24 478:1,21
480:18 485:8
520:8 534:16

faced 510:18,26

faces 430:18

facing 483:16

fact 421:17 440:2
453:16 471:17
511:17 524:26

facto 463:8
523:3,18

facts 482:2

fair 442:23 537:5
538:20 540:24,26
541:9 542:7
544:5 552:22

fairness 530:20
541:22 542:13

fall 451:1

familiar 422:13
457:21 458:14
459:4 490:6
517:16 552:12

families 438:10,
13 439:8 440:3

family 438:12

fatal 500:4

father 439:11,26

favoured 413:21

February 488:6

feel 412:3 416:16
440:13,15 460:7

feeling 412:4

feelings 465:6
478:19 480:16,
18,25 481:1,3,8
483:6,18

fellow 438:14

felt 465:7 480:20,
23 481:5 484:5
487:6

fides 540:5

field 456:15

fields 488:19

figure 499:2

fill 483:4

final 448:2
535:23 551:22

find 450:24

finding 451:15
534:2 535:1
547:14,16,18
550:19

findings 527:18

fine 421:25
453:10 455:1
491:18,23 492:4
516:1 539:24
546:11,20 550:13
552:21

finish 538:15,22
552:14

finished 453:13
489:5 546:15
551:7

finishing 491:13

fishy 543:22

flavour 480:10

flexible 454:24

floor 410:9

flu 464:24

focused 508:23

follow 451:26
457:10 476:17
495:6 514:11
535:11 549:17

follow-up 476:25
485:10 516:10,22
526:4

follow-ups
525:21 547:2

Foothills 439:20

force 532:14

foregoing 554:3

forgive 428:13
486:6 522:23

forgot 518:7

form 410:21,25

411:4,17 412:8,
14 413:3,10
414:16 438:24,25

formal 538:12

format 432:1

forms 411:11
412:10 425:10
426:3 494:25
495:4

forthcoming
414:18

forward 433:4
505:7

found 472:11
477:18 485:13

four-page 477:10

framework
446:16

frank 542:1

frankly 552:3,11

free 453:13
508:12,19 509:1
510:20 511:3
531:20 532:5,8,9
547:26 548:5,9,
14

Freedoms
502:21 503:14

freezing 504:4

frequently 489:1

Friday 470:7
471:1

friend 538:18
549:10 552:12

friend's 541:6
547:3

front 419:26
477:1 519:13
522:3 542:20

front-line 517:10

full 412:1 427:15

fully 454:17

function 457:6,
20

functions 447:3
456:22
funeral 438:22
future 535:14

G

G-3 450:22
gather 528:3
gatherings
459:10
gave 461:21
551:26
gears 484:7
general 456:21
485:13
generally 415:2,9
441:26 445:14
457:6 459:3,7
547:19
get-go 442:10
give 417:25
426:10 427:22
432:21 433:10
441:12 444:14
455:13 456:1
481:7 496:15,17
510:10 519:1
525:4
giving 484:5
492:2
gloves 419:20
goal 454:20
good 409:24
410:8,13 418:16
435:18 441:12
453:23 456:4
487:4 491:5
494:5 511:2
518:24 525:11
541:5 551:1
govern 429:9
434:24,25 436:2,
3

governed 457:26
governing 458:2
government
418:22 419:1,6
438:19 458:2
Government's
447:14
governs 429:9
526:16
gowns 419:19
grammatical
536:13
great 461:13
517:24
greater 440:26
460:4 474:21
480:24 496:3,25,
26 498:10

Green 505:8
greet 517:24
guess 425:12
427:5 430:10
520:17 529:26
532:20 533:9
guidance 420:17
437:2 446:2
451:11,18 452:5
535:12,15,16
549:18
guide 422:8
guidelines 421:3
447:26 490:2
497:20
guides 497:7
512:25
guilt 527:23

H

hairs 433:5
Halowski 408:6
409:25 410:3,6,7,
11,13,14,21
417:9,20 420:4

423:1 431:13
432:3,4,6,15,25
433:3,8 435:11,
13,18,24 438:8
440:22 441:6,19,
21 443:3 445:9,
13 449:15,23
450:3,5,7 452:1,
12,15 453:11
454:15 461:11
462:11 479:18
480:13 481:24
502:17 538:8

hand-based
413:26

handle 423:12
handling 458:13
hands 413:23
525:14,16 542:7,
12 544:16

handy 536:4

hanging 455:11

happen 449:5,10
450:26 453:17
514:11 552:2

happened 463:10
464:8

happening
465:26 466:3
473:19

harboured
486:19

harm 425:1
428:19 429:15,
18,25 430:4,8,10,
26 433:17,20
445:15,18,19
446:26 458:9
494:17 495:13,16
511:21,22 526:11
537:24

harmed 523:21
524:2,4,9

harmful 430:22
431:5 433:14

478:1 502:4

harming 537:16

head 444:12
518:5

heading 484:12

health 411:14
413:17 415:17
418:24,26 419:3,
7,10 420:15,17
421:2 424:25
425:2 427:7
428:1 429:9
430:13,17

436:12,17,20,24
439:8,9 446:3,10
448:1 450:21,24
451:2 452:4
457:7,21,26
458:5,6,14
460:11,25 461:2
464:18 467:7
469:26 470:17
471:9,21 472:6,7,
15 473:10,16

478:12 487:4,8
489:15 495:24
496:2,26 497:1,
18,24 498:10
499:24 501:16
512:12,15,18
513:5 515:18,24
517:10 523:8
524:17 527:5
549:1

healthy 481:21,
26

hear 466:21,22,
25 543:12,26

heard 424:13
434:4 540:17
542:16

hearing 409:7
410:4 412:23
414:25 441:17
449:24 450:2
451:4 452:21

453:3,14 456:18
457:3,17 487:24
488:4,6 493:7
503:23 504:12
526:3 527:22,24
531:15 533:20,22
537:22,23 551:26
553:4

Hearings 409:13
493:13

Heidi 464:19

held 435:19
515:19

helps 542:21,22

hiccups 504:4

high 476:4,12,13
483:3 508:1,2

historically
411:20

history 456:9
487:2

Ho 464:19

hold 453:6,18
455:7 456:11
457:11 490:10,15
501:5 508:16
513:12 528:11
537:1

home 438:22

honest 542:8
545:19

hope 504:5

hospital 439:18

hour 453:26
491:13 525:14

hour-and-a-half
453:24

HPA 457:13,15,
18 458:19 463:2,
4,22 466:6
473:24 521:4
526:26 527:21
531:11 536:3,22

Hu 507:17 508:4
human 415:14
 416:1,9,13,17
 424:6 435:9,12,
 20 444:6,26
 445:5,10 456:13
 465:12 474:24
 475:5,9 504:25
 506:2,4 517:15,
 16,18,25 518:8
 529:21,22,25
 530:7,12,18
hundred 430:16
hung 433:5
hurts 542:21,22
husband 439:11,
 18
hypothetical
 426:15 496:17
hypotheticals
 499:20

I

i.e. 419:19
idea 441:12
 447:17 525:11
 545:2,8 546:3
ideal 426:18
identical 530:1
identify 466:20
 469:3
illnesses 415:3,10
 442:1
illustrated
 440:20
imagine 454:13
 543:14
immediately
 472:18
immobilization
 411:1
impact 426:12
 438:13 487:9

impacted 426:7,9
 477:19 478:2
implemented
 421:7,18
important
 416:10 417:2
 418:2 428:19
 436:5 442:18
 458:9 480:10
 494:15 495:17,19
 518:6,7
impose 434:18
 435:8 502:10
imposes 511:11
impossible
 433:23 434:1,8
inability 486:20
inappropriate
 411:10
include 415:12,
 26 418:19 424:10
included 487:3
Including 444:2,
 3
inclusion 530:11
income 510:19
 532:4
increasingly
 451:15
indented 467:12
 487:14
independent
 414:16 418:21
 419:6 503:19
 504:7
indicating
 476:25
indication 452:7
indifferent 546:1
**INDISCERNIB
 LE** 494:15 499:16
 500:11 515:1,3
 518:1 534:24

individual 426:7
 427:2,14 481:26
 495:8 498:17
individuals
 422:17 426:24
 438:16 440:6
indoor 473:4
infection 415:6,7
 440:5
infections 415:5
 442:11
infectious 415:3,
 10 442:1,5
inform 412:23
 449:4 469:24
 505:21 535:6
 549:21
information
 433:1 436:24
 439:9 440:1
 463:4,16 464:17
 467:13 471:7,12
 472:5 477:2
 485:11,15 486:4,
 23,26 516:21
 542:12
informed 439:10
 475:13,16 476:6
initial 437:6
 448:3
initiate 466:2
 506:16 547:8,12
initiated 460:22
 471:18 472:13
 477:5 506:26
 524:17
initiating 475:7
innocence
 527:24
inquire 451:10
 539:7
inquiring 451:14
inquiry 437:14
inside 446:7

install 481:17
installed 476:26
 477:4
instance 449:5
instruction
 411:1
instructions
 546:9
**instrument-
 assisted** 413:26
intend 539:20
 540:5 543:21
intending 540:20
interact 425:16
 426:22 480:21
interaction
 464:7 468:23
 545:24
interchangeably
 413:15
interest 425:10
 426:3,8,17,19
 427:4 429:13
 494:26 495:1,4,9
interested 544:9
interests 425:9
 426:2,6 427:2,3
 428:4 494:25
 495:3,7
interfered
 480:20 484:4
interim 466:4
 467:1,4 471:19
 518:19 520:18
 532:16,18 534:8
Internal 409:9
 493:9
internally 544:12
internet 504:3
interpreted
 477:26 509:4,5
interrupt 510:3
intervention
 411:25

interview
 479:20,24 480:1,
 4,9,11,12 483:20
 522:12,14 538:7
interviewed
 479:16
introduce 434:15
 539:6
investigate 489:9
investigation
 457:2,16 473:23
 474:2,13,16
 478:25 479:12,
 13,22,26 484:10,
 11 486:1,13
 487:13,23 489:10
 513:24 517:21
 522:19 528:2
 536:18,20 537:13
 547:8
investigator
 473:25 523:6,9,
 12,17 536:3,17
investigators
 523:10,11,13
invite 455:3
 530:22
invited 444:18
involve 489:16
involved 471:21
involvement
 457:1 462:8
 473:21,23
 532:23,24
IP 450:14,15
isolate 451:5
issue 454:16
 464:10 489:4
 501:20 503:21
 504:12 506:24
 528:14 529:18
 531:3,7 540:10
issued 451:7
 521:18 522:6

issues 444:25
506:12 526:13
546:24
iterations 535:15

J

J.s.m 493:20
J.S.M. 409:19
January 419:5
422:26 460:17
474:10 479:16
480:2,13 485:16
486:10 504:19
522:6,12
jeopardy 491:12
job 418:16 494:12
503:1 509:18
513:9,11 514:25
join 453:15
judgment
527:12,14,15
June 477:23
480:19 482:16
483:10
jurisdiction
443:10,15,19
531:22
justified 469:18
534:9

K

Karoline 554:3,
14
key 424:24
428:22 447:24
479:24 480:1
486:4,9,15
killed 438:8
439:10,26 440:4
kind 542:23
kinds 496:8
500:4 526:13

Kitchen 408:7,
17,19 409:19
410:9,10,12,13
417:5,7,19,20
420:3,4 431:26
432:5,7,10,14,20,
22 433:3,7,8
435:21,23 441:3,
4,24 442:24
443:7,12,18
444:4,17,21,23
445:1,3,14 446:8,
25 448:3,17
452:22 453:2,21
454:6,11 455:7,
17,19 477:3
480:14 486:6
491:7,10,19,22
493:20,26 494:2,
4,5 498:15,19,22
499:16,22 500:2,
7,10,12,13
502:18 503:12,26
504:7,14,15
510:2,8,16,17
519:2,8,10,11,12
524:1 525:4
526:5,9,23
527:10 528:6,11,
19,22,24 529:4,
10,14,17,26
530:5,20,25
531:2,3,8,13,17
532:2,12,19,26
533:14 534:2
535:1,26 536:24
537:1,4,7,15
538:4,20,24
539:1,20,24
540:7,14,22
541:10,11,21
542:13 543:5,11
544:14 545:1,15,
18 546:1,11,21
547:5,6,7 549:3,
8,9 550:8,13,14
551:2,9,10,13
552:16,21

Kitchen's 432:23
469:4 491:3
542:6,22
knew 419:22
439:24
knowing 499:19
knowledge
435:11 439:12,
15,16 470:23,25
500:1 503:1,3,4
519:7 523:25
541:19

L

lack 433:24
434:3,9 547:24
language 449:3,7
largely 424:1
late 474:10
477:23
latest 491:15
latitude 530:10
law 434:18
502:14
lawful 434:19
435:2
Lawrence
408:11,16 453:3,
9,19,25 454:2,4,
21 455:4,22,26
456:4,17,20
457:5 460:15
462:17 463:1
466:11 472:2
474:6 479:17
485:22 489:6
491:2 492:1
493:16 494:1,3,5
498:16 500:8,10,
13 502:15,19
503:13 504:15
510:3,17 519:3,
12 523:3 524:1
525:12 526:5,8

528:20 529:1,3,4,
23 530:16 531:8
535:26 538:13,22
539:14 540:1,17
541:4 543:9
546:5,19 547:7
551:15,22 552:23

Lawrence's
523:25

lays 458:19,24

lead 523:6,9,11,
17

leading 442:25,
26 443:13 486:7

learned 549:10

leave 451:14
452:18 455:11

535:23 539:12
540:3 544:21

545:22,26 546:2

leaving 533:15

led 518:12,13
526:17

Lees 409:8 493:8

left 537:4

legal 409:9,16,19
439:16 466:23

479:19 480:4
493:9,17,20
502:22,23 503:4,
19 504:7

legalese 541:4

legislation
434:26 435:12,20

436:1,3,10,11,16,
20,22 437:1

457:26 476:17

479:3,6 496:11,
21 497:6,20,23,
24 498:2,6,7

511:8,12 513:11
517:15,16 518:11

526:16,18 533:5,
7

legislative 548:3

length 522:19

lengthy 480:10

letter 462:11,18,
23 463:15 466:14

467:9 469:8,11
476:21,25 477:6,
10,13 478:23

484:17,19,24,26
485:1,3,9,17

486:10,21,24
506:8 516:3,10,
15,22 517:19

519:26 533:24
534:3

letterhead
485:17

letters 469:4
484:8

level 446:15

levels 477:20
478:18

licence 516:16

lied 513:19

life 436:6 468:21
508:15,20,22,24
509:3,17,21

531:21,23,25
547:21 548:1,4,5,
8,10,11,13

likelihood
547:13

limit 418:12

limitation 422:20
482:11

limitations 478:6

Linford 466:15,
19,24,26 469:8,
17,23 476:25

518:21,23,26
519:5,16 520:3,6,
14,19,22,25

521:13 522:25
532:22,23,24

533:14 548:15

550:1,4,8,11
Linford's
 469:11,16 520:22
 521:8,11 522:23
 533:24 534:5,18
 548:18
list 519:20
listen 427:18
 453:13
listening 434:21
 540:16
literally 487:14
literature 506:6
locate 456:2
located 462:14
log 470:18
long 454:3,15
 455:8
longer 452:17
 453:12 454:4
 491:10
lot 473:19 485:14
 522:22 538:26
loved 440:4
low 465:13 483:5
lunch 453:26
 454:1,24,26
 491:6,11
lying 513:22
 514:9

M

Madam 417:5,7
 455:16
made 418:8
 424:19 426:24
 437:10,13 438:2
 447:6 450:20
 452:6 457:2
 469:5,23 478:21
 480:19 481:4,7
 483:17 514:4,6,
 20 515:10 523:16

532:2,21 545:17
 548:9 552:16
maintain 470:18
 481:23 505:13
maintained
 442:17 482:20,22
majority 413:17
make 421:23
 423:25 427:3,14
 428:14 429:20
 431:25 437:15
 448:25 452:6
 462:13,25 466:8,
 17,22 495:8
 497:22 499:5
 503:6 505:6
 508:11,16 509:17
 511:17 513:14,26
 527:13,18 533:21
 536:13 539:16
 541:12,16
 544:13,22 545:5
 548:20 551:21
makes 424:18
 435:17 446:19
 527:22
making 416:20,
 25 432:12 445:23
 446:3 500:15
 505:22 511:23
 520:14 527:12
manage 423:12
management
 456:15
managing
 458:26 527:6
mandate 419:15
 423:17,18 434:26
 490:10 511:6
mandated 458:5,
 10 476:17 479:9
mandates 469:1
 479:3,7 490:11
 497:26 498:1,6,9
 503:11 506:24

508:17 513:6,11
 514:10,11 515:8
 518:11 526:17
 527:8,15 533:8
mandating
 478:21
mandatory
 415:12,16,26
 418:19 419:7
 424:7 488:23
 489:25 504:25
 506:7
manipulation
 410:22 411:3,5,
 20 412:7 413:2,6,
 7,9,12,15,16,19,
 20,21,23 414:1,4,
 7
manner 461:4
 520:26 521:9
March 448:4,8
 456:8 481:15
 494:10 524:15
Martens 409:11
 493:11
mask 422:18
 423:3,17,22,25
 424:11 437:10,
 23,26 438:6
 443:9,22 449:11
 451:17,19 467:7
 468:16 470:1,5,
 15 472:9 473:8
 474:26 476:7,19
 477:15,24 478:1,
 11 480:20,24
 481:4,25 482:10,
 14,15 483:8,9
 485:7 487:5,7
 496:20 497:1,12,
 18,21 498:13,25
 499:25 500:15
 501:25 502:20
 505:4,15,19
 508:12,19 509:1,
 7 510:18,25

511:1,18,23
 512:9,22 514:21
 515:11,14 516:6
 517:7 520:8
 522:10 523:23
 524:11 526:25
 528:8,18 531:20
 534:16 547:26
 548:10,17
masked 418:11
 446:7 461:7
 467:19 472:24,26
 473:3 481:17
 482:24 500:21
 523:1
masking 415:12,
 16,26 418:12,19
 419:7 423:12
 424:6,7 443:24
 446:1,4 448:13
 451:8 459:10,13,
 14,23 461:5,8,17,
 19 462:6 464:17
 465:1,9,15
 467:16,22 468:4
 472:12 478:5
 480:16,20 481:3,
 8 482:16,21
 483:1,10,18,21
 486:20 496:22
 499:23 500:18
 504:26 505:11
 506:7,25 512:12
 531:10,23,26
 532:4,6,14,20
 535:17 536:26
 537:2,17
masks 470:9
 478:21 483:24
 484:1 498:11
 506:21 507:3,9
Masters 456:11
mat 451:14
matter 478:25
 495:13 517:6,13
 526:11 538:18

matters 416:19
 471:2 518:15
Maxston 408:8,
 12,18 409:16
 410:20 424:14
 426:14 431:25
 432:14,23
 435:10,17 437:5
 441:5,7,13,18,20,
 23,24 442:24
 443:2,3,14,17,21
 444:17,18,21,26
 445:8 448:9
 449:12,16 452:22
 453:3,8,21,23
 455:2,18,23,26
 456:1,4,18 457:4
 462:15,17,25
 463:1 471:24
 472:2 474:3,6
 484:13,15
 485:19,20,22
 486:6,8 487:20,
 23 491:1,17,18,
 23 493:17 502:13
 503:6 504:11
 519:2 523:24
 525:7,10 526:4,6,
 7,8 528:12,16,20,
 23,26 529:6,8,13,
 16,20 530:4,14,
 16 531:1,8
 535:22,26 537:3,
 5,7,26 538:4,10
 539:3,13,26
 540:12 541:1,3,9,
 13,21 542:3,6,26
 543:2,5,8,16
 544:6,11,16,20,
 24 545:18 546:4,
 14,15,17,26
 547:20 549:3
 550:6,18 551:7,
 16,21 552:10
Maxston's
 503:20 545:2

meaning 434:22
472:18

means 411:21
463:3 490:9

meant 411:24
426:20,22 434:13
446:16 468:20
517:1 548:2

medical 458:7
460:2,11 468:10,
14 469:25 478:13
482:11,16 483:11
485:6 486:3
487:2 498:18,20,
24 499:3 500:1,9,
15 512:9,13,18,
21 513:5 514:7,
20 515:10,21,24
516:4,20 517:10,
13 520:7 527:12
533:1

medically 483:25
498:16 512:10
514:21 516:5
517:6

medication
487:4

meets 424:18

member 409:10,
11,12 420:12,14
421:1 425:7
451:13,22 458:24
466:10 478:2
479:10 488:11
489:9 493:10,11,
12 494:21 500:22
518:10 523:21
524:5,13 532:16
548:6

member's
468:21 478:2
531:23 533:16

members 421:8,
10 424:23 425:2
436:25 446:24
447:12,14,21,25

449:5,14,24
450:9,17,18
451:4 455:4
456:19 457:10,11
458:11,23 462:14
466:21,24 467:6
474:1 477:9
479:8 488:15
490:11,13,15,20
495:12 501:3
514:25 515:18
525:23 527:9
533:11

membership
473:17

memory 437:18
475:1 530:22

mental 422:19
478:6 482:11
487:8

mention 453:11
465:9 483:20,23,
24 509:20 534:20

mentioned
425:21 444:5
464:5 465:12

met 418:7

metre 465:19
467:18 472:9,25
473:6 482:22

metres 414:8
446:7 451:20
461:20,23 505:13

metropolitan
459:12

middle 534:6
538:2

mind 429:17
450:4 479:12
535:20

mingle 481:19

minimal 446:14

minute 456:1
462:13

minutes 441:13,
15 449:21 453:4,
7 459:16 460:4
473:18 476:22
503:25 525:8,9,
15,18 533:15
549:14

misconduct
489:17 547:9,14,
18 550:20

misheard 551:14

misquoting
514:8

mistake 487:21,
22

**misunderstandi
ng** 509:5

modalities 411:2,
6 461:22

modality 505:5,7

moment 417:9
473:11

months 518:4
521:10 524:24
545:3 550:1

moot 440:12

morning 408:5
409:5,24,25
410:3,6,13 456:4
491:21 538:23
543:4 551:6,9,11
553:5

mortuary 438:22

mouth 462:4

move 433:4,10
531:1

moving 491:19
503:22

Municipal
423:13

municipalities
443:23

musculoskeletal
410:23 412:8

413:2,13 414:21

mute 453:18

N

N-O-T-E 487:14

necessity 532:10

needed 478:10

negative 426:12

negatively
477:19 478:2

Nelson 409:13
493:13

nominate 466:20

non-optional
511:14

noncompliance
501:17,19,20
509:19 512:24
515:22 527:17
533:17

noncompliant
512:16 513:6,19
515:25 521:1,9

noon 454:1

note 482:11
485:13 486:15
487:10,14 507:12
516:11,12,20,24,
26 517:2,4
518:22 520:3,14

noted 487:16

notes 441:9 554:6

notice 438:21
471:26 473:13
522:5,8 531:14
534:22 535:2,9
537:22,23
549:10,13

notices 444:8,11

notify 458:23

number 440:25
463:21 469:24
470:10 534:3

535:8

numbered

469:22

O

oath 410:8

obituary 438:18
439:1

object 435:10
443:1,12 502:14,
17 519:4 523:24
539:2,3 543:21
545:4,5 546:26
549:4 550:12

objected 502:16

objection 435:4

objections
483:20

obligated 430:20
431:3 433:12
434:18 435:7
502:2,7,10

obligation
511:10,11 532:11

obligations
432:19 446:17
489:7

obligatory 511:7
observing 465:18
473:6

obtain 470:2
478:10

occasionally
514:1

occupied 456:6

occurred 437:7
480:2,8 539:22
542:16

occurs 527:17
537:13

offer 413:8

offered 412:25

office 425:17
470:11 485:5,10
521:19 522:8
524:6

Officer 471:26
472:15

Official 409:21
493:22 554:15

one's 540:9

onset 494:12

open 457:16
463:7 538:10,14

opened 458:21
463:21 550:23

opening 463:1
523:17 536:12

operation 471:22

opinion 416:18,
19 428:9 448:16
498:20,24 499:7
502:19,22,23
503:1,5 504:10

opinions 498:18

opportunity
437:2 441:18
450:8 452:20,23
481:25 510:11
539:4,5

oppressive
419:15

option 511:13

optional 479:4
488:11 490:5

options 412:24
458:25 461:22
488:17

oral 521:21

order 419:26
420:6,8,10,12,26
421:4,9,22 422:5,
7,11,17 459:9,19,
20,24,25 460:1
469:26 470:8
471:6,26 472:13

473:15 482:13,19
483:12 521:18,
21,22,25,26
522:26 532:5
535:8,19 542:23
552:11

ordered 470:2

orders 422:17
423:6,14 443:21,
24 456:24 459:3,
5,8 463:17 464:4,
21 469:22
470:13,24 481:10
520:9 521:13,15

organization
418:25

organize 441:9

original 524:16

originally 451:7
465:6 477:14
480:16

osseous 413:7

outcome 449:4
537:20

outline 486:8

outlined 467:7
486:4

owner 472:18

P

pages 479:21
554:4

paid 418:10
470:12

pandemic
415:13,25
418:15,20 419:4
421:6,18 422:23
423:2,16,23
437:12 442:17
443:8 444:5
448:11,21 456:25
460:16,20,22
461:1,2,11,18

462:2 463:18
467:17 468:3,6,
18 477:25 478:20
481:6,10,15
482:4,8 488:13
498:12 503:11
504:16 505:12
512:16 517:11
521:1,10 526:20
527:6,7 535:16

panic 544:4

paragraph
459:17 460:1
463:2,3,12,23
467:24,25 468:8
469:14 472:16
474:16,22 475:26
476:22 479:14
519:16,21 522:7
534:6 535:2,3
549:12,16

paragraphs
476:20

paramount
416:24,25
417:23,25,26
425:16 431:9
447:5

paraphrase
446:9

Pardon 448:7
538:9

part 425:2,4,10
426:3 440:15
442:9,18 443:26
444:4 451:3
457:10,14 460:26
461:8 466:20
471:12 473:24
489:22 494:25
495:4,11 503:14
506:4 521:3
522:16 530:13
531:11,14 539:7
548:26 549:1

parties 491:25

past 452:16

path 449:10

patient 416:3,21
417:6,12 425:6,9,
17 426:2,7 427:3,
13,15 429:5,6
433:16,19

434:14,16 442:5,
22 445:20 446:6,
20 451:19 461:7,
19 462:6 467:22
469:25 470:3,4
472:10 478:3
490:3,5 494:20,
23,25 495:3,8,11
498:14 500:22
505:14 524:17
535:6 549:21

patient's 416:7
417:16 425:13,16
431:8 497:18
498:10 506:13

patients 410:23
413:22 414:8
415:5,11,18,22
416:10,23,25
417:3,23 418:2,
13,16 423:2,9,11,
12,17,18,21,25
427:7 428:1,25
430:14,17 433:25
434:3,6,10 442:1,
3,11 443:3,9,10,
16,19,22,25,26
444:2,3 445:24
446:11 458:7
460:12 461:26
462:5 467:20,23
468:23 470:19,22
472:24,26 477:19
478:4,7 480:22
482:10,24 483:1,
15 489:20 495:24
497:12 498:26
499:24 501:26
505:18 511:1,18,

24 522:10 523:1,
22 524:2,9,10
526:10 534:17
537:17,24

pause 465:24
473:19

Pavlic 409:9
493:9

pending 548:25

people 415:2,9
439:13 440:8,10,
19 453:6 466:21
467:17 476:14
482:25 483:2,4
517:9

percent 430:16
447:12 464:26
476:12 507:14,
18,22,25 508:9
531:13

percentage
508:2

perfectly 431:14

perform 411:13

performance
446:15

period 524:14

permanent
505:6

permit 466:9
467:2 469:19
505:23 511:17
512:2 518:20
520:19,25 534:9,
14 539:8 548:25

permitted 522:9
539:8

persisted 477:18

person 439:23
470:11 481:13
511:18,25 522:10
523:22 524:10

person's 496:26
497:1

personal 423:26
424:3 428:9
436:6 439:9,12,
15,16,17 450:15,
22 468:16,21
497:2,3,7 504:21
509:17

persons 469:26
473:7

perspective
417:23 424:23
425:18 426:1
428:17 432:26
495:20

phone 414:5
437:22 438:5
448:3,20 449:9
514:5 522:13

phrase 474:17
490:6 552:12

phrased 445:4

phrasing 431:26

physical 410:22
411:3,24 412:7
413:9,12 414:12
422:19 431:11
470:13 473:6
481:23 482:19

physically 414:8
505:18

physician 520:1

picking 490:20

pictures 471:8
477:4

pieces 436:20,22
437:1

PIPA 436:25,26

place 439:7
440:13,15 442:12
461:1 470:1
471:10 505:2,16

plan 411:9 473:9
491:26

plans 445:21

played 542:4

plexiglass
461:14,15 465:21
467:15 476:26
477:4 524:5
537:18

PM 470:7 471:1
492:7 493:24

point 435:18
450:23 467:21
486:14 490:25
499:11 534:10
543:3,13 544:4
545:3 551:19
552:13

point's 545:16

pointed 504:10,
11 543:6

points 479:24
480:1 482:2
486:4,9,15
487:19

policies 457:9
498:5 526:20

policy 424:17

pose 489:18

posed 446:4
496:19 497:1
526:25

position 431:11
456:7 494:9
497:22 500:9,24
501:3,10 503:3
514:24 532:3
546:5 552:10

positive 426:12

positively 470:21
471:14

possession
438:23 472:3
544:18

possibility
499:21 547:9

possibly 502:20

potential 517:18

potentially
447:22 513:25
517:14

PPE 419:15,22
424:3 444:4
451:2 461:5

practice 415:21
416:26 419:17
421:8 423:24
427:9 430:21
431:4 433:13,24
434:2,9,11,12,19,
24 435:3,8
446:12,13,14
447:25 448:13
449:6 451:6,7,16,
23 457:9 458:1
460:21,24,26
461:3,10 463:17,
18 464:5 466:9,
10 467:2,6 468:5,
23,25 469:19
475:10,14 479:6
482:6 488:2
489:4,19 490:11,
13,18 495:10
497:26 498:1,5
500:18,20 502:3
505:4,10,22
506:24 508:17
510:24 511:6,16
512:2 513:7,12
514:10 515:9,26
517:12 518:20
520:19,26 521:7
522:9 526:17,19,
20 527:8,15
528:8,18 532:15,
21 533:8,10
534:9,14 535:12
548:18,24 549:18

practiced 425:21
510:23 521:9

practicing
420:15 436:11
437:11,23,26

438:6 447:5
468:26 532:15,17

practitioner
413:4 418:7
430:19 433:18,
20,21 446:6,17
472:8,22 473:2
478:12

practitioners
413:15 416:14
418:10 424:8
442:13 446:1,15
447:12 452:8

precise 529:7
530:14

prefaced 437:24

prefer 454:10,11
491:10 544:1,2

preference
546:10

pregnant 451:16

prepare 525:21
539:18

prepared 544:23

prescript 442:16

presence 452:16

present 450:4
479:19 480:5
528:3

presentation
427:15

presented 482:2
488:3

presently 550:23

press 432:17

pretending
428:15

pretty 441:21
525:11 546:22,23

prevent 472:25
479:11

preventing
446:26

prevents 520:8

previous 459:24

previously
408:6,16 410:11
481:2 494:3

primary 410:21
411:4,16,18,21
412:8,15,17

413:3,8,10
415:11,20 424:15
427:10 439:13
442:2 456:24

principle 425:1
428:7,18,20
445:15 494:16,17
495:15,17

prior 448:10

453:5 481:3
494:12 535:5
549:20

priorities 427:8
428:2 446:11

prioritize 427:6,
26 446:10

prioritizing
418:16

priority 424:15
495:20

private 456:15
459:10 508:20,22
509:3,21 531:21,
23,25 547:21
548:1,4,10,11,13

problem 432:11

procedurally
539:8

proceed 449:1
476:8,18 508:18
547:4 548:21

proceeded 449:9

proceeding
464:11 479:12
517:20

proceedings
409:1,23 492:7

493:1,24 553:7 554:5	progressed 478:15	478:3 482:9 499:20 503:4 540:25 541:24	456:15 458:9 460:25 461:1,4 466:8 467:6,7 469:20,26 470:1, 8 471:26 472:15 473:4 475:15 476:3,6,16 483:12 493:12 494:17,21,26 495:1,4,8,11,13, 16,21 496:11,12 498:26 499:4 500:14,26 501:12,15 506:18 508:15 511:20, 21,22 512:15 517:22 518:9 523:21 524:5,13, 16 527:5,11 534:15,20 548:16	<hr/> Q <hr/>
process 455:25 467:3 505:2,16 528:7,17,23 529:3,5,9,22,24 530:6,8,17 544:14 548:26 550:3	prohibited 527:21	provided 410:22, 25 412:1 421:10 423:6 436:18 440:18 447:14 449:8 460:9 466:23 471:8 472:5 476:24 477:4 481:25 483:14 484:20,21 486:2,17 487:2 490:2 499:23 519:23,26 521:6 533:11 540:2 547:1	QC 409:16 493:17	
produce 414:26 538:14	prohibiting 489:19	providing 413:6 420:19 424:12 431:12 432:6 433:18,19,21 445:22,23 447:17 461:7,19 500:22 549:22	qualified 416:16	
produced 414:15,24 439:2 540:9,10	proposal 545:8	province 459:11 554:8	qualify 537:2	
profession 428:21,25 429:11,14,16 434:24,25 436:23 440:20 446:24 447:1,2,4,8,10, 21,22 450:18 451:12,13 460:23 466:21 479:8 490:19,24 495:18 500:22 502:9 515:18 532:6	propose 491:16 546:21	provinces 447:23	quarter 453:6	
professional 420:19 429:7 456:10 458:8 490:7 508:23 547:9,14,18 548:8 550:20	proposed 504:6	Provincial 423:13	question 412:6,7, 18,21 413:1 415:24 420:25 422:2 425:15,19 427:24 429:1,21 430:7 431:6,8,17, 19,23 432:2,4,5,8 433:9,26 434:4 435:13,15 440:13 442:25 444:16 445:6,9 446:9,26 448:2 449:20 450:10,19,25 453:23 458:11 463:24 484:16 486:7 488:18 489:3,17 498:22 499:10,13,21 501:7 502:16 503:8,12,17 504:6,9,13 514:22 515:20 526:9,23 527:10 528:7,12,15,25 529:20 530:3,11, 15,21 534:12 535:3,23 537:6 540:4,8,21 542:2 549:10,11 550:6, 14	
professionals 458:5 460:11 512:19 513:5 515:24	protect 415:18 447:5 461:4 475:15 495:12 511:21,22 526:10	provision 425:5 426:22 446:21	question's 445:3	
professions 411:14 413:18 420:15 421:2 429:10 436:12, 17,21 448:1 452:9 457:7,21, 26 458:15 489:15 497:25 523:8 549:1	protecting 424:24,25 425:2 428:19,20,24 429:13,15,16,17, 18,24,25 430:8,9 458:8 467:19 494:17 495:16,17	proximity 461:25 467:6,23 472:25	questioned 522:13 545:21	
	protection 418:6 424:14 427:7 428:1 430:4 450:22 451:5,12 495:21 518:9	public 409:12 415:17 418:6,24, 26 419:2,6,9,10 424:15,20,23,24 425:3,7,10 426:3, 5,8,17,19,21,24 427:4 428:19,22 429:5,10,12,15, 17,24,25 430:7,8, 9,18 443:26 446:2,4,18,20,26 447:6,12,14	questioning 452:23 502:16 539:25 542:25 544:4	

questions 408:9
410:17 425:20
431:13,18,19
432:12,13,19,23
435:16 437:5
441:3,5,10,21
442:8,18,26
444:19 449:12,
15,22 450:3,5,6
452:13 456:20,
21,26 457:5
459:2 462:8
469:10 470:19,22
471:11,15 474:15
483:4,19 488:14,
20,24 489:1,5
491:2,8 503:9
519:4,6 525:5,19,
25 530:10 531:4,
5,7 537:15 538:2,
3,4,26 539:2,15,
21 540:6,16
541:4,5,6,15,23
542:14,15,17
543:6 545:23
546:8,19,22
551:14
quick 444:15
449:21 450:20
541:15 547:2
quickly 474:5
quote 419:14
quoting 464:26

R

raise 545:1,22
550:15
raised 437:17
444:26 445:5
530:6,13 546:24
ran 454:18
rate 464:25
476:3,10,13
507:12,17,22,25
531:14

rate's 508:9
rates 531:14
re-asking 445:6
Re-cross-
examines 408:19
547:6
re-direct 539:11
re-examine
540:20
Re-examines
408:8,18 441:23
526:7
re-going 528:14
re-occur 504:5
re-opening 461:9
522:8 535:12
re-re-direct
539:14
reach 488:16,20,
25 505:3
reached 450:23
reaching 466:11
read 420:9,10,24,
25 422:18 463:24
467:25 468:9,13
472:17,23 474:23
475:12,23,25
476:1,23 477:21
478:8,14 479:15,
23 485:2 486:1
487:15 519:17
520:6,11 534:7,
11,12 535:4,8,10
536:12,14,16
549:16,19
reading 417:10
421:16,23,24
520:6 534:4
ready 451:23
453:10,19 543:19
realistic 426:20,
23 454:20,23
realistically
448:23

reason 425:14
488:5 508:6,8
510:9
reasonable
478:16 491:13
reasons 465:9
483:7,8 485:6
491:12 545:25
recall 444:7
445:15 465:23
549:13 551:23
recalls 510:14
receive 426:21
434:14 446:19
471:2
received 419:9
438:18,24,26
439:19 462:18
463:5,16 464:9,
18 473:15 477:6
478:23 505:8
516:3,8,12 517:4,
19 524:18,23
receiving 418:14
434:16 473:1
516:15
recent 452:14
reception 467:16
recess 441:14
449:21 503:19,23
525:22
recognized
411:12 413:17
recognizing
413:16
recollection
448:17,18 465:16
RECOMMENC
ED 493:24
recommendatio
n 452:7 490:23
recommendatio
ns 418:24 419:2,9

reconvene
441:13 525:23
543:25
record 450:12,15
455:15,20 509:25
530:3 551:25
552:3
recording 522:14
538:5,13,21
539:16 540:2,18,
23,26 541:7,14,
16,24 542:3,9
543:18
records 437:8
recovery 464:25
476:3,10,13
507:12,14,17,22,
25 508:9 531:13,
14
recross 546:22
recross-
examination
550:10
redirect 441:5,19
442:25 444:25
491:8 525:8
529:11,19
546:16,23,24
549:11
redo 543:9
reduce 430:25
498:13
refer 410:18
427:12 445:18
448:24 487:24
498:3 533:22
reference 410:19
445:14 460:18
464:6 474:18
530:12
referenced 484:9
524:19
referral 457:2,17
463:14 464:9

referred 450:8
462:19 486:9
488:5 520:14
521:13,26
referring 448:14
478:24 498:4
501:24 533:9
refers 463:2
468:7
reflection 474:12
refrain 432:8,20
refresh 475:1
530:22
refused 499:11,
25 506:18,22
507:2,9 531:9
refuses 509:18
regard 416:19
434:8 495:22
507:15
Registered
409:10,11
493:10,11
Registrar 418:3
425:23 428:12,17
434:7 462:19,20
463:14,15,26
464:9 474:19
475:21 479:18
488:16,19 489:3
regulate 423:18
443:19 468:24,25
regulated
420:12,13 421:1
446:23 450:18
458:5 468:20
490:10 515:18
518:10 531:22
regulating
424:22 447:25
regulation 437:3
457:25
regulations
512:11 526:17

regulatory 456:22 457:6,20	repeating 432:3	require 434:5 438:24,25 453:3 481:16 500:1 505:10 532:14 535:16	responded 481:22 506:11 531:21	revised 419:4
reiterated 481:26	rephrase 443:14	required 412:6 421:3 423:21 427:23 443:22,24 451:5,12 452:17 457:17 462:6 489:9 505:15 520:9 532:6	responding 445:1	reword 499:21
related 486:2	rephrasing 432:8	requirements 415:18 418:8 430:21,22 431:4, 5 433:13,14,24 434:2,8,19 435:8, 12 443:9 459:13 460:20 461:5,13 464:3,4 479:2 490:18 502:3,4 506:26 512:17 533:13	response 437:4 442:1 477:6 485:23 486:2 497:6 506:8 537:11 544:24 552:1	rightly 545:23
relating 460:20 462:9	replied 482:25	requirement 452:5,8 459:23 461:8 465:19 468:15 476:16	responses 431:26 452:14 486:17	rights 415:14,15 416:1,2,3,5,9,10, 13,17,23,24 417:1,2,11,14,23, 24 418:2,3,4,16, 17 424:7 435:9, 12,20 444:6 445:1,5,10 465:12 474:25 475:5,9 502:21 503:14 504:25 506:2,4 517:15, 16,18,25 518:8 529:21,22,25 530:7,12,18
relation 469:4	reply 499:17	requirements 415:18 418:8 430:21,22 431:4, 5 433:13,14,24 434:2,8,19 435:8, 12 443:9 459:13 460:20 461:5,13 464:3,4 479:2 490:18 502:3,4 506:26 512:17 533:13	responsibilities 458:20	risk 430:26 433:17 446:4,5 447:7 465:13 466:7 469:20 480:23 481:22 483:3,5,16 498:13 500:23 517:22 534:15,20 548:16
relationship 490:4	report 414:18 438:11 450:22 474:2,7,16 479:13,22,26 484:10,11 486:1, 13 487:13 522:19 552:2	requires 423:2	responsibility 415:21 416:4,11, 14 417:12 418:5 434:23 436:1,2 475:14	risks 448:21
relationships 489:20	reported 438:10 439:14	requiring 532:14	responsible 436:24,26 468:26	road 543:26 547:3
relaunch 473:9 532:5	reporter 409:21 417:7,10 455:16, 24 493:22 544:12 554:15	requisite 502:26	rest 437:11 473:16 543:26 553:3	Rockyview 439:20
relevant 533:2,5, 6 537:18	reports 414:17 439:22 440:18 451:4	rescind 522:5 534:22 535:2,9 549:9,13	restate 422:2	role 418:3 425:23 434:7 457:11,14 458:12,17 466:20 468:22 488:22 489:22,23 490:14 501:4,6 526:12, 26 527:13 528:2 531:11 533:12
relied 518:21 537:11	represent 446:14	rescinding 534:23	restating 430:7	roughly 484:21
religious 483:21	representation 447:13	resolution 505:3, 17	restricted 411:13	rules 538:12 545:10
rely 466:2 536:19	represents 446:22	resolve 489:4	restrictions 466:9 502:10 548:19	
remainder 453:14	reputation 428:20,25 429:5, 7,13,14,16 447:1, 2,4,7,9,16,24 495:18	Resources 456:13	result 433:24 434:2,5,9 440:4 449:11	
remember 444:10 445:17 476:11,12 484:21 507:19 508:3 509:15,26	request 464:13 466:4 467:1 469:5,12 471:9, 19 473:21 476:8, 19 485:10 505:22 506:17,26 512:2 516:16 517:5 518:13,19 520:18,23	respect 421:1 441:19	resume 454:1 551:5,6	
remembers 437:20	requesting 511:16	respond 485:9 548:15	return 421:8 460:25 461:3,10	
remind 410:1,4,7 552:6	requests 466:22, 25		review 419:7 423:10 444:12 456:24,25	
reminder 432:21 526:3			reviewed 419:4	
reminding 432:18			reviewing 419:17 538:15	
remove 510:11				
reopening 549:17				
repeat 433:26 501:8				
repeated 432:8				
repeatedly 432:18				

S			
sacrificing	554:3,14	sentence	463:13, 23 468:8 474:23 475:12,23,25 534:11
510:19	scientific	23 468:8 474:23	shorthand
safe	500:16	475:12,23,25	6
417:13 427:11	506:21 507:3	534:11	shortly
430:25 433:19	527:12 531:9	separate	484:23
434:16 442:19	scientist	428:23	show
445:22,24,25	418:21	467:20	415:5
447:5,18 451:18	419:6	separating	483:15
461:4	screen	467:20	shown
safeguard	453:9	September	414:15,22
511:20	screening	408:5,15 409:5	shows
safely	442:8,	410:2 493:5	450:13
447:25	18 470:18,20,22	553:7 554:9	shut
safer	471:11,15 483:4	series	460:23
427:11,12	screens	537:15	472:14
safest	504:4	serves	sic
415:21	searching	485:3	432:1 502:19
416:20 434:14	498:19	service	sign
safety	section	420:19	470:3
416:7,25	420:6,7,8,	services	significant
417:6,16 418:6	9,11,22,26 421:4,	450:22,	447:20 486:20
424:23 425:16	12,14,16,17,21	24 458:6 471:21	488:1
427:9,10,17	422:4,7,16	549:22	similar
428:22 429:5,6,	423:26 424:3	session	429:18
12,22 430:4,6,13	444:4 457:1,21,	408:5,15	459:26 462:3
431:9 433:16,25	25 458:6,14,19	409:5 410:5	526:23
434:3,10 446:20	459:11,22 463:2,	441:18 450:1	simple
462:6 476:6,16	4,9,21 464:13	493:5,25 504:3	501:7
495:1,3,4 496:11,	466:2,4,5,6	526:3 551:5	simply
12 499:4 506:13,	467:1,10 469:4,	set	433:11
18	12 471:18,19	431:10 434:23	499:8 501:1
sailed	473:21 475:7	435:2 453:4	531:7
539:5	476:8,18 502:20	457:8 458:2	Sir
Salem	504:22,23 506:16	527:5 535:12	416:9
482:18	518:12 520:18	549:18	sit
484:8,12,19	526:26 532:13,	setting	437:11,23
485:23 486:2,5,	15,18,21 536:2,3,	411:10	438:6
17 487:2,7,19	11,19 537:12	Settings	site
516:3,22,25	549:19	420:18	472:6
517:1 520:1	seek	severe	situation
Salem's	415:4	496:3	415:19
476:21	seeking	severity	416:7 417:17
484:17 485:10,17	416:18	440:21	426:11
516:19 518:22	seeks	sexual	situations
scenario	545:12	489:16,19	460:24
511:23	sees	share	skill
Schaefer	469:25 483:2	450:9	554:7
552:15	self-regulating	shield	skip
Schaefer's	490:24	470:5	467:24
552:1	self-regulation	477:17,24 478:11	479:21
Schumann	490:12	480:18 485:8	skipped
409:21 493:22	send	505:9 520:9	466:18
	470:26	534:16	skipping
	543:20 544:11	shields	485:25
	sense	419:20	slightly
	429:8	shift	491:10
	455:8,13 536:13	451:9	small
	538:25 545:21	ship	413:23
		539:5	426:3,8
		short-term	social
		549:26	459:10
			461:14 465:18
			470:14 537:17
			society
			427:1
			soft
			410:26
			solicit
			432:24
			somebody's
			434:15 436:6
			514:1
			son
			439:25
			481:12,16,18,20,
			21,22,24 482:4
			sort
			464:14
			478:10 506:23
			538:1 546:5
			sorts
			411:23
			sought
			483:13
			sounded
			546:2
			sounds
			442:14,15
			540:26
			source
			500:26
			501:11,17 540:5
			space
			473:4
			span
			543:17
			speak
			411:9
			416:12,16 423:9
			424:22 434:23
			436:22
			speaking
			423:5
			430:18 451:2
			speaks
			460:1
			specific
			414:22
			435:5 449:2
			530:12
			specifically
			416:6 417:16
			422:3 436:9,12,
			23 439:8 445:4,
			21 451:11 470:26
			473:23 507:19
			533:25
			spelled
			446:17
			spent
			447:18
			456:14
			splash
			419:20
			splitting
			433:5
			spoke
			417:6
			439:17 458:12

spoken 452:20
504:7

spread 472:11,26

spreading
483:25

staff 461:6,16
465:15 467:16,18
470:10,20 472:11
473:2,4 500:21

standard 419:17

standards
434:11,12,24
435:3 446:12,13,
14 457:9,13
458:1 463:17
464:5 468:4
479:6 482:5
488:2 489:18,25
498:5 500:17
511:8 513:19
517:12 526:19
533:10

STANDS 452:26
553:2

stars 486:13

start 410:3,5,16
423:5 454:10,11
455:10 464:16
491:4,20 493:26
494:24

started 451:2,4
452:1 494:9

starting 453:5
454:7,9

starts 477:14
519:21

state 498:9

stated 414:11
428:26 483:6
528:6

statement
411:19,26 438:2
441:25 471:5
473:16 479:14,23
534:5,18

statements 534:3

states 498:12
520:6

stating 511:5
516:4

station 473:3,5

statutes 435:25
502:8,9

statutory 415:14

stay 453:18

stays 424:1 470:8

step 489:4

steps 463:19
464:2,20

stop 465:24
480:19 481:8
483:17 511:18,24
532:15,16

stopped 482:16
540:21

strategy 461:9

struck 540:15

studies 414:17

study 414:18

subject 420:11
541:21 543:7
548:25

submitted 415:1
512:1 550:17

substance 530:3

succumbed
439:21

sufficient 534:14

suggest 540:1
543:24 546:4

suggesting 544:8

suggestion
490:23

summarize
477:11

summer 451:14

support 506:7

supposed 472:21
501:4 515:17

survival 464:25

suspect 491:14

suspend 505:22
512:2 516:16
517:5

suspended 449:6

suspension
466:4,8 467:2,4
469:18 471:19
476:19 511:16
518:20 520:18
532:18 534:8

suspensions
532:16

switch 484:7

sworn 455:23

symptoms
442:14 470:21
471:14 477:16,18

system 410:23
412:8 413:13

T

table 408:1
546:12

tail 474:21 538:2

takes 487:3

taking 415:17
455:18 463:19
464:2,20 475:11

talk 459:15
476:20 488:16
507:12

talked 413:7
419:18 448:2
459:9,10,11,14,
25 466:1 470:10
471:17,18 475:6
476:10 480:15
481:10 482:23
488:7,9 507:11
532:19

talking 425:25
429:4 454:2
456:25 482:5
496:16 504:23
507:6,7 508:14,
20 509:6 532:24
533:7 548:13
550:11

talks 457:25
458:21 459:22
472:17

tape 546:8

taught 411:7

Telehealth
414:11,14,21
505:6 510:23

telephone 531:19
538:6

telling 513:10,15
514:1,6,13 515:5

template 473:9

term 413:18
498:3 501:20
512:23 533:9
553:1

termed 490:16

terms 457:1
458:17 460:20
462:8 471:5,21
475:1 530:10
536:25 537:2
542:24

testify 510:5

testimony 440:16
448:19 450:2
452:16 453:13
454:2 488:8
492:3 538:15
552:24

tests 486:22,25

theoretical
489:17

thing 442:9
450:13 458:10
466:3 471:20

519:26 540:24

things 410:17
419:19,21 429:2,
4 430:5 436:23
447:19,21 449:10
454:5 465:26
476:21 503:22
511:3 519:20
525:20 545:26
549:4

thinking 426:11
455:6 488:12
519:5

thinks 499:5
530:21

thought 454:20,
23 474:24 475:8
477:18 478:20
483:24 484:1,3
499:23 501:6,11
502:19 511:2
513:2 515:13,21
517:25 518:5
540:19 542:19
550:3

Thoughtexchange
450:8,10,14

thoughts 454:6,9
503:18

threat 430:17
496:3,5,6,10,18,
19,25 497:1,18,
21 498:10
526:24,25

threat's 496:6

threats 430:12
495:23 496:1,7,9,
11,12,13,15

threshold 527:26

throat 487:6

Thursday 410:18
414:11,14 415:8
419:14 422:14
424:14 425:21
437:4 444:7,24

445:7 450:20
tickle 487:5
till 454:26 482:17
 546:12
time 416:8
 417:18 418:12
 419:23 421:21,26
 422:4 423:13
 427:11 429:7
 430:17 433:9,19,
 22 437:14,26
 439:6 441:1
 442:20 443:22
 449:4 451:4
 452:10,18 453:15
 454:19 455:11
 460:7 464:22
 465:10 467:8,15
 469:17 471:20
 472:8 478:9,15
 481:14 483:13
 484:15 491:5
 517:8 518:8
 522:24 524:14
 530:13 534:10
 543:17,18
timelines 453:22
times 424:13
 429:6 443:23
 445:11 461:7,26
 473:3 481:23
 499:10 500:21
tissue 411:1
today 440:25
 454:9,20,24
 485:5 491:13
 497:13 524:15
 540:3 551:5,6
 552:24
today's 411:21
Todd 408:6
 410:11 479:18
told 437:9 440:7
 475:4 482:3
 507:22 512:8

tomorrow
 454:10,12
 455:11,14 491:21
 538:15,23 539:15
 543:4 544:5,7
 546:10,13 551:6,
 9,11 552:9,11
 553:5
top 424:15 444:12
 479:23
topic 544:3
touching 413:22
trained 411:12
 413:5,8 498:16
transactions
 481:19
transcribe
 544:10
transcribed
 542:5,9 543:18
 554:6
transcript
 408:21 437:17
 509:12,24 522:13
 535:24 538:5,13,
 18,21 539:11,17
 540:2,8,18,23,25
 541:7,14 554:1,4
transcription
 543:19 544:2,23
 545:6,13
transmission
 418:13 446:5
 462:1 498:13
treat 415:5
 458:22 505:18
 511:2 522:9
treated 463:20
 470:4
treating 414:20
 472:24 497:12
 498:26 501:26
 511:1,18,24
 523:22 524:9
 534:17

treatment
 410:25 411:2,6,9,
 11,18,21 412:24
 413:8 415:11
 442:3 445:21,24
 460:13 467:22
 468:17 473:1
 483:13
treatments
 411:24
triage 442:10,13
Tribunal 408:9
 409:7,8 410:5
 412:23 419:24
 435:16 449:15,24
 450:2,6 452:21,
 24 455:3 456:18
 462:13 466:17
 474:1 477:9
 488:4 493:7,8
 503:9,23 514:23
 521:6 525:13,19,
 23 527:22,25
 528:4 533:20
 538:11,14 539:23
 540:14,20,24
 541:24 543:25
 545:10 548:20
 551:15,26
trick 501:9
triggered 517:14
true 428:6
trust 419:8
truth 412:4,5
 513:7,10,15
 514:2,7,9,14
 515:5
truthful 507:22
 512:26 513:3
turn 410:9
 455:22 459:1
 484:14
type 539:17
types 442:3
 466:22 476:21

488:20
typically 413:25
 415:4 552:17

U

ultimate 435:15
 503:9
ultimately
 469:16 533:16
unable 422:19
 514:21 515:11
 517:6
undated 477:6
understand
 412:22 425:14
 429:19 456:5
 483:2 515:2,4
understanding
 459:7,20 460:19
 461:24 478:7
 491:20 551:24
understood
 412:26 501:10
undertake
 472:19
unfair 539:8
ungovernability
 490:6,19
ungovernable
 490:7,16 515:15
University
 456:12,14
unmasked
 483:16 535:6
 549:21
unnecessary
 484:6
unpaid 470:12
unprofessional
 489:14 527:19
 533:17
unqualified
 537:4

unreasonable
 482:9
unsafe 434:6
 475:13
unusual 538:17
utilize 411:12
utilizing 536:1

V

varying 482:2
VERBAL 544:24
version 422:26
 423:5 504:20
versions 422:24
 423:1,20 424:2
 504:18 542:10
versus 429:24
Videoconference
 409:1 493:1
view 438:17
 467:26
viewed 438:15
 439:2
violating 475:10
violation 467:26
 468:1 474:25
 475:5 502:20
virtue 503:2
visits 472:6
vital 425:2
volunteer 470:12

W

wait 462:13
Wall 409:18
 420:7,13,20
 421:15,21 422:4
 437:6,9,20 438:1
 448:4,11,20
 449:8 454:9
 455:8 460:6,8
 462:9,23 463:16,

19 464:7,10,14
 467:21,26
 468:11,15 469:8,
 24,25 470:2,4,10,
 16,18,21,23
 471:8,14 472:7,
 18,21,22 474:19
 476:9,24 477:3,6,
 12,14 478:23
 479:16,18 480:2,
 4,14,15 481:5,24,
 25 482:3,6,13,15,
 23 483:1,6,10,17,
 20 484:17,20
 485:4 486:19
 487:3,5,7 488:9
 493:19 497:11
 498:25 500:14
 501:12 505:21
 506:1,6,25 507:1,
 21 508:8,11,21
 509:1,11,20
 510:17,26
 511:17,23 512:2,
 8 513:6 514:5,13
 515:4 516:4
 517:6,10,13
 519:23,26 520:7,
 25 521:8 522:9,
 13,20,21 523:1,
 21 524:2,4,14,17,
 24 525:2 527:11
 528:9,10 529:5,9,
 24 530:16,23
 531:10,18,20
 532:2,14,19
 533:1 534:15
 535:5,11 537:9,
 16 545:11
 547:21,25 548:8
 549:17,20
 550:17,19 551:11

Wall's 432:1
 444:2,3 448:19
 454:7 469:19
 471:22 489:16
 501:1,23,24

507:8 511:16
 516:16 518:20
 520:19 521:18
 522:8 531:25
 532:9 534:9,13
 536:25 548:24
 550:21
wanted 428:14
 500:7 515:4
 545:22 552:6
wanting 540:15
warnings 449:8
ways 440:3
 451:17 500:4
wear 419:19,20
 423:2,17,22
 437:10,22 438:5
 449:11 452:8
 470:1,14 477:17,
 23 482:1 485:7
 487:5 508:12,19
 509:1 510:24
 511:18,23 514:21
 515:11,14 517:7
 547:26 548:9
wearing 422:18
 451:16 470:5
 472:9 474:26
 478:1,11,22
 480:24 482:14,15
 487:7 496:20
 497:12,18,21
 498:12,25 499:25
 500:14 501:25
 502:20 510:18,26
 512:9,21 516:6
 520:8 523:23
 524:10 526:25
 534:16 548:16
week 444:7 470:7
 471:1
weekly 471:3
weeks 439:19
 477:22 543:14,25
weight 528:5

Wesam 484:8,12
wife 439:18
window 458:23
withdraw 516:16
 517:5
witness's 519:7
witnesses 547:3
 551:8
wondering
 487:17 498:17
word 413:14,20
 429:22 430:6
 433:6 437:18
 439:16 459:26
 497:11,15,16
 498:7 507:10
 544:7
worded 433:3
wording 509:14
 530:12
words 411:17
 418:5 427:18
 434:22 435:4
 464:24 506:4
 522:20 530:2
 532:13
work 415:2,9
 435:19 441:26
 472:20 473:5
 508:15 513:26
worked 472:12
workers 512:12
 517:10
working 462:3
 473:2,4 481:13
Workplace
 420:17
works 410:15
worthy 513:24
write 474:6
written 470:3
 471:1,2 486:2,17
 520:22 521:14,22
 522:26 550:2,4

wrong 428:2
 448:5
wrote 474:9

Y

year 418:9 448:4,
 6
years 430:19
 456:14
young 481:21

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

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	September 8, 2021	Morning Session	558
6	Discussion		559
7	DR. CURTIS WALL, Sworn, Examined by Mr. Kitchen		559
8	Mr. Maxston Cross-examines the Witness		611
9			
10	September 8, 2021	Afternoon Session	631
11	Discussion		632
12	DR. CURTIS WALL, Previously sworn,		635
13	Cross-examined by Mr. Maxston		
14	Discussion		720
15	Mr. Kitchen Re-examines the Witness		724
16	Mr. Maxston Re-cross-examines the Witness		732
17	Mr. Kitchen Re-examines the Witness		733
18	The Tribunal Questions the Witness		735
19	JARVIS KOSOVAN, Affirmed, Examined by		737
20	Mr. Kitchen		
21	Discussion		741
22	Certificate of Transcript		746
23			
24			
25			
26			

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

EXHIBITS

Description	Page
EXHIBIT H-7 - Response to Curtis Wall Re - Vaccinations	635

1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 September 8, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:03 AM)

24 THE CHAIR: Good morning everybody. We
25 will start this morning with Mr. Kitchen's examination
26 of Dr. Wall, and before we do that, we will have

1 Dr. Wall sworn by Karoline.

2 Discussion

3 MR. MAXSTON: Chair, it's Blair Maxston. I
4 have a quick housekeeping matter to attend to from
5 yesterday. When we concluded our -- if I could just
6 deal with that very briefly -- when we concluded our
7 discussion yesterday, there was a discussion about
8 whether the Complaints Director would seek to have the
9 recording of the interview entered and placed before
10 you. I have received instructions from Mr. Lawrence to
11 not to do that, so that won't be placed then before
12 you.

13 THE CHAIR: Okay, thank you for clarifying
14 that.

15 DR. CURTIS WALL, Sworn, Examined by Mr. Kitchen

16 MR. KITCHEN: Just to confirm, everyone can
17 hear me.

18 Q MR. KITCHEN: Dr. Wall, you can hear me?

19 A (NO VERBAL RESPONSE)

20 Q Good. Dr. Wall, just to confirm, can you give us your
21 full name for the record?

22 A Curtis Wall.

23 MR. KITCHEN: My fault, I apologize. Like I
24 said, I think we can make this work; I'm just going to
25 have to be diligent.

26 Q MR. KITCHEN: Now, Dr. Wall, when did you

1 first become a chiropractor?

2 A I attended Palmer College of Chiropractic in Davenport,
3 Iowa, and I graduated with a Doctor of Chiropractic in
4 1996.

5 MR. KITCHEN: Now, I apologize, I notice
6 that produced some feedback as well, so if this
7 continues, we might have to devise a separate way of
8 doing this, but I'm going to just keep trying it a
9 little bit longer. I had no way to really to test this
10 prior to doing this.

11 THE CHAIR: Mr. Kitchen, would it help if
12 there was maybe a couple of seconds pause between the
13 end of your question and Dr. Wall's replying? I gather
14 you're muting after you've spoken?

15 MR. KITCHEN: Yes, so that's what we're
16 going to try to do is have more of a time lag in
17 between each one. Just give me a second. Okay.

18 Q MR. KITCHEN: I'm just going to confirm,
19 because of that issue, it was, in fact, Palmer College
20 that you went to?

21 A That's correct.

22 Q All right, and, Dr. Wall, tell me why did you choose to
23 go to that particular college amongst all the
24 chiropractic colleges you could have gone to?

25 A That could be a long drawn-out answer. I'll give you a
26 few of the salient points. I have a Bachelor of

1 Religious Education degree from a Canadian college, and
2 in order to attend a Canadian chiropractic college,
3 CMCC, I would have needed to take quite a few more
4 credits in the social science end of things, and so I
5 began looking at American colleges to attend because
6 they did recognize my social science credits from the
7 college I had attended in Canada.

8 And also I went to a chiropractor who had gone to
9 Palmer College in Davenport, Iowa, and my wife attended
10 a -- went to see a chiropractic who also went to Palmer
11 College in Iowa. Another chiropractic friend, who --
12 whose practice I actually purchased, attended Palmer
13 College in Iowa. And so all those recommendations to
14 attend Palmer were the reasons why.

15 And Palmer College in Davenport is considered a
16 fountainhead. It was the original college that was
17 started by B.J. Palmer. And so it has a very strong
18 reputation for academic excellence, strong in
19 philosophy, the philosophy of chiropractic, so the
20 science, philosophy, and art were very strong
21 components of Palmer College. So those are some of the
22 specific reasons why I attended Palmer.

23 Q Thank you. Now, I heard you mention the philosophy of
24 chiropractic, which is interesting. I don't know that
25 I would have expected to hear that word. Can you just
26 elaborate a little bit on what the philosophy of

1 chiropractic was when you went there?

2 A Quite basically, I would say that the philosophy of
3 chiropractic is based on the fact that the body has an
4 innate ability to heal itself and that the nervous
5 system is a very strong component in the body's healing
6 capabilities.

7 At times, there are interferences to the nervous
8 system through spinal misalignments, and so the
9 chiropractic adjustment just removes those
10 interferences and helps the body to heal itself in a
11 manner.

12 And so those are some of the philosophical
13 understandings. Innate intelligence, the body was
14 created or made with an ability to heal itself, and so
15 yeah.

16 Q Thank you. Were there any core principles of
17 chiropractic that were taught to you when you were at
18 Palmer?

19 A Yes, core principles, basically stated what I was just
20 referring to, some of those principles being that the
21 body has innate intelligence, that there is a science
22 component to chiropractic. So that core understanding
23 is that the body is physical, and that, at times, we do
24 have spinal misalignments that interfere with the
25 nervous system and that chiropractic, through an
26 adjustment, can remove those interferences and help the

1 body to heal in a natural way.

2 Q Thank you. Now, let's back up a little bit. Why did
3 you want to become a chiropractor in the first place?

4 A Excuse my long answer. My initial intention with a
5 career path was to become a youth pastor. In the
6 process of doing that, my wife and I spent four years
7 in lay work in a church doing youth ministry work.

8 And in so doing, I was working at the University
9 of Calgary in the phys. ed. department, and I played
10 quite a bit of squash at the time. And at one point, I
11 was playing squash, and I ruptured my achilles tendon.
12 That put me in the hospital, and while I was in the
13 hospital for surgery, a friend of mine, a very close
14 friend of mine was in his first year at Palmer College
15 of Chiropractic in Davenport, and he sent me a
16 prospective student packet.

17 And I looked at that packet while I was in the
18 hospital, and I said to myself I wish I could do that.
19 I was very much interested in health, natural healing
20 processes, lifestyle choices. And I looked at that
21 packet, and I thought I would love to be a
22 chiropractor.

23 And all I can say is that the pieces of the puzzle
24 were being put together very specifically and
25 amazingly, which I won't go into detail, but that
26 unfolded the desire to pursue becoming a chiropractor,

1 and there's so much to the story, but, yeah, that's
2 basically how I got into it.

3 Q Thank you. Do you feel like then that chiropractic is
4 more than a mere occupation for you?

5 A Yes, I thoroughly enjoy what I do. I thoroughly enjoy
6 the privilege of helping assist people in their health
7 care goals. Yes, it is an occupation, but I love
8 coming to work. I love coming to work to help people
9 and to assist people in lifestyle choices, and the
10 basic understanding of removing nervous system
11 interference so that their bodies can carry out health
12 in the best possible way, so, yes, it is more than an
13 occupation, but that is one component of it.

14 Q Thank you. When did you first start practicing as a
15 chiropractor in Alberta?

16 A I first started practicing in Alberta in 1996, shortly
17 after graduation, perhaps early '97. I saw a few
18 patients in a colleague's office, began that way, and
19 then I started doing locums for a year or two, and then
20 I purchased a practice in 1998.

21 I had a young family. I decided that perhaps that
22 was a better way to go to have a patient base to start
23 with, and so in 1998, I purchased a practice, and
24 that's how I've practiced ever since.

25 Q When you started practicing in Alberta, did you think
26 the chiropractic profession in Alberta held to the same

1 principles emphasized at Palmer College when you went
2 to Palmer College?

3 A Yes, generally I would say so, yes.

4 Q When it comes to those principles, do you think things
5 have changed here in Alberta since then?

6 A I have seen, over the last 20 years, a slow but steady
7 change in chiropractic. I've seen a stronger role of
8 governance from the College of less perhaps freedom to
9 do some of the things that some chiropractors would
10 prefer to do. I understand some of the reasoning that
11 the College uses to create some of these restrictions
12 perhaps or boundaries, but I have seen a steady
13 decrease in the ability to do certain things that
14 perhaps 20 years ago would not have been an issue.

15 Q Do you know roughly how many patients you've seen over
16 the years that you've been a chiropractor?

17 A Very hard to tell, but several thousand for sure,
18 multiple thousands, yeah.

19 Q Wow. Okay, do you have any patients that you have been
20 treating for many years or even decades?

21 A Yes, yes, I have several patients that have started and
22 stayed with me right from the beginning, so up to 25
23 years, yes.

24 Q Now, let's go to the spring of 2020. Were
25 chiropractors ordered by the Alberta Government to stop
26 practicing in March of 2020?

1 A There were, yes, restrictions on our ability to
2 practice. We were told that we could only practice if
3 the situation was an emergency, and so that was a
4 regulation by the College to restrict only those people
5 who had an emergency situation.

6 Q And did the restrictions only come from the College, or
7 did they also come from any other sources?

8 A I believe the College placed that restriction in place
9 due to Alberta Health Services. I'm sure they worked
10 in collaboration with each other, so that's my
11 understanding.

12 Q And what was it like for you during that time that you
13 could only treat emergencies?

14 A Very challenging. My -- I support my family strictly
15 through chiropractic, and I have a large family, many
16 needs, and so when that happened, essentially my
17 practice load went just about to zero, and I perhaps
18 might see a patient in a day, maybe not. Some days
19 were blank for sure, but, yeah, it was a stressful
20 time.

21 Q Do you have any sense of what it was like for your
22 patients during that time?

23 A I had several people say that it was difficult because
24 they needed care, they needed to receive an adjustment
25 to relieve their discomfort or their ailment. And so,
26 yeah, many people were certainly -- had to wait, had to

1 wait it out or take painkillers or some other thing,
2 but, yeah, it was challenging for everybody I think.

3 Q And were you permitted to -- or were chiropractors
4 permitted to re-open and start practicing again?

5 A Yes, I believe -- I can't remember the exact date, but
6 I believe it was sometime in May that that occurred.

7 Q And did the College implement a directive in May that
8 imposed extra requirements for chiropractic practice
9 related to practicing under COVID?

10 A Yes, they did.

11 Q And do you recall the name of the document, and this is
12 in the record, but I'll ask you anyways, do you recall
13 the name of the particular document that contained all
14 these requirements and restrictions?

15 A It was called the Pandemic Practice Directive.

16 Q Thank you. And I'm just going to call it the Pandemic
17 Directive. Did the Pandemic Directive contain a
18 requirement that chiropractors wear a mask?

19 A Yes, it did.

20 Q And do you recall specifically what types of masks were
21 mandated in the directive to be worn?

22 A Yes, it would have been a surgical style mask, so the
23 blue type of mask, not a cloth mask, no homemade
24 materials, a surgical mask.

25 Q Now, we've heard a lot about how the Pandemic Directive
26 was not optional. Did you regard the Pandemic

1 Directive as optional?

2 A No, I did not.

3 Q Okay, thank you. Now, did you start wearing a mask
4 while treating patients once you became aware of the
5 mandatory mask requirement in the Pandemic Directive?

6 A Yes, I did off and on. It was very apparent to me
7 right from the start when I put on a mask that I did
8 experience mental concerns, and so -- but I did put the
9 mask on to treat patients, again off and on. It was
10 very quickly that I realized my mental concern.

11 Q And just to confirm, the Pandemic Directive at the
12 time, so this is spring of 2020, May of 2020, did you
13 have to wear the mask all the time, or was there only
14 certain times that you had to wear it according to the
15 directive?

16 A According to the directive, we were supposed to wear a
17 mask at all times unless we kept the physical distance
18 barrier of 2 metres.

19 Excuse us, sorry, we forgot to lock the door.

20 Q Now, I'm curious, did you have any prior experience to
21 regularly wearing a mask?

22 A None whatsoever.

23 Q So you didn't have any prior experience with being
24 required to wear a mask then, I take it?

25 A That's correct.

26 Q Now, did you eventually stop wearing a mask while

1 treating patients, and by that, I mean being within 2
2 metres of them?

3 A Yes, I did. Probably by the end of June, I made the
4 decision that, with my mental concern and limitation, I
5 decided that it was not productive for me to continue
6 wearing a mask, and so I did stop by the end of June
7 2020.

8 Q And did you try wearing a face shield after you stopped
9 wearing a mask?

10 A Yes, I actually went out and purchased a face shield to
11 see if that was also a problem, and when I put the face
12 shield on, I also experienced the same symptoms. And
13 so, yes, I did purchase a face shield and tried that
14 for several times.

15 Q Now, why was it that you decided to try that as opposed
16 to just taking off the mask and leaving it at that?

17 A A face shield, I would think, provides a little more
18 breathing room and space, and so that was my reasoning
19 behind that, and so that's why I went to the face
20 shield.

21 Q Did you attempt to -- at that time, did you attempt to
22 obtain a doctor's note that would provide you with a
23 medical exemption to wearing a mask?

24 A No, I did not.

25 Q Did you think there was any requirement that you do so?

26 A No, I didn't.

1 Q Did you understand the Pandemic Directive to include
2 any direction about reaching out to the College if you
3 were having problems with wearing a mask?

4 A No, I didn't see anything in the directive that stated
5 that. I initially -- my thought was that my health
6 information is private, between me and my doctor, and
7 so I didn't decide that that was privy information to
8 discuss with anybody at the time.

9 Q Did the College give you any reason to think that it
10 would be supportive and work with you if you had
11 reached out and told them your concerns about wearing a
12 mask?

13 A No, they did not. Of course, the College is always of
14 the stance that we should reach out if we have concerns
15 and -- but on the same note, from my calls with
16 Dr. Halowski and with Mr. Lawrence, it was apparent to
17 me that, even as I expressed my concerns, there was no
18 option with respect to the mask wearing.

19 Q Dr. Halowski mentioned an email that you had written to
20 him I think just a few months before all this. Did you
21 ever receive a response to that email?

22 A No, I did not.

23 Q Did that contribute to your apprehension about whether
24 or not the College would be supportive?

25 A Yes, it did. In fact, in addition to sending an email
26 to Dr. Halowski, I sent an email to a trusted, tenured

1 chiropractor, whom I've known for 30 years, and the
2 response I received back was also very vague and
3 disheartening when I expressed my concerns in that
4 email. So I was reluctant that the College was going
5 to have any, you know, understanding with my situation.

6 Q During this time, in the spring of 2020, did you have
7 some doubts or fears about the College penalizing you
8 or punishing you for what was going on?

9 A Yes, I did.

10 Q Did you think in the spring of 2020, so around this
11 time, that the so-called surgical or blue or medical
12 masks were effective at preventing the transmission of
13 respiratory viruses such as the COVID virus?

14 A I had done my own research, and it's not -- again, I
15 don't want to say that this is my word, this is
16 research that I -- as doctors, we all look into various
17 research, and so having researched this issue with
18 respect to masks, yes, I did have some very strong
19 concerns that they were effective at reducing the
20 transmission of viral particles, specifically COVID in
21 this situation, and I also had concerns about their
22 health risks to the person wearing them.

23 Q So you started being concerned about what you just
24 called the health risks right away then?

25 A Yes, I did.

26 Q And can you describe for me what some of those health

1 risks are?

2 A Specifically, when one wears a mask, there's decreased
3 oxygen that you're taking in, and there is an increase
4 in carbon dioxide intake. And whether perceptible or
5 not, these physical facts are certain, and, at varying
6 degrees, people will experience symptomatology, so,
7 yes, I'm very aware of these physical issues.

8 Q Now, have you, since the spring of 2020, developed any
9 other concerns or personal objections to wearing a
10 mask?

11 A Yes, I have. I would say that I do have religiously,
12 sincerely held religious beliefs that would preclude me
13 from wearing a mask. Specifically, I'm a Christian,
14 and that means that I am a born-again follower of Jesus
15 Christ. And as such, I adhere to the teachings and
16 requirements of the Holy Bible. And in Genesis 1:27,
17 it states that: (as read)

18 God created mankind in his own image, in the
19 image of God he created them, male and female
20 he created them.

21 So I believe that, number one, my face is sacred and
22 sacred to me and sacred to God, because it is -- it's a
23 manifestation of his image. So for me to cover up my
24 face, essentially places a barrier between me and
25 Jesus.

26 And for someone to require me to wear a mask,

1 who's in a position of authority, when there's no other
2 reason to put that mask on other than the fact that
3 they are telling me to, when I don't exhibit any
4 symptoms or any upper respiratory issue, to me, is
5 essentially fearing man and not God, and so that's one
6 aspect of it.

7 Also, as a Christian, I believe that I am to live
8 my life in the fullest measure and expression of faith.
9 And just to clarify that, I just want to read a couple
10 of, again, passages of the Bible that support my
11 religious conviction. Hebrews 11:6 says: (as read)

12 And without faith, it is impossible to please
13 God: for whoever comes to God must believe
14 that he exists and that he rewards those who
15 diligently seek him.

16 The 2nd Corinthians 5:7 says: (as read)

17 For we walk by faith and not by sight.

18 And Romans 14:23 says: (as read)

19 For whatever does not proceed from faith is
20 sin.

21 And so when I have to wear a mask, I am not living by
22 faith; I am living because someone in a position of
23 authority has told me, Put that mask on, whether it's
24 fear-based or whether it's for some other reason, it
25 violates my life of faith, and so that's one of the
26 aspects of my religious convictions.

1 Also, I would have to clarify to say that the
2 Canadian Charter of Rights and Freedoms and the Alberta
3 Human Rights Act protect my expression of my
4 religiously held beliefs, and it guards against anybody
5 discriminating against those beliefs, and so that's
6 kind of all wrapped up into that section.

7 Q Thank you. Why do you think it took you time to come
8 to that conclusion instead of that being instantly
9 apparent?

10 A Sometimes you don't know the significance of an issue
11 until or the significance of a freedom until it is
12 taken away, and this would apply in this situation.
13 Until our freedoms have been -- our health freedoms
14 have been slowly chipped away, you don't realize what
15 it is that you have or the significance of it, and so
16 that's how I would answer that question. It took some
17 time to formulate that and to recognize, listen, this
18 is going on.

19 Q Had you ever in your life before this thought about
20 masking or mandatory masking in the context of your
21 religious beliefs as a Christian?

22 A Never.

23 Q You just never had any reason to; is that it?

24 A That's correct.

25 Q Do you think mandatory masking interferes with bodily
26 autonomy?

1 A Yes, I do when it's mandated. I believe that, as a
2 chiropractor, I have been and we have all been trained
3 to respect the principles of, first, do no harm and the
4 principle of informed consent; extremely important
5 principles that we are required to carry out in our
6 profession every day.

7 So mandatory masking does violate those things.
8 Specifically, the College has never performed informed
9 consent to the issue of mask mandating, and this is a
10 medical procedure, wearing a mask is a medical
11 procedure because there is an imminent risk of mental
12 or physical harm by putting the mask on. And so I
13 believe that, essentially, the College has violated
14 that aspect of informed consent and the right to bodily
15 autonomy and, first, do no harm.

16 Putting on a mask harms me, and it harms my
17 patients. And so as a doctor, which means teacher, I
18 have to educate my patients; I have to tell them the
19 specific harms of a treatment, risks of potential
20 harms, and so that's all wrapped up in mandatory
21 masking. It's not following informed consent, and it's
22 not following, first, do no harm

23 Q Do you seek to obtain informed consent when you do your
24 treatments with patients?

25 A From every patient at the outset of their becoming a
26 patient, that is required, and if there's any changes

1 in treatment protocol or in their health picture, yes,
2 we have to keep informed consent updated.

3 And informed consent is not implied; it has to be
4 expressed, and so that's a very specific thing, it has
5 to be communicated. We have to say here are the risks
6 to this treatment, here are the benefits to this
7 treatment, and here are some alternatives that you can
8 do if you would like to investigate those. So these
9 are core principles for sure.

10 Q And are there some treatments -- generally speaking,
11 are there some treatments where the risks become quite
12 high and the benefits become quite tenuous, and there's
13 a difficult decision to make about whether you actually
14 proceed with that treatment?

15 MR. MAXSTON: Mr. Kitchen, I'm sorry to
16 interrupt, I've been a little bit liberal here; I think
17 you're asking some fairly leading questions --

18 MR. KITCHEN: Okay --

19 MR. MAXSTON: -- so I'm a little concerned
20 about that. Just thought I'd mention it.

21 MR. KITCHEN: That's fine. That one was ad
22 hoc, and it was a little leading, I'll admit. That's
23 fine.

24 Q MR. KITCHEN: Do you think wearing a mask
25 also impacts psychological illness?

26 A Yes, I do. It can.

1 Q I'm going to take you to -- talk a little more about
2 your patients. When you stopped wearing a mask, how
3 did your patients react?

4 A Most of my patients never said a thing. They were very
5 understanding. I would express to several patients,
6 who did ask me if I would be wearing a mask, that I did
7 have an exemption. And I would say 99 percent of those
8 patients were very understanding and unconcerned, and
9 there was the odd person who requested, you know, more
10 information, and if I was at liberty to discuss that, I
11 would. But, yes, 99 percent of my patients were
12 unconcerned and were okay with my not wearing a mask.

13 Q So for those who wanted more information, was there any
14 kind of discussion about why you weren't wearing one?

15 A Yeah, I -- for somebody that I felt in a trusted
16 position, I would talk about my mental concern, but
17 others, I would just, you know, give a very generalized
18 answer.

19 Q Why do you think so many of your patients were so
20 understanding?

21 A My patients know who I am. They know my character.
22 They know who I am as a chiropractor, that I believe in
23 their health. They trust me with their health. They
24 trust me as somebody who understands the health
25 process. And so I believe that it was a doctor/patient
26 trust relationship that enabled people to feel

1 comfortable and to understand that they were coming
2 into an office that was safe, and there was no risk of
3 harm from them by me not wearing a mask.

4 Q Now, let's jump forward six, seven months to December
5 of 2020. Did AHS close down your chiropractic office?

6 A Yes, it did.

7 Q Now, I'm going to take you and everybody else to that
8 closure order, which is Exhibit D as in dog, D-1. Now,
9 was there a CMOH order that was specified in that
10 closure order?

11 A Yes, there is.

12 Q And which one was it?

13 A That is CMOH Order 38-2020.

14 Q Now, I'm going to come back to all the things that
15 happened in December, but let's forward to early
16 January; did AHS permit your chiropractic office to
17 re-open?

18 A Yes, it did.

19 Q And was that done through another document that
20 rescinded the closure order?

21 A Yes, it was. I had to complete a re-opening template
22 and meet some of the requirements that were specified
23 with that template.

24 Q Okay, so I'll bring you to that notice; it's Exhibit
25 D-2. Now, did AHS permit you to continue treating
26 patients in person without wearing a mask?

1 A Yes, they did.

2 Q Did you provide AHS with a doctor's note verifying your
3 medical exemption from wearing a mask?

4 A I believe I did.

5 Q And why did -- looking at this rescind notice, why did
6 AHS permit you to practice without wearing a mask?

7 A I believe they recognized the doctor's -- the medical
8 doctor's note and decided that was sufficient grounds
9 to permit me to treat patients.

10 Q You said earlier that it was CMOH Order 38-2020 that
11 was mentioned in the closure order, so I'm going to
12 take you to CMOH Order 38-2020. Just got to get the
13 exhibit number. 38-2020 is Exhibit D-8. Now, I know
14 we've been over this, but let me ask you is there
15 anything in that order that provides for medical
16 exemptions to wearing a mask?

17 A Yes, there is. Yes, there is.

18 Q All right, let's go back now to December. Did you hear
19 from the College in early December?

20 A Yes, I did.

21 Q Did you receive a call from the Registrar, Todd
22 Halowski?

23 A Yes, I did.

24 Q And did Dr. Halowski say anything in that call about
25 how a decision may be made that you either wear a mask
26 or sit out from practicing?

1 A Yes, he did.

2 Q Did you receive a call from the Complaints Director,
3 David Lawrence?

4 A Yes, I did.

5 Q And did he say anything in that call about suspending
6 your licence?

7 A Yes, he did.

8 Q Did you ask him any questions about accommodation?

9 A Yes, I did. I asked him, I said I knew the College was
10 in a difficult place because of their desire to protect
11 the public, and I also said but they also had a role in
12 protecting its members; and so I discussed my mental
13 concern, that I was exempt, and left that on the table
14 and asked if there would be accommodation for that.

15 Q Did you mention anything about human rights?

16 A Yes, I did.

17 Q Did you say anything to him about how the literature
18 does not support wearing a mask?

19 A Yes, I did.

20 Q What was Mr. Lawrence's response when you made that
21 comment about the literature?

22 A I believe his response was that he didn't want to
23 debate me on the issues. He felt he just had a
24 responsibility to protect the public. He also said
25 that he disagreed with me, and he said that I was a
26 danger to the public and that he was going to initiate

1 this investigative process.

2 Q Did you say anything to Mr. Lawrence about the
3 percentage of the COVID recovery rate?

4 A Yes, I did. I stated that there was a 99.97 percent
5 recovery rate for people who were infected with COVID.

6 Q Did Mr. Lawrence say anything to you about making or
7 not making you wear a mask?

8 A Yes, he said he couldn't make me wear a mask, but that
9 if I was not going to wear a mask, he would have to
10 initiate this practice suspension, suspending my
11 licence.

12 Q And did Mr. Lawrence say anything to you about you
13 being free to not wear a mask?

14 A Yes, yeah, he said I was free to wear a mask, but there
15 would be the consequence, of course, of my licence
16 being suspended.

17 Q Did you understand this comment about "free" from
18 Mr. Lawrence to mean that the College's masking mandate
19 was actually optional?

20 A No, this mandate was not optional.

21 Q Do you think "mandate" and "optional" are contradictory
22 terms?

23 A I don't know the answer to that.

24 Q Did Mr. Lawrence say anything to you about your private
25 life or what you do in your private time during that
26 call?

1 A No, not to my knowledge. I can't remember him talking
2 about me and my private life or what I do with that.

3 No, I can't remember that. I don't think he did.

4 Q Now, after talking to Mr. Lawrence, did you feel like
5 you were free to decide whether or not to wear a mask?

6 A No, I did not feel like I was free. I felt that there
7 was a very strong arm of the College that was about to
8 step in and stop my practice.

9 Q And was this call with Mr. Lawrence around December 3rd
10 or 4th?

11 A That's correct.

12 Q Did Mr. Lawrence submit a request to suspend your
13 licence?

14 A Yes, he did.

15 Q Now, you said earlier that you did not attempt, in the
16 spring of 2020, to obtain a doctor's note in support of
17 your inability to wear a mask. Did you now at this
18 time, in December, attempt to obtain a doctor's note?

19 A Yes, I did. It seemed that there was an unspecified
20 requirement from the College that verification of a
21 mental or physical limitation or concern was required,
22 and so I did try to obtain one at that time, yes.

23 Q When you first told Mr. Lawrence that you had a medical
24 exemption, did you have doubts about whether or not he
25 believed you?

26 A M-hm, yes, I did have doubts.

1 Q Did you end up receiving a medical note from a medical
2 doctor regarding your inability to wear a mask?

3 A Yes, I did.

4 Q And do you recall when you received that?

5 A I can't remember the exact date in December, but
6 sometime after December 5th.

7 Q It's an exhibit in the records, so I could give it to
8 you to refresh your memory about when, but is it your
9 recollection that you provided this note to him before
10 Dr. Linford made a decision about Mr. Lawrence's
11 request?

12 A I can't remember the exact timeline, but, yes, I
13 believe it was before, but I'm unclear on the specific
14 dates.

15 Q Were you at all surprised that Dr. Lawrence forged
16 ahead with the request even though you gave him this
17 medical note?

18 A No, I wasn't surprised. Dr. Lawrence was very clear
19 that his role was to protect the public and that he
20 needed to initiate this process, and so, yeah, he was
21 going to do that, and so I wasn't surprised.

22 Q Did you feel like your medical concerns mattered at all
23 to the College?

24 A No, I didn't feel like they mattered.

25 Q And what actually were your medical reasons for not
26 being able to wear a mask?

1 A When I put on a mask, I experience feelings of anxiety
2 and a sense of claustrophobia, like somebody's cutting
3 off my air supply. And so what that does is it
4 decreases my concentration level, and it makes it
5 difficult for me when I am treating patients and
6 note-taking to maintain proper concentration and
7 provide the best possible care to my patients, and so
8 that specifically is what my mental concern was.

9 Q And were those things reflected in the medical
10 documentation you received from the doctor that you
11 saw?

12 A Yes, that was reflected in that doctor's note.

13 Q Now, of course, there's this original note from
14 Dr. Salem. Did the College ask -- I shouldn't say the
15 College, forgive me. Did the Complaints Director,
16 Mr. Lawrence, did he ask for further details from
17 Dr. Salem?

18 A Yes, he did.

19 Q And did Dr. Salem provide those?

20 A Yes, he did.

21 Q Was a decision made regarding Mr. Lawrence's request to
22 suspend your practice permit?

23 A Yes, a decision was made.

24 Q And who made that decision?

25 A I believe Dr. Linford had to make that decision.

26 Q And as part of Dr. Linford's written decision, did he

1 consider your medical note from Dr. Salem?

2 A Yes, he did.

3 Q So then were you permitted by Dr. Linford to continue
4 practicing without wearing a mask?

5 A Yes, I was permitted. There were further conditions
6 and restrictions placed on me at the time, but, yes, I
7 was permitted.

8 Q Did the College ever raise the possibility of you
9 practicing without a mask but with conditions?

10 A Yes, it did, after Dr. Linford's decision came out.

11 Q What about before?

12 A No, there -- no.

13 Q Let's just talk a little bit about your office. Have
14 you had any staff at your office since the spring of
15 2020?

16 A Yes, I employ members of my family in my office
17 occasionally, and so, yeah, my son was working in the
18 spring of 2020 up until December of 2020.

19 Q How old was he at that time?

20 A He was 17.

21 Q And as of December, just before he stopped working with
22 you in your office, was he wearing a mask when he was
23 working in your office?

24 A No, he wasn't.

25 Q And why is that?

26 A He has religious concerns and beliefs that preclude him

1 from wearing a mask.

2 Q Are those similar to yours?

3 A Yes, they are.

4 Q Yesterday, Mr. Lawrence read into the record as part of
5 his testimony that you did not tell him, during the
6 January 25th, 2021 interview, that you had any other
7 reasons that you did not mask. Did you tell
8 Mr. Lawrence you had other reasons for not masking
9 besides your issues with anxiety and claustrophobia in
10 that interview?

11 A I don't believe I did. Yeah, I'm unclear, but I don't
12 think I did.

13 Q And you had by now, by January 25th, you had made some
14 conclusions about your religious beliefs around
15 masking?

16 A Absolutely.

17 Q So why didn't you tell Mr. Lawrence about those beliefs
18 during that interview?

19 A I believe that the primary issue was my mental concern
20 and limitation. The religious beliefs are very strong,
21 but I didn't believe that that was to come into play at
22 the moment, so I left it at the mental concern, because
23 it appears to me, from the CMOH order, that the only
24 real exemptions that are provided are through physical
25 or mental concerns or limitations.

26 Q Just want to ask you a few questions about the

1 treatments you provide your patients. What is the
2 standard treatment you provide your patients when they
3 come in to see you?

4 A The standard type of treatment that I provide is a
5 chiropractic manual adjustment. And "chiropractic" is
6 a term that means chiro, it means hand, and practice,
7 which means work done by hand, and so that is my --
8 from day one, that's been my primary form of treating
9 patients.

10 Q Forgive my ignorance as a non-chiropractor, but did you
11 just tell me that "chiro" means hand, and the reason
12 it's chiropractic is because "practic" is a reference
13 to practice, is that what you just said?

14 A Yes.

15 Q So the name itself means using your hands to treat the
16 body of another?

17 A That is correct.

18 Q What system of the body does this treatment intend to
19 impact or improve?

20 A That's a loaded question. There are many aspects to a
21 person's body, many different systems, and so
22 essentially when you adjust a person, you're physically
23 adjusting the skeletal structure, but there are
24 far-reaching implications to that, because in the
25 chiropractic philosophy and science aspect of it,
26 you're also removing nervous system interference, and

1 you're also causing soft tissues to perhaps relax and
2 come into better function.

3 So you're dealing with multiple systems of the
4 body, but you're primarily adjusting, you know, the
5 skeletal soft tissue component from an outward
6 perspective.

7 Q This treatment, this physical manipulation, is this the
8 primary form of care you provide?

9 A Yes, it is.

10 Q Can you provide this treatment from a distance?

11 A No, you cannot.

12 Q Can you provide it over the phone?

13 A I wish, but no.

14 Q Can your patients providing this treatment to
15 themselves?

16 A No, they cannot.

17 Q Are there any treatments you can provide your patients
18 that are as effective as manual manipulation that do
19 not require you to be within 2 metres of your patients?

20 A No, there is not.

21 Q Do you think Telehealth is effective?

22 A It may have its place, but it doesn't -- it's not
23 effective in my situation for what I do.

24 Q Do you think your patients find it effective?

25 A I haven't had a single patient tell me that they've had
26 a Telehealth experience or treatment.

1 Q Do you think you'd be properly caring for your patients
2 if you could only provide them with Telehealth?

3 A Absolutely not.

4 Q Do you think it likely that some of your patients would
5 eventually have to seek care from a different
6 chiropractor if you could only provide Telehealth to
7 them?

8 MR. MAXSTON: Mr. Kitchen, I hate to
9 interrupt, but the last two questions in particular
10 aren't questions; they're leading questions in my view.
11 I'm sorry to interrupt you, but I've raised this
12 concern before, but those are loaded questions, they're
13 not a regular question.

14 MR. KITCHEN: All right, I'll rephrase.

15 THE CHAIR: Mr. Kitchen, this might be an
16 appropriate time to ask you how much longer you
17 anticipate your examination will be in terms of a
18 possible break. We've been going for an
19 hour-and-a-quarter, and we'd just like to get an idea.

20 MR. KITCHEN: Well, I might be about
21 halfway, so a break would make sense to me. I'm pretty
22 sure I'm on track here to finish by the lunch hour, as
23 you can see, Dr. Wall is not a big talker. So I --
24 yeah, I think now is fine for a break, and we should
25 not be in any jeopardy of not finishing by the lunch
26 hour.

1 THE CHAIR: Okay, I think that would be a
2 good idea. So let's take a break. It's 10:14 by my
3 watch. Let's come back at 10:30, and we'll continue
4 with Dr. Wall's testimony. So we'll convene for now,
5 and we'll see everybody in 15 minutes.

6 MR. KITCHEN: Thank you.

7 (ADJOURNMENT)

8 THE CHAIR: Okay, we're back in session,
9 and, Mr. Kitchen, the floor is yours.

10 MR. KITCHEN: Thank you. We're having some
11 technical difficulties. Just bear with me. Let's turn
12 your mic on.

13 (DISCUSSION OFF THE RECORD)

14 MR. KITCHEN: Sorry, my apologies.

15 Q MR. KITCHEN: Dr. Wall, before the break,
16 I'd asked you if you think you were properly caring for
17 your patients if you could only provide Telehealth, and
18 you answered no, and then the next question was
19 objected to.

20 So let me ask you this: Do you think your
21 patients are receiving the care they need from you if
22 you're only providing them with Telehealth?

23 A No, they would not.

24 Q Do you think your patients would need to seek manual
25 adjustment treatment from another private chiropractor
26 if they couldn't get it from you?

1 A Yes, I believe they would.

2 Q How do you think your ability to keep practicing and
3 earning an income would be impacted if all you could do
4 was provide Telehealth?

5 A I believe it would be severely impacted. Again,
6 hands-on procedure for me is the primary form of care
7 that I provide. Patients would go elsewhere, and so,
8 yeah, it would be severely impacted.

9 Q Do you care about more than just the musculoskeletal
10 health of your patients?

11 A Yes, I do. I believe that a person is not just
12 physical, there is an emotional and spiritual component
13 to it, so if that's what you're referring to, but --
14 so, yes.

15 Q Thank you. Do you feel like you owe any other duties
16 to your patients other than a duty to provide good
17 adjustments to their musculoskeletal system?

18 A That's a very good question. I'm sure there are other
19 duties. I would have to give that some thought, but
20 that would be a primary duty is to provide safe and
21 effective chiropractic care to my patients, so yeah.

22 Q When it comes to treating your patients, are there any
23 principles that come to mind that are important to you?

24 A Again, I touched on this earlier, but the principle of,
25 first, do no harm is an oath that we take when we
26 graduate, become chiropractors, and so that

1 encapsulates the principle of we are to very cautiously
2 and carefully and thoughtfully examine what we are
3 doing with our patients and teach and instruct them,
4 you know, lifestyle issues, but -- so that's a primary
5 principle. And, again, the principle of informed
6 consent is also paramount when it comes to dealing with
7 treating our patients.

8 Q Do you think those principles are engaged when it comes
9 to masking or the masking of your patients?

10 A I believe they're engaged in my office, so, yes, I
11 instruct my patients. If I see there's a potential for
12 something to cause harm, many times I'll have to
13 educate my patients on that, and so yes.

14 Q Do you permit your patients to not wear a mask in your
15 office?

16 A Yes, I do.

17 Q Why?

18 A I believe everybody has the responsibility to make
19 their own health choices. Health freedom is very
20 important to me, and, again, that is a decision that
21 has to be between that person and their personal health
22 belief, personal bodily autonomy, and so that's an
23 extremely important aspect of how I treat my patients.
24 So, yes, everybody that comes in has the freedom to
25 wear a mask or not to wear a mask based on their
26 personal decision.

1 Q Do you feel like the College's stance regarding
2 mandatory masking has placed you in a difficult
3 position regarding your patients?

4 A A very difficult position, yes.

5 Q Do you feel AHS's stance on mandatory masking has put
6 you in a difficult position?

7 A It appears that the Alberta Health Services has left
8 some room for people who have physical or mental
9 concerns to exercise those concerns and not wear a
10 mask.

11 It appears that the College has no wiggle room for
12 that expression. If somebody has a mental or physical
13 concern or disability, yeah, there's no wiggle room for
14 the College when it comes to that and the members of
15 the College.

16 Q Does the College require patients to wear a mask?

17 A No, it does not.

18 Q And you've given some thoughts on masks, you gave some
19 thoughts back in the spring of 2020, and, you know,
20 you've given some religious objections, but have your
21 thoughts changed at all regarding masks in the last 18
22 months?

23 A No, they have not.

24 Q Do you think, if you did require your patients to wear
25 a mask while you treated them in your office, that you
26 would be causing harm to them?

1 A Yes, I do. I believe that wearing a mask does decrease
2 oxygen levels, increase CO2 levels, and that, again,
3 whether perceptive to that person or not, the physical
4 fact remains, and it's to the extent physically that it
5 imposes a real imminent physical harm and danger.

6 Q Have you read or heard anything, whether in this
7 hearing or before, that has caused you to change your
8 mind on the ineffectiveness of masks?

9 A No, nothing I've heard would cause me to change my
10 mind.

11 Q Let's just discuss your office a little more. Are you
12 aware of any instance where COVID was transmitted in
13 your office?

14 A No, I am not.

15 Q Do you think you ever put any of your patients at a
16 higher risk of contracting COVID than they would
17 otherwise regularly encounter by treating them without
18 wearing a mask?

19 A No, I don't. I am asymptomatic. I come to work; I
20 have to adhere to the very same prescreening questions
21 that all patients must adhere to.

22 When it comes to treatment, I treat patients one
23 on one. There is no one else in the office but that
24 patient and myself. And so, no, I don't believe that
25 there is an increased risk.

26 Q Have you ever treated patients while being symptomatic

1 with COVID symptoms?

2 A No, I have not.

3 Q Do you think you've done anything since COVID that has
4 in any way threatened the health or safety of your
5 patients?

6 A Absolutely not.

7 Q Do you think your actions since March of 2020 have
8 caused any harm to any of your patients?

9 A No, I do not.

10 Q Just a quick side question here, did you ever receive a
11 ticket for not wearing a mask, contrary to the Calgary
12 mask bylaw?

13 A No, I did not.

14 Q Do you think you are a health care worker?

15 A Yes, I do.

16 Q Do you think there are different types of health care
17 workers?

18 A Yes, I do.

19 Q Do you think health care workers fall on the spectrum?

20 A Can you explain that question?

21 MR. MAXSTON: Mr. Kitchen, I hate to keep
22 interrupting, but that's a fairly leading question, a
23 fairly leading couple of questions, "Do you think".
24 I'd just ask you to rephrase that. I know where you're
25 going, but I think the introduction presupposes an
26 answer.

1 Q MR. KITCHEN: Now, Dr. Wall, you said that
2 you do think there are different types of health care
3 workers. Please explain, in as much detail as you can,
4 what you think those differences are?

5 A I would say that there are emergency room doctors,
6 there are paramedics, there are pathologists, all could
7 be classified, there are chiropractors, naturopaths,
8 all could be classed as health care workers, facing all
9 kinds of different situations and treatments and
10 patient needs. So, yes, there is a very wide spectrum
11 of health care workers.

12 Q And how would you say, you as a chiropractor, how would
13 you say that's different than, for example, being a
14 doctor in an ER?

15 A Quite different in the sense that, number one, I'm
16 seeing people one on one, I'm seeing people who have
17 been prescreened in this last year-and-a-half, and I am
18 seeing people who are asymptomatic obviously. And I
19 would say that somebody in the ER, a doctor, is seeing
20 more emergency types of situations with significant
21 potential for bodily fluid contact and so on. So I
22 would say it's a much different experience than what
23 I'm doing in my office.

24 Q Do you think your chiropractic office is a health care
25 setting?

26 A Yes, I do.

1 Q Do you think all health care settings are the same?

2 A No, I don't.

3 Q Could you describe for me how you think the health care
4 setting in your office is different than the health
5 care setting of a hospital?

6 A I believe the setting in my office is much more
7 personable if you're looking at it from an emotional
8 component perhaps, so it's much more welcoming; it's a
9 homier feel; it's I would say much smaller; there's
10 less fear involved in my office compared to perhaps a
11 hospital or an ER setting.

12 So -- and I'm treating people with chiropractic
13 care; I'm not treating people for cuts and stitches and
14 broken bones and these types of situations, so I would
15 say there's quite a big difference.

16 Q Is making your patients feel comfortable really
17 important to you?

18 A Yes, it is; it establishes a sense of trust and, yes,
19 so people want to come to my office. It's a very
20 important part.

21 Q Do you directly treat infectious illnesses?

22 A No, I do not.

23 Q Do patients come to you for you to directly treat
24 infectious illness?

25 A No, they do not.

26 Q Do you agree with Dr. Halowski that, generally, as a

1 chiropractor, you don't see people with infectious
2 illnesses?

3 A No, people will have infectious illnesses. So I will
4 see people with infectious illnesses, but I am not
5 treating them for infectious illnesses. If I could
6 clarify that also.

7 Q Go ahead.

8 A That's not a norm; that's a very rare thing. And,
9 again, in the last year-and-a-half, we have to
10 prescreen people. So if they are exhibiting any
11 symptoms, we are not allowed to treat them; you have to
12 reschedule them. And so in this last year-and-a-half,
13 I have not seen anybody that has exhibited a
14 symptomatic infectious illness.

15 Q You mentioned "prescreening" a lot; is it your
16 understanding that prescreening is something that's
17 quite important to the College?

18 A Yes, it is very important.

19 Q Have you received any communication from the College
20 that indicates which is more important between
21 prescreening and masking?

22 A No, I have not.

23 Q I'm going to shift gears a little bit here. Do you
24 think it's possible to know the scientific truth about
25 things like viruses?

26 A Yes, I do.

1 Q Including COVID?

2 A Yes.

3 Q Do you think there's a large amount of scientific
4 information now available about COVID?

5 A Yes, a lot of information.

6 Q Do you think it's enough to actually make an informed
7 determination on whether or not certain measures are
8 effective at preventing the transmission of COVID?

9 A Yes, I do.

10 Q And would that include masking as a measure?

11 A Are you asking if masking is an effective measure at
12 preventing COVID?

13 Q No, I'm just wondering if you think there's enough
14 scientific knowledge to actually make an informed
15 determination on whether or not masking is effective or
16 not?

17 A Yes, I do believe that.

18 Q Do you think there's enough scientific information to
19 make an informed determination on whether or not
20 physical distancing is effective?

21 A Yes, I do.

22 Q Do you think there's enough scientific information
23 available now to make an informed determination on
24 whether or not masking as a restriction is harmful to
25 the health of individuals?

26 A There is enough information, yes.

1 Q Would you agree with Dr. Hu that COVID Public Health
2 restrictions have probably killed more people than
3 COVID itself?

4 A Yes, I would agree with that. Yes, I would agree with
5 that.

6 THE CHAIR: I'm sorry, Mr. Kitchen, I
7 missed your question; would you mind repeating it,
8 please.

9 MR. KITCHEN: Sure, yeah.

10 Q MR. KITCHEN: Dr. Wall, do you agree with
11 Dr. Hu that COVID Public Health restrictions have
12 probably killed more people than COVID itself?

13 A Yes, my answer is yes.

14 THE CHAIR: Thank you.

15 Q MR. KITCHEN: And just to confirm, do you
16 agree with Dr. Hu that the COVID survival rate is 99
17 percent?

18 A Yes, I agree with that.

19 Q Do you think the College is making scientific knowledge
20 the top priority when they make decisions about
21 restricting the behaviour of chiropractors?

22 A I believe the College thinks they have. I think they
23 have consulted with Alberta Health Services, and they
24 believe that they are using information that is
25 accurate, but I believe it is inaccurate. And there's
26 too much conflicting scientific evidence that comes

1 from very credible, credible sources that would
2 contradict the measures that have been put in place.

3 I am not a lone wolf stating some of those
4 scientific issues. These scientific facts come from
5 people much more knowledgeable and skilled to be able
6 to represent that information in their fields of
7 expertise, and so, yeah.

8 Q Well, in fact, some of those people are going to
9 provide expert testimony.

10 Do you find it surprising that the College seems
11 so unwilling to consider other viewpoints like yours?

12 A Not really, because I understand that our College is
13 regulated by the Health Professions Act, which has a
14 strong medical model, and there is a certain mindset
15 about how legislation is formulated. So I can -- I'm
16 not surprised by it, but I wish it were different.

17 Q Do you think Alberta Public Health has generally gotten
18 it wrong when it comes to masking?

19 A Yes, I do.

20 Q Do you think Alberta Public Health has generally got it
21 wrong when it comes to other COVID restrictions?

22 A Yes, I do, and I wouldn't say that's just my opinion.
23 As we know, that will be backed up by our expert
24 witness, and it is a testimony of so many others in so
25 many different fields, not only health care, but
26 emergency preparedness within the military, it's been

1 demonstrated that what has happened in the last
2 year-and-a-half has not followed the methods that would
3 be acceptable for an emergency situation such as COVID.

4 Q Do you think there is fear to challenge the perspective
5 of Government Public Health?

6 A Yes, I do. Fear is a very big motivator in this
7 situation, always has been. And in this situation,
8 yes, if you stand up to the Public Health authority or
9 your regulatory body, you risk -- you risk being
10 censured, you risk your licence being suspended, and
11 nobody wants that, nobody wants to experience what I'm
12 experiencing right now. There are other chiropractors
13 out there who believe as I do, but they are afraid of
14 being in my situation.

15 I am the -- I would say one of the least likely
16 people to be in this situation right now. From the
17 standpoint that, if I can say, I am a very compliant
18 person, generally speaking. I do not like to make
19 waves. I do not like conflict. But a barrier was
20 crossed, my health freedoms were crossed, and I have to
21 say something, and I know I'm not the only one. I know
22 there are many others out there, but they're afraid.
23 And so, yes, that is a very accurate statement: Fear
24 is a huge motivator to not step out.

25 Q Do you feel like, as a professional, you have an
26 ethical obligation to speak the truth?

1 A Absolutely.

2 Q You described just a few minutes ago COVID being an
3 emergency, did you think it was an emergency last
4 spring?

5 A It was put out that way, but, no, I did not think it
6 was an emergency.

7 Q Do you think it's an emergency now?

8 A No, I do not.

9 Q Is your integrity something that's really important to
10 you?

11 A Extremely important.

12 Q If you were told that there was going to be an
13 application to suspend your licence, why didn't you
14 just put the mask on?

15 A Well, number one, as I've said, wearing a mask causes
16 me anxiety and the inability to concentrate properly to
17 do my -- the best work I can. So that's reason number
18 one.

19 But I also understand it to affect my physical
20 health. I know there's -- there are physical
21 limitations and harms about putting a mask on, and so I
22 had to -- I had to go with a personal health choice and
23 freedom, bodily autonomy. No informed consent was
24 provided to me by the College, and I had to stand up
25 for those basic rights and freedoms.

26 Q Even though doing so might risk your licence?

1 A Yes, that's correct. I would emphasize character over
2 reputation.

3 Q Do you think the College has violated your legal rights
4 over the last year-and-a-half?

5 A Yes, I do.

6 Q Do you think the College's mandatory masking directive
7 is unreasonable?

8 A Yes, I do insofar as other mandates, orders have
9 allowed provisions for exemptions, and the Pandemic
10 Directive has not allowed for any exemptions.

11 Q Do you think you've done anything unethical by
12 permitting your patients to leave their faces uncovered
13 when you treat them?

14 A No, I do not.

15 Q Who do you believe you owe your first loyalty to?

16 A First loyalty is to my patients. It's -- that's who I
17 come to see every day, and they're my priority. And
18 so, yeah, my ethical and moral responsibility is to my
19 patients primarily, not to the College.

20 Q What about government?

21 A Well, the same would go for that. Ethically and
22 morally, it's first to my patients, and if there's
23 something I see from the government that violates that,
24 I have to speak up, and I have to stick to treating my
25 patients and treating them with the utmost respect
26 first.

1 Q Do you think you've done any unethical by not wearing a
2 mask yourself when treating your patients?

3 A No, I don't.

4 Q Do you have any concerns about the future of the
5 chiropractic profession in Alberta?

6 A Yes. I have spoken about this to my wife. Over the
7 last ten years, I have seen the steady increase in
8 regulatory control, which has a veneer of protecting
9 the public with decreased freedom for the chiropractor,
10 and I've seen it occurring, and so, yes, I do have
11 concerns for the chiropractic profession at this time,
12 yes.

13 Q Do you think increased freedom for chiropractors to do
14 lawful things is good for patients?

15 A Yes, I do.

16 Q Do you think if chiropractors were less constrained by
17 the College that they would be more likely to engage in
18 sexual impropriety with their patients?

19 A No, I don't. Somebody who's going to engage in sexual
20 impropriety, whether there are restrictions or not, is
21 likely going to commit that offence.

22 Q Why do you think the College has done all that it's
23 done to you since December of 2020?

24 A I understand the College has a responsibility to
25 protect the public, and that, again, is what they
26 consider to be their highest mandate over protecting

1 the rights and freedoms of its members. And so I
2 think, based on the legislation that has come down from
3 the Public Health and the collaboration that has
4 happened to create our Health Professions Act has
5 created a difficult situation for the College whereby
6 they cannot make this distinction between protecting
7 the public and protecting the rights of its members.

8 And it's a very fine line. I think there needs to
9 be some renegotiating that occurs to balance that out.
10 I am not against rules and regulations, but I believe
11 in this situation, there has been a line that has been
12 crossed, so ...

13 Q Do you think mandating that chiropractors wear masks
14 while treating patients is in any way actually
15 protecting the public?

16 A No, I don't.

17 Q Do you think the College is trying to protect the
18 public?

19 A Yes, I do.

20 Q Do you think the College is very concerned with
21 pleasing the Chief Medical Officer of Health?

22 A Yes, I do. Again, I believe that much that has been
23 collaborated with the Alberta Health Services and the
24 College of chiropractic has created this dynamic, this
25 relationship whereby the College does want to please
26 authority, and so yeah.

1 Q Do you think when it comes to COVID, there is a tension
2 between the desire to please government and the duty to
3 protect patients?

4 A Are you referring to the College or to myself?

5 Q I'll ask it again. Do you think, in the context of
6 COVID and when it comes to the College, there is a
7 tension there between desiring to please the government
8 and desiring to protect the interests of patients?

9 A I don't think I'd be able to speak to that because I'm
10 not part of council, I'm not part of those people that
11 make those decisions. That would be a tough decision
12 for me to say. I don't think I could say that.

13 Q I asked you earlier if you ever received a ticket for
14 not wearing a mask contrary to the Calgary bylaw; did
15 you ever receive a ticket for not wearing a mask
16 contrary to a CMOH order?

17 A No, I have not.

18 Q Do you think you've actually breached any CMOH orders?

19 A No, I don't.

20 Q Have your patients expressed any thoughts to you about
21 the fact that you have -- that you're not wearing a
22 mask?

23 A Did you ask have they expressed any concerns that I'm
24 not wearing a mask?

25 Q No, I asked if your patients have expressed any
26 thoughts about the fact that you're not wearing a mask

1 when you treat them?

2 A Yeah, I've had a few patients express their thoughts,
3 so we have engaged in some discussion, and there are
4 some people that believe in mask wearing, there are
5 some people that don't believe in mask wearing, and so,
6 yeah, I have definitely interacted with both sides of
7 the fence with respect to that.

8 Q Do you think the fact that masks are mandated in spaces
9 like chiropractic offices, do you think that interferes
10 at all with that, an attempt by you to create an
11 emotionally welcoming environment?

12 A Yes, I do. I believe when you cover the face with a
13 mask, you are taking away a significant portion of
14 communication ability. You're not able to read lips.
15 You're not able to see facial expression as well. And
16 not only that, your voice is muffled. So many times
17 you can't hear or distinguish what the person is
18 saying. So, yeah, it definitely creates a less
19 welcoming environment, an environment for potential or
20 greater misunderstanding between you and the patient,
21 and, yeah.

22 MR. KITCHEN: Thank you, Dr. Wall. Those
23 are my questions.

24 A Thank you.

25 MR. KITCHEN: Now, I note we're at 11:20,
26 which is a little early for lunch, so, you know, I

1 guess we'll have to hear from Mr. Maxston what his
2 thoughts are about his cross. I doubt he wants to
3 break it up with a lunch break, so -- but I'm very
4 flexible.

5 THE CHAIR: Okay, thank you, Dr. Wall,
6 thanks, Mr. Kitchen.

7 Mr. Maxston, what are your thoughts on next steps?

8 MR. MAXSTON: Well, I'm going to propose
9 this potentially: Maybe we take a break for 10 or 15
10 minutes. What I -- because I'd like to press on with
11 Dr. Wall in just one respect.

12 I've been making notes of the direct examination,
13 and I have questions arising from that. I wonder if
14 it's a good idea for me to try and get through those
15 questions now while Dr. Wall's testimony is fresh in
16 everyone's mind, and then -- and I hope I can do that
17 before lunch. And then at 1:00 or 1:15, whatever
18 works, then I would start my planned questions if I can
19 describe it that way.

20 I'm just a little reluctant to -- I think
21 Mr. Kitchen's nodding his head -- I'm a little
22 reluctant to start lunch at 11:30. Maybe I can make
23 some headway at least with Dr. Wall in a good way in
24 terms of asking those questions now. I just need a
25 little bit of time to prep for that and consult with my
26 client.

1 THE CHAIR: Okay, Mr. Kitchen, I'll take
2 your nodding as agreement with that approach, so --

3 MR. KITCHEN: Yeah, if we could just have 10
4 minutes, because we've got to work on the technology on
5 our end too, so ...

6 MR. MAXSTON: I think even 15 minutes to be
7 honest, yeah.

8 THE CHAIR: It's 11:20, let's recess until
9 11:35. We'll reconvene then, and Mr. Maxston can start
10 his cross-examination.

11 (ADJOURNMENT)

12 THE CHAIR: We're back in session, and,
13 Mr. Maxston, the floor is yours.

14 MR. MAXSTON: I just want to be sure, is
15 Mr. Dawson in attendance? I don't know if he's gone --
16 if he's activated his camera.

17 THE CHAIR: Okay, yeah, we were having a
18 caucus during the break, so he might be a minute or two
19 late. Thank you, I didn't notice that. Let's just
20 wait for Mr. Dawson. He won't be long I'm sure.

21 (ADJOURNMENT)

22 THE CHAIR: Okay, not to interfere in the
23 exchange, but Mr. Dawson is back, so we'll resume the
24 session with Mr. Maxston and his cross-examination.

25 MR. MAXSTON: So again, Mr. Chair, what I'm
26 going to do now is I'm going to go through my questions

1 that I noted during Mr. Kitchen's direct examination,
2 and I'm going to stop at 12, regardless of where I'm
3 at, whether I'm finished or not. I'll finish after
4 1:00, if need be, with those questions, and I'll then
5 begin my more structured questions after that.

6 Mr. Maxston Cross-examines the Witness

7 Q MR. MAXSTON: Dr. Wall, in the beginning of
8 your questions with Mr. Kitchen, you talked about the
9 fact that, in your mind over 20 years, you've seen a --
10 I think you said a slow and steady decrease -- slow and
11 steady change, pardon me, in the College and I think an
12 increase in restrictions. Wouldn't it be fair to say
13 though that professions evolve and grow, and we become
14 better at regulating professionals over time?

15 A I would say we evolve and grow but not necessarily
16 better.

17 Q You had a discussion with Mr. Kitchen, and in fairness
18 to him, you talked about restrictions coming from the
19 College, and you said, well, they also came from
20 government; and you were talking there about the CMOH
21 orders and I think the re-opening order, that type of
22 thing. You're aware that all professions have to have
23 a re-opening plan and have to have some type of
24 restriction on masking; is that correct?

25 A Yes, I'm aware of that.

26 Q So it wasn't just this college or you as a

1 chiropractor?

2 A That's right.

3 MR. KITCHEN: Sorry, Mr. Maxston, I
4 sincerely apologize. I have another headset, and I'm
5 going to go quickly get that and put that on, because I
6 just want to make sure that there's no feedback that's
7 interfering with you; is that all right if I just run
8 and do that?

9 MR. MAXSTON: Oh, I don't I can continue
10 without that, Mr. Kitchen, so you've got to hear the
11 question, so, yeah, sure thing.

12 (ADJOURNMENT)

13 THE CHAIR: All right, we're back on the
14 record. Mr. Maxston.

15 Q MR. MAXSTON: Dr. Wall, you had a discussion
16 where Mr. Kitchen asked you did the Pandemic Directive
17 include direction to reach out to the College if there
18 were problems with masking, and I think your answer was
19 no.

20 Isn't it fair to say though that you can always
21 reach out to the College? You don't need, a standard
22 of practice, for example, doesn't have to say, Call us
23 if you have a question or a policy on this or that; you
24 can always reach out though, can't you?

25 A That's right.

26 Q You had an exchange with Mr. Kitchen about the

1 requirement to obtain a doctor's note, and you said
2 there was nothing in the Pandemic Directive requiring
3 that, and I think you also mentioned that your health
4 information is private between you and your doctor. If
5 you were to disclose that information to the College
6 though, it wouldn't become public, would it?

7 A Insofar as addressing it to the College is addressing
8 it to the public. The College is not my doctor, and so
9 I believe that's public.

10 Q But I guess what I'm getting at is if you send that
11 information to the College and you say, Look, I've got
12 a medical condition, that information is not
13 distributed to the public at large; it goes to the
14 College; isn't that correct?

15 A That would be correct.

16 Q You had a discussion about your March 3 email to
17 Dr. Halowski, and I believe you said you didn't receive
18 a response. This isn't a gotcha question, I just want
19 to say to you that Dr. Halowski, his recollection, is
20 that there was, in fact, a response, and it was a March
21 4 email to you, where he essentially said, Thank you
22 for your note, I'm going to send this to counsel. I'm
23 just asking if that refreshes your memory about getting
24 a response.

25 A Yes, that is very correct, but no further follow-up to
26 that.

1 Q Just wanted to be clear that it wasn't unanswered.

2 You had a discussion about I think your
3 apprehension with coming forward to the College, and
4 you said you were reluctant to do so because you felt
5 the College would not be supportive, but isn't it fair
6 to say from June until December, you really didn't
7 reach out to test the College's temperature, so to
8 speak, on this?

9 A That is correct, but I also, as previously stated, did
10 not believe that it was the College's position to hear
11 my private health information, and so that is another
12 reason why I didn't reach out to the College.

13 Q I think you'd agree with me though when you do your
14 annual practice permit renewal, there are questions
15 that go to your personal and private information. You
16 have to disclose fitness to practice issues and those
17 types of things, and you would routinely send that to
18 the College, wouldn't you?

19 A Did you say "fitness practice issues"?

20 Q Sorry, fitness to practice is what I said.

21 A Yes.

22 Q You had a discussion with Mr. Kitchen at a number of
23 points about consent and informed consent regarding
24 masking, and I think you said that the College's
25 mandatory masking requirement for you violated consent,
26 and I'm going to suggest to you that that's the wrong

1 way about looking at consent, and that patient consent
2 is the proper way to frame that phrase, and it's about
3 getting consent from a patient to treatment. So the
4 College doesn't have to get consent from members, do
5 they, to Standards of Practice or things like the
6 Pandemic Directive?

7 A I would disagree with that because my position would be
8 the wearing of a mask is a medical procedure or a
9 treatment, and, as such, it requires informed consent.

10 Q Aren't all of the College's requirements though, like
11 infection control, those kinds of things, wouldn't it
12 be a little unusual to say members have to consent to
13 all those types of things?

14 A I'd have to say that mandating a mask poses an imminent
15 risk to mental or physical harm, whereas infectious
16 measures perhaps don't carry that imminent risk to
17 harm, and so I would disagree with that.

18 Q Well, we'll agree to disagree on whether consent really
19 applies here then.

20 One thing to be clear though, the College in the
21 Pandemic Directive never said there must be masking for
22 patients, correct?

23 A That is correct.

24 Q You had a discussion about what happened when you
25 stopped masking and how patients reacted, and I think
26 you said most never said a thing, 99 percent were

1 unconcerned, but, Dr. Wall, isn't it fair to say that
2 patients don't vote on what standards apply to their
3 health care provider?

4 MR. KITCHEN: I take an issue with that,
5 because that's not a proper quote from what Dr. Wall
6 said, he didn't say anything about 99 percent. So
7 perhaps we need to go back to the record, but,
8 Mr. Maxston, I only object to that question because
9 you're putting words in Dr. Wall's mouth that aren't
10 his.

11 MR. MAXSTON: You know, I think he did say
12 99 percent, but that's really not the point of my
13 question, (INDISCERNIBLE) just forgetting than that
14 (INDISCERNIBLE) --

15 Q MR. MAXSTON: But I think you had a -- made
16 a comment that most of your patients never said a
17 thing, but, again, my question is then patients don't
18 vote on what you should or shouldn't apply as part of
19 your practice when it comes to your college; they don't
20 tell you what to do; is that not correct?

21 A That's correct.

22 Q You, in response to a question about why so many
23 patients were understanding, you mentioned that there
24 was patient trust and character, and you said that
25 there was no risk of harm to your patients. And I'm
26 going to suggest to you that that's, frankly, kind of

1 an astonishing statement to make. Are you absolutely
2 confident that not masking poses absolutely no risk to
3 your patients?

4 A Yes.

5 Q I want to turn to some of the questions you had with
6 Mr. Kitchen about the phone discussion you had with
7 Mr. Lawrence, and I think you mentioned that the
8 College was in a difficult place, but their role is
9 protecting the public. You've talked about literature
10 not supporting masking and kind of talked about what I
11 think you felt were Mr. Lawrence's -- the tone of his
12 comments. But I just want to be clear, Mr. Lawrence,
13 at that stage, is the Complaints Director; he's not
14 making any findings of unprofessional conduct, is he?

15 A That's --

16 Q I don't mean to trick you, that's the Hearing Tribunal,
17 isn't it?

18 A I would agree, yes.

19 Q So you talked to Mr. Kitchen about the commencement of
20 an investigation, and that's a discretion that a
21 Complaints Director has, correct?

22 A Yes.

23 Q And, again, this isn't a gotcha question, but Section
24 65 of the HPA allows a Complaints Director to seek a
25 suspension; is that not accurate?

26 A Yes.

1 Q And I think you said in response to, again, one of the
2 questions about Mr. Lawrence's interaction with you,
3 you said that Mr. Lawrence advised you that he was
4 fulfilling his public protection duty; is that
5 accurate?

6 A Yes.

7 Q Mr. Kitchen asked you a question about what happened
8 after your discussion with Mr. Lawrence. I think there
9 was a question about whether Mr. Lawrence asked you
10 anything about your private life, and you said no, and
11 the question was something along the lines --

12 MR. MAXSTON: -- Mr. Kitchen, you can jump
13 in --

14 Q MR. MAXSTON: -- did you then feel free to
15 decide to wear or not wear a mask, and your answer was,
16 no, you felt the strong arm of the College was about to
17 step in and stop your practice. But it really wasn't
18 the College that stepped in to stop your practice, it
19 was AHS, wasn't it?

20 A Well, it was AHS that closed my practice in December,
21 but it was the College that was ensuing the
22 investigation further and looking into the suspension
23 of my licence.

24 Q Again, what I think I was really getting at is your
25 wording was that you were afraid the College was going
26 to step in and stop you from practicing, but the

1 College never did that ultimately. Dr. Linford didn't
2 do that, and it was AHS that did that?

3 A Yes, but this is still an ongoing investigation, and
4 the College still has the possibility of shutting my
5 practice down if they deem so at the end of the
6 hearing.

7 Q And I guess I disagree with you a bit. I would say it
8 would be a Hearing Tribunal not the College, because
9 the Hearing Tribunal issues orders.

10 You talked about your son practicing at the
11 clinic, and you indicated that he wasn't masking. Did
12 he have a medical exemption note?

13 A No, he did not.

14 Q He didn't have a doctor's note then is what I'm getting
15 at?

16 A That's correct.

17 Q You talked with Mr. Kitchen about the standard
18 treatment you provide to patients, and you engaged in
19 an interesting discussion about hand and practice and
20 chiropractic, filling us all in on the nature of that,
21 but I really want to stress, I think this is consistent
22 with Dr. Halowski's testimony yesterday, you would
23 agree there are other elements of practice, like
24 educating patients?

25 A Absolutely.

26 Q And consulting them?

1 A Absolutely.

2 Q Yeah, and you can do that with social distancing?

3 A Absolutely.

4 Q Mr. Kitchen asked you questions about the principles
5 that you employ in your practice, which ones are
6 important to you, and I think you said the first one is
7 do no harm to patients. Have you ever considered what
8 the impact would be if you were wrong about masking?

9 A I'm confident in my understanding of masking to such an
10 extent that I know it's not harmful.

11 Q Mr. Kitchen asked you a question, do you permit
12 patients to not mask, and I believe you said yes, and
13 he said why, and you said about freedom to make their
14 own choices, something along those lines. I wonder if
15 you can go back to Exhibit D-2, which is the AHS
16 rescind order, which re-opened your clinic. And I'll
17 just give you and the Tribunal Members a couple of
18 minutes to go to that. Are you there, Dr. Wall?

19 A Yes, I am.

20 Q Okay. Order Number 4 says: (as read)

21 Dr. Curtis Wall must ensure that all patients
22 he treats continuously wear a mask that
23 covers their mouth and nose for the duration
24 of their time in the clinic, unless they are
25 able to provide evidence that they have been
26 granted a mask exemption.

1 I'm going to suggest to you that you're in breach of
2 that order, aren't you, because you don't require a
3 mask exemption order or letter?

4 MR. KITCHEN: Mr. Maxston, forgive me, I'm
5 going to object to your question only on the basis that
6 you just called this an order; it's not an order. If
7 you call it what it is, then I have no issue with your
8 question.

9 MR. MAXSTON: Well, you know what, it says
10 "following conditions".

11 Q MR. MAXSTON: So you're not in compliance
12 with Condition Number 4 then?

13 A That would be correct.

14 Q Yeah, and to be clear, the first line says: (as read)
15 Notice is to inform you, on January 5, 2021,
16 the undersigned Executive Officer of Alberta
17 Health Services rescinded an order.

18 So they're rescinding an order, and they're placing new
19 conditions on your practice; that's correct?

20 A Correct.

21 Q And, again, Order Number 4 -- sorry, Provision Number 4
22 is something you're not complying with? Correct?

23 A Correct.

24 Q You had a discussion --

25 MR. MAXSTON: I'm just mindful of time here;
26 I think I can wrap this up in just another maybe 5

1 minutes.

2 Q MR. MAXSTON: You had a discussion about
3 AHS, and you said that there was really no wiggle room
4 from the College as a result of AHS's I guess
5 pronouncements, but for seven months, you never
6 inquired about whether there was any wiggle room, did
7 you?

8 A No, I did not.

9 Q You had a discussion about requiring patients to mask
10 and causing them harm and discussed your concerns about
11 oxygen and carbon dioxide, and you said even -- I think
12 you said even if it's imperceptible, that is, imminent
13 physical harm and danger; isn't COVID also an imminent
14 physical harm and danger?

15 A If you look at the statistics of people who are dying
16 from COVID and the recovery rate, 99.97 percent of
17 people recover, and this is no different than an
18 average seasonal flu. And so if an average seasonal
19 flu is also an imminent risk or harm, then, yes, we
20 could say they're on the same level.

21 Q I think along the same lines a little later on, you
22 made a comment that COVID-19 isn't an emergency; is
23 that your recollection?

24 A Yes, it is.

25 MR. MAXSTON: This isn't in evidence, so,
26 Mr. Kitchen, you can object if you want.

1 Q MR. MAXSTON: But we hear on TV about the
2 fourth wave, you heard last year about the first,
3 second, third wave, and high ICU numbers and
4 hospitalizations. If COVID isn't an emergency, what
5 is?

6 MR. KITCHEN: I'm going to have to object.
7 It's a hypothetical, plus you're bringing in evidence
8 that's just not --

9 MR. MAXSTON: Sure, I'll rephrase it.

10 Q MR. MAXSTON: Why isn't COVID an emergency?

11 MR. KITCHEN: Okay, hold on. Again, you're
12 asking an opinion that's completely out of the scope to
13 give.

14 MR. MAXSTON: Well, Mr. Kitchen, your client
15 described COVID as not being an emergency, so he's
16 offered that view. I'm certainly allowed to question
17 him about that.

18 MR. KITCHEN: All right --

19 Q MR. MAXSTON: And I'll just base the
20 question: Why isn't it an emergency?

21 A I'm basing that on the research that I have heard. I'm
22 basing that on many people that are well beyond my
23 knowledge level with respect to emergency --
24 emergencies and emergency preparedness, and so that is,
25 again, an opinion based on other expert evidence, not
26 my own.

1 MR. MAXSTON: Mr. Chair, can you give me 5
2 minutes. I think I can finish up a little bit into the
3 lunch hour. Is that fair?

4 THE CHAIR: Yeah, that's fine.

5 MR. MAXSTON: Okay, I'll try to be quick.

6 Q MR. MAXSTON: You had an exchange with
7 Mr. Kitchen about whether there was any comment from
8 the College about which is more important, prescreening
9 or masking, and I think you said no, but you'll recall
10 when I took Dr. Halowski through Exhibits C-21 to C-22,
11 don't those contain numerous statements where the
12 College is inviting you to contact the College?

13 A Can you rephrase that question, please?

14 Q Yeah, you said that there was no comment from the
15 College about which is more important, prescreening or
16 masking. And I'm going to suggest to you that that
17 really isn't the issue; that you could have reached out
18 to the College and asked them what was more important.

19 A Yes.

20 Q You made some comments in response to a question that
21 you believed that the College consulted with AHS and
22 that it believes the information is accurate and that
23 it's relying on that, so would it be fair to say that,
24 in your view, the College is acting in good faith when
25 it's carrying out these pandemic steps?

26 A According to their idea of good faith, yes.

1 Q There were a number of questions Mr. Kitchen asked you
2 about were you surprised by the College doing this, or
3 the College created this step, did these things, and I
4 think my concern with that was isn't it fair that the
5 College is made up of chiropractors?

6 A Yes, a majority of chiropractors, and I believe there
7 are some public members.

8 Q Yeah, I think, in fairness, you're quite right on
9 council and on Hearing Tribunals, there are public
10 members, but I think my concern was that the way those
11 questions were phrased and the way your answers were
12 phrased, it made it sound like the College was sort of
13 a third-party entity out there, kind of hovering
14 around. The College is made up of chiropractors, and
15 don't chiropractors vote on these, as councillors, vote
16 on pandemic directives and standards of practice?

17 A I don't know if every individual chiropractor actually
18 voted on the Pandemic Directive.

19 Q I should have been more precise, you're right,
20 chiropractors on council.

21 A Yes.

22 Q So these are decisions, at least in part, where public
23 members made by chiropractors to apply to the
24 chiropractor profession?

25 A That's correct.

26 Q You talked about the Pandemic Directive being

1 unreasonable because there are no provisions for
2 exemptions. Do you recall Dr. Halowski's testimony
3 that, in his knowledge, no other college has exemptions
4 for masking?

5 A Yes, I do.

6 Q I'm almost there. Mr. Kitchen asked you a question to
7 the effect of is the College very concerned with
8 pleasing the CMOH, and you said -- I think you said
9 yes, and there's collaboration between CMOH and AHS and
10 the College. That's really your opinion though; you
11 don't -- haven't tendered any evidence to support that,
12 have you?

13 A No evidence tendered, but it stands to reason that
14 there has to be collaboration between the College and
15 Alberta Health Services.

16 Q One of Mr. Kitchen's final comments, and this is my --
17 I think my final question was do you believe you've
18 breached any CMOH orders, and you said no. But isn't
19 it fair that when we look at the AHS closure order,
20 they referred to CMOH orders being breached, and that's
21 why they closed the clinic?

22 MR. KITCHEN: Mr. Maxston, I don't know that
23 you're -- I think you're misleading here, because you
24 are saying --

25 MR. MAXSTON: (INDISCERNIBLE)

26 MR. KITCHEN: -- well, you're saying in your

1 question that there's a breach of a CMOH order. Well,
2 that's kind of an ultimate issue. If there was no
3 doctor's note from Dr. Wall verifying that he fell into
4 an exemption, I'd agree with you, but --

5 MR. MAXSTON: You know what I'm going to do,
6 I'm going to -- it's a fair comment, Mr. Kitchen.

7 Q MR. MAXSTON: Just very briefly, Dr. Wall,
8 can you go to the closure notice, which is Exhibit D-1.
9 I'll get everybody to do that, and, I'm sorry, this is
10 my last question.

11 And, Dr. Wall, let me know when you're there, and
12 I'll start my question then.

13 A Yeah, go ahead.

14 Q So what I was really getting at is (a) and (b) are kind
15 of mirror images, this is on page 1, but it says --
16 I'll just read item (a), and then there's a question:
17 (as read)

18 Practitioner does not wear a face mask while
19 providing care within 2 metres distance from
20 patients. This activity could contribute to
21 the spread of COVID-19. This is a breach of
22 Section 2(1) of the nuisance and general
23 sanitation regulation, which states that [I
24 won't read that out] and of Section 26 of the
25 CMOH-38-2020, which states that ...

26 So on the face of it, this order says you're breaching

1 a CMOH order.

2 A Yes, on the face of it.

3 MR. MAXSTON: Okay, those are all my
4 questions, Mr. Chair. Thank you for your indulgence in
5 going a little bit into the lunch hour.

6 I welcome Mr. Kitchen's comments, we could
7 reconvene at 1:00, we could reconvene at 1:15, whatever
8 your decision is.

9 THE CHAIR: Before we decide that, can we
10 get an idea of what the afternoon will look like?

11 MR. MAXSTON: I expect I will be a couple of
12 hours in questioning Dr. Wall. I don't know how long
13 of course Mr. Kitchen's cross-examination -- or, pardon
14 me, redirect will be, and then, of course, there's your
15 time for questions.

16 I'm hopeful we can get through Dr. Wall today
17 but --

18 Q MR. MAXSTON: And, Dr. Wall, you've given me
19 some very short answers at times, which is helpful for
20 moving ahead, but at other times, I'm sure you're going
21 to want to elaborate on some of my questions.

22 MR. MAXSTON: And, in fairness, I do have a
23 lot of questions for Dr. Wall.

24 THE CHAIR: Okay, Mr. Kitchen, is that
25 your vision of this afternoon? I don't see us calling
26 any other witnesses today, unless we get --

1 MR. KITCHEN: I have --

2 THE CHAIR: -- through more quickly.

3 MR. KITCHEN: Well, I have one witness
4 standing by, who is one of the four patient witnesses,
5 so it will be quick. Each one of these four patient
6 witnesses will be quick. Mr. Maxston and I have talked
7 about this.

8 So as I see it, we're likely to be done with
9 Dr. Wall by 3:30, 3:45. I'd like to use the entire day
10 to get one more witness in, considering how slow we're
11 moving and that -- you know, yesterday, we finished --
12 it's my fault, I understand this, but yesterday we
13 didn't quite use the full time; I'd like to try to use
14 the full time to get in that one extra witness, because
15 I cannot see that taking more than an hour total.

16 MR. MAXSTON: I think maybe, Mr. Kitchen,
17 I'd invite your comments, maybe just see where we're at
18 by, you know, 3:00, 3:30, and then -- I know it's tough
19 to have a witness hanging, but I'm going to be very
20 brief with that witness if we get to him or her today.

21 MR. KITCHEN: Okay, well, I, yeah, that's
22 important to me that we at least try to preserve that.

23 THE CHAIR: Okay, that's our objective.

24 So we will recess for lunch. It's 10 after 12, so
25 let's reconvene at 1:15, and we'll continue with
26 Mr. Maxston's cross-examination at that time. Thank

1 you.

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3 PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 September 8, 2021

Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees

Tribunal Chair

9 W. Pavlic

Internal Legal Counsel

10 Dr. L. Aldcorn

ACAC Registered Member

11 Dr. D. Martens

ACAC Registered Member

12 D. Dawson

Public Member

13 A. Nelson

ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC

ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen

Legal Counsel

20

21 K. Schumann, CSR(A)

Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 1:15 PM)

24 THE CHAIR:

Okay, it's 1:15. Mr. Kitchen,

25 you're okay; your technology is okay?

26 MR. KITCHEN:

I'm ready to go.

1 THE CHAIR: Okay.

2 MR. KITCHEN: Can you hear me? Good.

3 THE CHAIR: Yes, we can hear and see you.

4 So, Mr. Maxston, the floor is yours.

5 Discussion

6 MR. MAXSTON: Sure. Mr. Chair, during the
7 break, I think about 12:15 or so, 12:20, I asked
8 Ms. Nelson to send Mr. Kitchen a document I intend to
9 rely on in cross-examination, and it is the email
10 exchange, the March 4 response from Dr. Halowski and
11 Dr. Wall's March 3 email to him.

12 I, frankly, don't intend to spend a lot of time
13 with that, but I, of course, wanted to send it to
14 Mr. Kitchen. I'm going to get to that probably 5 or 10
15 minutes into my examination. I wonder if Mr. Kitchen
16 will consent to Ms. Nelson sending that to the Hearing
17 Tribunal Members now.

18 MR. KITCHEN: Yeah, that's fine. Just
19 forward it to Dr. Wall, so he has a copy.

20 MR. MAXSTON: And, again, I don't intend to
21 spend a lot of time with that. I think it should
22 probably be marked as an exhibit, and I think we might
23 be up to H-4 or 5, if we are -- Mr. Chair, and
24 Ms. Nelson can do that; she can put it into the
25 Dropbox, and we'll ask the court reporter to mark that
26 as part of her --

1 MR. KITCHEN: I do have an issue with --
2 okay, let me just pull up what you sent me here,
3 because I think I might --

4 MS. NELSON: I also just want to hop on and
5 let you know, Walter Pavlic is not currently on the
6 call, so I'm just going to give him a call on his cell
7 phone and try to get him in the meeting. It looks like
8 he's dropped off.

9 THE CHAIR: Yeah, and my oversight. Thank
10 you, Amber.

11 MR. MAXSTON: Mine as well. Maybe,
12 Mr. Kitchen, we should not discuss this further until
13 Mr. Pavlic comes online.

14 MR. KITCHEN: That's fine. Yeah, no, but I
15 do want to discuss a point with you.

16 MR. MAXSTON: Yeah.

17 (ADJOURNMENT)

18 MR. MAXSTON: Mr. Pavlic, just before you
19 came on, I mentioned to the Chair that, I think about
20 12:15 or 12:30, I asked Ms. Nelson to send Mr. Kitchen
21 a document by email that I intend to rely on in
22 cross-examination, and it is the March 3, 2020 email
23 from Dr. Wall to Todd Halowski, and Dr. Halowski's
24 March 4 response. I'm going to briefly refer to that
25 in my cross-examination. I would like that to be
26 entered as an exhibit, and I understand Mr. Kitchen

1 might have some questions about that, so I'll turn the
2 floor over to him.

3 MR. KITCHEN: I received instructions from
4 my client, and there's no objection to putting that in
5 as is.

6 THE CHAIR: Okay, thanks, Mr. Kitchen. So
7 if we could have that document shared to the members of
8 the Hearing Tribunal and --

9 MS. NELSON: So what I'm going to do, I'm
10 going to add it to the Dropbox file, you should all
11 still have access to that file. I'm going to put it in
12 File H, so you can find it there. Just give me about 2
13 minutes to add that in, and I'll let you know when it's
14 there for your review.

15 THE CHAIR: Would it be possible to email
16 it?

17 MS. NELSON: Sure, yeah, I can email it
18 instead if that's easier for everyone.

19 THE CHAIR: It's certainly easier for me
20 than having to go in and getting into the Dropbox
21 again.

22 MS. NELSON: Okay, so what I'll do I'll
23 send everyone an email now, all the Tribunal Members,
24 so you have it, and then while the hearing's in
25 session, I'll still upload it to Dropbox, so, Karoline,
26 you'll be able to find it in File H.

1 EXHIBIT H-7 - Response to Curtis Wall Re -
2 Vaccinations

3 THE CHAIR: Excellent, thank you, Amber.

4 Mr. Maxston, are you going to start with this
5 document?

6 MR. MAXSTON: No, I think in about 10
7 minutes I'll get to it, and it will be very brief, so I
8 wonder if I might just start now, and when I get to
9 that, I'll get to that document, I'll make sure
10 everybody's been able to access it.

11 THE CHAIR: I think that's a wise idea.
12 Let's use the time.

13 DR. CURTIS WALL, Previously Sworn, Cross-examined by
14 Mr. Maxston

15 Q MR. MAXSTON: So, Dr. Wall, I'm just going
16 to ask you a couple of questions about your educational
17 background baed on what Mr. Kitchen said, and I
18 understand you graduated from Palmer College in
19 Davenport, Iowa, in 1996. Did you receive any public
20 health education at Palmer?

21 A Yes.

22 Q And was that health education in relation to public
23 disease management?

24 A No, it was not. It was a very basic course, going over
25 basic microbiology and discussing infectious diseases,
26 but not in management.

1 Q And do you have any advance training or degrees in
2 public health?

3 A No, I do not.

4 Q When you graduated from Palmer, do you recall taking an
5 oath that included, in part, an obligation to preserve
6 the integrity of the profession?

7 A Yes, I do.

8 Q You came a licensed chiropractor in 1996 in Alberta I
9 understand, and I believe you said this during your
10 discussion with Mr. Kitchen, but would you agree that
11 practicing in the profession of chiropractic is a
12 privilege not a right?

13 A Yes, I would.

14 Q And would you also agree that the chiropractic
15 profession is a self-regulating profession under the
16 Health Professions Act in Alberta?

17 A Yes, it is.

18 Q I'm not going to ask you to go to this, but are you
19 familiar with Section 3 of the Health Professions Act
20 and the public protection mandate it establishes for
21 colleges?

22 A I believe I've read through it, yes.

23 Q You're also, I'm assuming, familiar with the fact that
24 the College, as a regulator, governs the conduct of
25 chiropractors in their professional capacities?

26 A Yes, I'm aware of that.

1 Q Section 3 of the HPA, and, again I'm not asking you to
2 go there, talks about the College establishing and
3 enforcing requirements for the profession, and I just
4 want to take you through a couple of things quickly
5 here. You would agree that the College sets initial
6 registration requirements?

7 A Yes.

8 Q For the profession?

9 A Yes.

10 Q And that's mandatory?

11 A That's correct.

12 Q And happily, you met those requirements a few years
13 ago?

14 A Yes.

15 Q There are annual practice permit renewal requirements?

16 A Yes, there are.

17 Q And those are mandatory?

18 A Yes.

19 Q The College has a continuing competence program; is
20 that correct?

21 A Yes, it does.

22 Q And is that mandatory in order to keep practicing?

23 A Yes, it is.

24 Q You're aware that the College creates Standards of
25 Practice and Codes of Ethics?

26 A Yes, I am.

1 Q You're aware that the College creates practice visits?

2 A Yes.

3 Q For members?

4 A Yes.

5 Q And a participation and practice visit is mandatory,
6 isn't it?

7 A Can you explain a practice visit?

8 Q If the College sends someone out to do a practice visit
9 under the Health Professions Act, and they come to your
10 clinic and assess what's occurring at the clinic,
11 that's what I'm referring to.

12 A Yeah, I think there are definitely parameters
13 surrounding that. It's -- I'm not sure that the
14 College can just randomly come to a practice. I think
15 there has to be some reason behind it, to my knowledge.

16 Q Yeah, and I think I'm referring to the practice visit
17 program established under the HPA, and I think you're
18 quite right, there are some parameters for how practice
19 visits occur.

20 I'd like to ask you to go to the Standards of
21 Practice -- I'm just going to digress for a moment --
22 the Standards of Practice are in Exhibit A-11, and I'm
23 not going to be long on this, but once you're there on
24 A-11 and Tribunal Members are there, I'm going to ask
25 you to go to page 20 and the standard of practice for
26 recordkeeping. And that's Standard of Practice 5.1.

1 A Yeah, I'm there.

2 MR. MAXSTON: Mr. Chair, I'll assume, unless
3 someone waves their hand, everybody else is at Standard
4 5.1.

5 Q MR. MAXSTON: Dr. Wall, my purpose in taking
6 you to this, number one, to flag that it addresses
7 recordkeeping requirements, and it says: (as read)
8 Patient health records must be dated,
9 accurate, legible, and comprehensive.
10 You'd agree that's mandatory?

11 A Yes, I would.

12 Q (as read)

13 All services provided by the chiropractor
14 must be documented by the chiropractor and
15 entries must be clearly identifiable as
16 having been made by the chiropractor.

17 Again, a mandatory requirement, correct?

18 A Correct.

19 Q And if you skip down a couple of lines, there's a
20 paragraph that says: (as read)

21 All patient health records must include the
22 following information.

23 And there's some bullets, "Personal Information
24 History", "Physical Exam", "Findings", "Written
25 Diagnosis". You would agree that that's a mandatory
26 set of contents for your records?

1 A Correct.

2 Q Is it fair to say that, until you independently decided
3 that you weren't going to follow the Pandemic
4 Directive, that you always follow ACAC requirements?

5 A That's correct.

6 Q I think you describe yourself as a fairly compliant
7 person, and I'm not surprised to hear that. I'm
8 wondering if I can get you to go to the notice of
9 hearing, which is Exhibit A-1. It's the first
10 document. I just want to take you through it.

11 A I'm good to go.

12 Q Okay. So I want to be careful, Mr. Kitchen can jump in
13 here, but I don't think we ever heard -- we talked
14 about this at the beginning of the hearing, but I don't
15 think we ever heard from you whether you are denying or
16 contesting the charges and are saying they don't
17 constitute unprofessional conduct. I assume you're
18 going to agree that that's what you're doing in the
19 hearing?

20 A Can you repeat that, sorry?

21 Q Yeah, you're contesting the charges; you're arguing
22 that you did not commit unprofessional conduct?

23 A That is correct.

24 Q Okay. I'm going to take you through each of the
25 charges, and I want to be very clear, I'm not asking
26 you to make admissions of unprofessional conduct; I'm

1 more interested in the facts in the charges are the
2 factual foundation.

3 So Charge 1 says: (as read)

4 Beginning on or about June of 2020 and at the
5 Wall Chiropractic Clinic: (a), [you] failed
6 to use PPE, specifically failed to wear a
7 mask; (b), failed to observe the required 2
8 metres of social distancing when unmasked;
9 (c), until on or about December 2020, failed
10 to have a plexiglass barrier at the clinic
11 reception and/or did not require patients to
12 mask; [and then] when he interacted with
13 patients, members of the public, or both.

14 Do you dispute any of those facts?

15 A No, I do not.

16 Q And if we go to Charge Number 2: (as read)

17 Beginning on or about June of 2020 in the
18 clinic, one or more staff members of the
19 clinic, the staff, failed to use PPE,
20 specifically staff failed to wear masks; (b),
21 failed to observe the required 2 metres of
22 social distancing when unmasked and/or, (c),
23 did not require patients to be masked when
24 they interacted with patients, members of the
25 public, or both.

26 Again, I'm not asking you to make an admission of

1 unprofessional conduct, but do you accept those facts?

2 MR. KITCHEN: Mr. Maxston, I don't mind the
3 question, but, in general, I'm going to ask that you
4 break it up for each one of these pieces.

5 MR. MAXSTON: Sure, I'm happy to do that.

6 MR. KITCHEN: Okay, thank you.

7 MR. MAXSTON: Yeah.

8 Q MR. MAXSTON: Let's go to 2(a), do you
9 dispute those facts, Dr. Wall?

10 A No, I do not.

11 Q And similarly for 2(b)?

12 A No, I do not.

13 Q And similarly for 2(c)?

14 A No, I do not.

15 Q Okay, we go to Charge Number 3: (as read)

16 Beginning on or about June 2020, Dr. Wall
17 treated patients while not wearing a mask
18 and/or did not require patients to be masked,
19 and, (a), he did not advise patients of the
20 increased risk of transmission of COVID-19
21 due to masks being worn.

22 Do you agree with that factually?

23 A Like "masks not being worn" I believe is --

24 Q Yeah.

25 A -- what you meant?

26 Q Yeah, sorry, yeah.

1 A That's correct.

2 Q And (b): (as read)

3 He advised patients that masks were not
4 required.

5 Is that factually accurate?

6 A Correct.

7 Q And (c): (as read)

8 He advised patients that wearing masks had no
9 effect concerning transmission of COVID-19.

10 Is that accurate factually?

11 A Correct.

12 Q So if we go to Charge Number 4: (as read)

13 Beginning on or about June of 2020, Dr. Wall
14 failed to chart and/or failed to properly
15 chart communications with his patients about,
16 (a), him not wearing a mask.

17 Would you agree with that?

18 A Yes, I would.

19 Q (b): (as read)

20 His staff not wearing masks.

21 Would you agree with that?

22 A Yes, I would.

23 Q And (c): (as read)

24 His patients not wearing masks?

25 A Yes, I would.

26 Q And then, finally, Charge Number 5: (as read)

1 Beginning on or about June of 2020, Dr. Wall
2 and/or the staff, (a), failed to follow CMOH
3 orders regarding masking and COVID-19.

4 Do you accept that factually?

5 A Yes.

6 Q And (b): (as read)

7 Failed to follow the ACAC Pandemic Practice
8 Directive.

9 Do you agree with that factually?

10 A Partially, but, yes, with respect to masking; is that
11 what that (b) would be?

12 Q Yeah, I would -- yes, I think, in fairness to you, I'm
13 thinking of masking, social distancing, and the
14 plexiglass barrier.

15 A Correct, yeah.

16 Q Okay, thank you. So I think, Dr. Wall, it's fair to
17 say that you're arguing that you have an exemption to
18 masking, but you're also calling four experts who will
19 dispute the science behind masking, they'll argue that
20 masking causes harm, and argue that masking isn't
21 necessary. Is that your position as well; it's not
22 just that you have a medical exemption?

23 A That is correct.

24 Q And aside from any exemption for your anxiety disorder
25 personally not masking, is it not fair to say you don't
26 believe in masking generally in terms of COVID for a

1 number of reasons?

2 MR. KITCHEN: You're going to have to get a
3 little more specific. I don't necessarily object to
4 the question generally, but you're going to have to be
5 a little more specific about what you mean about
6 belief.

7 Q MR. MAXSTON: So I'll ask the question a
8 little differently. You don't believe in masking
9 generally in terms of COVID-19 as a preventative
10 measure?

11 A Correct.

12 Q And just to be clear, you don't believe that
13 chiropractors should have to mask or social distance or
14 use plexiglass barriers; is that fair?

15 A Correct.

16 Q I'd like to take you to Exhibit A-11, another standard
17 of practice, and specifically page 15, which is
18 Standard of Practice 4.3. And I'm sorry, Dr. Wall,
19 we're going to skip around a little bit with the
20 documents this afternoon, but I'll let you and the
21 Tribunal Members get to that document, and then I'll --
22 I've got a few questions for you.

23 THE CHAIR: Would you repeat that document
24 number, again, please.

25 MR. MAXSTON: Yes, Mr. Chair, it's A-11, the
26 Standards of Practice, and more specifically I'd like

1 you to go to page 15, which is 4.3, "Infection
2 Prevention and Control".

3 THE CHAIR: Thank you.

4 Q MR. MAXSTON: So, Dr. Wall, we heard
5 Dr. Halowski give some evidence about this standard,
6 and you'd agree with me that this standard was in place
7 before COVID?

8 A Yes, I would.

9 Q And you would agree that it was binding on you and is
10 binding on you?

11 A Yes.

12 Q You'll see at the end of the first paragraph, just
13 before the colon, it says "Chiropractors must", and
14 then it sets out a number of duties that you have -- I
15 shouldn't say "duties", I should say obligations.
16 Would you agree with me that those bullets that follow
17 are all musts, for lack of a better phrase?

18 A I'm sorry, are you still on 4.3?

19 Q Yeah, I'm just looking at that series of bullets. The
20 first one says: (as read)

21 Remain current and generally accepted routine
22 practices.

23 And I'm just looking at the -- just before that, it
24 says: (as read)

25 In their clinical practice, chiropractors
26 must ...

1 And my question was all those bullets are musts, if I
2 read this correctly; would you agree with that?

3 A Yes, I would.

4 Q And is it your evidence that you've complied with this
5 standard of practice at all times?

6 A Let me take a minute and just read those bullets,
7 please. It would appear that the protective barrier,
8 if that is referring to the plastic barrier, was
9 something that I did not do. So that one bullet,
10 there's --

11 Q You know, Dr. Wall, I'm not trying to sort of trick you
12 here. I had a question specifically, frankly, about
13 the second-last bullet. It says: (as read)

14 Must utilize appropriate personal protective
15 equipment in circumstances indicating such
16 measures.

17 I think you'd agree you're not complying with that
18 because you're not complying with the Pandemic
19 Directive?

20 A Correct.

21 Q And, again, on its face, to be fair to you. I'd like
22 to turn to the emails that were just entered as an
23 exhibit, and we have your March 3, 2020 email, and as I
24 asked you during my brief questions before, I asked you
25 to just refresh your memory, and you would acknowledge
26 now that Dr. Halowski did respond on March 4 to your

1 email?

2 A Yes, I would.

3 Q I'm looking at your email, and I just have a couple of
4 quick questions about it. The second paragraph says:
5 (as read)

6 I fully recognize the position chiropractors
7 are in with respect to being governed under
8 the HPA, and I intend to follow any
9 guidelines and rules put forth to our
10 profession through Standards of Practice and
11 bylaws.

12 Can you tell me why you said that?

13 MR. KITCHEN: Mr. Maxston, I understood that
14 you were putting this document in so that you could
15 discuss about whether or not there was a response. Now
16 you're asking a question about the substance of the
17 email.

18 MR. MAXSTON: I don't think I said I was
19 confining my questions; I was putting it in to be used
20 for cross-examination, and I only have a couple
21 questions.

22 MR. KITCHEN: Well, I don't think the
23 substance of the email is relevant. You and I have
24 both seen the email. There's nothing in there about
25 masking or the ACAC Pandemic Directive or any of that.
26 The contents of the email aren't relevant. It's not a

1 relevant question.

2 MR. MAXSTON: Well, I would disagree.
3 There's a comment in the second paragraph I'm taking
4 your client to about compliance with future
5 requirements of the College, so I guess we'll ask the
6 Tribunal to let us know whether I can ask that
7 question.

8 MR. KITCHEN: Well, I now admit I didn't ask
9 you this, but you did not indicate when you asked for
10 my consent to put this email in that you were going to
11 ask substantive questions on the content of what
12 Dr. Wall said in the email. I understood you to mean
13 you were putting it in to show that it was sent and
14 that Halowski -- Dr. Halowski sent a response, which I
15 have no issue with.

16 MR. MAXSTON: Well, I --

17 MR. KITCHEN: So I'm going to object to
18 questions on content, and I guess I'm going to have to
19 object to you putting the document in for the purposes
20 of asking substantive questions on the content of the
21 email that Dr. Wall sent, which is irrelevant to these
22 proceedings.

23 MR. MAXSTON: Well, I think it is, and when
24 I mentioned my intention to have this entered, I said I
25 intend to refer to it briefly during cross-examination.
26 I didn't put any parameters on it, and I --

1 MR. KITCHEN: Well, I was trying to be --
2 you know, because I don't want to unduly contest
3 things, okay? So that's why I didn't contest is
4 because I didn't understand you to mean, and you didn't
5 say you were going to ask questions on the contents.

6 MR. MAXSTON: Well, I'm just going to say
7 that in my experience when you tender a document to be
8 used in cross-examination, it's not limited. I don't
9 have to say that I'm going to ask questions on 'X',
10 'Y', and 'Z'; I simply say I intend to refer to this.

11 So, again, I think it's relevant, my client thinks
12 it's relevant, it talks about compliance issues, and
13 it's in March of 2020 just before COVID hits and the
14 directive comes out. I don't have a lot of questions,
15 but I'd like to ask them, so I think we'll have to ask
16 for the Tribunal to let us know what they --

17 MR. KITCHEN: Well, I'm going to object both
18 to the questions, but I'm going to go back to object to
19 the document being entered for substantive questions.
20 This is similar to the issue we faced last week when I
21 asked to have in the evidence that the studies that I
22 questioned Dr. Hu about exist, and I was limited to
23 asking procedural questions about their existence not
24 on contents. That's what I'm going to ask -- that's
25 how I ask this to be treated.

26 MR. MAXSTON: And I think the difference

1 from my perspective, Mr. Kitchen, is Dr. Hu is an
2 expert, and he was being confronted with expert reports
3 he didn't have any familiarity with, and I think, quite
4 properly, the Tribunal put some parameters on what
5 could be asked. This is an email exchange that your
6 client knows about, and it's relevant to the issues.
7 I'll let the Hearing Tribunal tell us what --

8 MR. KITCHEN: No, but if I had've known, if
9 you had've made your intentions about questioning a
10 little more clear, then I would have been in the
11 position to object to it being entered for broad
12 purposes as opposed to specific narrow purposes. I
13 wasn't given that opportunity.

14 MR. MAXSTON: Yeah, I think I said I was
15 going to refer to it. And, again, in my experience, in
16 cross-examination, when you tender a document, you
17 don't have to say what exactly you're going to ask
18 about.

19 Anyhow, I've made my submissions on this point.

20 THE CHAIR: Yeah, I think we'll take a
21 brief recess here so that the Tribunal can discuss this
22 and consult with our independent legal counsel. So if
23 we could be moved to a break-out room, please, and
24 we'll be back with everybody shortly. Thank you.

25 (ADJOURNMENT)

26 THE CHAIR: We've discussed this amongst

1 ourselves and with independent legal counsel. Our
2 decision is that the questioning can be allowed. We
3 feel the document is relevant. Cross-examination is
4 not limited in this regard. We don't feel that the
5 situation with Dr. Hu and the medical -- or the studies
6 is directly comparable. And, Mr. Kitchen, you have an
7 opportunity to address anything raised in redirect
8 examination of Dr. Wall. So on that basis,
9 Mr. Maxston, subject to any further objections from
10 Mr. Kitchen, please carry on.

11 MR. MAXSTON: Yeah, I'll be brief,
12 Mr. Chair.

13 Q MR. MAXSTON: Dr. Wall, I've taken you to
14 the second paragraph that says: (as read)

15 I fully recognize the position chiropractors
16 are in with respect to being governed under
17 the HPA, and I intend to follow any
18 guidelines and rules put forth to our
19 profession through Standards of Practice and
20 bylaws.

21 And my question to you was why did you make that
22 statement?

23 A I made that statement because I'm a compliant
24 chiropractor, and I, for the last 25 years, have upheld
25 the Standards of Practice and bylaws and the Code of
26 Ethics, but nobody could see what was coming around the

1 corner a month later, and here we are with different
2 Standards of Practice and bylaws through the Pandemic
3 Directive that have created the issue that's being
4 contested right now.

5 Q So you've changed your view I think is what you're
6 saying?

7 A Only to the point that it affects this particular
8 hearing.

9 Q And just briefly, this is in March, early March of
10 2020, before the directive, but you've got
11 Dr. Halowski's email address at that point, don't you?

12 A Yes, I do.

13 Q Dr. Wall, I'd like to take you to Exhibits D-8 and D-9,
14 the two CMOH orders, CMOH Order 38-20 and 42-20. I am
15 not going to take you through those in detail. I've
16 got some questions for you about them generally, but if
17 you want to have those in front of you, certainly
18 that's fine.

19 A Okay.

20 Q So just putting aside the Pandemic Directive for the
21 moment, was your understanding with CMOH Order 38-20
22 that you were required to mask when treating patients?

23 A That I was required to mask when treating patients?

24 Q M-hm.

25 A Yes, yes.

26 Q And in fairness to you, you also have taken the

1 position that there's an exemption or exception as well
2 in this CMOH order; is that correct?

3 A That is correct.

4 Q And when we look at CMOH Order 42-20, and I, again,
5 don't want you to go through that, I think it's also
6 fair to say that it essentially mirrors 38-20, and
7 would you agree there's an requirement for you to mask,
8 and then there's an exemption as well?

9 A Yes.

10 Q So I think the question I have or the thing I want to
11 explore with you is really timing. So in June of 2020,
12 you decided to not mask and not social distance and not
13 use barriers; that's fair to say?

14 A That's correct.

15 Q When we look at the CMOH orders, 38-20 is dated
16 November 14, 2020, and 42-20 is dated December 11,
17 2020. So my question to you is there wasn't a CMOH
18 order in force in June of 2020 that set out exemptions
19 for masking; is that correct?

20 A Correct.

21 Q And, again, I'm not going to take you through this in
22 detail, but Exhibit F-2 is CMOH Order 16-20, and you'll
23 probably recall that 16-20, again, is from May 3 of
24 2020, and it's what we discussed previously in the
25 hearing about requiring either adherence to the CMOH
26 schedule, which required masking --

1 MR. MAXSTON: -- and there's a question
2 coming, Mr. Kitchen --

3 Q MR. MAXSTON: -- or opting into a College
4 directive if they had one; is that your recollection?

5 A Yes, it is.

6 Q And would you agree that, when we look at that Exhibit
7 F-2, and then there's F-1, the Government of Alberta
8 safely staged COVID relaunch, that it was a requirement
9 for the College to establish a Pandemic Directive?

10 A Yes.

11 Q Just bear with me for a moment, Dr. Wall. Don't mean
12 to belabour this point, but on Exhibit F-1, which is
13 the government relaunch document, if I can get you to
14 go to that, it's Exhibit, again, F-1, "Alberta's safely
15 staged COVID-19 relaunch".

16 A Okay.

17 Q Page 2, the second bullet talks about: (as read)
18 Dental and other health care workers will be
19 allowed to resume services starting May 4, as
20 long as they are following approved
21 guidelines set by their professional
22 colleges.

23 You understand that that meant it was mandatory for you
24 to comply with the Pandemic Directive if you wanted to
25 re-open?

26 A Yes.

1 Q And when we look at CMOH Order 16-20, and, my
2 apologies, that's F-2 if you want to look at it, I have
3 a couple of quick questions for you.

4 Again, this is the CMOH order that talks about
5 colleges creating their own Pandemic Directives. This
6 CMOH order doesn't reference any exemptions, does it?
7 And I mean exemptions from masking and social
8 distancing.

9 A Not that I can see, yeah.

10 Q And you'd agree with me, of course, this is dated May
11 3, 2020, and it would have been in force in June of
12 2020 when you decided to not comply?

13 A Correct.

14 Q Dr. Wall, I'd like you to go to the Pandemic Directive
15 itself, and we've been using I think Exhibit C-22,
16 which is the, I'll call it, the most recent version,
17 January 26th, 2021, although the contents of it
18 relating to masking et cetera haven't changed. So I'll
19 just ask you to go to that, please.

20 A Okay.

21 Q So I think you may have discussed this with
22 Mr. Kitchen, but do you recall when you received the
23 Pandemic Directive?

24 A Are you referring to the very first one or this most
25 recent --

26 Q Thank you --

1 A -- one?

2 Q -- yes, thank you, the May 3, 2020 version, thank you.

3 A I believe it was in May, early May.

4 Q Yeah. And you would have received that as a regulated
5 member getting like I guess as part of the normal
6 communications from your college?

7 A Correct.

8 Q So I'd like you to go to page 1 of the -- pardon me,
9 page 2 of the Pandemic Directive. Page 1 is kind of an
10 introductory table of contents. Item number 1 in the
11 middle of the page, numbered item 1, says "Follow
12 all" -- I should go back, there's an opening
13 sentence -- or opening statement: (as read)

14 As regulated health professionals,
15 chiropractors are required to, 1, follow all
16 mandates and recommendations from Public
17 Health and the Government of Alberta
18 regarding your personal and professional
19 conduct. As a regulated health professional
20 you have a fiduciary responsibility to follow
21 all civil orders that originate from any
22 level of government.

23 Would you agree with that statement?

24 A Yes, I would.

25 Q And the second one is a little more specific, number 2,
26 it says, again chiropractors: (as read)

1 Read and adhere to all communications from
2 the ACAC.

3 Would you agree that that's intended to be a binding
4 direction from your college?

5 A Yes, I would.

6 Q Dr. Wall, I'm going to ask you to go to page 3 of the
7 Pandemic Directive, and in kind of the middle of that
8 page, there's a heading that says "Patient Screening",
9 and there's some comments there about: (as read)

10 Chiropractors must assess and screen patients
11 for symptoms of COVID-19 as per requirements
12 of Public Health.

13 Were you doing patient screening?

14 A Yes, I was.

15 Q Okay. If you skip head to page 4 of the Pandemic
16 Directive, and you go to the bottom of the page, there
17 is a heading "Hand Hygiene", and if we go to the next
18 page, there's a -- it's the first complete paragraph:
19 (as read)

20 When hands are visibly soiled, they must be
21 cleaned with soap and water, as opposed to
22 using alcohol hand-rub.

23 Again, the word "must" is used. Were you adhering to
24 the hand hygiene requirements in this Pandemic
25 Directive?

26 A Yes, I was.

1 Q If we skip ahead a couple of pages to page 6, at the
2 top of that page, Dr. Wall, there's a heading of
3 "Environment Cleaning and Disinfection", and then there
4 are some comments about proper disinfectant products
5 and some requirements there. Were you adhering to the
6 environment cleaning and disinfection part of the
7 standard?

8 A Yes, I was.

9 Q And if we go to page 7, there's a heading that says
10 "Required Clinic Environment Adaptions", and it's got
11 some interesting comments about books, magazines, toys,
12 et cetera. Were you adhering to that requirement?

13 A Yes, I was.

14 Q The next heading on that page is "Physical Distancing",
15 and I'm going to ask you a question about the very next
16 page, page 8, and that first black bullet on the top of
17 that page says: (as read)

18 Non-clinical employees and the public must be
19 2 metres from each other.

20 And then: (as read)

21 Reception and payment area -- [and there's a
22 question coming] -- if 2 metres cannot be
23 maintained at reception/payment area, either
24 staff must be continuously masked or the
25 installation of a plexiglass/plastic barrier
26 must occur to protect reception staff.

1 I'm assuming that you weren't following this part of
2 the Pandemic Directive; the only exception being after
3 December 20, you began using plexiglass; is that fair?

4 A That's correct.

5 Q So if we go to the next section on page 8, the heading
6 "Personal Protective Equipment", and there's a heading
7 "Staff and practitioner PPE", and it reads: (as read)

8 On April 23, 2020, AHS announced, effective
9 immediately, AHS is advising all health care
10 workers providing direct patient care in both
11 AHS and community settings to wear
12 surgical/procedure masks continuously at all
13 times and in all areas of the workplace if
14 they are involved in direct patient contact
15 or cannot maintain adequate physical
16 distancing from patients and co-workers.

17 I'm assuming you would say you weren't following that?

18 A That's correct.

19 Q And if we go to the next heading, "PPE requirements",
20 got three bullets: (as read)

21 Surgical or procedure masks are the minimum
22 acceptable standard; chiropractors and
23 clinical staff must be masked at all times
24 while providing patient care; [and then next]
25 nonclinical staff must be masked when a
26 physical distance of 2 metres cannot be

1 maintained.

2 I'm assuming you would agree that you weren't following
3 that aspect of the Pandemic Directive?

4 A That's correct.

5 Q And if we go to the very next page, that's page 9,
6 there are a series of steps for donning and doffing
7 masks. I'm assuming you couldn't have been following
8 those because you weren't masking; is that fair?

9 A That is correct.

10 Q Okay. Dr. Wall, I'd like you to go to the last page of
11 the Pandemic Directive, page 12, and that's a heading
12 "Resources". Do you recall whether you went through
13 and reviewed any of these resources?

14 A Yes, I did. I did click on them. I'm unfamiliar with
15 them now, but I did recall clicking on those at the
16 time.

17 Q Yeah, and I wasn't going to take you through them, I
18 just wondered if you'd accessed them.

19 Do you, in particular, remember whether you
20 accessed the three AHS ones that are listed under
21 "Personal Protective Equipment"?

22 A I'm positive that I looked at all of the resources,
23 but, yeah, so I would have come across it, I'm sure.

24 Q And I take it, Dr. Wall, I'm going to ask you a
25 question about what happens in a few weeks, but reading
26 those resources or accessing them didn't change your

1 mind later on about whether to comply?

2 A That is correct.

3 Q And this is a little housekeeping on my part, I think I
4 asked you this, but the Pandemic Directive does not
5 contain an exemption for masking; is that correct?

6 A That's correct.

7 Q And there's -- I should have been a little more
8 expansive -- there's no exemptions for social
9 distancing or plexiglass barriers?

10 A Correct.

11 Q Okay, I'd like to take you to the AHS closure and
12 rescind orders, and those are Exhibits D-1 and D-2.
13 I'm just wait for you to get to those and get the
14 Hearing Tribunal Members to those as well.

15 A I'm good.

16 Q So there's a couple "Whereas" paragraphs, and I went
17 through these with you a little bit in my prior
18 questions for you, but when we look at "Whereas"
19 paragraph 8, it says: (as read)

20 Practitioner does not wear a face mask while
21 providing care within 2 metres distance from
22 patients.

23 You'd agree with that, that's factually correct?

24 A Yes.

25 Q The next statement says: (as read)

26 This activity could contribute to the spread

1 of COVID-19.

2 Would you agree with that statement?

3 A No, I would not.

4 Q And if we go to item (b), "Whereas" Section (b): (as
5 read)

6 Practitioner does not implement continuous
7 masking by all staff and patients.

8 That's correct, isn't it?

9 A Yes, it is.

10 Q And: (as read)

11 Physical barrier at front desk reception is
12 also not available.

13 That was correct at that time?

14 A Correct, yeah.

15 Q And then we have another statement: (as read)

16 This activity could contribute to the spread
17 of COVID-19.

18 And again notwithstanding that this is Alberta Health
19 Services, you wouldn't agree with that, would you?

20 A No, I would not.

21 Q If we go to D-2, the rescind order -- oh, and I should
22 go back, you did close your clinic after receiving D-1?

23 A Yes, I did.

24 Q So you chose to comply with the AHS order?

25 A Yes.

26 Q I think I know the answer to this question, but did you

1 agree with the closure order?

2 A No, I did not.

3 Q And would it be fair to say that you strongly disagreed
4 with that order?

5 A Very strongly disagreed.

6 Q Would it be fair to say that, despite the references I
7 took you through in (a) and (b), you don't believe
8 there's a scientific basis for the conclusions in those
9 "Whereas" paragraphs?

10 A Correct.

11 Q And I suppose, a little more broadly, it would be fair
12 to say that you disagree with the CMOH orders and the
13 science they're based on?

14 MR. KITCHEN: If you specify a section, he
15 can answer, but --

16 MR. MAXSTON: Sure.

17 MR. KITCHEN: -- that's too broad.

18 MR. MAXSTON: Yeah, that's fair.

19 Q MR. MAXSTON: Do you agree with the CMOH
20 orders not having a scientific basis for masking and
21 social distancing and plexiglass barriers?

22 MR. KITCHEN: Again, when you went from all
23 to three, why don't you try them one at a time.

24 Q MR. MAXSTON: Dr. Wall, consistent with
25 Mr. Kitchen's advice, do you take issue with the
26 CMOH -- any science the CMOH orders are based on in

1 terms of masking?

2 A Yes, I do.

3 Q And any science in terms of social distancing?

4 A Yes, I do.

5 Q And any science in terms of plexiglass barriers?

6 MR. KITCHEN: You're going to have to point
7 us to what CMOH order requires plexiglass barriers?

8 MR. MAXSTON: I'll take that back; that may
9 be the Pandemic Directive alone, Mr. Kitchen, so I'll
10 leave that one.

11 Q MR. MAXSTON: I want to continue with
12 looking at the rescind order, and I think you told me
13 in some of the questions just before lunch you're not
14 in compliance with Order Number 4; is that correct?

15 A Correct.

16 Q And this is Exhibit D-2.

17 A Yeah.

18 Q There was a discussion yesterday about Orders 1 and 3,
19 Order 1 saying you must follow the Pandemic Directive,
20 which would include masking, and Order Number 3 that
21 says you can get consent to practice unmasked. Would
22 you agree that there's an inconsistency between those
23 two orders?

24 A Can you rephrase that or just --

25 Q Yeah, I'll break it down. Order number 1 says you have
26 to comply with the ACAC's requirements, which is the

1 Pandemic Directive, and that includes masking, doesn't
2 it?

3 A Yes, it does.

4 Q And if we look at Order Number 3, it says you must
5 inform the patient you will be unmasked while providing
6 services. And my question to you is there's an
7 inconsistency between those two orders, isn't there?

8 A Yes, it -- yes.

9 Q Okay. When your clinic was shut down, you said you
10 complied with the order, you didn't launch a court
11 challenge to it, did you?

12 A No, I did not.

13 Q So you were prepared to respect the authority of the
14 AHS? I'll rephrase it. Were you prepared to comply
15 with their direction?

16 A Yes, I was.

17 Q In terms of the re-opening order and the four orders,
18 was it your intention to comply with all of them?

19 A Are you referring to the four points under the rescind
20 notice?

21 Q Yeah, that's what I'm looking at, and in fairness to
22 you, we'll just call them the four points. Was it your
23 intention to comply with all four of those?

24 A I can see point number 4 talks about: (as read)

25 Ensuring all patients he treats continuously
26 wear a mask that covers their mouth.

1 At that point, I would say that I believe patients have
2 the need to exercise their own health freedom when it
3 comes to that point, in the same way that I would
4 exercise my own health freedom with respect to masking.

5 Q So would it be fair to say then that you re-opened, but
6 you weren't in compliance with that fourth point when
7 you re-opened?

8 A Yes.

9 Q I'd like you to go -- bear with me, Dr. Wall. I'd like
10 to take you back to the Standards of Practice, which
11 were Exhibit A-11 and specifically page 11. And,
12 again, no surprises, I want to talk to you about the
13 "Informed Consent", Standard 3.1.

14 A Go ahead.

15 Q Okay, there's under 3.1, we go to I think the third
16 paragraph, it says: (as read)

17 As part of the informed consent process,
18 chiropractors are responsible for disclosing
19 to each patient --
20 1 and 2 are diagnosis, purpose, nature of treatment,
21 but I'm curious about number 3: (as read)

22 The potential risks including those that may
23 be of a special or unusual nature.

24 First, would you agree that's a requirement for you to
25 do?

26 A Yes, I agree.

1 Q And when you talked to patients about masking, did you
2 tell them about the risks of you not masking?

3 A No, I didn't, because I didn't believe that there was a
4 risk to me not masking.

5 Q I take it then, when we go to the paragraph right after
6 that: (as read)

7 Chiropractors must private patients the
8 opportunity to ask questions concerning risks
9 [et cetera].

10 You really didn't engage in a Q-and-A then with
11 patients about masking, your masking?

12 A That is correct. And my understanding of this informed
13 consent process is that this is referring to
14 chiropractic care. I'm not sure that this is getting
15 into mask wearing per se. This looks like it's
16 regarding the treatment that is being proposed to the
17 patient. Wearing a mask in this situation seems
18 extraneous, but I could be wrong.

19 Q I just have one other quick question for you, if we go
20 to the final part of that page, it says: (as read)

21 Informed consent must -- [and then item 6] --
22 be present on all existing patient files if
23 verbal informed consent is noted from
24 previous treatment.

25 Did you take the position that you had to get consent
26 from a patient when you weren't masking?

1 A No, I did not.

2 Q And I'm going to skip around here a little bit. Order
3 Number 3 in the Exhibit D-2, the AHS rescind order,
4 says: (as read)

5 Prior to booking an appointment, Dr. Curtis
6 Wall must inform the patient he will be
7 unmasked while providing services.

8 And I'll just stop there. Were you complying with
9 that; prior to booking an appointment, were you
10 informing the patient that you would be unmasked?

11 A Yes, I was.

12 Q And then the second part is prior to booking an -- oh,
13 sorry, you: (as read)

14 -- must obtain a patient's explicit consent
15 to proceed with booking and undertaking said
16 services.

17 I take it you weren't getting the patient's explicit
18 consent based on what you were telling me before,
19 because you didn't think you had to do that?

20 A Okay, I understand now. Yes, I was getting there
21 consent, because I had to have them sign a form stating
22 that they were okay to be treated by me while I was not
23 wearing a mask. So perhaps I answered wrongly in the
24 first place, but, yes, I was following all the
25 conditions and restrictions on my practice, so that did
26 require a consent, you're right.

1 Q Okay, so if we were to look at every one of your files
2 after that rescind order, they'd have that patient
3 consent form on them?

4 A No, it wouldn't be in a form on every file. I had two
5 separate pieces of paper, each delineating -- one was
6 the prescreening questions, that they were all negative
7 to those questions, and the second form listed the
8 exemption that I had to wearing a mask and that that
9 patient was okay to be treated by me, so they would
10 sign that one too, yeah.

11 Q So that was -- the rescind order was dated January 5,
12 2021. Did you have those kinds of consents on your
13 charts before January 5, 2021?

14 A No, I did not.

15 Q And I don't want to put words in your mouth, is it fair
16 to say, if we looked at your charts then from June
17 onwards, we wouldn't see patient consent charted on,
18 patient to masking, you or you being unmasked?

19 A That is correct.

20 MR. KITCHEN: Hold on, just to clarify, you
21 mean June of 2020?

22 MR. MAXSTON: Did I say a different date?
23 My apologies.

24 MR. KITCHEN: No, you just said June. If we
25 had --

26 MR. MAXSTON: June of twenty --

1 MR. KITCHEN: -- (INDISCERNIBLE) to deal
2 with.

3 Q MR. MAXSTON: So I'll go back. From June of
4 2020 onward, we would see charting about -- on your
5 patient charts about you getting patient consent to you
6 not being masked?

7 MR. KITCHEN: Well, hold on, you're getting
8 confusing and misleading there, because he just said
9 that he does do it after he's been asked to do it. So
10 if you want to ask did he do it from June 2020 to when
11 he had to start doing it, that's fine.

12 MR. MAXSTON: Yeah, I was really asking
13 him --

14 MR. KITCHEN: But to try and -- okay.

15 MR. MAXSTON: Yeah, I was really asking that
16 because you sort of objected, so my point, I think the
17 answer was from June of 2020 onwards, there isn't
18 charting about Dr. Wall's masking or not being masked,
19 and I think Dr. Wall said that was correct.

20 A That is correct.

21 Q MR. MAXSTON: Dr. Wall, did you ever provide
22 patients with views about masking that were in
23 opposition to your own?

24 A I left it to the patient. If they were comfortable
25 with masking and believed in it, that they were very
26 willing to wear a mask, so we never engaged in strong

1 conversation about that.

2 Q Okay, and would that have applied to your decision to
3 mask as well; you didn't have a dialogue with them
4 about opposing views on that front?

5 A Only if a patient was really asking me questions about
6 it, then perhaps we would dialogue further.

7 Q Okay, so it was up to the patient to raise that; that
8 was your practice?

9 A Yeah, patients ask questions about all kinds of health
10 issues, and so, you know, in this situation, that was
11 no different.

12 Q Okay. I want to move now to your involvement with the
13 College, or the College's involvement with you is more
14 accurate, and I'd like you to go to Exhibits A-2 and
15 A-3, and, frankly, you could probably just go to A-3,
16 because A-3 includes A-2, which is Ms. Ho's email to
17 Dr. Halowski. Maybe just ask you to get there, and you
18 can let me know when you're ready to go.

19 A Okay, I'm on A-3.

20 Q And I'm going to refer to the email to Ms. Ho, even
21 though it's a separate exhibit, but I'm just going to
22 take you through it using A-3. I just have a couple of
23 questions about it.

24 So this was an email from Ms. Ho to you dated
25 December 1, 2020. Can you tell me if you have any
26 information about how that email was sent to you?

1 A Yes, I do. The email came to me, initially I thought
2 the email was spam quite honestly, and so I didn't
3 answer the email, and then it was followed up by a
4 telephone call, to which I took it.

5 Q I'm looking at the second paragraph, it says: (as read)

6 As per our phone conversation, you indicated
7 that you are [quote] mask exempt.

8 Is that a correct statement by Ms. Ho?

9 A Yes, it is.

10 Q And then: (as read)

11 As per CMOH 38-2020, please indicate which
12 exemption you would fall under; otherwise,
13 you are required to be masking within 2
14 metres distance with a patient.

15 Did you ever get back to her about your exemption?

16 A Yes, I did.

17 Q Okay. The next paragraph says: (as read)

18 As per your administrative staff, you
19 indicated that there is no plexiglass barrier
20 at reception and that staff are not masking.

21 Is that an accurate statement?

22 A Yes, it is.

23 Q If we go to the sort of tail end of that paragraph, it
24 says: (as read)

25 Your clinic must have control measures, eg.,
26 physical barrier, to promote physical

1 distancing at all times.

2 And you didn't have a physical barrier at that point,
3 did you?

4 A No, I did not.

5 Q And then it says: (as read)

6 Otherwise, the administrative staff must be
7 masked as per CMOH 38-2020.

8 Again, you'd agree with me that your administrative
9 staff wasn't masked?

10 A That's correct.

11 Q I'm looking at the letter that Dr. Halowski sent to
12 Mr. Lawrence, that's Exhibit A-3, and I just have one
13 question about it. At the very tail end of the email,
14 the second-last paragraph says: (as read)

15 Further to the email from Public Health, in
16 conversation with Dr. Wall, he indicated that
17 he does not mask and has provided for
18 barriers in his clinic.

19 Is that an accurate statement; that's an accurate
20 statement by Dr. Halowski of what you said?

21 A Yes.

22 MR. MAXSTON: Mr. Chair, I plan to go about
23 another 10, 15 minutes and take a break at 2:45, if
24 that works for everybody. And, Dr. Wall, if you need a
25 break sooner, you let me know, but we've been chatting
26 for about an hour and a bit now, so I'll just go about

1 another 10, 15 minutes, if that's okay.

2 THE CHAIR: That's okay, I believe,
3 Mr. Maxston. Thanks.

4 Q MR. MAXSTON: I'd like you to go to
5 Exhibit A-5, which is Mr. Lawrence's December 21, 2020
6 letter to you.

7 A Okay, I'm there.

8 Q And in paragraph 2, Mr. Lawrence is saying: (as read)
9 You [meaning you, Dr. Wall] would not be
10 taking steps to become compliant with these
11 requirements.

12 And that was what you had communicated to him?

13 A In respect of masking, is that what you're referring
14 to?

15 Q Yeah, I think so in the Pandemic Directive.

16 A Yeah, specifically to do with masking, yes.

17 Q And I guess, in fairness to you, and social distancing
18 and plexiglass barrier.

19 A Yeah. Is that prior to me installing the plexiglass
20 barrier or after?

21 Q Yeah, I think the plexiglass barrier is bit of a
22 variable, because I agree that after December of -- I
23 think it's December 20th, those came up, but my comment
24 to you was he accurate in saying you weren't going to
25 be taking steps then to become compliant?

26 MR. KITCHEN: Well, he's answered the

1 question; he said he's not going to be compliant with
2 masking, so it's fine if you want to get a little more
3 specific.

4 MR. MAXSTON: Well, I think I did.

5 Q MR. MAXSTON: Social distancing, you're not
6 going to be compliant with that?

7 A Correct.

8 Q And the plexiglass barriers referenced in the Pandemic
9 Directive, you're not going to be compliant with that?

10 MR. KITCHEN: Well, he's already answered --

11 A No, I've already put it --

12 MR. KITCHEN: -- that.

13 A Yeah, I've already put it up.

14 MR. MAXSTON: Okay. I was about to go on to
15 my next set of questions, but they're actually probably
16 going to be longer than 15 minutes. Mr. Chair, would
17 you want to take a 10- or 15-minute break now? I think
18 it would be --

19 THE CHAIR: Yeah, you know, if it makes
20 sense in terms of fluidity for your questioning, that's
21 fine. It's 2:30. Let's recess for 15 minutes and
22 reconvene at 2:45, and we'll continue with the
23 objective of meeting Mr. Kitchen's plans to have his
24 witness around 3:45.

25 MR. MAXSTON: We're going to follow the
26 accepted practice that, of course, Dr. Wall can't chat

1 about his testimony with Mr. Kitchen.

2 THE CHAIR: Yes, that's --

3 MR. MAXSTON: Thank you.

4 THE CHAIR: -- (INDISCERNIBLE). Okay,
5 we'll see you at 2:45.

6 (ADJOURNMENT)

7 THE CHAIR: Okay, we're back in session.

8 MR. MAXSTON: Sure.

9 Q MR. MAXSTON: Dr. Wall, I was just taking
10 you through your interactions with the College, and we
11 talked about Mr. Lawrence's letter. I'd like you to go
12 to Exhibit A-6, which is I think an undated, unless I
13 missed something, letter from you in response to
14 Mr. Lawrence, and I'd like to take you through that.

15 I think, in fairness, this document was received
16 by the College I think on January 11, but I'll ask you
17 to clarify when I start your questions, Dr. Wall, on
18 this when it was sent. I don't think there's a date on
19 it. So if you can let me know when you're at that
20 document. Again, A-6.

21 A Yeah, I'm there, and it does appear January 11th.

22 Q Yeah, okay. So, Dr. Wall, some of this we've covered
23 in some detail before, but I'm looking at the second
24 paragraph, and that's a summary, I believe, of your
25 comments about trying masking and trying a face shield,
26 and your decision in June of 2020 to not wear either;

1 is that fair to say?

2 A Yes, it is.

3 Q The next paragraph says: (as read)

4 I considered this decision to be reasonable
5 based on the information available to me and
6 based on my conclusion that the ACAC pandemic
7 practice directive could not be reasonably
8 interpreted to demand the wearing of a mask
9 if doing so was harmful to the member and
10 negatively impacted the member's ability to
11 provide the best possible patient care.

12 That's your interpretation without any consultation
13 with the College, correct?

14 A That's correct.

15 Q There's another paragraph just below that, beginning:
16 (as read)

17 The information available to me at the time
18 was that the benefit of masks vis-à-vis
19 reducing COVID-19 transmission was tenuous
20 and that mask wearing was an additional
21 precautionary measure, which was worth
22 implementing only if doing so did not result
23 in negative impacts that outweighed the
24 potential marginal benefits.

25 And you then say: (as read)

26 This has been borne out over time.

1 I just want to be clear here, this is stating the
2 obvious, but you're not a virologist or respirologist
3 or an epidemiologist?

4 A That's correct, yeah.

5 Q So this is your conclusion?

6 A That's correct.

7 Q The next paragraph says: (as read)

8 I did not think at the time that I should or
9 needed to obtain any sort of exemption to
10 wearing a mask or face shield from another
11 health care practitioner such as a medical
12 doctor.

13 And I'm going to suggest to you, Dr. Wall, that that's
14 really kind of an astonishing statement that, as a
15 health care provider, you would think you didn't need
16 to go see another health care practitioner. Can you
17 tell me why you would believe that, why you thought you
18 could self-diagnosis?

19 A Well, my very obvious symptoms of anxiety and
20 claustrophobia were very apparent to me. I didn't need
21 somebody to diagnose that. It was extremely obvious,
22 and so that would be my short answer.

23 Q The next paragraph you talk about a spring of 2020 AHS
24 report, and you quote from it briefly I think, or you
25 reference it. Do you recall Dr. Hu's testimony where
26 he said that masking guidance has changed since the

1 beginning of the pandemic?

2 A Yes, I do.

3 Q And would it be fair to say that when we look at those
4 three additional AHS documents, they do support
5 masking?

6 A I'm sorry, which three initial documents?

7 Q We had an application at the beginning of the hearing
8 where I asked three AHS documents be entered, and I
9 took Dr. Hu through them. Would you agree with me, and
10 I can take you through them, but I don't think I need
11 to, would you agree with me that those three AHS
12 documents are supportive of masking?

13 A I believe that's what they would believe, yes.

14 Q On the top of the next page, there's a closing
15 sentence: (as read)

16 Subsequent studies and reports have confirmed
17 that the benefits of masks is tenuous at
18 best.

19 Would you agree with me that there are other studies
20 that are strongly in support of masking?

21 A I think there are probably multiple studies that would
22 say that they are in strong support of masking. I
23 question some of the design flaws with respect to that,
24 but that is not my expertise, and so I'll leave it at
25 that.

26 Q Okay. The next paragraph talks about, in part, the

1 CMOH orders, and to use your wording: (as read)
2 Broadly worded exceptions and -- [sorry] --
3 broadly worded exceptions exempting
4 individuals from wearing masks if they had
5 mental concerns or limitations.

6 And then you talk about CMOH Order 38 and CMOH Order
7 42-2020, and we canvassed this before, but those orders
8 weren't in force until November and December of 2020;
9 isn't that correct?

10 A I believe so.

11 Q I'd like you to go to the -- I wish these pages were
12 numbered, it might be easier for me, but the top of
13 page 3 starts off with "Include exceptions for mental
14 conditions or limitations". Are you there, Dr. Wall?

15 A Yes, I am.

16 Q Okay. There is a -- the first complete sentence says:
17 (as read)

18 I have legitimate mental concerns and
19 limitations, and I'm, therefore, not bound by
20 any order of the CMOH to wear a mask.

21 You would agree with me that those were, again,
22 self-diagnosed mental concerns?

23 A Yes, I would. Initially.

24 Q If we go a little bit down, there's a paragraph
25 beginning: (as read)

26 As for the allegation I failed to comply with

1 the Pandemic Directive.

2 There's a closing statement, it says: (as read)

3 However, it appears the fact that I have not
4 been wearing a mask is the content of the
5 allegation I failed to comply with the ACAC
6 Pandemic Practice Directive.

7 And that's still your understanding, at least in part?

8 There's other issues, but ...

9 A That's correct.

10 Q You then say: (as read)

11 I acknowledge that, on its face, the Pandemic
12 Directive states that mask wearing is a
13 requirement of members. I further
14 acknowledge the fact that I have been not
15 wearing a mask, on its face, amounts to
16 noncompliance with the practice directive.

17 And you maintain those acknowledgments today, I assume?

18 A Yes, I do.

19 Q Final sentence in that paragraph says: (as read)

20 Any policy or directive of the ACAC that
21 imposes mandatory mask wearing upon members
22 but does not permit necessary exceptions is
23 unreasonable.

24 You never asked for an exception, did you?

25 A No, I did not.

26 Q The next paragraph: (as read)

1 I further submit it was reasonable of me to
2 conclude that a reasonable reading of the
3 ACAC Pandemic Directives requirement to wear
4 masks implicitly permitted necessary
5 exceptions such as for legitimate mental
6 health conditions, concerns, or limitations.
7 Again, that's your conclusion and your interpretation
8 alone?

9 A Correct.

10 Q Thank you, Dr. Wall, I don't have any further -- any
11 more questions on that document.

12 At this point or maybe it's happening already,
13 Mr. Lawrence is conducting the investigation into your
14 conduct under Part 4 of the HPA, and I'd like to take
15 you to the investigation report, which is Exhibit A-7.

16 A Okay, I'm there.

17 Q Okay. I'm looking at page 1, and the second paragraph
18 talks about a December 2, 2020 conversation with the
19 Registrar and December 3, 2020 conversation during
20 the -- with the Complaints Director. And we then have
21 some comments about masking, et cetera. I'm skipping
22 down to about the fourth-last line, there's a comment
23 which Mr. Lawrence: (as read)

24 He indicated -- ["he" meaning you] --
25 indicated that he did not believe he was
26 endangering the public, as the recovery rate

1 from COVID-19 is so high.

2 Is that your recollection of the statement you made as
3 well?

4 A Yes, it is.

5 Q You'd agree with me though that even if the recovery
6 rate is high, there are some individuals who have
7 serious medical complications because of COVID-19?

8 A Yes, I would.

9 Q And that it's fatal for some people?

10 A Correct.

11 Q Going to ask you to go to page 4 of the investigation
12 report, and this is a series of what Mr. Lawrence
13 describes as key points of the interview. Just got a
14 couple of questions for you about some of these,
15 because I think you've answered a lot of the questions
16 I was going to ask you. About the fifth bullet down
17 deals with your son working at the clinic, and the
18 second sentence says: (as read)

19 Dr. Wall indicated that he also did not
20 require his son to be masked and did not
21 think it necessary to install any barriers.

22 Is that accurate?

23 A Yes, it is.

24 Q And if it wasn't your son, if it was anyone else there,
25 would you take the same position?

26 MR. KITCHEN: That's a hypothetical. I

1 don't see the relevance.

2 Q MR. MAXSTON: Well, I'll ask you this: Did
3 you have anybody other than your son working at the
4 clinic during the time relating to the charges, working
5 as a receptionist?

6 A No, I did not.

7 Q Okay, well, that answers that question. And the next
8 arrow, there's a comment about Dr. Wall reiterated that
9 your son is a healthy individual, and he did not want
10 to wear a mask; that's accurate?

11 A That's correct.

12 Q I'm going to ask you, Dr. Wall, sort of a general
13 question, but would you agree that a chiropractor is
14 responsible for his staff members complying with the
15 requirements of practice for a chiropractic clinic?

16 A With respect to the mask wearing, I would tend to take
17 the same position that I've taken for myself. So if my
18 staff member, being my son, had legitimate concerns,
19 whether they were religious or physical or otherwise,
20 then we'd have to walk through that.

21 Q Okay, I was trying to be a little more precise there.
22 I'm thinking of things like the charting standard I
23 took you through. If you delegate charting to a staff
24 member, you're ultimately responsible, aren't you --

25 A That's correct.

26 Q -- for the charting?

1 A That's correct.

2 Q And the same would be true for Standards of Practice
3 and other College requirements; if staff do things,
4 you're ultimately responsible?

5 A Correct.

6 Q Dr. Wall, there's a bullet or an arrow about four from
7 the bottom, it says: (as read)

8 When asked if Dr. Wall ever alerted his
9 patients to the dangers of not being masked,
10 Dr. Wall replied that people are aware of the
11 dangers, and he did not explain any of the
12 dangers to patients of him not masking.

13 Is that sort of what you said to me before, that you
14 let patients raise things with you?

15 A If the conversation came up, yes.

16 Q And you rely on the patient to raise that discussion?

17 A As it pertained to mask wearing; is that what you're --

18 Q Yeah.

19 A -- referring to? Yes.

20 Q When you had -- I'm sorry, when you had your interview
21 with Mr. Lawrence, and I think it was a phone
22 interview, Mr. Kitchen was present, participated,
23 listened, I guess is maybe the best way, during the
24 interview; is that correct?

25 A Are you referring to the interview with Dr. Halowski
26 and Mr. Lawrence?

1 Q Yes, the one that would have occurred in -- oh, my
2 apologies, Dr. Wall, January 25, 2021.

3 A Yes, that's correct. Mr. Kitchen was present on that
4 call.

5 Q Okay, thank you. Would it be fair to say that when you
6 had that discussion during the interview that you
7 didn't mention the religious beliefs you talked about
8 today?

9 A I didn't; I don't think I did mention the religious
10 beliefs, yeah.

11 Q I'd like to turn to the Section 65 interim order
12 matters, and as you know from Exhibit -- I'm not going
13 to take you to this exhibit, but Exhibit D-1 was
14 Mr. Lawrence's December 3, 2020 letter to Mr. Linford.
15 I'd like to ask you though about the response letters
16 that Mr. Kitchen sent on your behalf, and those appear
17 as Exhibits B-3 and B-4. I'll take you to B-3 first,
18 which is the December 10, 2020 letter from Mr. Kitchen.

19 A Okay, I'm there.

20 Q So this was a letter written by Mr. Kitchen in response
21 to Mr. Lawrence's request for Section 65 suspension. I
22 take it you adopt the contents of this letter; you
23 instructed Mr. Kitchen to send this letter?

24 A Yes, I did.

25 Q Okay. I'm going to page 2, the second complete
26 paragraph says: (as read)

1 Any risk to Dr. Wall's patients as a result
2 of him not wearing a face covering is
3 speculative at best.

4 That's your position as well?

5 A Yes, it is.

6 Q And notwithstanding hearing from Dr. Hu, that's your
7 position still?

8 A Correct, yes.

9 Q And the next sentence, and I should go back,
10 notwithstanding looking at those AHS documents, that's
11 still your position?

12 MR. KITCHEN: You've asked that at least
13 once if not a couple times already, Mr. Maxston.

14 Q MR. MAXSTON: The next sentence says: (as
15 read)

16 There's a lack of scientific evidence that
17 face coverings have any measurable
18 effectiveness in preventing the transmission
19 of COVID-19.

20 Is that your position?

21 MR. KITCHEN: Again, Mr. Maxston, you've
22 asked that, and, obviously, his position, you've just
23 established, that this was sent on behalf of Dr. Wall
24 at his instructions, which means it is his position;
25 you've just established that. So now --

26 MR. MAXSTON: Well (INDISCERNIBLE) --

1 MR. KITCHEN: -- you're asking does Dr. Wall
2 agree that the sky is blue, does he agree that all the
3 sky is blue, you know, you don't get to -- I don't see
4 how you get to do that.

5 Q MR. MAXSTON: Well, I guess I could be more
6 global and say do you agree with every statement in
7 this letter that Mr. Kitchen has made about COVID and
8 masking and related matters?

9 MR. KITCHEN: You've already asked that --

10 MR. MAXSTON: Well --

11 MR. KITCHEN: -- and he's already given you
12 his answer.

13 MR. MAXSTON: I asked him whether he adopted
14 it but --

15 MR. KITCHEN: Yes, you did. And that means
16 that if he adopted it, he adopted all of it. And it's
17 his statement, not mine, so once he adopts it, it's
18 his, it's sent on his behalf by counsel.

19 MR. MAXSTON: I think even though he's
20 adopted it, I'm allowed to ask questions, but I'll move
21 on to something else.

22 Q MR. MAXSTON: I'm looking at the bottom of
23 page 2 of the letter, it says: (as read)

24 As a matter of factual clarity, Dr. Wall
25 employees [or "employees" I think should be
26 "employs"] no staff in his clinic that are

1 not members of his family.

2 You've confirmed that with me: (as read)

3 Dr. Wall reiterates that he has appropriately
4 installed the required plexiglass barriers at
5 his chiropractic office and will maintain
6 such barriers as long as they are required.

7 Why did you install the, quote, required plexiglass
8 barriers, Dr. Wall?

9 A I believe that was part of the re-opening process for
10 Alberta Health Services, that my plexiglass barriers be
11 up, so I did that.

12 Q So that was an aspect of the re-opening order that you
13 did choose to comply with?

14 A That's correct.

15 Q Okay, let's go to Exhibit B-4. That's Mr. Kitchen's
16 December 16, 2020 letter. I'll just ask you again, you
17 adopt this as your response?

18 A Yes, I do.

19 Q Okay I was going to ask you about item number 1, but
20 we've already dealt with why you installed the
21 plexiglass barriers. I'm curious about item number 2.
22 It says: (as read)

23 Attached to this letter as Appendix B is a
24 medical certificate from an M.D. exempting
25 Dr. Curtis Wall from being required to wear
26 any sort of face covering on the basis of a

1 mental disability.

2 At the time of this letter, December 16, I think the
3 only medical note we had was Exhibit A-8, Dr. Salem's
4 December 12th, 2020 letter.

5 MR. MAXSTON: I can ask Mr. Kitchen to help
6 out here, was that the enclosure you were referring to
7 in this letter, Mr. Kitchen? I don't think it's
8 attached as an exhibit. I think we probably didn't put
9 it in because it was redundant, but I just want to be
10 sure that --

11 MR. KITCHEN: It is (INDISCERNIBLE)
12 Exhibit A-8.

13 MR. MAXSTON: Yeah. When you -- in item 2,
14 when you --

15 MR. KITCHEN: You're asking this because
16 it's not contained in this letter, I take it, which --

17 MR. MAXSTON: Yeah, I just want to be sure,
18 in fairness to your client, I'm asking the right
19 question about the right document and --

20 MR. KITCHEN: (INDISCERNIBLE)

21 Q MR. MAXSTON: -- and we're digressing a
22 moment here, Dr. Wall --

23 MR. MAXSTON: --Mr. Kitchen, my sense is
24 that because your letter is dated December 16, 2020,
25 the only letter we can have from Dr. Salem is the one
26 from December 12. He didn't do his other letter

1 until --

2 MR. KITCHEN: Yeah, I can't object to that
3 as being factually inaccurate, so I'll let Dr. Wall
4 answer, but everything's --

5 MR. MAXSTON: Yeah.

6 MR. KITCHEN: -- everything's in order so
7 far.

8 MR. MAXSTON: Yeah, I think the other letter
9 from Dr. Salem is January 8, 2021, so I just want to be
10 clear I'm asking --

11 MR. KITCHEN: That's --

12 MR. MAXSTON: -- the right question.

13 MR. KITCHEN: That's right.

14 Q MR. MAXSTON: Okay, so if we're proceeding
15 then that the Appendix B that is being referred to in
16 this letter is Exhibit A-8, I'd just ask you to quickly
17 go to Exhibit A-8, Dr. Wall.

18 A Okay, go ahead.

19 Q I'm going to read this to you, if you want to go back,
20 but Exhibit B-4, the letter of December 16, 2020, item
21 2 says: (as read)

22 Appended to this letter as Appendix B is a
23 medical certificate from an M.D. exempting
24 Dr. Curtis Wall from being required to wear
25 any sort of face covering on the basis of a
26 mental disability, which, as you know, is a

1 protected ground under Section 4 [and they
2 have a reference to the Human Rights Act and
3 the Charter].

4 When I go to Exhibit A-8, I don't see any reference to
5 mental disability; would you agree with that?

6 A Yes, it is not included in that letter.

7 Q And it says "medical reasons" in Exhibit A-8; is that
8 correct?

9 A That is correct.

10 Q I would like to take you to Exhibit B-5, which is
11 Dr. Linford's decision on the Section 65 suspension.

12 A Sorry, can you clarify B dash what?

13 Q B dash 5, Bob dash 5, and it's the December 8th, 2020
14 decision letter from Dr. Linford, and specifically I'll
15 be taking you to page 2 when you get to it, Dr. Wall.

16 A Yeah, go ahead.

17 Q You would agree with me, I'm looking at the second
18 complete paragraph on page 2, Dr. Wall says: (as read)

19 The impact of COVID-19 on the Public Health
20 care system is undeniable.

21 That's correct?

22 A Correct.

23 Q At the end of that paragraph, the final two sentences
24 say -- and he's talking about full vaccination
25 occurring: (as read)

26 Until that time arrives, the COVID-19 virus

1 remains a real and imminent public health
2 threat.

3 You'd agree that's his statement?

4 A I'm sorry, where is that statement again?

5 Q Sorry, it's about two-thirds of the way down, it's the
6 second-last full sentence, beginning "Until that time
7 arrives", and it's in the same paragraph we were just
8 chatting about.

9 THE CHAIR: I think it's a third of the
10 way down the page, not two-thirds.

11 MR. MAXSTON: Yeah.

12 THE CHAIR: It's the third paragraph.

13 Q MR. MAXSTON: I don't know if it helps,
14 Dr. Wall, but I've taken you to the statement: (as
15 read)

16 The impact of COVID-19 on the public health
17 care system is undeniable.

18 I'm about five lines below that in the sentence
19 beginning "Until".

20 A Got it, yeah, I see that now.

21 Q Yeah, sorry, it's a little hard to follow, because
22 it's -- there's some incomplete paragraphs.

23 So I'm just asking you to confirm, Dr. Linford is
24 stating: (as read)

25 Until that time [I think he means full
26 vaccination] arrives, the COVID-19 virus

1 remains a real and imminent public health
2 threat.

3 Those are his words?

4 A Yes.

5 Q I take it you would disagree with that?

6 A Yes.

7 Q The next sentence is: (as read)

8 I find that the Complaints Director has a
9 legitimate concern of risk to the public by
10 Dr. Wall's decision to not wear a face mask
11 or face shield when seeing and treating
12 patients.

13 That's his statement?

14 A Yes, it is.

15 Q And you would disagree with it?

16 A Yes, I would.

17 Q We go to the next paragraph, there's a second sentence:
18 (as read)

19 I have decided that conditions on Dr. Wall's
20 practice permit will be sufficient to address
21 the risk to the public by Dr. Wall not
22 wearing a face mask or face shield when
23 seeing and treating patients.

24 So those are his words in identifying a risk to the
25 public?

26 A Correct.

1 Q And, again, you would disagree with that?

2 A No, he is saying that the conditions were sufficient to
3 address the risk to the public. That I agree, he
4 believes that the conditions on my practice would be
5 sufficient to meet -- to meet the risk to the public.

6 Q Okay, thanks for clarifying that. If we look at the
7 balance of the letter, there are a series of directions
8 on that page, and I'm using the word "directions"
9 because Dr. Linford uses that, he says: (as read)

10 Your practice permit will be subject to the
11 following practice -- I direct that

12 Dr. Wall's practice permit will be subject to
13 the following practice conditions pending
14 completion of this hearing.

15 There are, as I said, four directions from him then.

16 Would you agree that those are binding on you?

17 A Yes, I would.

18 Q And would you agree that they're still binding on you,
19 to be more clear?

20 A Yes.

21 Q And have you complied with those conditions or orders,
22 and are you continuing to comply with them?

23 A Yes, I have.

24 Q So in this case, you've determined that you will follow
25 a College requirement?

26 A Can you be more specific?

1 MR. KITCHEN: This isn't a College
2 requirement, or maybe it is, then we have to establish
3 that. It's obviously a requirement of Dr. Linford.

4 MR. MAXSTON: I'll rephrase my question.

5 Q MR. MAXSTON: This is a -- those are a
6 series of directions ordered by Dr. Linford under
7 Section 65 of the HPA; is that correct?

8 A Yes.

9 Q And Dr. Linford is appointed, pursuant to the HPA, to
10 make these kinds of decisions; would you agree with
11 that?

12 A Yes.

13 Q And my question was are you complying, are you
14 continuing to comply with the directions, the
15 conditions on your practice permit?

16 A Yes.

17 Q And my follow-up question was this is a situation where
18 you are complying with a direction from a College I'll
19 call him designate or officer?

20 A Correct.

21 Q And as you are likely aware, Section 65 of the HPA
22 contains a right for you to appeal a Section 65
23 direction to the courts. Did you launch any kind of
24 court deal concerning the Section 65 direction?

25 A No, I have not.

26 Q Dr. Wall, I want to switch gears now and talk about

1 your decisions you made, your decisions or independent
2 decisions in June of 2020 about not masking and not
3 social distancing, et cetera.

4 When you -- and I think we've covered this, but I
5 want to be clear -- when you decided in June of 2020
6 that you weren't going to wear a face mask or use
7 social distancing, you were aware that those choices
8 would contravene the Pandemic Directive as written?

9 MR. KITCHEN: Mr. Maxston, I'd have to say
10 that you've asked this and he's answered it, and the
11 answer's not controversial.

12 MR. MAXSTON: Well, I won't re-ask the
13 question on the basis that you're telling me your
14 client has already agreed to that.

15 Q MR. MAXSTON: Can you tell me, Dr. Wall,
16 when you started this review of, you know, the masking
17 issue for you? And by "review", I mean the inquiries
18 you made about efficacy of masking.

19 A Well, when the Pandemic Directive came into place for
20 chiropractors, I believe that was specific to May with
21 the Pandemic Directive, and so wearing a mask
22 immediately had me asking questions because I
23 experienced the symptoms that I was experiencing, so I
24 would have to say in early May.

25 Q Okay. When you did that, did you look for any articles
26 or studies that supported masking?

1 A I was looking, in general, at various articles, and so
2 I don't think I was looking for articles in support of
3 masking.

4 Q Did you consider any articles in support of masking
5 when you made your decision?

6 A Yeah, I've seen articles floating around supporting
7 masking, yes.

8 Q So I'm assuming then that you chose to discount those
9 articles or studies?

10 A That's correct. I have seen articles that support
11 masking, and then I've seen those particular articles
12 debunked, and so, yeah.

13 Q Did you contact any other organizations to get their
14 views on this masking efficacy question?

15 A No, I did not.

16 Q Specifically, did you contact the Canadian Chiropractic
17 Association?

18 A No, I did not.

19 Q Did you -- I should go back. Are you insured for
20 malpractice with the CCPA?

21 A Yes, I am.

22 Q Did you contact the CCPA about your decision?

23 A To not mask?

24 Q Yes.

25 A No.

26 Q Did you consult with any medical health care

1 professionals or specialists?

2 A Not until the time where I had to achieve a doctor's
3 note.

4 Q And I suppose this is an obvious question, but when you
5 made the decision in June of 2020, you didn't have the
6 four expert reports that are being tendered in this
7 hearing by you?

8 A That's correct.

9 Q Is it your position that it was professionally and
10 ethically acceptable for you to decide when and how the
11 Pandemic Directive applied to you?

12 A As it applied to masking, yes, and perhaps the social
13 distancing, like you mentioned.

14 Q Okay. I'm going to ask you to go to Exhibit A-8, we
15 went through this a little bit before, but I'm going to
16 ask you a little bit more detailed questions. That's
17 the letter from Dr. Salem, dated December 12th, 2020.
18 And I'll just wait till everybody's there. When did
19 you first contact Dr. Salem about an exemption letter?

20 A I believe I'd have to really look at my journal. It's
21 probably sometime in early December.

22 Q Was that after you had received an indication from the
23 College that there was a complaint?

24 A That is correct.

25 Q So it's fair to say that at least part of your
26 motivation in getting this letter was to be able to

1 respond to the College's complaint?

2 A To be supportive, and, yes, because I wasn't under the
3 understanding that there was a requirement to produce
4 some type of exemption letter, yes.

5 Q Is Dr. -- was Dr. Salem your regular family doctor at
6 the time?

7 A No.

8 Q So how did you choose him?

9 MR. KITCHEN: We're getting into something
10 that's pretty personal and private, and I'm not sure
11 that it's relevant.

12 MR. MAXSTON: Sure, I'll be a little more
13 general.

14 Q MR. MAXSTON: If he wasn't your regular
15 doctor -- I don't need any background -- did you sort
16 of pick him out of the phone book, so to speak? And I
17 remember when there were phone books or -- I'm just
18 wondering how you made your way to Dr. Salem; that's
19 what I'm really asking.

20 MR. KITCHEN: Again, personal, private, not
21 relevant.

22 Q MR. MAXSTON: When you made an appointment
23 with Dr. Salem and subsequently got this letter, were
24 you aware that Dr. Salem had ever issued any other
25 exemption letters?

26 A No, I'm not.

1 Q Was your attendance -- I think there were two
2 attendances with Dr. Salem, the but the first time you
3 saw Dr. Salem -- well, this is an obvious question, I
4 guess -- you'd never seen him for anything before,
5 anything other medical issues?

6 MR. KITCHEN: Again, this is personal, it's
7 private, it's not relevant.

8 Q MR. MAXSTON: Isn't it fair to say,
9 Dr. Wall, that you realized that your own
10 self-diagnosis of an anxiety issue wasn't going to
11 withstand scrutiny unless you had a doctor's letter?

12 A I would say that that's likely accurate, yes.

13 Q And you could have gone to a doctor like Dr. Salem in
14 May or June of 2020?

15 A I could have, yes.

16 Q When you were seeing Dr. Salem the first time, which
17 gave rise to the December 12th, 2020 letter, did he
18 perform any tests in terms of your anxiety issues?

19 A It was a consultation, and so we discussed at length my
20 issue.

21 Q Okay. Did he offer a prognosis to you?

22 A No.

23 Q Did he offer a treatment plan?

24 A No, he did not.

25 Q Did he recommend any steps to address the anxiety
26 disorder: Relaxation, anything like that?

1 A No.

2 Q If we go to the next document, Exhibit A-9, that's the
3 second letter, January 8, 2021 letter from Dr. Salem.
4 Just let you get to that, and I've just got a couple of
5 questions for you about it.

6 A Okay, go ahead.

7 MR. MAXSTON: Mr. Chair, I'm always just
8 pressing on. If someone hasn't got a document, raise a
9 hand or someone let me know if you're -- people haven't
10 quite gotten to where I am, but I'll just continue
11 here.

12 Q MR. MAXSTON: I'm looking at the first
13 paragraph, and it's -- this is a letter to David
14 Lawrence, and it says: (as read)

15 I am in receipt of your request for
16 information.

17 I think we've covered this, but this letter is coming
18 about because Mr. Lawrence is asking for something
19 further; is that correct?

20 A Yes.

21 Q Yeah, so you didn't ask for this letter is what I'm
22 getting at?

23 A Correct.

24 Q Okay. About a third of the way through, Dr. Salem
25 says: (as read)

26 There are no other pertinent documents to

1 satisfy your requests for [quote] tests
2 conducted or [quote] diagnostic information.
3 These items are not applicable to the nature
4 of Dr. Wall's medical issue. As you'll note
5 from my charting, the primary driver for his
6 inability to wear a mask is anxiety that is
7 precipitated by wearing a mask.

8 Just, again, to confirm, Dr. Salem doesn't ever mention
9 a medical disability in this letter, does he?

10 A Correct.

11 Q If we look at the following paragraphs, I'm going to
12 suggest to you that they are a summary of Dr. Salem's
13 views about the challenges that COVID presents and the
14 concerns he has about the validity of COVID testing,
15 and if we go to the next page, you'll see he talks
16 about AHS saying there's limited research, et cetera.
17 Would you agree with me that -- on masking -- would you
18 agree with me that a large chunk of Dr. Salem's letter
19 is dealing with his views on the efficacy of masking
20 and the science behind it?

21 A He does share his views, yes.

22 Q And it's fair to say that you and he are literally and
23 figuratively on the same page on those issues?

24 MR. KITCHEN: I think you're asking too much
25 about the mind of Dr. Salem. You're going to have to
26 get a little more specific here.

1 MR. MAXSTON: Sure, sure.

2 Q MR. MAXSTON: Dr. Wall, you agree with
3 Dr. Salem's comments in his letter about COVID and
4 masking, et cetera?

5 MR. KITCHEN: That's quite general. If you
6 want to get a little more specific, I'm not going to
7 take an issue.

8 MR. MAXSTON: Well, I don't think it's an
9 unfair question.

10 MR. KITCHEN: Well, it's only unfair because
11 it's so broad and vague. If you want to get more
12 specific, that's fine. What's --

13 Q MR. MAXSTON: Do you -- Dr. Wall, do you
14 agree with Dr. Salem's comments that mask wearing does
15 not reduce the transmission of COVID?

16 MR. KITCHEN: Well, hold on. Can you point
17 us to a specific comment, because --

18 MR. MAXSTON: Yeah.

19 MR. KITCHEN: -- is that supposed to be a
20 quote, or is that --

21 MR. MAXSTON: Third paragraph, first line:
22 (as read)

23 There are numerous studies that refute the
24 benefit of mask wearing in reducing the
25 transmission of respirator illnesses.

26 Q MR. MAXSTON: What I'm getting at -- I don't

1 want to have a debate about this -- Dr. Wall, again,
2 Dr. Salem's views, generally speaking, about masking
3 are consistent with yours?

4 MR. KITCHEN: Again, if you're asking if he
5 agrees with that statement that you just read, fair
6 question, but you brought it back as a very general,
7 vague question that I don't think is acceptable.

8 MR. MAXSTON: Well, I'm just going to move
9 on. I tried to establish that your client agrees with
10 Dr. Salem, but if you're going to object to that ...

11 Q MR. MAXSTON: In the second letter, would
12 you agree that there are still no mention of a
13 prognosis?

14 A I would agree.

15 Q And there is no mention of treatment options as next
16 steps?

17 A Yes, I would agree.

18 Q So I asked you before, you could have gotten the letter
19 from a doctor in May or June of 2020; why didn't you do
20 that?

21 A Well, at the time, I did not think it was a requirement
22 to get a doctor's note for a medical exemption. The
23 CMOH order does not specifically state that, and so
24 that's why I didn't get one.

25 Q I think that we've established though that those CMOH
26 orders don't come out until November or December, later

1 in the year.

2 MR. KITCHEN: Yes, you asked that, and
3 you've gotten the answer to it from before, nothing
4 controversial there.

5 MR. MAXSTON: Mr. Kitchen, I'm going to ask
6 a question, and unless you're going to object, I don't
7 think you can help your client with his answers, so I'm
8 moving along to a question.

9 MR. KITCHEN: I'm not trying to help; I'm
10 just objecting to questions that have already been
11 asked.

12 Q MR. MAXSTON: Wouldn't you agree, Dr. Wall,
13 that something as serious as an exemption to masking
14 would have required, from the very outset, some type of
15 medical verification?

16 A Perhaps our opinion about the seriousness of a mask
17 exemption is different. So, again, I, at the outset, I
18 thought my health information was a private matter and
19 that it was very specific to myself, and I didn't
20 believe that I needed to disclose that information at
21 the outset, so ...

22 Q So you don't have any training in anxiety disorders, do
23 you?

24 A No, I don't.

25 Q And, nonetheless, you reached a diagnosis that you had
26 an anxiety disorder sufficient to qualify you for some

1 type of exemption?

2 A Correct.

3 Q Do you believe it's appropriate for health care
4 providers to self-diagnose medical issues?

5 A Potentially.

6 Q Like an anxiety disorder?

7 A Potentially.

8 Q Dr. Wall, we've been chatting now I think for about an
9 hour and 15 minutes. I still have a fair number of
10 questions, do you need a quick break, and or do you
11 want to press on and just let me know when you need a
12 break?

13 A We can press on.

14 MR. MAXSTON: Okay, Mr. Chair, you can feel
15 free to jump in at any time if you need to direct a
16 break.

17 Q MR. MAXSTON: Dr. Wall, I want to switch
18 gears, and I want to go to the ACAC notices to you and
19 the profession that are set out at Exhibits C-1 to
20 C-22.

21 In my questioning of Dr. Halowski, I mentioned to
22 him that Exhibit C1, C-10, and C-13 relate to the
23 Telehealth option and the College council's ultimate
24 approval of that. I think your evidence with
25 Mr. Kitchen was you didn't feel that you could pursue
26 Telehealth; is that correct?

1 A That is correct. I actually did look at it, but it did
2 not fit my practice style. I'm a hands-on
3 chiropractor, and that was not the way I chose to go as
4 far as practicing.

5 Q I'm going to let your counsel decide if there is an
6 objection here, but I can take you through Exhibits C-2
7 onward and ask you specific questions about the College
8 saying you can contact them and asking for input, but
9 my question to you, to be more general and more
10 efficient, is would you agree that, throughout Exhibits
11 C-1 to C-22, there are numerous references to the
12 College asking for input and inviting members to
13 contact the College about the Pandemic Directive?

14 A Yes, I would agree with that.

15 Q So is it fair to say that you would have received all
16 of these documents?

17 A Yes, I did.

18 Q And you'd already had an email exchange with
19 Dr. Halowski, and you could have emailed him?

20 A Regarding what?

21 Q Regarding masking and the social distancing and I guess
22 your issues about the Pandemic Directive.

23 A Correct.

24 Q And just to be clear, you didn't participate in any of
25 the platform discussions on the Pandemic Directive?

26 A How many platform discussions were there?

1 Q You know, I can't recall. I think there's reference to
2 at least two in those exhibits. I'm just asking you if
3 you can recall whether you participated in any of those
4 exchanges.

5 A Yes, I believe I may have participated in the first
6 one, because I do recall -- and I may be corrected
7 here -- but I do recall the first draft included
8 vaguely perhaps specific terms about vaccine issues,
9 and that was a concern to me, and I think that's what
10 potentially precipitated the letter to Dr. Halowski,
11 but I may have participated in that first
12 ThoughtExchange that was regarding the first draft.

13 Q Okay. But other than that, no communication or contact
14 with the College?

15 A And then I also participated in a recent draft,
16 several -- perhaps a month-and-a-half to several months
17 ago.

18 Q Okay, I'm really concerned with the June to December
19 2020 time period. So just to be clear, other than your
20 participation on that one platform or ThoughtExchange,
21 you didn't have any communication with the College?

22 A That's correct.

23 Q Okay. I'm kind of switching gears a little bit here,
24 I've sort of got some general questions.

25 There's been comments about your human rights
26 being violated and Human Rights Act issues. You

1 haven't filed a complaint with the Alberta Human Rights
2 Commission though, have you?

3 A No, I have not.

4 Q I want to ask you some questions about your decision to
5 not comply with the Pandemic Directive, which I think
6 it's fair to say you've been very candid in indicating
7 that you haven't complied with certain parts of it. In
8 fairness, you said you have complied with others, I
9 don't want to be unfair. Is it your position that a
10 health care professional such as you, a chiropractor,
11 can decide when and if he'll follow a college's
12 requirements?

13 MR. KITCHEN: That's been asked and
14 answered.

15 MR. MAXSTON: Well, no, I don't think it
16 has. I've asked him about compliance with certain
17 specific things; that's a more general question, and
18 it's an important one.

19 MR. KITCHEN: Well, I understand you think
20 it's important, and I have no issue with you asking it
21 once, but you already asked him, and it's already been
22 answered. We've done a lot of that over the last few
23 hours.

24 MR. MAXSTON: I disagree.

25 Q MR. MAXSTON: My question for you,
26 Dr. Wall --

1 MR. MAXSTON: -- and I'll wait,

2 Mr. Kitchen --

3 Q MR. MAXSTON: -- is it your position that a
4 health care professional can decide when and if the
5 requirements of a profession apply to him?

6 MR. KITCHEN: That's fine. I won't object
7 to that, but we're going to have problems if you keep
8 going down this road because you've already been down
9 this road, but I won't object to this one.

10 MR. MAXSTON: Well, I --

11 MR. KITCHEN: (INDISCERNIBLE) ask it again.

12 MR. MAXSTON: I wonder if we can have the
13 court reporter repeat that question so I don't mangle
14 it and get an objection from you, Mr. Kitchen.

15 MR. KITCHEN: That's a good idea.

16 THE COURT REPORTER: (by reading)

17 Q Is it your position that a health care
18 professional such as you, a chiropractor,
19 can decide when and if he'll follow a
20 college's requirements?

21 A I believe if those requirements cause harm to the
22 member, then I do believe that the member has the right
23 to make those decisions. We are doctors of
24 chiropractic. We have spent a multitude of years
25 learning and applying science, logic, and reason. And
26 I believe that, in this situation regarding masks, if

1 there is harm being caused, yes, I do believe that a
2 member should be able to make a decision.

3 Q MR. MAXSTON: So if you personally decide
4 that a requirement of a college causes harm, your view
5 is you don't have to follow it?

6 A That is correct.

7 Q And that's if you personally make that decision?

8 A Yes, and I'm basing that on multiple studies, not my
9 own information only. It's based on other scientific
10 studies that corroborate what I believe, so ...

11 Q I'm going to suggest to you, Dr. Wall -- and I'm not
12 attacking your bona fides here, your sincerity -- but
13 if this happens, we don't have a governable profession
14 anymore, do we?

15 MR. KITCHEN: I think that's a hypothetical
16 that he can't answer.

17 Q MR. MAXSTON: Well, how do you think your --
18 if a chiropractor like you makes an independent
19 decision, how does that affect the College's role?

20 MR. KITCHEN: Well, I think that question's
21 fine, but you need to be a little more specific.

22 Q MR. MAXSTON: Dr. Wall, what I'm getting at
23 is would you agree or disagree with the statement that
24 health care providers making their own decisions about
25 requirements makes it challenging for a college to
26 govern its members?

1 A Yes, it may make it challenging.

2 Q We've gone through a number of situations where you
3 have chosen to follow and not follow certain
4 requirements from various authorities, so -- and
5 there's a question coming, but you've told me you
6 comply with some aspects of the Pandemic Directive but
7 not others; you've told me that you are complying with
8 some aspects of the re-opening order but not others; do
9 you think that's appropriate for a professional?

10 A To me, it always falls back to harm being done, the --
11 of course, the principle, first, do no harm applies
12 primarily to patients but, in this situation, wearing a
13 mask does harm. And in that situation, how can I
14 follow the College directive if it's causing harm? So
15 it makes it difficult for the College, but it doesn't
16 make it right.

17 Q And just to be clear, you've also chosen to not follow
18 the orders of -- the re-opening orders from AHS,
19 certain of them?

20 A Are you referring to the masking of patients?

21 Q Yes.

22 A Yeah, well, that would fall under the same category as
23 my understanding that wearing a mask causes harm.

24 Q You're going to be calling Dr. Gauthier as a lay
25 witness; is that correct?

26 A That is correct.

1 Q Your counsel, Mr. Kitchen, sent me something called a
2 will-say statement about what he anticipates
3 Dr. Gauthier will testify to. Because of the order of
4 witnesses that Mr. Kitchen has set out, we haven't
5 heard from Dr. Gauthier, but is it your understanding
6 that he has strong personal beliefs against masking?

7 MR. KITCHEN: Speaking to his mind and you
8 said "personal beliefs", if we go to the will-say
9 statement, you're going to see that Dr. Gauthier
10 disagrees with the Pandemic Directive, follows it,
11 disagrees with it. So if you want to question down
12 those lines, I think that makes sense.

13 MR. MAXSTON: Sure, I'll --

14 MR. KITCHEN: (INDISCERNIBLE)

15 MR. MAXSTON: -- rephrase that question.

16 MR. KITCHEN: Okay.

17 Q MR. MAXSTON: Do you understand that
18 Dr. Gauthier has concerns about complying with the
19 masking and social distancing requirements of the
20 Pandemic Directive?

21 A Yes, I believe so.

22 Q Is it your understanding that, nonetheless, he complied
23 with the Pandemic Directive?

24 A I can't speak to that.

25 Q Okay, we'll ask Dr. Gauthier about that then.

26 When we talked about you researching your decision

1 in June of 2020 to not comply with certain aspects of
2 the Pandemic Directive, wasn't it your obligation as a
3 professional to notify the College of your concerns and
4 your intention to breach parts of the Pandemic
5 Directive?

6 A I didn't see that anywhere in the Pandemic Directive
7 that stated I was supposed to consult the College
8 regarding my exemptions, and so ...

9 Q I guess what I'm saying to you is I mean we have, for
10 example, we have a standard of practice, and if you're
11 not going to follow the standard of practice, there
12 isn't anything in the standard of practice saying you
13 should call the College, but I'm asking you wasn't it
14 incumbent on you as a professional, a health care
15 provider, to reach out to your college in June of 2020
16 and tell them what you were intending to do?

17 MR. KITCHEN: Unless I'm wrong, I don't
18 think that is an allegation, and I may be wrong --

19 MR. MAXSTON: It's not an allegation; it's a
20 question --

21 MR. KITCHEN: But it's not -- no, no, no,
22 but it's not an allegation in the notice of hearing.

23 MR. MAXSTON: Mr. Kitchen --

24 MR. KITCHEN: So --

25 MR. MAXSTON: -- not every question I ask
26 has to be framed in the context of the exact charges,

1 and you've been objecting a fair bit to my questions,
2 and I'm going to ask for a ruling on this, because it's
3 another important question. I'm entitled to ask
4 Dr. Wall, as part of his views of his status as a
5 professional, what he views his obligations were in
6 that scenario.

7 MR. KITCHEN: But that's a question of the
8 ultimate issue, right? Is it unprofessional conduct to
9 not reach out. That's like an ultimate. You're asking
10 him a question about the ultimate issue, and an
11 ultimate issue that's not in the notice of hearing, so
12 I question the relevance of it. That's why I've
13 objected. I've objected because you've asked questions
14 that are worth objecting to.

15 MR. MAXSTON: Well, Mr. Chair, my question
16 is --

17 Q MR. MAXSTON: And, Dr. Wall, please don't
18 answer this question. You won't hear me say that very
19 often, but please don't answer this at this time,
20 wasn't it your obligation as a professional to notify
21 the College about your concerns with the Pandemic
22 Directive and that you were going to not follow it in
23 some respects?

24 MR. MAXSTON: So, Mr. Chair, I --
25 respectfully, the ultimate issue is whether not
26 following the -- certain things is unprofessional

1 conduct, but I think this is a fair question to ask,
2 because it goes to Dr. Wall's perception of what it
3 means to be a professional. So I've made some comments
4 about that question, and I'm going to ask for a ruling
5 on that.

6 THE CHAIR: And, Mr. Maxston, is that not
7 two questions? First question being the obligation to
8 notify the College, and then the second question, the
9 last part of your -- the last part of your statement,
10 is that a second question?

11 MR. MAXSTON: I can break it down into two:
12 wasn't it your obligation as a professional to notify
13 the College of your concerns about the Pandemic
14 Directive, and wasn't it your obligation as a
15 professional to notify the College of your intention to
16 ignore parts of it or not comply with parts of it.

17 MR. KITCHEN: So I'll just say two things:
18 One, Dr. Wall did answer by saying, I didn't see an
19 obligation in the Pandemic Directive, so he's provided
20 that answer. Nothing controversial there.

21 Secondly, we do have a relevance issue because
22 that's not about -- there is no allegation. And we've
23 talked a lot, which is kind of odd, and I haven't
24 objected much until this point, we've talked a lot
25 about whether or not Dr. Wall reached out. And that's
26 not really -- I don't know if that's a key issue until

1 now in this case, but that's not actually an
2 allegation. There is no allegation in the notice of
3 hearing that Dr. Wall engaged in professional
4 misconduct by not reaching out to the College.

5 So there is, for me, I think there's a lack of
6 relevance when we're making such a big deal out of this
7 issue when there's actually no allegation. If the
8 allegation was in there, that would make sense.
9 There's no allegation of that. So why are we going
10 down this road?

11 THE CHAIR: Okay, we will take a brief
12 recess while the Hearing Tribunal discusses this with
13 counsel, and we'll just ask you to give us a few
14 minutes, and if we could be moved to a break-out room,
15 thank you.

16 (ADJOURNMENT)

17 THE CHAIR: Thank you for your indulgence.
18 We've discussed the question or questions amongst
19 ourselves and with independent legal counsel. Our view
20 is that the question as posed as an obligation
21 pertaining to a health professional, so in a general
22 sense, and that this goes to what it means to be a
23 professional, what his obligations were.

24 We do feel that it's within the scope of
25 relevance, so we do agree with asking Dr. Wall to
26 respond to the question.

1 Q MR. MAXSTON: Well, I will try to be careful
2 in my wording here to capture exactly what I said
3 before, and it will be two questions, and those are my
4 last two questions, Dr. Wall. Wasn't it your
5 obligation as a professional to notify the College of
6 your concerns about the Pandemic Directive?

7 A I wish I could answer that simply. I will say yes.

8 Q The second question, wasn't it your obligation as a
9 professional to notify the College of your intention to
10 not comply with the Pandemic Directive?

11 A It's --

12 Q Pardon me --

13 A I'm sorry, go ahead.

14 Q Yeah, I'm sorry, I want to be fair to you, wasn't it
15 your obligation as a professional to notify the College
16 of your intention to partly not comply with the
17 Pandemic Directive, and I'm thinking of masking and
18 social distancing?

19 A Yeah, I -- with respect to masking, again, this was an
20 issue that was affecting my health, I believe it was
21 harmful to me, and so I didn't think that it was
22 necessary to respond to the College at the time.

23 MR. MAXSTON: Okay, those are my questions,
24 Mr. Chair.

25 Discussion

26 MR. MAXSTON: In terms of the remainder of

1 the day, my client and I certainly are prepared to stay
2 a little longer if we need time for Mr. Kitchen to do
3 his redirect and answer your questions. I think
4 probably about 4:30 or 5 is the latest we'd want to go,
5 and I know that may mean we're not finished with
6 Dr. Wall today, but my client's view and my view,
7 frankly, is that going any longer than 4:30 or 5 is a
8 little bit much for a Tribunal, even though we've got a
9 healthy, robust Tribunal here.

10 MR. KITCHEN: I have some thoughts on that.
11 One, my witness has arrived. He's Dr. Wall's witness.
12 He's left for now, because we're obviously not quite
13 there yet. I'm going to ask, because of the enormously
14 slow pace, and that's to no one's fault, but the
15 enormously slow pace at which we've moved that we press
16 ahead today and get in this witness after we're done
17 with Dr. Wall. I do have redirect, but I don't expect
18 to be long. So if we could get going at 4:30 with this
19 witness, I can't see that witness taking more than 45
20 minutes at most, which I understand that puts us past
21 5, but we've ended early quite a few days. We're
22 making pretty slow progress on evidence.

23 This particular witness, like I said, the reason I
24 wanted him here today is because he's the only witness
25 I have who cannot do virtual testimony, so I would ask
26 that the Tribunal to be gracious with Dr. Wall and I

1 and permit that witness today.

2 THE CHAIR: I think we'll make our best
3 efforts to achieve that. I don't personally have any
4 commitments that would prevent me from going to 5:15 if
5 we needed to. I'm not sure if anybody else -- perhaps
6 there are? One of the Tribunal Members --

7 DR. ALDCORN: Well, sorry, this is Leslie.
8 I'm actually seeing patients after we're done here. If
9 I knew we were done at 5:15, I could ask people to come
10 at 5:15 instead of 5:00. I would just need to know.

11 THE CHAIR: I think in the best interests
12 of not having to do this twice, let's decide that we
13 will go until 5:15 so that Dr. Aldcorn can make her
14 plans accordingly.

15 And I think it's a long time to go without a
16 break, I suggest we take maybe 10 minutes now and come
17 back at 5 after -- let's make it 10 after 4, and then
18 we'll plow through with Mr. Kitchen's redirect and then
19 any residual questions and then deal with Mr. Kitchen's
20 witness. Okay?

21 MR. MAXSTON: Mr. Chair, I just want to make
22 one comment, I'm very sensitive to Mr. Kitchen and his
23 witness's availability, but I do want to be clear that
24 I think -- in terms of chasing the clock, the Hearing
25 Tribunal shouldn't feel constrained about asking
26 questions of Dr. Wall and finishing quickly, and so I

1 really want to be -- I see Mr. Kitchen nodding, and I'm
2 glad, because I'm very sensitive to his witness, but
3 we've heard a lot from Dr. Wall today, and once he
4 stops testifying, Mr. Chair, you know this, your
5 colleagues know this, you can't ask him any other
6 questions, and there was some pretty important stuff
7 today. So I agree, let's press on and see where we're
8 at, but I think completing Dr. Wall today is the
9 priority, if we can.

10 THE CHAIR: Fair point, Mr. Maxston, and I
11 will share with both you and Mr. Kitchen that, during
12 our earlier breaks, we have discussed amongst ourselves
13 some questions with respect to Dr. Wall, and we are
14 holding back to determine which, if any, or all of them
15 are covered either through direct or cross-examine or
16 redirect. So, yes, the Hearing Tribunal may very well
17 have some questions for Dr. Wall, but we will cross
18 that bridge after we've dealt with the redirect.

19 So let's break now and come back at 10 after 4,
20 and we'll do our best, Mr. Kitchen.

21 MR. KITCHEN: Thank you.

22 (ADJOURNMENT)

23 THE CHAIR: Okay, I believe we are all
24 here, so the session is that we are reconvened, and,
25 Mr. Kitchen, you have the floor.

26 MR. KITCHEN: Thank you.

1 Mr. Kitchen Re-examines the Witness

2 Q MR. KITCHEN: Dr. Wall, that email that you
3 sent to Dr. Halowski, we talked about this, you said
4 earlier that Dr. Halowski sent you a response. Did you
5 ever get a response from council to your email?

6 A No, I did not.

7 Q Did you ever get a further response from Dr. Halowski?

8 A No, I did not.

9 Q And what was -- the one response you got from
10 Dr. Halowski, what did he say?

11 A I believe he was going to refer the matter to council,
12 and that was about the extent of it.

13 Q Do you think that was a substantive response?

14 A Not substantive. I'm fine if he wanted to have council
15 respond to it, but not a substantive response.

16 Q We've talked a lot about a risk from masking. I just
17 want to make sure everybody knows your position. Do
18 you think there is an increased risk beyond what
19 anybody already encounters in their daily life from you
20 not wearing a mask?

21 A No, I do not.

22 Q Did AHS close your office?

23 A Yes, they did.

24 Q Did AHS close -- did AHS take away your practice
25 permit?

26 A No, they did not.

1 Q The closure order, I'm going to take you there, that's
2 D-1, and Mr. Maxston can object to this if he wants to,
3 but I'm going to ask you to pick up -- do you see the
4 word "nuisance" in the middle of paragraph (a) there?

5 A Yes, I do.

6 Q Could you just read for me the rest of that sentence?

7 A I'll start: (as read)

8 This is a breach of Section 2(1) of the
9 Nuisance and General Sanitation Regulation,
10 which states that no person shall create,
11 commit, or maintain a nuisance, and of
12 Section 26 of the CMOH 38-2020, which states
13 that, subject to Section 27 of this order, a
14 person must wear a face mask at all times
15 while attending an indoor public place. For
16 greater certainty, an indoor public place
17 includes any indoor location where a business
18 entity is operating.

19 Q Do you think that you fall under Section 27? I can
20 take you to the Order 38 if you need me to. Do you
21 want me to do that?

22 A Yes, please, let's review that.

23 MR. MAXSTON: Mr. Kitchen, I'm not sure I'm
24 going to object to this question, but, with respect,
25 isn't it irrelevant; doesn't AHS decide who's subject
26 to it? It's not really your client.

1 MR. KITCHEN: Well, again, I don't know if
2 there's any controversy here. I think there probably
3 is going to be some controversy, because there's no
4 mention of CMOH 38 in the re-opening.

5 Q MR. KITCHEN: So, Dr. Wall, let me just ask
6 you this: We discussed that there's an exemption
7 clause in CMOH Order 38-2020 -- well, okay, is there a
8 general requirement to wear a mask in CMOH Order
9 38-2020?

10 A Yes, there is.

11 Q And there's an exemption, correct?

12 A That's correct.

13 Q Do you think you fell under the exemption?

14 A Yes, I do.

15 Q So do you think you breached the general requirement to
16 wear a mask?

17 A No, I don't.

18 Q Now, while I'm on this point, this is important
19 because -- so you just said now and you said earlier
20 that the -- you never breached any of the CMOH orders,
21 but when my learned friend asked you if you agreed
22 factually to the statement at 5(a) of the hearing
23 notice, that you failed to follow the Chief Medical
24 Officer of Health orders regarding masking and
25 COVID-19, you said, yes, that you agreed to that, so
26 let me ask you: Do you think that you failed to follow

1 any Chief Medical Officer of Health orders?

2 A No, I don't.

3 Q Dr. Wall, was there a CMOH order in place requiring
4 masking in June of 2020?

5 A I don't know the exact date of the CMOH order.

6 MR. MAXSTON: Mr. Kitchen, we have the
7 re-opening order. Are you referring to that, the CMOH
8 order that directed re-opening if guidelines were
9 followed from AHS or from CMOH or from the College? Is
10 that what you're referring to? I'm just asking because
11 I don't think we have any other exhibits to that
12 effect, and, clearly, the re-opening order would have
13 been in force.

14 MR. KITCHEN: Not --

15 MR. MAXSTON: 16-2020 is the re-opening
16 order.

17 MR. KITCHEN: Yes, right.

18 Q MR. KITCHEN: Well, Dr. Wall, you said to --
19 Mr. Maxston asked you, well, was there a CMOH order to
20 require masking and specifying exemptions before
21 November, and you said, no, there wasn't. We already
22 know that. So merely just asking, was there a CMOH
23 order in June of 2020 that generally required masking?

24 A No.

25 Q Do you think things like cleaning your office and
26 washing your hands are harmful?

1 A No, I don't.

2 Q Do you think preventing people from being within 2
3 metres of each other violates their personal liberty of
4 bodily autonomy?

5 A No, I don't.

6 Q So if you're told -- if your patients are told -- if
7 your patients are told that they have to stay 2 metres
8 away from you, do you think that violates their
9 personal liberty to come within 2 metres of you?

10 A They can choose to come within 2 metres of me, so I'm
11 not sure exactly of the -- maybe rephrase the question.

12 Q Well, let me ask you this -- and I'll leave it here, I
13 don't want to belabour the point -- but do you think
14 people's physical movements are restricted when they're
15 told that they cannot come within 2 metres of other
16 people?

17 A Yes, I do.

18 Q When -- and this goes back to a question Mr. Maxston
19 asked you about Dr. Linford's statements on risk, do
20 you agree with Dr. Linford that there is a risk to the
21 public from you not wearing a mask?

22 A No, I don't agree.

23 Q Now, you answered a question of Mr. Maxston about the
24 diagnosis or lack thereof in the December 12th note
25 from Dr. Salem, and of course, ultimately, there was
26 this note from January 11th. What was the ultimate

1 diagnosis in the January 11th letter?

2 MR. KITCHEN: While I'm here, I'll find it
3 for everybody's benefit.

4 MR. MAXSTON: Is it A-9, Mr. Kitchen?

5 MR. KITCHEN: It is A-9. I was just about
6 to say that.

7 Q MR. KITCHEN: So, yes, so this is the letter
8 that -- Mr. Maxston was questioning you on this letter.
9 This is the letter that Dr. Salem responds to
10 Mr. Lawrence. Does Dr. Salem discuss in this letter
11 the ultimate reason for why you couldn't wear a mask?

12 A Yes, he did.

13 Q And what was that reason?

14 A It was because of anxiety and dealing with
15 claustrophobia.

16 Q And is that consistent with what you thought about
17 yourself in June of 2020?

18 A Yes, it is.

19 Q Are the CMOH orders being challenged in court?

20 A I believe they are, yes.

21 Q Do you think a mandate from -- well, I'll ask you this:
22 Do you think a mandate that mandates somebody wear a
23 mask, do you think that violates that person's rights?

24 A Yes, I do.

25 Q Do you think if a mandate violates somebody's rights
26 that it's unlawful?

1 A Yes, I do.

2 Q Okay, almost done here. In the rescind notice from the
3 AHS, this is Exhibit D-2, we've talked about point 4,
4 Mr. Maxston asked you about that, do you regard point 4
5 as violating the rights of the patients?

6 A Yes, I do.

7 Q And do you regard point 4 as unlawful?

8 A Yes, I do.

9 Q Do you think it is professional to not comply with
10 requirements that are unlawful?

11 A Could you restate that, please, for me?

12 Q Sure. Do you think it is professional to not comply
13 with requirements that are not lawful?

14 A That was a lot of nots, I'm sorry.

15 Q No, no, it's okay, it's okay. It's no problem.

16 A Sorry, it is getting late in the day --

17 Q Do you think it's professionally acceptable to disobey
18 a requirement that is unlawful?

19 A Yes, I think that it is professionally (INDISCERNIBLE)
20 to (INDISCERNIBLE) a law that is --

21 THE COURT REPORTER: Dr. Wall, you're going to have
22 to speak up; you're not on speaker or something like
23 that. I'm finding you very quiet. So, sorry, could
24 you please restate your answer?

25 MR. KITCHEN: Madam Clerk, can you hear my
26 just fine?

1 THE COURT REPORTER: I can hear you fine, yeah.

2 MR. KITCHEN: I think what happened is he
3 turned the button, because he has to click it every
4 time so we don't get the feedback.

5 A I'm sorry.

6 THE COURT REPORTER: That's okay. Do you want me
7 to --

8 Q MR. KITCHEN: Do you want me to ask it
9 again, or are you ready to go?

10 A Go ahead and ask.

11 Q Okay. Do you think it is professionally acceptable to
12 disobey requirements that are unlawful?

13 A I think it is professionally (INDISCERNIBLE) --

14 THE CHAIR: We can't hear you, Dr. Wall.
15 Can't hear you at all.

16 A Sorry about that, yeah, I don't know what happened
17 there.

18 Q MR. KITCHEN: Well, I don't want to ask it a
19 third time, but I'm going to ask it a third time, and
20 I'm going to try to ask it exactly the same so that
21 there's nothing unfair here.

22 Do you think it is professionally acceptable to
23 disobey requirements that are unlawful?

24 A Yes, I do.

25 Q Do you think the masking mandate is unlawful?

26 A Yes, I do.

1 Q Last question, is it your understanding that Dr. Salem
2 recommended, as a means of dealing with your anxiety,
3 to not wear the mask?

4 A Yes, that's correct.

5 Q And I'm sorry, I have one more question. Do you think
6 not wearing a mask around your patients is a form of
7 treatment?

8 A No, it is not.

9 MR. KITCHEN: Okay, thank you, those are all
10 my redirect.

11 MR. MAXSTON: Mr. Chair, I'm going to ask my
12 friend's indulgence and yours, I do have one quick
13 follow-up question, and it relates to the second or
14 third-last question my friend asked because it was -- I
15 think it was something a little bit new. And maybe
16 I'll ask the question, if you're comfortable, Mr. Chair
17 and Mr. Kitchen, you'll let me know if you've got any
18 concerns.

19 MR. KITCHEN: Sure.

20 THE CHAIR: Okay.

21 MR. MAXSTON: And thank you for this
22 indulgence.

23 Mr. Maxston Re-cross-examines the Witness

24 Q MR. MAXSTON: Dr. Wall, this goes back to
25 the question that was repeated three times, so you're
26 probably pretty familiar with it, and I believe the

1 wording from my friend was do you believe it's
2 professionally acceptable to disobey requirements that
3 are unlawful, and I just want to be clear, who
4 determines whether they're unlawful?

5 A Well, I believe that -- sorry, I believe that there has
6 to be a higher standard. For example, I believe that
7 the Constitution, Charter of Rights and Freedoms, and
8 Alberta Human Rights are specifically aspects of the
9 law that would supersede, for example, a professional
10 regulatory body's requirements.

11 Q Sorry, just quickly, just to be clear, it's not the
12 professional who decides that though; it's the courts,
13 if it's the Charter or human rights?

14 A Yeah, well, a person has to go through those measures
15 for sure, and that's why I've obtained counsel, so,
16 yeah.

17 Q Yeah, I just wanted to be clear, when you talked about
18 "unlawful", I thought it was something I needed to kind
19 of clarify.

20 MR. MAXSTON: Thank you for that indulgence,
21 Mr. Chair and Mr. Kitchen.

22 MR. KITCHEN: You're welcome.

23 Mr. Kitchen Re-examines the Witness

24 Q MR. KITCHEN: I just want to ask one quick
25 re-cross [sic], which is, Dr. Wall, do you think you'd
26 ever be able to legally challenge these mandates if you

1 just went along with them and ignored them?

2 A No, I wouldn't be able to challenge them if I went
3 along with them and ignored them.

4 MR. KITCHEN: Okay, well, I guess it's back
5 to the Tribunal now.

6 THE CHAIR: Okay --

7 MR. KITCHEN: I just want to make a note, my
8 witness is in the room, so I want to give anybody an
9 opportunity to object if they -- I don't even know if
10 he can hear anything because we all have headsets on,
11 but I just -- I want to make a note of that if anybody
12 has any objections to him being in the room while we're
13 still doing this.

14 MR. MAXSTON: I don't, Mr. Kitchen, provided
15 he's not going to be asked questions about what
16 Dr. Wall is just testifying to.

17 MR. KITCHEN: I can't imagine. I have no
18 intention.

19 MR. MAXSTON: Okay, yeah, thank you.

20 THE CHAIR: Well, at this point, we're
21 going to take a brief recess so that we can discuss
22 whether Members of the Tribunal have any further
23 questions for Dr. Wall. So bear with us, we'll be back
24 to you as quickly as possible, and if we could go to a
25 break-out, please. Thank you.

26 (ADJOURNMENT)

1 THE CHAIR: We're back in session. Thank
2 you for your indulgence. Members of the Hearing
3 Tribunal do have a couple of questions they would like
4 to ask Dr. Wall. So I would first ask Dr. Aldcorn to
5 raise her questions.

6 The Tribunal Questions the Witness

7 Q DR. ALDCORN: Thank you. So, Dr. Wall, I'm
8 just wondering in the time frame between June and
9 December, if you had seen any new patients in your
10 office or patients who had yet to have been to your
11 office before?

12 A Yes, I have.

13 Q And my second question would be, because I don't know
14 how your clinic is set up, but when you indicated that
15 you saw one patient at a time, would that imply that
16 there was only one patient in your clinic at a time, or
17 could there be more than one patient in the clinic at
18 the time, or are you seeing only one patient at a time?

19 A Yeah, so I only saw one person at a time, and so, yeah,
20 no other people in the clinic.

21 DR. ALDCORN: Thank you.

22 THE CHAIR: Okay. Dr. Dawson --
23 Mr. Dawson, sorry.

24 Q MR. DAWSON: Dr. Wall, thank you. My
25 question is in two parts. The first part is has a
26 patient ever asked you to put on a mask, and if not,

1 how would you respond if a patient asked you to put on
2 a mask?

3 A Yes, I have had a patient ask me to put on a mask, and
4 at the time, I granted that request. They were a very
5 nervous person, and so I did put on a mask. I told her
6 that I did have an exemption and that I was --
7 experienced these symptoms that I've been discussing,
8 but for that one person and one person only, I did it.

9 Q THE CHAIR: Just a quick follow-up,
10 Dr. Wall. About what time period would that have
11 happened?

12 A That would have been likely between June and -- I'd
13 have to look back on my record, but, yeah, sometime
14 between June and October, I would think.

15 THE CHAIR: Thank you. Those were the
16 questions of the Hearing Tribunal for Dr. Wall.

17 If there's no other matters, Dr. Wall, we'll
18 dismiss you as a witness, and thank you very much for
19 your time and your testimony.

20 (WITNESS STANDS DOWN)

21 THE CHAIR: And, Mr. Kitchen, I believe
22 we're at the point where you could call in your
23 witness.

24 MR. KITCHEN: Thank you, which I'll do, and
25 if we only get to the end of my direct, and we can't do
26 the cross, obviously I don't want to rush Mr. Maxston's

1 cross, then so be it, we'll have to figure that out,
2 but I think we should at least try to get through the
3 direct and maybe even the whole thing.

4 THE CHAIR: It's quarter to 5. We've got
5 30 minutes. Mr. Maxston, are you okay with proceeding
6 in the eventuality that you don't get an opportunity to
7 cross-examine today?

8 MR. MAXSTON: Yeah. In fact, I think we've
9 got a 5:15 hard stop, and for obvious reasons, I'm not
10 going to want to rush through any cross-examination,
11 and then, of course, there's redirect and then Hearing
12 Tribunal questions. I think, regrettably, we're
13 probably not going to finish with this witness today,
14 but certainly if we go till 5:15 and see how far we
15 get, I think that's a good idea.

16 THE CHAIR: Okay --

17 MR. KITCHEN: I think that's reasonable, so
18 let's proceed on this basis. All right, so -- this is
19 just a procedural note, he's -- Mr. Kosowan is going to
20 be appearing on Dr. Curtis Wall's screen, so it has
21 Dr. Curtis Wall's name, but, obviously, we all know
22 it's not Dr. Wall; it's the witness I'm calling. So
23 I'm just going to ask him to have a seat.

24 Madam Clerk, did you want to go ahead and swear
25 him in.

26 JARVIS KOSOWAN, Affirmed, Examined by Mr. Kitchen

1 Q MR. KITCHEN: Mr. Kosowan, do you prefer I
2 call you Jarvis or Mr. Kosowan?

3 A Jarvis.

4 Q All right, thank you, Jarvis. What do you do for a
5 living?

6 A I own a (INDISCERNIBLE) agency for Alberta sales
7 organization.

8 Q And just to confirm, are you a patient of Dr. Wall's?

9 A Yes, I have been for about 20 years.

10 Q Could you just briefly describe for us why you've stuck
11 with Dr. Wall for your chiropractor for so long?

12 A I like the method that he uses. It's not the crunching
13 and everything else. It's in the technique that I
14 appreciate and enjoy, and Dr. Wall has become kind of a
15 friend also over the years, so ...

16 Q Do you respect Dr. Wall?

17 A Absolutely.

18 Q Do you wear a mask when you see Dr. Wall for treatment?

19 A Sometimes. Sometimes not. It all depends when the
20 mask mandate was invoked, I would bring it into the
21 clinic, but then after that, inside, because it was
22 only one on one, I had the respect to Dr. Wall to be
23 able to take my mask off.

24 Q Are you grateful that Dr. Wall gives you a choice on
25 whether or not to wear a mask, depending on whether or
26 not you want to?

1 A Absolutely. I totally appreciate that.

2 Q Does Dr. Wall wear a mask when you come in for
3 treatment?

4 A No, he does not.

5 Q Are you aware of the reasons for why Dr. Wall doesn't
6 wear a mask?

7 A We had a conversation. He had alluded to the fact that
8 he had a medical exemption for wearing a mask, and I
9 respect that.

10 Q Now, do you feel comfortable with Dr. Wall not wearing
11 a mask while he treats you?

12 A Absolutely, no qualms whatsoever.

13 Q Do you believe Dr. Wall puts you at any increased risk
14 or in any way threatens your health by treating you
15 without wearing a mask?

16 A No, I do not.

17 Q Are you at all concerned about catching COVID-19 from
18 Dr. Wall because he treats you without wearing a mask?

19 A No, I'm not.

20 Q Do you think Dr. Wall could provide you with the
21 treatment you want if all he could ever do is call you
22 on the phone and talk with you?

23 A Absolutely not. That's not possible physically, I
24 don't believe anyway, at least I haven't heard of a
25 procedure, so I prefer the in-office procedure that he
26 does.

1 Q So do you think Dr. Wall could provide you with the
2 treatment you want if he could never come within 2
3 metres of you?

4 A It would be physically impossible.

5 Q Do you have an interest in seeing Dr. Wall continue to
6 practice as a chiropractor?

7 A Absolutely. I believe he provides a worthwhile
8 community function to a lot of people that are -- have
9 the same issues I do.

10 Q Do you think it will harm your interests as a person if
11 Dr. Wall is ordered to stop practicing or ordered to
12 only practice over the phone?

13 A Definitely. I don't even know how he'd be able to
14 operate over the phone, quite honestly, that -- it just
15 escapes my imagination, quite honestly.

16 Q Do you want to keep Dr. Wall as your chiropractor?

17 A Absolutely.

18 Q Do you think your interests should be considered as
19 part of any decision to restrict or not restrict
20 Dr. Wall's ability to practice as a chiropractor?

21 A Absolutely. He's providing a service to me that makes
22 me feel better physically and also that comes mentally
23 also, and he provides a service that, without being
24 able to touch me, he wouldn't be able to provide it at
25 2 metres of social distancing or over the phone, so I
26 can't see how it would be possible.

1 Q If Dr. Wall is ordered to stop practicing or stop
2 treating you except by calling you on the phone, do you
3 think that would be the Chiropractic College's fault?

4 A Sorry, I didn't understand the question.

5 Q That's okay. I'll ask it again. If Dr. Wall is
6 ordered to stop practicing or he's ordered to stop
7 treating you except by calling you on the phone, whose
8 fault do you think that will be?

9 A I imagine the College did prevent him from practicing
10 as a chiropractor, because he provides an immense
11 service to me.

12 Q Do you think Dr. Wall has done the right thing by
13 letting you not wear a mask while he treats you?

14 A Yes, I do, absolutely. It gives me just -- it gives me
15 more comfort, knowing that we're not -- I'm not
16 concerned about getting COVID within the chiropractic
17 office with Dr. Wall, so, therefore, it gives me the
18 comfort of take the mask off, I feel better, and I'm
19 comfortable with that.

20 Q Thank you.

21 Discussion

22 MR. KITCHEN: Now, those are all my
23 questions, so I leave it to Mr. Maxston if he thinks he
24 can do a cross as fast as I've done my direct, but I
25 leave that up to him. I would suggest that that's the
26 better way to go just because it's more convenient for

1 Jarvis, but -- that's 20 minutes.

2 MR. MAXSTON: Yeah, Mr. Kitchen, I think
3 I'm, and this is no one's fault, but I think I'm put in
4 a bit of a difficult position because I've got to think
5 about my questions and then reconvene, and we've got
6 the 5:15 hard stop. I don't know how long I'm going to
7 be. I may be very short with this witness, but I don't
8 know, and I, frankly, would prefer to, and I know this
9 is an inconvenience, but I, frankly, would prefer to
10 come back another day and not be racing against the
11 clock.

12 MR. KITCHEN: You honestly think you're
13 going to be -- you know, it's likely you're going to be
14 more than 20 minutes?

15 MR. MAXSTON: I don't know. I'm just
16 chatting with -- Mr. Lawrence and I were chatting just
17 beforehand, and I don't know how long I'm going to be.
18 I suppose I could ask some questions, and then we could
19 see where we're at, but I might not be finished, but I
20 do think I'm going to be pretty short.

21 THE CHAIR: May I just interject and say
22 that don't discount the possibility that Members of the
23 Tribunal may have questions for the witness.

24 MR. KITCHEN: Well, I'm in the Tribunal's
25 hands. I prefer that we go ahead, so that's certainly
26 what I want, but, you know, the Tribunal ultimately

1 directs its own proceeding, so I really have to leave
2 it up to the Tribunal.

3 THE CHAIR: Okay, we do have 20 minutes.
4 I think Mr. Maxston has expressed his desire to not
5 have to interrupt his cross-examination, and I do
6 believe that there may be questions from the Hearing
7 Tribunal, so I'm -- I want to respect the hard deadline
8 of 5:15, because, quite frankly, there have been
9 patients booked based on that timeline.

10 So I think, unfortunately, for the witness, we
11 will -- and it's up to Mr. Maxston, if he wants to
12 start. If he wishes to defer until the next date that
13 we can find to accommodate everybody, then I'm -- I
14 would agree with that.

15 MR. MAXSTON: With a measure of reluctance,
16 because I'm sympathetic to Mr. Kitchen and his witness.
17 I would prefer to wait until we resume.

18 THE CHAIR: Okay. And, please, no
19 disrespect, sir, if I call you Jarvis, I would just
20 like to thank you for your testimony today and to
21 advise you that, at a future date to be determined,
22 there will be an opportunity for the College counsel to
23 cross-examine you on your testimony, and I would ask
24 your cooperation in that regard. We will be in touch
25 and the College will be in touch with you regarding
26 future dates. And I think on that basis, we can

1 dismiss you for today, and with our thanks once again,
2 we appreciate your testimony.

3 A Thank you.

4 MR. KITCHEN: Thanks.

5 THE CHAIR: Okay. With that, I think it
6 will be up to the College to solicit availability to
7 determine when we can reconvene to continue on with
8 this witness and the other witnesses that Mr. Kitchen
9 has before we get to closing arguments. So I guess
10 we're not going to go right till 5:15, which is, I'm
11 sure, good for Dr. Aldcorn.

12 I would like to say thank you to everybody, and,
13 Mr. Kitchen, I appreciate your comments and
14 Mr. Maxston's. There has been a lot of testimony, a
15 lot of documentation, a lot of information over the
16 last four days, and we appreciate -- on behalf of the
17 Tribunal, we appreciate everybody's, you know,
18 cooperation and participation in this. So we'll -- we
19 will --

20 MR. MAXSTON: Mr. Chair, I'm sorry, one
21 quick question, I think in terms of next steps,
22 Mr. Kitchen, I think it was earlier or later last week,
23 was good enough a list of his witnesses, the order he's
24 going to be calling them in, and I wonder if he's
25 comfortable sending that list again to Ms. Nelson but
26 with some estimated times for each witness, and that

1 would, I think, give us a sense of whether we need to
2 reschedule two days, three days. It might be we can
3 schedule two days and one day or something like that,
4 but I think my cross-examinations of the lay witnesses
5 will be brief. I'll be a little longer with the
6 experts. But I guess if we have a sense from
7 Mr. Kitchen about his timelines, I can jump in, and
8 then we can get back to the Tribunal saying we need 'X'
9 or 'Y' days, and then Ms. Nelson can canvass dates.

10 THE CHAIR: Okay. Is that okay with you,
11 Mr. Kitchen?

12 MR. KITCHEN: Yeah, I think that's a great
13 idea.

14 THE CHAIR: Okay, great. Okay, well, we
15 will wait for that to unfold and look forward to
16 hearing from the College about reconvening. So thank
17 you once again, we'll call the hearing closed for
18 today.

19

20 PROCEEDINGS ADJOURNED

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1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing
4 pages are a complete and accurate transcript of the
5 proceedings, taken down by me in shorthand and
6 transcribed from my shorthand notes to the best of my
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,
9 this 27th day of September, 2021.

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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<hr/> <p style="text-align: center;">Exhibits</p> <hr/> <p>Exhibit H-7 - Response to Curtis Wall Re - Vaccinations 557:5 635:1,2</p> <hr/> <p style="text-align: center;">(</p> <hr/>	<p>11:30 609:22 11:35 610:9 11:6 573:11 11th 677:21 728:26 729:1 12 611:2 629:24 661:11 691:26 12:15 632:7 633:20 12:20 632:7 12:30 633:20 12th 691:4 700:17 702:17 728:24 14 654:16 14:23 573:18 15 590:5 609:9 610:6 645:17 646:1 674:23 675:1 676:16,21 708:9 15-minute 676:17 16 690:16 691:2, 24 692:20 16-20 654:22,23 656:1 16-2020 727:15 17 585:20 18 593:21 1996 560:4 564:16 635:19 636:8 1998 564:20,23 1:00 609:17 611:4 628:7 1:15 609:17 628:7 629:25 630:3 631:23,24 1:27 572:16</p>	<hr/> <p style="text-align: center;">2</p> <hr/> <p>2 568:18 569:1 588:19 627:19 634:12 641:7,16, 21 655:17 657:9, 25 659:19,22 660:26 662:21 667:20 673:13 675:8 683:18 687:25 689:23 690:21 691:13 692:21 693:15,18 728:2,7,9,10,15 740:2,25 2(1) 627:22 725:8 2(a) 642:8 2(b) 642:11 2(c) 642:13 20 565:6,14 611:9 638:25 660:3 738:9 742:1,14 743:3 2020 565:24,26 568:12 569:7 571:6,10 572:8 578:5 582:16 585:15,18 593:19 595:7 605:23 633:22 641:4,9, 17 642:16 643:13 644:1 647:23 650:13 653:10 654:11,16,17,18, 24 656:11,12 657:2 660:8 670:21 671:4,10, 17 672:25 675:5 677:26 679:23 681:8 683:18,19 687:14,18 690:16 691:4,24 692:20 693:13 698:2,5 700:5,17 702:14, 17 706:19 710:19</p>	<p>716:1,15 727:4, 23 729:17 2021 556:5,10 558:5 586:6 621:15 631:5 656:17 670:12,13 687:2 692:9 703:3 746:9 20th 675:23 21 675:5 23 660:8 25 565:22 652:24 687:2 25th 586:6,13 26 627:24 725:12 26th 656:17 27 725:13,19 27th 746:9 2:30 676:21 2:45 674:23 676:22 677:5 2nd 573:16</p> <hr/> <p style="text-align: center;">3</p> <hr/> <p>3 613:16 632:11 633:22 636:19 637:1 642:15 647:23 654:23 656:11 657:2 658:6 665:18,20 666:4 667:21 669:3 681:13 683:19 687:14 3.1 667:13,15 30 571:1 737:5 38 681:6 725:20 726:4 38-20 653:14,21 654:6,15 38-2020 578:13 579:10,12,13 673:11 674:7 725:12 726:7,9</p>	<p>3:00 629:18 3:30 629:9,18 3:45 629:9 676:24 3rd 582:9</p> <hr/> <p style="text-align: center;">4</p> <hr/> <p>4 613:21 620:20 621:12,21 632:10 633:24 643:12 647:26 655:19 658:15 665:14 666:24 683:14 684:11 693:1 722:17 723:19 730:3,4,7 4.3 645:18 646:1, 18 42-20 653:14 654:4,16 42-2020 681:7 45 721:19 4:30 721:4,7,18 4th 582:10</p> <hr/> <p style="text-align: center;">5</p> <hr/> <p>5 621:15,26 624:1 632:14,23 643:26 670:11,13 693:13 721:4,7,21 722:17 737:4 5(a) 726:22 5.1 638:26 639:4 558 556:5 559 556:6,7 5:00 722:10 5:15 722:4,9,10, 13 737:9,14 742:6 743:8 744:10 5:7 573:16 5th 583:6</p>
<hr/> <p style="text-align: center;">-</p> <hr/> <p>--mr 691:23</p> <hr/> <p style="text-align: center;">1</p> <hr/> <p>1 627:15 641:3 657:8,9,10,11,15 665:18,19,25 667:20 672:25 683:17 690:19 10 609:9 610:3 629:24 632:14 635:6 674:23 675:1 687:18 722:16,17 723:19 10- 676:17 10:14 590:2 10:30 590:3 11 654:16 667:11 677:16 11:20 608:25 610:8</p>				

6	A	accepted 646:21 676:26	696:3 702:25	advised 618:3 643:3,8
6 659:1 668:21	A-1 640:9	access 634:11 635:10	addresses 639:6	advising 660:9
611 556:8	A-11 638:22,24 645:16,25 667:11	accessed 661:18, 20	addressing 613:7	affect 603:19 713:19
631 556:10	A-2 672:14,16	accessing 661:26	adequate 660:15	affecting 720:20
632 556:11	A-3 672:15,16,19, 22 674:12	accommodate 743:13	adhere 572:15 594:20,21 658:1	affects 653:7
635 556:12 557:5	A-5 675:5	accommodation 580:8,14	adherence 654:25	Affirmed 556:19 737:26
65 617:24 687:11, 21 693:11 697:7, 21,22,24	A-6 677:12,20	accurate 600:25 602:23 617:25 618:5 624:22 639:9 643:5,10 672:14 673:21 674:19 675:24 684:22 685:10 702:12 746:4	adhering 658:23 659:5,12	afraid 602:13,22 618:25
7	A-7 683:15	achieve 700:2 722:3	ADJOURNED 630:3 745:20	afternoon 556:10 628:10,25 631:5 645:20
7 659:9	A-8 691:3,12 692:16,17 693:4, 7 700:14	achilles 563:11	ADJOURNME NT 590:7 610:11, 21 612:12 633:17 651:25 677:6 719:16 723:22 734:26	agency 738:6
720 556:14	A-9 703:2 729:4,5	acknowledge 700:2 722:3	adjust 587:22	agree 597:26 600:1,4,10,16,18 614:13 615:18 617:18 619:23 627:4 636:10,14 637:5 639:10,25 640:18 642:22 643:17,21 644:9 646:6,9,16 647:2, 17 654:7 655:6 656:10 657:23 658:3 661:2 662:23 663:2,19 664:1,19 665:22 667:24,26 674:8 675:22 680:9,11, 19 681:21 684:5 685:13 689:2,6 693:5,17 694:3 696:3,16,18 697:10 704:17,18 705:2,14 706:12, 14,17 707:12 709:10,14 713:23 719:25 723:7 728:20,22 743:14
724 556:15	ability 562:4,14 565:13 566:1 591:2 608:14 678:10 740:20 746:7	acknowledgment s 682:17	adjusting 587:23 588:4	agreed 698:14 726:21,25
732 556:16	absolutely 586:16 589:3 595:6 603:1 617:1,2 619:25 620:1,3 738:17 739:1,12,23 740:7,17,21 741:14	Act 574:3 601:13 606:4 636:16,19 638:9 693:2 710:26	adjustments 591:17	agrees 706:5,9
733 556:17	ACAC 558:10, 11,13,16 631:10, 11,13,16 640:4 644:7 648:25 658:2 678:6 682:5,20 683:3 708:18	acting 624:24	administrative 673:18 674:6,8	
735 556:18	ACAC's 665:26	actions 595:7	admission 641:26	
737 556:19	academic 561:18	activated 610:16	admissions 640:26	
741 556:21	accept 642:1 644:4	activity 627:20 662:26 663:16	admit 576:22 649:8	
746 556:22	acceptable 602:3 660:22 700:10 706:7 730:17 731:11,22 733:2	ad 576:21	adopt 687:22 690:17	
8		Adaptions 659:10	adopted 689:13, 16,20	
8 556:5,10 558:5 631:5 659:16 660:5 662:19 692:9 703:3		add 634:10,13	adopts 689:17	
8th 693:13		addition 570:25	advance 636:1	
9		additional 678:20 680:4	advice 664:25	
9 661:5		address 652:7 653:11 695:20	advise 642:19 743:21	
97 564:17				
99 577:7,11 600:16 615:26 616:6,12				
99.97 581:4 622:16				
9:03 558:23				

ahead 583:16
598:7 627:13
628:20 659:1
667:14 692:18
693:16 703:6
720:13 721:16
731:10 737:24
742:25

AHS 578:5,16,25
579:2,6 618:19,
20 619:2 620:15
622:3 624:21
626:9,19 660:8,9,
11 661:20 662:11
663:24 666:14
669:3 679:23
680:4,8,11
688:10 704:16
714:18 724:22,24
725:25 727:9
730:3

AHS's 593:5
622:4

ailment 566:25

air 584:3

Alberta 558:1,3,
15 564:15,16,25,
26 565:5,25
566:9 574:2
593:7 600:23
601:17,20 605:5
606:23 621:16
626:15 631:1,3,
15 636:8,16
655:7 657:17
663:18 690:10
711:1 733:8
738:6 746:8

Alberta's 655:14

alcohol 658:22

Aldcorn 558:10
631:10 722:7,13
735:4,7,21
744:11

alerted 686:8

allegation 681:26
682:5 716:18,19,
22 718:22 719:2,
7,8,9

allowed 598:11
604:9,10 623:16
652:2 655:19
689:20

alluded 739:7

alternatives
576:7

amazingly
563:25

Amber 633:10
635:3

American 561:5

amount 599:3

amounts 682:15

and/or 641:11,22
642:18 643:14
644:2

announced
660:8

annual 614:14
637:15

answer's 698:11

answers 625:11
628:19 685:7
707:7

anticipate
589:17

anticipates 715:2

anxiety 584:1
586:9 603:16
644:24 679:19
702:10,18,25
704:6 707:22,26
708:6 729:14
732:2

anymore 713:14

apologies 590:14
656:2 670:23
687:2

apologize 559:23
560:5 612:4

apparent 568:6
570:16 574:9
679:20

appeal 697:22

appearing
737:20

appears 586:23
593:7,11 682:3

Appended
692:22

Appendix 690:23
692:15,22

applicable 704:3

application
603:13 680:7

applied 672:2
700:11,12

applies 615:19
714:11

apply 574:12
616:2,18 625:23
712:5

applying 712:25

appointed 697:9

appointment
669:5,9 701:22

apprehension
570:23 614:3

approach 610:2

appropriately
690:3

approval 708:24

approved 655:20

April 660:8

area 659:21,23

areas 660:13

argue 644:19,20

arguing 640:21
644:17

arguments 744:9

arising 609:13

arm 582:7 618:16

arrived 721:11

arrives 693:26
694:7,26

arrow 685:8
686:6

art 561:20

articles 698:25
699:1,2,4,6,9,10,
11

aspect 573:6
575:14 587:25
592:23 661:3
690:12

aspects 573:26
587:20 714:6,8
716:1 733:8

assess 638:10
658:10

assist 564:6,9

Association
558:2,15 631:2,
15 699:17

assume 639:2
640:17 682:17

assuming 636:23
660:1,17 661:2,7
699:8

astounding
617:1 679:14

asymptomatic
594:19 596:18

attached 690:23
691:8

attacking 713:12

attempt 569:21
582:15,18 608:10

attend 559:4
561:2,5,14

attendance
610:15 702:1

attendances
702:2

attended 560:2
561:7,9,12,22

attending 725:15

authorities 714:4

authority 573:1,
23 602:8 606:26
666:13

autonomy
574:26 575:15
592:22 603:23
728:4

availability
722:23 744:6

average 622:18

aware 568:4
572:7 594:12
611:22,25 636:26
637:24 638:1
686:10 697:21
698:7 701:24
739:5

B

B-3 687:17

B-4 687:17
690:15 692:20

B-5 693:10

B.E. 558:16
631:16

B.J. 561:17

Bachelor 560:26

back 563:2 571:2
578:14 579:18
590:3,8 593:19
610:12,23 612:13
616:7 620:15
650:18 651:24
657:12 663:22
665:8 667:10
671:3 673:15
677:7 688:9
692:19 699:19
706:6 714:10
722:17 723:14,19

589:5 590:21 591:6,9,21 595:14,16,19 596:2,8,11,24 597:1,3,5,13 601:25 616:3 627:19 655:18 660:9,10,24 662:21 668:14 678:11 679:11, 15,16 693:20 694:17 699:26 708:3 711:10 712:4,17 713:24 716:14 career 563:5 careful 640:12 720:1 carefully 592:2 caring 589:1 590:16 carry 564:11 575:5 615:16 652:10 carrying 624:25 case 696:24 719:1 catching 739:17 category 714:22 caucus 610:18 caused 594:7 595:8 713:1 causing 588:1 593:26 622:10 714:14 cautiously 592:1 CCPA 699:20,22 cell 633:6 censured 602:10 certainty 725:16 certificate 556:22 690:24 692:23 746:1 certify 746:3	cetera 656:18 659:12 668:9 683:21 698:3 704:16 705:4 Chair 558:8,24 559:3,13 560:11 589:15 590:1,8 600:6,14 609:5 610:1,8,12,17,22, 25 612:13 624:1, 4 628:4,9,24 629:2,23 631:8, 24 632:1,3,6,23 633:9,19 634:6, 15,19 635:3,11 639:2 645:23,25 646:3 651:20,26 652:12 674:22 675:2 676:16,19 677:2,4,7 694:9, 12 703:7 708:14 717:15,24 718:6 719:11,17 720:24 722:2,11,21 723:4,10,23 731:14 732:11, 16,20 733:21 734:6,20 735:1, 22 736:9,15,21 737:4,16 742:21 743:3,18 744:5, 20 745:10,14 challenge 602:4 666:11 733:26 734:2 challenged 729:19 challenges 704:13 challenging 566:14 567:2 713:25 714:1 change 565:7 594:7,9 611:11 661:26	changed 565:5 593:21 653:5 656:18 679:26 character 577:21 604:1 616:24 Charge 641:3,16 642:15 643:12,26 charges 640:16, 21,25 641:1 685:4 716:26 chart 643:14,15 charted 670:17 Charter 574:2 693:3 733:7,13 charting 671:4, 18 685:22,23,26 704:5 charts 670:13,16 671:5 chasing 722:24 chat 676:26 chatting 674:25 694:8 708:8 742:16 Chief 606:21 726:23 727:1 chipped 574:14 chiro 587:6,11 chiropractic 560:2,3,24 561:2, 10,11,19,24 562:1,3,9,17,22, 25 563:15 564:3, 26 565:7 566:15 567:8 578:5,16 587:5,12,25 591:21 596:24 597:12 605:5,11 606:24 608:9 619:20 636:11,14 641:5 668:14 685:15 690:5 699:16 712:24 741:3,16	chiropractor 560:1 561:8 563:3,22,26 564:15 565:16 571:1 575:2 577:22 589:6 590:25 596:12 598:1 605:9 612:1 625:17,24 636:8 639:13,14, 16 652:24 685:13 709:3 711:10 712:18 713:18 738:11 740:6,16, 20 741:10 chiropractors 558:2,15 565:9, 25 567:3,18 591:26 596:7 600:21 602:12 605:13,16 606:13 625:5,6,14,15,20, 23 631:2,15 636:25 645:13 646:13,25 648:6 652:15 657:15,26 658:10 660:22 667:18 668:7 698:20 choice 603:22 738:24 choices 563:20 564:9 592:19 620:14 698:7 choose 560:22 690:13 701:8 728:10 chose 663:24 699:8 709:3 chosen 714:3,17 Christ 572:15 Christian 572:13 573:7 574:21 chunk 704:18 church 563:7	circumstances 647:15 City 746:8 civil 657:21 clarify 573:9 574:1 598:6 670:20 677:17 693:12 733:19 clarifying 559:13 696:6 clarity 689:24 classed 596:8 classified 596:7 clause 726:7 claustrophobia 584:2 586:9 679:20 729:15 cleaned 658:21 cleaning 659:3,6 727:25 clear 583:18 614:1 615:20 617:12 621:14 640:25 645:12 651:10 679:1 692:10 696:19 698:5 709:24 710:19 714:17 722:23 733:3,11, 17 Clerk 730:25 737:24 click 661:14 731:3 clicking 661:15 client 609:26 623:14 634:4 649:4 650:11 651:6 691:18 698:14 706:9 707:7 721:1 725:26 client's 721:6
---	--	---	--	--

clinic 619:11
620:16,24 626:21
638:10 641:5,10,
18,19 659:10
663:22 666:9
673:25 674:18
684:17 685:4,15
689:26 735:14,
16,17,20 738:21

clinical 646:25
660:23

clock 722:24
742:11

close 563:13
578:5 663:22
724:22,24

closed 618:20
626:21 745:17

closing 680:14
682:2 744:9

closure 578:8,10,
20 579:11 626:19
627:8 662:11
664:1 725:1

cloth 567:23

CMCC 561:3

CMOH 578:9,13
579:10,12 586:23
607:16,18 611:20
626:8,9,18,20
627:1 628:1
644:2 653:14,21
654:2,4,15,17,22,
25 656:1,4,6
664:12,19,26
665:7 673:11
674:7 681:1,6,20
706:23,25 725:12
726:4,7,8,20
727:3,5,7,9,19,22
729:19

CMOH-38-2020
627:25

co-workers
660:16

CO2 594:2

Code 652:25

Codes 637:25

collaborated
606:23

collaboration
566:10 606:3
626:9,14

colleague's
564:18

colleagues 723:5

college 558:2,15
560:2,19,23
561:1,2,7,9,11,
13,15,16,21
563:14 565:1,2,8,
11 566:4,6,8
567:7 570:2,9,13,
24 571:4,7 575:8,
13 579:19 580:9
582:7,20 583:23
584:14,15 585:8
593:11,14,15,16
598:17,19
600:19,22

601:10,12 603:24
604:3,19 605:17,
22,24 606:5,17,
20,24,25 607:4,6
611:11,19,26

612:17,21 613:5,
7,8,11,14 614:3,
5,12,18 615:4,20
616:19 617:8
618:16,18,21,25
619:1,4,8 622:4
624:8,12,15,18,
21,24 625:2,3,5,
12,14 626:3,7,10,
14 631:2,15
635:18 636:24
637:2,5,19,24
638:1,8,14 649:5
655:3,9 657:6
658:4 672:13
677:10,16 678:13

686:3 696:25
697:1,18 700:23
708:23 709:7,12,
13 710:14,21
713:4,25 714:14,
15 716:3,7,13,15
717:21 718:8,13,
15 719:4 720:5,9,
15,22 727:9
741:9 743:22,25
744:6 745:16

colleges 581:18
593:1 604:6
614:7,10,24
615:10 672:13
701:1 711:11
712:20 713:19
741:3

colleges 560:24
561:5 636:21
655:22 656:5

colon 646:13

comfort 741:15,
18

comfortable

578:1 597:16
671:24 732:16
739:10 741:19
744:25

COMMENCED
558:23

commencement
617:19

comment 580:21
581:17 616:16
622:22 624:7,14
627:6 649:3
675:23 683:22
685:8 705:17
722:22

comments
617:12 624:20
626:16 628:6
629:17 658:9
659:4,11 677:25
683:21 705:3,14

710:25 718:3
744:13

Commission
711:2

commit 605:21
640:22 725:11

commitments
722:4

communicated
576:5 675:12

communication
598:19 608:14
710:13,21

communications
643:15 657:6
658:1

community
660:11 740:8

comparable
652:6

compared
597:10

competence
637:19

complaint
700:23 701:1
711:1

Complaints
559:8 580:2
584:15 617:13,
21,24 683:20
695:8

complete 578:21
658:18 681:16
687:25 693:18
746:4

completely
623:12

completing
723:8

completion
696:14

compliance
621:11 649:4

650:12 665:14
667:6 711:16

compliant
602:17 640:6
652:23 675:10,25
676:1,6,9

complications
684:7

complied 647:4
666:10 696:21
711:7,8 715:22

comply 655:24
656:12 662:1

663:24 665:26
666:14,18,23
681:26 682:5

690:13 696:22
697:14 711:5

714:6 716:1
718:16 720:10,16

730:9,12

complying
621:22 647:17,18
669:8 685:14
697:13,18 714:7
715:18

component
562:5,22 564:13
588:5 591:12
597:8

components
561:21

comprehensive
639:9

concentrate
603:16

concentration
584:4,6

concern 568:10
569:4 577:16
580:13 582:21
584:8 586:19,22
589:12 593:13
625:4,10 695:9
710:9

<p>concerned 571:23 576:19 606:20 626:7 710:18 739:17 741:16</p> <p>concerns 568:8 570:11,14,17 571:3,19,21 572:9 583:22 585:26 586:25 593:9 605:4,11 607:23 622:10 681:5,18,22 683:6 685:18 704:14 715:18 716:3 717:21 718:13 720:6 732:18</p> <p>conclude 683:2</p> <p>concluded 559:5, 6</p> <p>conclusion 574:8 678:6 679:5 683:7</p> <p>conclusions 586:14 664:8</p> <p>condition 613:12 621:12</p> <p>conditions 585:5, 9 621:10,19 669:25 681:14 683:6 695:19 696:2,4,13,21 697:15</p> <p>conduct 617:14 636:24 640:17, 22,26 642:1 657:19 683:14 717:8 718:1</p> <p>conducted 704:2</p> <p>conducting 683:13</p> <p>confident 617:2 620:9</p> <p>confining 648:19</p>	<p>confirm 559:16, 20 560:18 568:11 600:15 694:23 704:8 738:8</p> <p>confirmed 680:16 690:2</p> <p>conflict 602:19</p> <p>conflicting 600:26</p> <p>confronted 651:2</p> <p>confusing 671:8</p> <p>consent 575:4,9, 14,21,23 576:2,3 592:6 603:23 614:23,25 615:1, 3,4,9,12,18 632:16 649:10 665:21 667:13,17 668:13,21,23,25 669:14,18,21,26 670:3,17 671:5</p> <p>consents 670:12</p> <p>consequence 581:15</p> <p>considered 561:15 620:7 678:4 740:18</p> <p>consistent 619:21 664:24 706:3 729:16</p> <p>constitute 640:17</p> <p>Constitution 733:7</p> <p>constrained 605:16 722:25</p> <p>consult 609:25 651:22 699:26 716:7</p> <p>consultation 678:12 702:19</p> <p>consulted 600:23 624:21</p> <p>consulting</p>	<p>619:26</p> <p>contact 596:21 624:12 660:14 699:13,16,22 700:19 709:8,13 710:13</p> <p>contained 567:13 691:16</p> <p>content 649:11, 18,20 682:4</p> <p>contents 556:1 639:26 648:26 650:5,24 656:17 657:10 687:22</p> <p>contest 650:2,3</p> <p>contested 653:4</p> <p>contesting 640:16,21</p> <p>context 574:20 607:5 716:26</p> <p>continue 569:5 578:25 585:3 590:3 612:9 629:25 665:11 676:22 703:10 740:5 744:7</p> <p>continues 560:7</p> <p>continuing 637:19 696:22 697:14</p> <p>continuous 663:6</p> <p>continuously 620:22 659:24 660:12 666:25</p> <p>contracting 594:16</p> <p>contradict 601:2</p> <p>contradictory 581:21</p> <p>contrary 595:11 607:14,16</p> <p>contravene 698:8</p>	<p>contribute 570:23 627:20 662:26 663:16</p> <p>control 605:8 615:11 646:2 673:25</p> <p>controversial 698:11 707:4 718:20</p> <p>controversy 726:2,3</p> <p>convene 590:4</p> <p>convenient 741:26</p> <p>conversation 672:1 673:6 674:16 683:18,19 686:15 739:7</p> <p>conviction 573:11</p> <p>convictions 573:26</p> <p>cooperation 743:24 744:18</p> <p>copy 632:19</p> <p>core 562:16,19,22 576:9</p> <p>Corinthians 573:16</p> <p>corner 653:1</p> <p>correct 560:21 568:25 574:24 582:11 587:17 604:1 611:24 613:14,15,25 614:9 615:22,23 616:20,21 617:21 619:16 621:13, 19,20,22,23 625:25 637:11,20 639:17,18 640:1, 5,23 643:1,6,11 644:15,23 645:11,15 647:20 654:2,3,14,19,20</p>	<p>656:13 657:7 660:4,18 661:4,9 662:2,5,6,10,23 663:8,13,14 664:10 665:14,15 668:12 670:19 671:19,20 673:8 674:10 676:7 678:13,14 679:4, 6 681:9 682:9 683:9 684:10 685:11,25 686:1, 5,24 687:3 688:8 690:14 693:8,9, 21,22 695:26 697:7,20 699:10 700:8,24 703:19, 23 704:10 708:2, 26 709:1,23 710:22 713:6 714:25,26 726:11,12 732:4</p> <p>corrected 710:6</p> <p>correctly 647:2</p> <p>corroborate 713:10</p> <p>council 607:10 625:9,20 724:5, 11,14</p> <p>council's 708:23</p> <p>councillors 625:15</p> <p>counsel 558:9,16, 19 613:22 631:9, 16,19 651:22 652:1 689:18 709:5 715:1 719:13,19 733:15 743:22</p> <p>couple 560:12 573:9 595:23 620:17 628:11 635:16 637:4 639:19 648:3,20 656:3 659:1 662:16 672:22</p>
--	---	--	---	---

684:14 688:13
703:4 735:3
court 558:21
631:21 632:25
666:10 697:24
712:13,16 729:19
730:21 731:1,6
746:15
courts 697:23
733:12
cover 572:23
608:12
covered 677:22
698:4 703:17
723:15
covering 688:2
690:26 692:25
coverings 688:17
covers 620:23
666:26
COVID 567:9
571:13,20 581:3,
5 594:12,16
595:1,3 599:1,4,
8,12 600:1,3,11,
12,16 601:21
602:3 603:2
607:1,6 622:13,
16 623:4,10,15
644:26 646:7
650:13 655:8
689:7 704:13,14
705:3,15 741:16
COVID-19
622:22 627:21
642:20 643:9
644:3 645:9
655:15 658:11
663:1,17 678:19
684:1,7 688:19
693:19,26
694:16,26 726:25
739:17
create 565:11
606:4 608:10
725:10

created 562:14
572:18,19,20
606:5,24 625:3
653:3
creates 608:18
637:24 638:1
creating 656:5
credible 601:1
credits 561:4,6
cross 609:2
723:17 736:26
737:1 741:24
cross-
examination
610:10,24 628:13
629:26 632:9
633:22,25 648:20
649:25 650:8
651:16 652:3
737:10 743:5
cross-
examinations
745:4
cross-examine
723:15 737:7
743:23
Cross-examined
556:13 635:13
Cross-examines
556:8 611:6
crossed 602:20
606:12
crunching
738:12
CSR(A) 558:21
631:21 746:14
curious 568:20
667:21 690:21
current 646:21
Curtis 556:7,12
557:5 558:18
559:15,22 620:21
631:18 635:1,13
669:5 690:25
692:24 737:20,21

cuts 597:13
cutting 584:2

D

D-1 578:8 627:8
662:12 663:22
687:13 725:2
D-2 578:25
620:15 662:12
663:21 665:16
669:3 730:3
D-8 579:13
653:13
D-9 653:13
daily 724:19
danger 580:26
594:5 622:13,14
dangers 686:9,
11,12
dash 693:12,13
date 567:5 583:5
670:22 677:18
727:5 743:12,21
dated 639:8
654:15,16 656:10
670:11 672:24
691:24 700:17
746:8
dates 583:14
743:26 745:9
Davenport 560:2
561:9,15 563:15
635:19
David 580:3
703:13
Dawson 558:12
610:15,20,23
631:12 735:22,
23,24
day 566:18 575:6
587:8 604:17
629:9 721:1
730:16 742:10
745:3 746:9

days 566:18
721:21 744:16
745:2,3,9
deadline 743:7
deal 559:6 671:1
697:24 719:6
722:19
dealing 588:3
592:6 704:19
729:14 732:2
deals 684:17
dealt 690:20
723:18
debate 580:23
706:1
debunked
699:12
decades 565:20
December 578:4,
15 579:18,19
582:9,18 583:5,6
585:18,21 605:23
614:6 618:20
641:9 654:16
660:3 672:25
675:5,22,23
681:8 683:18,19
687:14,18 690:16
691:2,4,24,26
692:20 693:13
700:17,21 702:17
706:26 710:18
728:24 735:9
decide 570:7
582:5 618:15
628:9 700:10
709:5 711:11
712:4,19 713:3
722:12 725:25
decided 564:21
569:5,15 579:8
640:2 654:12
656:12 695:19
698:5
decides 733:12

decision 569:4
576:13 579:25
583:10 584:21,
23,24,25,26
585:10 592:20,26
607:11 628:8
652:2 672:2
677:26 678:4
693:11,14 695:10
699:5,22 700:5
711:4 713:2,7,19
715:26 740:19
decisions 600:20
607:11 625:22
697:10 698:1,2
712:23 713:24
decrease 565:13
594:1 611:10
decreased 572:2
605:9
decreases 584:4
deem 619:5
defer 743:12
degree 561:1
degrees 572:6
636:1
delegate 685:23
delineating
670:5
demand 678:8
demonstrated
602:1
Dental 655:18
denying 640:15
department
563:9
depending
738:25
depends 738:19
describe 571:26
597:3 609:19
640:6 738:10
describes 684:13

Description 556:3 557:3	digress 638:21	directly 597:21, 23 652:6	discussion 556:6, 11,14,21 559:2,7 577:14 590:13 608:3 611:17 612:15 613:16 614:2,22 615:24 617:6 618:8 619:19 621:24 622:2,9 632:5 636:10 665:18 686:16 687:6 720:25 741:21	674:1 675:17 676:5 698:3,7 700:13 709:21 715:19 720:18 740:25
design 680:23	digressing 691:21	Director 558:13 559:8 580:2 584:15 617:13, 21,24 631:13 683:20 695:8	discussions 709:25,26	distinction 606:6
designate 697:19	diligent 559:25	directs 743:1	disease 635:23	distinguish 608:17
desire 563:26 580:10 607:2 743:4	diligently 573:15	disability 593:13 691:1 692:26 693:5 704:9	diseases 635:25	distributed 613:13
desiring 607:7,8	dioxide 572:4 622:11	disagree 615:7, 17,18 619:7 649:2 664:12 695:5,15 696:1 711:24 713:23	disheartening 571:3	doctor 560:3 570:6 575:17 583:2 584:10 596:14,19 613:4, 8 679:12 701:5, 15 702:13 706:19
desk 663:11	direct 609:12 611:1 660:10,14 696:11 708:15 723:15 736:25 737:3 741:24	disagreed 580:25 664:3,5	disinfectant 659:4	doctor's 569:22 579:2,7,8 582:16, 18 584:12 613:1 619:14 627:3 700:2 702:11 706:22
detail 563:25 596:3 653:15 654:22 677:23	direction 570:2 612:17 658:4 666:15 697:18, 23,24	disagrees 715:10, 11	disinfection 659:3,6	doctor/patient 577:25
detailed 700:16	directed 727:8	disclose 613:5 614:16 707:20	dismiss 736:18 744:1	doctors 571:16 596:5 712:23
details 584:16	direction 570:2 612:17 658:4 666:15 697:18, 23,24	disclosing 667:18	disorder 644:24 702:26 707:26 708:6	document 567:11,13 578:19 632:8 633:21 634:7 635:5,9 640:10 645:21,23 648:14 649:19 650:7,19 651:16 652:3 655:13 677:15,20 683:11 691:19 703:2,8
determination 599:7,15,19,23	directive 567:7, 15,17,21,25 568:1,5,11,15,16 570:1,4 604:6,10 612:16 613:2 615:6,21 625:18, 26 640:4 644:8 647:19 648:25 650:14 653:3,10, 20 655:4,9,24 656:14,23 657:9 658:7,16,25 660:2 661:3,11 662:4 665:9,19 666:1 675:15 676:9 678:7 682:1,6,12,16,20 698:8,19,21 700:11 709:13, 22,25 711:5 714:6,14 715:10, 20,23 716:2,5,6 717:22 718:14,19 720:6,10,17	discomfort 566:25	disorders 707:22	documentation 584:10 744:15
determine 723:14 744:7	directions 696:7, 8,15 697:6,14	discoun 699:8 742:22	dispute 641:14 642:9 644:19	documented 639:14
determined 696:24 743:21	directive 567:7, 15,17,21,25 568:1,5,11,15,16 570:1,4 604:6,10 612:16 613:2 615:6,21 625:18, 26 640:4 644:8 647:19 648:25 650:14 653:3,10, 20 655:4,9,24 656:14,23 657:9 658:7,16,25 660:2 661:3,11 662:4 665:9,19 666:1 675:15 676:9 678:7 682:1,6,12,16,20 698:8,19,21 700:11 709:13, 22,25 711:5 714:6,14 715:10, 20,23 716:2,5,6 717:22 718:14,19 720:6,10,17	discretion 617:20	disrespect 743:19	documents 645:20 680:4,6,8, 12 688:10 703:26 709:16
determines 733:4	directions 696:7, 8,15 697:6,14	discriminating 574:5	distance 568:17 588:10 627:19 645:13 654:12 660:26 662:21 673:14	doffing 661:6
developed 572:8	directive 567:7, 15,17,21,25 568:1,5,11,15,16 570:1,4 604:6,10 612:16 613:2 615:6,21 625:18, 26 640:4 644:8 647:19 648:25 650:14 653:3,10, 20 655:4,9,24 656:14,23 657:9 658:7,16,25 660:2 661:3,11 662:4 665:9,19 666:1 675:15 676:9 678:7 682:1,6,12,16,20 698:8,19,21 700:11 709:13, 22,25 711:5 714:6,14 715:10, 20,23 716:2,5,6 717:22 718:14,19 720:6,10,17	discuss 570:8 577:10 594:11 633:12,15 648:15 651:21 729:10 734:21	distancing 599:20 620:2 641:8,22 644:13 656:8 659:14 660:16 662:9 664:21 665:3	
devise 560:7	directives 625:16 656:5 683:3	discusses 719:12		
diagnose 679:21		discussing 635:25 736:7		
diagnosis 639:25 667:20 707:25 728:24 729:1				
diagnostic 704:2				
dialogue 672:3,6				
difference 597:15 650:26				
differences 596:4				
differently 645:8				
difficult 566:23 576:13 580:10 584:5 593:2,4,6 606:5 617:8 714:15 742:4				
difficulties 590:11				

dog 578:8
donning 661:6
door 568:19
doubt 609:2
doubts 571:7
 582:24,26
draft 710:7,12,15
drawn-out
 560:25
driver 704:5
Dropbox 632:25
 634:10,20,25
dropped 633:8
due 566:9 642:21
duration 620:23
duties 591:15,19
 646:14,15
duty 591:16,20
 607:2 618:4
dying 622:15
dynamic 606:24

E

earlier 579:10
 582:15 591:24
 607:13 723:12
 724:4 726:19
 744:22
early 564:17
 578:15 579:19
 608:26 653:9
 657:3 698:24
 700:21 721:21
earning 591:3
easier 634:18,19
 681:12
ed 563:9
Edmonton 558:2
 631:2
educate 575:18
 592:13

educating 619:24
education 561:1
 635:20,22
educational
 635:16
effect 626:7
 643:9 727:12
effective 571:12,
 19 588:18,21,23,
 24 591:21 599:8,
 11,15,20 660:8
effectiveness
 688:18
efficacy 698:18
 699:14 704:19
efficient 709:10
efforts 722:3
elaborate 561:26
 628:21
elements 619:23
email 570:19,21,
 25,26 571:4
 613:16,21 632:9,
 11 633:21,22
 634:15,17,23
 647:23 648:1,3,
 17,23,24,26
 649:10,12,21
 651:5 653:11
 672:16,20,24,26
 673:1,2,3 674:13,
 15 709:18 724:2,
 5
emailed 709:19
emails 647:22
emergencies
 566:13 623:24
emergency
 566:3,5 596:5,20
 601:26 602:3
 603:3,6,7 622:22
 623:4,10,15,20,
 23,24
emotional
 591:12 597:7

emotionally
 608:11
emphasize 604:1
emphasized
 565:1
employ 585:16
 620:5
employees
 659:18 689:25
employs 689:26
enabled 577:26
encapsulates
 592:1
enclosure 691:6
encounter
 594:17
encounters
 724:19
end 560:13 561:4
 569:3,6 583:1
 610:5 619:5
 646:12 673:23
 674:13 693:23
 736:25
endangering
 683:26
ended 721:21
enforcing 637:3
engage 605:17,19
 668:10
engaged 592:8,
 10 608:3 619:18
 671:26 719:3
enjoy 564:5
 738:14
enormously
 721:13,15
ensuing 618:21
ensure 620:21
Ensuring 666:25
entered 559:9
 633:26 647:22
 649:24 650:19
 651:11 680:8

entire 629:9
entitled 717:3
entity 625:13
 725:18
entries 639:15
environment
 608:11,19 659:3,
 6,10
epidemiologist
 679:3
equipment
 647:15 660:6
 661:21
ER 596:14,19
 597:11
escapes 740:15
essentially
 566:16 572:24
 573:5 575:13
 587:22 613:21
 654:6
establish 655:9
 697:2 706:9
established
 638:17 688:23,25
 706:25
establishes
 597:18 636:20
establishing
 637:2
estimated 744:26
ethical 602:26
 604:18
ethically 604:21
 700:10
Ethics 637:25
 652:26
eventuality
 737:6
eventually
 568:26 589:5
everybody's
 635:10 700:18
 729:3 744:17

everyone's
 609:16
everything's
 692:4,6
evidence 600:26
 620:25 622:25
 623:7,25 626:11,
 13 646:5 647:4
 650:21 688:16
 708:24 721:22
evolve 611:13,15
exact 567:5
 583:5,12 716:26
 727:5
Exam 639:24
examination
 558:25 589:17
 609:12 611:1
 632:15 652:8
examine 592:2
Examined 556:7,
 19 559:15 737:26
excellence
 561:18
Excellent 635:3
exception 654:1
 660:2 682:24
exceptions
 681:2,3,13
 682:22 683:5
exchange 610:23
 612:26 624:6
 632:10 651:5
 709:18
exchanges 710:4
Excuse 563:4
 568:19
Executive 621:16
exempt 580:13
 673:7
exempting 681:3
 690:24 692:23
exemption
 569:23 577:7

579:3 582:24 619:12 620:26 621:3 627:4 644:17,22,24 654:1,8 662:5 670:8 673:12,15 679:9 700:19 701:4,25 706:22 707:13,17 708:1 726:6,11,13 736:6 739:8	727:11 exist 650:22 existence 650:23 existing 668:22 exists 573:14 expansive 662:8 expect 628:11 721:17 expected 561:25 experience 568:8,20,23 572:6 584:1 588:26 596:22 602:11 650:7 651:15 experienced 569:12 698:23 736:7 experiencing 602:12 698:23 expert 601:9,23 623:25 651:2 700:6 expertise 601:7 680:24 experts 644:18 745:6 explain 595:20 596:3 638:7 686:11 explicit 669:14, 17 explore 654:11 express 577:5 608:2 expressed 570:17 571:3 576:4 607:20,23,25 743:4 expression 573:8 574:3 593:12 608:15 extent 594:4 620:10 724:12	extra 567:8 629:14 extraneous 668:18 extremely 575:4 592:23 603:11 679:21	<hr/> F <hr/> F-1 655:7,12,14 F-2 654:22 655:7 656:2 face 569:8,10,11, 13,17,19 572:21, 24 608:12 627:18,26 628:2 647:21 662:20 677:25 679:10 682:11,15 688:2, 17 690:26 692:25 695:10,11,22 698:6 725:14 faced 650:20 faces 604:12 facial 608:15 facing 596:8 fact 560:19 562:3 570:25 573:2 594:4 601:8 607:21,26 608:8 611:9 613:20 636:23 682:3,14 737:8 739:7 facts 572:5 601:4 641:1,14 642:1,9 factual 641:2 689:24 factually 642:22 643:5,10 644:4,9 662:23 692:3 726:22 failed 641:5,6,7, 9,19,20,21 643:14 644:2,7	681:26 682:5 726:23,26 fair 611:12 612:20 614:5 616:1 624:3,23 625:4 626:19 627:6 640:2 644:16,25 645:14 647:21 654:6,13 660:3 661:8 664:3,6,11,18 667:5 670:15 678:1 680:3 687:5 700:25 702:8 704:22 706:5 708:9 709:15 711:6 717:1 718:1 720:14 723:10 fairly 576:17 595:22,23 640:6 fairness 611:17 625:8 628:22 644:12 653:26 666:21 675:17 677:15 691:18 711:8 faith 573:8,12,17, 19,22,25 624:24, 26 fall 595:19 673:12 714:22 725:19 falls 714:10 familiar 636:19, 23 732:26 familiarity 651:3 family 564:21 566:14,15 585:16 690:1 701:5 far-reaching 587:24 fast 741:24 fatal 684:9 fault 559:23 629:12 721:14	741:3,8 742:3 fear 597:10 602:4,6,23 fear-based 573:24 fearing 573:5 fears 571:7 feedback 560:6 612:6 731:4 feel 564:3 577:26 582:4,6 583:22, 24 591:15 593:1, 5 597:9,16 602:25 618:14 652:3,4 708:14, 25 719:24 722:25 739:10 740:22 741:18 feelings 584:1 fell 627:3 726:13 felt 577:15 580:23 582:6 614:4 617:11 618:16 female 572:19 fence 608:7 fides 713:12 fiduciary 657:20 fields 601:6,25 figuratively 704:23 figure 737:1 file 634:10,11,12, 26 670:4 filed 711:1 files 668:22 670:1 filling 619:20 final 626:16,17 668:20 682:19 693:23 finally 643:26 find 588:24 601:10 634:12,26 695:8 729:2
--	--	--	---	--	--

743:13
finding 730:23
findings 617:14
 639:24
fine 576:21,23
 589:24 606:8
 624:4 632:18
 633:14 653:18
 671:11 676:2,21
 705:12 712:6
 713:21 724:14
 730:26 731:1
finish 589:22
 611:3 624:2
 737:13
finished 611:3
 629:11 721:5
 742:19
finishing 589:25
 722:26
fit 709:2
fitness 614:16,19,
 20
flag 639:6
flaws 680:23
flexible 609:4
floating 699:6
floor 590:9
 610:13 632:4
 634:2 723:25
flu 622:18,19
fluid 596:21
fluidity 676:20
follow 640:3,4
 644:2,7 646:16
 648:8 652:17
 657:11,15,20
 665:19 676:25
 694:21 696:24
 711:11 712:19
 713:5 714:3,14,
 17 716:11 717:22
 726:23,26

follow-up 613:25
 697:17 732:13
 736:9
follower 572:14
force 654:18
 656:11 681:8
 727:13
foregoing 746:3
forged 583:15
forgetting
 616:13
forgive 584:15
 587:10 621:4
forgot 568:19
form 587:8 588:8
 591:6 669:21
 670:3,4,7 732:6
formulate
 574:17
formulated
 601:15
forward 578:4,
 15 614:3 632:19
 745:15
foundation
 641:2
fountainhead
 561:16
fourth 623:2
 667:6
fourth-last
 683:22
frame 615:2
 735:8
framed 716:26
frankly 616:26
 632:12 647:12
 672:15 721:7
 742:8,9 743:8
free 581:13,14,17
 582:5,6 618:14
 708:15
freedom 565:8
 574:11 592:19,24

603:23 605:9,13
 620:13 667:2,4
freedoms 574:2,
 13 602:20 603:25
 606:1 733:7
fresh 609:15
friend 561:11
 563:13,14 726:21
 732:14 733:1
 738:15
friend's 732:12
front 653:17
 663:11 672:4
fulfilling 618:4
full 559:21
 629:13,14 693:24
 694:6,25
fullest 573:8
fully 648:6
 652:15
function 588:2
 740:8
future 605:4
 649:4 743:21,26

G

gather 560:13
Gauthier 714:24
 715:3,5,9,18,25
gave 583:16
 593:18 702:17
gears 598:23
 697:26 708:18
 710:23
general 627:22
 642:3 685:12
 699:1 701:13
 705:5 706:6
 709:9 710:24
 711:17 719:21
 725:9 726:8,15
generalized
 577:17
generally 565:3
 576:10 597:26
 601:17,20 602:18
 644:26 645:4,9
 646:21 653:16
 706:2 727:23
Genesis 572:16
give 559:20
 560:17,25 570:9
 577:17 583:7
 591:19 620:17
 623:13 624:1
 633:6 634:12
 646:5 719:13
 734:8 745:1
glad 723:2
global 689:6
goals 564:7
God 572:18,19,22
 573:5,13
good 558:24
 559:20 590:2
 591:16,18 605:14
 609:14,23
 624:24,26 632:2
 640:11 662:15
 712:15 737:15
 744:11,23
gotcha 613:18
 617:23
govern 713:26
governable
 713:13
governance
 565:8
governed 648:7
 652:16
government
 565:25 602:5
 604:20,23 607:2,
 7 611:20 655:7,
 13 657:17,22
governs 636:24
gracious 721:26

graduate 591:26
graduated 560:3
 635:18 636:4
graduation
 564:17
granted 620:26
 736:4
grateful 738:24
great 745:12,14
greater 608:20
 725:16
ground 693:1
grounds 579:8
grow 611:13,15
guards 574:4
guess 609:1
 613:10 619:7
 622:4 649:5,18
 657:5 675:17
 686:23 689:5
 702:4 709:21
 716:9 734:4
 744:9 745:6
guidance 679:26
guidelines 648:9
 652:18 655:21
 727:8

H

H-4 632:23
H-7 557:5 635:1
had've 651:8,9
halfway 589:21
Halowski
 570:16,19,26
 579:22,24 597:26
 613:17,19 624:10
 632:10 633:23
 646:5 647:26
 649:14 672:17
 674:11,20 686:25
 708:21 709:19
 710:10 724:3,4,7,

10	head 609:21 658:15	healthy 685:9 721:9	highest 605:26	652:5 680:9 688:6
Halowski's	heading 658:8,17 659:2,9,14 660:5, 6,19 661:11	hear 559:17,18 561:25 579:18 608:17 609:1 612:10 614:10 623:1 632:2,3 640:7 717:18 730:25 731:1,14, 15 734:10	History 639:24	Hu's 679:25
619:22 626:2 633:23 653:11	headset 612:4	heard 561:23 567:25 594:6,9 623:2,21 640:13, 15 646:4 715:5 723:3 739:24	hits 650:13	huge 602:24
hand 587:6,7,11 619:19 639:3 658:17,24 703:9	headsets 734:10	hearing 558:7 594:7 617:16 619:6,8,9 625:9 631:7 632:16 634:8 640:9,14, 19 651:7 653:8 654:25 662:14 680:7 688:6 696:14 700:7 716:22 717:11 719:3,12 722:24 723:16 726:22 735:2 736:16 737:11 743:6 745:16,17	Ho 672:20,24 673:8	human 574:3 580:15 693:2 710:25,26 711:1 733:8,13
hand-rub 658:22	headway 609:23	hearing's 634:24	Ho's 672:16	hygiene 658:17, 24
hands 587:15 658:20 727:26 742:25	heal 562:4,10,14 563:1	Hearings 558:13 631:13	hoc 576:22	hypothetical 623:7 684:26 713:15
hands-on 591:6 709:2	healing 562:5 563:19	Hebrews 573:11	hold 623:11 670:20 671:7 705:16	<hr/>
hanging 629:19	health 563:19 564:6,11 566:9 570:5 571:22,24, 26 574:13 576:1 577:23,24 591:10 592:19,21 593:7 595:4,14,16,19 596:2,8,11,24 597:1,3,4 599:25 600:1,11,23 601:13,17,20,25 602:5,8,20 603:20,22 606:3, 4,21,23 613:3 614:11 616:3 621:17 626:15 635:20,22 636:2, 16,19 638:9 639:8,21 655:18 657:14,17,19 658:12 660:9 663:18 667:2,4 672:9 674:15 679:11,15,16 683:6 690:10 693:19 694:1,16 695:1 699:26 707:18 708:3 711:10 712:4,17 713:24 716:14 719:21 720:20 726:24 727:1 739:14	held 564:26 572:12 574:4	holding 723:14	<hr/>
happened 566:16 578:15 602:1 606:4 615:24 618:7 731:2,16 736:11	heal 562:4,10,14 563:1	held 564:26 572:12 574:4	Holy 572:16	I
happening	healing 562:5 563:19	helpful 628:19	homemade 567:23	<hr/>
683:12	health 563:19 564:6,11 566:9 570:5 571:22,24, 26 574:13 576:1 577:23,24 591:10 592:19,21 593:7 595:4,14,16,19 596:2,8,11,24 597:1,3,4 599:25 600:1,11,23 601:13,17,20,25 602:5,8,20 603:20,22 606:3, 4,21,23 613:3 614:11 616:3 621:17 626:15 635:20,22 636:2, 16,19 638:9 639:8,21 655:18 657:14,17,19 658:12 660:9 663:18 667:2,4 672:9 674:15 679:11,15,16 683:6 690:10 693:19 694:1,16 695:1 699:26 707:18 708:3 711:10 712:4,17 713:24 716:14 719:21 720:20 726:24 727:1 739:14	helping 564:6	homier 597:9	ICU 623:3
happily 637:12	heal 562:4,10,14 563:1	helps 562:10 694:13	honest 610:7	idea 589:19 590:2 609:14 624:26 628:10 635:11 712:15 737:15 745:13
happy 642:5	healing 562:5 563:19	high 576:12 623:3 684:1,6	honestly 673:2 740:14,15 742:12	identifiable 639:15
hard 565:17 694:21 737:9 742:6 743:7	health 563:19 564:6,11 566:9 570:5 571:22,24, 26 574:13 576:1 577:23,24 591:10 592:19,21 593:7 595:4,14,16,19 596:2,8,11,24 597:1,3,4 599:25 600:1,11,23 601:13,17,20,25 602:5,8,20 603:20,22 606:3, 4,21,23 613:3 614:11 616:3 621:17 626:15 635:20,22 636:2, 16,19 638:9 639:8,21 655:18 657:14,17,19 658:12 660:9 663:18 667:2,4 672:9 674:15 679:11,15,16 683:6 690:10 693:19 694:1,16 695:1 699:26 707:18 708:3 711:10 712:4,17 713:24 716:14 719:21 720:20 726:24 727:1 739:14	higher 594:16 733:6	hop 633:4	identifying 695:24
harm 575:3,12, 15,22 578:3 591:25 592:12 593:26 594:5 595:8 615:15,17 616:25 620:7 622:10,13,14,19 644:20 712:21 713:1,4 714:10, 11,13,14,23 740:10	heal 562:4,10,14 563:1		hope 609:16	ignorance 587:10
harmful 599:24 620:10 678:9 720:21 727:26	healing 562:5 563:19		hopeful 628:16	ignore 718:16
harms 575:16,19, 20 603:21	health 563:19 564:6,11 566:9 570:5 571:22,24, 26 574:13 576:1 577:23,24 591:10 592:19,21 593:7 595:4,14,16,19 596:2,8,11,24 597:1,3,4 599:25 600:1,11,23 601:13,17,20,25 602:5,8,20 603:20,22 606:3, 4,21,23 613:3 614:11 616:3 621:17 626:15 635:20,22 636:2, 16,19 638:9 639:8,21 655:18 657:14,17,19 658:12 660:9 663:18 667:2,4 672:9 674:15 679:11,15,16 683:6 690:10 693:19 694:1,16 695:1 699:26 707:18 708:3 711:10 712:4,17 713:24 716:14 719:21 720:20 726:24 727:1 739:14		hospital 563:12, 13,18 597:5,11	illness 576:25 597:24 598:14
hate 589:8 595:21	heal 562:4,10,14 563:1		hospitalizations 623:4	illnesses 597:21 598:2,3,4,5 705:25
he'll 711:11 712:19	healing 562:5 563:19		hour 589:22,26 624:3 628:5 629:15 674:26 708:9	image 572:18,19, 23
	health 563:19 564:6,11 566:9 570:5 571:22,24, 26 574:13 576:1 577:23,24 591:10 592:19,21 593:7 595:4,14,16,19 596:2,8,11,24 597:1,3,4 599:25 600:1,11,23 601:13,17,20,25 602:5,8,20 603:20,22 606:3, 4,21,23 613:3 614:11 616:3 621:17 626:15 635:20,22 636:2, 16,19 638:9 639:8,21 655:18 657:14,17,19 658:12 660:9 663:18 667:2,4 672:9 674:15 679:11,15,16 683:6 690:10 693:19 694:1,16 695:1 699:26 707:18 708:3 711:10 712:4,17 713:24 716:14 719:21 720:20 726:24 727:1 739:14		hour-and-a- quarter 589:19	images 627:15
	heal 562:4,10,14 563:1		hours 628:12 711:23	imagination 740:15
	healing 562:5 563:19		housekeeping 559:4 662:3	imagine 734:17 741:9
	health 563:19 564:6,11 566:9 570:5 571:22,24, 26 574:13 576:1 577:23,24 591:10 592:19,21 593:7 595:4,14,16,19 596:2,8,11,24 597:1,3,4 599:25 600:1,11,23 601:13,17,20,25 602:5,8,20 603:20,22 606:3, 4,21,23 613:3 614:11 616:3 621:17 626:15 635:20,22 636:2, 16,19 638:9 639:8,21 655:18 657:14,17,19 658:12 660:9 663:18 667:2,4 672:9 674:15 679:11,15,16 683:6 690:10 693:19 694:1,16 695:1 699:26 707:18 708:3 711:10 712:4,17 713:24 716:14 719:21 720:20 726:24 727:1 739:14		hovering 625:13	immediately 660:9 698:22
	heal 562:4,10,14 563:1		HPA 617:24 637:1 638:17 648:8 652:17 683:14 697:7,9, 21	
	healing 562:5 563:19		Hu 600:1,11,16 650:22 651:1	

immense 741:10	inaccurate 600:25 692:3	individual 625:17 685:9	initiate 580:26 581:10 583:20	interaction 618:2
imminent 575:11 594:5 615:14,16 622:12,13,19 694:1 695:1	include 570:1 599:10 612:17 639:21 665:20 681:13	individuals 599:25 681:4 684:6	innate 562:4,13, 21	interactions 677:10
impact 587:19 620:8 693:19 694:16	included 636:5 693:6 710:7	indoor 725:15, 16,17	input 709:8,12	interest 740:5
impacted 591:3, 5,8 678:10	includes 666:1 672:16 725:17	indulgence 628:4 719:17 732:12,22 733:20 735:2	inquired 622:6	interested 563:19 641:1
impacts 576:25 678:23	including 599:1 667:22	ineffectiveness 594:8	inquiries 698:17	interesting 561:24 619:19 659:11
imperceptible 622:12	income 591:3	infected 581:5	inside 738:21	interests 607:8 722:11 740:10,18
implement 567:7 663:6	incomplete 694:22	infection 615:11 646:1	install 684:21 690:7	interfere 562:24 610:22
implementing 678:22	inconsistency 665:22 666:7	infectious 597:21,24 598:1, 3,4,5,14 615:15 635:25	installation 659:25	interference 564:11 587:26
implications 587:24	inconvenience 742:9	inform 621:15 666:5 669:6	installed 690:4, 20	interferences 562:7,10,26
implicitly 683:4	increase 572:3 594:2 605:7 611:12	information 570:6,7 577:10, 13 599:4,5,18,22, 26 600:24 601:6 613:4,5,11,12 614:11,15 624:22 639:22,23 672:26 678:5,17 703:16 704:2 707:18,20 713:9 744:15	installing 675:19	interferes 574:25 608:9
implied 576:3	increased 594:25 605:13 642:20 724:18 739:13	informed 575:4, 8,14,21,23 576:2, 3 592:5 599:6,14, 19,23 603:23 614:23 615:9 667:13,17 668:12,21,23	instance 594:12	interfering 612:7
imply 735:15	incumbent 716:14	informing 669:10	instantly 574:8	interim 687:11
important 575:4 591:23 592:20,23 597:17,20 598:17,18,20 603:9,11 620:6 624:8,15,18 629:22 711:18,20 717:3 723:6 726:18	independent 651:22 652:1 698:1 713:18 719:19	initial 563:4 637:5 680:6	instruct 592:3,11	interject 742:21
imposed 567:8	independently 640:2	initially 570:5 673:1 681:23	instructed 687:23	Internal 558:9 631:9
imposes 594:5 682:21	indicating 647:15 711:6		instructions 559:10 634:3 688:24	interpretation 678:12 683:7
impossible 573:12 740:4	indication 700:22		insured 699:19	interpreted 678:8
impropriety 605:18,20	INDISCERNIB LE 616:13,14 626:25 671:1 677:4 688:26 691:11,20 712:11 715:14 730:19,20 731:13 738:6		intake 572:4	interrupt 576:16 589:9,11 743:5
improve 587:19			integrity 603:9 636:6	interrupting 595:22
in-office 739:25			intelligence 562:13,21	interview 559:9 586:6,10,18 684:13 686:20, 22,24,25 687:6
inability 582:17 583:2 603:16 704:6			intend 587:18 632:8,12,20 633:21 648:8 649:25 650:10 652:17	interruption 595:22
			intended 658:3	intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18
			intending 716:16	intentional 651:9
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	interacted 608:6 641:12,24
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention 563:4 649:24 666:18,23 716:4 718:15 720:9,16 734:18	
			intentionally 574:8	
			intentioned 658:3	
			intending 716:16	
			intention	

619:3 683:13,15 684:11	items 704:3	658:7 679:14 697:23 710:23 718:23 733:18 738:14	20,23 692:2,6,11, 13 697:1 698:9 701:9,20 702:6 704:24 705:5,10, 16,19 706:4 707:2,5,9 708:25 711:13,19 712:2, 6,11,14,15 713:15,20 715:1, 4,7,14,16 716:17, 21,23,24 717:7 718:17 721:2,10 722:22 723:1,11, 20,21,25,26 724:1,2 725:23 726:1,5 727:6,14, 17,18 729:2,4,5,7 730:25 731:2,8, 18 732:9,17,19 733:21,22,23,24 734:4,7,14,17 736:21,24 737:17,26 738:1 741:22 742:2,12, 24 743:16 744:4, 8,13,22 745:7,11, 12	<hr/> L <hr/>
investigative 581:1	<hr/> J <hr/>	kinds 596:9 615:11 670:12 672:9 697:10	lack 646:17 688:16 719:5 728:24	
invite 629:17	J.S.M. 558:19 631:19	Kitchen 556:7, 15,17,20 558:19 559:15,16,18,23, 26 560:5,11,15, 18 576:15,18,21, 24 589:8,14,15, 20 590:6,9,10,14, 15 595:21 596:1 600:6,9,10,15 608:22,25 609:6 610:1,3 611:8,17 612:3,10,16,26 614:22 616:4 617:6,19 618:7, 12 619:17 620:4, 11 621:4 622:26 623:6,11,14,18 624:7 625:1 626:6,22,26 627:6 628:24 629:1,3,16,21 631:19,24,26 632:2,8,14,15,18 633:1,12,14,20, 26 634:3,6 635:17 636:10 640:12 642:2,6 645:2 648:13,22 649:8,17 650:1, 17 651:1,8 652:6, 10 655:2 656:22 664:14,17,22 665:6,9 670:20, 24 671:1,7,14 675:26 676:10,12 677:1 684:26 686:22 687:3,16, 18,20,23 688:12, 21 689:1,7,9,11, 15 691:5,7,11,15,	lag 560:16	
inviting 624:12 709:12	January 578:16 586:6,13 621:15 656:17 670:11,13 677:16,21 687:2 692:9 703:3 728:26 729:1	Jarvis 556:19 737:26 738:2,3,4 742:1 743:19	large 566:15 599:3 613:13 704:18	
invoked 738:20	Jarvis 556:19 737:26 738:2,3,4 742:1 743:19	jeopardy 589:25	late 610:19 730:16	
involved 597:10 660:14	Jesus 572:14,25	Jesus 572:14,25	latest 721:4	
involvement 672:12,13	journal 700:20	journal 700:20	launch 666:10 697:23	
Iowa 560:3 561:9,11,13 635:19	jump 578:4 618:12 640:12 708:15 745:7	jump 578:4 618:12 640:12 708:15 745:7	law 730:20 733:9	
irrelevant 649:21 725:25	June 569:3,6 614:6 641:4,17 642:16 643:13 644:1 654:11,18 656:11 670:16, 21,24,26 671:3, 10,17 677:26 698:2,5 700:5 702:14 706:19 710:18 716:1,15 727:4,23 729:17 735:8 736:12,14	June 569:3,6 614:6 641:4,17 642:16 643:13 644:1 654:11,18 656:11 670:16, 21,24,26 671:3, 10,17 677:26 698:2,5 700:5 702:14 706:19 710:18 716:1,15 727:4,23 729:17 735:8 736:12,14	lawful 605:14 730:13	
issue 560:19 565:14 571:17 573:4 574:10 575:9 586:19 616:4 621:7 624:17 627:2 633:1 649:15 650:20 653:3 664:25 698:17 702:10,20 704:4 705:7 711:20 717:8,10,11,25 718:21,26 719:7 720:20	<hr/> K <hr/>	<hr/> K <hr/>	Lawrence 559:10 570:16 580:3 581:2,6,12, 18,24 582:4,9,12, 23 583:15,18 584:16 586:4,8, 17 617:7,12 618:3,8,9 674:12 675:8 677:14 683:13,23 684:12 686:21,26 703:14,18 729:10 742:16	
issued 701:24	Karoline 559:1 634:25 746:3,14	Karoline 559:1 634:25 746:3,14	Lawrence's 580:20 583:10 584:21 617:11 618:2 675:5 677:11 687:14,21	
issues 572:7 580:23 586:9 592:4 601:4 614:16,19 619:9 650:12 651:6 672:10 682:8 702:5,18 704:23 708:4 709:22 710:8,26 740:9	key 684:13 718:26	key 684:13 718:26	lay 563:7 714:24 745:4	
item 627:16 657:10,11 663:4 668:21 690:19,21 691:13 692:20	killed 600:2,12	killed 600:2,12	leading 576:17, 22 589:10 595:22,23	
	kind 574:6 577:14 616:26 617:10 625:13 627:2,14 657:9	kind 574:6 577:14 616:26 617:10 625:13 627:2,14 657:9	learned 726:21	
			learning 712:25	
			leave 604:12 665:10 680:24	

728:12 741:23,25
743:1
leaving 569:16
Lees 558:8 631:8
left 580:13 586:22
593:7 671:24
721:12
legal 558:9,16,19
604:3 631:9,16,
19 651:22 652:1
719:19
legally 733:26
legible 639:9
legislation
601:15 606:2
legitimate
681:18 683:5
685:18 695:9
length 702:19
Leslie 722:7
letter 621:3
674:11 675:6
677:11,13
687:14,18,20,22,
23 689:7,23
690:16,23 691:2,
4,7,16,24,25,26
692:8,16,20,22
693:6,14 696:7
700:17,19,26
701:4,23 702:11,
17 703:3,13,17,
21 704:9,18
705:3 706:11,18
710:10 729:1,7,8,
9,10
letters 687:15
701:25
letting 741:13
level 584:4
622:20 623:23
657:22
levels 594:2
liberal 576:16

liberty 577:10
728:3,9
licence 580:6
581:11,15 582:13
602:10 603:13,26
618:23
licensed 636:8
life 573:8,25
574:19 581:25
582:2 618:10
724:19
lifestyle 563:20
564:9 592:4
limitation 569:4
582:21 586:20
limitations
586:25 603:21
681:5,14,19
683:6
limited 650:8,22
652:4 704:16
lines 618:11
620:14 622:21
639:19 694:18
715:12
Linford 583:10
584:25 585:3
619:1 687:14
693:14 694:23
696:9 697:3,6,9
728:20
Linford's 584:26
585:10 693:11
728:19
lips 608:14
list 744:23,25
listed 661:20
670:7
listen 574:17
listened 686:23
literally 704:22
literature
580:17,21 617:9

live 573:7
living 573:21,22
738:5
load 566:17
loaded 587:20
589:12
location 725:17
lock 568:19
locums 564:19
logic 712:25
lone 601:3
long 560:25 563:4
610:20 628:12
638:23 655:20
690:6 721:18
722:15 738:11
742:6,17
longer 560:9
589:16 676:16
721:2,7 745:5
looked 563:17,20
661:22 670:16
lot 567:25 598:15
599:5 628:23
632:12,21 650:14
684:15 711:22
718:23,24 723:3
724:16 730:14
740:8 744:14,15
love 563:21
564:7,8
loyalty 604:15,16
lunch 589:22,25
608:26 609:3,17,
22 624:3 628:5
629:24 665:13

M

M-HM 582:26
653:24
M.D. 690:24
692:23

Madam 730:25
737:24
made 562:14
569:3 579:25
580:20 583:10
584:21,23,24
586:13 616:15
622:22 624:20
625:5,12,14,23
639:16 651:9,19
652:23 684:2
689:7 698:1,18
699:5 700:5
701:18,22 718:3
magazines
659:11
maintain 584:6
660:15 682:17
690:5 725:11
maintained
659:23 661:1
majority 625:6
make 559:24
576:13 581:8
584:25 589:21
592:18 599:6,14,
19,23 600:20
602:18 606:6
607:11 609:22
612:6 617:1
620:13 635:9
640:26 641:26
652:21 697:10
712:23 713:2,7
714:1,16 719:8
722:2,13,17,21
724:17 734:7,11
makes 584:4
676:19 713:18,25
714:15 715:12
740:21
making 581:6,7
597:16 600:19
609:12 617:14
713:24 719:6
721:22

male 572:19
malpractice
699:20
man 573:5
management
635:23,26
mandate 581:18,
20,21 605:26
636:20 729:21,
22,25 731:25
738:20
mandated
567:21 575:1
608:8
mandates 604:8
657:16 729:22
733:26
mandating 575:9
606:13 615:14
mandatory
568:5 574:20,25
575:7,20 593:2,5
604:6 614:25
637:10,17,22
638:5 639:10,17,
25 655:23 682:21
mangle 712:13
manifestation
572:23
manipulation
588:7,18
mankind 572:18
manner 562:11
manual 587:5
588:18 590:24
March 565:26
595:7 613:16,20
632:10,11
633:22,24
647:23,26 650:13
653:9
marginal 678:24
mark 632:25

marked 632:22
Martens 558:11
 631:11
mask 567:18,22,
 23,24 568:3,5,7,
 9,13,17,21,24,26
 569:6,9,16,23
 570:3,12,18
 572:2,10,13,26
 573:2,21,23
 575:9,10,12,16
 576:24 577:2,6,
 12 578:3,26
 579:3,6,16,25
 580:18 581:7,8,9,
 13,14 582:5,17
 583:2,26 584:1
 585:4,9,22 586:1,
 7 592:14,25
 593:10,16,25
 594:1,18 595:11,
 12 603:14,15,21
 605:2 607:14,15,
 22,24,26 608:4,5,
 13 615:8,14
 618:15 620:12,
 22,26 621:3
 622:9 627:18
 641:7,12 642:17
 643:16 645:13
 653:22,23 654:7,
 12 662:20 666:26
 668:15,17 669:23
 670:8 671:26
 672:3 673:7
 674:17 678:8,20
 679:10 681:20
 682:4,12,15,21
 685:10,16 686:17
 695:10,22 698:6,
 21 699:23 704:6,
 7 705:14,24
 707:16 714:13,23
 724:20 725:14
 726:8,16 728:21
 729:11,23 732:3,
 6 735:26 736:2,3,

5 738:18,20,23,
 25 739:2,6,8,11,
 15,18 741:13,18
masked 641:23
 642:18 659:24
 660:23,25 671:6,
 18 674:7,9
 684:20 686:9
masking 574:20,
 25 575:7,21
 581:18 586:8,15
 592:9 593:2,5
 598:21 599:10,
 11,15,24 601:18
 604:6 611:24
 612:18 614:24,25
 615:21,25 617:2,
 10 619:11 620:8,
 9 624:9,16 626:4
 644:3,10,13,18,
 19,20,25,26
 645:8 648:25
 654:19,26 656:7,
 18 661:8 662:5
 663:7 664:20
 665:1,20 666:1
 667:4 668:1,2,4,
 11,26 670:18
 671:18,22,25
 673:13,20
 675:13,16 676:2
 677:25 679:26
 680:5,12,20,22
 683:21 686:12
 689:8 698:2,16,
 18,26 699:3,4,7,
 11,14 700:12
 704:17,19 705:4
 706:2 707:13
 709:21 714:20
 715:6,19 720:17,
 19 724:16 726:24
 727:4,20,23
 731:25
masks 567:20
 571:12,18
 593:18,21 594:8

606:13 608:8
 641:20 642:21,23
 643:3,8,20,24
 660:12,21 661:7
 678:18 680:17
 681:4 683:4
 712:26
materials 567:24
matter 559:4
 689:24 707:18
 724:11
mattered 583:22,
 24
matters 687:12
 689:8 736:17
Maxston 556:8,
 13,16 558:16
 559:3 576:15,19
 589:8 595:21
 609:1,7,8 610:6,
 9,13,14,24,25
 611:6,7 612:3,9,
 14,15 616:8,11,
 15 618:12,14
 621:4,9,11,25
 622:2,25 623:1,9,
 10,14,19 624:1,5,
 6 626:22,25
 627:5,7 628:3,11,
 18,22 629:6,16
 631:16 632:4,6,
 20 633:11,16,18
 635:4,6,14,15
 639:2,5 642:2,5,
 7,8 645:7,25
 646:4 648:13,18
 649:2,16,23
 650:6,26 651:14
 652:9,11,13
 655:1,3 664:16,
 18,19,24 665:8,
 11 670:22,26
 671:3,12,15,21
 674:22 675:3,4
 676:4,5,14,25
 677:3,8,9 685:2
 688:13,14,21,26

689:5,10,13,19,
 22 691:5,13,17,
 21,23 692:5,8,12,
 14 694:11,13
 697:4,5 698:9,12,
 15 701:12,14,22
 702:8 703:7,12
 705:1,2,8,13,18,
 21,26 706:8,11
 707:5,12 708:14,
 17 711:15,24,25
 712:1,3,10,12
 713:3,17,22
 715:13,15,17
 716:19,23,25
 717:15,17,24
 718:6,11 720:1,
 23,26 722:21
 723:10 725:2,23
 727:6,15,19
 728:18,23 729:4,
 8 730:4 732:11,
 21,23,24 733:20
 734:14,19 737:5,
 8 741:23 742:2,
 15 743:4,11,15
 744:20
Maxston's
 629:26 736:26
 744:14
meaning 675:9
 683:24
means 572:14
 575:17 587:6,7,
 11,15 688:24
 689:15 694:25
 718:3 719:22
 732:2
meant 642:25
 655:23
measurable
 688:17
measure 573:8
 599:10,11 645:10
 678:21 743:15

measures 599:7
 601:2 615:16
 647:16 673:25
 733:14
medical 569:23
 571:11 575:10
 579:3,7,15
 582:23 583:1,17,
 22,25 584:9
 585:1 601:14
 606:21 613:12
 615:8 619:12
 644:22 652:5
 679:11 684:7
 690:24 691:3
 692:23 693:7
 699:26 702:5
 704:4,9 706:22
 707:15 708:4
 726:23 727:1
 739:8
meet 578:22
 696:5
meeting 633:7
 676:23
member 558:10,
 11,12 631:10,11,
 12 657:5 678:9
 685:18,24 712:22
 713:2
member's
 678:10
members 580:12
 585:16 593:14
 606:1,7 615:4,12
 620:17 625:7,10,
 23 632:17 634:7,
 23 638:3,24
 641:13,18,24
 645:21 662:14
 682:13,21 685:14
 690:1 709:12
 713:26 722:6
 734:22 735:2
 742:22

memory 583:8
613:23 647:25
mental 568:8,10
569:4 575:11
577:16 580:12
582:21 584:8
586:19,22,25
593:8,12 615:15
681:5,13,18,22
683:5 691:1
692:26 693:5
mentally 740:22
mention 561:23
576:20 580:15
687:7,9 704:8
706:12,15 726:4
mentioned
570:19 579:11
598:15 613:3
616:23 617:7
633:19 649:24
700:13 708:21
mere 564:4
met 637:12
method 738:12
methods 602:2
metres 568:18
569:2 588:19
627:19 641:8,21
659:19,22 660:26
662:21 673:14
728:3,7,9,10,15
740:3,25
mic 590:12
microbiology
635:25
middle 657:11
658:7 725:4
military 601:26
mind 591:23
594:8,10 600:7
609:16 611:9
642:2 662:1
704:25 715:7

mindful 621:25
mindset 601:14
mine 563:13,14
633:11 689:17
minimum 660:21
ministry 563:7
minute 610:18
647:6
minutes 590:5
603:2 609:10
610:4,6 620:18
622:1 624:2
632:15 634:13
635:7 674:23
675:1 676:16,21
708:9 719:14
721:20 722:16
737:5 742:1,14
743:3
mirror 627:15
mirrors 654:6
misalignments
562:8,24
misconduct
719:4
misleading
626:23 671:8
missed 600:7
677:13
**misunderstandi
ng** 608:20
model 601:14
moment 586:22
638:21 653:21
655:11 691:22
month 653:1
**month-and-a-
half** 710:16
months 570:20
578:4 593:22
622:5 710:16
moral 604:18
morally 604:22

morning 556:5
558:5,24,25
motivation
700:26
motivator 602:6,
24
mouth 616:9
620:23 666:26
670:15
move 672:12
689:20 706:8
moved 651:23
719:14 721:15
movements
728:14
moving 628:20
629:11 707:8
muffled 608:16
multiple 565:18
588:3 680:21
713:8
multitude 712:24
musculoskeletal
591:9,17
musts 646:17
647:1
muting 560:14

N

narrow 651:12
natural 563:1,19
nature 619:20
667:20,23 704:3
naturopaths
596:7
necessarily
611:15 645:3
needed 561:3
566:24 583:20
679:9 707:20
722:5 733:18
negative 670:6
678:23

negatively
678:10
Nelson 558:13
631:13 632:8,16,
24 633:4,20
634:9,17,22
744:25 745:9
nervous 562:4,7,
25 564:10 587:26
736:5
nodding 609:21
610:2 723:1
**non-
chiropractor**
587:10
Non-clinical
659:18
nonclinical
660:25
noncompliance
682:16
nonetheless
707:25 715:22
norm 598:8
normal 657:5
nose 620:23
note 569:22
570:15 579:2,8
582:16,18 583:1,
9,17 584:12,13
585:1 608:25
613:1,22 619:12,
14 627:3 691:3
700:3 704:4
706:22 728:24,26
734:7,11 737:19
note-taking
584:6
noted 611:1
668:23
notes 609:12
746:6
notice 560:5
578:24 579:5
610:19 621:15

627:8 640:8
666:20 716:22
717:11 719:2
726:23 730:2
notices 708:18
notify 716:3
717:20 718:8,12,
15 720:5,9,15
nots 730:14
notwithstanding
663:18 688:6,10
November
654:16 681:8
706:26 727:21
nuisance 627:22
725:4,9,11
number 572:21
579:13 596:15
603:15,17 614:22
620:20 621:12,21
625:1 639:6
641:16 642:15
643:12,26 645:1,
24 646:14
657:10,25
665:14,20,25
666:4,24 667:21
669:3 690:19,21
708:9 714:2
numbered
657:11 681:12
numbers 623:3
numerous
624:11 705:23
709:11

O

oath 591:25
636:5
object 616:8
621:5 622:26
623:6 645:3
649:17,19
650:17,18 651:11

692:2 706:10
 707:6 712:6,9
 725:2,24 734:9
objected 590:19
 671:16 717:13
 718:24
objecting 707:10
 717:1,14
objection 634:4
 709:6 712:14
objections 572:9
 593:20 652:9
 734:12
objective 629:23
 676:23
obligation
 602:26 636:5
 716:2 717:20
 718:7,12,14,19
 719:20 720:5,8,
 15
obligations
 646:15 717:5
 719:23
observe 641:7,21
obtain 569:22
 575:23 582:16,
 18,22 613:1
 669:14 679:9
obtained 733:15
obvious 679:2,
 19,21 700:4
 702:3 737:9
occasionally
 585:17
occupation
 564:4,7,13
occur 638:19
 659:26
occurred 567:6
 687:1
occurring 605:10
 638:10 693:25
occurs 606:9

October 736:14
odd 577:9 718:23
offence 605:21
offer 702:21,23
offered 623:16
office 564:18
 578:2,5,16
 585:13,14,16,22,
 23 592:10,15
 593:25 594:11,
 13,23 596:23,24
 597:4,6,10,19
 690:5 724:22
 727:25 735:10,11
 741:17
officer 606:21
 621:16 697:19
 726:24 727:1
offices 608:9
Official 558:21
 631:21 746:15
one's 721:14
 742:3
ongoing 619:3
online 633:13
onward 671:4
 709:7
onwards 670:17
 671:17
opening 657:12,
 13
operate 740:14
operating 725:18
opinion 601:22
 623:12,25 626:10
 707:16
opportunity
 651:13 652:7
 668:8 734:9
 737:6 743:22
opposed 569:15
 651:12 658:21
opposing 672:4

opposition
 671:23
opting 655:3
option 570:18
 708:23
optional 567:26
 568:1 581:19,20,
 21
options 706:15
order 561:2
 578:8,9,10,13,20
 579:10,11,12,15
 586:23 607:16
 611:21 620:16,20
 621:2,3,6,17,18,
 21 626:19 627:1,
 26 628:1 637:22
 653:14,21 654:2,
 4,18,22 656:1,4,6
 663:21,24 664:1,
 4 665:7,12,14,19,
 20,25 666:4,10,
 17 669:2,3 670:2,
 11 681:6,20
 687:11 690:12
 692:6 706:23
 714:8 715:3
 725:1,13,20
 726:7,8 727:3,5,
 7,8,12,16,19,23
 744:23
ordered 565:25
 697:6 740:11
 741:1,6
orders 604:8
 607:18 611:21
 619:9 626:18,20
 644:3 653:14
 654:15 657:21
 662:12 664:12,
 20,26 665:18,23
 666:7,17 681:1,7
 696:21 706:26
 714:18 726:20,24
 727:1 729:19

organization
 738:7
organizations
 699:13
original 561:16
 584:13
originate 657:21
outset 575:25
 707:14,17,21
outward 588:5
outweighed
 678:23
oversight 633:9
owe 591:15
 604:15
oxygen 572:3
 594:2 622:11

P

pace 721:14,15
packet 563:16,
 17,21
pages 659:1
 681:11 746:4
painkillers 567:1
Palmer 560:2,19
 561:9,10,12,14,
 15,17,21,22
 562:18 563:14
 565:1,2 635:18,
 20 636:4
pandemic
 567:15,16,17,25,
 26 568:5,11
 570:1 604:9
 612:16 613:2
 615:6,21 624:25
 625:16,18,26
 640:3 644:7
 647:18 648:25
 653:2,20 655:9,
 24 656:5,14,23
 657:9 658:7,15,
 24 660:2 661:3,

11 662:4 665:9,
 19 666:1 675:15
 676:8 678:6
 680:1 682:1,6,11
 683:3 698:8,19,
 21 700:11
 709:13,22,25
 711:5 714:6
 715:10,20,23
 716:2,4,6 717:21
 718:13,19 720:6,
 10,17
paper 670:5
paragraph
 639:20 646:12
 648:4 649:3
 652:14 658:18
 662:19 667:16
 668:5 673:5,17,
 23 674:14 675:8
 677:24 678:3,15
 679:7,23 680:26
 681:24 682:19,26
 683:17 687:26
 693:18,23 694:7,
 12 695:17 703:13
 705:21 725:4
paragraphs
 662:16 664:9
 694:22 704:11
paramedics
 596:6
parameters
 638:12,18 649:26
 651:4
paramount
 592:6
pardon 611:11
 628:13 657:8
 720:12
part 584:26 586:4
 597:20 607:10
 616:18 625:22
 632:26 636:5
 657:5 659:6
 660:1 662:3

667:17 668:20 669:12 680:26 682:7 683:14 690:9 700:25 717:4 718:9 735:25 740:19 Partially 644:10 participate 709:24 participated 686:22 710:3,5, 11,15 participation 638:5 710:20 744:18 particles 571:20 partly 720:16 parts 711:7 716:4 718:16 735:25 passages 573:10 past 721:20 pastor 563:5 path 563:5 pathologists 596:6 patient 564:22 566:18 575:25,26 588:25 594:24 596:10 608:20 615:1,3 616:24 629:4,5 639:8,21 658:8,13 660:10, 14,24 666:5 667:19 668:17, 22,26 669:6,10 670:2,9,17,18 671:5,24 672:5,7 673:14 678:11 686:16 735:15, 16,17,18,26 736:1,3 738:8 patient's 669:14, 17 patients 564:18 565:15,19,21	566:22 568:4,9 569:1 575:17,18, 24 577:2,3,4,5,8, 11,19,21 578:26 579:9 584:5,7 587:1,2,9 588:14, 17,19,24 589:1,4 590:17,21,24 591:7,10,16,21, 22 592:3,7,9,11, 13,14,23 593:3, 16,24 594:15,21, 22,26 595:5,8 597:16,23 604:12,16,19,22, 25 605:2,14,18 606:14 607:3,8, 20,25 608:2 615:22,25 616:2, 16,17,23,25 617:3 619:18,24 620:7,12,21 622:9 627:20 641:11,13,23,24 642:17,18,19 643:3,8,15,24 653:22,23 658:10 660:16 662:22 663:7 666:25 667:1 668:1,7,11 671:22 672:9 686:9,12,14 688:1 695:12,23 714:12,20 722:8 728:6,7 730:5 732:6 735:9,10 743:9 pause 560:12 Pavlic 558:9 631:9 633:5,13, 18 payment 659:21 penalizing 571:7 pending 696:13 people 564:6,8,9 566:4,23,26	572:6 577:26 581:5 593:8 596:16,18 597:12,13,19 598:1,3,4,10 600:2,12 601:5,8 602:16 607:10 608:4,5 622:15, 17 623:22 684:9 686:10 703:9 722:9 728:2,16 735:20 740:8 people's 728:14 percent 577:7,11 581:4 600:17 615:26 616:6,12 622:16 percentage 581:3 perceptible 572:4 perception 718:2 perceptive 594:3 perform 702:18 performed 575:8 period 710:19 736:10 permit 578:16,25 579:6,9 584:22 592:14 614:14 620:11 637:15 682:22 695:20 696:10,12 697:15 722:1 724:25 permitted 567:3, 4 585:3,5,7 683:4 permitting 604:12 person 571:22 577:9 578:26 587:22 591:11 592:21 594:3 602:18 608:17 640:7 725:10,14 733:14 735:19	736:5,8 740:10 person's 587:21 729:23 personable 597:7 personal 572:9 592:21,22,26 603:22 614:15 639:23 647:14 657:18 660:6 661:21 701:10,20 702:6 715:6,8 728:3,9 personally 644:25 713:3,7 722:3 perspective 588:6 602:4 651:1 pertained 686:17 pertaining 719:21 pertinent 703:26 philosophical 562:12 philosophy 561:19,20,23,26 562:2 587:25 phone 588:12 617:6 633:7 673:6 686:21 701:16,17 739:22 740:12,14,25 741:2,7 phrase 615:2 646:17 phrased 625:11, 12 phys 563:9 physical 562:23 568:17 572:5,7 575:12 582:21 586:24 588:7 591:12 593:8,12 594:3,5 599:20	603:19,20 615:15 622:13,14 639:24 659:14 660:15,26 663:11 673:26 674:2 685:19 728:14 physically 587:22 594:4 739:23 740:4,22 pick 701:16 725:3 picture 576:1 pieces 563:23 642:4 670:5 place 563:3 566:8 580:10 588:22 601:2 617:8 646:6 669:24 698:19 725:15,16 727:3 places 572:24 placing 621:18 plan 611:23 674:22 702:23 planned 609:18 plans 676:23 722:14 plastic 647:8 platform 709:25, 26 710:20 play 586:21 played 563:9 playing 563:11 pleasing 606:21 626:8 plexiglass 641:10 644:14 645:14 660:3 662:9 664:21 665:5,7 673:19 675:18, 19,21 676:8 690:4,7,10,21 plexiglass/plastic 659:25
--	---	--	---	---

plow 722:18	practic 587:12	precise 625:19 685:21	previous 668:24	737:18
PM 630:3 631:23	practice 561:12 564:20,23 566:2, 17 567:8,15 579:6 581:10 582:8 584:22 587:6,13 612:22 614:14,16,19,20 615:5 616:19 618:17,18,20 619:5,19,23 620:5 621:19 625:16 637:15,25 638:1,5,7,8,14, 16,18,21,22,25,26 644:7 645:17,18, 26 646:25 647:5 648:10 652:19,25 653:2 665:21 667:10 669:25 672:8 676:26 678:7 682:6,16 685:15 686:2 695:20 696:4,10, 11,12,13 697:15 709:2 716:10,11, 12 724:24 740:6, 12,20	preclude 572:12 585:26	previously 556:12 614:9 635:13 654:24	proceeding 692:14 737:5 743:1
point 563:10 616:12 633:15 651:19 653:7,11 655:12 665:6 666:24 667:1,3,6 671:16 674:2 683:12 705:16 718:24 723:10 726:18 728:13 730:3,4,7 734:20 736:22	practiced 564:24	prefer 565:10 738:1 739:25 742:8,9,25 743:17	primarily 588:4 604:19 714:12	proceedings 558:1,23 630:3 631:1,23 649:22 745:20 746:5
points 560:26 614:23 666:19,22 684:13	practices 646:22	prep 609:25	primary 586:19 587:8 588:8 591:6,20 592:4 704:5	process 563:6 577:25 581:1 583:20 667:17 668:13 690:9
policy 612:23 682:20	practicing 564:14,16,25 565:26 567:4,9 579:26 585:4,9 591:2 618:26 619:10 636:11 637:22 709:4 740:11 741:1,6,9	prepared 666:13, 14 721:1	principle 575:4 591:24 592:1,5 714:11	processes 563:20
portion 608:13	practitioner 627:18 660:7 662:20 663:6 679:11,16	preparedness 601:26 623:24	principles 562:16,19,20 565:1,4 575:3,5 576:9 591:23 592:8 620:4	produce 701:3
posed 719:20	practices 646:22	prescreen 598:10	prior 560:10 568:20,23 662:17 669:5,9,12 675:19	produced 560:6
poses 615:14 617:2	practicing 564:14,16,25 565:26 567:4,9 579:26 585:4,9 591:2 618:26 619:10 636:11 637:22 709:4 740:11 741:1,6,9	prescreened 596:17	priority 600:20 604:17 723:9	productive 569:5
position 573:1,22 577:16 593:3,4,6 614:10 615:7 644:21 648:6 651:11 652:15 654:1 668:25 684:25 685:17 688:4,7,11,20,22, 24 700:9 711:9 712:3,17 724:17 742:4	practicing 564:14,16,25 565:26 567:4,9 579:26 585:4,9 591:2 618:26 619:10 636:11 637:22 709:4 740:11 741:1,6,9	prescreening 594:20 598:15, 16,21 624:8,15 670:6	private 570:6 581:24,25 582:2 590:25 613:4 614:11,15 618:10 668:7 701:10,20 702:7 707:18	products 659:4
positive 661:22	practitioner 627:18 660:7 662:20 663:6 679:11,16	present 668:22 686:22 687:3	prior 560:10 568:20,23 662:17 669:5,9,12 675:19	profession 564:26 575:6 605:5,11 625:24 636:6,11,15 637:3,8 648:10 652:19 708:19 712:5 713:13
possibility 585:8 619:4 742:22	practicing 564:14,16,25 565:26 567:4,9 579:26 585:4,9 591:2 618:26 619:10 636:11 637:22 709:4 740:11 741:1,6,9	presents 704:13	prior 560:10 568:20,23 662:17 669:5,9,12 675:19	professional 602:25 636:25 655:21 657:18,19 711:10 712:4,18 714:9 716:3,14 717:5,20 718:3, 12,15 719:3,21, 23 720:5,9,15 730:9,12 733:9, 12
potential 575:19 592:11 596:21 608:19 667:22 678:24	practitioner 627:18 660:7 662:20 663:6 679:11,16	preserve 629:22 636:5	priority 600:20 604:17 723:9	professionally 700:9 730:17,19 731:11,13,22 733:2
potentially 609:9 708:5,7 710:10	practicing 564:14,16,25 565:26 567:4,9 579:26 585:4,9 591:2 618:26 619:10 636:11 637:22 709:4 740:11 741:1,6,9	press 609:10 708:11,13 721:15 723:7	private 570:6 581:24,25 582:2 590:25 613:4 614:11,15 618:10 668:7 701:10,20 702:7 707:18	professionals 611:14 657:14 700:1
PPE 641:6,19 660:7,19	practitioner 627:18 660:7 662:20 663:6 679:11,16	pressing 703:8	privilege 564:6 636:12	professions 601:13 606:4 611:13,22 636:16,19 638:9
	precautionary 678:21	presupposes 595:25	privy 570:7	
	precipitated 704:7 710:10	pretty 589:21 701:10 721:22 723:6 732:26 742:20	problem 569:11 730:15	
		prevent 722:4 741:9	problems 570:3 612:18 712:7	
		preventative 645:9	procedural 650:23 737:19	
		preventing 571:12 599:8,12 688:18 728:2	procedure 575:10,11 591:6 615:8 660:21 739:25	
		Prevention 646:2	proceed 573:19 576:14 669:15	

prognosis 702:21
706:13

program 637:19
638:17

progress 721:22

promote 673:26

pronouncements
622:5

proper 584:6
615:2 616:5
659:4

properly 589:1
590:16 603:16
643:14 651:4

propose 609:8

proposed 668:16

prospective
563:16

protect 574:3
580:10,24 583:19
605:25 606:17
607:3,8 659:26

protected 693:1

protecting
580:12 605:8,26
606:6,7,15 617:9

protection 618:4
636:20

protective 647:7,
14 660:6 661:21

protocol 576:1

provide 569:22
579:2 584:7,19
587:1,2,4 588:8,
10,12,17 589:2,6
590:17 591:4,7,
16,20 601:9
619:18 620:25
671:21 678:11
739:20 740:1,24

provided 583:9
586:24 603:24
639:13 674:17
718:19 734:14

provider 616:3
679:15 716:15

providers 708:4
713:24

providing 588:14
590:22 627:19
660:10,24 662:21
666:5 669:7
740:21

Province 746:8

Provision 621:21

provisions 604:9
626:1

psychological
576:25

public 558:12
580:11,24,26
583:19 600:1,11
601:17,20 602:5,
8 605:9,25 606:3,
7,15,18 613:6,8,
9,13 617:9 618:4
625:7,9,22
631:12 635:19,22
636:2,20 641:13,
25 657:16 658:12
659:18 674:15
683:26 693:19
694:1,16 695:1,9,
21,25 696:3,5
725:15,16 728:21

pull 633:2

punishing 571:8

purchase 569:13

purchased
561:12 564:20,23
569:10

purpose 639:5
667:20

purposes 649:19
651:12

pursuant 697:9

pursue 563:26
708:25

put 563:12,24
568:7,8 569:11
573:2,23 584:1
593:5 594:15
601:2 603:5,14
612:5 632:24
634:11 648:9
649:10,26 651:4
652:18 670:15
676:11,13 691:8
735:26 736:1,3,5
742:3

puts 721:20
739:13

putting 575:12,
16 603:21 616:9
634:4 648:14,19
649:13,19 653:20

puzzle 563:23

Q

Q-AND-A
668:10

QC 558:16
631:16

qualify 707:26

qualms 739:12

quarter 737:4

question 560:13
574:16 587:20
589:13 590:18
591:18 595:10,
20,22 600:7
612:11,23 613:18
616:8,13,17,22
617:23 618:7,9,
11 620:11 621:5,
8 623:16,20
624:13,20 626:6,
17 627:1,10,12,
16 642:3 645:4,7
647:1,12 648:16
649:1,7 652:21
654:10,17 655:1
659:15,22 661:25

663:26 666:6
668:19 674:13
676:1 680:23
685:7,13 691:19
692:12 697:4,13,
17 698:13 699:14
700:4 702:3
705:9 706:6,7
707:6,8 709:9
711:17,25 712:13
714:5 715:11,15
716:20,25 717:3,
7,10,12,15,18
718:1,4,7,8,10
719:18,20,26
720:8 725:24
728:11,18,23
732:1,5,13,14,16,
25 735:13,25
741:4 744:21

question's
713:20

questioned
650:22

questioning
628:12 651:9
652:2 676:20
708:21 729:8

questions 556:18
576:17 580:8
586:26 589:9,10,
12 594:20 595:23
608:23 609:13,
15,18,24 610:26
611:4,5,8 614:14
617:5 618:2
620:4 625:1,11
628:4,15,21,23
634:1 635:16
645:22 647:24
648:4,19,21
649:11,18,20
650:5,9,14,18,19,
23 653:16 656:3
662:18 665:13
668:8 670:6,7
672:5,9,23

676:15 677:17
683:11 684:14,15
689:20 698:22
700:16 703:5
707:10 708:10
709:7 710:24
711:4 717:1,13
718:7 719:18
720:3,4,23 721:3
722:19,26 723:6,
13,17 734:15,23
735:3,5,6 736:16
737:12 741:23
742:5,18,23
743:6

quick 559:4
595:10 624:5
629:5,6 648:4
656:3 668:19
708:10 732:12
733:24 736:9
744:21

quickly 568:10
612:5 629:2
637:4 692:16
722:26 733:11
734:24

quiet 730:23

quote 616:5
673:7 679:24
690:7 704:1,2
705:20

R

racing 742:10

raise 585:8 672:7
686:14,16 703:8
735:5

raised 589:11
652:7

randomly 638:14

rare 598:8

rate 581:3,5
600:16 622:16
683:26 684:6

re-ask 698:12	666:24 667:16,21	710:1,3,6,7	732:2	638:11,16 647:8
re-cross 733:25	668:6,20 669:4,	receipt 703:15	reconvene 610:9	656:24 666:19
Re-cross-	13 673:5,10,17,	receive 566:24	628:7 629:25	668:13 675:13
examines 556:16	24 674:5,14	570:21 579:21	676:22 742:5	686:19,25 691:6
732:23	675:8 678:3,16,	580:2 595:10	744:7	714:20 727:7,10
Re-examines	25 679:7 680:15	607:15 613:17	reconvened	reflected 584:9,
556:15,17 724:1	681:1,17,25	635:19	723:24	12
733:23	682:2,10,19,26	received 559:10	reconvening	refresh 583:8
re-open 567:4	683:23 684:18	571:2 583:4	745:16	647:25
578:17 655:25	686:7 687:26	584:10 598:19	record 559:21	refreshes 613:23
re-opened	688:15 689:23	607:13 634:3	567:12 586:4	refute 705:23
620:16 667:5,7	690:2,22 692:19,	656:22 657:4	590:13 612:14	regard 567:26
re-opening	21 693:18,25	677:15 700:22	616:7 736:13	652:4 730:4,7
578:21 611:21,23	694:15,24 695:7,	709:15	recording 559:9	743:24
666:17 690:9,12	18 696:9 703:14,	receiving 583:1	recordkeeping	Registered
714:8,18 726:4	25 705:22 706:5	590:21 663:22	638:26 639:7	558:10,11
727:7,8,12,15	725:6,7	recent 656:16,25	records 583:7	631:10,11
reach 570:14	reading 661:25	710:15	639:8,21,26	Registrar 579:21
612:17,21,24	683:2 712:16	reception 641:11	recover 622:17	683:19
614:7,12 716:15	reads 660:7	659:21,26 663:11	recovery 581:3,5	registration
717:9	ready 631:26	673:20	622:16 683:26	637:6
reached 570:11	672:18 731:9	reception/	684:5	regrettably
624:17 707:25	real 586:24 594:5	payment 659:23	redirect 628:14	737:12
718:25	694:1 695:1	receptionist	652:7 721:3,17	regular 589:13
reaching 570:2	realize 574:14	685:5	722:18 723:16,18	701:5,14
719:4	realized 568:10	recess 610:8	732:10 737:11	regularly 568:21
react 577:3	702:9	629:24 651:21	reduce 705:15	594:17
reacted 615:25	reason 570:9	676:21 719:12	reducing 571:19	regulated 601:13
read 572:17	573:2,24 574:23	734:21	678:19 705:24	657:4,14,19
573:9,11,16,18	587:11 603:17	recognize 561:6	redundant 691:9	regulating
586:4 594:6	614:12 626:13	574:17 648:6	refer 633:24	611:14
608:14 620:20	638:15 712:25	652:15	649:25 650:10	regulation 566:4
621:14 627:16,	721:23 729:11,13	recognized 579:7	651:15 672:20	627:23 725:9
17,24 636:22	reasonable 678:4	recollection	724:11	regulations
639:7,12,20	683:1,2 737:17	583:9 613:19	reference 587:12	606:10
641:3,16 642:15	reasoning 565:10	622:23 655:4	656:6 679:25	regulator 636:24
643:2,7,12,19,23,	569:18	684:2	693:2,4 710:1	regulatory 602:9
26 644:6 646:20,	reasons 561:14,	RECOMMENC	referenced 676:8	605:8 733:10
24 647:2,6,13	22 583:25 586:7,	ED 631:23	references 664:6	reiterated 685:8
648:5 652:14	8 645:1 693:7	recommend	709:11	reiterates 690:3
655:17 657:13,26	737:9 739:5	702:25	referred 626:20	relate 708:22
658:1,9,19	recall 567:11,12,	recommendatio	692:15	related 567:9
659:17,20 660:7,	20 583:4 624:9	ns 561:13 657:16	referring 562:20	689:8
20 662:19,25	626:2 636:4	recommended	591:13 607:4	
663:5,10,15	654:23 656:22			
	661:12,15 679:25			

relates 732:13
relating 656:18
685:4
relation 635:22
relationship
577:26 606:25
relaunch 655:8,
13,15
relax 588:1
Relaxation
702:26
relevance 685:1
717:12 718:21
719:6,25
relevant 648:23,
26 649:1 650:11,
12 651:6 652:3
701:11,21 702:7
relieve 566:25
religious 561:1
572:12 573:11,26
574:21 585:26
586:14,20 593:20
685:19 687:7,9
religiously
572:11 574:4
reluctance
743:15
reluctant 571:4
609:20,22 614:4
rely 632:9 633:21
686:16
relying 624:23
Remain 646:21
remainder
720:26
remains 594:4
694:1 695:1
remember 567:5
582:1,3 583:5,12
661:19 701:17
remove 562:26
removes 562:9

removing 564:10
587:26
renegotiating
606:9
renewal 614:14
637:15
repeat 640:20
645:23 712:13
repeated 732:25
repeating 600:7
rephrase 589:14
595:24 623:9
624:13 665:24
666:14 697:4
715:15 728:11
replied 686:10
replying 560:13
report 679:24
683:15 684:12
reporter 558:21
631:21 632:25
712:13,16 730:21
731:1,6 746:15
reports 651:2
680:16 700:6
represent 601:6
reputation
561:18 604:2
request 582:12
583:11,16 584:21
687:21 703:15
736:4
requested 577:9
requests 704:1
require 572:26
588:19 593:16,24
621:2 641:11,23
642:18 669:26
684:20 727:20
required 568:24
575:5,26 582:21
641:7,21 643:4
653:22,23 654:26
657:15 659:10

673:13 690:4,6,7,
25 692:24 707:14
727:23
requirement
567:18 568:5
569:25 582:20
613:1 614:25
639:17 654:7
655:8 659:12
667:24 682:13
683:3 696:25
697:2,3 701:3
706:21 713:4
726:8,15 730:18
requirements
567:8,14 572:16
578:22 615:10
637:3,6,12,15
639:7 640:4
649:5 658:11,24
659:5 660:19
665:26 675:11
685:15 686:3
711:12 712:5,20,
21 713:25 714:4
715:19 730:10,13
731:12,23 733:2,
10
requires 615:9
665:7
requiring 613:2
622:9 654:25
727:3
reschedule
598:12 745:2
rescind 579:5
620:16 662:12
663:21 665:12
666:19 669:3
670:2,11 730:2
rescinded 578:20
621:17
rescinding
621:18
research 571:14,
16,17 623:21

704:16
researched
571:17
researching
715:26
residual 722:19
resources
661:12,13,22,26
respect 570:18
571:18 575:3
604:25 608:7
609:11 623:23
644:10 648:7
652:16 666:13
667:4 675:13
680:23 685:16
720:19 723:13
725:24 738:16,22
739:9 743:7
respectfully
717:25
respects 717:23
respirator
705:25
respiratory
571:13 573:4
respirologist
679:2
respond 647:26
701:1 719:26
720:22 724:15
736:1
responds 729:9
response 557:5
559:19 570:21
571:2 580:20,22
613:18,20,24
616:22 618:1
624:20 632:10
633:24 635:1
648:15 649:14
677:13 687:15,20
690:17 724:4,5,7,
9,13,15

responsibility
580:24 592:18
604:18 605:24
657:20
responsible
667:18 685:14,24
686:4
rest 725:6
restate 730:11,24
restrict 566:4
740:19
restricted 728:14
restricting
600:21
restriction 566:8
599:24 611:24
restrictions
565:11 566:1,6
567:14 585:6
600:2,11 601:21
605:20 611:12,18
669:25
result 622:4
678:22 688:1
resume 610:23
655:19 743:17
review 634:14
698:16,17 725:22
reviewed 661:13
rewards 573:14
rights 574:2,3
580:15 603:25
604:3 606:1,7
693:2 710:25,26
711:1 729:23,25
730:5 733:7,8,13
rise 702:17
risk 575:11 578:2
594:16,25 602:9,
10 603:26
615:15,16 616:25
617:2 622:19
642:20 668:4
688:1 695:9,21,
24 696:3,5

724:16,18
728:19,20 739:13
risks 571:22,24
572:1 575:19
576:5,11 667:22
668:2,8
road 712:8,9
719:10
robust 721:9
role 565:7 580:11
583:19 617:8
713:19
Romans 573:18
room 569:18
593:8,11,13
596:5 622:3,6
651:23 719:14
734:8,12
roughly 565:15
routine 646:21
routinely 614:17
rules 606:10
648:9 652:18
ruling 717:2
718:4
run 612:7
ruptured 563:11
rush 736:26
737:10

S

sacred 572:21,22
safe 578:2 591:20
safely 655:8,14
safety 595:4
Salem 584:14,17,
19 585:1 691:25
692:9 700:17,19
701:5,18,23,24
702:2,3,13,16
703:3,24 704:8,
25 706:10 728:25
729:9,10 732:1

Salem's 691:3
704:12,18 705:3,
14 706:2
sales 738:6
salient 560:26
sanitation
627:23 725:9
satisfy 704:1
scenario 717:6
schedule 654:26
745:3
Schumann
558:21 631:21
746:3,14
science 561:4,6,
20 562:21 587:25
644:19 664:13,26
665:3,5 704:20
712:25
scientific 598:24
599:3,14,18,22
600:19,26 601:4
664:8,20 688:16
713:9
scope 623:12
719:24
screen 658:10
737:20
screening 658:8,
13
scrutiny 702:11
seasonal 622:18
seat 737:23
second-last
647:13 674:14
694:6
seconds 560:12
section 574:6
617:23 627:22,24
636:19 637:1
660:5 663:4
664:14 687:11,21
693:1,11 697:7,
21,22,24 725:8,

12,13,19
seek 559:8 573:15
575:23 589:5
590:24 617:24
self-diagnose
708:4
self-diagnosed
681:22
self-diagnosis
679:18 702:10
self-regulating
636:15
send 613:10,22
614:17 632:8,13
633:20 634:23
687:23
sending 570:25
632:16 744:25
sends 638:8
sense 566:21
584:2 589:21
596:15 597:18
676:20 691:23
715:12 719:8,22
745:1,6
sensitive 722:22
723:2
sentence 657:13
680:15 681:16
682:19 684:18
688:9,14 694:6,
18 695:7,17
725:6
sentences 693:23
separate 560:7
670:5 672:21
September
556:5,10 558:5
631:5 746:9
series 646:19
661:6 684:12
696:7 697:6
seriousness
707:16

service 740:21,23
741:11
services 566:9
593:7 600:23
606:23 621:17
626:15 639:13
655:19 663:19
666:6 669:7,16
690:10
session 556:5,10
558:5 590:8
610:12,24 631:5
634:25 677:7
723:24 735:1
set 639:26 654:18
655:21 676:15
708:19 715:4
735:14
sets 637:5 646:14
setting 596:25
597:4,5,6,11
settings 597:1
660:11
severely 591:5,8
sexual 605:18,19
share 704:21
723:11
shared 634:7
shield 569:8,10,
12,13,17,20
677:25 679:10
695:11,22
shift 598:23
short 628:19
679:22 742:7,20
shorthand 746:5,
6
shortly 564:16
651:24
show 649:13
shut 666:9
shutting 619:4
sic 733:25

side 595:10
sides 608:6
sight 573:17
sign 669:21
670:10
significance
574:10,11,15
significant
596:20 608:13
similar 586:2
650:20
similarly 642:11,
13
simply 650:10
720:7
sin 573:20
sincerely 572:12
612:4
sincerity 713:12
single 588:25
sir 743:19
sit 579:26
situation 566:3,5
571:5,21 574:12
588:23 602:3,7,
14,16 606:5,11
652:5 668:17
672:10 697:17
712:26 714:12,13
situations 596:9,
20 597:14 714:2
skeletal 587:23
588:5
ski 689:3
skill 746:7
skilled 601:5
skip 639:19
645:19 658:15
659:1 669:2
skipping 683:21
sky 689:2
slow 565:6
611:10 629:10

721:14,15,22
slowly 574:14
smaller 597:9
so-called 571:11
soap 658:21
social 561:4,6
620:2 641:8,22
644:13 645:13
654:12 656:7
662:8 664:21
665:3 675:17
676:5 698:3,7
700:12 709:21
715:19 720:18
740:25
soft 588:1,5
soiled 658:20
solicit 744:6
somebody's
584:2 729:25
son 585:17
619:10 684:17,
20,24 685:3,9,18
sooner 674:25
sort 625:12
647:11 671:16
673:23 679:9
685:12 686:13
690:26 692:25
701:15 710:24
sound 625:12
sources 566:7
601:1
space 569:18
spaces 608:8
spam 673:2
speak 602:26
604:24 607:9
614:8 701:16
715:24 730:22
speaker 730:22
speaking 576:10
602:18 706:2
715:7

special 667:23
specialists 700:1
specific 561:22
575:19 576:4
583:13 645:3,5
651:12 657:25
676:3 696:26
698:20 704:26
705:6,12,17
707:19 709:7
710:8 711:17
713:21
specifically
563:24 567:20
571:20 572:2,13
575:8 584:8
641:6,20 645:17,
26 647:12 667:11
675:16 693:14
699:16 706:23
733:8
spectrum 595:19
596:10
speculative
688:3
spend 632:12,21
spent 563:6
712:24
spinal 562:8,24
spiritual 591:12
spoken 560:14
605:6
spread 627:21
662:26 663:16
spring 565:24
568:12 571:6,10
572:8 582:16
585:14,18 593:19
603:4 679:23
squash 563:10,11
staff 585:14
641:18,19,20
643:20 644:2
659:24,26 660:7,
23,25 663:7

673:18,20 674:6,
9 685:14,18,23
686:3 689:26
stage 617:13
staged 655:8,15
stance 570:14
593:1,5
stand 602:8
603:24
standard 587:2,4
612:21 619:17
638:25,26 639:3
645:16,18 646:5,
6 647:5 659:7
660:22 667:13
685:22 716:10,
11,12 733:6
standards 615:5
616:2 625:16
637:24 638:20,22
645:26 648:10
652:19,25 653:2
667:10 686:2
standing 629:4
standpoint
602:17
stands 626:13
736:20
start 558:25
564:14,22 567:4
568:3,7 609:18,
22 610:9 627:12
635:4,8 671:11
677:17 725:7
743:12
started 561:17
564:16,19,25
565:21 571:23
698:16
starting 655:19
starts 681:13
state 706:23
stated 562:19
570:4 581:4
614:9 716:7

statement 602:23
617:1 652:22,23
657:13,23 662:25
663:2,15 673:8,
21 674:19,20
679:14 682:2
684:2 689:6,17
694:3,4,14
695:13 706:5
713:23 715:2,9
718:9 726:22
statements
624:11 728:19
states 572:17
627:23,25 682:12
725:10,12
stating 601:3
669:21 679:1
694:24
statistics 622:15
status 717:4
stay 721:1 728:7
stayed 565:22
steady 565:6,12
605:7 611:10,11
step 582:8 602:24
618:17,26 625:3
stepped 618:18
steps 609:7
624:25 661:6
675:10,25 702:25
706:16 744:21
stick 604:24
stitches 597:13
stop 565:25
568:26 569:6
582:8 611:2
618:17,18,26
669:8 737:9
740:11 741:1,6
742:6
stopped 569:8
577:2 585:21
615:25

stops 723:4
story 564:1
stress 619:21
stressful 566:19
strictly 566:14
strong 561:17,18,
20 562:5 571:18
582:7 586:20
601:14 618:16
671:26 680:22
715:6
stronger 565:7
strongly 664:3,5
680:20
structure 587:23
structured 611:5
stuck 738:10
student 563:16
studies 650:21
652:5 680:16,19,
21 698:26 699:9
705:23 713:8,10
stuff 723:6
style 567:22
709:2
subject 652:9
696:10,12
725:13,25
submissions
651:19
submit 582:12
683:1
Subsequent
680:16
subsequently
701:23
substance
648:16,23
substantive
649:11,20 650:19
724:13,14,15
sufficient 579:8
695:20 696:2,5
707:26

suggest 614:26
616:26 621:1
624:16 679:13
704:12 713:11
722:16 741:25
summary 677:24
704:12
supersede 733:9
supply 584:3
support 566:14
573:10 580:18
582:16 626:11
680:4,20,22
699:2,4,10
supported
698:26
supporting
617:10 699:6
supportive
570:10,24 614:5
680:12 701:2
suppose 664:11
700:4 742:18
supposed 568:16
705:19 716:7
surgery 563:13
surgical 567:22,
24 571:11 660:21
**surgical/
procedure**
660:12
surprised
583:15,18,21
601:16 625:2
640:7
surprises 667:12
surprising
601:10
surrounding
638:13
survival 600:16
suspend 582:12
584:22 603:13

suspended
581:16 602:10
suspending
580:5 581:10
suspension
581:10 617:25
618:22 687:21
693:11
swear 737:24
switch 697:26
708:17
switching 710:23
sworn 556:7,12
559:1,15 635:13
sympathetic
743:16
symptomatic
594:26 598:14
symptomatology
572:6
symptoms
569:12 573:4
595:1 598:11
658:11 679:19
698:23 736:7
system 562:5,8,
25 564:10
587:18,26 591:17
693:20 694:17
systems 587:21
588:3

T

table 556:1
580:13 657:10
tail 673:23 674:13
taking 569:16
572:3 608:13
629:15 636:4
639:5 649:3
675:10,25 677:9
693:15 721:19
talk 577:1,16
585:13 667:12

679:23 681:6
697:26 739:22
talked 611:8,18
617:9,10,19
619:10,17 625:26
629:6 640:13
668:1 677:11
687:7 715:26
718:23,24 724:3,
16 730:3 733:17
talker 589:23
talking 582:1,4
611:20 693:24
talks 637:2
650:12 655:17
656:4 666:24
680:26 683:18
704:15
taught 562:17
teach 592:3
teacher 575:17
teachings 572:15
technical 590:11
technique 738:13
technology 610:4
631:25
Telehealth
588:21,26 589:2,
6 590:17,22
591:4 708:23,26
telephone 673:4
telling 573:3
669:18 698:13
temperature
614:7
template 578:21,
23
ten 605:7
tend 685:16
tender 650:7
651:16
tendered 626:11,
13 700:6

tendon 563:11
tension 607:1,7
tenuous 576:12
678:19 680:17
tenured 570:26
term 587:6
terms 581:22
589:17 609:24
644:26 645:9
665:1,3,5 666:17
676:20 702:18
710:8 720:26
722:24 744:21
test 560:9 614:7
testify 715:3
testifying 723:4
734:16
testimony 586:5
590:4 601:9,24
609:15 619:22
626:2 677:1
679:25 721:25
736:19 743:20,23
744:2,14
testing 704:14
tests 702:18
704:1
thereof 728:24
thing 567:1 576:4
577:4 598:8
611:22 612:11
615:20,26 616:17
654:10 737:3
741:12
things 561:4
565:4,9,13 575:7
578:14 584:9
598:25 605:14
614:17 615:5,11,
13 625:3 637:4
650:3 685:22
686:3,14 711:17
717:26 718:17
727:25

thinking 644:13
685:22 720:17
thinks 600:22
650:11 741:23
third-last 732:14
third-party
625:13
thought 563:21
570:5 574:19
576:20 591:19
673:1 679:17
707:18 729:16
733:18
Thoughtexchange
e 710:12,20
thoughtfully
592:2
thoughts 593:18,
19,21 607:20,26
608:2 609:2,7
721:10
thousand 565:17
thousands
565:18
threat 694:2
695:2
threatened 595:4
threatens 739:14
ticket 595:11
607:13,15
till 700:18 737:14
744:10
time 560:16
563:10 566:12,
20,22 568:12,13
569:21 570:8
571:6,11 574:7,
17 581:25
582:18,22 585:6,
19 589:16 605:11
609:25 611:14
620:24 621:25
628:15 629:13,
14,26 632:12,21
635:12 661:16

663:13 664:23
 678:17,26 679:8
 685:4 691:2
 693:26 694:6,25
 700:2 701:6
 702:2,16 706:21
 708:15 710:19
 717:19 720:22
 721:2 722:15
 731:4,19 735:8,
 15,16,18,19
 736:4,10,19
timeline 583:12
 743:9
timelines 745:7
times 562:7,23
 568:14,17 569:14
 592:12 608:16
 628:19,20 647:5
 660:13,23 674:1
 688:13 725:14
 732:25 744:26
timing 654:11
tissue 588:5
tissues 588:1
today 628:16,26
 629:20 682:17
 687:8 721:6,16,
 24 722:1 723:3,7,
 8 737:7,13
 743:20 744:1
 745:18
Todd 579:21
 633:23
told 566:2 570:11
 573:23 582:23
 603:12 665:12
 714:5,7 728:6,7,
 15 736:5
tone 617:11
top 600:20 659:2,
 16 680:14 681:12
total 629:15
totally 739:1

touch 740:24
 743:24,25
touched 591:24
tough 607:11
 629:18
toys 659:11
track 589:22
trained 575:2
training 636:1
 707:22
transcribed
 746:6
transcript
 556:22 746:1,4
transmission
 571:12,20 599:8
 642:20 643:9
 678:19 688:18
 705:15,25
transmitted
 594:12
treat 566:13
 568:9 579:9
 587:15 592:23
 594:22 597:21,23
 598:11 604:13
 608:1
treated 593:25
 594:26 642:17
 650:25 669:22
 670:9
treating 565:20
 568:4 569:1
 578:25 584:5
 587:8 591:22
 592:7 594:17
 597:12,13 598:5
 604:24,25 605:2
 606:14 653:22,23
 695:11,23 739:14
 741:2,7
treatment
 575:19 576:1,6,7,
 14 587:2,4,18
 588:7,10,14,26

590:25 594:22
 615:3,9 619:18
 667:20 668:16,24
 702:23 706:15
 732:7 738:18
 739:3,21 740:2
treatments
 575:24 576:10,11
 587:1 588:17
 596:9
treats 620:22
 666:25 739:11,18
 741:13
Tribunal 556:18
 558:7,8 617:16
 619:8,9 620:17
 631:7,8 632:17
 634:8,23 638:24
 645:21 649:6
 650:16 651:4,7,
 21 662:14 719:12
 721:8,9,26 722:6,
 25 723:16 734:5,
 22 735:3,6
 736:16 737:12
 742:23,26 743:2,
 7 744:17 745:8
Tribunal's
 742:24
Tribunals 625:9
trick 617:16
 647:11
true 686:2
trust 577:23,24,
 26 597:18 616:24
trusted 570:26
 577:15
truth 598:24
 602:26
turn 590:11
 617:5 634:1
 647:22 687:11
turned 731:3
TV 623:1

twenty 670:26
two-thirds
 694:5,10
type 567:23 587:4
 611:21,23 701:4
 707:14 708:1
types 567:20
 595:16 596:2,20
 597:14 614:17
 615:13

U

ultimate 627:2
 708:23 717:8,9,
 10,11,25 728:26
 729:11
ultimately 619:1
 685:24 686:4
 728:25 742:26
unanswered
 614:1
unclear 583:13
 586:11
unconcerned
 577:8,12 616:1
uncovered
 604:12
undated 677:12
undeniable
 693:20 694:17
undersigned
 621:16
understand
 565:10 570:1
 578:1 581:17
 601:12 603:19
 605:24 629:12
 633:26 635:18
 636:9 650:4
 655:23 669:20
 711:19 715:17
 721:20 741:4
understanding
 562:22 564:10

566:11 571:5
 577:5,8,20
 598:16 616:23
 620:9 653:21
 668:12 682:7
 701:3 714:23
 715:5,22 732:1
understandings
 562:13
understands
 577:24
understood
 648:13 649:12
undertaking
 669:15
unduly 650:2
unethical 604:11
 605:1
unfair 705:9,10
 711:9 731:21
unfamiliar
 661:14
unfold 745:15
unfolded 563:26
University 563:8
unlawful 729:26
 730:7,10,18
 731:12,23,25
 733:3,4,18
unmasked 641:8,
 22 665:21 666:5
 669:7,10 670:18
unprofessional
 617:14 640:17,
 22,26 642:1
 717:8,26
unreasonable
 604:7 626:1
 682:23
unspecified
 582:19
unusual 615:12
 667:23

unwilling 601:11
updated 576:2
upheld 652:24
upload 634:25
upper 573:4
utilize 647:14
utmost 604:25

V

vaccination
 693:24 694:26
Vaccinations
 557:6 635:2
vaccine 710:8
vague 571:2
 705:11 706:7
vaguely 710:8
validity 704:14
variable 675:22
varying 572:5
veneer 605:8
verbal 559:19
 668:23
verification
 582:20 707:15
verifying 579:2
 627:3
version 656:16
 657:2
Videoconference
 558:1 631:1
view 589:10
 623:16 624:24
 653:5 713:4
 719:19 721:6
viewpoints
 601:11
views 671:22
 672:4 699:14
 704:13,19,21
 706:2 717:4,5

violate 575:7
violated 575:13
 604:3 614:25
 710:26
violates 573:25
 604:23 728:3,8
 729:23,25
violating 730:5
viral 571:20
virologist 679:2
virtual 721:25
virus 571:13
 693:26 694:26
viruses 571:13
 598:25
vis-à-vis 678:18
visibly 658:20
vision 628:25
visit 638:5,7,8,16
visits 638:1,19
voice 608:16
vote 616:2,18
 625:15
voted 625:18

W

wait 566:26 567:1
 610:20 662:13
 700:18 712:1
 743:17 745:15
walk 573:17
 685:20
Wall 556:7,12
 557:5 558:18,26
 559:1,15,18,20,
 22,26 560:22
 589:23 590:15
 596:1 600:10
 608:22 609:5,11,
 23 611:7 612:15
 616:1,5 620:18,
 21 627:3,7,11
 628:12,16,18,23

629:9 631:18
 632:19 633:23
 635:1,13,15
 639:5 641:5
 642:9,16 643:13
 644:1,16 645:18
 646:4 647:11
 649:12,21 652:8,
 13 653:13 655:11
 656:14 658:6
 659:2 661:10,24
 664:24 667:9
 669:6 671:19,21
 674:16,24 675:9
 676:26 677:9,17,
 22 679:13 681:14
 683:10 684:19
 685:8,12 686:6,8,
 10 687:2 688:23
 689:1,24 690:3,8,
 25 691:22 692:3,
 17,24 693:15,18
 694:14 695:21
 697:26 698:15
 702:9 705:2,13
 706:1 707:12
 708:8,17 711:26
 713:11,22 717:4,
 17 718:18,25
 719:3,25 720:4
 721:6,17,26
 722:26 723:3,8,
 13,17 724:2
 726:5 727:3,18
 730:21 731:14
 732:24 733:25
 734:16,23 735:4,
 7,24 736:10,16,
 17 737:22
 738:11,14,16,18,
 22,24 739:2,5,10,
 13,18,20 740:1,5,
 11,16 741:1,5,12,
 17
Wall's 560:13
 590:4 609:15
 616:9 632:11

671:18 688:1
 695:10,19 696:12
 704:4 718:2
 721:11 737:20,21
 738:8 740:20
Walter 633:5
wanted 577:13
 614:1 632:13
 655:24 721:24
 724:14 733:17
washing 727:26
watch 590:3
water 658:21
wave 623:2,3
waves 602:19
 639:3
wear 567:18
 568:13,14,16,24
 572:26 573:21
 579:25 581:7,8,9,
 13,14 582:5,17
 583:2,26 592:14,
 25 593:9,16,24
 606:13 618:15
 620:22 627:18
 641:6,20 660:11
 662:20 666:26
 671:26 677:26
 681:20 683:3
 685:10 690:25
 692:24 695:10
 698:6 704:6
 725:14 726:8,16
 729:11,22 732:3
 738:18,25 739:2,
 6 741:13
wearing 568:3,
 21,26 569:6,8,9,
 23 570:3,11,18
 571:22 572:9,13
 575:10 576:24
 577:2,6,12,14
 578:3,26 579:3,6,
 16 580:18 585:4,
 22 586:1 594:1,
 18 595:11 603:15

605:1 607:14,15,
 21,24,26 608:4,5
 615:8 642:17
 643:8,16,20,24
 668:15,17 669:23
 670:8 678:8,20
 679:10 681:4
 682:4,12,15,21
 685:16 686:17
 688:2 695:22
 698:21 704:7
 705:14,24
 714:12,23 724:20
 728:21 732:6
 739:8,10,15,18
wears 572:2
week 650:20
 744:22
weeks 661:25
welcoming 597:8
 608:11,19
whatsoever
 568:22 739:12
wide 596:10
wife 561:9 563:6
 605:6
wiggle 593:11,13
 622:3,6
will-say 715:2,8
wise 635:11
wishes 743:12
withstand
 702:11
witness's 722:23
witnesses 628:26
 629:4,6 715:4
 744:8,23 745:4
wolf 601:3
wondered
 661:18
wondering
 599:13 640:8
 701:18 735:8

word 561:25 571:15 658:23 696:8 725:4	<hr/> X <hr/>	
worded 681:2,3	X' 650:9	
wording 618:25 681:1 720:2 733:1	<hr/> Y <hr/>	
words 616:9 670:15 695:3,24	Y' 650:10	
work 559:24 563:7 564:8 570:10 587:7 594:19 603:17 610:4	year 563:14 564:19 623:2 707:1	
worked 566:9	year-and-a-half 596:17 598:9,12 602:2 604:4	
worker 595:14	years 563:6 565:6,14,16,20, 23 571:1 605:7 611:9 637:12 652:24 712:24 738:9,15	
workers 595:17, 19 596:3,8,11 655:18 660:10	yesterday 559:5, 7 586:4 619:22 629:11,12 665:18	
working 563:8 585:17,21,23 684:17 685:3,4	young 564:21	
workplace 660:13	youth 563:5,7	
works 609:18 674:24	<hr/> Z <hr/>	
worn 567:21 642:21,23	Z' 650:10	
worth 678:21 717:14		
worthwhile 740:7		
Wow 565:19		
wrap 621:26		
wrapped 574:6 575:20		
written 570:19 584:26 639:24 687:20 698:8		
wrong 601:18,21 614:26 620:8 668:18 716:17,18		
wrongly 669:23		

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

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	November 16, 2021	Morning Session	749
6	Discussion		750
7	CHARLES RUSSELL, Sworn, Examined by Mr. Kitchen		752
8	Mr. Maxston Cross-examines the Witness		758
9	Discussion		761
10	DAVID WARREN HILSABECK, Sworn, Examined by		765
11	Mr. Kitchen		
12	Mr. Maxston Cross-examines the Witness		777
13	Mr. Kitchen Re-examines the Witness		780
14	JARVIS KOSOWAN, Previously affirmed,		784
15	Cross-examined by Mr. Maxston		
16			
17	November 16, 2021	Afternoon Session	789
18	DR. JUSTIN ROBERT GEZA GAUTHER, Sworn,		790
19	Examined by Mr. Kitchen		
20	Mr. Maxston Cross-examines the Witness		817
21	The Chair Questions the Witness		831
22	Discussion		833
23	Certificate of Transcript		837
24			
25			
26			

1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 November 16, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:06 AM)

24 THE CHAIR: This Hearing Tribunal is

25 reconvened. We are in session.

26 Mr. Kitchen?

1 Discussion

2 MR. KITCHEN: So the witness who was
3 supposed to go first thing this morning to be
4 cross-examined is Jarvis Kosowan, is who we ended with
5 last time. He's feeling quite under the weather; he
6 didn't sleep well. He's asked to go this afternoon.

7 I've just spoken with Mr. Maxston, because,
8 obviously, the greatest concern there is any prejudice
9 raised by the other side or -- by the College I should
10 say.

11 So the plan at this point is to have him go this
12 afternoon because he's unavailable this morning. So I
13 guess what I'm doing is asking if the Tribunal will
14 permit that.

15 THE CHAIR: Mr. Maxston, did you want to
16 speak to that?

17 MR. MAXSTON: Yeah, thank you very much.
18 Mr. Kitchen was really candid with me, and I really
19 have no concern here. We can call the witnesses in
20 whatever order will work for him.

21 THE CHAIR: Okay. Mr. Kitchen, with us
22 not having Mr. Kosowan this morning, how did you plan
23 to proceed from this point?

24 MR. KITCHEN: The first two witnesses after
25 that I had scheduled are Charles Russell and Dave
26 Hilsabeck, in that order, and then I want to go on to

1 Dr. Justin Gauthier after that. I had another witness
2 planned for today, but he is unavailable due to urgent
3 work requirements, and his name was Elvin Music. So at
4 this point, I have three witnesses I want to do, and
5 then circle back to Jarvis Kosowan for
6 cross-examination this afternoon.

7 Now, unfortunately, Dr. Gauthier, because, of
8 course, he's a practicing chiropractor, he has patients
9 all this morning. He's blocked off the entire
10 afternoon, so he can go immediately after lunch, even
11 if we take an early lunch, but he cannot go this
12 morning because he's with patients.

13 I had originally planned for the morning to be
14 quite full with the four other witnesses I had. Now, I
15 only have two. So that's where I'm at, which makes a
16 little bit of a rocky day, I understand, but at least I
17 don't think we'll be running out of time. If anything,
18 it will be the opposite.

19 THE CHAIR: So you would start with either
20 Russell, Hilsabeck, or Music?

21 MR. KITCHEN: I'll be starting with Charles
22 Russell and then moving on to Hilsabeck. And at that
23 point, I have no witnesses available until first thing
24 in the afternoon, and that will be either Jarvis
25 Kosowan, if he's available, or Dr. Justin Gauthier. He
26 will be available right after lunch.

1 THE CHAIR: Okay, Mr. Maxston, any comment
2 or thoughts?

3 MR. MAXSTON: No, I'm fine with that
4 approach. Mr. Kitchen's been very candid, and I know
5 we all have problems, from time to time, getting our
6 witnesses to attend, so that's just fine.

7 THE CHAIR: Okay, thank you, Mr. Kitchen,
8 Mr. Maxston, then we will proceed based on
9 Mr. Kitchen's comments, and you can call your first
10 witness this morning, Mr. Kitchen.

11 MR. KITCHEN: Okay, well, I see that, as far
12 as I can see, Charles -- oh, there he is. Mr. Russell,
13 can you hear us?

14 THE WITNESS: I can.

15 MR. KITCHEN: Excellent. Now, Madam Court
16 Reporter is Karoline, her name is Karoline, she's going
17 to swear you in --

18 THE WITNESS: Okay.

19 MR. KITCHEN: And then we'll get started.

20 CHARLES RUSSELL, Sworn, Examined by Mr. Kitchen

21 Q MR. KITCHEN: Well, good morning,
22 Mr. Russell. I'm going to, unless you object, I'm
23 going to call you by your first name, Charles?

24 A Fair enough.

25 Q For the record. Charles, can you tell us what you do
26 for a living?

- 1 A I'm a commercial real estate agent.
- 2 Q And are you a patient of Dr. Wall?
- 3 A I am.
- 4 Q How long have you been a patient of Dr. Wall?
- 5 A At least 20 years, by my recollection.
- 6 Q And why have you stuck with Dr. Wall as your
7 chiropractor for so long?
- 8 A Because he's effective. He does -- he fixes me when I
9 need to be fixed.
- 10 Q How do you find that Dr. Wall's treatments help you?
- 11 A I come in in pain, and I leave without pain.
- 12 Q Thank you. Now, let me ask you, do you respect
13 Dr. Wall?
- 14 A Absolutely.
- 15 Q Do you wear a mask when you come in to see Dr. Wall for
16 treatment?
- 17 A I don't wear a mask for anything.
- 18 Q And so just to confirm, that includes when you're in
19 Dr. Wall's office?
- 20 A Absolutely.
- 21 Q Are you grateful that Dr. Wall does not require you to
22 wear a mask when you come in for treatment?
- 23 A Absolutely. I probably wouldn't come otherwise.
- 24 Q Does Dr. Wall wear a mask when you come in for
25 treatment?
- 26 A No.

1 Q Are you aware of the reasons why Dr. Wall doesn't wear
2 a mask?

3 A Yes.

4 Q Do you feel comfortable with Dr. Wall not wearing a
5 mask while he treats you?

6 A Absolutely.

7 Q Now, let me ask you this: Do you prefer that Dr. Wall
8 not wear a mask while he treats you?

9 A I wouldn't come if he wore -- if I had to wear a mask,
10 if he was wearing a mask. I might sit still for him
11 wearing a mask, but I sure won't wear one.

12 Q But if you had the choice, if you could choose, would
13 you prefer to see Dr. Wall not wearing a mask or with
14 wearing a mask?

15 A I'd prefer to see Dr. Wall not wearing a mask or
16 anybody else.

17 Q Why is that?

18 A Because I believe they're ineffective, I believe
19 they're dangerous, I believe they create more bad
20 health than they do good health, and it's -- I just
21 don't believe in that. I've studied it enough to know
22 it's the wrong thing to do.

23 Q Do you believe Dr. Wall puts you at any increased risk
24 or in any way threatens your health by treating you
25 without a mask?

26 A Absolutely not.

1 Q Do you think Dr. Wall has done the right thing by
2 letting you not wear a mask when you come in for
3 treatment?

4 A Yes.

5 Q I'm going to shift gears a little bit. Let me ask you
6 this: Do you think Dr. Wall could provide you --

7 MR. KITCHEN: -- oh, my apologies -- I had
8 turned it off, and then I called Mr. Maxston, and I
9 forgot to turn it off again. I apologize. I'll start
10 again.

11 Q MR. KITCHEN: Do you think Dr. Wall could
12 provide you with treatment that you want if he could
13 not come within 2 metres of your body?

14 A I think it would be pretty much virtually impossible.

15 Q And do you think Dr. Wall could provide you with the
16 treatment you want if all he could ever do is call you
17 on the phone and talk with you?

18 A I don't think that would work.

19 Q And I know it might be a bit obvious, but could you
20 tell me why?

21 A He needs to have the hands on.

22 Q And, again, I know it might be a bit obvious, but what
23 is the treatment that Dr. Wall gives you when you come
24 into the office?

25 A He adjusts my spine and my neck and whatever else might
26 be out of line and checks to make sure I'm --

1 everything's lined up.

2 Q And what does he use to do that?

3 A His hands.

4 Q Do you want to keep Dr. Wall as your chiropractor?

5 A Absolutely.

6 Q Do you think it would be against your interests if
7 Dr. Wall is ordered to stop practicing or to only
8 practice over the telephone?

9 A Absolutely, I would be upset.

10 Q Do you think your interests should be considered as
11 part of any decision to restrict or not restrict
12 Dr. Wall's ability to practice?

13 A I would hope it would have some bearing.

14 Q If Dr. Wall is ordered to stop practicing or to stop
15 treating you except by calling you on the phone, would
16 you be upset with that order or that decision and the
17 person or body that made it?

18 A Absolutely.

19 Q Could you explain why?

20 A It's not fair. It's not reasonable. It goes against
21 the Hippocratic Oath. It goes against a lot of things.

22 Q Do you think the chiropractic profession has important
23 core principles?

24 A Absolutely.

25 Q And what do you think some of those are?

26 A Promote natural health, to give people an alternative

1 to the pharmaceutical/medical establishment; to mainly
2 promote natural health, just natural treatments.

3 Q Do you think those treatments are currently being
4 adhered to -- sorry, let me say that again, I said it
5 wrong. Do you think those principles are currently
6 being adhered to?

7 A Well, I think they are by most of the practitioners.
8 I'm not sure about the administrative side of it.

9 Q And why do you say that?

10 A Because we're having this hearing right now. I think
11 it's a travesty that we're even having this hearing.

12 Q And as far as your knowledge, what is it that Dr. Wall
13 has done wrong that brings us here today?

14 A I don't think he's done anything wrong, but I think one
15 person out of hundreds was living in fear and thought
16 they should do something about it.

17 Q How do you think the chiropractic profession should be
18 acting in response to the Government COVID
19 restrictions?

20 A I think they should be pushing back. I think they've
21 got plenty of evidence that the Government's mandates
22 are unreasonable and not in the interest of good
23 health.

24 Q Forgive me for asking, Charles, but how old are you?

25 A I don't tell people how old I am. I'm 55 in my mind.

26 Q Do you regard yourself as being in the at-risk category

1 for COVID?

2 A No.

3 Q And why is that?

4 A Because I'm healthy, and I practice good health
5 practices, and I do the things that make a difference,
6 and I stay away from chemical drugs.

7 Q And just one more question, I just want to go back to
8 what you said earlier, you talked a lot about natural
9 health. So you -- would you say that chiropractic
10 treatments, hands-on chiropractic treatments, that's a
11 part of natural health?

12 A Absolutely.

13 MR. KITCHEN: Well, those are all my
14 questions. Thank you, Charles.

15 A You're welcome.

16 THE CHAIR: Mr. Maxston?

17 MR. MAXSTON: Thank you, Mr. Chair.

18 Mr. Maxston Cross-examines the Witness

19 Q MR. MAXSTON: Mr. Russell, my name is Blair
20 Maxston. I'm the lawyer for the College's Complaints
21 Director, and I've just got a few questions for you,
22 and I will not be asking you how old you are, so you
23 cannot worry about that. I just have --

24 A I plead the fifth on it.

25 Q -- a few questions for you. Sorry?

26 A I plead the fifth on that one.

1 Q Yeah, well, I probably would too, so good for you.

2 Would you agree with me, Mr. Russell, that
3 practicing as a chiropractor is a privilege not a
4 right?

5 MR. KITCHEN: Hold on, that's a legal
6 opinion question.

7 MR. MAXSTON: Well, I'll rephrase it.

8 Q MR. MAXSTON: Would you agree with me that
9 not everyone can be a chiropractor; you have to earn
10 it?

11 A I think you should be qualified.

12 Q And you're aware that the Alberta College and
13 Association of Chiropractors is the professional
14 regulator for chiropractors in Alberta, correct?

15 A That's what I understand, yes.

16 Q Are you aware that that college has mandatory
17 requirements for registration before someone can be a
18 chiropractor, like going to a certain school, that type
19 of thing?

20 A That would seem reasonable to me.

21 Q And are you also aware that the College has ongoing
22 requirements for chiropractors so they can stay in good
23 standing with the College, like continuing education
24 and those kinds of things?

25 A Makes sense.

26 Q Would you agree that those requirements are important

1 in order to ensure that chiropractors are competent and
2 can practice safely?

3 A I would say so.

4 Q Now, Mr. Kitchen sort of touched on this with you, but
5 you're aware that, at times, the College, the College
6 of Chiropractors, has had a directive requiring that
7 its members, people like Dr. Wall, wear masks when they
8 treat patients; is that your understanding?

9 A It's my understanding, yeah.

10 Q You've made comments today in support of Dr. Wall not
11 following the requirement for masking; is that correct?

12 A Yes.

13 Q Would you agree with me, Mr. Russell, that you can only
14 speak for yourself on those matters?

15 A Yes.

16 Q And would you agree with me that there might be other
17 patients of Dr. Wall who don't share your views?

18 A Could be.

19 Q And would you agree that there could be other patients
20 who might want Dr. Wall to comply with the College's
21 pandemic masking directive?

22 A Could be.

23 MR. MAXSTON: Those are all my questions for
24 you, Mr. Russell.

25 THE CHAIR: Thank you, Mr. Russell.

26 Mr. Kitchen, anything on redirect?

1 MR. KITCHEN: No, I do not have any
2 redirect.

3 THE CHAIR: Okay, perhaps we can take a
4 quick break just to see if -- or maybe I'll ask the
5 Panel now, do any of the Panel Members have any
6 questions that they would like to discuss in caucus
7 before we dismiss Mr. Russell? Apparently not,
8 Mr. Kitchen.

9 So thank you, Mr. Russell. I believe your
10 testimony today is concluded.

11 A Okay.

12 MR. KITCHEN: Thank you, Charles. You're
13 free to go in other words.

14 A Okay.

15 MR. KITCHEN: Take care.

16 (WITNESS STANDS DOWN)

17 Discussion

18 MR. KITCHEN: Chair, I guess I'm going to
19 have to ask that we take a break, and I'm going to try
20 to get my second witness here as fast as I can, and
21 I'll also start putting in calls to the other witnesses
22 I have, because we're moving at opposite of the speed
23 we were last time.

24 THE CHAIR: It's 9:30 -- just about 9:30,
25 Mr. Kitchen. How long would you like, and how long do
26 you think you need?

1 MR. KITCHEN: Well --

2 THE CHAIR: If we check back in 15
3 minutes?

4 MR. KITCHEN: Yeah, we could check back. I
5 don't know if I'll have my witness available. He
6 was -- he preferred to come to the office because
7 he didn't want to do the technology, so I'm going to
8 have to call him and see how quickly he can get here.
9 So --

10 THE CHAIR: Okay.

11 MR. KITCHEN: -- I can't say that he'll be
12 ready in 15 minutes, but we can check in. Is that all
13 right?

14 THE CHAIR: Okay. Yeah. I wonder if
15 there's another way of doing this. Ms. Nelson, can
16 Mr. Kitchen contact you when his witness is ready, and
17 you can let us know. We'll shift to our break-out
18 room.

19 MS. NELSON: Yeah, that works.
20 Mr. Kitchen, you have my cell number, correct?

21 MR. KITCHEN: No, but I'd like it.

22 MS. NELSON: Okay, so 780-938-1666 is my
23 cell number.

24 MR. KITCHEN: Okay, thank you.

25 MS. NELSON: What I'll do is I'll just open
26 up all the break-out rooms, everyone can go into their

1 break-out room, and then, Mr. Kitchen, when you kind of
2 have an idea of scheduling, just send me a text, and
3 then I'll communicate to everybody through the rooms.

4 MR. KITCHEN: Excellent, thank you.

5 MS. NELSON: Okay, thank you.

6 THE CHAIR: Okay, we'll take a break.

7 We'll head to our break-out rooms and reconvene at such
8 time as we have another witness. Thank you.

9 (ADJOURNMENT)

10 THE CHAIR: Mr. Kitchen, could I ask, were
11 you able to contact your witness or witnesses?

12 MR. KITCHEN: So Mr. Kosowan is available at
13 10:45 to be cross-examined, and he'll be appearing
14 virtually, and what I mean by that is he won't be here
15 in the office with me like he was the last time.

16 THE CHAIR: Okay.

17 MR. KITCHEN: Dr. Gauthier, the earliest he
18 can be available is 12:45. He expects to be done with
19 his last patient at 12:30. So wherever we're at with
20 that means we have this witness now, we have
21 Mr. Kosowan at 10:45. Then I would propose we have a
22 lunch break, and then we come back, and we have
23 Dr. Gauthier.

24 THE CHAIR: I'm sorry, when you say "we
25 have this witness now", who is that?

26 MR. KITCHEN: That is Dave Hilsabeck. Now,

1 we had this issue last time, of course, because he's in
2 the office with Dr. Wall and I, so he's appearing on
3 Dr. Wall's screen, that's why it says "Dr. Curtis
4 Wall", so just note that it's not Dr. Curtis Wall, it
5 is, in fact, the witness, Dave Hilsabeck.

6 THE CHAIR: Okay, so I'm sorry, I should
7 have asked this, are we prepared to resume then?

8 MR. KITCHEN: I am.

9 THE CHAIR: Okay, and Mr. Maxston?

10 MR. LAWRENCE: I don't think Mr. Pavlic is
11 back, Mr. Chair.

12 MR. MAXSTON: Yeah, I was just going to say,
13 on my screen, I'm not sure, but I don't think
14 Mr. Pavlic is here.

15 THE CHAIR: Okay.

16 MR. PAVLIC: Can you hear me?

17 THE CHAIR: Yeah, can't see you; your
18 camera's off.

19 MR. PAVLIC: Okay, I can put my camera on.
20 Here we go. There I am. Yeah, sorry, my apologies, I
21 didn't put my camera on, forgive me.

22 THE CHAIR: We will forgive you.

23 Okay, I think we're all here now. Mr. Maxston,
24 you're okay to resume?

25 MR. MAXSTON: Yes, thank you for checking.

26 THE CHAIR: Okay. All right, Mr. Kitchen.

1 And just for the record, we are back in session, thank
2 you.

3 MR. KITCHEN: All right, Madam Court
4 Reporter, we're ready when you are.

5 DAVID WARREN HILSABECK, Sworn, Examined by Mr. Kitchen

6 Q MR. KITCHEN: All right, Dave, could you
7 please just say your full name for the record?

8 A My name is David Warren Hilsabeck.

9 Q Thank you. Dave, could you tell me what you do for a
10 living?

11 A At present, I'm a corporate pilot for an energy company
12 here in Calgary, based out of Calgary.

13 Q Are you a patient of Dr. Wall's?

14 A Yes, I've been a patient for him for at least 15 years.

15 Q Okay, why have you stuck with Dr. Wall as your
16 chiropractor for so long?

17 A I appreciate how he manages business with my body,
18 let's put it that way, how he conducts business with
19 me, his communication with me, and his responses to me
20 and my needs, and that's why I've always come back to
21 him. His gentle nature. I've been to other
22 chiropractors before, and sometimes are definitely
23 rougher, but I appreciate how his gentle nature looks
24 after me.

25 Q Thank you. Now, I'm going to ask you a couple
26 questions that might seem pretty obvious, so bear with

1 me. Can you describe for me in detail the treatment
2 that Dr. Wall does on you when you come in to see him?

3 A The treatment in detail, so a lot of times what we'll
4 do is discuss where -- the back issues that I'm having,
5 for example, or hip issues or whatever the case may be.
6 He will then examine me and to find out where the -- my
7 problems lie and then will start to treat me
8 step-by-step, let's say up and down my spine and into
9 my hips or whatever that my problems are at the moment.
10 Is that enough detail for what you need?

11 Q Yes, but let me ask you a question, what does he use to
12 treat you?

13 A What does he use. Well, he uses his hands, we're using
14 his workbench, uses different tools as far as vibrating
15 massage therapy or the pressure point actuator, and we
16 use a couple of different benches that he has here to
17 figure out where my faults are and to help correct
18 that.

19 Q Thank you. Dave, do you respect Dr. Wall?

20 A Greatly, yes, very much so. I appreciate what he has
21 to say, and how he suggests going forward, what to do
22 with my body, stretching exercises, strengthening
23 exercises, those kind of things to get me back into
24 shape and where I need to be.

25 Q Do you think Dr. Wall could provide you with the
26 treatment you want if he could not come within 2 metres

1 of you?

2 A Oh, definitely not, no. Chiropractic is a hands on,
3 and I mean hands on to my body to be able to adjust me
4 correctly. If he was 2 feet away, there would be no
5 sense in even coming here. Like I could not -- he
6 could not do the adjustments that need to be done at a
7 2 foot mark -- or a 2 metre mark, so, no, he couldn't
8 do that.

9 Q If he wasn't able to do that, what do you think you
10 would do?

11 A I'd be in a world of hurt. First of all, to find other
12 chiropractor that I trust and respect and have used for
13 so many years; I've gone to a few other ones, you know,
14 over the last 40 years, let's say, some with some
15 success, some without success, and so I would be in a
16 world of hurt. I wouldn't be able to keep going as
17 often and, you know, do the things that I do without a
18 proper chiropractor that can help me out.

19 And chiropractic I find is -- it's different for
20 everybody -- sorry, it's different for every
21 chiropractor, they do it in so many different ways. So
22 one adjustment from one chiropractor doesn't
23 necessarily mean that it's going to work for me.
24 Dr. Wall has figured out my body, what I need and where
25 my weak points are and has been able to fix me up with
26 that.

1 So going to another one, I'd be in a -- I'd be in
2 trouble, I think, in very short order, because I'd
3 probably have to go to a number of them to even figure
4 out if that style of chiropractic would work for me or
5 not.

6 Q Thank you, and I know this may be obvious, do you think
7 Dr. Wall could provide you with the treatment you want
8 if all he could ever do was call you on the phone and
9 talk with you?

10 A Oh, no way. It's physically impossible. Physically,
11 because I have to be here, he has to be able to adjust
12 my back, my spine, my hips, whatever the case may be,
13 so definitely not.

14 Q We've already touched on this, but just to confirm, do
15 you think it would be against your interests if
16 Dr. Wall was ordered to stop practicing or to only
17 practice over the phone?

18 A Yes, of course, it would be against my interests. If
19 he wasn't available to do this, like I said, I'm in a
20 world of hurt, and it would take me a long time, a lot
21 of money just to find another chiropractor. Every time
22 you go into a new chiropractor, you've got to start all
23 over; you've got to do the whole process of an initial
24 consultation and whatnot. So it would take a long time
25 and a lot of money.

26 So, yes, it's -- your question was is it in my

1 best interest that he is here, most definitely, both
2 physically and monetarily.

3 Q Do you think, as a member of the public, that your
4 interests should be considered as part of any decision
5 to restrict or not restrict Dr. Wall's ability to
6 practice?

7 A Yes. And as a member of the public, I understand what
8 he's doing, I appreciate what he's doing, and his
9 thoughtful manner in how he manages me and my family,
10 and so as a member of the public, yes, it affects me
11 greatly, and it would -- I guess all I can say is yes.

12 Can you say the question again for me, please?

13 Q I will, but I just want to confirm something, so your
14 family comes to see Dr. Wall as well?

15 A Yes, over the last, you know, 15 years, both my wife
16 and my kids have come numerous times, and so, yes, it
17 would affect us greatly to have all of us be affected
18 this way.

19 Q Now, let me ask you this: If Dr. Wall is ordered to
20 stop practicing or to stop treating you except by
21 calling you on the phone, would you and your family be
22 upset with that order or decision and the person or
23 body who made it?

24 A Most definitely. That affects us greatly. So we would
25 not be able to -- Dr. Wall could not do what he does
26 over the phone for us. You know, you can say, Oh, do

1 this exercise or that exercise; but if you need your
2 spine, your hips, whatever, knees, actually
3 manipulated, he can't do that over the phone. So, yes,
4 it would affect us greatly. It would be a huge
5 hindrance, a big disappointment that somebody would
6 actually take away his ability to do that.

7 Q Thank you. Now, I'm going to take us to the -- to some
8 of the deeper issues. Do you wear a mask when you come
9 to see Dr. Wall for treatment?

10 A No, I don't, I don't wear a mask in the office here.

11 Q Are you grateful that Dr. Wall does not require you to
12 wear a mask when you come in for treatment?

13 A Yes, most definitely. I am -- it's frustrating wearing
14 masks. I find that so often people that are wearing a
15 mask, if he was wearing a mask, and we're trying to
16 converse and trying to figure out what's going on with
17 me, if I can't read the lips sometimes or just see
18 what's going on, facial expressions, I lose a lot of
19 communication that way.

20 I find it a huge inconvenience to have to wear a
21 mask. It doesn't matter where I go. You go into as
22 simple as a -- into a restaurant, and you're trying to
23 order, and you're trying to figure out what the
24 specials are for the day, but you can't hear what
25 they're saying; you go through a drive-through, for
26 example, to get some food, and you go -- they're

1 mumbling, it's very, very, frustrating. You go to a
2 hardwood store, and you're trying to figure out what
3 you need for parts and pieces, and this guy is sitting
4 there mumbling, and you can't see what he's talking
5 about, or you can barely hear what he's talking about,
6 so with my hearing diminished a little bit, it's very
7 frustrating. I just don't appreciate it at all having
8 to wear a mask everywhere.

9 Q Thank you. Does Dr. Wall wear a mask when you come in
10 for treatment?

11 A No, he doesn't, and then, again, you know, in his
12 office here, he's had the shields up and whatnot, so if
13 the -- he is protected, but, you know, when he is
14 working on me and my body, no, he's not wearing a mask.
15 My -- you know, I want be able to hear him, I want to
16 be able to see what he's got to say, so I appreciate
17 that he doesn't wear a mask and that we're able to
18 communicate properly without me asking, What did you
19 say, what did you say, what did you say all the time.
20 It's just so much better for me personally.

21 Q Do you believe Dr. Wall puts you at any increased risk
22 in any way or threatens your health in any way when he
23 treats you without wearing a mask?

24 A No, not at all. I feel very comfortable with him.
25 I've known him and his family, a lot of his kids have
26 been the receptionists and things like that, so over

1 the years, we've got to know each other, and I wouldn't
2 say on a -- necessarily a personal level, but you
3 understand where they're coming from. They are not the
4 partying type of people that are out carousing all the
5 time. You know, he's not exposing himself to any risk
6 that I can see or have ever heard of even when he's not
7 at work here.

8 So for him to -- I do not feel threatened at all
9 coming in here, it's just a safe environment, and I
10 haven't got a problem with it at all. It's like our
11 work environment, you know, we know the people that we
12 work with, and have we had any COVID problems at work?
13 No, we haven't. But you know the people, you know what
14 they're trying to do. So his threat level I think is
15 next to zero.

16 And even with COVID, you know, we know that you
17 look at the statistics, and for people that get COVID,
18 we're sitting at 99.8 percent of the people that get it
19 survive it. You know, that's huge. Even people, you
20 know, that get the flu don't even have that kind of
21 access -- or don't have that kind of, not access, but
22 record of survival, so I don't feel threatened at all
23 with what he does here.

24 Q You are, of course, aware that the Alberta College of
25 Chiropractic has required, mandated that Dr. Wall wear
26 a mask when he's treating you; would you agree with

1 that?

2 A That's what I've heard, that they are mandating it, but
3 I find that that mandate -- how do I put it? I find
4 that that mandate isn't necessarily based on strong
5 data. I feel that a lot of this mandate is more on a
6 political side of things, and that, you know, you look
7 at the mask mandates around the world, and I fly around
8 the world, I see all sorts of different things.

9 So you look at some place like Japan, for example,
10 and Japan was masked-up, they were sitting in the high
11 98, 99 percent of people were masked-up, they still had
12 huge outbreaks, so masks didn't necessarily fix the
13 problem.

14 And I feel that the political side of things, you
15 know, we're being forced to do this, but the data
16 doesn't necessarily support it as far as I'm concerned.

17 Q You say you go around the world, and you see other
18 places; are there any places where you don't encounter
19 any mask mandates?

20 A Oh, sure. Like last week, I was down in Dallas, Texas,
21 for the week. I went down there training, and
22 everybody has a different way of doing things. So you
23 get to the airport, for example, and you have to be
24 masked-up because it's federally regulated in the
25 airports. They sit there, and they say you've got to
26 stand 6 feet apart when you're in the waiting area for

1 the airport. So everybody's 6 feet apart. Then all of
2 a sudden, it's all okay because we can all go through a
3 tunnel, hop on an airplane, sit side by side, and
4 that's perfectly fine, and I'm rubbing shoulders with
5 the person next to me, and that's perfectly fine.

6 So you look at the different ways of doing
7 business, and you kind of go, well, okay, that makes
8 sense, that doesn't make sense, that's just plain
9 stupid. I get down to Texas, I get out of the airport,
10 we take our mask off, and I didn't put a mask on for a
11 week. I went to -- into the class, I went to the
12 simulator, I went to restaurants, we went to hardware
13 stores, nobody was wearing masks down there. And
14 people say, Well, you know, that's because they've had
15 a huge outbreak.

16 Actually it's not. If you look at the statistics,
17 percentage-wise, we are at a higher percentage of
18 infection than they do down there, and they don't
19 have -- they're just not wearing masks. You do see
20 masks in some of the restaurants, and some of the
21 servers and whatnot were wearing masks, but none of the
22 clientele.

23 So I hear, I haven't been to Arizona for a couple
24 months now, and Florida have been for a while, but I
25 hear that both those states are the same way: They
26 have gone away from their masks, and it has not

1 affected them whatsoever.

2 Q I think I just have one more question for you. Do you
3 think Dr. Wall has done the right thing by letting you
4 not wear a mask when you don't want to?

5 A Yes, I do. I think he's done the right thing. First
6 of all, he knows what I do and the risk. You know,
7 I've had to take so many tests and whatnot traveling
8 across the border, back and forth all the time, and so
9 I know where I'm at, and I think he knows where I'm at.

10 So when I come in and he's not requiring a mask,
11 it's -- there's a mutual agreement there that, yeah, we
12 are both on the safe side of things. We're both very
13 conscious that COVID is out there, both responsible
14 with what we're doing and how we're acting and -- with
15 our lives, but we both appreciate where we're at.

16 And so to come in here and not wear a mask, I
17 appreciate that we do not have to, he's not requiring
18 it. If he said I had to wear a mask to be treated, I
19 wouldn't be happy about it, but would I do it? Yes,
20 because I need the treatment. So if he's forced into
21 it, it's not because of his doings, but because of
22 somebody else is, you know, forcing him to go down this
23 path.

24 Q Forgive me, one last question for you, do you think
25 Dr. Wall prioritises your interests above his
26 interests?

1 A That's a good question. I will say yes, because he's
2 my doctor, my chiropractor, worrying about me. And so
3 where I'm at, I believe that he's looking after me and
4 not necessarily him. I don't know what else I can say
5 about that, but I would agree with that, that he's
6 looking after me and my best interests.

7 Q Do you think, by having this hearing, the Complaints
8 Director for the College is acting in your best
9 interests?

10 MR. MAXSTON: I'm going to object to that,
11 Mr. Chair. There's no way this individual can comment
12 on the motivations or intentions of the Complaints
13 Director.

14 MR. KITCHEN: Well, I didn't ask about
15 motivations of the Complaints Director. I asked if he
16 thinks it's in his interest, and that's in his
17 knowledge.

18 MR. MAXSTON: Well, I think this line of
19 questioning is entirely subjective. I suppose I won't
20 object further to it, but I don't see any value in this
21 witness expressing personal opinions about the actions
22 of the College.

23 THE CHAIR: Could you repeat the question,
24 please, Mr. Kitchen?

25 MR. KITCHEN: The question I asked is if
26 Mr. Hilsabeck thought that having this hearing was in

1 his best interests as a patient.

2 THE CHAIR: I'm going to sustain that
3 objection.

4 A Okay, so I can answer it?

5 Q MR. KITCHEN: No. That means you can't.
6 Those are all my questions.

7 THE CHAIR: Thank you.

8 Mr. Maxston?

9 Mr. Maxston Cross-examines the Witness

10 Q MR. MAXSTON: Good morning, Mr. Hilsabeck, I
11 just have a couple of quick questions I want to ask you
12 based on some exchanges you had with Mr. Kitchen, and
13 then I've got a few other questions I do want to ask
14 you.

15 You made some comments earlier about survival rate
16 and threat and those types of things, and I just to be
17 clear, you're not a physician or an immunologist or a
18 virologist; those are your personal views?

19 A That is correct; that would be my personal views on my
20 research of those subjects.

21 Q You also talked about your belief that the College's
22 pandemic masking and I should say required masking
23 mandate wasn't based on strong data, but you, of
24 course, don't have any knowledge of the process the
25 College undertook to create that mandate, do you?

26 A No, that's correct, I do not know what the College has

1 done.

2 Q So I'll just ask you some questions then from a broader
3 perspective. Would you agree with me that a person has
4 to earn the right to practice as a chiropractor in
5 Alberta?

6 A Earn the right? He has to take the training. So the
7 right, I'm not sure what you're going with as far as
8 the right is concerned.

9 Q I think --

10 A My knowledge --

11 Q Go ahead, sorry.

12 A Okay, my knowledge is for like a chiropractor, a
13 doctor, they take the training, and then I'm assuming
14 there is an application for that province or whatnot to
15 be able to accept -- or to be able to license -- to get
16 licensed in that province.

17 Q And that kind of ties into my next question, which is
18 you're aware that the Alberta College and Association
19 of Chiropractors is the professional regulator or
20 licensing body for chiropractors in Alberta?

21 A Yes, I understand that, yes.

22 Q And based on your comments just now, I think you'd also
23 agree with me that there are mandatory requirements to
24 become registered with the College to be a
25 chiropractor, like education?

26 A That's correct, yes.

1 Q And would you also agree with me that there are
2 requirements the College has to keep a licence for a
3 chiropractor, things like continuing education or
4 payment of fees?

5 A Oh, sure, yes, I understand that completely. I'm a
6 pilot; that's all we do.

7 Q I kind of thought you would, yeah. You probably get a
8 lot of con ed from your regulators as well, so
9 mandatory con ed.

10 Would you agree that those requirements to keep
11 registration for a chiropractor are intended to ensure
12 safe and competent practice?

13 A Would you say that again, please?

14 Q Yeah, those mandatory requirements to keep your
15 licence, the mandatory requirements the College issues,
16 would you agree that those are in place in order to
17 ensure safe and competent practice?

18 A I would, yes.

19 Q Mr. Kitchen spoke with you about the College's
20 directive, Pandemic Directive, requiring the wearing of
21 masks when a chiropractor is treating, and I just want
22 to be clear that, to this day, you're not wearing a
23 mask, and Dr. Wall isn't wearing a mask when he
24 performs treatment on you?

25 A That is correct.

26 Q I think it's fair to say you've made comments today in

1 support of Dr. Wall not masking when he treats you.

2 Would you agree that you can only speak for yourself

3 when you make those comments?

4 A I can speak for myself and for my family, yes.

5 Q Fair enough. Would you agree that there could be other

6 patients of Dr. Wall who don't share your views?

7 A Oh, definitely.

8 Q And do you --

9 A Yes.

10 Q -- agree -- I'm sorry.

11 A No, go ahead.

12 Q Would you agree that there may be other patients of

13 Dr. Wall who, in fact, want him to comply with the

14 College's masking requirement?

15 A There is that possibility, sure.

16 MR. MAXSTON: Those are all my questions.

17 Thank you, Mr. Hilsabeck.

18 A Thank you.

19 THE CHAIR: Mr. Kitchen, anything on

20 redirect?

21 MR. KITCHEN: Just one question.

22 Mr. Kitchen Re-examines the Witness

23 Q MR. KITCHEN: Dave, my friend, my learned

24 friend, Mr. Maxston, he asked you do you think the

25 College's mandates are for the purposes of keeping the

26 public safe. I don't know if those were his exact

1 words, but he can object if he thinks that's not
2 reflective of the substance of what he said, do you
3 have any actual knowledge yourself of what motivates
4 the College when they have mandates for chiropractors?

5 A Do I have any knowledge? No, I don't have any
6 knowledge of how they do their -- how they do that.
7 What do I say there? A lot of this stuff, a lot of the
8 mask wearing, a lot of our regulations, it seems like
9 it's politically based.

10 Case in point, Calgary, we got a new mayor here in
11 the last month, and her first response was basically
12 whatever the Alberta Government says, we're going to
13 add 28 days to it. Now, how does she become more
14 knowledgeable than our head of our medical people,
15 Dr. Hinshaw and her group of people with the AHS? How
16 do they make those kind of claims after being elected
17 and within 24 hours make a claim like that? This is
18 why a lot of this stuff is so political and not
19 necessarily scientific in my mind.

20 And it's not the same the world over. So I see,
21 as I'm flying around different places in the world, or
22 I see different countries and their requirements and
23 whatnot, I see such a variety of mandates and
24 requirements, and it's not on science, it's on personal
25 belief or a political belief or whatever the case may
26 be, but not necessarily science.

1 So why the difference between Alberta and Texas,
2 for example? Why such a wide variety of understanding
3 of what COVID is, what the requirements are, and you
4 look at the percentage of COVID cases, there's really
5 no difference. If you look at John Hopkins, and you
6 look at what Texas has, and you look at Alberta, and
7 you look at percentages, they are just about identical.

8 Q Why do you think the College is acting political?

9 MR. MAXSTON: Mr. Chair, I might ask my
10 friend to rephrase that question. I think there's a
11 premise in that question that the College is acting
12 politically, and I don't know if this witness has any
13 information in that regard, and, again, I think we're
14 going very far from the core issues here.

15 MR. KITCHEN: Well, it wasn't a presumption
16 because that's what he said, so I just asked him why he
17 thought that. That's all. This is in the same line of
18 questioning you asked him, Do you think the College is
19 doing this for safety. Now, he has no knowledge of
20 that, he said so, but you asked him anyways. I'm
21 asking the same type of question, asking him why he
22 thinks the College is acting in a political manner.

23 THE CHAIR: I'll allow that.

24 A I don't see -- you look from Alberta Health Care, for
25 example, a lot of their decisions keep flip-flopping,
26 and it doesn't seem to be on science, it seems to be

1 political. You look at each level of government, it
2 seems to be political, not scientific.

3 Now, you say, Well, where are you getting your
4 information from. Well, I get it from a lot of
5 different sources. I read a lot of different -- and
6 I'm not just talking the main media; I go to different
7 places and do some analysis myself, and you start
8 looking at, typical is, John Hopkins, which you would
9 think would be a fairly reliable source with the data
10 that they present, and you look at percentages.

11 So why does Alberta have one set of rules, Calgary
12 have another set of rules, and you think that it's
13 political. So I'm going down the road there, yes, I
14 believe that everybody is doing it on a political side
15 of things and not necessarily a scientific.

16 So do I think that the -- your Association is
17 doing that? I feel that in a way, yes. I do not know
18 that you are doing it purely scientific.

19 MR. KITCHEN: Thank you. That's it for my
20 redirect.

21 THE CHAIR: Okay, I'll just quickly poll
22 the Panel, are there any questions that the Panel wish
23 to discuss before we release the witness?

24 Nothing further, okay. Okay, thank you very much.
25 You are excused, sir, and we appreciate your coming in,
26 and you can leave if you wish.

1 A Oh, good, thanks very much.

2 (WITNESS STANDS DOWN)

3 THE CHAIR: So, Mr. Kitchen, we have 15
4 minutes before your next witness; is that correct?

5 MR. KITCHEN: Yes, that's correct.

6 THE CHAIR: Okay, perhaps Ms. Nelson can
7 put us in break-out rooms until 10:45, and then we'll
8 reconvene. We'll adjourn for now and reconvene at
9 10:45 for the cross-examination of -- I'm sorry, I've
10 forgotten his name -- Kosowan; is that right?

11 MR. KITCHEN: That's right.

12 THE CHAIR: Yeah, okay. Mr. Maxston,
13 you're okay?

14 MR. MAXSTON: Yes, that's fine. Thank you
15 for asking.

16 (ADJOURNMENT)

17 THE CHAIR: We'll reconvene, and
18 Mr. Maxston will start his cross-examination of
19 Mr. Kosowan.

20 JARVIS KOSOWAN, Previously affirmed, Cross-examined by
21 Mr. Maxston

22 Q MR. MAXSTON: Good morning, Mr. Kosowan.

23 Can you hear me?

24 A Yes, I can.

25 Q Thank you. Can you just confirm for me that you're
26 still under oath when you're giving your testimony

1 today?

2 A Yes, I am.

3 Q I just have a few questions for you. The first
4 question I have is are you aware that the Alberta
5 College and Association of Chiropractors is the
6 professional regulator and licensing body for
7 chiropractors in Alberta?

8 A Yes, I am.

9 Q And are you also aware that the College has mandatory
10 requirements such as education before someone can
11 become licensed as a chiropractor?

12 A Not totally, no.

13 Q You'd agree with me though that, generally, that would
14 be the case to become a member of a profession?

15 A I would believe that would be correct, yes.

16 Q Are you also aware, or if you're not, would you agree
17 with me that the College of Chiropractors has ongoing
18 requirements to keep registration as a chiropractor,
19 things like continuing education or paying a yearly
20 fee?

21 A Yes, I'm aware of that.

22 Q And would you agree that the College, having those
23 requirements, is important to ensure chiropractors are
24 competent and can practice safely?

25 A I agree with that.

26 Q You spoke with Mr. Kitchen, my friend Mr. Kitchen, a

1 little while ago, and you talked about the College's
2 Pandemic Directive which required masking by
3 chiropractors when they treated patients; do you recall
4 that?

5 A Yes, I do.

6 Q And do you also recall that when you first testified,
7 you made comments in support of Dr. Wall not following
8 that requirement and not masking when he treated you?

9 A That is correct.

10 Q Would you agree that when you made those comments, you
11 could only speak for yourself?

12 A That is correct.

13 Q And would you agree with me that there could be other
14 patients of Dr. Wall who don't share your views?

15 A That's possible.

16 Q And would you agree with me that there could be other
17 patients of Dr. Wall who want him to comply with the
18 requirement to mask when he's treating patients?

19 A Obviously. I believe that's the way this whole thing
20 got initiated, by one of the clients complaining about
21 the mask not being worn, so I agree with that
22 statement.

23 MR. MAXSTON: Those are all my questions for
24 you, Mr. Kosowan. Thank you for making yourself
25 available today.

26 A Thank you. Am I done or --

1 THE CHAIR: Mr. Kitchen, did you have
2 anything on redirect?

3 MR. KITCHEN: No, I don't.

4 THE CHAIR: Well, Mr. Kosowan, thank you
5 very much, once again, for finishing with your
6 testimony. You are free to leave. We do appreciate
7 your assistance in this.

8 A All right, thank you very much.

9 THE CHAIR: Thank you.

10 MR. KITCHEN: Thank you.

11 (WITNESS STANDS DOWN)

12 THE CHAIR: So I guess we are on an
13 extended break, Mr. Kitchen, until 12:45; is that
14 correct?

15 MR. KITCHEN: Yes, that's correct, my
16 apologies, that's the earliest my next witness can be
17 available.

18 THE CHAIR: Okay, we will have an early
19 and extended lunch break I guess. Perhaps we can --
20 we'll reconvene at 12:45, and hopefully we'll -- and
21 that will be the last witness of the day for today; is
22 that correct?

23 MR. KITCHEN: Very likely. There is an
24 unlikely chance that the witness, who I was hoping to
25 call this morning but who's busy with work, may be able
26 to make it this afternoon after Dr. Gauthier. It's

1 unlikely, but possible; I'm just going to check with
2 him at lunch.

3 THE CHAIR: Okay, very good. Then we will
4 recess for now and reconvene at 12:45. Did the Panel
5 Members wish to caucus? I don't see a need to. Okay,
6 we'll see everybody back at 12:45. Thank you.

7 MR. KITCHEN: Thank you.

8

9 PROCEEDINGS ADJOURNED UNTIL 12:45 PM

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1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 November 16, 2021

Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees

Tribunal Chair

9 W. Pavlic

Internal Legal Counsel

10 Dr. L. Aldcorn

ACAC Registered Member

11 Dr. D. Martens

ACAC Registered Member

12 D. Dawson

Public Member

13 A. Nelson

ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC

ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen

Legal Counsel

20

21 K. Schumann, CSR(A)

Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 12:47 PM)

24 THE CHAIR:

The Hearing Tribunal is back

25 in session at 12:45, and Mr. Kitchen will be examining

26 on direct Dr. Gauthier.

1 MR. KITCHEN: All right. Well, Mr. Maxston,
2 you're ready to proceed?

3 MR. MAXSTON: Yes, I am, thank you.

4 MR. KITCHEN: All right, Madam Clerk, could
5 you please proceed to swear in Dr. Gauthier.

6 DR. JUSTIN ROBERT GEZA GAUTHER, Sworn, Examined by
7 Mr. Kitchen

8 Q MR. KITCHEN: Good afternoon, Dr. Gauthier.
9 Could you just please tell us your full name so we have
10 it for the record?

11 A Sure, Justin Robert Geza Gauthier.

12 Q Thank you. And, Dr. Gauthier, do you practice in
13 Alberta?

14 A Yes, I practice in Medicine Hat, Alberta.

15 Q And how long have you been practicing?

16 A About two-and-a-half years. I started in practice in
17 Medicine Hat in March of 2019.

18 Q Thank you. And where did you go to school?

19 A Palmer College of Chiropractic down in Davenport, Iowa.

20 Q And can you tell us anything that sticks out to you
21 that you were taught at Palmer College?

22 A Can you repeat that?

23 Q Is there anything you learned at Palmer College that
24 was particularly important to you?

25 A They had a good balance of teaching chiropractic,
26 integrating it within the medical system. I thought it

1 was a good balance of learning both sides of health.
2 So talked about the importance of keeping a body in a
3 frame, a structure, a spine that is balanced and in
4 line, while understanding there's other issues that
5 chiropractic does not deal with, and that's where we
6 kind of work as a team with the medical system, so I
7 thought it was a good balance of learning the health
8 system.

9 Q When you graduated and joined the profession here in
10 Alberta, were there any principles that you thought
11 were at the core of chiropractic?

12 A I think first and foremost our job is to take care of
13 the spine. That is the core of most chiropractors, and
14 manipulation or adjusting of the spine is I was taught
15 quite vital to the profession. There's many other
16 things that chiropractors will do in addition, but
17 adjusting and the spine was always the core primary
18 treatment that chiropractors would give.

19 Q And how do chiropractors administer that treatment?

20 A In their office, you've got to assess that person's
21 spine based on what you see, based on what you feel,
22 based on the feedback from the patient. Most
23 chiropractors adjust with their hands, some use an
24 instrument or a tool, but it's essentially always,
25 always with contact I guess.

26 Q And what's the primary treatment that you provide your

1 patients?

2 A I practice an upper cervical technique, so I focus on
3 correcting the neck as much as possible, so with my
4 technique there won't be more cracking. If a patient
5 needs that, I will have them go to another
6 chiropractor, and so I adjust with the upper neck
7 primarily, and it's a very low force technique without
8 twisting or cracking.

9 Q Okay, and what do you use to do that?

10 A But -- it's all by hand, yeah, it's all using --
11 adjusting by hand.

12 Q Now, forgive me if some of these questions are a bit
13 obvious, but can you provide that treatment from a
14 distance?

15 A I might lose my licence if I tried. I don't think it's
16 possible to do it without actually contacting the
17 patient. You can't -- I would not be able to properly
18 assess them. I wouldn't be able to properly adjust
19 them. I wouldn't reasonably be able to walk anybody
20 through treating themselves that way or having another
21 person treating them in that way, so, no, it wouldn't
22 be possible with what I do.

23 Q And forgive the redundancy, but you wouldn't be able to
24 provide that type of treatment over the phone?

25 A No. I've had a couple phone calls with patients as
26 follow-ups a few days later if they're from out of

1 town, and they can't -- just to ensure after their
2 first appointment that things are going well, and
3 they're not experiencing any issues, a checkup over the
4 phone, very, very seldom, less than since I've started
5 practicing, but the primary treatment is always in
6 person.

7 Q So do you think Telehealth could be effective for you
8 to help your patients?

9 A No, no, not with what I do and not with how the
10 chiropractic that I learned, you know, adjusting by
11 hand as your primary treatment, I would argue it's not,
12 it's not possible to do.

13 Q Do you think your patients would find it effective?

14 A No, I don't think I'd have any patients if I tried
15 doing that.

16 Q Do you believe you would be properly caring for your
17 patients if you could only provide Telehealth over the
18 phone?

19 A No, not at all. I wouldn't be able to properly assess
20 them. I wouldn't be able to feel or see what's going
21 on, and there's many intangibles that you get from
22 patients after you've seen them several times that,
23 over the phone, you simply don't get that you'll see
24 and hear when the patient is with you. So, no, I don't
25 think there's any way I would be able to take care of
26 patients to the same level that I am now, not even

1 close. I don't know what it would look like.

2 Q And if you could only provide Telehealth, you said
3 earlier that you don't think you'd have very many
4 patients, so what do you think your patients would do
5 if you could only provide Telehealth?

6 A I think they would go to another chiropractor, either
7 somebody in town that does maybe a different style, or
8 they would travel a couple hours to find someone that
9 does. I mean, that's what we have. I have a lot of
10 patients that come from Saskatchewan, Swift Current,
11 Moose Jaw, Regina from up to three, four, five hours
12 away, and they specifically come here because they
13 can't get what they want in those places, so they would
14 find somewhere else to go. I'd lose probably over 95
15 percent of my patients if I tried it. Maybe a hundred,
16 I don't know. I would lose a very exceptionally high
17 number of patients.

18 Q And forgive me if this question is a bit obvious, but
19 if you did that, if you only did Telehealth, would you
20 be able to earn enough income to keep practicing?

21 A I don't think so, not as I've learned to practice, not
22 as I've learned to practice chiropractic, or as I've
23 been practicing for the last two-and-a-half years. I
24 mean if I lost 95 percent of my patients, I wouldn't
25 have much income at all, so no.

26 Q I'm going take you in a slightly different direction

1 now.

2 A Sure.

3 Q Dr. Gauthier, are there different types of health care
4 workers?

5 A Yeah. Yes.

6 Q Do you think there's a difference between yourself as a
7 health care worker and so-called frontline health care
8 workers like nurses and doctors at a hospital?

9 A Yeah, I think we have very different roles and fulfil
10 different needs, yeah.

11 Q Do you regard your chiropractic office as a health care
12 setting?

13 A Yeah, it's a health care setting.

14 Q Are there different types of health care settings?

15 A Yeah, absolutely.

16 Q Is there a difference between your office as a health
17 care setting and a hospital as a health care setting?

18 A Having been a patient in a hospital and a chiropractor
19 in an office, it's my experience, yeah, they're very
20 different.

21 Q How so?

22 A Mainly just the types of patients and the types of
23 complaints that we get are very different, but I think
24 (INDISCERNIBLE) ER specific, it's very acute care or
25 injuries or accidents, whereas I've never
26 (INDISCERNIBLE) driven to my office in an ambulance,

1 right? That's not the role of my office is to take
2 care of people with their acute injuries that are more
3 serious, and that's in regards to, say, physical
4 injuries or bleeding, that type of issue.

5 In my couple of years practicing, I've never had a
6 patient come with a primary (INDISCERNIBLE) of a heart
7 attack --

8 THE COURT REPORTER: Primary what? Primary what?

9 A -- or come to me saying, Do I have a heart attack, or I
10 feel like I am, can you examine me? I've never had a
11 patient come, wondering if they're in the middle of a
12 stroke. I've never had a complaint of stroke or heart
13 attack. You know, I've had patients that I've sent to
14 be assessed for stroke, but that's never been the
15 primary complaint.

16 Same thing with pneumonia, bronchitis, or anything
17 like that, I've never had a patient come to me, saying,
18 Hey, I think I have pneumonia, can you help? I've
19 never had that type of complaint, whereas in the ER,
20 from what I've seen, that's a -- those are some of the
21 more common complaints that ERs get.

22 Q Thank you.

23 (DISCUSSION OFF THE RECORD)

24 Q MR. KITCHEN: So, Dr. Gauthier, let me ask
25 you this: Do you care about more than just the spine
26 of your patients?

1 A Yeah, of course.

2 Q Give me an example; what are some of the things that
3 you tend to care about when it comes to your patients?

4 A So just one example, recently I had a patient who has a
5 lot of pain and spine, like musculoskeletal issues, so
6 we went through (INDISCERNIBLE). She's also been a
7 smoker for 40 years and drinks, you know, five or six
8 or seven drinks of alcohol per night. And so at our
9 initial appointment, I said, Hey, like I can help you a
10 certain amount I believe, but the reality is that if
11 you continue, you know, smoking and drinking to this
12 level, you're going to have a difficult time getting to
13 your full potential, right; like there's a good chance
14 you're always going to have some issues if you continue
15 doing those things. It's not -- and I told her, it's
16 not up to me to make you stop, it's not up to me to
17 counsel you on how to stop, but to let you know it is
18 going to prevent, you know, your energy levels, your
19 fatigue, your immune system, your pain levels, all
20 those things, and I said I'm happy to find, if you
21 want, a counsellor to help with that, could be as
22 simple as a health coach or something. But that was
23 just somebody last week where I had to have that
24 discussion with her; it was, you know, beyond what I
25 could do, but I felt like if I didn't at least
26 acknowledge those limitations for her, I wasn't doing

1 her justice by just saying, I'm going to help you with
2 your spine and neck. So we had a discussion on that,
3 and she was open to looking at other things, so that
4 was one more recent example.

5 Q Do you care about the overall health of your patients
6 then?

7 A Yeah. Yeah. Totally, because I mean -- I mean, you
8 can see it in people when they're in physical pain, you
9 can tell when people are in a stressful state. Another
10 patient just last week was -- could tell was very -- in
11 a lot of mental distress, and, you know, for a couple
12 minutes, as I was treating her, she starts confessing
13 to me about stress within her marriage and other issues
14 that her concussion resulted in. You know, so I
15 listened and said, Hey, like that's again more than
16 what I do, and it's not my -- I'm not a marriage
17 counsellor, but I'm happy to help you find somebody
18 with that.

19 So, yeah, the emotional, the physical, the
20 nutritional. Those are all important aspects of it
21 that don't come up with every patient, but they do come
22 up.

23 Q When it comes to treating your patients, are there any
24 principles or ideals that guide you?

25 A Can you explain that a little bit or ...

26 Q Well, I can't too much or else Mr. Maxston will rightly

1 say that I'm leading you, so I'm just wondering if
2 there's -- do you have any core ideas about the
3 practice or core ideas about your approach to health or
4 core principles when it comes to interacting with your
5 patients that are really important to you as a
6 practitioner?

7 A Sure, so I mean my primary view of patients is to view
8 them as people, right, and to want to take care of them
9 the best that I can, right, and that's not telling them
10 what to do, not telling them what their treatment is,
11 and allowing them to make that decision for themselves,
12 and if they make a choice that I think is bad, that's
13 their choice, but it doesn't mean I don't take care of
14 them to the best of my ability, to treat those patients
15 with respect regardless of whether I think what they're
16 doing is good or not, they're still deserving that
17 respect and love that I think we're supposed to have as
18 health care providers.

19 So to me, that's kind of my core principle that
20 guides me is to take care of people to the best of my
21 ability without causing them harm and allowing them to
22 make choices whether I think it's good or not.

23 Q So that allowing them to make choices then, is that,
24 for you, is that the same idea as consent?

25 A Yeah, yeah, like they -- I can't force them to do
26 something that has an impact on their health or

1 otherwise, and I can't do something to them that they
2 don't want to. So if that day they came in, and they
3 don't want me to adjust them for whatever reason, even
4 if everything inside of me, everything that I'm seeing
5 about them says they need to be adjusted, I don't
6 adjust them, right, because that's their choice.

7 And if I think they shouldn't get a massage for
8 the next day for whatever reason, but they choose to,
9 that's their choice, and it's not going to affect how I
10 take care of them. They've got to decide for
11 themselves what they allow me to do and do at other
12 times as well.

13 Q You mentioned something in your last answer to me about
14 harm. Is it important to you to make sure you don't
15 cause any harm to your patients?

16 A Oh, yeah, yeah, I mean if I'm causing more harm than
17 good, (a), they're not going to come to me for very
18 long, and (b), I'm not -- even if they did continue
19 coming to me, I'm not doing my job as a health care
20 provider to create an overall improvement in their
21 health, right? So causing harm is a big part of that.

22 Q That's a good idea. All right, Dr. Gauthier, are you
23 aware that the Alberta College of Chiropractors has
24 mandated that all chiropractors must wear a mask when
25 they're treating patients?

26 A Yes.

1 Q And have you worn a mask while treating patients when
2 required to do so by the College?

3 A Yes.

4 Q Have you done so willingly?

5 A No, it's not been comfortable, but I still have done
6 it.

7 Q And why do you do it even though you didn't want to?

8 A I mean, it was in our practice directive, right, so the
9 way I understood it if I didn't, I wouldn't be able to
10 take care of patients, so it was kind of a -- didn't
11 really have a choice, a choice in that matter.

12 Q If you didn't have a choice for you, is that the same
13 as saying you were coerced into doing it?

14 A Well, yeah, I mean if there's not (INDISCERNIBLE)
15 choice for not doing something I'm supposed to do,
16 then, yes, it's not a choice. It feels like that to a
17 certain degree. Sorry, can you repeat that?

18 Q I think I said, to get it exactly right, for you -- is
19 for you not having a choice in doing something, is that
20 the same as coercion? And I believe your answer was
21 yes, with some explanation, but you did break up so
22 feel free to repeat it, if you can still hear me.

23 A I apologize James, I had a bad internet connection for
24 a bit. Can you repeat that?

25 Q Yes.

26 THE COURT REPORTER: Did you want me to read it

1 back?

2 MR. KITCHEN: Madam Clerk, yes, because that
3 way, I'm not slightly varying my question.

4 THE COURT REPORTER: (by reading)

5 Q If you didn't have a choice for you, is
6 that the same as saying you were coerced
7 into doing it?

8 A Sorry, can you repeat that, please?

9 THE COURT REPORTER: I'll give you more context if
10 that helps. Is that okay, Mr. Kitchen?

11 MR. KITCHEN: That's fine, yeah.

12 THE COURT REPORTER: Okay, a series of questions
13 and answers for you, Dr. Gauthier: (by reading)

14 Q And have you worn a mask while treating
15 patients when required to do so by the
16 College?

17 A Yes.

18 Q Have you done so willingly?

19 A Sorry, can we pause so I can try to (INDISCERNIBLE)
20 different location?

21 MR. MAXSTON: Mr. Kitchen, this isn't my
22 preference but -- because I'd like to see your witness
23 when he testifies, but sometimes turning off the video
24 can make it easier.

25 MR. KITCHEN: Yes, I was going to raise
26 that, because I understand your position on that.

1 Q MR. KITCHEN: Dr. Gauthier, if you could
2 turn off your video to see if that improves it, and
3 then we can decide from there how we want to proceed,
4 but we should just try it to see if it actually helps.
5 Is that all right with you?

6 A Sure, so I've got my video off here. Is this sounding
7 okay or not?

8 Q Sounding better so far. You let us know if you can
9 hear us better.

10 MR. KITCHEN: Madam Court Reporter, do you
11 mind reading my -- the first time I asked the question,
12 if you could read it to Dr. Gauthier again and see if
13 he's able to fully hear it and respond?

14 THE COURT REPORTER: (by reading)

15 Q If you didn't have a choice for you, is
16 that the same as saying you were coerced
17 into doing it?

18 A To me, it is, yeah, without a choice, it feels a
19 certain amount like coercion, whether the consequences
20 are severe or not. Yeah, when there isn't a choice, it
21 feels like that, a certain amount, yeah.

22 MR. KITCHEN: Well, Mr. Maxston, it does
23 seem to be a little better with his video off, but I'm
24 sensitive to the fact that you want to be able to see the
25 witness. Do we want to go back to having his video on,
26 and then as needed, we'll (INDISCERNIBLE) the question?

1 MR. MAXSTON: Well, I'll ask Mr. Lawrence if
2 he has any concerns, but I'm prepared, frankly, to go
3 ahead without the video.

4 MR. LAWRENCE: I have no concerns.

5 THE CHAIR: I think, Mr. Kitchen, we could
6 try having his audio through a cell phone, but let's
7 continue with this option to see if this solves it,
8 because I know there's synchronization problems when
9 you have different audio and video links.

10 MR. KITCHEN: Okay, thank you.

11 Q MR. KITCHEN: All right, Dr. Gauthier, we're
12 going to try it with the video off, see if that
13 improves the audio. It does typically, so we'll go on
14 that basis for now.

15 A Okay.

16 Q So thank you for your answer to my last question.

17 So let me ask you this because you said you don't
18 wear the mask willingly, can you tell me what's
19 difficult about wearing the mask for you or why don't
20 you willingly wear it?

21 A Sure. So, yeah, I've got asthma, and it's --
22 typically, it's pretty well controlled, I haven't
23 really had issues with it over the years. I noticed
24 shortly after needing to wear the mask, whenever it was
25 in 2020, March or April, when we were supposed to wear
26 them, not just at work, but, you know, in the hours and

1 days after working, I just noticed a lot more
2 difficulty breathing. I just noticed, in general, my
3 asthma flaring up considerably. It was hard to know
4 first if it was the mask or whether -- there was a lot
5 of variables, but that's kind of been the one constant
6 was that.

7 And it definitely has been for me, the last
8 year-and-a-half or so has been the worst -- the most
9 difficulty I've had breathing in relation to, you know,
10 asthmatic symptoms that I've had in, I don't know, at
11 least ten years. I've gone through more inhalers than
12 I had for a long time.

13 I notice especially at the initial appointment
14 where there's more talking, because I spend a lot of
15 time with patients, I was just getting short of breath
16 much quicker. So I just had a lot of difficulty
17 breathing, and I recognize not everybody feels that
18 way, but, you know, with the way that my asthma has
19 been, it's been difficult, yeah.

20 Q Speaking now just for yourself --

21 A Yeah.

22 Q -- do you regard your asthma as a medical -- as a form
23 of a medical disability?

24 A Yeah, like I didn't really think of it like that, you
25 know, until the last year or so when I recognized how
26 limiting it's been, but, yeah, it's definitely caused

1 me some distress or dysfunction.

2 Q Are you aware that, due to human rights legislation in
3 the Province, that there are sometimes obligations on
4 parties to accommodate medical disabilities?

5 A Yes.

6 Q Have you ever asked the ACAC if they would accommodate
7 you and your asthma medical disability?

8 A No, I haven't.

9 Q When the ACAC mandatory mask directive was issued to
10 the Practice Pandemic Directive in the spring of 2020,
11 did the College give you any reason to think that it
12 would permit you to treat patients without wearing a
13 mask if you told them about your medical disability and
14 asked for accommodation?

15 A I honestly can't say I remember what I thought when I
16 went through that first directive. For me, the reason
17 I didn't ask I guess, from what I'm remembering, was
18 that I got the impression that I just -- I wouldn't be
19 able to treat patients whether I had an exemption or
20 not, but, again, I can't -- I don't have that practice
21 directive from that time memorized or remember it
22 perfectly.

23 Q But what gave you the impression that the College
24 wouldn't accommodate you?

25 A Well, in the directive, again from what I remember, it
26 was very clear that wearing a mask was required no

1 matter what, so it didn't seem worth it to even try to
2 get an exemption or ask about an exemption or, you
3 know, go to a medical doctor over that.

4 Q Now, you've touched on this, but just to clarify --

5 A Yeah.

6 Q -- however small or however large, do you think wearing
7 a mask the last year-and-a-half while treating patients
8 has caused you any degree of harm?

9 A Yeah, I mean I think so. I've definitely noticed like
10 just more restriction in general, having to wear the
11 mask, you know, at work, because we're, you know, here
12 lots of the time. Yeah, I find myself out of breath
13 just talking to patients, which is not a normal
14 experience for me. So I mean that combined with the
15 fact that I've gone through more inhalers, you know,
16 which I would much prefer not to do, yeah, it's
17 definitely made -- just restricted my lung function.

18 Q Do you think informed consent should be obtained before
19 someone requires somebody else to wear a mask?

20 A I do, because I think it has an impact on health. It
21 doesn't necessarily impact everybody in health, but
22 some people it does. I know many patients will say
23 they hate wearing it because it restricts them; other
24 patients say they don't care.

25 But I've seen that same principle at work in
26 certain types of shoes, some people put on a pair of

1 shoes that cause them lots of foot and hip and knee
2 pain, and other people put the same pair of shoes on,
3 and it doesn't bother them whatsoever. So I've just --
4 I've kind of come to realize that because something
5 does not cause one person harm or discomfort doesn't
6 mean it doesn't do that to another.

7 So because it impacts health, I mean I've noticed
8 impact to my energy levels and fatigue and breathing,
9 if it's going to be mandated or examined or pushed, I
10 think it should be -- it is -- the idea of informed
11 consent should be applicable to it as well, yeah.

12 Q Was informed consent obtained from you by the College?

13 A No, there was no questions or answers or anything about
14 it. It was just part of the practice directive that we
15 had to wear it if we wanted to keep treating patients.

16 Q You mentioned your patients commenting on masks, so
17 have you noticed that, in some of your patients,
18 wearing a mask has negatively impacted their health?

19 A Yeah, I've had a lot of patients mention it, and it's
20 hard to know because there's -- again, there's so many
21 variables, but many, many patients have mentioned just
22 their general like energy levels or if it's fatigue,
23 some of them have noticed headaches when they're
24 wearing it. Some of them it's very acutely, they have
25 symptoms within minutes of wearing a mask. When you
26 see it so many times, and it's so strongly correlated

1 with certain patients, it's hard to deny it. Yeah,
2 it's definitely come up.

3 And like I said, some patients don't notice a
4 change at all, whereas some patients really do, and
5 I -- I mean, I've had some patients develop skin rashes
6 and, you know, acne-type issues. I myself, about three
7 months into wearing a mask, ended up with quite a
8 significant boil on my nose that I never had before.
9 Again, is it attributable to the mask? Maybe, maybe
10 not but it was definitely a very noticeable change
11 shortly after starting to wear them.

12 Q I'm going to ask you some different questions now. Do
13 you think it's possible, Dr. Gauthier, to actually know
14 the scientific truth about things like viruses?

15 MR. MAXSTON: I'm going to have to object to
16 that, Mr. Kitchen. This is a lay witness not being
17 called for expert opinion evidence, and I think I've
18 been pretty generous in the types of questions you've
19 asked. You've got four experts coming. I am going to
20 object to this, because I think this goes far afield of
21 what this witness can testify to as a lay witness.

22 MR. KITCHEN: Okay, I understand what you're
23 saying, and I agree with you. I haven't in any way
24 asked for an opinion, but I think maybe if you'll let
25 me go, you'll see I'm not going to ask his opinion on
26 COVID or the effectiveness of lockdowns; he isn't

1 qualified to give that. I'm asking him if he thinks
2 it's possible to know the scientific truth, not what
3 that truth is, but if he thinks it's possible to know
4 that truth, and that's not an opinion question; that's
5 a question that could be asked to anyone.

6 MR. MAXSTON: I suppose, frankly -- well, I
7 guess you can ask your question. I'm not sure what the
8 value of it is, because you're right, I guess it's a
9 possibility for everyone to know the truth, but I'll
10 let you know if I'm concerned you're kind of heading
11 off in the wrong direction.

12 MR. KITCHEN: Okay, thank you.

13 Q MR. KITCHEN: So, Dr. Gauthier, let me ask
14 you that again.

15 A Sure.

16 Q Is it possible -- speaking for yourself, right?

17 A M-hm.

18 Q From your perspective, is it possible to actually know
19 the scientific truth about things like viruses?

20 A Given time and observation and enough people and study,
21 I think it's possible, yeah.

22 Q Speaking for yourself, from your perspective, is there
23 enough scientific information now available to you for
24 you to determine if restrictions like masking and 2
25 metres distancing are effective or not effective in
26 preventing the transmission of COVID?

1 A Can you repeat that?

2 Q Sure. Is there enough scientific information now
3 available to you for you to be able to make an
4 assessment if restrictions like masking and distancing
5 are actually effective or not at preventing the
6 transmission of COVID?

7 A Well, I think there's quite a bit of evidence about
8 those things that have come out in the last
9 year-and-a-half. I mean, I have opinions on it, but,
10 yeah, I do think there's a lot of information that's
11 available to tell us how likely it is that they're
12 helping or not.

13 Q And as far as you're concerned -- and, again, I don't
14 want you to give me your opinion -- but for you --

15 A M-hm.

16 Q -- is there enough scientific information available for
17 you to be able to make an assessment whether masking is
18 working and should be supported or is not working and
19 should be opposed?

20 A I think, yeah, there is a decent amount of evidence --
21 there's a decent amount of evidence demonstrating --
22 I've seen a decent amount of evidence demonstrating
23 that they may not be working as well as we want them
24 to. To say with a hundred percent certainty, I can't
25 do that, but I think the evidence is there.

26 Q Do you think the mask mandate of the College is 100

1 percent based on science?

2 A No.

3 Q And if it's not 100 percent based on science, what do
4 you think of the other things that it's also based on?

5 A Do you mean what other -- what other ideas is it based
6 on, or are you talking about like masking or -- like
7 are you talking specifically of masking in that --

8 Q If mandating masking is not 100 percent based on
9 science --

10 A M-hm.

11 Q -- then what else do you think it's based on?

12 A What is it based on, okay. So from my experience, a
13 lot of the decision -- the decision especially with,
14 say, patients and masks, they're not mandated to wear
15 any particular kind, right? We know some masks are not
16 very effective, some masks are a little more effective.
17 So the masks that we're mandated to wear, the surgical
18 or N95 have a little bit better use, still not great,
19 but a little bit better.

20 Whereas patients, they don't have to wear the
21 masks properly. There could be gaps in it. They could
22 be wearing a mask that filters out an extremely
23 miniscule amount of, you know, viral particles. We
24 know that the virus is, in many ways, say largely
25 airborne in addition to other modes of transmission.
26 And so when patients are coming in with all these

1 different kinds of masks that don't work, I know that
2 it is not doing the job that it is supposed to, that we
3 want it to, but we do it a certain amount out of fear
4 or to say we're doing something; it's better to do
5 something than nothing. So I'm not entirely sure
6 what -- you know, what's driving that.

7 But when I look at, you know, what I see in the
8 clinic specifically, if I stick to the workplace, what
9 patients wear and what they're allowed to wear as per
10 the mandate, it's doing very little to prevent -- if
11 they did have COVID, right, if they were symptomatic
12 for COVID -- or not symptomatic but had COVID. So
13 there's the science part of it, but there's also maybe
14 the optics part of it. We don't want to be afraid of
15 doing something that is wrong, so we err on the side of
16 caution, but, again, that's not necessarily a
17 scientific debate, that's a, you know, say, ethical or
18 moral thing.

19 So I know that's a long-winded answer, but, yeah,
20 it's hard to know what it's based on when it's not a
21 hundred percent on science.

22 Q Thank you. You mentioned fear, what do you think the
23 fear is of?

24 MR. MAXSTON: Mr. Kitchen, I do have to
25 object here formally. There's been a lot of
26 information from this witness, and I know he's

1 responding to your questions, we're talking about what
2 is or isn't effective in masking, what does or doesn't
3 prevent COVID. Again, I think we're now going far
4 afield. He can't speculate on fear; I don't know how
5 he can comment on that. He's not a psychologist; he's
6 not a public health provider. I'm going to have to
7 object to this line of questioning. I just don't think
8 it's appropriate for a lay witness. And I'll ask the
9 Chair to, in concert with the Tribunal Members if
10 necessary, make a ruling on that.

11 MR. KITCHEN: Well, Chair, I'd like him to
12 be able to answer the question, so I guess I'll put it
13 to you to make a ruling on that.

14 THE CHAIR: Would you repeat the question,
15 please, Ms. Schumann.

16 THE COURT REPORTER: (by reading)

17 Q You mentioned fear, what do you think the
18 fear is of?

19 THE CHAIR: That's the question you wish a
20 ruling on?

21 MR. KITCHEN: Yes, please.

22 THE CHAIR: Okay. We'll take a break for
23 5 or 10 minutes and caucus and come back with an answer
24 for you.

25 MR. KITCHEN: Thank you.

26 (ADJOURNMENT)

1 THE CHAIR: Okay, we're back in session.

2 The Hearing Tribunal has discussed the objection
3 to the question, and we are going to sustain the
4 objection. We feel this would be pure speculation on
5 the part of this witness on what others fear, and we
6 don't believe that's appropriate. We're also of the
7 feeling that it's nonprobative, and it's not going to
8 be helpful in terms of finding a ruling on this issue,
9 so the objection is upheld.

10 MR. KITCHEN: Thank you.

11 Q MR. KITCHEN: Dr. Gauthier, just a couple
12 more questions. Does the phrase "First, do no harm"
13 mean anything to you?

14 A Yeah, that's our primary directive. It doesn't matter
15 how much good we're doing, if we're, at the same time,
16 harming in a small way or maybe outweighing the
17 benefits, so, yeah, it's, to me, one of the most
18 important aspects of health care.

19 Q When you say, "we", you said something about that's our
20 primary directive; when you say "we", who are you
21 referring to?

22 A I mean, I'm referring to chiropractors primarily, but I
23 would apply it to all health care providers.

24 Q Do you think it should apply to health care regulatory
25 bodies like the College of Chiropractors or College of
26 Physicians?

1 A If something that's being mandated affects something in
2 regards to health, then yes.

3 Q Do you think mandating masks aligns with the principle
4 of "First, do no harm"?

5 A No, no, I don't, because, as I said before, it may not
6 affect Person A negatively, but it may affect Person B
7 negatively, and until each individual person is
8 assessed, it's really difficult to know how it's going
9 to affect those people. So, you know, it may be not
10 doing harm to someone, but it might be doing harm to
11 another, and the mandate is kind of a blanket
12 treatment, so to speak, so I'm not sure it was
13 considered or should be.

14 MR. KITCHEN: Those are all my questions.

15 THE CHAIR: Thank you, Mr. Kitchen.

16 Mr. Maxston, did you want a short break before you
17 start?

18 MR. MAXSTON: You know, I don't think I need
19 a break, but I just want to double-check with
20 Mr. Lawrence. Can we maybe have 10 minutes?

21 THE CHAIR: Yes. It's -- let's reconvene,
22 we might as well take a break now, and then we'll push
23 through for the afternoon, so let's come back at 2:00.
24 We'll close the hearing for now and be back at 2.

25 (ADJOURNMENT)

26 THE CHAIR: I think we're back in session,

1 and the floor is Mr. Maxston's for his
2 cross-examination of Dr. Gauthier.

3 Mr. Maxston Cross-examines the Witness

4 Q MR. MAXSTON: Good afternoon, Dr. Gauthier.
5 I can't see you, but I'm assuming you can hear me and
6 see me?

7 A Yeah, as long as you're okay without the video for now,
8 I am here.

9 Q Yeah, that's just fine. So I want to start --

10 A Okay.

11 Q -- off, Dr. Gauthier, with just some basic questions.
12 I'm sure you'd agree with me that the College is the
13 licensing and regulatory body for chiropractic in
14 Alberta?

15 A Yeah, that's correct.

16 Q And you'd also agree with me that for you to become a
17 regulated member of the College, you had to go to an
18 approved educational institution like Palmer; there was
19 a requirement for you to become a chiropractor; is that
20 correct?

21 A Correct.

22 Q And would you also agree with me that in order to keep
23 your licence as a chiropractor, you have to meet
24 ongoing requirements that the College issues, like
25 continuing competence, for example?

26 A Yeah, those are all things that were laid out

1 beforehand, and, yeah, those were expectations I
2 understood.

3 Q So I want to ask you some questions in that context
4 about your comments with my friend about the fact that
5 the Pandemic Directive was coercion and that you
6 were -- you had no choice but to comply with it, and
7 I'm going to suggest to you, Dr. Gauthier, that
8 something like mandatory continuing competence, you
9 don't have any choice in that, do you?

10 A Correct.

11 Q But that isn't coercion, is it?

12 A I think because it was something I knew, going into it,
13 I do see it as a little different, but there is a
14 difference between expectations and coercion; yeah,
15 there is an expectation.

16 Q I guess you knew what it was when you were going into
17 it, but continuing competence changes over time,
18 doesn't it, or can change over time?

19 A Yeah, I can't comment on that. I imagine it can change
20 a certain amount, but there is a limit to that change.
21 I don't know what that would be.

22 Q So if the College sends you a bill each year for \$250
23 for your yearly practice permit, you don't have any
24 choice about paying that, do you?

25 A Correct.

26 Q And having said that though, that isn't coercion, is

1 it; it's just something you have to do to be a member
2 of the profession?

3 A Yeah, that's correct.

4 Q So when it comes to something like the Code of Ethics
5 or the Standards of Practice that the College issues,
6 you don't have a choice about whether to comply with
7 them, do you?

8 A No, there's -- no, there's not a choice in whether you
9 comply with that, no.

10 Q And I would, again, suggest to you that complying with
11 the Code of Ethics or the Standards of Practice isn't
12 coercion, it's just part of the responsibility of being
13 a professional; would you agree with that?

14 A Yes, yeah.

15 Q You talked about -- with my friend, Mr. Kitchen, about
16 the College not getting informed consent with you. I'm
17 going to suggest to you that the concept of informed
18 consent applies to a caregiver and a patient; isn't
19 that correct?

20 A I think it's correct with some caveats, I think. When
21 there's -- when someone is doing something to you that
22 has a direct impact on your health, I think they are,
23 de facto, a care provider in that particular instance,
24 so, yes, but I think there is a caveat in there.

25 Q Well, let me ask you this: You're aware of the Chief
26 Medical Officer of Health orders that have come out

1 from time to time in the pandemic requiring masking,
2 for example, not just chiropractors but the public?

3 A Yeah, correct.

4 Q When the Chief Medical Officer of Health issues those
5 orders, there is no requirement to get consent from
6 anyone, is there?

7 A I don't know if there is or isn't by law. I think
8 there largely hasn't been, but I don't know if there
9 is, or I don't know what the legality is on that.

10 Q Would you agree with me that the primary purpose of the
11 College, if you look at the Health Professions Act or
12 otherwise, the primary purpose of the College of
13 Chiropractors, like other colleges, medical colleges,
14 healthcare colleges, is public protection?

15 A The primary goal?

16 Q Yeah.

17 A Again, I don't have that memorized, but I was kind of
18 under the impression that the primary goal is
19 protection of individual patients not necessarily the
20 public, and I think there is a distinction there.

21 But --

22 Q Yeah, sorry, were you finished?

23 A Yes, yeah. I apologize.

24 Q Okay. You talked about, with my friend, Mr. Kitchen,
25 you talked about the Do No Harm principle, and I think
26 you said, when talking about masking, that it may not

1 affect Person A negatively, but it could affect
2 Person B negatively, and it's difficult to know that.
3 Would you agree with me, Dr. Gauthier, that regulators
4 like the College can't assess individuals; they have to
5 put in place general requirements for the profession?

6 A I guess from a -- from like a fundamental standpoint,
7 it would be very difficult to assess each individual
8 person, but I think that would be the correct way to
9 go. Whether they could or not, I can't speak to that.

10 Q I'll just give you an example. You know, when we talk
11 about the College's Standards of Practice for informed
12 consent or charting, the College doesn't, of course,
13 have to go out and poll patients and poll individual
14 chiropractors when they create those kinds of
15 directions, do they?

16 A I'm not sure I understood what your question was there.

17 Q Well, maybe I'll turn to a different aspect here. I
18 take it your position is that where a college
19 requirement, in your view, harms a patient, you can
20 decide not to follow it; is that correct?

21 A No, that's a pretty broad statement, so, no, I can't
22 say I would agree to that.

23 Q So is it fair to say then you think members of a
24 profession can't selectively decide what requirements
25 of their profession to follow and then not follow?

26 A So if I'm looking at letter of the law, like to --

1 yeah, to try to explain it as well as I can, if our
2 Alberta Human Rights Act says one thing and the College
3 mandates another, I'm kind of put at a crossroads, and
4 I'm put in kind of a lose/lose situation as a
5 practitioner. And what I would do in each individual
6 circumstance, I can't say. I mean, that's theoretical
7 and projecting and subjective based on that time.

8 If the Human Rights Act says one thing and the law
9 says one thing and the College says another, yeah, it
10 puts it in a very difficult position, and then you do
11 have to choose whether you are going to do what the law
12 says or do what the College says, and I don't like that
13 that happens -- or if -- I don't like that that could
14 happen, but it, you know, logically could occur.

15 Q Well, I guess, we'll leave the human rights legislation
16 argument to a different day, but I think what I was
17 driving at -- sorry, are you okay, can I continue?

18 A Sure.

19 Q What I was driving at is, in your discussions with
20 Mr. Kitchen, you said that you don't believe the
21 College's Pandemic Directive is valid; is that fair to
22 say, and I should say masking?

23 A No, I didn't say valid. I didn't -- I said I didn't --
24 I wasn't convinced that it was based 100 percent on
25 science. And I say that because science doesn't tell
26 us what we should do; science tells us what will happen

1 or what most likely will happen with a given situation,
2 but ethics and morals and politics look at what we
3 should do in a given situation.

4 So to say it's a hundred percent based on science
5 is not accurate, because science doesn't tell us what
6 should happen; it tells us what might. I didn't say it
7 wasn't valid; I said I didn't think it was a hundred
8 percent based on science.

9 Q So is it fair to say that you do think it's valid?

10 MR. KITCHEN: Well, hold on, hold on. I
11 mean, we can look at the record, but you didn't use
12 that word or even a synonym for that word, so -- and,
13 you know, he's already told you that -- he's already
14 explained what he said, and it's totally different from
15 his question, so I have an issue with that.

16 MR. MAXSTON: I guess, Mr. Kitchen, in his
17 response, he said to me, I didn't say it was invalid,
18 so I'd like to ask him whether he thinks it's valid. I
19 think that's a reasonable question.

20 MR. KITCHEN: Well, okay, I guess my problem
21 is is that's vague. That was relative to what? Valid
22 legally, valid scientifically, valid (INDISCERNIBLE).
23 If you could just qualify it, I think it would be okay.

24 MR. MAXSTON: Yeah, well, you know, fair
25 enough, I guess it's his word, Mr. Kitchen, but, you
26 know, I'll ask Dr. Gauthier.

1 Q MR. MAXSTON: Do you think the College's
2 Pandemic Directive was valid in terms of you as a
3 professional?

4 A Like valid like for what, what goals? Like do I think
5 it was valid in terms was it like reasonable
6 expectations for me, valid in terms of did it do the
7 job of preventing infection? In what way do you mean?

8 Q Well, I'm going to take a different sort of approach on
9 this, but I just want to go back and say, just to be
10 clear, you didn't agree with the masking requirement
11 the College issued; is that fair to say?

12 A For my particular situation, yeah, I found it pretty
13 restricting, and I wish it was not a requirement for
14 me, yeah.

15 Q And I think it went a little bit more than sort of, you
16 know, you personally and your asthma condition, I think
17 you said that you were concerned that there wasn't
18 science that would support it; is that fair?

19 A Yeah, I think that's fair. I'm not -- I wasn't
20 convinced that there was complete agreement as far as
21 saying, Wear a mask, that the benefits were very
22 obviously outweighing the risks for our particular
23 setting. I'm not convinced that for our setting when
24 there's other options like, you know -- not other
25 options, but when there are other settings that can be
26 more, say, an issue with this particular Coronavirus,

1 when I look at the type of patients, the screening that
2 we do, I wasn't convinced that it was the best
3 decision, yeah.

4 Q Yeah, and that's kind of what I was getting at when I
5 was going back to my questions that Mr. Kitchen --

6 A Okay.

7 Q -- objected to. I just wanted to kind of establish
8 here that you had a personal/medical/scientific
9 objection, I guess, to the application of the
10 directive. What I think is important here though is
11 despite your concerns about the science or your medical
12 condition, your personal views, you still chose to
13 follow the masking directive; that's correct?

14 A Yeah, because for my situation, I didn't see any other
15 option.

16 Q And you're aware that Dr. Wall did not follow the
17 Pandemic Directive in terms of masking?

18 A I don't -- yeah, I don't know on the details, I don't
19 know if he had an exemption or not, but -- or if that
20 matters, but, yeah, it sounds like he wasn't doing it,
21 and that was kind of how he chose to go about it, I
22 guess.

23 THE CHAIR: Dr. Gauthier, are you moving
24 away from your microphone, because your voice is fading
25 and then coming back in.

26 A Okay, I apologize. No, I wasn't moving, but I'll try

1 to sit maybe closer, more still.

2 MR. MAXSTON: Mr. Kitchen, I hope you'll
3 just allow me a little bit of latitude here, I'll just
4 go back.

5 Q MR. MAXSTON: And my question to you,
6 Dr. Gauthier, was you were aware that, unlike yourself,
7 Dr. Wall did not comply with the masking Pandemic
8 Directive requirements from the College; is that
9 correct?

10 A I was aware he had -- he was not wearing the mask while
11 treating patients, yes.

12 Q And I think it's fair to say, would you agree, that you
13 ultimately concluded you could not disregard your
14 regulatory bodies or your College's direction; is that
15 correct?

16 A Yeah, because when I looked at the risk and the
17 benefits, I was still able to function, albeit at a
18 lower level; say, you know, as far as headaches and
19 fatigue and breathing and energy, I was able to
20 function. So my circumstance, it was not worth it to
21 not comply even though I didn't want to. But, again,
22 everybody has to weigh that themselves, and that was
23 the conclusion that I ultimately came to for me.

24 Q I think this will be my final question. When you say
25 so each person or everyone has to weigh that for
26 themselves, do you think, again, a member of a

1 profession can decide what requirements of his or her
2 college they have to follow and what ones they don't?

3 MR. KITCHEN: Hold on. My only issue with
4 that is just it requires a qualification. I mean, are
5 you asking legally, or are you asking practically,
6 ethically?

7 MR. MAXSTON: I'll just say ethically, and
8 I'll repeat the question.

9 Q MR. MAXSTON: But as a professional, do you
10 think that members of a profession can decide what they
11 will and won't follow from their college?

12 A So, I mean, since you qualified it as "ethically", I
13 mean I would say no. If the College mandated that I
14 could only -- and, again, this is very theoretical,
15 because when you're dealing with ethics and morals, it
16 is largely theoretical -- if the College mandated I was
17 only allowed to care for males or only care for females
18 or only care for a certain person, I would have to look
19 at that ethically and say that's wrong. And I do
20 believe it's up to the individuals to say, ethically,
21 what is correct and incorrect, and if there's something
22 they believe is wrong, then they should not be forced
23 to go through with doing something they believe is
24 incorrect.

25 Q If you think you have a concern or a problem with
26 following one of your College's requirements, do you

1 think you have to talk to the College about that?

2 A Yeah, I mean especially depending -- in most
3 circumstances, probably, yeah.

4 Q I'm going to go back to your example, but if you
5 decided that, boy, my asthma is so bad or my objections
6 to the directive are -- you know, my science-based
7 objections are so significant, would it --

8 A M-hm.

9 Q -- be fair to say before you disregard the or not
10 comply with the directive, you should reach out to your
11 college and try and explore options?

12 A I think, again, that depends like on how -- like I'd
13 have to go back to the mandate and look at it and
14 compare that to what we are supposed to do or what is
15 allowable, and from a human rights perspective, if my
16 understanding -- like if I was in that situation and my
17 understanding was that if there was an exemption,
18 whether it had to be official or if my understanding
19 was that an exemption was just a health condition, and
20 I didn't require any sort of note, if I was under
21 the -- under the -- if I was with the understanding
22 that I had a legal exemption to following the mandate,
23 I don't know that I would first think to ask the
24 College about that if the mandate said to me exemptions
25 are allowed or if the mandate said to me you have to
26 wear a mask but then the law says you don't have to

1 with an exemption, it probably wouldn't be my first
2 instinct to ask the College if it's seems clear that
3 there are exceptions to that rule, so --

4 Q I just want to -- oh, sorry.

5 A No, no, that's okay, go ahead.

6 Q So I just want to understand that if you think you've
7 got a legal exemption to a College requirement, you
8 don't have to let the College know that you're not
9 going to follow it?

10 A No, I don't know that. I'm saying so in this
11 situation, if the mandate said that we have to wear --
12 again, I'd have to go back and look at that mandate
13 from April 2020 or whatever it was, then if that
14 mandate said that we had to wear masks, but then I also
15 look at the law and the legality within the Human
16 Rights Commission, as one example, and if the Alberta
17 Human Rights Commission says you do not have to wear a
18 mask with an exemption, then I would look at that and
19 say that makes sense to me that I would not have to.

20 And if it was clear enough to me that I didn't
21 have to, I don't know that it would be my first
22 instinct to ask the College if the law seems very
23 clear. I can't speak to every circumstance, and I
24 can't speak to every issue, but on that particular
25 issue, if my interpretation was the law, it was that --
26 was in that way, I don't know that I would ask for

1 permission --

2 Q So last year when the directive came out, and --

3 A M-hm.

4 Q -- I'm going to assume for the moment, you didn't have
5 a Human Rights Commission ruling --

6 A M-hm.

7 Q -- you know, about your condition, you decided --

8 A M-hm.

9 Q -- to follow the Pandemic Directive with reluctance?

10 A Yeah, because in my case, again, it was -- you know, it
11 takes effort if I want to go that route. Say, if I
12 thought I needed an exemption, you hear through doctors
13 and patients that doctors are not really writing
14 exemptions, maybe I have to go see a specialist,
15 fitting that into my schedule; there's just a lot of
16 barriers to doing that, time being one of them.

17 And at that time, with the amount of negative I
18 experienced with a mask, it wasn't worth it for me at
19 that time. If it was worse, say I noticed significant
20 headaches, or if I noticed I was having significant
21 issues breathing, then it would have been worth it for
22 me to go and get an exemption and deal with that in
23 that way, but in my situation, it wasn't.

24 Q I just have one final question for you, Mr. Kitchen and
25 you engaged in a discussion about how the Pandemic
26 Directive was created and your concerns I think about

1 whether there were other elements that went into the
2 creation of it other than perhaps science; you don't
3 have any direct knowledge of how the Pandemic Directive
4 was created or on what basis it was created, do you?

5 A No.

6 MR. MAXSTON: Those are all my questions.
7 Thank you, Dr. Gauthier.

8 A Thank you.

9 THE CHAIR: Can I just remind everybody,
10 we're picking up a lot of paper shuffling from the
11 microphones, so if you're not involved in an exchange
12 or a discussion, please mute. It's getting
13 distracting.

14 Thank you, Mr. Maxston. Mr. Kitchen, anything on
15 redirect?

16 MR. KITCHEN: No.

17 THE CHAIR: Okay, any of the Panel Members
18 have a question? I would actually like to caucus with
19 the Hearing Tribunal for a moment. There may be a
20 question, so if you could bear with us. We would like
21 to go into our break-out room, please, Ms. Nelson.

22 (ADJOURNMENT)

23 The Chair Questions the Witness

24 Q THE CHAIR: There's one question that came
25 up, Dr. Gauthier, Mr. Maxston referred to getting an
26 exemption, but the Hearing Tribunal wanted to ask you

1 if you did go to the trouble and time and effort to get
2 an exemption, what would you do with it?

3 A What would I do with the exemption?

4 Q Yes.

5 A Well, I mean if my health was being compromised enough
6 that I felt like it was wronging me and I couldn't
7 practice, I would have that exemption, and I suppose I
8 would use it as much as possible, as much as I felt was
9 needed. Anything with health is -- I guess I'm not
10 sure what you mean.

11 Q Would you feel the need to provide that exemption to
12 anybody? How would people know if you had an
13 exemption?

14 A I don't know that -- I mean -- by law, I don't know if
15 they're required to know. I don't know that I would
16 take it that far, because I'm not necessarily that kind
17 of person that, you know, says, Oh, it's my freedom and
18 my right, and this is the law, so I'm going to go by
19 letter of the law. I think if patients ask, I would
20 have no problem providing that exemption even if
21 they're not -- even if I'm not obligated to do so.

22 THE CHAIR: Okay, that's fine. Thank you,
23 Dr. Gauthier.

24 A Okay.

25 THE CHAIR: I believe that that's the end
26 of your testimony with us this afternoon. Thank you

1 for coming in, and you are free to leave, sir.

2 A Thank you very much. Have a good afternoon.

3 THE CHAIR: You too.

4 (WITNESS STANDS DOWN)

5 Discussion

6 THE CHAIR: Mr. Kitchen, do we have
7 another witness coming today or is --

8 MR. KITCHEN: I don't believe so. Like I
9 said, I wanted to have -- yeah, no, Mr. Elvin Music has
10 told me he's still stuck at work, so either we won't be
11 calling that witness or we will try to fit him in
12 during one of the days scheduled for the scientific
13 experts.

14 THE CHAIR: Okay, with that in mind,
15 perhaps I could ask you and Mr. Maxston what the agenda
16 for Saturday will look like.

17 MR. KITCHEN: So I'm calling two witnesses,
18 Chris Schaefer is first, Dr. Bao Dang is second. Based
19 on history, I thought it was ambitious to even try to
20 get those two in during that day. What I'm hoping is
21 that we can get through Chris Schaefer in the morning.
22 His report's pretty small. Obviously, that depends on
23 how much he talks and Mr. Maxston crosses, but,
24 ideally, we would get through that in the morning; that
25 would leave the entire afternoon for Dr. Dang, and
26 again, ideally, we would, you know, in

1 three-and-a-half, four hours, we would get through
2 Dr. Dang. I think that's realistic, but based on
3 history, we might not finish, but that's what I have
4 set up is to have those two called that day with the
5 idea that we actually fill the day but don't overflow.

6 THE CHAIR: Any comment, Mr. Maxston?

7 MR. MAXSTON: No, I think that's a fair
8 assessment. I don't -- my sense is that I will not be
9 as long with Dr. Dang or Mr. Schaefer as I was in my
10 direct with Dr. Hu, so I think we'll just make as much
11 progress as we can that day, and as Mr. Kitchen said,
12 hopefully we can finish both of those witnesses on
13 Saturday.

14 THE CHAIR: And that will be the closing
15 of your case then; we can move on to arguments in
16 January; is that correct?

17 MR. KITCHEN: No, so January 28th and 29th
18 are reserved for Dr. Thomas Warren and Dr. Byram
19 Bridle.

20 THE CHAIR: Okay.

21 MR. KITCHEN: Both of those reports are
22 quite extensive. I do expect to be quite a long time
23 with both of them. I know from experience that
24 Dr. Bridle is a talker like Dr. Hu, so Dr. Hu took a
25 whole day, spread out over two, but took a whole day,
26 so what I've done is I've asked for those two days on

1 the basis that I doubt it would take less than a day to
2 do either of those witnesses, so that's why I've
3 scheduled those two days with those two witnesses. So
4 after the 29th of January, then Dr. Wall's case is in,
5 we're done with the evidence, and we would move on to
6 closing statements.

7 THE CHAIR: Okay, so we will need to book
8 some more time after the 28th and 29th?

9 MR. KITCHEN: Yes.

10 THE CHAIR: Perhaps we can give that some
11 thought and maybe talk about that on Saturday if we
12 have a few minutes. It's just getting so hard to
13 accommodate people's schedules; if we can do it with a
14 little notice, it would be helpful.

15 MR. KITCHEN: Well, closing statements are
16 easy because it's only Mr. Maxston and I and probably
17 Mr. Lawrence, so that should be -- I mean, I'm
18 certainly very flexible. I actually don't have any
19 commitments yet in February and March, so if we can do
20 closing, you know, within three or four weeks of
21 January 29th so that we have the transcripts, that
22 seems to me to be a good way to move this forward.

23 THE CHAIR: Okay, well, we can talk more
24 about that, the scheduling, on Saturday, but I guess,
25 on that basis, that will conclude things for today,
26 unless there's anything anybody else would like to

1 bring up at this time. Mr. Maxston, do you have
2 anything?

3 MR. MAXSTON: No, I don't, thank you.

4 THE CHAIR: Okay. All right, then we will
5 adjourn the hearing for today. We will reconvene at --
6 what time is your witness coming on Saturday,
7 Mr. Kitchen?

8 MR. KITCHEN: 9 AM.

9 THE CHAIR: 9 AM, okay. We will reconvene
10 on Saturday, November 20th, at 9 AM and plan to have a
11 full day, I think.

12 MR. KITCHEN: Yes.

13 MR. MAXSTON: Mr. Chair, just before we
14 break, I wonder if I can ask Amber to put Mr. Lawrence
15 and I in a break-out room. I don't know if we have
16 anything to chat about, but I wouldn't mind just a
17 brief chance just to chat with him.

18 MS. NELSON: Yeah, I can do that for you.

19 THE CHAIR: And, Ms. Nelson, if you could
20 do the same with the Hearing Tribunal and Mr. Pavlic,
21 we would like to caucus for a few minutes.

22 Thank you everybody. We will see you on Saturday.

23 MR. KITCHEN: Thank you.

24 _____

25 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, NOVEMBER 20, 2021

26 _____

1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing
4 pages are a complete and accurate transcript of the
5 proceedings, taken down by me in shorthand and
6 transcribed from my shorthand notes to the best of my
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,
9 this 1st day of December, 2021.

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Karoline Schumann, CSR(A)

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Official Court Reporter

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<hr/>	28 781:13	<hr/>	actions 776:21	afield 809:20
\$	28th 834:17	9	actual 781:3	814:4
<hr/>	835:8	<hr/>	actuator 766:15	afraid 813:14
\$250 818:22	29th 834:17	9 836:8,9,10	acute 795:24	afternoon 748:17
<hr/>	835:4,8,21	95 794:14,24	796:2	750:6,12 751:6,
(2:00 816:23	98 773:11	acutely 808:24	10,24 787:26
<hr/>	<hr/>	99 773:11	add 781:13	789:5 790:8
(a) 800:17	4	99.8 772:18	addition 791:16	816:23 817:4
(b) 800:18	<hr/>	9:00 836:25	812:25	832:26 833:2,25
<hr/>	40 767:14 797:7	9:06 749:23	adhered 757:4,6	agenda 833:15
1	<hr/>	9:30 761:24	adjourn 784:8	agent 753:1
<hr/>	5	<hr/>	836:5	agree 759:2,8,26
10 814:23 816:20	<hr/>	A	ADJOURNED	760:13,16,19
100 811:26 812:3,	5 814:23	ability 756:12	788:9 836:25	772:26 776:5
8 822:24	55 757:25	769:5 770:6	ADJOURNME	778:3,23 779:1,
10:45 763:13,21	<hr/>	799:14,21 837:7	NT 763:9 784:16	10,16 780:2,5,10,
784:7,9	6	absolutely	814:26 816:25	12 785:13,16,22,
12:30 763:19	<hr/>	753:14,20,23	831:22	25 786:10,13,16,
12:45 763:18	6 773:26 774:1	754:6,26 756:5,9,	adjust 767:3	21 809:23
787:13,20 788:4,	<hr/>	18,24 758:12	768:11 791:23	817:12,16,22
6,9 789:25	7	795:15	792:6,18 800:3,6	819:13 820:10
12:47 789:23	<hr/>	ACAC 749:10,	adjusted 800:5	821:3,22 824:10
15 762:2,12	749 748:5	11,13,16 789:10,	adjusting	826:12
765:14 769:15	750 748:6	11,13,16 806:6,9	791:14,17 792:11	agreement
784:3	752 748:7	accept 778:15	793:10	775:11 824:20
16 748:5,17 749:5	758 748:8	access 772:21	adjustment	ahead 778:11
789:5	761 748:9	accidents 795:25	767:22	780:11 804:3
1st 837:9	765 748:10	accommodate	adjustments	829:5
<hr/>	777 748:12	806:4,6,24	767:6	AHS 781:15
2	780 748:13	835:13	adjusts 755:25	airborne 812:25
<hr/>	780-938-1666	accommodation	administer	airplane 774:3
2 755:13 766:26	762:22	806:14	791:19	airport 773:23
767:4,7 810:24	784 748:14	accurate 823:5	administrative	774:1,9
816:24	789 748:17	837:4	757:8	airports 773:25
20 753:5 836:25	790 748:18	acknowledge	affect 769:17	albeit 826:17
2019 790:17	<hr/>	797:26	770:4 800:9	Alberta 749:1,3,
2020 804:25	8	acne-type 809:6	816:6,9 821:1	15 759:12,14
806:10 829:13	<hr/>	Act 820:11 822:2,	affected 769:17	772:24 778:5,18,
2021 748:5,17	817 748:20	8	775:1	20 781:12 782:1,
749:5 789:5	831 748:21	acting 757:18	affects 769:10,24	6,24 783:11
836:25 837:9	833 748:22	775:14 776:8	816:1	785:4,7 789:1,3,
20th 836:10	837 748:23	782:8,11,22	affirmed 748:14	15 790:13,14
24 781:17			784:20	791:10 800:23
				817:14 822:2
				829:16 837:8

alcohol 797:8	approved 817:18	806:2 819:25	benches 766:16	bring 836:1
Aldcorn 749:10 789:10	April 804:25 829:13	825:16 826:6,10	benefits 815:17 824:21 826:17	brings 757:13
aligns 816:3	area 773:26		big 770:5 800:21	broad 821:21
allowable 828:15	argue 793:11	B	bill 818:22	broader 778:2
allowed 813:9 827:17 828:25	argument 822:16	B.E. 749:16 789:16	bit 751:16 755:5, 19,22 771:6	bronchitis 796:16
allowing 799:11, 21,23	arguments 834:15	back 751:5 757:20 758:7	792:12 794:18	business 765:17, 18 774:7
alternative 756:26	Arizona 774:23	762:2,4 763:22	798:25 801:24	busy 787:25
Amber 836:14	aspect 821:17	764:11 765:1,20	811:7 812:18,19	Byram 834:18
ambitious 833:19	aspects 798:20 815:18	766:4,23 768:12	824:15 826:3	
ambulance 795:26	assess 791:20 792:18 793:19	775:8 788:6	Blair 758:19	C
amount 797:10 803:19,21	821:4,7	789:24 802:1	blanket 816:11	Calgary 765:12
811:20,21,22	assessed 796:14 816:8	803:25 814:23	bleeding 796:4	781:10 783:11
812:23 813:3	assessment 811:4,17 834:8	815:1 816:23,24, 26 824:9 825:5, 25 826:4 828:4, 13 829:12	blocked 751:9	837:8
818:20 830:17	assistance 787:7	bad 754:19 799:12 801:23 828:5	bodies 815:25 826:14	call 750:19 752:9, 23 755:16 762:8
analysis 783:7	Association 749:2,15 759:13	balance 790:25 791:1,7	body 755:13 756:17 765:17	768:8 787:25
answers 802:13 808:13	778:18 783:16	balanced 791:3	766:22 767:3,24	called 755:8 809:17 834:4
apologies 755:7 764:20 787:16	785:5 789:2,15	Bao 833:18	769:23 771:14	calling 756:15 769:21 833:11,17
apologize 755:9 801:23 820:23 825:26	assume 830:4	barely 771:5	778:20 785:6	calls 761:21 792:25
Apparently 761:7	assuming 778:13 817:5	barriers 830:16	791:2 817:13	camera 764:19, 21
appearing 763:13 764:2	asthma 804:21 805:3,18,22	based 752:8 765:12 773:4	boil 809:8	camera's 764:18
applicable 808:11	806:7 824:16	777:12,23 778:22	book 835:7	candid 750:18 752:4
application 778:14 825:9	828:5	781:9 791:21,22	border 775:8	care 761:15 782:24 791:12
applies 819:18	asthmatic 805:10	812:1,3,4,5,8,11, 12 813:20 822:7, 24 823:4,8	bother 808:3	793:25 795:3,7, 11,13,14,17,24
apply 815:23,24	at-risk 757:26	833:18 834:2	boy 828:5	796:2,25 797:3
appointment 793:2 797:9 805:13	attack 796:7,9,13	basic 817:11	break 761:4,19 763:6,22 787:13, 19 801:21 814:22	798:5 799:8,13, 18,20 800:10,19
approach 752:4 799:3 824:8	attend 752:6	basically 781:11	816:16,19,22	801:10 807:24
	attributable 809:9	basis 804:14 831:4 835:1,25	836:14	815:18,23,24
	audio 804:6,9,13	basis 804:14 831:4 835:1,25	break-out 762:17,26 763:1, 7 784:7 831:21	819:23 827:17,18
	aware 754:1 759:12,16,21	bear 765:26 831:20	836:15	caregiver 819:18
	760:5 772:24	bearing 756:13	breath 805:15 807:12	caring 793:16
	778:18 785:4,9, 16,21 800:23	belief 777:21 781:25	breathing 805:2, 9,17 808:8	carousing 772:4
			826:19 830:21	
			Bridle 834:19,24	

case 766:5 768:12
781:10,25 785:14
830:10 834:15
835:4

cases 782:4

category 757:26

caucus 761:6
788:5 814:23
831:18 836:21

caused 805:26
807:8

causing 799:21
800:16,21

caution 813:16

caveat 819:24

caveats 819:20

cell 762:20,23
804:6

certainty 811:24

Certificate
748:23 837:1

certify 837:3

cervical 792:2

Chair 748:21
749:8,24 750:15,
21 751:19 752:1,
7 758:16,17
760:25 761:3,18,
24 762:2,10,14
763:6,10,16,24
764:6,9,11,15,17,
22,26 776:11,23
777:2,7 780:19
782:9,23 783:21
784:3,6,12,17
787:1,4,9,12,18
788:3 789:8,24
804:5 814:9,11,
14,19,22 815:1
816:15,21,26
825:23 831:9,17,
23,24 832:22,25
833:3,6,14 834:6,
14,20 835:7,10,
23 836:4,9,13,19

chance 787:24
797:13 836:17

change 809:4,10
818:18,19,20

Charles 748:7
750:25 751:21
752:12,20,23,25
757:24 758:14
761:12

charting 821:12

chat 836:16,17

check 762:2,4,12
788:1

checking 764:25

checks 755:26

checkup 793:3

chemical 758:6

Chief 819:25
820:4

chiropractic
756:22 757:17
758:9,10 767:2,
19 768:4 772:25
790:19,25 791:5,
11 793:10 794:22
795:11 817:13

chiropractor
751:8 753:7
756:4 759:3,9,18
765:16 767:12,
18,21,22 768:21,
22 776:2 778:4,
12,25 779:3,11,
21 785:11,18
792:6 794:6
795:18 817:19,23

chiropractors
749:2,15 759:13,
14,22 760:1,6
765:22 778:19,20
781:4 785:5,7,17,
23 786:3 789:2,
15 791:13,16,18,
19,23 800:23,24
815:22,25 820:2,

13 821:14

choice 754:12
799:12,13 800:6,
9 801:11,12,15,
16,19 802:5
803:15,18,20
818:6,9,24 819:6,
8

choices 799:22,
23

choose 754:12
800:8 822:11

chose 825:12,21

Chris 833:18,21

circle 751:5

circumstance
822:6 826:20
829:23

circumstances
828:3

City 837:8

claim 781:17

claims 781:16

clarify 807:4

class 774:11

clear 777:17
779:22 806:26
824:10 829:2,20,
23

Clerk 790:4
802:2

clientele 774:22

clients 786:20

clinic 813:8

close 794:1
816:24

closer 826:1

closing 834:14
835:6,15,20

coach 797:22

Code 819:4,11

coerced 801:13
802:6 803:16

coercion 801:20
803:19 818:5,11,
14,26 819:12

college 749:2,15
750:9 759:12,16,
21,23 760:5
772:24 776:8,22
777:25,26
778:18,24 779:2,
15 781:4 782:8,
11,18,22 785:5,9,
17,22 789:2,15
790:19,21,23
800:23 801:2
802:16 806:11,23
808:12 811:26
815:25 817:12,
17,24 818:22
819:5,16 820:11,
12 821:4,12,18
822:2,9,12
824:11 826:8
827:2,11,13,16
828:1,11,24
829:2,7,8,22

College's 758:20
760:20 777:21
779:19 780:14,25
786:1 821:11
822:21 824:1
826:14 827:26

colleges 820:13,
14

combined 807:14

comfortable
754:4 771:24
801:5

COMMENCED
749:23

comment 752:1
776:11 814:5
818:19 834:6

commenting
808:16

comments 752:9
760:10 777:15

778:22 779:26
780:3 786:7,10
818:4

commercial
753:1

Commission
829:16,17 830:5

commitments
835:19

common 796:21

communicate
763:3 771:18

communication
765:19 770:19

company 765:11

compare 828:14

competence
817:25 818:8,17

competent 760:1
779:12,17 785:24

complaining
786:20

complaint
796:12,15,19

complaints
758:20 776:7,12,
15 795:23 796:21

complete 824:20
837:4

completely 779:5

comply 760:20
780:13 786:17
818:6 819:6,9
826:7,21 828:10

complying
819:10

compromised
832:5

con 779:8,9

concept 819:17

concern 750:8,19
827:25

concerned
773:16 778:8

810:10 811:13 824:17	context 802:9 818:3	couple 765:25 766:16 774:23 777:11 792:25 794:8 796:5 798:11 815:11	<hr/> D <hr/>	decision 756:11, 16 769:4,22 799:11 812:13 825:3
concerns 804:2,4 825:11 830:26	continue 797:11, 14 800:18 804:7 822:17	Court 749:21 752:15 765:3 789:21 796:8 801:26 802:4,9, 12 803:10,14 814:16 837:15	Dallas 773:20	decisions 782:25
concert 814:9	continuing 759:23 779:3 785:19 817:25 818:8,17	COVID 757:18 758:1 772:12,16, 17 775:13 782:3, 4 809:26 810:26 811:6 813:11,12 814:3	Dang 833:18,25 834:2,9	deeper 770:8
conclude 835:25	controlled 804:22	create 754:19 777:25 800:20 821:14	dangerous 754:19	degree 801:17 807:8
concluded 761:10 826:13	converse 770:16	created 830:26 831:4	data 773:5,15 777:23 783:9	demonstrating 811:21,22
conclusion 826:23	convinced 822:24 824:20,23 825:2	creation 831:2	Dated 837:8	deny 809:1
concussion 798:14	core 756:23 782:14 791:11, 13,17 799:2,3,4, 19	cracking 792:4,8	Dave 750:25 763:26 764:5 765:6,9 766:19 780:23	depending 828:2
condition 824:16 825:12 828:19 830:7	Coronavirus 824:26	create 754:19 777:25 800:20 821:14	Davenport 790:19	depends 828:12 833:22
conducts 765:18	corporate 765:11	created 830:26 831:4	David 748:10 765:5,8	describe 766:1
confessing 798:12	correct 759:14 760:11 762:20 766:17 777:19,26 778:26 779:25 784:4,5 785:15 786:9,12 787:14, 15,22 817:15,20, 21 818:10,25 819:3,19,20 820:3 821:8,20 825:13 826:9,15 827:21 834:16	creation 831:2	Dawson 749:12 789:12	Description 748:3
confirm 753:18 768:14 769:13 784:25	correcting 792:3	cross- examination 751:6 784:9,18 817:2	day 751:16 770:24 779:22 787:21 800:2,8 822:16 833:20 834:4,5,11,25 835:1 836:11 837:9	deserving 799:16
connection 801:23	correctly 767:4	cross-examined 748:15 750:4 763:13 784:20	days 781:13 792:26 805:1 833:12 834:26 835:3	detail 766:1,3,10
conscious 775:13	correlated 808:26	Cross-examines 748:8,12,20 758:18 777:9 817:3	de 819:23	details 825:18
consent 799:24 807:18 808:11,12 819:16,18 820:5 821:12	counsel 749:9,16, 19 789:9,16,19 797:17	crossroads 822:3	deal 791:5 830:22	determine 810:24
consequences 803:19	counselor 797:21 798:17	CSR(A) 749:21 789:21 837:14	dealing 827:15	develop 809:5
considerably 805:3	counsellor 797:21 798:17	Current 794:10	debate 813:17	difference 758:5 782:1,5 795:6,16 818:14
considered 756:10 769:4 816:13	countries 781:22	Curtis 749:18 764:3,4 789:18	December 837:9	difficult 797:12 804:19 805:19 816:8 821:2,7 822:10
constant 805:5			decent 811:20,21, 22	difficulty 805:2, 9,16
consultation 768:24			decide 800:10 803:3 821:20,24 827:1,10	diminished 771:6
contact 762:16 763:11 791:25			decided 828:5 830:7	direct 789:26 819:22 831:3 834:10
contacting 792:16				direction 794:26 810:11 826:14
CONTENTS 748:1				directions 821:15
				directive 760:6, 21 779:20 786:2 801:8 806:9,10,

16,21,25 808:14
815:14,20 818:5
822:21 824:2
825:10,13,17
826:8 828:6,10
830:2,9,26 831:3
Director 749:13
758:21 776:8,13,
15 789:13
disabilities 806:4
disability 805:23
806:7,13
disappointment
770:5
discomfort 808:5
discuss 761:6
766:4 783:23
discussed 815:2
discussion 748:6,
9,22 750:1
761:17 796:23
797:24 798:2
830:25 831:12
833:5
discussions
822:19
dismiss 761:7
disregard 826:13
828:9
distance 792:14
distancing
810:25 811:4
distinction
820:20
distracting
831:13
distress 798:11
806:1
doctor 776:2
778:13 807:3
doctors 795:8
830:12,13
doings 775:21

double-check
816:19
doubt 835:1
drinking 797:11
drinks 797:7,8
drive-through
770:25
driven 795:26
driving 813:6
822:17,19
drugs 758:6
due 751:2 806:2
dysfunction
806:1

E

earlier 758:8
777:15 794:3
earliest 763:17
787:16
early 751:11
787:18
earn 759:9 778:4,
6 794:20
easier 802:24
easy 835:16
ed 779:8,9
Edmonton 749:2
789:2
education 759:23
778:25 779:3
785:10,19
educational
817:18
effective 753:8
793:7,13 810:25
811:5 812:16
814:2
effectiveness
809:26
effort 830:11
832:1

elected 781:16
elements 831:1
Elvin 751:3 833:9
emotional
798:19
encounter
773:18
end 832:25
ended 750:4
809:7
energy 765:11
797:18 808:8,22
826:19
engaged 830:25
ensure 760:1
779:11,17 785:23
793:1
entire 751:9
833:25
environment
772:9,11
ER 795:24 796:19
err 813:15
ERS 796:21
essentially
791:24
establish 825:7
establishment
757:1
estate 753:1
ethical 813:17
ethically 827:6,7,
12,19,20
ethics 819:4,11
823:2 827:15
everybody's
774:1
everything's
756:1
evidence 757:21
809:17 811:7,20,
21,22,25 835:5

exact 780:26
examine 766:6
796:10
examined 748:7,
10,19 752:20
765:5 790:6
808:9
examining
789:25
Excellent 752:15
763:4
exceptionally
794:16
exceptions 829:3
exchange 831:11
exchanges
777:12
excused 783:25
exemption
806:19 807:2
825:19 828:17,
19,22 829:1,7,18
830:12,22 831:26
832:2,3,7,11,13,
20
exemptions
828:24 830:14
exercise 770:1
exercises 766:22,
23
expect 834:22
expectation
818:15
expectations
818:1,14 824:6
expects 763:18
experience
795:19 807:14
812:12 834:23
experienced
830:18
experiencing
793:3

expert 809:17
experts 809:19
833:13
explain 756:19
798:25 822:1
explained 823:14
explanation
801:21
explore 828:11
exposing 772:5
expressing
776:21
expressions
770:18
extended 787:13,
19
extensive 834:22
extremely
812:22

F

facial 770:18
fact 764:5 780:13
803:24 807:15
818:4
facto 819:23
fading 825:24
fair 752:24
756:20 779:26
780:5 821:23
822:21 823:9,24
824:11,18,19
826:12 828:9
834:7
fairly 783:9
family 769:9,14,
21 771:25 780:4
fast 761:20
fatigue 797:19
808:8,22 826:19
faults 766:17
fear 757:15

813:3,22,23
814:4,17,18
815:5
February 835:19
federally 773:24
fee 785:20
feedback 791:22
feel 754:4 771:24
772:8,22 773:5,
14 783:17 791:21
793:20 796:10
801:22 815:4
832:11
feeling 750:5
815:7
feels 801:16
803:18,21 805:17
fees 779:4
feet 767:4 773:26
774:1
felt 797:25 832:6,
8
females 827:17
figure 766:17
768:3 770:16,23
771:2
figured 767:24
fill 834:5
filters 812:22
final 826:24
830:24
find 753:10 766:6
767:11,19 768:21
770:14,20 773:3
793:13 794:8,14
797:20 798:17
807:12
finding 815:8
fine 752:3,6
774:4,5 784:14
802:11 817:9
832:22
finish 834:3,12

finished 820:22
finishing 787:5
fit 833:11
fitting 830:15
fix 767:25 773:12
fixed 753:9
fixes 753:8
flaring 805:3
flexible 835:18
flip-flopping
782:25
floor 817:1
Florida 774:24
flu 772:20
fly 773:7
flying 781:21
focus 792:2
follow 821:20,25
825:13,16 827:2,
11 829:9 830:9
follow-ups
792:26
food 770:26
foot 767:7 808:1
force 792:7
799:25
forced 773:15
775:20 827:22
forcing 775:22
foregoing 837:3
foremost 791:12
forgive 757:24
764:21,22 775:24
792:12,23 794:18
forgot 755:9
forgotten 784:10
form 805:22
formally 813:25
forward 766:21
835:22
found 824:12

frame 791:3
frankly 804:2
810:6
free 761:13 787:6
801:22 833:1
freedom 832:17
friend 780:23,24
782:10 785:26
818:4 819:15
820:24
frontline 795:7
frustrating
770:13 771:1,7
fulfil 795:9
full 751:14 765:7
790:9 797:13
836:11
fully 803:13
function 807:17
826:17,20
fundamental
821:6

G

gaps 812:21
GAUTHER
748:18 790:6
Gauthier 751:1,
7,25 763:17,23
787:26 789:26
790:5,8,11,12
795:3 796:24
800:22 802:13
803:1,12 804:11
809:13 810:13
815:11 817:2,4,
11 818:7 821:3
823:26 825:23
826:6 831:7,25
832:23
gave 806:23
gears 755:5
general 805:2

807:10 808:22
821:5
generally 785:13
generous 809:18
gentle 765:21,23
Geza 748:18
790:6,11
give 756:26
791:18 797:2
802:9 806:11
810:1 811:14
821:10 835:10
giving 784:26
goal 820:15,18
goals 824:4
good 752:21
754:20 757:22
758:4 759:1,22
776:1 777:10
784:1,22 788:3
790:8,25 791:1,7
797:13 799:16,22
800:17,22 815:15
817:4 833:2
835:22
government
757:18 781:12
783:1
Government's
757:21
graduated 791:9
grateful 753:21
770:11
great 812:18
greatest 750:8
greatly 766:20
769:11,17,24
770:4
group 781:15
guess 750:13
761:18 769:11
787:12,19 791:25
806:17 810:7,8
814:12 818:16

821:6 822:15
823:16,20,25
825:9,22 832:9
835:24
guide 798:24
guides 799:20
guy 771:3

H

hand 792:10,11
793:11
hands 755:21
756:3 766:13
767:2,3 791:23
hands-on 758:10
happen 822:14,
26 823:1,6
happy 775:19
797:20 798:17
hard 805:3
808:20 809:1
813:20 835:12
hardware 774:12
hardwood 771:2
harm 799:21
800:14,15,16,21
807:8 808:5
815:12 816:4,10
820:25
harming 815:16
harms 821:19
Hat 790:14,17
hate 807:23
he'll 762:11
763:13
head 763:7
781:14
headaches
808:23 826:18
830:20
heading 810:10
health 754:20,24
756:26 757:2,23

758:4,9,11 771:22 782:24 791:1,7 795:3,7, 11,13,14,16,17 797:22 798:5 799:3,18,26 800:19,21 807:20,21 808:7, 18 814:6 815:18, 23,24 816:2 819:22,26 820:4, 11 828:19 832:5, 9	751:20,22 763:26 764:5 765:5,8 776:26 777:10 780:17 hindrance 770:5 Hinshaw 781:15 hip 766:5 808:1 Hippocratic 756:21 hips 766:9 768:12 770:2 history 833:19 834:3 hold 759:5 823:10 827:3 honestly 806:15 hop 774:3 hope 756:13 826:2 hoping 787:24 833:20 Hopkins 782:5 783:8 hospital 795:8, 17,18 hours 781:17 794:8,11 804:26 834:1 Hu 834:10,24 huge 770:4,20 772:19 773:12 774:15 human 806:2 822:2,8,15 828:15 829:15,17 830:5 hundred 794:15 811:24 813:21 823:4,7 hundreds 757:15 hurt 767:11,16 768:20	<hr/> I <hr/> idea 763:2 799:24 800:22 808:10 834:5 ideally 833:24,26 ideals 798:24 ideas 799:2,3 812:5 identical 782:7 imagine 818:19 immediately 751:10 immune 797:19 immunologist 777:17 impact 799:26 807:20,21 808:8 819:22 impacted 808:18 impacts 808:7 importance 791:2 important 756:22 759:26 785:23 790:24 798:20 799:5 800:14 815:18 825:10 impossible 755:14 768:10 impression 806:18,23 820:18 improvement 800:20 improves 803:2 804:13 includes 753:18 income 794:20, 25 inconvenience 770:20	incorrect 827:21, 24 increased 754:23 771:21 INDISCERNIB LE 795:24,26 796:6 797:6 801:14 802:19 803:26 823:22 individual 776:11 816:7 820:19 821:7,13 822:5 individuals 821:4 827:20 ineffective 754:18 infection 774:18 824:7 information 782:13 783:4 810:23 811:2,10, 16 813:26 informed 807:18 808:10,12 819:16,17 821:11 inhalers 805:11 807:15 initial 768:23 797:9 805:13 initiated 786:20 injuries 795:25 796:2,4 inside 800:4 instance 819:23 instinct 829:2,22 institution 817:18 instrument 791:24 intangibles 793:21 integrating 790:26	intended 779:11 intentions 776:12 interacting 799:4 interest 757:22 769:1 776:16 interests 756:6, 10 768:15,18 769:4 775:25,26 776:6,9 777:1 Internal 749:9 789:9 internet 801:23 interpretation 829:25 invalid 823:17 involved 831:11 Iowa 790:19 issue 764:1 796:4 815:8 823:15 824:26 827:3 829:24,25 issued 806:9 824:11 issues 766:4,5 770:8 779:15 782:14 791:4 793:3 797:5,14 798:13 804:23 809:6 817:24 819:5 820:4 830:21
			<hr/> J <hr/> J.S.M. 749:19 789:19 James 801:23 January 834:16, 17 835:4,21 Japan 773:9,10 Jarvis 748:14 750:4 751:5,24	

784:20

Jaw 794:11**job** 791:12 800:19
813:2 824:7**John** 782:5 783:8**joined** 791:9**justice** 798:1**Justin** 748:18
751:1,25 790:6,
11

K

Karoline 752:16
837:3,14**keeping** 780:25
791:2**kids** 769:16
771:25**kind** 763:1
766:23 772:20,21
774:7 778:17
779:7 781:16
791:6 799:19
801:10 805:5
808:4 810:10
812:15 816:11
820:17 822:3,4
825:4,7,21
832:16**kinds** 759:24
813:1 821:14**Kitc1hen** 789:25**Kitchen** 748:7,
11,13,19 749:19,
26 750:2,18,21,
24 751:21 752:7,
10,11,15,19,20,21
755:7,11 758:13
759:5 760:4,26
761:1,8,12,15,18,
25 762:1,4,11,16,
20,21,24 763:1,4,
10,12,17,26
764:8,26 765:3,5,6 776:14,24,25
777:5,12 779:19
780:19,21,22,23
782:15 783:19
784:3,5,11
785:26 787:1,3,
10,13,15,23
788:7 789:19
790:1,4,7,8
796:24 802:2,10,
11,21,25 803:1,
10,22 804:5,10,
11 809:16,22
810:12,13 813:24
814:11,21,25
815:10,11
816:14,15 819:15
820:24 822:20
823:10,16,20,25
825:5 826:2
827:3 830:24
831:14,16 833:6,
8,17 834:11,17,
21 835:9,15
836:7,8,12,23**Kitchen's** 752:4,
9**Knee** 808:1**knee** 808:1**knees** 770:2**knew** 818:12,16**knowledge**
757:12 776:17
777:24 778:10,12
781:3,5,6 782:19
831:3**knowledgeable**
781:14**Kosowan** 748:14
750:4,22 751:5,
25 763:12,21
784:10,19,20,22
786:24 787:4

L

laid 817:26**large** 807:6**largely** 812:24
820:8 827:16**latitude** 826:3**law** 820:7 821:26
822:8,11 828:26
829:15,22,25
832:14,18,19**Lawrence**
764:10 804:1,4
816:20 835:17
836:14**lawyer** 758:20**lay** 809:16,21
814:8**leading** 799:1**learned** 780:23
790:23 793:10
794:21,22**learning** 791:1,7**leave** 753:11
783:26 787:6
822:15 833:1,25**Lees** 749:8 789:8
legal 749:9,16,19
759:5 789:9,16,
19 828:22 829:7**legality** 820:9
829:15**legally** 823:22
827:5**legislation** 806:2
822:15**letter** 821:26
832:19**letting** 755:2
775:3**level** 772:2,14
783:1 793:26
797:12 826:18**levels** 797:18,19
808:8,22**licence** 779:2,15
792:15 817:23**license** 778:15**licensed** 778:16
785:11**licensing** 778:20
785:6 817:13**lie** 766:7**limit** 818:20**limitations**
797:26**limiting** 805:26**lined** 756:1**links** 804:9**lips** 770:17**listened** 798:15**lives** 775:15**living** 752:26
757:15 765:10**location** 802:20**lockdowns**
809:26**logically** 822:14**long** 753:4,7
761:25 765:16
768:20,24 790:15
800:18 805:12
817:7 834:9,22**long-winded**
813:19**looked** 826:16**lose** 770:18
792:15 794:14,16**lose/lose** 822:4**lost** 794:24**lot** 756:21 758:8
766:3 768:20,25
770:18 771:25
773:5 779:8
781:7,8,18
782:25 783:4,5794:9 797:5
798:11 805:1,4,
14,16 808:19
811:10 812:13
813:25 830:15
831:10**lots** 807:12 808:1**love** 799:17**low** 792:7**lower** 826:18**lunch** 751:10,11,
26 763:22 787:19
788:2**lung** 807:17

M

M-HM 810:17
811:15 812:10
828:8 830:3,6,8**Madam** 752:15
765:3 790:4
802:2 803:10**made** 756:17
760:10 769:23
777:15 779:26
786:7,10 807:17**main** 783:6**make** 755:26
758:5 774:8
780:3 781:16,17
787:26 797:16
799:11,12,22,23
800:14 802:24
811:3,17 814:10,
13 834:10**makes** 751:15
759:25 774:7
829:19**making** 786:24**males** 827:17**manages** 765:17
769:9**mandate** 773:3,
4,5 777:23,25

811:26 813:10 816:11 828:13, 22,24,25 829:11, 12,14 mandated 772:25 800:24 808:9 812:14,17 816:1 827:13,16 mandates 757:21 773:7,19 780:25 781:4,23 822:3 mandating 773:2 812:8 816:3 mandatory 759:16 778:23 779:9,14,15 785:9 806:9 818:8 manipulated 770:3 manipulation 791:14 manner 769:9 782:22 March 790:17 804:25 835:19 mark 767:7 marriage 798:13, 16 Martens 749:11 789:11 mask 753:15,17, 22,24 754:2,5,8, 9,10,11,13,14,15, 25 755:2 770:8, 10,12,15,21 771:8,9,14,17,23 772:26 773:7,19 774:10 775:4,10, 16,18 779:23 781:8 786:18,21 800:24 801:1 802:14 804:18, 19,24 805:4 806:9,13,26	807:7,11,19 808:18,25 809:7, 9 811:26 812:22 824:21 826:10 828:26 829:18 830:18 masked-up 773:10,11,24 masking 760:11, 21 777:22 780:1, 14 786:2,8 810:24 811:4,17 812:6,7,8 814:2 820:1,26 822:22 824:10 825:13,17 826:7 masks 760:7 770:14 773:12 774:13,19,20,21, 26 779:21 808:16 812:14,15,16,17, 21 813:1 816:3 829:14 massage 766:15 800:7 matter 770:21 801:11 807:1 815:14 matters 760:14 825:20 Maxston 748:8, 12,15,20 749:16 750:7,15,17 752:1,3,8 755:8 758:16,17,18,19, 20 759:7,8 760:23 764:9,12, 23,25 776:10,18 777:8,9,10 780:16,24 782:9 784:12,14,18,21, 22 786:23 789:16 790:1,3 798:26 802:21 803:22 804:1 809:15 810:6 813:24	816:16,18 817:3, 4 823:16,24 824:1 826:2,5 827:7,9 831:6,14, 25 833:15,23 834:6,7 835:16 836:1,3,13 Maxston's 817:1 mayor 781:10 means 763:20 777:5 media 783:6 medical 781:14 790:26 791:6 805:22,23 806:4, 7,13 807:3 819:26 820:4,13 825:11 Medicine 790:14, 17 meet 817:23 member 749:10, 11,12 769:3,7,10 785:14 789:10, 11,12 817:17 819:1 826:26 members 760:7 761:5 788:5 814:9 821:23 827:10 831:17 memorized 806:21 820:17 mental 798:11 mention 808:19 mentioned 800:13 808:16,21 813:22 814:17 metre 767:7 metres 755:13 766:26 810:25 microphone 825:24 microphones 831:11	middle 796:11 mind 757:25 781:19 803:11 833:14 836:16 miniscule 812:23 minutes 762:3,12 784:4 798:12 808:25 814:23 816:20 835:12 836:21 modes 812:25 moment 766:9 830:4 831:19 monetarily 769:2 money 768:21,25 month 781:11 months 774:24 809:7 Moose 794:11 moral 813:18 morals 823:2 827:15 morning 748:5 749:5 750:3,12, 22 751:9,12,13 752:10,21 777:10 784:22 787:25 833:21,24 motivates 781:3 motivations 776:12,15 move 834:15 835:5,22 moving 751:22 761:22 825:23,26 mumbling 771:1, 4 musculoskeletal 797:5 Music 751:3,20 833:9 mute 831:12	mutual 775:11 <hr/> N <hr/> N95 812:18 natural 756:26 757:2 758:8,11 nature 765:21,23 necessarily 767:23 772:2 773:4,12,16 776:4 781:19,26 783:15 807:21 813:16 820:19 832:16 neck 755:25 792:3,6 798:2 needed 803:26 830:12 832:9 needing 804:24 negative 830:17 negatively 808:18 816:6,7 821:1,2 Nelson 749:13 762:15,19,22,25 763:5 784:6 789:13 831:21 836:18,19 night 797:8 nonprobative 815:7 normal 807:13 nose 809:8 note 764:4 828:20 notes 837:6 notice 805:13 809:3 835:14 noticeable 809:10 noticed 804:23 805:1,2 807:9 808:7,17,23 830:19,20
---	---	---	---	--

November

748:5,17 749:5
789:5 836:10,25

number 762:20,
23 768:3 794:17

numerous
769:16

nurses 795:8

nutritional
798:20

O

oath 756:21
784:26

object 752:22
776:10,20 781:1
809:15,20 813:25
814:7

objected 825:7

objection 777:3
815:2,4,9 825:9

objections 828:5,
7

obligated 832:21

obligations
806:3

observation
810:20

obtained 807:18
808:12

obvious 755:19,
22 765:26 768:6
792:13 794:18

occur 822:14

office 753:19
755:24 762:6
763:15 764:2
770:10 771:12
791:20 795:11,
16,19,26 796:1

Officer 819:26
820:4

official 749:21
789:21 828:18
837:15

ongoing 759:21
785:17 817:24

open 762:25
798:3

opinion 759:6
809:17,24,25
810:4 811:14

opinions 776:21
811:9

opposed 811:19

opposite 751:18
761:22

optics 813:14

option 804:7
825:15

options 824:24,
25 828:11

order 750:20,26
756:16 760:1
768:2 769:22
770:23 779:16
817:22

ordered 756:7,14
768:16 769:19

orders 819:26
820:5

originally 751:13

outbreak 774:15

outbreaks
773:12

outweighing
815:16 824:22

overflow 834:5

P

pages 837:4

pain 753:11
797:5,19 798:8
808:2

pair 807:26 808:2

Palmer 790:19,
21,23 817:18

pandemic 760:21
777:22 779:20
786:2 806:10
818:5 820:1
822:21 824:2
825:17 826:7
830:9,25 831:3

Panel 761:5
783:22 788:4
831:17

paper 831:10

part 756:11
758:11 769:4
800:21 808:14
813:13,14 815:5
819:12

particles 812:23

parties 806:4

parts 771:3

partying 772:4

path 775:23

patient 753:2,4
763:19 765:13,14
777:1 791:22
792:4,17 793:24
795:18 796:6,11,
17 797:4 798:10,
21 819:18 821:19

patients 751:8,12
760:8,17,19
780:6,12 786:3,
14,17,18 792:1,
25 793:8,13,14,
17,22,26 794:4,
10,15,17,24
795:22 796:13,26
797:3 798:5,23
799:5,7,14
800:15,25 801:1,
10 802:15 805:15
806:12,19 807:7,
13,22,24 808:15,

16,17,19,21
809:1,3,4,5
812:14,20,26
813:9 820:19
821:13 825:1
826:11 830:13
832:19

pause 802:19

Pavlic 749:9
764:10,14,16,19
789:9 836:20

paying 785:19
818:24

payment 779:4

people 756:26
757:25 760:7
770:14 772:4,11,
13,17,18,19
773:11 774:14
781:14,15 796:2
798:8,9 799:8,20
807:22,26 808:2
810:20 816:9
832:12

people's 835:13

percent 772:18
773:11 794:15,24
811:24 812:1,3,8
813:21 822:24
823:4,8

percentage
774:17 782:4

percentage-wise
774:17

percentages
782:7 783:10

perfectly 774:4,5
806:22

performs 779:24

permission
830:1

permit 750:14
806:12 818:23

person 756:17
757:15 769:22

774:5 778:3
792:21 793:6
808:5 816:6,7
821:1,2,8 826:25
827:18 832:17

person's 791:20

personal 772:2
776:21 777:18,19
781:24 825:12

**personal/
medical/
scientific** 825:8

personally
771:20 824:16

perspective
778:3 810:18,22
828:15

**pharmaceutical/
medical** 757:1

phone 755:17
756:15 768:8,17
769:21,26 770:3
792:24,25 793:4,
18,23 804:6

phrase 815:12

physical 796:3
798:8,19

physically
768:10 769:2

physician 777:17
Physicians
815:26

picking 831:10

pieces 771:3

pilot 765:11
779:6

place 773:9
779:16 821:5

places 773:18
781:21 783:7
794:13

plain 774:8

plan 750:11,22
836:10

planned 751:2,13
plead 758:24,26
plenty 757:21
PM 788:9 789:23
pneumonia
 796:16,18
point 750:11,23
 751:4,23 766:15
 781:10
points 767:25
political 773:6,14
 781:18,25 782:8,
 22 783:1,2,13,14
politically 781:9
 782:12
politics 823:2
poll 783:21
 821:13
position 802:26
 821:18 822:10
possibility
 780:15 810:9
potential 797:13
practically 827:5
practice 756:8,12
 758:4 760:2
 768:17 769:6
 778:4 779:12,17
 785:24 790:12,
 14,16 792:2
 794:21,22 799:3
 801:8 806:10,20
 808:14 818:23
 819:5,11 821:11
 832:7
practices 758:5
practicing 751:8
 756:7,14 759:3
 768:16 769:20
 790:15 793:5
 794:20,23 796:5
practitioner
 799:6 822:5

practitioners
 757:7
prefer 754:7,13,
 15 807:16
preference
 802:22
preferred 762:6
prejudice 750:8
premise 782:11
prepared 764:7
 804:2
present 765:11
 783:10
pressure 766:15
presumption
 782:15
pretty 755:14
 765:26 804:22
 809:18 821:21
 824:12 833:22
prevent 797:18
 813:10 814:3
preventing
 810:26 811:5
 824:7
Previously
 748:14 784:20
primarily 792:7
 815:22
primary 791:17,
 26 793:5,11
 796:6,8,15 799:7
 815:14,20
 820:10,12,15,18
principle 799:19
 807:25 816:3
 820:25
principles
 756:23 757:5
 791:10 798:24
 799:4
prioritises
 775:25

privilege 759:3
problem 772:10
 773:13 823:20
 827:25 832:20
problems 752:5
 766:7,9 772:12
 804:8
proceed 750:23
 752:8 790:2,5
 803:3
proceedings
 749:1,23 788:9
 789:1,23 836:25
 837:5
process 768:23
 777:24
profession
 756:22 757:17
 785:14 791:9,15
 819:2 821:5,24,
 25 827:1,10
professional
 759:13 778:19
 785:6 819:13
 824:3 827:9
Professions
 820:11
progress 834:11
projecting 822:7
promote 756:26
 757:2
proper 767:18
properly 771:18
 792:17,18
 793:16,19 812:21
propose 763:21
protected 771:13
protection
 820:14,19
provide 755:6,
 12,15 766:25
 768:7 791:26
 792:13,24 793:17
 794:2,5 832:11

provider 800:20
 814:6 819:23
providers 799:18
 815:23
providing 832:20
province 778:14,
 16 806:3 837:8
psychologist
 814:5
public 749:12
 769:3,7,10
 780:26 789:12
 814:6 820:2,14,
 20
pure 815:4
purely 783:18
purpose 820:10,
 12
purposes 780:25
push 816:22
pushed 808:9
pushing 757:20
put 764:19,21
 765:18 773:3
 774:10 784:7
 807:26 808:2
 814:12 821:5
 822:3,4 836:14
puts 754:23
 771:21 822:10
putting 761:21

Q

QC 749:16
 789:16
qualification
 827:4
qualified 759:11
 810:1 827:12
qualify 823:23
question 758:7
 759:6 766:11
 768:26 769:12

775:2,24 776:1,
 23,25 778:17
 780:21 782:10,
 11,21 785:4
 794:18 802:3
 803:11,26 804:16
 810:4,5,7 814:12,
 14,19 815:3
 821:16 823:15,19
 826:5,24 827:8
 830:24 831:18,
 20,24
questioning
 776:19 782:18
 814:7
questions 748:21
 758:14,21,25
 760:23 761:6
 765:26 777:6,11,
 13 778:2 780:16
 783:22 785:3
 786:23 792:12
 802:12 808:13
 809:12,18 814:1
 815:12 816:14
 817:11 818:3
 825:5 831:6,23
quick 761:4
 777:11
quicker 805:16
quickly 762:8
 783:21

R

raise 802:25
raised 750:9
rashes 809:5
rate 777:15
Re-examines
 748:13 780:22
reach 828:10
read 770:17
 783:5 801:26
 803:12

reading 802:4,13
803:11,14 814:16
ready 762:12,16
765:4 790:2
real 753:1
realistic 834:2
reality 797:10
realize 808:4
reason 800:3,8
806:11,16
reasonable
756:20 759:20
823:19 824:5
reasons 754:1
recall 786:3,6
recent 798:4
recently 797:4
receptionists
771:26
recess 788:4
recognize 805:17
recognized
805:25
recollection
753:5
**RECOMMENC
ED** 789:23
reconvene 763:7
784:8,17 787:20
788:4 816:21
836:5,9
reconvened
749:25
record 752:25
765:1,7 772:22
790:10 796:23
823:11
redirect 760:26
761:2 780:20
783:20 787:2
831:15
redundancy
792:23

referred 831:25
referring 815:21,
22
reflective 781:2
regard 757:26
782:13 795:11
805:22
Regina 794:11
registered
749:10,11 778:24
789:10,11
Regina 794:11
registered
749:10,11 778:24
789:10,11
registration
759:17 779:11
785:18
regulated 773:24
817:17
regulations
781:8
regulator 759:14
778:19 785:6
regulators 779:8
821:3
regulatory
815:24 817:13
826:14
relation 805:9
relative 823:21
release 783:23
reliable 783:9
reluctance 830:9
remember
806:15,21,25
remembering
806:17
remind 831:9
repeat 776:23
790:22 801:17,
22,24 802:8
811:1 814:14
827:8
rephrase 759:7
782:10
report's 833:22

Reporter 749:21
752:16 765:4
789:21 796:8
801:26 802:4,9,
12 803:10,14
814:16 837:15
reports 834:21
require 753:21
770:11 828:20
required 772:25
777:22 786:2
801:2 802:15
806:26 832:15
requirement
760:11 780:14
786:8,18 817:19
820:5 821:19
824:10,13 829:7
requirements
751:3 759:17,22,
26 778:23 779:2,
10,14,15 781:22,
24 782:3 785:10,
18,23 817:24
821:5,24 826:8
827:1,26
requires 807:19
827:4
requiring 760:6
775:10,17 779:20
820:1
research 777:20
reserved 834:18
respect 753:12
766:19 767:12
799:15,17
respond 803:13
responding
814:1
response 757:18
781:11 823:17
responses 765:19
responsibility
819:12

responsible
775:13
restaurant
770:22
restaurants
774:12,20
restrict 756:11
769:5
restricted 807:17
restricting
824:13
restriction
807:10
restrictions
757:19 810:24
811:4
restricts 807:23
resulted 798:14
resume 764:7,24
rightly 798:26
rights 806:2
822:2,8,15
828:15 829:16,17
830:5
risk 754:23
771:21 772:5
775:6 826:16
risks 824:22
road 783:13
Robert 748:18
790:6,11
rocky 751:16
role 796:1
roles 795:9
room 762:18
763:1 831:21
836:15
rooms 762:26
763:3,7 784:7
rougher 765:23
route 830:11
rubbing 774:4

rule 829:3
rules 783:11,12
ruling 814:10,13,
20 815:8 830:5
running 751:17
Russell 748:7
750:25 751:20,22
752:12,20,22
758:19 759:2
760:13,24,25
761:7,9

S

safe 772:9 775:12
779:12,17 780:26
safely 760:2
785:24
safety 782:19
Saskatchewan
794:10
Saturday 833:16
834:13 835:11,24
836:6,10,22
Schaefer 833:18,
21 834:9
schedule 830:15
scheduled
750:25 833:12
835:3
schedules 835:13
scheduling 763:2
835:24
school 759:18
790:18
Schumann
749:21 789:21
814:15 837:3,14
science 781:24,26
782:26 812:1,3,9
813:13,21
822:25,26 823:4,
5,8 824:18
825:11 831:2

science-based 828:6
scientific 781:19
 783:2,15,18
 809:14 810:2,19,
 23 811:2,16
 813:17 833:12
scientifically
 823:22
screen 764:3,13
screening 825:1
seldom 793:4
selectively
 821:24
send 763:2
sends 818:22
sense 759:25
 767:5 774:8
 829:19 834:8
sensitive 803:24
series 802:12
servers 774:21
session 748:5,17
 749:5,25 765:1
 789:5,25 815:1
 816:26
set 783:11,12
 834:4
setting 795:12,
 13,17 824:23
settings 795:14
 824:25
severe 803:20
shape 766:24
share 760:17
 780:6 786:14
shields 771:12
shift 755:5
 762:17
shoes 807:26
 808:1,2
short 768:2
 805:15 816:16

shorthand 837:5,
 6
shortly 804:24
 809:11
shoulders 774:4
shuffling 831:10
side 750:9 757:8
 773:6,14 774:3
 775:12 783:14
 813:15
sides 791:1
significant 809:8
 828:7 830:19,20
simple 770:22
 797:22
simply 793:23
simulator 774:12
sir 783:25 833:1
sit 754:10 773:25
 774:3 826:1
sitting 771:3
 772:18 773:10
situation 822:4
 823:1,3 824:12
 825:14 828:16
 829:11 830:23
skill 837:7
skin 809:5
sleep 750:6
slightly 794:26
 802:3
small 807:6
 815:16 833:22
smoker 797:7
smoking 797:11
so-called 795:7
solves 804:7
sort 760:4 824:8,
 15 828:20
sorts 773:8
sounding 803:6,8
sounds 825:20

source 783:9
sources 783:5
speak 750:16
 760:14 780:2,4
 786:11 816:12
 821:9 829:23,24
speaking 805:20
 810:16,22
specialist 830:14
specials 770:24
specific 795:24
specifically
 794:12 812:7
 813:8
speculate 814:4
speculation
 815:4
speed 761:22
spend 805:14
spine 755:25
 766:8 768:12
 770:2 791:3,13,
 14,17,21 796:25
 797:5 798:2
spoke 779:19
 785:26
spoken 750:7
spread 834:25
spring 806:10
stand 773:26
Standards 819:5,
 11 821:11
standing 759:23
standpoint 821:6
STANDS 761:16
 784:2 787:11
 833:4
start 751:19
 755:9 761:21
 766:7 768:22
 783:7 784:18
 816:17 817:9
started 752:19

790:16 793:4
starting 751:21
 809:11
starts 798:12
state 798:9
statement 786:22
 821:21
statements
 835:6,15
states 774:25
statistics 772:17
 774:16
stay 758:6 759:22
step-by-step
 766:8
stick 813:8
sticks 790:20
stop 756:7,14
 768:16 769:20
 797:16,17
store 771:2
stores 774:13
strengthening
 766:22
stress 798:13
stressful 798:9
stretching
 766:22
stroke 796:12,14
strong 773:4
 777:23
strongly 808:26
structure 791:3
stuck 753:6
 765:15 833:10
studied 754:21
study 810:20
stuff 781:7,18
stupid 774:9
style 768:4 794:7
subjective
 776:19 822:7

subjects 777:20
substance 781:2
success 767:15
sudden 774:2
suggest 818:7
 819:10,17
suggests 766:21
support 760:10
 773:16 780:1
 786:7 824:18
supported
 811:18
suppose 776:19
 810:6 832:7
supposed 750:3
 799:17 801:15
 804:25 813:2
 828:14
surgical 812:17
survival 772:22
 777:15
survive 772:19
sustain 777:2
 815:3
swear 752:17
 790:5
Swift 794:10
Sworn 748:7,10,
 18 752:20 765:5
 790:6
symptomatic
 813:11,12
symptoms
 805:10 808:25
synchronization
 804:8
synonym 823:12
system 790:26
 791:6,8 797:19

T

TABLE 748:1

takes 830:11
talk 755:17 768:9
 821:10 828:1
 835:11,23
talked 758:8
 777:21 786:1
 791:2 819:15
 820:24,25
talker 834:24
talking 771:4,5
 783:6 805:14
 807:13 812:6,7
 814:1 820:26
talks 833:23
taught 790:21
 791:14
teaching 790:25
team 791:6
technique 792:2,
 4,7
technology 762:7
Telehealth
 793:7,17 794:2,5,
 19
telephone 756:8
telling 799:9,10
tells 822:26 823:6
ten 805:11
tend 797:3
terms 815:8
 824:2,5,6 825:17
testified 786:6
testifies 802:23
testify 809:21
testimony 761:10
 784:26 787:6
 832:26
tests 775:7
Texas 773:20
 774:9 782:1,6
text 763:2
theoretical 822:6
 827:14,16

therapy 766:15
thing 750:3
 751:23 754:22
 755:1 759:19
 775:3,5 786:19
 796:16 813:18
 822:2,8,9
things 756:21
 758:5 759:24
 766:23 767:17
 771:26 773:6,8,
 14,22 775:12
 777:16 779:3
 783:15 785:19
 791:16 793:2
 797:2,15,20
 798:3 809:14
 810:19 811:8
 812:4 817:26
 835:25
thinks 776:16
 781:1 782:22
 810:1,3 823:18
Thomas 834:18
thought 757:15
 776:26 779:7
 782:17 790:26
 791:7,10 806:15
 830:12 833:19
 835:11
thoughtful 769:9
thoughts 752:2
threat 772:14
 777:16
threatened
 772:8,22
threatens 754:24
 771:22
three-and-a-half
 834:1
ties 778:17
time 750:5
 751:17 752:5
 761:23 763:8,15
 764:1 768:20,21,

24 771:19 772:5
 775:8 797:12
 803:11 805:12,15
 806:21 807:12
 810:20 815:15
 818:17,18 820:1
 822:7 830:16,17,
 19 832:1 834:22
 835:8 836:1,6
times 760:5 766:3
 769:16 793:22
 800:12 808:26
today 751:2
 757:13 760:10
 761:10 779:26
 785:1 786:25
 787:21 833:7
 835:25 836:5
told 797:15
 806:13 823:13
 833:10
tool 791:24
tools 766:14
totally 785:12
 798:7 823:14
touched 760:4
 768:14 807:4
town 793:1 794:7
training 773:21
 778:6,13
transcribed
 837:6
transcript
 748:23 837:1,4
transcripts
 835:21
transmission
 810:26 811:6
 812:25
travel 794:8
traveling 775:7
travesty 757:11
treat 760:8 766:7,
 12 799:14

806:12,19
treated 775:18
 786:3,8
treating 754:24
 756:15 769:20
 772:26 779:21
 786:18 792:20,21
 798:12,23 800:25
 801:1 802:14
 807:7 808:15
 826:11
treatment
 753:16,22,25
 755:3,12,16,23
 766:1,3,26 768:7
 770:9,12 771:10
 775:20 779:24
 791:18,19,26
 792:13,24 793:5,
 11 799:10 816:12
treatments
 753:10 757:2,3
 758:10
treats 754:5,8
 771:23 780:1
Tribunal 749:7,
 8,24 750:13
 789:7,8,24 814:9
 815:2 831:19,26
 836:20
trouble 768:2
 832:1
trust 767:12
truth 809:14
 810:2,3,4,9,19
tunnel 774:3
turn 755:9 803:2
 821:17
turned 755:8
turning 802:23
twisting 792:8
two-and-a-half
 790:16 794:23
type 759:18 772:4
 782:21 792:24

796:4,19 825:1
types 777:16
 795:3,14,22
 807:26 809:18
typical 783:8
typically 804:13,
 22

U

ultimately
 826:13,23
unavailable
 750:12 751:2
understand
 751:16 759:15
 769:7 772:3
 778:21 779:5
 802:26 809:22
 829:6
understanding
 760:8,9 782:2
 791:4 828:16,17,
 18,21
understood
 801:9 818:2
 821:16
undertook
 777:25
unlike 826:6
unreasonable
 757:22
upheld 815:9
upper 792:2,6
upset 756:9,16
 769:22
urgent 751:2

V

vague 823:21
valid 822:21,23
 823:7,9,18,21,22
 824:2,4,5,6

variables 805:5
808:21
variety 781:23
782:2
varying 802:3
vibrating 766:14
video 802:23
803:2,6,23,25
804:3,9,12 817:7
Videoconference
749:1 789:1
view 799:7
821:19
views 760:17
777:18,19 780:6
786:14 825:12
viral 812:23
virologist 777:18
virtually 755:14
763:14
virus 812:24
viruses 809:14
810:19
vital 791:15
voice 825:24

W

waiting 773:26
walk 792:19
Wall 749:18
753:2,4,6,13,15,
21,24 754:1,4,7,
13,15,23 755:1,6,
11,15,23 756:4,7,
14 757:12 760:7,
10,17,20 764:2,4
765:15 766:2,19,
25 767:24 768:7,
16 769:14,19,25
770:9,11 771:9,
21 772:25 775:3,
25 779:23 780:1,
6,13 786:7,14,17

789:18 825:16
826:7
Wall's 753:10,19
756:12 764:3
765:13 769:5
835:4
wanted 808:15
825:7 831:26
833:9
Warren 748:10
765:5,8 834:18
ways 767:21
774:6 812:24
weak 767:25
wear 753:15,17,
22,24 754:1,8,9,
11 755:2 760:7
770:8,10,12,20
771:8,9,17
772:25 775:4,16,
18 800:24
804:18,20,24,25
807:10,19 808:15
809:11 812:14,
17,20 813:9
824:21 828:26
829:11,14,17
wearing 754:4,
10,11,13,14,15
770:13,14,15
771:14,23
774:13,19,21
779:20,22,23
781:8 804:19
806:12,26 807:6,
23 808:18,24,25
809:7 812:22
826:10
weather 750:5
week 773:20,21
774:11 797:23
798:10
weeks 835:20
weigh 826:22,25
whatnot 768:24

771:12 774:21
775:7 778:14
781:23
whatsoever
775:1 808:3
wide 782:2
wife 769:15
willingly 801:4
802:18 804:18,20
witnesses 750:19,
24 751:4,14,23
752:6 761:21
763:11 833:17
834:12 835:2,3
wondering
796:11 799:1
word 823:12,25
words 761:13
781:1
wore 754:9
work 750:20
751:3 755:18
767:23 768:4
772:7,11,12
787:25 791:6
804:26 807:11,25
813:1 833:10
workbench
766:14
worker 795:7
workers 795:4,8
working 771:14
805:1 811:18,23
workplace 813:8
works 762:19
world 767:11,16
768:20 773:7,8,
17 781:20,21
worn 786:21
801:1 802:14
worry 758:23
worrying 776:2
worse 830:19

worst 805:8
worth 807:1
826:20 830:18,21
writing 830:13
wrong 754:22
757:5,13,14
810:11 813:15
827:19,22
wronging 832:6

Y

year 805:25
818:22 830:2
year-and-a-half
805:8 807:7
811:9
yearly 785:19
818:23
years 753:5
765:14 767:13,14
769:15 772:1
790:16 794:23
796:5 797:7
804:23 805:11

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

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	November 20, 2021	Morning Session	841
6	CHRIS SCHAEFER, Sworn, Examined by Mr. Kitchen		842
7	(Qualification)		
8	Mr. Maxston Cross-examines the Witness		847
9	(Qualification)		
10	Discussion		849
11	Ruling (Qualification)		854
12	CHRIS SCHAEFER, Previously sworn, Examined by		856
13	Mr. Kitchen		
14	Mr. Maxston Cross-examines the Witness		900
15	Mr. Kitchen Re-examines the Witness		910
16			
17	November 20, 2021	Afternoon Session	914
18	DR. BAO DANG, sworn, Examined by Mr. Kitchen		915
19	Discussion		969
20	Mr. Maxston Cross-Examines the Witness		971
21	Mr. Kitchen Re-examines the Witness		979
22	Certificate of Transcript		982
23			
24			
25			
26			

EXHIBITS

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

Description	Page
EXHIBIT H-8 - Excerpt from the Canadian Thoracic Society guidelines (Document not Provided to be Marked)	964

1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 November 20, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS COMMENCED AT 9:16 AM)

24 THE CHAIR: This is continuation of the

25 Hearing Tribunal for Dr. Wall is back in session.

26 And Ms. Nelson does have your witness in the

1 waiting room and is prepared to bring him into the
2 meeting, Mr. Kitchen, so I'll turn the floor over to
3 you.

4 MR. KITCHEN: Good morning, Mr. Schaefer,
5 can you hear us?

6 THE WITNESS: Yes, good morning.

7 MR. KITCHEN: Excellent. Are you able at
8 all to tip your camera down about -- yeah, perfect,
9 there you go, excellent.

10 All right, so, Mr. Schaefer, the first thing we're
11 going to do is we're going to swear you in, and
12 Karoline, our court reporter, is going to do that, and
13 once she does that, then we'll get into the
14 questioning.

15 THE WITNESS: Sounds good.

16 CHRIS SCHAEFER, Sworn, Examined by Mr. Kitchen
17 (Qualification)

18 MR. KITCHEN: So, Mr. Chair, I'm going to
19 start with some qualification questions. As you'll
20 know from my end the other day, there was consent
21 between the parties on the qualification of the next
22 witness but not on this one, so I'm going to run
23 through some questions and then propose a qualification
24 to you, and then, of course, Mr. Maxston will have some
25 opportunity to make some comments.

26 Q MR. KITCHEN: Mr. Schaefer, the first thing

1 I'll start with is what's your current occupation?

2 A My current occupation is as an Occupational Health and
3 Safety consultant. I have been doing that now for
4 quite a number of years. Since 2004, I've had my own
5 company, but I've been working in Occupational Health
6 and Safety as a consultant since 1994.

7 Q Okay, thank you. Now, you said "consulting", what are
8 the types of things you consult on?

9 A Well, I consult on all aspects of Occupational Health
10 and Safety training. Primarily what I do is one of my
11 specialties is respirator fit testing and training. So
12 respirator fit testing and training that I would
13 consult on would be for any atmospheric hazard from
14 anything that would require the most basic level of
15 respiratory protection all the way up to and including
16 respiratory protection for emergency responders like a
17 self-contained breathing apparatus, both closed- and
18 open-circuit systems.

19 Q And do you teach any courses on respirators or how they
20 fit?

21 A Yes, I do. I do teach a course, a course on respirator
22 fit testing and training, and I have been teaching that
23 course as an advisor to the University of Alberta
24 Faculties of Medicine and Dentistry for several years,
25 as well as private clients.

26 Q I just want to -- on your résumé, you've got a long

1 list of certifications, I don't want to bring you
2 through all of them, but I'll just ask you about a
3 couple of them. One is a CSA respirator training and
4 fit testing instructor. Can you tell me about that
5 certification?

6 A Sure. CSA, if you're not already aware, is equipment
7 certification, and they do have their own standards for
8 equipment certification. So CSA stands for the
9 Canadian Standards Association, and if you have ever
10 worked in an industrial environment, from a very basic
11 perspective, you would know that CSA does the approvals
12 for basic safety equipment like steel-toed boots, hard
13 hats, and safety glasses, among many others, but those
14 would be probably basic ones that you would be aware
15 of, and CSA is the certification body for the standards
16 set for the safety of that equipment and others as
17 well.

18 So as the course for CSA goes, it's a course that
19 is within the standards of the use of that equipment
20 through the Canadian Standards Association.

21 Q Thank you. I see also hazmat instructor. Now, I think
22 I know what hazmat is, but could you please tell me
23 what that's all about?

24 A Hazmat is hazards materials and training. So for
25 people that go into high-risk situations like
26 biohazardous environments, they need specialized

1 training and specialized equipment, because there is a
2 lot of chemicals, vapours, and gases and even
3 particulates that are very small, and those can
4 penetrate through basically any part of your body.

5 So with hazmat training, it's all about, the
6 basics are, is you've got to have full containment,
7 you've got to have full encapsulation of workers or
8 responders, and they have to be provided for any
9 potential exposure through either inhalation or skin
10 absorption of contaminants that could negatively affect
11 their health.

12 Q Thank you. And just one more, right under that, you
13 have "H2S alive instructor". Can you tell me what the
14 H2S alive thing is?

15 A Yes, absolutely. H2S is the chemical formula for
16 hydrogen sulphide gas. Hydrogen sulphide gas is a
17 common detriment to oil and gas workers for --
18 primarily in Western Canada. We see our highest levels
19 of hydrogen sulphide gas in Western Canada oil fields,
20 so that is a course that is required for anybody that
21 works in oil and gas situations that they have that
22 course so that they know how to protect themselves and
23 also respond to help others in the event of unintended
24 or accidental hydrogen sulphide release or exposure.

25 Q All right, thank you. So if I understand this, I don't
26 think I do, the 'S' stands for sulphide. I'm curious,

1 in your line of work, have you dealt with issues around
2 carbon dioxide?

3 A Yes, absolutely.

4 Q Have you dealt with issues around oxygen in the air?

5 A Always, always. Yeah, you know, having a safe amount
6 of oxygen in air is pretty essential to personal
7 safety, so that's definitely a big part of my whole
8 career.

9 Q And are you familiar with the Occupational Health and
10 Safety legislation?

11 A M-hm, yes, I am.

12 Q Thank you. Is that something you commonly work with?

13 A You know, it depends on the course that I'm offering
14 and the training that I'm offering, but, yeah,
15 absolutely. Atmospheric hazards are a big, huge
16 component of Occupational Health and Safety.

17 Q Have you done any testing on the cloth or nonmedical
18 masks that have been commonly used to try and prevent
19 the spread of COVID?

20 A Yes, I have.

21 Q Have you done any testing on the medical or procedural
22 or surgical masks that have been commonly used to try
23 and prevent the spread of COVID?

24 A Yes, I have.

25 Q Thank you.

26 MR. KITCHEN: Well, Mr. Chair, I'm going to

1 read out for you -- those are all my questions on
2 qualification -- I'm going to read out what I'd like to
3 have Mr. Schaefer qualified as. I'd like to have
4 Mr. Schaefer qualified as an expert in the area of
5 Occupational Health and Safety, in particular, all
6 types of respirator masks, including the medical and
7 nonmedical masks used to attempt to prevent the
8 transmission of COVID-19. And, of course, I --

9 THE CHAIR: Can you just read that one
10 more time, please?

11 MR. KITCHEN: Sure. I'd like to have
12 Mr. Chris Schaefer qualified as an expert in the area
13 of Occupational Health and Safety, in particular, all
14 types of respirator masks, including the medical and
15 nonmedical masks used to attempt to prevent the
16 transmission of COVID-19.

17 THE CHAIR: Mr. Maxston, did you wish to
18 comment before we --

19 MR. MAXSTON: I have I think two brief
20 questions for Mr. Schaefer, and then my friend is aware
21 of this, I've got a few comments about the
22 qualification that's being tendered, so I'll just ask
23 my questions briefly.

24 Mr. Maxston Cross-examines the Witness (Qualification)

25 Q MR. MAXSTON: Good morning, Mr. Schaefer.

26 A Good morning.

1 Q My two questions for you are this: I'm looking at the
2 bottom of page 2 of your cv, and it talks about, you
3 say, "Associations: Member of Alberta College of
4 Paramedics"; are you still a regulated member of the
5 Alberta College of Paramedics?

6 A No, I am not, but that is a -- that is a course that I
7 had -- that is a -- sorry, that is a membership that I
8 had a couple years ago. I had completed the Alberta
9 College of Paramedic program as far as the emergency
10 medical responder is concerned, and I did have that
11 membership, yes.

12 Q Forgive me for not quite understanding this then, were
13 you a regulated member of the Alberta College of
14 Paramedics, so you could practice as a paramedic, or
15 had --

16 A Yes --

17 Q -- just taken the --

18 A -- yes, I was --

19 Q -- courses --

20 A -- yes, I was. I was an actual member of the Alberta
21 College of Paramedics, registered through the course
22 that I had taken, so I had specific registration by
23 completing exams with the Alberta College of Paramedics
24 to practice as a medic within Alberta.

25 Q Sure, and I --

26 A So I was definitely registered.

1 Q And how long were you a regulated member of the Alberta
2 College of Paramedics?

3 A One year.

4 Q And do you recall your designation, or were you an
5 advanced care paramedic, primary care paramedic, EMT,
6 EM -- you know, do you recall the designation that you
7 were in?

8 A Of course. EMR, emergency medical responder.

9 Q And you can correct me if I'm wrong, but I think "EMR"
10 is -- I think there's three designations; the first is
11 advanced care paramedic, then there's primary care
12 paramedic, and then there's the designation you were
13 in, which is EMR; is that correct, to your
14 understanding?

15 A That's absolutely correct, yes.

16 Q And, I'm sorry, you said you were an EMR for one year
17 with the College?

18 A Yes.

19 Q Okay.

20 MR. MAXSTON: Those are all my questions,
21 Mr. Chair, for the witness. I wonder if I might
22 provide some responses to the qualification that
23 Mr. Kitchen has tendered.

24 THE CHAIR: Okay.

25 Discussion

26 MR. MAXSTON: My friend will rightly point

1 out to you that I could make these same comments during
2 my closing statement, and I made them during the
3 opening statement, but I just want to reiterate the
4 Complaints Director's position this is not a question
5 of the efficacy of masking in this hearing, it's about
6 compliance with regulatory responsibilities. We'll
7 review that in greater detail. You can, of course,
8 accept evidence in whatever manner you see fit. The
9 Complaints Director maintains his position that this
10 type of evidence should be given little weight in terms
11 of the charges that are in front of you.

12 I do want to mention that the College anticipated
13 that Mr. Schaefer's testimony would be confined or
14 largely confined to the question of surgical or
15 procedure masks that are set out in the Pandemic
16 Directive, and, of course, the College does not have
17 any ability to regulate or control the types of masks
18 that members of the public wear. So I think the
19 qualification that's been tendered is perhaps a little
20 bit broad in terms of it referring to all types of
21 respirator masks, so I have a little concern in that
22 regard -- have a concern in that regard.

23 And I'll just, for reference sake, I just want to
24 remind the Tribunal of some comments that were made by
25 Mr. Kitchen during the qualification -- pardon me, the
26 preliminary application that occurred in terms of

1 whether Mr. Schaefer could be called at all as an
2 expert witness, and you'll recall we objected to that,
3 and you made a ruling that you would allow
4 Mr. Schaefer.

5 And just very briefly, this is on page 55 of the
6 transcripts, this is my friend commenting on what
7 Mr. Schaefer will be called to testify about: (as
8 read)

9 It should be quite obvious that this report
10 [meaning Mr. Schaefer's] deals with a
11 different subject than Dr. Wall's other three
12 experts. The other three experts are various
13 scientists and medical doctors ... They are
14 all dealing with COVID-19; they're dealing
15 with the SARS-CoV-2 virus. They're not
16 dealing with whether or not masks are
17 harmful. Certainly not in a specific sense
18 that Chris Schaefer is doing, that being
19 oxygen levels and carbon dioxide ...

20 The effectiveness of masks is a different
21 subject from the harms of masks.

22 And a few pages later, you made a ruling that
23 Mr. Schaefer can testify. So my client's clear
24 expectation is that Mr. Schaefer's testimony will be
25 confined to, again, the harms of masks, not the science
26 related to COVID or transmissibility or anything along

1 those lines.

2 So Mr. Kitchen has been scribbling, and I'm sure
3 may want to made some response comments to what I said,
4 but again I think it's important to remember the basis
5 on which this witness was offered initially when we had
6 our preliminary application on that, and I think it's
7 very important for Mr. Schaefer's comments to be
8 confined to the question of the harm of masks and
9 nothing more. Thank you, Mr. Chair.

10 MR. KITCHEN: Mr. Chair, if I could, just a
11 couple comments in response.

12 THE CHAIR: Yeah.

13 MR. KITCHEN: First, the reason I say all
14 types of respirator masks is because, well, that's just
15 the reality; that's what Mr. Schaefer has dealt with in
16 his line of work. And I'm a little surprised to hear
17 that the Complaints Director didn't anticipate evidence
18 about nonmedical masks in addition to medical, as, of
19 course, you'll see in the first paragraph of
20 Mr. Schaefer's report, it talks about the different
21 kinds of masks, and so it's a little surprising.

22 But the reason that I've asked inclusion of cloth
23 masks is -- or nonmedical masks is because that's a
24 reality of what we're dealing with, and that's what
25 Mr. Schaefer has dealt with, and those aren't
26 dramatically different, they're very similar, and so I

1 don't think that scope is too broad, I don't think it's
2 inappropriately broad, I don't think it's irrelevantly
3 broad. So I would ask that he not be limited to talk
4 about medical masks but also be permitted to talk about
5 nonmedical or cloth masks.

6 And, of course, I have no issue with my friend's
7 comments about being limited to talk about the harms of
8 masks and not the efficacy. We won't have any
9 questions about that, so it's just the harms of masks,
10 but when I say "masks", I mean medical and nonmedical.
11 Those are all my submissions in response.

12 THE CHAIR: Thank you. I think we'll take
13 a short break while the Hearing Tribunal caucuses to
14 give you an answer to your request, Mr. Kitchen. So if
15 we could be moved to a break-out room. Hopefully this
16 won't take very long. Thank you.

17 MR. KITCHEN: Thank you.

18 (ADJOURNMENT)

19 THE CHAIR: Okay, we're back in session,
20 and the Hearing Tribunal discussed your request,
21 Mr. Kitchen, and we have one question for Mr. Maxston,
22 and we wanted a clarification on why Mr. Schaefer
23 should be limited to medical masks.

24 MR. MAXSTON: I think, Mr. Chair --

25 THE CHAIR: Is it because of what's in the
26 transcript? Is it because of what's in the CMOH

1 orders?

2 MR. MAXSTON: I think it's because primarily
3 of what is in the Pandemic Directive that the College
4 has, which refers to the requirement for chiropractors
5 to wear surgical or procedure masks as being the
6 minimum acceptable standard.

7 I think I said in my comments about this question,
8 and I'll invite Mr. Lawrence to comment if he wants to,
9 but we anticipated that the primary focus of
10 Mr. Schaefer's testimony would be on those matters,
11 because the College cannot -- I see Mr. Lawrence
12 nodding his head -- the College cannot regulate what
13 members of the public do, it can only regulate what
14 chiropractors do. I'm not sure if that answers your
15 question, but that was the concern. We didn't want
16 this net to be cast too broadly.

17 THE CHAIR: Okay, I think we're just going
18 to take that under advisement, Mr. Maxston. We'll go
19 back into our cubbyhole, and we should have an answer
20 here shortly, thank you. Just please bear with us, and
21 we'll go to our break-out room.

22 (ADJOURNMENT)

23 Ruling (Qualification)

24 THE CHAIR: The hearing is back in
25 session. The Hearing Tribunal has discussed the issues
26 raised. We just want to clarify that the testimony

1 will be regarding the harm and not the efficacy
2 associated with these masks, and we've also ruled that
3 the testimony will relate to the medical masks not the
4 nonmedical masks.

5 Having said that, we're aware that there are some
6 issues here, and if Mr. Maxston feels that the line of
7 questioning goes beyond the scope that we've discussed,
8 then he certainly has the option to raise objections.

9 MR. KITCHEN: I wonder, and I invite
10 comments on this, and I can be corrected if I'm off the
11 mark on this, is it possible for me to receive written
12 reasons for that decision, because that will likely be
13 something that will end up being appealed, so -- and
14 maybe that comes at the very, very end when we get
15 written decisions -- written reasons on the whole
16 decision, but that's something I would -- I'd ask for
17 written reasons on it.

18 THE CHAIR: At the risk of taking us back
19 to a break-out room, my thought would be that we can
20 address it in the decision, once the decision is made,
21 make a note to that effect. I don't think we want to
22 interrupt this hearing to be doing that. I don't want
23 to start writing parts of decisions, so --

24 MR. KITCHEN: No, no, I'm not asking you for
25 it right now, I apologize. No, what I meant is I'm
26 just asking whether it's, you know, tomorrow or a week

1 from now or a month from now or at the very end,
2 that's -- I'm not asking for it right now. I'm just,
3 in general, I'm making it known that, you know, likely
4 that will be a source of appeal, so I think it best
5 that there be reasons for that.

6 THE CHAIR: Duly noted, Mr. Kitchen.

7 MR. KITCHEN: Thank you.

8 CHRIS SCHAEFER, Previously sworn, Examined by
9 Mr. Kitchen

10 Q MR. KITCHEN: All right, well, with that,
11 Mr. Schaefer, you can hear me?

12 A Yes, I can.

13 Q Excellent, we'll jump right in. And I think you've
14 already answered this, but just to clarify, you live
15 and work in Alberta; is that correct?

16 A That is correct, yes.

17 Q Can you tell me what was the, generally speaking, what
18 was the type of work you did prior to the onset of
19 COVID?

20 A I had been doing safety training for my own company,
21 but I had been doing safety training for a lot longer
22 than that, but -- so safety courses in a variety of
23 disciplines, as well as fit testing and training.
24 So -- but fit testing and training has definitely been
25 a significant portion of the work that I've done in
26 clients that range from the military, to health care,

1 to educational institutions and private industry.

2 Q Has that work changed any since the onset of COVID?

3 A Absolutely, it's changed a lot. It's changed a lot
4 primarily because there's so much -- there's no real --
5 there's no real requirement for many of the masks that
6 are mandated for COVID, that they would be fit tested,
7 there's no requirement to that.

8 So before the COVID thing, everything -- any type
9 of mask whatsoever had to be fit tested on the wearer.
10 They had to have approval fit test for safety. But
11 since COVID, since this virus, there has been no
12 requirement for the majority types of these devices to
13 require a fit test to the user, which is really, really
14 odd.

15 Q And why is that odd?

16 A It's odd, because in order to determine whether or not
17 the wearer is suitable for wearing a mask, there are
18 some screening processes that have be completed first.

19 So, for instance, if you have difficulty breathing
20 without a mask, wearing a mask is going to make it much
21 harder for you to breathe. It will increase breathing
22 resistance for everybody. So if you're healthy, you
23 breathe effortlessly right now, you will experience
24 increased breathing effort by covering your mouth and
25 nose, and so there's a screening process. Not
26 everybody is capable of wearing a mask. Nobody -- like

1 there's a screening process that has to be completed.

2 So for people that have pre-existing medical
3 conditions or identify pre-existing medical conditions
4 within screening to wear a mask, they have to go to
5 their doctor and get further testing done to determine
6 their suitability or ability to be able to wear a mask
7 and stay healthy. So that's one thing. The screening
8 process, there's no screening to determine the
9 suitability of masking for the general population and
10 employment in general, right? So any workers, there's
11 no screening anymore; it's just wear one or else, and
12 that's never happened before.

13 The other thing is is that in order for any type
14 of mask to protect the wearer, that mask has to make an
15 airtight seal around the face. Without an airtight
16 seal, there's no way that it can provide any
17 respiratory protection. So a fit test determines that
18 it is making an air-tight seal to your face so that it
19 can verify that the contaminant is being filtered; it
20 is having to flow through the filter into the wearer's
21 mouth and then lungs.

22 But if you don't have an airtight seal, then the
23 air that you inhale is -- a lot of it's going to follow
24 the path of least resistance, which is through the
25 openings, any openings, available openings, because
26 it's harder to pull air through a filter than it is

1 just to breathe surrounding air. So if there's leaks,
2 that's where you're going to be pulling the contaminant
3 in from.

4 Q And so you talked about air coming in, and it coming in
5 through what I'm going to call the path of least
6 resistance, is that also true for air going out?

7 A Well, you know, there is some air coming in, but when
8 you look at the volumes of breathing of inhalation and
9 exhalation, it's going to cause an insufficient air
10 supply. You're going to get a buildup of your own
11 exhaled carbon dioxide in the cover, and if you're
12 going to get -- see, in an actual respirator --

13 Let me explain in an actual respirator, actual
14 respirators have an exhalation valve built into them,
15 so that every time you exhale, your carbon dioxide gets
16 pushed out the exhalation valve so you don't rebreathe
17 it. If you just put a closed cover on your face, then
18 it will capture some part of dioxide, and as you
19 inhale, it will force you to rebreathe some air but
20 also carbon dioxide that can be significant amounts
21 above and beyond what is considered safe according to
22 Occupational Health and Safety air quality standards.

23 Q Thank you. All right, well, you've already answered
24 some questions, but just to go back to sort of a
25 preliminary issue, let me ask you a couple different
26 questions. Mr. Schaefer, do you know Dr. Curtis Wall

1 personally?

2 A I've never met him. I don't know what he looks like,
3 and I really don't know much about him at all.

4 Q Do you have any personal interest or personal stake in
5 the outcome of this case?

6 A Absolutely not. I've just been hired to give my expert
7 opinion, and that's what I'm here for.

8 Q You don't have any financial interest or stake in the
9 outcome of this case then?

10 A No, because I'm getting paid by the hour, and so it
11 doesn't matter to me what the outcome is.

12 Q And just to confirm, do you understand your duty to
13 provide this Tribunal with your expert knowledge and
14 opinions in an objective and neutral manner?

15 A Absolutely.

16 Q Thank you. Now, just to give a bit of a road map,
17 we've already got into the meat of it a little bit, but
18 I'm going to be asking you about, you know, what masks
19 really actually are, and then I'm going to ask you
20 about carbon dioxide, about oxygen, a little bit about
21 testing, and then, lastly, I'll ask you, from an
22 Occupational Health and Safety perspective, a little
23 bit about the harms or hazards involved.

24 So to start off, now -- and my friend may want to
25 object to this, because we've got issues with different
26 types of masks, but in the very first paragraph of your

1 report, you say -- we're talking about the masks that
2 are being mandated to attempt to prevent the stop of
3 COVID, you say: (as read)

4 These masks are the medical, nonmedical, and
5 procedural masks.

6 Now, can you please explain for us what those terms and
7 what those types of masks mean to you?

8 A Sure, absolutely. So a medical mask in a health care
9 setting is referred to an N95. It's something that
10 is -- what health care uses is a closed cover
11 primarily, it is N95, which means that it's a filter, a
12 filtration that's not resistant to oil, that's what the
13 'N' is. 95 refers to the best-case scenario protection
14 that you could get with that device if it's properly
15 fitted and used and disposed of and replaced as
16 specified, as required, as the manufacturer requires.
17 And that's what the medical is.

18 The nonmedical is any device that is really you
19 put it on your mouth and nose. So you could take a
20 plastic bag put it over your head; I mean, that's not a
21 nonmedical mask, but, you know what, a nonmedical mask
22 is anything that covers your mouth and nose. So if you
23 want to put a bandana on your mouth and nose, you want
24 to -- you want to -- anything literally that covers
25 mouth and nose is classified as a nonmedical mask.

26 And a procedural mask is something that is -- is

1 something that they will typically use, and I won't say
2 what they use it for because it's kind of -- you know,
3 they use it for different things in health care
4 settings, but it's a looser fitting -- it's a slightly
5 looser fitting style, but it's still -- it's still
6 enclosed enough that it typically -- it's like the blue
7 mask, right? So a procedural mask is kind of -- it's a
8 looser fitting than the N95, N95 is a tighter fitting
9 and, depending on nonmedical, it can be anything from
10 cloth to virtually anything anybody wants to do to
11 cover their mouth and nose, because there's really
12 no -- there's no rules on nonmedical masks; it's really
13 just anything you put on your mouth and nose could be
14 considered a nonmedical mask that covers your face.

15 And procedural mask, like I said, it's really just
16 a -- it's a device. These are all -- they're all like
17 the -- N95 and procedural would be considered temporary
18 use only, to be replaced regularly, as needed when
19 there's moisture buildup inside, and disposed of
20 immediately. So the procedural and the medical in
21 health care settings, both have to be used -- they're
22 really only designed for short duration use and then to
23 be immediately disposed of. They were never designed
24 for hour upon hour use. It was never designed that
25 way, and it's still not designed that way. So it's
26 been used that way, but it's not designed that way.

1 So there are some dangers to that, but as far as
2 procedural masks go, just -- it's a looser fitting mask
3 that they use in the health care settings and
4 disposable, just like N95. N95s are tighter fitting;
5 procedurals are looser fitting.

6 Q Thank you, that's helpful. Would you say that when we
7 use the word "surgical mask", in your experience, is
8 that typically a reference to that category of
9 procedural or blue masks?

10 A Yeah, you know, surgical masks, you know, in surgery,
11 physicians and other health care practitioners, they
12 may use N95, or they may use procedural. It's -- it
13 depends on -- depends on what's going on, but both may
14 be used.

15 Q So you're aware that what the Alberta College of
16 Chiropractors has mandated that chiropractors must
17 wear -- this mandate is found in the COVID-19 Pandemic
18 Practice Directive, you're aware that the masks -- the
19 type of masks that the Alberta College of Chiropractors
20 is requiring chiropractors to wear are those procedural
21 or blue masks?

22 A Yes, I am aware.

23 Q Okay. And you're aware that the CMOH orders that
24 mandate masking for the general public mandates the
25 nonmedical masks?

26 A Yes, I am aware.

1 Q All right, in the second paragraph of your report, you
2 state that: (as read)

3 Masks are required to have engineered
4 breathing openings.

5 Can you explain what "engineered breathing openings"
6 are, and why masks are required to have them?

7 A Okay, so if you are going to cover your mouth and nose
8 with any device, it's important that you do not
9 restrict your oxygen coming in, the air coming in, and
10 your carbon dioxide and expelled toxic air leaving, and
11 that is why we exhale outside of our bodies in the
12 first place.

13 If we take a look at a mask, a mask has to have
14 engineered openings. So, for instance, if you take a
15 look at, say, here is a common Halloween-style mask,
16 it's got engineered openings for nostrils for
17 breathing, as well as mouth for breathing. It's
18 important to be able to have easy, free breathing.
19 When you restrict your breathing, then you get that
20 accumulations of exhaled carbon dioxide that are then
21 rebreathed because there's no exhalation valve to purge
22 it, so you rebreathe your own exhaled waste toxic
23 carbon dioxide, which is not going to be good for
24 anybody, and for people over a longer period of time
25 and if there's any pre-existing medical conditions
26 could be a very serious situation.

1 Now, if you look at an actual respirator, like
2 this, you can see that it is covered, there are two
3 filters attached in the design. In the middle, there's
4 an exhalation valve. That's to purge exhaled heat,
5 moisture, and carbon dioxide, okay, for a reason,
6 because we don't want to rebreathe it. So air comes in
7 here, air can only enter through inhalation, air can
8 only leave through exhalation.

9 And when I say "engineered openings" -- I say
10 engineered opening and exhalation, but also engineered
11 opening and inhalation. So if I unscrew the filter,
12 you can see, if I just turn it like this, you can see
13 it's a big hole, there's a big hole there. The reason
14 the hole is there is so that air can flow in very
15 easily and freely so that, you know, it can enter your
16 lungs as unobstructed as possible, because anything
17 that you put on your mouth or nose, it makes it harder
18 to breathe. Depending upon the person, the length of
19 exposure, the type of work or activity they're engaged
20 in, and any pre-existing medical conditions could all
21 change their ability to be able to wear that device at
22 all.

23 Q I notice you used the word "device", just to clarify,
24 you would say that these procedural or blue masks we're
25 talking about, you would call that a device?

26 A Well, let me explain something, it's very difficult for

1 me to refer to any of the mandated masks for COVID as
2 actual masks. It's really difficult. I struggle with
3 it. It's hard, because they don't meet the actual
4 definition of a mask from anything as simple as a
5 Halloween mask, to a goalie mask, to a scuba mask, any
6 kind of actual mask that's engineered, it's engineered
7 for easy breathing.

8 If you look in a goalie mask, it looks full faced,
9 it looks pretty encapsulated, but it does have
10 breathing vents, so the air can flow in and out easily.
11 Every type of mask, it's important that air flows in
12 easily and air flows out easily.

13 Now, a goalie mask isn't going to offer anybody
14 respiratory protection or a scuba mask, but they are
15 devices that are engineered for breathing, but if you
16 just close your -- take a piece of material or a paper
17 and cover your mouth and nose with it, it will restrict
18 breathing, it will restrict your ability to inhale, and
19 it will restrict your ability to exhale.

20 Q So I know in your report, you use the term "breathing
21 barriers" to describe these types of so-called masks
22 that are mandated for COVID. Can you just explain to
23 me why you use that term?

24 A Well, I coined that term actually, and the reason I use
25 it is because I think it most accurately describes the
26 situation -- what actually happens when you wear one of

1 these. If you've ever worn one, and, for most people,
2 they probably have, they probably notice immediately
3 that it does become increasingly difficult to breathe
4 with one on. There's a reason that you're blocking
5 your breathing. So when I call them breathing
6 barriers, it's based upon the practicality that they
7 block breathing, they block the normal flow of
8 breathing.

9 Now, all respirators, even proper respirators,
10 like the one I showed you, with the two filters and
11 exhalation valve in the middle will increase breathing
12 difficulty a little bit because you are going to pull
13 air through the filter, so it's going to be a slight
14 increase in inhalation effort but very minimal, and
15 because it's designed for breathing, it's very minimal.

16 Let me remind you what I said earlier, anybody
17 that wears any respirator before COVID needed -- or
18 mask, for that matter -- needed any type of filtering
19 mask needed to be fit tested. And before they could be
20 fit tested, they had to be screened for their ability
21 to wear it safely.

22 And without that screening, it's like Russian
23 roulette, who's going to have to wear one and shouldn't
24 be wearing one. Somebody with COPD, somebody with
25 heart conditions, lung conditions of any type, high
26 blood pressure, these are all people that need to be,

1 before COVID, needed to be examined by a physician to
2 determine their ability to safely wear a respirator
3 that's actually engineered for breathing, much less a
4 closed cover over your mouth and nose that caps -- that
5 makes it exponentially harder to breathe and captures
6 carbon dioxide in significant amounts.

7 So that's why I call it a breathing barrier.

8 Q Thank you. Do you find it strange that we seem to be
9 doing -- based on what you've said, we seem to be doing
10 things very differently post-COVID than pre-COVID when
11 it comes to things like fit testing? Do you find that
12 strange?

13 A I think it's incredibly strange that there would be
14 mandates for closed-cover barriers that aren't
15 engineered -- aren't engineered for easy breathing, and
16 I find it very strange that there is no requirement for
17 a fit test for a filtering mask or respirator. That
18 should be paramount; that should be primary.

19 Q Now, I know you've touched on this, but just to
20 clarify, you say in the fourth paragraph in your report
21 that wearing these what we're going to call breathing
22 barriers are hazardous to the wearer.

23 A M-hm.

24 Q Why exactly are they hazardous?

25 A Well, think about it like this, if you take something,
26 like if you take a piece of cloth or a piece of paper

1 towel or whatever it is, hold it closely to your mouth
2 and nose, it becomes more difficult to breathe, right?

3 So we know that it's harder to breathe, which
4 increases respiration effort. For people with
5 pre-existing conditions, it's not going to be good.
6 But even for people without pre-existing conditions,
7 increased breathing effort, you increase the capture of
8 carbon dioxide, and then you are re-inhaling that
9 carbon dioxide, it's going to cause a variety of
10 negative health effects, even if the person has no
11 pre-existing medical conditions.

12 So common symptoms of blocking your flow of
13 breathing and inhaling excess carbon dioxide can be
14 things like experiencing a headache, nausea, dizziness,
15 lack of coordination, maybe impaired hearing,
16 impaired -- sometimes impaired vision. It can be a --
17 it can be feeling faint, overheating. And it can be
18 worse than that, it could be people that have a very
19 difficult time breathing, feel like they can't catch
20 their breath, and it can go down from there. So
21 anybody that inhales more than what the -- anybody that
22 inhales above what the indoor Occupational Health and
23 Safety standard is for carbon dioxide is at risk.

24 So if you were to look at my report, you would see
25 the standards for carbon dioxide according to the
26 Alberta standards for safety and see that the maximum

1 exposure for indoor carbon dioxide is a thousand parts
2 per million. That's not very high. That's not very
3 high. That's over a 24 period -- 24-hour period, but
4 it's not very high. Because the normal oxygen that we
5 have currently in our atmosphere is around 3 to 400
6 parts per million. So it doesn't have to go very high
7 to get to a thousand.

8 And the testing that I've done inside these
9 breathing barriers is very high levels of carbon
10 dioxide. Even if somebody like -- here's the thing, if
11 you wear a breathing barrier, and you are just sitting
12 at a desk, looking at a computer, you're going to have
13 hazardous levels of low oxygen just from having it on,
14 any one of those three devices on it.

15 And if you are doing an activity like lots of
16 speaking, those levels will drop dramatically, because
17 your oxygen demand will increase dramatically.

18 And as well as, if you look at physical activity
19 like, say, going for a run or something, and your
20 oxygen demands go up significantly, then putting a
21 closed cover on your face and blocking that ability to
22 breathe can have a very severe negative impact of your
23 ability to properly absorb oxygen or as much oxygen as
24 your body needs and dispel -- disperse and dispel
25 carbon dioxide away from you so you don't re-inhale it.

26 Q Thank you. I know you said that a thousand parts per

1 million is the sort of the safe limit for carbon
2 dioxide. How long is too long to be exposed to that
3 much carbon dioxide or more?

4 A Well, according to the -- the highest level that you
5 can legally be exposed to in Alberta, according to
6 Alberta standards -- and they revised their standards
7 in the spring of this year, they actually -- it was
8 actually higher, but they lowered it, instead it's
9 lower, so -- is a thousand parts per million. That's
10 based on a 24-hour exposure.

11 But I'll tell you based upon the testing that I've
12 done and other research publications that I have as
13 references, medical reports and research that I
14 could -- I'm more than happy to submit a long list of
15 certified medical scientific reports to show that
16 levels of carbon dioxide in one of these devices exceed
17 5, 10,000 parts per million within a minute, anybody
18 wearing any one of those three.

19 And oxygen levels -- here's -- carbon dioxide is
20 only one part of the equation. The other immediately
21 life-threatening condition is low oxygen. Hypoxemia is
22 low oxygen in the blood; hypoxia is low oxygen in
23 tissues. So what happens is is if you are not inhaling
24 oxygen concentration, enough of an oxygen concentration
25 in air, you're going to suffer -- you're going to
26 suffer oxygen deficiency in your blood and in your

1 tissues.

2 And so the normal oxygen level in air is 19.5 --
3 20.9 percent, 20.9 percent. Where it becomes dangerous
4 to health becomes immediately dangerous, life and
5 health, according to our regulations is 19.5 percent or
6 lower.

7 So using instrumentation, you could see that the
8 oxygen drop between the breathing barrier in the
9 person's mouth or nose is significantly below 19.5
10 percent. Immediately, within the first 20 seconds,
11 you'll see oxygen drop below 19.5 percent, which is
12 safe levels. And if they're -- if they've got a
13 tight-fitting cover, if their cover is very
14 tight-fitting, especially like the N95 style or some of
15 these cloth covers that are especially tight fitting,
16 but even with a procedural-based mask, you're going to
17 see unsafe levels of carbon dioxide and unsafe levels
18 of oxygen. And even with the procedural-based what
19 they call mask, which I call breathing barrier, is
20 levels far in excess of a thousand parts per million,
21 multiples higher, 10,000, 20,000 parts per million.

22 And I have done -- I've done testing. I've done
23 video to show it. I am competent to operate testing
24 equipment, and my testing equipment has been, you know,
25 properly calibrated and properly tested to ensure that
26 it's working properly as well, so I could verify it.

1 The readings that I take would hold up in a court of
2 law.

3 Q What's the device that you use; what's the name of it?

4 A Well, there's -- I -- there's a number of devices that
5 I could use. It's not -- it's not restricted to one
6 type of device, because any device that has those
7 appropriate sensors with those arrangements -- with those
8 ranges of gas detection, as well as, you know, proper
9 use and maintenance of the device would be suitable,
10 but the one that I used was a MultiRAE Lite most
11 recently.

12 Q And is that -- is that testing device, is it designed
13 to test levels of carbon dioxide and oxygen in the
14 atmosphere?

15 A Yes, it is.

16 Q Okay.

17 A So with these devices, you can get to a (INDISCERNIBLE)
18 quick with any number of sensor configurations, because
19 they're designed to test multiple types of gases, but
20 carbon dioxide and oxygen is a very common
21 configuration, and the sensors can be -- they can be in
22 the monitor and installed in the monitor for that
23 purpose, yes.

24 Q So we know the limit for carbon dioxide is a thousand
25 parts per million, and I heard you say that you took
26 readings inside these masks while they're being worn,

1 and some of those readings were 5 or 10,000 parts per
2 million, but could you give me an idea of what an
3 average would be inside the mask after it's been on for
4 a bit?

5 A Okay, so let's say a couple minutes of wearing either a
6 nonmedical, a medical, or a procedural based, you're
7 looking at, a couple minutes of wearing, 20,000 parts
8 per million carbon dioxide, oxygen levels as low as 18
9 percent, 18 to 18-and-a-half percent. The lowest
10 oxygen can go legally is 19.5 before it becomes
11 immediately dangerous to life and health.

12 So in Occupational Health and Safety standards,
13 when we talk about IDLH, which stands for immediately
14 dangerous to life and health, we're looking at
15 device -- we're looking at levels that might not
16 necessarily cause you to drop dead once they're
17 reached, but certainly they're considered levels that
18 now become -- those exposures become harmful without
19 protection from those exposures.

20 Q And so now I've heard you use the number 20,000. So
21 are these -- well, let me ask you this: The parts per
22 million of carbon dioxide inside the mask while it's
23 being worn, does it fluctuate, or is it steady?

24 A Well, it depends on a number of things. It depends
25 upon what's the activity level of the person that's
26 wearing it. The hard -- the more exertion, the higher

1 the carbon dioxide's going to go. It also depends upon
2 what is the -- how tight-fitting is it around mouth and
3 nose. If it's very tight-fitting, obviously it's going
4 to trap more carbon dioxide than if it's a looser
5 fitting.

6 So there's various factors. So, yes, it can
7 fluctuate, or it can remain steady, depending upon the
8 fit of it and depending upon the activity level of the
9 person that's wearing it.

10 Q But in your experience with the loose-fitting ones,
11 even though there are these leaky areas where air gets
12 in and out, the parts per million of carbon dioxide
13 stays above a thousand inside --

14 A Absolutely. It's still harmful to wear. It's still
15 hazardous to wear for sure, because when you're exposed
16 to levels that are levels that are far in excess, even
17 with the looser -- even if it's not loose-fitting, it's
18 a looser, slightly looser fitting, you're still going
19 to find levels of oxygen that are lower than what is
20 legislatively allowed and levels of carbon dioxide that
21 are higher than what is legislatively allowed.

22 Q Now, you talked about some of the effects of this
23 overexposure to carbon dioxide. Have you, in your line
24 of work, have you ever encountered individuals
25 suffering from these effects?

26 A You know, I am not a physician; I am an Occupational

1 Health and Safety specialist, so I primary measure the
2 hazard. So I test people and equipment for their
3 occupations to ensure that they are protected from
4 respiratory hazards, but I do not evaluate the health
5 conditions of people that may be affected by low carbon
6 dioxide or high levels.

7 Q Okay.

8 MR. LAWRENCE: I'm sorry, to interrupt,
9 Mr. Chair, I don't see Dr. Aldcorn on the screen. I'm
10 just wondering, did we lose somebody? Excuse me,
11 sorry, Mr. Kitchen.

12 MR. KITCHEN: That's okay. I don't see him
13 either. He's --

14 MR. LAWRENCE: She.

15 MR. KITCHEN: I'm sorry, yes, she. Yeah,
16 that's a concern.

17 MR. LAWRENCE: Oh, there she is, okay.

18 DR. ALDCORN: Sorry.

19 MR. LAWRENCE: So I'm not sure if we want to
20 just read the last couple of minutes back for
21 Dr. Aldcorn's benefit.

22 MR. MAXSTON: Maybe we can ask Dr. Aldcorn
23 when she went offline --

24 DR. ALDCORN: Yeah.

25 MR. MAXSTON -- intentionally or not or
26 when she came back.

1 DR. ALDCORN: Completely unintentionally.

2 The last we were discussing was the fact that the
3 numbers of the CO2 and O2 levels would depend on the
4 nature of the tight-fittingness of the mask and the
5 exercise level of the individual. And I apologize.

6 MR. KITCHEN: So that means you did miss one
7 question --

8 DR. ALDCORN: I'm so sorry.

9 MR. KITCHEN: -- well, there's two ways we
10 can handle this: One, there's going to be a
11 transcript, of course, you'll get to read it; two, we
12 could just give Miss -- Miss Karoline to read it. It
13 doesn't matter to me, so I leave it to the Tribunal.

14 THE CHAIR: Let's have the court reporter
15 read it back. That way, she'll get the same thing we
16 all got.

17 THE COURT REPORTER: (by reading)

18 Q Now, you talked about some of the effects
19 of this overexposure to carbon dioxide.
20 Have you, in your line of work, have you
21 ever encountered individuals suffering
22 from these effects?

23 A You know, I am not a physician. I am an
24 Occupational Health and Safety specialist, so
25 I primary measure the hazard. So I test
26 people and equipment for their occupations to

1 ensure that they are protected from
2 respiratory hazards, but I do not evaluate the
3 health conditions of people that may be
4 affected by low carbon dioxide or high levels.

5 Q MR. KITCHEN: Mr. Schaefer -- I take it --
6 yes, everybody's here, good -- Mr. Schaefer, are you
7 confident that if somebody else did the same tests that
8 you've done on these masks or breathing barriers, are
9 you confident they would come up with the same results
10 that you have?

11 A If they're properly --

12 MR. MAXSTON: I'm a little concerned, that's
13 a little speculative. I don't know if you want to
14 consider rephrasing that, because I mean that -- what
15 studies, who is conducting them? I think that's just a
16 little bit broad, because there may well be studies
17 which disagree with Mr. Schaefer. I'm just a little
18 concerned about that type of question.

19 MR. KITCHEN: Well, I didn't use the word
20 "studies", but let me try this.

21 Q MR. KITCHEN: Are you confident,
22 Mr. Schaefer, that if somebody did the same testing
23 you've done with the same device that you used that
24 they would produce the same data regarding carbon
25 dioxide and oxygen?

26 A Well, if they're following the proper procedure, as I

1 have, and they had done everything the same that I did
2 as far as making sure that the equipment is -- has been
3 properly calibrated, properly bump-tested, and making
4 sure that everything is working as it should, then I
5 would anticipate that the difference being them holding
6 it versus you holding it should have no effect on the
7 readings whatsoever.

8 Q And just to be clear, you used the same device to test
9 the levels of oxygen and the levels of carbon dioxide?

10 A Yes, because the device was equipped with two sensors,
11 one with oxygen and one with carbon dioxide, to measure
12 these simultaneously, so I measured them both at the
13 same time actually.

14 So there's a display on the monitor, there's a
15 display for the readings of oxygen, and there's a
16 separate display for the readings of carbon dioxide, so
17 you can see both in realtime.

18 Q I see. Now, I notice you used the word "asphyxiation"
19 at one point in your report; can you just, for those of
20 us who do not know what that means, can you explain to
21 me what asphyxiation is?

22 A Well, asphyxiation is when your body is suffering from
23 insufficient oxygen, so whether it's, you know,
24 accidental, intentional, whatever it may be, your
25 body's not getting enough oxygen, that's asphyxiation.

26 And so there's various levels of it, but

1 asphyxiation may be fatal. It may cause injury. So
2 these are the kinds of things that this is what -- and
3 it's all due -- asphyxiation's due exclusively in
4 this -- in this -- I guess how I should say -- view to
5 insufficient oxygen.

6 Q Now, you say carbon dioxide is an asphyxiant, and it
7 displaces oxygen.

8 A M-hm.

9 Q Can you explain why or how that happens?

10 A Well, carbon dioxide is used to -- carbon dioxide can
11 displace oxygen, because it is considered an inert gas,
12 so pure carbon dioxide is able to displace oxygen.

13 So, for instance, let me give you an example,
14 carbon dioxide is often used in industrial situations
15 to purge out hazardous atmospheres of, say, things like
16 confined spaces and such to remove oxygen from those
17 spaces. So we know carbon dioxide can cause
18 displacement of oxygen. And it can do that in any
19 closed container, it doesn't have to be a confined
20 space like industrial, but any closed container where
21 you've got accumulations of carbon dioxide, and it can
22 affect how you can absorb and how you can be exposed to
23 oxygen, how you can absorb oxygen basically.

24 Q Now, I know you've mentioned the 19.5 figure, but I'm
25 just curious, what is the number that the Occupational
26 Health and Safety code in Alberta describes as being

1 the point at which, if you go below it, it becomes
2 hazardous?

3 A 19.5 percent. That's immediately dangerous to life and
4 health. So you can't go below 19.5 percent for any
5 reason.

6 And if you are exposed to air in Alberta, if you
7 are exposed in air -- breathing air that has an oxygen
8 concentration below 19.5 percent, you have to be
9 equipped with a separate air source, like
10 self-contained breathing apparatus, a supplied-air
11 system, that will give you the correct oxygen
12 requirement that you need.

13 Q That number of 19.5, is that fairly universal
14 throughout jurisdictions?

15 A Yes, it is.

16 Q Okay. I know in your report, you mention the
17 Occupational Health and Safety Administration [sic];
18 could you tell us what that is?

19 A Occupation Health and Safety Administration? What
20 exactly is your question?

21 Q I'm just wondering what is the Occupational Health and
22 Safety Administration, because that's not Occupational
23 Health and Safety Alberta. I just want to know what
24 that is.

25 A Okay, so Occupational Health and Safety
26 Administration [sic] is the US standard of safety

1 requirements. So it's funny, because when you say
2 it -- you said it full out; I'm more familiar with it
3 in its abbreviated form, which is OSHA.

4 Q OSHA.

5 A If you would have said "OSHA", I'm like absolutely, but
6 because I never hear it as Occupational Safety and
7 Health Administration, that's why I kind of just
8 hesitated for a second.

9 So anyhow, OSHA is the governing body for safety
10 standards and exposures in the United States.

11 Q Okay, and is that -- are they similar to OHS here in
12 Alberta?

13 A Yeah, many of the OSHA standards are accepted in
14 various jurisdictions in Canada as well.

15 Q So in your report, you refer to a 2007 letter from
16 OSHA. Can I just get you to turn to the first page of
17 this letter, that's page 085 or 85 from your report,
18 and for those who are following along, that's near the
19 end of the report, and then the top left-hand corner is
20 the page number, 085. Now, this letter, can I just ask
21 you to read out the first sentence of the third
22 paragraph there at the bottom of that page.

23 A (as read)

24 This letter constitutes OSHA's interpretation
25 of the requirements discussed.

26 Q We must be on different pages. So I'm looking at the

1 first page of the letter --

2 A Okay, I'm looking at -- I'm on page 085.

3 Q Maybe you've got a different page 085. Well, can I get
4 you to go to just the first page of this letter, where
5 it says "April 2nd, 2007, Mr. William Costello"; do you
6 see that?

7 A Oh, okay, okay, yes, I see that now, yeah.

8 Q Okay. And if we go down, the first paragraph starts
9 with "Thank you", second paragraph --

10 A Yeah.

11 Q -- starts "Within your letter", if you could just read
12 the first sentence of the third paragraph there.

13 A Okay, so the third sentence of the second paragraph --
14 third paragraph, okay, okay, I got you, okay. So it
15 is -- is it the one "to ensure that employees", is that
16 the second one?

17 Q No, it's starts with the word "Paragraph".

18 A Oh, "Paragraph", okay: (as read)

19 Of paragraph (d)(2)(iii) of the respiratory
20 protection standard considers any atmosphere
21 with an oxygen level below 19.5 percent to be
22 oxygen deficient and immediately dangerous to
23 life or health.

24 Did you want me to continue?

25 Q No. That sounds a little dramatic to me. Can you help
26 me understand, you know, from the perspective of an

1 Occupational Health and Safety expert, what does
2 "immediately dangerous to life or health" actually
3 mean?

4 A Well, I thought I actually explained that a little
5 earlier, but I'll tell you what, I'll go over it again.

6 So "immediately dangerous to life and health"
7 means that if you are exposed at that level or below
8 that level especially, then you are going to be putting
9 your health in harm's way. So that can have
10 significantly dangerous impacts on your health. And
11 the lower it goes, the lower it goes, like the more it
12 differentiates, like if it's -- the lower it -- for
13 oxygen, oxygen requirements here, the lower it goes
14 below the minimum oxygen requirement, the 19.5 percent,
15 the more dramatic and the more negative those effects
16 are going to be. So it's bad.

17 You never are allowed to exceed -- you're never,
18 ever allowed to breathe air less than 19.5 percent
19 under any circumstance in Occupational Health and
20 Safety settings. There's no -- there's no exceptions.
21 This is the deadline. You can't go below 19.5.

22 If you do, if somebody is tested and they are
23 exposed to levels of oxygen below 19.5 percent, the
24 operation, the working operation, would have to be
25 immediately shut down, and they would have to be
26 evacuated from that space; even if it was 19.4, they'd

1 have to be immediately evacuated. There's nothing
2 below 19.5 that's acceptable.

3 If somebody had to work in an atmosphere of 19.5
4 percent or lower, they would have to be equipped with a
5 separate source of clean air with -- delivered via air
6 line, supplied air-breathing apparatus. For those of
7 you listening that might not necessarily be aware what
8 that is, that is the same type of breathing apparatus
9 that fire fighters wear when they go into smoking
10 buildings, so they have a separate source of air. Why?
11 Because they need it, because they go into
12 oxygen-deficient atmospheres. And that's the type of
13 equipment you need to be exposed to any oxygen
14 concentration below 19.5 percent.

15 Q So when people are working with a procedural mask on,
16 are they working in an environment that's immediately
17 dangerous to life or health?

18 A The barrier, the breathing barriers create this
19 environment. So if you are in your office or home or
20 wherever it may be, and you are exposed to good
21 breathing air without a breathing barrier, wearing a
22 breathing barrier will create this hazardous
23 environment for your body.

24 Q Could I get you to turn the page over on this letter,
25 and you'll see there a box containing two paragraphs of
26 text; do you see that?

1 A Yes, I do.

2 Q Can I just get you to read the first three sentences of
3 text inside that box?

4 A (as read)

5 Human beings must breathe oxygen to survive
6 and begin to suffer adverse health effects
7 when the oxygen level of their breathing air
8 drops below 19.5 percent oxygen.

9 So for the person doing the documentation on this, I
10 should probably say that -- I'll read it over again,
11 just so that they can do their recording properly on it
12 by hand. So: (as read)

13 Human beings must breathe oxygen ... to
14 survive, and begin to suffer adverse health
15 effects when the oxygen level of their
16 breathing air drops below (19.5 percent
17 oxygen). Below 19.5 percent oxygen ...,
18 air is considered oxygen deficient. At
19 considerations of 16 to 19.5 percent, workers
20 engaged in any form of exertion can rapidly
21 become symptomatic as their tissues fail to
22 obtain the oxygen necessary to function
23 properly.

24 And do you want me to read what's in the brackets as
25 well there as reference?

26 Q No, that's good, thank you. Now, this concentration of

1 16 to 19.5, that range, is that what you've discovered
2 when you've tested the levels of oxygen between these
3 breathing barriers and the faces of those wearing them?

4 A Absolutely. Every oxygen concentration, whether it's
5 procedural they're wearing, and even at resting rate
6 without any form of exertion, just resting rate,
7 resting rate, we're seeing an oxygen drop of below 19.5
8 percent within 2 minutes of wearing it on either
9 procedural, nonmedical, or medical masks. Within 2
10 minutes, and that's without, that's without speaking a
11 lot or any other type of obvious exertion.

12 THE CHAIR: Mr. Kitchen --

13 MR. KITCHEN: Yes.

14 THE CHAIR: -- I'm just wondering, it's
15 quarter to 11, we started at 9, and I don't want to
16 interrupt the flow, but I'm wondering if people would
17 like to take a 5- or 10-minute break just to stretch
18 and whatever.

19 MR. KITCHEN: I'm fine with that. Can I
20 just -- because I'm almost done with this area of
21 questioning; can I just -- can I ask one question to
22 tie that up?

23 THE CHAIR: Certainly, certainly.

24 Q MR. KITCHEN: Mr. Schaefer, I'll just get
25 you to turn the next page over, can you just tell me
26 who is it that wrote this letter, and what's his title?

1 A The person who wrote this letter is Richard E. Fairfax,
2 F-A-I-R-F-A-X, Director, and his title is Directorate
3 of Enforcement Programs. So he would be in charge
4 of -- just for the record, this is somebody that's in
5 charge of enforcement programs for all of OSHA, which
6 is -- encompasses all of the United States, and in
7 Canada, we have the same even, within our own
8 individual provinces, we have the same standards for
9 oxygen that nothing under 19.5 percent. Everything
10 below 19.5 percent is immediately dangerous to life and
11 health. It's universal throughout North America -- or
12 I should say through the US and Canada.

13 Q One last question before we break, do you find it
14 strange that the public has been mandated to wear, by
15 various government bodies, devices that cause their
16 oxygen to be below a level that's safe?

17 A Well, I don't know if "strange" is the right word,
18 James. I'm not sure if "strange" is the right word. I
19 think it's much more serious than "strange", because I
20 know how serious it is, I know how serious the rules
21 are regarding oxygen concentrations below 19.5 percent.
22 In every one I've tested, every one, I've tested
23 adults, I've tested children, everyone, within 2
24 minutes of wearing either a procedural, nonmedical, or
25 the medical N95, even that's (INDISCERNIBLE) approved,
26 within 2 minutes is having oxygen drops below 19.5

1 percent.

2 Q Thank you.

3 MR. KITCHEN: And that's it for me for now
4 until we come back after our break.

5 THE CHAIR: Okay, well, let's reconvene at
6 11:00 then, and we'll continue on with Mr. Kitchen and
7 Mr. Schaefer. Thank you.

8 MR. KITCHEN: Thank you.

9 (ADJOURNMENT)

10 THE CHAIR: We are back in session, and
11 we'll have Mr. Kitchen continue with his direct exam of
12 Mr. Schaefer.

13 MR. KITCHEN: All right, thank you.

14 Q MR. KITCHEN: Now, Mr. Schaefer, I think you
15 touched on this, but just to clarify, in your
16 experience, do some people tolerate wearing these
17 breathing barriers better than others?

18 A Oh, absolutely, because some people have pre-existing
19 medical conditions that make it difficult to breathe
20 without any restriction. If you added a restriction on
21 top of that, it could be life threatening for those
22 people, and every bit of, you know -- depending upon --
23 there's levels, right? So if it's -- it depends on the
24 level of pre-existing medical condition they have and
25 the severity of it, but it could be life threatening,
26 it could cause somebody a life-threatening medical

1 emergency to wear a breathing barrier, even a properly
2 certified respirator, if they haven't -- if they don't
3 have the health and they haven't been properly screened
4 beforehand, before wearing it. It's important. It's
5 important that we check out and people are
6 health-assessed before we restrict our breathing. It's
7 important.

8 Q Do you do screening and fit testing at workplaces for
9 employees?

10 A Absolutely. Screening is a prerequisite for fit
11 testing. I can't fit test anybody that hasn't
12 completed screening protocol.

13 Q Can you tell me what are some of the things you look
14 for when you're screening?

15 A Well, the screening is a document that the patient -- I
16 shouldn't say "patient", but the client, the customer
17 or client is going to complete in their own -- with
18 their own privacy, so they're going to complete it
19 completely themselves, and then I just look at the
20 results.

21 The results that I'm looking for, there's a list
22 of pre-existing medical conditions, and if they
23 identify that they currently have any of those
24 pre-existing medical conditions, then my obligation, as
25 an Occupational Health and Safety fit testing
26 professional, is that I have to refer them to their

1 physician for further testing and analysis to determine
2 whether or not they have the physical fitness to be
3 able to handle a restriction in their breathing.

4 Q Is asthma one of those conditions?

5 A Yes. Do you want me to mention some of the conditions?

6 Q Well, you can only do that if I ask you to do that.
7 Well, let me ask you, just off the top of your head,
8 you don't need to go through the whole list, but just
9 give me some examples of some of these conditions just
10 so we have an idea. We know one of them is asthma, but
11 give us an idea.

12 A Allergies, high blood pressure, cardiac conditions,
13 lung illnesses. I'm not reading; I'm just going off
14 memory right now. Let's just see here, I can look up
15 that form quickly here if you would like me to read
16 them all, but, you know, those are included in that, so
17 allergies, asthma, heart disease, high blood pressure.

18 Okay, I'm just going to open it up right now.

19 Q Well --

20 MR. MAXSTON: Mr. Kitchen, I'm not going to
21 contest your client's view on different conditions.
22 I'm not sure if we have to go down this road, to be
23 honest with you. I don't --

24 MR. KITCHEN: Yeah --

25 MR. MAXSTON -- want to have to get him to
26 read from something, if that's what you need him to do.

1 MR. KITCHEN: No, I don't.

2 Q MR. KITCHEN: And, you know, since what
3 you're reading from, Mr. Schaefer, is not actually in
4 the record. I think that's fine, that answers my
5 question anyways.

6 Now, we've talked about this immediate danger,
7 that life and health, but does it surprise you then
8 that most people, when they wear these breathing
9 barriers, even for hours on end, that they don't pass
10 out from wearing them?

11 A Well, it doesn't surprise me, but just because they're
12 not physically passing out does not mean that harm is
13 not being done.

14 So here's the facts that I've been able to
15 establish from my testing: People that wear breathing
16 barriers are subjecting themselves to an oxygen
17 deficient IDL -- IDLH inhalation atmosphere. And in
18 many cases, they subject themselves to an IDLH level
19 carbon dioxide as well.

20 If you subject yourself to IDLH levels of low
21 oxygen, it will negatively impact your health whether
22 you're aware of it or not, and that's why all the
23 governing bodies that govern the rules of health and
24 safety legislate what the minimum oxygen concentration
25 in air that you can be exposed to, because you might
26 not necessarily feel harm right away, you might not

1 necessarily have a headache right away or dizziness,
2 you might not necessarily feel nausea right away, any
3 of these other minor -- more minor types of symptoms of
4 low oxygen.

5 But we know that if you are exposed to a hazard in
6 a low enough concentration or a high enough
7 concentration, depending on what the hazard is, harm
8 will occur, and it might be something -- it might not
9 necessarily be something that the wearer or user is
10 aware of, at least not immediately.

11 Q In your experience, has Alberta Health Services or the
12 Alberta Public Health authorities generally, have they
13 acknowledged the risks and harms associated with these
14 breathing barriers that you've been talking about?

15 A I've reached out to Dr. Hinshaw back in June of last
16 year with a very detailed letter on pointing out -- at
17 that time, it was -- nothing was mandated, it was just
18 a recommendation that people wear, in Alberta, N95,
19 nonmedical, or procedural what they call, you know,
20 surgical mask for protection from COVID, and I had to
21 point out a lot of the errors that she had stated.

22 I have read -- the only reply that I have received
23 from Dr. Hinshaw's office to date is a read receipt.
24 Actually it was CC'd to 23 other doctors in charge of
25 public health in Alberta. So I have a lot of read
26 receipts, no official response.

1 To also clarify, besides not having an official
2 response, I have never -- there's been numerous
3 attempts to contact Dr. Hinshaw's office for a
4 response, and it has not been granted, it's been
5 denied.

6 Q Do you have any thoughts on why Alberta Health Services
7 or the Chief Medical Officer of Health hasn't been
8 willing to discuss these risks and harms?

9 A I have thought --

10 MR. MAXSTON: I don't want to be difficult
11 here, but I think that question really is asking your
12 witness to talk about what's in the minds of the other
13 people. I think if you rephrase it and ask him a
14 different question, I might not object, but I don't
15 think he can speak to why they're not doing or doing
16 anything.

17 MR. KITCHEN: Right, I was asking him his
18 thoughts, so I'll just ask it again with those words in
19 there.

20 Q MR. KITCHEN: Mr. Schaefer, and, you know,
21 maybe you just have no idea, and that's okay, but do
22 you, from your perspective, can you think of any
23 reason -- or what do you think the reason is that there
24 hasn't been any discussion on this?

25 A I don't know. In all honesty, Mr. Kitchen, I have no
26 clue, but I will tell you this, is that normally,

1 normally, before any types of mask mandates are --
2 would be even recommended in Occupational Health and
3 Safety settings, professionals like myself would be
4 consulted long in advance of any potential mandates
5 that would occur, and that has not happened this time,
6 in this instance.

7 Q Now, as an Occupational Health and Safety expert, as an
8 Occupational Health and Safety consultant, do you work
9 at all with Occupational Health and Safety Alberta?

10 A I'm always -- I don't work specifically for
11 Occupational Health and Safety Alberta; they have their
12 employees, their own government employees, but do I
13 work in union with them, like in cooperation?
14 Absolutely. Everything that is Occupational Health and
15 Safety-related in Alberta works in cooperation with
16 Occupational Health and Safety representatives in
17 Alberta.

18 Q And in your experience, has Occupational Health and
19 Safety, OHS, have they acknowledged any of these risks
20 or harms associated with these breathing barriers?

21 A There hasn't been any -- there hasn't been any real
22 willingness to discuss that on behalf of OH&S, and
23 they're more than happy to back Provincial mandates
24 without discussion and without discussion or any other
25 opinion that's contrary to the AHS mandate.

26 Q Why do you think that is?

1 A I don't know. I don't know, Mr. Kitchen, but it is
2 very strange, because in a normal time, before COVID,
3 there was so much discussion about any new policy that
4 could be implemented long in advance before it would
5 become a mandate. There's planning, there's
6 discussion, there's determination.

7 But I think what I find that's very interesting is
8 that this is not just an Alberta situation; this is a
9 worldwide thing. How strange is it that something like
10 this type of breathing barrier could be mandated,
11 rolled out so fast without any consulting of, you know,
12 no one, no one trusted respirator professionals, by
13 medical staff, who aren't experts in respiratory
14 protection, they aren't qualified to -- medical doctors
15 alone are not qualified to comment or give advice on
16 various aspects of respiratory protection because
17 they're not asked -- they don't deal in respirators
18 professionally, they have very limited knowledge about
19 respirators and masks and their protection levels and
20 what they can do and what they can't do. And I find it
21 strange that this has been implemented on a worldwide
22 basis with virtually no contest, without official
23 contesting of it, it's very strange.

24 Q In fact, earlier you said, it was more than strange,
25 you said it was serious?

26 A Well, strange that it hasn't been documented, but when

1 I said serious, I said serious in relation to oxygen --
2 I said serious in response to your question for me on
3 the effects on people being exposed to less than 19.5
4 percent oxygen. Yes, that is beyond strange. That is
5 alarming. That is alarming that these devices could be
6 mandated when they clearly -- when the testing that I
7 am trained to perform clearly shows oxygen levels
8 dropping below 19.5 percent with all three of these
9 versions of mandated breathing barriers, whether it's
10 an adult or a child even at resting rate, and we know
11 that the drop is going to be even more significant for
12 people that are engaged in any kind of activity.

13 Q And do you understand that we're here today because
14 Dr. Wall has contested these breathing barriers and
15 that, for doing so, he is facing professional
16 discipline?

17 A Yes, I'm aware.

18 Q On page 8 of his report, Dr. Hu, I think his first name
19 is Jia, but Dr. Hu says -- and just to clarify, he is
20 the expert tendered by the Alberta College of
21 Chiropractors -- on page 8 of his report, he says: (as
22 read)

23 There are no known harms associated with
24 masking.

25 Now, maybe it's obvious, but do you disagree with his
26 statement?

1 A Completely. I completely disagree with Dr. Hu's
2 statement, because there are numerous scientific
3 research papers and studies. I've looked through
4 Dr. Hu's references, and I didn't see one registered
5 scientific study in any one of his references, but I
6 have references from registered scientific journals,
7 medical journals. I have references from the --
8 published by the National Library of Medicine to show
9 quite the opposite of what Dr. Hu's references claim.

10 Plus, in addition, my own -- obviously, my own
11 testing, of course, but then as far as scientific
12 references go, there's -- I can send a whole bunch of
13 actual registered, published, scientific medical
14 researchers that have shown quite the contrary to what
15 Dr. Hu has stated.

16 Q A number of witnesses in this hearing, including
17 Dr. Hu, have said that the issue of masking as it
18 relates to COVID is a politicised issue. Do you think
19 it's a politicised issue?

20 MR. MAXSTON: I am going to have to object
21 to that, Mr. Chair, that runs afoul of commenting on
22 the harm or lack thereof in terms of masking.

23 MR. KITCHEN: I think that's a fair
24 question.

25 THE CHAIR: Can you restate it?

26 MR. KITCHEN: And this is part of the reason

1 why I raised the fact that this has been a constant
2 issue in the hearing, the other expert, Dr. Hu, who
3 Mr. Schaefer just responded to, said that masking is a
4 politicised issue, and so have several other witnesses,
5 so now I'm asking Mr. Schaefer if he thinks masking as
6 it relates to COVID is a politicised issue.

7 MR. MAXSTON: I'll just again state,
8 Mr. Chair, that I think this witness is being tendered
9 for a very specific purpose, and that was harms, in his
10 view, that are caused by masking, and I don't think
11 this witness is anywhere near the -- is a very
12 different type of witness from the other experts that
13 have testified.

14 MR. KITCHEN: I don't see what entitles
15 Dr. Hu to talk about the politicisation of the issue
16 that doesn't also entitle Mr. Schaefer to talk about
17 it.

18 THE CHAIR: Well, I don't want to go back
19 and retroactively deal with Dr. Hu, but I do think this
20 witness was qualified as an expert in a very specific
21 area, and I do think the question extends beyond that.

22 Q MR. KITCHEN: Well, just one more question
23 then, Mr. Schaefer, from your perspective, do you think
24 Occupational Health and Safety is the primary
25 consideration in forming these mask mandates?

26 A Well, Mr. Kitchen, Occupational Health and Safety has

1 not been a consideration at all in these mask mandates,
2 as demonstrated, and I would contest any safety
3 professional with qualifications equal to mine to prove
4 otherwise, that oxygen deficiency is created by wearing
5 a breathing barrier. That is why our parents taught us
6 to never put a bag over our heads. It is pretty
7 standard, you cover your mouth and nose with a random
8 object, it limits your ability to breathe naturally,
9 and anything that limits your ability to breathe
10 naturally can potentially be harmful to health. That's
11 why we have screening, and anybody with pre-existing
12 medical conditions that has a limit on their breathing
13 could cause a life threatening medical emergency.

14 MR. KITCHEN: Thank you. Those are all my
15 questions.

16 MR. MAXSTON: Mr. Chair, if you're
17 comfortable, I'll just continue on. I don't expect to
18 be too long.

19 THE CHAIR: Yes, that's fine. Just before
20 you start, Mr. Maxston, Mr. Schaefer, you're okay to
21 continue with this cross-examination, or did you want a
22 break?

23 A I'm fine. Thank you very much, Mr. Lees.

24 THE CHAIR: Okay.

25 Mr. Maxston Cross-examines the Witness

26 Q MR. MAXSTON: Mr. Schaefer, I've got some

1 questions I'm going to take you to in a couple of
2 minutes that I had thought of in advance of the
3 hearing, but I want to touch on a few things that are
4 fresh in my mind now that you've just talked about with
5 Mr. Kitchen, if you don't mind.

6 A Sure.

7 Q So a few minutes ago, you talked about the fact that
8 some people tolerate masking better than others and
9 that that was a function of pre-existing medical
10 conditions and the severity of those medical
11 conditions; do you remember that exchange you had?

12 A Yes, I do.

13 Q And I think you talked about properly screening
14 individuals as well, and it's important that people are
15 health-tested in terms of masking and medical
16 preconditions; do you remember that?

17 A Well, at least as far as identifying pre-existing
18 medical conditions that could make them not a good
19 candidate for wearing any type of mask or respirator.

20 Q Sure. And you would agree with me that it's important
21 to go to a doctor to determine whether they have any
22 pre-existing medical conditions?

23 A That is correct.

24 Q I want to touch on a few things that you talked about
25 with Mr. Kitchen. You talked about, in your view, that
26 Dr. Hinshaw didn't contact OHS, I think that's the

1 Provincial OHS, but I think you'd agree with me that
2 you don't have any direct knowledge of that, do you?

3 A I didn't say that Dr. Hinshaw didn't contact OH&S.

4 What I had said was that Dr. Hinshaw has not been --
5 air testing on these masks has not been done, so they
6 haven't -- the safety of people wearing them has not
7 been properly determined, because there has been
8 absolutely no air testing on oxygen deficiencies or
9 carbon dioxide accumulations on these masks by --

10 Q Well, I don't want to belabour -- oh, sorry, so sorry,
11 were you finished?

12 A Yeah.

13 Q I don't want to belabour this, but I think,
14 Mr. Schaefer, it's fair to say though you haven't been
15 involved in the development of the CMOH orders, have
16 you?

17 A That is fair to say; I have not been involved in the
18 development of those orders.

19 Q You made a comment I think it was a couple times during
20 your testimony then, Mr. Kitchen had sort of a wrap-up
21 question for you, and you were talking about the fact
22 that it was strange that devices are mandated, that
23 breathing devices are mandated. Would you agree with
24 me that it is clear they are mandatory though?

25 A I would agree with you that it is clear that these
26 breathing barriers are currently mandated, that's

1 correct.

2 Q And you've had a chance to look at the College's
3 Pandemic Directive, I assume?

4 A I have not memorized it, but I have had exposure to it;
5 I have looked at it, yes.

6 Q Yeah, and it's not a memory test for you. I'm just --
7 there's a phrase, and my friend and I talked about this
8 when you were being qualified, there's a phrase in it
9 that says "surgical or procedure masks are the minimum
10 acceptable standard", and it goes on to say that
11 chiropractors and staff must be masked. You'd agree
12 with me that that's mandatory for chiropractors?

13 A You know, I can't agree with -- look, just because --
14 just because it's -- just because one of these or more
15 of these breathing barriers is mandatory for
16 chiropractors and other professions, doesn't mean
17 they're safe.

18 Q Oh, I'm not asking you that. I'm asking you it's
19 mandatory for chiropractors, question mark, full stop.

20 A Aware a procedural-based is what you're saying?

21 Q Yeah, I'm just saying that the Pandemic Directive, and
22 I pointed you to the masking situation in particular,
23 that's mandatory for chiropractors; aside from your
24 views on the safety or harm, that's mandatory?

25 A That appears to be correct.

26 Q So, Mr. Schaefer, I'm going to turn you to now a couple

1 of, I guess, more generic questions, and I just wanted
2 to be clear, and you kind of touched on this with
3 Mr. Kitchen and I think with me a minute or 2 ago, you
4 haven't been involved in the Government's response to
5 COVID-19; that's correct?

6 A That is correct.

7 Q And you've been qualified today to provide your opinion
8 about the harms that masking can cause for the wearer,
9 and that's correct?

10 A That's correct.

11 Q And you're not here, of course, to provide any evidence
12 about the benefits that might accrue from masking for
13 people in the presence of the person being masked; is
14 that correct?

15 MR. KITCHEN: Hold on, hold on --

16 A Well -- well --

17 MR. KITCHEN: -- that question --

18 THE CHAIR: Just (INDISCERNIBLE),
19 Mr. Schaefer. Sorry, go ahead, James.

20 MR. KITCHEN: That question is premised on
21 efficacy of masks, which my friend, my learned friend,
22 went out of his way to make sure we were not going to
23 talk about, and now he's trying to talk about it.

24 MR. MAXSTON: I'm trying to just make a
25 comment that this witness isn't providing that
26 evidence.

1 MR. KITCHEN: Well, that's been established
2 time and over again, so I don't understand why we're
3 just filling the record with repeats of what we've
4 already established.

5 MR. MAXSTON: Well, I just wanted to be
6 clear that this witness is not providing evidence about
7 any potential benefits to persons in the presence of
8 the wearer of a mask.

9 MR. KITCHEN: Well, I think we're --

10 MR. MAXSTON I'll move on, I'll move one,
11 yeah. Mr. Kitchen, if you have a problem with this,
12 you'll let me know.

13 Q MR. MAXSTON: You're not here to provide any
14 evidence about the transmission of COVID for preventive
15 measures for COVID?

16 A That's correct.

17 Q Would it be fair to say that your views about mandatory
18 masking are inconsistent with most government Public
19 Health agencies, in Canada I should say?

20 A In Canada, as far as the mandates that have come down
21 provincially and nationally?

22 Q Yeah, that would be correct.

23 A Yeah, I would say that we definitely have a difference
24 of opinion.

25 Q You talked with my friend, Mr. Kitchen, about the
26 testing that you've done. None of that testing is

1 attached to your expert report, is it?

2 A That testing that I've done is not -- let me just take
3 a look here.

4 MR. KITCHEN: Perhaps you could be a little
5 more specific, Mr. Maxston --

6 MR. MAXSTON Yeah (INDISCERNIBLE) --

7 MR. KITCHEN: -- there's no exhibit that has
8 a list of the readings. Is that what you're getting --

9 MR. MAXSTON: Yeah, that's kind of what I'm
10 getting at.

11 Q MR. MAXSTON: And, Mr. Schaefer, this isn't
12 a gotcha question, but I'm just looking at the second
13 page of your report, and you talk about using the
14 MultiRAE Lite, and you observed that upon commencement,
15 and you have some comments then. I'm just saying
16 there's no data or test results from those tests you
17 performed which are part of your expert report,
18 correct?

19 A I don't have it in the report, specific readings, but I
20 have -- I've done lots of documentation on it and
21 reports on it, so --

22 Q Yeah, I'm just -- I wasn't trying to take you down the
23 road of what you did; I just wanted to be clear they're
24 not attached.

25 A Yeah, the specific testing, I've done a lot of testing,
26 so for me to have all of the different test subjects

1 and all of the different readings would be quite
2 extensive as far as those testing results would be, so
3 they're not attached, no.

4 Q Okay. I want to ask you some questions about your
5 registration with the Alberta College of Paramedics,
6 and I think you've told me that you were at EMS for one
7 year, you were a regulated member of that college for
8 one year. Did you have to meet any entry requirements
9 to get your EMS registration with the ACP --

10 A Absolutely.

11 Q -- College of Paramedics?

12 A Yes, I did.

13 Q And that's a mandatory requirement to become an EMS
14 with the College of paramedics?

15 A It's a mandatory requirement to be registered with the
16 Alberta College of Paramedics to work in an
17 occupational setting as a medic in Alberta.

18 Q And even though you were only a -- I shouldn't say
19 "only" -- but it was a one-year period you were a
20 regulated member, there were mandatory requirements you
21 had to follow during that year like con ed or paying a
22 licence fee; would you agree with that?

23 A Yes, in fact, the only requirements they registered
24 with Alberta College of Paramedics, because I completed
25 all of their requirements, the only requirement, moving
26 forward from year to year, was to pay the fee to stay

1 registered. And that registration is required to work
2 as a medic in Alberta, and I had no intention of
3 working as a medic in Alberta as I was already fully
4 employed as an Occupational Health and Safety
5 specialist, so that's why I ended it.

6 Q Sure. And just to be clear, is it your understanding
7 that if you don't follow those requirements, you can't
8 be a member of the College?

9 A Yeah, you have to follow -- you have to work -- you
10 have to practice your skills within a protocol as
11 determined by Alberta College of Paramedics, yes, in an
12 occupational setting.

13 Q Sure. I'm going to ask you a fairly specific question
14 here, but would you comply with the paramedic
15 equivalent of the College's pandemic requirement about
16 mandatory masking if you were in the field?

17 A I would comply with wearing a mask, but I would not
18 wear a breathing barrier. I have not worn a breathing
19 barrier, and I won't. So, remember, there's a big
20 difference between what's currently been mandated and
21 what an engineered mask is.

22 A mask is safe to wear. A mask is engineered
23 inhalation openings. A mask has an engineered
24 exhalation opening. That's safe. It's established as
25 safe. It's proven as safe over many decades.

26 So a closed cover is not something that I would

1 wear, no, but I would wear an actual mask.

2 Q So I just want to be clear, again, when we look at the
3 Pandemic Directive for the College of Chiropractors, it
4 says that the requirement is a surgical or a procedure
5 mask; you would comply with that kind of directive from
6 your regulatory body if that was applicable?

7 A I know that those aren't masks. Those are breathing
8 barriers. I'm not going to jeopardize my health and
9 safety through low oxygen and accumulations of carbon
10 dioxide for any occupation, because that's my health,
11 and my health is important to me. It's more important
12 than anything else.

13 Q So you would choose to not comply with it?

14 A I would wear -- I would wear something that far exceeds
15 the recommended protection, which is an actual
16 certified respirator that actually is designed for easy
17 and safe breathing, I would wear that, and it would far
18 exceed any potential respiratory benefit that a
19 breathing barrier could provide.

20 Q Those are all my questions --

21 A (INDISCERNIBLE)

22 Q Sorry, did you want to finish? I cut you off.

23 A Oh, sorry, I just wanted to say that -- so what I would
24 wear would be far and above what has been currently
25 mandated.

26 MR. MAXSTON: Those are all my questions,

1 Mr. Schaefer, thank you.

2 A Thank you very much, Mr. Maxston.

3 THE CHAIR: Mr. Kitchen, did you have
4 anything on redirect?

5 MR. KITCHEN: Just a couple.

6 Mr. Kitchen Re-examines the Witness

7 Q MR. KITCHEN: Mr. Schaefer, you attest to
8 the truth of what you said about the results of the
9 testing you did?

10 A Well, I am under oath in this courtroom, so I believe
11 I've already done that.

12 Q You just finished a discussion with my learned friend
13 about whether or not you would wear a breathing barrier
14 if your regulatory body told you you had to in order to
15 practice, and if you didn't have access to the
16 respirator, if all you had access to was the breathing
17 barrier that they said you had to wear, would you wear
18 it to keep your licence?

19 A No, I would not wear it to keep my licence because my
20 health is more important than my job.

21 MR. KITCHEN: Thank you.

22 Q MR. KITCHEN: Wait, hold on, forgive me.
23 Mr. Maxston asked you about screening and
24 pre-conditions. Just to clarify, you would say that
25 masks -- well, would you say that masks are harmful to
26 people who have no pre-existing conditions at all?

1 A Look, a mask is engineered for breathing. People
2 without pre-existing conditions should be able to wear
3 an actual engineered mask with engineered inhalation
4 and exhalation valves no problem, provided -- you know,
5 depend -- again, it depends like on previous -- if
6 there's no pre-existing conditions, they're considered
7 fit, then an actual mask is safe to wear for that
8 person.

9 But if you're talking -- I'm not talking about a
10 breathing barrier here. A breathing barrier with no
11 inhalation valves, no exhalation valve, that's not safe
12 for anybody.

13 MR. KITCHEN: Thank you. Those are actually
14 all my redirect questions.

15 THE CHAIR: Thank you very much,
16 Mr. Schaefer. I believe that concludes your testimony
17 this morning, and we thank you for your attendance and
18 for your testimony, and you're free to leave the
19 hearing.

20 A Thank you very much, Mr. Lees.

21 THE CHAIR: It's 20 to 12, and we could
22 start at 12:45. Mr. Maxston?

23 MR. MAXSTON: Yes, I wondered, do you have
24 any questions? You didn't have any questions, I'm
25 assuming, of Mr. Schaefer --

26 THE CHAIR: Oh, I'm sorry, I jumped the

1 gun there. Did the Members of the Tribunal want to
2 caucus and discuss that? I think I'll have to take a
3 lashing for that, probably ten lashes, but yeah.

4 So I suggest then that we break for lunch, and we
5 reconvene at 12:45 with Mr. Kitchen's witness and go
6 from there.

7 MR. MAXSTON: Just so I'm clear, Mr. Chair,
8 my apologies, will you want Mr. Kitchen -- maybe this
9 is a question Mr. Kitchen is going to ask, do you want
10 him to have Mr. Schaefer available then at 12:45 if you
11 have any further questions? And I'm just asking, I
12 don't know exactly where we're heading at 12:45.

13 THE CHAIR: Okay, I'll touch base with the
14 Tribunal Members when we break here, and if there are
15 some follow-up issues from the Hearing Tribunal with
16 respect to Mr. Schaefer, I'll get in touch with
17 Mr. Kitchen, and we'll arrange to get him back.

18 MR. KITCHEN: Yeah, if you could just please
19 let me know within 10, 15 minutes, just that way, I can
20 release him or I can keep him around.

21 THE CHAIR: Yeah, thank you for bringing
22 that up. That's my fault, I got ahead of myself. When
23 we break now, we'll go into a break-out room first, the
24 Panel Members and our legal counsel, and we'll just
25 find out if there are any follow-up questions, and then
26 I will let you know, Mr. Kitchen.

1 MR. KITCHEN: Okay, thank you.

2 _____

3 PROCEEDINGS ADJOURNED UNTIL 12:45 PM

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1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 November 20, 2021

Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees

Tribunal Chair

9 W. Pavlic

Internal Legal Counsel

10 Dr. L. Aldcorn

ACAC Registered Member

11 Dr. D. Martens

ACAC Registered Member

12 D. Dawson

Public Member

13 A. Nelson

ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC

ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen

Legal Counsel

20

21 K. Schumann, CSR(A)

Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 12:46 PM)

24 THE CHAIR:

Mr. Kitchen, the floor is

25 yours.

26 MR. KITCHEN:

All right, Dr. Dang, first

1 thing is we're going to have you sworn in by Madam
2 Court Reporter, Karoline, so she's going to do that,
3 and then we'll switch over to me asking you questions.

4 THE WITNESS: Okay.

5 DR. BAO DANG, Sworn, Examined by Mr. Kitchen

6 MR. KITCHEN: So, Chair, Mr. Maxston and I
7 have agreed we're going to consent to the qualification
8 for Dr. Dang. However, I know Mr. Maxston has a couple
9 comments, so what I'm going to do is I'm going to put
10 the qualification forward, and then Mr. Maxston can
11 give comments, and if there's anything I need to say in
12 reply, then I'll do that.

13 So, Mr. Chair, the -- Dr. Wall tenders Dr. Bao
14 Dang as an expert in the area of respirology and, in
15 particular, COVID-19 and the efficacy of masking and
16 related measures.

17 Now, I'll turn it over to Mr. Maxston, who I think
18 wants to just make some comments on that.

19 MR. MAXSTON: Mr. Chair -- thank you,
20 Mr. Kitchen -- Mr. Chair, as I've discussed with
21 Mr. Kitchen, I just want to, again, emphasize the
22 Complaints Director's view that you can accept evidence
23 in whatever manner you see fit, but that the Complaints
24 Director's position is with respect to these expert
25 witnesses that the focus of this case is regulatory
26 compliance and not the efficacy of masking, and you

1 should place appropriate weight on the evidence of this
2 expert. Thank you, Mr. Kitchen.

3 MR. KITCHEN: Thank you.

4 THE CHAIR: Okay, thank you both. We're
5 okay to proceed then, Mr. Kitchen?

6 MR. KITCHEN: Unless you have any objections
7 to the qualification that I've provided for you.

8 THE CHAIR: I heard comments; I didn't
9 hear any objections, so --

10 MR. KITCHEN: Okay.

11 THE CHAIR: -- let's proceed.

12 Q MR. KITCHEN: Okay, all right. Well,
13 Dr. Dang, let's start with, do you practice here in
14 Alberta?

15 A I do.

16 Q And where?

17 A My main clinical practice is in Medicine Hat, and then
18 I do mainly consultancy work in Calgary.

19 Q And what does your clinical practice in Medicine Hat
20 consist of?

21 A It is an outpatient community respirology practice in
22 my own office, as well as interpreting and managing my
23 own pulmonary function lab there, as well as seeing
24 patients in hospital at the Medicine Hat Regional
25 Hospital for internal medicine, critical care, and
26 respirology.

1 I should mention I also have a satellite clinic in
2 Brooks, which is a small city near Medicine Hat as
3 well, with an associate pulmonary function lab there as
4 well, and I spend a few days per month there as well.

5 Q Can you tell us what's a pulmonary lab?

6 A They -- well, basically we do pulmonary function
7 testing, which is a series of breathing tests. Some
8 people here may have done it, where you sit in a glass
9 booth and you blow through a tube at the instruction of
10 a respiratory therapist to see if you have chronic lung
11 disease such as asthma or COPD or other lung disease,
12 as well as doing things like teaching on how to use
13 inhalers and also other tests such as methacholine
14 challenge test and arterial blood gases.

15 Q So you're familiar with doing what I'm going to call
16 breathing testing?

17 A Correct, I think the -- the respiratory therapist does
18 most of the hands-on teaching and testing, but I'm the
19 medical director, so I run it, yes.

20 Q Okay, thank you. And how much of your practice would
21 you say is at the hospital as opposed to at your
22 clinic?

23 A I would estimate 20 to 30 percent at the hospital and
24 the rest in my office.

25 Q And can you give us an idea of the type of things you
26 do at the hospital?

1 A So I am part of the call schedule for general internal
2 medicine, as well as doing respirology consults as
3 well, so we see everything. Basically, the family
4 doctor or the hospitalist would consult internal
5 medicine for any complicated case of heart, lung, or
6 any body system disease, as well as managing patients
7 in the intensive care unit, and we would see patients
8 in the emergency room at the request of the emergency
9 physician for a consultation and ward consultations as
10 well.

11 Q So would you, just to give me an idea of this, would
12 you be confined to simply reading charts and talking to
13 doctors, or would you actually go into the room where
14 the patient is?

15 A Yes, we would always go to examine the patient as well
16 and get a full history, so it would be a full
17 assessment of the patient, reviewing the chart of
18 course as well, but examining and talking to the
19 patients and then formulating our opinions and advice.
20 Occasionally, I do procedures as well and -- or
21 interventions to help the patient or to diagnose
22 disease in patients.

23 Q Thank you. So would you refer to what you do, what you
24 just described, as direct patient care; would that be a
25 fair assessment?

26 A That is correct.

1 Q I just want to ask you a few questions about your
2 impartiality. Dr. Dang, do you know Dr. Curtis Wall
3 personally?

4 A No, I've never met him.

5 Q Do you have any personal interest or personal stake in
6 the outcome of this case?

7 A I do not.

8 Q Do you have any financial interest or stake in the
9 outcome of this case?

10 A No, I do not.

11 Q Do you understand your duty to provide this Tribunal
12 with your expert knowledge and opinions in an objective
13 manner?

14 A Yes.

15 Q Thank you. Dr. Dang, are there different types of
16 health care settings?

17 A Yes.

18 Q Is there a big difference between, let's say, the
19 hospital in Medicine Hat and your clinic?

20 A Yes, that is correct.

21 Q Is there a big difference between a hospital setting
22 and a chiropractor's office?

23 A I would say so.

24 Q Based on your knowledge and the type of work you do at
25 the hospital, would you say the type of the work you do
26 is quite different than what a chiropractor does in a

1 chiropractic office?

2 A Yes, I would think so.

3 Q In a setting like the hospital in Medicine Hat, are a
4 large number of the people there symptomatic?

5 A Generally, yes, that is usually one of the requirements
6 of being hospitalized.

7 Q In a setting like a hospital, do nurses and doctors
8 regularly interact with people that possibly have an
9 infectious illness?

10 A Yes, potentially.

11 Q In settings like hospitals, are they designed to
12 receive symptomatic patients potentially ill with
13 infectious illnesses?

14 A Yes, absolutely.

15 Q What would you say are some of the big differences
16 between a hospital setting and a setting like a
17 chiropractic office?

18 A Well, I would think the acuity, patients are -- tend to
19 be quite sick, sick enough certainly to go to the
20 hospital and sometimes be admitted. They're
21 symptomatic. There are lots of interventions that are
22 offered to patients, some of them quite invasive.

23 And basically, generally, I think the biggest
24 difference would be the degree of acuity of sickness of
25 a patient as it would merit them coming to the hospital
26 and usually being admitted to the hospital.

1 Q Thank you. Now, I'm going to move into your report.
2 In the second paragraph of your report, you state how
3 ridiculous it would have been to mandate the entire
4 public wear masks during past outbreaks of respiratory
5 infections, such as H1N1 and SARS. Now, the first
6 question I have for you on that is are those infections
7 viral-based or bacterial-based?

8 A Both of them are viral-based.

9 Q And you said H1N1 was in 2009 and SARS was in 2003;
10 that's correct, right?

11 A Yes, I actually, of course, took part in the medical
12 care during those time periods as well.

13 Q Well, that was my next question, so you were practicing
14 medicine during both of those?

15 A Well, in 2003, I was in medical school, and then in
16 2009, I was in my full practice at that time.

17 Q Okay.

18 A But in both cases, I had clinical exposures, of course,
19 to them.

20 Q Right. Besides those, are there any other historical
21 viral outbreaks that you've had experience dealing
22 with?

23 A Not major ones that I can think of, to my knowledge,
24 directly.

25 Q Now, forgive my ignorance, I can't help but notice that
26 SARS must have something to do with what's going on

1 now, because the virus that causes COVID-19 is
2 SARS-CoV-2. Can you just briefly tell me is there --
3 well, let me ask you this: Is there a relation between
4 SARS in 2003 and COVID-19?

5 A Correct, yes. They're both made by a similar family
6 type, shall we say, of the virus. SARS just means
7 severe acute respiratory syndrome, so it described
8 usually the type of illness a patient could get being
9 exposed to the Coronavirus. Now, these viruses, of
10 course, are related to each other then, they do share a
11 lot of similar properties, but they are different
12 viruses. I suppose, as an analogy, you could say those
13 species, and then you have different types of dogs.

14 Q Okay, thank you. Now, you said back then that there
15 was no, quote, controversy about masks. What do you
16 mean by that?

17 A Well, I just meant that in terms of our approach to
18 public health at that time was radically different.
19 There was no thought of having universal mandatory
20 masking. The most -- even in the hospital setting, we
21 didn't have continuous masking. We had masking for
22 patients at risk in isolated rooms, which we always
23 would have but just I would say of a higher volume, but
24 there was no question of having mandatory masking in
25 the community setting or in any public setting, either
26 indoors or outdoors. It wasn't even contemplated.

1 Q And in your opinion, was that the correct approach to
2 take back then?

3 A Yes, I believe so.

4 Q And do you think back then that not mandating masking
5 was an unsafe thing to do for patients and for health
6 care workers?

7 A No, I mean -- you're asking is -- because we didn't
8 mandate masks in our universal setting, was that unsafe
9 for the --

10 Q Yeah --

11 A -- patients?

12 Q -- that's what I'm asking.

13 A Yeah, yeah. So, no, I don't think -- I think we did
14 the right -- I think the public health authorities did
15 the right thing at that time, it just had masking in
16 very limited settings, which was what was always
17 applied in the past anyways -- or in the past in terms
18 of modern medicine.

19 Q Why do you think it is that there was no attempt to
20 implement or impose mandatory masking back then?

21 A Well, I don't think anyone can say with certainty.
22 There are multi-factorial reasons. One, I don't think
23 at that time or as I say even now there was any firm
24 evidence that that would work. Applications to general
25 population would be problematic to say the very least,
26 and it would be, at that time, probably considered a

1 great infringement upon people's ability to do their
2 day-to-day activities. And it was also, I would say --
3 I believe the health authorities would not have made an
4 impact upon reducing transmission.

5 Q In your opinion, has anything changed since then to
6 make mandatory universal masking more scientific now
7 than it was back then?

8 A No, I can't think, from a scientific perspective, why
9 it is more advantageous now than then.

10 Q And why do you think now, this time, for the first
11 time, we've done this mandatory universal masking in
12 response to a respiratory virus?

13 A Well, again, I think it's multi-factorial, and I can't
14 say with certainty. I can only think that our
15 situation is different from a social and political
16 aspect, which has led to this in terms of causing mass
17 paranoia and fear and panic. And with, you know,
18 communications and everything being so much more
19 instantaneous now, I think that has led to these
20 reactions.

21 Q Would you consider what you just said to be
22 sociopolitical reasons?

23 A Correct.

24 Q So not scientific reasons?

25 A Correct.

26 Q Now, you were there back then; was there less fear back

1 then?

2 A I think there was less global fear that led -- that
3 prevented this domino effect, yes, partially because of
4 not -- the lack of social media, the lack of all these
5 things we're doing right now. I mean, obviously,
6 there's the internet, and there was online
7 communications and telecommunications, but not anywhere
8 to the extent that we have now.

9 Q You discussed in the third paragraph of your report
10 that: (as read)

11 Despite decades of mask wearing in the
12 operating theatre, in many studies looking at
13 whether masking prevented infection in that
14 type of health care setting, the evidence
15 does not support the conclusion that masks
16 are effective at preventing transmission in a
17 setting like the operating room.

18 Now, do you find it surprising that Dr. Hu has so
19 confidently claimed that these same masks are now
20 highly effective at preventing the transmission of
21 COVID in health care settings?

22 A Yes, I would disagree with that assessment.

23 Q Is there anything fundamentally different about COVID
24 as compared to past respiratory infections that make it
25 likely for masks to work now against COVID even though
26 they did not work in the past against other respiratory

1 infections?

2 A No, I don't think so. Many of the studies that myself
3 and he posted cited literature in the past, which is
4 how you build up on scientific knowledge; you base your
5 theories and evidence on previous evidence.

6 Q In order for masks to work now, would there have to be
7 something fundamentally different about COVID?

8 A Well, just the virus itself would have to behave in an
9 entirely different manner, I would think, and be an
10 entirely different size. But, no, with regards to what
11 the virus is currently, there would be no substantial
12 difference.

13 Q Speaking of size, is SARS-CoV-2, the virus, is it
14 larger in size than past viral respiratory infections
15 like SARS or H1N1?

16 A I don't think so. I don't know the exact size off my
17 memory, but viruses generally are of the order -- a
18 different size compared to bacteria. So I think
19 that -- I think I gave it in my report the size of the
20 SARS virus, it was I think 100 microns, but I could be
21 off by a decimal point or two. I just can't remember
22 that.

23 Q Well, you have here, it's 0.1 micron.

24 A Oh, then that's the correct answer.

25 Q Okay, and then, in brackets, you say about a hundred
26 times smaller than a bacteria.

1 A That would be correct, yes.

2 Q Help us understand, us nonmedical people, what is a
3 micron?

4 A Well, a micron is microscopic so you can't see it
5 unless it's under a microscope, and even smaller than
6 that, not even a regular microscope. So I imagine most
7 of the audience here had to use a regular microscope at
8 some point in their schooling, high school or
9 university. You would have to go up to the next order,
10 which is an electron microscope, to probably see these
11 viroids. So we're talking about a magnification of
12 100,000 to a million times to even see a dot, for
13 example.

14 Q Is electron microscopes what they use to be able to see
15 things like RNA and DNA?

16 A Yeah, I'm not even sure they can see that, but they
17 could see bacteria, and they could see some viruses.
18 They're those kind of microscopes that fill up the
19 entire room basically in the old days. Maybe they're
20 smaller now, but I used to work, when I was doing my
21 training, on an electron microscope, and it filled up
22 the entire room, and, yeah, it required a lot of power.
23 It was like one of those super computers you would
24 think of in the old days.

25 Q So just to try and get an idea of the size of the
26 SARS-CoV-2 virus, is it similar to a really large

1 molecule?

2 A It's very small molecule. Like a virus would be the
3 size of an mRNA or a DNA, for example, so it would be
4 extremely small. Probably one of the smallest forms of
5 life forms possible.

6 Q So would it be smaller than, for example, a protein?

7 A Yes, I think it would be generally smaller than a
8 protein.

9 Q Now, SARS-CoV-2, this tiny little molecule-sized virus,
10 is it only transmitted through like large water
11 droplets, or is it also transmitted through what's
12 called aerosols?

13 A Well, I think in the early days, they thought it was
14 more droplets, because that would be the typical nature
15 of this infection, but I think there's more and more
16 convincing evidence that aerosolized is possible and
17 also a common route of transmission as well. The exact
18 degree in terms of which one is more I don't think has
19 been sorted out, but I think it is universally
20 recognized now that it can be transmitted in both
21 methods.

22 Q And can you just explain for us what's the difference
23 between these large droplets and aerosols?

24 A Well, large droplets are, as the name implies, say you
25 cough or you speak or sing or shout, you can spew
26 droplets. Sometimes you see them, like if they're very

1 big, and they kind of go to a front trajectory, I would
2 say, in layman's terms, almost similar to a shotgun,
3 for example, it sprays out. So it's a very brief
4 interaction, and whatever it hits, it potentially could
5 attach to that and infect, and then it's gone. So if
6 you were too far away, for example, then it probably
7 wouldn't reach you.

8 Aerosolized means that it is suspended in air, and
9 it could stay there for minutes to hours, and it would
10 float. So think of it as a floating cloud, for
11 example. And if some living thing got in the way of
12 it, it could potentially could attach to that living
13 organism.

14 Q And these large droplets, you described how they come
15 out and kind of like a shotgun, how far do they tend to
16 go typically?

17 A Well, I don't think anyone knows for sure. The
18 regulations say 2 metres in Canada because they figured
19 that that would be roughly the safest distance to stay
20 apart, but that's far from universal. Every country
21 has their own rules.

22 I think the references for this date all the way
23 back to research from the 1930s, so I don't think
24 anyone knows for sure. It obviously depends upon the
25 intensity of the cough or the sneeze or whatever
26 propellant propelled the droplets. It's entirely

1 dependent on that. Just like if you shoot something
2 with a rifle or whatever, it depends on how much
3 pressure is applied.

4 Q So we'll pick a number, let's call it 3 metres; if
5 COVID was only transmitted through large droplets, and
6 we all stayed 3 metres apart all the time, do you think
7 that would actually work to stop the transmission of
8 the virus?

9 A Theoretically, if that was true, that it only
10 transmitted 3 metres, and the only way of transmission
11 was through large droplets, and every organism or human
12 being could stay more than 3 metres apart for an
13 appropriate length of time, and there's no
14 aerosolization, then theoretically, in a perfect world,
15 that would be possible. But in my opinion, in a
16 practical sense, that would be impossible, so short of
17 isolating everyone, you know, like completely.

18 Q So is the reason these 2 metre distancing rules don't
19 work is it because of the aerosolization?

20 A I believe that's a large part of it, not the only part.
21 I believe that 2 metres or any distance that you
22 enforce -- that by mandated is unenforceable in a
23 practical sense, because everyone at some point
24 inadvertently or under circumstances where they allow
25 exceptions are put in very closer. Just, for example,
26 being packed in airplanes, despite being lined up 2

1 metres apart before boarding the plane.

2 Q Right. Is there any logical or scientific reason to
3 think that masks are significantly more effective at
4 preventing the transmission of COVID in a health care
5 setting than in the general community?

6 A I don't think, from a scientific point of view,
7 necessarily, because the masks are the same and the
8 virus are the same theoretically, if you're talking
9 about mask for mask.

10 The applications of the rules may be more vigorous
11 in the hospital and under certain circumstances may be
12 beneficial, but they would be, in my opinion,
13 impossible to enforce and to make perfect in a
14 community or a general population setting.

15 Q In your experience, is there any sort of significant
16 difference in efficacy between nonmedical cloth masks
17 or the medical blue procedural masks?

18 A Well, yes, they're quite different, and I would say the
19 blue ones for certain things are certainly better than
20 the cloth masks.

21 Q Are the blue procedural masks, are they better at
22 stopping the large droplets than the cloth masks?

23 A They would be -- I think they would be superior at
24 stopping anything compared to -- relatively compared to
25 the cloth mask. I'm not saying that they're effective
26 against viral transmission, but if you compare, of

1 course, a disposable medical grade blue mask to, well,
2 a nonstandardized cloth mask, I would have to say they
3 would be superior in every way for stopping things.

4 Q So the procedural blue masks, they would stop more
5 aerosols?

6 A Well, they're not aerosols, but they potentially would
7 stop more droplets, yes.

8 Q Oh, okay. So with aerosols, is there much difference
9 between the two?

10 A I don't think so, because aerosols would then just, as
11 I say, it's like a cloud, so unless you seal any mask
12 airtight, it's just going to seep around the masks.

13 Q Is that what you see in your work; do you observe that;
14 do you observe the aerosols coming out of the blue
15 masks?

16 A Well, you can't observe it if it's invisible; you have
17 to theorize that that's what's happening. They have
18 done studies I think looking in terms of within the lab
19 where you can see it, because they can trace the gases
20 and see that it's clearly going around the masks. One
21 experiment you can do is just if you see people vaping
22 or that sort of thing through a mask, and you can see
23 it going around it, so -- or the other way around.

24 Q Would you say the idea that these blue surgical masks
25 are effective at preventing the transmission of COVID,
26 would you say that's a scientific theory or a

1 scientific fact?

2 A I'd say that's a theory that has been debated and
3 disputed, yes. Not a fact.

4 Q On the second page of your report, you mention a
5 randomised control trial on the effectiveness of masks
6 regarding COVID that was conducted in Denmark --

7 A Correct.

8 Q -- for short, it's called the DANMASK-19 study. Can
9 you just tell me briefly about some of the findings of
10 this study?

11 A Well, it was a study in a public setting looking at
12 masks and seeing if it would reduce rates of COVID, and
13 the findings were negative, meaning it didn't
14 significantly show a reduction in COVID infection.

15 The significance of this study -- I mean, every
16 study has problems -- is that it is the only randomised
17 control trial looking specifically at COVID. Every
18 other piece of evidence so far is based on either
19 previous literature pre-COVID or else based on
20 observational data. So the only randomised control
21 study, which is considered -- generally considered the
22 highest form of research, looking specifically at this
23 issue during the COVID pandemic so far is a negative
24 study for showing benefits with wearing a mask.

25 Q Now, you've said that randomised control trials are,
26 you said, the highest -- of the highest value, is that

1 what you said?

2 A Yes. Well, they are the -- they're generally accepted
3 as the most difficult studies to set up. Generally, if
4 you start a medical treatment or something like that,
5 and you want it to be approved, you have to have a
6 randomised control trial -- or more than one usually,
7 but you have to have randomised control trials to prove
8 that it is better than the alternative, which is
9 usually whatever was done before, or a placebo.

10 This is the study that can -- randomised control
11 studies are those that can show causation.
12 Observational studies can show correlation, but they
13 generally cannot conclude that it causes it, for
14 example.

15 Q Okay, so to go back to what you're saying, you said
16 generally these randomised control trials are what's
17 required for a new product or intervention, so I guess
18 this mandatory universal masking was imposed without
19 any randomised control trials that demonstrate that
20 it's a good idea?

21 A Correct. I believe Dr. Hu also said the same thing,
22 but then he mentioned because you wouldn't -- the
23 analogy he put up of not testing someone without a
24 parachute.

25 Q Yeah, what's the likelihood of surviving jumping out of
26 an airplane without a parachute?

1 A Well, I guess it depends how high the plane is, but I
2 would say, under normal circumstances, zero.

3 Q Right, okay. And what's the likelihood of surviving
4 COVID if you contract it?

5 A Well, taking the general population, it would be more
6 than 99 percent.

7 Q Taking the population of health care workers, would
8 that number go up?

9 A It has more to do with health, age, and risk factors,
10 so on the whole, in general, no, it would stay the
11 same, over 99 percent survival rate.

12 Q And forgive me, I know this question is obvious, but
13 what's the difference between 0 and 99?

14 A I think infinity, if you argue that way,
15 mathematically, but obviously quite extreme opposite
16 ends of each other.

17 Q It's not really a fair assessment to compare jumping
18 out of a plane with a parachute with COVID, is it?

19 A I think not. May I just take a 1-minute pause?

20 MR. KITCHEN: Yeah, you know what, Chair,
21 can we take just a little bit of a break; is that all
22 right? Maybe until 1:30. Mr. Lees?

23 A I just need 2 minutes, but whatever you ...

24 THE CHAIR: That's fine. I was just going
25 to ask, Mr. Maxston, you're okay?

26 MR. MAXSTON: Yes, I'm fine, thank you.

1 THE CHAIR: Okay, we'll reconvene at 1:30.

2 MR. KITCHEN: Thank you.

3 (ADJOURNMENT)

4 THE CHAIR: Okay, Mr. Kitchen, I believe
5 we're all back, so please continue.

6 MR. KITCHEN: Thank you.

7 Q MR. KITCHEN: Now, Dr. Dang, before the
8 break, you were talking a little bit about randomised
9 control trials versus observational evidence. Now,
10 observational evidence does have some value; is that
11 right?

12 A Correct, lots of studies are observational studies, far
13 more than randomised control trials, I would say.

14 Q But just to properly contextualize this, observational
15 evidence has some value but less than randomised
16 control trials?

17 A Correct, generally speaking, the gold standard to try
18 to find causation would be to do a randomised control
19 trial. Observational trials often can lead to
20 randomised control trials if there is enough
21 correlation.

22 Q Well, I'm going to ask you some questions about your
23 observations, and you mention this in your report, I'm
24 going to ask you first about some international
25 observations. From what you've seen, has the
26 transmission of COVID noticeably decreased in

1 jurisdictions with mandatory masking, let's say,
2 California as compared to jurisdictions with no
3 mandatory masking like Florida or Texas?

4 A No, they have not decreased.

5 Q Now, bear with me, but has the transmission of COVID
6 noticeably increased in jurisdictions like Florida or
7 Texas with no mandate as compared to jurisdictions with
8 a mandate?

9 A Not necessarily, no. I don't think they have any
10 correlation honestly.

11 Q Now, Dr. Hu has stated that every country that has
12 imposed masking as a mandate has experienced decreased
13 transmission of COVID; do you agree with him?

14 A Well, no, I think that's patently false because we have
15 higher rates now than ever, so -- in some places.

16 Q Are you aware of any academic literature that would
17 support his claim?

18 A None that could support it conclusively.

19 Q Now, I want to ask you about closer to home, but
20 Alberta and your practice in Medicine Hat, and you
21 state in the third page of your report that you have
22 seen patients who have contracted COVID despite
23 diligently wearing a mask as directed by the mandates.
24 Can you tell me any more about that?

25 A Well, in general, yes, I think everyone has made a
26 sincere effort to just obey the law, because that's

1 kind of the nature of our civil society, but almost all
2 the patients that I've seen have been respectful of the
3 laws and the rules, and they have contracted COVID.

4 Q Do you have any patients that generally don't wear a
5 mask?

6 A For various reasons, I do, yes.

7 Q Do you see any difference between the two as far as
8 contracting COVID?

9 A I don't, no, not in my personal experience.

10 Q And some of your patients that wear a mask, are they
11 themselves health care workers?

12 A Some of them directly are my patients, or some are --
13 just happen to be health care workers that I have known
14 to have contracted COVID, but some are directly under
15 my care.

16 Q You mean like the health care workers that you work
17 with?

18 A Correct, yes, I know some of them, they aren't
19 necessarily my patients, but I know they've contracted
20 COVID because they chose to make it public, for
21 example, or it became public, one way or the other.

22 Q Okay. Now, Dr. Hu has said that despite hundreds of
23 thousands of interactions between Alberta health care
24 workers and patients with COVID, he says transmissions
25 have been very, very, very low, likely less than 100.
26 Based on your experiences and observations, is Dr. Hu's

1 statement likely to be true?

2 A I think it would be more than 100. I think there may
3 be a degree of less than, say, in the community because
4 of various factors, not just -- not primarily masking
5 that may reduce the incidents to some extent, but I
6 don't see that as being supported by evidence.

7 Q If we had to put a number on it, how many would you --
8 how many transmissions of COVID between patient and
9 health care worker do you think has happened in
10 Medicine Hat?

11 A Well, we're not a big facility, first of all, but I
12 would say, I'm just estimating here, I would say in the
13 hundreds.

14 Q Hundreds just in Medicine Hat?

15 A Yeah.

16 Q (INDISCERNIBLE)

17 A Over the last two years though, that's --

18 Q Right, but Dr. Hu has said that it's less than 100 for
19 the whole province.

20 A Well, I don't think that's true.

21 Q Now, I want to ask you about the general community.
22 From your perspective as a clinical respirologist in
23 Medicine Hat, has mandatory masking noticeably reduced
24 the transmission of COVID in the general community in
25 Medicine Hat?

26 A No. Medicine Hat, up until the very first mandate,

1 was -- some people may or may not know -- the last
2 major jurisdiction in Alberta to enforce the mask
3 mandate. They did it very reluctantly in terms of all
4 the other -- compared to the other City councils, and
5 their numbers, up until that date, had faired much
6 better than Calgary or Edmonton, for example, whereby
7 they imposed mask mandates very early on, independent
8 of the Provincial guidelines.

9 Q So I just want to make sure I understand you then, and
10 you tell me whether or not it's correlation or
11 causation, but you're saying that, with mandatory
12 masking, cases actually seemed to go up after the
13 mandatory masking?

14 A Well, that would be a correlation. That was what was
15 observed. It can't be disputed because that simply is
16 what was observed. Whether that is due to the mandates
17 or not is debatable, of course.

18 Q Right. But you haven't seen any correlation of cases
19 going down with mask mandates, have you?

20 A No firm correlation. I think the virus itself has
21 cyclical natures, just like any other typical virus, so
22 it will peak and ebb throughout the seasons and
23 throughout the year, but due to many, many
24 circumstances, I don't think masking has any impact on
25 that.

26 Q Is a peak and a wave sort of the same thing?

1 A Yes, correct.

2 Q And how many peaks or waves of the virus have we had so
3 far?

4 A I believe we're in the fourth one they say in Alberta
5 anyways.

6 Q And for how many of those waves has mandatory masking
7 been in place?

8 A In terms of the Alberta rules, I believe it was
9 instituted December 8 -- or announced on December 8th,
10 2020, which is I believe during the second wave.

11 Q So is there any data to suggest that the third wave and
12 fourth wave were decreased because of masking?

13 A No, because their waves were much higher than the very
14 first wave when there was no mandatory masking at all,
15 provincially or by city.

16 Q So the cyclical nature of the virus is going on
17 unabated by universal widespread masking?

18 A Correct, I think it's independent of that. I don't
19 think it has made any impact on viral transmission.

20 Q So you wouldn't say there's even any correlation, let
21 alone causation?

22 A Correct.

23 MR. MAXSTON: Just while you gather your
24 thoughts, I just want to express a bit of a concern
25 that some of the questions have some preambles to them
26 and the question at the end; I'm a little concerned

1 that there's a bit of a leading question pattern here.
2 I wonder if I can just ask you to think about that
3 maybe when you're asking your questions. I'm not going
4 to formally object, but I've just seen a -- I think a
5 little bit of that that causes me a little concern.

6 MR. KITCHEN: Sure, I'll slow down and ask
7 some more questions so that we're not leading anywhere.

8 Q MR. KITCHEN: Dr. Dang, do you think enough
9 evidence has accumulated over the last year-and-a-half
10 to allow us to reasonably know, one way or the other,
11 whether the Public Health restrictions have been
12 effective regarding COVID?

13 A No, I think it's highly debatable to now.

14 Q So mindful of my learned friend's comments, it's highly
15 debatable, so you're saying -- I want to make sure I
16 understand -- is there enough evidence to say that the
17 restrictions definitely don't work?

18 A No, I don't think anyone can say that either with
19 certainty. I say that is debatable that you can say
20 that these restrictions have had a meaningful impact.
21 If you go by case numbers itself, in terms of the
22 volume of COVID cases, in some jurisdictions, we have
23 seen the highest rates ever despite vaccinations,
24 restrictions, et cetera. So if you go by results, you
25 could argue that they've had no impact because you have
26 more cases than ever.

1 Q And just to be clear, there is not enough evidence to
2 definitely say they do work?

3 A Correct, yes, there's -- I would agree with that
4 statement completely. There is no definite evidence
5 that they do work as they were intended, and that the
6 point is really debatable at this point.

7 Q Based on a preponderance of evidence, if you had to
8 choose between the restrictions are generally working
9 or the restrictions are generally not working, which
10 would you say is the case?

11 A Well, I said previously, given the -- many
12 jurisdictions having the highest cases ever since the
13 pandemic began, over almost two years now, I would say
14 that they generally are not working.

15 Q You said the word "debatable"; is there a debate
16 currently ongoing about the effectiveness of these
17 measures?

18 A I think, to some extent, there is a debate. I believe
19 currently the debate has been more leaning to one side
20 than the other in terms of the ability to debate, but
21 anything in the scientific realm should be debatable
22 and argued reasonably.

23 Q Do you think the Alberta Public Health authorities are
24 open to debate?

25 A Based on what I can see so far of their actions, no, I
26 do not think they are open to debate.

1 Q Do you find that strange?

2 A I do. Normally, the scientific community should be
3 open to debate and arguments and to see both sides of
4 the situation before making profound measures that
5 impact basically the entire population.

6 Q Do you think the decisions that Alberta Health Services
7 or the CMOH are making, do you think they're entirely
8 informed by science?

9 A I do not think they have considered all the evidence in
10 science that is available or looked at both sides of
11 the situation, so the short answer to that being, no, I
12 don't.

13 Q Do you think there's anything nonscientific that's
14 influencing these decisions?

15 A Well, I think there's always an element of a bit of
16 fear and the tendency, it appears, from this
17 organization to err on one side rather than the other.
18 I think there's also, to some extent, a kind of a
19 domino effect from what is happening around the world,
20 so that every jurisdiction has to feel like they're
21 following everyone else's, and it's reached a point
22 where it's very hard to go against the grain, as it
23 were. But there have been some countries that have
24 successfully done that, and I think I put a point in my
25 report to that effect as well.

26 Q And would you say that impact, is that a scientific

1 impact?

2 A Sorry, can you clarify that?

3 Q You said there's the domino effect of feeling like you
4 have to follow what other jurisdictions are doing; is
5 that effect a scientific effect?

6 A No, I think that's mainly a social political effect.

7 Q Dr. Hu has repeatedly stated that the evidence
8 supporting the effectiveness of masks is, quote,
9 overwhelming. Do you think that's a scientifically
10 accurate statement?

11 A Well, I disagree with that statement is I think the
12 best I can say. I think that there is not overwhelming
13 evidence. I think it is still highly debatable at this
14 point, and there have been studies in the past for and
15 against his position.

16 Q Dr. Hu has also said that there's heaps and mounds of
17 evidence supporting the effectiveness of masks.

18 A I would not say --

19 Q Do you -- I was just going to ask you, do think the
20 statement is an exaggeration?

21 A I disagree with the statement.

22 Q Would you say he's -- you merely disagree with him, or
23 would you say he's exaggerating?

24 A Well, I don't think what he said is true. I don't
25 think there are heaps and mounds. Although heaps and
26 mounds is a very subjective description, so maybe, in

1 his mind, heaps and mounds are -- is different from
2 what I think of heaps and mounds.

3 Q Dr. Hu said masks are an effective tool for preventing
4 the spread of respiratory viruses writ large. In your
5 opinion, is this a medically sound statement?

6 A Again, I would disagree with that, based on the studies
7 in the past, looking specifically at viral
8 transmission, masks have not been proven to be
9 beneficial in that sense. And from a structural point
10 of view, I don't see how they could be, given the sizes
11 of viruses versus the pores of masks.

12 Q And forgive me if this seems redundant, but then Dr. Hu
13 goes on to say in the last page of his report that:
14 (as read)

15 The efficacy of masking on disease
16 transmission is beyond doubt.

17 Do you agree with that statement?

18 A I do not.

19 Q Let me ask you a different question: Do you think that
20 statement is even reasonable?

21 A Well, personally, I don't think it's reasonable. As I
22 mentioned before, science is open to debate, and so
23 this is I think still a very debatable point. And
24 there has been some research looking into this long
25 before COVID, and the results have been mixed at best.
26 So to say that this is definitely one way or the other

1 is not right.

2 Q Do you think there are some things about science or
3 medicine that really aren't debatable because we know
4 what the answer is?

5 A Yes, but very few things.

6 Q Okay. So does it surprise you then that Dr. Hu is so
7 confident that he's absolutely right about the efficacy
8 of masks?

9 A Well, really I can't speak for Dr. Hu or his intention,
10 I presume they're honourable, but I think, as I say, in
11 any scientific debate, especially on a question as
12 this, that potentially it could affect civil society to
13 such a broad extent, I think it should be open to
14 debate, and I don't think that there is firm evidence
15 saying conclusively that masking worked or that they
16 justify the measures that have been in place.

17 Q Now, of course, to Dr. Hu's credit, he specifically
18 said masks aren't perfect, nothing's perfect, masks
19 aren't perfect.

20 A Correct.

21 Q Are you -- would you say that masks don't work at all
22 ever?

23 A It -- no, I think that it depends on what the purpose
24 of the mask is and the conditions that they're used.
25 In some very limited settings, they might be useful to
26 some extent. Even in the days, as I mentioned, the

1 previous pandemics that I was experiencing, we didn't
2 have these universal rules in the community of
3 populations, but we certainly had limited settings in
4 isolated rooms, in negative pressure rooms, and
5 different types of masks and different procedures for
6 wearing the masks.

7 So -- but the original purpose of wearing masks,
8 supporting my OR research -- or in the studies that
9 looked at it in the operating room, it's not for viral
10 transmission protection but really to prevent
11 transmission of very large things like blood and saliva
12 and things like that.

13 Q So some masks could work sometimes for some things?

14 A Correct, yes.

15 Q But when it comes to COVID, from your observations, are
16 the masks working to stop the transmission of COVID?

17 A No, and if we go completely by result-based assessment,
18 then I think that definitely you can say, no, it has
19 not been successful in that way.

20 Q Now, I want to go back to this issue of causation and
21 correlation, because I think this is probably pretty
22 important.

23 Dr. Hu stated in his testimony that a very, very,
24 very large number of health care workers in Italy
25 contracted and died from COVID early on. He concluded
26 that part of the reason that happened was because the

1 Italian health care workers ran out of masks. Now, in
2 your opinion, is there a causal link between masking
3 and what happened to the Italian health care workers,
4 or is that only correlation?

5 A Well, that would be, at best, correlation. I think
6 even if you clarified that with Dr. Hu, he would agree
7 with that if he's a clinician and a researcher because
8 that's -- that's not a randomised control study, and
9 that's not -- there are other factors at play, so you
10 can always say, at best, that there's a -- there may be
11 a correlation.

12 Q So there's no scientific basis to attribute causation
13 to that?

14 A Correct.

15 Q Dr. Hu in his testimony described the lockdown
16 restrictions imposed last December -- which we've
17 already talked about, that's the first time universal
18 masking was in place all across the province -- he
19 stated that cases went up after that November, December
20 lockdown, but then eventually later, the cases went
21 down. He then concluded that the lockdown caused the
22 cases to eventually go down, and that the initial rise
23 in cases was only correlated with the lockdown. Do you
24 agree with Dr. Hu's analysis?

25 A No, I don't think you can have one or the other. You
26 have to say, at best, there may be a correlation. As I

1 mentioned too before, I believe that the virus is
2 cyclical.

3 And if -- and I remember that first lockdown quite
4 clearly in my mind, because I kept track of it, and for
5 personal reasons, I just remember it, but the
6 Government announced -- well, Medicine Hat was the last
7 city that announced a mandatory mask, of all the major
8 cities in Alberta, on December the 4th, and then four
9 days later, the Premier announced a lockdown on -- a
10 masking and general restrictions on December the 8th,
11 but to be effective that weekend, so it would be a few
12 days to give people some time to prepare for that.

13 Even though he instituted that, at that time, the
14 cases for that time period had reached the highest it
15 had seen at that time. It continued to reach -- go up
16 slightly for the first few days, but then it peaked,
17 and then after that, it steadily started to go down. I
18 mean, you can look into the statistics for this; you
19 yourself can easily prove that.

20 Now, obviously even by their own words, they said
21 that it would take two -- at least two weeks or more
22 before any of these measures would take -- would have
23 any benefit. So the fact that it peaked already and
24 started to come down two or three days after they
25 announced the general lockdown shows that those
26 restrictions had nothing to do with the cases going

1 down, but I believe just due to the cyclical nature and
2 the natural path -- pathogenicity of the virus, so --
3 and then we've seen that since with subsequent waves
4 from what I can see.

5 Q So did Dr. Hu make a mistake when --

6 A Dr. Hu's entitled to his opinion. I don't know, I
7 can't speak to what he says. I can only tell you what
8 I believe, and I disagree with his assessment.

9 Q Okay. He was very clear on this, because I asked him
10 his position.

11 Is conflating causation and correlation, is that a
12 pretty big mistake?

13 A I believe so --

14 MR. MAXSTON: I'm sorry, I'm going to have
15 to comment again. I think you can ask your client
16 where he disagrees and why he disagrees, but that kind
17 of a question sort of presumes a response.

18 Q MR. KITCHEN: Dr. Dang, when it comes to
19 medicine and science, is it really important to not
20 conflate correlation and causation?

21 A Correct, the two do not always end up agreeing.
22 Correlation may be helpful to stimulate further
23 research and hypotheses, but the causation may turn out
24 to be something completely different.

25 Q Do you see any causal link, causal link between the
26 lockdown measures like mandatory masking and the COVID

1 numbers, be it cases, ICUs, or deaths; do you see any
2 causation between these lockdown measures like masking
3 and those COVID number?

4 A No, I don't see any conclusive evidence of that, and I
5 don't think anyone can say conclusively that the
6 lockdowns or these restrictions caused lower cases.

7 Q But that's what -- isn't that what Public Health says?

8 A Well, I can't speak for what Public Health says. I can
9 observe what I see and what the numbers are like in the
10 world and in our province throughout all this.

11 Q But you said, you know, I can't see how anyone could
12 say this, and yet isn't just about everybody saying it?

13 A I can only speak to myself and my own conscience and
14 the evidence that is presented to me that is available
15 to everyone else. I can't speak for anyone else. I
16 would say it's universal, but I agree that there are --
17 I think the majority of people do believe, at least at
18 this point, that these restrictions have had some
19 impact, but, again, I believe that is probably due a
20 lot to social political reasons as well.

21 Q Maybe you can't answer this and you tell me if you
22 can't, but why do you think it is that we are making
23 Public Health decisions based on social and political
24 concerns and not scientific concerns?

25 A Well, I think like everything else in civilization,
26 we're human beings, so we don't just deal with facts,

1 we deal with emotions too, and we deal with -- right
2 now we're dealing with fear and panic and paranoia,
3 et cetera, and I believe that each and every government
4 is trying to respond in, they think, the best way to
5 deal with that.

6 Q To deal with the fear?

7 A Correct, and to maintain, perhaps in their eyes, a
8 civil order and control perhaps, but that is my
9 opinion.

10 Q Well, and that's what you're here to give us.

11 Do you think the term "anti-mask" is pejorative?

12 A Correct, I do.

13 Q Do you think it is fair and accurate to label someone
14 as an anti-masker if they are opposed to mandatory
15 masking but not voluntary masking?

16 A I believe that is pejorative in that case, yes.

17 Q Do you think people should be free to mask if they want
18 to?

19 A Well, yes, in general, that I think was always an
20 option in the past in -- many jurisdictions did that;
21 for example, Japan, a lot of people wear masks for
22 other reasons, but, yes, I believe it should be a free
23 choice.

24 Q What does the phrase "informed consent" mean to you?

25 A Well, it generally means that you tell the patient what
26 can happen -- the procedure that you plan to do, the

1 risks and benefits of it, the evidence for or against
2 it, and then they make a decision after being informed
3 of all relative and important features about the
4 decision; they make a decision whether to go for it or
5 against it, and without any coercion or duress.

6 Q Do you think informed consent is obtained if only the
7 benefits are discussed but not the risks?

8 A Correct -- no, correct, I -- yes, you're -- I do not
9 think informed consent is obtained in that case. You
10 have to give the risks and benefits and all the
11 important salient features about whatever that decision
12 is before informed consent is obtained.

13 Q When it comes to masks, would you say that there are
14 both potential benefits and potential risks?

15 A Yes, I would.

16 Q So do you think mandatory masking is consistent with
17 informed consent?

18 A No, because there is no consent being sought. It is
19 just a rule being imposed. So by definition, that is
20 the complete opposite of informed consent.

21 Q What does the phrase, "First, do no harm" mean to you?

22 A That's one of the tenets of any physician, primum non
23 nocere in Latin, that we are taught, first, do no harm,
24 and the principle is whatever we suggest, we always
25 have to keep in mind that whatever we do, not cause
26 harm to the patient.

1 Q Do you think mandatory masking is consistent with,
2 first, do no harm?

3 A I do not.

4 MR. KITCHEN: Mr. Maxston, just to give you
5 an idea. I'm probably only about 20 minutes from being
6 done; 30 minutes at the very most. Yeah, I'm going to
7 say probably 20 minutes or less.

8 Q MR. KITCHEN: All right, Dr. Dang, with
9 that, I'm going to move into asking you some questions
10 about the harms of masking as you've discussed them in
11 your report.

12 A Okay.

13 Q You state near the bottom of the second page of your
14 report that wearing a mask is, quote, not harmless.
15 You go on to discuss how humans are designed to
16 breathe. Now, can you tell me, as a respirologist, how
17 are humans designed to breathe?

18 A Well, I can certainly tell you as a respirologist, but
19 I think anyone can tell, without respirology training,
20 that we're meant to breathe as we are, unobstructed,
21 freely through our mouth and nose, ideally good air of
22 course, clean air.

23 Q So even if we're breathing unobstructed, if we're
24 breathing bad air, what happens?

25 A Well, then we have to -- then, as I mention in the
26 report, in certain circumstances, we have to, of

1 course -- we can use protective measures if the
2 benefits outweigh the drawbacks of that.

3 So if you're -- obviously, if you were exposed to
4 mustard gas or something like that in World War I, then
5 you would have to wear a special gas mask to prevent
6 that. It would obstruct your breathing, and no one, I
7 think, would argue with that, but, for that temporary
8 purpose, that would be beneficial.

9 Q So given the choice between access to -- or decreased
10 access to oxygen and breathing mustard gas, which is
11 the better choice?

12 A Well, breathing the lower oxygen as long as it can
13 still sustain life for the shortest period of time
14 possible.

15 Q And forgive me, but is that because mustard gas is so
16 dangerous?

17 A Correct, I believe it is deadly in many cases.

18 Q If you're exposed to mustard gas, is your rate of
19 survivability less than 99 percent?

20 A I don't have the exact numbers, but I certainly
21 wouldn't want to be exposed to mustard gas under any
22 circumstances. Even the survivors have damage in terms
23 of pneumonitis and other chronic health problems too.

24 Q So we would never do a randomised control trial with
25 mustard gas?

26 A Not during these days. Maybe during World War I, they

1 might have, but, no, we wouldn't.

2 Q It's kind of like the parachute example?

3 A Correct.

4 Q Now, the types of masks that are mandated for COVID,
5 how do those types of masks interfere with the normal
6 breathing process as you've described it?

7 A Well, it could be something from very mild to very
8 significant, depending on the type of mask, how it is
9 worn, how much it has changed, et cetera, and also
10 their condition of the patient -- or the person who
11 wears the mask. If they have chronic lung disease,
12 they may be impacted more severely than others.

13 I can tell you just from personal -- I mentioned,
14 I run a pulmonary function lab, and just as kind of a
15 personal inquiry, I had some healthy testing whereby
16 just wearing a mask versus not wearing a mask and doing
17 a pulmonary function test, and these are completely
18 healthy people. The lung functioning drops about 15 to
19 20 percent. So it does play an impact, in my opinion.

20 Obviously, that's just my own anecdotal kind of
21 evidence, but I believe that any reasonable person
22 would agree that wearing anything that covers the mouth
23 and nose would, at least to some degree, obstruct your
24 airways and breathing. Whether it's clinically
25 significant or not is debatable though.

26 Q So this reduction in lung function, that's across the

1 board, the same for everybody?

2 A Well, it's rough -- because everyone's going to be
3 slightly different, but, yeah, in a healthy individual,
4 it seems to me, from what I've seen, roughly 15 to 20
5 percent.

6 Q But help me understand, is that really significant or
7 not really?

8 A It won't be noticeable if you're sitting still, doing
9 light stuff, but if you're exerting yourself or
10 exercising, you could definitely notice a difference,
11 and if you have some sort of lung health problem --
12 other health problems, it would probably be much more
13 noticeable.

14 Q So do you find it surprising that some people seem to
15 tolerate wearing these masks more than others?

16 A No because everyone has different lungs, shall we say,
17 and also everyone in the public wears masks differently
18 and the types of masks, so everyone will have a
19 different response.

20 Q You mentioned in your report self-contamination due to
21 moisture retention. Can you just describe, what is
22 this self-contamination due to moisture retention?

23 A Well, it's just simply when you breathe, of course,
24 you're breathing moist air, there's water in it,
25 et cetera, water vapour, and anything that it hits will
26 condense. I mean, you see that so when you wear

1 scarves or anything to cover your face.

2 So same thing with masks; if you wear a mask long
3 enough, you're going to collect moisture there, and
4 then that can, in turn, collect secretions, your own
5 secretions, or things that are exposed at -- or
6 contaminants around you, and then in the end, you're
7 going to be breathing that in again. So that's what I
8 mean by moisture contamination.

9 In fact, the appropriate way to wear a mask before
10 all this began, in a health care setting is that we had
11 to change our masks frequently. So, generally, I would
12 change it, if I had to -- first of all, I wouldn't wear
13 it any longer than I had to, but if you had to wear it
14 for an extended period of time, you should probably
15 change it every hour, and we're talking about
16 disposable, you know, surgical-type masks.

17 But that's simply not happening in the public.
18 You're having people wearing cloth masks or the same
19 surgical mask over and over again and touching them,
20 et cetera. So even the application of wearing them
21 safely is not -- is not done. I would say in 99.9
22 percent of the population in a community setting.

23 Q And what would some of these contaminants be?

24 A Well, it would be whatever is in your saliva basically.
25 So it could be bacteria, it could be viruses, and then
26 whatever you breathe around you, could be particulate

1 matter, could be anything from just smoke, dust,
2 vapours, allergens, could be viruses. I mean, if you
3 were exposed to someone coughing with COVID or any
4 other virus, it could go onto there, then you could
5 have breathing it in theoretically.

6 Q Hold on. So, theoretically, wearing a mask could
7 actually increase your chance of contracting COVID?

8 A Well, could increase your chance of getting any
9 infection, if you don't wear -- if you don't change the
10 masks and don't keep them clean, correct, yes.

11 Q Okay. In your practice or in the literature, either
12 one, what are some of the harms that you have observed
13 from continuous or prolonged mask wearing?

14 A Well, there's -- of course, there's psychological
15 damage that could be done, both to patients,
16 particularly in younger ones, kids for example. There
17 are things like severe allergic reactions.

18 I had one patient, a health care worker in the
19 hospital who couldn't wear a mask, because every time
20 the patient wore the mask, there would be a very severe
21 rash, and this is well-documented, she -- the patient
22 had pictures to prove it, and despite wearing several
23 types of masks of different material, they all produced
24 the same results.

25 And then, of course, there's people -- my
26 practice, of course, consists of mostly people who are

1 short of breath, so if they're extremely short of
2 breath, of their oxygen, et cetera, they are severely
3 impacted by wearing a mask.

4 Q Can you describe for me generally what lung disease is?

5 A Well, lung disease just means any disease that affects
6 the lung, but the most common ones that I see would be
7 chronic obstructive pulmonary disease, also known as
8 COPD or emphysema, and asthma --

9 Q Okay.

10 A -- those would probably be the two commonest chronic
11 lung disease seen in the community.

12 Q Are those people more negatively impacted by wearing a
13 mask than people who don't have those conditions?

14 A Many of them are because their lung functions are
15 already impaired to start off with.

16 Q So you have patients with asthma?

17 A I have many patients with asthma.

18 Q In your opinion, is asthma, you know, a valid medical
19 basis for having an exemption from wearing a mask?

20 A In some circumstances, depending on the severity of the
21 asthma or any lung disease, something that's very mild
22 and if the patient can tolerate wearing a mask, then it
23 may not be a problem that way, but other people are
24 severely impacted.

25 I believe Dr. Hu mentioned the Canadian Thoracic
26 Society saying that masks weren't harmful or were safe,

1 but if you look at the actual guidelines, and I have
2 them in front of me, it's a very short statement by the
3 way, and they reference old literature, for the most
4 part, but even within their context, they do leave room
5 for patients to remove masks if it causes them
6 shortness of breath. So they recognized -- and in
7 their own statement, they recognize that -- they say
8 that wearing a mask will obstruct breathing to some
9 extent, so ...

10 Q Well, Dr. Hu didn't give us the whole quote, but what
11 he said twice was that he said that the Thoracic
12 Society said that prolonged mask wearing does not
13 exasperate any underlying lung condition. Is that what
14 the Thoracic Society has said?

15 A Well, I have the argument here. This is quoting what
16 they say exactly. What they say is quite -- a little
17 bit different, they say: (as read)

18 There is no evidence that wearing a
19 mask/facial covering will lead to prolonged
20 symptoms or a flare-up of an underlying lung
21 condition.

22 They say there's no evidence; that's as far as they're
23 willing to go. I personally believe that statement is
24 still too strong, but that doesn't mean that there
25 isn't any harm; it just says that from what they can
26 see, there's no evidence.

1 However, in that same paragraph that I quote that
2 statement, at the very beginning, they say: (as read)
3 Breathing through a mask takes more effort,
4 and this may vary depending on whether one is
5 using a commercially produced mask, a mask
6 made at home, or a simple cloth covering.
7 For those with underlying lung diseases, the
8 effort required may cause a feeling of
9 shortness of breath while wearing the mask.
10 In such situations, we recommend that
11 individuals remove the face mask, and if
12 symptoms do not immediately settle, they
13 should follow the existing strategy for
14 relief of acute symptoms.

15 MR. KITCHEN: Mr. Maxston, how do you feel
16 about me providing you a copy of this statement and
17 then asking to have it entered as an exhibit?

18 MR. MAXSTON: I don't think I have a problem
19 with it, Mr. Kitchen, but I think, to the extent your
20 client is expressing an opinion different than
21 Dr. Hu's, the Tribunal is aware of that, and they're
22 going to have to make their determination. So I don't
23 think a great deal turns on it. Mr. Lawrence might
24 have some different views on that, but he's shaking his
25 head no. Frankly, if it will move us ahead, and you
26 think you don't have to go through the document in

1 detail, I'm happy to have it sent over, but I think
2 this is just another point the Tribunal is going to
3 have to dissect and decide on, Mr. Kitchen.

4 MR. KITCHEN: Okay, so here's what I'll do,
5 when we're done, I'm going to get a copy of this, it
6 should be easy, because it's the Thoracic Society of
7 Canada, I'll get a copy of it. I'll submit it to you,
8 and then you can let me know if you consent on it being
9 entered as an exhibit, and then we can provide it to
10 the Tribunal.

11 MR. MAXSTON: I think, Mr. Kitchen, I'd be
12 very reluctant to object to it being entered as an
13 exhibit. Your client has read from it. Again, I think
14 it's just something the Tribunal's going to have to
15 digest, so I think you can send it to --
16 Mr. Nelson's [sic] nodding his head -- you can send it
17 to Ms. Nelson, at some point, and it can be distributed
18 to the Tribunal.

19 MR. KITCHEN: Thank you.

20 THE CHAIR: And to our reporter too.

21 MR. KITCHEN: I don't know where we're at
22 for letters and numbers, so we'll figure that out after
23 the fact.

24 EXHIBIT H-8 - Excerpt from the Canadian
25 Thoracic Society guidelines (Document not
26 Provided to be Marked)

1 Q MR. KITCHEN: So, Dr. Hu -- Dr. Dang, I
2 apologize -- I've got Dr. Hu in front of me here -- the
3 Thoracic Society statement said there's no evidence for
4 masking impacting underlying lung conditions. Do you
5 disagree with that?

6 A Well, yes, I think there has been some evidence that it
7 does potentially show potential harm, but my point was
8 their statement was much more limited than what Dr. Hu
9 was saying. They're saying, in their statement, they
10 have found no evidence. That doesn't mean it's not
11 there; it just means that they look -- and if you look
12 at the reference, which I can certainly send you or you
13 can find yourself, it's a very short statement. It's
14 only I think two or three pages, and it has very few
15 references. So it's not like they did an expansive
16 literature review to look at this, nor, would I expect
17 there'd be a lot of research into this. I think
18 pre-COVID, it just made sense that wearing a mask when
19 you have severe lung disease, unless you actually have
20 to, was not something that would be done.

21 Q All right, so in your opinion, as a respirologist, are
22 there medically valid reasons for exemptions from being
23 required to wear a mask?

24 A Absolutely.

25 MR. KITCHEN: I think I'm just about there.
26 Just give me a second.

1 Q MR. KITCHEN: Dr. Dang, I'm just going to
2 ask you one more question -- and I'll give my learned
3 friend a chance to object, because he might -- there's
4 been a particular word used by both you and Dr. Hu and
5 others, but, particularly, you and Dr. Hu that I have
6 found very interesting, and that word is the word
7 "politicised". Dr. Hu has said that the masking issue
8 is politicised, and you have said the same thing, but
9 I'm not sure that we've really heard an explanation of
10 what the heck that means. When you say that the mask
11 issue is politicised, what do you mean by that?

12 A I mean, I think that the decisions on masking have not
13 been made based on the medical literature, medical
14 debate, or medical judgments mainly, but has been based
15 on what is happening with human interactions in society
16 and with the governments currently, and is made based
17 on a lot of emotional and nonmedical reasons.

18 Q Do you find that surprising?

19 A I actually don't. I think that in times when people
20 are calling for crisis or certainly the pandemic has
21 probably been the largest crisis we've ever dealt with
22 in a long time and certainly in terms of magnitude
23 extending around the globe, there's very little else to
24 compare within recent history, that when something like
25 that happens, and we are dealing with raw emotions,
26 especially when we're dealing with fear, paranoia, and

1 power, so we are dealing with, you know, the very
2 features of politics.

3 Q You said "power", so do you think power is part of
4 what's influencing the decisions on mandatory masking?

5 A I believe --

6 MR. MAXSTON: Mr. Kitchen, I think I'll
7 object to that. I think your last question was
8 debatable, I didn't object to it, but we're now --
9 "power", you tell me what that means, I think that
10 one's just a little too far. I would --
11 politicisation, correct, Dr. Hu weighed in on that, but
12 I think it might just be a little too far.

13 Q MR. KITCHEN: Dr. Dang, you're aware that
14 every health professional regulatory body has imposed
15 mandatory masking on their members; is that your
16 understanding?

17 A Well, more or less indirectly. I believe the
18 Government, that has done that, and then the regulatory
19 bodies have approved of it or have been either
20 explicitly or tacitly agreeing to it; they're certainly
21 not opposed to it.

22 Q Right, and my learned friend can stop me here, but
23 that's actually I think a fair description of what
24 happened with the College. We had a lot of evidence
25 from -- the College said, Well, when we constituted the
26 mask mandate, we had to because Dr. Deena Hinshaw said

1 that in order for our members to practice, we had to
2 have a mask mandate. So I think what you've just said
3 is not controversial.

4 Last question I'll ask you on this, you said you
5 didn't find it surprising; do you find it strange?

6 A About the masking pandemic worldwide or restrictions in
7 general?

8 Q Do you find it strange that politics is influencing
9 decisions on whether people wear masks or not?

10 A I disagree with those things profoundly, but I don't
11 find it strange that politics has done that, because it
12 has endeavoured to do that sort of thing throughout
13 history. I myself have fled from a communist country,
14 so I know what these things are.

15 MR. KITCHEN: Those are all my questions.

16 THE CHAIR: Okay, Mr. Maxston, did you
17 want a moment before you start? It's 2:30, and we've
18 been going for just about two hours, why don't we take
19 a 10-minute break.

20 MR. MAXSTON: Mr. Chair, I have a question
21 for Mr. Kitchen before I begin my cross-examination,
22 and I think it's something that Dr. Dang shouldn't be
23 present to hear, there's no magic in it, but it's about
24 my cross-examination. I'd like to ask him a question
25 on the record. Can we just take 5 minutes, if
26 Ms. Nelson can put Dr. Dang into a break-out room and

1 then break for -- I think it's good idea to have a
2 break. I won't be terribly long, but I think if we can
3 just deal with that one matter now, I'd like to do
4 that.

5 THE CHAIR: Okay, so we will move Dr. Dang
6 into a break-out room, and then you can put your
7 question on the record.

8 And so, Dr. Dang, we're going to transfer you to a
9 break-out room so you won't be participating in the
10 hearing, and we have a matter that we need to deal with
11 without your presence, and then we're going to take a
12 short break, then you can come back and have
13 Mr. Maxston conduct his cross-examination.

14 A Okay, that's fine, thank you.

15 THE CHAIR: Okay, thank you.

16 Discussion

17 MR. MAXSTON: So, Mr. Chair and Mr. Kitchen,
18 you know, pre-virtual hearings, when I was going to do
19 a cross-examination of a witness, and I wanted them to
20 look at a document, I'd walk across to my friend and
21 I'd give him the document, and I'd say, Do you want to
22 take a look at this. The document that I have that I
23 can potentially give to Mr. Kitchen and to you, but I
24 don't know if it's necessary, and that's why I raise
25 it, is the CPSA's COVID re-opening practice document,
26 and it essentially says -- and I'm happy to send it as

1 a courtesy, in any event, to Mr. Kitchen -- that masks
2 are required for physicians, and I'm going to ask
3 Dr. Dang, Are you aware of masking requirements for
4 your profession last year, are you aware of the AHS
5 mandate. I don't have to put that document in, unless
6 my friend's going to object and say, Oh, no, no, I take
7 issue with whether there were masking requirements for
8 the CPSA, that kind of thing.

9 So I don't want to sandbag my friend, I don't want
10 to sandbag the witness, but I don't know if I need to
11 send this document or not.

12 MR. KITCHEN: I have no issue. I mean, I
13 don't have it. I mean, Dr. Dang and I essentially
14 established that fact, so --

15 MR. MAXSTON: That's why I think it may not
16 be necessary. Some of the tail end of your questions,
17 Mr. Kitchen, were you're aware of imposing these. So I
18 think my question will be to Dr. Dang, You're aware of
19 your profession having one of these and requirements.

20 So if we can go on that basis, then I don't think
21 I need to provide this document to Mr. Kitchen, but I
22 didn't want to surprise him, of course.

23 MR. KITCHEN: No, I appreciate that.

24 THE CHAIR: Okay, just before we break,
25 Mr. Maxston, how long do you anticipate your cross will
26 be?

1 MR. MAXSTON: I'm hoping 20 minutes.

2 THE CHAIR: Okay, then let's take a
3 shorter rather than a longer break; let's just break
4 for 10 minutes and come back at, I don't know, 20 to 3,
5 and then maybe we can wrap up around 3. So a 10-minute
6 break for now, and we'll see you in 10.

7 (ADJOURNMENT)

8 THE CHAIR: Okay, it's Mr. Maxston's turn
9 for cross-examination of Dr. Dang, and just I'll
10 mention it now so I don't forget, we would like to
11 caucus with the Hearing Tribunal after Dr. Dang has
12 finished the cross-examination to see whether or not
13 the Panel has any questions of him.

14 Mr. Maxston.

15 Mr. Maxston Cross-examines the Witness

16 Q MR. MAXSTON: Good afternoon, Dr. Dang.

17 A Good afternoon, Mr. Maxston.

18 Q I'm going to take you through three or four questions
19 relating to the things you just talked about with my
20 friend, Mr. Kitchen.

21 I think you made a comment -- I think there was a
22 question, rather, from Mr. Kitchen, when it comes to
23 mandatory masks, are there potential risks and
24 potential benefits, and I think your answer was one
25 word "yes". Would you agree with me that Alberta
26 Health Services and the Chief Medical Officer of Health

1 and Health Canada, and the College of Chiropractors in
2 terms of its Pandemic Directive, which you've seen,
3 they're erring on the side of potential benefits?

4 A Yes, I agree that that is their intent.

5 Q We talked a little bit -- or you and Mr. Kitchen,
6 rather, talked a little bit about this concept of
7 informed consent. Would you agree with me that when
8 we're talking about that, it's typically, as you
9 mentioned, in the context of informed consent between a
10 caregiver and a patient?

11 A That's classically the case that I'm experienced with
12 anyways, yes.

13 Q And it really isn't a concept that applies to let's
14 say, for example, you and the CPSA; they don't come to
15 you and get your consent for a fee or something like
16 that, do they?

17 A Not in that manner, no, correct.

18 Q Okay. Towards the tail end of Mr. Kitchen's questions
19 with you, he asked you is asthma a valid exemption to
20 masking, and I think you answered to him that it may or
21 may not be depending on the person and the, I guess,
22 the nature of the asthma or maybe the severity of the
23 asthma --

24 A Correct.

25 Q -- would you agree with me -- oh, I'm sorry.

26 A Sorry, I was just agreeing with you; I said "correct",

1 yes.

2 Q Would you agree with me that it's appropriate to get a
3 physician to make a proper assessment and diagnosis of
4 whether asthma is a valid exemption for a particular
5 patient?

6 A I think, most of the time, that would be a reasonable
7 thing depending on access, of course.

8 Q You talked about with my friend, I think the question
9 was, as a respirologist, are there medically valid
10 exemptions from wearing a mask, and I think your answer
11 was, yes, absolutely. This will be a little redundant,
12 but, again, is the best course of action to get a
13 physician to properly assess any medical exemption?

14 A Generally speaking, that would be the usual route, yes.

15 Q Okay. I'm going to ask you some general questions.
16 Mr. Kitchen went through a great deal of your
17 background in your practice, but I just want to ask
18 you, you haven't had any experience working with the
19 Chief Medical Officer of Health on COVID-19 measures?

20 A No, I have not.

21 Q Okay. Would it be fair to say that your views in your
22 expert report are contrary to what AHS or the Chief
23 Medical Officer of Health or the Public Health Agency
24 of Canada say about requirements for masking?

25 A Yes, they are in opposition.

26 Q One of the reasons we're at this hearing is the Alberta

1 College and Association of Chiropractors Pandemic
2 Directive, which I assume you've had a chance to
3 review, and you stop me if I'm wrong, but I think it's
4 fair to say that, under that document when you get into
5 about page 9 or 10, that there's a requirement to wear
6 surgical or procedure masks. You're a member of the
7 CPSA; are you aware that they also have similar masking
8 requirements for you?

9 A I actually haven't read yours because I never received
10 it, but, yes, if you are -- I'll take your word for it,
11 but, yes, the CPSA also follows the law, I mean that is
12 a Provincial law, so I -- whether or not the College
13 has expressly stated it, I think they're obliged to
14 follow the law, so yes.

15 Q Yeah, the -- now, there is no great surprise here, but
16 during the break, the question I was asking of
17 Mr. Kitchen was, you know, I've got a CPSA document,
18 and it talks about mandatory masking, and you've just
19 confirmed that I didn't think that was an issue or that
20 I needed to present it to you, so I'm glad we're on the
21 same page.

22 This is a fairly direct question, I'm assuming you
23 comply with the CPSA's masking requirements?

24 A Yes, I have, and I've done whatever I legally can to
25 mitigate it, but, yes, I've been in full compliance
26 with the rules.

1 Q And it's sort of the flip-side of the same coin here,
2 but Alberta Health Services has some mandatory masking
3 requirements as well, and I'm assuming, when you're in
4 the Medicine Hat Regional Hospital, you comply with
5 those as well?

6 A I do certainly, yes. I obey the law. Doesn't mean I
7 have to agree with them though.

8 Q Yeah, fair enough, fair enough. As part of you obeying
9 the law -- I'm assuming you would say yes -- I'm
10 wearing a mask when I have to, and I'm observing social
11 distancing when I have to in my practice?

12 A Correct.

13 Q This applies to Dr. Wall, but I'll phrase it in the
14 context of you as a physician: There were requirements
15 for you to become a regulated member of the CPSA; is
16 that correct?

17 A Correct.

18 Q That would have been your initial registration, your
19 education, et cetera, correct?

20 A That's correct.

21 Q And would you also agree that there are ongoing
22 requirements that the CPSA has for you to maintain your
23 licence, like con ed or record retention or paying
24 those fees every year?

25 A Correct.

26 Q Would you agree with me that it's the responsibility of

1 a professional to follow those requirements of their
2 regulatory college?

3 A For the most part, as long as they do it within their
4 just limits, correct.

5 Q So is it your view that a member of a profession can
6 opt out of the requirements of their college or
7 regulatory body at their choosing?

8 A Again, generally, no, but it depends on what the -- as
9 long as they act within their just limits. I mean, the
10 College couldn't say you had to get a golf membership
11 to be -- remain a member, then I think you could justly
12 fight that or even oppose that. I'm just giving a
13 hyperbole example. But within your just limits, yes,
14 there are -- I bring that up because the CPSA had a
15 recent issue, which I think they acted -- where they
16 tried to act beyond their just limits, and they did
17 back down, so I just want to point that out.

18 Q Sure, well, you know, I'm not trying to be cagey here.
19 The mandatory masking requirement that the CPSA has,
20 even if you disagree with it, that's part of their just
21 limits, isn't it?

22 A Well, that's I say -- that -- the Province imposed
23 that; they didn't impose that; they just went along
24 with it. But, yes, so far, you know, I should stay in
25 practice, I have to agree to it -- or I'm following the
26 law.

1 Q And you followed your college?

2 A Yes.

3 Q Dr. Wall's testimony was, in part, that he had a
4 medical exemption that allowed him to not comply with
5 CMOH orders, and his medical exemption, and Mr. Kitchen
6 can correct me, but I believe it was two-fold, it was
7 anxiety and claustrophobia. Consistent with the
8 discussion I had with you a few minutes ago, I'm
9 assuming that you would expect someone would approach a
10 physician to have a clinical diagnosis of anxiety or
11 claustrophobia when they're seeking a medical exemption
12 for masking?

13 A That would be the usual case. I mean, there is
14 certainly individual circumstances, but that is
15 generally the case.

16 Q Would you want someone to self-diagnose, a nonphysician
17 to self-diagnose their own exemption for masking, their
18 medical exemption for masking?

19 A Am I okay to explain this a little bit more or --

20 Q I asked the question, so yeah.

21 A So in general, yes, I would agree with you. However,
22 as I mentioned before, it depends on access and the
23 situation. If I fill -- I fill out -- as you know or
24 you may not know, the Province has its specific mask
25 exemption form there to fill, and in it, I'm not --
26 because I've signed some of them -- it lists all the

1 different conditions, amongst them psychiatric, of
2 course, or anxiety and that sort of thing.

3 And, generally speaking, a patient comes, and I
4 assess them within my competence, which would be lung
5 disease, and if I agree with them, then I would fill
6 out the form, and it's basically just signing the form.

7 The form, because of patient confidentiality, does
8 not require you to tell anyone -- the patient's telling
9 anyone else what specific condition they have; they
10 just have to indicate they have a valid medical
11 condition from amongst a list of that, and one of them,
12 of course, is psychological or psychiatric.

13 I will say, however, the -- if a patient comes in
14 and tells me they are extremely short of breath, and
15 the mask makes it worse, I mean I can do a whole bunch
16 of testing, but at the end of the day, you have to
17 rely, to some degree, on the patient being truthful and
18 honest, right? Everyone -- we're not here -- we're not
19 a court of law, we're here to try to help our patient,
20 we assume they tell us what is true or not. So if a
21 patient comes in and says, This causes me severe
22 anxiety or whatever, and I cannot wear the mask and
23 function; well, what are you going to do, you're going
24 to agree to that, I think, because --

25 Q I think we're on the same page. Yeah, I think we're on
26 the same page. My comment to you is shouldn't the

1 person come to you as the physician or respirologist
2 and review that with you?

3 A Generally speaking, yes. I mean, I don't know the
4 circumstances of Dr. Wall honestly but -- in terms of
5 his medical exemption, but, yes, generally, that would
6 be the case.

7 MR. MAXSTON I'm going to ask Mr. Lawrence
8 if he thinks we need to caucus, but other than that, I
9 don't think I have any further questions for you. He's
10 saying no; he's shaking his head. So those are all my
11 questions, Dr. Dang. Thank you for your time today.

12 A Sure. Thank you.

13 THE CHAIR: Thank you, Mr. Maxston. The
14 Hearing Tribunal is going to caucus for just a couple
15 of minutes to see if we have any questions.

16 Yes, Mr. Kitchen, did you have anything in
17 redirect?

18 MR. KITCHEN: I've just got one question on
19 redirect.

20 THE CHAIR: Okay.

21 Mr. Kitchen Re-examines the Witness

22 Q MR. KITCHEN: Dr. Dang, you said -- you were
23 talking to Mr. Maxston, you said that you do wear a
24 mask when you legally have to. When you wear a mask
25 because you have to because of the CPSA or the CMOH
26 orders, are you doing it against your will?

1 A Well, I'm being coerced I believe, yes. If it were not
2 for that rule, I would not be wearing it.

3 Q So you're not wearing it willingly?

4 A Correct.

5 MR. KITCHEN: Thank you. That's it.

6 THE CHAIR: Okay, Dr. Dang, if you could
7 just bear with us for 2 or 3 minutes while we caucus to
8 see if the Hearing Tribunal has any further questions
9 of you, and we'll be right back.

10 A Okay.

11 THE CHAIR: Thank you.

12 (ADJOURNMENT)

13 THE CHAIR: We're back in session.

14 Dr. Dang, the Hearing Tribunal does not have any
15 further questions for you. We'd like to thank you for
16 taking the time to attend and to provide your
17 testimony. You are free to leave and with our good
18 wishes.

19 A All right, thank you, you as well, good night.

20 (WITNESS STANDS DOWN)

21 THE CHAIR: On that note, we will adjourn
22 the hearing for today. We've got dates set for I think
23 the end of January, if I remember. So unless either
24 party has something they wish to raise at this time.

25 MR. MAXSTON: I think, Mr. Chair,

26 Mr. Kitchen and I are to stay on to help out the court

1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing
4 pages are a complete and accurate transcript of the
5 proceedings, taken down by me in shorthand and
6 transcribed from my shorthand notes to the best of my
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,
9 this 1st day of December, 2021.

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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0	1930s 929:23 1994 843:6 1:30 935:22 936:1 1st 982:9	4	9:16 841:23	accumulations 864:20 880:21 902:9 909:9
0 935:13 0.1 926:23 085 882:17,20 883:2,3	2	400 870:5 4th 950:8	A	accurate 945:10 953:13 982:4
1	2 848:2 887:8,9 888:23,26 904:3 929:18 930:18, 21,26 935:23 980:7 20 839:5,17 841:5 872:10 911:21 914:5 917:23 955:5,7 957:19 958:4 971:1,4 20,000 872:21 874:7,20 20.9 872:3 2003 921:9,15 922:4 2004 843:4 2007 882:15 883:5 2009 921:9,16 2020 941:10 2021 839:5,17 841:5 914:5 982:9 23 893:24 24 870:3 24-hour 870:3 871:10 2:30 968:17 2nd 883:5	5	abbreviated 882:3 ability 850:17 858:6 865:21 866:18,19 867:20 868:2 870:21,23 900:8,9 924:1 943:20 982:7 absolutely 845:15 846:3,15 849:15 857:3 860:6,15 861:8 875:14 882:5 887:4 889:18 890:10 895:14 902:8 907:10 920:14 947:7 965:24 973:11 absorb 870:23 880:22,23 absorption 845:10 ACAC 841:10, 11,13,16 914:10, 11,13,16 academic 937:16 accept 850:8 915:22 acceptable 854:6 885:2 903:10 accepted 882:13 934:2 access 910:15,16 956:9,10 973:7 977:22 accidental 845:24 879:24 accrue 904:12 accumulated 942:9	accurately 866:25 acknowledged 893:13 895:19 ACP 907:9 act 976:9,16 acted 976:15 action 973:12 actions 943:25 activities 924:2 activity 865:19 870:15,18 874:25 875:8 897:12 actual 848:20 859:12,13 865:1 866:2,3,6 898:13 909:1,15 911:3,7 962:1 acuity 920:18,24 acute 922:7 963:14 added 889:20 addition 852:18 898:10 address 855:20 adjourn 980:21 ADJOURNED 913:3 981:10 ADJOURNME NT 853:18 854:22 889:9 936:3 971:7 980:12 Administration 881:17,19,22,26 882:7 admitted 920:20, 26 adult 897:10
1-minute 935:19 10 912:19 971:4,6 974:5 10,000 871:17 872:21 874:1 10-minute 887:17 968:19 971:5 100 926:20 938:25 939:2,18 100,000 927:12 11 887:15 11:00 889:6 12 911:21 12:45 911:22 912:5,10,12 913:3 12:46 914:23 15 912:19 957:18 958:4 16 886:19 887:1 18 874:8,9 18-and-a-half 874:9 19.4 884:26 19.5 872:2,5,9,11 874:10 880:24 881:3,4,8,13 883:21 884:14, 18,21,23 885:2,3, 14 886:8,16,17, 19 887:1,7 888:9, 10,21,26 897:3,8	3	8	absorb 870:23 880:22,23 absorption 845:10 ACAC 841:10, 11,13,16 914:10, 11,13,16 academic 937:16 accept 850:8 915:22 acceptable 854:6 885:2 903:10 accepted 882:13 934:2 access 910:15,16 956:9,10 973:7 977:22 accidental 845:24 879:24 accrue 904:12 accumulated 942:9	
	3 870:5 930:4,6, 10,12 971:4,5 980:7 30 917:23 955:6	9	8 897:18,21 941:9 841 839:5 842 839:6 847 839:8 849 839:10 85 882:17 854 839:11 856 839:12 8th 941:9 950:10	
		9 887:15 974:5 900 839:14 910 839:15 914 839:17 915 839:18 95 861:13 964 840:5 969 839:19 971 839:20 979 839:21 982 839:22 99 935:6,11,13 956:19 99.9 959:21		

adults 888:23	ahead 904:19 912:22 963:25	Aldcorn 841:10 876:9,18,22,24 877:1,8 914:10	apologize 855:25 877:5 965:2	asphyxiant 880:6
advance 895:4 896:4 901:2	AHS 895:25 970:4 973:22	Aldcorn's 876:21	apparatus 843:17 881:10 885:6,8	asphyxiation 879:18,21,22,25 880:1
advanced 849:5, 11	air 846:4,6 858:23,26 859:1, 4,6,7,9,19,22 864:9,10 865:6,7, 14 866:10,11,12 867:13 871:25 872:2 875:11 881:6,7,9 884:18 885:5,10,21 886:7,16,18 892:25 902:5,8 929:8 955:21,22, 24 958:24	alive 845:13,14	appeal 856:4	asphyxiation's 880:3
advantageous 924:9	air-breathing 885:6	allergens 960:2	appealed 855:13	assess 973:13 978:4
adverse 886:6,14	air-tight 858:18	allergic 960:17	appears 903:25 944:16	assessment 918:17,25 925:22 935:17 948:17 951:8 973:3
advice 896:15 918:19	airplane 934:26	allergies 891:12, 17	applicable 909:6	associate 917:3
advisement 854:18	airplanes 930:26	allowed 875:20, 21 884:17,18 977:4	application 850:26 852:6 959:20	Association 841:2,15 844:9, 20 914:2,15 974:1
advisor 843:23	airtight 858:15, 22 932:12	alternative 934:8	applications 923:24 931:10	Associations 848:3
aerosolization 930:14,19	airways 957:24	Amber 981:2	applied 923:17 930:3	assume 903:3 974:2 978:20
aerosolized 928:16 929:8	alarming 897:5	America 888:11	applies 972:13 975:13	assuming 911:25 974:22 975:3,9 977:9
aerosols 928:12, 23 932:5,6,8,10, 14	Alberta 841:1,3, 15 843:23 848:3, 5,8,13,20,23,24 849:1 856:15 863:15,19 869:26 871:5,6 880:26 881:6,23 882:12 893:11,12,18,25 894:6 895:9,11, 15,17 896:8 897:20 907:5,16, 17,24 908:2,3,11 914:1,3,15 916:14 937:20 938:23 940:2 941:4,8 943:23 944:6 950:8 971:25 973:26 975:2 982:8	amount 846:5	approval 922:17 923:1 977:9	asthma 891:4,10, 17 917:11 961:8, 16,17,18,21 972:19,22,23 973:4
affect 845:10 880:22 947:12		amounts 859:20 868:6	approvals 844:11	atmosphere 870:5 873:14 883:20 885:3 892:17
affected 876:5 878:4		analogy 922:12 934:23	approved 888:25 934:5 967:19	atmospheres 880:15 885:12
affects 961:5		analysis 891:1 949:24	April 883:5	atmospheric 843:13 846:15
afoul 898:21		anecdotal 957:20	area 847:4,12 887:20 899:21 915:14	attach 929:5,12
afternoon 839:17 914:5 971:16,17		announced 941:9 950:6,7,9, 25	areas 875:11	attached 865:3 906:1,24 907:3
age 935:9		answers 854:14 892:4	argue 935:14 942:25 956:7	attempt 847:7,15 861:2 923:19
agencies 905:19		anti-mask 953:11	argued 943:22	attempts 894:3
Agency 973:23		anti-masker 953:14	argument 962:15	
agree 901:20 902:1,23,25 903:11,13 907:22 937:13 943:3 946:17 949:6,24 952:16 957:22 971:25 972:4,7, 25 973:2 975:7, 21,26 976:25 977:21 978:5,24		anticipate 852:17 879:5 970:25	arguments 944:3	
agreed 915:7		anticipated 850:12 854:9	arrange 912:17	
agreeing 951:21 967:20 972:26		anxiety 977:7,10 978:2,22	arrangers 873:7	
		anymore 858:11	arterial 917:14	
		apologies 912:8	aspect 924:16	
			aspects 843:9 896:16	

attend 980:16
attendance
 911:17
attest 910:7
attribute 949:12
audience 927:7
authorities
 893:12 923:14
 924:3 943:23
average 874:3
aware 844:6,14
 847:20 855:5
 863:15,18,22,23,
 26 885:7 892:22
 893:10 897:17
 903:20 937:16
 963:21 967:13
 970:3,4,17,18
 974:7

B

B.E. 841:16
 914:16
back 841:25
 853:19 854:19,24
 855:18 859:24
 876:20,26 877:15
 889:4,10 893:15
 895:23 899:18
 912:17 922:14
 923:2,4,20 924:7,
 26 929:23 934:15
 936:5 948:20
 969:12 971:4
 976:17 980:9,13
background
 973:17
bacteria 926:18,
 26 927:17 959:25
bacterial-based
 921:7
bad 884:16
 955:24

bag 861:20 900:6
bandana 861:23
Bao 839:18
 915:5,13
barrier 868:7
 870:11 872:8,19
 885:18,21,22
 890:1 896:10
 900:5 908:18,19
 909:19 910:13,17
 911:10
barriers 866:21
 867:6 868:14,22
 870:9 878:8
 885:18 887:3
 889:17 892:9,16
 893:14 895:20
 897:9,14 902:26
 903:15 909:8
base 912:13
 926:4
based 867:6
 868:9 871:10,11
 874:6 919:24
 933:18,19 938:26
 943:7,25 946:6
 952:23 966:13,
 14,16
basic 843:14
 844:10,12,14
basically 845:4
 880:23 917:6
 918:3 920:23
 927:19 944:5
 959:24 978:6
basics 845:6
basis 852:4
 896:22 949:12
 961:19 970:20
bear 854:20
 937:5 980:7
begin 943:13
 959:10
begin 886:6,14
 968:21

beginning 963:2
behalf 895:22
behave 926:8
beings 886:5,13
 952:26
belabour 902:10,
 13
beneficial 931:12
 946:9 956:8
benefit 876:21
 909:18 950:23
benefits 904:12
 905:7 933:24
 954:1,7,10,14
 956:2 971:24
 972:3
best-case 861:13
big 846:7,15
 865:13 908:19
 919:18,21 920:15
 929:1 939:11
 951:12
biggest 920:23
biohazardous
 844:26
bit 850:20 860:16,
 17,20,23 867:12
 874:4 878:16
 889:22 935:21
 936:8 941:24
 942:1,5 944:15
 962:17 972:5,6
 977:19
block 867:7
blocking 867:4
 869:12 870:21
blood 867:26
 871:22,26
 891:12,17 917:14
 948:11
blow 917:9
blue 862:6 863:9,
 21 865:24
 931:17,19,21

932:1,4,14,24
board 958:1
boarding 931:1
bodies 864:11
 888:15 892:23
 967:19
body 844:15
 845:4 870:24
 879:22 882:9
 885:23 909:6
 910:14 918:6
 967:14 976:7
body's 879:25
booth 917:9
boots 844:12
bottom 848:2
 882:22 955:13
box 885:25 886:3
brackets 886:24
 926:25
break 853:13
 887:17 888:13
 889:4 900:22
 912:4,14,23
 935:21 936:8
 968:19 969:1,2,
 12 970:24 971:3,
 6 974:16
break-out
 853:15 854:21
 855:19 912:23
 968:26 969:6,9
breath 869:20
 961:1,2 962:6
 963:9 978:14
breathe 857:21,
 23 859:1 865:18
 867:3 868:5
 869:2,3 870:22
 884:18 886:5,13
 889:19 900:8,9
 955:16,17,20
 958:23 959:26
breathing 843:17
 857:19,21,24

859:8 864:4,5,17,
 18,19 866:7,10,
 15,18,20 867:5,7,
 8,11,15 868:3,7,
 15,21 869:7,13,
 19 870:9,11
 872:8,19 878:8
 881:7,10 885:8,
 18,21,22 886:7,
 16 887:3 889:17
 890:1,6 891:3
 892:8,15 893:14
 895:20 896:10
 897:9,14 900:5,
 12 902:23,26
 903:15 908:18
 909:7,17,19
 910:13,16 911:1,
 10 917:7,16
 955:23,24 956:6,
 10,12 957:6,24
 958:24 959:7
 960:5 962:8
 963:3
briefly 847:23
 851:5 922:2
 933:9
bring 842:1
 844:1 976:14
bringing 912:21
broad 850:20
 853:1,2,3 878:16
 947:13
broadly 854:16
Brooks 917:2
build 926:4
buildings 885:10
buildup 859:10
 862:19
built 859:14
bump-tested
 879:3
bunch 898:12
 978:15

bye-bye 981:8

C

cagey 976:18

Calgary 916:18

940:6 982:8

calibrated

872:25 879:3

California 937:2

call 859:5 865:25

867:5 868:7,21

872:19 893:19

917:15 918:1

930:4

called 851:1,7

928:12 933:8

calling 966:20

camera 842:8

Canada 845:18,

19 882:14 888:7,

12 905:19,20

929:18 964:7

972:1 973:24

Canadian 840:5

844:9,20 961:25

964:24

candidate 901:19

capable 857:26

caps 868:4

capture 859:18

869:7

captures 868:5

carbon 846:2

851:19 859:11,

15,20 860:20

864:10,20,23

865:5 868:6

869:8,9,13,23,25

870:1,9,25 871:1,

3,16,19 872:17

873:13,20,24

874:8,22 875:1,4,

12,20,23 876:5

877:19 878:4,24

879:9,11,16

880:6,10,12,14,

17,21 892:19

902:9 909:9

cardiac 891:12

care 849:5,11

856:26 861:8,10

862:3,21 863:3,

11 916:25 918:7,

24 919:16 921:12

923:6 925:14,21

931:4 935:7

938:11,13,15,16,

23 939:9 948:24

949:1,3 959:10

960:18

career 846:8

caregiver 972:10

case 860:5,9

915:25 918:5

919:6,9 942:21

943:10 953:16

954:9 972:11

977:13,15 979:6

cases 892:18

921:18 940:12,18

942:22,26 943:12

949:19,20,22,23

950:14,26 952:1,

6 956:17

cast 854:16

catch 869:19

category 863:8

caucus 912:2

971:11 979:8,14

980:7

caucuses 853:13

causal 949:2

951:25

causation 934:11

936:18 940:11

941:21 948:20

949:12 951:11,

20,23 952:2

caused 899:10

949:21 952:6

causing 924:16

CC'D 893:24

certainty 923:21

924:14 942:19

Certificate

839:22 982:1

certification

844:5,7,8,15

certifications

844:1

certified 871:15

890:2 909:16

certify 982:3

cetera 942:24

953:3 957:9

958:25 959:20

961:2 975:19

Chair 841:8,24

842:18 846:26

847:9,17 849:21,

24 852:9,10,12

853:12,19,24,25

854:17,24 855:18

856:6 876:9

877:14 887:12,

14,23 889:5,10

898:21,25 899:8,

18 900:16,19,24

904:18 910:3

911:15,21,26

912:7,13,21

914:8,24 915:6,

13,19,20 916:4,8,

11 935:20,24

936:1,4 964:20

968:16,20 969:5,

15,17 970:24

971:2,8 979:13,

20 980:6,11,13,

21,25 981:4,8

challenge 917:14

chance 903:2

960:7,8 966:3

974:2

change 865:21

959:11,12,15

960:9

changed 857:2,3

924:5 957:9

charge 888:3,5

893:24

charges 850:11

chart 918:17

charts 918:12

check 890:5

chemical 845:15

chemicals 845:2

Chief 894:7

971:26 973:19,22

child 897:10

children 888:23

chiropractic

920:1,17

chiropractor

919:26

chiropractor's

919:22

chiropractors

841:2,15 854:4,

14 863:16,19,20

897:21 903:11,

12,16,19,23

909:3 914:2,15

972:1 974:1

choice 953:23

956:9,11

choose 909:13

943:8

choosing 976:7

chose 938:20

Chris 839:6,12

842:16 847:12

851:18 856:8

Christmas 981:5

chronic 917:10

956:23 957:11

961:7,10

circumstance

884:19

circumstances

930:24 931:11

935:2 940:24

955:26 956:22

961:20 977:14

979:4

cited 926:3

cities 950:8

city 917:2 940:4

941:15 950:7

982:8

civil 938:1 947:12

953:8

civilization

952:25

claim 898:9

937:17

claimed 925:19

clarification

853:22

clarified 949:6

clarify 854:26

856:14 865:23

868:20 889:15

894:1 897:19

910:24 945:2

classically

972:11

classified 861:25

claustrophobia

977:7,11

clean 885:5

955:22 960:10

clear 851:23

879:8 902:24,25

904:2 905:6

906:23 908:6

909:2 912:7

943:1 951:9

client 890:16,17

951:15 963:20

964:13	collect 959:3,4	communications 924:18 925:7	977:4	900:12 901:10, 11,18,22 910:26 911:2,6 947:24 961:13 965:4 978:1
client's 851:23 891:21	college 841:2,15 848:3,5,9,13,21, 23 849:2,17 850:12,16 854:3, 11,12 863:15,19 897:20 907:5,7, 11,14,16,24 908:8,11 909:3 914:2,15 967:24, 25 972:1 974:1, 12 976:2,6,10 977:1	communist 968:13	component 846:16	conduct 969:13
clients 843:25 856:26	College's 903:2 908:15	community 916:21 922:25 931:5,14 939:3, 21,24 944:2 948:2 959:22 961:11	computer 870:12	conducted 933:6
clinic 917:1,22 919:19	comfortable 900:17	company 843:5 856:20	computers 927:23	conducting 878:15
clinical 916:17, 19 921:18 939:22 977:10	COMMENCED 841:23	compare 931:26 935:17 966:24	con 907:21 975:23	confident 878:7, 9,21 947:7
clinically 957:24	commencement 906:14	compared 925:24 926:18 931:24 937:2,7 940:4	concentration 871:24 881:8 885:14 886:26 887:4 892:24 893:6,7	confidentiality 978:7
clinician 949:7	comment 847:18 854:8 896:15 902:19 904:25 951:15 971:21 978:26	competence 978:4	concentrations 888:21	confidently 925:19
close 866:16	commenting 851:6 898:21	competent 872:23	concept 972:6,13	configuration 873:21
closed 859:17 861:10 868:4 870:21 880:19,20 908:26	comments 842:25 847:21 850:1,24 852:3,7, 11 853:7 854:7 855:10 906:15 915:9,11,18 916:8 942:14	Complaints 850:4,9 852:17 915:22,23	concern 850:21, 22 854:15 876:16 941:24 942:5	configurations 873:18
closed- 843:17	commercially 963:5	complete 890:17, 18 954:20 982:4	concerned 848:10 878:12,18 941:26	confined 850:13, 14 851:25 852:8 880:16,19 918:12
closed-cover 868:14	common 845:17 864:15 869:12 873:20 928:17 961:6	completed 848:8 857:18 858:1 890:12 907:24	concerns 952:24	confirm 860:12
closely 869:1	commonest 961:10	completely 877:1 890:19 898:1 930:17 943:4 948:17 951:24 957:17	conclude 934:13	confirmed 974:19
closer 930:25 937:19	commonly 846:12,18,22	completing 848:23	concluded 948:25 949:21	conflate 951:20
closing 850:2		compliance 850:6 915:26 974:25	concludes 911:16	conflating 951:11
cloth 846:17 852:22 853:5 862:10 868:26 872:15 931:16, 20,22,25 932:2 959:18 963:6		complicated 918:5	conclusion 925:15	conscience 952:13
cloud 929:10 932:11		comply 908:14, 17 909:5,13 974:23 975:4	conclusive 952:4	consent 842:20 915:7 953:24 954:6,9,12,17,18, 20 964:8 972:7,9, 15
clue 894:26			conclusively 937:18 947:15 952:5	conflating 951:11
CMOH 853:26 863:23 902:15 944:7 977:5 979:25			condense 958:26	conscience 952:13
CO2 877:3			condition 871:21 889:24 957:10 962:13,21 978:9, 11	consent 842:20 915:7 953:24 954:6,9,12,17,18, 20 964:8 972:7,9, 15
code 880:26			conditions 858:3 864:25 865:20 867:25 869:5,6, 11 876:5 878:3 889:19 890:22,24 891:4,5,9,12,21	consideration 899:25 900:1
coerced 980:1				considerations 886:19
coercion 954:5				considered 859:21 862:14,17 874:17 880:11 886:18 911:6 923:26 933:21
coin 975:1				
coined 866:24				

944:9	contest 891:21 896:22 900:2	copy 963:16 964:5,7	countries 944:23	22 938:3,8,14,20, 24 939:8,24
considers 883:20	contested 897:14	corner 882:19	country 929:20 937:11 968:13	942:12,22 946:25
consist 916:20	contesting 896:23	Coronavirus 922:9	couple 844:3 848:8 852:11	948:15,16,25
consistent 954:16 955:1 977:7	context 962:4 972:9 975:14	correct 849:9,13, 15 856:15,16	859:25 874:5,7	951:26 952:3
consists 960:26	contextualize 936:14	881:11 901:23	876:20 901:1	957:4 960:3,7 969:25
constant 899:1	continuation 841:24	903:1,25 904:5,6, 9,10,14 905:16,	902:19 903:26	COVID-19
constituted 967:25	continue 883:24 889:6,11 900:17, 21 936:5	22 906:18 917:17	910:5 915:8	847:8,16 851:14
constitutes 882:24	continued 950:15	918:26 919:20	979:14 981:1	863:17 904:5
consult 843:8,9, 13 918:4	continuous 922:21 960:13	921:10 922:5	courses 843:19 848:19 856:22	915:15 922:1,4 973:19
consultancy 916:18	contract 935:4	923:1 924:23,25	court 841:21 842:12 873:1	CPSA 970:8
consultant 843:3,6 895:8	contracted 937:22 938:3,14, 19 948:25	926:24 927:1	877:14,17 914:21	972:14 974:7,11, 17 975:15,22
consultation 918:9	contracting 938:8 960:7	933:7 934:21	915:2 978:19	976:14,19 979:25
consultations 918:9	contrary 895:25 898:14 973:22	936:12,17 938:18	980:26 982:15	CPSA's 969:25 974:23
consulted 895:4	control 850:17 933:5,17,20,25	941:1,18,22	courtesy 970:1	create 885:18,22
consulting 843:7 896:11	934:6,7,10,16,19	943:3 947:20	courtroom 910:10	created 900:4
consults 918:2	936:9,13,16,18, 20 949:8 953:8	948:14 949:14	cover 859:11,17 861:10 862:11	credit 947:17
contact 894:3 901:26 902:3	956:24	951:21 953:7,12	864:7 866:17	crisis 966:20,21
container 880:19,20	controversial 968:3	954:8 956:17	868:4 870:21	critical 916:25
containment 845:6	controversy 922:15	957:3 960:10	872:13 900:7	cross 970:25
contaminant 858:19 859:2	convincing 928:16	967:11 972:17, 24,26 975:12,16, 17,19,20,25	908:26 959:1	cross-
contaminants 845:10 959:6,23	cooperation 895:13,15	976:4 977:6	covered 865:2	examination
contamination 959:8	coordination 869:15	980:4	covering 857:24 962:19 963:6	900:21 968:21,24 969:13,19 971:9, 12
contemplated 922:26	COPD 867:24 917:11 961:8	corrected 855:10	covers 861:22,24 862:14 872:15	Cross-examines
CONTENTS 839:1		correlated 949:23	957:22	839:8,14,20
		correlation 934:12 936:21	COVID 846:19, 23 851:26 856:19	847:24 900:25 971:15
		937:10 940:10, 14,18,20 941:20	857:2,6,8,11	CSA 844:3,6,8, 11,15,18
		948:21 949:4,5, 11,26 951:11,20, 22	861:3 866:1,22	CSR(A) 841:21 914:21 982:14
		Costello 883:5	867:17 868:1	cubbyhole 854:19
		cough 928:25 929:25	893:20 896:2	curious 845:26 880:25
		coughing 960:3	898:18 899:6	current 843:1,2
		councils 940:4	905:14,15	Curtis 841:18 859:26 914:18
		counsel 841:9,16, 19 912:24 914:9, 16,19	925:21,23,25	
			926:7 930:5	
			931:4 932:25	
			933:6,12,14,17, 23 935:4,18	
			936:26 937:5,13,	

919:2 customer 890:16 cut 909:22 cv 848:2 cyclical 940:21 941:16 950:2 951:1	day-to-day 924:2 days 917:4 927:19,24 928:13 947:26 950:9,12, 16,24 956:26 dead 874:16 deadline 884:21 deadly 956:17 deal 896:17 899:19 952:26 953:1,5,6 963:23 969:3,10 973:16 dealing 851:14, 16 852:24 921:21 953:2 966:25,26 967:1 deals 851:10 dealt 846:1,4 852:15,25 966:21 deaths 952:1 debatable 940:17 942:13,15,19 943:6,15,21 945:13 946:23 947:3 957:25 967:8 debate 943:15, 18,19,20,24,26 944:3 946:22 947:11,14 966:14 debated 933:2 decades 908:25 925:11 December 941:9 949:16,19 950:8, 10 982:9 decide 964:3 decimal 926:21 decision 855:12, 16,20 954:2,4,11 decisions 855:15, 23 944:6,14 952:23 966:12 967:4 968:9	decreased 936:26 937:4,12 941:12 956:9 Deena 967:26 deficiencies 902:8 deficiency 871:26 900:4 deficient 883:22 886:18 892:17 definite 943:4 definition 866:4 954:19 degree 920:24 928:18 939:3 957:23 978:17 delivered 885:5 demand 870:17 demands 870:20 demonstrate 934:19 demonstrated 900:2 denied 894:5 Denmark 933:6 Dentistry 843:24 depend 877:3 911:5 dependent 930:1 depending 862:9 865:18 875:7,8 889:22 893:7 957:8 961:20 963:4 972:21 973:7 depends 846:13 863:13 874:24 875:1 889:23 911:5 929:24 930:2 935:1 947:23 976:8 977:22 describe 866:21 958:21 961:4	describes 866:25 880:26 description 839:3 840:3 945:26 967:23 design 865:3 designation 849:4,6,12 designations 849:10 designed 862:22, 23,24,25,26 867:15 873:12,19 909:16 920:11 955:15,17 desk 870:12 detail 850:7 964:1 detailed 893:16 detection 873:8 determination 896:6 963:22 determine 857:16 858:5,8 868:2 891:1 901:21 determined 902:7 908:11 determines 858:17 detriment 845:17 development 902:15,18 device 861:14,18 862:16 864:8 865:21,23,25 873:3,6,9,12 874:15 878:23 879:8,10 devices 857:12 866:15 870:14 871:16 873:4,17 888:15 897:5	902:22,23 diagnose 918:21 diagnosis 973:3 977:10 died 948:25 difference 879:5 905:23 908:20 919:18,21 920:24 926:12 928:22 931:16 932:8 935:13 938:7 958:10 differences 920:15 differentiates 884:12 differently 868:10 958:17 difficult 865:26 866:2 867:3 869:2,19 889:19 894:10 934:3 difficulty 857:19 867:12 digest 964:15 diligently 937:23 dioxide 846:2 851:19 859:11, 15,18,20 860:20 864:10,20,23 865:5 868:6 869:8,9,13,23,25 870:1,10,25 871:2,3,16,19 872:17 873:13, 20,24 874:8,22 875:4,12,20,23 876:6 877:19 878:4,25 879:9, 11,16 880:6,10, 12,14,17,21 892:19 902:9 909:10 dioxide's 875:1
D				
damage 956:22 960:15 Dang 839:18 914:26 915:5,8, 14 916:13 919:2, 15 936:7 942:8 951:18 955:8 965:1 966:1 967:13 968:22,26 969:5,8 970:3,13, 18 971:9,11,16 979:11,22 980:6, 14 danger 892:6 dangerous 872:3,4 874:11, 14 881:3 883:22 884:2,6,10 885:17 888:10 956:16 dangers 863:1 DANMASK-19 933:8 data 878:24 906:16 933:20 941:11 date 893:23 929:22 940:5 Dated 982:8 dates 980:22 Dawson 841:12 914:12 day 842:20 978:16 982:9				

direct 889:11 902:2 918:24 974:22	946:15 957:11 961:4,5,7,11,21 965:19 978:5	dogs 922:13	ed 907:21 975:23	emphasize 915:21
directed 937:23	diseases 963:7	domino 925:3 944:19 945:3	Edmonton 841:2 914:2 940:6	emphysema 961:8
directive 850:16 854:3 863:18 903:3,21 909:3,5 972:2 974:2	dispel 870:24	dot 927:12	education 975:19	employed 908:4
directly 921:24 938:12,14	disperse 870:24	doubt 946:16	educational 857:1	employees 883:15 890:9 895:12
director 841:13 850:9 852:17 888:2 914:13 917:19	displace 880:11, 12	dramatic 883:25 884:15	effect 855:21 879:6 925:3 944:19,25 945:3, 5,6	employment 858:10
Director's 850:4 915:22,24	displacement 880:18	dramatically 852:26 870:16,17	effective 925:16, 20 931:3,25 932:25 942:12 946:3 950:11	EMR 849:8,9,13, 16
Directorate 888:2	displaces 880:7	drawbacks 956:2	effectiveness 851:20 933:5 943:16 945:8,17	EMS 907:6,9,13
disagree 878:17 897:25 898:1 925:22 945:11, 21,22 946:6 951:8 965:5 968:10 976:20	display 879:14, 15,16	drop 870:16 872:8,11 874:16 887:7 897:11	effects 869:10 875:22,25 877:18,22 884:15 886:6,15 897:3	EMT 849:5
disagrees 951:16	disposable 863:4 932:1 959:16	droplets 928:11, 14,23,24,26 929:14,26 930:5, 11 931:22 932:7	efficacy 850:5 853:8 855:1 904:21 915:15,26 931:16 946:15 947:7	encapsulated 866:9
discipline 897:16	disposed 861:15 862:19,23	dropping 897:8	encapsulation 845:7	enclosed 862:6
disciplines 856:23	disputed 933:3 940:15	drops 886:8,16 888:26 957:18	enccompasses 888:6	encountered 875:24 877:21
discovered 887:1	dissect 964:3	due 880:3 940:16, 23 951:1 952:19 958:20,22	end 842:20 855:13,14 856:1 882:19 892:9 941:26 951:21 959:6 970:16 972:18 978:16 980:23	endeavoured 968:12
discuss 894:8 895:22 912:2 955:15	distance 929:19 930:21	duly 856:6	effort 857:24 867:14 869:4,7 937:26 963:3,8	ended 908:5
discussed 853:20 854:25 855:7 882:25 915:20 925:9 954:7 955:10	distancing 930:18 975:11	duration 862:22	effortlessly 857:23	ends 935:16
discussing 877:2	distributed 964:17	duress 954:5	electron 927:10, 14,21	enforce 930:22 931:13 940:2
discussion 839:10,19 849:25 894:24 895:24 896:3,6 910:12 969:16 977:8	dizziness 869:14 893:1	dust 960:1	element 944:15	enforcement 888:3,5
disease 891:17 917:11 918:6,22	DNA 927:15 928:3	duty 860:12 919:11	else's 944:21	engaged 865:19 886:20 897:12
	doctor 858:5 901:21 918:4		EM 849:6	engineered 864:3,5,14,16 865:9,10 866:6, 15 868:3,15
	doctors 851:13 893:24 896:14 918:13 920:7		emergency 843:16 848:9 849:8 890:1 900:13 918:8	
	document 840:6 890:15 963:26 964:25 969:20, 21,22,25 970:5, 11,21 974:4,17	earlier 867:16 884:5 896:24	emotional 966:17	
	documentation 886:9 906:20	early 928:13 940:7 948:25	emotions 953:1 966:25	
	documented 896:26	easily 865:15 866:10,12 950:19		
		easy 864:18 866:7 868:15 909:16 964:6		
		ebb 940:22		
		E		

908:21,22,23 911:1,3 enjoy 981:6 ensure 872:25 876:3 878:1 883:15 enter 865:7,15 entered 963:17 964:9,12 entire 921:3 927:19,22 944:5 entitle 899:16 entitled 951:6 entitles 899:14 entry 907:8 environment 844:10 885:16, 19,23 environments 844:26 equal 900:3 equation 871:20 equipment 844:6,8,12,16,19 845:1 872:24 876:2 877:26 879:2 885:13 equipped 879:10 881:9 885:4 equivalent 908:15 err 944:17 erring 972:3 errors 893:21 essential 846:6 essentially 969:26 970:13 establish 892:15 established 905:1,4 908:24 970:14 estimate 917:23	estimating 939:12 evacuated 884:26 885:1 evaluate 876:4 878:2 event 845:23 970:1 eventually 949:20,22 everybody's 878:6 everyone's 958:2 evidence 850:8, 10 852:17 904:11,26 905:6, 14 915:22 916:1 923:24 925:14 926:5 928:16 933:18 936:9,10, 15 939:6 942:9, 16 943:1,4,7 944:9 945:7,13, 17 947:14 952:4, 14 954:1 957:21 962:18,22,26 965:3,6,10 967:24 exact 926:16 928:17 956:20 exaggerating 945:23 exaggeration 945:20 exam 889:11 examine 918:15 examined 839:6, 12,18 842:16 856:8 868:1 915:5 examining 918:18 examples 891:9 exams 848:23	exasperate 962:13 exceed 871:16 884:17 909:18 exceeds 909:14 excellent 842:7,9 856:13 exceptions 884:20 930:25 Excerpt 840:5 964:24 excess 869:13 872:20 875:16 exchange 901:11 exclusively 880:3 Excuse 876:10 exemption 961:19 972:19 973:4,13 977:4,5, 11,17,18,25 979:5 exemptions 965:22 973:10 exercise 877:5 exercising 958:10 exerting 958:9 exertion 874:26 886:20 887:6,11 exhalation 859:9,14,16 864:21 865:4,8, 10 867:11 908:24 911:4,11 exhale 859:15 864:11 866:19 exhaled 859:11 864:20,22 865:4 exhibit 840:5 906:7 963:17 964:9,13,24 EXHIBITS 840:1	existing 963:13 expansive 965:15 expect 900:17 965:16 977:9 expectation 851:24 expelled 864:10 experience 857:23 863:7 875:10 889:16 893:11 895:18 921:21 931:15 938:9 973:18 experienced 937:12 972:11 experiences 938:26 experiencing 869:14 948:1 experiment 932:21 expert 847:4,12 851:2 860:6,13 884:1 895:7 897:20 899:2,20 906:1,17 915:14, 24 916:2 919:12 973:22 experts 851:12 896:13 899:12 explain 859:13 861:6 864:5 865:26 866:22 879:20 880:9 928:22 977:19 explained 884:4 explanation 966:9 explicitly 967:20 exponentially 868:5 exposed 871:2,5 875:15 880:22 881:6,7 884:7,23	885:13,20 892:25 893:5 897:3 922:9 956:3,18, 21 959:5 960:3 exposure 845:9, 24 865:19 870:1 871:10 903:4 exposures 874:18,19 882:10 921:18 express 941:24 expressing 963:20 expressly 974:13 extended 959:14 extending 966:23 extends 899:21 extensive 907:2 extent 925:8 939:5 943:18 944:18 947:13,26 962:9 963:19 extreme 935:15 extremely 928:4 961:1 978:14 eyes 953:7
F				
F-A-I-R-F-A-X 888:2 face 858:15,18 859:17 862:14 870:21 959:1 963:11 faced 866:8 faces 887:3 facility 939:11 facing 897:15 fact 877:2 896:24 899:1 901:7 902:21 907:23 933:1,3 950:23 959:9 964:23				

970:14
factors 875:6
 935:9 939:4
 949:9
facts 892:14
 952:26
Faculties 843:24
fail 886:21
faint 869:17
fair 898:23
 902:14,17 905:17
 918:25 935:17
 953:13 967:23
 973:21 974:4
 975:8
faired 940:5
Fairfax 888:1
fairly 881:13
 908:13 974:22
false 937:14
familiar 846:9
 882:2 917:15
family 918:3
 922:5
fast 896:11
fatal 880:1
fault 912:22
fear 924:17,26
 925:2 944:16
 953:2,6 966:26
features 954:3,11
 967:2
fee 907:22,26
 972:15
feel 869:19
 892:26 893:2
 944:20 963:15
feeling 869:17
 945:3 963:8
feels 855:6
fees 975:24
field 908:16

fields 845:19
fight 976:12
fighters 885:9
figure 880:24
 964:22
figured 929:18
fill 927:18 977:23,
 25 978:5
filled 927:21
filling 905:3
filter 858:20,26
 861:11 865:11
 867:13
filtered 858:19
filtering 867:18
 868:17
filters 865:3
 867:10
filtration 861:12
financial 860:8
 919:8
find 868:8,11,16
 875:19 888:13
 896:7,20 912:25
 925:18 936:18
 944:1 958:14
 965:13 966:18
 968:5,8,11
findings 933:9,13
fine 887:19 892:4
 900:19,23
 935:24,26 969:14
finish 909:22
finished 902:11
 910:12 971:12
fire 885:9
firm 923:23
 940:20 947:14
fit 843:11,12,20,
 22 844:4 850:8
 856:23,24 857:6,
 9,10,13 858:17
 867:19,20
 868:11,17 875:8

890:8,10,11,25
 911:7 915:23
fitness 891:2
fitted 861:15
fitting 862:4,5,8
 863:2,4,5 872:15
 875:5,18
flare-up 962:20
fled 968:13
flip-side 975:1
float 929:10
floating 929:10
floor 842:2
 914:24
Florida 937:3,6
flow 858:20
 865:14 866:10
 867:7 869:12
 887:16
flows 866:11,12
fluctuate 874:23
 875:7
focus 854:9
 915:25
follow 858:23
 907:21 908:7,9
 945:4 963:13
 974:14 976:1
follow-up
 912:15,25
force 859:19
foregoing 982:3
forget 971:10
forgive 848:12
 910:22 921:25
 935:12 946:12
 956:15
form 882:3
 886:20 887:6
 891:15 933:22
 977:25 978:6,7
formally 942:4
forming 899:25

forms 928:4,5
formula 845:15
formulating
 918:19
forward 907:26
 915:10
found 863:17
 965:10 966:6
fourth 868:20
 941:4,12
Frankly 963:25
free 864:18
 911:18 953:17,22
 980:17
freely 865:15
 955:21
frequently
 959:11
fresh 901:4
friend 847:20
 849:26 851:6
 860:24 903:7
 904:21 905:25
 910:12 966:3
 967:22 969:20
 970:9 971:20
 973:8
friend's 853:6
 942:14 970:6
front 850:11
 929:1 962:2
 965:2
full 845:6,7 866:8
 882:2 903:19
 918:16 921:16
 974:25
fully 908:3
function 886:22
 901:9 916:23
 917:3,6 957:14,
 17,26 978:23
functioning
 957:18

functions 961:14
fundamentally
 925:23 926:7
funny 882:1

G

gas 845:16,17,19,
 21 873:8 880:11
 956:4,5,10,15,18,
 21,25
gases 845:2
 873:19 917:14
 932:19
gather 941:23
gave 926:19
general 856:3
 858:9,10 863:24
 918:1 923:24
 931:5,14 935:5,
 10 937:25
 939:21,24
 950:10,25 953:19
 968:7 973:15
 977:21
generally 856:17
 893:12 920:5,23
 926:17 928:7
 933:21 934:2,3,
 13,16 936:17
 938:4 943:8,9,14
 953:25 959:11
 961:4 973:14
 976:8 977:15
 978:3 979:3,5
generic 904:1
give 853:14
 860:6,16 874:2
 877:12 880:13
 881:11 891:9,11
 896:15 915:11
 917:25 918:11
 950:12 953:10
 954:10 955:4
 962:10 965:26
 966:2 969:21,23

giving 976:12		harms 851:21,25	886:6,14 888:11	979:14 980:8,14,22
glad 974:20		853:7,9 860:23	890:3,25 892:7,	hearings 841:13
glass 917:8	H	893:13 894:8	21,23 893:11,12,	914:13 969:18
glasses 844:13	H-8 840:5 964:24	895:20 897:23	25 894:6,7 895:2,	heart 867:25
global 925:2	H1n1 921:5,9	899:9 904:8	7,8,9,11,14,16,18	891:17 918:5
globe 966:23	926:15	955:10 960:12	899:24,26 900:10	heat 865:4
goalie 866:5,8,13	H2s 845:13,14,15	Hat 916:17,19,24	905:19 908:4	heck 966:10
gold 936:17	Halloween 866:5	917:2 919:19	909:8,10,11	helpful 863:6
golf 976:10	Halloween-style	920:3 937:20	910:20 919:16	951:22
good 842:4,6,15	864:15	939:10,14,23,25,	922:18 923:5,14	hesitated 882:8
847:25,26 864:23	hand 886:12	26 950:6 975:4	924:3 925:14,21	high 867:25
869:5 878:6	handle 877:10	hats 844:13	931:4 935:7,9	870:2,3,4,6,9
885:20 886:26	891:3	hazard 843:13	938:11,13,16,23	876:6 878:4
901:18 934:20	hands-on 917:18	876:2 877:25	939:9 942:11	891:12,17 893:6
955:21 969:1	happen 938:13	893:5,7	943:23 944:6	927:8 935:1
971:16,17	953:26	hazardous	948:24 949:1,3	high-risk 844:25
980:17,19	happened 858:12	868:22,24 870:13	952:7,8,23	higher 871:8
gotcha 906:12	895:5 939:9	875:15 880:15	956:23 958:11,12	872:21 874:26
govern 892:23	948:26 949:3	881:2 885:22	959:10 960:18	875:21 922:23
governing 882:9	967:24	hazards 844:24	967:14 971:26	937:15 941:13
892:23	happening	846:15 860:23	972:1 973:19,23	highest 845:18
government	932:17 944:19	876:4 878:2	975:2	871:4 933:22,26
888:15 895:12	959:17 966:15	hazmat 844:21,	health-assessed	942:23 943:12
905:18 950:6	happy 871:14	22,24 845:5	890:6	950:14
953:3 967:18	895:23 964:1	head 854:12	health-tested	highly 925:20
Government's	969:26	861:20 891:7	901:15	942:13,14 945:13
904:4	hard 844:12	963:25 964:16	healthy 857:22	Hinshaw 893:15
governments	866:3 874:26	979:10	858:7 957:15,18	901:26 902:3,4
966:16	944:22	headache 869:14	958:3	967:26
grade 932:1	harder 857:21	893:1	heaps 945:16,25	Hinshaw's
grain 944:22	858:26 865:17	heading 912:12	946:1,2	893:23 894:3
granted 894:4	868:5 869:3	heads 900:6	hear 842:5	hired 860:6
great 924:1	harm 852:8	health 843:2,5,9	852:16 856:11	historical 921:20
963:23 973:16	855:1 892:12,26	845:11 846:9,16	882:6 916:9	history 918:16
974:15	893:7 898:22	847:5,13 856:26	968:23	966:24 968:13
greater 850:7	903:24 954:21,	859:22 860:22	heard 873:25	hits 929:4 958:25
guess 880:4 904:1	23,26 955:2	861:8,10 862:3,	874:20 916:8	hold 869:1 873:1
934:17 935:1	962:25 965:7	21 863:3,11	966:9	904:15 910:22
972:21	harm's 884:9	869:10,22 872:4,	hearing 841:7,25	960:6
guidelines 840:6	harmful 851:17	5 874:11,12,14	850:5 853:13,20	holding 879:5,6
940:8 962:1	874:18 875:14	876:1,4 877:24	854:24,25 855:22	hole 865:13,14
964:25	900:10 910:25	878:3 880:26	869:15 898:16	holidays 981:6
gun 912:1	961:26	881:4,17,19,21,	899:2 901:3	
	harmless 955:14	23,25 882:7	911:19 912:15	
		883:23 884:1,2,6,	914:7 969:10	
		9,10,19 885:17	971:11 973:26	

home 885:19 937:19 963:6	hundred 926:25	888:10 893:10 963:12	inclusion 852:22	influencing 944:14 967:4 968:8
honest 891:23 978:18	hundreds 938:22 939:13,14	impact 870:22 892:21 924:4 940:24 941:19 942:20,25 944:5, 26 945:1 952:19 957:19	inconsistent 905:18	informed 944:8 953:24 954:2,6,9, 12,17,20 972:7,9
honestly 937:10 979:4	hydrogen 845:16,19,24	impacted 957:12 961:3,12,24	increase 857:21 867:11,14 869:7 870:17 960:7,8	infringement 924:1
honesty 894:25	hyperbole 976:13	impacts 884:10	increased 857:24 869:7 937:6	inhalation 845:9 859:8 865:7,11 867:14 892:17 908:23 911:3,11
honourable 947:10	hypotheses 951:23	impaired 869:15, 16 961:15	increases 869:4	inhale 858:23 859:19 866:18
hoping 971:1	Hypoxemia 871:21	impartiality 919:2	increasingly 867:3	inhalers 917:13
hospital 916:24, 25 917:21,23,26 919:19,21,25 920:3,7,16,20,25, 26 922:20 931:11 960:19 975:4	hypoxia 871:22	impacting 965:4	incredibly 868:13	inhales 869:21,22
hospitalist 918:4	I	impacts 884:10	independent 940:7 941:18	inhaling 869:13 871:23
hospitalized 920:6	ICUS 952:1	impaired 869:15, 16 961:15	indirectly 967:17	initial 949:22 975:18
hospitals 920:11	idea 874:2 891:10,11 894:21 917:25 918:11 927:25 932:24 934:20 955:5 969:1	impartiality 919:2	INDISCERNIB LE 873:17 888:25 904:18 906:6 909:21 939:16	initially 852:5
hour 860:10 862:24 959:15	ideally 955:21	implement 923:20	individual 877:5 888:8 958:3 977:14	injury 880:1
hours 892:9 929:9 968:18	identify 858:3 890:23	implemented 896:4,21	individuals 875:24 877:21 901:14 963:11	inquiry 957:15
Hu 897:18,19 898:15,17 899:2, 15,19 925:18 934:21 937:11 938:22 939:18 945:7,16 946:3, 12 947:6,9 948:23 949:6,15 951:5 961:25 962:10 965:1,2,8 966:4,5,7 967:11	identifying 901:17	implies 928:24	indoor 869:22 870:1	inside 862:19 870:8 873:26 874:3,22 875:13 886:3
Hu's 898:1,4,9 938:26 947:17 949:24 951:6 963:21	IDL 892:17	important 852:4, 7 864:8,18 866:11 890:4,5,7 901:14,20 909:11 910:20 948:22 951:19 954:3,11	indoors 869:22 870:1	installed 873:22
huge 846:15	IDLH 874:13 892:17,18,20	impose 923:20 976:23	industrial 844:10 880:14,20	instance 857:19 864:14 880:13 895:6
human 886:5,13 930:11 952:26 966:15	ignorance 921:25	imposed 934:18 937:12 940:7 949:16 954:19 967:14 976:22	industry 857:1	instantaneous 924:19
humans 955:15, 17	ill 920:12	imposing 970:17	inert 880:11	instituted 941:9 950:13
	illness 920:9 922:8	impossible 930:16 931:13	infect 929:5	institutions 857:1
	illnesses 891:13 920:13	inadvertently 930:24	infection 925:13 928:15 933:14 960:9	instruction 917:9
	imagine 927:6	inappropriately 853:2	infections 921:5, 6 925:24 926:1, 14	instructor 844:4, 21 845:13
	immediately 862:20,23 867:2 871:20 872:4,10 874:11,13 881:3 883:22 884:2,6, 25 885:1,16	incidents 939:5	infectious 920:9, 13	instrumentation 872:7
		included 891:16	infinity 935:14	
		including 843:15 847:6,14 898:16		

insufficient859:9 879:23
880:5**intended** 943:5**intensity** 929:25**intensive** 918:7**intent** 972:4**intention** 908:2
947:9**intentional**

879:24

intentionally

876:25

interact 920:8**interaction**

929:4

interactions

938:23 966:15

interest 860:4,8

919:5,8

interesting 896:7

966:6

interfere 957:5**internal** 841:9

914:9 916:25

918:1,4

international

936:24

internet 925:6**interpretation**

882:24

interpreting

916:22

interrupt 855:22

876:8 887:16

intervention

934:17

interventions

918:21 920:21

invasive 920:22**invisible** 932:16**invite** 854:8

855:9

involved 860:23

902:15,17 904:4

irrelevantly

853:2

isolated 922:22

948:4

isolating 930:17**issue** 853:6859:25 898:17,
18,19 899:2,4,6,
15 933:23 948:20
966:7,11 970:7,
12 974:19 976:15**issues** 846:1,4

854:25 855:6

860:25 912:15

Italian 949:1,3**Italy** 948:24

J

J.S.M. 841:19

914:19

James 888:18

904:19

January 980:23

981:6

Japan 953:21**jeopardize** 909:8**Jia** 897:19**job** 910:20**journals** 898:6,7**judgments**

966:14

jump 856:13**jumped** 911:26**jumping** 934:25

935:17

June 893:15**jurisdiction**

940:2 944:20

jurisdictions

881:14 882:14

937:1,2,6,7

942:22 943:12

945:4 953:20

justify 947:16**justly** 976:11

K

Karoline 842:12

877:12 915:2

982:3,14

kids 960:16**kind** 862:2,7

866:6 882:7

897:12 904:2

906:9 909:5

927:18 929:1,15

938:1 944:18

951:16 957:2,14,
20 970:8**kinds** 852:21

880:2

Kitchen 839:6,

13,15,18,21

841:19 842:2,4,7,

16,18,26 846:26

847:11 849:23

850:25 852:2,10,

13 853:14,17,21

855:9,24 856:6,7,

9,10 876:11,12,

15 877:6,9 878:5,

19,21 887:12,13,

19,24 889:3,6,8,

11,13,14 891:20,

24 892:1,2

894:17,20,25

896:1 898:23,26

899:14,22,26

900:14 901:5,25

902:20 904:3,15,

17,20 905:1,9,11,

25 906:4,7 910:3,

5,6,7,21,22

911:13 912:8,9,

17,18,26 913:1

914:19,24,26

915:5,6,20,21

916:2,3,5,6,10,12

935:20 936:2,4,6,

7 942:6,8 951:18

955:4,8 963:15,

19 964:3,4,11,19,

21 965:1,25

966:1 967:6,13

968:15,21

969:17,23 970:1,

12,17,21,23

971:20,22 972:5

973:16 974:17

977:5 979:16,18,

21,22 980:5,26

981:7

Kitchen's 912:5

972:18

knowledge

860:13 896:18

902:2 919:12,24

921:23 926:4

L

lab 916:23 917:3,

5 932:18 957:14

label 953:13**lack** 869:15

898:22 925:4

large 920:4

927:26 928:10,

23,24 929:14

930:5,11,20

931:22 946:4

948:11,24

largely 850:14**larger** 926:14**largest** 966:21**lashes** 912:3**lashing** 912:3**lastly** 860:21**Latin** 954:23**law** 873:2 937:26

974:11,12,14

975:6,9 976:26

978:19

Lawrence 854:8,

11 876:8,14,17,

19 963:23 979:7

laws 938:3**layman's** 929:2**lead** 936:19

962:19

leading 942:1,7**leaks** 859:1**leaky** 875:11**leaning** 943:19**learned** 904:21

910:12 942:14

966:2 967:22

leave 865:8

877:13 911:18

962:4 980:17

981:2

leaving 864:10**led** 924:16,19

925:2

Lees 841:8

900:23 911:20

914:8 935:22

left-hand 882:19**legal** 841:9,16,19

912:24 914:9,16,

19

legally 871:5

874:10 974:24

979:24

legislate 892:24**legislation**

846:10

legislatively

875:20,21

length 865:18

930:13

letter 882:15,17,

20,24 883:1,4,11

885:24 887:26
888:1 893:16
letters 964:22
level 843:14
871:4 872:2
874:25 875:8
877:5 883:21
884:7,8 886:7,15
888:16 889:24
892:18
levels 845:18
851:19 870:9,13,
16 871:16,19
872:12,17,20
873:13 874:8,15,
17 875:16,19,20
876:6 877:3
878:4 879:9,26
884:23 887:2
889:23 892:20
896:19 897:7
Library 898:8
licence 907:22
910:18,19 975:23
life 872:4 874:11,
14 881:3 883:23
884:2,6 885:17
888:10 889:21,25
892:7 900:13
928:5 956:13
life-threatening
871:21 889:26
light 958:9
likelihood
934:25 935:3
limit 871:1
873:24 900:12
limited 853:3,7,
23 896:18 923:16
947:25 948:3
965:8
limits 900:8,9
976:4,9,13,16,21
lined 930:26

lines 852:1
link 949:2 951:25
list 844:1 871:14
890:21 891:8
906:8 978:11
listening 885:7
lists 977:26
Lite 873:10
906:14
literally 861:24
literature 926:3
933:19 937:16
960:11 962:3
965:16 966:13
live 856:14
living 929:11,12
lockdown
949:15,20,21,23
950:3,9,25
951:26 952:2
lockdowns 952:6
logical 931:2
long 843:26 849:1
853:16 871:2,14
895:4 896:4
900:18 946:24
956:12 959:2
966:22 969:2
970:25 976:3,9
longer 856:21
864:24 959:13
971:3
looked 898:3
903:5 944:10
948:9
loose-fitting
875:10,17
looser 862:4,5,8
863:2,5 875:4,17,
18
lose 876:10
lot 845:2 856:21
857:3 858:23
887:11 893:21,25

906:25 922:11
927:22 952:20
953:21 965:17
966:17 967:24
lots 870:15
906:20 920:21
936:12
low 870:13
871:21,22 874:8
876:5 878:4
892:20 893:4,6
909:9 938:25
lower 871:9
872:6 875:19
884:11,12,13
885:4 952:6
956:12
lowered 871:8
lowest 874:9
lunch 912:4
lung 867:25
891:13 917:10,11
918:5 957:11,18,
26 958:11 961:4,
5,6,11,14,21
962:13,20 963:7
965:4,19 978:4
lungs 858:21
865:16 958:16

M

M-HM 846:11
868:23 880:8
Madam 915:1
made 850:2,24
851:3,22 852:3
855:20 902:19
922:5 924:3
937:25 941:19
963:6 965:18
966:13,16 971:21
magic 968:23
magnification
927:11

magnitude
966:22
main 916:17
maintain 953:7
975:22
maintains 850:9
maintenance
873:9
major 921:23
940:2 950:7
majority 857:12
952:17
make 842:25
850:1 855:21
857:20 858:14
889:19 901:18
904:22,24 915:18
924:6 925:24
931:13 938:20
940:9 942:15
951:5 954:2,4
963:22 973:3
makes 865:17
868:5 978:15
making 856:3
858:18 879:2,3
944:4,7 952:22
managing
916:22 918:6
mandate 863:17,
24 895:25 896:5
921:3 923:8
937:7,8,12
939:26 940:3
967:26 968:2
970:5
mandated 857:6
861:2 863:16
866:1,22 888:14
893:17 896:10
897:6,9 902:22,
23,26 908:20
909:25 930:22
957:4

mandates 863:24
868:14 895:1,4,
23 899:25 900:1
905:20 937:23
940:7,16,19
mandating 923:4
mandatory
902:24 903:12,
15,19,23,24
905:17 907:13,
15,20 908:16
922:19,24 923:20
924:6,11 934:18
937:1,3 939:23
940:11,13 941:6,
14 950:7 951:26
953:14 954:16
955:1 967:4,15
971:23 974:18
975:2 976:19
manner 850:8
860:14 915:23
919:13 926:9
972:17
manufacturer
861:16
map 860:16
mark 855:11
903:19
Marked 840:7
964:26
Martens 841:11
914:11
mask 857:9,17,
20,26 858:4,6,14
861:8,21,25,26
862:7,14,15
863:2,7 864:13,
15 866:4,5,6,8,
11,13,14 867:18,
19 868:17
872:16,19 874:3,
22 877:4 885:15
893:20 895:1
899:25 900:1
901:19 905:8

908:17,21,22,23
 909:1,5 911:1,3,7
 925:11 931:9,25
 932:1,2,11,22
 933:24 937:23
 938:5,10 940:2,7,
 19 947:24 950:7
 953:17 955:14
 956:5 957:8,11,
 16 959:2,9,19
 960:6,13,19,20
 961:3,13,19,22
 962:8,12 963:3,5,
 9,11 965:18,23
 966:10 967:26
 968:2 973:10
 975:10 977:24
 978:15,22 979:24

mask/facial

962:19

masked 903:11

904:13

masking 850:5

858:9 863:24
 897:24 898:17,22
 899:3,5,10 901:8,
 15 903:22 904:8,
 12 905:18 908:16
 915:15,26
 922:20,21,24
 923:4,15,20
 924:6,11 925:13
 934:18 937:1,3,
 12 939:4,23
 940:12,13,24
 941:6,12,14,17
 946:15 947:15
 949:2,18 950:10
 951:26 952:2
 953:15 954:16
 955:1,10 965:4
 966:7,12 967:4,
 15 968:6 970:3,7
 972:20 973:24
 974:7,18,23
 975:2 976:19
 977:12,17,18

masks 846:18,22

847:6,7,14,15
 850:15,17,21
 851:16,20,21,25
 852:8,14,18,21,
 23 853:4,5,8,9,
 10,23 854:5
 855:2,3,4 857:5
 860:18,26 861:1,
 4,5,7 862:12
 863:2,9,10,18,19,
 21,25 864:3,6
 865:24 866:1,2,
 21 873:26 878:8
 887:9 896:19
 902:5,9 903:9
 904:21 909:7
 910:25 921:4
 922:15 923:8
 925:15,19,25
 926:6 931:3,7,16,
 17,20,21,22
 932:4,12,15,20,
 24 933:5,12
 945:8,17 946:3,8,
 11 947:8,18,21
 948:5,6,7,13,16
 949:1 953:21
 954:13 957:4,5
 958:15,17,18
 959:2,11,16,18
 960:10,23 961:26
 962:5 968:9
 970:1 971:23
 974:6

mass 924:16**material** 866:16

960:23

materials 844:24**mathematically**
935:15**matter** 860:11

867:18 877:13
 960:1 969:3,10

matters 854:10**maximum**

869:26

Maxston 839:8,

14,20 841:16
 842:24 847:17,
 19,24,25 849:20,
 26 853:21,24
 854:2,18 855:6
 876:22,25 878:12
 891:20,25 894:10
 898:20 899:7
 900:16,20,25,26
 904:24 905:5,10,
 13 906:5,6,9,11
 909:26 910:2,23
 911:22,23 912:7
 914:16 915:6,8,
 10,17,19 935:25,
 26 941:23 951:14
 955:4 963:15,18
 964:11 967:6
 968:16,20
 969:13,17
 970:15,25 971:1,
 14,15,16,17
 979:7,13,23
 980:25

Maxston's 971:8**meaning** 851:10
933:13**meaningful**

942:20

means 861:11

877:6 879:20
 884:7 922:6
 929:8 953:25
 961:5 965:11
 966:10 967:9

meant 855:25

922:17 955:20

measure 876:1

877:25 879:11

measured 879:12**measures** 905:15

915:16 943:17
 944:4 947:16

950:22 951:26

952:2 956:1

973:19

meat 860:17**media** 925:4**medic** 848:24

907:17 908:2,3

medical 846:21

847:6,14 848:10
 849:8 851:13
 852:18 853:4,10,
 23 855:3 858:2,3
 861:4,8,17
 862:20 864:25
 865:20 869:11
 871:13,15 874:6
 887:9 888:25
 889:19,24,26
 890:22,24 894:7
 896:13,14 898:7,
 13 900:12,13
 901:9,10,15,18,
 22 917:19
 921:11,15 931:17
 932:1 934:4
 961:18 966:13,14
 971:26 973:13,
 19,23 977:4,5,11,
 18 978:10 979:5

medically 946:5

965:22 973:9

medicine 843:24

898:8 916:17,19,
 24,25 917:2
 918:2,5 919:19
 920:3 921:14
 923:18 937:20
 939:10,14,23,25,
 26 947:3 950:6
 951:19 975:4

meet 866:3 907:8**meeting** 842:2**member** 841:10,

11,12 848:3,4,13,
 20 849:1 907:7,
 20 908:8 914:10,

11,12 974:6

975:15 976:5,11

members 850:18

854:13 912:1,14,
 24 967:15 968:1

membership

848:7,11 976:10

memorized

903:4

memory 891:14

903:6 926:17

mention 850:12

881:16 891:5
 917:1 933:4
 936:23 955:25
 971:10

mentioned

880:24 934:22
 946:22 947:26
 950:1 957:13
 958:20 961:25
 972:9 977:22

merit 920:25**Merry** 981:5**met** 860:2 919:4**methacholine**

917:13

methods 928:21**metre** 930:18**metres** 929:18

930:4,6,10,12,21
 931:1

micron 926:23

927:3,4

microns 926:20**microscope**

927:5,6,7,10,21

microscopes

927:14,18

microscopic

927:4

middle 865:3

867:11

mild 957:7 961:21	month 856:1 917:4	nature 877:4 928:14 938:1 941:16 951:1 972:22	nonstandardized 932:2	numerous 894:2 898:2
military 856:26	morning 839:5 841:5 842:4,6 847:25,26 911:17	natures 940:21	normal 867:7 870:4 872:2 896:2 935:2 957:5	nurses 920:7
million 870:2,6 871:1,9,17 872:20,21 873:25 874:2,8,22 875:12 927:12	mounds 945:16, 25,26 946:1,2	nausea 869:14 893:2	North 888:11	<hr/> O <hr/>
mind 901:4,5 946:1 950:4 954:25	mouth 857:24 858:21 861:19, 22,23,25 862:11, 13 864:7,17 865:17 866:17 868:4 869:1 872:9 875:2 900:7 955:21 957:22	necessarily 874:16 885:7 892:26 893:1,2,9 931:7 937:9 938:19	nose 857:25 861:19,22,23,25 862:11,13 864:7 865:17 866:17 868:4 869:2 872:9 875:3 900:7 955:21 957:23	O2 877:3
mindful 942:14	move 905:10 921:1 955:9 963:25 969:5	needed 862:18 867:17,18,19 868:1 974:20	nostrils 864:16	oath 910:10
minds 894:12	moved 853:15	negative 869:10 870:22 884:15 933:13,23 948:4	note 855:21 980:21	obey 937:26 975:6
mine 900:3	moving 907:25	negatively 845:10 892:21 961:12	noted 856:6	obeying 975:8
minimal 867:14, 15	mrna 928:3	Nelson 841:13,26 914:13 964:17 968:26	notes 982:6	object 860:25 894:14 898:20 900:8 942:4 964:12 966:3 967:7,8 970:6
minimum 854:6 884:14 892:24 903:9	multi-factorial 923:22 924:13	Nelson's 964:16	nothing's 947:18	objected 851:2
minor 893:3	multiple 873:19	net 854:16	notice 865:23 867:2 879:18 921:25 958:10	objections 855:8 916:6,9
minute 871:17 904:3	multiples 872:21	neutral 860:14	noticeable 958:8, 13	objective 860:14 919:12
minutes 874:5,7 876:20 887:8,10 888:24,26 901:2, 7 912:19 929:9 935:23 955:5,6,7 968:25 971:1,4 977:8 979:15 980:7	Multirae 873:10 906:14	night 980:19	noticeably 936:26 937:6 939:23	obligation 890:24
mistake 951:5,12	mustard 956:4, 10,15,18,21,25	nocere 954:23	November 839:5,17 841:5 914:5 949:19 981:5	obliged 974:13
mitigate 974:25	<hr/> N <hr/>	nodding 854:12 964:16	number 843:4 873:4,18 874:20, 24 880:25 881:13 882:20 898:16 920:4 930:4 935:8 939:7 948:24 952:3	observational 933:20 934:12 936:9,10,12,14, 19
mixed 946:25	N95 861:9,11 862:8,17 863:4, 12 872:14 888:25 893:18	nonmedical 846:17 847:7,15 852:18,23 853:5, 10 855:4 861:4, 18,21,25 862:9, 12,14 863:25 874:6 887:9 888:24 893:19 927:2 931:16 966:17	noticeably 936:26 937:6 939:23	observations 936:23,25 938:26 948:15
modern 923:18	N95s 863:4	nonphysician 977:16	nothing's 947:18	observe 932:13, 14,16 952:9
moist 958:24	National 898:8	nonscientific 944:13	noticeable 958:8, 13	observed 906:14 940:15,16 960:12
moisture 862:19 865:5 958:21,22 959:3,8	nationally 905:21		noticed 856:6	observing 975:10
molecule 928:1,2	natural 951:2		notes 982:6	obstruct 956:6 957:23 962:8
molecule-sized 928:9	naturally 900:8, 10		nothing's 947:18	obstructive 961:7
moment 968:17			notice 865:23 867:2 879:18 921:25 958:10	obtain 886:22
monitor 873:22 879:14			noticeable 958:8, 13	obtained 954:6, 9,12

obvious 851:9
887:11 897:25
935:12

Occasionally
918:20

occupation
843:1,2 881:19
909:10

occupational
843:2,5,9 846:9,
16 847:5,13
859:22 860:22
869:22 874:12
875:26 877:24
880:25 881:17,
21,22,25 882:6
884:1,19 890:25
895:2,7,8,9,11,
14,16,18 899:24,
26 907:17 908:4,
12

occupations
876:3 877:26

occur 893:8
895:5

occurred 850:26

odd 857:14,15,16

offer 866:13

offered 852:5
920:22

offering 846:13,
14

office 885:19
893:23 894:3
916:22 917:24
919:22 920:1,17

Officer 894:7
971:26 973:19,23

official 841:21
893:26 894:1
896:22 914:21
982:15

offline 876:23

OH&S 895:22
902:3

OHS 882:11
895:19 901:26
902:1

oil 845:17,19,21
861:12

one's 967:10

one-year 907:19

ongoing 943:16
975:21

online 925:6

onset 856:18
857:2

open 891:18
943:24,26 944:3
946:22 947:13

open-circuit
843:18

opening 850:3
865:10,11 908:24

openings 858:25
864:4,5,14,16
865:9 908:23

operate 872:23

operating
925:12,17 948:9

operation 884:24

opinion 860:7
895:25 904:7
905:24 923:1
924:5 930:15
931:12 946:5
949:2 951:6
953:9 957:19
961:18 963:20
965:21

opinions 860:14
918:19 919:12

opportunity
842:25

oppose 976:12

opposed 917:21
953:14 967:21

opposite 898:9
935:15 954:20

opposition
973:25

opt 976:6

option 855:8
953:20

order 857:16
858:13 910:14
926:6,17 927:9
953:8 968:1

orders 854:1
863:23 902:15,18
977:5 979:26

organism 929:13
930:11

organization
944:17

original 948:7

OSHA 882:3,4,5,
9,13,16 888:5

OSHA's 882:24

outbreaks 921:4,
21

outcome 860:5,9,
11 919:6,9

outdoors 922:26

outpatient
916:21

outweigh 956:2

overexposure
875:23 877:19

overheating
869:17

overwhelming
945:9,12

oxygen 846:4,6
851:19 860:20
864:9 870:4,13,
17,20,23 871:19,
21,22,24,26
872:2,8,11,18
873:13,20 874:8,
10 875:19 878:25
879:9,11,15,23,
25 880:5,7,11,12,

16,18,23 881:7,
11 883:21,22
884:13,14,23
885:13 886:5,7,8,
13,15,17,18,22
887:2,4,7 888:9,
16,21,26 892:16,
21,24 893:4
897:1,4,7 900:4
902:8 909:9
956:10,12 961:2

oxygen-deficient
885:12

P

packed 930:26

pages 851:22
882:26 965:14
982:4

paid 860:10

pandemic 850:15
854:3 863:17
903:3,21 908:15
909:3 933:23
943:13 966:20
968:6 972:2
974:1

pandemics 948:1

Panel 912:24
971:13

panic 924:17
953:2

paper 866:16
868:26

papers 898:3

parachute
934:24,26 935:18
957:2

paragraph
852:19 860:26
864:1 868:20
882:22 883:8,9,
12,13,14,17,18,19
921:2 925:9

963:1

paragraphs
885:25

paramedic
848:9,14 849:5,
11,12 908:14

paramedics
848:4,5,14,21,23
849:2 907:5,11,
14,16,24 908:11

paramount
868:18

paranoia 924:17
953:2 966:26

pardon 850:25

parents 900:5

part 845:4 846:7
859:18 871:20
898:26 906:17
918:1 921:11
930:20 948:26
962:4 967:3
975:8 976:3,20
977:3

partially 925:3

participating
969:9

particulate
959:26

particulates
845:3

parties 842:21

parts 855:23
870:1,6,26 871:9,
17 872:20,21
873:25 874:1,7,
21 875:12

party 980:24

pass 892:9

passing 892:12

past 921:4 923:17
925:24,26 926:3,
14 945:14 946:7
953:20

patently 937:14	893:18 894:13	957:13,15	point 849:26	947:12 965:7
path 858:24	897:3,12 901:8,	personally 860:1	879:19 881:1	969:23
859:5 951:2	14 902:6 904:13	919:3 946:21	893:21 926:21	power 927:22
pathogenicity	910:26 911:1	962:23	927:8 930:23	967:1,3,9
951:2	917:8 920:4,8	persons 905:7	931:6 943:6	practical 930:16,
patient 890:15,16	927:2 932:21	perspective	944:21,24 945:14	23
918:14,15,17,21,	940:1 950:12	844:11 860:22	946:9,23 952:18	practicality
24 920:25 922:8	952:17 953:17,21	883:26 894:22	964:2,17 965:7	867:6
939:8 953:25	957:18 958:14	899:23 924:8	976:17	practice 848:14,
954:26 957:10	959:18 960:25,26	939:22	pointed 903:22	24 863:18 908:10
960:18,20,21	961:12,13,23	phrase 903:7,8	pointing 893:16	910:15 916:13,
961:22 972:10	966:19 968:9	953:24 954:21	policy 896:3	17,19,21 917:20
973:5 978:3,7,13,	people's 924:1	975:13	political 924:15	921:16 937:20
17,19,21	percent 872:3,5,	physical 870:18	945:6 952:20,23	960:11,26 968:1
patient's 978:8	10,11 874:9	891:2	politicisation	969:25 973:17
patients 916:24	881:3,4,8 883:21	physically	899:15 967:11	975:11 976:25
918:6,7,19,22	884:14,18,23	892:12	politicised	practicing
920:12,18,22	885:4,14 886:8,	physician 868:1	898:18,19 899:4,	921:13
922:22 923:5,11	16,17,19 887:8	875:26 877:23	6 966:7,8,11	practitioners
937:22 938:2,4,	888:9,10,21	891:1 918:9	politics 967:2	863:11
10,12,19,24	889:1 897:4,8	954:22 973:3,13	968:8,11	pre-conditions
960:15 961:16,17	917:23 935:6,11	975:14 977:10	population 858:9	910:24
962:5	956:19 957:19	979:1	923:25 931:14	pre-covid 868:10
pattern 942:1	958:5 959:22	physicians	935:5,7 944:5	933:19 965:18
pause 935:19	perfect 842:8	863:11 970:2	959:22	pre-existing
Pavlic 841:9	930:14 931:13	pick 930:4	populations	858:2,3 864:25
914:9	947:18,19	pictures 960:22	948:3	865:20 869:5,6,
pay 907:26	perform 897:7	piece 866:16	pores 946:11	11 889:18,24
paying 907:21	performed	868:26 933:18	portion 856:25	890:22,24 900:11
975:23	906:17	place 864:12	position 850:4,9	901:9,17,22
peak 940:22,26	period 864:24	916:1 941:7	915:24 945:15	910:26 911:2,6
peaked 950:16,	870:3 907:19	947:16 949:18	951:10	pre-virtual
23	950:14 956:13	placebo 934:9	possibly 920:8	969:18
peaks 941:2	959:14	places 937:15	post-covid	preambles
pejorative	periods 921:12	plan 953:26	868:10	941:25
953:11,16	permitted 853:4	plane 931:1	posted 926:3	preconditions
penetrate 845:4	person 865:18	935:1,18	potential 845:9	901:16
people 844:25	869:10 874:25	planning 896:5	895:4 905:7	preliminary
858:2 864:24	875:9 886:9	plastic 861:20	909:18 954:14	850:26 852:6
867:1,26 869:4,6,	888:1 904:13	play 949:9 957:19	965:7 971:23,24	859:25
18 876:2,5	911:8 957:10,21	PM 913:3 914:23	972:3	Premier 950:9
877:26 878:3	972:21 979:1	pneumonitis	potentially	premised 904:20
885:15 887:16	person's 872:9	956:23	900:10 920:10,12	prepare 950:12
889:16,18,22	personal 846:6	point 849:26	929:4,12 932:6	prepared 842:1
890:5 892:8,15	860:4 919:5	879:19 881:1		
	938:9 950:5	893:21 926:21		
		927:8 930:23		
		931:6 943:6		
		944:21,24 945:14		
		946:9,23 952:18		
		964:2,17 965:7		
		976:17		
		pointed 903:22		
		pointing 893:16		
		policy 896:3		
		political 924:15		
		945:6 952:20,23		
		politicisation		
		899:15 967:11		
		politicised		
		898:18,19 899:4,		
		6 966:7,8,11		
		politics 967:2		
		968:8,11		
		population 858:9		
		923:25 931:14		
		935:5,7 944:5		
		959:22		
		populations		
		948:3		
		pores 946:11		
		portion 856:25		
		position 850:4,9		
		915:24 945:15		
		951:10		
		possibly 920:8		
		post-covid		
		868:10		
		posted 926:3		
		potential 845:9		
		895:4 905:7		
		909:18 954:14		
		965:7 971:23,24		
		972:3		
		potentially		
		900:10 920:10,12		
		929:4,12 932:6		

preponderance 943:7	principle 954:24	product 934:17	893:20 896:14, 16,19 909:15 948:10	952:7,8,23 958:17 959:17 973:23
prerequisite 890:10	prior 856:18	profession 970:4, 19 976:5		publications 871:12
presence 904:13 905:7 969:11	privacy 890:18	professional 890:26 897:15 900:3 967:14 976:1	protective 956:1	published 898:8, 13
present 968:23 974:20	private 843:25 857:1	professionally 896:18	protein 928:6,8	pull 858:26 867:12
presented 952:14	problem 905:11 911:4 958:11 961:23 963:18	professionals 895:3 896:12	protocol 890:12 908:10	pulling 859:2
pressure 867:26 891:12,17 930:3 948:4	problematic 923:25	professions 903:16	prove 900:3 934:7 950:19 960:22	pulmonary 916:23 917:3,5,6 957:14,17 961:7
presume 947:10	problems 933:16 956:23 958:12	profound 944:4	proven 908:25 946:8	pure 880:12
presumes 951:17	procedural 846:21 861:5,26 862:7,15,17,20 863:2,9,12,20 865:24 874:6 885:15 887:5,9 888:24 893:19 931:17,21 932:4	profoundly 968:10	provide 849:22 858:16 860:13 904:7,11 905:13 909:19 919:11 964:9 970:21 980:16	purge 864:21 865:4 880:15
pretty 846:6 866:9 900:6 948:21 951:12	procedural- based 872:16,18 903:20	program 848:9	provided 840:6 845:8 911:4 916:7 964:26	purpose 873:23 899:9 947:23 948:7 956:8
prevent 846:18, 23 847:7,15 861:2 948:10 956:5	procedurals 863:5	programs 888:3, 5	providing 904:25 905:6 963:16	pushed 859:16
prevented 925:3, 13	procedure 850:15 854:5 878:26 903:9 909:4 953:26 974:6	prolonged 960:13 962:12,19	province 939:19 949:18 952:10 976:22 977:24 982:8	put 859:17 861:19,20,23 862:13 865:17 900:6 915:9 930:25 934:23 939:7 944:24 968:26 969:6 970:5
preventing 925:16,20 931:4 932:25 946:3	procedures 918:20 948:5	propellant 929:26	provinces 888:8	putting 870:20 884:8
preventive 905:14	proceed 916:5,11	propelled 929:26	Provincial 895:23 902:1 940:8 974:12	
previous 911:5 926:5 933:19 948:1	proceedings 841:1,23 913:3 914:1,23 981:10 982:5	proper 867:9 873:8 878:26 973:3	provincially 905:21 941:15	Q
previously 839:12 856:8 943:11	process 857:25 858:1,8 957:6	properly 861:14 870:23 872:25,26 878:11 879:3 886:11,23 890:1, 3 901:13 902:7 936:14 973:13	psychiatric 978:1,12	QC 841:16 914:16
primarily 843:10 845:18 854:2 857:4 861:11 939:4	processes 857:18	propose 842:23	psychological 960:14 978:12	qualification 839:7,9,11 842:17,19,21,23 847:2,22,24 849:22 850:19,25 854:23 915:7,10 916:7
primary 849:5, 11 854:9 868:18 876:1 877:25 899:24	produce 878:24	protect 845:22 858:14	public 841:12 850:18 854:13 863:24 888:14 893:12,25 905:18 914:12 921:4 922:18,25 923:14 933:11 938:20,21 942:11 943:23	qualifications 900:3
primum 954:22	produced 960:23 963:5	protected 876:3 878:1		
		protection 843:15,16 858:17 861:13 866:14 874:19 883:20		

qualified 847:3,
4,12 896:14,15
899:20 903:8
904:7

quality 859:22

quarter 887:15

question 850:4,
14 852:8 853:21
854:7,15 877:7
878:18 881:20
887:21 888:13
892:5 894:11,14
897:2 898:24
899:21,22 902:21
903:19 904:17,20
906:12 908:13
912:9 921:6,13
922:24 935:12
941:26 942:1
946:19 947:11
951:17 966:2
967:7 968:4,20,
24 969:7 970:18
971:22 973:8
974:16,22 977:20
979:18

questioning

842:14 855:7
887:21

questions

842:19,23 847:1,
20,23 848:1
849:20 853:9
859:24,26 900:15
901:1 904:1
907:4 909:20,26
911:14,24
912:11,25 915:3
919:1 936:22
941:25 942:3,7
955:9 968:15
970:16 971:13,18
972:18 973:15
979:9,11,15
980:8,15 981:1

quick 873:18

quickly 891:15

quote 922:15
945:8 955:14
962:10 963:1

quoting 962:15

R

radically 922:18

raise 855:8
969:24 980:24

raised 854:26
899:1

ran 949:1

random 900:7

randomised
933:5,16,20,25
934:6,7,10,16,19
936:8,13,15,18,
20 949:8 956:24

range 856:26
887:1

ranges 873:8

rapidly 886:20

rash 960:21

rate 887:5,6,7
897:10 935:11
956:18

rates 933:12
937:15 942:23

raw 966:25

Re-examines
839:15,21 910:6
979:21

re-inhale 870:25

re-inhaling
869:8

re-opening
969:25

reach 929:7
950:15

reached 874:17
893:15 944:21
950:14

reactions 924:20
960:17

read 847:1,2,9
851:8 861:3
864:2 876:20
877:11,12,15
882:21,23
883:11,18 886:2,
4,10,12,24
891:15,26
893:22,23,25
897:22 925:10
946:14 962:17
963:2 964:13
974:9

reading 877:17
891:13 892:3
918:12

readings 873:1,
26 874:1 879:7,
15,16 906:8,19
907:1

real 857:4,5
895:21

reality 852:15,24

realm 943:21

realtime 879:17

reason 852:13,22
865:5,13 866:24
867:4 881:5
894:23 898:26
930:18 931:2
948:26

reasonable
946:20,21 957:21
973:6

reasons 855:12,
15,17 856:5
923:22 924:22,24
938:6 950:5
952:20 953:22
965:22 966:17
973:26

rebreathe
859:16,19 864:22
865:6

rebreathed
864:21

recall 849:4,6
851:2

receipt 893:23

receipts 893:26

receive 855:11
920:12

received 893:22
974:9

recent 966:24
976:15

recently 873:11

recognize 962:7

recognized
928:20 962:6

**RECOMMENC
ED** 914:23

recommend
963:10

**recommendatio
n** 893:18

recommended
895:2 909:15

reconvene 889:5
912:5 936:1

record 888:4
892:4 905:3
968:25 969:7
975:23

recording 886:11

redirect 910:4
911:14 979:17,19

reduce 933:12
939:5

reduced 939:23

reducing 924:4

reduction 933:14
957:26

redundant
946:12 973:11

refer 866:1
882:15 890:26

918:23

reference 850:23
863:8 886:25
962:3 965:12

references
871:13 898:4,5,6,
7,9,12 929:22
965:15

referred 861:9

referring 850:20

refers 854:4
861:13

regard 850:22

Regional 916:24
975:4

registered
841:10,11
848:21,26 898:4,
6,13 907:15,23
908:1 914:10,11

registration
848:22 907:5,9
908:1 975:18

regular 927:6,7

regularly 862:18
920:8

regulate 850:17
854:12,13

regulated 848:4,
13 849:1 907:7,
20 975:15

regulations
872:5 929:18

regulatory 850:6
909:6 910:14
915:25 967:14,18
976:2,7

reiterate 850:3

relate 855:3

related 851:26
915:16 922:10

relates 898:18
899:6

relating 971:19	reporter 841:21 842:12 877:14,17 914:21 915:2 964:20 981:1 982:15	859:6	904:4 924:12 951:17 958:19	risk 855:18 869:23 922:22 935:9
relation 897:1 922:3	reports 871:13, 15 906:21	resistant 861:12	responses 849:22	risks 893:13 894:8 895:19 954:1,7,10,14 971:23
relative 954:3	representatives 895:16	respect 912:16 915:24	responsibilities 850:6	RNA 927:15
release 845:24 912:20	request 853:14, 20 918:8	respectful 938:2	responsibility 975:26	road 860:16 891:22 906:23
relief 963:14	require 843:14 857:13 978:8	respiration 869:4	rest 917:24	rolled 896:11
reluctant 964:12	required 845:20 861:16 864:3,6 908:1 927:22 934:17 963:8 965:23 970:2	respirator 843:11,12,21 844:3 847:6,14 850:21 852:14 859:12,13 865:1 867:17 868:2,17 890:2 896:12 901:19 909:16 910:16	restate 898:25	room 842:1 853:15 854:21 855:19 912:23 918:8,13 925:17 927:19,22 948:9 962:4 968:26 969:6,9 981:2
reluctantly 940:3	requirement 854:4 857:5,7,12 868:16 881:12 884:14 907:13, 15,25 908:15 909:4 974:5 976:19	respirators 843:19 859:14 867:9 896:17,19	resting 887:5,6,7 897:10	rooms 922:22 948:4
rely 978:17	requirements 882:1,25 884:13 907:8,20,23,25 908:7 920:5 970:3,7,19 973:24 974:8,23 975:3,14,22 976:1,6	respiratory 843:15,16 858:17 866:14 876:4 878:2 883:19 896:13,16 909:18 917:10,17 921:4 922:7 924:12 925:24,26 926:14 946:4	restrict 864:9,19 866:17,18,19 890:6	rough 958:2
remain 875:7 976:11	requires 861:16	respirologist 939:22 955:16,18 965:21 973:9 979:1	restricted 873:5	roughly 929:19 958:4
remember 852:4 901:11,16 908:19 926:21 950:3,5 980:23	requiring 863:20	respirology 915:14 916:21,26 918:2 955:19	restriction 889:20 891:3	roulette 867:23
remind 850:24 867:16	research 871:12, 13 898:3 929:23 933:22 946:24 948:8 951:23 965:17	respond 845:23 953:4	restrictions 942:11,17,20,24 943:8,9 949:16 950:10,26 952:6, 18 968:6	route 928:17 973:14
remove 880:16 962:5 963:11	researcher 949:7	responded 899:3	result-based 948:17	rule 954:19 980:2
repeatedly 945:7	researchers 898:14	responder 848:10 849:8	results 878:9 890:20,21 906:16 907:2 910:8 942:24 946:25 960:24	ruled 855:2
repeats 905:3	resistance 857:22 858:24	responders 843:16 845:8	retention 958:21, 22 975:23	rules 862:12 888:20 892:23 929:21 930:18 931:10 938:3 941:8 948:2 974:26
rephrase 894:13		response 852:3, 11 853:11 893:26 894:2,4 897:2	retroactively 899:19	run 842:22 870:19 917:19 957:14
rephrasing 878:14			review 850:7 965:16 974:3 979:2	ruling 839:11 851:3,22 854:23
replaced 861:15 862:18			reviewing 918:17	run 842:22 870:19 917:19 957:14
reply 893:22 915:12			revised 871:6	runs 898:21
report 851:9 852:20 861:1 864:1 866:20 868:20 869:24 879:19 881:16 882:15,17,19 897:18,21 906:1, 13,17,19 921:1,2 925:9 926:19 933:4 936:23 937:21 944:25 946:13 955:11, 14,26 958:20 973:22			Richard 888:1	Russian 867:22
			ridiculous 921:3	résumé 843:26
			rifle 930:2	
			rightly 849:26	
			rise 949:22	

S				
safe 846:5 859:21 871:1 872:12 888:16 903:17 908:22,24,25 909:17 911:7,11 961:26	scarves 959:1	screen 876:9	session 839:5,17 841:5,25 853:19 854:25 889:10 914:5 980:13	shortness 962:6 963:9
safely 867:21 868:2 959:21	scenario 861:13	screened 867:20 890:3	set 844:16 850:15 934:3 980:22	shotgun 929:2,15
safest 929:19	Schaefer 839:6, 12 842:4,10,16, 26 847:3,4,12,20, 25 851:1,4,7,18, 23 852:15,25 853:22 856:8,11 859:26 878:5,6, 17,22 887:24 889:7,12,14 892:3 894:20 899:3,5,16,23 900:20,26 902:14 903:26 904:19 906:11 910:1,7 911:16,25 912:10,16	screening 857:18,25 858:1, 4,7,8,11 867:22 890:8,10,12,14, 15 900:11 901:13 910:23	setting 861:9 907:17 908:12 919:21 920:3,7, 16 922:20,25 923:8 925:14,17 931:5,14 933:11 959:10,22	shout 928:25
safety 843:3,6,10 844:12,13,16 846:7,10,16 847:5,13 856:20, 21,22 857:10 859:22 860:22 869:23,26 874:12 876:1 877:24 880:26 881:17, 19,22,23,25,26 882:6,9 884:1,20 890:25 892:24 895:3,7,8,9,11, 16,19 899:24,26 900:2 902:6 903:24 908:4 909:9	Schaefer's 850:13 851:10,24 852:7,20 854:10	scribbling 852:2	settings 862:4,21 863:3 884:20 895:3 919:16 920:11 923:16 925:21 947:25 948:3	show 871:15 872:23 898:8 933:14 934:11,12 965:7
Safety-related 895:15	schedule 918:1	scuba 866:5,14	severe 870:22 922:7 960:17,20 965:19 978:21	showed 867:10
sake 850:23	school 921:15 927:8	seal 858:15,16,18, 22 932:11	severely 957:12 961:2,24	showing 933:24
salient 954:11	schooling 927:8	seasons 940:22	severity 889:25 901:10 961:20 972:22	shown 898:14
saliva 948:11 959:24	Schumann 841:21 914:21 982:3,14	seconds 872:10	shaking 963:24 979:10	shows 897:7 950:25
sandbag 970:9, 10	science 851:25 944:8,10 946:22 947:2 951:19	secretions 959:4, 5	share 922:10	shut 884:25
SARS 921:5,9,26 922:4,6 926:15, 20	scientific 871:15 898:2,5,6,11,13 924:6,8,24 926:4 931:2,6 932:26 933:1 943:21 944:2,26 945:5 947:11 949:12 952:24	seeking 977:11	she'll 877:15	sic 881:17,26 964:16
SARS-COV-2 851:15 922:2 926:13 927:26 928:9	scientifically 945:9	seep 932:12	shoot 930:1	sick 920:19
satellite 917:1	scientists 851:13	self-contained 843:17 881:10	short 853:13 862:22 930:16 933:8 944:11 961:1 962:2 965:13 969:12 978:14	sickness 920:24
	scope 853:1 855:7	self-contamination 958:20,22	shorter 971:3	side 943:19 944:17 972:3
		self-diagnose 977:16,17	shortest 956:13	sides 944:3,10
		send 898:12 964:15,16 965:12 969:26 970:11	shorthand 982:5, 6	signed 977:26
		sense 851:17 930:16,23 946:9 965:18	shortly 854:20	significance 933:15
		sensor 873:18		significant 856:25 859:20 868:6 897:11 931:15 957:8,25 958:6
		sensors 873:7,21 879:10		significantly 870:20 872:9 884:10 931:3 933:14
		sentence 882:21 883:12,13		signing 978:6
		sentences 886:2		similar 852:26 882:11 922:5,11 927:26 929:2 974:7
		separate 879:16 881:9 885:5,10		simple 866:4 963:6
		series 917:7		simply 918:12 940:15 958:23 959:17
		Services 893:11 894:6 944:6 971:26 975:2		

simultaneously 879:12	sociopolitical 924:22	speculative 878:13	946:5,17,20 962:2,7,23 963:2, 16 965:3,8,9,13	stuff 958:9
sincere 937:26	sort 859:24 871:1 902:20 931:15 932:22 940:26 951:17 958:11 968:12 975:1 978:2	spend 917:4	States 882:10 888:6	style 862:5 872:14
sing 928:25	sorted 928:19	spew 928:25	statistics 950:18	subject 851:11, 21 892:18,20
sit 917:8	sought 954:18	sprays 929:3	stay 858:7 907:26 929:9,19 930:12 935:10 976:24 980:26	subjecting 892:16
sitting 870:11 958:8	sound 946:5	spread 846:19,23 946:4	stayed 930:6	subjective 945:26
situation 864:26 866:26 896:8 903:22 924:15 944:4,11 977:23	sounds 842:15 883:25	spring 871:7	stays 875:13	subjects 906:26
situations 844:25 845:21 880:14 963:10	source 856:4 881:9 885:5,10	staff 896:13 903:11	steadily 950:17	submissions 853:11
size 926:10,13,14, 16,18,19 927:25 928:3	space 880:20 884:26	stake 860:4,8 919:5,8	steady 874:23 875:7	submit 871:14 964:7
sizes 946:10	spaces 880:16,17	standard 854:6 869:23 881:26 883:20 900:7 903:10 936:17	steel-toed 844:12	subsequent 951:3
skill 982:7	spaces 880:16,17	standards 844:7, 9,15,19,20 859:22 869:25,26 871:6 874:12 882:10,13 888:8	stimulate 951:22	substantial 926:11
skills 908:10	speak 894:15 928:25 947:9 951:7 952:8,13, 15	stands 844:8 845:26 874:13 980:20	stop 861:2 903:19 930:7 932:4,7 948:16 967:22 974:3	successful 948:19
skin 845:9	speaking 856:17 870:16 887:10 926:13 936:17 973:14 978:3 979:3	start 842:19 843:1 855:23 860:24 900:20 911:22 916:13 934:4 961:15 968:17	stopping 931:22, 24 932:3	successfully 944:24
slight 867:13	special 956:5	started 887:15 950:17,24	strange 868:8,12, 13,16 888:14,17, 18,19 896:2,9,21, 23,24,26 897:4 902:22 944:1 968:5,8,11	suffer 871:25,26 886:6,14
slightly 862:4 875:18 950:16 958:3	specialist 876:1 877:24 908:5	starts 883:8,11, 17	stretch 887:17	suffering 875:25 877:21 879:22
slow 942:6	specialized 844:26 845:1	state 864:2 899:7 921:2 937:21 955:13	strong 962:24	suggest 912:4 941:11 954:24
small 845:3 917:2 928:2,4	specialties 843:11	stated 893:21 898:15 937:11 945:7 948:23 949:19 974:13	structural 946:9	suitability 858:6, 9
smaller 926:26 927:5,20 928:6,7	species 922:13	statement 850:2, 3 897:26 898:2 939:1 943:4 945:10,11,20,21	struggle 866:2	suitable 857:17 873:9
smallest 928:4	specific 848:22 851:17 899:9,20 906:5,19,25 908:13 977:24 978:9		studies 878:15, 16,20 898:3 925:12 926:2 932:18 934:3,11, 12 936:12 945:14 946:6 948:8	sulphide 845:16, 19,24,26
smoke 960:1	specifically 895:10 933:17,22 946:7 947:17		study 898:5 933:8,10,11,15, 16,21,24 934:10 949:8	super 927:23
smoking 885:9				superior 931:23 932:3
sneeze 929:25				supplied 885:6
so-called 866:21				supplied-air 881:10
social 924:15 925:4 945:6 952:20,23 975:10				supply 859:10
society 840:6 938:1 947:12 961:26 962:12,14 964:6,25 965:3 966:15				support 925:15 937:17,18

supported 939:6
supporting
 945:8,17 948:8
suppose 922:12
surgery 863:10
surgical 846:22
 850:14 854:5
 863:7,10 893:20
 903:9 909:4
 932:24 959:19
 974:6
surgical-type
 959:16
surprise 892:7,
 11 947:6 970:22
 974:15
surprised 852:16
surprising
 852:21 925:18
 958:14 966:18
 968:5
surrounding
 859:1
survivability
 956:19
survival 935:11
survive 886:5,14
surviving 934:25
 935:3
survivors 956:22
suspended 929:8
sustain 956:13
swear 842:11
switch 915:3
sworn 839:6,12,
 18 842:16 856:8
 915:1,5
symptomatic
 886:21 920:4,12,
 21
symptoms
 869:12 893:3
 962:20 963:12,14

syndrome 922:7
system 881:11
 918:6
systems 843:18

T

TABLE 839:1
tacitly 967:20
tail 970:16 972:18
takes 963:3
taking 855:18
 935:5,7 980:16
talk 853:3,4,7
 874:13 894:12
 899:15,16 904:23
 906:13
talked 859:4
 875:22 877:18
 892:6 901:4,7,13,
 24,25 903:7
 905:25 949:17
 971:19 972:5,6
 973:8
talking 861:1
 865:25 893:14
 902:21 911:9
 918:12,18 927:11
 931:8 936:8
 959:15 972:8
 979:23
talks 848:2
 852:20 974:18
taught 900:5
 954:23
teach 843:19,21
teaching 843:22
 917:12,18
**telecommunicati
 ons** 925:7
telling 978:8
tells 978:14
temporary
 862:17 956:7

ten 912:3
tend 920:18
 929:15
tendency 944:16
tendered 847:22
 849:23 850:19
 897:20 899:8
tenders 915:13
tenets 954:22
term 866:20,23,
 24 953:11
terms 850:10,20,
 26 861:6 898:22
 901:15 922:17
 923:17 924:16
 928:18 929:2
 932:18 940:3
 941:8 942:21
 943:20 956:22
 966:22 972:2
 979:4
terribly 969:2
test 857:10,13
 858:17 868:17
 873:13,19 876:2
 877:25 879:8
 890:11 903:6
 906:16,26 917:14
 957:17
tested 857:6,9
 867:19,20 872:25
 884:22 887:2
 888:22,23
testified 899:13
testify 851:7,23
testimony 850:13
 851:24 854:10,26
 855:3 902:20
 911:16,18 948:23
 949:15 977:3
 980:17
testing 843:11,
 12,22 844:4
 846:17,21
 856:23,24 858:5

860:21 868:11
 870:8 871:11
 872:22,23,24
 873:12 878:22
 890:8,11,25
 891:1 892:15
 897:6 898:11
 902:5,8 905:26
 906:2,25 907:2
 910:9 917:7,16,
 18 934:23 957:15
 978:16
tests 878:7
 906:16 917:7,13
Texas 937:3,7
text 885:26 886:3
theatre 925:12
theoretically
 930:9,14 931:8
 960:5,6
theories 926:5
theorize 932:17
theory 932:26
 933:2
therapist 917:10,
 17
there'd 965:17
thereof 898:22
thing 842:10,26
 845:14 857:8
 858:7,13 870:10
 877:15 896:9
 915:1 923:5,15
 929:11 932:22
 934:21 940:26
 959:2 966:8
 968:12 970:8
 973:7 978:2
things 843:8
 862:3 868:10,11
 869:14 874:24
 880:2,15 890:13
 901:3,24 917:12,
 25 925:5 927:15
 931:19 932:3

947:2,5 948:11,
 12,13 959:5
 960:17 968:10,14
 971:19
thinks 899:5
 979:8
Thoracic 840:5
 961:25 962:11,14
 964:6,25 965:3
thought 855:19
 884:4 894:9
 901:2 922:19
 928:13
thoughts 894:6,
 18 941:24
thousand 870:1,
 7,26 871:9
 872:20 873:24
 875:13
thousands
 938:23
threatening
 889:21,25 900:13
tie 887:22
tight 872:15
tight-fitting
 872:13,14 875:2,
 3
tight-fittingness
 877:4
tighter 862:8
 863:4
time 847:10
 859:15 864:24
 869:19 879:13
 893:17 895:5
 896:2 905:2
 921:12,16 922:18
 923:15,23,26
 924:10,11 930:6,
 13 949:17
 950:12,13,14,15
 956:13 959:14
 960:19 966:22
 973:6 979:11

980:16,24 981:3
times 902:19
 926:26 927:12
 966:19
tiny 928:9
tip 842:8
tissues 871:23
 872:1 886:21
title 887:26 888:2
today 897:13
 904:7 979:11
 980:22 981:3
told 907:6 910:14
tolerate 889:16
 901:8 958:15
 961:22
tomorrow
 855:26
tool 946:3
top 882:19 889:21
 891:7
touch 901:3,24
 912:13,16
touched 868:19
 889:15 904:2
touching 959:19
towel 869:1
toxic 864:10,22
trace 932:19
track 950:4
trained 897:7
training 843:10,
 11,12,22 844:3,
 24 845:1,5
 846:14 856:20,
 21,23,24 927:21
 955:19
trajectory 929:1
transcribed
 982:6
transcript
 839:22 853:26
 877:11 982:1,4

transcripts
 851:6
transfer 969:8
transmissibility
 851:26
transmission
 847:8,16 905:14
 924:4 925:16,20
 928:17 930:7,10
 931:4,26 932:25
 936:26 937:5,13
 939:24 941:19
 946:8,16 948:10,
 11,16
transmissions
 938:24 939:8
transmitted
 928:10,11,20
 930:5,10
trap 875:4
treatment 934:4
trial 933:5,17
 934:6 936:19
 956:24
trials 933:25
 934:7,16,19
 936:9,13,16,19,
 20
Tribunal 841:7,
 8,25 850:24
 853:13,20 854:25
 860:13 877:13
 912:1,14,15
 914:7,8 919:11
 963:21 964:2,10,
 18 971:11 979:14
 980:8,14
Tribunal's
 964:14
true 859:6 930:9
 939:1,20 945:24
 978:20
trusted 896:12
truth 910:8

truthful 978:17
tube 917:9
turn 842:2
 865:12 882:16
 885:24 887:25
 903:26 915:17
 951:23 959:4
 971:8
turns 963:23
two-fold 977:6
type 850:10
 856:18 857:8
 858:13 863:19
 865:19 866:11
 867:18,25 873:6
 878:18 885:8,12
 887:11 896:10
 899:12 901:19
 917:25 919:24,25
 922:6,8 925:14
 957:8
types 843:8
 847:6,14 850:17,
 20 852:14 857:12
 860:26 861:7
 866:21 873:19
 893:3 895:1
 919:15 922:13
 948:5 957:4,5
 958:18 960:23
typical 928:14
 940:21
typically 862:1,6
 863:8 929:16
 972:8

U

unabated 941:17
underlying
 962:13,20 963:7
 965:4
understand
 845:25 860:12
 883:26 897:13

905:2 919:11
 927:2 940:9
 942:16 958:6
understanding
 848:12 849:14
 908:6 967:16
unenforceable
 930:22
unintended
 845:23
unintentionally
 877:1
union 895:13
unit 918:7
United 882:10
 888:6
universal 881:13
 888:11 922:19
 923:8 924:6,11
 929:20 934:18
 941:17 948:2
 949:17 952:16
universally
 928:19
university
 843:23 927:9
unobstructed
 865:16 955:20,23
unsafe 872:17
 923:5,8
unscrew 865:11
user 857:13 893:9
usual 973:14
 977:13

V

vaccinations
 942:23
valid 961:18
 965:22 972:19
 973:4,9 978:10
valve 859:14,16
 864:21 865:4

867:11 911:11
valves 911:4,11
vaping 932:21
vapour 958:25
vapours 845:2
 960:2
variety 856:22
 869:9
vary 963:4
vents 866:10
verify 858:19
 872:26
versions 897:9
versus 879:6
 936:9 946:11
 957:16
video 872:23
Videoconference
 841:1 914:1
view 880:4
 891:21 899:10
 901:25 915:22
 931:6 946:10
 976:5
views 903:24
 905:17 963:24
 973:21
vigorous 931:10
viral 921:21
 926:14 931:26
 941:19 946:7
 948:9
viral-based
 921:7,8
viroids 927:11
virtually 862:10
 896:22
virus 851:15
 857:11 922:1,6
 924:12 926:8,11,
 13,20 927:26
 928:2,9 930:8
 931:8 940:20,21
 941:2,16 950:1

951:2 960:4
viruses 922:9,12
 926:17 927:17
 946:4,11 959:25
 960:2
vision 869:16
volume 922:23
 942:22
volumes 859:8
voluntary 953:15

W

Wait 910:22
waiting 842:1
walk 969:20
Wall 841:18,25
 859:26 897:14
 914:18 915:13
 919:2 975:13
 979:4
Wall's 851:11
 977:3
wanted 853:22
 904:1 905:5
 906:23 909:23
 969:19
War 956:4,26
ward 918:9
waste 864:22
water 928:10
 958:24,25
wave 940:26
 941:10,11,12,14
waves 941:2,6,13
 951:3
ways 877:9
wear 850:18
 854:5 858:4,6,11
 863:17,20 865:21
 866:26 867:21,23
 868:2 870:11
 875:14,15 885:9
 888:14 890:1

892:8,15 893:18
 908:18,22 909:1,
 14,17,24 910:13,
 17,19 911:2,7
 921:4 938:4,10
 953:21 956:5
 958:26 959:2,9,
 12,13 960:9,19
 965:23 968:9
 974:5 978:22
 979:23,24
wearer 857:9,17
 858:14 868:22
 893:9 904:8
 905:8
wearer's 858:20
wearing 857:17,
 20,26 867:24
 868:21 871:18
 874:5,7,26 875:9
 885:21 887:3,5,8
 888:24 889:16
 890:4 892:10
 900:4 901:19
 902:6 908:17
 925:11 933:24
 937:23 948:6,7
 955:14 957:16,22
 958:15 959:18,20
 960:6,13,22
 961:3,12,19,22
 962:8,12,18
 963:9 965:18
 973:10 975:10
 980:2,3
wears 867:17
 957:11 958:17
week 855:26
weekend 950:11
weeks 950:21
weighed 967:11
weight 850:10
 916:1
well-
documented
 960:21

Western 845:18,
 19
whatsoever
 857:9 879:7
widespread
 941:17
William 883:5
willingly 980:3
willingness
 895:22
wishes 980:18
witnesses 898:16
 899:4 915:25
wondered
 911:23
wondering
 876:10 881:21
 887:14,16
word 863:7
 865:23 878:19
 879:18 883:17
 888:17,18 943:15
 966:4,6 971:25
 974:10
words 894:18
 950:20
wore 960:20
work 846:1,12
 852:16 856:15,
 18,25 857:2
 865:19 875:24
 877:20 885:3
 895:8,10,13
 907:16 908:1,9
 916:18 919:24,25
 923:24 925:25,26
 926:6 927:20
 930:7,19 932:13
 938:16 942:17
 943:2,5 947:21
 948:13
worked 844:10
 947:15
worker 939:9
 960:18

workers 845:7,
 17 858:10 886:19
 923:6 935:7
 938:11,13,16,24
 948:24 949:1,3
working 843:5
 872:26 879:4
 884:24 885:15,16
 908:3 943:8,9,14
 948:16 973:18
workplaces
 890:8
works 845:21
 895:15
world 930:14
 944:19 952:10
 956:4,26
worldwide
 896:9,21 968:6
worn 867:1
 873:26 874:23
 908:18 957:9
worse 869:18
 978:15
wrap 971:5
wrap-up 902:20
writ 946:4
writing 855:23
written 855:11,
 15,17
wrong 849:9
 974:3
wrote 887:26
 888:1

Y

year 849:3,16
 871:7 893:16
 907:7,8,21,26
 940:23 970:4
 975:24
year-and-a-half
 942:9

years 843:4,24
 848:8 939:17
 943:13
younger 960:16

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

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	January 28, 2022	Morning Session	986
6	Discussion		986
7	DR. BYRAM BRIDLE, Sworn, Examined by Mr. Kitchen		1000
8	(Qualification)		
9	Mr. Maxston Cross-examines the Witness		1020
10	(Qualification)		
11	Ruling (Qualification)		1024
12	DR. BYRAM BRIDLE, Previously sworn, Examined by		1025
13	Mr. Kitchen		
14			
15	January 28, 2022	Afternoon Session	1092
16	DR. BYRAM BRIDLE, Previously sworn, Examined by		1093
17	Mr. Kitchen		
18	Mr. Maxston Cross-Examines the Witness		1197
19	Mr. Kitchen Re-examines the Witness		1204
20	The Tribunal Questions the Witness		1210
21	Mr. Kitchen Re-examines the Witness		1213
22	Certificate of Transcript		1217
23			
24			
25			
26			

1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 January 28, 2022 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23

24

25

26

1 (PROCEEDINGS COMMENCED AT 9:18 AM)

2 THE CHAIR: Good morning, everybody. This
3 is a continuation of the Hearing Tribunal for Dr. Wall,
4 and we are back in session today, and I believe we left
5 off on November 20th with witness testimony with
6 Mr. Kitchen's witnesses. So that's the point at which
7 we will pick up again.

8 I believe the transcript indicates that there's a
9 Dr. Bridle that will be testifying today; is that
10 correct, Mr. Kitchen?

11 MR. KITCHEN: Correct.

12 THE CHAIR: Okay, just a quick
13 housekeeping item, I'd ask everybody to mute your cell
14 phones. And good morning, Mr. Maxston, as well.
15 Perhaps we'll start with you, if you have any comments
16 you wish to make.

17 Discussion

18 MR. MAXSTON: Yes, thank you, Mr. Chair.
19 Before we hear Dr. Bridle's evidence, I'd like to make
20 some comments to you and your colleagues regarding
21 process and scheduling matters. This isn't a
22 preliminary application in the true sense, but to the
23 extent you feel comfortable, my client will be asking
24 for some advice and direction, for lack of a better
25 phrase, I've advised him of my intention to raise these
26 matters before the beginning of the hearing -- or

1 Dr. Bridle's evidence, and I understand he'll have a
2 response.

3 Specifically the Complaints Director has asked me
4 to make comments regarding the scheduling of the
5 closing argument phase of the hearing and next steps,
6 and this arises from Ms. Nelson's recent emails and
7 Doodle poll to everyone, attempting to secure April 4
8 as the date for closing submissions. And the comments
9 I'm making this morning also arise from the Complaints
10 Director's ongoing and very serious concerns about the
11 length of the hearing and the costs that continue to be
12 incurred, and, as you know, I previously raised this
13 with the Tribunal when we were objecting to
14 Mr. Schaefer being called as a fourth expert witness.

15 My client was very, very supportive of proceeding
16 on April 4 with closing submissions, given the
17 considerable amount of time that has been spent on this
18 hearing and I think our understanding that perhaps most
19 people were available that day.

20 And by way of background, and recognizing the
21 difficulties that can sometimes occur in terms of
22 scheduling hearing dates and scheduling witnesses, my
23 client remains concerned about the significant number
24 of witnesses that Dr. Wall has called in terms of the
25 lay witnesses and the expert witnesses. As you know,
26 we've taken the position that the lay witnesses really

1 can't offer anything in terms of this hearing; it's
2 about Dr. Wall's conduct and his regulator, and we've
3 also indicated that we felt four experts was
4 repetitious and was unnecessary.

5 The Complaints Director's concerns also arise from
6 the number of days that have been scheduled for the
7 hearing to receive Dr. Wall's evidence, and, in some
8 cases, days where we haven't been able to utilize the
9 full day, and that, in turn, has made the hearing that
10 much longer.

11 So this leads me to my primary point today, and
12 that is that the Complaints Director, again, is very
13 strongly of the view that closing submissions should
14 only need one day. They are a summary of the parties'
15 positions and evidence, and scheduling closing
16 submissions for one day should be more than sufficient,
17 and, more specifically, April 4 should be sufficient in
18 terms of the amount of time necessary to prepare.
19 There's a lot of time coming now -- or that will occur
20 between now and April 4.

21 So, again, my client is prepared to proceed with
22 closing arguments on April 4, would like that to occur.
23 I know Mr. Kitchen disagrees with that, but the -- and
24 he has some comments he'll make, but the Complaints
25 Director is asking for, again for lack of a better
26 phrase, some advice and direction from the Tribunal

1 about how we're going to proceed and whether we can
2 proceed on April 4, all with a view to maximizing the
3 efficiency of the hearing.

4 I understand again that Mr. Kitchen has some
5 comments in response.

6 THE CHAIR: Thank you, Mr. Maxston.

7 Mr. Kitchen?

8 MR. KITCHEN: Thank you. I have several
9 comments.

10 We've heard a few times about the costs, and
11 that's not relevant. I'm sure it is for the Complaints
12 Director obviously but not for this hearing, not for
13 the Tribunal. Quite frankly, if he doesn't like his
14 costs, there's a way to remedy that, right? We don't
15 have to keep going on this. Nobody is set in stone:
16 Thou shalt, must continue this hearing. So I don't
17 understand why we keep hearing that.

18 It's expensive to prosecute members of a
19 regulatory body when those members put up a legitimate
20 legal defence. Of course it is; that should come as no
21 surprise.

22 So I say that because that can't be considered as
23 a relevant component here. I mean, we could go down
24 the road on how much Dr. Wall has suffered financially
25 through all of this, you know, how much his family has
26 suffered. He's had to hire legal counsel, right?

1 Enormous resources have been spent on his side. I
2 haven't mentioned that because it's not relevant.

3 So a considerable amount of time, yeah, of course,
4 of course it does, yes. This is a significant,
5 significant issue, right? This is a scientific issue,
6 it's a professional conduct issue, it's a matter of
7 truth, it's a matter of integrity and professional
8 regulation, and it's going to take some time. We
9 haven't been at it for 20 days. It's not unusual for
10 trials in the court to go for 20 or 40 days. My friend
11 knows that. I think we've been at it for six or seven
12 days. My friend took three days with his witnesses. I
13 tried to utilize time as best I could. That's why I
14 tried to fit in Mr. Jarvis [sic], and then, of course,
15 we weren't able to continue that. I had witnesses
16 standing by while we went through all of the Complaints
17 Director's witnesses. I had no issue with that.

18 So again, it's not -- it's almost as if my
19 friend's trying to say that Dr. Wall is doing a
20 filibuster; that's not what's going on, okay? I didn't
21 call 16 of his patients; he could have, he didn't. You
22 know, I could call expert witness after expert witness
23 after expert witness, and I could go, you know, go
24 through all the more and -- arguments about why each
25 witness should be allowed in, because there is no rule
26 of court that applies here that caps the witnesses, but

1 I haven't done that. I've brought in four relevant
2 witnesses, expert witnesses, and we're getting through
3 them as fast as we can.

4 There is an enormous amount of evidence though,
5 nonetheless, as you've seen. That evidence has to be
6 synthesized, and it has to be discussed in closing
7 argument. I'm not going to read to you line by line
8 what Dr. Hu said or what Dr. Bridle says today out of
9 the transcripts, but I'm going to have to go through
10 the evidence, because the evidence is what matters.
11 This case is about following the evidence to where it
12 leads.

13 So -- and I've reviewed the evidence obviously for
14 today, and there's a large amount of it, and we're not
15 done yet, and part of the reason I submit there's a lot
16 of evidence is because Dr. Wall's right, he's
17 scientifically right, he's professionally right.
18 That's why there's so much evidence to show that. I'm
19 not going to ask this Tribunal, at the end of all this,
20 to rule in his favour on a scant amount of evidence;
21 I'm going to ask them to rule on his favour on a large
22 amount of evidence. So I'm going to have to go through
23 that evidence, and I'm not going to take four days to
24 do it, but I'm not going to take 4 minutes to do it
25 either.

26 And then I have to get into the legal argument,

1 which is complex, it's long, and this Tribunal deserves
2 and Dr. Wall deserves for the Tribunal to hear a full
3 explanation of how statutory human rights works, of how
4 the Canadian Charter of Human Rights works, of how it
5 applies to the College, of how Section 1 works, of how
6 it's possible to justify these rights infringements. I
7 have to go through a long list of rights infringements,
8 because I have to establish that; it's Dr. Wall's
9 burden.

10 This is not something that's going to be done in a
11 couple hours. It's going to legitimately take me
12 several hours to go through this, and then, of course,
13 you may have questions, and we may have delays, like we
14 had this morning, we started 20 minutes late. It's
15 patently unreasonable to say we're going to get through
16 it in one day.

17 Now, I understand that, you know, the Complaints
18 Director is not a lawyer; I get that, I get that. But
19 I think my friend, because my learned friend, because
20 he is so reasonable, I think he can agree with me, that
21 we're not going to get through a closing argument in
22 five or six hours, which is typically what we have in
23 one day. I could be the entire day before I get
24 through mine, and then he deserves an opportunity to
25 respond, and he might have a lot to respond to. Then
26 I, of course, have an opportunity to rebut, and then we

1 have questions.

2 So it's not unreasonable, in any sense, to say
3 there's got to be two days, and it's not unreasonable
4 to say it's got to be two days in a row. We've broken
5 up the evidence; that's fine. It's not ideal, but
6 that's fine. But closing argument needs to be two
7 days, two consecutive days in a row. And it's not fair
8 to my friend, to be quite frank, if I go the whole day,
9 and then he has to wait four weeks before he gets to
10 respond to it because we've split it up.

11 The last thing I'll say is this: My client and I
12 were available for days in February and March. It just
13 so happens that the only day when everybody else was
14 available is April 4th, and there's no option for April
15 5th, notwithstanding the fact that I have a trial I
16 have to travel to for April 6th. I would have been
17 willing to do April 4th and 5th if it had've been
18 available. If we had've done those two days in a row,
19 I would have done that, because we might only need a
20 day-and-a-half, we might get through on the 5th, and
21 then I could travel that evening. I don't like that,
22 but I would have been willing to do that, but that
23 option wasn't even presented --

24 THE CHAIR: Mr. Kitchen --

25 MR. KITCHEN: -- for whatever reason --

26 THE CHAIR: -- I'm --

1 MR. KITCHEN: Go ahead.

2 THE CHAIR: -- committed to another
3 hearing with another college on the 5th.

4 MR. KITCHEN: No, and there we go. Now we
5 know -- yeah, I understand that. So I don't -- but I
6 don't know why it was always ever presented to Dr. Wall
7 for only one day. I've made my position clear. I've
8 explained to Ms. Nelson that the defence requires two
9 days. So I don't know why it was only presented as one
10 day; it should have been presented as two days, because
11 that's our position.

12 So I can see why my friend is asking for direction
13 here, because right now, as it is, we have a problem,
14 because the Hearings Director is looking for one day
15 when the defence has made it very clear there needs to
16 be two days, which is perfectly reasonable, and he has
17 a right to full answer in defence.

18 So I'm going to keep my calendar as open as I
19 possibly can. I'm open all through May, I'm open
20 almost all of June, I'm open all of July, so is my
21 client. As soon as -- the soonest that everybody else
22 can get two consecutive days, I'm going to be there,
23 unless it happens to fall on the one or two days in May
24 or June or July that I don't have available. So
25 Dr. Wall is obviously not trying to delay this, okay?

26 I'll remind you that the initial delay was the

1 College's -- I won't say fault -- it was due to the
2 College, okay? Dr. Wall filed his expert reports in
3 April 2021, almost a year ago now, and we were gearing
4 up, ready to go, and the College had to say, No, we're
5 not ready.

6 And so here we are, you know, over a year later,
7 after all this happened. That's not on Dr. Wall. He's
8 keen to see this go through, he's ready to see it go
9 through, but he has a right to full answer in the
10 defence, and he's going to assert that, and he's going
11 to require two days for closing argument. Those are my
12 submissions.

13 THE CHAIR: I think before we caucus to
14 consider a response, I will say that I can't speak for
15 the two regulated members on the Panel, but I can speak
16 for myself, and I think I can -- it's probably the same
17 situation for Doug -- we're under significant demands
18 these days. I'm booking 10 to 15 days a month for
19 hearings, so it's difficult to find these periods of
20 time. I know everybody has demands on their calendar.

21 We all just had a month off at -- some weeks off
22 at Christmas, but fair enough, Mr. Kitchen, we will --
23 the Hearing Tribunal will caucus with counsel, and
24 we'll take a -- and I hate to start doing this, but
25 we'll take as short a break as possible, we'll be back
26 in 10 minutes. If not, we'll let Amber know, and she

1 can advise everybody, and then hopefully we can move
2 forward. So if you could -- thank you, Amber.

3 (ADJOURNMENT)

4 THE CHAIR: Well, the Hearing Tribunal and
5 our counsel have considered the information we were
6 presented with. I think our conclusion is that
7 expecting to conclude final arguments and deliberations
8 on the same day is probably not realistic. We also
9 need time, and we also do not want a break following
10 closing arguments until we're able to meet and
11 deliberate on this matter. So I think it's realistic
12 to ask for two days and to find two days that are
13 consecutive. I'm not going to ask people to look at
14 calenders now. Perhaps we can do that over lunch or at
15 the end of the day.

16 I think we should get back on track and get this
17 witness in, but I will say that the Hearing Tribunal
18 has confirmed that they would be willing to meet on
19 April 3rd. We're meeting on Saturday, tomorrow, so if
20 Sunday, April 3rd, is an option, that could be two days
21 in a row. Otherwise, Ms. Nelson will be back in the
22 position of asking people if they could -- perhaps
23 there's been changes to people's calenders, but,
24 anyway, try and find two consecutive days.

25 It is a big -- I appreciate Mr. Kitchen's
26 comments, there is a lot of evidence to cover, there's

1 also some complex legal arguments to be made, and I'm
2 sure Mr. Maxston will have significant submissions to
3 make as well, so we will try to find two days. I'm not
4 going to cancel April 4th at the moment until we've
5 found an option, but we will ask Amber to focus on
6 doing that as soon as possible.

7 I understand that there's costs. These hearings
8 are not cheap. That's the cost of doing justice, and
9 that will be -- potentially it could be part and parcel
10 of any final decision on this, but, in any event, we do
11 not want to be in a position of telling either party,
12 the College or Dr. Wall, how to present their final
13 arguments. So we will look for two days. Hopefully
14 everybody will be able to find something in their
15 calendar that works without us incurring a further
16 undue delay.

17 On that note, Mr. Maxston?

18 MR. MAXSTON: Yeah, Mr. Chair, I just had
19 two comments, and I don't want to belabour this, I,
20 unfortunately, am out of town for that weekend, so the
21 3rd would not work for me, and my second thought was I
22 would suggest that we simply ask Ms. Nelson to send out
23 a Doodle poll as soon as possible, that we not try not
24 to compare schedules. I find that sometimes gets a
25 little cumbersome, as everybody's flipping back and
26 forth. Perhaps we could ask her to send out a Doodle

1 poll, you know, quite quickly with a two-day block.

2 The other comment I wanted to make was to my
3 friend, Mr. Kitchen, and it might assist him in terms
4 of Dr. Bridle, I've spoken with my client, and in terms
5 of the qualification process and your questions,
6 Mr. Kitchen, for Dr. Bridle; my client is prepared,
7 subject to hearing from you in terms of, you know, the
8 basis on which you're tendering your expert, my client
9 is prepared to accept him as an expert witness without
10 you having to go through, in any kind of detail, his
11 qualifications, making again the same -- or submitting
12 the same caveats we have before, that these issues are,
13 you know, compliance issues and not scientific masking
14 issues.

15 I don't know if that will assist you, Mr. Kitchen,
16 or if you want to go through, I'll call it, a typical
17 qualification process, but it might save you some time.
18 I anticipate your -- the basis on which you're going to
19 be tendering your expert witness is going to be, you
20 know, fairly similar to what you've done before, and
21 I -- if we can save some time that way, we're prepared
22 to do that. I'll leave that with you.

23 MR. KITCHEN: Well, thank you, I appreciate
24 that. I think that is probably an approach that I'll
25 take for Dr. Warren tomorrow, and I will send you a
26 proposed qualification today so that, you know, you

1 have notice about it tomorrow, and you can let me know
2 if there's any issues.

3 Today I am going to run through qualification with
4 Dr. Bridle, even though I don't anticipate a lot of
5 objections, and it will be similar to what I've asked
6 with Dr. Dang, but it's slightly different, and so I am
7 going to establish the record for that.

8 THE CHAIR: Okay, well, thank you both.
9 It's 8 minutes to 10, let's just take a quick break,
10 and then we can plow through until lunch. We'll start
11 at 10:00 with Dr. Bridle, okay?

12 MR. KITCHEN: Ms. Nelson, could you just --
13 because I haven't been able to communicate with
14 Dr. Bridle. Could you just let him know that we're
15 going to start at 10 so he has a heads-up?

16 MS. NELSON: Yes, I can do that for you.

17 MR. KITCHEN: Okay, thank you.

18 THE CHAIR: Thank you. And then, just to
19 confirm, April 3rd is off the table.

20 (ADJOURNMENT)

21 THE CHAIR: We're back in session. Just
22 two very quick items before I turn the floor over to
23 Mr. Kitchen. I wanted to ask, Mr. Kitchen, do you have
24 any documents that you plan to share with -- today or
25 table?

26 MR. KITCHEN: No. Dr. Bridle's report and

1 his cv are part of the record, so you should have
2 access to them.

3 THE CHAIR: Okay.

4 MR. KITCHEN: Please let us know if you
5 don't, and that's all I intend. So I mean that could
6 change if my friend brings something in, and then I
7 need to bring something in in -- I don't anticipate
8 that, but certainly for my direct, no documents.

9 THE CHAIR: Okay. And I just would like
10 to tell people that during our first break to discuss
11 your opening comments, one option we did look at very
12 briefly and discarded was the option of having written
13 closing arguments, and we decided that that was not an
14 attractive option for this case, but we did -- we were
15 trying to look at all options, and that was one that
16 was brought up.

17 So with that note, I'll ask Mr. Kitchen to call
18 your witness, and we can continue.

19 MR. KITCHEN: Sure, Ms. Nelson, if you could
20 bring him in, and then we'll -- and then, Karoline, if
21 you can swear him in.

22 (DISCUSSION OFF THE RECORD)

23 DR. BYRAM BRIDLE, Sworn, Examined by Mr. Kitchen

24 (Qualification)

25 Q MR. KITCHEN: So, Dr. Bridle, just to make
26 sure that you know where we're going, I'm going to be

1 asking you what we call qualification questions, and
2 then I'm going to be offering to the Tribunal the
3 qualification I'm going to qualify you as, they'll make
4 a ruling on that, my friend will have a chance to give
5 some comments, and then I'll get into questioning you
6 on substance, but this shouldn't take too long.

7 So to start with, Dr. Bridle, are you a doctor
8 because you have a Ph.D.?

9 A Yes, that is correct.

10 Q What's your Ph.D. in?

11 A It's -- okay, so my training is -- well, I guess is
12 to -- for -- to have a full understanding, I have a --
13 first, I obtained a Bachelor of Science degree in
14 biomedical sciences, then a Masters of Science degree
15 in immunology, and then a Ph.D. in immunology, and then
16 I did a six-year post-doctoral fellowship to become
17 certified as a viral immunologist, and I now hold, in a
18 faculty position, as an associate professor of viral
19 immunology at the University of Guelph.

20 Q Thank you. Your Ph.D., when did you get that and from
21 what university?

22 A So it was from the University of Guelph, and I guess I
23 would refer everybody to my cv, I -- it's been so long,
24 I can't even recall the exact date.

25 Q That's okay. Are you a professor now currently?

26 A Yes, I'm an associate professor.

1 So just so everybody understands what that
2 entails, the initial appointment for people for
3 academics in a university setting is as an assistant
4 professor. And then if we have progressed
5 satisfactorily in our development as a faculty member,
6 we then undergo usually about within, on average, about
7 six years -- no, sorry, five, five to six years after
8 being appointed as an assistant professor, we have to
9 be -- we undergo a very rigorous review process where
10 our performance is assessed independently by at least
11 three world-renowned experts in the field.

12 And if our progress is deemed to have been
13 satisfactory, then typically what happens is we are
14 awarded tenure and promoted to the position of
15 assistant professor.

16 And then the final stage would be full
17 professorship, and that usually is about eight years
18 later with a similar process involved.

19 So right now I am an associate professor of viral
20 immunology.

21 Q Thank you. Have you received any awards or
22 recognitions within the last two years?

23 A Yes. So you want to just limit it to the last two
24 specifically --

25 Q Yes.

26 A -- or last --

1 Q Otherwise, we'd be here for a while.

2 A Okay. So, yes, so I've won several teaching awards.
3 So one of the awards that I received was the equivalent
4 of teacher-of-the-year within my college. It's the
5 most -- like it's a prestigious award that's awarded
6 within -- for, you know, the college that I -- for the
7 college -- among the colleges that I'm involved in
8 teaching in.

9 And what that entails is -- entails -- so I'm
10 involved specifically with training or teaching
11 veterinary students and -- in the field of immunology,
12 general immunology. And so what happens is that, just
13 like an M.D. program, it's a four-year -- it's four
14 years of classes, four-year program.

15 And so for that award, what happens is all of the
16 students in the second, third, and fourth year of the
17 program vote on who they felt the top -- who the top
18 professor is in that program. So that's one of the
19 awards that I won recently.

20 Also what happens at the end of every academic
21 year, the -- these professional students then vote on
22 who they felt the top professor was for that given
23 academic year, but I received that recognition, and
24 that's -- so we get voted in basically as an honorary
25 class president for that class.

26 I also recently received a research award for

1 outstanding research.

2 And I'm just trying to think, I think those are
3 probably key highlights, you know, to highlight my --
4 yeah, the fact that I have been objectively assessed in
5 terms of my teaching ability and research ability and
6 have been recognized in those ways as being above
7 average.

8 Q Thank you. Just give me one second, my phone was off,
9 but my answering machine is on; I'm just going to turn
10 it off.

11 THE CHAIR: I'll just mention,
12 Mr. Kitchen, for everybody, Dr. Bridle's cv and other
13 related information is in Folder E, and it's package
14 number 5.

15 MR. KITCHEN: Yes, thank you.

16 Q MR. KITCHEN: Dr. Bridle, have you -- are
17 you currently performing or overseeing research
18 projects?

19 A Yes, a large number. So I'm known as what's called a
20 research-intensive faculty member. So as faculty
21 members at any university across Canada, our work is
22 divided into three areas, and we all have -- we
23 dealt [sic] on to have unique what we call
24 distributions of effort.

25 So our work is divided among, again, three areas
26 of focus, one is research, one is teaching, and one is

1 service. And so in my case, my distribution of effort
2 is divided as such: 65 percent devoted to research, 25
3 percent devoted to teaching, and 15 percent devoted to
4 service.

5 And just so there's some perspective with that,
6 the sort of average dedication to research, like for
7 the average faculty member across Canada, would be more
8 in the range of 40 percent. So, therefore, I'm
9 considered a research-intensive faculty member, and so
10 that's an emphasis. And as such, I do have a fairly
11 extensive research program and research team that I
12 manage.

13 And so right now, active within my lab, there's
14 sort of three areas of research that I'm focusing on.
15 I do a lot of basic fundamental viral immunology
16 research in which we look at the post-immune response
17 to viruses and, you know, how we protect ourselves from
18 viruses following infection.

19 And then the -- and then there's two more
20 translational/applied areas of research. One is -- in
21 both cases, they're using what we call immunotherapy,
22 and the most common immunotherapy that I do research on
23 are vaccines. And -- and for two purposes: So one arm
24 of this program is focused on trying -- developing
25 vaccines for the prevention of infectious diseases, and
26 then the other one is for developing immunotherapies

1 for the treatment of cancers. Similar technologies can
2 potentially apply to both, certainly scientific, the
3 principles are fairly -- you know, overlap between the
4 two. So I have those three areas of research is my
5 emphasis right now.

6 And I guess I also, for full disclosure, just
7 because it's probably most relevant to what's being
8 discussed today, I did receive two grants to support my
9 research program, infectious diseases, one from the
10 Ontario Government and one from the Federal Government,
11 and those are a specifically to conduct pre-clinical
12 research in the area of SARS-Coronavirus-2 vaccines.

13 Q Thank you, you've answered some other questions I have.

14 And forgive me if this is not the right way to ask
15 this, but are you currently a reviewer or an editor of
16 any academic journals?

17 A I recently served as the guest editor for a special
18 issue of a journal for -- and the journal is known as
19 Vaccines, and that issue is now complete.

20 I do serve -- I'm active as a reviewer for many
21 scientific journals, so that's a regular part of my
22 job, and that comes under the service component that I
23 was talking about. So that service component not only
24 involves service to my institution, but it involves
25 service to the -- well, to the public, but especially
26 service to the larger scientific community.

1 And part of that is I serve as a reviewer on
2 multiple grant review panels, including grant review
3 panels for the Federal Government, and our -- that's
4 our primary source of academic funding in Canada for
5 medical research. So that organization is known as
6 C-I-H-R for short or the Canadian Institutes of Health
7 Research.

8 For that, I have served on multiple committees,
9 including one that looks at grants that are being
10 applied for in an area of cancer research, but probably
11 my most -- definitely my most substantial contributions
12 to that grant review agency has been serving on their
13 virology and viral pathogenesis panel. In fact, I am
14 currently serving a three-year term, invited term, as a
15 reviewer.

16 And I guess, not that I usually like to tout, you
17 know, things like accolades and awards, but, again, I
18 understand that it's important to also -- you're trying
19 to make considerations in this case about my potential
20 to serve as an expert witness, so I'd have to point out
21 that I have received three consecutive citations
22 from -- and so I guess I forgot to mention this when
23 you were asking about awards, because this is within
24 the last two years -- and my service on the
25 virology/viral pathogenesis panel, in which we
26 determined which Canadian research -- researchers get

1 funding in that area. I have received three
2 citations -- consecutive citations from CHR as being
3 one of their most elite reviewers, which is an award
4 given after the -- end of review competition, the
5 chairs of the review panels, and the CHR staff that
6 attended those panels identify the top 15 percent of
7 reviewers for that particular review cycle across all
8 of their panels, and then those top 15 percent receive
9 these citations and try to set that standard for what
10 the other reviewers should try and achieve in terms of
11 the quality of the reviews that they provide.

12 And so as part of my job as well, yes, I routinely
13 provide reviews, it can be to any scientific journal,
14 and I do it for a large number of scientific journals.
15 There's no limitation on that. Any scientific journal,
16 if they feel that a faculty member anywhere in the
17 world possesses expertise relevant to what that paper
18 is about, then they can contact us and ask us if we
19 would like to review. That's done on a voluntary
20 basis; we're not required to do it, but it's done on a
21 voluntary basis. And that is the foundation, the
22 underpinning of how we establish the most rigorous
23 scientific data.

24 So the top scientific data in the world of science
25 is what we refer to as peer-reviewed scientific
26 publications, and so those are -- that's scientific

1 data that has been compiled into what we call a
2 manuscript, and that manuscript goes to what we call
3 peer reviewers, that would be somebody like myself,
4 who -- and we can have no conflict of interest, no
5 connection with the authors of that paper. So that's
6 important to make sure it's fully objective. And
7 then -- in many phases, it's not even disclosed who
8 the -- now with a lot of journals, not even disclosed
9 who the authors are, to ensure that there can be no
10 biases.

11 And then we give our feedback, either we recommend
12 that the paper be rejected because the science is not
13 of a sufficient quality, or we can recommend that it be
14 accepted with different amounts of revision required to
15 try and increase the quality of the science. And so,
16 ultimately, if accepted, that means that -- so what
17 we're talking about when we're talking about
18 peer-reviewed scientific literature, that's the process
19 that's followed. And so, yes, I participate in that
20 and have done so for a large number of journals, and I
21 do it on a regular basis and have throughout the
22 duration of my independent academic career.

23 Q Thank you. When you do your research, you obviously do
24 a lot of it, do you sometimes work with other
25 scientists?

26 A Yes. Yes, my research team is highly collaborative.

1 So, again, if anybody would like to refer to my cv,
2 you'll find that -- so the way authorship works in --
3 certainly in the area that I work in and so the
4 academic realm, there is typically -- and it varies
5 from research area to research area, there's sort of
6 different conventions in the authorship of what
7 typically happens. When you're looking at these
8 papers, you'll often see a large number of names
9 listed, and so those are all the people who contributed
10 in some way to the sciences in that manuscript.

11 And the names that are at the beginning -- so this
12 is the case for sure with all of my citations, the way
13 it works, all the names at the beginning are typically
14 the trainees that did most of the hands-on laboratory
15 work, and then the names that are in the latter half of
16 the authorship are what we call the senior authors.
17 They're the ones that got the funding for the research,
18 that often design the research project, and they
19 oversee the management of the trainees that are working
20 on that and provide feedback and troubleshooting,
21 et cetera.

22 So -- and so when you're looking at sort of the
23 level of collaborative-ness, you want to know who the
24 senior authors are. And one of the -- and immediate
25 ways to identify that is -- I mean, so, obviously, when
26 I'm publishing something, my trainees are readily

1 identifiable typically because they're going to be from
2 my institution. Although with that said, I have many
3 trainees actually who have collaborated with mine from
4 other institutions.

5 But so when you look at that latter part of the
6 list, when you see people, especially from other
7 institutions -- and I mean if there are any other
8 faculty members as senior scientists, those are
9 collaborators, official collaborators.

10 And so, yes, I've collaborated extensively.
11 There's no way I could go through all of them, but I
12 collaborate with researchers from around the world. I
13 guess I can give you an example. So, for example, with
14 a recent publication that we had on SARS-Coronavirus-2
15 vaccines, for example, that was a strategic
16 collaboration with the National Microbiology
17 Laboratory, which is part of the Public Health Agency
18 of Canada, where they conducted part of our research.
19 There were three separate research groups at the
20 University of Guelph where -- that we came together
21 strategically to do this work. So that's one type of
22 example. So, yes, so I've collaborated with scientists
23 in the Government and lots of scientists from other
24 academic institutions, including others around the
25 world.

26 So, yeah, my research team is highly

1 collaborative, so every one of my publications
2 represents some type of formal scientific
3 collaboration.

4 Q Thank you. Have you published any peer-reviewed
5 articles or any other type of publications in the last
6 two years either on your own or collaboratively with
7 others?

8 A Yes. So I'm actually quite proud of that fact
9 honestly, and this is why: So just to understand the
10 setting, what happens is because of the lockdowns
11 related to COVID-19 policy, a lot of research programs
12 had to shut down and for substantial periods of time.
13 And, indeed, my research was declared nonessential, and
14 so the worst shutdown that we were facing originally
15 was a -- it turned out to be six months of interruption
16 to research, really nonessential research.

17 However, again, like I mentioned because I do --
18 because -- so this problem of COVID-19, specifically
19 SARS-Coronavirus-2, the virus that causes COVID-19,
20 because that's in my area of expertise and so many of
21 the -- so much of the research and research tools that
22 I work with were applicable, my group pivoted very
23 rapidly to focus on COVID research, and like I said, we
24 were successful in getting grants available to pursue
25 that.

26 So we have continued our cancer research, we've

1 continued our basic virology research throughout this,
2 but those two aspects have -- you know, we have
3 experienced substantial interruptions to those
4 components and -- but we focused our efforts on
5 infectious diseases on the SARS-Coronavirus-2.

6 And so as a consequence, in fact, the last two
7 years, remarkably despite that -- those, you know,
8 impediments to research, the last two years have
9 actually been my most productive in terms of
10 publications. I -- again, you'd have to look at my cv
11 to get the exact number. I -- what I can tell you,
12 yeah, well -- oh, yeah, so, actually, I do have a
13 fairly accurately grasp. We actually have so many
14 papers that are currently under review that have been
15 submitted that, you know --

16 What I can say for sure is that by the end -- by
17 Christmas of last year, over the last two years, I had
18 published 29 paper -- 29 peer-reviewed, scientific
19 papers in scientific journals that are indexed in all
20 the common databases and -- so 29 publications. And
21 since then, I have had two or three more published. I
22 have had two more accepted, and I have two or three
23 more that are currently under review.

24 So, yeah, so it's been quite productive, and so
25 the reality is -- so, for example, my institution,
26 again, that has garnered attention because the average

1 publication record for faculty, in fact, dropped off
2 substantially, to the point -- in fact, I should point
3 out -- we actually normally have a performance review
4 every two years, and because of this impact, our
5 actual -- first performance review was supposed to
6 occur very early on during the declared pandemic but
7 was cancelled because of this impact at that time. And
8 then we were supposed to have our last review very
9 recently because this has been going on for two years
10 now, and that's been cancelled.

11 So the next time we're going to have a review
12 actually is going to have been -- at this point, it's
13 going to have been a six-year gap, and that is to
14 recognize the fact that it was unfair to evaluate the
15 performance of faculty members who had had such massive
16 interruptions to their research programs and their
17 ability to be productive.

18 So, in fact, you can't expect the review
19 committees to review six years of progress from every
20 faculty member, so what's happening -- so, in fact,
21 it's just been assumed that everybody -- at my
22 institution, that everybody has performed reasonably
23 well, because it actually gets linked to pay bonuses at
24 the end of that two-year period, and so everybody will
25 get the same pay bonus. And then when we have our next
26 review, which will have been a six-year gap, it will --

1 we'll be starting from scratch again in terms of a
2 review.

3 So, yeah, that's where I'm at with the publication
4 record that I am particularly proud of, that my
5 research team has been so incredibly productive
6 throughout all of this, so that's kudos to them.

7 Q Thank you. And just to clarify some of those
8 publications have been related to SARS-CoV-2 and/or
9 COVID-19?

10 A Yes, that's true, yes, we have several peer-reviewed
11 publications dealing with SARS-Coronavirus-2.

12 Q Have you been an expert witness in legal proceedings
13 before today?

14 A I have. So, yeah, to disclose my involvement with
15 those, I was in one that was ultimately not heard -- I
16 was -- I -- so -- and the first one that I was involved
17 with related to Corona -- SARS-Coronavirus-2. I served
18 as an expert witness, was involved with various aspects
19 of that case for many months leading up to it. I was
20 cross-examined for 5 hours and 15 minutes for that
21 case, but, ultimately, that case was thrown out. So
22 I'm not a legal expert, but my understanding,
23 therefore, is that I was not officially qualified as an
24 expert in that case because the case ultimately was not
25 heard, and my understanding is that's a requirement to
26 be considered qualified, but I served as an expert

1 witness in that case.

2 I have -- I've served in an unofficial capacity
3 for hearings that were run like court hearings for --
4 the most recent one was for a physician in Ottawa, an
5 ear, nose, and throat specialist, who was -- and this
6 was due to the vaccine mandates and whether or not
7 they're privileged to serve into hospitals in Ottawa
8 should be taken away because of not accepting, you
9 know, the two jabs in that case, but that was not an
10 official court proceeding, but it was run by lawyers.

11 And then I was also involved in a court case
12 dealing with vaccine mandates that were -- that was --
13 this was for hospital workers in Toronto, and now that
14 one is more complicated honestly. Again, I don't have
15 the legal expertise, but it was my understanding and
16 the understanding of the legal team that had recruited
17 me to provide expert evidence to the people hearing the
18 case that I had to qualify as an expert.

19 What I can tell you is that the -- one of the two
20 experts on the -- serving on the other side, they
21 were -- one was dismissed before the court hearing,
22 their expert report, and then the other one was
23 dismissed during the court hearing. Mine was
24 discussed, and the lawyers accepted my expertise, and
25 my report, my understanding was, had been admitted into
26 court. There was a court hearing. My report was

1 discussed.

2 But then in the final report, what confused
3 everybody is a -- the ruling ultimately was -- left
4 only my report on the table, because the other two had
5 been removed, and so, ultimately, the ruling was based
6 on wording that the lawyers had used to, I guess,
7 develop their case and not on the expert evidence. So
8 the expert evidence ultimately was not considered in
9 the ruling.

10 So, again -- so I was left with I had been told,
11 on one hand, that I was qualified as an expert in that
12 case, and then on the other hand, I was told that maybe
13 not because the expert evidence, ultimately, was not
14 considered. So that's just for full disclosure.

15 Because one of the things that I've got -- that
16 I -- that was brought up is anytime I -- I didn't know
17 from the first case, and I know it has to be disclosed,
18 and I didn't want to get in trouble, so I disclosed
19 that I was qualified as an expert witness in that --
20 the first case, and then I was accused of lying, but I
21 just didn't know because I'm not a legal expert, and so
22 that's been clarified.

23 So that's why, for your full disclosure, I want
24 you to know what's happened. So in that last case,
25 whether or not I was officially qualified, I'm actually
26 uncertain of, but certainly my -- in both cases, nobody

1 disputed my -- the ability to serve as an expert. And
2 in the last one, my expert report was actively
3 discussed in court. That's for full disclosure.

4 Q Thank you. Now, Dr. Bridle, do you know Dr. Curtis
5 Wall personally?

6 A I don't know him at all, no, and I -- so all I know is
7 the name, and, in fact, I still know very little about
8 him.

9 Q Do you have any financial interest in the outcome of
10 this case?

11 A No.

12 Q Do you understand your duty to provide this Tribunal
13 with your expert knowledge and opinions in an objective
14 and neutral manner?

15 A Yes, yeah, and that's -- as a scientist, that's what I
16 am expected to practice on a regular basis as I
17 mentioned, otherwise, the entire peer-review process
18 will be compromised, and I will endeavour to do that
19 today as well.

20 Q Thank you.

21 MR. KITCHEN: Well, those are my
22 qualification questions. Chair, I want to have
23 Dr. Bridle qualified as the following -- I can read
24 this a couple times -- but I want him to be qualified
25 as an expert in the area of viral immunology and, in
26 particular, SARS-CoV-2, COVID-19, and the efficacy of

1 masking, physical distancing, and other restrictions
2 intended to prevent the transmission of SARS-CoV-2.

3 THE CHAIR: Mr. Maxston?

4 MR. MAXSTON: Mr. Kitchen, I'm going to ask
5 you to read that back, I got part of it or most of it,
6 but I just need to hear all of it again, if you could
7 do that.

8 MR. KITCHEN: Yeah, no problem. I'd like to
9 have Dr. Bridle qualified as an expert in the area of
10 viral immunology and, in particular, SARS-CoV-2,
11 COVID-19, and the efficacy of masking, physical
12 distancing, and other restrictions intended to prevent
13 the transmission of SARS-CoV-2.

14 MR. MAXSTON: Thank you, Mr. Kitchen.

15 Mr. Kitchen, I don't want to -- I may have a
16 question or two for Dr. Bridle at this point, but can
17 you clarify what other restrictions you're referring
18 to? I don't want to be too difficult here, but that's
19 a little bit open-ended; I just wonder if you can
20 comment on that.

21 MR. KITCHEN: Sure. I'm going to ask Dr. --
22 what I anticipate asking Dr. Bridle specifically about
23 specific other restrictions, right. I've identified
24 masking and physical distance as specific restrictions,
25 right? But the reality is, and I -- you know, I think
26 we often hear this from the public health people is

1 that, Look, it's a whole, right? You can't talk about
2 these things very well isolated; they need to be talked
3 about as a whole. That's one reason I have that in
4 there is I'm going to have generalized questions, and
5 Dr. Bridle's going to have generalized answers, I
6 anticipate, about COVID restrictions globally or
7 generally. That's one.

8 And two, I'm following along the same lines that
9 you established with Dr. Hu, which I didn't take issue
10 with; you know, you had the catch-all other measures.
11 You know, I figured that was appropriate, so I didn't
12 object, and so I'm following along in the same vein so
13 that we don't get into issues of, well, you know, you
14 can only talk about masking or physical distancing.
15 That doesn't really make any sense. It wouldn't make
16 any sense for Dr. Hu, it wouldn't make any sense for
17 Dr. Dang, it wouldn't make any sense for Dr. Bridle, so
18 that's why I'm putting that in there; not because I'm
19 going to go to specific other restrictions, but because
20 I want to talk about them generally.

21 MR. MAXSTON: Okay, thank you for that. I
22 just have a couple of quick question for Dr. Bridle.

23 Mr. Maxston Cross-examines the Witness (Qualification)

24 Q MR. MAXSTON: Good morning, Dr. Bridle. I
25 wonder if you can answer a couple of quick things for
26 me. You had a discussion with Mr. Kitchen about the

1 fact that you have your Ph.D., I think you're a viral
2 immunologist. Is it correct that you're not a medical
3 doctor then? I just want to be clear about that.

4 A Yes, that is correct. I do not hold an M.D. degree,
5 nor a D.V.M. or any type of medical -- professional
6 medical degree. I'm not a professional --

7 Q And similar to that --

8 A -- (INDISCERNIBLE) --

9 Q -- are you now a member of a regulated profession
10 under, you know, the Ontario regulated Health
11 Professions Act or something similar?

12 A No.

13 Q So you're not a member of a regulatory college like the
14 College of Chiropractors of Alberta, for example, if
15 you were in Alberta?

16 A That is correct.

17 Q Have you ever been a member of a regulatory college?

18 A No.

19 Q I think you touched on this with Mr. Kitchen, but have
20 you advised any public health bodies concerning
21 COVID-19; have you been asked to consult with them?

22 A Yes. So I have -- so, for example, I've had numerous
23 interactions with the National Advisory Committee on
24 Immunization, lots of back-and-forth emails, so, yeah,
25 so that's a great question.

26 So I focus on research. I tend to focus more on

1 the pre-clinical side, feeding into the translational
2 research arm. I have had some of my research go into
3 clinical -- human clinical trials, but that gets passed
4 off to those who work on the clinical research side.

5 So the type of research that I do helps inform
6 public policy --

7 Q Yeah, I --

8 A -- public health policies but --

9 Q I think I --

10 MR. KITCHEN: Mr. Maxston, you need to let
11 my witness finish.

12 MR. MAXSTON: Yeah, sorry, sorry.

13 Q MR. MAXSTON: I just wanted to -- I didn't
14 want you to go down a certain road. I was more
15 interested in whether you, for example, worked with the
16 Ontario Chief Medical Officer of Health or anything
17 along those lines.

18 MR. KITCHEN: And he'll --

19 A No, I haven't worked directly -- sorry.

20 MR. KITCHEN: Obviously, he's going to
21 answer that question, but, Dr. Bridle, you are
22 permitted to finish your answer to my friend's two
23 questions ago.

24 A Okay, sure, yes. Yeah, so when it comes to public
25 health, the type of research that I do and the science
26 that I publish is what is used to inform public health

1 policy. So things like, for example, we've heard a lot
2 about the epidemiological modelling, so what -- so --
3 and what happens is when these epidemiological models
4 are made, there's a lot of assumptions that are plugged
5 into those.

6 And so, for example, the type of research that I
7 do would be important in terms of what kind of data
8 gets plugged into these models when it comes to
9 assumptions like naturally acquired immunity, for
10 example, or vaccine-related efficacy, right, these
11 assumptions that dictate how some of the measures right
12 now are performing, and that then influences the
13 output, which is when we're trying to predict what
14 cases and severe outcomes like hospitalizations and
15 intensive care unit admissions, for example, I get
16 into, just so that the -- everybody has an
17 understanding of sort of where I stand on that
18 spectrum. So my data feeds into that, you know, basic
19 science aspect that informs then these models and how
20 they're run.

21 But to directly answer your question, Mr. Maxston,
22 I have not worked directly with the medical -- with
23 Ontario's Medical Officer of Health. With that said, I
24 have provided letters to them, you know, with my input,
25 but I have not been formally recruited by them to
26 discuss, you know, scientific matters.

1 MR. MAXSTON: Thank you, Dr. Bridle, those
2 are all my questions.

3 Mr. Kitchen, I don't have any concerns with the
4 manner in which you're tendering this witness. I think
5 you've told me you wanted to have a little flexibility
6 in terms of the other restrictions phrased, and I'll
7 object if I need to, but I don't anticipate I would
8 have to do that.

9 MR. KITCHEN: Thank you. Well, Mr. Chair,
10 it's over to you then to let us know if you accept that
11 qualification. I can read it again --

12 THE CHAIR: Yeah, no, that's okay. I
13 think we all got it. Do we need to caucus, Mr. Pavlic?

14 MR. KITCHEN: You're muted.

15 MR. PAVLIC: My apologies, I had a little
16 bubble over my mute button. Yeah, maybe we should just
17 take a very brief minute.

18 THE CHAIR: Okay.

19 MR. PAVLIC: Yeah.

20 THE CHAIR: Thank you.

21 MR. PAVLIC: Thank you.

22 (ADJOURNMENT)

23 Ruling (Qualification)

24 THE CHAIR: We're back in session, and,
25 Mr. Kitchen, the Hearing Tribunal has no objection to
26 your qualifying this witness as an expert in his stated

1 field.

2 MR. KITCHEN: Thank you. Well, then I
3 propose we continue on with questioning, and then if we
4 need to take a break, then I'm sure somebody will put
5 their hand up.

6 DR. BYRAM BRIDLE, Previously sworn, examined by
7 Mr. Kitchen

8 Q MR. KITCHEN: Dr. Bridle, you can hear us,
9 right?

10 A Yes, I can.

11 Q Excellent, all right, well, I'm going to jump right in.
12 First, I want to start with a few basic questions,
13 I know you touched on this in the qualification, but
14 just to clarify, what is the virus that causes the
15 disease of COVID-19?

16 A Yeah, so just to be clear, the virus in question here
17 is known as the Severe Acute Respiratory
18 Syndrome-Coronavirus-2. It's specifically been given
19 that designation 2, because about 18, 19 years ago,
20 there was an outbreak, including in Canada, of the
21 original Severe Acute Respiratory Coronavirus, which is
22 now either just called SARS-CoV or sometimes now
23 referred to as SARS-CoV-1.

24 So this is dealing with the Severe Acute
25 Respiratory Syndrome-Coronavirus-2, which was first
26 identified and that information made public in the year

1 2019 now, late in the year 2019, and this is where we
2 get this term "COVID-19" from. So what COVID-19 is,
3 that's the Coronavirus disease, and then the 19 part
4 refers to that was initially identified in 2019.

5 And, again, yeah, to differentiate -- and this is
6 an important distinction for people to make --
7 SARS-Coronavirus-2 is the virus. COVID-19
8 is the disease. Being infected with the virus doesn't
9 equate with having a disease. To have a disease, one
10 must have signs for -- and/or symptoms of illness. So
11 there's a clinical part to that diagnosis. So, again,
12 one can be infected with the virus but not necessarily
13 have disease, and, in fact, scientific literature right
14 now shows that there's a much larger than previously
15 anticipated and still unknown proportion of the
16 population that has been or can be infected with
17 SARS-Coronavirus-2 and not get COVID-19, the disease.

18 And so a way to kind of make sure that everybody
19 understands that properly, we are all, all of us right
20 now, I can guarantee, are infected, infected with all
21 kinds of microorganisms, including lots of viruses. We
22 think -- we hear a lot about our microbiome, and we
23 often think about the bacteria that coat the outside
24 and inside of our linings specifically, like the
25 mucosal membranes throughout our body or gut, our
26 respiratory tract, reproductive tracts, et cetera, and

1 then, of, of course, our skin.

2 But part of that microbiome is also what we know
3 as the virome, so we actually have probably more
4 viruses in and on our body than we actually do
5 bacteria, and, interestingly, a lot of those viruses
6 are actually -- have infected the bacteria that are in
7 or on our body, and these are known as bacteriophage.

8 So I mean this just highlights that we can be
9 infected with an agent but not have disease, and so
10 that's the distinction here. SARS-CoV-2 is the virus
11 that, in some people, can cause the disease known as
12 COVID-19.

13 Q Thank you. Now, when it comes to the virus and the
14 disease and everything that's been going on in the last
15 two years, what would you say is the most important
16 difference or some of the most important differences
17 between scientists such as yourself and public health
18 doctors such as Dr. Hu?

19 A Yeah, so I can't comment specifically on Dr. Hu, but I
20 can provide some generic feedback, because, again --
21 so, for example, individuals like myself, again, so we
22 train -- we train medical professionals. In my
23 specific case, I've chosen to work with the University
24 of Guelph. I've been offered a position at the
25 University of Ottawa where I would have been teaching
26 students in the M.D. program, but because I felt I

1 could do more sophisticated research at the University
2 of Guelph, because there's more animal models available
3 and the type of research I do, I teach students in the
4 doctor veterinary program.

5 However with that said, I've also had many of my
6 undergraduate and graduate students that I've trained
7 and mentored have gone to medical school as well.

8 And so as a consequence because of this teaching,
9 I'm routinely involved with communicating, for example,
10 I've chaired for many years our department's seminar
11 series committee, and so through that, I host other
12 scientists through my collaborative network. I've been
13 in contact with all kinds of faculty members who teach
14 in these types of programs.

15 So what's important to note is when one has an
16 advanced degree, so, for example, a Master -- so that
17 would be like a Master's degree and especially a Ph.D.,
18 a Ph.D. takes it to a far greater extreme. What one is
19 being educated in in that area is a very deep
20 understanding of a particular area of expertise. So in
21 my case, I have spent years studying in incredible
22 detail the areas of virology and immunology, and
23 although not relevant to today, but also cancer
24 biology.

25 And so the key difference, what people have to
26 understand -- and, again, this -- I mean no offence by

1 this in any way, but it's just to encourage
2 understanding -- is if somebody holds an M.D., and the
3 same would be for a D.V.M., any of these professional
4 medical degrees, what you have to understand is when it
5 comes to the medical doctorate programs, these are
6 undergraduate programs -- they're undergraduate
7 professional programs, right? So people when they get
8 these degrees, they are declared professionals, but
9 they are undergraduate degrees. So that is why, for
10 example, if you see somebody who holds a graduate
11 degree, the graduate degree will always, even if it's a
12 Masters degree, it will always be listed after the
13 undergraduate medical degree, and that's to recognize
14 the fact that one is training at the undergraduate
15 level, whereas the other one is more in-depth training
16 at a graduate level. So literally -- so that's what
17 you'll typically see. So if I were to list my
18 credentials, I would be required to list my Bachelors
19 of Science first, my Masters of Science second, and my
20 Ph.D. last, and what we usually do is we just simply
21 list the Ph.D. because it essentially trumps the
22 others. So that's why you'll typically see -- not
23 people won't list the Bachelors or Masters, and I don't
24 like to do that because, you know, it's not about
25 trying to garner, you know, praise from others, it's
26 simply to recognize that, you know, ultimately we have

1 achieved -- we have -- we've got a Ph.D.

2 So that's why you see -- so the order in which
3 degrees are listed actually is important in the
4 scientific and medical community to recognize these
5 distinctions, and so at the -- so, in other words,
6 individuals like myself, who have deep expertise in
7 immunology and virology, so I would teach in these
8 programs in those areas that are under my expertise and
9 try and get as much of that expertise conveyed to the
10 people who are earning these undergraduate medical
11 degrees.

12 One of the universal concerns actually -- so when
13 I start my teaching -- and I mention this because it's
14 important to understand the full scope of your
15 question -- I -- so I -- one of the things I take pride
16 in, as far as I know to date within the D.V.M. program,
17 doctor veterinary medicine program that I teach, as far
18 as we know to date, it involves the most extensive
19 training in immunology in North America. I can't say
20 for sure, because I don't know what every medical
21 college in North America, what their programs entail,
22 but so far, and has been recognized by my
23 administration, we haven't seen one that's more
24 intensive.

25 And by that I mean, we teach -- I have 30 lecture
26 slots with my students to talk about -- you know, to

1 lecture them about immunology. Included with that is
2 we have what we call independent learning sessions,
3 where they also do some learning on their own about
4 immunology. We also have -- I've incorporated what I
5 call interactive learning sessions where we use a
6 technology called iClickers, where I can put up
7 questions and have the students then provide their
8 feedback so I can gauge how well they are or are not
9 understanding concepts, plus we have review sessions
10 where they can openly ask me any questions that they
11 want.

12 And then the other thing that we have is I run --
13 the class, because it's large, gets split into two, so
14 I run two laboratories split across two halves of the
15 class, so four laboratory sessions in total. So each
16 student gets six hours of laboratory exposure to
17 immunology, so hands-on learning.

18 So I just say that to put in perspective, because
19 in Canada, in the M.D. program, the average M.D.
20 program in Canada provides in the ballpark of ten
21 lectures, only lectures and none of these other
22 aspects, no laboratory, you know, hands-on learning,
23 ten lectures on average in the first year of the M.D.
24 program and less than that for virology.

25 So on the extreme end would be McMaster
26 University. I have had several of my students go to

1 McMaster University and of course to collaborate -- I
2 mean, I did my post-doctoral fellowship there, so I --
3 and I collaborate and still collaborate with people
4 from McMaster, so I know this very well. They're on
5 the extreme low end in Canada actually with five
6 lectures in immunology in the first year of the
7 program.

8 So I say that because when it comes to things like
9 immunology and virology, therefore, if it's just an
10 M.D., then somebody who just holds an M.D. and who has
11 not taken advanced training in these areas would have
12 only the most superficial understanding of these areas
13 of science. And at an extreme, it is possible to get
14 into these programs without completing an undergraduate
15 program. I'd like to point that out because their
16 undergraduate immunology training, for example, the
17 University of Guelph involves about 35 lectures in
18 immunology, so -- but those tend to be in third and
19 fourth year. People can get admitted into medical --
20 and they're not often prerequisites as well. So even
21 an undergraduate student with a Bachelor of Science
22 degree who has taken an undergraduate immunology
23 course, for example, from the University of Guelph
24 would have a much more comprehensive understanding of
25 immunology and virology than the average person at the
26 point of completing their medical doctorate.

1 Q Thank you. Okay, now I've got some questions about
2 your report. In Section 3 of your report, and just for
3 those following along, that's page 2 of 18. So in
4 Section 3, Dr. Bridle, you refer to the SARS-CoV-2
5 virus --

6 A Sorry, Mr. Kitchen, may I just ask a question; am I
7 allowed to bring up my report to refer to it?

8 Q Yes, yes, you are.

9 A Okay, I'm going to be looking -- I'm going to bring it
10 up on my -- I have a second screen here and that is
11 what I'm looking at. So, sorry, which page?

12 Q So I'm on page 2 and 3 of 18 pages, and this is Section
13 3, where you say: (as read)

14 SARS-CoV-2 is not a problem of pandemic
15 proportions.

16 A Okay, just let me get there, page 2. Yes, okay, I'm
17 there.

18 Q You discuss infection fatality rates in this. Well,
19 let's start here: Could you just briefly explain for
20 us, so we know, what is the infection fatality rate?

21 A Okay, yeah, so what -- infection fatality rate, what
22 that tells you is if you have a population and you can
23 confirm that an infection has occurred and how that --
24 and I want to point out how that is determined, what
25 method is used is important, because if techniques are
26 used improperly, one might be erroneously identified as

1 being infected. But so what infection fatality rate is
2 supposed to be is if somebody is genuinely infected, it
3 gives you an indication of what the chances are that
4 that is going to be fatal for that individual.

5 So the best way to understand it is, again,
6 because we're talking about percentages, it's best to
7 put it, give the example of how having a population of
8 100 people, so if you know what -- if you have a group
9 of people that you know for sure are infected with a
10 pathogen, then the infection fatality rate would tell
11 us how many, what proportion of those 100 people would
12 be expected to die as a result of that infection.

13 Q Could you please describe the relative danger of
14 SARS-CoV-2? And I say "relative" because, you know,
15 obviously we're not working in a vacuum here. So if
16 you could tell us the relative danger of SARS-CoV-2.

17 A Yes. So what I'd like to point out just before I start
18 giving the full answer, and I'll come back to this at
19 the end, there is -- what I want to point out is in my
20 report -- just, again, to put it in perspective, my
21 report was submitted I can't remember the exact date,
22 but it was, you know, well -- it was quite some time
23 back in 2021. So I'm going to talk about, because this
24 has been admitted as evidence, I want to talk about
25 what was available to me at that time, but it's
26 important to note that things have also changed quite a

1 bit in the context of the Omicron variant, so I'd like
2 to touch on that at the end.

3 So in terms of what I have in the report, what
4 you'll see is that ultimately I cite a scientific
5 paper, again, a peer-reviewed published paper that
6 estimates -- that estimated at that time that the
7 infection fatality rate for SARS-Coronavirus-2 was
8 likely in the ballpark of 0.15 percent. So, again, to
9 put that in perspective, if a hundred people were
10 infected with SARS-Coronavirus-2, you'd expect 0.15
11 percent of them to die.

12 Now, this is important because when the pandemic
13 was declared, many of us might recall or certainly you
14 can look up the, you know, the headlines, it was
15 declared -- there were concerns at the beginning,
16 because we didn't know a lot about this virus at the
17 very beginning, so what I'm referring to there is
18 towards the end of 2019 when this virus was first
19 identified, we didn't know, you know, what exactly the
20 outcome of infection would be, and there were serious
21 concerns that we might be looking at infection fatality
22 rates as high as 10 percent. So that was stated by
23 many health professionals including Anthony Fauci and
24 many others.

25 Then as time progressed, and we started to realize
26 that it was a relatively limited demographic that was

1 at high risk from this virus, that was rephrased, and
2 the concerns were then that this might be in the
3 ballpark of -- infection fatality rate might be in the
4 ballpark of about 1 percent, and that would be serious
5 if it was at 1 percent, definitely with 10 percent,
6 also at 1 percent. I would argue as an expert in this
7 area, a 1 percent infection fatality rate, that
8 declaration of a pandemic would likely -- would be
9 warranted at a 1 percent infection fatality rate.

10 But this is where it's important is what we soon
11 realized because of the way that the testing was being
12 done, and there'd certainly be flaws with the testing
13 as it's been performed in Canada, what I'm referring to
14 there are the reverse transcript-ase PCR tests or what
15 we often refer to as just the PCR test. "PCR" meaning
16 polymerase chain reaction test, which are -- the way
17 we're using them, they're notorious for identifying a
18 lot of false positives. So that's why you have to keep
19 sort of mentioning and when I'm giving these statements
20 that a lot of -- at its root is when you know
21 somebody's infected.

22 So what we know is that there have been a lot of
23 people who have been infected who never got sick, and
24 so initially our estimates of infection fatality rate
25 were based on people who actively had COVID. Now,
26 we -- again -- so, again, we recognize now that

1 there -- that there -- a lot of people can be infected
2 but for whom this is not even a pathogen. And what I
3 mean by that is because it does not count as disease in
4 those individuals.

5 For example, that's very common in children, and
6 one of the reasons for that is children simply have
7 physically expressed many fewer of the receptors the
8 virus uses to grab onto our cells and infect it. So
9 there's many children who get infected, but the
10 infection is -- never becomes productive enough to
11 cause disease.

12 And so as we've appreciated that, the way this is
13 calculated is, like I said, you have to have -- in
14 order to calculate infection fatality rate, you have to
15 know the number of deaths, and you divide that by the
16 denominator, which is the number of people who are
17 infected. So early on in this pandemic, we -- the way
18 this was being calculated, of course, we've always had
19 quite accurate numbers of deaths, because that's -- I
20 mean, you know, unfortunately, that is a very easy
21 outcome to define and identify and document, and
22 there's really -- there's no controversy about that
23 outcome, that a death is black or white, either
24 somebody's died or they have not. So we have very
25 accurate data about deaths.

26 The problem is we still don't have fully accurate

1 data for the denominator, which is how many people have
2 been infected. But as we have expanded the testing and
3 looking for evidence of -- and, again, it's not even
4 the virus but evidence that the virus is present in
5 somebody's body by detecting portions of the genetic
6 material that this virus would have, what we've been
7 able to appreciate is that the denominator -- the
8 denominators kept growing, in other words, right? We
9 have found that more and more people have been
10 infected.

11 So, for example, there's the great study that was
12 published, actually a Canadian study, a high -- that
13 was published in a very high-impact scientific journal,
14 and it was a clinical trial that was being run out of
15 British Columbia looking -- actually looking at healthy
16 people for evidence of immunity acquired against
17 SARS-Coronavirus-2, so, again, knowing that this was a
18 novel virus. And what it found is that a majority of
19 people who were not sick had evidence of having
20 acquired, especially as time has gone on, so a year
21 after the declaration of the pandemic, a large number
22 of people who were unaware that they were sick with
23 SARS-Coronavirus-2, you know, there was no sickness
24 that they could identify, had evidence of what we call
25 seroconversion, so the immune system having responded
26 to the virus and produced antibodies against it.

1 So what this publication that I cited here did is
2 it accounted for this ever increasing denominator, and
3 so it corrected for the early massive overestimations
4 of the infection fatality rate and came up with one
5 that they felt at that time was more reasonable. And,
6 again, I point out that this publication is from
7 earlier in 2021, much earlier in 2021. And they
8 estimated that the overall infection fatality rate was
9 0.15 percent.

10 So to put that into perspective for people, and
11 this is largely agreed upon, I mean people like
12 Dr. Fauci, for example, have publicly declared themselves
13 that, you know, the flu is often associated -- the
14 annual flu is often associated with an infection
15 fatality rate in the ballpark of 0.1 percent. So an
16 infection fatality rate of 0.15 percent would be like a
17 particularly bad flu season.

18 And the other thing to point out is when one looks
19 at this publication, that's the overall infection
20 fatality rate for the entire population. And in this
21 case, we know that this virus is much more dangerous
22 for a much more restricted subset of individuals,
23 specifically the frail elderly and those who are
24 immunosuppressed. And then we've come to identify some
25 very key predictors of dangerous outcomes of infection:
26 Obesity at the moment is the number one risk factor

1 associated with fatal outcomes, and alongside that are
2 multiple comorbidities. So the average person who has
3 died with SARS-Coronavirus-2 -- with the
4 SARS-Coronavirus-2 infection has had, on average, more
5 than three other comorbidities, meaning other
6 illnesses, other health problems in addition to
7 infection with the SARS-Coronavirus-2.

8 So why this is important is because if you were to
9 remove those individuals from this analysis, you end up
10 with an infection fatality rate for the rest of the
11 population that is well below 0.1 percent, with the
12 extreme being when you go into children. So if we go
13 to the under 18-year-old demographic, the infection
14 fatality rate would be well, well below 0.1 percent,
15 and our own public health data show that, that there
16 have been extremely few deaths. So, yeah, very few in
17 that young demographic. So -- but this is the thing,
18 so that's what I have in the report.

19 Now, what's important to note is that was dealing
20 with data where we were dealing with the original
21 variant and some of the variants that started to
22 emerge, so, for example, the Alpha variant. Those
23 variants we now know, certainly relative to the current
24 Omicron variant -- and I think this is important
25 because presumably I mean with this hearing happening
26 today, I guess we're talking about the relevance of

1 certain COVID-19 policies as it exists today. If we
2 ask somebody today to implement a certain policy,
3 what's relevant is what the situation looks like today.

4 So the Omicron variant is far more infectious than
5 the original variants -- actually I should restate
6 that. It's more infectious than the original variants.
7 The Delta variant was particularly infectious, that's
8 when we first saw a change in the virus towards one
9 that is more infectious and that can spread, therefore,
10 easier, and this seems to have continued with the
11 Omicron variant.

12 And this is very typical of viruses. What I'd
13 like to highlight is -- and so this leads to what we
14 call cases, right? Cases -- and, again, what I'd like
15 to point out is the cases that we are identifying in
16 our public health data are not actually cases of
17 COVID-19; they're cases that were called -- although we
18 often equate them to cases of COVID-19, what they are
19 in reality is they are positive test results, again,
20 for the presence of portions of the virus's genetic
21 material in an individual. So people tested positive
22 by the PCR test for -- and that provides some evidence
23 that they may be infected with a potentially infectious
24 form of SARS-Coronavirus-2. So that's important.

25 And what I'd like to point out is cases in and of
26 themselves are not dangerous. So if somebody were to

1 acquire any of the respiratory pathogens and develop
2 mild to moderate signs or symptoms of illness like
3 other common cold-causing viruses, including other
4 types of cold-causing Coronaviruses, like Norwalk
5 virus, like respiratory syncytial virus, and like
6 influenza viruses as examples, they would be cases of
7 respiratory illness. So that -- and all those cases,
8 those viruses are highly transmissible, but in most
9 cases do not cause -- well, I should -- I'll talk about
10 the cold-causing viruses, in most cases do not cause
11 severe disease.

12 So if we think about the common cold, highly
13 contagious. I mean, we've all seen this, especially
14 anybody who's been in -- volunteered in a school,
15 worked in a school, or has children in school, and in
16 also workplaces, schools especially, I mean, a cold
17 will spread rampantly throughout the school population
18 and in all the homes connected with the school. So the
19 ability to spread rapidly is not in itself a concern if
20 it's only causing, in most people, mild to moderate
21 disease. The reason why I focused on cold viruses is
22 they excluded things like respiratory syncytial virus
23 and influenza viruses, for example, because they
24 actually can be particularly dangerous, not only the
25 same demographics that we're talking about with
26 SARS-Coronavirus-2 but especially in young children,

1 which are quite -- actually protected because of that
2 unique physical, you know, lack of expression of the
3 receptor the virus uses to grab onto our cells that --
4 and it's not confined to SARS-Coronavirus-2, it's
5 unique in that our very young are not susceptible in
6 this case. But all these people are susceptible to
7 potentially severe and fatal outcomes with influenza
8 viruses and the young for sure with respiratory
9 syncytial virus.

10 And so that -- so that's why -- so, yes, so I want
11 people to understand Omicron is more -- because this
12 relates to the infection fatality rate, -- it can
13 spread easier, but it is definitely much less dangerous
14 than any of the previous variants. That is clear.
15 We're seeing that everywhere. I want to -- so what's
16 important to understand this -- is because of the
17 public health messaging, right, that's been out there,
18 and personally as an expert -- I have contentions with
19 this, but I'm just putting out what the public health
20 messaging is right at the moment -- is that the
21 vaccines being used for SARS-Coronavirus-2 have been
22 purported to be -- I mean, originally, they purported
23 to be very protective and protect people from infection
24 and disease and very good at preventing transmission.
25 That certainly has been downgraded, and I would argue
26 that current data suggests that they are not reducing

1 the spread of the disease at all.

2 In fact, the remarkable phenomenon and of concern
3 to me is that we're actually seeing cases occurring
4 predominantly among the fully vaccinated, which might
5 actually be evidence of vaccine-enhanced disease. But
6 I raise this because in vaccinated individuals, this is
7 the messaging, that it's supposed to be, supposed to be
8 reducing their chances of getting infected and their
9 chance of transmitting the virus to others. And yet in
10 all of our school and work environments where it's
11 almost completely people who are vaccinated, so there
12 should be reduced transmission and they're masking, the
13 viruses are still spreading rampantly. So this is the
14 nature of Omicron.

15 But our data also show that while the cases of
16 Omicron have skyrocketed across all of Canada,
17 including Alberta, the most serious outcomes have
18 steadily declined. So there's been a -- there's been,
19 over time, a complete uncoupling of cases and the most
20 severe outcomes. So as we've continued to have
21 these -- and, remember, the first wave early on in the
22 pandemic has been dwarfed by multiples -- recent waves,
23 including the most recent with Omicron, has completely
24 dwarfed the previous wave if you look on the graphs and
25 the number of cases that are occurring. Yet, we have
26 progressively gotten -- gone closer and closer to

1 baseline when it comes to hospitalizations and ICU
2 admissions and deaths, and so that's clear evidence
3 that Omicron is less dangerous.

4 Also biologically, I can explain why this is, and
5 it -- there's two phenomenon that explain why Omicron
6 now is much less dangerous than the previous variants.
7 So -- and this goes hand-in-hand actually with the
8 vaccines. The vaccines, unfortunately, we've delivered
9 them into the muscle, which is called a parenteral
10 route. That tricks the body, the immune system into
11 thinking that there's a systemic infection, not a
12 mucosal infection. Remember, the natural infection is
13 through the airways. And so when the body thinks that
14 there's a systemic infection, what it wants to do is it
15 protects all of the key entry points into the body to
16 protect from future systemic infections.

17 So when it comes to respiratory tract, the only
18 place that these vaccines confer some protection is in
19 the very lower airways, and that's because if a virus
20 gets into our lower airways, there's not much
21 physically to prevent that virus from getting into the
22 blood, and that's because of gas exchange, right?
23 We -- so in the alveolar space, we have blood vessels
24 that come very, very close to the alveolar space to
25 allow the gas exchange, oxygen to go into the blood and
26 carbon dioxide to be released. So that also means that

1 if a virus gets there, there's only the ever so tiniest
2 physical barrier to prevent it from getting into the
3 blood. So our body produces antibodies in the lower
4 airways.

5 So this is the thing -- and I say that because
6 this is important -- the most severe outcomes of
7 infection with SARS-Coronavirus-2 is when the virus
8 goes down into the lungs. When it's in the upper
9 airways, it's not particularly dangerous. When it gets
10 dangerous is when it gets down into the lungs, and it
11 causes a severe pneumonia, then you start getting
12 inflammation in the lower lungs, and that can interfere
13 with things like gas exchange, and it can cause a lot
14 of damage to the physical architecture of the lower
15 airways, which is where all the gas exchange has to
16 occur.

17 And when it gets into those lower -- in the lower
18 lungs, that's where the real problems are when the
19 virus then starts entering the bloodstream, and we get
20 what's called viraemia, and that means the virus can
21 distribute all throughout the body using the blood, our
22 blood, as highways of all the places -- all kinds of
23 different places in our body. So that's where the
24 severe outcome occurs.

25 And that's also why the vaccines with earlier
26 variants were doing, you know, a somewhat decent job at

1 dampening the most severe aspects of the disease. But,
2 as we've now recognized, they weren't preventing
3 infection, and they weren't preventing transmission.
4 And this is why they're having no impact on Omicron,
5 the spread of Omicron, is because -- this is the other
6 key biology you have to understand -- so if the virus
7 doesn't go deep in the lungs, you tend not -- you're
8 going to tend not to get severe disease. It's the
9 difference between bronchitis and pneumonia, and many
10 of us will know that pneumonia is -- has a much more
11 severe prognosis than bronchitis, which is the upper
12 airways. Pneumonia being in the lower airways.

13 So the interesting thing is Omicron now has
14 accumulated a lot of mutations, a lot of mutations, and
15 it has changed how this virus behaves. In one -- so
16 one way it changed it is has become more infectious,
17 but it's also become much less dangerous, because when
18 we talk about viruses, we refer to something that's
19 called tropism. Tropism is a scientific term that
20 means where the virus likes to go in our body. So the
21 original variants like to infect our upper airways and
22 then migrate into our lower airways, and that's where
23 they were dangerous.

24 The Omicron variant also infects through the nasal
25 passages and the mouth and infects our upper airways,
26 but it does not migrate down into the -- deeper into

1 the lower respiratory tract. It now has the more
2 restrictive tropism, meaning it likes to stay in the
3 upper airways. So this explains why the vaccines are
4 now largely irrelevant in the context of the Omicron
5 variant because the protection is in the lower airways
6 and not in the upper airways. And so somebody -- and
7 that also explains why the virus -- whether you have
8 immunity or not is not particularly dangerous because
9 it's restricted to the upper airways.

10 It also explains why everybody can equally
11 transmit the virus, because nobody -- well, sorry,
12 sorry, I -- that's untrue. I'm going with sort of the
13 public messaging that's out there. So I'll tell you
14 what the exception is to that. But it's thought right
15 now that everybody, whether or not they have been
16 vaccinated or not, can transmit at least the same
17 quantity of the virus because it's in the upper
18 respiratory tract.

19 But the reason why I want to point that out is I'm
20 an immunologist and have found it profoundly
21 frustrating that it's not recognized that our immune
22 system actually does its job and functions naturally.
23 The purpose of a vaccine is to simulate a natural
24 infection, try and do the best that we can to simulate
25 an actual infection as accurately as we can to confer
26 immunity. As I mentioned that these -- we've made a --

1 you know, the vaccines going parenterally actually
2 trick your immune system into thinking it's a systemic
3 infection, so we're not getting proper protection of
4 our airways.

5 Somebody who has been naturally infected will have
6 mounted an immune response, and their immune response
7 is going to be far more relevant, especially to the
8 Omicron variant, because they've been infected the
9 natural -- by the natural route. Our immune system
10 when infected by the respiratory tract makes sure that
11 it provides infector mechanisms that can protect all,
12 all areas of the respiratory tract, upper and lower.
13 So I want to point that out.

14 So we don't know a lot about natural immunity
15 because we haven't been looking for it, but somebody
16 who has natural immunity, we can't make any assumptions
17 about their health status without knowing, because if
18 somebody has natural immunity, they're actually going
19 to be the most protected in the context of Omicron, and
20 they're going to be the ones that spread the
21 SARS-Coronavirus-2 to the least of anybody in Canada
22 right now.

23 So I know that's a lot, but it's -- it's a lot of
24 science, again, to understand the importance of the
25 infection fatality rate, what it means, and why we have
26 been seeing it declining, and why we can conclude that

1 the danger of SARS-Coronavirus-2 even more recently has
2 continued to decline.

3 So, again, I'd just like to finish by, again,
4 saying SARS-Coronavirus-2 with the dominant -- the
5 variants out there right now, by far the dominant one
6 is Omicron. It is more transmissible right now and
7 much less dangerous right now.

8 And just to understand as well from the virology
9 perspective, that's typical for a virus. Any
10 pathogen -- so, again, you think about -- so if we
11 think about viruses as organisms, right, if we just
12 take that very like objective approach, and we think
13 about this from the perspective of an organism and an
14 organism trying to survive; it is never to an advantage
15 to any microorganism to cause severe harm or kill its
16 host, because if it does, it's going to render itself
17 extinct.

18 So what happens over time is, arguably -- so we --
19 we often forget about this, as I mentioned, our bodies
20 are loaded with viruses that causes no harm. The vast
21 majority of viruses that we're exposed to in the world
22 do not cause disease. That is where viruses want to
23 get to and for the reason of survival. Because, again,
24 like I said, if they were to infect the host and kill
25 that host, they're rendering themselves extinct.

26 So the natural progression for a virus is to

1 become -- so think about it, if you want to maximize
2 survival, if you want to maximize the number of your
3 kind, right, you can think about any organism, what you
4 want to do is maximize your ability to propagate and
5 minimize your ability to harm your host and especially
6 not kill them. And so that's why viruses over time
7 will naturally progress to ones that are more
8 infectious, because the more hosts they can infect, the
9 more they propagate, right, and the larger their
10 numbers become, but they simultaneously become less
11 dangerous, because if they were to kill all those
12 hosts, they're going to render themselves extinct.

13 So that's what this virus is doing, has been
14 doing. We have the evidence of this. This is the --
15 so this is a natural progression for this type of
16 virus: It's reaching -- starting to approach a more
17 ideal way to live with us by, you know, spread readily
18 among people but not cause substantial harm to people,
19 and it would probably -- likely continue to progress
20 this way ideally, and so that's very important to
21 understand.

22 So, again, just to highlight, being more
23 infectious does not equal more dangerous. Again, I'd
24 like to highlight the common cold is highly infectious,
25 but for most people not dangerous. That seems to be
26 where the Omicron variant is right now.

1 Sorry, Mr. Kitchen, it looks like you're muted.

2 Q Sorry, I muted, because I didn't want to cause any
3 noise to interrupt you.

4 Okay, if I understand you correctly then, we have
5 an infection fatality rate that has changed over time,
6 so I want to ask you a couple of questions about that.

7 You've said it's much less dangerous now. Can you
8 give me a rough number of what the IFR rate is now or
9 in the last few months? And I understand that might be
10 several decimal points, but if you could give us some
11 idea just so we have a number.

12 A Well, actually I haven't seen a good, reliable
13 peer-reviewed publication on that actually, and that's
14 because the Omicron variant, you know, has -- it's
15 quite recent, and, again, that would be the most
16 relevant data. So all I can tell you is that, again,
17 based on what I described for -- relative to the data
18 that I highlighted -- that was highlighted in my
19 report, which is dealing with older variants that
20 unquestionably were more dangerous to the high-risk
21 demographics, the Omicron is much less dangerous. So
22 all I can say with certainty is that it would be well
23 below the previously documented 0.15 percent, but I
24 don't have a specific number that I could give you
25 right now upon which I -- for which I could lean on a
26 legitimate peer-reviewed scientific paper.

1 Q Let me ask you this: Is the survivability rate sort of
2 the other side of the coin of the infectious fatality
3 rate?

4 A Yes.

5 Q Okay, so, you know, the 99 percent --

6 A So sorry, could I just clarify that, Mr. Kitchen?

7 Q Go ahead.

8 A So, yeah, so, in other words, just to make sure that
9 it's clear, yes, absolutely, infection fatality rate, I
10 mean, so if you take the inverse of that, that's the
11 survivability rate. So that infection fatality rate
12 that was updated early in 2021 of 0.15 percent, the
13 other way to put that is that 99.85 percent of those
14 deemed to have been infected with the virus would be
15 expected to survive, and, again, that was with the
16 older, more dangerous variants.

17 Q Okay, so just to clarify, 99.85 survivability rate,
18 that would have been the number in 2020?

19 A So, again, this is -- that publication was -- that I
20 cited was in 2021. It would have taken into account
21 data up until very early in 2021.

22 Q Okay, okay. So the survivability rate being 99.85 in
23 2020, that's gone up since 2020?

24 A Absolutely, yes, in the context of the Omicron variant.
25 So like I said, so in terms of that data, yeah. What
26 I've looking at, in particular, is the public health

1 data. And so, again, there -- so anybody can go to
2 public health websites to see this for themselves. But,
3 for example, I'm in Ontario, but Ontario, I mean,
4 there's nothing particularly unique about our
5 demographic relative to most of the other provinces,
6 especially Alberta, so a lot of our data are very
7 similar.

8 So, for example, like I mentioned public health
9 data, so I'm talking about this is not looking at
10 anybody else's interpretation of the data; this is the
11 public health data, the raw public health data that's
12 available to every Canadian. So you could go right now
13 onto the Public Health Ontario website or Public Health
14 Alberta website and see these data to confirm.

15 This phenomenon, which I get has caused some of us
16 to be worried about, that the vaccines in context of
17 the Omicron variant have actually set up the immune
18 system to respond suboptimally, meaning that there
19 might actually be enhanced potential for infection of
20 those who are vaccinated, right? What we see in terms
21 of public health data is that the cases right now have
22 been occurring for the past month. This happened --
23 this crossover happened at about -- at about -- well,
24 in Ontario it happened on Christmas Eve. In Alberta,
25 for example, the crossover happened a little bit later,
26 up to a week later. But now the -- for the last month,

1 the -- with the Omicron wave, the number of cases have
2 been occurring disproportionately among
3 double-vaccinators.

4 So that then -- so that's the public health data
5 that I'm relying on. So the same public health data,
6 when you look at it -- and so because I know the -- I
7 can -- I know the numbers much better off the top of my
8 head for Ontario, that's what I'll use as my example.
9 So keeping that in mind, simultaneously, the public
10 health data has been looking at the most severe
11 outcomes, and that includes data on hospitalizations.
12 So the way in Ontario we show it is hospitalizations
13 but not including admissions to ICU units, and then we
14 also look at the proportion of people that are in --
15 have been to the ICU unit, and then we also have data
16 on deaths. And so when we look at these outcomes, so
17 as we've seen this huge spike in the -- massive spike
18 in the cases of, again, I don't want to say COVID-19
19 but certainly infection, evidence of infection from
20 SARS-Coronavirus-2, of which a proportion of those
21 would have COVID-19, we have simultaneously seen,
22 again, an uncoupling of the most severe outcome. The
23 number of people admitted into the ICUs and hospitals
24 has been lower, so despite record cases, it's been
25 lower than the previous waves. All the more -- most
26 severe outcomes have been reduced. Again, so I

1 highlight this shows an uncoupling of this idea of
2 infectivity and the most severe outcomes of the
3 disease.

4 And this is important as well because -- well,
5 yeah, I guess I'll leave it at that, yeah. So using
6 public health data, so, again, I can't use that to give
7 you a specific infection fatality rate, current update
8 of one, but all I -- what I can tell you is the same
9 public health data that existed when this 0.15 percent
10 infection fatality rate was estimated, right, compared
11 to the public health data available now, the public
12 health data is clearly showing this is less dangerous.
13 So, again, I highlight that it -- the current rate
14 would be less than .15 percent, but I can't
15 definitively state what it would be.

16 Q I want to make sure we understand this, because I don't
17 think any of us are mathematicians, with a 99.85
18 survivability rate, if 1,000 people were actually
19 infected, statistically, how many of those would die?

20 A The -- so you're saying 1,000?

21 Q 1,000, yes.

22 A Okay, and this is with the assumption of .15 percent of
23 infection fatality rate? Is that what you're --

24 Q Yeah, exactly.

25 A -- wanting me to do? So that would be -- so 1.5 [sic],
26 and based on basic math, if we round up at a decimal

1 point of .52, two people. So I guess the more accurate
2 number, therefore, would be you would have -- because
3 rounding up actually has a substantial -- you're
4 increasing the outcome by -- what is that -- by a
5 third, so 2,000 people infected. In fact, in early
6 2021, you would have expected 1 to die.

7 Q Okay so if 10,000 people are known to be infected,
8 statistically, 15 of those would be expected to die?

9 A Yes -- back in 2021, early 2021. Not --

10 Q Okay --

11 A -- now, not now. It would be -- it would be --

12 Q Right.

13 A -- likely be much lower, but how much lower I can't say
14 definitively.

15 Q Now, you obviously touched on this, but the next thing
16 I wanted to ask you is about the issue of endemic,
17 because you touched on this in your report. Now, I'm
18 now in Section 6 of your report. I'm not necessarily
19 going chronologically through your report, but the
20 issue of endemic, first, can you help us understand --
21 because I know you used that term -- can you help us
22 understand what "endemic" actually means comparative
23 to, let's say, "pandemic" or "epidemic"?

24 A Yeah, obviously with the timing. So an epidemic and a
25 pandemic, you're dealing with an acute scenario,
26 meaning short time frame, where an infection is

1 occurring and spreading, and the difference between an
2 epidemic and a pandemic is the scope, the scope of the
3 problem.

4 So with an epidemic, the scope is much -- on
5 a much smaller geographical scale. So, for example,
6 with the SARS -- the original SARS, Severe Acute
7 Respiratory Syndrome by Coronavirus that caused the
8 disease SARS, which we called, you know, at that time,
9 the Severe Acute Respiratory Syndrome was the disease,
10 that was -- because it was much more limited scope,
11 that was declared in Canada to be an epidemic.

12 So a pandemic is all dealing with the scope. So
13 if it's on a much broader scale, and in this case, you
14 know, if that -- it's on a global scale, then it gets
15 declared as a pandemic. If the dangerous, right, the
16 most dangerous outcome -- because, again, I have to
17 highlight, so, for example, if you have a common
18 microbe that's part of the human microbiota, that's
19 something that can readily be transmitted potentially
20 around the globe, but if it has no dangers associated
21 with it, although it has that same scale, it's not
22 going to be defined as a pandemic.

23 So that's the two things, there has -- there's two
24 things for -- to declare something a pandemic: There
25 has -- it has to meet a certain threshold of danger and
26 a scope, a very large scope of the problem. But, yeah,

1 so that's dealing with things in the acute or
2 short-term.

3 When we talk about something being endemic, we're
4 talking about something long-term. So the -- most of
5 the Coronaviruses that we're used to, the ones that
6 cause the common cold, like I would argue the Omicron
7 variant is likely one that -- and the way it's behaving
8 is starting to fit largely into this category. They're
9 what we would call endemic; they're always with us,
10 right? We're always interacting with them. They're
11 always causing some form of mild disease.

12 So in that context, you know, we would not
13 declare -- so a cold definitely, even in terms of the
14 scope of a cold or the flu -- and the flu is a good
15 example. The reason why the flu sometimes meets this
16 threshold of an epidemic or pandemic is because the flu
17 can be very dangerous, right? So we've heard of flu
18 epidemics, and we -- you know, we -- many of us now
19 have probably heard, in one form or another, of the
20 Spanish flu outbreak in the early 1900s, right, which
21 was declared a pandemic. And we have had a pandemic
22 flu also declared as swine flu in the 2000s, back
23 around 2009. So, you know, that's because they can
24 spread on a large scale. But the flu gets called an
25 epidemic or a pandemic because it is also associated
26 with high fatality rates in those cases.

1 Now, when it comes to the common cold, again to
2 differentiate, the common cold spreads at least as
3 readily as the flu. So in terms of scope, it would fit
4 into the definition of an epidemic or a pandemic, but
5 it's never going to be declared as such because it
6 never reached the threshold of danger.

7 So these viruses -- so what "endemic" means is if
8 it is -- essentially in layman's terms, it would mean
9 these are viruses that we basically have to learn to
10 live with over the long term. So SARS-Coronavirus-2,
11 we can see we've tried -- we've tried all kinds of
12 things to stop it for two years. Not only have we
13 failed, it's -- I mean, it's spread among people better
14 than it ever has in the two years in the form of the
15 Omicron variant, right? And that, we just have to show
16 the number of cases. So that -- the virus has been
17 very successful in bypassing all of our attempts to
18 stop it.

19 The ideal, the ideal outcome, if you're dealing
20 with something that causes disease and you identify it
21 at the epidemic or pandemic stage, meaning short-term,
22 the ideal outcome, right, and the goal that we would
23 always have would be to eradicate that pathogen so we
24 never have to deal with any risk of illness from it,
25 again.

26 But an endemic agent is one in which we have

1 failed to eradicate it, and the virus now is able to
2 bypass any and all the barriers that we put up to try
3 and stop it. So there's no question, no question, in
4 my professional opinion, this virus has all of the
5 characteristics of an endemic pathogen now, including
6 the fact that we can already define it as being with --
7 having been with us for long term, right? It has now
8 existed, and we don't know how long it existed before
9 it was identified, but if we go with the starting point
10 being when it was first identified, it's now been with
11 us for over two years. That alone suggests it's
12 endemic.

13 The fact that our most recent wave was just
14 completely out of control in terms of cases, not in
15 terms of danger, again, show this is going to be
16 endemic, and the reason -- there's several biological
17 reasons. These are viruses that are amenable to
18 mutation. The Coronaviruses will just constantly
19 mutate. That's why we keep getting the cold.

20 Corona -- and to explain this, the reason is in
21 order for a virus to propagate, it has to copy itself.
22 When these viruses copy themselves, they actually -- so
23 you think about this as -- literally if somebody is --
24 if you want to photocopy -- the way I like to explain
25 this, say you have a report, a very large report of
26 hundreds of pages that you want to copy, if you put it

1 on a modern state-of-the-art photocopier, almost all
2 the time, you are going to get a complete, you know,
3 100 percent accurate replication of that document,
4 right, the copy that you pull up; you're going to have
5 all the pages copied. Many of us had familiarity with
6 some of the, as we were developing this technology, of
7 not having to put one page at a time on top of the
8 glass and copy, many of us have had the experience of
9 the early versions of doing the fully automated
10 copying, and it would be very frustrating, because you
11 would end up with, at the end, you would find out, as
12 you take the document back to your office and you start
13 going through it, you're missing page 7, and you're
14 missing page 132, there was a paper jam, you know, that
15 occurred or something.

16 So that's what these viruses are like, when they
17 copy their genetic materials, they actually have built
18 in to -- and this is a survival mechanism -- they have
19 built in, so that copying process, and it's an
20 error-prone process, intentionally error-prone. It
21 incorporates mistakes into the copying the genome, and
22 that's so you end up with different versions of the
23 virus that can probe the environment that it's in, and
24 if that change confers an advantage to the survival of
25 the virus, that subspecies of the virus will start to
26 dominate. That's how this happens. And so that's why

1 we're always going to -- we're never going to be able
2 to stop these viruses from mutating, and that's why
3 they become endemic.

4 So for the flu, for example, the flu is actually
5 way better than Coronaviruses, including
6 SARS-Coronavirus-2, at mutating. It mutates much more
7 rapidly. That is why our flu vaccines are so
8 ineffective from year-to-year, because if we were
9 dealing with the same strains that we were dealing with
10 the previous year, our vaccines would actually be much
11 more effective, because they're based on last year's
12 strains. The problem is we're using last year's strain
13 to educate our immune system to deal with a much
14 different-looking current strain.

15 So it's not as extreme as that with the
16 Coronaviruses, but they do the same, just a -- slower,
17 slower. And so that means that, almost certainly, we
18 are going to be, whether vaccinated or not, no matter
19 what we do, I can pretty much guarantee, and no matter
20 whether we have been naturally infected or not, I
21 pretty much guarantee we are all going to be infected,
22 for the rest of our lifetimes, with the
23 SARS-Coronavirus-2 repeatedly. It won't be as often as
24 the flu, because, again, it takes longer to mutate, so
25 I -- but we will all be infected and reinfected.

26 But, again, based on the course that it's been

1 following, that if it's like these other pathogens,
2 they will be relatively mild to moderate infections,
3 just like all of the other endemic respiratory
4 pathogens.

5 And what we'll have to be diligent about is, like
6 all these other respiratory pathogens, we will have to
7 be diligent to look after the very high risk but
8 limited demographics. So, for example, even the common
9 cold can potentially be dangerous, for example, in
10 babies and the frail elderly, right? So that's what we
11 mean by endemic.

12 And in my professional opinion, this virus is now
13 endemic, and it's going to be with us likely for the
14 rest of our lives. I don't see how now we can possibly
15 render it extinct from the globe.

16 Q So does that mean all of our measures right now to
17 attempt to prevent the spread of SARS-CoV-2 are
18 completely futile?

19 A There's one thing -- well, so I can tell you, the most
20 dominant benefit -- beneficial, you know, strategy that
21 anybody can use with any respiratory pathogen,
22 including SARS-Coronavirus-2, is stay home when you're
23 sick. That applies to any of the respiratory pathogens
24 that we have, and so we -- well, that's the one thing
25 that I really, really, really, really hope the global
26 population will have learned from this declared

1 pandemic is just what I call is basic social hygiene.
2 This has been the most frustrating thing for somebody
3 who has expertise in this area.

4 I see it in my workplace, and, I will admit, I'm
5 guilty as charged at times. As a faculty member, there
6 are certain deadlines that we absolutely -- I mean, we
7 can't push them off. So, for example, I have to get
8 grants in order to pay my research team and run the
9 research that I do. So if there is a grant deadline, a
10 submission deadline, and I say, I'm sick, I'm -- so,
11 therefore, I'm not going to go into work, and I'm not
12 going to submit this grant; the granting agency is
13 never going to give me an extension. I lose the
14 ability to get that funding.

15 So there are times -- and some households, maybe
16 both parents work, so it's very inconvenient if you
17 wake up on a given morning and your child is quite
18 sick. As long as I -- you know, I don't think most
19 parents aren't going to send their kids in if they
20 think it's literally going to be detrimental to their
21 physical wellbeing, they're -- you know, they're going
22 to collapse or something. But if they wake up sick,
23 clearly sick with signs or symptoms, it can be very --
24 very difficult to -- you know, very inconvenient to try
25 and find childcare or cancel your own work schedule so
26 that you can stay home.

1 And so many of us have gone into the public with
2 these -- with all of these pathogens that we're talking
3 about, the flu and everything else. One of the reasons
4 why it spreads so rapidly in all of our populations and
5 workplaces and schools is because we don't acknowledge
6 the fact that we are actively sick, that we're sneezing
7 and coughing, or that we have our kids that are
8 sneezing, coughing, and we send them into these areas,
9 and, of course, that's going to spread the pathogens.
10 Sick people spread pathogens. That's how it works.

11 So what I like to highlight as an immunologist is,
12 for some reason, we've gotten into this mindset that
13 somehow asystematic people are doing this, spreading.
14 And this is there the -- I would say this is where the
15 biggest disagreement -- this is the crux of the whole
16 problem when it comes to some earlier interventions,
17 like masking, is what is actually happening with
18 asymptomatic individuals -- I can explain that, if you
19 want, at another time, because it's not -- just so
20 you're not -- directly relevant to this question, but
21 keep that in mind, because prior to two years ago, the
22 term that we used instead of asymptomatic is we used
23 the term "healthy people". Right, if somebody didn't
24 have signs or symptoms of illness, I mean, if you go --
25 so, you could be asymptomatic with anything, if you go
26 to a physician and you're asymptomatic, and they say,

1 Okay, what are your signs, you know, what are your
2 symptoms. And I mean, so they can assess signs, as
3 what we mean by signs. Signs is something somebody
4 else can see that provides evidence that you're sick.
5 Symptoms are things that you feel that can provide
6 indications that you're sick. So signs and symptoms
7 are used.

8 So a physician cannot see a lot of your symptoms,
9 you have to describe them. So, for example, if you're
10 feeling pain, unless it's severe pain, a physician
11 isn't going to be able to see that you're in pain,
12 unless it's severe, and then we might need facial
13 grimacing that let's them know. Otherwise, you can
14 have a pain that they have no idea, they have no idea,
15 you have to tell them that.

16 So that's why -- if you were traditionally to go
17 to a physician and say, I have no symptoms, they're not
18 going to investigate you for a disease, right, because,
19 again, I'd like to highlight, people who are
20 asymptomatic are healthy.

21 So what I would -- so this is the interesting
22 thing, what I would say is the number one thing that we
23 have done to prevent this has been to not allow sick
24 people to go around others. So the one thing I would
25 say has worked very well is the screening, the
26 screening that ultimately got implemented, which

1 basically is asking, Are you sick, right? And if
2 you're sick, don't go into work.

3 So I would agree, scientifically, rock solid data,
4 because if you're not -- if you're coughing and
5 sneezing, of course, you're going to be spreading a
6 pathogen, and if you're not, you can likely go in -- go
7 in to work.

8 So that's the only thing, that stay at home if
9 you're sick that I would say -- and I would say this is
10 going to be effective all over the place. What people
11 don't realize is, this is fascinating, I would --
12 because I think most of you are in Alberta, so go to
13 your Alberta public health website and start looking at
14 the SARS-Coronavirus-2, look at the -- on the
15 SARS-Coronavirus-2 data page, they actually have a
16 link, the influenza page, go there, and I encourage you
17 to look at the cases.

18 What you will see is huge waves of the flu. They
19 only have the last five years currently showing
20 publicly on your web page. 5, 4, and 3 years ago, they
21 show the classic huge waves of the flu coming through
22 Alberta. And you know what's happened in the last two
23 years? No flu, no cases of the flu. It's not because
24 the flu disappeared; it's because we have told people,
25 If you're sick, stay home. Right? Because we have
26 always left the flu, for some reason, and encouraged

1 people to go to work and go to school, or at least not
2 discouraged them enough when they're sick, and the flu
3 kills people, and the flu is dangerous.

4 So to me, I hope and pray that when this is all
5 done, the people will remember, You know what, if
6 nothing else, if I'm sick, don't go around other
7 people. That is the simple -- that is the -- that is
8 going to help public health enormously moving forward
9 with all infectious agents that we've ever been living
10 with. So, yeah, that's the number one thing.

11 And I know that those of you who are here today
12 specifically are most interested in masking, so let me
13 comment on the masking specifically. I am -- masks do
14 quite a good job at preventing the spread of infectious
15 diseases under a certain circumstance, when people are
16 sick.

17 And (INDISCERNIBLE) so -- (INDISCERNIBLE) -- so I
18 told you, I have to admit, myself, I am guilty as
19 charged about going in to work sometimes when I'm sick.
20 One of the things I try and do is I do try and isolate
21 myself in my office. I do tell people, if they come to
22 my office, I do tell people -- if they come to my
23 office and knock on my door, I tell them, You might
24 want to chat through the door, I'm sick. You know, and
25 when I do have to go around people, I will wear a mask.
26 I have done that, when I've gone in to sick -- and to

1 work sick previously, because these masks are
2 reasonably well-designed to capture the large water
3 droplets that come out of our respiratory system when
4 we cough and sneeze.

5 The only way -- so if somebody's not sick, that
6 means they're not coughing and sneezing, so the only
7 theoretical way that a virus then could come out of our
8 respiratory tract is through what we call aerosols,
9 which are super tiny droplets that the cloth masks and
10 surgical masks that we have been using, they're not
11 designed to filter that out, and so this is an
12 intuitively -- like we even know this intuitively.

13 If you've ever been really sick, so I know this
14 because I have been respectful of those around me, and
15 if I'm actively coughing and sneezing, I will wear a
16 mask if I feel that I have had to go around people
17 because I don't want to miss a critical deadline. And
18 I'll also tell you from my own experience, those things
19 end up slimy and disgusting inside the mask if you are
20 doing a lot of coughing and sneezing. Why? Because
21 they're very good at capturing those large water
22 droplets, and so you have to change the mask quite
23 quickly. I will also tell you that if I'm not coughing
24 and sneezing, they don't get wet and slimy; they're not
25 capturing robust amounts of the moisture that's coming
26 out of our lungs.

1 There's a huge amount of moisture that comes out
2 of our lungs during regular breathing throughout the
3 day. We know -- just that's what happens. So in
4 Alberta, you'll notice like in Ontario, especially
5 during the winter, one of the phenomena are the
6 humidity goes way down, right? Cold air humidity tends
7 to be very low, and so if you don't have a humidifier
8 in your home, typically what happens during the winter
9 is you'll notice that when you wake up in the morning,
10 you will tend to have a much dryer throat than at any
11 other time of the year, and that's because there's so
12 much moisture that's given off, and all night long,
13 it's the air is wicking moisture as you breathe it out,
14 and your body's actually having trouble replenishing
15 it. You end up much more dehydrated in the morning
16 than -- and during the winter than you do at any --
17 during any other seasons. So there's a lot of
18 moisture, and the fact that it's not getting soaking
19 wet tells you that. So, again, a long answer, but I
20 want you to fully understand.

21 So to summarize, in terms of what's been
22 implemented, I think the number one effective strategy
23 has been keeping sick people away from others, and
24 hopefully that continues, and the masking. So if
25 people were to have to go around other people when they
26 have SARS-Coronavirus-2, masks would definitely help

1 prevent the spread of SARS-Coronavirus-2.

2 But in healthy people, I have never been able to
3 recommend masking of people who are not actively
4 coughing, sneezing, you know, who are not sick. So, in
5 other words, if you pass the screening that you're
6 supposed to do every morning before you go in, in my
7 professional opinion, there's nothing a mask is going
8 to do to protect yourself or others around you at that
9 point, because you are not -- you are not and nor are
10 those around you expelling the type of
11 infection-spreading water particles that spread
12 disease.

13 Q So symptomatic masking is rational and effective?

14 A 100 percent. I believe -- again, I hope that that will
15 be highly encouraged for everybody around the world
16 moving forward, that if they are going to make the
17 decision to send their child to school when sick or if
18 they're going to go in to work when sick, for the
19 respect of the health of others, yes, put on a mask,
20 100 percent.

21 Q But is asymptomatic irrational and ineffective?

22 A Yes, for the reasons that I said, because then you're
23 not spreading those large droplets that masks are
24 designed to stop.

25 Like -- so a lot of people don't realize, like
26 when you think about even a surgical mask and you think

1 about a surgeon, right, there's been studies that have
2 looked at this, this context, what people don't realize
3 is what those surgical masks are designed to do. It
4 doesn't sterilize your breath in any way, right? What
5 it does is it stops any large droplets. When a surgeon
6 is working over a surgical area, an open wound, it's
7 making sure that -- now, this is the other thing, any
8 surgeon who is doing surgery ideally should not be
9 doing the surgery if they are sick. But literally what
10 they're there for is to stop large water droplets.

11 It would be to -- and literally, for example, one
12 of the reasons for wearing the mask is drops, spittle.
13 Hey, we've all experienced that embarrassing time where
14 we're talking, and then, all of a sudden, a little bit
15 of spit comes out, and we're like, oh, I hope nobody
16 saw that, right? That's literally one of the reasons
17 why they wear the mask, to make sure large water
18 droplets, including spittle, don't drop out into the
19 surgical wound. So they're not designed, like I said,
20 again to filter out with any kind of efficiency the
21 aerosols, which are these super tiny water droplets
22 that are far tinier than the pore sizes in these masks.

23 And so, again, to highlight this, there's
24 something else that's important, because, again, this
25 comes back to the idea of symptomatic versus
26 asymptomatic or what I would call healthy people. Now,

1 what happens is in order for somebody to get sick, they
2 have to initially be infected. As I pointed out, the
3 infection does not necessarily equal sickness or
4 disease. And the other thing that's important to note
5 is infection certainly does not mean immediate disease.
6 Because you have a pathogen in your body, so you might
7 be -- so when people get sick, this is what happens,
8 when we do get sick, this is the sequence of events:
9 We have to be exposed to a certain threshold of the
10 pathogen, which is not once. Our bodies, we have
11 innate -- like we have physical barriers that
12 immediately protect us from infection. For example,
13 one of the things we have in our airways, our airways
14 are lined with mucous. That's one of the reasons why I
15 just said we have so much moisture coming out of them,
16 we're constantly covering all of the membranes
17 throughout our respiratory tract with mucous.

18 So if we have a pathogen come into our body, for
19 example, one of the immediate lines of defence is that
20 mucous, it will get buried in the mucous, and that
21 mucous constantly gets removed from the body. Even if
22 you're healthy, if you never clear your throat, you're
23 eventually going to have to clear your throat because
24 our airway is full of -- or your cells with these
25 specialized hairs on them, we call them cilia, and
26 their job is literally to, like fingers, to move this

1 mucous up. Because if you think about it, since our
2 airways are constantly producing mucous, if we didn't
3 have any way of getting that mucous out of the body,
4 under gravity, the force of gravity that would migrate
5 down into our lower airspaces, and we would literally
6 drown. They would fill up our lower airways, and we
7 would no longer be able to facilitate gas exchange. So
8 these little hairs push the mucous up and out of our
9 body. That's why, you know, it may end up getting --
10 accumulating in our throat so we can cough it out, or
11 if it's in our nose, we'll end up, you know, with the
12 mucous accumulating where you've got to blow it out of
13 our nose.

14 Now, if it's a pathogen that has been able to
15 bypass those barriers, our immune system has set up
16 what are called sentinel cells. These are cells that
17 are strategically located at critical entry points for
18 pathogens into the body, so they're distributed all
19 throughout our airways underneath the mucosal surface,
20 below that -- you know, the mucous that's on the
21 surface of our cells. And if a pathogen can get by
22 that, these sentinel cells very quickly identify that
23 there's a pathogen and start our immune response to
24 start clearing this.

25 Now, there's two parts to an immune response. One
26 is we call it the innate response. So, first of all,

1 we have to understand, actually there's three
2 technically in terms of timing. The one is physical
3 barriers that I just talked about like the mucous or
4 cell barriers, right, that a virus would have to get by
5 to get into the body. Those are always present. There
6 is no immune response that has to be mounted. That's
7 why, for example, burn victims, that they lose a large
8 amount of their skin, are highly prone to infections
9 because they've lost that physical barrier.

10 Now -- so in the lungs, these sentinel cells, if
11 the pathogen gets past these initial physical barriers,
12 and so that's why you have to have a certain threshold.
13 One viral will not cause disease; you have to bombard
14 these natural barriers with high numbers of the virus,
15 so you have to have it delivered to you, you have to
16 inhale a threshold dose, and that changes depending on
17 the infectivity of the virus.

18 But so you have to -- if you get that threshold
19 dose and your physical barriers can't deal with it, you
20 have those sentinel cells that will immediately start
21 detecting that virus and starts penetrating in -- and
22 starts infecting cells past those physical barriers,
23 and that they will start -- and trigger a whole series
24 of events that lead to what we call innate immune
25 responses, so those are very rapid, short-term
26 responses. And then if they fail to clear the

1 pathogen, then we mount the types of responses that
2 we're trying to get with these vaccines.

3 We call them acquired or adaptive immune
4 responses, and the key effector mechanisms there, the
5 key weapons are T cells, which could kill off
6 virus-infected cells so they can't serve as virus
7 replication factories and antibodies, which can block
8 viruses from getting into other cells. Now, those
9 latter things can take up to -- it takes about two
10 weeks for those T cell and antibody responses to peak,
11 so the innate response is very fast.

12 And so if you have an infection of the lungs, one
13 of the first things these sentinel cells start to do in
14 terms of communicating is they get these cells to
15 produce the mucous, to start producing lots of it,
16 because it -- we've got a virus that's bypassing this
17 barrier, so let's make this barrier even more rigorous,
18 a thicker mucous layer. And so that's why when we get
19 an infection, as the virus starts replicating -- this
20 is important -- so, in other words, early on in
21 infection, yes, so if we were to take somebody who was
22 infected early on, would we be able to detect the
23 virus? Yes. Is that virus a replication-competent
24 virus particle? Yes. Is it going to be able to infect
25 and cause disease in other people? No, for two
26 reasons: (a), a person has to reach a threshold level

1 in your own body such that you're delivering such a
2 large enough quantity of the virus for another person
3 to inhale that threshold dose to get them sick. The
4 second reason is you could even have potentially a
5 large amount of the virus in your body, but if you're
6 not sending it out of your body, you're not going to be
7 able to infect anybody else, and so this is the thing.

8 So our immune system -- so viruses take advantage
9 of this early immune response for the transmission
10 process. So because what happens is this mucous
11 secretion starts increasing, and so that means we have
12 a lot more mucous being brought up into our throat and
13 into our -- and our nasal passages, right, producing a
14 lot more of this. And so the body, to try -- you know,
15 what it wants to do is get rid of as much of the viral
16 particles as it can, because the fewer virus particles
17 it has left in the body, the more easily it's going to
18 be able to clear that infection.

19 And so the way our immune system gets it out of
20 the body is it causes us to cough out all this mucous
21 that's accumulating, all the liquid that's full of
22 these viral particles, and we sneeze it out of our
23 nose. That's literally -- we're trying to dump as much
24 of the viral particles out of our body as we can. That
25 is when we become an infection hazard to other people.
26 And that's why I say these masks are awesome at

1 stopping the transmission when this transmission is --
2 when there's the high risk of this transmission, and
3 that's when people are actively coughing and sneezing.
4 As long as you have the virus contained in your own
5 respiratory tract, you know, you're not doing that.

6 So in theory, you can -- so this is actually kind
7 of interesting. Much more so than viruses like the
8 influenza viruses that we live with, the
9 SARS-Coronavirus-2, there's been a lot of literature
10 suggesting, therefore, that one of the ways the virus
11 might spread is through aerosols, right? And so
12 that's -- because if you're not coughing, and you're
13 not sneezing, then the only way the virus theoretically
14 can get out of your body is being carried on the small
15 water droplets that come out of our -- come out with
16 our breath, right, with every exhalation we give.

17 So then that means that the masking, therefore, if
18 somebody is not symptomatic, the only thing that it
19 could potentially have to stop in terms of the virus
20 leaving the body would be these aerosols. And like I
21 said, while -- you know, I've got lots of figures and
22 pictures to show that, you know, the pore sizes of
23 these masks are not designed, they're not nearly small
24 enough to stop these viral particles from getting
25 through, that the water droplets that could potentially
26 have the virus on them, the pores are way, way, way too

1 big to stop that.

2 Now, granted, so, for example, I noticed in
3 Dr. Hu's report that he mentioned that -- actually
4 maybe it wasn't even his report, but some have pointed
5 out that it -- and I agree, it's not like it's one
6 pore, if the virus gets past one pore, it's out of the
7 mask. So, example, the surgical masks actually have
8 three layers. So what it is more like is it's having
9 pores all offset from one another. There's a whole
10 bunch of pores that the virus would have to navigate.
11 It would be like going through a maze.

12 So what these masks can do with aerosols is it can
13 slow down the transit time it takes to navigate this
14 maze of large pores that are all offset before it
15 leaves the mask, but it doesn't stop it from leaving
16 the mask. And, in fact, what ends up happening, this
17 is the predominant thing, this is also in my figures is
18 because it has to navigate this sort of complex maze to
19 get through all the open doorways, that provides
20 resistance, and any gas will follow the path of least
21 resistance. And that's exactly why when we wear our
22 masks, the vast majority of what we exhale never even,
23 unfortunately, gets through the filtering material,
24 again, which isn't designed to filter out these
25 aerosols, but rather bypasses it.

26 And we've all seen that phenomenon; I mean, you

1 know, I wear glasses, especially now is not a great
2 time, so I encourage anybody, put on a mask with
3 their -- so what's especially -- what I especially
4 recommend, if you -- so I have this every time I go to
5 the grocery store, go outside for a little bit, let
6 your glasses, you know, accommodate to the temperature
7 around, right, so they get nice and cold; then go into
8 a store, go into a warm location and put on your mask,
9 right, put on your mask and step through the door into
10 a warm location. Now your glasses are such that any
11 moisture that's coming out is going to readily
12 condense. I find it so frustrating because I can
13 hardly shop. It takes me about 10 minutes before I can
14 start shopping because I'm constantly taking my glasses
15 off and wiping them because of all the fogginess
16 happening. That's the aerosols, and that's, of course,
17 because of the mask. Even with the pinch piece, if you
18 have a good mask, a surgical mask that have the middle
19 pinch piece, very difficult to get a seal properly
20 around your nose. And so when you exhale, because
21 we're slowing down the progress of the air through the
22 filtering material, it'll just simply exit alongside
23 the nose; that's where we see the fogging.

24 Now, the other place a lot of people don't realize
25 is even the surgical masks are not designed to fit
26 properly around -- by -- in front of the ears, and so

1 you almost always have these large, relatively large,
2 triangular gaps at the back of the mask where it loops
3 over the ears. And so literally when we exhale with
4 these masks, the vast majority, when we exhale, fires
5 up past the nose and out past the ears, and so there is
6 no filter. And then, like I said, the limited amount
7 that does come through the filter, it's not designed to
8 stop these aerosols.

9 Like I said, if it did -- like, again, I can take
10 off my glasses right now, and, for example, watch
11 (UNREPORTABLE SOUND), I just breathed on my glasses,
12 and you can probably see it's fogged quite a bit
13 compared to my other lens, right? That's one exhale.
14 So you can imagine if I was wearing a -- had been
15 wearing a mask and go -- in some cases, I've had to,
16 you know, because of these requirements, if I'm wearing
17 a mask, there's not much aerosol coming out in just one
18 breath. You can imagine how much liquid would
19 accumulate in your mask if it is, in fact, filtering
20 that out. If it's filtering it, it means it has to
21 stop them from getting out in the air, from going
22 through. If it's not getting into the air, then it's
23 staying in the mask, the masking material. But I can
24 wear these masks, if I'm not coughing and sneezing, I
25 can wear them, and my mask will not get wet.

26 So, again, it's just intuitive to the point

1 where -- I like to use -- I'll just finish with this,
2 an example which I think is helpful to consider this.
3 Early on in the pandemic, in fact, every time I went to
4 get my hair cut, and thankfully I was able to, you
5 know, after quite some time, because my hair was
6 horrible, like many of us, for the longest time, but,
7 you know, when I actually first went and understanding
8 this, out of respect for the hairdressers, I tried to
9 explain this to them and actually asked them if they
10 wanted me to take my mask off, because if they were
11 worried about aerosolized transmission, right, the mask
12 for filtering this stuff, I tried to point out to them,
13 If it's my breath that you're worried about, do you
14 want me to take my mask off. Because they always cut
15 my hair from behind, right, and that way, if they're
16 afraid of my breath, I'm directing it away from them.
17 And they -- you know, but, no, because of the policy,
18 said no, no, no, no, everybody has to be masked to
19 keep -- you know, to keep us safe, and I tried to
20 explain.

21 And so the best way is -- again, to envision this,
22 again, if you go out in the winter time, cold air, and
23 you put your mask on, you'll see exactly what I'm
24 saying -- I put a picture of this in my report --
25 you'll -- because you can see these aerosols, because
26 these tiny water droplets, when it's really cold, will

1 condense, right? Again, if water -- the gaseous water
2 as -- when it's cool, it will turn into liquid. And so
3 winter time is a great time because you can see the
4 aerosols condensing in the cold air around you. And so
5 when you breathe out in the winter, you'll see the --
6 it blasts up, you see this fog essentially as the
7 aerosols are condensing, blasting up past your nose and
8 out past your ears just like I said.

9 And I've shown people, if you're a hairdresser,
10 what it does is it encases your head in this huge cloud
11 of aerosol, all right. I've tried to point this out to
12 my hairdressers is that if you are genuinely afraid of
13 my breath, you know, as an asymptomatic individual, do
14 you not realize that the whole time your hands are
15 immersed in my aerosols by you forcing me to blow them
16 around my hair instead of away from you.

17 So I'd just like to highlight that, because,
18 again, that's kind of science meeting the reality that
19 we currently have and how the two just simply don't
20 align. So I'll --

21 THE CHAIR: Dr. --

22 A -- just stop there.

23 THE CHAIR: -- yeah, Dr. Bridle, I think
24 it's now 10 after 12, Mr. Kitchen. I think it's time
25 for a break.

26 MR. KITCHEN: Yes, I agree, however, I do

1 want to ask one question.

2 Q MR. KITCHEN: And, Dr. Bridle, I invite you
3 to answer this in 5 minutes or less, and we can come
4 back to it after the break, but I want to ask this
5 question, because it's connected to the conversation
6 we've had. Dr. Bridle, so you've said now that where
7 we're really at is endemic, but I think the burning
8 question we all have is was SARS-CoV-2 ever actually a
9 pandemic? Right? You said declared pandemic, and you
10 said that there was a (INDISCERNIBLE) severity for it
11 to actually be really a scientifically a pandemic. So
12 was SARS-CoV-2 ever a pandemic, and if so, when did it
13 cease being a pandemic scientifically?

14 A Okay, yeah, that's an interesting question, but I can
15 keep this short, yes. Sorry about that, you're getting
16 the typical, you know, scientific, we like to make sure
17 that all the details are relayed. But in this case,
18 so -- this is -- the pandemic was declared again,
19 assuming that the -- sorry, Karoline --

20 (AUDIO/VIDEO LOST)

21 MR. LAWRENCE: Sorry, can we just -- sorry to
22 interrupt, Dr. Bridle -- I think we've lost a Tribunal
23 Member --

24 A Oh, okay.

25 MR. LAWRENCE: -- Dr. Martens, I don't see
26 her. Could we just --

1 MR. KITCHEN: Well --

2 MR. LAWRENCE: -- (INDISCERNIBLE) for a
3 minute. Oh.

4 MR. KITCHEN: Dr. Martens, if you need us to
5 break, we can, you know, we --

6 THE CHAIR: Dr. Martens is here.

7 DR. MARTENS: No, yeah, I came back, yeah,
8 sorry.

9 A Okay, great --

10 THE CHAIR: Thank you, Mr. --

11 A -- I don't think I said anything --

12 THE CHAIR: -- Lawrence.

13 A -- that you missed, Dr. Martens. Did -- what was it --
14 yeah, I think I was just starting to answer, so I'll
15 just start again --

16 THE CHAIR: Sure.

17 DR. MARTENS: Yeah, just when you were going
18 to answer the question, yeah.

19 A Oh, okay, great.

20 DR. MARTENS: Thank you.

21 A Yeah, so this pandemic was declared with, again, on the
22 initial concern that the infection fatality rate might
23 be as high as 10 percent, and, again, as I've said, an
24 infection fatality rate certainly between 1 and 10
25 percent. I don't think there's very many scientists
26 around the world that would agree that that would be a

1 pandemic situation provided the pathogen is genuinely
2 dangerous, because then you're, you know, talking
3 about -- well, the infection fatality rate, that is an
4 indication that it's going to be dangerous to far too
5 many people.

6 But the reality is, just like I said, as we have
7 come to appreciate the size of that denominator, which
8 we didn't know at the beginning, we now know that
9 the -- the real infection fatality rate is in the --
10 was in early 2021 in the ballpark -- and we're not even
11 sure it's the full estimate because we don't have a
12 full understanding of how big the denominator was. But
13 at that time, it was estimated to be about .15 percent.

14 So to put that in perspective again, that was
15 dealing with the earlier variants, which is when the
16 pandemic was declared, in that context. And, again, at
17 .15 percent, that is not a problem of pandemic
18 proportions. It is -- it just simply is -- that's a
19 fact.

20 And so it's not a case -- and then, again, that's
21 for the entire population. And if we go to the
22 demographics that we know, which is the vast majority
23 of the people that are in the -- and the lower-risk
24 demographics, it would be much lower. Again, I can't
25 say exactly how much, but it would be lower.

26 So, again, to put that in perspective of .15

1 percent, that is in the same realm as a bad flu season
2 and -- for which we never declare that to be a
3 pandemic, despite the fact that, you know, the flu
4 spreads around the world, nor is it declared an
5 epidemic, even though it certainly meets that
6 definition in terms of its spread throughout Canada.

7 Now -- so the thing to understand -- and now, as I
8 point out, as far as Omicron, it would be even lower,
9 but that's because there's been some biological changes
10 as well to the virus, right, that's made it less
11 deadly. So if I was going at .15 percent, because
12 that's dealing with the earlier variants where -- which
13 were relevant when the pandemic was declared, just to
14 clarify, it's not that we went from an infection
15 fatality rate of 1 to 10 percent to .15 percent, right,
16 because that would require some kind of biological
17 change or effective intervention that's completely
18 stopping those deaths. And, no, it's the initial
19 estimate was, the initial concern was that it was that
20 high.

21 So what happened is the mathematics became more
22 accurate by the time this paper was published. That
23 same math applied to the beginning of the pandemic.
24 So, in other words, if we knew by early 2021, you know,
25 what the accurate -- if we had those same accurate
26 numbers at the beginning of the pandemic, the pandemic

1 would not have been declared; it would not have been a
2 problem of pandemic proportions. As I've pointed out,
3 the flu is -- equals this, a bad flu season.

4 So, in my opinion, and based on our own policy,
5 health policies in Canada, this would not have
6 qualified as a pandemic. It qualified as a pandemic
7 because we thought the infection fatality rate was much
8 higher than what it really has been and what it has
9 proven to be.

10 And the point that I'd like to make as well is,
11 because a lot of people have probably heard of this
12 term with the emergency use authorization in Canada for
13 the vaccines, in Canada, we called it the authorization
14 for interim use, but it means the same thing.

15 And the reason why that's important is because
16 that's something -- and this whole -- actually, this
17 whole concept actually we have right now of overriding
18 constitutional freedoms, and we're hearing about this
19 all the time, what a lot of people don't realize is,
20 you know, this imposition where the Government can
21 start dictating things and overriding potential
22 individual, you know, constitutional policy rights is
23 often -- is based on the perception -- like the impact
24 of something on Canada. Technically it has to
25 incapacitate the ability for Canada to operate in a
26 certain way.

1 So a classic example would be if we were at war.
2 At war, that's where you can have overriding executive
3 decisions, right, and if Canada is at risk of being
4 destroyed, being overtaken, right, being taken over.

5 So at a 10 percent or even 1 percent, that would
6 have a dramatic impact on Canada, you know, death rate;
7 that would have a dramatic impact on Canada to be able
8 to function as a country. But at 0.15 percent, we've
9 never done -- like I said, we have that for the flu
10 routinely.

11 So, again, I hope that helps put it in some
12 perspective. So, again, based on the science, the
13 publications, my, you know, summarized answer to you,
14 Mr. Kitchen, is that, with the math corrected, this has
15 not been an issue of pandemic proportions, true
16 pandemic proportions.

17 MR. KITCHEN: Thank you. We'll leave it
18 there for lunch.

19 Mr. Lees, I'm fine if you want 45 minutes or an
20 hour, an hour-and-15, I'm fine either way. As much
21 as -- we'll definitely finish today. I think we're
22 going to be a while yet, but we will finish today.

23 THE CHAIR: Okay. Let's take an hour;
24 let's come back at 1:15. I think we all -- we went
25 straight through from 10:00, so I think an hour is
26 fine, and we'll see everybody at 1:15.

1 And do we need to caution the witness in any
2 respect, Mr. Pavlic?

3 MR. KITCHEN: You're muted.

4 MR. PAVLIC: I've got it now.

5 Other than --

6 THE CHAIR: Okay.

7 MR. PAVLIC: -- he's not supposed to
8 discuss his evidence with his counsel or anyone else --

9 THE CHAIR: Yeah.

10 MR. PAVLIC: And I'm sure --

11 THE CHAIR: Thank you.

12 MR. PAVLIC: -- Mr. Kitchen has given that
13 warning in advance.

14 THE CHAIR: Okay, we'll see everybody at
15 1:15. Thank you.

16

17 PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 January 28, 2022 Afternoon Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23 (PROCEEDINGS RECOMMENCED AT 1:16 PM)

24 THE CHAIR: We will be back in session for

25 the afternoon, and just before I ask Mr. Kitchen to

26 continue, I just remind you, Dr. Bridle, that you are

1 still under oath.

2 A I understand, thank you.

3 THE CHAIR: Okay. All right, Mr. Kitchen.

4 DR. BYRAM BRIDLE, Previously sworn, Examined by

5 Mr. Kitchen

6 MR. KITCHEN: Thank you. And, Chair, I'll
7 try to be mindful of the time. If we get an hour or so
8 into it, and we're still going, I'll try to find a good
9 time for a break.

10 Q MR. KITCHEN: Dr. Bridle, thank you so much
11 for all that information prior to the lunch break, but
12 to continue where we left off, the question I had is we
13 talked -- you talked about how isolation works, masking
14 for asymptomatic doesn't work, and then we didn't get
15 into any other restrictions yet, but I'm very curious,
16 if isolation at home does work, and you said,
17 intuitively, it does, can you give some insight as to
18 why Omicron is still spreading the way it is unabated?

19 A Yeah, so, first of all, just to clarify, meaning
20 isolating at home when symptomatic, right, when
21 actually sick. I don't recommend that people have to
22 stay away from others if they're not sick.

23 So, yeah, in terms of the Omicron, you know, so
24 it's a multi-faceted answer, I guess. And so, first
25 of all, I guess I'll start off with the, you know, the
26 related topic of the vaccines, because that was

1 purported to be -- you know, we were hoping that was
2 going to be the number one strategy for stopping the
3 spread of this. And then the idea being, you know, the
4 concept was that only those who were vaccinated would
5 not be capable of transmitting the virus, and those who
6 were unvaccinated would be capable of transmitting the
7 virus, and, hence, you know, the isolation, kind of
8 segregation that's been occurring in society.

9 But so one needs to understand a little bit about
10 vaccines to understand that aspect because that's
11 critical, because, again, like I said, that was
12 supposed to be the number one strategy for stopping
13 transmission.

14 So these COVID-19 vaccines -- so, again, I mean,
15 I'd like to highlight and my record shows for itself,
16 being a publication record, that I've been actively
17 publishing in the area of vaccinology during the
18 declared pandemic. I am a vaccinologist. So, again,
19 you know, my expertise is in viral immunology, and
20 specifically I focus heavily on vaccinology.

21 So I am actually strongly in support of the
22 concept of vaccine mandates, but these COVID -- current
23 COVID-19 injections look nothing like and they perform
24 nothing like any historically mandated vaccines. And
25 that helps to understand a large part of the question
26 you're asking.

1 So what I mean by that is we're all probably
2 familiar with the vaccines that are mandated during
3 childhood, so the childhood -- what we call the
4 childhood series of vaccines. So that's things like --
5 things like the mumps, measles, and Rubella vaccines,
6 the ones we -- you know, we get for tetanus that get
7 updated every 10 years and so on, chicken pox as of
8 2010.

9 And so all of these previously mandated vaccines
10 have a quality that we refer to, as immunologists, as
11 conferring sterilizing or near sterilizing immunity.
12 And what that means is technically if somebody's
13 vaccinated, they can still get infected because
14 infected means you the get the pathogen in your body.
15 But what sterilizing and non-sterilizing --

16 THE CHAIR: Dr. Bridle, Dr. Bridle --

17 A Yes.

18 THE CHAIR: -- you're frozen.

19 MR. KITCHEN: He's not frozen.

20 THE CHAIR: Yeah, he's back now.

21 A Okay, do I need to repeat anything?

22 THE CHAIR: Just the last sentence.

23 A Oh, okay, thanks. So previously mandated vaccines
24 confer what we call sterilizing or near-sterilizing
25 immunity. And so sterilizing immunity means like, in
26 all cases, a pathogen can still get in your body. So a

1 respiratory pathogen like SARS-Coronavirus-2, obviously
2 we can still inhale it. If we had sterilizing
3 immunity, it would mean that we have the appropriate
4 type and quantity of antibodies in our upper
5 respiratory tract to be able to fully neutralize that
6 virus, meaning the antibodies would bind to the virus.

7 And that's one of the reasons why we've been
8 targeting the spike protein. The spike protein is the
9 thing that sticks up on the surface of the virus that
10 grabs onto the receptor on our cells, the same receptor
11 I was telling you about earlier that children express
12 at much lower concentrations, which is why they're
13 inherently protected.

14 So if you have an antibody that binds to the spike
15 protein, then that spike protein can't grab onto our
16 cells. And if the virus can't get into our cells,
17 there can be no replication whatsoever and, therefore,
18 no risk of disease and no risk of transmission. That
19 would be sterilizing immunity.

20 Near-sterilizing immunity means that the virus,
21 probably there would be a lot of neutralization of the
22 virus, but the virus might still be able to infect a
23 limited number of cells that we would have sufficient
24 additional immunological mechanisms to clear that virus
25 from the infected cells, things like T cells, which are
26 very good at this, and it would clear the virus again

1 before it would replicate to that -- to a quantity that
2 would reach what I referred to previously as the
3 threshold dose required to infect somebody else. So
4 that would be what we call near-sterilizing immunity,
5 meaning you can get some infection yourselves, limited
6 replication, but you're not going to get sick because
7 there hasn't been enough replication to cause illness,
8 and you're not going to transmit, because, again, you
9 haven't reached that threshold dose that needs to be
10 delivered. So that's what all our historical mandated
11 vaccines look like; they do this.

12 Oh, and the other thing they do is they -- they
13 not only confer this type of immunity but for very long
14 periods of time. So when you think about it, once we
15 are done our childhood vaccination series, except for
16 the, you know, update every 10 years for things like
17 diphtheria and -- for example, the -- and tetanus, we
18 never have to be vaccinated again, we don't have to get
19 boosters. So we call that robust or long-lasting
20 immunity. So that's the nature.

21 Now, we're all probably seeing -- you know, we're
22 already, in Canada, rolling out -- well on our way to
23 rolling out third doses. We've actually been
24 implementing fourth doses in some long-term care
25 facilities where there's been a complete inability to
26 control the spread of the Omicron variant. Israel, you

1 know, of course, is large -- most of their population
2 has got four doses.

3 So this highlights something, this is three to
4 four doses in well under a year. So that -- so,
5 clearly, they don't -- they don't have the duration of
6 immunity; they don't provide the, you know -- a
7 reasonable length of protection. That alone means
8 these vaccines will never be able to stop the
9 transmission of this virus, because there's no way we
10 can get the whole world vaccinated and under three
11 months, such that the people, you know, no longer -- we
12 haven't reached the point where people have lost
13 protection. Otherwise, if you get only -- if it's only
14 through part of the population by three months, by the
15 time you're vaccinating new people, the people who were
16 vaccinated at the beginning are going to be susceptible
17 again. So that's one of the problems.

18 The other problem is that -- I already explained
19 this, that the immunity is -- just really protects the
20 lower airways. And the Omicron variant, we're talking
21 about a version of the virus now that preferentially
22 stays in the upper airways, so there isn't that --
23 those aren't those neutralizing antibodies in the upper
24 airways conferred by this vaccine that would confer
25 that sterilizing protection.

26 So on that basis -- oh, and the other thing is

1 that there's been so many mutations in the spike
2 protein of the Omicron variant that the immunity
3 conferred by this, which is spike-protein specific, is
4 largely irrelevant. A lot of those antibodies can't
5 even physically bind to the spike protein anymore
6 because it's changed too much.

7 So for all those reasons, that's one of the
8 reasons why we're seeing the vaccine [sic] circulate
9 freely, because it's largely then the unvaccinated that
10 have been -- that have been -- or have continued to be
11 asked to isolate and have been basically -- you know,
12 segregated from society. So they are, you know, stay
13 at home, not being able to go into the workplaces and
14 so on.

15 So the fact -- and like I said, I've said this
16 before as well, some of the -- for those in school
17 settings or work locations, we're talking about people
18 where almost everybody is vaccinated, but the virus --
19 like I said, despite that, we had this record peak for
20 cases with the Omicron variant. So that's one of the
21 reasons, because the vaccines, unfortunately, have
22 failed to meet their goal.

23 If these conferred long-lasting sterilized or
24 near-sterilizing immunity, I may have had to have
25 retracted my earlier statement about this becoming
26 endemic. We may actually have had a chance of

1 eradicating this virus. But, you know, because of
2 these weaknesses in what an ideal vaccine should be --
3 I should even point out that even the very definition
4 of a vaccine was altered about a year ago to
5 accommodate these inoculations that we're providing,
6 because, again, the definition of a vaccine was one
7 that conferred sterilizing or near-sterilizing
8 immunity. They were originally designed to not blunt
9 the most severe forms of disease but actually prevent
10 disease and prevent transmission to others. So that's
11 why -- that's a primary reason why we're seeing this
12 virus continue to circulate.

13 So now when you think about that, it's annoying
14 that the vaccines are now largely irrelevant in terms
15 of their ability to stop transmission; at the same
16 time, we have kept -- we have remained -- keeping the
17 vaccinated individuals from workplaces, we continue to
18 require them to wear masks and do the physical
19 distancing. So -- and, again, the fact that we've been
20 doing this all along, but the waves of cases just keep
21 getting progressively higher, although, like I said,
22 the virus is progressively less -- that's the good news
23 in all this. As that happens, the virus becomes -- has
24 become less dangerous. So despite the spread, there is
25 less potential harm to people. So I always want to
26 remind people I don't want to be instilling unnecessary

1 fear.

2 But nevertheless ever increasing cases, and since
3 the focus is on cases, that means that we've been
4 trying to stop our cases. And, again, I won't say
5 cases of COVID-19, that is what we ultimately want to
6 prevent, but what we're actually measuring, again, are
7 positive test results for potential infection with
8 SARS-Coronavirus-2.

9 So what it tells us is that the masks and the
10 physical distancing, despite the fact that we have not
11 only maintained that all the way through but actually
12 removed the vast majority of people from the population
13 who are unvaccinated tells us that that combination of
14 those critical three, which are supposed to be the
15 three things to -- to end this pandemic, the
16 vaccination, the masking, and the physical distancing,
17 you know, that's real world evidence, you know, that
18 we've all seen that really we can't -- argue doesn't
19 exist, right, because we see it in our workplaces and
20 schools. It clearly shows those aren't working. They
21 can't be working while we're actually having, during
22 this process of maintaining those three strategies,
23 while removing most of those who are unvaccinated from
24 those scenarios, when you actually see ever-increasing
25 peaks in the, you know, recent waves, that clearly
26 suggests that these are not working efficiently, right?

1 They're not -- they're certainly not efficient
2 solutions to resolve the problem as we have it.

3 That's why many people are working right now on
4 trying to develop vaccine strategies that ideally would
5 be sterilizing or near-sterilizing because that would
6 provide, potentially, an ideal way to prevent this.
7 But then one even argues whether it's necessary if the
8 virus isn't dangerous enough because -- this is
9 something I teach my students -- one of the questions I
10 get asked all the time, with all the vaccine
11 technologies that we have, why don't we have a vaccine
12 for the common cold. Well, the reason is simple, no
13 medical intervention, no medical intervention comes
14 with zero risk. So you always do a risk-benefit
15 analysis.

16 And so the primary reason why we have never
17 developed a vaccine against the cold that we try and
18 implement is the cold in the vast majority of people
19 again is not a major issue. And so if people aren't at
20 substantial risk of harm from a pathogen, we're not
21 going to introduce an unknown potential amount of harm
22 from a novel medical intervention, and so that's why
23 we'll never have vaccines for the common cold.

24 But, nevertheless, I just wanted to bring that up
25 there, that that might be a viable strategy, if needed,
26 if we were to get a future version of the -- you know,

1 future variant or strain of the virus that were to
2 attain more dangerous characteristics again. But with
3 the current tools that we have, we have seen the
4 Omicron variant, the spread, the transmission go
5 completely out of control. So, yeah, I'll end it
6 there.

7 Q MR. KITCHEN: Well, thank you. But let's
8 talk about prevaccine, let's talk about 2020. My
9 understanding is, you know, the vaccine really didn't
10 start to get up to -- until January of 2021, so about a
11 year ago, you know, and the time that's really
12 relevant, of course, for this case is, you know, from
13 May 2020 till December 2020. That's when the
14 chiropractors were allowed to work, that's when
15 Dr. Wall was working, and that's when there was a
16 mandatory mask requirement in place by the College.

17 So let's talk -- and as far as I can see, that's
18 prevaccine. So let's talk back then. What's your take
19 on why these measures, no vaccine, why measures like
20 physical distancing and masking didn't work back then?

21 A Okay, so this leans heavily on what I already
22 explained. So pathogens are a spread, there's risk of
23 spreading it to somebody else when we're actively
24 releasing large enough quantities from our body to meet
25 the threshold dose needed to infect, bypass the initial
26 physical barriers, and initiate disease -- or initiate,

1 sorry, what we would call a productive infection that
2 would result in disease, because, again, disease is
3 when there's the onset of signs and symptoms.

4 And so the reason why these largely haven't
5 been -- weren't effective there, so outside of the
6 scope of vaccines, is because we were keeping people
7 out of the workplace who weren't sick. Again, I keep
8 emphasizing that. If you're not around sick people,
9 you tend not -- you're going to tend not to get sick.

10 And again -- so, again, these masks do a
11 reasonable job at preventing the spread of illness when
12 somebody's coughing and sneezing. That's what they're
13 really designed to do, that's what the pore size is
14 designed for in these masks.

15 And, otherwise, if -- so then the only argument
16 that remains then for why these masks attempt to
17 restrain the virus if somebody's not symptomatic would
18 be, again, the concept that they have -- the assumption
19 that they have a high enough dose of the virus in their
20 respiratory tract but are not yet sick because of it
21 and, therefore, exhaling large enough quantities, a
22 threshold dose, through aerosols, right? That's the
23 only physical way that a healthy person could,
24 therefore, be spreading this, and as I've explained
25 because of the pore size. And, more importantly, the
26 pore -- really, the pore size is irrelevant if you

1 don't have a proper fitting mask, such as the vast
2 majority is exiting the body unfiltered. You know, the
3 virus isn't going to respect the masking, nor --

4 And then when it comes to the physical distancing,
5 this is a complex process because some physical
6 distancing theory can help if you can control, if you
7 can control, because this is the thing, physical
8 distancing was primarily implemented -- and, in fact,
9 it's largely -- one can even argue what should be the
10 appropriate distance. Many studies would suggest that
11 an appropriate distance would only be 1 metre rather
12 than 2. So it's a rather -- beyond 1 metre becomes
13 rather arbitrary if you can -- if you pick a number
14 beyond that.

15 But what people need to understand is that the
16 reason this physical distancing was also selected was,
17 in the context of sick people who were actively
18 transmitting the virus by coughing and sneezing, it's
19 this idea of large water droplets again. And the
20 reason why 1 metre has always been recommended as the
21 minimum distance to try and minimize your chance of
22 getting infected -- so I would definitely recommend if
23 somebody is around somebody who is coughing and
24 sneezing, I would never recommend that you -- if you
25 want to keep yourself healthy, I would recommend that
26 you never go within 1 metre of their personal space,

1 and the further away you are, the less risk there is.
2 And that's because people -- you know, when we cough
3 and sneeze, the large droplets that we dispel land on
4 the ground approximately a metre away from us, up to a
5 metre away, so that's where that came from. But,
6 again, that's for people who are symptomatic and
7 meaning they're actively coughing and sneezing and
8 projecting these large water droplets.

9 Otherwise, we're talking about aerosols. And when
10 we're talking about aerosols, aerosols can travel very
11 large distances, massive distances, in fact, depending
12 on the environment. So, for example, there's very few
13 indoor places anymore, like work environments, that
14 have modern -- and even houses, you'll notice, most of
15 the -- most modern buildings now have air circulating
16 all the time, and so that creates currents, air
17 currents, all the time in our homes. We're often
18 unaware of these, but, you know, you know that you can
19 get the test kits to look at smoke detectors or even
20 smoke. If you ever put the smoke in a room, for
21 example, in air vents and so on, you can often see that
22 there are these air currents that are circulating. So
23 we can't see that, so where these aerosols go is going
24 to be dictated by the air currents that are around us.

25 So as an extreme example, and I've pointed this
26 out to people, you know, kind of in a half-joking way,

1 only half-joking because it is actually serious, so,
2 you know, I, from time to time, I've used -- you know,
3 I use a bus. I've got a bus stop not far from my home,
4 and again the best time -- the best time to see this,
5 there's two ways to actually visualize this, one is
6 observing smokers and the other one is observing people
7 breathing but in the winter time, where you -- again,
8 you can see the aerosols because of the condensation in
9 the cold air.

10 And so one of the things that I always, always do,
11 because I'm a nonsmoker myself, is if somebody's
12 smoking, I always stand upwind from them, right? There
13 is no defined distance at which smoke dissipates to --
14 and which it's safe, if there's a wind. If you can be
15 5 metres downwind of somebody at a bus stop, and you're
16 going to be inhaling their smoke if the wind's taking
17 it that way, because, yes, these aerosols dissipate,
18 but if you have a wind that's moving quickly, you're
19 going to be inhaling, you know, a reasonable amount of
20 smoke, secondhand smoke. So many of us recognize that,
21 and so if we don't want to inhale the smoke, we stay
22 upwind, and that's what I'm talking about with these
23 aerosols and air currents carrying this.

24 And so it's the same thing, if you have somebody
25 that's, for example, let's say, unmasked and breathe
26 out, if you -- if there's -- if the air is what we call

1 stale, is not moving, you're going to see a cloud that
2 forms in front of their mouth, and it's going to
3 dissipate as it moves out. In that case, the aerosol's
4 probably going to dissipate, pretty low concentrations,
5 right, per volume of air space at not too far a
6 distance. But, again, if you're standing, you know, 3
7 metres downwind of the person and, you know there's a
8 reasonable breeze, those vapours, you can see them
9 coming right by, right by your face. And so you're
10 actually inhaling, you know, reasonable concentrations
11 of the air being expelled by that individual. So
12 that's how, you know, is -- that's a good way to look
13 at it.

14 And so it's the same thing, so -- and worse, this
15 is the other thing, so I point out again that, in
16 fact -- so you combine that, we're talking about
17 aerosols with the masking, and the very frustrating
18 thing there is -- again, I try to point out -- if I'm
19 standing at a bus stop, and there's people sort of
20 downwind of me, and I want -- and if I were to feel
21 that I had to protect them from an aerosol, I would
22 actually rather have to take my mask off so I'm
23 projecting the aerosol ahead when then maybe it gets
24 dissipated, you know, down in front of the crowd of
25 people. By putting on the mask, I'm actually making
26 sure that I'm blowing lots of unfiltered air out past

1 my ear and actually firing it basically in the
2 direction of the people, right, or right beside me. So
3 that's what I mean.

4 So this is the problem, this is the problem when
5 it comes to the mask. We're not properly control --
6 and, in fact, it -- when you think about it, it's --
7 it's not logical, we don't think logically, because we
8 think about -- we've all seen our breath in cold air,
9 so we think if we're going to control our breath -- I'm
10 going to use the example, bad breath. If you want to
11 avoid somebody detecting bad breath, one of the things
12 you do you don't breathe on them, right? So you find a
13 way of making sure the breath goes some other way.
14 Even if you're looking at them, some people will sort
15 of breathe out the side of their mouth, change the
16 shape so it kind of directs it away from the person.
17 And this is inherently because we know that we can't
18 alter the direction that it goes, but so we're always
19 thinking of breath coming out from our mouths.

20 And so what the interesting thing is what people
21 often do, out of reflex, is in order to -- when they
22 have the masks on, in order to avoid having any of
23 these aerosols hit them or their breath hit them, they
24 tend to look away from them. And as I pointed out,
25 because of the -- what the direction -- the air -- the
26 air actually coming out, you know, by the ears, by

1 looking away from somebody, you actually redirect the
2 unfiltered air in their direction.

3 So an example, in my workplace, we were actually
4 told -- because it turns out that our hallways are less
5 than 2 metres, so we were actually -- what we were
6 actually asked to do was if we passed one another in
7 the hallways, we'd go belly to belly or chest against
8 the wall, like kind of inch our past one another with
9 our backs turned. And all time we're do -- all I --
10 you know, all I'm doing by doing that is, you know, at
11 least if I have the mask on and I'm looking at the
12 person, I'm directing the air away from them. As soon
13 as I turn my back on them, again, I'm directing air
14 toward -- in their general direction.

15 So this is the problem, and this is why we've had
16 trouble with the masking and controlling the spread of
17 aerosols, and why distancing, why distancing is quite
18 arbitrary in the context of aerosols. So, again, there
19 have -- there was a published scientific study in a
20 peer-reviewed journal that clearly showed with these
21 aerosols, they can travel -- they can travel, again
22 with the air currents, up to 30 metres, you know, if
23 they're carried on an air current that's swift enough
24 and going in a certain direction rather than swirling
25 air.

26 So it's all dependent on air currents, it's

1 dependent on the direction that the unfiltered air is
2 going. So we're talking about -- again, again, I would
3 say -- you know, I saw Dr. Hu's report, I agree 100
4 percent with him on the efficacy of masking with
5 symptomatic individuals, you know. But we're talking
6 about -- but, again, what you asked is people who are
7 going into the workplace who are asymptomatic, masking
8 to prevent the spread of aerosols and control the
9 direction in which they're going is not -- does not do
10 the job, not in the context of aerosols. So that's why
11 this virus has been spreading.

12 And I'd like to point out again, if you -- if
13 we -- if that is true, if the masks -- if the virus, it
14 could potentially spread on aerosols, and there's
15 some -- lots of studies have suggested that maybe it
16 can and -- but masks were doing their job, then we
17 would expect that people would have been protected.
18 But like I said, the actual -- in the study that was
19 published looking at immunity in healthy individuals,
20 people who never had any evidence that they were
21 infected or knew they were infected with the
22 SARS-Coronavirus-2, showed many healthy adults
23 acquiring immunity for the virus, and so that's been
24 occurring despite the masking.

25 Q Well, I need to ask you a couple questions about
26 asymptomatic transmission, because -- and symptomatic

1 transmission for that matter. Let me ask you this: Of
2 all the transmission of SARS-Coronavirus-2 or
3 SARS-Coronavirus-2, roughly how much comes from
4 asymptomatic people and roughly how much comes from
5 symptomatic people?

6 A So the subtotal of scientific literature would suggest
7 very little comes from asymptomatic individuals. It is
8 not zero. There is some asymptomatic transmission that
9 can occur.

10 One of the studies that often gets highlighted was
11 a -- again, it was a peer-reviewed scientific paper
12 published in an high-impact journal. It was actually
13 studied in a huge population in China, about 10 million
14 people, and the conclusion from that study was among a
15 sample size of 10 million people. They found no
16 substantial evidence of asymptomatic transmission.

17 And, again, it's not surprising, because, again,
18 for all the reasons I already explained, so I won't go
19 into them again in any detail, but just very quickly,
20 you have to have the virus in your lungs at a
21 sufficient quantity to be -- such that your body is
22 releasing enough to exceed that threshold dose needed
23 to cause illness in somebody else, and that almost
24 always requires active expelling of the virus from the
25 body through coughing and sneezing, but not always.

26 There is the theoretical scenario where you could

1 have somebody who's still not actively coughing and
2 sneezing, so they don't know that they're sick, it
3 might be a little bit threshold dose. When it comes to
4 biology, anything is possible. I'll never say anything
5 is impossible. So it is certainly theoretically
6 possible, and, in fact, I would argue it is a real --
7 real thing, but it would be high -- it's highly
8 improbable, meaning a rare event.

9 And there has been like a lot of agreement,
10 generally speaking, including among major public health
11 bodies, like the World Health Organization, there's
12 many organizations that, after a while into the
13 pandemic, we're starting to recommend just end the
14 testing, testing for evidence of SARS-Coronavirus-2 and
15 asymptomatic people for this very reason, because, you
16 know, again, we recognize you're testing healthy
17 people.

18 And what was being recognized though -- so
19 although there's very few cases, documented cases of
20 clear-cut transmission from asymptomatic people of
21 infectious viruses that may be at a dose that can cause
22 disease, it's definitely not a substantial driver of
23 this pandemic in any way, shape, or form.

24 So even, I'd like to point out -- so I notice
25 that -- you know, like Dr. Hu cited some peer-reviewed
26 scientific articles, and that's great, because, again,

1 that's the, you know, best type of evidence for this,
2 but even there, the important thing is looking at what
3 was actually measured.

4 So when you actually look, when they were
5 measuring some of the -- in some of those masking
6 studies, it was -- they were looking at, again, doing
7 genetic testing essentially, like PCR testing, to look
8 for evidence of the genetic material from the virus,
9 and so this -- you have to be very careful again
10 because -- okay, so this requires a little bit of
11 background in terms of measuring, measuring, how you
12 measure whether a virus is being filtered.

13 So with this PCR test that we've all probably
14 heard about, it's called polymerase chain reaction.
15 What it is is this concept that we can use little
16 pieces of genetic material that recognize sections of
17 the genetic material from the virus, and so if the
18 genetic material from the virus is present in a sample.

19 So, for example, if you put a mask on an
20 individual like -- and you ask them to breathe, and you
21 capture those samples, you can run this test to look
22 for evidence, you can ask is there any evidence of the
23 virus based on genetic material being present. And
24 when you do that, this test can detect small segments
25 of the genetic material from the virus, and then it --
26 this gets amplified, you run it for a number of cycles.

1 And if genetic material is present, you keep amplifying
2 it with each cycle, somewhat exponentially, until you
3 get enough of it, you can literally visualize it in a
4 test. So you can ultimately amplify it to such an
5 amount that you can visualize the genetic material, and
6 then you say, okay, so that genetic material seems to
7 have been present.

8 The problem with this is and the problem we've --
9 you know, I don't -- I can't comment on why this has
10 happened, because it's -- it's against all historical
11 standards, but we have relied on just the PCR test in
12 Canada for some reason, and we have arbitrarily picked,
13 in most cases, cycle cut-offs.

14 Because what happens, when you go to very high
15 cycles, your amplify -- you can -- what can end up
16 happening is you can end up amplifying background, you
17 get background signals we call it. And so you think
18 you see a causative result, but it's actually just
19 background. And we've been calling, running these
20 tests and calling -- so, for example, in Ontario, up to
21 38 cycles, if you can then detect a signal from this
22 test, we're calling that a positive test result for
23 SARS-Coronavirus-2.

24 But this is how it's supposed to work: We do
25 actually -- PCR is not a gold-standard test for
26 detecting it. Like it's a fabulous technology, but

1 like anything, all technology, it has limitations. It
2 is able -- what it's not able to do is detect -- it's
3 not able -- it's only going to tell you if a portion of
4 the genetic material -- material is present. It can't
5 tell you if there are replication-competent, intact
6 virus particles, in other words, virus particles that
7 have the potential to infect somebody.

8 But we do have a gold-standard test for that, a
9 virology assay. Remarkably, we abandoned this early on
10 in Canada. And specifically what's supposed to happen
11 is in order to validate your test, in order -- in other
12 words, in order to say, okay, my test, the results that
13 I'm showing in this test are proving -- or are
14 suggestive, highly suggestive that what I'm detecting
15 is infect -- or are virus particles with the potential
16 to infect somebody else. What you do is you take your
17 sample, and you split it into two, and with one, you
18 run your PCR test, and you determine at what cycle
19 number you get a positive result.

20 And in the other one, you do -- that uses
21 gold-standard virology test, which is actually a
22 functional test. What you do is apply the sample to
23 cells. You let these cells grow, you grow them on
24 plates, and we grow them for what's called confluence,
25 which means the entire bottom of the plate is covered
26 with these cells; you can't see the plate at the bottom

1 of the plate anymore.

2 And then what you do is you add your sample.
3 These are a special type of cell, we call them
4 permissive cell lines, and what they are are they are
5 cells that are stripped of all their anti-viral
6 properties, they're not able to protect themselves from
7 viruses, so that if there is a virus in your sample, it
8 can very efficiently infect these cells, and it will
9 start replicating and spreading, and it will kill the
10 cells. We call this cytopathic effect.

11 So what you do is you look at your cells under a
12 microscope, and you make sure, before you add your
13 sample, that the entire bottom of the plate is covered
14 with the cells, then you add your sample. If there's
15 any replication-competent virus there, which also
16 means, therefore, that it would have the potential to
17 infect and cause disease in somebody else, when you
18 look under the microscope later, you will see those
19 cells removed from the -- those cells have been killed
20 off, and now you'll be able to see the bottom of the
21 plate. And what you do is you find the cycle number at
22 which your samples no longer cause any damage to that
23 cell layer, and then that is how you prove,
24 objectively, the cutoff for your PCR.

25 And what's interesting is we actually did this --
26 I did. Our micro -- National Microbiology Laboratory,

1 which is part of the Public Health Agency of Canada.
2 It's located -- it's one of our -- it's a Containment
3 Level 3 and 4 facility in Winnipeg, Manitoba, they did
4 this at the beginning of the pandemic, and -- which was
5 the appropriate thing to do, and remarkably -- and this
6 is published, this is a peer-reviewed published paper
7 that they issued early on in the pandemic. And what's
8 remarkable there is they set the cut-off at 24 cycles.
9 Now, that doesn't mean anybody running a PCR test has
10 to have their cut-off at 24 cycles. The -- the actual
11 cycle cut-off, any person running this test should,
12 first, establish what the cut-off is for themselves, with
13 their particular protocol, their set of reagents, and
14 their particular technical expertise.

15 So the cycle number should act -- for the cut-off
16 should change from laboratory to laboratory, but
17 everybody should be able to show you that gold-standard
18 virology assay and the results from it to provide the
19 rationale as to why they picked that particular
20 cut-off.

21 But nevertheless, it -- because it's not going to
22 stray too far from that. And so my point is the
23 National Microbiology Laboratory showed that the proper
24 cut-off in their hands of the PCR assay was at 24
25 cycles. In other words, this paper, if you go and you
26 read it, our own public health scientists that

1 published this, what they found is that if the PCR test
2 came up positive at cycle numbers higher than 24, those
3 samples, they were unable to infect the cells in that
4 gold-standard virology assay with those samples.
5 Meaning, there was no evidence of replication-competent
6 or -- virus particles that had the potential to infect
7 anybody else.

8 So if they were running the diagnostic tests, for
9 example, to the PCR, therefore, they would set the
10 cutoff at 24. They would say anybody with a positive
11 test result up to 24 -- and they wouldn't have to run
12 this assay again, you don't have to do it every time,
13 and it makes no sense to do so -- they would then, with
14 high confidence, be able to say anybody who tests
15 positive up to a cycle number of 24 almost certainly
16 has infection of -- replication-competent viruses in
17 their body with the potential to infect others. But
18 the reverse of that conclusion is anybody with the test
19 result that is cycle number above 24, they would have
20 to conclude that those people are not able to infect
21 anybody else.

22 And so this is the problem, because a lot of the
23 publications that relied on this genetic test, and,
24 therefore, there is, without the gold-standard test
25 being run in parallel, there's no way to tell whether
26 their positive results were false positives, or even --

1 the thing I like to point out, there are genuine
2 positive tests but that do not -- but -- in which those
3 individuals, so they're genuinely detecting, they're
4 truly detecting genetic material from the virus, but
5 those people actually aren't infectious, and that's
6 actually people who have mounted immune responses.

7 This is very important to understand, because what
8 happens is one of the things our immune system does --
9 I didn't go into the details, but some of you may
10 recall when I was explaining kind of line of defences,
11 I mentioned that once the virus penetrates the physical
12 barriers and starts affecting cells, we have these
13 sentinel cells which will detect infection and trigger
14 these subsequent immune responses.

15 Well, these sentinel cells, one -- and a couple
16 other cell types, what they're designed to do very
17 on [sic], in order to detect these viruses is they
18 gobble them up, they actually consume them. We call
19 this phagocytosis, right? So they actually basically
20 eat, consume the virus, and then what they do is they
21 take the virus, and they break it into pieces, and then
22 they take these pieces, and they actually take it to
23 the draining lymph node, and they show it to our B and
24 T cells, to say, Look, here's a dangerous pathogen that
25 you need to go and try and clear from the body.

26 And then we get our B cells and T cells activated.

1 The B cells are the ones that then produce the
2 antibodies. And you know that this process is
3 happening when your lymph node swells, because if those
4 B and T cells are being activated, they start
5 proliferating in large numbers, so we have an army, an
6 army that's designed to go and recognize the pathogen.

7 So that's why if you're sick, like you have a
8 throat infection, you can often palpate the lymph
9 nodes, right, just behind your jaw, or your physician
10 does that. That's what they're looking for for
11 confirmation, because your lymph node is swelling; that
12 means you're actively mounting an immune response
13 against the pathogen, and it's clear evidence that
14 you're infected.

15 But, so, this is what you have to understand, this
16 is the key, to get to that process, we have to have
17 cells that gobble up the virus and carry it to the
18 lymph node and show pieces of it. These cells will
19 hold on to that so that virus is no longer
20 replication-competent. It's inside the phagocytic
21 cells and -- but it -- they will hold onto this for up
22 to weeks, even sometimes months, and that is to make
23 sure that there is always a supply of the target that
24 the immune system needs to respond to to protect the
25 body.

26 So it can take -- usually it doesn't take months,

1 but certainly, for sure, at least two to three weeks,
2 they'll be holding onto this material in case -- and
3 that's the case, the immune system has to keep
4 responding, in case they have to keep getting more
5 effectors recruited, depending on how virulent the
6 virus is.

7 And so in many cases, that -- then what you get is
8 you get a true positive test result with the PCR.
9 There's actually, you know, viral particles present --
10 or partial viral particles, at least pieces of the
11 general genetic material present in the body, but as
12 you can imagine, that's not ever going to infect
13 anybody, right? It's inside the cells of our immune
14 system that use that to educate the rest of our immune
15 system.

16 So this is why it's important to understand how
17 this works. Yeah, so I'll leave it at that.

18 Q Thank you. All right, so I need to go back to -- you
19 established that SARS-CoV-2 spreads by aerosols; we've
20 established that the masks don't stop aerosols; we've
21 established that they do tend to stop the bigger
22 droplets, we've established that asymptomatic spread is
23 rare. And that leaves the question then, forgive me,
24 but if I'm listening logically to what you're saying,
25 then, when symptomatic people wear a mask, they'll end
26 up spreading SARS-CoV-2 through aerosols; is that

1 correct?

2 A Yes. Again, there's evidence this virus can spread
3 through aerosols. So one thing, just to clarify what
4 you said just a moment ago, the -- so, yes, there's
5 evidence that the virus spreads by aerosols, but I also
6 want to make it clear, the virus is going to spread
7 very efficiently through the large water droplets with
8 the coughing and sneezing as well, as well as contact
9 media transmissions.

10 So I notice in Dr. Hu's report, you know, he had
11 mentioned that as well -- he had mentioned all three --
12 all three occur. He placed more emphasis on the large
13 water droplets and the contact transmission, so I don't
14 disagree. I just want to make that clear. But again,
15 those are symptomatic individuals; we're talking about
16 large water droplets and contact transmission, those
17 are people who are actively -- you know, actively
18 releasing large amounts of the virus.

19 And so with a contact transmission, actually I
20 have additional concern there, because I agree that
21 contact media transmission is an issue, and that's
22 where I'm concerned when we -- when we're old -- when
23 we're making people use these masks only in the context
24 of aerosol media transmission, because, again, those
25 who are actively sick are isolated, what we're doing
26 with these masks, because of the contact -- or

1 potential contact is where we -- people are constantly
2 handling their masks, right? So if there is any spread
3 of virus, we're actually bringing their hands to their
4 mask.

5 I have been -- I am unable -- I wear a mask on a
6 regular basis, clearly for some of the, you know,
7 surgical work that I do as part of my research program.

8 I -- when I'm doing the surgical stuff, I do tend
9 to be very careful, you know, very mindful of that.
10 And even there, it's very difficult not to touch a
11 mask, but you're taught, you know, when you're doing
12 surgical work not to touch it. But, otherwise, unless
13 you're doing surgery, I'm not able to -- especially if
14 I'm -- unless I'm focused on it all the time, I'm not
15 able to avoid touching my mask. In fact, the average
16 person cannot talk for any substantial period of time
17 and not have to touch their mask because it causes
18 bunching of the mask, you know, and it pulls off the
19 chin or it pulls off the nose. So there's very few
20 people who get through an eight-hour workday without
21 handling their masks over and over and over and over
22 again.

23 And worse, many people, unlike a surgery, where
24 you would then discard your mask, and then if you have
25 another surgery, you would put on a fresh one, there's
26 a lot of people who keep reusing their masks over and

1 over. So that potentially enhances the contact media
2 transmission. So I just want to be clear on that, that
3 it's not just the aerosol, it's contact media
4 transmission and large droplets. And wearing a mask
5 for the large droplets can handle that, but you don't
6 want to be handling the mask or else you're promoting
7 the contact via transmission. But, again, I highlight
8 that's symptomatic people, and we're screening those
9 individuals out, so they're not supposed to be in the
10 workplace, so that leaves, therefore, just the aerosol
11 media transmission.

12 And so, yes, I agree with you that in the context
13 of the aerosol transmission, an asymptomatic person
14 leaving their home and then donning their mask to try
15 and prevent the aerosol media transmission for all the
16 reasons that I just cited prior to this is not going to
17 be effective at preventing transmission by that route.

18 Q The question that I'm left with and I think many people
19 are if they have the masking in place, and we have the
20 screening in place, and yet what we've seen in the last
21 year-and-a-half that we've had masks, because we didn't
22 have it the first few months of the declared pandemic,
23 the last year-and-a-half that we've had masks, we've
24 just seen the spread increase and increase and increase
25 and increase. And yet, what you're telling me is that
26 it is effective with symptomatic people because it --

1 somewhat because it stops their droplets and spittle.

2 And I'm left with that question, right, of if
3 masks are somewhat effective with symptomatic people,
4 and symptomatic people are supposed to be removed, and
5 it seems like they sometimes are, and yet we still have
6 all this increase in spread, all right, so people --
7 nonscientific people like me are left scratching their
8 head.

9 A Would you like me to address that point?

10 Q Yes.

11 A Yeah, so it's for the reason that we've been talking
12 about is the aerosol media transmission.

13 Q Okay.

14 A So I've cited in my report, there's a large number in
15 there. I mean, that's exactly what was looked at. So,
16 again, just to make this clear, there's a big
17 difference between SARS-Coronavirus-2 and the viruses
18 that we're familiar with. This is why I took some time
19 to investigate it.

20 So what seems to relatively unique about the
21 SARS-Coronavirus-2 is this aerosol media transmission.
22 That's something else they should clarify. Previous
23 viruses historically -- because -- so this is again
24 why, initially, the masking seemed to make sense, but
25 only in the context of symptomatic individuals is
26 because we assumed that the primary mode of spread was

1 the coughing and sneezing and contact media
2 transmission. So that is pretty much what most of the
3 previous viruses and our other viruses that we're used
4 to causing respiratory infections, they usually fall
5 into that category.

6 For the flu virus, for example, that is the
7 primary way by which it is spread. It's not
8 recognized. In fact, it's well recognized that the
9 influenza viruses don't spread very efficiently via
10 aerosols. So that's what's unique to this virus.

11 So, again, like all our historical studies and the
12 masking studies, again, this is a strategy that is
13 designed to stop those kind of respiratory pathogens,
14 and that type of transmission, but not aerosol
15 transmission, and so that's why we've been seeing this.
16 And that's why I say when you take sick people away
17 from other people, that's the most effective way, but
18 the problem is with the aerosol transmission, people
19 are still able to go out there, right, and transmit
20 this virus.

21 And the issue here is with the -- yeah, the
22 masking in particular. So this is something that I
23 hadn't highlighted, which I think is important, because
24 what it comes down to then is what would a protective
25 mask look like or what would really protective masking
26 look like in the context of aerosol media transmission.

1 So as a researcher, this is something that they
2 deal with all the time. My entire laboratory is rated
3 as a Containment Level 2 laboratory, so all of my
4 entire research space. So this is because we work with
5 what's called Containment Level 2 biosafety hazards.
6 So -- and there's a certain amount of protection
7 that -- that we implement to protect us. So these are
8 not particularly -- these are not dangerous; these are
9 not dangerous pathogens; these are not disease-causing
10 agents, or, at most, if somebody were to get a large
11 dose of them, it would cause mild disease at the most.

12 But so -- but what we have to do all the time when
13 we are -- design a research program, I -- we're
14 constantly policed in the sense that I have to get a
15 biohazard permit in order to conduct my research. So I
16 have to describe how I'm conducting my research and
17 what protections are in place to make sure that people
18 aren't put at unnecessary risk from the Containment
19 Level 2 to agents that we work with.

20 The SARS-Coronavirus-2 -- and so I'm very
21 familiar, therefore, with biosafety strategies, right,
22 and personal protective equipment that one would use in
23 these scenarios. And like I said, I've done
24 collaborative research on the SARS-Coronavirus-2.

25 For the one publication that we published recently
26 dealing with the novel vaccine, that involved a

1 challenge study with the SARS-Coronavirus-2, where
2 animals were vaccinated and then challenged with the
3 virus. So that work is done, and it can take -- what
4 we call Containment Level 3. So SARS-Coronavirus-2 is
5 considered a Containment Level 3 pathogen.

6 Now, this is interesting because this then says --
7 so we have -- the Public Health Agency of Canada has
8 told us what the appropriate protection is against a
9 Containment Level 3 pathogen, and I have that in my
10 report. So, in fact -- not people to look at it, but
11 if you want to take a note and look at it later, I
12 would refer everybody to Figure 7 on page 13 of my
13 report, because what I've done there -- what I've shown
14 is a picture of a stereotypical personal protective
15 gear that one would wear to protect themselves against
16 infection with a Containment Level 3 pathogen.

17 And so what I can tell you is -- I mean, it would
18 be laughable if I ever put on a surgical mask or a
19 cloth mask and then asked to go in and challenge our
20 animals with a SARS-Coronavirus-2 wearing that. I
21 mean, I would get myself in serious trouble. I'd
22 probably have my biohazard permit revoked for showing
23 such lack of understanding of personal protective
24 equipment, because I'd be putting myself at incredible
25 risk of being infected with the SARS-Coronavirus-2,
26 because a lot of the procedures that we're doing create

1 aerosols. So if you're pipetting, which is a -- it's a
2 scientific tool for allowing us to deliver precise
3 quantities of fluid; that's known to create aerosols.

4 So a lot the work and manipulation we do -- and
5 we're working with high doses of viruses as well,
6 remember, in those kind of settings with lots of
7 potential for aerosol production, so I'm very familiar
8 with what it takes to protect one from a pathogen
9 that's been aerosolized.

10 And if you can refer to this picture, the first
11 thing you'll notice is the individual has the pathogen
12 in a tube, a closed tube, and these tubes will only be
13 opened inside this special unit that their arms are
14 inserted into. It's called a biological safety
15 cabinet. And if you can see the picture, you'll notice
16 that just in front of the individual's elbows, there's
17 a grate. There's a solid stainless steel surface
18 inside the hood, and what's in the front of it is a
19 grate.

20 And what happens is this has special air flow, and
21 what happens is air actually blasts up from this grate
22 and then up into the cabinet and then goes through a
23 HEPA filter -- actually a number of HEPA filters.
24 HEPA -- so unlike the masking material in the low-cost
25 masks like the surgical masks and the cloth masks,
26 which have very large pore sizes, HEPA filters have

1 extremely small pore sizes that are designed to filter
2 out most pathogens. And so what that air, therefore,
3 is -- so what it does is creates a wall of air in front
4 of you that is basic -- essentially sterile air. So
5 you actually run these things for 20 minutes, so if
6 there's any contaminants in it, after 20 minutes, the
7 air that's running is essentially sterile. So then
8 when you put your arm -- you put your arms in slowly,
9 because you don't want to disrupt the air flow too
10 much. By doing so, you're literally going through an
11 air barrier, so no aerosols can come out of that
12 cabinet.

13 But in case any does, however, say for example,
14 that individual were to make a mistake and insert the
15 arm too quickly to disrupt that air flow excessively
16 and allow a little bit, potentially, of aerosol to come
17 out, that's why they have the rest of the personal
18 protective equipment, the gloves and the gown, is to
19 minimize the potential for contact media transmission.
20 You don't want spills on your personal clothing, right,
21 such that, you know, if you go home, you know, you
22 might be touching your clothing, then touching other
23 things, so that's to protect against that contact media
24 transmission.

25 But you'll notice they don't -- they aren't
26 wearing a cloth mask or a surgical mask; they're

1 wearing a mask -- and as you can see, very different --
2 this is actually a requirement interestingly. I would
3 not be able to go into this facility with the mask
4 that's in this picture. And so if you notice what the
5 difference is between the individual wearing that mask
6 and me, I've got a beard. And so this is very
7 important to note. So if you look at their mask,
8 you'll see it has elasticized material such that it
9 provides a tight seal along the skin everywhere. And
10 then around the hair, you'll see a headband. And then
11 what you see is you see a tube coming out from the back
12 of the -- the headpiece, and what it goes to is a
13 little unit that mounts on the belt at the back of this
14 individual, and this actually actively filters air.

15 So what that -- what that has is has a fan in it,
16 and it has HEPA filters, and so it's actually drawing
17 in air from the environment, from the room this
18 individual is in, passing it through HEPA filters and
19 then into that hood and specifically the face mask area
20 so that what they're breathing is HEPA filtered air.

21 And like I said, so this individual -- so often,
22 people working in these facilities are required to
23 shave so that their mask can actually make proper
24 contact, right? Because right now, I'm allowed to wear
25 a cloth mask right now, and I'm not -- and I like to
26 have a beard, and it's winter time, and I'm not

1 required, but I'll tell you the -- and because I know
2 of the futility of masking in the context of aerosols,
3 but the reality is, you know, if I were to wear a mask
4 right now, I mentioned about how air would escape past
5 the ears and the nose, well, also around my beard
6 because the beard is holding the mask away from my
7 skin, and I can guarantee that my beard has far larger
8 pore sizes in it than the masking material.

9 So I just want to point that out, because that's
10 our own government agency that's designed for telling
11 us how we safely interact with Containment Level 3
12 pathogens, of which SARS-Coronavirus-2 is, that is how
13 one would protect themselves from aerosolized mediated
14 transmission of a Containment Level 3 pathogen, and as
15 I'm sure you can appreciate, it's not a cloth or a
16 surgical mask.

17 Again, I can't emphasize enough that if I were to
18 try to enter this facility and conduct this type of
19 research with that, I would almost certainly have my
20 biohazard permit rescinded and my ability to conduct
21 that type of research removed, at least temporarily,
22 until I underwent training to demonstrate that I
23 understand how to truly protect myself from a
24 Containment Level 3 pathogen.

25 And this isn't just for the individual of course.
26 The key thing, in any of this strategy should be both

1 protecting the individual and also the people around
2 them. You don't want a researcher coming out of a
3 Containment Level 3 facility potentially spreading
4 Containment Level 3 pathogens to the public.

5 Q Is there any logical or scientific reason to think that
6 masks are more effective at preventing transmission of
7 the virus by asymptomatic people in one place than
8 another?

9 A No, no. They're physically -- they're operating based
10 on the same physical principles. Now, I have seen the
11 argument made that maybe the environment can
12 potentially put an individual at greater risk. So, for
13 example, in the health care environment, again,
14 masking -- the physical protection conferred by a mask
15 doesn't change based on the environment that they're
16 in, but the potential risk of exposure does.

17 So a health care worker working with actively
18 infected individuals certainly might be at increased
19 risk of potentially being exposed. All the more reason
20 why I would argue that they actually need proper
21 protective equipment, so beyond the cloth mask, like
22 something that would actually be designed to filter out
23 this, and those are things that could not be worn for
24 long durations of time. That would, for example, be
25 like a rubber mask that could be fit-tested, again, to
26 seal on the face; you wouldn't be allowed the beard,

1 and would have -- potentially the filters mounted to
2 it. But you'll find that those devices, very difficult
3 to breath with those devices for long periods of time.
4 But that's the type of thing that might be appropriate
5 in those settings. So, no, this type of masking isn't
6 going to help in different settings.

7 But what I want to point out is -- so one of the
8 things I noticed actually in Dr. Hu's report is that he
9 brought this up in terms of health care workers. I
10 mean, I'm no expert with chiropractors, but I agree
11 with him that a health care worker working -- and he
12 used the example of people who are -- were known to be
13 actively infected and potentially infectious with
14 diagnosed COVID-19. Where, I guess, I differ on
15 this -- and, again, I'm not an expert in the world of
16 practicing as a chiropractor, so I could be
17 corrected -- but my understanding is that the average
18 chiropractor is not being expected to work with a
19 symptomatic COVID patient, diagnosed with COVID-19, so
20 I would -- especially in that case, I wouldn't have a
21 concern.

22 If -- so if a health care worker is working
23 with -- is asymptomatic, and the patient they're
24 working with is asymptomatic, having a mask just
25 doesn't seem to make logical sense to me. A mask that
26 is designed to effectively prevent transmission because

1 of lack of sickness doesn't make sense to me.

2 Q Forgive me, you've answered so many of my questions, I
3 have to do a bit of a review here.

4 Okay, so I'm going to ask a couple questions here
5 about aerosols and droplets, and then I think maybe we
6 can leave that behind, because there seems to be
7 contention on this. Would you say that the balance of
8 the available academic literature supports aerosol
9 transmission?

10 A So this is interesting, the -- it's debatable. This
11 aspect is debatable about the aerosol-mediated
12 transmission. Certainly without the act of coughing
13 and sneezing, it would be difficult to get a, again, a
14 threshold dose needed to infect somebody out with the
15 aerosols, and there was -- earlier on, in order to
16 explain this spread and the spread despite masking,
17 that that's where a lot of the publications were geared
18 towards were showing this aerosol-mediated
19 transmission, that's been questioned now as well. So
20 it's actually a little bit difficult to say
21 definitively, based on the scientific literature, it's
22 an active area of debate I would say.

23 And like I said, especially because, as we now
24 have two years of experience and despite this strategy
25 having been implemented throughout the duration, right
26 from the beginning, but the ongoing spread of

1 increasingly --

2 (AUDIO/VIDEO FEED LOST)

3 MS. NELSON: Sorry, I don't mean to
4 interrupt, but Dr. Martens has dropped off the call, so
5 if we could just pause until I get her back, please --

6 A Yes.

7 MS. NELSON: -- that would be great.

8 Q MR. KITCHEN: Thanks, Dr. Bridle.

9 Dr. Bridle, I welcome you to continue.

10 A Okay.

11 Q But I just want to make sure I have this right, are
12 there three potential or likely areas of methods of
13 transmission: Droplet, aerosol, and contact; is that
14 accurate?

15 A Yes.

16 Q Okay.

17 A Now, I guess, yeah, in the context of SARS-CoV-2. If
18 we're talking about pathogens in general --

19 Q Right.

20 A -- (INDISCERNIBLE) like sexually transmitted diseases,
21 but, yes, certainly SARS-CoV-2, for example --

22 Q Yes.

23 A -- those would be the three primary potential modes of
24 transmission.

25 Q Okay, well, let me ask you this, and, again, you can
26 continue going on about aerosols and droplets and all

1 that, but I -- what, if any effect on contact
2 transmission do masks have?

3 A Potentially increasing it for the very reason that I
4 said. I have -- I mean, I'm not going to excuse any
5 individual, because there might be individuals who,
6 miraculously, are able to wear a mask for very long
7 periods of time and never touch it. I'm not going to
8 say that's an impossibility, but I have watched
9 hundreds of people throughout this pandemic, you know,
10 because it's an area of interest of mine, because
11 everybody's been instructed to not touch their masks
12 because of the acknowledgment that there's
13 contact-mediated transmission. I know it's in Dr. Hu's
14 report that he -- you know, he mentioned that as a key
15 potential way to transmit.

16 And I have yet -- I have yet to observe any
17 individual who has not touched their mask multiple
18 times within certainly let's say within an hour. I
19 have not once seen anybody not touch their mask
20 multiple times during a one-hour span. And, again,
21 it's just natural with these masks. There are masks
22 that are designed to stay in place. Again, if you
23 refer to Figure 7 that I have in my report, that type
24 of mask will stay in place; it's got very firm
25 headbands, and it's designed to, you know, to seal.
26 It's got -- you'll notice that the material, if you'll

1 notice the material, it's elasticized, and it's
2 flexible. So, for example, this individual would be
3 able to talk, you can envision his jaw moving up and
4 down, and all the material that's attached to the
5 plastic face shield, it is flexible -- or not flexible
6 but loose enough that it allows that movement.

7 And see the differences with the mask, if I'm
8 talking to you -- if I put on a mask right now, as I'm
9 talking to you, within -- I don't exact time, but
10 probably within 30 seconds, the mask, again, will have
11 migrated off my nose or off my chin, and I'll have to
12 do an adjustment. So unless you're sitting with these
13 masks, never use -- never chewing, like not chewing on
14 gum, not talking, it's going to be very difficult. And
15 even at that, you know, people get itchy noses and so
16 on. And depending on how they take their masks on or
17 off, there's actually -- I mean, there's proper
18 training procedures even for putting masks on and off.

19 Especially for surgery, right, you want to keep
20 everything sterile, you want to keep your gloves
21 sterile, you want to keep any masks that you put on
22 sterile, right? So the proper thing would be just to
23 handle the mask by the straps that go over the
24 earpiece, right, and nothing else. But people, all the
25 time, are grabbing their mask, you know, or taking
26 their mask and grabbing it, you know, and stick in

1 their pockets or whatever. This is not the way these
2 masks were designed to work.

3 Again, originally, remember, these masks came out
4 of the concept of surgery and trying to make -- keep
5 surgical fields as clean as possible. And if you watch
6 how a surgeon dons and doffs their surgical equipment,
7 including their mask, it's very different from what the
8 average individual is right now, because we haven't
9 trained, we haven't trained the general public in that
10 kind of, you know, what we'll call sterile technique.

11 So, no, wearing a mask in an inappropriate
12 environment can potentially cause more harm. Again,
13 I'm not concerned. I'm not concerned about that
14 contact media transmission if the person isn't
15 symptomatic.

16 Q Right, so but, you know, I've heard you say, obviously,
17 the masks don't work for asymptomatic, but I've heard
18 you say they kind of work for symptomatic because
19 they'll stop the droplets, but, in your opinion, do
20 masks -- are they a net contributor to spread or a net
21 inhibitor of spread when you balance out the
22 contribution to contact spread with the reduction of
23 droplet spread?

24 A Okay, so I would think that the net would be
25 potentially enhancing for the -- again, for -- again --
26 and if it's an asymptomatic individual. And the reason

1 is if there is any --

2 Q Hold on, asymptomatic or symptomatic?

3 A The -- well, in both cases, right, they're going to do
4 something for the -- well, again, if somebody's not
5 sick, then I'm just not worried in general. If
6 somebody is shedding the virus, if that's the scenario
7 where somebody is shedding a virus, I think it's going
8 to have a net negative result. And that's because,
9 again, it's not designed to filter out the aerosols.

10 What happens when people put a mask on, there's
11 well-established behavioural changes that occur, right?
12 When we feel -- when we feel more protected, we tend to
13 behave -- it's human nature to tend to behave in
14 riskier ways.

15 So it's interesting, this is interesting: I play
16 hockey, for example, I'm an ice hockey goaltender.
17 Now, so one of the things is if you want to -- if you
18 want a contact game -- or, sorry, a contact-free game
19 of hockey, one of the general rules of thumb is you
20 don't have people put on -- you put -- you have them
21 put on the minimal amount of safety equipment. And
22 what will often happen is because, following -- what
23 often presents a very danger to the elbows is the elbow
24 pads, but a lot of people will not wear the shoulder
25 pads, because that's not a particularly risky area.
26 And one of the reasons is is because it's

1 well-established behaviour, if you load yourself up
2 with armour, you tend to be more risky in your
3 behaviour, potentially more aggressive in a sport like
4 that. And it's not different than everything.

5 And so what happens is when people -- when -- this
6 is the problem, see if people mask, and they understand
7 the limitations, they understand what they're designed
8 for, where their strengths are and where their
9 weaknesses are, you're fine. But the general messaging
10 that people have received is that these masks are
11 fabulous at preventing the spread of this. And so when
12 you have that program in your mind, As long as I have
13 my mask on, I'm not a risk now to anybody else, and
14 they're not a risk to me; what you inevitably see is,
15 on average, masked people will tend to interact closer
16 than people who are unmasked, and that's just the
17 reality.

18 And so if there is aerosol mediated transmission,
19 if you're, on average, interacting in closer vicinity
20 with somebody, there's the potential for greater
21 aerosol mediated transmission than if you're not
22 masked, you don't feel that, you know, (INDISCERNIBLE)
23 extra protection.

24 And so that's what I argue, as a scientist, I
25 mean, when I wear it, I know that it is -- you know, so
26 I wear them because I have to when I go to the grocery

1 store and everything, but I recognize that they're not
2 properly protecting against aerosol mediated
3 transmission. And so if there can be aerosol mediated
4 transmission, of which is active debate in the field,
5 you know, I recognize -- I'll stay in my -- you know,
6 far away from individuals. So that's one -- that's one
7 potential harm.

8 So, yes, the net effect on average is the average
9 person who is masked won't maintain as much distance,
10 and so if they are transmitting, that could potentially
11 be an issue. And then the other is that the contact
12 that I just mentioned with the mask.

13 So, again, I simply -- I just am not concerned
14 about asymptomatic or healthy people, period. But --
15 so -- but if anything, the net result of masking --
16 that's what I'm saying is especially if you're
17 symptomatic, that's where the mask can stop the
18 droplet -- the droplets, but there especially, you have
19 to be very careful. Again, you know, if you're going
20 to the workplace in, like I said, that I have, I have
21 multiple masks that I change regularly, and, again, I'm
22 mindful because I've been trained in this concept of,
23 you know, sterile technique in the microbiological
24 world and thinking from that perspective; because
25 especially if you're symptomatic, you are spewing
26 droplets into that mask, and it's getting soaked, and

1 it will soak through. This is material that's
2 absorbant. You can think, especially with a cloth
3 mask, it'll soak right through. And you can see
4 that -- the wet stains. And so if you're grabbing that
5 mask, you're going to dramatically enhance contact
6 mediated transmission and -- and you have to be, again,
7 mindful that when you have that mask on, although it's
8 effective with the large water droplets, you don't want
9 to go closer to people than necessary.

10 So, yes, you have to be very careful with masks:
11 You have to recognize the strengths, their limitation,
12 and you have to maintain other strategies that are
13 independent from the mask. And by that, I mean, again,
14 recognizing the inherent weaknesses of the masks and
15 so, you know, not grabbing them, you know, not touching
16 them and then, you know, touching others and that type
17 of thing.

18 Q So in your opinion, is this part of the reason why,
19 after a year-and-a-half of masking, the cases and the
20 infections just keep going up?

21 A Yes, yeah. It's ineffective in the context of
22 controlling the spread of SAR-Coronavirus-2. Again, I
23 can't emphasize that enough. I use my own workplace as
24 an example. We've prided ourselves on the fact that
25 well over 99 percent are vaccinated, and I can tell you
26 that the messaging both from the president of my

1 university and the Medical Officer of Health, who has
2 presented in multiple town halls, have told us,
3 although, again, it's -- this is -- it's often
4 difficult to comment as a scientist, because there's
5 the publicly acknowledged message, and then there's my
6 message as a scientist, but --

7 So their message has been that the vaccines are
8 excellent at protecting people, break-through
9 infections are very rare, and it either prevents
10 transmission or reduces that -- the number of viral
11 particles that get transmitted, so excellent at overall
12 trying to prevent transmission. So that's my campus
13 community, more than 99 percent fall into that
14 category.

15 And -- but everybody is still doing the exact same
16 masking and the physical distancing, and yet
17 SARS-Coronavirus-2 has ripped through our community.
18 We recently had two -- two of our residences with
19 outbreaks, declared outbreaks of -- so, you know --
20 and, again, I always find it difficult. So the public
21 messaging was those are outbreaks of COVID-19. What
22 they really were outbreaks of people identify -- who
23 had positive test results for SARS-Coronavirus-2. I
24 can tell you the majority of the students, you know, we
25 had no deaths. The vast majority of the students had
26 mild cold-like symptoms for a couple of days.

1 I can also give you the example at my son's high
2 school, the same Medical Officer of Health recently
3 declared an outbreak at his school. One of the cases
4 was confirmed, where sequencing was done, to confirm
5 that it was Omicron. And so the whole school was shut
6 down, right, and everybody went home. In that case,
7 the individuals both had -- they reported mild
8 cold-like symptoms for three days and then recovered.

9 But the whole point being in that school again,
10 this is high school, so they've been actively promoting
11 vaccination. It's not nearly close to a hundred
12 percent, like in the university, where it's been --
13 people are not allowed on campus if they're not
14 vaccinated, but a large profession, and masking every
15 day, right?

16 So this is all evidence -- and so that -- and
17 again, I'll emphasize again, Omicron, that wave in
18 terms of the number of people who tested positive for
19 SARS-Coronavirus-2, it dwarfed, I mean, it shattered
20 all previous records, you know, that we had in all
21 previous waves, and this is despite not only the
22 masking and the physical distancing that was there from
23 the beginning but added to it what we hoped was this
24 super strategy of vaccinating everybody. So even with
25 that thrown on board, the masks have not stopped the
26 spread.

1 So my professional opinion is and has been from
2 the beginning that the way we're using these masks is
3 not appropriate, it's not going to stop the spread, and
4 worse, that there are harms. Again, I am not concerned
5 in the context of symptomatic [sic] people, the masks
6 necessarily promoting harm of spread because they're
7 asymptomatic, they're not sick, but there are inherent
8 harms to the mask itself, to individuals wearing them.

9 Would you like me to talk about that at all; is
10 that something that's relevant?

11 Q Well --

12 A I have that in my report. I have it in my report if
13 you're interested.

14 Q No, and I see that. Well, I mean, you seem to talk
15 about -- well, let me ask you this: This fact that
16 masking potentially actually increases the spread of
17 SARS-Coronavirus-2, would you identify that as a harm?

18 A Yes.

19 Q Now, I know you identified the harm of low oxygen
20 levels, but you also, which I found interesting, you
21 mentioned the harm of muffling speech and inhibiting
22 communication between individuals. Do you identify
23 that as a significant harm?

24 A Yes, yeah. So I live in the world of special needs. I
25 have two children with special needs, one of them does
26 have speech difficulties. He has Down Syndrome, so I'm

1 around individuals with special needs all the time.
2 I've interacted as a parent supporting work done by a
3 speech therapist. And one of the things that I can
4 tell you that has been particularly difficult, his
5 speech through the speech therapy and also through
6 sheer hard work, especially through my wife, his speech
7 has dramatically improved, but this improvement has
8 largely happened over the last couple of years. You
9 know, he's in his formative years, he just turned 12.

10 It was exceptionally frustrating for him early on
11 in the pandemic and frustrating us as parents to
12 observe, because what a lot of people don't realize
13 that when it comes to Down Syndrome, a lot of
14 individuals have difficulty speaking. The best way to
15 explain or for people to experience what it's like if
16 an individual has Down Syndrome to try and speak is
17 there's physical reasons for this. They tend to have
18 smaller than average mouth cavities and larger than
19 average tongues, size of tongues, often length. So I
20 mean, my son, if he sticks out his tongue, a little bit
21 like a snake, so long, but also very thick, and this
22 combines to make it hard for them to speak like many of
23 us. Again, it's difficult for him to physically get
24 his tongue behind the teeth or the roof of the mouth,
25 for example, because of the length and because of the
26 size. So it's like if we were to stuff a couple of

1 marshmallows in our mouth and then try and talk, it
2 muffles the speech.

3 So he had difficulty being understood at the best
4 of times, and with the mask on, that further muffles
5 the speech. So he went through a period where he
6 progressed so well with his communication in school,
7 and all of a sudden, for a long period of time, his
8 teachers lost the ability to understand him for quite a
9 while, and he had to learn with the mask to speak
10 louder and to learn to annunciate even better to get
11 that back.

12 So it was very hard for that -- to see that step
13 backwards. You know, you have to understand for an
14 individual, especially a young person, to lose the
15 ability to communicate your thoughts and feelings
16 becomes very difficult. So that's just an example on
17 that side.

18 Even in terms of muffling the speech, so, again,
19 I'll give an example to try -- you know, to try and
20 convey, you know, an example of -- that we might be
21 able to familiarize ourselves with. I personally like
22 watching professional basketball. The Toronto Raptors
23 are my favourite team. If anybody has watched the
24 Toronto Raptors, one of the things that you'll know is
25 that their coach, Nick Nurse, has got himself into
26 trouble multiple times throughout the pandemic. He

1 always wears the mask, and he's always taking his mask
2 off, and he gets in trouble for it, you know, people
3 from the public complain that he's not wearing his mask
4 or not wearing it properly. And the reason he gives
5 every single time is he's the coach, he's trying to get
6 critical instructions to his players, and they can't
7 hear him or understand him. And you'll see it, it will
8 be in the heat of the moment of a game, and he's trying
9 to get instructions to his players, and that's when he
10 pulls his mask off and is giving instructions to his
11 players, and then he'll put it back on.

12 And that's the case, you know, we've all -- I'll
13 tell you in the context of teaching, we've really had
14 to adopt the whole concept of using microphones,
15 because it's even very -- more difficult to project our
16 voices to the back of the classroom. So, yeah, muffled
17 speech definitely has that in impairing the ability to
18 communicate.

19 MR. MAXSTON: Dr. Bridle and Mr. Kitchen, my
20 apologies for interrupting, but I think we've gone a
21 little far afield of the qualifications of this expert
22 when we're talking about communication. We're here to
23 talk and hear from him about transmission and efficacy
24 and those kinds of things. I'm not trying to be
25 unsympathetic to your comments, Dr. Bridle, but I think
26 you haven't been called as an expert to talk about

1 those things.

2 A Can I comment about the specific comments I had in my
3 report?

4 MR. MAXSTON: I'll leave that up to the
5 Tribunal. It depends on what question Mr. Kitchen asks
6 of you, but, again, I'm not trying to be difficult
7 here, but you were qualified to speak about the
8 transmission and efficacy of masking and physical
9 distancing, and I don't think we're here today -- I'm
10 not trying to be difficult, but I don't think we're
11 here today to talk about communication problems --

12 A Okay --

13 MR. MAXSTON: -- and those types of things.

14 A -- and I respect that. I'll wrap up then with
15 something that definitely is in my realm of expertise,
16 so --

17 MR. MAXSTON: I'll let Mr. Kitchen decide
18 what he wants to ask you next maybe, but I just wanted
19 to be clear we shouldn't go too far off what you were
20 called to testify about. So I might have an objection
21 to what you're about to say too, if it's going to be in
22 the same vein.

23 MR. KITCHEN: Well, let me jump in. I have
24 two comments: One, Mr. Maxston, let me know if you're
25 going to apply to strike that, because we'll have to
26 deal with that. Two, it doesn't take expertise to do

1 what he's doing: He's observing reality as a
2 scientist. You know, if he told me that clouds were
3 made out of water droplets, it's the same as saying
4 that masks muffle speech. So I don't think it requires
5 any expertise, but, nonetheless, I take your point.

6 Q MR. KITCHEN: So, Dr. Bridle, let me ask you
7 this: What would you identify as the three most severe
8 harms of masking? Oh, hold on, you're muted.

9 A Okay, yeah, I listed quite a few. Let me just go to
10 these points if you don't mind.

11 Q Yeah, I'm on page --

12 THE CHAIR: Excuse me, Dr. Bridle, what
13 page are you on in your report?

14 A Actually, I'm looking for the page right at the moment.
15 Okay, so page 8 would be one. So page -- I've listed
16 my concerns about the masking and potential harms on
17 page 8, and then also I would like you to refer to page
18 14, where I have some additional ones, and one that I
19 would highlight perhaps is one of my biggest concerns,
20 as Mr. Kitchen had indicated.

21 First of all, related to this, there's something
22 that I was hoping to have the opportunity to say, it's
23 directly related to this, in the expert report from
24 Dr. Hu that I was able to look at, there was an
25 accusation made against me actually with respect to
26 these harms. Can I just address that for a moment?

1 Q MR. KITCHEN: Well, that's fine with me, but
2 my friend might take issue with that, and I can
3 understand why.

4 MR. KITCHEN So, Mr. Maxston, I was going
5 to ask him a question on that. If you want me to hear
6 him [sic] ask the question, I can do that if that's
7 helpful to you.

8 MR. MAXSTON: Well, that might be helpful.
9 I think it's fair for your client to comment on
10 Dr. Hu's report, but I think it depends on the extent
11 of your question or the type of your question.

12 A Okay, what I would like to do, if you don't mind, I'll
13 just read something of the report and then see if
14 you're okay with me just commenting on it. Just let me
15 find this when it comes to the dangers.

16 Q MR. KITCHEN: Well --

17 A Okay, yeah, so the comment that I want -- the thing I
18 want to comment on is in the -- Dr. Hu's report on page
19 8, the one, two, third paragraph down. He says: (as
20 read)

21 Lastly, both Dr. Dang and Dr. Bridle make
22 unsubstantiated claims that there are
23 numerous harms associated with masking.

24 And then states: (as read)

25 There are no known harms associated with
26 masking.

1 So that is what I was hoping to respond to.

2 Q Yes, well, I'll let you respond however you like,
3 but -- well, let me ask you, I take it you would say
4 that claim is inaccurate?

5 A Yes, and I provided scientific citations to demonstrate
6 that that I'd like -- there is one in particular I'd
7 like to highlight that is clearly within my realm of
8 expertise, and it's a serious concern that I have.

9 Q And I want to hear your comments to that, and I --

10 A Okay.

11 Q -- invite you to, but I want to also ask you this:
12 That claim coming from a public health doctor, is it
13 merely inaccurate, or does it rise to the level of
14 willful ignorance?

15 A Well, yeah, that's -- yes, that's why I wanted to
16 comment on it, and also accusatory, indicating that
17 we -- you know, that we -- suggesting that we have
18 failed to -- or that I have somehow failed to
19 demonstrate harms associated with masking.

20 And, yeah, because there's numerous -- there are
21 numerous potential harms with masking. So I guess
22 this -- yes, and so I'll highlight. So if you like, I
23 can pick three. I can think of two right off the top
24 of my head, and I can look through the list.

25 But I guess what I would do is bring people to the
26 attention of those two pages, because I list numerous

1 potential harms on page 8, and I mention several more
2 on page -- as I said, page --

3 Q 14?

4 A -- 14. So it isn't that I failed to identify, and
5 these are substantiated, and I have peer-reviewed
6 scientific publications to back them up, so this --
7 yeah, that's what I just wanted to mention is that is,
8 I feel, a very untruthful statement and accusation
9 against me.

10 So let me go on to some of the major concerns.
11 I'll start with the hygiene hypothesis. So I just had
12 been asked to comment on harms with the mask, so this
13 one focuses on children. But what people need to
14 understand, and I wrote an article about this early
15 on -- after one year into the pandemic. I wasn't
16 concerned when we were told it was two weeks, you know,
17 and that was the original warning, even if it was a few
18 months.

19 But after a year, I expressed this serious
20 concern. It used to be called the hygiene hypothesis,
21 but the concept is this is that we're designed to
22 interact and interface with our microbial world. It's
23 absolutely required for proper physiological
24 development. For example, many people have shown --
25 and this has been shown with what we call
26 gnotobiotically delivered animals, so animals that have

1 no microbiome whatsoever. Behaviours are fundamentally
2 altered. They have the -- the development of the
3 central nervous system is altered. But one of the key
4 things is the immune system does not develop properly
5 if we don't have proper interaction, as we are growing
6 up with the microbial world.

7 So a lot of people don't realize when we're
8 born -- so, first of all, when we're born, we are
9 immunologically naive. Unless there was some kind of
10 in-utero infection, meaning infection of the fetus
11 while in the mother, then when born, the vast majority
12 of us are immunologically naive: We have not been
13 exposed to anything in the microbial world up to that
14 point.

15 But further -- so that means that our immune
16 system learns to interact with the immune system
17 following birth. Further, and because of that -- and
18 actually because of that and to have that opportunity
19 to learn what is dangerous and what is not dangerous in
20 the microbial world, our immune systems do not reach
21 full maturity, they are not fully developed until about
22 the age of 16, and the vast majority of that
23 development occurs between birth and the age of 6

24 And what we know is that if and especially young
25 people are not allowed to be exposed on a regular basis
26 to the microbial world, their immune system does not

1 develop properly, specifically the ability to
2 differentiate between the non-dangerous microbes that
3 we encounter all the time and the genuinely dangerous
4 pathogens. And it's only the latter we want to respond
5 to, because if you can imagine if we -- if our immune
6 system is what we call dysregulated, and it thinks that
7 non-harmful microbes are worth responding to, that's
8 very dangerous, because we have non-harmful microbes
9 all over and inside our body.

10 An individual who responds inappropriately, for
11 example, to -- and it's -- and it's many things, it's
12 in our environment, it's even the food that we sample,
13 the air that we breathe, the dust particles that we're
14 exposed to in the environment. If we're not adequately
15 exposed and our immune system learns to tolerate these
16 things, not respond, then we can end up with problems
17 like chronic inflammation in certain locations.

18 So, for example, if somebody were to develop a
19 food allergy, right, that food is something we should
20 be tolerized against, that you're going to have chronic
21 inflammation in the gut when exposed to it, or if you
22 haven't been properly exposed to the environment, so,
23 for example, a lot of people who are mainly -- you
24 know, grow up in urban areas might have more of a
25 propensity towards things like hayfever, because when
26 young and their immune system was learning to

1 differentiate the dangerous things in our environment
2 from the non-dangerous things, they weren't exposed to
3 some of these things that you're exposed to in a rural
4 environment.

5 And so what -- and so this is very important, and
6 the reason why this is important is because one of the
7 things that masks are exceptionally good at filtering
8 out are large particles, like I said, large water
9 particles, that also includes dust particles, so
10 environment -- things we are exposed to in the
11 environment that are not dangerous and also bacteria,
12 especially bacteria. And a lot of this development is
13 not actually around the virome that populates the body,
14 but it is, in fact, the bacterial.

15 So, for example, in these gnotobiotic animals that
16 have no microbiome whatsoever, if you want to correct
17 the behavioural deficits that they will develop and the
18 immunological deficits, we can repopulate their gut,
19 for example, with a lot of these what we call like
20 probiotic bacteria, the same ones you would get in
21 yogurt, like lactobacillus, for example, so it's
22 largely these bacteria, these non-harmful bacteria that
23 allow us to, you know, to educate our immune system.

24 Without that, what happens is a child's immune
25 system tends to become dysregulated, never learns to
26 differentiate properly, and individuals are at a much

1 enhanced risk of developing autoimmune disease --
2 anything that's disassociated with an improperly
3 regulated immune response. So allergies, which is
4 responding to non-dangerous things in our environment
5 and causing inflammation against them; asthma is when
6 you're responding to inert things in the air that you
7 inhale and responding inappropriately to those, that
8 cause asthma; and autoimmune diseases.

9 And so, and we know this is the case, because so,
10 for example -- and this is largely looking at those who
11 grew up largely in urban centres versus those who grew
12 up on farms. Those who grew up on farms are much more
13 exposed on a regular basis to a rich microbial
14 environment. And so those who grew up in these urban
15 area -- or, sorry, rural areas have a much lower
16 incidence overall of allergies, asthma, and autoimmune
17 diseases.

18 And so by -- so, again, by putting these masks on
19 children, first of all, they're not at high risk of the
20 most severe outcomes of SARS-Coronavirus-2, and I've
21 already explained one of the physical reasons, they
22 just don't -- simply don't express the receptors at
23 nearly the concentration that adults do in their lungs
24 that the virus uses to infect. But we have put masks
25 that are effective at isolating their lungs from the
26 microbial environment, and we, of course, isolated

1 them, kept them away from their friends, a lot of
2 family members, and a lot of social interactions.
3 Literally, for children, it's a good thing to get
4 dirty, to get dirty, to have dogs lick their faces, to
5 hug other people, that their immune systems need to
6 interact with other microbiomes in order to develop
7 properly. So that is an immunological concept that
8 long-term masking -- and, again, nobody has any
9 concern. I mean, kids get sick, and maybe they're at
10 home, relatively isolated for a couple of weeks. It's
11 not a problem if it's a couple of weeks or it's a
12 couple of months. But once we start -- I wrote my
13 article first about my serious concerns about that a
14 year in. A year is getting too long. A year is a
15 substantial amount of immunological development in a
16 young person. And now we're at two years with no
17 current end in sight. So that is a serious potential
18 harm. By masking children, we are potentially, there's
19 no question, we're going to have an unknown number of
20 children with allergies, asthma, and autoimmune
21 diseases in the future, and they're going to have those
22 for the rest of their lives because we masked them for
23 two-plus years. So that's one.

24 And then I guess another one that I would mention
25 is this idea of carbon dioxide, because this is just
26 intuitive, so, you know, fire fighters have the

1 equipment to do this. At my university, we have the
2 ability to do this, look at CO2 levels, and we often do
3 that when looking at how we adjust the air change rate
4 in our rooms, especially the work rooms we work in a
5 lot, like the laboratory space that we're in, the
6 animal research rooms that we're in.

7 And so if you monitor the carbon dioxide level in
8 front of your mouth without a mask and then with a mask
9 on, it goes up. And this makes intuitive sense,
10 because what you're doing by putting a mask on your
11 face is you are restricting, you know, the free flow of
12 oxygen. What you're doing is you're creating an
13 additional dead space. When we exhale, when we exhale,
14 there's always dead air. We cannot get all of the air
15 out of our lungs, and we can't get all of the air out
16 of our mouth. That's dead air. When we inhale, that
17 dead air, when there's not been fresh air exchanged,
18 gets inhaled back into the end of the lungs.

19 By -- so by putting on a mask, you're extending
20 that dead air space a bit, and so it does increase the
21 carbon dioxide level a little, not a lot, a little, and
22 this creates a condition of very mild hypoxia, it's not
23 severe hypoxia, but if you have high carbon dioxide,
24 then the net result is you have slightly higher --
25 lower oxygen levels. But, again, slight changes in
26 oxygen concentration we know can have profound

1 physiological consequences.

2 So, for example, on the positive side, endurance
3 athletes, especially if they know they're going to have
4 to compete at a higher elevation will often go to train
5 in areas with a higher elevation. There's not a
6 massive change in the oxygen concentration, but by
7 going there for a long period of time, being exposed to
8 that lower oxygen concentration and training in that
9 environment, their body gets more efficient at the
10 oxygen exchange. Then they can perform better in the
11 sporting activity at a higher elevation.

12 But so we're kind of expecting this from
13 individuals. So we're putting masks on -- again, I'd
14 like to emphasize, masks make sense if you're going to
15 wear it to go into work for, you know, a little bit of
16 time because you have to meet a deadline, but you're
17 sick. They make sense when you're doing surgical
18 procedures. You're doing a limited procedure, you
19 leave, you take the mask off. They're not designed to
20 be left on for long periods of time and exposing people
21 to chronic low levels of hypoxia.

22 And, again, I'd like to highlight this is just
23 kind of intuitive in the sense that -- like I know for
24 myself, if I wear -- and I wear masks all the time
25 except for surgical intervention stuff, but if I wear a
26 mask for several hours, I start developing a headache,

1 constant thing and consistently. I need to take a
2 break; I need to get out in the fresh air.

3 And I would encourage anybody, if -- just focus,
4 put on the mask and go outside, because often that's
5 where the air, you know, seems the freshest and
6 everything, keep your mask on and take several deep
7 breaths, right, and pay attention to what it feels
8 like. Then take that mask off and take in a big deep
9 breath; it feels so refreshing. And that's why,
10 because we are impacting, albeit to a small degree, our
11 ability to gas-exchange, by taking off that mask, we're
12 removing some of the dead air space that we've created;
13 we're reducing the dead air space.

14 And this has -- because we've never done this for
15 such a long period of time, we simply don't actually
16 know the extent of harm that we might be causing,
17 especially to developing children again, I'd like to
18 highlight, right, this constant, prolonged exposure to
19 low-level hypoxia it might be causing.

20 So I think I'll leave it at that, if that's okay,
21 Mr. Kitchen. I -- I mean, I could look through and
22 provide another one, but those are probably my two top
23 concerns at this point in general.

24 Q Thank you. I am going to try to bring you through
25 pretty quickly, I want to give my friend a chance to
26 cross-examine, and we are down to, you know, roughly

1 only two hours left.

2 MR. KITCHEN Well, Mr. Maxston, let me ask
3 you this because I want to be mindful of this. How
4 much time do you think you're going to want for
5 cross-examination?

6 MR. MAXSTON: Mr. Kitchen, I expect I'd
7 be -- and this is not a criticism of Dr. Bridle, but he
8 seems to give expansive answers -- so thank you,
9 Dr. Bridle, for that -- I would anticipate 20 minutes,
10 maybe a little longer just because of the nature of the
11 answers, but I don't think I'll need terribly long.

12 I'll leave it up to you in terms of how much you
13 think you'll want to be, but it may be time to take a
14 break right now as well, given how long you've been
15 asking questions.

16 MR. KITCHEN: Yeah, yeah, I agree.

17 THE CHAIR: Yeah, it's, by my watch, 5 to
18 3, so let's take 15 minutes, and we'll come back at 10
19 after 3 and resume then, okay?

20 MR. KITCHEN: Thank you.

21 THE CHAIR: Just a reminder, Dr. Bridle
22 you're still under oath.

23 (ADJOURNMENT)

24 THE CHAIR: And, Mr. Kitchen, we'll turn
25 it back to you.

26 MS. NELSON: Sorry, Mr. Kitchen, we can see

1 you talking, but we actually can't hear your audio.

2 MR. KITCHEN: Sorry, I have a mute button on
3 my mic, so I apologize, so you missed --

4 MS. NELSON: No worries.

5 MR. KITCHEN -- the last 10 or 15 seconds,
6 sorry.

7 Q MR. KITCHEN: Dr. Bridle, I just have some
8 specific questions about comments that Dr. Hu has made
9 both in his report and in questioning.

10 Dr. Hu has stated that every country that has
11 imposed masking has experienced decreased transmission
12 of COVID; do you disagree with him?

13 A Yes, I do. I'll point out again, you know, like -- you
14 know, my expertise isn't epidemiological per se, but as
15 a researcher, I certainly am qualified to look at the
16 scientific literature and interpret some basic data.

17 I do know of numerous countries where the opposite
18 is true. And, in fact, when we look at the United
19 States, we see states where that trend is the opposite
20 as well. I know that Dr. Hu did not like the example
21 of Sweden, but I mean that is an example. He didn't
22 seem to cite any science to -- he just said it's, you
23 know, complex to interpret the reasons for observing
24 differences, but, nevertheless -- and he didn't dispute
25 either that Sweden is a classic example of, you know, a
26 country where they went the natural immunity route, and

1 seem to have done just fine, and there's other
2 examples. But, yeah, so, in other words, that all we
3 need is one example to say that that is not true. So I
4 do disagree with that overgeneralization.

5 Q You just called it an overgeneralization. So is that a
6 fairly absolute statement?

7 A Could you remind me what page of that report is it on,
8 just so I can look at it myself?

9 Q I'm quite sure he said that in questioning, not in his
10 report.

11 A Oh, can you repeat --

12 Q I do know --

13 A -- (INDISCERNIBLE) --

14 Q -- that he said it --

15 A -- so could you repeat it again, please?

16 Q So he said that every country that has imposed
17 mandatory masking has experienced decreased
18 transmission of COVID.

19 A Okay, so, yeah, that's not an overgeneralization,
20 that's incorrect. Again, when somebody has said
21 "every", and all we need is one example where they
22 didn't do it, and the -- you know, the outcome has been
23 fine, like Sweden, so that makes it not just an
24 overgeneralization, it makes it incorrect.

25 Q Do you find it unusual that he makes such an absolute
26 statement?

1 A Yes. So in the sciences -- so I even mentioned this
2 before when I was giving examples of -- when we were
3 talking about asymptomatic and transmission, right,
4 I -- there is asymptomatic transmission. It's not
5 common, and it's not a driver in this. And when I
6 mentioned, when I talked about that, is when you're
7 dealing with biology, there are no absolutes. Biology
8 is not an absolute science. It's not black and white.
9 It's not like mathematics, it's not like chemistry,
10 it's not like physics.

11 Biology, there are general ways that, you know,
12 biological systems function, and there's almost always
13 exceptions to the rule. So there's what the dominant
14 biology is, and then there's always exceptions to the
15 rule. So very rarely, if ever, can you make definitive
16 statements like that when it comes to biology,
17 especially when you're talking about fairly complex
18 biology. Because here, we're talking about -- we're
19 not even talking about one biological system, like
20 people, like humans; we're talking about the
21 biologic -- the biology of people interfacing with the
22 biology of a virus in the context of a complex
23 environment. So there's absolutely no way you can make
24 absolute statements like that in the context of this
25 current medical scenario.

26 That's -- so, again, that's the -- you know, so as

1 a scientist, that's not the appropriate scientific
2 approach. One has to be open to the fact that there
3 are exceptions. What we always have to do, and also to
4 explain, the way science and medicine is supposed to
5 function is we should -- we need to weigh the weight of
6 the overall evidence.

7 Again, because there often are not absolutes,
8 often things are not intuitive or common sense, what
9 often happens is -- I mean, so it's very clear in
10 science, if somebody put -- as soon as -- so the first
11 time a paper is published, that's obviously the first
12 report on a given scientific issue, so it sets the
13 tone. At that point, that becomes what the scientific
14 community agrees at that point in time, early point in
15 time, seems to be the reality. If the subsequent
16 scientific literature is all in agreement, that's
17 something that usually then gets enshrined in science
18 as a -- as, you know, sort of as a classic paradigm in
19 science. But as soon as you have disagreement, say the
20 second publication find -- finds something different,
21 at that point, you automatically need additional
22 research to be done to sort out the problem.

23 And so at the end of the day, it's never about --
24 and so especially one thing to keep in mind, you know,
25 my advice to everybody with this is there's a lot of
26 science that has accumulated over the past two years,

1 and, therefore, it's always about the weight of the
2 science. They're not about citing one paper or, you
3 know, two papers or selective papers. One has to look
4 at the overall weight of the evidence, like on scales,
5 and see what the balance of that evidence is. So,
6 yeah, just by the very nature, we can't, in this
7 scenario, make such conclusive statements.

8 Q To give Dr. Hu, to properly and fairly characterize his
9 position -- and my friend can interject if he disagrees
10 with me -- Dr. Hu has said the evidence for the
11 effectiveness of masking in reducing the spread of
12 COVID-19 in a health care setting is overwhelming, and
13 there's heaps and mounds of it. And then he says in a
14 non-health care setting, well, it's less clear. He
15 makes no distinction between asymptomatic or
16 symptomatic; he simply says in a health care setting,
17 it's guaranteed to work, we know absolutely it works,
18 there's just no question, maybe there's a question
19 about the community.

20 What I've heard you say is, Well, look, it doesn't
21 work at all for asymptomatic people, it's just -- it
22 just doesn't -- it's not even relevant, it's not even
23 logical because they just don't spread it because
24 they're asymptomatic, there's no asymptomatic spread.
25 So, you know, you two, as experts, you're kind of
26 talking at cross-purposes.

1 So I want to ask you about the health care
2 setting, okay, and then the non-health care setting,
3 because that's how he's done it, okay, to be fair to
4 him.

5 So he says that the evidence for the effectiveness
6 of masking in the health care setting is, quote,
7 Overwhelming, and, quote, There's heaps and mounds of
8 it. Would you agree with that or disagree?

9 A Yeah, we wouldn't be here today hearing this case if
10 there was universal agreement and if it was
11 overwhelming evidence. This is an area of active
12 debate. It's an area of active research. I looked at
13 Dr. Hu's report, because the other experts have
14 provided that. Where the misunderstanding comes in is
15 this concept of asymptomatic transmission and this
16 misnomer, this concept.

17 Where it's been most exaggerated, for example, is
18 children. We've mislabelled children as somehow being
19 these individuals that rarely get sick but are
20 overflowing with large quantities of this incredibly
21 pathogenic virus, right, so they can spread it to
22 others. That's simply not the case.

23 So, again, I highlight, Dr. Hu and I are not far
24 off in our view of masking. We're in complete
25 agreement that masking makes sense if you're
26 symptomatic, and it can very much help as a tool to

1 curb the spread if you're symptomatic, and you're
2 choosing to go around other individuals in that state.
3 But not asymptomatic.

4 I mean, this is again, intuitively, I guess, you
5 know, again, to put it in a perspective that maybe the
6 average layperson could appreciate, knowing what I told
7 you about the Omicron variant, where the reality is the
8 average flu is more dangerous than the Omicron variant
9 for the vast majority of the people, especially the
10 very young, for which SARS-Coronavirus-2 is not
11 particularly dangerous, but, you know, we've never
12 implemented this, if this asymptomatic transmission was
13 always such an issue, and we were to accept this now as
14 a paradigm, we'd have to apply this to every -- every
15 infection -- we would never -- we would never know if
16 somebody is ever, quotes, healthier or unable to
17 transmit to anybody else. There would be no way of me
18 knowing of somebody else who has no signs or symptoms
19 has, you know, in their lungs, respiratory syncytial
20 virus or a flu virus or Norwalk virus or any of the
21 viruses that we face. So just from that perspective,
22 it's counterintuitive.

23 And this is definitely within the realm of
24 immunology, and it comes largely from a
25 misunderstanding -- and, again, you know, with all due
26 respect, the average physician who has been in a

1 position of authority, you know, to implement policies,
2 and this is one of the reasons why -- a lot of people
3 don't realize it, and this is an area I have expertise
4 in as well because we have an emergency preparedness
5 plan in our university for responding to a pandemic.
6 We were required to implement this by the Government
7 following the 2009 flu, declared swine flu pandemic,
8 where people realized that there was initially -- the
9 response was one of panic and realizing that we really
10 did not have a coordinated response, we hadn't really
11 prepared for such a scenario. Now, that turned out --
12 that fizzled and that was not a true pandemic.

13 But so all the -- the Government made all publicly
14 instituted -- institutions, including my university,
15 come up with a pandemic preparedness plan. Our country
16 came up with a pandemic preparedness plan. Every
17 province and territory was required. We threw these
18 out within the first week to two. At my institution,
19 we threw it out within five days of the pandemic being
20 declared, and we haven't been following any defined
21 plan since.

22 And that applies at the Federal level as well.
23 We -- like, if you look, we still don't know what the
24 goalposts are. We don't know what the finish line is
25 before we declare that we're out of this. In fact, the
26 goalposts have kept moving.

1 And what I can tell you is that in those pandemic
2 preparedness plans, none of them looked like this at
3 all. They relied on the more traditional ways that we
4 approach this kind of problem, which was you treat
5 people who are sick as sick, and you keep them away,
6 especially from the vulnerable populations, and you
7 focus your protective efforts and your protective
8 measures on the high-risk demographics if, if, and when
9 a pathogen shows a predilection towards causing harm in
10 limited demographics. And so, you know, we haven't
11 reached that point here. You know, we didn't follow
12 those kind of plans, and so this is where we've come in
13 with these other approaches.

14 And what I do want to point out then is --
15 actually to get back on track, Mr. Kitchen, can you
16 remind me what your core question was? I was just
17 coming to it, and I wanted to find something in the
18 report here.

19 Q Well, like I said, Dr. Hu says, end quote, heaps and
20 mounds of evidence supporting the effectiveness of
21 masks in --

22 A (INDISCERNIBLE)

23 Q -- a health care setting --

24 A -- yes, and so -- so, no, that is a point of
25 contention, and so his report even highlights this. So
26 one of the things -- I mean, he hasn't -- he hasn't

1 cited heaps and mounds of evidence. It's a limited
2 number of citations.

3 And this is -- so this is something that I want to
4 deal with head-on just so that people, when
5 interpreting the two reports, can understand. He
6 accused me of solely leaning on outdated documentation,
7 or maybe not solely but certainly leaning on outdated
8 documentation when it came to my report. People are
9 free to look at my reference section. I have lots of
10 updated citations in there.

11 I want to highlight that, in fact, after accusing
12 me of using outdated literature, the two things that he
13 most emphasized when talking about this -- when talking
14 about this concept of masking, the first one was a
15 citation from 2011. So he actually set the record for
16 the oldest cited paper with respect to masking and
17 citing the one from 2011, a Cochrane review. And so --

18 Oh, and the other thing he said is he accused me
19 of using examples from other viruses. And I want to
20 point out that this 2011 one is the oldest -- second
21 oldest reference of all the reports about masking and
22 dealt with influenza virus, not SARS-Coronavirus-2.

23 And one where he spent half of a paragraph
24 highlighting it was actually to describe what he felt
25 was, you know, sort of break-through work that was
26 done, and it's a study that was done in the early

1 1900s, which shattered records in this in terms of the
2 oldest citation, and that certainly wasn't dealing with
3 the SARS-Coronavirus 2.

4 So he's got that aspect wrong in terms of arguing
5 that he's got the updated literature. And, in fact, I
6 just want to highlight this as well, because this is
7 overstated again, he actually said in his report, on
8 pages 1 -- at the very end of page 1, the final last
9 few words, onto page 2, he said: (as read)

10 A vast majority of literature [this means his
11 literature] is from the years '20 to '21 with
12 emphasis on literature published in 2021.

13 So I actually went to his reference section, because,
14 again, I do lots of review of, you know, scientific and
15 medical documentation, and I excluded some of these
16 because they're not peer-reviewed articles. A couple
17 of them are websites. One of them was a website where
18 he -- that described the 2011 paper, the source of the
19 2011 paper that he got.

20 And so, in fact, it turns out that of his
21 citations, 19 of his citations about masking, of those
22 19, 11 were from 2020 to 2021. That's 58 percent. So
23 that's not a vast majority of the literature. And he
24 then emphasized that most of it was from 2011. Well,
25 in fact, only two of those is 11 -- sorry, two, the
26 emphasis was on literature published in 2021, but only

1 two of those 11 papers were from 2021, 18 percent of
2 the papers cited since 2020 were from 2021.

3 And so I think it's important, again, otherwise,
4 it gives a misconception that somehow he's captured the
5 recent, cutting-edge data, and I have -- again, people
6 are free to look through -- I've got plenty of
7 citations from 2020 to 2021, so that's not the case.
8 It's not -- this isn't the case of somebody having --
9 understanding current literature, and somebody else,
10 myself, not understanding the current literature and
11 only focusing on historical literature. I want to
12 point that out.

13 Further, he even states in this, if I can find it
14 here, and this is important because this is a very
15 important thing for us to understand, because we're all
16 hearing public messaging, and we're all trying to sort
17 through this information and understand, and there is
18 lots of misinformation, there's genuine information,
19 and there's been messaging that's been changing over
20 the course of this. And so this is very important
21 because one of his critical sources of information
22 about this are public health officials, especially
23 Dr. Theresa Tam, and that's why I'm hoping I can just
24 find this here quickly. Where is it?

25 Q He mentions Theresa Tam on page 8. I don't think he
26 mentions her anywhere else.

1 A Okay, thank you. Oh, Dr. -- sorry, I mean Dr. Tan,
2 sorry. Do you see the reference to Dr. Tan?

3 Q T-A-N?

4 A Yes.

5 Q 'N' as in "nothing"? No.

6 A Medical Officer of Health. Give me one second, because
7 this is an important point.

8 Q Okay.

9 A Let me just pull up the document here.

10 Q Do a search on it.

11 A Sorry for the extra time, but I just want to make sure,
12 because this is important.

13 Q I don't find anything for T-A-N.

14 A Okay, sorry, yes, that's why, I meant Theresa Tam. I'm
15 getting her Medical Officer of Health, her name messed
16 up here, it's Theresa Tam, Dr. Theresa Tam --

17 Q Yeah, page 8.

18 A -- so this is on page 8 just before the summary, the
19 subheading "Summary", and this is when talking about
20 that that I made unsubstantiated claims, that there are
21 numerous harms associated with masking, there are no
22 harms, but we've already discussed that.

23 And then -- this is very important, because --
24 this is very important here, so what he states in that
25 last sentence: (as read)

26 Indeed, public health experts, including

1 Dr. Theresa Tam, have walked back any
2 statements alluding to the potential harms
3 and increased infection risk of masking.

4 There's no scientific documentation there, so
5 peer-reviewed literature, and what this is -- so what
6 he means, what he means, and if we're blunt about it,
7 is that Dr. Theresa Tam has completely contradicted
8 herself in the context of this pandemic.

9 And specifically what he's referring to when he
10 talks about walking back in his statements, it was that
11 a lot of top public health officials, including
12 Dr. Tam, Dr. Fauci in the United States, and others and
13 agencies like Health Canada were actually discouraging
14 the use of masks and widespread use of masks earlier on
15 in the pandemic and widespread use of masks earlier on
16 in the pandemic, and that was because of the scientific
17 evidence available at the time.

18 So, yes, they later walked back the statements,
19 and I can tell you that I have yet to know what the
20 scientific foundation is for Dr. Theresa Tam walking
21 back that statement. And I point out, as you can see
22 by the wording here, you can ask yourself, it's not
23 scientific, I don't know what walking back a statement
24 actually means. She never rescinded the statement.
25 Yes, I will agree that she downgraded the -- I guess,
26 the importance she placed on that, you know,

1 down-playing of masking as an effective protective
2 strategy in the context of SARS-Coronavirus-2 early on,
3 but she never rescinded it. She did, indeed, dampen it
4 or walked it back to some degree. And, again, I have
5 yet to see, she hasn't produced any peer-reviewed
6 scientific literature that I've seen.

7 Now this -- so this becomes very critical, because
8 I'm not going to say -- I can tell you there's lots of
9 literature to suggest there's harms of masking, and it
10 doesn't work, and, again, this comes down to the whole
11 disagreement is about asymptomatic transmission. And,
12 again, I highlight that in the studies that are cited
13 to support this, the vast majority of those studies are
14 defining transmission based on PCR positivity, not
15 proof -- not demonstrating with using the functional
16 virology assay that I said, that there is definitively
17 replication-competent viral particles in the sample,
18 especially at a concentration that would meet the
19 threshold required to cause infection in other
20 individuals.

21 So a lot of those studies actually agree,
22 potentially, with the outcome that made -- where they
23 measured what they did, but they didn't prove that
24 there was transmissibility of the sample that they were
25 collecting. And so that's what it comes down to is how
26 we interpret asymptomatic transmission in this.

1 Because like I said, we are all in uniform agreement
2 that if somebody is sick, this makes some sense.

3 And then the other thing is, which I was very
4 surprised, because often scientists who have been
5 speaking out in a way that's perceived to be against
6 the narrative, one of the arguments that constantly
7 comes up is, well, you haven't proven your point with
8 the randomized controlled trials.

9 So I want to explain to everybody, a lot of
10 people, when it comes to clinical medicine, consider a
11 randomized controlled trial to be the be-all and
12 end-all. It's where you actually look at a relevant
13 clinical setting, and you have your treated group and
14 your placebo group or untreated group. If you're
15 talking about masking and SARS-Coronavirus-2, it would
16 be a compilation in the context of SARS-Coronavirus-2
17 with the potential for it to be transmitted, and you
18 would have a population that's masked and a population
19 that is unmasked, that would be the negative control
20 group, and then you actually see if there is an effect.
21 So for everything that has not been accepted in the
22 public health narrative, it's because there hasn't been
23 a randomized controlled trial.

24 Let me give you an example. The same Dr. Theresa
25 Tam told all of Canada that the concept of vitamin D
26 reducing the potential for infection is fake science.

1 I can believe -- I'm an immunologist. I'm even left
2 with -- I've actually sent a letter to my
3 administration university telling me [sic] that am I
4 going to get in trouble if I continue to teach
5 immunology like I have during my whole career, because
6 I can tell you vitamin D is a critical component of the
7 immune system. There are -- it functions at such a
8 basic fundamental level with so many aspects of the
9 immune system.

10 Without it, it would be like if somebody is
11 familiar with cars and a car engine, it would be like
12 if you have a high-performing race car, say, a
13 Formula One race car, there's no question, if you
14 deactivate one of the cylinders in that engine, it is
15 not going to perform as well as if it had that cylinder
16 functioning. It's not going to be competitive in the
17 race.

18 And that's the case with vitamin D. I mean,
19 there's thousands and thousands of papers -- I can tell
20 you -- I can give you 77 citations right now that show
21 the benefit of vitamin D in the context of
22 SARS-Coronavirus-2. That's why we have -- one of the
23 reasons we have our annual cold and flu season. As an
24 immunologist, I often don't refer to it as the cold and
25 flu season, I refer to it as the low vitamin D season.

26 THE CHAIR:

Dr. Bridle, I'm not sure that

1 vitamin D was really relevant --

2 A No --

3 THE CHAIR: -- to --

4 A -- no, I'll probably be back to it immediately, yes,
5 thanks, I appreciate that. So my next comment
6 immediately ties it in.

7 And the point being that it was declared that a
8 randomized controlled trial, therefore, was needed to
9 prove the effectiveness of vitamin D in the context of
10 SARS-Coronavirus-2.

11 And so that's where this ties in. So when you
12 have an area where there is definitely, clearly, far
13 more debate going on and the science is -- it's why you
14 have even more reason for a randomized clinical trial
15 if you really want to sort out this issue.

16 Now, what I was honestly shocked by is in Dr. Hu's
17 report, he acknowledged that but then went on to
18 proceed to argue that a randomized controlled trial
19 could not be done because this is such a cut-and-dry
20 topic, because everybody is in such uniform agreement
21 that masking works in the context of SARS-CoV-2. Well,
22 clearly, that is not the case. If nothing else, my
23 expert opinion disagrees with his expert opinion.
24 There's evidence of nonuniform agreement right there.
25 And when scientists disagree, we need further research
26 to work it out.

1 Now, I want to highlight something, because this
2 is very important to understand, randomized controlled
3 trials has been -- that's been the basis for promoting
4 anything to do with treating or protecting from
5 COVID-19. So what we get to here, and I just want to
6 go to this now -- I thought I'd have these better
7 marked -- so I want to get to this where he talks about
8 the randomized controlled trials, and I think this is
9 in his rebuttal section. And it talks about -- he uses
10 a -- an analogy there. Let me see here. Okay, yes,
11 right here: (as read)

12 With respect to the evidence for
13 effectiveness of masking [this is on page 7],
14 Dr. Warren states that in the absence of
15 evidence for randomized controlled trials in
16 meta-analyses ...

17 And then it continues on, and that's -- so that's what
18 he's responding to, this idea of randomized controlled
19 trials. So he admits it is correct that there are a
20 few randomized controlled trials on masking, and
21 there's none in the context of SARS-CoV-2 as -- so
22 we're talking about a fundamentally different virus.
23 Then he says: (as read)

24 There is an overwhelming burden of evidence
25 from other studies showing the benefits of
26 masking. Furthermore, it's not ethical to do

1 RCTs on masking given its significant
2 benefit.

3 Well, we've just talked about, there's potential harms,
4 potentially even in the context of symptomatic --
5 asymptomatic people, maybe more harm than good. And it
6 doesn't, for all the reasons I've explained, doesn't
7 help spread SARS-CoV-2 by the aerosol route. So none
8 of that fits into play here.

9 And then he goes on to give an analogy that
10 this -- to say why the randomized controlled trials
11 can't and should not be done with masking. He says
12 this is like parachute-jumping out of an airplane. We
13 wouldn't run a study right now, right, none of us would
14 ask for a study to be run asking people to jump out of
15 a plane with a control group that is not given a
16 parachute, right, and to the test the idea that
17 parachutes stop people from dying when jumping out of a
18 plane.

19 Well, this is not a fair comparison whatsoever.
20 Worse, he got upset about one of the other experts. He
21 actually says here: (as read)

22 Notwithstanding the factual error on page 6,
23 it is fallacious and unscientific to equate
24 death rates by age in the context of a global
25 pandemic with those of car accidents, with,
26 at a minimum, it is a false dichotomy and

1 then [et cetera, et cetera].

2 So he was really upset with the use of an analogy to --
3 due to car accidents with deaths caused by an
4 infectious agent in the context of a pandemic but then
5 goes on and uses his own completely, arguably even far
6 more inappropriate, analogy to argue that RCTs have no
7 role to play when it comes to considering the benefits
8 of masking.

9 And what do I mean by this? It's intuitive, I
10 agree, we're not going to run a study to determine
11 whether jumping out of a plane without a parachute
12 increases the risk of dying upon impact with the
13 ground, and we don't have to. That experiment has
14 naturally been run multiple times. If people -- if
15 somebody jumps from a large height, if they want to
16 commit suicide, they know they can jump from a large
17 height. Anybody who falls, plunges to the ground from
18 a large height will experience death. We've had people
19 with parachutes jump out of planes, and the parachutes
20 failed to deploy, and they've died. So this is not a
21 comparison.

22 The equivalent with -- the RC with masking would
23 be that we know that, in the control group, if they do
24 not wear the mask, they are going to die. Yes, that
25 would be unethical. We do not know that. In fact,
26 we're debating that very fact and whether it's actually

1 doing anything to protect these people from harm. And
2 so I would actually propose that the precise thing that
3 we do need scientifically to sort this out and
4 especially if we're going to force people to follow
5 this rule, we need to run a randomized controlled trial
6 and sort out the science once and for all.

7 So again, you know -- I mean, I'm not going to
8 apologize for the long answer, it's a thorough answer,
9 and so, no, this is not a clear path. And I'm sorry,
10 Dr. Hu has not cornered the market on, you know, the
11 fact that, you know, being be able to state that
12 everybody knows this, and everybody agrees on this
13 fact.

14 Q MR. KITCHEN: Thank you, Dr. Bridle that
15 answers several other questions that I had.

16 Since we're in that area on his report, on page 5
17 of your report in the last sentence of your section on
18 asymptomatic transmission, you kind of make a summary
19 statement, you say: (as read)

20 There is no substantial evidence to suggest
21 that people who are asymptomatic represent a
22 substantial risk of causing COVID-19 related
23 hospitalizations or deaths in others.

24 Now, as you know, Dr. Hu takes issue with this issue on
25 page 7 of his report. He says that you have no
26 scientific evidence for this statement. He also says

1 the fact that you would make such a statement, quote,
2 proves a lack of understanding of asymptomatic
3 transmission and its deadly effects on the community.

4 I have a couple questions on this. My first one
5 is do you think there's any scientific evidence to
6 support this statement that you made?

7 A Okay, that I think I can answer quickly. People, first
8 of all, can read page 5 of my report, see the citations
9 that I have there, and then refer to everything that
10 I've explained today.

11 I understand the science -- so again, with all due
12 respect, when it comes to asymptomatic transmission,
13 what we're talking about is we were talking about
14 fundamental, hard core immunology -- or, sorry,
15 virology at the interface with immunology. That is
16 precisely my area of expertise. I'm a viral
17 immunologist. This has nothing to do with public
18 health or anything like -- it has public health
19 implications, but the science behind this, this is how
20 a host immune system interacts with a virus that
21 dictates whether or not the outcome is going to be
22 potential transmission and infection and causing
23 disease in others. And I mean people can take my
24 expert, you know, commentary or not. Like I said, I
25 have the citations there, and I've talked at length
26 about the science, the precise mechanisms governing

1 this.

2 And just so that you understand, I don't know if
3 people can see, but I actually appreciate being asked
4 the question, because I've got that very thing marked
5 up, so I'm glad I actually got to talk about this,
6 because, again, I have been called upon to review lots
7 of literature, grant applications, scientific
8 publications, right, manuscripts people want to publish
9 in peer-reviewed journals. And sorry to be blunt here,
10 but this -- this report from Dr. Hu was and --
11 generally unprofessional, disrespectful in tone, very
12 much highlighted here. That's why I have this actually
13 underlined, because it's quite offensive. He uses
14 language that is offensive, accusatory. He makes
15 assumptions. He's hypocritical in areas of his report.
16 And I can give examples of all of these so -- if I
17 wish, and this is one of them. And he makes
18 demonstrable -- you know, many claims that lack
19 evidence, lacks citations or that are only backed up by
20 hearsay evidence, and then makes these kind of
21 statements, right, that as an expert in this area --
22 and I'm sorry, but looking at the expertise, I am quite
23 confident that I have deeper expertise in the area
24 directly relevant to understanding asymptomatic
25 transmission or lack thereof. And he's actually
26 arguing that I am provide -- that I have no scientific

1 evidence. That is a lie. That is a lie. I provided
2 the scientific evidence today. I have all these
3 citations. I'm looking at page 5 of -- and I see all
4 kinds of citations listed here and a description of the
5 science. And he says this proves -- somehow this
6 proves a lack of understanding. Like this means me,
7 that I do not understand this.

8 This is unprofessional. I don't do -- write this
9 way in any of my reports, so I'm sorry, this group
10 needs to understand this. I have been involved in a
11 lot of court proceedings. I have been involved in a
12 lot of scientific proceedings. This is not a
13 scientifically or medically acceptable document for
14 interacting with other scientists or medical
15 professionals, and this highlights it.

16 So thank you, because I didn't know if I'd have
17 the opportunity to share with the group, but this
18 statement is -- there's several others, and I'm not
19 going to take the time, but if anybody has a question,
20 I can prove what I just -- my overview of his report,
21 but that is, certainly I had listed, as the most
22 egregious statement against myself.

23 We have to respect one another as scientists and
24 physicians. I do respect Dr. Hu's perspective. Like I
25 said, I agree with much of his science, and I've
26 acknowledged the peer-reviewed publications that he's

1 used as valid, you know, acceptable scientific
2 publications. I think we need to be very careful, and
3 this stepped over the line, in my opinion, in terms
4 professionalism in this kind of environment.

5 Q Thank you, Dr. Bridle. I am almost done. I know this
6 might be obvious, is there an important difference
7 between correlation and causation?

8 A Yeah, absolutely. A massive difference. The burden of
9 proof is vastly higher for causations. Correlation can
10 contribute to the overall determination of causation,
11 but causation means that you know for sure that one
12 thing influences the outcome of another thing, directly
13 influences it, not, you know, has a direct impact on a
14 certain outcome.

15 So, for example, we know that SARS-Coronavirus-2
16 is the causative agent of the disease we call COVID-19.
17 If somebody is not infected with SARS-Coronavirus-2,
18 they will not get COVID-19, and if we infect them with
19 a different virus, they will not get COVID-19. It's a
20 causative agent, right? So it's a cause-and-effect
21 relationship.

22 A correlation means that something trends in the
23 same direction as something else, you know. And a
24 classic example -- and so I talk about this quite a
25 bit, because when I teach actually my immunology
26 students, because it is important to understand the

1 difference, so, for example, when it comes to -- you
2 know, one of the correlations that does -- that is
3 related and does have some link through causation, as
4 we get older, people tend to have a greater risk of
5 getting cancer. And there's two reasons:
6 Scientifically one is we get exposed to more potential
7 mutagens that can cause cells to turn cancerous; also
8 our immunological function declines, and our immune
9 system is very good at controlling cancers, right? But
10 there's many other things that correlate with age as
11 well, right?

12 So I don't know -- for example, as you get older,
13 there's also a greater use, on average, of dental
14 implants, right, as people lose their teeth, but that's
15 not a causation to have cancer, for example. So that
16 would be an example of a correlation, right, somebody
17 getting older, where if something gets -- as they get
18 older, there's an event that happens more frequently
19 among that population, but that event doesn't
20 necessarily mean that it's the cause of another event
21 that increases in frequency in that older population.
22 So, yeah, there's a huge difference.

23 Q Dr. Hu stated in his report that, quote: (as read)

24 A very, very, very large number of health
25 care workers in Italy contracted and died
26 from COVID in early 2020.

1 He concluded that part of the reason that happened is
2 because the Italian health care workers ran out of
3 masks. Now, in your opinion, is there a causal link
4 between masking and what happened to the Italian health
5 care workers, or is there only a correlation link?

6 A Do you have a page number for that so I can take a
7 quick look?

8 Q That I think was in his examination. It's not in his
9 report, but I can --

10 A Okay, I didn't recognize it --

11 Q -- invite my friend to --

12 A -- that's fine. So, yeah, I -- yeah, that's fine, I
13 can comment on that. I heard the question.

14 So, no, that's clearly not. So, again, if -- in
15 that case, when you're talking about a clinical
16 scenario, a complicated clinical scenario where there's
17 other things happened, so what I mean by this is it's
18 very different from a lot of the, for example,
19 preclinical experiments that I run. I can run
20 experiments in very controlled environments.

21 So, for example, if I run a study in mice, these
22 mice are all genetically identical. They are all the
23 same sex. They are fed the same food. They're housed
24 in the same environments. They -- and so we can divide
25 them, and we can have one treatment differ between
26 them, one thing. And so it's very easy then to

1 attribute an effect to that one thing because
2 everything else is controlled.

3 So in the scenario that Dr. Hu was talking about,
4 the only way that you could potentially allude strongly
5 to causation is with a randomized controlled trial.
6 That's the whole point. And so the reason it's so --
7 what randomized controlled trials are is they take
8 account for these real life settings. So in the real
9 world, when you're dealing with a clinical scenario
10 where you're talking about an outbred population,
11 you're talking about males and females, you're talking
12 about old and young, you're talking about different
13 lifestyles, different historical exposures to
14 pathogens, et cetera, et cetera, and, therefore,
15 different immunological programming and -- you know,
16 and you're dealing with a pathogen and different
17 potential exposures to that pathogen across that
18 population, you're talking about many, many
19 uncontrolled variables.

20 So what a randomized controlled trial is you try
21 to account for all those variables by getting those
22 variables equally distributed as much as possible among
23 the two groups. That's why it's called a randomized
24 trial: You literally random -- you can take two
25 people, they randomly get associated to either the test
26 arm or the control arm. And the idea of it's

1 totally -- if it is truly random, then at the end of
2 the day, both arms of your trial should have people
3 that represent the whole -- all those variables that
4 exist in the real world should be --

5 THE CHAIR: Dr. Bridle, could -- I'm
6 not --

7 A Yes.

8 THE CHAIR: -- sure that this is really
9 relevant. Could we get back to the question, please?

10 A Oh, yeah, well, it is relevant because this is the way
11 that Dr. Hu could have made his conclusion and should
12 have.

13 And so with the relevant -- and so what I'm saying
14 is with this randomized controlled trial, you equalize
15 all those variables, it's very large because of all the
16 variables, and then when you run those kind of studies,
17 that is what allows you to draw strong conclusions
18 about the potential causation of a variable, which, in
19 this case, is masking.

20 In the scenario that you just posed, there's no
21 way causation could be attributed to masking. There
22 were far too many uncontrolled variables that were not
23 accounted for.

24 Q MR. KITCHEN: I've only got one more
25 question on this and then one final question, and then
26 I'll be done.

1 Dr. Hu in his testimony, so in his questioning, he
2 described the lockdown restrictions imposed in Alberta
3 in November and December of 2020, so a little over a
4 year ago now. He stated cases went up after the
5 lockdown, but eventually later on cases went down. He
6 then concluded that the lockdown did not cause the
7 initial rise in cases, but that it did cause the
8 eventual drop in cases. In your opinion, is this a
9 logical or scientific conclusion?

10 A No. So actually he had the latter part of that
11 argument in his report highlighting -- trying to
12 highlight that these lockdown measures, including
13 masking a key component, had contributed to the
14 dramatic decline in cases.

15 So more recent history demonstrates that that is
16 patently false, that that's just the reality. That was
17 looking sort of -- taking a snapshot in time. So
18 again, first of all, it's correlative at best.
19 Secondly, I -- at least it was in the report. I didn't
20 see any peer-reviewed scientific -- I didn't see any
21 citations attributed to his comments there. That's one
22 thing that I had noted. And further, it's one snapshot
23 in time; it was looking at the tail end of one of major
24 waves of the pandemic -- waves of positive test results
25 for SARS-Coronavirus-2.

26 And what I would like to highlight is that since

1 he highlighted that snapshot in time, we have had a
2 record-shattering wave of the Omicron variant, where
3 all the historical stuff that was being I guess
4 highlighted as the reason for that decline, right, it
5 was still in place, coupled with the fact that the vast
6 majority of people were then vaccinated to add
7 additional -- an additional layer of protection, we had
8 record-shattering cases of Omicron.

9 So clearly, like -- and so again -- and I mean,
10 I'm a scientist and when I have the data, make certain
11 statements when there's overstatements or things
12 misstated. I don't think it's incorrect for me, as a
13 scientist, to declare something like that as being
14 patently false.

15 Q Thank you.

16 MR. KITCHEN Those are all my questions on
17 direct examination. So, Mr. Maxston, I've managed --
18 (INDISCERNIBLE) --

19 THE CHAIR: Mr. Maxston (INDISCERNIBLE),
20 would you like a few minutes?

21 MR. MAXSTON: I think, in fairness to Madam
22 Court Reporter, we should take at least a 10-minute
23 break. Again, I don't expect to be particularly long,
24 but Mr. Kitchen may have some redirect, and I think we
25 should take -- just take a 10-minute break if you're
26 comfortable with that, Mr. Chair.

1 THE CHAIR: I'm fine with that. It's
2 3:55, so we'll come back at 10 after 4. Thank you.
3 (ADJOURNMENT)

4 THE CHAIR: Okay, I think we're all back,
5 so Mr. Kitchen has completed his direct, and we'll ask
6 Mr. Maxston to continue.

7 MR. MAXSTON: Thank you, Mr. Chair.

8 Mr. Maxston Cross-examines the Witness

9 Q MR. MAXSTON: Good afternoon, Dr. Bridle. I
10 wanted to begin by saying that I was very displeased to
11 hear your expert testimony on the effects of aging. I,
12 however, will not use that to attack your credibility,
13 I tend to agree with it, I have to admit, but,
14 nonetheless, I thought that was something we should all
15 not take into account in today's hearing.

16 I have a couple of clarification questions for
17 you, Dr. Bridle. When I looked at your cv, and then I
18 Googled you at the University of Guelph, I just want to
19 be clear that your position is at the University of
20 Guelph in the pathobiology department at the Ontario
21 Veterinary College; is that accurate?

22 A That is accurate.

23 Q And that's part of the Doctor of Veterinary Medicine
24 program; is that correct?

25 A Yes, that's correct, yeah, as alluded to before, a lot
26 of my teaching is actually of the students enrolled in

1 the Doctor of Veterinary Medicine program.

2 Q Right.

3 A Yeah.

4 Q You had some discussions with Mr. Kitchen where you
5 talked about what was occurring at Guelph University.
6 Over the course of the pandemic, have there been any
7 requirements at Guelph University for you as staff or
8 perhaps students to mask if there's in-class settings
9 or teaching?

10 A So just -- so, yes, just to clarify, not just students
11 and staff but faculty as well. So actually I'm
12 technically not a staff member. So just so people
13 understand, yeah, there's three categories of people at
14 the university: Faculty, who are the professors is
15 what we're referred to; the staff -- we're represented
16 by the University of Guelph Faculty Association is kind
17 of the best way to distinguish; then there's our staff,
18 and many of them are affiliated with fundamentally
19 different unions; and then there's the student
20 population.

21 But all three populations, yes, there have been
22 masking policies that were implemented at the
23 University of Guelph, yes.

24 Q And did you comply with those masking policies,
25 Dr. Bridle?

26 A I did. I respect the law, and I respect rules, and so

1 even though I -- you know, what I've shared with you
2 today, I respect those rules and adhere to them, yes.

3 Q I think you mentioned as well that when you went for a
4 hair cut, you or the barber or the hairdresser had to
5 wear masks, and that, I'm assuming, was because of the
6 Chief Medical Officer of Health order or something like
7 that; would that be correct?

8 A That is correct, yes.

9 Q So you observed that as well, that masking requirement,
10 I should say?

11 A Oh, yes, I acknowledged that masking requirements have
12 been implemented in many places, yes, including my
13 public health area, yes.

14 Q Yeah, and more to the point, when you went to see the
15 barber or to get a hair cut, you complied with those?

16 A I did so I'd get my hair cut, yes.

17 Q I think you were very fair in saying, Dr. Bridle, that
18 there were I think some fairly significant areas where
19 you and Dr. Hu were, I think you'd even said, a hundred
20 percent in agreement, and I think that was in the
21 context of masking and persons who are symptomatic and
22 the benefits of masking. I think that's what you said
23 anyhow.

24 I think, isn't it fair to say, that for a
25 chiropractor, that person treating a patient can't
26 definitively know whether the patient is symptomatic or

1 asymptomatic; would you agree with that?

2 A Well, okay, so from a technical -- from a technical
3 standpoint, nobody can know without screening or asking
4 whether somebody is symptomatic. So again, as I
5 explained earlier, but I can explain again because it's
6 a common area where people don't quite understand the
7 distinction, so a sign is something that somebody
8 external to the individual can identify, can use to
9 identify that somebody is sick. A symptom is something
10 that a person experiences that's associated with
11 sickness.

12 So specific -- so nobody -- so, in other words, by
13 definition, nobody upfront can identify whether
14 somebody has a particular symptom, but you can identify
15 if somebody has a particular sign. And again, so --
16 and I can't comment beyond that in terms of
17 chiropractors. I -- that's not my area of expertise.
18 I'm not sure exactly how it works, but --

19 So, for example, in my field of expertise, that's
20 why we've been using the prescreening, and again it's
21 asking the questions. By asking the questions, if
22 people have -- are experiencing any symptoms or showing
23 any signs, then they are not to go in, you know, to the
24 workplace, my workplace, for example. I can't comment
25 on what happens in a chiropractor's office though.

26 Q Okay. I'm not going to take you through all the

1 exhibits that are in front of the hearing relating to
2 mask mandates and mask requirements, but -- and I'll
3 indulge -- hopefully my friend will indulge me a little
4 bit, rather, I'll just tell you that there have been
5 some exhibits from entities like Alberta Health
6 Services and the Chief Medical Officer of Health in
7 Alberta which set out mandatory masking and social
8 distancing, and I'm talking about the typical blue
9 medical masks, not N95s and things like that, and that
10 you referred to Dr. Tam as well.

11 It's probably fair to say, isn't it, that you
12 disagree with those type of mandates?

13 A In the context of asymptomatic individuals, yes. I
14 agree with them in the context of symptomatic
15 individuals for all the reasons that I've stated
16 earlier.

17 Q I'm wondering -- and again you may not have had the
18 chance to review this in detail, I'm not going to take
19 you towards it -- but one of the key documents in this
20 hearing is a Pandemic Directive that the College of
21 Chiropractors created that, among other things,
22 required social distancing and masking.

23 I'm assuming that, in your work, you do have
24 contact with members of regulated professions, perhaps
25 physicians, maybe lab techs, CLXTs, others. Are you
26 familiar with generally the concept of self-regulation

1 for professionals?

2 A Yes, I have, yeah, multiple clinical colleagues, so,
3 yes, through them, I understand this to a certain
4 degree.

5 Q And I don't want to go into a lot of detail, but if you
6 were to look at the Ontario Regulated Health
7 Professions Act, which I understand is an omnibus
8 legislation, it sets up a college like the College of
9 Physicians and Surgeons, the CPSO, and is it your
10 understanding that that organization sets up
11 registration requirements for physicians that they have
12 to meet before they can become registered as
13 physicians?

14 Sorry, you're muted.

15 A So I -- honestly, I can't comment in much detail on
16 that. I mean, I know that my clinical colleagues are
17 licensed by a body, for example, in Ontario, like you
18 said, like the College of Physician and Surgeons of
19 Ontario, but the actual licensing process and the
20 administrative structure and how that's managed, I --
21 I'm sorry, I don't have the expertise to comment on
22 that.

23 Q Yeah, and fair enough. I didn't want to take you
24 there; I was just trying to, you know, get your sense,
25 I mean, in your work, that you're aware of the fact,
26 for example, that a physician has to register with the

1 CPSO before they can practice as a physician.

2 Are you also generally aware that, again, a member
3 of the CPSO has to have annual, continuing competence
4 requirements, has to meet recordkeeping requirements,
5 and those type of things established by the CPSO?

6 MR. KITCHEN: Mr. Maxston, look, we all know
7 where you're going, and tomorrow I have a member of the
8 CPSO up, and I'm not going to object. You're going to
9 ask him these questions, I'm not going to object
10 because he's a member of the CPSO. Dr. Bridle --
11 (AUDIO/VIDEO FEED LOST)

12 THE CHAIR: You've gone -- you're frozen,
13 Mr. Kitchen.

14 MR. KITCHEN: -- have him talk about
15 regulated members when he's not one.

16 MR. MAXSTON: Mr. Kitchen, you just froze
17 there a bit, so I'm not going to proceed with that line
18 of questioning then, that's fine.

19 Q MR. MAXSTON: In your -- as your job and in
20 your area of expertise, I'm assuming you've looked at
21 the Ontario equivalents to, broadly speaking, the
22 Alberta Chief Medical Officer of Health masking and
23 social distancing requirements; is that fair to say?

24 Oh, I think you're muted, sorry.

25 A It's not showing that -- can you hear me?

26 MR. KITCHEN Yeah.

1 Q MR. MAXSTON: Yeah.

2 A Okay, yeah, so I -- yes, yes, is my answer.

3 Q Would it, keeping in mind your comments to me about
4 your visit to the barber and what happened at the
5 university, your university in terms of the masking
6 requirements, would you think that it's important to
7 comply with CMOH orders?

8 A So could you clarify that question? What do you mean
9 exactly, like in which context? I mean, if I want to
10 get food from a grocery store to feed my family, of
11 course, I think it's important to comply so that I can
12 get food.

13 Do I think that I need to be masked in those
14 scenarios? No. Do I take every opportunity to not
15 wear my mask where it's allowed? Yes. You know, so
16 I'm not quite clear. That's how I would answer that.
17 Maybe a more specific form --

18 Q No, I was looking -- I'm sorry, I was looking to ask
19 you some questions about the masking components of
20 Medical Officer of Health orders, but I think you
21 answered that before when we talked about the policies
22 at the University of Guelph.

23 MR. MAXSTON: Those are all my questions for
24 you, Dr. Bridle. Thank you very much.

25 A Okay, thank you.

26 Mr. Kitchen Re-examines the Witness

1 Q MR. KITCHEN: Dr. Bridle, I just have two
2 questions in redirect. When you wear a mask because
3 you have to to get groceries or work (INDISCERNIBLE),
4 do you do so willingly or is it (INDISCERNIBLE)?

5 THE CHAIR: Mr. Kitchen, you're frozen,
6 and you broke up with your question.

7 MR. KITCHEN Okay, I apologize, I'll ask it
8 again.

9 A I did -- I heard the question, but did the rest of the
10 members would like -- would you like them repeated?

11 MR. KITCHEN No, Karoline didn't hear it,
12 so I'll have to ask it again. I apologize.

13 Q MR. KITCHEN: When you wear the mask, you
14 just referred to wearing it to do groceries, you
15 referred to wearing it at work, at the University of
16 Guelph; when you wear it, do you wear it against your
17 will?

18 A 100 percent, yes.

19 Q Do you think the prescreening questions that are pretty
20 typical in your office and would be typical in
21 Dr. Wall's office and any other chiropractor's office,
22 do you think those questions are pretty effective at
23 keeping symptomatic people out of the offices?

24 MR. MAXSTON: Mr. Kitchen, I'm going to have
25 to object to that because Dr. Bridle has already said
26 he knows nothing about chiropractic clinics, so I

1 really don't think he can answer that question, at
2 least --

3 MR. KITCHEN Okay.

4 MR. MAXSTON: -- the second part of your
5 question anyhow.

6 MR. KITCHEN: Point taken.

7 Q MR. KITCHEN: Dr. Bridle, let me ask you it
8 this way: You have -- you said you have prescreening
9 questions for your laboratory; do you think those
10 prescreening questions are effective at keeping
11 symptomatic people away from the laboratory?

12 A Yes, absolutely. So as I explained, symptoms are
13 something that somebody experiences, and the only way
14 to understand whether somebody's experiencing them is
15 to ask questions.

16 So, for example, if you go to a physician, that's
17 what they're designed to do, there are certain signs
18 they can look for. So a sign, again, would be
19 something -- so, example, when they take your
20 temperature, they're looking for evidence of fever.
21 That's something they can objectively assess
22 themselves. You don't have to tell them that you have
23 a fever, and then that's something that's a sign -- or,
24 sorry, a -- yeah, a sign, therefore, of sickness.

25 Symptoms -- and symptoms can precede, can precede
26 a lot of the signs. So that's the best way to actually

1 screen is for symptoms, which is something somebody is
2 experiencing and an objective third party cannot
3 directly observe. So the only way to get that out,
4 whether you go to a physician or anything else is by
5 asking the relevant questions.

6 And the -- so, for example, so the one that's used
7 for my workplace was designed in consultation with
8 physicians, who are experts at asking the relevant
9 questions about symptomology, to assess whether
10 somebody is sick -- and in my experience, that has been
11 very effective. For the first time since those
12 questions were implemented at the university, and it's
13 the first time in the history of my laboratory that I
14 have consistently not seen, not even once, one of my
15 lab members come into work sick, whereas it was a
16 relatively common occurrence prior to that.

17 Q Is there any logical reason to think that if Dr. Wall
18 was to ask the same questions of his patients that it
19 would be any less effective for him than it is for you?

20 MR. MAXSTON: I'm going to object to that
21 too, Mr. Kitchen; it's just beyond his scope.

22 MR. KITCHEN: I disagree. I think it's
23 perfectly legitimate. The way I asked it was is there
24 any logical reason to think it would be any different,
25 so that's not a scope question.

26 MR. MAXSTON: I don't think Dr. Bridle can

1 even comment on whether it's logical or not when he
2 doesn't know what happens in a chiropractic office or
3 what the specific requirements were for any screening
4 that Dr. Wall carried out. I just think it's too far
5 afield of what he can comment on.

6 MR. KITCHEN: Well, Chair, I put it to you;
7 I think it's a perfectly legitimate question.

8 THE CHAIR: Okay, we will caucus and get
9 back to you as quickly as we can.

10 (ADJOURNMENT)

11 THE CHAIR: The Hearing Tribunal has
12 discussed the matter, and we've decided to allow the
13 question.

14 Q MR. KITCHEN: So, Dr. Bridle, I'll just
15 re-phrase it -- or not re-phrase it, re-ask it.

16 Is there any logical reason to think that if
17 Dr. Wall, in his chiropractic office was using the same
18 questions that you've been using that he would have
19 different results?

20 A There would be no reason to expect different results.
21 The expectation, what we were expected to do with ours
22 is make sure -- let's put it this way: As long as the
23 questions are comprehensive enough and thorough enough
24 that a -- the average physician would be able to make a
25 reasonable assessment as to whether or not somebody is
26 or is not infected, that that's going to be an

1 appropriate questionnaire.

2 And just I guess maybe to help for you to
3 interpret, one of the things that the -- well, yeah,
4 let's just leave it at that. That's ultimately the
5 litmus test: Physicians are the experts at diagnosing
6 disease, and if they've designed a questionnaire that
7 would allow them to get the same information that they
8 would out of the individual, should they be a patient
9 in their office, and they're screening for disease,
10 yes, that questionnaire would be university applicable
11 irrespective of the environment.

12 Q And my friend can object to this if he wants, but would
13 you agree with me that those are administrative
14 controls; is that an appropriate term to call those?

15 A Yes.

16 MR. KITCHEN: Those are my questions on
17 redirect.

18 THE CHAIR: Okay, thank you, Mr. Kitchen.
19 I think we'll just take a few brief minutes for a break
20 just to see if the Panel has any questions for
21 Dr. Bridle, so we'll be back with you as quickly as we
22 can. If you could put us in our break-out, thank you.

23 MR. KITCHEN Thank you.

24 (ADJOURNMENT)

25 THE CHAIR: Okay, I think we're all back.
26 Thank you for your patience.

1 Dr. Aldcorn does have one question she would like
2 to ask Dr. Bridle.

3 The Tribunal Questions the Witness

4 Q DR. ALDCORN: Hi, Dr. Bridle. Just
5 regarding the IFR, you commented that in 2019, there
6 was a prediction that the -- that there could be as
7 much as 10 percent with regards to COVID-19 in terms of
8 those who are infectious who get the disease, right?
9 And then you mentioned, in early 2021, studies had
10 shown that it was about .15 percent, and now even less.
11 So I'm curious to know if there's any research or
12 studies or -- to the best of your knowledge, if you
13 knew that there was any percentage given in the time
14 frame that we're concerned about, which would be from
15 May to December 2020.

16 A Yeah, in that -- so that study that I cited in my
17 report includes that time frame. So it would include
18 everything from -- I was assessing everything from the
19 beginning up until -- so the very earliest that it
20 would have included data, and I'm not even certain --
21 I'd have to go back, and I have -- and double-check,
22 but the earliest would have been, you know, like maybe
23 January 2021, but the data would have been all from the
24 start of the declared pandemic up until the end of
25 December for sure.

26 It wouldn't have anything much newer than that,

1 because the way publications work, the publication
2 process, just so you can understand the timing
3 therefore, is normally what happens is when we have a
4 manuscript ready, we submit it to a journal. And then
5 what will happen is an editor will be assigned, then
6 they'll try and recruit reviewers. Once they've
7 identified reviewers for it, that paper gets sent to
8 the reviewers. So there's a review process.

9 Normally reviewer -- so that process -- that
10 process right there often takes a week, and then the
11 review process always takes a minimum of two weeks,
12 depends on the journal. Some like report back in two
13 weeks, some three weeks, and sometimes they don't get
14 them back when requested from reviewers, and they have
15 to solicit them and try to remind the reviewers to get
16 it in.

17 But so the point is, ideally then, they're going
18 to get those initial reports after one month from the
19 initial submission, and almost always, it's very, very
20 rare for a manuscript to be accepted immediately with
21 no revisions. So almost always, if a manuscript is
22 going to be accepted, it is with revisions, and then,
23 depending on how much revision they feel is necessary,
24 that's going to dictate the -- dictate the time the
25 authors have to go back and revise their manuscript.
26 So for example, if they had to generate new data or run

1 new experiments, it's going to be -- it could be months
2 they're given.

3 But for an article like this though, it would
4 usually be a matter of weeks, and then that revised
5 version goes back, and then, often, their reviewers
6 have one final review, and then if they're satisfied
7 with the changes, they'll approve it, the manuscript
8 will be accepted. And then, at that point, it's called
9 what we call in press, and then a short time thereafter
10 it will be published. So --

11 Q So, sorry, so just -- so the question then, it was
12 released or -- in some capacity in 2021. It --

13 A Exactly.

14 Q -- was based on the information from 2020 --

15 A Exactly because --

16 Q -- so the --

17 A -- even though it was several months into 2021, the
18 data that they would have had available when they first
19 submitted it would have been for -- mainly from that
20 duration you're talking about.

21 Q Sure. So in the latter stages of 2020, would we have
22 had -- would you or the population or whatever have any
23 idea that 10 percent wasn't the number that we were
24 looking at in the middle of 2020?

25 A Yes, yes. Yeah, that was very quickly obvious. So,
26 again, what I mentioned is it wasn't a prediction that

1 the infection fatality rate would be 1 to 10 percent;
2 it was that initial like immediate concern that it
3 could potentially be that. It wasn't like any kind of
4 modelling was done. This was high profile public
5 health officials, like Fauci, like Theresa Tam,
6 expressing this potential concern, but we very
7 quickly -- it didn't take much time before we knew, we
8 really started to narrow down the high-risk
9 demographics.

10 And so we knew very early on, again, that the
11 highest risk demographics were the frail elderly, those
12 who are immunosuppressed, those who are obese, and
13 those who have multiple comorbidities. And for the
14 rest of the people, we knew, so very earlier on, that
15 the risk of fatality from infection from this
16 particular virus was quite low, yes.

17 DR. ALDCORN: Thank you.

18 A No problem.

19 MR. KITCHEN: I'm going to ask for
20 permission to ask a follow-up question.

21 THE CHAIR: Okay.

22 Mr. Kitchen Re-examines the Witness

23 MR. KITCHEN: And I'll give you the
24 question, and then you can let me know if you're okay
25 with it.

26 Q MR. KITCHEN: Dr. Bridle, what do you mean

1 by "very early", right? Because it came in March 2020.
2 So the Pandemic Directive came out in May of 2020, so
3 it's important that we know what you mean by what's
4 "very early", that we knew it wasn't going to be as
5 high as 1 percent.

6 MR. KITCHEN And, Chair, is that okay that
7 he answers that?

8 THE CHAIR: Mr. Maxston, do you have any
9 objection?

10 MR. MAXSTON: I don't object.

11 A Yeah, so that's a good question. It was prior to the
12 implementation of the policies that we knew that, in
13 the low-risk demographics, it wasn't going to be
14 anywhere close to 1 percent infection fatality rate.
15 So prior to May, right? The virus was first identified
16 in late 2019. It was only -- it only took a couple of
17 months to start identifying that this was -- so
18 basically what we refer to this as is this is a
19 virus -- we talk a lot about discrimination, you don't
20 want discrimination -- but this is a virus that very
21 much discriminates. And we knew that within a couple
22 of months, meaning, a potentially, a very dangerous
23 virus that would have a high infection fatality rate,
24 would indiscriminately kill people.

25 This virus is very discriminatory. We knew within
26 a couple of months of the -- when it was -- after the

1 virus was first identified. So by "very early", I mean
2 like by January, by the end of January 2020, we already
3 had a good idea that there was a limited number of
4 demographics that were at particularly high risk from
5 this virus.

6 THE CHAIR: I think we should leave it at
7 that. We're talking in generalities now.

8 MR. KITCHEN: I'm going to ask for
9 permission for one more question.

10 Q MR. KITCHEN: Because I want to -- I want
11 you to be able to answer Dr. Aldcorn's question.

12 At what month in 2020 did scientists know that the
13 IFR was going to be below 1 percent?

14 MR. MAXSTON: Mr. Kitchen, I'm going to have
15 to -- I don't want to be difficult here, but that is a
16 very vague question. When we say scientists knew,
17 which scientists, when, how did they know? I think
18 we've explored this a little bit, but I'm reluctant to
19 let it go much further than that, because it's just a
20 broad topic to begin that -- and, of course, in
21 fairness to Dr. Bridle, he can't speak to what other
22 people thought.

23 So I think my request to you is that you've
24 explored this enough, and I think you shouldn't go any
25 further, and I hope you're comfortable with that.

26 MR. KITCHEN: I'm going to ask Dr. Bridle --

1 Q MR. KITCHEN: -- when did you know?

2 A I was quite confident that -- about that by the end of
3 January 2020.

4 MR. KITCHEN: And I'll leave it there. I
5 think that was helpful for answering everybody's
6 questions.

7 THE CHAIR: Okay, I think that brings
8 today to a conclusion. We'll be back at 9:00
9 tomorrow morning. Mr. Kitchen, you can discharge your
10 witness, and thank you very much, Dr. Bridle, for a
11 very long and informative day.

12 A Thank you. Take care.

13 THE CHAIR: So we're back on at 9 with
14 your witness tomorrow morning, Mr. Kitchen, that's
15 correct?

16 MR. KITCHEN: That's right.

17 THE CHAIR: Okay. Very good, well, we
18 will recess until tomorrow morning. Thanks everybody,
19 and we'll see you then.

20

21 PROCEEDINGS ADJOURNED UNTIL 9:00 AM, JANUARY 29, 2022

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1 CERTIFICATE OF TRANSCRIPT:

2

3 I, Karoline Schumann, certify that the foregoing
4 pages are a complete and accurate transcript of the
5 proceedings, taken down by me in shorthand and
6 transcribed from my shorthand notes to the best of my
7 skill and ability.

8 Dated at the City of Calgary, Province of Alberta,
9 this 21st day of February, 2022.

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Karoline Schumann, CSR(A)

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Official Court Reporter

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(a) 1077:26	1024 984:11	2	28 984:5,15 985:5 1092:5	6
0	1025 984:12	2 1025:19 1033:3, 12,16 1105:12 1110:5 1128:3,5, 19 1175:3,9	29 1013:18,20 1216:21	6 1057:18 1156:23 1184:22
0.1 1039:15 1040:11,14	1092 984:15	2,000 1057:5	3	65 1005:2
0.15 1035:8,10 1039:9,16 1052:23 1053:12 1056:9 1090:8	1093 984:16	20 990:9,10 992:14 1131:5,6 1164:9 1175:11	3 1033:2,4,12,13 1068:20 1108:6 1118:3 1129:4,5, 9,16 1133:11,14, 24 1134:3,4 1164:18,19	6th 993:16
1	10:00 999:11 1090:25	2009 1059:22 1172:7	30 1030:25 1110:22 1139:10	7 1062:13 1129:12 1138:23 1183:13 1186:25
1 992:5 1036:4,5, 6,7,9 1057:6 1086:24 1088:15 1090:5 1105:11, 12,20,26 1175:8 1213:1 1214:5,14 1215:13	11 1175:22,25 1176:1	2010 1095:8	35 1032:17	77 1181:20
1,000 1056:18,20, 21	1197 984:18	2011 1174:15,17, 20 1175:18,19,24	38 1115:21	8
1.5 1056:25	12 1084:24 1148:9	2019 1026:1,4 1035:18 1210:5 1214:16	3:55 1197:2	8 999:9 1152:15, 17 1153:19 1155:1 1176:25 1177:17,18
10 995:18,26 999:9,15 1035:22 1036:5 1081:13 1084:24 1086:23, 24 1088:15 1090:5 1095:7 1097:16 1112:13, 15 1164:18 1165:5 1197:2 1210:7 1212:23 1213:1	1204 984:19	2020 1053:18,23 1103:8,13 1175:22 1176:2,7 1191:26 1195:3 1210:15 1212:14, 21,24 1214:1,2 1215:2,12 1216:3	3rd 996:19,20 997:21 999:19	9
10,000 1057:7	1210 984:20	2021 995:3 1034:23 1039:7 1053:12,20,21 1057:6,9 1087:10 1088:24 1103:10 1175:12,22,26 1176:1,2,7 1210:9,23 1212:12,17	4	9 1216:13
10-minute 1196:22,25	1213 984:21	2022 984:5,15 985:5 1092:5 1216:21 1217:9	4 987:7,16 988:17,20,22 989:2 991:24 1068:20 1118:3 1197:2	986 984:5,6
100 1034:8,11 1062:3 1072:14, 20 1111:3 1205:18	1217 984:22	20th 986:5	40 990:10 1005:8	99 1053:5 1144:25 1145:13
1000 984:7	13 1129:12	21 1175:11	45 1090:19	99.85 1053:13,17, 22 1056:17
	132 1062:14	21st 1217:9	4th 993:14,17 997:4	9:00 1216:8,21
	14 1152:18 1155:3,4	24 1118:8,10,24 1119:2,10,11,15, 19	5	9:18 986:1
	15 995:18 1005:3 1008:6,8 1015:20 1056:14,22 1057:8 1087:13, 17,26 1088:11,15 1164:18 1165:5 1210:10		5 1004:14 1015:20 1068:20 1085:3 1107:15 1164:17 1186:16 1187:8 1189:3	A
	16 990:21 1156:22		52 1057:1	abandoned 1116:9
	18 1025:19 1033:3,12 1176:1		58 1175:22	ability 1004:5 1014:17 1018:1 1042:19 1051:4,5 1065:14 1089:25 1100:15 1133:20
	18-year-old 1040:13			
	19 1025:19 1026:3 1175:21, 22			
	1900s 1059:20 1175:1			
	1:15 1090:24,26 1091:15,17			
	1:16 1092:23			

1149:8,15 1150:17 1157:1 1161:2 1163:11 1217:7 absence 1183:14 absolute 1166:6, 25 1167:8,24 absolutely 1053:9,24 1065:6 1155:23 1167:23 1169:17 1190:8 1206:12 absolutes 1167:7 1168:7 absorbant 1144:2 ACAC 985:10, 11,13,16 1092:10,11,13,16 academic 1003:20,23 1006:16 1007:4 1009:22 1010:4 1011:24 1136:8 academics 1002:3 accept 998:9 1024:10 1171:13 acceptable 1189:13 1190:1 accepted 1009:14,16 1013:22 1016:24 1180:21 1211:20, 22 1212:8 accepting 1016:8 access 1000:2 accidents 1184:25 1185:3 accolades 1007:17 accommodate 1081:6 1100:5 account 1053:20	1193:8,21 1197:15 accounted 1039:2 1194:23 accumulate 1082:19 accumulated 1047:14 1168:26 accumulating 1075:10,12 1078:21 accurate 1037:19,25,26 1057:1 1062:3 1088:22,25 1137:14 1197:21, 22 1217:4 accurately 1013:13 1048:25 accusation 1152:25 1155:8 accusatory 1154:16 1188:14 accused 1017:20 1174:6,18 accusing 1174:11 achieve 1008:10 achieved 1030:1 acknowledge 1066:5 acknowledged 1145:5 1182:17 1189:26 1199:11 acknowledgmen t 1138:12 acquire 1042:1 acquired 1023:9 1038:16,20 1077:3 acquiring 1111:23 act 1021:11 1118:15 1136:12 1202:7	activated 1120:26 1121:4 active 1005:13 1006:20 1112:24 1136:22 1143:4 1170:11,12 actively 1018:2 1036:25 1066:6 1070:15 1072:3 1079:3 1094:16 1103:23 1105:17 1106:7 1113:1 1121:12 1123:17, 25 1132:14 1134:17 1135:13 1146:10 activity 1162:11 actual 1014:5 1048:25 1111:18 1118:10 1202:19 acute 1025:17,21, 24 1057:25 1058:6,9 1059:1 adaptive 1077:3 add 1117:2,12,14 1196:6 added 1146:23 addition 1040:6 additional 1096:24 1123:20 1152:18 1161:13 1168:21 1196:7 address 1126:9 1152:26 adequately 1157:14 adhere 1199:2 ADJOURNED 1091:17 1216:21 ADJOURNME NT 996:3 999:20 1024:22 1164:23 1197:3 1208:10 1209:24	adjust 1161:3 adjustment 1139:12 administration 1030:23 1181:3 administrative 1202:20 1209:13 admissions 1023:15 1045:2 1055:13 admit 1065:4 1069:18 1197:13 admits 1183:19 admitted 1016:25 1032:19 1034:24 1055:23 adopt 1150:14 adults 1111:22 1159:23 advance 1091:13 advanced 1028:16 1032:11 advantage 1050:14 1062:24 1078:8 advice 986:24 988:26 1168:25 advise 996:1 advised 986:25 1021:20 Advisory 1021:23 aerosol 1082:17 1084:11 1108:21, 23 1123:24 1125:3,10,13,15 1126:12,21 1127:14,18,26 1130:7 1131:16 1136:8 1137:13 1142:18,21 1143:2,3 1184:7 aerosol's 1108:3	aerosol- mediated 1136:11,18 aerosolized 1083:11 1130:9 1133:13 aerosols 1070:8 1073:21 1079:11, 20 1080:12,25 1081:16 1082:8 1083:25 1084:4, 7,15 1104:22 1106:9,10,23 1107:8,17,23 1108:17 1109:23 1110:17,18,21 1111:8,10,14 1122:19,20,26 1123:3,5 1127:10 1130:1,3 1131:11 1133:2 1136:5,15 1137:26 1141:9 affecting 1120:12 affiliated 1198:18 afield 1150:21 1208:5 afraid 1083:16 1084:12 afternoon 984:15 1092:5,25 1197:9 age 1156:22,23 1184:24 1191:10 agencies 1178:13 agency 1007:12 1011:17 1065:12 1118:1 1129:7 1133:10 agent 1027:9 1060:26 1185:4 1190:16,20 agents 1069:9 1128:10,19
---	---	---	---	---

aggressive 1142:3	15 1047:12,21, 22,25 1048:3,5,6, 9 1049:4 1074:13 1075:2,6,19 1098:20,22,24	America 1030:19,21	antibodies 1038:26 1046:3 1077:7 1096:4,6 1098:23 1099:4 1121:2	approaches 1173:13
aging 1197:11	albeit 1163:10	amount 987:17 988:18 990:3 991:4,14,20,22 1071:1 1076:8 1078:5 1082:6 1102:21 1107:19 1115:5 1128:6 1141:21 1160:15	antibody 1077:10 1096:14	approve 1212:7
agree 992:20 1068:3 1080:5 1084:26 1086:26 1111:3 1123:20 1125:12 1135:10 1164:16 1170:8 1178:25 1179:21 1185:10 1189:25 1197:13 1200:1 1201:14 1209:13	Alberta 985:1,3, 15 1021:14,15 1044:17 1054:6, 14,24 1068:12, 13,22 1071:4 1092:1,3,15 1195:2 1201:5,7 1203:22 1217:8	amounts 1009:14 1070:25 1123:18	anticipate 998:18 999:4 1000:7 1019:22 1020:6 1024:7 1164:9	approximately 1106:4
agreed 1039:11	Aldcorn 985:10 1092:10 1210:1,4 1213:17	amplified 1114:26	anticipated 1026:15	April 987:7,16 988:17,20,22 989:2 993:14,16, 17 995:3 996:19, 20 997:4 999:19
agreement 1113:9 1168:16 1170:10,25 1180:1 1182:20, 24 1199:20	Aldcorn's 1215:11	amplify 1115:4, 15	anymore 1099:5 1106:13 1117:1	arbitrarily 1115:12
agrees 1168:14 1186:12	align 1084:20	amplifying 1115:1,16	anytime 1017:16	arbitrary 1105:13 1110:18
ahead 994:1 1053:7 1108:23	allergies 1159:3, 16 1160:20	analogy 1183:10 1184:9 1185:2,6	apologies 1024:15 1150:20	architecture 1046:14
air 1071:6,13 1081:21 1082:21, 22 1083:22 1084:4 1106:15, 16,21,22,24 1107:9,23,26 1108:5,11,26 1109:8,25,26 1110:2,12,13,22, 23,25,26 1111:1 1130:20,21 1131:2,3,4,7,9, 11,15 1132:14, 17,20 1133:4 1157:13 1159:6 1161:3,14,15,16, 17,20 1163:2,5, 12,13	allergy 1157:19	analysis 1040:9 1102:15	apologize 1165:3 1186:8 1205:7,12	area 1006:12 1007:10 1008:1 1010:3,5 1012:20 1018:25 1019:9 1028:19,20 1036:7 1065:3 1073:6 1094:17 1132:19 1136:22 1138:10 1141:25 1159:15 1170:11, 12 1172:3 1182:12 1186:16 1187:16 1188:21, 23 1199:13 1200:6,17 1203:20
airplane 1184:12	allowed 990:25 1033:7 1103:14 1132:24 1134:26 1146:13 1156:25 1204:15	and/or 1015:8 1026:10	applicable 1012:22 1209:10	areas 1004:22,25 1005:14,20 1006:4 1028:22 1030:8 1032:11, 12 1049:12 1066:8 1137:12 1157:24 1159:15 1162:5 1188:15 1199:18
airspace 1075:5	allowing 1130:2	animal 1028:2 1161:6	application 986:22	arguably 1050:18 1185:5
airway 1074:24	allude 1193:4	animals 1129:2, 20 1155:26 1158:15	applications 1188:7	argue 1036:6 1043:25 1059:6 1101:18 1105:9
airways 1045:13, 19,20 1046:4,9,	alluded 1197:25	annoying 1100:13	applied 1007:10 1088:23	
	alluding 1178:2	annual 1039:14 1181:23 1203:3	applies 990:26 992:5 1064:23 1172:22	
	alongside 1040:1 1081:22	annunciate 1149:10	apply 1006:2 1116:22 1151:25 1171:14	
	Alpha 1040:22	answering 1004:9 1216:5	appointed 1002:8	
	alter 1109:18	answers 1020:5 1164:8,11 1186:15 1214:7	appointment 1002:2	
	altered 1100:4 1156:2,3	Anthony 1035:23	appreciated 1037:12	
	alveolar 1045:23, 24	anti-viral 1117:5	approach 998:24 1050:12 1051:16 1168:2 1173:4	

1113:6 1134:20
1142:24 1182:18
1185:6
argues 1102:7
arguing 1175:4
1188:26
argument 987:5
991:7,26 992:21
993:6 995:11
1104:15 1134:11
1195:11
arguments
988:22 990:24
996:7,10 997:1,
13 1000:13
1180:6
arise 987:9 988:5
arises 987:6
arm 1005:23
1022:2 1131:8,15
1193:26
armour 1142:2
arms 1130:13
1131:8 1194:2
army 1121:5,6
article 1155:14
1160:13 1212:3
articles 1012:5
1113:26 1175:16
asks 1151:5
aspect 1023:19
1094:10 1136:11
1175:4
aspects 1013:2
1015:18 1031:22
1047:1 1181:8
assay 1116:9
1118:18,24
1119:4,12
1179:16
assert 995:10
assess 1067:2
1206:21 1207:9

assessed 1002:10
1004:4
assessing
1210:18
assessment
1208:25
assigned 1211:5
assist 998:3,15
assistant 1002:3,
8,15
associate
1001:18,26
1002:19 1039:13
Association
985:2,15 1092:2,
15 1198:16
assumed 1014:21
1126:26
assuming
1085:19 1199:5
1201:23 1203:20
assumption
1056:22 1104:18
assumptions
1023:4,9,11
1049:16 1188:15
asthma 1159:5,8,
16 1160:20
asymptomatic
1066:18,22,25,26
1067:20 1072:21
1073:26 1084:13
1093:14 1111:7,
26 1112:4,7,8,16
1113:15,20
1122:22 1125:13
1134:7 1135:23,
24 1140:17,26
1141:2 1143:14
1147:7 1167:3,4
1169:15,21,24
1170:15 1171:3,
12 1179:11,26
1184:5 1186:18,
21 1187:2,12

1188:24 1200:1
1201:13
asystematic
1066:13
athletes 1162:3
attached 1139:4
attack 1197:12
attain 1103:2
attempt 1064:17
1104:16
attempting
987:7
attempts
1060:17
attended 1008:6
attention
1013:26 1154:26
1163:7
attractive
1000:14
attribute 1193:1
attributed
1194:21 1195:21
audio 1165:1
AUDIO/VIDEO
1085:20 1137:2
1203:11
authority 1172:1
authorization
1089:12,13
authors 1009:5,9
1010:16,24
1211:25
authorship
1010:2,6,16
autoimmune
1159:1,8,16
1160:20
automated
1062:9
automatically
1168:21
average 1002:6

1004:7 1005:6,7
1013:26 1031:19,
23 1032:25
1040:2,4 1124:15
1135:17 1140:8
1142:15,19
1143:8 1148:18,
19 1171:6,8,26
1191:13 1208:24
avoid 1109:11,22
1124:15
award 1003:5,15,
26 1008:3
awarded
1002:14 1003:5
awards 1002:21
1003:2,3,19
1007:17,23
aware 1202:25
1203:2
awesome
1078:26

B

B.E. 985:16
1092:16
babies 1064:10
Bachelor
1001:13 1032:21
Bachelors
1029:18,23
back 986:4
995:25 996:16,21
997:25 999:21
1019:5 1024:24
1034:18,23
1057:9 1059:22
1062:12 1073:25
1082:2 1085:4
1086:7 1090:24
1092:24 1095:20
1103:18,20
1110:13 1122:18
1132:11,13

1137:5 1149:11
1150:11,16
1155:6 1161:18
1164:18,25
1173:15 1178:1,
10,18,21,23
1179:4 1182:4
1194:9 1197:2,4
1208:9 1209:21,
25 1210:21
1211:12,14,25
1212:5 1216:8,13
back-and-forth
1021:24
backed 1188:19
background
987:20 1114:11
1115:16,17,19
backs 1110:9
backwards
1149:13
bacteria 1026:23
1027:5,6
1158:11,12,20,22
bacterial
1158:14
bacteriophage
1027:7
bad 1039:17
1088:1 1089:3
1109:10,11
balance 1136:7
1140:21 1169:5
ballpark 1031:20
1035:8 1036:3,4
1039:15 1087:10
barber 1199:4,15
1204:4
barrier 1046:2
1076:9 1077:17
1131:11
barriers 1061:2
1074:11 1075:15
1076:3,4,11,14,
19,22 1103:26

1120:12	behaving 1059:7	birth 1156:17,23	1112:21,25	Bridle 984:7,12,
based 1017:5	behaviour	bit 1019:19	1119:17 1120:25	16 986:9 991:8
1036:25 1052:17	1142:1,3	1035:1 1054:25	1121:25 1122:11	998:4,6 999:4,11,
1056:26 1063:11,	behavioural	1073:14 1081:5	1157:9 1158:13	14 1000:23,25
26 1089:4,23	1141:11 1158:17	1082:12 1094:9	1162:9 1202:17	1001:7 1004:16
1090:12 1114:23	Behaviours	1113:3 1114:10	body's 1071:14	1018:4,23
1134:9,15	1156:1	1131:16 1136:3,	bombard	1019:9,16,22
1136:21 1179:14	belabour 997:19	20 1148:20	1076:13	1020:17,22,24
1212:14	belly 1110:7	1161:20 1162:15	bonus 1014:25	1022:21 1024:1
baseline 1045:1	belt 1132:13	1190:25 1201:4	bonuses 1014:23	1025:6,8 1033:4
basic 1005:15	beneficial	1203:17 1215:18	booking 995:18	1084:23 1085:2,
1013:1 1023:18	1064:20	black 1037:23	boosters 1097:19	6,22 1092:26
1025:12 1056:26	benefit 1064:20	1167:8	born 1156:8,11	1093:4,10
1065:1 1131:4	1181:21 1184:2	blasting 1084:7	bottom 1116:25,	1095:16 1137:8,9
1165:16 1181:8	benefits 1183:25	blasts 1084:6	26 1117:13,20	1150:19,25
basically	1185:7 1199:22	1130:21	break 995:25	1152:6,12
1003:24 1060:9	biases 1009:10	block 998:1	996:9 999:9	1153:21 1164:7,
1068:1 1099:11	big 996:25 1080:1	1077:7	1000:10 1025:4	9,21 1165:7
1109:11120:19	1087:12 1126:16	blood 1045:22,	1084:25 1085:4	1181:26 1186:14
1214:18	1163:8	23,25 1046:3,21,	1086:5 1093:9,11	1190:5 1194:5
basis 998:8,18	bigger 1122:21	22	1120:21 1163:2	1197:9,17
1008:20,21	biggest 1066:15	bloodstream	1164:14 1196:23,	1198:25 1199:17
1009:21 1018:16	1152:19	1046:19	25 1209:19	1203:10 1204:24
1098:26 1124:6	bind 1096:6	blow 1075:12	break-out	1205:1,25 1206:7
1156:25 1159:13	1099:5	1084:15	1209:22	1207:26 1208:14
1183:3	binds 1096:14	blowing 1108:26	break-through	1209:21 1210:2,4
basketball	biohazard	blue 1201:8	1145:8 1174:25	1213:26 1215:21,
1149:22	1128:15 1129:22	blunt 1100:8	breath 1073:4	26 1216:10
be-all 1180:11	1133:20	1178:6 1188:9	1079:16 1082:18	Bridle's 986:19
beard 1132:6,26	biologic 1167:21	board 1146:25	1083:13,16	987:1 999:26
1133:5,6,7	biological	bodies 1021:20	1084:13 1109:8,	1004:12 1020:5
1134:26	1061:16 1088:9,	1050:19 1074:10	9,10,11,13,19,23	briefly 1000:12
begin 1197:10	16 1130:14	1113:11	1135:3 1163:9	1033:19
1215:20	1167:12,19	body 989:19	breathe 1071:13	bring 1000:7,20
beginning	biologically	1026:25 1027:4,7	1084:5 1107:25	1033:7,9 1102:24
986:26 1010:11,	1045:4	1038:5 1045:10,	1109:12,15	1154:25 1163:24
13 1035:15,17	biology 1028:24	13,15 1046:3,21,	1114:20 1157:13	bringing 1124:3
1087:8 1088:23,	1047:6 1113:4	23 1047:20	breathed	brings 1000:6
26 1098:16	1167:7,11,14,16,	1074:6,18,21	1082:11	1216:7
1118:4 1136:26	18,21,22	1075:3,9,18	breathing 1071:2	British 1038:15
1146:23 1147:2	biomedical	1076:5 1078:1,5,	1107:7 1132:20	broad 1215:20
1210:19	1001:14	6,14,17,20,24	breaths 1163:7	broader 1058:13
behave 1141:13	biosafety 1128:5,	1079:14,20	breeze 1108:8	broadly 1203:21
behaves 1047:15	21	1095:14,26		broke 1205:6
		1103:24 1105:2		broken 993:4

bronchitis 1047:9,11
brought 991:1
 1000:16 1017:16
 1078:12 1135:9
bubble 1024:16
buildings
 1106:15
built 1062:17,19
bunch 1080:10
bunching
 1124:18
burden 992:9
 1183:24 1190:8
buried 1074:20
burn 1076:7
burning 1085:7
bus 1107:3,15
 1108:19
button 1024:16
 1165:2
bypass 1061:2
 1075:15 1103:25
bypasses
 1080:25
bypassing
 1060:17 1077:16
BYRAM 984:7,
 12,16 1000:23
 1025:6 1093:4

C

C-I-H-R 1007:6
cabinet 1130:15,
 22 1131:12
calculate
 1037:14
calculated
 1037:13,18
calendar 994:18
 995:20 997:15
calenders

996:14,23
Calgary 1217:8
call 990:21,22
 998:16 1000:17
 1001:1 1004:23
 1005:21 1009:1,2
 1010:16 1031:2,5
 1038:24 1041:14
 1059:9 1065:1
 1070:8 1073:26
 1074:25 1075:26
 1076:24 1077:3
 1095:3,24
 1097:4,19 1104:1
 1107:26 1115:17
 1117:3,10
 1120:18 1129:4
 1137:4 1140:10
 1155:25 1157:6
 1158:19 1190:16
 1209:14 1212:9
called 987:14,24
 1004:19 1025:22
 1031:6 1041:17
 1045:9 1046:20
 1047:19 1058:8
 1059:24 1075:16
 1089:13 1114:14
 1116:24 1128:5
 1130:14 1150:26
 1151:20 1155:20
 1166:5 1188:6
 1193:23 1212:8

calling 1115:19,
 20,22

campus 1145:12
 1146:13

Canada 1004:21
 1005:7 1007:4
 1011:18 1025:20
 1031:19,20
 1032:5 1036:13
 1044:16 1049:21
 1058:11 1088:6
 1089:5,12,13,24,
 25 1090:3,6,7

1097:22 1115:12
 1116:10 1118:1
 1129:7 1178:13
 1180:25

Canadian 992:4
 1007:6,26
 1038:12 1054:12

cancel 997:4
 1065:25

cancelled 1014:7,
 10

cancer 1007:10
 1012:26 1028:23
 1191:5,15

cancerous
 1191:7

cancers 1006:1
 1191:9

capable 1094:5,6

capacity 1016:2
 1212:12

caps 990:26

capture 1070:2
 1114:21

captured 1176:4

capturing
 1070:21,25

car 1181:11,12,13
 1184:25 1185:3

carbon 1045:26
 1160:25 1161:7,
 21,23

care 1023:15
 1097:24 1134:13,
 17 1135:9,11,22
 1169:12,14,16
 1170:1,2,6
 1173:23 1191:25
 1192:2,5 1216:12

career 1009:22
 1181:5

careful 1114:9
 1124:9 1143:19
 1144:10 1190:2

carried 1079:14
 1110:23 1208:4

carry 1121:17

carrying 1107:23

cars 1181:11

case 991:11
 1000:14 1005:1
 1007:19 1010:12
 1015:19,21,24
 1016:1,9,11,18
 1017:7,12,17,20,
 24 1018:10

1027:23 1028:21
 1039:21 1043:6

1058:13 1085:17
 1087:20 1103:12

1108:3 1122:2,3,
 4 1131:13

1135:20 1146:6
 1150:12 1159:9

1170:9,22
 1176:7,8 1181:18

1182:22 1192:15
 1194:19

cases 988:8
 1005:21 1017:26

1023:14 1041:14,
 15,16,17,18,25

1042:6,7,9,10
 1044:3,15,19,25

1054:21 1055:1,
 18,24 1059:26

1060:16 1061:14
 1068:17,23

1082:15 1095:26
 1099:20 1100:20

1101:2,3,4,5
 1113:19 1115:13

1122:7 1141:3
 1144:19 1146:3

1195:4,5,7,8,14
 1196:8

catch-all 1020:10
categories
 1198:13

category 1059:8
 1127:5 1145:14

caucus 995:13,23
 1024:13 1208:8

causal 1192:3

causation
 1190:7,10,11
 1191:3,15 1193:5
 1194:18,21

causations
 1190:9

causative
 1115:18 1190:16,
 20

cause-and-effect
 1190:20

caused 1054:15
 1058:7 1185:3

causing 1042:20
 1059:11 1127:4

1159:5 1163:16,
 19 1173:9

1186:22 1187:22

caution 1091:1

caveats 998:12

cavities 1148:18

cease 1085:13

cell 986:13
 1076:4 1077:10
 1117:3,4,23
 1120:16

cells 1037:8
 1043:3 1074:24
 1075:16,21,22

1076:10,20,22
 1077:5,6,8,13,14

1096:10,16,23,25
 1116:23,26

1117:5,8,10,11,
 14,19 1119:3

1120:12,13,15,
 24,26 1121:1,4,
 17,18,21 1122:13

1191:7

central 1156:3	chance 1001:4 1044:9 1099:26 1105:21 1163:25 1201:18	1096:11 1147:25 1155:13 1159:19 1160:3,18,20 1163:17 1170:18	25 1188:19 1189:3,4 1195:21	1204:16
centres 1159:11	chances 1034:3 1044:8	chin 1124:19 1139:11	cite 1035:4 1165:22	clear-cut 1113:20
certainty 1052:22	change 1000:6 1041:8 1062:24 1070:22 1088:17 1109:15 1118:16 1134:15 1143:21 1161:3 1162:6	China 1112:13	cited 1039:1 1053:20 1113:25 1125:16 1126:14 1174:1,16 1176:2 1179:12 1210:16	clearing 1075:24
Certificate 984:22 1217:1	changed 1034:26 1047:15,16 1052:5 1099:6	chiropractic 1205:26 1208:2, 17	citing 1169:2 1174:17	client 986:23 987:15,23 988:21 993:11 994:21 998:4,6,8 1153:9
certified 1001:17	changing 1176:19	chiropractor 1135:16,18 1199:25	City 1217:8	clinical 1022:3,4 1026:11 1038:14 1180:10,13 1182:14 1192:15, 16 1193:9 1202:2,16
certify 1217:3	characteristics 1061:5 1103:2	chiropractor's 1200:25 1205:21	claim 1154:4,12	clinics 1205:26
cetera 1010:21 1026:26 1185:1 1193:14	characterize 1169:8	chiropractors 985:2,15 1021:14 1092:2,15 1103:14 1135:10 1200:17 1201:21	claims 1153:22 1177:20 1188:18	close 1045:24 1146:11 1214:14
chain 1036:16 1114:14	charged 1065:5 1069:19	choosing 1171:2	clarification 1197:16	closed 1130:12
Chair 985:8 986:2,12,18 989:6 993:24,26 994:2 995:13 996:4 997:18 999:8,18,21 1000:3,9 1004:11 1018:22 1019:3 1024:9,12,18,20, 24 1084:21,23 1086:6,10,12,16 1090:23 1091:6, 9,11,14 1092:8, 24 1093:3,6 1095:16,18,20,22 1152:12 1164:17, 21,24 1181:26 1182:3 1194:5,8 1196:19,26 1197:1,4,7 1203:12 1205:5 1208:6,8,11 1209:18,25 1213:21 1214:6,8 1215:6 1216:7, 13,17	Charter 992:4	chosen 1027:23	clarified 1017:22	closer 1044:26 1142:15,19 1144:9
chaired 1028:10	chat 1069:24	CHR 1008:2,5	clarify 1015:7 1019:17 1025:14 1053:6,17 1088:14 1093:19 1123:3 1126:22 1198:10 1204:8	closing 987:5,8, 16 988:13,15,22 991:6 992:21 993:6 995:11 996:10 1000:13
chairs 1008:5	cheap 997:8	Christmas 995:22 1013:17 1054:24	class 1003:25 1031:13,15	cloth 1070:9 1129:19 1130:25 1131:26 1132:25 1133:15 1134:21 1144:2
challenge 1129:1,19	chemistry 1167:9	chronic 1157:17, 20 1162:21	classes 1003:14	clothing 1131:20, 22
challenged 1129:2	chest 1110:7	chronologically 1057:19	classic 1068:21 1090:1 1165:25 1168:18 1190:24	cloud 1084:10 1108:1
	chewing 1139:13	cilia 1074:25	classroom 1150:16	clouds 1152:2
	chicken 1095:7	circulate 1099:8 1100:12	clean 1140:5	CLXTS 1201:25
	Chief 1022:16 1199:6 1201:6 1203:22	circulating 1106:15,22	clear 994:7,15 1021:3 1025:16 1043:14 1045:2 1053:9 1074:22, 23 1076:26 1078:18 1096:24, 26 1120:25 1121:13 1123:6, 14 1125:2 1126:16 1151:19 1168:9 1169:14 1186:9 1197:19	CMOH 1204:7
	child 1065:17 1072:17	circumstance 1069:15		CO2 1161:2
	child's 1158:24	citation 1174:15 1175:2		coach 1149:25 1150:5
	childcare 1065:25	citations 1007:21 1008:2,9 1010:12 1154:5 1174:2,10 1175:21 1176:7 1181:20 1187:8,		coat 1026:23
	childhood 1095:3,4 1097:15			Cochrane 1174:17
	children 1037:5, 6,9 1040:12 1042:15,26			

coin 1053:2	College's 995:1	common 1005:22	992:17	1140:4 1143:22
cold 1042:12,16, 21 1051:24 1059:6,13,14 1060:1,2 1061:19 1064:9 1071:6 1081:7 1083:22, 26 1084:4 1102:12,17,18,23 1107:9 1109:8 1181:23,24	colleges 1003:7	1013:20 1037:5 1042:3,12 1051:24 1058:17 1059:6 1060:1,2 1064:8 1102:12, 23 1167:5 1168:8 1200:6 1207:16	complete 1006:19 1044:19 1062:2 1097:25 1170:24 1217:4	1150:14 1155:21 1160:7 1170:15, 16 1174:14 1180:25 1201:26
cold-causing 1042:3,4,10	Columbia 1038:15	communicate 999:13 1149:15 1150:18	completed 1197:5	concepts 1031:9
cold-like 1145:26 1146:8	combination 1101:13	communicating 1028:9 1077:14	completely 1044:11,23 1061:14 1064:18 1088:17 1103:5 1178:7 1185:5	concern 1042:19 1044:2 1086:22 1088:19 1123:20 1135:21 1154:8 1155:20 1160:9 1213:2,6
collaborate 1011:12 1032:1,3	combine 1108:16	communication 1147:22 1149:6 1150:22 1151:11	completing 1032:14,26	concerned 987:23 1123:22 1140:13 1143:13 1147:4 1155:16 1210:14
collaborated 1011:3,10,22	combines 1148:22	community 1006:26 1030:4 1145:13,17 1168:14 1169:19 1187:3	complex 992:1 997:1 1080:18 1105:5 1165:23 1167:17,22	concerns 987:10 988:5 1024:3 1030:12 1035:15, 21 1036:2 1152:16,19 1155:10 1160:13 1163:23
collaboration 1011:16 1012:3	comfortable 986:23 1196:26 1215:25	comorbidities 1040:2,5 1213:13	compliance 998:13	conclude 996:7 1049:26 1119:20
collaborative 1009:26 1012:1 1028:12 1128:24	COMMENCED 986:1	comparative 1057:22	complicated 1016:14 1192:16	concluded 1192:1 1195:6
collaborative- ness 1010:23	comment 998:2 1019:20 1027:19 1069:13 1115:9 1145:4 1151:2 1153:9,17,18 1154:16 1155:12 1182:5 1192:13 1200:16,24 1202:15,21 1208:1,5	compare 997:24	complied 1199:15	conclusion 996:6 1112:14 1119:18 1194:11 1195:9 1216:8
collaboratively 1012:6	commentary 1187:24	compared 1056:10 1082:13	comply 1198:24 1204:7,11	conclusions 1194:17
collaborators 1011:9	commented 1210:5	comparison 1184:19 1185:21	component 989:23 1006:22, 23 1181:6 1195:13	conclusive 1169:7
collapse 1065:22	commenting 1153:14	compete 1162:4	components 1013:4 1204:19	condensation 1107:8
colleagues 986:20 1202:2,16	comments 986:15,20 987:4, 8 988:24 989:5,9 996:26 997:19 1000:11 1001:5 1150:25 1151:2, 24 1154:9 1165:8 1195:21 1204:3	competence 1203:3	comprehensive 1032:24 1208:23	condense 1081:12 1084:1
collecting 1179:25	commit 1185:16	competition 1008:4	compromised 1018:18	condensing 1084:4,7
college 985:2,15 992:5 994:3 995:2,4 997:12 1003:4,6,7 1021:13,14,17 1030:21 1092:2, 15 1103:16 1197:21 1201:20 1202:8,18	committed 994:2	competitive 1181:16	concentrations 1096:12 1108:4, 10	condition 1161:22
	committee 1021:23 1028:11	compilation 1180:16	concept 1089:17 1094:4,22 1104:18 1114:15	
	committees 1007:8 1014:19	compiled 1009:1		
		complain 1150:3		
		Complaints 987:3,9 988:5,12, 24 989:11 990:16		

conduct 988:2 990:6 1006:11 1128:15 1133:18, 20	consequences 1162:1	contained 1079:4	continues 1071:24 1183:17	cool 1084:2
conducted 1011:18	considerable 987:17 990:3	Containment 1118:2 1128:3,5, 18 1129:4,5,9,16 1133:11,14,24 1134:3,4	continuing 1203:3	coordinated 1172:10
conducting 1128:16	considerations 1007:19	contaminants 1131:6	contracted 1191:25	copied 1062:5
confer 1045:18 1048:25 1095:24 1097:13 1098:24	considered 989:22 996:5 1005:9 1015:26 1017:8,14 1129:5	contention 1136:7 1173:25	contradicted 1178:7	copy 1061:21,22, 26 1062:4,8,17
conferred 1098:24 1099:3, 23 1100:7 1134:14	consistently 1163:1 1207:14	contentions 1043:18	contribute 1190:10	copying 1062:10, 19,21
conferring 1095:11	constant 1163:1, 18	CONTENTS 984:1	contributed 1010:9 1195:13	core 1173:16 1187:14
confers 1062:24	constantly 1061:18 1074:16, 21 1075:2 1081:14 1124:1 1128:14 1180:6	context 1035:1 1048:4 1049:19 1053:24 1054:16 1059:12 1073:2 1087:16 1105:17 1110:18 1111:10 1123:23 1125:12 1126:25 1127:26 1133:2 1137:17 1144:21 1147:5 1150:13 1167:22, 24 1178:8 1179:2 1180:16 1181:21 1182:9,21 1183:21 1184:4, 24 1185:4 1199:21 1201:13, 14 1204:9	contribution 1140:22	cornered 1186:10
confidence 1119:14	constitutional 1089:18,22	continuation 986:3	contributions 1007:11	Corona 1015:17 1061:20
confident 1188:23 1216:2	consult 1021:21	continue 987:11 989:16 990:15 1000:18 1025:3 1051:19 1092:26 1093:12 1100:12, 17 1137:9,26 1181:4 1197:6	contributor 1140:20	Coronavirus 1025:21 1026:3 1058:7
confined 1043:4	consultation 1207:7	continued 1012:26 1013:1 1041:10 1044:20 1050:2 1099:10	control 1061:14 1097:26 1103:5 1105:6,7 1109:5, 9 1111:8 1180:19 1184:15 1185:23 1193:26	Coronaviruses 1042:4 1059:5 1061:18 1063:5, 16
confirm 999:19 1033:23 1054:14 1146:4	consume 1120:18,20		controlled 1180:8,11,23 1182:8,18 1183:2,8,15,18, 20 1184:10 1186:5 1192:20 1193:2,5,7,20 1194:14	correct 986:10, 11 1001:9 1021:2,4,16 1123:1 1158:16 1183:19 1197:24, 25 1199:7,8 1216:15
confirmation 1121:11	contact 1008:18 1028:13 1123:8, 13,16,19,21,26 1124:1 1125:1,3, 7 1127:1 1131:19,23 1132:24 1137:13 1138:1 1140:14, 22 1141:18 1143:11 1144:5 1201:24		controlling 1110:16 1144:22 1191:9	corrected 1039:3 1090:14 1135:17
confirmed 996:18 1146:4	contact-free 1141:18		controls 1209:14	correctly 1052:4
conflict 1009:4	contact-free 1141:18		controversy 1037:22	correlate 1191:10
confluence 1116:24	contact-mediated 1138:13		conventions 1010:6	correlation 1190:7,9,22 1191:16 1192:5
confused 1017:2	contagious 1042:13		conversation 1085:5	correlations 1191:2
connected 1042:18 1085:5			convey 1149:20	correlative 1195:18
connection 1009:5			conveyed 1030:9	cost 997:8
consecutive 993:7 994:22 996:13,24 1007:21 1008:2				costs 987:11 989:10,14 997:7
consequence 1013:6 1028:8				

cough 1070:4 1075:10 1078:20 1106:2	COVID 1012:23 1020:6 1036:25 1094:22 1135:19 1165:12 1166:18 1191:26	Cross-examines 984:9,18 1020:23 1197:8	cycle 1008:7 1115:2,13 1116:18 1117:21 1118:11,15 1119:2,15,19	1157:3,8 1158:1, 11 1171:8,11 1214:22
coughing 1066:7, 8 1068:4 1070:6, 15,20,23 1072:4 1079:3,12 1082:24 1104:12 1105:18,23 1106:7 1112:25 1113:1 1123:8 1127:1 1136:12	COVID-19 1012:11,18,19 1015:9 1018:26 1019:11 1021:21 1025:15 1026:2, 7,17 1027:12 1041:1,17,18 1055:18,21 1094:14,23 1101:5 1135:14, 19 1145:21 1169:12 1183:5 1186:22 1190:16, 18,19 1210:7	cross-purposes 1169:26	cycles 1114:26 1115:15,21 1118:8,10,25	dangers 1058:20 1153:15
counsel 985:9,16, 19 989:26 995:23 996:5 1091:8 1092:9,16,19	create 1129:26 1130:3	crossover 1054:23,25	cylinder 1181:15	data 1008:23,24 1009:1 1023:7,18 1037:25 1038:1 1040:15,20 1041:16 1043:26 1044:15 1052:16, 17 1053:21,25 1054:1,6,9,10,11, 14,21 1055:4,5, 10,11,15 1056:6, 9,11,12 1068:3, 15 1165:16 1176:5 1196:10 1210:20,23 1211:26 1212:18
count 1037:3	created 1163:12 1201:21	crowd 1108:24	cyinders 1181:14	databases 1013:20
counterintuitive 1171:22	creates 1106:16 1131:3 1161:22	crux 1066:15	cytopathic 1117:10	date 987:8 1001:24 1030:16, 18 1034:21
countries 1165:17	creating 1161:12	CSR(A) 985:21 1092:21 1217:14	<hr/> D <hr/>	Dated 1217:8
country 1090:8 1165:10,26 1166:16 1172:15	credentials 1029:18	cumbersome 997:25	D.V.M. 1021:5 1029:3 1030:16	dates 987:22
couple 992:11 1018:24 1020:22, 25 1052:6 1111:25 1120:15 1136:4 1145:26 1148:8,26 1160:10,11,12 1175:16 1187:4 1197:16 1214:16, 21,26	credibility 1197:12	curb 1171:1	damage 1046:14 1117:22	Dawson 985:12 1092:12
coupled 1196:5	critical 1070:17 1075:17 1094:11 1101:14 1150:6 1176:21 1179:7 1181:6	curious 1093:15 1210:11	dampen 1179:3	day 987:19 988:9, 14,16 992:16,23 993:8,13 994:7, 10,14 996:8,15 1071:3 1146:15 1168:23 1194:2 1216:11 1217:9
court 985:21 990:10,26 1016:3,10,11,21, 23,26 1018:3 1092:21 1189:11 1196:22 1217:15	criticism 1164:7	current 1040:23 1043:26 1056:7, 13 1063:14 1094:22 1103:3 1110:23 1160:17 1167:25 1176:9, 10	dampening 1047:1	day-and-a-half 993:20
cover 996:26	cross-	currents 1106:16,17,22,24 1107:23 1110:22, 26	Dang 999:6 1020:17 1153:21	days 988:6,8 990:9,10,12 991:23 993:3,4,7, 12,18 994:9,10, 16,22,23 995:11, 18 996:12,20,24 997:3,13 1145:26 1146:8 1172:19
covered 1116:25 1117:13	examination 1164:5	Curtis 985:18 1018:4 1092:18	danger 1034:13, 16 1050:1 1058:25 1060:6 1061:15 1141:23	
covering 1074:16	cross-examine 1163:26	cut 1083:4,14 1199:4,15,16	dangerous 1039:21,25 1041:26 1042:24 1043:13 1045:3,6 1046:9,10 1047:17,23 1048:8 1050:7 1051:11,23,25 1052:7,20,21 1053:16 1056:12 1058:15,16 1059:17 1064:9 1069:3 1087:2,4 1100:24 1102:8 1103:2 1120:24 1128:8,9 1156:19	
	cross-examined 1015:20	cut-and-dry 1182:19		
		cut-off 1118:8, 10,11,12,15,20,24		
		cut-offs 1115:13		
		cutoff 1117:24 1119:10		
		cutting-edge 1176:5		
		cv 1000:1 1001:23 1004:12 1010:1 1013:10 1197:17		

deactivate 1181:14	decent 1046:26	defence 989:20 994:8,15,17 995:10 1074:19	Delta 1041:7	description 984:3 1189:4
dead 1161:13,14, 16,17,20 1163:12,13	decide 1151:17	defences 1120:10	demand 995:17, 20	deserves 992:1,2, 24
deadline 1065:9, 10 1070:17 1162:16	decided 1000:13 1208:12	deficits 1158:17, 18	demographic 1035:26 1040:13, 17 1054:5	design 1010:18 1128:13
deadlines 1065:6	decimal 1052:10 1056:26	define 1037:21 1061:6	demographics 1042:25 1052:21 1064:8 1087:22, 24 1173:8,10 1213:9,11 1214:13 1215:4	designation 1025:19
deadly 1088:11 1187:3	decision 997:10 1072:17	defined 1058:22 1107:13 1172:20	demonstrable 1188:18	designed 1070:11 1072:24 1073:3,19 1079:23 1080:24 1081:25 1082:7 1100:8 1104:13, 14 1120:16 1121:6 1127:13 1131:1 1133:10 1134:22 1135:26 1138:22,25 1140:2 1141:9 1142:7 1155:21 1162:19 1206:17 1207:7 1209:6
deal 1060:24 1063:13 1076:19 1128:2 1151:26 1174:4	decisions 1090:3	defining 1179:14	demonstrate 1133:22 1154:5, 19	destroyed 1090:4
dealing 1015:11 1016:12 1025:24 1040:19,20 1052:19 1057:25 1058:12 1059:1 1060:19 1063:9 1087:15 1088:12 1128:26 1167:7 1175:2 1193:9,16	declaration 1036:8 1038:21	definition 1060:4 1088:6 1100:3,6 1200:13	demonstrates 1195:15	detail 998:10 1028:22 1112:19 1201:18 1202:5, 15
dealt 1004:23 1174:22	declare 1058:24 1059:13 1088:2 1172:25 1196:13	definitive 1167:15	demonstrating 1179:15	details 1085:17 1120:9
death 1037:23 1090:6 1184:24 1185:18	declared 1012:13 1014:6 1029:8 1035:13,15 1039:12 1058:11, 15 1059:21,22 1060:5 1064:26 1085:9,18 1086:21 1087:16 1088:4,13 1089:1 1094:18 1125:22 1145:19 1146:3 1172:7,20 1182:7 1210:24	definitively 1056:15 1057:14 1136:21 1179:16 1199:26	denominator 1037:16 1038:1,7 1039:2 1087:7,12	detect 1077:22 1114:24 1115:21 1116:2 1120:13, 17
deaths 1037:15, 19,25 1040:16 1045:2 1055:16 1088:18 1145:25 1185:3 1186:23	decline 1050:2 1195:14 1196:4	degrees 1029:4,8, 9 1030:3,11	denominators 1038:8	detecting 1038:5 1076:21 1109:11 1115:26 1116:14 1120:3,4
debatable 1136:10,11	declined 1044:18	dehydrated 1071:15	dental 1191:13	detectors 1106:19
debate 1136:22 1143:4 1170:12 1182:13	declines 1191:8	delay 994:25,26 997:16	department 1197:20	determination 1190:10
debating 1185:26	declining 1049:26	delays 992:13	department's 1028:10	determine 1116:18 1185:10
December 1103:13 1195:3 1210:15,25	decreased 1165:11 1166:17	deliberate 996:11	dependent 1110:26 1111:1	
	dedication 1005:6	deliberations 996:7	depending 1076:16 1106:11 1122:5 1139:16 1211:23	
	deemed 1002:12 1053:14	deliver 1130:2	depends 1151:5 1153:10 1211:12	
	deep 1028:19 1030:6 1047:7 1163:6,8	delivered 1045:8 1076:15 1097:10 1155:26	deploy 1185:20	
	deeper 1047:26 1188:23	delivering 1078:1	describe 1034:13 1067:9 1128:16 1174:24	

determined 1007:26 1033:24	difference 1027:16 1028:25 1047:9 1058:1 1126:17 1132:5 1190:6,8 1191:1, 22	Directive 1201:20 1214:2	discriminates 1214:21	dismissed 1016:21,23
detrimental 1065:20	differences 1027:16 1139:7 1165:24	directly 1022:19 1023:21,22 1066:20 1152:23 1188:24 1190:12 1207:3	discrimination 1214:19,20	dispel 1106:3
develop 1017:7 1042:1 1102:4 1156:4 1157:1,18 1158:17 1160:6	different- looking 1063:14	Director 985:13 987:3 988:12,25 989:12 992:18 994:14 1092:13	discriminatory 1214:25	displeased 1197:10
developed 1102:17 1156:21	differentiate 1026:5 1060:2 1157:2 1158:1,26	Director's 987:10 988:5 990:17	discuss 1000:10 1023:26 1033:18 1091:8	disproportionate ly 1055:2
developing 1005:24,26 1062:6 1159:1 1162:26 1163:17	difficult 995:19 1019:18 1065:24 1081:19 1124:10 1135:2 1136:13, 20 1139:14 1145:4,20 1148:4,23 1149:16 1150:15 1151:6,10 1215:15	directs 1109:16	discussed 991:6 1006:8 1016:24 1017:1 1018:3 1177:22 1208:12	dispute 1165:24
development 1002:5 1155:24 1156:2,23 1158:12 1160:15	difficulties 987:21 1147:26	disagree 1123:14 1165:12 1166:4 1170:8 1182:25 1201:12 1207:22	discussion 984:6 986:17 1000:22 1020:26	disputed 1018:1
devices 1135:2,3	difficulty 1148:14 1149:3	disagreement 1066:15 1168:19 1179:11	discussions 1198:4	disrespectful 1188:11
devoted 1005:2,3	diligent 1064:5,7	disagrees 988:23 1169:9 1182:23	disease 1025:15 1026:3,8,9,13,17 1027:9,11,14 1037:3,11 1042:11,21 1043:24 1044:1,5 1047:1,8 1050:22 1056:3 1058:8,9 1059:11 1060:20 1067:18 1072:12 1074:4,5 1076:13 1077:25 1096:18 1100:9,10 1103:26 1104:2 1113:22 1117:17 1128:11 1159:1 1187:23 1190:16 1209:6,9 1210:8	disrupt 1131:9, 15
diagnosed 1135:14,19	dioxide 1045:26 1160:25 1161:7, 21,23	disappeared 1068:24	discarded 1000:12	dissipate 1107:17 1108:3,4
diagnosing 1209:5	diphtheria 1097:17	disassociated 1159:2	discussions 1198:4	dissipated 1108:24
diagnosis 1026:11	direct 1000:8 1190:13 1196:17 1197:5	discard 1124:24	disease 1025:15 1026:3,8,9,13,17 1027:9,11,14 1037:3,11 1042:11,21 1043:24 1044:1,5 1047:1,8 1050:22 1056:3 1058:8,9 1059:11 1060:20 1067:18 1072:12 1074:4,5 1076:13 1077:25 1096:18 1100:9,10 1103:26 1104:2 1113:22 1117:17 1128:11 1159:1 1187:23 1190:16 1209:6,9 1210:8	dissipates 1107:13
diagnostic 1119:8	directing 1083:16 1110:12, 13	discarded 1000:12	disease-causing 1128:9	distance 1019:24 1105:10,11,21 1107:13 1108:6 1143:9
diagnosis 1026:11	direction 986:24 988:26 994:12 1109:2,18,25 1110:2,14,24 1111:1,9 1190:23	discharge 1216:9	diseases 1005:25 1006:9 1013:5 1069:15 1137:20 1159:8,17 1160:21	distances 1106:11
diagnosing 1209:5		disclose 1015:14	discuss 1000:10 1023:26 1033:18 1091:8	distancing 1019:1,12 1020:14 1100:19 1101:10,16 1103:20 1105:4, 6,8,16 1110:17 1145:16 1146:22 1151:9 1201:8,22 1203:23
diagnosis 1026:11		disclosed 1009:7, 8 1017:17,18	discussed 991:6 1006:8 1016:24 1017:1 1018:3 1177:22 1208:12	distinction 1026:6 1027:10 1169:15 1200:7
diagnostic 1119:8		disclosure 1006:6 1017:14, 23 1018:3	discussion 984:6 986:17 1000:22 1020:26	distinctions 1030:5
diagnosis 1026:11		discouraged 1069:2	discussions 1198:4	dissipates 1107:13
diagnostic 1119:8		discouraging 1178:13	disease 1025:15 1026:3,8,9,13,17 1027:9,11,14 1037:3,11 1042:11,21 1043:24 1044:1,5 1047:1,8 1050:22 1056:3 1058:8,9 1059:11 1060:20 1067:18 1072:12 1074:4,5 1076:13 1077:25 1096:18 1100:9,10 1103:26 1104:2 1113:22 1117:17 1128:11 1159:1 1187:23 1190:16 1209:6,9 1210:8	distance 1019:24 1105:10,11,21 1107:13 1108:6 1143:9
dichotomy 1184:26			disease-causing 1128:9	distances 1106:11
dictate 1023:11 1211:24			diseases 1005:25 1006:9 1013:5 1069:15 1137:20 1159:8,17 1160:21	distancing 1019:1,12 1020:14 1100:19 1101:10,16 1103:20 1105:4, 6,8,16 1110:17 1145:16 1146:22 1151:9 1201:8,22 1203:23
dictated 1106:24			discarded 1000:12	distinction 1026:6 1027:10 1169:15 1200:7
dictates 1187:21			disclosure 1006:6 1017:14, 23 1018:3	distinctions 1030:5
dictating 1089:21			discouraged 1069:2	distinguish 1198:17
die 1034:12 1035:11 1056:19 1057:6,8 1185:24			discouraging 1178:13	distribute 1046:21
died 1037:24 1040:3 1185:20 1191:25				
differ 1135:14 1192:25				

distributed
1075:18 1193:22

distribution
1005:1

distributions
1004:24

divide 1037:15
1192:24

divided 1004:22,
25 1005:2

doctor 1001:7
1021:3 1028:4
1030:17 1154:12
1197:23 1198:1

doctorate 1029:5
1032:26

doctors 1027:18

document
1037:21 1062:3,
12 1177:9
1189:13

documentation
1174:6,8 1175:15
1178:4

documented
1052:23 1113:19

documents
999:24 1000:8
1201:19

doffs 1140:6

dogs 1160:4

dominant
1050:4,5 1064:20
1167:13

dominate
1062:26

donning 1125:14

dons 1140:6

Doodle 987:7
997:23,26

door 1069:23,24
1081:9

doorways
1080:19

dose 1076:16,19
1078:3 1097:3,9
1103:25 1104:19,
22 1112:22
1113:3,21
1128:11 1136:14

doses 1097:23,24
1098:2,4 1130:5

double-check
1210:21

**double-
vaccinators**
1055:3

Doug 995:17

down-playing
1179:1

downgraded
1043:25 1178:25

downwind
1107:15 1108:7,
20

draining 1120:23

dramatic 1090:6,
7 1195:14

dramatically
1144:5 1148:7

draw 1194:17

drawing 1132:16

driver 1113:22
1167:5

drop 1073:18
1195:8

droplet 1137:13
1140:23 1143:18

droplets 1070:3,
9,22 1072:23
1073:5,10,18,21
1079:15,25
1083:26 1105:19

1106:3,8 1122:22
1123:7,13,16
1125:4,5 1126:1
1136:5 1137:26
1140:19 1143:18,
26 1144:8 1152:3

dropped 1014:1
1137:4

drops 1073:12

drown 1075:6

dryer 1071:10

due 995:1 1016:6
1171:25 1185:3
1187:11

dump 1078:23

duration
1009:22 1098:5
1136:25 1212:20

durations
1134:24

dust 1157:13
1158:9

duty 1018:12

dwarfed
1044:22,24
1146:19

dying 1184:17
1185:12

dysregulated
1157:6 1158:25

E

ear 1016:5 1109:1

earlier 1039:7
1046:25 1066:16
1087:15 1088:12
1096:11 1099:25
1136:15 1178:14,
15 1200:5
1201:16 1213:14
earliest 1210:19,
22

early 1014:6
1037:17 1039:3
1044:21 1053:12,
21 1057:5,9
1059:20 1062:9
1077:20,22
1078:9 1083:3
1087:10 1088:24

1116:9 1118:7
1148:10 1155:14
1168:14 1174:26
1179:2 1191:26
1210:9 1213:10
1214:1,4 1215:1

earning 1030:10
earpiece 1139:24

ears 1081:26
1082:3,5 1084:8
1109:26 1133:5

easier 1041:10
1043:13

easily 1078:17

easy 1037:20
1192:26

eat 1120:20

editor 1006:15,17
1211:5

Edmonton 985:2
1092:2

educate 1063:13
1122:14 1158:23

educated
1028:19

effect 1117:10
1138:1 1143:8
1180:20 1193:1

effective 1063:11
1068:10 1071:22
1072:13 1088:17
1104:5 1125:17,
26 1126:3
1127:17 1134:6
1144:8 1159:25
1179:1 1205:22
1206:10 1207:11,
19

effectively
1135:26

effectiveness
1169:11 1170:5
1173:20 1182:9
1183:13

effector 1077:4

effectors 1122:5

effects 1187:3
1197:11

efficacy 1018:26
1019:11 1023:10
1111:4 1150:23
1151:8

efficiency 989:3
1073:20

efficient 1102:1
1162:9

efficiently
1101:26 1117:8
1123:7 1127:9

effort 1004:24
1005:1

efforts 1013:4
1173:7

egregious
1189:22

eight-hour
1124:20

elasticized
1132:8 1139:1

elbow 1141:23

elbows 1130:16
1141:23

elderly 1039:23
1064:10 1213:11

elevation 1162:4,
5,11

elite 1008:3

else's 1054:10

emails 987:6
1021:24

embarrassing
1073:13

emerge 1040:22

emergency
1089:12 1172:4

emphasis
1005:10 1006:5
1123:12 1175:12,

26	endurance 1162:2	epidemic 1057:23,24 1058:2,4,11 1059:16,25 1060:4,21 1088:5	established 1020:9 1122:19, 20,21,22 1203:5	10 1170:5,11 1173:20 1174:1 1178:17 1182:24 1183:12,15,24 1186:20,26 1187:5 1188:19, 20 1189:1,2 1206:20
emphasize 1133:17 1144:23 1146:17 1162:14	engine 1181:11, 14	epidemics 1059:18	estimate 1087:11 1088:19	exact 1001:24 1013:11 1034:21 1139:9 1145:15
emphasized 1174:13 1175:24	enhance 1144:5	epidemiological 1023:2,3 1165:14	estimated 1035:6 1039:8 1056:10 1087:13	exaggerated 1170:17
emphasizing 1104:8	enhanced 1054:19 1159:1	equal 1051:23 1074:3	estimates 1035:6 1036:24	examination 1192:8 1196:17
encases 1084:10	enhances 1125:1	equalize 1194:14	ethical 1183:26	examined 984:7, 12,16 1000:23 1025:6 1093:4
encounter 1157:3	enhancing 1140:25	equally 1048:10 1193:22	evaluate 1014:14	examples 1042:6 1166:2 1167:2 1174:19 1188:16
encourage 1029:1 1068:16 1081:2 1163:3	enormous 990:1 991:4	equals 1089:3	Eve 1054:24	exceed 1112:22
encouraged 1068:26 1072:15	enormously 1069:8	equate 1026:9 1041:18 1184:23	evening 993:21	excellent 1025:11 1145:8, 11
end 991:19 996:15 1003:20 1008:4 1013:16 1014:24 1031:25 1032:5 1034:19 1035:2,18 1040:9 1062:11,22 1070:19 1071:15 1075:9,11 1101:15 1103:5 1113:13 1115:15, 16 1122:25 1157:16 1160:17 1161:18 1168:23 1173:19 1175:8 1194:1 1195:23 1210:24 1215:2 1216:2	enrolled 1197:26	equipment 1128:22 1129:24 1131:18 1134:21 1140:6 1141:21 1161:1	event 997:10 1113:8 1191:18, 19,20	eventually 1074:23 1195:5
end-all 1180:12	enshrined 1168:17	equivalent 1003:3 1185:22	events 1074:8 1076:24	ever-increasing 1101:24
endeavour 1018:18	ensure 1009:9	equivalents 1203:21	eventual 1195:8	everybody's 997:25 1138:11 1216:5
endemic 1057:16,20,22 1059:3,9 1060:7, 26 1061:5,12,16 1063:3 1064:3, 11,13 1085:7 1099:26	entail 1030:21	eradicate 1060:23 1061:1	eventually 1074:23 1195:5	evidence 986:19 987:1 988:7,15 991:4,5,10,11,13, 16,18,20,22,23 993:5 996:26 1016:17 1017:7, 8,13 1034:24 1038:3,4,16,19, 24 1041:22 1044:5 1045:2 1051:14 1055:19 1067:4 1091:8 1101:17 1111:20 1112:16 1113:14 1114:1,8,22 1119:5 1121:13 1123:2,5 1146:16 1168:6 1169:4,5,
ends 1080:16	entails 1002:2 1003:9	eradicating 1100:1	eventually 1074:23 1195:5	exception 1048:14
	enter 1133:18	erroneously 1033:26	eventually 1074:23 1195:5	exceptionally 1148:10 1158:7
	entering 1046:19	error 1184:22	eventually 1074:23 1195:5	exceptions 1167:13,14 1168:3
	entire 992:23 1018:17 1039:20 1087:21 1116:25 1117:13 1128:2,4	error-prone 1062:20	eventually 1074:23 1195:5	excessively 1131:15
	entities 1201:5	escape 1133:4	eventually 1074:23 1195:5	exchange 1045:22,25 1046:13,15 1075:7 1162:10
	entry 1045:15 1075:17	essentially 1029:21 1060:8 1084:6 1114:7 1131:4,7	eventually 1074:23 1195:5	exchanged 1161:17
	environment 1062:23 1106:12 1132:17 1134:11, 13,15 1140:12 1157:12,14,22 1158:1,4,10,11 1159:4,14,26 1162:9 1167:23 1190:4 1209:11	establish 992:8 999:7 1008:22 1118:12	eventually 1074:23 1195:5	excluded 1042:22 1175:15
	environments 1044:10 1106:13 1192:20,24		eventually 1074:23 1195:5	excuse 1138:4 1152:12
	envision 1083:21 1139:3		eventually 1074:23 1195:5	

executive 1090:2	1207:2	explained 994:8	extensively	1099:15 1100:19
exhalation	experiment	1098:18 1103:22	1011:10	1101:10 1105:8
1079:16	1185:13	1104:24 1112:18	extent 986:23	1106:11 1108:16
exhale 1080:22	experiments	1159:21 1184:6	1153:10 1163:16	1109:6 1113:6
1081:20 1082:3,	1192:19,20	1187:10 1200:5	external 1200:8	1124:15 1127:8
4,13 1161:13	1212:1	1206:12	extinct 1050:17,	1129:10 1144:24
exhaling 1104:21	expert 987:14,25	explaining	25 1051:12	1147:15 1158:14
exhibits 1201:1,5	990:22,23 991:2	1120:10	1064:15	1165:18 1168:2
exist 1101:19	995:2 998:8,9,19	explains 1048:3,	extra 1142:23	1172:25 1174:11
1194:4	1007:20 1015:12,	7,10	1177:11	1175:5,20,25
existed 1056:9	18,22,24,26	explanation	extreme 1028:18	1185:25,26
1061:8	1016:17,18,22	992:3	1031:25 1032:5,	1186:11,13
exists 1041:1	1017:7,8,11,13,	explored	13 1040:12	1187:1 1196:5
exit 1081:22	19,21 1018:1,2,	1215:18,24	1063:15 1106:25	1202:25
exiting 1105:2	13,25 1019:9	exponentially	extremely	factor 1039:26
expanded 1038:2	1024:26 1036:6	1115:2	1040:16 1131:1	factories 1077:7
expansive 1164:8	1043:18 1135:10,	exposed 1050:21		factual 1184:22
expect 1014:18	15 1150:21,26	1074:9 1134:19	F	faculty 1001:18
1035:10 1111:17	1152:23 1182:23	1156:13,25		1002:5 1004:20
1164:6 1196:23	1187:24 1188:21	1157:14,15,21,22	fabulous 1115:26	1005:7,9 1008:16
1208:20	1197:11	1158:2,3,10	1142:11	1011:8 1014:1,
expectation	expertise	1159:13 1162:7	face 1108:9	15,20 1028:13
1208:21	1008:17 1012:20	1191:6	1132:19 1134:26	1065:5 1198:11,
expected	1016:15,24	exposing	1139:5 1161:11	14,16
1018:16 1034:12	1028:20 1030:6,	1162:20	1171:21	fail 1076:26
1053:15 1057:6,8	8,9 1065:3	exposure	faces 1160:4	failed 1060:13
1135:18 1208:21	1094:19 1118:14	1031:16 1134:16	facial 1067:12	1061:1 1099:22
expecting 996:7	1151:15,26	1163:18	facilitate 1075:7	1154:18 1155:4
1162:12	1152:5 1154:8	exposures	facilities 1097:25	1185:20
expelled 1108:11	1165:14 1172:3	1193:13,17	1132:22	fair 993:7 995:22
expelling	1187:16 1188:22,	express 1096:11	facility 1118:3	1153:9 1170:3
1072:10 1112:24	23 1200:17,19	1159:22	1132:3 1133:18	1184:19 1199:17,
expensive 989:18	1202:21 1203:20	expressed 1037:7	1134:3	24 1201:11
experience	experts 988:3	1155:19	facing 1012:14	1202:23 1203:23
1062:8 1070:18	1002:11 1016:20	expressing	fact 993:15	fairly 998:20
1136:24 1148:15	1169:25 1170:13	1213:6	1004:4 1007:13	1005:10 1006:3
1185:18 1207:10	1177:26 1184:20	expression	1012:8 1013:6	1013:13 1166:6
experienced	1207:8 1209:5	1043:2	1014:1,2,14,18,	1167:17 1169:8
1013:3 1073:13	explain 1033:19	extending	20 1018:7 1021:1	1199:18
1165:11 1166:17	1045:4,5	1161:19	1026:13 1029:14	fairness 1196:21
experiences	1061:20,24	extension	1044:2 1057:5	1215:21
1200:10 1206:13	1066:18 1083:9,	1065:13	1061:6,13 1066:6	fake 1180:26
experiencing	20 1136:16	extensive	1071:18 1080:16	fall 994:23 1127:4
1200:22 1206:14	1148:15 1168:4	1005:11 1030:18	1082:19 1083:3	1145:13
	1180:9 1200:5		1087:19 1088:3	fallacious

1184:23	fear 1101:1	filed 995:2	finish 1022:11,22 1050:3 1083:1 1090:21,22 1172:24	focuses 1155:13
falls 1185:17	February 993:12 1217:9	filibuster 990:20	fires 1082:4	focusing 1005:14 1176:11
false 1036:18 1119:26 1184:26 1195:16 1196:14	fed 1192:23	fill 1075:6	fire 1160:26	fog 1084:6
familiar 1095:2 1126:18 1128:21 1130:7 1181:11 1201:26	Federal 1006:10 1007:3 1172:22	filter 1070:11 1073:20 1080:24 1082:6,7 1130:23 1131:1 1134:22 1141:9	firing 1109:1	fogged 1082:12
familiarity 1062:5	feedback 1009:11 1010:20 1027:20 1031:8	filtered 1114:12 1132:20	firm 1138:24	fogginess 1081:15
familiarize 1149:21	feeding 1022:1	filtering 1080:23 1081:22 1082:19, 20 1083:12 1158:7	fit 990:14 1059:8 1060:3 1081:25	fogging 1081:23
family 989:25 1160:2 1204:10	feeds 1023:18	filters 1130:23,26 1132:14,16,18 1135:1	fit-tested 1134:25	Folder 1004:13
fan 1132:15	feel 986:23 1008:16 1067:5 1070:16 1108:20 1141:12 1142:22 1155:8 1211:23	final 996:7 997:10,12 1002:16 1017:2 1175:8 1194:25 1212:6	fits 1184:8	follow 1080:20 1173:11 1186:4
farms 1159:12	feeling 1067:10	financial 1018:9	fitting 1105:1	follow-up 1213:20
fascinating 1068:11	feelings 1149:15	financially 989:24	fizzled 1172:12	food 1157:12,19 1192:23 1204:10, 12
fast 991:3 1077:11	feels 1163:7,9	find 995:19 996:12,24 997:3, 14,24 1010:2 1062:11 1065:25 1081:12 1093:8 1109:12 1117:21 1135:2 1145:20 1153:15 1166:25 1168:20 1173:17 1176:13,24 1177:13	flaws 1036:12	force 1075:4 1186:4
fatal 1034:4 1040:1 1043:7	fellowship 1001:16 1032:2	finds 1168:20	flexibility 1024:5	forcing 1084:15
fatality 1033:18, 20,21 1034:1,10 1035:7,21 1036:3,7,9,24 1037:14 1039:4, 8,15,16,20 1040:10,14 1043:12 1049:25 1052:5 1053:2,9, 11 1056:7,10,23 1059:26 1086:22, 24 1087:3,9 1088:15 1089:7 1213:1,15 1214:14,23	felt 988:3 1003:17,22 1027:26 1039:5 1174:24	fine 993:5,6 1090:19,20,26 1142:9 1153:1 1166:1,23 1192:12 1197:1 1203:18	flexible 1139:2,5	foregoing 1217:3
Fauci 1035:23 1039:12 1178:12 1213:5	females 1193:11	fingers 1074:26	flipping 997:25	forget 1050:19
fault 995:1	fetus 1156:10		floor 999:22	forgive 1006:14 1122:23 1136:2
favour 991:20,21	fever 1206:20,23		flow 1130:20 1131:9,15 1161:11	forgot 1007:22
favourite 1149:23	fewer 1037:7 1078:16		flu 1039:13,14,17 1059:14,15,16, 17,20,22,24 1060:3 1063:4,7, 24 1066:3 1068:18,21,23, 24,26 1069:2,3 1088:1,3 1089:3 1090:9 1127:6 1171:8,20 1172:7 1181:23,25	form 1041:24 1059:11,19 1060:14 1113:23 1204:17

four-year 1003:13,14	1065:2 1081:12 1108:17 1148:10, 11	gap 1014:13,26	1120:3 1157:3	gold-standard 1115:25 1116:8, 21 1118:17 1119:4,24
fourth 987:14 1003:16 1032:19 1097:24	full 988:9 992:2 994:17 995:9 1001:12 1002:16 1006:6 1017:14, 23 1018:3 1030:14 1034:18 1074:24 1078:21 1087:11,12 1156:21	gaps 1082:2	geographical 1058:5	good 986:2,14 1020:24 1043:24 1052:12 1059:14 1069:14 1070:21 1081:18 1093:8 1096:26 1100:22 1108:12 1158:7 1160:3 1184:5 1191:9 1197:9 1214:11 1215:3 1216:17
frail 1039:23 1064:10 1213:11	fully 1009:6 1037:26 1044:4 1062:9 1071:20 1096:5 1156:21	garner 1029:25	get all 1161:14, 15	Googled 1197:18
frame 1057:26 1210:14,17	function 1090:8 1167:12 1168:5 1191:8	garnered 1013:26	give 1001:4 1004:8 1009:11 1011:13 1034:7 1052:8,10,24 1056:6 1065:13 1079:16 1093:17 1146:1 1149:19 1163:25 1164:8 1169:8 1177:6 1180:24 1181:20 1184:9 1188:16 1213:23	governing 1187:26
frank 993:8	functional 1116:22 1179:15	gas 1045:22,25 1046:13,15 1075:7 1080:20	giving 1034:18 1036:19 1150:10 1167:2	government 1006:10 1007:3 1011:23 1089:20 1133:10 1172:6, 13
frankly 989:13	functioning 1181:16	gas-exchange 1163:11	glad 1188:5	gown 1131:18
free 1161:11 1174:9 1176:6	functions 1048:22 1181:7	gaseous 1084:1	glass 1062:8	grab 1037:8 1043:3 1096:15
freedoms 1089:18	fundamental 1005:15 1181:8 1187:14	gauge 1031:8	glasses 1081:1,6, 10,14 1082:10,11	grabbing 1139:25,26 1144:4,15
freely 1099:9	fundamentally 1156:1 1183:22 1198:18	gear 1129:15	global 1058:14 1064:25 1184:24	grabs 1096:10
frequency 1191:21	funding 1007:4 1008:1 1010:17 1065:14	geared 1136:17	globally 1020:6	graduate 1028:6 1029:10,11,16
frequently 1191:18	future 1045:16 1102:26 1103:1 1160:21	gearing 995:3	globe 1058:20 1064:15	grant 1007:2,12 1065:9,12 1188:7
fresh 1124:25 1161:17 1163:2		general 1003:12 1110:14 1122:11 1137:18 1140:9 1141:5,19 1142:9 1163:23 1167:11	gloves 1131:18 1139:20	granted 1080:2
freshest 1163:5	G	generalities 1215:7	gnatobiotic 1158:15	granting 1065:12
friend 990:10,12 992:19 993:8 994:12 998:3 1000:6 1001:4 1153:2 1163:25 1169:9 1192:11 1201:3 1209:12		generalized 1020:4,5	gnatobiotically 1155:26	grants 1006:8 1007:9 1012:24 1065:8
friend's 990:19 1022:22		generally 1020:7, 20 1113:10 1188:11 1201:26 1203:2	goal 1060:22 1099:22	graphs 1044:24
friends 1160:1		generate 1211:26	goalposts 1172:24,26	grasp 1013:13
front 1081:26 1108:2,24 1130:16,18 1131:3 1161:8 1201:1		generic 1027:20	goaltender 1141:16	grate 1130:17,19, 21
froze 1203:16		genetic 1038:5 1041:20 1062:17 1114:7,8,16,17, 18,23,25 1115:1, 5,6 1116:4 1119:23 1120:4 1122:11	gobble 1120:18 1121:17	gravity 1075:4
frozen 1095:18, 19 1203:12 1205:5		genetically 1192:22		
frustrating 1048:21 1062:10	game 1141:18 1150:8	genome 1062:21		
		genuine 1120:1 1176:18		
		genuinely 1034:2 1084:12 1087:1		

great 1021:25
1038:11 1081:1
1084:3 1086:9,19
1113:26 1137:7
greater 1028:18
1134:12 1142:20
1191:4,13
grew 1159:11,12,
14
grimacing
1067:13
groceries 1205:3,
14
grocery 1081:5
1142:26 1204:10
ground 1106:4
1185:13,17
group 1012:22
1034:8 1180:13,
14,20 1184:15
1185:23 1189:9,
17
groups 1011:19
1193:23
grow 1116:23,24
1157:24
growing 1038:8
1156:5
guarantee
1026:20 1063:19,
21 1133:7
guaranteed
1169:17
Guelph 1001:19,
22 1011:20
1027:24 1028:2
1032:17,23
1197:18,20
1198:5,7,16,23
1204:22 1205:16
guess 1001:11,22
1006:6 1007:16,
22 1011:13
1017:6 1040:26
1056:5 1057:1

1093:24,25
1135:14 1137:17
1154:21,25
1160:24 1171:4
1178:25 1196:3
1209:2
guest 1006:17
guilty 1065:5
1069:18
gum 1139:14
gut 1026:25
1157:21 1158:18

H

had've 993:17,18
hair 1083:4,5,15
1084:16 1132:10
1199:4,15,16
hairdresser
1084:9 1199:4
hairdressers
1083:8 1084:12
hairs 1074:25
1075:8
half 1010:15
1174:23
half-joking
1106:26 1107:1
halls 1145:2
hallways 1110:4,
7
halves 1031:14
hand 1017:11,12
1025:5
hand-in-hand
1045:7
handle 1125:5
1139:23
handling 1124:2,
21 1125:6
hands 1084:14
1118:24 1124:3

hands-on
1010:14 1031:17,
22
happen 1116:10
1141:22 1211:5
happened 995:7
1017:24 1054:22,
23,24,25 1068:22
1088:21 1115:10
1148:8 1192:1,4,
17 1204:4
happening
1014:20 1040:25
1066:17 1080:16
1081:16 1115:16
1121:3
hard 1148:6,22
1149:12 1187:14
harm 1050:15,20
1051:5,18
1100:25 1102:20,
21 1140:12
1143:7 1147:6,
17,19,21,23
1160:18 1163:16
1173:9 1184:5
1186:1
harms 1147:4,8
1152:8,16,26
1153:23,25
1154:19,21
1155:1,12
1177:21,22
1178:2 1179:9
1184:3
hate 995:24
hayfever
1157:25
hazard 1078:25
hazards 1128:5
he'll 987:1
988:24 1022:18
1150:11
head 1055:8
1084:10 1126:8

1154:24
head-on 1174:4
headache
1162:26
headband
1132:10
headbands
1138:25
headlines
1035:14
headpiece
1132:12
heads-up 999:15
health 1007:6
1011:17 1019:26
1021:10,20
1022:8,16,25,26
1023:23 1027:17
1035:23 1040:6,
15 1041:16
1043:17,19
1049:17 1053:26
1054:2,8,11,13,
21 1055:4,5,10
1056:6,9,11,12
1068:13 1069:8
1072:19 1089:5
1113:10,11
1118:1,26 1129:7
1134:13,17
1135:9,11,22
1145:1 1146:2
1154:12 1169:16
1170:1,6 1173:23
1176:22 1177:6,
15,26 1178:11,13
1180:22 1187:18
1191:24 1192:2,4
1199:6,13
1201:5,6 1202:6
1203:22 1204:20
1213:5
healthier
1171:16
healthy 1038:15
1066:23 1067:20

1072:2 1073:26
1074:22 1104:23
1105:25 1111:19,
22 1113:16
1143:14
heaps 1169:13
1170:7 1173:19
1174:1
hear 986:19
992:2 1019:6,26
1025:8 1026:22
1150:7,23 1153:5
1154:9 1165:1
1197:11 1203:25
1205:11
heard 989:10
1015:15,25
1023:1 1059:17,
19 1089:11
1114:14 1140:16,
17 1169:20
1192:13 1205:9
hearing 985:7
986:3,26 987:5,
11,18,22 988:1,7,
9 989:3,12,16,17
994:3 995:23
996:4,17 998:7
1016:17,21,23,26
1024:25 1040:25
1089:18 1092:7
1170:9 1176:16
1197:15 1201:1,
20 1208:11
hearings 985:13
994:14 995:19
997:7 1016:3
1092:13
hearsay 1188:20
heat 1150:8
heath 1169:12
heavily 1094:20
1103:21
height 1185:15,
17,18

helpful 1083:2
1153:7,8 1216:5
helps 1022:5
1090:11 1094:25
HEPA 1130:23,
24,26 1132:16,
18,20
Hey 1073:13
high 1035:22
1036:1 1038:12
1059:26 1064:7
1076:14 1079:2
1086:23 1088:20
1104:19 1113:7
1115:14 1119:14
1130:5 1146:1,10
1159:19 1161:23
1213:4 1214:5,23
1215:4
high-impact
1038:13 1112:12
high-performing
1181:12
high-risk
1052:20 1173:8
1213:8
higher 1089:8
1100:21 1119:2
1161:24 1162:4,
5,11 1190:9
highest 1213:11
highlight 1004:3
1041:13 1051:22,
24 1056:1,13
1058:17 1066:11
1067:19 1073:23
1084:17 1094:15
1125:7 1152:19
1154:7,22
1162:22 1163:18
1170:23 1174:11
1175:6 1179:12
1183:1 1195:12,
26
highlighted
1052:18 1112:10

1127:23 1188:12
1196:1,4
highlighting
1174:24 1195:11
highlights
1004:3 1027:8
1098:3 1173:25
1189:15
highly 1009:26
1011:26 1042:8,
12 1051:24
1072:15 1076:8
1113:7 1116:14
highways
1046:22
hire 989:26
historical
1097:10 1115:10
1127:11 1176:11
1193:13 1196:3
historically
1094:24 1126:23
history 1195:15
1207:13
hit 1109:23
hockey 1141:16,
19
hold 1001:17
1021:4 1121:19,
21 1141:2 1152:8
holding 1122:2
1133:6
holds 1029:2,10
1032:10
home 1064:22
1065:26 1068:8,
25 1071:8
1093:16,20
1099:13 1107:3
1125:14 1131:21
1146:6 1160:10
homes 1042:18
1106:17
honestly 1012:9
1016:14 1182:16

1202:15
honourary
1003:24
hood 1130:18
1132:19
hope 1064:25
1069:4 1072:14
1073:15 1090:11
1215:25
hoped 1146:23
hoping 1094:1
1152:22 1154:1
1176:23
horrible 1083:6
hospital 1016:13
hospitalizations
1023:14 1045:1
1055:11,12
1186:23
hospitals 1016:7
1055:23
host 1028:11
1050:16,24,25
1051:5 1187:20
hosts 1051:8,12
hour 1090:20,23,
25 1093:7
1138:18
hour-and-15
1090:20
hours 992:11,12,
22 1015:20
1031:16 1162:26
1164:1
housed 1192:23
households
1065:15
housekeeping
986:13
houses 1106:14
Hu 991:8 1020:9,
16 1027:18,19
1113:25 1152:24
1165:8,10,20

1169:8,10
1170:23 1173:19
1186:10,24
1188:10 1191:23
1193:3 1194:11
1195:1 1199:19
Hu's 1080:3
1111:3 1123:10
1135:8 1138:13
1153:10,18
1170:13 1182:16
1189:24
hug 1160:5
huge 1055:17
1068:18,21
1071:1 1084:10
1112:13 1191:22
human 992:3,4
1022:3 1058:18
1141:13
humans 1167:20
humidifier
1071:7
humidity 1071:6
hundred 1035:9
1146:11 1199:19
hundreds
1061:26 1138:9
hygiene 1065:1
1155:11,20
hypocritical
1188:15
hypothesis
1155:11,20
hypoxia 1161:22,
23 1162:21
1163:19

I

ice 1141:16
iclickers 1031:6
ICU 1045:1
1055:13,15

ICUS 1055:23
idea 1052:11
1056:1 1067:14
1073:25 1094:3
1105:19 1160:25
1183:18 1184:16
1193:26 1212:23
1215:3
ideal 993:5
1051:17 1060:19,
22 1100:2 1102:6
ideally 1051:20
1073:8 1102:4
1211:17
identical 1192:22
identifiable
1011:1
identified
1019:23 1025:26
1026:4 1033:26
1035:19 1061:9,
10 1147:19
1211:7 1214:15
1215:1
identify 1008:6
1010:25 1037:21
1038:24 1039:24
1060:20 1075:22
1145:22 1147:17,
22 1152:7 1155:4
1200:8,9,13,14
identifying
1036:17 1041:15
1214:17
IFR 1052:8
1210:5 1215:13
ignorance
1154:14
illness 1026:10
1042:2,7 1060:24
1066:24 1097:7
1104:11 1112:23
illnesses 1040:6
imagine 1082:14,
18 1122:12

1157:5	immunologists 1095:10	implications 1187:19	inability 1097:25	1191:21
immediately 1074:12 1076:20 1182:4,6 1211:20	immunology 1001:15,19 1002:20 1003:11, 12 1005:15 1018:25 1019:10 1028:22 1030:7, 19 1031:1,4,17 1032:6,9,16,18, 22,25 1094:19 1171:24 1181:5 1187:14,15 1190:25	importance 1049:24 1178:26	inaccurate 1154:4,13	increasing 1039:2 1057:4 1078:11 1101:2 1138:3
immersed 1084:15	immunosuppres sed 1039:24 1213:12	important 1007:18 1009:6 1023:7 1026:6 1027:15,16 1028:15 1030:3, 14 1033:25 1034:26 1035:12 1036:10 1040:8, 19,24 1041:24 1043:16 1046:6 1051:20 1056:4 1073:24 1074:4 1077:20 1089:15 1114:2 1120:7 1122:16 1127:23 1132:7 1158:5,6 1176:3,14,15,20 1177:7,12,23,24 1183:2 1190:6,26 1204:6,11 1214:3	inappropriate 1140:11 1185:6	increasingly 1137:1
immune 1038:25 1045:10 1048:21 1049:2,6,9 1054:17 1063:13 1075:15,23,25 1076:6,24 1077:3 1078:8,9,19 1120:6,8,14 1121:12,24 1122:3,13,14 1156:4,15,16,20, 26 1157:5,15,26 1158:23,24 1159:3 1160:5 1181:7,9 1187:20 1191:8	immunotherapie s 1005:26	importantly 1104:25	inappropriately 1157:10 1159:7	incredible 1028:21 1129:24
immunity 1023:9 1038:16 1048:8, 26 1049:14,16,18 1095:11,25 1096:3,19,20 1097:4,13,20 1098:6,19 1099:2,24 1100:8 1111:19,23 1165:26	immunotherapy 1005:21,22	imposed 1165:11 1166:16 1195:2	incapacitate 1089:25	incredibly 1015:5 1170:20
Immunization 1021:24	impact 1014:4,7 1047:4 1089:23 1090:6,7 1185:12 1190:13	imposition 1089:20	inch 1110:8	incurred 987:12
immunological 1096:24 1158:18 1160:7,15 1191:8 1193:15	impacting 1163:10	impossibility 1138:8	incidence 1159:16	incurring 997:15
immunologically 1156:9,12	impairing 1150:17	impossible 1113:5	include 1210:17	independent 1009:22 1031:2 1144:13
immunologist 1001:17 1021:2 1048:20 1066:11 1181:1,24 1187:17	impediments 1013:8	imposition 1089:20	included 1031:1 1210:20	independently 1002:10
	implants 1191:14	imposition 1089:20	includes 1055:11 1158:9 1210:17	indexed 1013:19
	implement 1041:2 1102:18 1128:7 1172:1,6	imposition 1089:20	including 1007:2,9 1011:24 1025:20 1026:21 1035:23 1042:3 1044:17,23 1055:13 1061:5 1063:5 1064:22 1073:18 1113:10 1140:7 1172:14 1177:26 1178:11 1195:12 1199:12	indicating 1154:16
	implementation 1214:12	imposition 1089:20	inconvenient 1065:16,24	indication 1034:3 1087:4
	implemented 1067:26 1071:22 1105:8 1136:25 1171:12 1198:22 1199:12 1207:12	impossibility 1138:8	incorporated 1031:4	indications 1067:6
	implementing 1097:24	improbable 1113:8	incorporates 1062:21	INDISCERNIB LE 1021:8 1069:17 1085:10 1086:2 1137:20 1142:22 1166:13 1173:22 1196:18, 19 1205:3,4
		improperly 1033:26 1159:2	incorrect 1166:20,24 1196:12	indiscriminately 1214:24
		improved 1148:7	increase 1009:15 1125:24,25 1126:6 1161:20	individual 1034:4 1041:21 1084:13 1089:22 1108:11 1114:20 1130:11 1131:14 1132:5,14,18,21 1133:25 1134:1, 12 1138:5,17 1139:2 1140:8,26 1148:16 1149:14 1157:10 1200:8
		in-class 1198:8	increased 1134:18 1178:3	
		in-depth 1029:15	increases 1147:16 1185:12	
		in-utero 1156:10		

1209:8	1057:5,7	1144:20 1145:9	inherent 1144:14	1172:14
individual's	1063:20,21,25	infectious	1147:7	instructed
1130:16	1074:2 1077:22	1005:25 1006:9	inherently	1138:11
individuals	1095:13,14	1013:5 1041:4,6,	1096:13 1109:17	instructions
1027:21 1030:6	1096:25 1105:22	7,9,23 1047:16	inhibiting	1150:6,9,10
1037:4 1039:22	1111:21 1121:14	1051:8,23,24	1147:21	intact 1116:5
1040:9 1044:6	1129:25 1134:18	1053:2 1069:9,14	inhibitor	integrity 990:7
1066:18 1100:17	1135:13 1190:17	1113:21 1120:5	1140:21	intend 1000:5
1111:5,19 1112:7	1208:26	1135:13 1185:4	initial 994:26	intended 1019:2,
1120:3 1123:15	infecting	1210:8	1002:2 1076:11	12
1125:9 1126:25	1076:22	infectivity	1086:22 1088:18,	intensive
1134:18 1138:5	infection	1056:2 1076:17	19 1103:25	1023:15 1030:24
1143:6 1146:7	1005:18 1033:18,	infector 1049:11	1195:7 1211:18,	intention 986:25
1147:8,22	20,21,23 1034:1,	infests 1047:24,	19 1213:2	intentionally
1148:1,14	10,12 1035:7,20,	25	initially 1026:4	1062:20
1158:26 1162:13	21 1036:3,7,9,24	inflammation	1036:24 1074:2	interact 1133:11
1170:19 1171:2	1037:10,14	1046:12 1157:17,	1126:24 1172:8	1142:15 1155:22
1179:20 1201:13,	1039:4,8,14,16,	21 1159:5	initiate 1103:26	1156:16 1160:6
15	19,25 1040:4,7,	influences	injections	interacted
indoor 1106:13	10,13 1043:12,23	1023:12 1190:12,	1094:23	1148:2
indulge 1201:3	1045:11,12,14	13	innate 1074:11	interacting
ineffective	1046:7 1047:3	influenza 1042:6,	1075:26 1076:24	1059:10 1142:19
1063:8 1072:21	1048:24,25	23 1043:7	1077:11	1189:14
1144:21	1049:3,25 1052:5	1068:16 1079:8	inoculations	interaction
inert 1159:6	1053:9,11	1127:9 1174:22	1100:5	1156:5
inevitably	1054:19 1055:19	inform 1022:5,26	input 1023:24	interactions
1142:14	1056:7,10,23	information	insert 1131:14	1021:23 1160:2
infect 1037:8	1057:26 1074:3,	996:5 1004:13	inserted 1130:14	interactive
1047:21 1050:24	5,12 1077:12,19,	1025:26 1093:11	inside 1026:24	1031:5
1051:8 1077:24	21 1078:18,25	1176:17,18,21	1070:19 1121:20	interacts
1078:7 1096:22	1086:22,24	1209:7 1212:14	1122:13 1130:13,	1187:20
1097:3 1103:25	1087:3,9 1088:14	informative	18 1157:9	interest 1009:4
1116:7,15,16	1089:7 1097:5	1216:11	insight 1093:17	1018:9 1138:10
1117:8,17	1101:7 1104:1	informs 1023:19	instilling	interested
1119:3,6,17,20	1119:16 1120:13	infringements	1100:26	1022:15 1069:12
1122:12 1136:14	1121:8 1129:16	992:6,7	instituted	1147:13
1159:24 1190:18	1156:10 1171:15	inhale 1076:16	1172:14	interesting
infected 1026:8,	1178:3 1179:19	1078:3 1096:2	Institutes 1007:6	1047:13 1067:21
12,16,20 1027:6,	1180:26 1187:22	1107:21 1159:7	institution	1079:7 1085:14
9 1034:1,2,9	1213:1,15	1161:16	1006:24 1011:2	1109:20 1117:25
1035:10 1036:21,	1214:14,23	inhaled 1161:18	1013:25 1014:22	1129:6 1136:10
23 1037:1,9,17	infection-	inhaling	1172:18	1141:15 1147:20
1038:2,10	spreading	1107:16,19	institutions	interestingly
1041:23 1044:8	1072:11	1108:10	1011:4,7,24	1027:5 1132:2
1049:5,8,10	infections			
1053:14 1056:19	1045:16 1064:2			
	1076:8 1127:4			

interface 1155:22 1187:15	invited 1007:14	item 986:13		Kitchen 984:7, 13,17,19,21 985:19 986:10,11 988:23 989:4,7,8 993:24,25 994:1, 4 995:22 998:3,6, 15,23 999:12,17, 23,26 1000:4,17, 19,23,25 1004:12,15,16 1018:21 1019:4, 8,14,15,21 1020:26 1021:19 1022:10,18,20 1024:3,9,14,25 1025:2,7,8 1033:6 1052:1 1053:6 1084:24, 26 1085:2 1086:1,4 1090:14,17 1091:3,12 1092:19,25 1093:3,5,6,10 1095:19 1103:7 1137:8 1150:19 1151:5,17,23 1152:6,20 1153:1,4,16 1163:21 1164:2, 6,16,20,24,26 1165:2,5,7 1173:15 1186:14 1194:24 1196:16, 24 1197:5 1198:4 1203:6,13,14,16, 26 1204:26 1205:1,5,7,11,13, 24 1206:3,6,7 1207:21,22 1208:6,14 1209:16,18,23 1213:19,22,23,26 1214:6 1215:8, 10,14,26 1216:1, 4,9,14,16
interfacing 1167:21	involved 1002:18 1003:7,10 1015:16,18 1016:11 1028:9 1128:26 1189:10, 11	items 999:22	<hr/> K <hr/>	
interfere 1046:12	involvement 1015:14	<hr/> J <hr/>	Karoline 1000:20 1085:19 1205:11 1217:3, 14	
interim 1089:14	involves 1006:24 1030:18 1032:17	J.S.M. 985:19 1092:19	keen 995:8	
interject 1169:9	irrational 1072:21	jabs 1016:9	keeping 1055:9 1071:23 1100:16 1104:6 1204:3 1205:23 1206:10	
Internal 985:9 1092:9	irrelevant 1048:4 1099:4 1100:14 1104:26	jam 1062:14	key 1004:3 1028:25 1039:25 1045:15 1047:6 1077:4,5 1121:16 1133:26 1138:14 1156:3 1195:13 1201:19	
interpret 1165:16,23 1179:26 1209:3	irrespective 1209:11	January 984:5, 15 985:5 1092:5 1103:10 1210:23 1215:2 1216:3,21	kids 1065:19 1066:7 1160:9	
interpretation 1054:10	isolate 1069:20 1099:11	Jarvis 990:14	kill 1050:15,24 1051:6,11 1077:5 1117:9 1214:24	
interpreting 1174:5	isolated 1020:2 1123:25 1159:26 1160:10	jaw 1121:9 1139:3	killed 1117:19	
interrupt 1052:3 1085:22 1137:4	isolating 1093:20 1159:25	job 1006:22 1008:12 1046:26 1048:22 1069:14 1074:26 1104:11 1111:10,16 1203:19	kills 1069:3	
interrupting 1150:20	isolation 1093:13,16 1094:7	journal 1006:18 1008:13,15 1038:13 1110:20 1112:12 1211:4, 12	kind 998:10 1023:7 1026:18 1051:3 1073:20 1079:6 1084:18 1088:16 1094:7 1106:26 1109:16 1110:8 1120:10 1127:13 1130:6 1140:10,18 1156:9 1162:12, 23 1169:25 1173:4,12 1186:18 1188:20 1190:4 1194:16 1198:16 1213:3	
interruption 1012:15	Israel 1097:26	journals 1006:16,21 1008:14 1009:8, 20 1013:19 1188:9	kills 1069:3	
interruptions 1013:3 1014:16	issue 990:5,6,17 1006:18,19 1020:9 1057:16, 20 1090:15 1102:19 1123:21 1127:21 1143:11 1153:2 1168:12 1171:13 1182:15 1186:24	July 994:20,24	kind 998:10 1023:7 1026:18 1051:3 1073:20 1079:6 1084:18 1088:16 1094:7 1106:26 1109:16 1110:8 1120:10 1127:13 1130:6 1140:10,18 1156:9 1162:12, 23 1169:25 1173:4,12 1186:18 1188:20 1190:4 1194:16 1198:16 1213:3	
intervention 1088:17 1102:13, 22 1162:25	issued 1118:7	jump 1025:11 1151:23 1184:14 1185:16,19	kind 1026:21 1028:13 1046:22 1060:11 1150:24 1189:4	
interventions 1066:16	issues 998:12,13, 14 999:2 1020:13	jumping 1184:17 1185:11		
introduce 1102:21	Italian 1192:2,4	jumps 1185:15		
intuitive 1082:26 1160:26 1161:9 1162:23 1168:8 1185:9	Italy 1191:25	June 994:20,24		
intuitively 1070:12 1093:17 1171:4	itchy 1139:15	justice 997:8		
inverse 1053:10		justify 992:6		
investigate 1067:18 1126:19				
invite 1085:2 1154:11 1192:11				

Kitchen's 986:6 996:25	1061:25 1070:2, 21 1072:23	lead 1076:24	1017:21 1092:9, 16,19	1082:6 1096:23
kits 1106:19	1073:5,10,17	leading 1015:19		1097:5 1162:18
knew 1088:24	1076:7 1078:2,5	leads 988:11	legislation	1173:10 1174:1
1111:21 1210:13	1080:14 1082:1	991:12 1041:13	1202:8	1215:3
1213:7,10,14	1094:25 1098:1	lean 1052:25	legitimate	lined 1074:14
1214:4,12,21,25	1103:24 1104:21	leaning 1174:6,7	989:19 1052:26	lines 1020:8
1215:16	1105:19 1106:3, 8,11 1121:5	leans 1103:21	1207:23 1208:7	1022:17 1074:19
knock 1069:23	1123:7,12,16,18	learn 1060:9	legitimately	1117:4
knowing 1038:17	1125:4,5 1126:14	1149:9,10	992:11	linings 1026:24
1049:17 1171:6, 18	1128:10 1130:26	1156:19	length 987:11	link 1068:16
knowledge	1144:8 1146:14	learned 992:19	1098:7 1148:19, 25 1187:25	1191:3 1192:3,5
1018:13 1210:12	1158:8 1170:20	1064:26	lens 1082:13	linked 1014:23
kudos 1015:6	1185:15,16,18	learning 1031:2, 3,5,17,22	letter 1181:2	liquid 1078:21
	1191:24 1194:15	1157:26	letters 1023:24	1082:18 1084:2
	largely 1039:11	learns 1156:16	level 1010:23	list 992:7 1011:6
	1048:4 1059:8	1157:15 1158:25	1029:15,16	1029:17,18,21,23
	1099:4,9 1100:14	leave 998:22	1077:26 1118:3	1154:24,26
	1104:4 1105:9	1056:5 1090:17	1128:3,5,19	listed 1010:9
	1148:8 1158:22	1122:17 1136:6	1129:4,5,9,16	1029:12 1030:3
	1159:10,11	1151:4 1162:19	1133:11,14,24	1152:9,15
	1171:24	1163:20 1164:12	1134:3,4 1154:13	1189:4,21
	larger 1006:26	1209:4 1215:6	1161:7,21	listening 1122:24
	1026:14 1051:9	1216:4	1172:22 1181:8	literally 1029:16
	1133:7 1148:18	leaves 1080:15	levels 1147:20	1061:23 1065:20
	Lastly 1153:21	1122:23 1125:10	1161:2,25	1073:9,11,16
	late 992:14	leaving 1079:20	1162:21	1074:26 1075:5
	1026:1 1214:16	1080:15 1125:14	licensed 1202:17	1078:23 1082:3
	laughable	lecture 1030:25	licensing	1115:3 1131:10
	1129:18	1031:1	1202:19	1160:3 1193:24
	law 1198:26	lectures 1031:21, 23 1032:6,17	lick 1160:4	literature
	Lawrence	Lees 985:8	lie 1189:1	1009:18 1026:13
	1085:21,25	1090:19 1092:8	life 1193:8	1079:9 1112:6
	1086:2,12	left 986:4 1017:3, 10 1068:26	lifestyles 1193:13	1136:8,21
	lawyer 992:18	1078:17 1093:12	lifetimes 1063:22	1165:16 1168:16
	lawyers 1016:10, 24 1017:6	1125:18 1126:2,7	likes 1047:20	1174:12 1175:5, 10,11,12,23,26
	lay 987:25,26	1162:20 1164:1	1048:2	1176:9,10,11
	layer 1077:18	1181:1	limit 1002:23	1178:5 1179:6,9
	1117:23 1196:7	legal 985:9,16,19	limitation	1188:7
	layers 1080:8	989:20,26 991:26	1008:15 1144:11	litmus 1209:5
	layman's 1060:8	997:1 1015:12,22	limitations	live 1051:17
	layperson 1171:6	1016:15,16	1116:1 1142:7	1060:10 1079:8
			limited 1035:26	1147:24
			1058:10 1064:8	lives 1064:14
				1160:22

L

lab 1005:13
1201:25 1207:15

laboratories
1031:14

laboratory
1010:14 1011:17
1031:15,16,22
1117:26 1118:16,
23 1128:2,3
1161:5 1206:9,11
1207:13

lack 986:24
988:25 1043:2
1129:23 1136:1
1187:2 1188:18,
25 1189:6

lacks 1188:19

lactobacillus
1158:21

land 1106:3

language
1188:14

large 991:14,21
1004:19 1008:14
1009:20 1010:8
1031:13 1038:21
1058:26 1059:24

living 1069:9	looked 1073:2 1126:15 1170:12 1173:2 1197:17 1203:20	1077:15 1079:21 1108:26 1111:15 1130:6 1174:9 1175:14 1176:18 1179:8 1188:6	23 1032:10	1132:23 1135:25 1136:1 1137:11 1140:4 1148:22 1153:21 1162:14, 17 1167:15,23 1169:7 1177:11 1186:18 1187:1 1196:10 1208:22, 24
load 1142:1	loose 1139:6	louder 1149:10	machine 1004:9	
loaded 1050:20	lose 1065:13 1076:7 1149:14 1191:14	low 1032:5 1071:7 1108:4 1147:19 1162:21 1181:25 1213:16	Madam 1196:21	
located 1075:17 1118:2	lost 1076:9 1085:20,22 1098:12 1137:2 1149:8 1203:11	low-cost 1130:24	made 988:9 994:7,15 997:1 1023:4 1025:26 1048:26 1088:10 1134:11 1152:3, 25 1165:8 1172:13 1177:20 1179:22 1187:6 1194:11	
location 1081:8, 10	lot 988:19 991:15 992:25 996:26 999:4 1005:15 1009:8,24 1012:11 1023:1,4 1026:22 1027:5 1035:16 1036:18, 20,22 1037:1 1046:13 1047:14 1049:14,23 1054:6 1067:8 1070:20 1071:17 1072:25 1078:12, 14 1079:9 1081:24 1089:11, 19 1096:21 1099:4 1113:9 1119:22 1124:26 1129:26 1130:4 1136:17 1141:24 1148:12,13 1156:7 1157:23 1158:12,19 1160:1,2 1161:5, 21 1168:25 1172:2 1178:11 1179:21 1180:9 1189:11,12 1192:18 1197:25 1202:5 1206:26 1214:19	low-level 1163:19	maintain 1143:9 1144:12	makes 1049:10 1119:13 1161:9 1166:23,24,25 1169:15 1170:25 1180:2 1188:14, 17,20
locations 1099:17 1157:17		low-risk 1214:13	maintained 1101:11	making 987:9 998:11 1073:7 1108:25 1109:13 1123:23
lockdown 1195:2,5,6,12		lower 1045:19,20 1046:3,12,14,17 1047:12,22 1048:1,5 1049:12 1055:24,25 1057:13 1075:5,6 1087:24,25 1088:8 1096:12 1098:20 1159:15 1161:25 1162:8	maintaining 1101:22	males 1193:11
lockdowns 1012:10		lower-risk 1087:23	major 1102:19 1113:10 1155:10 1195:23	manage 1005:12
logical 1109:7 1134:5 1135:25 1169:23 1195:9 1207:17,24 1208:1,16		lunch 996:14 999:10 1090:18 1093:11	majority 1038:18 1050:21 1080:22 1082:4 1087:22 1101:12 1102:18 1105:2 1145:24,25 1156:11,22 1171:9 1175:10, 23 1179:13 1196:6	managed 1196:17 1202:20
logically 1109:7 1122:24		lungs 1046:8,10, 12,18 1047:7 1070:26 1071:2 1076:10 1077:12 1112:20 1159:23, 25 1161:15,18 1171:19	make 986:16,19 987:4 988:24 997:3 998:2 1000:25 1001:3 1007:19 1009:6 1020:15,16,17 1026:6,18 1049:16 1053:8 1056:16 1072:16 1073:17 1077:17 1085:16 1089:10 1117:12 1121:22 1123:6,14 1126:16,24 1128:17 1131:14	management 1010:19
long 992:1,7 1001:6,23 1060:10 1061:7,8 1065:18 1071:12, 19 1079:4 1097:13 1134:24 1135:3 1138:6 1142:12 1148:21 1149:7 1160:14 1162:7,20 1163:15 1164:11, 14 1186:8 1196:23 1208:22 1216:11		lying 1017:20		mandated 1094:24 1095:2, 9,23 1097:10
long-lasting 1097:19 1099:23		lymph 1120:23 1121:3,8,11,18		mandates 1016:6,12 1094:22 1201:2, 12
long-term 1059:4 1097:24 1160:8				mandatory 1103:16 1166:17 1201:7
longer 988:10 1063:24 1075:7 1098:11 1117:22 1121:19 1164:10				manipulation 1130:4
longest 1083:6	lots 1011:23 1021:24 1026:21			Manitoba 1118:3
				manner 1018:14 1024:4
				manuscript 1009:2 1010:10 1211:4,20,21,25 1212:7
		M		
		M.D. 1003:13 1021:4 1027:26 1029:2 1031:19,		

manuscripts 1188:8	1201:2 1204:15 1205:2,13	1073:3,22 1078:26 1079:23 1080:7,12,22 1081:25 1082:4, 24 1100:18 1101:9 1104:10, 14,16 1109:22 1111:13,16 1122:20 1123:23, 26 1124:2,21,26 1125:21,23 1126:3 1130:25 1134:6 1138:2, 11,21 1139:13, 16,18,21 1140:2, 3,17,20 1142:10 1143:21 1144:10, 14 1146:25 1147:2,5 1152:4 1158:7 1159:18, 24 1162:13,14,24 1173:21 1178:14, 15 1192:3 1199:5 1201:9	math 1056:26 1088:23 1090:14	1096:6 1097:5 1106:7 1113:8 1119:5 1156:10 1214:22
March 993:12 1214:1	masked 1083:18 1142:15,22 1143:9 1160:22 1180:18 1204:13	1081:25 1082:4, 24 1100:18 1101:9 1104:10, 14,16 1109:22 1111:13,16 1122:20 1123:23, 26 1124:2,21,26 1125:21,23 1126:3 1130:25 1134:6 1138:2, 11,21 1139:13, 16,18,21 1140:2, 3,17,20 1142:10 1143:21 1144:10, 14 1146:25 1147:2,5 1152:4 1158:7 1159:18, 24 1162:13,14,24 1173:21 1178:14, 15 1192:3 1199:5 1201:9	mathematicians 1056:17	means 1009:16 1045:26 1046:20 1047:20 1049:25 1057:22 1060:7 1063:17 1070:6 1078:11 1079:17 1082:20 1089:14 1095:12,14,25 1096:20 1098:7 1101:3 1116:25 1117:16 1121:12 1156:15 1175:10 1178:6,24 1189:6 1190:11,22
marked 1183:7 1188:4	masking 998:13 1019:1,11,24 1020:14 1044:12 1066:17 1069:12, 13 1071:24 1072:3,13 1079:17 1082:23 1093:13 1101:16 1103:20 1105:3 1108:17 1110:16 1111:4,7,24 1114:5 1125:19 1126:24 1127:12, 22,25 1130:24 1133:2,8 1134:14 1135:5 1136:16 1143:15 1144:19 1145:16 1146:14, 22 1147:16 1151:8 1152:8,16 1153:23,26 1154:19,21 1160:8,18 1165:11 1166:17 1169:11 1170:6, 24,25 1174:14, 16,21 1175:21 1177:21 1178:3 1179:1,9 1180:15 1182:21 1183:13, 20,26 1184:1,11 1185:8,22 1192:4 1194:19,21 1195:13 1198:22, 24 1199:9,11,21, 22 1201:7,22 1203:22 1204:5, 19	1101:9 1104:10, 14,16 1109:22 1111:13,16 1122:20 1123:23, 26 1124:2,21,26 1125:21,23 1126:3 1130:25 1134:6 1138:2, 11,21 1139:13, 16,18,21 1140:2, 3,17,20 1142:10 1143:21 1144:10, 14 1146:25 1147:2,5 1152:4 1158:7 1159:18, 24 1162:13,14,24 1173:21 1178:14, 15 1192:3 1199:5 1201:9	mathematics 1088:21 1167:9	meant 1177:14
market 1186:10	masks 1069:13 1070:1,9,10 1071:26 1072:23	massive 1014:15 1039:3 1055:17 1106:11 1162:6 1190:8	matter 990:6,7 996:11 1063:18, 19 1112:1 1208:12 1212:4	measles 1095:5
marshmallows 1149:1	masking 998:13 1019:1,11,24 1020:14 1044:12 1066:17 1069:12, 13 1071:24 1072:3,13 1079:17 1082:23 1093:13 1101:16 1103:20 1105:3 1108:17 1110:16 1111:4,7,24 1114:5 1125:19 1126:24 1127:12, 22,25 1130:24 1133:2,8 1134:14 1135:5 1136:16 1143:15 1144:19 1145:16 1146:14, 22 1147:16 1151:8 1152:8,16 1153:23,26 1154:19,21 1160:8,18 1165:11 1166:17 1169:11 1170:6, 24,25 1174:14, 16,21 1175:21 1177:21 1178:3 1179:1,9 1180:15 1182:21 1183:13, 20,26 1184:1,11 1185:8,22 1192:4 1194:19,21 1195:13 1198:22, 24 1199:9,11,21, 22 1201:7,22 1203:22 1204:5, 19	Master 1028:16	maturity 1156:21	measure 1114:12
Martens 985:11 1085:25 1086:4, 6,7,13,17,20 1092:11 1137:4	masked 1083:18 1142:15,22 1143:9 1160:22 1180:18 1204:13	Master's 1028:17	matters 986:21, 26 991:10 1023:26	measured 1114:3 1179:23
mask 1069:25 1070:16,19,22 1072:7,19,26 1073:12,17 1080:7,15,16 1081:2,8,9,17,18 1082:2,15,17,19, 23,25 1083:10, 11,14,23 1103:16 1105:1 1108:22, 25 1109:5 1110:11 1114:19 1122:25 1124:4, 5,11,15,17,18,24 1125:4,6,14 1127:25 1129:18, 19 1131:26 1132:1,3,5,7,19, 23,25 1133:3,6, 16 1134:14,21,25 1135:24,25 1138:6,17,19,24 1139:7,8,10,23, 25,26 1140:7,11 1141:10 1142:6, 13 1143:12,17,26 1144:3,5,7,13 1147:8 1149:4,9 1150:1,3,10 1155:12 1161:8, 10,19 1162:19,26 1163:4,6,8,11 1185:24 1198:8	masking 998:13 1019:1,11,24 1020:14 1044:12 1066:17 1069:12, 13 1071:24 1072:3,13 1079:17 1082:23 1093:13 1101:16 1103:20 1105:3 1108:17 1110:16 1111:4,7,24 1114:5 1125:19 1126:24 1127:12, 22,25 1130:24 1133:2,8 1134:14 1135:5 1136:16 1143:15 1144:19 1145:16 1146:14, 22 1147:16 1151:8 1152:8,16 1153:23,26 1154:19,21 1160:8,18 1165:11 1166:17 1169:11 1170:6, 24,25 1174:14, 16,21 1175:21 1177:21 1178:3 1179:1,9 1180:15 1182:21 1183:13, 20,26 1184:1,11 1185:8,22 1192:4 1194:19,21 1195:13 1198:22, 24 1199:9,11,21, 22 1201:7,22 1203:22 1204:5, 19	Masters 1001:14 1029:12,19,23	maximize 1051:1,2,4	measures 1020:10 1023:11 1064:16 1103:19 1173:8 1195:12
marshmallows 1149:1	masking 998:13 1019:1,11,24 1020:14 1044:12 1066:17 1069:12, 13 1071:24 1072:3,13 1079:17 1082:23 1093:13 1101:16 1103:20 1105:3 1108:17 1110:16 1111:4,7,24 1114:5 1125:19 1126:24 1127:12, 22,25 1130:24 1133:2,8 1134:14 1135:5 1136:16 1143:15 1144:19 1145:16 1146:14, 22 1147:16 1151:8 1152:8,16 1153:23,26 1154:19,21 1160:8,18 1165:11 1166:17 1169:11 1170:6, 24,25 1174:14, 16,21 1175:21 1177:21 1178:3 1179:1,9 1180:15 1182:21 1183:13, 20,26 1184:1,11 1185:8,22 1192:4 1194:19,21 1195:13 1198:22, 24 1199:9,11,21, 22 1201:7,22 1203:22 1204:5, 19	Maxston 984:9, 18 985:16 986:14,18 989:6 997:2,17,18 1019:3,4,14 1020:21,23,24 1022:10,12,13 1023:21 1024:1 1092:16 1150:19 1151:4,13,17,24 1153:4,8 1164:2, 6 1196:17,19,21 1197:6,7,8,9 1203:6,16,19 1204:1,23 1205:24 1206:4 1207:20,26 1214:8,10 1215:14	maximizing 989:2	measuring 1101:6 1114:5,11
Martens 985:11 1085:25 1086:4, 6,7,13,17,20 1092:11 1137:4	masked 1083:18 1142:15,22 1143:9 1160:22 1180:18 1204:13	Master 1028:16	maze 1080:11,14, 18	mechanism 1062:18
mask 1069:25 1070:16,19,22 1072:7,19,26 1073:12,17 1080:7,15,16 1081:2,8,9,17,18 1082:2,15,17,19, 23,25 1083:10, 11,14,23 1103:16 1105:1 1108:22, 25 1109:5 1110:11 1114:19 1122:25 1124:4, 5,11,15,17,18,24 1125:4,6,14 1127:25 1129:18, 19 1131:26 1132:1,3,5,7,19, 23,25 1133:3,6, 16 1134:14,21,25 1135:24,25 1138:6,17,19,24 1139:7,8,10,23, 25,26 1140:7,11 1141:10 1142:6, 13 1143:12,17,26 1144:3,5,7,13 1147:8 1149:4,9 1150:1,3,10 1155:12 1161:8, 10,19 1162:19,26 1163:4,6,8,11 1185:24 1198:8	masking 998:13 1019:1,11,24 1020:14 1044:12 1066:17 1069:12, 13 1071:24 1072:3,13 1079:17 1082:23 1093:13 1101:16 1103:20 1105:3 1108:17 1110:16 1111:4,7,24 1114:5 1125:19 1126:24 1127:12, 22,25 1130:24 1133:2,8 1134:14 1135:5 1136:16 1143:15 1144:19 1145:16 1146:14, 22 1147:16 1151:8 1152:8,16 1153:23,26 1154:19,21 1160:8,18 1165:11 1166:17 1169:11 1170:6, 24,25 1174:14, 16,21 1175:21 1177:21 1178:3 1179:1,9 1180:15 1182:21 1183:13, 20,26 1184:1,11 1185:8,22 1192:4 1194:19,21 1195:13 1198:22, 24 1199:9,11,21, 22 1201:7,22 1203:22 1204:5, 19	Masters 1001:14 1029:12,19,23	Mcmaster 1031:25 1032:1,4	mechanisms 1049:11 1077:4 1096:24 1187:26
marshmallows 1149:1	masking 998:13 1019:1,11,24 1020:14 1044:12 1066:17 1069:12, 13 1071:24 1072:3,13 1079:17 1082:23 1093:13 1101:16 1103:20 1105:3 1108:17 1110:16 1111:4,7,24 1114:5 1125:19 1126:24 1127:12, 22,25 1130:24 1133:2,8 1134:14 1135:5 1136:16 1143:15 1144:19 1145:16 1146:14, 22 1147:16 1151:8 1152:8,16 1153:23,26 1154:19,21 1160:8,18 1165:11 1166:17 1169:11 1170:6, 24,25 1174:14, 16,21 1175:21 1177:21 1178:3 1179:1,9 1180:15 1182:21 1183:13, 20,26 1184:1,11 1185:8,22 1192:4 1194:19,21 1195:13 1198:22, 24 1199:9,11,21, 22 1201:7,22 1203:22 1204:5, 19	Master 1028:16	meaning 1036:15 1040:5 1048:2 1054:18 1057:26 1060:21 1093:19	media 1123:9,21, 24 1125:1,3,11, 15 1126:12,21 1127:1,26 1131:19,23 1140:14
Martens 985:11 1085:25 1086:4, 6,7,13,17,20 1092:11 1137:4	masked 1083:18 1142:15,22 1143:9 1160:22 1180:18 1204:13	Master 1028:16	Mcmaster 1031:25 1032:1,4	mediated 1133:13 1142:18, 21 1143:2,3 1144:6
mask 1069:25 1070:16,19,22 1072:7,19,26 1073:12,17 1080:7,15,16 1081:2,8,9,17,18 1082:2,15,17,19, 23,25 1083:10, 11,14,23 1103:16 1105:1 1108:22, 25 1109:5 1110:11 1114:19 1122:25 1124:4, 5,11,15,17,18,24 1125:4,6,14 1127:25 1129:18, 19 1131:26 1132:1,3,5,7,19, 23,25 1133:3,6, 16 1134:14,21,25 1135:24,25 1138:6,17,19,24 1139:7,8,10,23, 25,26 1140:7,11 1141:10 1142:6, 13 1143:12,17,26 1144:3,5,7,13 1147:8 1149:4,9 1150:1,3,10 1155:12 1161:8, 10,19 1162:19,26 1163:4,6,8,11 1185:24 1198:8	masking 998:13 1019:1,11,24 1020:14 1044:12 1066:17 1069:12, 13 1071:24 1072:3,13 1079:17 1082:23 1093:13 1101:16 1103:20 1105:3 1108:17 1110:16 1111:4,7,24 1114:5 1125:19 1126:24 1127:12, 22,25 1130:24 1133:2,8 1134:14 1135:5 1136:16 1143:15 1144:19 1145:16 1146:14, 22 1147:16 1151:8 1152:8,16 1153:23,26 1154:19,21 1160:8,18 1165:11 1166:17 1169:11 1170:6, 24,25 1174:14, 16,21 1175:21 1177:21 1178:3 1179:1,9 1180:15 1182:21 1183:13, 20,26 1184:1,11 1185:8,22 1192:4 1194:19,21 1195:13 1198:22, 24 1199:9,11,21, 22 1201:7,22 1203:22 1204:5, 19	Master 1028:16	medical 1007:5	

1021:2,5,6 1022:16 1023:22, 23 1027:22 1028:7 1029:4,5, 13 1030:4,10,20 1032:19,26 1102:13,22 1145:1 1146:2 1167:25 1175:15 1177:6,15 1189:14 1199:6 1201:6,9 1203:22 1204:20	mention 1004:11 1007:22 1030:13 1155:1,7 1160:24 mentioned 990:2 1012:17 1018:17 1048:26 1050:19 1054:8 1080:3 1120:11 1123:11 1133:4 1138:14 1143:12 1147:21 1167:1,6 1199:3 1210:9 1212:26 mentioning 1036:19 mentions 1176:25,26 mentored 1028:7 message 1145:5, 6,7 messaging 1043:17,20 1044:7 1048:13 1142:9 1144:26 1145:21 1176:16, 19 messed 1177:15 meta-analyses 1183:16 method 1033:25 methods 1137:12 metre 1105:11, 12,20,26 1106:4, 5 metres 1107:15 1108:7 1110:5,22 mic 1165:3 mice 1192:21,22 micro 1117:26 microbe 1058:18 microbes 1157:2, 7,8 microbial 1155:22 1156:6, 13,20,26	1159:13,26 microbiological 1143:23 Microbiology 1011:16 1117:26 1118:23 microbiome 1026:22 1027:2 1156:1 1158:16 microbiomes 1160:6 microbiota 1058:18 microorganism 1050:15 microorganisms 1026:21 microphones 1150:14 microscope 1117:12,18 middle 1081:18 1212:24 migrate 1047:22, 26 1075:4 migrated 1139:11 mild 1042:2,20 1059:11 1064:2 1128:11 1145:26 1146:7 1161:22 million 1112:13, 15 mind 1055:9 1066:21 1142:12 1152:10 1153:12 1168:24 1204:3 mindful 1093:7 1124:9 1143:22 1144:7 1164:3 mindset 1066:12 mine 992:24 1011:3 1016:23 1138:10	minimal 1141:21 minimize 1051:5 1105:21 1131:19 minimum 1105:21 1184:26 1211:11 minute 1024:17 1086:3 minutes 991:24 992:14 995:26 999:9 1015:20 1081:13 1085:3 1090:19 1131:5,6 1164:9,18 1196:20 1209:19 miraculously 1138:6 misconception 1176:4 misinformation 1176:18 mislabelled 1170:18 misnomer 1170:16 missed 1086:13 1165:3 missing 1062:13, 14 misstated 1196:12 mistake 1131:14 mistakes 1062:21 misunderstandi ng 1170:14 1171:25 mode 1126:26 modelling 1023:2 1213:4 models 1023:3,8, 19 1028:2 moderate 1042:2,20 1064:2	modern 1062:1 1106:14,15 modes 1137:23 moisture 1070:25 1071:1, 12,13,18 1074:15 1081:11 moment 997:4 1039:26 1043:20 1123:4 1150:8 1152:14,26 monitor 1161:7 month 995:18,21 1054:22,26 1211:18 1215:12 months 1012:15 1015:19 1052:9 1098:11,14 1121:22,26 1125:22 1155:18 1160:12 1212:1, 17 1214:17,22,26 morning 984:5 985:5 986:2,14 987:9 992:14 1020:24 1065:17 1071:9,15 1072:6 1216:9,14,18 mother 1156:11 mounds 1169:13 1170:7 1173:20 1174:1 mount 1077:1 mounted 1049:6 1076:6 1120:6 1135:1 mounting 1121:12 mounts 1132:13 mouth 1047:25 1108:2 1109:15 1148:18,24 1149:1 1161:8,16 mouths 1109:19
---	---	--	--	---

move 996:1 1074:26	mute 986:13 1024:16 1165:2	1136:14 1182:8	nonetheless 991:5 1152:5 1197:14	1038:21 1039:26 1044:25 1051:2 1052:8,11,24 1053:18 1055:1, 23 1057:2 1060:16 1067:22 1069:10 1071:22 1094:2,12 1096:23 1105:13 1114:26 1116:19 1117:21 1118:15 1119:15,19 1126:14 1130:23 1145:10 1146:18 1160:19 1174:2 1191:24 1192:6 1212:23 1215:3
movement 1139:6	muted 1024:14 1052:1,2 1091:3 1152:8 1202:14 1203:24	negative 1141:8 1180:19	nonscientific 1126:7	numbers 1037:19 1051:10 1055:7 1076:14 1088:26 1119:2 1121:5
moves 1108:3		Nelson 985:13 994:8 996:21 997:22 999:12,16 1000:19 1092:13 1137:3,7 1164:26 1165:4	nonsmoker 1107:11	numerous 1021:22 1153:23 1154:20,21,26 1165:17 1177:21
moving 1069:8 1072:16 1107:18 1108:1 1139:3 1172:26	N	Nelson's 987:6	nonuniform 1182:24	Nurse 1149:25
mucosal 1026:25 1045:12 1075:19	N95s 1201:9	nervous 1156:3	North 1030:19,21	O
mucous 1074:14, 17,20,21 1075:1, 2,3,8,12,20 1076:3 1077:15, 18 1078:10,12,20	naive 1156:9,12	net 1140:20,24 1141:8 1143:8,15 1161:24	Norwalk 1042:4 1171:20	oath 1093:1 1164:22
muffle 1152:4	names 1010:8,11, 13,15	network 1028:12	nose 1016:5 1075:11,13 1078:23 1081:20, 23 1082:5 1084:7 1124:19 1133:5 1139:11	obese 1213:12
muffled 1150:16	narrative 1180:6,22	neutral 1018:14	note 997:17 1000:17 1028:15 1034:26 1040:19 1074:4 1129:11 1132:7	Obesity 1039:26
muffles 1149:2,4	narrow 1213:8	neutralization 1096:21	noted 1195:22	object 1020:12 1024:7 1203:8,9 1205:25 1207:20 1209:12 1214:10
muffling 1147:21 1149:18	nasal 1047:24 1078:13	neutralize 1096:5	notes 1217:6	objecting 987:13
multi-faceted 1093:24	National 1011:16 1021:23 1117:26 1118:23	neutralizing 1098:23	notice 999:1 1071:4,9 1106:14 1113:24 1123:10 1130:11,15 1131:25 1132:4 1138:26 1139:1	objection 1024:25 1151:20 1214:9
multiple 1007:2, 8 1040:2 1138:17,20 1143:21 1145:2 1149:26 1185:14 1202:2 1213:13	natural 1045:12 1048:23 1049:9, 14,16,18 1050:26 1051:15 1076:14 1138:21 1165:26	newer 1210:26	noticed 1080:2 1135:8	objections 999:5
multiples 1044:22	naturally 1023:9 1048:22 1049:5 1051:7 1063:20 1185:14	news 1100:22	notwithstanding 993:15 1184:22	objective 1009:6 1018:13 1050:12
mumps 1095:5	nature 1044:14 1097:20 1141:13 1164:10 1169:6	nice 1081:7	November 986:5 1195:3	
muscle 1045:9	navigate 1080:10,13,18	Nick 1149:25	number 987:23 988:6 1004:14,19 1008:14 1009:20 1010:8 1013:11 1037:15,16	
mutagens 1191:7	near-sterilizing 1095:24 1096:20 1097:4 1099:24 1100:7 1102:5	night 1071:12		
mutate 1061:19 1063:24	necessarily 1026:12 1057:18 1074:3 1147:6 1191:20	node 1120:23 1121:3,11,18		
mutates 1063:6	needed 1102:25 1103:25 1112:22	nodes 1121:9		
mutating 1063:2, 6		noise 1052:3		
mutation 1061:18		non-dangerous 1157:2 1158:2 1159:4		
mutations 1047:14 1099:1		non-harmful 1157:7,8 1158:22		
		non-health 1169:14 1170:2		
		non-sterilizing 1095:15		
		nonessential 1012:13,16		

1207:2	offices 1205:23	Ontario's	organization	overgeneralizati
objectively	official 985:21	1023:23	1007:5 1113:11	on 1166:4,5,19,24
1004:4 1117:24	1011:9 1016:10	open 994:18,19,	1202:10	overlap 1006:3
1206:21	1092:21 1217:15	20 1073:6	organizations	overriding
observe 1138:16	officially	1080:19 1168:2	1113:12	1089:17,21
1148:12 1207:3	1015:23 1017:25	open-ended	original 1025:21	1090:2
observed 1199:9	officials 1176:22	1019:19	1040:20 1041:5,6	oversee 1010:19
observing 1107:6	1178:11 1213:5	opened 1130:13	1047:21 1058:6	overseeing
1152:1 1165:23	offset 1080:9,14	opening 1000:11	1155:17	1004:17
obtained	older 1052:19	openly 1031:10	originally	overstated
1001:13	1053:16 1191:4,	operate 1089:25	1012:14 1043:22	1175:7
obvious 1190:6	12,17,18,21	operating 1134:9	1100:8 1140:3	overstatements
1212:25	oldest 1174:16,	opinion 1061:4	Ottawa 1016:4,7	1196:11
occur 987:21	20,21 1175:2	1064:12 1072:7	1027:25	overtaken
988:19,22 1014:6	Omicron 1035:1	1089:4 1140:19	outbreak	1090:4
1046:16 1112:9	1040:24 1041:4,	1144:18 1147:1	1025:20 1059:20	overview
1123:12 1141:11	11 1043:11	1182:23 1190:3	1146:3	1189:20
occurred	1044:14,16,23	1192:3 1195:8	outbreaks	overwhelming
1033:23 1062:15	1045:3,5 1047:4,	opinions 1018:13	1145:19,21,22	1169:12 1170:7,
occurrence	5,13,24 1048:4	opportunity	outbred 1193:10	11 1183:24
1207:16	1049:8,19 1050:6	992:24,26	outcome 1018:9	oxygen 1045:25
occurring	1051:26 1052:14,	1152:22 1156:18	1035:20 1037:21,	1147:19 1161:12,
1044:3,25	21 1053:24	1189:17 1204:14	23 1046:24	25,26 1162:6,8,
1054:22 1055:2	1054:17 1055:1	opposite	1055:22 1057:4	10
1058:1 1094:8	1059:6 1060:15	1165:17,19	1058:16 1060:19,	
1111:24 1198:5	1088:8 1093:18,	option 993:14,23	22 1166:22	P
occurs 1046:24	23 1097:26	996:20 997:5	1179:22 1187:21	
1156:23	1098:20 1099:2,	1000:11,12,14	1190:12,14	package 1004:13
offence 1028:26	20 1103:4	options 1000:15	outcomes	pads 1141:24,25
offensive	1146:5,17	order 1030:2	1023:14 1039:25	pages 1033:12
1188:13,14	1171:7,8 1196:2,	1037:14 1061:21	1040:1 1043:7	1061:26 1062:5
offer 988:1	8	1065:8 1074:1	1044:17,20	1154:26 1175:8
offered 1027:24	omnibus 1202:7	1109:21,22	1046:6 1055:11,	1217:4
offering 1001:2	one-hour	1116:11,12	16,26 1056:2	pain 1067:10,11,
office 1062:12	1138:20	1120:17 1128:15	1159:20	14
1069:21,22,23	ongoing 987:10	1136:15 1160:6	outdated 1174:6,	palpate 1121:8
1200:25 1205:20,	1136:26	1199:6	7,12	pandemic 1014:6
21 1208:2,17	onset 1104:3	orders 1204:7,20	output 1023:13	1033:14 1035:12
1209:9	Ontario 1006:10	organism	outstanding	1036:8 1037:17
Officer 1022:16	1021:10 1022:16	1050:13,14	1004:1	1038:21 1044:22
1023:23 1145:1	1054:3,13,24	1051:3	overestimations	1057:23,25
1146:2 1177:6,15	1055:8,12 1071:4	organisms	1039:3	1058:2,12,15,22,
1199:6 1201:6	1115:20 1197:20	1050:11	overflowing	24 1059:16,21,25
1203:22 1204:20	1202:6,17,19		1170:20	1060:4,21 1065:1

1083:3 1085:9, 11,12,13,18 1086:21 1087:1, 16,17 1088:3,13, 23,26 1089:2,6 1090:15,16 1094:18 1101:15 1113:13,23 1118:4,7 1125:22 1138:9 1148:11 1149:26 1155:15 1172:5,7,12,15, 16,19 1173:1 1178:8,15,16 1184:25 1185:4 1195:24 1198:6 1201:20 1210:24 1214:2	paragraph 1153:19 1174:23 parallel 1119:25 parcel 997:9 parent 1148:2 parenteral 1045:9 parenterally 1049:1 parents 1065:16, 19 1148:11 part 991:15 997:9 1000:1 1006:21 1007:1 1008:12 1011:5,17,18 1019:5 1026:3,11 1027:2 1058:18 1094:25 1098:14 1118:1 1124:7 1144:18 1192:1 1195:10 1197:23 1206:4 partial 1122:10 participate 1009:19 particle 1077:24 particles 1072:11 1078:16,22,24 1079:24 1116:6, 15 1119:6 1122:9,10 1145:11 1157:13 1158:8,9 1179:17 parties' 988:14 parts 1075:25 party 997:11 1207:2 pass 1072:5 passages 1047:25 1078:13 passed 1022:3 1110:6 passing 1132:18	past 1054:22 1076:11,22 1080:6 1082:5 1084:7,8 1108:26 1110:8 1133:4 1168:26 patently 992:15 1195:16 1196:14 path 1080:20 1186:9 pathobiology 1197:20 pathogen 1034:10 1037:2 1050:10 1060:23 1061:5 1064:21 1068:6 1074:6, 10,18 1075:14, 21,23 1076:11 1077:1 1087:1 1095:14,26 1096:1 1102:20 1120:24 1121:6, 13 1129:5,9,16 1130:8,11 1133:14,24 1173:9 1193:16, 17 pathogenesis 1007:13,25 pathogenic 1170:21 pathogens 1042:1 1064:1,4, 6,23 1066:2,9,10 1075:18 1103:22 1127:13 1128:9 1131:2 1133:12 1134:4 1137:18 1157:4 1193:14 patience 1209:26 patient 1135:19, 23 1199:25,26 1209:8 patients 990:21 1207:18	pause 1137:5 Pavlic 985:9 1024:13,15,19,21 1091:2,4,7,10,12 1092:9 pay 1014:23,25 1065:8 1163:7 PCR 1036:14,15 1041:22 1114:7, 13 1115:11,25 1116:18 1117:24 1118:9,24 1119:1,9 1122:8 1179:14 peak 1077:10 1099:19 peaks 1101:25 peer 1009:3 peer-review 1018:17 peer-reviewed 1008:25 1009:18 1012:4 1013:18 1015:10 1035:5 1052:13,26 1110:20 1112:11 1113:25 1118:6 1155:5 1175:16 1178:5 1179:5 1188:9 1189:26 1195:20 penetrates 1120:11 penetrating 1076:21 people 987:19 996:13,22 1000:10 1002:2 1010:9 1011:6 1016:17 1019:26 1026:6 1027:11 1028:25 1029:7, 23 1030:10 1032:3,19 1034:8,9,11 1035:9 1036:23, 25 1037:1,16 1038:1,9,16,19, 22 1039:10,11 1041:21 1042:20 1043:6,11,23 1044:11 1051:18, 25 1055:14,23 1056:18 1057:1, 5,7 1060:13 1066:10,13,23 1067:19,24 1068:10,24 1069:1,3,5,7,15, 21,22,25 1070:16 1071:23,25 1072:2,3,25 1073:2,26 1074:7 1077:25 1078:25 1079:3 1081:24 1084:9 1087:5,23 1089:11,19 1093:21 1098:11, 12,15 1099:17 1100:25,26 1101:12 1102:3, 18,19 1104:6,8 1105:15,17 1106:2,6,26 1107:6 1108:19, 25 1109:2,14,20 1111:6,17,20 1112:4,5,14,15 1113:15,17,20 1119:20 1120:5,6 1122:25 1123:17, 23 1124:1,20,23, 26 1125:8,18,26 1126:3,4,6,7 1127:16,17,18 1128:17 1129:10 1132:22 1134:1,7 1135:12 1138:9 1139:15,24 1141:10,20,24 1142:5,6,10,15, 16 1143:14 1144:9 1145:8,22 1146:13,18
--	---	---	--

1147:5 1148:12, 15 1150:2 1154:25 1155:13, 24 1156:7,25 1157:23 1160:5 1162:20 1167:20, 21 1169:21 1171:9 1172:2,8 1173:5 1174:4,8 1176:5 1180:10 1184:5,14,17 1185:14,18 1186:1,4,21 1187:7,23 1188:3,8 1191:4, 14 1193:25 1194:2 1196:6 1198:12,13 1200:6,22 1205:23 1206:11 1213:14 1214:24 1215:22 people's 996:23 perceived 1180:5 percent 1005:2,3, 8 1008:6,8 1035:8,11,22 1036:4,5,6,7,9 1039:9,15,16 1040:11,14 1052:23 1053:5, 12,13 1056:9,14, 22 1062:3 1072:14,20 1086:23,25 1087:13,17 1088:1,11,15 1090:5,8 1111:4 1144:25 1145:13 1146:12 1175:22 1176:1 1199:20 1205:18 1210:7, 10 1212:23 1213:1 1214:5,14 1215:13 percentage 1210:13	percentages 1034:6 perception 1089:23 perfectly 994:16 1207:23 1208:7 perform 1094:23 1162:10 1181:15 performance 1002:10 1014:3, 5,15 performed 1014:22 1036:13 performing 1004:17 1023:12 period 1014:24 1124:16 1143:14 1149:5,7 1162:7 1163:15 periods 995:19 1012:12 1097:14 1135:3 1138:7 1162:20 permission 1213:20 1215:9 permissive 1117:4 permit 1128:15 1129:22 1133:20 permitted 1022:22 person 1032:25 1040:2 1077:26 1078:2 1104:23 1108:7 1109:16 1110:12 1118:11 1124:16 1125:13 1140:14 1143:9 1149:14 1160:16 1199:25 1200:10 personal 1105:26 1128:22 1129:14, 23 1131:17,20 personally 1018:5 1043:18	1149:21 persons 1199:21 perspective 1005:5 1031:18 1034:20 1035:9 1039:10 1050:9, 13 1087:14,26 1090:12 1143:24 1171:5,21 1189:24 Ph.d. 1001:8,10, 15,20 1021:1 1028:17,18 1029:20,21 1030:1 phagocytic 1121:20 phagocytosis 1120:19 phase 987:5 phases 1009:7 phenomena 1071:5 phenomenon 1044:2 1045:5 1054:15 1080:26 phone 1004:8 phones 986:14 photocopier 1062:1 photocopy 1061:24 phrase 986:25 988:26 phrased 1024:6 physical 1019:1, 11,24 1020:14 1043:2 1046:2,14 1065:21 1074:11 1076:2,9,11,19, 22 1100:18 1101:10,16 1103:20,26 1104:23 1105:4, 5,7,16 1120:11	1134:10,14 1145:16 1146:22 1148:17 1151:8 1159:21 physically 1037:7 1045:21 1099:5 1134:9 1148:23 physician 1016:4 1066:26 1067:8, 10,17 1121:9 1171:26 1202:18, 26 1203:1 1206:16 1207:4 1208:24 physicians 1189:24 1201:25 1202:9,11,13 1207:8 1209:5 physics 1167:10 physiological 1155:23 1162:1 pick 986:7 1105:13 1154:23 picked 1115:12 1118:19 picture 1083:24 1129:14 1130:10, 15 1132:4 pictures 1079:22 piece 1081:17,19 pieces 1114:16 1120:21,22 1121:18 1122:10 pinch 1081:17,19 pipetting 1130:1 pivoted 1012:22 place 1045:18 1068:10 1081:24 1103:16 1125:19, 20 1128:17 1134:7 1138:22, 24 1196:5 placebo 1180:14	places 1046:22, 23 1106:13 1199:12 plan 999:24 1172:5,15,16,21 plane 1184:15,18 1185:11 planes 1185:19 plans 1173:2,12 plastic 1139:5 plate 1116:25,26 1117:1,13,21 plates 1116:24 play 1141:15 1184:8 1185:7 players 1150:6,9, 11 plenty 1176:6 plow 999:10 plugged 1023:4,8 plunges 1185:17 PM 1091:17 1092:23 pneumonia 1046:11 1047:9, 10,12 pockets 1140:1 point 986:6 988:11 1007:20 1014:2,12 1019:16 1032:15, 26 1033:24 1034:17,19 1039:6,18 1041:15,25 1048:19 1049:13 1057:1 1061:9 1072:9 1082:26 1083:12 1084:11 1088:8 1089:10 1098:12 1100:3 1108:15,18 1111:12 1113:24 1118:22 1120:1
---	---	--	--	--

1126:9 1133:9 1135:7 1146:9 1152:5 1156:14 1163:23 1165:13 1168:13,14,21 1173:11,14,24 1174:20 1176:12 1177:7 1178:21 1180:7 1182:7 1193:6 1199:14 1206:6 1211:17 1212:8 pointed 1074:2 1080:4 1089:2 1106:25 1109:24 points 1045:15 1052:10 1075:17 1152:10 policed 1128:14 policies 1022:8 1041:1 1089:5 1172:1 1198:22, 24 1204:21 1214:12 policy 1012:11 1022:6 1023:1 1041:2 1083:17 1089:4,22 poll 987:7 997:23 998:1 polymerase 1036:16 1114:14 populates 1158:13 population 1026:16 1033:22 1034:7 1039:20 1040:11 1042:17 1064:26 1087:21 1098:1,14 1101:12 1112:13 1180:18 1191:19, 21 1193:10,18 1198:20 1212:22 populations 1066:4 1173:6	1198:21 pore 1073:22 1079:22 1080:6 1104:13,25,26 1130:26 1131:1 1133:8 pores 1079:26 1080:9,10,14 portion 1116:3 portions 1038:5 1041:20 posed 1194:20 position 987:26 994:7,11 996:22 997:11 1001:18 1002:14 1027:24 1169:9 1172:1 1197:19 positions 988:15 positive 1041:19, 21 1101:7 1115:22 1116:19 1119:2,10,15,26 1120:2 1122:8 1145:23 1146:18 1162:2 1195:24 positives 1036:18 1119:26 positivity 1179:14 possesses 1008:17 possibly 994:19 1064:14 post-doctoral 1001:16 1032:2 post-immune 1005:16 potential 1007:19 1054:19 1089:21 1100:25 1101:7 1102:21 1116:7,15 1117:16 1119:6, 17 1124:1 1130:7	1131:19 1134:16 1137:12,23 1138:15 1142:20 1143:7 1152:16 1154:21 1155:1 1160:17 1178:2 1180:17,26 1184:3 1187:22 1191:6 1193:17 1194:18 1213:6 potentially 997:9 1006:2 1041:23 1043:7 1058:19 1064:9 1078:4 1079:19,25 1102:6 1111:14 1125:1 1131:16 1134:3,12,19 1135:1,13 1138:3 1140:12,25 1142:3 1143:10 1147:16 1160:18 1179:22 1184:4 1193:4 1213:3 1214:22 pox 1095:7 practice 1018:16 1203:1 practicing 1135:16 praise 1029:25 pray 1069:4 pre-clinical 1006:11 1022:1 precede 1206:25 precise 1130:2 1186:2 1187:26 precisely 1187:16 preclinical 1192:19 predict 1023:13 prediction 1210:6 1212:26	predictors 1039:25 predilection 1173:9 predominant 1080:17 predominantly 1044:4 preferentially 1098:21 preliminary 986:22 prepare 988:18 prepared 988:21 998:6,9,21 1172:11 preparedness 1172:4,15,16 1173:2 prerequisites 1032:20 prescreening 1200:20 1205:19 1206:8,10 presence 1041:20 present 997:12 1038:4 1076:5 1114:18,23 1115:1,7 1116:4 1122:9,11 presented 993:23 994:6,9,10 996:6 1145:2 presents 1141:23 president 1003:25 1144:26 press 1212:9 prestigious 1003:5 pretty 1063:19, 21 1108:4 1127:2 1163:25 1205:19, 22	prevaccine 1103:8,18 prevent 1019:2, 12 1045:21 1046:2 1064:17 1067:23 1072:1 1100:9,10 1101:6 1102:6 1111:8 1125:15 1135:26 1145:12 preventing 1043:24 1047:2,3 1069:14 1104:11 1125:17 1134:6 1142:11 prevention 1005:25 prevents 1145:9 previous 1043:14 1044:24 1045:6 1055:25 1063:10 1126:22 1127:3 1146:20,21 previously 984:12,16 987:12 1025:6 1026:14 1052:23 1070:1 1093:4 1095:9,23 1097:2 pride 1030:15 prided 1144:24 primarily 1105:8 primary 988:11 1007:4 1100:11 1102:16 1126:26 1127:7 1137:23 principles 1006:3 1134:10 prior 1066:21 1093:11 1125:16 1207:16 1214:11, 15 privileged 1016:7
--	---	--	---	--

probe 1062:23	produced 1038:26 1179:5	prognosis 1047:11	proof 1179:15 1190:9	1145:8 1183:4
probiotic 1158:20	produces 1046:3	program 1003:13,14,17,18 1005:11,24 1006:9 1027:26 1028:4 1030:16, 17 1031:19,20,24 1032:7,15 1124:7 1128:13 1142:12 1197:24 1198:1	propagate 1051:4,9 1061:21	protection 1045:18 1048:5 1049:3 1098:7, 13,25 1128:6 1129:8 1134:14 1142:23 1196:7
problem 994:13 1012:18 1019:8 1033:14 1037:26 1058:3,26 1063:12 1066:16 1087:17 1089:2 1098:18 1102:2 1109:4 1110:15 1115:8 1119:22 1127:18 1142:6 1160:11 1168:22 1173:4 1213:18	producing 1075:2 1077:15 1078:13	programming 1193:15	propensity 1157:25	protections 1128:17
problems 1040:6 1046:18 1098:17 1151:11 1157:16	production 1130:7	programs 1012:11 1014:16 1028:14 1029:5, 6,7 1030:8,21 1032:14	proper 1049:3 1105:1 1118:23 1132:23 1134:20 1139:17,22 1155:23 1156:5	protective 1043:23 1127:24, 25 1128:22 1129:14,23 1131:18 1134:21 1173:7 1179:1
procedure 1162:18	productive 1013:9,24 1014:17 1015:5 1037:10 1104:1	progress 1002:12 1014:19 1051:7, 19 1081:21	properties 1117:6	protects 1045:15 1098:19
procedures 1129:26 1139:18 1162:18	profession 1021:9 1146:14	progressed 1002:4 1035:25 1149:6	properly 1026:19 1081:19, 26 1109:5 1143:2 1150:4 1156:4 1157:1,22 1158:26 1160:7 1169:8	protein 1096:8, 15 1099:2,5
proceed 988:21 989:1,2 1182:18 1203:17	professional 990:6,7 1003:21 1021:5,6 1029:3, 7 1061:4 1064:12 1072:7 1147:1 1149:22	progression 1050:26 1051:15	proportion 1026:15 1034:11 1055:14,20	protocol 1118:13
procedure 1162:18	professionalism 1190:4	progressively 1044:26 1100:21, 22	proportions 1033:15 1087:18 1089:2 1090:15, 16	proud 1012:8 1015:4
procedures 1129:26 1139:18 1162:18	professionally 991:17	project 1010:18 1150:15	propose 1025:3 1186:2	prove 1117:23 1179:23 1182:9 1189:20
proceed 988:21 989:1,2 1182:18 1203:17	professionals 1027:22 1029:8 1035:23 1189:15 1202:1	projecting 1106:8 1108:23	proposed 998:26	proven 1089:9 1180:7
proceeding 987:15 1016:10	professions 1021:11 1201:24 1202:7	projects 1004:18	prosecute 989:18	proves 1187:2 1189:5,6
proceedings 985:1 986:1 1015:12 1091:17 1092:1,23 1189:11,12 1216:21 1217:5	professor 1001:18,25,26 1002:4,8,15,19 1003:18,22	proliferating 1121:5	protect 1005:17 1043:23 1045:16 1049:11 1072:8 1074:12 1108:21 1117:6 1121:24 1128:7 1129:15 1130:8 1131:23 1133:13,23 1186:1	provide 1008:11, 13 1010:20 1016:17 1018:12 1027:20 1031:7 1067:5 1098:6 1102:6 1118:18 1163:22 1188:26
process 986:21 998:5,17 1002:9, 18 1009:18 1018:17 1062:19, 20 1078:10 1101:22 1105:5 1121:2,16 1202:19 1211:2, 8,9,10,11	professors 1198:14	prolonged 1163:18	protected 1043:1 1049:19 1096:13 1111:17 1141:12	provided 1023:24 1087:1 1154:5 1170:14 1189:1
produce 1077:15 1121:1	professorship 1002:17	promoted 1002:14	protecting 1134:1 1143:2	providing 1100:5
	profile 1213:4	promoting 1125:6 1146:10 1147:6 1183:3		province 1172:17 1217:8
	profound 1161:26	prone 1076:8		provinces 1054:5
	profoundly 1048:20			

proving 1116:13
public 985:12
 1006:25 1011:17
 1019:26 1021:20
 1022:6,8,24,26
 1025:26 1027:17
 1040:15 1041:16
 1043:17,19
 1048:13 1053:26
 1054:2,8,11,13,
 21 1055:4,5,9
 1056:6,9,11
 1066:1 1068:13
 1069:8 1092:12
 1113:10 1118:1,
 26 1129:7 1134:4
 1140:9 1145:20
 1150:3 1154:12
 1176:16,22
 1177:26 1178:11
 1180:22 1187:17,
 18 1199:13
 1213:4
publication
 1011:14 1014:1
 1015:3 1039:1,6,
 19 1052:13
 1053:19 1094:16
 1128:25 1168:20
 1211:1
publications
 1008:26 1012:1,5
 1013:10,20
 1015:8,11
 1090:13 1119:23
 1136:17 1155:6
 1188:8 1189:26
 1190:2 1211:1
publicly 1039:12
 1068:20 1145:5
 1172:13
publish 1022:26
 1188:8
published 1012:4
 1013:18,21
 1035:5 1038:12,

13 1088:22
 1110:19 1111:19
 1112:12 1118:6
 1119:1 1128:25
 1168:11 1175:12,
 26 1212:10
publishing
 1010:26 1094:17
pull 1062:4
 1177:9
pulls 1124:18,19
 1150:10
purported
 1043:22 1094:1
purpose 1048:23
purposes
 1005:23
pursue 1012:24
push 1065:7
 1075:8
put 989:19
 1025:4 1031:6,18
 1034:7,20 1035:9
 1039:10 1053:13
 1061:2,26 1062:7
 1072:19 1081:2,
 8,9 1083:23,24
 1087:14,26
 1090:11 1106:20
 1114:19 1124:25
 1128:18 1129:18
 1131:8 1134:12
 1139:8,21
 1141:10,20,21
 1150:11 1159:24
 1163:4 1168:10
 1171:5 1208:6,22
 1209:22
putting 1020:18
 1043:19 1108:25
 1129:24 1139:18
 1159:18 1161:10,
 19 1162:13

Q

QC 985:16
 1092:16
qualification
 984:8,10,11
 998:5,17,26
 999:3 1000:24
 1001:1,3 1018:22
 1020:23 1024:11,
 23 1025:13
qualifications
 998:11 1150:21
qualified
 1015:23,26
 1017:11,19,25
 1018:23,24
 1019:9 1089:6
 1151:7 1165:15
qualify 1001:3
 1016:18
qualifying
 1024:26
quality 1008:11
 1009:13,15
 1095:10
quantities
 1103:24 1104:21
 1130:3 1170:20
quantity 1048:17
 1078:2 1096:4
 1097:1 1112:21
question 1019:16
 1020:22 1021:25
 1022:21 1023:21
 1025:16 1030:15
 1033:6 1061:3
 1066:20 1085:1,
 5,8,14 1086:18
 1093:12 1094:25
 1122:23 1125:18
 1126:2 1151:5
 1153:5,6,11
 1160:19 1169:18
 1173:16 1181:13

1188:4 1189:19
 1192:13 1194:9,
 25 1204:8
 1205:6,9 1206:1,
 5 1207:25
 1208:7,13 1210:1
 1212:11 1213:20,
 24 1214:11
 1215:9,11,16
questioned
 1136:19
questioning
 1001:5 1025:3
 1165:9 1166:9
 1195:1 1203:18
questionnaire
 1209:1,6,10
questions 984:20
 992:13 993:1
 998:5 1001:1
 1006:13 1018:22
 1020:4 1022:23
 1024:2 1025:12
 1031:7,10 1033:1
 1052:6 1102:9
 1111:25 1136:2,4
 1164:15 1165:8
 1186:15 1187:4
 1196:16 1197:16
 1200:21 1203:9
 1204:19,23
 1205:2,19,22
 1206:9,10,15
 1207:5,9,12,18
 1208:18,23
 1209:16,20
 1210:3 1216:6
quick 986:12
 999:9,22
 1020:22,25
 1192:7
quickly 998:1
 1070:23 1075:22
 1107:18 1112:19
 1131:15 1163:25
 1176:24 1187:7

1208:9 1209:21
 1212:25 1213:7
quote 1170:6,7
 1173:19 1187:1
 1191:23
quotes 1171:16

R

race 1181:12,13,
 17
raise 986:25
 1044:6
raised 987:12
rampantly
 1042:17 1044:13
ran 1192:2
random 1193:24
 1194:1
randomized
 1180:8,11,23
 1182:8,14,18
 1183:2,8,15,18,
 20 1184:10
 1186:5 1193:5,7,
 20,23 1194:14
randomly
 1193:25
range 1005:8
rapid 1076:25
rapidly 1012:23
 1042:19 1063:7
 1066:4
Raptors 1149:22,
 24
rare 1113:8
 1122:23 1145:9
 1211:20
rarely 1167:15
 1170:19
rate 1033:20,21
 1034:1,10 1035:7
 1036:3,7,9,24
 1037:14 1039:4,

8,15,16,20 1040:10,14 1043:12 1049:25 1052:5,8 1053:1, 3,9,11,17,22 1056:7,10,13,18, 23 1086:22,24 1087:3,9 1088:15 1089:7 1090:6 1161:3 1213:1 1214:14,23	1191:23 readily 1010:26 1051:17 1058:19 1060:3 1081:11 ready 995:4,5,8 1211:4 reagents 1118:13 real 1046:18 1087:9 1101:17 1113:6,7 1193:8 1194:4 realistic 996:8,11 reality 1013:25 1019:25 1041:19 1084:18 1087:6 1133:3 1142:17 1152:1 1168:15 1171:7 1195:16 realize 1035:25 1068:11 1072:25 1073:2 1081:24 1084:14 1089:19 1148:12 1156:7 1172:3 realized 1036:11 1172:8 realizing 1172:9 realm 1010:4 1088:1 1151:15 1154:7 1171:23 reason 991:15 993:25 1020:3 1042:21 1048:19 1050:23 1059:15 1061:16,20 1066:12 1068:26 1078:4 1089:15 1100:11 1102:12, 16 1104:4 1105:16,20 1113:15 1115:12 1126:11 1134:5, 19 1138:3 1140:26 1144:18 1150:4 1158:6 1182:14 1192:1	1193:6 1196:4 1207:17,24 1208:16,20 reasonable 992:20 994:16 1039:5 1098:7 1104:11 1107:19 1108:8,10 1208:25 reasons 1037:6 1061:17 1066:3 1072:22 1073:12, 16 1074:14 1077:26 1096:7 1099:7,8,21 1112:18 1125:16 1141:26 1148:17 1159:21 1165:23 1172:2 1181:23 1184:6 1191:5 1201:15 rebut 992:26 rebuttal 1183:9 recall 1001:24 1035:13 1120:10 receive 988:7 1006:8 1008:8 received 1002:21 1003:3,23,26 1007:21 1008:1 1142:10 recent 987:6 1011:14 1016:4 1044:22,23 1052:15 1061:13 1101:25 1176:5 1195:15 recently 1003:19, 26 1006:17 1014:9 1050:1 1128:25 1145:18 1146:2 receptor 1043:3 1096:10 receptors 1037:7 1159:22	recess 1216:18 recognition 1003:23 recognitions 1002:22 recognize 1014:14 1029:13, 26 1030:4 1036:26 1107:20 1113:16 1114:16 1121:6 1143:1,5 1144:11 1192:10 recognized 1004:6 1030:22 1047:2 1048:21 1113:18 1127:8 recognizing 987:20 1144:14 RECOMMENC ED 1092:23 recommend 1009:11,13 1072:3 1081:4 1093:21 1105:22, 24,25 1113:13 recommended 1105:20 record 999:7 1000:1,22 1014:1 1015:4 1055:24 1094:15,16 1099:19 1174:15 record- shattering 1196:2,8 recordkeeping 1203:4 records 1146:20 1175:1 recovered 1146:8 recruit 1211:6 recruited 1016:16 1023:25 1122:5	redirect 1110:1 1196:24 1205:2 1209:17 reduced 1044:12 1055:26 reduces 1145:10 reducing 1043:26 1044:8 1163:13 1169:11 1180:26 reduction 1140:22 refer 1001:23 1008:25 1010:1 1033:4,7 1036:15 1047:18 1095:10 1129:12 1130:10 1138:23 1152:17 1181:24,25 1187:9 1214:18 reference 1174:9,21 1175:13 1177:2 referred 1025:23 1097:2 1198:15 1201:10 1205:14, 15 referring 1019:17 1035:17 1036:13 1178:9 refers 1026:4 reflex 1109:21 refreshing 1163:9 register 1202:26 registered 985:10,11 1092:10,11 1202:12 registration 1202:11 regular 1006:21 1009:21 1018:16 1071:2 1124:6 1156:25 1159:13
--	--	--	---	---

regularly 1143:21	reliable 1052:12	repetitious 988:4	reported 1146:7	9,12 1007:5,7,10, 26 1009:23,26 1010:5,17,18 1011:18,19,26 1012:11,13,16, 21,23,26 1013:1, 8 1014:16 1015:5 1021:26 1022:2, 4,5,25 1023:6 1028:1,3 1065:8, 9 1124:7 1128:4, 13,15,16,24 1133:19,21 1161:6 1168:22 1170:12 1182:25 1210:11
regulated 995:15 1021:9,10 1159:3 1201:24 1202:6 1203:15	relied 1115:11 1119:23 1173:3	rephrased 1036:1	Reporter 985:21 1092:21 1196:22 1217:15	research- intensive 1004:20 1005:9
regulation 990:8	reluctant 1215:18	replenishing 1071:14	reports 995:2 1174:5,21 1189:9 1211:18	researcher 1128:1 1134:2 1165:15
regulator 988:2	relying 1055:5	replicate 1097:1	represent 1186:21 1194:3	researchers 1007:26 1011:12
regulatory 989:19 1021:13, 17	remained 1100:16	replicating 1077:19 1117:9	represented 1198:15	residences 1145:18
reinfected 1063:25	remains 987:23 1104:16	replication 1062:3 1077:7 1096:17 1097:6,7	represents 1012:2	resistance 1080:20,21
rejected 1009:12	remarkable 1044:2 1118:8	replication- competent 1077:23 1116:5 1117:15 1119:5, 16 1121:20 1179:17	reproductive 1026:26	resolve 1102:2
related 1004:13 1012:11 1015:8, 17 1093:26 1152:21,23 1186:22 1191:3	remarkably 1013:7 1116:9 1118:5	repopulate 1158:18	request 1215:23	resources 990:1
relates 1043:12	remedy 989:14	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	requested 1211:14	respect 1072:19 1083:8 1091:2 1105:3 1151:14 1152:25 1171:26 1174:16 1183:12 1187:12 1189:23, 24 1198:26 1199:2
relating 1201:1	remember 1034:21 1044:21 1045:12 1069:5 1130:6 1140:3	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	require 995:11 1088:16 1100:18	respectful 1070:14
relationship 1190:21	remind 994:26 1092:26 1100:26 1166:7 1173:16 1211:15	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	required 1008:20 1009:14 1029:18 1097:3 1132:22 1133:1 1155:23 1172:6, 17 1179:19 1201:22	respiratory 1025:17,21,25 1026:26 1042:1, 5,7,22 1043:8 1045:17 1048:1, 18 1049:10,12
relative 1034:13, 14,16 1040:23 1052:17 1054:5	reminder 1164:21	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	requirement 1015:25 1103:16 1132:2 1199:9	
relayed 1085:17	remove 1040:9	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	requirements 1082:16 1198:7 1199:11 1201:2 1202:11 1203:4, 23 1204:6 1208:3	
released 1045:26 1212:12	removed 1017:5 1074:21 1101:12 1117:19 1126:4 1133:21	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	requires 994:8 1112:24 1114:10 1152:4	
releasing 1103:24 1112:22 1123:18	removing 1101:23 1163:12	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	rescinded 1133:20 1178:24 1179:3	
relevance 1040:26	render 1050:16 1051:12 1064:15	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	research 1003:26 1004:1,5,17,26 1005:2,6,11,14, 16,20,22 1006:4,	
relevant 989:11, 23 990:2 991:1 1006:7 1008:17 1028:23 1041:3 1049:7 1052:16 1066:20 1088:13 1103:12 1147:10 1169:22 1180:12 1182:1 1188:24 1194:9,10,13 1207:5,8	repeated 1205:10	report 999:26 1016:22,25,26 1017:2,4 1018:2 1033:2,7 1034:20,21 1035:3 1040:18 1052:19 1057:17, 18,19 1061:25 1080:3,4 1083:24 1111:3 1123:10 1126:14 1129:10, 13 1135:8 1138:14,23 1147:12 1151:3 1152:13,23 1153:10,13,18 1165:9 1166:7,10 1168:12 1170:13 1173:18,25 1174:8 1175:7 1182:17 1186:16, 17,25 1187:8 1188:10,15 1189:20 1191:23 1192:9 1195:11, 19 1210:17 1211:12	research 1003:26 1004:1,5,17,26 1005:2,6,11,14, 16,20,22 1006:4,	

1058:7,9 1064:3, 6,21,23 1070:3,8 1074:17 1079:5 1096:1,5 1104:20 1127:4,13 1171:19	restrictive 1048:2	revoked 1129:22	round 1056:26	safety 1130:14 1141:21
respond 992:25 993:10 1054:18 1121:24 1154:1,2 1157:4,16	result 1034:12 1104:2 1115:18, 22 1116:19 1119:11,19 1122:8 1141:8 1143:15 1161:24	rich 1159:13	rounding 1057:3	sample 1112:15 1114:18 1116:17, 22 1117:2,7,13, 14 1157:12 1179:17,24
responded 1038:25	results 1041:19 1101:7 1116:12 1118:18 1119:26 1145:23 1195:24 1208:19,20	rid 1078:15	route 1045:10 1049:9 1125:17 1165:26 1184:7	samples 1114:21 1117:22 1119:3,4
responding 1122:4 1157:7 1159:4,6,7 1172:5 1183:18	resume 1164:19	rights 992:3,4,6,7 1089:22	routinely 1008:12 1028:9 1090:10	SAR-
responds 1157:10	retracted 1099:25	rigorous 1002:9 1008:22 1077:17	row 993:4,7,18 996:21	CORONAVIRU
response 987:2 989:5 995:14 1005:16 1049:6 1075:23,25,26 1076:6 1077:11 1078:9 1121:12 1159:3 1172:9,10	reusing 1124:26	ripped 1145:17	rubber 1134:25	S-2 1144:22
responses 1076:25,26 1077:1,4,10 1120:6,14	reverse 1036:14 1119:18	rise 1154:13 1195:7	Rubella 1095:5	SARS 1058:6,8
rest 1040:10 1063:22 1064:14 1122:14 1131:17 1160:22 1205:9 1213:14	review 1002:9 1007:2,12 1008:4,5,7,19 1013:14,23 1014:3,5,8,11,18, 19,26 1015:2 1031:9 1136:3 1174:17 1175:14 1188:6 1201:18 1211:8,11 1212:6	risk 1036:1 1039:26 1060:24 1064:7 1079:2 1090:3 1096:18 1102:14,20 1103:22 1106:1 1128:18 1129:25 1134:12,16,19 1142:13,14 1159:1,19 1178:3 1185:12 1186:22 1191:4 1213:11, 15 1215:4	rule 990:25 991:20,21 1167:13,15 1186:5	SARS-
restate 1041:5	reviewed 991:13	risk-benefit 1102:14	rules 1141:19 1198:26 1199:2	CORONAVIRU
restrain 1104:17	reviewer 1006:15,20 1007:1,15 1211:9	riskier 1141:14	ruling 984:11 1001:4 1017:3,5, 9 1024:23	S 1175:3
restricted 1039:22 1048:9	reviewers 1008:3,7,10 1009:3 1211:6,7, 8,14,15 1212:5	risky 1141:25 1142:2	run 999:3 1016:3, 10 1023:20 1031:12,14 1038:14 1065:8 1114:21,26 1116:18 1119:11, 25 1131:5 1184:13,14 1185:10,14 1186:5 1192:19, 21 1194:16 1211:26	SARS-
restricting 1161:11	reviews 1008:11, 13	road 989:24 1022:14	run 999:3 1016:3, 10 1023:20 1031:12,14 1038:14 1065:8 1114:21,26 1116:18 1119:11, 25 1131:5 1184:13,14 1185:10,14 1186:5 1192:19, 21 1194:16 1211:26	CORONAVIRU
restrictions 1019:1,12,17,23, 24 1020:6,19 1024:6 1093:15 1195:2	revise 1211:25	robust 1070:25 1097:19	running 1115:19 1118:9,11 1119:8 1131:7	S-2 1006:12 1011:14 1012:19 1013:5 1015:11, 17 1026:7,17 1035:7,10 1038:17,23 1040:3,4,7 1041:24 1042:26 1043:4,21 1046:7 1049:21 1050:1,4 1055:20 1060:10 1063:6,23 1064:22 1068:14, 15 1071:26 1072:1 1079:9 1096:1 1101:8 1111:22 1112:2,3 1113:14 1115:23 1126:17,21 1128:20,24 1129:1,4,20,25 1133:12 1145:17, 23 1146:19 1147:17 1159:20 1171:10 1174:22 1179:2 1180:15, 16 1181:22 1182:10 1190:15,

17 1195:25	1072:17 1099:16	991:17 1068:3	section 992:5	series 1028:11
SARS-COV	1146:2,3,5,9,10	1085:11,13	1033:2,4,12	1076:23 1095:4
1025:22	1149:6	1186:3 1189:13	1057:18 1174:9	1097:15
SARS-COV-1	schools 1042:16	1191:6	1175:13 1183:9	seroconversion
1025:23	1066:5 1101:20	scientist 1018:15	1186:17	1038:25
SARS-COV-2	Schumann	1142:24 1145:4,6	sections 1114:16	serve 1006:20
1015:8 1018:26	985:21 1092:21	1152:2 1168:1	secure 987:7	1007:1,20 1016:7
1019:2,10,13	1217:3,14	1196:10,13	segments	1018:1 1077:6
1027:10 1033:4,	science 1001:13,	scientists	1114:24	served 1006:17
14 1034:14,16	14 1008:24	1009:25 1011:8,	segregated	1007:8 1015:17,
1064:17 1085:8,	1009:12,15	22,23 1027:17	1099:12	26 1016:2
12 1122:19,26	1022:25 1023:19	1028:12 1086:25	segregation	service 1005:1,4
1137:17,21	1029:19 1032:13,	1118:26 1180:4	1094:8	1006:22,23,24,
1182:21 1183:21	21 1049:24	1182:25 1189:14,	selected 1105:16	25,26 1007:24
1184:7	1084:18 1090:12	23 1215:12,16,17	selective 1169:3	Services 1201:6
satisfactorily	1165:22 1167:8	scope 1030:14	self-regulation	servicing 1007:12,
1002:5	1168:4,10,17,19,	1058:2,4,10,12,	1201:26	14 1016:20
satisfactory	26 1169:2	26 1059:14	seminar 1028:10	session 984:5,15
1002:13	1180:26 1182:13	1060:3 1104:6	send 997:22,26	985:5 986:4
satisfied 1212:6	1186:6 1187:11,	1207:21,25	998:25 1065:19	999:21 1024:24
Saturday 996:19	19,26 1189:5,25	scratch 1015:1	1066:8 1072:17	1092:5,24
save 998:17,21	sciences 1001:14	scratching	sending 1078:6	sessions 1031:2,
scale 1058:5,13,	1010:10 1167:1	1126:7	senior 1010:16,	5,9,15
14,21 1059:24	scientific 990:5	screen 1033:10	24 1011:8	set 989:15 1008:9
scales 1169:4	998:13 1006:2,	1207:1	sense 986:22	1054:17 1075:15
scant 991:20	21,26 1008:13,	screening	993:2 1020:15,	1118:8,13 1119:9
scenario 1057:25	14,15,23,24,25,26	1067:25,26	16,17 1119:13	1174:15 1201:7
1112:26 1141:6	1009:18 1012:2	1072:5 1125:8,20	1126:24 1128:14	sets 1168:12
1167:25 1169:7	1013:18,19	1200:3 1208:3	1135:25 1136:1	1202:8,10
1172:11 1192:16	1023:26 1026:13	1209:9	1161:9 1162:14,	setting 1002:3
1193:3,9 1194:20	1030:4 1035:4	seal 1081:19	17,23 1168:8	1012:10 1169:12,
scenarios	1038:13 1047:19	1132:9 1134:26	1170:25 1180:2	14,16 1170:2,6
1101:24 1128:23	1052:26 1085:16	1138:25	1202:24	1173:23 1180:13
1204:14	1110:19 1112:6,	search 1177:10	sentence 1095:22	settings 1099:17
Schaefer 987:14	11 1113:26	season 1039:17	1177:25 1186:17	1130:6 1135:5,6
schedule 1065:25	1130:2 1134:5	1088:1 1089:3	sentinel 1075:16,	1193:8 1198:8
scheduled 988:6	1136:21 1154:5	1181:23,25	22 1076:10,20	severe 1023:14
schedules 997:24	1155:6 1165:16	seasons 1071:17	1077:13 1120:13,	1025:17,21,24
scheduling	1168:1,12,13,16	secondhand	15	1042:11 1043:7
986:21 987:4,22	1175:14 1178:4,	1107:20	separate 1011:19	1044:20 1046:6,
988:15	16,20,23 1179:6	seconds 1139:10	sequence 1074:8	11,24 1047:1,8,
school 1028:7	1186:26 1187:5	1165:5	sequencing	11 1050:15
1042:14,15,17,18	1188:7,26	secretion	1146:4	1055:10,22,26
1044:10 1069:1	1189:2,12 1190:1	1078:11		1056:2 1058:6,9
	1195:9,20	scientifically		1067:10,12

1100:9 1152:7 1159:20 1161:23 severity 1085:10 sex 1192:23 sexually 1137:20 shalt 989:16 shape 1109:16 1113:23 share 999:24 1189:17 shared 1199:1 shattered 1146:19 1175:1 shave 1132:23 shedding 1141:6, 7 sheer 1148:6 shield 1139:5 shocked 1182:16 shop 1081:13 shopping 1081:14 short 995:25 1007:6 1057:26 1085:15 1212:9 short-term 1059:2 1060:21 1076:25 shorthand 1217:5,6 shoulder 1141:24 show 991:18 1040:15 1044:15 1055:12 1060:15 1061:15 1068:21 1079:22 1118:17 1120:23 1121:18 1181:20 showed 1110:20 1111:22 1118:23 showing 1056:12 1068:19 1116:13 1129:22 1136:18	1183:25 1200:22 1203:25 shown 1084:9 1129:13 1155:24, 25 1210:10 shows 1026:14 1056:1 1094:15 1101:20 1173:9 shut 1012:12 1146:5 shutdown 1012:14 sic 990:14 1004:23 1056:25 1099:8 1120:17 1147:5 1153:6 1181:3 sick 1036:23 1038:19,22 1064:23 1065:10, 18,22,23 1066:6, 10 1067:4,6,23 1068:1,2,9,25 1069:2,6,16,19, 24,26 1070:1,5, 13 1071:23 1072:4,17,18 1073:9 1074:1,7, 8 1078:3 1093:21,22 1097:6 1104:7,8, 9,20 1105:17 1113:2 1121:7 1123:25 1127:16 1141:5 1147:7 1160:9 1162:17 1170:19 1173:5 1180:2 1200:9 1207:10,15 sickness 1038:23 1074:3 1136:1 1200:11 1206:24 side 990:1 1016:20 1022:1,4 1053:2 1109:15 1149:17 1162:2	sight 1160:17 sign 1200:7,15 1206:18,23,24 signal 1115:21 signals 1115:17 significant 987:23 990:4,5 995:17 997:2 1147:23 1184:1 1199:18 signs 1026:10 1042:2 1065:23 1066:24 1067:1, 2,3,6 1104:3 1171:18 1200:23 1206:17,26 similar 998:20 999:5 1002:18 1006:1 1021:7,11 1054:7 simple 1069:7 1102:12 simply 997:22 1029:20,26 1037:6 1081:22 1084:19 1087:18 1143:13 1159:22 1163:15 1169:16 1170:22 simulate 1048:23,24 simultaneously 1051:10 1055:9, 21 single 1150:5 sitting 1139:12 situation 995:17 1041:3 1087:1 six-year 1001:16 1014:13,26 size 1087:7 1104:13,25,26 1112:15 1148:19, 26	sizes 1073:22 1079:22 1130:26 1131:1 1133:8 skill 1217:7 skin 1027:1 1076:8 1132:9 1133:7 skyrocketed 1044:16 slight 1161:25 slightly 999:6 1161:24 slimy 1070:19,24 slots 1030:26 slow 1080:13 slower 1063:16, 17 slowing 1081:21 slowly 1131:8 small 1079:14,23 1114:24 1131:1 1163:10 smaller 1058:5 1148:18 smoke 1106:19, 20 1107:13,16, 20,21 smokers 1107:6 smoking 1107:12 snake 1148:21 snapshot 1195:17,22 1196:1 sneeze 1070:4 1078:22 1106:3 sneezing 1066:6, 8 1068:5 1070:6, 15,20,24 1072:4 1079:3,13 1082:24 1104:12 1105:18,24 1106:7 1112:25 1113:2 1123:8 1127:1 1136:13	soak 1144:1,3 soaked 1143:26 soaking 1071:18 social 1065:1 1160:2 1201:7,22 1203:23 society 1094:8 1099:12 solely 1174:6,7 solicit 1211:15 solid 1068:3 1130:17 solutions 1102:2 somebody's 1036:21 1037:24 1038:5 1070:5 1095:12 1104:12, 17 1107:11 1141:4 1206:14 son 1148:20 son's 1146:1 soonest 994:21 sophisticated 1028:1 sort 1005:6,14 1010:5,22 1023:17 1036:19 1048:12 1053:1 1080:18 1108:19 1109:14 1168:18, 22 1174:25 1176:16 1182:15 1186:3,6 1195:17 SOUND 1082:11 source 1007:4 1175:18 sources 1176:21 space 1045:23,24 1105:26 1108:5 1128:4 1161:5, 13,20 1163:12,13 span 1138:20 Spanish 1059:20
---	---	--	---	--

speak 995:14,15 1148:16,22 1149:9 1151:7 1215:21	1099:3	staff 1008:5 1198:7,11,12,15, 17	state 1056:15 1171:2 1186:11	sterile 1131:4,7 1139:20,21,22 1140:10 1143:23
speaking 1113:10 1148:14 1180:5 1203:21	spills 1131:20	stage 1002:16 1060:21	state-of-the-art 1062:1	sterilize 1073:4
special 1006:17 1117:3 1130:13, 20 1147:24,25 1148:1	spittle 1073:12, 18 1126:1	stages 1212:21	stated 1024:26 1035:22 1165:10 1191:23 1195:4 1201:15	sterilized 1099:23
specialist 1016:5	split 993:10 1031:13,14 1116:17	stainless 1130:17	statement 1099:25 1155:8 1166:6,26 1178:21,23,24 1186:19,26 1187:1,6 1189:18,22	sterilizing 1095:11,15,24,25 1096:2,19 1098:25 1100:7 1102:5
specialized 1074:25	spoken 998:4	stains 1144:4	statements 1036:19 1167:16, 24 1169:7 1178:2,10,18 1188:21 1196:11	stick 1139:26
specific 1019:23, 24 1020:19 1027:23 1052:24 1056:7 1099:3 1151:2 1165:8 1200:12 1204:17 1208:3	sport 1142:3	stale 1108:1	states 1153:24 1165:19 1176:13 1177:24 1178:12 1183:14	sticks 1096:9 1148:20
specifically 987:3 988:17 1002:24 1003:10 1006:11 1012:18 1019:22 1025:18 1026:24 1027:19 1039:23 1069:12, 13 1094:20 1116:10 1132:19 1157:1 1178:9	sporting 1162:11	stand 1023:17 1107:12	statements 1056:19 1057:8	stone 989:15
spectrum 1023:18	spread 1041:9 1042:17,19 1043:13 1044:1 1047:5 1049:20 1051:17 1059:24 1060:13 1064:17 1066:9,10 1069:14 1072:1, 11 1079:11 1088:6 1094:3 1097:26 1100:24 1103:4,22 1104:11 1110:16 1111:8,14 1122:22 1123:2,6 1124:2 1125:24 1126:6,26 1127:7,9 1136:16,26 1140:20,21,22,23 1142:11 1144:22 1146:26 1147:3, 6,16 1169:11,23, 24 1170:21 1171:1 1184:7	standing 990:16 1108:6,19	status 1049:17	stopped 1146:25
speech 1147:21, 26 1148:3,5,6 1149:2,5,18 1150:17 1152:4	spreading 1044:13 1058:1 1066:13 1068:5 1072:23 1093:18 1103:23 1104:24 1111:11 1117:9 1122:26 1134:3	standpoint 1200:3	statutory 992:3	stopping 1079:1 1088:18 1094:2, 12
spent 987:17 990:1 1028:21 1174:23	spreads 1060:2 1066:4 1088:4 1122:19 1123:5	start 986:15 995:24 999:10,15 1001:7 1025:12 1030:13 1033:19 1034:17 1046:11 1062:12,25 1068:13 1075:23, 24 1076:20,23 1077:13,15 1081:14 1086:15 1089:21 1093:25 1103:10 1117:9 1121:4 1155:11 1160:12 1162:26 1210:24 1214:17	stay 1048:2 1064:22 1065:26 1068:8,25 1093:22 1099:12 1107:21 1138:22, 24 1143:5	stops 1073:5 1126:1
spewing 1143:25		started 992:14 1035:25 1040:21 1213:8	staying 1082:23	store 1081:5,8 1143:1 1204:10
spike 1055:17 1096:8,14,15 1099:1,5		starting 1015:1 1051:16 1059:8 1061:9 1086:14 1113:13	stays 1098:22	straight 1090:25
spike-protein		starts 1046:19 1076:21,22 1077:19 1078:11 1120:12	steadily 1044:18	strain 1063:12,14 1103:1
			steel 1130:17	strains 1063:9,12
			step 1081:9 1149:12	straps 1139:23
			stepped 1190:3	strategic 1011:15
			steps 987:5	strategically 1011:21 1075:17
			stereotypical 1129:14	

strategies 1101:22 1102:4 1128:21 1144:12	stuff 1083:12 1124:8 1148:26 1162:25 1196:3	sufficient 988:16, 17 1009:13 1096:23 1112:21	surface 1075:19, 21 1096:9 1130:17	1025:6 1093:4
strategy 1064:20 1071:22 1094:2, 12 1102:25 1127:12 1133:26 1136:24 1146:24 1179:2	subheading 1177:19	suggest 997:22 1105:10 1112:6 1179:9 1186:20	surgeon 1073:1, 5,8 1140:6	symptom 1200:9, 14
stray 1118:22	subject 998:7	suggested 1111:15	Surgeons 1202:9, 18	symptomatic 1072:13 1073:25 1079:18 1093:20 1104:17 1106:6 1111:5,26 1112:5 1122:25 1123:15 1125:8,26 1126:3,4,25 1135:19 1140:15, 18 1141:2 1143:17,25 1147:5 1169:16 1170:26 1171:1 1184:4 1199:21, 26 1200:4 1201:14 1205:23 1206:11
strengths 1142:8 1144:11	submission 1065:10 1211:19	suggesting 1079:10 1154:17	surgery 1073:8,9 1124:13,23,25 1139:19 1140:4	symptomology 1207:9
strong 1194:17	submissions 987:8,16 988:13, 16 995:12 997:2	suggestive 1116:14	surgical 1070:10 1072:26 1073:3, 6,19 1080:7 1081:18,25 1124:7,8,12 1129:18 1130:25 1131:26 1133:16 1140:5,6 1162:17,25	symptoms 1026:10 1042:2 1065:23 1066:24 1067:2,5,6,8,17 1104:3 1145:26 1146:8 1171:18 1200:22 1206:12, 25 1207:1
strike 1151:25	submit 991:15 1065:12 1211:4	suggests 1043:26 1061:11 1101:26	surprise 989:21	syncytial 1042:5, 22 1043:9 1171:19
stripped 1117:5	submitted 1013:15 1034:21 1212:19	suicide 1185:16	surprised 1180:4	Syndrome 1058:7,9 1147:26 1148:13,16
strongly 988:13 1094:21 1193:4	submitting 998:11	summarize 1071:21	surprising 1112:17	Syndrome- coronavirus-2 1025:18,25
structure 1202:20	suboptimally 1054:18	summarized 1090:13	survival 1050:23 1051:2 1062:18, 24	synthesized 991:6
student 1031:16 1032:21 1198:19	subsequent 1120:14 1168:15	summary 988:14 1177:18,19 1186:18	survive 1050:14 1053:15	system 1038:25 1045:10 1048:22 1049:2,9 1054:18 1063:13 1070:3 1075:15 1078:8,
students 1003:11,16,21 1027:26 1028:3,6 1030:26 1031:7, 26 1102:9 1145:24,25 1190:26 1197:26 1198:8,10	subset 1039:22	Sunday 996:20	survivability 1053:1,11,17,22 1056:18	
studied 1112:13	subspecies 1062:25	super 1070:9 1073:21 1146:24	survival 1050:23 1051:2 1062:18, 24	
studies 1073:1 1105:10 1111:15 1112:10 1114:6 1127:11,12 1179:12,13,21 1183:25 1194:16 1210:9,12	substance 1001:6	superficial 1032:12	survive 1050:14 1053:15	
study 1038:11,12 1110:19 1111:18 1112:14 1129:1 1174:26 1184:13, 14 1185:10 1192:21 1210:16	substantial 1007:11 1012:12 1013:3 1051:18 1057:3 1102:20 1112:16 1113:22 1124:16 1160:15 1186:20,22	supply 1121:23	susceptible 1043:5,6 1098:16	
studying 1028:21	substantially 1014:2	support 1006:8 1094:21 1179:13 1187:6	swear 1000:21	
	substantiated 1155:5	supporting 1148:2 1173:20	Sweden 1165:21, 25 1166:23	
	subtotal 1112:6	supportive 987:15	swelling 1121:11	
	successful 1012:24 1060:17	supports 1136:8	swells 1121:3	
	sudden 1073:14 1149:7	supposed 1014:5,8 1034:2 1044:7 1072:6 1091:7 1094:12 1101:14 1115:24 1116:10 1125:9 1126:4 1168:4	swift 1110:23	
	suffered 989:24, 26		swine 1059:22 1172:7	
			swirling 1110:24	
			sworn 984:7,12, 16 1000:23	

19 1120:8 1121:24 1122:3, 14,15 1156:3,4, 16,26 1157:6,15, 26 1158:23,25 1167:19 1181:7,9 1187:20 1191:9 systemic 1045:11,14,16 1049:2 systems 1156:20 1160:5 1167:12	1040:26 1042:25 1054:9 1059:4 1066:2 1073:14 1087:2 1098:20 1099:17 1106:9, 10 1107:22 1108:16 1111:2,5 1123:15 1126:11 1137:18 1139:8, 9,14 1150:22 1165:1 1167:3, 17,18,19,20 1169:26 1174:13 1177:19 1180:15 1183:22 1187:13 1192:15 1193:3, 10,11,12,18 1201:8 1212:20 1215:7 talks 1178:10 1183:7,9 Tam 1176:23,25 1177:14,16 1178:1,7,12,20 1180:25 1201:10 1213:5 Tan 1177:1,2 target 1121:23 targeting 1096:8 taught 1124:11 teach 1028:3,13 1030:7,17,25 1102:9 1181:4 1190:25 teacher-of-the- year 1003:4 teachers 1149:8 teaching 1003:2, 8,10 1004:5,26 1005:3 1027:25 1028:8 1030:13 1150:13 1197:26 1198:9 team 1005:11 1009:26 1011:26	1015:5 1016:16 1065:8 1149:23 technical 1118:14 1200:2 technically 1076:2 1089:24 1095:12 1198:12 technique 1140:10 1143:23 techniques 1033:25 technologies 1006:1 1102:11 technology 1031:6 1062:6 1115:26 1116:1 techs 1201:25 teeth 1148:24 1191:14 telling 997:11 1096:11 1125:25 1133:10 1181:3 tells 1033:22 1071:19 1101:9, 13 temperature 1081:6 1206:20 temporarily 1133:21 ten 1031:20,23 tend 1021:26 1032:18 1047:7,8 1071:10 1104:9 1109:24 1122:21 1124:8 1141:12, 13 1142:2,15 1148:17 1191:4 1197:13 tendering 998:8, 19 1024:4 tenure 1002:14 term 1007:14 1026:2 1047:19 1057:21 1060:10	1061:7 1066:22, 23 1089:12 1209:14 terms 987:21,24 988:1,18 998:3,4, 7 1004:5 1008:10 1013:9 1015:1 1023:7 1024:6 1035:3 1053:25 1054:20 1059:13 1060:3,8 1061:14,15 1071:21 1076:2 1077:14 1079:19 1088:6 1093:23 1100:14 1114:11 1135:9 1146:18 1149:18 1164:12 1175:1,4 1190:3 1200:16 1204:5 1210:7 terribly 1164:11 territory 1172:17 test 1036:15,16 1041:19,22 1101:7 1106:19 1114:13,21,24 1115:4,11,22,25 1116:8,11,12,13, 18,21,22 1118:9, 11 1119:1,11,18, 23,24 1122:8 1145:23 1184:16 1193:25 1195:24 1209:5 tested 1041:21 1146:18 testify 1151:20 testifying 986:9 testimony 986:5 1195:1 1197:11 testing 1036:11, 12 1038:2 1113:14,16 1114:7	tests 1036:14 1115:20 1119:8, 14 1120:2 tetanus 1095:6 1097:17 thankfully 1083:4 themselves 1039:12 1041:26 1050:25 1054:2 1118:12 1129:15 1133:13 theoretical 1070:7 1112:26 theoretically 1079:13 1113:5 theory 1079:6 1105:6 therapist 1148:3 therapy 1148:5 there'd 1036:12 thereof 1188:25 Theresa 1176:23, 25 1177:14,16 1178:1,7,20 1180:24 1213:5 thick 1148:21 thicker 1077:18 thing 993:11 1031:12 1039:18 1040:17 1046:5 1047:13 1057:15 1064:19,24 1065:2 1067:22, 24 1068:8 1069:10 1073:7 1074:4 1078:7 1079:18 1080:17 1088:7 1089:14 1096:9 1097:12 1098:26 1105:7 1107:24 1108:14, 15,18 1109:20 1113:7 1114:2 1118:5 1120:1 1123:3 1130:11
--	---	--	---	---

T

T-A-N 1177:3,13
table 984:1
999:19,25 1017:4
tail 1195:23
takes 1028:18
1063:24 1077:9
1080:13 1081:13
1130:8 1186:24
1211:10,11
taking 1081:14
1107:16 1139:25
1150:1 1163:11
1195:17
talk 1020:1,14,20
1030:26 1034:23,
24 1042:9
1047:18 1059:3
1103:8,17,18
1124:16 1139:3
1147:9,14 1149:1
1150:23,26
1151:11 1188:5
1190:24 1203:14
1214:19
talked 1020:2
1076:3 1093:13
1167:6 1184:3
1187:25 1198:5
1204:21
talking 1006:23
1009:17 1034:6

1133:26 1135:4 1139:22 1144:17 1153:17 1160:3 1163:1 1168:24 1174:18 1176:15 1180:3 1186:2 1188:4 1190:12 1192:26 1193:1 1195:22 things 1007:17 1017:15 1020:2, 25 1023:1 1030:15 1032:8 1034:26 1042:22 1046:13 1058:23, 24 1059:1 1060:12 1067:5 1069:20 1070:18 1074:13 1077:9, 13 1089:21 1095:4,5 1096:25 1097:16 1101:15 1107:10 1109:11 1120:8 1131:5,23 1134:23 1135:8 1141:17 1148:3 1149:24 1150:24 1151:1,13 1156:4 1157:11,16,25 1158:1,2,3,7,10 1159:4,6 1168:8 1173:26 1174:12 1191:10 1192:17 1196:11 1201:9, 21 1203:5 1209:3 thinking 1045:11 1049:2 1109:19 1143:24 thinks 1045:13 1157:6 Thou 989:16 thought 997:21 1048:14 1089:7 1183:6 1197:14 1215:22 thoughts	1149:15 thousands 1181:19 three-year 1007:14 threshold 1058:25 1059:16 1060:6 1074:9 1076:12,16,18 1077:26 1078:3 1097:3,9 1103:25 1104:22 1112:22 1113:3 1136:14 1179:19 threw 1172:17,19 throat 1016:5 1071:10 1074:22, 23 1075:10 1078:12 1121:8 thrown 1015:21 1146:25 thumb 1141:19 ties 1182:6,11 tight 1132:9 till 1103:13 time 987:17 988:18,19 990:3, 8,13 995:20 996:9 998:17,21 1012:12 1014:7, 11 1034:22,25 1035:6,25 1038:20 1039:5 1044:19 1050:18 1051:6 1052:5 1057:26 1058:8 1062:2,7 1066:19 1071:11 1073:13 1080:13 1081:2,4 1083:3,5,6,22 1084:3,14,24 1087:13 1088:22 1089:19 1093:7,9 1097:14 1098:15 1100:16 1102:10 1103:11 1106:16,	17 1107:2,4,7 1110:9 1119:12 1124:14,16 1126:18 1128:2, 12 1132:26 1134:24 1135:3 1138:7 1139:9,25 1148:1 1149:7 1150:5 1157:3 1162:7,16,20,24 1163:15 1164:4, 13 1168:11,14,15 1177:11 1178:17 1189:19 1195:17, 23 1196:1 1207:11,13 1210:13,17 1211:24 1212:9 1213:7 times 989:10 1018:24 1065:5, 15 1138:18,20 1149:4,26 1185:14 timing 1057:24 1076:2 1211:2 tinier 1073:22 tiniest 1046:1 tiny 1070:9 1073:21 1083:26 today 986:4,9 988:11 991:8,14 998:26 999:3,24 1006:8 1015:13 1018:19 1028:23 1040:26 1041:1, 2,3 1069:11 1090:21,22 1151:9,11 1170:9 1187:10 1189:2 1199:2 1216:8 today's 1197:15 told 1017:10,12 1024:5 1068:24 1069:18 1110:4 1129:8 1145:2	1152:2 1155:16 1171:6 1180:25 tolerate 1157:15 tolerized 1157:20 tomorrow 996:19 998:25 999:1 1203:7 1216:9,14,18 tone 1168:13 1188:11 tongue 1148:20, 24 tongues 1148:19 tool 1130:2 1170:26 tools 1012:21 1103:3 top 1003:17,22 1008:6,8,24 1055:7 1062:7 1154:23 1163:22 1178:11 topic 1093:26 1182:20 1215:20 Toronto 1016:13 1149:22,24 total 1031:15 totally 1194:1 touch 1035:2 1124:10,12,17 1138:7,11,19 touched 1021:19 1025:13 1057:15, 17 1138:17 touching 1124:15 1131:22 1144:15,16 tout 1007:16 town 997:20 1145:2 track 996:16 1173:15	tract 1026:26 1045:17 1048:1, 18 1049:10,12 1070:8 1074:17 1079:5 1096:5 1104:20 tracts 1026:26 traditional 1173:3 traditionally 1067:16 train 1027:22 1162:4 trained 1028:6 1140:9 1143:22 trainees 1010:14, 19,26 1011:3 training 1001:11 1003:10 1029:14, 15 1030:19 1032:11,16 1133:22 1139:18 1162:8 transcribed 1217:6 transcript 984:22 986:8 1217:1,4 transcript-ase 1036:14 transcripts 991:9 transit 1080:13 translational 1022:1 translational/ applied 1005:20 transmissibility 1179:24 transmissible 1042:8 1050:6 transmission 1019:2,13 1043:24 1044:12
--	---	---	---	--

1047:3 1078:9 1079:1,2 1083:11 1094:13 1096:18 1098:9 1100:10, 15 1103:4 1111:26 1112:1, 2,8,16 1113:20 1123:13,16,19, 21,24 1125:2,4,7, 11,13,15,17 1126:12,21 1127:2,14,15,18, 26 1131:19,24 1133:14 1134:6 1135:26 1136:9, 12,19 1137:13,24 1138:2,13 1140:14 1142:18, 21 1143:3,4 1144:6 1145:10, 12 1150:23 1151:8 1165:11 1166:18 1167:3,4 1170:15 1171:12 1179:11,14,26 1186:18 1187:3, 12,22 1188:25	treatment 1006:1 1192:25 trend 1165:19 trends 1190:22 trial 993:15 1038:14 1180:11, 23 1182:8,14,18 1186:5 1193:5, 20,24 1194:2,14 trials 990:10 1022:3 1180:8 1183:3,8,15,19, 20 1184:10 1193:7 triangular 1082:2 Tribunal 984:20 985:7,8 986:3 987:13 988:26 989:13 991:19 992:1,2 995:23 996:4,17 1001:2 1018:12 1024:25 1085:22 1092:7,8 1151:5 1208:11 1210:3 trick 1049:2 tricks 1045:10 trigger 1076:23 1120:13 tropism 1047:19 1048:2 trouble 1017:18 1071:14 1110:16 1129:21 1149:26 1150:2 1181:4 troubleshooting 1010:20 true 986:22 1015:10 1090:15 1111:13 1122:8 1165:18 1166:3 1172:12 trumps 1029:21	truth 990:7 tube 1130:12 1132:11 tubes 1130:12 turn 988:9 999:22 1004:9 1084:2 1110:13 1164:24 1191:7 turned 1012:15 1110:9 1148:9 1172:11 turns 1110:4 1175:20 two-day 998:1 two-plus 1160:23 two-year 1014:24 type 1011:21 1012:2,5 1021:5 1022:5,25 1023:6 1028:3 1051:15 1072:10 1096:4 1097:13 1114:1 1117:3 1127:14 1133:18,21 1135:4,5 1138:23 1144:16 1153:11 1201:12 1203:5 types 1028:14 1042:4 1077:1 1120:16 1151:13 typical 998:16 1041:12 1050:9 1085:16 1201:8 1205:20 typically 992:22 1002:13 1010:4, 7,13 1011:1 1029:17,22 1071:8	21,24 1017:3,5,8, 13 1029:26 1035:4 1067:26 1101:5 1115:4 1209:4 unabated 1093:18 unable 1119:3 1124:5 1171:16 unaware 1038:22 1106:18 uncertain 1017:26 uncontrolled 1193:19 1194:22 uncoupling 1044:19 1055:22 1056:1 undergo 1002:6, 9 undergraduate 1028:6 1029:6,9, 13,14 1030:10 1032:14,16,21,22 underlined 1188:13 underneath 1075:19 underpinning 1008:22 understand 987:1 989:4,17 992:17 994:5 997:7 1007:18 1012:9 1018:12 1028:26 1029:4 1030:14 1034:5 1043:11,16 1047:6 1049:24 1050:8 1051:21 1052:4,9 1056:16 1057:20,22 1071:20 1076:1 1088:7 1093:2 1094:9,10,25	1105:15 1120:7 1121:15 1122:16 1133:23 1142:6,7 1149:8,13 1150:7 1153:3 1155:14 1174:5 1176:15, 17 1183:2 1187:11 1188:2 1189:7,10 1190:26 1198:13 1200:6 1202:3,7 1206:14 1211:2 understanding 987:18 1001:12 1015:22,25 1016:15,16,25 1023:17 1028:20 1029:2 1031:9 1032:12,24 1083:7 1087:12 1103:9 1129:23 1135:17 1176:9, 10 1187:2 1188:24 1189:6 1202:10 understands 1002:1 1026:19 understood 1149:3 underwent 1133:22 undue 997:16 unethical 1185:25 unfair 1014:14 unfiltered 1105:2 1108:26 1110:2 1111:1 uniform 1180:1 1182:20 unions 1198:19 unique 1004:23 1043:2,5 1054:4 1126:20 1127:10 unit 1023:15
<hr/> U <hr/>				
ultimately 1009:16 1015:15,				

1055:15 1130:13 1132:13	unsympathetic 1150:25	vaccination 1097:15 1101:16 1146:11	1047:24 1048:5 1049:8 1051:26 1052:14 1053:24 1054:17 1059:7 1060:15 1097:26 1098:20 1099:2, 20 1103:1,4 1171:7,8 1196:2	view 988:13 989:2 1170:24
United 1165:18 1178:12	untreated 1180:14	vaccine 1016:6, 12 1048:23	1098:20 1099:2, 20 1103:1,4 1171:7,8 1196:2	viraemia 1046:20
units 1055:13	untrue 1048:12	1094:22 1098:24 1099:8 1100:2,4, 6 1102:4,10,11, 17 1103:9,19 1128:26	variants 1040:21,23 1041:5,6 1043:14 1045:6 1046:26 1047:21 1050:5 1052:19 1053:16 1087:15 1088:12	viral 1001:17,18 1002:19 1005:15 1007:13 1018:25 1019:10 1021:1 1076:13 1078:15, 22,24 1079:24 1094:19 1122:9, 10 1145:10 1179:17 1187:16
universal 1030:12 1170:10	untruthful 1155:8	vaccine- enhanced 1044:5	1052:19 1053:16 1087:15 1088:12	virology 1007:13 1013:1 1028:22 1030:7 1031:24 1032:9,25 1050:8 1116:9,21 1118:18 1119:4 1179:16 1187:15
university 1001:19,21,22 1002:3 1004:21 1011:20 1027:23, 25 1028:1 1031:26 1032:1, 17,23 1145:1 1146:12 1161:1 1172:5,14 1181:3 1197:18,19 1198:5,7,14,16, 23 1204:5,22 1205:15 1207:12 1209:10	unusual 990:9 1166:25	vaccine- related 1023:10	1087:15 1088:12	virology/viral 1007:25
unknown 1026:15 1102:21 1160:19	unvaccinated 1094:6 1099:9 1101:13,23	vaccines 1005:23,25 1006:12,19 1011:15 1043:21 1045:8,18 1046:25 1048:3 1049:1 1054:16 1063:7,10 1077:2 1089:13 1093:26 1094:10,14,24 1095:2,4,5,9,23 1097:11 1098:8 1099:21 1100:14 1102:23 1104:6 1145:7	1145:25 1156:11, 22 1171:9 1175:10,23 1179:13 1196:5	virome 1027:3 1158:13
unlike 1124:23 1130:24	update 1056:7 1097:16	vaccinologist 1094:18	vastly 1190:9	virulent 1122:5
unmasked 1107:25 1142:16 1180:19	updated 1053:12 1095:7 1174:10 1175:5	vaccinology 1094:17,20	vast 1050:20 1080:22 1082:4 1087:22 1101:12 1102:18 1105:1 1145:25 1156:11, 22 1171:9 1175:10,23 1179:13 1196:5	virus 1012:19 1025:14,16 1026:7,8,12 1027:10,13 1033:5 1035:16, 18 1036:1 1037:8 1038:4,6,18,26 1039:21 1041:8 1042:5,22 1043:3,9 1044:9 1045:19,21 1046:1,7,19,20 1047:6,15,20 1048:7,11,17 1050:9,26 1051:13,16 1053:14 1060:16 1061:1,4,21 1062:23,25 1064:12 1070:7 1076:4,14,17,21
unnecessary 988:4 1100:26 1128:18	upfront 1200:13	vacuum 1034:15	vein 1020:12 1151:22	
unofficial 1016:2	upper 1046:8 1047:11,21,25 1048:3,6,9,17 1049:12 1096:4 1098:22,23	vague 1215:16	vents 1106:21	
unprofessional 1188:11 1189:8	upset 1184:20 1185:2	valid 1190:1	version 1098:21 1102:26 1212:5	
unquestionably 1052:20	upwind 1107:12, 22	validate 1116:11	versions 1062:9, 22	
unreasonable 992:15 993:2,3	urban 1157:24 1159:11,14	vapours 1108:8	versus 1073:25 1159:11	
UNREPORTABLE 1082:11	utilize 988:8 990:13	variable 1194:18	vessels 1045:23	
unscientific 1184:23		variables 1193:19,21,22 1194:3,15,16,22	veterinary 1003:11 1028:4 1030:17 1197:21, 23 1198:1	
unsubstantiated 1153:22 1177:20		variant 1035:1 1040:21,22,24 1041:4,7,11	viable 1102:25 vicinity 1142:19 victims 1076:7 Videoconference 985:1 1092:1	
	V			
	vaccinated 1044:4,6,11 1048:16 1054:20 1063:18 1094:4 1095:13 1097:18 1098:10,16 1099:18 1100:17 1129:2 1144:25 1146:14 1196:6			

1077:6,16,19,23, 24 1078:2,5,16 1079:4,10,13,19, 26 1080:6,10 1088:10 1094:5,7 1096:6,9,16,20, 22,24,26 1098:9, 21 1099:18 1100:1,12,22,23 1102:8 1103:1 1104:17,19 1105:3,18 1111:11,13,23 1112:20,24 1114:8,12,17,18, 23,25 1116:6,15 1117:7,15 1119:6 1120:4,11,20,21 1121:17,19 1122:6 1123:2,5, 6,18 1124:3 1127:6,10,20 1129:3 1134:7 1141:6,7 1159:24 1167:22 1170:21 1171:20 1174:22 1183:22 1187:20 1190:19 1213:16 1214:15,19,20, 23,25 1215:1,5 virus's 1041:20 virus-infected 1077:6 viruses 1005:17, 18 1026:21 1027:4,5 1041:12 1042:3,6,8,10,21, 23 1043:8 1044:13 1047:18 1050:11,20,21,22 1051:6 1060:7,9 1061:17,22 1062:16 1063:2 1077:8 1078:8 1079:7,8 1113:21 1117:7 1119:16 1120:17 1126:17,	23 1127:3,9 1130:5 1171:21 1174:19 visit 1204:4 visualize 1107:5 1115:3,5 vitamin 1180:25 1181:6,18,21,25 1182:1,9 voices 1150:16 volume 1108:5 voluntary 1008:19,21 volunteered 1042:14 vote 1003:17,21 voted 1003:24 vulnerable 1173:6 <hr/> W <hr/> wait 993:9 wake 1065:17,22 1071:9 walked 1178:1, 18 1179:4 walking 1178:10, 20,23 wall 985:18 986:3 987:24 989:24 990:19 992:2 994:6,25 995:2,7 997:12 1018:5 1092:18 1103:15 1110:8 1131:3 1207:17 1208:4, 17 Wall's 988:2,7 991:16 992:8 1205:21 wanted 998:2 999:23 1022:13 1024:5 1057:16	1083:10 1102:24 1151:18 1154:15 1155:7 1173:17 1197:10 wanting 1056:25 war 1090:1,2 warm 1081:8,10 warning 1091:13 1155:17 warranted 1036:9 Warren 998:25 1183:14 watch 1082:10 1140:5 1164:17 watched 1138:8 1149:23 watching 1149:22 water 1070:2,21 1072:11 1073:10, 17,21 1079:15,25 1083:26 1084:1 1105:19 1106:8 1123:7,13,16 1144:8 1152:3 1158:8 wave 1044:21,24 1055:1 1061:13 1146:17 1196:2 waves 1044:22 1055:25 1068:18, 21 1100:20 1101:25 1146:21 1195:24 ways 1004:6 1010:25 1079:10 1107:5 1141:14 1167:11 1173:3 weaknesses 1100:2 1142:9 1144:14 weapons 1077:5 wear 1069:25 1070:15 1073:17	1080:21 1081:1 1082:24,25 1100:18 1122:25 1124:5 1129:15 1132:24 1133:3 1138:6 1141:24 1142:25,26 1162:15,24,25 1185:24 1199:5 1204:15 1205:2, 13,16 wearing 1073:12 1082:14,15,16 1125:4 1129:20 1131:26 1132:1,5 1140:11 1147:8 1150:3,4 1205:14,15 wears 1150:1 web 1068:20 website 1054:13, 14 1068:13 1175:17 websites 1054:2 1175:17 week 1054:26 1172:18 1211:10 weekend 997:20 weeks 993:9 995:21 1077:10 1121:22 1122:1 1155:16 1160:10, 11 1211:11,13 1212:4 weigh 1168:5 weight 1168:5 1169:1,4 well-designed 1070:2 well-established 1141:11 1142:1 wellbeing 1065:21 wet 1070:24 1071:19 1082:25	1144:4 whatsoever 1096:17 1156:1 1158:16 1184:19 white 1037:23 1167:8 wicking 1071:13 widespread 1178:14,15 wife 1148:6 willful 1154:14 willingly 1205:4 wind 1107:14,18 wind's 1107:16 Winnipeg 1118:3 winter 1071:5,8, 16 1083:22 1084:3,5 1107:7 1132:26 wiping 1081:15 witnesses 986:6 987:22,24,25,26 990:12,15,17,26 991:2 won 1003:2,19 wondering 1201:17 wording 1017:6 1178:22 words 1030:5 1038:8 1053:8 1072:5 1077:20 1088:24 1116:6, 12 1118:25 1166:2 1175:9 1200:12 work 997:21 1004:21,25 1009:24 1010:3, 15 1011:21 1012:22 1022:4 1027:23 1044:10 1065:11,16,25 1068:2,7 1069:1,
--	--	---	---	---

19 1070:1
 1072:18 1093:14,
 16 1099:17
 1103:14,20
 1106:13 1115:24
 1124:7,12
 1128:4,19 1129:3
 1130:4 1135:18
 1140:2,17,18
 1148:2,6 1161:4
 1162:15 1169:17,
 21 1174:25
 1179:10 1182:26
 1201:23 1202:25
 1205:3,15
 1207:15 1211:1

workday
 1124:20

worked 1022:15,
 19 1023:22
 1042:15 1067:25

worker 1134:17
 1135:11,22

workers 1016:13
 1135:9 1191:25
 1192:2,5

working 1010:19
 1034:15 1073:6
 1101:20,21,26
 1102:3 1103:15
 1130:5 1132:22
 1134:17 1135:11,
 22,24

workplace
 1065:4 1104:7
 1110:3 1111:7
 1125:10 1143:20
 1144:23 1200:24
 1207:7

workplaces
 1042:16 1066:5
 1099:13 1100:17
 1101:19

works 992:3,4,5
 997:15 1010:2,13
 1066:10 1093:13

1122:17 1169:17
 1182:21 1200:18
world 1008:17,24
 1011:12,25
 1050:21 1072:15
 1086:26 1088:4
 1098:10 1101:17
 1113:11 1135:15
 1143:24 1147:24
 1155:22 1156:6,
 13,20,26 1193:9
 1194:4

world-renowned
 1002:11

worn 1134:23

worried 1054:16
 1083:11,13
 1141:5

worries 1165:4

worse 1108:14
 1124:23 1147:4
 1184:20

worst 1012:14

worth 1157:7

wound 1073:6,19

wrap 1151:14

write 1189:8

written 1000:12

wrong 1175:4

wrote 1155:14
 1160:12

Y

year 995:3,6
 1003:16,21,23
 1013:17 1025:26
 1026:1 1031:23
 1032:6,19
 1038:20 1063:10
 1071:11 1098:4
 1100:4 1103:11
 1155:15,19
 1160:14 1195:4

year's 1063:11,
 12

year-and-a-half
 1125:21,23
 1144:19

year-to-year
 1063:8

years 1002:7,17,
 22 1003:14
 1007:24 1012:6
 1013:7,8,17
 1014:4,9,19
 1025:19 1027:15
 1028:10,21
 1060:12,14
 1061:11 1066:21
 1068:19,20,23
 1095:7 1097:16
 1136:24 1148:8,9
 1160:16,23
 1168:26 1175:11

yogurt 1158:21

young 1040:17
 1042:26 1043:5,8
 1149:14 1156:24
 1157:26 1160:16
 1171:10 1193:12

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

TABLE OF CONTENTS

1		
2		
3	Description	Page
4		
5	January 29, 2022	Morning Session 1221
6	DR. THOMAS WARREN, Sworn, Examined by Mr. Kitchen	1223
7	(Qualification)	
8	The Chair Questions the Witness (Qualification)	1228
9	Ruling (Qualification)	1228
10	DR. THOMAS WARREN, Previously sworn, Examined by	1229
11	Mr. Kitchen	
12	Mr. Maxston Cross-examines the Witness	1312
13	Mr. Kitchen Re-examines the Witness	1319
14	Certificate of Transcript	1325
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		

1 Proceedings taken via Videoconference for The Alberta
2 College and Association of Chiropractors, Edmonton,
3 Alberta

4

5 January 29, 2022 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

23

24

25

26

1 (PROCEEDINGS COMMENCED AT 9:08 AM)

2 THE CHAIR: Well, good morning, everybody.
3 We've got one witness I believe to examine today,
4 Mr. Kitchen, and just before we do that, Mr. Maxston,
5 anything to raise?

6 MR. MAXSTON: No, thank you for asking, but
7 I should mention, Mr. Kitchen, you'll probably speak to
8 this, but he has sent Mr. Lawrence and I his proposed
9 qualification for his expert witness, and I don't think
10 there will be an issue.

11 Mr. Kitchen, I would have responded to you, but I
12 needed to run that by my client, and I just saw it this
13 morning, so I'll let you know that in advance.

14 MR. KITCHEN: Thanks.

15 THE CHAIR: Okay, let's turn the floor
16 over then to Mr. Kitchen, and you can bring your
17 witness in, and I just remind everybody to mute
18 yourself, please, and hopefully we'll have enough
19 bandwidth today that we don't have any interruptions.

20 MR. KITCHEN: All right. So, Dr. Warren,
21 I'll just do some introductions because we have so many
22 people, and I don't know if you can see everybody on
23 the screen. I've got mine on gallery view so I can see
24 everybody.

25 The four Tribunal Members are Dr. Dianna Martens,
26 Dr. Leslie Aldcorn, those are chiropractic members of

1 the Tribunal; and then Mr. Jim Lees and Mr. Doug Dawson
2 are public members of the Tribunal. So there's four in
3 total.

4 Walter Pavlic is the lawyer for the Tribunal,
5 probably won't hear anything from him, but he's the one
6 that advises the Tribunal, so if they caucus, he goes
7 caucusing with them, and don't wonder at that.

8 Mr. Maxston is the lawyer for the -- what I will
9 refer to as the prosecutor in this case. So we have
10 the College, we have the Tribunal, those are separate.
11 The College is bringing the action against Dr. Wall,
12 and that's happening through the Complaints Director,
13 that's David Lawrence. His lawyer is Blair Maxston, so
14 he'll be the one that cross-examines you.

15 And then, of course, there's the Hearings
16 Director, you won't see her, but that's Ms. Nelson.

17 And then have our court reporter, Karoline.

18 And then of course, Dr. Wall is here. You won't
19 see him or hear him, but he's listening. And that's
20 everybody.

21 So with that, Karoline, could you please swear him
22 in.

23 THE CHAIR: Dr. Warren, just before
24 Karoline swears you in, I'll just -- we tell this to
25 everybody, Karoline is a court reporter. She's making
26 a verbatim record of the proceedings, and so we would

1 ask that you try not to speak real quickly. I have no
2 idea whether that's your speech pattern or not, but if
3 you could just keep that in mind, please.

4 THE WITNESS: Sure.

5 THE COURT REPORTER: And please wait for
6 Mr. Kitchen and Mr. Maxston to finish their entire
7 question before you answer. Do not interrupt them.
8 It's just makes the audio very difficult for me, so ...

9 DR. THOMAS WARREN, Sworn, Examined by Mr. Kitchen
10 (Qualification)

11 Q MR. KITCHEN: Dr. Warren, I just have a few
12 questions for you about your background, and then I'm
13 going to tender your qualification, and then we'll go
14 from there, so I don't imagine that it'll take too
15 long.

16 A Sure.

17 Q Dr. Warren, do you have a medical degree?

18 A I do.

19 Q And what have you done for residencies and fellowships?

20 A Sure. So I did four years of medical school at the
21 University of Western Ontario, graduated in 2005. Then
22 I did three years of residency at the University of
23 Ottawa in internal medicine. And then I did two
24 fellowships in infectious diseases and medical
25 microbiology from 2008 to 2011. So I'm Royal College
26 certified in three different specialties.

1 Q Thank you. This may come up in your questioning, but
2 I'll ask it now, can you give us an idea, just briefly,
3 of what infectious disease, what that speciality is?

4 A Sure. So I'm an infectious disease specialist and a
5 medical microbiologist. People can be one or the other
6 or both.

7 So as an infectious diseases specialist, I treat
8 patients with infections, so diseases caused by
9 viruses, bacteria, parasites, fungus. So about
10 two-thirds of my practice is clinical work, taking care
11 of patients with infections, mostly in the hospital but
12 some outpatient work as well. And then about a third
13 of my practice is more administrative-type work. So as
14 a medical microbiologist for ten weeks, I manage the
15 microbiology laboratory in the hospital that I work in.

16 I also am responsible for covering the infection
17 control service at the hospital I'm at for about ten
18 weeks a year.

19 And then my primary administrative responsibility
20 is something called antimicrobial stewardship, and so
21 that's really just monitoring antimicrobial, antibiotic
22 use within the hospital, ensuring that it's appropriate
23 and controlling its use and intervening when needed.

24 Q Excellent, thank you. Are you currently enrolled in a
25 graduate program?

26 A Yes, I'm doing a Masters in science and epidemiology at

1 the London School of Hygiene & Tropical Medicine, which
2 is part of the University of London, England, and I'm
3 in my fourth year, so I should finish later this year.

4 Q Thank you. Do you teach in any capacity?

5 A Yeah, I have an adjunct appointment at McMaster
6 University as an assistant clinical professor, and so
7 in my ten years of full-time practice and my eight
8 years of my appointment with McMaster, I've had all
9 levels of learners from medical students, first-,
10 second-, third-year medical students, all the way up to
11 infectious diseases fellows.

12 Q Now, I know you mentioned you work at the hospital, but
13 could you tell us in more detail what your current
14 occupation is?

15 A Like as an infectious diseases specialist?

16 Q Yes, yeah, exactly, we want to know --

17 A So --

18 Q -- about just what that actually looks like.

19 A Okay. So I have hospital privileges at Halton
20 Healthcare Services, which is a medium-size hospital
21 just west of Toronto. It has three campuses, an
22 Oakville campus, a Milton, and a Georgetown campus.
23 And so I am oncall for 17 weeks a year for infectious
24 diseases, which is 24/7 call, can be quite busy.

25 And then other than that, as I said, I have a fair
26 amount of administrative responsibilities, which is

1 basically the rest of my time, apart from vacation and
2 being oncall. And then I have a small outpatient
3 practice, which would involve things like hepatitis C,
4 latent tuberculosis, HIV management.

5 Q Thank you. Are you a member of the CPSO?

6 A I am.

7 Q Have you been an expert witness in legal proceedings
8 before today?

9 A Yes, I have.

10 Q And have you prepared other expert opinion reports
11 regarding SARS-CoV-2 and/or COVID-19?

12 A Yes. I prepared I think nine expert reports in five
13 provinces for -- regarding COVID-19 for SARS-CoV-2.

14 Q Thank you.

15 MR. KITCHEN Those are all my questions.

16 Mr. Maxston, did you want to ask any questions
17 before I tender the qualification I want?

18 MR. MAXSTON: I don't think so, Mr. Kitchen.
19 Thank you.

20 MR. KITCHEN: Chair, I want to qualify
21 Dr. Thomas Warren as an expert in the areas of
22 infectious diseases and medical microbiology, in
23 particular, SARS-CoV-2, COVID-19, and the efficacy of
24 masking, physical distancing, and other restrictions
25 intended to prevent transmission of SARS-CoV-2.

26 MR. MAXSTON: Mr. Chair, as I mentioned

1 before, Mr. Kitchen provided this to me and my client
2 in advance, and we're not going to object to it.

3 I will repeat our prior comments with respect to
4 Dr. Wall's expert witnesses that we, again, don't
5 believe this is a hearing about mask efficacy and
6 social distancing, et cetera. We've placed that same
7 qualifier for all of Dr. Wall's witnesses as we have
8 before.

9 MR. KITCHEN: And I'll provide the same
10 response: It's borderline nonsensical to say such a
11 thing when the Complaints Director has submitted an
12 expert on the very issue of masking from a scientific
13 and medical perspective, and that was in response to
14 Dr. Wall's experts. So I understand my friend wants to
15 continue to fill the record with that, but I guess I'm
16 going to have continue to fill the record with saying
17 that I don't understand how it makes any sense to say
18 so.

19 THE CHAIR: You're both on the record on
20 that point, so I don't think we need --

21 MR. MAXSTON: And, Mr. Chair, I'm sorry, I
22 just want to make one comment, I've said this before
23 and I'll say it again, we called an expert because
24 Dr. Wall was calling experts, and we didn't introduce
25 Dr. Hu at our own initiative. It was to respond to
26 what we understood would be expert testimony, so I just

1 wanted to be clear about that. We didn't introduce
2 Dr. Hu for anything other than to rebut the expert
3 witness testimony from Dr. Wall. We've covered this,
4 but I wanted to mention that.

5 THE CHAIR: Let's get back on track and
6 deal with Dr. Warren. I just had one question I would
7 like to ask Dr. Warren.

8 The Chair Questions the Witness (Qualification)

9 Q THE CHAIR: Good morning, sir, thank you
10 for joining us.

11 A Morning. Thank you.

12 Q I was just looking at your résumé and your cv, and I
13 noted that peer-reviewed publications, the last one is
14 noted as 2015. Have you shifted your focus away from
15 research in the last few years?

16 A Yeah, usually most people in academia have either one
17 of two streams: One is research-based or
18 teaching-based. And so my appointment with McMaster is
19 a teaching-based appointment.

20 THE CHAIR: Thank you for clarifying that.

21 Ruling (Qualification)

22 THE CHAIR: Okay, I don't know that
23 there's a need for us to caucus to consider approving
24 Dr. Warren as an expert witness in the fields noted.
25 The College has no objection.

26 So, Mr. Kitchen, I'll ask you to continue with

1 your direct examination of Dr. Warren.

2 MR. KITCHEN: Thank you.

3 DR. THOMAS WARREN, Previously sworn, Examined by
4 Mr. Kitchen

5 Q MR. KITCHEN: Dr. Warren, just going to
6 start with a couple standard questions. Do you know
7 Dr. Curtis Wall personally?

8 A No.

9 Q Do you have any financial interest in the outcome of
10 this case?

11 A No.

12 Q And do you understand your duty today to provide this
13 Tribunal with your expert knowledge and opinions in an
14 objective and neutral manner?

15 A Yes.

16 Q And then the last thing is this: Do you understand
17 that if and when, in the likely event we're going to
18 have a break, you and I are not permitted to speak
19 until your testimony is done?

20 A Yes.

21 Q All right, well, I'm going to start with your report.
22 In the second section of your report, and that starts
23 on page 1, you identified three factors that are
24 driving SARS-CoV-2 transmission and mortality and state
25 that those factors are, quote, non-modifiable. Now,
26 I'm going to ask you about the factors, but, first,

1 could you please explain what "non-modifiable" means?

2 A "Non-modifiable" means that they can't be changed. For
3 instance, I speak about a person -- or a person's age,
4 you can't change someone's age or you can't change the
5 age structure of a population. So non-modifiable means
6 it cannot be changed by some sort of intervention.

7 Q The first non-modifiable factor you discuss is the
8 timing of peak virus transmission or wave of
9 transmission. You say the timing is primarily affected
10 by seasonal patterns. First, I want to ask you, since
11 your report is almost a year old now and we're two
12 years in experiencing this with SARS-CoV-2, has your
13 opinion in this regard changed in any way since
14 drafting this report?

15 A It only changed in that I'm more certain of it. In the
16 last nine or ten months since I wrote my report,
17 there's been even much more accumulating evidence to
18 show that SARS-CoV-2 is similar to essentially every
19 other respiratory -- important respiratory infection in
20 humans, in that it follows a seasonal pattern. We can
21 just even see that in our Canadian data that -- and I
22 mentioned it in my report, but other Coronaviruses have
23 their peaks in January, and across Canada, this
24 January, 2022, we have another peak of SARS-CoV-2.

25 Q Now, I know you cited to a lot of literature in your
26 report, of course, and you just said that there's even

1 more literature since, but can you give us an idea of
2 what is that literature that supports your position?
3 Just a -- I know you can't go into every study, but
4 please give us an idea of what that literature is.

5 A Specifically about seasonal patterns?

6 Q Yes.

7 A Yeah, so I quoted, I don't know, probably about a dozen
8 studies or so, yeah, at least seven or eight, that
9 talked about or showed that SARS-CoV-2 follows a
10 seasonal pattern, which was fairly early, because by
11 the time I wrote the report, it had only been around
12 for just over a year, I think 15 months.

13 And so similar to those studies, there have been
14 more studies looking at the timing of SARS-CoV-2 in
15 different jurisdictions. So some of the studies I
16 quoted were country-specific, others were global. And
17 those similar types of studies, because we have one
18 more year of data have continued to accumulate and been
19 published in the peer-reviewed literature.

20 Q These are peer-reviewed academic articles, is that a
21 good way to describe them?

22 A Correct.

23 Q And can you explain how or why these seasonal or
24 cyclical patterns are, in fact, non-modifiable?

25 A Well, the weather is non-modifiable, and so we know,
26 for instance, with influenza, that it kind of usually

1 starts in the southern hemisphere and moves to the
2 northern hemisphere. Maybe potentially the time of
3 year or the exact time in the winter, the colder
4 season, when the peak occurs might be different, might
5 be December one year, might be January the next or
6 February, but it's always kind of in the winter months
7 in the northern hemisphere.

8 And so the climate and the temperature is not
9 something that can be changed, and that affects
10 multiple things. It affects how often people are
11 inside. It affects transmissibility, because the
12 relative humidity in the air affects water droplets,
13 which is, you know, aerosol droplets is one of the --
14 the primary way that SARS-CoV-2 and many other
15 respiratory viruses are transmitted. So those type of
16 factors can't be changed, but we're going to have a
17 winter in the northern hemisphere every year around the
18 same time, you know, between November and March, and so
19 we can expect a peak of respiratory viruses to occur in
20 that time frame.

21 Q So the theory that lockdowns or restrictions work based
22 on the theory of being able to modify that or being
23 able to work notwithstanding that?

24 A The main -- well, the main purpose, I guess, of
25 lockdowns would be to reduce the frequency of contacts
26 and then, therefore, infection, with the goal, you

1 know, it's usually the stated purpose of not
2 overwhelming health care capacity.

3 But in my second point, I talk about population
4 density. And the number of infections in a
5 geographical location is primarily going to be
6 influenced by population density, and I give an example
7 of New York. Like in the first wave, there was a huge
8 number of infections in New York City, because it's so
9 population-dense, and you can't change that. You can't
10 take 8 million people in New York City and put them in
11 upstate New York, distribute them along upstate New
12 York. So you're still going to have 8 million people
13 in a small number of burrows in New York City, and even
14 though there's a lockdown, you still have large
15 apartment buildings with people in very close quarters.
16 So you're not modifying the population density, which
17 is the most important factor.

18 Q So the idea behind restrictions is not that
19 restrictions can change that factor but that
20 restrictions can work notwithstanding the presence of
21 that factor?

22 A That's the idea. The idea would be by having a
23 lockdown restriction, you're reducing the number of
24 people that you would come in contact with and,
25 therefore, the number of potential infectious contacts
26 or the statistical risk of someone being infected.

1 What I'm arguing in this and what I think some of
2 what the literature clearly shows in the studies that I
3 quoted is that it has a negligible effect in a place
4 that is already population-dense.

5 And so you have a rural location, those people
6 already are going to come into contact with much fewer
7 people. Let's just say, you know, give a number of 8
8 or something per day, whereas you have a
9 population-dense place like New York City, I'm just
10 throwing it out there, but you have people on a random
11 day coming into contact with 80 people, you know what I
12 mean.

13 And lockdown is modifying that slightly, like
14 you're taking in a rural location, 8 down to 5, and
15 then New York City, 80 down to 60. You still have a
16 very population-dense area. When you go out to buy
17 groceries in New York City, you're passing by lots of
18 people, and so you can't modify that population
19 density. And that, as I showed in the studies I
20 quoted, is a very important factor to predict the
21 number of infections in the current wave.

22 The timing is going to be predicted by season.
23 The number of infections is going to be predicted by
24 population density, and the mortality is going to be
25 predicted by the age structure.

26 Q So is part of the reason why we keep getting wave after

1 wave after wave because the cyclical pattern just can't
2 be stopped even by intense interventions?

3 A Yeah, SARS-CoV-2 is now the fifth seasonal Coronavirus.
4 There have been four prior to SARS-CoV-2, and now it's
5 the fifth. And it will continue to cause infections
6 and waves in a seasonal pattern just like the other
7 four do.

8 And so just like we can't prevent influenza or
9 other seasonal Coronaviruses, we can't prevent the
10 waves on a population level, we're not going to be able
11 to prevent SARS-CoV-2 waves. We haven't been able to
12 in the past two years, and we won't be able to going
13 forward.

14 Q So at this point in time, are any attempts, any human
15 attempts to try to stop SARS-CoV-2 from continuing as
16 the fifth Coronavirus, are they just futile?

17 A Yeah, to stop it circulating within the community like
18 globally, yeah. Like trying to stop it, the whole
19 notion of zero COVID makes no sense. It can be done
20 for short periods of time in places like New Zealand,
21 which can -- are literally in the middle of the ocean
22 and can hibernate themselves from the rest of the
23 world. But even there, you see places like Australia
24 that were able to maintain that for periods of time,
25 but now it's circulating in Australia like anywhere
26 else in the world.

1 And so, yeah, it would be utterly futile to say
2 that we tried to stop the circulation of SARS-CoV-2
3 right now, like on a global level within the community.

4 Q So even if an entire nation went into, you know, a
5 complete, you know, locked in your house kind of
6 lockdown for a year on end, it wouldn't matter, because
7 as soon as you lifted that, Coronavirus would come in;
8 is that what you're saying?

9 MR. MAXSTON: Mr. Kitchen, I'm sorry, I
10 don't want to interrupt, but I got the sense on the
11 last three or four questions that there's a lot of
12 lead-in, and I don't want to cramp your style here, but
13 I think there's a lot of lead-in on some of these
14 questions. I wonder if you could consider maybe
15 rephrasing them a little bit.

16 MR. KITCHEN: That's fine.

17 Q MR. KITCHEN: Dr. Warren, just give me a
18 second; you've already answered so many of my
19 questions.

20 So let's talk about the -- I mean, you've already
21 touched on this, but let's talk about the third factor.
22 And I think I understand this better now, you say the
23 third non-modifiable factor is just how old people are.
24 But the first question I have for you to help us
25 understand is what is infection fatality ratio?

26 A Okay, let me just bring that up here on my report.

1 Q Yeah, it's on page -- end of page 2, it's the third
2 portion of that section.

3 A So the infection fatality ratio, so that's the number
4 of people with the infection that died or the
5 percentage. It's a ratio, so it would be a percentage.

6 Q And do you have any idea roughly what that is right now
7 with COVID?

8 A It's unchanged from what I say in my report. So in my
9 report, I say that persons over 80, the IFR is
10 approximately a thousand times greater than the IFR in
11 those under 20, and so the age of a patient is by far
12 the most predictive measure of the risk of mortality.

13 Q In your opinion, is the IFR of people above 80 more
14 relevant than the overall IFR?

15 A Well, I think the IFR in any age group is going to be
16 important, so if we look at -- if we compare the
17 mortality risk in persons under 20, I think that helps
18 shape policy for that age group, so that's school-age
19 people. And we know and it's clear from the literature
20 now, it was when I wrote my report, but it's much
21 clearer now, that the actual risk of death from
22 SARS-CoV-2 infection is lower for that age group,
23 persons under 20, than for seasonal influenza.

24 And so when you're considering policy in that age
25 group, that's important to look at. It's also
26 important to look at what the IFR is in other age

1 groups as well, but it's important to be able to break
2 that down. And so, likewise, when we look at the IFR
3 in persons over 80, that helps us form a policy for
4 that age group, whether it's care homes, nursing homes,
5 retirement homes. It matters what the IFR is in other
6 populations, but it's very helpful to break it down,
7 because each age group and demographic is going to have
8 different policy implications, because policy
9 implications for a school should be very different than
10 a policy implication for a nursing home.

11 Q We've heard in the proceedings so far that the IFR
12 overall for all age groups for COVID is about 0.15 or
13 less now, but what we've heard, at least at one point,
14 it was 0.15. Do you have any reason to agree with that
15 number?

16 A No, that's roughly accurate. I would say it's probably
17 lower now, having gone through the Omicron wave.
18 Omicron has been much less severe with regards to
19 mortality. There are various factors regarding that,
20 but, yeah, that number is roughly accurate. Again, it
21 really depends. When you talk about an IFR in a
22 sub-Saharan African country, which has a much lower
23 population, it's going to be quite different.

24 So in statistics, we use age -- like there's a way
25 of age-standardizing when you compare different
26 countries, and that would always have to be done when

1 you compare or when you discuss these things, because
2 if you calculate an IFR of the Canadian population,
3 without age-standardizing it and then comparing it to
4 another country like say Nigeria, which is much
5 younger, you're comparing apples to oranges. And so
6 there's clear statistical methods if you want to do
7 that comparison.

8 And so generally, when you talk about an IFR
9 overall globally, well, then you have kind of
10 standard -- well, what's your standard population
11 scale, and then you normalize it to that. So it's not
12 an easy answer, but that's a roughly good ballpark
13 number, but I would say it's maybe slightly lower now.

14 Q Okay. So if I'm understanding you, in sort of
15 nonscientific language, the more old people you have in
16 your society, the higher the IFR in that society?

17 A Yeah, absolutely. If you're calculating it just based
18 on your country, yeah.

19 Q And it's lower in Nigeria because they have less old
20 people?

21 A Yeah, the age structure is different. So the
22 proportion of, say, persons in over 70 in a younger
23 country, and that would often be countries in
24 sub-Saharan Africa or different places in Asia, it's
25 going to be different, yeah.

26 And people discussed this with regard to the

1 Omicron wave in South Africa, because the South African
2 population is quite a bit younger, and so people
3 rightly said, okay, well, we need to compare apples to
4 apples here, rather than apples to oranges. And there
5 are standard statistical ways of kind of doing that
6 comparison. There -- and I won't get into that, but
7 you can still do it.

8 Q So when I look at your report, you say 95 percent --
9 we're in Canada -- 95 percent of deaths are in persons
10 over 60. So do I understand correctly then that 95
11 percent of what contributes to that overall IFR of 0.15
12 is from people over 60?

13 A That's right.

14 Q So if we took those people out of the equation, instead
15 of 0.15, we'd have something that might look like
16 0.00000 et cetera; is that accurate?

17 A Yeah, it would be -- if you look at the IFR of only
18 persons 60 and under, it's substantially less, yes,
19 that's right.

20 And again -- and then -- you know, it's
21 affected -- there are other factors, right? There are
22 comorbidities, and, you know, the CDC had a good study
23 just recently that was published that just -- that
24 looked at both age but then comorbidities as well. The
25 risk of death increases significantly when you go from
26 zero to one comorbidity and then to two and then to

1 three.

2 So you have someone who is over 80 with, you know,
3 two or three comorbidities, their risk of death is very
4 high and substantially higher than -- orders of
5 magnitude higher than someone, you know, much younger
6 with no comorbidities. And, you know, statistically,
7 it's closer to zero once you get below a certain age
8 with no comorbidities; it's for all intents and
9 purposes zero.

10 Q Okay. So the IFR differs dramatically over age groups
11 then?

12 A Yes.

13 Q Now, and this has been a big issue in this hearing, the
14 overall IFR, was it ever much higher than this 0.15
15 figure even in the beginning?

16 A Well, it's changed, so if you -- it can be tracked over
17 time, and what you'll see is that, very early on, it
18 was very high because the number of infections detected
19 was much lower very early on because testing was
20 limited, but quite soon after the first wave, the IFR
21 came down significantly.

22 So if you look at the very beginning when people
23 were (INDISCERNIBLE) in the spring of 2020, it was
24 quite high, but over time -- I mean, you could -- there
25 are graphs of this, but over time, the IFR has been
26 going down and down and down, and actually, you know,

1 quite significantly dropped in the Omicron wave,
2 because you have a whole bunch of infections but
3 relatively fewer deaths, and so it's been going down
4 over time.

5 Q That IFR rate early on, so let's say early 2020, is
6 that a highly reliable figure?

7 A No, because it was -- in statistics, you know, we talk
8 about things like bias, like so that would be selection
9 bias. And so early on, it was only the most evident,
10 so symptomatic, the sickest who were being tested, and
11 so you had a selection bias early on.

12 But as with -- in most things in statistics, the
13 larger sample size, the more accurate it's going to be.
14 And so now that we've got, you know, hundreds of
15 millions of cases worldwide that we can reliably make a
16 much better estimate as to what the true IFR is.

17 Q Is it possible that, in early 2020, a very large number
18 of people were infected, but nobody really knew about
19 it?

20 A Yes. It's hard to know that for sure, because there
21 are a number of different factors, one of which just
22 being limitations of testing, particularly in different
23 places in the world.

24 Even in our institution, I remember for the first
25 few weeks at least, if not longer, like we had quite
26 significant limitations on who we could test, who we

1 could only run a certain number of tests per day. But,
2 yeah, there have been other studies that have been done
3 subsequently to say and estimate at least how many
4 other infections are there apart from the ones that
5 we've actually picked up with positive testing, for
6 instance.

7 The estimates varied from, again, the country and
8 various separate testing procedures or protocols, or,
9 you know, who can be tested, who not. Because even
10 here in Ontario, we've changed who's going to be
11 tested. Our Chief Medical Officer of Health says
12 that -- now said, you know, if you have minor symptoms
13 and, you know, are otherwise healthy and stuff, you
14 don't necessarily have to be tested, you just assume
15 you have COVID and stay home. So over time there has
16 been changes to testing protocols and stuff, and so
17 that's going to change how many people are actually
18 detecting.

19 So certainly very early on, there would have been
20 a fair number of people who had the infection but were
21 not detected, because we know the asymptomatic rate is
22 about 10 to 20 percent as well, I said that as well.
23 So at least early on, unless they were close contacts
24 and similarly infected, they probably weren't being
25 tested.

26 Q Now, obviously any IFR is, I guess, concerning or

1 upsetting, because that ultimately means people die,
2 but can you help us understand, give us a figure of
3 what would be considered in the medical community as a
4 dangerously high IFR?

5 A Well, you know, that's a bit of a tricky question, but
6 like I think what we're seeing now, I think one of the
7 important things to say with regards to the IFR of
8 SARS-CoV-2 is that, overall, what we're seeing is that
9 the IFR is approaching seasonal influenza, and seasonal
10 influenza varies quite a bit from year-to-year, and
11 some years are very bad, other years aren't.

12 And actually they're related, because what happens
13 is if you have a bad flu year, because many elderly
14 people, no matter what, are -- in the end, are going to
15 die of a respiratory tract infection. Canada's
16 greatest physician, William Osler, kind of referred to
17 it as -- respiratory infections, at least overall, as
18 the old man's friend. It was just kind of something
19 that just took off the elderly. So whether it's
20 bacterial pneumonia, influenza, Coronaviruses, the
21 frail elderly and, you know, with heart disease or
22 cancer or other things that have debilitated them, it's
23 the heart disease or the cancer that's debilitated
24 them, but the thing in the very end, the last few days,
25 that they might actually die of, is going to be a
26 respiratory tract infection. And so it's very common

1 in that age group.

2 And so influenza, we know that if you have a bad
3 influenza year, the next year is often going to be
4 light, and one of the reasons is that the previous
5 severe season has, unfortunately, killed many of the
6 most vulnerable, and so you've now removed a good
7 proportion of the most vulnerable from the population,
8 and so the next year, the flu, at least in that
9 population may be -- the IFR at least may be relatively
10 low. And so there's multiple different factors going
11 on here.

12 But what we're seeing is that now, overall, the
13 IFR of SARS-CoV-2 is approaching and very similar to
14 seasonal influenza.

15 Q So when you say a bad year, so the IFR for influenza
16 fluctuates then?

17 A Absolutely from year-to-year. So you -- and during
18 pandemic years, the IFR is going to be very high. So
19 if we're just talking about 1919 to 1920, like the 18
20 months from late '17 to, you know -- or late 2018 to
21 2-thousand -- or, sorry, 1918 to 1920, during the
22 Spanish the flu, the IFR would be huge, but there are
23 other years when influenza IFR is quite low. And so
24 you can talk about it on a yearly basis or a strain
25 basis, or we can talk about it over years or decades.
26 And if we kind of generally talk about it over years

1 and decades, then the IFR of SARS-CoV-2 is now
2 approaching the IFR of influenza.

3 But, yes, the estimated mortality of influenza
4 year-to-year can change by two or three times in a
5 season even in Canada. And, again, that's affected by
6 multiple factors. One of the factors, as I said, is
7 the previous year and the proportion of vulnerable
8 people, but it's also going to be the natural mutation,
9 the strains of influenza. We would call them strains.
10 Now, you know, we call them for SARS-CoV-2, it's
11 variants, but it's the exact same process. It's
12 natural mutation of a respiratory virus.

13 Q Right, but you used the word "pandemic" in describing a
14 bad influenza year. Are you aware of what number,
15 what -- you know, the IFR we know for low influenza
16 must be somewhere around 0.15, but what's the number,
17 roughly, for a bad influenza year or a pandemic
18 influenza year? What's the IFR rate? I mean, you
19 know, it could be 50 percent, it could be 25 percent.
20 You know, we don't know because we don't look at this
21 on a daily basis, and so I -- you know, it would be
22 very helpful to have some sort of number to work with.

23 A Yeah, I don't know the exact number for Spanish flu,
24 but the most kind of reasonable estimates for the
25 Spanish flu is that between 50 and 75 million people
26 died, so we're talking an IFR in the global population

1 was not that high, so we're talking an IFR of at least
2 1 percent in that case, if not higher.

3 Q Okay, so 1 percent is high?

4 A Well, it would be -- you know, I think the global
5 population at that point was about 2 billion, so we're
6 talking an IFR probably at that time of about 2
7 percent. Yeah, and these are just rough estimates. I
8 know that the most conservative estimates of the
9 mortality was about 50 million, so that's an example.

10 Q So has the IFR of COVID ever exceeded the IFR of a bad
11 flu year?

12 A Yeah, certainly early on. And with different variants
13 and as it starts to circulate, it's -- it doesn't
14 happen all the time, but the general way a virus
15 circulates is that it attenuates as it goes through a
16 population. So SARS-CoV-2 was a new virus in the human
17 population, and there's some cross-protection from
18 seasonal Coronaviruses, there's some cross-immunity,
19 but because it's a new virus, early on, it's going to
20 be more severe.

21 But what we've seen, especially with the Omicron
22 variant, and what happens with many new virus
23 infections within a population is that they attenuate
24 over time, because it's to the evolutionary advantage
25 of that virus to do that, because it infects more
26 people.

1 Just like one of the reasons we don't see massive
2 Ebola outbreaks is because it kills too many people too
3 quickly, and so it just burns itself out.

4 So we saw that with the Spanish flu. The flu we
5 have now is a descendant of that flu. And what
6 happened is, over time, the virus itself attenuated
7 itself, so as it just started passing through just
8 millions of people, it became less severe. And one of
9 the reasons for that is that -- a virus -- the
10 evolutionary advantage for a virus is to find kind of
11 that balance between causing some disease but not
12 killing the people too quickly, and so we've seen that
13 with SARS-CoV-2 as well.

14 It would be expected. It's not unexpected at all
15 for a variant like Omicron to occur, because Omicron,
16 for a variety of reasons, but one of the primary ones
17 it that it has less severity, infects way more people,
18 and that's expected.

19 Q Okay, you said early on -- I need you, if you can, to
20 try and give me months and years -- so what would be --
21 you said, you know, it was severe early on, well, when
22 was that, and when did that period end?

23 A Well, we know, looking at the variants that there was a
24 variant, even -- I don't know if I referenced it in my
25 report, but there was a variant even just within the
26 first few weeks of the pandemic that quickly switched.

1 I can look up the name. It wasn't given a name like
2 Alpha, Beta, or Delta and stuff. It was given a name
3 based on the base pair change. It was 'D' something,
4 something, changed to 'G' something, I think. It was
5 where the mutation was. So as the variants changed,
6 they're going to have different IFRs, and we've kind of
7 seen that. It does seem as though Delta was a little
8 more severe than, say, Alpha. But that change started
9 very early on, within weeks, and then we started seeing
10 things like Alpha and then Delta and now Omicron.

11 And so very early on, the IFR is going to be high,
12 because the most -- again, various reasons, but the
13 most susceptible are going to be dying, and then once
14 you eliminate those -- the most frail and -- who have
15 been infected from the population, you also have a less
16 frail population, and so that's one reason. I don't
17 want to oversimplify it here. One is inherent to the
18 virus itself. There's a difference between Delta and
19 Omicron, and so the IFR is going to change between the
20 variants, but the population itself is going to change.
21 And so if you have a complete naive population early in
22 the pandemic, that's going to change once the first
23 wave goes through, because, all of a sudden, the
24 frailest population are no -- are, unfortunately, no
25 longer in the population because they've died, and so
26 you have a population change. And these are just two

1 factors.

2 It's complicated. I think one of the risks, at
3 any point, is oversimplifying, but those are two very
4 important factors.

5 Q Thank you. When did the first wave end roughly in
6 Canada?

7 A Well, would have been the late spring of 2020, and I
8 don't have the graphs ahead of me, but I certainly
9 think by May absolutely.

10 Q At what point did the data indicate that the IFR was no
11 longer severe or high or whatever word you want to use?
12 You used the word "severe"; at what point did the data
13 indicate that the IFR was no longer severe?

14 A Well, it was within a couple months as we gathered more
15 data. By the end of the first wave, the idea of the
16 dramatic difference in mortality between the young and
17 the old was evident, and by the end of that first wave,
18 you know, within the first kind of three months, we had
19 a rough estimate at that point of what the IFR would
20 be, and then since then, it's been just trending down.
21 Again, as more and more people get infected, and,
22 unfortunately, the -- you know, the oldest, the
23 frailest have already died, the IFR has been trending
24 down.

25 Q Would you say the official definition of a pandemic is
26 objective or subjective?

1 A Well, I think any definition, you know, you can get
2 pedantic about it, but SARS-CoV-2 is clearly a
3 pandemic. Some people define it as, you know,
4 affecting multiple continents. Some people will argue
5 the first pandemic was the Antonine plague in the '160s
6 because it occurred in Africa, Europe, and Asia. And,
7 at least based on the records we have, we don't know of
8 any other infection before then that occurred on three
9 different continents. So it depends on how you define
10 your terms, but I think it's clear that SARS-CoV-2 is a
11 pandemic; there's no doubt about it.

12 Q Is it pandemic because it's "pan" because it's global?

13 A Well, yeah. It comes from -- you know, "pandemic" just
14 comes from the Latin root of "pan", which is all, and
15 "demus", which is people, and so it's all people.
16 We've seen that. Like it's even on Antarctica. I
17 think this is the first pandemic in history that's been
18 on all seven continents.

19 Q Is there no severability criteria for determining
20 something is or is not a pandemic?

21 A Yeah, you know, I think for something like seasonal
22 influenza, you have global infections every year, you
23 have waves every year, and so you would talk about
24 severity, so we would have a pandemic when -- in the
25 scientific literature about influenza, we talk about
26 antigenic drifts, which is the small changes that occur

1 year to year, and then antigenic shifts, which is the
2 major changes.

3 And, generally, when there's an antigenic shift,
4 we have a pandemic because we have a significant change
5 in the virus, which then you have a large proportion of
6 the population which don't have good cross-reactive
7 immunity. And so whether it's swine flu in 2009 or
8 previous pandemics in the 20th century, like 1968 and
9 there's been others, but at least in influenza, yeah,
10 it's not occurring on -- everywhere in the world,
11 because that occurs every year, but it's a major change
12 that increases the symptomatic infectivity, so
13 morbidity as well as mortality.

14 Q So some years, influenza is severe enough to be
15 pandemic and other years, it's not; do I have that
16 right?

17 A Correct, yeah.

18 Q So you said that COVID was severe enough in the
19 beginning to be, you know, at least as bad as a
20 pandemic influenza, but is it now at the point of
21 seasonal influenza? Is that a proper way to
22 characterize it?

23 A Yeah, once it becomes endemic, that's a good question.
24 Again, some of the definitions are going to be
25 arbitrary. You'll talk to some experts now who will
26 say, oh, COVID's already endemic, others will say no.

1 You know, a lot of people will say, okay, with Omicron,
2 that's what we're seeing now, it's endemic, we have so
3 many people infected. And others will say, well, no,
4 we can't call it endemic.

5 There's essentially uniform agreement that it will
6 be endemic, it's just kind of defining where that's
7 going to be is somewhat arbitrary. But, yes,
8 SARS-CoV-2 will be endemic, and whether you want to say
9 that that's now or whether it's going to be three, six
10 months from now, it's I think relatively arbitrary how
11 you say it. It was pandemic; it's going to be endemic.
12 Where you define that cutoff, I don't think it's easy
13 to kind of say one particular --

14 How I would define is that we start seeing a
15 different respiratory virus predominantly, because we
16 haven't seen massive waves of influenza, and that's not
17 unusual. So like in the hospital, we see different
18 respiratory viruses at different times, and so we have
19 a usual wave of influenza, say, in January, it's after
20 influenza leaves that we're going to see some of the
21 other important respiratory viruses in the waves of,
22 say, parainfluenza or human metapneumovirus.

23 And how I would define the endemic state of
24 SARS-CoV-2 is once we start seeing the return of waves
25 of other important respiratory viruses, maybe it's in
26 the spring with human metapneumovirus, I don't know,

1 but once that occurs, when we're having more cases of a
2 different respiratory virus, I think we can safely --
3 to me, that's an objective criteria of how to kind of
4 define the endemicity of SARS-CoV-2.

5 Q At what point in time did you become confident that
6 SARS-CoV-2 was going to be endemic?

7 A Once you have community transmission on every
8 continent, yeah. So it would have been within weeks of
9 the pandemic.

10 Q Okay, but just to clarify then, that would place you in
11 January 2020?

12 A No, no. Like early April 2020.

13 Q Okay, so just to clarify, by early April 2020, you
14 looked at the data and thought this is going to be
15 endemic?

16 A Yeah, absolutely.

17 Q So at that point, attempts to completely stop the virus
18 are futile?

19 A Yeah, absolutely.

20 Q At that point, were attempts to slow it down
21 theoretically possible to work?

22 A No. I think each different thing can be judged based
23 on the evidence, and that's what I do in my report. I
24 think most interventions had little or no effect, and
25 the evidence is bearing that out. We know that from
26 previous similar infections and -- but each different

1 intervention would have to be judged on its own merits,
2 so whether it's masking or lockdown, kind of
3 shelter-in-place, or, you know, testing in isolation,
4 each of those factors can be judged on its different
5 merits. But I think what we've clearly seen is that
6 the interventions put in place have not had a
7 significant effect.

8 Q And you do realize that many people say that they have
9 had a positive effect?

10 A Yeah.

11 Q And you disagree with them; is --

12 A I do.

13 Q -- that fair to say?

14 A Yeah.

15 Q And now, generally speaking, correct me if I'm wrong,
16 but at least in Canada, aren't the vast majority, if
17 not all, you know, public health agencies and
18 government bodies and medical officers of health saying
19 that, look, these measures did work over the last two
20 years; isn't that right?

21 A Yeah, there's lots of people claiming that, but it can
22 be debated endlessly as to what actual effect they did
23 or did not have.

24 Q Well, at least for you personally, is there a debate
25 happening?

26 A Yeah, there's actually really starting to be a debate

1 both in society generally but in the academic
2 literature as to what effect these different measures
3 had or didn't have, and again each one needs to be
4 judged based on the merits of each different
5 intervention.

6 But, yeah, both in the general public, I think,
7 globally, we're seeing an openness to debating and
8 seeing what the actual risk and downsides have been to
9 each individual intervention, but we're seeing that in
10 the academic literature as well.

11 Q In your experience, have the public health agencies and
12 medical officers of health in Canada been open to
13 having that debate.

14 A You know, I think most of the public health agencies in
15 Canada have had similar strategies and have not kind of
16 differed too much from themselves. I think if you look
17 at somewhere like Europe or the United States, which
18 have similar numbers of jurisdictions, a few dozen
19 jurisdictions in each of them and there's been wide
20 differences, and so looking at different states and
21 comparing them and looking at different countries in
22 Europe and comparing them can be helpful. But, again,
23 that has to be done carefully, because, as I mentioned
24 in my report, just doing that is the lowest level of
25 evidence, and it kind of commits the ecological fallacy
26 in statistics.

1 But, anyway, I do see quite a change in, you
2 know -- for instance, right now, a big debate, you're
3 seeing it in all sorts of media, whether it's the
4 New York Times or The Atlantic but also in the academic
5 literature just this week about, you know, masking
6 school age children. Like the New York Times and The
7 Atlantic, you know, having articles this week, it's
8 just been in the last few days, saying, yeah, the
9 evidence just isn't there, you know, we don't need to
10 be masking young school age children in schools. And
11 we're seeing these kind of studies come out in the
12 medical, the academic literature as well.

13 And I think what happened in the past is that, in
14 the absence of a lot of that evidence, assumptions were
15 made, and we -- you know, the term for that is called
16 medical reversal, and it's very difficult, once
17 assumptions are made, to reverse kind of course, and so
18 you're gathering a lot more information now and seeing
19 both the risks and benefits of various different
20 interventions.

21 Q You just talked about how, once assumptions are in
22 place, they're very difficult to reverse or change;
23 does that help to explain why the public health
24 agencies in Canada sort of refused to listen to experts
25 like you and cease the restrictions?

26 A Yeah, you know, there are many different reasons for

1 why things occurred, yeah. You know, that's a whole
2 other topic, why one group was listened to and one not.
3 But that evidence is accumulating now, and so that's
4 why you're seeing a lot of jurisdictions treat this
5 very differently. Once that evidence is becoming more
6 and more clear, more and more robust, you're seeing a
7 lot less restrictions.

8 Q Those assumptions you mentioned, are they, for the most
9 part, false or wrong or inaccurate?

10 A Well, again, it really depends on what you're talking
11 about I think. If you talk about, say, again masking
12 children, there's next to no studies in that. We can
13 talk about studies in masking adults. The masking of
14 healthy children, there was just no studies prior to
15 the pandemic, but the assumption is, well, masks are
16 good for health care workers in high-risk settings,
17 they must be good for children.

18 And as evidence accumulates, there should have
19 been more. There -- no randomized control trials of
20 children were done in the pandemic when they should
21 have been, they should have done cluster-randomized
22 trials of different schools and classrooms, just like
23 they did the cluster-randomized trial in Bangladesh,
24 and then we could have quantitated. But the assumption
25 was made, oh, they must be good, so we're going to do
26 it, but then as the evidence accumulates, we learn more

1 that there is no benefit, and so we shouldn't be doing
2 it.

3 In fact, there's lots of harms with regards,
4 particularly, with emotional and cognitive learning in
5 children if you mask both the children and the
6 teachers.

7 Q Now, I'm going to ask you a little bit about one of
8 those assumptions, and that's asymptomatic
9 transmission. So this is on page 3 of your report, the
10 third section. You say in your report that the rates
11 of transmission from asymptomatic persons is
12 substantially less than from symptomatic persons. So
13 the first question I have for you, of course, is has
14 the data or your opinion changed on that in the last
15 year?

16 A No, it has not changed.

17 Q Now, what do you mean by "substantially less"? Give us
18 an idea of how much less asymptomatic transmission is
19 than symptomatic.

20 A Well, I note a number of studies, but I think the most
21 important one would be study 53, because it's a
22 meta-analysis of household transmission, and household
23 transmission is, by far, the most important location of
24 transmission. So some estimates are as high as 80
25 percent of all transmission occurs within the
26 household, and that makes sense, this is where people

1 are in intimate contact with each other. So this study
2 I think is very helpful and very reliable.

3 So it's looking at household transmission, which
4 is the most important factor or place where
5 transmission occurs. It had a large number of
6 participants, close to 80,000, and the difference
7 between -- and it can be controlled. Like a household
8 is kind of like a unit, and so, again, I think this was
9 a very good study and very representative of the
10 literature and reliable, and it showed that the
11 difference between symptomatic transmission and
12 asymptomatic transmission was about 25 times. And so I
13 think that would be where I would -- you know, get that
14 word "substantial".

15 Q Thank you.

16 THE CHAIR: Mr. Kitchen --

17 MR. KITCHEN Yes.

18 THE CHAIR: -- I just wonder, is there a
19 point, a logical point in your approach where we could
20 take a short break?

21 MR. KITCHEN: Yes, I was planning to after I
22 finished asymptomatic transmission, and I don't think
23 I'm going to be on that very much longer --

24 THE CHAIR: Okay, thank you.

25 MR. KITCHEN -- so just a couple more
26 minutes.

1 Q MR. KITCHEN: Dr. Warren, you further say
2 that asymptomatic transmission does not warrant being
3 considered a significant contributor to the overall
4 transmission burden. Now, maybe that's obvious based
5 on what you just said, but can you just explain why
6 that's your opinion?

7 A So it can be -- my opinion can be considered in a
8 number of domains. The first is just the number
9 itself. So if we're talking about something that's 25
10 times less important, I think that's one domain. The
11 other domain, you know, relates to the point we've
12 already discussed, which is the fact that the virus is
13 going to be around forever, and kind of related to that
14 is the idea of treating an asymptomatic person as
15 diseased. I think that has huge, kind of moral,
16 philosophical, whatever implications. And so you have
17 something that's going to be around forever, you can't
18 treat the entire population, you know asymptomatic, as
19 potentially infected with regards -- just on a moral --
20 in my opinion, of course, but on a philosophical level,
21 you can't -- it's dangerous I think, societally, to be
22 treating everybody who otherwise looks healthy as a
23 potential germ carrier for an infection that's widely
24 prevalent and going to be around forever.

25 Q But is it, nonetheless, scientifically accurate?

26 A What's scientifically accurate?

1 Q That there are a large number of asymptomatic healthy
2 people going around that, you know, are harbouring
3 something that can make people really sick, and they're
4 likely to transmit it even though they're healthy?

5 A Well, I think it's just best to use numbers like I use
6 in my report. Like I think the best evidence that we
7 have is that asymptomatic transmission is 25 times less
8 than symptomatic transmission, and to me, that -- you
9 know, that's -- statistically that's a relatively large
10 number. I'm happy to call that substantially
11 different.

12 Q So it's not a good assumption that -- that most healthy
13 people could transmit this thing?

14 A No, I don't think it's justified, based on the
15 evidence, that we should be treating every healthy
16 asymptomatic person as a potential -- potentially
17 infected with SARS-CoV-2. You know, I think -- again,
18 everything to be qualified, if you're talking about
19 someone who is in very close contact, you know, of
20 course. And so, of course, there's going to be
21 exceptions to the rule, but it just proves the rule.
22 But I think, generally, at a population level, I don't
23 think the evidence warrants treating everybody in the
24 population who is asymptomatic as a potential
25 transmission risk for SARS-CoV-2.

26 Q Now, I'm going to come to masking after the break, but

1 just help me out, isn't that the assumption behind
2 mandatory masking of all healthy people? Like
3 (INDISCERNIBLE) --

4 A That's -- yeah, that's certainly one of the assumptions
5 for masking the healthy general public, absolutely.

6 Q Almost done before we break. Now, as you know, Dr. Hu
7 on page 6 of his report says your opinion regarding
8 asymptomatic transmission is, quote, contradicted by a
9 CDC report which says that 60 percent of COVID
10 transmission is asymptomatic. Now, Dr. Hu does not
11 provide the citation for this report, but are you aware
12 of what report he is referring to?

13 A No, I'm not aware.

14 Q Do you find that strange that he didn't cite to the
15 report?

16 A Well, I can't comment specifically on that, but
17 generally if you're going to cite a number or a
18 statistic or discuss a number or statistic in either
19 the academic literature or a formal document such as
20 this, you would provide a reference, like I did with
21 all of mine.

22 Q Well, do you think the -- I guess you've already
23 answered this, but, just to clarify, do you think the
24 balance of the scientific literature that is available
25 supports your opinion that symptomatic transmission is
26 way more prevalent than asymptomatic?

1 A Yes, that's what I state in my report, and I don't --
2 my opinion has not changed, that symptomatic
3 transmission is substantially more important than
4 asymptomatic transmission.

5 MR. KITCHEN: So that's it for me for the --
6 you know, we can break now, and then I'll have some
7 more when we come back. I'm, you know, probably
8 halfway through, maybe a little less, but close to
9 halfway through.

10 THE CHAIR: Okay. Thank you, Mr. Kitchen.
11 And, Dr. Warren, we're going to take a 15-minute break,
12 and you can put your connection -- you can mute and
13 turn your camera off during this period, but please
14 don't break the connection to the meeting and don't
15 speak with Mr. Kitchen, and we will see everybody in 15
16 minutes. 25 to 11 I think.

17 (ADJOURNMENT)

18 THE CHAIR: Mr. Kitchen, the floor is
19 yours once again; we'll resume your direct examination
20 of Dr. Warren.

21 MR. KITCHEN: Thank you.

22 Q MR. KITCHEN: Dr. Warren, from pages 3 to 5
23 of your report, you discuss the evidence for lockdown
24 measures, generally speaking, including physical
25 distancing. Prior to the year 2020, was there much
26 scientific evidence or academic literature in support

1 of the effectiveness of physical distancing?

2 A No, there was essentially none, and that -- I think I
3 gave a quote in -- yeah, there's a systematic review
4 published in -- it was a Cochrane systematic review,
5 and towards the end of page 4, I quote: (as read)

6 There was only one randomized controlled
7 trial of quarantine and no trials of
8 screening and (INDISCERNIBLE) or for physical
9 distancing.

10 So the highest level of evidence, as I discussed in
11 other parts of my report, are randomized controlled
12 trials or meta-analysis of randomized controlled
13 trials, and there was just none of that evidence with
14 regards to various lockdown measures prior to the
15 pandemic.

16 I can discuss that one randomized trial that they
17 discuss there, but -- in a quote. There was a
18 randomized controlled trial in influenza in Japanese
19 persons. What they basically randomized Japanese
20 workers to is that home quarantine while they were
21 symptomatic or not. And what it found is it had no
22 significant difference on overall rates of influenza.

23 So what happened is these Japanese workers, who
24 were quarantined at home, did -- their offices, their
25 co-workers had lower rates of influenza, but it was
26 counter-balanced by higher rates of influenza within

1 these quarantine workers' families. And so in the end,
2 it made no overall difference, because it just shifted
3 the number of infections from one place to the other.

4 And there are some interesting papers out there to
5 suggest the same thing happened in COVID-19, because
6 the household is already the highest -- or the most
7 likely case -- a place of transmission, when you have a
8 whole bunch of people sheltering in place, either
9 you're just transferring infections from one place to
10 the other, or, in fact, there's some people that would
11 argue that infections may have been increased because
12 of that.

13 Particularly in congregate settings, because
14 you're -- places like nursing homes, group homes, other
15 places where people are living but within close
16 proximity to others that we have these shelter-in-place
17 restrictions, it may actually increase the numbers of
18 infection.

19 But, again, the evidence there isn't clear.
20 There's lots of people kind of debating that, but prior
21 to COVID-19, there was essentially no evidence for the
22 positive effect of various different lockdown measures,
23 including physical distancing, isolation -- or, you
24 know, sheltering in place.

25 Q So is it basically there was a hypothesis that this
26 could work, and then that hypothesis was implemented;

1 is that sort of what happened back in the -- you know,
2 early 2020 in Canada?

3 A Yeah, there are a lot of different things going on
4 here, I'm happy to talk about that, but, number one, a
5 lot of the decisions were based on modelling. And as
6 part of my Masters, I've done some modelling courses.

7 And one of the key metrics in modelling is this
8 factor called Beta, which is just the average number of
9 interactions a person in the model is going to have
10 with other people. And by changing that one number in
11 modelling, at least, you can change the size of waves
12 or the number of infections and things like that.

13 So because a lot of decisions were based on
14 modelling, and that one factor is so important in the
15 modelling, the idea was if we can decrease the number
16 of interactions people have with other people, then
17 we're going to greatly decrease the number of
18 infections. Again, I think there's various problems
19 with that: Number one, the idea that most transmission
20 occurs in households and kind of really isn't
21 considered in that; number two, as I talked about in
22 population density, in very population-dense areas,
23 even sheltering at home, you're actually not reducing
24 the number of -- significantly reducing the number of
25 people, other people you are going to interact with,
26 because you're still going out to walk your dog, you're

1 still going to the grocery store. You know, if I'm in
2 downtown Toronto, and I'm walking two blocks to the
3 nearest grocery store, I'm interacting with a lot of --
4 I'm going by a lot of people, and -- anyway. So that's
5 one thing number one.

6 Then the other issue is that policies were
7 going -- at least early on, very early on, were going
8 to be heavily influenced by what happened with
9 SARS-CoV-1. And what happened with that infection is
10 that various different quarantine -- there were no
11 lockdowns, but that infection was able to be controlled
12 with various public health measures, mostly just the
13 usual stuff: Sick patients are kind of quarantined to
14 learn better; testing and tracing, so testing and
15 tracing all of their contacts. But that infection,
16 didn't last long, occurred -- recurred briefly in
17 various places like Singapore and different cities in
18 China and stuff.

19 But I think early on, because it wasn't that long
20 ago, it was I think only 16 years previous, a lot of
21 the policy was heavily influenced from that, and
22 pandemics have a deep kind of social history, right?
23 Like when you talk about things like the Black Death,
24 in a lot of places in Europe, you know 50 percent of
25 the population died from that pandemic and from plague,
26 and there have been many others and stuff as well.

1 So deep within the societal consciousness, you
2 know, there's fear of major infections. And in some
3 cases, in different infections historically, lockdown
4 or lockdown-like measures have worked, and you think of
5 things like smallpox and quarantine. So you had, you
6 know, a boat with -- you know, you think of 1720s
7 Boston, and there's evidence, you know, of this, you
8 have a -- and there's no smallpox in Boston, but you
9 have a boat coming in over from England where there's
10 people with smallpox on it, well, that boat is
11 quarantined, it's locked down in the harbour for
12 several weeks until there's no more transmission of
13 smallpox. And I can give many other examples from
14 history.

15 And so it's a complicated issue with regards to
16 lockdown, quarantine, things like that, so I think
17 those are kind of the three main ones that I just
18 addressed.

19 Q Thank you. I mean, I guess you've touched on this, but
20 just to be specific, has the evidence, you know, over
21 the last two years substantiated the theory that
22 physical distancing is effective?

23 A No, but, again, it's a hotly debated topic because we
24 don't have the best evidence. The best evidence is
25 randomized controlled trials, and those trials could
26 have been done. And, in fact, in small instances, they

1 have.

2 So most of the evidence, what we're doing is
3 ecological studies, so comparing one jurisdiction to
4 the other. And as I mentioned with regards to masks,
5 there's all sorts of statistical problems with that.

6 And, you know, debating various different lockdown
7 measures kind of with the type of evidence we have is a
8 whole other discussion, but the best evidence,
9 randomized controlled trials, which should be done for
10 everything, we just don't have that evidence.

11 But I give an example of one that was done, and
12 it's something that should have been done more, so in
13 Massachusetts, they did a randomized controlled trial
14 of school children of 3-foot distancing versus 6-foot
15 distancing, and there was no difference. Okay, so it
16 was a cluster-randomized trial, much like the
17 Bangladeshi mask study, so you randomized classrooms
18 versus -- rather than people. That's the standard way
19 of doing this type of intervention. And they showed
20 that there's no difference between 3 feet and 6 feet.

21 And so that study kind of proved the point that
22 that type of study can be done and should have been
23 done everywhere throughout the pandemic, looking at a
24 variety of different interventions. And when that type
25 of study is done, what it will show, and what it showed
26 prior to, as I talked about with that Japanese worker

1 study in influenza, which I think was 2010 or so,
2 somewhere around there, when those types of studies are
3 done prior to COVID and the very few that have been
4 done during, they don't show much of an effect of these
5 different lockdown-type procedures.

6 Q Thank you. Now, I want to ask you some questions about
7 masks. On page 5 of your report, your section on the
8 evidence regarding masks, you refer to, quote, healthy
9 people, and I think we've touched on this, but just to
10 be clear, for you is asymptomatic the same as healthy?

11 A Well, asymptomatic, I think you're -- yes, I guess.
12 Again, it's depends on how you define your terms. If
13 we're talking asymptomatic with regards to SARS-CoV-2,
14 they could be unhealthy otherwise. They could have
15 heart failure and diabetes and advanced-stage cancer; I
16 wouldn't call them healthy, but they're asymptomatic
17 with regards to respiratory symptoms.

18 Q So healthy in regards to not having cold flu symptoms?

19 A Right, yeah.

20 Q Okay. Is a mandate that all chiropractors wear a mask
21 at all times in their office, is that effectively a
22 mandate that all asymptomatic chiropractors wear a mask
23 at all times in their office?

24 MR. MAXSTON: I'm going to have to object to
25 that, Mr. Kitchen. I think that's a pretty central
26 question for the Hearing Tribunal to decide.

1 MR. KITCHEN: Well, you're going to have to
2 explain that.

3 MR. MAXSTON: Well, we can't ask this
4 witness to comment on the College's mandate and its
5 broader implications of it. I think your question is a
6 little too broad, Mr. Kitchen.

7 MR. KITCHEN: Well, I'll rephrase it again,
8 just -- not rephrase it, but say it again, because I'm
9 struggling with that. I'm asking him is it logically
10 accurate that a mandate that all chiropractors wear
11 masks at all times in their office is a mandate that
12 all asymptomatic chiropractors wear a mask at all times
13 in their office? I'm asking if those two things are
14 logically equitable. That's got nothing to do with any
15 determination that the Tribunal has to make.

16 MR. MAXSTON: I guess you can take this
17 witness to the Pandemic Directive, Mr. Kitchen, and you
18 could ask him to comment on that, but I'm not sure I
19 agree with you. I think that that's a broader question
20 that goes to I think one of the conclusions the
21 Tribunal is going to have to make based on the issues
22 you are raising.

23 MR. KITCHEN: That being --

24 THE CHAIR: Mr. Kitchen, the first part of
25 your question is all chiropractors, right?

26 MR. KITCHEN: Right. And I, you know -- I

1 thought this was not contentious. Maybe my friend can
2 tell me. I mean, as far as I know, there's no
3 disagreement here that the Pandemic Directive says that
4 all chiropractors must wear a mask at all times while
5 in their office.

6 Do you take issue with my characterization,
7 Mr. Maxston?

8 MR. MAXSTON: The Pandemic Directive says
9 what it says in terms of chiropractors having to wear
10 masks when they treat patients. But I think, in
11 fairness, you'd have to take this witness to the actual
12 wording in the Pandemic Directive and ask him what his
13 interpretation of it is, and I might have some
14 objections I suppose to that. But I think your
15 question, as it's framed, I just think is too
16 general --

17 MR. KITCHEN Okay.

18 MR. MAXSTON: -- or relates to one of the
19 issues this Tribunal's going to have to decide on.

20 I don't have a problem with you asking questions
21 about masking and asymptomatic patients, you know,
22 that's not -- I'm not going to object to that, of
23 course.

24 MR. KITCHEN: Well, do you have any
25 objections to me reading to him what the directive says
26 in that portion?

1 MR. MAXSTON: I don't think I would. I
2 think I would have objections to you asking him about
3 the -- I want to say it, how that applies in the
4 chiropractic office vis-à-vis a chiropractor and
5 patients.

6 MR. KITCHEN: Well, at least for this
7 question, I'm not asking.

8 MR. MAXSTON: Yeah. Well, as I said, I
9 think it's probably better to take him to the Pandemic
10 Directive if you want to ask questions about the
11 meaning and intent of the Pandemic Directive. That's
12 all I'm saying here is it just seems to me that this is
13 a little bit of a bigger picture issue that the
14 Tribunal's going to have to decide on.

15 THE CHAIR: Would it be possible to put
16 that directive up on the screen?

17 MR. KITCHEN: I don't know if Ms. Nelson can
18 do that quickly. The only reason I don't want to --
19 I'm just trying to save time.

20 MR. MAXSTON: And, Mr. Kitchen, you know, it
21 says what it says --

22 MR. KITCHEN: Yeah.

23 MR. MAXSTON: -- I'm not -- if you want to
24 ask your client about whether he thinks that directive
25 is, you know, scientifically supported, you've been
26 doing that already, I suppose, indirectly; I'm just a

1 little concerned about saying -- you know, asking him
2 to draw a conclusion about this specific directive in
3 the context of, I guess, the charges that are in front
4 of the Tribunal.

5 MR. KITCHEN: Well, let me ask a series of
6 open-ended questions, and maybe we can resolve this.

7 Q MR. KITCHEN: Dr. Warren -- my friend can
8 intervene if he thinks this is a problem -- but there
9 are approximately 1150 regulated chiropractors in
10 Alberta. That's somewhere in the record; I don't think
11 that's contentious. Is it possible that -- well, is it
12 possible that all of them are going to be symptomatic
13 at exactly the same time?

14 A I don't totally understand the question, but obviously
15 not; I don't think there would be 1100 people
16 symptomatic at the same time.

17 Q And I can tell you this because it's in the record, I
18 don't think it's contentious, chiropractors are not
19 actually in the directive. I can't say precisely right
20 now. Certainly in the relevant time period here which
21 we're talking about, which is about May 2020 to
22 December 2020, chiropractors weren't, in fact, allowed
23 to be in their office if they were symptomatic, okay?
24 So if there's a requirement -- and I'll read it to you
25 if I have to, but, again, I don't think I'm
26 mischaracterizing it -- if there's a requirement that

1 chiropractors wear a mask while in their office
2 treating patients, and that requirement is static or
3 universal, is that not a requirement that asymptomatic
4 chiropractors wear a mask at all times in their office
5 when they're treating their patients?

6 A So from what I understand from the question, I'm not
7 again entirely sure, but it sounds like the directive
8 says that chiropractors may not practice or be in their
9 office if they're asymptomatic [sic], and presumably
10 that's the same for their patients as well with regards
11 to COVID symptoms; and so I think the question then is
12 if they're not allowed to be in their office or
13 practicing -- seeing patients, if they're symptomatic,
14 then, by definition, they're wearing a mask as
15 asymptomatic persons while performing the chiropractic.
16 Is that correct? And so that's what you're asking?

17 Q That's what I'm asking, yes.

18 A Yes, okay.

19 Q I'm going to ask you a few questions about health care
20 settings and non-health care settings, but let's first
21 talk about non-health care settings. You say in your
22 report that when limited to the strongest types of
23 evidence, RCTs as we've discussed, there is no evidence
24 in support of healthy or asymptomatic people wearing
25 masks in non-health care settings. You've already
26 explained all that.

1 Just to clarify, because I know that, you know,
2 this is an issue with Dr. Hu, there are multiple
3 peer-reviewed publications that support your position
4 on that?

5 A Yes, so as I state in my report, pages -- and page 5
6 primarily, so prior to COVID, there was studies of
7 randomized controlled trials of masking asymptomatic
8 persons. Most of the studies were relatively small.
9 Some showed marginal benefit, others didn't. And when
10 those -- when randomized controlled trials are put
11 together and all of the evidence and all of the
12 patients are compared in one big group, it's called
13 meta-analysis. And there's three meta-analyses, all of
14 them done just prior to COVID, in fact, one of them,
15 the Cochrane review, done during COVID but was only
16 including studies done prior to COVID that showed there
17 was no difference.

18 And so that's what happens, when you have
19 randomized -- and the randomized controlled trials
20 looking at masking healthy people primarily to prevent
21 influenza were relatively small, and they're
22 contradictory. Some would say, yeah, there's some
23 marginal benefit, others no.

24 And so the standard way of kind of deciding the
25 issue is a meta-analysis. And three meta-analyses said
26 that the bottom line is that there is no evidence of

1 masking healthy persons in the community to prevent
2 respiratory tract infection, and that was primarily
3 influenza, but not -- see, that's tricky, it was
4 primarily influenza, but it was influenza-like illness,
5 ILI, which is a very standard, more or less symptomatic
6 definition than a laboratory based definition, because
7 never in history have we done such extensive testing on
8 a respiratory virus than we've done on SARS-CoV-2,
9 COVID-19.

10 Q Now, to your knowledge, have there been RCTs done since
11 writing your report, you know, on masking in the
12 context of COVID?

13 A Yeah, so in my report, I mention one randomized
14 controlled trial done early in Denmark --

15 Q Yeah.

16 A -- with regards to masking, and it showed no
17 significant difference. And since then, there has --
18 there's been two performed, one of -- so one was in
19 Africa, I forget the exact country, that has -- even
20 the preliminary results haven't been published, but it
21 just finished I think in November, Guinea-Bissau I
22 think is where it -- anyway, I don't want to say for
23 sure -- but it was a -- I think a large
24 cluster-randomized trial as well.

25 But there was a large study that's been discussed
26 in the media for the last few months, done in

1 Bangladesh. It was a cluster-randomized trial of over
2 300,000 persons in Bangladesh. And so what they did is
3 they randomized villages to wearing masks or not,
4 rather than persons, but the number of -- total number
5 of people was over 300,000.

6 It's interesting that study was finished last
7 summer and published on the study investigator's
8 website I think at least September 1st, but it hasn't,
9 as far as I'm aware, even appeared in a preprint form,
10 much less peer-reviewed literature, but it's widely
11 discussed in the media, and there are certainly some
12 conclusions that can be taken from the data that's
13 available.

14 Q And what would those conclusions be?

15 A So the bottom-line conclusions were that -- so they
16 cluster-randomized some villages to cloth masks and
17 some villages to medical masks, and the overall
18 benefit, if you include both those groups, was very
19 small. So the absolute risk reduction -- I can just
20 bring it up here -- the absolute risk reduction was
21 from .76 percent down to .69 percent, so a 0.7 percent
22 reduction. That's the absolute risk reduction.

23 So what that says is that -- and so there's some
24 important features to consider when we're talking about
25 this study. One of the most important things is what
26 was the primary end point. So the primary end point

1 was not death, was not hospitalization -- at least in
2 the initial report, they don't even mention that -- the
3 primary end point was serologically confirmed symptoms,
4 so people who had symptoms of COVID and then had a
5 serology test indicating that they had the infection.
6 Okay, so it's really produced -- it's really a study of
7 where the end point is infection, okay?

8 And in the control group, no masks. The rate of
9 infection was .76 percent, and in the treatment group,
10 overall, it was .69. So relatively low rates of
11 infection in both, but then we can compare them. So
12 that's important.

13 But then when they broke that down into the
14 treatment, and they broke it down into cloth masks
15 versus medical masks, the cloth masks actually had no
16 effect, no benefit whatsoever statistically. And then
17 when they look at surgical masks only compared to
18 control, which is no masks; in controls, again, it was
19 .76 percent, in surgical mask villages, it was .67
20 percent. So for an absolute risk reduction of .9
21 percent.

22 And in randomized controlled trials, the absolute
23 risk reduction is a very important number, because when
24 we take the inverse of it, so we just 1 divided by the
25 absolute risk reduction, we get what's called the
26 number needed to treat; so if we did the same thing in

1 the study that they did, how many people would we need
2 to treat without intervention to get one effect.

3 So if we take .09 percent and do the inverse of
4 it, it's approximately 1100, just over 1100. And so
5 what you need to do is take 0.009 and then take the
6 inverse. So 1 divided by 0.009, you get 1100, okay?
7 And so what that said -- and the study went on for
8 eight weeks; you can find that in the "Methods".

9 So what that tells us is we need to -- in a
10 general healthy population, we need to have 1100 people
11 wear a mask for eight weeks to prevent one infection,
12 not one death, not one hospitalization, but one
13 infection. So 1100 people wearing a mask for eight
14 weeks to prevent one infection, and that's a remarkably
15 high number. Like if there's any sort of intervention
16 that we're studying in cardiology or infectious
17 diseases or, you know, in my -- like with antibiotics
18 and bacteria or, you know, cardiology, that number is
19 remarkably high. Generally something over -- between
20 50 to 100 is high, but anything over that -- like
21 anything under 50 would be kind of low.

22 And it's not a hard outcome. It's always
23 important to say what's the outcome. And maybe it is
24 worth masking 1100 people for eight weeks to prevent
25 one death, but it's not; it's masking 1100 for eight
26 weeks to prevent one infection.

1 So that's the best evidence we have in SARS-CoV-2

2 Q Thank you. Now, on this vein, Dr. Hu compared
3 conducting RCTs on masking in the context of COVID and
4 health care workers to conducting RCTs on parachutes in
5 the context of people jumping out of airplanes. You're
6 aware of that, right?

7 A Yeah, I read that.

8 Q What's the likelihood that a person who jumps out of a
9 plane without a parachute will live?

10 A Presumably zero.

11 Q What's the likelihood that a person who contracts COVID
12 will live?

13 A Depends on the age group, but, overall, in all persons,
14 it's probably over 99 percent.

15 Q Is it reasonable to compare the strength of evidence in
16 support of the effectiveness of parachutes to the
17 strength of the evidence in support of the
18 effectiveness of masks?

19 A No, not at all. This is how we answer questions in
20 medicine; we do randomized controlled trials, and those
21 randomized controlled trials have been done with masks
22 and health care workers in lots of other contexts,
23 including other important infections like influenza.

24 Yeah, there have been randomized controlled trials
25 looking at is a cloth mask similar to a medical mask in
26 health care workers in influenza, and it showed cloth

1 masks -- and just that study too, I don't know, it was
2 done 10, 15 years ago, showed cloth masks are -- yeah,
3 cloth masks were useless for health care workers. The
4 medical mask was better for the health care worker
5 taking care of a patient with influenza.

6 We've looked at masks in a lot of surgical
7 contexts. So there's lots of places in the hospital,
8 especially -- like prior to COVID, there's a lot of
9 places in the hospital, a lot of contexts, where masks
10 were not indicated, and it was studied. Yeah, I think
11 a lot of surgical indications, they've tried to prevent
12 surgical site infections with wearing masks, and there
13 was no benefit.

14 We've looked at a lot of -- some pretty good
15 studies published in the New England Journal and JAMA I
16 think, again prior to COVID, in the context of
17 influenza or influenza-like illness, comparing N95s to
18 surgical masks for health care workers taking care of
19 persons with ILI, the most -- prime-most influenza, and
20 there was no difference, and so --

21 And I know that one of the main authors of that
22 study was at McMaster, Mark Loeb, and he tried to do a
23 randomized controlled trial in COVID, but just there
24 was such a default assumption that N95s would be better
25 for treatment of COVID that, as far as I'm aware, that
26 they were not able to actually do that study, because

1 the assumption was made, even though I think in the
2 absence of evidence, what you do look at is similar
3 context, and in this case, similar context done by the
4 same authors, looking at N95s versus surgical masks in
5 the context of influenza showed that there was no
6 difference. And so I think it was very reasonable,
7 from a clinical equipoise, statistical equipoise to
8 ethics to do that study in SARS-CoV-2 as well.

9 So there's been lots of randomized controlled
10 trials in health care workers to define who and who
11 does not need to wear a mask, and who and who does not
12 need to wear certain types of masks, lots of areas
13 where masks are not needed for health care workers,
14 including in infections, think of things like
15 c. difficile or MRSA, we don't mask health care
16 workers, but we make them gown and glove because of the
17 route of transmission is not the respiratory tract.

18 Q Dr. Hu is adamant that mandatory masking in a health
19 care setting prevents the spread of COVID, although
20 he's less certain about community settings. You refer
21 to a large body of evidence in your report that
22 mandatory masking of healthy people does not work at
23 all in community settings, we've been discussing that,
24 but do you have any reason to think that although
25 masking of healthy people is completely ineffective in
26 community settings, it might, nonetheless, be highly

1 effective in health care settings as Dr. Hu says?

2 A Sorry, I was looking at my report. Can you just
3 restate that?

4 Q Sure. So, you know, Dr. Hu says, look, they're really
5 effective in health care settings, probably effective,
6 but less effective in community settings. That's
7 basically his position. Your position, in your report,
8 is that, well, look, it's completely ineffective in the
9 healthy community, in the non-health care setting. So
10 even though that's your opinion, and you have all this
11 scientific evidence to back it up, do you, nonetheless,
12 think that Dr. Hu might be right in that, even though
13 it's not effective at all in the community setting, it
14 could be really effective in the health care setting?

15 A Well, yeah, masks are effective in the health care
16 setting, if that's what you're asking. Masks are
17 effective in a health care setting, yeah, because it's
18 been studied, but, again, it's totally
19 context-dependent. And everything is context-dependant
20 and should be studied with regards to its context. So
21 we know, because we did the studies, that for taking
22 care of influenza patients, health care workers should
23 wear a medical mask, which is a three-ply mask. It was
24 compared in a randomized controlled trial to cloth
25 masks, and it was superior, and it was control -- and
26 it was compared in multiple randomized controlled

1 trials to N95s, and there was no difference. So an N95
2 was not needed, so a medical mask, no worse than an N95
3 medical mask, no -- certain better than cloth, and so
4 that context is clearly established. Health care
5 workers taking care of patients who have influenza-like
6 illness should wear a medical mask.

7 And so -- and there is definitely context in the
8 health care environment where masks have shown, through
9 randomized controlled trials, which are the highest
10 level there is, that they're helpful, they're
11 beneficial, but that evidence just does not exist in a
12 community setting.

13 And also prior to COVID, studies have been done in
14 other health care settings within the hospital with
15 other types of infections that show that masks aren't
16 universally necessary all the time, and it's totally
17 context dependent.

18 Q Right, so the effectiveness of the masks is dependent
19 on the context of there being interactions between a
20 symptomatic patient and a health care worker?

21 A That's correct.

22 Q Let me ask you a few questions about, you know, the
23 issue with health care settings and non-health care
24 settings, and I know we've touched on this, but in a
25 health care setting like a hospital, are there a large
26 number of symptomatic people expected to be present?

1 A Yeah, absolutely. That's -- hospitals are -- have
2 lots, very high rates of symptomatic persons, and,
3 again, it depends on what you're talking about.
4 Just unhealthy, yeah, they have all sorts of aches and
5 pains, and, you know, heart attack, stroke, the -- but
6 also symptoms from respiratory virus, and, again, it's
7 going to depend on the season, because, in the middle
8 of the summer, we don't really see much viral
9 respiratory -- viral respiratory tract illness, but we
10 do see that, you know, in the winter months. So,
11 again, it's going to depend on those other factors that
12 I talked about as well.

13 Q And that's been your experience working at the hospital
14 you work at?

15 A Yeah.

16 Q And, forgive me, but hospitals are -- are they designed
17 to receive patients symptomatic with a potentially
18 infectious illness?

19 A Yeah, there are other factors other than masks,
20 obviously, there's ventilation, there's how rooms and
21 wards are designed, there's cleaning, so lots of
22 evidence about different cleaning things. So, you
23 know, we have three main types of cleaners:
24 Ammonium-type cleaners and bleach-type cleaners and
25 peroxide; we talk about each of the different pros and
26 cons of those, so -- and then different types of

1 ventilation systems: You have negative-pressure
2 ventilation for certain infections like tuberculosis
3 that are not required for other important respiratory
4 infections like influenza.

5 Yeah, you have kind of distance between patients,
6 whether they're in their own room or whether they can
7 be divided by, you know, just a screen; you have other
8 personal protective equipment like gloves or gowns.
9 Yeah, there's a variety of different factors that are
10 built into kind of the design and how a hospital works.

11 Q Are there any important differences between a setting,
12 a health care setting or any setting, where symptomatic
13 people are regularly present and then a setting where
14 symptomatic people are not present and only
15 asymptomatic people are present?

16 A Yeah, I think so. Like, you know, there's -- I think
17 of something like a hospital, even in that case, you
18 know, there would be scenarios where it doesn't make
19 sense to have everybody masked, even in the context of
20 COVID. Like if you have an outpatient clinic, say a
21 mental health clinic, where you have a psychiatrist,
22 who is obviously healthy, he or she is not allowed to
23 come to work if they have symptoms, and a healthy
24 patient, you know, let's say with some anxiety issues,
25 and there's cognitive behavioural therapy, which is --
26 you know, they're talking, you have a context like

1 that, it's occurring in a hospital, but really that
2 context, from a transmission risk point of view, can be
3 considered like any other context within the
4 population; and so you have them sitting 3 feet apart,
5 they're just talking, they're both healthy, the risk of
6 transmission, I would say it's even less than, say,
7 that patient after discussing anxiety issues with the
8 psychiatrist, going and getting their hair cut, because
9 the person trimming their hair or giving them a haircut
10 is actually closer to them than the psychiatrist.

11 And so even within the hospital, it's completely
12 context-dependent. Even in kind of health care
13 settings, it can be a relatively arbitrary definition.
14 Yeah, it occurs in a hospital, but what's the actual
15 risk, like how are these people physically relating to
16 each other, what are their symptoms, and what's the
17 actual risk?

18 So I would argue that the actual risk for the
19 scenario I provided, you know, would be the same as
20 essentially a similar type of scenario within the
21 general public. Whereas it's completely different if
22 you have symptomatic people on a ward that then -- the
23 benefit of masking is theoretically there but then also
24 proven by previous randomized controlled trials and
25 influenza disease.

26 Q Thank you. Dr. Warren, where you work, are you

1 currently required to where a mask because of COVID
2 even when you're asymptomatic?

3 A Yes.

4 Q And are there any similar or extra requirements from
5 the CPSO to wear a mask because of COVID even when
6 you're asymptomatic?

7 A I'm not sure. I'm not sure entirely what you're
8 asking, but I think most of the policies that I would
9 follow, because I'm in infectious diseases, so I'm
10 taking care of COVID patients and stuff, so I think
11 most of the policies would be from my hospital rather
12 than the CPSO. Yeah. Sorry, I'm just not entirely
13 sure what you're asking there.

14 Q Well, I mean, certainly the general understanding is
15 that most regulatory bodies, health professional
16 regulatory bodies across the province have fairly
17 sweeping requirements that their members wear masks
18 regardless of their symptoms. You know, the College of
19 Chiropractors has it, the College of Physicians and
20 Surgeons of Alberta has it. So I'm just asking if
21 you're aware if the College of Physicians and Surgeons
22 of Ontario has a requirement like that.

23 A Oh, I'm sure they do, yeah. Yeah, and it probably
24 doesn't really impact me because I'd be doing it
25 anyway, taking care of patients with infections, so --
26 but, yes, I'm sure they do. I haven't read it in

1 detail, but it wouldn't impact me like it might impact
2 some other people who wouldn't routinely be wearing a
3 mask anyway in the course of their work.

4 Q Okay, so do you now wear a mask a whole lot more now
5 than you used to prior to COVID just because of the
6 type of work you do?

7 A Yeah, absolutely. Yeah, I have to wear a mask in all
8 contexts now, whereas before, it was context-dependent.

9 Q And do you think the requirements now are equally
10 rational or equally logical to what they were before
11 when they were context-specific?

12 A Well, as I discussed earlier, the evidence base is not
13 there. And as I discussed earlier prior to COVID, the
14 requirement or need for masking, different types of
15 masking was based on the context. And in many of those
16 scenarios, it was actually studied, the most important
17 scenarios, things like TB and influenza. So now
18 there's a requirement for masking in every context, but
19 it's not substantiated by evidence.

20 Q In the new context, where you are required to wear a
21 mask, do you, in fact, wear a mask even though you
22 didn't used to before COVID?

23 A Yes, I wear a mask at all times when I'm in the
24 hospital. But the type of mask I wear is still
25 different based on the context. So it can be a Level 1
26 mask in certain areas. When I'm actually in my office

1 with my door closed, I'm by myself, I don't wear a mask
2 because I don't have to. But in other areas, if I'm
3 just going to Tim Hortons to get a coffee, I just wear
4 a Level 1 mask. In many clinical contexts, I can wear
5 a Level 3 and then an N95 in certain clinical contexts.

6 Q When you wear a mask to go to Tim Hortons, do you do so
7 because there's a law that requires you to do so?

8 A Yes.

9 Q Do you disagree with that law?

10 A I would say it's not based on evidence, universal
11 masking. And so I would say when I'm standing in line
12 at Tim Hortons, I would say that's similar to like a
13 community setting. Presumably, you know -- well, yeah,
14 people who have symptoms are not allowed to be in line
15 at the Tim Hortons as you are at the hospital. If
16 they're symptomatic patients, they need to, you know,
17 reside in the rooms, and symptomatic staff are not
18 allowed to come, not allowed to have symptomatic
19 visitors, that kind of stuff. And so that would be
20 considered community context, so as I've kind of argued
21 in and out of places, the evidence base just is not
22 there to say that that is required.

23 Q I'm nearing the end, believe it or not. I just have
24 some more questions about Dr. Hu.

25 Now, from your observations, has the transmission
26 of COVID decreased in jurisdictions of mandatory

1 masking as compared to jurisdictions with no masking?

2 So, you know, the classic example would be California

3 and Florida. Have you seen COVID transmissions

4 decrease in California because of mandatory masking?

5 A Yeah, again, so this is a huge other wide body of

6 literature and fraught with all sorts of methodological

7 and statistical problems, but what work there is out

8 there, there is no difference with regards to masking.

9 You know, I think people can know that intuitively.

10 Like we've had in Canada all of these mask mandates for

11 15 -- yeah, probably 15, 16 months before Omicron hit,

12 and then, you know, it just blew through the society,

13 didn't make any difference.

14 I think intuitively no, but when we do ecological

15 studies, which, again, have all sorts of methodological

16 problems, I would argue that the evidence shows that

17 there is no effect on transmission. And the best ones

18 are, you know, looking at the different states, because

19 you have 50 different states or Europe, because you

20 have a similar health care systems, relatively similar

21 population, things like that. And, no, I would argue

22 that it does not.

23 Q Dr. Hu has stated that every country that has imposed

24 masking has experienced decreased transmission of

25 COVID. Do you disagree with him?

26 A Yeah, I don't know what that assertion is based on.

1 I'd love to kind of know what study he's referring to
2 in that.

3 Q Well, that's my next question. So you're not aware of
4 any academic literature that would support such a
5 claim?

6 A No. Again, there's a wide literature in that, but it's
7 fraught with all types of problems, and so one of the
8 kind of classic fallacies is the progression toward the
9 mean, and we see this all the time where in the middle
10 of a wave, stuff is done, and then the cases come down,
11 and then it's attributed to whatever was done, but
12 that's just statistically wrong because there's always
13 going to be a regression toward the mean. A wave is
14 going to go up, and then it's going to come down, and
15 you have to have a control group to decide whether your
16 intervention -- those are kind of before/after
17 ecological studies, which are even lower than, you
18 know, ecological studies with regards to the value of
19 the evidence. It's essentially -- it's
20 hypothesis-generating at most, but very low quality of
21 evidence.

22 And whatever -- what evidence there is out there,
23 can be -- because it's some very low methodological
24 quality, it can often be twisted all sorts of different
25 ways. And there is -- and there is hundreds of
26 publications in that area with low methodological

1 qualities, so ecological studies or before/after
2 studies, which, by definition, are low methodological
3 quality, showing both sides.

4 So there's lots showing one side, lots showing the
5 other, but the best evidence is randomized controlled
6 trials and meta-analysis that there's no benefit in
7 masking a healthy general population.

8 Q Well, I'm going to ask you if that's what Dr. Hu has
9 done. I'm going to tell you what he said. He said
10 that the lockdown restrictions imposed in Alberta in
11 November and December of 2020, he said that those
12 lockdown restrictions did not cause the initial rise in
13 cases during the lockdown but did cause the eventual
14 drop in cases. So did Dr. Hu do there what you just
15 described?

16 A Yeah, there's no statistical epidemiologic way of
17 making that conclusion, because there's all sorts of
18 problems with it, but -- before/after, like you have
19 all sorts of bias and confounding, especially
20 confounding, and that conclusion just can't be made
21 statistically, it's just not good practice, that that
22 is not a high level of evidence because there's so many
23 confounding factors.

24 And we just know, and we've seen this all over the
25 world now for two years that you have waves that go up
26 and waves that come down, in many cases no matter what

1 you do. We've seen that in different provinces in this
2 wave. You know, provinces like Quebec who had the most
3 extreme measures are having more per capita cases than
4 places like Saskatchewan, which are having many fewer
5 restrictions.

6 And I would argue I know exactly why Quebec is
7 having more cases than Saskatchewan because the
8 population weighted density in Quebec is much higher.
9 You have a lot of people living in a relatively small
10 area in Quebec. So it's predictable why they're going
11 to have more cases than Saskatchewan. And every
12 jurisdiction in Ontario follows the same pattern we're
13 seeing in other places, which is that the most
14 important factor for number of cases is population
15 weighted density.

16 And it's not just overall area divided by the
17 people. So you look at places like Ontario, most
18 people don't live up in the north; it's population
19 weighted density, which is a specific measure. So you
20 take -- so the idea is you take any random person in
21 that population, how many people live near them. It's
22 not take the whole area of Ontario and divide it by the
23 people. That's just population density. But the
24 people of Ontario are not evenly spread over the entire
25 province.

26 Population weighted density is a statistical

1 method of determining if you take a random Ontarian,
2 how many, on average, people is that person near within
3 like, say, a square kilometre. And that measure is, by
4 far, the best predictor of how many cases you're going
5 to have. And we see that -- you have provinces that
6 have low population density have lower numbers of
7 cases. Populations with high -- provinces with high
8 population density, like Quebec, having very large --
9 Ontario as well, most people in Ontario live in the
10 corridor between Windsor and Ottawa, and it's
11 relatively population dense.

12 Q You said earlier something about reversal. You said it
13 was very difficult to reverse (INDISCERNIBLE) trend.
14 Does that help to explain that even though this data
15 you're talking about is so obvious, does that help to
16 explain why Quebec continues to do something that is
17 very obvious doesn't work?

18 A Yeah. So it's difficult once there's an established
19 practice, and we know this from thousands of years of
20 history in medicine, it's very difficult once there's
21 an assumed standard of practice to change practice.
22 Now, I deal with that on a daily basis, and I have been
23 for almost 11 years of practice now in antimicrobial
24 stewardship, because my main role is to convince
25 people, okay, we don't need to treat people with
26 pneumonia with 14 days of antibiotics anymore. We've

1 had lots of randomized controlled trials that say three
2 to five days is okay. But people are still practicing
3 what they learned in med school 25, 30 years ago.

4 And so effecting that change is very challenging,
5 and there's all sorts of books written about that and
6 things like that. And so once a practice is assumed to
7 be beneficial, even early on in the -- when there's
8 clear evidence to the contrary, it's very difficult for
9 medical practitioners, it's a psychological thing, you
10 know, just part of humans and who we are as well, to
11 change practice.

12 Q Is that what's going on generally with COVID now?
13 We've got this practice in place, you know, revolving
14 lockdowns must be effective because we thought they
15 were going to be in the beginning, even though the data
16 shows they're not, we must keep doing them because we
17 thought they were effective. Is that -- you know, the
18 example that you gave with treating pneumonia, is that
19 what's going on with COVID?

20 A Well, you know, it's a very complicated topic. As I
21 mentioned before, it needs to be looked at in the
22 historical context as well, because as a -- you know,
23 as human populations, we have gone through massive
24 events that have decimated our populations that is
25 still historically remembered in our social
26 consciousness. And as I said, so you think of things

1 like the Black Death, as I said before, historically
2 some sorts of quarantine, especially for things like
3 smallpox and plague, frankly, have worked. Like when
4 you kind of cut yourself off from the world, that
5 actually saves a lot of lives with regards to smallpox
6 and plague.

7 And so a lot of these things have very deep-rooted
8 factors that come into play, but one of them is this
9 medical reversal idea, and others kind of -- you know,
10 the idea of some costs, like once you've invested
11 billions or whatever dollars in something, you know,
12 you really want that to work.

13 And it's political, right? Like it just comes
14 down to politics, a philosophy of how things are done,
15 whether you're interventionist or not, and people are
16 interventionists in the economy, people are
17 interventionists in the climate, people are
18 interventionists in medicine, and to some degree,
19 that's a political question as well. So there's many
20 different factors.

21 I think there's a few problems that have occurred
22 over the -- I think everybody will admit this that
23 there's been some major problems that occurred over the
24 last couple years. One is that, you know, we haven't
25 subjected or made decisions based on enough evidence,
26 and I think many people would agree on that, but I

1 think also that it's things are oversimplified. So I
2 don't want to be one person that says, well, people do
3 this because of one reason; I think it's very complex.

4 Q Right. Dr. Hu said quite a few times in his report and
5 in questioning that the evidence supporting the
6 effectiveness of masks is, quote, overwhelming and,
7 quote, there's heaps and mounds of evidence. Do you
8 find these statements to be reasonable?

9 A If he's referring to in the community, then, no,
10 absolutely not, but I -- quite the opposite actually.
11 So I don't have that direct quote in front of me, but
12 if he's referring to masking healthy persons in the
13 community, no, I would completely disagree with him.

14 Q Well, you know, to be fair, he's saying it in the
15 context of health care settings --

16 A But, again, it's context-dependent, so, yes, for health
17 care providers taking care of patients with influenza
18 or influenza-like illness or tuberculosis or, you know,
19 certain -- the context, then, yes, there is lots of
20 evidence, but there's also lots of evidence for the
21 fact that masks are not required in lots of health care
22 contexts as well.

23 Q On page 7 of his report, Dr. Hu says that the issues of
24 asymptomatic transmission, of symptomatic transmission,
25 and the severity of COVID are not salient to the issue
26 of the effectiveness of masking.

1 A Sorry, can you say that again?

2 Q Sure. And you might want to have it in front of you,
3 on page 7 of his report, it's actually in the bold text
4 in the third paragraph there of page 7, he says: (as
5 read)

6 The severity of COVID-19 right through
7 transmission of --

8 A His report, sorry, Dr. Hu's report?

9 Q Yeah.

10 A Okay. Let me just bring it up. Page 7?

11 Q Page 7, yeah, there's the bold text.

12 A Okay, got it here.

13 Q So he says: (as read)

14 The severity of COVID-19 rates of
15 transmission amongst asymptomatic infected
16 individuals, testing, et cetera, none are
17 salient to the question at hand around
18 whether or not masks provide benefit in a
19 health care setting.

20 Do you disagree with him?

21 A I just have to look at this.

22 Q Now, mind you, we don't have a definition of "health
23 care setting" of course, but ...

24 A No, I wouldn't agree at all. Like whenever we decide
25 or whenever we're thinking conceptually about whether
26 health care workers should wear masks, the severity of

1 the infection, the rates of transmission of the
2 infection, whether asymptomatic persons can transmit,
3 all of those are very important as to whether masks
4 should be used in that context. I'm not arguing that
5 masks shouldn't be used in a health care context. I
6 would define that like as a hospital, you know, but
7 health care providers should wear a mask when taking
8 care of a patient who is symptomatic with COVID-19.
9 I'm not disagreeing with that at all.

10 But this statement is not true, like whenever we
11 think of, even in the health care environment, whether
12 someone should be masked, we think of the severity of
13 the infection, we think of the rates of transmission,
14 we think of whether someone who is asymptomatic can
15 transmit, absolutely.

16 Q I want to take you back to your comparison of a year of
17 COVID death numbers to a year of vehicle fatality
18 numbers. I think you do this on the bottom of page 2
19 and the top of page 3 of your report.

20 A Right.

21 Q Now, the first question I have for you is, and you may
22 not know this, but when did COVID-related deaths in
23 people under the age of 60 first start occurring in
24 Canada in 2020?

25 A Oh, it would have started occurring very early, yeah.

26 Q "Very early" being?

1 A April.

2 Q So I'm going to ask you some obvious questions, bear
3 with me. How many months are there between April 2020
4 and April 2021?

5 A 12.

6 Q And how many months were in the year 2019?

7 A 12.

8 Q Now, in your report, you say that there were 1,010
9 COVID-related deaths in people under 60 years of age as
10 of April 16th, 2021, and that there were 1,191 motor
11 vehicle fatalities in 2018 in people under 55 years of
12 age. Do you still hold the opinion that the risk of
13 death from COVID to people under the age of 60 between
14 April 2020 and April 2021 was less than the risk of
15 dying from a motor vehicle accident?

16 A Yeah, absolutely. And, in fact, the first -- when I
17 kind of look at the number -- what you need to do is
18 look at basically the average number of deaths per day,
19 and in this analysis, I'm actually being generous,
20 because the first death in Canada I think was around
21 March 9th, 2020, and so what you're talking about is
22 over 13 months of data until April 16th, 2021, and
23 there were less deaths in that age group than just 12
24 months of persons -- and, again, it's under the age of
25 55. So not only am I doing it longer with regards to
26 COVID deaths, I'm -- have a slightly larger age group.

1 So the number -- and if you continue that on, and
2 you always have to -- the denominator is important,
3 like you always have to divide it by the number of
4 days, and I counted from the day of the first COVID
5 death in Canada, and this holds today, so the number of
6 deaths in Canada in persons under 60, if we divide it
7 by almost two years, the number of deaths per day on
8 average is less than what we would expect in that same
9 age group, persons under 60, the number of deaths due
10 to motor vehicle accidents.

11 Q Thank you. On page 6 of his report, Dr. Hu stated that
12 you committed a, quote, factual error. He said your
13 comparison was fallacious and unscientific. He went on
14 to say that no scientist, doctor, or epidemiologist
15 with a basic understanding of disease patterns would
16 make this comparison.

17 Now, on cross-examination, Dr. Hu retracted his
18 accusation that you have no basic understanding of
19 disease patterns, but how do you respond to his claim
20 that you made a factual error?

21 A Well, the mistake he made is he continued to accrue
22 patient numbers without dividing -- without changing
23 the denominator. So he changed the numerator without
24 changing the denominator. What I was saying was that
25 in a year, and it was actually more, the numerator was
26 1,000 -- what did I have -- 1,010, that was my

1 numerator, and my denominator would have been about a
2 year, it was actually 13 months, but it was a year. In
3 his report, he continues to increase the numerator, so
4 1,475 as of June 29th, but then he has to increase the
5 denominator as well. And if you change the denominator
6 to the June 29th, so approximately 16 months, you're
7 finding the same thing: You're finding the average
8 numbers of death per day in that age group is still
9 less. So it's --

10 And, you know, saying it's fallacious and
11 unscientific, well, it's very important, we do this all
12 the time in medicine; like if we're talking to people
13 that have a potential rare effect of a drug or, you
14 know, a particular intervention, like my obligation is
15 to provide the patient with informed consent, and part
16 of that informed consent is providing a contextual
17 risk. This is done all the time. It's done all the
18 time at population health bubbles as well, because
19 everything in life has a risk, you know. Me walking
20 into my bathtub or shower has a risk, you know; there
21 are certain numbers of people that die every year
22 because of that. And getting struck by lightning or
23 whatever and --

24 In fact, driving a car is one of the riskiest
25 things in, you know, persons under a certain age that
26 they can do in Canada. It's one of the major

1 preventable causes of death. And so it's always
2 used -- not always, but often used as a way of
3 contextualizing a risk of death, and I think it is very
4 helpful in COVID-19. If you have people under 60,
5 that's all persons under 60, all persons under 60,
6 their risk of dying of COVID is actually lower than
7 their historical risk of dying in a car accident.

8 And, again, you can talk about sub groups and
9 things like that if you have -- if you're talking about
10 healthy people under 40 with no risk factors, like
11 you're talking about a phenomenally lower risk actually
12 with no kind of comorbidities and lowering the age
13 group and stuff. But it's routinely done in many areas
14 of life, not only medicine, to contextualize a risk.

15 Q Just a couple more questions. In your experience as an
16 infectious disease specialist, do government bodies
17 tend to be more factually accurate than non-government
18 bodies regarding scientific issues?

19 MR. MAXSTON: Mr. Kitchen, I'm sorry to
20 interrupt, but I struggle with how that falls within
21 the efficacy of masking and other qualifications. I
22 think that's almost political, sociological. I know
23 where you're going, but I wonder if you could think
24 about rephrasing that, because that's awfully broad and
25 really doesn't speak to efficacy of masking; that's
26 governmental society.

1 MR. KITCHEN: No, I'm simply asking if the
2 evidence he's seen for government bodies and the
3 evidence he's seen from non-government bodies, if the
4 scientific evidence -- if governments tend to be more
5 right than non-government bodies.

6 MR. MAXSTON: Well, it's pretty open-ended,
7 which governments, what evidence, provincial, federal,
8 municipal. I mean, that's a pretty broad question,
9 Mr. Kitchen. That's my concern.

10 MR. KITCHEN: I can narrow it down to
11 specific governments, if you let me do that.

12 Q MR. KITCHEN: Well, Dr. Warren, I'm not
13 going to ask you about the Alberta government because
14 you're not in Alberta, but the Ontario government,
15 generally speaking, in your -- and you've only be doing
16 this for 11 years, so in your 11 years of infectious
17 disease experience, do governments tend to be more
18 factually or scientifically accurate in Ontario, the
19 Ontario government, does the Ontario government tend to
20 be more factually or scientifically accurate than
21 non-government bodies?

22 A What do you mean by "non-government bodies"; like what
23 would be the comparative group?

24 Q Independent scientists, private universities, people in
25 bodies that are clearly unrelated to government.

26 A Yeah, again, that is a hard question to really answer,

1 because it all depends. Like I've seen it every single
2 different way. Sometimes I've seen how the
3 Government's just way behind the times. Other times,
4 they're way more accurate than a different -- like,
5 again, it's completely context-dependent, so I really
6 can't answer that question, to be honest with you.

7 Q Do you think a scientific or medical proposition or
8 theory is likely to be more accurate because it comes
9 from a government source?

10 A I don't personally think that, no. I always look at
11 the underlying data, so the primary evidence. So, you
12 know, if you talk about historical analysis, the
13 primary evidence is people who were there in that part
14 of history or the archeological evidence or whatever.

15 You know, in scientific stuff, it's the studies,
16 it's the bench research or the randomized controlled
17 trials, yeah. So that's how I would form my opinion.

18 So what different bodies say, governments,
19 whatnot, like that would be part of kind of how I think
20 about things, but it's certainly not the most
21 important, but I would want to look at the primary
22 evidence, and that's what I did in my report.

23 Q So is the most important thing what the evidence and
24 the data says?

25 A Absolutely.

26 Q What if government disagrees with that evidence and

1 data?

2 A Well, governments have, you know -- throughout the
3 history of medicine, there's all sorts of examples of
4 when governments got it wrong, different medical bodies
5 got it wrong. You know, data is always accumulating,
6 and so -- but, you know, lots of times they get it
7 right, but, of course, they're going to get it wrong.
8 Governments or any sort of political body or
9 educational institution or even scientific community
10 are not going to be infallible. Like there's lots of
11 people that make mistakes, and evidence is going to
12 change, you know, and they're influenced by a variety
13 of factors. They are -- and things are influenced by
14 cultural factors, things are influenced by political
15 factors, so, yeah, it's a very complex thing.

16 (AUDIO/VIDEO FEED LOST)

17 THE CHAIR: Can we just --

18 MR. KITCHEN We've lost --

19 THE CHAIR: Yeah.

20 MR. KITCHEN I only have one more question,
21 so if we get Dr. Martens back, then I'll be done.

22 THE CHAIR: Okay, we'll just wait a
23 moment; I'm sure she'll be reconnecting.

24 (DISCUSSION OFF THE RECORD)

25 Q MR. KITCHEN: Dr. Warren, thank you, you've
26 been very patient with me. My last question for you

1 is, as a medical professional working with infectious
2 diseases, have you found the information or opinions
3 regarding COVID restrictions coming from government
4 sources such as the Public Health Agency of Canada to
5 be well supported by real scientific evidence or not so
6 well supported by real scientific evidence?

7 A So with regards to COVID-19?

8 Q With COVID restrictions.

9 A Yeah, I -- again, it's a complex question, but, in
10 general, I would disagree with a fair amount of what my
11 Provincial government has done. Like they've
12 admitted -- you know, they were taping up children's
13 playgrounds in two different waves, it just makes no
14 sense.

15 But, again, it all depends on what we're talking
16 about. Some things I do agree with, certain quarantine
17 and testing and various treatment things I do agree
18 with, other things I don't, but anything that I would
19 have had issue with would have been found in my report.

20 Q So you don't agree with the masking and physical
21 distancing, I take it?

22 A Yeah, my position is as it is in the report, and that
23 would be quite different than what has occurred in my
24 jurisdiction.

25 MR. KITCHEN: Well, those are all my
26 questions.

1 Now, I know it's getting close to lunch, but I
2 suspect Mr. Maxston's going to be quite brief, and so I
3 propose that we go until lunch, but I leave that with
4 Mr. Maxston.

5 THE CHAIR: I was just going to ask you,
6 Mr. Maxston, if you have some idea of how long you
7 might be.

8 MR. MAXSTON: I think I'll be 15 minutes, I
9 don't know, depending on how, you know, again
10 Dr. Warren might respond, I might have some follow-up
11 questions. My sense is, and I leave this up to you to
12 decide, but people would probably, and I invite
13 Dr. Warren's comments and your colleagues', we probably
14 want to plow through into the lunch hour and maybe try
15 to finish any redirect and any questions from the
16 Tribunal before we break for lunch. Now, that's -- I
17 don't want to see us going till, you know, 1:25 and
18 missing lunch for everybody, but my sense is maybe we
19 should try to press ahead here for 15 or 20 minutes,
20 see where we're at. Mr. Kitchen may have some
21 follow-up. Let's just try to make as much progress as
22 we can before maybe 12:30 or something like that.

23 THE CHAIR: I agree with you, and I see a
24 very vigorous nod from Dr. Warren; I think he's
25 supportive of that. I'm going to suggest that we just
26 take a 5-minute stretch, bio break now, and we'll come

1 back, and we'll -- nose to the grindstone and try and
2 see where that takes us, okay?

3 MR. LAWRENCE: Sorry, can I just -- Amber,
4 can you stick us in a break-out room? I just want to
5 chat with Blair for a few minutes.

6 THE CHAIR: Think we'll be back at 10
7 after 12, because I do anticipate there's going to be
8 some discussion, so we'll see everybody in 15 minutes.

9 (ADJOURNMENT)

10 THE CHAIR: So we're back in session, and
11 Mr. Maxston has some questions on cross-examination for
12 you, Dr. Warren.

13 A Okay.

14 Mr. Maxston Cross-examines the Witness

15 Q MR. MAXSTON: Afternoon, Dr. Warren.

16 A Afternoon.

17 Q It's noon here now as well, so that's universal. Thank
18 you for taking your time out of a Saturday. I don't
19 have a lot of questions for you.

20 I just wanted to start off by confirming a few
21 things you said to Mr. Kitchen, and the first was that
22 the, I think, the infection fertility ratio varies over
23 time; is that correct?

24 A Infection fatality ratio, yes, not fertility.

25 Q Thank you, not -- yes, thank you. And the IFR for
26 COVID, I think you said exceeded a bad influenza year

1 when COVID-19 first began in Canada; is that correct?

2 A Yeah, so what I was saying is that very early on,
3 because it was really only symptomatic cases being
4 detected and tested for, and there was still a very
5 vulnerable population, the IFR was quite high. But
6 over time, as COVID has infected more and more people,
7 there have been different strains, including especially
8 Omicron, the IFR has continued to drop over the past 21
9 months or so --

10 Q Yeah.

11 A -- so --

12 Q I think that --

13 A -- I think it's graphed out in a number of places, and
14 it's declining over time.

15 Q I think you might have said that in April or May of
16 2020, that was the first wave for COVID-19, and that's
17 when the IFR would have been its highest; is that fair
18 to say?

19 A Correct, yeah.

20 Q You had a discussion with Mr. Kitchen about the word
21 "pandemic", and I think you said that COVID-19 is
22 definitely a pandemic, and you supported that by saying
23 that this is the first time we've seen a virus on all
24 seven continents; is that correct?

25 A Correct.

26 Q You also said that there's going to be some debate

1 about when it's becomes endemic, and I think you said
2 the decision about when it's going to become endemic is
3 arbitrary, is that your evidence?

4 A Well, yeah, different people are -- you see some people
5 saying now that it's endemic, others are going to say,
6 well, there's these and these criteria. There's no
7 established criteria. I gave kind of what I think is a
8 reasonable thing, which is that once it's replaced with
9 a different virus, not entirely, because COVID-19 or
10 SARS-CoV-2 will continue to circulate indefinitely, but
11 once the predominant virus is something else in most
12 regions, I think that's a good place to say, well, it's
13 now endemic.

14 Q You're kind of leading --

15 A There's no established -- sorry, there's just no
16 established definition as to when the pandemic ends and
17 when the endemic phase begins.

18 Q And you're kind of leading me to my next question,
19 which was inasmuch as it's going to be arbitrary, it's
20 probably going to be subjective as well, isn't it?

21 A Yeah, you can use whatever term you want, arbitrary,
22 subjective, yeah.

23 Q You had, a number of times, interactions with
24 Mr. Kitchen about how science has evolved with respect
25 to each virus or pandemic, and that there is discussion
26 and debate within the scientific community, and I think

1 you referred to different studies, and Mr. Kitchen took
2 you through that. While that debate is occurring --
3 and I'll be more specific, while that debate was
4 occurring in Canada when COVID-19 started and is still
5 continuing, it's up to governments to make decisions
6 though and orders in terms of how we respond to the
7 pandemic; is that fair?

8 A Yeah, that's the role of government is to make
9 decisions.

10 Q Yeah, and what I'm getting at there, I believe this is
11 consistent with what you said, the CMOH, and I'll use
12 Ontario, for example, but it's the same here, it's the
13 CMOH that issues those public health orders that the
14 public is required to follow; is that fair to say?

15 A Yes, the CMOH does have an important role -- or
16 that's -- the CMOH has had an important role in Canada
17 in different jurisdictions and provinces, but, yeah,
18 it's still the government itself as well making certain
19 things mandatory and usually will do so with
20 consultation of the CMOH.

21 Q And I'm not trying to be cagey here, I'm just trying
22 to -- I want to be clear that there's a distinction
23 between the scientific debate, which has people on both
24 sides or multiple sides of an issue, versus the
25 decision-making, which is done by government and other
26 government entities, I suppose. That's really what I'm

1 getting at.

2 A Yeah, I would agree with that. I would agree with that
3 a hundred percent, because policy is always very
4 different than scientific rationale, and so --

5 Q Right.

6 A -- there's lots of policy decisions that have been made
7 that are not justified by science.

8 Q Yeah, and I think -- you know, I was talking with you
9 about CMOH orders, but I'm thinking in Alberta, and I
10 know -- I'm pretty sure they had these in Ontario, we
11 had various re-opening requirements issued by
12 government. If you wanted to open your gym, your
13 salon, what have you, there were certain requirements
14 that have to be followed, and I think you probably
15 agree that, despite the scientific debate going on,
16 businesses had to follow those requirements if they
17 wanted to re-open?

18 A Yeah, that would be their decision, but, yeah.
19 Absolutely.

20 Q You had a very I think fulsome discussion with
21 Mr. Kitchen about you and wearing of masks, and I think
22 you said to him that you are required to wear a mask at
23 work when you're asymptomatic regardless of, you know,
24 symptoms; that was your evidence, I think?

25 A Yeah, when I'm working in the hospital, I'm required
26 to -- except when I'm in my own private office --

1 Q Right --

2 A -- with the door closed.

3 Q -- right. And in fairness --

4 A (INDISCERNIBLE)

5 Q -- I'm really concerned about the situation where
6 you're treating patients, because that's what our
7 hearing is talking about, and I think you were pretty
8 candid about that. Mr. Kitchen mentioned to you CPSO,
9 College of Physicians and Surgeons of Ontario,
10 requirements for masking, and I think you said -- he
11 asked you whether you knew whether they had any, and
12 you said, I'm sure they do. And I think you indicated
13 you would follow them if they applied to you, and in
14 fact, I think you said you are following them when you
15 wear a mask in the hospital. Is that fair to say?

16 A That's correct.

17 Q Would you agree that, as a member of the CPSO, you
18 can't pick and choose which of their requirements for
19 your practice applies or doesn't apply for you?

20 A I don't have a choice in the matter, no. The CPSO and
21 various other regulatory bodies can make requirements,
22 my hospital can make requirements of something that I
23 don't agree with or I think is not based on evidence --

24 Q That was going to be my next -- sorry, were you
25 finished?

26 A Yeah.

1 Q Yeah. That was going to be my next question was, you
2 know, there's situations, and I think masking might be
3 one of them, where you would disagree with your
4 regulator or maybe a hospital policy where you're at,
5 but your evidence I think is that you, nonetheless,
6 would follow those requirements?

7 A That's correct.

8 Q Mr. Kitchen and you engaged in a discussion about
9 government and non-government bodies, and he asked you
10 some questions about that. I just want to be clear,
11 you gave some answers about your knowledge of the
12 Ontario experience, but you don't have any knowledge of
13 the Alberta experience in terms of how CMOH orders were
14 issued or weren't issued; that's correct?

15 A I have some knowledge of Alberta, but certainly nothing
16 like I would have here in Ontario, because -- like you
17 know, this case or whatever else, I've got some
18 knowledge of Alberta, but not nearly as much as I would
19 have of Ontario.

20 Q And I think, again, and I'm not trying to be critical
21 here, I just think it's factual, Dr. Hu, in his
22 testimony and his expert report, was directly involved
23 in working with the CMOH office on certain aspects of
24 their orders in Alberta; is that your understanding?

25 A I know nothing about Dr. Hu.

26 Q You had a discussion about, and Mr. Kitchen can correct

1 me if I'm paraphrasing his words incorrectly, but I
2 think generally he asked you about whether government
3 or non-government entities can be -- are more accurate,
4 or less accurate, or more correct or less accurate, you
5 know, when we compare them, and I think you were pretty
6 candid in saying that it's fairly divergent, and lots
7 of times government gets it right, and lots of times
8 non-government entities get it right; is that fair to
9 say?

10 A Yeah, it's a very complex issue, and it's such a broad
11 question that I don't think any kind of sweeping
12 statements can be made.

13 MR. MAXSTON: Those are all my questions,
14 Dr. Warren. Thank you for your time.

15 A Thank you.

16 MR. KITCHEN And I --

17 THE CHAIR: Thank you.

18 MR. KITCHEN: -- just have two in redirect.

19 THE CHAIR: Okay.

20 Mr. Kitchen Re-examines the Witness

21 Q MR. KITCHEN: Dr. Warren, you said there's
22 no established criteria for establishing an endemic.
23 Is there any established criteria for establishing a
24 pandemic?

25 A I think the -- yes, there would be, you know,
26 established -- you know, the WHO, different

1 organizations would have definitions for a pandemic,
2 however you want to define a pandemic. SARS-CoV-2 is a
3 pandemic, and there are certainly more definitions or
4 clearer definitions for when there is a pandemic and
5 when it's been established than when an infection
6 transitions from pandemic to endemic.

7 Q How come only some flu years are pandemic and some
8 aren't? I don't want you to -- I don't want to rehash
9 what we did earlier. You said something about --
10 something I didn't, frankly, understand. I think
11 something about how the virus has changed. That's what
12 I'm trying to get at. Is there --

13 A Yeah. So year to year, influenza changes, it mutates,
14 we have different strains. It's equivalent to
15 SARS-CoV-2, how we have different variants. They're
16 both very -- they're similar viruses; they're RNA
17 viruses; they mutate at approximately the same rate.

18 So in influenza, year to year, there's something
19 called antigenic drift, which are minor changes that
20 produce the seasonal yearly influenza. Every few
21 decades, there's an antigenic shift, so not drift but
22 shift, and that's a major reassortment of a virus,
23 which generally causes more widespread illness, more
24 severe illness, because many people in the population
25 do not have sufficient immunity, and so that's, you
26 know, swine flu 2009 would be kind of the last example

1 of that. The Spanish flu from a hundred years ago is
2 another example. And there were I think three or so
3 other pandemic influenza years in the 20th century.

4 Q When we go from variant to variant in COVID, is that a
5 similar thing, or is that different?

6 A So that would be, if you want to make it analogous to
7 influenza, that would be the antigenic drift part of
8 influenza, and so that would be the -- kind of the
9 yearly fluctuations, and we'll continue to have that,
10 there'll be a new wave after Omicron, something of a
11 new variant. In influenza, we called it the yearly
12 strain. And so that's what the analogy would be with
13 influenza. The variants are new -- are analogous to
14 influenza antigenic drift.

15 Q And that's what we referred it to, COVID-19 or
16 SARS-CoV-2, is one big long event, they don't -- we
17 haven't chopped it up; we refer to it as one big long
18 thing, that's -- because there's only drifting not
19 shifting?

20 A That's correct.

21 Q Last question I think, if government has a role to
22 impose measures to protect the public, do they also
23 have a corresponding role to remove those measures once
24 it's clear that they don't work or cause more harm than
25 good?

26 A I think any policy decision needs to be based on

1 evidence, and I think the more significant a policy
2 decision is, the more evidence should be behind it,
3 because if you're going to make a policy decision that
4 significantly impacts people's lives, there should be a
5 lot of good evidence for that.

6 And so same with changing policy decisions, any
7 time a policy decision is changed, it should be based
8 on evidence. And again, I think the burden of proof,
9 the more significant the policy decision, the more the
10 higher burden of proof is on the evidence that that
11 policy decision is based on.

12 Q And are you seeing that evidentiary burden being met
13 for things like masking and distancing?

14 A Yeah, yeah, for sure. With regards to masking for
15 sure. Like a lot of places -- a lot of places like
16 Denmark, the UK, Ireland, many places in the States, a
17 lot of jurisdictions are getting rid of masking because
18 there's no -- like the evidence just isn't there.
19 There was an assumption, and so the policy decision was
20 based on an assumption, that I would argue flawed
21 assumptions, but as evidence accumulates, jurisdictions
22 are now starting to get rid of mask mandates, for
23 example.

24 Q Logically speaking, if the virus is the same and the
25 scientific evidence is the same between Florida and
26 Alberta or between Canada and Denmark, then can it

1 logically be said that Canada's decision to keep
2 masking in place is based on science, or is it based on
3 something else?

4 A Well, I argue in my report I don't think that -- I
5 would argue in my report that there was never a
6 justification to mask healthy persons in the general
7 public. That evidence base was never there. I argued
8 that from the meta-analyses and studies in flu, and
9 that evidence continues to be accumulating specifically
10 for SARS-CoV-2.

11 Q So is it fair to say that places that are removing mask
12 restrictions are following the science, and places that
13 aren't are ignoring it?

14 A Yeah, I think the word "the science" has been way
15 misused in --

16 Q (INDISCERNIBLE)

17 A -- this last two years, so I won't use that term, but I
18 would say the --

19 Q How about the evidence?

20 A The evidence, I would say the evidence never has --
21 there has been no evidence that masking the general
22 public is of any benefit, the healthy general public.

23 Q So at some level, isn't it required of governments that
24 are continuing to impose mask mandates that they're
25 ignoring the evidence?

26 A Again, policy and evidence-based decision-making are

1 often very different things. Policy is informed by
2 many other factors other than evidence.

3 MR. KITCHEN: Thank you. Those are my
4 questions in redirect.

5 THE CHAIR: Okay. Dr. Warren, the Members
6 of the Tribunal may have questions for you. We're just
7 going to take a 5-minute break while we discuss what
8 questions, if any, we have for you. So if you can just
9 bear with us for 5 minutes, I don't think we'll be any
10 longer. Thank you.

11 (ADJOURNMENT)

12 THE CHAIR: The Hearing Tribunal is back
13 in session. And, Dr. Warren, we'd like to thank you
14 very much for your time and your expertise and your
15 testimony today. Members of the Tribunal do not have
16 any additional questions for you. We appreciate you
17 participating in this process, and Mr. Kitchen will
18 discharge you, unless there's anything else.

19 There's just one matter I would like to ask of the
20 College. Ms. Nelson, we are concerned over finding two
21 consecutive dates, and we would really appreciate
22 seeing the Doodle poll go out as soon as possible,
23 knowing how much pressure there is on various people's
24 calenders, so we'll look forward to getting that in the
25 near future.

26 And unless there's anything else, I'll declare the

1 hearing closed until we meet again, and we will meet
2 again sometime in the spring.

3

4 PROCEEDINGS ADJOURNED

5

6 CERTIFICATE OF TRANSCRIPT:

7

8 I, Karoline Schumann, certify that the foregoing
9 pages are a complete and accurate transcript of the
10 proceedings, taken down by me in shorthand and
11 transcribed from my shorthand notes to the best of my
12 skill and ability.

13 Dated at the City of Calgary, Province of Alberta,
14 this 22nd day of February, 2022.

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Karoline Schumann

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Karoline Schumann, CSR(A)

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Official Court Reporter

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0.00000 1240:16	15 1231:12	1275:21,22	1247:9 1268:24	99 1282:14
0.009 1281:5,6	1264:15 1283:2	1295:11 1302:24	1281:20,21	9:08 1221:1
0.15 1238:12,14	1293:11 1311:8,	1303:3,14,21	1293:19	9th 1303:21
1240:11,15	19 1312:8	1313:16	53 1259:21	<hr/> A <hr/>
1241:14 1246:16	15-minute	2021 1303:4,10,	55 1303:11,25	ability 1325:12
0.7 1279:21	1264:11	14,22	<hr/> 6 <hr/>	absence 1257:14
09 1281:3	16 1268:20	2022 1219:5	6 1263:7 1270:20	1284:2
<hr/> 1 <hr/>	1293:11 1305:6	1220:5 1230:24	1304:11	absolute
1 1229:23 1247:2,	160s 1251:5	1325:14	6-feet 1270:14	1279:19,20,22
3 1280:24 1281:6	16th 1303:10,22	20th 1252:8	60 1234:15	1280:20,22,25
1291:25 1292:4	17 1225:23	1321:3	1240:10,12,18	absolutely
1,000 1304:26	1245:20	21 1313:8	1263:9 1302:23	1239:17 1245:17
1,010 1303:8	1720s 1269:6	22nd 1325:14	1303:9,13	1250:9 1254:16,
1304:26	18 1245:19	24/7 1225:24	1304:6,9 1306:4,	19 1263:5 1287:1
1,191 1303:10	1918 1245:21	25 1246:19	5	1291:7 1300:10
1,475 1305:4	1919 1245:19	1260:12 1261:9	67 1280:19	1302:15 1303:16
10 1243:22	1920 1245:19,21	1262:7 1264:16	69 1279:21	1308:25 1316:19
1283:2 1312:6	1968 1252:8	1298:3	1280:10	ACAC 1220:10,
100 1281:20	1:25 1311:17	29 1219:5 1220:5	<hr/> 7 <hr/>	11,13,16
11 1264:16	1st 1279:8	29th 1305:4,6	7 1300:23 1301:3,	academia
1297:23 1307:16	<hr/> 2 <hr/>	<hr/> 3 <hr/>	4,10,11	1228:16
1100 1275:15	2 1237:1 1247:5,6	3 1259:9 1264:22	70 1239:22	academic
1281:4,6,10,13,	1302:18	1270:20 1289:4	75 1246:25	1231:20 1256:1,
24,25	2-thousand	1292:5 1302:19	76 1279:21	10 1257:4,12
1150 1275:9	1245:21	3-feet 1270:14	1280:9,19	1263:19 1264:26
12 1303:5,7,23	20 1237:11,17,23	30 1298:3	<hr/> 8 <hr/>	1294:4
1312:7	1243:22 1311:19	300,000 1279:2,5	8 1233:10,12	accident 1303:15
1221 1219:5	2005 1223:21	<hr/> 4 <hr/>	1234:7,14	1306:7
1223 1219:6	2008 1223:25	4 1265:5	80 1234:11,15	accidents
1228 1219:8,9	2009 1252:7	40 1306:10	1237:9,13 1238:3	1304:10
1229 1219:10	1320:26	<hr/> 5 <hr/>	1241:2 1259:24	accrue 1304:21
12:30 1311:22	2010 1271:1	5 1234:14	80,000 1260:6	accumulate
13 1303:22	2011 1223:25	1264:22 1271:7	<hr/> 9 <hr/>	1231:18
1305:2	2015 1228:14	1277:5 1324:9	9 1280:20	accumulates
1312 1219:12	2018 1245:20	5-minute		1258:18,26
1319 1219:13	1303:11	1311:26 1324:7		1322:21
1325 1219:14	2019 1303:6			accumulating
	2020 1241:23			1230:17 1258:3
	1242:5,17 1250:7			1309:5 1323:9
	1254:11,12,13			accurate
				1238:16,20

1240:16 1242:13 1261:25,26 1272:10 1306:17 1307:18,20 1308:4,8 1319:3, 4 1325:9	affecting 1251:4 affects 1232:9,10, 11,12 Africa 1239:24 1240:1 1251:6 1278:19 African 1238:22 1240:1 Afternoon 1312:15,16 age 1230:3,4,5 1234:25 1237:11, 15,18,22,24,26 1238:4,7,12,24 1239:21 1240:24 1241:7,10 1245:1 1257:6,10 1282:13 1302:23 1303:9,12,13,23, 24,26 1304:9 1305:8,25 1306:12	1316:9 1318:13, 15,18,24 1322:26 1325:13 Aldcorn 1220:10 1221:26 allowed 1275:22 1276:12 1288:22 1292:14,18 Alpha 1249:2,8, 10 Amber 1312:3 Ammonium- type 1287:24 amount 1225:26 1310:10 analogous 1321:6,13 analogy 1321:12 analysis 1303:19 1308:12 and/or 1226:11 answers 1318:11 Antarctica 1251:16 antibiotic 1224:21 antibiotics 1281:17 1297:26 anticipate 1312:7 antigenic 1251:26 1252:1,3 1320:19,21 1321:7,14 antimicrobial 1224:20,21 1297:23 Antonine 1251:5 anxiety 1288:24 1289:7 anymore 1297:26 apartment 1233:15	appeared 1279:9 apples 1239:5 1240:3,4 applied 1317:13 applies 1274:3 1317:19 apply 1317:19 appointment 1225:5,8 1228:18,19 approach 1260:19 approaching 1244:9 1245:13 1246:2 approving 1228:23 approximately 1237:10 1275:9 1281:4 1305:6 1320:17 April 1254:12,13 1303:1,3,4,10,14, 22 1313:15 arbitrary 1252:25 1253:7, 10 1289:13 1314:3,19,21 archeological 1308:14 area 1234:16 1294:26 1296:10, 16,22 areas 1226:21 1267:22 1284:12 1291:26 1292:2 1306:13 argue 1251:4 1266:11 1289:18 1293:16,21 1296:6 1322:20 1323:4,5 argued 1292:20 1323:7	arguing 1234:1 1302:4 articles 1231:20 1257:7 Asia 1239:24 1251:6 aspects 1318:23 assertion 1293:26 assistant 1225:6 Association 1220:2,15 assume 1243:14 assumed 1297:21 1298:6 assumption 1258:15,24 1262:12 1263:1 1283:24 1284:1 1322:19,20 assumptions 1257:14,17,21 1258:8 1259:8 1263:4 1322:21 asymptomatic 1243:21 1259:8, 11,18 1260:12,22 1261:2,14,18 1262:1,7,16,24 1263:8,10,26 1264:4 1271:10, 11,13,16,22 1272:12 1273:21 1276:3,9,15,24 1277:7 1288:15 1290:2,6 1300:24 1301:15 1302:2, 14 1316:23 Atlantic 1257:4,7 attack 1287:5 attempts 1235:14,15 1254:17,20 attenuate 1247:23
--	--	--	--	--

attenuated 1248:6	bandwidth 1221:19	benefit 1259:1 1277:9,23 1279:18 1280:16 1283:13 1289:23 1295:6 1301:18 1323:22	Boston 1269:7,8	calculate 1239:2
attenuates 1247:15	Bangladesh 1258:23 1279:1,2	benefits 1257:19	bottom 1277:26 1302:18	calculating 1239:17
attributed 1294:11	Bangladeshi 1270:17	Beta 1249:2 1267:8	bottom-line 1279:15	calenders 1324:24
audio 1223:8	base 1249:3 1291:12 1292:21 1323:7	bias 1242:8,9,11 1295:19	break 1229:18 1238:1,6 1260:20 1262:26 1263:6 1264:6,11,14 1311:16,26 1324:7	Calgary 1325:13
AUDIO/VIDEO 1309:16	based 1232:21 1239:17 1249:3 1251:7 1254:22 1256:4 1261:4 1262:14 1267:5, 13 1272:21 1278:6 1291:15, 25 1292:10 1293:26 1299:25 1317:23 1321:26 1322:7,11,20 1323:2	big 1241:13 1257:2 1277:12 1321:16,17	break-out 1312:4	California 1293:2,4
Australia 1235:23,25	basic 1304:15,18	bigger 1274:13	briefly 1224:2 1268:16	call 1225:24 1246:9,10 1253:4 1262:10 1271:16
authors 1283:21 1284:4	basically 1226:1 1265:19 1266:25 1285:7 1303:18	billion 1247:5	bring 1221:16 1236:26 1279:20 1301:10	called 1224:20 1227:23 1257:15 1267:8 1277:12 1280:25 1320:19 1321:11
average 1267:8 1297:2 1303:18 1304:8 1305:7	basis 1245:24,25 1246:21 1297:22	billions 1299:11	bringing 1222:11	calling 1227:24
aware 1246:14 1263:11,13 1279:9 1282:6 1283:25 1290:21 1294:3	bathtub 1305:20	bio 1311:26	broad 1272:6 1306:24 1307:8 1319:10	camera 1264:13
	bear 1303:2 1324:9	bit 1236:15 1240:2 1244:5,10 1259:7 1274:13	broader 1272:5, 19	campus 1225:22
	bearing 1254:25	Black 1268:23 1299:1	broke 1280:13,14	campuses 1225:21
	before/after 1294:16 1295:1, 18	Blair 1222:13 1312:5	bubbles 1305:18	Canada 1230:23 1240:9 1246:5 1250:6 1255:16 1256:12,15 1257:24 1267:2 1293:10 1302:24 1303:20 1304:5,6 1305:26 1310:4 1313:1 1315:4,16 1322:26
	begin 1313:1	bleach-type 1287:24	buildings 1233:15	Canada's 1244:15 1323:1
	beginning 1241:15,22 1252:19 1298:15	blew 1293:12	built 1288:10	Canadian 1230:21 1239:2
	begins 1314:17	blocks 1268:2	bunch 1242:2 1266:8	cancer 1244:22, 23 1271:15
	behavioural 1288:25	boat 1269:6,9,10	burden 1261:4 1322:8,10,12	candid 1317:8 1319:6
	beneficial 1286:11 1298:7	bodies 1255:18 1290:15,16 1306:16,18 1307:2,3,5,21,22, 25 1308:18 1309:4 1317:21 1318:9	burns 1248:3	capacity 1225:4 1233:2
		body 1284:21 1293:5 1309:8	burrows 1233:13	capita 1296:3
		bold 1301:3,11	businesses 1316:16	car 1305:24 1306:7
		books 1298:5	busy 1225:24	
		borderline 1227:10	buy 1234:16	
			C	
			cagey 1315:21	

cardiology 1281:16,18	certified 1223:26	children 1257:6, 10 1258:12,14, 17,20 1259:5 1270:14	clarifying 1228:20	CMOH 1315:11, 13,15,16,20 1316:9 1318:13, 23
care 1224:10 1233:2 1238:4 1258:16 1276:19, 20,21,25 1282:4, 22,26 1283:3,4,5, 18 1284:10,13, 15,19 1285:1,5,9, 14,15,17,22 1286:4,5,8,14,20, 23,25 1288:12 1289:12 1290:10, 25 1293:20 1300:15,17,21 1301:19,23,26 1302:5,7,8,11	certify 1325:8	children's 1310:12	classic 1293:2 1294:8	co-workers 1265:25
carefully 1256:23	cetera 1227:6 1240:16 1301:16	China 1268:18	classrooms 1258:22 1270:17	Cochrane 1265:4 1277:15
carrier 1261:23	Chair 1219:8 1220:8 1221:2,15 1222:23 1226:20, 26 1227:19,21 1228:5,8,9,20,22 1260:16,18,24 1264:10,18 1272:24 1274:15 1309:17,19,22 1311:5,23 1312:6,10 1319:17,19 1324:5,12	chiropractic 1221:26 1274:4 1276:15	cleaners 1287:23,24	coffee 1292:3
case 1222:9 1229:10 1247:2 1266:7 1284:3 1288:17 1318:17	challenging 1298:4	chiropractor 1274:4	cleaning 1287:21,22	cognitive 1259:4 1288:25
cases 1242:15 1254:1 1269:3 1294:10 1295:13, 14,26 1296:3,7, 11,14 1297:4,7 1313:3	change 1230:4 1233:9,19 1243:17 1246:4 1249:3,8,19,20, 22,26 1252:4,11 1257:1,22 1267:11 1297:21 1298:4,11 1305:5 1309:12	chiropractors 1220:2,15 1271:20,22 1272:10,12,25 1273:4,9 1275:9, 18,22 1276:1,4,8 1290:19	clear 1228:1 1237:19 1239:6 1251:10 1258:6 1266:19 1271:10 1298:8 1315:22 1318:10 1321:24	colder 1271:18
caucus 1222:6 1228:23	changed 1230:2, 6,13,15 1232:9, 16 1241:16 1243:10 1249:4,5 1259:14,16 1264:2 1304:23 1320:11 1322:7	choice 1317:20	clearer 1237:21 1320:4	colleagues' 1311:13
caucusing 1222:7	causing 1248:11	choose 1317:18	client 1221:12 1227:1 1274:24	College 1220:2, 15 1222:10,11 1223:25 1228:25 1290:18,19,21 1317:9 1324:20
caused 1224:8	caucus 1222:6 1228:23	chopped 1321:17	climate 1232:8 1299:17	College's 1272:4
causing 1248:11	caucus 1222:6 1228:23	circulate 1247:13 1314:10	clinic 1288:20,21	COMMENCED 1221:1
CDC 1240:22 1263:9	change 1230:4 1233:9,19 1243:17 1246:4 1249:3,8,19,20, 22,26 1252:4,11 1257:1,22 1267:11 1297:21 1298:4,11 1305:5 1309:12	circulates 1247:15	clinical 1224:10 1225:6 1284:7 1292:4,5	comment 1227:22 1263:16 1272:4,18
cease 1257:25	changed 1230:2, 6,13,15 1232:9, 16 1241:16 1243:10 1249:4,5 1259:14,16 1264:2 1304:23 1320:11 1322:7	circulating 1235:17,25	close 1233:15 1243:23 1260:6 1262:19 1264:8 1266:15 1311:1	comments 1227:3 1311:13
central 1271:25	changing 1267:10 1304:22, 24 1322:6	circulation 1236:2	closed 1292:1 1317:2 1325:1	commits 1256:25
century 1252:8 1321:3	characterization 1273:6	citation 1263:11	closer 1241:7 1289:10	committed 1304:12
Certificate 1219:14 1325:6	characterize 1252:22	cite 1263:14,17	cloth 1279:16 1280:14,15 1282:25,26 1283:2,3 1285:24 1286:3	common 1244:26
	charges 1275:3	cited 1230:25	cluster- randomized 1258:21,23 1270:16 1278:24 1279:1,16	community 1235:17 1236:3 1244:3 1254:7 1278:1 1284:20, 23,26 1285:6,9, 13 1286:12 1292:13,20 1300:9,13 1309:9 1314:26
	chat 1312:5	cities 1268:17		comorbidities 1240:22,24 1241:3,6,8
	Chief 1243:11	City 1233:8,10,13 1234:9,15,17 1325:13		

1306:12	20	CONTENTS	1323:9	19,24,25 1317:16
comorbidity	conclusions	1219:1	continuing	1318:7,14,26
1240:26	1272:20 1279:12,	context 1275:3	1235:15 1315:5	1319:4 1321:20
comparative	14,15	1278:12 1282:3,5	1323:24	correctly
1307:23	conducting	1283:16 1284:3,5	contracts	1240:10
compare	1282:3,4	1285:20 1286:4,	1282:11	corridor 1297:10
1237:16 1238:25	confident 1254:5	7,17,19 1288:19,	contradicted	costs 1299:10
1239:1 1240:3	confirmed	26 1289:2,3	1263:8	Counsel 1220:9,
1280:11 1282:15	1280:3	1291:15,18,20,25	contradictory	16,19
1319:5	confirming	1292:20 1298:22	1277:22	counted 1304:4
compared	1312:20	1300:15,19	contrary 1298:8	counter-
1277:12 1280:17	confounding	1302:4,5	contributes	balanced
1282:2 1285:24,	1295:19,20,23	context-	1240:11	1265:26
26 1293:1	congregate	dependant	contributor	countries
comparing	1266:13	1285:19	1261:3	1238:26 1239:23
1239:3,5	connection	context-	control 1224:17	1256:21
1256:21,22	1264:12,14	dependent	1258:19 1280:8,	country 1238:22
1270:3 1283:17	cons 1287:26	1285:19 1289:12	18 1285:25	1239:4,18,23
comparison	consciousness	1291:8 1300:16	1294:15	1243:7 1278:19
1239:7 1240:6	1269:1 1298:26	1308:5	controlled	1293:23
1302:16 1304:13,	consecutive	context-specific	1260:7 1265:6,	country-specific
16	1324:21	1291:11	11,12,18 1268:11	1231:16
Complaints	consent 1305:15,	contexts 1282:22	1269:25 1270:9,	couple 1229:6
1222:12 1227:11	16	1283:7,9 1291:8	13 1277:7,10,19	1250:14 1260:25
complete 1236:5	conservative	1292:4,5 1300:22	1278:14 1280:22	1299:24 1306:15
1249:21 1325:9	1247:8	contextual	1282:20,21,24	courses 1267:6
completely	considered	1305:16	1283:23 1284:9	court 1220:21
1254:17 1284:25	1244:3 1261:3,7	contextualize	1285:24,26	1222:17,25
1285:8 1289:11,	1267:21 1289:3	1306:14	1286:9 1289:24	1223:5 1325:20
21 1300:13	1292:20	contextualizing	1295:5 1298:1	covered 1228:3
1308:5	consistent	1306:3	1308:16	covering 1224:16
complex 1300:3	1315:11	continent 1254:8	controlling	COVID 1235:19
1309:15 1310:9	consultation	continents	1224:23	1237:7 1238:12
1319:10	1315:20	1251:4,9,18	controls 1280:18	1243:15 1247:10
complicated	contact 1233:24	1313:24	convince	1252:18 1263:9
1250:2 1269:15	1234:6,11 1260:1	continue	1297:24	1271:3 1276:11
1298:20	1262:19	1227:15,16	Coronavirus	1277:6,14,15,16
conceptually	contacts 1232:25	1228:26 1235:5	1235:3,16 1236:7	1278:12 1280:4
1301:25	1233:25 1243:23	1304:1 1314:10	Coronaviruses	1282:3,11
concern 1307:9	1268:15	1321:9	1230:22 1235:9	1283:8,16,23,25
concerned	contentious	continued	1244:20 1247:18	1284:19 1286:13
1275:1 1317:5	1273:1 1275:11,	1231:18 1304:21	correct 1231:22	1288:20 1290:1,
1324:20	18	1313:8	1252:17 1255:15	5,10 1291:5,13,
conclusion		continues	1276:16 1286:21	22 1292:26
1275:2 1295:17,		1297:16 1305:3	1312:23 1313:1,	1293:3,25

1298:12,19
1300:25 1302:17
1303:13,26
1304:4 1306:6
1310:3,8 1312:26
1313:6 1321:4

COVID's
1252:26

COVID-19
1226:11,13,23
1266:5,21 1278:9
1301:6,14 1302:8
1306:4 1310:7
1313:1,16,21
1314:9 1315:4
1321:15

COVID-RELATED
1302:22 1303:9

CPSO 1226:5
1290:5,12
1317:8,17,20

cramp 1236:12
criteria 1251:19
1254:3 1314:6,7
1319:22,23

critical 1318:20
cross-examination
1304:17 1312:11

cross-examines
1219:12 1222:14
1312:14

cross-immunity
1247:18

cross-protection
1247:17

cross-reactive
1252:6

CSR(A) 1220:21
1325:19

cultural 1309:14

current 1225:13
1234:21

Curtis 1220:18
1229:7
cut 1289:8 1299:4
cutoff 1253:12
cv 1228:12
cyclical 1231:24
1235:1

D

daily 1246:21
1297:22
dangerous
1261:21
dangerously
1244:4
data 1230:21
1231:18 1250:10,
12,15 1254:14
1259:14 1279:12
1297:14 1298:15
1303:22 1308:11,
24 1309:1,5

Dated 1325:13

dates 1324:21

David 1222:13

Dawson 1220:12
1222:1

day 1234:8,11
1243:1 1303:18
1304:4,7 1305:8
1325:14

days 1244:24
1257:8 1297:26
1298:2 1304:4

deal 1228:6
1297:22

death 1237:21
1240:25 1241:3
1268:23 1280:1
1281:12,25
1299:1 1302:17
1303:13,20
1304:5 1305:8
1306:1,3

deaths 1240:9
1242:3 1302:22
1303:9,18,23,26
1304:6,7,9

debate 1255:24,
26 1256:13
1257:2 1313:26
1314:26 1315:2,
3,23 1316:15

debated 1255:22
1269:23

debating 1256:7
1266:20 1270:6

debilitated
1244:22,23

decades 1245:25
1246:1 1320:21

December
1232:5 1275:22
1295:11

decide 1271:26
1273:19 1274:14
1294:15 1301:24
1311:12

deciding 1277:24

decimated
1298:24

decision 1314:2
1316:18 1321:26
1322:2,3,7,9,11,
19 1323:1

decision-making
1315:25 1323:26

decisions 1267:5,
13 1299:25
1315:5,9 1316:6
1322:6

declare 1324:26

declining
1313:14

decrease
1267:15,17
1293:4

decreased
1292:26 1293:24

deep 1268:22
1269:1

deep-rooted
1299:7

default 1283:24

define 1251:3,9
1253:12,14,23
1254:4 1271:12
1284:10 1302:6
1320:2

defining 1253:6

definition
1250:25 1251:1
1276:14 1278:6
1289:13 1295:2
1301:22 1314:16

definitions
1252:24 1320:1,
3,4

degree 1223:17
1299:18

Delta 1249:2,7,
10,18

demographic
1238:7

demus 1251:15

Denmark
1278:14 1322:16,
26

denominator
1304:2,23,24
1305:1,5

dense 1297:11

density 1233:4,6,
16 1234:19,24
1267:22 1296:8,
15,19,23,26
1297:6,8

depend 1287:7,
11

dependent
1286:17,18

dependents
1287:3

depending
1311:9
depends 1238:21
1251:9 1258:10
1271:12 1282:13
1308:1 1310:15

descendant
1248:5

describe 1231:21

describing
1246:13

Description
1219:3

design 1288:10

designed
1287:16,21

detail 1225:13
1291:1

detected 1241:18
1243:21 1313:4

detecting
1243:18

determination
1272:15

determining
1251:19 1297:1

diabetes 1271:15

Dianna 1221:25

die 1244:1,15,25
1305:21

died 1237:4
1246:26 1249:25
1250:23 1268:25

differed 1256:16

difference
1249:18 1250:16
1260:6,11
1265:22 1266:2
1270:15,20
1277:17 1278:17
1283:20 1284:6
1286:1 1293:8,13

differences
1256:20 1288:11

differently 1258:5	1314:25 1316:20 1318:8,26	Doug 1222:1	1278:14 1298:7 1302:25,26 1313:2	1265:5 1266:1 1279:26 1280:3,7 1292:23
differs 1241:10	disease 1224:3,4 1244:21,23 1248:11 1289:25 1304:15,19 1306:16 1307:17	downsides 1256:8	easy 1239:12 1253:12	endemic 1252:23,26 1253:2,4,6,8,11, 23 1254:6,15 1314:1,2,5,13,17 1319:22 1320:6
difficile 1284:15	diseased 1261:15	downtown 1268:2	Ebola 1248:2	endemicity 1254:4
difficult 1223:8 1257:16,22 1297:13,18,20 1298:8	diseases 1223:24 1224:7,8 1225:11,15,24 1226:22 1281:17 1290:9 1310:2	dozen 1231:7 1256:18	ecological 1256:25 1270:3 1293:14 1294:17, 18 1295:1	endlessly 1255:22
direct 1229:1 1264:19 1300:11	distance 1288:5	drafting 1230:14	economy 1299:16	ends 1314:16
directive 1272:17 1273:3, 8,12,25 1274:10, 11,16,24 1275:2, 19 1276:7	distancing 1226:24 1227:6 1264:25 1265:1,9 1266:23 1269:22 1270:14,15 1310:21 1322:13	dramatic 1250:16	Edmonton 1220:2	engaged 1318:8
directly 1318:22	distinction 1315:22	dramatically 1241:10	educational 1309:9	England 1225:2 1269:9 1283:15
Director 1220:13 1222:12,16 1227:11	distribute 1233:11	draw 1275:2	effect 1234:3 1254:24 1255:7, 9,22 1256:2 1266:22 1271:4 1280:16 1281:2 1293:17 1305:13	enrolled 1224:24
disagree 1255:11 1292:9 1293:25 1300:13 1301:20 1310:10 1318:3	divergent 1319:6	drift 1320:19,21 1321:7,14	effecting 1298:4	ensuring 1224:22
disagreeing 1302:9	divide 1296:22 1304:3,6	drifts 1321:18	effective 1269:22 1285:1,5,6,13,14, 15,17 1298:14,17	entire 1223:6 1236:4 1261:18 1296:24
disagreement 1273:3	divided 1280:24 1281:6 1288:7 1296:16	driving 1229:24 1305:24	effectively 1271:21	entities 1315:26 1319:3,8
disagrees 1308:26	dividing 1304:22	drop 1295:14 1313:8	effectiveness 1265:1 1282:16, 18 1286:18 1300:6,26	environment 1286:8 1302:11
discharge 1324:18	doctor 1304:14	droplets 1232:12,13	effectively 1271:21	epidemiologic 1295:16
discuss 1230:7 1239:1 1263:18 1264:23 1265:16, 17 1324:7	document 1263:19	dropped 1242:1	efficacy 1226:23 1227:5 1306:21, 25	epidemiologist 1304:14
discussed 1239:26 1261:12 1265:10 1276:23 1278:25 1279:11 1291:12,13	dog 1267:26	drug 1305:13	elderly 1244:13, 19,21	epidemiology 1224:26
discussing 1284:23 1289:7	dollars 1299:11	due 1304:9	eliminate 1249:14	equally 1291:9, 10
discussion 1270:8 1309:24 1312:8 1313:20	domain 1261:10, 11	duty 1229:12	emotional 1259:4	equation 1240:14
	domains 1261:8	dying 1249:13 1303:15 1306:6,7	end 1236:6 1237:1 1244:14, 24 1248:22 1250:5,15,17	equipment 1288:8
	Doodle 1324:22			equipose 1284:7
	door 1292:1 1317:2			equitable 1272:14
	doubt 1251:11			equivalent 1320:14
		E		
		earlier 1291:12, 13 1297:12 1320:9		
		early 1231:10 1241:17,19 1242:5,9,11,17 1243:19,23 1247:12,19 1248:19,21 1249:9,11,21 1254:12,13 1267:2 1268:7,19		

error 1304:12,20
essentially
 1230:18 1253:5
 1265:2 1266:21
 1289:20 1294:19
established
 1286:4 1297:18
 1314:7,15,16
 1319:22,23,26
 1320:5
establishing
 1319:22,23
estimate 1242:16
 1243:3 1250:19
estimated 1246:3
estimates 1243:7
 1246:24 1247:7,8
 1259:24
ethics 1284:8
Europe 1251:6
 1256:17,22
 1268:24 1293:19
evenly 1296:24
event 1229:17
 1321:16
events 1298:24
eventual 1295:13
evidence 1230:17
 1254:23,25
 1256:25 1257:9,
 14 1258:3,5,18,
 26 1262:6,15,23
 1264:23,26
 1265:10,13
 1266:19,21
 1269:7,20,24
 1270:2,7,8,10
 1271:8 1276:23
 1277:11,26
 1282:1,15,17
 1284:2,21
 1285:11 1286:11
 1287:22 1291:12,
 19 1292:10,21
 1293:16 1294:19,

21,22 1295:5,22
 1298:8 1299:25
 1300:5,7,20
 1307:2,3,4,7
 1308:11,13,14,
 22,23,26 1309:11
 1310:5,6 1314:3
 1316:24 1317:23
 1318:5 1322:1,2,
 5,8,10,18,21,25
 1323:7,9,19,20,
 21,25 1324:2
evidence-based
 1323:26
evident 1242:9
 1250:17
evidentiary
 1322:12
evolutionary
 1247:24 1248:10
evolved 1314:24
exact 1232:3
 1246:11,23
 1278:19
examination
 1229:1 1264:19
examine 1221:3
Examined
 1219:6,10 1223:9
 1229:3
examples
 1269:13 1309:3
exceeded
 1247:10 1312:26
Excellent
 1224:24
exceptions
 1262:21
exist 1286:11
expect 1232:19
 1304:8
expected
 1248:14,18
 1286:26

experience
 1256:11 1287:13
 1306:15 1307:17
 1318:12,13
experienced
 1293:24
experiencing
 1230:12
expert 1221:9
 1226:7,10,12,21
 1227:4,12,23,26
 1228:2,24
 1229:13 1318:22
expertise
 1324:14
experts 1227:14,
 24 1252:25
 1257:24
explain 1230:1
 1231:23 1257:23
 1261:5 1272:2
 1297:14,16
explained
 1276:26
extensive 1278:7
extra 1290:4
extreme 1296:3

F

fact 1231:24
 1259:3 1261:12
 1266:10 1269:26
 1275:22 1277:14
 1291:21 1300:21
 1303:16 1305:24
 1317:14
factor 1230:7
 1233:17,19,21
 1234:20 1236:21,
 23 1260:4
 1267:8,14
 1296:14
factors 1229:23,
 25,26 1232:16

1238:19 1240:21
 1242:21 1245:10
 1246:6 1250:1,4
 1255:4 1287:11,
 19 1288:9
 1295:23 1299:8,
 20 1306:10
 1309:13,14,15
 1324:2
factual 1304:12,
 20 1318:21
factually
 1306:17 1307:18,
 20
failure 1271:15
fair 1225:25
 1243:20 1255:13
 1300:14 1310:10
 1313:17 1315:7,
 14 1317:15
 1319:8 1323:11
fairly 1231:10
 1290:16 1319:6
fairness 1273:11
 1317:3
fallacies 1294:8
fallacious
 1304:13 1305:10
fallacy 1256:25
falls 1306:20
false 1258:9
families 1266:1
fatalities 1303:11
fatality 1236:25
 1237:3 1302:17
 1312:24
fear 1269:2
features 1279:24
February 1232:6
 1325:14
federal 1307:7
FEED 1309:16
feet 1270:20
 1289:4

fellows 1225:11
fellowships
 1223:19,24
fertility 1312:22,
 24
fewer 1234:6
 1242:3 1296:4
fields 1228:24
figure 1241:15
 1242:6 1244:2
fill 1227:15,16
financial 1229:9
find 1248:10
 1263:14 1281:8
 1300:8
finding 1305:7
 1324:20
fine 1236:16
finish 1223:6
 1225:3 1311:15
finished 1260:22
 1278:21 1279:6
 1317:25
first- 1225:9
flawed 1322:20
floor 1221:15
 1264:18
Florida 1293:3
 1322:25
flu 1244:13
 1245:8,22
 1246:23,25
 1247:11 1248:4,5
 1252:7 1271:18
 1320:7,26 1321:1
 1323:8
fluctuates
 1245:16
fluctuations
 1321:9
focus 1228:14
follow 1290:9
 1315:14 1316:16
 1317:13 1318:6

follow-up 1311:10,21
foregoing 1325:8
forever 1261:13, 17,24
forget 1278:19
forgive 1287:16
form 1238:3 1279:9 1308:17
formal 1263:19
forward 1235:13 1324:24
found 1265:21 1310:2,19
fourth 1225:3
frail 1244:21 1249:14,16
frailest 1249:24 1250:23
frame 1232:20
framed 1273:15
frankly 1299:3 1320:10
fraught 1293:6 1294:7
frequency 1232:25
friend 1227:14 1244:18 1273:1 1275:7
front 1275:3 1300:11 1301:2
full-time 1225:7
fulsome 1316:20
fungus 1224:9
futile 1235:16 1236:1 1254:18
future 1324:25

G

gallery 1221:23

gathered 1250:14
gathering 1257:18
gave 1265:3 1298:18 1314:7 1318:11
general 1247:14 1256:6 1263:5 1273:16 1281:10 1289:21 1290:14 1295:7 1310:10 1323:6,21,22
generally 1239:8 1245:26 1252:3 1255:15 1256:1 1262:22 1263:17 1264:24 1281:19 1298:12 1307:15 1319:2 1320:23
generous 1303:19
geographical 1233:5
Georgetown 1225:22
germ 1261:23
give 1224:2 1231:1,4 1233:6 1234:7 1236:17 1244:2 1248:20 1259:17 1269:13 1270:11
giving 1289:9
global 1231:16 1236:3 1246:26 1247:4 1251:12, 22
globally 1235:18 1239:9 1256:7
glove 1284:16
gloves 1288:8
goal 1232:26
good 1221:2 1228:9 1231:21

1239:12 1240:22 1245:6 1252:6,23 1258:16,17,25 1260:9 1262:12 1283:14 1295:21 1314:12 1321:25 1322:5
government 1255:18 1306:16 1307:2,13,14,19, 25 1308:9,26 1310:3,11 1315:8,18,25,26 1316:12 1318:9 1319:2,7 1321:21
Government's 1308:3
governmental 1306:26
governments 1307:4,7,11,17 1308:18 1309:2, 4,8 1315:5 1323:23
gown 1284:16
gowns 1288:8
graduate 1224:25
graduated 1223:21
graphed 1313:13
graphs 1241:25 1250:8
greater 1237:10
greatest 1244:16
greatly 1267:17
grindstone 1312:1
groceries 1234:17
grocery 1268:1,3
group 1237:15, 18,22,25 1238:4, 7 1245:1 1258:2

1266:14 1277:12 1280:8,9 1282:13 1294:15 1303:23, 26 1304:9 1305:8 1306:13 1307:23
groups 1238:1,12 1241:10 1279:18 1306:8
guess 1227:15 1232:24 1243:26 1263:22 1269:19 1271:11 1272:16 1275:3
Guinea-bissau 1278:21
gym 1316:12

H

hair 1289:8,9
haircut 1289:9
halfway 1264:8,9
Halton 1225:19
hand 1301:17
happen 1247:14
happened 1248:6 1257:13 1265:23 1266:5 1267:1 1268:8,9
happening 1222:12 1255:25
happy 1262:10 1267:4
harbour 1269:11
harbouring 1262:2
hard 1242:20 1281:22 1307:26
harm 1321:24
harms 1259:3
he'll 1222:14
health 1233:2 1243:11 1255:17, 18 1256:11,12,14

1257:23 1258:16 1268:12 1276:19 1282:4,22,26 1283:3,4,18 1284:10,13,15,18 1285:1,5,14,15, 17,22 1286:4,8, 14,20,23,25 1288:12,21 1289:12 1290:15 1293:20 1300:15, 16,21 1301:19, 22,26 1302:5,7, 11 1305:18 1310:4 1315:13
Healthcare 1225:20
healthy 1243:13 1258:14 1261:22 1262:1,4,12,15 1263:2,5 1271:8, 10,16,18 1276:24 1277:20 1278:1 1281:10 1284:22, 25 1285:9 1288:22,23 1289:5 1295:7 1300:12 1306:10 1323:6,22
heaps 1300:7
hear 1222:5,19
heard 1238:11,13
hearing 1220:7 1227:5 1241:13 1271:26 1317:7 1324:12 1325:1
Hearings 1220:13 1222:15
heart 1244:21,23 1271:15 1287:5
heavily 1268:8, 21
helpful 1238:6 1246:22 1256:22 1260:2 1286:10 1306:4

helps 1237:17 1238:3	1266:14	humidity 1232:12	1283:19	1277:16 1282:23 1284:14 1313:7
hemisphere 1232:1,2,7,17	honest 1308:6	hundred 1316:3 1321:1	illness 1278:4 1283:17 1286:6 1287:9,18 1300:18 1320:23, 24	incorrectly 1319:1
hepatitis 1226:3	Hortons 1292:3, 6,12,15	hundreds 1242:14 1294:25	imagine 1223:14	increase 1266:17 1305:3,4
hibernate 1235:22	hospital 1224:11, 15,17,22 1225:12,19,20 1253:17 1283:7,9 1286:14,25 1287:13 1288:10, 17 1289:1,11,14 1290:11 1291:24 1292:15 1302:6 1316:25 1317:15, 22 1318:4	Hygiene 1225:1	immunity 1252:7 1320:25	increased 1266:11
high 1241:4,18, 24 1244:4 1245:18 1247:1,3 1249:11 1250:11 1259:24 1281:15, 19,20 1287:2 1295:22 1297:7 1313:5	hospitalization 1280:1 1281:12	hypothesis 1266:25,26	impact 1290:24 1291:1	increases 1240:25 1252:12
high-risk 1258:16	hospitals 1287:1, 16	hypothesis- generating 1294:20	impacts 1322:4	indefinitely 1314:10
higher 1239:16 1241:4,5,14 1247:2 1265:26 1296:8 1322:10	hour 1311:14	I	implemented 1266:26	Independent 1307:24
highest 1265:10 1266:6 1286:9 1313:17	house 1236:5	idea 1223:2 1224:2 1231:1,4 1233:18,22 1237:6 1250:15 1259:18 1261:14 1267:15,19 1296:20 1299:9, 10 1311:6	implication 1238:10	indicating 1280:5
highly 1242:6 1284:26	household 1259:22,26 1260:3,7 1266:6	identified 1229:23	implications 1238:8,9 1261:16 1272:5	indications 1283:11
historical 1298:22 1306:7 1308:12	households 1267:20	IFR 1237:9,10, 13,14,15,26 1238:2,5,11,21 1239:2,8,16 1240:11,17 1241:10,14,20,25 1242:5,16 1243:26 1244:4, 7,9 1245:9,13,15, 18,22,23 1246:1, 2,15,18,26 1247:1,6,10 1249:11,19 1250:10,13,19,23 1312:25 1313:5, 8,17	important 1230:19 1233:17 1234:20 1237:16, 25,26 1238:1 1244:7 1250:4 1253:21,25 1259:21,23 1260:4 1261:10 1264:3 1267:14 1279:24,25 1280:12,23 1281:23 1282:23 1288:3,11 1291:16 1296:14 1302:3 1304:2 1305:11 1308:21, 23 1315:15,16	indirectly 1274:26
historically 1269:3 1298:25 1299:1	Hu 1227:25 1228:2 1263:6,10 1277:2 1282:2 1284:18 1285:1, 4,12 1292:24 1293:23 1295:8, 14 1300:4,23 1304:11,17 1318:21,25	IFRS 1249:6	impose 1321:22 1323:24	INDISCERNIB LE 1241:23 1263:3 1265:8 1297:13 1317:4 1323:16
history 1251:17 1268:22 1269:14 1278:7 1297:20 1308:14 1309:3	Hu's 1301:8	ignoring 1323:13,25	imposed 1293:23 1295:10	individual 1256:9
hit 1293:11	huge 1233:7 1245:22 1261:15 1293:5	ILI 1278:5	inaccurate 1258:9	individuals 1301:16
HIV 1226:4	human 1235:14 1247:16 1253:22, 26 1298:23		include 1279:18	ineffective 1284:25 1285:8
hold 1303:12	humans 1230:20 1298:10		including 1264:24 1266:23	infallible 1309:10
holds 1304:5				infected 1233:26 1242:18 1243:24 1249:15 1250:21 1253:3 1261:19 1262:17 1301:15 1313:6
home 1238:10 1243:15 1265:20, 24 1267:23				infection 1224:16 1230:19 1232:26 1236:25 1237:3,4,22 1243:20 1244:15, 26 1251:8
homes 1238:4,5				

1261:23 1266:18 1268:9,11,15 1278:2 1280:5,7, 9,11 1281:11,13, 14,26 1302:1,2, 13 1312:22,24 1320:5	1271:1 1277:21 1278:3,4 1282:23,26 1283:5,17,19 1284:5 1285:22 1288:4 1289:25 1291:17 1300:17 1312:26 1320:13, 18,20 1321:3,7,8, 11,13,14	interesting 1266:4 1279:6 internal 1220:9 1223:23 interpretation 1273:13 interrupt 1223:7 1236:10 1306:20 interruptions 1221:19 intervene 1275:8 intervening 1224:23 intervention 1230:6 1255:1 1256:5,9 1270:19 1281:2,15 1294:16 1305:14 interventionist 1299:15 interventionists 1299:16,17,18 interventions 1235:2 1254:24 1255:6 1257:20 1270:24 intimate 1260:1 introduce 1227:24 1228:1 introductions 1221:21 intuitively 1293:9,14 inverse 1280:24 1281:3,6 invested 1299:10 investigator's 1279:7 invite 1311:12 involve 1226:3 involved 1318:22 Ireland 1322:16 isolation 1255:3 1266:23	issue 1221:10 1227:12 1241:13 1268:6 1269:15 1273:6 1274:13 1277:2,25 1286:23 1300:25 1310:19 1315:24 1319:10 issued 1316:11 1318:14 issues 1272:21 1273:19 1288:24 1289:7 1300:23 1306:18 1315:13	justified 1262:14 1316:7
infections 1224:8,11 1233:4,8 1234:21,23 1235:5 1241:18 1242:2 1243:4 1244:17 1247:23 1251:22 1254:26 1266:3,9,11 1267:12,18 1269:2,3 1282:23 1283:12 1284:14 1286:15 1288:2,4 1290:25	influenza-like 1278:4 1283:17 1286:5 1300:18 information 1257:18 1310:2 informed 1305:15,16 1324:1 inherent 1249:17 initial 1280:2 1295:12 initiative 1227:25 inside 1232:11 instance 1230:3 1231:26 1243:6 1257:2 instances 1269:26 institution 1242:24 1309:9 intended 1226:25 intense 1235:2 intent 1274:11 intents 1241:8 interact 1267:25 interacting 1268:3 interactions 1267:9,16 1286:19 1314:23 interest 1229:9	issue 1221:10 1227:12 1241:13 1268:6 1269:15 1273:6 1274:13 1277:2,25 1286:23 1300:25 1310:19 1315:24 1319:10 issued 1316:11 1318:14 issues 1272:21 1273:19 1288:24 1289:7 1300:23 1306:18 1315:13	<hr/> K <hr/> Karoline 1222:17,21,24,25 1325:8,19 key 1267:7 killed 1245:5 killing 1248:12 kills 1248:2 kilometre 1297:3 kind 1231:26 1232:6 1236:5 1239:9 1240:5 1244:16,18 1245:26 1246:24 1248:10 1249:6 1250:18 1253:6, 13 1254:3 1255:2 1256:15,25 1257:11,17 1260:8 1261:13, 15 1266:20 1267:20 1268:13, 22 1269:17 1270:7,21 1277:24 1281:21 1288:5,10 1289:12 1292:19, 20 1294:1,8,16 1299:4,9 1303:17 1306:12 1308:19 1314:7,14,18 1319:11 1320:26 1321:8 Kitchen 1219:6, 11,13 1220:19 1221:4,7,11,14, 16,20 1223:6,9, 11 1226:15,18,20 1227:1,9 1228:26 1229:2,4,5 1236:9,16,17 1260:16,17,21,25	infectious 1223:24 1224:3, 4,7 1225:11,15, 23 1226:22 1233:25 1281:16 1287:18 1290:9 1306:16 1307:16 1310:1 infectivity 1252:12 infects 1247:25 1248:17 influenced 1233:6 1268:8,21 1309:12,13,14 influenza 1231:26 1235:8 1237:23 1244:9, 10,20 1245:2,3, 14,15,23 1246:2, 3,9,14,15,17,18 1251:22,25 1252:9,14,20,21 1253:16,19,20 1265:18,22,25,26
		intending 1229:9 intention 1229:9 1230:6 1255:1 1256:5,9 1270:19 1281:2,15 1294:16 1305:14 intentional 1299:15 intentionally 1299:16,17,18 intentioned 1235:2 1254:24 1255:6 1257:20 1270:24 intimate 1260:1 introduce 1227:24 1228:1 introductions 1221:21 intuitively 1293:9,14 inverse 1280:24 1281:3,6 invested 1299:10 investigator's 1279:7 invite 1311:12 involve 1226:3 involved 1318:22 Ireland 1322:16 isolation 1255:3 1266:23	<hr/> J <hr/> J.S.M. 1220:19 JAMA 1283:15 January 1219:5 1220:5 1230:23, 24 1232:5 1253:19 1254:11 Japanese 1265:18,19,23 1270:26 Jim 1222:1 joining 1228:10 Journal 1283:15 judged 1254:22 1255:1,4 1256:4 jumping 1282:5 jumps 1282:8 June 1305:4,6 jurisdiction 1270:3 1296:12 1310:24 jurisdictions 1231:15 1256:18, 19 1258:4 1292:26 1293:1 1315:17 1322:17, 21 justification 1323:6	

1261:1 1264:5,
10,15,18,21,22
1271:25 1272:1,
6,7,17,23,24,26
1273:17,24
1274:6,17,20,22
1275:5,7 1306:19
1307:1,9,10,12
1309:18,20,25
1310:25 1311:20
1312:21 1313:20
1314:24 1315:1
1316:21 1317:8
1318:8,26
1319:16,18,20,21
1324:3,17

knew 1242:18
1317:11

knowing 1324:23

knowledge
1229:13 1278:10
1318:11,12,15,18

L

laboratory
1224:15 1278:6

language
1239:15

large 1233:14
1242:17 1252:5
1260:5 1262:1,9
1278:23,25
1284:21 1286:25
1297:8

larger 1242:13
1303:26

late 1245:20
1250:7

latent 1226:4

Latin 1251:14

law 1292:7,9

Lawrence
1221:8 1222:13
1312:3

lawyer 1222:4,8,
13

lead-in 1236:12,
13

leading 1314:14,
18

learn 1258:26
1268:14

learned 1298:3

learners 1225:9

learning 1259:4

leave 1311:3,11

leaves 1253:20

Lees 1220:8
1222:1

legal 1220:9,16,
19 1226:7

Leslie 1221:26

level 1235:10
1236:3 1256:24
1261:20 1262:22
1265:10 1286:10
1291:25 1292:4,5
1295:22 1323:23

levels 1225:9

life 1305:19
1306:14

lifted 1236:7

light 1245:4

lightning
1305:22

likelihood
1282:8,11

likewise 1238:2

limitations
1242:22,26

limited 1241:20
1276:22

listen 1257:24

listened 1258:2

listening 1222:19

literally 1235:21

literature
1230:25 1231:1,
2,4,19 1234:2
1237:19 1251:25
1256:2,10
1257:5,12
1260:10 1263:19,
24 1264:26
1279:10 1293:6
1294:4,6

live 1282:9,12

1296:18,21
1297:9

lives 1299:5
1322:4

living 1266:15
1296:9

location 1233:5
1234:5,14
1259:23

lockdown
1233:14,23
1234:13 1236:6
1255:2 1264:23
1265:14 1266:22
1269:3,16 1270:6
1295:10,12,13

lockdown-like
1269:4

lockdown-type
1271:5

lockdowns
1232:21,25
1268:11 1298:14

locked 1236:5
1269:11

Loeb 1283:22

logical 1260:19
1291:10

logically 1272:9,
14 1322:24
1323:1

London 1225:1,2

long 1223:15
1268:16,19

1311:6 1321:16,
17

longer 1242:25
1249:25 1250:11,
13 1260:23
1303:25 1324:10

looked 1240:24
1254:14 1283:6,
14 1298:21

lost 1309:16,18

lot 1230:25
1236:11,13
1253:1 1257:14,
18 1258:4,7
1267:3,5,13
1268:3,4,20,24
1283:6,8,9,11,14
1291:4 1296:9
1299:5,7 1312:19
1322:5,15,17

lots 1234:17
1255:21 1259:3
1266:20 1282:22
1283:7 1284:9,12
1287:2,21 1295:4
1298:1 1300:19,
20,21 1309:6,10
1316:6 1319:6,7

love 1294:1

low 1245:10,23
1246:15 1280:10
1281:21 1294:20,
23,26 1295:2
1297:6

lower 1237:22
1238:17,22
1239:13,19
1241:19 1265:25
1294:17 1297:6
1306:6,11

lowering
1306:12

lowest 1256:24

lunch 1311:1,3,
14,16,18

M

made 1257:15,17
1258:25 1266:2
1284:1 1295:20
1299:25 1304:20,
21 1316:6
1319:12

magnitude
1241:5

main 1232:24
1269:17 1283:21
1287:23 1297:24

maintain
1235:24

major 1252:2,11
1269:2 1299:23
1305:26 1320:22

majority
1255:16

make 1227:22
1242:15 1262:3
1272:15,21
1284:16 1288:18
1293:13 1304:16
1309:11 1311:21
1315:5,8
1317:21,22
1321:6 1322:3

makes 1223:8
1227:17 1235:19
1259:26 1310:13

making 1222:25
1295:17 1315:18

man's 1244:18
manage 1224:14

management
1226:4

mandate
1271:20,22
1272:4,10,11

mandates
1293:10 1322:22
1323:24

mandatory 1263:2 1284:18, 22 1292:26 1293:4 1315:19	1310:20 1317:10 1318:2 1322:13, 14,17 1323:2,21	meaning 1274:11	mental 1288:21	mine 1221:23 1263:21
manner 1229:14	masks 1258:15	means 1230:1,2,5 1244:1	mention 1221:7 1228:4 1278:13 1280:2	minor 1243:12 1320:19
March 1232:18 1303:21	1270:4 1271:7,8 1272:11 1273:10 1276:25 1279:3, 16,17 1280:8,14, 15,17,18 1282:18,21 1283:1,2,3,6,9, 12,18 1284:4,12, 13 1285:15,16,25 1286:8,15,18 1287:19 1290:17 1300:6,21 1301:18,26 1302:3,5 1316:21	measure 1237:12 1296:19 1297:3	mentioned 1225:12 1226:26 1230:22 1256:23 1258:8 1270:4 1298:21 1317:8	minutes 1260:26 1264:16 1311:8, 19 1312:5,8 1324:9
marginal 1277:9, 23	Massachusetts 1270:13	measures 1255:19 1256:2 1264:24 1265:14 1266:22 1268:12 1269:4 1270:7 1296:3 1321:22, 23	merits 1255:1,5 1256:4	mischaracterizin g 1275:26
Mark 1283:22	massive 1248:1 1253:16 1298:23	med 1298:3	met 1322:12	missing 1311:18
Martens 1220:11 1221:25 1309:21	Masters 1224:26 1267:6	media 1257:3 1278:26 1279:11	meta-analyses 1277:13,25 1323:8	mistake 1304:21
mask 1227:5 1259:5 1270:17 1271:20,22 1272:12 1273:4 1276:1,4,14 1280:19 1281:11, 13 1282:25 1283:4 1284:11, 15 1285:23 1286:2,3,6 1290:1,5 1291:3, 4,7,21,23,24,26 1292:1,4,6 1293:10 1302:7 1316:22 1317:15 1322:22 1323:6, 11,24	matter 1236:6 1244:14 1295:26 1317:20 1324:19	medical 1223:17, 20,24 1224:5,14 1225:9,10 1226:22 1227:13 1243:11 1244:3 1255:18 1256:12 1257:12,16 1279:17 1280:15 1282:25 1283:4 1285:23 1286:2, 3,6 1298:9 1299:9 1308:7 1309:4 1310:1	meta-analysis 1259:22 1265:12 1277:13,25 1295:6	mistakes 1309:11
masked 1288:19 1302:12	matters 1238:5	medicine 1223:23 1225:1 1282:20 1297:20 1299:18 1305:12 1306:14 1309:3	metapneumovir us 1253:22,26	misused 1323:15
masking 1226:24 1227:12 1255:2 1257:5,10 1258:11,13 1262:26 1263:2,5 1273:21 1277:7, 20 1278:1,11,16 1281:24,25 1282:3 1284:18, 22,25 1289:23 1291:14,15,18 1292:11 1293:1, 4,8,24 1295:7 1300:12,26 1306:21,25	Maxston 1219:12 1220:16 1221:4,6 1222:8, 13 1223:6 1226:16,18,26 1227:21 1236:9 1271:24 1272:3, 16 1273:7,8,18 1274:1,8,20,23 1306:19 1307:6 1311:4,6,8 1312:11,14,15 1319:13	medium-size 1225:20	method 1297:1	model 1267:9
	Maxston's 1311:2	meet 1325:1	methodological 1293:6,15 1294:23,26 1295:2	modelling 1267:5,6,7,11,14, 15
	Mcmaster 1225:5,8 1228:18 1283:22	meeting 1264:14	methods 1239:6 1281:8	modify 1232:22 1234:18
		member 1220:10,11,12 1226:5 1317:17	metric 1267:7	modifying 1233:16 1234:13
		members 1221:25,26 1222:2 1290:17 1324:5,15	microbiologist 1224:5,14	moment 1309:23
			microbiology 1223:25 1224:15 1226:22	monitoring 1224:21
			middle 1235:21 1287:7 1294:9	months 1230:16 1231:12 1232:6 1245:20 1248:20 1250:14,18 1253:10 1278:26 1287:10 1293:11 1303:3,6,22,24 1305:2,6 1313:9
			million 1233:10, 12 1246:25 1247:9	moral 1261:15,19
			millions 1242:15 1248:8	morbidity 1252:13
			Milton 1225:22	morning 1219:5 1220:5 1221:2,13 1228:9,11
			mind 1223:3 1301:22	mortality 1229:24 1234:24 1237:12,17 1238:19 1246:3

1247:9 1250:16 1252:13 motor 1303:10, 15 1304:10 mounds 1300:7 moves 1232:1 MRSA 1284:15 multiple 1232:10 1245:10 1246:6 1251:4 1277:2 1285:26 1315:24 municipal 1307:8 mutate 1320:17 mutates 1320:13 mutation 1246:8, 12 1249:5 mute 1221:17 1264:12	1324:20 neutral 1229:14 Nigeria 1239:4, 19 nod 1311:24 non-government 1306:17 1307:3, 5,21,22 1318:9 1319:3,8 non-health 1276:20,21,25 1285:9 1286:23 non-modifiable 1229:25 1230:1, 2,5,7 1231:24,25 1236:23 nonetheless 1261:25 1284:26 1285:11 1318:5 nonscientific 1239:15 nonsensical 1227:10 noon 1312:17 normalize 1239:11 north 1296:18 northern 1232:2, 7,17 nose 1312:1 note 1259:20 noted 1228:13, 14,24 notes 1325:11 notion 1235:19 notwithstanding 1232:23 1233:20 November 1232:18 1278:21 1295:11 number 1233:4, 8,13,23,25 1234:7,21,23 1237:3 1238:15,	20 1239:13 1241:18 1242:17, 21 1243:1,20 1246:14,16,22,23 1259:20 1260:5 1261:8 1262:1,10 1263:17,18 1266:3 1267:4,8, 10,12,15,17,19, 21,24 1268:5 1279:4 1280:23, 26 1281:15,18 1286:26 1296:14 1303:17,18 1304:1,3,5,7,9 1313:13 1314:23 numbers 1256:18 1262:5 1266:17 1297:6 1302:17,18 1304:22 1305:8, 21 numerator 1304:23,25 1305:1,3 nursing 1238:4, 10 1266:14	obvious 1261:4 1297:15,17 1303:2 occupation 1225:14 occur 1232:19 1248:15 1251:26 occurred 1251:6, 8 1258:1 1268:16 1299:21,23 1310:23 occurring 1252:10 1289:1 1302:23,25 1315:2,4 occurs 1232:4 1252:11 1254:1 1259:25 1260:5 1267:20 1289:14 ocean 1235:21 office 1271:21,23 1272:11,13 1273:5 1274:4 1275:23 1276:1, 4,9,12 1291:26 1316:26 1318:23 Officer 1243:11 officers 1255:18 1256:12 offices 1265:24 official 1220:21 1250:25 1325:20 oldest 1250:22 Omicron 1238:17,18 1240:1 1242:1 1247:21 1248:15 1249:10,19 1253:1 1293:11 1313:8 1321:10 oncall 1225:23 1226:2 Ontarian 1297:1 Ontario 1223:21 1243:10 1290:22	1296:12,17,22,24 1297:9 1307:14, 18,19 1315:12 1316:10 1317:9 1318:12,16,19 open 1256:12 1316:12 open-ended 1275:6 1307:6 openness 1256:7 opinion 1226:10 1230:13 1237:13 1259:14 1261:6, 7,20 1263:7,25 1264:2 1285:10 1303:12 1308:17 opinions 1229:13 1310:2 opposite 1300:10 oranges 1239:5 1240:4 orders 1241:4 1315:6,13 1316:9 1318:13,24 organizations 1320:1 Osler 1244:16 Ottawa 1223:23 1297:10 outbreaks 1248:2 outcome 1229:9 1281:22,23 outpatient 1224:12 1226:2 1288:20 oversimplified 1300:1 oversimplify 1249:17 oversimplifying 1250:3 overwhelming 1233:2 1300:6
<hr/> N <hr/>				
N95 1286:1,2 1292:5 N95s 1283:17,24 1284:4 1286:1 naive 1249:21 narrow 1307:10 nation 1236:4 natural 1246:8, 12 nearest 1268:3 nearing 1292:23 necessarily 1243:14 needed 1221:12 1224:23 1280:26 1284:13 1286:2 negative- pressure 1288:1 negligible 1234:3 Nelson 1220:13 1222:16 1274:17				
		<hr/> O <hr/>		
		Oakville 1225:22 object 1227:2 1271:24 1273:22 objection 1228:25 objections 1273:14,25 1274:2 objective 1229:14 1250:26 1254:3 obligation 1305:14 observations 1292:25		

P	1321:7	7,10,11,18	19,20,21 1281:3	philosophy
pages 1264:22	participants	1236:23 1237:4,	1282:14 1316:3	1299:14
1277:5 1325:9	1260:6	13,19 1239:15,	percentage	physical 1226:24
pains 1287:5	participating	20,26 1240:2,12,	1237:5	1264:24 1265:1,8
pair 1249:3	1324:17	14 1241:22	performed	1266:23 1269:22
pan 1251:12,14	parts 1265:11	1242:18 1243:17,	1278:18	1310:20
pandemic	passing 1234:17	20 1244:1,14	performing	physically
1245:18 1246:13,	1248:7	1246:8,25	1276:15	1289:15
17 1248:26	past 1235:12	1247:26 1248:2,	period 1248:22	physician
1249:22 1250:25	1257:13 1313:8	8,12,17 1250:21	1264:13 1275:20	1244:16
1251:3,5,11,12,	patient 1237:11	1251:3,4,15	periods 1235:20,	Physicians
13,17,20,24	1283:5 1286:20	1253:1,3 1255:8,	24	1290:19,21
1252:4,15,20	1288:24 1289:7	21 1259:26	permitted	1317:9
1253:11 1254:9	1302:8 1304:22	1262:2,3,13	1229:18	pick 1317:18
1258:15,20	1305:15 1309:26	1263:2 1266:8,	peroxide	picked 1243:5
1265:15 1268:25	patients 1224:8,	10,15,20	1287:25	picture 1274:13
1270:23 1272:17	11 1268:13	1267:10,16,25	person 1230:3	place 1234:3,9
1273:3,8,12	1273:10,21	1268:4 1269:10	1261:14 1262:16	1254:10 1255:6
1274:9,11	1274:5 1276:2,5,	1270:18 1271:9	1267:9 1282:8,11	1257:22 1260:4
1313:21,22	10,13 1277:12	1275:15 1276:24	1289:9 1296:20	1266:3,7,8,9,24
1314:16,25	1285:22 1286:5	1277:20 1279:5	1297:2 1300:2	1298:13 1314:12
1315:7 1319:24	1287:17 1288:5	1280:4 1281:1,	person's 1230:3	1323:2
1320:1,2,3,4,6,7	1290:10,25	10,13,24 1282:5	personal 1288:8	places 1235:20,
1321:3	1292:16 1300:17	1284:22,25	personally	23 1239:24
pandemics	1317:6	1286:26 1288:13,	1229:7 1255:24	1242:23 1266:14,
1252:8 1268:22	pattern 1223:2	14,15 1289:15,22	1308:10	15 1268:17,24
papers 1266:4	1230:20 1231:10	1291:2 1292:14	persons 1237:9,	1283:7,9 1292:21
parachute	1235:1,6 1296:12	1293:9 1296:9,	17,23 1238:3	1296:4,13,17
1282:9	patterns 1230:10	17,18,21,23,24	1239:22 1240:9,	1313:13 1322:15,
parachutes	1231:5,24	1297:2,9,25	18 1259:11,12	16 1323:11,12
1282:4,16	1304:15,19	1298:2 1299:15,	1265:19 1276:15	plague 1251:5
paragraph	Pavlic 1220:9	16,17,26 1300:2	1277:8 1278:1	1268:25 1299:3,6
1301:4	1222:4	1302:23 1303:9,	1279:2,4 1282:13	plane 1282:9
parainfluenza	peak 1230:8,24	11,13 1305:12,21	1283:19 1287:2	planning
1253:22	1232:4,19	1306:4,10	1300:12 1302:2	1260:21
paraphrasing	peaks 1230:23	1307:24 1308:13	1303:24 1304:6,9	play 1299:8
1319:1	pedantic 1251:2	1309:11 1311:12	1305:25 1306:5	playgrounds
parasites 1224:9	peer-reviewed	1313:6 1314:4	1323:6	1310:13
part 1225:2	1228:13 1231:19,	1315:23 1320:24	perspective	plow 1311:14
1234:26 1258:9	20 1277:3	people's 1322:4	1227:13	pneumonia
1267:6 1272:24	1279:10	1324:23	phase 1314:17	1244:20 1297:26
1298:10 1305:15	people 1221:22	percent 1240:8,9,	phenomenally	1298:18
1308:13,19	1224:5 1228:16	11 1243:22	1306:11	point 1227:20
	1232:10 1233:10,	1246:19 1247:2,	philosophical	1233:3 1235:14
	12,15,24 1234:5,	3,7 1259:25	1261:16,20	
		1263:9 1268:24		
		1279:21 1280:9,		

1238:13 1247:5 1250:3,10,12,19 1252:20 1254:5, 17,20 1260:19 1261:11 1270:21 1279:26 1280:3,7 1289:2	portion 1237:2 1273:26	presence 1233:20	privileges 1225:19	protocols 1243:8, 16
policies 1268:6 1290:8,11	position 1231:2 1277:3 1285:7 1310:22	present 1286:26 1288:13,14,15	problem 1273:20 1275:8	proved 1270:21
policy 1237:18,24 1238:3,8,10 1268:21 1316:3,6 1318:4 1321:26 1322:1,3,6,7,9, 11,19 1323:26 1324:1	positive 1243:5 1255:9 1266:22	press 1311:19	problems 1267:18 1270:5 1293:7,16 1294:7 1295:18 1299:21, 23	proven 1289:24
political 1299:13, 19 1306:22 1309:8,14	potential 1233:25 1261:23 1262:16,24 1305:13	pressure 1324:23	procedures 1243:8 1271:5	proves 1262:21
politics 1299:14	potentially 1232:2 1261:19 1262:16 1287:17	pretty 1271:25 1283:14 1307:6,8 1316:10 1317:7 1319:5	proceedings 1220:1 1221:1 1222:26 1226:7 1238:11 1325:4, 10	provide 1227:9 1229:12 1263:11, 20 1301:18 1305:15
poll 1324:22	practice 1224:10, 13 1225:7 1226:3 1276:8 1295:21 1297:19,21,23 1298:6,11,13 1317:19	prevalent 1261:24 1263:26	process 1246:11 1324:17	provided 1227:1 1289:19
population 1230:5 1233:3,6, 16 1234:18,24 1235:10 1238:23 1239:2,10 1240:2 1245:7,9 1246:26 1247:5,16,17,23 1249:15,16,20, 21,24,25,26 1252:6 1261:18 1262:22,24 1267:22 1268:25 1281:10 1289:4 1293:21 1295:7 1296:8,14,18,21, 23,26 1297:6,8, 11 1305:18 1313:5 1320:24	practicing 1276:13 1298:2	prevent 1226:25 1235:8,9,11 1277:20 1278:1 1281:11,14,24,26 1283:11	produce 1320:20	providers 1300:17 1302:7
population-dense 1233:9 1234:4,9,16 1267:22	practitioners 1298:9	preventable 1306:1	produced 1280:6	providing 1305:16
populations 1238:6 1297:7 1298:23,24	precisely 1275:19	prevents 1284:19	professional 1290:15 1310:1	province 1290:16 1296:25 1325:13
	predict 1234:20	previous 1245:4 1246:7 1252:8 1254:26 1268:20 1289:24	professor 1225:6	provinces 1226:13 1296:1,2 1297:5,7 1315:17
	predictable 1296:10	Previously 1219:10 1229:3	program 1224:25	provincial 1307:7 1310:11
	predicted 1234:22,23,25	primarily 1230:9 1233:5 1277:6,20 1278:2,4	progress 1311:21	proximity 1266:16
	predictive 1237:12	primary 1224:19 1232:14 1248:16 1279:26 1280:3 1308:11,13,21	progression 1294:8	psychiatrist 1288:21 1289:8, 10
	predictor 1297:4	prime-most 1283:19	proof 1322:8,10	psychological 1298:9
	predominant 1314:11	prior 1227:3 1235:4 1258:14 1264:25 1265:14 1266:20 1270:26 1271:3 1277:6, 14,16 1283:8,16 1286:13 1291:5, 13	proper 1252:21	public 1220:12 1222:2 1255:17 1256:6,11,14 1257:23 1263:5 1268:12 1289:21 1310:4 1315:13, 14 1321:22 1323:7,22
	predominantly 1253:15	private 1307:24 1316:26	propose 1311:3	publications 1228:13 1277:3 1294:26
	preliminary 1278:20		proposed 1221:8	published 1231:19 1240:23 1265:4 1278:20 1279:7 1283:15
	prepared 1226:10,12		proposition 1308:7	
	preprint 1279:9		pros 1287:25	
			prosecutor 1222:9	
			protect 1321:22	
			protective 1288:8	

purpose 1232:24 1233:1	1299:19 1301:17 1302:21 1307:8, 26 1308:6 1309:20,26 1310:9 1314:18 1318:1 1319:11 1321:21	1282:20,21,24 1283:23 1284:9 1285:24,26 1286:9 1289:24 1295:5 1298:1 1308:16	1248:1,9,16 1249:12 1257:26	regression 1294:13
purposes 1241:9			reassortment 1320:22	regularly 1288:13
put 1233:10 1255:6 1264:12 1274:15 1277:10			rebut 1228:2	regulated 1275:9
<hr/> Q <hr/>	questioning 1224:1 1300:5	rare 1305:13	receive 1287:17	regulator 1318:4
QC 1220:16	questions 1219:8 1223:12 1226:15, 16 1228:8 1229:6 1236:11,14,19 1271:6 1273:20 1274:10 1275:6 1276:19 1282:19 1286:22 1292:24 1303:2 1306:15 1310:26 1311:11, 15 1312:11,19 1318:10 1319:13 1324:4,6,8,16	rate 1242:5 1243:21 1246:18 1280:8 1320:17	recently 1240:23	regulatory 1290:15,16 1317:21
qualification 1219:7,8,9 1221:9 1223:10, 13 1226:17 1228:8,21		rates 1259:10 1265:22,25,26 1280:10 1287:2 1301:14 1302:1, 13	reconnecting 1309:23	rehash 1320:8
qualifications 1306:21		ratio 1236:25 1237:3,5 1312:22,24	record 1222:26 1227:15,16,19 1275:10,17 1309:24	related 1244:12 1261:13
qualified 1262:18		rational 1291:10	records 1251:7	relates 1261:11 1273:18
qualifier 1227:7		rational 1291:10	recurred 1268:16	relating 1289:15
qualify 1226:20		rationale 1316:4	redirect 1311:15 1319:18 1324:4	relative 1232:12
qualities 1295:1	quickly 1223:1 1248:3,12,26 1274:18	RCTS 1276:23 1278:10 1282:3,4	reduce 1232:25	relevant 1237:14 1275:20
quality 1294:20, 24 1295:3		Re-examines 1219:13 1319:20	reducing 1233:23 1267:23, 24	reliable 1242:6 1260:2,10
quantitated 1258:24	quote 1229:25 1263:8 1265:3,5, 17 1271:8 1300:6,7,11 1304:12	re-open 1316:17	reduction 1279:19,20,22 1280:20,23,25	reliably 1242:15
quarantine 1265:7,20 1266:1 1268:10 1269:5, 16 1299:2 1310:16		re-opening 1316:11	refer 1222:9 1271:8 1284:20 1321:17	remarkably 1281:14,19
quarantined 1265:24 1268:13 1269:11	quoted 1231:7,16 1234:3,20	read 1265:5 1275:24 1282:7 1290:26 1301:5, 13	reference 1263:20	remember 1242:24
quarters 1233:15	<hr/> R <hr/>	reading 1273:25	referenced 1248:24	remembered 1298:25
Quebec 1296:2,6, 8,10 1297:8,16	raise 1221:5	real 1223:1 1310:5,6	referred 1244:16 1315:1 1321:15	remind 1221:17
question 1223:7 1228:6 1236:24 1244:5 1252:23 1259:13 1271:26 1272:5,19,25 1273:15 1274:7 1275:14 1276:6, 11 1294:3	raising 1272:22	realize 1255:8	referring 1263:12 1294:1 1300:9,12	remove 1321:23
	random 1234:10 1296:20 1297:1	reason 1234:26 1238:14 1249:16 1274:18 1284:24 1300:3	refused 1257:24	removed 1245:6
	randomized 1258:19 1265:6, 11,12,16,18,19 1269:25 1270:9, 13,17 1277:7,10, 19 1278:13 1279:3 1280:22	reasonable 1246:24 1282:15 1284:6 1300:8 1314:8	regard 1230:13 1239:26	removing 1323:11
		reasons 1245:4	regions 1314:12	repeat 1227:3
			Registered 1220:10,11	rephrase 1272:7, 8
				rephrasing 1236:15 1306:24
				replaced 1314:8
				report 1229:21, 22 1230:11,14, 16,22,26 1231:11 1236:26 1237:8, 9,20 1240:8

1248:25 1254:23 1256:24 1259:9, 10 1262:6 1263:7,9,11,12, 15 1264:1,23 1265:11 1271:7 1276:22 1277:5 1278:11,13 1280:2 1284:21 1285:2,7 1300:4, 23 1301:3,8 1302:19 1303:8 1304:11 1305:3 1308:22 1310:19, 22 1318:22 1323:4,5	residency 1223:22 resolve 1275:6 respect 1227:3 1314:24 respiratory 1230:19 1232:15, 19 1244:15,17,26 1246:12 1253:15, 18,21,25 1254:2 1271:17 1278:2,8 1284:17 1287:6,9 1288:3 respond 1227:25 1304:19 1311:10 1315:6 responded 1221:11 response 1227:10,13 responsibilities 1225:26 responsibility 1224:19 responsible 1224:16 rest 1226:1 1235:22 restate 1285:3 restriction 1233:23 restrictions 1226:24 1232:21 1233:18,19,20 1257:25 1258:7 1266:17 1295:10, 12 1296:5 1310:3,8 1323:12 results 1278:20 resume 1264:19 retirement 1238:5 retracted 1304:17	return 1253:24 reversal 1257:16 1297:12 1299:9 reverse 1257:17, 22 1297:13 review 1265:3,4 1277:15 revolving 1298:13 rid 1322:17,22 rightly 1240:3 rise 1295:12 risk 1233:26 1237:12,17,21 1240:25 1241:3 1256:8 1262:25 1279:19,20,22 1280:20,23,25 1289:2,5,15,17, 18 1303:12,14 1305:17,19,20 1306:3,6,7,10,11, 14 riskiest 1305:24 risks 1250:2 1257:19 RNA 1320:16 robust 1258:6 role 1297:24 1315:8,15,16 1321:21,23 room 1288:6 1312:4 rooms 1287:20 1292:17 root 1251:14 rough 1247:7 1250:19 roughly 1237:6 1238:16,20 1239:12 1246:17 1250:5 route 1284:17	routinely 1291:2 1306:13 Royal 1223:25 rule 1262:21 Ruling 1219:9 1228:21 run 1221:12 1243:1 rural 1234:5,14 résumé 1228:12	scale 1239:11 scenario 1289:19,20 scenarios 1288:18 1291:16, 17 school 1223:20 1225:1 1238:9 1257:6,10 1270:14 1298:3 school-age 1237:18 schools 1257:10 1258:22 Schumann 1220:21 1325:8, 19 science 1224:26 1314:24 1316:7 1323:2,12,14 scientific 1227:12 1251:25 1263:24 1264:26 1285:11 1306:18 1307:4 1308:7,15 1309:9 1310:5,6 1314:26 1315:23 1316:4,15 1322:25 scientifically 1261:25,26 1274:25 1307:18, 20 scientist 1304:14 scientists 1307:24 screen 1221:23 1274:16 1288:7 screening 1265:8 season 1232:4 1234:22 1245:5 1246:5 1287:7 seasonal 1230:10,20 1231:5,10,23
<hr/> S <hr/>				
		safely 1254:2 salient 1300:25 1301:17 salon 1316:13 sample 1242:13 SARS-COV-1 1268:9 SARS-COV-2 1226:11,13,23,25 1229:24 1230:12, 18,24 1231:9,14 1232:14 1235:3, 4,11,15 1236:2 1237:22 1244:8 1245:13 1246:1, 10 1247:16 1248:13 1251:2, 10 1253:8,24 1254:4,6 1262:17,25 1271:13 1278:8 1282:1 1284:8 1314:10 1320:2, 15 1321:16 1323:10 Saskatchewan 1296:4,7,11 Saturday 1312:18 save 1274:19 saves 1299:5		

1235:3,6,9	1248:8,21 1249:8	sickest 1242:10	smallpox 1269:5,	specialties
1237:23 1244:9	1250:11,12,13	side 1295:4	8,10,13 1299:3,5	1223:26
1245:14 1247:18	1252:14,18	sides 1295:3	social 1227:6	specific 1269:20
1251:21 1252:21	1320:24	1315:24	1268:22 1298:25	1275:2 1296:19
1320:20	severity 1248:17	significant	societal 1269:1	1307:11 1315:3
second- 1225:10	1251:24 1300:25	1242:26 1252:4	societally	specifically
section 1229:22	1301:6,14,26	1255:7 1261:3	1261:21	1231:5 1263:16
1237:2 1259:10	1302:12	1265:22 1278:17	society 1239:16	1323:9
1271:7	shape 1237:18	1322:1,9	1256:1 1293:12	speech 1223:2
selection 1242:8,	she'll 1309:23	significantly	1306:26	spread 1284:19
11	shelter-in-place	1240:25 1241:21	sociological	1296:24
sense 1227:17	1255:3 1266:16	1242:1 1267:24	1306:22	spring 1241:23
1235:19 1236:10	sheltering	1322:4	someone's	1250:7 1253:26
1259:26 1288:19	1266:8,24	similar 1230:18	1230:4	1325:2
1310:14 1311:11,	1267:23	1231:13,17	sort 1230:6	square 1297:3
18	shift 1252:3	1245:13 1254:26	1239:14 1246:22	staff 1292:17
separate 1222:10	1320:21,22	1256:15,18	1257:24 1267:1	standard 1229:6
1243:8	shifted 1228:14	1282:25 1284:2,3	1281:15 1309:8	1239:10 1240:5
September	1266:2	1289:20 1290:4	sorts 1257:3	1270:18 1277:24
1279:8	shifting 1321:19	1292:12 1293:20	1270:5 1287:4	1278:5 1297:21
series 1275:5	shifts 1252:1	1320:16 1321:5	1293:6,15	standing 1292:11
serologically	short 1235:20	similarly	1294:24 1295:17,	start 1229:6,21
1280:3	1260:20	1243:24	19 1298:5 1299:2	1253:14,24
serology 1280:5	shorthand	simply 1307:1	1309:3	1302:23 1312:20
service 1224:17	1325:10,11	Singapore	sounds 1276:7	started 1248:7
Services 1225:20	show 1230:18	1268:17	source 1308:9	1249:8,9 1302:25
session 1219:5	1270:25 1271:4	single 1308:1	sources 1310:4	1315:4
1220:5 1312:10	1286:15	sir 1228:9	South 1240:1	starting 1255:26
1324:13	showed 1231:9	site 1283:12	southern 1232:1	1322:22
setting 1284:19	1234:19 1260:10	sitting 1289:4	Spanish 1245:22	starts 1229:22
1285:9,13,14,16,	1270:19,25	situation 1317:5	1246:23,25	1232:1 1247:13
17 1286:12,25	1277:9,16	situations 1318:2	1248:4 1321:1	state 1229:24
1288:11,12,13	1278:16 1282:26	size 1242:13	southern 1232:1	1253:23 1264:1
1292:13 1301:19,	1283:2 1284:5	1267:11	Spanish 1245:22	1277:5
23	shower 1305:20	skill 1325:12	speak 1221:7	stated 1233:1
settings 1258:16	showing 1295:3,	slight 1234:13	1223:1 1229:18	1293:23 1304:11
1266:13 1276:20,	4	1239:13 1303:26	1230:3 1264:15	statement
21,25 1284:20,	shown 1286:8	slow 1254:20	1306:25	1302:10
23,26 1285:1,5,6	shows 1234:2	small 1226:2	speaking	statements
1286:14,23,24	1293:16 1298:16	1233:13 1251:26	1255:15 1264:24	1300:8 1319:12
1289:13 1300:15	sic 1276:9	1269:26 1277:8,	1307:15 1322:24	states 1256:17,20
severability	sick 1262:3	21 1279:19	specialist 1224:4,	1293:18,19
1251:19	1268:13	1296:9	7 1225:15	1322:16
severe 1238:18			1306:16	
1245:5 1247:20			speciality 1224:3	

static 1276:2	students 1225:9, 10	1260:14	swine 1252:7	1252:25 1258:11, 13 1267:4
statistic 1263:18	studied 1283:10	substantially	1320:26	1268:23 1276:21
statistical	1285:18,20	1240:18 1241:4	switched	1287:25 1306:8
1233:26 1239:6	1291:16	1259:12,17	1248:26	1308:12
1240:5 1270:5	studies 1231:8,	1262:10 1264:3	sworn 1219:6,10	talked 1231:9
1284:7 1293:7	13,14,15,17	substantiated	1223:9 1229:3	1257:21 1267:21
1295:16 1296:26	1234:2,19 1243:2	1269:21 1291:19	symptomatic	1270:26 1287:12
statistically	1257:11 1258:12,	sudden 1249:23	1242:10 1252:12	talking 1245:19
1241:6 1262:9	13,14 1259:20	sufficient	1259:12,19	1246:26 1247:1,6
1280:16 1294:12	1270:3 1271:2	1320:25	1260:11 1262:8	1258:10 1261:9
1295:21	1277:6,8,16	suggest 1266:5	1263:25 1264:2	1262:18 1271:13
statistics 1238:24	1283:15 1285:21	1311:25	1265:21 1275:12,	1275:21 1279:24
1242:7,12	1286:13 1293:15	summer 1279:7	16,23 1276:13	1287:3 1288:26
1256:26	1294:17,18	1287:8	1278:5 1286:20,	1289:5 1297:15
stay 1243:15	1295:1,2 1308:15	superior 1285:25	26 1287:2,17	1303:21 1305:12
stewardship	1315:1 1323:8	support 1264:26	1288:12,14	1306:9,11
1224:20 1297:24	study 1231:3	1276:24 1277:3	1289:22 1292:16,	1310:15 1316:8
stick 1312:4	1240:22 1259:21	1282:16,17	17,18 1300:24	1317:7
stop 1235:15,17,	1260:1,9	1294:4	1302:8 1313:3	taping 1310:12
18 1236:2	1270:17,21,22,25	supported	symptoms	TB 1291:17
1254:17	1271:1 1278:25	1274:25 1310:5,6	1243:12 1271:17,	teach 1225:4
stopped 1235:2	1279:6,7,25	1313:22	18 1276:11	teachers 1259:6
store 1268:1,3	1280:6 1281:1,7	supporting	1280:3,4 1287:6	teaching-based
strain 1245:24	1283:1,22,26	1300:5	1288:23 1289:16	1228:18,19
1321:12	1284:8 1294:1	supportive	1290:18 1292:14	tells 1281:9
strains 1246:9	studying 1281:16	1311:25	1316:24	temperature
1313:7 1320:14	stuff 1243:13,16	supports 1231:2	systematic	1232:8
strange 1263:14	1249:2 1268:13,	1263:25	1265:3,4	ten 1224:14,17
strategies	18,26 1290:10	suppose 1273:14	systems 1288:1	1225:7 1230:16
1256:15	1292:19 1294:10	1274:26 1315:26	1293:20	tend 1306:17
streams 1228:17	1306:13 1308:15	Surgeons	<hr/>	1307:4,17,19
strength	style 1236:12	1290:20,21	T	tender 1223:13
1282:15,17	sub-saharan	1317:9	TABLE 1219:1	1226:17
stretch 1311:26	1238:22 1239:24	surgical 1280:17,	takes 1312:2	term 1257:15
stroke 1287:5	subjected	19 1283:6,11,12,	taking 1224:10	1314:21 1323:17
strongest	1299:25	18 1284:4	1234:14 1283:5,	terms 1251:10
1276:22	subjective	susceptible	18 1285:21	1271:12 1273:9
struck 1305:22	1250:26 1314:20,	1249:13	1286:5 1290:10,	1315:6 1318:13
structure 1230:5	22	suspect 1311:2	25 1300:17	test 1242:26
1234:25 1239:21	submitted	1302:7 1312:18	1302:7 1312:18	1280:5
struggle 1306:20	1227:11	swear 1222:21	talk 1233:3	tested 1242:10
struggling	subsequently	swears 1222:24	1236:20,21	1243:9,11,14,25
1272:9	1243:3	sweeping	1238:21 1239:8	1313:4
	substantial	1290:17 1319:11	1242:7 1245:24,	
			25,26 1251:23,25	

testimony 1227:26 1228:3 1229:19 1318:22 1324:15	thinks 1274:24 1275:8	timing 1230:8,9 1231:14 1234:22	1269:12 1284:17 1289:2,6 1292:25 1293:17,24 1300:24 1301:7, 15 1302:1,13	1324:6,12,15
testing 1241:19 1242:22 1243:5, 8,16 1255:3 1268:14 1278:7 1301:16 1310:17	third-year 1225:10	today 1221:3,19 1226:8 1229:12 1304:5 1324:15	transmissions 1293:3	Tribunal's 1273:19 1274:14
tests 1243:1	Thomas 1219:6, 10 1223:9 1226:21 1229:3	top 1302:19	transmit 1262:4, 13 1302:2,15	tricky 1244:5 1278:3
text 1301:3,11	thought 1254:14 1273:1 1298:14, 17	topic 1258:2 1269:23 1298:20	transmitted 1232:15	trimming 1289:9
theoretically 1254:21 1289:23	thousand 1237:10	Toronto 1225:21 1268:2	treat 1224:7 1258:4 1261:18 1273:10 1280:26 1281:2 1297:25	Tropical 1225:1
theory 1232:21, 22 1269:21 1308:8	thousands 1297:19	total 1222:3 1279:4	treating 1261:14, 22 1262:15,23 1276:2,5 1298:18 1317:6	true 1242:16 1302:10
therapy 1288:25	three-ply 1285:23	totally 1275:14 1285:18 1286:16	tracked 1228:5	tuberculosis 1226:4 1288:2 1300:18
there'll 1321:10	throwing 1234:10	touched 1236:21 1269:19 1271:9 1286:24	tracking 1268:14, 15	turn 1221:15 1264:13
thing 1227:11 1229:16 1244:24 1254:22 1262:13 1266:5 1268:5 1280:26 1298:9 1305:7 1308:23 1309:15 1314:8 1321:5,18	till 1311:17	tracing 1268:14, 15	treatment 1280:9,14 1283:25 1310:17	twisted 1294:24
things 1226:3 1232:10 1239:1 1242:8,12 1244:7,22 1249:10 1258:1 1267:3,12 1268:23 1269:5, 16 1272:13 1279:25 1284:14 1287:22 1291:17 1293:21 1298:6, 26 1299:2,7,14 1300:1 1305:25 1306:9 1308:20 1309:13,14 1310:16,17,18 1312:21 1315:19 1322:13 1324:1	Tim 1292:3,6,12, 15	track 1228:5	trend 1297:13	two-thirds 1224:10
thinking 1301:25 1316:9	time 1226:1 1231:11 1232:2, 3,18,20 1235:14, 20,24 1241:17, 24,25 1242:4 1243:15 1247:6, 14,24 1248:6 1254:5 1274:19 1275:13,16,20 1286:16 1294:9 1305:12,17,18 1312:18,23 1313:6,14,23 1319:14 1322:7 1324:14	tract 1244:15,26 1278:2 1284:17 1287:9	trial 1258:23 1265:7,16,18 1270:13,16 1278:14,24 1279:1 1283:23 1285:24	type 1232:15 1270:7,19,22,24 1289:20 1291:6, 24
	times 1237:10 1246:4 1253:18 1257:4,6 1260:12 1261:10 1262:7 1271:21,23 1272:11,12 1273:4 1276:4 1291:23 1300:4 1308:3 1309:6 1314:23 1319:7	transcribed 1325:11	trending 1250:20,23	types 1231:17 1271:2 1276:22 1284:12 1286:15 1287:23,26 1291:14 1294:7
		transcript 1219:14 1325:6,9	transferring 1266:9	
		transferring 1266:9	transitions 1320:6	<hr/> U <hr/>
		transmissibility 1232:11	transmissions 1293:3	UK 1322:16
		transmission 1226:25 1229:24 1230:8,9 1254:7 1259:9,11,18,22, 23,24,25 1260:3, 5,11,12,22 1261:2,4 1262:7, 8,25 1263:8,10, 25 1264:3,4 1266:7 1267:19	trials 1258:19,22 1265:7,12,13 1269:25 1270:9 1277:7,10,19 1280:22 1282:20, 21,24 1284:10 1286:1,9 1289:24 1295:6 1298:1 1308:17	ultimately 1244:1
			Tribunal 1220:7, 8 1221:25 1222:1,2,4,6,10 1229:13 1271:26 1272:15,21 1275:4 1311:16	unchanged 1237:8
				underlying 1308:11
				understand 1227:14,17 1229:12,16 1236:22,25 1240:10 1244:2 1275:14 1276:6 1320:10
				understanding

1239:14 1290:14
1304:15,18
1318:24

understood

1227:26

unexpected

1248:14

unhealthy

1271:14 1287:4

uniform 1253:5**unit** 1260:8**United** 1256:17**universal** 1276:3

1292:10 1312:17

universally

1286:16

universities

1307:24

University

1223:21,22

1225:2,6

unrelated

1307:25

unscientific

1304:13 1305:11

unusual 1253:17**upsetting** 1244:1**upstate** 1233:11**useless** 1283:3**usual** 1253:19

1268:13

utterly 1236:1

V

vacation 1226:1**variant** 1247:22

1248:15,24,25

1321:4,11

variants 1246:11

1247:12 1248:23

1249:5,20

1320:15 1321:13

varied 1243:7**varies** 1244:10

1312:22

variety 1248:16

1270:24 1288:9

1309:12

vast 1255:16**vehicle** 1302:17

1303:11,15

1304:10

vein 1282:2**ventilation**

1287:20 1288:1,2

verbatim

1222:26

versus 1270:14,

18 1280:15

1284:4 1315:24

Videoconference

1220:1

view 1221:23

1289:2

vigorous 1311:24**villages** 1279:3,

16,17 1280:19

viral 1287:8,9**virus** 1230:8

1246:12 1247:14,

16,19,22,25

1248:6,9,10

1249:18 1252:5

1253:15 1254:2,

17 1261:12

1278:8 1287:6

1313:23 1314:9,

11,25 1320:11,22

1322:24

viruses 1224:9

1232:15,19

1253:18,21,25

1320:16,17

vis-à-vis 1274:4**visitors** 1292:19**vulnerable**

1245:6,7 1246:7

1313:5

W

wait 1223:5

1309:22

walk 1267:26**walking** 1268:2

1305:19

Wall 1220:18

1222:11,18

1227:24 1228:3

1229:7

Wall's 1227:4,7,

14

Walter 1222:4**wanted** 1228:1,4

1312:20 1316:12,

17

ward 1289:22**wards** 1287:21**warrant** 1261:2**warrants**

1262:23

Warren 1219:6,

10 1221:20

1222:23 1223:9,

11,17 1226:21

1228:6,7,24

1229:1,3,5

1236:17 1261:1

1264:11,20,22

1275:7 1289:26

1307:12 1309:25

1311:10,24

1312:12,15

1319:14,21

1324:5,13

Warren's

1311:13

water 1232:12**wave** 1230:8

1233:7 1234:21,

26 1235:1

1238:17 1240:1

1241:20 1242:1

1249:23 1250:5,

15,17 1253:19

1294:10,13

1296:2 1313:16

1321:10

waves 1235:6,10,

11 1251:23

1253:16,21,24

1267:11 1295:25,

26 1310:13

ways 1240:5

1294:25

wear 1271:20,22

1272:10,12

1273:4,9 1276:1,

4 1281:11

1284:11,12

1285:23 1286:6

1290:5,17

1291:4,7,20,21,

23,24 1292:1,3,4,

6 1301:26 1302:7

1316:22 1317:15

wearing 1276:14,

24 1279:3

1281:13 1283:12

1291:2 1316:21

weather 1231:25**website** 1279:8**week** 1257:5,7**weeks** 1224:14,18

1225:23 1242:25

1248:26 1249:9

1254:8 1269:12

1281:8,11,14,24,

26

weighted 1296:8,

15,19,26

west 1225:21**Western** 1223:21**whatnot** 1308:19**whatsoever**

1280:16

wide 1256:19

1293:5 1294:6

widely 1261:23

1279:10

widespread

1320:23

William 1244:16**Windsor**

1297:10

winter 1232:3,6,

17 1287:10

witnesses 1227:4,

7

word 1246:13

1250:11,12

1260:14 1313:20

1323:14

wording 1273:12**words** 1319:1**work** 1224:10,12,

13,15 1225:12

1232:21,23

1233:20 1246:22

1254:21 1255:19

1266:26 1284:22

1287:14 1288:23

1289:26 1291:3,6

1293:7 1297:17

1299:12 1316:23

1321:24

worked 1269:4

1299:3

worker 1270:26

1283:4 1286:20

workers 1258:16

1265:20,23

1282:4,22,26

1283:3,18

1284:10,13,16

1285:22 1286:5

1301:26

workers' 1266:1

working 1287:13
1310:1 1316:25
1318:23

works 1288:10

world 1235:23,26
1242:23 1252:10
1295:25 1299:4

worldwide
1242:15

worse 1286:2

worth 1281:24

writing 1278:11

written 1298:5

wrong 1255:15
1258:9 1294:12
1309:4,5,7

wrote 1230:16
1231:11 1237:20

Y

year 1224:18
1225:3,23
1230:11 1231:12,
18 1232:3,5,17
1236:6 1244:13
1245:3,8,15
1246:7,14,17,18
1247:11 1251:22,
23 1252:1,11
1259:15 1264:25
1302:16,17
1303:6 1304:25
1305:2,21
1312:26 1320:13,
18

year-to-year
1244:10 1245:17
1246:4

yearly 1245:24
1320:20 1321:9,
11

years 1223:20,22
1225:7,8 1228:15
1230:12 1235:12

1244:11 1245:18,
23,25,26 1248:20
1252:14,15
1255:20 1268:20
1269:21 1283:2
1295:25 1297:19,
23 1298:3
1299:24 1303:9,
11 1304:7
1307:16 1320:7
1321:1,3 1323:17

York 1233:7,8,
10,11,12,13
1234:9,15,17
1257:4,6

young 1250:16
1257:10

younger 1239:5,
22 1240:2 1241:5

Z

Zealand 1235:20