

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 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

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██████████

Tribunal Chair

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██████████

Internal Legal Counsel

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Dr. ██████████

ACAC Registered Member

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Dr. ██████████

ACAC Registered Member

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██████████

Public Member

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██████████

ACAC Hearings Director

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15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

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D. ██████████

ACAC Complaints Director

17

██████████████████

ACAC Legal Counsel

18

19 FOR DR. CURTIS WALL

20

J.S.M. Kitchen

Legal Counsel

21

22

██████████ 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. [REDACTED] to introduce his first witness, but before
2 doing so, Dr. [REDACTED] we would ask that our court reporter,
3 [REDACTED] either swear or affirm you prior to
4 your giving testimony.

5 THE WITNESS: Sure.

6 DR. [REDACTED] Sworn, Examined by Mr. [REDACTED]

7 (Qualification)

8 MR. [REDACTED] 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. [REDACTED] will know this, before I
13 begin asking Dr. [REDACTED] 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. [REDACTED] So, Dr. [REDACTED] I'll just ask you
23 to state your full name for the record, please.

24 A Yeah, [REDACTED]

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. [REDACTED] 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. [REDACTED] Sorry, I was diving right in
12 there.

13 Q MR. [REDACTED] 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 [REDACTED] and [REDACTED]

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

19 A Yeah, so [REDACTED] 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. [REDACTED] 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. [REDACTED] Dr. [REDACTED] 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 [REDACTED], 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 [REDACTED] with Alberta
18 Health Services in the [REDACTED] 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 [REDACTED];

1 medical degree from the [REDACTED], medical
2 doctor degree; a residency in Public Health and
3 preventative medicine and (INDISCERNIBLE) medicine from
4 the [REDACTED]; 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 [REDACTED]
[REDACTED]
[REDACTED]

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 [REDACTED] 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 [REDACTED]

████████████████████, 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 ████████████████████. 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 ████████████████████

████████████████████, 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 [REDACTED] Can I ask you to describe
8 what that is?

9 A Yeah. So, I mean, [REDACTED] 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 [REDACTED]. 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 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED].

[REDACTED]. 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 [REDACTED]
[REDACTED]
[REDACTED].

[REDACTED] 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 [REDACTED]: (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, [REDACTED]". Can you tell me
11 about that and the other --

12 A Yeah.

13 Q -- two entries there?

14 A Yeah, so [REDACTED] is an NGO, [REDACTED]
15 NGO, that -- well, they're pretty well known. Actually
16 they do a lot of global health work, [REDACTED]

[REDACTED]
[REDACTED]. 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. [REDACTED] 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. [REDACTED]
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. [REDACTED] 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. [REDACTED] you're now muted. I've given you
3 the idea.

4 MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] I think I said preventive
14 measures.

15 MR. KITCHEN: And other preventative
16 measures.

17 MR. [REDACTED] Measures, yeah.

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

19 Q MR. KITCHEN: All right, well, Dr. [REDACTED] 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. [REDACTED] you worked for AHS as a [REDACTED]
[REDACTED]; 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. [REDACTED] help me out if I
14 don't have this quite right, I understand you want
15 Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED]

9 Mr. [REDACTED] Re-examines the Witness (Qualification)

10 MR. [REDACTED] Mr. Chair, it's [REDACTED]
11 I'll have a couple of comments in response, but I think
12 Dr. [REDACTED] 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. [REDACTED] Mr. Chair, I think,

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

26 MR. KITCHEN: Yes, I am.

1 Discussion

2 MR. [REDACTED] Yeah, thank you, yeah.

3 Mr. Chair, I was going to ask Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED]

3 Dr. [REDACTED] 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. [REDACTED] And, Mr. Chair, I wonder if I
7 can just make one quick comment for Dr. [REDACTED] 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. [REDACTED] 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 [REDACTED]
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. [REDACTED] as an expert witness, and our
2 decision is that we will qualify Dr. [REDACTED] as an expert
3 witness as submitted by Mr. [REDACTED]

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

6 MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] -- 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. [REDACTED] based on Mr. [REDACTED] submission, so
21 we'll move on from there.

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

24 MR. [REDACTED] Thank you, Mr. Chair.

25 Dr. [REDACTED] Previously sworn, Examined by Mr. [REDACTED]

26 Q MR. [REDACTED] 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. [REDACTED] and that was in the context of
4 grants and Dr. [REDACTED] losing money if COVID goes away. And
5 I just want to be very clear, Dr. [REDACTED] 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. ██████████ -- 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. ██████████ -- 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 [REDACTED] 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. ██████ 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED]

15 Q MR. [REDACTED] Okay, I'll go ahead then.

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

18 MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] you said the date
3 on D-9 was --

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

6 THE CHAIR: Okay.

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

10 MR. [REDACTED] -- and, Mr. Kitchen, there's a
11 question coming --

12 Q MR. [REDACTED] -- 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. [REDACTED] 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. [REDACTED] which
6 CMOH order are we talking about?

7 MR. [REDACTED] It's Exhibit F-2.

8 MR. KITCHEN: F-2.

9 MR. [REDACTED] 'F' as in Fred, and that's
10 16-2020, and May 3, 2020.

11 MR. KITCHEN: Thank you.

12 MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] using Exhibit
15 C-22, which is the January 26th, 2021 Pandemic
16 Directive because, as you'll hear from Dr. [REDACTED]
17 this document, insofar as the issues we're talking
18 about, didn't change.

19 Q MR. [REDACTED] So, Dr. [REDACTED] 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. [REDACTED] so you're going
25 to ask questions about --

26 MR. [REDACTED] 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. [REDACTED] going to
4 testify to what I said a couple of minutes ago.

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

6 MR. [REDACTED] January 6th, pardon me. I may
7 have written that down wrong.

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

10 MR. [REDACTED] Yeah --

11 THE CHAIR: -- 'C' folder?

12 MR. [REDACTED] -- 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. [REDACTED] Yeah.

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

19 MR. [REDACTED] 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. [REDACTED]
22 to haven't changed from -- that's what Dr. [REDACTED]
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 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] -- Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED]

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. ██████████ I'll just everybody get to
9 that document.

10 Q MR. ██████████ 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. ██████████ I'll just wait. Is everybody
14 there? Okay.

15 Q MR. ██████████ 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. ██████████ 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. ██████████ I just have a general question
23 for you, Dr. ██████ 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 [REDACTED] 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 [REDACTED] I keep on
20 talking over [REDACTED] 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. [REDACTED]

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. [REDACTED] 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. [REDACTED] it
5 sounds like we're not going to have time for
6 cross-examination today; is that you're thinking?

7 MR. [REDACTED] I'm thinking, and as I
8 mentioned to you, Mr. Kitchen, Dr. [REDACTED] 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. [REDACTED] The next paragraph in your
14 report, Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. ■ 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. ■ 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. ■ 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. ■

19 So I'll turn it back to you, Mr. ■

20 MR. ■ Thank you, Mr. Chair.

21 Q MR. ■ Dr. ■ 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. ██████████ 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. [REDACTED] And I just want to, Mr. Chair,
26 be clear to the Tribunal that in asking these questions

1 of Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED] Okay, well, thank you, Dr. [REDACTED]

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. [REDACTED] 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. [REDACTED] to have Dr. [REDACTED] testify.

23 MR. KITCHEN: That's fine with me.

24 THE CHAIR: Okay, Dr. [REDACTED] 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. [REDACTED] 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:

2

3 I, [REDACTED] certify that the foregoing
4 pages are a complete and accurate transcript of the
5 proceedings, taken down by me in shorthand and
6 transcribed from my shorthand notes to the best of my
7 skill and ability.

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

10

11

12 [REDACTED]

13 [REDACTED]

14 [REDACTED] CSR (A)

15 Official Court Reporter

16

17

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19

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26

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

DISCIPLINARY HEARING

VOLUME 2

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 2, 2021

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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

██████████

Tribunal Chair

9

██████████

Internal Legal Counsel

10

Dr. ██████████

ACAC Registered Member

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Dr. ██████████

ACAC Registered Member

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██████████

Public Member

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██████████

ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16

████████████████████

ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19

J.S.M. Kitchen

Legal Counsel

20

21

██████████ 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. ██████████ 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. [REDACTED] Mr. Chair, it's Mr. [REDACTED]
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. [REDACTED] which my client is objecting, and we'll have to
13 ask Dr. [REDACTED] 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. [REDACTED] 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 [REDACTED]
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 [REDACTED]

16 THE COURT REPORTER: (NO VERBAL RESPONSE)

17 THE CHAIR: Good. So then --

18 MR. [REDACTED] 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. [REDACTED] to move Dr. [REDACTED]
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. [REDACTED]
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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. ██████████

9 MR. ██████████ 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. ██████████ 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. ██████████ (Application)

21 MR. ██████████ 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 say 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. [REDACTED] hasn't
10 been able to read them, and certainly Dr. [REDACTED] hasn't
11 been able to read them.

12 Mr. Kitchen has had Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] or I to read
5 and review these, certainly no time to consult with
6 Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. ■ 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. [REDACTED] (Application)

10 MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. ■ 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. ■
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. ■ 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. ■
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. ■ 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. [REDACTED] 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. [REDACTED] 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. ■ 15 minutes to
13 review them, if that --

14 MR. ■ Can I --

15 THE CHAIR: Yeah?

16 MR. ■ I welcome Mr. Kitchen's
17 comments on this, but I wonder if we could bring Dr. ■
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. ■ has
22 to get going as well.

23 MR. ■ 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. ■ in
6 please then, and I'll give him an explanation. Do we
7 have a copy of the documents for him?

8 MS. ■ I can send those to him via
9 email right now.

10 THE CHAIR: Could you send them, please.

11 Dr. ■ we're back. Dr. ■ 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. ■
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. ■ 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. ■

9 MR. KITCHEN: Thank you, Chair.

10 DR. ■ Previously sworn, Cross-examined by
11 Mr. Kitchen

12 Q MR. KITCHEN: Dr. ■ 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. [REDACTED] 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. [REDACTED] 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. ██████████ Mr. Chair, Mr. Chair, it's
25 Mr. ██████████ 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. ■ 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. ■ Dr. ■ 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. [REDACTED] Mr. Chair, I have to object to
26 that question. This is far beyond the purview of what

1 Dr. ■ 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. ■ to comment on.

4 MR. KITCHEN: Chair, Dr. ■ 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. ■ 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. ■ that's a protected ground. I don't think
20 we need to get into that.

21 Q MR. KITCHEN: Dr. ■ 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. [REDACTED] I can tell you
15 I'm at least half way through.

16 MR. [REDACTED] I think we should let Dr. [REDACTED]
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. [REDACTED] 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. [REDACTED] Mr. Kitchen, if needed?

7 MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED]

2 MR. KITCHEN: Thank you.

3 Q MR. KITCHEN: Now, Dr. [REDACTED] 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. [REDACTED] [REDACTED]
11 on page 6 of his report in the second-to-last paragraph
12 of his report. Dr. [REDACTED] --

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. [REDACTED] 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. [REDACTED] 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. [REDACTED] quotes directly from this Jefferson/Cochrane
5 review, in which it is stated that the [REDACTED] 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. [REDACTED] do you?

15 A No.

16 Q You don't contest that the portion of the
17 Jefferson/Cochrane review quoted by Dr. [REDACTED] was
18 quoted accurately, do you?

19 A No.

20 Q And you don't disagree with Dr. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] Mr. Chair, Mr. Chair,
10 Mr. Kitchen may not like the answer Dr. [REDACTED] 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. [REDACTED]

14 A So I mean, I think that Dr. -- that is what Dr. [REDACTED]
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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED]
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. [REDACTED] look, I didn't ask, and Mr. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] We will
9 now turn the floor back to Mr. [REDACTED] for his -- any
10 redirect.

11 MR. [REDACTED] Thank you.

12 Mr. [REDACTED] Re-examines the Witness

13 Q MR. [REDACTED] I'm just going to start with a
14 question, Dr. [REDACTED] 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. ██████ objected to on the basis that,
24 ultimately, Dr. ████ 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. [REDACTED] I'll skip on, I'll skip on.

2 Q MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] 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. [REDACTED] Mr. Kitchen, it's Mr. [REDACTED]
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. ■■■ 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. ■■■ 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, [REDACTED] 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. [REDACTED]
14 is your next witness available for 1:00, or do we know
15 that?

16 MR. [REDACTED] He is. I can certainly make
17 him available for 1, and that would be Dr. [REDACTED]

18 THE CHAIR: Yes, I think that's the next
19 step; is that correct? So why --

20 MR. [REDACTED] 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. [REDACTED] 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. [REDACTED] I think you're right, it was a
9 fairly full morning, and it would be good to get away
10 from the computer screen and the pen and paper for a
11 little while. So thanks everybody, we'll see you at
12 1:15, and we are now in recess until 1:15 for the
13 record.

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15 PROCEEDINGS ADJOURNED UNTIL 1:15 PM

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