NATIONAL CITIZENS INQUIRY

Red Deer, AB **Day 2**

April 27, 2023

EVIDENCE

Witness 2: Dr. Justin Chin (Parts I and II)
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PART I

[00:00:00]

Allison Pejovic
I'd like to welcome everyone back to the National Citizens Inquiry. My name is Allison Pejovic, last name P-E-J-O-V-I-C. I am a lawyer called to the bar of Alberta, and I'll be asking questions of our witnesses today.

My first witness today is Dr. Justin Chin. Could you state and spell your name for the record, sir?

Dr. Justin Chin
That's Justin Chin, J-U-S-T-I-N C-H-I-N.

Allison Pejovic
And do you swear to tell the truth, the whole truth, and nothing but the truth, so help you God?

Dr. Justin Chin
I do.

Allison Pejovic
Thank you. Now, Dr. Chin, I believe you have something that you wanted to say before you begin in terms of disclosure?

Dr. Justin Chin
Yeah, I would just like to disclose that what I'm saying is my personal opinion. It doesn't necessarily reflect any opinions of the institutions that I represent or I am affiliated with. As you go through my speech, you'll see why I've been asked to make that clear.

Allison Pejovic
Thank you. And very briefly, Doctor, could you please provide us today with a brief overview of your qualifications?

Dr. Justin Chin
Sure. I'm a specialist emergency physician. I have a bachelor's degree in science, followed by a medical degree, and then a five-year specialty with the Royal College of Physicians and Surgeons of Canada in emergency medicine. And then I've been practicing full-time as an emergency physician, since 2013, so for almost a decade now.

In addition to that, I have disaster medicine training. I have my master's degree in that field, as well as field experience. I was a response coordinator for an NGO [Non-Government Organization], a disaster relief organization that deployed to multiple places. I helped coordinate a response to Nepal after the earthquakes. I was also the chair of that organization for a term and deployed myself to Haiti three times after the disaster there, as well as to Pakistan after floods. And in addition to that to the Philippines after Typhoon Haiyan.

I work as a full-time physician, as I mentioned, including an additional role as a trauma team lead for major traumas in our accredited trauma program. And even during the pandemic, there were shifts where I helped out and took evening coverage in the hospital, in the COVID ICU [Intensive Care Unit]. So I have experience in varied fields. That would sort of summarize my training and experience, though I know I'm listed as an expert witness. I myself don't like that term for various reasons, so I like to tell people to take that with a grain of salt, but we move on.

Allison Pejovic
Thank you and just for the commissioner's benefit, his CV [Curriculum Vitae] was provided to you as Exhibit RE-10.

Now to begin, Dr. Chin, I'd like to talk about your early role in the COVID pandemic. Can you provide us with an overview of early disaster response preparations that you were involved with during the COVID pandemic?

Dr. Justin Chin
I think it's very interesting that I'm following Lieutenant Colonel Redmond who spoke at length about this. And I'm someone who likes to keep informed on many different aspects of the world, from health to fitness to economics to finance to medicine, obviously. So I was aware of what was going on from various channels and all the reporting that was going on about this new emerging pathogen sort of in late 2019 and coming into early 2020. Thinking about it, and following along closely, I was wondering about preparations and starting to make them myself and in that way sort of felt myself a little bit ahead of the curve.

And so I began, obviously, making various preparations for myself, my family, as well as speaking to people in the hospital saying, you know, there seems to be something going on around the world, and if this escalates, then we should be prepared, and I have some training in this, and so I'd be a resource to help out.

And I must say that a part of that, when I think about it looking back, I almost feel a bit ashamed because I too was captured by some of that fear and some of the propaganda that was being disseminated out. It was even to the point where, you know, very early on, I think it was early February of 2020, I went to the Home Depot with a mask on and got some funny looks because this is well before anybody was even wearing masks.

But I was preparing quite ahead of time. It is even to the point where before we even had these lockdown restrictions, I had this zone director of emergency medicine at my dinner table, a friend of mine, because we'd prepared in the past,

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our hospital, for different things. And we've had in services on how to put on the protective equipment for Ebola and where to separate patients and so on. But what seemed to be coming down the pipeline here was much worse than that, and it was portrayed as being something that would be, you know, massive numbers of patients. So how are we going to cope, and how are we going to manage that? And, so we were drawing up plans to help assist with things.

So I mention these things just to show that, like, I'm not someone who was reckless about health or didn't take risk seriously from the beginning. I was actually someone who—When we didn't know, we were trying to augment everything to the biggest capacity. And now, looking back, it seems a little bit foolish that, you know, I advocated for some measures in the name of safety because we obviously didn't consider the long-term harms if these measures were implemented, especially for a prolonged period of time. So I had this interesting role where I was preparing for the pandemic.

And just to give you a quick story here, I was the physician who was involved in caring for one of the first patients who came to the emergency department, before we had community spread. So we were being told by authorities that we were only having patients who were known connected to travelers, or travelers. And the patient that was triaged that came into the hospital, came in with the cardiac potential condition. So he got put in a room, and I examined this patient and was in there. And it was only later that it seemed more apparent that he was having breathing difficulties. And I was exposed to this patient. I wasn't wearing any protective equipment at the time. And you know, the next day, because we have access to all the records and different alerts from our emergency medicine systems, I got the notification that his test had come back positive for COVID.

And at the time, this was quite frightening. You know, being captured by that fear, there were reports and stories out of different parts of the world where young physicians were dying and were put on ventilators. And this was seemingly a big deal because we were talking about it all around the world and there seemed to be some rise in the curve in different places like Iran and in Italy and in Washington state.

And so, you know, it seems kind of a crazy memory to have now, but I remember that evening in the middle of the night saying well, if this is community spread—because this person that I spoke to, he reported to me that he had not travelled anywhere and was not in contact with anybody that was travelling—that this was a big deal. We should probably

have to get everybody that he's been in contact with, notified—everybody certainly in the hospital that I was working with, that are taking care of this patient—because now he was in the hospital and brought to the ICU, so all of them need to know sort of right away. And I got on the phone, and I actually woke up many people in the middle of the night that night: the medical officer of health, ICU doctors, the infectious disease doctor. I let them know that, "Listen, I was exposed to this patient and his test had just come back positive, just came along the way, and we should be starting to get things going."

And in the middle of it, I hung up the phone and I looked at my wife and I said, "Well, I've been exposed. Now it's been over a day since I saw this patient, and from what we're hearing, this could be devastating. It could be that the virus is already replicating in my oropharynx, or in me and my respiratory tract. And so, you know, I need to isolate myself instantly. So I will lock myself up in the third floor—the bedroom floor of our house— and there's a bathroom up there. But I won't kind of get close to you right now to give you a hug goodbye, and I won't say bye to the kids—I had a newborn as well as a three-year-old. I won't say bye to them either because as devastating as it might be, maybe in two weeks from now I'm going to be admitted to ICU, and I might pass away. But I chose this and the last thing I would want is me saying goodbye to them for even a minute here, then two weeks later you're dealing with, you know, our children being sick."

So I say this just to point out that, you know, I too was captured by this fear and I took things seriously. There were risks that were perceived. And I think it's some context of background that whenever the information comes in, you should evaluate it, and then see if it matches. And then over time my position changed. And so yeah, that's my background from that.

Allison Pejovic
Thank you. I wanted to ask you about

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was there a difference between what you were hearing in the media in respect of the types of people who were being hospitalized and dying of COVID and the types of people that you were seeing firsthand. And what I mean by that are, Were the people that were being hospitalized and dying of COVID otherwise healthy people in your professional opinion? Could you describe for us that, some of their characteristics?

Dr. Justin Chin
Yeah, I sort of alluded to that my position changed over time because, you know, what I was seeing in the emergency department myself—and obviously I'm a single physician, not representative of everybody—, but it wasn't as severe as what was being reported in the media. And so that to me was kind of a first thing that maybe started me to become skeptical of, you know, how much fear was being driven.

Even some specific cases. Like I was the physician who cared for a patient who was young who ended up getting quite sick and passing away. And it was reported that this was a mostly healthy individual who had died from COVID, and now even young people are dying that are healthy. But in reality, that wasn't the case. The media didn't get that right. They were inaccurate in that this patient had a very low injection fraction, which means he had pre-existing severe cardiac disease, and he also wasn't on his medications for type 1 diabetes, which are necessary.

So his presentation was not consistent, quite, with COVID itself. It might have contributed to his presentation, and maybe even exacerbated, made it worse. But this patient himself— It was reported one way, but clearly, I won't give specific details of the patient more than that, but it wasn't accurate. And so the media reporting in my mind wasn't quite what we were seeing in the front lines. And even the numbers: We were seeing COVID patients, but it wasn't to the extent that it was being portrayed in the media.

You know, it was a time when my overall thinking on this changed. I was seeing other patients, too. So I recall vividly then seeing patients who appeared to be suffering from more mental illness, overdoses, things that I was wondering whether or not these could be attributed to the lockdown restrictions or non-pharmaceutical interventions, as Colonel Redmond puts it.

And I recall this one patient, he was in his late 30s, you know, very fit looking gentleman, and he came into the hospital with thoughts of wanting to end his life. And looking at this gentleman, I spoke to him, and I was wondering: What led to this? And he outlined to me that he used to work in the trades for about two years before the pandemic and had decided at one point that he no longer wanted to have that sort of a life. He was pretty much healthy, but thought he wanted to settle down, build a family, meet someone. So he moved to Edmonton. And he had made some money before that, so he had some savings, but he decided to stop his job, get his personal trainer certificate, and go from there. So that's what he did. He had moved to the city and started to work as a personal trainer. But very shortly, it was only a few weeks after he had just started working in that field that the lockdown restrictions had come down, and he was no longer allowed to work.

And so this patient, he outlined to me how he wasn't somebody who really— He did drink alcohol, but not a lot. And he told me that when he had nothing to do and nowhere to go, he couldn't make a living. He had no meaning in his life anymore. He was basically in tears and telling me that all he wanted to do was make a life for himself, and he was being restricted from doing that. He told me that he had tried to beat alcohol addiction and alcohol use disorder a couple of times through detoxification programs and rehabilitation and that it failed. And now he said to me, "You know, what is there left to live for? I can't work. I can't do anything." And he asked, you know, he was hopeless. He told me he wanted to end his life.

These were the type of patients I was seeing, and he asked me some directed questions. He said to me, "How does it make sense that people can go and there can be hundreds of people in Costco, but I can't go to a gym to teach people how to exercise?" And then he said, "How does it make sense that people can walk into the front of a restaurant wearing a mask, sit down and talk for two hours and eat dinner together? And you know, I can't socialize in other settings?" I didn't really have a good answer for him because, you know, things weren't matching what I was seeing.

At the same time, I was having these discussions with other physicians in the back office. And I had an environmental service worker come in

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and interrupt us and apologize and said to the doctors—and we were discussing the absurdity of some of the mask restrictions—and she said, "Oh, I, you know, I didn't know that the doctors felt this way. I thought you were all on the same page that we had to do everything, and mask all the time, and fully abide by all these restrictions." And I said, "Well, yeah, but everything should be questioned and debated, and we should look for

evidence towards it." And she said, "Well, I just wanted to bring that up because my daughter,"—and I still get sad when I hear this—she said that her daughter used to come home from school every day crying and upset and didn't want to go anymore. And we questioned her, "What was that all about?" And she said, "Well, she can't play with her friends at recess. She can't socialize. She's told that during lunch hours, she has to sit straight forward at her desk and eat, but not—Pull the mask down, take a bite, and pull the mask back up. One day she turned over to talk to a friend while it was happening and she got yelled at by her teacher."

And I was just thinking how devastating that was, that she mentioned that her child was an only child. And I have children of my own, and I was doing the best to ensure that they could still socialize. Thankfully they have siblings at home that they can interact with, but this child was an only child, and I couldn't imagine that she couldn't do her extracurricular activities. She couldn't do so many different things. So I was seeing things and effects of the restrictions that were causing harm. And then I was seeing the fear that was being pushed on the other way, and I started to ask quite a few questions about what was going on, and really started to look more closely into whether or not we were causing more harm than good.

Allison Pejovic
So earlier you talked about a shift in your own thinking about COVID and the dangers of COVID, and you started to see— You just talked about potential harms. Is there anything further that you wanted to discuss in terms of what you saw could be potential harms of carrying down this path, towards citizens and society?

Dr. Justin Chin
Yeah, I mean, I think there's numerous examples that I can provide. I think going into the details of each single one isn't sort of necessary. But when people say that there is, you know, developmental deficits and damage to society from many different aspects from— I mean, people will say that, well it's just the economy or just a business, but I mean that's more than that. Businesses are people's livelihoods; it's how they provide for their families.

So I took this as something that— I took an oath in medicine to do no harm. And if we were doing things that were causing harm, I really thought that we needed to ask questions about things. I thought, as a scientist and as somebody— I don't like the term when people say, "Well, trust the science" because clearly people quite understand that science isn't something to be just trusted blindly as authority. It's a process. It's a method by which we evaluate the world. It's a method by which people look at data and come up with the best actions to go forward. It's a process. And so you know, in that way my opinion is that robust debate about the things that we were doing and evaluating: Both the benefits and the harms are necessary.

So I mean, that sort of leads into something that I really wanted to point out today is that, you know, I took to different venues to try to— I guess I was now differing from what was common narrative, but I was saying, "Well, we should question, we should ask these different things." I spoke to colleagues over the course of the last couple of years. I've written letters to elected officials. And just like everybody else, I could see the messages being shared by other physicians, other people on what we should do for restrictions. And I was putting on posts on my social media mostly just questioning what was going on and asking some legitimate, I thought scientific, questions and generating hypotheses of whether or not these could cause harms.

I have a list of things here that I've printed off that I can share that are interesting because the next thing that happened was, because of those posts came a coordinated attack, what seemed to be a coordinated attack, against me from another activist physician in Alberta. It was one where it rapidly escalated, where that came on, and then there was a subsequent unfavourable piece in the CBC [Canadian Broadcasting Corporation] about me.

A CBC reporter emailed me one day, while I was on shift, and asked me

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if I wanted to respond to a piece he was doing on misinformation. And I actually emailed it back within a couple of minutes and said, "Absolutely." I was kind of questioning whether or not he was thinking I was spreading some misinformation, and I don't believe I ever was. But he then asked. I said, "Well, absolutely, I'm happy to respond. If there's something specific you'd like me to comment on, please send me, you know, what comments I can make," and then he responded, "No, we won't be doing that. We just want to get a comment on why you've been spreading misinformation."

So he clearly wasn't looking out for the truth or for unbiased reporting. He basically said, "Well, you're guilty of this crime, and we don't really want you to speak to any of the things we're accusing you of. We just want you to comment on why you're guilty." So it was quite amusing to me, and that escalated very shortly. I received an email a couple of days later from the chair of my department, the Dean at the University of Alberta, that I was being terminated.

So right away, it took me aback to think, wow, I'm a part of a sort of respected academic institution that's supposed to search for truth, ask questions, generate hypotheses, yet what I was doing in good faith with that violated their code of conduct.

And it's interesting because they write these codes of conduct, and they're not legal frameworks, they're just what they say, and they're very vague: how to be respectful or professional or maintain certain levels of conduct. But then after that, I guess they get to be the judge, jury, and executioner as well because when they first presented to me, I just got this email saying I was terminated. I didn't have a chance to defend myself. I wasn't even told which pieces of post they were concerned about. You know, there was no trial, there was no hearing, it was just, you're terminated.

And so it hit quite hard, because it was something that I didn't think would happen, clearly. And it speaks to the censorship of physicians because, I mean, I'll put it a couple of ways: One is that as soon as I get that, it makes me a bit more hesitant to continue to speak out because I lost one portion of my ability to work. Now, I hadn't lost yet the ability to work in Alberta Health Services as a practicing physician. So when I hadn't lost that ability to work yet I could still pay my mortgage and feed my children and earn an income. But if another institution, if the College or somebody else came after me for their same vague code of conduct violations, then 20 years of education and training would be gone, like I would no longer be allowed to work.

So that puts a bit of a hesitation on me to continue to spread truth, and my concerns with what we were doing. But it also makes other people hesitant too because my colleagues who know that happened to me might also say, "Well, if this could happen to Dr. Chin, then I won't speak either because I don't want to risk that same type of loss." Now thankfully, I didn't have a massive academic appointment, as some people do with research portfolios and everything else, but if it happened to them, it could be a huge loss.

And it was quite interesting that I was—for the social media posts that were very benign, or asking questions, really—that I was attacked for this in that way. When I asked my chair directly, I said "What was the specific post that you were concerned about, or what was it?" and he said "Well I—" He couldn't tell me, first of all, and he said he had no choice. He said he had no choice but to sign off on this. So his superior told him that he had no choice but to terminate me.

So if you think about how that works in a hierarchical system, it just means that if he's responsible for all of the academic emergency physicians, and he's been told by one person. Well, that same person can tell the chair of medicine or the chair of surgery or the chair of any other department, and they can silence people, you know, in a systematic format and stop people from speaking because then they'll be self-censored.

So it was quite devastating to me and disappointing that the academic institution would take this route. And it was quite comical too because at the same time because of this, I was getting threats on social media. Some were calling for, you know, violent assaults of me and attacks, and some of these threats were from other health care providers.

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And one of them called for me to be, if I would be seen on the street to be, let's just say, injured or murdered.

And the person who commented on that same post said, who's in support of that said that, I think if the words were actually, "I support this," was another emergency physician, not in my hospital but in the same zone. So he would have been under the same academic umbrella as the chair. And to my knowledge, and I could be wrong on this, I don't think that he suffered any consequences or had his academic appointment abruptly terminated for code of conduct violations. So the double standard is interesting, that somebody can wish harm on another person on social media and that's all fair and games, but if I ask questions, then somehow I should be injured or hurt.

So you know these attacks, they certainly prevent other physicians from speaking out. And I know of other people who've asked, "Well, are you sure you want to attend this testimony and testify, and what risks will you have upon you?" and I said, "Well, I know people who've declined and not been interviewed, given their testimony. And it's fully understandable because threats of harm can come to them, or even just the risk of loss of their employment or academic appointments." That risk was definitely present.

Allison Pejovic
Thanks, Dr. Chin. Would we be able to get more of a specific idea of what was it that you said that you considered truth and it was deemed misinformation that was so bad that it got you fired and threats were made against your life? What did those posts say?

Dr. Justin Chin
I have a few of them here, so I can read them. One of them was, "Strong social connections improve health." I said that, "I'm against the restrictions. There are scientific reasons why they are likely to make health outcomes worse." I said, "Taking a calculated risk in the present includes the comparison with the future potential risk." I mean, these are apparently very egregious. The next one was, "COVID is real," so I wanted to make that clear. And then I said, "But there are serious questions with regards to the restriction

policies which need to be explored. Restrictions should be evaluated as an intervention considering potential harms and potential benefits."

I mean, I have lots here, but some of them link to articles that people had said, so I would basically say something. There was one that I just said, "Time will tell," and it would link to an article that was written that said, "Decision to lock down caused 228 times loss of years of life, as reported."

Now, again, it's just questioning. I wasn't saying that necessarily I agree with everything in every article, but I had questions. And I thought that as a scientist or a health advocate or somebody who's taken an oath to helping people, that these questions should be addressed, and we should have the freedom to speak about them.

Allison Pejovic
And was your academic appointment reinstated?

Dr. Justin Chin
Yeah, so there was an appeals process, and that's how I eventually was able to obtain which posts they were concerned about. It's kind of funny because when you look at the digital tracking of those, they all came from maybe two or three—it doesn't seem like very many, however—people who would have complained. Because it said screenshot 834, screenshot 835, screenshot 836. So essentially, the same person went and screenshotted everything and sent them off. But it doesn't matter. A mob, I guess in this sense, came after me and complained and then, yeah, I was promptly terminated.

Allison Pejovic
And now that we know more about COVID than we did before, and since your reinstatement, have you received an apology from those health care workers who you say threatened you physically?

Dr. Justin Chin
Uh, no. I have not. I know we know a lot more. It's most of the things that I stated at the time are now quite well known, or at least we're asking more questions about it, and it's acceptable to, I guess, ask these questions. And no, nobody has apologized to me. I mean, I still have good relationships with the people I work with, and I've had discussions with them, and some of them have apologized about the way things went. But I haven't received apologies from the people who put out threats of harm online.

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No.

Allison Pejovic
Okay. So I'd like to move into a different area. Now we've had other experts at this inquiry testify about adverse events resulting from the COVID-19 vaccines. Have you personally encountered or treated anyone who you believe was suffering an adverse event from a COVID-19 vaccine?

Dr. Justin Chin
Yes, I have. I think as a part of this testimony, I want to help provide, you know, fill in some of the pieces of different areas. I think many people have talked to different level data of what vaccine adverse events numbers might look like and how they might be quite a bit higher than what's being reported, or how the reporting systems are flawed in different ways. And I would fully agree with that.

And I think it's important from the front lines for me to relay exactly some specific examples again of how these adverse event reporting, or even acknowledgment, might be biased or even unrecognized. And the reason I say that is because I believe many physicians—and not intentionally, maybe just because of subconscious bias—are not aware of it. And maybe, and even patients may not even be aware that they're suffering from a vaccine adverse event because of how difficult it is to recognize them in some ways.

So the first is that, you know, I think there are very plausible mechanisms that we need to consider for why a vaccine adverse event may take longer than a few minutes or a few days to manifest in a patient, right? So if there's an ongoing antigen production or spike protein production that causes immune complexes, or if there's some way that different systems in the body have been altered, then that may not manifest in the first day or two days as like anaphylaxis would necessarily, or instantly, or it might manifest over time. So a patient might start to develop something a few weeks, two weeks after, for example, getting an injection, and then they're feeling something but don't realize it—don't tie it back—especially if they're being told over and over again that this is safe.

So you have to imagine what it's like to be a physician in the position where you're in an emergency room, and if you think about 2021, the early months, we had patients coming in just like they always did. So we have now patients that are coming into the hospital with maybe a new headache, and it's very severe. And maybe somebody comes in with palpitations, and you check and their blood pressure is a bit higher. And so you know, during those months that I'm referring to, you can have about 50 per cent, almost half, or maybe even more that would have had the injection in the recent preceding week, two weeks, four weeks, five weeks, because there was a massive uptake at that point in time.

So what do you do as an emergency physician when somebody comes in, you've worked them up, they don't have something that's very dangerous: You're going to send them home. Do you then go and report every headache that comes in? Every vague, arm weakness or neurologic complaint? Well, it's hard. It's hard to know. So that's why surveillance data afterwards doesn't capture nearly everything that we need to. But even if you think about severe diseases, so let's talk about something that's more pathological, more of a serious condition. And I'll give you a specific example.

So I had a patient who came in, in his fifties, who had some high blood pressure before. He was a smoker and had diabetes. So he wasn't in great health; he had some comorbidities, and he had gotten the injection a few days before. And so he comes in with chest pain and ends up having a heart attack and gets admitted. Well, I certainly would report that. But, you know, when I see my colleagues or I see other people look at that case, some of them don't even look back to see if he had a vaccine recently. And even if they did, they say, "Well, you know, this patient has a long-standing smoking history. You know, they probably would have gotten an MI [Myocardial Infarction] or a heart attack anyway. So how do we know if it's, you know, the vaccine caused it?" But the important point is that the surveillance isn't supposed to check for causation. It's supposed to look for correlation in a temporal relationship. So those ones don't get reported, or may not get reported.

And I had patients who I saw with sudden cardiac death soon after the vaccination.

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You know, the bias that I'm trying to point out here, I'll give you another story of a patient that I saw. And it was quite interesting because this patient came in with—was in their sixties, a female who had symptoms of a stroke—so the patient couldn't move one side of their body and their face was drooping. When you come to the emergency department where I work, you have a team that comes. So the paramedic reports to the nursing staff and the physician staff and there's an emergency team as well as a stroke team. So we're a very coordinated system that works together to rapidly assess this patient for what's going on. And this patient did have comorbidities. This patient had diabetes and had abnormal lipids. And so came in, and the paramedic is reporting to the nurses that the symptoms started at two hours ago, and the family noticed they couldn't move the one side and rushed in and reports all of the comorbidities to us. And funny enough, the paramedic says to the nurse as she's reporting, "Oh, but great news. The patient just got their third booster four days ago." And the nurse goes, "Oh, how awesome."

Like it was, when you don't even think that somebody with pre-existing vascular disease, and now gets an injection, that may exacerbate that in some way—and there are definitely mechanisms by which this could happen—that you're actually just cheering on that this injection is almost going to save us from the pandemic. You're not thinking that this patient might have contributed. In fact, that's the first thing I was thinking was, "Just had this a few days before?" This should be something that makes you stop and question and ask.

But those type of cases don't get reported because— I had certainly reported that one, but I don't believe that all physicians would do that. Because in that case, actually, what I did was I stood by and I listened to the stroke resident speak to the stroke staff who was admitting the patient and I listened in, I listened in as they were reporting the case, and the plan was to admit the patient for ongoing treatment in the hospital. And then as I listened in I was very careful to make sure it was told. And the stroke resident didn't report to the attending physician that they had a recent injection.

So I interrupted and I said, "You know, I see you guys are finished here, but uh, did you notice that the patient had this injection very recently?" "Oh, oh, no. Yeah, we didn't notice that," was the response I got. And I said, "Well, yeah, so you know, don't you think we should be reporting this as a possible, uh, you know adverse event, you know it's a quite serious condition. It's a debilitating stroke very soon after." And the stroke neurologist said to me "Well, no," and he made excuses. He said, "This patient does have abnormal lipids and high blood pressure and their age in their 60s, so this patient could have had a stroke anyway." But you know, that's not the point. The point is that at that level, you're not supposed to make subjective decisions on this.

I had a young patient in their 30s who had known high blood pressure and came in because he also was paralyzed. But not from the same clot in his brain; this patient had a bleed in his brain, and his blood pressure was very high. And on a CT [Computed Tomography] scan, the characteristic area where a high blood pressure bleed would occur, that's what we diagnosed. And when I got all the consultant reports back, none of the consultant reports mentioned that this patient had a recent vaccination.

Now, I'm not saying that that was the only factor in his permanent paralysis from a brain bleed. But because, again, I can only even look to correlation as well. The point is that if this patient maybe didn't have as high blood pressure, or his pressure brought up by a recent

injection, which could have happened. And maybe for the vast majority of healthy people who take an injection, their blood pressure goes up transiently for a week or two, and so they get some palpitations, and it goes away, and there's no problems. But for this patient with pre-existing high blood pressure, that was enough to push him up higher. But the consultant reports didn't mention that at all. They just said that this is a high blood pressure bleed and that's where the blame should lay, and that it doesn't get recorded.

So you know, taking adverse event reporting, as much as there's some great testimony beforehand about how the difficulties are, with even once you report it, to get it counted, we have to remember that this is not the way to look for events. There's people ask well, how do we tell? Well, you know, retrospective data or looking back and surveillance, it'll always be flawed. Because the question will always be there:

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Was there some other contributing factor that caused this? Maybe the lockdowns caused the person to be more stressed and his high blood pressure went up.

So you know, there's too many things. The only way you could really do that—well, there's a few ways—but more accurate ways of determining the cause would be tissue level, things like from a pathologist point of view which people have testified to how difficult that is. But then in science we use randomized control trials.

So when randomized control trials, you look beforehand and you say, okay, if we group certain patients and we control for other medications, we're blinded. What happens if we give 50 people an intervention, 50 people we don't? How many people on one get any sort of side effect, or not. And we look at the data.

Now, unfortunately, we're in a situation where even some of those trials are, you know, there's some flaws, but they're biased by who's running them, if it's run by the pharmaceutical company. But even with that, we don't have trials that are continuing to go into long term. The groups that were intervention versus placebo, the intervention group was unblinded, and we've lost that control group. So it is very difficult.

Allison Pejovic
Thank you and next question. How did your first-hand experience with possible vaccine adverse events that you saw in some patients shape your own opinion on the COVID vaccine?

Dr. Justin Chin
Well, certainly I had evidence first-hand of how I did not believe that safe and effective narrative because I could see with my own eyes deficiencies in safety, right? And as far as efficacy is concerned there is bias reporting when you use different tricks like reporting relative risk reduction and not absolute risk reduction. Other people have testified to that as well. So when I was seeing this, you know, I had my concerns.

Now, I'm not one that is in a position to recommend or dissuade anybody individually from vaccination because I'm not a primary care physician, I'm an emergency physician. But for myself, I had to make a decision. And so I had to come up with looking at all of the different potential benefits and the possible risks. And from a benefit point of view, I had to look at multiple factors.

So what was my risk of the disease? It was very, very low from the data at my age, but probably magnitudes lower than that because I had a complete absence of comorbidities. I was fit and healthy. You know, there's evidence that people didn't go to the ICU at the same proportions, depending on their vitamin D levels. And I had an optimal vitamin D level. So again, magnitudes lower risk of the disease. So the benefit is going to be much lower for me too.

And in addition to that, I checked my antibodies. So I had, at some point, had a small illness that must have been COVID. It wasn't that severe. And I knew that I was protected. So I guess I had natural immunity, lots of factors, and proof of concept, because now I know my body system could beat it. And then there were other treatments that were available, so I was willing to take them if I needed to. So the benefit was marginal. Any claims that this was going to prevent transmission or cause me to harm other people by not getting it, those were unfounded and weren't borne out in the data.

So then I had to take into account the risks. So I took into account the risks for myself, known ones. Younger males tend to have increased adverse events in myocarditis. I was fit and healthy and still performed active sports and competitive sports. And there's even long-term unknown risks. So I made the choice, my personal choice, to exercise my medical autonomy, and after becoming informed, I chose not to get vaccinated.

This led to quite a bit of absurdity in my perspective, because there was a time when I wasn't allowed to work. I was restricted from working in the hospital because of that choice at a time when supposedly we needed all hands on deck in an ongoing fashion. And up until that point, I was caring for a variety of patients, including COVID patients that I had intubated, including elderly, and all sorts of the variety that we see in the emergency department.

And, you know, when that happened, it was something that, it became absurd because, yeah, I was allowed to— Sorry, I'll correct myself here.

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I wasn't allowed for a certain period of time, but then I was allowed back. So just to be clear, thankfully, our provincial authorities, I guess, received enough pressure from various places to let people who were exercising their medical autonomy back to work. Other places still don't, which is shocking to me.

But we were allowed back. And so here I was going in to work daily, helping people with their illnesses, caring for people. And at the same time, I was being restricted, and I wasn't allowed to go to restaurants or some hotels. And when I tried to travel the country, I wasn't allowed to get on a plane to visit people. I wasn't allowed to do certain sports, and it wasn't just me. There were millions of other Canadians who were being restricted on certain aspects of their lives.

This included my children, who suffered from this too. Because you know people say, well, they missed one sports competition, or one dance competition, or this. These things, I coached and volunteered for youth sports and childhood sports, and missing one is maybe not a big deal, but missing a number of events over two, three years, these are developmental and very integral parts of children's lives to train for something like a dance competition or a national championships. This was stolen from them, and some of them weren't allowed to because of their informed personal choices.

And it was worse than that because the language that was used against us, it was hateful. We were marginalized, right? We were being portrayed as this small fringe group. Fringe. What does fringe mean—on the margins? We were being marginalized. The language that was being used towards myself and millions of other Canadians was that we were an enemy, right? They used language like, we were putting others at risk, we were dangerous, it was said that we were part of an angry mob, that we're lashing out.

These are words designed to divide, to make somebody seem like an enemy, right? That we were putting other children at risk, which we clearly weren't because of the characteristics of the inoculation, you know, didn't stop transmission. But we were labelled in this way. I was labelled as a racist or a misogynist. And these terms, I mean, it was appalling to me because I was going in to work every day helping people, and I wasn't allowed to do certain things. If I had a family member in the part of the country who got sick, I wasn't allowed to go visit them and help them.

I've lived in Canada for my whole life. I'm of a visible minority and a son of immigrant children—a son of, sorry, immigrant parents—a child of an immigrant. And, when this happened, I reflected upon what it meant to be Canadian, how I had never really faced that. I had never faced discrimination or anything here. I actually think that, and I'll defend that this country is probably one of the least racist countries. I mean, certainly there are flaws, and I don't want to take away from anybody else's personal experience that they have. But when I reflected upon, you know, decades of living in Canada, I thought maybe there's one or two times I've been in a new city and I go somewhere and somebody looks at you funny and you wonder, well, are they looking at you because you're different? Well, it's probably because they haven't seen you before. But I've never really had any overt discrimination against me my whole life.

Yet all of a sudden—and it wasn't just a person looking sideways at you or being rude to you—it was our elected officials who were supposed to represent us, putting in place policies and mandates that were preventing me from living, from freely engaging in activities. I mean, they say, well, it's a personal choice and there are consequences, but you know it wasn't right because of the characteristics of what they were proposing—you know, we violate our medical autonomy.

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I mean, the policies are in place that you need to show a certain card or something to get into a restaurant, or you stop showing up to work the day the mandates come in. It becomes quite obvious to the people around you that the reason you're not there is because you've chosen something. So you become an identifiable group. So an identifiable group was now being discriminated against. And we were— Hateful rhetoric was thrown at us.

So you know, to think that I could— I've represented my country on a small-scale stage and sports competitions internationally with the Canada flag proudly on my back. And I've had disaster relief missions where I had the Canada flag on my backpack as I went to Haiti and as a part of a charitable organization and volunteered to help other countries, representing our country. And I was proud of that. And then I had people who were elected to represent me imply that I was taking up space, and that questioned whether I and millions of other Canadians should be tolerated.

Allison Pejovic
And Dr. Chin, thank you for that explanation of what happened to you in a very factual way. Are you able to just go in a little bit more detail about how did that treatment affect you, if at all, mentally?

Dr. Justin Chin
I mean I have a strong support system, I have good family. It wasn't pleasant to face attacks in various ways as I had mentioned today, but you— It wasn't pleasant. I like to think of myself as a very resilient person, I like to stand up for my principles. And I knew that every night that what I was doing was because I was standing for my principles. And so as much as the attacks came, I think I was able to withstand them quite well. But again, I'm not going to speak for everybody on this. I'm sure some people had worse attacks, or also because of it, the impact that hit them could have been much, much worse as well.

Allison Pejovic
And do you believe that a false consensus amongst the medical community was obtained in respect of this response to COVID?

Dr. Justin Chin
Yeah, I think that, you know, I alluded to before that how when you censor or attack groups, or you vilify them, that a false sense of consensus might be obtained because you're not going to hear from the physicians that want to speak out, right? And so when you think about how that happens, those attacks, they serve a very deep psychological purpose, right? Like in our whole evolutionary history of humans, we have a lot of things that are very nice for us: running water and everything that's built up the infrastructure that we have. But for large parts of our evolution, being a part of a tribe and the safety of that tribe was very important. And if you were ostracized and kicked out of the tribe, I mean, that could mean starvation and the cold and dying. So in some ways it's a threat that can impact you very— Let's say it's very impactful.

And you know, those type of things certainly tell people, "Let's not speak out." So you know, it's interesting because people ask me this question every once in a while and they say, "Well, if all this data is true, that, you know, there are more adverse events, why aren't we hearing physicians speak out about it more, or why didn't we hear physicians speak out about it or other people say things?" And I say, "Well, obviously—," and I pointed to the ways where a physician might be biased and not even think to report something or not even understand that it might come up. But physicians, we're trained in medicine and evidence-based medicine in various ways. And so we like to think that we live in an ideal world where the evidence is great. The studies show this and we can follow our practice. But in reality, it's an applied science, and there's always new data coming in.

And so what the vast majority of physicians will do—and this heuristic is one that's understandable, right?

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So if you have a certain disease that you want a treatment for, and you have accumulated mountains of studies over many, many years that show that this treatment is the one you should use—treatment A is the one you should use—so what happens then is that so many studies accumulate that people start to write consensus statements, and different bodies

the urologic society might say that we should use this medication for it. So they put up their consensus statement.

And then so what do many of the physicians do? Well, they don't necessarily have the time to go through and look at all of the papers that made up that consensus statement. And they don't sit us down in a room and say, well, here's 50 papers on COVID and the harms of lockdowns or this, or the harms of this medication and the benefits of it. Spend five hours, come out, and see what you think. Well, no, physicians don't have time for that. We're working hard every day to see a variety of things. You have obstetricians going to deliver babies, you have pediatricians treating kids, you have surgeons operating. And so the heuristic is that you can follow that consensus statement. And it may be imperfect, but it works. What else do you have?

So and yes, some people do dig into the data more deeply and look at these things. But it's a good heuristic to follow because if you've worked all day long as a physician in your family medicine practice or your obstetrics practice or whatever, you want to come home and maybe see your family and enjoy the rest of the day. You don't want to go digging into tons of papers of the latest emerging evidence on COVID. So you just follow what is coming down from you from medical officers of health or from the Public Health Agency of Canada. It's not, you know, as ideal as we would think about how evidence-based medicine comes out.

Now you have to think of in COVID, the problem with COVID is that all of this evidence didn't have years to accumulate. It was a small amount. So following the consensus statement in this case, especially if there's political aspects that bias people from publishing or reporting or disseminating information, that is when the heuristic fails. And so you know, for many of the physicians out there, I don't necessarily blame them. I think that they were a little bit too naive and should be a little bit more skeptical to trust, sort of, just top-down authority in certain ways. And so that's how, I think, another way false consensus can be achieved because people are following these failed, these flawed heuristics.

And you know, then there's the other group of people that were skeptical, physicians who testified, physicians who were much more brave than I was, who spoke out in various different ways. And you know, I applaud those physicians because I hold them to the highest esteem. They risked a lot to speak out and try to inform the public about what they were concerned about. I mean, that's two of the groups: the people who were just kind of not skeptical enough, the people who were skeptical, and they spoke out even despite the attacks because being a martyr certainly or choosing that path is not easy.

You know, then there's a third group of people out there that I would really hope could have some self-reflection and maybe listen to all the testimony that they've heard, and some of the things that they may not be aware of about how the world isn't as ideal as they think that they can maybe just trust authority or trust experts. Because there was a third group that went out of their way to attack the people who were asking questions. They slandered us; they mischaracterized us. Even if they had the best of intentions, they were censoring us and doing things. And they were part of the process that when they took those actions, they caused people not to be informed fully about what was going on.

And when they took those actions, they contributed to the harms of prolonged non-pharmaceutical interventions or lockdowns. They contributed to the harms of people who are now suffering from vaccine adverse events, particularly for those who were coerced into taking a test they didn't want, or not informed fully—especially if for that individual patient the risk-benefit ratio was not in their favor and now they're suffering from the

consequences of it. For the people who were attacking us, I think they should take some self-reflection about how they contributed to harming others.

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And it disappoints me that it even still exists out there that I can see people being falsely mislabeled or mischaracterized when they're actually out there trying to help people and protect people.

Allison Pejovic
Thank you, Dr. Chin. Those are my questions today. I'm wondering if the commissioners have any questions.

Commissioner Massie
Good afternoon, Dr. Chin. I first want to acknowledge your courage in coming forward with this. We all know that we've had witnesses still talk about consequences to this day that are being hurled at them. So I just wanted to mention that first.

My first question is, and you mentioned that late in 2019, early 2020, you became aware of this COVID-19, or a potential pandemic. And my question to you is, at what time did you become aware, or what time were you trained in the pre-existing pandemic plan that was in place for the health sector in Alberta or in Canada?

Dr. Justin Chin
Yeah, so even though I had a disaster medicine masters and had worked in other areas with the charitable organization, I was not formally a part of our own disaster preparedness framework in Alberta. I knew we had one and I had seen it briefly, but I wasn't completely versed in that. So I knew it existed and I guess that's where, you know, I apologize too that by being captured by the fear and pushing some of the early interventions that the Lieutenant Colonel Redmond spoke about here. Because yes, a complete task force that encompassed all aspects of the pandemic should have been made up. Now obviously when you're in your silo from the medical aspect you're going to push for everything, and so well, we want more of this and more beds, and we need to augment it in these sort of ways. So but then you hope that there's a framework in place that restrains that and takes into account everything else.

Commissioner Massie
Well, I wasn't particularly speaking about the overall disaster plan. What I was speaking about is the influenza pandemic plan that existed in Canada overall, and it was authored by Theresa Tam. And I believe there was one in Alberta, as there were in many other provinces, which were specifically focused on what the health care sector should do in the case of a new influenza pandemic. So again, my question was, were you given training in that? Did your employer make that available to you?

Dr. Justin Chin
No, in general we have so many different aspects of our jobs that we're responsible for, but I wasn't and most physicians aren't.

Commissioner Massie
Okay, my second follow-up on that then is we were told that we were in an unprecedented pandemic and it was gripping the world and there were tremendous deaths going on. And you were trained as not just an emergency doctor, but I think you have training and experience in disasters. How often did your hospital scrum, or make meetings, or get the staff together to talk about what was going on, what they were experiencing, what they expected from the staff directly about the pandemic?

Dr. Justin Chin
There were meetings, and there were people that got together in various groups that reported to the zone structure, and it just seemed very disorganized. It wasn't one that met sort of a good and proper framework. And so early on I was asked to help in certain groups. "So can you make a recommendation on what we should do, how do we double the number of beds, or how do we put patients in this?" You know, as time went on and I started to ask questions about, "Do we still— Does it really make sense to have these plexiglass barriers, and is it really helping, or is it reducing the ventilation?" When you spoke on something that appeared to be looking at a more complex or more nuanced look at the intervention, but the other side might say, "Well, it's for— It's just for safety." I mean, somebody who spoke with that wasn't listening to—

Commissioner Massie
You know, that's an interesting answer because we had a witness testify in Saskatoon,

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and he owned a manufacturing facility; they manufactured tillage equipment. And every week, according to his testimony, he would bring out a newsletter, and he would have meetings with staff to describe to them what was going on, what were the reasons for it, what they were planning to do in the future. And he was manufacturing farm equipment. And if I understand properly, that same kind of thing, at least in your experience, wasn't going on in our hospital.

Dr. Justin Chin
Well, I want to state that it was going on, but not in a very clear and organized way. So we were getting briefings and memos from all different sorts of places, so to make sense of it all was challenging and almost nearly impossible. But to say it say didn't happen is not quite characterizing. We were getting: "We're going to do with this today." and "These groups have decided," "Well, we're going to put a new triage process," "This is the route people are going to go."

But, most of it was all driven by, "Well, what is the maximal thing we can do more to this," and not, "Okay, well, if this is the intervention we're going to be proposing, do we really have good evidence for the benefits, and do we really have evidence for the harms?"

And sometimes there was. Sometimes there was a few studies or something cited. Well, the evidence for doing this is a theoretical paper on transmission, or some study that showed that COVID spread this way in a bus somewhere—a very small study. And so it was either limited evidence or poor evidence, and any evidence to the contrary would say, "Well, that might make things— We might as well be safe than sorry." It's that, sort of, pushing the safety-ism window farther.

Commissioner Massie
One of the things that I've been told over and over again by witnesses, particularly professional. No, not particularly, [inaudible] constantly professional witnesses. We had a retired judge on, and we had doctors and retired doctors, and we've had retired police officers. And I always ask the question, "How did this happen, and what kind of pressures were they under?" And each one of them has always said to me, "Well, you know, we judges and we doctors are part of the community, part of the society, so we feel those societal pressures."

So my question to you is this: You are a medical doctor—and I think I heard you say at one point that you had 20 years of training that were potentially going to be thrown away if you lost your position. So you're a trained doctor means you're a trained scientist to some degree. And yet, at the beginning of the pandemic, listening to the reports, with your training as a medical doctor—I don't know if you categorize it this way—but I think I heard you say that you were somewhat terrorized by this. And so my question is, with your significant training and experience, how do you think the general public were affected by the same things that you were hearing, despite the fact that you had this potential buffer of many, many years of training as a doctor?

Dr. Justin Chin
Yeah, so yeah, physicians or experts or whatever field, we're human. And I too can be captured by fear of death or disability, or death or disability of my loved ones. So obviously, it could happen to not just anyone, it could happen to everyone. And that's exactly why it's important to let people know exactly what I might have been seeing that might differ from the narrative. Because you frame that correctly in that, of course, they're going to have a much worse time, when behind the doors of the emergency department their impression might be that we're intubating every second patient that's coming in, and sending them to ICU, and body bags are rolling out. And if they had that impression, then the fear is going to be much worse in them. It can even happen to me, it can happen to everybody, and it's important to be able to speak freely about what you're seeing so that if accurate and valid information can come out, then it can alleviate those fears.

Commissioner Massie
You know, you talked a little bit about when you were in the emergency room, and you overheard some discussions, and you questioned about the possibility— Or sorry, you volunteered information to some other doctors that this patient had just recently received the injection. And they had dismissed the possibility that

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the injection may have contributed to or caused the issue on the basis that the patient was elderly or had these comorbidities.

And my question is: It doesn't sound like—could you comment on this for me—but to me it doesn't sound like they had the same reflectiveness when they were counting COVID deaths. In other words, I've heard statistics from witnesses that whatever the number is, 80 or 85 or whatever per cent of the people that deaths that were attributed to COVID had three or more comorbidities, and we had testimony I think yesterday, 90-some per cent had at least one comorbidity. So it almost sounds to me like there's a difference in the way they evaluated the two instances.

Dr. Justin Chin
The discrepancy that you're mentioning here, it's quite interesting because on the one hand you're under counting because of the biases of the vaccine adverse events, right?

And the reasons for undercounting I'll just say, you know, if you're in such fear, or you really want to get out of this pandemic, and you believe, or you've been sold the idea that it's safe and effective, then, you know, you're going to push this, and you're going to continue to believe that. And so it's a self-fulfilling prophecy, right? Like, so you don't see it because you're not looking. And then you don't think that anybody has strokes with it, so you just continue to ignore it over and over again.

But the other side is, what you're saying is that people will be overcounted the other way. Because there's a subjective decision that's required to determine if you're going to recognize it, I guess, or report it if it's correlated. But there's not a subjective decision necessarily for a PCR [Polymerase Chain Reaction] test—and there are many reasons to talk about how it's flawed. But so yes, that patient who comes in with comorbidities and has an event. They have a heart attack and they say, "Well, you know, COVID is a pathogen that actually affects the vascular system too," and we swab them and the test was positive, so they get counted for sure.

So it'll be automatically counted that COVID is in there. Because you have a binary there; you have a one or a zero: COVID test positive or COVID test negative. If it's a positive, it's like, "Oh." And if they end up progressing to death within that time, they go, "Somebody who tested positive for COVID on day one, on day seven they died," because it pushed their comorbidities or their pre-existing health to this new place of damage, and they passed away.

So a specific example is, I had a patient who came in and they had a known blood disorder, and they were in their 60s or 50s—I can't remember, I think it was 50s—and this patient, because of their blood disorder, their platelets had gone down, and they had a devastating catastrophic internal brain bleed, okay? And their platelets had gone down only a few days after they had gotten the injection, right? So it's another one where I questioned, and I looked at the reports, and the thinking here from the doctors is, "Well, a patient with this type of blood disorder, it's very common for them to suddenly drop their platelets. And so it was their underlying disorder that caused the platelets to go down, and then just suffer and die."

Now again, I don't know that the injection— Maybe that would have happened. Maybe the patient would have had their platelets drop and this devastating outcome would have happened. So I'm not saying that the injection definitely caused it. I'm saying it's temporally correlated to it. But I can tell you this: is that what would have happened if that same patient had come in a few months prior and they had had a bit of a sore throat, or maybe even no symptoms, but they were swabbed and the test was positive, and their platelets had dropped. And if he noticed their platelets had dropped and their brain was bleeding, we would have said that this patient is suffering from one of the other vascular complications or other problems with this very variable pathogen, COVID. It caused them to drop their platelets, and then they ended up having a devastating outcome. So we'll count that in the count box of COVID. But they're not going to be counted on the other side because it takes this objective decision to report them.

So you have this imbalance. And you know what, for many people they may not even notice it. The patient might not even know because if they're admitted to the hospital or the patient's family asks multiple times, "Well, what happened?" "Oh, you know, this is what

happens during your known blood disorder, is your platelets go down; this is an unfortunate and sad known complication." And the family might not even know, the patient might not know, the doctors don't even know, and there's biases that humans, we're not perfect.

Commissioner Massie
Of course, I mean, if I understand part of what you were talking about, then, in your answer and previously, the reporting system is not intended to report absolute numbers. It's intended to report trends.

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In other words, if you see something, you report it, and it goes into the system. And then later on when you evaluate the system, you might see a number of reports of such-and-such, but if it's not an unusual raise in the numbers, then it's not an indicator of a problem. But if you don't report it, you can never get those indicators, those warning messages.

Dr. Justin Chin
Yeah, and I thought about this for a long time, and I mentioned it when I was saying earlier, is that even then, it will always be undercounted, subject to bias, and flawed by the retrospective nature of the study. So that's why you need prospective, properly done science, randomized controlled trials that can evaluate this in a proper fashion. We just don't have those.

Commissioner Massie
My last question, before the other commissioners pull me off the stage, is if you're dealing with a highly infectious patient—I don't know, HIV [Human Immunodeficiency Virus], something like that—and you give that person a needle, you inject them with something, what do you do with the syringe afterwards? Do you put it on the countertop? Do you hand it over to somebody?

Dr. Justin Chin
Yeah, so the proper procedure would be to place any sort of sharps in a specific sharp container so that nobody else can be injured by that, and any biohazard material needs to be placed in an appropriate biohazard container.

Commissioner Massie
So would that count for, let's say you've got an infectious patient and you use gauze and you wipe the infection, and is that a biohazardous material as well that would be disposed of in some way?

Dr. Justin Chin
Yeah, the proper procedure would be that if you had a bodily fluid or any sort of vector of transmission, or potential vector of transmission, that that should be placed in the appropriate biohazard container.

Commissioner Massie
Then, given that—and I've been thinking about this for a while, and my apologies for putting you on the spot on this—but we were told that COVID-19 was deadly. We were told it was incredibly contagious, and we were told to wear cloth or paper masks. But I'm not aware of any instructions about those masks becoming biohazardous material and being disposed of in a way that wouldn't reinfect the person's hands, or the person touching the garbage can or whatever else. Is that an inconsistency, do you think?

Dr. Justin Chin
Well, it's hard to explain inconsistencies at that level because, overall, there were many levels of inconsistency with regards to the characteristics of a novel, what appears to be aerosol-spread virus that doesn't tend to infect from a contact drop—like from a direct contact of it—but needs to be exposed to certain mucous membranes of your respiratory oropharynx, you know, the certain ocular exposure.

So it's hard for me to give a quick, simple answer to that, other than to say that there are glaring inconsistencies in our attempted management of these through non-pharmaceutical interventions that, I believe, in some ways people who pushed for them had the best—Let's say, many people probably had the best intentions and may have been captured by fear or so on as well but don't realize the true nature of their intervention, or they may not have had any effect on preventing transmission or decreasing anybody from getting infected. And in addition to that, I would say that they almost certainly didn't calculate the second and third order harms of what those interventions might be.

Commissioner Massie
I appreciate your diplomacy and—

Dr. Justin Chin
And it's interesting, but I do think that many people did have good intentions. I don't necessarily want to attribute malice when you just don't know. But I think that the road to hell can be paved with good intentions in some ways.

Commissioner Massie
I appreciate that and—

Shawn Buckley
Can I break in and it's just I'm going to ask the doctor are you available later for questions? It's just the kitchen closes in half an hour. So if we're going to eat at all, then we have to take a break.

Dr. Justin Chin
I can take quick questions right after lunch. I have to work at an emergency shift this evening, but yeah, I'm available for that, yeah.

Shawn Buckley
Okay, so we will if it's okay with commissioners, because it's just there's a whole group that needs to eat and that will be impossible because the kitchen staff's already agreed to stay a little later for us. So we're going to adjourn for half an hour.

[01:19:42]

PART II

[00:00:00]

Allison Pejovic
Welcome back to the National Citizens Inquiry. We're still speaking with Dr. Justin Chin and he's going to take some follow-up questions from the commissioners.

Commissioner DiGregorio
Dr. Chin, thank you for staying to answer our questions. I just had one question. You spoke a little bit in your presentation today about concerns with using the adverse events reporting system to detect issues that may happen during the vaccine rollout. And we heard a similar concern from a doctor actually in some testimony in Truro, Nova Scotia. And whereas you've talked about really randomized control trials being the best way to get the data that's necessary, he spoke about the possibility of population-level studies following up and looking at population rates of things such as strokes, cardiac events. And is this the best thing that we can do in the absence of randomized control trials, which I've understood from other testimony that we don't have the ability to do anymore?

Dr. Justin Chin
Yeah, I think that as far as the process is going to be concerned regarding a scientific evaluation of what's going on, we should take into account all different types of evidence. From evidence that is, you know, specific patient level—an adverse event—and we can dig in deeply into that. We can take, I guess, pathology level data too where tissue samples can be evaluated under a microscope. We should take in levels of data that are retrospective that look back. We should take in levels of data that look at, you know, other metrics that might pop up and suggest things. And people are doing that in insurance data and in population level data.

Now, with each level of scientific evaluation, it'll have different potential limitations to it. So with a trial that looks at the population level, I alluded to you before, is you don't know if there was some other factor that changed in the population or over that time period that wasn't just, you know, an injection, right? It could be an effective and new environmental thing that we don't really know about, or it could be some other thing that confounded. That's why you need the prospective trials.

But, to answer your question, in a specific way, yes, we should be looking at everything. We should take into account the data at multiple different ways, understand their limitations, but still try to figure out the best way to move forward, and actionable items that we can do and make the best recommendations that we can as human beings trying to navigate this

world because it's challenging. The best process that I know of is the scientific process and method.

So clearly, I'm not anti-science. I advocate for doing these, but I think we need to be rigorous about the methodology of what we do. We also need to be skeptical of different things and ensure that we know that different things can confound studies and bias them in different directions. And those can be incentives from different ways, from how they get published or who has the funding to do a large study or what incentives that the intervention might bring profit to companies. And so we need to be aware of all of the different things that can influence what we're looking into.

Commissioner DiGregorio
Thank you.

Commissioner Kaikkonen
My question has to do with disclaimer that you offered at the beginning of your testimony and the code of conduct. Codes of conduct traditionally are just words on a page, and I don't think there's a whole lot of legal basis for having codes of conduct, but it seems that more workplaces do have them: organizations, health sector, education sector. So I'm just wondering, it's often used, the codes of conduct seem to be increasingly used—maybe that's a better way to put it—for discipline, suspension, you know, acts of contrary opinions, as in your case. And I'm just actually wondering, when did— So I understand why you use the disclaimer, I understand that totally. I'm just wondering, when did the academic and health care sectors move to this place where legitimate questioning, investigative thought processes, critical thinking, where do we move from this place, and when did it become a societal and workplace norm to the point where we are no longer able to ask the questions that just contribute to conversations across this country?

Dr. Justin Chin
I can comment on it.

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I can't speak to, you know, a specific timeline when certain codes of conduct might have been introduced in different levels of institutions or academia. But you're certainly correct in that I see that it is used as a tool for enforcement or compliance. I mean, I think that it's challenging because, as an institution, you need to safeguard those institutions against certain things, right? Or you believe you need to. Like, you believe you, as an institution, as a university, that if somebody does something that's, you know, going to bring the institution into, or shed a bad light on it, or do something that's egregious and is going to reflect badly on them, that perhaps they need to find a way to have something in place where they can distance themselves from that. And they create these policies or codes such that, "Well, we have these in place so that, you know, if such an event occurs, then that person can face consequences."

Now, the thing about it is that in a proper, just society, you could probably not require that at every single given level. You could probably say that, well, we have an overarching legal system that is predicated on principles. And I'm not a lawyer here, but that they would tell you that it requires that evidence be presented. That a person has their right to defend themselves, that they're innocent until proven guilty, that there's due process involved,

right? And so that's the system under which people should be evaluated for their conduct. And we live in a society, so we need some sort of guiding principles by which we behave and we treat each other and we don't harm each other. So I can see the— I can give some, you know, understanding to why institutions might develop these.

But the problem is when they become vague and when they reach a point where they're used as a tool and the effects are unintended, I would assume, that stifles debate or diminishes progress, or in the worst cases, prevents accurate information from coming out. And that accurate information, had it come out, might have prevented people from being harmed for various reasons that I spoke to.

So how do we stop that? I think we have to, I think— I think it's a job for the lawyers. But the lawyers in Canada have to start going towards these institutions and saying, "Yes, you've disciplined or done something to this person in the name of your code and conduct. But your code of conduct does not really have any legal basis, or it is not following the due process. And therefore, we have to strike down this action that you took because—" Well, I mean, in the proper process too, like through a hearing or with the judge saying that, "Yeah, you can write whatever you want on a code of conduct that your employees have to do x, y, and z, but great that you put it down, but that's not valid legally. You can't force them to do this. You can't prevent them from speaking. You can't just subjectively decide that what they're saying is harmful, or unbecoming, or it's unprofessional because those terms are just too vague and you need more strict guidelines or how you're going to enforce this."

Because enforcement of these types of codes of conduct come with real action. So you enforce something because of a subjective interpretation, and the real action is somebody loses their job or they lose their ability to earn a living or provide for their family or the years of their training are now being, negated.

So it's a form of— I guess, it's a way of writing cancel culture on a piece of paper, and the words should be meaningless because they should be evaluated within the system of the proper, legal framework of the jurisdiction that you're in.

Commissioner Kaikkonen
Thank you very much for your testimony.

Commissioner Drysdale
Thank you very much, Dr. Chin, for your very courageous testimony. I have a couple of questions. I'd like to come back to the question about the side effects. Because you mentioned frequently during your testimony that when faced with some side effect, one way to examine whether it could actually be related to the vaccine was to examine other pre-existing conditions. And if so then you say, "Well, maybe it's not linked to the vaccine because there are some other conditions that could explain that." But what I'm thinking is that is it fair to say that in the population—people—don't display the same level, say, of propensity to have autoimmune disease?

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Is it something that is widely distributed equally, or is it some people that are much more prone to that than others?

Dr. Justin Chin
Yeah, so I mean the answer is that it is very complex. And, you know, we try to generalize from studies or from report data, and so on, what certain effects might mean. But that's very different from at the individual level. At the individual level, one person might have a severe autoimmune reaction, but 999 of people don't, so it's a one in a thousand. It doesn't mean that there's only a small autoimmune reaction in a thousand people. It means that the one person is suffering severely, or one person already has some pre-existing condition and some new antigen in the body now causes an immune response. Or causes some other effect that tips them to the point where they experience something more severely. Whereas even that little extra injury or insult to a different person, they might have felt nothing.

So it is completely variable. And that's why, as I was stating before in the previous a couple of questions ago, is that population level data can give you one piece of the puzzle. Individual level that I can give you another piece of the puzzle. Pathologic data give you— All these pieces of puzzles need to be looked at and evaluated, and we can learn a lot from different levels of evidence.

Commissioner Drysdale
But given that it was very challenging, as we've heard from many people that had vaccine injury, to get medical exemption for a number of reasons, it was very often dismissed. Isn't that reasonable to expect that these people that had a condition that might then make them more susceptible to adverse event. If you refuse a medical exemption and after that they'll get vaxxed, and they will probably get the side effect that otherwise they would not have gotten because they knew that they were more prone to get it in the first place.

Dr. Justin Chin
Yeah, there are so many unknowns, and how do you guard against that? And how do you figure out the best plan of action for any new therapeutic? And there are some suggestions that I can make is that obviously you don't rush things. You evaluate things with proper randomized controlled trials. But some trials might not include every patient. They might have excluded people at the beginning because they had comorbidities. And so then there's no side effects. And then you rolled it out, this intervention, to people who did have comorbidities or were in different age demographics.

So you do as much evaluation of the data as you can and you try to generalize it; you might not be able to. You also try to do as many different studies and different populations and with different doses and you evaluate them in the proper methodologic fashion. At the end of the day, all of this will always lead to some unknown because that's life. We live in this world and there are tons of unknowns. So what do you need to do. You need to step back and say, "Okay, well what are the guiding principles."

The guiding principles are that as a physician, when you have an intervention, you don't as an authority tell them what to do. What you do is you say, "To the best of what we have available, there's this intervention or drug. And it looks like the benefit could be this, and the risk without getting it could be some certain thing that we think, based on these studies, and the side effects could be these. And some of the side effects we don't know, and we're going to give you the best data. And this study actually didn't really include you because you are older, and they didn't put people at your age in that study." Or, "You have these medical conditions, and they didn't put those people in the studies. But this is the best we have. I'm sorry, this is— Medicine can only— Humans can't be perfect." But that's as far as we go.

And then we say, “Now that we’ve given you all the proper information, I can maybe suggest what I think what I would do if I was you. But at the end of the day, I’ve tried my best to inform you fully.”

And that’s the principle of informed consent, right? We’ve given you all the information, and now you have the choice without coercion to make a decision. Do you grant the consent for this? Or do you withdraw your consent? And if you do that, then you leave it up to the individual to make the decision with imperfect data and some unknowns. But you leave, at the level of the individual, you have them decide what to do.

And that to me was a principle of medicine that I was taught, and that I truly believe in, and I follow. And even if a patient with malignant cancer tells me

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that they don’t want chemotherapy, and I think, well, at your age you might actually benefit from it, that’s still not my position to impose my values or my choices onto that patient. It’s for that patient to decide after I can inform them fully of what the risks, benefits, treatment of everything might be. And their values can help direct them, and their decision must be made without coercion or influence that is unbecoming.

Commissioner Drysdale
Maybe one last question about the bias you mentioned that you have seen from people that are very busy and may or may not have the time to do the in-depth research on every topic.

Is it fair to say that in the medical profession, and even for the public in general, vaccines are seen as a process, or a technology, that has really helped to improve the general health of people in many conditions, with several examples showing that these vaccines have contributed to improve the health? This is taught in medical school. Is it fair to say that?

Dr. Justin Chin
Yeah, I think that we have a history of other— I mean, you can’t always compare things that have studies for many, many years to new things now. You know, the evidence that you have to go back and look towards, you need to always know that there could be flaws in everything. But to answer your question, like, I’ve been vaccinated for many things now, and I based that decision off the evidence I knew at the time. And when you come to something new, you have to say, “Well, it’s not the exact same thing. Or is it similar enough?” But you can make your decision. And I think people just need to be educated about that. And you have to ultimately leave it to them to decide.

Commissioner Drysdale
Is it fair to say that based on that, I would say the benefit of the doubt would be given to the practice of vaccine. And even with the new technology, anybody who’d want to exercise some sort of questioning or critical thinking would have a very big case to put in order to raise the awareness and say, “Are you sure that in this particular case, this approach is the appropriate approach?”

Dr. Justin Chin
Yeah, how to comment on that is I think that there is a status quo, and if you have to challenge that in any way, in any field, it becomes difficult, and it becomes challenging. But the best way to do that is to have people express their opinions, present their data or their claims. So science is about falsifiable claims, right? So somebody makes a claim that's falsifiable. And it holds true until such time as somebody else can come along and falsify that in a way and say, "No, I've got evidence, and it's this." And if they're wrong and it's not actually falsifying it, then you discard it and you keep going on. But if something else comes along, it's different. Like, if you lived thousands of years ago and you thought that you had a different model of the way the solar system worked, but then somebody comes in and provides some other evidence, you change your mind, right? You can't just say, "Well, the status quo is everybody believes in this, so we're just going to exclude people from continuing." It's not the way to advance progress in my opinion.

Commissioner Drysdale
Thank you very much.

Allison Pejovic
I believe we're finished. Thank you very much, Dr. Chin, for attending today and telling us your professional opinions and views. And thank you very much.

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