

Long-Term Care COVID-19 Commission Meeting

Dr. Réka Gustafson and Dr. Perry Kendall
on Wednesday, February 17, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 17th day of
February, 2021, 11:00 a.m. to 1:00 p.m.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Commission Chair

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7

8 PRESENTERS:

9

10 BC CENTRE FOR DISEASE CONTROL, PROVINCIAL HEALTH

11 SERVICES AUTHORITY:

12 Dr. Réka Gustafson, Vice President, Public Health

13 and Wellness, Provincial Health Services Authority,

14 and Deputy Provincial Health Officer

15 Dr. Perry Kendall, Public Health Consultant, Past

16 BC Provincial Health Officer (1999-2018)

17

18 PARTICIPANTS:

19

20 John Callaghan, Co-Lead Commission Counsel, Gowling

21 WLG

22 Lynn Mahoney, Counsel, Gowling WLG

23 Michael Finley, Counsel, Gowling WLG

24 Jennifer King, Counsel, Gowling WLG

25 Alison Drummond, Assistant Deputy Minister,

1 Long-Term Care Commission Secretariat
2 Rose Bianchini, Senior Policy Analyst, Long-Term
3 Care Commission Secretariat
4 Adriana Diaz Choconta, Senior Policy Analyst,
5 Long-Term Care Commission Secretariat

6
7 ALSO PRESENT:

8 Deana Santedicola, Stenographer/Transcriptionist
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1 -- Upon commencing at 11:00 a.m.

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3 COMMISSION CHAIR FRANK MARROCCO:

4 Let me start. I am Frank Marrocco.

5 This is Dr. Jack Kitts and Commissioner Angela

6 Coke. We are the Commissioners on this inquiry.

7 I want to thank you both for agreeing

8 to meet with us, and I think we'll benefit

9 considerably from your experience. And, of course,

10 Dr. Kendall, you have one foot that was formerly in

11 Toronto, anyway, before you made the mistake of

12 leaving Toronto and going to another part of

13 Canada, but in any event, welcome.

14 We do have a reporter here, Deana. We

15 create a transcript, and we will post the

16 transcript on the website so that people can

17 understand what we are hearing and what we are

18 doing.

19 Because we have an April 30th deadline,

20 we have had to follow a somewhat less traditional

21 approach to this. We have had to expedite the

22 hearing of information, and we have used this

23 interview format to do that.

24 With your permission, if we have

25 questions, we'll just interrupt and ask them rather

1 than wait until you are finished, if that is all
2 right with the two of you.

3 And with that, Ms. King, go ahead.

4 JENNIFER KING: Thank you, Commissioner
5 Marrocco. Good morning, everyone. I am Jennifer
6 King. I'm a lawyer assisting the Commission. And
7 I wanted to thank you, Drs. Kendall and Gustafson,
8 for meeting with the Commission this morning.

9 And, Commissioners, Dr. Kendall and
10 Dr. Gustafson will be talking with you about the
11 Public Health response to COVID-19 in British
12 Columbia and, where they can, talk about the
13 differences between the Public Health systems in BC
14 and Ontario and how these differences may have
15 impacted the province's responses to the pandemic.

16 The Doctors do not have a PowerPoint
17 presentation for you this morning, but I have a
18 series of questions for them to assist in guiding
19 the discussion, and, Commissioners, if you have any
20 questions for either of the Doctors, of course,
21 please interject.

22 Just by way of brief introduction,
23 Dr. Kendall, I am going to tell the Commissioners
24 something about your background. You are a Public
25 Health physician, yes, and you served as BC's first

1 Provincial Health Officer from 1999 to 2018?

2 DR. PERRY KENDALL: Technically not
3 correct. I wasn't the first Provincial Health
4 Officer. They have had Provincial Health Officers
5 since the 1940s. I was the second Provincial
6 Health Officer under a Public Health Act that gave
7 the Provincial Health Officer an independent voice
8 and a role in monitoring the health of the
9 population.

10 JENNIFER KING: Thank you.

11 And you served in that role until 2018,
12 and you were replaced by the current BC Provincial
13 Health Officer, Dr. Bonnie Henry?

14 DR. PERRY KENDALL: Correct.

15 JENNIFER KING: And Dr. Henry was your
16 former Deputy Provincial Health Officer?

17 DR. PERRY KENDALL: Yes, she was.

18 JENNIFER KING: And public health
19 issues that arose during your tenure as Provincial
20 Health Officer in BC included your declaration of a
21 public health emergency of overdose deaths in 2016?

22 DR. PERRY KENDALL: Correct.

23 JENNIFER KING: Yes, and H1N1 in 2009?

24 DR. PERRY KENDALL: Correct.

25 JENNIFER KING: And the establishment

1 of Insite, the needle exchange program and Canada's
2 first safe injection site in Vancouver of 2003?

3 DR. PERRY KENDALL: That's correct. We
4 also had the avian influenza outbreak in the Lower
5 Mainland, and SARS, and the response to Ebola in
6 Africa. Those were considerable issues.

7 JENNIFER KING: Right, and you served
8 in that role for 20 years?

9 DR. PERRY KENDALL: Almost 20 years,
10 yes.

11 JENNIFER KING: Almost 20 years. And
12 before you had that role in BC, you had experience
13 in the Ontario public health system where you were
14 the City of Toronto's Medical Officer of Health
15 from 1989 to 1995?

16 DR. PERRY KENDALL: That's correct, and
17 during that time, I was one year on secondment to
18 the Deputy Minister of Health in the -- to the ADM
19 in long-term care.

20 JENNIFER KING: And you also were the
21 President of the Addiction Research Foundation of
22 Ontario?

23 DR. PERRY KENDALL: That's correct, for
24 three years.

25 JENNIFER KING: Great. And I see that

1 you were awarded the Order of British Columbia in
2 2005, and you were appointed to the Order of Canada
3 in 2019 in honour of your leadership in public
4 health in BC and nationally?

5 DR. PERRY KENDALL: I had that honour,
6 yes.

7 JENNIFER KING: Great. Thank you,
8 Dr. Kendall. And I will introduce Dr. Gustafson
9 because I think most of the questions that you'll
10 be addressing will probably be addressed by both of
11 you as we go through.

12 So, Dr. Gustafson, you are also a
13 medical doctor specializing in Public Health?

14 DR. RÉKA GUSTAFSON: Correct.

15 JENNIFER KING: Yes, and since February
16 of 2020, you have had the role of Deputy Provincial
17 Health Officer at the BC Provincial Health Services
18 Authority?

19 DR. RÉKA GUSTAFSON: Deputy Provincial
20 Health Officer and Vice President of Public Health
21 and Wellness at the Provincial Health Services
22 Authority, yes.

23 JENNIFER KING: And in these roles, you
24 lead the integration of population and public
25 health promotion, planning and prevention across

1 the Provincial Health Services Authority's clinical
2 programs?

3 DR. RÉKA GUSTAFSON: Right.

4 JENNIFER KING: And you also are
5 responsible for the delegated functions of the BC
6 Centre for Disease Control under the Public Health
7 Act?

8 DR. RÉKA GUSTAFSON: That's correct.

9 JENNIFER KING: So you have been right
10 in the thick of BC's response to COVID-19 during
11 your time at the Provincial Health Services
12 Authority.

13 DR. RÉKA GUSTAFSON: That's right.

14 JENNIFER KING: Yes. So thank you so
15 much for taking time out of your busy schedule to
16 speak with the Commission.

17 I think it is also relevant for the
18 Commissioners to know that, before your current
19 position, you practised public health as the Deputy
20 Chief Medical Health Officer and Medical Health
21 Officer in Vancouver Coastal Health for over 15
22 years?

23 DR. RÉKA GUSTAFSON: That's right.

24 JENNIFER KING: And you are currently a
25 Clinical Associate Professor at the School of

1 Population and Public Health at UBC?

2 DR. RÉKA GUSTAFSON: That's right.

3 JENNIFER KING: Great. Is there
4 anything else you would like to add about your
5 background or experience for the Commissioners'
6 benefit?

7 DR. RÉKA GUSTAFSON: Just that the
8 focus of my practice was for many years
9 communicable disease control, so that would have
10 been outbreak detection and outbreak management,
11 participated in a number of large outbreaks, such
12 as the outbreak of pneumococcal disease in the
13 Downtown East Side, H1N1, and a measles outbreak
14 right after the Olympics.

15 JENNIFER KING: Thank you so much for
16 coming and speaking with us this morning.

17 Perhaps we can start, Dr. Kendall, and
18 we'll get right into it. If you could provide an
19 overview, a brief overview of the structure of
20 Public Health in British Columbia and the roles and
21 relationships between the various participants.

22 DR. PERRY KENDALL: Certainly. So
23 prior to 2002, essentially most of Public Health in
24 British Columbia was performed by physicians,
25 nurses, Environmental Health Officers, et cetera,

1 who were employees of the BC Ministry of Health and
2 they were directly linked with the municipalities.
3 There were 18 organizations.

4 And outside of Vancouver and Victoria
5 and a couple of Health Authorities in the Lower
6 Mainland which were municipal and their public
7 health folk were employees of the municipality,
8 although the funding came largely from the
9 province.

10 In 2002, there was a major
11 re-organization of health services in British
12 Columbia so that hospitals and long-term care
13 facilities, certain community care organizations
14 and Public Health were reorganized into five
15 geographical health authorities under the Health
16 Authorities Act.

17 So we had the Northern Health
18 Authority, the Interior Health Authority, the
19 Fraser Health Authority, Vancouver Coastal Health
20 Authority, and Vancouver Island Health Authority,
21 and a Provincial Health Services Authority which
22 gathered together province-wide functions such as
23 the responsibilities for transplant, BC Women and
24 Children's Hospital and the BC Cancer Agency and
25 the BC Centres for Disease Control.

1 So this brought Public Health
2 integrated into the health services delivery.
3 Pieces that were outside of the Regional Health
4 Authorities were the primary care -- most primary
5 care physicians and the pharmaceutical component,
6 which was not actually run -- other than drugs for
7 cancer control and HIV, the pharmaceutical area was
8 outside of the ambit of the Regional Health
9 Authorities.

10 If we look just at Public Health, the
11 Act, the Health Act in 2002 was amended to give the
12 Provincial Health Officer a role to advise
13 government on the health of the population and to
14 report publicly on progress to achieving British
15 Columbia's health goals and also gave the
16 Provincial Health Officer the responsibility for
17 setting standards for the Medical Officers of
18 Health in the Health Authorities.

19 We also reorganized the Public Health
20 system, at least as far as the Medical Health
21 Officers were concerned, so that each Regional
22 Health Authority had a Chief Medical Health Officer
23 and a number of Associate Medical Health Officers.

24 So de facto each Regional Health
25 Authority had the equivalent of an obstetrics and

1 gynaecology surgical ward or cancer specialty, and
2 the Chief Medical Health Officers had a dual
3 reporting role under the Public Health Act. They
4 reported -- they were responsible to the Provincial
5 Health Officer for their duties and authorities in
6 regards to health hazards, communicable diseases,
7 and reporting on the health of the public, and then
8 administratively they were responsible to the CEO
9 of the Regional Health Authority, who in turn was
10 responsible to the Chair of the Board of the Health
11 Authority, who in turn was responsible to the
12 Minister of Health.

13 The other component Act which is
14 relevant is the Long-Term Care and Assisted Living
15 Act. In the 1970s, the late 1970s in British
16 Columbia, the non-institutional components of
17 community care, which was home nursing care,
18 assisted living, et cetera, were brought into the
19 Regional Health Authorities and became part of
20 the -- well, brought into the Public Health system
21 at that time and then in 2002 became part of the
22 Regional Health Authorities' mandate. The Regional
23 Health Authorities were also given the
24 responsibility under the Community Care and
25 Assisted Living Act to manage the funding, the

1 public funding of long-term care facilities.

2 And under the long-term care and
3 assisted living act -- the Community Care and
4 Assisted Living Act, there is a Chief Licensing
5 Officer who can direct the Health Authorities to
6 provide reports.

7 And under the CCALA, the Chief Medical
8 Health Officer or the Medical Health Officer has
9 the responsibility for issuing licences, dealing
10 with complaints, adding conditions to licences,
11 responding to every complaint and publishing those
12 reports on a public basis essentially.

13 And at the Ministry of Health, the
14 Chief Public Health Officer has a close
15 relationship with the Chief Licensing Officer as it
16 pertains to residential care standards and the
17 responsibilities of Medical Health Officers, who
18 kind of in a way have a bifurcated relationship
19 both to the PHO and to the Chief Licensing Officer,
20 and maybe it is trifurcated because they also have
21 a responsibility to oversee long-term care
22 residences that might be actually owned and run by
23 the Health Authority.

24 And when you get into some detail,
25 long-term care in BC is -- we have got 27,000 beds.

1 About one-third of them are publicly not-for-profit
2 owned and funded, one-third are for-profit, and
3 one-third are run by the Regional Health
4 Authorities directly.

5 So that is in essence the sort of
6 structure with the three components, the Regional
7 Health Authorities, Public Health Act, the Regional
8 Health Authorities Act, and Community Care and
9 Assisted Living Act.

10 Under the Public Health Act, Medical
11 Health Officers and the Chief, the PHO, have a
12 responsibility to report publicly on the health of
13 the public. The PHO has a responsibility to report
14 annually to the legislature on the health of the
15 public. He or she also has a responsibility to
16 provide reports and advice on any matter pertaining
17 to public health and to ensure that those reports
18 are publicized or made public in however the Chief
19 Public Health Officer determines is the most
20 appropriate way of doing it.

21 And the Provincial Health Officer has a
22 direct reporting line to the Minister of Health,
23 but also administratively, in the Ministry of
24 Health, to the Deputy Minister of Health and --

25 JENNIFER KING: Dr. Kendall, sorry for

1 interrupting you, but I think I saw that
2 Commissioner Kitts had a question.

3 DR. PERRY KENDALL: Of course.

4 COMMISSION CHAIR FRANK MARROCCO:
5 He is gone.

6 JENNIFER KING: Oh, he is gone.

7 COMMISSION CHAIR FRANK MARROCCO:
8 He'll be back.

9 DR. PERRY KENDALL: Shall I continue?

10 JENNIFER KING: Should we continue, or
11 should we wait for --

12 COMMISSION CHAIR FRANK MARROCCO:
13 Well, why don't we just wait a few
14 seconds and see if he logs back on. Usually what
15 happens to me is the phone rings, and it is a
16 variety of telephone providers or the air duct
17 people. I don't know if you have had the pleasure
18 of dealing with them in BC, but they are forever
19 interrupting these. In fact, I think what I will
20 do is I'll get rid of this while we are waiting for
21 Dr. Kitts.

22 COMMISSIONER ANGELA COKE: He did
23 mention that he was having some wi-fi issues.

24 DR. PERRY KENDALL: That is the curse
25 of Zoom, I think.

1 JENNIFER KING: But we have the
2 convenience of being able to meet with people in
3 British Columbia, so there is trade-offs,
4 Commissioner.

5 COMMISSION CHAIR FRANK MARROCCO:
6 Well, Ms. Drummond, could you give him
7 a call and see if he is going to join us presently?

8 ALISON DRUMMOND: Yes, I will.

9 COMMISSION CHAIR FRANK MARROCCO:
10 If he isn't, we'll just proceed because
11 there is a transcript, but we'll just give him
12 another minute or so.

13 ALISON DRUMMOND: Dr. Kitts asked that
14 people go ahead. There seems to be problems with a
15 fiber optic cable in the neighbourhood.

16 COMMISSION CHAIR FRANK MARROCCO:
17 Okay. Well, then, Ms. King, why don't
18 we carry on with the doctors.

19 JENNIFER KING: Okay. So, Dr. Kendall,
20 I had interrupted you, but I think that you -- if
21 you can proceed.

22 COMMISSION CHAIR FRANK MARROCCO:
23 With the interruption.

24 JENNIFER KING: Yes.

25 DR. PERRY KENDALL: It couldn't have

1 been the air duct people anyway. The fiber optic
2 duct people -- anyway, excuse me.

3 So I was just going to say, I think,
4 that -- I was going to talk a little bit about the
5 Public Health Act which arose out of the BC Health
6 Act, preceded the Public Health Act, and was
7 basically a complicated Act that was first written
8 in 1945 and had substantial changes and alterations
9 over 20, 30, 40, 60 years. So it was sort of an
10 archaeological trove of what people had thought
11 Public Health and Health Authorities should be.

12 And it was substantially revised in the
13 early 2000s and promulgated in 2008 to be a more
14 public -- a more modern Public Health Act that
15 outlined the powers and the independence of Medical
16 Health Officers and the Provincial Health Officer,
17 and also gave them powers in the case of an
18 emergency, which could either be a local emergency
19 which could be declared by the Local Medical Health
20 Officer or a regional or a provincial public health
21 emergency. And the standard for declaring an
22 emergency was a threat to the health of the public,
23 primarily deemed to be a communicable disease, but
24 not necessarily. It could be other issues. And
25 for communicable diseases and actually for

1 radiation, the Medical Health Officer was deemed to
2 be the person in charge and the person most
3 responsible for guiding the responses.

4 And under the powers when an emergency
5 was declared, certain regulatory processes could be
6 speeded up. Written orders could be delivered
7 verbally. The ability to contest such an order was
8 basically put in place. You could still contest
9 the order, but the order stood in place while the
10 hearing was being heard. And rather than having to
11 write individual orders for quarantine on
12 individuals, it could be applied to groups of
13 people or individuals. So the powers became a lot
14 more effective and a lot more rapid and gave
15 Medical Health Officers and the Provincial Health
16 Officer sort of considerable authority once an
17 emergency had been declared.

18 And that I think was a very helpful
19 tool to have when you are dealing with, say, an
20 outbreak of measles in a religious community that
21 involved several hundred people, and that could be
22 dealt with as a group.

23 And that, I think -- unless there is
24 any questions, hopefully that at least gives a
25 little bit of an outline of the sort of

1 relationships between the Provincial Health Officer
2 and the Ministry of Health, the long-term care, the
3 community area of long-term care, the home care, et
4 cetera, and the Public Health in the field.

5 In the field, Public Health is
6 integrated into service delivery. Most of the
7 Executive Committees in the Regional Health
8 Authorities have the Chief Public Health Officer --
9 have the Chief Medical Health Officer as part of
10 their organizational structure. Not all of them
11 and that isn't mandated, so the structures do
12 differ somewhat. And each Regional Health
13 Authority has a Chief Medical Health Officer and
14 four or five Associate Medical Health Officers with
15 them.

16 The funding for Public Health is
17 roughly about 3.5 percent of the total global
18 budget. It isn't ring-fenced. And it has had its
19 ups and downs. It has been invested in, and it has
20 also been diminished. And I would say, going into
21 COVID, we were in a situation where I think my
22 successor, Dr. Bonnie Henry, shared my concerns
23 about the level of funding that was available at
24 the community level and the capabilities of the BC
25 CDC in terms of budget and particularly in terms of

1 the Public Health Act, which were also associated
2 with the BC Centres for Disease Control and fell
3 under the Provincial Health Services Agency.

4 COMMISSION CHAIR FRANK MARROCCO:

5 Doctor, if I could interrupt for a
6 minute, I am trying to -- in this COVID outbreak,
7 then you or your successor is the decision-maker?
8 My question is related to leadership in the end,
9 but I am trying to understand the structure in
10 terms of decision-making power.

11 DR. PERRY KENDALL: The Local Chief
12 Medical Health Officer has the ability to declare a
13 local emergency. He or she would do that in
14 consultation with the Provincial Health Officer.
15 The Provincial Health Officer has the ability to
16 declare a public health emergency. I declared the
17 first public health emergency under the Public
18 Health Act in 2016 and that was in respect of the
19 opioid overdose crisis which has its epicentre in
20 British Columbia. I did that actually in
21 consultation with the Minister of Health, who
22 agreed that that was a rational thing to do, and I
23 did it with the support and at the request of Local
24 Medical Officers of Health and others.

25 The power technically was within my

1 rights to declare it even if the Minister of Health
2 had not agreed, but fortunately, we had a long
3 history of working quite closely with Ministers of
4 Health who respected the independence of the Public
5 Health Officer and the Medical Health Officer's
6 expertise, just as we respected the fact that they
7 had been elected and we had only been appointed.

8 COMMISSION CHAIR FRANK MARROCCO:

9 Did --

10 DR. PERRY KENDALL: I don't know if
11 that answers your question, but --

12 COMMISSION CHAIR FRANK MARROCCO:

13 Well, it does in a way. One of the
14 other issues is timeliness of decision-making. You
15 know, in long-term care, for example, masking or
16 not, these decisions have to be made it seems
17 promptly, and I was just curious what your views
18 were on ensuring timely decision-making.

19 DR. PERRY KENDALL: Well, if it comes
20 to masking, I would say that probably North America
21 or English speaking had a different take on masking
22 than, say, the Asian continents. There was almost
23 a global divide in the degree to which people
24 accepted the efficacy or the efficiency of masking.

25 So I don't think it was central to our

1 considerations around disease control back at the
2 beginning of 2020.

3 I don't know, Réka, would you have a
4 comment on that?

5 DR. RÉKA GUSTAFSON: Yes. So I think
6 the importance of masking notwithstanding, the
7 response -- the timeliness of the response to the
8 first outbreak in a long-term care facility was
9 important, and that was done -- that is under the
10 authority of the Local Medical Health Officer.

11 So our first outbreak in a long-term
12 care facility happened to occur in Vancouver
13 Coastal Health, and the Medical Health Officer was
14 actually immediately there. They physically went
15 to the long-term care facility. They tested all
16 the staff -- or tested those who needed to be
17 tested and immediately implemented infection
18 control recommendations. That did not need to wait
19 to go up a chain of command to a provincial
20 setting.

21 So that is a relationship -- that is an
22 existing relationship, an existing authority. And
23 in that particular case, as we found out in many
24 other outbreaks before we had the level of
25 surveillance that we do now, is that it probably

1 was in the facility for a little while before it
2 was detected. But as soon as it was detected, the
3 Local Medical Health Officer has both the authority
4 but the relationships to respond to that outbreak,
5 so that is just to answer your timeliness question.

6 DR. PERRY KENDALL: Yes, and that
7 relationship has existed for years, ever since
8 long-term care facilities and community care were
9 brought into the public health system in the late
10 '70s.

11 And when we go back to masking, I
12 should say there is a big difference between
13 masking in the community, which is where North
14 America and Canada did not see much evidence for
15 the protective effect of that, versus masking in
16 health care facilities where it has long been the
17 standard for personal protective equipment. The
18 degree to which masks should be used and when has
19 often been a bone of contention between some health
20 professionals and other people in infection
21 control.

22 JENNIFER KING: Dr. Gustafson, you were
23 talking about I guess it was Dr. Daly, who is the
24 Medical Health Officer in Vancouver, and her role
25 with the first outbreak. And can you tell the

1 Commissioners a little bit more about the existing
2 relationship between the Regional Health Authority
3 and long-term care homes.

4 DR. RÉKA GUSTAFSON: Absolutely. So as
5 Dr. Kendall mentioned, there is a role of the local
6 medical -- or the Chief Medical Health Officers via
7 the Community and Assisted Living Act that names
8 the Medical Health Officer as the licenser for
9 long-term care facilities.

10 How that has actually manifested in
11 practice is that the Local Medical Health Officer
12 issues the licence but also has a set of licensing
13 officers. These licensing officers carry out the
14 duties of licensing on behalf of the Local Medical
15 Health Officer. And that relationship I think
16 consists of sort of a number of things. One, some
17 understanding of administrative law, so clear
18 understanding of what the role actually is;
19 expertise, expertise in surveillance, outbreak
20 detection and management, as well as an infection
21 control.

22 A really big part of that is
23 resourcing. You have to be resourced by the
24 Regional Health Authority to actually carry out
25 those duties.

1 And then really the long-standing
2 relationships, these long-standing relationships
3 that are established through the management of
4 outbreaks that occur on a regular basis in
5 long-term care facilities. So the most common ones
6 are norovirus and influenza, and these are annual
7 occurrences that happen in long-term care
8 facilities with some predictability. And so that
9 relationship is really maintained through the fact
10 that there is a common body of work that happens
11 between Public Health and the long-term care
12 facilities.

13 So, to me, I think that is probably one
14 of the most important things to have at your
15 disposal when an emergency is declared, is that you
16 are not meeting for the first time, that you have
17 an established relationship and, in particular,
18 protocols in place, protocols that you renew, that
19 you communicate every year.

20 We have respiratory illness outbreak
21 protocols that exist and get updated, and you work
22 with long-term care facilities to make sure that
23 they are implemented. We have swabs to collect.
24 Samples for influenza are sent to the long-term
25 care facilities every fall. There is a pathway for

1 those swabs to the lab to be identified as outbreak
2 swabs. There is a reporting mechanism for
3 outbreaks for long-term care facilities.

4 So really all the components of the
5 response are actually in existence and are
6 exercised every year. The packaging changed quite
7 profoundly, though.

8 COMMISSION CHAIR FRANK MARROCCO:

9 Are they required to have a pandemic
10 plan? What kind of plans are they required to
11 have, if they are --

12 DR. RÉKA GUSTAFSON: There are regional
13 pandemic plans, and there is also a provincial
14 pandemic plan, and so yes, they do exist. I worked
15 on them quite a lot.

16 One of the challenges with pandemic
17 plans, however, is that people tend to plan for the
18 last pandemic or the last event they had rather
19 than the next one. So I have long held that a
20 pandemic plan is probably something that should be
21 renewed. It should actually be a flexible version
22 of the existing outbreak plans that should probably
23 be reviewed every year after your influenza season
24 to see what you would want to change rather than
25 sort of a plan that exists in isolation for an

1 event that may take years and years to come.

2 So yes, there is a pandemic plan, but I
3 think what is more important is that there is a
4 living document, which is the Outbreak Response
5 Plan, that is actually used for the outbreaks that
6 we experience on a regular and predictable basis.

7 COMMISSION CHAIR FRANK MARROCCO:

8 Do you think maybe -- oh, go ahead,
9 Commissioner Coke.

10 COMMISSIONER ANGELA COKE: No, if you
11 are following on, it is okay.

12 COMMISSION CHAIR FRANK MARROCCO:

13 Well, no, I was just asking if you had
14 any views on how you maintain that sense of
15 vigilance. It seemed here that after SARS people
16 were vigilant for a short period of time, two or
17 three, four years, and then gradually -- because
18 pandemics don't occur -- or because infectious
19 disease outbreaks of significance don't occur that
20 regularly, that there was kind of a fall-off. They
21 let it go. The supplies of PPE expired and weren't
22 replaced. And this created a problem in long-term
23 care.

24 So how do you maintain that sense? Do
25 you have any views on how you maintain that sense

1 of vigilance?

2 DR. RÉKA GUSTAFSON: So my personal
3 view - and Dr. Kendall may feel differently about
4 it - I think that natural falling off of interest
5 is entirely predictable and expected.

6 And so from my perspective, what you
7 want to do is to really do an excellent job of
8 managing the events that do occur, and maybe with
9 some regularity apply what you would know to a
10 potential larger outbreak or event.

11 I think that decline in interest was a
12 result of the fact that pandemic planning almost
13 turned into a self-perpetuating industry, and it
14 was not always related to your primary work, to the
15 thing that you actually had to do every day.

16 So for me, if you can connect the
17 activities that you are doing, that you need to do,
18 to exercising something more extraordinary rather
19 than a separate division of your organization or an
20 administrative requirement for accreditation, then
21 I think it remains alive and exercised, and keeping
22 in mind that this pandemic planning has to occur in
23 the context of very busy Health Authorities that
24 have the urgent needs of the everyday to tend to.

25 So from my perspective, the key to a

1 pandemic plan would be for it to be very simple,
2 very conceptual, not focussed on the last pathogen
3 that you had, not necessarily telling you what to
4 think but how to think and be exercised in the
5 context of regular outbreaks.

6 I don't know what Perry thinks about
7 that.

8 DR. PERRY KENDALL: Yes, I agree that
9 on the front line that is what you need to do.

10 I have also observed, though, over the
11 nearly 20 years that I was in the job that no
12 matter how much planning is being done, you have to
13 take advantage of a crisis when it occurs.

14 So with avian influenza, the focus was
15 on adequate respiratory equipment, personal
16 protective equipment, to protect people from the
17 possibility of getting avian flus.

18 In 2003, the SARS outbreak brought a
19 lot of attention to personal protective equipment
20 and everybody -- we were at first -- well, no, we
21 were at first kind of surprised by that, but that
22 gave a whole new level of awareness certainly on
23 the front lines around PPE and the necessity to
24 have that equipment.

25 But as things drift off and away, you

1 lose administrative focus on this, and you get more
2 focussed on the next urgent issue in health care,
3 which is invariably a shortage of beds or a
4 shortage of cardiac surgery or a shortage of cancer
5 therapies, and the attention drifts away until the
6 next crisis comes along, and then you realize that
7 your stocks of equipment have been forgotten. The
8 training that you were supposed to put in place for
9 PPE has gone out of the window. And everybody is
10 panicked all over again.

11 And then you think about building a
12 centre at, say, a particular hospital that will
13 have the responsibility for maintaining stocks and
14 training people, and then you discover that the
15 budget that was put aside for that after three
16 years has gone into general revenue because of cost
17 pressures in another area.

18 So we see this cyclical interest
19 response fading away and loss of attention, and
20 then the next crisis comes in and we go back into
21 reactive mode.

22 Hopefully we'll learn from it, but I
23 kind of think it is a human condition that you
24 can't maintain a state of readiness all the time
25 because there is always something else that will

1 detract from that focus.

2 COMMISSION CHAIR FRANK MARROCCO:

3 Commissioner Coke, I am monopolizing
4 the --

5 COMMISSIONER ANGELA COKE: No, no, this
6 was just going back to a comment you had made about
7 the Local Medical Officer issues the licence for
8 the long-term care homes. I am just trying to
9 understand, are they responsible for the inspection
10 regime as well?

11 DR. RÉKA GUSTAFSON: Yes. So there is
12 an inspection -- so under the licensing, the
13 Community and Assisted Living Act, yes, they do
14 regular inspections. There is a set of criteria by
15 which they inspect long-term care facilities. It
16 is quite wide-ranging. It includes the physical
17 layout. It can include the processes in place for
18 TB testing.

19 And so, yes, they inspect all licensed
20 facilities on a periodic basis.

21 COMMISSIONER ANGELA COKE: Okay.

22 DR. RÉKA GUSTAFSON: Not the Medical
23 Health Officer, but their licensing officers.

24 COMMISSIONER ANGELA COKE: Okay.

25 COMMISSION CHAIR FRANK MARROCCO:

1 So go ahead, Ms. King.

2 JENNIFER KING: We have been touching
3 on a number of different topics, and I just wanted
4 to bring you back to -- we have talked about the
5 different players in the Public Health system in
6 BC.

7 And before I ask you about the actual
8 response to COVID-19 in BC, I just wanted to ask
9 you, Dr. Gustafson, you currently have a role
10 leading the BC CDC, and I am wondering if you could
11 talk about the BC CDC's role in the Public Health
12 system and if you can say anything about comparing
13 it to the equivalent in Ontario, which is Public
14 Health Ontario.

15 DR. RÉKA GUSTAFSON: So I will actually
16 invite Dr. Kendall to speak to this as well,
17 because the BC CDC, he has been more familiar with
18 it for more years than I have. I actually started
19 on February the 3rd, 2020, at the BC Centre for
20 Disease Control, not the ideal timing.

21 So the BC Centre for Disease Control
22 didn't exist within the Public Health Act, as far
23 as I know, until the renewal of the Public Health
24 Act that Dr. Kendall spoke to.

25 It is a body under the Provincial

1 Health Services Authority. It is a provincial
2 body. It carries out -- my role is that of -- as a
3 Deputy Provincial Health Officer, the primary role
4 is to collect reportable disease information,
5 collect and analyze, so really perform those
6 surveillance functions that enable the Provincial
7 Health Officer to monitor the health of the
8 population.

9 Over the last several years, I would
10 say that mandate has evolved and developed. It
11 includes a number of other functions. We do carry
12 out the provincial management of one communicable
13 disease, which is tuberculosis, in collaboration
14 with the Regional Health Authorities who do contact
15 tracing for tuberculosis. We also have a
16 provincial sexually transmitted infection clinic
17 that is primarily responsible for the management of
18 syphilis. That is sort of the sole responsibility
19 for the BC CDC. And we are co-located with the
20 provincial laboratory, and that does allow us to
21 combine epidemiology with the laboratory to monitor
22 things like testing rates, for example.

23 So that is actually an advantage that
24 we have, that for certain pathogens we can also
25 monitor not just the numerator, which is how many

1 positive tests we have had, but also the
2 denominator of how many negative tests we have had.

3 Over the last little while, the BC
4 Centre for Disease Control also is -- and it is
5 something I will build on, is expanding its role in
6 population health management.

7 The role of BC CDC in the management of
8 outbreaks in long-term care facilities has actually
9 been quite minimal. So the majority -- the role
10 really is with the provincial laboratory. And that
11 is I think an important thing to note. But by and
12 large, outbreaks in long-term care facilities are
13 managed by the Regional Health Authorities under
14 the auspices of the Chief Medical Health Officer.

15 And other than reporting on the number
16 of outbreaks -- so influenza outbreaks and
17 norovirus outbreaks are reported to the BC Centre
18 for Disease Control and form the part of our, say,
19 biweekly or weekly influenza surveillance report.

20 The actual management of those
21 outbreaks the BC CDC does not participate in, by
22 and large.

23 COMMISSION CHAIR FRANK MARROCCO:

24 And so the management of the outbreak
25 is really local -- the decision-making is

1 anticipated will be driven down and be local?

2 DR. RÉKA GUSTAFSON: Yes.

3 COMMISSION CHAIR FRANK MARROCCO:

4 Okay.

5 DR. RÉKA GUSTAFSON: And certainly in
6 non-emergent times, the management of outbreaks in
7 long-term care facilities is entirely a local
8 public health activity.

9 COMMISSION CHAIR FRANK MARROCCO:

10 No, but in a pandemic, in our situation
11 here.

12 DR. RÉKA GUSTAFSON: So in the
13 pandemic, again, the day-to-day decision-making
14 around what to do around the outbreak was still
15 made locally, but there was more involvement than
16 is in peacetime.

17 So there would have been -- there would
18 certainly have been a discussion with the
19 Provincial Health Officer. There would be a
20 discussion with the BC Centre for Disease Control
21 as well. There would certainly be sort of a joint
22 consideration of, you know, what this means for us
23 now in British Columbia.

24 But sort of in my experience, the
25 Provincial Health Officer didn't direct the

1 response within a long-term care facility. There
2 is a -- what did happen and I think this -- and Dr.
3 Kendall can comment on this. I think we benefit in
4 British Columbia being relatively small, and so
5 from fairly early on, the Public Health community
6 consisting of all the Chief Medical Health
7 Officers, the Provincial Health Officer, as well as
8 the Provincial Health Officers' Deputies, started
9 meeting on a three-times-a-week basis to
10 essentially form a community of practice to discuss
11 practice issues because they were evolving in real
12 time.

13 And the role of BC CDC in that was to
14 make sure that those discussions get consolidated
15 into guidelines, guidelines on how to detect and
16 manage outbreaks in long-term care facilities
17 fairly rapidly, in collaboration with an
18 organization called PICN, which is the Provincial
19 Infection Control Network. And while Health
20 Authorities with a lot of capacity would have
21 written their own guidelines probably in real time,
22 in relatively short order the BC Centre for Disease
23 Control made sure that those guidelines were
24 consolidated into something provincial.

25 So that is something that we did

1 discuss provincially and its implementation is done
2 locally.

3 I don't know, Dr. Kendall, if you agree
4 with that assessment.

5 DR. PERRY KENDALL: Yes, and the only
6 thing I would add to that is that it built on a
7 long past history of the BC Centres for Disease
8 Control working on communicable disease control
9 with the Regional Medical Health Officers, and not
10 every Public Health area within every Regional
11 Health Authority is equipped to the same extent
12 that, say, Vancouver Coastal and the Lower Mainland
13 might be, but there has been a long-standing BC
14 communicable disease policy control organization
15 with Public Health physicians from the Regional
16 Health Authorities and BC CDC working together to
17 try and establish the best practices in
18 communicable disease management and outbreak
19 control.

20 The BC CDC had a particular role when
21 more than one Health Authority is involved or when
22 you have a provincial outbreak that needs
23 coordination. So the BC CDC had that coordination
24 role and collecting data from the whole of the
25 province to put the epidemiological picture

1 forward.

2 And also I think their role nationally,
3 connecting nationally with the Public Health Agency
4 of Canada and hence through internationally when
5 you were dealing with issues that spanned
6 continents, like Ebola, like SARS, like MERS, and
7 like COVID-19.

8 DR. RÉKA GUSTAFSON: Thank you, and now
9 you are bringing me things to my mind.

10 The other thing I think that the BC
11 Centre for Disease Control has a significant role
12 in is things like evidence reviews to inform the
13 management.

14 So as Dr. Kendall mentioned, there is
15 significant differences in the capacity of Health
16 Authorities. We have some parts of our province,
17 of course, like everywhere else, which are densely
18 populated and there is significant expertise and
19 just concentration or number of people who can do
20 the work, and there are other parts that are quite
21 geographically distributed and just a lot fewer
22 human resources to do the work.

23 So there is direct support for
24 outbreaks from the BC Centre for Disease Control
25 for the regions that have less capacity. There is

1 an evidence synthesis component. I think the other
2 part that BC CDC played a part in is that our
3 physicians in the laboratory are actually part of
4 the BC Centre for Disease Control, and we in
5 British Columbia had a test very, very early. We
6 had a test that the -- I believe the genetic code
7 of the virus was published on January 10th, a local
8 test was developed by the 13th, and the first
9 person was diagnosed by the 26th of February.

10 And what that meant -- and yes, this
11 laboratory and our physicians went through the
12 approval process with the National Microbiology
13 Lab, and for some time samples were being sent to
14 the National Microbiology Lab, but we didn't wait
15 for that process to occur before we acted on
16 results. So that was actually a very significant
17 role that the BC Centre for Disease Control played.

18 So now you are making me think about
19 things that I hadn't thought of before.

20 The other area that was very important
21 is whole genome sequencing. Whole genome
22 sequencing within BC CDC actually allowed us to
23 distinguish between multiple introductions of a
24 virus within a long-term care facility as opposed
25 to ongoing transmission to be able to actually

1 identify what we can attribute to the long-term
2 care facility and what we cannot.

3 There is also a sero-survey that was
4 done to try and understand the extent of
5 transmission, undetected transmission in the
6 population that we may not be able to understand.
7 And right now, one of the roles of the BC Centre
8 for Disease Control, which we are going to hear
9 about at 11:30, is an assessment of the vaccine
10 effectiveness in long-term care facilities.

11 So yes, I think I understated the role
12 a little bit, but -- so there is -- that would be
13 the historical role, and I think a really important
14 part of the role of BC CDC, for example, is an
15 annual assessment of vaccine effectiveness of the
16 influenza vaccine, as well as whole genome
17 sequencing for other outbreaks, such as norovirus.

18 JENNIFER KING: Dr. Gustafson, can you
19 talk about the independence of BC CDC? Like does
20 the BC CDC report directly to the public? Are
21 their recommendations and advice public?

22 DR. RÉKA GUSTAFSON: So that is an
23 excellent question. And what is interesting is
24 that there is a Memorandum of Understanding between
25 the Provincial Health Officer and the BC Centre for

1 Disease Control, which at the moment, I believe, is
2 expired, so it is not at the moment signed.

3 So that I, as a Deputy Provincial
4 Health Officer, am responsible to the Provincial
5 Health Officer for the activities that are outlined
6 in the Public Health Act, but I would not say that
7 the independence of BC CDC one year after this is
8 entirely clear to me. I don't think it is
9 particularly well articulated, and so -- and the
10 mandate is probably something that I would think
11 needs some clarification, just so that I could
12 answer that question very, very clearly.

13 The BC Centre for Disease Control, in
14 an ideal state, I believe it is able to put out a
15 report that is an independent assessment of the
16 health of the population. That is something that
17 certainly -- in the terms of routine surveillance,
18 BC CDC puts out information that isn't vetted, but
19 I don't believe that that independence is clearly
20 articulated in any legislation.

21 DR. PERRY KENDALL: I could perhaps add
22 to that. When the BC Centre for Disease Control --
23 the BC Centre for Disease Control does its
24 analytics and its data collection on behalf of the
25 Provincial Health Officer, so that is a delegated

1 function.

2 The BC Centre for Disease Control is
3 part of the organization which is the Provincial
4 Health Services Authority, but in order to try and
5 establish the independence of the agency and be
6 clear about its responsibilities, there was a
7 Memorandum of Understanding developed, that
8 Dr. Gustafson has referred to, which I think is
9 under revision currently. It was signed. It was
10 in existence. It was fairly clear.

11 The other piece that we were concerned
12 about when I was the PHO and the BC CDC and was
13 incorporated into the Provincial Health Services
14 Authority was that Regional Health Authorities have
15 their own legal advisors. The Provincial Health
16 Officer has his or her own legal advisor within the
17 Ministry of the Attorney General. And we wanted to
18 be sure that the BC CDC had advantage of that legal
19 advice so that we were not getting competing legal
20 advisories from the PHSA legal services and the PHO
21 legal services.

22 So it is really clear in the BC CDC
23 mandate that the BC CDC, when it comes to issues of
24 health hazards or communicable diseases, shares the
25 legal advice of the Ministry of the Attorney

1 General legal advisor who gives advice to the
2 Provincial Health Officer.

3 The other thing that we put in place a
4 few years ago to ensure that independence was
5 previously the Executive Director or Executive
6 Medical Director of the BC CDC was not officially
7 an Order in Council Medical Health Officer. We
8 made that a requirement that the Executive Director
9 of the BC CDC should be eligible to be a Deputy
10 Provincial Health Officer and hold an OIC
11 appointment, which gives the holder of that
12 appointment all of the authorities of a Provincial
13 Health Officer and can speak on behalf of and
14 independently on public health issues.

15 That was to give the Director of the BC
16 CDC the ability to raise concerns of budget cuts
17 which otherwise might have been imposed upon the BC
18 CDC with adverse public health consequences.

19 JENNIFER KING: Thank you. So I think
20 why don't we get into -- we have already talked
21 about -- you have already talked to us about the
22 response in BC, but can you talk -- I think just to
23 both of you, comment on what has worked in BC in
24 terms of the pandemic response, specifically with
25 respect to the response of long-term care homes,

1 and if you can, talk about -- if you have
2 information about it, compare it to Ontario and
3 Ontario's response.

4 DR. PERRY KENDALL: I'll just start off
5 by saying I think that the organizational structure
6 and the regulatory structures, which had been in
7 place for over a decade, really make responses to
8 emergencies a lot more coordinated and integrated
9 in British Columbia. Admittedly, we have a smaller
10 population, but the regionalization of the Health
11 Authorities, the clear authority that Public Health
12 has in respect to long-term care and the
13 relationship with the Regional Health Authorities
14 and the relationship with the Ministry mean that
15 with one telephone call, within an hour the Deputy
16 Minister can have the CEOs of each Health Authority
17 on the line to plan something together in real
18 time, and the Chief Public Health Officer and the
19 Provincial Health Officer can do the same with the
20 Chief Medical Health Officers in the region.

21 And so the organizational structure is
22 there for a really rapid, integrated response, both
23 clinically or with the continuing care of a
24 long-term care area.

25 So over to you, Réka.

1 DR. RÉKA GUSTAFSON: Well, I would
2 second that.

3 So just some examples of that. As
4 Dr. Kendall mentioned, we had the Long Standing
5 Communicable Disease Advisory Committee, as well as
6 we have something called a Leadership Council where
7 the CEOs of each Health Authority meet with the
8 Deputy Minister, and I believe they meet on a
9 weekly basis or even during not a pandemic and much
10 more frequently now.

11 So that is a level of provincial
12 coordination and familiarity which I think is
13 absolutely critical in an emergency. I think
14 the -- for me, I don't think we can underestimate
15 the value of knowing who your partners in an
16 emergency are and having worked with them and
17 having them on your speed dial and knowing who you
18 are going to call.

19 I think that is actually really key.

20 Then the other part that I think makes
21 a really big difference is, within the Regional
22 Health Authority structure, as Dr. Kendall
23 mentioned, the Chief Medical Health Officer by and
24 large sits I think in just about every Health
25 Authority now on the executive team, which means

1 that within the hospital setting or within the
2 Health Authority setting those are individuals that
3 they meet with and work with to address daily
4 crises or larger crises on a regular basis.

5 So they not only have the authority,
6 but they have an associated credibility. And as a
7 result, I would say that their guidance -- the
8 legislation enables -- is an enabling legislation.
9 It is not something you have to call upon and is
10 unfamiliar to the people who need to act on your
11 advice or only act on your advice because they are
12 directed to do so by legislation. You have a
13 long-standing practice of having supported them in
14 responding to a hospital-wide norovirus outbreak or
15 a community outbreak of whooping cough or whatever
16 it might be that has existed, or MRSA or C.
17 difficile or whatever it is that you are supporting
18 them with, and that has been happening over many
19 years.

20 And I think then a really important
21 thing that doesn't necessarily exist in every
22 Regional Health Authority is that, upon your
23 direction or advice, the Health Authorities will
24 actually deploy resources. And again, I think that
25 varies by Health Authority, Health Authority by

1 Health Authority, the extent to which that will
2 actually happen, but I think it says a lot that
3 then when there were a number of outbreaks, then
4 the Regional Health Authority actually deployed
5 resources to go to contracted health care
6 facilities that came from acute care.

7 And some Health Authorities did that
8 and others followed suit, and I think that is
9 not -- I don't think that would be the consequence
10 of just the legislative authority. I think it is
11 the ongoing practice that is nurtured over time.

12 And the legislative authority is a
13 really, really strong enabling tool, but it is not
14 the motivation.

15 COMMISSION CHAIR FRANK MARROCCO:

16 Can I just follow up. It is one thing
17 to have the authority, the legal authority, but it
18 is another thing to have what it takes to exercise
19 it. And I'm wondering how you address -- or what
20 your views are and how you address the question of
21 leadership. Like, I mean, saying that you need
22 effective leadership doesn't say much. Very few
23 people would say that you need ineffective
24 leadership.

25 But is there a way of addressing that

1 that we might find helpful?

2 DR. PERRY KENDALL: I think it does
3 help if you have the mandate and can point to it.
4 There are independent agencies, Auditors General,
5 Seniors Advocate, and the Representative for
6 Children and Youth, who very clearly are
7 independent of government and report to government.

8 Public Health, in BC at least, has the
9 mandate to report independently and give advice but
10 not to the same degree of freedom that, say, the
11 Auditor General has or the Privacy Commissioner
12 has.

13 So you have to build up on that through
14 relationship-building, through professional
15 training in leadership, and there are leadership
16 courses that are available. I think having good
17 communication skills is essential. I think the
18 ability personally to take a certain amount of risk
19 and the ability to speak effectively to power is an
20 important issue and to be able to communicate what
21 might be unpopular at the time but do so in such a
22 way that doesn't get you disrespected.

23 And I think it is important to
24 understand the difference between people who were
25 appointed to a position and people who were elected

1 to a position, and those -- the opinions don't
2 necessarily always gel. Politicians make policies
3 which are not always -- or not frequently enough,
4 shall I say, sort of supportive of general public
5 health across the field, but the ability to be able
6 to make a point and provide advice that is unbiased
7 and non-political and has some grounding is
8 important.

9 But I think it is also important to
10 relate it -- an effective Public Health Officer
11 tries to make a difference rather than necessarily
12 making a point. So choosing your issues - and
13 there are always many issues - choosing your issues
14 is important. Choosing when to push an issue is
15 important, and having a measure of trust behind you
16 is really critical as well.

17 So every time there is a new elected
18 leader, it is important to build on whatever legacy
19 of trust you have and try and develop a
20 relationship, even if you do hold opposing
21 political philosophies.

22 Réka, you could add to that, I am sure.

23 DR. RÉKA GUSTAFSON: So I very strongly
24 agree with that. A strong Public Health Act that
25 clearly outlines your mandate is actually critical.

1 It is really, really important.

2 I think the point I was probably making
3 is that by itself it doesn't get you there. And I
4 think your question, Commissioner, about the
5 courage to exercise your power or exercise your
6 authority, I think that, again, comes with
7 practice.

8 And one of the things that I have seen,
9 for example, not necessarily in long-term care
10 facilities but in others, where there has been a
11 differential courage to shut something down where
12 there is an outbreak, to actually exercise your
13 power to -- your authority to put an intervention
14 in place.

15 And I think there is a number of things
16 that can contribute to that. Again, practice is
17 one of them. The other is that because you are
18 functioning within Regional Health Authorities, the
19 Regional Health Authority can over time either
20 increase or decrease your power within that
21 organization.

22 And one of the -- and I don't know if,
23 Perry, this is an explicit role of the Provincial
24 Health Officer, but in the 20 years that Dr.
25 Kendall was the Provincial Health Officer, in that

1 time, if I needed backup, if I needed support from
2 the Provincial Health Officer and I demonstrated -
3 this is in my role as a Regional Medical Health
4 Officer - and I demonstrated the public health
5 merits or necessity of taking a step that may or
6 may not have been popular, I could reach out to my
7 Provincial Health Officer and get that support.

8 And that support was actually really,
9 really important because there is both a legal
10 authority and a gravitas that goes with the role of
11 the Provincial Health Officer. And if you are
12 about to exercise your authority, there is actually
13 a procedural step whereby, if you issue an
14 order, the Provincial Health Officer approves that
15 order. But it is more than a procedural step. It
16 is also -- it also actually ensures that you go
17 through the process of having considered the pros
18 and the cons of taking that step and that you are
19 actually exercising your authority with discretion.

20 And so I think that's, again, sort of
21 a -- part of our day-to-day life, that whether you
22 are going to issue an order over a drinking water
23 operator or actually restricting the rights of
24 another human being, you do have that exercise of
25 both requiring the Provincial Health Officer's

1 approval, but then actually having their support.

2 So I would say that those are really
3 important parts of the overall practice, but again,
4 I do think that if the only time you were to
5 exercise your authority is during an emergency,
6 that is a dangerous place to be.

7 One of the things I tend to see in
8 emergency responses is that it tends to draw in a
9 lot of players who may not actually have the
10 greatest amount of experience and that isn't always
11 to the benefit of the response.

12 Sometimes it is great, it is fresh
13 troops, but we also have to be careful to make sure
14 that people who are making the difficult decisions
15 have the experience to do so.

16 COMMISSION CHAIR FRANK MARROCCO:

17 Well, the different players bring
18 different perspectives, and what they think is
19 important and what the Medical Officer of Health
20 thinks is important might not be the same.

21 DR. RÉKA GUSTAFSON: Right.

22 COMMISSION CHAIR FRANK MARROCCO:

23 All right.

24 JENNIFER KING: Dr. Kendall and
25 Dr. Gustafson, you talked about having a strong

1 Public Health Act that sets out the mandate. Is
2 there anything else in the legislation that you
3 think is necessary to ensure that you get the right
4 kind of leader, the kind of leader that you have
5 described, Dr. Kendall, in the role of the top
6 Public Health official in the province?

7 DR. PERRY KENDALL: I can't think of
8 anything that could be written into the legislation
9 that would make that choice inevitable.

10 I think BC has fortunately had a good
11 history of carefully vetting who moves into the
12 position. They certainly have to have the
13 appropriate technical and educational capabilities,
14 and I would like to think that the people who made
15 the ultimate decisions made good decisions.
16 Obviously, I would like to think that.

17 But I don't know, Réka, if you could
18 think of anything else?

19 DR. RÉKA GUSTAFSON: Well, I have
20 actually been thinking about it, and I don't know
21 if necessarily the Provincial Health Officer, but
22 these leadership roles that a number of us are in,
23 I have some thoughts about it.

24 I actually think being deeply rooted in
25 practice is important to a certain degree and -- or

1 a certain period of your practice has to be in
2 actually practising in the area of public health,
3 so I think that is really important.

4 The other that I am starting to think
5 about is that I think an opportunity to rotate in
6 those positions. The way we set up our positions,
7 all of our Public Health positions in British
8 Columbia is they are sort of lifetime appointments,
9 and I think they should be -- like I think there
10 should be an option to renew.

11 But I also think there should be an
12 option to not renew without it being a dismissal.
13 And the reason that I think about that is that I
14 think these types of positions benefit into a
15 rotation back into practice and think about them a
16 little bit -- not the Provincial Health Officer but
17 the other, because that is such a position so
18 deeply rooted in legislation, but sort of
19 leadership positions in Public Health, to recognize
20 that Public Health is ultimately, you know, rooted
21 in local practice and then coordinated through
22 provincial practice and supported with a provincial
23 or national evidence review.

24 But I do find that there is an
25 artificial hierarchy that is set up that isn't

1 necessarily commensurate with depth of experience,
2 and so one of the things that I sometimes wonder
3 about is it is a form of medical practice and
4 sometimes the conversation at the national level
5 that I am privy to reflects the disconnect from
6 practice that I find concerning.

7 So to me, that is one of the things
8 that I think we need to just be thoughtful about,
9 about whether or not is it really a hierarchy or is
10 it practising at different levels.

11 And that may just be because I come
12 from a communist country and, therefore, I am
13 just -- I don't believe in hierarchies, but I just
14 think the leadership -- I think the leadership has
15 to be humble. I think it has to be more rooted in
16 responsibility than authority. And I think it has
17 to be a leader that can consult in a meaningful
18 way.

19 And I will bring back, again, H1N1,
20 Dr. Kendall, when there was an issue that came up
21 around vaccine and potentially the effect of a
22 previous vaccine, and you formed a solace that I
23 need my wise counsellors to answer this question.
24 And I think that -- I still remember that, that was
25 11 years ago, and I think that is what a Provincial

1 Health Officer needs to do because you can't, as a
2 single practitioner, have the depth of knowledge
3 about every single area in every single moment, but
4 you have the judgment and the ability to synthesize
5 that information into a decision.

6 I don't know what you think about that,
7 Perry, but I think those are the qualities that I
8 would want.

9 DR. PERRY KENDALL: I think it is
10 extraordinarily helpful to be able to do that and
11 have that body of expertise to consult, because you
12 are right, no one individual can possibly know
13 enough about everything to make sensible decisions
14 or wise decisions.

15 JENNIFER KING: So, Dr. Kendall and
16 Dr. Gustafson, I know we have talked about how it
17 works in BC, and, Dr. Kendall, you have experience
18 in Ontario. I know it was some time ago. Can you
19 comment on -- specifically compare the BC Public
20 Health response to Ontario's and perhaps what about
21 the successes in BC are translatable to Ontario?

22 DR. PERRY KENDALL: Thank you.

23 JENNIFER KING: You have talked about
24 the size -- the difference in size, but what is
25 translatable to our context.

1 DR. PERRY KENDALL: If I was to make
2 recommendations, it would be to aggregate health
3 care delivery in Ontario. I think it is the only
4 province that hasn't really moved to a regionalized
5 system, for whatever reason.

6 I think Public Health -- there are pros
7 and cons to integrating Public Health with a
8 regional health service delivery system. Certainly
9 for British Columbia, I have seen benefits, and I
10 have seen downsides of integrating the Public
11 Health into part of a global budget.

12 If I was going to make a strong
13 recommendation, it would be that the Public Health
14 should be adequately resourced to manage issues,
15 and nationally, for at least two decades, we
16 recommended roughly 6 percent of the Health
17 Authority budget should be engaged in the Public
18 Health piece.

19 Many Public Health functions could be
20 carried out in community health centres where you
21 had populations who were enrolled and had health
22 care teams, which could include Public Health for
23 the health promotion components.

24 I think integrating the long-term care
25 oversight into Public Health was really critical to

1 British Columbia's success. Having separate
2 organizations who do the inspections and the
3 infection control and take it out of the ambit of
4 the health care delivery system and Public Health
5 piece is not an ideal situation when you want to
6 coordinate a swift, effective response.

7 So some of those organizational and
8 regulatory principles I think would benefit Ontario
9 if they could move to put them in place. I don't
10 know if the Commissioners were aware, but the
11 February Canadian Medical Association Journal
12 published a review around COVID-19 in long-term
13 care homes in Ontario and British Columbia, which
14 is looking at the first few months of the response,
15 and it is a very coherent review, and the
16 recommendations basically reflect that those were
17 some of the key differences that made a difference.

18 The political aspect of it in Ontario
19 is BC has had a very consistent public face to the
20 response, which in the past has been really
21 important, and I think in this particular aspect
22 has been really important in keeping the public
23 informed on what was going on with transparency and
24 a single voice, or if it is not a single voice, at
25 least the voices are basically conveying the same

1 message, which I think has been more effective than
2 the Ontario response. At times it was less than
3 clear who was on first and what the message was.

4 And, Réka, would you have anything to
5 add to that?

6 DR. RÉKA GUSTAFSON: I think -- and I
7 may not be as familiar with the Ontario system, but
8 the one thing I would add to that is I think we may
9 have, based on our Public Health Act, struck a
10 slightly better balance between distributed versus
11 centralized authority and responsibility.

12 One of the things that I understand
13 about the Ontario system is that there is one
14 Medical Officer of Health for each jurisdiction,
15 and then the Associate Medical Health Officers, as
16 far as I know, do not have orders in council,
17 whereas in British Columbia every Medical Health
18 Officer has an Order in Council and that carries
19 with it a depth of responsibility that builds also
20 a depth of experience over time.

21 Similarly, our Environmental Health
22 Officers also have independent powers under the
23 Public Health Act, and that also -- and again, I
24 don't know if that is different from Ontario.

25 But one of the -- as a result of which,

1 in the areas where that is well established, there
2 is a workforce of Environmental Health Officers who
3 have the experience of public health practice that
4 we can call upon, and we can call upon at times
5 that are really, really important, such as during
6 an emergency.

7 So one of the things that that allows
8 us to do is actually create a surge capacity with a
9 depth of public health practitioner experience that
10 I think is less likely to develop if your systems
11 are set up more likely that there is one ultimate
12 decision-maker and then everyone else follows a
13 protocol.

14 So I think that is a really important
15 one. We have also been moving over the last while
16 in a number of our Public Health activities to be
17 really focussing on risk-based rather than
18 protocol-based practice, both in environmental
19 health and in communicable disease control, and I
20 think those are really, really important ways of,
21 again, building sort of depth of practice that you
22 can call upon when something new is emerging and
23 you actually have to assess it in real time and you
24 don't have a protocol to fall back on.

25 So I think those are important aspects

1 of how we set things up.

2 And as Dr. Kendall mentioned, there is
3 advantages and disadvantages of Public Health being
4 in Health Authorities, but overall, I would say,
5 certainly in an emergency like this, it is an
6 advantage. It is actually a very, very large
7 advantage because you are integrated with a health
8 care system. Medical Health Officers are regular
9 communicators to primary care physicians. The
10 Provincial Health Officers are regular
11 communicators to primary care physicians. If a
12 letter comes from Public Health about an outbreak,
13 you know it is happening and you know it is
14 relevant to you.

15 And the hospitals and primary care
16 physicians follow that advice. They know that that
17 is their directive and that that is also their best
18 advice available to them.

19 And again, I think, especially in an
20 emergency where we are fighting the cacophony of
21 media voices about what you should do or what you
22 shouldn't do and how many masks you should be
23 wearing, the fact that you have a body of people
24 who have communicated to you about Ebola and about
25 H1N1 and about measles and, you know, the newest

1 meningitis vaccine, that is your source of
2 information for Public Health, then you know where
3 that information is going to come from.

4 When we talk to our primary care
5 providers, often they told us that it is that
6 regular newsletter that comes from Public Health
7 that tells you what is happening in your community
8 is the thing they don't shred, and so I think those
9 are really -- those would be for me the important
10 parts of that relationship with the clinical
11 practice community.

12 And we still have the responsibility to
13 advise local government on policies, so that
14 relationship exists, and it needs to be nurtured
15 more actively than when you are within a municipal
16 government. But I think being within a Regional
17 Health Authority overall is a benefit.

18 DR. PERRY KENDALL: And if I could add
19 something a little bit -- I agree with everything
20 Dr. Gustafson says. I also think, looking
21 specifically at long-term care facilities and the
22 experience during COVID, what it has shown very,
23 very clearly is that the importance we have put
24 into continuing care for seniors and the long-term
25 care housing and the way we have structured the

1 funding and the staffing of that has been, I would
2 say, less than ideal. Older facilities, multi-room
3 facilities, poorly paid staff, no benefits, lack of
4 sick pay, the requirement that in order to make a
5 living, we have to have people working casually
6 between several institutions, including potentially
7 hospitals, has certainly contributed to the very
8 poor outcomes we saw and the high morbidity and
9 mortality among people who are extraordinarily
10 vulnerable.

11 So if I could make one recommendation
12 to health care in Canada, it would be it is way
13 past time to start investing in care -- in
14 community care for people with chronic and multiple
15 conditions and frailty, both to keep them
16 independent in the home where we can and out of
17 facilities, and then, when they are in a facility,
18 be sure that facility is adequately built,
19 adequately staffed and provides decent, humane
20 care.

21 I honestly think, having been involved
22 in long-term care and community care for many, many
23 years, both in BC and in Ontario, I think we have
24 gone backwards over the last three decades, to be
25 honest.

1 COMMISSION CHAIR FRANK MARROCCO:

2 Do you agree with the idea that if
3 people stay in their homes longer, then the people
4 who go into long-term care residences are going to
5 be older and sicker, and so therefore the staffing
6 that you need needs to be more sophisticated, not
7 less sophisticated?

8 DR. PERRY KENDALL: Absolutely. Yes, I
9 do. And BC also has the assisted living. I mean,
10 it is a Community Care and Assisted Living Act, so
11 it is the licensed facilities, and then it is
12 facilities that are registered have to meet certain
13 standards but actually fall outside the long-term
14 care provisions. They are less tightly regulated.
15 So there is a gradation, and the idea that you can
16 age in place I think is an important idea.

17 But I do agree -- and there are
18 multiple studies over decades -- that seniors would
19 rather live independently in the community, and if
20 you can provide the services, whether it is
21 assistance in daily living, shopping, bathing,
22 dressing, et cetera, many seniors function very
23 well in the community and do not need to go into
24 the long-term care facility, and their morbidity
25 can be reduced. Their dependence on emergency

1 rooms and hospitals can be reduced. And you have a
2 smaller group who are more chronically ill and do
3 require more sophisticated care, and we are not
4 providing necessarily that level of care to those
5 individuals under the current system.

6 DR. RÉKA GUSTAFSON: And in British
7 Columbia, we are there in terms of the level of
8 care people require once they go to long-term care
9 facilities. The median life expectancy in
10 long-term care facilities in BC is 18 months, so
11 people do not go there.

12 So the people who are there already
13 need that level of sophisticated care, and there is
14 a great variation whether they are receiving it,
15 and I would very much agree with that, that I
16 suspect this is going to be the biggest thing that
17 every jurisdiction, including British Columbia,
18 will take away from this, is that the staffing
19 levels need to be adequate and that the physical
20 space needs to be adequate, the level of care that
21 people need today.

22 So, Commissioner, I was sort of
23 referring to the fact that I don't think that is a
24 projection to the future, and we already have
25 people needing very complex care in long-term care

1 facilities.

2 COMMISSIONER ANGELA COKE: I just have
3 a question about, before the pandemic, would your
4 long-term care homes have had a better capacity and
5 skill in terms of their IPAC practices just because
6 of the nature of the relationship you have in terms
7 of how you work with them, but I am just curious as
8 to how they were pre-pandemic and during the
9 pandemic in terms of their IPAC knowledge and
10 expertise and practices.

11 DR. RÉKA GUSTAFSON: So I can bring
12 some of my experience to that.

13 The long-term care facilities that are
14 owned and operated by the Health Authority have the
15 benefit of infection prevention and control support
16 from the Health Authority, from the hospital Health
17 Authorities, so they are a different -- they are in
18 a different category. So they have the -- again,
19 they have the benefit of that. But frequently,
20 again, resources are limited and focus tends to be
21 on acute care, but I would say that, in my
22 experience, owned and operated long-term care
23 facilities receive very good infection and
24 prevention support from their acute care
25 colleagues, especially during outbreaks.

1 In the contracted facilities, it really
2 varies depending on the investment that is made in
3 that practice. So Public Health by and large has
4 the ability to provide guidance, to provide
5 guidance documents, education every year about
6 influenza vaccination. Our licensing officers
7 provide a lot of shoulder-to-shoulder training and
8 education, but it is not a requirement, per se, and
9 I would say that I have seen great variation in
10 long-term care facilities on how much they invest
11 or are able to invest depending on their funding on
12 actual infection and prevention control knowledge.

13 And in keeping in mind that, you know,
14 the level of education of the staff will also vary
15 in that area.

16 So certainly I wouldn't say that is
17 consistently where we would want it to be.

18 COMMISSION CHAIR FRANK MARROCCO:

19 The staffing issues, from what we have
20 been able to determine, have been long-standing,
21 and I am just curious if you have a view -- perhaps
22 this is more directed to Dr. Kendall, but not
23 really, if you have a view on why the staffing
24 issues would be outstanding for so long and not
25 be -- what the barrier is or has been to addressing

1 the issue.

2 And I was just wondering if you have a
3 view on why that is?

4 DR. PERRY KENDALL: Yes, I do. I think
5 the centrality of -- I mean, a couple of things.

6 Health care funding is expensive. It
7 is the largest proportion of provincial and
8 territorial budgets eating -- you know, using about
9 50 percent of the budget.

10 The sort of rate of inflation and
11 increased funding has been high year over year over
12 year.

13 The focus on the media and on the
14 politicians is always on the acute care side and
15 access to care and beds, and the answer is always
16 to add more to the acute care and more diagnostics.

17 As the population ages, there is also
18 more acuity of care and more care is provided, and
19 so the central focus is always on the acute and the
20 urgent. And over the last couple of decades, as
21 politicians have sought to rein in expenditures and
22 control the budgets, exert control over the budgets
23 of the health care system, the priority has nearly
24 always been the number of operations you can do,
25 the number of cardiac surgeries you can do, the

1 number of MRIs that you have, et cetera, et cetera,
2 et cetera.

3 And as Health Authorities run
4 over-budget, all of the areas that haven't run
5 over-budget tend to be tithed to make up the
6 deficit because one of the key areas in the mandate
7 letter to the CEO of a Health Authority is manage
8 within your budget.

9 And there has not been a very large
10 outcry or demand for the community care services or
11 the long-term care services. This minority of
12 patients don't have much of a voice. They don't
13 have a lot of political clout. And so they have
14 become neglected, and that has become an area which
15 has become un-unionized and has become a pink and
16 often English-second-language ghetto for lower paid
17 casual workers. It goes against the evidence of
18 where and how you should invest in care for aging
19 populations.

20 One example of what I think is
21 cognitive dissonance is that our primary care
22 system operated on fee for service, was designed
23 for a younger population with acute illnesses or
24 accidents who were treated and got better. What we
25 are seeing is a growing population of people with

1 multiple morbidities, who have chronic conditions
2 which are, quite frankly, really ill-served by a
3 fee-for-service system which functions on volume.

4 And so the decades' worth of
5 recommendations for building primary care systems
6 which reach out into the community using health
7 care expanders or physician expanders and nurse
8 educators, nurse practitioners, et cetera, has
9 actually been largely ignored in favour of a focus
10 on institutionalization in the acute care system
11 and the primary fee for service, which does no
12 justice to what are the health needs of an aging
13 population.

14 Yes, we need acute care and fee for
15 service for the younger individuals and for some
16 services, something that is performance-driven, you
17 know, independent performance-driven, like having
18 access to good prenatal care, for example, and
19 certain obstetrical services, but for people of my
20 generation who have a number of chronic, ongoing
21 conditions, the primary care service or fee for
22 service is just not the best model to do it, and it
23 leaves people needing care who don't have it, and
24 it provides sub-optimal chronic care, and it
25 underfunds the community support services, and it

1 underfunds the long-term care and residential needs
2 of individuals.

3 Sorry, that was a bit of an exposition,
4 my hobby horse when it comes to --

5 COMMISSION CHAIR FRANK MARROCCO:

6 Well, I was hoping to get an
7 exposition, so that is why I'm asking the
8 questions. So thank you for the answer.

9 Ms. King, are we -- well, actually, let
10 me change topics, if you don't mind, for one
11 second.

12 One of the debates here is whether
13 for-profit homes should exist or not and because
14 the performance of the for-profit homes seems to
15 have been -- in terms of preserving the lives of
16 the people under their care, seems to have been not
17 as good as the not-for-profit. There has been a
18 view expressed quite a few times that we should get
19 rid of for-profit homes.

20 And I was wondering -- I noticed you
21 said there is for-profit homes in British Columbia.
22 Do you have a view on the role of for-profit and
23 not-for-profit?

24 DR. PERRY KENDALL: Yes. Isobel
25 Mackenzie, who is the Seniors Advocate in British

1 Columbia, has done a lot of work looking at the
2 levels of service provided for the amounts of money
3 that are provided by government to the for-profits.
4 She has found that on average for-profit homes
5 provide less care for the dollar that is given to
6 them than do not-for-profits who often provide more
7 care than is actually paid for by the state.

8 So I think if you are going to have
9 for-profits -- and I think that politically it is
10 probably infeasible not to have them just because
11 of the politics of the issue and the strength of
12 the lobby groups, that they should be really
13 carefully and closely regulated so that they are
14 not diverting funds that are meant for care into
15 profit and that there are levels of investment that
16 are actually required, so that what we see in
17 for-profit homes, that there are more of them have
18 multi-room -- multi-bedroom facilities as opposed
19 to the single-room facilities. And I think that
20 Isobel Mackenzie, her work shows, at least in BC,
21 on average you get better care and better outcomes
22 in the not-for-profit homes than you do in those
23 that are profit-driven because you have to take a
24 percentage of the margin out for your shareholders.

25 COMMISSION CHAIR FRANK MARROCCO:

1 Well, I don't know if you remember from
2 your time in Toronto or if it was the same, but
3 what we were told sometime ago was that the
4 municipality contributes over and above the
5 provincial contribution to maintain its long-term
6 care homes, and at the same time, we read about
7 for-profits declaring substantial dividends even in
8 a pandemic.

9 So it is hard to know how, on the one
10 hand, you have to contribute money to make it work,
11 and on the other hand, you are able to pay
12 dividends. I don't know if it was the same when
13 you were here or not.

14 DR. PERRY KENDALL: Well, one of the
15 differences between Public Health in BC and Ontario
16 is that, as Medical Health Officer for Toronto, I
17 had absolutely no relationship with the continuing
18 care community until I spent a year on secondment
19 to the Deputy Minister when the government - the
20 then government, and Ruth Grier was the Minister -
21 was trying to reform the continuing care component,
22 which in British Columbia a couple of decades
23 before had been brought into the Public Health, and
24 rather than having independent agencies like the
25 Victoria Order of Nurses competing for contracts to

1 provide community care, the nurses became employees
2 of the Regional Health Authority or the Public
3 Health Services, basically Ministry employees, now
4 Regional Health Authority employees.

5 So I was completely distanced as a
6 Public Health official from the long-term care and
7 continuing care services, let alone the long-term
8 care residences. We had no contact with them at
9 all.

10 DR. RÉKA GUSTAFSON: And if I may just
11 add to that, whereas sort of from my experience as
12 a Medical Health Officer, it is a substantial part
13 of our body of work, and I have seen Medical Health
14 Officers not only sort of carry out their duties
15 under the Licensing Act and managing outbreaks and
16 surveillance, but also advocating for long-term
17 care facilities, so advocating for better resources
18 or better physical space, so things like that.

19 I do think that -- just in terms of the
20 profit versus non-profit question, I think it is
21 also -- that may be one variable that is very easy
22 to measure. I think it would be really important
23 to look at staff-to-resident ratio, whether or not
24 there is an infection prevention and control
25 individual actually assigned, as I say, per bed,

1 how many infection control nurses you would need
2 per bed, what are the actual resources that you can
3 put in place, but also then indicators that you
4 measure, just as you measure hips and knees, as a
5 performance measure for long-term care facilities.

6 And the profit/non-profit difference
7 may not be the variable most important. I don't
8 know that. But I think there are other indicators
9 that need to be measured as to assess quality of
10 care.

11 COMMISSION CHAIR FRANK MARROCCO:

12 Thank you.

13 JENNIFER KING: So I only really have
14 one follow-up question for Dr. Kendall and, unless
15 the Commissioners have any other questions, I think
16 that will be all my questions.

17 Dr. Kendall, you talked a little bit,
18 and Dr. Gustafson, you talked about the qualities
19 of a leader, of a Provincial Health Officer that
20 are required.

21 Is there anything, Dr. Kendall, that
22 you can talk about, what is accountability or
23 independence, and how in BC the Public Health Act
24 ensures both the independence and accountability of
25 your Provincial Health Officer and perhaps compare

1 that to Ontario's Chief Medical Officer of Health?

2 DR. PERRY KENDALL: I mean, I think it
3 has been really very, very, very, very helpful to
4 have the mandate for independence and speaking
5 independently and having had predecessors who used
6 that and exercised that mandate to the full, so at
7 least -- I mean, I did not come into a job where I
8 was the first person to be independent and say
9 things that were unpopular or put forward policies
10 that were not exactly current with what government
11 thinking was.

12 So that was important, and I think I
13 see more of that in BC than I do in other
14 provinces. I won't, you know, necessarily single
15 out Ontario, but other provinces where the Medical
16 Health Officers do not have that reporting
17 relationship to the Minister or that public access
18 to the press or have developed that ability and
19 that history of speaking out or working with
20 government even when they are not necessarily, you
21 know, in accord with the policies.

22 So I think it is important to do that,
23 but there are other provinces where Medical Health
24 Officers report to Assistant Deputy Ministers and
25 are buried somewhere deep in the bowels of the

1 bureaucracy, and we have seen Medical Health
2 Officers being dismissed for putting reports out on
3 oil sands development in smaller jurisdictions
4 which the government didn't like, and they lost
5 their job.

6 One of the issues with being a Public
7 Health physician, I think, is that you ought to be
8 prepared to resign if your advice is not being
9 taken, or you ought to have written into your
10 contract that if you are dismissed, you have at
11 least a cushion to enable you to be able to speak
12 independently without fear of finding yourself on
13 the street without an income. And we have seen
14 that happen in recent -- in the last five years to
15 Medical Health Officers in various jurisdictions
16 across the country.

17 And we had one Medical Health Officer
18 whose Deputy Minister -- no, whose Minister of
19 Health mused quite publicly about whether or not it
20 would be worth the trouble of firing the Chief
21 Public Health Officer because of his comments
22 around the alcohol programs and controls and
23 policies that were being put in by the present
24 government as opposed to what the Provincial Health
25 Officer was saying would be a sensible regime.

1 JENNIFER KING: Are there protections
2 in the Public Health Act in BC to protect the
3 Public Health -- or the Provincial Health Officers'
4 employment if they do speak out to the public?

5 DR. PERRY KENDALL: Not in the Act
6 itself. The Order in Council and the fact that it
7 is clear that that is your authority to do that and
8 then the individual's contract with the government
9 and labour law would be a protection against that.

10 In Ontario, the protection against
11 dismissal from the Medical Health Officer by the
12 local Board of Health does exist because you have
13 to have the approval of the Provincial Health
14 Officer or the Chief Medical Health Officer, as you
15 do in British Columbia. So Medical Officers can be
16 dismissed for cause, but it has to be in
17 consultation with the Provincial Health Officer who
18 could say that there was no cause for doing this or
19 there was cause and then it goes to labour law.

20 JENNIFER KING: Thank you. Unless the
21 Commissioners have any additional questions, those
22 are all of the questions that I wanted to take you
23 through today.

24 Is there anything else?

25 COMMISSION CHAIR FRANK MARROCCO:

1 Nothing. Commissioner Coke, do you
2 have any questions?

3 COMMISSIONER ANGELA COKE: No, that is
4 fine. Thank you.

5 COMMISSION CHAIR FRANK MARROCCO:

6 No, I think we asked them as we went
7 along, and so if that concludes, then let me say
8 thank you for a very informative presentation and
9 really an opportunity to get a candid response to a
10 number of issues that have been bobbing up and down
11 before our Commission.

12 And so thank you both very much.

13 DR. RÉKA GUSTAFSON: Thank you.

14 COMMISSION CHAIR FRANK MARROCCO:

15 And thank you, Dr. Gustafson. I know
16 that -- I read the newspapers, and I understand BC
17 has some issues to deal with, just like us, so --

18 DR. RÉKA GUSTAFSON: Oh, yes.

19 COMMISSION CHAIR FRANK MARROCCO:

20 So thank you for taking the time.

21 DR. RÉKA GUSTAFSON: My pleasure.

22 COMMISSION CHAIR FRANK MARROCCO:

23 And, Dr. Kendall, thank you for the
24 benefit of your experience and meeting with us.

25 DR. PERRY: Thank you.

1 COMMISSION CHAIR FRANK MARROCCO:

2 It is much appreciated.

3 COMMISSIONER ANGELA COKE: Thank you

4 very much.

5 JENNIFER KING: Thank you very much.

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8 -- Adjourned at 12:45 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

5 That the foregoing proceedings were
6 taken before me at the time and place therein set
7 forth;

8 That all remarks made at the time
9 were recorded stenographically by me and were
10 thereafter transcribed;

11 That the foregoing is a true and
12 correct transcript of my shorthand notes so taken.

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16 Dated this 17th day of February, 2021.

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22 NEESONS, A VERITEXT COMPANY

23 PER: DEANA SANTEDICOLA, RPR, CRR, CSR

C L A R I F I C A T I O N S

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Page 21, line 1: "Public health lab" not "Public Health Act"

Page 21, line 3: "Provincial Health Services Authority" not "Provincial Health Services Agency"

Page 25, line 8: "is the licenser" not "as the licenser"

Page 37, line 18: "PICNet" not "PICN"

Page 43, lines 12-13: "BC CDC was incorporated" not "BC CDC and was incorporated"

Page 45, line 18: Strike "and the Chief Public Health Officer"

Page 56, line 22: "called a teleconference" not "formed a solace"

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