Long Term Care Covid-19 Commission Mtg.

Dr. Jennifer Gibson
on Thursday, February 4, 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 4th day of February, 2021, 9:00 a.m. to 11:28 a.m.

APPEARANCES:

Dr. Jennifer Gibson, Ph.D., Sun Life Financial Chair in Bioethics and Director, Joint Centre For Bioethics, Associate Professor, Division of Clinical Public Health and Institute of Health Policy, Management and Evaluation Dalla Lana School of Public Health

The Honourable Frank N. Marrocco, Lead commissioner

Angela Coke, Commissioner

Dr. Jack Kitts, Commissioner

Lynn Mahoney, Esq., Counsel

Jennifer King, Esq., Counsel

Derek Lett, Policy Director

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

Alain Daoust, Team Lead, Long-Term Care Commission Secretariat

Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat

Ida Bianchi, Senior Legal Counsel, Long-Term Care Commission Secretariat

Eveliene Symonds, Stenographer/Transcriptionist

-- Upon commencing at 9:00 a.m.

COMMISSIONER MARROCCO: I'm Frank Marrocco. There's Dr. Jack Kitts and Commissioner Angela Coke. Welcome and thank you for coming.

We do have a transcript. We have a court reporter, Eveliene, who you can see on your screen somewhere. And so we will post a transcript of this so that people can understand what we're doing and how we're gathering information.

Beyond that, we're ready when you are.

DR. GIBSON: Thank you. So how about I -- I just have a very small slide deck that I thought we might be able to run through.

MS. MAHONEY: Is it just me, or is there a lot of static in the connection?

DR. GIBSON: Let me see if I can get my other microphone working here.

MS. MAHONEY: Okay. And don't worry, Dr. Gibson. Yesterday was a bad internet day for me. Everyone has bad days in this Zoom world. So we'll figure it out.

No. Can't hear it. No. That's okay. We'll work with the static. Okay. You're on mute, I think.

(DISCUSSION OFF THE RECORD)

MS. MAHONEY: Dr. Gibson, I think you're going to do this, but if -- sorry. I have to change my view as well. I just want to thank you for coming, and I'm just going to briefly introduce you to the commissioners. You have your -- I've got this information from your CV that was attached to the Affidavit that you swore in connection with the litigation regarding PPE.

You have a Ph.D. in philosophy. Your specialisation is in bioethics from the University of Toronto. You are a -- currently, you're associate professor, clinical public health; Sun Life Financial chair in bioethics; and director of joint studies for bioethics at the Dalla Lana School of Public Health. You're a full member, School of Graduate Studies at the University of Toronto. You're cross-appointed to the Institute of Health Policy Management and Evaluation at the Dalla Lana School of Public Health, the University of Toronto. You're a director of the WHO Collaborating Centre for Bioethics at the University of Toronto.

Previous work that you have -- and I do note that I'm only highlighting it, because Dr. Gibson has extensive experience and relevant

expertise here. She is a -- from 2015 to 2016, she worked with the WHO Ethics and Epidemics working group.

2015, she worked with the WHO Consultation on Ethics and Epidemics. Sorry, it was probably a presentation that you did in May in Dublin.

2014 to 2015, you were in the WHO ethics working group on Ebola.

2014 to 2015, you were the chair Ebola bioethics table with the Ontario Ministry of Health and Long-Term Care.

2010 to 2011, you worked with the Baycrest Centre for Geriatric Care. You did ethics strategic planning.

In 2005 to 2006, you were on the Ontario pandemic influenza planning committee, antivirals and vaccines task force, public health division.

In 2006, you did pandemic planning in clinical ethics education with the Hastings Centre in New York.

And I know you're going to get to this and you've addressed it in your slides. You also coauthored an ethical framework for public and

private sector pandemic preparedness planning, which is entitled Stand on Guard For Thee, and this framework has been adopted or influenced government and institutional pandemic plans provincially, nationally, internationally.

And so I just wanted to highlight that for the Commission, and I do know that you have some slides that address some of it, and maybe there are some things that I missed that you perhaps want to highlight for the Commission.

DR. GIBSON: Thanks so much for the introduction, Lynn. I really appreciate that. And some of the things that you pointed to just remind me just how many years I've been sort of dabbling in and out of pandemic ethics. And, nevertheless, it continues to be humbling work. There's always so much that we don't know; we're still striving to learn more. So thank you so much to the commissioners for the invitation to join you today. This is really important work.

I just wanted to signal something that I think is really powerful about the ways in which you are introducing your recommendations. The recommendations as introduced iteratively means that these concerns inform current -- the current

state as well as provide insight on what we want to prevent in the future. So it's really humbling to be invited, to be honest, when I see the line-up of folks you've already spoken with, many of whom are much closer to the issues and have a much broader expertise and relevant expertise than I may be able to offer. But I really hope that I might be able to add something that may be helpful to you, and you can help me focus my thinking around this in a way that hopefully will achieve that aim.

So what I thought I --

Next slide, please, Jennifer.

What I hoped I might do is really four buckets, and I'm very happy to pause at any point alone along the way. In fact, we might just see these as just sort of moments for pausing in between each of these, because I know that there may be some questions that are perhaps better addressed in the moment than left to the end.

But -- so a little bit of background, to flesh out a bit of what Lynn has said. I'll move on to a bit more of a description of how bioethics has been informative of the current COVID pandemic, including some areas where some of that -- the bioethics work has actually been

informing issues related to long-term care.

Also, I'd like to offer some general observations just over the last number of months and then possibly some future directions.

I will say, though, just by way of framing where I'm coming from, I'm coming to you as an individual today, and so any views that I may share are my own and don't represent any institution or group. I will endeavour to be as factual as possible, and where I don't know the answers to your question, I will let you know. And if it's something that I can follow up on, I will commit to -- I will commit to do so.

MS. MAHONEY: Dr. Gibson, I will probably intervene and ask you questions, because I have reviewed documents that you have provided to me, and also I've had the opportunity to review documents provided -- some documents provided by the government. And so I think we'll just use it to refresh your memory sort of chronologically about the various issues --

DR. GIBSON: Yeah.

MS. MAHONEY: -- that you were involved with.

DR. GIBSON: Yes. Thanks, Lynn.

That's terrific.

And just by way of sort of final comments about this, I will point out too that bioethics is a very broad field. It ranges from folks working in the front line in terms of clinical ethics to folks working primarily in research ethics to hopefully help ethics and health system and policy ethics, and so most of my work has been at sort of the health system and policy perspective. So that will be a lens that I'll be bringing today. And so with that in mind, you know, there are -- that's the -- that's the starting point for my reflections with you.

MS. MAHONEY: Dr. Gibson, with that, and you do address it in your slides, before we start with the role that you had in the COVID --

DR. GIBSON: Yeah.

MS. MAHONEY: -- 19 pandemic, I'd like to bring you back to work that you did and the paper that you produced --

DR. GIBSON: Oh, yeah. Absolutely.

MS. MAHONEY: -- post-SARS, Stand on Guard For Thee, and you do reference it here.

Just for the commissioners' benefit, I'd ask, Jen, could you pull up the article for the

commissioners? And, commissioners, I'll bring you to page 3, Jen, please. And keep going, please. Page 3 in the introduction. There we go. Thank you.

And I just refer you to this, and I'll read some extracts from it. It says:

> "When an influenza pandemic strikes the world, many people ranging from government and medical leaders to health care workers will face a host of difficult decisions that will affect people's freedoms and their chance of survival. There will be choices about the level of risk health care workers should face while caring for the sick, the imposition of restrictive measures such as quarantines, the allocation of limited resources such as medicines, and the use of travel restrictions and other measures to contain the spread of disease.
>
> Governments and health care leaders have been working on pandemic plans in many parts of the

world. However, most of their communication to the public has focussed on technical issues."

And I'll advance, Jen, a couple paragraphs on. There's a line at the end of the paragraph there that says -- the very last line that says:

"They need to do this in advance of a health crisis, not when people are lining up at emergency ward doors."

So if you could, please -- I know you've had extensive experience on the ethical side on pandemic planning, and this paper formed the basis of pandemic plans world-wide. And I would ask you to comment on this particular notion about the requirement to have planning in advance, not when people are lining up at the emergency ward doors.

DR. GIBSON: Sure, Lynn. Happy to do so.

So the genesis of this particular document, Stand on Guard For Thee -- which has definitely got a Canadian flavour by its title -- was based on experience with SARS. So in 2003,

then director of the Joint Centre For Bioethics Peter Singer convened a group of members of the bioethics community to reflect on some of the key ethical issues that had surfaced through SARS.

And, of course, SARS was a time-limited spring -- late winter/spring event, and so what we were able to capture just from that intense period of time were some insights that served to provide a direction for a possible ethical framework for pandemic planning in general. As you will recall, SARS took the Ontario Health system by surprise.

So there was around this time, though, I think especially in the wake of the Mailer report and other reports, there was a strong intention to really get ahead of the next pandemic and do some planning.

And so this was part of what was propelling our own thinking around developing Stand on Guard For Thee but also kicked off a number of years of work, I think including with the Ministry of Health, as Lynn had pointed out, which was to start thinking about what a pandemic influenza plan ought to look like for Ontario.

In 2006 and '7, at that point, I was part of a working group of the Ontario pandemic --

related to the pandemic influenza plan focusing on -- or doing some thinking about so what would be -- how might we approach antiviral and vaccine prioritisation, should the need arise.

But more generally, we also worked with the Ministry to -- to build the Stand on Guard For Thee framework into the 2008 Ontario pandemic influenza plan. And it was one of the opening chapters, if you will -- or sections of the opening chapters of that particular personal plan.

Subsequent to this, though, we continued to explore from a research perspective the ethical issues related to pandemic in the years of 2007 and following. This was led through the work of Dr. Russ Upshire, who is now the director of the Joint Centre For Bioethics, a primary care physician, and also one who worked very actively on the public health side during SARS, where we pivoted our attention not just simply to the articulation of ethical principles but engaging voices of the public.

And so we conducted a series of surveys right in the lead up to H1N1, actually, in 2008, 2009. And based on that, we were able to -- and then did a series of public engagement exercises

across the country as well, town hall discussions around some of the substantive issues.

This led into the creation of a set of policy briefs that captured some of those findings, and that was published in 2010.

So this is -- there has been a legacy of conversation and work related to ethics and pandemics in the Ontario context over a number of years. And this led in part, I believe, to the invitation to strike a bioethics table related to Ebola in fall 2014, where the Ministry's emergency management branch was starting to plan for the possibility of Ebola -- the Ebola virus presenting itself at Pearson airport and then potentially into the community. This is -- so the -- the pandemic ethics work has been unfolding.

There has also been some additional work that has been done in other sort of more specific topic areas relating to duty to care, to critical care and triage that also is being undertaken around this time.

So just to circle back, Lynn, to your question about the importance of being prepared, my -- my observation is that after SARS, there was a great deal of momentum around being prepared, and

we were fortunate to be a part of some of those conversations about what preparation might look like leading into 2008.

I note that in -- by 2013, the most recent version of the Ontario pandemic influenza plan is silent about the ethical framework of these ethical principles in a way. So it's much more technical again and perhaps less aspirational, less focused on the core values that may be animating that plan.

MS. MAHONEY: And could I just -- to that point --

DR. GIBSON: Yes.

MS. MAHONEY: -- the 2013 pandemic influenza plan, which was the last plan that we have, it doesn't articulate these ethical issues in a way you really warn about in Stand on Guard For Thee, the necessity of doing that.

And if I could just bring you to your paper Stand on Guard For Thee again and another warning in that regard.

Jen, if you could just scroll down? And I'm just -- let's see if I can find a page number here. Page number 4 in the top right corner. Okay. So the bottom of that page, please.

Leaders in government, that paragraph leaders in government. Yes, thank you.

The last sentence in that paragraph says:

> "Therefore, the lesson learned is to establish the ethical framework in advance and do it in a transparent manner."

A few lines down, it says:

> "Although these principles can sometimes be difficult to implement during a crisis, SARS showed there are costs from not having an agreed-upon ethical framework, including loss of trust, low morale, fear, and misinformation.
>
> SARS taught the world that if ethical frameworks had been more widely used to guide decision-making, this would have increased trust and solidity within and between health care organisations."

Is that a fair statement of what happens when you don't have these issues set out in

advance?

DR. GIBSON: I would say, Lynn, that there is perhaps -- I would nuance that a bit, and I would nuance it in the following way, that if you look at -- and at the tables that I've sat, I would say that a lot of these ethical considerations and values have been implicit rather than explicit.

So the question may be, what is the value of having explicit ethical frameworks? Not just simply knowing the value that -- that certain values are being surfaced, where their intention is being articulated, but people are using ethics like language like using -- being concerned about trust or being concerned about equity or being concerned about transparency. I mean, in many of the conversations that I've been part of by virtue of my roles, these terms, these ethical concepts are regularly and consistently being used.

Now, where -- how those actually translate into the lived experience of people working at the front line and providing care into public consciousness, into the -- into the experiences of patients and residents is -- is another question.

So one of the -- one of the

observations I would make, and it's with humility that I share this, is that even a couple of years ago when the WHO listed amongst its priority areas for research and development -- it usually lists, you know, a different set of diseases that are going to be priorities. And about three years ago, it -- it started to include disease X, and disease X was that unknown, that thing that we can't anticipate.

And I remember at the time thinking, hmm. Maybe now is the time to dust off Stand on Guard For Thee. You never know when disease X might arise. And I think this is something where I wish I had sort of -- I had sort of run with my instincts there, dusted it off, brought it back out into the public forum again so that it could become a framing document for what we might be dealing with.

Now, that doesn't quite address the issue of plan that, Lynn, you're pointing to. What was the plan in place --

MS. MAHONEY: Right.

DR. GIBSON: -- to inform decision-making at the end of February? And so the absence of the plan or lack of -- the perception

that there isn't a plan or a plan that seems to be evolving and changing may by itself actually contribute to degrees of trust or sense of solidity that may be experienced.

So ethical frameworks are important, and they are essential in making those explicit. It's really about making transparent the values that are informing decisions, and having plans in place -- even if imperfect. At least it's a starting point for building some of that trust and solidity over time.

So, yes, planning, having a plan, as imperfect as it may be, at least is a starting point. And we need to be able to -- and I think that's a future direction for sure that I would land on that we need to actually be thinking now, this moment about six months from now, planning for six months to ensure that we are in position to be able to continue to sustain and foster trust and solidity, particularly with those that are most vulnerable at this time.

MS. MAHONEY: Okay.

COMMISSIONER MARROCCO: Doctor, sorry the interrupt, but did I understand you correctly that there was pandemic planning in 2006, 2007?

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: And do you know what happened to it?

DR. GIBSON: Well, it culminated -- my understanding is it culminated in the 2008 pandemic influenza plan in Ontario. So there were discussions leading up to its development. I've been unable to find a copy of the 2008 plan on the internet. It used -- it used to be there.

COMMISSIONER MARROCCO: That in itself is not a good comment, but -- but, in any event.

DR. GIBSON: Yeah. So what you can find is the 2013 version of it, which is -- which I no longer see within that, the explicit ethical principles that had originally been in the 2008 one.

COMMISSIONER MARROCCO: Can you give me an example how that relates to long-term care, which is, of course, something that we're tasked with?

DR. GIBSON: M-hm. Yeah. So I would say that there's a couple of ways in which this may tie in. And, in fact, the principles themselves are sufficiently general so as to be applicable across a range of different settings.

So I can give you a few examples where I've seen in the long-term care context some of these principles come to bear.

So on the one hand, we think of locking down communities and society and putting restrictions on visitors. This is a restriction on what we would see is on the one hand individual liberty, individual liberty either from -- from the perspective of a resident wanting to see their family members on a regular basis. On the other hand, a population health priority, a duty to protect the public, which these two then become -- come in tension when we start to restrict visiting. We introduce IPAC measures that actually restrict what might normally be a free interaction of residents with whomever they should choose to have in the home with them.

So it's -- that's just one example where you -- where -- and we can think of a number of examples where that individual liberty and the duty to protect the public have come into tension within the pandemic. And articulating it in those terms serves to reveal what may be partly at stake in any policy choice that may be introduced.

COMMISSIONER MARROCCO: So we've heard,

for example, that when they introduced the single site restriction, you can only work at a single site --

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: -- at the same time, family members were being denied access to their family -- to their loved ones, which further -- the single site policy created a staffing shortage. We've heard that.

DR. GIBSON: Yeah.

COMMISSIONER MARROCCO: And the restriction on family members from providing care exacerbated the staffing shortage.

DR. GIBSON: Right.

COMMISSIONER MARROCCO: Would you get to a problem like that if you have an ethical framework, which circumscribes your response to the pandemic?

DR. GIBSON: I would say that the way in which an ethical framework works, at least in my experience, is that it does a few things. One, it makes a set of principles or core values explicit, so not letting them sort of sit implicitly operating and then subject to scrutiny.

Second, it can provide some parameters

within which decision-making may take place.

And then, third, because they may have a certain level of generality to them, they may be applicable across different settings.

So framing in the sense of helping to frame the ethical nature of a policy decision around, say -- which you point out -- single site restriction -- single site restriction of staff, and compounding that with restrictions around visiting culminates in residents not having access to the -- the same level of support of care that they would normally have had neither from staff or a family member.

And so what we see here is two things, I would say. One is on a pragmatic matter, which is you can have two entirely reasonable -- reasonably seeming policy directions, but when you layer those together, you end up with outcomes that were not desirable. So that's a -- that's a policy concern.

Would an ethical framework have been able to flag that in advance? Perhaps with the relevant information to inform the application of the ethical framework, but the ethical framework by itself might have done the following. It may have

put on notice -- it may have raised the question, what are potential adverse consequences of this policy choice if we want to minimise harm to long-term care residents? And so what would that be -- just follow that through. Policy option one, policy option two, what are the downstream consequences for long-term residents given a commitment to minimise harm to residents in the context of the pandemic?

So it's really the ethical thinking together with some evidence and policy thinking together, it's a -- it's a combination of the three that ideally should be sort of working for the benefit of long-term care residents.

COMMISSIONER MARROCCO: So just taking that example --

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: -- then I take it from what you said earlier, that sort of thinking has to go on in advance. It can't go on at the same time as you're trying to respond to the pandemic.

DR. GIBSON: Commissioner, I can say that it's going to be both. And so thinking -- anticipating what types of ethical issues might

surface means there's a state readiness in order to respond. And if you can actually flesh that out in terms of sort of walking that through and imagining different scenarios and sort of envisioning, so what would we do then if such and such were to occur?

But I think there's also you need to be able to, in the moment, in an evolving situation, be able to bring some of that thinking into -- into decisions, be responsive to the moment. Which may mean that what was initially imagined or envisioned in that planning may actually not look the same on the ground, in fact. And there may be other factors that come into play that may serve to recalibrate what might be a response.

So the simple answer to the question would be both/and. So it's not do all the planning work, and then you just implement. Planning is also a verb that continues in the midst of -- in the midst of the implementation as well as new knowledge emerges, as stakeholder feedback comes in that brings insight that might not have been there, and as we -- as we proceed forward. So both/and would be --

COMMISSIONER MARROCCO: Thank you. I'm

looking down, because I'm making a note.

DR. GIBSON: Okay.

COMMISSIONER MARROCCO: It's a compulsion that arises from an earlier generation of people.

DR. GIBSON: Oh, I'm a pen to paper person as well.

COMMISSIONER MARROCCO: Okay.

DR. GIBSON: No so -- computers, hmm. I like my pen.

MS. MAHONEY: Okay. So what I would like to do next, Dr. Gibson, is, if I could --

DR. GIBSON: Yeah.

MS. MAHONEY: -- situate you. We've talked about the importance of pandemic planning and the --

DR. GIBSON: Yeah.

MS. MAHONEY: -- importance of having an ethical framework set out in a pandemic plan. And you've told us that you did that work post-SARS --

DR. GIBSON: Yeah.

MS. MAHONEY: -- and it does not seem to have found its way into the 2013 pandemic influenza plan, that ethical framework.

If we could, I would just like to situate you in the work that you did during this pandemic.

DR. GIBSON: M-hm.

MS. MAHONEY: And if I could, Jen has put up a slide, and it comes from a presentation that we had several days ago about the response table structure. And this is as of March 5th, 2020.

DR. GIBSON: M-hm.

MS. MAHONEY: Jen, if you could just blow it up, please? And if you could just point with your cursor for the commissioners' perspective and Dr. Gibson's perspective?

The bioethics table is in red on this chart. So this is as of March 5th. She sits at the bioethics table, she is co-chair of the bioethics table, and that bioethics table, as I understand it, reports through to the command table. And I understand as well, Dr. Gibson, that you had a seat at the command table. Is that correct?

DR. GIBSON: M-hm. That's correct. That's correct.

MS. MAHONEY: Okay. And that command

table changes its name over time and eventually is named the -- I think the health coordination --

DR. GIBSON: Coordination.

MS. MAHONEY: -- table over time.

DR. GIBSON: Yeah.

MS. MAHONEY: So if we fast forward, Jen, if we could, to the next slide. And this is the later structure as of -- I think it's September.

DR. GIBSON: M-hm.

MS. MAHONEY: And you can see the --

Jen, if you could show the commissioners where the bioethics table is?

The bioethics table is there in this new structure, and then the -- where is that, the command table, the health coordination table?

DR. GIBSON: The health coordination table isn't on this slide. Right?

MS. MAHONEY: It's the health command table, sorry.

DR. GIBSON: There it is. Yes, the health command table.

MS. MAHONEY: Right. So those are the two tables that you are sitting at in the response to this pandemic. Is that correct?

DR. GIBSON: Yes. I will add to this as well that I was also produced as the co-chair of the critical care -- provincial critical care table. And then I also am a member of the science table. And I've also participated in a number of other sort of task forces and working groups as well along the way.

MS. MAHONEY: Okay. And I think we're going to -- we'll go through some of those task forces.

DR. GIBSON: Yeah.

MS. MAHONEY: Because I wasn't able find much information about them other than what you're going to be able to tell us.

DR. GIBSON: M-hm.

MS. MAHONEY: So if we could go, Jen, to the charter at the end of the -- Dr. Gibson provided us with a charter of the bioethics table.

And in there, there's the list of the people who --

DR. GIBSON: Yeah.

MS. MAHONEY: -- were members of the bioethics table. Is that right?

DR. GIBSON: Yes. That's the -- that -- yes, that's correct.

MS. MAHONEY: Okay. And this -- this list is as of when?

DR. GIBSON: So this was as of the end of October, and we -- there are -- there's just one small amendment in terms of membership. There has been one change --

MS. MAHONEY: Okay.

DR. GIBSON: -- since that time.

MS. MAHONEY: And was this -- this membership in the bioethics table, I assume it started, and we'll see along the way some various e-mails or meetings you had with the minister and --

DR. GIBSON: M-hm.

MS. MAHONEY: -- that long-term care was -- long-term care expertise was, I believe, added to this table at a certain point.

DR. GIBSON: Well, the -- not specifically to this table. I know long-term care expertise was added to other tables, including the Ontario health oversight table.

MS. MAHONEY: Okay.

DR. GIBSON: But there were -- maybe it may be helpful to just contextualise a little bit the genesis of this table and some of the thinking

that went into it.

MS. MAHONEY: Could you actually talk about that? Could you tell the commissioners how this came to be?

DR. GIBSON: Absolutely.

MS. MAHONEY: Because I believe it was you who contacted --

DR. GIBSON: Absolutely.

MS. MAHONEY: -- the deputy to strike such a table.

DR. GIBSON: So, commissioners, at the end of -- at the end of February, given the relationship of the Joint Centre For Bioethics has had over many years with the Ministry of Health over a number of different issues, I reached out to Deputy Minister Angus and said, "Look, it looks like we'll be moving into pandemic mode here. If there's anything that the Joint Centre For Bioethics can do to support, let us know."

Within -- I think it was later that day, I heard from Clint Shingler, who was director of the Ministry Emergency Operations Centre, flagging that a command table was being struck and that just as a heads up that I would be invited to join that table and that there would be interest in

me striking a bioethics table. So --

MS. MAHONEY: So is it your understanding it was your out-reach to Deputy Angus that then caused Clint Shingler to reach out to you?

DR. GIBSON: It may. It's hard to say, Lynn, because Clint Shingler and I had regular correspondence in the past. And it would be -- you know, the connection may have been made at some point in the future. I don't actually think it was my instigation, per se. It was just a matter of time. I just got ahead of the gate.

MS. MAHONEY: Okay.

DR. GIBSON: And so in comprising this -- this table, I was given no direction on what the table ought to look like. I was given free reign to comprise it. And some of things that I had in mind while putting this together was that it not -- that it actually have representation from across the province, that it have persons with expertise in clinical ethics, in public health ethics more broadly. So some members of the table have been working on the pandemic ethics work over the previous years. Was also wanting to ensure a mix of scholars and frontline clinicians, people

who were actually at the cold face of providing care.

And so to circle back to your question, Lynn, one of the things that I was looking for was how could we ensure that there is somebody with bioethics expertise who has insight into long-term care related issues? And it happens my colleague Paula Chidwick at William Osler and her team have been working on long-term care ethics over some time around those long-term care facilities affiliated with the William Osler Health System and then more broadly with the focus on effective -- or effective transfers between long-term care and hospital.

So my -- it was -- it was very intentional to invite Dr. Paula Chidwick to join the committee with that in mind.

MS. MAHONEY: Okay. Thank you very much. I think we're now going to go to, if we could -- subject to your presentation, I thought what I would do is I would walk you through some various policy briefs that I -- that were worked on or were issued by your table and whether or not you saw those recommendations adopted in --

DR. GIBSON: M-hm.

MS. MAHONEY: -- various documents that the government subsequently issued. So --

COMMISSIONER MARROCCO: Lynn, just before us that.

So you made your call, Doctor, at the end of February. So it was obvious to you. When did it become apparent to you that the province would have to be moving into pandemic? Or not have to be but likely be moving into pandemic mode? Can you fix that either in time or in an event?

DR. GIBSON: Yeah. I don't know that it's so much an event. It was something that I've been watching and reading about in the news starting in December. And also because of my relationship with colleagues with the World Health Organisation, I knew that a working group had been struck at the World Health Organisation -- an ethics working group had been struck and had been kept apprised to some extent by its chair, who was Dr. Ross Upshire, who then subsequently joined the bioethics table.

So it was really anticipating that we were going to be moving into pandemic -- in a pandemic mode and just wanting to ensure that we were ready to go.

So I -- to -- Commissioner, I wouldn't say there was a particular moment. It was really December and January and into February, it was starting to -- it was very clear that there was some movement towards the possibility of a pandemic being declared and -- and a desire on my part to ensure that we were able to contribute in somehow a positive way to that work.

COMMISSIONER MARROCCO: Okay.

MS. MAHONEY: If we could go to the -- so I understand the work of your table began in March, and I have here an ethics policy brief, brief number 3 --

DR. GIBSON: M-hm.

MS. MAHONEY: -- dated March 24th.

Jen, if you could pull that up, please?

Thank you. So it's dated March 24th, and so these -- so do I understand it that your table would work together, you were asked to work on an issue, and then you would develop a brief and then you would submit it somewhere? If you could just talk to us about that process?

DR. GIBSON: M-hm. Well, for this, and there's another related brief, a bioethics policy brief number two, both of which are pertaining to

PPE. I was hearing about concerns around access to PPE from multiple sources. Certainly it was a topic of discussion at the command table. My colleagues at the bioethics table and their institutions and the regions were surfacing -- surfacing concerns about availability of PPE.

MS. MAHONEY: Did you understand that there was an expired stockpile of PPE?

DR. GIBSON: This was -- I -- I subsequently -- I subsequently learned that. I think it was at this point a more general concern about supply chain. Would there be enough available? And so we were trying to anticipate as well as to be responsive to what we were hearing was a concern about a shortage that may be arising.

MS. MAHONEY: Well, in fact, this document, which is dated March 24th --

DR. GIBSON: M-hm.

MS. MAHONEY: -- the highlighted portion, it says that Ontario faces critical shortages --

DR. GIBSON: Yes.

MS. MAHONEY: -- of PPE. So at this point, that was critical shortage of PPE.

DR. GIBSON: Yes. Yes, there was. In

part because we were hearing from the institutions that they were difficulties sourcing gloves or -- and, of course, around this time, there were discussions about N95 masks. And so this was the science around whether or not N95 masks ought to be used, starting to raise concerns of, if we do need the use this product, do we have enough? So these shortages were very real.

MS. MAHONEY: Yes.

DR. GIBSON: And so there was a real concern about them. So now what do we do? This is our starting point.

MS. MAHONEY: I'd just like to refer you to pages 2 to 3 --

DR. GIBSON: Okay.

MS. MAHONEY: -- of this document.

DR. GIBSON: Yes.

MS. MAHONEY: At the very bottom of Page 2 moving on to Page 3, it says:

"Cohorting COVID-19 positive patients/clients/residents and thus cohorting staff who care for them should be considered."

So March 24th, 2020, the advice from your table up through to the command table is that

cohorting COVID-19 positive patients is a fact that must be considered?

DR. GIBSON: Yes. That's what we said here. And I was informed by our evolving understanding of some of the discussions that are happening relating perhaps to protection of patients and residents at that time. So this is a reflection of our -- our then understanding of what some of the options might be available.

In this particular context, what this would be pointing to would be that some of -- some of the concerns that have been surfaced was for staff. For example, if they would be working with patients, residents, or clients who may be COVID positive, they would not need to be donning and doffing quite so much. They could actually be present with the patients, residents, and clients in a continuous way.

And so cohorting was on the one hand potentially protective of other patients and clients and residents, but it might also afford the staff to be more present with -- over a duration of time with the patients, residents, and clients if they were together in a -- in a common place.

MS. MAHONEY: Okay .

COMMISSIONER MARROCCO: So if I can understand how this ethics table is working?

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: The ethics table becomes aware of the fact that --

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: -- the view is that there's a critical shortage.

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: And it responds by saying from an ethical perspective, if you have a critical shortage, then you should be cohorting staff -- well, everybody. You -- cohorting is an option --

DR. GIBSON: Is an option.

COMMISSIONER MARROCCO: -- that you should employ in order to respond in an ethical way to the critical shortage of PPE. Have I got that correct?

DR. GIBSON: What I would say, Commissioner, is if -- is that what we were -- so it is an option, and that's why we've framed it as a "should be considered." There were a number of different ways in which there were efforts underway to be able to provide better guidance or clearer

guidance to homes, to hospitals, and providers about how to use PPE.

And so, really, if the ethical framework has three phases or stages, one is about what steps can be taken to conserve or to stretch or to augment availability before priorities even need to be set.

And so one of the options that was being considered that happened at that time was the possibility of cohorting patients. So that's -- or residents.

So that's why it is amongst a list of different options for achieving the aim of implementing strategies to preserve an approximate standard of care and best IPAC practices to the extent possible within this supply.

COMMISSIONER MARROCCO: Okay.

MS. MAHONEY: So can you tell us, Dr. Gibson, so what happened with the brief? And was it -- was the recommendations of the ethics table then embodied in specific guidance from the government to the long-term care homes?

DR. GIBSON: So I -- I'm not sure how far this went in terms of direct guidance to long-term care homes, but I can describe how it did

inform the government's allocation approach to PPE based on its stockpile.

So it informed the -- so there -- a table was struck called the control table that was responsible for allocation of the stockpile. And so they -- the principles that we'd identified here and the overall approach through -- and stages that we proposed here served as the basis for the control table's framework, which I believe was in some of the documentation that you have pulled related to that exchange with Frederick Escar and Clint Shingler. So that's where the Ministry level uptake emerged.

MS. MAHONEY: Okay. And the cohorting, the recommendation about cohorting, are you aware of if that guidance was also given?

DR. GIBSON: I actually don't think that that was -- that was taken up. The -- the -- the -- when we -- when we shared the -- the ethics policy briefs, we shared it with those who were focusing on PPE allocation. It wasn't -- it was not shared with long-term care, per se. We were really seeing this as a PPE-specific issue.

And I note that cohorting then was not part of the conversation that was taking place at

the control table. It was really much more focusing on how to allocate the available supply out to high needs areas without looking at alternatives.

So I actually -- I'm not aware of how this policy brief may have been taken up and influenced other work by the Ministry of Health. I do know where it did influence for sure, and that's in relation to the control table.

MS. MAHONEY: Okay.

COMMISSIONER MARROCCO: There's a question from Dr. Kitts.

DR. KITTS: Yeah, Jennifer, I just want to go back to the PPE, because I'm sure you were aware of probably the continuous media frenzy around ONA and RNAO --

DR. GIBSON: Yeah.

DR. KITTS: -- pushing for the precautionary principle. And I suspect because of the shortage of PPE, it was very difficult. And it didn't seem to come out.

So in terms of the trust and transparency, it seemed right off the bat that trust and transparency didn't exist. Just wondering if your table dealt with that, and what

was the discussion around that?

DR. GIBSON: As I recollect, I don't think we went that far in terms of our own thinking around additional interventions to foster trust and transparency, other than what we were recommending here.

But -- but, Dr. Kitts, do you want to perhaps push that a little bit further? Just so I'm making sure I'm thinking in the same space as you are about this. Because I do indeed remember some of the real worries that people would not be -- staff would not be protected and yet being really torn between sense of professional duty to care and on the other hand not really feeling safe and being really unsure about the direction and guidance that was coming about of whether or not this was aerosolised or not as -- as per virus transmission. So it was a time of great uncertainty around this.

DR. KITTS: Yes. And so that's why they were pushing the precautionary principle.

DR. GIBSON: Yes.

DR. KITTS: It's uncertain if it was aerosolized, and in SARS, we saw what happened. So they were pushing for N95s. It came back that

there wasn't evidence to suggest we needed N95s, but the precautionary principle says you should overprotect.

And I'm just wondering, you know, it didn't come out that -- I'm sure if you told the nurses or the staff, "We're going to run out; we won't have enough, so we have to do this based on --"

DR. GIBSON: Yes.

DR. KITTS: "-- the circumstances." I don't think that other side of the serious shortage of PPE was well enough discussed, and it became a -- do you believe it's aerosol or -- or droplet.

DR. GIBSON: Yes. My sense too, and I think you may be able to even -- just from Ottawa Hospital, you would probably be able to comment on this as well to inform us. I think there was also -- what was revealed was a latent mistrust. I think that people were quite scared, and when they were, you know, anchoring to the precautionary principle, which is entirely reasonable in a time of uncertainty, we actually don't know for sure if an N95 would be required compared to something else or rather that the evidence was emerging.

But, nevertheless, the feeling --

regardless of the -- what type of protection were available, I think that the signalling of mistrust, the lack of safety that I'm not going to be protected was -- it was a reasonable fear that was being expressed.

And although, fortunately, we were -- there was -- you know, it didn't take too, too long for the availability of PPE to come online, it was still long enough for -- especially during that first month for health workers to feel quite wobbly about whether or not -- as they're at the front line of caring for patients and residents -- whether or not someone's got their back.

And so I would say that it raises a more broad question about how to communicate issues around risk and limitation in a way that fosters trust and fosters sort of shared understanding, especially when the evidence is changing.

So might it have been helpful if -- or -- or who would have been the appropriate spokesperson to have said, "Look, the evidence is emerging. This is our best advice. It may not be perfect. Here is -- we will keep you up to date. We will reassure you. But the answer is not always N95. It may be. We need to have a candid

conversation about what can be done, and let us work together to find solutions together to ensure that you are as safe as possible as well as your patients, clients, and residents."

And I don't think we were at a readiness to have those conversations, problem solving conversations, solution generating conversations, especially when there's so much fear during that time.

DR. KITTS: Yeah.

DR. GIBSON: It kind of goes back to wouldn't it have been great to have those conversations beforehand?

DR. KITTS: Yes, and hindsight is always 20/20.

DR. GIBSON: It's always 20/20.

DR. KITTS: And you've captured it well. I think what wasn't communicated -- what you said was communicated, it's the best evidence we have at the time, doing the best, but it wasn't communicated that we were seriously, seriously going to run out of PPE --

DR. GIBSON: Yeah.

DR. KITTS: -- if we didn't take these -- I think it was that side of the trust and

transparency that might have been well received.

DR. GIBSON: Yes. And I think this is where -- I mean, there was sort of a -- it would be reasonable for somebody on the front line to think that information was being withheld. Something just didn't -- something didn't quite feel right.

And so a transparency, you know, has been a theme throughout the pandemic, particularly related to the transparency with the public, let alone with patients, residents, and staff.

But this was a time when, I think, in retrospect, this should be a -- let me put it this way. I'm hopeful that one of the lessons we may have learned from the pandemic is that there is confidence-building that comes with transparency even about the direness of our situation and what is being done to mitigate that and what measures are in place and what supports may be available so that people are not second guessing.

So these are for risk and communication, but I think it's fundamentally something about how government and how ministries and how institutions relate to those who are, you know, the most vulnerable -- staff, residents and clients -- and in a way that actually acknowledges

that there is this power difference in terms of information that is especially transparent. That was especially transparent in March. Absolutely.

DR. KITTS: Yeah. You've captured it very well. Thank you.

MS. MAHONEY: Dr. Gibson, just to take that point.

DR. GIBSON: M-hm.

MS. MAHONEY: Given the fact that we now know -- and this Commission has heard that there was a stockpile and the stockpile was expired and the stockpile was in the process of being destroyed, that, I would think, would be a factor that would be important to relay and -- and to overlay over the precautionary principle, because the precautionary principle says, just do what you now know.

DR. GIBSON: M-hm. M-hm.

MS. MAHONEY: But if you don't have the N95 masks because they're all expired or they've been destroyed, then you can't use them. But you don't recall that that discussion took place, do you?

DR. GIBSON: I --

MS. MAHONEY: "You can't have N95s,

because we don't have any"?

DR. GIBSON: Yeah. So this was certainly conversations that were happening at various tables, but I -- I wasn't always party to how this was being communicated out.

I know that there was some work underway to try to see if there were -- if the stockpile had -- was salvageable in certain ways. So were there some items in the stockpile which could be used for different purposes rather than simply seeing it discarded? And so some of that investigation was going on concurrently. So trying to salvage what we could.

But, you know, it's -- it's a difficult message to communicate out that one of the reasons why we don't have enough PPE is because we don't have a stockpile of PPE to start with.

MS. MAHONEY: But --

DR. GIBSON: So, you know, I could -- this is -- that's a type of transparency that shows that we weren't prepared.

MS. MAHONEY: Right.

DR. GIBSON: Which is a difficult message to communicate.

MS. MAHONEY: AND --

DR. GIBSON: I think there are also other differences, though too, Lynn, which was that different institutions had better capacity to be able to leverage the supply chains than others and to even be able to store PPE.

So there were some additional vulnerabilities that were revealed related to the supply chain that were less transparent unrelated to stockpile, per se, but more so related to just differences in capacity to be able to tap additional supply compared to others. And which is, you know -- which is something that -- would go, again, concurrently even with a stockpile, there may still be some challenges in terms of availability just through existing supply chain.

So, yeah, I'll just leave it as that.

MS. MAHONEY: Okay. Thank you.

COMMISSIONER MARROCCO: Do I understand that the ethics table --

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: -- which is wrestling with this tension between the duty of a professional person to care for a sick person --

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: -- and the

right of a professional person to be as protected as possible from the effects of the disease they're trying to treat, that the ethnics tables' consideration of this conflict expresses itself in the form of a recommendation to the control table? Is that how the ethical conversation evolves?

DR. GIBSON: That's one way in which it evolves. So these policy briefs were shared with Ontario Health and the -- the five regions. It was also shared with the Ministry. And because it was sufficiently --

MS. MAHONEY: Ministry of Health or Ministry of Long-Term Care?

DR. GIBSON: Ministry of Health.

MS. MAHONEY: Thank you.

DR. GIBSON: Ministry of Health, because it was -- the control table was actually struck by the Ministry of Health. It was co-chaired by -- it -- its genesis was from the Ministry of Health, but the control table had representation from a variety of different ministries, including long-term care.

So our -- the reporting relationship of the bioethics table, which was to the command table, which was chaired by -- co-chaired by the

deputy minister of health, the chief medical officer of health and the CEO of Ontario Health was our first line of -- first line of contact.

COMMISSIONER MARROCCO: Okay.

MS. MAHONEY: And so if we could move -- Jen, if you could put up the document that shows the -- I don't know what document number it is, the e-mail chain with Brian Pollard and Ms. Gibson dated April 8th?

And I believe, Dr. Gibson, you indicated that you had a meeting.

And if we scroll down through the -- if we scroll down through that e-mail chain to the very bottom?

DR. GIBSON: M-hm.

MS. MAHONEY: It indicates that there was -- you sent an e-mail on March 25th, I believe. And I think when we spoke, you indicated that you had had a meeting on March 25th with the bioethics -- with you and Dr. Smith. You met with Deputy Minister Steele and Brian Pollard about long-term care transfer.

DR. GIBSON: Yes.

MS. MAHONEY: So you had a meeting. And then does this e-mail, March 25th e-mail,

follow up on this meeting?

DR. GIBSON: Yes, I believe so. I've got my notes sort of here. I believe that's -- that's correct.

And I would say that what precipitated the meeting in the first place was a conversation at the command table that had surfaced concerns that we were starting to hear about -- long-term care was starting to hear and also I was aware of as well that there were some -- some concerns being raised about whether or not long-term care residents were having access to hospitals.

And the precipitating concern from my point of view, which, you know, sort of compelled me to raise to the command table was a letter that had gone out from Quinte Health Care to long-term care facilities suggesting that long-term care patient -- the residents should not be transferred to hospital. And so this obviously raised some concerns.

So this was flagged at the command table, and the intention was set between Deputy Minister Steele and myself to circle in. And hence this change of this meeting, subsequent change of conversations, and then subsequently the creation

of a -- of another policy brief with long-term care input into that.

MS. MAHONEY: So if --

COMMISSIONER MARROCCO: Doctor, was there any consideration from an ethical perspective about the idea that somebody --

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: -- would decide that you can't go to a hospital? You can't physically get yourself to the hospital, because you're infirm in some way --

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: -- and so someone decides that you won't go to the hospital? Was there any discussion about the -- about how or the appropriateness of this kind of decision?

DR. GIBSON: So there are different -- there are different decision-makers that -- that might be relevant here.

One actually may be simply the resident themselves. It may be -- they may not wish to receive acute care, and this may be part of their, if you will, treatment plan. Or their substituted decision-maker so that is one decision-maker that would inform whether or not a resident would be

transferred.

The second might be on the direction of a medical director at the home, whether the -- this -- the patient -- the client's needs or the resident's needs were requiring a level of care, which could only be provided at hospital, in which case, that would be a medical decision.

And then the third decision-maker. And I think what was really precipitating this exchange with our colleagues in the Ministry of Long-Term Care was a decision by a hospital, a letter that was issued by, I believe, their -- I can -- you know, the -- it was picked up in the media, a decision to not -- recommending that patients not be transferred as part of the COVID response to protect the acute care system.

So those are three. And really we were responding to the third, the concern that, in fact, that residents might be denied access to acute care, which they were certainly entitled to access to acute care if it's needed and if it's wanted even in a pandemic.

MS. MAHONEY: And that was advice and that was the subject matter of the brief?

DR. GIBSON: That's correct.

MS. MAHONEY: And if you scroll down the e-mail chain, Jen?

You can -- we can see the e-mail brief that was submitted, ethics table, policy brief number 4, and entitled "Access to Acute Care By Long-Term Care Residents During the COVID-19 Pandemic." Where did that brief get sent?

DR. GIBSON: So this was sent to Deputy Minister Steele and Assistant Deputy Minister Brian Pollard in follow up to the phone call we had.

They had also, along the way, done some of their own thinking and making suggestions to us, which is part of that e-mail chain you've provided. One of their key suggestions, which we took on wholeheartedly was to -- in addition to providing ethics-informed guidance, that we seek to see how this lines up with the Long-Term Care Act in terms of the resident rights enumerated there, which is what we did in this particular guidance that we sent back.

MS. MAHONEY: Okay. Okay. So if we could move to -- I believe you had a meeting on April 13th with Minister Fullerton and Deputy Minister Steele, and we have some April 14th e-mail exchanges with deputy Steele --

DR. GIBSON: Yes.

MS. MAHONEY: -- after that. So if you could --

DR. GIBSON: Yes.

MS. MAHONEY: -- tell us about that meeting that you had with Minister Fullerton and -- and then about this e-mail exchange, please?

DR. GIBSON: Sure. Happy to. So this -- this meeting with Mr. Fullerton and Deputy Minister Steele arose following the release of a critical care triage framework, which the bioethics table had worked on quickly through the month of March as we were watching what was happening in Italy and seeing in New York and the real concerns about the possibility that we might find ourselves facing a major surge in demand for critical care and sort of a sense of urgency to at least have something available to provide guidance out into the field.

And that would have been released to the hospital sector and critical care folks on the 28th of March. And it was -- it was a green document, and we knew that we would learn a great deal from feedback that might emerge along the way.

The -- Minister Fullerton wanted to

speak to us about this, because in the document -- and it's something that -- which was subsequently very quickly corrected, and it was an oversight. There was -- there were concerns about whether or not this might actually mean that long-term care residents might not have access to a hospital, let alone -- hospital and critical care in a pandemic.

And so she wanted to broach this with us and to flag this as a concern and ask that we give serious consideration to the needs of long-term care residents to ensure that they weren't disproportionally disadvantaged by a critical care triage approach.

MS. MAHONEY: So can I just understand? So there was a document that was issued from the ethics table about access to critical care, and it was subsequently amended, was it? Was there some --

DR. GIBSON: Yes.

MS. MAHONEY: -- issue that it missed or --

DR. GIBSON: It has been significantly amended in a number of different ways. Obviously during week one, certainly during March and April, we did not face a major surge of demand in critical

care such that triaging of critical care services was required.

MS. MAHONEY: Right.

DR. GIBSON: Once the document was release -- and it was actually in collaboration with Ontario Health -- it was released out into the field, we started to receive letters back from a variety of different organisations, patient -- or human rights stakeholder organisations. We also heard from associations, so Ontario Medical Association, the Ontario Hospital Association.

Some of those letters came directly to me with having read the document, offering advice and some direction and querying some things that were of concern. Sometimes these are sent directly to the minister -- the Minister of Health.

MS. MAHONEY: M-hm.

DR. GIBSON: And her office would then send these along to us. So we were throughout the month of April gathering in all this really constructive, helpful feedback, and we began to iterate the document.

So this was Minister Fullerton reaching in to share her views on what she had seen and raising some of her concerns was actually part of

a -- part of a series of similar sorts of conversations or letters that we were receiving that were really helping to sharpen our attention to some issues we had missed.

MS. MAHONEY: So what was the issue about the advice that was offered that the minister was flagging? Or what was the concern that had to be addressed?

DR. GIBSON: There was a diagram in the document that I --

MS. MAHONEY: I'm sorry. I don't have the document, so...

DR. GIBSON: Yeah. It's -- yes. And it's not a public -- it hasn't been a public document.

MS. MAHONEY: No.

DR. GIBSON: But I'd be happy to share. It's been superceded. It was no longer -- it was never implemented, and it's certainly not the most contemporary version of the first document.

But in the first document, there was a diagram that was showing sort of a -- trying to demonstrate what a proportional response would be. So if there was a major surge, it ought to only be access to a standard of care, and access to

critical care services should only be as restricted as is required in order to be able to be -- to sort of -- to meet that demand. And as demand eased, it then -- access to critical care should be less so. So this is trying to demonstrate this proportional response.

In it, there was a small section that said something along the lines of not permitting transfers from long-term care, which I missed. I think other members of the bioethics table may have missed it as well. So it was really important for Minister Fullerton to flag this with us, because it certainly was not our intention to -- especially since we have been talking about transfers between hospital and long-term care in the preceding weeks, it was something that had been missed. It was an older version of the diagram.

So that was a correction that we made. And there have been subsequent iterations since then that we make very explicit now in the document that access to critical care should not be determined by what your home is, where you happen to be, let alone any -- let alone any considerations of demograph -- demographic disability or disease.

MS. MAHONEY: So can I understand this? So there was a document that did get released that did have that statement in there that long-term care residents --

DR. GIBSON: It had a small -- small section of a diagram that -- that -- that indicated that. It was not in the text of the description of the document. So it was a dissonance that we needed to correct.

MS. MAHONEY: Okay. And who produced or disseminated that document?

DR. GIBSON: The document, it was produced by the bioethics table through the month -- month of March, and then it was disseminated by Ontario Health.

MS. MAHONEY: Okay. And so that was -- then had to be subsequently rectified. And probably did that have any relationship with the Quinte Hospital saying that they weren't going to accept long-term care residents?

DR. GIBSON: It -- it certainly did not -- to my mind, these seem to be entirely separate issues and certainly was not a topic of conversation was -- certainly the bioethics was not understanding this as the extension of the Quinte

situation at all.

MS. MAHONEY: Okay.

DR. GIBSON: It was much more focussed on how one would set priorities for access to critical care. So this was a very significant oversight that we flagged, and we fixed. So we were really grateful for the minister flagging that for us.

MS. MAHONEY: Okay. And that resulted in this ethics brief number 4, access to acute care by long-term care residents?

DR. GIBSON: Actually, that was the -- policy brief number 4, which was access to care, this was actually -- this -- we were treating these as separate. There was a critical care triage work and long-term care transfer work. So these were not connected documents.

We were certainly not thinking about critical care triage when we drafted the ethics policy brief. Was -- if a long-term care resident needs acute care, whatever the nature of that acute care is, and if they wish it, they should have access to it was the -- was what we were stating here in the ethics policy.

MS. MAHONEY: So there was a

distinction between acute care and critical care?

DR. GIBSON: Not in the ethics policy brief. We were not drawing that distinction at all. The critical care triage work was one that -- as I'm suggesting, it was something that I missed in the diagram. I would certainly not have advocated and did not advocate that long-term residents should not have access to critical care. And, in fact, that was inconsistent with the rest of the document. But we were really seeking to be non-discriminatory to best of our ability.

MS. MAHONEY: Right.

DR. GIBSON: So that was where it was a correction that was made.

MS. MAHONEY: Okay. Thank you.

So in this e-mail chain, there's a discussion -- your e-mail to Minister Fullerton and Deputy Steele talk about engaging with Ministry of Long-Term Care --

DR. GIBSON: Yeah.

MS. MAHONEY: -- on an ongoing basis. So is this a new development as of -- I believe it's April --

DR. GIBSON: Yeah.

MS. MAHONEY: -- that you were going to

engage with Ministry of Long-Term Care?

DR. GIBSON: So it was an invitation to engage. And we had not previously had any interaction with long-term care prior to the pandemic, so this was a new set of relationships that we would be cultivating.

And so -- but there seemed to be interest from the Ministry of Long-Term Care, starting with the initial meeting on March 25th around the question of hospital long-term care transfers that lead to the creation of the -- the ethics policy brief number 4.

Then this conversation that we had with Minister Fullerton and Deputy Minister Steele on April 13th that was -- we were -- Max Smith and I as co-chairs of the bioethics table, we were reinforcing our willingness to continue to engage and to work there.

This was followed by a subsequent meeting, which -- which we had -- that I had with Minister Fullerton together with my colleague who I mentioned earlier in the call, Paula Chidwick, whose bioethics team at her hospital are doing quite a bit of work with long-term care institutions.

We had follow-up call at the request of Minister Fullerton, who was thinking about -- was beginning to ponder what would be some of the -- what would be the need for -- like, we're -- given that consent is required in terms of treatment plans for long-term residents, how did that fit with the possibility of cohorting or specifically transferring patients -- not patients, pardon me, residents out of long-term care into other facilities?

And so she was opening it as a question. She was thinking about it, and she wanted -- she was inviting us to be a sounding board with her on that particular issue.

MS. MAHONEY: Okay.

DR. GIBSON: So that would have been -- and I'm just looking at my notes.

MS. MAHONEY: So there's an April 20th e-mail exchange with you --

DR. GIBSON: That's right.

MS. MAHONEY: -- and Brian Pollard relating --

And if we can pull that up.

DR. GIBSON: That's correct. Thanks for flagging that, Lynn. Yes, there was a

follow-up exchange with Brian Pollard on the 20th, which was in response to earlier conversations and exchange that we --

MS. MAHONEY: It's not this one, Jen King. It's not this one. There's other one.

DR. GIBSON: That's the testing. And we wanted more -- the impetus for this was to, again, to reinforce our willingness to work with long-term care -- the Ministry of Long-Term Care and around priorities that they thought were front of mind.

And so that's where we had floated, of course, long-term care transfers, issues -- questions related to isolation, cohorting, and decanting. And Brian had responded and said it's in testing.

MS. MAHONEY: Can you talk to us about the issues of -- because this Commission made in one of its interim reports -- urged the government to consider the issue of decanting.

DR. GIBSON: Yeah.

MS. MAHONEY: And so we haven't seen decanting being taken up by the government to any great degree.

DR. GIBSON: Right.

MS. MAHONEY: Definitely not in wave one --

DR. GIBSON: Yes.

MS. MAHONEY: -- of the pandemic and perhaps to a small degree in wave two. I understand there was a field hospital that was --

DR. GIBSON: Yes.

MS. MAHONEY: -- erected.

DR. GIBSON: Yes.

MS. MAHONEY: Could you talk to us and tell us whether or not you issued any ethical briefs? I haven't seen any related to decanting.

DR. GIBSON: We have not, actually, issued anything. We were working on a draft and -- in anticipation of a follow-up exchange with Brian, but that did not materialise.

MS. MAHONEY: And what do you mean, that did not materialise?

DR. GIBSON: So we had -- in response to this, I have been looking for -- I've been anticipating that the Ministry of Long-Term Care might follow up with us on these issues, and they did not.

I will -- I just flag that around this time, my sense at the time too was that there was

a -- there was a great deal of activity happening related to long-term care in response to the outbreaks that were emerging, and so I -- in some ways, I felt like this fell off the -- our exchange related to ethics and long-term care fell off the radar. And so we -- and I take responsibility for this. I did not pursue it further in anticipation that if our support would be needed, that we would hear from long-term care about this.

MS. MAHONEY: And what issues are you referring to in particular? Decanting. Any others?

DR. GIBSON: No. No. These -- these were the only ones that we had floated. And his response was about testing but didn't have any insight into specifically what his concerns were about testing.

MS. MAHONEY: Okay. So in your e-mail to Brian Pollard, you indicate -- and this is the e-mail of --

DR. GIBSON: April 20th.

MS. MAHONEY: Yes. It says:

"I've been invited to the long-term care COVID action plan implementation and intervention

table meetings --"

That's quite a mouthful.

DR. GIBSON: M-hm.

MS. MAHONEY: "-- this week."

DR. GIBSON: Yes.

MS. MAHONEY:

"With this in mind, I'm circling back for your advice on priorities of the ethics table.

Two immediate thoughts. Number one, evacuate versus isolate issue, which the minister flagged with me last week, and number two, acute LTC transfers -- I think this is referred to as decanting -- at this weekend's command table meeting. Are these the priorities?"

So you raised with him on April 20th the issue of decanting?

DR. GIBSON: M-hm.

MS. MAHONEY: And I can see in a meeting agenda of April 27th --

Jen, if you could pull that up, please?

There's an April 27 meeting agenda.

MS. KING: Which document number is it?

MS. MAHONEY: I -- it is -- if you just -- in the file that you sent me. Oh, Document 13, I believe. It's a meeting agenda. Meeting -- so it's -- the meeting agenda is a meeting with Blair Hains and Deputy Steele, and the date is April 27th. The meeting invitees are Deputy Steele, Blair Hains, who is chief of staff of the Ministry of Long-Term Care at the present time, and Jovana Blegodic from the Ministry of Long-Term Care.

And there's an agenda item, and if you can see, number two refers to hospital long-term care transfers memo. And then it says "parameters" and then it says:

> "Decanting, ethical issues around consent and moving, call with Jennifer Gibson."

DR. GIBSON: Correct.

MS. MAHONEY: So I don't have -- I note that you told me that on April 28th, you began working on the long-term care transfers during outbreaks brief. And is that the decanting work that you were referring to?

DR. GIBSON: Yes. And -- yes, that's correct, Lynn. And the phone call, this I see --

this is the first time -- well, last night was the first time I'd seen this agenda item.

The phone call that this is referring to is the phone call which -- that I and my bioethics colleague Paula Chidwick had with Minister Fullerton later that day.

MS. MAHONEY: And what was the discussion about decanting?

DR. GIBSON: So the question was really related to whether or not consent is required for transfer of long-term care patients for the purposes of -- in the case where it may be to protect the patient or to actually create -- to serve better social distance -- or better isolation within -- within a home.

MS. MAHONEY: Okay. So as far as you knew, the issue -- was the issue of decanting being considered by the command table as to what could be done to decant residents from these long-term care homes?

DR. GIBSON: I would have to take from this agenda that, yes, it was. I think it was -- I certainly noted in my e-mail to -- to Brian that this was -- the word decanting had come up at the command table, and it's right around this

particular time.

MS. MAHONEY: Okay. And did you -- were you asked to provide and did you provide any advice with respect to decanting?

DR. GIBSON: We did not provide any advice, although anticipating that we might be asked for such an advice, we did start working on a policy brief.

MS. MAHONEY: And what would the -- did you run it to ground? Did you land anywhere on what the advice was with respect to decanting?

DR. GIBSON: There was -- there was some -- we were -- it was still in draft. We were still working on it. And I think that there was an appreciation that, on one hand, the -- the rights of -- of long-term care residents are both to be safe and also to be able to have control of what happens to them.

And so this was a tension between those rights, and so we were working through those issues on how to balance those rights particularly in relation to decanting.

But we didn't -- we didn't go any further than that. We do have a draft version of the document, but we didn't go any further.

MS. MAHONEY: So since this timeframe, April 27th, April 28th, you've not been asked to provide any further advice on it?

DR. GIBSON: We have not, no.

MS. MAHONEY: And so to the extent that the government has issued or made any decisions regarding the issue of decanting, it hasn't benefitted from your input, the input --

DR. GIBSON: That's correct.

MS. MAHONEY: Okay.

DR. GIBSON: That's correct.

COMMISSIONER MARROCCO: Was the general format, Doctor, then that a policy issue would be referred to the ethics table, and it would, in effect then, be asked for an opinion?

DR. GIBSON: There were a number of ways in which this would happen, Commissioner. Sometimes it's exactly as you described. So sometimes we might have the question posed to us, and we would say, "Well, let us take it away, circle back, and get back to you," which we try to do within the week.

Sometimes we would surface an issue and say, "Look, this actually is something that requires attention." And surfacing the issue might

or might not lead to the creation of a policy brief.

But I'll give you one example. One was we were anticipating that at some point during the pandemic, we might experience shortages of drugs or other types of -- other types of products that might be required. So we drafted an ethics policy brief related to that. It was led by another member of the bioethics table.

And so then that was taken forward into our colleagues within the Ministry of Health as an offering of help and support if they were moving in that direction.

A third way in which we might be asked to have input would be on a document that was being drafted within the Ministry of Health and would be -- would be -- so as part of its consultation, reaching out to a range of different perspectives.

It would sometimes come us to be able to provide an ethics lens on -- on that -- that piece of work. This also included a few of the directives that were developed through the CMOH, the staff, especially in the early days, in March and -- in March and early April.

And then, finally, there would be

occasionally times just -- just being at the command table, I might surface an issue, raise a question, and sometimes that wouldn't necessarily come back to the bioethics table, but it might be a consideration that would taken forward by others who were doing related work.

We didn't always feel that an issue needed only be addressed by the bioethics table, but part of our role would be to surface an ethical issue with those who might actually need to contend with it in terms of they continue their work, which might be more operational than we were well-suited to do.

COMMISSIONER MARROCCO: How many policy briefs were produced?

DR. GIBSON: So we published -- we've got five. We've got -- I'm just -- I'm sort of scrolling through my head, because the policy brief evolved a bit. I believe we have seven -- I will confirm that -- not all of which were published. As I noted, the one not published because it was still in the works was the one that Lynn was mentioning related to April 28th.

MS. MAHONEY: The decanting? The decanting one?

DR. GIBSON: The decanting one.

MS. MAHONEY: And if I'm correct, Commissioner, I believe there are two about prioritisation of PPE. One is within the health care sector and the other is a regional/provincial one. There's two on those. There's one on swabbing, which -- prioritisation --

DR. GIBSON: That's correct.

MS. MAHONEY: -- of testing supplies, which we are about to talk about. There is another one on --

DR. GIBSON: There was one on drugs, drug shortage.

MS. MAHONEY: Yes, and access to acute care by long-term care residents, which is brief number four.

DR. GIBSON: That's right. And then there was the first one, which was about -- during the time when the hospitals were focusing -- going to be focusing only on emergency and emergent care needs, so going be to ramping down of elective and scheduled surgeries and procedures.

MS. MAHONEY: That's the critical care one that you referenced earlier?

DR. GIBSON: No. Actually, this is one

that was really about service reduction just in general. So that would have been -- and so that subsequently went on to inform some of Ontario Health's guidance to the field about how they should manage procedures and surgical volumes during the -- during the -- the -- during wave one. So we were providing guiding principles for that work.

MS. MAHONEY: Okay.

COMMISSIONER MARROCCO: Can I -- Jennifer, did the visitors policy come across your table, and was ethics involved in that one?

MS. MAHONEY: Commissioner, it does, and we're about to get into that, because that comes up in June.

COMMISSIONER MARROCCO: Okay. It wasn't on the list.

MS. MAHONEY: No, it isn't in the list, but we're about to get to it in June. And there was a -- there was input from the bioethics table, and we can talk about that. If you're okay, Commissioner, I was going to get -- the next one sort of chronologically was the testing supplies, priority of testing supplies, if you're okay to go there right now.

COMMISSIONER MARROCCO: Absolutely. I apologise. I thought you'd given us a list, but clearly it's -- so go ahead, yes.

MS. MAHONEY: Okay. Thank you. So if we could pull up the document, Jen, relating to the testing swabs?

And as I understand it, Dr. Gibson, there were -- you were invited to a meeting, I believe, on April 21st with a panel that was called long-term care COVID action plan implementation intervention table, at which time there was -- and I understand that the --

If we could look at the agenda? Sorry, Jen, to confuse you, if we could look up the calendar invitation for that meeting. And it has an agenda for that meeting. And the agenda for that meeting...

MS. KING: I apologise. It's opening now.

MS. MAHONEY: Yeah. Thank you. There's various items here: lab capacity and testing and long-term care testing report is listed there. I understand you attended some of these meetings. Is that right?

DR. GIBSON: I attended two of these

meetings, and then this -- this table, I understand, was replaced by the long-term care IMS structure, And we were not invited to participate in that structure.

MS. MAHONEY: Okay. And I understand that you did have involvement in generating a policy brief -- an ethics brief, I apologise, with respect to prioritising testing swabs.

DR. GIBSON: That's correct.

MS. MAHONEY: Okay.

DR. GIBSON: That came, though, not from the long-term care action plan intervention table. This actually came from Stephanie Lockhart on behalf of the testing strategy expert panel, which was -- I believe the commissioners would have heard a bit about from Jenny Johnston and from Vanessa Alan (phonetic) as well in previous -- in previous meetings of the Commission.

MS. MAHONEY: That's right. So if we could -- if we could pull up? There's a brief.

DR. GIBSON: Yes. And this is the brief right now.

MS. MAHONEY: Okay. So if you could talk to the commissioners about the issue that was before you about -- I understand there was a

shortage of --

DR. GIBSON: M-hm.

MS. MAHONEY: -- testing supplies and swabs.

DR. GIBSON: There was an anticipation that there may be a shortage, and so this was to -- this was an example of the expert panel trying to get ahead of that to try to be able to think how they would set priorities for the use of those swabs if the shortage materialised.

Fortunately, the shortage of materials did not materialise, but this was some early thinking that we did with them. You'll notice here that some of the copy edits -- there are copy edits that were added by Stephanie Lockhart at OH and her team.

So we got to the point of getting varying input on this but did not take it further, because it proved not to be needed but could be dusted off and made ready if it -- should it be needed in the future.

MS. MAHONEY: And am I correct that this is premised on -- and the guidance given is premised on the fact that priority testing should be -- and it says:

"Priority should be given to populations that are at increased risk of exposure --"

DR. GIBSON: M-hm.

MS. MAHONEY: "-- and/or vulnerable."

DR. GIBSON: That's correct.

MS. MAHONEY: And that would include long-term care?

DR. GIBSON: Absolutely.

MS. MAHONEY: Is that correct?

DR. GIBSON: Absolutely. Because you might recall too that concurrent with this time, the testing strategy expert panel was also looking at testing in terms of priorities for testing. So the -- this was going to be complementary to some of their work they were trying to do, trying to clarify who the vulnerable populations are and really bringing sharpness to that.

And if you scroll down a little bit, you can see how priority populations -- I think there's a little bit further down -- one of the populations that is flagged explicitly by the team responding to this pulls out the vulnerability priority populations related to long-term care, organisations in outbreak, and then northern

communities. So they had started to flesh out who those priorities -- priority groupings would actually be.

MS. MAHONEY: So as I understand it, this brief was never finalised or delivered. It just remained in this draft form?

DR. GIBSON: That's correct. That's correct. And so we -- we -- we sort of in our own -- in our own work plan, this is -- this is a sleeping document, but it could be reawoken if it -- should it be needed.

MS. MAHONEY: Okay. Were you asked a -- was the bioethics table asked to provide advice with respect to testing in terms of the lab capacity and the prioritisation of testing populations given the lab capacity in Ontario?

DR. GIBSON: Not specifically, no.

MS. MAHONEY: Okay.

DR. GIBSON: No.

MS. MAHONEY: Was that an issue that was discussed at the command table, that you're aware of?

DR. GIBSON: This -- let me think about this. It would have been one -- certainly one of the report-ins. I would certainly be able to

circle back into my notes to be able to clarify that for you.

MS. MAHONEY: Thank you. So if we could move to your -- there's e-mails regarding June 11th of 2020. If you could just pull those up? And this, Commissioner --

MS. KING: Bear with me a moment. I'm having some issues with opening.

MS. MAHONEY: Okay. Commissioner Kitts, we're now going to move into the issue of the -- issues that Dr. Gibson was hearing about the essential visitor policy.

MS. KING: There it is.

MS. MAHONEY: Okay. So, Dr. Gibson, you wrote an e-mail to Mike Heenan, the Ministry of Health, and Brian Pollard, the Ministry of Long-Term Care, with respect to concerns that were being identified related to the essential visitor policy.

DR. GIBSON: M-hm.

MS. MAHONEY: So could you, please, tell the commissioners what your involvement was in this and what the issues were and what advice was being given? So this is in June of 2020.

DR. GIBSON: That's right. And for

context, it was around this time that the Ministry Emergency Operations Centre was going through a review and edit of directive number 3. So I think that if there was a great deal of concern at this point in general, we certainly have been heard that the restrictions around visitor policy was actually -- there needed to be some changes to those restrictions, and so that was happening concurrently.

But what precipitated this e-mail was a meeting that I -- I was part of with the regional bioethics lead. So right from the very beginning, the bioethics table was struck. For each of the five Ontario Health regions, a bioethics lead was identified. So we met weekly on what are issues not just institution-specific but might be regional or potentially provincial related concerns.

And one theme that through the -- partly through May but certainly reaches a point of acuity by May and into June were concerns about visitor policy. This one was a bit of a unique issue that was speaking to the intersection between the -- the movement of patients between a hospital and a long-term care home, often within the same local health system.

So many, many hospitals have agreements with long-term care homes, and so what -- and in some cases, if they're sited -- geographically sited together, in some of those long-term care homes, there might be the palliative care unit is housed there. And so a patient might have been receiving care within the hospital and moved to the palliative care unit.

And so what started to emerge was there was dissonance in between the -- in some cases the guidelines around visitors in hospital versus in a long-term care setting, where the long-term care setting were in most cases much stricter than they were in the hospital.

So there were patients and families using -- well, let's use palliative care in this case as an example. Whilst they were -- the patient was in hospital, their family member would have been able to have ready access to them, whereas when they moved into palliative care units there was a change in terms of access.

So this was to flag. What I was seeking to do was to flag for Mike Heenan, who was ADM responsible for hospitals, and Brian Pollard within the Ministry of Long-Term Care, that in

thinking about visitor policy, it's not just the policies in health or long-term care, but it's their interaction and best possible impact on -- on patients and on residents at the intersection of those two policies.

So this is where, as you can see noted here, some of what I had heard I summarised in this particular e-mail.

MS. MAHONEY: Okay. So if we look at your e-mail, you talk about the impact on patient access and outcomes.

DR. GIBSON: M-hm.

MS. MAHONEY: And so were you hearing that there was a -- that there was a deleterious impact on patient outcomes as a result of the visitor policy?

DR. GIBSON: So this is what I think had been surfaced primarily as a concern that, in terms of health outcomes, there -- perhaps that would -- I'm not sure what impact that this might have. But in terms of outcomes, in terms of this, the emotional/psychological well-being of a person who was dying being unable to visit with family would certainly be an outcome of concern.

So these were some of the examples that

from -- from different settings that have been surfaced related to particularly persons who were dying in terms of what the impact of the dissonance between the visit ever policies was happening at a patient level at the home.

MS. MAHONEY: So prior to this, prior to your e-mail in June, had you been asked to give input with respect to the visitor policy?

DR. GIBSON: We had not been asked to do so. No, we had not. The only time that we were invited to provide feedback on visitor policy was an out-reach from the -- the Ministry Emergency Operations Centre that was in the process of -- as noted here in e-mail that, they were working on an amendment to directive number 3. And we had -- so we had been made aware of this, had a conversation with the then-director Clint Shingler about this, and we were not -- the draft was not actually shared with us for input, but our input was verbally invited to help inform their thinking.

MS. MAHONEY: This was around that time?

DR. GIBSON: Yes, this was around this time. And I apologise, Lynn, this was something that I rediscovered as I was going through my

e-mail. So that was the tail -- tail end of May, the 29th, 30th. And what we did to help inform the Ministry was to provide examples of essential visitor policies from four different settings that could be -- serve as ways to think about how to amend -- to broaden the definition of what "essential" might actually be. And these were provided by members of the bioethics table from the institutions with which they worked.

MS. MAHONEY: Was there around the end of May -- and I understand that you weren't provided a copy of directive number 3.

DR. GIBSON: That's right.

MS. MAHONEY: But did you provide any views as to the visitor policy and the impact that keeping out visitors would have on residents of long-term care homes?

DR. GIBSON: We did not. And in part because I think that message was being resoundingly made both by family members and by others. So that advocacy work was having its effect, so we ourselves, though, were not actually invited to weigh in on this issue.

MS. MAHONEY: And when you say that that advocacy was having its effect, what you're

saying is that the visitor policy is rolled out, keeping out visitors from long-term homes?

DR. GIBSON: M-hm.

MS. MAHONEY: And families who have loved ones in the long-term care homes are talking about the deleterious effect --

DR. GIBSON: Yes.

MS. MAHONEY: -- that it is having on their loved ones?

DR. GIBSON: Yes. And this was being noted both at the command table and at the Ontario Health oversight table in discussions related to long-term care involved in those places, especially during this time and in the weeks leading and proceeding.

MS. MAHONEY: I note as well that you have a -- you have dealings in September.

DR. GIBSON: Yes.

MS. MAHONEY: Sorry, August 24th. I may have a something, a document --

DR. GIBSON: August 24th. Yes. That's correct.

MS. MAHONEY: August 24th, you are asked to review the draft visitor policy.

DR. GIBSON: M-hm. Correct.

MS. MAHONEY: Okay. And is this a new visitor policy? And what was your input into this?

DR. GIBSON: So this was a policy which Ministry of Long-Term Care was working on. It was subsequently published in early December. And so we were invited to weigh in on it.

So at the time over the summer, we had struck within the bioethics table a work stream which was comprised of members of the bioethics table as well as others with expertise with long-term care ethics to take a look at this and provide their feedback on it.

That was summarised in a short document that was sent to myself and to my bioethics table co-chair, which we then sent on to Nadine Rhodd, who had made the initial request on the 28th of August. So that was fairly quick turnaround in terms of that exchange to provide feedback.

MS. MAHONEY: I understand you subsequently saw -- you were asked to work on the policy, and you subsequently saw -- the September policy document that you saw --

DR. GIBSON: M-hm.

MS. MAHONEY: -- and I believe what you said to me was that policy document you saw

reflects some of the recommendations you made.

DR. GIBSON: That's correct.

MS. MAHONEY: Am I correct from inferring from that it does not reflect all of the recommendations you made?

DR. GIBSON: Well, just based on -- and I must apologise. I haven't gone through line by line to review, but I did see that there was uptake, at least in terms of some. And I'd be happy to scroll through and provide feedback on the extent to which some were not rejected -- were not accepted.

We know always that in putting forward recommendations that we -- some may be accepted and some may not. And this may also reflect some of the limitations of our understanding of what was in the document.

So an omission may be a reasonable omission, but I'm happy to circle back with the Commission and with yourself, Lynn, on that with sort of much more detail about how closely those recommendations were going.

MS. MAHONEY: Okay. Thank you.

In September, you were also asked to work on the hospital long-term care task force

patient flow. Is that correct?

DR. GIBSON: That's correct.

MS. MAHONEY: So what was that?

DR. GIBSON: So this was a task force -- time-limited task force that met three -- a few times over a period of about a week or so to respond -- to provide a response to a letter that had been sent by a number of organisations and -- who -- well, who care for persons who are older persons or persons who may be residents in long-term care settings as well as some other community-based organisations making a request to be able to transfer COVID-positive residents from long-term care to hospital.

And the specific concern raised in the letter was in many older homes, it was not possible to isolate or to care for patients -- care for residents in a way that would keep them safe and to maintain their well-being.

So this was a letter that had been sent to Minister Fullerton and to Minister Elliott and then subsequently was sent to Ontario Health with a request that a response be -- response be made as to recommendations for a way forward.

And so this was -- these

recommendations -- so Ontario Health struck a task force, which was co-chaired by Catherine Brown of Ontario Health, Mike Heenan from Ministry of Health, and Sheila Bristo from the Ministry of Long-Term Care. And it brought forward a number of different members, some reflecting the long-term care sector, others reflecting a hospital sector.

And if you look at the composition, it was also seeking a broader -- seeking, to the extent that it's possible, a balance of geographic regions in order to develop a brainstorm and to develop a set of recommendations to improve patient flow between hospital and long-term care settings and respond to the request for transferring patients from -- COVID-positive patients from long-term care into hospital as -- as one option that was being put forward by the letter writers.

MS. MAHONEY: Okay. And could you tell me again, who wrote this letter?

DR. GIBSON: So the letter was written by -- the organisations represented who signed on the letter: Addictions and Mental Health Ontario, the Canadian Mental Health Association, Advantage Ontario, CMHO, the Ontario Community Support Association, and the Alliance For Healthier

Communities.

MS. MAHONEY: And the concern is, is this a decanting issue?

DR. GIBSON: It is -- it is more of an appeal to provide a place for COVID-positive patients, a safe place they can go to be cared for, especially -- especially those whose homes may be older homes, where they cannot be isolated. So it is an example of -- it's a -- one could say -- and, in fact, the letter does make reference to decanting --

MS. MAHONEY: Yes.

DR. GIBSON: -- here specifically. And so this is an appeal to be able to decant patients into hospital in very -- in particular cases where it's not possible to isolate or to cohort them within the constraints of the -- of the institution itself.

MS. MAHONEY: So once again, this issue of decanting is --

DR. GIBSON: M-hm.

MS. MAHONEY: -- being raised, and you're being asked to look at it. And this harkens back to your April 28th --

DR. GIBSON: Yes.

MS. MAHONEY: -- draft brief that you had about long-term care during outbreaks. Is that right?

DR. GIBSON: M-hm. That's correct. Yes.

MS. MAHONEY: Did you finalise your thoughts on this issue as part of this task force?

DR. GIBSON: So recommendations were struck (audio glitch) were put forward, some of which were specific to, on the one hand, noting in the letter that there was -- that some of these homes don't have capacity or are constrained in capacity.

So there was some recommendation about building capacity within long-term care homes and then also recommendations about -- related to patients who may be transferring out of hospital back into long-term care, ensuring that they are -- that residents may be identifying a range of homes in the interim that they may go to as well.

So there were -- I would say when I was looking at the document again, I think what was really being sought was to strike a balance between ensuring the flow of long-term care residents to hospitals where acute care might be needed.

Also -- there and back.

Also strengthening capacity to meet the needs of residents in their homes. So the -- this is where these recommendations came forward, and that's -- and I believe you -- you've got the document there.

MS. MAHONEY: Yes. So as far -- the recommendations that were being made from the task force, were they followed -- were they followed up on, and were they embodied in actions taken by the government related to this issue?

DR. GIBSON: I -- I don't have an answer to that. I know that it came up as a question several times by a couple of members of the task force at the Ontario Health oversight table meeting, and the message that was consistently raised is we haven't heard back yet. We haven't heard back yet.

I'm not sure what the status of the response may have been, but it may -- this may also have -- have sort of evolved into some of the current discussions that you're referring to potentially around decanting rather than this being a recommendations document that went forward to full implementation.

MS. MAHONEY: Okay. So this issue was raised as early as April. It's again raised again by this --

DR. GIBSON: Yes.

MS. MAHONEY: -- group asking that something be done. The recommendations --

DR. GIBSON: Yes.

MS. MAHONEY: -- were made by your group in September, and you have not heard what, if anything, has been done with respect to these recommendations?

DR. GIBSON: Not specifically to this document. But, again, I'm happy to further follow up on the specific recommendations, individual recommendations, because I'm imagining there has been action on at least some of these. But I'm happy to follow up.

MS. MAHONEY: But right now as we speak, you're not aware of any --

DR. GIBSON: I don't. Correct. The correct answer would be I do not know.

MS. MAHONEY: I'm just going to ask you to look at --

Jen, if we could pull up the September 24th, 2020, e-mail from Dr. Gibson to

Catherine Brown --

DR. GIBSON: M-hm.

MS. MAHONEY: -- Mike Heenan and Sheila Bristo?

DR. GIBSON: Yes.

MS. MAHONEY: And if you could -- so Commissioners, this e-mail discusses Dr. Gibson's work with this task force.

And I'm just going to quote some statements from you, Dr. Gibson, in this e-mail. You say:

"After seeing this week's numbers -- "

So date of this is September 24th, 2020.

DR. GIBSON: M-hm.

MS. MAHONEY: You talk about:

"After seeing this week's numbers and the modelling scenarios, I worry that we might be nibbling around the edges instead of getting to the heart of what's at stake for wave 2.

On the one hand, the letter writers are calling out for the

support of the long-term care sector and its vulnerable residents. On the other hand, hospitals are struggling to deal with a backlog of surgeries and procedures. All the while, both sectors are watching community transition numbers going up and worrying about their staff and capacity and feeling like any interventions might be too late.

All the recommendations are sensible, but are they all working toward a shared goal of addressing a common understanding of the problem? Are we working with the same guiding principles?

Given uncertainty about how wave 2 will unfold, the TF -- the task force -- may wish to consider how its recommendations would be calibrated to different wave 2 scenarios using the scenarios Alison Blare and Ronda McMichael have been working on. (The draft optimising care through COVID-19 transmission

scenarios might serve as a model for this approach.)"

And you continue to say that:

"If a long-term care home is unable to provide appropriate and safe care to a COVID-positive resident, prompting a transfer to another setting, which is a key concern to letter writers, or how home care might be a critical enabler of continuity of care in the pandemic."

So is it fair to say that this e-mail is a warning on your part that we're going to have issues in wave 2, and these issues are going to continue to raise their heads?

DR. GIBSON: That's an interesting choice of term. Yes, you know, when I read this now and I'm sort of seeing where we are now, this should have served as a warning -- could have served as a warning. My concern was that -- and this point about nibbling around the edges was not just myself on the task force who shared that concern that we are sort of just moving, as you -- you know, moving chairs around. It was really

like, what would be the deeper thing? What would be the really radical way of addressing this concern, anticipating that we -- beginning -- at the end of September, we didn't know what version of wave 2 was going to be materialising.

And we -- what I was hoping was that we might be able to think about these recommendations in the context of, you know, a mild wave 2, a moderate waive 2, like, a harrowing wave 2 where this would only make this more acute, not less acute. And so this is -- this was a recommendation that we actually take this into consideration.

So perhaps I'll just stop there just in terms of what I thought I was seeking to achieve with this e-mail.

MS. MAHONEY: And did you get a response back?

DR. GIBSON: So I did hear back from Catherine, yes. Let's bring this -- I think this is part of the e-mail -- she responds to that. I also heard from Mike Heenan, also saying, "Yes, we really need to think about this along those lines." And I can provide that e-mail to you.

MS. MAHONEY: Yeah, I have the e-mail from Catherine Brown. It says:

"Thank you for your insights. All good points for us to ponder further."

DR. GIBSON: Yes.

MS. MAHONEY: So you'd been pondering it since April, when you were dealing with the decanting issue. You're then been asked to deal with it again in September, when the letter -- this urgent letter comes that you're asked to respond to. And Catherine Brown is saying --

DR. GIBSON: M-hm.

MS. MAHONEY: -- those are all good points to ponder.

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: Wave 2 is coming at this point.

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: Were you at all frustrated by the fact that what they're proposing to do is think some more? I mean, the virus is not thinking. The virus is --

DR. GIBSON: No.

COMMISSIONER MARROCCO: -- returning --

DR. GIBSON: No.

COMMISSIONER MARROCCO: -- if it ever

left.

DR. GIBSON: Right.

COMMISSIONER MARROCCO: Did that --

DR. GIBSON: Well --

COMMISSIONER MARROCCO: How did --

DR. GIBSON: Yeah. So I think what I had been hoping was this would actually be something that could be discussed at the task force, understanding and appreciating too that there were time constraints set around the task force's work.

But, nevertheless, this was something that was starting to strike me. Even though a composition of the task force itself were bringing folks who were bringing a long-term care lens and a hospital lens, who were the relevant parties to that conversation, I was -- I was becoming nervous that, in some ways, this was a very conservative set of recommendations -- sensible, but conservative -- that might not have us fully prepared for wave 2, whatever that might look like. So this was my effort to flag that.

I didn't at the time have -- I mean, we were just starting to see some -- some of the modelling scenarios that were starting to release,

starting to build a sense of urgency. Numbers were starting to increase. The summer lull was behind us. And so what I was also hoping to be able to achieve was that these recommendations would not be seen in isolation of related important work that was happening. And so these were some of disconnections I was hoping could be achieved.

So, you know, this was serving a couple of purposes. One, which was to raise the -- the issue about we're not -- we're being too conservative here. We're nibbling around the edges. And also trying to underline a sense of urgency and a pathway forward that would be focusing on where some of the scenario work might be happening and building some of these recommendations in -- within that context if and as needed.

COMMISSIONER MARROCCO: Doctor, I can understand what you're trying to achieve.

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: That's pretty clear.

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: Stop nibbling around the edges, and let's try to arrive at some

concrete recommendations --

DR. GIBSON: Yes.

COMMISSIONER MARROCCO: -- to deal with wave 2, which we know is coming. It's the idea that what your attempt to do is met with further pondering --

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: -- that is difficult for me to put into any kind of context, because the time for pondering can run out.

DR. GIBSON: M-hm. Yes.

COMMISSIONER MARROCCO: And, I mean, did you have the same sort of sense that there was some urgency to this?

DR. GIBSON: I had a sense of urgency around that, especially since I knew that the runway for the task force's work was coming rapidly to a close. So we didn't have much time to spend time on pondering, and I do not know that Catherine is pointing to -- you know, let's -- you know, hopefully I would bring this forward at the next -- at the next meeting, which was the next day. And so I did surface some of these issues as -- as well at that time.

So, you know, I think -- yes, I mean,

this was not -- these were points to ponder, absolutely. But it's not -- it's beyond just pondering. I was also hoping that there could be a way forward to incorporate that into the task force's thinking in a way that could be reflected in the recommendations themselves, which I -- I don't see to this -- to the extent that I would have liked to have seen there. Certainly not in terms of scenario planning, which I think was going to be an important piece of work.

Now, that may also reflect -- I would have to go back to the terms of reference. The task force -- we may have been prescribed a set of terms we were supposed to be operating within.

But that aside, this seemed to be an important set of flags to be raising at this time.

MS. MAHONEY: So subsequent to the September exchanges and this issue, what additional -- so the bioethics table still exists?

DR. GIBSON: Yes, it still exists.

MS. MAHONEY: Okay. And what work has it been doing since this time?

DR. GIBSON: So it's been working on a few things. So to wrap up on -- we're continuing to amend and evolve, and the critical triage works,

that's a major area of work.

We've also been developing a partnership with the Indigenous primary health care counsel with its reference groups, so we're working on a work plan with them in terms of some key areas of shared work related to bioethics and Indigenous health.

There is also -- we were also starting to think forward into the future, which is about -- so where does bioethics table need to be even in six months' time? And I mention that, because that -- there is, I think, in many ways throughout most of the -- or a good part of the response, there's on the one hand this impulse to try to plan forward, and on the other hand, a reactive mention to what's going on. Issues emerge, need to be solved, work on the issues.

And so, nevertheless, though, as we think forward into where we need to be as a system, where we need to be in terms of -- and I'm thinking about, where does bioethics need to be? We're starting to focus about how we might be better connected to communities on the ground.

Right now, we're very well connected to clinicians. We're very well connected to policy

makers. We're very well connected to a range of different types of institutions. But, nevertheless, it's really where this really -- I'll use the example of where this really impacts, particularly in long-term care is that some of those who are providing care and long-term care are also challenged by the COVID pandemic in ways that are putting them at risk not from an infectious disease perspective, per se, but also in terms of different socioeconomic and other vulnerabilities that they may be facing. So really trying to get our heads around interdependency that creates vulnerabilities.

MS. MAHONEY: You're doing work on --

DR. GIBSON: Another major area of work -- Lynn, if I could just close off --

MS. MAHONEY: Yeah.

DR. GIBSON: -- is in relation to vaccines.

MS. MAHONEY: Yes, that's what I was going to ask you about.

DR. GIBSON: I was saving the best to last.

MS. MAHONEY: Okay.

DR. GIBSON: And so the -- in terms of

vaccine distribution, a number of pieces of work have been happening there. One of the bioethics table work streams was called public health measures, and they had started work starting in the summer to think about vaccine prioritisation.

Related to this, the lead on the vaccine prioritisation work is Professor Max Smith, who is -- who was my co-chair at the bioethics table, continues to be a bioethics member, is now a member of Hilliar's task force and is working really closely with Dirk Hire in the clinical guidelines and surveillance work stream of the task force.

But related to this work, the -- some of the work that was done was an environmental scan just to see how other -- other countries -- other countries were approaching prioritisation, identification of which principles -- ethical principles they were drawing from, how they were prioritising particular groups. And so this has generated a few things.

One is -- as was reported by the task force not too long ago is an ethical framework for vaccine distribution that identifies four priority principles to guide that work. This was partly

developed with input from the Indigenous bioethics group as well. And so that is publicly available.

MS. MAHONEY: And what is the -- can you tell me -- from the recommendations that are made, I assume that the priority is for vulnerable populations, and that would most certainly include long-term care residents?

DR. GIBSON: Yeah, that's correct. And I would also point out as well that like many of the provinces across the country, the starting point for thinking about priority groups was taken from the national advisory committee on immunisation's work federally that had undertaken a consultation across the country with a number of different stakeholders, experts, and so on.

And so they are -- long-term care was identified as a priority. Long-term residents and staff are identified as priority groups. And so this is reflected in the Ontario approach as well.

MS. MAHONEY: So the recommendations, do I take it from that that the recommendations made by the bioethics table with respect to vaccine prioritisation are reflected in the rollout of this plan by the government and the vaccinations that are taking place?

DR. GIBSON: So what I would say is that the recommendations are consistent with what the bioethics table would support, although we did not actually specify which groups ought to be prioritised. Again, to what -- following up on what you'd said, it would be based on vulnerability. And very clearly, the -- the groups that have been identified are -- are vulnerable, and so we would certainly be supportive of the groups that have been identified as a result of that.

MS. MAHONEY: So just to close that out, the long-term care home residents would be a priority group to get vaccinated?

DR. GIBSON: That's correct.

MS. MAHONEY: If we could -- and I know later in your slides -- and I could take you back to your deck. I know that you have some comments, and you may have given them already about communication issues --

DR. GIBSON: M-hm.

MS. MAHONEY: -- as you experience them in the tables that you sat on. And so if we could -- if you could elaborate on those?

DR. GIBSON: Well, I mean, these --

these were just some additional reflections that are coming to mind, because I think these are more the -- where we go from here and how we got here in the first place. And one was just simply an observation that with pandemic plans -- even with a plan, there's a practice. And the challenge with pandemic practice is you do need to figure things out to some extent as you go. In part because we're dealing with evolving evidence, also dealing with human beings. And so this is where sometimes it was often -- you know, I heard it said we're building the plane while flying it.

And one of the concerns that surfaced -- has surfaced a few times is, unlike SARS, it was intense. It was an acute episode, which has left tremendous residue. We know that the -- this is an episode that has haunted health workers subsequently and even to this day, those who are in the institutions, particularly where there may have been deaths.

We've said we're also thinking about planning from a -- for the perspective of a marathon rather than a sprint. So one of the concerns I've been sort of thinking about is how do we foster resilience to sustain good planning

whilst also engaging in pandemic practice? And that sustainability is really speaking to the -- the human dimension of pandemic planning, which is affecting leaders in institutions and in policy making, it's affecting clinicians, it's affecting residents. We're certainly hearing -- hearing that as well.

So, you know, even though we might say that, well, gosh, there was wave one and there was wave two, I think what's novel about wave two, at least in part, aside from the permutations of the infectious disease and the way it's expressing itself, is that it is also surfacing the urgency of ensuring resilience and sustainability through this at all levels.

I do note also that in wave 1 -- this is more of a wave 1 comment, and I'm sure you've heard from it others -- was there was confusion around who was doing what. There were many people who wanted to contribute, many people, associations, community groups raising their hand and saying, "What can I do? I care about communities." So it was really difficult.

I even found this difficult, navigationally. Who do I call if an issue should

surface in order to seek insight or to raise a concern or a question?

MS. MAHONEY: And so you as the co-chair of the bioethics table --

DR. GIBSON: Yeah.

MS. MAHONEY: -- had an issue as to who do you call if you're hearing that there's something going on? You didn't know who you should call, who was -- who could --

DR. GIBSON: Yeah.

MS. MAHONEY: -- assist?

DR. GIBSON: And I think this is partly the proliferation -- I use the word proliferation there also is response to the evolving nature of the pandemic itself, which was, okay so there was a new issue that emerged. Let's bring a bunch of people together to think and work that through, which was really pragmatic.

At the same time, it did contribute to some confusion about how decisions were being made, who was making which decisions, who was informing. So what was pragmatic was not always optimal for fostering transparency and cooperation necessarily.

The other just observation I would have is just in terms of composition and

representativeness at the table -- certainly this is something that the bioethics table is grappling with right now -- a lot of folks who understand the of hospital experience, a lot of folks who are either clinicians or who hold positions of power or influence and yet underrepresentation of communities who are most affected. And so that's something that our table is grappling with.

But also I think in general if we think about where the leadership capacity is, where the capacity -- institutional capacity resides, it resides in hospitals and especially large academic hospitals.

And so, you know, it does sort of raise a question for me as we're thinking about advice giving, do we have a really well-rounded -- where are we getting that well-rounded advice and input in a way that is seen to be legitimate, that is seen to be credible, and that is timely and informative? So it's representative, partly, but also, you know, it's also an issue of about who has access to be able to have influence, which is something which we need to be concerned of.

But one thing that I am encouraged by -- and, again, let us not let perfect be the

enemy of the good here, but I've heard more and more conversations at almost every table where I am of really thinking about -- thinking in a non-institutional way, thinking beyond the boundaries of sector and beyond the boundaries of institution to be really thinking about something along the lines of all patients are our patients. It doesn't matter if they present in your emergency department versus yours. We need to, as a system, come together to ensure that we have a place to go. And so this sense of emerging solidity.

Proportionality as well, so really trying to see -- so if one -- one institution is particularly stressed, others are stepping in to be able to support. You see that partly in terms of the relationship with hospitals and some long-term care facilities providing to the extent that they're able people and expertise to support long-term care homes that may be struggling.

On the other hand, though, it is surfacing, I think, some broader questions around equity. Not geographic equity, not institutional equity, but how to -- if we're taking a more systematic approach, we need to also be thinking about the disproportionate way in which some

patient populations and residents are starting from a place of disadvantage and how we might be able to advance greater equity in the system by leveraging this sort of -- everybody leaning in, this philosophy of solidity and how we could sustain that after -- after the pandemic. I'm not even sure when "after" would be, but sustain that going forward, because it will certainly be a benefit to patients and residents and communities in ways that I don't think we've been as successful up until this point within our system.

MS. MAHONEY: I note on the next slide, you talk about planning for the worst and hope for the best.

DR. GIBSON: Yeah.

MS. MAHONEY: In your view, ought that to have been done? And was it done, the planning?

DR. GIBSON: I think that certainly through the fall as we saw -- let me put it this way. Ontario has really benefitted from the experience of other health systems around the world. Watching their experience and watching their journey has helped to inform thinking about what possibilities -- what the possibilities might be for Ontario. I think the modelling work has

really made that much, much more stark.

It's been able -- some of that modelling work that is particularly being shared through the science table in the fall is presenting what the worst case scenario would be and what the impact might be.

And so I think that we may have found ourselves, perhaps through the summer of, you know, the confidence that comes from having gotten through wave 1, a lot of measures that were implemented seems to have had an effect. If we only stick with those and continue and sustain that, perhaps we may be able to avert the same type of wave 2 as we've seen in other jurisdictions. I think that that's -- there's -- there's considerable risk in doing that.

I think we still need to plan for the worst, anticipate what may be coming, and really push ourselves to envision what the worst case scenario might actually be so that we can be -- and it's hard. I mean, obviously we're guessing to some extent. But we can learn from other jurisdictions about what worst looks like.

So the -- where I'm feeling a sense of urgency right now is it's wonderful to see the

number of outbreaks in long-term care homes coming down or the -- we are seeing --

MS. MAHONEY: In wave 2, you're talking about?

DR. GIBSON: Wave 2, yeah.

MS. MAHONEY: But between -- like, you would have thought after wave 1 --

DR. GIBSON: Yes.

MS. MAHONEY: -- the modeling is done and everybody knows --

DR. GIBSON: That's right.

MS. MAHONEY: -- how it's getting in and that they don't know the homes don't have a handle on IPAC and everybody knows --

DR. GIBSON: Yes.

MS. MAHONEY: -- that it's not good enough just to leave the homes to their own devices.

DR. GIBSON: Right.

MS. MAHONEY: Don't you then wonder how this is as bad or worse in wave number 2? Like, what learning happened?

DR. GIBSON: Well, you know, I think -- and this is where there's variability. Also there's a gap, often, in that emergence between

planning and execution. And so it may be to where should the focus of attention go? Should it be on implementation, on the execution as opposed to on the planning, per se?

So I think others that you've heard from -- the Commission has heard from would be the best place to provide a candid accounting of what the gap looks like and what was and was not done.

So the gap between intention -- a good idea and good implementation is certainly something which they may have been able to inform. I do think, though, that we -- there's an obligation of thinking forward. So certainly we're starting to see the effects of the lockdown on cases of -- of COVID -- on COVID positivity in long-term care homes amongst residents and staff. Perhaps vaccine will have an effect.

The big uncertainty in the midst of this are these variabilities of concern. So although on the graph it looks like, hmm, we're trending in right direction, the big uncertainty is what will the impact of variance of concern actually be?

And so that's where we're -- some of that scenario planning that imagines the worst but

still works towards the best is really what -- like, we need to be doing.

But it strikes me there may be a lot of folks who may be thinking about this already, but when I -- what I think we may also want to be attentive to as well is how might we better prepare residents and family caregivers now for the possibility of whatever the variance of concern might actually bring? And I'm not thinking of supporting homes in terms of IPAC, because that's still is important. But I wonder if there's still other types of the supports that may be needed?

Certainly we're seeing considerable efforts to bring increased staff in homes, which is great. IPAC, hub -- the hub and spoke model. Fine.

But really where it really may matter to residents and family caregivers and to staff is how they are being able to foster -- and that's the second point, their resilience and well-being for the long haul, especially since some will have seen some tragic circumstances and will be carrying that with them for the rest of their lives.

So where might we be able to infuse greater support for staff and their well-being in

their care of residents? And not just simply in a reactive way in terms of mental health support, which is certainly very important, but also some prevention, which might lead to really sort of seeing residents or staff and family caregivers as partners in responding to the possibility of a variance of concern.

So I mean, it's just -- this is sort of -- you know, I don't have a good sense of what -- where some of that work might actually be happening. But I think in some ways, we need to sort of remember that all the humans in this really enrich that -- the wider intelligence of all parties here to be able to respond together to something which may be difficult to control to the extent that such measures are introduced.

And my final point is sometimes we hear this language of recovery, and, you know, I'm starting to question the term "recovery." Because what are we recovering? We don't want to go backwards. Right? We don't want to recover the way we did things in the past. It's can we find a way to think about recovery that is really about what are the ways in which we can bring the lessons learned forward into a different way of caring for

long-term care residents, supporting staff, organising perhaps long-term care? And so my question would be where's the think tank or whatever it happens to be, that is envisioning what long-term care will look like in one year, in three years, in five years?

And start doing that now, not until some sort of magical moment of recovery has happened or when the pandemic is declared over. Now would be the time for -- I think for us to be able to see what roots we put down for a better long-term care system than we've got now. Building on what we've learned, but making it intentional that we are going to be moving forward to learn about some transformation.

And the government cannot do that alone. So this is where I'm floating the notion of think tank if only because there would be -- multiple perspectives would need to weigh in.

MS. MAHONEY: Well, thank you, Dr. Gibson. I do not have any further questions.

Commissioners.

COMMISSIONER MARROCCO: I don't think we do either.

MS. KING: Lynn, I have one point, if I

may.

Dr. Gibson, just a point of clarification, just to get it on the transcript. Dr. Gibson, early on in your presentation, you talked about the 2008 influenza pandemic plan.

DR. GIBSON: Yes.

MS. KING: And I -- in the meantime, because we have the benefit of having these computers, we -- I tracked down that plan, and I believe it's the 2006 plan.

DR. GIBSON: Oh, is it 2006? Apologies, Jennifer.

MS. KING: So I just wanted to confirm that for the record. And, in fact, it does reference you and your work in Section 2.5.

DR. GIBSON: Correct. Wonderful. Thanks. Thanks so much, Jennifer. I appreciate you correcting that.

COMMISSIONER MARROCCO: Well, Doctor, you know, on behalf of all of us, thank you for this presentation. We have a modest sense of urgency about our own work.

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: And we're quite familiar with deadlines for completing a task.

It's very instructive for us, though, to appreciate that there's an attempt to act in an ethical way or having regard to ethical principles. I think that's encouraging for us.

DR. GIBSON: M-hm.

COMMISSIONER MARROCCO: We, of course, recognise, as you did in your e-mail, that there comes a time when you have to stop pondering, and you have to take action. We understand that, and we experience that very much as we hear what we've been hearing.

But, nevertheless, the thought that there is an ethical perspective in existence, I think, is encouraging, and so thank you for that. And thank you for generally being so instructive about your work, and we'll try to provide a product that's consistent with the products that you've provided. So thank you.

DR. GIBSON: Thank you, Commissioner. Thank you for the opportunity. And, again, I'm, again, feeling very humbled by this whole process. Obviously feeling like there's so much more that can be done and really encouraged by the work that you're doing.

COMMISSIONER MARROCCO: Thank you.

DR. KITTS: Thank you, Jennifer.

COMMISSIONER COKE: Thank you very much.

DR. GIBSON: Bye. Have a great day, everyone.

MS. MAHONEY: You too. Bye.

-- upon concluding at 11:28 a.m.

REPORTER'S CERTIFICATE

I, Eveliene Symonds, BA, CSR(A), Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

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

I further certify that this questioning was conducted in accordance with the Protocol for Remote Questioning, Revised 05/05/2020.

Dated this 4th day of February, 2021.

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