

Long Term Care Covid-19 Commission Mtg.

Dr. Jennifer Gibson
on Thursday, February 4, 2021



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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16	Held via Zoom Videoconferencing, with all
17	participants attending remotely, on the 4th day of
18	February, 2021, 9:00 a.m. to 11:28 a.m.
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1 APPEARANCES:

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

8 The Honourable Frank N. Marrocco, Lead commissioner
9 Angela Coke, Commissioner

10 Dr. Jack Kitts, Commissioner

11 Lynn Mahoney, Esq., Counsel

12 Jennifer King, Esq., Counsel

13 Derek Lett, Policy Director

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

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

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

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

22

23 Eveliene Symonds, Stenographer/Transcriptionist

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

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

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

10 Beyond that, we're ready when you are.

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

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

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

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

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

25 (DISCUSSION OFF THE RECORD)

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

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

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

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

4 2015, she worked with the WHO
5 Consultation on Ethics and Epidemics. Sorry, it
6 was probably a presentation that you did in May in
7 Dublin.

8 2014 to 2015, you were in the WHO
9 ethics working group on Ebola.

10 2014 to 2015, you were the chair Ebola
11 bioethics table with the Ontario Ministry of Health
12 and Long-Term Care.

13 2010 to 2011, you worked with the
14 Baycrest Centre for Geriatric Care. You did ethics
15 strategic planning.

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

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

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

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

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

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

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

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

11 So what I thought I --

12 Next slide, please, Jennifer.

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

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

1 informing issues related to long-term care.

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

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

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

22 DR. GIBSON: Yeah.

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

25 DR. GIBSON: Yes. Thanks, Lynn.

1 That's terrific.

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

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

17 DR. GIBSON: Yeah.

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

21 DR. GIBSON: Oh, yeah. Absolutely.

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

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

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

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

7 "When an influenza pandemic
8 strikes the world, many people
9 ranging from government and medical
10 leaders to health care workers will
11 face a host of difficult decisions
12 that will affect people's freedoms
13 and their chance of survival. There
14 will be choices about the level of
15 risk health care workers should face
16 while caring for the sick, the
17 imposition of restrictive measures
18 such as quarantines, the allocation
19 of limited resources such as
20 medicines, and the use of travel
21 restrictions and other measures to
22 contain the spread of disease.

23 Governments and health care
24 leaders have been working on
25 pandemic plans in many parts of the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And so we conducted a series of surveys
23 right in the lead up to H1N1, actually, in 2008,
24 2009. And based on that, we were able to -- and
25 then did a series of public engagement exercises

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

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

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

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

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

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

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

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

13 DR. GIBSON: Yes.

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

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

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

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

3 The last sentence in that paragraph
4 says:

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

9 A few lines down, it says:

10 "Although these principles can
11 sometimes be difficult to implement
12 during a crisis, SARS showed there
13 are costs from not having an
14 agreed-upon ethical framework,
15 including loss of trust, low morale,
16 fear, and misinformation.

17 SARS taught the world that if
18 ethical frameworks had been more
19 widely used to guide
20 decision-making, this would have
21 increased trust and solidity within
22 and between health care
23 organisations."

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

1 advance?

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

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

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

25 So one of the -- one of the

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

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

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

22 MS. MAHONEY: Right.

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

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

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

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

22 MS. MAHONEY: Okay.

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

1 DR. GIBSON: Yes.

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

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

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

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

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

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

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

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

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

25 COMMISSIONER MARROCCO: So we've heard,

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

4 DR. GIBSON: M-hm.

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

10 DR. GIBSON: Yeah.

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

14 DR. GIBSON: Right.

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

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

25 Second, it can provide some parameters

1 within which decision-making may take place.

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

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

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

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

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

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

15 COMMISSIONER MARROCCO: So just taking
16 that example --

17 DR. GIBSON: M-hm.

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

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

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

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

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

25 COMMISSIONER MARROCCO: Thank you. I'm

1 looking down, because I'm making a note.

2 DR. GIBSON: Okay.

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

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

8 COMMISSIONER MARROCCO: Okay.

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

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

13 DR. GIBSON: Yeah.

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

17 DR. GIBSON: Yeah.

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

22 DR. GIBSON: Yeah.

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

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

4 DR. GIBSON: M-hm.

5 MS. MAHONEY: And if I could, Jen has
6 put up a slide, and it comes from a presentation
7 that we had several days ago about the response
8 table structure. And this is as of March 5th,
9 2020.

10 DR. GIBSON: M-hm.

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

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

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

25 MS. MAHONEY: Okay. And that command

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

3 DR. GIBSON: Coordination.

4 MS. MAHONEY: -- table over time.

5 DR. GIBSON: Yeah.

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

10 DR. GIBSON: M-hm.

11 MS. MAHONEY: And you can see the --
12 Jen, if you could show the
13 commissioners where the bioethics table is?

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

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

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

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

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

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

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

11 DR. GIBSON: Yeah.

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

15 DR. GIBSON: M-hm.

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

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

21 DR. GIBSON: Yeah.

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

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

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

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

7 MS. MAHONEY: Okay.

8 DR. GIBSON: -- since that time.

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

14 DR. GIBSON: M-hm.

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

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

22 MS. MAHONEY: Okay.

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

1 that went into it.

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

5 DR. GIBSON: Absolutely.

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

8 DR. GIBSON: Absolutely.

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

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

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

1 me striking a bioethics table. So --

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

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

13 MS. MAHONEY: Okay.

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

1 who were actually at the cold face of providing
2 care.

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

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

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

25 DR. GIBSON: M-hm.

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

3 COMMISSIONER MARROCCO: Lynn, just
4 before us that.

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

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

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

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

9 COMMISSIONER MARROCCO: Okay.

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

14 DR. GIBSON: M-hm.

15 MS. MAHONEY: -- dated March 24th.

16 Jen, if you could pull that up, please?

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

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

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

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

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

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

18 DR. GIBSON: M-hm.

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

22 DR. GIBSON: Yes.

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

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

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

9 MS. MAHONEY: Yes.

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

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

15 DR. GIBSON: Okay.

16 MS. MAHONEY: -- of this document.

17 DR. GIBSON: Yes.

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

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

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

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

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

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

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

25 MS. MAHONEY: Okay .

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

3 DR. GIBSON: M-hm.

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

6 DR. GIBSON: Yes.

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

9 DR. GIBSON: Yes.

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

15 DR. GIBSON: Is an option.

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

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

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

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

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

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

17 COMMISSIONER MARROCCO: Okay.

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

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

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

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

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

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

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

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

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

10 MS. MAHONEY: Okay.

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

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

17 DR. GIBSON: Yeah.

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

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

1 was the discussion around that?

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

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

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

22 DR. GIBSON: Yes.

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

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

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

9 DR. GIBSON: Yes.

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

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

25 But, nevertheless, the feeling --

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

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

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

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

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

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

10 DR. KITTS: Yeah.

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

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

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

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

23 DR. GIBSON: Yeah.

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

1 transparency that might have been well received.

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

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

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

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

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

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

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

8 DR. GIBSON: M-hm.

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

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

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

24 DR. GIBSON: I --

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

1 because we don't have any"?

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

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

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

18 MS. MAHONEY: But --

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

22 MS. MAHONEY: Right.

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

25 MS. MAHONEY: AND --

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

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

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

17 MS. MAHONEY: Okay. Thank you.

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

20 DR. GIBSON: M-hm.

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

24 DR. GIBSON: M-hm.

25 COMMISSIONER MARROCCO: -- and the

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

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

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

14 DR. GIBSON: Ministry of Health.

15 MS. MAHONEY: Thank you.

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

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

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

4 COMMISSIONER MARROCCO: Okay.

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

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

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

15 DR. GIBSON: M-hm.

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

23 DR. GIBSON: Yes.

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

1 follow up on this meeting?

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

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

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

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

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

3 MS. MAHONEY: So if --

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

7 DR. GIBSON: M-hm.

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

12 DR. GIBSON: M-hm.

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

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

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

1 transferred.

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

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

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

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

25 DR. GIBSON: That's correct.

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

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

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

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

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

1 DR. GIBSON: Yes.

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

4 DR. GIBSON: Yes.

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

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

20 And that would have been released to
21 the hospital sector and critical care folks on the
22 28th of March. And it was -- it was a green
23 document, and we knew that we would learn a great
24 deal from feedback that might emerge along the way.

25 The -- Minister Fullerton wanted to

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

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

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

19 DR. GIBSON: Yes.

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

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

1 care such that triaging of critical care services
2 was required.

3 MS. MAHONEY: Right.

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

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

17 MS. MAHONEY: M-hm.

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

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

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

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

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

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

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

16 MS. MAHONEY: No.

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

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

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

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

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

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

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

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

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

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

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

1 situation at all.

2 MS. MAHONEY: Okay.

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

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

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

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

25 MS. MAHONEY: So there was a

1 distinction between acute care and critical care?

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

12 MS. MAHONEY: Right.

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

15 MS. MAHONEY: Okay. Thank you.

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

20 DR. GIBSON: Yeah.

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

24 DR. GIBSON: Yeah.

25 MS. MAHONEY: -- that you were going to

1 engage with Ministry of Long-Term Care?

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

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

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

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

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

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

15 MS. MAHONEY: Okay.

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

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

20 DR. GIBSON: That's right.

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

23 And if we can pull that up.

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

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

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

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

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

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

21 DR. GIBSON: Yeah.

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

25 DR. GIBSON: Right.

1 MS. MAHONEY: Definitely not in wave
2 one --

3 DR. GIBSON: Yes.

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

7 DR. GIBSON: Yes.

8 MS. MAHONEY: -- erected.

9 DR. GIBSON: Yes.

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

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

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

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

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

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

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

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

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

21 DR. GIBSON: April 20th.

22 MS. MAHONEY: Yes. It says:

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

1 table meetings --"

2 That's quite a mouthful.

3 DR. GIBSON: M-hm.

4 MS. MAHONEY: "-- this week."

5 DR. GIBSON: Yes.

6 MS. MAHONEY:

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

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

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

20 DR. GIBSON: M-hm.

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

23 Jen, if you could pull that up, please?
24 There's an April 27 meeting agenda.

25 MS. KING: Which document number is it?

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

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

15 "Decanting, ethical issues
16 around consent and moving, call with
17 Jennifer Gibson."

18 DR. GIBSON: Correct.

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

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

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

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

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

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

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

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

1 particular time.

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

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

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

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

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

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

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

4 DR. GIBSON: We have not, no.

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

9 DR. GIBSON: That's correct.

10 MS. MAHONEY: Okay.

11 DR. GIBSON: That's correct.

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

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

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

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

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

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

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

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

25 And then, finally, there would be

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

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

14 COMMISSIONER MARROCCO: How many policy
15 briefs were produced?

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

24 MS. MAHONEY: The decanting? The
25 decanting one?

1 DR. GIBSON: The decanting one.

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

8 DR. GIBSON: That's correct.

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

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

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

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

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

25 DR. GIBSON: No. Actually, this is one

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

9 MS. MAHONEY: Okay.

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

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

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

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

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

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

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

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

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

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

25 DR. GIBSON: I attended two of these

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

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

9 DR. GIBSON: That's correct.

10 MS. MAHONEY: Okay.

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

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

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

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

1 shortage of --

2 DR. GIBSON: M-hm.

3 MS. MAHONEY: -- testing supplies and
4 swabs.

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

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

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

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

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

4 DR. GIBSON: M-hm.

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

6 DR. GIBSON: That's correct.

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

9 DR. GIBSON: Absolutely.

10 MS. MAHONEY: Is that correct?

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

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

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

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

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

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

17 DR. GIBSON: Not specifically, no.

18 MS. MAHONEY: Okay.

19 DR. GIBSON: No.

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

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

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

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

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

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

13 MS. KING: There it is.

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

20 DR. GIBSON: M-hm.

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

25 DR. GIBSON: That's right. And for

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

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

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

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

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

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

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

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

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

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

12 DR. GIBSON: M-hm.

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

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

25 So these were some of the examples that

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

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

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

21 MS. MAHONEY: This was around that
22 time?

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

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

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

13 DR. GIBSON: That's right.

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

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

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

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

3 DR. GIBSON: M-hm.

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

7 DR. GIBSON: Yes.

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

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

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

18 DR. GIBSON: Yes.

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

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

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

25 DR. GIBSON: M-hm. Correct.

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

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

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

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

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

23 DR. GIBSON: M-hm.

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

1 reflects some of the recommendations you made.

2 DR. GIBSON: That's correct.

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

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

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

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

23 MS. MAHONEY: Okay. Thank you.

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

1 patient flow. Is that correct?

2 DR. GIBSON: That's correct.

3 MS. MAHONEY: So what was that?

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

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

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

25 And so this was -- these

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

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

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

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

1 Communities.

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

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

12 MS. MAHONEY: Yes.

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

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

21 DR. GIBSON: M-hm.

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

25 DR. GIBSON: Yes.

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

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

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

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

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

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

1 Also -- there and back.

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

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

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

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

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

4 DR. GIBSON: Yes.

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

7 DR. GIBSON: Yes.

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

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

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

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

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

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

1 Catherine Brown --

2 DR. GIBSON: M-hm.

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

5 DR. GIBSON: Yes.

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

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

12 "After seeing this week's
13 numbers -- "
14 So date of this is September 24th,
15 2020.

16 DR. GIBSON: M-hm.

17 MS. MAHONEY: You talk about:

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

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

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

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

17 Given uncertainty about how wave
18 2 will unfold, the TF -- the task
19 force -- may wish to consider how
20 its recommendations would be
21 calibrated to different wave 2
22 scenarios using the scenarios Alison
23 Blare and Ronda McMichael have been
24 working on. (The draft optimising
25 care through COVID-19 transmission

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

3 And you continue to say that:

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

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

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

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

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

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

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

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

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

1 "Thank you for your insights.

2 All good points for us to ponder
3 further."

4 DR. GIBSON: Yes.

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

11 DR. GIBSON: M-hm.

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

14 DR. GIBSON: Yes.

15 COMMISSIONER MARROCCO: Wave 2 is
16 coming at this point.

17 DR. GIBSON: Yes.

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

22 DR. GIBSON: No.

23 COMMISSIONER MARROCCO: -- returning --

24 DR. GIBSON: No.

25 COMMISSIONER MARROCCO: -- if it ever

1 left.

2 DR. GIBSON: Right.

3 COMMISSIONER MARROCCO: Did that --

4 DR. GIBSON: Well --

5 COMMISSIONER MARROCCO: How did --

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

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

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

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

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

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

20 DR. GIBSON: Yes.

21 COMMISSIONER MARROCCO: That's pretty
22 clear.

23 DR. GIBSON: Yes.

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

1 concrete recommendations --

2 DR. GIBSON: Yes.

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

7 DR. GIBSON: M-hm.

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

11 DR. GIBSON: M-hm. Yes.

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

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

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

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

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

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

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

20 DR. GIBSON: Yes, it still exists.

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

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

1 that's a major area of work.

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

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

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

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

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

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

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

17 MS. MAHONEY: Yeah.

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

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

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

24 MS. MAHONEY: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

15 DR. GIBSON: That's correct.

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

21 DR. GIBSON: M-hm.

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

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

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

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

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

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

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

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

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

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

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

5 DR. GIBSON: Yeah.

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

10 DR. GIBSON: Yeah.

11 MS. MAHONEY: -- assist?

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

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

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

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

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

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

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

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

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

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

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

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

15 DR. GIBSON: Yeah.

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

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

1 really made that much, much more stark.

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

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

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

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

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

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

5 DR. GIBSON: Wave 2, yeah.

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

8 DR. GIBSON: Yes.

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

11 DR. GIBSON: That's right.

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

15 DR. GIBSON: Yes.

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

19 DR. GIBSON: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 may.

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

6 DR. GIBSON: Yes.

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

11 DR. GIBSON: Oh, is it 2006?

12 Apologies, Jennifer.

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

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

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

23 DR. GIBSON: M-hm.

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

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

5 DR. GIBSON: M-hm.

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

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

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

25 COMMISSIONER MARROCCO: Thank you.

1 DR. KITTS: Thank you, Jennifer.

2 COMMISSIONER COKE: Thank you very
3 much.

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

6 MS. MAHONEY: You too. Bye.

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

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