NATIONAL CITIZENS INQUIRY

Truro, NS **Day 3**

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EVIDENCE

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Ches Crosbie
Dr. Davidson, while you're assuming your position there, do you affirm that you will tell the truth, the whole truth, and nothing but the truth?

Dr. Dion Davidson
I do.

Ches Crosbie
Thank you.

Chad Horton
Good afternoon, Dr. Davidson. Before we get into your examination proper, could you kindly provide the Commission with an overview of your education, training, and experience?

Dr. Dion Davidson
My name is Dr. Dion Davidson. In summary, I'm a vascular surgeon and critical care doctor. I went to medical school in Saskatchewan. I went on to do eight years of general surgery and vascular surgery training after that. My family and I moved to Nova Scotia here to a relatively smaller town in 2005 with a relatively larger hospital, so a regional hospital that had a vascular surgery program. And I've practised in Nova Scotia ever since, basically as a community vascular surgeon and ICU doctor.

Chad Horton
And for the benefit of our audience, what is vascular surgery?

Dr. Dion Davidson
Vascular surgery is the surgical procedures but also a lot of medical management and other aspects of diseases that have to do with arteries and veins, to put it simply.

Chad Horton
And do you have any other areas of interest with respect to your involvement in medicine beyond what you've just described?

Dr. Dion Davidson
As I said, I am or I have, for most of my career, been an ICU doctor as well. For most of my career I served as one of the attending doctors in the ICU at our regional hospital. So I have an interest in critical care; I've worked in that area as well. In addition to sort of community vascular surgery, what we do as vascular surgeons, we do a lot of surgeries on carotid arteries in the neck in order to prevent strokes. We do a lot of surgeries and various procedures for arteries in the legs to relieve pain and prevent amputations. And we repair abdominal aneurysms and other types of aneurysms to prevent rupture and death. So that's kind of the core, I would say, of a community vascular surgery practice, so all vascular surgeons do a lot of that.

In my case, I've also taken a special interest in what's called chronic venous disease, which is a bit of a different offshoot, kind of a less dramatic offshoot of all that. Not life or limb threatening but certainly very common and kind of underserved in the medical community. So those have been my areas of interest. That's what's taken up a lot of my career. I've contributed to two different national committees developing guidelines for carotid artery surgery to prevent stroke and with respect to chronic venous disease as well.

Chad Horton
Well, this is my assumption, but I want to get this on the record. As a layperson, when you tell me that you're a vascular surgeon, my presumption is that perhaps there may not be a great many vascular surgeons practising in the province of Nova Scotia. Are you able to tell us how many vascular surgeons were practising at the start of the pandemic in early 2020, including yourself?

Dr. Dion Davidson
It's maybe not quite as simple to answer as you might think. I'll say that, at the beginning of the pandemic, there would have been five to six full-time vascular surgeons, maybe four to five full-time vascular surgeons. For example, my partner in the Annapolis Valley is also a general surgeon, so he maybe wouldn't be termed a full-time vascular surgeon, and there was some of the same sort of thing happening in Halifax. So it would be a number something like that. And that would be to cover vascular surgery for Nova Scotia and PEI.

Chad Horton
In your practice, how many patients could you expect to treat in the run of a week?

Dr. Dion Davidson
Again, not super easy to answer, but I'll say, in terms of new consults and follow-ups in a given week, maybe 50 to 80, something like that.

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And then maybe another 10 patients I would provide minor surgeries for, such as wound debridements. Wound debridements would be an example, some minor office procedures. And then, maybe anywhere from one to five bigger surgeries per week that might be sort of planned surgeries during the day, and then, maybe more urgent surgeries during the evening or night time.

Chad Horton
And do you have any experience as an educator?

Dr. Dion Davidson
Yes, I would say I've spent a lot of time in education of nurses, medical students, general surgery residents, family medicine residents as well, in terms of lectures. And then for their electives, accompanying me in clinic and in the operating room. And kind of how we do it as doctors is teach as you interact, as you're working.

Chad Horton
Now, at the beginning of the pandemic, let's say early 2020, what had been your plan for both yourself and your family with respect to your professional future in Nova Scotia?

Dr. Dion Davidson
Before the pandemic, we were dug in. We had been there for, I guess about 15 years at that point, my wife and I. We had raised our three daughters there. I was a really hardworking vascular surgeon. My career and my profession took up obviously most of my life. And my wife became a prominent community leader and businesswoman, including helping the Nova Scotia Health with efforts such as recruiting doctors into the community and things like that—a lot of other volunteer-type work. Two of my daughters were still in the Annapolis Valley at that time. So before the pandemic, we had no plans to ever go anywhere. We were dug into Nova Scotia, specifically the Annapolis Valley. Our plan was to stay there forever.

Chad Horton
Okay, and we'll get into your experience throughout the pandemic in a moment. I just want to bring us up to the present and ask you, Dr. Davidson, what are your plans professionally for yourself and your plans for your family currently?

Dr. Dion Davidson
Well, I've resigned my position, kind of at the tail end now of a long and awkward process of resigning. And my wife and our youngest daughter and I are moving out of Nova Scotia.

Chad Horton
Why is that, Dr. Davidson?

Dr. Dion Davidson
We're moving because, I mean, to put it simply: we're moving because of the public health response to the COVID pandemic.

Chad Horton
We'll come back to that. Now can you speak to any experience or qualifications you have with respect to the review and interpretation of medical research literature?

Dr. Dion Davidson
Yeah, I'm not an epidemiologist, but I'm a doctor. And a major aspect of medical school education is the concept of evidence-based medicine. We're taught quite extensively from a very early point how to interpret scientific papers—we're talking about research methods and biostatistics—so that we can, throughout our careers, be able to look at the scientific literature and know what to look for in terms of quality of scientific literature, what it's trying to say, what it's actually saying, what data means. So that's a major component of medical school education. And almost every doctor, almost every day, to some extent, has to assess the medical literature and interpret it. In addition, I took some additional biostatistics classes during my surgical training. Yeah, I mean, maybe no more than any other specialist, but it's certainly part of what we normally do as doctors is review scientific literature.

Chad Horton
Do you have any specific education or training with respect to medical ethics?

Dr. Dion Davidson
It'd be the same answer. I guess the short answer is, not in addition to what we are taught as doctors from a very early point, before we're doctors. A very early point in medical school and all through medical school, principles of medical ethics are strongly emphasized.

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I mean, not only that, but they come up every day and with every patient to a certain extent. So I also don't have a PhD in philosophy, but I would say that I'm very knowledgeable about the basic premises of medical ethics.

Chad Horton
Can you talk about the concept of informed consent as it applies to the practice of medicine?

Dr. Dion Davidson
Yeah, informed consent is a major cornerstone of medical ethics. And I don't know, maybe it's more obvious to some than others. But obviously, it is a principle that we never as doctors, ever, ever, force a medical intervention on someone. History is replete with examples of times where doctors have done that. And those very sad episodes in history are sort of in the background as we talk about consent. Consent needs to be free—free of coercion—and informed in order to mean anything.

Chad Horton
And does that principle apply to all medical interventions in Canada?

Dr. Dion Davidson
Does it apply? I mean, historically it would have applied, I would say. One would think, and I think we all would have said before the pandemic, that the threshold for even considering contravening the ethic of informed consent should be extremely high.

Chad Horton
As we entered the pandemic in early 2020, what was your understanding of the danger posed to public health in this province by COVID-19?

Dr. Dion Davidson
Well, I was as concerned as anybody else about COVID-19. Similar to Dr Lavranos' testimony, in early 2020, nobody knew much of anything about this virus, except that it was really serious and that it could be a catastrophe. So I was very concerned about it; I took it very seriously. I started to work with other doctors in our hospital—and again, a lot of this will sound familiar from Aris's testimony—in trying to learn as much as we could about it with the limited information that we had at the time, and then trying to prepare for these waves of critically ill COVID patients that surely were going to be coming to our door. So that concern and fear took up—and trying to prepare—many months going into and through the summer, for sure.

Chad Horton
Okay I'm going to touch on something you just said or perhaps we can expand on it. So you indicated that you were very concerned, like many people were, during the early stages of the pandemic. What was your observation during the early stages of the pandemic regarding the allocation of in-hospital resources?

Dr. Dion Davidson
Well, I think, again, we were all very concerned. We didn't have much data, but we were concerned enough, early on, that we all agreed that we needed to be ready and that it was probably appropriate to slow the hospital down as much as possible. So one thing that was certainly very prominent in our hospital, which has a relatively big surgery department, is that elective surgeries were halted for months. So elective means surgeries that aren't urgent were just deferred. Put on hold. Not done.

Chad Horton
Now when you say surgeries that were not urgent, is that the same as surgeries that were not important? Or are those two different things?

Dr. Dion Davidson
Yeah, certainly, two different things.

Chad Horton
So could an elective surgery still be an important surgery?

Dr. Dion Davidson
Oh, for sure. Yes. I mean, no surgeon should be doing any surgery they don't think it's an important surgery to do.

Chad Horton
Okay, so you've discussed the allocation of in-hospital resources. Shift gears a little bit. What were your observations in hospital with respect to COVID-related illness during the initial stages of the pandemic?

Dr. Dion Davidson
Yeah, again, similar to what Aris was saying: we were geared up and spun up. We were getting ready. I was part of teams of people that where we were trying to develop these protocols about how we would safely intubate patients in respiratory distress and safely get them to the ICU.

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Including the possibility of emergency surgical airways, if that was going to be needed. And really, certainly, in the early months, there was very little of that. Very few, very small numbers of critically ill COVID patients at first. It's hard for me to kind of remember the exact timeline. But certainly, for the first several months, there was a lot more sort of preparing than there was actually looking after critically ill COVID patients.

Chad Horton
And I think you just referenced critically ill COVID patients, how about during the initial months of the pandemic COVID admissions generally?

Dr. Dion Davidson
I wouldn't have been involved. I would only be involved if they were ICU patients, so there probably were some. My impression was that, again, for several months, it wasn't nearly the numbers that we feared that it would be, even the less sick.

Chad Horton
So you had spoken earlier about your significant apprehensions at the front end of the pandemic. Did your level of apprehension or your areas of concern evolve over time, and if so, how and why did they evolve?

Dr. Dion Davidson
Certainly. I mean, as with many other people, as the spring turned into the fall, we had more data. And it became evident pretty quickly that, again, the virus was serious, and it could be very serious for certain people, but we were getting a very clear picture of who was most at risk. And as we've heard, age was the major factor for that. Comorbidities such as obesity and diabetes played a role as well, but age was certainly the major risk factor. And I feel like that was becoming very clear, certainly as 2020 turned into 2021. So I was becoming, I guess, less concerned that the virus was going to be a world catastrophe. I'm still taking it seriously but less concerned about that.

Chad Horton
And where you're talking about age being a significant factor, is that the idea that Dr. Milburn and Dr. Lavranos described as age stratification of risk, as it relates to COVID-19? Is that the concept?

Dr. Dion Davidson
Yes, exactly. You know, the concept that if you're a healthy child— I mean, there's no such thing as zero in medicine, but if you're a healthy child, your risk of a bad outcome from COVID approaches zero. If you're 80 years old, you're at much higher risk, like a thousandfold risk.

Chad Horton
Okay, what's your understanding of the risk for a healthy adult, somebody who wouldn't be medically classified as elderly? If that's an appropriate classification.

Dr. Dion Davidson
Again, by now there's very good data, even on a decade-by-decade basis. It would be hard for me to give you a number, but for the average healthy 40-year-old, your case fatality, certainly your infection fatality number, is low, less than 1 per cent.

Chad Horton
Is that 1 per cent relative to infections or 1 per cent relative to the population?

Dr. Dion Davidson
Certainly, IFR (infection fatality rate), even the case fatality rate, was probably about that. I don't want to overstate it.

Chad Horton
Sure. Okay, so I believe that you said a few moments ago that the risk posed to children is close to zero. Did I hear you correctly?

Dr. Dion Davidson
Yeah.

Chad Horton
Okay. In light of that perspective, what was your sense of locking down schools or locking down society generally?

Dr. Dion Davidson
Well, yeah, that was my first major crisis moment, I would say. So like everybody else or most people, I understood and probably even supported the idea of two weeks to flatten the curve.

But even then, and certainly as that became two months to flatten the curve and extended longer, I was increasingly distressed about the idea of wide society lockdowns. And for all the reasons that I'm sure, even at that time let alone now, would be obvious to everybody in this room. And it boggled my mind why public health wasn't discussing the potential dangers—not potential dangers but dangers of wide society lockdowns, in terms of rationalizing why they were recommending that.

You know, the downsides are obvious. And you know, again, Aris talked about this.

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You've heard it before, but the missed cancer screening, the missed cancer diagnoses, the patients staying at home and not seeing their family doctor to manage their diabetes and their blood pressure—all of the strict health downsides should have been obvious. And then the society downsides: children not going to school, not getting the development that they get from going to school, older people dying alone and away from their loved ones.

Again, it was obvious to me, and I have no special insight into this sort of thing. I know it was obvious to many people. Why it wasn't being publicly discussed was very distressing to me. And why, month after month, it was decided that this one virus—which was now just one more way among a thousand other ways that we could die in life—why that one virus was the only thing that public health was concerned with. I just didn't understand that at all, and it really distressed me.

Chad Horton
In your professional medical opinion, was there any medical or scientific evidence that you were aware of during that time that suggested that these ongoing lockdowns should have been or remained implemented?

Dr. Dion Davidson
Not on an ongoing basis. You know, again, we were getting more and more data about who was at risk and who wasn't. The downsides of lockdowns, if they weren't obvious before, I think were becoming more evident. So certainly not on an ongoing basis. There were preeminent, very prominent PhD epidemiologists from Harvard, Oxford, Stanford, who took a step to organize and gather other preeminent PhDs and other researchers and scientists from around the world to suggest that wide society lockdowns were a bad idea.

And they base this on very old planning: that before Covid, somewhat further back in time, the approach to pandemics it had been agreed would be focused protection of those at most risk. It was only with Covid that was actually this new idea that you had to shut down the entire society because of this one virus. And their ideas made a lot of sense to me. I didn't understand why they were being demonized in the public and among this new public health establishment and in the media.

And then, as time wore on, we had glimpses into what other jurisdictions were doing. Countries like Sweden, states like Florida and Texas were not widely shutting down. Or you know, they were undertaking more humane versions of that, again more focused and shorter lockdowns and their age-adjusted mortalities were no worse. In some cases, they were better than areas like New York or California—or Nova Scotia, at least later on—that were undertaking these draconian lockdowns.

Chad Horton
Were you aware of any debate or discussion happening either in hospital amongst your colleagues and leadership or in the public health sphere in Nova Scotia regarding whether these ongoing lockdowns were appropriate? Was it a matter of discussion and debate that you were aware of?

Dr. Dion Davidson
Well, as I said, I was actually very disappointed that it wasn't a matter of public debate. And it wasn't even anything that public health was bringing up, which I would have thought would have been public health's job. So certainly not at that level. In terms of otherwise—Other than me just grumbling and complaining and others sort of agreeing—you know, my colleagues around me sort of agreeing that there would be downsides—there really wasn't a lot of discussion about it, not nearly enough in my opinion.

Chad Horton
You've just discussed your views on the lockdowns. As time wore on, did your concerns begin to evolve or did you have other concerns?

Dr. Dion Davidson
Well, I had other concerns. You know, elective surgeries don't apply so much to vascular surgery. A lot of what we do is life or limb threatening more immediately, if not emergently. So you know, I was still operating, my practice was continuing.

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And then, in addition to all that, I was trying to help prepare and trying to learn more about COVID. So I was very busy. I carried on. I hoped that public health knew what they were doing in terms of the lockdowns. But as time went on, I was just more and more suspicious of that. I'm not sure if that answers your question or not, but that's how that evolved.

Chad Horton
Absolutely. How about based on your education, training and experience and your understanding of clinical literature, how did you feel about the vaccine rollout and/or the implementation of vaccine mandates?

Dr. Dion Davidson
Yeah, so that was the next point of concern for me. So when the vaccines were being developed, I remember being somewhat concerned at the speed at which it was happening. As you've heard, it would normally take multiple years—five years, ten years minimum—to get a vaccine to the point of new pathogen-to-public rollout.

Donald Trump's administration authorized Operation Warp Speed. And the whole idea of that was that there weren't going to be these normal regulatory processes. They were going to cut the red tape so that these vaccines could be developed more quickly. Which is great if everything goes well, but that means, by definition, you don't have the long-term data, especially in terms of safety. So I had some concern about that. The randomized trials came out, and to be honest again, I was busy. I scanned them and in retrospect, I did not read them critically enough, but they seemed to be saying good things about the mRNA vaccines.

And then public health, obviously, was all in. They were immediately safe and effective. It was amazing the confidence with which they could tell us that these were safe and effective vaccines based on two randomized trials and a couple of months of data. But again, I was busy and I was naive. I should have questioned things more at that time. But I assumed, hoped, that the powers that be knew what they were doing in terms of pushing these vaccines. So I myself, I got vaccinated. I got the two primary vaccinations, mRNA vaccinations in early 2021.

Chad Horton
I'm just going to ask you one question about what you said. You talked about cutting the red tape and pushing the vaccines out, and you mentioned two months of data, trial data. With your experience as a physician and a surgeon, and you also indicated, "I should have read the studies more carefully." Based on your experience and where we are today, do you believe that that was a responsible statement? A medically responsible statement or a socially responsible statement to characterize those interventions as safe and effective?

Dr. Dion Davidson
No, I think that's an irresponsible way to describe almost any medical intervention, let alone a brand-new technology that had been studied in two randomized trials with a couple of months of data. We never talk about medical interventions like that. I never sit down with a patient who has a problem and I have a surgery that maybe could fix that problem. I hope it would, I think it will. I never just sit down with them or stand up with them and say, "This is safe and effective, do it." That's never how we talk about things as doctors. Ever.

You talk to the patient about what's happening with them, what their options are. And maybe even I give a recommendation, but I also talk to them about the risks of what I'm proposing and the potential benefits. And it's always, always up to the patient. And if the patient decides against what I'm recommending, you stick with them and you try something else. You never just say, "This is safe and effective; do this, take this." That's never how we talk about medical interventions.

Chad Horton
Well, I thank you for that doctor. A logical corollary to what you've just said is, or the next logical question then, given what you've just expressed to the Commission: How did you feel about the mandates themselves when the vaccines actually became mandated in this province?

Dr. Dion Davidson
Well, so that was the next issue. It's one thing to heavily promote a medical intervention like that to the public. And you know, there's arguments to be made, certainly that that shouldn't have happened.

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To then force people to take that intervention is a whole new level. And I really couldn't comprehend that the discussion was even being undertaken. By then, we had even more data about what was happening with the virus. And it was serious; the virus was serious. I'm not a COVID denier. I eventually, later on, helped look after extremely sick patients in

the ICU who had COVID. And so, I don't deny that: for a relatively small number of people, it is a very serious disease and it can cause death. There was no doubt about that.

But again, by then we had much more data about who was at risk and who wasn't. We had much more data about the magnitude of mortality that COVID was bringing us. And even at that point that mandates were being discussed, we were starting to get data about how the vaccines did little or nothing to reduce transmission of the disease.

So as Aris was saying earlier, in order to even contemplate a mandate where you're forcing someone to take a medical intervention on pain of losing their job or they're being able to participate in society as they normally would— In order to even think about that, it would have to be an infectious disease situation where the pathogen is so serious and the intervention is so safe and so effective that you can then contravene this extremely important ethic of informed and free consent. So at that point, it did not seem that any of those criteria were being met.

The data was becoming more clear to the extent that it was being admitted on American national television by the CDC and Anthony Fauci that the vaccines were, first of all, losing their effectiveness even in contracting COVID fairly early, within four or five months. We all saw the 95 per cent effective go down to 50 per cent effective over the next few months. But more importantly, they were admitting that they did little or nothing to reduce transmission of the virus. And so then, in my mind—and I challenge anybody to tell me how this cannot be—the whole argument for even considering forcing vaccination on someone is null and void.

Chad Horton
Changing topics here a little bit, Doctor. As the vaccines were rolled out and as we got into a vaccine mandate situation here in Nova Scotia, did you have any direct or indirect experience with adverse events in your medical practice with respect to the COVID-19 vaccinations?

Dr. Dion Davidson
Yes, I did. And you know, just to clarify, the term is not adverse event due to vaccination. The term is adverse event following vaccination or following immunization. And the whole point there is that it's extremely difficult to prove that any adverse event is because of a vaccination. But that's part of the point of encouraging, or what we should have been doing is encouraging, people to report adverse events happening after. And there was not the sort of burden of proof for health care professionals—for example, nurses or doctors—to know that an adverse event was because of the vaccination. We are supposed to be reporting adverse events, whether we think they have any relationship or whether we can sort of explain any relationship or not.

I certainly had first-hand experience of at least—I have to be careful about patient personal health information—life-threatening, and many more cases of more minor thrombotic events, shortly after vaccination. And when I first saw those, that was my first introduction into the online adverse events reporting system that you heard about. I must say: I think Aris left, but he must be many orders of magnitude smarter than me because I don't know how you could get through one of those reports in five minutes. I mean it took me 45 minutes; it took me 10 minutes just to figure out the links on the website to try to get to the five-page PDF that you'd have to fill out. I found it—and I spoke to many other people that

agreed with me—a very cumbersome, very awkward process to report an adverse event occurring after a vaccination.

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Chad Horton
Would it be your opinion that the way that the reporting system was set up, that it could potentially impair the reporting of adverse events, or otherwise inhibit the reporting of adverse events?

Dr. Dion Davidson
Yes. And in addition to that is the whole issue of communication with us as health care professionals. We were relentlessly bombarded with how great the vaccines were, that they were safe and effective, safe and effective a thousand times a day, this oversimplification of this new medical intervention.

And informed by our various regulatory bodies—the College of Physicians and Surgeons in my case—that if we did not publicly voice support or if we publicly voiced anything other than support of public health's statements about that, that we would be disciplined or that we would face disciplinary measures. So not only is the mechanics of reporting the adverse event very cumbersome and time consuming, the overall messaging, I can tell you, was not, "Be sure to look out for these adverse events." I think I saw one email during those years. And again, that was after the newspaper article that you heard about, that it felt like public health was forced to say something about this adverse event's reporting system.

So every day, relentless: "vaccines are safe and effective." Maybe one message about reporting adverse events.

Chad Horton
I'm going to ask you this in a general way, Dr. Davidson. Is it your opinion that the messaging that you just described had a dissuasive effect on the reporting of adverse events?

Dr. Dion Davidson
I don't know how it couldn't have.

Chad Horton
And I'm going to back up just a little bit. You had mentioned thrombotic events. For those of us who aren't physicians, what is a thrombotic event? And just so everyone can remember, Dr. Davidson, I believe your evidence was you observed an increase in thrombotic events as an adverse event post-vaccination. Is that correct?

Dr. Dion Davidson
That's correct.

Chad Horton
And what is a thrombotic event?

Dr. Dion Davidson
Simply put, it is blood clots forming in blood vessels. In my case, you know I saw a couple in arteries but more so in veins.

So much so that it did lead me to change my practice, my office practice, where I provide relatively minor venous procedures to advising patients about more anticoagulation or medications that would reduce their risk of clots in the superficial veins and the deep veins, which could potentially be life threatening.

Chad Horton
Did you prescribe interventions in connection with adverse events post-vaccination?

Dr. Dion Davidson
Not specifically procedures for those clots—you don't really do procedures in the midst of an acute clot—but just the additional blood thinners, anti-coagulants to prevent them.

Chad Horton
So prescriptions. Yeah. Okay. And I've just been told that we're nearing the conclusion of our time, so I'll try to get through the rest of this quickly. But as a physician and surgeon with, I believe, based on what you had said—that I think you came into the province in 2005—by my counting that would give you approximately 18 years' experience as a physician and surgeon in Nova Scotia. Correct?

Dr. Dion Davidson
Yes.

Chad Horton
Yeah, okay. So as a physician and surgeon with 18 years' experience practising in Nova Scotia specifically, is it your opinion that the implementation of vaccine mandates was a necessary public safety measure?

Dr. Dion Davidson
Vaccine mandates were an unnecessary public safety measure.

Chad Horton
Okay. And similarly, is it your opinion that the implementation of vaccine mandates was a reasonable public safety measure?

Dr. Dion Davidson
No, they were not a reasonable public safety measure.

Chad Horton
Final question, Dr. Davidson. You indicated that, based on your experience, you were leaving the practice of medicine in Nova Scotia. You shared with us what I believe any layperson would believe is a fairly impressive history and list of credentials. What I'd like to ask you, sir, is what does your departure from medicine mean for Nova Scotians?

[00:40:00]

Dr. Dion Davidson
It's a difficult question to answer. I mean, certainly, you know, it would be true to say that I have been a hard-working community vascular surgeon. I do a lot of call coverage, or I did, before I was in the process of resigning. I do a lot of call coverage in terms of frequency of call coverage, covering the western zone of Nova Scotia for general vascular surgical sort of concerns and urgencies and emergencies. As I said, I was one of the attendings in the ICU. So I had a very busy practice, was a real hard worker for sure.

And so, you know, when someone like that resigns, it certainly leaves at least somewhat of a hole. And you know, in my case specifically: So it means that the remaining vascular surgeons, first of all, until they can find a replacement, will be working harder. There is a shortage of vascular surgeons around the world and across Canada, and I don't know how long it will take to recruit another vascular surgeon. Patients will wait longer. I think in particular some areas that unfortunately are chronically underserved, like diabetic foot infections and some of the aspects of chronic venous disease that I was talking about, that I spent more time on—those patients, I think, are going to be quite ill-served until and whether that gap is filled. Yeah.

Chad Horton
All right. Those are my questions, sir. I will turn you over to the Commission. Thank you.

Commissioner Massie
Thank you very much for your testimony. I have a question. I realize that you're very busy, so you didn't have the time maybe to do the critical analysis of the literature, so you decided to take on the vaccine. Was it because you were influenced by the environment, or was it something that you wanted to do initially because you wanted maybe to protect vulnerable patients in the hospital?

Dr. Dion Davidson
I'd say a little of both. I mean, you know, again, I just sort of trusted what my bosses and elders were telling me, right. I mean, ostensibly, public health should know more about all this stuff than I do. And even though some of it didn't make sense at various junctures, at times it's much easier just to accept what you're being told and do what you're told rather than do your own research, do your own reading. So we were told the vaccines were safe and effective and we should get them. So I just got them. At that time. Not since.

Commissioner Massie
And did you encourage people in your family to also get vaccinated?

Dr. Dion Davidson
No, I wouldn't say so. I'm just trying to think back to that time period. I didn't necessarily encourage my wife to get vaccinated, I left it up to her. And I think I might have encouraged my parents to at least consider it. I don't remember ever being so— I was never aggressive about it, but I think I may have encouraged my parents to consider it at the time.

Commissioner Massie
Thank you very much.

Commissioner DiGregorio
Thank you for your testimony. Just a few questions. You spoke a little bit about the cumbersome reporting process for adverse events. And I'm just wondering if you have any thoughts or recommendations on how that process could be improved upon.

Dr. Dion Davidson
Yeah, I mean, not specifically. Along with all the other things, I'm not an IT specialist. But it seems to me, it would be quite simple to make the process—the mechanics of that process—a lot more straightforward. First of all, in terms of, "Here's what you click on. Here's a few boxes to click. Now you can scan a QR code." I mean, surely things like that could be brought into play.

But even, again, more importantly than that, I would say, would be that overall messaging—that this is our responsibility as health care workers to look out for these adverse events. We don't have to prove that they're because of the vaccination. The whole point is that this is a screening system. And that and along with every email that said that the vaccines are safe and effective should have been a line right underneath saying, "And by the way, it's your responsibility to look out for adverse events and report those as well." So those would be two, I think, fairly simple recommendations moving forward.

[00:45:00]

Commissioner DiGregorio
So would that include maybe part of the education and training that doctors receive?

Dr. Dion Davidson
Yeah, I suppose. But I mean, it wouldn't take much education and training. It's like one sentence.

Commissioner DiGregorio
And one other question. You mentioned that you have resigned and that you're leaving Nova Scotia. I'm just wondering if there is something now that Nova Scotia could do that would prevent you from leaving.

Dr. Dion Davidson
Yeah, I mean, I don't know. I guess, a complete turnaround of public health and its attitude toward the public. And some overtures that they're going to seek to be more holistic and humanistic about their approach to things like this.

Yeah, I don't know. Maybe. I'm pretty far down the road of leaving, but you never know.

Commissioner DiGregorio
Thank you.

Commissioner Drysdale
I have a couple of questions, Doctor. Thank you for your testimony. First question was— Do you know of any other professionals currently leaving the province of Nova Scotia for these types of reasons?

Dr. Dion Davidson
That's a very good question. At least a couple have left. But also, I know of dozens that have— You know, I heard the term quiet-quit recently. So I know of dozens of doctors and nurses who have taken leaves of absences, have downsized their practice. And some of these are people that were basically fired for not getting vaccinated. And even now, two years later: even now, we have all this data about how the vaccines don't reduce transmission. Even to this day, you can't work as a health care worker in Nova Scotia Health unless you got those two vaccines, two years ago.

So I know of dozens of nurses and doctors who aren't working because of that. A few that actually even got vaccinated but just like me, just got sick of things, and so they've retired early and are in the process of moving away. So I guess the short answer is, yes, I know about others.

Commissioner Drysdale
This question might seem odd. How much did you know about mRNA technology prior to you taking the vax yourself?

Dr. Dion Davidson
Not much at all. You know, as I said, scanned the RCTs that were done at that time. And then, you know, maybe a quick internet search here and there about what this technology was. And that was about it.

Commissioner Drysdale
But were you aware of it being a novel technology to be used on the population?

Dr. Dion Davidson
Well, mRNA technology, the technology, the idea is not new per se. I mean it was, I don't know, 10 years ago or whatever that it came about and it's been used in very limited ways over those years. So it wasn't new in that way. But I was aware that this was obviously the biggest application that had been made of mRNA technology. And in that sense, it was new.

Commissioner Drysdale
It's just the reason I asked that question is because you're right: as I understand from previous testimony, the mRNA technology has been around for quite some time. But this, as I understand, was the first time it was introduced in mass to the human population.

Dr. Dion Davidson
It was my understanding as well.

Commissioner Drysdale
And considering that it had never been done before, you would have thought that there would not just be the standard review process in place, but it would be an additional process.

Dr. Dion Davidson
One would have thought.

Commissioner Drysdale
You know, I have another question that's a very short one. And I can't imagine you can answer this, but my question to you is, why? Why did this happen? Why did we— And I think you were here earlier and listening to the testimony, but we heard from Dr. Braden about—this is my words, not hers—the breakdown in the process from conceptual science to production of product, to putting it in arms. And there seemed to be a breakdown in the entire system from top to bottom. Even after it went into arms, the reporting of adverse reactions or even the reporting of efficacy seemed to all break down on this.

Dr. Dion Davidson
How did that happen?

[00:50:00]

Commissioner Drysdale
How did that happen? Why? Or why did it happen? Perhaps those are two different questions.

Dr. Dion Davidson
From what I understand, there was somewhat of a new public health elite that emerged early in the pandemic. And they became obsessed with this one virus—with some good reason, it was bad—to the negation of literally every other public health concern.

And then it became political, and then it became tribal. So that you were either on team "coronavirus is going to kill us all, and everything and anything that we need to do to stop it or that could even possibly stop it, is justified" or you're on "team critical" of all that. And I think just many public health officials chose their team. Many doctors chose their team, and they just stuck with it, no matter what the data said. And that carried through the entire pandemic. People chose their team, they chose their tribe, and they just stuck to their guns, no matter what else came up.

Commissioner Drysdale
Thank you.

Commissioner DiGregorio
Sorry, I just have one more question that I forgot to ask you. How long did you train to become a vascular surgeon?

Dr. Dion Davidson
So medical school for me was four years. It is for most people four years. And then I trained in general surgery first and then vascular surgery. That was a total of eight years after that.

Commissioner DiGregorio
So 12 years. Is my math okay there?

Dr. Dion Davidson
From the beginning of medical school till the end of my surgical training was 12 years. And I did, you know, four years of university before medical school, so 16. A lot of years.

Commissioner DiGregorio
And did I hear you correctly say that there is, not really a shortage of vascular surgeons, but that you are in short supply?

Dr. Dion Davidson
Yeah, there is a shortage of vascular surgeons. I mean, there's a shortage of any number of specialties around the world and doctors in general, right. But certainly, specifically vascular surgery, yeah.

Commissioner DiGregorio
Thank you.

Dr. Dion Davidson
You're welcome.

Ches Crosbie
Thank you, Dr. Davidson.

[00:52:33]

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