IN THE MATTER OF A HEARING OF THE HEARING TRIBUNAL OF THE COLLEGE OF CHIROPRACTORS OF ALBERTA (FORMERLY KNOWN AS THE ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS) (THE "COLLEGE") INTO THE CONDUCT OF DR. CURTIS WALL, A REGULATED MEMBER OF THE COLLEGE

Pursuant to *THE HEALTH PROFESSIONS ACT,*

R.S.A. 2000 c.P-14 being Chapter H-7 of the Revised Statutes of Alberta

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WRITTEN SUBMISSIONS OF DR. CURTIS WALL IN RESPONSE TO THE CHARGES AGAINST HIM

JULY 7, 2022

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I. Overview

1. This case is about honesty. Honesty and truth. It is not about compliance, as the Complaints Director would have this Hearing Tribunal believe. If that was true, this matter would not be before a Hearing Tribunal. Legal matters are rarely that simple.

2. Dr. Wall implores this Tribunal to be honest with the evidence, honest with itself, honest with him, and, ultimately, honest with the public.

3. This Tribunal is in an extraordinary position. Through this case, it will rule on one of the most pressing, ubiquitous, and controversial issues of the last two years: masks. More testimony, more information, and more scientific material about masks has been presented in this case more than any other that has yet dealt with this issue. The Tribunal has a unique opportunity to pronounce on this issue form a fully informed position.

4. Dr. Wall could ask the Tribunal to strike down the mask mandate contained in the College of Chiropractors of Alberta's (the "College") Pandemic Directive as an unlawful violation of the *Constitution Act, 1982*. The evidence is present to support that, and the Tribunal has the authority pursuant to section 24(1) of the *Canadian Charter of Rights and Freedoms* to do that.

5. However, the Tribunal need not go that far and Dr. Wall does not ask it to. Rather, Dr. Wall asks, first, that the Tribunal find the College's mask mandate is an unjustified violation of the *Alberta Human Rights Act*, and that the College unlawfully discriminated against Dr. Wall on the basis of mental disability and religious beliefs when it refused to accommodate him and instead attempted to discipline him. Dr. Wall submits that all charges against him related to not wearing a mask while treating patients must fail as a result.

6. As for the remaining charges, Dr. Wall submits that he acted professionally in protecting his patients from the harms of masking, that he lawfully exercised his *Charter* 2(b) right to free expression in discussing the truth of masks with his patients, and that he did not breach any applicable CMOH Orders.

II. The College's Duty to Accommodate Pursuant to its Human Rights Obligations

7. Professional regulatory bodies such as the College are bound by the *Alberta Human Rights Act* (*AHRA*).[1] As the Court of Appeal of Alberta has stated:

> The law to be applied is well-established. The *Human Rights Act* prohibits discrimination by an occupational association like the College against any member on various grounds, including physical disability or mental disability.[2]

8. The College must not unlawfully discriminate against its members. The flip side of this is that the College must reasonably accommodate its members. This duty to accommodate and obligation to not discriminate applies to both the College's actions and to its policies, including the Pandemic Directive.

III. Charges that Fail due to Discrimination

9. All the Charges against Dr. Wall that relate, directly or indirectly, to him treating patients while not wearing a mask are tied to the discriminatory nature of the Pandemic Directive or to the College's discriminatory conduct toward Dr. Wall and his son, who was a staff at Dr. Wall's clinic during the material time. These are Charges 1(a), 1(b), and 1(c), which regard not wearing a mask, not distancing, and not erecting a plastic barrier; Charges 2(a) and 2(b), which regard Dr. Wall's son not wearing a mask and distancing; Charges 4(a) and 4(b), which regard not charting about Dr. Wall and his son not wearing masks; and Charge 5(b), which regard not "following" the Pandemic Directive.

10. Factually, Charge 5(b) is entirely duplicative of Charges 1(a), 1(b), and 1(c), as the only aspects of the Pandemic Directive that Dr. Wall did not adhere to are masking, distancing, and the erection of a plastic barrier. Any answer to Charges 1(a), 1(b), and 1(c) is also an answer to Charge 5(b).

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[1] *Alberta Human Rights Act*, RSA 2000, c A-25.5, section 9(c).
[2] *Wright v College and Association of Registered Nurses of Alberta*, 2012 ABCA 267 at para. 50.

IV. *Prima Facie* Discrimination

11. To be unlawful, discrimination must impact a protected characteristic. Mental disability is one of the protected characteristics in the *AHRA*. Religious beliefs is another protected characteristic.[3]

12. Discrimination on the basis of a protected characteristic is *prima facie* unlawful, however the discrimination can be justified if certain requirements are met. There are legal tests for determining when *prima facie* discrimination has occurred and whether it is justified.

13. The onus is on the claimant, in this case, Dr. Wall, to establish on a balance of probabilities that he has been discriminated against. To demonstrate *prima facie* discrimination, claimants "are required to show that they have a characteristic protected from discrimination… that they experienced an adverse impact… and that the protected characteristic was a factor in the adverse impact".[4]

14. A review of the evidence reveals that Dr. Wall has two relevant protected characteristics, mental disability and religious beliefs, that he has and is experiencing adverse impacts, and that his protected characteristics are factors in the adverse impact.

A. Mental Disability

15. Dr. Wall provided extensive testimony as to the negative mental impacts he experienced when he attempted to wear a mask. Dr. Wall described the claustrophobia, anxiety, inability to concentrate, and other disabling symptoms he experienced when he initially wore a mask while treating patients.[5] These are traditional mental disabilities that have been repeatedly recognized as serious, debilitating, and falling within the scope of what is protected by the *AHRA*.

16. Significant weight must be placed on this evidence from Dr. Wall, who was open, candid, direct, and consistent throughout his testimony. As his testimony demonstrated,

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[3] *AHRA*, section 9(c).
[4] *Moore v. British Columbia (Ministry of Education)*, 2012 SCC 61 at para. 33.
[5] See, for example, pages 568-569 of Dr. Wall's testimony.

he is a person of few words who does not embellish or overstate. At no point during questioning did he evade questions or attempt to answer a different question than what was asked. Even when pressed by counsel for the Complaints Director, who put it to Dr. Wall that his stance on the futility of masks was astonishing, Dr. Wall did not vary his prior statements or his positions regarding masks.[6] None of his evidence regarding his mental disabilities as regards masking was challenged or contradicted. Dr. Wall is therefore a highly credible and reliable witness.

17. Further, Dr. Wall's description of his symptoms and assessment that the cause of those symptoms was the wearing of a mask was verified by a physician, Dr. Salem. Predictably, the Complaints Director criticizes Dr. Salem's notes confirming the anxiety and claustrophobia experienced by Dr. Wall when wearing a mask, but, importantly, there is no evidence contrary to Dr. Salem's evidence. The Complaints Director has adduced no evidence from a physician, expert opinion or otherwise, that differs from Dr. Salem's assessment. There is no reason to doubt Dr. Salem's assessment and full weight must be accorded to it.

18. Further still, common sense and the expert opinion evidence from Respirologist Dr. Bao Dang and from Occupational Health and Safety expert Chris Schaefer confirm that is it entirely expected that some individuals will experience severe mental disability symptoms similar to those of Dr. Wall when wearing a mask.

19. Dr. Wall is therefore medically unable to wear a mask because of his mental disabilities of claustrophobia and anxiety, which are uniquely triggered by the wearing of a mask. Dr. Wall has testified to these facts, a physician has verified these facts, and these facts are consistent with the other evidence in this case.

B. Religious Beliefs

20. The legal test for demonstrating a protected religious belief comes from *Syndicat Northcrest v Amselem*.[7] Dr. Wall must demonstrate that he holds sincere religious beliefs regarding the wearing of masks that have a nexus with religion (Christianity),

[6] Testimony of Dr. Wall at page 616, line 22 – page 617, line 4.
[7] 2004 SCC 47.

and that would be interfered with in a manner that is more than trivial or insubstantial if he wore a mask.[8]

21. Dr. Wall explained in detail his Christian beliefs regarding masking and why it would be sinful and contrary to his faith to wear a mask.[9] He further explained how these beliefs developed over time, which is unsurprising considering the novelty of the issue of compelled masking and the fact Dr. Wall had never worn a mask prior to the COVID restrictions. Dr. Wall's religious beliefs about not wearing a mask are sincere, have a nexus with Christianity, and are substantially interfered with if he wears a mask. His religious beliefs are therefore protected for the purposes of the *AHRA*.

C. Adverse Impact and Protected Characteristics as Factors in the Adverse Impact

22. Dr. Wall has suffered adverse impacts as a result of not wearing a mask. This much is obvious. The first adverse impact was the College's attempt to strip him of his practice permit, and therefore his livelihood, when the Complaints Director applied to suspend Dr. Wall's ability to practice pending the outcome of a hearing. Had the Complaints Director's request for a suspension been granted, Dr. Wall would have lost all his income for months or years. That would have been a scandalous outcome. It is one the law protects against and one implicitly acknowledged by Dr. [redacted] when he denied the Complaints Director's application to suspend Dr. Wall's practice permit.

23. The second adverse impact is the Complaints Director's ongoing prosecution of Dr. Wall and the Charges brought against him that he is herein contesting.

24. These adverse impacts are clearly a result of the College's actions and policies and clearly flow from Dr. Wall not wearing a mask while treating patients. Obviously, his mental disabilities and religious beliefs are a factor in the adverse impact because these characteristics are why he cannot and does not wear a mask. The reason the College has taken these actions against Dr. Wall and levied most of the Charges it has is because he

[8] *Amselem*, at paras. 46-56.
[9] Testimony of Dr. Wall at pages 572-574.

practiced without wearing a mask, which is directly connected to his mental disabilities and religious beliefs that render him unable to wear a mask.

D. The College's Claim Dr. Wall did not Request Accommodation

25. At paragraphs 168-172 of his written submissions, the Complaints Director argues that Dr. Wall did not request accommodation and therefore the College is, effectively, "off the hook".

26. First, as will be discussed in detail below, the Pandemic Directive, as a standard set by the College, is required to adhere to the *AHRA*, full stop. That requirement is not contingent on a regulated member saying or doing anything. The College's policies always must comply with the *AHRA*, be it May 2020, December 2020, or any other time. The Pandemic Directive is the only relevant item for the period between June - December 2020. The College's discriminatory conduct toward Dr. Wall does not become relevant until December 2020, which means knowledge of Dr. Wall's protected characteristics do not become relevant until this time. As the Court of Appeal of Alberta has ruled:

> ***Demonstrating an employer's knowledge of an employee's disability is unnecessary***, in a case alleging adverse-effect discrimination. ***By definition, adverse-effect discrimination is the uniform application of a seemingly neutral employment policy to all employees, regardless of whether some employees have protected characteristics***. The impugned policy applies to a disabled employee whether or not the employer knows about the disability. The basic three-part test is sufficient to accommodate cases where an employer's knowledge is relevant to a *prima facie* case, and thus "knowledge" should not be added as a fourth element of the *prima facie* case test.[10]

27. As for the College's actions regarding Dr. Wall from December 2020 onward, the fact is Dr. Wall ***did*** ask for accommodation in his phone conversations with Dr. [redacted] and Mr. [redacted] on or around December 2-5, 2020. Although, Dr. Wall testified that he

[10] *TWU v. Telus Communications Inc.*, 2014 ABCA 154 at para. 29 [emphasis added].

doubted whether Mr. [redacted] even believed him when he referred to his mental disabilities.[11]

28. In a call with Dr. [redacted], Dr. Wall specified his concerns about masking, the mental disability effects it had on him, and the availability of accommodation options.[12] Dr. [redacted] response to Dr. Wall was that he either wear a mask or "sit out" from practicing.[13]

29. Dr. [redacted] denies making the comment about "sitting out" from practicing.[14] However, to whatever degree Dr. [redacted] evidence conflicts with Dr. Wall's regarding what was said during this call, the Tribunal should favour Dr. Wall's evidence as being more credible and reliable.

30. Generally, Dr. [redacted] was evasive and avoided providing the candid, direct, and open answers that Dr. Wall consistently provided. Representative examples of Dr. [redacted] evasiveness include when he was asked to acknowledge the truth that physical manipulation is the primary form of care provided by chiropractors,[15] and when he would not even acknowledge that the *AHRA* applies to the College.[16] A comment like "sit out from practicing" is very specific and not easy to forgot due to being a common statement.

31. In a subsequent call with Mr. [redacted], Dr. Wall raised the issue of possible accommodation and his mental disabilities. Mr. [redacted] response was that he was not going to debate the issues and that if Dr. Wall was not going to wear a mask, he would take action to suspend Dr. Wall's practice permit. Mr. [redacted] engaged in no discussion whatsoever regarding accommodation.[17]

32. Mr. [redacted] was repeatedly equivocal and self-contradicting regarding what was said on the call with Dr. Wall.[18] Despite acknowledging on cross-examination that Dr. Wall

[11] Testimony of Dr. Wall at page 582, lines 23-26.
[12] Testimony of Dr. Wall at pages 570.
[13] Testimony of Dr. Wall at pages 579-580.
[14] Testimony of Dr. [redacted] at pages 437-438.
[15] Testimony of Dr. [redacted] at pages 410-414.
[16] Testimony of Dr. [redacted] at pages 435-436.
[17] Testimony of Dr. Wall at pages 580-582.
[18] Testimony of Mr. [redacted] at pages 506-509.

asked a question about "human rights", on re-direct, Mr. [redacted] denied that Dr. Wall asked about a process to address human rights concerns or that Dr. Wall asked for an exemption.[19]

33. Again, to whatever degree Mr. [redacted] evidence conflicts with Dr. Wall's regarding what was said during the call with Dr. Wall, the Tribunal should favour Dr. Wall's evidence as being more credible and reliable. Mr. [redacted] was also evasive and avoided providing the candid, direct, and open answers that Dr. Wall consistently provided. Mr. [redacted] often did his best to avoid agreeing with the simple questions asked of him.[20]

34. If Dr. Wall testifies that he mentioned accommodation on the calls with Dr. [redacted] and Mr. [redacted], there is every reason to believe he did, regardless of what Dr. [redacted] or Mr. [redacted] may say otherwise.

35. Further still, it was plain and obvious by mid-December 2020 that Dr. Wall was asserting a protected characteristic regarding the requirement to wear a mask. On December 12, 2020, Dr. Wall obtained a doctor's note from a physician stating that for "medical reasons" he was "exempt" from wearing a mask. This note was then provided to Mr. [redacted] on or around December 14.[21] The provision of a doctor's note to the College citing a medical inability to wear a mask undoubtedly triggers the College's duty to accommodate such an inability, even if, upon review, it is determined that accommodation is impossible. If the Complaints Director was acting reasonably and fulfilling his duty to accommodate, he would have withdrawn his application to suspend Dr. Wall's practice permit and assessed whether the College could accommodate Dr. Wall. But, as Mr. [redacted] admitted, human rights accommodation did not matter to him, only Dr. Wall's compliance with the Pandemic Directive under penalty of suspension.[22]

[19] Testimony of Mr. [redacted] at page 506.
[20] See, for example, the testimony of Mr. [redacted] at pages 516-520.
[21] Testimony of Mr. [redacted] at page 516, lines 3-18.
[22] Testimony of Mr. [redacted] at page 517, line 4 – page 518, line 18.

36. As for Dr. Wall's religious beliefs regarding masks, the College was made aware of these in Dr. Wall's written submissions in response to the Complaints Director's application to suspend his practice permit.[23] It is no defence to point out that Dr. Wall did not ask for accommodation in those submissions. Dr. Wall instructed his counsel to only discuss the legal test for practice permit suspension and his *Charter* rights because, by then, it was apparent to him the College had no interest in discussing human rights accommodation. Indeed, by so quickly applying to suspend his practice permit, the College reacted to Dr. Wall not wearing a mask in the most extreme fashion it possibly could have.

E. Conclusion

37. Dr. Wall has therefore established a *prima facie* case of discrimination on the basis of mental disability and religious beliefs. This is so both because of the College's actions in enforcing the Pandemic Directive through discipline, and the nature and content of the Pandemic Directive itself. Any policy or requirement that discriminates against protected characteristics by not accounting for them, as the Pandemic Directive does, is contrary to the *AHRA* and therefore unlawful unless it can be justified.

V. Is the Discrimination Justified?

38. The College can only justify its discrimination against Dr. Wall, as manifested in both its actions and its Pandemic Directive, if it can demonstrate its requirements to wear a mask, and distance if not masking, are *bona fide* occupational requirements ("BFOR").

39. There is a three-part test for establishing a BFOR that was laid down by the Supreme Court of Canada in a 1999 case that is referred to as "*Meiorin*".[24]

40. This Tribunal must keep in mind that the onus to demonstrate a BFOR is on the College, not on Dr. Wall.[25] As Justice Abella of the Supreme Court stated in *Moore*:

> Once a prima facie case has been established, the burden shifts to the respondent to justify the conduct or practice, within the framework of the

[23] Exhibit B-3.
[24] *British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U.*, [1999] 3 S.C.R. 3. ["*Meiorin*"].
[25] *Meiorin*, at paragraph 72.

> exemptions available under human rights statutes. If it cannot be justified, discrimination will be found to occur.[26]

41. The first step of the test is to show that the standard adopted, in this case, universal mandatory masking, is rationally connected to practicing Chiropractic at the material time. The second step is to show the standard was adopted in a good faith belief it was necessary.[27]

42. Dr. Wall concedes these first two points. There is no doubt the College honestly, even if mistakenly, believed that no-exceptions masking was called for. And, although the College's mask mandate is itself irrational in light of the scientific evidence, its purpose is arguably rationally connected to safety.

A. Undue Hardship – The Law

43. The third step is to show that the standard is reasonably necessary. This is where the majority of human rights cases are decided. This is the part of the test that is often referred to as "undue hardship".[28]

44. This part of the test is often difficult conceptually to apply, because mere hardship is not enough—the hardship must be "undue". But that begs the question, where is the line between hardship and undue hardship? The applicable case law provides this Tribunal guidance on this question.

45. In discussing "undue hardship" in *Meiorin*, the Supreme court stated those seeking to justify an impugned standard must:

> …establish that it cannot accommodate the claimant and others adversely affected by the standard without experiencing undue hardship. When referring to the concept of "undue hardship," it is important to recall the words of Sopinka J. who observed in *Renaud v. Central Okanagan School District No. 23*, [1992] 2 S.C.R. 970(S.C.C.) , at p. 984, that ***"[t]he use of the term 'undue' infers that some hardship is acceptable; it is only 'undue' hardship that satisfies this test." It may be ideal from the employer's perspective to choose a standard that is uncompromisingly***

[26] *Moore,* at para. 33.
[27] *Meiorin*, at paragraph 54.
[28] *Meiorin*, at paragraph 54.

> ***stringent. Yet the standard, if it is to be justified under the human rights legislation, must accommodate factors relating to the unique capabilities and inherent worth and dignity of every individual, up to the point of undue hardship.***[29]

46. The Supreme court went on to list some "important questions" that may be asked as part of the legal analysis. These are questions the Tribunal should ask to assist it in determining if the College's actions and its Pandemic Directive are justified forms of discrimination. The questions are:

> (a) ***Has the employer investigated alternative approaches that do not have a discriminatory effect***…?
>
> (b) If alternative standards were investigated and found to be capable of fulfilling the employer's purpose, why were they not implemented?
>
> (c) ***Is it necessary to have all employees meet the single standard for the employer to accomplish its legitimate purpose*** or could standards reflective of group or individual differences and capabilities be established?
>
> (d) ***Is there a way to do the job that is less discriminatory while still accomplishing the employer's legitimate purpose***?
>
> (e) ***Is the standard properly designed to ensure that the desired qualification is met without placing an undue burden on those to whom the standard applies***?
>
> (f) Have other parties who are obliged to assist in the search for possible accommodation fulfilled their roles?...[30]

47. To dispel any doubt that the Pandemic Directive itself is required to comply with the *AHRA* by not, itself, being discriminatory, the Supreme Court stated in *Meiorin*:

> Employers designing workplace standards owe an obligation to be aware of both the differences between individuals, and differences that characterize groups of individuals. They must build conceptions of equality into workplace standards. By enacting human rights statutes and providing that they are applicable to the workplace, the legislatures have determined that the standards governing the performance of work should be designed to reflect all members of society, in so far as this is reasonably possible. Courts and ***tribunals must bear this in mind when confronted with a claim of employment-related discrimination***. ***To the extent that a***

[29] *Meiorin*, at paragraph 62 [emphasis added].
[30] *Meiorin*, at paragraph 65 [emphasis added].

> ***standard unnecessarily fails to reflect the differences among individuals, it runs afoul of the prohibitions contained in the various human rights statutes and must be replaced. The standard itself is required to provide for individual accommodation, if reasonably possible.*** A standard that allows for such accommodation may be only slightly different from the existing standard but it is a different standard nonetheless.[31]

48. The only evidence that the College ever considered alternatives to its universal mask requirement is the unsupported testimony of College personnel that unspecified alternatives were considered in the spring of 2020 and rejected.

49. Further, there is no evidence that the College considered any alternatives in the individual case of Dr. Wall in December 2020. Rather, the Complaints Director immediately moved to suspend Dr. Wall's practice permit. In order to now defend its "no alternatives" approach, the College must demonstrate through ***factual***, or, in this case, ***scientific*** evidence that all other alternatives to simply disallowing an unmasked chiropractor like Dr. Wall from practicing would constitute undue hardship. This the College cannot do.

50. Further still, the fact the College made no attempt whatsoever to consider how it might accommodate Dr. Wall's protected characteristics in December 2020 is highly relevant.[32] It is incumbent upon the Tribunal to take a "holistic approach in examining the question of accommodation, both as to the procedural and substantive components".[33] At no point did the College dialogue with Dr. Wall about possible accommodation. For the College, it was always compliance or the hammer.

51. The law requires the College to be flexible, even if doing so is inconvenient.[34] As the Supreme Court has stated:

> …the goal of accommodation is to ensure that an employee who is able to work can do so. In practice, this means that the employer must accommodate the employee in a way that, while not causing the employer undue hardship, will ensure that the employee can work. The purpose of

[31] *Meiorin*, at paragraph 68 [emphasis added].
[32] *Meiorin*, at paragraph 66.
[33] *University of British Columbia v. Kelly*, 2016 BCCA 271 at para. 42.
[34] *Syndicat des employé-e-s de techniques professionnelles & de bureau d'Hydro-Québec, section 2000 (SCFP-FTQ) v. Corbeil*, 2008 SCC 43 at para. 13.

> the duty to accommodate is to ensure that persons who are otherwise fit to work are not unfairly excluded where working conditions can be adjusted without undue hardship.[35]

52. There are only two forms of hardship the College can or has pointed to. One is harm to patients, or to the protection of the public. The extensive scientific evidence adduced by Dr. Wall closes the door on that.

53. The other possible form of hardship are the College's obligations to keep its practices and policies aligned with the wishes of Alberta Health Services ("AHS") and the Chief Medical Officer of Health ("CMOH"). But, as will be demonstrated, the College's obligations to adhere to the *AHRA* supersede any ostensibly conflicting obligations to AHS or the CMOH.

B. The Supremacy of the *AHRA*

54. The *AHRA* is quasi-constitutional. It is of a higher order than mere legislation such as the *Public Health Act* and the *Health Professions Act*.[36] All provincial statutes are subject to it, as are all state decision-makers and government bodies.

55. Section 1(1) of the *AHRA* sates:

> Unless it is expressly declared by an Act of the Legislature that it operates notwithstanding this Act, every law of Alberta is inoperative to the extent that it authorizes or requires the doing of anything prohibited by this Act.[37]

56. Section 12 of the *AHRA* states:

> The prohibitions contained in this Act apply to and bind the Crown in right of Alberta and every agency and servant of the Crown in right of Alberta.

57. The authority underwriting the CMOH Orders and the dependent orders of AHS Officers are entirely and exclusively derived from the *Public Health Act*. The *Public*

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[35] *Corbeil*, at para. 14.
[36] *Wright v. College and Assn. of Registered Nurses of Alberta*, 2012 ABCA 267 at paras. 102-103.
[37] Section 1(2) of the *AHRA* states, "In this Act, "law of Alberta" means an Act of the Legislature of Alberta enacted before or after the commencement of this Act, any order, rule or regulation made under an Act of the Legislature of Alberta…".

Health Act contains no statement that it operates notwithstanding the *AHRA* and therefore no order of the CMOH or of an AHS Officer operates notwithstanding the *AHRA*.

58. Justice Berger of the Court of Appeal of Alberta describes this legal reality thus:

> Human rights legislation has primacy over all other legislative enactments; therefore, where provisions of human rights legislation conflict with provisions in another provincial enactment, it is the former that apply…[38]

59. Dealing with an argument that the *Worker's Compensation Act* encourages discrimination, the Court of Queen's Bench of Alberta stated in *Challenger Geomatics Ltd. v. Alberta (Appeals Commission for Workers' Compensation)* that an employer can choose to discriminate, but cannot use the legislation as a defence when it does so and is faced with the legal consequences.[39] A similar argument was also rejected by the Alberta Human Rights Commission in *Horvath v. Rocky View School Division No. 41*.[40]

60. To put it plainly, it is no defence for the College to say that the CMOH and AHS required, encouraged, or permitted the College to discriminate against chiropractors who cannot wear a mask due to a protected characteristic. The reality is the CMOH and AHS are also subject to the *AHRA* and the College is subject to it regardless of what the CMOH or AHS says or does.

61. Importantly, both the CMOH and AHS implicitly acknowledge this legal reality. First, as was repeatedly referred to by Dr. Wall and other witnesses, the material CMOH Orders[41] permitted very broad exemptions for masking based on "mental concerns and limitations".[42]

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[38] *Wright*, at para 103, Justice Berger dissenting, but not on this point.
[39] 2014 ABQB 712 at para. 116.
[40] 2016 AHRC 19 at paras. 164-165.
[41] CMOH Orders 38-2020 and 42-2020.
[42] See, for example, section 27(c) of CMOH Order 38-2020.

62. Further, and even more importantly, when AHS was presented with Dr. Salem's note verifying Dr. Wall's mental disability in December 2020, it permitted him to open his clinic and treat patients without wearing a mask, effectively accommodating him.[43]

63. Universal mandatory masking is either a BFOR because the science supports it, or it is not. It is irrelevant if the requirement is purportedly coming from the CMOH or AHS. The College is still required by law to refrain from discriminating against its members.

VI. Undue Hardship to the Protection of the Public

64. The "million-dollar" question in this case is whether the College's no-alternative, universal masking requirement is a BFOR because the protection of the public demands nothing less.

65. As discussed, the legal onus is on the College to prove this. Needless to say, the College fails on this point due to the abundance of evidence that masks are utterly ineffective. Although a detailed account of the expert evidence in this case will be provided below, the evidence can be summarized as follows:

    a. Since pre-screening administrative controls were in place, chiropractors almost never saw patients while symptomatic and patients almost never saw chiropractors while symptomatic.[44]

    b. The College's mask mandate is therefore, practically-speaking, an ***asymptomatic*** mask mandate.

    c. Asymptomatic transmission of the SARS-CoV-2 virus is very rare;

    d. A large degree of transmission of SARS-CoV-2 occurs through aerosols and the rest occurs through droplets and contact;

    e. Masks prevent droplet transmission from symptomatic people;

    f. Masks do ***not*** prevent ***aerosol*** transmission from ***symptomatic*** people;

[43] Testimony of Dr. Wall at page 578, line 25 – page 579, line 9.
[44] See pages 3-4 of the Pandemic Practice Directive. See also the Testimony of Dr. Wall at page 594.

g. Masks likely increase contact transmission from symptomatic people;

h. Masks have no impact whatsoever when worn by asymptomatic people. First, because asymptomatic people effectively do not transmit virus. Second, if asymptomatic people ever did transmit virus, it would only be through aerosols, since droplets only result from symptoms, and masks do not stop aerosols in any event.

i. The College's mask mandate therefore had an entirely neutral impact on transmission and Dr. Wall in no way increased the relative risk of transmission by not wearing a mask.

j. Masking chiropractors will not meaningfully reduce the relative risk of the transmission of SARS-CoV-2 in chiropractic offices. In other words, the risk of transmitting SARS-CoV-2 between chiropractors and patients will remain essentially the same with or with out masks.

k. Transmission of SARS-CoV-2 is very high and has only increased over time, regardless of massive efforts to produce the opposite outcome;

l. Lastly, the disease caused by SARS-CoV-2, which is COVID, poses a risk on a similar level with influenza as far as general risk of death, but is much easier to catch (regardless of any measures that are put in place to stop it), and disproportionally impacts small subsets of the population while barely impacting the rest of the population.

A. Dr. [redacted] as an Unreliable Expert Witness

66. Belying its repeated claim that this case is not about masks, the College adduced an expert witness, Dr. [redacted], to attempt to show that masks are effective at preventing the transmission of COVID.

67. Dr. [redacted] is an Alberta public health physician. There are many problems with Dr. [redacted] evidence, but there are also many problems with Dr. [redacted] credibility and reliability as a witness.

68. Throughout questioning, Dr. [redacted] was immature, unprofessional, and unreasonable. He was flippant, careless with his words, and insulting and accusatory of Dr. Wall's expert witnesses.

69. Dr. [redacted] included a section at the beginning of his report that he admitted he included for "fun". ***Fun***. He then admitted that doing so was very casual and he should not have. He then proceeded to retract that part of his report, admitting that it was not relevant.[45] It was not, of course, as it was about a ***bacterial*** infection from hundreds of years ago.[46] This is extraordinary. That an expert witness in a case of this magnitude would say things "just for fun" is shocking and exemplifies Dr. [redacted] immaturity and unprofessionalism.[47]

70. Dr. [redacted] retracted a portion of his expert report a second time. During cross-examination, Dr. [redacted] retracted his insults and accusations of Dr. [redacted], one of Dr. Wall's expert witnesses.[48] This is the same Dr. [redacted] who provided an expert report with 98 citations to academic literature, teaches at McMaster University, is an infectious disease specialist, and is currently completing a masters in epidemiology at the University of London, England. Dr. [redacted] said that Dr. [redacted] "lacks a basic understanding of disease patterns". That accusation has no basis in reality and is highly unprofessional to make. It is the product of someone who resorts to *ad hominem* when attempting to beat an academic opponent who outpowers them on merit. When confronted with the accusation, Dr. [redacted] retracted, as would anyone caught issuing such an insult to someone as credentialed as Dr. [redacted].[49]

71. When expert witnesses retract portions of their evidence, it is significant and strongly indicates a lack of credibility and reliability. In contrast, not once did any of Dr. Wall's four expert witnesses retract any statement they made in their report.

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[45] Testimony of Dr. [redacted] at pages 222 and 248-250.
[46] Bacteria being hundreds of times larger than virus, as every high-schooler knows.
[47] Keeping in mind that Dr. [redacted] is a regulated member of the College and Physicians of Alberta and this case is purportedly about unprofessional conduct.
[48] Testimony of Dr. [redacted] at page 285.
[49] See also the testimony of Dr. Bridle at pages 1184-85.

72. A representative example of Dr. [redacted] characteristic carelessness is found in his testimony regarding so-called "anti-mask" US governments and "anti-mask" protestors.[50] Dr. [redacted] seemed to think that the position of Dr. Wall and Dr. Wall's experts is that masks should not be used in health care settings. When it was put to him in questioning that Dr. Wall and his experts were in opposition to ***mandatory masking***, which is obviously different, Dr. [redacted] eventually agreed, but at one point bizarrely said, "Can I ask the ACAC for like – like what is the actual argument here?".[51]

73. Drs. Dang, [redacted], and Bridle all commented on Dr. [redacted] lack of reasonability in his statements, which were often outrageously absolute and arrogant, and his almost juvenile handling of causation vs correlation, which is a basic scientific concept.

74. Dr. Bridle in particular commented on Dr. [redacted] unprofessionalism in making the insults and accusations that Dr. [redacted] did. Dr. Bridle expressed his shock at how poorly Dr. [redacted] dealt with the issue of randomized control trials through his parachute example.[52] Dr. Bridle went on to say the following regarding Dr. [redacted]:

> …sorry to be blunt here, but this -- this report from Dr. [redacted] was and -- generally unprofessional, disrespectful in tone, very much highlighted here. That's why I have this actually underlined, because it's quite offensive. He uses language that is offensive, accusatory. He makes assumptions. He's hypocritical in areas of his report. And I can give examples of all of these so -- if I wish, and this is one of them. And he makes demonstrable -- you know, many claims that lack evidence, lacks citations or that are only backed up by hearsay evidence, and then makes these kind of statements, right, that as an expert in this area -- and I'm sorry, but looking at the expertise, I am quite confident that I have deeper expertise in the area directly relevant to understanding asymptomatic transmission or lack thereof. And he's actually arguing that I am provide -- that I have no scientific evidence. That is a lie. That is a lie. I provided the scientific evidence today. I have all these citations. I'm looking at page 5 of -- and I see all kinds of citations listed here and a description of the science. And he says this proves -- somehow this proves a lack of understanding. Like this means me, that I do not understand this.
>
> This is unprofessional. I don't do -- write this way in any of my reports, so I'm sorry, this group needs to understand this. I have been involved in a lot of court proceedings. I have been involved in a lot of scientific

[50] Testimony of Dr. [redacted] at pages 228-232.
[51] Testimony of Dr. [redacted] at page 232.
[52] Testimony of Dr. Bridle at pages 1182-85.

> proceedings. This is not a scientifically or medically acceptable document for interacting with other scientists or medical professionals, and this highlights it.[53]

B. Problems with Dr. [redacted] Evidence

75. Dr. [redacted] makes much of the arbitrary distinction between what he calls a health care setting and a community setting and between health care workers and non-health care workers. In reality, this distinction is useless and meaningless. The distinction that matters is what Dr. Wall's experts referred to, which is the distinction between the ***absence or presence of symptomatic individuals***.

76. Relative risk of transmission increases when symptomatic people are present. Of course it does. That is why in some health care settings, like hospitals, the relative risk of transmission is higher than in settings where there are only asymptomatic people. The relevant distinction between Dr. Wall's clinic and a hospital has everything to do with the fact there are not symptomatic individuals in Dr. Wall's office, but there are in a hospital.

77. The reason Dr. [redacted] fails to grasp this distinction is that he thinks asymptomatic transmission is high. But, on this point, he is repeatedly refuted by Drs. Bridle and [redacted], who both demonstrate a deeper knowledge of the subject and both refer to a large amount of academic literate to support their opinions that asymptomatic transmission is very low or negligible.

78. On this point, the Tribunal should prefer the opinions of Dr. [redacted] and Dr. Bridle over Dr. [redacted]. They have deeper knowledge, they are more reliable, and they support their opinions with citations to reliable academic literate at a much higher rate than Dr. [redacted].

79. For example, when Dr. [redacted] referred to his Italian healthcare worker theory, he cited no study, no report—no literature at all. He himself was his only authority. He did this again with his theory about the Alberta November-December 2020 lockdowns. He did it when he criticized Dr. Dang's Sweden example. He referred to no authority beyond himself when he made the outrageous claim that every country that has implemented

[53] Testimony of Dr. Bridle at page 1188, line 9 – page 1189, line 15.

mandatory masking has experienced less cases or less transmission. He admitting citing to no sources for this.[54]

80. Comparing the testimony of Dr. [redacted] specifically to Dr. Bridle demonstrates that Dr. [redacted] is the pupil and Dr. Bridle is the teacher. This can be observed in how much deeper Dr. Bridle's knowledge of key concepts is, but it is also true from a literal perspective insofar as Dr. Bridle, as a professor with a Ph.D. in viral immunology, teaches and trains physicians like Dr. [redacted] on the topis relevant to this case.[55]

81. Again, the onus is on the College to establish that masks reduce the relative risk of transmission and therefore may be a BFOR. Even without turning to the enormous amount of evidence adduced by Dr. Wall's expert witnesses that demonstrates the futility of masking, it is plain the College fails to meet its onus, given the problems with the evidence of Dr. [redacted].

C. The Evidence of Respirologist Dr. Bao Dang

82. Dr. Dang is a practicing Respirologist. He is categorically an expert on breathing and the lungs. Further, Dr. Dang has actually worked in a hospital during COVID and has actually treated patients—both patients with COVID and patients that are unable to wear a mask for medical reasons.[56] He has clinical experience that Dr. [redacted] does not have.

83. Some valuable knowledge that Dr. Dang provides us with is the reminder that widespread mandatory masking in the face of a respiratory virus is novel and was regarded as absurd in the past, such as during viral outbreaks in 2003 and 2008.[57] This highlights the absence then but presence now of the political influences on mask polices that nearly all of Dr. Wall's witnesses referred to in their testimony.

[54] Testimony of Dr. [redacted] at pages 270-280.
[55] Testimony of Dr. Bridle at pages 1028 – 1032.
[56] Testimony of Dr. Dang at pages 916 and 960.
[57] Testimony of Dr. Dang at pages 921-924.

84. Dr. Dang agreed with Drs. [redacted] and Bridle that masks do not stop the diffusion of aerosols.[58] It must be noted that, as a Respirologist, Dr. Dang knows a lot about what people dispel when they breath. Dr. Dang even runs his own breathing laboratory.[59]

85. Dr. Dang referred to the first RTC that studied the effectiveness of masks in preventing the transmission of SARS-CoV-2, the DANMASK study. That study showed masks had no impact on viral transmission.[60]

86. Dr. Dang opined that it is "patently false" for Dr. [redacted] to claim that viral transmission went down in every country that implemented mandatory masking. He confirmed that Dr. [redacted] cited no authority in support of his contention, and that there was no study, article, or report that would support Dr. [redacted] claim.[61]

87. Dr. Dang testified that he observed hundreds of COVID infections amongst healthcare workers just in Medicine Hat, demonstrating how absurd it was for Dr. [redacted] to claim that only a hundred events of viral transmission to healthcare workers have occurred province-wide.[62]

88. Dr. Dang opined that the mask mandates advocated for by the CMOH and AHS are politically influenced and not based wholly on science, again echoing what almost every witness has said in this case about the political nature of mask mandates. In fact, Dr. Dang opined that he was not surprised by the political nature of mask mandates and lockdown measures generally.[63]

89. And, obviously, several times Dr. Dang said that he disagreed with Dr. [redacted] about the effectiveness of masks, saying that he disagreed with Dr. [redacted] that there was a lot of evidence in support of masking and opining that masks had no impact on transmission.[64]

[58] Testimony of Dr. Dang at page 932.
[59] Testimony of Dr. Dang at page 917 and 957.
[60] Testimony of Dr. Dang at page 933.
[61] Testimony of Dr. Dang at page 937.
[62] Testimony of Dr. Dang at page 939.
[63] Testimony of Dr. Dang at pages 944 and 965-968.
[64] Testimony of Dr. Dang at pages 925, 937, 943, 945, 946, and 949.

D. The Evidence of Viral Immunologist Dr. Byram Bridle

90. Dr. Bridle is a professor of viral immunology, has a Ph.D. in immunology, and did a 6 year post-doctoral to become a viral immunologist.[65] The core of his expertise lies at the core of the issues in this case about how SARS-CoV-2 is transmitted, how it causes COVID, and how masks can and cannot impact viral transmission.

91. Dr. Bridle is the most academic of the expert witnesses in this case, being the only expert with a relevant Ph.D. and the only one who is a full-time professor and full-time researcher. Dr. Bridle is highly published, with 29 scientific publications in just the last two years,[66] and does a substantial amount of research in areas relevant to COVID. He serves as a peer-reviewer for per-reviewed scientific publications.

92. Dr. Bridle gave extensive testimony on how SARS-CoV-2 is transmitted through droplets and contact, but he also established that much viral transmission occurs via aerosols. The issue of aerosol transmission is a key one in this case. Dr. Bridle, ever the reasonable academic, acknowledged that it is not clear precisely how much transmission is attributable to aerosols, but it is a significant amount and the prevalence of aerosol transmission partly explains why SARS-CoV-2 is so very transmissible and why it continues to spread so much regardless of what or how many measures are put in place to prevent or slow transmission.[67]

93. Combining his deep knowledge with common sense, Dr. Bridle explained how droplet and contact transmission can actually be reduced rather effectively through the simple measure of people staying home when they are sick. Dr. Bridle confirmed the common-sense notion when masks are worn by ***symptomatic*** people that are producing infectious droplets, they are effective are stopping those droplets.

94. However, Dr. Bridle explained that masks do not prevent symptomatic individuals from spreading the virus through their aerosols, which easily escape the mask both through

[65] Testimony of Dr. Bridle at page 1001.
[66] Testimony of Dr. Bridle at page 1013. See also Dr. Bridle's CV.
[67] Testimony of Dr. Bridle at pages 1070-1123.

the mask itself, due to the large pore size, or around the mask in the areas where it does not seal to the face.

95. This is one of two key points of departure between Dr. Bridle and Dr. [redacted]. Dr. [redacted] does not acknowledge the reality of aerosol transmission by symptomatic people, which is why he mistakenly concludes that masks are effective at preventing transmission.

96. On the issue of aerosol transmission, the evidence of Dr. Bridle should be preferred over that of Dr. [redacted] when the two conflict. The scientific reality is that aerosol transmission is high, which is confirmed by the real-world observation that COVID has spread unabated for two years despite unprecedented, self-flagellating efforts to stop it or slow it down.

97. Further confirmation on this issue comes from a rare point of agreement between Dr. [redacted] and Dr. Wall's experts—that influenza is way down the last two years and that's because influenza does not spread much through aerosols, but rather mostly through droplet spread and contact, which are the two modes of transmission that are reduced by the pre-screening and isolating measures implemented in chiropractic offices in Alberta and everywhere in society these last two years. The difference between influenza and SARS-CoV-2 when it comes to transmission is that SARS-CoV-2 transmits by aerosols and therefore is both far more transmissible and cannot be stopped, especially by masks.

98. Dr. Bridle then also gave testimony about the lack of viral transmission by healthy people, otherwise referred to as asymptomatic people. This is corroborated by Dr. [redacted].

99. The issue of asymptomatic transmission is the other key point of divergence between Dr. Bridle and Dr. [redacted]. Without providing details as to why or how, Dr. [redacted] opined that individuals who appear healthy, otherwise referred to as asymptotic, somehow regularly transmit virus to others. Dr. Bridle, on the other hand, opined that almost all transmission of SARS-CoV-2 only occurs in concurrence with symptoms. Only when there are symptoms is there enough virus being put out by the infected person that

another person could become infected. Dr. Bridle spoke at length about this topic, as it falls squarely within the core of his expertise.[68]

100. When Dr. [redacted] and Dr. Bridle disagree, the Tribunal should favour the evidence of Dr. Bridle, who is more informative, more reliable, and has the greater expertise in the relevant areas.[69] Further, Dr. Bridle's evidence is corroborated by Dr. [redacted] evidence when it comes to how rare asymptomatic transmission is.

101. This is key because if it is true that asymptomatic spread is rare and almost all spread comes from symptomatic individuals—if Drs. Bridle and [redacted] are correct, which they are—then it has a dramatic impact on the legal analysis.

102. Universal masking of asymptomatic people will, categorically, have no impact because they are not transmitting the virus in a meaningful way in any event. And, as we know, the College's mask mandate was, in effect, an ***asymptomatic-only*** mandate because chiropractors were not permitted to work while experiencing symptoms and were not seeing patients who were symptomatic due to the pre-screening.[70]

103. Further, it is no justification or defence to assert that the mask mandate is still a BFOR because of the risk of a chiropractor treating patients while symptomatic and therefore transmitting the virus. First, this is a hypothetical with no evidence to suggest it ever occurred during the material time at Dr. Wall's clinic or elsewhere. But, even more importantly, the scientific reality is that masks have no meaningful impact on viral transmission by symptomatic people because they does not stop infectious aerosols.

104. It is also no defence for the College to say that, regardless of all this, in May of 2020, COVID was so terrible and likely to remain so terrible that no restriction was unjustified, no matter how ineffective the measure might be or how severe the rights violation. Both Drs. Bridle and [redacted] confirmed that by the spring of 2020, the infection facility ratio was approaching that of a bad flu year (0.15%) and that severe

[68] See, for example, pages 1077-79.
[69] Testimony of Dr. Bridle at page 1187.
[70] Testimony of Dr. Wall at page 594-596.

outcomes from contracting the illness were almost entirely limited to small subsets of the population, such as the elderly, the obese, and those with 3 or more co-morbidities.[71]

105. If the College was acting reasonably, with the knowledge it had or ought to have had by then, in December 2020, it would not seek to penalize Dr. Wall for not wearing a mask during June – December 2020. It must be remembered that, consistent with the evidence in this case, there was not and has never been adduced by the College any evidence that any real or actual harm flowed from Dr. Wall treating patients without a mask during June – December 2020. The College has made no attempt to demonstrate that any COVID transmission events ever occurred at Dr. Wall's clinic or as a result of his inability to wear a mask.

E. The Evidence of Infectious Disease Expert Dr. [redacted]

106. Dr. [redacted] is a practicing physician, an instructor with McMaster University, a medical microbiologist, and an infectious disease specialist. He provided some valuable contextual information about the factors that impact how much a virus does or does not spread. He discussed three factors that cannot be altered and how those three factors are what determined how SARS-CoV-2 spread and why no measures were able to contain it. Those factors are the cyclical pattern of the virus, population density, and the age structure of a population.

107. The theory underlying all the public health measures, including masking and distancing, is that these interventions could work despite the non-modifiable factors driving transmission. The last two years of unabated spread have demonstrated this theory to be false, but Dr. [redacted] testified that he was confident the theory was false as early as spring 2020. He knew then that nothing would slow down the natural spread of COVID.[72]

[71] Testimony of Dr. Bridle at pages 1210-1216; Testimony of Dr. [redacted] at pages 1241-1250.
[72] Testimony of Dr. [redacted] at pages 1233-36 and 1250-54.

108. Dr. [redacted]n agreed with Dr. Bridle that the overall infection fatality ratio for COVID was already down to 0.15% in spring 2020 and has decreased since so is lower than that now, in 2022.[73]

109. Regarding asymptomatic transmission, Dr. [redacted] stated several studies showed that asymptomatic transmission was rare or negligible, but he cited one study in particular which demonstrated that ***symptomatic*** transmission occurred at ***25 times*** the rate of ***asymptomatic*** transmission.[74]

110. It is noteworthy the difference between Dr. [redacted] evidence and Dr. [redacted] in this regard. Dr. [redacted] always referred back to scientific literature to support his points, including when it came to asymptomatic transmission. That is why he has almost 100 citations in his report. Whereas Dr. [redacted] rarely referred to scientific literature to support his opinions and referred to none to support his opinion that asymptomatic transmission was common. This largely explains why his report had only 22 citations.

111. This is very significant when it comes to weighing the evidence. When it comes to asymptomatic transmission, this Tribunal should prefer the opinion of Dr. [redacted] over Dr. [redacted] and attribute significant weight to Dr. [redacted] opinion in light of how well grounded in the scientific evidence it is.

112. Again, referring to scientific studies, Dr. [redacted] explained that there is no reliable evidence to support the theory that physical distancing has any effect on the transmission of SARS-CoV-2.[75] It must be kept in mind that physical distancing was an experimental measure and was based on an unproven theory that was ultimately faulty. It had not been tried before the way it was during COVID and there was no prior scientific evidence to indicate it was likely to work.

[73] Testimony of Dr. [redacted] at pages 1238-1250.
[74] Testimony of Dr. [redacted] at pages 1259-1260.
[75] Testimony of Dr. [redacted] at pages 1265-69.

113. Dr. [redacted] then discussed the available RTC evidence on masking. He referred to the same DANMASK study as Dr. Dang that demonstrated masking asymptomatic people has no meaningful impact on virus transmission.[76]

114. But Dr. [redacted] also went on to discuss a recent study from Bangladesh. Unsurprisingly, the study conclusively showed absolutely no impact from cloth masks.[77] The study did show a small impact from surgical masks. Dr. [redacted] described it as an absolute risk reduction of 0.9% and explained the importance of looking at both absolute risk reduction and relative risk reduction.[78]

115. To make sense of the number of 0.9%, Dr. [redacted] explained what that would look like in the real world:

> So if we take .09 percent and do the inverse of it, it's approximately 1100, just over 1100. And so what you need to do is take 0.009 and then take the inverse. So 1 divided by 0.009, you get 1100, okay? And so what that said -- and the study went on for eight weeks; you can find that in the "Methods".
>
> So what that tells us is we need to -- ***in a general healthy population, we need to have 1100 people wear a mask for eight weeks to prevent one infection, not one death, not one hospitalization, but one infection***. So 1100 people wearing a mask for eight weeks to prevent one infection, and that's a remarkably high number. Like if there's any sort of intervention that we're studying in cardiology or infectious diseases or, you know, in my -- like with antibiotics and bacteria or, you know, cardiology, that number is remarkably high. Generally something over – between 50 to 100 is high, but anything over that – like anything under 50 would be kind of low.
>
> And it's not a hard outcome. ***It's always important to say what's the outcome. And maybe it is worth masking 1100 people for eight weeks to prevent one death, but it's not; it's masking 1100 for eight weeks to prevent one infection.***
>
> ***So that's the best evidence we have in SARS-CoV-2.***[79]

[76] Testimony of Dr. [redacted] at page 1278.
[77] So-called "cloth" masks are what Dr. Wall's patients were generally required by CMOH Orders to wear when in his clinic. These are the masks Dr. Wall did not compel his patients to wear.
[78] Testimony of Dr. [redacted] at pages 1279-80.
[79] Testimony of Dr. [redacted] at pages 1281-82 [emphasis added].

116. This explanation is particularly helpful because there are about 1150 chiropractors in Alberta. All the chiropractors in Alberta need to mask for 8 weeks to prevent just one infection, statistically. COVID's infection fatality ratio, even in spring 2020, was only about 0.15%. Meaning that, statistically, only 1 person dies for every 667 infections. Statistically, that means all Alberta chiropractors would have to mask for over ***102 years*** to prevent one death. That's how incredibly ineffective the College's mask mandate was. It is clear the mandate did not prevent any deaths. At best, it may have prevented a few infections. It is no wonder, then, the College does not have any evidence of any actual harm resulting from Dr. Wall treating patients without wearing a mask. It is plain and obvious there is no ***undue*** hardship in accommodating Dr. Wall by permitting him to practice without a mask.

117. Discussing the issue of healthcare workers and non-healthcare workers and healthcare settings and non-healthcare settings, Dr. [redacted] opined that, again, it is all about the context of symptomatic people interacting with other people.[80] It is not the setting that matters *per se*, bur rather the presence or absence of symptomatic individuals. In some healthcare settings, symptomatic patients are always present. In others, such as chiropractor offices during June – December 2020, they very rarely are.

118. Dr. [redacted] provided some insightful comments about "medical reversal", which is the phenomenon of assumptions becoming entrenched, regardless of how faulty they are, and how hard it is to change the practices based on those assumptions once they are entrenched. This phenomenon explains why universal mandatory masking was not abandoned even in the face of evidence that it is futile.[81] That and politics, which, in this case, overlap. Dr. [redacted] alluded to the political influences of mask policies in a similar fashion to many other witnesses in this case.[82]

119. Dr. [redacted] responded to Dr. [redacted] allegation that he made a factual error when comparing motor vehicle deaths to covid deaths. Dr. [redacted] explains how it was

[80] Testimony of Dr. [redacted] at page 1286.
[81] Testimony of Dr. [redacted] at pages 1257 and 1297-1300.
[82] Testimony of Dr. [redacted] at pages 1299 and 1309.

actually Dr. [redacted] that made an error—an elementary one—by changing the numerator without changing the denominator.[83]

120. To summarize Dr. [redacted] evidence, his opinion is that the evidence base was never in place to justify masking asymptomatic people in the general public, which would include chiropractors and their offices in June – December 2020 since pre-screening was in place to keep symptomatic individuals out.

F. Cross-Examination of Dr. Wall's Expert Witnesses

121. Very little cross-examination of Dr. Wall's experts occurred. Counsel for the Complaints Director asked almost no questions of Drs. Dang, Bridle and [redacted] about the scientific evidence they provided, essentially only asking questions about whether they personally followed mask mandates, whether they agreed people were supposed to obey government authorities, and whether they advised government officials during COVID.

122. This lack of cross-examination on the substantive scientific issues is very telling and very important. Much of the evidence from Dr. Wall's expert witnesses was unchallenged and uncontested by the College either because there was no cross-examination or because Dr. [redacted] only spoke directly to some of the topics covered by Dr. Wall's experts.

G. Conclusion

123. The legal implication of the scientific evidence in this case is that the no-exceptions mask and distancing mandates contained in the College's Pandemic Directive are not BFORs. The discriminatory impact the Pandemic Directive had on Dr. Wall is not justified. The discriminatory treatment of Dr. Wall by the College in attempting to discipline him for not wearing a mask is not justified.

124. The College has failed to demonstrate undue hardship. It is plain to a reasonable person that if one chiropractor does not wear a mask, or did not between June – December

[83] Testimony of Dr. [redacted] at pages 1303-06

2020, there is no undue hardship to patients or the protection of the public. Not when it takes 1100 chiropractors wearing masks for 8 weeks just to prevent one infection, and 667 infections needing to occur before there is, statistically, a death.

125. Legally, this means Charges 1(a), 1(b), 1(c), 2(a), 2(b), 4(a), 4(b) and 5(b) have not been made out by the College. Dr. Wall could not and did not, as a mater of law, commit unprofessional conduct in areas where the College unlawfully discriminated against him contrary to the *AHRA*.

126. Charge 1(a), failure to wear a mask fails because the College's Pandemic Directive and actions toward Dr. Wall constitute unlawful discrimination. The College acted unlawfully, while Dr. Wall lawfully asserted his rights. As a matter of law, Dr. Wall did not act unprofessionally in not wearing a mask while treating patients.

127. Charge 1(b), failure to distance also fails. Distancing is not a BFOR. And, as established in the evidence, unless Dr. Wall can touch his patients, he cannot treat them and therefore cannot practice and earn an income.

128. Charge 2(a), failure of staff to wear a mask also fails because the reason Dr. Wall's son (who is the only staff member) was not masking was because of the protected ground of his religious beliefs.

129. The College may want to respond to this by saying that Dr. Wall's son did not testify, so Dr. Wall's testimony about his son is hearsay. However, hearsay evidence is admissible when it is necessary and reliable. This testimony is necessary to determine this issue and it is reliable insofar as Dr. Wall is competent to speak to his son's religious beliefs. At the time, Dr. Wall's son was a minor and lived with him.[84] The caselaw on religious freedom acknowledges that parents and children presumptively share similar religious beliefs. Further, as Dr. Wall notes, he himself has an obligation pursuant to the *AHRA* to accommodate his staff, including his son.[85]

[84] Testimony of Dr. Wall at pages 585-586
[85] Testimony of Dr. Wall at page 685.

130. Charge 2(b), failure of staff to distance fails for the same reasons already given, even if you find such lack of distancing factually occurred, which is far from clear.

131. Charges 4(a) and 4(b), the charting charges, must also fail because they are inextricably linked to masking itself. If masking is not a BFOR, Dr. Wall cannot have committed unprofessional conduct for not charting discussions about his lack of masking. It is discriminatory to place this burden on Dr. Wall and compel him to discuss his mental disability with his patients. Dr. Wall's testimony is that he was reluctant, for obvious privacy reasons, to have this type of discussion with patients. The discussions and the charting would serve no legitimate purpose, it would only impose a condition for the sake of imposing a condition.

132. Regarding Charge 5(b), because the distancing and masking requirements of the Pandemic Directive are discriminatory and therefore unlawful, Dr. Wall did not commit unprofessional conduct by not adhering to them.

133. The only remaining portion of Charge 5(b) is that Dr. Wall contravened the Pandemic Directive by not erecting a plexiglass barrier, which is redundant of Charge 1(c). This requirement was explicitly only to protect staff, not patients. It was required if staff did not mask. Dr. Wall's son was his only staff and was not masking due to a protected ground in the *AHRA*. To erect a barrier was to impose a discriminatory burden on his son, himself, and his office for which there was no justification. It is to literally put up a physical barrier between Dr. Wall's son and people who can wear a mask, if they choose to, a barrier that excludes and exposes him. There is no justification for this because the scientific evidence demonstrates how useless the plastic barriers are in the context of the fact there are no symptomatic patients in the office, and, even if there ever were, plastic barriers do not stop infectious aerosols. In this way, plastic barriers are no different than masks. Therefore, the plexiglass barrier to ostensibly protect staff is also not a BFOR. That disposes of Charges 5(b) and 1(c).

134. As a matter of law, Dr. Wall did not commit unprofessional conduct by not adhering to the three relevant requirements of the Pandemic Directive, all three being discriminatory.

VII. Reasonable Accommodation and Telehealth

135. The College has hinted that telehealth is a reasonable form of accommodation for Dr. Wall. Implicitly, the College has argued that its approach of "mask, do telehealth if you do not mask, or do not practice" is the only possible approach without undue hardship being incurred. As demonstrated above, this is not reasonable, scientifically.

136. However, telehealth is unreasonable from a practical and legal perspective because it effectively amounts to not practicing at all. The evidence in this case is clear that a chiropractor like Dr. Wall who provides traditional physical manipulation services can only practice if he can touch his patients. Talking to his patients over the phone is utterly useless. Dr. Wall testified to this, all three of his patients testified to it, as did chiropractor Dr. [redacted].[86] This is obvious and confirmed by common sense.

137. What reasonable accommodation would have looked like for Dr. Wall, had the College had any interest in accommodating Dr. Wall, is not difficult to envision. It would have looked something like the conditions decided upon by Dr. [redacted] on December 18, 2020. Dr. Wall's clinic and his mode of practice were particularly amenable to an accommodation solution because he practiced alone and only ever saw one patient at a time.

138. It is not reasonable accommodation to tell a professional that he, in effect, cannot practice his profession and cannot earn an income. The Complaints Director has often argued in this case that practicing a profession is not a "right", but Dr. Wall does have a "right" to practice free of discriminatory or otherwise unlawful conditions imposed upon him by his regulatory body.[87]

VIII. Charge 5(a): "Failing to Follow" CMOH Orders

139. Charge 5(a) is that Dr. Wall "failed to follow" CMOH Orders "regarding masking and COVID-19". This charge is not made out factually or legally. Dr. Wall did not, in fact, contravene any CMOH Order.

[86] Testimony of Dr. [redacted] at pages 792-795.
[87] *Derry v. College of Physicians and Surgeons of British Columbia*, 2002 BCSC 946 at para 34.

140. First, Dr. Wall did not contravene CMOH Order 16-2020, as no provision in that Order, including section 2, applied to him because he was covered by the Pandemic Directive.[88]

141. The only other CMOH Orders that Dr. Wall could have breached are 38-2020 and 42-2020, and only the mask requirement provisions in these orders are relevant. However, as already discussed, the mask requirements in these CMOH Orders included broad exceptions, including for the mental disabilities that Dr. Wall has proven he had at the material time.[89] Dr. Wall fell within those exceptions, as evidenced by the fact AHS permitted him to re-open his clinic without wearing a mask. That would have been impossible unless AHS determined that he was covered by section 24(c) of CMOH Order 42-2020, in force at the time. Further, the mask exception sections of these CMOH Orders ***did not require a doctor's note to be claimed***. Any individual could claim, through self-diagnosis, to fall within the scope of an exception due to a physical or mental concern or limitation. Evidence was not required to substantiate such a claim until May 2021, long after the material period of June – December 2020.

142. The Complaints Director wants to say that Dr. Wall admitted to the factual basis for Charge 5(a). Led by counsel for the Complaints Director in questioning, Dr. Wall did seem to admit to breaching CMOH Orders with a single word affirmative answer.[90] However, on re-direct, when Charge 5(a) was clarified for Dr. Wall and he was asked, "Do you think that you failed to follow any [CMOH] orders", he answered, "No, I don't".[91] The factual and legally reality remains unchanged by Dr. Wall's accidental admission, corrected on re-direct. Charge 5(a) fails; it is not factually or legally proven by the College on a balance of probabilities.

[88] Testimony of Dr. [redacted] at page 422, lines 4-6; See also section 6 of CMOH Order 16-2020, which says that section 2 does not apply to practitioners like Dr. Wall if their relevant regulatory body has adopted a directive like the College did.
[89] Section 27(c) of CMOH Order 38-2020 and section 24(c) of CMOH Order 42-2020.
[90] Testimony of Dr. Wall at page 644.
[91] Testimony of Dr. Wall at pages 726-727.

IX. Charges 3(a) and 3(c) – Censorship and Compelled Speech

143. Charges 3(a) and 3(c) purport to discipline Dr. Wall for telling his patients the truth regarding the ineffectiveness of masks. Charge 3(a) is that Dr. Wall did not tell his patients about the increased risk of transmission of COVID from not wearing masks. Charge 3(c) is that Dr. Wall did tell his patients that wearing masks has no effect on the transmission of COVID.

144. As already demonstrated, the scientific reality, that is, ***the truth of the matter***, is that masks are ineffective: wearing one does not reduce the risk of the transmission of COVID and not wearing one does not increase the risk of the transmission of COVID.

145. These charges cannot be made out. First, they represent an unjustified limitation of Dr. Wall's rights to freedom of expression as guaranteed by section 2(b) of the *Charter*. Second, as a matter of law, it is not unprofessional conduct to tell patients the truth, be it about masks, or anything else.

146. Telling patients masks have no effect concerning the transmission of COVID and declining to tell patients there is an increased risk of transmission if they do not wear masks does not contravene the Code of Ethics. In fact, it upholds it. Principle 1: Patient Autonomy and Informed Choice states:

> Chiropractors have a duty to inform the patient of their treatment options including the benefits, advantages and disadvantages; ***significant risks*** and cost… ***The patient makes the final decision to proceed with the treatment***…[92]

147. The Code of Ethics, Principle 5: Veracity states:

> Chiropractors must be ***truthful and forthright*** in all professional matters by ***fully disclosing and not misrepresenting information*** in ***dealings with patients***...[93]

[92] ACAC Code of Ethics, page 3 [emphasis added]. Wearing a mask is a "treatment" because it is the application of a medical device that comes with risks.
[93] ACAC Code of Ethics, page 3 [emphasis added].

148. Telling the truth to patients obviously also does not contravene the Standards of Practice or the *Health Professions Act*. The Tribunal is entitled to reject Charges 3(a) and 3(c) without resorting to anything other than the expert evidence, the Code of Ethics, and section 80(1) of the *Health Professions Act*.

149. However, Charges 3(a) and 3(c) are also an unjustified interference with Dr. Wall's *Charter* rights to freedom of expression.

150. The *Charter* protects professionals against the censorship or compelled speech of their regulatory bodies. The College must not censor their members or compel their member to utter expression they disagree with, unless doing show can be demonstrably justified.

151. Charge 3(a) is an attempt to penalize Dr. Wall for not saying something the College wants him to say. In other words, it is using professional discipline to compel him to say something against his will that he does not believe is true. This is compelled speech, which is presumptively unlawful.[94] The Supreme Court of Canada has long held that, "[t]here is no denying that freedom of expression necessarily entails the right to say nothing or the right not to say certain things."[95]

152. As Justice Beetz of the Supreme Court put it:

> It is one thing to prohibit the disclosure of certain facts. It is quite another to order the affirmation of facts, apart from belief in their veracity by the person who is ordered to affirm them. … to order the affirmation of facts, apart from belief in their veracity by the person who is ordered to affirm them, constitutes a much more serious violation of the freedoms of opinion and expression… In my view, such a violation is totalitarian in nature[.][96]

153. Charge 3(c) is an attempt to penalize Dr. Wall for saying something the College does not want him to say, which is a form of censorship and also presumptively unlawful.

154. There can be no doubt that what Dr. Wall said and what the College wants to compel him to say is protected speech. The expressive content engages one of the three

[94] *Lavigne v. O.P.S.E.U.*, [1991] 2 S.C.R. 211 at para. 105; *RJR-MacDonald Inc. v. Canada*, [1995] 3 S.C.R. 199 at paragraphs 113 and 124.
[95] *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038 at para. 95.
[96] *Slaight Communications Inc. v. Davidson* at para. 39.

underlying principles of freedom of expression, truth-seeking; the method of communication, speaking with his patients, does not remove the protection; and the effect of Charge 3(c) is to limit Dr. Wall's expression by penalizing him for, and therefore effectively preventing him from, saying something the College disagrees with.[97]

155. The College could only possibly justify such compelled speech and censorship if it could demonstrate that what it wanted Dr. Wall to say was true and that what Dr. Wall said that it did not want him to say was untrue. The onus is on the College to show that its preferred statements are the true ones. The College cannot demonstrate the truth of what it wants Dr. Wall to say, nor the lack of truth of what it wants Dr. Wall to not say. Rather, the expert evidence in this case demonstrates that what Dr. Wall said to his patients regarding masks was true and what the College wanted him to say was untrue.

156. The truth of the matter is highly determinative of the legal analysis in any case involving violations of free expression, including professional discipline cases. In the case of *Strom v. Saskatchewan Registered Nurses' Association*, the Saskatchewan Court of Appeal ruled that by disciplining Ms. Strom for her comments criticizing the care at a nursing home, the Saskatchewan Registered Nurses' Association unreasonably limited her free expression, partly because the Association could not show that what she said was not true.[98]

157. In conclusion, whether it is a mere matter of professionally telling the truth, or a matter of free expression, Charges 3(a) and 3(c) are not made out.

X. Patient Masking: Charges 1(d), 2(c), and 3(b)

158. Charges 1(d), 2(c), 3(b), and 4(c) involve Dr. Wall and his son not compelling patients to mask and not charting about his patients not masking (the "Patient Masking Charges").

[97] *Montreal (Ville) v. 2952-1366 Québec inc.*, 2005 SCC 62 at para. 56; *Sierra Club of Canada v. Canada (Minister of Finance)*, 2002 SCC 41 at paras.75-76.
[98] *Strom v. Saskatchewan Registered Nurses' Association*, 2020 SKCA 112 at para. 123.

A. The Patient Masking Charges Have No Basis in Law

159. The Pandemic Directive does not require chiropractors to compel patients to mask. No provision of any CMOH Order requires chiropractors to require patients in their offices to wear a mask. Dr. Wall did not contravene any applicable general mandate that he require patients to mask. There is also no applicable requirement from the College (or AHS) to chart about his patients wearing or not wearing a mask.

160. If any of the Patient Masking Charges are to be made out, the only basis the College can point to is the January 5, 2020 AHS Rescind Notice which permitted Dr. Wall to re-open his clinic after being closed by AHS.[99] Paragraph 4 of the Rescind Notice purports to deputize Dr. Wall by requiring him to "ensure that all patients he treats continuously wear a mask… unless they are able to provide evidence that they have been granted a mask exemption".

161. The lawfulness of this order is suspect, to say the least. First, no CMOH provision or section of the *Public Health Act* is referred to by the issuing AHS Officer. Indeed, this order directly contradicts the mask exception provisions of CMOH Orders 38-2020 and 42-2020. In the context of such a conflict, the CMOH Order is paramount and the Rescind Notice, to the degree of the conflict, should be regarded as being of no force or effect.

162. Second, Paragraph 4 is hopelessly vague and arbitrary, and therefore unenforceable, because Dr. Wall has no means of reasonably knowing what constitutes a "mask exception" and what "evidence" of said exemption is sufficient. Dr. Wall is not an AHS healthcare worker, he is a private professional. He reasonably and professionally decided to let his patients determine if they were exempt. In doing so, he is in company with the CMOH, who, during the material time, also permitted individuals to decide whether they were exempt.[100]

[99] Exhibit D-2.

[100] See, for example, section 24(c) of CMOH Order 42-2020. Dr. Deena Hinshaw did not issue orders requiring claimed mask exemptions to be supported with "evidence" form a designated practitioner until May 2021, long after the June – December 2020 period relevant to this case.

163. This basic problem also highlights the unlawfulness of government officials attempting to deputize private citizens to enforce *ad hoc* directives. At best, it is questionable whether an AHS officer has the lawful authority to make such a bizarre and draconian order. At worst, the order is blatantly unlawful. The Tribunal should approach this AHS requirement with great caution.

164. Further, as a matter of fundamental rights and procedural fairness, Dr. Wall cannot be found liable for something he is not properly Charged with. None of the Charges the College has levied against Dr. Wall make mention of the AHS Rescind Notice. The College has not Charged Dr. Wall with contravening an order of an AHS Officer.

165. Counsel for the Complaints Director submits that the Patient Masking Charges are grounded in the "further alleged" paragraph at the end of the Notice of Hearing, where AHS "directions and requirements" are listed. However, the "further alleged" paragraph is not a factual charge and cannot be a factual charge. Its only acceptable purpose is to describe the professional obligations that Dr. Wall has failed to meet ***if any of the Charges in the Notice of Hearing are made out***. Dr. Wall has the right to know the case against him. Dr. Wall has not been properly charged with the Patient Masking Charges and therefore they must fail.

166. Dr. Wall submits that he did not, as a matter of law, commit unprofessional conduct in declining to adhere to paragraph 4 of the AHS Rescind Notice. The Tribunal need not make any findings about the lawfulness of this requirement, as unlawful as it is, because the issue for the purposes of this case is whether the only professionally acceptable thing for Dr. Wall to do was adhere to paragraph 4 of the AHS Rescind Notice. Clearly it is not.

167. Even if this Tribunal finds that Dr. Wall is properly Charged with not requiring his patients to mask, there is no lawful basis for charging him with "failing" to chart about whether his patients wore a mask or not. Charge 4(c) must therefore be thrown out regardless.

B. Dr. Wall Acted Professionally in Permitting His Patients to Choose Whether to Wear a Mask in His Clinic

168. The reason Dr. Wall did not compel his patients to mask, or chart about it, is very simple: masks are harmful and Dr. Wall resolutely believes in protecting his patients from harm. As Dr. Wall testified to, he firmly believes in the ethical principles of first do not harm and informed consent.

169. ***If*** wearing masks are harmful, and, as has been demonstrated, do not prevent any harm from COVID, then, as a matter of law, Dr. Wall cannot possibly be found to have committed unprofessional conduct by refusing to compel his patients from wearing a mask in his clinic. On the contrary, he acted with utmost professionalism by protecting his patients from harm even at great cost to himself.[101] Dr. Wall fulfilled his ethical duty to stand in the gap between his patients and the oppression of authorities that sought to harm them, even if unintentionally, through compelled mask-wearing.

170. Of course, this begs the question whether masks are in fact harmful. If they are not—if they are merely useless, but not harmful—then Dr. Wall is arguably professionally obligated to follow the directions of AHS to compel his patients to mask, assuming they are lawful, regardless of how irrational those directions are. However, Dr. Wall has adduced extensive expert evidence that masks are indeed harmful, and very much so.

171. Of note, the evidence of the harms of masks adduced by Dr. Wall is almost entirely uncontested by the Complaints Director. Dr. [redacted] barely addressed the issue of the harms of wearing a mask.

C. The Evidence of Occupational Health and Safety Expert, Chris Schaefer

172. As we know from Chris Schaefer's CV and qualification during questioning, he has over 25 years experience as an occupational health and safety consultant, teaches courses on proper mask use, is certified regarding airborne toxins, and is experienced dealing with oxygen and carbon dioxide in the workplace.[102]

[101] See point 1 of the Code of Ethics and section 3.1 of the Standards of Practice.
[102] Testimony of Chris Schaefer at pages 843-846.

173. In his report, Mr. Schaefer discussed how the so-called "masks" that are used to ostensibly prevent the transmission of COVID are nothing more than barriers that impede airflow and are not true masks at all. He noted these "masks" do not have engineered breathing openings, merely impede breathing, and are hazardous, regardless of how well they filter SARS-CoV-2. Further, he detailed how an oxygen level below 19.5% is dangerous to human health and how the air breathed by a person wearing a mask is often below this level.

174. During questioning, Mr. Schaefer commented on the need for fit testing for a mask to provide any protection and for screening to be done to determine if it is safe for any one person to wear a mask.[103] This was required and was standard prior to COVID, but has been abandoned now. Mr. Schaefer's structural explanation of masks corroborates Dr. Bridle's evidence about the same problem with unsealed masks.[104]

175. Mr. Schaefer discussed how real respirator masks work, which is by using engineered breathing openings for inhaling filtered air and expelling exhaled air.[105] He discussed how mere barriers, like the "masks" mandated by the College and CMOH Orders, simply trap some of the exhaled air, even without a seal, causing the wearer to re-breath their own air, which has a high concentration of carbon dioxide in it.

176. This is all consistent with common sense and the Tribunal members even know this to be accurate through personal experience of wearing a mask. Mr. Schaefer confirms common sense that if a mask has no exhalation valve, carbon dioxide will quickly build up between the mask and the face of the wearer, even if the mask is not sealed.

177. Mr. Schafer discussed how the proper practice is to screen people even for wearing a proper respirator, which only minimally increases breathing effort.[106] The so-called masks used to ostensibly protect against COVID significantly increase breathing effort because they are simply barriers. It is unsafe to compel someone with a pre-existing

[103] Testimony of Chris Schaefer at pages 857-858.
[104] See the testimony of Mr. Schaefer at pages 858-859 and the testimony of Dr. Bridle at pages 1081-84.
[105] Testimony of Chris Schaefer at pages 864-867.
[106] Testimony of Chris Schaefer at pages 867-868.

condition to wear such a device without being medically screened and probably even after being medically screened.[107]

178. Mr. Schaefer again confirmed common sense and what Dr. Dang and other witnesses discussed about how some people, depending on pre-existing conditions, will tolerate masking differently than others, and how blocking normal breathing will result in the predicable symptoms of headaches, dizziness, lack of coordination, feeling faint, etc.[108]

179. During questioning, Mr. Schaefer discussed the precise level of oxygen that is acceptably safe and the level inside a mask while worn. 19.5% oxygen is the minimum that is safe, as confirmed in Alberta's Occupational Health and Safety legislation. Mr. Schaefer provided several examples to explain how oxygen levels below 19.5% are taken very seriously.[109] Anything below this is unsafe and dangerous to life and health and causes hypoxia.[110] Mr. Schaefer commented on how serious of a problem it is that government bodies have mandated the wearing of devices that cause oxygen levels to drop below safe levels.

180. He further stated:

> …a couple minutes of wearing either a nonmedical, a medical, or a procedural based, [*sic*] you're looking at, a couple of minutes of wearing, 20,000 parts per million carbon dioxide, oxygen levels as low 18 percent, 18 to 18-and-a-half percent. The lowest oxygen can go legally is 19.5 before it becomes immediately dangerous to life and health.
>
> So in Occupational Health and Safety standards, when we talk about… immediately dangerous to life and health, we're looking at device - - we're looking at level that might not necessarily cause you to drop dead once they're reached, but certainly they're considered levels that now become - - those exposures become harmful without protection from those exposures.[111]

181. Counsel for the Complaints Director noted that the actual data from test results are not in evidence. However, there is no reason to doubt the accuracy of the testing performed

[107] Testimony of Chris Schaefer at pages 867-870.
[108] Testimony of Chris Schaefer at page 869.
[109] Testimony of Chris Schaefer at pages 880-886.
[110] Testimony of Chris Schaefer at page 871.
[111] Testimony of Chris Schaefer at page 874.

by Mr. Schaefer. Almost all of Mr. Schaefer's evidence is uncontested. The Complaints Director, despite hinting that he would call an expert to respond to Mr. Schaefer, did not. The Complaints Director could have called an OH&S expert to rebut Mr. Schaefer's opinion and present differing test results, but he did not.

182. Mr. Schaefer's uncontradicted evidence regarding the results of his testing should be accepted. His testing results are consistent with common sense that oxygen levels drop inside masks while being worn. Further, Mr. Schaefer testified that he is confident anybody else trained to use the testing device he did would produce the same result.[112]

183. As for carbon dioxide, Mr. Schafer stated that, based on his testing, he registered 20,000 parts per million carbon dioxide inside a mask, which is ***20 times*** what is acceptable.[113] Those are toxic levels. It is no wonder symptoms result for some. Mr. Schaefer listed some of the common symptoms associated with carbon dioxide toxicity:

> So common symptoms of blocking your flow of breathing and inhaling excess carbon dioxide can be things like experiencing a headache, nausea, dizziness, lack of coordination, maybe impaired hearing, impaired -- sometimes impaired vision. It can be a -- it can be feeling faint, overheating. And it can be worse than that, it could be people that have a very difficult time breathing, feel like they can't catch their breath, and it can go down from there. So anybody that inhales more than what the -- anybody that inhales above what the indoor Occupational Health and Safety standard is for carbon dioxide is at risk.[114]

184. Mr. Schafer stated that his disagreed with Dr. [redacted] assertion that there are no known harms associated with masking. He noted that Dr. [redacted] cited no studies in support of his assertion. Mr. Schaefer's evidence repeatedly rebuts Dr. [redacted] flippant remark that if masks were so bad his colleagues would be passing out. Mr. Schaefer was asked if he was surprised that most people do not tend to pass out from wearing masks for prolonged periods. He disagreed and said that, "just because they're not physically passing out does not mean that harm is not being done".[115]

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[112] Testimony of Chris Schaefer at pages 878-879.
[113] Testimony of Chris Schaefer at page 859 and 874. See also the carbon dioxide Health Canada guideline appended to Mr. Schaefer's report.
[114] Testimony of Chris Schaefer at page 869.
[115] Testimony of Chris Schaefer at pages 892-893.

185. Mr. Schaefer further stated:

> If you subject yourself to [immediately dangerous to life and health] levels of low oxygen, it will negatively impact your health whether you're aware of it or not, and that's why all the governing bodies that govern the rules of health and safety legislate what the minimum oxygen concentration in air that you can be exposed to, because you might not necessarily feel harm right, you might not necessarily have a headache right away, or dizziness, you might not necessarily feel nausea right away, any of these other minor - - more minor types of symptoms of low oxygen.[116]

186. On cross-examination, an exchange occurred between Mr. Schaefer and counsel for the Complaints Director regarding whether Mr. Schaefer would wear a "mask" to keep his professional licence.[117] In his submissions, Mr. [redacted], quite disingenuously, only provided the Tribunal with a truncated quote which appears to show that Mr. Schaefer would wear a mask if his regulatory body told him he had to. The truth is that Mr. Schaefer was emphatic that he would never wear the types of "masks" mandated by the College's Pandemic Directive or by government public health authorities, even to keep a professional licence. Reproduced below is the full exchange:

> Q …would you comply with the paramedic equivalent of the College's pandemic requirement about mandatory masking if you were in the field?
>
> A I would comply with wearing a mask, but I would not wear a breathing barrier. I have not worn a breathing barrier, and I won't. So, remember, there's a big difference between what's currently been mandated and what an engineered mask is.
>
> A mask is safe to wear. A mask has engineered inhalation openings. A mask has an engineered exhalation opening. That's safe. It's established as safe. It's proven as safe over many decades.
>
> So a closed cover is not something that I would wear, no, but I would wear an actual mask.
>
> Q So I just want to be clear, again, when we look at the Pandemic Directive for the College of Chiropractors, it says that the requirement is a surgical or a procedure mask; you would comply with that kind of directive from your regulatory body if that was applicable?

[116] Testimony of Chris Schaefer at pages 892-893.

[117] Mr. Schaefer was previously a licensed paramedic. See pages 907-908 of Mr. Schaefer's Testimony.

> A I know that those aren't masks. Those are breathing barriers. ***I'm not going to jeopardize my health and safety through low oxygen and accumulations of carbon dioxide for any occupation, because that's my health, and my health is important to me. It's more important than anything else.***[118]

187. Shortly afterwards, the following exchange occurred on-redirect between Mr. Schaefer and counsel for Dr. Wall:

> Q You just finished a discussion with my learned friend about whether or not you would wear a breathing barrier if your regulatory body told you you had to in order to practice, and if you didn't have access to the respirator, ***if all you had access to was the breathing barrier that they said you had to wear, would you wear it to keep your licence?***
>
> A ***No, I would not wear it to keep my licence because my health is more important than my job.***[119]

188. That's how harmful to health Mr. Schaefer regards the "masks" that chiropractors were mandated to wear by the Pandemic Directive—that he would do precisely what Dr. Wall has done. Mr. Schaefer is someone who would know better than most, given his expertise. Significant weight should be given to the uncontested opinion of an occupational health and safety expert like Mr. Schaefer regarding the harms and dangers of cloth and surgical masks.

D. The Evidence of Respirologist Dr. Bao Dang

189. Dr. Dang provided evidence from his own testing on individuals wearing masks. He found through testing done at his pulmonary laboratory that while wearing a mask, lung function of the wearer drops by 15-20%.[120] This finding is consistent with common sense, corroborates Mr. Schaefer's findings and opinions, and is uncontested by the Complaints Director.

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[118] Testimony of Chris Schaefer at pages 908-909 [emphasis added].
[119] Testimony of Chris Schaefer at page 910.
[120] Testimony of Dr. Dang at pages 957-958.

190. Dr. Dang opined that mandatory masking violated both informed consent and the principle of first do no harm because of the potential harms of masking to each person who is compelled to wear one.[121]

E. The Evidence of Viral Immunologist Dr. Byram Bridle

191. Dr. Bridle noted three harms from wearing masks and mandating them. One, that masking actually increases the spread of COVID through contributing to contact transmission.[122]

192. Two, the issue of muffled speech and hindered communication, especially for those with special needs or hearing issues. This is not merely hypothetical. [redacted] provided testimony about how much he benefits from both himself and Dr. Wall not wearing a mask when he receives treatment because he is able to communicate effectively with Dr. Wall. Mr. [redacted] has a hard time elsewhere because his hearing is not the best and the muffled voices and loss of lip reading make it hard for him to understand people wearing a mask.[123]

193. Third, Dr. Bridle opined about the carbon dioxide buildup caused by wearing a mask, corroborating Mr. Schaefer's evidence. Dr. Bridle stated:

> … another one that I would mention is this idea of carbon dioxide, because this is just intuitive…
>
> And so if you monitor the carbon dioxide level in front of your mouth without a mask and then with a mask on, it goes up. And this makes intuitive sense, because what you're doing by putting a mask on your face is you are restricting, you know, the free flow of oxygen. What you're doing is you're creating an additional dead space. When we exhale, when we exhale, there's always dead air. We cannot get all of the air out of our lungs, and we can't get all of the air out of our mouth. That's dead air. When we inhale, that dead air, when there's not been fresh air exchanged, gets inhaled back into the end of the lungs.
> …
>
> And I would encourage anybody, if -- just focus, put on the mask and go outside, because often that's where the air, you know, seems the freshest and everything, keep your mask on and take several deep breaths, right,

[121] Testimony of Dr. Dang at pages 954-955.
[122] Testimony of Dr. Bridle at page 1147.
[123] Testimony of [redacted] at pages 770-771.

> and pay attention to what it feels like. Then take that mask off and take in a big deep breath; it feels so refreshing. And that's why, because we are impacting, albeit to a small degree, our ability to gas-exchange, by taking off that mask, we're removing some of the dead air space that we've created; we're reducing the dead air space.[124]

194. Importantly, these are some of the same harms Dr. Wall discussed in his testimony as reasons why he knew masking was harmful for him and his patients.[125]

F. Conclusion

195. The thrust of all this is that Dr. Wall did what was right. He allowed his patients to choose whether to incur the risks of masking. He adhered to the principle of informed consent. He upheld the principle of first do no harm. Three of his patients testified that they appreciate this and are thankful Dr. Wall gives them the choice.

196. [redacted] testified that he prefers not to wear a mask and that Dr. Wall not wear one as well. In fact, he testified that if Dr. Wall made him wear a mask, he probably would not seek treatment from him.[126]

197. [redacted] also testified how much he appreciates Dr. Wall giving him the choice of whether to mask or not. He stated:

> …to come in [to Dr. Wall's clinic] and not wear a mask, I appreciate that we do not have to, he's not requiring it. If he said I had to wear a mask to be treated, I wouldn't be happy about it, but would I do it? Yes, because I need the treatment. So if he's forced into it, it's not because of his doings, but because of somebody else is, you know, forcing him to go down this path.[127]

198. All this evidence leads to what appears to be an extraordinary conclusion—that Dr. Wall did the right thing, did the ethical thing, did the professional thing by ***disobeying government***. But, then again, maybe its not so surprising. Governments sometimes get things wrong. Sometimes their policy goals are wrong, sometimes they have the facts

[124] Testimony of Dr. Bridle at pages 1161-63.
[125] See, for example, page 572 of Dr. Wall's testimony.
[126] Testimony of [redacted] at pages 753-754.
[127] Testimony of [redacted] at page 775, lines 16-23.

wrong. Reason demands that professionalism is not synonymous with "following orders" that come from the government of the day. Is it ***normally*** professional to adhere to government directives or legislative requirements? Yes, ***but not always***. Are laws ***typically*** lawful. Yes, ***but not always***. Sometimes they are struck down. Do regulatory bodies ***usually*** act lawfully. Yes, ***but not always***. Sometimes they discriminate contrary to law. Do politics and power sometimes rule the day, instead of reason and science? Yes. Any history book cannot be opened without encountering instance after instance of this unfortunate reality.

199. Dr. Wall submits that in permitting his patients to choose whether or not they masked in his clinic, and thereby disobeyed the order of an AHS Officer, he upheld his requirements under the Code of Ethics and Standards of Practice.[128] Implicit within the principles underlying the professional practice of chiropractic is the recognition that doing whatever the government says or whatever the College says is not the highest priority, and, in fact, it is subject to putting patients' interests first in the rare circumstance that patients' interests collide with government or College directives.

200. At law, Dr. Wall did not commit unprofessional conduct by refusing to compel his patients to wear a mask. The broad discretion accorded to this Tribunal through section 80(1) of the *Health Professions Act* entitles the Tribunal to find that Dr. Wall acted professionally in this regard.

XI. Conclusion on Charges

201. In the words of Dr. Wall's patient, [redacted], it is a travesty that the hearing of this case occurred.[129] It is outrageous that Dr. Wall has been charged with unprofessional conduct for telling the truth, protecting his patients, and asserting his statutory human rights.

202. The scientific evidence in this case overwhelmingly establishes that masks are ineffective at preventing the transmission of COVID and are harmful to wear. As a

[128] See the Code of Ethics, Principle 1: Patient Autonomy and Informed Choice; Principle 2: Nonmaleficence (do no harm); and Principle 5: Veracity. See also the Standards of Practice, 1.2(a): Professional Communication - Truthful and factual in all respects; 3.1: Informed Consent; and 3.3: Disclosure of Harm.
[129] Testimony of [redacted] at page 757, lines 757.

result, the College has failed to prove any of the Charges against Dr. Wall. Contrary to the College's allegations, Dr. Wall acted with utmost professionalism at all times by resolutely speaking and acting in truth and by bravely protecting his patients even at great cost to himself.

ALL OF WHICH IS RESPECTFULLY SUBMITTED THIS 7th DAY OF JULY 2022

James S.M. Kitchen
Barrister & Solicitor
Counsel for Dr. Wall

LIST OF AUTHORITIES

1. *British Columbia (Public Service Employee Relations Commission) v. B.C.G.E.U.* ("*Meiorin*"), [1999] 3 S.C.R. 3.
2. *Challenger Geomatics Ltd. v. Alberta (Appeals Commission for Workers' Compensation)*, 2014 ABQB 712.
3. *Derry v. College of Physicians and Surgeons of British Columbia*, 2002 BCSC 946.
4. *Horvath v. Rocky View School Division No. 41*, 2016 AHRC 19.
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