Canadian Human Rights Tribunal **Tribunal canadien des droits de la personne**

BETWEEN:

RAYMOND IRVINE

Complainant

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

CANADIAN ARMED FORCES

Respondent

REASONS FOR DECISION

T.D. 15/01

2001/11/23

PANEL: Shirish P. Chotalia

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I. INTRODUCTION

[1] Mr. Irvine worked as an air force aviation technician with the Canadian Armed Forces (CAF) since 1967. On March 30, 1994, he suffered a heart attack. This event prompted the CAF to review his medical condition. In 1996, a CAF Career Board ruled that he was no longer fit to serve as a member of the CAF and should be released. His 29-year career was halted. Mr. Irvine lost his position as a Warrant Officer as well as a promised promotion to the rank of Master Warrant Officer.

[2] At issue in this proceeding is whether the CAF's decision to terminate Mr. Irvine was because of his physical disability and whether this decision was legally justifiable. Also at issue is whether the CAF policies relating to members who have suffered a heart attack and/or have coronary artery disease, discriminated against Mr. Irvine contrary to law.

II. FACTS

A. CAF Medical Category System

[3] CAF members serve in a range of occupations. For example, they serve as musicians, as chaplains, as aviation technicians. Ultimately, however, CAF members dedicate themselves to the defence of Canada. At the relevant time, the CAF had a medical categorization system for the minimum skills required of CAF members to ensure that they could perform their jobs around the world.

[4] The medical categories were expressed in a numerical category system to communicate to administrative and employment authorities a concise medical opinion of the employment capabilities of recruits and serving members. Each classification and trade in the CAF was assigned a medical category. These categories specified the minimum grading for continued full employment of a member in a specific military occupation. When a member's grading fell below the appropriate level, the limitations upon his career became a personnel administrative issue to be addressed by either a specialty medical Board or a Career Medical Review Board ("Career Board").

[5] In the case of an aviation technician, the minimum medical grading of "G3O3" was required for full employment. This was a "green light". An aviation technician who was assessed as a "G4O4" was subject to release. This category was a "red light".

[6] The "G" factor was the geographical factor. It broadly described where a member could be employed. This factor was based on the effects that environment, accommodation, living conditions and medical care available would have had on the medical status of a member. It was graded from 1 to 6 with increasing numerical value indicating greater limitations in employment. The "O" factor was the occupational factor. It broadly described the degree to which the member was employable. This factor involved physical and mental activity and stress. Physical or mental disabilities could limit a member's capability and performance of duties. It was also graded from 1 to 6 with increasing numerical value indicating greater limitations in employment.

[7] In addition to these "G" and "O" assessments, specific written employment limitations further delineated a member's full employment potential.

B. Administrative Process for Medical Category Assessment

i) CAD Committee

[8] The process whereby the medical categories and employment limitations were assigned was as follows: thorough examination of the member, comprehensive description of limitations, assignment of medical category. More specifically it is implemented in the following manner:

- First, a junior medical officer performed a medical examination of a member and recommended a category.

- Next, if the category recommendation was below the minimum standard a consultant was retained by the CAF to provide an opinion wherein he was to describe the appropriate employment limitations. These employment limitations were to be in clear and simple terms so that the member's supervisor could understand the same.

- Then, the base/wing surgeon was to determine the current medical category and recommend the permanent category. Temporary categories/employment limitations were allotted to allow time for a member to recover and stabilize after a medical event and to alert the base and commanding officer of the member's status.

- After such time had elapsed, usually 6 months or so, **a specialized medical board**, [in Mr. Irvine's case this was the CAD Committee] was to review the file and continue the temporary category, or recommend a permanent category.

- If that category was a "red light", i.e., it was below minimum required levels being "below trade standards", the recommendation would not become permanent until it was approved by the Directorate of Health Treatment Services (DHTS) in the Surgeon General's Branch and the member could not be released until that approval was received by the member's particular unit supervisors. DHTS could change the category.

[9] In the case of coronary artery disease ("CAD"), the specialized medical board was the CAD Committee, composed of DHTS staff and cardiologists who reviewed the member's file.

ii) Career Medical Review Board (Career Board)

[10] The CAF also had a 2nd review board. The case of a member whose category assignment was not relevant to a particular disease for which a specialized medical board existed, such as the CAD Committee, was referred to the Career Medical Review Board (Career Board). Since 1976, the CAF had established the Career Board to consider the best course of disposal of members whose medical category was lowered. It was created given that the consequent occupational or

geographical limitations could have necessitated a change in the member's classification or trade, a change in environment or employment, or release. The Career Board could recommend continued employment in present capacity with career limitations, continued employment in present capacity without career limitations, transfer, remuster or posting, or release. It was composed of representatives of the appropriate personnel and careers section; e.g. from the army, navy or air force, dependent upon the member's position. The Board also had one representative from the Surgeon General's division being medical personnel. The CAF policies stated that the Career Board was not to consider cases where a local medical board had declared a member medically unfit for military service.[(1)] The CAD Committee was a local medical board that dealt with members who had coronary artery disease (CAD).

[11] Again, any release decision by the Career Board was subject to approval by DHTS.

iii) Medical Policies Regarding Category Assignments

[12] There were two sets of policies regarding the assignment of medical categories and employment limitations relevant to Mr. Irvine's case: those that were in effect from 1979 to September 1995 (1979 Policies), and those in effect from September 1995 onwards (September 1995 Guidelines).

iv) 1979 Policies: Categories

[13] The relevant geographic ratings were as follows:

> "G1" indicated "no limitations" - health commensurate with full employment
>
> "G2" indicated "no climatic/environmental limitation" - minor medical condition
>
> "G3" indicated a medical condition that required closer medical supervision. Such personnel were considered capable of operating in the field and of full sea duty.
>
> "G4" precluded a member from "serving at sea, or in an isolated location where physician service was not readily available". G4 reflected climatic and isolation limitations.

[14] More specifically the geographic ratings delineated the following criteria:

> A. "G3" was assigned to members who were fit to serve in such postings for periods of up to 6 months and/or were considered unfit for **one** such specific posting.
>
> "G4" was assigned to members who, because of medical limitations inherent to the medical condition itself, or because of the unacceptable risk to the health and/or safety of the individual or to fellow workers imposed by the operational environment on the medical condition, were considered unfit for **two or more**

specific military environments (i.e. sea, field, operational taskings or isolated postings).

B. "G3" was assigned to members who may require and take prescription medications, the unexpected discontinuance (unavailability) of which would not create an unacceptable risk to the individual member's health and/or safety.

"G4" was assigned to members on medical prescriptions where the unexpected discontinuance of which, even for a few days, was considered likely to create an unacceptable safety risk.

C. "G3" was used for members whose limitations resulting from a known medical condition did not pose an unacceptable risk to the health and/or safety of the member or co-workers in the operation/work environment.

"G4" was used for members who may have required close proximity to medical services/physician-directed care.

D. "G3" was used for members who had a known requirement for scheduled medical service by a medical officer but no more frequently than every 6 months.

"G4" was assigned to members who required scheduled medical intervention more frequently than every 6 months.[(2)]

[15] The occupational ratings delineated the following criteria:

"O1" indicated members were above average fitness;

"O2" indicated members had no limitations; i.e. they were free from medical disabilities except minimal conditions that do not impair ability to perform front line combat and heavy physical work;

"O3" indicated members had a moderate physical disability preventing them from doing heavy physical work for sustained periods. However, they could perform most tasks in moderation. They were suitable for field unit but only for short periods;

"O4" indicated members were fit only for light duties because they had a physical disability or a demonstrated mental incapacity preventing them from dealing with prolonged stress when under pressure.

[16] The policies also contained a section specifically dealing with Cardiovascular disease that recommended:

> "G4" to a "G-5" rating and an "O4" to an "O5" rating for members suffering from coronary atherosclerosis (the thickening and hardening of the coronary arteries underlying most coronary artery disease) or its complications.

[17] As of 1994, the CAF policy shifted its emphasis from numbers to a description of limitations. The medical officer was to focus on the specific employment potential of each individual and describe the same in clear simple terminology.

[18] In addition, there was a bridging policy between the 1979 and 1995 policies, incorporated into the 1995 policies ("Bridging Policies"), specifically related to the assignment of medical categories in cases of CAD.[(3)] It stated that:

> "where members become entirely asymptomatic following medical or surgical treatment, "G4O3" will usually be approved although a better category may be awarded depending upon the clinical findings and the presence or absence of risk factors."

[19] It also provided that all members with suspected CAD shall be placed temporarily in the "G4O4" category until investigations and treatment were carried out. This category was to be extended for up to 12 months and in cases of surgery, the temporary category was to be routinely extended to 12 months after the date of surgery.

v) September 1995 Guidelines: Individualized Approach

[20] In September of 1995, the CAF created guidelines to assist medical personnel in their review and evaluation of medical conditions and the assignment of specific employment limitations.[(4)] These guidelines superseded the prior 1979 policies. These guidelines required an individualized approach to assessment. They provided more guidelines and fewer standards to Medical officers in assessing the medical fitness of members and in determining their employment capabilities. They emphasized consultation and a "team concept" assessment. Medical officers were to confer with each other, specialists, DHTS, and member's supervisors. The policies included questions designed to prompt the Medical Officer to reflect upon a number of issues in making the assessment. For example, in determining medical limitations and the need for medications, the following factors were to be considered:

1. potential side effects of any medication taken by the member;

2. requirements of scheduled medical follow-up;

3. frequency of laboratory testing;

4. level of medical support required to assess any side effects;

5. ability of member to serve without medication and risks;

6. availability of medication and alternate medication;

7. storage requirements of medication;

8. administration method.

[21] Other areas to be addressed in assigning limitations and category included:

- consideration of needs for physiotherapy/occupational therapy/acupuncture/ counselling etc. and its availability to areas of potential deployment;

- levels of medical care required (routine, periodic, scheduled);

- the specific medical condition of the member;

- living conditions in overseas bases;

- proper communication with the member emphasizing that the final decision regarding category designation was up to the Career Board.

vi) Military Duties

[22] The September 1995 Guidelines confirmed that there should be a direct linkage between members' limitations and their ability to function safely in their specific military occupations. Given that a medical officer may have had limited knowledge of the specific occupational tasks of a particular member, a synopsis of the essential tasks for each military job was compiled. For **aviation technician** the General Duties were:

> "Perform duties relating to supervising first and second line maintenance of aircraft. Duties may be performed in tactical units, airbase or onboard ships. Personnel are required to work from ladders and stands on rolling and pitching decks and in confined spaces."

[23] The Specific Duties were:

1. Work long and irregular shifts (up to 16 hours);

2. Cope with the stress of supervising aircraft operations;

3. Supervise maintenance and repairs in low/no light conditions;

4. Supervise maintenance in confined or cramped spaces;

5. Use mechanical, pneumatic, hydraulic or electrically powered tools;

6. Climb, stoop, bend and crawl around aircraft and support equipment;

7. Remain highly alert up to 12 hours per day;

8. Endure prolonged exposure to high noise levels;

9. Endure exposure to fuel fumes, oils and lubricants;

10. Supervise and direct personnel in combat or emergency conditions;

11. Concentrate under stress for long periods;

12. Require good hand to eye coordination;

13. Require good manual dexterity;

14. Work at heights up to 15 m.

[24] These duties/skills related specifically to the military duties the members could be called upon to perform to show that they met the principle of "universality of service" or "soldier first" which principle will be discussed later.

vii) Specific Medical Considerations Related to CAD

[25] In addition, the September 1995 Guidelines outlined considerations specific to selected medical conditions. These now provided that not all members with coronary atherosclerosis were necessarily to be released. Instead, 7 factors in assessing the probability of recurrence of a significant cardiac event in the foreseeable future were outlined:

1. recency of symptoms and cardiac events;

2. types of activities, including their intensity, duration and frequency, which provoke ischemic events;

3. the frequency and level of medical care needed to appropriately manage the member's disease;

4. The employability-limiting side effects of any cardiac medications being taken;

5. Whether there would be any exacerbation of the ischemia if the medications were withheld, for whatever reason;

6. The results of testing, such as coronary angiography [the insertion of a dye into the left ventricle to assess its function] or treadmill testing, used to identify the extent of disease and the functional capacity of the member; and,

7. The presence of any associated risk factors such as hypertension, smoking, family history and other systemic diseases such as diabetes or dyslipidemia.

[26] Ischemia refers to inadequate oxygen flow to the heart muscles. CAD cases were not considered for permanent category until a minimum of one (1) year post-heart attack.

C. CAF Fitness Policies

[27] Juxtaposed with the medical category procedures and policies were the CAF fitness policies. I will review these now.

i) Emphasis on Performance

[28] The CAF policies were centred around performance on physical fitness tests as opposed to the physical appearance of a member. In 1992, the CAF abandoned its weight-reduction policies in favour of performance measures.

ii) Stringency

[29] To encourage performance, the CAF offered a state of the art physical fitness program for members. Members underwent a preliminary health assessment. Then they performed an exercise prescription test known as the EXPRES test used to evaluate physical fitness. Post-evaluation they were given an exercise prescription to maintain or improve physical fitness. They performed a grip strength test (to measure upper body muscular strength), a treadmill test (to measure oxygen consumption ability/aerobic capacity - VO2 Max), 19 push-ups without a time line, and 19 sit-ups within 1 minute (to measure upper body and trunk muscular endurance). Members were encouraged to participate regularly in physical training activities at their own rate of progression. The CAF monitored their progress and offered them world class trainers and training equipment.

[30] In spite of such a mandatory and comprehensive program, the actual physical fitness expectation of CAF members was low. If members scored under the 20th percentile ranking, they failed the EXPRES test and were placed under the direct supervision of a physical education and recreation instructor. They were considered to be physically unfit for continued service.

[31] If members scored between the ranges of 20th to 25th percentile they were provided with semi-supervision; i.e., they were monitored by physical education staff. They were considered to have passed the physical fitness requirements of the CAF and were retained.

[32] The percentile scores reflected the fitness levels of members when compared with the fitness levels of average non-military Canadians. In other words, at the bottom end, as high as 80% of average non-military Canadians scored higher for physical fitness than CAF members who were still considered physically fit enough for service in the CAF. Thus the CAF retained members for service who were less physically fit than the average Canadian. In fact, today, the average member of the CAF scores at the 50th percentile for physical fitness when compared to the average Canadian; i.e., 50% of the average Canadian population scores better than the member and 50% scores lower. Few members were or are expected to be "athletes in a uniform".

iii) The Connection Between EXPRES Test and Military Tasks

[33] While the CAF, in practice, used the EXPRES test to measure a member's physical fitness, the CAF policy, in theory, used another set of criteria to determine whether members met its service criteria, better known as the principle of Universality of Service ("U/S").

iv) EXPRES Test Measured Ability to Perform the "Five Common Tasks":

[34] The acronym EXPRES test represents Exercise Prescription Test. The CAF used the EXPRES test since at least 1985, and continues to use it to date, as a way to measure a member's ability to perform the "Five Common Tasks" or core military duties. These tasks are:

> 1. Sea Evacuation: this task simulated casualty evacuation during a fire on board a ship. Working against time, the subject was required to carry an 80 kg stoker stretcher 12.5 m to the base of a flight of stairs plus the pushing of a skid up and down a flight of ship staircase carrying a defined mass.
>
> 2. Land Stretcher evacuation: this task was designed to simulate a land evacuation of a casualty on a stretcher over a distance of 750 m. Subject carried half of an 80 kg mass on a normal stretcher with wheels over the said distance as quickly as possible.
>
> 3. Low-high Crawl: This task simulated conditions of self-protection when moving in front of enemy fire. Each subject was to perform a low crawl for 30 m by moving under restraining barriers; turn 180 degrees, and perform a high crawl for 45 m as quickly as possible. Time to perform the task was the primary performance criterion.
>
> 4. Entrenchment dig: This task is intended to simulate self-protection in face of enemy fire by digging an entrenchment. Each person dug a one-person entrenchment 1.82 m. long, .61 m. wide, and .46 m deep. The entrenchment task entailed shovelling 1 m square of crushed rock from one box to another in the shortest period of time.
>
> 5. Sandbag Carry: This task was to simulate self-protection or protection of others from natural elements. The subject was asked to move the maximum number of sandbags a distance of 50 m in ten minutes. Each sandbag had a mass of 20 kg.

[35] Given that it is impractical to require each member to perform these tasks on an annual basis, the CAF correlated the physical requirements necessary to perform these duties to the EXPRES test. Thus a member's score on the EXPRES test provided the CAF with a "short hand" measure of the member's ability to perform the core military duties.

v) General Military Duties Used to Determine if Members Met "Universality of Service" Principles

[36] Concomitantly, from September 1995 to post December 1999, the CAF, in theory, also required members to be able to perform General Military Duties[(5)] to show that they were both employable (met physical-demand requirements and operational skill requirements) and deployable. Specifically, in the area of employability, every CAF member was to be capable of performing the following military tasks:

1. dig a personal trench;

2. perform sentry duties;

3. be able to run at a speed other than own pace;

4. march on a forced march for lengthy period while carrying a rucksack and a personal weapon;

5. perform a drill;

6. perform PT [physical training] without significant restriction(s);

7. medically fit to attempt CF EXPRES;

8. wear protective equipment required for fire-fighting and NBCW duties;

9. handle and fire personal weapon;

10. carry one end of a stretcher bearing 90 kg load cross-country;

11. work effectively in extremes of temperature for long periods outside;

12. perform arduous tasks.

[37] As seen from item number 7, included in the list was the ability of the member to attempt the EXPRES test.

[38] In the area of deployability each member was required to perform the military duties under the following conditions:

- under any climatic condition;

- without advance notice; and to:

- perform unpredictable physical activity;

- have the capacity to sustain irregular, limited or missing meals; and

- have the capacity to fly as a passenger in a CAF aircraft.[(6)]

[39] Every member, irrespective of rank, was to meet these absolute requirements. Failure to meet any single one of these requirements was held to likely result in a finding that the person did not meet U/S principles.

[40] Dr. Lee, a long time CAF exercise physiologist, testified that these General Military Duties did not correlate to a person's ability to pass an EXPRES test or to any other scientifically quantifiable exercise. In the late 1980s, Dr. Lee assisted in creating and assessing the physical fitness standards for the CAF. Through Queen's University, he, and others, performed extensive research in the area of exercise physiology and ergonomics and the development of minimum physical fitness standards. While he advocated the use of the EXPRES test to measure a member's ability to perform core military duties, he critiqued the theoretical use of General Military Duties as a standard of assessing whether a member met U/S principles. Dr. Lee asked, "What does 'dig a personal trench' mean? How deep? How long? " His criticisms were ignored by the administrative department of the CAF that had created and implemented the General Military Duties.

[41] It was not until after a CAF December 1999 review of U/S that General Military Duties were abolished as a measure of U/S. The review acknowledged that a serious weakness of the General Military Duties as a measure of individual capability was that many of the tasks were vaguely worded and failed to specify parameters (when, where, how) under which the duties of universality were to be performed, and where applicable, the individual level of capability or standard of performance necessary. The review recommended that concrete minimum requirements necessary for safe, efficient, and reliable performance be utilized to assess U/S.

[42] Both the "Five Common Tasks" and the "General Military Duties" existed in addition to the September 1999 Guidelines which outlined the General Duties and Specific Duties particular to an **aviation technician**.

vi)Universality of Service (U/S)

[43] The adherence to the principle of U/S has been a longstanding principle for all CAF members. Prior to 1999 the CAF defined U/S in various ways ranging from "soldier first - tradesman second" to "the capability to perform general military duties as required by General Specifications".[(7)] The several definitions varied in their elements. Not all mentioned deployability. Most referenced the obligation to perform general military duties which were not necessarily linked to the performance of concrete demonstrable tasks. Not all mentioned the conditions under which these duties were to be performed.

[44] After December of 1999, the CAF reconstructed its U/S policies. In the CAF December 1999 Review of U/S, (December 1999 Review) the CAF confirmed that U/S itself was a "vaguely defined concept". The CAF confirmed that court decisions defining U/S as an obligation for each member to engage in combat duty overreached the cited statutory authority being s. 33 of the *National Defence Act* which only makes members liable for "lawful duty". [(8)] The CAF identified difficulties with court interpretations equating U/S with combat duty by noting that some CAF personnel are exempted from combat duty such as chaplains and health-care personnel, and more recently, those under 18 years of age. Secondly, it observed:

> "...there is a big difference between a general liability to perform any lawful duty and an unspecified duty to engage in combat. This distinction leaves open the possibility that the meaning of lawful duty could change if defence policy changes, defence tasks change, or occupational specifications change. In the final analysis, it seems more plausible that sub-section 33(1) [*NDA*] simply asserts the broad authority of the State and the CF over the individual member in matters of duty assignments, and was intentionally written that way to give the State and the CF the necessary flexibility to alter the meaning of lawful duty in response to a changing strategic environment, changing defence commitments, and changing human resource capabilities." (9)
>
> [emphasis added]

[45] The CAF acknowledged that employment policy is to some degree discretionary and that the CAF could adopt a policy defining "lawful duty" at a given time period consistent with the CAF's current defence objectives. As was aptly put by the CAF itself, "U/S is the product of the tension between capabilities and commitments." (10)

[46] As well, the review found that while all members must contribute to the defence mission, "there is no logical requirement for *everyone* in uniform to be a combatant or to be deployable to contribute to the operational effectiveness of the CF". (11) It reasoned that while the role of the CAF is to defend Canada and Canadian interests by resort to arms when necessary, it does not follow that at the individual level, every member must be capable of using armed force. After such analysis, the CAF review recommended that:

- Universality of Service be strictly defined as the liability of every member to perform any lawful duty including the liability to be operationally employable and deployable;

- an operational employment policy be drafted confirming this obligation unless a justifiable exemption exists or an accommodation of individual employment limitations has been explicitly granted through other CAF procedures. (12)

vii) Accommodation

[47] Before 2000, when new U/S policies were implemented, the CAF provided limited accommodation to members found to be in breach of U/S principles.

viii) Specific and Limited Accommodation - 1994 Retention Guidelines

[48] Members who could not perform their occupational and general military duties wherever and whenever required were only to be recommended for retention under specific circumstances:

> a. The member could continue to serve with minor restrictions or through an occupational transfer;

b. The member had an urgently required skill or qualification, in which case the member would be retained only until a suitable replacement could be trained;

c. the member was within 2 years of a major career gate, in which case retention would be authorized to that point but not beyond. (13)

d. If truly exceptional circumstances existed the member could be exempted which did not include personal factors such as high regard for a member.

[49] The December 1999 Review confirmed that initially determinations of individual employability were not based on "hard empirical analysis". In fact, a prior 1985 policy, in effect to the 1990s, accommodated members who did not meet the medical category for their occupation but who were otherwise employable in 80% of the relevant established positions. They could be retained without career limitations.(14) This policy was altered, and as of January 1996, policies provided that career managers were no longer to calculate percentage of employability for members with employment limitations placing them in breach of U/S principles.(15)

[50] The December 1999 review recommended reconstruction of accommodation policies: the CAF acknowledged that it should accommodate members whose medical employment limitations placed them in breach of U/S on each relevant employment standard to the point of undue hardship The review recommended that the CAF shift from a "zero-risk" tolerance model to one tolerating some degree of risk. The review acknowledged that its past practice of accommodation was not a maximal response.

ix) Tailoring Standards to Probability of Involvement In Military Duties

[51] The December 1999 review also acknowledged that some within the CAF had argued that minimum physical capability standards ought to be tailored to rank or according to the probability of involvement in General Military Duties or physically demanding activities. For example, in the case of an officer, it conceded that Career Review decisions did not place much emphasis on whether the officer had the ability to perform General Military Duties. This was in part because the specification of duties was indefinite and also because of the greater managerial/supervisory responsibilities of officers and their more numerous options for staff employment. Unfortunately this argument of tailoring standards to probability of involvement had been internally rejected on the basis that:

"... consistency in policy was essential **if credibility with the Human Rights Commission were to be maintained.** In other words, the Working Group concluded that it would be better to defend a one-dimensional policy that looked consistent, but which had little or no empirical grounding, than to attempt to defend a differentiated policy that more accurately reflected the requirements of different rank levels." [emphasis added](16)6

x) The CAF's Capacity For Accommodation - FRP/Budgetary Restraint 4/1995

[52] The CAF was involved in a large number of dismissals in the CAF during the years 1994 to 1998. Some 8100 military positions were deleted due to significant budget reductions. The magnitude of these numbers was such that a special FRP release program was designed to encourage members to voluntarily retire. Those who opted for the package received a monetary incentive. However, several years later, the December 1999 Review confirmed that at the time of the 1999 review there were 6000 Military Non-Essential (MNE) positions in the CAF regular force. It acknowledged that the CAF's capacity for accommodation may be empirically greater than what had been traditionally claimed. (17)

xi) November 2000 Policies - Reasonable Accommodation

[53] In November 2000 the CAF implemented changes to its U/S policy providing that thereon the CAF would make reasonable accommodation for members whose medical employment limitations placed them in breach of the U/S principle. (18) Such members are now to be retained subject to periodic reassessment, as long as they can be fully employed in a position established for their rank and military occupation and the operational tempo is such that other members of that rank and occupation are not exposed to undue hardship as a result of the decision to retain; "...every effort will be made to ensure that individual capabilities and limitations are considered against valid occupational requirements." (19) Accommodation is possible if the member can fulfil all normal duties for his rank and occupation. For example, an infantry soldier who can fulfil all the normal duties of an established position in an infantry battalion but cannot deploy to high-risk theatres of operation will be retained if the chain of command and Managing Authority for the Infantry Branch allows a number of positions or percentage of unit strength to accommodate soldiers in breach of U/S. Alternatively this soldier can be retained if this soldier could also be re-assigned to a garrison support position established for his or her military occupation for which he or she can fulfil all normal duties. There will not normally be accommodation if the military occupation is overstaffed at that rank level. An administrative structure to manage the limits of the CAF ability to accommodate was created.

[54] While the November 2000 Policies retained concepts of U/S in terms of employability and deployability, they specifically provided for accommodation of members with individual employment limitations. Members may be employed in positions where they are not directly exposed to any of the tasks or working conditions contemplated by U/S. Nevertheless, they will be liable for reassignment as required by the CAF. All cases are individually reviewed from an accommodation perspective.

xii) Method of Assessing Member's Ability to Perform General Military Duties

[55] Another surprising characteristic of the CAF's U/S policy prior to December 1999 was that a member's inability to perform General Military Duties only came to the attention of medical officers if a member self-reported such inability in a routine medical examination conducted once every five years (20) or if a member reported for medical treatment. There were no other formal assessments of a member's ability to satisfy these requirements, and no objective checks for self-reported assessments. The CAF itself acknowledged that even though the requirement to perform the Five Common Tasks as measured by the EXPRES test "was designed and validated

as a measure of individual ability to meet the physical demands of common military tasks, it was not used as a universality of service standard."[21] It observed that "one unfortunate consequence of these practices" was that:

> "by default, medical officers have become the primary enforcers of common individual operational readiness standards. This is not only inappropriate to their role and responsibilities but undermines their ability to provide care and treatment to members who may be reluctant to disclose medical problems to them."[22]

[56] Thus, the duty of determining whether a member met all aspects of U/S principles, fell inappropriately and inconsistently upon the shoulders of medical officers. This is not the case today, as post December 1999 Review, CAF members who pass the EXPRES test are held to meet U/S principles. The Review recommended that U/S be based on three general levels:

> (1) ability to meet the physical demands of general military service, as indicated by attainment of the "Five Common Tasks";
>
> (2) ability to perform the skill elements of common operational tasks, as indicated by satisfactory routine unit and pre-deployment training evaluations; and
>
> (3) operational deployability, as indicated by the absence of any medical or other limitations on deployability.[23]

[57] Thus it was recommended that the singular role of medical officers as guardians of U/S ought to be altered.

D. Mr. Irvine's Particular Circumstances

[58] Against the backdrop of these policies I will now examine Mr. Irvine's particular circumstances.

i) General History

[59] Mr. Irvine was a member of the Royal Canadian Air Force since July 1967. He commenced as an air force technician at the rank of private at the age of 19 years. Today he is 53 years old. His love of aviation and people led him to excel. He was promoted over the years to corporal, master corporal, sergeant, warrant officer, and finally to master warrant officer.

[60] Mr. Irvine used to smoke but quit completely in 1990. He was warned as early as February 1987 that he was overweight. From that date to his release, he attempted repeatedly with mixed success to reduce his weight through a combination of diet, exercise and drugs. He was counselled by CAF staff and physicians.

[61] Mr. Irvine experienced chest pain in December 1992. He was seen at the Royal Alexandria Hospital and found to be asymptomatic but was counselled with respect to low fat and cholesterol diet and to lose weight. He had also suffered chest pains in February 1993 which he reported to the base hospital. Shortly thereafter, he was tested by the base physician who also discussed the risk factors that he possessed making it likely that he would suffer a heart attack. He was found to be fit to return to work and was not offered medication to lower his cholesterol levels. He obtained such "excellent results" on an exercise stress test on April 1, 1993 that his cardiologist did not recommend further treatment or investigations at the time.

[62] Mr. Irvine continued to pass each of his EXPRES tests consistently but for one exception in January 1994 when he failed the push-up component of the EXPRES Test. He took another EXPRES test again within 2 months and passed the EXPRES test in March 1994. Unfortunately, within 24 hours of taking the test, on March 30, 1994, he suffered a heart attack. A subsequent 1994 CAF summary investigation concluded that Mr. Irvine's heart attack "was attributable" to his "military service" in that the CAF EXPRES test "aggravated an existing medical condition".

[63] After the heart attack Mr. Irvine underwent angiography and successful double by-pass surgery, involving vein grafting, performed by Dr. Koshal at the University of Alberta Hospital.

[64] Up to May 1994 Mr. Irvine's category was "*G2O2"*. In May 1994 it was temporarily restricted for 6 months to "*G4O4"* with notations "medical services readily available" and "light duties only". The temporary category was assigned to allow time for recovery, stabilization, and receipt of reports and recommendations. The wing surgeon, Dr. Christiansen, advised Mr. Irvine's current medical officer that his "best possible [permanent] medical category will be "G4O3". Shortly thereafter, Dr. Hui, a cardiologist, retained by the CAF to advise base surgeons about Mr. Irvine's condition, consulted with Mr. Irvine's physicians, Drs. Black and Koshal. On June 13, 2001, Dr. Hui assessed Mr. Irvine as fit to return to full-time employment and that from a cardiac standpoint no restriction in physical activities was in order. He warned Mr. Irvine to work very hard towards risk factor reduction in terms of regular exercise and dietary modification. Mr. Irvine accepted this direction and made lifestyle changes in diet (elimination of sugar/salt and restriction to decaffeinated coffee) that he adheres to to-date. He also committed himself to an exercise program that he adheres to-date.

[65] On June 10, 1994, Mr. Irvine entered an 8-week cardiac rehabilitation program at the Glenrose Rehabilitation Hospital under the care of cardiologist Dr. Black. There he performed a treadmill test. The treadmill test uses an assessment method known as the Bruce Protocol: the test is structured on the basis of 3-minute intervals of exercise up to a total of 7 stages. The subject is to run on the treadmill until he reaches his predicted maximum heart rate. The average person is able to persevere to 9 minutes while an athlete such as Wayne Gretsky could persevere to 21 minutes. The treadmill test is the same one used as part of the EXPRES test. In June 1994 Mr. Irvine was able to persevere only 8 minutes on the treadmill test; his heart rate and blood pressure rose very quickly. Dr. Black found that he was "out of shape". However, he did not have any significant chest pain or evidence of ongoing ischemia.

[66] After his heart attack, Mr. Irvine's immediate supervisors remained impressed with his abilities. On July 6, 1994, Mr. Irvine was promoted to the position of Master Warrant Officer

which promotion was to take effect August 17, 1994. His posting was changed from Edmonton to Halifax. On July 12, 1994, his promotion was deferred until his permanent category was assessed. Mr. Irvine spoke to his Career Officer about this deferral and was encouraged to move to Halifax from his positing in Alberta to pursue acting Master Warrant Officer duties pending a final decision about his ability to serve in the CAF. He was told that once his final category was resolved he would receive back-pay to the date he started performing Master Warrant Officer duties.

[67] Prior to moving to Halifax, during the month of August 1994, Mr. Irvine continued follow-up care at the Glenrose Hospital. There he performed the treadmill test and was able to persevere to 10 minutes reaching his maximum heart rate of 180. He had no chest pain and no evidence of ischemia. On August 29, 1994, Dr. Black wrote that Mr. Irvine "has done extremely well" since his entry into the program. He wrote that "His bypasses appear to have been successful. He has an improved and reasonable exercise tolerance and will be continuing on his diet and exercise program and would, certainly appear to be ready to return to full time work." Dr. Black confirmed that Mr. Irvine was discontinuing the rehabilitation program prematurely but did not express any concerns about the same.

[68] Mr. Irvine moved to Halifax at the end of August 1994. His main duties as Master Warrant Officer were to chair meetings, supervise aviation technicians, and qualify staff to run airplanes. He had the same duties as a Warrant Officer but exercised greater leadership skills for leading a squadron.

[69] In November 1994, Dr. Buchholtz, Chief of Medicine, Consultant to the CAF, examined Mr. Irvine. He advised that Mr. Irvine had "done an excellent job in trying to control risk factors", but continued to have abnormal lipid levels. Accordingly, Mr. Irvine was prescribed medication, Lipidil. Mr. Irvine was also booked for an "exercise Mibi" test to ascertain disease progression. Thereafter the consultant was to make recommendations regarding his medical category.

[70] The exercise Mibi was a safe and simple evaluation procedure. It involved recording the member's ECG results before, during and after exercise, usually on a treadmill machine. This technique can provide a measure of ventricular volume, ejection fraction, and regional ventricular wall motion at rest and during exercise, and can identify transient global and regional left ventricular dysfuntion due to ischemia. [(24)] The test could be enhanced by injecting the test taker with a radioisotope and assessing regional heart perfusion by means of a gamma camera.

[71] On November 24, 1994, Mr. Irvine performed the treadmill test and persevered for 10 minutes reaching a maximum heart rate of 170. He had no chest discomfort despite an exercise workload of 11 METs reflecting the fact that he was performing very well.[(25)]5 He had no ischemia and according to Dr. Buchholtz's December 1994 assessment, he was completely asymptomatic and was doing "exceedingly well". Mr. Irvine had lost 35 pounds, and had normal cholesterol levels. Dr. Buchholtz was "tempted" to recommend a "G3O3" category which he believed "was justified in the long term". However, Dr. Buckholtz wrote that Mr. Irvine's cholesterol was normal when in fact an October 1994 laboratory report showed that it was still high.

[72] On January 16, 1995, Dr. MacKinnon, a base examining physician, recommended a "G3O3" finding him fit for promotion. However, Mr. Irvine's case was brought to the attention of Dr. Kafka, base surgeon, by Drs. Dubinsky and Dr. MacKinnon. On February 7, 1995 Dr. Kafka, the base surgeon, reviewed Mr. Irvine's chart from the perspective of risk factor control. Dr. Kafka did not take exception with the "O3" rating but expressed concerns about the "G3" portion of the assessment. Dr. Kafka identified that Mr. Irvine was a former smoker; that in spite of significant weight reduction after the heart attack he was still heavier than he had been in 1990; and that his more recent cholesterol test showed higher cholesterol levels than those reviewed by Dr. Buchholtz in December 1994. Dr. Kafka confirmed that he had recommended a "G3" category for a:

> "small group of patients who, post bypass surgery, have no evidence of ischemia, have limited disease and have excellent control of their risk factors. W.O. Irvine will need to better control his diet and with the use of medication get his cholesterol down lower."

[73] His opinion was made in accordance with the Bridging Policies in effect at the time. Dr. Kafka felt that if Mr. Irvine could reach a targeted LDL level (2.6), then a "G3" category would not be unreasonable. However, Dr. Kafka premised his view with the provision that Mr. Irvine was to be assessed with an exercise Mibi and that Mr. Irvine was to be given an angiography in another year so that the CAF could collect data on post-heart attack members who had brought risk factors under excellent control. Angiography, the insertion of a dye into the left ventricle to assess its function, is an invasive procedure. Dr. Fisher confirmed that it was potentially life-threatening and should only be used where there would be a real benefit to the patient.

[74] On February 13, 1995, Dr. Dubinsky found that Mr. Irvine still needed better control of weight and lipids. On the same day he excused Mr. Irvine from taking another CAF EXPRES test. No explanation for this decision was provided. On February 23, 1995, Mr. Irvine's occupational category was only partially upgraded to "G4O3" (temporary for 4 months). He was assessed as being "fit for most tasks in moderation" and to take "physical training at his own pace" but geographically he was found to be "unfit sea, field, UN, isolation, more frequent medical supervision".

[75] On July 4, 1995, Dr. Buchholtz, Consultant, observed that Mr. Irvine had achieved an "excellent exercise program" and was seen by the Dietary unit. Mr. Irvine's total cholesterol was lowered although his LDL, being a specific type of cholesterol, was still above the target of 2.6. Dr. Buchholtz acknowledged Dr. Kafka's view and agreed that if risk factors were not modified, a "G4" would be warranted. However, he noted that Mr. Irvine was exercising and following his diet, and felt that as long as he continued with his exercise program and risk modification he would be fit for all activities, and that a "G3" would reflect his posting ability to both isolated and foreign duty."

[76] On July 11, 1995, Mr. Irvine was geographically upgraded to "G3O3" to "medical condition requiring closer medical supervision" and found to be "within trade standards". However, immediately thereafter, his career officer "flagged his file" and his medical category was placed

on hold pending a review of his file by the CAD Committee at DHTS. A new change of category form was issued, apparently backdated, with a "G3O3" rating, but which indicated that the category was to be reviewed by the CAD Committee.

[77] At this time, his base recommendations continued to be overwhelmingly positive and commended his service and his ability to carry out 100% of MWO duties. His supervisors evaluated his performance as exemplary and assessed him as having produced "exceptional results in all endeavours". They wrote that he was "undaunted by the pressures and challenges of MWO responsibilities" and recommended that he be promoted to Master Warrant Officer immediately. Regarding the possibility of foreign postings, his Colonel and Commanding officer wrote:

> < "With only 7 years remaining to CRA [compulsory retirement age], he is likely to remain in a CP140 position [(26)] until then. In this capacity, it is highly unlikely that he would be required to serve in field, sea, UN or isolated postings. Strongly recommend continued employment in present capacity without career limitations."

[78] On August 30, 1995, a CAD Committee reviewed Mr. Irvine's medical file and noted that the consultant had recommended a "G4O3", but if lipids come down, "G3" and that a base surgeon had recommended "G3O3" - "closer medical supervision". The CAD Committee in accordance with the "1979 Policies" assessed him as unfit for two or more specific military environments and recommended a permanent medical category of:

> "*G4"*: physician services required; unfit field, sea, UN and isolated postings" and "*O3"*: fit PT [physical training], but may be limited in type, duration, frequency and intensity of the activity; no sudden or sustained heavy physical exercise"

[79] In downgrading Mr. Irvine's category, the CAD Committee identified:

> Risk Factors: overweight, dyslipidemia, family history of heart disease, ex-smoker. 2-Vessel disease; still has high risk factors.

[80] Mr. Irvine did not have ischemia and the Committee did not obtain and consider Mr. Irvine's ejection fraction.[(27)]

[81] In its Medical Statement the CAD Committee in September 1995, in accordance with the September 1995 policies, stated:

> "W.O. Irvine, an aviation tech., has a heart condition with a significant risk of a sudden life-threatening event."

[82] In January 1996, the CAF forwarded disclosure materials to Mr. Irvine indicating that his case would be considered by the Career Board to determine appropriate career action, and that he could provide written materials to it. Contrary to the prevailing policies the matter was forwarded to the Career Board for further consideration.

[83] Concurrent with this process medical treatment continued. In March 1996 CAF physicians prescribed him another cholesterol lowering drug called Lescol, as Lipidil had not been effective in reducing his cholesterol. This medication led to some improvement to Mr. Irvine's cholesterol levels but they remained elevated.

[84] On April 11, 1996, the Career Board reviewed Mr. Irvine's file, accepted the CAD Committee recommendation and assessed his permanent medical category as *G4O3*. The board found that Mr. Irvine: "could not perform any lawful duty." It found that these employment limitations drastically restricted Mr. Irvine's capacity to perform the full spectrum of the general military duties and precluded him from performing them in any operational theatre. It found that "the CAF has 'BFORs' for WO Aviation Technicians to perform their duties in a tactical environment and at sea and to perform arduous tasks."

[85] Occupational transfer, further to the exceptional circumstances provision, was not an option, even though he was found to be capable of performing 86% of his occupational specific tasks at his rank. The Board applied the "1994 Retention Guidelines" and found that Mr. Irvine could not be accommodated under the same.

[86] Subsequently, the decision was approved by DHTS and Mr. Irvine was released from the CAF on medical grounds due to a disability as of August 1996. Thus his 29-year career was halted.

[87] Fearing that the CAF might ultimately release him, Mr. Irvine had voluntarily opted for and finalized an early retirement option (FRP). Further to this FRP he retired on August 15, 1996 and received a cash settlement and fully-indexed pension.

ii) Mr. Irvine's Post-Release Condition

[88] In November 1996, Mr. Irvine returned to Edmonton, Alberta and consulted a private physician, Dr. Gregson. After confirming that his cholesterol levels were elevated, Dr. Gregson initially doubled the dosage of Lescol for a 6-8 week period. When Mr. Irvine's levels did not decrease, Dr. Gregson prescribed another drug, Zocor. Within a 2-month period Mr. Irvine's cholesterol levels dropped significantly. Dr. Gregson describes this as an "excellent response to Zocor" and suggested that Mr. Irvine continue the Zocor which he continues to date.

[89] Unfortunately, on August 10, 2000, Mr. Irvine had chest pain and was diagnosed as having suffered a small non-Q wave heart attack. This is one of the mildest forms of a heart attack involving the right side of the heart. Dr. Black testified that if he were to choose to have a heart attack he would choose to have this type of a heart attack. No surgery was required. After this heart attack, on August 14, 2000, his ejection fraction was 45% indicating strong ventricular function. Mr. Irvine re-entered a rehabilitation program and on September 18, 2000, he underwent a treadmill test and was able to perform reasonably well with no evidence of ischemia.

E. Relevant Medical Data

i) Medication

[90] Zocor is part of the Statin group of drugs and had been used to control blood fat and cholesterol levels since the late 1980s and early 1990s by physicians, including Drs. Gregson, Cheung and Black. It was a common practice since at least the early 1990s to prescribe Zocor to patients with coronary artery disease.

[91] Mr. Irvine's experience with medication was consistent with the scientific opinion in 1996, that drugs usually decreased LDL and total cholesterol levels more effectively than does diet. (28) In fact, in July 1995, in spite of an excellent exercise program, Mr. Irvine's cholesterol levels were high.

[92] Cholesterol levels can be significantly reduced through the use of medication. Serum lipid modifying drugs can reduce the risk of another cardiac event by 25% to 30%. Total mortality is less affected with a reduction in risk of approximately 10%. (29)

ii) Predictors of Future Cardiac Events

a) Extent of Disease and Ejection Fraction

[93] There were two important predictors of the likelihood of a further cardiac event. One was the "Extent of coronary disease". For example, the greater the number of vessels affected, the greater the disease. Left ventricular disease was more serious than right ventricular disease. Other indicators of disease were evidence of ischemia and the existence of graft disease.

[94] The second powerful prognostic indicator was the ejection fraction. The ejection fraction reflects the functional capacity of the left ventricular region and a 45% to a 49% rating reflects good ventricular function. The ejection fraction varies and a patient can improve his ejection fraction through medication, re-vascularization (by-pass surgery) and exercise.

[95] In addition to the numerical value of the ejection fraction, the 1994 data show that the ability to predict mortality increased tremendously if the ejection fraction was considered in conjunction with data from a treadmill exercise test. For example, data show that reaching stage 3 of the Bruce Protocol test as opposed to reaching only stage 1 could lead to significantly different survival rates. The member who reached stage 3 with certain parameters could have a survival rate of 95% as opposed to a 72% survival rate for those who reached only stage 1. (30) Also, in Mr. Irvine's case, he underwent angiography and double by-pass surgery, and thereafter had an ejection fraction of 49% in April 1994. This figure, when combined with the factor of two-vessel disease, would lead to a prognosis of risk of death at 10% over the next three years. (31) In Mr. Irvine's case he had reached the 4th stage of the Bruce Protocol treadmill test without evidence of ST segment depression signifying cardiac abnormality or ischemia. (32) He had performed well on the exercise Mibi test.

b) Risk Factors for a Future Heart Attack

[96] In addition to the use of prognostic factors such as "extent of disease" and "ejection fraction", risk factors were relevant to assessing morbidity and mortality. Dr. Black testified that the "Big 3" risk factors for a heart attack were: high cholesterol, smoking, and high blood pressure. Having had a heart attack is a significant risk factor in the likelihood of having another one. In particular, a patient with diabetes who had survived a heart attack is at high risk of another event. Obesity and family history were associated risks. Male gender is, itself, a risk factor.[(33)] Other risks include: hypertension, stress, and physical inactivity.

[97] Dr. Fisher confirmed that, unlike the medical opinion today, in 1995 it was being debated as to whether dyslipidemia or hypertriglyeridemia (high cholesterol levels) were independent risk factors. [(34)] She provided a series of articles showing how controversial the issue of whether high blood cholesterol levels were linked to atherosclerois was, as late as 1996. Some of the medical literature listed abdominal obesity as an independent risk factor, such as Harrison's Principles of Internal Medicine 1994.

[98] With respect to diet, Harrisons Principles of Internal Medicine 1994 confirms that the relationship of diet to IHD (ischemic heart disease) was an area of intense interest and persistent controversy at the time. The scientific literature at the time confirms that Mr. Irvine's sporadic results in weight control were consistent with the norm. The success of dietary changes and regular physical exercise were acknowledged to be largely dependent upon a patient's determination and self-discipline:

> "in hand-picked individuals endowed with exceptional motivation and determination, impressive changes were feasible; in nonselected, average patients with coronary disease, effects of lifestyle intervention are modest.[(35)] [emphasis added]

[99] Other articles confirmed that the general population's knowledge about weight was different from that of the medical community. Some of the literature indicates that while people generally identified fat in food as a risk factor only a small percentage identified weight as a factor.

c)Inability to Accurately Predict Another Event

[100] In spite of these various ways to predict another event, and the fact that Drs. Fisher, Leach and Black agree today that there may be a 30% risk of another event within 10 years, this risk varies from patient to patient. Drs. Fisher and Black and the medical literature confirmed that a person with mild CAD could have accelerated disease progression and a person with severe CAD could have slow progression. Changes can occur unexpectedly or suddenly, rather than gradually.

d)Vein Graft Disease

[101] By-pass surgery involves grafting of an alternate "blood route" to the heart to by-pass the occluded artery. This is done through using vein grafts. After surgery these vein grafts can become occluded, a condition known as vein graft disease. The rate of occlusion of vein grafts can be predicted.[(36)]

e) EXPRES Test

[102] Although some of the literature indicated that vigorous exercise for a person with CAD might not be prudent, Dr. Lee testified that a patient with CAD could safely perform an EXPRES test wearing a heart rate monitor under medical supervision.

III. LEGAL PRINCIPLES

A. Law

i) Sections 7 & 10

[103] Mr. Irvine has filed a complaint pursuant to sections 7 and 10 of the *Canadian Human Rights Act* against the Canadian Armed Forces ("CAF"). Section 7 makes it a discriminatory practice to directly or indirectly refuse to employ an individual, or in the course of employment, to differentiate adversely in relation to an employee, on a prohibited ground of discrimination. Section 10 makes it a discriminatory practice for an employer to establish or pursue a policy or practice that deprives or tends to deprive an individual or class of individuals of any employment opportunities on a prohibited ground of discrimination. Section 3 of the *Act* designates disability as a prohibited ground of discrimination.

ii) Universality of Service

[104] The Federal Court, in its famous 1993/1994 trilogy [(37)], ruled that universality of service (U/S) required every CAF member to be fit at all times for combat duty even though the member may have other functions. The Federal Court wrote:

> "As such he is expected to live and work under conditions unknown in civilian life and to be able to function, on short-notice, in conditions of extreme physical and emotional stress and in locations where medical facilities for the treatment of his condition might not be available, or if available, might not be adequate." [(38)]

[105] Because medical attention may not be available the member must not have occupational limitations, which, in the event that medical attention is required and is not available, would place the success of the operation, the safety of the member or of his or her co-workers in jeopardy. The Court cited the *National Defence Act* as authority for its rulings. The *NDA* requires that members at all times perform lawful duty, and be liable to perform national disaster relief service. In dissent, Mr. J. Robertson, found that the *NDA* did not require all members to engage in combat duty, only lawful duty, and that the *NDA* permitted the CAF to adopt a policy to determine which lawful duties may be imposed upon CAF members. He upheld the lower tribunal's decision on this matter and found that the "soldier first" policy was not uniformly adopted and applied to serving CAF members.

iii) Defences

[106] At the relevant time, section 15 of the *Act* excepted certain practices as non-discriminatory. Section 15(a) provided that any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is not a discriminatory practice if the employer establishes it to be based on a *bona fide* occupational requirement.

[107] In *Robinson*, the Federal Court of Appeal applied the BFOR test of *Etobicoke* to a disability case in the CAF. The Court found that the CAF's "seizure free" policy was directly discriminatory and therefore the CAF had no legal duty to accommodate. Still, the Court left open the possibility of individual testing as a practical alternative to the adoption of an occupational requirement that is *prima facie* discriminatory. The onus is on the employer to demonstrate, on a balance of probabilities, why a blanket policy of exclusion is reasonably necessary in circumstances where not all persons within the excluded group pose the same risk of unpredictable employee failure; i.e. why individual testing is not a practical or reasonable alternative.

iv) *Meiorin* Analysis

[108] Subsequent to the Federal Court trilogy, and the filing of Mr. Irvine's complaint, the Supreme Court of Canada reconstructed the approach to be taken in discrimination cases in its decisions in British Columbia (Public Service Employee Relations Commission) v. BCGSEU[(39)] [also known as "*Meiorin*"] and *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)* [also known as "*Grismer*"].[(40)]0 The classic distinction between direct and indirect discrimination has now been replaced by a unified approach to the adjudication of human rights complaints. Under this unified approach, the initial onus is still on a complainant to establish a *prima facie* case of discrimination. A *prima facie* case is one which covers the allegations made, and which, if believed, is complete and sufficient to justify a verdict in the complainant's favour in the absence of an answer from the respondent.

[109] Once a *prima facie* case of discrimination has been established, the onus shifts to the respondent to prove, on a balance of probabilities, that the discriminatory standard or policy is a BFOR. In order to establish a BFOR, the respondent must now prove that:

> i) it adopted the standard for a purpose or goal that is rationally connected to the function being performed. At this stage the focus is not on the validity of the particular standard, but on the more general purpose, such as the need to work safely and efficiently to perform the job. Where the general purpose is to ensure the safe and efficient performance of the job it will not be necessary to spend much time at this stage.
>
> ii) it adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose, with no intention of discriminating against the claimant. Here the analysis shifts from the general purpose of the standard, to the standard itself; and<

iii) the impugned standard is reasonably necessary for the employer to accomplish its purpose; i.e. the safe and efficient job performance. The employer must establish that it cannot accommodate the claimant and others adversely affected by the standard without experiencing undue hardship. The employer must ensure that the procedure, if any, to assess the issue of accommodation, addressed the possibility that it might discriminate unnecessarily on a prohibited ground. As well the substantive content of a more accommodating standard offered by the employer must be individually sensitive. Alternatively, the employer must justify his reason for not offering such an alternative standard.

[110] The term 'undue hardship' is not defined in the *Act*, however, *Meiorin* and *Grismer* provide instruction in arriving at a determination of whether or not an undue hardship defence has been established. In *Meiorin*, the Supreme Court observed that the use of the word 'undue' implies that some hardship is acceptable: it is only 'undue' hardship that will satisfy the test. (41) An uncompromisingly stringent standard may be ideal from the employer's perspective. Yet, if it is to be justified under human rights legislation, the standard must accommodate factors relating to the unique capabilities and inherent worth and dignity of every individual, up to the point of undue hardship.

[111] The Supreme Court has further observed that in order to prove that a standard is reasonably necessary, a respondent always bears the burden of demonstrating that the standard incorporates every possible accommodation to the point of undue hardship. (42) It is incumbent on the respondent to show that it has considered and reasonably rejected all viable forms of accommodation. The onus is on the respondent to prove that incorporating aspects of individual accommodation within the standard was impossible short of undue hardship. (43) In some cases, excessive cost may justify a refusal to accommodate those with disabilities. However, one must be wary of putting too low a value on accommodation. It is all too easy to cite increased cost as a reason for refusing to accord equal treatment. (44) The adoption of the respondent's standard has to be supported by convincing evidence. Impressionistic evidence of increased cost will not generally suffice.(45) Innovative and practical non-monetary avenues of accommodation ought to be considered. Finally, factors such as the financial cost of methods of accommodation should be applied with common sense and flexibility in the context of the factual situation under consideration.(46)6 As observed by Cory J. in *Chambly v. Bergevin* [1994] 2 SCR 525, what may be entirely reasonable in prosperous times may impose an unreasonable financial burden on an employer in times of economic restraint or recession.

v) Risk

[112] The Supreme Court in *Grismer* expressly over-rules the case law that had evolved around prior concepts that "sufficient risk" could justify a discriminatory standard. The Court confirms that this is no longer the law, and that while risk can be considered under the "guise" of hardship, risk may not constitute an independent justification of discrimination. In the *Grismer* case it was used as a measure of the level of safety sought by the Superintendent, and as a factor in assessing the lack of accommodation provided by him for people with a disability.

vi) Use of Post-Discharge Evidence

[113] In a labour law context, *ex post facto* evidence is admissible only if it is relevant to the case or "sheds light" on the reasonableness and appropriateness of the dismissal under review at the time that it was implemented. [(47)] In reviewing an arbitrator's decision on an employee's dismissal grievance the Court held that post-discharge evidence is not admissible unless it sheds light on evidence leading to the dismissal. The Court propounded that as a general rule, an arbitrator reviewing a decision by the Company to dismiss an employee should uphold the dismissal where he is satisfied that the Company had just and sufficient cause for dismissing the employee at the time that it did so. To hold otherwise would be to accept that the result of a grievance concerning the dismissal of an employee could vary depending on when it is filed and the time lag between the initial filing and the final hearing by the arbitrator. Furthermore, it would lead to the absurd conclusion that a decision by the Company to dismiss an alcoholic employee could be overturned whenever that employee, as a result of the shock of being dismissed, decides to rehabilitate himself, even if such rehabilitation would never have occurred absent the decision to dismiss the employee. Such evidence can be prejudicial to one of the parties and distort the proper analysis of the case. [(48)] In a human rights context, a Human Rights Tribunal has ruled that the relevant time for assessing a termination decision is when the decision was made: Did the respondent make proper inquiries to determine the nature of the complainant's disability? What was the prognosis? What accommodation was required? Was there other work that the complainant could perform? [(49)] Axiomatically, in some labour law cases, it has been held that not only would it have been reasonable for arbitrators to consider such evidence, but that the failure to consider such evidence constituted a serious error. [(50)]

IV. ANALYSIS

A. Has the Complainant Proffered a *Prima Facie* Case of Discrimination Contrary To sections 7(a), 7(b) and 10?

i) Section 7(a) Release

[114] I find that Mr. Irvine has met his initial onus. Mr. Irvine's medical condition was at least one factor in the CAF's ultimate decision to release him contrary to s. 7(a) of the *Act*. His release was expressly stated to be on "medical grounds" which were specified as "being disabled and unfit to perform the duties in the member's present trade or employment, and not otherwise advantageously employable under existing service policy". The CAF does not dispute that this is the case.

[115] Given that Mr. Irvine was released contrary to s. 7(a), I do not find it necessary to individually analyse whether the CAF's conduct during his employment was contrary to s. 7(b).

ii) Policies - Section 10

[116] The CAF medical policies related to members with disabilities, and in particular to members with coronary artery disease. They specified differential processes and criteria to

evaluate such members than from those that were applicable to able-bodied members. Thus they *prima facie* discriminated against Mr. Irvine on the basis of his disability.

[117] The CAF fitness policies and procedures that required that Mr. Irvine demonstrate an ability to perform the General Military Duties once subjected to individual examination differentiated between able-bodied and disabled members. Able-bodied members were able to demonstrate fitness by passing the EXPRES test that evaluated their abilities to perform the Five Common Tasks. Once disabled, Mr. Irvine was not given the opportunity to perform the EXPRES test. This differentiation in policies towards Mr. Irvine when disabled constitutes *prima facie* discrimination on the basis of disability.

B. *Bona Fide* Occupational Requirement

[118] Having found a *prima facie* case of discrimination on the basis of disability, the onus shifts to the CAF to establish that its medical and fitness standards constitute a BFOR.

i) Retroactivity of *Meiorin*

[119] In addressing the BFOR the CAF alleges that the 1999 *Meiorin* (*supra*) and *Grismer* (*supra*) decisions do not apply to its 1996 termination decision vis-à-vis Mr. Irvine. The respondent argues that to retroactively apply *Meiorin* to past actions of the CAF is prejudicial. It argues that new law and new consequences should not be applied to old actions.

[120] I reject this argument. It is a fundamental tenet of our legal system that the common law is "always speaking" in that it speaks from the moment that it is pronounced to all prior events. (51) Had the Supreme Court of Canada intended otherwise, it would have expressly stated this. To the contrary, Chief Justice McLachlin confirmed the immediacy of the *Meiorin* test in *Grismer* when she wrote that "Employers and others governed by human rights legislation are ***now*** required in all cases to accommodate the characteristics of affected groups within their standards, rather than maintaining discriminatory standards supplemented by accommodation." [emphasis added] For that matter, in both *Meiorin* and in *Grismer*, the Supreme Court applied the newly formulated approach to events that had occurred many years before. While in *Meiorin* the first level arbitrator had found that the aerobic standard constituted adverse effect discrimination, and the Court of Appeal, did not characterize the discrimination as either direct or adverse effect, in *Grismer*, the Supreme Court expressly noted that neither the Member hearing the case at the first instance and finding that the driving standard constituted direct discrimination, nor the reviewing courts "had the benefit" of the new *Meiorin* test. (52) The Court unequivocally and without hesitation applied the new test to the facts of the case.

[121] Courts and adjudicators are following the direction of the Supreme Court. Subsequent to *Meiorin*, an example of its retroactive application arises in *Entrop v. Imperial Oil*. (53) The Ontario Court of Appeal applied *Meiorin* to a fact situation arising well before *Meiorin* was pronounced, and in that case the complaint had already been adjudicated by the Ontario Board of Inquiry on the basis of the pre-*Meiorin* bifurcated discrimination analysis. While *Entrop* was

based on an analysis of a statute that expressly involved accommodation as part of the BFOR, contrary to the case here, it is still helpful in assessing the judicial trend on this issue. Lastly, this Tribunal has applied *Meiorin* to evaluate complaints arising from incidents occurring prior to the pronouncement of *Meiorin*.[(54)]

ii) Evidentiary Issues

[122] In assessing the evidence, I note that the CAF failed to produce a physician who had medically examined Mr. Irvine at the relevant times. The best evidence of Mr. Irvine's condition emanates from his non-military physicians who testified on his behalf and provided evidence about their direct knowledge of his medical history. Further, Dr. Leach, who was a member of the CAD Committee, did not examine Mr. Irvine. For that matter Dr. Leach did not review Mr. Irvine's medical file prior to providing his expert report to this tribunal, and did not have independent recollection of the CAD Committee review of Mr. Irvine's case when he sat as a member of the Committee. As well, there was a difference of opinion between CAF consultant physician Dr. Buckholtz and CAF Base Surgeon, Dr. Kafka. Dr. Bucholtz examined Mr. Irvine and Dr. Kafka did not. In all cases, I prefer the evidence of those physicians who examined Mr. Irvine over the evidence of others. I also find that the best evidence of the CAD deliberations comes from the filed exhibits of its decisions, as no minutes of its meeting were produced.

[123] Also, much evidence was led about Mr. Irvine's August 2000 heart attack. The CAF argues that this evidence confirms the CAD Committee prognosis in 1995, that Mr. Irvine was subject to a sudden life-threatening event. I have allowed the admission of such evidence in this case given that the Commission has not objected to its admission. However, I do not find that the evidence is extremely helpful. Placing excessive weight on such evidence is tantamount to allowing the CAF to substantiate the accuracy of its 1995/96 prognosis retroactively. The difficulty with this position is that the CAF is given the potential to make less than reliable assessments of the possibility of a future heart attack in the hope that time would prove the earlier prognosis correct. Further, the date of the hearing of the complaint might dictate the result. Lastly, it is not possible today to assess the factors that contributed to the recent heart attack. It is entirely possible, that in spite of Mr. Irvine's positive lifestyle changes, the emotional stress of job loss and pursuing this complaint could have cumulatively contributed to Mr. Irvine's stress levels and physiological changes which could have cumulatively led to the occurrence of another heart attack.

[124] Lastly, I find that the relevant policies were those that were in effect when the relevant decisions were made. Major Lussier testified that it was his practice to apply existing policies and this is a rational position.

iii) Universality of Service

[125] In this case neither the Commission nor Mr. Irvine have contested the CAF's right to require him to perform general military duties over and above his career specific duties of aviation technician. The only issue is whether or not the medical and fitness standards applied

were applied correctly, and if so, whether or not the CAF accommodated Mr. Irvine to the point of undue hardship.

iv) Identifying the Standards Leading to Mr. Irvine's Release

[126] Mr. Irvine's release was based on three dispositive medical assessments:

a) Dr. Kafka

[127] Dr. Kafka recommended a "G3" category for a:

> "small group of patients who post bypass surgery have no evidence of ischemia, have limited disease and have excellent control of their risk factors. W.O. Irvine will need to better control his diet and with the use of medication get his cholesterol down lower."

[128] This opinion was consistent with the Bridging Policies in effect at the time that provided that a "G4O3" will usually be approved for entirely asymptomatic members although a better category may be awarded depending upon the *clinical findings and the presence or absence of risk factors*.

b) CAD Committee

[129] The CAD Committee in accordance with the "1979 Policies" assessed him as unfit for two or more specific military environments and recommended a permanent medical category of:

> "*G4"*: physician services required; unfit field, sea, UN and isolated postings" and "*O3/*: fit PT [physical training], but may be limited in type, duration, frequency and intensity of the activity; no sudden or sustained heavy physical exercise"

[130] In downgrading Mr. Irvine's category, the CAD Committee identified:

[131] In Medical Statement the CAD Committee in September 1995, in accordance with the September 1995 policies, stated:

> "W.O. Irvine, an aviation tech., has a heart condition with a significant risk of a sudden life-threatening event."

c) Career Board:

[132] It assessed his permanent medical category as *G4O3*. The board found that Mr. Irvine:

> "...could not perform any lawful duty. It found that these employment limitations drastically restricted Mr. Irvine's capacity to perform the full spectrum of the general military duties and precluded him from performing them in any operational theatre. It found that the CAF has "BFORs" for WO Aviation

> Technicians to perform their duties in a tactical environment and at sea and to perform arduous tasks...."

v) *Meiorin* Analysis

a) Rational Connection

[133] The first step in the analysis of determining whether a standard constitutes a BFOR is to identify the underlying goal of the standards. The goal of all three medical standards and their underlying policies was to ensure that Mr. Irvine could safely and efficiently perform the tasks of his occupation and the general military duties. I find that the CAF has established this branch of the test.

b) Was the Standard Adopted in Good Faith?

[134] The second step is to determine whether the particular assessments were implemented in an honest and good faith belief that they were necessary for meeting the goal. I have no doubt that all three medical assessments were conducted in a good faith effort to ensure that Mr. Irvine was fit enough to perform the general occupational duties applicable to aviation technicians, and the general military duties.

[135] Further, the underlying policies were also developed in the good faith belief that the CAF ought to retain members with CAD.

[136] With respect to the Career Board the Commission has invited me to find that the CAF acted in bad faith by subjecting Mr. Irvine to a CAD Committee assessment and a subsequent Career Board even though the policies in effect at the time did not contemplate a Career Board hearing. I do not accept this argument. I agree that referring the CAD decision to a Career Board was not consistent with CAF policies. The policies did not contemplate a Career Board hearing at all once a CAD Committee ruled that a member was militarily unfit to serve. However, I find that allowing the Career Board to consider Mr. Irvine's file was, in fact, tantamount to "giving him another chance" outside of the scope of the existent policies. I find that this constitutes further evidence of good faith on the part of the CAF.

vi)Reasonable Necessity and Accommodation

[137] As prescribed in *Meiorin*, Mr. Irvine was to be tested against a realistic standard that reflected his unique capabilities and inherent dignity up to the point of undue hardship. The standard itself, including a medical standard, in this case, must provide for accommodation within its parameters.

a) **Policies**

1. Bridging Policies

[138] I find that the Bridging Policies providing that a "G4" would be usually approved for members who became asymptomatic detracted from a true individual assessment of Mr. Irvine's abilities. Even though the policy provided a broad based exception for a better category dependant upon the clinical findings and risk factors, this did not enshrine a minimally necessary category assessment process. The existence of the September 1995 guidelines focussing on individual assessment, testify to the fact that more accommodating policies could have been utilized by the CAF with careful consideration to additional medically credible factors that ought to form the basis of category assessment.

3. September 1995 Guidelines

[139] In this case the CAF proffered the September 1995 guidelines of individual assessment to show that these were more accommodating than the prior policies of sweepingly categorizing members suffering from coronary atherosclerosis as "G4"-"G-5" and "O4" - "O5". I find that the September 1995 guidelines, to the extent that they promulgated an individualized assessment of the member, are rational and reasonable and are consistent with the medical evidence adduced. Of significance to this case is that the September 1995 guidelines identified 7 factors for assessing members with coronary artery disease vis-à-vis the probability of recurrence of a significant cardiac event in the foreseeable future. These include factors not considered by Dr. Kafka, the CAD Committee and the Career Board. One very important identified factor was the use of testing, such as coronary angiography or treadmill testing (enhanced by performing exercise Mibi), used to identify the extent of the disease, and functional capacity of the member. Another factor was the employability-limiting side effects of any cardiac medications being taken. As well they placed significant emphasis on the presence of ischemia.

[140] However, I find that the CAF failed to justify the category assignment mechanics of these 1995 policies. While some portions of these policies appear reasonable on their face, the CAF led little evidence regarding why "G4" was rationally and minimally required to be assigned to members in specific cases rather than "G3". For example, why was it appropriate to assign "G3" to members who were fit to serve in certain postings for periods of up to 6 months and/or who were considered unfit for **one** such specific posting? Why was it appropriate to assign "G4" to other members who, because of medical limitations inherent to the medical condition itself, or because of the unacceptable risk to the health and/or safety of this person or to fellow workers imposed by the operational environment on the medical condition, considered unfit for **two or more** specific military environments (i.e. sea, field, operational taskings or isolated postings)? Why was it appropriate to assign a "G3" to a member who had a known requirement for scheduled medical service by a medical officer but no more frequently than every 6 months and, correspondingly, why was a "G4" assigned to a member who required scheduled medical intervention more frequently than every 6 months? Why were these time periods relevant and how did they constitute minimal requirements upon members with disabilities, and coronary artery disease? The CAF failed to explain these questions and failed to meet its onus.

b)Assessments

1. Dr. Kafka's Assessment

[141] In insisting on a "G4O3" for Mr. Irvine, I find that Dr. Kafka, adhered to the bridging policy rather than using a larger individualized approach. Dr. Kafka over-ruled the views of other physicians that Mr. Irvine was fit to receive a "G3O3" and identified his professional standard for such a category. The CAF failed to provide sufficient evidence to show that Dr. Kafka's standard evaluated and gave due weight to the other factors listed in the September 1995 policies, such as, testing to determine Mr. Irvine's functional capacity, the frequency and level of medical care needed to appropriately manage Mr. Irvine's disease; and the employability-limiting side effects of any cardiac medications being taken. It failed to consider Mr. Irvine's physical, occupational and emotional strengths vis-à-vis his ability to serve in the CAF. The standard failed to provide for accommodation.

[142] I also find that Dr. Kafka's recommendation that Mr. Irvine undergo a subsequent coronary angiography in another year was inappropriate. Dr. Kafka wished to use the angiography, an invasive and potentially life-threatening procedure, for the purposes of data collection on heart attack survivors who had controlled their risk factors. It was not related to Mr. Irvine's individual medical needs.

2. CAD Committee and Career Board Assessments

[143] The CAF did not lead sufficient evidence of a subsequent individualized assessment conducted by either the CAD Committee or the Career Board of the likelihood of Mr. Irvine having another event with due consideration to each of the 7 factors.

[144] The Committee stated that Mr. Irvine "has a heart condition with a significant risk of a sudden life-threatening event"; yet, the CAF proffered no analysis made at the time as to the level of risk of another event based on Mr. Irvine's particular conditions over the next 7 years - being to the date of his retirement. The evidence was uncontroverted that physicians cannot predict the rate of progression of CAD. It is non-linear and varies from individual to individual. While Drs. Fisher, Leach and Black agree today that there may be a 30% risk of another event within 10 years, this risk varies from patient to patient, and can be reduced significantly with the lowering of cholesterol. Cholesterol can be significantly reduced through the use of medication. The CAF argues that medication would reduce risk by 10% to approximately 20% morbidity rate, and that this rate still constitutes a significant risk. While this may be the case, there is little evidence that the CAF, at the relevant time, conducted such an analysis. As the Commission points out, all members who had had a heart attack were at such risk; yet, the CAF retained some of these members. The onus was on the CAF to show why Mr. Irvine was not retained while other heart attack survivors were retained. Further, in my view, reliance upon such statistics does not relieve the CAF of its obligation to consider and weigh all other available data that would affect the reliability of a prognosis of morbidity and mortality.

[145] In particular, there were two powerful prognostic indicators of the likelihood of another event. One of these was the ejection fraction. Surprisingly, in releasing Mr. Irvine on the basis of a significant risk of a sudden life-threatening event, neither the CAD Committee nor the Career Board solicited, and thus considered, Mr. Irvine's ejection fraction. In fact, Mr. Irvine's ejection fraction was 49% in April 1994 obtained after a medically necessary angiography. This ejection fraction was easily obtainable from his medical records. This figure indicated good ventricular

function, and when combined with the factor of two vessel disease would have led to a prognosis of risk of mortality at 10% over the next three years.

[146] Further, the ejection fraction could have been combined with data from treadmill test results and/or an exercise Mibi with isotope injection, to further diagnose mortality and morbidity. The ejection fraction could have been easily and safely obtained in this way. Omitting to obtain the ejection fraction, foreclosed the CAF's opportunity to make these evaluations. For that matter, Dr. Kafka had expressly contemplated that Mr. Irvine was to given an exercise Mibi. Mr. Irvine was not given this test.

[147] The second important predictor of the likelihood of another event was the "Extent of coronary disease". While the CAD Committee and the Career Board had before them evidence of moderate coronary heart disease, the CAF did not produce an objective assessment of the extent of this disease made by either of these bodies at the time. The CAF argues that Mr. Irvine had double-vessel disease, as opposed to single-vessel disease. However, this is not the only indicator of extent of coronary disease. Other indicators of disease expressly included evidence of ischemia as per the September 1995 Guidelines themselves, and the existence of graft disease. Mr. Irvine had neither ischemia nor graft disease.[(55)] A subjective assessment without due analysis of all of the scientifically relevant factors was unreliable. I find that there was excessive reliance upon the singular "mind set" of "risk factors" as per the bridging policies. This is contrary to the very purpose for which an individual assessment is to be performed; i.e. the purpose of an individual assessment is to be more sensitive to the abilities and attributes of a particular individual, than a proffered general standard applicable to everyone in a group can be.

[148] For that matter, the CAF did not lead sufficient evidence that either body made a careful and individual assessment of risk factors. The CAF did not show that the CAD Committee did not simply make a blanket impressionistic ruling that Mr. Irvine "still has high risk factors" and "a heart condition with a significant risk of a sudden life-threatening event". Mr. Irvine certainly possessed certain risk factors, such as being a heart attack survivor, family history of CAD, male gender, age, and high cholesterol levels. Of these, high cholesterol levels could have been effectively controlled by drug therapy. The CAF argues that risk factors remained high some 15 months post heart attack and therefore the CAF provided Mr. Irvine with ample time to bring his risk factors under control. It argues, "time is muscle". It argues that the CAF could not reasonably have waited any longer to have the CAD Committee assess Mr. Irvine. I do not agree that the time factor can be assessed without considering the significant effect that medications had in reducing the risk factor of high cholesterol, generally for all patients, and in particular for Mr. Irvine. Mr. Irvine's excellent and expeditious response to Zocor, post-release, demonstrates that both the CAD Committee and the Career Board were premature in permanently assigning Mr. Irvine a lower category. In my view, the CAF had a duty to wait as long as reasonably possible for Mr. Irvine to stabilize and to use all reasonably available and scientifically acceptable medications and treatments to control disabilities prior to awarding him a permanent category leading to his termination. The CAF argues that Mr. Irvine was to blame for stopping the Lipidil and thus not giving the medication a fair trial. I do not find this argument persuasive as irrespective of whether Mr. Irvine stopped or did not stop the Lipidil, the CAF physicians had prescribed the Lipidil in November 1994. The CAF physicians waited until March 1996 to prescribe him with another cholesterol lowering drug. This 15-month period of time to

experiment with a new drug is in stark contrast to the 6-8 week period that Dr. Gregson waited for changes in cholesterol levels before altering medication. Initially, in November 1996, Dr. Gregson doubled the dosage of Lescol and when this did not bring desired results he immediately prescribed a different medication. While this case is not about assigning blame to either party, I do believe that the CAF's 15 month trial period with Lipidil, entails that it should have waited for a greater time to experiment with Lescol, and should have tried all reasonably relevant medication in the event of the lack of efficacy of a particular drug, prior to releasing Mr. Irvine.

3. Proportionate and Measured Expectations of Those with Disabilities

[149] The CAF has failed to establish that the individual testing performed in this case did not have a discriminatory effect on Mr. Irvine, and that the particular individual testing was sensitive to the needs of preventing discrimination on the basis of disability. There are difficulties with the CAF's administration of its individual assessment on a number of fronts. First, it appears that the individual testing was applied more vigorously to exclude Mr. Irvine from service when he was disabled, than the EXPRES testing was applied to him when he was able bodied. Given that the EXPRES testing, then and today, has a low threshold of physical performance for those who are not disabled, only a proportionate and measured medical or other standard may be applied to exclude members from service once they become disabled. When able bodied, Mr. Irvine was only required to score at the 20th to 25th percentile of the average Canadian to demonstrate his physical fitness and ensure retention. Post heart-attack the standard appears significantly more exigent. It is discriminatory to assess healthy members with a lenient yardstick, yet to assess disabled members with an onerous yardstick. At a minimum, the bar can only be moved ahead in step with that applicable to healthy members.

[150] Second, today if a member passes the EXPRES test he meets U/S principles. In Mr. Irvine's case, he was administered the EXPRES test throughout his service with the CAF up until the date of his heart attack. Thereafter he was not administered further EXPRES tests. There was no clear evidence as to why he was excused from the same. The CAF did not argue this point. While it may well be that the CAF was concerned about preventing further injury to Mr. Irvine, Mr. Irvine had safely performed other treadmill tests, a component of the EXPRES test, post-heart attack with good results. He could have performed the EXPRES test under medical supervision wearing a heart rate monitor. Yet, the CAF failed to provide Mr. Irvine with any further opportunity to take another EXPRES test thus preventing him from meeting the standards imposed upon the general CAF population. The CAF had an obligation to allow Mr. Irvine to take the EXPRES test prior to release. The best evidence before this tribunal indicates that he may very well have been successful in meeting this standard: he performed other physical fitness tests after his heart attack with surprising success including the Bruce Protocol treadmill test. Mr. Irvine's success on such an EXPRES test and exercise Mibi, with isotope injection, would have provided the CAF with further evidence of his fitness and his mortality and morbidity. It would have been another important factor in determining safety risks.

[151] Lastly, all members should have the opportunity prior to termination, of demonstrating their ability to serve in the CAF by performing the actual military tasks required of them. In this

case, Mr. Irvine was not afforded the opportunity of demonstrating his ability to perform the general military duties or the military duties specific to his military occupation.

4. Subjective Nature of Assignment of Limitations and Category

[152] Aside from the difficulties I have found with the medical assessments, I also find that the process of assigning employment limitations and categories based on Mr. Irvine's assessed medical condition was too imprecise to justify Mr. Irvine's release from the CAF. The CAF acknowledges that describing limitations and assigning medical category is an "inexact"[(56)]6 and subjective process itself. I find that the CAF failed to adduce sufficient evidence to justify the employment limitations imposed on Mr. Irvine of "*G4"*: physician services required; unfit field, sea, UN and isolated postings" as opposed to a "*G3"* which was assigned to members who were fit to serve in such postings for periods of up to 6 months and/or were considered unfit for one such posting only.

[153] Again the concerns about the mechanics of category assignment under the September 1995 policies are equally applicable to the decisions made thereunder.

5. Imposition of Medical Conditions

[154] In addition, I find that if a medical assessment is made conditional on a particular action by a member, as it was in this case by Dr. Kafka (i.e. that Mr. Irvine would have to better control his diet and lower his cholesterol through medication) then such condition must also constitute a minimal limitation. Undoubtedly, the condition must be transparent to the member, and consistently applied to all members with due accommodation to the circumstances of an individual case. Given the imbalance in the knowledge and resources between the CAF and its medical officers vis-à-vis Mr. Irvine, the medical officers had a duty to share with Mr. Irvine at the time the most current scientific and research evidence available with respect to his medical condition. In this hearing, the CAF produced extensive research, studies, exhibits and explanations about cardiology, cardiac disease, prevention and risk factors. Dr. Fisher must be commended for her thorough treatment of the subject material. In my view, this is the type and quality of medical information that must be shared with members at the first instance, i.e. when a decision to terminate them or to impose employment limitations potentially leading to employment release could first be reasonably contemplated.

6. Accommodation of Unfit Members

[155] Finally, even if the CAF had established that Mr. Irvine was not fit enough to meet the employability and deployability criteria of the CAF, I find that the CAF failed to produce sufficient evidence of accommodating Mr. Irvine to the point of undue hardship. As *Meiorin* professes, innovative but practical means of accommodation must be considered.

7. Accommodation of Members with 80% Employabilty

[156] Mr. Irvine was found to be employable in 86% of the positions established for his military occupational category. Under a prior 1985 policy, in effect to the 1990s, the CAF accommodated

members who did not meet the medical category for their occupation but who were otherwise employable in 80% of the relevant established positions. They could be retained without career limitations. The onus was upon the CAF to explain why it could accommodate members under this former policy, but not thereafter. The CAF did not provide sufficient explanation for the same.

8. The 1994 Retention Guidelines

[157] The Board applied the 1994 Retention Guidelines and found that Mr. Irvine could not be accommodated under the same. I find that these policies did not provide accommodation of members to the point of undue hardship. The December 1999 Review and the 2000 U/S policies contemplate greater accommodation than contemplated by these 1994 guidelines to meet the *Meiorin* criteria. The 1994 Retention Guidelines are of limited flexibility and provide limited accommodation. This becomes evident when they are compared to the November 2000 Polices professing reasonable accommodation by the CAF. Members are now to be retained as long as they can be fully employed in a position established for their rank and military occupation. Mr. Irvine fell into such a category. His commanding officers confirmed that he could fulfil the general and specific tasks of an aviation technician for his rank. Under the November 2000 policies, even members who cannot deploy to high-risk theatres of operation will be retained or re-assigned to another position established for his military occupation for which he can fulfil all normal duties. Also, members may be employed in positions where they are not directly exposed to any of the tasks or working conditions contemplated by U/S principles. An individual review from an accommodation perspective as required under these 2000 policies was not available to Mr. Irvine.

9. Costs of Accommodation - Physician Services in Isolated Postings

[158] I find that the CAF has not justified its decision on the basis of excessive costs. The CAF has alluded indirectly to the cost of providing physician services for Mr. Irvine in foreign posts. It argued that his squadron was deployable to Central America, Somalia and Bosnia where physician services were not readily available. It argued that Mr. Irvine was not "good to go", meaning deployable, without notice or on short notice, to such environments. Such an argument required the CAF to deal unequivocally with the possibility as to whether Mr. Irvine in the circumstances of his case would reasonably have been expected to be posted to a foreign unit. On this point, Mr. Irvine's Colonel and Commanding officer emphasized that he had only 7 years to retirement, and that he was likely to remain in the Halifax Master Warrant Officer position until then. In this capacity, it was highly unlikely that he would be required to serve in field, sea, UN or isolated postings. They strongly recommended his continued employment as Master Warrant Officer without career limitations. This is consistent with the fact that Mr. Irvine serviced Aurora aircraft, which were sent to patrol in the Adriatic Sea, and were deployed to a NATO base in Sigonella, Italy. He was "good to go" to this major military base in a Western country. The CAF had a duty to make a due assessment of the likelihood of particular foreign postings for Mr. Irvine, particularly in light of the interchangeability of the workforce, prior to using this criteria in his release decision.

[159] As well, the evidence led by the CAF about the need for physician services in these foreign posts was of an anecdotal and impressionistic nature. There was a lack of cogent evidence of the costs of accommodating Mr. Irvine with physician services in a particular foreign post. Dr. Leach's current opinion that a coronary healthy lifestyle is even more difficult to follow in an isolated and stressful military mission was not supported by a concrete assessment at the time of Mr. Irvine's particular posting possibilities.

[160] Lastly, I accept that in 1994/1995 the CAF was in the midst of large budgetary restraint. However, the evidence was generalized and anecdotal largely relating to a "shrinking military" with no further cogent evidence and clear analysis of the actual costs of accommodating Mr. Irvine in particular, and how such costs constituted undue hardship to the CAF.

10. Retention in a Non-Deployable Position

[161] *Meiorin* requires that the CAF retain members with a disability for such period of time that does not cause it undue hardship. The December 1994 Guidelines for Retention of Members with Employment Limitations with its minimal accommodation provisions did not meet this standard. In Mr. Irvine's case, he could certainly have continued to serve in Halifax where medical services were available. He was even capable of deployment to Signonella, Italy; the CAF did not lead evidence that medical services were not available there.

[162] Further the CAF itself recognized in the December 1999 review that it had some empirical capacity to accommodate members in Military Non-Essential positions. [(57)] In my view, the duty of accommodation requires an assessment of the ability of the CAF to retain members in such positions prior to termination. No such assessment was made in Mr. Irvine's case. [(58)]

[163] Put in another way, in Mr. Irvine's case, his supervisory responsibility and likelihood of involvement in specific military duties as MWO ought to have been individually and carefully considered. With respect to the Career Board finding that he could not perform any lawful duty and did not have the capacity to perform the full spectrum of the general military duties in any operational theatre, the CAF in its 1999 policy acknowledged the argument that minimum physical capability standards ought to be tailored to rank or according to the probability of involvement in General Military Duties or physically demanding activities. Unfortunately the CAF rejected this argument citing the goal of maintaining credibility with the Human Rights Commission as its reason. Thus the CAF implicitly recognized that it had the ability to accommodate Mr. Irvine in this way.

V. CONCLUSION

[164] For all of the reasons cited I find that the CAF adversely differentiated against Mr. Irvine during Mr. Irvine's employ, on the basis of his disability, in many of its identified policies governing Mr. Irvine as a member with coronary artery disease, and in its medical assessments of his condition and its assignments of employment limitations to him. The CAF failed to

establish a BFOR as mandated by *Grismer* and *Meiorin* establishing accommodation to the point of undue hardship in its policies and decisions subjecting Mr. Irvine to differential treatment and standards once disabled. It failed to establish a BFOR for its decision to terminate him based on his disability.

VI. REMEDIES

[165] I decline to address the issue of damages at the request of the parties but retain jurisdiction to hear evidence on the same if the parties cannot reach consensus. I do find that it was reasonable for Mr. Irvine to move to Halifax in expectation that once his medical category was finalized he would receive appropriate back pay to compensate him for the MWO duties he performed. But for the release decision of the Career Board, Mr. Irvine was expected to serve with the CAF until his retirement in the year 2003 at the minimum rank of Master Warrant Officer. But for the release decision Mr. Irvine would not have opted for and finalized an early retirement option (FRP). Barring other contingencies, Mr. Irvine would have retained his title, rank, position and benefits with the CAF, as well as any available possibilities for further promotion.

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Shirish P. Chotalia

Edmonton, Alberta

November 23, 2001

CANADIAN HUMAN RIGHTS TRIBUNAL

COUNSEL OF RECORD

TRIBUNAL FILE NO.: T584/4200

STYLE OF CAUSE: Raymond Irvine v. Canadian Armed Forces

PLACE OF HEARING: Edmonton, Alberta: April 2, 3, 4, 5, 6, 2001;

Ottawa, Ontario: April 9, 10, 11, 12, 2001;

May 15, 16, 17, 18, 2001;

Edmonton, Alberta: June 4, 5, 6, 8, 14, 15, 2001

DECISION OF THE TRIBUNAL DATED: November 23, 2001

APPEARANCES:

Raymond Irvine On his own behalf

Patrick O'Rourke and Carla Qualtrough For the Canadian Human Rights Commission

Sanderson A. Graham For the Canadian Armed Forces

1. Exhibit R-35, Tab 14, February 13, 1976, CAF Administration Order - Career Medical Review Board (CFAO 34-26).

2. Exhibit R-35, Tab 4, A-MD-154-000/FP-000, Chapter 3, p. 3-1 to 3-4.

3. Exhibit R-37: CFMO-26-01 - Ch 45 - 1988-04-08.

4. Exhibit R-35: Medical Standards for the Canadian Armed Forces A-MD-154-000/FP-000, Department of National Defence, September 1995.

5. These were delineated in the "Generic Task Statement - All CF Members" being Exhibit R-35, Appendix 1, Annex D to Medical Standards For Canadian Forces, September 15, 1995.

6. Although these 17 requirements were revised in June 1997 they continued to remain the de facto specifications of U/S until 1999.

7. Other definitions were: the ability to perform basic military duties anywhere in the world; the requirement that members must, at all times, and under any circumstances, perform their operational roles; joint requirements for members to perform duties outside their occupations, to perform these duties under any type of living/working conditions anywhere in the world, to be able to perform these duties without advance notice, and to be able to serve in locations where medical support may be limited or non-existent; the requirement to be sailors/soldiers/airmen first and be sufficiently fit and healthy to perform a basic core of military duties in a variety of geographical locations. See Exhibit HR-38: Review of the Universality of Service Principle and Its Application CAF Directorate of Policy Analysis & Development, December 1999, National Defence Headquarters, Ottawa, Canada, p. 10-11.

8. "The court, moreover, further muddied the meaning of universality of service by inferring an obligation under this section for all members to engage in combat duties, but there is nothing in the section [s. 33 *National Defence Act* R.S.C. 1985, C. N-5], which, either directly or indirectly, makes reference to combat." *Ibid*, p. 12, para 20.

9. Exhibit HR-38: Review of the Universality of Service Principle and Its Application CAF Directorate of Policy Analysis & Development, December 1999, National Defence Headquarters, Ottawa, Canada, p. 16.

10. *Ibid*, December 1999, Page 17

11. *Ibid*, p. 25.

12. *Ibid*, p. 25.

13. *Exhibit R-34, Tab 3, December 1994 Guidelines For Retention of Members with Employment Limitations*

14. December 1999 policy, p. 3

15. Exhibit R-35: Memorandum CRB(M) Percentage Employment Calculation, January 15, 1996.

16. *Ibid*, p. 6.

17. *Ibid*, p. 38.

18. Exhibit R-35, Tab 11 Memorandum re: Changes to Universality of Service Policy Application (November 2000)

19. *Ibid*, p. 2/4.

20. Or every two years for members over 40 years of age.

21. *Ibid*, p. ii.

22. December 1999 Policy: U/S, p. ii

23. *Ibid*, p. 34.

24. Exhibit R-2, Tab 18, Harrisons Principles of Internal Medicine , 1994, vol 1, p. 1079-1080.

25. MET represents the metabolic equivalent for measuring oxygen uptake per kilogram body weight per minute. The clinically significant key metabolic equivalents for maximum exercise are as follows: 1 MET resting; 2 METs level walking at 2mph, 10 METs prognosis with medical therapy as good as coronary artery bypass surgery (cut-off point); 13 METs excellent prognosis

regardless of other exercise responses; 29 METs world class athletes: Exhibit R-2, Tab 12. AHA Medical /Scientific Statement, p. 580-581.

26. Master Warrant Officer position in the cell/unit in which he was employed in Halifax.

27. For discussion of ejection fraction see below.

28. Exhibit R-31, "Cholesterol Agonistics", J. LaRosa 1996 American College of Physicians (from Annals of Internal Medicine March 1, 1996) at p. 519

29. R-2, Tab 2 "Optimal Risk Factor Management in the Patient After Coronary Re-vascularization" Pearson, T. et. al., p. 3127.

30. *Ibid*, p. 10: CASS Data show that if the individual achieved only Stage 1 or less of the Bruce Protocol treadmill test and had ST segment depression of more than 1 mm, 5-year survival was 72%, but this would rise to 95% if stage 3 or greater was reached with less than 1 mm of ST segment depression.

31. Exhibit R-2, Tab 11, p. 10 Hammermeiser prognosis diagram.

32. ST segment depression represents a depression between certain "S" and "T" waves of the ECG or electrical impulse record of a patient's heart indicating abnormality.

33. Exhibit R-2, Tab 18, Harrisons Principles of Internal Medicine , 1994, vol 1, p. 1110 outlines the risk factors.

34. *Ibid*, There was no absolute quantitative definition. p. 1110.

35. Exhibit R-2, Tab 3.8 "Regular Physical Exercise and Low-Fat Diet Effects on Progression of Coronary Artery Disease" G. Schuler et. al. p. 1.

36. Occlusion rates were 5-15% per distal anastomosis at 1 month after surgery; 15-25% at 12 months; after 10 years 50% will become occluded: Exhibit R-2, Tab 2 "Optimal Risk Factor Management in Patient After Coronary Re-vascularization"

37. *Robinson* [1994] 3 F.C. 228 (F.C.A.) *Husband* [1994] 3 F.C. 1888 (F.C.A.) *St. Thomas* (1993) 162 N.R. 228 (F.C.A.)

38. C.J. Isaac, p. 233 *St. Thomas*

39. [1999] 3 S.C.R. 3

40. [1999] 3 S.C.R. 868

41. *Meiorin* adopts the decision in *Central Okanagan School District v. Renaud*, [1992] 2 S.C.R. 984.

42. *Grismer, supra,* at para 32.

43. *Grismer, supra,* at para 42.

44. *Grismer, supra,* at para 41.

45. *Grismer, supra,* at paras 41 and 42.

46. *Meiorin, supra,* at para 63. See also Chambly v. Bergevin [1994] 2 S.C.R. 525 at p. 546.

47. Cie minière *Québec Cartier v. Quebec (Grievances Arbitrator),* [1995] 2 S.C.R. 1095 Once an arbitrator concludes that a decision by the Company to dismiss an employee was justified at the time that it was made, he cannot then annul the dismissal on the sole ground that subsequent events render such an annulment, in the opinion of the arbitrator, fair and equitable. In these circumstances, an arbitrator would be exceeding his jurisdiction if he relied on subsequent-event evidence as grounds for annulling the dismissal.

48. *Farber v. Royal Trust Co.* [1997] 1 S.C.R. 846: the Court held that the trial judge erred in admitting *ex post facto* evidence when its relevance to the case had not been established, and found that moreover, its admission prejudiced the appellant since, in the Court's view it distorted the trial judge's analysis.

49. *Conte v. Rogers Cablesystems Ltd.* (1999) 36 C.H.R.R. D/403 (CHRT)

50. *Toronto (City) Board of Education v. O.S.S.T.F., District 15* [1997] 1 S.C.R. 487.

51. See *Gallant v. Labrador City-Schefferville (diocese of)* (2001) 200 D.L.R. (4th) 643 (Nfld. C.A).

52. *Meiorin,* p. 878.

53. 50 O.R. (3d) 18 (Ont. C.A.)

54. See *Oster v. International Longshoreman's and Warehouseman's Union (Marine Section), Local 400* T.D. 4/00 (CHRT) and *Vlug v. Canadian Broadcasting Corporation* T.D. 6/00 (CHRT).

55. In 1994, it was understood that coronary artery bypass grafting did not appear to reduce the incidence of future heart attacks in patients with chronic ischemic heart disease.

56. September 1995 CAF Medical Standards

57. December 1999 policy, pp. 38-39.

58. *Ibid,* December 1999