T.D. 9/93
Decision rendered on June 7, 1993

CANADIAN HUMAN RIGHTS ACT
R.S.C., 1985, c. H-6 (as amended)
HUMAN RIGHTS TRIBUNAL
BETWEEN
SIMON THWAITES
Complainant
- and -
CANADIAN HUMAN RIGHTS COMMISSION
Commission
-and-
CANADIAN ARMED FORCES
Respondent
DECISION
TRIBUNAL: Sidney Lederman, Q.C. - Chairman
Gillian D. Butler - Member
Roger Bilodeau - Member

APPEARANCES: Peter C. Engelmann
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DATES AND June 17, 18 and 19, 1992
PLACE OF July 28, 29, 30 and 31, 1992
HEARING: August 24, 25, 26 and 27, 1992
September 23, 24 and 25, 1992
October 14, 15 and 16, 1992
November 10, 11, 12 and 13, 1992
Halifax, Nova Scotia

This case deals with two competing interests: the legitimate concern by the Canadian Armed Forces for the health of their members infected with human immunodeficiency virus (HIV) on the one hand, and on the other, the right of such individuals to be gainfully employed in positions which they can perform to satisfactory standards but which, because of their nature, subject their safety or health to increased risks.

I . BACKGROUND FACTS

The Complainant, Simon Thwaites, ("Thwaites") enlisted with the Respondent, Canadian Armed Forces ("CAF") on the 19th day of June 1980 and from that time until his discharge from the CAF on the 23rd day of October, 1989 he progressed from the rank of Private to Master Corporal (Acting/Lacking). Thwaites was, at all times material to the complaint in the trade of a Naval Electronics Sensor Operator ("NESOP") previously known as an electronic warfare operator which is described in the evidence of the CAF's witnesses as a "hard sea trade". Thwaites was stationed at Canadian Forces Base Halifax from the 1st day of May, 1987 until his medical discharge.

Although Thwaites' career progression was uneventful and (from his own evidence) he was always promoted on time, one fact deserves special attention. On June 18, 1983, Thwaites requested remuster or transfer to another trade namely, medical assistant. He commenced training in Borden in February, 1984 on which date his geographical and occupational limitations were recorded as G2 02 meaning fit, full duties.

Unfortunately, for Thwaites, a change in his occupational limitations resulted from problems he experienced with his right arm while on course and he was removed before he was able to complete his last examination. Thwaites returned to his ship and reported to the base hospital with hopes of completing his last examination there but instead was advised that this was not possible and indeed, it would be another year and one-half before he was eligible to complete the course.

On July 9, 1985, Thwaites applied to be released from the CAF. In his testimony before the Tribunal he cited his frustration at not having successfully remustered as the motivation for seeking release. However, by December 30, 1985, he had a change of mind and he withdrew his release in sufficient time to prevent its becoming effective.

Within the next month, Thwaites received a letter from the Canadian Red Cross which indicated that a patient in a hospital had had a reaction to some blood that was transfused and that Thwaites' donation was among many transfusions given to the patient. As a result, Thwaites reported to the base hospital on the advice of his superiors and ultimately to the Canadian Red Cross where blood was taken. By letter dated March 26, 1986, addressed to Dr. MacCullam of the Canadian Forces Hospital at Halifax, the contents of which were communicated to Thwaites by Dr. MacCullam (albeit without providing Thwaites with a copy), Thwaites learned that he was HIV positive. A confirmatory test was conducted upon blood drawn at Canadian Forces Base Halifax and the results became known to Thwaites between April 17 and May 9, 1986. Thereafter, the military doctors referred Thwaites to an infectious disease specialist, Dr. Walter Schlech at the Victoria General Hospital in Halifax.

By April 10, 1986, Thwaites' commanding officer was aware of Thwaites' HIV positive status but notwithstanding this knowledge, the CAF made a re-engagement offer to Thwaites and subsequently promoted him to the rank of Acting/Lacking Leading Seaman. Thwaites' alleged physical disability therefore posed no impediment to his career thus far.

Thwaites' career with the CAF took a different turn shortly thereafter. Unknown to Thwaites at the time, he had been cited by another CAF member as a homosexual and he was under

investigation by the military police during the period July 2 - August 22, 1986. By October 13, 1986, Thwaites' Commanding Officer had completed a Change of Circumstances Report having the effect of downgrading Thwaites' security clearance on the basis of sexual deviation and Thwaites was removed from a course which he was attending at Osborne Head to requalify for the NESOP trade. Upon reporting to Canadian Forces Base Halifax, he was advised that he was assigned to land but Thwaites testified that he was unable to obtain satisfactory answers to his enquiries respecting the reasons for this change. He assumed that it was his HIV positive condition. On November 7, 1986, Thwaites was advised that his security clearance had been downgraded to 'restricted' and very shortly thereafter, he was assigned (or 'misemployed') to the position of doorman at the petty officer's quarters.

Thwaites described his feelings about this time as confused and stressed-out by the treatment he had received and the lack of information. Thwaites attempted (without success) to get placed back on his ship and by January 7, 1987, he learned that he was being recommended for release on the basis of homosexuality.

The Tribunal concludes that the recommendation for release on the basis of homosexuality stemmed from the military police investigation which in turn led to a report to Thwaites' commanding officer. From there, a further report dated January 7, 1987 was made by Commanding Officer Power to the Base Commander at Canadian Forces Base Halifax. This report requested that Thwaites be directed to attend his medical referral and a strong recommendation for release be forwarded to National Defence Headquarters.

Between March 6 and June 2, 1987, the Commanding Officer's request had received the support of the Base Commander and Lieutenant Commander Taylor at Maritime Command Headquarters of National Defence. Consistent with an Administrative Order in effect at the time, Thwaites was to be offered two choices namely, be frozen in rank and position or resign. However, for reasons that will be discussed herein, nothing further was done in relation to the recommendation for release until one year later.

By agreement between Thwaites and Dr. John Smith (the base doctor) Dr. Walter Schlech was to send reports concerning Thwaites' condition to Dr. Smith at his private clinic in Porter's Lake instead of the Base Hospital. This arrangement was made in an attempt to ensure confidentiality.

Reports from Dr. Schlech (and latterly Dr. Lynn Johnston) of the Infectious Diseases Clinic of the Victoria General Hospital were forwarded on a fairly regular basis during the period May 14, 1986 to and including July 11, 1989 after which date the evidence shows that reports were directed instead to Thwaites' family doctor, Dr. Bruce Elliott. Of particular interest to the subject matter of this complaint are letters dated October 22, November 12 and November 26, 1987.

On October 22, 1987, Dr. Lynn Johnston reported that she had discussed with Thwaites the possibility of beginning AZT therapy which she described to Dr. Smith as an anti-viral agent presently being used on an experimental basis in HIV positive patients.

On November 12, 1987, Dr. Schlech reported to Dr. Smith that: the Complainant had been developing some constitutional symptoms including night sweats; his blood tests showed

leukopenia; and his total T-cell count was 220. In this set of circumstances, Dr. Schlech advised Dr. Smith that Thwaites qualified for the AZT trial. This letter also contains the following reference which was the subject of a great deal of evidence before the Tribunal;

"I have suggested to him that he enroll and given the protocol to study. He asked me specifically to make you aware of this as he was concerned the side-effects of therapy would disqualify him for his military benefits as this was a 'volunteer' program. I do not think this is the case but decided to check with you. AZT is the current 'gold standard' of treatment for individuals slipping into the CDC group 4 category".

At least three copies of this correspondence appear in the exhibits filed before the Tribunal. On one only, however, the following notation appears handwritten at the bottom right-hand corner of the document:

"NTF I have discussed this with Dr. Schlech and approved Cpl. Thwaites treatment with whatever is appropriate. This was also passed on to Thwaites by Col. McLean, C. Surg. J.D. Smith' (Exhibit HRC 1, p. 148)

The discussions referred to in this handwritten note to file are confirmed to some degree by Thwaites' own diary of events being Exhibit HRC 8. By entry dated November 20, 1987, he indicated that he had spoken to Col. McLean, Command Surgeon who advised 'no problem, no question; it's my decision; nothing to disagree with for Schlech; he would back up my decision fully; I should treat my decision without feeling any military pressure.'

On November 26, 1987, Thwaites attended at the Infectious Diseases Clinic for further discussion of the AZT Protocol and agreed to enroll. As a result, the November 26, 1987 letter directed to Dr. J. Smith and referred to above contains the following reference:

"...We will enroll him as a group 4a patient. He remains relatively asymptomatic but has been bothered by night sweats, and has an absolute T4 count of 230 with 300 being the cut off for enrollment."

On January 14, 1988, Thwaites started AZT treatment under the supervision of Dr. Schlech.

Within the next two months, Thwaites was requested to attend for a two-stage full medical with the Base Surgeon, Major Sutherland. This was conducted on March 14, 1988 with the explanation to Thwaites that it was for a Career Medical Review Board (CMRB) which would probably result in a medical release from the CAF. Once again Thwaites' diary for the relevant date records the following:

"the reason for a medical release was based around the fact as an aids anti-body positive individual that I need the drug AZT to maintain my health. The AZT is an experimental drug and cannot be issued to just anybody -- in fact it is only available in major Canadian cities that have an infectious disease clinic. Therefore, I could not be posted from or leave a major Canadian city. Thus the CMRB decision to alter my medical category to G-5 unfit any posting. It possibly could be down-graded to G-3 but that still makes me unfit my present trade."

Major Sutherland completed a Notification of Change of Medical Category on March 14, 1988 recommending a downgrading in the Complainant's medical category from a G-2 to a G-5 on the basis that he required specialist services and treatment. This was recorded on Part 2 of a form referred to throughout the evidence as a "2088". From his office the 2088 was directed to the office of the Command Surgeon who, on March 21, 1988 noted "G-5 - requires specialist medical services. Unfit isolation, sea, field duties. For CMRB decision."

The 2088 was then forwarded to the offices of the Surgeon General in Ottawa where the following notation was made in part 4 on March 29, 1988 "G-5 - requires specialist services readily available - unfit duty outside Canada or U.S.".

On May 31, 1988, Thwaites was requested to sign and did in fact sign the 2088 in Part 5 acknowledging his change in medical category and on June 7, 1988 the unit base commander completed the final portion of the 2088 form stating as follows:

"in accordance with CFAO 34-30 Annex B, MS Thwaites' newly assigned category render him unfit for continued service in his present or any other occupation in the Canadian Forces. His release is therefore recommended."

From there, Thwaites' case was referred to a CMRB as indicated on the 2088 form. On August 4, 1988 the CMRB met in National Defence Headquarters at Ottawa and the board, (comprised of one member from each of the Navy, Army and Air Force together with a member of the Career Management Directorate and a consulting Canadian Forces doctor) determined that there was no option other than to release Thwaites on medical grounds, being disabled and unfit to perform his duties in his present trade or employment and not otherwise advantageously employable under existing service policy. The board determined that Thwaites would commence terminal leave on July 5, 1989.

Thwaites was advised of the CMRB decision on November 10, 1988 and (presumably because of his severance pay entitlements) his release became effective on October 23, 1989. In the meantime, Thwaites had filed a Grievance in relation to the CMRB decision and on October 31, 1989 he filed a complaint with the Canadian Human Rights Commission at Dartmouth, Nova Scotia. On the basis of the facts known to Thwaites as of October 31, 1989, his complaint alleged discrimination on the basis of his disability (HIV positive status) contrary to Section 7 of the Canadian Human Rights Act.

II. THE INVESTIGATIONS

As the facts recited in Part I herein indicates, Thwaites was under review or investigation by more than one arm of the CAF during the period July 2, 1986 - October 1989. In fact, it finally became clear to the Tribunal after some 20 days of evidence that there were three processes at work at various times.

(a) Career Medical Review Board

The CMRB process was initiated by the Base Doctor, Dr. Sutherland, as a result of information contained in the letters from Drs. Schlech and Johnston which caused him to conclude that Thwaites was unfit for duty at sea as a result of his need for specialist services. On various dates between March 14, 1988 and August 4, 1988, this recommendation was sanctioned by others within the CAF and the Tribunal concludes that this information was released to the military police who were investigating Thwaites on the separate issue of homosexuality.

(b) The Security Intelligence Unit

Once Thwaites had been cited as a homosexual, and an investigation was carried out by the military police, he was on track for a Security Clearance Review Board. However, because of the CAF's interim policy on homosexuals and because of the Security Intelligence Unit's knowledge that Thwaites was facing a CMRB, no review board was ever held and the Tribunal heard no direct evidence on the investigation.

(c) Special Career Review Board

The Security Intelligence Unit's report referred to above was provided to the Captain of the Fraser on which ship Thwaites was posted. He in turn filed the Change of Circumstances Report which ultimately led to the recommendation for Thwaites' release on the basis of homosexuality. On June 8, 1988, the DGPCOR (Director General, Personnel Careers Other Ranks) recommended Thwaites' release on the basis of homosexuality purportedly with no knowledge that only one day earlier on June 7, 1988 the Career Management Directorate had recommended the Thwaites' release on medical grounds. On July 20, 1988, Thwaites was offered a release or be frozen. He refused both options and again presumably because of the status of his recommendation for medical release, nothing further was done to bring this matter before a Special Career Review Board.

The evidence given by Thwaites and the CAF witnesses who testified in relation to these channels of investigation was, to say the least, confusing. The Tribunal concludes, however, that there is no doubt of two facts. First, Thwaites had every right to doubt that the reason for his recommended release was his HIV positive status and to question what knowledge of his homosexuality was being shared with those individuals who were to make the decision respecting his medical release. Secondly, all members of the CMRB who sat on August 4, 1988, had received in advance of their meeting in Ottawa, copies of background material which candidly discussed the earlier attempt to release Thwaites on grounds of homosexuality.

III. MEDICAL EVIDENCE

(a) Nature Of HIV/AIDS

The Tribunal heard several witnesses who were either qualified as experts on the diagnosis and treatment of HIV/AIDS or who had treated Thwaites during the relevant time period of this case. In addition, CAF medical personnel (while not qualified as experts per se), offered their perspective on this disease, its treatment and how the CAF could best deal with its members who had contracted the disease.

HIV/AIDS is one of the most complex and deadly diseases ever encountered by mankind. In addition, HIV/AIDS is not a static disease, in the sense that it evolves quite quickly in its nature and form.

HIV/AIDS is also a relatively young disease, having been identified in the early 80's. Medical knowledge and expertise regarding HIV/AIDS and its treatment have evolved, and continue to do so, since it was first identified. In terms of the medical profession's knowledge of HIV and AIDS, the relevant period for consideration by this Tribunal is January 1986 to and including October 1989 and indeed within this time frame, the period October 1987 to August 4, 1988 becomes critical.

AIDS (Acquired Immune Deficiency Syndrome) is caused by HIV, which in its most basic form is a human retrovirus. The time span between an individual becoming infected with HIV until he or she develops AIDS can be anywhere from a few months to approximately ten years. Although many individuals can live for some years without manifestation of illness, the probability is that ultimately they will develop AIDS. Once the disease reaches that stage, life expectancy depends on the nature of the final illness, the average survival being 18-24 months.

Although individuals with HIV may go for years without any outward sign of illness, most and probably all will eventually develop symptoms. There is no known cure for this disease; treatment can retard but not reverse its progression.

HIV replicates principally, but not exclusively, in CD4 positive lymphocytes, also known as T helper lymphocytes (T-cells) which are essential cells in the various human body functions. During the course of an HIV infection, the numbers of such T-cells diminish in a significant way, thus contributing to a major weakening of the body's immune system.

The evidence has shown that the weakening of the immune system is the most crucial aspect of this disease and of its characterization in patients who are HIV positive.

In fact, the HIV infection is diagnosed and treated in large part on the basis of a patient's T-cell count. This count is also used to assess a patient in terms of his or her position on the HIV infection scale.

As a result of a low T-cell count, a person who has acquired HIV becomes susceptible to a variety of opportunistic diseases which would not normally appear in an otherwise healthy person. One of the most frequent and common opportunistic diseases is pneumocystis pneumonia (PCP). This disease was of great concern to clinicians during the period in question, although by today's standards, physicians are more relaxed about the patient's risk of developing PCP.

(b) Classification Systems Used In Respect Of HIV/AIDS Patients

Individuals with HIV were formerly described as falling within one of three stages:

(I) Asymptomatic;

(ii) AIDS Related Complex (ARC); and

(iii) Full Blown AIDS.

That rudimentary classification system was replaced by the four stage CDC (Center for Disease Control) classification which is based on the signs and symptoms of the infection. There are other recognized classification systems but CDC was the primary one referred to in the evidence in respect of Thwaites' condition.

The CDC system has identified the following groups for the purpose of characterizing HIV/AIDS patients:

GROUP 1: acute infection;

GROUP 2: asymptomatic infection;

GROUP 3: symptomatic infection, for example, persistent generalized lymphadenopathy; and

GROUP 4: development of symptoms consistent with impairment of immune function and development of opportunistic disease.

Group 1 includes people who show signs of recent infection and who have antibodies to the HIV virus. Within a month after exposure, many individuals experience acute flu-like symptoms which usually resolve themselves.

Group 2 includes those who have been infected with the virus for some time but who are asymptomatic. Those within Group 1 and Group 2 appear healthy and can maintain a normal lifestyle.

Group 3 includes those who have a persistent generalized lymph node enlargement that lasts more than three months but who evidence no other outward signs or symptoms.

Group 4 includes those with varying outward symptoms of the disease and they are described as having AIDS. Symptoms include wasting syndrome, dementia and other neurologic diseases; opportunistic infections such as PCP; or certain forms of cancer such as Kaposi's Sarcoma, a skin cancer.

There would appear to be at least three main reasons for a classification systems:

(I) epidemiological, which is the charting of the disease and its study on an overall basis in terms of its impact in the human community;

(ii) biological, in terms of situating an HIV patient on a medical scale which determines the severity of the HIV infection;

(iii) For medical trials, in the sense of a decision by a doctor to prescribe an investigational drug in the fight against HIV. In other words, the point at which a patient has arrived in terms of HIV progression will determine the possibility of prescribing an investigational drug to the patient.

Whatever classification system is used, its primary purpose is epidemiological and thus the decision of placing an HIV patient in a particular group is somewhat arbitrary as the categories do not necessarily reflect disease progression precisely in the individual patient. The disease does not necessarily proceed through each of the four stages. Some individuals never experience the acute infection of Group 1. Some go directly from being outwardly asymptomatic to having a life threatening opportunistic infection without going through any intermediate stages. Some manifestations of Group 4 may be early manifestations of HIV infection unrelated to its subsequent course. The classification system has proved useful for surveillance and administrative purposes and recognizes the concept that an individual with HIV infection can be considered to have AIDS related illness without manifesting life-threatening opportunistic diseases.

In any event, most patients can be classified into broad categories which are independent of the classification systems per se, namely that they are either:

(I) asymptomatic;

(ii) somewhat symptomatic;

(iii) fully symptomatic; and

(iv) at the AIDS stage, which includes any one of several possible opportunistic infections.

These broad categories reflect the fact that there is generally speaking a downward progression in the status of HIV infected persons.

There is an emerging consensus within the medical community that the best indicator of how HIV patients are likely to do is that of their overall T-cell count. This factor is increasingly relied upon by doctors in terms of how they classify and treat HIV patients. Under the new proposed definition of AIDS, as of 1992, those individuals whose T-cell count had fallen below 200 would be described as having AIDS.

During the crucial time frame which is in issue in this case, most general practitioners had little knowledge of HIV/AIDS in itself. They also had limited knowledge of the classification systems used to pinpoint an HIV positive patient's status in terms of the disease.

Considering the very complex nature of this disease and of its evolution in a patient, it should come as no surprise that most general practitioners would easily defer to a specialist regarding the treatment and care of an HIV positive patient. This is especially true in light of the fact that during the 1986-89 period, even the HIV/AIDS specialist doctors were still on a learning curve and in some cases, were just beginning to have a substantial number of regular HIV/AIDS patients.

For example, both Drs. Lynn Johnston and Walter Schlech testified that during this period, they wanted to have as many HIV/AIDS patients as possible to increase their knowledge of the disease and its progression.

(c) Thwaites' Medical Status As An HIV Patient During The Period 1986-89

From the evidence given by Dr. Johnston and Dr. Schlech, Thwaites reported the following symptoms during his initial visits to the Infectious Diseases Clinic of Halifax's Victoria General Hospital, none of which were thought to be AIDS related:

(i) a suspicion of leukoplakia in the buccal mucosa;

(ii) acid pepsin disease (also referred to as upper gastrointestinal disease, or UGI).

One of the earliest changes in Thwaites' medical condition was the occurrence of night sweats, which he reported to the Infectious Diseases Clinic. On various occasions, Thwaites also reported other changes in his condition, such as fatigue and a recurrence of UGI. During the initial stages of Thwaites' status as an HIV positive patient, the crucial question soon became that of knowing whether or not Thwaites was HIV symptomatic or asymptomatic. During the period, 1986-1988, the Infectious Diseases Clinic monitored Thwaites' T-cell count and found that it fluctuated between 220 and 350.

During these initial visits to the Infectious Diseases Clinic, the attending doctor (Dr. Johnston or Dr. Schlech) attempted to determine whether or not the changes in Thwaites' medical condition were HIV related or whether they simply occurred as a result of other factors, such as fatigue and sleep deprivation.

At one point in 1987, the combination of reported night sweats and of a decreasing T-cell count resulted in a determination that Thwaites had in fact become HIV symptomatic. This determination by the treating specialist at the Infectious Diseases Clinic was crucial since it would allow Thwaites to enroll in an investigational drug treatment program specifically designed for HIV positive patients.

For the purposes of enrolling Thwaites in this investigational drug treatment program for HIV positive patients, the Infectious Diseases Clinic specialists decided upon Thwaites' status in terms of the CDC classification system. It was thus determined that Thwaites would be classified in the 4A group (symptoms of constitutional disease), enabling him to receive the investigational drug RETROVIR (also known as "AZT") which had just recently been made available on a trial basis for HIV positive patients. Thus, as of November 12, 1987, Thwaites was said to be an HIV symptomatic patient eligible to receive the investigational drug, AZT. In hindsight, the specialists who made this determination admitted to the Tribunal that Thwaites was probably not symptomatic at that time. The decision to classify him as being symptomatic was made to facilitate Thwaites' enrollment in the AZT trial program which doctors felt was the only available tool to combat the progression of HIV.

All infectious diseases clinicians who testified before the Tribunal were in agreement that in 1987, it would have been reasonable to >- - 11 -categorize a patient such as Thwaites as CDC Group 4A in order to allow the patient to avail himself of the only drug known to be beneficial to HIV positive individuals. In other words, any doubt with respect to symptoms being expressed by the patient would have been resolved in favour of the symptoms being relevant to the patient's HIV status (as opposed to some other cause) and the strict guidelines of this drug's protocol would have been interpreted perhaps more loosely or bent in favour of the optimal patient care.

The Tribunal also heard evidence that an HIV positive patient can be at various times symptomatic or asymptomatic. Notwithstanding this fact, once a patient is determined to be symptomatic and classified as a Group 4A patient in the CDC classification system, there is no going back. An HIV positive patient will remain in the CDC symptomatic class, 4A, even though he or she thereafter becomes asymptomatic.

In summary, Thwaites' T-cell count was gradually decreasing. He also showed signs which could reasonably be linked to his HIV status. In November 1987, the Infectious Diseases Clinic made a determination that he was HIV symptomatic and that he should embark on the AZT trial program as soon as possible to help reduce the progression of HIV in his body. The Infectious Diseases Clinic informed the CAF medical personnel of these facts and as of that date, the CAF took the position that Thwaites had crossed an important threshold in his status as an HIV positive patient.

(d) The Primary Form Of Medication Given To HIV/AIDS Patients: AZT

In itself, the drug AZT is not new and has apparently been used in the past to combat some forms of cancer. It is only since approximately 1987 that it has been offered to HIV/AIDS patients as an important drug in helping to slow, if not to stop, the progression of HIV in a patient's body.

The Tribunal heard evidence that the drug was first offered on a trial basis, both in the United States and in Canada, to see if it would be effective in the fight against HIV/AIDS. In Canada, AZT became available on such a basis sometime in 1987.

In the face of such a complex and deadly enemy as HIV/AIDS, the medical community involved in the treatment of HIV/AIDS was quite excited with the prospect of being able to prescribe a drug against a killer which had up to that point gone completely unchecked. This enthusiasm for the drug AZT (albeit investigational) can surely not be faulted.

During the entire period at issue in this case, AZT was an experimental or investigational drug as it did not receive the Canadian government's full approval until October 1990. As an investigational drug, AZT was only made available to HIV/AIDS patients through the open trials of the long term safety of the drug conducted by Burroughs Wellcome Inc. Canada and the drug was only available through a provincial co-ordinator who was charged with the administration and distribution of the drug.

In this particular case, Dr. Walter Schlech was appointed the co-ordinator for the Maritime provinces. He occupied that role until the drug's full accreditation in October 1990, at which time it ceased to be an investigational drug and could be prescribed by way of regular channels.

Through the evidence of Dr. William Cameron, Dr. Walter Schlech and Dr. Lynn Johnston, it became evident that in late 1987 and throughout 1988, clinicians did not know very much about AZT and the medical standards of the day required vigilance in following patients who had consented to enroll on the compassionate program which made this otherwise unapproved drug available to HIV positive individuals.

As is most likely the case with any investigational drug, there were many unknown factors regarding its use and distribution to HIV/AIDS patients. For example, there was some uncertainty over the required dosage and there was most likely greater uncertainty regarding possible side effects, namely nausea, anaemia and neutropenia, to name but a few.

In Thwaites' particular case, he did experience some nausea during the first few weeks of taking this drug but the evidence shows that he most likely did not experience any other symptoms as a result of AZT use, except for a short period when it was decided that he should stop taking the drug on account of recurring UGI symptoms. From the very start, Thwaites took the recommended dosage which was prescribed at the time, namely 1200 milligrams per day.

Due to the investigational nature of this drug, the drug company which was producing it also issued a Protocol which was to be closely followed by all doctors prescribing the drug to their patients. Of most importance to this case is the fact that this Protocol required that the patient be seen by the administering doctor once every two weeks during the first two months and thereafter on a monthly basis. Also, the patient had to go undergo extensive laboratory tests (hematology and chemistry) on a regular basis to ensure that anaemia or other such manifestations would not result from the use of AZT.

As indicated previously, AZT did receive full government accreditation in October 1990 and could thereafter be prescribed through regular channels. The testing period had shown that it could safely be administered to HIV/AIDS patients and that in addition, it did produce beneficial results in most, if not all patients who took the drug.

At the same time, it was also decided that the recommended dosage should be reduced to approximately 500 milligrams a day and that such amount would be sufficient for the purposes of combatting the HIV virus.

In summary, AZT was rightfully seen as a drug which could mean the difference between life and death for many, if not all, HIV/AIDS patients. In the context of this particular case, the evidence suggests that Thwaites has most likely benefitted from the use of AZT.

(e) Suggested Medical Care For HIV/AIDS Patients During The Period 1986-89

In general terms, patients who have been diagnosed as HIV positive and who show no symptoms are not required to make any drastic changes to their lifestyle and habits. However, the Tribunal

did hear evidence that such patients should closely watch their daily eating and sleeping habits. Generally, they should maintain a very healthy lifestyle to assist their body in its struggle to maintain a healthy immune system in the face of HIV. There was no evidence that physical exertion would increase an HIV positive patient's susceptibility to opportunistic diseases.

In regard to HIV/AIDS patients who were on AZT during the period 1986-1989, the Tribunal also heard evidence that it was preferable, but not mandatory, for such patients (at least at that time) to have ready access to a specialist, taking into account the still undefined nature of HIV/AIDS and the potential risk resulting from the use of AZT on an investigational basis.

In this particular case, the CAF medical personnel in Halifax referred Thwaites to the best available specialist (in the Metropolitan Halifax area) and he was in fact seen as a regular patient by the Infectious Diseases Clinic during this entire period.

The evidence also indicates that Thwaites did report to his treating doctors on a quite regular basis that he suffered from fatigue and sleep deprivation which were in good part attributed to the fact that he was holding down a second job, in addition to his regular duties in the CAF. However, there is no evidence to suggest that this factor had any bearing whatsoever on his status as an HIV positive patient.

Finally, although Thwaites consulted with CAF medical doctors in Halifax on a regular basis, his main treatment throughout in regard to HIV/AIDS was administered by the Infectious Diseases Clinic. In turn, this clinic provided regular updates to the CAF regarding Thwaites' medical status and his AZT treatment.

Professor Mark Wainberg testified that he agreed in a general sense with the recommendation of a Royal Society of Canada Report, prepared in 1988, that patients with HIV infections should not be discriminated against in terms of their status in the workplace. Professor Wainberg also agreed with that Report's recommendation that people who are HIV positive and asymptomatic are competent to perform virtually any task in Canadian society. In his opinion, there was nothing to prevent an HIV positive patient from continuing to be a productive member of society.

(f) Medical Personnel And Facilities Available On CAF Destroyers

As we have seen earlier, Thwaites was posted to the destroyer HMCS Fraser during the relevant time frame applicable to this case. Before 1986, Thwaites had been posted to other similar destroyers, all based at CFB Halifax. Various CAF witnesses testified regarding the availability and use of medical personnel and facilities on board destroyers. This evidence clearly brought out the fact that destroyers did not carry elaborate medical equipment. In addition, destroyers were generally staffed by a single medical assistant who would have received only basic training in health care and treatment. A destroyer was not staffed with a medical practitioner.

In terms of medical testing, a blood count (particularly in regard to a T-cell evaluation) could be done on a destroyer, albeit with basic equipment as opposed to the modern tools used in land-based medical laboratories. On the other hand, the evidence indicated that chemistry-type tests

could not be handled on board a destroyer. Finally, the CAF witnesses having medical knowledge and expertise were clearly of the view that a medical assistant did not have enough training or experience to assess and treat HIV related symptoms or side effects flowing from the use of AZT by an HIV positive patient.

On some of the longer missions and exercises to which a destroyer would be assigned, there would usually be an auxiliary oiler or supply ship which would accompany the fleet during the entire mission. Such auxiliary oiler ships did in fact carry one or more medical doctors, medical assistants and more substantial medical equipment than would be found on a regular destroyer. Of course, this personnel and equipment were much better suited to handle a medical emergency or situation which could arise during such a mission or exercise.

Notwithstanding the above, the CAF witnesses were not at all convinced that the medical personnel and equipment on an auxiliary oiler ship could have responded adequately to the needs and situation of an HIV patient, either because of HIV symptoms or in regard to the side effects resulting from AZT use. It should also be noted that the medical staff on board the auxiliary oiler ship consisted only of general practitioners and that during the relevant time period of this case, none of them had received any particular training or had acquired specialized knowledge regarding the treatment of HIV/AIDS patients.

Finally, the CAF medical witnesses all referred to the possibility, if not the necessity, of proceeding by airborne medical evacuation in order to treat and respond to the emergency needs or symptoms of an HIV positive patient on board a destroyer. There was also evidence that such an airborne medical evacuation could only be effective in limited circumstances and that the response time might not always be adequate for the needs of an emergency related to an HIV/AIDS patient. The Tribunal also heard evidence that in other cases where a CAF member would require emergency or swift medical treatment, the only other alternative would be for a destroyer on a fleet mission to abort its mission and to head for the closest port, which would vary in distance depending on the location and size of a particular mission.

(g) CAF Policy Directives Regarding The Status Of HIV/AIDS Patients

A number of policy directives have been prepared and circulated by the CAF Surgeon General on the topic of HIV/AIDS patients in the CAF. To date, the CAF has adopted four successive policy directives on this topic, with the first one dating back to 1985. These followed three revisions to the 1985 policy directive namely, one in 1988, and two in 1991.

Of particular relevance to this case are the policy directives dated 1985 and 1988. Among other things, these policy directives set out the CAF medical approach to treating HIV/AIDS patients. These policy directives also established a classification system whereby reference is made to an HIV/AIDS patient's status to determine if any geographical or occupational limitations should be imposed regarding the HIV/AIDS patient's status within the CAF.

As we will see further on, this determination of an HIV/AIDS patient in the CAF was crucial regarding Thwaites' status and his eventual release which forms the basis of this complaint.

It is also significant to note that the evaluation of an HIV/AIDS patient in the CAF places much emphasis on whether or not the patient was symptomatic or asymptomatic.

In this particular case, Thwaites was categorized as being in the G2 category when he was first diagnosed as being HIV positive. This classification was assigned to him on the basis of the first CAF policy directive dated 1985. This category reflected the fact that he was HIV positive and also that he was asymptomatic.

As was to be expected, the CAF medical personnel were kept informed of Thwaites' medical status during the relevant period of this case. The evidence also shows that in November 1987, the Infectious Diseases Clinic diagnosed Thwaites as being symptomatic. This information was passed on to the CAF medical personnel. As a result of receiving this information, steps were taken to re-evaluate Thwaites' medical category in relation to the CAF policy directive on HIV/AIDS.

At about that same time, CAF medical experts were preparing the 1988 version of the CAF HIV/AIDS policy directive. That document provided that a G5 category be given to any HIV/AIDS patient who was symptomatic and who required the services of a medical specialist.

On the basis of Thwaites' symptomatic status, the CAF proceeded to assign him to the G5 category, as of January 1988. Dr. Kenneth Sutherland of CFB Halifax initiated this change in medical category. The process leading up to the CMRB was thus set in motion. Thwaites' G5 medical category would eventually be approved by the CMRB, leading to his release on medical grounds.

IV. APPLICABLE LEGAL PRINCIPLES

(a) Nature Of The Complaint And Defence

Thwaites alleges that the CAF has discriminated against him by refusing to continue to employ him and by differentiating adversely in relation to his employment by restricting his duties and opportunities because of his disability (i.e. HIV positive) contrary to Section 7 of the Canadian Human Rights Act ("CHRA"). Section 7 reads as follows:

"7. It is a discriminatory practice, directly or indirectly,

(a) to refuse to employ or continue to employ any individual, or

(b) in the course of employment, to differentiate adversely in relation to an employee, on a prohibited ground of discrimination."

Under Section 3(1) of the CHRA, "disability" is a prohibited ground of discrimination. No issue was taken by the CAF that Thwaites' condition at the material time constituted a "disability" within the meaning of Section 3(1) and thus was a prohibited ground of discrimination. Moreover, the CAF conceded that it did in fact prima facie discriminate against Thwaites on the prohibited ground of disability.

It asserts, however, that it is absolved because its treatment of Thwaites constitutes a bona fide occupational requirement and, therefore, cannot be said to be a discriminatory practice. Section 15(a) of the CHRA provides:

"15. It is not a discriminatory practice if (a) any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is established by an employer to be based on a bona fide occupational requirement;" ("BFOR Defence")

Most human rights disputes in the employment context arise from the tension between the fundamental right of an individual to equal opportunity in employment as set out in Section 2 of the CHRA,

"that every individual should have an equal opportunity with other individuals to make for himself or herself the life that he or she is able and wishes to have, consistent with his or her duties and obligations as a member of society, without being hindered in or prevented from doing so by discriminatory practices ..."

and the occupational requirements of the employer which preclude the employment of such individuals but are necessary, according to the employer, to operate the business safely, efficiently and economically.

(b) Fundamental Individual Rights And The BFOR

Defence In the evolution of human rights case law, increased emphasis has been placed on the individual rights enshrined in the CHRA. With it, has come a corresponding insistence that employers make every effort to give effect to the principle set out in Section 2 of the CHRA.

To begin with, the Supreme Court of Canada has repeatedly stated that human rights legislation is intended to give rise, amongst other things, to individual rights of vital importance and that we should not search for ways and means to minimize those rights and to enfeeble their proper impact. (See C.N. v. Canada (Action Travail des Femmes) at [1987] 1 S.C.R. 1114 at pp. 1134-1137) The Court has emphasized the special nature of human rights legislation in that it declares public policy regarding matters of general concern and, therefore, constitutes fundamental law (See Winnipeg School Division No. 1 v. Craton [1985] 2 S.C.R. 150 at p. 156; >- - 17 -I. C.B.C. v. Heerspink [1982] 2 S.C.R. 145 at p. 158; C.H.R.C. v. Simpsons Sears Ltd. [1985] 2 S.C.R. 536 at pp. 546-547; and Robichaud v. Canada [1987] 2 S.C.R. 84 at pp. 89-91; Zurich Insurance v. Ontario Human Rights Commission [1992] 93 D.L.R. (4th) 346 at 374).

In respect of the BFOR defence provided for in Section 15(a) of the CHRA, the Supreme Court of Canada initially held in Bhinder v. C.N. in 1985 that consideration of a BFOR was to be without regard to the particular circumstances or abilities of the individual in question. In the short span of five years, the majority of the Court in Alberta Human Rights Commission v. Central Alberta Dairy Pool [1990] 2 S.C.R. 489 reversed its position and held that in cases of adverse effect discrimination, the employer cannot resort to the BFOR defence at all. In such cases, there is now a positive duty on employers to accommodate the needs of employees disparately affected by a neutral rule unless to do so would create undue hardship for the

employer. Put another way, the employer must establish that the application of the neutral rule or practice to the individual was reasonably necessary in that allowing for individual accommodation within the general application of the rule or practice would result in undue hardship. No longer, in such cases, can an employer justify its practice as a BFOR in relation to safety of employees in a general way and maintain that its discriminatory effect on certain groups of individuals is totally irrelevant.

The BFOR defence is now only available to an employer when, as in the case before us, direct discrimination is involved: Central Alberta Dairy Pool supra, at pp. 516-517, i.e. where the employer's rule or practice makes assumptions or generalizations about the capabilities of individuals because they belong to a particular group. In those cases, the BFOR defence allows the employer to justify its departure from the principle of individualized equal treatment by leading evidence in support of its general policy or the impossibility of individual assessment.

(c) Requirements On Employer To Establish BFOR

Even when the BFOR defence is applicable, the Supreme Court of Canada has held that the BFOR exception must be interpreted restrictively so that the larger objects of the CHRA are not frustrated. (See University of Alberta v. Alberta Human Rights Commission (1993), 17 C.H.R.R. D/87 at p. D/96; Ontario Human Rights Commission v. Etobicoke, [1982] 1 S.C.R. 202 at p. 208; Bhinder v. C.N. [1985] 2 S.C.R. 561 at p. 589; Ville de Brossard v. Quebec [1988] 2 S.C.R. 279 at p. 307). As Sopinka J. stated in Zurich Insurance v. OHRC supra at p. 374:

"One of the reasons such legislation has been so described [of a special nature] is that it is often the final refuge of the disadvantaged and the disenfranchised. As the last protection of the most vulnerable member of society, exceptions to such legislation should be narrowly construed".

As far as the burden of proof upon the employer to establish a BFOR is concerned, the applicable rule is the ordinary civil standard on the balance of probabilities (Etobicoke, supra, at p. 208). Some earlier cases held that the burden might be regarded as somewhat lighter when >- - 18 - issues of public safety were in question. However, given the Supreme Court of Canada's direction that the BFOR exception must be restrictively interpreted, more recent decisions have held that it is inappropriate to reduce the civil standard even in cases where public safety lies at the root of the employer's defence (Robinson v. CAF (1992) 15 C.H.R.R. D/95; St. Thomas v. CAF (1991) 14 C.H.R.R. D/301; Seguin v. R.C.M.P. (1989) 10 C.H.R.R. D/5980; DeJager v. Department of National Defence (1986) 7 C.H.R.R. D/3508).

The evidence furnished by the employer must satisfy the two branches of the test laid down by the Supreme Court of Canada in Etobicoke, supra, one subjective, the other objective, in order to establish the BFOR defence. The employer must first provide subjective evidence of its good faith in establishing its policy or requirements:

"To be a bona fide occupational qualification and requirement a limitation, such as a mandatory retirement at a fixed age, must be imposed honestly, in good faith, and in the sincerely held belief that such limitation is imposed in the interests of the adequate performance of the work involved with all reasonable dispatch, safety and economy, and not for ulterior or extraneous

reasons aimed at objectives which could defeat the purpose of the Code." (per McIntyre J. in Etobicoke supra at p. 208)

In the past this subjective criterion has not been examined closely and Tribunals and Courts generally presumed that the employer was acting in good faith in the absence of any evidence to the contrary. Recently, however, some Tribunals have indicated that more is required to satisfy this criterion. It must mean more than merely condoning an employer for prejudices that it holds in good faith in regard to a group of persons protected by the CHRA. To do so, would only undermine the very objectives of the CHRA which are specifically to eliminate prejudices and stereotypes concerning certain groups. Accordingly, there is an onus upon an employer to show the purpose of its employment policy rule and the reasons that have led it to adopt the said policy were not founded on prejudices or stereotypes whether of the employer or of the employer's clientele but rather "in the interests of sound and accepted business practice" (Per Sopinka J. in Zurich Insurance supra at p. 376; also see Robinson v. CAF, supra, at p. D/117.)

As for the objective part of the BFOR defence, it was defined by McIntyre J. in Etobicoke supra at p. 208 as follows:

"In addition it [the occupational requirement] must be related in an objective sense to the performance of the employment concerned, in that it is reasonably necessary to assure the efficient and economical performance of the job without endangering the employee, his fellow employees and the general public".

Here, as well, there has been considerable refinement in the treatment of this objective part of the employer's evidence since it was first formulated in 1982. First, the Supreme Court has in fact imposed a burden of objective proof on the employer: "[The occupational requirement] must be related in an objective sense to the performance of the employment". This implies that the relationship between requirement and employment must be proved on the basis of real facts not on the basis of impressions. Secondly, the Supreme Court speaks of an occupational requirement that is "reasonably necessary" to ensure the adequate performance of the employment. It is a criterion of necessity not convenience (See Robinson v. CAF; supra at p. D/118; Martin v. CAF T.D. 11/92, unreported at p. 21.) An employer cannot overcome the fundamental aim under the CHRA of ensuring equal opportunity for individuals regardless of certain personal characteristics identified by the CHRA on the basis that life would be simpler for the employer, if such people were excluded. On the contrary, case law has interpreted the objective criterion of reasonable necessity in such a way as to ensure that the occupational requirement is truly necessary. In fact, one judge has gone so far (perhaps too far) as to say that the case law has evolved to the point where an employer must show that it is absolutely necessary. Marceau J. in Levac v. CAF (F.C.A.), July 8, 1992, unreported at pp. 10-11 stated:

"I am prepared to admit that there is also another aspect on which this Alberta Dairy Pool judgment may be considered somewhat innovative, at least indirectly, particularly if the reasons of the minority are read in conjunction with those of the majority. It may have rendered the defence of BFOR even less available than previously. Until now, the prevalent view, I believe, was that, to be justified, a bona fide occupational requirement had to be, as expressed in Etobicoke (at p. 208); "reasonably necessary to assure the efficient and economical performance

of the job without endangering the employee, his fellow employees and the general public". It seems from now on that it must be, not only "reasonably", but absolutely necessary, that is, it must be without any other workable, less stringent, alternative". (But see dissenting view of Desjardins J. at p. 7)

The Ontario Court of Appeal more recently in Ontario Human Rights Commission v. London Monenco Consultants Ltd. (1992) 9 O.R. (3d) 509 at pp. 516-517, stated that:

"A discriminatory qualification cannot be justified in the absence of a direct and substantial relationship between the qualification and the abilities, qualities or attributes needed to satisfactorily perform the employment given its particular nature." (emphasis added)

Moreover, if an employer is relying upon a general rule of exclusion, it must explain why as a practical alternative, it was not possible to assess individually the risk presented by each employee and thus had to impose a blanket practice. (Wardair Canada Inc. v. Cremona (F.C.A.) October 9, 1992, unreported at p. 6; Saskatchewan Human Rights Commission v. Saskatoon [1989] 2 S.C.R. 1297 at pp. 1313-14; Central Alberta Dairy Pool supra at p. 518).

The employer must also show that its practice or rule is not disproportionate in that there are no other means less prejudicial to the concerned group's right to equal treatment than its general exclusion on the basis of the criterion employed. (Ville Brossard, supra at p. 312; Central Alberta Dairy Pool, supra at pp. 526-527).

(d) Distinction Between Direct Discrimination and Adverse Effect Discrimination

The logical conclusion from this analysis is that there is very little, if any, meaningful distinction between what an employer must establish by way of a defence to an allegation of direct discrimination and a defence to an allegation of adverse effect discrimination. The only difference may be semantic. In both cases, the employer must have regard to the particular individual in question. In the case of direct discrimination, the employer must justify its rule or practice by demonstrating that there are no reasonable alternatives and that the rule or practice is proportional to the end being sought. In the case of adverse effect discrimination, the neutral rule is not attacked but the employer must still show that it could not otherwise reasonably accommodate the individual disparately affected by that rule. In both cases, whether the operative words are "reasonable alternative" or "proportionality" or "accommodation", the inquiry is essentially the same: the employer must show that it could not have done anything else reasonable or practical to avoid the negative impact on the individual.

(e) Safety Risk as a BFOR

(i) Increase In Risk

It was once thought that, an employer, relying on safety reasons, as in the present case, could establish a BFOR by merely showing that the employment of such individuals would result in a marginal increase of risk to public safety. (Bhinder, supra; Canadian Pacific v. Canada (Mahon) [1988] 1 F.C. 209). It is now clear that the standard that the employer must meet is that the group

of persons in question excluded by the employment practice will present a "sufficient risk of employee failure" (see Etobicoke, supra at p. 210; Central Alberta Dairy, Supra, at p. 513; Robinson v. CAF, supra at p. D/119-D/123.)

This test of sufficient risk has been recently confirmed by the Federal Court of Appeal in Attorney-General of Canada v. Rosin, [1991] 1 F.C. 391. Noting that Wilson, J. had held in Central Alberta Dairy Pool, supra pp. 512-513, that the Supreme Court had erred in Bhinder, in accepting as evidence of BFOR the proof of a very slight increase in risk for the safety of the employee, Linden J. dismissed on behalf of the Court in Rosin the position that proof of any risk, even the most minimal, constitutes proof of sufficient risk consistent with a BFOR. (Linden J. indicated that the Federal Court of Appeal decision in Canadian Pacific v. Canada (Mahon) supra may have been impliedly overruled as well).

The Tribunal in Robinson v. Canadian Armed Forces, supra recently rendered a decision along the same lines. In that case, which dealt with a policy excluding persons suffering from epilepsy from the Armed Forces, the Tribunal concluded that in light of the decision in Central Alberta Dairy Pool, the criterion of unacceptable risk stated by MacGuigan, J. in Air Canada v. Carson, [1985] 1 F.C. 209 had again become the applicable criterion for sufficient risk. According to the Tribunal, this criterion means that proof of a slight or negligible risk is not sufficient to constitute a BFOR. It seems that the risk must be substantial.

The significant risk standard recognizes that some risk is tolerable in that human endeavours are not totally risk free. While this standard protects genuine concerns about workplace safety, it does not guarantee the highest degree of safety which would be the elimination of any added risk. What it does, is ensure that the objectives of the CHRA are met by seeking to integrate people with disabilities into the workplace even though such persons may create some heightened risk but within acceptable limits.

(ii) Measuring the Increase in Risk

The thorny question is determining when some increased risk amounts to significant risk. What must be evaluated, in each case, is whether the risk to safety is sufficiently high to be described as unacceptable in relation to a particular job. In Levac v. CAF (1991) 15 C.H.R.R. D/175 aff'd, A.G. of Canada v. Levac, July 8, 1992, unreported, the evidence was that the complainant who had a heart condition, was at an eight to ten per cent risk of having a heart attack within the next five years (or six to nine per cent within the next three years); and he was two to three times more likely to die if he was at sea when a heart attack occurred because of the remoteness of care at sea than if he was on shore. This was not considered sufficient risk. In De Jager v. DND (1987) 7 C.H.R.R. D/3508, there was evidence that there would be increased danger or risk to the Complainant in that case, an asthmatic, if he were to be in an isolated post, away from medical attention but the Tribunal did not find this to be a sufficient risk so as to justify the CAF discriminating against him.

The dividing line between insufficient and sufficient risk is ultimately judgmental and turns on the circumstances of each case. In particular, a careful assessment would have to be made of the actual health and safety risks posed by such employees and how they compare with other risks

that the employer is willing to accept. If such risks were determined to be significantly higher, then it would have to be asked whether there are any reasonable measures that can be put in place to minimize such risks to an acceptable level - a level that makes them comparable with other tolerated risks.

The determination of significant risk requires a Tribunal to balance the disabled individual's interest in working and participating in society against the need to protect that individual and others from harm. In an attempt to strike the appropriate balance, it is appealing to rely upon percentages of increased risk. High percentages of say 80% or even 50% can be quite compelling. However, this is a less useful tool when the percentages are low. A raw percentage figure of say 2% or 3% or even 12% might seem appreciable to one person and yet quite small or insignificant to another. Since reasonable people can reach very different conclusions based upon an abstract percentage, it may not provide the appropriate or sole bench mark for drawing the necessary conclusion. This seemed to trouble the Tribunal in Levac v. CAF supra at pp. D/193-194, as well.

Significant risk can best be measured in the context of the particular job and then only in comparison with other risks posed by that workplace. In this way, other tolerable risks arising from the employment establish risk thresholds. If risks of comparable magnitude are acceptable in a particular work environment then risks posed by a person who is HIV positive cannot be considered significant. By utilizing a comparative risk analysis, there is recognition that employers cannot expect a completely risk free work environment. Instead, the standard of significant risk seeks to eliminate those risks that pose a significant or substantial threat to health and safety. In any particular situation, one must determine when risks are deemed significant and thus unacceptable by identifying the nature and quantum of other risks that are tolerated as acceptable in that particular work environment. By applying a comparative risk analysis, one can best determine if the risk is substantial. (See generally S.D. Watson, "Eliminating Fear Through Comparative Risk: Docs, AIDS and the Anti-Discrimination Ideal" (1992) 40 Buffalo L. Rev. 738). (

iii) Nature of the Evidence of Risk

Whenever an employer relies on health and safety considerations to justify its exclusion of the employee, it must show that the risk is based on the most authoritative and up to date medical, scientific and statistical information available and not on hasty assumptions, speculative apprehensions or unfounded generalizations (Heincke et al. v. Emrick Plastics et al. (1992) 55 O.A.C. 33 at 37-38 (Div. Ct.); Etobicoke supra at p. 212; Rodger v. C.N. (1985) 6 CHRR D/2899 at p. D/2907).

(f) Reasonable Alternatives or Accommodation if No Undue Hardship

The importance of searching for reasonable alternatives or accommodating the individual to permit him or her to do the job or to lessen any risk (if risk is a factor) is now the bedrock of human rights law in this country. Indeed, without such accommodation, the protection given by the CHRA to certain groups, the disabled in particular, would be quite illusory. Anne M. Molloy,

in "Disability and the Duty To Accommodate" (1992) 1 Can Lab. Law Journal 23 put it well at p. 26:

"For persons with disabilities, the right to accommodation goes to the very heart of equality. To appreciate the importance of this right, one must understand the reality of discrimination. Much of the problem is attitudinal. The barriers to people with disabilities in employment are rarely rooted in loathing or malevolence. On the contrary, the discrimination is quite often perpetrated with the best of intentions - a genuine concern about the capabilities of persons with disabilities, a desire to protect the disabled person from harm or injury or to shield him or her from the embarrassment of what is seen as the inevitability of his failure to measure up. While this may explain the discrimination, it does not, of course, excuse it nor does it make the ugliness of its result any more acceptable. The accommodation of differences for persons with disabilities therefore requires overcoming the ignorance, stereotypical attitudes and paternalism that are the source of much of the overt disability discrimination."

Accordingly, the pendulum has swung such that a BFOR can rarely be established if the rule or practice makes generalizations about people solely on the basis of disability without regard to the particular circumstances of the specific class of individuals affected. Moreover, in order for there to be true individualization, a close assessment should be made of the individual in question since even persons with the same disability vary markedly in how they personally function and cope with their affliction or vary in the degree of impairment because of the different stages of their infirmity. This was emphasized by Ms. Molloy in her article at p. 26:

"It is of critical importance that the accommodation of persons with disabilities be approached on an individual basis. Disabilities differ dramatically, one from another. There are also great individual variations within the same disability group. The effect of a particular disability on a particular person is very individualized and the accommodation of that disability must therefore also be individualized. In some cases, all that will be required is a little flexibility and creativity. In others, advances in technology will provide a means for a person with a disability to perform a job that years ago would have been utterly impossible. The key in all cases is to consider the individual needs and to provide the individualized accommodation required to meet those needs in a manner consistent with the employee's dignity and self-worth."

It should be acknowledged that this may add some risks and make matters somewhat more burdensome for employers but this is a small price to pay for the higher value that society has placed on equal opportunity. (In a different context see Huck v. Canadian Odeon Theatres [1985] 3 W.W.R. 717 at 744 (Sask. C.A.), leave to appeal to S.C.C refused.) An employer cannot rely on undue hardship unless it would be forced to take action requiring significant difficulty or expense which would clearly place upon the business enterprise an undue economic or administrative burden. Professor Cumming in Mahon v. Canadian Pacific (1986) 7 CHRR D/3278 stated at p. D/3305:

" It would be less costly in the immediate, narrow economic sense simply to allow employers who act with honesty of motive ... to preclude the disabled from being employed. Difficult evaluations, with attendant time-consuming uncertainty and expense, would be avoided. However, our society has chosen the course of ensuring 'equality of opportunity' for the disabled

in respect of employment, because the immediate cost and difficulty in employment decision-making is far outweighed by the protection and enhancement of core values for the disabled, and hence indirectly, for all members of society. It is only through the extension of equality of opportunity to the disabled as with other so-called minority groups, that a society can say it is truly free and just."

V. THE CAF'S POSITION

It is the CAF's position that Thwaites was not discharged simply because he had an HIV positive infection. He was retained in the CAF for 3 1/2 years from the Spring of 1986 to the Fall of 1989 after both he and the CAF learned that he was HIV positive. He was released from the CAF because the progression of his disease had reached a point where he had become increasingly dependent on physician's and particularly, specialist physician's care. The CAF responded to the fact that it perceived Thwaites as entering into the more advanced stage of the disease which had been commonly described as AIDS Related Complex.

It is this dependence on specialist care which impacts on a member's ability to serve in remote regions and postings including at sea where an appropriate level of medical attention might not readily be available. This was of greater concern in the case of Thwaites since his occupation was "a hard sea trade" which required him to be at sea and away from appropriate medical facilities and specialists for significant periods of time. The position thus advanced by the CAF is not "the fear of transmission of disease" defence but rather "the altruistic" defence (i.e. a concern over possible harm to Thwaites himself).

No issue was raised as to whether an asymptomatic carrier of the HIV virus could be said to be under a "disability" within the meaning of Section 3(1) of the CHRA. The CAF conceded that Thwaites' release from the CAF was based on the prohibited ground of disability. However, it relies on Section 15(a) of the CHRA. It takes the position that it was not a discriminatory practice contrary to the Act because his expulsion was based on a bona fide occupational requirement.

VI. HAS THE BFOR DEFENCE BEEN ESTABLISHED?

(a) The Subjective Element

The CAF must prove on the balance of the probabilities that it acted in good faith in taking the job action that it did against Thwaites on the basis of his requiring medical specialist's care which would not be readily available to him in his occupation. Some suspicion has been raised in respect of the CAF's motives in this regard because of its then existing policy against homosexuals (which presumably is no longer in effect since the decision in Haig v. Canada) (1992), 9 O.R. (3d) 495). Paragraph 7 of CFAO 19-20 originally provided:

"Service policy does not allow homosexual members or members with a sexual abnormality to be retained in the CF. When it is decided that a member is to be released, appropriate action shall be taken as quickly as possible with a minimum of publicity."

At the material time, CFAO 19-20 was under review and interim administrative procedures were in place whereby a homosexual member of the CAF was offered release under item 5(d) of the table to QR & 0 15.01; or, if he objected to this, he would be frozen as far as career progression and rank were concerned. Indeed, a concurrent special investigation of Thwaites was being carried on resulting in the recommendation that Thwaites be given a 5(d) release or be frozen in his position and rank because of his sexual orientation. This option was put to Thwaites but he did not respond as he sought the advice of counsel. Rather than pressing this issue, the Special Investigative Unit gave way to the process that had also been undertaken by reason of Thwaites' medical condition which indeed ultimately resulted in his being given a 3(d) medical release by the CMRB.

Counsel for the Canadian Human Rights Commission submitted that this overlapping of the sexual orientation and disability issues indicates a lack of good faith on the part of the CAF. He has argued that from the coincidence of these events, one can infer that influence was brought to bear, either consciously or, at the least, subconsciously, upon those who decided the medical issue. Both the CMRB and Chief of Defence Staff (who was reviewing Thwaites' Grievance) were aware of the sexual orientation issue. It is suggested that the CAF was not being honest in its decision to release Thwaites because of his medical condition but rather used this as a convenient, arbitrary reason to more effectively eliminate him. Since he was a homosexual and, therefore, persona non grata, it is argued that the CAF made no effort to realistically assess his medical status or to accommodate his circumstances.

All the CAF physicians who were involved in the career decisions with respect to Thwaites, however, testified that they were motivated entirely by his medical condition and not by any ongoing special investigation being conducted into Thwaites' homosexuality. It is true that a Personnel Selection Report which contained references to Thwaites' sexual orientation and recommendations for release on that basis was before the CMRB. However, the CMRB representatives who considered the matter testified that that issue was of no importance in their decision. In May or June of 1987, when Thwaites was unquestionably asymptomatic, a Special Career Review Board report was prepared in respect of Thwaites' sexual orientation. Included in that report was a comment by the Director of Medical Treatment Services saying that there was no medical reason to do anything in respect of Thwaites' career. Accordingly, it is argued by the CAF that there is no real evidence to suggest any degree of collusion between the medical personnel and the special investigative group.

We heard testimony from all of the relevant CAF individuals involved in the process and we found them to be credible on this issue. Although the overlap of the two matters is striking, we find that on balance the CAF held the honest belief that Thwaites' medical condition had proceeded to the point where he required ongoing specialist care which could not be made available to him at sea. Accordingly, we find that the CAF has satisfied the subjective element of the BFOR test.

(b) The Objective Element: Assessment Of Risk

(i) Need For Specialist Care

It should be noted that Thwaites always retained his rating of "02". His HIV infection did not affect his ability to perform tasks involving physical, mental activity and stress. In other words, he appeared healthy and was able to work and maintain a normal daily schedule and the CAF recognized that he could deal with the more severe and prolonged stressful demands when under pressure at sea.

The CAF maintained, however, that it was reasonably necessary for a member to satisfactorily perform the job of a NESOP to be in a medical state which does not require regular specialist care and follow up. To otherwise permit Thwaites to serve in his position as a NESOP would create an inordinate and unacceptable risk both to his own health and safety and to any mission that he might be serving on at the given time. The medical facilities and care on ships were inadequate to provide the appropriate assessment of and treatment for Thwaites. In essence, the CAF was concerned that Thwaites was subject to sudden deterioration which would be difficult to predict. This risk would pose an unacceptable diagnostic and therapeutic dilemma for medical care personnel aboard ships. Immediate evacuation might be required but might be difficult to effect given the range of onboard helicopters and/or their deployment on military exercise.

(ii) AZT Therapy.

Much of the evidence related to the need for specialist care once an HIV positive patient has been placed on AZT therapy. As indicated in Part III herein, at the material time, i.e. 1987-1988, the drug AZT was available in Canada only through the Burroughs Wellcome Protocol on a compassionate basis since the Canadian government had not granted the drug a Certificate of Compliance. In fact, it was not granted until October 1990. However, the drug had been certified in the United States and its beneficial effects were well known within the medical profession. Accordingly, pending further investigation by the authorities in Canada, it was decided that, at the least, it would be made available to patients through controlled centres if the patients had reached a certain stage of the disease in the CDC classification. The following appears in the Burroughs Wellcome Protocol:

"2.1 Objectives

The objectives of the study are to provide for the administration of RETROVIR (AZT) to eligible patients, with careful follow-up to monitor survival, disease progression, toxicity and drug interactions.

2.2 Physicians/facilities

RETROVIR is an investigational drug. It will be supplied by Burroughs Wellcome Inc. and will be controlled and distributed by provincially designated authorizing physicians who are knowledgeable and experienced in the diagnosis and treatment of AIDS, and are willing to assume responsibility for supervising the administration of this investigational drug. It will be dispensed only under the authority of these authorizing physicians."

The Protocol goes on to say that with respect to patient management, patients should be seen at least once every two weeks for the first two months and once per month thereafter for the

duration of the study. The Protocol then prescribed the items that should be assessed and recorded and the laboratory studies that should be performed on such occasions.

These requirements, the CAF suggests, preclude an individual who is receiving AZT pursuant to the Protocol from going to sea since it would inhibit his or her ability to be monitored and assessed by the specialist as required.

As Regional Co-ordinator for the administration of AZT, it was Dr. Schlech's responsibility to make sure that patients were using the drug properly and having appropriate laboratory investigations done. But it did not require his personal intervention so long as it was under his general supervision. Although Dr. Schlech and Dr. Johnston preferred to see their patients monthly in order to broaden their own experience (from an educational point of view) of the progression of the disease, they believed it was quite permissible to have competent general practitioners monitor the patients. Our conclusion is that notwithstanding the Protocol, it appears that it was not absolutely necessary to have the AZT distributed to patients directly from a specialist or for the specialist to do the monthly assessment. A general practitioner, sufficiently instructed by a specialist, could carry on this role.

Dr. Schlech and Dr. Johnston testified that the laboratory work required by the Protocol was quite straightforward. The significant ones would be a complete Blood Count (CBC) with Differential as the major toxicity of AZT was related to blood counts. There were also chemistries to be done; for example, testing liver and renal functions to assess whether there were side effects. These tests need not be administered by a specialist. They did not require sophisticated equipment or analysis and a crude CBC could be done at sea, although, the chemistries could not be done on Canadian naval vessels.

The issue of sufficient supply of AZT for use by a patient who might not be able to make monthly visits to his physician was raised in the evidence as well; however, it was clearly demonstrated that any problem that existed in this respect disappeared after the first few months of the trial study. Apparently, physicians were then able to access more than one month's supply at any given time, if the circumstances warranted. It seems that two or three month's supply could have been given to the patient or the ship's dispensary. Moreover, AZT had a long shelf life and did not require refrigeration.

(iii) Side Effects Of AZT

Evidence was given about the side effects of AZT. Dr. Schlech said that when a person initially starts the drug, he or she may suffer some nausea. In his experience of approximately 170 patients, only one had to terminate AZT therapy because of this side effect. If patients persevere, this side effect is usually gone within a week or so and doesn't require any real intervention. In Dr. Schlech's opinion about one out of twenty might have a side effect of this kind.

Another side effect is the possibility of headaches and approximately 5% of patients suffer these. Of those, perhaps one or two patients of Dr. Schlech have had to stop the drug entirely because the headaches became too severe. Dr. Schlech testified that if most patients who have such headaches persevere, they will go away and the matter will resolve itself. Anaemia, a deficiency

of red blood cells, is another side effect of AZT. It occurs fairly frequently particularly in patients taking the higher doses of 1200 mg./day of AZT that patients were initially using in 1988. This problem is usually minor, and does not require acute intervention but rather a reduction in the dose of AZT. The anaemia usually develops rather gradually over a month to two months if it is going to occur at all and usually stabilizes or equilibrates as therapy continues. It is less than 3% of patients who develop significant degrees of anaemia. Vigilance by measuring haemoglobin during the induction period is necessary. But once a point of stability is achieved after two months, there is less risk of anaemia occurring.

Dr. Schlech saw no problem with a patient who was on AZT of going to sea so long as he or she had sufficient lead time on the drug beforehand and the patient during that period had not shown any anaemia and had been fairly stable. He felt that in such a situation he would certainly feel comfortable with the fact that laboratory tests were not being conducted every month.

Furthermore, although AZT was theoretically an investigative drug, ample experience with it in the United States provided a sufficient base of information as to its possible side effects and their control to permit patient use even when in isolated places.

(iv) Possibility Of Opportunistic Diseases

There is no doubt that when patients have a severely depressed T4 cell count, they may be considered to be at grave risk of developing a serious opportunistic disease. There is a wide range of diseases that could be life threatening including PCP (62% of cases) and Kaposi's Sarcoma (17%). However, such opportunistic diseases are rather gradual in their onset and so long as a patient is alert as to symptoms and signs, there would be ample time to get appropriate medical care.

It is possible that individuals can present at a late stage but it should not happen with patients who are knowledgeable about symptoms and conscious of what is going on. There have been instances where a patient may not be aware of its progress until relatively later in the development of the opportunistic infection because the prodrome of an infection such as PCP can be so gradual and the individual has denied or ignored the symptoms. The prodrome typically extends over weeks or over a few months but the person can present in an advanced stage in 24 to 48 hours. Such persons are likely to be non-compliant with treatment and non-vigilant.

Also, Dr. Schlech testified that the symptomatology of PCP is quite specific. In other words, the symptoms are not just a cough per day over a period of time which might not be recognized by an individual as a symptom of PCP. Rather, it is a cough that begins and resists such that it is very noticeable to the individual. Moreover, the shortness of breath which could also be a symptom is not mere episodic shortness of breath but rather something akin to someone who may have to stop at the top of stairs to catch his or her breath. Thus, the symptoms are dramatic even if they are rather indolent in their onset.

Counsel for the CAF has argued that the basis for the military's concern back in 1987 and 1988 was over the fact that these opportunistic diseases could arise rather abruptly. Yet, if the matter was examined closely and if an appropriate dialogue had taken place with Dr. Schlech, and/or

Dr. Johnston, and an assessment made in that light, it would have been reasonable to conclude that with a patient such as Thwaites, there was little, if any likelihood, that any opportunistic disease would come on suddenly without there being sufficient time for detection and appropriate treatment. It would appear that there would be no greater chance of Thwaites suffering sudden incapacitation than someone else who might, for no apparent reason, suffer a seizure or a stroke or cardiac arrest. If such occurred, there would have to be the traditional reliance on the medical services available on board or on medical evacuation by helicopter. An HIV positive member would have available to him or her the same medical emergency services (limited though they may be) available to anyone suffering an unexpected sudden life threatening incapacitation. On a comparative basis, the risk to Thwaites was not significantly higher than the risks tolerated by the CAF for others serving at sea.

(v) Inevitability Of Opportunistic Disease

Based on Dr. Cameron's evidence, counsel for the CAF submitted that a distinctive feature of this case was the cumulative aspect of the risk, i.e. that sooner or later, but inevitably, an opportunistic disease would befall Thwaites. Although certain therapies in 1988 were being applied which would have a prophylactic effect, nevertheless there was this cumulative risk that some day an opportunistic disease not prevented by such therapies would develop. Accordingly, if Thwaites was at sea for one-third of the time that he served as a NESOP then it follows that there was a one-third chance that he was going to develop an opportunistic disease while at sea and out of reach of appropriate specialist care.

However, we feel that it is not the inevitability of opportunistic disease, or indeed death, which can legitimately be factored into the assessment of risk. Rather, it is the suddenness or abruptness of the incapacitation which would create risk for the individual, others and the mission as a whole. Absent that, the fact that a member of the CAF has a terminal condition does not necessarily prevent that individual from performing his or her occupation and functioning as an effective and risk free (at least comparable to others) member of the Forces for the balance of his or her life. So long as there is reasonable assurance that the individual's condition is being monitored by both himself or herself and by the available medical staff and given that the onset of an extreme condition can be detected and treated within an appropriate time frame, then the risk of harm is sufficiently controlled.

(vi) Failure Of Communication

The turning point for the CAF was the pivotal letter of November 12, 1987 from Dr. Schlech. There followed, however, a series of letters to the CAF which, it appears, were largely ignored as to their content (although they did confirm in Dr. Smith's mind that Thwaites was indeed required to be followed monthly by a specialist). Among other things, the following notable comments appear in these letters:

November 27, 1987 - "He remains relatively asymptomatic... "Examination today revealed a well looking gentleman in no distress ...

Mr. Thwaites does continue to have some systemic symptoms, mainly of decreased energy, but they are quite mild."

January 28, 1988 - "He is doing well on AZT therapy ..."

March 11, 1988 - "Simon does appear clinically improved."

April 8, 1988 - "He has been really doing quite well in the past month. ... In summary, he seems to be doing quite well."

May 6, 1988 - "He has been doing quite well, continuing on his AZT without any side effects".

June 3, 1998 - "He is doing very well on AZT without major side effects."

July 4, 1988 - "Simon continues to do well on the AZT therapy."

August 3, 1988- "He continues to tolerate his AZT quite well."

Thus, during the period that a decision was taken to restrict Thwaites' geographical rating to G5 and a decision ultimately taken by the CMRB to release him from the CAF, there was an indication from the treating physicians that Thwaites was asymptomatic and doing well on AZT therapy. Yet, for some reason, no one in the CAF picked up the telephone and called Dr. Johnston or Dr. Schlech to discuss Thwaites' condition and the ramifications it may have for his career in the CAF. Had they done so, they would have learned from Dr. Johnston that when Thwaites went on AZT in January of 1988, he was essentially asymptomatic contrary to what was said in the November 12, 1987 letter; but it was felt that the diagnosis had to be overstated somewhat in order to obtain for him the benefit of AZT therapy under the Protocol. Although Thwaites had night sweats, they were not of a type to be HIV related but they permitted Dr. Schlech to categorize Thwaites within a symptomatic class in order to access AZT.

AZT was beneficial for HIV patients who were asymptomatic and they did better if they were started on the drug as early as possible. Thus, physicians did not adhere literally to the requirements of the Protocol but were prepared to shade their diagnosis to get their patients on AZT.

Dr. Johnston testified that Thwaites was as well as other healthy patients in his age group that she treated either with HIV infection or other illnesses not related to HIV. Furthermore, as Dr. Johnston testified, HIV infected patients are more apt to report and exaggerate symptoms, regardless how minor, early in their diagnosis rather than in later stages because they do not know the significance of them yet. This is part of the process of getting in tune with their illness. In fact, over the time he was on AZT, Thwaites remained asymptomatic. But none of these matters were discussed between the CAF physicians and Dr. Schlech or Dr. Johnston.

Consider the following exchange in Dr. Schlech's testimony:

"Q. This is my really final point. You said that you wished you had a conference with Dr. Smith. Dr. Smith's testimony was to the effect that they took from you Mr. Thwaites' clinical situation and took from your letters and your conduct what was required of him in terms of attendance and so on and then they, as the military people, had to plug that in to make a determination as to whether he could be fitted into the military. Now does that strike you as reasonable or unreasonable for Smith to say that that's a decision for the military to take in terms of --

A. Well, I think the military has to take the decision it feels it needs to take. I think that our goal would be to provide the best information. I'm not sure in something of this gravity as far as a person's career and that type of thing that simply an exchange of letters or a brief, you know, couple of minutes phone call or something is appropriate is all I'm saying. In retrospect, considering all that's happened, my preference would be, as I'm sure it might have been the military's preference, to sit down and let's really go over this case and look at the implications both for medical care as well as career situation.

Q. Is that preference at all driven by the fact that you now wished to back away from your description of him as being CDC Group 4?

A. It has nothing to do with that. It's my preference in any case where difficulties arise in a career or medical care. I think that our goal is to communicate as fully as possible and, once again, I think that in retrospect it would have been nicer to maybe spend more time discussing the realities of the case." (Transcript of Evidence, Vol. 12, pp. 2005-2006)

Earlier, Dr. Schlech, had testified:

"In retrospect, you know, my preference in this case, and I think we can all learn a lesson from this, is that what we should have done is had a conference with Dr. Smith, Mr. Thwaites, myself, and say, Look, let's put it out on the line, okay. If we have to make these geographic restrictions, then his career is in jeopardy, okay. What you really think about the need to follow up blood work and other things, and then I would either decide, well, gee, I'm either trapped by the protocol and must do this and, therefore, Simon cannot have access to this agent. Or I would have said, Okay. let's see what we can do to allow him to take the agent but continue on his regular duties including any geographic thing. In retrospect, that's what should have been done. Often the communications are not that good and, therefore, I think things sort of developed in isolation without a lot of conversation about the necessity for doing this. And I certainly, as I've stated before, would have "bent over backwards" in order to, one, make the drug accessible to him; and, secondly, to insure that he would be able to carry out his career goals as well. But those issues never really came up in the course of how we were operating in our clinic and how the military was operating on the other side." (Transcript of Evidence, Vol. 12, pp. 1971-1972)

All agree that there was an unfortunate lack of communication between the doctors. Dr. Schlech feels somewhat responsible for not advising the CAF himself that intensive specialist care was not necessary. However, the law certainly places an obligation upon an employer to accommodate a disabled person to the extent that it can reasonably do so. Concomitant with that obligation is the necessity by the employer to make the appropriate inquiry to ensure that a realistic assessment of the individual has taken place. In view of the letters written by the treating

physicians, subsequent to November 12, 1987, sufficient indication had been given that Thwaites was asymptomatic and doing well. This should have been followed up by the CAF's physicians to ensure that nothing short of release would do. The fact is that neither Dr. Schlech nor Dr. Johnston were ever specifically asked any questions by the CAF medical people as to what could be done with respect to Thwaites fulfilling his duties as a NESOP. There were no discussions concerning what problems would arise with Thwaites going on AZT and whether he indeed had to be seen by a specialist on a monthly basis as required by the Protocol or whether any changes to that schedule could safely be made. The failure by the CAF physicians to inquire further of the specialists is particularly puzzling in view of the following facts:

(a) The CAF was dealing with a new and relatively unknown disease, and thus greater consultation with the specialists would have been expected;

(b) Thwaites was one of the very early CAF members who contracted the HIV infection and thus his file should have attracted special attention;

(c) The CAF did not at the time have an in-house HIV/AIDS specialist and, therefore, regular consultation with Dr. Schlech and/or Dr. Johnston would have been appropriate;

(d) Dr. John Smith, the Deputy Command Surgeon, at the time, knew Dr. Schlech before Thwaites had been referred to him and had referred other patients to him. They had a professional and personal relationship which should have facilitated easy and regular communication between the two of them. Although Dr. Smith advised Dr. Schlech that he had approved Thwaites' AZT treatment, strangely, he did not address with Dr. Schlech the longer career ramifications for Thwaites of his going on AZT.

In our view no real assessment was made by the CAF as to whether the theoretical risk of sending to sea an HIV member in Thwaites' condition had any basis in fact. No attempt was made to determine the actual state of Thwaites' condition and the nature of the risks that such condition posed in comparison with the usual risks that seamen face, and what, if necessary, could be done to work around the condition to reduce the risk to an acceptable level.

(vii) CAF'S HIV Policies

What is curious is that the CAF policies on HIV positive members have moved from one of individualistic assessment to a rather generalized approach to all members who fit within a particular stage of the disease regardless of the individual differences that may exist among those members in regard to the type of medical care that is required. The November 8, 1985 interim guidelines for dealing with HTLV - III infection in the CAF emphasized individuality and the need for case by case assessment. It did not provide for the automatic regrading of a member.

Paragraph 20 of the guideline stated:

"20. HTLV-III infected persons will require individualized medical follow-up and, if symptomatic, will likely require some medical restrictions that could involve a change in medical category. Of particular note is that these persons are likely at increased risk for infection and

adverse reactions to the administration of live vaccines. Some advice for symptomatic HTLV-III infected persons is contained in Annex D. It is inappropriate to specify an across-the-board medical category for infected persons; the category will result from restrictions which, in turn, will depend upon the clinical status and trade or classification." (Emphasis added).

On February 2, 1988 the CAF issued a directive for discussion purposes (NDHQ 6635-2-2 DPM 2) which suggested a G3 category (Fit for sea, field, isolated and UN duties) for HIV infected but non-symptomatic members. However, several field comments urged a more restrictive category mainly based on the fact that clinical deterioration was a real possibility, could be sudden, and may need urgent diagnosis and therapy of an advanced type to provide the optimum result. Therefore, a more restrictive category than G3 was recommended and in fact incorporated into the directive. The medical directive which was issued on May 9, 1988 specifically directed that members who had clinically expressed HIV disease requiring fairly frequent medical follow-up of a specialist nature would get a geographic category no better than G5. Those HIV infected members who were asymptomatic would be issued a G4 category (unfit sea, field, medically isolated and UN duties; physician services required). Thus, the CAF had moved from a truly individualized approach to the problem to a more category driven designation depending on the particular stage of the disease in which the afflicted member found himself or herself.

The most recent guidelines set out in Medical Directive 2/91 allow for a temporary G4 category while the HIV infected member is being assessed. Once that is completed, if asymptomatic and inter alia if his or her T4 cell count is in normal range, then the member will be given a G2 rating. If the T4 cell count fell below 500, G4 would be assigned. If specialist treatment is indicated, then a G5 (or G4, as apparently provided for in a decision taken in December 1991) profile will be awarded.

As Dr. Sutherland testified, it was the implementation of this category approach in early 1988 which essentially caused him to issue a G5 rating to Thwaites. Dr. Schlech's letter of November 12, 1987 indicated that Thwaites was symptomatic and being put on AZT and for Dr. Sutherland that required the application of the new directive and the downgrading of Thwaites to a G5 rating without the necessity of further personal assessment of Thwaites' medical condition.

If anything, the development of human rights law over the last few years has held that arbitrary policies of a general nature routinely applied without personalized assessment of the individual cannot stand. For a large institution such as the CAF, there would be a natural preference to apply a general policy since its administration would be an easier task than individual assessment. Moreover, the 1988 directives have the deceptive appearance of an individualized approach since they specifically deal with various stages of the HIV infection. However, even within those stages individuals vary as to their abilities to function and their need to access regular specialist services and care. The CAF cannot escape its responsibility for dealing with such members as individuals and should return to the position stated in its original guidelines that it "is inappropriate to specify an across-the-board medical category for infected persons"; rather, appropriate consultation should take place with the treating physician and a decision made on the real, not perceived, circumstances of that person. It is no longer sufficient to consider diseases in the abstract without regard to how the particular person in question is actually coping with his or her affliction.

(viii) Inadequacy Of Review

Nor did the various review levels provide the appropriate safety net for an adequate assessment of Thwaites' condition. Every military occupation has a minimum medical standard which reflects the level of medical fitness required to perform the duties of that particular occupation. The geographical and occupation profile of a NESOP is G202. There are no military occupations that have a profile below G303. When permanent illness or injury leads to a downgrading of a member's category below the minimum required for his or her occupation, the member's situation must be reviewed to determine whether he or she has a viable career in the Forces. In Thwaites' case, a G5 category was recommended by the Base Surgeon and then reviewed at Command level, at Headquarters level and ultimately by the CMRB. The CMRB has the responsibility of reviewing the case of every member whose medical profile has been downgraded below that required for his or her military occupation. The Board's decision in each case normally consists of one of the following:

- accommodation of the member's disability or condition and retention in present occupation without career restrictions; accommodation of the member's disability or condition to the point of retention in present occupation with restrictions placed on the member's career progression;

- accommodation of the member's disability or condition by means of remuster to a trade or transfer or posting in which the member can be retrained and function fully; or

- release - According to the CAF medical review procedures: "Release is recommended only when the member cannot reasonably be expected to perform a significant proportion of the duties required of him/her in his/her current rank and occupation, and when he/she is not considered suitable for remuster to a vacancy in another military occupation."

- delay the question until some further time allows the Board to know more about the member's health.

The CMRB process in the case of Thwaites was nothing more than a paper review. It was merely a review by a number of non-medical CAF members sitting in Ottawa (with the benefit of a non-voting general practitioner present) of the documentation provided to them. The CMRB did not seek out the advice of Thwaites' treating physicians in order to obtain his true medical status and prognosis. This was a medical review in name only. It was not an independent assessment by any stretch of the imagination. So, after all is said and done, the decision to release Thwaites hinged solely on Dr. Schlech's November 12, 1987 letter, without any dialogue or follow up with the treating physicians. The process was described as a "review" system but, in fact, all of the CAF doctors closed their minds to the matter following Dr. Schlech's November 12, 1987 letter. In essence, a G5 category was assigned to Thwaites by Dr. Sutherland solely on the basis of Dr. Schlech's letter and in accord with the new HIV policy which had just come into place. At the point of making this decision, Dr. Sutherland had not yet even seen Thwaites nor had any contact with the treating specialist. When the matter came before the CMRB, the G5 rating was accepted without any real assessment of Thwaites and release was ordered. In this entire process, Thwaites was never given the benefit of any meaningful individual assessment which is his right under the law.

In fact, at the conclusion of the Grievance process which ended unfavourably for Thwaites, The Chief of Defence Staff, General de Chastelain, acknowledged errors in the documentation in Thwaites' file and specifically that the medical statement of March 29, 1988 to the CMRB was in error in describing Thwaites as symptomatic from HIV infection. He conceded it should have read that he was asymptomatic. This just highlights the inadequacy of the review that had been undertaken. There had in fact been no medical review.

(ix) Reasonable Measures To Lessen Any Increased Risk

In an ideal world, the cautious approach, for physicians, the CAF and the patient himself would be to restrict Thwaites' lifestyle so that he would always be in fairly close proximity to a specialist knowledgeable in HIV infection and to appropriate hospital facilities, particularly while he was on an investigative drug. The earlier the diagnosis of incipient opportunistic infection, the greater the possibility of successfully combatting it. However, people with disability have the right to seek out and attain for themselves as normal a lifestyle as they would like to and as their capabilities permit, unless doing so would significantly increase risk to safety. They are entitled to be employed without undue limitations or restrictions short of causing undue hardship for their employer. With respect to medical treatment, Dr. Schlech acknowledged that there were different levels of care that he was prepared to give his patients. His view is that it is the whole patient that has to be taken care of and that means a doctor has to look beyond just the medical situation but the entire life situation of his or her patient. Although it may be better to treat HIV positive patients and keep them restricted geographically, close to Dr. Schlech's clinic, he felt that there has to be accommodation to the individual's lifestyle and adjustments made in order to allow an individual to travel to locations quite remote from any significant medical centre so long as it can be done with relative safety. Dr. Cameron agreed that a physician should be flexible to accommodate medical therapy to the individual's life goals so long as the patient is aware of and willing to accept the attendant risks.

Although he was never asked at the time, Dr. Schlech did testify that if there had been a discussion about the possibility of Thwaites going to sea, he would have wanted to talk to or brief the military medical doctors or assistants about the management of patients with HIV.

There is no doubt that the presence of HIV infection requires close follow-up and awareness of signs and symptoms to ensure early recognition of problems. This, of course, places a greater burden on the medical staff on board a ship to become knowledgeable about signs and to familiarize themselves with Thwaites' condition and to be watchful. There would be continual concern over the possibility of opportunistic infection developing or some risk of AZT complications. This would be so whether Thwaites was on shore or at sea. But there is no reason to believe that a well-briefed medical assistant (on a destroyer) or a general practitioner (on a auxiliary oiler) would not be able to cope with any incipient problems that could arise. Because Thwaites has been a compliant and vigilant patient, the risk of a sudden onset of opportunistic disease without detection of early warning signs was quite remote. Moreover, it appears that if necessary, certain rudimentary but sufficient blood tests could be conducted on the ships to control for anaemia and to give better insight into whether there was a greater risk of an opportunistic infection developing. If doubtful about the situation, there could be radio

communication with the supervising specialist. These accommodations which would not have caused undue hardship to the CAF would have lessened the degree of risk faced by Thwaites.

There is no doubt that Thwaites' going to sea and being away from direct specialist care would have increased the risk element but we are not satisfied that the increased risk was sufficient to warrant his exclusion.

(x) Other Alternatives To Release

At the very least, if the November 12, 1987 letter posed legitimate concern, the CAF could have placed Thwaites into a temporary category for six months (with extensions, if necessary) until a sufficient period had passed to determine the effects of the AZT treatment by which time the resulting reassessment would either raise Thwaites' grading or confirm it as permanently reduced.

Alternatively, certain limitations could have been placed on his duties as a NESOP. For example, given the few NATO missions that such individuals are sent on, (one every three years or more) he could have been relieved from that duty which required being at sea for three to four months at a time.

The CAF argued that in view of the principle of universality of service of the CAF, there was no way to accommodate Thwaites in that trade by changing the nature of his duties so as to avoid either his going to sea altogether or to excuse his going to sea for long periods of time. His retention would result in an inequitable proportion of postings to bases and static positions; others in the same occupation would have to serve greater shifts at sea to make up for this accommodation. Nor could his position in the CAF be salvaged by permitting him to remuster to some other occupation. However, it is difficult to believe that the CAF's sea/shore ratio was not sufficiently flexible to accommodate Thwaites' needs. Certain exceptions have traditionally been made from the sea/shore rotation policy and there was no evidence that so accommodating Thwaites would cause the CAF undue hardship in this instance. This would have been in keeping with the CAF's own policy as stated in its "Medical Standards for the Canadian Forces" at p. 3-2:

"When the classification is lowered below G2 02, it is necessary to outline briefly the disability, to enable personnel administrative officers to deal intelligently with the person. A close liaison between medical and personnel administrative officers will ensure that a man with a medical limitation is employed to his best advantage as well as in the best interest of the Service."

Thus, release from the CAF was too drastic. Medical limitations' policy in the CAF supports accommodation and yet no attempt at any accommodation was made for Thwaites.

VII. CONCLUSION

When all is said and done, the one real issue that this Tribunal must decide is whether the Respondent, CAF, could (and should) have made further enquiries of Dr. Schlech, Dr. Johnston and Thwaites himself following receipt by the CAF's non-specialist medical personnel of Dr. Schlech's November 12, 1987 letter. Alternatively, could (and should) the CAF have taken the

opportunity to have Dr. Schlech, Dr. Johnston or Thwaites appear personally before the CMRB in order that there be a proper opportunity for individualized assessment?

The question for this Tribunal therefore is whether this would set a standard of individual assessment which is greater than the CHRA requires and is, therefore, too high.

In addressing this question, we have considered the following facts which, at first blush justify the CAF's reliance upon Dr. Schlech's November 12, 1987 letter:

1. The CAF is a large organization but did not have an Infectious Disease Specialist on staff at CFB Halifax so it was reasonable for it to rely upon reports from a civilian expert in assessing Thwaites' medical condition.

2. The CAF referred Thwaites to the Province of Nova Scotia's leading specialist as soon as his HIV positive status was brought to their attention.

3. The CAF did not take steps to dismiss Thwaites on the basis of his HIV positive status until correspondence from Dr. Schlech put Thwaites in a category which necessitated (or desired) an experimental drug.

4. In their testimony, Drs. Schlech and Johnston as well as Professor Wainberg, agreed that it was appropriate (and indeed in Thwaites' best interests) to resolve any question of doubt in their minds in favour of a diagnosis that would put Thwaites in a category that would qualify him for the only known treatment, namely, AZT. Thus, the November 12, 1987 letter described him as symptomatic; the letter, however, does not raise the issue of doubt which the Tribunal accepts existed in the mind of Dr. Schlech (and perhaps Dr. Johnston) at that time.

5. Although Dr. Schlech testified that he saw no problem with a patient on AZT going to sea (provided certain requirements were met) this information was never communicated by him to the CAF.

6. There is no direct evidence to suggest that Thwaites himself questioned whether his AZT treatment would inevitably result in his discharge; the Tribunal heard evidence only that he questioned whether the costs of the treatment would be covered by the CAF benefits plan since AZT was, at the time, experimental.

7. The CAF's medical personnel to whom Dr. Schlech was reporting did not have the same ability to appreciate the significance of the information provided to them about Thwaites' condition, i.e. whether he was symptomatic or asymptomatic.

8. It is not a simple task for medical experts in 1992 to draw their minds back to the level of medical knowledge which they had about HIV and AZT at the time that the letters were written and the decisions made concerning Thwaites' health and employment.

As a question of fact and bearing in mind the purpose of the governing legislation, we conclude, however, that the CAF did not go far enough and did not do what it could to reasonably and

properly assess Thwaites. It failed to make a full assessment of Thwaites' condition and determine whether he was exposed to risks significantly greater than the usual risks for those who are not disabled of going to sea and being remote from hospital facilities and specialist care should an unexpected medical emergency arise. In essence, the CMRB decision to dismiss him was not based upon the most authoritative and up-to-date medical, scientific and statistical information available. No individual assessment was performed to determine how he was functioning at the various stages of his infirmity. Moreover, the CAF has failed to show that it could not otherwise reasonably and practically accommodate Thwaites' needs without exposing him or others to unacceptable risks. Nor did it demonstrate that no other reasonable or practical alternative (other than dismissal) could have been found for Thwaites. Accordingly, the complaint has been substantiated.

VIII. REMEDY

The final issue to be addressed is that of Thwaites' remedy and in particular the loss of wages, expenses and special compensation to which Thwaites is entitled as a result of the CAF's breach of the CHRA.

(a) Loss Of Wages

At the opening of the case, counsel for Thwaites indicated that she would be seeking damages as a result of the financial losses and emotional suffering which he had endured as a result of his discharge from the CAF. Most of the evidence which the Tribunal heard in relation to the issue of loss of wages came from two experienced and well-regarded actuaries.

In this regard, counsel for Thwaites called Mr. Brian Burnell to give expert actuarial evidence on Thwaites' past and future loss of income. In response, counsel for the CAF called Mr. Michael Cohen. Both experts had prepared very detailed reports and explained their assumptions and calculations in viva voce testimony before the Tribunal. In the case of Mr. Burnell, the basis of his testimony is contained in three documents entered as Exhibits C1, C3 and C7. Mr. Cohen's evidence is summarized in Exhibits R32, 33 and 34.

There was no disagreement between Mr. Burnell and Mr. Cohen on the interpretation of statistical data nor on the use of the 'middle scenario' of transition from HIV positive to AIDS as a reasonable assumption on which their respective calculations should be based (see transcript page 3103). Further, the Tribunal understood from both actuaries that subjective medical information about Thwaites' condition was not considered (transcript pages 3091-3095 and 3106).

(b) Past Income Loss

On the issue of past income loss (to June 1992), the actuaries' opinions differed slightly. Mr. Burnell's calculation totalled $112,734.00 whereas Mr. Cohen's was $97,132.99. The Tribunal finds that this difference was attributable to three factors: first, to an assumption made by Mr. Burnell about sea pay being paid to Thwaites 100% of the time; Secondly, by some differences

in income figures used for the 1989-1992 years (see transcript pages 3116-3119); and, finally, a small mathematical mistake contained in Mr. Burnell's report, C7, at Exhibit B.

The Tribunal is satisfied that the assumptions and calculations made by Mr. Cohen on this portion of Thwaites' loss should be accepted over those of Mr. Burnell and, therefore, subject to what is stated later, it is the figure of $97,132.00 which the Tribunal accepts as the best actuarial evidence of Thwaites' loss of income to June 1992.

(c) Future Loss Of Income

On the issue of future loss of income, the mathematical calculations of the actuaries differed substantially with Mr. Burnell's opinion being in the range of $150,000.00 (after some adjustments flowing from the evidence of Mr. Cohen) and Mr. Cohen's opinion being $66,218.00. Once again the differences related to the assumptions made by the respective actuaries (sometimes on the direction of counsel). These differences are summarized as follows:

1. Mr. Burnell assumed sea pay would be paid 100% of the time; Mr. Cohen assumed 75% (transcript page 3108);

2. Mr. Burnell assumed Thwaites would progress through the ranks of the CAF with automatic promotion; Mr. Cohen did not make this assumption believing that it would be dependent upon a number of other factors, i.e. the availability of a position in the rank at any given time (transcript page 3107);

3. Mr. Cohen assumed a higher mitigating income from Thwaites' employment in the video store or elsewhere (transcript page 3128);

4. The interest discount factors utilized by the experts were not consistent. Mr. Cohen's report assumed a real rate of return of 6% grading down to 3.5% after 5 years and an inflation rate of 4.5% (transcript pages 3139 - 3141);

5. Mr. Cohen used 1983 as the year in which it is assumed Thwaites became infected with the HIV whereas Mr. Burnell used the year 1984 (transcript page 3178);

6. Mr. Cohen's report made no allowance for the fact that medical expenses beyond 3% were tax deductible (transcript page 3153).

Because of these different considerations, the experts' conclusions on future loss of income differed by approximately $100,000.00. Once again, the Tribunal concludes that the assumptions and calculations of Mr. Cohen are more consistent with the facts than those represented in Mr. Burnell's report and, therefore (subject to what is stated later herein), the Tribunal accepts that the best actuarial evidence of Thwaites' future loss of income (from and after June 1992) is $66,218.00.

(d) Factors Not Considered By The Actuaries

Certain factors which occurred to the Tribunal to be relevant were not considered by either actuary. Neither Mr. Cohen nor Mr. Burnell addressed as a mitigating factor whether Thwaites would have left the CAF's employment for factors aside from his HIV positive condition (Transcript page 3181). However, the Tribunal heard evidence from many CAF witnesses and Thwaites himself which clearly indicated that Thwaites had been disillusioned with military life in 1985 and had applied to be released from the Forces (see Exhibit R1 at Tab 11).

Of perhaps even greater significance, the Tribunal was interested in receiving the most up-to-date and authoritative evidence possible on Thwaites' life expectancy in order to address potential damages over his future working life. In this respect, both actuaries testified that they utilize scientific data which is more objective than subjective and do not consider medical opinions expressed on the individual. (We note however that Mr. Cohen's report contains a note on page 2 to the effect that Thwaites' current medical condition may indicate that the "middle scenario" may be overly optimistic). While scientific evidence may be the correct basis for an actuarial report, this Tribunal must only grant damages that flow from the discriminatory act and, in our opinion, the medical evidence received from Drs. Schlech, Johnston and Professor Wainberg is of great value in assessing whether the range of damages suggested by the actuaries for Thwaites' future income loss is reasonable.

In this regard, although admittedly not embodied in his report as a consideration, Mr. Cohen testified that eyeballing his calculations, if an award of $66,218.00 for future loss of income were made, Thwaites would effectively be compensated for a future loss of income (and therefore a corresponding life expectancy) of five years from June 1992 (see transcript page 3187). Mr. Burnell's figures would therefore suggest a far greater life expectancy than that expressed in Mr. Cohen's opinion. The opinion expressed by Dr. Schlech on the life expectancy of an individual with characteristics similar to Thwaites who had AIDS (under the current proposed definition) was 2.5 - 3 years (see transcript page 1930). Applied to the facts of this case, Thwaites could be said to have AIDS from and after February 1991 after which date the Tribunal had no evidence of a T-cell count in excess of 200. The most up-to-date medical evidence therefore would (subjectively speaking) suggest a life expectancy of only 14 months from June of 1992 calculated as 2.5 - 3 years from February 1991. As a result, the Tribunal is satisfied that Mr. Cohen's opinion is the more reasonable of the two opinions expressed on future loss of income.

The Tribunal finds that the past ($97,132.00) and future ($66,218.00) loss of income calculations require the application of a contingency deduction for two reasons: first, to provide for the >- -
possibility that Thwaites would have discontinued his career with the CAF for other reasons either before or after June of 1992 and secondly, because Thwaites' current medical condition suggests that a life expectancy of five years from June 1992 may indeed be overly optimistic. As a result, the Tribunal applies a 10% contingency reduction to the accepted actuarial calculations of past and future income. In conclusion, the Tribunal feels that an award of $147,015.00 would be reasonable.

Thwaites' counsel in her written submissions also seeks compensation for expenses. With the exception of actuarial fees, the Tribunal finds that to award a sum for expenses incurred on Thwaites' bankruptcy, automobile, loan from parents, groceries, and others would either amount

to double recovery or would be too remote. This portion of his claim for relief is therefore denied.

(e) Special Compensation

That leaves for consideration the issue of special compensation under Section 53(3) of the CHRA. The Tribunal recognizes that the maximum award recoverable is $5,000.00 but in view of the ordeal that Thwaites and his family were put through in a public hearing that lasted in excess of 20 days over a period of seven months and the arbitrary way in which Thwaites was treated by the CAF, the Tribunal feels that the maximum recoverable for this head of damages is reasonable for Thwaites' hurt feelings.

(f) Interest

Thwaites is entitled to interest on the special compensation portion of the award ($5,000.00) from the date of his complaint. On past and future income portion of the award ($147,015.00) Thwaites is entitled to interest from and after June 1992 as interest prior to this date has already been factored into this portion of the award. Interest shall be simple and at the Bank of Canada prime rate.

(g) Costs

We feel, given the complex nature of this case, that Ms. Reierson served an important and useful function in acting as counsel for Thwaites. We agree with the Tribunal in Grover v. National Research Council (T.D. 12/92) that Section 53(2)(c) of the CHRA, granting the Tribunal power to compensate "for any expenses incurred by the victim as a result of the discriminatory practice" is of sufficient latitude to encompass the power to award costs. That Tribunal stated at p. 91:

"If the purpose of remedies is to fully and adequately compensate a complainant for the discriminatory practices, then surely the consequence of costs is part and parcel of a meaningful remedy for a successful complainant."

Accordingly, in the circumstances of this case, we order the CAF to pay the reasonable legal costs of Thwaites, including the actuarial fees incurred in support of the presentation of his case. If the parties cannot agree as to the amount, the costs should be assessed on the Federal Court scale.

(h) Nature Of Order The Tribunal orders that the CAF pay to Thwaites:

(i) $147,015.00 for past and future loss of wages under Section 53(2) of the CHRA plus interest thereon from and after June 1992;

(ii) $5,000.00 for special compensation under Section 53(3) of the CHRA plus interest thereon from and after the date of the complaint; and

(iii) reasonable costs of his counsel including the cost of actuarial services.

DATED this day of May, 1993.

SIDNEY N. LEDERMAN (Chairman)

GILLIAN D. BUTLER (Member)

ROGER BILODEAU (Member)