T.D. 8/94
Decision rendered on May 20, 1994

THE CANADIAN HUMAN RIGHTS ACT
R.S.C., 1985, C. H-6 (as amended)

HUMAN RIGHTS TRIBUNAL

BETWEEN:

CURTIS BRADLEY IRWIN
Complainant

and

CANADIAN HUMAN RIGHTS COMMISSION
Commission

and

CANADIAN ARMED FORCES
Respondent

DECISION

TRIBUNAL: RONALD W. McINNES Chairperson

APPEARANCES: PRAKASH DIAR For the Commission

DONALD J. RENNIE For the Respondent
ANNE M. TURLEY
MAJOR RANDY SMITH

DATES & PLACE August 23, 24, 25, 26, 27, 1993
OF HEARING: November 23 and 24, 1993
Toronto, Ontario

COMPLAINT

On April 17, 1990, Curtis Bradley Irwin ("Irwin") filed a Complaint with the Canadian Human Rights Commission (the "Commission") against the respondent, the Canadian Armed Forces (the "CAF") alleging that the CAF had discriminated against him on the ground of disability (asthma), contrary to

Section 7 of the Canadian Human Rights Act (the "CHRA"). He alleged that on September 29, 1989, pursuant to a Career Medical Review Board ("CMRB") decision, he had been released from the CAF on medical grounds because he was deemed unfit to perform his duties and not otherwise employable. Irwin took issue with this decision and alleged in his complaint that he had experienced no problems prior to the appointment of the CMRB. He admitted that he had asthma and stated that the CAF had been aware of his asthma since his pre-enrolment medical conducted on November 20, 1984.

By letter dated December 9, 1992 I was appointed by Mr. Keith Norton, President of the Human Rights Tribunal Panel, to conduct a hearing of this Complaint.

CAF MEDICAL STANDARDS

The following is summarized from the manual entitled Medical Standards for the Canadian Forces as it existed during the period that Irwin was in the CAF.

The CAF maintains a common medical categorization for candidates and serving members of the Forces. Medical category includes year of birth and six factors. The factors relevant to this case are Geographical Limitation (G) and Occupational Limitation (O). Medical category is determined by the results of medical examination and assessment in accordance with the manual of Medical Standards. Numerical gradings are entered under the designated factors.

The Geographical Factor is assessed in order to know where a person can be expected to perform efficiently. The main factors involved in this assessment are climate, accommodation and living conditions and medical care available.

G2 is the grade assigned to an individual who has a minor medical condition that does not require regular medical support and does not preclude employment in any climatic or environmental condition.

G3 is the grade assigned to an individual who has a medical condition that requires more frequent medical supervision. Such personnel have a requirement to seek medical care, but not necessarily a physician's services, approximately every three months.

G4 is the grade assigned, inter alia, to any individual who has a medical condition that has the potential for sudden serious complications or

a medical disability which is persistently mildly incapacitating. Such individuals will usually require readily available physician's services.

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The Occupational Factor involves an assessment of physical activity and physical stress, together with mental activity and mental stress, associated with the particular occupation or trade of the individual.

The O2 grade is assigned to an individual who is free from medical disabilities except for minimal conditions that do not impair ability to perform at an acceptable level of endurance in a front-line combat environment and to do heavy physical work.

O3 is the grade assigned to an individual who has moderate medical or psychological disability which prevents him from doing heavy physical work or operating under stress for sustained periods although he can do most tasks in moderation.

The common enrolment standard for new recruits is G2O2. The standards for various occupations or trades within the military are separately assessed and may be higher than the enrolment standard.

When a serving member is found to have a medical condition that requires recognition of a limitation in his employment, he will be reclassified under the applicable factor or factors. When the grading falls below that stated for his trade, the effect upon his military career of a member's employment limitation becomes a personnel administrative problem to be dealt with by a CMRB. Experienced tradesmen who have their category lowered will be considered for retention in the trade on their individual merits. Members may also be remustered to another trade.

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Medical conditions and physical defects which result in a category which is below standards are set out in the manual. It is recognized that some of the conditions are remedial or self-limiting and the category may be temporary until the condition is resolved. A suggested category for each condition is listed in the manual but this may vary depending on the severity of the condition.

One of the causes listed for a restricted category is "bronchial asthma in adult life" and the suggested category for this condition is G4 or 5 and O3 or 4.

FACTS

Irwin applied to the CAF in Saskatoon, Saskatchewan on May 17, 1984. At this time he was 19 years old, had completed high school and had been employed for several months as a doorman, bartender and other similar positions in. the hospitality industry after dropping out of a business course at a community college. His initial enrolment was through the Youth Training Employment Program for a one year period. Irwin was remustered in the CAF for a further three years in 1986 and again in May 1988 for further period to August 31, 1992. At some point, he was promoted from Ordinary Seaman to Able Seaman.

On November 20, 1984 Irwin completed a pre-enrolment physical examination in which he revealed that he had asthma. According to the Report of Physical Examination, he advised that he "was asthmatic up to 6 years ago" and "still uses Ventolin very intermittently".

On entering the CAF, Irwin selected the trade Marine Engineering Mechanic. The minimum medical standard for this trade is G2O2. He underwent

basic training at Cornwallis, Nova Scotia following which he was posted to Canadian Forces Fleet School, Halifax for sea and environmental training and Marine Engineering Mechanical training. Immediately after this, he was posted to the HMCS Ottawa where he worked at his trade until the time of his release.

Irwin testified that he was asthmatic throughout his military service but that symptoms were kept under control generally by the use of a Ventolin inhaler. He stated that he had never failed to perform his assigned duties nor had he taken time off because of asthma during his entire career in the CAF. He also testified that he had never in his life required hospitalization for asthma.

Irwin described his participation in the East Coast Naval Gun Run in 1986. This involved seven weeks of intensive physical training followed by several strenuous competitions on both the east and west coasts. He testified that he experienced no breathing problems and that his asthma was kept under control with his medication.

Considerable evidence was given about Irwin's frequent after hours visits to emergency departments of base hospitals. Thirty-two instances were cited. Irwin explained that, in almost all cases, this was simply to replenish his supply of Ventolin and that he preferred to go in the evenings

rather than take time off from his regular duties. There were, however, some occasions on which medical assistance was clearly required.

The first official notice of any problems related to his asthma came on March 1, 1988 when his medical classification was downgraded to G4O2(T3). T3

indicates that it was a temporary classification for three months. On April 11, 1988, following a consult with Dr. O'Brien, a resident in internal medicine, Irwin was again upgraded to G2O2 which permitted him to go to sea while his ship was undergoing an exercise called "workups".

One evening in June, 1988 Irwin presented himself at the emergency room at the base hospital in Halifax for a refill of his Ventolin inhaler. Dr. MacDonald, the Duty Medical Officer, was informed of this by the emergency room staff. It raised a concern in his mind because refills of prescriptions after hours was not standard procedure and he felt that there might be a problem with the continuity of Irwin's care and the assessment of his condition. On the following day, Dr. MacDonald contacted the Medical Assistant on HMCS Ottawa. The Medical Assistant expressed concern about an incident involving Irwin after a boiler cleaning exercise on board ship. This cleaning process had gone on for a matter of perhaps three weeks. The Medical Assistant apparently reported to Dr. MacDonald that Irwin had experienced increased shortness of breath and increased Ventolin usage as a result of exposure to certain solvents being used in the process. Dr. MacDonald asked for the medical documents from the ship to review and asked the Medical Assistant to set up an appointment for Irwin to see him. He met with Irwin on June 9, 1988.

Dr. MacDonald testified that he advised Irwin that he was concerned that G2O2 was not the appropriate medical category for him. He advised Irwin that one option would be to assign a temporary medical category again while they reviewed his situation and referred him for further assessment. He testified that

Irwin responded that he was getting tired of being checked up for asthma and that if he was going to be given a restricted medical category, he would prefer to know right away as he had other things to do with his life. Irwin's testimony was consistent with this.

Dr. MacDonald then discussed the situation with his superior, the Base Surgeon, who felt on review of the medical information that G4O3 might be a more appropriate category for Irwin. Dr. MacDonald then spoke to Dr. Guy, an an internal medicine specialist, who reviewed Irwin's medical file. Dr. Guy did not see Irwin on that occasion but made a recommendation for a G4O3 category on the basis of the medical file and the information provided by Dr. MacDonald. His report dated June 17, 1988 states:

"I have reviewed the CF 2034 as well as the CF 2016, and it would appear that OS Irwin's asthma may have been significantly more severe than was earlier appreciated. When seen by Dr. O'Brien in MOPD on the 5th of April of this year, information was obtained by Dr. O'Brien that OS Irwin was "able to do everything he wants to do" and as a member of the gun run team, in 1986, he has apparently had no significant difficulties.

Recorded in the CF 2016, is a comment that OS Irwin did in fact have an acute bronchospastic episode during that time, and history obtained today by Maj. MacDonald would suggest that there had been ongoing problems with exertional asthma in spite of treatment with both bronchodilators (oral or inhaled), and inhaled cortico steroids for at least several years.

Under the circumstances, several things should be done. The first is that this young man should be placed back on oral Theophylline in therapeutic doses (probably Theodur 400 mg. bid given that 300 mg. bid gave him subtherapeutic levels), and he should continue on his ventolin and Beclovent on a qid basis. As suggested on the 5th of April, we would normally see OS Irwin in MOPD in July for re-assessment.

Thirdly, it would certainly appear that a medical category of G2 O2 is not accurate. At the very best, OS Irwin would be G3 O3 (even if he were to become entirely asymptomatic with good exercise tolerance on "triple therapy"), a good case could be made for him being recommended for a G4 O3 medical category as the odds are that improvement with oral bronchodilators will only be partial, and not allow him to be completely fully active to the extent that someone in a "hard sea trade" might be otherwise expected to be. One option would be to give him a G4 Category temporarily but I gather that OS Irwin wanted things settled one way or the other. Under the circumstances, I think that' a recommendation for G4 O3 medical category is not unreasonable, particularly given the history as we now know it."

In order to change the medical category of a member of the CAF, a full medical must be performed. Dr. MacDonald performed this medical on June 30, 1988. In Dr. MacDonald's opinion, the significant finding was that there was a wheeze present on the examination of Irwin's lungs. At this time, Irwin was on "triple therapy" - Ventolin, Beclovent and Theodur.

In explaining the reasons for his conclusions, Dr. MacDonald stated:

> "When you assess the risk level in the situation, again you look at the potential for sudden and serious complications. In that sense, what Mr. Irwin required really was a physician to manage his asthma, with the triple therapy and occasional blood levels of the Theodur. In fact, with an exacerbation, he should have had access to a physician and, therefore, a G4 category, which includes physicians' services available, was appropriate in my mind."

As a result, Irwin's medical category was officially downgraded to G4O3. This meant that he was regarded as unfit for sea, field, United Nations or isolated postings and unfit for sustained arduous duty. It also meant that he was unable to go to sea which, in turn, resulted in him being unable to accumulate the

400 hours of sea time necessary for promotion to the next rank. His situation was referred for CMRB consideration with a recommendation, from his Commanding Officer, that he be retained in the CAF in another trade.

As a result of this recommendation, a personnel selection referral was made on February 21, 1989 for an assessment of whether Irwin could be transferred to another occupation within the CAF. A Personnel Selection Report dated March 9, 1989 recommended that he was suitable for a possible transfer to four other trades. According to the evidence of Captain Michel Dupont, Secretary of the CMR.B, the Personnel Selection Officer should not have made any recommendation to transfer him since he did not meet medical criteria for an occupational transfer. He testified that the lowest medical category for employment in the CAF is G3O3 unless there were special circumstances depending on rank and time in the CAF and that Irwin did not qualify for these special circumstances. However, an Occupation Transfer Request was sent to the Career Manager in each of the trades for which Irwin was recommended. All reported back that the particular trade in question was not a possibility for Irwin because of his G4 medical limitation and, in any case, there were no openings at that time or expected in the near future within that trade. Other evidence was given to the effect that most trades in the military were overstaffed at that time because of budget cutbacks and

changing technology and that this was particularly severe within the lower ranks.

All of this information was considered by the CMRB and in its decision dated June 1, 1989, it stated:

> "The Board agreed that there was no option but to release OS Irwin under the provisions of QR&O Articles 15.01 Item 3(b), 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. He is to commence terminal leave 28 Feb 90 or earlier if he so desires."

This decision was conveyed to Irwin on September 29, 1989.

Irwin chose to leave the CAF earlier than the termination date specified by the CMRB. He testified that he was involved with a young woman who had a job opportunity in Toronto and that he decided to go with her to Toronto and seek employment there. His last day in the military was December 28, 1989.

EXPERT MEDICAL EVIDENCE

Dr. Ronald Skrastins gave expert medical testimony on behalf of the Complainant and the Commission. Expert medical evidence for the CAF was given by Captain Cora Fisher and Dr. C.P.W. Warren.

Dr. Skrastins was qualified as an expert in asthma and pulmonary functions. He noted that asthma is a relatively common condition affecting of about 5% if the Canadian population.

Dr. Skrastins examined Irwin on August 16, 1993 shortly prior to the hearing. His report is dated August 19, 1993. The only medication which Irwin was using at this time was a Ventolin inhaler. Dr. Skrastins also reviewed a file of medical documents related to Irwin which had been provided to him by the Commission.

It was the opinion of Dr. Skrastins that, on August 16, 1993 the history given to him by Irwin was consistent with mild asthma dating back to age 12. He

stated that Irwin did not advise him of any time during his lifetime when he had needed either cortisone in pill form or intravenous cortisone medications commonly used to treat severe asthma symptoms. The fact that Irwin had never been hospitalized and had never required these types of medication led to him categorizing Irwin's asthma as being "mild".

It was Dr. Skrastins opinion that someone with mild, well-controlled asthma could manage quite well in isolated locations so long as they were sufficiently knowledgeable about their condition and medications to keep the asthma under control and so long as the appropriate medications were available. He felt that there was nothing in the history of Irwin to indicate that he was at any great risk of suffering a severe asthma attack and that, of the attacks which lie had had, all could have been controlled without the intervention of a physician.

On cross-examination, he admitted that any asthmatic, in whatever field of work, presented increased risk of reacting in certain situations. He was only giving an assessment of how he found the condition of Irwin when he saw him on August 16, 1993 and was not second guessing the opinions formed by doctors in 1988.

He also agreed that asthma was a condition that could wax and wane in intensity over the years and that severe.attacks could occur suddenly . He further admitted that he did not have any information other than that provided by Irwin as to what Irwin's responsibilities were in the military and had no information on the occupational specifications or job requirements that went along with his position. He could not express an opinion on Irwin's current

ability to serve in the military without reviewing in detail such occupational requirements.

Dr. Warren is the Associate Dean of Medicine at the University of Manitoba. He was qualified as an expert in respirology. He had reviewed the medical case history material on Irwin and in his medical report dated August 3, 1993, he concluded:

"My interpretation of the Canadian regulations for asthma is -

1) O.S. Irwin is G4 moderate to severe asthma since he requires prophylactic inhaler medication permanently (beclovent) and takes theophylline.

2) O.S. Irwin is O3 exercise or cold-temperature induced asthma requiring mild activity restrictions."

This was a conclusion with respect to Irwin's condition in 1988 and confirms the levels assigned by CAF medical personnel at that time.

With reference to categorizing levels of severity of asthma, Dr. Warren stated:

"This is a very difficult area because an asthmatic can be perfectly normal one minute and desperately ill the next and then by the next day be back to normal again. So we have to think about the severity of an attack. But we have to also think about questions like frequency of attack, persistence of attacks and things like this to try and figure them in."

On cross-examination , Dr. Warren also spoke of the "capricious nature of asthma" whereby a person can be feeling well and healthy but still have the potential of getting a sudden severe attack.

Dr. Warren also testified that the treatment provided to Irwin was consistent with acceptable medical practice at the time. However, with the information presently available, he would have had more concern about Irwin's condition and would have recommended more active treatment.

Captain Cora Fisher is Chief of Medicine at the National Defence Medical Centre. She was qualified as an expert in general internal medicine of which respirology is a sub-specialty. She was also qualified in military medicine and gave evidence with respect to the Canadian Forces Medical Standards. She emphasized that assessing the appropriate medical standard for an individual was a matter of both medical and military judgment in that it was necessary to understand the military task that someone has to do. Assessment of asthmatics involves a considerable amount of judgment since there are no tests which provide a reliable quantification of the risk factor.

She also spoke of the unpredictable nature of asthma, which she described as a "latent disability", and concluded:

"I have to regard the fact that there had been no incidents on the job as pure luck, because there had been enough other incidents that I am not quite sure I know why there hadn't been one on the job."

In her opinion, Irwin would have been in a position of risk had he continued in his trade.

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She testified that physician's services were not available on destroyers. She felt that it would be difficult for a Medical Assistant at sea to deal with an asthmatic attack of even moderate severity and went on to state:

"A Med A has basic level training, but even if there were a physician there, he wouldn't have all of the things he needed to deal with that kind of emergency. It is not just the people; it is also the realities. Destroyers, particularly Canadian destroyers, are small ships."

She further testified that neither an aerosol mask nor a ventilator would normally have been aboard a destroyer in the 1980's and that there are limitations on helicopter evacuations from destroyers; namely, distance and weather.

Captain Fisher had also reviewed Irwin's medical file and expressed her opinion that the medical category assigned to him in 1988 was appropriate. The particular aspects of his clinical history which she felt supported the assessment were the number of visits to medical facilities, the number of different triggers - things which precipitate asthma attacks - and the fact that he was described as still having a wheeze present when he was on triple therapy. The triggers for Irwin, as shown by his medical records, were cats, cold air, exercise, humid air and infections, either upper respiratory or flu.

She considered that the medical assessment and diagnosis of Irwin in 1988 was consistent with current prevailing medical theory and practice in Canada at the time.

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ROLE OF THE CAF

Evidence with respect to the structure of the CAF and its present day role was given by Major Julien Bibeau. Major Bibeau is posted to the Directorate of Force Concepts in Ottawa.

He stated that the role of the CAF as mandated by Parliament is to protect and defend the national interests of Canada; to enforce national security at home and abroad; and to enforce Canadian sovereignty and territorial integrity through the use of force, if necessary. The purpose of the CAF is to provide combat-ready forces, trained and equipped to face all kinds of scenarios in Canada or in the international environment under the UN and NATO.

Peacekeeping is also one of the priorities of the CAF. In 1989, the CAF participated in nine missions. To a greater or lesser extent, there were assignments to Korea, the Middle East, Cyprus, Iraq, El Salvador, Western Sahara, Yugoslavia, Cambodia, Somalia, Mozambique, Uganda and Rwanda.

All members of the military are expected to be combat ready and available on very short notice for deployment to a wide variety of geographic locations and climatic conditions.

Captain Karen Armour is with the Directorate of Manpower Planning in Ottawa. She testified with respect to the military occupational structure. Her testimony also emphasized that all members in the CAF are first military and then members of their occupation or trade. All personnel must be capable of serving under a wide variety of conditions without option. This could include postings to

remote locations where medical assistance and medication might not be readily available.

Irwin's trade and rank put him at the 312 level. Trades at this level are referred as "hard sea trades". All positions required service at sea with no ship/shore rotation and Irwin could not be promoted to a higher level without having served 400 watch hours at sea. As noted above, Irwin had not reached this number of hours at the time of his medical reclassification.

The Specification for Irwin's occupational category, a Marine Engineering Mechanic, describes the physical working conditions as follows:

> "Personnel are employed in operational (watchkeeping) duties in machinery spaces on a continuous three watch rotation for extended periods of time at sea and in harbour. Personnel perform maintenance

duties at sea and in harbour in enclosed and confined spaces above and below the waterline. They are exposed to extremely high noise levels, extreme heat, sudden changes in temperature, sudden changes in air pressure, and lung, ear and eye irritants. Their duties require physical effort and endurance, and on occasion, extreme effort is required. Personnel may also be required to work on weather decks in all weather conditions."

Lt. Kirby Smith, a Marine Engineer Officer, testified that this was an accurate description of the physical conditions. He also testified in detail about- the duties of a Marine Engineering Mechanic in the boiler room and engine room. He noted that there were circumstances where, if a marine engineering mechanic had to leave his station for medical reasons, it could result in a boiler blowing up and the ship being put at risk.

Lt. Smith also testified with respect to other exercises run by crew members when not on watch. Mechanical engineers form the nucleus of damage control teams fighting fires, either actual or simulated. During these exercises, members wear a rubberized fire-fighting suit over their regular clothing. This would include gloves, hat, boots and a full face mask self-contained breathing apparatus referred to as a "chemox". Evidence was given that it would be virtually impossible for a person to use a ventilator or bronchodilator under such conditions.

In addition, there was testimony by several military witnesses who expressed the opinion that there would be an overall decline in morale and crew efficiency if a member were unable, on a continuing basis, to carry out all the regular duties of his rank and occupation.

THE LAW

The onus is on the Complainant and the Commission to establish a prima facie case of discrimination.

Section 15(a) of the CHRA provides a defence if the discriminatory practice constitutes a bona fide occupational requirement ("BFOR"):

"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;"

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The burden of proof in establishing this defence is on the Respondent and the onus is the ordinary civil standard of proof upon a balance of probabilities.

Many cases have analyzed the various elements of the BFOR defence.

Ontario Human Rights Commission v Etobicoke, [1982] 1 S.C.R. 202 settled that there is both a subjective and an objective test to be met. The subjective test is stated at page 208:

> "To be a bona fide occupational qualification and requirement, a limitation ... 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.;

The objective test, also at page 208, is stated as follows:

> "In addition it 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."

With respect to this test, Sopinka J. in Saskatchewan (Human Rights Commission) v Saskatoon, [1989] 2 S.C.R. 1297 stated at page 1309:

> "This test obliges the employer to show that the requirement, although it cannot necessarily be justified with respect to each individual, is reasonably justified in general application. ... In the limited circumstances in which this defence applies, it is not individual characteristics that are determinative but general characteristics reasonably applied."

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To be bona fide, a rule or requirement must be demonstrated to be directed toward a real risk. In his reasons in Etobicoke, McIntyre J. also stated at pages 209-210 that a tribunal, in deciding whether a BFOR has been shown must consider:

> " ... whether the evidence adduced justifies the conclusion that there is sufficient risk of employee failure ..."

In Canadian Pacific Limited v. Canada, [1988] 1 F.C. 209, Marceau J. elaborated on these words at p. 224:

> "When I read the phrase in context, however, I understand it as being related to the evidence which must be sufficient to show that the risk is real and not based on mere speculation. In other words, the 'sufficiency' contemplated refers to the reality of the risk not its degree."

The analysis of a BFOR is to be directed to the occupation and riot an individual. As stated in Bhinder v Canadian National Railway Co., [1985] 2 S.C.R. 561 per McIntyre J. at page 588:

> "The words of the Statute speak of an "occupational requirement". This must refer to a requirement for the occupation, not a requirement limited to an individual. It must apply to all members of the employee group concerned because it is a requirement of general application concerning the safety of employees. The employee must meet the requirement in order to hold the employment. It is, by its nature, not susceptible to individual application."

and at page 589:

> "To apply a bona fide occupational requirement to each individual with varying results, depending on individual differences, is to rob it of its character as an occupational requirement and to render meaningless the clear provisions of [s. 15(a)]."

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Similarly, where a rule constitutes direct discrimination against a group, there is no duty to accommodate individual members of that group. See Central Alberta Dairy Pool v Alberta (Human Rights Commission), [1990] 2 S.C.R. 489 at 514:

> "Where a rule discriminates on its face on a prohibited ground of discrimination, it follows that it must rely for its justification on the validity of its application to all members of the group affected by it. There can be no duty to accommodate individual members of that group within the justificatory test because, as McIntyre J. pointed out, that would undermine the rationale of the defence. Either it is valid to make a rule that generalizes about members of a group or it is not. By their very nature rules that discriminate directly impose a burden on all persons who fall within them. If they can be justified at all, they must be justified in their general application."

However, individual testing may be a consideration in establishing a BFOR. In the Saskatoon case, Sopinka J. stated at p. 1313:

> "While it is not an absolute requirement that employees be individually tested, the employer may not satisfy the burden of proof of establishing the reasonableness of the requirement if he fails to deal satisfactorily with the question as to why it was not possible to deal with employees on an individual basis by, inter alia, individual testing. If there is a practical alternative to the adoption of a discriminatory rule, this may lead to a determination that the employer did not act reasonably in not adopting it."

ANALYSIS

This case was presented on the basis that Irwin was discharged pursuant to a policy of the CAF which discriminates against persons diagnosed as having bronchial asthma. Asthma was recognized as constituting a physical

disability as defined in the CHRA. It was conceded that this policy prima facie constitutes a discriminatory practice contrary to the provisions of the CHRA. It was also conceded that this policy constitutes direct discrimination against that group of persons with asthma.

There was no suggestion either in the evidence adduced or the argument that the CAF did not subjectively believe that the CAF Medical Standard, specifically that part related to bronchial asthma, was necessary for the adequate performance of the job. Accordingly, the subjective element of the BFOR is not an issue in this case.

To determine whether or not the objective element of the BFOR test has been met by the CAF, the starting point is s.33(1) of the National Defence Act which provides:

> "The regular Force, all units and other elements thereof and all officers and non-commissioned members thereof are at all times liable to perform any lawful duty."

and the "contextual element" emphasized in The Attorney General of Canada v Robert St. Thomas and the Canadian Human Rights Commission (F.C.A., unreported, October 8, 1993) where the Chief justice, in a case also dealing with the discharge from the CAF of a member with asthma, stated:

"In my view, examination of this issue must take account of a contextual element to which the Tribunal did not give sufficient consideration. It is that we are here considering the case of a soldier. As a member of the Canadian Forces, the Respondent, St. Thomas, was first and foremost a soldier. As such he was expected to live and work under conditions unknown in

civilian life and to be able to function, on short-notice in conditions of extreme physical and emotional stress and in locations where medical facilities for the treatment of his condition might not be available or, if available, might not be adequate. This, it seems to me, is the context in which the conduct of the Canadian Forces in this case should be evaluated."

Accordingly, Irwin's occupation must be considered both as a marine engineering mechanic on a destroyer and as a member of the Canadian military. This was the job which he was required to be able to perform.

Courts and other tribunals have found health-related medical standards to constitute a BFOR where it has been shown that the standard is reasonably necessary to assure the efficient and economic performance of the job without endangering the employee, his fellow employees and the general public. There are two aspects to this test - the "performance" aspect and the "risk" aspect.

Cases in which a health-related medical standard has been found to be a BFOR include Canadian Pacific Limited v Canada (Canadian Human Rights Commission) (F.C.A.), [1988] 1 F.C. 209 (diabetes); Galbraith v Canadian Armed Forces, (C.H.R.T.) (1989), 10 C.H.R.R. D/6501 (continent ileostomy); Siguin v Royal Canadian Mounted Police (C.H.R.T.) (1989), 10 C.H.R.R. D/5980 (visual acuity); Husband v Canada (Armed Forces) (C.H.R.T.) (1991), 15 C.H.R.R. D/197 (visual acuity); Bouchard v Canada (Armed Forces) (C.H.R.R.T.) (1992), 15 C.H.R.R. D/362 (kidney stones); Attorney General of Canada v Beaulieu (F.C.A.) (unreported, February 25, 1993) (epilepsy); Attorney General of Canada v St. Thomas (F.C.A.) (unreported, October 8, 1993) (asthma); and Boivin v Canadian Armed Forces (C.H.R.T.) (unreported, January 25, 1994) (recurrent knee dislocation).

However, there are also cases where a medical standard has been found not to be a BFOR. These include Dejager v Department of National

Defence (C.H.R.T.) (1986), 7 C.H.R.R. D/3508 (asthma); Canada (Attorney General) v Rosin (F.C.A.) [19911 1 F.C. 391 (monocular vision); Canada (Attorney General) v Levac (F.C.A.) [1992] 3 F.C. 463 (heart condition); Robinson v Canada (Armed Forces) (C.H.R.T.) (1992), 15 C.H.R.R. D/95 (epilepsy); and Thwaites v Canadian Armed Forces (C.H.R.T.) (unreported, June 7, 1993) (AIDS).

Each case will, therefore, depend on its own particular facts.

This case deals with the downgrading of the medical category of a serving member as opposed to the enrolment of a new recruit. This is of considerable significance. Medical Standards For The Canadian Forces, referred to above, specifically states that the suggested category for a condition may vary depending on the severity of the condition. Accordingly, even if it is not otherwise required by law to establish a BFOR, individual testing becomes an inherent part of the process in this situation. As shown in the evidence of Captain Dupont, the consequences of a reclassification even to G3O3 are potentially less severe than G4O3 in that the former may permit retention in the CAF in a different trade while the latter does not.

The entire process under which Irwin's medical classification was downgraded and a decision was eventually made to discharge him depended on evidence with respect to his medical condition. The decision to release him by the CMRB was essentially an administrative or "paper" review which depended on the prior medical assessment. The result of the medical examination was not simply a

diagnosis of asthma but an assessment of its severity at that time and the application of military as well as medical judgment in assessing whether or not Irwin was able to adequately and efficiently perform his job without risk to himself or others. This latter part of the decision was dictated to some extent by the Medical Standards in that there is a policy with respect to bronchial asthma. However, in its application to serving members, it is not an inflexible policy. The process cannot be set in motion without individual medical testing.

Although cited by counsel for the CAF for the proposition that individualized testing was not required to establish a BFOR defence, I find support for this approach in the St. Thomas case, supra. At page 8, the Chief justice states:

> "For the reasons that follow, it is my respectful view that the Tribunal erred in concluding that individual testing was required to determine whether the Respondent, St. Thomas, could perform his duties."

but immediately thereafter, he continues:

> "It is clear from a review of the Record that individual testing of the Respondent, St. Thomas, was carried out in this case before the decision was taken to discharge him."

The Chief justice then proceeds to discuss at considerable length the individual medical testing which was conducted and concludes that this was sufficient for the CAF to make the determination that the Respondent, a serving member, was not fit to perform his duties. This is the ratio of the case in my opinion.

Counsel for the CAF also cited the Husband and Galbraith cases, supra, for the proposition that any individual testing required need simply be diagnostic of the disability and that there is no duty to do any further testing directed at

determining whether or not the person can fulfill the requirements of the job. In his submission, such a requirement in a military context would not be practical. The comments from these cases are not applicable here. Both were concerned with the enrolment of new recruits where different considerations apply.

The medical examinations of Irwin in 1988 were not directed solely at diagnosing asthma. There was really no doubt in anyone's mind that he had asthma. It is not possible to say from the evidence whether Irwin's medical condition became a problem in 1988 or whether it was simply recognized as such at that time. In any case, the activities of Dr. MacDonald and other CAF medical personnel at this time were primarily directed at determining the severity of Irwin's condition and the appropriate categorization with respect to the G and O factors discussed above. The numerical grades assigned are intended to reflect the degree of risk. It is at this stage that the CAF Medical Standards come in to play and, no doubt, the suggested category for "bronchial asthma in adult life" influenced the medical classification assigned to Irwin. However, the doctors made the determination that the severity of Irwin's condition at that time was such that he had the "potential for sudden serious complications" and this translates to G4 in the Medical Standards. It was this G4 classification which most influenced the eventual decision to release Irwin from the CAF.

The remaining issue is whether there was sufficient individual medical testing of Irwin in this case.

The evidence was that there was an initial assessment by Dr. MacDonald and a consult by Dr. Guy, which included a review of Irwin's complete

medical file, in June, 1988. Dr. Guy was not called as a witness but was identified as follows by Dr. Fisher:

> "... Captain (N) Fred Guy who, at that time, was the Chief of Medicine at CFH Halifax. He is qualified in internal medicine and by that time would have had over 10 years experience as an internist in the Forces."

A full medical was performed by Dr. MacDonald on June 30, 1988. Prior to the CMRB review, Irwin was seen on July 15, 1988 by Dr. Guy and Dr. Theakston, a medical resident, had a pulmonary function test conducted at Victoria General Hospital on July 19, 1988 and underwent a further assessment on September 8, 1988. The documents relating to these later medical tests were introduced by the Commission to show that Irwin's levels at these times were within acceptable limits but, although there is no evidence that they formed part of the record before the CMRB, they do indicate ongoing medical testing by the CAF.

In addition, there was the evidence of Dr. MacDonald that Irwin had, on June 9, 1988, been offered a temporary medical category while the CAF reviewed his situation and referred him for further assessment. Irwin refused this option and is not now in a position to maintain that further testing by the CAF in 1988 might have led to a different result.

With respect to the expert medical evidence, Dr. Skrastins concluded that his conclusions were based solely on an assessment of the condition of Irwin on August 16, 1993 and stated that he was not second guessing the opinions formed by other doctors in 1988. Both Dr. Warren and Captain Fisher specifically agreed with

the earlier opinions and testified that the assessment of Irwin in 1988 was consistent with medical practice and knowledge at that time.

In Attorney General of Canada v Beaulieu, supra, the Federal Court of Appeal found a tribunal in error in finding that there had been a discriminatory practice because it concluded that the complainant had been misdiagnosed at the time of his discharge from the Armed Forces. Marceau J.A. summarized as follows at page 12:

> "I feel that the tribunal could not find Beaulieu's complaint to be valid merely because it was persuaded that the diagnosis of partial temporal lobe epilepsy was incorrect. It would further have to have been satisfied either that the diagnosis was arrived at imprudently, in which case it could perhaps have spoken of a disguised discrimination and a false and hasty perception, or that the requirement that an Armed Forces driver not be subject to epileptic problems was not a bona fide requirement, which would have destroyed the Armed Forces defence."

There is no issue of "disguised discrimination" in this case. Accordingly, it is not part of my function to review the accuracy of the medical findings in 1988 even if there was evidence which would enable me to do so.

Asthma was described in the expert medical evidence as "capricious" and as a "latent disability". There is always the potential of a sudden severe attack regardless of how well a person may be feeling. Assessment involves a considerable amount of medical judgment as there are no tests which can reliably quantify the risk of an attack. The fact that Irwin had never been hospitalized or subject to a severe asthmatic attack while in the military and that he was able to perform his duties without failure over a period of five years is not determinative in assessing

the future risk. For the same reason, neither the present medical condition of Irwin nor his medical history since leaving the military is of assistance.

The expert medical evidence in this case establishes to my satisfaction that there was a real risk that Irwin could have suffered a sudden severe asthmatic attack. The evidence with respect to his duties, both as a marine engineering mechanic and a member of the military, establishes that such an attack could have occurred in circumstances where it not only could have prevented him from performing his job but could have put at risk both him and other members of the crew.

I am also satisfied on the evidence before me in this case that the CAF did make a reasonable effort to review alternatives to releasing Irwin through the Occupation Transfer process referred to above. Irwin's refusal to accept a temporary medical reclassification for further assessment may

have contributed to this being a futile endeavour.

In the circumstances of this case, it is not necessary for me to make a finding as to whether or not the standard with respect to bronchial asthma imposed by the CAF, in itself, constitutes a BFOR. The inquiry in this case is less far reaching. My conclusions relate only to the Complainant and are based on his medical condition as diagnosed in 1988. In these limited circumstances, I conclude that the Respondent has established a BFOR defence in this case.

Since preparing these reasons, I have been referred to the decision dated March 25, 1994 of the Federal Court of Canada dismissing an application for

judicial review of the decision of the Tribunal in Thwaites, supra. I do not find any inconsistency between the reasons of Gibson J. and my analysis of the evidence in this case.

Accordingly, this Complaint is dismissed.

Dated at Toronto, Ontario this 18th day of April, 1994.

Ronald W. McInnes
Chair