T.D. 9/91
Decision rendered July 4, 1991

CANADIAN HUMAN RIGHTS ACT
(S.C. 1976-77, c 33 as amended)

HUMAN RIGHTS TRIBUNAL

BETWEEN:

JAMES ROBINSON

Complainant

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

CANADIAN ARMED FORCES

Respondent

DECISION OF THE TRIBUNAL

TRIBUNAL: Peter Bortolussi
Daniel Proulx
Ruth Goldhar

APPEARANCES BY:

Peter Engelmann, counsel for the Commission

Brian Evernden, counsel for the Respondent

LCol. R.A. McDonald, Department of National Defence

DATES AND PLACE OF THE HEARINGS: March 20 to 23, 1990 and April 12, 1990 in Ottawa, Ontario.

I- THE FACTS

The Circumstances Leading Up to the Complainant's Release

The only witness called by counsel for the Human Rights Commission was the complainant himself, former Sergeant James Robinson, who explained that he decided to consult a physician in 1981 for problems of "absence" or of "blanking out" he had been experiencing for a few years. They lasted a maximum of one minute and had as such already occurred at work.

He therefore saw Dr. Anderson, a CFB Winnipeg physician, who decided to refer him to a neurologist, Dr. Habib (Exhibit R-1, tab 1). After having met with him on December 30, 1981, Dr. Habib had him take an electroencephalogram (EEG), which proved normal (Exhibit R-1, tab 3).

Nevertheless, taking the symptoms described by Sergeant Robinson himself into account, Dr. Habib reached the following conclusion: "I feel that these spells are most likely seizure manifestations, perhaps of temporal lobe origin, despite the normal EEG" (Exhibit R-1, tab 4).

In February 1982, Dr. Habib therefore gave him a prescription for Tegretol, an anti-convulsant drug, which he was to take three times daily.

Noting that Sergeant Robinson was "in excellent health" and had never suffered from "blackout" or total loss of consciousness as such (Exhibit R-1, tab 3), Dr. Habib did not recommend that Sergeant Robinson be removed from his duties as a Flight Engineer.

The complainant was nevertheless forbidden from flying for several months. During that period, he stopped taking Tegretol and took another apparently normal EEG in April 1982 (Exhibit R-1, tab 6), and the Career Medical Review Board (CMRB) lowered his G2 medical category to G3.

Moreover, in June of the same year he was offered a contract for an Indefinite Period of Service, which he accepted and according to which he could remain in the Forces until August 5, 1999, that is, until he was 55, which is the mandatory retirement age for everybody.

Since the CMRB decided on August 11, 1982, that he was fit to return to his duties ("fit for full duty": Exhibit R-1, tab 11), Sergeant Robinson was then able to return to his trade as a Flight Engineer until May 24, 1983. Furthermore, since he had succeeded in getting out of the alcoholism

problems he suffered until 1979, Sergeant Robinson registered during this period for special courses given to help members of the Forces with that type of problems, and began to work occasionally at CFB Winnipeg's Alcohol Rehabilitation Clinic.

On May 24, 1983, Sergeant Robinson was awakened in the middle of the night by an epileptic seizure that he himself described as "grand mal".

Dismayed by what she saw, his wife had him taken to hospital, where he was treated by Dr. Burling of CFB Winnipeg. After having noted, probably from reports by the nursing staff, that Sergeant Robinson had had other episodes of loss of consciousness during the week he was admitted to hospital, Dr. Habib made the following recommendations: "Not to operate any equipment or machines" and "No flying" for a while (Exhibit R-1, tab 12, p. 2). He also recommended that his medical category be changed temporarily from G3 O2 A2 to G4 O4 A7 (Exhibit R-1, tab 13).

Sergeant Robinson was therefore assigned to light duties at CFB Winnipeg since he was confined to the ground. He therefore began working full time in September 1983 as an Alcoholism Counsellor in the Winnipeg

clinic. Since he had taken several alcohol rehabilitation courses, he was considered qualified for this type of function (Exhibit HR-1, tab 20).

He also applied to become a full-time Alcoholism Counsellor in the Winnipeg clinic for a four-year term. HQ dismissed his application on the ground that no positions would be open before July 1986 (Exhibit HR-1, tab 10). However, the counsellor's position in the Winnipeg clinic was filled the following summer, on June 25, 1984, by another non-officer, Master Corporal Ozzie Cawlishaw (Exhibit HR-3), who, according to the complainant, was not qualified for the position. Paragraph 3(a)(5) of CFSO 98/84 required that every applicant have at least five years of sobriety, and paragraph 3(d)(1)(b) required a minimum rank of Sergeant (Exhibit R-2, tab 17); Corporal Cawlishaw did not satisfy either of these conditions.

According to the complainant, the rejection of his application could therefore only be explained on the basis of his epilepsy, since he was notified at about the same time - that is, in the fall of 1983 - of his new medical category: G4 O4 A7, which is below the minimum medical standard for being a member of the Army (Exhibit R-1, tabs 21 and 22). According to the complainant, this is obvious because he himself met all the eligibility criteria of the Alcoholism Counsellor's position and because all those involved in studying his file recommended that he be retained in the Forces

as an Alcoholism Counsellor: the director of the Prairie Region clinic (Exhibit HR-1, tab 7), the personnel selection officer (Exhibit HR-1, tab 8), the base physician (Exhibit R-1, tab 23) and the commander of his base unit (Exhibit R-1, tab 22).

The CMRB's final decision came on June 21, 1984, and, because the medical category given Sergeant Robinson was below the minimum standard, it recommended to HQ that he be released as of January 14, 1985. He then stopped working as an Alcoholism Counsellor but returned to this job from May 21, 1985, to March 31, 1986, as a member of the Reserves. He was in effect able to get the CMRB to waive his medical category so that he could join the Primary Reserve as a Flight Engineer on the ground with the rank of Sergeant.

After he was released from the regular Forces, the complainant still performed the same duties as an Alcoholism Counsellor, although at the clinic in Lahr, Germany, as a civilian employee under contract to the Department of National Defence. He was also a member of the Supplementary Reserve.

Several times during his testimony, the complainant stressed his disagreement with the restrictions set by the CMRB because of his epilepsy. Those restrictions are as follows: "G4 - Unfit field, sea and isolated postings, requires physician services readily available; O3 - unfit handling chemicals, climbing ladders or working at heights, unfit to handle firearms, ammunition or to work with power tools, unfit to drive service vehicles; A7 - unfit flight duties" (Exhibit HR-1, tab 12, p. 2, and Exhibit R-1, tab 29).

With the exception of category A7, which he does not dispute, the complainant maintained in his testimony that he was perfectly able to do everything the CMRB's report had prohibited him from doing under categories G and O, and that this is shown by the intense physical activity he has always maintained in spite of his epilepsy. Thus, he said several times that he very regularly, and intensively, jogs, cycles, lifts weights and goes cross-country skiing. He also belongs to a rifle club. All these

physical activities keep him in shape and have never led to seizures. He repeated that his prescription for Tegretol keeps his epilepsy under perfect control.

At any rate, the complainant asserted that the ability to handle firearms and to go into combat, which is a requirement common to all

members of the Forces, is a hypothetical requirement for those, like Flight Engineers, with a specialized trade unrelated to combat. He agreed that, according to the regulations, he could in the event of an armed conflict be called upon to go to the front in a combat position but said that that would not happen in reality. According to him, that would be unrealistic because as a Flight Engineer he has only very little knowledge of and training in combat techniques and the handling of weapons of combat; thus, it is those who are specialized in combat positions, whether working in the infantry, as airplane pilots or in the navy, who would be called upon to take up arms to attack the enemy or defend military bases. The only serious training he had had in combat techniques was in 1975, when he had to take the Junior Leaders Course to become a Sergeant. He considers all that to be normal, however, as he feels that the art of war as such is a matter for the Army's combat specialists (Transcript, Vol. 1, pp. 96-101 and 133-34).

The complainant also forcefully disputed the CMRB's second conclusion that he was "not otherwise advantageously employable under existing service policy". Mr. Robinson feels that in the light of the vast experience he had acquired over the 21 years of his career there are many other trades in the Army for which he would be fit. With his resumé in support (Exhibit HR-1, tab 3), Mr. Robinson indicated that he had only become a Flight Engineer in 1974. During the eleven preceding years, he had been in training and had carried on a variety of trades related to maintaining aircraft on the ground, including those of Aero Engine Technician, Aero Frame Technician and Aviation Technician. He therefore feels that he was qualified for those positions, inter alia, to which he could have been "remustered" (i.e. transferred) and in which his epilepsy, under control, would not have endangered anyone.

This is why on August 21, 1984, he filed a grievance in accordance with the procedures provided for in the Forces (Exhibit HR-1, tab 13). He also took the precaution of consulting another expert - a civilian this time - the neurologist M. Del Campo, who, after having examined him and reviewed his medical file, said in his report that he was "perfectly controlled" with his standard dose of Tegretol, which was the case with 80 percent of patients in his situation (Exhibit HR-1, tab 14). In spite of other letters from his superiors recommending his retention in the Forces as an Alcoholism Counsellor, Robinson's grievance was rejected (Exhibit HR-1, tabs 15-17).

Under cross-examination, the complainant refused to admit that he was prone to having other seizures seeing as the Tegretol was controlling them, but he did admit that if ever he had one on board an aircraft or while working with power tools on the ground or while up on a ladder, he could injure himself or nearby co-workers. Finally, he added that as a member of

the Reserves at CFB Lahr he could at any rate be called upon in an emergency to carry out military activities even though he was hired as a civilian on a contract basis for the Alcoholism Counsellor's position.

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Finally, to former Sergeant Robinson, his release from the Forces due to his epilepsy in spite of the fact that it was under control, was profoundly humiliating. He had never contemplated any career other than in the Forces, and all his efforts to put an end to his alcohol problems therefore appeared to him to have been in vain. That had a significant negative impact on his family and undermined his self-confidence. He said that it is because nobody in civilian life was interested in an applicant with military experience that he was ultimately unable to find a position anywhere but on a military base in Europe. Even some five years after these events, Mr. Robinson is still so disturbed by them that the Tribunal had to interrupt his hearing to permit him to continue testifying.
Mr. Evernden, counsel for the Forces, had six members of the Forces testify; they dealt in order with the military profession, the Army's medical classification system, including the system of waivers for members whose medical categories drop below the minimum standard, and epilepsy and its risks.

The Structure of the Forces and the Military Profession

Commander H.C.C. Sylvester, who has worked in the Directorate of Forces Structure for nine months, came to present the organization and philosophy of the Forces to the Tribunal.

Commander Sylvester began by explaining that the primary role of the Canadian Armed Forces is to prepare for war and to execute government directives in the event of war. This is why all members of the Forces, with the exception of medical and religious personnel, must be able to bear arms and why every function in the Army involves the ability to handle firearms.

There are two types of functions in the Forces: the operational function, which consists of members who are on a priority basis trained in handling weapons and in combat techniques, and the support function, which consists of members trained above all to support those who are specialized in weapons and combat. It goes without saying, however, that every member of the Forces must have a minimum knowledge of handling weapons in order at least to be able to defend his military base in the event of an enemy attack (Transcript, pp. 219-21 and 226-34). As a result, someone who does not want to, or cannot, handle firearms can in no case be retained in the

Forces since the role of the Forces is to defend the country. In this sense, there can be no place there for Alcoholism Counsellors who are not first and foremost members of the Forces with a military occupation and trained and ready to use their weapons.

Commander Sylvester also tried to clarify the position of Reservists in relation to members of the regular Forces, which might be relevant because the complainant is a member of the Reserves. There are two kinds of Reservists: (1) those in the Primary Reserve, who are called up automatically in the event of war, and (2) those in the Supplementary Reserve, who are only called up in the event of a conflict if they are still qualified for a given function and if the Forces need their services. There are also different classes (A, B, C) of Reservists, but that is unimportant here. What is important is that no matter what a Reservist's status, there is no distinction, from the point of view of their military obligations, between a member of the regular Forces and a Reservist who is recalled for military service (Transcript, pp. 230 and 240-45).

Captain Metro MacKnie then came to testify regarding the organization of trades or occupations in the Forces. Having worked for thirteen years as a Specification Staff Officer in the Directorate of Military Operational Structures, he was fully qualified to deal with the minimum requirements for the various occupations in the Army.

The witness said clearly that every member of the Forces must necessarily have a trade or occupation in the Forces, or else he could not be a member. Thus, a recruit who arrives without specific qualifications will be trained in a given trade by the Forces and must always retain a trade throughout his career, although that trade can change along the way. The Army is in fact an organization that is structured in such a way that each of its members must have a role in the success of a defence or military combat operation if the need arises. From this perspective, therefore, a member of the Forces who does not have a trade is a useless member.

Members of the Forces are trained for many trades and occupations. Thus, according to Captain MacKnie, in the field of aviation alone there are some one hundred trades open to non-officers, that is, the simple Private, Corporal, Sergeant and Warrant Officer.

There are also specialties and sub-specialties, such as the Alcoholism Counsellor's position. However, a member of the Forces can only have access to a specialty if he remains qualified in a trade as such. A

specialty cannot replace a trade, and it is the trade that is required for membership in the Forces. In this sense, it is clear that the Alcoholism Counsellor's position is not a trade and that an individual cannot be retained in the Forces solely because he is competent in that function. He must also remain fit to carry on his trade while temporarily devoting himself to a speciality.

Captain MacKnie also presented the General Specifications Other Ranks (GSOR), which concern the minimum requirements for non-officers (Exhibit R-2, tab 9). According to these standards, a Sergeant must have detailed knowledge, inter alia, of the handling of combat weapons, of biological weapons, of defence techniques and of various defence-related statutes and regulations (e.g. National Defence Act, Official Secrets Act, Canadian Forces Administrative Orders).

When cross-examined by counsel for the Human Rights Commission on the feasibility of such minimum requirements, Captain MacKnie gave the opinion that the standards were reasonable but that appropriate training was needed to meet them adequately. He also explained that such knowledge should be reviewed annually to ensure that it is kept up. When counsel for the Commission pointed out to him that Sergeant Robinson had only been re-evaluated three or four times in a 21-year career, Captain MacKnie said that he hardly found that surprising, as he himself had received no military training for thirteen years. Although he was unable to give a number, he thus acknowledged that "there are probably people who cannot meet these standards" (Transcript, p. 318).

When later questioned, on the basis of former Sergeant Robinson's file, on the possibilities of transfer to another trade than that of Flight Engineer, Captain MacKnie gave the opinion that according to this member's resumé he could certainly be "remustered" to his former trades - either that of Aviation Technician or those of Aero Frame Technician or Aero Engine Technician - which would have enabled him, had he been selected, to

have the speciality of Alcoholism Counsellor. To do so, he had to meet the minimum medical standards for those trades, however. Furthermore, a transfer is generally accompanied by a demotion to the rank of Corporal because the member must be retrained in a new trade.

The third witness called by Mr. Evernden was Major Catherine MacCullam. Major MacCullam, who has been the co-ordinator of the Alcoholism Rehabilitation Program in the Forces since 1988, came to explain how Alcoholism Counsellors working in a rehabilitation clinic are selected.

She then confirmed that there was only one such position in the Prairie Region clinic in Winnipeg in which the complainant had been interested, that the normal duration of such a position was four years and that this type of specialty was highly coveted. Thus, in 1988-89, there were approximately 75 qualified applicants for a total of only six positions in all the clinics in Canada and Europe. However, Major MacCullam was unable to supply any data for 1983 and 1984, that is, the period when the complainant had applied for the Alcoholism Counsellor's position.

The Medical Standards for the Canadian Forces

Colonel R. Bélanger was summoned to explain to the Tribunal the manual containing the Medical Standards for the Canadian Forces, which was issued on the authority of the Chief of the Defence Staff (Exhibit R-5, tab 2). As a physician and the Director of Medical Treatment Services, he is responsible for establishing the said standards on behalf of the Surgeon General.

These medical standards have already been presented by Colonel Bélanger or other officers in other decisions rendered by the Canadian Human Rights Tribunal (for example, see Galbraith v. Canadian Armed Forces (1989), 10 C.H.R.R. D/6501, and Rivard v. Canadian Armed Forces (1990), 12 C.H.R.R. D/35). Nevertheless, it would appear to be appropriate to repeat their essence here.

The medical standards require that each member of the Forces have a medical category based on the evaluation of seven different factors, including geographical factors (G), occupational factors (O) and the air factor (A), which are the only ones that matter in the present case. For each of these factors, a member receives a grade from 1 to 6 (even 7 for factor A), with the best being 1 and the worst being 6.

For a recruit to be enrolled in the Forces, his medical category must be equal to or higher than G2, O2 and A5. This does not for all that mean he must retain this medical category permanently to remain a member, as is expressly recognized in paragraph 1 of Chapter 3 of the Standards. The minimum grade required of serving personnel with respect to the key G and O factors has been set at 3. Moreover, many trades require no more than a medical category of G3, O3, A5, and these include the various aviation support trades, including Aero Frame and Aero Engine Technicians working on the ground (Annex D of the Standards, Exhibit R-5, tab 2). On the other hand, a higher medical category is required of aircrew personnel considering that they have high-risk occupations. Thus, a Flight Engineer's minimum medical grade is G2, O2, A2.

These categories are of course granted with the help of a medical examination. This is required of every recruit from the start and is subsequently required of every serving member when he requests a promotion, and once a year after he reaches forty years of age. The frequency of

these medical examinations appears to have changed somewhat recently, but that is irrelevant to the present case.

The Medical Standards manual already indicates grades for certain illnesses or disabilities. Thus, when a physician diagnoses epilepsy, he must normally recommend grade 4 or 5 for the geographic G factor and grade 3 or 4 for the occupational O factor (Ch. 7, p. 7-20). However, there are other more inflexible standards with respect specifically to epilepsy, including CFMO 26-12, which is entitled Seizure Disorders - Category Policy (Exhibit R-8). Paragraph 7 of this policy provides that "if a remediable cause is not found, a G4 O3 category is the minimum limitation necessary to protect the individual...." Paragraph 8 lays down the content of the restrictions imposed by that category: "G4 - unfit field, sea, medically isolated and UN duties, physician services required. O3 - unfit to drive any service vehicles, unfit to handle arms and ammunition, unfit to work at heights or with power tools, unfit to work in hazardous places or with hazardous materials."

In such a case, which is that faced by the complainant, the medical category is set in advance and the attending physician as well as the Forces' medical authorities lose any discretion regardless of the severity of the case or the degree to which his epilepsy is controlled by means of appropriate medication (Transcript, p. 421). Thus, this policy, which has been in force since September 6, 1983, appears to have been applied to the complainant. This also explains the decision to release him, as it is not normally possible to remain in the Forces with a medical category lower than G3 O3 without receiving a waiver, which would only be granted on an exceptional basis.

According to Colonel Bélanger, if the complainant was given category O3 with the restrictions indicated above, it was because of the risk an epileptic would present were he to have a seizure in performing his military work, for example when handling firearms. As for category G4, it is based on the fact that someone with a seizure disorder is less mobile in that he might have an urgent need for the services of a physician and in that the provision of prescription medication, such as Tegretol, is not always possible on the battlefield (Sources: Medical Standards, pp. 2-2A/2B and 3, and Seizure Disorders - Category Policy, paragraph 4).

Why, however, are there three categories below the minimum of G3 and O3 if categories G4 and O4 are at any rate sufficient to exclude a member from the Forces? According to Colonel Bélanger, who is involved in the work of the Career Medical Review Board (CMRB), this is because the Board has the possibility of waiving a serving member's medical category if it is below the minimum medical standards, but only if his category is not below G5, O5. A member of the Forces with a grade of G6, O6 can in no case be waived and must automatically be released whereas, if he has a grade of G4 or G5 and O4 or O5, there is still a possibility that he will be retained in his trade or transferred to another. Thus, of the total personnel of over 85,000 individuals, there are apparently several thousand members who do not meet the minimum medical standards but are still on active service in the Forces because they have received waivers. A member with a medical category below G3 or O3 is one who is retained in spite of the fact that his condition might present a risk of endangering himself or the others. The decision to grant him a waiver and retain him is an exceptional measure based on the acceptability of the risk he presents in the circumstances, in

the light of the Forces' needs in the type of occupation held by the member in question (Transcript, pp. 422-25).

Lieutenant Colonel Robert Swan, who has been Director of the CMRB's Other Ranks section for some twenty months, came to add to the information given by Colonel Bélanger concerning that body's role, the waiver system and conditions for transfer.

Thus, when the medical category of a member of the Forces is lowered, his file is automatically sent to the CMRB, and its role is then to recommend to HQ "a change in classification or trade, a change in environment or employment, or release" (paragraph 1, CFAO 34-26: Exhibit R-10, tab 1).

The CMRB's objective is not to release a member unless that is absolutely necessary. However, even if a member of the Forces retains a medical category that meets the standards of another trade, this does not automatically mean that the CMRB is going to recommend that he be "remustered". That will depend on his entire file, including his performance in the trade he has to leave, his potential for promotion, his ability to carry out strictly military activities and the existence of openings in the desired trade. Moreover, when an individual is transferred, he is usually demoted to the rank of Corporal because he must relearn a new trade.

When asked by counsel for the Commission to comment on the CMRB's decision (Exhibit HR-1, tab 12) regarding the possibilities of transferring the complainant to his previous trades of Aviation, Aero Frame or Aero Engine Technician, Lieutenant Colonel Swan first said that the CMRB must have considered these possibilities because it is common practice to do so.

After the Tribunal had pointed out to him that this appeared nowhere in the report and after counsel for the Commission had returned to this question in cross-examination, the witness finally conceded that the CMRB had probably not seriously considered the possibility of a transfer in the case of former Sergeant Robinson, as can be seen from the following exchange (Transcript, p. 686):

Q. What were the options of the CMRB in the Robinson case?

A. When we saw the medical categories, when we saw the restrictions, and we saw the unfit flight attendance, unfit flying duties, the options were release.

Q. So there was no other option was there? They wouldn't have considered any other trade because they knew that he was below the minimum medical standard?

A. We knew with his medical limitations that he would not be occupationally transferred.

Thus, the possibility of transferring the complainant was probably not considered because the restrictions recorded in the medical report due to his diagnosis of epilepsy made him unfit to perform military duties as such (O3 - unfit to handle firearms, ammunition...) and required him to obtain on a continuous basis a drug not available in a battlefield dispensary and to remain where a physician is always available (G4 - unfit field, sea and isolated postings, requires physician services readily available).

Finally, Lieutenant Colonel Swan mentioned two cases of Flight Engineers who were retained in the Forces because their medical category of G4 O3 A7 had been waived. The first case involved a serving member with a coronary artery disease who was prohibited from working on board an aircraft; because he had nevertheless been judged fit for general military duties (handling of firearms, etc.), he was retained in the Forces but transferred to a desk job.

The second case was that of an epileptic. He was retained for some time in order accurately to assess his medical condition. When the diagnosis of seizure disorder was confirmed, the CMRB's decision was to release him as of May 1990.

Epilepsy and its Safety Risks

Lieutenant Colonel Christopher Skinner, who has been a physician since 1979, has been specialized in neurology since 1987 and works mainly in that specialty as a medical officer, was called by Mr. Evernden, and the Tribunal recognized him as an expert in the sphere of seizure disorders. He began by making an initial distinction between a simple seizure, which consists of abnormal electrical activity in the brain, and epilepsy or seizure disorder, which is diagnosed when the abnormal activity is recurrent. When asked to define the term "seizure disorder", he said the following: "An individual suffering from a seizure is an individual who has paroxysmal electrical activity in the brain which alters the individual's behaviour to lesser and greater degrees from the point of just having minor symptoms to the point of total incapacitation and life threatening convulsions. So that the electrical activity depending on where it occurs in the brain determines the amount of disability that a given individual has while that electrical activity is present." Then defining the word "paroxysmal", he explained that it means "spontaneous, unprovoked... on a recurrent basis..." (Transcript, p. 486).

There are several forms of epilepsy (or seizure disorder), which have been standardized by the International League Against Epilepsy. A distinction is made first between partial and generalized epilepsy. Epilepsy is said to be partial when the abnormal activities are located in just one part of the brain; it is said to be generalized if the abnormal activities are observed throughout the brain.

Partial epilepsy can be divided into two categories: simple and complex. Simple partial epilepsy appears through such symptoms as numbness of the face or twitching of the hand. However, the person does not lose consciousness and can continue communicating normally, as the mental process remains normal.

Complex partial epilepsy presents the following outward symptoms: the individual stares in one direction, his hands or other limbs move abnormally, and he smacks his lips. During a seizure, which might occur four or five times a month if not controlled by medication, and which lasts an average of 30 to 45 seconds, the individual does not fall and does not have a convulsion in the strict sense, but he is unable to communicate because he loses consciousness. When the seizure comes to an end, the individual experiences some confusion. It might happen either during the

day or at night. If it happens during the day while the individual is performing hazardous work, there is a serious risk that he could injure himself or other people. By means of appropriate medication, such as

Tegretol, an average of approximately 70 percent of the seizures of those suffering from complex partial epilepsy can be controlled. However, full control is possible and not uncommon.

As for generalized epilepsy, it too can be divided into two main categories: "grand mal" and "petit mal". Grand mal is the most common form, and it is now called generalized tonic-clonic seizure in modern medicine. In this case, the individual's behaviour during a seizure is quite frightening for those not used to it. It begins with a clonic phase of muscle contraction, which is followed by a phase of back and forth tonic muscle activity. Grand mal can also be either purely tonic or purely clonic. It goes without saying that the patient is fully unconscious during a grand mal seizure.

The outward symptoms of petit mal are very different, although it is also a generalized form of epileptic seizure: here too, the abnormal electric activity is not located in a specific part of the brain but is distributed throughout it. In this case, the individual has no, or almost no, physical reaction during a seizure but is fully unconscious and is consequently unable to communicate. For example, an abnormal blinking of the individual's eyes might be observed, but he will not fall and will have no convulsions. It is as though he is daydreaming. The modern term used by specialists for petit mal epilepsy is generalized absence. The average duration of a seizure is from 15 to 30 seconds. It might occur an average of 10 to 20 times a day when not controlled by medication. Generalized absence is a form of epilepsy that is easier to control than complex partial epilepsy: in fact, approximately 80 percent of seizures are effectively controlled by medication, and full control is possible and not uncommon.

There is another phenomenon that occurs in some epileptics.

Approximately 25 percent of them are warned that a seizure is imminent by what is conventionally called an "aura". This is technically an abnormal discharge of electrical activity before the seizure itself occurs, so that someone driving his car would have time to pull over to the side of the road and thus avoid an accident. However, Dr. Skinner did not elaborate further on this phenomenon, which the complainant claimed to have experienced quite often.

In addition to Dr. Skinner's oral explanations, the Tribunal benefited from visual aids to understand the outward symptoms of two forms of epilepsy: complex partial epilepsy and generalized absence. In spite of objections by counsel for the Commission, the Tribunal viewed a short videotape used by Dr. Skinner in his courses at the University of Ottawa.

Counsel for the Commission argued that this material was irrelevant because it did not concern Mr. Robinson, it was consequently "impressionistic" evidence and, at any rate, the complainant's epilepsy was not in dispute.

The Tribunal dismissed these objections on the grounds that the videotape might prove relevant to verifying whether the symptoms of a seizure could prevent an individual from performing normal tasks in the Army and constitute a risk of danger for an epileptic member or his co-workers.

Dr. Skinner also elaborated upon the methods of controlling epilepsy and upon how the risk presented by those suffering from this illness is calculated. It is clear that epilepsy cannot be cured; attempts can only be made to control it by means of a variety of medications in tablet form, such as Tegretol, Dilantin, Valproic Acid or Phenobarbital. More than 90

percent of epileptics are considered controlled by one of these medications, although full control from a clinical point of view is achieved in approximately 70 percent of cases. Clinical control means that the individual has no seizures as such between two medical examinations, but this does not necessarily mean that there are no more abnormal electrical activities in his brain. That can be checked by administering an EEG. A case of total absence of abnormal activities is referred to instead as electrical control, but Dr. Skinner supplied no information on the success rate of the electrical control of epilepsy. It can also be noted from his testimony that the long-term effectiveness of controlling the symptoms of epilepsy is determined during the first two years of a patient's treatment. This probably explains why several provincial statutes permit epileptics to obtain driver's licences if a physician certifies that they have had no more seizures during a time period varying from one year (e.g. in Ontario) to two years (e.g. in Quebec).

With respect to calculating the risk of recurrence, studies show that it lies at about 30 percent among uncontrolled epileptics, that is, among those who are not taking medication or for whom no medication has succeeded in effectively controlling the seizures. This is a very general figure, however. The risk is assessed in a much more sophisticated and personalized manner by taking account of specific information on a patient,

such as his particular type of epilepsy, what caused it and his family history.

Thus, Dr. Skinner explained that, on the basis of studies published in the New England Journal of Medicine by Delgado and Escueta in 1983 and by Eloise in 1984, which were redone and confirmed by Callaghan in 1988, a given epileptic's rate of risk can be assessed in two stages. First of all, a sort of "rule of eights" is applied; it gives each of the factors relevant to epilepsy a rate of risk of 8 percent.

For example, the probability of recurrence for someone who has already had an epileptic seizure is 8 percent. If that person has suffered a violent blow to the head or a skull fracture (cause factor), the risk is 16 percent (8 + 8). Furthermore, if one of his parents has already been diagnosed as an epileptic (family history factor), the risk climbs to 24 percent (8 + 8 + 8).

This first stage establishes the probable risk of patients not controlled by medication. Thus, it is necessary secondly to calculate the rate of risk of patients controlled by medication. It is well-known that some forms of epilepsy are harder to control than others. Dr. Habib and Dr. Del Campo diagnosed Mr. Robinson as having "complex partial" epilepsy, and Dr. Skinner agreed with that diagnosis. In such a case, it is then necessary to subtract from the risk calculated in the first stage a rate of 70 to 80 percent, which corresponds to the average rate of control of this type of epilepsy. Thus, an individual like former Sergeant Robinson, who has already had at least one seizure (8 percent) and for whom the cause of the illness was probably the two skull fractures he suffered on the left side in 1967 and on the right side in 1975 (8 percent), represents without medication a 16 percent risk of having at least one other seizure without warning at a time that cannot be predicted. This rate of 16 percent must be reduced by 70 to 80 percent because medication seems to have the complainant well under control, which means that the risk of his having another seizure lies between 3 and 6 percent. The rate of 3 percent is

obtained on the basis of the following figures: 15 percent (risk without medication) - 80 percent (the highest average rate of control with medication). The rate of 6 percent is the result of the following calculation: 20 percent (risk without medication) - 70 percent (the lowest average rate of control with medication). Dr. Skinner did not explain why he placed the complainant's risk of recurrence without medication at between 15 and 20 percent, whereas according to the rule of eights, his risk should be set at 16 percent, as he admitted, moreover, under cross-

examination (Transcript, p. 580). If we repeat the calculations of risk using his own criteria, the complainant's risk should instead lie between 3.2 percent (16 percent - 80 percent) and 4.8 percent (16 percent - 70 percent). Dr. Skinner also spoke of a risk of approximately 5 percent for Mr. Robinson (Transcript, p. 540). However that may be, Dr. Skinner admitted that epileptics do not form a homogeneous group and that some patients are more at risk than others in the light of their own factors. Moreover, an epileptic's risk of recurrence must be put in perspective if it is to be understood. It must be compared with the risk faced by anyone in the population of having an epileptic seizure one day. According to the medical studies consulted by Dr. Skinner, that risk is between 2 and 4 percent.

Dr. Skinner's testimony is also relevant with respect to the Forces' Seizure Disorders - Category Policy established by CFMO 26-12 (Exhibit R-8). At least three paragraphs of that Policy were amended on September 6, 1983, or in the very period when the complainant's medical category was modified because of his major seizure in May of that year.

Thus, paragraph 4, which concerns the difficult conditions of combat and training, such as going without sleep and regular meals, and the fact that these factors can lower seizure thresholds, was amended in 1983 by the addition of a consideration that was not there before: the problem of supplying medication if it is lost on the battlefield.

The other important provision that was amended in 1983 is paragraph 7, which now provides that when a member of the Forces is diagnosed as an epileptic, the appropriate initial medical category for a temporary six-month period is G4 O4. That category lies below the minimum required by the Forces, but the CMRB makes no decision concerning a member's career prospects when he is subject to a temporary classification. Thus, he is protected from immediate transfer or release. Be that as it may, it appears that until 1983 the suggested temporary initial category was G3 O3. Although the final category for a member positively diagnosed as an epileptic was the same - G4 O3 - both before and after the 1983 amendment, Dr. Skinner confirmed that the old paragraph 7, a copy of which the Tribunal was unable to obtain, gave the CMRB greater latitude, permitting it to reclassify a member to category G2 O2 if he remained seizure-free after a two-year period. In other words, the 1983 amendment "was a somewhat more restrictive Order than the one present between '81 and '83..." (Transcript, pp. 559 and 586-87). As for the amendments to paragraph 8 (which describes the restrictions that are supposed to apply to medical category G4 O3 for a member of the Forces suffering from a seizure disorder), the Tribunal was given no explanations. Nevertheless, it is clear that these medical categories and restrictions have not been revised since 1983.

When asked to comment on the relevance of the medical category - that is, G4 O3 - provided for in CFMO 26-12, Dr. Skinner gave the opinion that it was justified because a member of the Army is always in a context presenting a higher risk than in civilian life in general. He must be able to handle firearms and to work long hours in extreme conditions. Add to that the difficulties of supplying medication on the battlefield and the witness feels that the medical category G4 is appropriate. Moreover, Dr. Skinner said that all trades do not present the same risk in the Army, and he made a distinction in this respect between three categories of positions: 1) high-risk positions, such as those of an aircraft pilot and of aircrew personnel; 2) moderate-risk positions, such as those of operators of hazardous machines or of drivers of passenger transport vehicles; and 3) the other positions, which are of low risk. Nevertheless, since every member of the Forces must be able to carry a weapon and use it, this must always be taken into account in assessing the risk, which remains higher than in civilian life.

Finally, when asked to comment on the medical reports of the various physicians consulted by the complainant between 1981 and 1984 - that is, medical officers Dr. Smallman and Dr. Burling and civilian neurologists Dr. Habib and Dr. Del Campo - all of whom recommended that Sergeant Robinson be kept in the forces and disputed the medical category of G4, Dr. Skinner asserted that those medical reports were not too valid in scientific terms because they only contained medical "opinions". According to him, it is not scientific to say, as did Dr. Del Campo (Exhibit HR-1, tab 14), that the epilepsy was perfectly controlled as of August 24, 1984, with a standard dose of Tegretol, as is the case with 80 percent of patients with complex partial epilepsy, because the medical reports reveal that Robinson had only taken three electroencephalograms. Along these lines, all the medical opinions in Robinson's file indicating that he was a controlled epileptic capable of functioning in the Army are only opinions in the sense that they do not appear to him to have been proven scientifically. Thus, he feels that the medical category of G3 O3 set by Dr. Burling (Exhibit R-1, tabs 21 and 22) was too liberal and that its downward modification to G4 O4 and G4 O3 by Dr. Lange (Exhibit R-1, tabs 21 and 22, see the handwritten corrections to the original classification), Colonel Thatcher (Exhibit R-1, tab 25) and Dr. Greenidge (Exhibit R-1, tab 28) was perfectly appropriate.

II- THE ALLEGATION OF DISCRIMINATION

As we know, the analysis of a question of discrimination under the Canadian Human Rights Act, R.S.C. 1985, c. H-6, or under any provincial anti-discrimination legislation, is carried out in two steps. First of

all, it is necessary to determine whether, directly or indirectly, a person or a group of persons has been treated differently, whether that difference in treatment caused an injury to that person or group, whether it was based on one of the grounds set out in the Act and whether it occurred in one of the activities covered by the Act. If this is in fact the case, it is then necessary to verify whether or not such discrimination is authorized by one of the exceptions under s. 15 of the Act because, for example, it is a bona fide occupational requirement (BFOR): Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 143, at pp. 172-76 (it should be noted that the French version of the Canadian Act referred to "exigences professionnelles

normales" before the 1985 revision of federal statutes whereas it referred to "exigences professionnelles justifiées" after the revision; in our opinion, however, that does not affect the interpretation of s. 15(a), the English version of which has always referred to a bona fide occupational requirement, so the concept is still the same).

In analyzing discrimination, it must be remembered that the Canadian Human Rights Act is legislation of a special, indeed fundamental or almost constitutional, nature and that for this very reason it must be given a broad and liberal interpretation so as to guarantee its purpose: Winnipeg School Division No. 1 v. Craton, [1985] 2 S.C.R. 150, at p. 156; O'Malley v. Simpsons-Sears, [1985] 2 S.C.R. 536, at p. 547; Robichaud v. Canada, [1987] 2 S.C.R. 84, at p. 92; R. v. Mercure, [1988] 1 S.C.R. 234, at p. 268.

The Supreme Court of Canada has also explained the purpose of human rights legislation, which the tribunals and courts must constantly keep in mind in their interpretations: to guarantee to all members of society that they will be assessed as individuals on the basis of their own merits rather than on the basis of belonging to a group identified by a personal characteristic mentioned in the Act: Town of Brossard v. Quebec, [1988] 2 S.C.R. 279, at pp. 297-98 (Beetz J.) and 344 (Wilson J.). See also along the same lines: Air Canada v. Carson, [1985] 1 F.C. 209, at p. 239 (C.A.); Cashin v. Canadian Broadcasting Corporation [1988], 3 F.C. 494, at p. 506 (C.A.). Thus, the case law is in perfect harmony with s. 2 of the Canadian Human Rights Act, which states that its purpose is to give effect to the principle "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... without being hindered in or prevented from doing so by discriminatory practices based on... disability," which, according to s. 25, includes both mental and physical disability.

In the present case, the complaint is that the respondent released former Sergeant Robinson from the Canadian Armed Forces because he was an epileptic. It goes without saying that the burden is on the complainant to prove this in accordance with the ordinary civil standard of the balance of probabilities.

There is no problem here with the ground of discrimination. Counsel for the respondent has admitted that the Forces' decision to release Mr. Robinson was based on epilepsy and that epilepsy is a disability within the meaning of the Canadian Human Rights Act. At any rate, the evidence was very clear on this point, as the CMRB's written decision expressly stated that epilepsy was the reason for its recommendation of release.

Since the complainant was refused the opportunity to retain his employment as a Flight Engineer or to be transferred to another trade in the Forces because of his epilepsy, the Tribunal finds that s. 7 of the Act has been contravened. According to that section, it is a discriminatory practice directly or indirectly to refuse to continue to employ someone or to differentiate adversely in relation to that person in the course of employment.

The evidence shows not only that the complainant was refused the opportunity to continue his trade as a Flight Engineer because of his epilepsy but that in all probability his medical condition led the CMRB to fail to consider the possibility of a transfer to a trade for which the complainant was qualified. It emerges clearly from Lieutenant Colonel

Swan's testimony that any transfer of Mr. Robinson was in fact ruled out because of the restrictions automatically placed, under the Forces' Seizure Disorders - Category Policy, on a member of the Forces diagnosed as an epileptic. Thus, the respondent differentiated adversely in relation to the complainant in the course of employment by denying him a benefit - the possibility of transfer - normally considered when a career member's medical category is lowered. Possible reclassification and transfer, as opposed to automatic release, is a benefit of employment as a serving member that is expressly recognized in Chapter 3 of the Medical Standards for the Canadian Forces. Paragraph 1 of that Chapter provides: "it is inevitable that the category of many serving personnel will be lowered during their career...." Paragraph 7 adds that medical officers must consequently "ensure that a man with a medical limitation is employed to his best advantage as well as in the best interest of the Service."

Moreover, Lieutenant Colonel Swan confirmed that the CMRB's objective is in no way to release a member of the Forces whose medical category has been lowered and that this option is only considered if absolutely necessary.

Thus, the transfer system is a benefit of employment as a serving member of the Forces. Moreover, several decisions have already recognized that that benefit exists and that the distinction made by the Forces between recruits and serving personnel regarding the right to take advantage of it is legitimate: Galbraith, supra, paragraphs 45803, 45850-51 and 45864; Séguin and Tuskovich v. R.C.M.P. (1989), 10 C.H.R.R. D/5980, paragraphs 43268-69 and 43386; Parent v. Department of National Defence (1980), 1 C.H.R.R. D/121, paragraph 1062. Although an employer is not obligated to give such a benefit to its employees, when it does so it cannot deny it to some of its employees on grounds of discrimination.

It is one thing to say, as the Supreme Court of Canada confirmed in Central Alberta Dairy Pool v. Alberta Human Rights Commission, [1990] 2 S.C.R. 489, that an employer has no duty to accommodate its employees in relation to direct discrimination if such discrimination constitutes a bona fide occupational requirement. It is another thing to say that an employer can arbitrarily exclude a category of people because of their race, sex or disability when setting up a system of fringe benefits that includes a variety of accommodations such as sick leave, maternity leave and transfers for family or medical reasons. The fact that an employer is not legally obligated to provide certain accommodations in favour of its employees does not mean that it is automatically authorized to act in a discriminatory manner in granting or applying the benefits it has decided to grant its employees on its own initiative or under a private or collective employment contract. Central Alberta Dairy Pool, supra, and Bhinder v. C.N., [1985] 2 S.C.R. 561, can in no event be interpreted to permit discrimination in a fringe benefit system set up by the employer on the ground that the employer is not obligated to provide a reasonable accommodation in relation to justified direct discrimination. Thus, the issue is not, as counsel for both parties claimed, whether the respondent was obligated, in the circumstances of the case, to transfer the complainant. Instead, it is whether the transfer system set up by the Canadian Forces for the benefit of all its employees is discriminatory in itself or was applied in a discriminatory manner. Section 7 of the Act forbids an employer not only to dismiss an employee on a prohibited ground of discrimination, but also, "in the course of employment, to differentiate adversely in relation to an

employee...." This most certainly refers to the employer's policies or decisions mentioned expressly in s. 10(b) of the Act: those affecting

promotion, training, apprenticeship, transfer, leave and any other condition of employment or benefit granted in the context of employment. Since Captain MacKnie acknowledged that the complainant was qualified to carry on other trades in the Forces, including those of Aero Frame Technician, Aero Engine Technician and Aviation Technician, which he had carried on in turn during the first ten years of his career in the Forces, the onus was on the respondent to show that former Sergeant Robinson was, in the CMRB's own words, "not otherwise advantageously employable under existing service policy."

There was not a hint of evidence on this subject, however. The respondent did not try to demonstrate that a transfer was impossible because there were no positions available in any of those trades in 1984 or because the proportion of serving members who had had their medical categories lowered under the medical standards but enjoyed a CMRB waiver was too high at that time. It goes without saying that the statistics submitted to the Tribunal on this subject (Exhibit R-10, tabs 3 and 4) have no probative force because they only concern the situation prevailing in the various trades considered by the complainant during 1988, 1989 and 1990.

The preponderant evidence is therefore clear: the complainant's epilepsy was the only reason behind the refusal to consider the possibility of transferring him, and in doing this the respondent differentiated adversely in relation to the complainant in the course of employment within the meaning of s. 7(b) of the Canadian Human Rights Act. Moreover, Lieutenant Colonel Swan was unable to identify a single case in which a member was retained in the Forces by means of a transfer after having been diagnosed as an epileptic. He did mention the case of an epileptic member who was able to retain his position as a Flight Engineer on a temporary basis, but this was solely to enable the diagnosis of his epilepsy to be verified. As soon as the diagnosis was confirmed, a decision was made to release him.

However, Mr. Robinson's complaint goes farther. He submits that his physical disability was also the reason for the refusal to appoint him to the Alcoholism Counsellor's position in the Alcohol Rehabilitation Clinic at CFB Winnipeg. Counsel for the respondent forcefully objected to such a conclusion because that would mean that the Forces were guilty of "covert" discrimination. Mr. Robinson was never told that he was denied the position because of his epilepsy but because there were no positions available when he applied. This question is more difficult to answer because there is no direct evidence or admission of the reason behind the discrimination.

The sequence of events that emerges from the complainant's uncontradicted testimony and from the documentary evidence submitted by both parties is as follows. When his medical category was still temporarily set at G4 O4, and thus below the Forces' minimum medical standards, Sergeant Robinson applied for the Alcoholism Counsellor's position in the Winnipeg clinic. That was in the fall of 1983, in September or October. It should be recalled here that as long as a member of the Forces has a temporary medical category he is protected from any decision to release him and can remain in the Forces. The complainant's

permanent medical category - G4 O4 A7 - was decided upon in November 1983, however (Exhibit R-1, tab 22). In January 1984, HQ in Ottawa notified Robinson that his application for the Alcoholism Counsellor's position had been rejected because there would be no positions available in this field until 1986 ("all positions filled until 1986": Exhibit HR-1, tab 10). In February 1984, the complainant's medical category was revised to be set at G4 O3, although with the same restrictions making him unfit either to carry on his trade as a Flight Engineer or to perform his military function. On June 4, 1984, the Director of Personnel Career Other Ranks again indicated on a CMRB form "no ARC position available at this time," and the CMRB recommended on June 21, 1984, that the complainant be released (Exhibit HR-1, tab 12). Finally, on June 25, 1984, HQ in Ottawa informed Master Corporal Ozzie Cawlishaw that his application to be an Alcoholism Counsellor in the Winnipeg clinic had been accepted even though the regulations indicate clearly that this speciality cannot be offered to a member of the Forces who has not yet obtained the rank of Sergeant (paragraph 3(d)(1)(b), CFSO 98/84: Exhibit R-2, tab 17).

What conclusion can be reached as a result of these events? Mr. Evernden argued that they prove nothing other than an administrative error in good faith by military authorities concerning the availability of Alcoholism Counsellor positions at CFB Winnipeg. In our opinion, this explanation is too obvious to fool anyone for two reasons established in evidence by Mr. Evernden himself: 1) that an administrative error was maintained for six months - from January to June 1984 - appears impossible considering that there was only a single Alcoholism Counsellor's position in Winnipeg (see Major MacCullam's testimony); 2) because the Alcoholism Counsellor's position is not strictly speaking a trade or occupation in the Forces but a speciality, a member must at all times retain his trade's minimum qualifications from both a medical and an occupational point of view to have access to the said specialty. Since Sergeant Robinson had just officially lost the said minimum qualifications for his Flight Engineer's trade in November 1983, however, it was only logical that he

would be denied the specialty of Alcoholism Counsellor. What is less logical is that an attempt was made to make him believe that there were no openings for this position in the Winnipeg clinic when there quite obviously was one, which was in fact filled the following summer.

Moreover, that position was offered to a co-worker from the clinic (at the time, the complainant was already working there part-time) who, unlike Sergeant Robinson, did not have the minimum rank required by the regulations to carry on this specialty.

The Tribunal therefore finds that, on the balance of probabilities, the real reason for the rejection of the complainant's application for the Alcoholism Counsellor's position was his physical disability, as it is because of his diagnosis of epilepsy that he was definitively considered unfit for military life and for his Flight Engineer's trade in November 1983. It was repeated several times by various witnesses that fitness for a trade in the Forces was and still is a prerequisite for access to any speciality. Any other conclusion, such as administrative error, therefore appears to be groundless.

Thus, the refusal to transfer former Sergeant Robinson to the Alcoholism Counsellor's position constituted a discriminatory practice within the meaning of s. 7 of the Canadian Human Rights Act. Furthermore,

the respondent's Seizure Disorders - Category Policy, on which the military authorities' decision to release Sergeant Robinson was based, constitutes a discriminatory policy within the meaning of s. 10(a) of the Act.

III- THE BONA FIDE OCCUPATIONAL REQUIREMENT (BFOR) DEFENCE

A) The Applicable Legal Principles

The interpretation of the Act must be as broad and liberal when analyzing the discrimination as it must be restrictive when considering the bona fide occupational requirement defence. As McIntyre J. said in Ontario Human Rights Commission v. Etobicoke, [1982] 1 S.C.R. 202, at p. 208, "...non-discrimination is the rule of general application and discrimination, where permitted, is the exception"; this led Beetz J. to explain in Town of Brossard, supra, that "...bona fide occupational qualification exceptions in human rights legislation should, in principle, be interpreted restrictively since they take away rights which otherwise benefit from a liberal interpretation" (at p. 307).

Thus, the onus is on the employer to prove that there is a BFOR, and the applicable rule is the ordinary civil standard of the balance of probabilities: Etobicoke, supra, at p. 208. Should the employer's burden of proof be regarded as lighter when it raises an argument of public safety? Such a proposal has been accepted in a certain number of this Tribunal's decisions, including Rodger v. C.N.R. (1985), 6 C.H.R.R. D/2899, paragraph 23660. This method of tackling the employer's burden of proof was expressly rejected, with good reason, by a Review Tribunal in Gaetz v. Canadian Armed Forces (1989), 10 C.H.R.R. D/6375, paragraph 45199.

Considering that the BFOR exception must be given a restrictive interpretation, it is not appropriate to reduce the civil standard of the balance of probabilities established by the Supreme Court in the Etobicoke case, in which public safety was at the core of the employer's defence. Along the same lines, see: St-Thomas v. Canadian Armed Forces, Can. Hum. Rights Trib., April 25, 1991, at p. 5 (unreported); Séguin and Tuskovich, supra, paragraphs 43378-80; DeJager v. Department of National Defence (1986), 7 C.H.R.R. D/3508, paragraph 28016.

To demonstrate on the basis of the balance of probabilities that an occupational requirement is bona fide, the employer must produce evidence on two branches. As the Supreme Court held in the Etobicoke case, supra, at p. 208, it must first produce subjective evidence of its good faith in establishing its requirement:

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.

The introduction of a subjective element of good faith into the BFOR defence has been criticized by legal theorists (see B. Vizkelety, Proving Discrimination in Canada (Carswell, 1987), at pp. 204-06). If good faith or good intentions are irrelevant at the first stage of the analysis, that of establishing whether there has been discrimination, why would they be relevant at the level of the BFOR exception? Would that not permit an

employer to argue that its discriminatory requirement is legitimate because it is based on stereotypes maintained in good faith, that is, without malicious intent toward a category of persons protected by the Act?

It is probably for this reason that this subjective test has been expressly ruled out in at least one statute: Quebec's Charter of Human Rights and Freedoms, R.S.Q., c. C-12. Section 20, which deals with the BFOR exception, originally provided that a "distinction, exclusion or preference based on the aptitudes or qualifications required in good faith for an employment... is deemed non-discriminatory." The words in good faith were removed from this section as part of a series of amendments made to that Charter in 1982.

As for the other anti-discrimination legislation, however, the subjective good faith test appears to have been retained by the legislatures, the courts and the Supreme Court. It should be noted, however, that analysis of this test is almost always very brief. In the absence of evidence on this topic, the courts generally assume that the employer has acted in good faith since, at any rate, there is normally a legal presumption of good faith. Thus, for example, even though the Tribunal has pointed out in some decisions that the Canadian Armed Forces had failed to explain the origin, basis or validity of their medical standards, their "sincere belief" that those standards were imposed to ensure that military work would be performed well has not been challenged (for example, see DeJager, supra, paragraph 28020; Galbraith, supra, paragraph 45812). There is a recent decision that appears to be an exception from this general approach of not controlling the subjective good faith test: Bouchard v. Canadian Armed Forces (1991), 13 C.H.R.R. D/111.

In that case, the Tribunal held that the Forces had not proven that they had acted in good faith in lowering the applicant's medical category to G4 on grounds of obesity because the attending physician had not approved this change of category.

The Supreme Court has established a second test, which is objective and is much more important: this is really the test on the basis of which the courts have verified the legitimacy of an employer's a priori discriminatory occupational requirement. Thus, McIntyre J. said the following in Etobicoke, supra, at p. 208:

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.

Since this exception must be interpreted restrictively so as not to rob of its meaning the right to equal opportunity enjoyed by those - in the present case, individuals suffering from a physical disability such as

epilepsy - protected by the Act, it is necessary to emphasize certain key elements of this objective test.

First, since the occupational requirement must be related objectively to the performance of the employment, its necessity must be proven and core evidence based on hard verifiable facts -as opposed to mere impressions or generalizations - must be adduced (see Carson, supra, at p. 234). Next, it is obvious from the Supreme Court's reference to a "reasonable necessity" that this test requires much more than mere convenience. In other words, if the Forces' medical categorization system exists solely because it is

more convenient for managing military personnel, this system, which discriminates against those suffering from a disability, cannot constitute a BFOR within the meaning of the Act. A group of persons who are often already at a disadvantage because of social prejudices cannot purely for reasons of administrative convenience be denied the right to an equal opportunity with others to make for themselves the lives that they are able and wish to have.

How can the employer discharge his burden of proof for the objective branch of the BFOR? McIntyre J. gave valuable hints on this topic in the Etobicoke case, as he said the following on page 209: "The answer to [this] question will depend in this, as in all cases, upon a consideration of the evidence and of the nature of the employment concerned."

Concerning the nature of the employment, the employer must first establish whether or not it is employment involving a safety risk, such as that of an airplane pilot or bus driver. This is important because if there is no safety risk it might be difficult, if not impossible, McIntyre J. added, to demonstrate that a discriminatory requirement the effect of which is to exclude an entire category of persons is bona fide. The alternative solution to excluding an entire group appears to stand out on its own: the principle of equality requires that the employer assess the capabilities of each employee before reaching a decision about him. He cannot be excluded by virtue of a blanket rule if it is possible to assess him on an individual basis.

On the other hand, if the employment presents a risk for the safety of the employee, of his fellow employees or of the public, the employer must demonstrate this by submitting detailed evidence related to the duties to be discharged and the working conditions in its business. It is possible that there will then be no other solution than to recognize the need for an occupational requirement consisting of the blanket exclusion of a group

protected by the Act. To reach that conclusion, however, the employer must also prove on the basis of the balance of probabilities (1) that the group of persons - for example, epileptics - excluded by its employment policy presents "a sufficient risk of employee failure" (Etobicoke, at p. 210) to warrant its general exclusion, (2) that it is impossible to assess the risk presented by each member of a protected group on an individual basis and (3) that the blanket exclusion of a category of persons is not an excessive means, that is, it is proportional to the end being sought. We will consider these three points in order.

1) The Applicable Standard for Sufficient Risk

When an employer invokes safety, the keystone of its evidence regarding a BFOR is the evidence that a group of employees presents a "sufficient" risk of danger for themselves or for others. But what exactly is the applicable standard for "sufficient" risk? Two divergent currents of thought have been developed in the case law on this subject.

The first current was established in 1985 by Mahoney and MacGuigan JJ. of the Federal Court of Appeal in Air Canada v. Carson, supra. Those judges rejected the American approach based on Hodgson v. Greyhound Lines (1974), 499 F. 2d 859, according to which evidence of any risk of danger, even minimal, justifies the exclusion of an entire group of persons.

According to MacGuigan J., who elaborated further on the issue (see pp. 230-32), the very fact that McIntyre J. formulated a "sufficient" risk test

in the Etobicoke case implies by definition that a certain risk, especially if it is minimal, might be acceptable to ensure that the disabled actually enjoy the equal opportunity the Act is supposed to guarantee them. The Tribunal held in a number of subsequent decisions that the employer, to succeed in its BFOR defence, must demonstrate not only that there is a risk but also that the risk is unacceptable for the employee or for the public (for example, see DeJager (1986), supra; Mahon v. C.P.R. (1986), 7 C.H.R.R. D/3278; Nowell v. C.N.R. (1987), 8 C.H.R.R. D/3727; Mackenzie v. Quintette Coal (1987), 8 C.H.R.R. D/3762 (B.C. Council)).

In fact, these latter cases probably went farther than the Federal Court in Carson because after 1982 they were based on another legal standard: s. 8(b) of the Bona Fide Occupational Requirement Guidelines, SI/82-3, (1982) 116 Can. Gaz. (Part II) 311, which were enacted by the Canadian Human Rights Commission under the Canadian Human Rights Act and were binding at that time. The paragraph in question required that the

employer demonstrate that the safety hazard would be "significantly greater" if a disabled person was hired than if he was not hired. Although that legal standard was applicable when the complainant in the present case was released from the Forces, none of the parties claimed that these guidelines should have been applied to the present case. In any event, the Commission repealed the guidelines in 1988 (see SI/88-184, (1988) 122 Can. Gaz. (Part II) 4360).

In 1988, the Federal Court of Appeal was to invalidate that approach regarding sufficient risk in Canadian Pacific v. Canada, [1988] 1 F.C. 209. Pratte and Marceau JJ. totally rejected the idea that sufficient risk could imply society's acceptance of some risk in order to promote equal opportunity for all. Thus, they rejected not only the test of significantly greater risk, which was set out in the Bona Fide Occupational Requirement Guidelines and had consequently been adopted by the Canadian Human Rights Tribunal, but also that of "minimum acceptable risk" evoked by MacGuigan J. in Carson.

According to Pratte J., even a minimal risk is sufficient evidence of a BFOR in the light of the Supreme Court of Canada's decision to that effect in Bhinder v. C.N., [1985] 2 S.C.R. 561. In that case, which concerned the mandatory requirement to wear a hard hat in a marshalling yard of the Toronto train station, McIntyre J. had decided, writing for the majority, that a BFOR had been demonstrated even though his failure to satisfy the requirement of wearing a hard hat would only expose Bhinder to a "slightly greater" risk of injury (Bhinder, at pp. 584 and 588).

As a result, Pratte J. held that sufficient risk had been proven even though the Human Rights Tribunal in Canadian Pacific had found at first instance that Mahon, a stable insulin dependent diabetic, had only a "slight possibility", and not a probability, of passing out while working as a railway trackman because of an uncontrollable reaction called a neuroglycopenic reaction. Although the exclusion of stable insulin dependent diabetics would, because of the minimal nature of the risk they present, only marginally increase public safety, the existence of a "real" risk within the meaning of the Bhinder case had been proven. Thus, Pratte J. replaced the minimum acceptable risk test with that of a "real" risk as follows (at pp. 221-22):

Once it had been found that the applicant's policy not to employ insulin dependent diabetics as trackmen was reasonably necessary to

eliminate a real risk of serious damage for the applicant, its employees and the public, there was only one decision that the Tribunal could legally make, namely, that the applicant's refusal to engage the respondent Wayne Mahon was based on a bona fide occupational requirement....

Agreeing from the outset with his colleague Pratte J., Marceau J. tried to reinterpret the Etobicoke case's "sufficient risk" standard accordingly as follows (at p. 224):

When I read the phrase [on sufficient risk in the Etobicoke case] 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.

Thus, to Marceau J., evidence of sufficient risk does not mean evidence that a risk is high enough to be deemed sufficient but means that the evidence must be sufficient to demonstrate the existence of a risk, whatever it may be.

According to Pratte and Marceau JJ. in Canadian Pacific, therefore, no risk or even increase in risk to safety is acceptable, and a risk must be considered real even if it is minimal, indeed negligible, as soon as the employer is able to demonstrate that it might exist, even if it is not at all probable. In effect, the degree of a risk has nothing to do with the risk's real or sufficient nature.

This manner of tackling the question of sufficient risk to safety has in subsequent Human Rights Tribunal decisions rightly been considered inconsistent with that proposed in Carson. Since the Canadian Pacific case is more recent than Carson, the "real" risk test of Pratte and Marceau JJ. is therefore the one that has been applied (for example, see Séguin and Tuskovich (1989), supra, paragraph 43377; Gaetz. v. Canadian Armed Forces (1989), 10 C.H.R.R. D/5902, paragraphs 42983-85; Galbraith (1989), supra, paragraphs 45815-17; Rivard (1990), supra, paragraphs 98-120).

In our opinion, this "real" risk test is inconsistent with the philosophy of both the Canadian Human Rights Act and any other legislation of the same nature. The purpose of such legislation is to guarantee, inter alia, to disabled persons that they will not be excluded by society and that they enjoy a real, and not simply hypothetical, right to equal opportunity with other individuals to make for themselves the lives that they are able and wish to have through their fullest possible integration into and participation in society. Isolation is probably the best ally of preconceived notions about a group or category of persons identified by a

personal characteristic. It fosters ignorance, which leads to and nurtures prejudice and discrimination. It is to counter these very scourges that human rights legislation has been adopted.

In our opinion, the concept of "real" risk within the meaning intended by Pratte and Marceau JJ. in Canadian Pacific was correctly rejected by the Supreme Court of Canada in a recent case : Central Alberta Dairy Pool v. Alberta Human Rights Commission, [1990] 2 S.C.R. 489. That case is known above all for having reversed the Bhinder case, supra, on the issue of reasonable accommodation with respect to adverse effect discrimination.

However, Wilson J. reversed the reasoning of the majority in Bhinder on the issue of the standard they had adopted with respect to risk. After having re-examined the Human Rights Tribunal's findings of fact in Bhinder,

according to which the hazard faced by Mr. Bhinder in not wearing a hard hat was negligible and there was practically no hazard for the public or his fellow employees, Wilson J., writing for the majority, said the following at pages 512-13 (it should be noted that Sopinka J. expressed no disagreement on this point in his own reasons):

It seems to me in retrospect that the majority of this Court may indeed have erred in concluding that the hard hat rule was a BFOR....

First, the rule was not, to use the terminology of Etobicoke, supra, "reasonably necessary to assure the efficient and economical performance of the job without endangering the employee, his fellow employees and the general public." The Tribunal found as a fact that the failure of Mr. Bhinder to wear a hard hat would not affect his ability to work as a maintenance electrician or pose any threat to the safety of his co-workers or to the public at large. The Tribunal did find that not wearing a hard hat would increase the risk to Mr. Bhinder himself, but only marginally. In light of the findings of fact by the Tribunal, I think it is difficult to support the conclusion of the majority of the Court that the hard hat rule was reasonably necessary for the safety of Mr. Bhinder, his fellow employees and the general public.

By so clearly reversing the decision of McIntyre J. in Bhinder that a very slight risk is sufficient for a BFOR, the Supreme Court also unequivocally rejected the approach taken by the Federal Court in Canadian Pacific, as that decision was based on the reasoning adopted in Bhinder. This change in course, which implies that a certain risk is

acceptable, is good for minority groups. Otherwise, as Professor Cumming pointed out for the Tribunal in Mahon, employers with offices in tall buildings would be justified in excluding people in wheelchairs because they would in the event of fire present a slight, but additional, risk both to their own safety and to that of others; cinema owners would be justified in doing the same for identical reasons; the government would be justified in denying driver's licences to all those with disabilities, even those well controlled by medication, in the light of the "real", although minimal, possibility of their losing control of their vehicles without warning. In other words, the right of disabled persons to enjoy equal opportunity with other individuals to make for themselves the lives that they are able and wish to have would be completely undermined by any argument of a risk, no matter how slight, as soon as the hazard was described as "real", and this is what the Supreme Court of Canada understood in the context of religious minorities in Central Alberta Dairy Pool.

Since a certain risk is acceptable in the public interest to ensure that the purpose of the Canadian Human Rights Act is fulfilled, this means that the employer must, with respect to a BFOR, demonstrate not only that the presence of disabled persons involves a safety risk, but that the risk is unacceptable. It is hard to establish what an unacceptable risk is, and it is probably impossible to formulate a specific rule for this.

Nevertheless, this Tribunal is of the opinion that the employer must at the very least demonstrate that the risk with respect to a given employment is neither slight nor negligible because, as is shown by the Carson case, supra, a certain risk, such as a minimal risk, might sometimes be

acceptable in the fundamental public interest represented by the full application of human rights legislation, which, it is not pointless to recall, has an almost constitutional status. On the other hand, the employer does not in our opinion have to demonstrate that the presence of a certain group in the business implies a significantly or substantially greater hazard for the public within the meaning of s. 8 of the old Bona Fide Occupational Requirement Guidelines, which were repealed in 1988. In our opinion, that test is too restrictive and is likely to expose society to an unacceptable risk of human error or failure.

Therefore, it must be demonstrated by the employer that the presence of a particular employee or group of employees poses a sufficiently higher safety hazard within a given job context to be found unacceptable by a tribunal or a court. Whether or not the increased risk is acceptable will

then depend on a) how hazardous is a particular employment, b) how great a risk is an individual or a group with a given disability, e.g. epilepsy, and c) how closely related to the safe and efficient performance of the work responsibilities are the risks assciated with a given disability. All the jobs in a single business do not involve the same responsibilities with respect to public safety, and all epileptics are not necessarily in the same situations in this regard.

The quality of the employer's evidence is therefore crucial.

Scientific evidence, that is, "statistical and medical evidence based upon observation and research on the question [of the risk presented by certain individuals in performing a given task] ...will certainly be more persuasive than the testimony of persons, albeit with great experience [in a given business]" (Etobicoke, supra, at p. 212). The Tribunal has had occasion several times to stress the scientific nature of the evidence concerning employment policies excluding various categories of persons with disabilities, including diabetes, asthma and epilepsy. For example, see Rodger, supra, in which President Lederman said the following:

23674 Although society cannot permit any substantial threat to public safety, it cannot condone hasty assumptions about the capabilities of the handicapped. Employers must ensure that in imposing BFORs, they are relying upon the most authoritative and up to date medical and statistical information available and adapted to the circumstances of each individual case.

Along the same lines, see Séguin and Tuskovich, supra, paragraphs 43378-80; Galbraith, supra; DeJager, supra.

2) Individual Assessment of the Employee

If there is one point the Human Rights Tribunal has been stressing for several years, especially with respect to complaints of discrimination on the basis of disability, it is the employer's obligation to assess the capabilities of each current or possible employee, along with the risk of failure he might present because of his personal limitations, on an individual basis. Since the purpose of the Canadian Human Rights Act is to combat generalizations based on society's prejudices toward, inter alia, disabled people, it follows logically that it is necessary to avoid "lumping them all together", so to speak. It is in fact false to claim that "all" diabetics or "all" epileptics are on the same footing as far as work safety is concerned. Some are well under control by means of appropriate medication, while others are not. It is surely not reasonably

necessary to exclude all the members of a group identified by a disability if they do not all present an unacceptable safety risk.

It should also be pointed out that unwarranted generalizations on the physical fitness and capabilities of persons handicapped by certain disabilities are not made only by neophytes. Some physicians can give in to this temptation. The fact that an individual is a doctor of medicine does not shelter him from prejudices. Thus, when a physician, especially if he has a close working relationship with an employer, gives the opinion that an applicant presents a risk for work safety because he is an epileptic, this is not necessarily an adequate individual assessment of the real capabilities and risk the particular applicant might present in the job he is seeking. His assessment might be based on pure, groundless generalization or on outdated medical studies. As Professor William Black has pointed out, it might also be coloured by his bias in favour of his client, who is the employer:

Often medical examinations of job applicants are done by a doctor who has an ongoing relationship with an employer.... Even though the doctor may try to be objective, I think it is unavoidable that the interests of the firm will be preferred to those of the applicant in close cases. Usually, an unsuccessful applicant will simply disappear, whereas a doctor is likely to be criticized if he or she approves an applicant who subsequently proves unable to perform the work.... I believe that doctors conducting medical examinations usually view their job as one of determining who are the least risky applicants rather than determining whether a person can perform the required duties.

W. Black, Bona Fide Occupational Requirements and Physical and Mental Conditions, Research Paper: Outline of Comments (Ottawa: Human Rights Centre of the University of Ottawa, 1985), at p. 6.

In such a context, a medical opinion is not to be taken at its face value by a tribunal.

Moreover, it might prove impossible to assess on an individual basis the risk presented by persons with a given affliction for a given job because there are neither sufficiently specific scientific studies on the topic nor suitable tests. If so, the onus is on the employer to prove such impossibility, as the Supreme Court said in City of Saskatoon v. Saskatchewan Human Rights Commission, [1989] 2 S.C.R. 1297, at p. 1313:
In my opinion, these cases point the way to the proper approach with

respect to individual testing. 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.

The Court repeated this position in Central Alberta Dairy Pool, supra, both through Wilson J. (at p. 519) and through Sopinka J. (at pp. 526-27).

3) The Proportionality of the Occupational Requirement

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Even if the employer succeeds in proving that certain disabled persons present an unacceptable risk for themselves or for others, that is not necessarily enough to demonstrate that purely and simply excluding them from the business is a reasonably necessary occupational requirement to guarantee safe and efficient performance of the work. Such a measure might be too broad and might constitute an excessive means for achieving an otherwise valid objective, as Beetz J. explained in Town of Brossard, supra, at p. 312:

In the case at bar, I believe that this "reasonable necessity" can be examined on the basis of the following two questions:

(1)...; (2) Is the rule properly designed to ensure that the aptitude or qualification is met without placing an undue burden on those to whom the rule applies? This allows us to inquire as to the reasonableness of the means the employer chooses to test for the presence of the requirement for the employment in question.

Thus, after having noted that the Town of Brossard's anti-favouritism rule excluded any applicant, without exception and no matter what the job being sought, who was related to an employee of the town, no matter what the job held by the employee in question, Beetz J. found such a requirement to be excessive. It did not at all take into consideration the degree of probability of abuse of power or of conflicts of interest and could not therefore be a reasonably necessary occupational requirement for eliminating favouritism in the town in question.

To Wilson J., both in Town of Brossard (at p. 344) and in Central Alberta Dairy Pool, supra (at p. 518), in which she wrote the decision for the majority, the undue burden test laid down by Beetz J. means that an occupational requirement is only justified if the employer demonstrates that there were no other less drastic means to achieve the intended end of the requirement in question.

Applying this to questions concerning safety, it means that there might be other less drastic means to achieve the legitimate end of work safety than excluding any person presenting a risk of employee failure from every position in the business without exception. If the risk of injury is high in some positions but negligible in others, or if the consequences of failure for the life or property of others are extreme in some positions but insignificant in others, generally excluding a group protected by the Act from all activities in the business will not be considered to be a BFOR. In fact, this test flows directly from the principles already laid down by McIntyre J. in the Etobicoke case, supra, when he indicated clearly that the nature of the job was an important factor in assessing the necessity of a discriminatory occupational requirement.

B) Applying the Legal Principles to the Present Case

Has the employer, in this case the Canadian Armed Forces, succeeded in proving in accordance with the standard of the balance of probabilities that its medical requirements, and in particular its Seizure Disorders - Category Policy, the result of which is that every epileptic member of the Forces is automatically released, are reasonably necessary to guarantee the safe and efficient performance of every trade in the Forces, and in particular the various aviation-related trades for which former Sergeant Robinson was qualified? If the answer to this first question is negative,

has it proven that the complainant could not as a result of his medical condition safely and efficiently perform any military function? These are the questions this Tribunal must answer. To do so, it must verify first whether the medical standards for the Forces were established in good faith (subjective branch) and then whether they objectively satisfy the reasonable necessity test set out in the Etobicoke case, supra, which was elaborated in later cases.

As we pointed out above, none of the officers called to testify for the respondent either in this case or in others was in a position to explain the basis or origin of, or reason for, the Forces' minimum medical standards. There is at least an official explanation for the existence of

those standards in paragraph 2 of Chapter I of the manual of Medical Standards for the Canadian Forces, which describes the purpose of the system as follows: "2. A combination of a physical profile and a category system has been adopted. Its purpose is to communicate to administrative and employment authority a concise medical opinion of the employment capabilities of recruits and serving members."

In other words, the purpose of the system of categories granted in accordance with specific factors, such as geographical (G) or occupational (O) factors, is to facilitate personnel management. Basically, this appears very convenient from an administrative point of view, in addition to being very likely to save time and money. Although that is not enough to demonstrate that these standards constitute a BFOR, it at least shows that the reasons behind them are not discriminatory, that the standards were established in good faith and that, in the absence of evidence to the contrary, they appear to be devoid of "ulterior or extraneous reasons aimed at objectives which could defeat the purpose of the Code" (Etobicoke, supra, at p. 208). Thus, the respondent has succeeded in discharging the burden of proof on the subjective branch of the BFOR.

As for the objective branch, the respondent had to prove that epilepsy is a disability that is inconsistent with military life and obligations for reasons of safety. It therefore had to convince the Tribunal that epileptics present a sufficient risk of employee failure, that is, an unacceptable risk to their own lives or safety or to those of others, if they are members of the Forces.

On this point, Lieutenant Colonel Skinner's evidence is clear:

epileptics do not form a homogeneous group from the point of view either of the risk they might present or of the control they might have over their disability. Although the general risk, in people diagnosed as epileptics, of recurrence of a seizure is about 30 percent, it is possible to determine the rate of risk presented by an individual much more precisely in the light of a variety of factors, including the type of epilepsy he has, its causes and his family history. Moreover, it appears that such methods of calculation were already known scientifically when the decision was made to release Sergeant Robinson in 1984.

Thus, in the case of an individual who has had an epileptic seizure the specific cause of which (e.g.: violent blow to the head or alcoholism) could not be identified, the risk of his having another seizure would be 8 percent; if that individual was controlled by an appropriate medication, his risk of recurrence would in all probability fall to that of the general public - between 2 and 4 percent - since the original risk must be reduced

by the rate of control of seizures, which varies from 70 to 80 percent depending on the type of epilepsy (generalized, partial, etc.).

With respect to the complainant, Dr. Skinner established that, if he was to stop taking Tegretol, there was a 15 to 20 percent risk of his having another epileptic seizure, whether it took the form of slight symptoms, like the abnormal movement of a hand or staring with loss of consciousness for 30 to 45 seconds, or deteriorated in a secondary manner into a generalized tonic-clonic seizure. However, the risk that either of these forms of seizure will occur while he is regularly taking his medication is only from 3 to 6 percent. Moreover, approximately 25 percent of epileptics can avoid a dangerous situation because a discharge of abnormal electric activity known as an "aura" occurs shortly before a seizure and warns them that it is imminent. As we know, the complainant testified that he had experienced this phenomenon when he was having seizures, that is, before his condition was controlled by Tegretol.

Finally, Dr. Skinner confirmed that the prognosis of a given epileptic's rate of risk can reliably be established within a two-year time frame. In other words, if an epileptic has no seizures within that time frame, he is considered to be under control, and the risk of recurrence can reliably be established for that individual.

Although each epileptic's risk is very personal and can be close to that of a normal individual, the respondent argues that a general exclusion of epileptics is reasonably necessary considering that every member of the Forces is liable to be called upon at any time "to perform any lawful duty" in combat under the National Defence Act, R.S.C. 1985, c. N-5, s. 33. Thus, nothing guarantees to a member of the Forces, no matter what his trade, that he will not one day be asked to go hold a combat position if necessary in an emergency. However, a combat position is likely to place an individual in extreme circumstances (e.g. exhaustion due to lack of sleep and of food and to the stress of war), which might lower the threshold for occurrence of an epileptic seizure. In addition, as is explained by the medical standards, an epileptic member of the Forces who needs prescription medication like Tegretol might be unable to stock up on it while in combat, with the result that the risk of his wounding another nearby member would rise significantly.

While it cannot be denied that the military function is generally more risky than most jobs in civilian life, the various trades in the Forces nevertheless do not all present the same risk. In this respect, Commander Sylvester made a distinction between support trades and combat trades,

saying that the latter are much more demanding and stressful than the former. Dr. Bélanger and Dr. Skinner also confirmed this: a risk assessment proper to each trade explains why military authorities have set medical requirements that vary from one trade to another in the medical standards manual. Dr. Skinner added that a distinction is in this way made between high-risk (e.g. airplane pilots), moderate-risk (e.g. transport vehicle drivers) and low-risk (e.g. clerks, maintenance trades) trades.

Considering the variation in risk between trades, the respondent has not succeeded in persuading the Tribunal that epileptics as a group pose a sufficiently higher safety hazard to warrant excluding them from all the trades carried on in the Forces. When it can be established scientifically that the risk that an epileptic who is controlled as the complainant is might have a seizure is from 3 to 6 percent and that he is also likely to

be warned by an aura, it is hard to see how it could be concluded that there would be an unacceptable increase in risk for himself or for others in positions involving as little danger as those of Aero Frame or Aero Engine Technicians. In our opinion, the complainant presents a negligible risk in the context of performing a ground support function. Thus, the respondent has not persuaded the Tribunal that the complainant constitutes a sufficient risk, within the meaning of the Etobicoke case, in performing such a function.

As for the Flight Engineer's trade, on the other hand, although the increase in risk is modest in the complainant's case, we feel that it is sufficiently high to warrant excluding him from this position. Considering the extremely serious consequences for the lives and property of others that could be caused by employee failure by a Flight Engineer on a military transport aircraft (which is the type of aircraft for which Sergeant Robinson was qualified), an employer like the Armed Forces is justified in wanting to avoid any increased risk factor. This does not for all that mean that the exclusion of all epileptics from the trade of Flight Engineer is a BFOR. It is clear from the evidence that some only present a risk equivalent to that of any other normal member of the Forces once they are controlled by appropriate medication.

However, the respondent claims that, on the one hand, every member of the Forces is liable to be called upon for combat duty and that, on the other hand, he could have trouble getting his medication supplied on the battlefield. We feel that both of these arguments are hypothetical, indeed specious. The evidence has revealed that the possibility of a member being transferred from a support position to a combat position is implausible

because combat requires special training, which is given specifically to members who have chosen to carry on specialized combat trades. Moreover, Captain MacKnie conceded that the occupational requirements known as the General Specifications Other Ranks (GSOR) concerning the skills required with respect to firearms, which are aimed at seeing to it that every member of the Forces can be called upon to go to combat, are not the subject of regular training. However, according to him, such training is necessary in order to retain these minimum qualifications. Both Sergeant Robinson and the officers who testified before the Tribunal confirmed that they had not been trained regularly for the purely military requirements necessary for the combat function. Captain MacKnie even admitted that he had not received such training for thirteen years. In other words, the respondent has failed to demonstrate that a member of the Forces assigned to a support function, in particular one as highly specialized as that of Flight Engineer or Aviation Technician, is likely to be "remustered" to a combat position. Nor was an attempt made to prove that such a possibility is practical. How many Flight Engineers or technicians specialized in military aircraft maintenance have been transferred to a combat function over, for example, the last ten years? Evidence to answer this question should have been given in order to demonstrate that the requirement of unlimited mobility is anything other than a hypothetical statement.

At any rate, the respondent's policies are contradictory as regards the duty of every member of the Forces to fight. Commander Sylvester asserted that there is no difference between the military obligations of a regular member of the Forces and those of a member of the Reserves should Reservists be called up. How then can it be explained that Mr. Robinson is

considered fit to bear arms and defend his country as a Reservist and not as a regular member of the Forces? The Tribunal was not given a satisfactory answer to explain this serious contradiction.

As for the argument of the difficulty of supplying prescription medication in combat, it too must be rejected. It was not proven that it is impossible for a member of the Forces to keep the tablets he needs on him in a sufficient quantity to keep him going for several months. Nor was there any evidence that the medication controlling epilepsy is so big that it would take too much space in a member's pockets or backpack or that taking such medication presents particular difficulties. Moreover, it has been noted that the argument of the difficulty of supply were added to paragraph 4 of the Seizure Disorders - Category Policy in 1983, that is, at a time when studies were being more precise as to methods of controlling

and calculating the risk of recurrence of seizure disorders. This may or may not be coincidental.

Finally, the respondent argued that an epileptic member should be excluded from the Forces because he more frequently requires the services of a physician, which are not always available, in particular during assignments to isolated posts. This argument was supported by neither the facts nor the testimony, however. The complainant asserted that he did not need to consult a physician more than once a year, that he had no specific side effects from his medication and that at any rate he was in perfect shape and in very good health at the time of his release, and remains so today. Nobody contradicted this testimony. On the contrary, Dr. Skinner confirmed that an epileptic's medical condition can be determined within a two-year time frame. As a result, the question whether the services of a physician are absolutely necessary depends in our opinion on a particular epileptic's rate of risk of seizure. Since the rate of 3 to 6 percent submitted by the complainant is only very slightly higher than that of 2 to 4 percent for every other member of the Forces, the argument related to medical services must therefore be rejected because it is not reasonably necessary to the purpose of safety pursued by the Forces.

As a result, the medical standards concerning epilepsy, including CFMO 26-12 containing the Seizure Disorders - Category Policy, do not constitute bona fide occupational requirements. They instead constitute a discriminatory employment policy within the meaning of s. 10(a) of the Canadian Human Rights Act because the respondent has not succeeded in demonstrating a sufficiently close relationship between the risks of danger presented by epilepsy and the military function. In effect, epilepsy is not a uniform medical condition, and the Forces do not just offer high-risk trades.

Thus, the means adopted by the respondent, which consists of preventing all epileptics from being transferred to another trade in the Canadian Forces regardless of their personal medical situations, appears to be excessive and disproportionate within the meaning given by Beetz J. in the Town of Brossard case, supra. Although it is of course more convenient in administrative terms to exclude all those who are diagnosed as epileptics on a systematic basis, that is certainly not necessary, as they do not all present an unacceptable risk in every trade. Some might present a high risk in a high-risk position; others, on the contrary, might present a low risk in a low-risk position, it being understood that there is always

a risk involved in being a member of the Armed Forces, even as an office clerk.

It would therefore have been possible to make a distinction between (very high-risk) combat positions and (varying-risk) support positions, on the one hand, and among support positions themselves, between high-, moderate- and low-risk positions, and then to establish a relationship between this risk and that of a given epileptic member of the Forces according to his own medical history. Moreover, it was on this basis that the Forces were able to win in the Galbraith case, supra. A recruit who had undergone a resection of the bowel was refused access to a combat trade: that of an artilleryman in the Reserve Militia. He argued inter alia that this was unjustified considering that another member of the Forces who had undergone the same operation was still employed by the Forces. The answer the Tribunal gave the complainant in that case is especially relevant here: "Although the outcome of this process [that of the CMRB] was that he was retained 'without career restriction,' it is important to note that this individual is employed as an 'Air Frame Tech' and, according to Dr. Roy [an officer], unlike an artilleryman, would not be required to go into the field" (paragraph 45864).

As for the proof the respondent had to provide of an individual assessment, aside from demonstrating that it was impossible according to the test of the City of Saskatoon case, supra, it is clear, given the absolute nature of its policy concerning epileptics, that the respondent failed. The complainant really was assessed on an individual basis by several physicians who examined him, but the evidence shows that those assessments were not taken into consideration. All those who examined him personally, whether in the Forces or in civilian life, noted that his medical condition was well under control, that his risk of recurrence of a seizure was low and that he was, moreover, in excellent physical shape. It is clear that his medical category was dropped below the Forces' minimum medical standards by medical and administrative authorities who had neither seen nor examined the complainant and who did so because the Seizure Disorders - Category Policy now required it, that is, since the amendments made to that policy in September 1983.

Lieutenant Colonel Skinner did try to discredit the medical opinions of the physicians, both general practitioners and specialists, who had examined Mr. Robinson before he was released. According to him, those opinions were not "scientific" because, inter alia, they were based on the results of only three negative EEGs, which was not enough to assert with certainty that Mr. Robinson was at that time perfectly controlled. All that Dr. Skinner has managed to confirm through his eagerness to defend the Forces' inflexible policy toward epileptics is that the decision to release Sergeant Robinson was made prematurely. If three EEGs were not enough to

demonstrate that Mr. Robinson's epilepsy was effectively controlled, the authorities should have carried out other tests to obtain a positive result before releasing him.

Dr. Skinner's testimony has also brought to light the striking contrast between the flexibility of the Forces' policy toward epileptics before 1983 and the inflexibility of the amendments made to that policy in that year. Mandatory and general classification standards were added to a policy that had previously taken account of the individual risk of each epileptic. The effect of these amendments was to eliminate any discretion,

and the considerations on which they were based were questionable in the light of the undeniable progress made by science in controlling epilepsy over the last few years.

For all that, if we compare how Sergeant Robinson was treated before and after 1983, the difference in approach of the military authorities toward him is very clear. It is possible, as Dr. Skinner claimed, that the military authorities were too lax in 1982 when they recommended that he be returned to his duties as a Flight Engineer after only a few months of medication, which, moreover, he was only given for some three months in early 1982. That does not for all that justify a policy as inflexible as the one for epileptics adopted by the Forces in 1983, which has not been amended since then.

Conclusion

By establishing an inflexible mandatory classification that eliminated any discretion or individual assessment of members of the Forces diagnosed as epileptics, the Seizure Disorders - Category Policy (CFMO 26-12) constitutes a discriminatory policy within the meaning of s. 10(a) of the Canadian Human Rights Act. It cannot be a requirement reasonably necessary for the objective of the safe and efficient performance of all trades in the Canadian Armed Forces. Instead, that policy is diametrically opposed to the philosophy adopted by Parliament with respect to human rights since 1977, which the tribunals and courts must apply: every individual is entitled to be considered on the basis of his or her personal merits and capabilities and must therefore be protected from peremptory exclusions based on irrelevant personal characteristics, such as race, sex or, in the present case, disability. If there is a disability that must be assessed on an individual basis in the light of the very different restrictions it imposes on the various people who suffer from it, it is indeed epilepsy, as the evidence has shown and as, moreover, the Tribunal has already pointed

out in the Rodger case, supra (paragraph 23673): "The importance of assessing each individual case on its own terms cannot be emphasized enough, especially given the need to overcome prejudicial generalizations about conditions such as epilepsy."

It also appears appropriate to remind the Forces that they, like any other employer in Canadian society, must respect in full their members' fundamental right to equal opportunity. As the Tribunal said in Gauthier v. Canadian Armed Forces (1989), 10 C.H.R.R. D/6014, paragraph 43450, which concerned the policy of excluding women from combat positions: "... the CAF is a unique institution in Canada, but it is not an isolated institution.

It has in the past, and must certainly now, reflect societal values and changes, not the least because it is an all-volunteer force." The Tribunal also added very appropriately: "The balance between individual rights and collective security had swung more to the rights side. Only strong evidence could move it to the security side again" (paragraph 43532).

The scope of the present decision should not be misjudged, however.

The Forces' policy is only held to be discriminatory and unjustified in relation to those members who, like the complainant, are already in active service in the regular Forces or the Reserves. This Tribunal is giving no opinion on the respondent's policies and requirements for the admission of recruits. As has been recognized in a certain number of decisions by the Tribunal, that is a different context and is likely to bring into play

other considerations that were not before this Tribunal and that it did not have to resolve.

Finally, since the Tribunal agreed to split up the evidence in order to answer the substantive questions before hearing the evidence and claims of the parties related to the appropriate remedy, that remedy will be the subject of a new hearing and a later decision.

DATED at Ottawa, this 17th day of June 1991.

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Peter BORTOLUSSI, Chairperson

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Daniel PROULX, member

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Ruth GOLDHAR, member