Canadian Human Rights Tribunal

Tribunal canadien des droits de la personne

Citation: 2025 CHRT 96
Date: September 18, 2025
File No.: T2409/6819

Between:

Joshua Dorais

Complainant

- and -

Canadian Human Rights Commission

Commission

- and -

Canadian Armed Forces

Respondent

Decision

Member: Gary Stein

Table of Contents

I. Overview

A. Introduction

[1] Joshua Dorais has alleged that the Canadian Armed Forces (CAF) discriminated against him based on having a previous medical diagnosis and a perceived ongoing disability when he applied to re-enrol in the CAF to work as a nurse. Mr. Dorais and the Canadian Human Rights Commission (the "Commission") also assert that the CAF systematically and reflexively deny enrolment to all applicants who have a history of post-traumatic stress disorder (PTSD) from any source or, specifically, service-related PTSD. In response, the CAF submits that it denied Mr. Dorais' application for re-enrolment for reasons that were justified under the *Canadian Human Rights Act*, R.S.C., 1985, c H-6 (CHRA). The CAF also denies that it rejects applicants without having considered their applications appropriately.

[2] Mr. Dorais was a member of the CAF from 1993 to 2001. In 1994, during a training accident and then while he was deployed internationally, he witnessed the death and injury of fellow soldiers.

[3] Mr. Dorais returned to Canada after completing his deployment and he continued to serve in the CAF, although he experienced symptoms affecting his mental health. In 2001, he was honourably discharged. After his release, a psychiatrist diagnosed him with PTSD. He experienced a mental health crisis soon afterwards.

[4] After receiving medical treatment, Mr. Dorais went back to school, trained to be a nurse and started working as a nurse in correctional institutions.

[5] In 2016, Mr. Dorais applied to re-enrol in the CAF to serve in the Primary Reserve. However, the CAF decided that Mr. Dorais did not meet the medical standard for enrolment because of his medical history and the risk that symptoms of PTSD/depression could recur in a military environment. The CAF denied his application to re-enrol.

[6] In 2017, Mr. Dorais filed a human rights complaint to the Commission about the CAF's refusal of his application to re-enrol.

[7] In 2019, the Commission referred Mr. Dorais' complaint to the Tribunal.

[8] Mr. Dorais alleges that:

a) the CAF refused to employ him because he had a previous diagnosis of PTSD;

b) the CAF did not conduct a fair assessment of his medical condition and did not accommodate him appropriately; and

c) the CAF's enrolment medical standard is discriminatory.

[9] The Commission also alleges that the CAF did not conduct an appropriate, individualized assessment of Mr. Dorais. It also asserts that prejudice and stereotypes against people with PTSD have seeped into the CAF's assessment of applicants and that the CAF has a practice of reflexively denying applicants with a history of service-related PTSD.

[10] The CAF's response to this complaint is that its decision to deny enrolment to Mr. Dorais was conducted appropriately, that its assessment of applicants is appropriately individualized, and that its enrolment medical standard is valid. According to the CAF, the enrolment medical standard is also consistent with the principle of universality of service, which means that it is protected by section 15(9) of the CHRA.

[11] The CAF does not dispute that it denied Mr. Dorais' application based on the enrolment medical standard that all applicants must meet and on applying the standard to Mr. Dorais' medical conditions and medical history. However, it denies any generalized practice of rejecting applicants with a history of PTSD. It submits that its policies and practices involving the enrolment medical standard, and its decision about Mr. Dorais' application, were justified.

[12] The Tribunal heard this case in 2021 and 2022. The Tribunal Member who heard it became a judge before making a decision. In 2024, the Tribunal's Chairperson assigned me to decide this case based on the record of the proceedings.

B. The issues

[13] The issues that I must decide are

A. Is there a *prima facie* case of discrimination, as follows:
   i. Did Mr. Dorais have or was he perceived to have a disability?
   ii. If so,
      i. did the CAF refuse to employ Mr. Dorais (section 7(a) of the CHRA), and/or
      ii. did the CAF establish or pursue a policy or practice that deprived or tended to deprive Mr. Dorais of an employment opportunity (section 10(a) of the CHRA)?
   iii. If so, was Mr. Dorais' protected characteristic a factor in the adverse impacts:
      i. was disability or a perceived disability a factor in the CAF's refusal to employ him (section 7(a) of the CHRA), and/or
      ii. was disability or perceived disability a factor in the policy or practice that deprived or tended to deprive him of an employment opportunity (section 10(a) of the CHRA)?

B. If there is a *prima facie* case of discrimination, did the CAF prove that:
   i. The CAF's policies and practices involving the medical standard for enrolment were justified?
   ii. The CAF's medical assessment and refusal of Mr. Dorais' application to re-enrol were justified?

C. If Mr. Dorais and the Commission have proven a discriminatory practice, what are the remedies?

C. Decision

[14] Mr. Dorais and the Commission established a *prima facie* case of discrimination under sections 7(a) and 10(a) of the CHRA. They demonstrated that the CAF had established a policy that would deprive or tend to deprive some applicants of enrolment

based on their medical conditions. They also demonstrated that the CAF denied Mr. Dorais' application to re-enrol under its medical enrolment standard, based on the medical information that Mr. Dorais had provided. However, Mr. Dorais and the Commission did not demonstrate that the CAF systematically rejects applicants with a history of service-related PTSD or PTSD generally or that Mr. Dorais experienced systemic prejudice or stereotyping against individuals who have previous diagnoses of PTSD.

[15] In terms of the justifications that are recognized under the CHRA:

a) The CAF's enrolment medical standard is a *bona fide* occupational requirement when it is applied appropriately. For that reason, the medical standard for enrolment is justified and is not a discriminatory policy under section 10(a) of the CHRA.

b) However, the CAF did not fairly assess Mr. Dorais' medical conditions to the point of undue hardship under sections 15(2) and 15(9) of the CHRA before denying Mr. Dorais' application. This failure to fairly assess him and the resulting refusal of his application to re-enrol were a discriminatory practice under section 7(a) of the CHRA. For these reasons, Mr. Dorais is entitled to a remedy for the CAF's discriminatory practice.

II. Key facts and context

A. Mr. Dorais' military service (1993–2001)

[16] Mr. Dorais became interested in military service early in his life. As a child, he joined the Royal Canadian Air Cadets. He later saw news reports of Canadian soldiers deployed overseas and, as he says, he was hooked. Fresh out of high school, Mr. Dorais enrolled as a part-time member of the CAF's Primary Reserve. He completed basic training and reported to the 15 Medical Company Primary Reserve unit (now 15 Field Ambulance) in Edmonton, Alberta. In April 1994, when he was twenty years old, Mr. Dorais was deployed to Croatia as a medical assistant, where he participated in emergency medical response work.

[17] Mr. Dorais returned from deployment and continued as a medical assistant in the Primary Reserve. In 1998, Mr. Dorais transferred to the CAF's Regular Force. He trained and worked for three years as a Land Communications and Information Systems technician.

[18] Mr. Dorais was released from the CAF in 2001 with an honourable discharge and with medals for serving as a Canadian Peacekeeper and for participating in the United Nations Protection Force in Croatia. Mr. Dorais' military service record was a point of pride for him. It was also a source for his decision, 15 years later, to re-apply to the CAF in the hope of again serving as a soldier.

B. The events on deployment and their effect on Mr. Dorais

[19] Mr. Dorais' deployment included difficult and tragic experiences. He witnessed trauma in a training accident and on an overseas deployment, and he worked in situations where two CAF members died.

[20] After returning from Croatia, Mr. Dorais struggled with the trauma of what he had seen and experienced. According to Mr. Dorais' testimony, he became a "psychological mess" over the seven-year period after his deployment while he continued to serve as a CAF member. He experienced immediate mental health concerns, but he did not understand what was going on. He saw doctors, took antidepressant medication and developed difficult personal issues. He sought medical care, but the only diagnoses he received were for situational depression and anxiety.

[21] These difficulties led Mr. Dorais to consult a CAF psychologist. The psychologist told him that he probably had PTSD and that he should see a CAF psychiatrist, but Mr. Dorais' view at that time was that doing so was a "career-ender" for soldiers. As Mr. Dorais testified, "I thought I was a tough guy and wanted to stay that way".

C. Release from the CAF (2001) and the PTSD diagnosis

[22] Mr. Dorais was released from the CAF in 2001, moved to Calgary, took educational courses and worked as a by-law officer. It was not what he hoped to do. As his emotional

problems mounted, he followed up on the CAF psychologist's recommendation and began seeing Dr. Leo Elwell, a CAF psychiatrist.

[23] Mr. Dorais did not know exactly when Dr. Elwell diagnosed him with PTSD, but it was in 2001 or 2002. Dr. Elwell attributed Mr. Dorais' PTSD to his exposure to traumatic events involving his CAF service. He noted that Mr. Dorais also had great difficulty changing from infantry to civilian life, although Mr. Dorais testified that his mental health symptoms had also been present when he was serving as a CAF member.

D. Suicide attempt (2003)

[24] In July 2003, Mr. Dorais attempted suicide by an overdose of medication. He has few memories of it except being in an ambulance and seeing a psychiatrist.

E. Obtaining nursing credentials (2005–2016)

[25] After his medical recovery, Mr. Dorais went back to school. He completed a college diploma in psychiatric nursing in 2005, a college nursing diploma in 2007, a university degree in nursing in 2011 and an occupational health nursing certificate in about 2016.

F. Employment as a nurse (2008 and ongoing)

[26] Mr. Dorais started working as a full-time nurse in 2005. In 2008, he started working for Correctional Service Canada (CSC) as a nursing supervisor at maximum security institutions in Edmonton. He has continued to work full-time for CSC except for educational and sick leaves.

G Medical treatment (2003–2016)

[27] After the attempted suicide, Mr. Dorais continued taking antidepressants and seeing Dr. Elwell. In 2003, Dr. Elwell reported that Mr. Dorais was also in group therapy, but I accept that, from 2003 to 2019, Mr. Dorais' only regular treatment was taking antidepressant medications.

i. Psychiatric treatment

[28] Mr. Dorais continued to see Dr. Elwell until 2011 or 2012, when Dr. Elwell stopped seeing patients with PTSD. One document that Dr. Elwell prepared in 2003 was entered in evidence. There were no other documents in evidence of Dr. Elwell's treatment between 2004 and 2012. Dr. Elwell's progress notes or a discharge report would have closed the gap in the evidence about the psychiatric treatment that Mr. Dorais received for PTSD.

[29] Mr. Dorais testified that, around the time that Dr. Elwell stopped providing medical care, Dr. Elwell sent him an email stating that Mr. Dorais was doing well. The email was not in evidence, and there is no other independent evidence about the status of Mr. Dorais' mental health in 2012. Mr. Dorais' testimony about Dr. Elwell's email to him is not sufficient to confirm Dr. Elwell's medical opinion in 2012.

[30] There is also no independent evidence about the medical treatment that Mr. Dorais received after Dr. Elwell stopped treating him in about 2012 and until Mr. Dorais started seeing a general practitioner. This means that Mr. Dorais' testimony is the only information in evidence about the status of Mr. Dorais' health from 2003 to 2015.

ii. Medical care from a general practitioner

[31] In January 2015, Mr. Dorais came under the care of Dr. E. Buchner, a general practitioner. The only evidence about Dr. Buchner's medical treatment consists of the CAF forms that Dr. Buchner completed for Mr. Dorais' application to re-enrol discussed below.

H. Application to re-enrol in the CAF (October 2015 to April 2016)

[32] After releasing from the CAF in 2001, experiencing a health crisis in 2003, studying to be a nurse and then working as a nurse from 2005 to 2016, Mr. Dorais wanted to return to the CAF in a nursing role. He worked as a full-time nursing professional in a demanding environment and had achieved stability in his personal life. His desire to re-enrol in the CAF was an attempt at a personal reconciliation. In 2015, Mr. Dorais started the process to re-enrol as a part-time member of the CAF's Primary Reserve.

[33] Mr. Dorais contacted the reserve unit that he served with in the 1990s. He testified that he satisfied himself of his suitability for a nursing officer position and that a position was available. He passed a physical fitness test and an aptitude test and submitted his application. The CAF recruiters were satisfied that Mr. Dorais met the specific requirements to work as a nurse, but his eligibility was subject to Mr. Dorais completing the medical evaluation for enrolment in the CAF and receiving confirmation that he would be employed as a nursing officer.

[34] The medical evaluation involved assessing the medical information that Mr. Dorais provided to the CAF against the medical standard that the CAF had established as a required minimum for recruits, who must also complete their basic training requirements. The medical standard for recruits entering basic training is higher than the standard for the nursing officer position for which Mr. Dorais had expressed a preference in his application.

I. The universality of service principle, the CAF's operational standards and the medical category system

[35] For context, I now describe the enrolment medical standard that the CAF applies to evaluate applicants and the policies related to the medical standard. The standard is known as the Common Enrolment Medical Standard (CEMS). The main related policies that are involved when the CAF applies the CEMS are as follows:

a) Instruction 11/04 issued under the authority of the Assistant Deputy Minister (Human Resources – Military) (the "Policy Instruction 11/04"), *Canadian Forces Medical Standards.*

b) The *Canadian Armed Forces Medical Standards (CFP 154)* (the "CAF Medical Standards (CFP 154)").

c) Defence Administrative Order and Directive (DAOD) 5023-0, *Universality of Service* (DAOD 5023-0).

d) DAOD 5002-1, *Enrolment.*

e) DAOD-5023-1, *Minimum Operational Standards Related to Universality of Service.*

For ease of reference, I refer to these policies collectively as the “Related Medical Policies”.

i. The universality of service principle

[36] Universality of service is the term given to a set of principles which govern the service of members of the CAF. The statutory source for the universality of service principle is the *National Defence Act,* R.S.C., 1985, c N-5. It states that members of the CAF’s regular and reserve forces are liable to perform any lawful duty that is military in nature, including any authorized duty involving public service (sections 33(1), (2) and (4) of the *National Defence Act*; *Canada (Attorney General) v. Irvine*, 2005 FC 122 at para 6 [*Irvine FC*], aff’d 2005 FCA 432).

[37] Universality of service consists of three “essential principles”. First, whatever a CAF member’s trade or profession might be, CAF members are soldiers first and foremost. Second, the duty of a soldier is to be ready to serve at all times, in any place and under any conditions. Third, this duty is universal in that it applies to all members of the CAF (*Irvine FC* at para 6, citing *Irvine v. Canadian Armed Forces*, 2004 CHRT 9 at para 31).

[38] The universality of service principle is incorporated into the CHRA. According to section 15(9) of the CHRA, the obligation in section 15(2) for the CAF to prove that accommodating a person’s needs would impose undue hardship “is subject to the principle of universality of service under which members of the Canadian Forces must at all times and under any circumstances perform any functions that they may be required to perform”.

[39] The CAF applied the CEMS to Mr. Dorais when he applied to re-enrol, and how that was done is at the heart of this case. Mr. Dorais and the Commission questioned whether the universality of service obligation requires a medical standard as rigorous as the CEMS for all applicants. According to the CAF, the CEMS is associated with the universality of service principle and is the required standard that all applicants must meet. According to

Mr. Dorais and the Commission, it should be sufficient for an applicant to meet the medical standards for the specific position that they hope to fill within the CAF, without necessarily meeting all the requirements of the CEMS.

ii. References to universality of service in the Related Medical Policies

[40] Under the *National Defence Act* and related regulations, the CAF's Director of Medical Policy may develop orders and directives, called Defence Administrative Orders and Directives (DAODs), to guide medical decision making.

[41] The DAODs set out how the universality of service principle is built into the CAF's minimum operational standards. DAOD 5023-0, *Universality of Service* says the following:

a) The CAF's mission is to defend Canada, its interests and values, while contributing to international peace and security.

b) To execute this mission, the CAF requires broad authority and latitude over how to make use of CAF members and their skills. According to this DAOD, section 33 of the *National Defence Act* provides the statutory basis for this authority, and section 15(9) of the CHRA recognizes the "fundamental importance" of this authority by making the CHRA's duty to accommodate subject to the universality of service principle.

c) The universality of service principle, also known as the "soldier first" principle, requires that CAF members are liable to perform general military duties and common defence and security duties, and not just the duties of each CAF member's occupation. This may include the requirement to be "physically fit, employable and deployable for general operational duties".

[42] The obligation in DAOD 5023-0 that CAF members must be "physically fit, employable and deployable" relates to the question of whether universality of service requires all applicants to meet the requirements of the CEMS.

[43] According to Annex C to the CAF Medical Standards (CFP 154), there are six "common military tasks" which form the physical fitness standard associated with universality of service. These are "essential, physically demanding tasks [that] anyone in the Canadian Armed Forces (CAF) is expected to be able to perform".

[44] DAOD 5023-1, *Minimum Operational Standards Related to Universality of Service,* sets out "the minimum operational standards related to the principle of universality of service". It requires that all members of the CAF's Regular Force and Primary Reserve meet the following standards:

a) To meet the standard to be physically fit, CAF members must be able to perform a high-low crawl, a sea evacuation, dig an entrenchment, evacuate a casualty and carry a sandbag. The Generic Task Statement for CAF members, in Annex B to the CAF Medical Standards (CFP 154), also refers to these tasks as "the minimum operational requirement applying to all service members".

b) To meet the standard to be employable, CAF members must be able to perform common military tasks, which include the ability to "fire and maintain a personal weapon". CAF members must also have no "medical employment limitations" (discussed below) that would preclude them from performing the common operational core tasks.

c) To meet the standard to be deployable, CAF members must "not have a medical or other employment limitation that would preclude deployment". It requires that CAF members be able to perform duties in any geographical location, climatic conditions and physical environment, as well as deploy on short notice, sustain irregular or prolonged working hours, sustain irregular or limited meals (and possibly miss meals altogether), travel as a passenger in any mode of transportation, perform duties under physical and mental stress, perform duties with minimal or no medical support, and perform effectively without critical medication.

iii. The medical category system

a) The CAF assigns a medical category to every applicant and member of the CAF

[45] The CAF's decisions about what minimum operational standards should be required to satisfy universality of service are built into the CAF's medical category system. In 2004, the Government of Canada released Policy Instruction 11/04 about the CAF Medical Standards (CFP 154). Policy Instruction 11/04 describes the CAF's approach of determining a "medical category" for individuals based on a medical examination and a medical assessment conducted under CFP 154. Following each person's medical examination, CAF physicians decide on and assign health-related employment limitations (the "Medical Employment Limitations"). Policy Instruction 11/04 describes the purpose for the Medical Employment Limitations, the considerations for determining them, and how they are to be "tailored to individuals". With the information from the medical examination and the Medical Employment Limitations, the CAF physicians decide on the individual's medical category, which provides a summary of the individual's general fitness based on six factors, including the "geographic" and "occupational" factors described in detail below. Policy Instruction 11/04 also refers to the minimum medical category that applicants must obtain to be enrolled.

[46] The CAF Medical Standards (CFP 154) provides more details about the medical category system and the CEMS. Under this medical guide, the CAF medically evaluates every applicant and serving CAF member and assigns a medical category to them based on their health status. The medical category summarizes information about each person's employability and deployability and gives commanding officers an overview of the health of the CAF members under their command.

[47] The medical category is a series of letters and numbers. Each letter represents a factor that the CAF evaluates:

- Visual Acuity ("V")
- Colour Vision ("CV")
- Hearing ("H")

- Geographic Factor (“G”)
- Occupational Factor (“O”)
- Air Factor (“A”)

[48] Each number represents a grading (referred to below as a “rating”) for the medical factor. To determine the ratings, CAF physicians determine if the individual has Medical Employment Limitations and the extent to which they may affect the individual’s ability to perform their duties safely, jeopardize the health and safety of others, or compromise the CAF’s operational effectiveness. With that information, the physician assigns a rating for each medical factor in which “1” is the highest rating and “5” is the lowest.

[49] The result of this medical assessment is the individual’s medical category (for example, V3 CV1 H2 G3 O2 A4).

[50] To give the CAF’s commanding officers the context for each person’s medical category, the person’s Medical Employment Limitations are provided with their medical category.

b) CAF occupations have medical category requirements

[51] Every military occupation also has a corresponding medical category. The CAF determines the function of every occupation and the core activities needed to perform it and establishes a minimum medical standard that CAF members must meet to work in the occupation. The CAF’s occupations and corresponding medical categories are listed in Annex E of the CAF Medical Standards (CFP 154) manual. Each occupation also has an identification number, referred to as the Military Occupational Structure Identification (MOSID).

[52] When Mr. Dorais applied to the CAF, his preferred occupation was nursing officer. CFP 154 lists it as MOSID 00195. The minimum required medical category to be a nursing officer is V4 CV3 H3 G3 O2 A5. The G3 and O2 ratings for this occupation are particularly significant for two reasons, as will be further explained: the CAF assessed Mr. Dorais as not meeting them, and the G rating for a nursing officer differs from the G rating in the CEMS.

c) The medical category that applicants must obtain is the "Common Enrolment Medical Standard"

[53] The 2016 version of DAOD 5002-1, *Enrolment* refers to the process for assessing applicants and enrolling recruits. Like DAOD 5023-1, *Minimum Operational Standards Related to Universality of Service*, DAOD 5002-1 states that minimum operational standards must be achieved to meet the universality of service principle and that, to meet the medical fitness standard, the common enrolment medical standard of V4 CV3 H2 G2 O2 A5 must be achieved as set out in the "Medical Standards for the Canadian Forces". According to the CAF Medical Standards (CFP 154), the CEMS is required for recruit candidates, and all applicants to the CAF's Regular Force and Primary Reserve must initially meet this minimum standard.

[54] The CEMS' requirement for G2 and O2 ratings is a higher standard than the G and O requirements for some military occupations. The G3 and O2 ratings for the nursing officer occupation are a less rigorous standard.

[55] Other CAF documents refer to the CEMS and the universality of service principle as if they are linked:

a) The Standard Operating Procedures for Recruitment Screening Medicals (the "Procedures for Recruitment Screening") require that applicants to the CAF be medically screened and assigned a medical category before enrolment "to ensure they meet the Universality of Service (U of S) and Common Enrolment Medical Standards (CEMS)". They also identify the information that is to be included in a letter to applicants if "they do not meet the principles of U of S and thus the CEMS".

b) A document titled Processing at CFRC Medical Sections includes similar instructions.

c) A CAF PowerPoint presentation titled Recruiting Medical Office (RMO) Annual Review 2015, dated in January 2016, states that the RMO is responsible to

"ensure that applicants meet universality of service and the 'Common Enrolment Medical Standard' (CEMS)".

d)The G and O factors of the CEMS

[56] Annex A of the CAF Medical Standards (CFP 154) sets out the medical circumstances that correspond to each CEMS factor. I describe how the G and O factors are defined, what circumstances are associated with each G and O rating, the G and O ratings that the CAF assigned to Mr. Dorais, and the G and O requirements that must be met to work as a nursing officer.

1. The geographic factor

[57] The geographic factor (G) is the determination of a CAF member's required physical proximity to medical care. The rating includes an assessment of the risk of recurrence of a person's medical condition and the extent of medical care that would be required if there was a recurrence.

[58] According to the CAF Medical Standards (CFP 154), the circumstances that correspond to G2, G3 and G4 ratings are as follows:

a) G2 is the G requirement of the CEMS. It is assigned to a person who has no geographical limitations due to a medical condition, who is considered healthy and, at most, requires only routine, periodic or scheduled medical services no more frequently than every twelve months.

b) G3 must be met to be a nursing officer. It is assigned to a person:

i. who has a known requirement for scheduled medical service no more frequently than every six months;

ii. whose limitations from a medical condition do not pose an unacceptable risk to the health and/or safety of the individual or other CAF members in their work environment;

iii. who may require and take prescription medications, the unexpected discontinuance or unavailability of which will not create an unacceptable risk to the member's health and/or safety (e.g., thyroid, stable blood pressure);

iv. who may require a specific medical evaluation before being sent on a tasking;

v. who should require only basic levels of medical care in the case of a recurrence or exacerbation of the medical condition; and

vi. whose assessed risk and required level of equates to a "green" area on the Medical Risk Matrix (explained below) in Annex F of the CAF Medical Standards (CFP 154).

c) The CAF assigned a G4 rating to Mr. Dorais. It is assigned to an individual who generally requires scheduled medical care more frequently than every six months and/or whose assessed level of risk equates to a "yellow" area on the Medical Risk Matrix (the "Matrix").

[59] The CAF called Lieutenant-Colonel Aaron Minkley to testify about the Matrix and other matters. There were disputes among the parties about Lieutenant-Colonel Minkley's testimony.

[60] Lieutenant-Colonel Minkley has been a CAF member since 2002 and a physician since 2005. He completed a residency in family medicine and postgraduate training in occupational medicine. Lieutenant-Colonel Minkley had formerly been posted as a CAF flight surgeon, as a wing surgeon and as a medical standards flight surgeon in the Royal Canadian Air Force. From 2018 to 2020, he was the CAF's Senior Staff Officer of Medical Standards in the Directorate of Medical Policy, in which he was responsible for all medical personnel in the Recruit Medical Office and the Medical Standards Branch, and for all personnel who assess medical fitness of families to be posted outside of Canada. At the time of the hearing of this case, Lieutenant-Colonel Minkley had been the Canadian Joint Operations Command Surgeon since 2020, in which he was responsible for the provision of health care for all CAF members deployed internationally and domestically, except for

Special Operations Forces. Lieutenant-Colonel Minkley was also deployed five times as a medical officer.

[61] Lieutenant-Colonel Minkley testified over several days, and Mr. Dorais and the Commission cross-examined him. Large parts of the testimony are subject to a confidentiality order because Lieutenant-Colonel Minkley referred to the confidential situation of a person referred to as Individual A.

[62] The Commission argued that Lieutenant-Colonel Minkley was not a reliable witness, in part due to his testimony about Individual A's situation. I have carefully considered this evidence and the parties' submissions about it. The confidentiality order restricts me from providing details, but I find that Lieutenant-Colonel Minkley's overall testimony was credible and reliable and that the substance of Lieutenant-Colonel Minkley's testimony concerning Individual A, including Lieutenant-Colonel Minkley's description of the facts during his examination-in-chief and the changes that he made on cross-examination, did not affect his overall reliability. Lieutenant-Colonel Minkley's testimony was helpful due to his extensive and ongoing experience as a CAF medical officer, his knowledge of the CAF's medical standards drawn from personal experience, and his direct participation in the CAF's consideration about the medical policies that are central to this case.

[63] Lieutenant-Colonel Minkley did not testify as an expert witness. For that reason, the Commission argued that Lieutenant-Colonel Minkley's testimony should be restricted to facts and that the Tribunal should not consider testimony in which he expressed a professional opinion, for example, about Mr. Dorais' medical conditions and the medical category that the CAF assigned to him. To the extent that I refer to Lieutenant-Colonel Minkley's testimony in this decision, I am satisfied that it involved his direct knowledge and his experience as a CAF senior medical officer.

[64] The CAF also argued that the Tribunal made unfair rulings during the hearing by restricting Lieutenant-Colonel Minkley's evidence about the CEMS and the Related Medical Policies and about how the CAF applied them to Mr. Dorais' medical conditions. I accept those rulings. It is not my role to revisit them and, in any case, I find them reasonable.

[65] I return to the evidence about the G factor and the role of the Matrix.

[66] The CAF developed the Matrix in 2008 to assess medical risk in complex files. In summary:

a) The Matrix aims to predict the likelihood of a future recurrence of a CAF member's medical condition and the consequences of a recurrence for the CAF's operations. According to Annex F of the CAF Medical Standards (CFP 154), its intent "is to balance an acceptable level of risk to the health and safety of the member, taking into account the potential unavailability of the appropriate level of medical care required for a medical condition, while simultaneously considering the effect on the operational mission".

b) The Matrix considers the likelihood that a CAF member's medical condition may recur over a period of ten years and expresses it as a percentage of less than 10%, 10–19%, 20–50% or greater than 50%. It also considers the severity of the condition for the individual based on the extent of their need for medical attention and their ongoing ability to perform the CAF's mission.

c) Based on these factors, the Matrix expresses the level of risk as a colour: green indicates a low medical risk, in which the member could contribute greatly to the CAF; yellow indicates a moderate risk, in which the member could contribute acceptably; and red indicates a high medical risk, in which caution should be exercised.

d) As noted above, green (low risk) is associated with a G3 rating, and yellow (moderate risk) is associated with a G4 rating. There is no colour associated with a G2 rating because an individual with that rating has no geographical limitations.

[67] Lieutenant-Colonel Minkley testified that the Matrix takes published studies about risk assessment into account and is an evidence-based risk assessment model. I accept that the Matrix is a useful tool in assessing risk, but it is important to note that a risk assessment must be based on reliable information in order to produce useful results.

2. The occupational factor

[68] The O factor is the CAF's determination of an individual's ability to perform the physical and mental requirements of an occupation and the ability to cope with the stress of a military environment.

[69] The CAF Medical Standards (CFP 154) explains the O2, O3 and O4 ratings:

a) O2 is a requirement of the CEMS. It is also a requirement to be a nursing officer. It is assigned to a CAF member who has no Medical Employment Limitations.

b) O3 is assigned to a person with specific Medical Employment Limitations which can be clearly and specifically detailed and which may prevent the CAF member from fully participating in common military tasks.

c) The CAF assigned O4 to Mr. Dorais. It is assigned to a person who:

i. may be unable to tolerate the inherent psychological stress of an operational environment;

ii. is generally restricted to light duties only (i.e., general office tasks, including delivering mail, parcels and supplies and maintaining a stock room);

iii. is unable to perform one or more tasks listed on the Generic Task Statement in CFP 154, Annex B; and/or

iv. is capable of working eight hours per day and/or is considered fit for shift work as long as the shifts are stable.

[70] In 2016, the CAF had draft guidelines to help its health care practitioners evaluate patients with mental health issues and assign Medical Employment Limitations. The draft guidelines are titled Guidelines for the Application of Medical Employment Limitations – Mental Health Disorders. They did not appear to apply to applicants, but they are relevant because they were meant to assist physicians in applying the CAF Medical Standards (CFP

154), and they have examples of Medical Employment Limitations related to PTSD. The draft guidelines state the following:

a) Military personnel are at greater risk for PTSD than civilians due to higher rates of repeat exposures to traumatic events.
b) Some people with PTSD recover spontaneously, others will recover with treatment, and some will remain permanently disabled. As a result, the need for Medical Employment Limitations will vary widely.
c) A CAF member with a suspected or confirmed diagnosis of PTSD should be given temporary Medical Employment Limitations to ensure adequate time for assessment and treatment. Temporary Medical Employment Limitations of 18 to 24 months are frequently required. For the G factor, the suggested temporary Medical Employment Limitation is “G5: Requires specialist care more frequently than every 6 months”. For the O factor, the suggested temporary Medical Employment Limitation is “O4: Unfit military operational environment”.
d) Some CAF members may be considered for minimally restrictive Medical Employment Limitations, when there has been proper treatment aimed at processing the trauma, including some element of exposure therapy where the maintenance stage of treatment is completed with full participation in tasks normal for the CAF occupation. Consideration also requires that there have been no significant symptoms or disability, that any medications, if required, have been consistent and at the same dosage for some months and that a psychiatrist has indicated that the CAF member is stable and their symptoms are in full remission.

e) Possible waiver of the CEMS requirements

[71] According to DAOD 5002-1, in some situations the CAF may waive the need for an applicant to meet the CEMS. It requires that the CAF consider the applicant to either be “skilled”, in the sense that they are fully able to perform the occupation for which they are seeking enrolment without the need for training, or “semi-skilled”, in the sense that they

require a limited amount of training that they can obtain on the job. The CAF did not waive the CEMS requirements for Mr. Dorais, as discussed below.

f) Summary: positions of the parties, the universality of service principle, the CAF's minimum operational standards, the medical category system and the CEMS

[72] In summary:

a) From the CAF's perspective, the universality of service principle is the requirement that CAF members be physically fit and able to perform all general military duties, in addition to the duties of a member's actual occupation.

b) The CAF's position is that the CEMS and the Related Medical Policies are an application of the universality of service principle. They require that CAF members be able to perform defined core military tasks, including using a weapon, that they be able to perform the tasks with minimal or no medical support and without "critical" medication, and that they not have Medical Employment Limitations that preclude them from performing the core tasks.

c) The Common Enrolment Medical Standard that all applicants must meet is V4 CV3 H2 G2 O2 A5. In the CAF's view, the Related Medical Policies require that the CEMS be applied in order to meet the principle of universality of service.

d) The CEMS' G2 and O2 ratings require that an individual be able to perform any task anywhere in the world, without expectation that medical care will be required for routine or chronic conditions more than once per year.

e) The CAF can waive the CEMS requirements in some situations, but the CAF did not waive it for Mr. Dorais.

f) According to Mr. Dorais and the Commission, the CAF applied its medical standards to Mr. Dorais in a discriminatory way. Moreover, the CAF does not

need to rely on the strict requirements of the CEMS and Related Medical Policies to implement the universality of service principle, and doing so is discriminatory.

J. The medical evaluation of Mr. Dorais' application

[73] I return to the facts about Mr. Dorais' medical evaluation. The medical evaluation process and the discussions between Mr. Dorais and the CAF's medical technicians during the medical examination are important elements of this case. I consider them in greater detail below, but I summarize them here as follows:

a) On April 7, 2016, Mr. Dorais met with medical technicians at a CAF recruitment centre. The technicians examined Mr. Dorais, took his medical history and completed a report of the examination.

b) A senior medical technician made a statement about the probable negative effect of Mr. Dorais' PTSD diagnosis on his application. I review the facts about the statement in further detail below. Despite the statements, Mr. Dorais continued with his application.

c) The medical technician provided forms for Mr. Dorais' general practitioner, Dr. Buchner, to complete, including a request for information about PTSD. Dr. Buchner completed the forms, and Mr. Dorais returned them to the recruitment office.

d) The medical technician's recommendation for Mr. Dorais' medical category was V1 CV1 H1 **G4 O3** A5 (emphasis added).

e) The medical technician sent Mr. Dorais' recruitment file to the RMO, in the Directorate of Medical Policy, for a decision. Dr. Jeffrey Murphy, an RMO medical evaluator, reviewed the file and decided that Mr. Dorais' medical category was V1 CV1 H1 **G4 O4** A5 (emphasis added). Because the G4 and O4 medical category ratings did not meet the G2 and O2 requirements of the CEMS, Mr. Dorais did not medically qualify for enrolment.

K. Application is refused (November 2016 to February 2017)

[74] On November 4, 2016, the RMO sent its first decision letter to Mr. Dorais. It referred to Mr. Dorais' history of recurrent lower back pain and PTSD/depression, his previous drug overdose, and his ongoing medication. The letter said that Mr. Dorais remained at increased risk for a recurrence of symptoms, especially if he was subject to the stress of a military environment and that, for these reasons, Mr. Dorais did not meet the medical standard for re-enrolment.

[75] The letter informed Mr. Dorais of his options. He could submit "new pertinent medical information" to the Canadian Forces Recruiting Centre for reconsideration, or he could explain why he disagreed with the decision and ask for a "secondary review" of his existing file.

[76] On December 12, 2016, Mr. Dorais requested a secondary review. He provided a detailed explanation for his request. He did not provide further information from his doctors. He testified that he would have done so if the CAF had asked for it.

[77] Dr. Murphy reviewed the file again. On February 3, 2017, the RMO again decided that Mr. Dorais did not meet the medical standard for re-enrolment. The second decision was essentially the same as the first decision except it did not include the reference to recurrent lower back pain that was in the first decision.

[78] Mr. Dorais did not appeal the second decision. His view was that there was nothing more he could do to change the decision. Two months later, Mr. Dorais filed a complaint to the Commission.

L. Robert Claypool's application for re-enrolment in the CAF (December 2019 to March 2020)

[79] The Tribunal also received evidence about Robert Claypool's application to re-enrol in the CAF. This evidence was provided to support the allegation that the CAF had a widespread practice of rejecting applicants with previous diagnoses of PTSD without appropriate assessment of their medical fitness. Like Mr. Dorais, Mr. Claypool was a former

CAF member. In 1986 and 1987, Mr. Claypool served in the Primary Reserve as a cook. From 1988 to 2000, he served in the Regular Force as a radio operator, with a break in service in 1995 and 1996. He was deployed overseas in the Persian Gulf for approximately four months in 1990–91, in Croatia from April to October 1992, and in Bosnia from January to July 1997. He released from the Regular Force in August 2000. In 2001, Mr. Claypool started working as a correctional officer at a federal correctional institution in Edmonton, Alberta. He was working as a correctional officer in December 2019 when he applied to re-enrol in the CAF.

[80] Mr. Claypool knew of Mr. Dorais from having worked in the same correctional institutions as him. He testified that he and Mr. Dorais were work colleagues for approximately three years, beginning in 2008, but they did not know each other well. Then, in approximately December 2017, Mr. Claypool read a newspaper article about Mr. Dorais' application to re-enrol, recognized him, contacted him on social media and exchanged a few messages. They were not in contact again until May 2019, when Mr. Claypool was transferred to work at the same correctional institution where Mr. Dorais was working. They exchanged more social media messages from October to December 2019. Mr. Claypool messaged Mr. Dorais about his own application to re-enrol. At Mr. Dorais' request, he also attended a mediation session about Mr. Dorais' human rights complaint, as a support person. Mr. Claypool testified that some of what he heard during the mediation motivated him to reapply, and he filed his application to re-enrol a few days later.

[81] Mr. Claypool was diagnosed with PTSD in October 2017. According to the CAF's medical information in 2020, the diagnosis was due to the cumulative effects of job stress as a corrections officer, and his therapy also revealed issues arising from his deployment to Bosnia in 1992. He testified that his PTSD stemmed from coming under fire many times during that deployment.

[82] Mr. Claypool was off work, based on a workers' compensation claim, for ten months in 2018. He attended a therapy program for traumatic psychological injuries for approximately five months, he saw a psychologist from time to time in 2018 and attended a one-week therapeutic program in November 2019. Mr. Claypool described the treatments

that he received as being instrumental in his recovery. He was not taking medication for PTSD when he applied to re-enrol.

[83] Mr. Claypool applied to enrol in the Primary Reserve for the navy. The evidence shows that, on January 8, 2020, the CAF conducted its medical examination of Mr. Claypool. On January 13, 2020, Mr. Claypool's general practitioner completed further medical screening forms. According to his physician, Mr. Claypool had no limitation to working as a CAF member under conditions of extreme physical or mental stress in remote areas. The form requesting psychiatric information refers to the diagnosis of PTSD on October 26, 2017. It shows that Mr. Claypool had psychotherapy and that he had been taking medication but discontinued it in April 2018. The physician indicated that Mr. Claypool's risk of recurrence was "Nil" and his coping skills and ability to tolerate stress were "good". A separate form refers to a diagnosis of tinnitus. The physician refers to it as a permanent condition of a slight hearing loss. Mr. Claypool did not receive treatment for it, the follow-up was for an annual hearing test, the prognosis is "uncertain", and Mr. Claypool's limitation is noted as "avoid very loud noises".

[84] On February 25, 2020, Dr. Murphy considered Mr. Claypool's application. Dr. Murphy's notes refer to Mr. Claypool as having a history of PTSD as a corrections officer and that he remains at increased risk for recurrence of symptoms, especially if he was subject to the demands of a military environment. There is no reference to any other medical conditions. Dr. Murphy decided that Mr. Claypool's medical category included ratings of G4 and O2 and that he was "unfit CEMS".

[85] On March 19, 2020, the senior medical technician who had conducted Mr. Claypool's physical examination emailed Mr. Claypool with the news that the RMO had determined that he did not meet the CEMS. The email says that the reason is "PTSD due to duty as a Corrections Officer". It also states: "Given the unique nature of the military environment, one can see how this condition could be problematic. The RMO's concern would be the possibility of exacerbation or re-injury and thus would be a liability for the CAF".

[86] The email suggests that, if Mr. Claypool wanted to appeal, he should consider getting an assessment by a psychiatrist or psychologist, but that the medical technician "cannot

guarantee that additional info provided in the form of a letter or report will reverse the RMO's decision" and that "Experience has shown that applicants with a history of PTSD will unfortunately not be enrolled". It also states: "Please be advised that due to a high volume of medical files that we process and in light of the current pandemic, we simply do not have time to entertain repeated questioning of the RMO's decision". Finally, the email says that Mr. Claypool's only options are to withdraw his application or attempt an appeal.

[87] The email attached what appears to have been the CAF's standard denial letter at that time. It concludes that the CAF had reviewed Mr. Claypool's medical records and that he does not meet the CEMS.

[88] Mr. Claypool testified that he did not appeal the RMO's decision because, after reading the medical technician's email, he thought it would be a waste of time. He did not ask that the CAF conduct a psychological or psychiatric assessment. He did not follow up with his physician or take any further steps to continue his application.

III. Analysis

[89] There are two steps to proving discrimination in the employment context. In the first step, the onus is on the complainant to establish what is referred to as a *prima facie* case of discrimination. In the second step, the respondent has the burden of showing that their actions were justified under the CHRA. If a *prima facie* case is established and the respondent does not successfully justify their actions, the Tribunal finds that a discriminatory practice under the CHRA has occurred. If the respondent successfully justifies their actions, the Tribunal finds that no discriminatory practice occurred.

A. Has Mr. Dorais established a *prima facie* case of discrimination under sections 7(a) or 10(a), or both, of the CHRA?

[90] For the reasons set out below, I find that, in the first step, Mr. Dorais and the Commission have established a *prima facie* case of discrimination with respect to some, but not all, of the allegations.

i. The *prima facie* legal test

[91] To establish a *prima facie* case of discrimination, the Supreme Court of Canada has laid out this generalized test:

a. the complainant has a characteristic that is protected under the CHRA.

b. the complainant experienced an adverse impact with respect to employment; and

c. the prohibited ground of discrimination was a factor in the adverse impact.

(*Moore v. British Columbia (Education)*, 2012 SCC 61 at para 33)

[92] Mr. Dorais has alleged two interrelated discriminatory practices under the CHRA: a policy or practice that tended to deprive him of an employment opportunity (section 10(a)) and a denial of employment (section 7(a)) that he alleges were both connected to the prohibited ground of disability. To establish the *prima facie* case, Mr. Dorais must prove that it is more likely than not that:

a) he has or was perceived to have a disability;

b) the CAF refused to employ Mr. Dorais (section 7(a) of the CHRA) and/or the CAF established or pursued a policy or practice that deprived or tended to deprive him of an employment opportunity (section 10(a) of the CHRA); and,

c) a disability or perceived disability was a factor in:

i. the CAF's refusal to employ him; and/or

ii. the policy or practice that tended to deprive him of an employment opportunity.

[93] Discrimination can be intentional or unintentional. Mr. Dorais contends that the CAF intentionally discriminated against him. However, proving intention is not required (*Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Bombardier Inc. (Bombardier Aerospace Training Centre)*, 2015 SCC 39 at paras 40–41 [*Bombardier*]). The

CHRA also recognizes unintentional adverse effects in which a prohibited ground is a factor (*Desson v. Royal Canadian Mounted Police*, 2023 CHRT 1 at para 21, citing *Ont. Human Rights Commission v. Simpsons-Sears*, [1985] 2 SCR 536, 1985 CanLII 18 at paras 12, 14).

[94] Where a finding of *prima facie* discrimination is not obvious or clear by direct evidence, the Tribunal should assess all the circumstances and the facts to evaluate whether, on a balance of probabilities, an inference of discrimination is more probable than the other possible inferences. In this way, the Tribunal determines if a "subtle scent of discrimination" exists (*Canada (Human Rights Commission) v. Canada (Attorney General)*, 2024 FC 1404 at para 19; *Basi v. Canadian National Railway*, 1988 CanLII 108).

ii. Part 1 of the *prima facie* test: does Mr. Dorais have or was he perceived to have a disability?

[95] Yes. Disability is a prohibited ground of discrimination (section 3 of the CHRA). It includes any previous or existing mental or physical disability (section 25 of the CHRA). The CHRA also "prohibits discrimination in the workplace based on a perception or impression of a disability" (*Dupuis v. Canada (Attorney General*), 2010 FC 511 at para 25). This emphasis on functional limitations and discriminatory perceptions of impairment was expressed by the Federal Court of Appeal in *Desormeaux v. Ottawa (City)*: "Disability in a legal sense consists of a physical or mental impairment, which results in a functional limitation or is associated with a perception of impairment" (*Desormeaux v. Ottawa (City),* 2005 FCA 311 at para 15, citing *Granovsky v. Canada (Minister of Employment and Immigration)*, 2000 SCC 28 at para 34).

[96] In the April 7, 2016, report on the CAF's physical examination of Mr. Dorais, the first question is "are you suffering from, or under treatment for any disease or disability?" The answer is shown as "yes", and "PTSD" is written next to the question.

[97] The CAF's November 4, 2016, and February 3, 2017, decision letters about Mr. Dorais' application to re-enrol refer to Mr. Dorais' history of PTSD/depression and state that he remained at "increased risk for a recurrence of symptoms".

[98] That said, Mr. Dorais' view is that he did not have a functional limitation when he applied to re-enrol. According to Mr. Dorais, the CAF perceived him to have a functional limitation based on the PTSD diagnosis from at least 13 years before he applied to re-enrol in the CAF. Mr. Dorais' December 12, 2016, letter requesting a review of the CAF's decision refers to the CAF's understanding of PTSD as having "stereotypical and punitive connotations" and being based on "veiled assumptions" and states that "there is no significant health reason to preclude me from my CAF candidacy".

[99] It is not necessary to make a finding on whether Mr. Dorais had a functional limitation when he applied to re-enrol. The evidence confirms that Mr. Dorais had a prior diagnosis of PTSD that he informed the CAF about when he applied to join the CAF. This is sufficient to conclude that the protected ground of "disability" was engaged. Disability is a prohibited ground of discrimination within the meaning of sections 7 and 10 of the CHRA.

iii. Part 2 of the *prima facie* test: did the CAF refuse to employ Mr. Dorais, and/or did the CAF establish or pursue a policy or practice that deprived or tended to deprive Mr. Dorais of an employment opportunity?

[100] Yes, in part. When Mr. Dorais applied, the CEMS and the Related Medical Policies were in effect. The CAF's decision letters state that Mr. Dorais did not meet the medical standard for enrolment. This was the reason that the CAF gave Mr. Dorais for denying his re-enrolment. The decision was based on the CAF's assignment of G4 and O4 medical category ratings to Mr. Dorais, which did not meet the CEMS' requirement for G2 and O2 ratings.

[101] These facts satisfy me that the CAF refused to employ Mr. Dorais as a re-enrolled recruit. This refusal meets the second element of the *prima facie* test in relation to section 7(a) of the CHRA.

[102] These facts also demonstrate that the CEMS, the Related Medical Policies and the CAF's application of them to Mr. Dorais tended to deprive him of the opportunity to re-enrol and be employed in the CAF. These actions satisfy the second element of the *prima facie* test under section 10(a) of the CHRA in relation to the CAF's policy.

[103] To be clear, the CAF widely applies the CEMS and Related Medical Policies and so, in this sense, this adverse treatment of Mr. Dorais stemmed from systemic policies and the practices involved in applying them. However, as will be elaborated below, I am not convinced by Mr. Dorais' and the Commission's further submissions that the CAF had a systemic practice of stereotyping and reflexively rejecting applicants with a history of PTSD or service-related PTSD. The evidence in this regard was not sufficiently developed to substantiate it. Because these allegations largely related to the facts about how disability factored into the adverse impact that Mr. Dorais' experienced, I analyze these allegations in the next part.

iv. Part 3 of the *prima facie* test: was Mr. Dorais' protected characteristic a factor in the adverse impact?

[104] The prohibited ground for discrimination must be a factor in the adverse treatment, but it does not have to be the sole factor. While the prohibited ground must have contributed to the adverse treatment, a causal connection is not necessary (*First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada)*, 2016 CHRT 2 at para 25; *Bombardier* at paras 45–52).

a) Was disability or perceived disability a factor in the CAF's refusal to employ Mr. Dorais (section 7(a) of the CHRA)?

[105] Yes. According to the CAF's decision letters of November 4, 2016, and February 3, 2017, Mr. Dorais' history of PTSD/depression, and the risk that the symptoms of PTSD/depression may recur if Mr. Dorais was subject to the stress of a military environment, were factors for the CAF's denial of Mr. Dorais' application to re-enrol. The CAF did not dispute this.

[106] This finding meets the third element of the *prima facie* test for discrimination on the basis of disability in relation to section 7(a) of the CHRA.

b) Was disability or perceived disability a factor in the policy or practice that deprived or tended to deprive Mr. Dorais of an employment opportunity (section 10(a) of the CHRA)?

[107] Yes. The evidence supports a finding that disability is a factor in how the medical standard in the CAF's policies, and the CAF's application of them, tended to deprive Mr. Dorais of an employment opportunity.

[108] The CEMS and the Related Medical Policies establish the standard that applicants must meet to be enrolled. In the CAF's view, Mr. Dorais continued to have a disability in 2016 based on a diagnosis of PTSD/depression, a previous drug overdose and other medical issues. The CAF implemented the medical evaluation process in the CAF Medical Standards *(*CFP 154) by considering Mr. Dorais' medical issues, assigning Medical Employment Limitations based on the medical issues, and assigning G4 and O4 medical category ratings. This led to the conclusion that Mr. Dorais did not meet the G2 and O2 requirements of the CEMS.

[109] This evidence is sufficient for me to make a *prima facie* finding of discrimination under section 10(a) of the CHRA. It is clear that the CAF established the CEMS and Related Medical Policies and applied them to Mr. Dorais and that the CAF's application of them deprived or tended to deprive Mr. Dorais of employment opportunities on a prohibited ground of discrimination.

[110] That said, I did not find sufficient evidence to substantiate the allegation that the CAF had a practice of relying on stereotypes and systematically and reflexively discouraging and rejecting applications from individuals with a history of PTSD or military service-related PTSD without first evaluating them in the manner required by the CAF's policies. Having considered the anecdotal evidence in light of all the evidence, I do not agree with this aspect of the allegations under section 10(a) of the CHRA. It is clear that the CEMS and Related Medical Policies were broadly applied to applicants to the CAF and that these policies can lead to the CAF rejecting a person's application on medical grounds. Beyond that, I have insufficient evidence before me to support a finding of widespread, systemic discouragement of applicants with a history of PTSD or a misapplication of the CEMS and Related Medical Policies to such applicants. I also have insufficient evidence to conclude

that the CEMS and Related Medical Policies reflect stereotypes and prejudice regarding PTSD or that the CEMS and the CAF deliberately excluded applicants with a history of PTSD.

1. The parties' positions

[111] Mr. Dorais submitted as follows:

a) The CAF deliberately did not properly assess his health after learning about his history of PTSD and used its medical standards, which he said were "ostensibly benign but subjectively scripted guidelines" that are "designed to steer medical evaluators to this end", as a "specious excuse" to refuse his application.

b) The CAF's failure to conduct individualized medical assessments for him, for Mr. Claypool and for the person referred to as Individual A, together with the expert testimony and documentary evidence, proves bias and systemic discrimination.

[112] The Commission submitted the following:

a) Attitudes of prejudice and stereotypes have seeped into the CAF's medical evaluations of applicants with a history of service-related PTSD. The events involved in evaluating Mr. Dorais' application prove that these attitudes contributed to the perception that Mr. Dorais had a "handicap".

b) These attitudes resulted in the CAF's assignment of G4 and O4 medical category ratings to Mr. Dorais and in the overall higher standard that applicants with PTSD must meet when compared with applicants who do not have mental health disorders or other health conditions.

c) The CAF's failure to ask Mr. Dorais for specific medical information about his medical history and treatment is evidence of a "blanket exclusion" of applicants with service-related PTSD.

d) The facts involving CAF's refusal in 2020 of Mr. Claypool's application to re-enrol in the CAF are incontrovertible evidence of the CAF's differential treatment of applicants with PTSD.

[113] The CAF submitted the following:

a) Systemic discrimination against applicants with PTSD has not been proven.

b) The decision about the risk of recurrence of Mr. Dorais' symptoms was based on the effect of several medical issues, including an attempted suicide.

c) The standard for enrolment is based on individualized assessments related to each applicant's medical conditions, and evidence and research has shown that individuals with PTSD can be admitted into the CAF.

d) Dr. D.G. Passey, an expert witness, testified that he had successfully treated an individual's PTSD and wrote a letter to the CAF on his behalf, which resulted in the person being re-enrolled. This evidence supports the CAF's position that there is no blanket exclusion of individuals with PTSD.

e) The facts about the refusal of Mr. Claypool's application are significantly different from the facts about Mr. Dorais' application, and they are not an example of a discriminatory practice.

f) There is a high evidentiary bar to prove systemic discrimination, and Mr. Dorais and the Commission have not provided the substantial evidence that is required to support a finding of systematic exclusion of applicants with PTSD.

2. The evidence does not prove that the CAF intentionally refused applicants with a history of PTSD

[114] I do not agree with the submission that the CAF's enrolment medical standards are "subjectively scripted guidelines" that are designed to steer CAF's medical evaluators to refuse enrolment to applicants with a history of PTSD or service-related PTSD. I understand this submission to be arguing that the CAF intentionally engaged in practices to exclude

applicants who have a history of PTSD. I find that there is no convincing evidence that the CAF designed or applied the CEMS and the Related Medical Policies to intentionally exclude applicants with PTSD, service-related or otherwise.

[115] The evidence does not lead me to infer on a balance of probabilities that the CAF deliberately intended to exclude applicants with a history of PTSD.

[116] Major Eastwood is the Recruiting Personnel Selection Officer at the CAFs Recruiting Group Headquarters. Her role is to oversee recruiting activities to ensure compliance with policy, to interpret policy in support of recruiting processes, to monitor the quality of recruiting processes, and to oversee the complex files within the recruiting group. I found Major Eastwood's testimony to be credible and reliable.

[117] In cross-examination, counsel for the Commission asked Major Eastwood if she agreed that the CEMS are in place to ensure that the CAF only recruits individuals who have no disabilities, medical conditions or limitations. Major Eastwood disagreed. In her view, the CEMS are in place to enable individuals to successfully complete their training requirements without injuring themselves.

[118] The Commission's counsel asked similar questions to Lieutenant-Colonel Minkley. Counsel suggested that the CAF did not specify what medical information it wanted from Mr. Dorais because the CAF was not interested in getting more information from him due to his service-related history of PTSD. Counsel stated that the CAF rejected Mr. Dorais' application because it had a blanket policy of rejecting applicants with service-related PTSD. Lieutenant-Colonel Minkley disagreed. He testified that the CAF does not treat applicants with a history of PTSD any differently than it treats individuals with other medical conditions and that the intent of the wording of the CAF's denial letter, informing applicants that they may submit "new pertinent information", is not to exclude anybody from enrolling in the CAF.

[119] Mr. Dorais also suggested to Lieutenant-Colonel Minkley that the CAF rejected his application because of his history of PTSD. Lieutenant-Colonel Minkley replied that the CAF did not deny his application because of a PTSD diagnosis, but due to the multiple mental and physical aspects that were identified during his physical examination and due to the CAF's conclusion that there was a high risk of recurrence of his medical conditions.

[120] There is also no documentary evidence to satisfy me that, more likely than not, the CAF intentionally denied enrolment to applicants with a history of PTSD.

[121] Overall, I conclude that the CAF did not have a practice of intentionally designing or applying the CEMS and the Related Medical Policies in a manner that denied enrolment to applicants with a history of PTSD.

3. There was no CAF practice involving an unconscious bias or stereotypes leading to systemic, reflexive refusal of applicants with a history of PTSD

[122] I accept that systemic discrimination does not require intention and that it can occur due to "the combined impact of attitudes marked by often unconscious biases and stereotypes, and policies and practices generally adopted without taking into consideration the characteristics of the members of groups contemplated by the prohibition of discrimination" (*Dorais v. Canadian Armed Forces*, 2021 CHRT 13 at para 55, citing *Commission des droits de la personne et des droits de la jeunesse c. Gaz métropolitain inc.,* 2008 QCTDP 24 at para 36). However, the evidence does not satisfy me that prejudicial attitudes or stereotypes about PTSD created an environment of reflexive rejection of applicants with a history of PTSD, including Mr. Dorais.

[123] The Commission asserted that prejudicial attitudes resulted in the CAF's failure to ask Mr. Dorais for specific medical information about his medical history and treatment, to assign Mr. Dorais ratings of G4 and O4, and to impose an overall higher standard for applicants with PTSD to meet than applicants who do not have mental health disorders or related health conditions.

[124] Mr. Dorais also submitted that the CAF's alleged failure to conduct individualized medical assessments for him, Mr. Claypool and Individual A proves that bias and systemic discrimination were factors in a practice of refusing applicants with a history of PTSD. However, that is not my view of the evidence about the medical assessments for these individuals and the CAF's decisions about them. I find that the CAF's approach to Mr. Dorais was unique to his application and was based on the issues that his application presented.

Similarly, I find that the circumstances of Mr. Claypool and Individual A were unique, and the CAF's decisions about them were based on their unique circumstances.

[125] Regarding Mr. Claypool's application, he, too, had a history of PTSD, but the evidence about Mr. Claypool's application is materially different from Mr. Dorais' application:

a) The medical histories are distinct. The report about Mr. Dorais' physical examination refers to his military service from 1993 to 2001, a diagnosis of PTSD in approximately 2002, a suicide attempt in 2002 and a history of depression and low back pain. For Mr. Claypool, the medical history included his military service from 1986 to 2000, a diagnosis of PTSD in late 2017 due to the cumulative effects of job stress as a corrections officer and treatment, including exposure therapy. That treatment revealed issues from a 1992 CAF tour in Croatia.

b) The CAF's reasons for refusing Mr. Dorais' application included reference to the attempted suicide, but the reasons for refusing Mr. Claypool's application referred only to his history of PTSD.

c) The CAF's decision on Mr. Dorais' application referred to Mr. Dorais' continued use of antidepressant medication, but the decision on Mr. Claypool's application does not refer to medications, and the evidence indicates that Mr. Claypool stopped taking antidepressant medication before he applied to the CAF.

[126] The evidence about the CAF's communications to Mr. Claypool about his history of PTSD is materially different from its communications to Mr. Dorais:

a) Mr. Dorais testified that, during his medical examination, Sergeant McLagan, the medical technician, said that "the Forces are kicking people out with PTSD, why would they let people with PTSD in". The Commission submitted that Sergeant McLagan's statement suggests differential treatment from applicants who do not have a history of PTSD.

b) Sergeant McLagan testified about his meeting with Mr. Dorais. He did not remember Mr. Dorais or their conversations, but he said that he would have had

a frank and honest discussion, based on his personal experience, about Mr. Dorais' medical evaluation.

c) A February 2016 CAF document titled Discuss Screening and Assessment Techniques instructs medical technicians not to "reject or tell an applicant that he will be unfit" and that "[E]veryone is entitled to apply and get their medical process" even if they have an important medical condition. It says that "[if] applicant asks for your opinion, you can tell him/her that based on your personal experience, cases like his/hers are normally found unfit but you are not the one who makes the final decision".

[127] I am satisfied that medical technicians are permitted to give applicants their views about the outcome of the medical evaluation and that they make recommendations to the medical evaluators at the RMO but do not make decisions about an applicant's medical category. Although there is no evidence that Mr. Dorais asked Sergeant McLagan for his opinion, I accept Sergeant McLagan's testimony that he would have shared his personal view about the outcome of Mr. Dorais' application. Without more, and in the context of all the other evidence, his one statement does not convince me that, more likely than not, it was a component of a systemic CAF practice to refuse applicants with a history of PTSD.

[128] The RMO's decision letters to Mr. Dorais state that one of his appeal options was to submit "new pertinent medical information". Mr. Dorais testified that it was not clear to him what that phrase meant. The phrase is part of a specifically worded paragraph that the "Processing at CFRC Medical Sections" document says the RMO always includes in its denial letters to applicants. My view is that the option to submit "new pertinent medical information" is vague about what an applicant can do to appeal, but I am satisfied that the CAF's intention was to give information to applicants and inform them that they could provide pertinent medical information, and not to exclude applicants with a history of PTSD. The testimony of Lieutenant-Colonel Minkley above also supports the conclusion that the letter, despite its unclear wording, was not part of a systemic practice to dissuade Mr. Dorais and other applicants with similar medical conditions from taking further action.

[129] Regarding the CAF's communications to Mr. Claypool, Mr. Claypool received an email from a different CAF medical technician more than three years after Mr. Dorais received his first decision letter. The email informed him that the CAF denied his application because of "PTSD due to duty as a Corrections Officer". It also stated that, to appeal, an assessment by a psychiatrist or psychologist is suggested, but that the medical technician cannot guarantee that additional information will reverse the RMO's decision, and "experience has shown that applicants with a history of PTSD will unfortunately not be enrolled".

[130] The Commission submitted that the statement in the email suggests differential treatment from applicants who do not have a history of PTSD. Mr. Claypool testified that he thought he would have the opportunity to see a CAF psychiatrist or psychologist as part of the recruitment process, but that the statement in the email about applicants with PTSD led him to conclude that obtaining a psychiatrist's or psychologist's report would be a waste of time, and it was a reason why he did not appeal.

[131] The evidence included testimony about CAF medical technicians' ability to provide "counselling" to applicants about the outcome of an application. Such counselling could range from an explanation by email to a one-on-one meeting. It was to be based on the technicians' experience and was meant to provide reasonable expectations to an applicant about their next steps.

[132] The wording of the email to Mr. Claypool left it open to different interpretations. It should have been more clearly worded. In the context of the denial of an application, Mr. Claypool's understanding of the email was fair. I also note that the medical technician sent the email to Mr. Claypool when the CAF recruiting centre would have restricted its services due to the COVID epidemic. On balance, however, I find that it was more likely than not that the statement in the medical technician's email that "experience has shown" that applicants with a history of PTSD will not be enrolled was the medical technician's attempt to counsel Mr. Claypool, and it was not evidence of a CAF practice to systemically discriminate against applicants with a history of PTSD.

[133] Mr. Dorais and Mr. Claypool both had a history of PTSD, but the evidence about whether their experiences support the allegation of systemic stereotyping and reflexive rejection of applicants with a history of PTSD is inconclusive. This evidence must be evaluated in light of all the evidence.

[134] I have also considered the confidential documentary evidence and testimony involving Individual A's circumstances. Mr. Dorais and the Commission cross-examined Lieutenant-Colonel Minkley at length about his testimony, and the Commission made oral submissions. On balance, I find that the evidence about Individual A tends to only support the conclusion that the CAF can make individual assessments based on each applicant's situation and that the CAF can amend an applicant's medical category in appropriate circumstances. I do not find that the evidence involving Individual A supports the inference that the CAF had a practice involving generalized bias or systemic discrimination against applicants with a history of PTSD.

4. The expert evidence does not support a finding of systemic, reflexive rejection of applicants with a history of PTSD

[135] The expert report and the testimony of Dr. Passey, a psychiatrist and former military officer, was also included in evidence. In 2021, when this case was heard, Dr. Passey had been a medical doctor for almost 41 years, including 26 years as a psychiatrist. He served in the CAF for 22 years. He was a CAF general duty medical officer for ten years. He conducted medical assessments and assigned medical categories to individuals, including CAF recruits, between 1981 and 1987. After 1991, Dr. Passey's duties included making recommendations for medical categories. He was the Chief of Medical Staff and Services at a CAF hospital in 1990–91, the Chief of Mental Health Services at a CAF base in 1995–97, and the psychiatrist for a CAF medical group from 1997 to 2000. After Dr. Passey released from the military in 2000, he specialized in assessing and treating serving members of the CAF, serving members of the RCMP, and veterans of both the CAF and the RCMP.

[136] I address here only the parts of Dr. Passey's testimony related to the allegation of a CAF blanket policy to refuse applicants with PTSD.

[137] Dr. Passey testified that the CAF has a blanket policy to medically release CAF serving members with medical conditions when they cannot meet the medical category requirements for their specific occupation. However, this testimony about the medical release of serving CAF members does not support Mr. Dorais' and the Commission's position that there is a systemic practice to refuse **applicants** with a history of PTSD. Dr. Passey did not refer to any individual circumstances, and there were no facts presented for me to determine their relevancy to this case.

[138] The CAF's counsel asked Dr. Passey on cross-examination if he was aware of any blanket policy to prevent individuals with PTSD from being hired. He answered: "not in writing". I understood this testimony to be inferring that the CAF has an unwritten policy or a practice of that nature, but Dr. Passey did not provide any facts to support this statement. This testimony is not persuasive, and I give it no weight.

[139] Dr. Passey also provided examples of situations, in approximately 2010 or 2012, in which he treated veterans who had been medically released for PTSD, but who were able to re-enrol after Dr. Passey treated them and provided information to the CAF about the treatment. The CAF submitted that Dr. Passey's evidence supports the conclusion that having a history of PTSD is not a determinative factor in whether an individual can re-enrol. I agree.

[140] The CAF called Dr. Andrea Tuka as an expert witness. Dr. Tuka was a General Duty Medical Officer from 2003 to 2005, and she was deployed to Afghanistan. As a psychiatrist, she served in a CAF Operational Trauma Stress Support Centre from 2009 to 2011 and was again deployed to Afghanistan in 2010. Since 2011, Dr. Tuka has been a Clinical Leader in Mental Health Services / Operational Trauma Stress Services Centre for the CAF in Victoria, B.C. She has diagnosed and treated CAF members with mental health disorders, including PTSD and depression. She also advises the CAF's Surgeon General on clinical matters in psychiatry and develops policies related to clinical psychiatric and mental health care. As of the date of her testimony in 2021, she had conducted approximately 40 "technical suicide reviews" for the CAF.

[141] On cross-examination, Mr. Dorais asked Dr. Tuka if there are CAF members serving in the military who have successfully recovered from their PTSD and are serving in their original occupations. Dr. Tuka's response was that there are members of the CAF who recovered from PTSD after treatment, but she did not know if they continued to serve in their original occupations. She assumed that many of them had to change their trade if they were, for example, infantry or combat engineers, so that they could continue to serve within their Medical Employment Limitations and have a reduced risk of being re-traumatized in their work. Although this testimony involved serving CAF members with PTSD and not applicants with a history of PTSD, the evidence that the CAF has treated and reintegrated CAF members with PTSD also supports the conclusion that PTSD does not automatically disqualify a person from being able to serve in the CAF.

[142] In summary, the expert evidence does not support the view that stereotyping or unconscious bias against people with a history of PTSD underpinned the CEMS and Related Medical Policies or otherwise led to a systemic practice within the CAF of reflexively refusing applicants with PTSD.

5. The research does not support a finding of a CAF practice of systemic, reflexive refusal of applicants with a history of PTSD

[143] The Commission's closing submissions refer, for context, to a 2012 report by the Ombudsman for the Department of National Defence (DND) and the Canadian Forces, titled Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve (the "2012 Report"). It is based on an initial Ombudsman's report in 2002 that evaluated the CAF's ability to respond to the challenge of PTSD and on follow-up reports in 2002 and 2008. The 2012 Report is a third follow-up report that examines the DND's and the CAF's response to the previously identified challenge of PTSD and other operational stress injuries. As its title suggests, the 2012 Report's stated objective is to deliver an accurate and fair representation of the DND's and the CAF's ability to identify, prevent and treat PTSD and other operational stress injuries. It presents "a clear and revealing trajectory of the DND/CF mental health capability over time" (2012 Report

at 8), but it is based on a "snapshot in time" (2012 Report at 8). It updates the recommendations of the previous reports and makes further recommendations.

[144] The Commission referred to the 2012 Report to support the position that negative attitudes of CAF superiors and peers toward those who have mental health conditions, and the self-stigmatization of CAF members with mental health conditions, are still major impediments to proper health care treatment in the CAF. However, the report's "Background" concludes that, although the CAF's mental health capability is not perfect, and there is still important work to be done, the "ceaseless devotion of the medical professionals, care providers, managers, clerical staff, and peers both enabling and delivering care has been the single constant throughout this analysis" (2012 Report at 9). This conclusion does not support the inference that the Commission asks me to draw.

[145] I also find that the 2012 Report is not useful context. Its broad focus on the CAF's capability to provide mental health care treatment does not, in my view, provide a background or a social context for this complaint about alleged discrimination involving applicants with a history of PTSD or a context about whether the CAF's enrolment medical standard and related policies are discriminatory.

[146] The Commission also referred for context to a 2021 research report in evidence (the "2021 Report"), titled Factors That Help and Factors That Prevent Canadian Military Members' Use of Mental Health Services. It finds that depression is higher in the CAF than in the general population but that CAF members do not always make use of existing mental health services. The report notes that military culture is changing but it still plays a role in creating barriers to obtaining care and that the continued existence of stigma and self-stigmatization prevents CAF members from seeking access to care. It concludes that changes ("strides") have been made to reduce structural barriers to mental health care, but that more research is needed to address biases and stigma towards the use of mental health care services.

[147] Although the 2021 Report supports the position that barriers to CAF members' access to mental health care services continue to exist and that stigma continues to play a role, it does not follow that prejudice and stereotype have seeped into the CAF's medical

evaluations of applicants with a history of PTSD. The continued military-cultural reasons why CAF members have not sought mental health treatment does not support the inference that a practice exists within the CAF that is rooted, even unconsciously, in prejudice and stereotypes to exclude applicants with a history of PTSD.

[148] The Commission also referred to other secondary sources and web pages. The CAF argued that these documents were not entered as exhibits during the hearing, that they are consequently not admissible as evidence, and that it would be procedurally unfair to consider them. The Commission argued that there is legal authority for allowing secondary sources as social context for a complaint. It relies on section 50(3)(c) of the CHRA, which permits the Tribunal to "receive and accept any evidence and other information, whether on oath or by affidavit or otherwise, that the member or panel sees fit, whether or not that evidence or information is or would be admissible in a court of law".

[149] The CHRA does, indeed, give the Tribunal authority to accept any evidence and other information that the Tribunal sees fit to accept, but I do not accept information that a party did not enter as evidence and that is referred to only in closing submissions. This information was not considered during the examinations-in-chief of Mr. Dorais' or the Commission's witnesses, and it was not available for the CAF during its cross-examination of witnesses, or for the CAF to ask their witnesses to testify about. It would be procedurally unfair to the CAF if I considered this evidence, even for context.

[150] The Commission and Mr. Dorais have not referred to other research to support the argument that a CAF practice of systemic discrimination exists against applicants with a history of PTSD or that the CAF has a practice of a blanket refusal of such applications. Although I agree with the Commission that evidence in an individual complaint can prove a systemic pattern of discrimination, the evidence in this case has not persuaded me that this practice existed or that this type of systemic discrimination was a factor in the denial of Mr. Dorais' application.

6. Conclusion on the allegation of systemic bias and stereotyping leading to widespread exclusion of applicants with a history of PTSD

[151] I have carefully considered the evidence regarding Mr. Dorais' and the Commission's systemic allegations. Mr. Dorais' history of PTSD was certainly a factor in the CAF's refusal to re-enrol him. However, the evidence does not satisfy me that prejudicial attitudes or stereotypes were involved in the CAF's decision-making on Mr. Dorais' application. I am also not convinced that the CAF applied a "blanket exclusion" against applicants with a history of PTSD.

i. Conclusion about the *prima facie* case

[152] Mr. Dorais and the Commission have proven a *prima facie* case of discrimination with respect to the CAF's denial of Mr. Dorais' application under section 7(a) of the CHRA and with respect to the policies, applied to Mr. Dorais, that establish and implement the medical standard for enrolment, under section 10(a) of the CHRA. Mr. Dorais' history of PTSD was a factor in the CAF's evaluation of his application under the CEMS and Related Medical Policies and was a factor in the CAF's denial of his application to re-enrol. However, Mr. Dorais and the Commission made further allegations about systemic discrimination that have not been substantiated. Mr. Dorais and the Commission have not established a *prima facie* case with respect to the allegations that (1) the CEMS and Related Medical Policies are intended to exclude applicants with PTSD, (2) stereotypes and bias against such applicants pervade the CAF's practices with respect to applicants, or (3) the CAF reflexively denies applications from individuals with a history of PTSD or service-related PTSD.

B. Did the CAF justify its reliance on the CEMS for all applicants, its application of the CEMS and the Related Medical Policies to Mr. Dorais, and its refusal to re-enrol him (section 15 of the CHRA)?

i. Legal framework

a) Justification

[153] When a complainant proves a *prima facie* case of discrimination, a second step is required for determining if a discriminatory practice under the CHRA occurred. The burden of proof shifts to the CAF to justify its conduct and its decision based on the exemptions in the CHRA or developed by the courts (*Bombardier* at para 37).

[154] The CAF must prove that its reliance on the CEMS to evaluate all applicants regardless of the position within the CAF that they hope to fill, and the CAF's application of the CEMS and the Related Medical Policies to Mr. Dorais, are justified under section 15 of the CHRA. If the CAF does not do so, there will be a finding of a discriminatory practice under section 10(a) of the CHRA.

[155] Additionally, if the CAF does not justify its decision to deny employment to Mr. Dorais, there will be a finding of a discriminatory practice under section 7(a) of the CHRA, based on disability having been a factor in the CAF's refusal to employ Mr. Dorais *(Bombardier* at para 37).

[156] To prove that the CEMS and the Related Medical Policies, their application to Mr. Dorais and the decision to deny Mr. Dorais' application are justified under the CHRA, the CAF must prove that it is more likely than not that the policy, practice and/or denial of Mr. Dorais' application were:

a) adopted or done for purposes that are rationally connected to the performance of a CAF recruit's work;

b) done with honest and good faith belief that they were necessary to fulfill the CAF's purposes; and,

c) reasonably necessary to accomplish the CAF's purposes. To prove reasonable necessity, the CAF must show that it was impossible to accommodate the needs of Mr. Dorais without imposing undue hardship on the CAF.

(*British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, 1999 CanLII 652 (SCC), [1999] 3 S.C.R. 3 [*Meiorin*] at para 54)

[157] I refer to these criteria as "the *Meiorin* test."

b) Accommodation and undue hardship

[158] A search for accommodation under section 15 of the CHRA begins when those involved in the search have at their attention the facts relating to discrimination (*Air Canada v. Marcovecchio*, 2024 FC 1639 at para 58 [*Marcovecchio*], citing *Central Okanagan School District No. 23 v. Renaud*, 1992 CanLII 81 (SCC), [1992] 2 SCR 970 at 994 [*Renaud*]).

[159] A person seeking accommodation for a disability must disclose sufficient information to the employer to enable it to fulfill its duty to accommodate (*Marcovecchio* at para 63, citing *Renaud* at 994). The determination of what information is sufficient is fact-specific, related to the individualized nature of the accommodation process. At a minimum, an employer must have enough information to understand the extent of the person's disability as it relates to their duties and environment (*Marcovecchio* at paras 64–65; *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal,* 2007 SCC 4 (CanLII), [2007] 1 SCR 161 at para 22).

[160] When a duty to accommodate is triggered, the search for accommodation is a multi-party inquiry. Both parties have a duty to assist in securing the appropriate accommodation (*Marcovecchio* at para 61, citing *Renaud* at 994).

[161] The extent of an employer's duty to accommodate is also individualized. Determining it requires proof of undue hardship for the employer. The evidence does not need to prove that it is impossible to accommodate an employee or, as in this case, a prospective employee. An employer does not have to change its working conditions in a fundamental way, but it must be flexible and avoid rigid rules in applying its standard, if such flexibility

would enable a person to work and not cause undue hardship for the employer (*Hydro-Québec v. Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ)*, 2008 SCC 43, [2008] 2 S.C.R. 561 at paras 12–18).

[162] Standards must be as inclusive as possible. Some measure of individual assessment may be required as proof that individual accommodation within the standard was impossible without undue hardship. A failure to accommodate may be established by evidence of arbitrariness in setting the standard, by an unreasonable refusal to provide individual assessment, or perhaps in some other way (*British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*, 1999 CanLII 646 (SCC) at para 22 [*Grismer*]). But if a policy or standard is reasonably necessary to an appropriate purpose or goal, and accommodation short of undue hardship has been incorporated into the standard, the fact that the standard excludes some classes of people does not amount to discrimination (*Grismer* at para 21).

[163] If an employer adopts an absolute standard, it must be supported by convincing evidence to link the outright refusal of even the possibility of accommodation with an undue safety risk. If a respondent can show that accommodation is impossible without risking safety or that it imposes some other form of undue hardship, it can maintain the absolute prohibition. If not, the employer is under an obligation to accommodate the claimant by allowing the person an opportunity to show that he or she does not present an undue threat to safety (*Grismer* at paras 41–45).

[164] If an employer has not engaged in any accommodation analysis or attempts at accommodation at the time a request by an employee is made, it is likely to be very difficult to satisfy a tribunal on an evidentiary level that it could not have accommodated that employee short of undue hardship. That is the very real and practical effect of the employer's evidentiary burden to establish a *bona fide* occupational requirement (*Canada (Attorney General) v. Cruden*, 2013 FC 520 at para 70 [*Cruden FC*], citing *Koeppel v. Canada (Department of National Defence)*, 1997 CanLII 1443 at paras 212–228).

[165] Generally, the Tribunal can look at the procedure employed in an accommodation process as a practical tool for deciding whether an employer has established, according to the evidence, undue hardship (*Cruden FC* at para 69).

[166] The universality of service principle affects the justification analysis. The universality of service principle is recognized in section 15(9) of the CHRA, which confirms that the duty to accommodate is subject to the principle that "members of the Canadian Forces must at all times and under any circumstances perform any functions that they may be required to perform". This qualification of the CAF's duty to accommodate applicants cannot be challenged, but how the universality of service principle is applied can be. Mr. Dorais and the Commission have put in issue whether the application of the CEMS and Related Medical Policies to all recruits is justified by the principle of universality of service. They have also put in issue the manner in which the CAF applied the CEMS and Related Medical Policies to Mr. Dorais.

[167] Regarding the CAF's medical assessment of Mr. Dorais, the duty to accommodate requires that the CAF undertake, in each case, a fair assessment of all the available medical evidence (*Best v. Canada (Attorney General)*, 2011 FC 71 at paras 26–29, upheld 2011 FCA 351; *Canada (Canadian Armed Forces) v. Irvine*, 2005 FCA 432 at para 5 [*Irvine FCA*]). The Tribunal must consider whether the CAF's application of standards that are proffered as a *bona fide* occupational requirement was instead discriminatory. The obligation to decide whether appropriate accommodation has been provided cannot be met without a careful analysis of the medical decision making (*Irvine FC* at para 12, citing *Irvine* at para 43, and *Irvine FC* at para 24; upheld *Irvine FCA*). Arbitrary, hasty, imprudent or inadequate medical assessments may fail to meet the test for justification.

1. Positions of the parties on justifications for the application of the CEMS and Related Medical Policies to all recruits, including Mr. Dorais, and the denial of his application to re-enrol

[168] Mr. Dorais asserted that the CEMS is not a reasonable policy, that it is not necessary for an applicant who has selected an occupation in their application, that the CAF did not adopt the policy in good faith, and that the CAF did not properly consider his application

under the CEMS but, instead, denied his application because he had a diagnosis of PTSD/depression and relied on the CEMS as a “specious excuse” to reject his application.

[169] The Commission argued that the medical standard for new recruits is not necessary for the nursing position to which Mr. Dorais applied and that the CAF’s process for evaluating Mr. Dorais’ application to enrol was discriminatory because the CAF conducted it inadequately and did not individualize its assessment to the facts of Mr. Dorais’ situation.

[170] The CAF argued that the CEMS meets the CHRA’s requirements for a *bona fide* occupational requirement. The CAF also said that the CEMS and Related Medical Policies are justified based on the universality of service principle and on section 15(9) of the CHRA, as well as in light of the volume of applications that it received.

[171] The CAF also argued that it conducted a proper and individualized evaluation of Mr. Dorais’ application based on the medical information that Mr. Dorais provided and that the evaluation confirmed that Mr. Dorais did not meet the requirements of the CEMS.

2. Summary findings about justification

[172] Based on my reasons below, I find as follows:

a) The CAF has justified its reliance on the CEMS as the medical standard that all applicants to the CAF must meet. As a policy, it is a *bona fide* occupational requirement. The CEMS and Related Medical Policies are not discriminatory policies under section 10(a) of the CHRA if the CAF applies the CEMS appropriately, which includes a requirement for a fair evaluation of an applicant’s medical conditions.

b) However, the CAF has not proven that it conducted a prudent and fair assessment of Mr. Dorais’ medical conditions. Mr. Dorais informed the CAF about his PTSD diagnosis. The CAF had a duty to accommodate Mr. Dorais but the CAF’s process for evaluating Mr. Dorais’ application did not include accommodations for Mr. Dorais’ disability to the point of undue hardship. During the medical evaluation of Mr. Dorais’ application, it would not have been an

undue hardship for the CAF to inform Mr. Dorais about the specific medical information that it needed to decide whether his medical conditions had been successfully treated and whether he had employment limitations related to PTSD. Not taking this action during the application process was a failure to accommodate Mr. Dorais' disability. Therefore, the CAF has not justified its assessment of Mr. Dorais and decision to refuse his application.

ii. Analysis of whether the CEMS and Related Medical Policies, the application of the CEMS to Mr. Dorais, and the denial of Mr. Dorais' application to re-enrol were justified

a. Part 1: Purposes are rationally connected to a CAF recruit's work

[173] The CAF submits that there were three purposes for adopting the CEMS and that the purposes are connected to the work performance of CAF recruits. The purposes are that:

1. the CEMS ensures that applicants will be eligible for the widest range of military occupations;

2. the CEMS ensures that recruits are physically and mentally fit to complete basic training; and

3. the CEMS ensures that recruits can safely access prohibited weapons.

[174] The second and third purposes also include the purpose of minimizing the risk of harm for recruits.

[175] As explained below, the evidence confirms that the CAF adopted the CEMS and the Related Medical Policies to support these purposes and that there is a rational connection between the purposes and the work that a CAF recruit must perform. The rational connection also exists in Mr. Dorais' situation of having requested a nursing officer position, for which the CAF has different medical category requirements than the CEMS.

1. A purpose of the CEMS is to ensure eligibility for the widest range of military occupations

[176] The CAF's policies state that the CEMS ensures that CAF recruits will be eligible for a wide range of military occupations:

a) Policy Instruction 11/04 about the CAF Medical Standards (CFP 154) refers to the CEMS requirement for recruits "to be eligible for the widest selection of trades".

b) DAOD 5023-1 lists the operational standards that are required for all members of the CAF's Regular Force and Primary Reserve. Having common operational standards supports the goal of CAF members being able to work in many occupations.

c) The Generic Task Statement in Appendix B to CFP 154 lists the minimum operational requirements for all CAF members.

d) Annex C to CFP 154 refers to the "common military tasks" as the minimum physical fitness standard associated with universality of service. It links the physically demanding tasks that all CAF members must be able to perform with the "essential principles" of universality of service, in which a soldier must be ready to serve at all times, in any place and under any conditions (*Irvine FC* at para 6).

e) The CAF Medical Standards (CFP 154) also states that the CAF's objectives require "all members to serve in a variety of geographic locations and environmental conditions" and that the CEMS "is required for recruit candidates in order to ensure that they remain eligible for assignment to the widest range of MOSIDs".

[177] Major Eastwood's testimony also confirmed that the CEMS is meant to ensure that the widest breadth of occupations are available to an individual. She gave the example of enrolling an individual who may have expressed a preference for a particular occupation but

is injured and requires reassignment. Major Eastwood also referred to other situations where an applicant's preferred military occupation becomes unavailable after they have completed the application process. In these situations, the rigorous CEMS requirements allow the CAF to offer the applicant other employment opportunities. Ensuring that applicants are eligible for many occupations supports both the applicant's desire to enrol and the CAF's operational requirements.

[178] Dr. Passey testified that the reason for requiring G2 and 02 ratings on enrolment is to qualify recruits for every military occupation and that applying the CEMS is appropriate for a recruit who has not identified a preferred occupation or in situations where the CAF is not sure where to place them. In Dr. Passey's opinion, the CAF should not have applied the CEMS to Mr. Dorais and other applicants who have expressed preferences for an occupation, but the testimony supports the finding that a general purpose of the CEMS is to ensure eligibility for the widest range of occupations.

[179] Mr. Dorais and the Commission submitted that there is no rational connection between the high bar of the CEMS and the occupational requirements of a nursing officer that Mr. Dorais applied for. The Commission submitted that the CEMS' requirement for G2 and O2 ratings is unreasonable because Mr. Dorais and other applicants select their preferred occupations and the CAF regularly assigns recruits to their preferred occupation, so the proper enrolment standard in Mr. Dorais' situation should have been the nursing officer's medical category of G3 and O2 instead of the harder-to-achieve G2 and O2 of the CEMS. As noted above, Dr. Passey's opinion supports that position.

[180] Mr. Dorais and the Commission framed this argument as being about the lack of **rational connection** between the CEMS' stringent requirements and the nursing officer's job responsibilities, but I understand the argument to be that the CEMS is not **necessary** for an applicant who applied to work as a nursing officer. I consider this argument below under part 3 of the *Meiorin* test.

[181] The evidence satisfies me that the CAF adopted the CEMS and Related Medical Policies to have recruits be eligible to perform the widest range of military occupations and

that there is a rational connection between this purpose and the work that the CAF expects a recruit to perform.

2. A purpose of the CEMS is to have CAF recruits who are fit to complete basic training

[182] The evidence also satisfies me that the CEMS is meant to ensure that recruits are physically and mentally fit to complete their basic training.

[183] The basic training requirement is a fundamental condition of employment in the CAF and a condition for employment in a military occupation. The interview guide that a military career counselor completed after his February 2016 interview with Mr. Dorais indicates that the counselor informed Mr. Dorais that he would be released from the CAF if he failed basic military qualification training.

[184] Major Eastwood testified that the CEMS enables recruits to attend basic training with a limited risk of injury or aggravation of an existing condition. According to Major Eastwood, it is a CAF priority that recruits not be harmed during basic training.

[185] Major Eastwood distinguished between the risks involved in basic training and the risks of performing the tasks of an occupation to which the CAF assigns members after they complete basic training. She gave the example of recruits engaging during their training in the CAF's common core tasks (the common operational core tasks described in *DAOD 5023-1*, *Minimum Operational Standards Related to Universality of Service*) but possibly not engaging in them later during their employment in an occupation. If a recruit cannot complete these tasks, they do not complete their training requirements. According to Major Eastwood, meeting the CEMS' requirements ensures that they will be able to complete these tasks during basic training.

[186] Lieutenant-Colonel Minkley also testified as follows:

a) The CEMS' G2 and O2 requirements incorporate the ability to complete the minimum operational requirements listed in the Generic Task Statement (Annex B to CFP 154) and in DAOD 5023-1.

b) When the RMO does its medical evaluation of an applicant, it considers whether they can safely complete the rigours of basic training. The RMO's decision-making also involves a determination about the risk of recurrence of an applicant's medical conditions during basic training.

c) The CEMS' ratings are established at a restrictive level based on the unique circumstances and the stress of basic training, which is meant to replicate the stresses of a deployment.

[187] Lieutenant-Colonel Minkley also testified that, in determining the medical category for applicants, CAF physicians consider whether the applicant can safely undergo the rigours of basic training, although that consideration is not set out in policy. Lieutenant-Colonel Minkley said that this is an example of the CAF's need for continuous evaluation of the CEMS and discussions about changes to the CEMS, but that no decisions had been made and the outcome of the CAF's discussions could not be predicted.

[188] Mr. Dorais submitted that this testimony about the evolving nature of the CEMS' purposes indicates that the CAF has an underlying agenda to only choose applicants that the CAF identifies as fit. That is not my view. In my view, it is appropriate for the CAF to continuously re-evaluate its enrolment policies even if the process is lengthy. I am not convinced the CAF's internal policy review processes are meant to exclude applicants who have a history of PTSD.

[189] The Commission argued that there is no data to support the CAF's contention that it adopted the CEMS to avoid the risk of injury for recruits during basic training and that, without data, the evidence about this purpose for the CEMS is impressionistic and should be considered with caution.

[190] I do not agree. Scientific data was included in evidence to support this purpose for the CEMS. A report dated May 2010, titled Prospect Analysis of Canadian Forces Basic Training Attrition, included information from a study that was designed to identify key predictors of attrition from basic training. Lieutenant-Colonel Minkley testified that this was the first independent analysis that he was aware of to consider the factors involved in a recruit's ability to complete basic training.

[191] The report's summary of findings stated that "some of the strongest predictors of basic training attrition were related to health status" and that "recruits who reported poor/fair health or who reported a medium/high severity of somatic symptoms had approximately twice the odds of being released from basic training as those who reported excellent health or a minimal severity of somatic symptoms, respectively". According to Lieutenant-Colonel Minkley, somatic symptoms refer to a general feeling of fatigue, malaise or generally not feeling well.

[192] The report states that the "findings of the present study generally favour psychological factors over physical aspects of health and lifestyle as predictors of basic training outcomes". The report's "Implications" section stated that "[as] they emphasize the importance of psychological health and personality, results presented in the current report are particularly relevant in terms of the selection and training of recruits". The abstract stated that the results "underscored the importance of good overall health and resilient personality to basic training success."

[193] This study gathered data about the factors affecting the ability of CAF recruits to successfully complete basic training. It supports the finding that the CEMS is meant to ensure that recruits will be medically fit to complete their basic training.

[194] The evidence satisfies me that a purpose of the CEMS is to have recruits who are able to sustain the rigours of completing basic training, and that there is a rational connection between this purpose and the work of a CAF recruit.

3. A purpose of the CEMS is to ensure that recruits can safely access prohibited weapons

[195] According to *DAOD 5023-1, Minimum Operational Standards Related to Universality of Service,* the minimum operational standard for CAF members to "be employable" requires that they "fire and maintain a personal weapon".

[196] The Generic Task Statement (Annex B to CFP 154) also refers to the ability to "safely handle and effectively operate a personal weapon" as a minimum operational requirement

for all service members and as a factor that the CAF's medical personnel may consider in determining a member's Medical Employment Limitations.

[197] According to the interview guide that the military career counselor completed after interviewing Mr. Dorais, the counselor informed Mr. Dorais that, regardless of his occupation, rank or position, he would be required to carry and fire a personal weapon and that he might have to use a weapon in a military operation to protect himself or to harm others.

[198] Lieutenant-Colonel Minkley testified that the ability to meet the minimum operational requirements set out in DAOD 5023-1 and the Generic Task Statement are incorporated into the CEMS' G2 and O2 ratings. He said that it is a universal principle that all members of the CAF must be able to safely operate a firearm without risk to themselves or others, and that, if there is a medical reason to believe that an individual may not be able to handle a prohibited weapon, they do not meet this element of the universality of service principle and cannot be enrolled.

[199] The evidence about minimizing the safety risk for new recruits also focused on the importance of suicide prevention. In light of the evidence below about the CAF's history of suicidality, I accept that minimizing the risk of harm is an important basis for ensuring that CAF recruits can safely operate weapons.

[200] The CAF developed Annex G to CFP 154 after 2016. It is also referred to in evidence as the Clinical Council Combined Medical Employment Limitations Guidelines (the "Clinical Council MEL Guidelines"). They provide guidance to CAF clinicians in evaluating medical conditions. The Clinical Council MEL Guidelines were not in effect when Mr. Dorais applied to the CAF, but they have useful context about the risks of suicidality:

a. In 2016, 85.7% of males in the Regular Force that died by suicide had at least one work and/or life stressor, and over half of them had at least three stressors before their death.

b. Patients with a prior history of suicide are 5–6 times more likely to make another attempt.

c. The risk of suicide increases in patients who have access to weapons, especially firearms.

d. The CAF conducts annual reviews of suicides.

e. The medical record required up-to-date copies of patients' mental health assessments, treatment plans, progress notes, inpatient records, emergency room visits, medical consultations and hospital discharge summaries, as well as information about the frequency of medical follow-up for treatment and monitoring.

[201] The guidelines give direction for the determination of CAF members' Medical Employment Limitations and their medical category. For example, they state that a G2 rating is to be assigned to a CAF member with no history of a suicide attempt, or who has a remote history of a single attempt and who, after assessment by a psychiatrist/psychologist, has been determined to have a negligible increased risk of recurrence.

[202] Dr. Tuka testified there was a significant increase in the rate of PTSD diagnoses among CAF members from 2002 to 2013, following the end of Canada's military mission in Afghanistan. She estimated that, at the CAF base in Victoria, British Columbia, there was approximately one suicide attempt per month or two.

[203] A research report in evidence also found that a past suicide attempt is among the strongest predictors of a future suicide attempt and to death by suicide. Dr. Tuka accepted the report's finding that the risk of future suicidal ideation and behaviour is highest within the first two years of a first suicide attempt and that 70% of people who have attempted suicide will never attempt suicide again. However, Dr. Tuka also opined that a past suicide attempt continues to be a risk factor even many years later, and it is important to have the details of every past suicide attempt to understand the extent of the current risk of another suicide attempt.

[204] I accept Dr. Tuka's opinion that the reduction in the risk of further suicidal behaviour based on the passage of time since a suicide attempt is not a sufficient basis for modifying the assessment of actual risk of suicidality. I find that, in an application to serve in the CAF

as a recruit, who must access, fire and maintain a personal weapon during basic training, an assessment of the risk of suicidality is essential.

[205] I conclude from the evidence above that ensuring that recruits have safe access to weapons is a purpose of the CEMS and that this purpose is rationally connected to the work that a CAF recruit is expected to perform.

4. The CAF made its decision to assign G4 and 04 ratings and deny Mr. Dorais' application for purposes that are rationally connected to the performance of a CAF recruit's work.

[206] The CAF applied the CEMS and Related Medical Policies to Mr. Dorais when assessing his application, resulting in the G4 and O4 ratings and the CAF's denial of his application. Therefore, for the same reasons, I find that the CAF's decisions to assign Mr. Dorais ratings of G4 and O4 and deny his application were made for purposes rationally connected to a recruit's work. I am not convinced of any discriminatory purpose.

[207] The Commission made submissions that there is no rational connection between the assignment of G4 and O4 ratings to Mr. Dorais and the medical evidence that Dr. Murphy, the medical evaluator at the RMO, had available to him when he assigned these ratings. However, I find that the purposes behind these decisions were the same purposes of job readiness, fitness and safety just described. The quality of Dr. Murphy's medical assessment relates to the degree of accommodation that the CAF provided to Mr. Dorais, which I discuss below. Here, the focus is on the CAF's purposes for adopting the policies in issue and for rejecting Mr. Dorais' application and the relationship between the purposes and the performance of the work of a recruit.

b. Part 2: Did the CAF adopt the CEMS and Related Medical Policies, apply them to Mr. Dorais and deny his application in an honest and good faith belief that these actions were necessary to fulfill its purposes?

[208] Yes. I am satisfied by the evidence that the CAF adopted the CEMS and Related Medical Policies in the honest and good faith belief in their purposes.

[209] The CEMS and Related Medical Policies are derived from the *National Defence Act's* requirement that CAF members perform any lawful duty that is military in nature. They are also based on the universality of service principle that is set out in section 15(9) of the CHRA and confirmed in the jurisprudence of the Federal Court and Federal Court of Appeal. It is appropriate for the CAF to have policies and processes with the details for implementing these legal obligations. The policies define the operational standards for requiring that CAF members be physically fit, employable and deployable. They define the actual tasks that CAF members must be able to accomplish to meet the operational standards. They set out the requirements of the medical category system and assimilate the operational standards into medical category ratings that an applicant must meet to be enrolled.

[210] The evidence also satisfies me that the CAF conducted research about the CEMS and that it regularly reviews the CEMS' requirements. The evidence refers to research that supports the minimal operational requirements set out in the Generic Task Statement (Annex B to CFP 154). The "frequently asked questions" in the appendix to the Generic Task Statement notes that the specific numbers for some of the required tasks, such as the ability to carry a stretcher for 750 metres, come from a validation study conducted by a team of specialists in sports medicine and exercise physiology.

[211] Lieutenant-Colonel Minkley also testified about the role of the CAF's working groups, or review boards, and his participation in them. The review boards develop the Medical Employment Limitations that underlie every person's medical category. Clinical experts on the review boards consider the medical evidence about each medical condition, evaluate how to assess an individual with this condition and develop a framework for determining each condition's severity. They draft policies for approval by the CAF's Clinical Council, which includes senior physicians and the CAF's Surgeon General. The policies guide the RMO physicians' medical category decision-making. This approach has resulted in the production of the Clinical Council MEL Guidelines.

[212] Regarding ongoing reviews of the CEMS, Lieutenant-Colonel Minkley testified that, since 2019, he has participated in a working group that has met since at least 2012 to re-evaluate the CEMS, the related policies, and the principle of universality of service, based

on the federal government's direction to consider methods by which an individual who does not meet the principle of universality of service may continue to be employed.

[213] The evidence satisfies me that the CAF acted honestly and in good faith in following a complex path that begins with the universality of service principle and ends with the medical category requirements of the CEMS and the Related Medical Policies.

[214] Mr. Dorais submitted that the CAF has used the CEMS "as a specious excuse to cast aside my employment application using ostensibly benign but subjectively scripted guidelines designed to steer medical evaluators to this end". The submission suggests that the CAF did not act in good faith when it adopted the CEMS. I am satisfied that there is no convincing evidence to support this position.

[215] The Commission also submitted that the CAF did not adopt the CEMS or act toward Mr. Dorais in a manner that reflected an honest and good faith belief that its actions were necessary for its purposes. However, the evidence that the Commission cited for this position relates to whether the CAF made sufficient effort to accommodate Mr. Dorais during its assessment. For example, the Commission argued that the lack of specific information in the CAF's decision letters to Mr. Dorais about what further medical documentation he should provide is proof that the CAF did not make honest or good faith efforts to assess Mr. Dorais' application. That submission addresses the CAF's degree of effort to accommodate Mr. Dorais, and not the good faith adoption of the enrolment standard or the CAF's honest belief about whether its denial of Mr. Dorais' application was necessary to fulfill its purposes. I address that submission below, under the third part of the *Meiorin* analysis.

[216] I am satisfied that the evidence supports the finding that the CAF acted in the honest and good faith belief that adopting the CEMS, applying it to Mr. Dorais and deciding to deny his application were necessary to fulfill the CAF's purposes.

c. Part 3: Are the CEMS and Related Medical Policies necessary to accomplish the CAF's purposes, and would it have been impossible

to accommodate Mr. Dorais' needs without imposing undue hardship on the CAF?

[217] I now consider, first, whether the policies that define the medical standard for applicants, including the CEMS and the group of Related Medical Policies, are necessary under section 15 of the CHRA. I find that they are.

[218] Following the reasons about the necessity for the CEMS and the Related Medical Policies, I consider the sufficiency of the CAF's medical evaluation of Mr. Dorais' application and the alleged flaws in the evaluation.

1. Are the CEMS and the Related Medical Policies necessary, including for an applicant who requested a nursing officer position?

[219] Yes. Based on the evidence, the CEMS and the Related Medical Policies are necessary for the purposes of having CAF recruits be eligible for the widest range of occupations, fit to complete basic training and able to safely access weapons. These policies are also necessary to implement the universality of service principle.

[220] *DAOD 5023-0, Universality of Service*, requires that CAF members be "physically fit, employable and deployable". *DAOD-5023-1, Minimum Operational Standards Related to Universality of Service,* applies the universality of service principle by requiring that members of the CAF's Regular Force and Primary Reserve meet defined minimum standards. The Procedures for Recruitment Screening require medical screening of CAF applicants and the assignment of a medical category to ensure that they meet the requirement of universality of service and the CEMS. The CAF Medical Standard (CFP 154) sets out the details for the medical evaluations.

[221] Mr. Dorais argued that the CEMS only exists to restrict admission to the CAF and for basic training. He said it was an unreasonable and overly rigid policy that only permitted entry to the CAF to people with perfect health and that, after admission, perfect health was no longer necessary. Since the higher G and O ratings of the CEMS are harder to achieve than the G and O requirements for a nursing officer position, he considered the CEMS

requirement to be unjustified for an applicant such as himself. However, the evidence does not support this view.

[222] As I found above, the evidence does not support the allegation of a practice of blanket exclusions. I have also found that the CAF adopted the CEMS for purposes that are rationally connected to the work of a CAF recruit and that the evidence demonstrates that people with varied characteristics can meet the requirements of the CEMS. These findings tend to support the view that the CEMS is not aimed at the systematic exclusion of applicants with a history of PTSD and is instead more flexible and nuanced when it comes to such applicants.

[223] The Commission asked Major Eastwood if the CEMS is meant to ensure that the CAF only recruits young, able-bodied individuals with no medical conditions or limitations. Major Eastwood disagreed. She testified that she knew of applicants in their 40s and early 50s who have met the CEMS.

[224] Lieutenant-Colonel Minkley testified about research showing that approximately 4% of recruits who are accepted into basic training have PTSD, and 4% have depression. The evidence is based on a 2019 report titled Descriptive Analyses of the Recruit Health Questionnaire, 2013–2015 Cohort. It analyzes the results of a health questionnaire that the CAF has provided to CAF recruits and officer cadets on a voluntary basis during the early weeks of their basic military qualification course since 2003. It provides information about the health of recruits who began basic military training between 2013 and 2015 and compares them to the cohort from 2010 to 2012. It is meant to help the CAF understand "who the CAF recruits are, and what are their demographic, health, and psychosocial characteristics when they enter the CAF".

[225] According to Table 8 of the report, the proportion of probable cases of recruits with PTSD increased from approximately 2.2% in 2010–2012 to approximately 3.9% in 2013–2015. The proportion of probable cases of depression in the 2013–2105 group was approximately 4.7%, probable cases of other anxiety disorders was approximately 1.4%, and probable cases of panic disorder was approximately 0.9%.

[226] According to Lieutenant-Colonel Minkley, the report demonstrates that applicants with PTSD diagnoses have been accepted into the CAF. The report does not indicate if the recruits disclosed their diagnoses during the application process, but I find that it supports the finding that recruits with PTSD have been able to meet the requirements of the CEMS and enrol in the CAF.

[227] I have also referred above to Dr. Passey's testimony that he has treated veterans who had been released from the CAF for PTSD but were able to re-enrol after Dr. Passey treated them.

[228] Mr. Dorais also relied on Dr. Passey's expert evidence that the enrolment standard for Mr. Dorais should be based on a G3 rating, not G2, because G3 is the standard for Mr. Dorais' preferred occupation. In Dr. Passey's opinion, the CEMS is not necessary to enrol applicants who have indicated a preference for an occupation that requires a less rigorous medical category.

[229] The Tribunal qualified Dr. Passey as an expert in psychiatry with particular expertise in PTSD and PTSD in the military context. Dr. Passey's experience is extensive, and his expert evidence assisted me in understanding the issues. However, on the question of whether the G2 and O2 requirements of the CEMS are a necessary medical standard for all applicants to the CAF, I do not agree with Dr. Passey's opinions.

[230] As explained above, Dr. Passey testified that the G2 and 02 medical category ratings are required on enrolment because they qualify recruits to work in all military occupations but that this standard is not appropriate where an applicant has selected a preferred occupation. Paragraph 20 of Dr. Passey's expert report states that "requiring G2O2 on enrolment does not make any clinical sense in Mr. Dorais' specific case but also for any other applicant for the nursing officer occupation or any military occupation that allows serving members to have a G3O3 category [corrected to G3O2 during Dr. Passey's testimony] …", and that "[it] presents an unreasonable mental health obstacle that is not supported by any medical evidence given that currently enrolled nursing officers can have a G3O3 profile [corrected to G3O2], be allowed to continue to work in the CAF, and are not medically released because of a G3O3 [corrected to G3O2] profile".

[231] Respectfully, I do not agree. Despite the CAF's practice of assigning recruits to their preferred occupations, the CAF assigns them to other occupations when necessary. Major Eastwood gave examples, such as when an individual expressed a preference for an occupation but requires reassignment due to injury. The example highlights the importance of maintaining the more rigorous enrolment standard so that CAF members are fit for employment in many other occupations if the need arises.

[232] The universality of service principle is the foundation for this requirement. Major Eastwood's testimony confirms that the CEMS' G2 and O2 ratings apply the principle that every CAF member must be ready to serve at all times, in any place and under any conditions, despite an applicant's original occupational preference and despite the CAF's practice of assigning CAF members to an occupation of their choice.

[233] If the medical enrolment standard was based on the medical category requirements of an occupation that applicants can select, I am not satisfied that the CAF could adhere to the universality of service principle. The list of medical categories for the CAF's occupations in Annex E to the CAF Medical Standards (CFP 154) indicates that almost half of the occupations require G2 and O2 ratings. If the enrolment medical standard was based on the medical category for an applicant's preferred occupation, recruits who qualify for enrolment based on ratings that are lower than G2 and O2 ratings would not be fit to perform work in many occupations and would be excluded from possible reassignment to them. This proposed approach to enrolment is inconsistent with the evidence about the alignment between the CEMS and the principle of universality of service. Although there was evidence that CAF working groups have been reviewing the relationship between the CEMS and the universality of service, there were no changes in effect when the Tribunal heard this complaint.

[234] Dr. Passey also opined that it does not make clinical sense to require every applicant to meet the requirements of the CEMS when the CAF has serving members who continue to meet the requirement of the universality of service principle but who do not have G2 and O2 medical category ratings. The Commission made a similar point, arguing that the CEMS is not necessary to ensure compliance with the universality of service principle because some CAF members with a history of PTSD continue to serve in the CAF—and, therefore,

must be complying with universality of service requirements—despite not having G2 and O2 ratings.

[235] On this point as well, I respectfully disagree, for two reasons.

[236] First, I have accepted the evidence that the G2 and O2 requirements of the CEMS serve the purpose of ensuring that new recruits can safely complete basic training. For that reason, it is appropriate for the CAF to require a recruit (in this case, a prospective nursing officer) to meet the G2 and O2 requirements of the CEMS and to also permit a serving nursing officer to maintain a less rigorous standard.

[237] I am not satisfied that the approach of comparing the circumstances of CAF applicants with the circumstances of serving CAF members is appropriate to support the argument that the CEMS is not a necessary policy. CAF applicants have not completed basic training and cannot start work in their military occupation until they do so. Serving CAF members have completed basic training and are assigned to an occupation. Based on the differences in the work expectations for these two groups, and the differences in the physical and mental demands on them, it is reasonable for the CAF to treat their circumstances differently.

[238] Major Eastwood and Lieutenant-Colonel Minkley testified that the CEMS intends to consider the risk of an applicant having a recurrence or exacerbation of a medical condition during basic training that may affect their ability to complete the training, to do their job, or which may lead to a safety risk for the applicant or fellow CAF members. These are valid reasons for the discrepancy between the requirements of the CEMS and the requirements of the occupation-based medical categories for CAF members who have completed basic training.

[239] Second, the evidence confirms that some CAF serving members will develop medical conditions resulting in Medical Employment Limitations and medical category ratings that do not meet the requirements of their occupations but that their ability to remain as serving CAF members can continue for a limited period of time:

a) Policy Instruction 11/04 distinguishes between temporary and permanent Medical Employment Limitations.

b) The CAF Medical Standards (CFP 154) explains the process of temporarily changing a CAF member's medical category ratings while waiting for a medical condition to stabilize enough to revert to their previous medical category ratings and that a twelve-month time frame is allowed for an accurate prognosis for most medical conditions.

c) The draft Guidelines for the Application of Medical Employment Limitations – Mental Health Disorders state that CAF members with a suspected or confirmed diagnosis of PTSD should be given temporary Medical Employment Limitations, frequently for periods of 18 to 24 months to allow for treatment.

d) Dr. Tuka's testimony confirmed that, if an individual's medical condition does not improve after 18 to 24 months of treatment, their file is sent to the Directorate of Medical Policy for the assignment of permanent Medical Employment Limitations. In cases involving complex mental health conditions, a mental health board that includes military psychiatrists is involved in the assignment of the permanent limitations.

e) Major Eastwood testified that a member with G4 and O4 ratings can make representations if they think their medical category was incorrectly assigned and that, if their G4 and 04 ratings do not change, there are opportunities for them to continue serving for a limited time, perhaps as long as three years, to receive vocational rehabilitation and to assist in the transition out of the CAF.

[240] I have found that there are valid reasons to have a common medical standard for applicants to the CAF that differs from the medical standards that apply to serving CAF members. There are also valid reasons for the CAF to have policies that permit serving CAF members who develop medical conditions to continue serving for a limited time, even if their medical category ratings do not meet the requirements of their occupation or the principle of universality of service. Having policies that respond appropriately to the disabilities of

serving members does not convince me that the G2 and O2 requirements of the CEMS are an “unreasonable mental health obstacle” or that the CEMS is not necessary to ensure that the health of recruits is aligned with the universality of service principle.

[241] In summary, I find that the CEMS and the Related Medical Policies were necessary to accomplish their purposes. The evidence satisfies me that they are sufficiently linked to the universality of service principle that is established in the *National Defence Act* and defined in *Irvine FC.* Section 15(9) of the CHRA affirms that the duty to accommodate is “subject to the principle of universality of service under which members of the Canadian Forces must at all times and under any circumstances perform any functions that they may be required to perform”. The duty to accommodate does not require the CAF to accept applicants whose medical evaluation, when properly conducted, indicates they are not able to satisfy the requirements of universality of service. I accept that the CEMS is the appropriate medical standard for all applicants to the CAF, on the condition that the CAF’s medical evaluation process is appropriately applied and is not arbitrary, hasty, imprudent or inadequate (*Irvine FC* at para 21).

[242] The adoption of the CEMS and the Related Medical Policies and their application to all new recruits are justified under sections 15(1)(a), 15(2) and 15(9) of the CHRA. The CAF is justified in applying the CEMS to evaluate the medical fitness of all applicants. Therefore, it was not a discriminatory practice under section 10(a) of the CHRA for the CAF to have established or pursued these policies.

2. Having concluded that the CEMS and the Related Medical Policies are necessary, could the CAF have accommodated Mr. Dorais without undue hardship?

[243] Yes. As explained below, Mr. Dorais disclosed sufficient information about his medical history during the medical examination process to trigger the CAF’s duty to accommodate him to the point of undue hardship. I describe the required accommodations and why they would not have imposed an undue hardship.

a) The CAF's application process

[244] Major Eastwood testified about the CAF application process in 2016. A person who wanted to join the CAF applied online. Generally, if a person wanted to join a Primary Reserve unit, their application would be forwarded to the reserve unit of interest. If the reserve unit decided that the person is a likely candidate, it would send the file to a Canadian Forces Recruitment Centre detachment, which was the primary contact point and processing centre for applicants. The detachment would conduct an aptitude test, a personality test, a criminal record check and other reliability screenings. If the person passed the testing and screenings, a CAF military career counselor would interview them, discuss the occupation for which the applicant expressed a preference and consider their overall suitability. For an application to a reserve unit, the CAF would also assess the "person job fit" because, for the most part, applications for reserve unit occupations were competitive.

[245] After the interview, a medical evaluation would take place separately from the earlier steps in the recruitment process. The Procedures for Recruitment Screening, and the Processing at CFRC Medical Sections document, describe the medical evaluation process.

[246] To summarize the evidence, all applicants that a detachment deemed to be administratively suitable to apply for a CAF occupation must be medically examined and assigned a medical category prior to enrolment to ensure they meet the requirements of universality of service and the CEMS.

[247] In general, Phase 1 of the medical evaluation includes a medical questionnaire that a junior medical technician completes with the applicant, an eye exam, a hearing test (audiogram) and a colour vision exam.

[248] In Phase 2, a senior medical technician reviews information that the junior medical technician obtained in Phase 1, meets the applicant, takes a medical history and does a physical and mental assessment. If needed, the medical technician gives additional forms (FDLs) to the applicant for their general practitioner or medical specialist to complete, and the medical technician receives and reviews the FDLs. Based on this information, the medical technician makes recommendations about the applicant's medical category and sends the file to the RMO for its decision.

[249] In some situations, an applicant can be recommended for enrolment after Phase 2 pending medical approval in Phase 3. However, the operating procedures do not authorize this approach for applicants with a current or previous history or a diagnosis of certain medical conditions for which the applicant can be found temporarily or permanently medically unfit to join the CAF, including psychological/psychosocial issues, drug or alcohol misuse, seizure disorders, ulcerative colitis, asthma and an allergy with possible anaphylactic reaction.

[250] In Phase 3, a Recruiting Medical Evaluator at the RMO reviews the applicant's medical file, determines which Medical Employment Limitations apply, and decides on the applicant's medical category. In 2016, the RMO sent a decision letter to inform the applicant if they met the CEMS. If not, the letter would include the standard paragraphs from the Procedures for Recruitment Screening about the next steps that an applicant could take. An applicant could also discuss the information with medical technicians at the recruitment centre.

[251] There is a high volume of applications for enrolment, but the evidence varied about the number of applications that the RMO processes per year:

a) Dr. Long Truong, a former director of the Medical Policy Directorate in the RMO, testified that his group processed up to 20,000 applications for enrolment per year.

b) A 2019 email from Major Susan Atherley, responding to questions from the Commission, says that the CAF receives 39,000 electronic applications, of which 11,000 applicants undergo medical examinations.

c) Lieutenant-Colonel Minkley testified that the RMO received roughly 12,000 to 16,000 files per year, leading to about 5,000 to 6,000 files that required a review and that involved an underlying mental illness. In the period of 2015 to 2017, the number of full-time-equivalent medical analysts at the RMO varied from four to six.

d) Dr. Murphy estimated that RMO received more than 10,000 files per year, and that, in 2016, there were 3.5 employees in the RMO, of which two physicians reviewed the more complicated files.

[252] Whether there were 10,000 or closer to 20,000 medical evaluations in 2016, the work volume for the medical evaluators was high.

b) The application process for Mr. Dorais

I. Mr. Dorais' application to a Primary Reserve unit

[253] Mr. Dorais applied to the CAF in 2015 to be a part-time member of the 15 Field Ambulance Primary Reserve unit. Between November 2015 and January 2016, Mr. Dorais passed the testing and screening components. On February 2, 2016, a military career counselor interviewed Mr. Dorais and confirmed, as shown on the standard interview form, that Mr. Dorais was eligible and suitable for a nursing officer position, although the final determination of Mr. Dorais' eligibility was conditional on meeting the CAF's medical standard. The criminal record check was also outstanding but was later fulfilled.

[254] Mr. Dorais' understanding was that he passed all components of the application process, and his reserve unit of interest was ready to make an offer of employment if he met the medical standard. In his closing submissions, Mr. Dorais argued that he was "clearly moving through the recruitment process with supervision and guidance of the Master Corporal Mason, a 15 Field Ambulance recruiter, with unequivocal understanding that a Nursing Officer position was available and waiting for me". Mr. Dorais' evidence included email discussions with the reserve unit's recruiter in November 2015 and from January 14 to February 3, 2016. However, on cross-examination, Mr. Dorais testified that he was not told that he was the only applicant for the reserve unit's nursing officer position, that he did not know how many applicants there were for the position, and that it was his understanding that a position as a nursing officer was available but he could not say for sure if the position was guaranteed for him.

[255] According to Major Eastwood's testimony, all CAF applicants sign a conditional offer of employment at the end of their interview, which allows the CAF to continue its

administrative processes for enrolment. A document containing a log of the CAF's administrative processes involving Mr. Dorais (the "Log in Favour Document") confirms that Mr. Dorais signed a conditional offer of employment on the same day as his interview. Because Mr. Dorais had applied to a reserve unit, his file would have been returned to the unit with a recommendation that he was suitable and eligible for enrolment. Major Eastwood testified that nursing positions in the CAF's Regular Force were highly competitive, and she had no reason to believe that the demand for a nursing position in a reserve unit would be different. She explained that, if there were several candidates for a position, the reserve unit's commanding officer would have to decide whom to accept. According to Major Eastwood, that is why the CAF informs all applicants that there is no guarantee of enrolment until an applicant receives an actual employment offer.

[256] On cross-examination, Mr. Dorais asked Major Eastwood if it was reasonable to say that he would have been "good to go" if he met the medical standard. Major Eastwood said no because of the possible need for the reserve unit's commanding officer to decide among several suitable candidates. In her view, it was reasonable to expect that there was at least one open nursing position in the 15 Field Ambulance unit, but a disconnect sometimes exists between a recruiter's understanding of a job's availability and the actual situation.

[257] Considering all the evidence about the availability of the nursing officer position, I am satisfied that it is more likely than not that the 15 Field Ambulance reserve unit had not guaranteed the nursing officer position to Mr. Dorais if he met the CEMS. The recruiter's emails to Mr. Dorais were not conclusive. They do not say, as Mr. Dorais understood, that a nursing position was available and waiting for him. I am more convinced by Major Eastwood's explanation of the conditional nature of Mr. Dorais' enrolment, as shown on the Log in Favour Document, than by Mr. Dorais' understanding.

II. Mr. Dorais was not eligible for a CEMS waiver

[258] There was no waiver of the CEMS' requirements for Mr. Dorais. Major Eastwood testified that Mr. Dorais did not meet the criteria of a skilled or semi-skilled applicant for the nursing officer position that he was seeking. According to Major Eastwood, basic military officer training is mandatory for all former CAF members who are seeking re-enrolment as

an officer if they did not have experience as an officer or the advanced leadership qualifications of a very senior non-commissioned CAF member, such as a Master Warrant Officer. Mr. Dorais wanted to enrol as an officer but had no officer experience or leadership qualifications. I accept this reason for why a CEMS waiver was not available to Mr. Dorais.

[259] A second reason is that Mr. Dorais' nursing qualifications made him eligible for a nursing officer position, but his qualifications were not sufficient to bypass the basic nursing officer training course which followed the basic military officer training. According to Major Eastwood, the training courses are necessary for applicants to practise their profession in a military context. I also accept this reason for why Mr. Dorais was not eligible for a CEMS waiver.

[260] Major Eastwood also testified that, to be eligible for a waiver of the CEMS' requirements, an applicant must obtain the medical category ratings required for the occupation they are seeking. Because Mr. Dorais' G and O ratings were lower than the G and O requirements for a nursing officer, he was not eligible for the CEMS waiver. In other words, when granting a CEMS waiver to an applicant, the CAF still considered the medical category ratings of the occupation that the applicant sought to be a minimum requirement.

[261] Because Mr. Dorais was not eligible for a CEMS waiver for the other reasons described above, assessing Mr. Dorais' medical conditions differently would not have made him eligible for the waiver.

III. Preliminary information in the Report of Physical Examination

[262] After the interview with the military career counselor, the CAF scheduled Mr. Dorais' medical examination.

[263] On April 7, 2016, Mr. Dorais attended an appointment for a physical examination at the CAF recruitment centre. He met first with Corporal Smith, a junior medical technician. Corporal Smith gave Mr. Dorais a form titled Report of Physical Examination (For Enrolment) (the "Report"). Mr. Dorais reviewed the questions on the first page and checked the boxes corresponding to his answers. Corporal Smith reviewed the page with him and added notes next to some questions, based on information from Mr. Dorais, to clarify the answers. The

evidence is not clear if Corporal Smith added the handwritten notes on this page or if someone else did, but the facts are not disputed, and I find that she did so.

[264] On the first page of the Report:

a) In response to the question, “Are you suffering from, or under treatment for any disease or disability?” Mr. Dorais checked “yes”. Corporal Smith wrote “PTSD” beside the question.

b) In response to the question asking about “Nervous trouble or breakdowns”, Mr. Dorais checked “yes”. Corporal Smith wrote “PTSD”.

c) In response to a question about back pain, Mr. Dorais checked “yes”. Corporal Smith wrote “LPB”, referring to low back pain.

d) In response to a question about whether Mr. Dorais was “presently taking any medication or pills”, Mr. Dorais checked “yes”. Corporal Smith wrote “Trintellix”.

e) Corporal Smith and Mr. Dorais signed at the bottom of the page, declaring that the information provided is true, and this part of the interview ended.

IV. Medical examination with Sergeant McLagan

a) “The Forces are kicking members with PTSD out, why would they let people with PTSD in?”

[265] Mr. Dorais met next with Sergeant McLagan, a former sergeant and senior medical technician with 31 years of experience, now retired. Sergeant McLagan obtained Mr. Dorais’ medical history, which is set out in the next four pages of the Report.

[266] Mr. Dorais testified that:

a) Sergeant McLagan entered the room and focused on the Report’s references to PTSD.

b) Sergeant McLagan said that he would be honest with Mr. Dorais and said that, when the recruitment medical office in Ottawa sees the references to PTSD, it will reject Mr. Dorais' application and send him a letter to that effect. He asked if Mr. Dorais still wanted to continue the application process.

c) Mr. Dorais was shocked by Sergeant McLagan's comment at this early stage of the application process. Sergeant McLagan said: "The forces are kicking members with PTSD out, why would they let people with PTSD in?"

d) Mr. Dorais insisted on continuing with the examination, but Sergeant McLagan's comment made him feel upset, a little angry, embarrassed, humiliated and a bit ashamed. The interview continued and, according to Mr. Dorais, it went fine.

[267] On cross-examination, Mr. Dorais testified as follows:

a) In response to the statement by CAF's counsel that Sergeant McLagan did not say that Mr. Dorais' medical fitness was certain to be rejected by the CAF's director of medical policy, Mr. Dorais said that he absolutely did say that and that "I absolutely do remember it, 100%".

b) Mr. Dorais remembers that Sergeant McLagan said that "the Forces is kicking members with PTSD out. Why would they let people with PTSD in?"

c) Mr. Dorais did not make contemporaneous notes of his discussion with Sergeant McLagan.

d) In response to the statement that Mr. Dorais did not remember his conversation with Sergeant McLagan, Mr. Dorais testified that he recalled pieces of the conversation and how it made him feel.

[268] Sergeant McLagan also testified about his meeting with Mr. Dorais. He did not remember Mr. Dorais or their conversations. He said that he considers himself to be an open, upfront and honest person and that he would have had a frank and honest discussion, based on his personal experience, about Mr. Dorais' medical evaluation.

[269] I accept that Sergeant McLagan's comments to Mr. Dorais were meant to be frank and honest discussions based on his own experience. His testimony is also consistent with information he gave to the Commission during an interview with a human rights officer on January 31, 2019.

[270] Sergeant McLagan testified that, based on his experience, Mr. Dorais' application would not meet the G and O requirements of the CEMS because of Mr. Dorais' medical history with a suicide attempt and hospitalization, having seen a specialist and then ceasing to do so, taking medication for PTSD, and due to the information that he received from Mr. Dorais' family doctor. His view was that, based on his experience, it might have been a waste of time and money for an applicant with this history to see a specialist, but there is no evidence that Sergeant McLagan made that comment to Mr. Dorais.

[271] Sergeant McLagan did not recall saying that "The Forces are kicking people out with PTSD, why would they let people with PTSD in". He testified that the CAF was releasing people with PTSD at that time and that he was one of them.

[272] Based on the witnesses' testimony, it is more likely than not that Sergeant McLagan made this statement. Mr. Dorais' testimony about this part of the examination was clear, and Sergeant McLagan did not remember the meeting. However, as I have found above, the statement does not indicate that the CAF had a practice of refusing applications from individuals with a history of PTSD.

b) The Report's references to "MDD" (Major Depressive Disorder)

[273] Another factual dispute arose about Sergeant McLagan's handwritten references on the second, fourth and sixth pages of the Report to "MDD", meaning major depressive disorder (MDD):

a) On the second page, "MDD" is written under the note that Mr. Dorais was diagnosed in approximately 2002 with PTSD, and an arrow points from "PTSD" to "MDD".

b) On the fourth page, a list about Mr. Dorais' past medical history includes "depression: MDD - 2002".

c) On the sixth page under Part F, the "Recommended Medical Category," Sergeant McLagan's notes refer to "PTSD" and "MDD", with "MDD" again written under "PTSD" and an arrow point pointing from "PTSD" to "MDD".

[274] According to the CAF's submissions, the evidence confirms that Mr. Dorais had an MDD diagnosis in 2002 and that this diagnosis was related to a further MDD diagnosis in 2018 (further discussed below) that occurred approximately two years after Mr. Dorais' application.

[275] Mr. Dorais testified that he did not tell Sergeant McLagan that he had been diagnosed with MDD in 2002, that there was no such diagnosis, and that any references that he made to depression were symptoms related to PTSD.

[276] Sergeant McLagan testified that, although he did not remember the interview with Mr. Dorais, he would have referred to MDD in the Report because it came up during the examination.

[277] On cross-examination, Sergeant McLagan testified as follows:

a) In his notes, there was no significance to the arrow pointing from "PTSD" to "MDD", that it was just his note-taking method, and that he probably should have used a slash instead of an arrow.

b) Mr. Dorais asked whether it was correct that, if someone mentioned depression during an examination, it would be considered to be MDD. Sergeant McLagan answered: "**no**, depression would be…**yes, sure**". (emphasis added)

c) Mr. Dorais repeated the question. Sergeant McLagan answered: "**not necessarily, no**. I mean depression, there's different forms of depression". He added: "To be honest with you, **I'm not sure why I didn't put depression with psych**, that one below it there, that little symbol. **Again, I can't recall why I did that**". (emphasis added)

d) Mr. Dorais asked what Sergeant McLagan would say his diagnosis was. Sergeant McLagan answered: "**I would say it was PTSD**, perhaps, um, again I'd have to review but, uh, **there might have been some depression in there, a past history of depression, um, but PTSD depression**." (emphasis added)

[278] During the CAF counsel's cross-examination, Sergeant McLagan also testified as follows:

a) Counsel asked Sergeant McLagan why the Report has "MDD" written under "PTSD". Sergeant McLagan answered: "Because the applicant **probably** told me that." (emphasis added)
b) Counsel asked why, on the fourth page of the Report, it says "depression: MDD – 2002". Sergeant McLagan answered: "**Because it was brought up as I said before**." (emphasis added)
c) Sergeant McLagan said that he would have written "MDD" under depression because it was brought up previously by the applicant and that he would have gathered the information about MDD because "**the applicant would have told me**." (emphasis added)

[279] Having carefully considered all the evidence on this issue, I am satisfied that it is more likely than not that Mr. Dorais did not tell Sergeant McLagan that he was diagnosed with MDD in 2002. Mr. Dorais' testimony that he was not diagnosed with MDD in 2002 is credible, and Sergeant McLagan's evidence about whether Mr. Dorais told him about a 2002 MDD diagnosis is not clear. Sergeant McLagan did not remember the interview with Mr. Dorais. His answers to Mr. Dorais' questions were different from his answers to CAF's counsel, and his answers about whether Mr. Dorais told him that he had MDD in 2002 also shifted in their clarity.

c) The prescribed medication

[280] During the medical examination, Mr. Dorais disclosed that he was taking Trintellix, a prescribed medication. Mr. Dorais testified that Trintellix is not commonly prescribed for

PTSD but that that his general practitioner prescribed it because it did not have the significant side effects that Mr. Dorais had experienced with other medications.

[281] The parties disagreed about the medical condition for which Trintellix had been prescribed and about the extent to which Mr. Dorais relied on it.

[282] Dr. Tuka, the expert that the CAF called as a witness, testified that the medical evidence was not clear about why Trintellix was prescribed and the extent to which Mr. Dorais required it to control symptoms.

[283] Dr. Passey, the expert witness that the Commission called, also testified that more information was needed to determine if Trintellix was prescribed for PTSD symptoms. Dr. Passey testified that, because medication use is a factor in determining a person's medical category, further medical records or a medical report was needed to clarify the extent to which Mr. Dorais relied on it. He also stated that offering Mr. Dorais the opportunity to taper off the medication, and to re-apply if he was able to stop taking it, might have resulted in Mr. Dorais meeting the CEMS and that the CAF should have discussed that option with Mr. Dorais.

[284] The CAF submitted that nothing prevented Mr. Dorais from independently consulting his doctor about discontinuing the medication and that the speculation about the intended use of Trintellix would have been resolved if Mr. Dorais had called his doctor as a witness. The Commission argued that the CAF could have called Mr. Dorais' doctor to testify. The parties asked me to draw an adverse inference based on the other party's failure to call the doctor as a witness. However, I do not draw any adverse inferences. These disputes of fact might have been resolved by medical records contemporaneous to Mr. Dorais' application to re-enrol that were not in evidence, but which either party was in a position to obtain.

d) The Family Doctor Letters

[285] Sergeant McLagan gave Mr. Dorais two forms for his physician to complete: the Medical Screening for Recruitment (40–50 years old) form and the Psychiatric – Information for Recruitment form. Dr. Buchner completed them on May 11, 2016. They are referred to above as the FDLs.

[286] According to the FDLs, Mr. Dorais met Dr. Buchner in January 2015 and was present when Dr. Buchner completed the forms. Mr. Dorais testified that Dr. Buchner relied on information that Mr. Dorais gave him, but he did not remember whether Dr. Buchner asked for his input to complete the forms.

[287] The questions and Dr. Buchner's answers on the Medical Screening for Recruitment (40–50 years old) FDL are as follows:

> A. Diagnosis: "Healthy"
>
> B. Pertinent history (date of onset, investigations, consultations, etc.): "None"
>
> C. Treatment: "None"
>
> D. Follow-up requirements: "None"
>
> E. Risk of recurrence: "None"
>
> F. Prognosis: "Healthy"
>
> G. Resulting limitations with regards to physical and mental capacity, considering a member of the Canadian Forces may work under conditions of extreme physical / mental stress in remote areas: "No limitations"
>
> Is there any other significant past medical / surgical /psychiatric history? "PTSD"
>
> How long has this applicant been under your care? "January 2015"

[288] The information on the Psychiatric – Information for Recruitment FDL (Exhibit R-23) is as follows:

> A. Psychiatric diagnosis(es) with date(s): "Post traumatic stress disorder – diagnosed 2003-04"
>
> B. Suicidal thought(s), attempt(s) or gesture(s) date(s)? "Only in 2003"
>
> C. Treatment (medication, psychotherapy, etc.)? "Medication – Trintellix 10 mg daily"
>
> D. Is treatment ongoing (if not when discontinued)? "Yes"
>
> E. Is follow-up required? "Yes, has been stable and functional very well & full time employed"

F. What is the risk of recurrence? “Negligible”

G. Applicant’s coping skills and ability to tolerate stress? “Well developed, working well under stress”

H. Is your patient at risk of self-harm or of harming others? Box checked “no”

Is there any other significant past medical/psychiatry surgical history? [No answer]

How long as this applicant been under your care? “Since January 2015”

[289] Sergeant McLagan testified that the FDLs did not provide much information. I agree. They have insufficient detail about Mr. Dorais’ health, particularly in the context of Mr. Dorais’ medical history of an attempted suicide, psychiatric treatment by Dr. Elwell until 2011 or 2012, and a period after Dr. Elwell stopped treating Mr. Dorais but before Dr. Buchner started treating him in 2015. They provide a different view of Mr. Dorais’ health conditions in 2016 than is provided in the Report that Sergeant McLagan completed.

V. The recommendation for Mr. Dorais’ medical category

[290] On May 17, 2016, after receiving Dr. Buchner’s completed forms. Sergeant McLagan recommended a medical category of V1 CV1 H1 **G4 O3** A5. (emphasis added)

[291] Sergeant McLagan testified about his recommendations as follows:

a) Sergeant McLagan’s initial recommendation was for G3 and O3 ratings, based on Mr. Dorais’ past history, his use of daily medication and the information that Mr. Dorais gave him during the interview, but he changed the G3 rating to G4 because, in his experience and understanding of CFP-154, G4 was the more appropriate rating based on Mr. Dorais’ history and medication use. He applied the RMO’s guidelines when he evaluated applicants with mental health disorders.

b) Dr. Buchner’s note that Mr. Dorais had “no limitations” did not have much impact because Dr. Buchner did not provide much information. Dr. Buchner’s reference to the “negligible” risk of recurrence of PTSD symptoms did not override other

information, but this would be a decision for the medical analyst at the RMO to make.

c) Despite Dr. Buchner's note that Mr. Dorais' coping skills were "well-developed" and that he was "working well under stress," Sergeant McLagan testified that, based on his understanding of the G and O factors, the stress of a military operational environment might have been a problem for Mr. Dorais.

d) In other applications, the RMO has asked the family doctor for clarification or more information and has asked the family doctor to refer the applicant to a specialist, but Sergeant McLagan testified that he could only base his recommendation on the information he received from the applicant and the applicant's doctors.

e) In making his recommendations, he would have considered any report that Mr. Dorais provided, including from a psychiatrist or psychologist. In hindsight, he should have recommended that Mr. Dorais have a psychiatrist complete the form.

[292] Sergeant McLagan testified that, based on his experience and his knowledge of the medical standards in the CAF Medical Standards (CFP 154), he knew that Mr. Dorais would not be expected to meet the CEMS' G and O requirements due to his medical history that included a suicide attempt and hospitalization, having seen a specialist and ceasing that treatment, taking daily medication for PTSD, and based on the information that Dr. Buchner included in the FDLs. He stated that it was not the medical technician's role to request further medical information, and that, although he could have suggested that Mr. Dorais obtain a report from a psychologist or psychiatrist, he did not do so because he anticipated that Mr. Dorais would not meet the CEMS requirements and that it would be a waste of time and money for him.

[293] The CAF's policies support Sergeant McLagan's understanding of the medical technician's role. The Processing at CFRC Medical Sections document gives direction to

medical technicians about preparing an applicant's medical file for the RMO's medical evaluator. It states the following:

a) Medical staff are not permitted to tell an applicant that they are medically unfit to join the CAF, they should not influence the applicant to withdraw their application, and applicants must be able to make an informed decision without pressure from the medical staff.

b) An applicant "may have to provide additional medical information that must be obtained from the family doctor or a specialist to complete his medical file before sending it to the RMO," and that "this step can be time consuming and costly for the applicant as he must bear all the costs".

[294] Additionally, the Procedures for Recruitment Screening say that the recruitment medical staff must not "extrapolate, or guess," what information the RMO would need to change an RMO decision to deny enrolment to an applicant. This restricts the medical technician's role **after** the RMO has decided that an applicant does not meet the CEMS, but the same principle logically applies **before** the RMO reviews an applicant's file and prohibits a medical technician from guessing what further information the RMO would need to make its decision.

[295] The Procedures for Recruitment Screening give examples of what Sergeant McLagan should not do: he should not tell an applicant to be off medication or treatment for a specific period of time and he should not tell an applicant to provide a specific evaluation or a testing result.

[296] I am satisfied that it was not Sergeant McLagan's role to obtain further medical information or to recommend that Mr. Dorais do so. Sergeant McLagan testified that he could have suggested that Mr. Dorais have a psychiatrist or psychologist complete the FDLs, and he acknowledged that, in hindsight, he should have done so, but the CAF's procedural directives do not give him that responsibility.

VI. The RMO's medical category decision and its first decision letter

[297] After Sergeant McLagan made his recommendation for Mr. Dorais' medical category, he sent the file to the RMO for decision.

[298] Dr. Murphy reviewed Mr. Dorais' application. At the time of the hearing, Dr. Murphy was a civilian family physician. He began working for the CAF in 2000 and joined the RMO in 2009.

[299] On August 24, 2016, Dr. Murphy assigned a medical category to Mr. Dorais with G4 and O4 ratings. The ink stamp on the Report states "Does not meet CEMS (432225). See letter".

[300] On November 4, 2016, the RMO sent its first decision letter to Mr. Dorais. It is a form letter with Dr. Murphy's input added. The third and fourth paragraphs state:

> We have reviewed the medical records accompanying your application for re-enrolment in the Canadian Forces. **The information that you have provided indicates that you have been diagnosed with a history of recurrent lower back pain and PTSD/depression with a previous drug overdose for which you are currently taking Trintellix and remain at increased risk for a recurrence of symptoms, especially if subject to the stress of a military environment.** We regret to inform you that that because of this you do not meet the medical standards for re-enrolment. (Emphasis added)
>
> Should you not be in agreement with your medical fitness determination, your avenues of appeals are: to submit for consideration new pertinent medical information **through your local Canadian Forces Recruiting Centre (CFRC) medical section**; or to forward a request for a secondary review of your existing file to the Director of Medical Policy **through your local CFRC medical section**, being sure to outline the aspect(s) of the decision with which you disagree and the reasons why. (Emphasis in original)

[301] Dr. Murphy's decision is based on the following Medical Employment Limitations:

- Requires periodic medical follow-up no more frequently than every six months
- At risk of a potential exacerbation of a chronic medical condition when exposed to a military work environment
- Applicant has a chronic medical condition with a risk of recurrence of unknown frequency

- PT [physical training] limited in type, duration, intensity or frequency

- Unfit work in a military operational environment

[302] Dr. Murphy testified about his rationale for the Medical Employment Limitations:

a) The requirement for “periodic medical follow-up no more frequently than every six months” relates to the need to monitor Mr. Dorais’ antidepressant medication if he was to be deployed or work in a fluid military environment.

b) The risk of “a potential exacerbation of a chronic medical condition when exposed to a military work environment” relates to the increased risk for depression and PTSD.

c) The “chronic medical condition with a risk of recurrence of unknown frequency” also relates to the unknown extent of the risk when exposing a person with PTSD to a military environment.

d) “PT [physical training] limited in type, duration, intensity or frequency” relates to the history of recurrent lower back pain.

e) Being “unfit work in a military operational environment” is based on Mr. Dorais’ history of depression and PTSD, suicidality, and continuing to take medication.

VII. Mr. Dorais’ request for reconsideration

[303] On December 12, 2016, Mr. Dorais sent a six-page letter of appeal to the Director of Medical Policy, requesting a secondary review. I summarize Mr. Dorais’ letter as follows:

a) Mr. Dorais stated that the CAF used generalized statements about universality of service to support negative decisions about Mr. Dorais’ medical fitness, instead of specific information that applied the principle of universality of service to his medical history.

b) The reference to recurrent lower back pain as a reason for the refusal is not correct. According to Mr. Dorais, he did not identify it as an issue in his medical history and his family doctor did not refer to it.

c) Regarding the diagnosis of PTSD:

   i. Mr. Dorais stated that he had the “cognitive-behavioural tools” to deal with the PTSD symptoms that arise.

   ii. He wrote that the CAF’s use of the universality of service policy to medically release members or to prevent applicants with manageable psychiatric disorders from joining or rejoining the CAF is “fraught with stereotypical and punitive connotations” that are outdated and prejudicial.

   iii. The letter referred to Mr. Dorais’ deployment experiences in 1994 that are at the heart of the PTSD diagnosis and to later receiving appropriate care for his PTSD.

d) Regarding the attempted suicide, Mr. Dorais stated that the suicide attempt was the “rock-bottom” that led him to a better life. With psychotherapy, medication, initiative and motivation, Mr. Dorais understood his triggers and had better resiliency to deal with all PTSD symptoms. He stated that the result has been a better temperament, a stable income and home, an education that led to his profession and a highly supportive social network.

e) Regarding prescription medications, Mr. Dorais stated that it is not true that he cannot function or survive without Trintellix. He takes it by choice, “as an adjunct to other stress coping strategies,” and to stay at the top of his game as much as possible. He stated that, if he was deployed, he could “easily miss one or more doses with little or no side effects”, that his life would not be at risk, nor would anyone else’ life, and that he has coped with this condition before in a military occupation.

f) Mr. Dorais asserted that it is not true that he needed to be followed regularly by a physician because of his medical conditions and medication use.

g) Regarding the statement that Mr. Dorais would be at an increased risk for a recurrence of symptoms, especially if subject to the stress of a military environment, Mr. Dorais stated that Dr. Buchner's FDLs did not refer to this concern and that he has been employed as a nurse in the extremely stressful work environment of federal prisons for nine years. He credits his lengthy employment to the treatment he received for PTSD.

h) In summary, Mr. Dorais stated that there is no significant health reason that precluded him from working in the CAF. He asked for reconsideration of the decision, and, if the CAF upheld its refusal, that the CAF give him a "more objective explanation" that outlines the "undue hardship to the CAF with respect to health, safety, and cost of medically clearing me for military service once again".

[304] Mr. Dorais did not provide medical records with his letter. He testified that he would have provided new medical information if he had been asked to.

VIII. The RMO's second decision letter

[305] After receiving Mr. Dorais' letter, Dr. Murphy reviewed the file again. On January 9, 2017, he decided again that Mr. Dorais did not meet the CEMS. He made no changes to the original G4 and O4 medical category ratings. He noted Mr. Dorais' history of PTSD and overdose and his continued use of Trintellix. The updated list of Medical Employment Limitations was unchanged except for the deletion of the reference to recurrent lower back pain.

[306] The Director of Medical Policy's second decision letter, dated February 3, 2017, included the following paragraphs:

> All prospective applicants with documented medical conditions must be able to demonstrate that they are free of medical requirements (this means for example, the requirement to be followed regularly by a physician for a chronic

> medical condition, the requirement to be on longstanding medication for a chronic medical condition, or a previous medical condition with a high risk of recurrence, amongst others) in order to be considered fit to re-enroll. Medical files for all re-enrollee applicants are reviewed on a case-by-case basis to determine their eligibility for re-enrolment. Previous CF service medical documents are reviewed as needed.
>
> We have again reviewed the medical records accompanying your application for re-enrolment in the Canadian Forces including the additional information in your personal letter dated December 12, 2016. **The documents indicate you have a history of PTSD/depression with a suicidal attempt by a drug overdose for which you are taking Trintellix and remain at increased risk for a recurrence of symptoms, especially if again subject to the stress of a military environment.** We regret to inform you that that because of this you do not meet the medical standards for re-enrolment. (emphasis added)

[307] The second letter is similar to the first letter except it does not include recurrent lower back pain as a reason for the refusal.

[308] The second decision refers again to the appeal options. Mr. Dorais did not appeal. He testified that the deletion of the reference to recurrent back pain indicated that the CAF had considered his letter, but that the CAF had made its decision, and he thought there was nothing more he could do to change it.

IX. Dr. Murphy's testimony

[309] Dr. Murphy testified that the medical category recommendation he received from Sergeant McLagan did not influence his decision. When asked if G4 and O4 ratings were default categories for an applicant with a history of PTSD, Dr. Murphy's response was "absolutely not" and that there is no mental health diagnosis that is absolutely exclusionary.

[310] Dr. Murphy testified that he assessed the risk of a recurrence of Mr. Dorais' symptoms based on his experience and training and on the standards in the CAF Medical Standards (CFP 154) for meeting the CEMS' G and O ratings. Dr. Murphy said he had also referred to Annex G to CFP 154, referred to above, but Lieutenant-Colonel Minkley testified that Annex G had not been completed at the time. I prefer Lieutenant-Colonel Minkley's testimony on this point based on his knowledge about the development of the CAF's medical standards policies.

[311] Dr. Murphy testified that Mr. Dorais' history of PTSD, his attempted suicide and his continued use of Trintellix were significant factors in his file review and in his determination that Mr. Dorais did not meet the CEMS. Dr. Murphy's handwritten reference to these factors on the Report, next to his decision about the medical category and his signature, confirms their significance for him.

[312] When asked if further medical information might have been useful for his decision making, Dr. Murphy testified that, although the RMO would frequently request additional information from applicants, he did not do so for Mr. Dorais because, in his view, it was clear that Mr. Dorais could not obtain G2 and O2 ratings, even with additional information, due to his history of depression and PTSD and a suicide attempt and by continuing to take Trintellix. Dr. Murphy testified that, even based on the information in Mr. Dorais' appeal letter, he did not foresee that more information would change the outcome.

[313] However, when asked on cross-examination if Mr. Dorais could "meet G2" ratings if, hypothetically, Mr. Dorais' suicide attempt in 2003 and his continued reliance on medication were removed from consideration and that the only factor for consideration was the PTSD diagnosis, Dr. Murphy's answer was "possibly".

[314] When asked if it would have been helpful for the medical technician to have asked Mr. Dorais if he had any symptoms of PTSD in 2016, Dr. Murphy said that it might have been a little more information but that he did not know if it would have changed his decision.

[315] When asked if Mr. Dorais might have obtained a G3 rating if he was able to taper off medication and reapply to enrol, Dr. Murphy said there are situations in which the CAF has suggested that a person taper off a medication and reapply, but "not usually" with anti-depressants or psychiatric medications. He also testified that, hypothetically, if an applicant had tapered off their medication for one year, the CAF might ask for a psychiatric assessment, and "maybe" the applicant could meet a criterion for a G3 rating, and that "it's possible" that the CAF would consider that. Dr. Murphy also confirmed that, in the same hypothetical situation, the CAF would consider if it might lead to an O2 rating, in which an applicant has no Medical Employment Limitations.

X. Findings about applying the CEMS to Mr. Dorais' application

a) The CAF had a duty to accommodate Mr. Dorais

[316] The CAF's medical decision making is complex, and, in 2016, it occurred in a context of high work volumes. There were only two physicians reviewing most of the complex medical files.

[317] However, despite this context, I find that the decision-making about Mr. Dorais' health conditions was not adequately conducted and led to an RMO decision that was not adequately informed.

[318] The information in Sergeant McLagan's report on Mr. Dorais' medical examination indicated that Mr. Dorais had a previous diagnosis of PTSD/depression and that he was taking medication. With this information, the CAF knew that Mr. Dorais had a history of disability, or it perceived that he had a disability. That knowledge was sufficient to trigger a search for accommodation. As Mr. Dorais' prospective employer, the CAF was in the best position to determine if, and how, Mr. Dorais could have been accommodated without undue interference in the CAF's operations (*Renaud* at page 994). The CAF had an obligation to accommodate Mr. Dorais but it did not engage in an adequate accommodation process.

b) The CAF did not have sufficient medical information to make an informed decision

[319] Dr. Murphy testified that further medical information could not have changed the outcome from a refusal of Mr. Dorais' application to an approval, but I find that Dr. Murphy's testimony about how he evaluated Mr. Dorais' medical information was vague and lacked specificity. I appreciate that some of Dr. Murphy's answers were responses to hypothetical situations, but his evidence nevertheless convinces me that, more likely than not, the outcome of the medical evaluation might have been different if he had requested further medical information before making his decision.

[320] Dr. Murphy testified about the distinction between a CAF physician's role for a member of the CAF, for whom there is an ongoing doctor-patient relationship and a duty of care, and the physician's reduced role of "reviewing a chart" for applicants to the CAF. Dr. Tuka's expert report also distinguishes between these roles. I accept that these differing roles create different relationships, but this distinction does not affect the CAF's obligation to accommodate an applicant's disability to the point of undue hardship.

[321] I find that the medical information that the CAF relied on in its decision-making process was insufficient. It had insufficient details about Mr. Dorais' PTSD, his attempted suicide, and the mental health treatment that he received from 2003 to 2015. The CAF also had Dr. Buchner's 2016 FDLs but gave them little consideration because they had few details. The CAF should have taken steps to identify the additional medical information that it required for an informed decision about Mr. Dorais' application and informed Mr. Dorais of his opportunity to provide it. It would not have been an undue hardship for the CAF to have made this request before making its first decision about Mr. Dorais' medical category.

[322] The evidence confirms that the RMO had an obligation to take steps to request a full medical record before making its decision.

[323] Lieutenant-Colonel Minkley testified that a CAF physician's ability to assess the health and safety of a CAF applicant or current CAF member with a history of mental illness is based on the specific circumstances that existed at the time of the diagnosis, a description of the treatment, the severity of the illness, the duration of the recovery and the subsequent exposure to stresses.

[324] The Procedures for Recruitment Screening state that, if the RMO thinks that an applicant might meet the universality of service principle and the CEMS in the near future, the CAF's decision letter "will tell them exactly what to do and when to reapply". Dr. Murphy testified that Dr. Buchner's FDL indicated that taking medication was part of Mr. Dorais' treatment plan and that Mr. Dorais was doing well on the medication, so Mr. Dorais could not meet the CEMS while continuing to take medication. However, I am satisfied that the RMO should have taken steps to determine whether taking medication was an ongoing treatment requirement, as Dr. Murphy understood, or whether it was a choice, "as an adjunct

to other stress coping strategies", as Mr. Dorais stated in his appeal letter. Dr. Murphy relied on Dr. Buchner's FDL to support his opinion about Mr. Dorais' need for medication but discounted Dr. Buchner's other views about Mr. Dorais' health status. The RMO should have tried to obtain more information to resolve this contradiction before making its decision.

[325] Lieutenant-Colonel Minkley testified that the CAF developed its request to an applicant's family doctor as a method for obtaining this information and "as much information as possible to the RMO to make an initial decision". However, the receipt of an FDL with inadequate medical information does not relieve the RMO of its obligation to seek adequate information. In my view, it must try to clarify information about an applicant's medical conditions if there are inconsistencies in the information that it has received.

[326] The Guidelines for the Application of MELs to Personnel Suffering from Mental Illness came into effect in 2005 and continued to apply in 2016. Paragraph 23 states that a CAF mental health provider or a civilian health care provider seeing a CAF member for the first time about a longstanding mental disorder "should obtain and consult existing medical records on prior care" before offering advice about the person's Medical Employment Limitations. The guidelines encourage a safe return to work for CAF members who have been off work or on modified work due to a mental disorder. They provide guidance to CAF personnel providing health services to CAF members. Dr. Murphy did not provide services to serving members, and there is no evidence that he was aware of these guidelines. However, Lieutenant-Colonel Minkley testified that the principle of obtaining medical records about prior care is equally important for determining whether an applicant is fit to work in a CAF environment.

[327] According to Lieutenant-Colonel Minkley, the CAF did not have a clear policy in 2016 about the information that was required from applicants with histories of mental illness, and the CAF had identified this need for a policy as a concern. He testified that Mr. Dorais' complaint highlighted the importance of having more specific guidelines about the medical information that applicants must provide and that it would be fair to applicants if they understood the documents that the RMO was seeking to make a determination of the risk of recurrence of medical conditions. These concerns led to the development of the Clinical Council MEL Guidelines, which provide clearer direction about these issues. Lieutenant-

Colonel Minkley testified that it would have assisted Mr. Dorais if there had been direction available in 2016 about what additional information the RMO was looking for. However, I am satisfied that the CAF had an obligation to ask Mr. Dorais for the specific additional medical information that Lieutenant-Colonel Minkley testified about and that doing so was not conditional on whether the CAF had a clear policy in 2016 to guide the RMO's medical evaluators.

[328] The evidence of the expert witnesses, Dr. Tuka and Dr. Passey, also confirmed that the CAF needed more medical information to fairly assess an applicant with a history of PTSD and attempted suicide. The evidence also demonstrates that the CAF recognized the importance of addressing suicidality and has devoted resources to guide CAF clinicians in evaluating the risk of suicidality, including in the Clinical Council MEL Guidelines (Annex G to CFP 154) that the CAF developed after 2016.

[329] Dr. Tuka testified that, where there has been an attempted suicide, a hospital discharge report or any medical documentation that described the individual's history should be obtained and is needed for an informed decision. Paragraph 11 of Dr. Tuka's report dated March 8, 2021, states that "[to] be able to understand and meaningfully comment about Mr. Dorais' future risk for suicide, the medical documentation related to the hospital admission due to his suicide attempt would have to be reviewed".

[330] Dr. Tuka's report also states that Dr. Buchner's brief comments in the FDL could not be relied upon to determine the risk of a recurrence of PTSD. Information about Mr. Dorais' history of mental illness and related documentation (such as a family history of mental illness) should have been obtained.

[331] Dr. Tuka also testified that more information was needed to clarify the treatment that Mr. Dorais had previously received and his need for ongoing treatment. She was also not able to comment on the severity of Mr. Dorais' symptoms because she had not seen any documents with information about it. Similarly, paragraph 12 of Dr. Tuka's report also states that

> "[as] no medical documentation is available from the medical professionals who provided care for Mr. Dorais, it is currently not known what was his

> diagnosis, how severe were the signs and symptoms of his illness, what type of treatment he received, what was the frequency of the visits with his clinicians and what was the deemed prognosis upon discharge from care".

[332] I accept Dr. Tuka's opinion that a person's history of an attempted suicide and medical notes about treatment are important to understand the extent of the current risk of recurrence. I also accept the opinion that, although Mr. Dorais' suicide attempt occurred thirteen years before his CAF medical examination, medical information since the suicide attempt was still important to assess the risk of suicidality in 2016. However, Dr. Tuka confirmed that there was no documentation related to Mr. Dorais' symptoms of depression, PTSD or suicidality, and no documents from the clinicians who treated Mr. Dorais between 2003 and 2012.

[333] Paragraphs 43 and 44 of Dr. Tuka's report lists six factors that must be considered for an applicant with a history of PTSD, and 14 factors for an applicant with a history of PTSD and a suicide attempt.

[334] Dr. Passey also opined that the CAF did not have information about whether Mr. Dorais had PTSD, depression or suicidal symptoms at the time of the CAF's medical examination, and, therefore, it could not determine if Mr. Dorais had any symptoms that would preclude him from functioning adequately as a nursing officer. Dr. Passey also testified that the medical information available to the CAF should have included a mental status examination and psychiatric history, including information about the precipitating events, the type and duration of treatment, and reports on treatment if they were available.

[335] On the issue of the CAF's denial letter to Mr. Dorais, it was not sufficient to have informed Mr. Dorais after its first decision that he could submit "new pertinent medical information" for a reconsideration. As the prospective employer, the CAF knew what medical information was pertinent, and it had a duty to make clear what it needed to make an adequately informed decision.

[336] Lieutenant-Colonel Minkley also testified that the reference to submitting "new pertinent medical information" in the CAF's first denial letter to Mr. Dorais was vague and did not refer to any specific additional information that Dr. Murphy might require to reassess Mr. Dorais' file.

[337] On the issue of the RMO's assessment of the risk of recurrence of medical conditions, Lieutenant-Colonel Minkley testified that, if there is insufficient medical information to confirm that the risk of a recurrence is low, the RMO assigned a more restrictive medical category based on the presumption that the risk of recurrence is high. He said that the RMO invited Mr. Dorais to provide additional information, and that, after doing so, the obligation to provide information rested with Mr. Dorais. However, that approach is not consistent with the CAF's obligation to accommodate Mr. Dorais. The CAF's letter about the opportunity to submit "new pertinent medical information" did not shift the burden to Mr. Dorais or affect its obligations. Evaluating Mr. Dorais and assigning a medical category based on a presumption about the risk of recurrence derived from insufficient medical information was not reasonable in these circumstances. A proper assessment of the risk of recurrence required diligent attempts to obtain "full scale knowledge" about Mr. Dorais' illness.

[338] I do not conclude that the CAF had an obligation to ask Mr. Dorais, as an accommodation measure, to taper off his medication. If the CAF had requested the further medical information described above, and if Mr. Doras provided it, it would have provided further insight into Mr. Dorais' medication needs.

[339] After the CAF's first denial, Mr. Dorais' request for reconsideration provided a detailed account about his medical conditions. It referred to his view of the CAF's mistaken findings about his health status, and it explained why, in his view, there were no significant health reasons preventing his employment. It asked the CAF to justify its refusal. Significantly, it also used the language of the CHRA to ask for an explanation of the undue hardship that the CAF would experience by approving his application.

[340] If the need for the CAF to accommodate Mr. Dorais had not been clear before the first decision letter, Mr. Dorais' request for reconsideration made it explicit. Mr. Dorais stated his view that, despite his previous diagnosis and a history of PTSD, and despite a suicide attempt and ongoing use of medication, there were no limitations on his ability to perform the work of a soldier. Whether this view was reasonable was open to question, but the evidence satisfies me that the CAF should have known about its obligation to seek more information about Mr. Dorais' disability.

[341] Taking these steps as an accommodation measure would not have imposed an undue hardship on the CAF in relation to the health, safety and cost issues that section 15(2) of the CHRA requires an employer to consider.

[342] Regarding cost, the CAF's evidence is not convincing. The testimony about the volume of applications that the RMO annually considered does not satisfy me that requesting that an applicant provide specific additional medical information would impose an undue hardship. Doing so might have required the CAF to commit more resources to the consideration of Mr. Dorais' application, but I am not satisfied that it would have amounted to an undue hardship.

[343] Lieutenant-Colonel Minkley testified that, in 2018, the CAF digitized its use of healthcare documents for applicants to decrease the time between an applicant's medical examination and the RMO's decision about their medical fitness. The rationale for the change was that, since the RMO decided in 75% of cases that applicants were fit to be enrolled, digitizing the internal sharing of documents would result in faster decisions in 75% of cases and allow for a longer period for decision making in the 25% of applications that required more review. Although the digitization process occurred in 2018, this evidence supports the conclusion that the cost of committing resources to allow for the extended reviews of more complex applications was manageable.

[344] I accept the evidence that the risk to the health and safety of new recruits is of paramount importance to the CAF, but the requirement to accommodate Mr. Dorais by requesting that he provide additional information—effectively giving him the opportunity to show that his medical conditions would not present a health or safety risk, before making a decision—would not have imposed an undue hardship in relation to the health or safety of CAF recruits.

[345] I also find that section 15(9) of the CHRA, in which the CAF's duty to accommodate an individual is subject to the principle of universality of service, does not relieve the CAF of its obligation described above. Under section 15(9), the principle of universality of service requires that the CAF's members must at all times and under any circumstances be able to perform any functions that they may be required to perform. Section 15(9) qualifies the

CAF's obligations under section 15(2), and it acknowledges the necessity for the CAF to have broad discretion in assessing the employability of its members (*Jones v. Canada (Attorney General),* 2009 FC 46 at para 25). However, it does not reduce the CAF's obligation to fairly assess an applicant's medical condition. This includes the obligation to avoid making medical determinations that are so "arbitrary, hasty, imprudent or inadequate" that they do not satisfy the duty to accommodate (*Irvine FC* at paras 21–28, 43, aff'd *Canada (Canadian Armed Forces) v. Irvine*, 2005 FCA 432 [*Irvine FCA*]). The Court of Appeal affirmed that while "every conceivable form of medical test" is not required, a "fair assessment" must reflect the duty to accommodate (*Irvine FCA* at para 5).

XI. The evidence of a diagnosis of MDD in 2018

[346] An issue arose involving evidence about a diagnosis of MDD in 2018 and its relationship to the CAF's denials of Mr. Dorais' application in 2016 and 2017.

[347] Mr. Dorais submitted that the two months that he took off work in 2018 was a "short-lived bout of depression", that it is not fair to assume a connection between his mental health in 2018 and his past mental health without further proof, and that he had no break in employment as a nurse in a penitentiary from the time he started working in 2008 until 2018.

[348] The Commission submitted that there was little evidence that what occurred in 2018 can be extrapolated backwards to the CAF's decisions in 2016 and 2017.

[349] The CAF submitted that Mr. Dorais' testimony about having depression in 2018 supports the conclusion that the CAF's refusal of Mr. Dorais' application in 2016 was correct. The CAF argued that the diagnosis in 2018 occurred close in time to the CAF's denial of enrolment, and it shows that the CAF's risk occurrence analysis, including its use of the Matrix, correctly predicted the reoccurrence of depressive symptoms. The CAF also argued that Mr. Dorais' assertion that there is a qualitative difference between his depressive symptoms resulting from PTSD and the depressive symptoms that resulted in an MDD diagnosis is not credible.

[350] I do not agree with the CAF's submissions. First, there is limited evidence about the MDD diagnosis in 2018 and the extent of its effect on Mr. Dorais at that time. Second, I do

not assume that there is a connection between Mr. Dorais' medical conditions at the time of his application to enrol and the MDD diagnosis in 2018, and I am not satisfied that there is convincing evidence about a nexus between them. Third, I am not satisfied that it is more likely than not that a diagnosis in 2018 is relevant to the CAF's decision-making process or to its obligation to accommodate Mr. Dorais in 2016 and 2017. Fourth, although I accept the value of the CAF's risk analysis and its use of the Matrix, I agree with the Commission that the precision of the analysis is conditional on the information that it considers. There is no evidence that Dr. Murphy relied on the Matrix in his evaluation of Mr. Dorais' application.

[351] I have considered the evidence on this issue and the parties' submissions. I find that the evidence about an MDD diagnosis in 2018 and its effect on Mr. Dorais is not clear or convincing, and I am not satisfied on a balance of probabilities that an inference of a connection can be drawn between the 2018 diagnosis and Mr. Dorais' health conditions when the CAF denied his application in 2016 and 2017.

[352] In conclusion, the CAF had the burden of proof to justify its assessment of Mr. Dorais and decision to deny Mr. Dorais' application. I have found that the CAF had a duty to accommodate Mr. Dorais to the point of undue hardship, but it did not do so. It has not justified its assessment of him and the resulting decision to refuse Mr. Dorais' application to re-enrol in the CAF.

IV. Remedies

[353] The remedies available under the CHRA are discretionary (section 53(2) of the CHRA). Overall, the CHRA is aimed at the prevention of discrimination rather than punishment (*Hughes v. Canada (Attorney General)*, 2019 FC 1026 at para 32 [*Hughes*]). Section 53 of the CHRA also includes compensatory provisions and their purpose is "to make a victim of discrimination whole and to put the complainant back in the position he or she would have been in had the discrimination not occurred" (*Christoforou v. John Grant Haulage Ltd*, 2021 CHRT 15 [*Christoforou*], aff'd 2022 FC 162 and 2022 FCA 182, citing *Public Service Alliance of Canada v. Canada Post Corporation*, 2010 FCA 56 at para 299, aff'd 2011 SCC 57).

[354] To make complainants whole, the Tribunal has the authority to order a respondent to "make available to the victim of the discriminatory practice… the rights, opportunities or privileges that are being or were denied the victim as a result of the practice" and to compensate a complainant for losses that flowed from the discriminatory practice (sections 53(2)(b) and (c) of the CHRA). The Tribunal's discretion to compensate for losses must be exercised on a principled basis (*Hughes* at para 41). As explained in *Christoforou*, "[t]here must be a causal link between the discrimination and the loss claimed (see *Chopra* at paras 32, 37). The onus is on the complainant to establish that it is more likely than not that this causal connection exists". In this case, Mr. Dorais requested lost wages; he did not request to be re-evaluated and re-enrolled in the CAF.

[355] The CHRA also makes possible orders to pay complainants for pain and suffering and for the willful and reckless way in which a respondent may have engaged in the discriminatory practice (sections 53(2)(e) and 53(3) of the CHRA). Mr. Dorais seeks both these remedies.

[356] The Tribunal also can make orders aimed at stopping the discriminatory practice and preventing recurrences (section 53(2)(a) of the CHRA). Mr. Dorais and the Commission also made requests under this provision of the CHRA.

A. Lost wages: the request for lost wages is dismissed

[357] Mr. Dorais sought lost wages amounting to $20,000 "at a minimum". There was some conflicting evidence about the entry-level rank that the CAF would assign to a nursing officer. Mr. Dorais asserted that, without the discriminatory practice, he would have entered the CAF as a Second Lieutenant and would have rapidly achieved the rank of Lieutenant, based on evidence about the CAF's approach to nursing recruits. Mr. Dorais testified generally about his schedule and about the number of hours he worked per week, and he provided the Tribunal with evidence of the CAF's pay rates.

[358] The CAF submitted that if its assessment of Mr. Dorais revealed an inadequate or discriminatory medical assessment of Mr. Dorais, that finding would not reveal anything

about the likely outcome of an adequate assessment. To demonstrate the required causal link, the CAF submitted that Mr. Dorais would have needed to show:

a) that he would have met the CEMS if the CAF had assessed him properly;
b) that an appropriate nursing position existed at the time that would have been offered to him;
c) the rank and pay scale at which he would have entered the CAF and the related promotion practices;
d) evidence about his availability and the number of hours he would most probably have worked, recognizing that there are no guarantees of minimum hours in the Primary Reserve; and
e) evidence specific to the amount of his loss, including evidence about sick periods, contingencies, retirement, discount rates, taxation and/or interest.

[359] The CAF also submitted that before any order for lost wages could be made, the Tribunal would need to consider mitigation, taking account of Mr. Dorais' employment since the time of his application to re-enrol with the CAF.

[360] To make an order for lost wages, it is not necessary that the Tribunal conclude with certainty that, without the discriminatory practice, an applicant would have been evaluated and employed in a particular way. A causal connection must be found, but an order for lost wages can take account of uncertainties if the evidence supports that approach (*Tahmourpour v. Royal Canadian Mounted Police*, 2008 CHRT 10 at paras 206–210 [*Tahmourpour*], upheld in 2010 FCA 192 except for a separate, narrow ground; *Hughes v. Transport Canada*, 2018 CHRT 15 at paras 190–197, affirmed 2019 FC 1026 (this point was not part of the appeal)). If the evidence indicates a "serious possibility" that without the discrimination, the applicant would have been employed by the respondent, then the Tribunal has discretion to order lost wages, adjusting for the probability of that result (*Tahmourpour* at para 206; *Hughes v. Transport Canada* at para 195; *Chopra v. Canada (AG)*, 2007 FCA 268 at 45–46).

[361] In this case, what must be remedied is Mr. Dorais' lost opportunity to be medically evaluated for re-enrolment in a non-discriminatory way. The Tribunal must consider whether

the evidence is sufficient to allow the Tribunal to estimate Mr. Dorais' chances of success if the opportunity had been provided in a non-discriminatory way (for example, *Tahmourpour* at para 210).

[362] I agree with the CAF that too many uncertainties exist to merit an order for lost wages. I am not satisfied that there is a serious possibility that Mr. Dorais' application would have been accepted if the CAF had conducted a medical evaluation in a non-discriminatory way. First, if the CAF had informed Mr. Dorais of the specific medical information that it required to conduct a fully informed evaluation of his medical status, and if Mr. Dorais had provided new medical information, it is unknown what the result would have been. The Tribunal can assess whether the CAF carried out its medical assessment in a discriminatory way, but it is not the role of the Tribunal to determine what result a proper medical assessment would have found (*Canada (Attorney General) v. Irvine,* 2005 FC 122 at paras 35–37; affirmed 2005 FCA 432). I do not have sufficient evidence to allow me to estimate the probability of any particular result of a non-discriminatory medical evaluation.

[363] Second, even if I were to assume that the result of a non-discriminatory medical evaluation is that Mr. Dorais would have met the requirements of the CEMS (which I do not), I do not have sufficient evidence to allow me to estimate the chances that Mr. Dorais would have been offered a nursing officer position. Job availability based on the extent of competition for a nursing officer position would have been in play and the evidence on that issue was not sufficient.

[364] Additionally, if I were to assume that Mr. Dorais would have been offered a nursing officer position in the 15 Field Ambulance Primary Reserve unit (which I also do not), it is unknown if Mr. Dorais would have completed the basic training requirements. Finally, if Mr. Dorais completed the training requirements, I do not have sufficient evidence to determine the amount of time that Mr. Dorais would have been available or required to work.

[365] The uncertainties are too great for me to conclude that there was a serious possibility that Mr. Dorais would have been hired into the nursing position. Mr. Dorais has not established the loss claimed. The request for lost wages is dismissed.

B. Pain and Suffering: Mr. Dorais is entitled to $9,000

[366] Mr. Dorais has asked for the maximum amount that the Tribunal can order for pain and suffering under the CHRA. In *Christoforou*, the Tribunal noted that the maximum of $20,000 "tends" to be ordered in "the very worst cases or the most egregious of circumstances (*Grant v Manitoba Telecom Services Inc.,* 2012 CHRT 10 at para 115; *Alizadeh-Ebadi v Manitoba Telecom Services Inc*., 2017 CHRT 36 at para 213)". That said, the Tribunal's assessment of damages "should not be so trivial or insignificant so as to be meaningless" (*Christoforou* at para 100). The Tribunal may consider "the objective seriousness of the conduct and the effect on the particular applicant who experienced discrimination" (*Christoforou* at para 104, citing *Arunachalam v. Best Buy Canada*, 2010 HRTO 1880 (CanLII) at para 52; *Sanford v. Koop*, 2005 HRTO 53 (CanLII) at para 35). Medical information can support an order in this category, but such evidence is not required (*Dicks v. Randall,* 2023 CHRT 8 at para 50). Some of the subjective factors that the Tribunal may consider include: "emotional consequences, frustration, disappointment, loss of self-esteem and self-confidence, grief, emotional well-being, stress, anxiety and sometimes even depression, suicidal thoughts and other psychological symptoms resulting from the discriminatory practice": *Youmbi Eken v. Netrium Networks Inc.*, 2019 CHRT 44 at para 71.

[367] In his testimony, Mr. Dorais said that the comments that Sergeant McLagan made during the medical examination on April 7, 2016, made him feel kind of shocked, upset, a little angry, embarrassed, a bit ashamed, humiliated, and a lot of emotion that he was trying to keep inside. He also testified that he felt defeated and disappointed after receiving the CAF's second denial letter. In closing submissions, Mr. Dorais expressed his "tremendous feelings of grief and humiliation" that he says extend to the present day, that he felt "shunned" by the CAF, and that the CAF "took a giant piece of my dignity and self-esteem".

[368] The CAF submitted that the Tribunal has no evidence, examples or descriptions of these effects, only Mr. Dorais' statements. The CAF noted that the stress of advancing the human rights complaint is separate and voluntary and should not be considered in assessing a remedy for pain and suffering.

[369] Mr. Dorais experienced an unfortunate result as a former soldier who had experienced service-related trauma, was diagnosed with PTSD, and later hoped that re-enrolment in the CAF would bring him “full circle”. However, the CAF did not give him the opportunity for a proper evaluation of his health status.

[370] I do not minimize the effects of the CAF’s discriminatory practice on Mr. Dorais, but the evidence does not satisfy me that they were among the very worst cases or the most egregious of circumstances. Mr. Dorais experienced a range of emotions, but the evidence does not convince me that he experienced a major emotional impact. The emotions that Mr. Dorais expressed in his testimony were also not as strong as his description of them in the closing submissions. Mr. Dorais is entitled to $9,000 for the pain and suffering that he experienced due to the CAF’s discriminatory practice.

C. Special Damages: Mr. Dorais is entitled to $4,000

[371] Under section 53(3) of the CHRA, the Tribunal may award special damages of up to $20,000 if it concludes that the respondent has engaged in a discriminatory practice wilfully or recklessly. As explained in *Christoforou*:

> Special damages are punitive and intended to provide a deterrent and discourage those who deliberately discriminate. A finding of wilfulness requires an intention to discriminate and to infringe a person’s rights under the Act. Recklessness usually denotes acts that disregard or show indifference to the consequences, such that the conduct is done wantonly or needlessly (*Canada (Attorney General) v. Johnstone*, 2013 FC 113 at para 155). A finding of recklessness does not require proof of intention to discriminate (see *Hughes* at para 89, citing *Collins v. Canada (Attorney General),* 2013 FCA 105 at para 4, rev’g *Canada (Attorney General) v. Collins*, 2011 FC 1168 at para 33).

[372] When assessing special damages, the Tribunal looks at the respondent’s conduct rather than effects on the complainant (*Christoforou* at para 108, citing *Beattie and Bangloy v. Indigenous and Northern Affairs Canada*, 2019 CHRT 45 at 210 and *Warman v. Winnicki*, 2006 CHRT 20 at paras 178, 180*).* Recklessness implies disregard or indifference to consequences such that the conduct is done wantonly or heedlessly (*Canada (Attorney General)* v. *Johnstone*, 2013 FC 113 aff’d 2014 FCA 110). Like awards for pain and

suffering, an award of $20,000 is reserved for the very worst cases (*First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada (representing the Minister of Indigenous and Northern Affairs Canada)* 2019 CHRT 39 at para 230).

[373] Mr. Dorais submitted that he should receive the maximum of $20,000 based on the CAF's "deliberate and irresponsible behaviour" and for having carelessly shredded his recruitment file. Mr. Dorais did not provide any case law to support his submission.

[374] The CAF submitted that Dr. Murphy's testimony explained how he reached his decision on Mr. Dorais' file and that other evidence canvassed in great detail the policies and other documents that informed the decisions of Dr. Murphy and other RMO medical evaluators. Based on this evidence, the CAF argues that there is no support for a finding of special compensation.

[375] The Commission did not make submissions about this remedy.

[376] The evidence does not satisfy me that the CAF deliberately discriminated against Mr. Dorais, so no compensation for wilfully engaging in a discriminatory practice is available.

[377] I must also consider whether the CAF's actions or inactions were reckless. I have found that the CAF did not conduct its evaluation of Mr. Dorais' medical conditions adequately, but whether it acted recklessly, by disregarding or being indifferent to the consequences, requires close examination of the facts.

[378] I am satisfied that there was no reckless conduct when Sergeant McLagan examined Mr. Dorais and made recommendations for his medical category. Although Sergeant McLagan testified that, in hindsight, he should have recommended that Mr. Dorais obtain a psychiatric assessment, I have found that he was not required to do so.

[379] Dr. Murphy's evaluation of Mr. Dorais' medical health status included elements of recklessness. He should have considered the deficiencies in the medical information before him. If the deficiencies were not evident during his first review of Mr. Dorais' file, they should have been evident after reading Mr. Dorais' detailed request for reconsideration. I am satisfied that, more likely than not, this was reckless conduct in the circumstances, based on an indifference to the consequences for Mr. Dorais.

[380] The evidence about the shredding of Mr. Dorais' paper recruitment file in March 2020, and particularly Major Eastwood's testimony, satisfied me that the file shredding was an unfortunate administrative oversight.

[381] The CAF's recklessness is not among the most egregious of cases. It occurred in a complex and high-volume decision-making environment with limited policy support at that time for the RMO medical evaluators. However, the fact remains that the CAF did not give adequate care for or attention to Mr. Dorais' application and disregarded the need for accommodation. The CAF's failure to consider its obligations under the CHRA based on its perception of Mr. Dorais' disability demonstrated an indifference to the consequences of its actions (*Marcovecchio v. Air Canada*, 2023 CHRT 56 at para 124) and meets the test for compensation to be paid under section 53(3) of the CHRA.

[382] Mr. Dorais is entitled to $4,000 for special damages.

D. The request to repeal section 15(9) of the CHRA dealing with universality of service is dismissed

[383] Mr. Dorais requested that the Tribunal order the repeal of section 15(9) of the CHRA, dealing with universality of service. The submissions on this point were not developed. The Tribunal does not have the authority under the CHRA to order Parliament to change laws and, given the absence of submissions on the remedial authority of the Tribunal relating to section 15(9), I decline to make an order with respect to section 15(9).

E. Order to stop and prevent recurrences

[384] Under section 53(2)(a) of the CHRA, the Tribunal can order a respondent to stop the discriminatory practice and make further orders to prevent recurrences. An order to prevent recurrences must flow from the discriminatory practice that has been found (*Moore* at para 64).

[385] Mr. Dorais emphasized the need for the CAF to have standards and practices that provide for sufficiently individualized assessment and individual accommodation.

[386] The Commission requested that the Tribunal order the CAF to:

a) consult with the Commission and a medical expert(s) on policies and practices regarding medical standards for enrolment that relate to PTSD, depression or both;

b) amend policies or develop documentation explaining the requirements for individualized assessments of applicants with PTSD and/or depression and the steps to conduct them;

c) communicate these policies to staff and the public;

d) develop consistent policies regarding medical standards for new recruits and current staff; and

e) ensure that if a medical assessment will potentially reflect medical health diagnosis, the medical assessment takes account of whether the diagnosis is for a current or past disorder.

[387] The CAF submitted that it has acted since at least 2012 to review the CEMS, improve the enrolment system, make efforts to better understand mental health disorders, and to develop and refine policies to clarify the information that it needs from applicants with mental health diagnoses and assign medical categories appropriately.

[388] I have found that it was not a discriminatory practice to have established and pursued the policies and practices involving the CEMS. I have also found that the CAF did not engage in a discriminatory practice by applying the CEMS and the Related Medical Policies to all applicants or by applying the CEMS to applicants and applying different minimum medical standards to serving CAF members. I make no order about these policies.

[389] I have also found that there is no discriminatory practice when the CEMS and the Related Medical Policies are applied by conducting individualized medical assessments of applicants that do not violate the CAF's duty to accommodate, as *Irvine FC* requires.

[390] The evidence satisfies me that the CAF has made changes to its enrolment processes that address the discriminatory practice that occurred in Mr. Dorais' 2016 application to re-enrol.

[391] The 2018 digitization of the enrolment process and the use of the Canadian Forces Health Information System for recruitment instead of the previous paper-based system demonstrates that there have been improved communications between the medical technicians who conduct the physical examinations and the RMO's medical evaluators. This improvement has, in turn, allowed for improved communications, or what the CAF refers to as counselling, between medical technicians and applicants about concerns arising from the RMO's denial decisions. The digitization process has also permitted the CAF to spend less time on applications for enrolment that are likely to be approved and more time on more complex applications.

[392] The evidence also satisfies me that the CAF has been conducting an ongoing review of the CEMS and its relationship to the universality of service principle.

[393] Mental health support services and information are also available for CAF members and their families, including a confidential CAF member assistance program available 24 hours per day and seven days per week. A Government of Canada web page informs CAF members and the public about these resources. Although these services do not directly address the importance of fairly considering enrolment applications from individuals with PTSD, the expansion of mental health support services indicates responsiveness to concerns about the mental health of applicants.

[394] The CAF acknowledged in evidence the importance of having full knowledge about an applicant's medical conditions, medical history and treatment in order to make an adequately informed decision about each applicant's medical fitness for enrolment. The evidence also confirmed that Mr. Dorais' human rights complaint highlighted for the CAF the importance of having more specific directives to guide the information-gathering steps and the decision-making in the medical evaluation of applicants. I accept that the CAF has acted upon these needs by developing and implementing the Clinical Council MEL Guidelines.

[395] The Clinical Council MEL Guidelines assist CAF physicians in assigning medical category ratings in cases where complex medical conditions, including mental health conditions, must be considered. Their stated purpose is “to assist Canadian Forces Health Services clinicians in their review and evaluation of medical conditions, and treatments, to ensure consistency, transparency, and fairness in the assignment of the medical category and medical employment limitations (MELs)”.

[396] The guidelines give clear direction about the medical records that must be obtained for a medical assessment. They also give direction to RMO physicians for properly assigning the G and O medical category ratings.

[397] The Clinical Council MEL Guidelines are intended to cover a wide range of medical conditions in a format that can be updated as new or amended information about medical conditions becomes available. The guidelines in evidence did not have information for every condition because some sections had not yet received formal approval. For example, although the guidelines indicate that they will include information for ten mental health diagnoses (addictions, attention-deficit/hyperactivity disorder, adjustment disorder, anxiety, bipolar disorder, depressive disorder, personality disorder, psychosis, PTSD and suicidal risk), the information for some of them had not yet been approved, including for PTSD.

[398] The section on suicidality provides an example of how the guidelines are to be applied. They list the health records that the CAF requires before an individual’s file is submitted to the RMO for its consideration, including “up to date copies of all mental health assessments, treatment plans and progress notes”, “copies of any inpatient records or emergency room visits, consultations and discharge summaries related to the hospitalization”, “reports from residential treatment programs that the member may have attended as part of their treatment”, and “current and anticipated future frequency of medical follow-up that will be required for ongoing treatment and monitoring”. Because the guidelines require that this information be provided, the CAF’s medical technicians can rely on them to inform applicants what must be provided and thereby prevent the type of medical information deficit that occurred in Mr. Dorais’ case.

[399] The guidelines also direct the RMO about the appropriate assignment of G and O ratings, and they include examples of Medical Employment Limitations that would apply to each rating. For example, the following information applies to a G3 rating:

> "**G3**: CAF members who have had a suicide attempt associated with an underlying mental illness, and have met the following criteria –
>
> There has been appropriate treatment (eg. CBT) aimed at processing the trigger symptoms (i.e. therapy to address management of the stressors that provoke symptoms);
>
> The maintenance and reintegration stages of treatment for the underlying condition is completed with full participation in tasks normal for the occupation, and there has been no recurrence of symptoms/disability;
>
> The clinical record reflects that the member has completed all treatments, is stable, their symptoms are in ***full*** remission, has been discharged from the MH service, and that the member is medically fit for full duties, to include deployment/operational environment. The member must be formally discharged, in writing, as not needing care, and not stopped due to posting, avoidance, non-compliance, or other non-clinical reasons.
>
> **G3 Medical Employment Limitations include:**
> Requires screening with a medical officer/specialist prior to deployment.
>
> Requires periodic medical follow-up no more frequently than every six months."
> (emphasis in the original document)

[400] In my view, these guidelines respond to the need to implement policies that identify the medical information that the CAF must obtain to conduct non-discriminatory medical assessments and clarify how the RMO assigns medical category ratings and Medical Employment Limitations in cases involving the mental health conditions of applicants at the time when they apply to enrol.

[401] However, based on my findings in this decision, the Clinical Council MEL Guidelines must be updated to include information for cases involving applicants with a history of PTSD. It is possible that the CAF has updated the Clinical Council MEL Guidelines since the hearing of this case to include that information. If not, the CAF must expedite its approvals process and update the Clinical Council MEL Guidelines to include information for the

medical evaluation of applicants who have a history of PTSD. The CAF must also provide a copy of the Clinical Council MEL Guidelines, as updated, to Mr. Dorais and the Commission.

[402] Other than this order to update the Clinical Council MEL Guidelines as described, the evidence satisfies me that an order under section 53(2)(a) of the CHRA to prevent a recurrence of a discriminatory medical assessment is not required.

V. Decision and Order

[403] The CAF engaged in a discriminatory practice when it failed to provide an adequate individualized assessment of Mr. Dorais' application to re-enrol in the CAF, when it failed to adequately inform Mr. Dorais about the information he needed to provide to the CAF to be appropriately evaluated, and when, as a result, it rejected his application. The other alleged discriminatory practices were not substantiated.

[404] I order the following remedies:

a) The CAF shall pay Mr. Dorais $9,000 for pain and suffering under section 53(2)(e) of the CHRA.

b) The CAF shall pay Mr. Dorais $4,000 as special compensation under section 53(3) of the CHRA.

c) If since the hearing the CAF has not updated the Clinical Council MEL Guidelines to include information for cases involving applicants to the CAF who have a history of PTSD, the CAF shall expedite its approvals process and update the guidelines so that they include information for the medical evaluation of applicants with a history of PTSD.

d) The CAF shall provide a copy of the Clinical Council MEL Guidelines, updated as ordered above, to Mr. Dorais and the Commission.

Signed by

Gary Stein

Tribunal Member

Ottawa, Ontario
September 18, 2025

Canadian Human Rights Tribunal

Parties of Record

Tribunal File: T2409/6819

Style of Cause: Joshua Dorais v. Canadian Armed Forces

Decision of the Tribunal Dated: September 18, 2025

Date and Place of Hearing:

April 6-9, 2021, April 12-14, 2021, July 6-9, 2021, October 18-22, 2021, and March 9-10, 2022

Videoconference

Appearances:

Joshua Dorais, the Complainant

Caroline Carrasco, Christine Singh, and Sarah Chênevert-Beaudoin, for the Canadian Human Rights Commission

Cynthia Lau and Samantha Gergely, for the Respondent