T.D. 14/93
Decision rendered on August 20, 1993

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

HUMAN RIGHTS TRIBUNAL

BETWEEN:

PATRICIA HEBERT

Complainant

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

CANADIAN ARMED FORCES

Respondent

DECISION OF TRIBUNAL

TRIBUNAL: J. GRANT SINCLAIR, Chairman
MARIE CROOKER, Member
RICHARD NOONAN, Member

APPEARANCES:

ARNOLD FRADKIN AND LT. COMDR. H. MacDOUGALL — Counsel for the Respondent

PETER ENGELMANN — Counsel for the Commission

DATES AND LOCATION OF HEARING: February 17 - 19, 1992; Halifax, Nova Scotia

March 3 - 5, 1992 and May 4 - 6, 1992;
Ottawa, Ontario



## I. BACKGROUND FACTS

### a) Patricia Hebert

Patricia Hebert, ("Hebert") the Complainant in this case, comes from a military family. Her father joined the RCAF in 1964 and presently holds the rank of Warrant Officer in the Canadian Armed Forces (CAF). He is posted to Lahr, Germany, and at the time of this hearing, Hebert was living with her family, working part-time on the base and attending a community college.

Being part of a military family, her life has been one of much movement and change. She has lived at various military bases, both in Canada and in Europe. Her ambition is to continue in the military tradition and become a physiotherapist in the CAF.

In pursuit of this ambition, Hebert applied in April, 1987 to the Regular Officer Training Program (ROTP) of the CAF. If accepted, her plan was to enrol at Dalhousie University for a B.Sc. and after the first year, apply to the School of Physiotherapy.

Hebert completed the CAF aptitude test successfully, but after her medical examination, she was told by the examining doctor that her eyesight without visual correction was very poor and her chances of being accepted into the CAF were slim. Otherwise, she was medically fit.

On the day of her next interview in May, 1987, she was called by the CAF Recruiting Centre and told "not to bother coming" because her visual classification, according to the CAF 'Table of Visual Standards" was V6. This Table prescribes the common enrolment standard for visual acuity for both corrected and uncorrected vision. Hebert met the corrected visual standard. She did not meet the minimum uncorrected standard of V4 and her candidacy was rejected.

### b) Comparison of Hebert with other ROTP candidates

Captain Jacques De Bellefeuille is with the Directorate of the Recruiting Section of the CAF. He commented on Hebert's ROTP application. The ROTP is designed to educate candidates to the first undergraduate degree level.

Those accepted into the ROTP attend at a Canadian military colleges or civilian university if the courses chosen were not offered at a military colleges. The program normally subsidizes 500 to 700 candidates per year and upon completion of their subsidized education, the candidates became officers in the CAF and are employed in their specialty.

In 1987, the year Hebert applied, there were 41 application to the ROTP for physiotherapy, of which 10 offers were made and 8 accepted. Of the eight acceptances, two were high school candidates and the remainder were university undergraduates.

Capt. De Bellefeuille compared Hebert's high school marks and her result on the CAF general ability test with the results of the eight candidates that are accepted. At the time Hebert applied to the ROTP, she had just



completed high school, but at the time the Tribunal hearing was held, she had obtained a B.Sc. from Dalhousie University.

The criteria used in selecting applicants for the ROTP are based on medical standards, general learning ability test results, academic achievement and military potential. Hebert did not take the military potential test because she did not pass the medical. According to Capt. De Bellefeuille, Hebert would have had to excel on the military potential test to surpass the other candidates in terms of overall results since she had performed lower in the other criteria than the ten to whom offers had been made.

Capt. De Bellefeuille indicated that the assessment of military potential was the most important of the criteria for acceptance into the ROTP and Hebert may well have done well given her military background. Further, it is an advantage to have a university degree when applying to the ROTP.

## II. THE COMPLAINANT

Hebert filed a complaint with the Canadian Human Rights Commission dated June 6, 1987 against the Department of National Defence (DND) alleging that DND discriminated against her on the basis of disability, contrary to section 7 of the Canadian Human Rights Act ("CHRA"). She later amended her complaint on December 15, 1988 to allege discrimination by the CAF on the basis of disability contrary to section 7 and section 10 of the CHRA.

## III. VISUAL ACUITY AND REFRACTIVE ERROR

(a) Hebert's visual acuity/refractory error

Hebert first began wearing contact lenses in 1984 and has worn them continually since. She is a patient of Dr. Mohammad Humayun, a practising ophthalmologist and a consultant at a number of hospitals in the Halifax area. Dr. Humayun first examined her in September, 1984. At that time, her refractive error, uncorrected, was in the range of -6 3/4 to -7 dioptres. When he last examined Hebert in 1990 her refractive error was -8 dioptres in her left eye and -8.5 dioptres in her right eye although there was no change over the last two years. Her corrected vision is 20/25, which is near normal vision.

(b) Refractive Error

Evidence was given by Maj. Walter Delpero, a member of the CAF and a qualified ophthalmologist. According to Maj. Delpero, dioptres is a term that is used to describe weakness in the eye or the corollary, the strength of correction required. Refractive error is the inability of the eye to focus precisely on the retina and dioptres then is the measure of refractive error.

There are two types of refractive error, hyperopia, which is the inability to see objects up close which occurs when light rays focus behind the retina so that the image is blurred. The second type of refractive error is myopia or the inability to see objects at a distance, which occurs where the light rays focus in front of the retina. Hyperopia is measured in



terms of positive dioptres and a positive lens or a positive dioptre power is used to correct this type of refractive error; myopia is measured in terms of minus dioptres and a minus dioptre lens would be used to correct the problem. Hebert is myopic.

(c) Visual Acuity

Visual acuity is commonly measured according to the Snellen Chart. The standard for visual acuity on the Snellen Chart is measured at a distance of 20ft. A person who measures 20/20 has "normal vision." A person who measures for example at 20/60 on the Snellen Chart can see at 20ft. the same level of detail that a person with normal vision can see at 60ft. The Snellen fraction represents the ratio of distance at which the measured eye can discriminate detail compared to the normal eye. The lower the ratio on the Snellen Chart, the more a person's vision is degraded, that is, the greater the refractive error.

(d) Correlation between Refractive Error and Visual Acuity

The correlation between error and acuity was demonstrated by Table X-10 of the Duke-Elder study and is as follows:

| MYOPIA | V.A. | MYOPIA | V.A. |
|---|---|---|---|
| 0.50D. | 20/25 | 3.00D. | 20/285 |
| 1.00D. | 20/65 | 4.00D. | 20/420 |
| 1.50D. | 20/110 | 5.00D. | 20/565 |
| 2.00D. | 20/165 | 6.00D. | 20/775 |

Although not shown on this Table, -7 dioptres would equate to approximately 20/1000 and, -8 dioptres about 20/1500. Thus, for example, a myope, with a refractive error of -0.5 dioptres would have a visual acuity of 20/25. At the other end of the scale, a myope with a refractive error of -8.0 dioptres (such as Hebert) would have a visual acuity of 20/1500.



(e) The CAF Table of Visual Standards

The common enrolment visual standard for the CAF is V4 for both uncorrected and corrected vision. The various visual acuity gradings are set out in the Table of Visual Standards which is reproduced below.

TABLE OF VISUAL STANDARDS

| | Uncorrected Vision | | | | Corrected Vision | | | |
|---|---|---|---|---|---|---|---|---|
| Grading | Better Eye | | Other Eye | | Better Eye | | Other Eye | |
| | Distance | Near* | Distance | Near* | Distance | Near* | Distance | Near* |
| VI | 6/6 | N5 & N14 | 6/9 | N6 & N18 | N/A | N/A | N/A | N/A |
| V2 | 6/18 OR 6/12 | N10 & N24 OR N8 & N16 | 6/18 OR 6/30 | N10 & N24 OR N12 & N36 | 6/6 | N5 & N14 | 6/9 | N/6 & N18 |
| V3 | 6/120 | N/A | 6/120 | N/A | 6/6 | N5 & N14 | 6/9 | N/6 & N/18 |

V4 N/A N/A N/A N/A 6/9 N6 & 6/120 N36
N18

As long as the refractive error does not exceed plus or minus 7.00 dioptres spherical equivalent.

V5 The category is reserved for serving personnel whose visual category is less than V4 but who, in the opinion of a consultant ophthalmologist, have sufficient visual acuity to perform their duties satisfactorily in their present trade or employment and for whom continued service employment will have no adverse effect. When there are career implications or a satisfactory remustering cannot be done, then a release under QR&O 15.01 (3)(b) should be considered.

V6 This category is assigned to candidates whose visual acuity is less than V4 standards. In the case of serving members, it will be assigned only by an ophthalmologist to those who cannot qualify for a higher grading.

* Near vision is determined using "TIMES ROMA" type and is assessed at reading distance 930 to 50cm and at 100cm. The 100cm distance is important in the aircraft cockpit and similar environments and for users of CRT displays. When two values are shown, such as N5 & N14, the first value refers to the reading distance and the second value to the 100cm distance.

N5 = J2 = 0.5m N6 = J3 = 0.6m N8 = J5 = 1.0m N10 = J7 = 14m N12 = J8 = 1.6m
N14 = J10 = 20m N16 = J11 = 2.2m N18 = J12 = 2.5m N24 = J20 = 40m
N36 = J30 = 6.0m

(français au verso)

A person in the V1 category essentially has normal or close to



normal vision, 20/20 or 20/30 on the Snellen Chart. Persons with this level of acuity have minimal refractive problems and require no correction.

A V2 grading indicates a small degree of myopia or hyperopia. Persons within this category have a visual acuity in the 20/40 - 20/60 range and are able to function without correction. A person in the V3 grading would have a visual acuity of around 20/400 and probably could not function without correction. However, they could still see well enough to get around without stumbling about and could read a street sign at a reasonable distance or see oncoming people or traffic.

V4, the minimum common vision standard for the CAF, specifies that the refractive error does not exceed plus or minus 7 dioptres and would correlate on the Snellen Chart somewhere between 20/400 to 20/1000. Persons in this category have poor uncorrected vision but whose vision could correct quite nicely with corrective lenses.

Dr. Delpero's evidence was that a refractive error of -8 dioptres would correlate to a visual acuity of about 20/1500. However, at this degree of visual degradation, it is more meaningful to apply a smaller equivalence of 20 so that the measurement would be 1/75. Beyond one foot, a myope of 8 dioptres uncorrected, would probably be able to make out the colour of a car but not the details or type and certainly not the license plate number or the driver's features. What they would see would be a moving blur.

The Table of Visual Standards has two further gradings, V5 and V6. A V5 grading applies only to serving members and allows for a serving member, who initially satisfied the common visual standard of V4, but whose acuity is now below V4, to remain in the CAF if the member can perform his or her occupational duties satisfactorily.

The assumption of the V5 category is that, a serving member will have acquired expertise and experience in their military occupation which can compensate for their lower visual acuity. It is not automatic however that such a person will continue in their occupation or indeed in the CAF and this is subject to the opinion of consultant ophthalmologist.

It is the corollary of this reasoning that precludes a recruit for the CAF from being graded as V5. Such a person would be untrained and lack experience in the military. Usually, they would be enroling at a young age, 18 or 19 and it is difficult to predict, says Dr. Delpero, the decrement in vision they may experience. Because of the uncertainty both as to future visual degradation and ability to perform occupational duties recruits are not graded as V5.



Dr. Delpero agreed that there is very little difference between a person with a refractive error of -7 dioptres and -8 dioptres, but in his view, there is a significant difference in that high levels of myopia are associated with a higher incidence of various ocular pathologies. Studies show that at -8.00D and

beyond there is a significant increased risk of retinal detachment. Glaucoma and cataracts are other pathologies resulting from high myopia.

In his view, the V4 common enrolment standard of 7 dioptres uncorrected is a very generous standard although not the optimum. However, if the CAF raised the standard to say V2, a more optimum level in terms of functioning effectively, this would cut down significantly on the number of people who would qualify for enrolment into the CAF.

f) Expert Evidence - Myopia and Visual Acuity

The Respondents also called Dr. James Sheedy, a qualified optometrist who obtained his Ph.D. in Physiological Optics to give evidence on their behalf. He is an Associate Clinical Professor and Chief of the VDT/Occupational Vision Clinic at the University of California, School of Optometry. He is also the Director of Clinical Research for Allergon Humphrey, a company which manufactures ophthalmic instruments which are used to diagnose and treat the eyes. He has written numerous articles on the subject and has given many educational presentations and has been involved in various types of professional consultations and litigation.

Dr. Sheedy presented to the Tribunal a series of 3mm slides pictures demonstrating what a myopic person can see at 20ft. at day time, each slide representing a different refractory error ranging from -.5 dioptres to -8 dioptres. He also presented a series of 6mm slides demonstrating the same range of refractory error at night time. Each daytime slide was a photograph of the same scene, two individuals standing on the boulevard of a residential street with a typical background of trees, grass, sky and parked cars; one of the individuals held a small sign which showed the refractory error in dioptres.

Dealing first with the 3mm series of daytime slides, it is clear that a -8 dioptre myope would be unable to identify anything in the picture. It was a blur of images and colours. At -7 dioptres, the images were still very blurred and unidentifiable. There is little or no distinction between -7 dioptres and -8 dioptres in terms of identifying anything in the picture. At -6 dioptres, the objects surrounding the picture get larger and shapes are discernible but unrecognizable. The difference between -6 and -5 dioptres in terms of object recognition, is negligible.

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It is only at -4 dioptres that the objects and surroundings in the slides start to become recognizable and clearer. At -3 dioptres the objects or images are recognizable and at -2 dioptres the people and surroundings in the picture are clear. These slides demonstrate, that for a myope, in daytime, it is very difficult to distinguish anything in a meaningful way until one approaches -4 dioptres and really it is only at -3 dioptres that one is able to distinguish objects and spatial relationships.

The nighttime slides represent a series of photographs of the same scene involving various persons and objects inside a residence. At -8 dioptres, it is not possible at all to identify anything in the picture. Again, there is little difference between -8 and -7 dioptres in terms of object or spatial identification and it is not until one views the -3 dioptre slide that images begin to come into focus. At -2 dioptres, it is possible to distinguish between people and surroundings. The images only become clear at -1 dioptre.

According to Dr. Sheedy, the daytime slides presented a visually rich environment having many high contrasts and objects. Yet, the subject matter only becomes clear at the -2 dioptre level.

The nighttime slides show that where the visual environment is not rich in clues such as a nighttime scene, even good vision is taxed to perform. It is much more blurred for a person with admittedly poor vision.

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Dr. Sheedy also introduced into evidence the "International Classification of Diseases, 9th ed. (ICD-9)" and referred specifically to Table 3 of ICD-9 which is entitled "Classification of Levels of Impairment by Visual Acuity (ICD-9, 1978)". It is important to note that this Table classifies visual acuity on a corrected basis not an uncorrected basis.

Table 3 reads as follows:

| Best Corrected Acuity | Classification |
|---|---|
| 20/10 to 20/25 | Normal vision |

| | |
|---|---|
| 20/30 to 20/60 | Near normal vision |
| 20/70 to 20/160 | Moderate visual impairment or low vision |
| 20/200 to 20/400 | Severe visual impairment or low vision, legal blindness (US) |
| 20/500 to 20/1000 | Profound visual impairment or low vision, moderate blindness |
| less than 20/1000 | Near total visual impairment, severe blindness, near total blindness |

This evidence emphasizes the degree of Hebert's visual impairment in the event that her corrective apparatus were lost or dislodged, so that visually, she would be in an uncorrected state. At -8 dioptres, uncorrected, she would be considered near total blindness. This Table also emphasizes the level of visual acuity that is acceptable to the CAF in terms of the common enrolment standard. A person in the V4 category, uncorrected could have a refractive error of ±7 dioptres. According to Table 3, such a person would be classified as having profound visual impairment or low vision moderate blindness. The V3 grading would include those who have severe visual impairment or legal blindness. It is only the V2 category and above which includes those who would have moderate visual impairment according to this classification.

It is problematic as to whether this evidence argues for an uncorrected visual standard for the CAF or for a higher uncorrected visual standard for the CAF.

g) Vision Standards for Public Safety Occupations

Dr. Sheedy sought to justify an uncorrected standard for public safety occupations and the military on the basis that for persons



in these occupations, there is a need to perform effectively without visual correction and because of the risk of losing their corrective lenses while performing their duties. For example, police officers are often involved in situations where glasses may get knocked off or contacts displaced. There is also the

possibility that glasses can compromise or severely reduce the vision of the wearer in rain, snow, mist or fog.

Dr. Sheedy referred to a Report that he had prepared for the R.C.M.P. entitled "Visual Requirements: Static Guard of the Royal Canadian Mounted Police". This report analyzed the requirements of the R.C.M.P. with respect to the visual skills required to perform the job requirements which essentially is to protect foreign embassies in Ottawa. A major part of the job is observation of persons and vehicles under a variety of conditions. It is common for the Static Guard to walk on foot patrol and members carry hand guns on duty and have access to machine guns in the guard hut. Dr. Sheedy pointed out that the minimum requirements for the Static Guard are the same as other members of the RCMP, namely, a corrected vision of 20/20 in the better eye and 20/30 in the poorer eye, and uncorrected vision of 20/60 in each eye or 20/40 in the better eye with 20/100 in the poorer eye.

He also pointed out in his Report that an RCMP survey of the vision requirements of eighteen police forces across Canada shows fifteen to have more stringent standards, two approximately equal and one a lesser standard than the RCMP. Vision standards for anti-terrorist units in other countries were also surveyed and all had an uncorrected standard ranging from 20/20 to 20/200 with most in the 20/40 to 20/60 range.

This Report also set out the results from a questionnaire from 108 police officers who wore contact lenses while performing police duties. The results are reported as follows:

1. Have your contact lenses ever dislodged such that it interfered with your vision?

Hard 31.3% Yes
Gas Perm. 10.5%
Soft 19.2%

2. Have your eyes ever become irritated from environmental factors (dust, smoke, wind, etc.) while on duty such that the contact lenses had to be removed?

Hard 56.2% Yes
Gas Perm. 57.9%
Soft 46.6%

3. Have your eyes become irritated from environmental factors while on duty such that it interfered with your vision?

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Hard 68.8% Yes
Gas Perm. 52.6%
Soft 46.6%

4. Have you ever lost a contact lens while on duty?

Hard 18.8% Yes
Gas Perm. 10.5%
Soft 9.6%

5. Have your eyes ever been sufficiently irritated (from overwear, an infection or injury, etc.) such that you were unable to wear your contact lenses on duty?

Hard 37.5% Yes
Gas Perm. 31.6%
Soft 32.9%

Of equal relevance is an article by Dr. Sheedy in 1986 entitled "Contact Lenses for Police Officers" in the Journal of the American Optometric Association. The Abstract for this article states:

Most municipalities require that police officer applicants have a minimum level of uncorrected visual acuity. The primary basis for the uncorrected acuity standards is that an officer can have spectacles forcibly removed and would need a minimum level of vision to continue performing his/her duties. This article discusses the pros and cons of allowing contact lens wearers to bypass the uncorrected visual acuity standard. Although there are several factors that can make the contact lens wearer a less desirable recruit, a good contact lens wearer who doesn't meet the uncorrected standard could safely and efficiently perform the duties of a police officer. It is recommended that a municipality may consider waiving the uncorrected visual acuity standard for a good contact lens wearing candidate. Suggested guidelines for implementing this policy are discussed.

Dr. Sheedy concluded that:

"An individual who is a good contact lens wearer and who does not meet the uncorrected visual acuity standard would be able to safely and efficiently perform the duties of a police officer with only minimal risks. While wearing contact lenses, the excess risk involves the very slight risk of contact lens loss during scuffles or in the water. It would be



very difficult to deny employment on this basis alone. Therefore, it is reasonable to waive the uncorrected vision standard for a good contact lens wearing candidate."

Appendix C to Dr. Sheedy's article sets out recommended changes to the AOA, Recommended Vision Standards for Police Officers. It states that:

A contact lens wearer is probably at less risk of having his or her vision correction dislodged or forcibly removed while on duty than is a spectacle wearer. Therefore, a police department may consider waiving the uncorrected visual acuity standard for a successful contact lens wearer under the following conditions:

1. The candidate must have been verified as a successful contact lens wearer for the year prior to application.

2. The department recognizes the need to routinely verify that the lenses are actually being worn while on duty.

3. The individual has at least annual examinations by an optometrist or ophthalmologist to verify that they are a continuing successful contact lens wearer.

On the question of dislodgment or loss of contact lenses, all three medical experts, Dr. Humayun, Dr. Delpero and Dr. Sheedy, agreed that there had been significant improvements in contact lenses in the past few years, particularly in the materials used for contacts and in the solutions for cleaning and storing the

lenses. The result is that there are far less problems with dislodgment or displacement and infections and eye irritation.

Hebert's evidence, was that, in high school, she participated in a number of sports, including basketball and track and competed for school teams. She is also an active camper and does a lot of back-packing and swimming. She wears her contact lenses when participating in these activities and stated in her evidence that she had only lost a contact lens once when she was taking it out over the sink. Her contacts have never been dislodged or displaced in all the years that she has been wearing them. She removes her contact lenses when she goes to bed and puts them back in when she wakes up and she doesn't need a mirror to take out her lenses and put them in her eyes. She stated that she uses a multiple purpose solution for storing, disinfecting and cleaning her lenses and she never need to remove her contacts because of discomfort in her eyes. She has had one eye infection since she has been wearing the contacts.



Dr. Sheedy's and Dr. Delpero's concern was not so much the loss of the contact lenses but rather that, contacts must be properly cared for in a hygienic fashion and this requires a clean environment where the wearer can wash their hands and use a sterile solution to avoid contamination which may lead to eye infections. Dr. Delpero's experience in the CAF is that there are occasions when serving members are in the field and hygienic conditions are not possible because hot water and sterile solutions are not readily available.

Further, Dr. Delpero contended that contact lenses are not appropriate in situations involving extreme heat or dryness or where there is dust, smoke or dirt in the atmosphere. In his view, soft contact lenses may act as a sponge and soak up the moisture in a dry environment and the contacts tend to get stuck to the eye, feel uncomfortable and cause irritation.

Dr. Humayun agreed that there are times when a person can not wear contact lenses such as when they have an eye irritation or infection. He also agreed that dust or dirt particles could get behind the contact lens and affect the cornea. He would therefore recommend that a contact wearer have a back up pair of glasses and wear them in cases of an infection or irritation. He did not agree that intense heat would preclude the wearing of contact lenses. In his experience, coming from a country where

there is intense heat, that has not caused significant problems for contact wearers.

Dr. Humayun believes that Hebert is a very suitable candidate for contacts because of her high refractive error and because she is a highly motivated person who has demonstrated a high level of hygiene. He was not able, because of his lack of knowledge and experience of CAF policies and procedures, to give any opinion as to how Hebert would function in a wartime situation. He did, however express the opinion that Hebert would function as well as anyone in a clinical or hospital setting.

Commission counsel introduced an Abstract of a NATO study entitled "Danish Briefing on Contact Lenses Trials" and sought to challenge Dr. Delpero's position that contact lenses should not be worn in certain environments. The abstract concluded that soft contact lenses used by police forces as an eye protection against tear gas improved the performance of those who were wearing soft contact lenses. They were able to keep their eyes open more easily and had quicker and better orientation.

The ocular effect of tear gas was minimal compared to those not wearing soft contact lenses and the safety and efficiency of a soft lens wearer in a tear gas environment was clearly demonstrated according to this study.



Dr. Delpero was unwilling to accept only an Abstract until he understood better the context and terms of reference for the study. He also pointed out that the study dealt with tear gas and not an irritant gas or particular matter such as smoke or dust. He maintained his position that contact lenses are contra-indicated if there are smoke, gas or dust in the environment.

Both Dr. Sheedy and Dr. Delpero agreed that everyone would be affected in an environment which is degraded by heavy smoke or dust. Both however, maintain that in this situation, it would be necessary for a contact lens wearer to remove their lenses.

## IV. TRAINING OF A PHYSIOTHERAPIST IN THE CAF

Major Peter Bey, Chief Standards Officer at the Canadian Forces Officer Candidate School at Chilliwack, gave evidence as to the basic training program for officer candidates in the CAF. The

training course is designed to provide basic military skills. It is a twelve week course which is broken down into seven weeks and five weeks. The basic training is designed to train officer candidates to perform command, leadership, managerial and other assigned duties that are common to all officers in accordance with the specifications set out in the "The Officer General Specifications" (OGS).

Basic training is a controlled type of training to ensure that candidates in the course will complete their training with a minimum risk of serious injury. The training does not involve a simulation of actual war conditions so that an officer candidate going through basic training would not actually experience what it would be like to operate in this type of conditions. Basic training is also used to evaluate candidates in terms of their potential as officers in the CAF.

In the first seven weeks, basic training consists, on a daily basis, of calisthenics, drills and lectures. The lectures include first aid, basic survival and map reading. In the third and fourth weeks, candidates are in the field learning to live and operate in this environment. In the last week, candidates receive rifle training under closely monitored conditions. During this week, they will also complete their physical fitness testing.

Part two of training for physiotherapist takes place at Camp Borden. During this phase, they receive weapons training on pistols and are required to qualify on the pistol. They are also trained in NBCW drills including donning and removing the NBCW suit and gas mask and functioning with the suit and mask on as well as decontaminating the mask or the suit. This training is carried out under controlled conditions in a gas chamber and not under wartime or battle conditions.



A considerable amount of the Respondent's evidence was directed towards this particular aspect of the training and the difficulties that may be experienced with respect to a person who wears corrective lenses.

Warrant Officer Douglas Humby of the CAF and an instructor at the Camp Borden, NBCW School, gave a demonstration of the NBCW drills and training. He demonstrated, particularly, the NBCW masking

drill in terms of putting on the mask and removing it and also putting on and taking off the NBCW suit.

According to W.O. Humby, the donning of the NBCW suit is done in accordance with various codes or warnings. There are three standards of warnings, TOPP low, TOPP medium and TOPP high. TOPP low is when it is clear that the enemy has chemical weapons but has not yet used them; medium is when the enemy has used chemicals and will use them again; and high is when the enemy has just used chemicals and the effects are about to be experienced. In TOPP low, the NBCW suit is not worn but each member of the Force keeps the suit in close proximity at all times. In TOPP medium, the suit is worn but the mask is not yet put on and in TOPP high, the complete NBCW equipment is put on.

The masking drill is to be done in nine seconds after the warning is sounded and it involves removing the mask from the holder, stopping the breathing, closing the eyes and putting on the respirator by the prescribed method.

If a member of the CAF wears glasses, then the masking drill still must be completed in nine seconds but there is a different method of putting on and taking off the mask. Contact lenses are not to be worn where there may be a danger of chemicals and they are not worn in the NBCW training. It should be noted that every candidate in the CAF who wears corrective lenses is entitled to two pairs of glasses and one pair of combat glasses. Combat glasses are prescription glasses and are customized for each member of the CAF who wears them. They are designed in such a way that they fit flat on the face and on the temples and can be worn under an NBCW mask without breaking the seal of the mask.

W.O. Humby gave a demonstration of the mask wearing combat glasses and from the demonstration it appeared that under the mask, the glasses did not sit squarely on his face. His experience in training members of the CAF in NBCW equipment is that, they do not like to wear combat glasses because of the difficulty of positioning them over the eyes when wearing the mask. In this situation, they tend not to wear any glasses under the mask.

In giving this evidence, W.O. Humby admitted that the glasses that he was using in the demonstration were not fitted specifically for his face and he would agree that it is possible

to achieve an air-tight effect wearing the combat glasses.

There was no unanimity in the evidence as to whether combat glasses could be worn effectively under the NBCW mask.

Major Delpero's experience was that combat lenses tend to become very uncomfortable in a short period of time when worn under the mask, and also tend to become foggy. However, he had never heard personally of any complaints over the wearing of combat glasses or having them dislodged under the mask.

Major Robert Moneypenny, a Health Care Administrator in the CAF and the Commander of the First Canadian Field Hospital at Petawawa had a different experience. His evidence is particularly relevant because he was the only person who gave evidence at this hearing who served in the Gulf War and was required to don the complete NBCW suit in circumstances when there was a real possibility of chemical attack. Major Moneypenny wears glasses. He said that on no occasion did he wear his combat glasses or any other glasses under the mask when the warning was given. The reason was that he was not willing to take the chance of wearing anything that might break the seal of the mask. If he wore his combat glasses, then a good seal could be achieved but he found that his combat glasses when worn under his mask did not fit properly and did not sit flat over his eyes.

Either he ended up with double vision or no corrected vision at all with the added disadvantage of having the combat glasses located somewhere on his face under the mask but not in the proper position. His practice therefore was whenever an NBCW alert was given, he would put on his mask without any glasses.

His visual acuity is such that, though he was not able to function as effectively as he would have liked, he was able to function without any corrective lenses while wearing his NBCW mask. In his view, it was an individual decision as to whether or not to wear glasses under the mask; he chose not to and preferred having a good seal and not being able to see as well as he could with combat glasses rather than risking not achieving a good seal.

Col. R.J. Hotchin, a Health Care Administrator, who gave evidence on other matters, also gave evidence on the question of combat glasses. He found his combat glasses fairly comfortable to wear and could tolerate wearing them for some time under the NBCW

mask. He did however experience some difficulty getting the mask on and off over the glasses even though the glasses are flat.

a) The Career Pattern of a CAF Physiotherapist

Both Major Kellerman, Career Manager for Medical Service Officers and Captain Patrick Todd, an Occupational Specifications Staff Officer with the Directorate of Manpower Planning, gave evidence as to the career pattern of a CAF physiotherapist.



There are currently 25 physiotherapist positions in the CAF. Once a physiotherapist finishes basic training, he/she is assigned to a base hospital or clinic, or to one of the major CAF hospitals. Each of the major hospitals, in Halifax, Valcartier, Esquimalt, Victoria and National Defence Medical Centre in Ottawa, has a physiotherapist as does each of the major CAF bases.

The CAF also operates One Canadian Field Hospital which is headquartered in Petawawa and staffed with small cadre of about 36 persons who maintain the unit and keep it ready for deployment. There are a total of 224 positions assigned to the Field Hospital and the remaining positions including a physiotherapist are staffed by augmentees who are in an established position elsewhere and are posted to the Field Hospital when it deploys.

CAF medical personnel do not remain in one posting. Rather, they are rotated through various postings. This is done for two reasons. From a professional point of view, an individual must rotate through various types and levels of employment to obtain the experience and training necessary for higher positions in the CAF. Secondly, there is morale consideration. All postings are not equally appropriate, some involve isolation or remoteness and it is not desirable from a morale point of view to leave people in these positions for an extended period of time. Thus, the operative principle for all CAF medical personnel is that everyone shares both the wealth and the hardship.

Individual circumstances may be considered when postings are made. For example, the stage at which a member is in his/her career, the family situation and the impact of a particular posting are relevant factors. But, the overriding factor is the service requirement. If there is a requirement to post a

physiotherapist into a certain posting that position has to be filled. Though individual preference is taken into account, ultimately , it is the service requirement that takes precedence over the wish of the individual.



b) CAF Physiotherapist Specifications

Within the CAF, there are approximately 100 non-commissioned MOCs and approximately 38 officer MOCs. A military occupation (MOC) is basically a career field within the military. Although, the principle of flexibility of employment exists in the CAF, practically, it is rare for a serving member to move from one MOC into another MOC.

Each MOC has occupational specifications (OS) which detail those tasks or duties that an individual must be capable of performing and to what level of skill and knowledge. Officers must also perform according to the OGS.

Essentially, the role of a physiotherapist is directed to the conservation of military manpower through the provision of physical therapeutic care and the prevention of physical disfunction. In addition, their duties include the operation and management of physical therapy facilities and resources, the training of personnel, the education and counselling of patients and the provision of consulting services. There are no sub-occupations in the regular force physiotherapy occupational structure.

Physiotherapist officers play an important role in the rapid return to duty of patients and complements the medical officer's diagnosis through assessment of patients and the development and implementation of appropriate treatment plans.

The normal progression of a physiotherapist officer after university graduation is outlined in the OS and covers three development periods. During the First Development Period, Level 1, all officers complete the basic occupational training and undergo preceptorship training at a major Canadian military hospital. At that time, they concentrate on consolidating their recently acquired clinical and military skills and knowledge in a medical branch environment. Upon completion of the preceptorship program, lieutenants continue their employment at a major Canadian military hospital as a staff therapist. This is

normally the first posting and the beginning of the level two first development period.

As Captains entering the second development period, level one, they may be posted to sole charge positions at base hospitals or clinic.
Employment at level two of this period becomes more diversified. At this time, officers may compete for the research and training positions, foreign exchange positions, staff officer positions at NDHQ and selected non-occupational positions. During this period, training is directed at developing managerial and specialized clinical skills. As well, applications for post-graduate masters level training may be submitted during this



period.

Upon promotion to Major, the physical officer enters the Third Development Period Level I. These officers will be employed in senior staff positions at major medical facilities or Regional Medical Headquarters. Non-occupational employment will be encouraged. Training will focus on advanced managerial skills and senior staff duties. Senior physiotherapist officers may be given the opportunity of attending Canadian Forces Commandant's Staff College.

According to the evidence there is only one physiotherapist in the CAF who holds the rank of Major.

The Development Periods are set out in the following Tables:

FIRST DEVELOPMENT PERIOD - LEVEL 1

Rank: Lieutenant
Occupational Employment: Preceptorship at a major Canadian military hospital under the supervision of a senior captain physical therapist

FIRST DEVELOPMENT PERIOD - LEVEL 2

Rank: Lieutenant
Occupational Employment: General duty physiotherapist officer at a major Canadian military hospital.

SECOND DEVELOPMENT PERIOD - LEVEL 1

Rank: Captain
Occupational Employment
- Base Hospital or Clinic Physical therapist
- General Duty physical therapist at a major Canadian military hospital.

SECOND DEVELOPMENT PERIOD - LEVEL 2

Rank: Captain
Occupational Employment:
- Senior Physical Therapist at a major Canadian military hospital.
- Section Senior at NDMC.
- Training Officer for Physical Therapy technicians, physical therapy interns and students.

THIRD DEVELOPMENT PERIOD - LEVEL 1

Rank: Major
Occupational Employment:
- Head of Physical Therapy Division at NDMC.

It is instructive to note that in the occupational progression of a CAF physiotherapist, each level of rank and development period involves working at a major Canadian military hospital or at a base hospital or a clinic.

The physiotherapist OS also set out the duties/tasks, skills and knowledge that a physiotherapist must have. It is not necessary to reproduce the OS here. For the purposes of this case, it is relevant to know that physiotherapists must provide physiotherapy services to medical operations and must be skilled in providing such services under all types of environmental conditions, not just in a hospital or clinical setting. In this respect, they must have a basic knowledge of the principles in the various levels and echelons of medical support, the role and capabilities of third and fourth line medical units including the Field Hospital and Convalescent Centres, the role and capabilities of

the Field Ambulance including the patient evacuation system and the role of static medical facilities during mobilization.

Of importance is the requirement that a physiotherapist is required to provide physical therapy during NBCW defence operations and must be skilled in responding to an NBCW emergency. They must have a basic knowledge of casualty handling techniques in such an environment and of NBC decontamination of personnel and equipment.

Finally, a physiotherapist must be able to provide physical



therapy services during disaster situations, must be semi-skilled in responding to a disaster and must have a basic knowledge of hospital disaster planning, nuclear emergency response in a medical facility and detailed knowledge of the physical therapy role in the implementation of the disaster plan.

c) Doctrine of Unlimited Liability

Lieutenant Commander Kenneth Lait of the Directorate of the Force Structure, testified as to the role of the CAF. According to Comdr. Lait, the first priority or primary role of the CAF is the protection of Canada and Canadian national interests at home and abroad. This role includes the defence, sovereignty and civil responsibilities in Canada. The second priority is collective defence arrangements through NATO including continental defence partnership with the United States; and the third role is the CAF support to international peace and security through stability and peacekeeping operations, arms control verification and humanitarian assistance.

Commander Lait referred the Tribunal to section 33(1) of the National Defence Act which codifies the CAF policy of unlimited liability. It provides as follows:
The regular force, all units and other elements thereof and all officers and non-commissioned members thereof are at all times liable to perform any lawful duty.

However, although, every member of the CAF is liable to perform any lawful duty, it is uncommon for health care professionals to perform duties other than their occupational duties. With respect to non occupational duties, this would usually arise in respect of internal duties in Canada such as medevacs or disaster

relief or similar type of emergencies. An example would be the recent Barrie tornado whereby relief assistance was provided by military personnel who were taking courses at Camp Borden at the time. CAF personnel were involved in a number of what could be called non-occupational activities.

Commander Lait was questioned as to the likelihood of a physiotherapist being sent to a war type situation . His response was that since World War II, the CAF has been involved in two military operations as contrasted with peacekeeping, in Korea and in the Gulf war. The CAF, however, has been involved in a number of United Nations international peacekeeping operations over the years. These operations and the participation of the CAF in terms of the CAF contribution and the MOC's involved are detailed in a document submitted in evidence entitled "Aide-Memoire, International Peacekeeping Operations 1947-1991". An examination of this document shows that in this period, there were thirty U.N. peacekeeping operations in which Canada was involved. The Canadian contribution included observers, signals engineers, military police, liaison officers,



etc. No physiotherapist was involved in these peacekeeping operations.

Commander Lait does not know of any situation where a CAF physiotherapist was required to serve on the frontline in a combat situation and it is highly unlikely that this would ever happen.

Brigadier General W. B. Vernon, Chief of Staff, Operations, gave evidence for the Respondents. He has been an Infantry Officer in the CAF since 1965 and before that was a member of the militia. His experience has been primarily commanding field units or as an operational staff officer.

Gen. Vernon made the point that it is an article of faith of the CAF that every member of the CAF is a soldier first and a tradesman second. There is a basic level of performance that requires from every member of the CAF to have basic combat skills. However, the CAF does not train every member with the same frequency and degree or with the same skills because of limitations of money and time. Rather, the CAF seeks to achieve a balance between the soldier needs and the specialty needs. If a CAF member is on the support side, not in combat battalion, as

is the case with 50% of the CAF, they should be performing their primary responsibilities not practising combat skills. Thus, training is based on the requirement for operational readiness depending on the unit to which a member is posted.

He also reinforced the concept of the unlimited liability of a member of the CAF, namely that when you put on the uniform and swear the oath whatever happens up to and including death is a logical consequence of that. The result is that anyone is liable to go anywhere when required by the CAF. No one is given a choice. You go where you are sent, either because your unit has been selected or as an individual augmentee or reinforcement.

Gen. Vernon was questioned as to the predictability of the Field Hospital deploying elsewhere than in Canada. His reply was that, in terms of U.N. peacekeeping operations, the CAF has at the moment a very good reputation for providing combat engineers with the result that the U.N. consistently asks Canada for these personnel. Prior to that, the CAF provided headquarters and signal squadrons and logistic units. Over the years, the CAF has varied the type of units that have been sent to the various U.N. missions. In Cyprus, they are mainly infantry units, but there have been artillery and armoured units serving there as well. Today, the demand is for combat troops, headquarters personnel, engineers and some specialists. In terms of predictability, the CAF has about 30% control over the type of troops that are sent on U.N. missions. The rest of the decision making lies with the Canadian government and the U.N. and depends upon its requirements and the needs and the ability of countries to meet



them. All of this gives a degree of unpredictability to the whole process.

As to whether in the foreseeable future, it is likely that in fulfilling its obligations to the U.N., Canada will deploy a field hospital which will include one or two physiotherapists, Gen. Vernon's response was that at the present time, the Army has a contingency plan which requires that the CAF develop and deploy a substantial number of troops overseas. This plan envisages a unit called the Canadian Support Group which has a strong medical component.

Having said that, Gen. Vernon went on to say the CAF has no intention in the near future of deploying the Field Hospital

overseas. He could not offer any guarantee that the Field Hospital would be exempt from deployment overseas in an area of danger in the near future. On the other hand, he could not say that it would not occur.

Major Robert Moneypenny, Commander of the First Canadian Field Hospital, also stated that there is no simple answer to the question of the probability whether a physiotherapist would be deployed in a wartime situation. Rather, the answer to the question is that it depends on the mission. It is relevant to understand the process by which augmentees, including physiotherapists, are chosen for the Field Hospital.

First of all, the First Canadian Field Hospital is not a doctrinal concept and does not yet exist. The Field Hospital that was sent to the Gulf War as part of the Canadian contribution was not a field hospital but rather, according to Maj. Moneypenny, the Commander of the Field Hospital, a forward surgical hospital. At the present time, the CAF is in the process of planning for and acquiring the resources for a full field hospital.

A full field hospital has the capability of deploying 140 beds and 11 operating rooms. It also can deploy advanced surgical centres which can respond more quickly and get to a location before the remainder of the unit can get there. The field hospital is virtually a 100% mobile and self-sufficient and can be deployed anywhere in the world. There are two physiotherapists within the establishment of the unit and two medical assistants that work as physio assistants with the physiotherapist. It can be deployed in humanitarian operations or in aid of the civil power or provincial or federal authorities anywhere in Canada. It is also available for peacekeeping and can go anywhere that the United Nations may wish to have a field hospital set up.

Major Moneypenny described the process of staffing the Field Hospital by reference to Rendez-vous '92, an extensive training exercise held at Wainwright every 2 to 3 years. The mission for



the Canadian Field Hospital was to provide third line support including emergency surgery, X-ray services, limited laboratory services and requirement to hold people so that a 20 to 40 bed ward was required. Once the mission was defined, a medical plan

had to be devised and the service support elements and the administrative resources to support the medical plan then had to be determined.

Once the medical, administrative and other support services were determined and the number of persons and specific MOC's required, the augmentees are selected, brought together, their training begins.

Each member of the medical unit is trained to the same standard of individual training, their personal weapon skills are reviewed and they are required to qualify on the weapon required for their rank. They also receive refresher training for NBCW.

After all are brought up to the same level of soldierly skills, they engage in sub-unit training in their specialty in the Field Hospital. For example, the physiotherapist would be trained as to how the physiotherapy section works; the pharmacist as to how the pharmacy works, the nurses the same procedure. Finally, all of the medical personnel would come together for collective training by unit to understand how the Hospital unit works as a whole.

The same planning and organization was done with respect to Canadian medical participation in the Gulf. There was no physiotherapist in the CAF contingent sent to the Gulf. This was because the Canadian medical contribution was a forward surgical hospital that was sent to the Gulf as part of the British Forces, Middle East. The Force "holding policy" and the mission precluded a forward surgical hospital holding for more than 48 hours. Within the 48 hour holding policy, it was only possible to evacuate a wounded soldier and do whatever surgery was necessary to keep the person alive. In the 48 hour phase, there was no requirement for a physiotherapist.



d) CAF Medical Support System in the Field

Evidence on this was given by both Major Moneypenny and Colonel R.J. Hotchin, a Health Care Administrator in the CAF. The Medical Support System is divided into four lines which are successive in nature and the system become more complicated as they go further back. The concept of "lines" of medical support is really a doctrinal term and does not refer to a linear line.

The first line is closest to the battlefront and refers to a medical unit that is self supportable. It consists typically of a medical officer, medical assistants, and stretcher bearers. The main function is to locate and rescue wounded and apply life saving measures to keep them alive long enough to move them to the rear, but not to hold casualties or treat them beyond battlefield first aid.

The second line is primarily concerned with evacuation and provides a rudimentary form of triage. It has a number of field ambulances, and the main function is to make sure that patients can be evacuated to the first point where they can undergo initial surgery which occurs at the third line.

The key is the field hospital, a medical facilities that is field deployed as compared to a purpose built medical structure. It is usually under canvas and has the medical capacity to adequately treat the wounded. Initial surgery is the essence of the third line medical support which has two main units, a forward surgical hospital which is 100% mobile to keep up with the battle and which performs primarily life saving surgery. Slightly further back from the forward surgical hospital is the field hospital which can perform all of the surgical functions of the forward hospital but has a greater medical capacity and surgical capacity and the ability to hold patients for a period of time.

Evacuation is from the field hospital to the fourth line which is normally a civilian type of hospital having complete, definitive care facilities.

A forward surgical hospital usually consists of about 60 beds, a field hospital may range from 100 to 500 beds and a fourth line hospital could have as many as a thousand beds.

Physiotherapists are assigned to the third line in the field hospital. Normally, they are not found in the forward surgical unit. They have two main functions in the field hospital, a clinical function which includes alleviating pain and suffering, triaging, assisting in pre-surgery to better prepare the injured for surgery at the field hospital and in post-surgery, to provide for a better possibility of recovery when they go back to the fourth line.

The second main function as relates to physiotherapist treatment to enable the less seriously injured to return to active duty.

In today's warfare, the battlefield and the areas around it are not neat and tidy arrangements. It is only under conditions of positional warfare that a field hospital would have the sort of relative surety that it would be separate from the battle and protected from it. In fact, today's warfare is more fluid and there is a great deal more movement than just two opposing lines moving back and forth.

The effect is to put in danger medical organizations that would normally be protected and to the rear of the battle. Now, they could be vulnerable to ground action, air attack or artillery or NBCW attack. Further, although under the Geneva Convention medical facilities are protected, often medical facilities are close to other installations such as ammunition dumps, fixed communication sites and fuel supplies which are legitimate targets. This presents considerable danger for medical installations having this close proximity to these other installations.

e) Experiences of Michelle Lott - CAF Physiotherapist

Michelle Lott, currently a practising physiotherapist in a private clinic in New Brunswick, gave evidence on behalf of the Commission. Prior to that, she was a physiotherapist for five years in the CAF. Ms. Lott was selected for the ROTP training in February, 1983. At that time, her visual category was V3 which changed to V4 during her time in the CAF. Ms. Lott wears glasses and needs to wear glasses to perform normal functions.

Ms. Lott did her basic training program at Chilliwack in the summer of 1983. During basic training, she wore her glasses continuously and did not experience any difficulties except that during the NBCW training she had to remove her glasses because they did not fit under the gas mask. The only other occasion that she could recall having to remove her glasses was when she was involved in repelling training. She removed her glasses as a preventative measure to prevent breakage.

During basic training, she had second pair of glasses which were provided by the military. She understood the policy of the military is to provide two pairs of glasses for those members who wear corrective lenses. There were other officer candidates with her during her basic training who also wore glasses or other

visual aides and she does not recall any of them experiencing any problems during the basic training. She completed her basic training successfully as did other in the basic training course who wore glasses.

During her five years in the CAF, Ms. Lott worked as a



physiotherapist either in a CAF hospital or clinic setting. On only one occasion did she work outside of a hospital setting when in September, 1986, she went with the Canadian medical group to Norway and was there for about five weeks providing medical care to other units of the CAF engaged in training exercises.

During that time, she provided physiotherapy treatment to soldiers who were injured during the training exercises. The physiotherapy services were provided in the field hospital which was located back from the training "battlefield".

During these exercises, when she provided physiotherapy services, she wore her glasses and did not have any difficulty performing her duties.

The type of treatment that Ms. Lott gave in the field was similar to the type of treatment and therapy she provided in the civilian setting. It included treatment for musculo skeletal conditions, treatment for pain relief, muscle education, etc. The main function of a physiotherapist during these exercises was to provide treatment necessary to enable the injured to return to their units and participate in the training exercises if possible.

The conditions that Ms. Lott experienced working as a physiotherapist in Norway at this training exercises did not simulate wartime conditions and in fact, the conditions were quite comfortable. They were not under attack by any automatic weapons or rockets or concerned with chemical, biological or nuclear weapon attack. In her time in the CAF, she never was in this type of "wartime" situation and was not able to comment as to her ability under these conditions to function as a physiotherapist who wears glasses.

Ms. Lott did not wear contact lenses during basic training because she did not feel there was sufficient time to insert her contacts and carry out her other tasks within the time available

in the morning. She also stated that there was not adequate sterile facilities to care for her contact lenses when she was involved in field exercises.

When Ms. Lott left the CAF, she was a Captain. In addition to her duties as a physiotherapist, she had to perform the regular duties of a military officer which included acting from time to time as the base duty officer. The only other non-occupational duty that she had to fulfil as a military officer was acting as the hospital administrative officer when she was serving in Halifax. This was an on-call position for a week at a time.



Essentially, her work as a physiotherapist in the military involved dealing with orthopaedic and musculo skeletal conditions. Treatment normally involved with either some form of electrical modality, muscle re-education or manual therapy. If she had been involved in a war situation, as a physiotherapist, the treatment she would have provided would have been more extensive.

f) Experiences of a U.S. Military Physiotherapist in the Gulf War

Lieutenant Lisa Depasquale is a physiotherapist with the United States Navy who was assigned as part of the Navy fleet hospital that went to the Gulf. Her evidence was directed to the difficulties and experiences that a military physiotherapist would have in a wartime conditions. A fleet hospital is similar to a field hospital, it operates on land, is flexible and can be taken up and moved from point to point. It is designed primarily to provide medical support for the Marine Corps.

As a physiotherapist, her normal duties consisted of treating various types of injuries including shoulder, leg & arm sprains, closed head injuries, spinal cord injuries, wound care, burn care and sports type injuries.

While in the Gulf, prior to war starting, she treated similar types of injuries plus blast injuries, burns, snake bites and a number of minor wounds resulting from fuel and trash burning. In the Gulf, she also served as a surgical assistant in the operating room and as a triage officer once the actual ground conflict began.

The objective was to treat the injured and return as many to their units as possible. Lt. Depasquale and two physiotherapist technicians treated 4658 patients during their deployment. The majority of the sports type injuries were sent back to their units, the more serious injured were returned home.

Lt. Depasquale wears glasses. Her refractive error is -1.75 dioptres in her right eye and -2.75 dioptres in the left eye or 20/100 and 20/150. She does wear contact lenses from time to time and has been a contact wearer for the last five years.

She went to the Gulf on September 1, 1990. She took three pairs of glasses and also a gas mask insert. The insert is for the gas mask which forms part of the MOP suit which is the U.S. military equivalent of the CAF NBCW suit. U.S. military personnel were prohibited from wearing contact lenses in the Gulf because of the risk of eye infections resulting from environmental conditions.

The first task that Lt. Depasquale faced on arrival was to complete the construction of the fleet hospital. The core of the



hospital, a 38 unit tent sections each 300 feet long, had been constructed by an advance party and the rest of the hospital was constructed by the additional staff that made up the fleet hospital. All medical personnel including doctors, physiotherapist, participated in the erection of the hospital.

It took approximately 12 days to complete the erection of the hospital. The environmental conditions which prevailed when the hospital was erected consisted of very hot weather with strong winds and blowing sand. These hot and windy conditions persisted throughout the six months she was in the Gulf. Because of limited water and sanitary facilities, it was very difficult to maintain sterile conditions or even wash her hands as much as she wanted.

Lt. Depasquale was involved as was everybody else associated with the fleet hospital, not only in the construction of the fleet hospital but also in filling sand-bags and building trenches. During the course of doing this work, she broke and ultimately lost or had to discard all of the glasses that she brought with her. She was unable to replace her glasses and spent the latter part of her time in the Gulf without visual correction. She

could see close-up, but had difficulty recognizing people 60 -70 yards away.

According to her observations, others experienced similar problems with their glasses either losing or breaking them although some people were able to deal with the problem because they came with four or five pairs of glasses. She did notice that although there was an order not to wear contact lenses, some people wore soft contacts and when the wind got to be more of an issue, they experienced eye infections and were not able to wear them.

In describing the environmental conditions, Lt. Depasquale pointed out that there were two oil refineries very close to the field hospital. The fuel had been burnt off and the products were thick in the air. This had a very irritating effect on her eyes. Because of these conditions, the heat, the wind and the blowing sand, she never considered wearing contact lenses during her stay in the Gulf.

During the military build up prior to the commencement of the war or military hostilities, the most common injuries were sports type injuries and a few blast injuries. Once the hostilities began, there was numerous alerts and always the potential for chemical attacks which required the hospital staff to wear their gas masks and suits frequently. The gas mask insert that was provided to the U.S. military was essentially non-functional because it would not stay in position inside the mask. All of her colleagues had similar experiences with the inserts. The result was that Lt. Depasquale essentially functioned in this situation without visual correction.



In the event of a missile alert, the procedure was to go to a protective bunker which was surrounded by sandbags and which were located around the hospital compound and some yards away. The bunkers could be easily found during daylight but at night, they were very difficult to locate. If there was an alert, the first thing she would do was to put on her gas-mask within 8 seconds and then her MOP suit and find her way to the bunker. She recalled one occasion when one of her colleagues who wore glasses, panicked during a chemical alert, became confused and ultimately found the protective bunker but the wrong one.

Her point was that there are major differences between working in peace-time conditions and during war time. One is the availability of supplies and a sterile environment. Another is maintaining a constant state of readiness and at times working under conditions of NBC warfare. A third difference is the nature of the wounds, there are many more blast and burn type injuries than in peacetime. A fourth difference is the imminent threat of danger.

Finally, in wartime, there is a much greater interdependence among medical staff. Each individual must be able to carry their own weight as Lt. Depasquale put it. Otherwise they become a liability. If a colleague who wore glasses could not function effectively without them, Lt. Depasquale would not want that person as part of her unit because of the safety implications for that individual and the others in the unit and their patients.

In cross-examination, Lt. Depasquale said that there were about 750 people working in the fleet hospital and she would say that the greater majority of them wore glasses. She also stated that although they were ordered not to wear contact lenses, some people did nonetheless, and at least two of her tent mates wore contact lenses. She also agreed that the mask inserts provided by the U.S. Military were quite different from the combat glasses supplied by the CAF in that they were not customized or fitted for each individual wearer.

Lt. Depasquale also pointed out that there were several people who suffered eye irritations as a result of the environmental conditions and also because of having to wash with water that wasn't sterile.

g) Waiver of the Common Enrolment Standard

Captain De Bellefeuille was questioned by Commission as to whether the CAF could waive the common enrolment visual standard. While he agreed that the CAF does have a waiver policy, he was careful to distinguish between the medical category for an MOC and the minimum common enrolment standard. There can be a waiver of the common enrolment standard but only if the MOC standard is lower. With regard to the vision standard, there are no



occupations in the CAF that have a lower vision standard than V4. So when one talks of waivers at the recruit level, they are

talking of waiving the minimum common enrolment standard to a lower level than that standard but no lower than the MOC standard.

This evidence is confirmed by reference to the document entitled "Medical Standards for the Canadian Forces" a part of which was submitted as an exhibit by Commission Counsel. Chapter 3, "Interpretation of the Medical Standards", paragraph 1 provides: Common Enrolment Standard

1. A certain standard is required of recruits so that they may be eligible for the widest selection of trades. To take the highest common denominator would be too restrictive and to take the lowest common denominator would be to accept too many recruits with employment limitations. As it is the aim to keep the medical standards of the CAF high and it is inevitable that the category of many serving personnel will be lowered during their career, it is required that we demand a high medical standard of our recruits. For these reasons a minimal medical category for enrolment in the Canadian Forces shall be:

| V | CV | H | G | O | A |
|---|---|---|---|---|---|
| 4 | 3 | 2 | 2 | 2 | 5 |

This is the common enrolment standard. Applicants for enrolment must meet at least this standard. If the trade into which they are being enroled requires a higher standard, then they also meet the standard.

2. Certain applicants for the Canadian Forces may possess special qualifications, such as experience and skill in a trade or professional qualifications, which make their enrolment desirable. Under such circumstances administrative authority may waive the common enrolment standard and the medical category shown at Annex D will apply for the employment for which they are being considered.

5. A grading of V6, G6 or O6 means the member is medically unfit for the Service and a recommendation for his release should be made. Release under QR & O item 15.01(3) (q) may only be approved by the Surgeon General/DMTS.

6. When the grading falls below that stated in Annex D for his trade, but not to the low level in para. 5, then the effect upon his military career of a member's



employment limitation becomes a personnel administrative problem to be dealt with by a Career Medical Review Board.

Reference to Annex D of the Medical Standards confirm that there is no MOC that has a visual category lower than V4.

As can be seen from paragraph 1 of the Medical Standards, the CAF has a six digit medical standard profile for enrolment, V CV H G O A. The minimum common enrolment standard is 4 3 2 2 2 5. According to Capt. De Bellefeuille, the two standards for which waivers are most frequently given are the G and O factor.

An example would be, an aviation mechanic who works for a private aircraft company and who meets all the enrolment criteria that he is a G3. It may be that because of his specialized training, it would be very desirable to enrol him in the CAF providing that the CAF is not denying any other Canadian within Canada an opportunity of filling the position. In these circumstances, the CAF would certainly consider a waiver of the enrolment standard.

Capt. De Bellefeuille also distinguished between applicants to the CAF and serving members. If a serving member falls below the medical profile for the MOC, it becomes a matter not for waiver but review by the Career Medical Review Board (CMRB) which considers the individual's performance over the years and decides whether that member can remain within the occupation even though there may be limitations on his/her ability to perform the duties required. Although called an "in-service waiver", it is not a waiver. Rather, it is a CMRB decision to continue to employ someone whose medical profile is below that for the MOC.



## IV. APPLICABLE LEGAL PRINCIPLES

a) The Complaint and the Defence

Hebert alleges that the DND and the CAF have discriminated against her by refusing to employ her because of her disability contrary to sections 7 and 10 of the CHRA. Section 7 provides:

It is a discriminatory practice, directly or indirectly,

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

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

Section 10 of the CHRA provides:

It is discriminatory practice for an employer, employee organization or organization of employers

(a) to establish or pursue a policy or practice, or

(b) to enter into an agreement affecting recruitment, referral, hiring, promotion, training, apprenticeship, transfer or any other matter relating to employment or prospective employment,
that deprives or tends to deprive an individual or class of individuals of any employment opportunities on a prohibited ground of discrimination.

Under section 3(1) of the CHRA, disability is a prohibited ground of discrimination.

The Respondents do not dispute that Hebert's visual refractive error is a disability within the Act, nor did they dispute that the refusal of the CAF to further process her application for enrolment in the CAF amounts to prima facie discrimination on a prohibited ground under the CHRA. Rather, the Respondents contend that Hebert was not accepted into the CAF because she failed to meet the minimum common enrolment medical standards which are a legitimate and justifiable basis for deciding who shall be enroled in the CAF. Thus the Respondents' evidence and argument was directed to showing that the common enrolment visual standard constitutes a bona fide occupational requirement ("BFOR") within section 15(a) of the CHRA. Section 15(a) which provides that:

It is not a discriminatory practice if

(a) any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is established by an employer to be based on a bona fide occupational requirement



b) Interpretive Principles

We begin by reference to section 2 of the CHRC which sets out the legislative purpose of the Act and provides in part:

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

We must be also mindful of the interpretive principle enunciated many times by the Supreme Court that the CHRA is legislation that is special or indeed, quasi-constitutional and human rights must be interpreted in a broad and liberal fashion to achieve the elimination of discriminatory practises: Winnipeg School Division No.1 v. Craton, [1985] 2 S.C.R. 150, 156; O'Malley v. Simpson-Sears, [1985] 2 S.C.R. 536, 547; C.N. v. Canada [1987] 1 S.C.R. 1114, 1134-1136; Robichaud v. Canada [1987] 2 S.C.R. 84, 92; R v. Mercure [1988] 1 S.C.R. 234, 268.

The corollary of this principle is to necessarily give a restrictive interpretation to the exceptions provided in anti-discrimination laws. As the Supreme Court put it in Brossard (Ville) v. Quebec, (1988) 10 CH. R.R. D/5515; 2 S.C.R. 279, bona fide occupational qualification exceptions in human rights legislation, should, in principle, be interpreted restrictively since they take away rights which otherwise benefit from a liberal interpretation.

Once a prima facie case of discrimination is made out, the onus to show a BFOR shifts to the employer. The burden of proof is the ordinary civil standard of the balance of probabilities: Etobicoke, Supra para. D/783.

c) The BFOR Defence

The applicable legal principles relating to a BFOR have been considered in numerous Human Rights Tribunal, Federal Court of Appeal and Supreme Court of Canada decisions: in the latter Court, starting with Ontario Human Rights Commission v. Etobicoke, [1982] 1 S.C.R. 202 and leading up to the latest Supreme Court decision in Central Alberta Dairy Pool v. Alberta Human Rights Commission, [1990] 12 CH. R.R. D/417; [1990] 2 S.C.R. 489.

It is the Etobicoke decision which first considered the BFOR and is the starting point for our analysis. It was in the context of a human rights challenge to mandatory retirement age for fire fighters that McIntyre J., writing for the Supreme Court first

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enunciated the BFOR test as having both a subjective and objective element:

> To be a bona fide occupational qualification and requirement a limitation, such as a mandatory retirement at a fixed age, must be imposed honestly, in good faith, and in the sincerely held belief that such limitation is imposed in the interests of the adequate performance of the work involved with all reasonable dispatch, safety and economy, and not for ulterior extraneous reasons aimed at objectives which could defeat the purpose of the Code. In addition it must be related in an objective sense to the performance of the employment concerned, in that it is reasonably necessary to assure the efficient and economical performance of the job without endangering the employee, his fellow employees and the general public. (at p. D/783).

No evidence was called or argument made that the visual acuity enrolment standards are imposed by the CAF other than honestly and in good faith. This is not an issue in this case.

Thus, it is the second or objective branch of the Etobicoke test that engages this Tribunal. The employer must prove "reasonable necessity" by evidence based on hard facts not generalizations or mere impressions. When doing so, the employer must also consider the nature of the employment and whether or not it involves a "safety risk". As McIntyre J. said in Etobicoke:

"Faced with the uncertainty of the aging process an employer has, it seems to me, two alternatives. He may establish a retirement age at sixty-five or over, in which case he would escape the charge of discrimination on the basis of age under the Code. On the other hand, he may, in certain types of employment, particularly in those affecting public safety such as that of airline pilots, train and bus drivers, police and firemen, consider that the risk of unpredictable individual human failure involved in continuing all employees to age sixty-five may be such that an arbitrary retirement age may be justified for application to all employees.

In an occupation where, as in the case at bar, the employer seeks to justify the retirement in the interests of public safety, to decide whether a bona fide occupational qualification and requirement has been shown the board of inquiry and the court must consider whether the evidence adduced justifies the conclusion that there is sufficient risk of employee failure in those over the mandatory retirement age to



warrant the early retirement in the interests of safety of the employee, his fellow employees and the public at large. (at p. D/783-784)

The Respondents' case is that there is a need for an occupational requirement consisting of a blanket exclusion for all those who can not meet the visual acuity standard. The reason for such a blanket exclusion, simply put, is that this group of persons presents a "sufficient risk of employee failure" with all of its attendant consequences. This Tribunal is therefore obliged to consider whether the Respondents have established, through hard evidence, that the common visual enrolment standard is reasonably necessary because of the safety risk.

d) Safety Risk and BFOR

The concept of risk in the context of a BFOR defence has a been considered in a number of cases since Etobicoke. In Air Canada v. Carson, (1985), 5 C.H.R. D/2848 (F.C.A.), the Court was presented with the argument that it was enough, to establish a BFOR, to show a minimal increase in risk of harm. The Court rejected this proposition and stated that:

"there is a significant difference between "a minimal increase in risk of harm" and a "minimally acceptable risk of harm" because the latter implies a measure of acceptability of risk that the former does not..."

An examination of the cases cited by McIntyre, J. thus makes it clear that he did not intend by his reference to give approval to a particular measure of risk. Nevertheless, his own posing of the issue in terms of whether there is "sufficient risk of employee failure" indicates a recognition of a certain degree of risk that sits better with the notion of "acceptable" than with that of "minimal". (at p. D/2854)

The Federal Court of Appeal moved away from this interpretation in C.P.R. v. Mahon, (1987) 8 C.H.R.R. D/4263. The Court in this case concluded that to establish "sufficient risk of employee failure":

...the evidence must be sufficient to show that the risk is real and not based on mere speculation. In other words, the "sufficiency" contemplated refers to the reality of the risk not its degree"... (at p. D/4268)

For some time after the Mahon decision, it was thought that if an employer could show that employing a particular individual would result in an increased safety risk, that was sufficient to establish a BFOR whether or not the increased risk was marginal



or significant.

In our view, Mahon is no longer the law. Recent Tribunal and Court decisions support our conclusion. In Central Alberta Dairy Pool, supra, the Supreme Court in revisiting the correctness of its decision in CNR v. Bhinder, [1985] 2 S.C.R. 561, concluded that the Court erred in concluding that the occupational requirement in Bhinder (wearing a hard hat) was a BFOR. This is because the facts as found by the Tribunal were that the failure to wear a hard hat would increase the risk but only marginally.

The Supreme Court went on to say:

"In light of the findings of fact by the Tribunal, I think it is difficult to support the conclusion of the majority of the Court that the hard hat rule was reasonably necessary for the safety of Mr. Bhinder, his fellow employees and the general public." (at p. D/432)

Further support for our conclusion is found in the recent decision of the Federal Court of Appeal in Attorney General of Canada v. Rosin, [1991] 1 F.C. 391, (FCA), Linden J., dealing with the question of risk said:

"A second complaint of the applicant is that if any degree of risk is proven, however small, a BFOR is established. I have already indicated that the Tribunal was not satisfied by the evidence that there was any increased risk. Hence, it is not necessary to deal with this issue. If it were, one would have to take into account the Central Alberta Dairy Pool case, where Madam Justice Wilson indicated that the Bhinder case may have been incorrectly decided on the basis that the increased risk there was only marginal, and hence, may not have sufficient to support the BFOR defence. (at p. 411)

The Tribunal in Robinson v. The Canadian Armed Forces, (1992) 15 C.H.R.R. D/95 and in Thwaites v. Canadian Armed Forces, Decision T.D. 9/93 rendered June 7, 1993, have come to the same conclusion, namely that proof of a slight or negligible increase in risk is not sufficient for a BFOR. The increased risk must substantial.

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Indeed, this interpretation harmonizes with section 2 of the CHRA and was well put by the Tribunal in Thwaites, when it said:

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

heightened risk but within acceptable limits." (at p.32)

How to Measure a Substantial Increase in Risk

When does an increased risk amount to a substantial risk. Can it be measured on a quantitative basis as a percentage. Is a 5% increase significant; is a 20% increase significant. We are not aware of any Tribunal or Court decisions that have addressed this question other than Thwaites. We consider the analysis in Thwaites to be an excellent starting point and we propose to apply this analysis in our decision.

In Thwaites, the Tribunal rejected the percentage approach because of the difficulty of deciding what is significant particularly when the percentages are low.

Rather, the Tribunal suggested that:

"Significant risk can best be measured in the context of the particular job and then only in comparison with other risks posed by that workplace. In this way, other tolerable risks arising from the employment establish risk thresholds. If risks of comparable magnitude are acceptable in a particular work environment then risks posed by a person [who is HIV positive] cannot be considered significant. By utilizing a comparative risk analysis, there is recognition that employers cannot expect a completely risk free work environment. Instead, the standard of significant risk seeks to eliminate those risks that pose a significant or substantial threat to health and safety. In any particular situation, one must determine when risks are deemed significant and thus unacceptable by identifying the nature and quantum of other risks that are tolerated as acceptable in that particular work environment. By applying a comparative risk analysis, one can best determine if the risk is substantial. (See generally S.D. Watson, "Eliminating Fear Through Comparative Risk" Docs, AIDS and the Anti-Discrimination Ideal" 91992) Buffalo L. Rev. 738)" (at p.34).



e) Evidence of Increased Risk

The minimum visual enrolment standard acceptable to the Respondents is V4. As V4 is a standard that allows less than normal vision, it is clear that the Respondents are willing to accept some risk of employee failure and the acceptable level of risk is ±7 dioptres. The question therefore is whether Hebert presents a substantial increase or even an increase in the level of risk accepted by the Respondents in formulating its enrolment standards.

What this Tribunal observed when viewing the slides presented by Dr. Sheedy, is that there is little or no distinction between -7 dioptres and -8 dioptres in terms of being able to distinguish between objects and spatial relationships at a distance of 20ft. In fact, this evidence demonstrates that it is very difficult to make any meaningful visual distinctions until one approaches -4 dioptres and it is only at -3 dioptres that objects clearly come into focus. As we understand the evidence, -3 dioptres would equate to at least a V3 and perhaps a V2 on the Table of Visual Standards.

We should also point out that Dr. Delpero agreed that there is very little difference to the visual acuity of a person with a refractive error of -7 dioptres and -8 dioptres. He did qualify his answer however, by saying that there is a significant difference in these two levels of refractive error in that higher levels of myopia are associated with higher incidents of various ocular pathologies. While this may be valid as a generalization, there is no evidence to suggest that Hebert was either suffering from any ocular disease as a result of her high myopia or was likely to in the near future.

Also relevant to this question is the evidence of Dr. Sheedy relating to the "International Classification of Diseases, (9th ed. (ICD-9)". Table 3 of ICD-9 "Classifications of Levels of Impairment by Visual Acuity", classifies visual acuity on a best corrected acuity. At a best corrected level of 20/25, Hebert would be classified as near normal vision under their Table. However, Dr. Sheedy used this Table to emphasize the degree of Hebert's visual impairment, uncorrected. According to Table 3, Hebert would be classified as "near total visual impairment, severe blindness". This Table classifies a person with a refractive error of -7 dioptres as having "moderate blindness, profound visual impairment."

That the Respondents are willing to admit into the CAF a person whose vision uncorrected is only marginally better than Hebert's,

belies the argument that there is a need for an uncorrected vision standard for a physiotherapist. It must be either this conclusion or the conclusion that Hebert's refractive error at -8



dioptres would not be a substantial increase or even an increase in the level of risk that the Respondents consider acceptable. We therefore conclude that the Respondents have failed to establish that the V4 uncorrected standard as it applies to the physiotherapist MOC is reasonably necessary.

However, we do not base our conclusions on this reasoning alone. In order for the Respondents to justify the visual acuity standard, they must demonstrate that there is a real as opposed to a possible risk of a CAF physiotherapist losing their corrective lenses and being unable to function effectively. According to the occupational specifications, in the occupational progression of a CAF physiotherapist, each level of rank and development period involves working at a major Canadian military hospital or at a base hospital or clinic. The evidence of Michelle Lott, who served as a physiotherapist in the CAF for five years, was that, as a physiotherapist, she worked only in a hospital setting, except for one occasion when she accompanied the Canadian Field Hospital to Norway for a period of five weeks, during which the Field Hospital supported combat units of the CAF engaged in training exercises.

During that time, the Field Hospital itself was not involved in any training exercises and was located well back from the training battlefield. The only non-occupational duties that she fulfilled as a military officer were acting from time to time as the base duty officer or as the hospital administrative officer when she was serving in Halifax. This was an on-call position for a week at a time.

The Respondents say that the doctrine of unlimited liability applies equally to a military physiotherapist as to other members of the CAF. This means that any member of the CAF is liable to go anywhere when required by the CAF. No one is given a choice. As General Vernon put it, you go where you are sent either because your unit has been selected or as an individual augmentee or reinforcement.

The most likely posting of a physiotherapist outside of Canada would be as an augmentee with the Canadian Field Hospital when it

is deployed. Major Moneypenny described the process by which the Field Hospital is staffed and pointed out that every physiotherapist in the pool of 25 physiotherapist in the CAF is liable and eligible to be chosen to be deployed with the Field Hospital.

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The Respondents' point to the experiences of Lieutenant Depasquale, a physiotherapist in the U.S. Military, who graphically described her experiences as a physiotherapist during the Gulf War. She encountered adverse environmental conditions such as intense heat, blowing sand, contaminants in the air and lack of sterile washing facilities. In addition, she was required to participate in heavy physical work during which she lost or broke three pairs of glasses and was constantly subjected to the threat of biological and chemical warfare attack.

The Respondents also rely on the evidence of Warrant Officer Humby and Major Moneypenny, who described the difficulties of wearing glasses under the NBCW mask. In the case of Major Moneypenny, the only witness at this hearing who actually was sent to the Gulf, he chose not to wear any glasses under this mask because of the difficulties he encountered putting on his mask quickly and maintaining his glasses in the proper position on his face under the mask.

There was further evidence that both the CAF and the American military prohibited the wearing of contact lenses when serving in the Gulf because of the environmental conditions and the risk of eye infections or irritations.

The evidence clearly establishes that Hebert, given her refractive error of -8 dioptres would have much difficulty functioning as a physiotherapist if she was unable to wear her contact lenses or lost them and was unable to replace them.

But what is the likelihood of Hebert finding herself in the same situation as Lieutenant Depasquale. According to Commander Lait, during the period 1947 to 1991, there were thirty United Nations peace-keeping operations in which Canada was involved. No physiotherapist was involved in any of these operations. Major Moneypenny, the Commander of the Canadian Field Hospital, testified that although Canada provided a forward surgical hospital in the Gulf War, no physiotherapist was deployed with the Field Hospital. Major Moneypenny also stated that there is

no simple answer to the question of whether a CAF physiotherapist would be deployed in a wartime situation and it depended upon the nature of the mission and the needs of the mission. In the case of the Gulf War, because of the Forces' "forty-eight hour holding policy", there was no requirement for a physiotherapist to go with the Field Hospital which was a forward surgical hospital.

General Vernon, in responding to the question of the predictability of the Field Hospital deploying elsewhere than in Canada, was unable to guarantee that it would not happen or say that it would occur.

CAF physiotherapists are always liable to be deployed to a hostile environment and in such circumstances, there is risk that they will be in a position where they will be required to function in the absence of corrective lenses.

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But so many things have to happen: the Field Hospital must be deployed and a physiotherapist with it; the deployment must be to a hostile environment; the environment must be such that contact lenses cannot be worn or glasses if lost cannot be readily replaced.

In the approximately forty-five years that Canada has been participating in peace-keeping operations or other military operations such as the Gulf War, there has not been one occasion when a CAF physiotherapist has been deployed in this type of situation. It is our conclusion that the possibility of all of these events happening is not a sufficient justification for excluding Hebert from the CAF. The possibility is too remote to establish that an uncorrected standard is reasonably necessary for physiotherapist.

Finally, we point to the 1986 article entitled "Contact Lenses for Police Officers" by Dr. Sheedy, in the Journal of the American Optometric Association which was submitted as an exhibit. This Article discusses the pros and cons of allowing contact lens wearers to by-pass the uncorrected visual standard. It is interesting to note that Dr. Sheedy relied partly on another Report submitted in evidence relating to the Static Guard, to justify an uncorrected standard for police officers and anti-terrorist units. In the Static Guard Report, Dr. Sheedy

produced results of a questionnaire from police officers who wear contact lenses while performing police duties. In this questionnaire, police officers reported that their contact lenses become dislodged and interfered with their vision during duty; that their eyes became irritated from environmental factors such as dust, smoke and wind while on duty so that the contact lenses had to be removed; that their eyes became irritated from environmental factors while on duty such that it interfered with their vision; that their eyes have been sufficiently irritated from overwear or infection that they were unable to wear contact lenses while on duty. Notwithstanding these results, in his 1986 Article, Dr. Sheedy concluded that although there are several factors that make the contact lens wearers a less desirable recruit, a good contact lens wearer who doesn't meet the uncorrected standard could safely and efficiently perform the duties of a police officer and it is reasonable to waive the uncorrected vision standard for a good contact lens wearing candidate.

Hebert is considered to be a good contact lens wearing candidate. If a police officer who wears contact lenses and who experiences problems from dust, smoke and wind, or irritation from environmental factors or irritation such that they are unable to wear contact lenses on duty should not be subject to an uncorrected standard, equally, neither should a CAF physiotherapist whose occupational duties take place predominantly in a hospital or clinical setting.



For all these reasons, we conclude that the evidence presented to the Tribunal in this hearing, by the Respondents does not prove the need for an uncorrected visual enrolment standard for physiotherapist, and in our opinion, the Respondents therefore have failed to establish a BFOR.

## VI. REMEDY

In argument, Commission counsel suggested that an appropriate remedy would be:

i) that Hebert be put in the same position she would have been in but for the discriminatory practise;

ii) that the Tribunal make an order that the Respondents cease the discriminatory practice; and

iii) that the Tribunal award compensation in respect of hurt-feelings or loss of self-respect as a result of the discriminatory practice.

There was some uncertainty as to when the next ROTP competition for physiotherapist would be held or if one would be held. Also, we consider it more appropriate that Hebert be considered in terms of her qualifications at the time of this hearing rather than at the time of her original application. Then, she was a high school graduate, now she has a B.Sc. degree.

The Tribunal hereby orders that the Respondents accept Hebert into the ROTP if she chooses to apply on condition that she satisfy the minimum common enrolment standards of the CAF other than the uncorrected visual acuity standard and otherwise satisfies the conditions for acceptance into the ROTP. The Tribunal also orders that the Respondents consider Hebert's application on its own and not in competition with any other ROTP application for the physiotherapist position.

The Tribunal further orders that the Respondents cease and desist their discriminatory practise of using an uncorrected visual acuity standard in determining enrolment in the CAF physiotherapist occupation.

Finally, the Tribunal orders that the Respondents pay Hebert the amount of $5,000.00 as compensation under section 53 of the CHRA plus interest thereon from and after the date of the Complaint.

Dated this 24th day of June, 1993.

J. Grant Sinclair, Q.C.
Chairman



Marie Crooker
Member

Richard Noonan
Member