T.D. 17/94
Decision rendered on November 18, 1994

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

HUMAN RIGHTS TRIBUNAL

BETWEEN:

WILLIAM CLARKE

Complainant

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

THE CANADIAN ARMED FORCES

Respondent

DECISION OF TRIBUNAL

TRIBUNAL: Sidney N. Lederman, Chairperson
Joanne Cowan-McGuigan, Member
Miroslav Folta, Member

APPEARANCES: Fiona Keith & Helen Beck
Counsel for the Canadian Human Rights Commission

Alain Préfontaine & Captain Roger Strum
Counsel for the Respondent

DATES AND
LOCATION OF HEARING: October 13, 1993
December 6, 7, 8, 9, 10, 1993
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Ottawa, Ontario

FACTS

William Clarke ("Clarke") enrolled in the Canadian Armed Forces ("CAF") on September 24, 1965, and was released on October 6, 1989, at the age of 41, as a result of a decision of the CAF Career Medical Review Board ("CMRB").

In 1965, after completing recruit training, he joined the Princess Patricia Canadian Light Infantry, an infantry unit. Clarke was eventually promoted to the rank of Master Corporal. In 1979 he remustered into the military occupation of metal technician. As a consequence of remuster, he had to revert to the rank of corporal. From 1980 until his release from the CAF, Clarke worked as a fully qualified metal technician.

While stationed in Lahr, Germany, on April 22, 1986, at the age of 37, Clarke experienced discomfort and visited the base physician at the CFB Baden Solingen hospital. The duty physician diagnosed the condition as indigestion. Clarke returned home and the following morning resumed his duties as a welder with the Princess Patricia Battalion.

Approximately ten days after being seen by the battalion physician, he was summoned by him to the unit aid station. He was told that the electrocardiogram ("ECG") that had been done on April 22 had been reviewed by an internal medicine specialist and it showed evidence of a recent myocardial infarction. He was transferred from Baden Solingen that same day to the hospital in Lahr, Germany, for the purpose of assessment and education. He stayed at the hospital approximately four days. Various risk factors were identified at that time. He indicated that he smoked 30 packages of cigarettes a year. He had a positive family history of coronary artery disease: his father died of a myocardial infarction at age 42; his sister had coronary artery by-pass surgery at the age of 40; and all paternal uncles had experienced coronary artery disease in their early forties. During his stay at the hospital an angiogram was taken and he was prescribed a beta blocker and discharged. Following his release from hospital, he went on sick leave for six weeks. He was re-evaluated at the end of the sick leave period and returned to work half days only and later full time carrying out light duties.

Clarke was re-posted from Baden Solingen to Aircraft Maintenance and Development Unit ("AMDU") Trenton in July 1986 and

assumed his duties in August or September 1986. Clarke stated that, in his opinion, there was no connection between his myocardial infarction and his re-posting. His duties at AMDU Trenton were that of a metal technician in the Specialist Workshop Research and Development section, which was basically a desk job.

Clarke was followed up at the Coronary Pulmonary Unit ("CPU") at National Defence Medical Centre in Ottawa in the Fall of 1986. Through physical testing, he was diagnosed as being hypothyroid and was prescribed medication to correct his thyroid status before further cardiac testing was done.

On December 2, 1986, Clarke underwent selective coronary angiography and left ventriculography. This latter test revealed mild generalized reduction and function of the left ventricle thought to be secondary to the effect of his beta blocker medication. The left coronary system was considered to be free of disease. The dominant

right coronary artery was found to have a long narrowing of 75% severity in its proximal course.

Dr. Alan J. Leach, who was Clarke's physician at the CPU, made a diagnosis of coronary atherosclerosis, limited at that time to a long segment of the right coronary artery. He concluded that in April 1986, a plaque accident in the course of the diseased segment of the right coronary artery caused a temporary interruption of blood flow sufficient to produce a small heart attack. If the occlusion of this vessel had been maintained, it would have led to a much larger area of heart muscle damage.

Clarke was treated with medication rather than operative intervention. Clarke was next seen in the CPU out patient clinic on May 3, 1988. He was asymptomatic and was no longer smoking (the smoking had ceased after the April 1986 incident). He had a submaximal treadmill test but reached 7.5 minutes on the NDMC protocol without symptoms or ECG changes. At that visit, a medical category of G403 was recommended on the basis of his coronary artery disease ("CAD").

On July 12, 1988, Clarke's CAF unit recommended a G403 category restricting him from duty at sea, isolated posting and

excusing him from drill and parades. On November 17, 1988, Clarke's category was changed to a permanent G403.

Clarke was seen again in the CPU outpatient clinic on May 9, 1989. He remained asymptomatic. He continued to be a non-smoker. His cardiac medications were unchanged. A treadmill test was submaximal by heart rate but he walked for 8 minutes. His ECG did not show any ischemia. It was recommended that his thyroid function and cholesterol levels be monitored and that if his cholesterol remained abnormal despite normal thyroid function, he be started on lipid lowering medication.

Clarke's performance evaluation reports in January 1987, 1988 and 1989 indicated that his duties were performed in a suitable manner and it was stated, in each report, that he was capable of carrying out work at the next higher rank.

Captain C.R. Gilman, the Base Personnel Selection Officer, carried out an assessment of Clarke for the CMRB on January 12, 1989 and made the following appraisal:

> Cpl. Clarke has progressed steadily throughout his military career and is reported to be performing at an acceptable level. His CO does not consider that his performance has been significantly down-graded as a result of his medical condition and has recommended that he be retained in his present MOC.

However, this recommendation was not accepted and he was released on October 6, 1989 as a result of a decision made by the CMRB.

By way of postscript, some years later, on February 6, 1993, Clarke experienced cardiac arrest due to ventricular fibrillation and was saved through successful resuscitation. Of note, on admission to the hospital, he indicated that he had resumed smoking after his release from the CAF. He was diagnosed as having severe disease of all three major coronary arteries. He was recommended for coronary bypass surgery which took place in early 1994.

Clarke has brought a complaint against the CAF alleging that it discriminated against him on the ground of disability (i.e. CAD), contrary to s.7 of the Canadian Human Rights Act ("CHRA") by releasing him from the CAF while he was still able to perform his duties in a satisfactory manner. He further alleges that the CAF's policy regarding the classification of persons with CAD (i.e. CFMO 26-01) has deprived or tended to deprive him and continues to deprive other

individuals with CAD of employment opportunities on the basis of disability, contrary to s.10 of the CHRA.

SAFETY RISK AS A BFOR IN THE CAF

The CAF has expressly conceded that Clarke was released because of a physical disability, namely CAD, and, accordingly, there

has been prima facie direct discrimination within the purview of s.3(1) of the CHRA. It is the CAF's position, however, that persons suffering from CAD face a greater risk of injury to themselves than comparable persons free of such disease; thus, Clarke's geographical restriction and ultimate release were based on a bona fide occupational requirement (BFOR) within the meaning of s.15(a) of the CHRA and were therefore justifiable.

The CAF has argued that release from its service of those members suffering from CAD is necessary for two reasons. First, the condition renders those persons incapable of performing all of the tasks of their military occupation in all the circumstances and conditions in which those tasks must be carried out. Secondly, the condition renders such persons more susceptible to heart attacks. Should such a member suffer a sudden incapacitating heart attack while serving in a remote location, the chances of injury and death to that person are dramatically increased. Given that risk, the CAF contends that its policy and practice which may lead to the release of service persons with CAD is a justifiable BFOR.

The CAF relies particularly on the trilogy of cases decided recently by the Federal Court of Appeal pertaining to "disabled" members of the CAF: (A.G. (Can.) v. St. Thomas, [1994] 1 F.C. D-6; A.G. (Can.) v. Robinson, May 26, 1994, unreported; and C.H.R.C. v. CAF (Husband), April 14, 1994, unreported.)

As a starting point, the standard that an employer, relying on safety reasons to establish a BFOR, must meet is that the group of persons in question excluded by the employment practice will present a "sufficient risk of employee failure" (Ontario Human Rights Commission v. Etobicoke, [1982] 1 S.C.R. 202 at 210). Early cases held that a "minimal increase in risk" was sufficient to constitute a BFOR (Bhinder v. CNR, [1985] 2 S.C.R. 561 at 584 and 588; Canadian Pacific Limited v. Canada (Mahon), [1988] 1 F.C. 209 at 221 and 224). That standard was

found too restrictive by Wilson J. in Alberta Human Rights Commission v. Central Alberta Dairy Pool, [1990] 2 S.C.R. 489 at 513 and by Linden J.A. in Canada (A.G.) v. Rosin, [1991] 1 F.C. 391, who stated that proof of a slight or negligible risk is not sufficient to constitute a BFOR. However, the Federal Court of Appeal in Husband, and Robinson found that Wilson J.'s and Linden J.A.'s statements were made in obiter dicta and that Dairy Pool had not effectively overruled Bhinder or Mahon insofar as they can be said to have propounded a test for sufficient risk. The Federal Court of Appeal has definitively held that Dairy Pool has not laid down any new test of "substantial risk" in substitution for the test of "sufficient risk" propounded in Etobicoke. Nor did the majority in Husband agree with MacGuigan J.A.'s statement in Air Canada v. Carson et al., [1985] 1 F.C. 209 (C.A.) at 232 that "sufficient risk of employee failure" recognizes a degree of risk that is "acceptable" as opposed to just "minimal".

Thus, this Tribunal must take the law as presently being that the phrase "sufficient risk of employee failure" used by McIntyre J. in the Etobicoke case, means (as interpreted by the Federal Court of Appeal in Mahon supra) that the evidence must be sufficient to show

that the risk is real and not based on mere speculation. Marceau J.A. in the Mahon case stated that the "sufficiency" contemplated refers to the reality of the risk, not its degree. However, Chief Justice Isaac in Husband, at p. 17, described this statement as "infelicitous, since 'sufficiency' does connote degree". What emerges clearly from these cases is that a minimal increase in the risk of employee failure is a sufficient risk for the purpose of establishing a BFOR.

In the context of the CAF, the risk must be seen in light of the "soldier first" requirement, namely, that the medical standard in question has to be considered in the context of the requirement that all members of the CAF are eligible to engage in combat conditions in extreme environments as and if called upon or if circumstances so require. This policy is reflected in s-s.33(1) of the National Defence Act, R.S.C. 1985, c.N-5, that a member of the regular force is "at all times liable to perform any lawful duty". This "soldier first" policy was enunciated by Chief Justice Isaac in the St. Thomas case, supra, at p. 8 as follows:

> In my view, examination of this issue must take account of a contextual element to which, the Tribunal did not give sufficient consideration. It is that we

> are here considering the case of a soldier. As a member of the Canadian Forces, the Respondent, St. Thomas, was first and foremost a soldier. As such he was expected to live and work under conditions unknown in civilian life and to be able to function, on short notice, in conditions of extreme physical and emotional stress and in locations where medical facilities for the treatment of his condition might not be available or, if available, might not be adequate. This, it seems to me, is the context in which the conduct of the Canadian Forces in this case should be evaluated.

The net result of the application of the "minimal" risk standard and the "soldier first" policy was aptly described by Robertson J.A. dissenting in the Robinson case, supra, at p.24 as follows:

> I feel compelled to point out that if the "soldier first" policy is accepted and applied, together with the "minimal" risk standard, then the CAF is effectively given carte-blanche to release any disabled person from the Forces. To me it seems clear that virtually every person with any formal disability will present a "real" risk of employee failure in a combat situation. If it was the intention of Parliament to insulate the CAF from disability-related complaints under s.7 of the Canadian Human Rights Act, then the alliance of these policies has certainly given effect to that intent. As a matter of law, it is a position which I cannot support.

The resurrection of the "minimal" risk standard is therefore a major set-back for all "disabled" individuals serving in the military.

THE RISK CREATED BY CLARKE'S CONDITION

There is no doubt that at the time of his release, Clarke's condition created sufficient risk so as to constitute a BFOR, whether one utilized the "minimal" risk standard or a higher than minimal risk standard. The following comments about risk appear in the report of

Dr. Gordon Cumming, a cardiologist, who gave evidence on behalf of the CAF:

- Risk in coronary disease needs to take into consideration the risk of progression, and this risk in Clarke was about as bad as it gets (page 1);

- Mr. Clarke's case should not be regarded in isolation to his risk factors. He was not the usual patient with single vessel coronary disease with a reasonable exercise test. His risk of a heart attack in 1982 was extremely high and in 1989 despite his perhaps having quit smoking his risk of future problems continue to be very high because of his risk factors. (page 10)

...

Judging from the severity of Clarke's risk factors: family history considerably more adverse than table 3 considers; cholesterol not just high but extremely high; obesity - eventually 70 - 100 pounds overweight and low fitness; heavy smoker before 1986, not just a mild smoker, Clarke's risk would be far in excess of 15 times, perhaps as high as 50 times that of the normal population. (page 10)

...

Clarke's mortality ratio was estimated at 450% (page 10).

...

In my opinion, Clarke was a very high risk for problems dating back to 1982. Certainly in 1989 I can't see any cardiologist seriously stating that this man: 1. was not at high risk for a progression of his coronary disease; 2. was not at high risk for service in remote areas; 3. was fit for highly stressful military duty. (Page 16).

Dr. Alan J. Leach, the Director of the Cardio-Pulmonary Unit at the National Defence Medical Centre, who treated Clarke, testified on behalf of the CAF with respect to Clarke's condition, and the risk that it posed. In his report which was submitted into evidence, Dr. Leach drew the following conclusion:

> His coronary artery disease was known to have the potential for future life threatening complications without warning. Clinical criteria put him in our best prognostic group with an annual mortality rate of 1-2% and an annual myocardial infarction rate of 2-4%. At first glance, these risks seem small but are at least 5 times higher than the risk for an aged matched healthy Canadian male.
>
> Mr. Clarke's risk of cardiac events was likely to increase rather than remain static, given that coronary artery disease usually progresses . . . lack of medical resources capable of treating the complications of coronary artery disease reduce the chances of survival and increase the degree of resultant disability.

Dr. Andreas Wielgosz, the Head of the Division of Cardiology at the Ottawa General Hospital, gave evidence on behalf of the CHRC and Clarke. He has served as a consultant to the Medical Advisory Board for Civil Aviation, Department of National Health and Welfare and participated in the formulation of Guidelines for the Assessment of Cardiovascular Fitness in Canadian Pilots (1988). These guidelines permit individuals who otherwise satisfy strict medical criteria to be licensed to fly as civilian commercial pilots without compromising air safety even though they have suffered acute myocardial infarction. In his evidence, he indicated that the risk of an untoward cardiac event, fatal or non-fatal, in Clarke's circumstances would be in the order of 2-5% per year. He thought that may be an acceptable risk since it would place Clarke in the same order of risk as that of a same aged and sex matched soldier whose cardiac health was not clearly defined.

Dr. Gordon Cumming, a cardiologist, who is employed in the insurance industry testified that a risk of a cardiac event of 2-5% per year is a reasonable estimate of the danger that Clarke faced at the time.

Dr. Wielgosz parted company with Dr. Leach on the issue of the acceptability of risk. Dr. Wielgosz concluded that in Clarke's case, the risk of a second cardiac mishap was reasonably low in the

circumstances. However, when Dr. Wielgosz was advised of the exigencies of life in the military flowing from 'the soldier first' policy, he conceded that there was reality to the risk involved. Consider the following exchange in the cross-examination of Dr. Weilgosz:

At pp. 213-215:

Q. You have frankly conceded that you had no knowledge of what life in the Forces implied by way of physical demands?

A. Correct.

Q. You also have no knowledge, I take it, of the occupation of metal technician?

A. Correct.

Q. Either in the Forces or as a civilian occupation?

A. Correct.

Q. Did you know that, as a member of the Forces, Mr. Clarke was required to, for example, be engaged in combat if he was required to?

A. I didn't know that for sure, but that wouldn't surprise me.

Q. And that being engaged in combat means having to endure severe stresses, both physical and emotional?

A. Right.

Q. Is that a fair -- something that you can agree with?

A. That goes with the territory.

Q. Because the emotional stress is caused by the fact that your life or the life of your comrades is at risk.

A. Right.

Q. And the physical stress comes from the fact that you are demanded to produce a strenuous level of activity on an on/off basis, stop/go, stop/go.

A. Right.

Q. And that's very demanding for the body?

A. Correct.

Q. Would you recommend that somebody with Mr. Clarke's condition be engaged in that type of activity?

A. No.

Q. Why is that?

A. I think when you are talking about such an extreme exposure, then with any degree of coronary artery disease I think the risk of an event is increased and I would, therefore, recommend against that, if there is a choice.

At pp. 227-230:

Q. In your assessment of the risk that Mr. Clarke faces, is the risk heightened by the fact that Mr. Clarke might be asked to perform his duties as a member of the Armed Forces far away from any type of medical attention?

A. We are talking about two different risks here. One is the risk in the case of a myocardial infarction occurring, the need for some medical care,

and that would apply to anybody that, in an isolation posting if an event occurs, they would be disadvantaged by not having care available.

The other risk that you are talking about, I think, is whether Mr. Clarke has an increased risk of cardiac event by the nature of his responsibilities in the Armed Forces. I would think that risk, if it is increased, is not significantly increased over that for other soldiers.

Q. But those two types of risks that you have differentiated between compound one another, don't they?

A. If you have an event -- if you are at an increased risk of an event and you have an event in an isolated posting, then you are disadvantaged; no question.

Q. And you face a much higher type of risk?

A. Of ...?

Q. Risk, much higher risk. If you are a member of this group of persons who is more likely to suffer from a heart attack ---

A. Oh, "if", yes, certainly.

Q. -- and if a heart attack does materialize and you are in isolated surroundings without medical attention close at hand, then you are definitely disadvantaged. Your chances of survival have declined drastically.

A. You don't need to invoke the first risk. The second risk alone is already putting you at a disadvantage, the fact that you have an event in an isolated posting, and that could occur to anybody.

Q. Yes. You see, Doctor, it's part and parcel of the duties of the members of the Armed Forces to perform those duties at isolated postings.

A. Right.

Q. But that's not part and parcel of the duties of the general population. Members of the general population are not required to serve at isolated postings.

A. Right.

Q. They can elect to do so if they so wish ---

A. Right.

Q. -- but they are not required. That's the difference, because the Forces could say to Mr. Clark, 'You are sent up north to do your work as a metal technician or to do this because of military exigencies', and he had to go.

A. Right.

Q. It's that type of risk that the Forces were trying to assess back in 1989 and I am trying to find out from you if you agree that the assessment that was made was reasonable; trying to look at the job, trying to look at the man and trying to see whether having this person perform the job places him at a higher risk.

A. Certainly, we could agree that it would be a higher risk. I'm not sure I could be very precise in telling you how much higher that risk would be and the question of whether that is still within the realm of an acceptable level of risk or not is another matter.

What I have indicated is that Mr. Clarke cannot be looked at simply in black and white terms of he has coronary artery disease or he doesn't have coronary artery disease because we know what the

severity and the extent of his coronary artery disease is and we know that, by the best clinical parameters that we can assess his risk, he falls into the category with a very low level of risk, albeit at a low level of risk or lower than somebody with more extensive disease. Does exposure to the military environment in an isolated posting put him at a disadvantage? Yes, the answer is it does.

At pp. 231-236:

Q. If that is true, if it is true that the pharmacy doesn't contain the drugs required to treat him, would you recommend to Mr. Clarke that he be placed in such an environment?

A. Yes. I would still feel comfortable with Mr. Clarke being in that environment because I think that his risk of an acute myocardial infarction remains low. The risk of an acute infarction exists in some of the other soldiers and if I were really concerned about an acute infarction in an isolated posting, then I would make sure that the medical panier has some drugs and appropriate personnel to treat that.

It's a risk that exists in everybody. I think in Mr. Clarke's case it is a low risk and a reasonably low risk for the demands of the posting and the circumstances of the environment.

Q. What do you mean by 'reasonably low risk'?

A. Well, I cannot say that there is no risk, just as I cannot say that there is no risk of a heart attack for any soldier going out into an isolated posting, but I think that that is such a low risk that I would not have concerns about Mr. Clarke going into that kind of posting. I could envision a patient with a different profile of disease and risk in whom I would have that concern.

Q. Presumably, you could.

Let's turn now to the duties of Mr. Clarke as a metal technician. You can take it that a metal

technician is the person who applies everything metallic on an airplane.

A. Yes.

Q. And that requires them to do fairly strenuous work. For example, they have to climb up and down scaffolds to do the repairs to the plane that they are working on.

A. Right.

Q. And they might have to do that on a number of occasions per day.

A. Right.

Q. They might have to do that carrying equipment and sheets of metal that they are working on.

A. Right.

Q. Is that something that you feel Mr. Clark can undertake without risk?

A. I would even recommend that to him.

Q. If he was required to do that in remote locations, that still would not bother you?

A. That would still not bother me.

Q. For example, if he was required to serve with a tactical helicopter squadron deployed in the field and he has to live in a tent and do the repairs in the mud, that doesn't cause you concern?

A. I would certainly like to know how Mr. Clarke feels about that. If he was reluctant, then I would have concerns, but ---

Q. Take it that the point of military discipline is that the Forces don't care how he feels. If they

tell him, 'You go', he goes. That's the conditions of service.

A. Right.

Q. So, what's your assessment of the risk then?

A. I would still think that's an acceptable risk. I would assume that if Mr. Clarke didn't like that, he would resign from the Armed Forces.

Q. I will surprise you, Doctor. There is no such thing as resigning from the Forces. It doesn't exist. You have to ask to be released and the Forces can say yea or nay. If they say 'nay', then you are in.

A. I wasn't aware of that. I was in fact under the impression that one could withdraw from the Armed Forces and that's, I think, an important back-out that I'm not aware does not exist.

Q. Obviously, in time of peace, you won't be surprised to learn that usually the Forces don't say 'nay', they say 'yea'. But it's not at your immediate disposal, let's put it that way.

A. Right.

Q. So, to take this example that we have discussed, if Mr. Clarke was unhappy about his life as a metal technician serving with a tactical squadron in the field and he wanted out of the Forces, the Forces could say, 'Yes, but in six months' time.' Under those conditions, does that change your assessment of the risk?

A. Yes.

Q. What is the effect on the ---

A. I think that would put him at an increased risk of a cardiac event because that would be a psychological stress that he would be exposed to.

Q. Would you recommend that he serve under those conditions?

A. No, I would not.

At pp. 241-242:

Q. So, because of his condition, coronary artery disease, it is fair to say that he can't do 100 per cent of the duties of his job?

A. Oh, no, I wouldn't say that. I think he can perform 100 per cent of his duties and that's why I would feel comfortable in his returning to his posting and to his responsibilities as a soldier.

I think exposure to those kinds of stresses that you have mentioned is not heart-healthy for any individual and I think that, for that reason, I would say to Mr. Clarke, 'If you can avoid it, fine, you can avoid it and I would advise you to avoid it.' But if he has no choice in the matter, then I think that he could still engage in that activity, although I think that that would obviously put him at some increased risk.

Q. So, the gist of it is the risk that he faces is not that he is incapable of performing those tasks; rather, the risk is that if he performs them, he places himself at an increased risk of injury to himself?

A. There is a slight increase in risk. I would have to concede that, absolutely.

Q. And depending on the surroundings where he performs those tasks -- i.e., the immediate availability of medical attention -- then that can further compound the risk?

A. It certainly could aggravate the situation, yes.

Given the low threshold set by the Federal Court of Appeal with respect to the risk attendant upon a member of the CAF having to fulfil his or her solider first obligations, there is no doubt that the increased risk of a possible sudden incapacitating cardiac event facing Clarke was sufficient to justify a geographical restriction and, upon further review, release from the CAF. The mere presence of CAD, regardless of all other mitigating circumstances, would increase the risk to Clarke of another cardiac event, even if it was just minimally. All three medical doctors who testified were in general agreement as to the extent of the annual rate of risk of a second sudden myocardial infarction posed by Clarke's circumstances. This, of course, would easily come within the "minimal" risk standard in a "soldier first" context. Accordingly, on the basis of the principles laid down by the Federal Court of Appeal, we must dismiss Clarke's complaint.

ACCEPTABLE INCREASE IN RISK

We cannot leave this matter without adding that our conclusion would have been different if the test for determining sufficiency of risk had been that as set out in Thwaites v. CAF (1994), 19 H.R.R. D/259; aff'd F.C.T.D., March 25, 1994, unreported, i.e. that the CAF had to establish that Clarke's condition posed more than a minimal or slight increase in risk. Under that test a heightened risk but within acceptable limits would not be sufficient to constitute a BFOR.

The timing and adequacy of the assessment by the CAF of Clarke's condition were such that it did not allow for a proper and fair determination of the extent of the risk. We believe that there was a good chance that if a full and fair assessment were made of Clarke after a period of cardiac rehabilitation, the CAF may well have concluded that the increased risk of a second heart attack would not have been greater than slight or negligible.

The CAF conducted an individual assessment of Clarke and now relies upon that assessment in defence of its alleged BFOR. By so doing, this Tribunal is entitled to inquire into the adequacy of the assessment. Gibson J. in Thwaites, supra, made this clear at pp.23-24 as follows:

... But whether or not individual assessment is required as a matter of law, the CAF purported to undertake individual assessment in relation to

Thwaites and relied on that assessment in defence of its alleged BFOR. Put another way, the CAF chose to defend its BFOR as being reasonably necessary by relying on its individual assessment of Thwaites. That being the case, it was incumbent on the Tribunal to examine the individual assessment that was undertaken as an element of its examination of the 'reasonably necessary' standard for the BFOR defence. I concur with the conclusion of the Tribunal that the individual assessment process was inadequate to support the BFOR against a 'reasonably necessary' standard.

Both Dr. Weilgosz and Dr. Cumming testified that persons diagnosed with single vessel CAD, particularly in the right descending coronary artery, with good exercise tolerance and good control of risk factors could return to strenuous work in an isolated posting. Both physicians testified that these persons would not pose a risk which would be significantly greater than persons without CAD. Accordingly the mere existence of CAD alone does not substantially increase the risk that a CAF member would have if obliged to perform his or her "soldier first" functions so long as the CAD was limited to the right descending coronary artery and all of the lifestyle factors were vigorously controlled, such as cholesterol level, blood pressure, abstinence from smoking, proper diet and appropriate level of physical fitness.

Given the location and nature of Clarke's CAD, he was a good candidate for rehabilitation. That was so even having regard to the Clarke family's troubling cardiac history. Control of lifestyle factors forms part of an appropriate cardiac rehabilitation program. It is clear that in Clarke's case, apart from recommending lifestyle changes, no real rehabilitative program was undertaken by the CAF. Certain drugs were administered but their purpose was to prevent a second coronary event. Dr. Cumming was puzzled by the fact that Clarke was not put on cholesterol lowering drug therapy, nor provided with a physical fitness program. As a result Clarke was never truly able to control his cholesterol level.

It is true that Clarke might not have been compliant, in which case his risk exposure for another heart attack would never have been brought down to an acceptable level. The CAF was remiss, however, in leaving matters entirely in Clarke's hands. It had an obligation to embark upon a thorough and aggressive rehabilitative program for a period of at least a year to determine whether the risk posed by Clark could be lessened to a level such that the attendant risk could be brought within an acceptable range to permit Clarke to perform his military functions. As stated by the Tribunal in Thwaites, supra, at p. D/283:

> If such risks were determined to be significantly higher, then it would have to be asked whether there

> are any reasonable measures that can be put in place to minimize such risks to an acceptable level - a level that makes them comparable with other tolerated risks.

One might ask why the CAF's doctors did not work with Clarke on rehabilitative measures to minimize the risk.

An analogy may be made to a situation where a member of the CAF breaks his or her leg. At the time of the fracture that individual is disabled in such a way that he or she cannot perform the "soldier first" function; yet no one would expect the CAF to make its assessment of the individual to perform the "soldier first" function when he or she incurs the fracture. Rather, the CAF undertakes a rehabilitative program to permit the leg to heal so that the member can return to full active duty free of risk. This example, of course, is very simplistic. We certainly agree that there is a greater predictability in the healing of a broken leg than there is with the rehabilitation of an individual with CAD. However, just as the CAF actively attempts to treat an individual with a broken leg it should have done the same with Clarke. During the period of treatment, obviously, a temporary category would have to be assigned to restrict the geographical movements of the individual. However, after a suitable period of treatment, a final assessment of risk could be made either in the case of an individual with a broken leg or with CAD. If all of the factors are not in place to indicate that return to duty could be accomplished within an acceptable level of risk, then there would be justification in issuing a permanent restrictive category which could lead to the release of

that individual. This would all be in keeping with the CAF's own policy on CAD which will be referred to later.

The problem in Clarke's case is that no meaningful program of cardiac rehabilitation was ever undertaken and therefore no attempt was ever made to lessen the risk posed by his CAD.

According to Dr. Leach's view, once CAD exists, regardless of its location and nature, then that individual poses too great a risk to return to full-time duties even if he or she managed to vigorously control all of the lifestyle factors. We prefer the evidence of Dr. Weilgosz and Dr. Cumming on this point and believe that had Clarke been sufficiently rehabilitated with strict control of his own lifestyle factors, there was a real probability that the risk posed would not have been substantial but would have been brought within acceptable limits. If that were so, he would not have required a permanent restricted geographical rating. Of course, we will never know whether he could have been so rehabilitated or not. As we pointed out he may not have been a compliant individual himself, or for any number of reasons his lifestyle factors may not have been brought under satisfactory control. The fact is that the CAF did nothing to embark upon a rehabilitation program for Clarke. It, thus, should not be permitted to rely upon its individual assessment of Clarke as establishing a BFOR. The use of a temporary category and a program of

rehabilitation and treatment are not means of accommodating Clarke but, rather, are part and parcel of making a proper assessment of the risk that his long term condition would pose.

POLICY ON CAD

The CAF's policy on CAD (CFMO 26-01) reads in part as follows:

> CATEGORIES
>
> 4. All members with suspected CAD shall be temporarily placed in the G4 04 category (and A7 for aircrew) until investigations and treatment, if indicated, have been carried out. This categorization will be extended for up to 12 months, following investigations and treatment, if a definite

> possibility exists of a category change at the end of that time. In cases of surgical treatment the temporary category will be routinely extended to 12 months after the date of surgery.
>
> ...
>
> 6. When the recommended investigation has been completed and the maximum benefit from treatment achieved the permanent category recommendation shall be forwarded, in accordance with CFAO 34-33, to DMTS for consideration. Members with confirmed CAD who remain symptomatic or who refuse recommended investigation or treatment shall be categorized no better than G4 04 (and A7 for aircrew). Where members become entirely asymptomatic following medical or surgical treatment, G4 03 (and A7 for aircrew) will usually be approved although a better category may be awarded depending upon the clinical findings and the presence or absence of risk factors.

Although the policy suggests a restrictive rating of G403 in the usual case for an individual who has CAD but is asymptomatic, it does not mandate it. Thus, the policy, though recommending a rating in the abstract, indicates that it is open to award a better category if the individual clinical assessment so warrants. It is true that Dr. Leach has interpreted the policy to mean that if someone merely has CAD that alone should result in a category no higher than G403, even if that individual

is asymptomatic. Dr. Leach testified that the application of the CAF policy on CAD is such that individuals who have been diagnosed with CAD will not receive a medical classification better than G403 unless all visible signs of CAD have been removed from the arteries by way of angioplasty as evidenced by a clear angiogram. That is not what the policy says, however. If there is any quarrel with Dr. Leach's approach, then it is with him and not with the wording of the policy.

The CHRC has argued that the s.10 complaint relates not only to the policy per se but also to its application by Dr. Leach to Clarke and other members of the CAF with CAD. That may be but, as we pointed out, under the low threshold test of risk established by the Federal Court of Appeal, it appears that the mere existence of CAD is

sufficient to justify the category that was imposed on Clarke and perhaps on others since it would minimally increase his risk. For this reason, the s.10 complaint must be dismissed. As stated earlier, we believe that a different result would have been justified in Clarke's case if the "greater than slight or negligible" standard had governed and had been applied. If so, the CAF's general application of its policy on CAD would have been brought into question as well.

Dated at Ottawa, Ontario, on this day of October, 1994.

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SIDNEY N. LEDERMAN
Chairperson

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JOANNE COWAN-McGUIGAN
Member

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MIROSLAV FOLTA
Member