T.D. 7/95
Decision rendered on March 6, 1995

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

HUMAN RIGHTS TRIBUNAL

BETWEEN:

DANIEL F. MACPHERSON

Complainant

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

DEPARTMENT OF NATIONAL DEFENCE

Respondent

- and -

CANADIAN DIABETES ASSOCIATION

Intervenor

TRIBUNAL DECISION

TRIBUNAL: Roger Bilodeau - Chairperson

APPEARANCES BY: Margaret-Rose Jamieson and Helen Beck, Counsel for the Canadian Human Rights Commission

Brian J. Saunders and Anne Turley, Counsel for the Respondent

Peter Rogers, Counsel for the Canadian Diabetes Association

DATES AND PLACE
OF HEARING: June 22-25, 1993 Halifax, Nova Scotia
July 5-6, 1993 Ottawa, Ontario
December 2-3, 1993 Ottawa, Ontario

Introduction

This case can best be described as follow-up to the Gaetz matter which was decided by a Human Rights Tribunal in 1988 and subsequently confirmed by a Review Tribunal in 1989. As in Gaetz, the Tribunal must determine if it was discriminatory for the Department of National Defence \ Canadian Armed Forces ("CAF") to release Daniel Franklin MacPherson ("MacPherson") on the grounds that he is a diabetic.

There are many similarities between this case and the Gaetz matter. In fact, counsel for the Commission readily indicated during their closing submissions that the end result of this case turns on the applicability and the impact of the Central Alberta Dairy Pool case ("Pool"), which was decided after the Review Tribunal's decision in Gaetz.

THE COMPLAINT AND A BRIEF SUMMARY OF RELATED EVENTS

On December 1, 1984, MacPherson filed a Complaint with the Canadian Human Rights Commission ("Commission") against the CAF, alleging that it had discriminated against him on the ground of disability (diabetes), contrary to Section 7 and 10 of the Canadian Human Rights Act. ("CHRA").

The complaint then followed a lengthy and tortuous route. In or about April 1985, MacPherson asked the Commission to hold off its investigation until such time as his grievance with the CAF had been settled. In July 1985, the Commission advised MacPherson that it would start its investigation. In actual fact, that investigation did not get underway until some time in 1987. The Tribunal also heard evidence that from 1987 on, as many as three (3) different Commission agents were assigned to this complaint. The investigative report was finally completed in October 1988. That report recommended that the complaint be dismissed. However, the Commission decided to hold off any further action on the complaint, pending a final decision in Gaetz.

The Review Tribunal's decision in Gaetz was delivered in July 1989. In addition, the Supreme Court's decision in Pool was issued in September 1990. The Commission then decided to proceed with the MacPherson complaint. This Tribunal was appointed in April 1992.

During eight (8) days of hearings held in the period June to December 1993 this Tribunal received extensive evidence and exhibits from a total of twelve (12) witnesses, including that of the intervenor Canadian Diabetes Association ("CDA"). Following these hearings, the Tribunal also received written submissions from the CAF and the CDA. Furthermore, the Tribunal received additional material and submissions from all parties on the topic of policies followed by other institutions or organizations regarding serving members who become diabetic. The last of these materials and submissions were provided to the Tribunal in May 1994.

THE DECISION

In coming to my decision, I have reviewed and considered the extensive evidence of all parties involved, as well as the relevant case law.

On the basis of the above, MacPherson's complaint cannot succeed. As indicated previously, there are many similarities between this case and the Gaetz matter. In my view, there is nothing in the evidence to warrant a decision different from that of the Human Rights Tribunal and the Review Tribunal in Gaetz.

Furthermore, I am bound by recent decisions of the Federal Court of Appeal which clearly state that the Pool case does not offer a new test in regard to measuring the appropriate degree of risk within the context of a BFOR defence.

The complaint is therefore dismissed. The full written reasons in support of my decision will available shortly.

Dated this th day of February, 1995.

Roger Bilodeau
Chairperson

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REASONS FOR TRIBUNAL DECISION

TRIBUNAL: Roger Bilodeau, Chairperson

APPEARANCES: Margaret-Rose Jamieson and Helen Beck, Counsel for the Canadian Human Rights Commission

Brian J. Saunders and Anne Turley, Counsel for the Respondent

Peter Rogers, Counsel for the Canadian Diabetes Association

DATES AND LOCATION
OF HEARING : June 22 and 25, 1993 Halifax, Nova Scotia
July 5 and 6, 1993 Ottawa, Ontario
December 2 and 3, 1993 Ottawa, Ontario

INTRODUCTION

[1] This complaint was dismissed in a decision issued on March 6, 1995. The complete factual background and the full written reasons in support of that decision were prepared separately and are now made available in the following pages.

[2] This case can best be described as a follow-up to the Gaetz (1) matter which was decided by a Tribunal in November 1988 and subsequently (2) confirmed by a Review Tribunal in July 1989. As in the Gaetz matter, this Tribunal must determine if it was discriminatory for the Department of National Defence \ Canadian Armed Forces ("CAF") to release Daniel Franklin MacPherson ("MacPherson") on the grounds that he is a diabetic.

[3] Further on, it shall become apparent that there are many similarities between this case and the Gaetz matter. In fact, counsel for the Commission readily indicated during their closing submissions that the end result of this case will turn on the applicability and the impact of the Supreme Court of Canada's Central Alberta Dairy Pool case (1990), which had not been decided when the Gaetz matter was decided by the Tribunal and the Review Tribunal.

COMPLAINT

[4] On December 1, 1984, MacPherson filed a complaint with the Canadian Human Rights Commission ("Commission") against the CAF alleging that it had discriminated against him on the ground of disability (diabetes), contrary to Sections 7 and 10 of the Canadian Human Rights Act ("CHRA").

[5] He further alleged that on August 20, 1984, he was released from

the CAF on medical grounds because he was deemed unfit to perform his duties and was found to be not otherwise employable, pursuant to a decision of the CAF's Career Medical Review Board ("CMRB").

FACTS

[6] MacPherson joined the CAF on March 10, 1978. He completed his basic training at Cornwallis in the prescribed 11 week period. From July to November 1978, he then underwent training for his chosen trade as a Weapons Technician Air - code 571 ("WTA 571") at CFB Borden. From January 1979 to the date of his release on August 20, 1984, he was posted at CFB Shearwater.

[7] He remained in that trade throughout his posting, although he did at various times switch to different areas of activity within that trade, more specifically the armament shop, the explosives area, the rotary wing armament section, the helicopter air department, and finally, the fixed wing utility VU-32 section.

[8] One of the important aspects of this complaint consists of

1 Gaetz v. Canada (Canadian Armed Forces), [1988], Human Rights Tribunal Decision T.D. 14/88
2 [1989] Human Rights Review Tribunal Decision T.D. 9/89

assessing MacPherson's position and trade in the CAF, in light of his medical condition and of CAF working conditions. For that reason, it is useful to recall the most relevant parts of the job description for WTA 571, which are as follows (Exhibit R-8, tab 6):

1. Scope

a. This specification describes the Regular Force trade of Weapons Technician Air which is the only trade in the Air Weapons career field.

[...]

(1) Operations

(a) performs first line maintenance on aircraft, ... acts as a member of a start crew, ...operates military vehicles and towing tractors.

(c) prepares and transports aircraft weapons, missiles, cannons, explosive stores, and devices.
Loads and unloads weapons, missiles, pyrotechnics, and air dropable detection stores. Performs tasks associated with the operation of air to ground, aircraft firing-in, and small arms ranges. Performs tasks associated with the disposal/destruction of

environmental explosives/weapons.

(5) Nuclear, Biological, and Chemical Defence (NBC Defence)
Performs NBC Defence duties as required.

[...]

4. Working Conditions

a. Physical

Duties are carried out in hangars and workshops, in aircraft, and in the open on flight lines, flight decks, arming areas, and ranges. Duties require personnel to be exposed to all climates and environmental conditions, often over extended periods of time. ... Personnel may be required to work from ladders and stands, on rolling or pitching decks, or in confined spaces and must exercise extreme caution at all times.

Attached postings on ships

[9] In the course of his posting at CFB Shearwater, there were two instances where MacPherson had an attached posting to a ship (HMCS Huron) because his duties were directly linked to the operation of Sea King helicopters on that ship. The evidence shows that he was to be on board the ship when required to be with the helicopters. If the helicopters were not in use, he would stay at CFB Shearwater.

[10] The longest trip on that ship lasted two months, during a tour of Scandinavia. There were several other outings of one to two weeks' duration, which consisted mainly of surveillance duties.
Other duties

[11] MacPherson also participated in exercises termed "operation evaluation", which consisted of training to ensure that base members could respond adequately to armed conflict. Such exercises were usually three or four days in length. They were designed to simulate wartime conditions, using various types of scenarios, ranging from an attack by ground troops to an attack by enemy air force planes.

[12] During those exercises, MacPherson was often required to work longer shifts than normal (12 to 16 hours a day), mostly without notice. In addition, those exercises could cause him to miss a scheduled meal or to have it delayed.

[13] In fact, MacPherson acknowledged that due to his position as a WTA 571 during those exercises, one of his main roles was to ensure that the planes would be getting off in time to complete their missions. In that sense, his work schedule during those exercises was in fact dictated by the planes' schedules.

[14] Finally, MacPherson was also called upon to do base defence duty, again with often little or no notice.

Diagnosis for diabetes mellitus and subsequent events

[15] On September 9, 1982, MacPherson was admitted to hospital (CFH Halifax) and was diagnosed as having diabetes mellitus. On that same date, his medical category was temporarily changed from G1 O2 to G4 O4, along with an A7 restriction on flying. His trade (WTA 571) required a minimum medical category of G2 O2.

[16] After his release from hospital, MacPherson served three months in his trade, in the same section as he was in prior to his diagnosis, more specifically the VU-32 section. However, he was not allowed to fly. The evidence also shows that he did not load any bombs on CAF aircraft during that time. His duties consisted mainly of maintaining equipment used for target towing.

[17] Following that short stint in the VU-32 section, MacPherson was sent for training as an instructor at the HT 406 training school for WTA 571. He then began his work as an instructor in April 1983, being initially assigned to rewriting various course materials.

[18] When MacPherson was first diagnosed as an insulin-dependent diabetic, he experienced some difficulty in controlling at least part of the symptoms (i.e. blood sugar level, etc.), which is in fact quite normal at the onset of diabetes. During the following months, he was seen regularly by CAF medical personnel. The issue of control was mentioned in a few CAF medical reports following those visits.

[19] In addition, MacPherson was sent to Dr. Meng-Hee Tan for

assessment (who was in fact called by the Commission as an expert witness in the hearing of this complaint). In his report to the CAF medical staff dated December 22, 1983, Dr. Tan concluded as follows (Exhibit HR-1, tab 24):

In summary, this [MacPherson] is a 29 year old Type I diabetic who has had the disorder for slightly over one year. His diabetes is not in best of control at present, but I feel that with proper attention to diet, exercise and his insulin dose, there is a very good chance he can have good control. When his diabetes is properly controlled, he should be able to continue on his present position as an instructor. It is my understanding that the instruction does not involve the use of guns.

Performance Evaluations

[20] The Commission put forth as evidence several performance evaluations regarding MacPherson's work in the CAF.

[21] Those reports clearly show that MacPherson was well regarded by

his superiors. Brief extracts from those evaluations are useful in showing this:

...superior performance, superior trade knowledge;
an unusual display of self-control;

a high degree of initiative;

conduct of very high standard, an excellent example for his peers;

most highly recommended for promotion, best weapons tech air private on the base;

one of two very exceptional privates;
his work was error free;

quite simply, a superb technician recommended for immediate promotion.

[22] The performance evaluations for the period when he served as an instructor show him as being categorized as a Type 1 diabetic and that this did not impact in any way on his work or physical activities.

Release from CAF

[23] After considering MacPherson's medical record, including all relevant recommendations from CAF medical and non-medical personnel, the CMRB decided that his permanent medical category would be that of G4 O3, in light of his diabetic condition.

[24] That decision by the CMRB effectively brought about MacPherson's release as no position in the CAF can be held with a G4 O3 medical category, unless one obtains a waiver or restriction, which was not the case in this matter. MacPherson's permanent medical category also led to the CMRB's refusal to consider the possibility of a transfer or a remustering because he was given a G4 03 status.

[25] Although MacPherson's initial release date was set for May 1984, he applied for and obtained an extension. He also took some terminal leave between July 1984 and August of 1984. As a result, the actual date of release was August 20, 1984.

EXPERT MEDICAL EVIDENCE

[26] Dr. Meng-Hee Tan gave expert medical testimony on behalf of the Commission. In turn, Captain Cora Fisher and Dr. Bernard Zinman gave similar evidence on behalf of the CAF.

[27] The main thrust of this expert evidence was to provide a basic description of diabetes, its symptoms and treatment.

Dr. Meng-Hee Tan

[28] Dr. Tan is a professor of medicine at Dalhousie University and the director of the Nova Scotia Diabetes Centre at Camp Hill Medical Centre. He is also a member of the Canadian Diabetes Association, being actively involved in the clinical and scientific sections of that association. On the international scene, he has served as Chairman of the North American Regional Council of the International Diabetes Federation, as well as vice-president of the International Diabetes Federation.

[29] To date, Dr. Tan has published close to 100 articles in refereed journals. Finally, Dr. Tan sees patients on a regular basis in his clinical practice, in addition to his academic duties at the university.

[30] On the basis of the above, Dr. Tan was qualified as an expert in the treatment of diabetes.

Dr. Bernard Zinman

[31] Dr. Zinman is an endocrinologist who specializes in diabetes, being a professor in the Department of Medicine at the University of Toronto. He is also :

- on staff at the Mount Sinai Toronto Hospital and the director of the Banting & Best Diabetes Centre Core Laboratory within that hospital; and

- the director of the Diabetes Clinical Research Unit. That unit is involved in two major programs. One is the management of diabetes using, as Dr. Tan pointed out, a diabetes health care team, including diabetes educators, dieticians and other support staff. The other unit does diabetes-related research.

[32] From 1986 to 1988, Dr. Zinman was chairman of the Clinical and Scientific Section of the Canadian Diabetes Association. More recently, he held the position of principal investigator for the University of Toronto in the Diabetes Control and Complications Trial ("DCCT") which was organized by the National Institute of Health.

[33] The focus of Dr. Zinman's research has been in diabetes, concentrating primarily on the complications caused by diabetes and examining different ways in which those complications can be prevented. As well, he has done research in the area of diabetes and exercise and, more

recently, in the area of native health as it relates to diabetes.

[34] The Tribunal readily recognized Dr. Zinman as an expert in the treatment of diabetes. The Commission did not object.

Dr. Cora Fisher

[35] Captain Cora Fisher is Chief of Medicine at the National Defence

Medical Centre ("NDMC") in Ottawa. In that position, she is responsible for all patient care in the Department of Internal Medicine at NDMC. She is also the coordinator of the NDMC's Diabetic Clinic.

[36] Dr. Fisher was qualified as an expert in general internal medicine, with knowledge of diabetes. She was also qualified in military medicine and gave evidence with respect to the CAF Medical Standards.

[37] Finally, Dr. Fisher had previously testified as an expert witness in two previous cases, in particular the Gaetz case referred to at the beginning of this decision. Her qualifications as an expert were not challenged by the Commission.

Description of diabetes

[38] Diabetes is a chronic disease of the body's metabolism. It can also be described as a disease where there is a relative or absolute lack of insulin in the body. This insulin deficiency produces several metabolic abnormalities, especially a high sugar level. In some instances, this can bring about hyperglycemia.

[39] Diabetes affects the utilization of carbohydrates, proteins and fats in the human body. In addition, it contributes to the development of complications in various organs in the body: the eyes, the kidneys, the nervous system, the heart, the circulation to the brain, circulation to the legs, skin, gums. It can therefore be described as a multi-system disease.

[40] There are four broad categories of diabetes, depending on which classification is adopted. There is insulin-dependent diabetes, often referred to as Type 1 diabetes (MacPherson's condition). The second major category is non-insulin-dependent diabetes, or Type 2 diabetes. The third category, called gestational diabetes, occurs when a woman is not normally diabetic but develops diabetes during the course of a pregnancy. The last category is an amalgam of other types of sickness that includes some, or several, conditions which are associated with diabetes.

[41] In North America, approximately 10 to 15 percent of the diabetic population has Type 1 diabetes. The Type 2 diabetics constitute approximately 80 to 85 percent of the diabetic population group.

Treatment of diabetes

[42] The key aspect of a diabetic treatment plan is setting up a management plan that provides for meal planning (content and timing) and physical activity. In the case of an insulin-dependent diabetic (Type 1) such as MacPherson, meal planning and physical activity alone will not

produce a lower blood sugar level. Therefore, the management plan also has to include medication, usually taken in the form of insulin. The last component of any such plan consists of educating the patient in the treatment and management of diabetes.

[43] Such a management plan is usually developed by a diabetes health

care team which consists of a physician, a nurse educator and a dietitian. The team works with the patient, who is considered to be an essential member of the team. In the process of developing such a management plan, the team and the patient aim for a desired level of blood sugar (i.e. control).

[44] It is extremely important to note that any management plan is to a certain extent a balancing act since its main goal is to lower the patient's blood sugar level, but not so low as to bring about hypoglycemia (low blood sugar), which is of course the opposite of hyperglycemia (high blood sugar). Added to this is the fact that insulin injections are intended to replace the body's normal production of that hormone.

[45] As the medical evidence shows, balancing the appropriate amounts of insulin injections, along with meal planning and exercise, becomes one of a diabetic's most important challenges, especially in the early stages of the disease. Seen in that context, it becomes quickly apparent that a diabetic patient's lifestyle and work conditions can have an impact on the management of diabetes and its symptoms.

[46] It is therefore necessary to consider the impact of insulin (taken as medication) on a diabetic, as well as the possible occurrence of hypoglycemia (mild, moderate or severe). The most common causes of hypoglycemia in a Type 1 diabetic are not taking the right amount, or the right type, of insulin; exercising too much; or finally, not eating the proper amount of food. We also know that hypoglycemia can be caused by a combination of these factors.

[47] There are two major groups of symptoms. One is where a patient becomes sweaty and pale, along with a quick heart rate and palpitations. The patient may also be shaky, have a tremor and feel anxious or hungry.

[48] Not every patient will have all symptoms. The type of symptoms and the severity of the symptoms will vary from patient to patient depending on the magnitude of the hypoglycemia.

[49] The second category of symptoms is referred to as neuroglycopenia. This is usually a more severe hypoglycemia which occurs when the blood sugar is drastically lower than normal. In this case, the patient feels tired, irritable and there may be mood changes. Further on, there can be impairment of the intellectual function, as well as visual/sensory problems, confusion and inappropriate behaviour.

[50] Dr. Tan also pointed out that some diabetics have blood sugar levels which are hypoglycemic by definition, i.e. in the low range, and that they don't feel any of the symptoms normally associated with

hypoglycemia. That condition is called "hypoglycemia unawareness". These patients are unaware that their blood sugar level has dropped considerably. The causes of hypoglycemic unawareness in some diabetics are still unknown.

[51] Returning to hypoglycemia per se, the general form of treatment is for the patient to consume sugar in the form of glucose tablets or

drinks, to raise the blood sugar level. In the most severe cases, there is also the possibility of injecting a large dose of glucose (sugar) by way of intravenous. Another part of the treatment is educating the patient to prevent the re-occurrence of hypoglycemia.

[52] Dr. Tan explained to the Tribunal that studies have shown that not every Type 1 diabetic has hypoglycemic reactions. Their occurrence mainly depends on the balance between the amount of insulin in circulation, on one hand, and the glucose level, on the other. Also, other studies do show that approximately 55 to 60 percent of diabetics who use insulin do have such reactions, albeit mild reactions, at least once a year.

[53] However, there are also Type 1 diabetics who don't experience any hypoglycemic reactions. Some of these patients usually keep their blood sugar level a little bit on the high side. The frequency and the severity of hypoglycemia depends on how tightly one controls the blood sugar level.

[54] On this topic, Dr. Zinman added that he quite often sends diabetic patients with a relatively normal health status for a blood test. The test results are sometimes surprising because they show a very low blood sugar level. Neither he nor the patient suspected such a result, which becomes a big concern because it points to hypoglycemic unawareness, especially since the next symptom can be confusion, a seizure or a coma. Dr. Zinman therefore emphasized that there are times when despite being a trained professional, one cannot detect hypoglycemia in a diabetic patient.

[55] A large part of Dr. Zinman's evidence flowed from the findings of the DCCT. The DCCT was one of the most extensive, and recent (1993), studies ever conducted on the treatment of diabetes. The subjects were divided into two groups: one where the patients were given a standard dosage of insulin, and another where the patients were given an intensive insulin dosage.

[56] One of the main findings of the DCCT was that an intensive insulin dosage greatly reduces the risk of long-term complications which are normally generated by diabetes (for example, blindness). However, the downside of this positive result is an increased risk of hypoglycemia, produced by a low blood sugar level which is often perilously close to the limit in terms of the hypoglycemic cutoff point. In medical jargon, keeping the blood sugar level very low and close to the hypoglycemic cutoff point is referred to as "tight control".

[57] Other important findings flowing from the DCCT can be summarized as follows:

- 10% of all Type 1 diabetics fall victim to a severe hypoglycemic attack in their first year;

- approximately 20% of such diabetics will have such an attack within 2 years of becoming diabetic;

- approximately 25 to 30% of such diabetics will have experienced at least one severe hypoglycemic reaction within 3 years of

becoming diabetic;

- 43% of all severe hypoglycemic reactions occur during the night (midnight to 8 a.m.), without any warning signs, whether or not the diabetic is asleep;

- 36% of these same reactions occur in the daytime while a diabetic is awake, again without warning; and

- finally, 51% of such reactions involve situations where the diabetic is awake and where he\she did not recognize the symptoms at the time of the event, even though there would very likely be some confusion or sweating.

[58] In Dr. Zinman's opinion, the DCCT confirmed that there are certain characteristics which help predict if a diabetic will have a hypoglycemic attack but that in general terms, there is no way of identifying these people in advance. It appears that the best identifier is the fact of having had at least one previous attack, which can best be described as a "Catch-22" situation.

[59] In addition, the fact that a diabetic has not yet had a hypoglycemic reaction is no indicator that he/she will not suffer one in the future.

[60] Dr. Zinman also pointed out that in an ideal world, one could identify Type 1 diabetics who are susceptible to complications, since the serious complications (i.e severe hypoglycemia) only occur in about half of all Type 1 diabetics. In this way, doctors and their patients could watch more carefully the patient's blood sugar level. Unfortunately, the research to date, including the DCCT, shows that there is absolutely no way of singling out that group of Type 1 diabetics (approximately 50%) who are most susceptible to a severe hypoglycemic attack.

[61] In response to a question as to whether or not the lifestyle and work characteristics of a diabetic could be predictors of hypoglycemia, Dr. Zinman answered that the DCCT did not address that topic. However, he offered that in his own professional opinion, there is an obvious link between exercise, meal timing, nutrient intake and insulin administration. This link makes it important for a diabetic to have control of his or her environment, to be able to stop work at appropriate times, to take a snack, to be able to monitor his\her blood sugar level, and finally, of being able to treat hypoglycemia appropriately (if it occurs). He offered that some activities or job situations which have regular features will allow a diabetic to follow these steps more easily than others. On the other hand, a lifestyle or employment which is more unpredictable and which requires emergency, prolonged or uninterrupted efforts could be more dangerous.

[62] In cross-examination, Dr. Zinman readily admitted that there have

been many advances in diabetes treatment in the last 5 years, to the point where one could say that there is less need to worry about severe reactions. However, he pointed out that in his opinion, all the advances

that have occurred, whether they be improved self-monitoring, intensive control or multiple daily injections, are all associated with more hypoglycemic reactions.

[63] Dr. Zinman also stressed the importance for a diabetic to closely monitor his\her blood sugar level, especially if taking multiple daily injections of insulin. Monitoring often identifies hypoglycemia before any symptoms arise. In his view, monitoring is a very important safety issue.

[64] Finally, Dr. Zinman readily conceded that he did not have a military background or experience. In any event, he was not asked, nor could he have expressed an opinion on MacPherson's ability to serve in the CAF.

Status of MacPherson as diabetic

[65] Upon and after being diagnosed as a Type 1 diabetic, MacPherson was discharged from hospital on September 20, 1982 and was then seen weekly in the out-patient section for several months afterwards.

[66] The medical records and the evidence show that he did not experience any severe hypoglycemic reactions while in the CAF. However, MacPherson did experience mild hypoglycemic reactions on at least a few occasions, which he described as causing a tingling in his hands and a strange feeling which he could not adequately describe.

[67] MacPherson controlled these reactions by consuming glucose in the form of candy, sugar or juice, which he always carried with him. According to his evidence, he would be completely back to normal in less than ten minutes.

[68] MacPherson also reported to CAF physicians that on a few occasions, he experienced difficulty waking in the morning. On those occasions, his wife had to serve him a drink of some kind which contained sucrose.

[69] On the other hand, MacPherson never required nor was he assisted by friends or work colleagues during such reactions. He was always able to control them by himself.

[70] Except for Dr. Tan's assessment of MacPherson as a patient, the Tribunal did not hear evidence from any of the treating doctors regarding MacPherson's condition as a diabetic. However, Dr. Fisher was called upon to comment MacPherson's medical records, keeping in mind that she did not see him as a patient. She noted the following:

- a blood sugar level which was often quite low, noting in particular an incident on December 9, 1982 at 1100 hours, which pointed to severe hypoglycemia of which MacPherson was unaware, after having played hockey;

- on December 23 and 31, 1982, the treating doctors' conclusion was

that he was in an unstable diabetic state;

- a lack of apparent precipitating factors in regard to his poor blood sugar control, i.e. lack of another illness or factor that could have caused his low blood sugar levels. In Dr. Fisher's view, the meaning of such a diagnosis is that MacPherson was probably having difficulty controlling his blood sugar level; and

- the fact that he forgot to take his insulin on at least 2 occasions (one in January 1983 and another in April 1983, also being hospitalized in April 1983) raised more concerns about his control and the stability of his diabetes, keeping in mind that this happens to almost all diabetics.

[71] In summary, Dr. Fisher agreed with Dr. Tan that MacPherson's control was not good during at least the period 1982 to 1983. She was also struck by Dr. Tan's letter (quoted above) where he stated that MacPherson could continue his position as an instructor, as long as it was understood that the use of guns was not involved. She thought it was extremely significant that Dr. Tan had put an occupational restriction on MacPherson's status in the CAF, especially since he was dealing with someone in the WTA 571 trade who normally handles ammunition on a regular basis.

[72] In cross-examination, MacPherson was questioned by counsel for the CAF on the notion of controlling diabetes and what it meant to him. He readily acknowledged that it meant keeping one's blood sugar at a recommended level. He also acknowledged the impact of the lifestyle factors which have been mentioned in the expert medical evidence, i.e. exercise, meals and insulin injections.

[73] Furthermore, MacPherson recognized that to achieve good control of diabetes, it was slightly more important for a diabetic to have a regular lifestyle, as opposed to a non-diabetic. In addition, MacPherson acknowledged that he could have a hypoglycemic reaction if he missed or delayed a meal.

[74] On the topic of insulin usage and storage, MacPherson agreed with packaging instructions which recommend that it be kept in a fridge. At the very least, he also agreed that it must be kept away from heat and direct sunlight.

[75] Finally, the evidence showed that MacPherson was re-admitted to the hospital in March 1993 (therefore after his release from the CAF) due to an episode of extremely severe hypoglycemia, as a result of having injected the wrong kind of insulin.

CAF MEDICAL CATEGORIES

[76] The next major topic to consider is that of the CAF medical categories. The main purpose of this section is to briefly describe the main medical categories and their relevance. Secondly, it is necessary to look at how diabetics are categorized, along with the reasons for such categorizations. Finally, the CMRB process will be briefly described and considered as it pertains to MacPherson's situation.

[77] The Tribunal heard Dr. Fisher on these topics. In addition, the Tribunal was referred to the Manual of Medical Examination for Canadian Armed Forces ("Manual"). Captain Dupont of the CAF also gave evidence in regard to the CMRB process.

Captain Michel Dupont

[78] Captain Dupont ("Dupont") is a Personnel Administration Officer in the CAF. At the time of this hearing, he held the position of Secretary to the Non-Commissioned Members Career Medical Review Board ("CMRB"), in Ottawa.

[79] The CMRB is charged with determining the career paths of CAF members in light of various medical conditions and factors. In his position, Dupont is in charge of all the documents that are presented before the Board and of ensuring their accurateness.

[80] Although Dupont did not hold this position at the time when MacPherson's file was dealt by the CMRB, he did examine his file for the purpose of giving evidence at this hearing.

Purpose of the CAF medical categories

[81] Dr. Fisher was called upon to describe the process used in assessing the appropriate medical category for CAF members. She emphasized that it was a matter of both medical and military judgment which requires a good understanding of the military task assigned to any one CAF member.

[82] In her opinion, one purpose of the medical category is to ensure that all CAF members are treated in the same manner, no matter who is the examining physician or on which CAF base one is posted.

[83] A second purpose is to communicate medical information to CAF supervisors and career managers who need to know a member's medical limitations, if any. In Dr. Fisher's opinion, all of the military forces world-wide have an equivalent categorization system for these purposes.

Summary of CAF medical categories

[84] The CAF maintains a common medical categorization for candidates and serving members. The medical category of a member or candidate includes year of birth and six factors. The factors most relevant to this case are Geographical Limitation (G) and Occupational Limitation (O), because they are most important in determining a member's global employability. The medical category is determined by the results of medical examination and assessment in accordance with the Manual. Numerical gradings are then entered for each designated factor.

The Geographical Factor

[85] The Geographical Factor is assessed in order that the CAF may determine where a member can be expected to perform efficiently. The main factors involved in this assessment are climate, accommodation, living conditions and the availability of medical care.

[86] G2 is the grade assigned to a person who has a minor medical

condition which does not require regular medical support and does not preclude employment in any climatic or environmental condition.

[87] G3 is the grade assigned to a person who has a medical condition that requires more frequent medical supervision. Such personnel are required to seek medical care, but not necessarily a physician's services, approximately every three months.

[88] G4 is the grade assigned to any person who has a medical condition that has the potential for sudden serious complications or a medical disability which is persistently mildly incapacitating.

[89] In Dr. Fisher's opinion, G4 is where you start to get into problems with a member's employability because he/she either needs barrack accommodation, a temperate climate or readily available physician's services. In the case of a diabetic, the main priority is having a physician's services readily available, along with the appropriate primary tools, such as lab and x-ray facilities.

The Occupational Factor

[90] The Occupational Factor involves an assessment of physical activity and physical stress, along with mental activity and mental stress, which are associated with the particular occupation or trade of a CAF member.

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

[92] O3 is the grade assigned to an individual who has a moderate medical or psychological disability which prevents him/her from doing heavy physical work or operating under stress for sustained periods. However, most tasks can be done in moderation.

[93] Dr. Fisher then commented that the occupational factor is intended to reflect the requirements in terms of heavy physical activity and response to stress within an occupation or a trade.

[94] A member who is classified as an O2 has to be able to do heavy physical work in a combat environment. At the O3 level, we have a member who can do almost anything, but only for a non-sustained period of time. In other words, we are dealing with members who can only do most tasks in moderation.

[95] At the O4 level, we are dealing with someone who has a more

severe disability, such as being incapable of doing any heavy work, or someone who reacts badly to stress and cannot work under battlefield conditions, although he/she may be extremely useful at a base level.

The Categorization Process

[96] Dr. Fisher then commented on the process which determines the category which is assigned to a given member. She explained that what

physicians are asked to do when assigning a category is to not in fact assign a number, but rather to answer a series of questions about what the member can do. After answering that series of questions, they refer to the definitions in the Manual and ask themselves "[W]here does someone with those limitations fit in terms of definitions?"

[97] The common enrolment standard for new recruits is G2 O2. The standards for various occupations or trades within the military are all separately assessed and may be higher than the enrolment standard.

[98] When a serving member is found to have a medical condition that requires recognition of a limitation in his employment, he/she will be reclassified under the applicable factor or factors. When the grading falls below that stated for his/her trade, the effect upon the military career of a member's employment limitation becomes a personnel and administrative matter to be dealt with by the CMRB. In some cases, experienced tradesmen who have their category lowered will be considered for retention in the trade on their individual merits. In other cases, members may also be remustered to another trade.

[99] Medical conditions and physical defects which result in a category which is below the required minimum levels are set out in the Manual. Some of the conditions are remedial or self-limiting and the category may be temporary until the condition is resolved. A suggested category for each condition is listed in the Manual but it may vary depending on the severity of the condition.

[100]One of the causes listed for a restricted category in the Manual (p. 7-13, at paragraph 18) is diabetes and the suggested category for this condition is G5 and O3, O4 or O5.

[101]In fact, Dr. Fisher went on to state that this guideline is more severe than most categories which are in fact assigned. She added that most diabetics will fit somewhere between G5 and G3 and between O3 and O5, depending on the severity of their condition.

[102]Dr. Fisher then discussed CAF concerns with Type 1 diabetics. She stated that the most severe concern is with an acute reaction, particularly hypoglycemia, because there is concern for the individual member's safety as well as for that of the people working with him\her. She pointed out that losing consciousness while handling explosives is not an acceptable risk.

[103]Dr. Fisher expressed the opinion that Type 1 diabetics are unfit

for field duties because the CAF simply doesn't have the resources in the field (at least at the first two levels of medical support) to deal with a diabetic who is having an acute problem. Although she acknowledged that a diabetic can do almost any task if it can be pre-scheduled and if meals and insulin can be adjusted, she personally feels that meal hours in the field are often irregular and that work may be heavy, prolonged, and unscheduled, none of which serve a diabetic well.

[104]In regard to fitness for sea and ship duty, Dr. Fisher also believes that there is a problem of limited resources. The helicopter destroyers usually have a physician on board but they don't have anything in terms of laboratory facilities.

[105]Dr. Fisher then dealt with the next category, i.e. isolated postings. As in the case of sea duty, Dr. Fisher stated that the medical personnel (not necessarily being a trained physician) at these postings, for example Alert, do not have the training nor the lab and x-ray equipment that might be needed for someone with a significant illness.

[106]Dr. Fisher continued by stating that in her experience, all Type 1 diabetics receive an occupational and geographic limitation. In fact, any member with a significant medical illness will be looked at to see where he/she fits in the medical categories and what their illness will allow them to do. The category limitation will only depend on the member's personal performance.

[107]Dr. Fisher further explained that for all her time in the CAF, she had not encountered one Type 1 diabetic who was fit for duty at sea or field. Furthermore, she was categoric in stating that to her knowledge, all Type 1 diabetics are categorized as G4 or G5, depending on whether or not they need specialist care.

[108]In Dr. Fisher's opinion, the CAF does not have a blanket policy excluding diabetics. The major factors which determine a Type 1 diabetic's medical category in the CAF are:

- whether he/she can be controlled by diet or insulin, and in the affirmative, the level of control; and

- whether or not he\she has hypoglycemic reactions.

[109]Finally, Dr. Fisher expressed the opinion that the final medical category assigned to MacPherson in 1983 was appropriate, based on her reading of his medical file. She considered that MacPherson's medical assessment and diagnosis was consistent with current prevailing medical theory and practice in Canada at the time (i.e. 1983-84).

The CMRB Process

[110]When a serving member's medical category has been temporarily downgraded, usually for a period of 6 months, CAF medical personnel must then make a recommendation in regard to a permanent medical category. This process is triggered by a Notification of Change of Medical Category ("Form

2088") which is prepared for evaluation by the CMRB. Form 2088 is in fact an administrative document that is separate from all medical documents concerning a member's medical category.

[111]Dr. Fisher went on to explain that Form 2088 contains the following essential information:

- the individual's name, service number and date of birth; and

- the medical category, including the member's temporary category in the geographic and occupational factors since his/her illness, as well as the category being permanently recommended by Form

2088.

[112]In MacPherson's case, the previous temporary category for the G factor was a G4 and the permanent category which was recommended on Form 2088 is identical. For the O factor, the previous temporary category was O4 and the permanent category which was recommended is O3.

[113]Form 2088 also contains a coded medical diagnosis prepared by various CAF medical physicians. This diagnosis is coded to ensure the confidentiality of a member's medical condition having regard to CAF non-medical staff who are involved in the administrative CMRB process.

[114]Dupont explained the factors which are considered in coming to a decision regarding a member whose case comes before the CMRB. First of all, the CMRB looks at the limitations imposed by the CAF medical authorities. The CMRB is not concerned with the type of illness but rather with the limitations imposed by the member's illness or medical condition. In essence, the CMRB is seeking to determine what the person being assessed can do or cannot do.

[115]The CMRB's next step is to look at the member's current occupation, including its requirements and the type of duties he\she is required to do. The CMRB also considers the Career Manager's recommendation and the percentages of employability, before coming to a final decision.

[116]In MacPherson's case, the minimum medical category for his WTA 571 trade was G2 O2. Dupont then noted that MacPherson was recommended for a permanent medical category of G4 O3 and that he was assessed as being 15 per cent employable at his rank and occupation.

[117]Dupont explained that the employability rate is an indicator of the number of positions that a serving member is capable of filling with the medical limitation imposed on him by the medical authorities. In MacPherson's case, the 15 per cent employability rate applied to positions in his current rank and trade as well as those in the next highest rank and trade for which he was eligible.

[118]Dr. Fisher then explained that the CMRB decision is individualized and that it depends in large part on the member's exact

medical limitations and the exact requirements for his/her trade. In her mind, there was no doubt that the employability rate is a key factor in its decision. She also added that as the CAF becomes smaller, which is currently the case, serving members need to have the highest possible employability rate.

[119]Dupont then confirmed the CMRB recommendation for MacPherson's release. That recommendation, including the prescribed limitations, reads as follows (Exhibit R-14, page 35):

G4 - physician services readily available, unfit field, sea, medically isolated and UN duties; O3 - unfit prolonged

physical exertion and unfit compulsory PT test. These limitations render Cpl MacPherson unfit for further service in his current trade and render him unfit for remuster as he does not meet the minimum medical entry criteria for any other trade. Consequently, Cpl MacPherson is not advantageously employable under Service policy.

ROLE & STRUCTURE OF THE CAF

[120]Evidence with respect to the structure of the CAF and its present day role was given by several CAF officers who hold various positions and responsibilities as described below. In their various capacities, these officers also gave evidence regarding the requirements and stresses of WTA 571, as occupied by MacPherson.

Major Hans Gartner

[121]Major Gartner ("Gartner") is a Military Engineer in the CAF. Since May 1993, he occupies the position of Technology Trends Analyst with the CAF's Directorate of Force Concepts.

[122]This Directorate's responsibilities are to assist the Canadian government in interpreting its armed forces policy. It also runs scenarios, does operational research and provides options analysis to the Minister and to the Chief of Defence Staff. The Directorate's personnel also write the CAF development plan, i.e. the equipment to be held, the number of personnel and occupations required.

[123]On the basis of his work within the above described Directorate, Gartner is quite familiar with the structure and roles of the Canadian Armed Forces.

[124]According to Gartner, the sole purpose of the CAF is to be prepared for war. It is the ultimate aim of all of the CAF's training and planning. The Governor-General in Council, under the guidance of the Minister of National Defence, determines where and when CAF units are sent on duty, whether in peacetime or during times of war. As of late, there have been several assignments on UN peacekeeping tours to various countries around the world. Gartner stated that all members of the military are

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

[125]Gartner also informed the Tribunal that weapons are issued to each member of the base defence force. Each CFB has a base defence force. Various members of a CFB are called upon to serve on base defence duty, including members in WTA 571 occupations, such as MacPherson. Such base defence force personnel are required to train and qualify each year regarding the use of weapons grenades, even if weapons are not used regularly during base defence duties.

[126]The type of training given to base defence force members is basically low-level infantry tactics. The training is based on vital point

security, i.e. sentry patrols to man a bunker, an observation post, to go through identification, the taking of prisoners as well as some sort of riot control exercise. The intensity and the duration of the training depends on the Base Commander.

[127]Based on his personal experience as a Platoon Commander, Gartner explained some of the training conditions that a member of the base defence force would expect to find during these yearly training sessions. Although some vital point teams have to be sent out and be self-sufficient for several days, on the whole they're able to rotate through the kitchens for warm meals. However, everyone on the team has to be prepared to be deployed to a vital point and to stay there until relieved. If so ordered, these members have no option. In regard to the riot control exercise, Gartner pointed out the high stress associated with that activity.
Captain Karen Armour

[128]Captain Armour ("Armour") is with the Directorate of Manpower Planning where she is the officer responsible for air operations occupations, including WTA 571, as it existed during MacPherson's posting in the CAF.

[129]She testified that her directorate has a number of sections within it. One section is involved with force reduction. There are other sections involved with task allocation within the Canadian Forces. Another is involved with occupational analysis, where occupational specifications are set by studying the occupation itself and determining what task, skills and knowledge are required in order to perform a particular trade.

[130]Armour's section of the directorate (DMP-3) controls the occupation structures that have been developed through occupational analysis. It controls all aspects of the military occupational structures. She is responsible for all of the air operations occupational specifications.

[131]Armour explained that CAF personnel could be subjected to extreme physical stress. During field exercises, for example, a member might be operating for periods of time where there is no sleep or little opportunity for rest, limited food and reduced rations, perhaps finding water only on

occasion as opposed to having it regularly available, and a lot of physical activity such as marching, moving and climbing. She also explained that within various occupations, there may be other kinds of physical stress, for example motion sickness if one were posted on a ship.

[132]In addition, she referred to the fact that a WTA 571 can be exposed to all climates and environmental conditions. Also, he\she will almost certainly have to unload explosive stores and weapons, plus handling live rounds in an operational environment such as in or around a CF-18. The live rounds on that aircraft have to be loaded and unloaded regardless of the weather conditions.

[133]In addition, a WTA 571 such as MacPherson could be working on a ship, arming a Seaking helicopter. They can also be called upon to carry weapons and to work on the pitching deck of a ship, along with ice

depending on the location of the ship.

Chief Warrant Officer Thomas Gerald Hammond

[134]At the time of this hearing, Chief Warrant Officer Hammond ("Hammond") was stationed at National Defence Headquarters in Ottawa. Since 1989, he has held the position of Career Manager for the Air Weapons Systems occupations.

[135]As a Career Manager, he is involved in all aspects of career management, from posting of personnel to any type of compassionate requests, as well as promotions. Previously, he had served at Canadian Forces Europe.

[136]Hammond testified that based on his experience, the biggest stress in the WTA 571 is to achieve efficiency and safety. In his opinion, the conditions surrounding an occupation such as WTA 571 were probably the hardest that he had ever encountered in his career, especially as a result of loading live weapons aboard fighter or similar aircraft. Once the aircraft were loaded and launched, WTA 571 crews then have to replenish weapon storage areas to prepare for the next aircraft which have to be loaded.

[137]Hammond further testified that there were occasions when he was required to wear a nuclear/biological/chemical ("NBC") warfare suit. The NBC suit basically covers the entire body, including the hood that goes up over the head. It is taped off at the wrists and at the ankles. The suit goes down over top of the boots. The entire body is covered with the exception that there is a zipper that one is sometimes allowed to leave open with the hood down. However, the gas mask and the rubber gloves are at the ready. There is also a belt around the waist to carry essentials such as atropine. Atropine is a drug to be self-injected if there are signs of nerve gas in the atmosphere. It is meant to be injected right through the NBC charcoal impregnated suit.

[138]Hammond further explained that as a WTA 571, he would also have to exercise when wearing the full NBC suit. Each individual exercise

varied in length from 15 minutes to over an hour. Hammond himself once wore the suit for over four hours, with the hood and gas mask. The NBC suits which were in use at that time did not allow one to eat or drink with the gas mask on. Army combats would be worn underneath the NBC suit. The entire suit was extremely uncomfortable. It did not take very much movement or exercise to work up a total sweat. In addition, all personnel wearing these NBC suits would be required to do their normal work when wearing it.

[139]Hammond further added that the lifestyle for a WTA 571 who is on-board ship is difficult because of the pitching and rolling of the ship, while carrying out regular and sometimes extra duties. He then cited as an example that the WTA 571 personnel who went to the Gulf War on ships sometimes worked up to 16 hours a day in preparation for the actual arrival in the war zone.

[140]As a Career Manager, Hammond explained that there are limited numbers of WTA 571 who act as instructors, such as MacPherson did towards the end of his CAF posting. According to Hammond, these are never permanent assignments. What usually happens is that members of that trade with a specific expertise are trained as instructors to then serve in that position for roughly three to four years. The reason for this is to have a viable contingent of trained instructors. However, the fact remains that after about four years in a teaching position, the individual is sent back out into the "real world" of CAF duties.

[141]As a Career Manager for personnel in the WTA 571 trade, Hammond was clear that he could not guarantee that someone in that trade could have regular hours and the ability to control his/her working environment. In his capacity as a Career Manager, his job is to ensure that personnel are posted to specific bases. Once they are on the base, it is entirely up to the Base Commander to determine how each member of that trade is to be employed.

Warrant Officer Ron Western

[142]Warrant Officer Western ("Western") is stationed at National Defence Headquarters in the Directorate of Fighters Training and Release Equipment. During his entire career in the CAF, he has always worked in either the Air Weapons Tech or the Air Weapons System trades (WTA 571 and 572).

[143]His current duties are those of a Life Cycle Manager for the F-18 rack and release equipment i.e. the weapons release equipment on the F-18 aircraft. In that position, he oversees all life cycle costing and procuring of spare parts for the F-18 armament equipment.

[144]Western also served in the Gulf War. At that time, he was a training officer at Canadian Forces Europe.

[145]Western was called upon to describe the working conditions for WTA 571 personnel who served in the Gulf War, including the preparatory work leading up to it. He stated that the work hours were very long, both

before and during the war, loading planes as they went out and returned. Shift lengths would depend on the work that was to be done. In any case, they were usually longer than the normal eight hours.

[146]Prior to the actual war period, the work mainly involved setting up various equipment in relation to getting the aerodrome operational, including runway preparation and building shelters. There were also several warm-up periods and training periods.

[147]There were also duties which were in addition to normal occupational duties, for example, preparing sandbags. These extra duties would be done after one's normal shift, usually in rotating two hour sessions involving all personnel ranks.

[148]According to Western, a normal shift in the pre-war period would be approximately eight to ten hours in duration. Once the war got

underway, or just a bit before that, he went to a 12 hour shift system, being for example from 12 noon to midnight. Western states that he never had the chance to rotate or change shifts, that he never had a day off, working 12 hour shifts seven days a week. He also added that on occasion, he would be called upon for extra duties outside the 12 hour shift period, usually for sandbagging or kitchen duties.

[149]Western then continued on the topic of the NBC warfare suit, saying that he had to wear it as often as was required, especially during several alert statuses in the first part of the war. In addition, there were drills and practices prior to the war. He added that it was impossible to drink or eat with the gas mask on and with the hood in the closed position. Also, one was not allowed to take off the gloves, boots or the suit outside a controlled environment.

[150]Prior to the Gulf War, he would be called upon to wear it for exercises in Europe, for periods of up to three or four hours. He stated that the NBC suit was very uncomfortable, restrictive and at times quite hot. It was very cumbersome and in his opinion, nobody enjoyed it.

[151]Western was then questioned on sleeping hours for personnel on the 12 hour shift. In his opinion, it was a matter of getting whatever rest one could get. Unfortunately, this was often difficult during the first part of the war because of frequent interruptions due to air raids during sleeping hours.

[152]With respect to eating hours, Western indicated that they were fairly regular. He would normally eat prior to, and after, going on shift at the main camp. During the shift, a mobile mess kitchen was made available.

THE CDA AND ITS POSITION AS INTERVENOR

[153]Mr. Peter Rogers appeared on behalf of and as the sole witness of the Canadian Diabetes Association ("CDA"). He is a member of the National Board of Directors, Chairman of the National Advocacy Council, legal

advisor to the Nova Scotia Division Board of Directors, and a member of the National Task Group on Public Health Care Policy.

[154]Mr. Rogers also made extensive reference to the Clinical and Scientific Section of the CDA. He emphasized that the section is regarded as an independent body in itself. He also added that the membership of the Clinical and Scientific Section includes a large number of members involved in diabetes research.

[155]Mr. Rogers then pointed out that The National Advocacy Council of the CDA reports to its National Board of Directors. His evidence focused on the activities of the National Advocacy Council. He informed the Tribunal that the National Advocacy Council is essentially a standing committee responsible for implementing the policies of the National Board of Directors regarding advocacy or public affairs issues.

[156]The principle issues with which the National Advocacy Council are

seized are of two types. The first is advocating for the elimination of barriers to equal opportunity arising from discrimination against persons with diabetes. The second is advocating to public health care policy makers for adequate and appropriate resources to minimize barriers to equal opportunity which arise from the financial cost of treating the disease.

[157]Over the years, the National Advocacy Council has been involved in negotiating, making submissions and being involved in litigation with a number of entities which the CDA has regarded as having a discriminatory blanket policy that treats all persons with Type 1 diabetes in the same way without distinguishing individual circumstances. Some of the entities with which the CDA has dealt with over the years include the Toronto Fire Department; Canadian Pacific Railways; Canadian National Railways; the CAF; motor vehicle licensing authorities; the Canadian Council of Motor Transport Administrators, which is essentially a body which consists of provincial and territorial Registrars of Motor Vehicles; and also the Canadian Medical Association Committee Responsible for Preparing the Physician's Guide to Motor Vehicle Licensing.

[158]From the perspective of the National Advocacy Council of the CDA, the CAF remains the primary object of its efforts to remove barriers to opportunity created by what it believes to be discriminatory policies in regard to Type 1 diabetics.

[159]According to counsel for the CDA, and in response to questions from the Tribunal, all employers should be able to accommodate most Type 1 diabetic patients, especially those who are controlled. In addition, he acknowledged that one of the relevant factors in this regard is the type of work environment or context, as well as the amount of control that the employer and the employee may or may not have over the working conditions and timing of events.

POLICIES OF OTHER EMPLOYERS IN REGARD TO EMPLOYEES WHO BECOME DIABETIC

[160]Both during and after the hearing, the Tribunal received oral and written submissions from the CDA, the CAF and the Commission regarding the policies of other employers or organizations in regard to employees who become diabetic (Type 1), as opposed to admission policies for diabetics.

[161]For convenience and clarity, I have divided these policies in two groups, namely a) military and b) non-military. In group a), we have the following:

- the United States Air Force ("USAF"); and

- the Israeli Defence Forces ("IDF").

[162]Policies received in group b) are as follows:

- the RCMP ("RCMP"); and

- the CN ("CN").

[163]In addition, the Tribunal was referred to documents or articles which explained the policies of the following organizations. These will also be considered in group b):

- CP Rail ("CP");

- the Toronto Fire Department ("TFD");

- the American Diabetes Association ("ADA");

- the Clinical and Scientific Section of the CDA ("CSS-CDA");

- the CDA Submission to Canadian Human Rights Commission on Canadian Forces Limitations Associated with Diabetes (authored by Tan, Yale and Corry) ("CDA Draft policy"); and

- the Canadian Medical Association's Physicians' Guide to Driver Examination ("CMA").

[164]I will firstly deal with the policies of non-military employers. For the sake of brevity, I will only point out the most relevant aspects of any particular policy in this group.

[165]The RCMP policy contains a medical grading system which is very similar to that of the CAF. Type 1 diabetics are graded more severely than Type 2 diabetics, along with tighter restrictions, unless blood sugar is kept at a high level and there have been no symptoms for 24 months.

[166]The CSS-CDA produced a position statement on diabetes and commercial driving. This statement indicates that with appropriate guidelines for the medical certification of commercial drivers, there is no need for a blanket policy preventing Type 1 diabetics from entering that line of work. However, some of the proposed exclusion criteria are as

follows:

- any episode of hypoglycemia requiring a need for intervention by an outsider for correction within the past two years; and

- appearance of hypoglycemia in the absence of warning symptoms.

[167]The ADA Employment Policy Statement provides that all diabetics (whether Type 1 or Type 2) should be eligible for any employment for which he\she is qualified. The policy encourages individual consideration of each employment candidate and the avoidance of blanket policies. In addition, there is the following comment (Exhibit I-2, tab 1):

...[i]ndividual jobs and individual people with diabetes should be considered, weighing such factors as treatment regimen,...presence of complications of diabetes, and specific job requirements or hazards.

[168]CP has adopted a policy of individualized assessment which permits all Type 1 diabetics to qualify for safety-sensitive positions in that organization. According to a September 1993 article submitted by the CDA, that policy would appear to be similar to that of CN's.

[169]The CN policy is designed to avoid a blanket prohibition of all Type 1 diabetics. It does however include the following guidelines (Exhibit R-13):

- ...no history of hypoglycemia requiring a need for intervention by an outsider during the past two years; [...]

- blood glucose concentration must be tested within an hour before work and approximately every 4 hours during working hours; [...]

- a 12 hour advance notice is essential before a work shift can start;

- work should not include unanticipated heavy musculoskeletal demands;
[...]

- assignment of these individuals to be contingent on each individual's condition, and subject to final adjudication by CN Medical department in consultation with Operations and Diabetes Specialist.

[170]The CDA Draft Policy states that there should be as few limitations as possible on diabetics in the CAF. However, it goes on as follows in regard to Type 1 diabetics (Exhibit HR-1, tab 25 at p. 169):

No matter how well controlled insulin-dependent [Type 1] diabetics were prior to military deployment, such persons

might have difficulty maintaining control during deployment. Therefore, most persons with insulin-dependent diabetes would require some Occupational and Geographic limitation on their employment. The category imposed however, would vary from case to case depending on the medical fitness of the person involved.

The risks associated with insulin-dependent diabetes and the performance of demanding military duties can be minimized by the formulation of precise guidelines, aimed at avoiding the risk of harm to the person with insulin-dependent diabetes and others, such as:

i) [e]xcluding the people with insulin-dependent diabetes from physically demanding military duties who cannot recognize their early hypoglycemic symptoms, as well as those diabetic complications that may affect their ability to perform a certain occupation;

ii) [i]ncreasing target glucose values during the work shifts where alertness and fitness is crucial, and more frequent monitoring during irregular periods of activity and meals;

iii) [r]egulating the work pattern so as to eliminate conditions that would lead to an increased risk of hypoglycemic reactions.

[171]Finally, the CDA Draft Policy contains guidelines which are very comparable to that of CN's.

[172]In regard to the CDA Draft Policy, Dr. Fisher was asked to compare that document with CN's. In her opinion, the policy adopted by CN is much stricter than the policy suggested by the CDA submission. It is also much more detailed, which would probably make it considerably easier to implement.

[173]She agreed that all of the CN guidelines were very important. In particular, she was struck by the clause stating that "[w]ork should not include unanticipated heavy musculoskeletal demands." In her view, CN has thus limited quite significantly the type of position that a person can hold because there are positions where the workload can be programmed in terms of its physical demands and there are others where that cannot be done. In her view, CN has simply excluded Type 1 diabetics from certain positions where the work cannot be planned sufficiently in advance. a) The TFD has adopted individual assessment criteria for persons with diabetes. They do accommodate Type 1 diabetics upon assessing an individual on a set of criteria and being satisfied that he/she does in fact have stable control.

[174]We now go on to the case of other military forces, namely the USAF and the IDF, and their position in regard to Type 1 diabetics. At the

outset, it should be noted that they both have stringent policies against retaining Type 1 diabetics.

[175]Extracts from the USAF's relevant regulation read as follows (Exhibit R-12):

The causes for rejection for appointment, enlistment, and induction are as follows:

...[d]iabetes mellitus...when proven to require hypoglycemic drugs...in addition to restrictive diet for control.

[176]Relevant extracts from an IDF letter addressed to the Commission's Counsel read as follows:

In the I.D.F., we have a long standing policy[.] regarding insulin-dependent diabetics, which declares them absolutely disqualified from combat duties. As a matter of fact, the mere diagnosis of I.D.D.M. indicates an immediate expulsion from any military service altogether.

[177]In addition to the above, Dr. Fisher added that to her knowledge, serving members of the USAF who are diagnosed as Type 1 diabetics are subject to a "CMRB" procedure, just as in the CAF. In regard to flying duties, she stated that the USAF will let diabetics fly only if they do not require oral hypoglycemic medication of any kind, whether in the form of pills or insulin injections.

[178]She also added that the USAF has a recall statement so that if they are in a war status, for example during the Gulf War, they in fact would have called up diabetics but would have considered them non-deployable. They would have put them in base jobs (in the continental U.S.A.) to free up other people to go to Europe, but they would not have deployed them outside of the continental U.S.A.

[179]In response to questions from CAF counsel, Rogers (for the CDA) acknowledged that the USAF has some form of blanket prohibition regarding

Type 1 diabetics.

[180]Finally, Dr. Fisher pointed out that the USAF does not even retain non-insulin-dependent diabetics (Type 2) whereas the CAF has on occasion done so, based on an individual's control and stability.

THE LAW

[181]As is usually the case in these types of complaints, the onus is on the Complainant and the Commission to establish a prima facie case of discrimination.

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

"15. It is not a discriminatory practice if
(a) any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is established by an employer to be based on a bona fide occupational requirement;"

[183]The burden of proof in establishing this defence is on the Respondent, CAF, and the onus is the ordinary civil standard of proof, i.e. upon a balance of probabilities.

[184]Following are brief references to most of the leading cases which have analyzed the various elements of the BFOR defence.

[185]The case of Ontario Human Rights Commission v. Etobicoke, [1982] 1 S.C.R. 202 ("Etobicoke") is authority for the proposition that both a subjective and an objective test have to be met. The subjective test is stated as follows at page 208:

"To be a bona fide occupational qualification and requirement a limitation ... must be imposed honestly, in good faith, and in the sincerely held belief that such limitation is imposed in the interests of the adequate performance of the work involved with all reasonable dispatch, safety and economy, and not for ulterior or extraneous reasons aimed at objectives which could defeat the purpose of the Code."

[186]The objective test, also at page 208, reads as follows:

"In addition it must be related in an objective sense to the performance of the employment concerned, in that it is reasonably necessary to assure the efficient and economical performance of the job without endangering the employee, his fellow employees and the general public."

[187]With respect to the objective test, Mr. Justice Sopinka wrote as follows in Saskatchewan (Human Rights Commission) v. Saskatoon, [1989] 2

S.C.R. 1297 ("Saskatoon") at page 1309:

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

[188]To be bona fide, a rule or requirement must be demonstrated to be

directed toward a real risk. In his reasons in Etobicoke, Mr. Justice McIntyre also stated at pages 209-210 that a tribunal, in deciding whether a BFOR has been shown must consider:

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

[189]In Canadian Pacific Limited v. Canada, [1988] 1 F.C. 209 (F.C.A.) (commonly referred to as "Mahon"), Mr. Justice Marceau elaborated on these words at p. 224:

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

[190]Furthermore, the analysis of a BFOR is to be directed to the occupation and not to an individual. As stated in Bhinder v. Canadian National Railway Co., [1985] 2 S.C.R. 561 ("Bhinder") per Mr. Justice McIntyre at page 588:

"The words of the Statute speak of an "occupational requirement". This must refer to a requirement for the occupation, not a requirement limited to an individual. It must apply to all members of the employee group concerned because it is a requirement of general application concerning the safety of employees. The employee must meet the requirement in order to hold the employment. It is, by its nature, not susceptible to individual application."
And at page 589:

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

[191]Similarly, where a rule constitutes direct discrimination against a group, there is no duty to accommodate individual members of that group. See Central Alberta Dairy Pool v. Alberta (Human Rights Commission), [1990]

2 S.C.R. 489 at p. 514 ("Dairy Pool"):

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

discriminate directly impose a burden on all persons who fall within them. If they can be justified at all, they must be justified in their general application."

[192]Finally, individual testing may be a consideration in establishing a BFOR. In the Saskatoon case, Mr. Justice Sopinka J. wrote at p. 1313:

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

COMPARISON OF THIS CASE AND OF THE GAETZ MATTER

[193]As stated earlier in this decision, this case can best be described as a follow-up to the Gaetz matter decided in 1988 and 1989. In the circumstances, and before proceeding any further, I believe it is appropriate to set out the major similarities and differences between the two cases.

[194]In both cases:

- Gaetz and MacPherson (having both been diagnosed as Type 1 diabetics) were given a permanent medical category of G4 03 by the CMRB;

- Dr. Fisher, one of the CAF's expert medical witnesses, gave evidence which was not weakened or contradicted in cross-examination.

[195]The major differences between the two cases are as follows. Firstly, in regard to the Gaetz matter:

- the Commission called Gaetz as its sole witness: there were no medically-trained witnesses or experts;

- the CAF called five witnesses, including Dr. Fisher as the sole medical expert: she was in fact acknowledged as an expert in

internal medicine and diabetes by all parties involved;

- the Commission did not call any rebuttal evidence whatsoever.

[196]Having regard to this case:

- the Commission called one medical expert on the treatment and management of diabetes, namely Dr. Tan;

- the Commission also called a nurse whose expertise lies in assisting and educating diabetic patients;

- the CAF called Dr. Zinman and Dr. Fisher as experts on the treatment of diabetics;

- the Canadian Diabetic Association ("CDA") was granted intervenor status and gave evidence on that basis.

- the Tribunal received evidence on a major and thorough study (the "DCCT") dealing with diabetes, mainly via Dr. Zinman's testimony;

- the Tribunal received in evidence the policies of other military forces as well as that of other non-military employers in regard to Type 1 diabetics;

- in addition to oral submissions by the Commission, the Complainant and the CAF, the Tribunal received written submissions from the CAF and the intervenor CDA.

RECENT DEVELOPMENTS IN THE APPLICABLE LAW

[197]In reply argument, counsel for the Commission stated that the facts or the time frame in this case were not necessarily stronger than in Gaetz. In addition, the Commission noted that the Review Tribunal in Gaetz applied Mahon and Bhinder, which were both decided before Dairy Pool. One of the Commission's main contentions was that this matter should now be considered and decided in light of Dairy Pool. According to the Commission, this was especially important because in their opinion, Mahon and Bhinder had been changed, if not overruled, by Dairy Pool.

[198]In my view, a recent Federal Court of Appeal decision fully answers the Commission's argument. Since the result in this case rests in such great part on the Dairy Pool argument put forth by the Commission, I have reproduced below the most relevant portions of the majority's decision in that recent Federal Court of Appeal decision :

[para56] ... the Applicant contends that Bhinder has effectively been overruled in its conclusion that a marginal risk was enough to satisfy the test for determining the "sufficient risk of employee failure" as propounded in Etobicoke and that Dairy Pool lays down a new test of "substantial risk". For the reasons that follow, I disagree.

[para57] First, the passage upon which the Applicant relies was not necessary for the decision in Dairy Pool. In any case, the most that can be claimed for it, in my view, is that the majority in Bhinder has misapplied the Etobicoke test, given the findings by the Tribunal that Bhinder's failure to wear a hard hat posed no risk of injury to his co-workers and the public; posed only a negligible risk of injury to himself and, Bhinder's exemption

from the hard hat policy would not jeopardize the employer's safety policy. Secondly, at pages 516-17, Wilson J. summarizes the results of her examination of Bhinder as follows:

For these reasons, I am of the view that Bhinder is correct in so far as it states that accommodation is not a component of the BFOR test and that once a BFOR is proven the employer has no duty to accommodate. It is incorrect, however, in so far as it applied that principle to a case of adverse effect discrimination. The end result is that where a rule discriminates directly it can only be justified by a statutory equivalent of a BFOQ, i.e., a defence that considers the rule in its totality. (I note in passing that all human rights codes in Canada contain some form of BFOQ provision.) However, where a rule has an adverse discriminatory effect, the appropriate response is to uphold the rule in its general application and consider whether the employer could have accommodated the employee adversely affected without undue hardship.

[para58] If the Applicant's claim had any validity, one would have expected to find in this summary some reference to the fact that Bhinder was also in error in adopting the test for "sufficient risk" that it did. Indeed, in the passage that I quoted earlier Wilson J. stated expressly that she did not disagree with the test set out in Etobicoke. Her disagreement on this point, as I apprehend it, is limited only to its application by the majority in that case.

[para59] Finally, the impact of a rule requiring a showing of "substantial risk" on the standard of proof laid down in Etobicoke should not be overlooked. In my respectful view, the substitution of "substantial" for "sufficient" might well have the effect of requiring an employer to justify a BFOR in the interest of public safety by a higher degree of probability than is implied in the test laid down in Etobicoke.

[para60] I conclude by summarizing:

1. Neither Bhinder nor Mahon propounded any new test for determining "sufficient risk" in public safety cases;

2. The test applied in each case was that propounded in Etobicoke, which remains unchallenged and unimpaired;

3. Dairy Pool has not effectively overruled either Bhinder or Mahon in so far as they can be said to have propounded a test for sufficient risk.

4. Dairy Pool has not laid down any new test of

"substantial risk" in substitution for the test of
"sufficient risk" propounded in Etobicoke.

- Husband v. Canada (Canadian Armed Forces), (1994) 167 N.R. 258
at p. 272-73 (F.C.A.) ("Husband").

[199]An application for leave to appeal that decision to the Supreme Court of Canada was dismissed on December 8, 1994.

- Canadian Human Rights Commission v. Canada (Attorney General),
[1994] S.C.C.A. No. 269 (S.C.C.)

[200]The state of the law as put forth in Husband was followed in at least one other recent decision of the Federal Court of Appeal. An application for leave to appeal to the Supreme Court of Canada was also dismissed in that case.

- Robinson v. Canada (Canadian Armed Forces), (1994) 170 N.R. 283
(F.C.A.); [1994] S.C.C.A. No. 309 (S.C.C.)

[201]A Human Rights Tribunal decision which also dealt with the issue of "sufficient risk" and the BFOR defence in the CAF is a further confirmation of the current state of the law on this topic. The relevant extracts of that decision read as follows:

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. (my emphasis)

- Clarke v. Canada (Canadian Armed Forces), [1994] Human Rights
Tribunal Decision T.D. 17/94, at p. 8. ("Clarke")

[202]The Clarke decision also serves to remind us of another policy

which must be taken into account when examining the "risk concept" in the CAF context, namely the "soldier first" policy. The following extract is also found in Clarke:

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.

- Clarke, supra, at p. 9.

[203]Accordingly, MacPherson's occupation must be considered both as a WTA 571 and as a member of the CAF. This was the job which he was called upon to perform.

ANALYSIS AND APPLICATION OF THE LAW

[204]Even if the recent trilogy of decisions from the Federal Court of Appeal (St.Thomas, Husband and Robinson) can be taken as a complete answer to the Commission's position, I wish to add the following points in support of my decision.

[205]This case, as many others before it which have involved the CAF, deals with the downgrading of the medical category of a serving member. Individual testing thus becomes an inherent part of the process, even if it is not strictly required by law to establish a BFOR.

[206]The entire process under which MacPherson's medical category was downgraded and a decision was eventually taken to discharge him depended on evidence with respect to his medical condition. The decision to release

him by the CMRB was essentially an administrative review which depended on

a prior medical assessment. The result of the medical examination was not simply a diagnosis of Type 1 diabetes but an assessment of its severity at that time and the application of military as well as medical judgment in assessing whether or not he was able to adequately and efficiently perform his job without risk to himself or others.

[207]Therefore, the record shows that in arriving at their decision, the CAF\CMRB had access to MacPherson's entire medical history. In my view, the CAF did not act hastily and without consideration of MacPherson's circumstances. After the initial diagnosis, he was kept on in various temporary functions. He was also seen regularly by CAF physicians, as well as by an outside specialist.

[208]As Dr. Zinman pointed out in his evidence, there is always the potential of a sudden severe hypoglycemic attack regardless of how well a person may be feeling. Assessment involves a considerable amount of medical judgment as there are no tests which can reliably quantify the risk of an attack. The fact that MacPherson was not subject to a severe attack while in the military could not be the sole factor in assessing future risk.

[209]The expert medical evidence in this case establishes to my satisfaction that there was a real risk that MacPherson could have suffered a sudden, and severe, hypoglycemic attack. The evidence with respect to his duties, both as a WTA 571 and as a member of the CAF, establishes that such an attack could have occurred in circumstances where it not only could have prevented him from performing his job but could have put at risk both himself, work colleagues and possibly members of the public.

[210]In fact, that very issue was also front and centre in the Gaetz matter. The Tribunal described it in these terms:

Mr. Duval [counsel for the Commission in Gaetz] conceded that the Respondent [CAF] had met the subjective portion of the test and focused on the objective portion. Reading from the testimony of Doctor Fisher at page 345, Mr. Duval submitted that there is no question that Mr. Gaetz could perform this job as effectively and economically as everyone else and submitted that the problem that the Canadian Armed Forces had is with the risk that the Complainant endangers himself and others involved in teamwork as soldiers. (my emphasis)

At this stage it appeared to the Tribunal that Mr. Duval had capsulized the whole issue pursuant to the Tribunal.

- Gaetz, supra note 1, at p. 40-41.

[211]In the circumstances of this case I am satisfied that the medical restriction placed upon MacPherson qualified as a BFOR and that the "real risk factor" in this case was more than a possibility. As in Gaetz, I am

satisfied that the present case falls within the parameters of the test set

out in Etobicoke and Bhinder.

[212]Furthermore, I accept the CAF's position that cases such as this one must be looked at in light of the medical knowledge, expertise and resources which were available at the time of the CAF's decision. There is no doubt that there have been medical advances and that the medical community has improved its knowledge and treatment of diabetes since the CAF's decisions regarding both Gaetz and MacPherson. However, this Tribunal can only examine this matter in light of what was known in 1982-84.

[213]My last comments in this section are in regard to the policies of other employers, especially those of other military forces. Even if those policies did not play a decisive role in this matter, I am struck by the fact that both foreign military forces which were examined above have stringent rules against retaining diabetics.

[214]In regard to the policies of other non-military employers or organizations, they do provide interesting insight and guidelines. As they stand, however, they are too far removed from most, if not all, of the types of tasks and duties which CAF members are required to perform.

[215]In the final analysis, my decision in this matter is dictated in large part by the trilogy of Federal Court decisions referred to above. As a result, I feel bound by the two decisions in Gaetz, especially in light of the significant similarities between the facts in Gaetz and this matter.

CLOSING REMARKS

[216]Given the somewhat exceptional nature of this case, in that it followed on the heels of Gaetz, I take the liberty of pointing out that a major problem facing this case and others like it is the CAF's soldier first policy. This policy allows for no exceptions and no flexibility. Until such time as Parliament modifies that policy, it will be difficult indeed for persons with a disability such as diabetes to play a role of some kind in the CAF.

[217]It may be that Parliament should consider some reforms to the National Defence Act. I believe that I am supported in that view by the following statement:

My review of the military medical system has shown that several of its aspects, while different from the mainstream of employment practices, can withstand legal scrutiny and have been accepted by the human rights tribunals. On the other hand, a number of areas invite reform. (my emphasis)

- S.J. BLYTHE, "Disabilities and the Canadian Forces Medical System", (1994) 33 Alta. L. Rev. 1 at p. 42.

[218]I note also that counsel for the Commission in Gaetz had

expressed the hope that the Tribunal decision in that case would settle the issue of the employability of diabetics in the CAF.

As we all know, that did not happen.

[219]In light of the case-law applicable to this area of law, it would appear that only Parliament can now modify any rules or policies which might make it possible for diabetics to occupy a role of some kind in the CAF. Other portions of the policies of the USAF and of the IDF which I did not quote in this decision, and possibly those of other non-military employers and organizations, could be useful in this regard.

[220]Before closing, I sincerely regret that my decision and reasons were not provided earlier. I wish to thank all concerned parties for their patience.

[221]Finally, I wish to thank the complainant and counsel for all parties involved for their input in this matter. It has been of great assistance.

Dated at Moncton (New Brunswick), June 26, 1995.

ROGER BILODEAU
Chairperson