Federal Court  Cour fédérale

Date: 20141218

Docket: T-250-14

Citation: 2014 FC 1231

[UNREVISED ENGLISH CERTIFIED TRANSLATION]

Montréal, Quebec, December 18, 2014

PRESENT: The Honourable Madam Justice Bédard

BETWEEN:

MARTIN BOUCHARD

Applicant

and

THE ATTORNEY GENERAL OF CANADA

Respondent

JUDGMENT AND REASONS

[1] The applicant, Martin Bouchard, was released from the Canadian Armed Forces (CAF) for medical reasons. He filed a grievance that was dismissed on November 28, 2013, by General T.J. Lawson, Chief of Defence Staff (CDS). He is seeking judicial review of this decision under section 18.1 of the *Federal Courts Act*, RSC 1985, c F-7. For the reasons that follow, the application is allowed.

I. **Background**

[2] The applicant joined the CAF as a reservist on the Sherbrooke military base in 2000. In October 2006, he submitted an application to register for the Regular Officer Training Plan (ROTP). The application was granted. From January to May 2007, he was assigned to the Canadian Forces Leadership and Recruit School (CFLRS). In May 2007, the applicant informed the medical authority of the CFLRS that he had a medical condition, and his transfer to the ROTP was suspended pending a review of his medical category.

A. ***Diagnosis of treating physician***

[3] In November 2005, the applicant consulted a psychiatrist, Dr. A. Fallu, after being referred by his family physician for trouble concentrating. Dr. Fallu diagnosed the applicant with Bipolar II disorder. On June 11, 2007, at the request of the CAF, Dr. Fallu completed a medical information disclosure request concerning the applicant's condition. He confirmed the Bipolar II diagnosis and indicated what medication the applicant was taking. He also replied to the other questions in the form and made the following observations:

> [TRANSLATION]
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> - The patient is being actively treated with medication;
> - Follow-up is required once or twice a year;
> - Risk of recurrence is very low;
> - The prognosis is good;
> - The patient can safely use a personal weapon;
> - The patient can tolerate the extreme stress of military operations (periods of duties in isolated conflict zones);

- The patient experienced symptoms for almost five years before being diagnosed and receiving treatment, without this posing a problem;
- In extreme cases, the patient can stop treatment without complications.

B. ***Imposition of temporary medical employment limitations (MELs)***

[4] On June 14, 2007, the applicant was seen by a military officer from the medical clinic at Saint-Jean Garrison, Dr. S. Brault. In the Medical Examination Record he completed, Dr. Brault noted that the applicant had studied and functioned normally until this date, even during a 2002 mission to Bosnia. In the box concerning recommendations for employment limitations, he indicated for the Geographical Factor (G) that the applicant required follow-up but no more frequently than every six months and that he was taking medication that he could discontinue without any complications. Regarding the Occupational Factor (O), he noted that the applicant had no limitations.

[5] However, in the medical category section, Dr. Brault recommended that the applicant's grade for the Geographic Factor be changed from G2 to G4, and for the Occupational Factor, from O2 to O3. He issued temporary MELs for the applicant pending a decision by the Directorate of Medical Policy (D Med Pol) on his case.

C. ***Imposition of permanent MELs***

[6] On October 22, 2007, Major M. Storrier, physician and member of D Med Pol, imposed permanent MELs on the applicant. His medical statement reads as follows:

[TRANSLATION]

MEDICAL STATEMENT

Permanent medical limitations have been determined for this soldier due to a chronic health problem.

Limitations:

- needs regular medical follow-up with a physician more frequently than every six months;
- needs to take medication every day, failing which he could suffer a relapse related to his chronic medical condition requiring the immediate attention of a specialist physician;
- should avoid working in an environment where he cannot get regular sleep;
- must wear corrective eyewear as prescribed.

[7] On the same day, Major Storrier reviewed the applicant's medical category, assigning him a grade of G4 for the Geographic Factor and O3 for the Occupational Factor. These changes resulted in the applicant being given a lower medical profile than he required.

[8] On October 20, 2008, the applicant received a Notification of Change of Medical Employment Limitations, which confirmed the imposition of the MELs issued by Major Storrier and his revised medical category.

D. ***Administrative review***

[9] In September 2008, the Land Force Quebec Area/Joint Task Force (East) Headquarters (LFQA/JTF (East) HQ) performed an administrative review in order to assess the impact of the MELs on the applicant's capacity to continue serving in the CAF. The administrative review

process is described in Defence Administrative Order and Directive (DAOD) 5019-2, entitled "Administrative Review". The review involved several stakeholders, and the decision to impose an administrative action on the applicant was made by the approval authority, in this case, the commander of LFQA/JTF (East) (the Comd LFQA).

[10] Item 3(*a*) of the table to article 15.01 of the *Queen's Regulations and Orders* (QR&O) provides that a member may be released from the CAF on medical grounds if he or she is "disabled and unfit to perform duties as a member of the Service".

[11] The Comd LFQA, on the basis of the recommendations made by the officers who performed the administrative review, including that of the senior medical officer of the LFQA, found that the permanent MELs imposed on the applicant made him unfit to be able to meet two of the sixteen (physical and stress) factors used to assess CAF members' fitness for duty and to respect the principle of universality of service. This principle requires all members to be deployable and liable to perform certain duties at all times. In the matter at bar, the Comd LFQA found that the applicant no longer met the following two stress factors:

> [TRANSLATION]
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> 4. Must be able to perform duties in unpredictable working conditions, which may involve such stresses as:
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> - no advance notice, limited rations, missed meals, irregular or prolonged hours and lack of sleep.
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> 5. Must be able to perform duties with minimal medical support, which may include:
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> - limited frequency of care; limited access to health care personnel; limited access to medical services and supplies; unavailability of medication or inability to take them on time; and the exacerbating effects of a particular climate, physical

> environment or mental environment on the member's medical condition.

[12] The decision to release the applicant was recorded in a letter from Lieutenant-Colonel L.A. Boisvert to LFQA/JTF (East) HQ, dated January 20, 2009. The letter indicates that the MELs determined for the applicant meant that he no longer satisfies the criteria of the universality of service principle and that he had to be released on medical grounds by October 17, 2009. The applicant received the letter on January 27, 2009, and his release became effective on October 17, 2009.

E. ***Grievance filed by the applicant***

[13] On October 6, 2009, the applicant filed a grievance against the decision to release him. In his grievance, he raised the following grounds:

- He was never assessed by a D Med Pol medical officer.
- The MELs imposed on him do not match his condition. Regarding the limitation according to which he was required to take medication, the applicant noted that none of the physicians who assessed him had issued this limitation and that he had been recommended to take medication to improve the quality of his life. He added that all the physicians who assessed him had indicated that taking medication was not imperative in his case.
- Regarding the limitation according to which he had to avoid working in an environment where he could not sleep during the day, he remarked that this limitation [TRANSLATION] "came out of nowhere". He added that none of the physicians who assessed him had determined such a limitation and that neither in his personal life nor as part of the duties he had carried out in the CAF had he ever needed to sleep during the day.
- In his case, taking medication does not breach the CAF directive stipulating that members cannot take medication if discontinuing the medication would stop them from functioning normally.
- His military record does not contain any investigations concerning administrative or disciplinary actions, and his conduct had never endangered anyone within the CAF. He added that all the physicians who assessed him had stated that he met the criteria of the CAF's universality of service principle.

- He feels that he is being discriminated against because of his having a mild case of bipolar disorder. He believes that he is the victim of a narrow, unlawful interpretation of what it is to be bipolar.

II. **Impugned decision**

[14] The grievances filed by members are subject to a multi-level process governed by the *National Defence Act*, RSC 1985, c N-5 [the Act], and by Chapter 7 of the QR&O. The grievance first goes to an officer who acts as the initial authority (IA). Section 29.11 of the Act provides that the Chief of the Defence Staff (CDS) is the final authority in the grievance process. Some grievances, including those challenging a CAF release action, must be referred to the Military Grievances External Review Committee (the Committee) before the CDS makes a final decision on the grievance (subsection 29.12(1) of the Act and subparagraph 7.12(1)(*a*) of the QR&O). The Committee must review every grievance referred to it and make recommendations to the CDS (subsection 29.2(1) of the Act and article 7.13 of the QR&O). The CDS is not bound by any recommendation of the Committee, but if he does not act on a recommendation, he must provide reasons for his decision (section 29.13 of the Act and paragraph 7.14(2) of the QR&O).

A. ***Initial authority's decision***

[15] The applicant's grievance was first referred to the IA. The director of D Med Pol, Captain Courchesne, was asked to submit his observations to the IA regarding the grounds raised by the applicant in his grievance. Captain Courchesne recommended that the MELs imposed on the applicant be maintained. He found, among other things, that the taking of medication was

essential to the applicant's well-being and that the MELs issued were consistent with the diagnosis and the taking of medication.

[16] In support of his grievance, the applicant submitted a statement signed by Dr. Fallu on September 8, 2011. In it, Dr. Fallu expressed his disagreement with the MELs imposed on the applicant. The relevant excerpts from his statement read as follows.

> [TRANSLATION]
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> 3. I met with MCpl Bouchard for the first time in November 2005, after he was referred to me by his family physician for trouble concentrating;
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> 4. I subsequently diagnosed MCpl Bouchard with Bipolar II disorder and explained to him that he could try medication voluntarily for preventive purposes;
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> 5. I told MCpl Bouchard that he could stop this medication if the context required it;
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> 6. His condition at the time did not result in any professional or personal limitations;
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> 7. On or around June 11, 2007, MCpl Bouchard came to see me to ask me to complete a document entitled [TRANSLATION] "medical information disclosure request" (regarding a psychiatric condition), which I did. I stated that I had prescribed medication to him, which he agreed to take voluntarily, and that he could stop taking the medication at any time;
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> 8. The report I produced at that time stated that MCpl Bouchard's medical condition did not entail any particular or foreseeable difficulties;
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> 9. In the fall of 2007, MCpl Bouchard returned to see me, handing me a document called [TRANSLATION] "Administrative Review", signed by Major S. Storrier, M.D., who had provided a medical statement and imposed permanent medical limitations on MCpl Bouchard as a result of a chronic medical problem;
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> . . .

> 11. First, I note that the medical statement was based on the record; there was no meeting with MCpl Bouchard, since, as I understand it, medical officer Major M. Storrier never met with him;
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> 12. I therefore do not know where these so-called limitations come from since they do not seem to be based on any medical observation of MCpl Bouchard's condition;
>
> 13. In my view, MCpl Bouchard's medical record in no way suggests the conclusion drawn by medical officer Major Storrier to impose the limitations set out in his letter dated October 22, 2007.

[17] Lieutenant-General P.J. Devlin, acting as IA, dismissed the applicant's grievance. His decision essentially reiterates Captain Courchesne's comments and makes no reference to Dr. Fallu's statement. Indeed, Lieutenant-General Devlin states that nothing in the information provided by the applicant or received from D Med Pol (Captain Courchesne) suggested that the assessment leading to the imposition of permanent MELs was incorrect. He concluded that the applicant had been treated fairly according to CAF policies and that, as a result of the MELs, he no longer respected the universality of service principle.

B. ***Committee's recommendations***

[18] The Committee performed an exhaustive review of the medical evidence and of the process that led to the imposition of the MELs, the administrative review and the applicant's release on medical grounds.

[19] Based on its analysis, the Committee found that the MELs imposed on the applicant were not justified in light of the evidence on file.

[20] The Committee considered it to be worrying that there was such a significant gap between the observations of the physicians who examined the complainant and the seriousness of the MELs imposed by Major Storrier, without there being any explanation to justify this discrepancy. It further found that the limitations concerning the taking of medication and access to health care were not warranted in light of the medical evidence on file, even though these factors had been determinative in the recommendation to release the applicant.

[21] As part of its review, the Committee studied the online information on bipolar disorder published by the Public Health Agency of Canada. It noted from this information that the relationship between the patient and the specialist was a decisive factor given that every person was different and that diagnosis and follow-up were the first steps towards stabilizing the condition. It also noted that medication and therapy were then used to control the illness so that patients could lead normal lives.

[22] The Committee then gathered information from D Med Pol in order to understand why permanent MELs had been imposed on the applicant. D Med Pol made the following observations:

> [TRANSLATION]
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> - It is impossible to determine the risk of a relapse among people with bipolar disorder.
> - When it imposes MELs, D Med Pol attempts to examine the type of medication prescribed, the frequency of mood swings and the care and services that were required to stabilize the member's condition.
> - In terms of the limitation regarding hours of sleep, because of the nature of bipolar disorder, precarious and stressful conditions during deployments pose a considerable risk.
> - People with bipolar disorder need stability and have to take medication daily in order to stay healthy, and taking medication indefinitely is a violation of the universality of service principle.

[23] Despite the explanations received from D Med Pol, the Committee found that the limitation according to which the applicant absolutely had to take medication could not be reconciled with the medical evidence on file. In the Committee's view, the limitation ran counter to the opinion of the applicant's psychiatrist and that of the medical officer he had met with (Dr. Brault), without there being any explanation to justify this discrepancy.

[24] The Committee therefore concluded that the permanent MELs imposed on the applicant were neither supported nor justified by the evidence. The Committee added that since the administrative review that led to the decision to release the applicant was based on the MELs, it had to be performed again, from the beginning.

[25] The Committee also noted that between the moment when the process leading to the applicant's release began and the date on which the Comd LFQA made the decision to release the applicant, the CAF had approved CANFORGEN 187/08, entitled "Use of Medical Risk Matrix for AR/MELS". This CANFORGEN entered into effect on October 14, 2008, and imposed the use of a risk matrix when assessing the consequences of imposing permanent MELS for a member's career. The risk matrix takes into account medical factors such as the prognosis, severity and short- and long-term effects of the condition, and military factors such as employability despite the MELs, deployment ability and medical needs.

[26] The Committee found that the risk matrix, which was in effect when the decision to release the applicant was made on January 15, 2009, should have been used and applied during

the administrative review of the applicant's case. In the Committee's opinion, this omission undermined the decision-making process and the decision to release the applicant.

[27] The Committee therefore recommended that the applicant's grievance be allowed and that the process leading to his release be recommenced, from the beginning, including the assessment of whether or not to impose permanent MELs on him.

C. ***Decision of the CDS***

[28] The applicant's grievance was then forwarded to the CDS. Before the CDS ruled on the applicant's grievance, the file was reviewed by an analyst. The analyst sent a request for information to D Med Pol, which submitted several observations and opinions. It is useful to set out some of the questions asked, and the responses given by Captain Courchesne, the director of D Med Pol, because the CDS's decision essentially reiterates the opinions expressed by Captain Courchesne and because Captain Courchesne's comments make it possible to understand the basis for the CDS's decision.

[29] In his request for information, the analyst noted that Dr. Fallu was a medical specialist who was well known to the CAF, which had requested his opinion on numerous occasions, and that there was a significant gap between Dr. Fallu's opinion and the MELs imposed by Major Storrier, specifically with respect to the taking of medication and the possibility of discontinuing this medication. He also pointed out that Major Storrier's statement according to which the applicant might need immediate services from a specialist following an episode related to a chronic illness was not corroborated by Dr. Fallu.

[30] In reply to the analyst's questions, Captain Courchesne stated that D Med Pol was the authority acting on behalf of the Surgeon General. He explained that MELs were never imposed following a single diagnosis, but that some illnesses, because of their nature, were unpredictable and serious, and therefore more likely to result in significant MELs.

[31] Regarding the applicant's situation, Captain Courchesne explained that the MELs had been imposed on the basis of D Med Pol's general knowledge about bipolar disorder, the need by persons with this illness to take medication, the risks of relapse related to this disorder and factors likely to result in exacerbating the symptoms. He also noted that the opinions and recommendations of civilian physicians were taken into account, but that their opinions on the risks posed by a pathology were not particularly relevant as they did not have any military experience. He found that the MELs imposed on the applicant were warranted. It is useful to reproduce the following excerpt from Captain Courchesne's opinion because he clearly sets out the basis for his reasoning and opinion:

> [TRANSLATION]
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> 5. . . . MCpl (Ret) Bouchard was diagnosed with Bipolar II disorder. Bipolar disorder is a chronic psychiatric illness the course of which is unpredictable: it generally diminishes and intensifies over time and is marked by relapses and remission. Physicians prescribe medication, which is required to control the symptoms. Ninety percent of individuals with bipolar disorder have been hospitalized in a psychiatric institution at least once, and about two-thirds have been hospitalized at least twice during their lifetime. It is also known that periods of long-term stress, not having access to medication and lack of sleep can aggravate the symptoms. This pathology is therefore not compatible with military operations and the military context.
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> 6. The information and recommendations provided by civilian consultants are taken into consideration when imposing MELs. Even though we appreciate specialists' opinions on risks, such as the opinion expressed by Dr. Fallu, we do not find them very

> useful as these specialists do not have any experience of military operations. This is why the experienced medical officers working at D Med Pol Standards are tasked with determining and approving final and permanent MELs. Medical officers consider not only the diagnosis (as confirmed by the specialist), but also the natural course of the illness and medical needs in terms of medication, ongoing support and the level of medical support required should the pathology get worse. Consequently, Major Storrier was completely right to consider Dr. Fallu's opinion, but to impose MELs based on his knowledge of the pathology and its application in a military and operational context. The imposed MELs are consistent with this chronic pathology. We also agree with Major Storrier's assessment that the complainant has to take medication every day. The natural course of this illness indicates that discontinuing medication increases the risks of a relapse requiring the services of a specialist. Overall, we disagree with Dr. Fallu's assessment. Dr. Fallu may disagree with the imposed MELs, but we are military medical experts.

[32] The analyst also pointed out that the Committee had found that the risk matrix should have been used to assess the applicant's fitness. Captain Courchesne replied that the medical risk matrix was not in effect when the MELs were imposed on the applicant, and he explained that, even if it had been used, the applicant would have been assigned to the high-risk-of-recurrence category.

[33] Captain Courchesne concluded by stating that D Med Pol did not apply a zero tolerance policy to specific illnesses or diagnoses and that each case was assessed on its own merits. He added that some illnesses, because of their nature, their clinical course and their entailing need for the patient to take medication in order to control the symptoms, were more likely to result in MELs that are contrary to the universality of service principle.

[34] The CDS's decision essentially reiterates the opinions issued by D Med Pol. The decision reveals that the CDS accepted the following factors:

- The Bipolar II disorder diagnosis was indisputable and was made by the applicant's specialist.
- Regarding the taking of medication, he noted the differing opinions of Dr. Fallu and of the director of D Med Pol and stated that the assessment made by D Med Pol that the applicant had to take medication every day was justified in the military context as a result of the Bipolar II disorder diagnosis and the chronic and unpredictable nature of this illness.
- He disagreed with the applicant's assertion that the MELs imposed on him did not represent his condition. He stated that D Med Pol was the only authority within the CAF qualified to review and approve permanent medical categories and MELs and that members were assessed in light of their entire medical record. He also noted that D Med Pol had confirmed that the information and recommendations provided by the civilian specialists had been considered but that the other information and opinions expressed by specialists were rarely useful in establishing MELs because these physicians did not have the experience required to express an opinion on operational risks. He added that the MELs had been developed by a committee of experts composed of senior medical officers and psychiatrists all of whom had knowledge and experience of operational deployment.
- He stated that the CAF did not apply a zero tolerance policy, that every case was assessed independently and that the MELs were not determined based solely on diagnosis, but also on historical data concerning the illness in question.
- He agreed with the opinion of D Med Pol that Bipolar II disorder required sufferers to take medication to avoid relapses and that this condition was incompatible with operational needs and the military context. The applicant's condition therefore made him non-deployable and ran counter to the universality of service principle.
- Regarding the medical risk matrix, he stated that the matrix was merely a communication tool designed to articulate the risks associated with CAF members' medical conditions and that it did not change the fact that D Med Pol was ultimately responsible for determining permanent MELs. He added that the matrix had not been in place when the MELs were imposed on the applicant, but had it been used, the applicant would certainly have been placed in a high-risk category because of the significant risk of his symptoms reoccurring and serious concerns about the consequences of a relapse in an operational context. He therefore concluded that the LFQA senior medical officer had not acted with negligence in concluding that the risk matrix did not apply to the applicant's case.
- He also found that all procedural fairness requirements had been met.

III. **Issue and applicable standard of review**

[35] The only issue here concerns the reasonableness of the CDS's decision to dismiss the applicant's grievance. The parties agree that the CDS's decision should be reviewed on a standard of reasonableness. I share this view.

[36] The CDS's decision raises a question of mixed fact and law. In *Dunsmuir v New Brunswick*, 2008 SCC 9 at para 51, [2008] 1 SCR 190 [*Dunsmuir*], the Supreme Court of Canada held that questions of fact, discretion or policy, as well as questions of mixed fact and law, are reviewable against a standard of reasonableness. Also in *Dunsmuir*, at para 57, the Court ruled that an exhaustive analysis is not required to determine the applicable standard of review when it is already deemed to have been determined by case law.

[37] In the present case, I am satisfied that the case law has established that decisions of the final authority in the CAF grievance process that raise questions of fact or questions of mixed fact and law must be reviewed against a standard of reasonableness (*Harris v Canada (Attorney General)*, 2013 FCA 278, [2013] FCJ No 1312 (aff'g 2013 FC 571 at para 30, [2013] FCJ No 595); *Babineau v Canada (Attorney General)*, 2014 FC 398 at para 22, [2014] FCJ No 440; *Osterroth v Canada (Canadian Forces, Chief of Defence Staff)*, 2014 FC 438 at para 18, (sub nom *Osterroth v Canada (Canadian Forces, Chief of Defence Staff)*, [2014] FCJ No 483; *Moodie v Canada (Attorney General)*, 2014 FC 433 at para 44, [2014] FCJ No 447; *Lampron v Canada (Attorney General)*, 2012 FC 825 at para 27, [2012] FCJ No 1713; *Birks v Canada (Attorney General)*, 2010 FC 1018 at paras 25-27, [2010] FCJ No 1278).

[38] In applying the reasonableness standard, I must inquire into the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes. As indicated by the Supreme Court, at para 47 of *Dunsmuir*, "reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law".

IV. **Parties' positions**

A. ***Applicant's arguments***

[39] The applicant essentially criticizes the CDS for confirming D Med Pol's decision of imposing permanent MELs on him even though the evidence on file did not support the limitations imposed on him. The applicant submits that the MELs were imposed on him without considering the opinion of Dr. Fallu, who is his specialist. The applicant added that it appears from Dr. Brault's notes that he agreed with Dr. Fallu's opinion and that D Med Pol diverged from this opinion without any justification.

[40] The applicant submits that the MELs that led to his release were based on generalizations and on the opinion of D Med Pol regarding Bipolar II disorder generally, without his personal situation being analyzed. He added that the MELs are incompatible with Dr. Fallu's opinion and ignore the fact that bipolar disorder can be of varying severity.

[41] The applicant also advances that the file clearly shows that the MELs were imposed in a discriminatory manner in application of a zero tolerance policy to anyone with bipolar disorder. The applicant submits that D Med Pol and the CDS claim that the CAF do not apply a zero tolerance policy but that the file clearly reveals that, in fact, such a policy is applied to anyone with bipolar disorder. The applicant also adds that in failing to perform a personalized analysis, D Med Pol imposed MELs on him without considering the Guidelines for the Application of MELs to Personnel Suffering from Mental Illness.

[42] The applicant further submits that when D Med Pol imposed MELs on him, it did not explain the basis for its decision or the reasons why it had completely disregarded the opinion of the applicant's psychiatrist. The applicant argues that, in his decision, the CDS also did not explain why he accepted D Med Pol's opinion rather than Dr. Fallu's.

[43] For the applicant, in approving the MELs imposed on him and the administrative process that led to his release, the CDS made a decision that is not reasonably supported by the evidence on file. He also submits that the CDS's reasons are inadequate because the discrepancy between Dr. Fallu's opinion and the MELs remains unexplained.

[44] The applicant further submits that it was unreasonable to consider that the medical risk matrix did not apply to his case and to find, without analyzing the matter, that its application would, in any event, have led to the same result.

B. ***Respondent's arguments***

[45] The respondent submits that the CDS's decision falls within the range of possible, reasonable outcomes in respect of the evidence and insists on the fact that the Court must avoid substituting its own opinion for that of the CDS. The respondent emphasizes that a high degree of deference is owed to the decisions of the CDS, who acts as the final grievance authority because of his knowledge and his expertise concerning all military matters.

[46] The respondent submits that the CDS's decision is thorough, articulate and intelligible, and reasonably based on the evidence, and that the CDS explains why he disagrees with the recommendations made by the Committee. The respondent adds that the decision clearly shows that the CDS considered all the relevant evidence and the grounds relied on by the applicant and that his analysis provides a clear understanding of the basis for his decision.

[47] The respondent further submits that D Med Pol's opinion according to which Bipolar II disorder is a chronic illness the development of which is unpredictable and which diminishes or intensifies over time with periods of relapse and remission is completely reasonable and reflects the medical knowledge about this pathology. The respondent submits that it was also reasonable to conclude, in light of medical knowledge about bipolar disorder, that this illness requires taking medication and that it has a high risk of recurrence, with potentially significant repercussions should a relapse occur in an operational context. The respondent insists on the fact that nothing in the medical evidence, including the opinions expressed by Dr. Fallu, suggests with certitude that there is no risk or recurrence for the applicant.

[48] The respondent submits that the applicant's condition and his ability to serve within the CAF then had to be analyzed in light of the universality of service principle, a fundamental principle in assessing a member's fitness for performing his or her military duties and being deployable. The respondent argues that CAF medical officers and other officers are the only people who have the necessary expertise to assess and measure the potential risks of a member's medical condition in the context of a military operation.

[49] The respondent also submits that, in *McBride v Canada (Minister of National Defence)*, 2012 FCA 181 at para 38, [2012] FCJ No 747 [*McBride*], the Federal Court of Appeal clearly held that civilian physicians could not challenge the conclusions and opinions of medical officers with respect to the effects and risks caused by the medical condition of a CAF member.

V. **Analysis**

[50] For the following reasons, I find that, in confirming the permanent MELs imposed on the applicant and in upholding the decision to release him on medical grounds, the CDS made an unreasonable decision that justifies this Court's intervention.

[51] First, it is clear that the basis for the decision to release the applicant is the permanent MELs determined by D Med Pol for the applicant. Had it not been for the significance and the restrictive nature of the MELs imposed, the administrative review could very well have led to a different outcome. Indeed, the CDS identified this cause and effect relationship when he stated that he had to determine whether the applicant's release was justified and complied with the policies, but that, in order to do so, he had to [TRANSLATION] "first examine whether the medical

evidence on file reasonably supported the medical employment limitations (MELs) . . . determined [for the applicant]".

[52] It also appears from the decision that the CDS clearly agreed with D Med Pol's opinion, and his decision essentially reiterates the opinions and comments expressed by Captain Courchesne, the director of D Med Pol.

[53] With respect, my review of the record does not suggest that the process leading to the determination of the MELs imposed on the applicant, and ultimately the decision to release him from the CAF, was logical or rational. In my opinion, the manner in which D Med Pol dealt with the medical evidence on file was inadequate, and, in agreeing with the opinions expressed by D Med Pol, the CDS made a decision that does not have the qualities of reasonableness.

[54] First, it is clear that the limitation that was fatal to the applicant was the fact that he takes medication. Major Storrier stated, without any explanation, that the applicant had to take medication every day or else risk suffering an episode related to his chronic medical condition that would require the immediate services of a specialist physician. It is this limitation, when contemplated in the context of a military operation, that formed the basis for the opinion that the applicant was not deployable.

[55] It appears clearly from the observations submitted by Captain Courchesne, the director of D Med Pol, during the grievance process, that D Med Pol's opinions are based on a general assessment of bipolar disorder and its characteristics made by its medical officers, and nothing

suggests that a personalized analysis of the applicant's condition, based on his medical history, was made. On the contrary, all of D Med Pol's statements refer to its assessment of bipolar disorder in general. Yet in the submissions it made to the Committee, D Med Pol indicated that when it imposes MELs, it tries to examine the type of medication prescribed, the frequency of mood swings, and the care and services that were required to stabilize the member's condition. Moreover, the Guidelines for the Application of MELs to Personnel Suffering from Mental Illness also require a personalized analysis. The following excerpts are relevant:

> Determination of Permanent MELs
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> 36. Determinations of permanent MELs related to a mental disorder are made by the physician (general practitioner), who has an extensive knowledge of military roles and work functions. However, in determining permanent MELs the physician (general practitioner) should obtain the opinion of an appropriate specialist mental health practitioner who possesses an expert knowledge of the prognosis and course of mental disorders. In many situations, assessment by an interdisciplinary team will be recommended.
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> 37. . . . the evaluator must also consider the risk of recurrence, and the likelihood that the recurrence of the disorder will be associated with significant impairment.
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> 38. Permanent MELs will normally only be recommended on the basis that the member suffering from a mental disorder has a permanent impairment. Risk of recurrence (and associated impairment/disability) is the only other significant consideration. This factor must also be incorporated into the assessment for permanent MELs.
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> 39. In determining whether an impairment related to a mental disorder is permanent, the evaluator must consider the prognosis, evaluate whether the mental disorder has become stable, and decide whether maximum psychological recovery has been attained. The determination of maximum psychological recovery depends upon the adequacy and thoroughness of treatment received during the course of the disorder, as well as the adequacy of rehabilitation attempts.
>
> [Emphasis added.]

[56] Nothing in the record suggests that, in its assessment of the applicant's condition, D Med Pol examined and considered the frequency of mood swings, the type of medication he was taking, the care and services that had been required to stabilize his condition, the presence or absence of limitations arising from his condition, and so forth. The only physician who fully assessed the applicant's personal situation is Dr. Fallu. It is useful to recall that Dr. Fallu is a psychiatrist whose expertise is recognized by the CAF, which regularly use his services.

[57] The limitations imposed, specifically the limitation concerning the taking of medication, are in complete contradiction with the opinion expressed by Dr. Fallu. Dr. Fallu stated that the applicant had functioned without any problems for about five years before he was diagnosed with bipolar disorder, while experiencing symptoms. He also noted that he had prescribed medication to the applicant for preventive reasons and that the applicant could discontinue this medication at any time, that the prognosis was good, that the risk of recurrence was very low, that the applicant needed medical follow-up once or twice a year, that his condition did not entail any particular or foreseeable limitations and that he could tolerate extremely stressful situations.

[58] Dr. Brault, the only medical officer who examined the applicant also wrote in his examination notes that the applicant had functioned normally to date and that he could discontinue his medication without any complications. However, Dr. Brault recommended a medical category that seems to contradict his examination notes on file, but nothing in the record suggests that Dr. Brault was asked to explain this apparent discrepancy.

[59] Captain Courchesne, and the CDS who agreed with his opinion, expressed his disagreement with Dr. Fallu's opinion. D Med Pol was not obliged to accept Dr. Fallu's opinion, but I find its explanations for justifying its assessment of the applicant's condition to be irrational and plainly inadequate in the present context.

[60] First, Captain Courchesne expressed his disagreement with Dr. Fallu, but he provided no explanation whatsoever, other than generalizations, why he rejected Dr. Fallu's opinion and his assessment of the applicant's condition. In the observations it sent to the Committee, D Med Pol stated that individuals with bipolar disorder need stability and medication, and that taking medication indefinitely is a violation of the universality of service principle. In his letter dated February 26, 2013, Captain Courchesne stated that the course of bipolar disorder is completely unpredictable, which makes it incompatible with military operations. He also stated that the applicant needed a regular sleep schedule, which is often impossible during a military deployment.

[61] The opinions expressed by Captain Courchesne are all based on generalizations and seem to disregard any possibility that bipolar disorder may manifest itself in varying degrees depending on the individual. Captain Courchesne completely disregards Dr. Fallu's opinion on the basis of generalizations without explaining why he is of the opinion that Dr. Fallu's assessment of his patient's condition is incorrect.

[62] Captain Courchesne indicated moreover that the opinions of civilian physicians on the risks posed by a medical condition in a military context were of limited usefulness because civilian physicians do not have any knowledge or expertise of this context.

[63] I have no difficulty acknowledging the particular expertise of military physicians and officers when it comes to assessing the impact, risks and consequences a medical condition may entail for a member's capacity to be deployed and to respect the universality of service principle. The specific nature of the military context, and especially of military operations, requires military physicians and officers to have the necessary discretion to assess the consequences that may arise from the medical condition of a CAF member in an operational context.

[64] However, in the matter at bar, it was not Dr. Fallu's opinion on the risks posed by the applicant's medical condition in a military context that was rejected, but his opinion on the applicant's actual condition, its severity and the treatment required to control it.

[65] When it analyzes the medical record of a member to determine whether MELs should be imposed, D Med Pol must, first, assess the member's condition and reach an opinion on various factors including the nature of the member's pathology, the severity of the member's condition, the required treatment, the member's capacity to remain stable, the presence or absence of any limitations arising from the condition, the risks of a relapse and the potential symptoms in the event of a relapse. The purpose of this first step is to properly understand the member's condition and the limitations and risks arising from it. This first step entails a medical assessment that has no bearing on the military context. Naturally, the member's medical condition, including any

related consequences and risks, must then be assessed in light of the special needs and duties of the CAF in the context of a military operation, in order to determine whether the member's medical condition requires permanent MELs. But if the assessment of a member's condition is wrong from the start, or lacks justification, any review leading to the imposition of permanent MELs, and ultimately an administrative action as a result of the MELs, is flawed.

[66] The respondent relied on *McBride* to argue that the Federal Court of Appeal had held that civilian physicians could not challenge the opinions and conclusions of military physicians with respect to the risks caused by a member's medical condition. In the case at bar, the applicant criticizes the CAF for failing to disclose to him certain documents, including the administrative policy guiding medical officers in determining MELs. At paragraph 38, the Federal Court of Appeal had the following to say:

> **38** Mr. McBride argues that the failure to disclose the policy document CFP 154 is also a breach of procedural fairness. As noted earlier, CFP 154 is a document intended to assist military physicians in assessing MELs. Mr. McBride argues that, without access to CFP 154, a non-military physician cannot challenge the specific limitations imposed by the Director, Medical Policy. I am not persuaded that it is the role of a civilian physician to second-guess the judgment of a military physician as to the effect of a medical condition on a member's ability to perform core military tasks. The civilian physician can provide a second opinion as to the diagnosis and prognosis for recovery, and he or she may offer comments with respect to the effect of that condition on the member's ability to function in civilian life. However, I accept the Canadian Forces' submission that it is not the role of a civilian physician to apply the criteria set out in CFP 154 and its affiliated policies to a member of the Canadian Forces. Consequently, I am of the view that the failure to disclose CFP 154 did not amount to a breach of procedural fairness.
>
> [Emphasis added.]

[67] The present context is distinct from the context in *McBride* because, as I mentioned, D Med Pol did not only disregard Dr. Fallu's opinion on his assessment of the applicant's capacity to function in the context of a military operation; it also rejected his opinion on the severity of the applicant's condition, on the fact that he could discontinue his medication, on the absence of limitations arising from his condition, on the prognosis and on the very low risk of a relapse. These factors are not specific to the military context and clearly fall under Dr. Fallu's expertise in psychiatry.

[68] D Med Pol was not obliged to accept Dr. Fallu's opinion, but in rejecting it, it had a duty to explain the basis for its decision. I find that, in this matter, it was frankly insufficient for D Med Pol to limit itself to expressing its disagreement with Dr. Fallu's assessment in relying on general statements on the nature of bipolar disorder, without any reference to the applicant's specific case. Dr. Fallu expressed his opinion on the specific questions asked of him by the CAF in relation to the applicant's condition and which were within his area of expertise.

[69] The imposition of permanent MELs was a determining factor in the review of the applicant's medical category, in the administrative review and in the decision to release the applicant from the CAF. But the evidence in the record does not explain why Dr. Fallu's specialized personalized assessment was rejected in favour of D Med Pol's purely medical one. Moreover, nothing in the record suggests that D Med Pol relied on the medical literature to reject Dr. Fallu's opinion.

[70] In addition, both Captain Courchesne and the CDS indicated that the CAF did not apply a zero tolerance policy and that each case was assessed on its own merits while not limiting the assessment to the diagnosis alone. Yet, in two instances in his letter dated February 26, 2013, Captain Courchesne expressly states that bipolar disorder is incompatible with military operations and the military context. Such a statement seems to predetermine the outcome of any assessment of the personal situation of members with bipolar disorder.

[71] In its decision, the CDS clearly agrees with D Med Pol's opinion. Indeed, he essentially reiterated the observations made by Captain Courchesne and noted that D Med Pol had the authority to impose MELs. In approving D Med Pol's opinion without explaining why he preferred this opinion to that of Dr. Fallu other than by stating that D Med Pol was [TRANSLATION] "the only competent CAF authority to review and approve permanent medical categories and MELs", the CDS, in my opinion, made a decision that does not have the qualities of reasonableness. The CDS did not explain why he was rejecting the opinion of the medical specialist treating the applicant in favour of D Med Pol's opinion. Consequently, I find it impossible to conclude that the CDS's decision was based on a rational, non-arbitrary decision-making process, and his handling of the contradictory medical evidence seems utterly insufficient to me.

[72] The Federal Court of Appeal, in *Kanthasamy v Canada (Citizenship and Immigration)*, 2014 FCA 113, at para 99, [2014] FCJ No 472, recently reiterated the role of the reviewing court when applying the reasonableness standard. Writing on behalf of the Court, Justice Stratas held as follows:

> **99** In conducting [a] reasonableness review of factual findings such as these, it is not for this Court to reweigh the evidence. Rather, under reasonableness review, our quest is limited to finding irrationality or arbitrariness of the sort that implicates our rule of law jurisdiction, such as a complete failure to engage in the fact-finding process, a failure to follow a clear statutory requirement when finding facts, the presence of illogic or irrationality in the fact-finding process, or the making of factual findings without any acceptable basis whatsoever: *Toronto (City) Board of Education v. O.S.S.T.F., District 15*, [1997] 1 S.C.R. 487 at paragraphs 44-45; *Lester (W.W.) (1978) Ltd. v. United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry, Local 740*, [1990] 3 S.C.R. 644 at page 669.

[73] In the matter at bar, I find that the explanations given, or the lack of a satisfactory explanation for rejecting Dr. Fallu's opinion, make the CDS's conclusion irrational and arbitrary. This is a case where, in my opinion, the manner in which D Med Pol and the CDS handled the medical evidence was insufficient (*Yantzi v Canada (Attorney General)*, 2014 FCA 193, at para 5).

[74] For all of these reasons, the application for judicial review is allowed.

JUDGMENT

THIS COURT ORDERS AND ADJUDGES that:

1. The application for judicial review is allowed.
2. The decision of the CDS is set aside.
3. The matter is referred back to the CDS so that he may take the necessary measures for the process that led to the determination of permanent MELs and to the administrative review resulting in the applicant's release to be undertaken from the beginning by different stakeholders.
4. With costs to the applicant.

"Marie-Josée Bédard"
Judge

Certified true translation
Johanna Kratz, Translator

FEDERAL COURT

SOLICITORS OF RECORD

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