**IN THE MATTER OF AN ARBITRATION**

**BETWEEN:**

VANCOUVER DRYDOCK COMPANY LTD.

(the "Employer")

**AND:**

MARINE WORKERS & BOILERMAKERS INDUSTRIAL UNION, LOCAL 1
(the "Union")

'G.C.' Grievance

AWARD

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| **ARBITRATOR:** | David C. McPhillips |
| **ON BEHALF OF THE EMPLOYER:** | Chris E. Leenheer and Carly Stanhope |
| **ON BEHALF OF THE UNION:** | Richard L. Edgar and Janna Crown |
| **DATES OF HEARING:** | November 16, 19 and 20, 2020 |
| **DATE OF AWARD:** | December 9, 2020 |

The parties are agreed that this Board has the jurisdiction to determine this matter. This case involves a claim of discrimination by the Union in that the Employer did not properly accommodate the Grievor when it failed to reinstate him to his employment on the basis he was being treated with methadone for an addiction problem.

FACTS:

Vancouver Drydock is part of the Seaspan Group of Companies and operates a shipyard in North Vancouver which is in the business of repair and maintenance of sea-going vessels. It is not disputed that this workplace is safety sensitive.

The Grievor, 'GC', is 59 years of age and began working at Vancouver Drydock in 2004. 'GC' occupied a safety sensitive role as a Painter/Sandblaster and he has been a member of the Painters Union since 1979 and also the Marine Workers Union since 2004.

The facts in this case are not greatly in dispute. The Grievor had serious family difficulties in his early years and in 2000 he began to use heroin and other drugs. In 2016 the Grievor disclosed to the Employer that he was dealing with addiction issues and sought treatment through the Employer's Courage to Care Program.

At the time, the Employer provided the Grievor with accommodation for his addictions. It supported him in attending two residential programs at the Cedars and Together We Can addiction recovery services. The Grievor's treatment plans following his residential treatment at each of these facilities included abstinence from psychoactive drug use and ongoing monitoring for the same. On each of the two occasions, 'GC' relapsed.

Beginning in October 2017, the Grievor attended a third residential treatment program, this one for 90 days at King Haven in Abbotsford, B.C. At King Haven, the Grievor met his current addiction medicine physician, Dr. Patrick Fay, who recommended that the Grievor begin methadone maintenance therapy ("MMT") to reduce his cravings for heroin and decrease the likelihood of another relapse.

The Grievor did as suggested and began methadone maintenance therapy. His evidence is that this approach had been completely successful and he takes a dose of 85 mg a day which is below the therapeutic dose of 100 mg a day.

On May 3, 2018, Dr. Fay provided the following letter to the Union with respect to his patient:

> I have been requested to write a brief note re his fitness to return to his regular work duties as a painter now that he is in recovery from an addiction illness. He has done this job for many years – his work involves some safety sensitive tasks.
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> Apparently the issue in this case is related to the fact that his diagnosis is Opiate Use Disorder and a large part of his recovery will be his need to remain on Opiate Substitute Treatment (OST) – this is the current standard of care. He informs me that should he taper off methadone there would be no difficulty with him resuming his regular work duties.
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> He is not showing any side effects from methadone such as drowsiness and on visits to my office he seems totally alert and functional. He states the methadone makes him feel normal and he has no craving for illicit opiates. Also he remains involved in a 12 step program with sponsor and regular meetings.
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> Methadone is his lifeline and recent studies show that without it his risk of relapse would be almost 100%. The demand for him to stop methadone is in my opinion akin to asking a diabetic to stop insulin or indeed requesting another chronic illness sufferer to stop their meds.
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> My belief is that these situations should be client centered, and because the idea of long term OST (methadone or suboxone) for recovery is relatively new, they should be assessed on an individual basis. I would suggest that the fair approach would be to have him assessed by a neurologist and/or a physician with expertise in occupational medicine. He would also have ongoing monitoring for relapse as determined by his independent medical assessor.
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> The comments that I make are from the viewpoint of an addictions medicine specialist (cv attached) with a long history of working in the field and very often seeing patients get into good recovery but suffer ongoing discrimination because of their history of addiction illness. This tends to drive the problem 'underground' and make it difficult for people to seek help for a treatable illness.

The Grievor resumed working in the spring of 2018 and he was dispatched by the Union to a variety of jobs. On May 24, 2018, Denyse Dehler, Assistant to the President of the Union, sent an email to Tina Craig, Manager, Employee Wellness & Ability Management at Vancouver Drydock and attached the May 3 letter from Dr. Fay indicating the Grievor's fitness to return to work. Ms. Dehler's email stated as follows:

> Attached is a report from Dr. Patrick Fay, whose practice and education revolves around addiction. The union was advised by the St Paul's Rapid Access Addiction Clinic that Dr. Fay, as 'GC's' treating addiction medical specialist, would be the most knowledgeable, and he is qualified to supply you with a report.
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> As suggested by Dr. Fay, 'GC's" family physician has referred him to see a neurologist for an assessment, however the waiting time is approximately six months. 'GC' does not have the financial means to expedite this through private clinic, however, should the company be willing to cover the expense, 'GC' would be happy to arrange for an earlier appointment.

Ms. Craig responded to Ms. Dehler the next day:

> Thank you for the update and the medical note. I am glad to hear that 'GC' is doing well in his recovery; however, it is important to note that his entire role is considered safety sensitive and he would be operating within a heavy industrial yard. The Addiction Specialist Doctors that we have used in the past have all stated that an individual receiving methadone treatment is not fit for work in a safety sensitive role. It was unclear to me if Dr. Fay was indicating 'GC' would be able to work and still be taking Methadone., This is something that would need to be confirmed prior to discussing around 'GC's' return to work.

On May 26, 2018, Ms. Craig sent an email to Dr. Jennifer Melamed inquiring whether she could advise if methadone maintenance therapy is ever considered safe for safety sensitive workers. Dr. Melamed replied by email that, "[T]he literature and present occupational health guidelines do not support the use of methadone in safety sensitive positions".

On June 27, 2018, Ms. Craig requested a second opinion from Dr. Donald Hedges. Dr. Hedges provided a two page report to Ms. Craig and he concluded as follows:

> It is good to know that 'GC' has apparently achieve stable early recovery from his potentially fatal illness, and I wish him well in the future. In my opinion, the crucial question here is whether or not his daily use of methadone poses a significant risk of disordered mental function that he could, as a result, harm himself or others while at work in a safety-sensitive occupation.
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> As Dr. Fay wrote, "The idea of long term OST (methadone or suboxone) for recovery is relatively new." There is a paucity of scientific research on the deleterious effects, if any, on cognitive, emotional or other mental functions arising from the daily use of methadone. As afar as I can ascertain, there is no reliable way to determine whether an individual using methadone daily will be impaired by its use at any given dose or any given time of day, and it certainly could be the case that such an individual would not be aware of such impairment (most drivers impaired by alcohol do not think they are impaired or perceive the degree of their impairment). Although "GC' seemed to Dr. Fay to be "totally alert and functional" in Dr. Fay's office, he might well not be totally alert and functional at different times of the day, depending especially on the time he last took his daily dose of methadone,.
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> In my serious but not exhaustive search for relevant scientific research on this matter, I found one peer-reviewed research paper to be quite relevant in this matter ("Cognitive Performance in Methadone Maintenance Patients: Effects of Time Relative to Dosing and Maintenance Dose Level" by Rass, Kleykamp, Vandrey et al., *Experimental and Clinical Psychopharmacology,* 2014, attached). Briefly, an association was found between cognitive performance and the time of the does of methadone, with worse performance in the first two hours after the daily dose ("peak sessions", when the serum levels were low). Specifically, "Peak sessions were associated with worse performances on measures of sensory processing, psychomotor speed, divided attention, and working memory, compared with trough sessions". The authors noted that their findings could not be applied universallym, and the matter needs more research.

> Based on all of the information available to me, and speaking not about 'GC' (or Seaspan or any other employer or agency) but only in general, it is my opinion that, at this time, the use of methadone is incompatible with safety-sensitive occupations.

Ms. Dehler then contacted Ms. Craig again in early August and requested a meeting with the Company. At this point, Ms. Craig informed the Director of Employee Relations, Dianne Richards, about the situation with 'GC' and indicated that Ms. Dehler wished to meet regarding the prospect of the Grievor returning to work.

A meeting was scheduled for August 8 at which Ms. Dehler conveyed the Union's view that it considered it was safe for the Grievor to return to work at Vancouver Drydock and that the Union did not want to waste more time by sending the Grievor for an assessment by a neurologist. Ms. Craig and Ms. Richards explained that, based on the medical advice that the Employer had received, they could not allow the Grievor to return to work in his safety sensitive position.

As well, in her cross-examination at the hearing Ms. Richards acknowledged the Employer does not have any policies preventing people from working at Vancouver Drydock who are epileptics, diabetics, those having sleep disorders, those with cardiovascular diseases or vision/hearing problems, or those who are on anti-depressants.

As well, the parties stipulated that there is one unnamed employee who is on methadone treatment and has worked at Vancouver Drydock for a number of years.

The next development with respect to 'GC' did not occur until late September 2018 when he was dispatched to Vancouver Drydock with a contractor (Ross Rex Industrial Painters) with whom he had been working. 'GC' worked at the site from September 19 to 29 and during that time, the Grievor spoke with both Will O'Neill, Director Operations, and Paul Hebson, General Manager. The Grievor testified both individuals wished him well and appeared pleased when 'GC' told them he was doing well. 'GC' agreed in his testimony he never informed either of them that he was being treated with methadone at the time.

On October 19, Fred Simmons, President of Local 1, wrote to Ms. Richards indicating that the Company had not responded to the Union's earlier requests concerning 'GC's' return to work. On October 25, 2018, the Union sent a further letter to Ms. Richards which followed up on its request to return the Grievor to work and pointed out that the Grievor had worked at Vancouver Drydock from September 19 to 29 with Ross Rex. Ms. Richards was surprised to

hear that the Grievor had been working at the Drydock, and immediately forwarded the Union letter to Ms. Craig and Mr. O'Neill. Ms. Richards discussed the letter with Mr. O'Neill and advised him that the Grievor was not permitted to be on their worksite. The next time that the Grievor was dispatched to Vancouver Drydock by the Union he was not permitted to work and Mr. O'Neill informed the Union not to dispatch him in the future.

On October 29, the parties each sent a letter to the other. The Union's letter, from Mr. Simmons, stated, in part:

> On October 26, 2018, we dispatched 'GC' for work at Vancouver Drydock commencing Monday, October 29, 2018.
>
> We are advised by Mr. O'Neill that he was required to "follow directions from HR", which has led Mr. O'Neill to refusing to accept the dispatch of 'GC' to the yard.
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> Given that Seaspan had no problem with 'GC' working in the yard when working with a contractor we can see no valid objection to him working there when dispatched by this Local Union. The matter is now not only a question of his fitness for work (we say there is absolutely no question that he is fit to work at the yard) but one of discrimination against this Local Union.
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> Accordingly, by this letter we are referring 'GC's' grievance dated June 2, 2017 to arbitration and will seek full compensation for 'GC' and damages payable to this Local Union, in addition to the remedies set out in that grievance. A copy of the grievance is attached for your convenience.

The Employer's letter to the Union from Ms. Richards stated:

> I am writing in response to your letter of October 25, 2018. As you are aware, 'GC' is recovering from a serious opioid addiction and is currently undergoing treatment that requires the indefinite use of methadone.
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> The Union provided us with a letter from Dr. Fay and appears to be using this to support a return to work for 'GC'. The Dr. Fay letter does not, however, clear 'GC' for work in a safety sensitive environment. Instead, Dr. Fay suggested 'GC' be assessed by a neurologist or occupational medicine physician.
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> As you are also aware, the Company sought the opinions of two physicians with expertise in addiction, both of whom clearly stated the use of methadone is inconsistent with working in a safety sensitive occupation.
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> Pursuant to the Company's Substance Use Policy, prior to any return to work, 'GC' is required to attend at an independent medical exam and be cleared to return to work. The Company is prepared to set up an appointment for 'GC' to be seen by Dr. Hedges, who has previously assessed 'GC", and have Dr. Hedges determine whether 'GC' can safely return to work at this time.
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> Should 'GC' or the Union refuse to have 'GC' assessed, he will remain ineligible for work at Vancouver Drydock.

The parties then set this grievance down for hearing and each side obtained an expert opinion with respect to the medical issues which had arisen. The Employer's expert was Dr. Melamed who is a family practice physician with an interest and experience in addiction medicine. The Union obtained an opinion from Dr. Ewan Wood who has a Ph.D. in clinical epidemiology and is a Professor of Medicine and a Tier 1 Canada Research Chair in Addiction Medicine at UBC. Both doctors gave oral testimony at the hearing. In that regard, I wish to thank Dr. Melamed and Dr. Wood for their efforts in aiding this Board in understanding the medical issues.

As indicated, Dr. Melamed was asked by the Employer to provide a report and she did so on October 10, 2019. It is agreed that Dr. Melamed was not asked to address the specific situation with respect to 'GC' but restricted her opinion to general conclusions based on the literature in the field. In her report Dr. Melamed answered six specific questions. These questions and her responses are reproduced in edited form below (with footnotes omitted):

1. Does methadone cause impairment?

   Response:
   Impairment refers to an objectively measurable loss of function. The American Medical Association's Guides to the Evaluation of Permanent Impairment' defines impairment as "[A] significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder, or disease." Impairment rating is also a "consensus-derived percentage estimate of loss of activity reflecting severity for a given health condition, and the degree of associated limitations in terms of activities of daily living (ADLs),"

   The use of methadone (i.e. when a person is placed on Methadone Maintenance Treatment, or MMT) is associated with impairment.

2. If so, what are the impairing effects of methadone?

   Response:
   The preponderance of empirical research suggests that the use of methadone (MMT) is associated with impairment in cognitive function. These cognitive deficits extend across a broad range of domains.

   Methadone is a synthetic, long acting opioid which is effective for maintenance therapy in patients who have an opioid use disorder. Opioids are centrally acting drugs that produce sedation and analgesia. Methadone elicits its pharmacodynamic effects by binding to mu opiate receptors as do other opiates, but it has a much slower onset and longer duration of action, partly due to its oral absorption. Methadone is given as an oral dose and is rapidly absorbed.' Methadone has been associated with neurological symptoms such as headache, dizziness, and somnolence.'

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Some degree of impairment among methadone-maintained individuals has been identified in almost all experimental studies.

In the meta-analysis completed by Wang et al', 85% of the studies showed impaired cognitive function in patients undergoing methadone maintenance treatment with the majority receiving an average dose of greater than 60mg per day. Major differences were observed in the domains of memory, attention, psychomotor speed, decision-making, emotional interpretation and verbal function. Decreased performance was seen in all domains compared to the study controls.

…

There are some conflicting opinions on improvement of cognitive and psychomotor functioning among opioid maintenance therapy patients when compared to control groups or baseline. This could potentially be the result of a less harmful lifestyle, a reduction in the use of other (illicit) drugs, or the stabilization and benefits following maintenance therapy.

3. What effect (s) does the use of methadone have on an individual's ability to work in a safety sensitive position?

   Response:
   In 2017, the Canadian Human Rights Commission ("CHRC") defined a safety-sensitive position as one which: ...[I]f not performed in a safe manner, can cause direct and significant damage to property, and/or injury to the employee, others around them, the public and/or the immediate environment.

   Using this definition of a safety-sensitive position, the use of methadone is not recommended for persons working in a safety sensitive position.

   The American College of Occupational and Environmental Medicine (ACOEM) published their updated Practice Guidelines related to Opioids and Safety Sensitive Work in 2014. The conclusion of the ACOEM Practice Guidelines is as follows: "Acute or chronic opioid use is not recommended for patients who perform safety-sensitive jobs. These jobs include operating motor vehicles, other modes of transportation, forklift driving, overhead crane operation, heavy equipment operation, sharps work (e.g. knives, box cutters, needles), work with injury risks (e.g. heights) and tasks involving high levels of cognitive function and judgment."

   The skills required include unimpaired alertness, attention, concentration, reaction time, coordination, memory, multitasking abilities, perceptual abilities, thought processing and judgment. There is documented evidence that opioids produce cognitive impairments, perceptual deficits, and slowed reaction times.

…

Although some experimental studies have not been able to demonstrate the impairing effects of opioids (such as methadone), on either cognitive or psychomotor task performance of relevance to driving20, the majority of studies supported the evidence of increased crash risk, and by extension it may impact risk in an occupational context.

When studying the effects of methadone on opioid naïve subjects, comparatively low doses caused marked impairments in performance tasks of relevance to driving. Thus, it can be stated that methadone can have an impairing potential. Even after the individual has been stabilized on a specific dose of methadone, the development of tolerance may be incomplete and the impairing cognitive and psychomotor effect cannot be excluded.

4. How long would it take for the impairing effects of methadone use to wear off?

   Response:
   A determination of the time taken for impairment secondary to methadone to wear off is difficult to predict because of a number of variables.

   Methadone is given as an oral dose and is rapidly absorbed (being detectable in plasma 30 minutes after administration) with an elimination half-life of 24-36 hours. Normally, the peak plasma concentration occurs 2.5-4 hours after dosing, with a plasma trough level occurring 24 hours after the last dose.

   The individual dosages of methadone across various studies represent a wide range with the highest dosage up to ten times greater than the lowest. These groupings, with such wide variations in dosage, would most probably be represented by an equally wide variation in blood drug concentrations and even wider variations due to inter-and intra-individual variations in blood drug concentrations for any given dosage of methadone.

   Methadone is able to negate the aversive effects associated with acute opiate withdrawal and, compared to other opiates, has minimal euphoric effects. However, the dose required to effectively block withdrawal varies and is dependent on individual physiological variables, such as metabolic rate and the degree of tolerance developed.

   It is well known that an individual's methadone plasma concentration varies over time and this may contribute to differences in cognitive performance.

   The timing of plasma concentrations in relation to dose has been shown to negatively influence cognitive function. Poorer performance was often observed at the trough plasma level of methadone compared to the peak level.

   In addition, methadone dose increases can be associated with performance impairment. If an individual's dose is increased because of the change in treatment or if there is an abuse of methadone resulting in an individual taking more than the prescribed dose (e.g. by using diverted or take-home doses), it could result in an increase in cognitive impairment. In the study done by Kleykamp et al., this acute increase demonstrated attentional impairment.'

   In summation, although pharmacological tolerance may minimize the acute effects of methadone on cognitive function, longer lasting cognitive deficits cannot be excluded.

   According to the ACOEM Opioid Guidelines, among those treated with opioids, sufficient time after the last dose is recommended to eliminate approximately 90% of the drug and active metabolites from the system in order for an individual to be considered eligible to return to work in a safety sensitive position.

For individuals on methadone maintenance treatment, a daily oral dose is required and hence no opportunity for elimination is established.

5. If someone is regularly using methadone and is employed in a safety sensitive position, will they be able to safely perform their duties?

   Response:

   …

   Impairment of both cognitive and psychomotor function has been observed in methadone maintenance therapy individuals when compared to control groups.' Further impairments have been observed among methadone maintained individuals after single doses, after an additional versus regular daily dosing, in multiple versus single dosing, and after long-term treatment compared to baseline levels.

   As noted above, in accordance with the ACOEM Guidelines, the ongoing use of methadone would prevent an individual from performing their duties in a safety sensitive position.

6. Is there any treatment plan that would include taking methadone that would be consistent with safely performing work in a safety sensitive position?

   Response:

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   In opioid users, the magnitude of the deficit in decision-making was moderate to large relative to nondrug using controls. The results of the meta-analysis suggested that, at least for the first 1.5 years of abstinence, improvements in decision-making deficits might be minimal."

   It is critical to delineate whether any impairment, or slight deviation from the norm is acceptable during performance tasks.

   In a safety sensitive position any material degree of impairment may foreseeably be associated with increased occupational risk. Although this may result in the preclusion of individual(s) working who are theoretically not at increased risk, as there is no validated method to demonstrate a specific individual's safety while consuming methadone or other opioids, Methadone Maintenance Treatment is not compatible with safety sensitive work.

Dr. Wood's report to the Union was dated October 16, 2020 and contains the following information (again with footnotes omitted):

> Biological Testing:
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> 'GC' is in opioid agonist treatment with Dr. Fay where he has received continuous biological monitoring as part of his opioid agonist treatment. As part of obtaining collateral information from Dr. Fay (see below), it was confirmed 'GC's' long term abstinent remission from heroin addiction. As such, and due to the COVID-19 pandemic where unnecessary interactions with the health care system are discouraged, additional biological testing was deferred.

Collateral information:

Dr. Patrick Fay ('GC's' addiction medicine physician. Ph: 604 xxx-xxxx) confirmed 'GC''s success with his methadone treatment and confirmed his long term stable dose of 85mg per day and his long term abstinence from heroin and cocaine over the last approximately three years in all biological testing which, on average has been 2 times per month. He indicated that he has never seen 'GC' sedated or having any side effects of methadone that might imply a safety risk and went out of his way to say he's seen him at various times of day both close to and distanced from his methadone administration. He shared he had spoken with various individuals including 'GC's' friends and sponsor and that all of these individuals indicated 'GC's' excellent outcomes and no concerns with methadone side effects. It was Dr. Fay's opinion that every patient should be evaluated based on their individual circumstances including response to medication as the variables that should be considered with respect to a safety sensitive position and a patient's suitability for a given workplace while on methadone. In 'GC's' case, he was emphatic that he felt he was safe to return to work as a painter sandblaster.

Greg Bertram ('GC's' supervisor at Ross Rex Industrial Painters. Ph: 604 xxx-xxxx). I spoke with Mr. Bertram in detail regarding 'GC's' performance in the workplace at Ross Rex. He indicated he's in a safety sensitive role and confirmed job duties very similar to what 'GC' described including use of the sandblaster, forklift driving, etc. Mr. Bertram indicated that in the approximately 3 years he's been supervising 'GC' he's had zero concerns with his performance in the safety sensitive role. When I specifically asked about any fitness to work questions or any issues with performance as it related to safety, Mr. Bertram was emphatic that he thought 'GC' was an excellent employee and that there had been zero questions about his fitness or safety over the preceding approximately 3 year period.

Mental Status: 'GC' was early for his video conference which started on time. Within the limits of a video conference, he was entirely normal appearing. His activity, mood and affect all appeared completely normal. His speech and language were normal. His thought content and organization were entirely appropriate throughout the interview. I detected no perceptual disturbances and thought his insight and judgement were normal. There were no neuropsychiatric features. He seemed euthymic and upbeat. Overall, I viewed his mental status as overall entirely normal.

Prior Assessments and Expert Interpretation:

'GC' has had 5 prior reports prepared as part of his file that were provided to me. In each case, I will summarize the content of these reports and provide my expert interpretation below and – since I think issues of conflict of interest and non-evidence-based practice are relevant – I will cite the relevant research evidence that supports my interpretation.

1. Dr. Valentyna Koval (Neurological Report) dated September 24, 2018 which indicated that 'GC's' neurological assessment "was unremarkable" but indicated a referral to a neuro psychologist for further testing and assessment could be helpful.

My only comment on this report are that it is not particularly helpful to the matter at hand.

2. Dr. Patrick Fay (Family Physician) letter dated May 3, 2008 notes that opioid agonist therapy is the current standard of care, that 'GC'is not showing any side effects of methadone such as drowsiness and that he is totally alert and functional, that his risk for relapse off of methadone would be almost 100%, that the demand for him to stop methadone would be akin to asking a diabetic to stop insulin, and that these situations should be client centred rather than blanket policies.

This brief report is based on Dr. Fay's experience with 'GC' and there is little to add from an expert opinion perspective other than what I'll address below.

3. Dr. Donald Hedges' (Family Physician) IME report dated April 30, 2017 suggests 'GC' must continue to abstain completely and indefinitely from all psychoactive substances, comply with his relapse prevention agreement, and attend at least three NA and/or AA meetings every week indefinitely as well as to continue close contact with his sponsor. Dr. Hedges does not recommend that 'GC' initiate opioid agonist therapy.

…

Issues and Opinion:

The questions that have been posed to me will be addressed below:

1. What is 'GC's' prognosis in relation to his opioid use disorder if he continues to adhere to his current treatment regimen?

From an evidence-based medicine perspective, several research tools have been developed to assess risk of relapse through the assessment of an individual's overall "recovery capital" which is used as a proxy for prognosis for recovery or risk of relapse. Specifically, recovery capital has been defined as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and drug problems". Measures that can help quantify an individual's recovery capital have subsequently been developed and validated and generally include the following key factors: ongoing substance use vs. sobriety; global psychological health; global physical health; citizenship; social supports; engagement in meaningful activities; housing and safety; risk taking behaviours; coping and life functioning; and recovery experience. In this context, 'GC' has been to residential addiction treatment on three occasions and carries a host of skills (e.g. dealing with stressors, resiliency) from these experiences. He regularly attends peer support group meetings on his own volution and has close contact with his NA sponsor. He is on a therapeutic and stable dose of methadone and under the care of an expert-recovery oriented addiction medicine physician. He states he has been abstinent from heroin and cocaine for approximately 3 years and Dr. Fay confirmed his longterm abstinent remission from heroin and cocaine use. He has excellent mental health, he is employed and housed. He has good social supports. Based on all of the above, and based on the literature in this area, 'GC' has an excellent prognosis with respect to his opioid use disorder on his current regimen.

2. What is his prognosis if he is required to discontinue MMT in order to return to work at VDD?

'GC' has a clear pattern of relapse when psychosocial treatments are provided without opioid agonist therapy. This experience is consistent with the literature which demonstrates the high rates of relapse and increased mortality for individuals with opioid addiction provided treatment without opioid agonist therapy. By way of illustration, even when prescription opioid addicted individuals are considered (i.e. individuals who generally would have less severe health and social comorbidities on average in comparison to intravenous heroin users) rates of relapse with psychosocial treatment (even when stabilization on opioid agonist therapy is employed) are greater than 80%. For instance, in the National Institute on Drug Abuse Clinical Trials Network Prescription Opioid Addiction Treatment (POATS) clinical trial, greater than 80% of opioid addicted patients relapsed upon tapering of opioid agonist therapy despite a full psycho-social recovery-oriented treatment intervention including intensive counselling.

Of course, 'GC's' circumstances are different since he has a history of heroin rather than prescription opioid addiction, and since he's been stable on methadone for several years. Here, the literature again is highly informative. Specifically, a widely cited study from British Columbia which had the advantage of considering all patients on methadone between 1996 to 2006 (i.e. not a selected clinic based sample) looked at the rate of successful methadone tapers defined as "a daily dose ≤5 mg per day in the final week of the treatment episode and no treatment reentry, opioid-related hospitalization or mortality within 18 months following episode completion." This study demonstrated that only 13% of methadone tapers were successful (i.e. did not end up back on methadone, hospitalized or dead) and concluded that "the majority of patients attempting to taper from methadone maintenance treatment will not succeed."

Based on the above, I view 'GC' as having a high risk of hospitalization or death if his methadone is tapered and note that the above research was completed prior to the emergence of the opioid overdose epidemic as a result of the fentanyl adulteration of the heroin supply in BC. This is not to say that 'GC' may not have a good prognosis off of methadone, but to underline the possible harms that could result from unnecessary tapering. Fortunately, new medications are now routinely available that could be helpful for him should he ultimately choose to go off of methadone in the future including buprenorphine/naloxone (suboxone) or the new long acting buprenorphine (sublocade).

3. What impact, if any, does gainful employment have on recovery from substance use disorders?

As I shared above in my description of recovery capital, gainful employment has been consistently associated with increased recovery capital and long term abstinent remission of substance use disorders.

4. Is being treated with MMT incompatible in all cases with an employee working in all safety sensitive workplaces?

No. Being treated with methadone may be compatible with working in a safety sensitive workplace in some individuals and circumstances whereas it may not be compatible in others. For instance, there are genetic polymorphisms that may make some individuals more susceptible to being sedated with methadone (a safety risk) whereas other individuals may be rapid metabolizers of methadone. Some individuals using methadone, or any

employee frankly, may have a history of brain injury or other unique individual characteristics that may make opioid agonist therapy appropriate or unsuitable. Of course, additional factors, such as demonstrated workplace performance or considerations related to the specific job description, may also factor in to this decision.

In this context, it is worth sharing a possible explanation as to why the research on the possible impairing effects of methadone maintenance therapy leans towards it being safe for individuals to drive (e.g. see B.C. and international policies routinely allowing methadone users to drive when on a stable dose) while there are identifiable studies suggesting possible mild impairment. As I noted above, these studies could be due to comparisons of methadone users to normal controls and/or characteristics of heroin users independent of methadone. Alternatively, an epidemiologist from Stanford University, Dr. J.P. Ioannidis, wrote a now seminal article entitled "Why most published research findings are false". This article highlights when there are inconsistent findings (i.e. as in the case of methadone's impairing effects) it implies that there is not a causal relationship but that other confounding factors should strongly be considered. The article concludes a "research finding is less likely to be true when the studies conducted in a field are smaller; when effect sizes are smaller; when there is a greater number and lesser preselection of tested relationships; where there is greater flexibility in designs, definitions, outcomes, and analytical modes; when there is greater financial and other interest and prejudice; and when more teams are involved in a scientific field in chase of statistical significance. Simulations show that for most study designs and settings, it is more likely for a research claim to be false than true. Moreover, for many current scientific fields, claimed research findings may often be simply accurate measures of the prevailing bias." Many of these circumstances (e.g. small studies, small effect sizes, greater number of tested relationships, special interests, etc) are highly relevant to the methadone literature. Of course, the bulk of literature and experience clearly demonstrate that driving and other tasks on stable doses of methadone are safe – otherwise this policies would have long ago been revisited.

I cite this paper and provide the above not to suggest that methadone never causes impairment, rather so that explanations for the mixed literature in this area can be put in context and why I strongly suggest that individual patient circumstances be considered rather than blanket prohibitions against what is often a life-saving medication.

5. Can 'GC', based on your assessment and expertise, return to work at VDD in his job as a painter/sandblaster and perform that work in a reasonably safe manner while being treated with MMT?

Upfront I should acknowledge that assessment of 'GC' was limited by the fact that my consultation with him was limited to a single video medicine consultation though I doubt more detailed assessments would provide additional information over and above what information is available to me. Specifically:

a) A clear description of "not showing any side effects from methadone such as drowsiness and on visits to my office he seems totally alert and functional" from Dr. Fay an addiction medicine physician skilled in observing these side effects and who sees him routinely and who confirmed his impression to me directly;

> b) A review by a Neurologist who described his neurological exam as overall "unremarkable";
>
> c) A varied literature on the effects of methadone maintenance on impairment that consistently fails to demonstrate clinically significant impairment among individuals stable on methadone. Indeed, as described above, some studies show no deficits or "improved performance," whereas studies that have documented what appears to be mild impairment, go to lengths to indicate that the findings may be due to predisposing factors other than methadone (i.e. comparison of individuals on methadone to healthy controls) and/or that subtle laboratory identified deficits may not have any real world clinical significance.
>
> d) A description of 'GC's' workplace that does not appear to present complex cognitive or psychomotor tasks over and above what would be expected of an automobile operator and the fact that, as shared above, persons stable on methadone can routinely continue to operate motor vehicles in British Columbia.
>
> e) The literature demonstrating that individuals in vocations requiring a high degree of cognition (e.g. physicians) can work successfully when on opioid agonist therapy in jurisdictions like Quebec and elsewhere.
>
> f) The literature highlighting the likely ideological and conflict of interest concerns that have brought increasing scrutiny to physician health programs and the monitoring industry and that suggest, overall, employees in safety sensitive positions should be evaluated on an individual basis rather than "one size fits all" recommendations to all that work in a job that is classified as safety sensitive.
>
> g) Most importantly, a description of 'GC's' current performance in his safety sensitive duties with Ross Rex Industrial Painting as a model employee with three years of observed performance where no workplace safety or workplace fitness concerns have been observed.
>
> Based on the above, I see no reason why 'GC' could not continue in his safety sensitive work at VDD.

As indicated, both doctors provided oral testimony and their evidence aligned with the opinions contained in their reports.

DECISION:

This is a grievance about an alleged failure on the part of Vancouver Drydock to establish a *bona fide* occupational requirement ("BFOR") including a failure to accommodate the Grievor. Therefore, it is appropriate to begin with a brief review of the law which has been established, principally by the Supreme Court of Canada.

The seminal case in this area is the decision of that Court in *British Columbia (Public Service Employees Relations Commission v. British Columbia Government and Service Employees' Union (B.C.G.S.E.U.) ("Meiorin" Greivance),* [1999] 3 S.C.R. 3. The principles set out in "Meiorin" have been discussed and applied elsewhere: *Moore v. British Columbia (Education)* 2012, S.C.C. 61; *Interior Health Authority,* November 13, 2018 (Hall); *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)* [1999] 3 S.C.R. 868 ("Grismer"); *Lower Churchill Transmission Construction Employers' Association Inc. and Valard Construction LP v. International Brotherhood of Electrical Workers, Local 1620,* 2020 N.L.C.A. 20; *Quebec v. Caron,* 2018 SCC 3; *Hydro Quebec,* 2008 SCC 43; *Canada (Attorney General) v. Cruden,* [2014] A.F.C.R. 612, upheld at [2015] 3 F.C.R. 103; *Wallace v. United Grain Growers Ltd.,* [1997] 3 S.C.R. 701; *Code Electric Products,* [2005] B.C.C.A.A.A. No. 14 (Burke).

The first requirement in these types of cases is that the individual must first establish a case of *prima facie* discrimination by demonstrating: (i) the person has a characteristic and that characteristic is protected from discrimination; (ii) the person has experienced an adverse impact with respect to their employment; and, finally, (iii) the characteristic is a factor in the adverse impact on the individual.

In the case at hand, that *prima facie* case has been made out as it is clear 'GC' has a disability, specifically a drug addiction, and he is being prevented from working at Vancouver Drydock due to the nature of his treatment for that addiction.

Given that conclusion, the onus has shifted to the Employer to establish that the restrictions it has imposed constitute a *bona fide* occupational requirement. In order to satisfy that burden, the Company must satisfy, based on the civil test of a balance of probabilities, the following three-step test set out in *Meiorin*:

> 1. that the employer adopted the standard for a purpose rationally connected to the performance of the job;
> 2. that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
> 3. that the standard was reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.

In the present case, it is not in dispute that the first two steps have been met. It is with respect to the third step that the disagreement between the parties has arisen.

In *Meiorin, supra*, the Supreme Court provided guidance with respect to this third step. It stated, at paras. 62 – 65:

> 62 The employer's third and final hurdle is to demonstrate that the impugned standard is reasonably necessary for the employer to accomplish its purpose, which by this point has been demonstrated to be rationally connected to the performance of the job. The employer must establish that it cannot accommodate the claimant and others adversely affected by the standard without experiencing undue hardship. When referring to the concept of "undue hardship", it is important to recall the words of Sopinka J. who observed in *Central Okanagan School District No. 23 v. Renaud*, 1992 CanLII 81 (SCC), [1992] 2 S.C.R. 970, at p. 984, that "[t]he use of the term 'undue' infers that some hardship is acceptable; it is only 'undue' hardship that satisfies this test". It may be ideal from the employer's perspective to choose a standard that is uncompromisingly stringent. Yet the standard, if it is to be justified under the human rights legislation, must accommodate factors relating to the unique capabilities and inherent worth and dignity of every individual, up to the point of undue hardship.
>
> 63 When determining whether an existing standard is reasonably necessary for the employer to accomplish its purpose, it may be helpful to refer to the jurisprudence of this Court dealing both with the justification of direct discrimination and the concept of accommodation within the adverse effect discrimination analysis. For example, dealing with adverse effect discrimination in *Central Alberta Dairy Pool*, *supra*, at pp. 520-21, Wilson J. addressed the factors that may be considered when assessing an employer's duty to accommodate an employee to the point of undue hardship. Among the relevant factors are the financial cost of the possible method of accommodation, the relative interchangeability of the workforce and facilities, and the prospect of substantial interference with the rights of other employees. See also *Renaud*, *supra*, at p. 984, *per* Sopinka J. The various factors are not entrenched, except to the extent that they are expressly included or excluded by statute. In all cases, as Cory J. noted in *Chambly*, *supra*, at p. 546, such considerations "should be applied with common sense and flexibility in the context of the factual situation presented in each case".
>
> 64 Courts and tribunals should be sensitive to the various ways in which individual capabilities may be accommodated. Apart from individual testing to determine whether the person has the aptitude or qualification that is necessary to perform the work, the possibility that there may be different ways to perform the job while still accomplishing the employer's legitimate work-related purpose should be considered in appropriate cases. The skills, capabilities and potential contributions of the individual claimant and others like him or her must be respected as much as possible. Employers, courts and tribunals should be innovative yet practical when considering how this may best be done in particular circumstances.
>
> 65 Some of the important questions that may be asked in the course of the analysis include:

> (a) Has the employer investigated alternative approaches that do not have a discriminatory effect, such as individual testing against a more individually sensitive standard?
>
> (b) If alternative standards were investigated and found to be capable of fulfilling the employer's purpose, why were they not implemented?
>
> (c) Is it necessary to have <u>all</u> employees meet the single standard for the employer to accomplish its legitimate purpose or could standards reflective of group or individual differences and capabilities be established?
>
> (d) Is there a way to do the job that is less discriminatory while still accomplishing the employer's legitimate purpose?
>
> (e) Is the standard properly designed to ensure that the desired qualification is met without placing an undue burden on those to whom the standard applies?
>
> (f) Have other parties who are obliged to assist in the search for possible accommodation fulfilled their roles? As Sopinka J. noted in *Renaud*, *supra*, at pp. 992-96, the task of determining how to accommodate individual differences may also place burdens on the employee and, if there is a collective agreement, a union.

In this situation at Vancouver Drydock, the Employer, based on medical advice it had received, took the position that anyone who was being treated with methadone could not work in this safety sensitive environment and, as a result, asserts it has established a *bona fide* occupational requirement as the standard was reasonably necessary to the accomplishment of a safe workplace. For its part, the Union asserts this restriction does not constitute a BFOR and that the Employer has failed to accommodate the Grievor.

This leads us to considering the expert evidence which accounted for almost all the oral testimony in this case. A number of authorities address the requirements related to the use of expert evidence: *R. v. Mohan*, [1994] 2 S.C.R. 9; *Yewdale v. ICBC*, (1995) 3 B.C.L.R. (3d) 240; *Interior Health Authority, supra; Code Electric Products Ltd., supra; Burnaby (Rossner), supra.* Some of the principles which have been adopted include the following:

(i) the use of such expert evidence should preserve the integrity of a fair hearing;

(ii) the expert should be properly qualified;

(iii) the evidence should be relevant;

(iv) the expert should present as a neutral advisor and not as an advocate;

(v) the expert should not have any vested interest in the outcome;

(vi) the expert must stay within the area of his/her expertise;

(vii) the expert must not displace the role of the trier of fact.

With those principles in mind, we turn to the crux of this dispute which is whether a "blanket rule" indicating that an individual who is on any treatment involving methadone can be disqualified from working at Vancouver Drydock.

A review of the medical opinions of Dr. Melamed and Dr. Wood clearly indicate a division of opinion exists in the scientific community and that is readily apparent from the contents of their own written reports. Certain doctors, including Dr. Melamed and Dr. Hedges, take the view that if methadone treatment is undertaken with an individual, he/she can never work in a safety sensitive work.

Other physicians, including Dr. Wood, indicate that this approach is not justified. They point to the fact the scientific studies are inconclusive, that some of them do not separate out individuals who are on long term maintenance therapy (MMT) from those in the initiation stage or are in the process of taking increasing dosages. As well, they also observe there is some evidence in the studies that MMT may actually improve an individual's concentration and performance.

After reviewing the evidence of Dr. Melamed and Dr. Wood, as well as the articles referred to in their testimony, I have drawn the conclusion that it has not been established that the issue is as "black and white" as suggested by Dr. Melamed. It appears that there is some limited evidence that individuals who are taking methadone, and particularly MMT, may be stable enough that they could work in some safety sensitive jobs. It should also be emphasized that Dr. Melamed's position, by her own admission, is a very conservative one in which a "proportionality" test is used to conclude that the chance of any injury in a safety sensitive environment is too great a risk to take.

I find the following comments contained in Dr. Wood's report to be a useful and fair summary of the state of the literature:

> In this context, it is worth sharing a possible explanation as to why the research on the possible impairing effects of methadone maintenance therapy leans towards it being safe for individuals to drive (e.g. see B.C. and international policies routinely allowing methadone users to drive when on a stable dose) while there are identifiable studies suggesting possible mild impairment. As I noted above, these studies could be due to comparisons of methadone users to normal controls and/or characteristics of heroin users independent of methadone. Alternatively, an epidemiologist from Stanford University, Dr. J.P. Ioannidis, wrote a now seminal article entitled "Why most published research findings are false". This article highlights when there are inconsistent findings (i.e. as in the case of methadone's impairing effects) it implies that there is not a causal relationship but that other confounding factors should strongly be considered. The article concludes a "research

> finding is less likely to be true when the studies conducted in a field are smaller; when effect sizes are smaller; when there is a greater number and lesser preselection of tested relationships; where there is greater flexibility in designs, definitions, outcomes, and analytical modes; when there is greater financial and other interest and prejudice; and when more teams are involved in a scientific field in chase of statistical significance. Simulations show that for most study designs and settings, it is more likely for a research claim to be false than true. Moreover, for many current scientific fields, claimed research findings may often be simply accurate measures of the prevailing bias." Many of these circumstances (e.g. small studies, small effect sizes, greater number of tested relationships, special interests, etc) are highly relevant to the methadone literature. Of course, the bulk of literature and experience clearly demonstrate that driving and other tasks on stable doses of methadone are safe – otherwise this policies would have long ago been revisited.
>
> I cite this paper and provide the above not to suggest that methadone never causes impairment, rather so that explanations for the mixed literature in this area can be put in context and why I strongly suggest that individual patient circumstances be considered rather than blanket prohibitions against what is often a life-saving medication.

On that basis, it seems fair to say that the issue of the effects of ongoing methadone maintenance therapy on an individual has not been definitely settled in the literature. Specifically, I accept the Union's argument that no clear evidence or conclusions from the studies "that stabilized patients on MMT therapy suffer any cognitive deficit that is clinically significant or has any effect on occupational outcomes".

A second difficulty here is that even if it could be established that such a "near-blanket" rule had significant general merit, human rights legislation and the various legal authorities nevertheless require there must also be an individualized assessment made in each instance. There are numerous court and arbitral decisions to that effect.

For example, in *Grismer,* the Supreme Court of Canada stated, at paras. 30 and 42 – 43:

> 30 The third question is whether the standard chosen by the Superintendent was reasonably necessary to accomplish the legitimate purpose. To meet this requirement, the Superintendent had to show that he could not meet his goal of maintaining highway safety while accommodating persons like Mr. Grismer, without incurring undue hardship. Risk has a limited role in this analysis. It is clear from *Meiorin* that the old notion that "sufficient risk" could justify a discriminatory standard is no longer applicable. Risk can still be considered under the guise of hardship, but not as an independent justification of discrimination. In this case, risk is used as a measure of the level of safety which was sought by the Superintendent, and as a factor in assessing the lack of accommodation provided by the Superintendent for people with H.H. The critical issue is whether the Superintendent's non-accommodating standard was reasonably necessary to the achievement of reasonable highway safety.
>
> …

> 42 In summary, the Superintendent offered no evidence that he had considered any of the options that might have made an assessment of Mr. Grismer's driving abilities viable and affordable. Content to rely on the general opinion of the medical community, and ignoring the evidence that some people with H.H. can and do drive safely, he offered not so much as a gesture in the direction of accommodation. His position, quite simply, was that no accommodation was necessary. Under the *Meiorin* test, it was incumbent on the Superintendent to show that he had considered and reasonably rejected all viable forms of accommodation. The onus was on the Superintendent, having adopted a *prima facie* discriminatory standard, to prove that incorporating aspects of individual accommodation within the standard was impossible short of undue hardship. The Superintendent did not do so. On the facts of this case, the Superintendent's blanket refusal to issue a driver's licence was not justified. He fell into error in this case not because he refused to lower his safety standards (which would be contrary to the public interest), but because he abandoned his reasonable approach to licensing and adopted an absolute standard which was not supported by convincing evidence. The Superintendent was obliged to give Mr. Grismer the opportunity to prove whether or not he could drive safely, by assessing Mr. Grismer individually. It follows that the charge of discrimination under the *Human Rights Act* was established.
>
> 43 This is the conclusion that the *Meiorin* test requires, on the evidence and findings in this case. The question may be put, however, whether this approach places too high an evidentiary burden on the government, particularly in situations involving public safety. The obvious answer to this question is that it is the Legislature, not the Court, which has placed the evidentiary burden of showing reasonable necessity once *prima facie* discrimination has been made out. More fundamentally, is it really inappropriate to require a governmental body that rejects an application for a driver's licence on the basis of disability to prove on a balance of probabilities that the denial is reasonably necessary to the standard of highway safety it has selected? The government authority knows why it makes the denial and is in the best position to defend it. The government must only establish its justification according to the relaxed standard of proof on a balance of probabilities. Common sense and intuitive reasoning are not excluded, but in a case where accommodation is flatly refused there must be some evidence to link the outright refusal of even the possibility of accommodation with an undue safety risk. If the government agency can show that accommodation is impossible without risking safety or that it imposes some other form of undue hardship, then it can maintain the absolute prohibition. If not, it is under an obligation to accommodate the claimant by allowing the person an opportunity to show that he or she does not present an undue threat to safety.

Similarly, in *Lower Churchill Transmission Corporation, supra,* the Newfoundland Court of Appeal recently discussed the need for individualized considerations. Mr. Justice Welch writing in the majority, stated, at paras. 34 – 35:

> 34 In the absence of a scientific or medical test or standard, in order to discharge the onus of establishing that to accommodate the grievor would amount to undue hardship, it was necessary for the employer to demonstrate that to assess the grievor for impairment by some other means on a daily or periodic basis would result in undue hardship. That is, the absence of a test or standard does not lead inexorably to the conclusion that there is no means by which to determine whether an employee, by reason of ingesting cannabis, would be incapable of performing a specific job, including a safety-sensitive job. The onus was on the employer to establish on a

balance of probabilities that some means of individual testing of the grievor to assess his ability to perform the job was not an alternative.

35 Considerations discussed in *Meiorin*, when applied in the context of this case, lead to the conclusion that there is a danger in treating impairment by the use of medically authorized cannabis on the basis of the class of individuals who access that treatment. Rather, given the individual nature of the possible accommodation, the analysis requires an assessment regarding what alternatives were investigated by the employer that may have allowed for individual testing of the grievor. Was a scientific or medical standard the only option? If so, why? If alternate options were identified, why were they not implemented? For example, was a functional assessment of the grievor before his shift considered? If rejected, why? What discussion were had with the Union to identify and assess alternate options for determining whether the grievor was capable of safely performing the job despite his use of cannabis int eh evening? The employer failed to address these questions or provide evidence as necessary to discharge the onus of demonstrating that accommodation of the grievor on an individual basis would result in undue hardship.

In a concurring opinion, Justice Butler observed, at paras. 61 – 63:

61 As stated in *Grismer*, risk "has a limited role in the analysis" of the third prong of the BFOR test stated in *Meiorin.* "Risk can still be considered under the guise of hardship, but not as an independent justification of discrimination" (at paragraph 30). In my view the approach taken here was contrary to well established workplace disability discrimination principles because the arbitrator and applications judge relied upon "potential risk" as an independent justification for discrimination.

62 In other words, having already established in the Policy the general risk of side effects from prescription drug use and conditions to reflect that the standard was reasonable site safety, it was not sufficient for the employer to take the position that it could not employ someone because they posed a risk. They employer must go further and establish through an individualized analysis (not limited to medical or scientific testing) why allowing this grievor to perform this job on this site would not enable the employer to maintain reasonable site safety, short of undue hardship.

63 *Grismer* instructs that there is "more than one way to establish that the necessary level of accommodation has not been provided" (at paragraph 22). One of these is evidence that some persons with the disability can perform the function safely and that the standard is discriminatory because it does not provide for individualized assessment.

On this side of the continent, Arbitrator Hall, in *Interior Health Authority, supra,* observed the following at paras. 110 - 112:

110 A fundamental premise of the duty to accommodate is that employees will be considered on an individualized basis and within the particular circumstances of their employment. As stated in one of the Employer's cases, *Teamsters Local 879 and Holtz Environmental (Environsystems)* (2016), 264 LAC (4th) 131 (Knopf), ("*Holtz"*):

> *…In all issues involving the application of Human Rights protections to workplace rules and policies, it is imperative that individuals be given individualized consideration. …* Therefore, where drug or alcohol

> addiction issues are at play and the *Human Rights Code* must be respected, any consideration about the reasonableness of Return-to-Work Follow-up Testing must allow for the individualized treatment of each employee. (para. 44; italics added)

> 111 The Union quotes at paragraph 419 of its Closing Argument a passage found in *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal,* 2007 SCC 4:
>
> > The importance of the individualized nature of the accommodation process cannot be minimized. The scope of the duty to accommodate varies according to the characteristics of each enterprise, the specific needs of each employee and the specific circumstances in which the decision is to be made. Throughout the employment relationship, the employer must make an effort to accommodate the employee. … Reasonable accommodation is thus incompatible with the mechanical application of a general standard. (at para. 22)
>
> 112 This careful, individualized approach must be borne in mind when examining any aspect of the Employer's Policy and a "one size fits all" formula will not withstand scrutiny: *Holtz,* at para. 47.

Finally, very recently in *Air Canada Rouge,* [2020] C.L.A.D. No. 74, Arbitrator Stout confirmed that whatever accommodation must be provided to alleviate discrimination must be determined on an individual basis.

Therefore, on the basis of these and other authorities, it is clear Vancouver Drydock was under an obligation to take into account the Grievor's individual circumstances, including the nature of his ongoing treatment, whether he has reached a stable state, his work experience over the last three years, including an apparently similar type of job at Ross Rex, and the nature of his actual job duties at Vancouver Drydock. In the present case, no such individual assessments of 'GC' have taken place since he allegedly stabilized with his methadone treatment and the Employer has not established whether any necessary accommodation of the Grievor would produce undue hardship: *Meiorin, supra; Canada (Attorney General) v. Cruden, supra.*

It is also necessary that the "actual" level of the risk be taken into account. Obviously, different jobs would entail varying levels of risk to the operator, other employees and potentially even the public. Therefore, it follows that an assessment of the real, as opposed to speculative, risk should be undertaken with respect to ascertaining the actual magnitude of the risk in a particular situation: *Bendroht v. BC Transit,* [1992] B.C.C.H.R.D. No. 19; *Thwaites v. Canada (Armed Forces)*, (1993) 19 C.H.R.R. D259.

In that respect, in *Thwaites, supra,* the Canada Human Rights Tribunal stated, at paras. 109 – 117:

> 109 It was once thought that, an employer, relying on safety reasons, as in the present case, could establish a BFOR by merely showing that the employment of such individuals would result in a marginal increase of risk to public safety. (Bhinder, supra; Canadian Pacific v. Canada (Mahon) 1987 CanLII 5394 (FCA), [1988] 1 F.C. 209). It is now clear that the standard that the employer must meet is that the group of persons in question excluded by the employment practice will present a sufficient risk of employee failure (see Etobicoke, supra at p. 210; Central Alberta Dairy, Supra, at p. 513; Robinson v. CAF, supra at p. D/119-D/123.)
>
> …
>
> 112 The significant risk standard recognizes that some risk is tolerable in that human endeavours are not totally risk free. While this standard protects genuine concerns about workplace safety, it does not guarantee the highest degree of safety which would be the elimination of any added risk. What it does, is ensure that the objectives of the CHRA are met by seeking to integrate people with disabilities into the workplace even though such persons may create some heightened risk but within acceptable limits.
>
> …
>
> 114 The dividing line between insufficient and sufficient risk is ultimately judgmental and turns on the circumstances of each case. In particular, a careful assessment would have to be made of the actual health and safety risks posed by such employees and how they compare with other risks that the employer is willing to accept. If such risks were determined to be significantly higher, then it would have to be asked whether there are any reasonable measures that can be put in place to minimize such risks to an acceptable level - a level that makes them comparable with other tolerated risks.
>
> …
>
> **iii) Nature of the Evidence of Risk**
>
> 117 Whenever an employer relies on health and safety considerations to justify its exclusion of the employee, it must show that the risk is based on the most authoritative and up to date medical, scientific and statistical information available and not on hasty assumptions, speculative apprehensions or unfounded generalizations (Heincke et al. v. Emrick Plastics et al. (1992) 55 O.A.C. 33 at 37-38 (Div. Ct.); Etobicoke supra at p. 212; Rodger v. C.N. (1985) 6 CHRR D/2899 at p. D/2907).

In the appeal decision in the *Cruden* decision, the Federal Court stated, at para. 21:

> I agree with the Federal Court Judge that the Supreme Court of Canada was not intending to create a separate procedural right to accommodate. There is simply one question for the purposes of the third step of the test: has the employer "demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer"? Once the

> employer has established this, then it has satisfied the requirements of the third step. Assuming that the first two steps are also satisfied (which they were in this case), it is a bona fide occupational requirement and it is not a discriminatory practice.

Here, there is no evidence that the actual work duties of the Grievor at Vancouver Drydock were ever assessed by anyone. Generally in these types of cases, it is considered appropriate to have an occupational medical specialist inquire into the specific nature of the duties of the individual in the context of his medical limitations before opining on his/her capability to perform that work. Moreover, if such an individual assessment had been made by an independent person and it was determined that the Grievor should not perform the Painter/Sandblaster work because of safety concerns, there could have been a further inquiry about whether there were other positions/duties at Vancouver Drydock in which 'GC' could have been accommodated.

While there were perfunctory discussions between the parties beginning in August of 2018, there was never a serious consideration of the need to assess the specific facts of the Grievor's situation. In that respect, it must be noted that the Employer's suggestion in October, 2018 of referring the Grievor to Dr. Hedges cannot be taken as adequate inquiry as Dr. Hedges was already on record as favouring the "blanket rule"; as a result, it was likely a foregone conclusion that he would never have suggested any accommodation for the Grievor.

Therefore, on the basis of all of the above, it is concluded that the Employer has failed to establish that a *bona fide* occupation requirement existed and it failed to adequately consider its obligations to accommodate the Grievor short of undue hardship.

A very difficult question to answer in this case is the proper remedy to be afforded 'GC' and, more particularly, whether he is to be reinstated immediately to his employment or be required to undergo further assessment.

While I have great respect for the opinion of Dr. Wood that the Grievor can be put back to his position at Vancouver Drydock, there are nevertheless questions in my mind and I conclude a more conservative approach is appropriate.

First, there are the requirements for an Independent Medical Examination. In *Interior Health Authority, supra,* Arbitrator Hall provided the following guidance, at para. 117:

> 117 There is another significant area where the Policy does not allow for individualized assessment, and that concerns the IME itself. This shortcoming applies to both the IMEs arranged by the Employer and those arranged through GWL. In neither case does the Employer ensure that the specialist receives basic

> information such as the employee's job description, a list of tasks associated with the position or other similar documentation. Dr. Els identified the various characteristics of an IME in his Draft Report, and stated:
>
>> iii. It includes a review of background information/clinical and other records/documentation, typically prior to the actual day of the IME. It further includes obtaining a current history taken through interview, a physical examination (in some situations), obtaining collateral information; requesting further testing (under certain circumstances), and compiling of an opinion report, which includes responses to specific questions posed to the evaluating physician. (p. 14 of 54)

Among my concerns in the present case is the recognition that methadone is an impairing substance and the question here is specifically the effect the ongoing methadone maintenance therapy is having on 'GC' specifically.

As well, Dr. Wood's direct exposure to the Grievor was limited to a one hour virtual meeting, which he himself acknowledged and, as a result, there was also no physical examination of the Grievor. Moreover, as indicated above, neither Dr. Wood nor anyone else has ever performed an occupational analysis with respect to the specific duties of the Grievor's job at Vancouver Drydock so that the level of any actual safety risk could be established. The only evidence in that respect is the Grievor's own comparison of his position at Vancouver Drydock with the one at Rex Ross and such self assessments can often have particular reliability issues.

There are also comments expressed in the various medical reports that further assessments may be appropriate. Dr. Fay's report of May 3, 2018 is now 18 months old and, as a result, a more current written assessment would likely be helpful. In any event, Dr. Fay, who is the Grievor's own treating physician, wrote as follows:

> My belief is that these situations should be client centered, and because the idea of long term OST (methadone or suboxone) for recovery is relatively new, they should be assessed on an individual basis. I would suggest that the fair approach would be to have him assessed by a neurologist and/or a physician with expertise in occupational medicine. He would also have ongoing monitoring for relapse as determined by his independent medical assessor.

Therefore, Dr. Fay himself suggested further consultation with a "neurologist and/or a physician with expertise in occupational medicine". In the interest of fairness, however, it is important to acknowledge that Dr. Wood did testify he recently spoke directly with Dr. Fay in the process of preparing his own opinion and Dr. Fay was adamant 'GC' could now return to work. Nonetheless, in these proceedings Dr. Fay was not subject to cross-examination with

respect to that opinion. As well, it is always a concern that an individual's own doctor can be an advocate: *Burnaby (Rossner Grievance),* [2000] B.C.C.A.A.A. No. 95 (Sanderson).

Dr. Wood also noted in his report that Dr. Valentyna Koval in her Neurological Report of September 24, 2018 had stated "a referral to a neuropsychologist for further testing and assessment could be helpful".

Therefore, given the above cautions, I am not prepared to order the Grievor's immediate reinstatement. Rather, it is ordered that 'GC' be referred for an Independent Medical Examination involving a specialist (neuropsychologist/occupational health physician) selected jointly by the parties for a final and binding determination with respect to the compatibility of the Grievor's methadone maintenance therapy and the specific job duties at Vancouver Drydock.

Finally, in these circumstances it is appropriate to make an order that the Grievor be "made whole" commencing from October, 2018. That Order will apply up to the date of his reinstatement if he is cleared to return to his own duties (or an accommodated position) at Vancouver Drydock. If it is found that 'GC' cannot be returned to any position with this Employer, then this make whole remedy will expire as at the date the IME Report is received by the parties.

AWARD:

For all of the above reasons, the Union's grievance is upheld. The Grievor has been found to have been discriminated against and he is to be referred for a further assessment. As well, he is to be made whole from October, 2018 to the date of either his reinstatement or the date of the Independent Medical Examination Report.

It is so Ordered.

I will remain seized to deal with any matters arising from the interpretation or implementation of the terms of this Award.

Dated this 9th day of December, 2020.

"David McPhillips"

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David C. McPhillips
Arbitrator