SERVICE PENSION BOARD MEETING

10 November 82

BGen Karwandy - We have with us this morning General Fassold and Colonel Phillips who apparently are going to enlighten us on homosexuality. So without further adieu.

BGen Fassold - Well my understanding was that we would respond to any problem areas that you might want to address from a medical point of view. Are there any particular questions? What is the issue from your point of view?

BGen Karwandy - Well the issue has been, as I understand it up to this point, whether or not homosexuality is a condition that a person has that is beyond his control, or whether it is a condition that is, so to speak, an acquired taste. It was my understanding that perhaps there was a new study which tended to confirm that homosexuality was in fact an acquired taste as opposed to a condition for which a person has no control.

Col Phillips - It's a good question when looking at any form of social behaviour or conduct. Certainly at some stage or another there is an element of choice. Whether or not we can break this down, in other words an individual chooses a homosexual or deviate pattern, whether or not we, and I'm not aware of any study that would state whether or not this is a sort of an instinctive or a behavioural pattern beyond the individual's control. I would be inclined, in the absence of any information to the contrary, I would be inclined to say yes that a tendency toward homosexual and deviate behaviour is something beyond the individual's control up to a point. As is drawn here, what is control and what is not control, there are degrees of control but there is no doubt that in the modern social climate of acceptance between consenting adults for certain acts ordered by any manner of means, there is now an element of choice by an individual who up to that point in time has been controlling his urges or at least keeping them reasonably discreet. Now in the present social climate of society outside he is electing to follow that pattern because that's what his greatest kicks are derived from. I don't think that the basic urge or drive or tendency toward sexually deviate behaviour is something probably beyond the individual's control. I'm not aware of any studies that have indicated otherwise and therefore I'm prepared to give them the benefit of the doubt from that point of view, but how well he controls this, up to the point of purposely electing that life style, is something that is very dependent on social conduct and acceptance outside and the law.

BGen Karwandy - Perhaps it was my misunderstanding and I was under the impression that perhaps there was a very recent study to indicate that science had discovered something about these particular conditions.

Col Phillips - Not that I'm aware of at this point in time.

BGen Fassold - We had a discussion with NDMC on the subject and the only new platform that I'm aware of is that the American

Psychiatric Association officially does not regard homosexuality as an illness. It is not a medical condition and we have raised some observations on what appears to us to be some implied and inappropriate medical involvements in processing the cases, other than determining whether or not there was a concurrent illness in the first place.

BGen Karwandy - And that is what is referred to in the letter of 2 September, to that situation.

BGen Fassold - It creates a philosophical point and our point is, what is the definition of an homosexual? Our operating procedures seem to be that if there is evidence that an individual has engaged in a homosexual act then he is a homosexual. There is absolutely no scientific basis for that and there are reasons to believe that as with any other forms of behaviour one can experiment or become involved through some circumstantial situation in something that does not necessarily confirm that diagnosis if you will. That's the problem from our standpoint, the medical section, what is a homosexual? It's probably an academic question.

BGen Karwandy - From a medical point, assuming that homosexuality is not involved in medical problems it is academic, but we are stuck with the definition in the present CFAO.

Col Phillips - Which is a bad one.

BGen Karwandy - We have a representative here from the office responsible for that CFAO and perhaps he would like to speak on that issue.

Col Martin - The CFAO was amended in 76 or before that and the medical people agreed with it. I agree with you that generally speaking one act does not make an individual a homosexual but some acts could be so serious in nature that it could be called that.

Col Phillips - This is not the present act, this is the old one.

Col Martin - This is the old one

Col Phillips - This is the old one that I had and what I'm saying is that the present one which removes this sexual propensity, now we at least could make a medical judgement. After all, we're faced with a legal definition, we're faced with a lot of circumstantial evidence presented by the SIU reports usually and we're asked to make a medical judgement. Seldom, and I go back to this time frame of 76 when this was the definition, at least we could turn around and try and make a judgement call from a medical point of view as to whether or not this individual had a propensity . But this word propensity was removed from the definition.

Col Martin - No no, that's the current definition from 76. It hasn't been amended since.

Col Phillips - I'm sorry, I beg your pardon. The problem arises now from the medical point of view of what constitute a propensity. And

this is why we've been sending very conflicting reports back to DPLS, who forward them all to us for a medical imput, in that from a medical point of view we don't see a propensity. We see the performance of single acts and then it becomes a legal and administrative decision as to whether or not this constitutes the individual being a homosexual or deviate in accordance with the status. As I repeatedly send you the number of the ones I've been personally involved with, not so much this time around as I was back in 76, in defining, in refusing to give a medical judgement based on SIU reports, circustantial evidence and so on, which to me is a legal judgement.

BGen Fassold - The trouble with making a medical diagnosis on a homosexual is that all a physician is doing is going on what the, going by either the evidence of the circustances that he was in or the statement of the patient.

BGen Karwandy - And anyone can do that.

BGen Fassold - That's right.

BGen Karwandy - Anyone can do that. It's determining whether an act constitutes a homosexual act and then piling them up to determine whether or not there is a propensity.

BGen Fassold - I have a lot of discretion on the psychiatric aspect of this in the sense that there are no known psychiatric factors or conditions in which homosexual behaviour is a climate. There can be an individual with psychiatric problems who is a homosexual if you like, in other words it's not a recognized symptom of a psychiatric problem. So given that, even from a psychiatric evaluation point of view there is no way to make a diagnosis of homosexuality on the basis of a psychiatric diagnosis. All we go by we do our own assessment of the facts as presented and what the patient says. As you know we've had some awkward situations where the medical officer's conclusion has been contrary to, if you like, the facts, or vice versa. I would personally like to see us get out of that judgement role.

BGen Karwandy- Are there psychological tests or means, in whole or in part, to determine homosexuality?

Col Phillips - There are no signs or symptoms of the condition and even five or ten interviews with a psychiatrist is not necessarily going to have or result in the psychiatrist or psychiatric judgement that this person, notwithstanding what he says, is a homosexual. There is no way of determing that. If he persistently denies it he could have twenty interviews with a psychiatrist.

BGen Karwandy - Well I must confess that I thought that we were going to hear something different this morning.

LCol MacDonald - What about sexual abnormality in view of our problem with Sergeant _____?

Mr. Digby - Yes, whether there is any reason to differentiate the homosexual condition from other forms of sexual deviation or abnormality

Col Phillips - This is the reason why I was given to understand we were really here. My understanding, and I don't see anything different in Admiral Roberts' comment of 75, my understanding is that there is no difference, there is no medical difference. There's a difference in behaviour and possibly even a difference in personality of the individual concerned, but the fundamental reason is that these people, collectively, are the deviants and that frankly homosexuals should be released from the service for good reasons, may they be administrative or whathever. There is no difference between the two and my perception was that they were all to be quietly released under item 5D as being unsuitable, and I was not aware that the pension's board had released some of these people under item 5F.

Mr. Digby - We don't. We look at the circumstances.

Col Phillips - Whatever, that is your judgement and your deliberations and your prerogative. It has nothing to do with medical.

Mr. Digby - The role of the service pension board is simply to look at a case to determine what the actual reason for release is. Whether it was for inefficiency or other reasons, having reached retirement age or for medical reasons, but we do not assign the particular item of release to anybody, that is done by the service authorities, personnel people.

BGen Karwandy - But we have had discussions before the board in respective cases where the sexual deviational behaviour was different. Say the chap who likes female clothing is different than the chap who sleeps with another male and the discussions have been on the problem of whether or not there is something different about these people from the medical point of view.

Col Phillips - Only in their personality. But there should not be any difference in the process of release as far as I'm concerned. They both have, they have different personalities but both of these personalities are unacceptable for whatever reasons. There are no medical, purely medical differences, other than in their personalities. They are both deviates.

BGen Karwandy - Because we have come around to the conclusion that we don't see any reasons to distinguish between a chap who...

BGen Fassold - We support that.

Col Phillips - Right on. I don't see any reasons to distinguish between some guy who is proud of flashing and some guy who does worse things in the homosexual areas. Both of them have unacceptable personality disorders or behavioural patterns. Both of them are unacceptable and the regulations call that they be released.

Mr. Digby - But it depends where they do it and there's a difference as far as we're concerned.

Col Martin - The thing is that you have three levels. You have the one that has the propensity, the one that commits an act that is not criminal in nature or a service offence, and the other one that does commit an act that is criminal and/or service offence.

Mr. Digby - Or involves dependants, young dependants or young soldiers. But we do the same thing with the heterosexual. If he performs in public the way a homosexual might have we put them both the same way but as long as they both do it in private we just don't accept the homosexuals in the Forces.

Col Martin - But what if they have no control?

Mr. Digby - The doctors say they do have control.

Col Phillips - I tend to think they do have control. You see I don't think this is a medical issue. I think that the difference, and where I would see a difference is where somebody who has been reasonably discreet gets unlucky and gets caught and they label him as a homosexual. There is a difference between that individual certainly and I would feel, from a purely personnel judgement, that that guy should be given the benefit, if you want to put it that way, than some character who goes out and commits a criminal act, rapes a child or something, to be perfectly blunt, and goes through due process of the law. He commits a criminal act whereas the first guy was unlucky and he is not even committing a criminal act, except insofar as National Defence Regulations. Isn't still a criminal act in the Canadian Forces between consenting adults? But this is a legal/administrative judgement and not a medical issue, and that is the point that the deputy and myself have been trying to make. It's not a medical issue.

BGen Fassold - We have difficulties in some cases where an individual has gotten out and got drunk and said this is the first time he'd been involved and we through him out - homosexual. In many cases the psychiatrist's opinion is that he was not a homosexual.

Col Phillips - DPLS say the opposite.

Col Martin - In appreciating that there is booze involved, we would not say with reasonable certainty that he is one that 19-20 applies to.

Col Phillips - You've refined you approach in more recent times.

Col Martin - We haven"t refined our approach. We've been consistently right. Now, how important is the item of release to the board? Surely that's a factor in your consideration.

Mr. Digby - No.

Col Martin - Not at all?

Mr. Digby - No, we're there to look at the circumstances of the case which is what the Act requires us to do.

BGen Fassold - There's one aspect that we haven't mentioned which has some bearing on the military. If you realize that sex drive is one of the basic drive, an institutionalize setting can produce a different ball of wax, if you want to look at it that way, because if there is no outlet for the normal, if there is no exceptable outlet for sex drive, t there is very likely will be an unacceptable way.

Particularly if you take, and we have seen it many times with young females, someone who is really not well socialized in the first place. You take a young girl from Newfoundland who has probably never been, or may never have been in a city bigger than about 300 people and stick her immediately in a barracks with numerous other girls, with all the stress of her new lifestyle and so forth, and pressures from lets say outright homosexual females, it's pretty easy for that girl to end up in a compromising situation. And I would regard many of those as certainly not being a homosexual in any way shape or form and we're probably just as much at fault. It's a circumstantial thing.

Col Phillips - To my knowledge though, from when these cases have come to DMTS, and I'm going back to my 75, 76, 77 experience, we have said that in our opinion there is no medical evidence in support of a charge that this person meets the definition as set out in CFAO.

BGen Fassold - Our medical opinion is that the only medical opinion that should be applied to a case is to assure that there is not a concurrent illness. Because being a homosexual does not make you immune to being a psychiatric case or a cardiac case or anything else.

Cmdre Crickard - For the benefit of my own understanding if I may pursue this, in the Navy of course the officer of the day is told that if a man is carried aboard by his buddies, unconscious, the direction is clear that the man is taken to the medical officer, or carried to the medical officer, in a coma or semi-conscious state, and the medical officer does not verify whether he is drunk or not, all the medical officer is asked to verify is whether there is anything else wrong with him. So just for my own understanding of what you're saying, is that analogous of what you just said?

BGen Fassold - With the situation that you have described I think it's analogous but by convention medical officers have often, as part of the military network, physicians are often required to express a professional opinion or are questioned professionally. Now you have tests, blood alcohol test, finger to nose test, and you have legal standard.

BGen Karwandy - The medical officer in that case could give two opinions. One as a medical doctor that there is nothing wrong with the chap except that he was drunk, and as a layman he is of the opinion that he is drunk.

BGen Fassold - That's right.

BGen Karwandy - He is in a dual position.

Cmdre Crickard - It was just to clarify my own understanding of what you were saying. But going back to what you were saying, do you think that the procedures should be changed then in terms of referral of this type of individuals?

BGen Fassold - I think the initial involvement is appropriate in as much as an unusual case of anything. The way it reads is that if there is any reason to be concerned about a medical illness, and that's the way it is now, in the initial stages, then it should be evaluated. However it comes to what there is or there isn't.

Col Martin - Then it's not the CFAO that should be changed, it's our internal procedures.

BGen Fassold - No I think there are some modifications required from the CFAO.

Col Gardam - May I speak on the CFAO?

BGen Karwandy - Yes but I was wondering, because I certainly want to give everyone the opportunity to ask any questions, is there anything else from around the table?

Mr. Digby - We've addressed homosexuality but surely sexual deviation is another thing and that is the place where a psychiatrist can assist etc..

BGen Fassold - But it's still a behaviour problem. There are very rigid diagnosis of this personality or disorder.

Col Phillips - If he goes to a psychiatrist to establish whether or not he has an illness to account for his abnormal behaviour, the psychiatrist will come up with one of three things. The guy has a flagrant psychosis and he is psychotic which would account for his behaviour and we would release that guy as a psychotic under item 3A - a straight medical. The second entity would be those who have personality disorders but the regulations, and we agree with the regulations, state that personality disorders are not released under item 3B - the other medical administrative form of release. Personality disorders of whatever degree, from the very severe to the average personality disorder, if they conflict with the regulations, are recommended for release under item 5D as being unsuitable. That is from the severe personality disorder down. And, of course, then there is the third individual who has none of that. He has no psychosis, no apparent personality disorders, and he goes through due process like anyone else.

Mr. Digby - I think what you said is fine pre 1972 when we didn't have 5F. But 5F releases were brought in deliberately to separate the 5Ds into those where the individual has control and those who don't. Now, from what you're telling me, individuals may have tendencies but they have control over it. Maybe their item should be 5F.

Col Phillips - The same as heterosexuals yes.

Mr. Digby - It really depends on the circumstances whether it should go 5D or 5F. It's not of our concern at the service pension board but it is of concern to the Department.

Col Phillips - Well I think it is but it is an administrative legal decision. It is not a medical one.

Mr. Digby - I agree because that's why 5F was brought in and it was brought in to separate those that had control and those who didn't for the purpose of severance pay. Treasury Board weren't prepared to deal with all 5D releases as being severance pay cases so they said OK if you'll separate them out we'll deal with it. That's why it was brought in. For those that have control and those that don't.

Col Phillips - What's your feeling about the control? My feeling, as per a statement earlier on, is that the tendency is certainly, or could be beyond the individual's control. I'm not aware of any recent studies that have established otherwise.

BGen Fassold - I don't know. Personally I find that one hard to come to grips with, probably because there are degrees within this whole issue. On one hand one feels like since it is such a complex issue the benefit of the doubt should be given to the member. The conclusion being that in most cases there is no control. But I find that hard to scientifically or behaviouraly accept as much as some of the propensities. Surely if the rest of the personality had any disciplinary capability at least the individual wouldn't get into trouble whether he goes out and does whatever he wants to do on his own.

Col Phillips - Frankly I don't know. When I'm talking about control I'm not talking about control of his conduct, I'm talking about control of his propensity.

BGen Fassold - I would say he does not have control of his propensity.

Col Phillips - Right on. That's what I'm saying. But control of his conduct yes, as per a heterosexual.

Mr. Digby - Which is what Admiral Roberts says and what the board has been using.

BGen Fassold - My personal concern over the past few months was becoming involved in some of these cases because really I think there is some misunderstanding in the CFAO as to what the medical side can and cannot do. I think all we're doing is confusing the issue. We both know we have situations where the medical process has produced what is probably a useless statement which just confuses the issue. When the physician says this guy is not a homosexual, it doesn't matter whether the guy is a homosexual or not. If he's been caught in five or six homosexual acts, a situation which is not acceptable, he is a homosexual as far as DND is concerned.

Cmdre Crickard - You both agree that he probably doesn't have any control over propensity, may it be as homosexuality or any other form of abnormal behaviour. But the propensity is not evident unless an act is committed. I mean if he's thinking homosexual thoughts but never commits an act you don't know whether the propensity exists or not. You yourself have said there is no tell tale symptoms that a psychiatrist could unleash or undercover which would say this is a walking time bomb homosexual waiting for an act

to occur. You just said earlier that there is no psychiatric tell tales like that. You said he has no control over propensity but he has control over his act or his conduct, and we can not verify propensity until he commits an act. Therefore you shouldn't care at all and therefore you should be cut out of the system.

Col Phillips - Right on.

Cmdre Crickard - This is what you're getting at.

BGen Fassold - Except for ruling out other medical conditions. The medical system is far from perfect and you can't say that whatever has caused an individual, given a specific circumstance, to suddenly get into trouble. It might be due to an illness and not the homosexuality itself.

Cmdre Crickard - What do we do in the case of self evidence? The chap who wants to get out early and says I'm a homosexual.

Col Phillips - That's the only time when you find the physician say this man meets, or the medical evidence supports the contention that he meets the act.

Cmdre Crickard - You said earlier that you couldn't do this medically.

Col Phillips - Except where the guy comes in and admits to it.

Cmdre Crickard - But that's surely not medical. That's just an investigative procedure.

Col Martin - The first thing we do is look for obligatory service, examine that, and secondly is he under this three year mandatory service contract. They're very few and far between. I don't know of any case when someone's walked in and said I want psychiatric treatments because I'm a homosexual. I don't think I've ever seen that happen.

BGen Karwandy - Well that in itself raises an interesting point. Can a psychiatrist be of use to a pure and simple homosexual? I mean from a medical point of view.

Col Phillips - If other conduct and behaviour leads to the suspicion that this person may be psychotic.

BGen Fassold - This has nothing to do with the homosexual.

BGen Karwandy - You treat the psychotic condition but you can't treat the homosexual condition.

BGen Fassold - I think there's a tendency in the homosexual aspect, as it exists in society now, where we probably have a rather anachronistic approach to it. If you think about what we've been

discussing here, what we're talking about is behaviour unacceptable in the military environment. What has led to that unacceptable behaviour is probably just another factor the same as what happens if somebody throws a stone through the window at Hudson's Bay or uses foul language on the street or something. It's just a matter of degree. I think we're getting a little bit too qualitative.

BGen Karwandy - It has to do with social mores too. It's really a mix. Divorce those factors from the medical problem then it makes certain things easy. If someone happens to ask a doctor if in his opinion a person is or is not a homosexual he's getting an opinion as a layman not as a professional doctor.

BGen Fassold - That's true. As a layman with perhaps a higher level of experience in his personal evaluation. It's not a scientific determination.

BGen Karwandy - No but he bases that conclusion on the fact as he has determine them from the file.

Col Phillips - It seems that in the human rights legislation sexual orientation is or does become a gripe for discrimination. I perceive a great deal of difficulty in substantiating good reasons for not retaining homosexuals. There are no medical reasons. They are all administrative and perhaps legal though I doubt that there are any legal.

BGen Karwandy - Or environmental. We're faced with giving those reasons from time to time now to the human rights commission particularly when they propose amending the human rights act to include sexual orientation. We invariably produce the same reasons - the propensity, the blackmail, the communal living, isolated locations etc. Again those are essentially environmental service policies. It has nothing to do with medical.

Col Phillips - Exactly. That's the point the Deputy and I are trying to make. That in that climate there is really no medical, purely medical imput that we can put in this judgement call.

BGen Karwandy - That's not to say that a medical officer could not be called before a Tribunal to give his personal evidence respecting say the case you heard about the young Newfoundland girl, if he has actually some concrete knowledge of that sort of situation developing and leading up to this point.

BGen Fassold - There's probably many of those situations. I think they're probably far more common than some of us are aware because I think they're probably dealt with appropriately at the very beginning. I certainly have to confess that I've had two or three that I've put up a defence for.

BGen Karwandy - Undoubtedly some cases are hushed up too.

Cmdre Crickard - This happens all the time, no one would disagree, but what I'm saying is that one homosexual act does not make a homosexual. I mean in boys' schools this happens all the time. In the good old days of the Navy, the rum buggery, because they were all out there months on end with no one else around. But this does not make a homosexual.

Col Martin - We have a grievance before Cabinet where our policy in 19-20 could be commented upon. Although the grievance alleges that we didn't have evidence to support with reasonable certainty that that person was a homosexual as outlined in 19-20, we had to explain our policy in 19-20. I can see some comments by Cabinet in respect to our policy. It's been up there for six months.

BGen Karwandy - We've had to explain our policy on a number of occasions to the human rights commission.

Col Martin - This is a bit higher.

BGen Karwandy - Yes, but he's the one responsible for changing the act and he's trying damndest to get sexual orientation into the act.

Col Martin - If Cabinet come down and said we don't agree with your policy, that's stronger than human rights.

BGen Karwandy - The Minister had a few things to say too a few months ago.

Col Gardam - If I may address the board sir. First thing that I might mention is that this is DPLS' CFAO and Col Martin and I were of one mind to start amending 19-20 last summer. But as a result of the discussion between the Minister and the CDS on the question from Robinson and all of the untoward interest in the Canadian Forces policy regarding the retention or non-retention of homosexual, it was decided that this was a most inopportune moment to start revising the CFAO. What I'd like to raise however is not so much the way the CFAO is written but what has happened through practice brought about by the operating procedures manual within CPCSA. That tells us, the career managers, how we are to carry out our duties. If you look at the CFAO, in para 3, the third line, talking of the CO, it says, "he should make use of a medical officer (MO) and if necessary" etc... By practice, brought about through the OPM, that "should" has been changed by practice to "will". Now in para 4, sub b., it says again about the CO, "when the MO so recommends, refer the subject for psychiatric examination", and again it has become by practice the CO will refer for psychiatric examination. So in fact this is where the OPM, as an extension of the CFAO, has got us into the situation where in the practice of carrying out the administrative search on a case where we go to first of all the medical and ask, does CFAO 19-20 apply in this case and is there any medical reason that would have cause this act to happen. When we get you decision from DMTS we go to the legal people who go through SIU reports and they also are asked , is it appropriate that it should be covered under CFAO 19-20. Now,

where the lawyers say it is a case, and the doctors say they cannot say with reasonable certainty that it is a case, it then falls on my shoulders to call a decision on whether or not I consider taking in the CO's investigation, the man"s performance through his PER file, and every other piece of information I have to where I call a decision on whether he is release or stays. And that is how it is working now. I fully agree with the problem the medical profession has in dealing with the case, and I would suggest, which I'll talk to Cmdre Crickard about later, whether or not we need to go through the OPM, which is our own book, and have a look at it and not touch the CFAO at this time.

Col Phillips - I would like to discuss the very issue that you pointed out here where the "should" has been converted to "shall" and point out that we have recently had a couple of instances where a medical officer, quite rightly so, and he certainly has my support, has refused to investigate a case. And this was on the request of a CO on one of the bases where the body was dumped on this guy's doorstep and he said you will investigate in accordance with this act. This was an investigation and not a medical opinion that was requested. That's not a medical function at all - not in my book. So it has been abused even further than just converting from "should" to "may". It is now where the medical staff, and we have had another recent case where the medical staff, at a semi-isolated unit, was a nurse and in accordance with this para 3 the nurse was required by her CO to investigate whether or not this was a case of homosexuality.

BGen Karwandy - Was the subject of the investigation a woman in the case of the nurse?

Col Phillips - No, and this is where again it is being abused. A nursing officer doesn't have to be present in the case of a female as long as there is a chaperon present so the female's interests are protected.

Col Martin - Para 3 doesn't say that the medical officer "shall" investigate.

Cdmre Crickard - No it's just something that has gotten that way.

BGen Karwandy - You'll find that those problems arise from time to time no matter how careful your instructions are worded.

BGen Fassold - What we're really saying is that the medical law in the early stages should be similar to what it is in any number of things. It's not really with respect to homosexuality it's with respect to the health and well being of the individual - period.

Col Gardam - If you look at it in another way, when we come through and ask, is there any medical reason why this condition exists, we do the same thing for obesity, we do the same thing for personality disorder, and we do the same thing for alcohol. And of course we all know why we're doing it. Because through human rights and redresses of grievances, we have found out through the years that much of our investigation, or the way we have handled a case hasn't been done properly and we're trying to cover our backside

with asbestos.

BGen Fassold - There are some medical conditions in findings which generally would only be found in homosexuals.

BGen Karwandy - Like venereal diseases.

BGen Fassold - Yes but that would still just be a medical finding.

BGen Karwandy - You would treat that particular bug that the guy has.

BGen Fassold - Well if that should apply that would be one of the findings from the medical examination. How you want to use that finding, with medical assistance in its interpretation, you know if the question was asked of the medical branch, "what is the likelihood of this disease having been acquired other than in some homosexual practice?", some likelihood would be given. But even that is really a bit of an academic issue since your concern is really with the member's behaviour.

BGen Karwandy - There are a number of things that come to mind. The doctor might indicate in his report, might indicate to the layman that this person is a homosexual because of particular conditions that a doctor may find.

BGen Fassold - The doctor makes a diagnosis and then the data being collected on that disease either supports or does not support the type of population in which the disease is found.

Col Phillips - He still has to provide that information and make a judgement on it.

BGen Fassold - Yes but you state the facts. You don't say Joe Blow is a homosexual because 99% of these cases are found only in homosexuals. Joe Blow may happen to be the 1% who isn't.

BGen Karwandy - I was thinking of the guy who's diagnosed for gonorrhoea and he's been only with males for the last six months.

Mr. Digby - The other point, from a psychiastrist, I think he's useful and helpful in this because of his skills in intervieweing and drawing the individual out. Then he is not making a medical opinion he's giving a service officer's opinion.

BGen Fassold - The other common factor of a psychiatrist is that they are extremely conservative in any statement they put in writing. And when they're not conservative they're usually wrong. "This patient is definitely not suicidal", and the guy walks out the door and jumps off the building.

Col Martin - That's why they're conservative.

Col Phillips - I think one of the things though, and please don't misunderstand our approach, at least certainly not mine, from a DMTS point of view, we're not withdrawing or saying that it really has nothing to do with us. We're still there to provide a service to the managers in the form of DGPCOR and his staff and to anybody who wants a medical opinion. But that must be based on the clear understanding that the medical opinion will confine itself strictly to medical evidence and may be incorporated with the circumstantial evidence. I have instructed my staff that basically they will confine themselves to medical opinions and let the legal people here, DPLS, make the judgement call on whether or not that circumstantial evidence would stand up in court. So the replies are very often strictly medical evidence. We are not withdrawing that service if you wish to avail yourselves of it. There are three things that I feel should be included in that. If the individual wishes it, you can't deny him referral to a physician. I agree with para 4 that it should be left up to the judgement of the physician whether or not the individual is then referred on to a psychiatrist. This will ensure that no purely psychotic gets unjustly treated, people who should be classified as psychotics and go out under item 3A. The second area where they're prepared to continue to offer service is in those cases where the CO is uncertain as to whether or not there is a medical condition causing this. Then he can refer the patient to a physician for a medical opinion as the whether or not his behaviour and so on and so forth. But you confine yourselves to a medical opinion. As a third issue, if there is any doubt, from your point of view, we're quite prepared to offer you a medical opinion on any or all of these cases. We're still prepared to provide this service if you wish. Is that right?

BGen Fassold - We certainly will provide a medical evaluation of the case.

Cmdre Crickard - Are we sending you to many cases?

BGen Fassold - No. What is happening is, as Col Phillips has described and as the order seems to imply, our role as I see it is that we evaluate the case. Are they sick? Sick period. We don't want to evaluate the case for an explanation as to whether or not he is homosexual. There may very well be some explanation with respect to why his behaviour was unacceptable. There is no medical condition, according to the psychiatrists, in which homosexuality is a feature. There could be a medical condition, as I stated earlier, that would , lets say a brain tumor, you could have a brain tumor which could cause a disorder in behaviour. What I'm trying to draw to is that a medical evaluation of the patient, with respect to health, we give. But not a medical opinion on homosexuality because every investigating medical officer is not much more than perhaps a little more proficient investigator.

Cmdre Crickard - Well internally I agree with John that the trouble is with the OPM. Perhaps we're asking the wrong questions. But the CFAO is external and if the COs are now demanding investigations and so on, even though the CFAO doesn't go that far, I'm not quite sure how we can correct that.

BC [illegible]wandy - There are a lot of COs who feel this is a medical conditon.

Col Phillips - Yes and that gives them the out. As far as I can see the definition and application of this thing is a DPLS administrative responsibility. As far as the medical imput is concerned I proposed some amendments to this which are on the original file that I sent you last year. Of course you had an attempt at re-writing it as well. And its to put the physician back in the right perspective. As far as I can see.

Cmdre Crickard - We could do that by a letter from NDHQ signed at the appropriate level.

Col Martin - But when we start looking at the definition, that's ...

BGen Fassold - The definition doesn't concern us as long as the medical requirement is appropriate. It doesn't matter medically if you want to define 14 different categories of sexual abnormalities if all we're doing is giving a medical evaluation.

BGen Karwandy - Propensity is a bit of a problem. When you see the word propensity, because if I remember correctly you said that probably a person would not have control over his propensity.

BGen Fassold - Full control.

BGen Karwandy - Full control. But he certainly would have control of his overt acts that would manifest homosexual tendencies. So this thing takes you all the way back to the CFAO, to a condition over which a person may not have full control. You're concerned about the guy that manifests the propensity. There are people in this room that have propensities that could cause them to land in jail but they never allow those things to manifest themselves. Maybe that's the problem. We have a CFAO that says you're a homosexual if you have propensities. How the hell do you find out those propensities unless the guy manifests them.

Col Phillips - I think the intent of that word propensity is the 51%. If he's 49% homosexual and 51% heterosexual then he's not a homosexual in accordance with the act.

BGen Fassold - Shouldn't we just be dealing with the commission of the act.

BGen Karwandy - Who's committed an act yes. Homosexual acts. But then you argue is one act enough or does it take three.

Col Phillips - This is not a medical issue though. Whether one or three constitute infringement of the act is not a medical issue.

BGen Karwandy - But how do you know they havea propensity?

Mr. Digby - If you don't ask.

Col Phillips - Well this is a question that has been asked and very often, not very often but on occasions has been answered very bluntly. I can recall one fairly recently at my school where I asked the girl very bluntly, "Is this your inclination, is this your propensity", and she had been both homosexual and heterosexual and she said "you're damned right and I'm not going to change". I said she meets the act - recommended 5D. Now this was as a CO not as a medical officer.

BGen Fassold - Why is homosexuality of concern if it does not present a behaviour problem. How do you defend that.

Mr. Digby - Well that's gone out the window now since it came out of the closet.

Cmdre Crickard - Because of that attitude. Even though she doesn't commit an act, with that attitude if she's going to admit it to her CO she's going to admit it to her buddies. That can cause a lot of dissension amongst the ranks and its very bad for unit cohesiveness and that's intolerable.

BGen Fassold - But how would the Department defend the position of homosexuality based on the case of a girl who says I like girls and then is released and then complains because she was released?

Cmdre Crickard - It depends how frequently the statement is made and what other involvement she's in. You know if it is a statement this person makes all the time and has led to disputes in the junior ranks' mess, fracasses and so on, general turmoil, then that's a good reason for releasing her as a 5F.

Col Martin - That's only in the military. You have a public servant that's a homosexual, there was a case recently that confirmed that, he told his wife, told his friends, dressed like a girl, bondage etc... he still has a Top Secret clearance. He was just moved from one department to another. At the same time we have another case involving a serviceman. He was down graded to nil and he was released because he couldn't get a security clearance. The reason that the service used was because of his employment, particular type of employment, military attachés, support staff, close living quarters etc...

BGen Karwandy - There is also the problem of blackmail and they counter that with the argument that those people who come out of the closet are no longer subject to blackmail. But they forget that their partners are subject to blackmail as well. There are actually cases where the persons themselves have come and said I'm a homosexual but his friends, his sexual friends, are still in the closet and that's where the enemy agents work. So the blackmail threat is still a very real one from the point of view of security.

Col Phillips - We also had a case where an hospital Chief Warrant Officer was dishing out candies to the young male MedAs that came up from the school and it was an awful situation. The nursing staff and physicians in the hospital administrative office couldn't press charges against any of these kids because they were immediately protected by this CWO. There's the blackmail mess that is unacceptable in a hierarchy system like the military.

BGen Karwandy - That's another form of blackmail. I was thinking more of the susceptability of advance from enemy agents. But certainly within their own shop like that that is a problem.

Col Martin - In other departments dealing with civilians, and a year ago I had reasons to look into that, if he needs a security clearance in one department and he can't get it they'll transfer him to another department where they don't need it. They very rarely release because of that.

BGen Karwandy - I think most government departments don't have the requirement that everyone be security cleared like the Canadian Forces. You'll find that in most department very few people have security clearance or if they do they are very low.

Mr. Digby - I've been told that very few have top secret or secret clearances. Most have confidential.

BGen Karwandy - It's still much higher than you would find in say Energy Mine and Resources.

Cmdre Crickard - Certainly they were too high at one time on ships and we downgraded them all to confidential.

BGen Karwandy - Is there anything else that anyone would like to say concerning this matter. If no one else has anything I thank you very much.