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BARRIERS AFFECTING MODERNIZATION OF THE CAF NURSING OFFICER OCCUPATION

Lieutenant-Colonel Jo Schmid

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BARRIERS AFFECTING MODERNIZATION OF THE CAF NURSING OFFICER OCCUPATION

> *There are numerous issues that might be traced to the traditional divisions…in nursing education, regulation, scope of practice, and organizations. [Institutions must consider] …how the best-educated generation of nurses in history is locked in roles and functions defined decades ago that underuse the intellectual capital of the entire nursing workforce. To be effective in 21st century health care,… a more intra-professional approach that overcomes the restrictions of our traditional hierarchy will ensure better care for patients and a better functioning health care system overall*[1].
>
> - Joan Almost, *Regulated Nursing in Canada: The Landscape in 2021*

HISTORY OF CANADIAN ARMED FORCES (CAF) NURSING

Commencing in the early 20th century, the battlefield was recognized as a domain reserved exclusively for men. However, with the onslaught of casualties in the Boer War (1899) followed by World War I (WWI), Canadian women quickly found an indispensable role as military nurses in proximity to the line of fire[2]. Concurrent to this time, the nursing profession in Canada was becoming more organized, established, and educated, leading to the professionalization of the nurse role as well as the creation of the Canadian Army Nursing Service in 1901[3]. By 1908, over 2,000 military nurses were deployed overseas, risking their lives caring for over 540,000 soldiers[4], and earning a stamp of legitimacy as acclaimed war heroines. Through their training, resourcefulness, and ingenuity, these military nurses carved themselves a significant and respected place in a typically male bastion. This represented an important time in the evolution of the nursing profession in Canada and demonstrated that their specific skillset was an essential contribution and keystone role within the armed forces medical service[5].

CURRENT SITUATION

The importance of military nursing to the Canadian Forces Health Services (CFHS) since this time has been variable and seen with mixed support over the decades. Modern day warfare, humanitarian crises, international and domestic operations, and the ongoing global pandemic have clearly demonstrated the significant and critical roles that Nursing Officers (Nur O) hold in the CAF. Nevertheless, little advancement has been made towards broadening capacity or modernizing the CAF nursing construct, which can be deemed archaic when compared to the

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[1] Joan Almost, "Regulated nursing in Canada: The landscape in 2021," *Canadian Nurses Association*, February 2021: 89.
[2] Geneviève Allard, "Caregiving on the Front: The Experience of Canadian Military Nurses During World War I," in *On All Frontiers: Four Centuries of Canadian Nursing*, ed. Christina Bates, Dianne Dodd and Nicole Rousseau, (Ottawa: University of Ottawa Press, 2005), 153-167.
[3] *Ibid.*
[4] *Ibid.*
[5] *Ibid.*

pace at which the civilian health sector and allied militaries have reformed and adapted to meet present day population health needs.

This essay will demonstrate the multiple and compounding factors that impact the role, employment, and advancement of Nur O in the CAF[6]. Predominant issues will be assessed against the construct of the Walt and Gilson model of policy analysis[7], to highlight the most prominent deficiencies. It will further argue that from the inception of the Nursing Officer Occupation (NUR) role in the CAF, the profession has not advanced in an analogous manner as compared to other CFHS Officer occupations, in comparison to the employment of nurses in Canada, nor to other coalition nations' military nursing corps.

Overview of Current CAF NUR Roles

In the "official" capacity, the primary roles of NUR are to provide primary care to ill and injured CAF members within CFHS Centres in Canada, and/or tertiary patient care and in acute care hospitals while on operations abroad. Nur O work within multi-disciplinary teams across numerous domains; they provide direct patient care, occupational, preventive, and environmental health care services through clinical practice as well as through health education, administration, training and education, and policy development[8]. However, the individual employment of Nur O is controlled at the discretion of unit Commanding Officers[9], and is often subject to being misemployed within highly administrative and non-clinical roles such as unit Adjutant, Operations Officer, and Staff Officer[10]. National Defence reviews conducted by the Auditor General have concluded that too many clinicians in CFHS are performing strictly administrative functions[11].

In an attempt to direct NUR employment in clinical roles (recognizing that Nur O require to maintain clinically currency for CAF operations) and re-direct Nur O employment away from administrative roles (the domain of the Health Care Administrator (HCA) occupation), a foundational concept "The Future of Nursing" was approved in 2012. Through this Master Implementation Plan, 63 NUR positions from CFHS units were reallocated to newly formed High Readiness Detachments (HRD); enabling Nur O to cycle between the Maintenance of Clinical Readiness Program (MCRP) (maintaining clinical currency within their specialized area

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[6] This essay is predominantly focused on the Regular Force (Reg F).

[7] Walt, Gill, and Lucy Gilson, "Reforming the health sector in developing countries: the central role of policy analysis," *Health Policy and Planning* 9, no. 4 (1994): 354. This framework uses a simple analytical approach which incorporates the concepts of content, context, and process to address the actors (both the individuals (i.e.: Nur O) and the organization (i.e.: CFHS, CAF)), to better understand the process of health policy reform, and to plan for more effective implementation.

[8] Government of Canada, "Nursing Officer," last accessed 18 August 2021, https://forces.ca/en/career/nursing-officer/.

[9] Commanding Officers in CFHS are typically positions held by Health Service Operations (HSO) officers.

[10] Canadian Forces Health Services, *Canadian Forces Nursing 2020: A Concept Paper*, Canadian Forces Base Ottawa: October 2003: A-15/50.

[11] Canada, *Report of the Auditor General of Canada to the House of Commons. Chapter 4:Military Health Care - National Defence,* Ottawa: Office of the Auditor General, 2007, 5.

of practice[12]), and with the operational/ deployment/ tasking cycle[13]. While this validated HRD concept proved to address some issues within NUR in the operational context[14], it was not intended as a "cure-all" for the many complex issues plaguing CAF nursing practice as a whole.

Educational Background, Challenges, and Constraints

As an entry standard to CAF nursing, all Nur O must have obtained a Bachelor's degree in nursing and be credentialed as a Registered Nurse (RN) in Canada[15]. CAF Nur O focus on one or more domains during their career including primary care, medical-surgical, mental health, perioperative, critical care, and/or aeromedical evacuation nursing. Nursing Officer Specialist (NUR SPEC)[16] training is targeted within the Development Period (DP) 1-2, at the ranks of Lieutenant[17] (Lt) to Captain (Capt)[18]. Depending on the specialty, Individual Training & Education (IT&E) varies in length, with the majority requiring approximately 15 months to complete[19]. A significant flaw in the system exists however, in that these positions are not linked with the Basic Training List (BTL) nor Advanced Training List (ATL) credits. As a result, Nur O undergoing NUR SPEC training continue to occupy unit and operational positions, resulting in approximately 17% of the NUR workforce continuously locked into IT&E requirements instead of filling their duties[20]. This in itself is a crippling burden on the CAF's operational capability, on units who must manage this continuous decreased staffing level, and on colleagues who are often required to compensate by means of increased operational tempo and workload.

Medical educational and CAF foundational training[21] opportunities beyond specialty training are virtually non-existent for NUR[22]. Beyond the Basic Nursing Officer Course (BNOC)[23], there are no additional training or educational courses targeted specifically at nursing in the CAF. This also applies to the NUR senior ranks (Major (Maj) to Lieutenant-Colonel

[12]Nur O maintain their clinical currency in civilian hospitals (through placements in the ER, ICU, Ward, OR, etc.), as the CAF no longer has military hospitals within Canada.
[13] Canadian Forces Health Services, *Master Implementation Plan for the Reallocation of Nursing Positions Concept within Canadian Forces Health Services (CFHS)*, Canadian Forces Base Ottawa: file 3000-1, 9 July 2012.
[14] Daniel G. Hansen, *Program Evaluation Report- High Readiness Detachment Concept*, Canadian Forces Base Ottawa: file 3000-1 (Validation O), 27 October 2017.
[15] National Defence, Canadian Forces Manual of Military Employment Structure, Officer Job Based Specifications for the Nursing, Volume 2 Part 1 (2009).
[16] Critical Care, Perioperative, and Mental Health are designated as NUR SPEC.
[17] All ranks are referred to using army/air force rank structure; however, content/context also apply to navy personnel.
[18] Government of Canada, "Professional development for Officers," last accessed 17 August 2021, https://www.canada.ca/en/department-national-defence/services/benefits-military/education-training/professional-development/framework/officers.html.
[19] These 15 months includes a phase of clinical skills consolidation.
[20] As per CF H Svcs Gp Personnel Production-FMOST, on 9 July 2021, 37 Nur O were on specialty training. The TES on this same date was 222 pers, resulting in a calculation of 17% of positions left unfilled as a result of career training.
[21] CAF foundational training including those within the CAF officer general specification (OGS).
[22] James C. Taylor, "CFHS Heal Thyself: Developing Strategic Health Services Leaders for the Modern Milieu." In *The Operational Art: Canadian Perspectives- Health Service Support*, edited by Allan English and James C. Taylor, 161-186. Kingston: Canadian Defence Academy Press, 2006: 174. All CFHS senior officer occupations should complete the HSO training in order to grasp the "core business knowledge" of the organization, and to develop a requisite competency and credibility for CFHS leaders.
[23] BNOC is completed as part of the basic requirement to reach the occupational functional point at the rank of Lt.

(LCol)), as pertinent courses for both CFHS and/or CAF leadership are offered almost exclusively to Medical Officers (MED), Dental Officers (DENT), and Health Services Operations Officers (HSO)[24]. Subsidized post-graduate training opportunities (external/civilian academic) are severely constrained for NUR and limited to one ATL credit per year (for a two-year long post-graduate degree), and targeted for the rank of Maj (DP3)[25]. As such, 0.2% out the NUR Preferred Manning List (PML) have the opportunity to complete a Masters' level degree per year[26]. Aside from the newly commissioned Physician Assistant[27] (PA) MOSID, this is by far the lowest ratio within CFHS. The remainder of the ATL credits allocated for NUR annually are for Second Language Training (SLT)[28]. Due to the extremely slow rate of rank progression within NUR (which results in highly competitive selection), it is near imperative that Nur O hold a SLT profile of B/B/B in order to progress beyond the rank of Capt[29]. Table 1 demonstrates the ATL disparity comparing NUR against all other CFHS officer occupations.

[24] These positions/ATL credits are predominantly linked to the HSO occupation, however CFHS has the ability to manage the positions at their own discretion. Refer to CFHS selection board records of decision for historical results of course offerings distribution amongst MOSIDs.

[25] Government of Canada, "Professional development for Officers," last accessed 17 August 2021, https://www.canada.ca/en/department-national-defence/services/benefits-military/education-training/professional-development/framework/officers.html.

[26] Calculated out of the total PML of 260 personnel, there is 1 position allocated per year for PGT. However, 1 PGT program takes 2 years for completion, thereby the same member occupies the ATL credit for 2 consecutive years. Therefore, the "opportunity" for PGT is expressed as 0.5 positions per year (1 new person, every 2 years), and is factored against the entire size of the PML= 0.2%.

[27] Canadian PA, "Life as a Canadian Military Physician Assistant", last accessed 22 August 2021, https://canadianpa.ca/militarypa/. Physician Assistants are a newly formed officer MOSID, converted from Non-Commissioned MOSID in 2017. While this is not a new profession in the CAF, it is new to the domain of the officer occupation, and is not yet fully established. As such, at this time it serves as a poor historic comparison with regards to rank, positions, opportunities, etc.

[28] NUR are allocated three SLT credits/year for the rank of Capt, and one/year for the rank of Maj.

[29] Refer to NUR 00195 Merit board scoring criteria (SCRIT) and board results. Due to very few promotion opportunities in the occupation, NUR merit boards are an extremely competitive process. As such, it is typically required that for promotion to Maj, a Nur O must not only have had numerous Mastered/ Outstanding/ Immediate (MOI) Personnel Evaluation Reports (PERs), but also a SLT profile of B/B/B to maximize points on the SCRIT in order to be competitive enough to merit.

Table 1 - CFHS Officer Occupations- Size (PML) compared to number of ATL credits *(as expressed in percentage, in order from largest to smallest distribution)*

CFHS Officer Occupation	PML	ATL positions/ year (including SLT)	% Ratio
Bioscience	42	4	9.5%
Dental	142	13	9.2%
Medical Specialist	72	6	8.3%
Medical	226	14	6.2%
Pharmacy	52	3	5.8%
Physiotherapy	39	2	5.1%
Health Services Operations	86	3	3.5%
Health Care Administrator	158	4	2.5%
Social Work	42	1	2.4%
Nursing	260	5	1.9%
Physician Assistant[30]	118	1	0.8%

Source: National Defence, Director General Military Personnel Research and Analysis: Establishment and Strength Report- CFHS, FY20-21.

The absence of formalized educational opportunities is a significant dissatisfier within NUR[31], compelling many highly motivated Nur O to complete post-graduate and certificate level certifications on their own time, often at their own expense[32], and at times driving Nur O to release from the CAF to complete the clinical phase requirement of their program[33].

In order to justify additional funding and positions required for ATL credits beyond the individual desire to learn within this occupation, a thorough analysis is required. Current and potential NUR positions within CFHS must be mapped out, and a cross-analysis with comparable job-based specifications and requirements in the civilian sector and in allied militaries must occur. Exploration of core Advanced Practice Nursing (APN)[34] roles to include

[30] Canadian PA, "Life as a Canadian Military Physician Assistant", last accessed 22 August 2021, https://canadianpa.ca/militarypa/. Physician Assistants are a newly formed officer MOSID, converted from a Non-Commissioned MOSID in 2017.

[31] Canadian Forces Health Services, *Canadian Forces Nursing 2020: A Concept Paper*, Canadian Forces Base Ottawa: October 2003: A-11/50. Additionally, as recounted through current serving Nur O and numerous exit interviews of Nur O releasing from the CAF.

[32] Limited programs are approved as per Individualized Learning Plans (ILP) policy, and compounded upon cancellation of ILP funding in 2019.

[33] Such as in the case of Nurse Practitioner.

[34] Alba DiCenso, *et al*, "Advanced Practice Nursing in Canada: Overview of a Decision Support Synthesis," *Nursing Leadership*, 23 (December 2010): https://www.longwoods.com/content/22267/nursing-leadership/advanced-practice-nursing-in-canada-overview-of-a-decision-support-synthesis. APNs have an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of patients and special populations. It involves analyzing and synthesizing knowledge; understanding, interpreting and applying nursing theory and research; and developing and advancing nursing knowledge and the profession as a whole.

Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) is necessary. These roles have high potential for applicability in the CAF, as they involve the provision of direct patient care, research, education, consultation, collaboration and leadership activities[35]. For CFHS to maintain relevancy, currency, and creditability towards Canadian health care and best practice standards[36], and in order to ensure the provision of modern and effective care[37], a serious investment towards the domain of medical education is warranted[38]. For example, to credibly hold the role as a Nurse Educator in Canada, a Certificate in Nursing and/or Clinical Education is required at minimum; many institutions further requiring a master's degree in Nursing or Medical Education[39] if not a Doctorate degree. In the CAF however, junior Nur O (and other HS occupations) are posted into formal instructor and educator positions at Trauma Training Centres, CFHS Training Establishments, and within operational units, where they provide official medical education, typically armed with nothing more than "CAF Instructional Techniques[40]".

In order to ensure the appropriate employment of NUR within the clinical domain (thereby maximizing the contribution to CFHS and developing additional nursing expertise on par with Canadian standards[41]), a detailed analysis is required to compare CAF NUR against the utilization of nurses in allied militaries. Preliminary research indicates that the United States (US)[42], the United Kingdom (UK), Australia, and New Zealand routinely offer not only Master level degrees, but in the case of the US and UK, sponsor Doctorate (PhD) level educational opportunities to their military Nur O. In doing so, they have correlated clinical, educational, research, and leadership positions for their members; capitalizing on the strengths they bring forward to their military organizations.

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[35] *Ibid.*

[36] National Defence, *Review of CF Medical Service- Executive Summary and Action Plan Resulting from the CDS Task Force,* 7055-42-2 (Chief of Review Services), October 1999, 24-25. The gap between the civilian and military health care capabilities is widening rapidly. Part of the solution is via the maintenance of clinical competencies.

[37] Canada, National Defence, *An Evaluation Perspective: CF Medical Support to Deployed Operations*. Ottawa: Canada Communications Group, June 2006, iii, A-4/4. Recommendation: "Establish a coordinated and prioritized program of academic development, exchange/liaison and research in CF H Svcs Gp in order to develop new and improved ways of providing healthcare in operational settings that appropriately meets the various threats posed by modern warfare and operational environments."

[38] *Ibid.*, vi. "[CFHS] needs to remain attuned to the rapid advances in modern military training, tactics, techniques and equipment…. and continue to provide additional trauma training in Canadian institutions and with our allies whenever possible."

[39] Certificate programs for Nurse Educator range from 24 to 30 weeks in duration, followed by a certification exam. Masters of Nursing programs are typically 2-year post-graduate degrees.

[40] Instructional Techniques is a generic CAF course delivered via distance learning, completed over 5-6 hours, followed by a practical session evaluation.

[41] Canadian Forces Health Services, *Canadian Forces Nursing 2020: A Concept Paper,* Canadian Forces Base Ottawa: October 2003: A-23-24/50. The NPL and SPLs are identified as roles in which a Master's degree would enable these Nur O to promote and coordinate clinical Nursing Research, as well as hold equivalent qualifications to that of his/her nursing counterparts.

[42] US Army: https://m.goarmy.com/amedd/nurse/corps.m.html. "Education and advancement are hallmarks of the Army Nurse Corps. To help you advance professionally, you may take advantage of courses that cover a wide range of nursing specialties. You may also apply for a master's or doctoral nursing degree program. While you're working toward your degree and taking a full course load, you may receive tuition, pay and allowances—so you can focus on learning, not financial obligations. Many U.S. Army nurses have the opportunity to gain education and experience in advanced practice nursing roles such as clinical nurse specialists, nurse practitioners, nurse midwives and nurse anesthetists."

Failed Gender Integration and Equality

For over 100 years, the CAF has struggled with Gender Integration (GI)[43] and equality issues. In examining GI through the lens of the *context* dimension of the Walt and Gilson model[44], the CAF's historical approach to full integration has unveiled ignorance, inability, or unwillingness to address the core issues[45]. While nurses were the first female occupation to serve in the Canadian military, they were not permitted to do so at the equal status to their male counterparts[46]. Standards of entry were as high as for doctors; however, women were remunerated at far lower rates of pay[47]. Upon successful completion of military nurse training, they were commissioned to the rank of Lt. Their authority as officers; however, was limited only to the functions that they executed in the hospitals as nurses. Unlike their MED compatriots, they had no decision-making power at the military level[48]. In addition, although officers, they were only referred to as "nursing sisters," a title reminiscent of the religious vocation with which caregiving tasks were often associated[49]; this highly deemphasized and dampened their potential capabilities both within the military and the medical domain.

In 1970, the Royal Commission on the Status of Women in Canada compiled a report outlining recommendations to ensure equal opportunities for all Canadian women, with incorporated recommendations aimed specifically at equalization in the CAF[50]. While some progress was made, it is evident to this day that equal rank progression and career opportunities in all domains have not been fully enacted[51]. At its inception, 100% of the NUR were female, but over the course of time and as the nursing profession progressed, an increasing number of males entered this career field[52]. To date however, there still exists a massive gender predominance

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[43] Paula Tracy, "Gender Integration of the Canadian Forces," Master's thesis, McMaster University, July 2001.
[44] Gill Walt and Lucy Gilson, "Reforming the health sector in developing countries: the central role of policy analysis," *Health Policy and Planning* 9, no. 4 (1994): 355. Focusing only on the *content* of policy neglects the other dimensions of process, actors, whereas *context* (affected by many factors) can make the difference between effective and ineffective policy choice and implementation.
[45] Paula Tracy, "Gender Integration of the Canadian Forces," Master's thesis, McMaster University, July 2001.
[46] Geneviève Allard, "Caregiving on the Front: The Experience of Canadian Military Nurses During World War I," in *On All Frontiers: Four Centuries of Canadian Nursing*, ed. Christina Bates, Dianne Dodd and Nicole Rousseau, (Ottawa: University of Ottawa Press, 2005), 153-167. In order to join the forces, these women had to be single (and remain unmarried and without children to continue to serve).
[47] Bill Rawling, *The Myriad Challenges of Peace: Canadian Forces Medical Practitioners Since the Second World War,* Ottawa: Government of Canada Publications, 2004: 32.
[48] Geneviève Allard, *"Caregiving on the Front: The Experience of Canadian Military Nurses During World War I," in On All Frontiers: Four Centuries of Canadian Nursing,* ed. Christina Bates, Dianne Dodd and Nicole Rousseau, (Ottawa: University of Ottawa Press, 2005), 153-167.
[49] *Ibid.*
[50] Royal Commission on the Status of Women in Canada, "Report of the Royal Commission on the Status of Women in Canada," last modified 28 September 1970, https://women-gender-equality.canada.ca/en/commemorations-celebrations/royal-commission-status-women-canada.html. These included the standardization of enrolment criteria, universal pension benefits, prohibiting release for reasons of pregnancy or marriage, and equalized pay scales.
[51] Lynne Gouliquer, "Soldiering in the Canadian Forces: How and Why Gender Counts!", (Department of Sociology, McGill University, 2011):v-vi.
[52] Bill Rawling, *The Myriad Challenges of Peace: Canadian Forces Medical Practitioners Since the Second World War,* Ottawa: Government of Canada Publications, 2004: 139-141. In 1955, male nurses faced significant discrimination. The Canadian Forces Medical Council and Surgeon General staff deemed that men were not permitted to join as nurses (despite holding the requisite qualifications), and were required to be employed as

within nursing, in which 80% of Reg F Nur O are female[53], relative to the civilian sector in which 91% of regulated nurses in Canada are female[54].

Rank and Career Progression Related to Gender

NUR, the most female-dominated officer MOSID in the CAF is also one of the most drastically under-ranked within the senior ranks. This trend traces back decades, when in 1946, the Director General Medical Services requested the rank of the Matron-in-Chief be increased from Maj to LCol in order to equalize the rank, to which the Army refused[55]. Table 2 outlines the current rank percentages by gender, demonstrating the drastic differences in the Reg F officer average as compared to NUR. Further, it also includes rank comparison data to 1969, demonstrating how marginally NUR has progressed in holding senior positions.

Table 2 - Percentage of Rank Distribution-CAF Officer Average by Gender vs. NUR[56]

Rank	% at rank CAF average - MALE (2021)1	% at rank CAF average - FEMALE (2021)2	% at rank NUR (2021)3	% at rank CAF average- FEMALE (1969)4
Colonel and above	4.12%	1.97%	0%	0%
Lieutenant-Colonel	10.29%	8.96%	0.93%	0.4%
Major	27.89%	28.9%	9.01%	5.5%

Sources: 1,2,3- National Defence. Military Command Software (MCS) Personnel Dashboard. Last accessed 19 August 2021.

4- Royal Commission on the Status of Women in Canada, "Report of the Royal Commission on the Status of Women in Canada, 137.

stretcher bearer officers and /or in the Medical Administration branch instead. They believed "In the tradition of the Services a commissioned male officer must be qualified not only in his specialty, but in a series of subjects sometimes unrelated to his primary job. Such training, plus the ability to command and lead, are prerequisites for male officers."

[53] National Defence, Military Command Software (MCS) Personnel Dashboard, last accessed 19 August 2021.

[54] Canadian Nurses Association, "Nursing Statistics", last accessed 28 July 2021, https://www.cna-aiic.ca/en/nursing-practice/the-practice-of-nursing/health-human-resources/nursing-statistics

[55] Bill Rawling, *The Myriad Challenges of Peace: Canadian Forces Medical Practitioners Since the Second World War*, Ottawa: Government of Canada Publications, 2004: 32.

[56] National Defence, Military Command Software (MCS) Personnel Dashboard, last accessed 19 August 2021. The data extracted from this database reflects real-time statistics (how many personnel on this specific date hold each rank). This does not necessarily reflect the same percentages of data as compared to the PML (data accessed from the ESR), which reflect the positions and percentage of what each MOSID is allocated officially.

CFHS has a higher-than-average female to male ratio as compared to the rest of the CAF, totalling 41% of the remainder of CFHS officers (excluding nurses)[57] are female. In acknowledgement of this, and to further illustrate the rank ratio disparity, NUR was then studied against all other CFHS officer occupations. Table 3 below demonstrates that there is a disproportionate (low) rank dispersal for senior officers within all female-predominant MOSIDs within CFHS, with NUR as the most significantly under-ranked (by percentage).

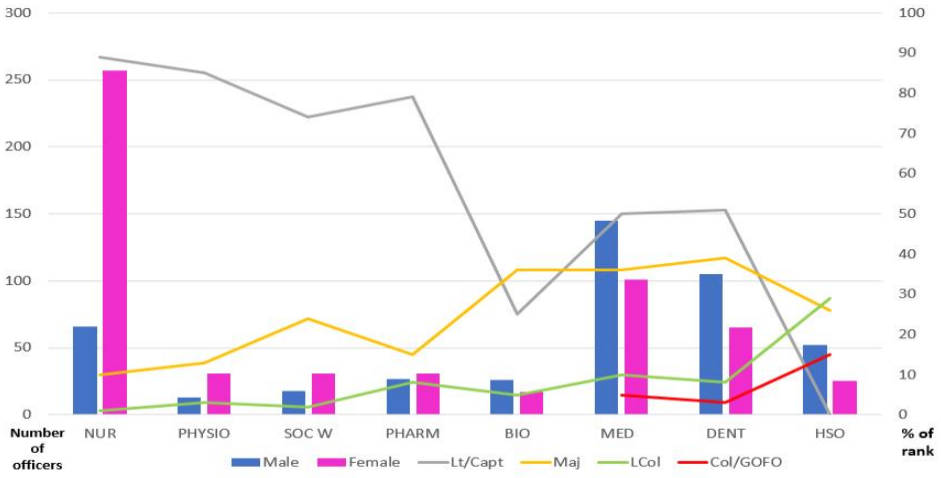
Table 3 - Percentage of Rank Distribution per Occupation- CFHS Officers *(in order from largest to smallest PML)*

Occupation	**PML (total # of positions)**	**Maj (% of rank)**	**LCol (%)**	**Col (%)**	**GOFO[58] (%)**
Nursing (80% female)	**260**	10	1	0	0
Medical (41% female)	**226**	36	10	4	1
Health Care Administrator (46% female)	**158**	24	n/a[59]	n/a	n/a
Dental (38% female)	**142**	39	8	2	0
Physician Assistant (26% female)	**118**	8	1	0	0
Health Services Operations (32% female)	**86**	56	29	15	0
Medical Specialist (15% female)	**72**	67	28	6	0
Pharmacy (53% female)	**52**	15	6	2	0
Social Work (63% female)	**42**	24	2	0	0
Bio Science (40% female)	**42**	36	5	0	0
Physiotherapy (70% female)	**39**	13	3	0	0

Source: National Defence, Director General Military Personnel Research and Analysis: Establishment and Strength Report- CFHS, FY20-21. **[60]**

[57] *Ibid.* CFHS averages an overall gender percentage of 49% female officers with NUR included.
[58] General (GOFO) ranks were not listed on the ESR against specific MOSIDs, however at this time, CFHS has 2 x MED GOFO (1 x BGen, 1 x MGen) that were included in table 3.
[59] HCAs are capped at the rank of Maj and are converted to the HSO MOSID (if selected).
[60] These percentages reflect the rank that is officially allocated per MOSID PML (as per the ESR). This however is not fully accurate to demonstrate the current state of how many members per MOSID are actually serving at present. For example, some MOSIDs have promoted over PML using other occupation's positions.

Table 4 - Gender Correlation (by CFHS Officer MOSID) Compared to Rank Distribution[61]
(in order from female-predominate MOSIDs ordered from left to right)



Source: National Defence, Director General Military Personnel Research and Analysis: Establishment and Strength Report- CFHS, FY20-21.

A Strained Occupation

As outlined in *Strong, Secure, Engaged*, the Government of Canada and the CAF alike intend to increase the overall percentage of women in the CAF to 25% by the year 2026[62]. Arguably, the focus appears to be on increasing attraction and recruiting strategies across all CAF occupations, with little emphasis on the retention of female-dominated occupations such as NUR. For multiple years, via the mechanism of the Annual Military Occupational Report (AMOR), the NUR MOSID advisor has called attention to the fact that the most-predominant female officer MOSID in the CAF also correlates with the highest rates of leave without pay (LWOP) for Maternity/Parental (MATA/PATA) reasons. For fiscal year 2020/21, the CAF average for MATA/PATA leave was 1.8% (male/female combined)[63]. The rate for NUR is quadrupled at a staggering 7.3%[64]. This results in over 7% of positions left unoccupied for upwards of 18 months at a time, the majority of which by regulation either cannot be, or are unsuccessfully backfilled with Reservists. Additionally, due to the CAF's rigid framework and structure, there is currently no mechanism to fill or compensate for this gap by increasing the PML in these known occupations of high percentage utilizers of MATA/PATA leave.

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[61] CFHS occupations were cross-compared for rank distribution, however purposeful omissions were made as follows: PAs were excluded, as they are a newly commissioned occupation (2017) that is still within the early stages of development. MED SPEC were excluded as the baseline rank starts at Maj and have automatic promotion to LCol. HCA were excluded as their rank ends at Maj (and they typically progress to HSO).
[62] Department of National Defence, *Strong, Secure, Engaged: Canada's Defence Policy* (Ottawa: DND, 2017), 12.
[63] National Defence, Director General Military Personnel Research and Analysis: *Annual Military Occupational Review- Nursing (00195), FY20-21*, slide 20.
[64] *Ibid.*

Couple this rate of vacancy (7.3%) with that of the NUR workforce speciality training vacancy (17%), and the end state is that at any given time, the CAF is running a deficit of approximately one quarter (24%) of Reg F NUR (independent to any additional shortages in the Total Effective Strength (TES)). These shortages coupled with the high operational tempo nature of this occupation[65] leads to an extremely strained occupation[66], subject to burnout[67] and moral distress[68].

Factors Impacting Career Satisfaction and Attrition

HSO is an occupation within CFHS that commences at the rank of Maj, and is derived from "feeder" trades[69]. HCA, NUR, and PHARM are potential candidates offered an Occupational Transfer (OT) to HSO after two years in rank as a Maj[70]. The role of the HSO is not clinical in nature, and as such, members of the clinical feeder occupations who select this career pathway typically revoke all clinical practice and affiliations upon undertaking this career path[71]. HSO are employed in operational units and static health care facilities, predominantly within the domains of administration and leadership[72]. The career pathway for the HSO progresses to Colonel (Col), and offers significantly more opportunities for career advancement, education, training, and promotion. Table 5 demonstrates the positions held by each rank level of HSO as compared to NUR; demonstrating a significantly more opportunistic route as an HSO.

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[65] Canada, National Defence, *Evaluation of Medical Support to Deployed Operations*, Ottawa: Canada Communications Group, November 2014. A key concern is the high operational tempo for the medical occupations. As these members are required for almost every deployed operation, there is a high demand and frequency of requests for deployment. This compounds the pressure on lower staffing levels and may lead to higher attrition rates, particularly since medical occupations are also sought after outside of the CAF.

[66] National Defence, *Review of CF Medical Service- Executive Summary and Action Plan Resulting from the CDS Task Force*, 7055-42-2 (Chief of Review Services), October 1999, iii-iv. A significant factor contributing to low levels of morale are from highly stressed professionals, "…wondering about the organization's strategic direction, fatigued by seemingly endless process changes and heavy workloads with little end in sight..."

[67]Sara T. Fry, Rose M. Harvey, Ann C. Hurley, and Barbara Jo Foley, "Development of a Model of Moral Distress in Military Nursing," *Nursing Ethics* 9 (4) (2002): 376. "Burnout" can be experienced as a sense of failure, and being worn out and exhausted through excessive and competing demands on one's resources, strength, and energy. Burnout is typically characterized by feelings of low job satisfaction, being alienated from their work, and/or experiencing deterioration in job performance and is associated with role conflict, work conditions and relationships, depersonalization and emotional exhaustion.

[68] *Ibid.* Similarly, issues compounding moral distress within military nursing include bureaucracy, inadequate management control, unclear responsibilities, and the nurse's subordinate role in patient care; leading to feelings of powerlessness and non-supportive work environment(s).

[69] National Defence, Canadian Forces Manual of Military Employment Structure, Officer Job Based Specifications for the Nursing, Volume 2 Part 1 (2009): 2-8.

[70] *Ibid.*

[71] Upon acceptance to HSO, CFHS ceases to support the maintenance of a clinical license (either with clinical time requirements or funding) as HSO duties have no clinical licensing requirements. However, members may elect to maintain licensure so at their own time/expense.

[72] National Defence, Canadian Forces Manual of Military Employment Structure, Officer Job Based Specifications for the Health Services Operations, Volume 2 Part 1 (2009).

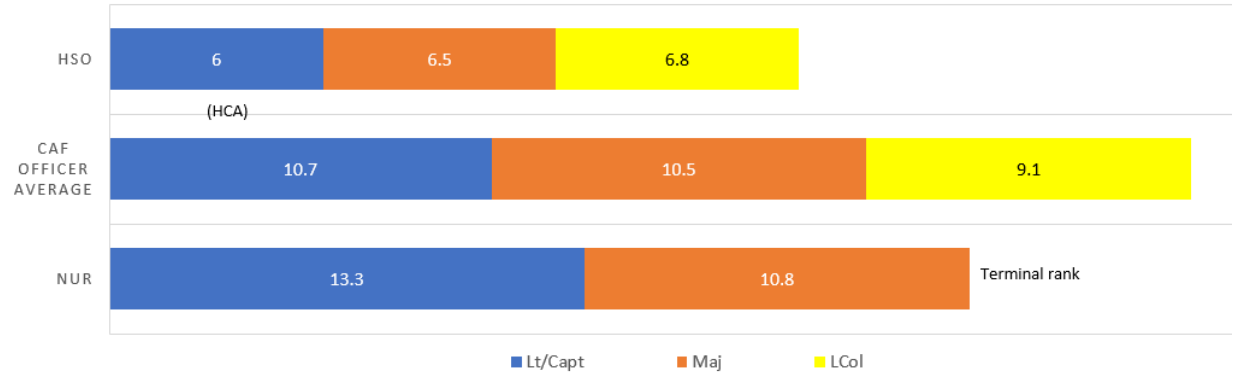
Table 5 - Number of Positions per Rank Level, by Occupation

Occupation	Maj	LCol	Col
HSO	48	25	13
NUR	25	3	0

Source: National Defence, Director General Military Personnel Research and Analysis: Establishment and Strength Report- CFHS, FY20-21.

In addition to the substantial opportunity for career progression, table 6 displays that progression to promotion occurs at a faster rate as an HSO, in comparison to both the CAF officer average, and significantly more so in comparison to NUR. Nur O in fact spend more than double the time as a junior officer (7.3 years longer) than HCAs (the main feeder occupation to HSO) before meriting for promotion to Maj, and an additional 4.3 years longer at the rank of Maj[73].

Table 6 - Rank Progression- Time in Rank (years) to Promotion



Source: National Defence, Director General Military Personnel Research and Analysis: Establishment and Strength Report- CFHS, FY20-21.

A five-year average (from 2017 to 2021) demonstrated the attrition of NUR OT to HSO at a loss of approximately 2.4 Maj per year (10% of the NUR Maj PML annually)[74]. For some Nur O, transferring to HSO can be attributed to a natural and preferred progression (especially those who held predominately administrative roles throughout their career vs. clinical/nursing

[73] National Defence, Director General Military Personnel Research and Analysis: Establishment and Strength Report- CFHS, FY20-21.
[74] National Defence. Director General Military Personnel Research and Analysis: Annual Military Occupational Review- Nursing (00195), FY20-21.

roles). However, others have indicated they have done so reluctantly, and solely for career progression opportunities/ advantages not offered via NUR.

In order to justify the additional fiscal cost and positional requirements for NUR positions and rank, a detailed assessment is required to cross-compare the employment and roles of the CAF NUR as compared to civilian institutions and allied nations. Preliminary data demonstrates that CAF NUR has not only stagnated for decades, but has in fact regressed in rank at the expense of the development of the HSO occupation in 1997, in which Col/LCol/Maj NUR positions were re-allocated to HSO[75].

Barriers to career advancement within NUR was identified in the 1950's, and persist in modern day:

> "In view of the increasing overseas commitments which the Canadian Forces have to cope with, a comparison with other Commonwealth countries… with reference to rank structure of nursing services was made, and it was decided that the Canadian Services were proportionately low…The Members agreed that this discrepancy in senior rank, both at home and abroad, make liaison and co-operation extremely difficult[76]".

Unlike the CAF, allied nations have embraced the role and capability of the modern-day nurse, and hold the appropriate rank levels to enable equal footing at the senior levels[77]. As an example, since 2017, the US military has appointed Nur O as SG[78] on two[79] occasions, serving at the rank of Rear-Admiral[80]. Table 7 below depicts the highest rank of Nur O employed by nation (within the capacity of NUR).

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[75] Canadian Forces Health Services, *Occupational Structure Implementation Plan (OSIP) for the Creation of the Health Services Operations Career Field, The Elimination of the DAO 52 Occupation and the Restructuring of the HCA 48, PHARM 54, and NUR 57 Military Occupations,* Canadian Forces Base Ottawa: file 5555-31-HSO (D Pers Plan 3-2), 10 February 1997.

[76] Bill Rawling, *The Myriad Challenges of Peace: Canadian Forces Medical Practitioners Since the Second World War,* Ottawa: Government of Canada Publications, 2004: 33.

[77] James C. Taylor, "CFHS Heal Thyself: Developing Strategic Health Services Leaders for the Modern Milieu." In *The Operational Art: Canadian Perspectives- Health Service Support*, edited by Allan English and James C. Taylor, 161-186. Kingston: Canadian Defence Academy Press, 2006: 174. The practices of our Allies and the civilian medical/dental clinical communities in Canada show that clinical specialists with the appropriate qualifications and credibility are often in top strategic leadership positions.

[78] https://nursingnotes.co.uk/news/international/nurse-named-as-acting-us-surgeon-general/

[79] The White House, "Vice Admiral Richard H. Carmona, M.D., M.P.H., F.A.C.S," last accessed on 24 August 2021. https://georgewbush-whitehouse.archives.gov/government/carmona-bio.html. There is a third cited "Nurse" Surgeon General in the literature (who was in fact a nursing officer at one point); however at the time he performed the duties as Surgeon General, he did so as a physician.

[80] Kat Jercich, "Biden appoints Rear Admiral Susan Orsega as acting surgeon general", last modified 27 January 2021, https://www.healthcareitnews.com/news/biden-appoints-rear-admiral-susan-orsega-acting-surgeon-general

Table 7 - Examples of Positions Held by the Lead Military NUR of Allied Forces

Country	Rank	Role
US (Army)[81]	Brigadier-General	Chief, Army Nurse Corps
UK (Army) - Queen Alexandra's Royal Army Nursing Corps [82]	Colonel	Chief Nursing Officer
Australia - Royal Australian Army Nursing Corps	Colonel	Chief Nursing Officer
Canada - CAF (tri-service)	Lieutenant-Colonel	Chief of Nursing Services, National Practice Leader[83], & MOSID Advisor

Assumptions and notions towards the root cause of NUR retention issues are evident and have been historically dismissive in nature. In 2008 it was felt that "Retaining nurses is a problem, partly because those not on deployment are routinely embedded in civilian health care settings to keep their skills up. Over time, they begin to identify more with the civilian than the military health care system."[84] Notions such as this led the Surgeon General (SG) at that time to concede, "[it's] possible we just have to accept….we won't have nurses for 25- or 30-year careers."[85] Dissatisfiers within NUR are historic and unchanged. A study conducted in 1974 found similarly to present day issues, that Nur O, "…express a good deal of concern about their proper utilization, their opportunities to progress in their careers and… about opportunities for professional development[86]." Continued efforts towards the retention of NUR is required, recognizing the value of retaining and implementing lessons learned from the clinical, operational, and institutional domains[87].

CAF Nursing - A Double Hierarchy

Trending back historically from the era of the "Nursing Sisters," to modern day Professional Technical command structures[88], NUR is still subject to a double hierarchy; subservient in both rank and clinical status[89]. Unlike the Canadian (civilian) nursing standard and

[81] https://medcoe.army.mil/amedd-army-nurse-corps
[82] https://www.qaranc.co.uk/Chief-Nursing-Officer-Army.php
[83] Canadian Forces Health Services, *Canadian Forces Nursing 2020: A Concept Paper,* Canadian Forces Base Ottawa: October 2003: A-22/50.
[84] Sharon Adams, "Doctors in the Ranks," Legion: Canada's Military History Magazine, 24 October, 2008: https://legionmagazine.com/en/2008/10/doctors-in-the-ranks/
[85] *Ibid.*
[86] Bill Rawling, *The Myriad Challenges of Peace: Canadian Forces Medical Practitioners Since the Second World War*, Ottawa: Government of Canada Publications, 2004: 283.
[87] Canada, National Defence, *Evaluation of Medical Support to Deployed Operations*, Ottawa: Canada Communications Group, November 2014. There is a requirement for continued efforts in the development of programs for retention. CFHS must use the experience gained on operations to develop an accepted methodology to identify/determine future personnel requirements.
[88] Canadian Forces Health Services, *Concept Paper for the Professional Technical Control of the Canadian Forces Medical Service*, Canadian Forces Base Ottawa, (Draft) February 2003: 6.
[89] *Canadian Forces Health Services, Canadian Forces Nursing 2020: A Concept Paper, Canadian Forces Base Ottawa: October 2003:* A-11/50.

comparable allied military health systems, CFHS is still caught in historical institutionalism[90] with regards to the roles, responsibilities and lack of opportunities for NUR (and numerous allied health practitioners) to contribute fully to the CAF healthcare system[91]. As an example, CFHS periodically holds Clinical Council and Capability Development Council (CDC) meetings; both of which drive decision-making for CFHS in regards to health care guidelines, protocols, regulations, and capabilities. Membership for these committees however is restricted to positions held by senior MED, DENT, and HSO[92]. The remainder of allied health professional (NUR, PHARM, PHYSIO, etc.) are "observers", with no direct influence or voting ability[93]. This approach is incongruent with a balanced multidisciplinary method to optimizing healthcare issues[94]. The multidisciplinary teamwork approach originated at the turn of the 20th century, and is proven to improve the quality and safety of patient care delivery as well as "break down the hierarchy and centralized power... giving more leverage to healthcare workers and producing a higher level of work and job satisfaction[95]", while assisting with retention of experienced personnel[96].

Within CFHS, the MED occupation holds the complete authority at every level for clinical, operational, and clinical staffing decisions[97], including those impacting all unregulated[98] (PA, Medical Technicians, etc.) and regulated[99] (PHARM, PHYSIO, NUR) health professions alike. While the Canadian Nurses Association regularly collaborates closely with the Canadian

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[90] Paula Trachy, "Gender Integration of the Canadian Forces," Master's thesis, McMaster University, July 2001: 10-13.

[91] National Defence, *Review of CF Medical Service- Executive Summary and Action Plan Resulting from the CDS Task Force,* 7055-42-2 (Chief of Review Services), October 1999, 16-17. There is little opportunity within CFMS to readily share innovating ideas and solutions. CFMS personnel are generating good ideas, however this sharing of ideas will not occur on its own. It requires a deliberate effort in order to derive maximum benefit from this concept.

[92] Canadian Forces Health Services, *Terms of Reference for – CF H Svcs Gp Capability Development Council.* Canadian Forces Base Ottawa: Draft version 2021. HSOs form membership on the CDC, but not on the Clinical Council.

[93] Canadian Forces Health Services, *Terms of Reference- Surgeon General's Clinical Council,* Canadian Forces Base Ottawa: 29 November 2015.

[94] Nancy Epstein, "Multidisciplinary in-hospital teams improve patient outcomes: A review," *Surgical Neurology International* 5, Suppl 7 (28 Aug 2014): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4173201/.

[95] Charlotte Hughes, "Multidisciplinary Teamwork Ensures Better Healthcare Outcomes," last modified 21 April 2021: https://www.td.org/insights/multidisciplinary-teamwork-ensures-better-healthcare-outcomes

[96] Nancy Epstein, "Multidisciplinary in-hospital teams improve patient outcomes: A review," *Surgical Neurology International* 5, Suppl 7 (28 Aug 2014): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4173201/.

[97] Canadian Forces Health Services, *Concept Paper for the Professional Technical Control of the Canadian Forces Medical Service,* Canadian Forces Base Ottawa, (Draft) February 2003: 6. The Surg Gen position was created in to exercise overall responsibility and control for all professional and clinical matters within the CFHS.

[98] Canadian Nurses Protective Society, "Ask a lawyer: Working with unregulated care providers," last accessed 24 August 2021: https://cnps.ca/article/ask-a-lawyer-working-with-unregulated-care-providers/. Unregulated care providers are not governed by legislation, have no legally defined scope of practice, and are not answerable to an external regulator that sets standards of practice and monitors the quality of care provided by these health-care providers. Typically, they have a scope of employment defined by their job description and are accountable to their employer.

[99] Ontario Ministry of Health, "Regulated Health Professionals," last accessed 23 August 2021: https://www.health.gov.on.ca/en/pro/programs/hhrsd/about/regulated_professions.aspx. Health regulatory colleges are responsible for ensuring that regulated health professionals provide health services in a safe, professional and ethical manner. This includes, among other things, setting standards of practice for the profession and investigating complaints about members of the profession and, where appropriate, disciplining them.

Medical Association (and vice versa)[100], one profession does not make decisions on behalf of another profession; however, this is common practice in CFHS[101].

Identified in 2003 in a draft concept paper for the Professional Technical control of CFMS, it was proposed that a LCol Nur O work jointly with the MED LCol, both serving as SSO to the SG[102]. It was recognized that "[the] Nur O MOC is the largest professional group in numbers [for officer MOCs]…and will provide input at the National prof/tech level [direct to the SG] on the diverse professional leadership issues facing Nur O."[103] Other fundamental concepts proposed included a key principle that prof/tech personnel must have the opportunity to remain current within the practice of their profession, serving to maintain credibility, stay connected to current health care issues, and allow the CAF to retain high quality and experienced clinicians[104]. Little has been actioned or advanced since this time however, with Maj and LCol Nur O filling HSO positions highly administrative in nature[105], and the majority of Nur O incapable of completing MCRP commencing as early as the rank of Lt (when posted outside of HRD positions) due to the overwhelming workload of their primary position/duties[106].

Moving forward, it is not enough for CFHS to simply extend an "invitation to the table" for the allied health professions. The positions, roles, rank, and educational opportunities need to be re-evaluated, realigned, and prioritized to enable meaningful contribution from within each domain. The intent is not to simply add more to the already full plate of existing administrative duties[107]. NUR positions need to be re-defined and mapped to allocate required resources/ personnel, time, IT&E, and exposure to foster clinical experience and nursing expertise; this will permit NUR to grow and maximize its capabilities and contributions to the CFHS.

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[100] Canadian Nurses Association, Canadian Medical Association and Health Action Lobby, "Integration: A New Direction for Canadian Health Care", November 2013: https://www.cna-aiic.ca/~/media/cna/files/en/cna_cma_heal_provider_summit_transformation_to_integrat ed_care_e.pdf

[101] Canadian Forces Health Services, *Concept Paper for the Professional Technical Control of the Canadian Forces Medical Service,* Canadian Forces Base Ottawa, (Draft) February 2003: 8. "Only the SG will be able to direct a medical professional on professional aspects of the care he/she is providing."

[102] *Ibid*., 28.

[103] *Ibid*., 28.

[104] *Ibid*., 7.

[105] National Defence, *Review of CF Medical Service- Executive Summary and Action Plan Resulting from the CDS Task Force,* 7055-42-2 (Chief of Review Services), October 1999, 9-10. Recommendations: "HCAs and HSOs [are required to]… assume more of the administrative responsibilities..., freeing up clinical practice time of the health care…[clinicians]."

[106] Canada, *Report of the Auditor General of Canada to the House of Commons. Chapter 4:Military Health Care - National Defence,* Ottawa: Office of the Auditor General, 2007, 22. In 2005, the Department implemented its MCRP for all military health care occupations. This program is a formal, mandatory process through which military health care providers must maintain knowledge and skills by completing a minimum number of training activities in a given amount of time. One of the mandatory activities is clinical placement in a civilian health care facility. Nur O were survey and found that few were able partake in the program, although it is mandatory, because they believe they cannot be spared from their regular duties. Only 43 percent of military nurses had begun a placement in a provincial facility and only 5 percent had completed the program.

[107] *Canadian Forces Health Services, Concept Paper for the Professional Technical Control of the Canadian Forces Medical Service, Canadian Forces Base Ottawa, (Draft) February 2003: 8.* "This overtasking of existing prof/tech staff has rendered the CF unable to respond…[to priority work]. It has also led to frequent staff burnouts…"

CONCLUSION

NUR is facing many challenges, impacting its ability to fully leverage the knowledge and experience of its members for the benefit of the CAF. This essay does not purport that all issues within NUR are solely attributed to failed application of gender integration and equity[108]. It does however, demonstrate direct correlations and evidence to suggest that further research and a complete analysis of this occupation is warranted; as the CAF has laid out clear indicators regarding priorities to modernize, which include the domain of gender inclusivity[109]. In order to achieve this objective, numerous CAF processes and policies including the overarching structure and framework need to be re-evaluated and adapted; with the fundamental realization that some occupations are more impacted by gender disparities than others. Within the framework of the Walt and Gilson model, "actors are influenced by the context within [which] they . . . work"[110]. Successful policy change requires leaders as actors who are the change they want to see. As a starting point, a complete and in-depth occupational review is required for NUR to address the critical issues impacting this most female-dominated officer MOSID in the CAF.

Lastly, NUR must be reconceptualized to ensure this profession is effectively employed in order to optimize scope, operational capacity, and innate clinical leadership potential[111]. As a result of the COVID-19 pandemic, we are amidst the greatest global crisis in healthcare ever witnessed in this generation[112].

> "The current pandemic has immeasurably transformed the [nursing] profession… As we begin to move forward past the pandemic and into its aftermath, the nursing profession must grapple with its future, and understand how… the nation's most trusted profession -now, more than ever -can be part of the [future healthcare] solution…"[113]

The CFHS must take a hard look in determining the institutional priorities, take action to preserve the finite resource of experienced Nur O, and separate out the roles of administration from those clinical in nature.

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[108]Krystal Hachey, "Rethinking Military Professionalism: Considering Culture and Gender," *In Rethinking Military Professionalism for the Changing Armed Forces*, ed. Krystal Hachey, Tamir Libel and Waylon Dean. New York: Springer International Publishing, 2020: 3. There are 5 key characteristics essential to the military profession: expertise, legitimacy, jurisdiction, identity and culture.

[109] Department of National Defence, *Strong, Secure, Engaged: Canada's Defence Policy* (Ottawa: DND, 2017), 12.

[110] Walt, Gill, and Lucy Gilson, "Reforming the health sector in developing countries: the central role of policy analysis," *Health Policy and Planning* 9, no. 4 (1994): 355.

[111] National Defence, *Review of CF Medical Service- Executive Summary and Action Plan Resulting from the CDS Task Force*, 7055-42-2 (Chief of Review Services), October 1999, 9-10. Recommendation: "Position analysis…of senior positions in the CFMS [must] by examined…to determine the skills sets required to perform the duties of the respective positions." "…[CFMS must] determine appropriate ways of encouraging clinicians to make a career of practicing clinical medicine within the CF."

[112] Edith M. Lederer, "UN chief says COVID-19 is worst crisis since World War II," last modified 31 Mar 2020.

[113] Jacqueline Nikpour, Lauren Arrington, Allyson Michels, and Michelle Franklin, "COVID-19 and the Nursing Profession: Where Must We Go From Here?" Last accessed 19 August 2021.

The first step necessary toward meaningful change encourages exploration of the structures and practices that facilitate the optimized delivery of nursing care, and to identify and dismantle barriers and traditions that hinder heath care delivery reform[114]. The collective vision must be focused towards a modernized, multidisciplinary, and collaborative CFHS, focused on maintaining the aim and needs of the evolving CAF climate[115].

[114] Joan Almost, "Regulated nursing in Canada: The landscape in 2021," *Canadian Nurses Association,* February 2021: 89.

[115] Canada. National Defence. *Evaluation of Military Health Care.* Ottawa: Canada Communications Group, November 2018. Canada's defence policy: *Strong, Secure, Engaged* (SSE), 2017 places substantial focus on and provides an investment in an inclusive approach to health. The CAF Health System must meet the unique needs of its personnel with efficient and effective care.

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