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EXERCISE NEW HORIZONS

CANADIAN FORCES HEALTH SERVICES UNIT COMMANDING OFFICERS: THE LYNCHPIN OF THE REFORM

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"'Understanding and Caring'
for those who serve - anytime, anywhere"
Canadian Forces Health Services' Motto[1]

INTRODUCTION

Since January 2000, the Canadian Forces Health Services (CFHS) have embarked on an ambitious, innovative, and comprehensive health care reform called PRESCRIPTION 2000 (Rx 2000), with a view to "create a patient-focussed, accessible and universal health care system that is delivered by a multi-disciplinary, and for military [health care providers], a fully deployable health care team."[2] The original mandate of RX 2000 was to develop and implement the necessary strategies to correct the numerous deficiencies and address the 359 recommendations highlighted through the various reviews and inquiries that examined the provision of health care in the Canadian Forces (CF) between 1997 and 2002.[3] In fact, a common trend underpinning all boards was that Canadian Forces (CF) members, their chain of command, and even health service providers had lost confidence and trust in the only Canadian health care system legally mandated to provide military members with the health

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[1] The Health Services briefing for CF members provides the following explanation regarding CF H Svcs' Motto: "*Understanding your health concerns and caring for you during your return to wellness is what we are all about - any time, anywhere."* http://www.forces.gc.ca/health/information/engraph/hs_briefing_home_e.asp#15 *CF H Svcs Website accessed 7 April 2005.*

[2] This goal and additional information regarding Project Rx 2000 may be found in the CF H Svcs website section - 'About us' at: http://www.forces.gc.ca/health/about_us/engraph/rx2000_e.asp?Lev1=5&Lev2=2&Lev3=6 accessed 7 April 2005.

[3] The reviews and Boards include the "Chief of Defence Staff Review of the Medical Services"; the "McLellan Report on The Care of Injured Personnel and Their Families"; the "Lowell Thomas Report on the military police investigation of certain events in the former Yugoslavia"; the "SCONDVA report"; and the "Croatia Board of Inquiry". Additional information regarding some of these boards and reports may be found in the ADM (HR Mil) internet website at: http://www.forces.gc.ca/hr/engraph/initiatives_e.asp accessed 7 April 2005.

services they rightly expected to receive.[4] Various factors contributed to the military medical system's difficulties in providing uniformed health care.[5] The ensuing requirement to rely heavily on a civilian health care sector already overstretched, further affected the effectiveness and credibility of the CFHS. When compounding these factors with an intense operational tempo, decreased clinical experiences (scope and quality), overly extensive command relationships,[6] and an operationally intensive focus to the detriment of in-garrison care, it became obvious that the military health care system needed a complete overhaul. Status quo was no longer an option, hence the prescribed reform: Project RX 2000.

Rx 2000 is truly a work in progress with most recommendations either implemented or completed. The CFHS command and control structure and the military health care delivery system underwent extensive changes. Despite some delays and setbacks--as could be expected with any such significant organizational reform-- noteworthy accomplishments in other areas have resulted in enhanced health service delivery and improved operational flexibility. At this stage, however, overall success remains undecided as 98 recommendations are still awaiting Project Management Board (PMB) and/or Treasury Board (TB) approval. Some other issues such as the new clinic model and the unified health

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[4] Drawn from personal observations and communications, such as PMO Rx 2000 briefings/ updates presented during the semi-annual CF H Svcs senior leadership conferences that the author attended from January 2000 to April 2004.

[5] The Canadian Forces Medical Service (CFMS) never truly overcame the mid 1990s' closure of CF Hospitals, the Force Reduction Program (FRP) release of one thousand military health care providers over a 15-month period, resulting in a heavy reliance on overly stretched provincial health care systems and resources. Similarly, prolonged critical shortages of uniformed physicians (-51/100 captains/Medical Officers) and other military providers (-131 officers/5 clinical MOCs) doubled with the difficulty to recruit and retain civilian health care providers in remote or unattractive areas (e.g. Petawawa, Shilo, Gagetown) led to system-wide imbalances in health service delivery that further affected continuity of care.

[6] All health services resources were centralized into one unified chain of command on 1 April 2001. Before then, 281 different commanding officers -- the majority being non-CF H Svcs -- managed the 2800 military medical personnel.

services chain of command remain highly contentious. Nonetheless, momentum must be maintained as even minor setbacks in implementation could rapidly void the recent gains made in rebuilding CFHS' credibility as a military health care system.

As the agent of change ultimately accountable for the health services provided in a given geographic idea, the CFHS unit CO is responsible to ensure that the local chain of command, as well as individual CF members are provided quality and responsive health services within the prescribed strategic and operational guidelines.[7] Moreover, clients' perception of quality and responsive care must accurately reflect the health services that they are in fact receiving. One could rightly argue, however, that as a senior officer, the CFHS unit CO is well prepared to successfully face such challenge.[8] Yet, is this assumption truly accurate? Or is this rather a wishful thought, when considering that prior to being selected as CO, their training focused exclusively on knowledge acquisition and specialist task performance.

In order to effectively command their unit, in the contemporary, fast-changing, and complex CFHS' external and internal environments, every CFHS CO must understand their role and responsibilities as 'captain' of an all-star team—the unit-level multidisciplinary health care team. Their effectiveness, and that of their team, will depend on the degree of self-efficacy they acquired before their selection as CO. Thus, this essay contends that because of their multi-faceted role and the complex environment in which they lead, CFHS

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[7] Within CF H Svcs , most unit-level COs bear the rank of major when commanding a CF H Svcs Centre, except for Ottawa, Esquimalt, and Halifax. The Valcartier and Petawawa Clinics are a sub unit of their parent Field Ambulance (Fd Amb) commanded by a Lieutenant Colonel.

[8] In this paper, the concepts of 'senior officer', 'senior leader', and 'intermediate leader' will interchangeably refer to the ranks of major and lieutenant colonel, while 'general officer', 'executive leader', and 'operational leader' will mean the ranks of colonel and general.

unit-level COs are the lynchpin to reform success. The CO plays a pivotal role—one for which they must be carefully groomed.

In order to understand the role of unit-level COs in the CFHS, a brief overview of the CFHS will be presented. The components of the CFHS mission will then be discussed, as understanding this role is central not only to the effectiveness of health services, but, equally important, to the *perception* of that effectiveness. Next, the challenges posed by the reform will be described and the main issues facing CFHS COs will be identified. Drawing on the proposed CF Leader framework, the leader elements and attributes required to effectively command a CFHS Centre will lead to the conclusion that self-efficacy is the single point of failure in the CO's preparation and a major risk to reform failure.

THE CANADIAN FORCES HEALTH SERVICES

OVERVIEW

Under the 1867 Constitution, military affairs, which include health services, are a mandated federal responsibility. The 1984 Canada Health Act (CHA) definition of 'insured person'[9] specifically excludes all Canadian Forces full time members from provincial publicly insured health care coverage (often referred to as 'Medicare'). The CFHS could be seen as the 14th health care system in Canada.[10] The only pan-Canadian health care system,

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[9] "The CHA definition of 'insured person' excludes members of the Canadian Forces . . . The exclusion of these persons from [provincially] insured health service coverage predates the adoption of the CHA and is not intended to constitute differences in access to publicly insured health care." Government of Canada. Canada Health Act http://laws.justice.gc.ca/en/C-6/17077.html#rid-17084 .accessed 15 April 2005.

[10] Major General Lise Mathieu during her tenure as DG H Svcs, often referred to the CF H Svcs in those terms in her addresses to the CF H Svcs senior leadership.

CFHS spans over ten provinces and one territory.[11] It currently employs nearly 3300 military personnel[12] 200 public service employees[13] and 800 civilian contractors[14].

Through a comprehensive and regularly updated Spectrum of Care published in 1999, the CFHS provide a broad range of medical and dental services[15] often surpassing those available to every Canadian via their provincial public health care insurance program.[16] The Spectrum of Care document delineates the standard of care available to every CF member. The CHA did not prescribe any limits or specific criteria for the provision of health care in the CF, nevertheless, the Canadian Forces Medical Service (CFMS) always strived to provide as a minimum the same level of health care that is afforded to every Canadian under their publicly insured provincial health care system. So how could there be a perception of inadequate health services being provided to military members? The key element here is *perception*.

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[11] Regular and Reserve Forces elements/units/formations are divided among the different provinces and territories. CF H Svcs Centres or units are co-located in 35 of these bases, wings, garrisons or support units in order to provide health services to the CF, except in the Yukon and Nunavut, where deployed CF elements buy locally the health services they require.

[12] Approximately 2400 full time Regular Force members and 900 part time Reservists.

[13] A presentation on the CF Health Services team, made by PMO RX 2000 to Parliament Secretary, Dr Keith Martin, on 14 December 2004 indicated that there are only 3391 military positions of the 4746 PML Regular and reserve Force target currently filled; as well as 181 Public Service employees of the targeted 708 positions by RX 2000 end-state. The office of the Deputy Commander CF H Svcs Group provided, on 26 April 2005, both the electronic copy of the presentation and an Excel listing by MOC of the current CF H Svcs personnel state.

[14] Theses persons are employed through various third party contractual arrangements.

[15] The Dental Service is not discussed in this paper as its credibility, trust, and organization were never at stake.

[16] The CF Spectrum of care further provides free of charge, a myriad of dental, physiotherapy, mental health, pharmaceutical, and other services that are usually covered in part by employer-employee co-insurance programs, Workman's Compensation Boards or private insurance. The comprehensive list of CF covered services may be consulted through the CF H Svcs website - *'Health Services for CF Members*' section: *http://www.forces.gc.ca/health/services/engraph/spectrum_of_care_home_e.asp?Lev1=1&Lev2=5*, accessed 7 April 2005.

Until the early 1990s, the CFMS provided to CF members, most if not all medical services they required, from within its own resources and infrastructure up to and including rehabilitative and palliative care. The continuum of care covered military members from their enrolment to their release and they never then complained of feeling abandoned by the CF because of an illness or disease. When a member was deemed unable to serve due to their medical condition, they were released and all required health service support was arranged in the member's community. In those days, however, the operational tempo was light, the CF population was 30,000 members stronger including 1000 more uniformed health care providers in the CFMS. Of note, an Auditor General's review of the CFMS

cutbacks that resulted in significant military and Public Service force reduction programs. The much leaner CF and CFMG could not withstand a long recovery period anymore. Concurrently, military hospital closures greatly limited the care provided within military health care infrastructure. Only routine and operationally relevant health care was provided at military medical clinics. As a result, CFMG relied heavily on provincial health care systems and infrastructure to provide nearly all its specialist care. Health care organizations across the country were over-stretched and simultaneously going through their own health reforms and personnel reductions—which are still being addressed today—resulting in lengthened waiting times, delayed access to specialized care, and morseled in-garrison care. This situation consequently led to a strong perception from both soldiers and the chain of command that health care in the CF was degraded below an acceptable standard in comparison to past standards. Thus, a further loss of trust and credibility ensued.

Training for CFMG personnel had also moved from a clinical focus to an operational focus, taking military health care providers away from their clinical practice to train for operations. Many felt ethically torn between the military requirement of being operationally ready and fit and their professional obligations to provide in-garrison health care to military members seeking help. Similarly, CFMG personnel were tasked to deploy abroad, leaving their in-garrison responsibilities often unattended for lengthy periods. This operational stance was compounded with critical health care provider shortages, increased operational tempo, continued budgetary restrictions and increased incidence of Post Traumatic Stress Disorders (PTSD).

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personnel who would be affected by such reform as well as realigning the culture to facilitate successful reform implementation.

The Military health care pendulum, which was deemed too clinically focused until the early 1990s, had swung a decade later to the operationally focused extreme. In both extremes, the health services provided were unacceptable. This time, individual military members, the chain of command, and the health care providers themselves asked for timely and responsive health services at home and abroad to replace what they perceived to be fragmented and unacceptable health care. Thus, the prescribed reform: Project RX 2000.

THE CFHS MISSION: A 3-TIER MISSION

The CFHS mission is "To promote health protection and deliver quality care to the Canadian Forces".[19] CFHS' Regular and Reserve Force field units, as well as its 35 Regular Force wing/base/garrison/support clinics, all share the same mission. This mission statement implies three interrelated components of the military health care system. One component of this mission statement is a requirement shared by every health care organization across Canada. The other two components do not exist in any other public-funded health care system in Canada.

The first component concerns the obligation to provide quality health care to the CF, which means that every health service provided must be based on sound and clinically proven evidence, and meet the spectrum of care standards. It also implies that CFHS providers must maintain their knowledge and practice to the level required by their respective professional licensing bodies.

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[19] CF H Svcs website - '*About us*' section: http://www.forces.gc.ca/health/engraph/about_us_e.asp?Lev1=5 accessed 7 April 2005

The second component of the CFHS mission statement relates to its function as a military health care organisation. In its military capacity, the CFHS has two distinct lines of responsibilities; it must concurrently serve two clients—the individual military members and the chain of command—each in accordance to their own 'health' requirements. Simultaneously serving two masters with potentially opposing interests and requirements is a unique and often-conflicting dichotomy, which has created serious challenges in the past decade and largely contributed to the diminished credibility and loss of trust from both clienteles. Indeed, CFHS provides health services to individual military members, as any other health care organization in Canada would. Yet, CFHS also serves another equally important client, the CF organization itself. As a corporate health services organization, CFHS must promote health protection and provide distinct yet specific health services to the maritime, air and field environments of the CF (often referred to as the operators). The CFHS must further ensure that it enables the CF, as a military force, to achieve operational readiness status. This requirement leads to the third component of the CFHS mission statement.

The final component of the CFHS mission lies in the geographical location where health services are delivered. Today, 'delivering health care to the CF' implies the task of providing health services in Canada and abroad, where abroad generally means in a deployed theatre of operations. This requirement further implies that CFHS military personnel must themselves be operationally deployable and capable of providing appropriate health services in a potentially austere, hostile, joint and/or combined theatre of operations. They must therefore understand the environment, doctrine, and tactics of the force they support, as well as their own role, responsibilities and tasks. In other words, they must be

able to provide responsive, timely, and quality health services to each of the CFHS clients, anytime, anywhere.

The combined components of the CFHS mission clearly sets the uniqueness of the CFHS as a dual patient-oriented and corporate military health services organisation. These components are unmatched in the civilian health care system in Canada. In fact, provincial Worker's Compensation Boards in Canada fulfil the corporate health services responsibilities and requirements for employers by acting as an intermediary between injured or sick workers and their employers for work related health concerns while the employee's own family physician look after the employee's health. In addition, private invalidity insurance covers other non-work related sickness and injuries. In the CF, physicians and other health care professionals perform all three functions. They individually treat soldiers while simultaneously providing the organisation (chain of command, career managers, etc.) with prognosis-related information about a soldier's health that could lead to job restrictions and eventually to the discharge of that soldier.

Over the past decade, the marked reduction of the CF population combined with a significant increase in operational tempo has highlighted the need for an operationally ready, combat capable military force that depends on a steady supply of fit and healthy soldiers.[20] As a result, soldiers who were previously cared for by and within the CF health care system are now released if they cannot be returned to health within two years to fit this operational mould. Numerous reviews conducted between 1997 and 2002 re-established the obligation

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[20] Role of the CF H Svcs as a force enabler. For additional information, the reader may consult the CF H Svcs Internet Website at: *http://www.forces.gc.ca/health/about_us/engraph/role_resp_e.asp?Lev1=5&Lev2=2&Lev3=1* . Website accessed 7 April 2005.

for the CF to care for soldiers throughout their career without distinction between in-garrison and deployed health care. Thus, the prescribed reform: Project RX 2000.

RX 2000 - A BALANCING ACT

Will RX 2000 truly resolve the CFHS credibility and trust issues? Will it enable the CFHS to achieve its mission? The short answer to both questions is undoubtedly 'YES'! Several RX 2000 initiatives have been implemented since 2000 and they have all proven their effectiveness. RX 2000 initiatives are grouped under four pillars—each pillar corresponding to one of the four reform objectives—as shown in Table 1.[21]

The continuity of care pillar regroups the initiatives that ensure serving members benefit from equal access and standardized health care, anytime, anywhere in Canada and abroad. In fact, measures are already in place to protect patient confidentiality and to set universal standards of practice across the CF. This pillar also re-centres the pendulum between the operational and the clinical or in-garrison focus by harmonizing clinical and operational excellence. Upon completion of the reform, health care will be delivered in garrison by a permanent core of civilian health care providers forming part of the multidisciplinary team, and on operations by military health care providers forming the other part of the multidisciplinary team. These initiatives will finally guarantee that military members are taken care of throughout their career, from enrolment to their retirement from

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[21] All information concerning the RX 2000 Integrated health care reform objectives and initiatives was taken from the CF H Svcs Internet Website About us" section accessed 7 April 2005 at: http://www.forces.gc.ca/health/about_us/engraph/rx2000_e.asp?Lev1=5&Lev2=2&Lev3=6 . It is to be noted however that CF H Svcs senior officers consider this information as general knowledge.

military service, including the transition of their care to the civilian health care sector.[22] Achieving the objective underpinning this pillar will certainly improve access, standardization, continuity of care, and continuum of care. Consequently, these initiatives should engender trust in the military health care system.

Table 1 - *Rx 2000* Integrated Pillars and Initiatives

359 Recommendations			
***Rx2000* 4 pillars**			
Continuity of Care[23]	**Accountability Framework**[24]	**Health Protection**[25]	**Sustainability of CFHS Human Resources**[26]
Case Manager Primary Care Renewal Initiative Standing Committee on Operational Medicine Review Pre Hospital Care Third Party Contract Material Management Mental Health Physiotherapy	Accreditation – Continuous quality Improvement Command & Control Health Policy Performance Management Modern Management Review	Force Health Protection	Health Services Reserves Human Resources Capability Enhancement Civilian – Military Cooperation [CIMIC]

Source:

http://www.forces.gc.ca/health/news_pubs/rx2000/engraph/HCReform_article02_e.asp?Lev1=4&Lev2=6&Lev3=3

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[22] CF H Svcs Internet Website '*About us*' section accessed 7 April 2005 at: *http://www.forces.gc.ca/health/about_us/Engraph/continuity_e.asp* .

[23] This objective reads: "Building a health care deli very structure that will ensure continuity of health care to CF members and other entitled personnel."

[24] This objective reads: "Implementing an accountability framework for the renewed CF health care system as a single corporate entity under the leadership of the Director General Health Services."

[25] This objective reads: "Establishing programs for the mitigation of preventable injuries and illnesses." thereby protecting CF members and meeting requirements of DND/CF operations.

[26] This objective reads: "Developing a human resources network to ensure sustainability of the CF health services"

The Health protection pillar provides a new capability to the CF especially for deployed operations. Not limited to health promotion programs and communicable disease prevention and control anymore, this pillar integrates two new capabilities—health threat assessment and epidemiology—both based on sound research methodology. This pillar further formalizes the initiatives related to military-specific or operation-specific occupational and environmental medicine. "Striving to minimize health hazards while preventing diseases and illnesses, and maintaining the fighting capability of the force"[27] will help to rebuild CFHS credibility as a force enabler and consequently the corporate trust in its military health care system.

The last two pillars complement each other. First, the health care accountability framework has put in place all the checks and balances to ensure that the care being delivered is in fact what is required and indeed corresponds to widely recognized standards of health care. For example, the accreditation process through the Canadian Council of Health Services Accreditation will ensure that the care provided, in CFHS C across the country, meets Canadian standards—amongst the highest in the world. Similarly, a Modern Management Review conducted by the Canadian College of Health Service Executives[28] provided the basis for the development of a management structure and accountability framework for in-garrison care that combines central control and policy making with a decentralized application. This will ensure that personnel are empowered to make decisions

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[27] CF H Svcs Internet Website 'About us' section accessed 7 April 2005: *http://www.forces.gc.ca/health/about_us/engraph/rx2000_e.asp?Lev1=5&Lev2=2&Lev3=6* .

[28] As a result of this review, the CHE qualification is now a prerequisite for selection as CO of a CF H Svcs Centre (military clinic). To date, ninety-five officers within CF H Svcs are currently members in good standing of the Canadian Council of Health Service Executives (CCHSE); with 80 per cent of them having also achieved the Canadian Health Executive (CHE) certification, thus indicating through Maintenance of Competence, a continuous commitment towards lifelong learning.

within their sphere of authority. Another initiative relates to command and control centralization. The unification of all health services resources and personnel into a single chain of command under the leadership of the Director General Health Services (DG H Svcs) clearly improved accountability and mission effectiveness. Indeed, as proven over the past two years, centralization guarantees the most effective and efficient use of these resources to promote health and deliver quality care to the CF anytime, anywhere.

Finally, with all CFHS military and civilian personnel united under a single chain of command, building the necessary human resources networks will be much easier. This includes, for example, developing the right partnerships with the civilian health care sector and professional communities (national and provincial Associations and Colleges); or improving military health care providers access to broader clinical experiences through University hospitals and institutions across Canada.

Various RX 2000 initiatives were presented here, albeit a small sampling. In essence, every RX 2000 initiative constitutes a piece of the puzzle that delineates the reformed CFHS organization. At end-state, Canadian military health services will undoubtedly be world-class, credible and trustworthy. As a result, CF members and the chain of command will, as per the CFHS motto, both feel understood and cared for anytime, anywhere. Both clients will trust the CFHS because they will know that they will receive the best health services possible. Success, however, remains contingent upon the leadership.

THE KEY PLAYERS

Successful and long-lasting implementation of RX 2000 reform and particularly of the Primary Care Renewal Initiative (PCRI) depends on the willingness and ability of leaders throughout the organization to communicate clearly and constructively the benefits of the different initiatives being implemented. The CF effectiveness framework[29] suggests that the final implementation and application of the remaining initiatives at the coal face that will durably modify the perceived effectiveness of the military health care system and ultimately establishment of a solid reputation, trust, confidence and system-wide support. With the CF and CFHS executive cadre having correctly set the required conditions to achieve reform success. it is arguably, the unit-level Commanding Officer (CO) who currently holds the most crucial responsibility in this regards.

FROM LEADING THE INSTITUTION . . .

Since her nomination in January 2001, the Director General Health Services (DG H Svcs) led the transformation of the organisation. Beyond the prescription for change, the process of change itself was not a coerced endeavour; rather, it was a multi-level collaborative process appropriately conducted in accordance with Change Cycle Theory[30]. In fact, equitable representation from every stratum, occupation, and element under scrutiny were involved in the reform planning and implementation process. DG H Svcs gradually yet drastically reshaped the organizational culture by initially imparting the CFHS senior and

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[29] Department of National Defence, A-PA-005-000/AP-004, *Leadership in the Canadian Forces: Doctrine*, (Ottawa: CFLI, 2005), 3.

[30] Wenek, K. *Defining effective leadership in the Canadian Forces: A Content and Process Framework*. (CFLI Discussion Paper). (Kingston, ON: Canadian Forces Leadership Institute, 2003b), 70-84.

intermediate cadre with change-enabling learning experiences, which included reality-checks, cultural and climate awareness, and self-awareness initiatives designed to challenge their leadership acumen, practices and influence. After establishing a common understanding of the CFHS mission and tasks, she shepherded the whole organization in the development and adoption of an harmonizing, yet challenging vision that clarified behavioural expectations, and united the CFHS dual lines of responsibilities. She concurrently negotiated and secured commitments and loyalties first from the CF Executive cadre and the CFHS senior leadership, then gradually expanding the circle of influence to CFHS unit-level leaders (officers and non-commissioned members (NCMs).

Through her vision, guidance and personal actions, DG H Svcs set the right conditions for successful implementation of the reform. She rebuilt pride, motivation and trust across the organization. Throughout the health services' chain of command, the behaviours and collaborative attitudes expected in a learning organization are beginning to emerge. By espousing a values-based philosophy and promoting evidence-based standards of practice, she provided CFHS members with a set of principles that forms the basis of a credible military health care system. The CFHS' culture will continue to evolve, and albeit solid, the cultural foundations still require nurturing. With the completion of all reform initiatives not expected until 2010, maintaining momentum to the end will be crucial to reform success. At the executive and senior levels, leaders are clearly on board and indicate in their daily work that they 'walk the talk'. The institution is truly led in the right direction.

Another level of players that have a key role in the reform implementation is the CFHS Centre health care team. They are critical to the change process, since they deal

directly with the clientele and many stakeholders. However, it is the Commanding Officer upon whom success of the reform rests.

. . . TO LEADING PEOPLE

Under the varied RX 2000 initiatives, CFHS health care providers incur a number of moral and professional obligations in delivering quality health care to individuals. Indeed, every civilian and military health care provider employed or contracted by the CFHS has the obligation to "listen to what individual military members have to say concerning their health; to involve them in the process of prevention, diagnosis, and treatment, and finally, to provide them with high quality, evidence-based diagnosis, advice, and treatment."[31] Yet, they must always ensure that their actions and treatments optimise the return to duty of individual soldiers to the best extent possible.[32] They must also communicate clearly their clients' prognosis, limitations, and return to work conditions in a timely manner to the chain of command without breaching 'client-provider confidentiality'. Finally, all CFHS providers are under the obligation to collaborate with each other as members of the multidisciplinary team. It is expected that each member of the health care team will abide by these standards and obligations. Moreover, there are tools and processes such as the Performance Development and Appraisal System to ensure that the expectations are clearly communicated.

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[31] These obligations are the commitment made to military members by the Surg Gen in the information brief to CF Members and which can be viewed on the CF H Svcs website at *http://www.forces.gc.ca/health/information/engraph/hs_briefing_home_e.asp#1*, Accessed 7 April 2005.

[32] Department of National Defence. B-GL-300-004/FP-001 *Land Force Sustainment*. (Ottawa: DND Canada), 1999.

Although not directly involved in the provision of health care, every CFHS C CO must in turn, foster and generate optimum synergy and cohesiveness from their health care team in order to effectively fulfil their mission. This requires that the CO understands each team member's role, responsibilities, professional and ethical obligations, professional and personal capacities, contractual arrangements or collective agreements, and the level of supervision or guidance they need. This is a daunting challenge, since CFHS members are not only bound by CF policies and regulations, but also by external, civilian regulatory bodies.

The CO must also understand the role, responsibilities, concerns, obligations, and needs of the 'operators' and their chain of command in order to generate in his team the proper degree of responsiveness and collaboration the supported units and formations will rightly expect. This is even more crucial during this acclimatization period under a new command and control relationship. Similarly, during the implementation phase of the new primary care model (PCRI), the perceptions, concerns and needs of the clientele must be closely monitored and addressed so as to ensure that CFHS mission, vision, values, commitment are congruent with the quality of service the clientele actually receives.

Delivering quality and evidence-based health care to the CF further implies the need to maintain very close ties with the civilian health care community at large. Close relationships must be fostered with local civilian health care providers and establishments that would be contracted, either to provide health services not available within CFHS resources or, to allow military health care providers to conduct maintenance of competence activities in a broader clinical setting. Ties must also be fostered with national and provincial professional Colleges and Associations as they control the professional practices

of both military and civilian health care providers working within CFHS units. Similar relationships must be established and nurtured with numerous and diverse academic institutions as well as regulatory bodies, as they are instrumental in providing specific aspects of training, or in certifying the quality of health care provided to CF members. Although established at the national and provincial level by members of the Civil Military Cooperation (CIMIC) cell, COs play a key role in maintaining such relationships at the local level. Juggling these competing obligations and relationships with such a variety of stakeholders requires a broad behaviour repertoire as each of the stakeholders have a unique set of requirements to which the CO must cater in order to nurture the necessary partnerships.

Although the complexity of the CF H Svcs environment and the multi-faceted role of the CO have been clearly established, can the CO truly be the lynchpin to reform success?

THE LYNCHPIN

Following extensive contracted work including systematic literature reviews and discussion papers by renowned Canadian Academics,[33] the Canadian Forces Leadership Institute (CFLI) published in April 2005 two capstone manuals on leadership—Leadership Doctrine[34] and Conceptual Foundations.[35] Effective leadership in the CF is defined as:

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[33] Information regarding the CFLI, its mission, role and research/discussion papers may be found at the CFLI Website: *http://www.cda.forces.gc.ca/CFLI/engraph/about/mandate_e.asp* , accessed 7 April 2005.

[34] This manual provides "an authoritative guide to leadership training, education, and practice throughout the CF." Department of National Defence, A-PA-005-000/AP-004, *Leadership in the Canadian Forces: Doctrine*, (Ottawa: CFLI, 2005).

> Directing, motivating, and enabling others to accomplish the mission professionally and ethically, while developing or improving capabilities that contribute to mission success. Effective CF leaders get the job done, look after their people, think and act in terms of the larger team, anticipate and adapt to change, and exemplify the military ethos in all they do.[36]

A leadership framework has been adopted; expected responsibilities and requirements of leaders at the different hierarchical levels have been identified and explained in relation to the focus of effective leadership in a CF context. This resulted in the clear articulation of a CF effectiveness framework[37] and a continuum of leadership from leading people at the tactical level[38] to leading the institution at the strategic level.[39]

Further academic discussions, reviews and research are being conducted in order to identify which leader's elements, attributes, and competencies would be required in CF human resources processes including selection, development, assessment, and promotion.[40] To this effect, Walker (2004) proposed a CF Leader Framework, that identifies five leader elements and sixteen supporting leader attributes, required to achieve effective leadership in the CF. [41] Okros (2004) discussed and confirmed the applicability of this CF Leader Framework although competency profiling remain to be defined. Okros further suggested

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[35] "This manual provides an extended discussion of the theories and ideas underpinning the doctrinal manual." Department of National Defence, A-PA-005-000/AP-004, *Leadership in the Canadian Forces: Conceptual Foundations*, (Ottawa: CFLI, 2005).

[36] Introduction to capstone manual: Department of National Defence, A-PA-005-000/AP-004, *Leadership in the Canadian Forces: Conceptual Foundations*, (Ottawa: CFLI, 2005).

[37] *DND, A-PA-005-000/AP-004, Leadership in the CF: Conceptual Foundations. . . , 3*

[38] *Ibid*., 75-95.

[39] *Ibid*., 97-118.

[40] R. W. Walker, *Requisite Leader Attributes for the Canadian Forces,* (Kingston: CFLI Draft Discussion Paper, 2004), 1-2.

[41] *Walker, Requisite Leader Attributes. . . , 3-4.*

that "…unit and formation-level leadership teams…represents the most complex challenges in achieving Institutional Effectiveness objective."[42]

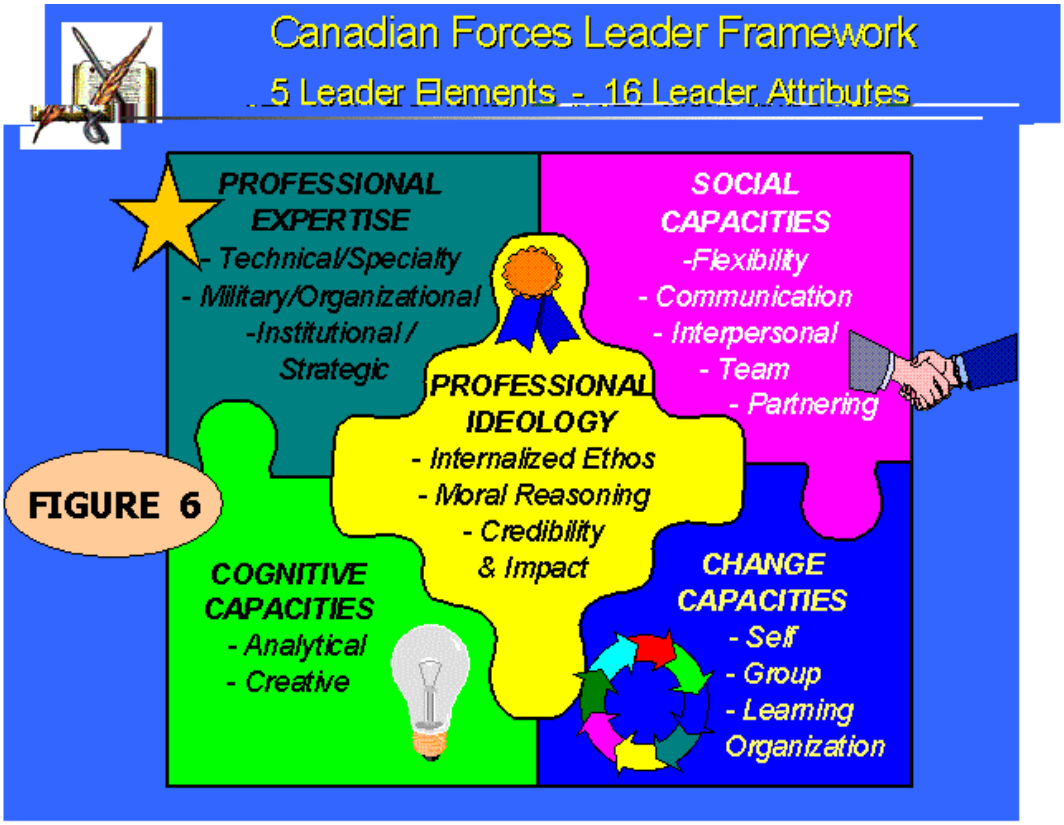

Figure 1 - CF Leader Framework
Source: R. W. Walker, Requisite Leader Attributes for the Canadian Forces, (Kingston: CFLI Draft Discussion Paper, 2004), 22.

Figure 1 represents the "inter-relationship of leader elements … [the visual] interconnectedness and interdependency of leader elements that collectively make effective leadership possible."[43] Professional expertise, cognitive capacities, social capacities, change capacities, and professional ideology are the five broad categories under which the sixteen attributes are regrouped. Some elements, such as professional expertise and part of the

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[42] A.C Okros, *Applying the CFLI Leader Framework*. (CFLI Discussion Paper Kingston, ON: Canadian Forces Leadership Institute, 2004), 6.

[43] *Walker, Requisite Leader Attributes. . . , 17.*

cognitive capacities are developed through knowledge acquisition and experience as individuals move in rank and change position. Other elements, such as cognitive capacities, social capacities, change capacities, and professional ideology are learned through socialization and experience but mostly through self-development with self-awareness the main driver for learning to take place.[44] may need to be operating at the intermediate or advanced levels in certain domains)."[45]

As discussed by Wenek (2003b)[46], Walker (2004)[47], and Okros (2004)[48], achieving self-efficacy takes time and is a self-driven endeavour. By adulthood, every individual has developed certain personality traits, as well as personal and social capacities such as communication, preferred thinking style, likes and dislikes, and an array of response behaviours. Depending on "life and work experiences, education, maturity, etc." [49]some of these capacities are better developed. As such, the requirements for attribute development will vary between individuals. [50]

It is through the socialization process—first within the larger CF community, then within CFHS health care team—that expected values and behaviours are learned. Furthermore, it is widely accepted that with each rank level the position requirements and professional/personal capacities become more complex and demanding. As such, proper

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[44] Ibid., 23-27. The CF leader elements and corresponding attributes, as well as the acquisition process and requirements for each are discussed in detail throughout Walker's paper.

[45] *Okros*, *Applying the CFLI Leader Framework. . . , 6.*

[46] *Wenek (2003b), Defining effective leadership in the Canadian Forces. . .,66.*

[47] *Walker, Requisite Leader Attributes. . . , 17.*

[48] *Okros*, *Applying the CFLI Leader Framework. . . , 6-10.*

[49] Ibid.

[50] Ibid.

synchronization of the acquisition of the requisite skills and capacities is essential to optimise institutional effectiveness. Hence, these skills and capacities must be demonstrated *before* the incumbent is placed in a key leadership role. This is especially true of commanding officers since

> …[they] have a stronger role to play in reinforcing professional values and in ensuring compliance with professional norms of behaviour. Moreover, because professional acculturation is a relatively slow process, unit level leaders also have to

Finally, building on the CF Effectiveness Framework at figure 2, Wenek (2003b) suggests that:

> "… the effectiveness of CF leaderhip should be assessed with reference to [five] principles: [the fourth one being]—Effective leaders understand the broad dimension of CF effectiveness, the interrelationships among these dimensions, and their specific responsibilities related to each dimension; they endeavour, through direct and indirect influence processes and by discharging their responsibilities competently and with integrity, to contribute to mission success, the well-being and commitment of members, internal stability and cohesion (internal integration), and the continuous improvement of CF capabilities (external adaptability)."[52]

Unit-level COs are part of the greater CFHS community and do not lead in isolation. However, the manner in which they lead their diversely professional health care teams, nurture the required partnerships, and generate synergy and cohesiveness to achieve their mission, will ultimately influence the reform success and will greatly impact the perceive effectiveness of the CFHS as a military health care system. To be effective as COs, they must have developed strong change capacities, social capacities, and professional ideology attributes. Self-efficacy being the prerequisite for learning and integration of most attributes of these leader elements, achieving the right degree of self-efficacy becomes the single point of failure of COs' effectiveness as leaders. Thus the CFHS unit-level CO is deemed to be the lynchpin to RX 2000 reform success. In playing such a pivotal role, it becomes obvious that they must be carefully groomed before being selected for command.

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[52] *Wenek (2003b), Defining effective leadership in the Canadian Forces. . .*, 94.

CONCLUSION

CFHS COs definitely lead diverse and highly professional health care teams. The CFHS environment has evolved dramatically over the past decade and will undoubtedly continue to evolve while its complexity is clearly established. The ongoing implementation of the prescribed RX 2000 reform and varied initiatives imposes even greater demands on COs who, in order to effectively command their unit, must understand their role and responsibilities as 'captain' of their all-star team—the unit-level multidisciplinary health care team. With all the required conditions being set at the strategic level, individual COs' effectiveness and that of their team, depends primarily on the degree of self-efficacy COs acquired before their selection for command. A greater degree of self-efficacy facilitates the development of most change capacities, social capacities, and professional ideology attributes, which are so fundamental in achieving mission success. Hence, because of their multi-faceted role, the complex environment in which they lead, the impact their multidisciplinary team have at the coal face on the reputation of CF H Svcs as an effective military health care system, CFHS unit-level COs are the lynchpin to reform success. The CFHS unit CO truly plays a pivotal role in the reform—one for which they must be carefully groomed.

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