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MASTER OF DEFENCE STUDIES RESEARCH PAPER

Canadian Forces Casualty Support: The need to re-open the military hospital

By /par Major Peter K. Scott

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ABSTRACT

The Canadian Forces' soldier is one of Canada's greatest assets. It is paramount that soldiers be properly cared for when they fall ill or when wounded in combat. Since the closure of the Canadian Forces' (CF) dedicated military hospitals in the 1990s there have been many instances of soldiers crying foul over the level of care and treatment that they have received under the public health care system. The Department of National Defence (DND) has recognized that issues in care delivery do exist and is attempting to streamline the casualty management process. However, through all of the Department's reviews, working groups and studies, it has failed to see that the root cause of the majority of the expressed problems is that there is too strong a reliance on civilian hospitals to take care of the soldier. There is a lack of a coordinated and centralized approach to casualty management, no standardization of care across the country, a reliance on civilian doctors who do not understand the needs of the soldier, soldiers that are isolated from the rest of the military environment and an overall reliance on medical and rehabilitation centres that do not meet the needs of the soldier.

This paper argues that in order to provide a suitable level of care for our sick and wounded soldiers, there is a need to re-open our military hospital system. By centralizing Canada's ability to provide care and rehabilitation, DND will be able to have a coherent, effective and efficient manner to treat our sick and wounded in an environment which is comfortable for them. A single structured approach to casualty care will meet all of the needs of the wounded soldier from surgery, to convalescence, to rehabilitation, to administration. The military hospital can and should become the centre of excellence for casualty support.

INTRODUCTION

The level of importance the government places on the Afghanistan mission is brought home to our living rooms on a daily basis as Canadian policy makers debate the future roles and tasks that the country will take in restoring peace and security to the troubled country. The inherent danger of the mission is made abundantly clear, as the media often highlight the deaths of Canadian soldiers in combat. At the time of writing, Canada has lost over 80 soldiers and one diplomat since the mission first started in 2002, with at least 65 of the deaths directly attributed to combat or improvised explosive devices.[1]

In all of the reporting on this conflict, one crucial aspect of Canada's mounting casualties is often overlooked, or rather, is hidden from the public eye. On top of the dozens of lives that have been lost, there are hundreds of wounded soldiers whose lives have been forever changed. It is not commonly known that there are a great number of soldiers who have been repatriated for medical treatment due to injuries sustained in combat and non-combat situations. There has been little public analysis or understanding of the conditions they face when they reach national medical treatment facilities.

In the early to mid 1990s the Canadian Forces (CF) decided, with good reason at the time, to close down its dedicated military hospitals across the country. The last remaining bastion of dedicated care is the National Defence Medical Centre (NDMC) in Ottawa, which has seen its role reduced to that of a simple medical clinic and will soon

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[1]Canadian Broadcasting Corporation, "In the line of duty: Canada's casualties," http://www.cbc.ca/news/background/afghanistan/casualties/total.html; Internet; accessed 17 March 2008.

cease to provide any medical care with the opening of a new military patient wing inside the Montfort Hospital in Ottawa.[2] Today, returning wounded soldiers, as well as military members injured or ill here in Canada, receive the majority of their treatment, with the exception of daily clinical care, through the publicly funded provincial health care systems. The Department of National Defence (DND) in turn repays the provinces for their services rendered. The Chief of Military Personnel informed the Veterans Affairs subcommittee in November 2006 that "the Canadian Forces leadership has a strong legal and moral obligation to provide comprehensive dental and medical services to members of the Canadian Forces whenever and wherever they serve. This mandate is based in part on the 1984 Canada Health Act, which specifically excludes Canadian Forces members from the definition of 'insured persons'"[3]

Since the closure of the CF dedicated hospitals, there have been instances of soldiers expressing disappointment over the level of care and treatment that they have received through the civilian system. In the 1997 *Care of Injured Personnel and Their Families Review* 50% of the respondents indicated that the medical system was not responsive to their needs.[4] In the 1999 Chief of Review Services report, 68% of the soldiers that were interviewed responded that civilian physicians did not have a sufficient understanding of the military work environment in order to prescribe appropriate

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[2]Colonel R.F. Pucci, *Briefing Note for Minister of National Defence – Montfort Hospital Project* (Director Health Services Delivery), 16 January 2008.

[3]Proceedings of the Subcommittee on Veterans Affairs, "Issue 2 – Evidence – Meeting of November 22, 2006," http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/vete-e/02eva-e.htm?Language=E&Parl=39&Ses=1&comm_id=79 ; Internet; accessed 15 January 2008.

[4]Department of National Defence, "Care of Injured Personnel and their Families Review – Introduction," http://www.forces.gc.ca/site/minister/eng/Injury/Intro_e.htm; Internet; accessed 23 November 2007.

treatment and rehabilitation.[5] In 2002, Statistics Canada found that 75% of respondents who reported symptoms of mental health or other similar disorders were not receiving sufficient help from the civilian health care system.[6] Today, DND is fully aware that the current approach to casualty care also has its problems; a recent national level symposium attended by hundreds of military and civilian members of DND attempted to find solutions to an increasing level of dissatisfaction amongst mentally and physically wounded soldiers who are placed into the civilian health care system.[7]

Public support for the men and women of the CF has clearly risen within the last half decade. A joint CBC/Environics survey conducted in November 2006 concluded that 87% of the Canadian population supports the military.[8] In February 2008, the Chief of the Defence Staff, General Rick Hillier, affirmed this notion stating that "Canadians have woken up to the men and women in uniform. Everything we do is with the support of Canadians. We have the support from the Prime Minister, the cabinet and most importantly from all Canadians. We now have to make sure that we look after our people in the correct manner."[9] It is this last statement by the Chief of the Defence Staff that needs to be further examined.

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[5]Department of National Defence, *Chief Review Services – Review of Medical Service October 1999* (Ottawa: National Defence, 1999), D-25/28.

[6]Office of the Auditor General, "2007 Report of the Auditor General of Canada," http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_2007_4_e_23828.html

The current reliance on the public health care system to treat Canada's wounded and sick soldiers is the root cause of several problems. Wounded soldiers now encounter civilian doctors that cannot relate to their experiences and very often have never been exposed to their types of injuries. Secondly, the soldiers are suddenly removed from their comfortable military environment and are usually interspersed amongst the civilian population of the hospital. They are therefore, no longer surrounded by their support network of fellow soldiers who understand what they have been through. Furthermore, using civilian hospitals has translated into a lack of a coordinated and centralized approach to casualty management. Moreover, there is no standard level of care across the country in the civilian hospitals. In addition, soldiers are encountering civilian medical facilities and rehabilitation centres that do not meet their needs. Finally, the CF is relying on an already fragile public health care system that is struggling to meet the needs of the civilian population. If Canada is willing to send soldiers into dangerous situations, the country should inform them that they will receive the best care possible. Currently, our reliance on the public health care system does not provide our soldiers with the optimum level of care.

This paper will argue that in order to provide a suitable level of care for our sick and injured soldiers, there is a need to re-open our military hospitals. By centralizing our ability to provide care and rehabilitation, the Department of National Defence will be able to have a coherent, effective and efficient manner to treat our sick and wounded in an environment that is comfortable for them. A single structured approach to casualty care will meet all of the needs of the wounded soldier from medical surgery, to

convalescence, rehabilitation and administration. The military hospital will become the centre of excellence for casualty support.

The paper begins with an examination of the historical aspect of casualty care. It will delve briefly into how civilizations elevated the importance of the soldier to society and how the state provided a dedicated separate medical support system to take care of the wounded.

The second chapter will investigate the history of the Canadian approach to casualty care from the North West Rebellion to the 1990s and how Canada came to establish our military hospitals across the country. The paper will then turn to the decision to close the military hospitals. This section will provide a look into the reaction of the Auditor General's Report of 1990 and will also outline the plans that were implemented to improve the military health care system.

The paper will then consider how casualty support is conducted today. This section will highlight the use of civilian hospitals for medical care and it will delve into the decentralized approach that is currently being taken to care for and rehabilitate our wounded soldiers across the country. It will outline the systemic and human issues that have arisen since Canada began relying on the public health care system. It will also discuss the plans and studies that have been undertaken by the Department of National Defence to try to improve casualty care.

The last chapter of the paper will draw on the previous chapters and will outline why we need to re-open the military hospital system in order to properly care for our wounded soldiers. It begins with an examination of what exactly an internal medical capability does for a fighting force. It will first cite some practical reasons for

maintaining a military health care system and then describe the legal and moral obligations for a separate medical system for military members. It will demonstrate the need for a centralized approach to casualty care through the establishment of a centre of excellence that incorporates casualty administration, dedicated medical and rehabilitation support for the soldier. This section will further argue the need to place soldiers in the care of military physicians in a military surrounding. Finally, it will present some further options that DND may pursue once a military hospital system has been reintroduced.

Canada has been involved in numerous conflicts around the world. Throughout these battles, thousands of men and women have been inflicted with wounds that have required dedicated medical care in order to fully rehabilitate them. Having a dedicated military health care system will tell soldiers that the country cares for their well-being and is willing to elevate their medical needs to a separate level of care. If Canada is going to continue to send its soldiers into harm's way, then the country must be prepared to support them medically with the resurrection of a dedicated Canadian military hospital system.

CHAPTER ONE - A BRIEF HISTORY OF CASUALTY SUPPORT

The first recorded evidence of military hospitals and physicians dates back to almost 2400 B.C. Gabriel and Metz's research in *A History of Military Medicine: From Ancient Times to the Middle Ages* indicates that the Sumerians were the first to develop military physicians whose task was to take care of the injured soldier. They deduced that the military garrisons of the time were known to have dedicated health care in times of war. Military physicians were likely posted to military bases and might have actually been full-time servants of the military rather than simply "contracted for" during conflict.[10]

By the time of the Roman Empire, the importance of the soldier's role in society had emerged. In *From Sumer to Rome*, Gabriel and Metz explain that the "Roman soldier received good housing, excellent and varied food, clean water, and good preventive medical care. It was not accidental that despite the risk of death or injury in war, the average Roman soldier lived longer than the average Roman citizen."[11] Soldiers were thus elevated above the rest of the society to the point of receiving the best possible attention from the state. Roman commanders clearly understood that if soldiers were not properly cared for, they would not be able to fight effectively in combat. The care of the soldier was even recognized as a civic duty, and armies would bring their wounded with them in order to find a suitable house or legion garrison in which to leave them.[12]

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[10]Richard Gabriel and Karen Metz, *A History of Military Medicine: From Ancient Times to the Middle Ages* (Westport: Greenwood Press, 1992), 56.

[11]Richard Gabriel and Karen Metz, *From Sumer to Rome: The Military Capabilities of Ancient Armies* (Westport: Greenwood Press, 1991), 140.

There are a few examples of early benefits being given to veterans of the state throughout history. Alexander the Great is known to have provided a daily pension to those disabled through acts of war, as well as special privileges to the families of the fallen. We also know that the Romans established colonies for wounded veterans, where they were not required to pay certain state taxes. The first evidence of long term medical care for soldiers can also be seen in the Roman Empire, where severely wounded soldiers were provided for by a joint medical system run by the state and the church.[13] Here, wounded soldiers could finally look forward to an acceptable level of care for the rest of their lives.

By the seventeenth century we begin to see the surfacing of a moral obligation to care for the soldier. As soldiers were constantly being asked to serve in wars of national identity, governments realized that they had to take care of the sick and wounded as a moral obligation of the duties they were asking the soldiers to undertake.[14] Under the great leaders of France throughout the 1600s, we see the creation of financial pension systems for the sick and disabled soldiers, the creation of a veteran's hospital, and a housing allocation for widows and children of soldiers killed in action. This manner and level of care for the soldier also found its way into England, where relief houses were founded for the sick and wounded and government pensions were issued. By the end of Louis XIV's reign in France, we finally see the construction of permanent military

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[12]Gabriel, *A History of Military Medicine: From Ancient Times…*, 162.

[13]*Ibid*., 194.

[14]Richard Gabriel and Karen Metz, *A History of Military Medicine: From the Renaissance through Modern Times* (Westport: Greenwood Press, 1992), 88.

hospitals to care for the wounded soldiers. French engineers planned and provided space and buildings for military hospitals in all towns that had military fortifications.[15]

John Laffin, the author of *Combat Surgeons*, cites an example in 1792 France where pre-knowledge of good casualty care had a positive effect on soldiers. He describes the introduction of a new method of casualty evacuation from the field that would greatly increase the likelihood of the soldier's survival. According to Laffin, "this institution created a sensation among the soldiers, and they now felt confident that they would receive succour at whatever moment they might be wounded."[16]

In the mid 1800s, Queen Victoria took on a personal role in ensuring that the wounded and sick soldiers were properly cared for. She is known to have frequently inspected the military hospitals to ensure that they were of adequate standard. She stressed the importance and urgency required to build extra dedicated military hospitals as there was an increasing strong sense of support from the public to look after the well-being and comfort of soldiers.[17] Nearing the end of the 19th century, almost every major army of the world had some sort of casualty care system in place that was capable of treating wounded soldiers effectively. Although it was not perfect by any stretch, average soldiers realized that their government supported their efforts and had a strong sense of comfort in knowing that they would be taken care of in a proper military hospital system.

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[15]*Ibid*., 90.

[16]John Laffin, *Combat Surgeons* (Gloucestershire: Sutton Publishing, 1999), 61.

[17]*Ibid*., 129.

Providing care for wounded soldiers has greatly evolved throughout history. Each society realized the importance in providing medical support to the sick and wounded and how this dedicated level of care would contribute to their success. In the next chapter we will see how Canada has provided support to its wounded and sick soldiers by examining key examples from the North West Rebellion, the Boer War, the First World War, Korean War and throughout the Cold War. Further, this next section will briefly touch on the evolution of the Canadian Military hospital system and delve into the reasons behind its closure.

CHAPTER TWO – A BRIEF HISTORY OF CANADIAN CASUALTY SUPPORT AND THE MILITARY HOSPITAL

Since Confederation, Canadians have participated in numerous conflicts, including the North West Rebellion, the two world wars, the Korean War and the current mission in Afghanistan. As Canada has incurred casualties in battle, it has taken a variety of approaches to care for its wounded soldiers, from the use of coalition hospitals abroad, to integral military hospitals at home, to the current use and reliance on the public health care system.

The Northwest Rebellion provides the first example where Canada provided dedicated support to its wounded soldiers. Soon after Confederation the Federal Government developed a militia force with a supporting medical service. This new militia replaced the existing British garrisons across the country. In 1885, an insurgency broke out in Canada's Northwest Territory, and the government responded with a full field force expedition to quell the uprising. In addition to the fighting force, two field hospitals were mobilized and were predominantly staffed by civilian doctors and nurses.[18] At the conclusion of the battle to end the rebellion, the chief of medical staff established the first recorded Canadian military hospital. The hospital was erected near Batoche and was again manned by civilian doctors and nurses, but it was dedicated to treating the sick and wounded soldiers from both sides of the conflict.[19]

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[18] Department of National Defence, *Canadian Forces Medical Services: Introduction to its History and Heritage* (Ottawa: Director General Health Services, 2003), 4.

[19] *Ibid*.

The first step towards a centralized approach to casualty care was evident during the Boer War. Canada joined Britain in the campaign against the Boers in 1899 and formed its first permanent medical service called the Army Medical Department.[20] The medical officers and nurses that deployed with the contingent were at first not employed in their own Canadian hospital, but rather took positions alongside the British medical staff in British hospitals. The end of the conflict saw a steady rise of casualties, primarily due to poor hygiene and disease. With the rise in Canadian casualties, the first Canadian field hospital was deployed to South Africa. Here, Canadian soldiers received dedicated care and treatment from their own doctors and nurses. The staff of the hospital provided around the clock case management and dedicated casualty care.[21]

Although the Boer War, like the Northwest Rebellion, provides the first use of hospitals to care for Canada's wounded, neither case provides much insight into how the soldiers were treated upon their repatriation. For the most part, throughout the early conflicts, soldiers remained in the hospitals closer to the conflicts until they were healthy enough to return to normal life on their own. It was not until the 20th century that we began to see large numbers of soldiers being sent home to Canada for continuous care.

The First World War was the first real test of the nation to provide large contingents of fighting troops along with an adequate medical system to support them. Numerous aide stations, medical clearing stations, field hospitals and stationary hospitals were in use throughout the conflict by both British and Canadian forces. There are two main issues that arose throughout the conflict which still permeate in today's age of

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[20]*Ibid*.

[21]*Ibid*., 5.

Canadian casualty care. First, Canadian soldiers were initially not treated by their own medical personnel. Secondly, upon the creation of military hospitals in Canada to treat the wounded soldiers, there was an outcry when civilian practitioners were employed.

The first issue relates to the shock and bewilderment that were rampant when it was discovered that Canadian soldiers were not being treated by their own medical staff. At the outbreak of war, the best of the medical profession were recruited and trained at Valcartier, Quebec prior to their deployment overseas. Upon arrival in England and France, many were dispersed to varying locations and in many cases treated British soldiers vice Canadian. This caused an uproar. As noted by Andrew Macphail, the author of the *Official History of the Canadian Forces in The Great War 1914-19: The Medical Services*, "the situation was beyond comprehension, and caused a shock of bewilderment in the Canadian mind."[22] Macphail also describes the importance of a military medical component for an armed force:

> An army is like a living being in that it is composed of many organs which must do their specific work; and if one fails, all fail. The army is a complicated concern, and the medical service is the most complicated part, since it operates from the front line to the remotest base, and follows the soldiers into civil life again.[23]

The government responded to this issue and dispatched an inspector general to look into the care of the soldier: "He found Canadian soldiers 'asking and begging' to be removed from English hospitals; medical officers 'complaining;' 'errors of diagnosis and treatment;' [and] 'unnecessary surgery.'"[24] The inspector general, Col Herbert A. Bruce,

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[22]Andrew Macphail, *Official History of the Canadian Forces in the Great War 1914-19: The Medical Services* (Ottawa: F.A. Ackland, 1925), 170.

[23]*Ibid*., 171.

[24]*Ibid*., 174.

felt that Canadian soldiers would be better served if they were placed in Canadian hospitals under the care of Canadian military doctors with whom they would have something more in common.[25] The medical corps desperately wanted the soldiers to receive their care in Canadian facilities. They believed that the Canadian standard of care should continue with the soldier, even into the general military hospitals of the United Kingdom.[26] In the end, the government decided that despite what the medical field was advocating, Canadian soldiers would continue to receive treatment by British doctors and vice versa.

As an exception to Macphail's research, George Adami, the author of *War Story of the Canadian Army Medical Corps 1914-15,* provides us with a separate point of view during the Great War. He tells us that Canadian soldiers were in fact receiving good care from Canadian medical staff in Canadian convalescent hospitals in Britain: "All Canadian soldiers for convalescence are collected from the outer world into a convalescent hospital manned by the Canadian Army Medical Corps and under Canadian control."[27] Here they would remain and be put through a healthy diet of medical rehabilitation to the point that they could return to join their unit in the field. Regardless of the conflicting research between Macphail and Adami, both authors highlight an excellent example of a centralized approach to casualty care in which the soldiers are surrounded and cared for by military personnel from the moment of their entry into the hospital until their discharge back to combat: one centralized approach for medical

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[25]Herbert A. Bruce, *Politics and the Canadian Army Medical Corps* (Toronto: William Biggs, 1919), 43.

[26] Macphail, *Official History of the Canadian Forces*…, 194.

[27]George Adami, *War Story of the Canadian Army Medical Corps 1914-15*, (Westminster, Rolls House Publishing Co. Ltd., 1918), 96.

treatment and rehabilitation under one roof. This approach could surface again to properly treat our wounded casualties in the Afghan conflict.

The second issue that arose during the First World War deals with the dissatisfaction that arose when civilian practitioners were used to treat wounded soldiers. Back in Canada, in order to deal with the mounting number of casualties returning home for help, a commission was quickly established to find solutions. The commission was authorized full control of the care and treatment of all returning invalids. The operations of the commission established 57 institutions with a bed capacity of 3,980 using a combination of civilian hospital bed spaces, new buildings, and existing military establishments. Military hospitals were constructed in 11 districts from Charlottetown to Victoria and by the end of 1918 had received 10,876 casualties.[28] Here we begin to see the evolution of a Canadian home country casualty care system where the commission was responsible for caring for the sick, providing rehabilitation, artificial limbs and post military job training. Soon, a controversy began because the commission was a civilian authority and therefore the soldiers did not receive care from military staff. Quickly, this was officially recognized, and civilian practitioners were replaced with military officers who had experienced similar circumstances as the soldiers they were treating. The result was that there was greater contentment and discipline amongst the soldier patients "due to the sense of comradeship which is engendered in all ranks by active service."[29] Unfortunately, in many of our cases of wounded returning soldiers today we see that they continue to receive care from civilian practitioners who have not experienced the same

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[28]Macphail, *Official History of the Canadian Forces…*, 317,323.

[29]*Ibid.*, 320.

ordeals as the patients that they are serving and therefore we hear many of the soldiers grumbling over the level of care that they have received.

The Second World War again saw Canada entering into conflict. The three services of the armed forces each had their own separate medical corps which established their own general and convalescent hospitals across the country and in the combat zones to help treat the casualties. Those casualties that were in need of repatriation home did so for the most part by hospital ship and were subsequently placed into a military hospital for longer term care. In 1946 the number of patients in veteran hospitals had doubled to 22,000.[30] Fifteen years later saw the creation of the National Defence Medical Centre in Ottawa where the Department of Veterans Affairs was granted space to directly control, administer and care for patients.[31] Here we see a definitive split between the care for the veteran and the care for the serving soldier. The effect was that Canada was having two different organizations looking after the same thing: the wounded soldier. This model would lead to the surfacing of problems encountered by soldiers in Canada's peacekeeping era of the 1990s.

The Korean War, in general, saw Canadians attain a fairly positive record of looking after the wounded soldiers. Army statistics show that 256 soldiers were killed in action and 1101 more were wounded.[32] The medical treatment of casualties spanned the full spectrum of the conflict, from preventative-medicine programs to the staffing of treatment centres in Japan, where the Canadians were sharing a hospital in Kure with the

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[30]Bill Rawling, *The Myriad Challenges of Peace: Canadian Forces Medical Practitioners Since the Second World War* (Ottawa: Canadian Government Publishing, 2004), 17.

[31]*Ibid*.

[32]H.W. Thomas, *Canadian Participation in the Korean War, Part II 1 Apr 52 – 31 Jul 53* (Army Headquarters, 1955), Appendix C.

British, to the Canadian General Hospital in Seoul or to the veterans' hospitals in Canada.[33] Relying heavily on the US Mobile Army Surgical Hospital (MASH) system, most casualties were evacuated through these facilities, onward to Kure, and if necessary back to Canada by US strategic air lift. Canadian medical staff were co-located in some of the MASH facilities and were present at almost every level of care provided to the Canadian soldier. Additional care and treatment was provided to the soldiers upon return to Canada in the military hospitals across the country. Bill Rawling, a Department of National Defence official historian, noted that during this conflict the Canadian medical practitioners had to relearn what previous combat medical staff had gone through. Military medicine was different from civilian medicine. Whereas civilian medicine practitioners dealt with mostly clinical issues, the military doctor was also required to diagnose and treat common diseases but also treat diseases and wounds that are only found in combat environments and therefore rarely found in civilian hospitals.[34] This shows that military physicians must train in Canadian military hospitals or seek that expertise in countries that have a dedicated military hospital system. No doctor, military or civilian, can expect to be exposed to these types of issues in a civilian facility.

In 1963, in the middle of the Cold War, the Canadian government established the Glasco Commission (the Commission) to look into ways to make the government more efficient. One of its recommendations was that "the hospitals of Service Personnel in Canada be gradually transferred to civilian hospitals, and no building of new Service

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[33]Brent B. Watson, "Far Eastern Tour: The Experiences of the Canadian Infantry in Korea, 1950-1953" (Ph.D. thesis, University of Victoria, 1999), 276.

[34]Rawling, *The Myriad Challenges of Peace*…51.

hospitals or replacement or enlargement of existing institutions be undertaken."[35] With Canada no longer involved in any significant, combat-based conflicts and turning its focus to peacekeeping, the Commission felt that there was no reason why service personnel could not be treated in civilian hospitals. The Surgeon General of the day did not agree with the recommendation of the Commission, stating that the military hospital system was mandatory in order to provide competent training for a medical officer corps and that it had the potential to regress to "clinical impotence" if it no longer existed. Further, it was known that some service personnel were already receiving inferior care supplied by civilian staff in certain Department of Veterans' Affairs' (DVA) hospitals across the country.[36] The level of care in a military hospital was at a higher standard as the military staff were intimately involved with the same patient throughout his or her entire stay versus rotating civilian staff that did not have a full grasp of what it meant to be in the military. Secondly, it was argued that there would be an increase in costs by having civilian practitioners and various different provincial medical standards taking care of Canada's sick and wounded.[37] In the end, the government agreed with the Surgeon General and the military hospitals remained in tact. Below is the final winning argument of the Surgeon General:

> The Canadian Forces Medical Service is committed to the complete medical care of all Canadian Servicemen, not only in Canada but in Europe, Africa and the Middle and Far East, as well as certain civilians and over 35,000 dependents who accompany servicemen to isolated areas of Canada, and overseas. To maintain clinical proficiency and a practical

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[35]*Ibid*., 245.

[36]*Ibid*., 247.

[37]*Ibid*.

> rotational system, it is evident to the Committee that Canadian Forces Medical Service definitive care hospitals must be maintained in Canada.[38]

The budget crunch of the 1990s began to have a huge effect on the Department of National Defence and greatly affected the manner in which medical care was delivered to the service people. The lack of funding and restructuring of the CF eventually led to the closure of military hospitals across the country.

The Auditor General's report of 1990 provided the starting point for the Department of National Defence to have a hard look at how it was delivering medical care to soldiers. Coupled with a decreasing budget, the downsizing of the CF and a changing world operating environment, the decision was made to close Canada's last remaining military hospitals. Operation Phoenix, which is discussed below, was instituted to chart a path of improvement to the health care system. It was followed by Prescription 2000, a comprehensive transformational plan that continues to this day. A broad look at the issues behind the closures will provide a good background understanding of how casualty support is being conducted today.

In 1990, the Auditor General of Canada released a report outlining concerns regarding the delivery of medical support to Canadian Forces personnel. At the time, the CF had 52 small base hospitals and clinics, 6 regional hospitals, the National Defence Medical Centre and 6 medical equipment depots in addition to the numerous medical sections providing first line support to units.[39] The scope of the audit was to consider

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[38]*Ibid*., 248.

whether the current medical system was set up to meet the demands of long term conflict, and whether the system was efficient for peacetime operations. The report looked at the four largest medical facilities of the day: the National Defence Medical Centre (NDMC) in Ottawa and three CF hospitals Halifax, Nova Scotia, Valcartier, Quebec and Cold Lake, Alberta. It found that the medical system was not capable of sustaining itself in conflict; it had simply evolved into a peacetime capable organization. In addition, the occupancy rate of the hospitals for military members was low and there were relatively high operating costs compared to civilian hospitals offering the same service.[40]

DND responded to the report by presenting several reasons for the higher operating costs. First, it was thought that medical assessments for military personnel, when compared to civilian assessments, were much more labour intensive. Second, there was a high annual turnover rate of medical personnel within DND. Third, there were many requirements for military personnel to attend extra military and medical courses and also to deploy on operations. Fourth, costs were increasing due to the fact that hospital staff were constantly being loaned to bases that were short in personnel. Finally, the Department felt that military physicians' and nurses' salaries were higher compared to those of their civilian counterparts.[41] The Auditor General did not see how these reasons alone would elevate the cost difference between civilian and military hospitals and raised the question as to why it was fundamentally necessary to provide medical care for a small population of personnel that was separate from the public health care system.

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[39]Office of the Auditor General of Canada, "1990 Report of the Auditor General of Canada, Chapter 23 – Department of National Defence – Human Resource Management – Medical Support," http://www.oag-bvg.gc.ca/domino//

Previously, in 1977, the Department had stated that it was necessary to maintain the separate hospital system due to the military's unique requirements, and that it was necessary to provide career development and training to CF medical personnel internal to the organization.[42] The Auditor General agreed that the CF did have unique military requirements but found some fault with the other listed reasons. The report found that, for the most part, where there existed a military hospital, there was at least one civilian hospital close by, which eliminated the reason for rapid access for medical care. Further, in terms of maintaining the skills of the medical personnel, the report recognized that DND had problems retaining medical doctors and suggested that it rely more heavily on reservists and civilian practitioners on contract. Finally, although the report did find that there was some truth to the claim that the military hospitals were providing a good training ground for military medical staff, it also suggested that it should be DND that determined the minimum number of peacetime staff members required as a starting point for expansion in wartime.[43]

DND learned through the Auditor General's report that the current medical support system was not capable of meeting wartime needs, and that its costs were too high for the services that it was providing. In that report, the Auditor General stated that the department needed to find solutions to improve efficiency, which might include reliance on contract staff and on already existing provincial hospitals. That report was thus the starting block for the Canadian Forces Medical Services (CFMS) to begin to

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[42]*Ibid*.

[43]*Ibid*.

examine how it was conducting business. The report was also the impetus for Operation Phoenix.

Shortly after the Auditor General's report of 1990, the CF conducted its own internal analysis which confirmed the Auditor General's findings. In addition, the CF military health system had deteriorated to a point where it was creating dissatisfaction among serving members. This coupled with the effects of federal budget cuts, made it necessary for DND to close three of its six CF hospitals.[44] Operation Phoenix, launched in 1994, aimed at revamping the CF medical services. Specifically, it focused on maintaining a high standard of service, but with a greater shift towards the use of civilian contractors for delivery of care. It also restructured the CFMS to better support operations with uniformed personnel only providing in-garrison care on an as needed basis. The re-engineering saw a cut in military medical personnel from 3,000 to 2,400, with civilians filling in the holes.[45]

Operation Phoenix was not as successful as was envisioned for several reasons. Strategic level buy-in on critical change within CFMS was not received and therefore the roadmap for successful implementation of the project was never approved. Moreover, significant cuts to provincial health care budgets, higher costs relying on civilian contractors, lower intake of medical professionals into the CF and a higher demand from civilians for medical care all greatly increased the burden on the already stretched public sector. In addition, an increase in operational tempo of the CF, a shortage of critical

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[44]Department of National Defence, *Canadian Forces Personnel Newsletter: Medical Services Update* (Ottawa: ADM (HR-Mil), 2001), 1.

[45]National Defence, "Backgrounder – Medical Services Update," http://www.forces.gc.ca/site/newsroom/view_news_e.asp?id=62; Internet; accessed 25 January 2008.

specialists and the beginning of an increase of CF casualties all added stress to an already weakened medical system.[46]

Throughout the 1990s, the Canadian Forces struggled to revitalize the medical system. However, tough decisions had to be made and, unfortunately, the medical services continued down the path of greater reliance on civilian facilities resulting in the closure of all tertiary care CF hospitals.[47]

At the end of the 1990s, the Chief of the Defence Staff ordered a review of the CFMS to specifically look at continuity of care and other issues relating to the manner in which medical care was being provided to CF members.[48] The report of this review (the CFMS Report) highlighted numerous areas of concern including those found under the broad guidelines of standard of care. Noting a heavier reliance on civilian practitioners and institutions, the CFMS Report cited:

> significant patient concerns in the areas of timeliness and access to medical services, regional inconsistencies in levels of service and the manner in which in-garrison care is being delivered as a result of a focus on operational responsibilities. CF members have expressed particular frustration with poor administration relating to the delivery of their in-garrison medical care.[49]

Moreover, it described how other countries experiencing similar issues to the CFMS were also beginning to rely more and more on civilian run hospitals, and suggested that CFMS

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[46]Department of National Defence, *Chief Review Services – Review of CF Medical Services October 1999* (Ottawa: CRS, 1999), 12.

[47]CMAJ, "Preparing Canadian Military Surgeons for Afghanistan," http://www.cmaj.ca/cgi/reprint/175/11/1365.pdf; Internet; accessed 20 February 2008.

[48]Department of National Defence, *Chief of Review Services – Review of CF Medical Services Executive Summary and Action Plan Resulting from the CDS Task Force* (Ottawa: CRS, 1999), i.

[49]*Ibid*., ii.

continue to look to the examples of our allied nations to see if we could learn anything from them.

The CFMS Report also highlighted one area of concern regarding the release of the sick and injured from the Canadian Forces. In the past, individuals were largely left on their own to conduct administrative arrangements regarding their release from the CF. Needless to say, this approach did not go over well with many soldiers, sailors and aircrew who felt abandoned by the system. In 1999, the Department of National Defence/Veterans' Affairs Canada (VAC) Centre for Support of Injured and Retired Members and their Families was officially opened to assist releasing CF members.[50] The Department had begun to see that there was a need for a centralized organization to provide assistance to its wounded soldiers.

The report of the Chief of Review Services was eventually tabled before the Minister of National Defence and Senior DND/CF leadership, which led to the formulation of an action plan called Rx2000 (commonly known as Prescription 2000), which began in January 2000.[51] This project was established to examine four main areas of patient care: continuity of care, an accountability framework, health protection, and the sustainability of Canadian Forces Health Services (CFHS) human resources.[52] The scope of the project was to address the numerous recommendations made previously throughout

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[50]Department of National Defence, *Chief Review Services – Review of CF Medical Services* (Ottawa: CRS, 1999), 87.

[51]Department of National Defence, *Canadian Forces Personnel Newsletter: Medical Services Update* (Ottawa: ADM (HR-Mil), 2001), 3.

[52]Department of National Defence, "Rx2000 – A Prescription," http://www.dnd.ca/health/news_pubs/rx2000/engraph/HCReform_article02_e.asp?Lev1=4&Lev2=6&Lev3=3; Internet; accessed 12 March 2008.

the years in various different internal and external reports to the Department. The main objectives of the project included the following:

- modernizing the CF medical policy to provide up to date health care services to CF members;
- improving the standard of care comparable to that received by the majority of Canadians;
- reorganizing the management of medical supplies and equipment;
- ensuring that CF members received one standard of care across Canada;
- developing and implementing a national program aimed at preventing injuries and illnesses and protecting the health of servicemen;
- centralizing all health care resources under the command of the Director General Health Services;
- developing a human resources framework that promoted the recruitment and retention of clinically experienced, fully deployable CFHS personnel; and
- building a unified "total force" health services team including the reserves.[53]

According to the project management team for this endeavour, "when completed, the *Rx2000* reforms will provide the CF with a health care system that meets Canadian standards."[54] The project has a total of 22 initiatives, with a budget of $450 million and a planned completion date of 2011.[55]

Unfortunately, since the early 1990s, CFMS has been through much turmoil. Although great minds have come together to chart the appropriate path to take to improve

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[53]Department of National Defence, *Canadian Forces Personnel Newsletter: Medical Services Update* (Ottawa: ADM (HR-Mil), 2001), 4.

[54]*Ibid*.

[55]Office of the Auditor General of Canada, "2007 Report of the Auditor General of Canada, Chapter 4 – Military Health Care – National Defence," http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_2007_4_e_23838.html; Internet; accessed 13 March 2008.

services, the unforeseen loomed on the horizon which would raise more issues, not only for CFMS, but for all of DND as a whole. Canada had begun to take casualties in its operational missions of the mid to late 1990s. These casualties, upon return to Canada, although being treated through the CFMS, began to feel abandoned by the Department and the Forces. The *Croatia Board of Inquiry* and *The Care of Injured Personnel and Their Families Review*, which will be discussed in greater detail in Chapter Three, surfaced some serious issues in the manner in which casualty care was undertaken in this country.[56] Based on the recommendations of some of these reports, CFMS was beginning to heal itself and move into a firm direction of heavy reliance on the civilian health care sector with the public health care system providing the military with the beds and doctors that were needed to properly treat its sick and wounded soldiers. However, a greater reliance on the provincial systems has led to the surfacing of problems amongst military patients, problems inherent to those systems. The public health care system may be able to provide a band-aid solution, but what is truly required is a long term solution to issues related to casualty care.

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[56]Department of National Defence, "Board of Inquiry – Croatia: Executive Summary," http://www.dnd.ca/boi/engraph/summary_e.asp; Internet; accessed 29 February 2008.

and

Department of National Defence, "Care of Injured Personnel and their Families Review – Introduction," http://www.forces.gc.ca/site/minister/eng/Injury/Intro_e.htm; Internet; accessed 23 November 2007.

CHAPTER THREE - CANADIAN FORCES CASUALTY SUPPORT SYSTEM

The reviews noted in the previous chapter raised issues relating to the current state of casualty support in the CF. Before discussing how casualty support is being run across the country, as well as areas of concern and problems encountered through the military's reliance on civilian practitioners and hospitals, a closer look at these reviews is necessary.

The Croatia Board of Inquiry

The Croatia Board of Inquiry (CBI) was assembled to investigate whether soldiers who served in Croatia between 1993 to 1995 were exposed to environmental toxins.[57] However, the CBI was not completely limited to this task, and subsequently revealed some serious problems pertaining to casualty support in Canada. What emerged was that many soldiers had sustained injuries that had a marked effect on their lives and families, and that they all expressed great frustration trying to get the proper care and treatment that they required. Most felt that the casualty support system was not responding to their needs. Many of them also felt a sense of fear in coming forward to talk about their injuries as they thought they would be labeled by the organization and subsequently released from the CF for not meeting the universality of service rule. Essentially, as mandated by the Department's administrative orders, this rule requires that all members of the CF be physically and mentally fit for deployment on operations. Members

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[57]Department of National Defence, "Board of Inquiry – Croatia: Executive Summary," http://www.dnd.ca/boi/engraph/summary_e.asp; Internet; accessed 29 February 2008.

permanently unable to meet the minimum operational standards are either released from the CF or retained on a temporary basis.[58]

CBI members stated that they were shocked to hear of the frustrations and humiliating treatment that injured soldiers endured. "Too many of them ran into difficulty trying to get the care, consideration and compensation they deserve. The treatment received by many of the injured that came to our attention has been, at best, arbitrary and certainly inadequate."[59] The soldiers serving Canada during this mission came home to meet a support system that was undergoing extensive change and that was experiencing problems of its own. The normal support services that one would expect were basically non-existent. The CF had been through a long period of peace and had adjusted itself to this situation. The health services and the rest of the CF were attempting to realign themselves to be prepared for war, but they were not yet ready.

Many of the soldiers felt that the doctors and nurses of the military health services were simply policing the Universality of Service policy; they were reluctant to come forward and speak with military medical personnel out of fear of losing their employment. The wounded felt that the entire support system, or lack thereof, was confusing and bureaucratic. There was a definite lack of centralized control and oversight as there were many different agencies such as DND, Veterans Affairs and the Security Insurance Plan that were attempting to help the soldier, and yet they were not

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[58]Department of National Defence, "DAOD 5023-1: Minimum Operational Standards Related to Universality of Service," http://www.admfincs.forces.gc.ca/admfincs/subjects/daod/5023/1_e.asp; Internet; accessed 5 April 2008.

[59]*Ibid*.

talking to each other. The result was that the soldiers perceived the support from all as being poor.[60]

One key point that was raised through the investigations was that the medical system of the day did not allow for the creation of a doctor-patient relationship. Due to the increasing shortage of physicians, increased physician taskings and operational tempo, the military physician was simply not available. Many soldiers had to rely on civilian physicians or were meeting with a new physician each time they went to their medical clinic.[61]

The CBI did produce a series of recommendations that were acted upon by both Health Services and DND as a whole. Further, "The Centre," essentially a "unique inter-departmental initiative…designed to bring the efforts of both DND and VAC together in a cooperative venture to provide information and services to injured members, veterans, and their families,"[62] was created at the same time as the release of the results of the CBI. Canada was leaving the era of the Cold War and relative peace behind it. The country was entering into an era of conflict during which it would be sustaining casualties. The Croatia Board of Inquiry brought to light some serious issues and subsequently put in place the recommendations to try and rectify the problems to ensure that Canadian soldiers receive the optimum level of care.

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[60] *Ibid*.

[61] Department of National Defence, "Board of Inquiry – Croatia: Sustainment - General," http://www.dnd.ca/boi/engraph/sustainment_e.asp; Internet; accessed 29 February 2008.

[62] Department of National Defence/Veterans Affairs Canada, *Death and Disability Programs and Services* (Ottawa: ADM (PA) DPAPS, 2007), inside cover.

The Care of Injured Personnel and their Families Review

At roughly the same time as the CBI, the Acting Chief of Defence Staff ordered an investigation into the treatment of Canadian wounded soldiers. The ensuing C*are of Injured Personnel and Their Families Review* (the Care Review) was initiated in early 1997, and was asked to report back on its findings by the end of September that year. The Care Review team was tasked with collecting various comments from injured soldiers regarding their experiences with casualty care and identifying the dissatisfying aspects of that care.[63] The overall feedback from the report resulting from that review was not encouraging. It identified a definite problem with the manner in which casualty support was being conducted in this country and argued that it needed to change:

> Members of all components felt abandoned, mistreated and abused. Many indicated that they would never again trust the chain of command. They suggested, given what they had experienced, they would never go into harm's way again and would tell other service members to make the same choice.[64]

The view expressed in the above citation is important, for if there had been a firm, centralized, coherent and caring casualty support system in place prior to deployment, it is likely that none of these issues would have arisen. If soldiers knew that they would be well taken care of, they would have kept their minds on the task at hand (for instance, combat operations) and if they had sustained injuries, they would have known that they would be well taken care of.

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[63]Department of National Defence, "Care of Injured Personnel and their Families Review – Introduction," http://www.forces.gc.ca/site/minister/eng/Injury/Intro_e.htm; Internet; accessed 23 November 2007.

[64]Department of National Defence, "Care of Injured Personnel and their Families Review – Findings," http://www.forces.gc.ca/site/minister/eng/Injury/finding_e.htm; Internet; accessed 23 November 2007.

Dissatisfaction with medical care was the primary concern amongst respondents contacted within the framework of the Care Review. Many told stories of flying back to Canada unescorted; of families having a lack of information about their loved ones; of lacking information and follow-up on home care needs; and of a general lack of resources. Soldiers spoke of being placed in civilian hospitals and feeling abandoned by the system.[65] Frustration was rampant and the soldiers did not know who to turn to, for it felt as though nobody was stepping forward to fully support and take care of them. Issues ranging from administrative support to lack of support for injured reserve soldiers, and from delays in decision making to limited financial support were all raised by respondents to the study. The review team compiled a list of 65 recommendations for implementation. One of the recommendations involved the creation of the pre-cursor to the Directorate of Casualty Support Administration (DCSA), which would provide a centralized organization to provide answers on compensation and pensions. This would be the first step in a positive direction for DND to finally attempt to centralize control over casualty support.

As we moved into the 21st century, one can see that drastic improvements to casualty support have been made, but they are not yet perfect. The war in Afghanistan is a clear indication of what still needs to be improved. Problems that exist can be sub-divided into systemic and human issues. The systemic issues relate to those that deal with the current casualty support system that include: poor casualty tracking, lower standards of care received in civilian hospitals, a lack of a coordinated approach to

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[65]Department of National Defence, "Care of Injured Personnel and their Families Review – Discussion," http://www.forces.gc.ca/site/minister/eng/Injury/discussion_e.htm; Internet; accessed 23 November 2007.

casualty management across the country, the need to train our military doctors outside of our own institutions, a reliance on an already over-stretched public health care system, and a rise in the costs for DND medical care. The human issues are those that relate to the patient and include: a lack of contact with other military personnel and other wounded soldiers, feelings of inadequate care received through civilian hospitals and rehabilitation centres, and unwanted administrative headaches for the wounded soldier. The paper will first look at the systemic issues.

Systemic Issues

The first systemic issue relates to the tracking of casualties incurred during the Canadian presence in Afghanistan. According to the official DND media response line between 2002, when Canada entered into the Afghanistan conflict, and the end of 2007, 280 soldiers were wounded in action.[66] Table 3.1 provides a breakdown of the casualties in the mission as provided through the DND fact sheet.[67]

Table 3.1 – Canadian Forces Casualties Since April 2002

Year	Non-Battle Injuries (NBI)	Wounded In Action (WIA)	Deaths (those not KIA)	Killed In Action (KIA)
2002	1	8	0	4
2003	0	3	0	2
2004	5	3	0	1
2005	7	2	1	0
2006	84	180	4	32
2007	298	84	3	27
Total	395	280	8	66

Source: Department of National Defence, Media Response Line: Wounded in Action and Non-Battle Injury Statistics, 2008.

[66]Department of National Defence, Media Response Line (MRL 08.005) *Wounded in Action and Non-Battle Injury Statistics* (Ottawa: DND Canada, 2008).

[67]This information is only released from the Department at the end of each calendar year. In order to provide some operational security, DND does not release data concerning casualties on an ongoing basis as they do not want to provide the enemy with any incident specific correlation to their figures.

DND would not provide, through its various channels, the numbers of soldiers who were repatriated home to Canada due to their wounds. There are a number of possible reasons for this: they may consider this figure to be a matter of national security; they may have not kept track of this information; or, they may simply not wish to reveal the fact that so many soldiers are returning to Canada for care. Table 3.2, on the other hand, provides a slightly different view.[68] This table comes from another credible source which is a Canadian Forces directorate that is charged with casualty support policies and procedures. Here we see that up to the end of Rotation 4, which corresponds to the statistics available up to the beginning of December 2007, a total of 268 soldiers were wounded in action and 362 sustained non-battle injuries.[69]

Table 3.2 – Care of the Ill and Injured Demographics from Task Force Afghanistan

	Previous Rotos	**Roto 2**	**Roto 3**	**Roto 4**	**TOTAL**
Total WIA	**78**	**117**	**28**	**45**	**268**
LRMC	31	48	5	17	101
Repat to CA	33	49	5	15	102
Return to Duty	49	69	23	28	169
Total NBI	**41**	**86**	**158**	**77**	**362**
LRMC	15	12	3	2	32
Repat to CA	14	43	101	64	222
Return to Duty	22	43	59	10	134
Total	**119**	**203**	**186**	**122**	**630**

LRMC = Landstuhl Regional Medical Center
NBI = Non-battle injuries

Source: Department of National Defence, Director Military Personnel Strategy and Coordination – Enhanced Local Casualty Support Concept Paper, 2007.

[68]Department of National Defence, *Director Military Personnel Strategy and Coordination – Enhanced Local Casualty Support Concept* Paper (Ottawa: DND Canada, 2007).

[69]A single roto or rotation refers to a six month deployment of a contingent into a theatre of operations.

Of the total number of soldiers injured, 324 were repatriated to Canada, including 102 who were wounded in action. It is difficult to determine how many of the total wounded actually required hospitalization in Canada, but it is likely that at least 133 of the soldiers repatriated through Landstuhl required some hospitalization time in Canada. *Legion Magazine*, in its November/December 2007 issue, lists Canada as having 330 CF members with disabilities stemming from the Afghanistan conflict alone.[70] What is of note here is the discordance between these three "credible" sources. Casualty tracking is a very important aspect of casualty care, and if it is not done properly it is very easy for a soldier to be lost in the mix. One might conclude that the disparity amongst the figures cited stems from the lack of a central body in control of the administrative aspects of casualty tracking.

A second issue relates to the lower standard of care provided through the use of civilian hospitals. Wounded soldiers are usually airlifted from Kandahar and transferred through Landstuhl, Germany, where they are further stabilized and treated in the American military hospital before being airlifted to Canada. The decision on where a casualty will be flown is decided on a case by case basis. The current CFHS aide memoire for casualty reception and management states that "the CFHS has adopted no firm policy direction on this issue and it is recommended that decisions be made on a case by case basis considering first the medical requirements of the casualty, secondly the location of the social support network of the casualty, and lastly the proximity to a CF

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[70]Natalie Salat, "The Quiet Fight: Master Corporal Paul Franklin," *Legion Magazine*, (November/December 2007): 20.

clinic."[71] Soldiers having been accustomed to a military medical system in Kandahar, and subsequently, upon arrival in Landstuhl, are placed in a civilian health care system that is not capable of providing them a high standard of care. The CFHS is aware of this issue and warns its medical liaison officers to be prepared to warn off the receiving civilian hospital and the soldier's family:

> Accustomed to the military medical system they have been exposed to in theatre and at LRMC, [Landstuhl Regional Medical Centre], the member's expectations of medical care may be quite high and it can be a challenge for the Canadian health care system to meet these expectations…..When compounded with the overarching stress of the situation, it is easy to see how complaints and concerns about the adequacy of care can arise. Attention to preparing the receiving hospital to manage military casualties and proactive communication with the member and family about what to expect will make these problems less likely but will not eliminate them.[72]

A third systemic issue is the lack of a centralized and coordinated approach in supporting the casualty. Superimposed onto the treatment the casualty is receiving from hospitals and rehabilitation centres is the casualty support administration network. This conglomerate of support incorporates the Case Management Program, the wounded person's assisting officer, Veterans Affairs, Operational Stress Injury Social Support, the Return to Work Program, the soldier's home unit, the Transition Assistance Program, the Directorate of Casualty Support Administration, and a multitude of other administrative programs and agencies aimed at helping the wounded soldiers. Casualty support has been coined as a "growing industry" with an ever increasing number of agencies and individuals that are tasked to help.[73] The problem is that there are too many agencies,

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[71]Department of National Defence, *Aide Memoire: Casualty Reception and Management, A Canadian Forces Health Services Initiative* (Ottawa: DND Canada, 2006), 13.

[72]*Ibid*., 15.

which results in the wounded soldier and the assisting officer quickly become overwhelmed with information, with no coordinated approach to moving the healing process of the casualty forward. The current "stove-pipe" or non-team approach to casualty care has resulted in the existence of organizations that are not communicating with each other. If all these organizations could come together under one command and one organization, the clarity and effectiveness of casualty management would likely be greatly improved.

The fourth systemic issue is that in order for CF doctors to remain current within their field they must receive additional training outside of DND. With the closure of CF hospitals in the 1990s, it is now more challenging for CF doctors to remain competent in their field. This cannot be achieved during peacetime, for patient care is normally restricted to minor injuries that would be found in healthy young soldiers. A recent article in the *Canadian Medical Association Journal* sums up this situation:

> because CF surgeons no longer work in military hospitals, many complete trauma and critical care fellowships. Following their training, they remain at busy civilian hospitals to maintain their clinical competence. In addition, CF surgeons are sent for one month rotations to US trauma training centres.[74]

Most military physicians agree that the best thing to occur since the closure of the CF hospital has been the training they conduct in civilian facilities.[75] It would seem that there is some merit to having the training conducted in civilian facilities. However, the

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[73]Captain Mike Grills, LFCA G1 Pers, conversation with author, Canadian Forces Casualty Support Symposium, Ottawa, 5 February 2008.

[74]CMAJ, "Preparing Canadian Military surgeons for Afghanistan," http://www.cmaj.ca/cgi/content/full/175/11/1365?maxtoshow=&HITS=10&hits=10&RES...; Internet; accessed 20 February 2008.

[75]*Ibid*.

question remains as to whether our surgeons would receive a similar amount, as well as the same required level of training, if other options were explored.

The next systemic issue deals with DND's reliance on an already overstretched public health care system. CFHS relies heavily on civilian hospitals and civilian practitioners to provide front line care to the men and women of the CF. Imposing a civilian health care system in a military environment does not appear to be working. Furthermore, imposing our soldiers on the civilian hospitals translates into lower levels of care. Many of the returning wounded soldiers have been treated in Toronto's Sunnybrook, Ottawa's Civic or Edmonton's General hospitals and then those requiring long term rehabilitation have been moved to other civilian rehabilitation centres across the country. The public health care system is currently being pushed to its limits; this is seen in the many doctor shortages that exist across the country, along with long wait times for surgeries and the lack of existing bed spaces to treat the civilian population. It is now getting to the point where many hospitals are forced to send their patients south of the border to receive emergency care. In addition, 30% of the Ontario hospital beds are currently occupied by patients awaiting vacancies in other specialized care facilities.[76] Winnipeg is also suffering under the crunch, where they are experiencing an extreme shortage of intensive-care nurses. The regional health authority says that "a contingency plan is in place that allows intensive-care patients to be sent to hospitals in other regions of Canada or to North Dakota if necessary."[77] In October 2007, the Auditor General also noticed the effect that the lack of civilian medical specialists was having on CF members.

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[76]Lisa Priest, "Why Ontario keeps sending patients south," *Globe and Mail*, 1 March 2008, 1.

[77]Canadian Broadcasting Corporation, "Nursing shortage affects Winnipeg intensive-care units," http://www.cbc.ca/health/story/2008/03/05/nursing-icu.html; Internet; accessed 22 March 2008.

She noted that the public system cannot meet the growing demand of CF casualties and that the Department is unable to properly track and monitor the care of soldiers when they are placed in the hands of civilian practitioners.[78] Placing our wounded soldiers into a civilian health care system that is already overworked certainly raises the question as to how we can expect them to get the optimum level of care necessary.

The last systemic issue deals with increasing DND health care costs. With a heavy reliance on the public health care system, we may now be seeing the costs of a soldier's health care doubling when compared to that of the average civilian. According to the *2007 Auditor General's Report on Military Health Care*, National Defence spends $500 million annually to deliver health care benefits and services to CF personnel. The report estimates that health care for Canadians was approximately $4,500 per capita in 2006, while for military members it was approximately $8,600 per capita for the same year.[79] Figure 3.1 shows the rising costs of military health care per CF member. Although the Auditor General attributed some of these costs to contracted civilian physicians being paid higher rates than the provincial averages, along with the high costs to train military medical staff, the Department was unable to clearly link the rising costs to patient requirements and operational needs.[80]

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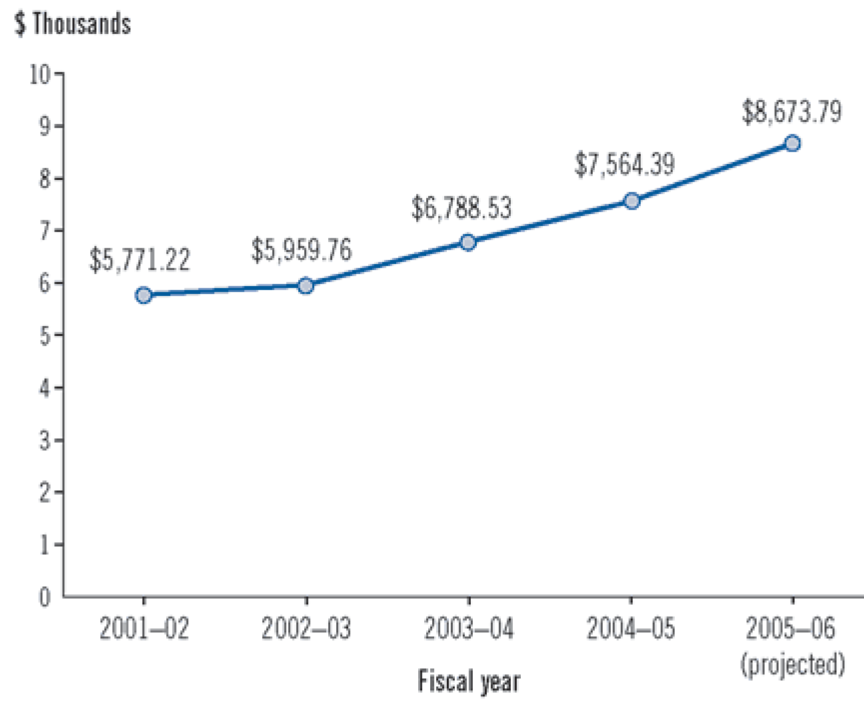
[78]The Chronical Herald, "Stress cases climb sharply among Afghan mission vets," http://thechronicleherald.ca/Canada/9005759.html; Internet; accessed 29 February 2008.

[79]Office of the Auditor General of Canada, "2007 Report of the Auditor General of Canada, Chapter 4 – Military Health Care – National Defence," http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_2007_4_e_23838.html; Internet; accessed 13 March 2008.

[80]*Ibid*.

Figure 3.1 – Military Health Costs per Person



Source: 2007 Report of the Auditor General of Canada, Chapter 4 – Military Health Care – National Defence.

What is of particular interest is that the cost per military member began to increase in 2002-03, the same period in which Canada began its involvement in the Afghanistan conflict and the same period in which we began to take on numerous casualties, who were receiving their medical treatment in civilian hospitals. All tolled, the costs of patient care have almost doubled since we began to take casualties in Afghanistan.

Human Issues

Having looked at the various systemic issues, the focus will now turn to the human issues that relate to patient care. The first issue to be dealt with in civilian hospitals is the lack of contact that soldiers have with military personnel and other

wounded soldiers. Once the wounded soldiers have arrived on Canadian soil and are admitted to Canadian civilian hospitals, it is the CFHS for the most part that makes the choice of the hospital; this choice is made as a function of where the wounded soldier's next of kin reside. From a family perspective, this does make some sense so that the support of the wounded soldier's family can be close to him or her. Unfortunately, what occurs more often than not is that the soldier resides in a civilian facility in isolation from his or her peers. The social network that the soldier had so much relied upon is no longer available. Besides the visits from the medical liaison officer, the dedicated care that the soldier is receiving originates most of the time from civilian practitioners who cannot relate to what the soldier has gone through and often have never encountered the type of injuries for which they are now responsible.[81] Again, CFHS acknowledges the fact that, where possible, it is important to keep soldiers together in hospitals. As set out in their aide memoire: "where possible, keep military casualties on the same ward and even in the same room…a trauma ward is preferable if available [and] consider using CF nurses to augment civilian staff to maintain the quality of care in a multiple casualty scenario."[82]

Currently, the most seriously wounded soldiers in Afghanistan transition through the American military hospital in Landstuhl, Germany, where they are treated and stabilized before flying home for further care. The current CF Surgeon General, Brigadier-General Hilary Yaeger, acknowledges that the military environment of Landstuhl is excellent for our soldiers and considers that the CF has a "very good

[81]"Life and Death in Kandahar*," The Fifth Estate.* Canadian Broadcasting Corporation. CBC Toronto, Toronto, 12 March 2008.

[82]Department of National Defence, *Aide Memoire: Casualty Reception and Management, A Canadian Forces Health Services Initiative* (Ottawa: DND Canada, 2006), 18.

relationship with Landstuhl. It is a culture in which our soldiers are comfortable and we prefer to use it to the point where it becomes unavailable. Our capacity in Canada is limited by the capacity of the Canadian health care system."[83]

The *2007 Draft Land Forces After Action Review on the Canadian contribution in Afghanistan in Regional Command (South) Kandahar* also acknowledges the importance of keeping wounded soldiers close together:

> Soldiers who have been taken due to serious wounds to a foreign medical facility without Canadians on staff should be returned to a Canadian facility as soon as possible. The longer a soldier is away from Canadian contact and particularly his peers, the deeper his emotional trauma is likely to be.[84]

The decision to move them to civilian facilities close to their next of kin may initially be of benefit to the soldiers and their families, but in the long term it is likely not the best decision for ensuring their physical and mental health.

At first glance, receiving medical care in civilian hospitals may seem to make perfect sense to most Canadian citizens as it is equal to their level of care, but soldiers are different from the average Canadian. Soldiers are molded and integrated into a second family where the bonds that are built are sometimes stronger than those that exist, for example, between husband and wife. An immense sense of belonging is quickly created, which puts the soldier at ease around other individuals who wear the uniform. It is this tight knit community that is critical in setting the conditions for success not only in combat situations but also in regard to soldiers recovering from their wounds sustained in

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[83]Proceedings of the Subcommittee on Veterans Affairs, "Issue 2 – Evidence – Meeting of November 22, 2006," http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/vete-e/02eva-e.htm?Language=E&Parl=39&Ses=1&comm_id=79; Internet; accessed 15 January 2008.

[84]Department of National Defence, *Draft Land Force After Action Review of Canadian Contribution in Afghanistan in Regional Command (South) Kandahar 2006-2007* (Ottawa: DND Canada, 2007), 54.

combat, or even from injuries and illnesses sustained when working in Canada, as well as their subsequent rehabilitation.

Upon discharge from hospital, soldiers normally enter into a period of rehabilitation either at home with a home care nurse or at a civilian rehabilitation facility. Again, soldiers are faced with a long period of isolation from other military personnel, which can be quite trying as they try to come to terms with the extent of their injuries. This is particularly apparent for the reserve soldiers who come from units that may not be close to large centres, or who are forced to return to the care of their small reserve force unit after spending the past year or more with the combat unit to which they were assigned. Suddenly, reserve soldiers are cast off by themselves, and sometimes are even forgotten.

Some of the most compelling human issues evidence regarding our current casualty support system have to come from those who have been through the system as patients. This evidence can be seen in the following stories about two CF soldiers.

Captain Kim Fawcett lost her leg in a tragic road accident in Kingston, Ontario in 2006. She is now a strong advocate for the institution of a centralized national casualty support program to ensure equality of medical services and rehabilitation.[85] According to Captain Fawcett, "care would have been much better for [her] if there was a centralized approach. I had to go out and find the necessary care myself."[86] This officer raised strong issues regarding the poor approach that the CF is taking toward rehabilitation of injured soldiers and the use of civilian hospitals.

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[85]Captain Kimberly Fawcett, personal correspondence with author, 2 March 2008.

[86]Captain Kimberly Fawcett, personal interview with author at the Canadian Forces Casualty Support Symposium, Ottawa, 5 February 2008.

The problems Captain Fawcett encountered with the civilian hospitals parallel experiences recounted by many other injured soldiers. Not all hospitals have the doctors with the expertise to deal with specific war-like injuries. Furthermore, not all civilian staff are sensitive to the military profession and they are generally unable to deal with operational stress injuries. Many are unfamiliar with the military environment and lack the ability to relate to the experiences that the soldier has been through. In addition, the soldier has been completely removed from the military environment and the normal internal support and the esprit de corps that exists within it. Finally, it is normally assumed that soldiers should be placed in local hospitals close to their homes so that they can receive the necessary social support from their loved ones. Captain Fawcett stressed the need to place soldiers in hospitals that can provide the best care, which usually is not close to their homes. She also emphasized the requirement to discuss the implications of injury in pre-deployment training so that soldiers can make informed decisions about where they should be placed for their long-term recovery should they incur an injury.

In terms of rehabilitation, Captain Fawcett found that the civilian centres are really only focused on bringing the soldier to a functional level. According to this officer "functional level for an amputee for example is to be able to get up out of your wheelchair and open the door to let the dog out. Functional level for me means getting back to work." Most rehabilitation centres appear to have a mindset of simply getting the casualty to a functioning state, whereas most soldiers are interested in getting a rucksack back on their shoulders and being back with their unit as quickly as possible. The civilian centres are predominantly focused on elderly patients and clients. This has been seen as a dangerous time for the soldiers as they can easily fall into a state of depression

if they do not have the proper motivation and strong rehabilitation team that is geared specifically toward the needs of the military. Through her experiences, this officer quickly discovered the many problems with not having a centralized rehabilitation program, and a centralized military hospital to properly care for her. Captain Fawcett further stated that:

> we of course employ civilian doctors [or use civilian facilities, which] is not good practice for CF members and this is why they are being lost and forgotten. I have the list of names of every amputee in the CF, their service number and particulars of their amputations. Why? Because these patients want to be identified and they want help. A centralized system would expose the decisions being made about patients and create commonality. I think the CF Med Svcs is afraid of this…Everything I have done for my own rehab and training, has been all on my own. I have had no help from CF Med Svcs. I avoid them at all costs because they are uninterested.

Master Corporal Paul Franklin was severely injured in Kandahar in January 2006 when the jeep he was driving was attacked by a suicide bomber. The bomber succeeded in killing diplomat Glyn Berry and Master Corporal Franklin lost both of his legs. Now, having completed a long road of rehabilitation, he is employed half-days at Canadian Forces Base Edmonton's casualty support cell.[87] Master Corporal Franklin recounted the administrative headaches he experienced in dealing with Veterans Affairs and the Department of National Defence; his wheelchair was taken away because bills had not been paid; he had to fight for monetary compensation for the installment of ramps and a special lift; and it was only after a wait of several months (compared to the advertised 11-day turnaround) that he finally received payment for a special deck that he had installed at his house.[88] One thing that Master Corporal Franklin would like to see is the creation

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of a rehabilitation centre of excellence in Canada. Echoing the same thoughts as Captain Fawcett, he notes that the military currently lacks a central organization that can properly provide a fully tailored rehabilitation program to its wounded soldiers. Having visited the Walter Reed Army Medical Clinic in the United States, he feels this would be an excellent model for Canada to follow. This centre will be discussed in more detail in chapter four.

Working Towards a Solution

The Chief of Military Personnel (CMP) has recognized that there is a problem with casualty support in Canada and is moving forward with many working groups and national-level symposiums to come up with a solution that will lessen the burden on the soldiers and increase the level of support that they are receiving. The work that CMP is conducting is less focused on the medical side and more focused on the social aspects of casualty care. Three areas that are being looked at include establishing a casualty support model for all of the CF to follow, designing an organization to properly manage those soldiers that are in breach of the Universality of Service policy, and investigating the possibility of creating a new sub-component of the reserve force where disabled soldiers or those that are in breach of the Universality of Service policy could still be employed.[89]

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[88]*Ibid*., 21.

[89]Department of National Defence, *Care, Employment and Management of the Ill and Injured*, (Ottawa:Presentation to Personnel Management Council), 4 December 2007. The second and third working groups focused their efforts on the issue of Universality of Service. Although, not pertinent to this paper, it is a topic that has caused much debate amongst policy makers and wounded soldiers uncertain about their future employment within the Canadian Forces. The working groups looked at how to provide the injured soldier who is no longer deemed fit for service in the CF the opportunity to continue to be employed and managed by a newly created organization. The working groups have recommended that a new sub-component of the reserve force be created and that it be managed by the Directorate of Casualty Support Administration. Although wounded soldiers may no longer be capable of performing the normal tasks of their trade, at least now they could be given the opportunity to remain employed in the CF in an administrative or supporting role.

The biggest challenge in casualty care is that there is not one template under which all casualties fall. Every Canadian Forces region is taking its own approach to supporting the casualty. The large geographic size of Canada makes it difficult to ensure that each wounded soldier is receiving the same standard of care and there is a chance that some wounded soldiers, especially reserve soldiers, could be forgotten by the system that is supposed to be supporting them. It is clear that with such diverse practices of casualty support, one soldier may be receiving better or worse care than another. A centralized approach would therefore ensure equality for all wounded and sick soldiers. The Enhanced Local Casualty Support Capability study was initiated by CMP in late 2007, first to define existing problems across all the different approaches available for casualty support and then to recommend a model to be implemented.[90] The study found that each area across Canada had its own method of managing and conducting casualty support.

Land Force Central Area (LFCA) and Land Force Atlantic Area (LFAA) were found to have similar approaches to casualty care in that they relied heavily on the soldier's home unit to conduct most of the administration. This led to an enormous work burden being placed on an already busy unit administrative staff. The unit staff was responsible for liaising with the soldier's assisting officer and subsequently with all the casualty support agencies for a long period of time.[91] This concept promotes the idea that soldiers will be better served if they are taken care of by their own units. This is very good for a few casualties but a unit with multiple casualties can quickly became over

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[90]Department of National Defence, *Director Military Personnel Strategy and Coordination – Enhanced Local Casualty Support Concept* Paper (Ottawa: DND Canada, 2007), 2.

[91]*Ibid*., 8.

burdened. In addition, there is no central tracking mechanism and no defined standard operating procedures in place to guide the units through their workload.

Land Force Quebec Area (LFQA) established a fairly decent support model in 2002 which provided a functioning and pro-active centralized organization that was responsible not only for support to the soldier, but also for grouping under one commander all the personnel support services, including case management and the DCSA cell.[92] Finally, an area headquarters in the Army had realized that to be effective in casualty support it was necessary to group all the resources together. Instead of having numerous agencies functioning independently, they would now be working in concert together under a single commander.

After studying all of the various different models of casualty support, the study highlighted a series of problems. There was a clear lack of communication between all the different agencies involved in supporting the soldier. There were even instances where units had not informed health care units that casualties had even occurred overseas.[93] Additionally, with many other agencies coming forward to add support to the soldier, it was difficult to understand who was responsible for doing what and one organization would assume that another organization was doing the required work. Unfortunately, the wounded soldier's unit was normally left trying to navigate its way through the mess of agencies to figure out if the soldier was getting the required care and support that he or she required.

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[92] *Ibid.*, 7.

[93] *Ibid.*, 9.

There were also definite inconsistencies in the delivery of services to the wounded soldier. With many of the units attempting to take care of their own soldiers, they quickly became overwhelmed with the amount of work required to try and administer the wounded properly. The result was that soldiers were receiving substantially different standards of care.

As noted above, monitoring and tracking of casualties is a major issue that needs to be improved upon. Tables 3.1 and 3.2 above are just two examples of the various discrepancies that exist at the highest level of the CF; such discrepancies are also found at the local level. Examples taken from recent deployments show that units have been notified that an individual will be arriving in Canada in a matter of hours without any explanation given, or even that some casualties are making their own way home from theatre unescorted on civilian flights.[94] The result is that some soldiers can fall through the cracks of the care system which obviously has an effect on their long term care and recovery.

Determining when a casualty should be handed off to another agency was also a highlighted issue that came out of the study. With many different organizations involved in supporting the casualty, it was difficult to define when someone should be taking the lead. In addition, if a soldier is under the administrative control of a unit, it is difficult for the unit to administer the soldier indefinitely due to the fact that the personnel of a unit are frequently changing over and the unit is often deployed on operations or training exercises. At some point the soldier should be handed off to a separate organization for tracking; in some cases, that organization should employ or find employment for the

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[94] 1st Battalion The Royal Canadian Regiment, *TF 3-06 Casualty Care After Action Review* (Canadian Forces Base Petawawa), October 2006.

casualty. This may mean transitioning to civilian life or finding a new military occupation within the Canadian Forces.

Management of ill and injured reserve force soldiers is also a critical area that is in need of improvement. Because many reserve force units are in remote locations and lacking the permanent staff to properly track and administer casualties, it was found that reservists were lacking far behind the level of care that most regular force soldiers were receiving.

CMP Working Group Recommendations

After the major issues were identified, the Chief of Military Personnel working groups provided the following set of recommendations:

- it is necessary to create a centralized approach to casualty care based on the model that was in use in LFQA and each region across Canada should attempt to establish a model that mirrors that of LFQA;
- comprehensive administrative procedures and standard operating procedures should be developed along with a framework that would create a civilian and military team of personnel working together for the casualty; and
- an efficient central tracking and monitoring capability was recommended as a necessary tool to properly take care of Canada's wounded soldiers.[95]

The CMP, in addition to directing the working groups to look into the issues above, has also created a master campaign plan with the overall objective that "CF injured receive the necessary care to heal, a choice to continue to serve with the CF or transition to civilian life while their families receive the support they need."[96] In order to

[95]Department of National Defence, *Director Military Personnel Strategy and Coordination – Enhanced Local Casualty Support Concept* Paper (Ottawa: DND Canada, 2007), 13.

meet this objective, several specific areas of casualty support are being examined in detail. The effects that he wishes to achieve are the improvement of services and dedicated care provided to the soldier, specifically under: care management, mental health, family support, a new CF prosthetics program, improving support to the reserve soldier and creating better awareness across the CF of the many programs that are available.

Significant steps are being taken by this organization to improve casualty support in Canada, and hopefully, with time, its plans will be solidified and put into place. It is unlikely, with these changes, the life of injured soldiers will be improved upon as they sit in civilian hospitals and rehabilitation centres here in Canada. Perhaps on the administrative side, many of the programs will be streamlined and made easier to access. Policies may become clear for the soldiers and they may know exactly what they are in for when they get injured or ill during their service time. But if one were to take a good look at most of the issues that have been raised, either directly from soldiers or through the various reports and working groups, there is one solution that the Department has not yet expended much effort in considering. If Canada is going to continue to send its sons and daughters into harm's way, then we must provide them with an exceptional level of care which can only be found in a dedicated military hospital system. The next chapter will explore a few of the solutions that the Department should endeavour to study in order to improve casualty care here in Canada.

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[96]Improved Care of Injured and their Families Program – Campaign Plan, as briefed at the Canadian Forces Casualty Support Symposium, Ottawa, 5 February 2008.

CHAPTER FOUR – THE RETURN OF THE CANADIAN FORCES HOSPITAL

The key to a successful casualty care program is through the proper coordination and integration of all casualty management elements, both on the administrative and direct medical care levels, into one coherent and effective organization. One of the best ways of achieving this goal is through the re-opening of our military hospitals. The previous chapters have provided an in-depth look at casualty management throughout history and how it is being conducted today. This final chapter will synthesize that information by examining how the problems previously listed can be solved by simply bringing all the casualty support players into one organization in order to provide effective casualty management for CF members.

Chapter Three raised numerous issues concerning the manner in which casualty care is delivered to soldiers of the Canadian Forces today. Although the Department does acknowledge the fact that there is a need for improvement, it is strongly felt that the currently outlined steps for improvement do not go far enough. A holistic view of the problems reveals that they essentially fall into two different categories: administrative care and medical care. Problems of the first type related, for example, to a lack of communication between stakeholders, poor casualty tracking, and a lack of centralized control. Problems of the second type related, for example, to the lack of contact that the soldier has with other soldiers, poor approaches to rehabilitation through civilian centres, civilian doctors who cannot relate to the patient's experiences, and increasing costs associated with using civilian centres.

There are five critical aspects of casualty care that will be greatly improved upon if Canada re-opens its military hospitals:

- the administrative processes of casualty management can be streamlined and brought together under one organization. The hospital can be a place where all resources involved with casualty support can be grouped together, thereby avoiding the current confusing stovepipe approach;

- Canadian soldiers will receive treatment from military doctors who understand the issues of the soldier. Soldiers are feeling neglected and abandoned through the use of the civilian hospital. The civilian practitioner does not have the ability to relate to the soldier and has not been exposed to various combat wounds. The civilian deals mostly with clinical issues whereas the military doctor must also treat wounds that are only found in combat situations;

- the opening of the military hospital will create an environment where wounded soldiers will be surrounded by other soldiers who are in the same situation. This will provide a place where the wounded are able to feel more comfortable and gather strength from each other rather than being isolated in a civilian health care system;

- soldier rehabilitation. The CF is in crucial need of a dedicated centre for physical and mental rehabilitation. The current reliance on civilian rehab centres is clearly failing the soldier; and

- the Canadian soldier will be able to receive one standard of care across the country, both in terms of direct medical attention and also crucial administrative support.

In order to simplify the casualty management process, and eventually make the life of the wounded soldier much more comfortable, it is necessary to group all the administrative aspects that deal with casualty support together into one coherent organization. In conjunction with this notion, it would make sense to group these administrative functions directly with those doctors and nurses that deliver the direct care to the soldier. It would make sense to simply re-open our military hospitals and create a centre of care that is all encompassing. A dedicated military hospital should be able to provide a place for all of our sick and wounded soldiers to receive a multitude of different

levels of care, from surgery, to convalescence, to an in-depth rehabilitation program. Without relying on civilian institutions to provide this care to our injured personnel, the military hospital would be able to provide a familiar surrounding both in terms of those providing the care and those who are receiving it. Before we delve further into the military hospital issue, it is first necessary to understand the practical, legal and moral reasons for having a separate military health care system.

Reasons for a Separate Health Care System

Ever since humankind has been involved in conflict, soldiers have been left to the mercy of politicians who decide where they will fight, of leaders who will take them there and of doctors who will take care of them should the need arise. In providing a service to their country, soldiers have always expected that someone will take the time to heal their wounds.[97] In 1999, then Chief of Defence Staff General Maurice Baril stated that our soldiers, "in return for their commitment and unlimited liability to serve…rightfully expect the best medical care and attention possible."[98] The soldiers, and society as a whole, should expect that those who put themselves in harm's way should be properly taken care of by society. This paper contends that a dedicated military medical system is the best way to care for injured soldiers. But why?

Colonel (retired) David Salisbury delves into this issue in his paper, *Prognosis 2020: A Military Medical Strategy for the Canadian Forces* by outlining four main reasons for having a separate military medical capability. First, an internal military medical capability to the armed force tells the citizens of a country that their politicians

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[97]John Laffin, *Combat Surgeons* (Gloucestershire: Sutton Publishing, 1999), 6.

[98]Department of National Defence (CANFORGEN 065/99CDS 054), *Special Message from the CDS*, 29 July 1999.

and leaders have established the necessary facilities to properly take care of those soldiers who are sent into dangerous situations on behalf of the government. Secondly, it shows the rest of the world that the country has the capability to properly sustain our soldiers as well as to present a fully functioning and credible force to our allies and adversaries. Third, it tells the leaders of the armed force that their missions will be sustained and supported. Lastly, and most importantly, it tells the soldiers that the nation they are fighting for actually cares about their welfare.[99]

Some may argue that a competent national health care system would be able to tackle these problems. However, a closer look at the types of injuries and illnesses that are encountered in the military compared to civilian life reveals a need for doctors and surgeons with specialized training to properly care for our soldiers. Further, although civilians may be subject to wounds similar to those incurred by soldiers, a different manner of treatment is necessary for those sustained in combat.[100]

The Canadian Forces Health Services' vision statement clearly reflects an understanding of the difference between a civilian and a soldier: "we are a professional military health service trusted for our expertise. We understand and respect the unique needs of those who serve anytime, anywhere. The excellence of our care makes us proud to serve."[101] Today, the Department of National Defence provides medical care to more than 63,500 regular force personnel on 37 military installations across Canada. In

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[99]David Salisbury and Allan English, "Prognosis 2020: A Military Medical Strategy for the Canadian Forces," in *The Operational Art: Canadian Perspectives Health Service Support,* ed. Allan English and James C. Taylor, 1-19 (Kingston: Canadian Defence Academy Press, 2006), 3.

[100]*Ibid*.,7.

[101]National Defence, "Health Services – Understanding and Caring," http://www.forces.gc.ca/health/engraph/about_us_e.asp?Lev1=5; Internet; accessed 8 March 2008.

addition, reserve soldiers receive dedicated care under certain contracts that they have signed. With an annual budget of approximately $500 million, National Defence provides medical and dental care to its military members. It is accessed through military clinics on bases or through the civilian health care systems and paid for by the Department. There are currently three thousand health care providers in DND who provide front line health care to the men and women of the Canadian Forces.[102]

An important part of the healing process is that the wounded soldier is surrounded by other military personnel. According to Lieutenant-Colonel Kevin Beaton, a UK military physician:

> a critical component of their healing process is that, when clinically appropriate, they wake up on a ward together with their comrades, nursed and cared for by people in a military environment who understand them and what they have been through. There is further benefit for the wives and families who are able to meet and mix with the other relatives and collectively draw strength from each other.[103]

Although very little has been written on the need to re-open our military hospitals here in Canada, we can find advocates for the cause in Britain. The United Kingdom underwent very similar changes to its military health care system that almost mirror those seen in Canada. In a 2007 interview with BBC news, the previous chief of the British General Staff, General Sir Mike Jackson, stated that:

> soldiers who have been wounded, psychologically are far better off one with the other in the same ward under a military environment. We ought to make a better effort to give soldiers, who are wounded in the course of their duty, care and rehabilitation within the military environment if at all possible.[104]

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[102]Office of the Auditor General, "2007 Report of the Auditor General of Canada," http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_2007_4_e_23828.html; Internet; accessed 15 January 2008.

[103]Lt Col K.C. Beaton, "Importance of the Defence Medical Services" (Shrivenham: Joint Services Command and Staff College Defence Research Paper, 2007), 17.

To help soldiers cope and deal with both their physical and mental scars, they need to be surrounded by fellow soldiers who have experienced similar horrors of war and go through extensive military rehabilitation programs with other soldiers who have incurred similar wounds. Further, keeping the soldiers within a military environment throughout their recovery will provide a constant reminder that the organization they belong to is taking the necessary steps to ensure the fastest recovery possible. Consider the following remark from a recently wounded soldier: "the best support you have is in your friends. What happened over there is pretty significant. It helps to be able to talk to someone who understands what you are going through and who will not judge you."[105]

The hospital would be a central hub, where all the support agencies involved in casualty care would be able to work under one roof and under one command, thereby providing dedicated care to the person that matters – the wounded soldier. The hospital would be a centralized organization where the soldiers would need to only be at one location throughout all of their recovery time. The hospital would ensure that a single standard of care was provided to all of Canada's wounded and would provide an ideal location for CF physicians to further their training.

As we look back to the First World War, this exact same issue confronted the United Kingdom. In *Healing the Nation*, the author, Jeffrey Reznick, describes the words of a renowned surgeon of the time:

> there was essentially a want of cohesion between departments of treatment….What was needed in lieu of this situation [….] was a comprehensive

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[104]BBC 2 Newsnight, "Interview with General Sir Mike Jackson", http://news.bbc.co.uk/2/hi/programmes/newsnight; Internet; accessed 25 March 2008.

[105]Anonymous wounded soldier, Canadian Forces Casualty Support Symposium, Ottawa, 5 February 2008.

> system of state-sponsored after care, one that could provide an extended period of recovery and continuity of treatment. [It was] concluded that the country required a central hospital where all existing resources could be brought to bear on the problem.[106]

The behaviour of soldiers in combat situations has long been an area of study for academics. What has been found, more often than not, is that soldiers, when confronted with a challenging and terrifying situation, will perform to a higher standard when they are in a group setting. Anthony Kellet, in his book, *Combat Motivation: The Behaviour of Soldiers in Battle*, described the effects of isolation on the soldier in the following manner:

> One reason isolation intensifies fear is that when a soldier is isolated; the need to keep up an appearance of control is diminished. Also, the soldier does not have the comforting, if negative, sense that his parlous situation is shared by others. Furthermore, when a man is alone he does not have the confidence by numbers and that helps convince him that a threatening situation can be mastered.[107]

We must bring this same context into the hospital or rehabilitation centre, where wounded soldiers are contemplating huge changes to their lives resulting from horrific wounds sustained in battle. It makes sense from a moral viewpoint that we group these soldiers together so that they can confront their fears and challenges together. In *Motivation and Behaviour: The Influence of the Regimental System*, Kellet describes how "loneliness and isolation unnerve soldiers and undermine their confidence…anxiety tends to encourage association, and thus the group generally provides the individual with psychological as well as physical security."[108] Again, this thought process should be

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[106]Jeffrey Reznick, *Healing the Nation: Soldiers and the culture of caregiving in Britain during the Great War* (New York: Manchester University Press, 2004), 121.

[107]Anthony Kellet, *Combat Motivation: The Behaviour of Soldiers in Battle* (Boston: Kluwer, 1982), 98.

considered when we are dealing with our wounded soldiers. When they come back to Canada without limbs, other forms of severe trauma, or post traumatic stress disorder, they should not be placed into civilian institutions amongst civilian practitioners and civilian patients. The wounded soldiers need to begin their long roads to recovery in the right direction from the very start.

A problem noted in the previous chapter dealt with the selection of civilian hospitals that were close to soldiers' homes so that they could be close to loved ones. Initially, this does seem like a fairly good idea, but only if the soldier is able to get the same standard of care in a hospital close to his home, compared to a large centralized hospital which specializes in that care. The military hospital could provide this specialized care. Captain Fawcett, cited previously in this paper, echoed this sentiment, stating that soldiers need to be placed in the proper medical facility that can provide them the necessary specialized physical and mental care, rather than in facilities that are close to their homes. Albert Cowdrey also speaks to this point in his book, *Fighting for Life,* by describing situations where wounded American soldiers of the Second World War were placed into hospitals that specialized in handling their specific cases rather than being sent to hospitals closer to their homes.[109]

The Legal Argument

The legal basis for the CFHS can be found in three pieces of legislation that make the Federal Government responsible for providing health care to members of the CF. The

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[108]Anthony Kellet, *Motivation and Behaviour: The Influence of The Regimental System, Part 1 – Esprit de Corps* (Ottawa: ORAE Report No. R109, 1991), 31.

[109]Albert Cowdrey, *Fighting for Life: American Military Medicine in World War II* (Toronto: Maxwell Macmillan, 1994), 320.

Constitution Act of 1867 specifies that certain matters, including military health care, fall within the jurisdiction of the government. Section 91 (7) of the Constitution Act is the constitutional basis for the CF health care mandate.[110] The second piece of legislation is found in the National Defence Act which essentially gives the Minister of National Defence the authority to direct the Canadian Forces, which includes the provision of health services to soldiers.[111] Finally, the last legal basis is found in the 1984 Canada Health Act which exempts CF members from the definition of 'insured persons.' The Chief of Review Services' report of 1999 noted that "while CF members are excluded by the [Health]Act from deriving benefit from provincial medical insurance coverage, as Canadian citizens, they too as a matter of policy and military efficiency should have their health protected, promoted and restored in accordance with the stated principles of Canadian health care policy."[112]

The Moral Obligation

In addition to having a legal obligation to provide adequate health care to its soldiers, Canada also has a moral obligation to do so. According to General Maurice Baril:

> Canadian soldiers, sailors, airmen and airwomen invest an awful lot of themselves for service to country, sometimes paying with their very lives. If we send healthy people to missions and they come back unwell, then appropriate health care support must be made available. That is not just our legal obligation, but more importantly, our moral obligation to see that it is so.[113]

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[110]National Defence, "News/Public Affairs – Health Services Factsheets," http://www.forces.gc.ca/health/news_pubs/hs_factsheets; Internet; accessed 25 January 2008.

[111]Department of National Defence, *Chief Review Services – Review of Medical Service October 1999* (Ottawa: National Defence, 1999), 5.

[112]*Ibid*.

CFHS contributes to this moral obligation by letting soldiers know that they will always be taken care of in their times of need. Soldiers should not be pre-occupied with the notion of not knowing if they will be cared for properly. If they realize that they will be in good hands upon injury, then this will further their ability to continue on in combat under adverse conditions. A well established medical system that properly takes care of its own soldiers will reap the benefits of praise from the sick and wounded while a poor system will see bad rumours spread quickly amongst the ranks.

Although Canada has not established a moral agreement between the soldier and the nation, we can look to the United Kingdom where there is decreed a Military Covenant (the Covenant) that states the following:

> Soldiers will be called upon to make personal sacrifices – including the ultimate sacrifice – in the service of the Nation. In putting the needs of the Nation and the Army before their own, they forego some of the rights enjoyed by those outside the Armed Forces. In return, British soldiers must always be able to expect fair treatment, to be valued and respected as individuals, and that they (and their families) will be sustained and rewarded by commensurate terms and conditions of service.[114]

British soldiers, in the context above, are expected to give up many rights in the service of the Nation and they, in turn, expect to be looked after by the Nation. When medical care is provided in order to contribute to the Covenant then it should be distinctive from the type of care that is afforded to the civilian population who are not

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[113]National Defence, "Backgrounder – Medical Services Update," http://www.forces.gc.ca/site/newsroom/view_news_e.asp?id=62; Internet; accessed 25 January 2008.

[114]Ministry of Defence, "Soldiering – The Military Covenant," http://www.army.mod.uk/servingsoldier/usefulinfo/valuesgeneral/adp5milcov; Internet; accessed 20 February 2008.

putting their lives at risk to serve their country.[115] The Covenant exists for these soldiers so that they know that the country will take good care of them. In Britain, there have been many who have cried foul when soldiers' medical needs are not being addressed. Commanding Officers have resigned and politicians have created controversy. For example, in March 2007, Liberal Democrat Leader Menzie Campbell charged that the Covenant had been broken when the government failed to look after its soldiers properly:

> the men and women of our armed forces deserve decent medical facilities and proper equipment. Successive governments should be ashamed of their failure to provide this for our dedicated servicemen and women. We have a duty to do our best by all men and women of the armed forces when we ask them to risk their lives on our behalf.[116]

Canada, like the United Kingdom, has a duty to care for those who are sent into harm's way. The nation has a moral obligation to take care of its servicemen and to elevate that care to the highest possible level. If we are going to continue to ask our soldiers to risk their lives for our country, then they deserve to know that they will be given the greatest level of care possible.

Although the legal obligation is clearly set out, we may need to formalize the moral obligation to the point that we have a written agreement between the nation and the soldier so that it is fully understood what the nation will provide to the soldier when he or she is injured. Although Canada does not have a written contract with its soldiers, the Standing Committee on National Defence and Veterans Affairs concluded that "national commitment – in essence a moral commitment - to the Canadian Forces [must be based

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[115]Lt Col K.C. Beaton, "Importance of the Defence Medical Services" (Shrivenham: Joint Services Command and Staff College Defence Research Paper, 2007), 5.

[116]Liberal Democrats, "Military Covenant has been broken – Campbell," http://www.libdems.org.uk/news/story.html?id=12178; Internet; accessed 20 February 2008.

on a series of five principles with one of them being] that suitable recognition, care and compensation be provided to veterans and those injured in the service of Canada. Here the guiding principle must always be compassion."[117] Although the military health care system is evolving and improving, there are still necessary steps that must be taken to fully provide the injured soldier with the best level of care possible

A Centralized Approach

In order to provide the optimum level of care for our sick and wounded soldiers, Canada needs to re-open a centralized military hospital that will become the centre of excellence in casualty care for the CF. The creation of a single, centralized hospital that incorporates full administrative and medical care for all wounded soldiers may be a costly endeavour for DND to undertake and one that likely cannot be created in the short term; however, when we are dealing with the lives and welfare of soldiers, it is something that must be looked at very seriously. This plan should be seen as a final end state for the Department to achieve with short and mid-term goals established prior to meeting this final aim. The first step in the evolution of casualty care is to group all of the supporting agencies under one organization.

DCSA, VAC, SISIP, Case Managers, Operational Stress Injury Social Support, Return to Work Program, Transition Assistance Program, and a multitude of other administrative agencies aimed at helping the wounded soldiers should all be co-located working together for one goal. All administrative policies and agencies would be

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[117]Government of Canada, "A Strategic Plan for Quality of Life Improvements in the Canadian Forces Standing Committee on National Defence and Veterans Affairs October 1998," http://cmte.parl.gc.ca/Content/HOC/committee/361/ndva/reports/rp1031525/ndvarp03-e.htm; Internet; accessed 9 March 2008.

grouped under one organization and under one commander, therefore providing a coordinated, coherent and efficient casualty support program that would eliminate the confusing and overwhelming stovepipe approach that is currently being undertaken. One of the key problems with our current casualty management system is the lack of communication amongst stakeholders. Again, the road to smooth communication will be achieved if they, or at the very least their representatives who are capable of making decisions, are grouped together into one organization under one commander. It is understood that several of these agencies are already embedded within different DND directorates, and even within some that are established in different federal government departments. If we want to provide our soldiers with a seamless and fully functional casualty support program, Canada needs to pull all of these resources together.

Although current administrative procedures for handling casualties differs across the country, this casualty management organization would create a single standard for casualty care and would eliminate the burden currently being taken by many home units. This single casualty management organization would streamline the current Canadian process of casualty care. Home units could still maintain contact with the sick and wounded but would no longer have the heavy administrative task of trying to provide the best care possible for the soldier. Assisting Officers could still be assigned to the wounded soldier and act as the single point of contact for all issues, but their jobs would be made easier by having all agencies and those responsible for policies in one location.

There would no longer be a handoff period between different organizations throughout the soldiers' progress. They would simply fall under one single organization from the time of injury until completion of all medical and administrative care. The

soldiers, once injured in theatre or here in Canada, would, upon arrival in Canada, fall under complete administrative control of the casualty management centre until they were deemed healthy again to return to work. The centre would be the only organization in DND responsible for casualty tracking from time of injury until return to normal health.

There is now sufficient evidence pointing to the critical need for the CF to establish at least one rehabilitation centre geared specifically toward physically and mentally wounded soldiers. The soldiers must have a centre that is catered to their needs rather than the needs of the civilian population. Programs need to be designed to train them to a high standard, so that they may once again return to their units as capable as the day that they were injured.

Many of our soldiers returning from combat situations are suffering from mental health issues brought on by post traumatic stress disorder. Some are receiving excellent treatment to return them to normalcy while many are slipping through the cracks of the system, being released from the CF and having their problems fester inside them as they sit at home. Many other soldiers are still not coming forward to let it be known that they are suffering inside out of fear of being labeled or released. Both VAC and DND are aware of the dramatic increase in the number of suffering soldiers both in and out of uniform.[118] This rehabilitation centre could also be tailored to the needs of our mental health patients. The Department can bring all the suffering soldiers together into an environment where they can receive dedicated treatment together. DND needs to take the

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[118] The Observer, "Military faces mental health crisis; Soldiers like Cpl. Travis Schouten of Sarnia are returning from Afghanistan with stress disorder," http://www.theobserver.ca/ArticleDisplay.aspx?e=938609&auth=JANE+SIMS; Internet; accessed 26 March 2008.

steps to take mental health seriously and we need to clearly tell our soldiers that we will take care of them if they become mentally injured. We also need to tell the soldiers that they will not be released from the CF until the Department is certain that normal mental health has been attained. Serious consideration needs to be given to the creation of a comprehensive rehab centre where the soldier would be surrounded by other sick and wounded soldiers and receive their treatment from military physicians.

It is clear that the Department is not in the business of promoting the Canadian public's awareness of our wounded soldiers. It is only on a few rare occasions that the public is made aware of the trials and tribulations of the injured combat veterans. Unfortunately, most of the stories that are made public are usually the negative ones concerning soldiers that are frustrated with a system that continues to neglect them. Canadians have full knowledge of those soldiers that have lost their lives in Afghanistan, but the Department has a hard time promoting the stories of the hundreds of wounded soldiers that have received care through the country's civilian hospitals. In order to garner support for the creation of military rehabilitation centres and hospitals, the Department needs to target the Canadian public and politicians. The Canadian Forces needs to tell the stories of our injured war heroes and let them tell the nation what they have been through. This will create an informed public, and also an informed cadre of civilian doctors and nurses who, until we have a dedicated military hospital, will be better prepared to provide treatment to the sick and wounded. Canada needs to stop hiding and abandoning our wounded soldiers. The country needs to bring the stories of the soldiers to the forefront and let them know that they are appreciated.

The next reasonable step for DND to consider is the purchase, allocation or construction of additional wings in currently existing civilian hospitals across the country. The Department is already pursuing this option with a collaborated effort with the Montfort hospital in Ottawa. Upon completion in mid 2008, this project will see a new pavilion added to the Montfort hospital which will provide a new workplace for DND civilian and military medical staff. The Department will provide certain aspects of health care directly to the patient and other services will be purchased from the Montfort hospital. Although service costs, physician fees and billing rates for services provided by Montfort have yet to be determined, the estimated total cost of the project is $200M.[119] The CF acknowledges the importance of having a hospital like facility of their own, especially "in the current environment of high operational tempo and increased number and variety of casualties."[120] This option could be duplicated across the country in numerous other civilian hospitals. At the very least, it would be a start to having a dedicated hospital where soldiers are surrounded by other soldiers and are receiving care from military physicians and nurses.

The next step to consider, and perhaps the most important one, is the creation of a single centralized super hospital. Here the soldier would receive one standard of care through dedicated medical care provided by military physicians and nurses. This would be the creation of only one hospital with one focus, for all sick and injured across the country.

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[119]Colonel R.F. Pucci, *Briefing Note for Minister of National Defence – Montfort Hospital Project* (Director Health Services Delivery), 16 January 2008.

[120]*Ibid*.

Although the figures have not been calculated, there may be significant costs in constructing a new hospital facility if an existing building that is of good quality cannot be found or used. An increase to the defence budget or to cost account the facility over its lifetime would be two possible solutions. Perhaps the navy, army and airforce could do with one less ship, a few less armoured vehicles or a few less airplanes if it means the difference between providing good care to soldiers versus mediocre to poor care received in civilian hospitals. Proponents of this option would argue that it should not be about the money and Canada needs to do what is morally right; however, if we are to realistically look at this, the country needs to take the centralized hospital concept as a goal that it wants to achieve as soon as possible. With the will of the Department and our political leaders we can achieve an end-state of having a centralized super hospital to take care of our soldiers.

The idea of getting a soldier placed in a hospital close to his or her family will not work for those families that do not reside close to the facility. There may be some merit in having soldiers moved close to their loved ones, as it does provide the soldier with a much needed level of comfort. However, this is really only beneficial in the short term and what the soldiers really need is to receive specialized care in a hospital that understands them and can place them together with other soldiers. This cannot be achieved in a civilian hospital. The follow-on question to this is where should the hospital be constructed? Should it be set up in a central part of the country, in a major city, or elsewhere? In the end, a well informed decision will have to be made and it is certain that it will not please everyone across the country, but if the Department wants to provide the best possible care to its wounded soldiers, then the centralized hospital should

be quickly pursued. The hospital is not established to please the needs of the family. Yes, they are important, but more importantly are the needs of the wounded soldier.

The third negative issue is finding enough military doctors and nurses to actually work in the hospital. The CF has had a difficult chore in trying to find applicants for physician positions. In 2006, then Chief of Military Personnel, Rear Admiral Pile, remarked before a Veterans Affairs committee that there were significant shortages in terms of medical officers and nurses but that the Department was working hard at trying to recruit sufficient numbers. The issue is not really in terms of financial compensation but more to do with the availability of appropriately trained people who are willing to come to work for the Department.[121] The 2007 Auditor General's Report "found that there were four times more physicians per 1,000 military members compared with the civilian systems. [It] also found that almost 40 percent of military physicians are not providing patient care but are, instead, employed in administrative or other functions."[122]

The Department is beginning to rely more and more on civilian practitioners to fill the gaps which may turn out to be more detrimental to soldiers in the long run if they are being treated by a physician who does not have the same military indoctrination as the patient that is being treated. Military doctors filling administrative roles need to be replaced by administrative staff or civilian contractors so that the physician can concentrate on the primary role of treating wounded and ill soldiers. In addition, a comprehensive public affairs campaign concerning our wounded soldiers will help to

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[121]Proceedings of the Subcommittee on Veterans Affairs, "Issue 2 – Evidence – Meeting of November 22, 2006," http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/vete-e/02eva-e.htm?Language=E&Parl=39&Ses=1&comm_id=79; Internet; accessed 15 January 2008.

[122]Office of the Auditor General of Canada, "2007 Report of the Auditor General of Canada, Chapter 4 – Military Health Care – National Defence," http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_2007_4_e_23838.html; Internet; accessed 13 March 2008.

inform aspiring military physicians about our needs and perhaps help them to make their decision easier to join the Canadian Forces. Furthermore, a career in the CF as a physician will likely be more appealing for prospective civilians if they know that DND had its own internal hospital system.

The single centralized hospital would mean that the soldier would be receiving treatment from those who are familiar with the military environment and can understand the military esprit de corps and what it means to be a soldier. Not only would the soldiers be receiving treatment from military physicians but they would also be surrounded by other wounded and sick soldiers who are all from the same "family." This super hospital would not only be the centre of excellence for primary medical care, but it could also contain the single centralized casualty management system and a comprehensive rehabilitation centre mentioned previously. All three crucial pieces of casualty care would be housed in one structure where physicians, therapists and administrative personnel would be able to concentrate their efforts in a coherent and efficient manner on the wounded soldier.

This new facility would provide an excellent training ground for our military physicians, thereby reducing the need to conduct extensive training in civilian institutions across Canada and the United States. The physicians and nurses would be dealing first hand with the traumas of war in their own hospital in their own country.

Reserve soldiers would receive the same standard of care in this facility and would not be left out on their own. No longer would the reserve soldier in a remote posting slip through the cracks as he or she sits idly in a distant hospital, far from a major centre. Reserve force units would not have to carry the administrative load of trying to

manage the recovery of the soldier. DND would take this task on at the highest level and implement a strategic casualty management plan that is controlled at the highest levels of the Department. The reserve soldier would continue to be a part of the entire CF family as he or she receives care amongst other soldiers in one centralized facility.

The public health care system is currently overstretched and being worked to its maximum potential. By removing our soldiers from the public health care system, the Department could slightly reduce the burden, but more importantly, it will tell the soldier that the country is willing to provide a separate level of medical care in its own hospital. This will create one single standard across the country for all of our sick and wounded soldiers.

An example for Canada to follow, albeit on a much larger scale, is The Walter Reed Army Medical Center in Washington, D.C:

> The Walter Reed Health Care System provides comprehensive health care for more than 150,000 soldiers, other service members, family members and retirees in the National Capital Area. Its hub is the Walter Reed Army Medical Center, the clinical center of gravity of American military medicine. The Walter Reed Health Care System (WRHCS) is an integrated health care delivery system offering military families, in and around Washington, D.C., access to quality, comprehensive medical care. WRHCS provides a full range of services for patients, from routine primary care to the most sophisticated, high-tech specialty care. It is patient-focused and dedicated to streamlining each patient's passage to the appropriate level of care he or she needs. Each facility within the system is a valuable partner and brings its unique expertise to bear on health care delivery.[123]

This immense organization is the first stop for many returning veterans of the Iraq and Afghanistan conflicts. Here they receive dedicated medical care and a fully integrated rehabilitation program to ensure that they are fully fit to return to active duty

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[123] Walter Reed Army Medical Centre, "About Walter Reed Health Care System," http://www.wramc.army.mil/Visitors/visitcenter/Pages/aboutus.aspx; Internet; accessed 26 March 2008.

or to transition to civilian life. The effectiveness of the centre has not gone unnoticed by the CF. Captain Fawcett, along with other high ranking DND leaders, toured the facility in April 2007, which they described as an amazing experience. The rehabilitation program is taken extremely seriously at the centre, where injured soldiers are not released from the care of the centre until they are physically capable of carrying on with their military occupation or have found employment as a civilian.[124]

Further Options to Pursue

In order to improve the level of care provided to the soldier, the United States Department of Defense has recently stood up what are called Warrior Transition Brigades. The idea behind these brigades is that they place combat veterans in primary positions of care for the wounded soldiers undergoing convalescence and rehabilitation. Essentially, acting as assisting officers to the wounded, these brigades of like minded soldiers offer extensive help to wounded, ill or injured soldiers. The program also provides assistance to family members and a myriad of administrative support services.[125] Through these Brigades, the US Army has "developed a system that incorporates both daily people-management needs and medical care needs of the soldier into an organizational structure that brings significant improvement to the transition process."[126] The United States takes casualty care seriously. It has even appointed an

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[124]Captain Kimberly Fawcett, personal correspondence with author, 2 March 2008

[125]Army, "Warrior Transition Leaders Meet: Mission Second Only to Combat," http://www.army.mil/-news/2008/01/22/7066-warrior-transition-leaders-meet.html; Internet; accessed 10 February 2008.

[126]Army Medecine, "Commentary: Warrior Transition Brigade Worth Emulating," http://www.armymedicine.army.mil/amap/2008014commentary.html; Internet; accessed 10 February 2008.

Assistant Surgeon General for Warrior Care and Transition.[127] Granted the US Armed Forces are much larger, but once we have implemented a centralized casualty support system we can then glean some lessons from the Americans and begin to truly elevate our casualty care to the level that it should be.

Another option to consider following the successful implementation of a centralized hospital system would be the opening of multiple CF hospitals across the country. Although this option may be viewed as initially cost intensive, it could serve as an appropriate longer term goal for DND. Upon implementation of the first centralized hospital, subsequent hospitals could be re-built at major bases across the country on a five to ten year cycle. An incentive to improve the feasibility of this option is to study the possibility of opening military health care to dependants. This means that the next of kin of the soldiers could receive medical treatment from military physicians. This option would likely gather great favour amongst military members as it would cater to the needs of their families as they are posted across the country from base to base. Families would no longer have to search for a family doctor on every posting. Furthermore, it could be a successful option not only for the military and the soldier's family, but also for the public health care plans.

One of the reasons why physicians are not staying with the Forces is that there are more opportunities for a wider breadth of clinical practice in the civilian world. Not including the doctors that deploy on operations, the military physician in Canada is normally treating minor injuries and ailments for healthy young individuals. In order to

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[127] *Ibid*.

provide our physicians with a broader scope of patients the Department could consider taking the monumental step of opening up our health care program to military families.

Although cost sharing and legal studies would have to be undertaken between the public health care plans and DND, the opening of numerous military hospitals across the country would have additional merit if the government and senior leadership have the will to undertake it. In addition to lessening the burden on the overstretched public health care system, this option would provide military physicians with extra patients to care for, help them remain fairly competent and fully trained within current medicine, and most importantly, show our military members that Canada truly does care about them and their families.

A final option to pursue upon re-opening of a centralized hospital system is to attempt to professionalize the role of the casualty manager and/or assisting officer. With casualty management becoming an increasing complex issue, which is compounded by the fact that it is multi-agency dependent, it may be time that we begin to consider the need to create a new military occupation that specializes in the administrative aspects of casualty management. It is a daunting task for an officer to take on the role of an assisting officer to a wounded soldier. There are too many complex policies and agencies to deal with, that a two or three day course in casualty care does not have the scope to fully prepare an individual for the task at hand. There must be a link between the wounded soldiers and the administrative machine that supports them. By professionalizing this role, Canada could invest the time and money in fully training individuals with the complex task, thereby ensuring that the delivery of all administrative

aspects of casualty care are conducted in a coherent and efficient manner for wounded soldiers.

There is no question that Canada needs to improve its casualty support mechanisms. Immediate and effective changes include the centralization of all casualty support agencies into a coherent and focused organization, the implementation of a comprehensive public affairs campaign, the stand-up of a military oriented rehabilitation centre for physically and mentally wounded soldiers and the continued efforts to amalgamate dedicated military medical care into existing civilian hospitals. The ultimate goal of re-opening a single and solely dedicated military hospital should become a major project for the Department to study. It must be carefully analyzed since this institution can and will be able to provide optimum casualty care to the Canadian soldier.

CONCLUSION

DND has articulated the need to show care and compassion for subordinates.[128] It notes that CF members must promote the well being of their subordinates and that leaders must have a full understanding, on both the professional and personal levels, that taking care of our subordinates is a crucial responsibility without which there could easily be a breakdown within a tight-knit and effective force with high morale. The Canadian Forces is attempting to provide proper care and treatment for its wounded and sick soldiers, but this effort is not being properly channeled to fully meet their needs.

Further, the overall casualty support system, which is in place to help these soldiers in their time of need, is failing to see the need for a coordinated and centralized approach to casualty care. The current system is confusing, with many different agencies claiming to be working to help the soldier, but not coordinating with one another. Casualty administration must be something that occurs in the background and must be efficient to the point that the soldier does not need to get involved in resolving administrative issues. We need to streamline the process so that we do not end up with comments such as the following that was received from a wounded soldier who was recently repatriated: "After the experience my family and myself have had to go through in serving my country in a proud and noble profession, [sic] feeling as if we would have been better off coming home in a pine box."[129]

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[128]Department of National Defence, *Duty With Honour: The Profession of Arms in Canada* (Kingston: Canadian Defence Academy, 2003), 14.

[129]Anonymous wounded soldier, Canadian Forces Casualty Support Symposium, Ottawa, 5 February 2008.

DND and the CF leadership do recognize the need to improve the level of care that is provided to our soldiers. The Chief of Military Personnel has instituted numerous projects and working groups to perform an in-depth examination of the problems and to institute a coherent campaign plan that should address the needs of our wounded and ill.[130] This devised plan is an attempt to streamline most of the administrative aspects of casualty care, but does not address the need to re-open our military hospitals. The current level of care provided to sick and wounded soldiers can be improved upon to the point where Canada, as a medium world power, could have a very credible and effective military health care system that it could start to move forward and build upon.

This paper has argued that in order to provide a suitable level of care for our sick and wounded soldiers, there is a need to re-open our military hospital system. By centralizing our ability to provide care and rehabilitation, the Department of National Defence will be able to have a coherent, effective and efficient manner to treat our sick and wounded in an environment which is comfortable for them. A single structured approach to casualty care will meet all of the needs of the wounded soldier from surgery, to convalescence, rehabilitation and administration. The military hospital can and will become the centre of excellence for casualty support.

This paper began with an examination of the historical aspects of casualty care throughout the world and it examined the origins of the Canadian casualty support system and the evolution of the CF hospital. It also provided an in-depth look at why Canada closed its military hospitals and how the Department of National Defence implemented

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[130]Department of National Defence, Chief of Military Personnel, Presentation to the Personnel Management Council on the care, employment and management of the ill and injured, 4 December 2007.

various plans to improve the military health care system. The paper then considered how casualty support is being conducted today, highlighting the use of civilian hospitals for medical care and it delved into the decentralized approach that is currently being taken to care for and rehabilitate our wounded soldiers across the country. It also outlined the systemic and human issues that have arisen since Canada began relying on the public health care system. Furthermore, it discussed the plans and studies that have been undertaken by the Department of National Defence to try and improve casualty care. The last chapter of the paper outlined why a military hospital system is needed to properly care for wounded soldiers. The chapter began with an examination of what exactly an internal medical capability does for a fighting force. It presented several practical, legal and moral reasons for the existence of a military hospital. Moreover, it demonstrated the need for a centralized approach to casualty care through the establishment of a centre of excellence that incorporates casualty administration, dedicated medical and rehabilitation support for the soldier. It further argued the need to place soldiers in the care of military physicians in a military surrounding. Finally, the paper presented a few additional options that the CF could pursue once a military hospital system has been reintroduced.

Soldiers of the Canadian Forces are one of the greatest assets that this country has. Fearlessly carrying out the wishes of the government here at home and further abroad, where they encounter perilous situations without pause. Canadian soldiers need to be elevated to the next standard of care and need to know that this nation fully supports them both in combat and through the entire medical and casualty management process if they become injured or ill. Our soldiers receive world class care in front line hospitals in Kandahar, and upon transition to Landstuhl, Germany, so why can we not continue that

same level of care here in Canada? Canada must provide them with the best possibilities to heal and to continue on with an exciting career in the CF. The Department must re-open the military hospital, re-align the casualty management process and tell the soldier that we truly care about their welfare. If political and military leaders are serious about caring for the soldier, then Canadian casualty care centralized in a military hospital can become a model for the rest of the world to follow.

Bibliography

Adami J. George. *War Story of the Canadian Army Medical Corps 1914-15.* Westminster: The Rolls House Publishing Co. Ltd., 1918.

Army. "Warrior Transition Leaders Meet: Mission Second Only to Combat." http://www.army.mil/-news/2008/01/22/7066-warrior-transition-leaders-meet.html; Internet; accessed 10 February 2008.

Army Medecine. "Commentary: Warrior Transition Brigade Worth Emulating." http://www.armymedicine.army.mil/amap/2008014commentary.html; Internet; accessed 10 February 2008.

BBC 2 Newsnight."Interview with General Sir Mike Jackson." http://news.bbc.co.uk/2/hi/programmes/newsnight/newsnight_interviews/default.stm; Internet; accessed 25 March 2008.

Baynes, John. *No Reward but honour? The British Soldier in the 1990s.* Toronto: Pergamon Press Canada Ltd, 1991.

Beaton, LT COL K.C. "Importance of the Defence Medical Services." Shrivenham: Joint Services Command and Staff College Defence Research Paper, 2007.

Bruce, Herbert A. *Politics and the Canadian Army Medical Corps*. Toronto: William Biggs, 1919.

Canada. Department of National Defence. "Board of Inquiry – Croatia: Sustainment – General." http://www.dnd.ca/boi/engraph/sustainment_e.asp; Internet; accessed 29 February 2008.

Canada. Department of National Defence. A-PA-005-000/AP-001 *Duty with Honour: The Profession of Arms in Canada*. Ottawa: DND Canada, 2003.

Canada. Department of National Defence. A-PA-005-000/AP-004 *Leadership in the Canadian Forces:Conceptual Foundations*. Ottawa: DND Canada, 2005.

Canada. Department of National Defence. *Aide Memoire: Casualty Reception and Management, A Canadian Forces Health Services Initiative.* Ottawa: DND Canada, 2006.

Canada. Department of National Defence, "Backgrounder – Medical Services Update." http://www.forces.gc.ca/site/newsroom/view_news_e.asp?id=62; Internet; accessed 25 January 2008.

Canada. Department of National Defence. "Board of Inquiry – Croatia: Executive Summary." http://www.dnd.ca/boi/engraph/summary_e.asp; Internet; accessed 29 February 2008.

Canada. Department of National Defence. *Canadian Forces Medical Service: Introduction to its History and Heritage*. Ottawa: Director General Health Services, 2003.

Canada. Department of National Defence. CANFORGEN 065/99CDS 054. *Special Message from the CDS*, 29 July 1999.

Canada. Department of National Defence. *Care, Employment and Management of the Ill and Injured*. Presentation to Personnel Management Council, 4 December 2007.

Canada. Department of National Defence. "Care of Injured Personnel and their Families Review." http://www.forces.gc.ca/site/minister/eng/Injury/Intro_e.htm; Internet; accessed 23 November 2007.

Canada. Department of National Defence. *Chief of Review Services – Review of CF Medical Services.* Ottawa: CRS, 1999.

Canada. Deparment of National Defence. *Chief of Review Services – Review of CF Medical Services Executive Summary and Action Plan Resulting from the CDS Task Force*. Ottawa: CRS, 1999.

Canada. Department of National Defence. "DAOD 5023-1: Minimum Operational Standards Related to Universality of Service." http://www.admfincs.forces.gc.ca/admfincs/subjects/daod/5023/1_e.asp; Internet; accessed 5 April 2008.

Canada. Department of National Defence. *Director Military Personnel Strategy and Coordination – Care of the Injured and Families Working Group: Transition and Support Cadre-Employment and Transition Management Capability Concept Paper.* Ottawa: DND Canada, 2007.

Canada. Department of National Defence. *Director Military Personnel Strategy and Coordination – Enhanced Local Casualty Support Concept* Paper. Ottawa: DND Canada, 2007.

Canada. Department of National Defence. *Director Military Personnel Strategy and Coordination – New Reserve Force Sub-Components.* Ottawa: DND Canada, 2007.

Canada. Department of National Defence. *Draft Land Force After Action Review of Canadian Contribution in Afghanistan in Regional Command (South) Kandahar 2006-2007.* Ottawa: DND Canada, 2007.

Canada. Department of National Defence. "Health Services – Understanding and Caring." http://www.forces.gc.ca/health/engraph/about_us_e.asp?Lev1=5; Internet; accessed 8 March 2008.

Canada. Department of National Defence. MRL 08.005 *Media Response Line: Wounded in Action and Non-Battle Injury Statistics.* Ottawa: DND Canada, 2008.

Canada. Department of National Defence. "News/Public Affairs – Health Services Factsheets." http://www.forces.gc.ca/health/news_pubs/hs_factsheets; Internet; accessed 25 January 2008.

Canada. Department of National Defence. "Rx2000 – A Prescription." http://www.dnd.ca/health/news_pubs/rx2000/engraph/HCReform_article02_e.asp?Lev1=4&Lev2=6&Lev3=3; Internet; accessed 12 March 2008.

Canada. Department of National Defence/Veterans Affairs Canada. *Death and Disability Programs and Services.* Ottawa: ADM (PA) DPAPS, 2007.

Canada. Proceedings of the Subcommittee on Veterans Affairs, Issue 2 – Evidence – Meeting of November 22, 2006. http://www.parl.gc.ca/39/1/parlbus/commbus/senate; Internet; accessed 15 January 2008.

Canadian Broadcasting Corporation. "In the line of duty: Canada's casualties." http://www.cbc.ca/news/background/afghanistan/casualties/total.html; Internet: accessed 9 March 2008.

Canadian Broadcasting Corporation. "Nursing shortage affects Winnipeg intensive-care units." http://www.cbc.ca/health/story/2008/03/05/nursing-icu.html; Internet: accessed 22 March 2008.

Canadian Broadcasting Corporation. "Results of the CBC/Environics poll November 2006." http://www.cbc.ca/news/background/public-opinion/; Internet: accessed 15 Februay 2008.

Canadian Forces Casualty Support Symposium. Organized by the Chief of Military Personnel. Ottawa, 5 February 2008.

CMAJ. "Preparing Canadian Military surgeons for Afghanistan." http://www.cmaj.ca/cgi/content/full/; Internet; accessed 20 February 2008.

Carter, Doris V. *Never Leave Your Head Uncovered: A Canadian Nursing Sister in World War Two.* Waterdown: Potlatch PublicationsLimited, 1999.

Cook, Tim. *At the Sharp End: Canadians Fighting the Great War, 1914-1916*. Toronto: Penguin Group, 2007.

Cowdrey, Albert E. *Fighting for Life: American Military Medicine in World War II*. New York: The Free Press, 1994.

Gabriel, R.A. and K.S. Metz. *A History of Military Medicine: From Ancient Times to the Middle Ages*. Westport: Greenwood Press, 1992.

Gabriel, R.A. and K.S. Metz. *A History of Military Medicine: From the Renaissance through Modern Times*. Westport: Greenwood Press, 1992.

Gabriel, R.A. and K.S. Metz. *Sumer to Rome: The Military Capabilities of Ancient Armies.* Westport: Greenwood Press, 1991.

Greenwood, John and F.C. Berry. *Medics at War: Military Medicine from Colonial Times to the 21st Century*. Annapolis: Naval Institute Press, 2005.

Government of Canada. "A Strategic Plan for Quality of Life Improvements in the Canadian Forces, Standing Committee on National Defence and Veterans Affairs October 1998." http://cmte.parl.gc.ca/Content/HOC/committee/361/ndva/reports/rp1031525/ndvarp03-e.htm; Internet; accessed 9 March 2008.

Hepenstall, Robert. *Find the Dragon: The Canadian Army in Korea 1950-1953*. Edmonton: Four Winds Publishing, 1995.

Kaufman, Matthew H. *Surgeons at War: Medical Arrangements for the Treatment of the Sick and Wounded in the British Army during the Late 18th and 19th Centuries*. Westport: Greenwood Press, 2001.

Kellet, Anthony. *Combat Motivation: The Behaviour of Soldiers in Battle.* Boston: Kluwer, 1982.

Kellet, Anthony. *Motivation and Behaviour: The Influence of The Regimental System, Part 1 – Esprit de Corps.* Ottawa: ORAE Report No. R109, 1991.

Laffin, John. *Combat Surgeons*. Gloucestershire: Sutton Publishing, 1999.

Liberal Democrats. "Military Covenant has been broken – Campbell." http://www.libdems.org.uk/news/story.html?id=12178; Internet; accessed 20 February 2008.

"Life and Death in Kandahar." *The Fifth Estate.* Canadian Broadcasting Corporation. CBC Toronto, Toronto. 12 March 2008.

Macphail, Andrew. *Official History of the Canadian Forces in the Great War 1914-19: The Medical Services*. Ottawa: F.A. Ackland, 1925.

Melady, John. *Korea: Canada's Forgotten War*. Toronto: Macmillan of Canada, 1983.

Ministry of Defence. "Soldiering – The Military Covenant." http://www.army.mod.uk/servingsoldier/usefulinfo/valuesgeneral/adp5milcov; Internet; accessed 20 February 2008.

Office of the Auditor General of Canada. "1990 Report of the Auditor General of Canada, Chapter 23 – Department of National Defence – Human Resource Management – Medical Support." http://www.oag-bvg.gc.ca/domino/reports.nsf/html/9023ce.html; Internet; accessed 25 January 2008.

Office of the Auditor General of Canada. "2007 Report of the Auditor General of Canada, Chapter 4 – Military Health Care – National Defence." http://www.oag-bvg.gc.ca/internet/English/aud_ch_oag_2007_4_e_23838.html; Internet; accessed 13 March 2008.

Priest, Lisa. "Why Ontario keeps sending patients south." *Globe and Mail*, 1 March 2008.

Pucci, Colonel R.F. *Briefing Note for Minister of National Defence – Montfort Hospital Project*. Ottawa: Director Health Services Delivery, 16 January 2008.

Quiney, Linda J. "Assistant Angels: Canadian Women as Voluntary Aid Detachment Nurses During and After the Great War, 1914-1930," Ph.D. thesis, University of Ottawa, 2002.

Rawling, Bill. *The Myriad Challenges of Peace: Canadian Forces Medical Practitioners Since the Second World War*. Ottawa: Communication Canada, 2004.

Rozelle, Captain David. *Back in Action.* Washington: Regnery Publishing, 2005.

Reznick, Jeffrey S. *Healing the Nation: Soldiers and the culture of caregiving in Britain during the Great War.* Manchester: Manchester University Press: 2004.

Salat, Natalie. "The Quiet Fight: Master Corporal Paul Franklin." *Legion Magazine*, November/December 2007, 18-21.

Salisbury, David and Allan English. "Prognosis 2020: A Military Medical Strategy for the Canadian Forces." In *The Operational Art: Canadian Perspectives Health Service Support*, edited by Allan English and James C. Taylor, 1-19. Kingston: Canadian Defence Academy Press, 2006.

The Chronical Herald. "Stress cases climb sharply among Afghan mission vets." http://thechronicleherald.ca/Canada/9005759.html; Internet; accessed 29 February 2008.

The Globe and Mail. "The working wounded." http://www.theglobeandmail.com/servlet/story/RTGAM.20080307.wsoldier_cover08/BNStory/Front/home?cid=al_gam_mostview; Internet; accessed 8 March 2008.

The Observer. "Military faces mental health crisis; Soldiers like cpl. Travis Schouten of Sarnia are returning from Afghanistan with stress disorder." http://www.theobserver.ca/ArticleDisplay.aspx?e=938609&auth=JANE+SIMS; Internet; accessed 26 March 2008.

Thomas, H.W. *Canadian Participation in the Korean War, Part Two: 1 April 1952 to 31 July 1953*. Report No. 72 Historical Section (G.S.) Army Headquarters, 1955.

Walter Reed Army Medical Center. "About Walter Reed Health Care System." http://www.wramc.army.mil/Visitors/visitcenter/Pages/aboutus.aspx; Internet; accessed 26 March 2008.

Watson, Brent B. "Far Eastern Tour: The Experiences of the Canadian Infantry in Korea, 1950-1953," Ph.D. thesis, University of Victoria, 1999.

1st Battalion The Royal Canadian Regiment Rear Party. *TF 3-06 Casualty Care After Action Review*. Canadian Forces Base Petawawa, October 2006.