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A STORY OF THE CANADIAN FORCES MEDICAL SERVICES AS TOLD BY THE COLONEL COMMANDANT ON THE OCCASION OF THE 25TH ANNIVERSARY

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A STORY OF THE CANADIAN FORCES MEDICAL SERVICES

AS TOLD BY

THE COLONEL COMMANDANT

ON THE OCCASION OF

THE 25TH ANNIVERSARY OF ITS FORMATION

CLARENCE HOUSE
S.W.1

When in 1977 I was invited to become Colonel-in-Chief of the Canadian Forces Medical Services I accepted the appointment with pride and pleasure.

I have been able to keep in close touch with your activities during my visits to Canada and through the frequent reports I have received from the Colonel Commandant, and I have been most interested to learn of the wide-ranging operations you are undertaking and of your splendid achievements both in Canada and in stations overseas.

This year the Canadian Forces Medical Services celebrate their 25th Anniversary and rightly enjoy a high reputation for loyalty, devotion to duty and efficiency. I send to All Ranks my congratulations on this important anniversary and my warmest good wishes for the year ahead.

Elizabeth R

1984

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PREFACE

It is useful for individuals and organizations periodically to review their past activities. By so doing, many advantages are gained: mistakes can be detected and actions taken to correct or, preferably, to avoid them in the future; trends can be recognized and rectified or pursued; good performance can be acknowledged; and satisfaction can be obtained from the results of that performance.

An opportunity to carry out a review of the conditions and the work of the Canadian Forces Medical Services (CFMS) since its formation in 1959 presents itself as we celebrate the 25th anniversary of the founding of the unified medical services. Unfortunately, a review of activities carried out over a quarter of a century must be in summary form only. Such a summary, of necessity, will leave out many details of people, places and events that have contributed to the total performance of the CFMS, details which serving and retired members of the medical services may consider should have been included. Despite these omissions and, possibly, some inaccuracies (for all of which I apologize), I believe that a summary account or story of the performance of the CFMS over the past 25 years will allow newer members of the medical services to gain from the experiences of their predecessors and will remind older members, and those who have retired, of the people and of the activities that have fashioned the proud record of the CFMS.

These are the purposes of this story. In its preparation I have been advised and assisted by a number of military members and civilian employees of the Surgeon General's staff. In particular, I am indebted to Mrs. J.C. Thomas, Secretary to the Surgeon General, whose contributions of information from her voluminous files and retentive memory have been invaluable to me in writing this story.

This account of the CFMS does not pretend to reflect the views of the Department of National Defence nor of those members of the Department who have provided me with advice and assistance. With the exception of statements and official documents that are quoted verbatim in the story, the opinions and views expressed are my own, and are based on information extracted from readily available papers and on recollections of my association with the CFMS since its founding 25 years ago.

It is my hope that this story will show that the CFMS has lived up to its motto, Militi Succurrimus — We Hasten to Aid the Soldier.

J.W.B. Barr (MGen Retd)
Colonel Commandant, Medical Branch
Canadian Forces

December, 1983

ERRATA

English Text

1. Page ii, Table of Contents, Chapter 8, "the Field Hospital" should read "The Field Hospital".
2. Page 5, 2nd para, line 2, "Canadian" should read "civilian".
3. Page 6, line 9, "forces" should read "Forces".
4. Page 7, line 3, "general" should read "General".
5. Page 11, line 2, "because" should read "Because".
6. Page 12, 3rd para under "The Canadian Forces Medical Services School (CFMSS) "(CFMSS)" should read "(CFMSS))".
7. Page 21, line 4, delete "," after the word "open".
8. Page 29, line 8, "assuring" should read "ensuring".
9. Page 40, line 3, "the Queen Mother" should read "The Queen Mother"
   line 7, "the Queen Mother" should read "The Queen Mother".
10. Page 51, Surgeons General, amend last entry to read:
    Major-General Robert Dupuis, CD, QHP, BA, MD, CSPQ, FRCP(C)
11. Page 52, Commandants of NDMC and Senior Clinical Consultants to the Surgeon General, amend fourth entry to read:
    Major-General Robert Dupuis, CD, QHP, BA, MD, CSPQ, FRCP(C)

ERRATA

Texte français

1. Page i, table des matières, chapitre 4, 5ième ligne, ajouter «m» à maladies.
2. Page iii, préface, 2ième ligne, ajouter «d'» à . . . avantages d'un . . .
3. Page 6, paragraphe 3, 13ième ligne, ajouter «d'» à . . . conseils d'ordre . . .
4. Page 12, paragraphe 1, 2ième ligne, voir militaires au lieu de militiares.
5. Page 12, paragraphe 5, dernière ligne, voir supérieur au lieu de supérieures.
6. Page 23, paragraphe 1, 6ième ligne, voir possibilité au lieu de faisabilité.
7. Page 38, paragraphe 2, 5ième ligne, voir Ismalia au lieu de Isma-57-lia.
8. Page 44, voir Capt au lieu de Cap sur la liste des membres de l'Ordre – MMM.
9. Page 55, paragraphe 2, dernière ligne, voir Major-général Robert Dupuis, CD, QHP, BA, MD, CSPQ, FRCP(C) au lieu de CD, QHP, MD, FRCP(C), FACP.

CHAPTER ONE

THE BIRTH OF THE CFMS

As reported in Hansard, the Minister of National Defence, the Honourable G.R. Pearkes, made the following statement to the House of Commons on Monday, 25 August, 1958:

> "Mr. Speaker, I am sure honourable members will be interested to hear that a decision has been reached to combine the medical services of the navy, army, and air force into one unified medical service. This decision has been taken after careful study extending over many months, and is in line with the recommendations of the estimates committee.
>
> The unification will commence on the 1st of January, 1959, and it is intended to include in the plan all medical officers, nursing sisters and non-medical administrative officers. Planning to this end is now proceeding at National Defence Headquarters, care being taken that the interest of all three armed forces is protected.
>
> The new armed forces medical service will be placed under the direction of a Surgeon General, who will be assisted by a single medical headquarters in Ottawa in place of four such medical headquarters as previously existed. Similarly, there will be subordinate regional medical headquarters appropriately located in relation to armed forces requirements both in Canada and abroad. The total number of regional headquarters will be, as a result of their unified character, considerably less than has been the case in the past.
>
> In reaching this decision I have had the advice of the Canadian Armed Forces Medical Council, which body includes prominent members of the civilian medical profession. I am satisfied that this move will result in more efficient and economical provision of medical service for the armed forces. As a result of unification, the professional development and career prospects of medical officers will be greatly improved."

This statement was based, in large part, on the report of a study conducted by the Canadian Forces Medical Council on ways to improve the efficiency of the medical services in war and peace, to remove the inequities in professional and technical medical training and in personnel administration that existed among the medical services of the navy, army, and air force, and to reduce duplication of service medical facilities in specific localities. The Council, which was made up of distinguished civilian medical administrators and educators and the heads of the service medical branches, arrived at its report after obtaining and consolidating the opinions of a broad sample of operational service authorities and of medical personnel, military and civilian, who had had experience in the armed forces before, during, and after the Second World War.

The statement of the Minister initiated a period of intensive studies by officers at the headquarters of the RCN, Canadian Army and RCAF, the object of which was to determine ways and means of implementing the intention of the Minister as announced in the House of Commons. In October 1958, Major-General K.A. Hunter, OBE, CD, QHP, was appointed Surgeon General, Canadian Forces. Later, each of the service headquarters issued instructions for implementing the unification of the medical units and personnel under their command into the new medical organization, the CFMS.

These instructions were similar in content and purpose, allowing for differences in the nomenclatures and procedures of the parent services, except that dietitians in the RCAMC were excluded from the provisions of the unification process. Because of the importance of these formal instructions, and because they demonstrated the cooperation of the separate operational services, the messages issued by the RCN are reported as an example, in detail, as follows:

"061501Z NOV 58
FM CANAVHED
TO AIG 1116
UNCLASSIFIED
CANGEN TWO FOUR TWO

1. THE MINISTER OF NATIONAL DEFENCE ANNOUNCED IN THE HOUSE OF COMMONS ON 25 AUGUST 1958 THAT UNIFICATION OF THE MEDICAL SERVICES WOULD COMMENCE ON 1 JANUARY 1959. AT THE SAME TIME HE STATED THAT A SURGEON GENERAL, CANADIAN FORCES, WOULD BE APPOINTED.

2. THE OBJECTIVE OF THIS UNIFICATION IS TO PROVIDE THE MOST FLEXIBLE EFFICENT AND ECONOMICAL MEDICAL SERVICE FOR THE ARMED FORCES. THE FLEXIBILITY WHICH WILL BE ATTAINED BY THE PROVISION OF A SINGLE POLICY AND CONTROL FOR THE FORCES MEDICAL SERVICE WILL ALSO RESULT IN ADVANTAGES TO THE PERSONNEL OF THAT SERVICE.

3. CONSEQUENT UPON THE COMBINATION OF THE THREE MEDICAL SERVICES, THE CONSOLIDATED RANK STRUCTURE WILL OFFER WIDER CAREER POSSIBILITIES APPLICABLE TO ALL OFFICERS AND OTHER PERSONNEL. SIMILARLY, THE RANGE OF PROFESSIONAL AND TECHNICAL TRAINING, EXPERIENCE AND EMPLOYMENT WILL BE INCREASED FOR ALL RANKS. IT IS NOT INTENDED THAT THERE BE RADICAL CHANGES IN THE EMPLOYMENT AND LOCATION OF MEMBERS OF THE MEDICAL SERVICE. ANY CHANGES WHICH ARE MADE WILL FLOW FROM THE MOST CAREFUL STUDY BY THE SURGEON GENERAL WITH IMPLEMENTATION OF THE RESULTS OF SUCH STUDY BEING CONTROLLED BY THE PERSONNEL MEMBERS COMMITTEE.

4. IT HAS NOW BEEN DECIDED THAT THE UNIFICATION OF THE MEDICAL SERVICES WILL BE CARRIED OUT ON THE BASIS OF THE FOLLOWING PRINCIPLES:

(A) A NEW ORGANIZATION WITHIN THE CANADIAN FORCES TO BE KNOWN AS THE QUOTE CANADIAN FORCES MEDICAL SERVICE UNQUOTE (CFMS) WILL BE CREATED.

(B) THE MEDICAL UNITS AND PERSONNEL OF THE THREE SERVICES, BOTH REGULAR AND RESERVE, WILL BE COMPRISED IN AND FUNCTION COLLECTIVELY AS THE CANADIAN FORCES MEDICAL SERVICE. EACH OFFICER AND MAN OF THE CFMS WILL BE ATTACHED FOR ALL PURPOSES TO THE SERVICE WITHIN WHOSE COMMAND STRUCTURE THE UNIT WITH WHICH HE IS SERVING FORMS A PART. IN THE CASE OF UNITS WHICH DO NOT FORM PART OF A COMMAND STRUCTURE, ATTACHMENT WILL BE TO THE SERVICE RESPONSIBLE FOR ADMINISTRATIVE SUPPORT OF THE UNIT IN WHICH THE OFFICER OR MAN IS SERVING.

(C) THE CFMS WILL BE UNDER THE DIRECTION OF A SURGEON GENERAL WHO WILL BE RESPONSIBLE TO PERSONNEL MEMBERS COMMITTEE FOR MEDICAL MATTERS COMMON TO ALL SERVICES AND TO EACH OF THE PERSONNEL MEMBERS FOR MATTERS SPECIAL TO THAT SERVICE. THE SURGEON GENERAL WILL BE AN EX OFFICIO MEMBER OF THE PERSONNEL MEMBERS COMMITTEE FOR MEDICAL MATTERS.

(D) NEW ENTRANTS WILL BE ENROLLED IN ANY ONE OF THE ARMED FORCES AND WILL BE ASSIGNED IMMEDIATELY TO THE CFMS.

(E) EXISTING TERMS OF SERVICE AND COMMITMENTS WILL BE VARIED ONLY TO THE EXTENT DESIRABLE TO EFFECT THE UNIFICATION OF THE MEDICAL SERVICES. ALL RANKS OF THE MEDICAL SERVICES ARE ASKED TO GIVE THIS NEW ORGANIZATION A FAIR TRIAL OF AT LEAST A YEAR. AFTER THIS TRIAL PERIOD, IF THEY ARE NOT SATISFIED, THEY MAY APPLY THROUGH THE NORMAL CHANNELS FOR THEIR RELEASE FROM THE SERVICES. AT THAT TIME, THE MINISTER HAS UNDERTAKEN TO REVIEW EACH SUCH APPLICATION FOR RELEASE ON ITS MERITS, AND TO GIVE FAVOURABLE CONSIDERATION, WITHIN THE REGULATIONS AND THE INDIVIDUAL'S OBLIGATIONS, TO SUCH RELEASE. THE MINISTER DOES NOT INTEND AT THIS TIME TO RECOMMEND ANY CHANGES IN EXISTING LEGISLATION OR REGULATIONS IN REGARD TO RELEASE OR THE GRANTING OF PENSION AS A RESULT OF THE CREATION OF THE CFMS.

(F) GENERAL ADMINISTRATION OF THE CFMS WILL BE CARRIED OUT USING THE EXISTING SERVICE ADMINISTRATIVE FACILITIES. LOCAL ADMINISTRATION WILL BE CARRIED OUT BY THE SERVICE WITH WHICH THE INDIVIDUAL OR UNIT IS SERVING.

(G) FOR THE TIME BEING, PERSONNEL OF THE CFMS WILL CONTINUE TO WEAR THE UNIFORM OF THE SERVICE IN WHICH THEY ARE ENROLLED.

(H) PROCUREMENT AND RESPONSIBILITY FOR CUSTODY OF MEDICAL STORES WILL BE UNDER THE DIRECTION OF THE SURGEON GENERAL, USING EXISTING FACILITIES.

(I) THE PERSONNEL MEMBERS COMMITTEE, WITH THE ASSISTANCE OF THE SURGEON GENERAL, WILL SUBMIT FOR APPROVAL THE ORGANIZATION AND RANK STRUCTURE OF THE CFMS HEADQUARTERS AND SUCH SUBORDINATE HEADQUARTERS AS MAY BE NECESSARY, TOGETHER WITH SUCH CHANGES AS ARE REQUIRED IN ORGANIZATION, ADMINISTRATION, TRAINING AND TERMS OF SERVICE FOR BOTH REGULAR AND RESERVE COMPONENTS.

(J) PENDING COMPLETION OF THE PLAN MENTIONED IN (I), THERE WILL BE NO SUBSTANTIAL CHANGE IN THE ORGANIZATION, OPERATION, COMMAND AND ADMINISTRATION OF THE THREE EXISTING MEDICAL SERVICES."

"151933Z JAN 59
TO AIG 1116
UNCLASSIFIED CANGEN ONE THREE

1. FURTHER TO CANGEN 242/58, THE MINISTER OF NATIONAL DEFENCE UNDER SECTION 4 OF THE NATIONAL DEFENCE ACT, HAS AUTHORIZED THAT, EFFECTIVE 15 JANUARY 1959 THERE SHALL BE AN ORGANIZATION WITHIN THE CANADIAN FORCES TO BE KNOWN AS QUOTE THE CANADIAN FORCES MEDICAL SERVICE UNQUOTE (CFMS) WHICH SHALL CONSIST OF SUCH UNITS AND OTHER PORTIONS OF THE CANADIAN FORCES AND SUCH OFFICERS AND MEN AS THE CHIEF OF THE NAVAL STAFF, THE CHIEF OF THE GENERAL STAFF, AND THE CHIEF OF THE AIR STAFF MAY FROM TIME TO TIME ASSIGN TO THE CANADIAN FORCES MEDICAL SERVICE FOR EMPLOYMENT THEREIN.

2. THE CHIEF OF THE NAVAL STAFF HAS ASSIGNED TO THE CANADIAN FORCES MEDICAL SERVICE, EFFECTIVE 15 JAN 1959, ALL MEDICAL PERSONNEL OF THE RCN AND RCN(R), THAT IS, ALL MEDICAL OFFICERS, MEDICAL ADMINISTRATIVE AND TECHNICAL OFFICERS, NURSING OFFICERS AND MEN AND WRENS OF THE FOLLOWING TRADES: MA, LA, HA, RR, TM, OR, PM, ME, ML AND MX.

3. THE RCN PERSONNEL THUS FORMING THE PARTS OF THE CFMS WILL, NOTWITHSTANDING PARA 2, CONTINUE FOR THE TIME BEING TO BE MEMBERS OF THEIR PARENT UNITS AND WILL CONTINUE TO BE GOVERNED FOR COMMAND AND ADMINISTRATION BY EXISTING RCN REGULATIONS AND TERMS OF SERVICE EXISTING AS OF 15 JAN 1959.

4. ALL OFFICERS AND MEN ASSIGNED TO THE CFMS UNDER PARA 2 WHO ARE SERVING WITH UNITS NOT WITHIN THE COMMAND STRUCTURE OF THE RCN HAVE BEEN ATTACHED, PURSUANT TO QRCN ARTICLE 10.17 TO THE SERVICE OF THE CANADIAN FORCES WITHIN WHOSE COMMAND STRUCTURE THE UNIT WITH WHICH THEY ARE SERVING FALLS.

5. QUEENS REGULATIONS ARE BEING AMENDED TO PROVIDE THAT AN OFFICER OR MAN ASSIGNED TO THE CANADIAN FORCES MEDICAL SERVICE FOR EMPLOYMENT SHALL OBEY THE ORDERS OF PERSONS SENIOR TO HIM IN RANK WHO ARE ASSIGNED TO THE CANADIAN FORCES MEDICAL SERVICES AS IF THOSE PERSONS WERE MEMBERS OF THE SERVICE TO WHICH HE BELONGS.

6. NOTWITHSTANDING THE FACT THAT THE STAFF OF MEDICAL DIRECTOR GENERAL (NAVY) NOW FORMS PART OF THE STAFF OF THE SURGEON GENERAL, EXISTING CHANNELS OF COMMUNICATION WILL BE MAINTAINED UNTIL FURTHER NOTICE.

7. FURTHER INSTRUCTIONS REGARDING DETAILS OF IMPLEMENTATION WILL FOLLOW."

Thus, only two weeks after the date specified by the Minister in his announcement to the House of Commons, the CFMS came into being officially on January 15, 1959, as a medical organization under the control of a Surgeon General that was intended to provide preventive and therapeutic medicine to the members of the armed forces of Canada in peace and in war.

How closely that intention was followed and what success the CFMS has achieved during the first 25 years of its existence are the themes of subsequent chapters of this story.

CHAPTER TWO

ORGANIZATION AND ADMINISTRATION

Associated Organizations

It is fitting to begin this account of the Canadian Forces Medical Services (CFMS) by paying tribute to two organizations associated with it which were in being prior to its formation and which are still active in advisory and supportive roles. These organizations are the Canadian Forces Medical Council (CFMC) and the Defence Medical Association of Canada (DMA).

The CFMC played an active and executive part in the development of the CFMS, as was evidenced in the Minister's announcement of August 1958. It was, and is, composed of four prominent members of the Canadian medical community in Canada, and the Surgeon General. Shortly after the CFMS was formed, CFMC decided to become an advisory body only. It has continued to assist the Surgeon General in the development of general medical policies and, by the appointment and maintenance of a panel of distinguished consultants in specialties in civilian practice, has continued to provide advice to the military practitioners of medicine, nursing and other supporting health disciplines on policies peculiar to the specialties to which they belong.

The DMA has been active in supporting the military medical services since its inception after the end of the North West Rebellion. At its founding, and for many years thereafter, its main role was to foster the development and efficiency of the medical services. It has continued to fulfil this function and has been charged with others, such as to provide support to the Surgeon General. Having been composed of officers, serving and retired, who have a continuing interest in the medical services of the Canadian Forces, the DMA has been well-equipped to carry out these functions and, equally important, to assist in keeping the civilian medical community aware of the activities of the CFMS. To help the DMA in these vital tasks, the Surgeon General has ensured that the members of the DMA were kept informed about the CFMS by means of briefings given at the annual meetings of the association.

The DMA has shown particular interest in the status of training and equipment of the medical services of the Reserves. It has recognized and rewarded outstanding performance on the part of individuals and of units of the Militia medical services by the award of prizes and trophies to the winners of searching competitions conducted by the Surgeon General, and more recently by Mobile Command, on behalf of the DMA.

Control, including Regionalization

After the formation of the CFMS in January, 1959, control of the medical services could not be assumed by the Surgeon General as easily as had been believed by the CFMC and the planners at the headquarters of the three services. It proved to be physically impossible to find accommodation for the Surgeon General and his staff in one location before the fall of 1961. Thereafter, with Surgeon Rear-Admiral T. Blair McLean as Surgeon General, and with three Deputy Surgeon Generals and a staff made up from the four previous

medical headquarters, centralized control was easier but not free from problems. Having to use separate service personnel channels for postings and promotions, for example, often required that messages announcing such changes had to be sent out in three separate wordings to agree with the terminology used by the different personnel directorates.

With persistence and persuasion by the Surgeon General and his staff, coupled with good will on the part of service authorities, progress was made. Officers and tradesmen were selected for posting to the medical establishments of services other than the one to which they belonged; funds for medical services and materiel were controlled by the Surgeon General; personnel were chosen by the new medical headquarters for professional and technical training and employment; Canadian forces Medical Orders governing medical matters were issued, replacing the medical instructions previously published by the separate services, that enjoyed authority equal to the administrative orders issued by the RCN, Canadian Army, and RCAF; medical establishments, except those of the Army Brigade group and the Air Division in Europe, were under the control of the Surgeon General. In 1962, the Surgeon General was authorized to hold selection boards for the promotion of officers assigned to the CFMS. This authority did not extend to tradesmen nor to members of the medical services of the Reserves whose training, promotion and employment continued to be controlled by the original operational services.

Regionalization was not achieved as quickly as was control by the Surgeon General mainly, it is believed, because operational commanders and staffs in Canada were reluctant to surrender control over their medical personnel. Within one year after the formation of the CFMS the Surgeon General had put forward a proposal to reduce the number of subordinate medical headquarters from the 21 remaining separate command and area headquarters to seven regional and nine sub-regional medical headquarters; to delegate to the regional establishments significant responsibility for liaison with local and regional civilian medical organizations; to give to regional surgeons responsibility for medical care within their regions, including responsibility for the temporary employment of medical personnel to meet unforeseen requirements; and most important, to make the regional surgeon responsible for the provision of medical advice on operational matters to the functional commanders located within the medical region. It was envisaged that the regional surgeon would be housed with the staff of the senior commander in the region to facilitate provision of medical advice; that there would be savings in the size of the medical staff through avoidance of duplication of tasks and with the reduction in the numbers of subordinate headquarters; and that increased efficiency in the use of medical resources would result from the delegation of responsibility to regional surgeons for the use of those resources within their regions.

Not until January 1, 1963 did regionalization come into effect. In the meantime, the report of the Royal Commission on Government Organization (the Glassco Report) was announced, a part of which concerned the federal medical services including the CFMS. In brief, concerning the latter the Glassco Report recommended that medical care be turned over largely to the provinces and that, except for one locality, the CFMS be not permitted to renovate existing, nor to construct new, medical facilities. With much valuable support from other federal medical authorities, the Surgeon General was able to resist the recommendations of the Commission, but the Glassco Report is believed to have given comfort to service authorities that tended to oppose regionalization. Certainly the Glassco Report was a deadly weapon against attempts by the CFMS to provide modern medical facilities in the regions.

Still, regionalization was reaching its objectives after it had overcome objections to its existence. Efficiency was increased, CFMS morale did improve, the medical services performed their daily functions well and operational medical advice was provided readily to commanders. Despite this success the system was destined to change when, in the late 1960's, planning toward the unified organization of the Canadian Forces was implemented.

Much of the autonomy of the Surgeon General was lost and his direct control over the regionalized medical services was surrendered to functional/regional commanders when the separate armed services were unified into the Canadian Forces. By 1970, the Surgeon general was responsible to the Chief of Personnel for the development of medical policy and the financial management of funds for medical services. He exercised direct control over the National Defence Medical Centre (NDMC) and the Canadian Forces Institute of Environmental Medicine (CFIEM) only, and continued the evolution of the staff and equipment of the field hospital. All other medical establishments, of whatever medical or medical support function, were assigned to functional/regional commands, and the regional surgeons became responsible to the commander for medical services within the region.

Over the ensuing years, as the Forces were reduced and other economic measures were implemented, it seemed that the Surgeon General and his staff spent an undue amount of time and effort defending their depleted resources against repeated reductions in order that the viability of the medical services could be maintained. These efforts were required particularly against the loss of establishment positions in facilities under the control of functional/regional commands, and in finding positions to staff new medical facilities.

There was a real danger that, along with the Surgeon General's loss of direct control of the majority of the day-to-day medical activities, there would be a similar dilution in his essential role in arranging for career progression, professional training and employment of CFMS personnel. Obviously it would be essential to safeguard this role to enable the Surgeon General to meet his responsibility for the standards and quality of the medical care provided to the Canadian Forces by the CFMS.

CFMC repeatedly supported the Surgeon General in his attempts to regain direct control of the medical services during the early 1970's. It was very concerned that regionalization of the medical services under the Surgeon General had been lost, and recommended strongly that the regional system, ordered at the time of unification of the medical services, be restored. No positive results were reported from these recommendations, although they may have been an indirect cause for Treasury Board ordering a study into the need for a medical service in the Canadian Forces, a study that came to be known as Study S42.

Study S42

This was to be a comprehensive study into the requirement for a dedicated medical service in the Canadian Forces. It was conducted at the behest of the Treasury Board over a four-year period in the mid-1970's. With the exception of one medical associate officer, the personnel making up the study group had no background of medical knowledge or experience. The investigators sought the opinions of service and civilian authorities, medical and community, in Canada, and studied the systems of medical support of the armed forces of our allies. The Surgeon General was not involved in the preparation of the early drafts of the report of the study but was free to comment on them. Later drafts of the report of the study group were revised extensively by the staff of the Surgeon General.

The Surgeon General reported on the progress of the study annually to CFMC until, in May 1977, he was able to state that the results of the study on "Requirement for a Dedicated Medical Service for the Canadian Forces" had been placed before the Treasury Board by the Department of National Defence. In a statement dated June 1977, the Treasury Board approved the "departmental policy for the provision of health care and the maintenance of the Canadian Forces Medical Services, and approved in principle the proposal to replace or renovate certain medical facilities." The present form of the CFMS was to be maintained, and the programme for construction of medical facilities was to be spread over 10 years with each project being subject to individual approval.

Study S42 cleared away the discussions on the future and the nature of the CFMS, and established the need for a dedicated medical service, finally laying to rest the effects of the Glassco Report on the CFMS. The study also disputed some of the recommendations of the CFMC on direct control by the Surgeon General over a regionalized medical service. It is unlikely that the medical service of any armed forces has been so thoroughly and so frequently investigated, and it has been said that none has had the term "dedicated" applied officially to it.

After the S42 study was completed and approved, an additional administrative step of significance that took place during the first 25 years of the CFMS was the transfer of the Directorate of Social Development Services to the Surgeon General Branch in January 1979 followed, in April 1980, by the Social Work Officers becoming a specialist classification in the Medical Branch.

Comment

Regionalization of the medical services and control of those services by the Surgeon General, as proposed by CFMC and authorized by the Minister as a part of the formation of the unified medical services, were implemented for only a few years during the first decade of the life of the CFMS. During the period when these concepts were in being, they worked well. They were ended by the implementation of the unification process on the remainder of the Canadian Forces, not by the opposition of their detractors.

The change to regionalization of medical services under functional/regional commanders was to be expected. These commanders were charged with responsibility for the health of their forces. What commander would accept that charge without being able to control the medical resources available to him?

Reasonable though it may have been, loss of control over the CFMS made negotiation one of the significant tasks of the Surgeon General. To use the personnel resources of the CFMS to meet unforeseen requirements, he had to obtain the approval of various functional/regional commanders for his actions because most of the members of the CFMS were within functional commands and systems. In times of emergency, this has not been a great problem because, in these circumstances, the Surgeon General has been looked upon as the commander of the CFMS and has had great support for his command decisions from authorities at Canadian Forces Headquarters and great cooperation with these decisions from the commands. But in the intervals between emergencies, much negotiation was needed, and much time and effort were spent, in attempting to spread resources to meet the medical requirements as foreseen by the Surgeon General and the commands.

Still, the unified medical service has worked in the Regular component of the Canadian Forces in an economical, efficient fashion and has been accepted officially by the Department of National Defence and the federal Treasury Board. The foresight and support of CFMS, and the efforts of the members of the CFMS over the first 25 years of the existence of the unified medical services have built a firm foundation for its continued success.

CHAPTER THREE

EDUCATION, STAFFING AND INDIVIDUAL TRAINING

Subsidization Programmes

One of the problems that CFMC could foresee in 1959 and that gave the Council great concern, was the loss of experienced officers and tradesmen from the separate medical services on retirement from those services in the near future. This problem, already serious and anticipated to become worse, was compounded by inadequate enrolment of recruits and an inadequate salary scale, both of which were at their worst in the case of medical officers. These were considered by CFMC and the staff of the Surgeon General to be prime targets for improvement in the early days of the CFMS.

Financial assistance to medical students who would, on graduation, join the individual medical services was in being but, because the subsidization programme only covered the last 21 months before coming to duty, the programme was not very effective in enrolling young medical officers. Consequently the Surgeon General, with the support of CFMC, in 1959 put forward a proposal that a Medical Officer Training Plan (MOTP) be instituted that would subsidize medical students during the last 45 months of their intramural and interneship training. For this assistance the trainee would return three years of service as a medical officer in the CFMS. This programme was approved quickly by Treasury Board and a quota of 50 applicants was set for the first enrolment. For this quota there were 119 applicants. The MOTP has continued in effect throughout the life of the CFMS, with varying degree of success. It has proven to be the mainstay of maintenance of medical officer strength, but has varied in effectiveness from time to time due to fluctuations in the national economy and to competition from subsidization programmes instituted by other governmental organizations. All of these programmes have had a detrimental effect on the attractiveness of the MOTP.

During the 1960s, the proposal was made that Regular members of the Canadian Forces might be subsidized during their education as physicians. Such a programme would have the advantages of training service physicians who had acquired already a good knowledge of military organization and procedures, who had demonstrated qualities desirable in a service medical officer and who would serve in the CFMS for a longer period than medical officers enrolled through the MOTP. This programme, which began as the Aircrew Medical Training Plan in 1963, was expanded in 1968 to include candidates from all three elements of the Canadian Forces with a quota of four applicants to be selected each year and was renamed the Military Medical Training Plan (MMTP). There never has been a shortage of applicants who were well-qualified militarily; to enable them to be accepted into the first year at a Canadian medical school was difficult in some cases because of deficiencies in credits obtained in their pre-medical training and, in some cases, because they were older than many universities wished their first year applicants to be. The MMTP has been a successful programme, and the medical officers produced by it have been among the best of the contributors to the performance of the CFMS.

Deficiencies in enrolment of nursing officers and medical associate officers did not create problems for many years. However, by 1970, the numbers of service pharmacists had decreased, and similar shortages occurred in the nursing service by 1980. In both instances, quotas were established for officers of these classifications to be produced through the Regular Officer Training Plan.

When the CFMS was formed the salaries of medical officers were said to be far less than the net income of their colleagues in civilian practice, and definitely were less than the salaries of physicians in other parts of the federal public service. In 1960 it was recorded that medical officers in the rank of captain received $6,084 in annual salary, majors received salaries in a range from $7,620 to $8,700, and the range of salaries for colonels was from $11,232 to $12,072 per year. Thirty medical officers asked for their release in 1960. A general salary increase was received later that year, and a medical officer's allowance was added. The Surgeon General continued to press for salaries for medical officers that were equal to those of physicians performing equivalent tasks in the public service. By 1970, parity with the salaries of public service physicians, except for those at senior specialist levels, had been achieved.

Staffing of Medical Units

Beginning in the summer of 1959, the Surgeon General began to propose establishments for Canadian Forces Hospitals. These proposals brought some standardization of staffing between the facilities of the separate medical services. Prior to this, there had been token postings of medical and nursing officers and senior tradesmen between the medical services. In 1960 the Surgeon General assumed the responsibility of proposing postings and transfers of medical personnel to staff the facilities of the RCN, Canadian Army, and RCAF. To achieve this, training of officers and men had to meet common standards, and the rank structures and promotion policies that existed in the separate medical services had to be adjusted to give equal opportunity for promotion to the members of the new CFMS.

These objectives were achieved in the Regular CFMS by 1964, and have continued throughout the life of the CFMS, although when the Canadian Forces were unified much of the authority of the Surgeon General in determining establishments and promotion policies was removed.

Postgraduate Training

When it was formed, the CFMS inherited three separate and distinct policies for selecting members of the medical services for postgraduate training, and three different means of obtaining higher medical qualifications. In one service, at least, criteria for selection were poorly defined; one encouraged training abroad, others preferred to have training done in Canada; one allowed only one year of training in each five year period of service, others provided for continuous training until the individual completed the requirements for the higher medical qualification.

In 1959, the Surgeon General completed a detailed study of professional training for medical and nursing officers, and proposed the programme for medical officer postgraduate training for the 1960-61 year. Inherent in this was acceptance of the concept that the largest service hospitals at Ottawa, Kingston, and Halifax be staffed and equipped so that they were accredited by the Royal College of Physicians and Surgeons of Canada (RCP&S(C)) for at least one year of training towards RCP&S(C) qualification as was the case with certain DVA hospitals. Criteria were established for postgraduate training: it was to be made available only to officers holding permanent commissions; it had to be suitable to the officer's abilities and aptitudes; it had to be in line with the military and medical requirements in either clinical or administrative fields; except in specialties that required continuous training in one programme, the first year of training in a civilian hospital would be followed by a year in an accredited DND or DVA hospital, and then the balance of the required training period would be completed in civilian hospitals.

Over the years, slight modifications were made in these criteria, and additional forms of postgraduate training were provided. because the RCP&S(C) did not have a specialty qualification that applied specifically to military medicine, in 1961 CFMC began to award a Certificate in Environmental Medicine to candidates who met criteria that the Council developed. This qualification was broadened in 1965 and renamed the CFMC Certificate in Military Medicine. In 1980, this certification was discontinued and replaced by the RCP&S(C) qualification in community medicine.

Training in hospital or health care administration to Diplomate or Master's level was provided to medical and medical associate officers. In nursing education, initially training was provided to baccalaureate level and in specialties in nursing. Subsequently, this was expanded to include education to Master's level and, in later years, service nurses underwent training on primary care nurses' courses. Pharmacists began attending courses leading to a Master's degree in their science early in the 1970's in addition to the refresher courses that had been available previously. Throughout the existence of the CFMS, care has been taken to keep laboratory, X-ray and bioscience officers trained to high levels on current knowledge and skills in their technical fields.

The training, discussed above, of largely civilian nature to meet the standards of civilian practice, was additional to the in-service education to meet military requirements. The latter included attendance at staff colleges, courses in flight surgeon's and flight nurse's duties and in diving medicine conducted in the US and UK, and short courses of a wide variety of military medical subjects which were attended by medical, nursing and medical associate officers. Also, valuable training was provided through a system of exchange postings of nurses between Canada and the US, and Canada and the UK. In the former, a Canadian nurse has been posted to flying stations in the US, and a USAF nurse posted to a Search and Rescue base followed by a posting to the aeromedical evacuation course at CFB Trenton for employment and instructional duties respectively; in the latter, a Canadian nurse has been posted to the British Army for training and employment in midwifery at military hospitals in England and with the British Army of the Rhine, while a member of the Queen Alexandra's Royal Army Nursing Corps has been posted to NDMC and CFH Cold Lake for general and obstetrical nursing duties.

Clinical Meetings

Clinical meetings had been held under RCAMC auspices at the military hospital at Kingston at irregular intervals prior to 1959. Following the formation of the CFMS, CFMC encouraged the policy of holding annual clinical meetings at varying locations in Canada as means of furthering acquaintance between members of the unified medical service, of making attendees more familiar with medical problems encountered in one or other of the operational forces, and of giving younger members experience in the preparation and delivery of formal presentations to peer groups.

These meetings continued to be held annually, usually at service hospitals but occasionally at the research establishments in Toronto, until the mid-1970s when fiscal constraints reduced their frequency to one meeting every two years. In addition to working toward the goals set out by CFMC, the meetings were used to maintain or improve the level of medical liaison with allied medical services when they were held on two occasions in Germany under the auspices of the Command Surgeon, Canadian Forces Europe. This venue was selected to facilitate the attendance at them of representatives of many of the NATO medical services. On another occasion a combined meeting of representatives of the CFMS and of the medical services of the RN, British Army, and RAF was held at the Royal Army Medical College in London followed, in a subsequent year, by a similar meeting hosted by the Defence and Civil Institute of Environmental Medicine (DCIEM) in Toronto.

These meetings, because of the experience gained by the participants in their preparation and because of the amount of knowledge regarding military medical matters that was gained by attendance at them, were considered to be a significant part of the postgraduate military medicine training of many officers of the CFMS.

The Canadian Forces Medical Services School (CFMSS)

Other problems with which the CFMS had to contend on its formation were disparity in trades standards of technicians between the separate medical services and differences in the systems of training. To arrive at common trades standards, and to set up an establishment where training designed to meet these standards would be given, were early goals of the Surgeon General and CFMC. Thus, it was decided in 1959 to concentrate officer and trades training at the RCAMC School at Camp Borden, combining the Medical Joint Training Centre in Toronto (where basic and military medicine courses for officers had been conducted for a few years in the 1950s), the RCAMC School and the RCAF medical assistant school from Aylmer, Ontario into one organization, the CFMS Training Centre. Medical assistants training at RCN facilities would join the training centre when further studies were completed, and the entire process of integrating the training establishments was to be evolutionary in nature.

Despite this cautious approach, by the end of the year the Medical Joint Training Centre had been disbanded, the CFMS Training Centre had been formed and the first officers' course, an indoctrination course for nursing officers, had been conducted at the new establishment. Early in 1960, medical assistant training began for candidates from the Canadian Army and the RCAF. By the end of 1962, a CFMS trades structure based on initial qualification as medical assistant, that applied to all tradesmen of the CFMS, had been developed. Trades specifications and standards were written during the 1960s, and a system of basic trades training at the training centre, followed by specified and supervised on-job experience in military hospitals, was implemented. Further academic training at the training centre was instituted to qualify medical assistants to higher trades levels. For some of these levels, clinical training and experience in selected hospitals were required. A somewhat parallel system of trades training was provided for hygiene (later preventive medicine) technicians.

When the Canadian Forces came into being and the functional commands were formed, the CFMS Training Centre (re-named the Canadian Forces Medical Services School (CFMSS) became a part of Training Command (later Training System) and the Surgeon General's role was reduced to the development of specifications and training standards for officer classifications and for tradesmen in the CFMS. These have not been static, as was shown, for example, by the development of the ophthalmic technician as a specialty qualification of the Medical Assistant trade in the early 1970s, and by the increased emphasis on occupational health that was inserted into the training of Preventive Medicine Technicians a year or two later.

The School has developed, or procured, significant resources of training aids and publications for use by trainees at different trades and rank levels. It has been involved in training personnel of all military classifications in First Aid, to meet standards set by the Order of St. John in Canada, for employment as First Aid instructors in the operational and support units of the Canadian Forces. Other specific tasks performed by the School over the years have been a major role in the production of the training film "CFMS in the Field" and conducting a symposium on medical services in cold weather warfare.

One of the most valuable adjuncts to the School has been the CFMS Museum. This began as a collection of pathological specimens from the First World War that was maintained by the RCAMC School. This part of the museum fell into disuse over the years as the CFMS Training Centre placed greater emphasis on non-clinical aspects of the operational roles of the medical services of the armed forces of Canada. The museum became part of the base museum of CFB Borden, but successive Commandants of the CFMSS have continued to ensure that trainees attending courses there are exposed to the history of the original medical services and of the CFMS as it was shown in the museum. This exposure has never been greater than at the present time.

Other Training

Military training, other than postgraduate courses, was changed from time to time in the CFMS to keep pace with changing situations in the Canadian Forces as a whole, and to keep abreast of technical training. After the basic training centres common to all elements were formed, new recruits into the ranks of the CFMS underwent common training there before beginning their medical assistant training. Basic military medical training for CFMS officers of all classifications was the responsibility of the CFMS Training Centre and, subsequently the School, until well into the 1970s. Then, newly enrolled officers began to take a part of their initial training at the common basic officers' course, whereas the part peculiar to the CFMS continued to be given at the School. Deviations from this pattern were appearing during the early 1980s.

The requirement for qualifying for promotion was evident when the CFMS was formed, but objection was taken to the method employed. For example, emphasis was placed on tactics a subject that had no bearing on the performance of most CFMS officers. A series of promotion courses were conducted at the CFMSS that would replace general service courses as preparation for advancement for the next higher rank. Tradesmen qualified for promotion by advancing in their trade, and by successful completion of NCOs qualifying courses.

In addition, the Surgeon General encouraged officers and men to attend short courses in Canada, the United States and, less commonly, abroad in order to improve and bring up to date their professional and technical qualifications. Experience in specific tasks, for example, the setting up and maintenance of the field hospital, was obtained by participation in training with the US Army Medical Corps.

The CFMS contributed medical training, as well as medical care, to developing countries. Examples of these were: the in-hospital training that was given to Tanzanian medical assistants; two military nurses from Ghana who were trained in NDMC and at CFH Cold Lake for six months at each hospital; and a CFMS team, as part of the Commonwealth group training the new Army of Uganda, that provided training in First Aid to recruits and in medical procedures to the Ugandan medical services in the early 1980s.

Comment

During the existence of the CFMS, CFMC and various Surgeon Generals have recognized the importance of education and training in maintaining a high level of performance among its members, and in instilling and fostering a high level of individual self-esteem and satisfaction as members of the medical services. Emphasis on postgraduate training and improvements in service hospitals to the extent that they were accredited by the RCP&S(C) for part of that clinical training have continued to meet one of the basic objectives of CFMC in the early days of the unified medical services.

To keep CFMS personnel qualified to maintain the past and present high standard of performance and to help them keep abreast of changes in medical care and military operations arising from rapidly changing technological advances, it will be essential in the future to continue this degree of education and training at its present, or higher, levels. Failure to do this can result, with certainty, in failure to fulfil the motto of the CFMS, "Militi Succurrimus".

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CHAPTER FOUR

PREVENTIVE MEDICINE

General

When unification of the medical services took place, each medical service had in being well-established public health programmes, with areas of interest and concern common to all to which were added problems peculiar to the occupations and operational commitments of each separate service. As well, prior to unification, some standardization of documentation and procedures had been achieved. These two situations made the integration of the preventive medicine elements of the separate medical services a relatively easy matter and an Assistant Surgeon General (Preventive and Industrial Medicine) was soon functioning on the staff of the Surgeon General, under the Deputy Surgeon General (Preventive and Environmental Medicine).

During the 1960s, the Assistant Surgeon General was re-named the Director of Preventive Medicine (DPM) and continued to emphasize the prevention of infectious diseases among serving personnel and their dependants. One of the activities in which the members of the staff of DPM became very adept was instructing members of the separate armed forces, particularly army personnel, on means to preserve their health while on UN peacekeeping operations in tropical and sub-tropical climates. At the other environmental extreme, DPM was deeply concerned with health problems in cold weather warfare, in the investigation of which close liaison was maintained with CFIEM and research personnel in the Defence Research Board. Measures to reduce casualties from exposure to nuclear and chemical agents, mainly under conditions of actual war but also from accidents, were addressed consistently. Much study was given to the use of articles of clothing and chemical agents as protective devices against the effects of weapons causing mass casualties. Much progress was made in hearing conservation and accident prevention. By the end of the decade, greater emphasis was being given to the diseases arising from smoking, abuse of alcohol and the non-medical use of other drugs.

Control of Meningococcal Meningitis

An example of the work of DPM was found in the problems and their solution arising from the occurrence of meningococcal meningitis in the Canadian Forces early in the 1970s. Although sporadic cases of meningitis had occurred from time to time in all three separate services, this disease first became a serious problem in the CFMS when the Canadian Forces were unified and when large numbers of recruits began to be housed and trained at centralized basic training establishments. It was a matter of great concern to the US forces at the same time that it became a problem in Canada because of its frequent occurrence in their "boot camps".

There were two outbreaks of meningitis of a particularly fulminating character in CFB Cornwallis in 1970, in the investigation of which the CFMC Consultant in Microbiology became deeply involved. Despite measures to lessen the opportunity for spread of the disease in barracks, and despite changes in the programme of basic training to lessen the fatigue of trainees, cases of meningitis characterized by rapid onset, evidence of acute, overwhelming whole-body involvement and frequently fatal outcome continued in the next year.

By 1972, with the cooperation of Training Command and the two regional surgeons involved, a study was in progress at the training centres at CFBs Cornwallis and St. Jean to assess the usefulness of vaccine against meningococcal meningitis, using Type C vaccine obtained from the United States. The study supported the value of the vaccine; there were no cases in CFB Cornwallis where the vaccine was used and where the disease had been more prevalent, whereas, at CFB St. Jean, two non-fatal cases had occurred in the control group of trainees. Swab monitoring programmes and the use of Type C vaccine were instituted at both basic training centres. In 1975 there were nine cases of meningococcal meningitis in the Canadian Forces, none of which were fatal. That year bivalent vaccine against Types A and C was introduced. There were no cases of the disease in 1976 and, thereafter, meningitis was only rarely mentioned in CFMC discussions and then only to report that no diseases had occurred. The swab monitoring programme was discontinued in 1980.

DPM has maintained an active programme of immunization using the bivalent vaccine and, through the Defence Research Establishment at Suffield, has cooperated with the US Army Surgeon General in the development of Type B vaccine. The necessity for these actions was indicated by the occurrence of one case of meningococcal meningitis at CFB Cornwallis in 1981, due to infection with Type B meningococcus.

Prevention of Exotic Communicable Diseases

The increase of the threat of exotic communicable diseases, such as Lassa Fever, along with increased air travel to and from Canada gave concern to HWC in the mid-1970s. These diseases created a particular hazard to the Canadian Forces because service aircraft likely would be used in aeromedical evacuation of patients suffering from these dangerous diseases and because their crews, operational and medical, would be at particular risk.

Consequently, the Surgeon General and HWC cooperated in obtaining an isolation unit for use at NDMC for the treatment of patients with exotic communicable diseases, and portable units (Containment Aircraft Transit Isolators or CATIs) for use during aeromedical evacuation. A federal policy was developed by HWC to the effect that patients for whom Canada was responsible and who were thought to be affected by an exotic and dangerous disease would be transported to NDMC by the aircraft and crews of the Department of National Defence, using the CATIs.

In 1979 DPM, as the DND Federal Response Coordinator under the Exotic Communicable Disease Canadian Contingency Plan, was made responsible for ensuring that civilian as well as military personnel in Canada, suspected of suffering from dangerous exotic diseases, were evacuated by military aircraft equipped with a portable isolator and cared for by a CFMS team, to NDMC for isolation, investigation and treatment. To date, only civilian patients have been cared for in this way, and in no case was Lassa Fever finally diagnosed.

Prevention of "Diseases of Choice"

The degree of interest in diseases which were created by the action of the serviceman himself, such as alcoholism, obesity and those arising from smoking and the non-medical use of drugs that had been shown by the Surgeon General in the 1960s became more prominent during the 1970s. In part, this was due to increasing emphasis on prevention and treatment of these illnesses in the total population; in part, it was due to increased emphasis in the education of medical and allied personnel; and in part it was due to the cooperation of the personnel directorate of the Canadian Forces in the real desire of the CFMS to reduce the incidence of these preventable diseases.

One measure that the Surgeon General proposed, but with which functional commanders did not fully agree, was the establishment of a centrally-located treatment facility for the management of service personnel addicted to alcohol and other drugs. Instead, and for good reasons, the commands preferred that such treatment centres be established regionally, and to be under medical control. This situation was achieved through the Surgeon General, in the person of DPM, assuming control of the drug and alcohol programme in 1979. A year later the programme, including the employment of seven full-time regional drug education coordinators and the operation of six regionally located alcohol treatment clinics, was approved by NDHQ. The clinic established in the building which originally housed CFH Kingston, in addition to its regional functions, was to act as an off-shoot of the Surgeon General's staff in the planning, supervision and evaluation of preventive programmes in the Canadian Forces against these avoidable diseases.

Life Quality Improvement Programme

Concurrently, interest in positive measures to improve the quality of life and the general physical well-being of members of the Canadian Forces and of their dependants increased during the late 1970s. Because some aspects of a life quality improvement programme (LQIP) had been in place in the Canadian Forces for many years with varying degrees of success, and because there was no equivalent, large-scale and controlled programme in civilian life with which to make comparisons, the LQIP in the Canadian Forces had to be launched with an investigative phase beginning in 1979. The following year, the programme was centralized under the Surgeon General and positive action to implement the LQIP was put in train.

Comment

The CFMS has kept in step with the times in the practice of Preventive Medicine. In so doing, it has increased immunization against some diseases, reduced the frequency of "shots" against others, maintained its input into the prevention of casualties from nuclear and chemical weapons, and taken positive steps to prevent illness from preventable diseases caused by the misuse of drugs and other chemicals.

CHAPTER FIVE

PROVISION OF MEDICAL SUPPLIES

Evolution of the Medical Supply System

Three separate medical services and three separate and distinct methods of providing drugs and medical equipment to their personnel and facilities — this was the situation prior to 1959. As the medical branches of the RCN and RCAF in war and peace were almost all based in established centres in Canada and abroad, supplies were obtained from the Army's central medical supply depot through the general supply systems or purchased locally from suppliers of pharmaceuticals. The RCN maintained small medical supply establishments on each coast. There was a medical cell in the RCAF supply depot in the UK for provision of medical items to 1 Air Division. In the Canadian Army, because its forces were stationed abroad in peace and war, and because of the lack of availability or reliability of equipment and pharmaceuticals that could be procured in many foreign areas of operations, the RCAMC had provided a system of medical supply depots for many years.

In the 1950s, in cooperation with Emergency Health Services of HWC, modern, secure and well-equipped depots were built to receive, house, and distribute medical equipment for daily use in service medical establishments, and for emergency use by HWC in the event of nuclear attack on Canada. To provide protection in nuclear warfare, the Central Medical Equipment Depot (CMED) and regional depots (RMEDs) were built (or, at one site, renovated) on military bases away from target cities and beyond the area of heavy radioactive fall-out from an attack on these cities. Small depots were maintained with the Brigade Group in Germany and the Canadian component with the UNEF in the Middle East.

To take advantage of the regional nature of the RCAMC medical supply system and of the economies that resulted from centralized and large-scale procurement of pharmaceuticals, when unification of the medical services took place the provision of medical equipment and supplies to all the CFMS was assumed by the CMED and the RMEDs under direction of the Surgeon General and his staff. Because this process was an extension of an existing, smaller system, it was achieved relatively easily. Economy was effected in procurement of supplies; medical equipment and drugs were standardized in many instances. Opportunities for more varied employment in medical depots became available to pharmacists in the medical branches of the RCN and the RCAF.

In addition to supplying all CFMS facilities in Canada with medical supplies except those pharmaceuticals which were purchased locally to meet limited needs, the medical equipment depots filled demands for supplies from the medical services of the Reserves. CMED received indents from, and shipped supplies to, the Air Division, the Brigade Group and later to the Canadian Forces establishments in Germany. In the early days of the CFMS, when formal and local supply systems were found to be inadequate for the needs of the area in which they were serving, CMED provided medical supplies to the Canadian facility in UNEF and to the Canadian medical officers in the Congo, Ghana and Tanzania.

On the field operational aspects, there was continued participation in the quadripartite study by which, to enable cross-servicing in medical supplies to take place between allied forces, a common catalogue of medical stores and common means of identifying medical gases were devised by the senior medical supply authorities of the United States, Britain, Canada and Australia. At the Canadian national level the CFMS pharmacists, with the advice of experienced medical officers, revised the equipment scale and re-equipped the operational medical units of the Canadian Army, the sick bays of the warships of the RCN and the emergency hospitals of the RCAF in Europe.

When unification of the Canadian Forces took place, the NDHQ planners foresaw the establishment of a common general supply system. As was to be expected, pressure was brought to bear on the Surgeon General to surrender the mechanism of medical supply to this integrated system of logistics. When the originators of the concept could show little advantage to the medical services from the proposal, the result was that only some minor adjustments of responsibility for supply of items were made between the medical and general supply systems. However, the CMED and the regional depots were assigned to the commands in whose regional areas of responsibility they fell, and the Surgeon General retained only the professional, technical and financial responsibilities for medical supply.

Partly because of the reassignment of control and partly because of changes in total and regional strengths of the Canadian Forces, the RMEDs at CFBs Borden and Shilo were closed in 1976 and 1980, respectively, their workload being assumed by CMED and the RMED at CFB Calgary. The latter event had a profound, adverse effect on support provided by the system to HWC. Despite the additional responsibility of detailed supply to Central Region, CMED was able to respond as usual to emergency situations. An example of this was its action in respect to a request from Guatemala in 1976 for medical supplies and equipment (especially for orthopaedic patients) to help in the treatment of casualties from an earthquake. The request was received one afternoon; the equipment and supplies were assembled and packed overnight and dispatched the following morning.

Cooperation with Other Federal Departments

Probably the longest standing example of interdepartmental cooperation in the Canadian medical field was the assistance provided mutually by HWC and DND in the procurement, storage and use of emergency medical supplies for survival of the population of Canada if under nuclear attack. Space was provided in the DND medical depots for storage of equipment and supplies purchased for this purpose. Service pharmacists were in charge of the depots; HWC provided civilian employees to assist in warehousing and conducting periodic inspections of the stored materials. This was particularly necessary in the case of items which had a short shelf-life. To avoid waste of large stocks of items with known limitations of effectiveness, the depots made certain that use was made of them in service hospitals well before the date of expiry was reached, and that replacement amounts of the items were procured and stored. These procedures in place before 1959, have been altered in detail, but in principle have continued through the life of the CFMS.

Another example of support to HWC was of much shorter duration. In 1969 HWC asked through official channels that the CFMS procure and supply drugs and other expendible items of medical materiel to the isolated stations of its medical services in the western part of the North. After some study, a pilot project was carried out by which the isolated stations in one area of the North were supplied from the RMED in CFB Calgary. This project proved the feasibility of the process, and the CFMS medical supply systems assumed responsibility for the task. In 1975, HWC withdrew from the programme because rumour had it that, as an economy measure, the RMED at Calgary was to be closed. It was true that one of the RMEDs

in the Prairie provinces was to close but it was the Surgeon General's intention to close the RMED at CFB Shilo, keeping the one at Calgary open. Political pressure favoured closing the Calgary depot and this was the basis of the rumour. In fact, with a change in political representation, the pressure to keep RMED (Shilo) open, soon disappeared. The depot was closed in 1980, leaving the RMED at Calgary open for good reasons, including the capability of supplying HWC isolated stations. By this time HWC had instituted a programme of supply of its own, duplicating the CFMS supply system. This was a great example of an opportunity for service and experience having been lost, through no fault of the CFMS, to the disappointment of both potential supplier and potential recipient.

Comment

No attempt has been made to discuss the increased role of the pharmacist as the expert in pharmacology in medical facilities from whom the medical and nursing staffs have sought advice and instruction. Close cooperation between service pharmacists and their colleagues in other health care fields in the CFMS made possible many changes in the scales of issue of medical equipment and supplies and, for example, enabled the metric system of measurement of medication to have been completely in place in the Canadian Forces by May 1970.

At the 25th Anniversary of the CFMS, there has been no evidence of erosion of that cooperation.

CHAPTER SIX

RESEARCH AND DEVELOPMENT

Policy on Research and Development (R & D)

Prior to the formation of the CFMC, much R&D applicable to problems associated with aircrew and military aircraft had been done at the Institute of Aviation Medicine (IAM). Some investigation of underwater problems had been carried out at the diving training establishment in Halifax. Much of the other research was carried out, at the requests of the three separate medical services, by the Defence Research Board (DRB). Some of this was done at the DRB establishments including the Defence Research Medical Laboratory (DRML) at Toronto, and some was contracted out to civilian research organizations.

At one of the early meetings of CFMC, the Council decided that research would be concentrated at IAM and NDMC. At the former, emphasis would be placed on research into the environmental and medical aspects of military operations; NDMC would, in conjunction with DRB, conduct research into epidemiological and biological matters, conduct cardiovascular research, and work on problems associated with metabolism and hypothermia, as examples. Soon afterwards, in the early 1960s, IAM was renamed the Canadian Forces Institute of Environmental Medicine (CFIEM), medical and combatant officers from the RCN and Canadian Army were added to their opposite numbers from the RCAF at the Institute, and the diving establishment was moved from the Halifax area to CFIEM. With its new complement, CFIEM was able to respond to requests for R&D in air operations, in underwater conditions and to a lesser extent, in problems arising from warfare on land.

Mount Logan Expeditions

An example of the prolonged and detailed work done by CFIEM, in this case for the Canadian Army, was the research carried out in the series of Mount Logan expeditions each summer between 1966 and 1971 in association with the Arctic Institute of North America and the US Army. The purpose of the research was, briefly, to investigate the effects of the environment on troops operating at high altitude and to determine if acclimatization could be achieved artifically by drugs or other means. The first year, observers were sent from CFIEM with personnel from the two participating organizations to take part in preliminary exploration of sites for a base camp at 4900 m and a permanent laboratory at 5,350 m. In 1967, these facilities were established, test patterns were developed and revised, and preliminary trials were carried out. On the 1968 expedition these were refined. During 1969-71, expeditions were made to the site of the laboratory where volunteers from Mobile Command provided great support as test subjects for research at high altitude. Each year, prior to proceeding with the research it was necessary to find the laboratory under the last year's accumulation of snow and to dig an entry down to it. These expeditions, which became increasingly hazardous, produced much information on the physical changes which were found in humans working in high altitudes, on the necessity for acclimatization of troops who are to be involved on land operations at these altitudes and on the results obtained by producing artificial acclimatization by chemical means.

Formation of the Defence and Civil Institute of Environmental Medicine

The availability of highly qualified research personnel at CFIEM resulted in more and more requests for investigation, some of which came from civilian organizations. The support which could be provided to civilian agencies was indicated in the name of the re-organized military research establishment in Toronto when, in 1970, the CFIEM and DRML (Toronto) were combined to form the Defence and Civil Institute of Environmental Medicine (DCIEM). One of the conditions under which the DCIEM was established was that service requirements must be met promptly. This has been achieved, and a significant military contribution made to DCIEM, by the formation and maintenance of the Canadian Forces Environmental Medicine Establishment as a part of the Institute.

After its founding DCIEM continued the work of CFIEM on improvement in helmets and aircrew life support systems, in sound surveys of training aircraft and helicopters, in underwater equipment for Maritime Command and combat spectacles for the Canadian Forces, and the interaction of man and machine in vehicles and in control centres on warships. As the prospects for introducing a new fighter aircraft improved in the 1970s, research into the physical and medical aspects of air operations at greatly increased speed and altitude was initiated. During this time, as well, the requirement for more study in the problems of deep diving was made more urgent by the foreseen increase in exploration for oil and gas off the coasts. To meet this requirement, largely a civilian one, DCIEM was authorized to procure a deep diving test facility with an initial capacity to a depth of 600m and a potential research capacity to 1500m.

The military research institute, under any of its names, has maintained a constant interest in the application of its R&D to the prevention or correction of medical problems connected with military service. There has always been a very large clinical element in, or associated with, the institute, that was concerned initially with aviation medicine but the interest of which has now expanded into underwater medicine and into other fields. Thus, in the mid-1970s, DCIEM was charged with planning and conducting the early trials in a programme to alter the system of enrolment physical examinations for service personnel. Earlier, research had been carried out, at the request of a university, into the efficacy of an influenza vaccine. As well, greater emphasis was given to submarine medicine and the investigation of diving accidents during the latter part of the 1970s.

The concentration of officers and technicians with knowledge and skills in research into environmental and clinical problems at the DCIEM has had other benefits to the CFMS and the Canadian Forces. Staff and facilities have been used consistently over the years for conducting courses for flight surgeons and diving medical officers. Personnel and equipment have been used on short notice for investigation of flying and underwater accidents. The facility has been used frequently as the venue for conferences on clinical and research matters.

Clinical research at NDMC

In 1959 it was the decision of CFMC that clinical research would be encouraged to be undertaken at NDMC particularly in specific areas of interest which included cardiac and pulmonary disease. This policy was further refined by the main investigator at NDMC during the early 1960s. In selecting research projects, it was decided to choose problems which were either of military importance or could be studied well in a military institution because of the special characteristics of the population from which subjects for special investigation could be drawn. Because of the excellence of the military administrative machinery and with a controlled population, it was anticipated that clinical research projects, important to military medicine and to the larger field of medical science in general, could be undertaken with great expectations of success.

Summaries of the investigative work carried out in three departments of the hospital are given below as examples of the applied research undertaken with these objectives in mind. The Department of Laboratories did a major project on preserving red blood cells by freezing, work on important biochemical projects including one on sensitive detection of myocardial necrosis and one on lipid abnormalities in coronary atherosclerosis, and made many contributions to advances in methodology. The Department of Ophthalmology carried out several prolonged and important projects which included attempting to improve corneal wound healing, investigating a method of detecting retinal lesions, and pioneering the use of soft hydrophilic contact lenses in military situations ranging from Arctic warfare to operational flying. The Cardio-Pulmonary Unit has investigated the early diagnosis of coronary artery disease and its complications. Much valuable work has been done on the medical treatment of coronary atherosclerosis, the surgical management of coronary stenosis, and especially on the long-term follow-up of coronary patients treated in a variety of ways.

Much of this research has been reported at meetings and published in the literature. There is much of value still to be mined from the lode of data that has been accumulated by NDMC.

Comment

R&D on environmental and clinical medical matters has followed, in general, the pattern foreseen during the early days of the CFMS. Unification of the medical services permitted personnel with interest and ability in investigation to follow their inclinations. This has resulted in environmental R&D being applied to all three elements of the Canadian Forces to a greater degree than was the case prior to 1959. Similarly, clinical research at NDMC, as intended by CFMC, has been undertaken on problems which were of importance in military operations. Some of these have had significance in broader fields of medical science. The results of the applied clinical research have been, and will continue to be, of benefit to personnel to all elements of the Canadian Forces.

CHAPTER SEVEN

PROVISION OF MEDICAL CARE IN PEACETIME

Medical, Obstetrical and Surgical Care

Before the medical services were unified, the standard of medical care provided by the separate medical services was acknowledged as being of a high order. The existence of service aligned medical services did not give concern to CFMC in this regard.

Concern was expressed about duplication of facilities in some localities, with consequent lack of economy in total service medical resources. Also, CFMC was concerned about the physical condition of many of the clinics and hospitals in which care was provided to servicemen. Most of these had been built as temporary structures almost 20 years before. Many had had little or no renovations carried out. These facilities were staffed by competent physicians, nurses, administrators and technicians, most of whom had served in Canadian or allied forces in the Second World War and many had served in operations in Korea. Medical personnel, some with specialist qualifications, had been recruited from civilian practice in Great Britain and Ireland. It was anticipated that members of this latter group would leave the service on completion of their short service commissions; age and length of service would deplete the numbers of the veterans in the former class.

In the early stages of unification the Surgeon General, on the advice of CFMC, took steps to replace this anticipated loss of officers and tradesmen with adequately trained personnel. Early plans were made to replace the more decrepit medical facilities and to make others more modern. These will be described in more detail later in this story.

The results of these steps, the qualities of the men and women who made up the CFMS and the assistance provided by the civilian employees who shared the workload of the military medical services, produced medical care that was professionally and technically as competent, and delivered in a more caring way, when compared with most health care systems provided in this country. In unit aid stations, in warships at sea, in base clinics, during aeromedical evacuation, in hospitals in Canada and with the Canadian Forces in Europe, personnel of the Armed Forces of Canada have been supplied with medical care at varying levels of complexity from first to third line and, on occasion, fourth line, with uniformly high standards of excellence and thoughtfulness.

When the CFMS was formed, dependants of service personnel and entitled civilians at isolated stations received the same high quality of medical care that was being delivered to service patients. This situation has continued although local conditions have changed. In Europe, ambulatory care in the family clinics and in-patient care in the Canadian section of the British Military Hospital at Iserlohn for dependants of the Army Brigade Group were replaced, in October 1969, by dependant care in the portions of Canadian Forces Hospital (CFH) Europe in the air bases at Lahr and Baden-Soellingen. When the remaining stations of 1 Air Division were closed out and moved to the new location of the combined Canadian Forces Base (CFB) Europe at Lahr and Soellingen, the dependants of the personnel of the air element joined those already being cared for at the clinics of the hospital.

In Canada, a variety of situations for care of dependants has met with a variety of solutions. At Cold Lake a hospital was built, and later renovated, with emphasis on the medical requirements of dependants; a dependant care clinic was improvised from two adjoining married quarters to provide ambulatory care at CFS Holberg; at Fort Churchill Military Hospital, a wing of the Second World War hospital was devoted to dependant care until the station was closed; at CFS Masset, the necessity for providing care to dependants was a significant element in the decision to construct the service medical facility there and, as a result, the layout and equipment was better suited to dependant care than most service medical facilities in Canada.

One of the earliest decisions made by CFMC in 1959 approved the provision of limited medical care to dependants at CFB Borden, which was not, by any means, an isolated station. In later years, dependants were admitted to NDMC if beds were available and on repayment from a health care programme. In NDMC, they joined dependants who had been evacuated from isolated stations, mainly in Europe, for the more complex care available at that hospital.

It being impossible to describe adequately the extent of medical care provided as a matter of course throughout the CFMS or to pay fitting tribute to the men and women who delivered that care, the remainder of this chapter will be used to describe some of the unusual activities that have taken place in the field of Canadian military medical care during the past 25 years.

Development of Standards of Personnel Medical Status (GO factors)

Although the CFMS inherited the bases of first class systems of medical care from the medical elements of the separate armed services, on the other hand it inherited disparate forms of personal medical categories. The RCN used a very general system with categories lettered from A (fully fit) to E (unfit) to describe the medical status of an individual. The Canadian Army used the PULHEMS system to describe the occupational and environmental requirements for a military occupation and to describe the physical status of a soldier. In theory and, to a degree, in practice, this system allowed the person to be assigned to a task which he was physically and emotionally capable of performing, and enabled personnel managers to determine the numbers of individuals with a particular degree of fitness that would be required for employment in an occupation in a specific geographic area. The RCAF made use of a system similar in philosophy but with variations in terminology to provide for the description of occupations and physical standards that were pertinent to air force personnel. All were different, none were compatible and no service was eager to relinquish its system of medical categories in favour of one of the other systems.

By the mid-1960's, cross-posting of individuals from one service to another (as in the CFMS) and the prospect of unification of the services both emphasized the need of a common system of medical categories that would be acceptable to the operational elements of a single, unified service, the Canadian Forces. The staff of the Surgeon General, working in close cooperation with the staffs of the personnel directorates of the three services, produced a new system of medical categories based on the requirements of tasks to demand, and of individuals to possess, specific abilities expressed numerically, in association with age, by geographic and environmental factors.

This system, which became known as the GO factors, began to be assigned to new recruits in the late 1960's. The medical categories of serving personnel were converted to the GO factors when a change was indicated following illness or accident, and when the individual underwent a routine complete physical examination. By 1970, when unification of the Regular elements of the Canadian Forces was completed, only 15% of service personnel remained to be recategorized. Two years later, less than 1% continued to have the old forms of medical categories.

The Career Medical Review Board (CMRB), largely an instrument of the personnel directorate but one in which the Surgeon General's staff played a significant role over the years, came into being with the introduction of the new system of medical categories. The career documents of all members of the Regular forces whose medical category was lowered by illness or injury below the standards required for their current military occupation were reviewed by members of the Board to determine if retention in trade or classification was possible or if alternative military employment could be found to the advantage of the Canadian Forces and of the individuals. If not, release on medical grounds was necessary. The medical adviser to the Board was charged with assuring that information on the physical and emotional condition of the person was fully explained to the other members. As a result of the CMRB, significant economies and increased personal satisfaction were achieved as thousands of officers and other ranks were able to be re-assigned to duties compatible with their medical status and to continue to serve in the Canadian Forces in a productive and self-fulfilling way.

Construction of Medical Facilities

In 1958, when the CFMS was being conceived, no new definitive care military hospitals had been built in Canada since the early days of the Second World War. In the 1950's, the RCAF had built some station hospitals when new bases were developed. At other bases, barrack blocks which could be made available were designated and equipped for ambulatory and minor in-patient care. Some improvement in this generally poor situation was in sight: at Kingston, the Canadian Army had begun to build a 125-bed hospital to replace the decrepit Kingston Military Hospital; at Ottawa, authority had been obtained to build a 320-bed "tri-service" facility to replace the base hospital in RCAF Station Rockcliffe.

In these circumstances, CFMC urged the beginning of a construction programme to replace the wartime hospitals in Halifax and Esquimalt, and to renovate or replace other facilities where change was badly needed. Planning for this programme was vigorous but results were less obvious. The new hospital at Kingston was opened officially in October 1959 and two years later NDMC opened in Ottawa. During the interval, CFMC expressed concern at the lack of progress in construction at Gagetown, Valcartier, Petawawa, Fort Churchill and Halifax.

Concern continued for many ensuing years as the programme lagged in the face of opposition and uncertainty. The opposition to it originated in the Glassco Report of 1962; uncertainty about the numbers of members of the Armed Services and their locations was common throughout most of the 1960's. As a result, during this period, a bare minimum of building or renovation was done, service hospitals were integrated into civilian and DVA facilities (e.g. at Gagetown and Quebec, respectively), and hospitals closed when bases were abandoned or reduced (e.g. at Fort Churchill and Goose Bay). Toward the end of the first decade, the structure and location of the Canadian Forces became more clear and the hospital construction programme quickened. A small clinic with beds was authorized for CFS Masset, and a 32-bed base hospital was authorized for CFB Petawawa to replace the existing hospital that had been housed in a Second World War nursing sisters' quarters for over 10 years. Still, the hospitals in Esquimalt and Halifax continued to function in their slightly renovated, but basically Second World War, condition.

In the 1970's, the construction programme continued with new hospitals opening at Petawawa in November 1971, at Valcartier in September 1972, and with clinics opening at Masset in 1971, Chilliwack in 1972 and with renovations taking place at several bases. At Halifax, several years of discussion took place in the mid 1970's on proposals for a combined Dalhousie University/DVA/DND hospital. Because the proposals did not satisfy the needs of the Canadian Forces, no new service hospital was built. At Kingston, further reduction in troop strength and financial constraint caused the closure of CFH Kingston.

Help was at hand in the Treasury Board approval of Study S42, which included approval of a 10 year hospital construction programme. As a result, a clinic with 8 beds was built at CFB Calgary and opened in 1981, approval was granted in 1981 for construction of a 100-bed definitive care hospital at CFB Halifax and, in the same year, plans were underway for a 25-bed base hospital in CFB Esquimalt.

It says much for the dedication of the medical staffs of the outdated medical facilities that they were able to provide high quality medical care despite the difficulties imposed by the physical plant. It says much for the service patients that their understanding and helpful attitude made possible the continued use of the old facilities. It says much, too, for the persistence of the Surgeon Generals and the planners on their staff over the years that the construction programme was kept to the fore, because only by this persistence were the present results obtained. In the case of the hospital at Halifax, it has required 25 years of effort!

Aeromedical Evacuation

Care of patients during evacuation by air is a function of the medical services that has grown in importance since the CFMS was formed. As transport aircraft, fixed or rotary wing, increased in quality and in number, so did the numbers of patients carried and the severity of their condition. So, too, did the demands and complexity of in-flight medical care.

Factors involved in aeromedical evacuation that have been consistently present were the requirements that evacuation by air be recommended by the senior medical officer in the region, that service aircraft be used and that CFMS personnel provide medical care during flight. To these have been added the high quality of the flight crews and the wholehearted cooperation of operational and administrative personnel of the air element of the Canadian Forces. In evacuation of patients from isolated points on both coasts and in the North, these factors have been particularly apparent.

Throughout the existence of the CFMS, annual reports by the Surgeon General have shown that civilian patients out-numbered military patients. In 1971, for example, 66% of patients carried were civilian. Aeromedical evacuation over long distances was improved that year by the procurement of a kit which enabled the CC 137 (Boeing 707) aircraft to be converted to an air evacuation vehicle carrying 88 patients. This conversion added greatly to the important, but limited, capability of the existing Hercules aircraft used for aeromedical evacuation at the time.

Assistance to Civilian Authorities

Since its beginning, the CFMS has provided assistance to civilian medical authorities on request. Generally this assistance was to cope with emergency situations, as in air evacuation of patients or by supplying medical staff and equipment to civilian establishments. Sometimes urgent responses became long-term assistance, such as the hospital care provided by CFH Kingston to the nearby federal correctional facilities from 1961 until the hospital closed 15 years later. Sometimes the assistance was provided as a planned and organized activity, as was the case in the provision, by NDMC, of medical care for veterans in the Ottawa area. Many instances of this aspect of the work of the CFMS are recorded; many others are known but are not on record. Even the officially reported ones are too numerous to recount, therefore a few examples of those recorded will have to speak for the others.

Early in the life of the CFMS, the Surgeon General was asked by the Canadian Red Cross to provide a specialist in rehabilitation medicine for service in Morocco. He spent several months helping in the long-term care of about 10,000 survivors of mass poisoning of the population by contaminated cooking oil. In 1963, a team from the Institute of Aviation Medicine went to Ste. Thérèse to assist in the investigation of the crash of a Trans Canada Airline aircraft, a task that required three weeks on site.

Health and Welfare Canada (HWC) has relied on the CFMS to support its medical services by small and large contributions. Most frequently, the former has consisted of medical officers serving at its isolated establishments in the North, often with very little warning. With little warning, as well, a team of eight CFMS laboratory and x-ray technicians, under command of a Master Warrant Officer, was required to go to Uganda in 1972 to assist HWC in the medical assessment of these citizens of Asian background who were about to be expelled from the country and who wished to emigrate to Canada. Within seven days after the request for help was received by DND, the CFMS technicians had been selected from units scattered across Canada, assembled, equipped and, after travelling to Uganda via London, England, were at work in Uganda assisting the HWC physicians. A little over two years later, a similar team was dispatched to Guam to assist HWC in the assessment of refugees from South Viet Nam who were seeking entrance to Canada. The lessons learned from the 1972 contribution proved to be valuable in the second episode, when only 24 hours notice of the mission was given to the CFMS.

In the area of larger contributions, there were: assistance at the Olympic Games in Montreal when, in July and August, 1976, 150 CFMS personnel (including 10 medical officers) assisted in providing first-line medical care for the athletes, and the field ambulance from CFB Valcartier provided medical support to the 17-18,000 service personnel who were on duty at the Games; medical support was provided for the Boy Scout Jamborees at Fort Churchill in 1970, in Prince Edward Island in 1977, in Quebec in 1978 and in Alberta in 1981 and 1983 when care was given to populations of scouts and staff ranging in numbers from 5,000 to 16,000; and Operation Magnet I, when the CFMS helped HWC and immigration authorities in the medical care of 600 Vietnamese refugees who were being admitted to Canada, on an emergency basis, from Malaysia in 1978. This involved the provision of in-flight care and, after arrival at Montreal, medical screening, primary medical care and arranging for definitive care of refugee patients in civilian hospitals. The largest short-term contribution was made in Operation Magnet II, the acceleration of admittance of refugees from Viet Nam, which took place a year later. The CFMS provided support, similar to that supplied at Montreal previously, at two reception centres, one at Montreal and one at Edmonton. Over a period of months, while the reception centres were in being, medical assessment and care were provided for 14,000 and 13,821 refugees at these cities respectively.

Not all requests for assistance to civilian authority that were received and responded to were, in fact, carried out. Plans were made, and medical supplies stockpiled at air bases, for on-site medical care and for care during evacuation in the event of a crash of a commercial passenger airplane in the North. To date, such a catastrophe has not occurred and the assistance has not been required. Another example of a response being prepared but not implemented was the formation of six medical teams from the CFMS, at the request of the Canadian Red Cross in November 1979, to assist in caring for refugees on the Cambodia/Thailand border. Members of the teams were selected, briefed and provided with medical supplies appropriate to the task. In February 1980, the request for assistance was withdrawn by the Red Cross.

Comment

The CFMS was formed in 1959 from separate viable medical services to provide an equally viable, more efficient and more economical medical organization, the CFMS. This has been, and is being, carried out. Medical care provided at small facilities and at definitive care hospitals has been of a high order; it has been provided

to service personnel, to their dependants in isolated stations and to other entitled patients under specific circumstances; it has been delivered in facilities that, after expenditure of much time and effort, have been improved greatly over the hospitals and clinics in being at the time of the formation of the CFMS.

Improvements have not been limited to the facilities. Vehicles used for the evacuation of patients by ground ambulance and by air transport have been greatly improved, and aeromedical evacuation, in particular, has advanced dramatically.

Despite the prime commitment of the CFMS to provide medical care to the Canadian Forces in peace and in war, and despite measures taken to effect economies in the forces, the CFMS has been willing to provide assistance to civilian medical authorities at their request. This assistance, when accepted, has often been supplied on very short notice and at the inconvenience of the individuals and to the detriment of the CFMS facilities from which they were drawn.

Nevertheless, it is generally the opinion of senior authorities that the provision of medical care in service hospitals by CFMS personnel and the experience acquired through responding to unusual demands for medical help in emergencies both contribute to the development of medical skills and responsibility of CFMS officers and tradesmen, as well as fulfilling the requirements for patient care and for urgent assistance.

The skills acquired and the ability developed to carry responsibility in peacetime are essential if the CFMS is to carry out the promise of its motto, "Militi Succurrimus", in time of war.

CHAPTER EIGHT

OPERATIONS AND OPERATIONAL TRAINING

General

From the early days of the CFMS, the importance of providing medical support to the combatant elements, and operational training to practise this support, has been paramount in the thinking of successive Surgeon Generals and their advisors in CFMC. Thus, one of the first actions taken after the formation of the CFMS was to provide cooperation to the newly appointed Director General Survival Operations in planning the medical aspects of survival of the population in Canada in the event of attack with weapons of mass destruction.

Although the types of threat to Canada and the Canadian Forces have changed since that time, the Surgeon General and CFMC have continued to emphasize the importance of medical involvement in planning and conducting military training and operations. Throughout the existence of the CFMS, medical support has been provided to the armed services individually, and later, to the Canadian Forces, in their tasks in the defence of North America, support of NATO, contribution to UN peacekeeping forces, maintenance of sovereignty of Canada and provision of military assistance to developing countries through bilateral agreements.

NATO Commitments

When the CFMS was formed, there were more members of the medical services involved in support of Canadian Forces in NATO than there are at the present time. At sea, medical assistants manned the sick bays of warships and medical officers were employed in squadrons and on the aircraft carrier. In Europe, a full-strength field ambulance exercised with, and provided minor non-surgical care for, the troops in the army brigade group in the Soest-Iserlohn area of Germany. Definitive care and out-patient consultant services were supplied by the Canadian section, and the British staff, of the British Military Hospital at Iserlohn. With the Air Division, there were clinics with beds at the air bases in France and Germany and at the headquarters at Metz for minor medical care of servicemen and their dependants. At 3 Wing, specialist medical, surgical and obstetrical care was available to all personnel of the division and their dependants. At the enlarged clinic at Marville, patients were cared for prior to aeromedical evacuation to Canada.

After unification of the medical services, cross-posting of personnel allowed men and women of the medical branch of the RCN to be employed with the forces in Europe for the first time since the Second World War. Medical personnel with army and RCAF background were employed in the other services to the professional and technical benefit of the forces and of the individuals. During the 1960s, there was little change in this situation until, in preparation for the concentration of the Canadian Forces in the south-western part of Germany, the hospital of the Air Division closed at Zweibrucken and opened at Lahr in a facility that had been used by the French forces.

In 1969 and 1970, when the forces were reduced and moved to CFB Europe at Lahr and Baden Soellingen, only the clinic at Soellingen remained unchanged. In the brigade group, all the dependant clinics were closed, the Canadian section of BMH Iserlohn was disbanded and some of its personnel joined the new hospital at CFB Lahr, the minor care facility run by the field ambulance closed and the field ambulance itself was reduced to a combat group medical unit of only 75 personnel. Drastic reduction took place in other elements of the Canadian Forces in Europe but few had as profound an effect as the reduction applied to the medical services.

In Canada, a field ambulance was retained at Gagetown for employment with forces in the defence of Canada role and to provide immediate reinforcements, if needed, for the combat group medical unit in Germany. As part of the overall reduction of the Canadian Forces at that time, all the field ambulances with the brigades in Canada were reduced in size, re-organized and re-named Combat Group Medical Units. Elsewhere, the number of warships was reduced and some air bases in Canada closed, with consequent reduction in the size of the medical services.

Since then, the medical support for NATO has improved. The hospital at Lahr, although greatly exposed to enemy attack, has been renovated and may be replaced. Second line medical units serving the land forces have again become field ambulances and all have similarly organized, although the one in Europe must be reinforced before it can be fully operational and all those in Canada have been kept at levels below their full establishment. Aircraft and conversion equipment have been provided so that air evacuation by Hercules and Boeing 707 transport aircraft has been possible from Europe to Canada. Sick bays in warships have been improved and their equipment expanded. Better liaison with senior medical authorities of our allies has been developed, more information has been exchanged and more international exercises have been held in NATO areas of responsibility. The provision of facilities for in-hospital care in a field operation was one of the most dramatic developments.

The Field Hospital

At the end of the Second World War, the one mobile hospital of the RCAF and the many field dressing stations, casualty clearing stations and general hospitals of various sizes in the Canadian Army were demobilized and their equipment dispersed. The supplies of only one casualty clearing station were retained in a medical equipment depot. Later these were used to re-equip a small civilian hospital that had been destroyed by fire. Consequently, when the CFMS was formed, it had no capacity to provide care in the field behind a field ambulance. This unacceptable situation was remedied in part, in the late 1960's, by the procurement of the medical equipment of a tented field hospital from the US army. In 1969, CFH Kingston carried out a trial of the hospital by caring for their real patients, and exercising other functions of the unit, under simulated field conditions. Because of its lack of environmentally controlled conditions for surgical and acutely ill patients, its primitive support facilities and its lack of mobility, the tented field hospital was judged to be unsuitable for employment in the field.

Over the next five years, procurement from the United States of a Medical Unit Self-Transportable (MUST) was planned, approved by DND and the Treasury Board, and some portions of this 100-bed mobile field surgical facility obtained. The MUST was located at CFB Petawawa, where a cadre of the unit personnel received and maintained equipment, developed operational procedures and instructions, and prepared for periodic training exercises of the hospital as a whole. The vast majority of the establishment was made up of medical officers, nursing officers and tradesmen carried on strength and working at medical establishments in Canada who had, as a secondary duty, augmentation of the field hospital if required for exercises and operations.

In 1975, 1 Cdn Fd Hosp carried out its first exercise in augmentation, in which some personnel from the medical reserves were included. In 1977 it carried out full augmentation and a unit exercise at which senior military operational authorities and the Minister of National Defence were observers. Since then, the hospital has participated in large scale medical exercises in addition to its own augmentation and unit exercises. As a result, almost all members of the augmentation group have attended at least one exercise during the period when they are named for employment with the field hospital as a secondary duty.

Medical Exercises

Training for employment in war has been an essential part of the role of the CFMS in support of NATO. The medical staffs of ships and squadrons of the sea element regularly have accompanied their warships on naval exercises. On-going peacetime employment and two aeromedical exercises, in the 1970s, have maintained the skills of the medical personnel who would be employed in evacuation of casualties by air in time of war. Medical personnel with battalions and in field medical units have exercised frequently with the formations which they support in Canada and in Europe. The Surgeon General and command medical officers and their staffs have participated regularly in large scale command post exercises. Two exercises in which the CFMS has played a particularly large role were Running Jump II and Rendez-Vous 81. In the former, in 1971, as an exercise designed to test procedures involved in the deployment of an air sea transportable brigade group, a field ambulance and the tented field hospital (including augmentees) were exercised at Gagetown, and formed the largest concentration of medical personnel on a medical exercise since the Second World War. Rendez-Vous 81, a concentration of operational and support components of the land element at Gagetown, again gave the field medical units extensive experience in handling real and token casualties. In 1981, as well, CFMS personnel including a surgeon and an anaesthetist from the Reserves, took part in an exercise in Norway in conjunction with one of that country's heavy field hospitals.

All these activities made up an impressive improvement over the Canadian medical contribution to NATO in 1959.

UN Commitments

Over the past 25 years, the CFMS has contributed to UN peacekeeping forces, frequently and for varying periods of time. When the CFMS was formed the United Nations Emergency Force (UNEF) was in being and included a Canadian military hospital in the Gaza Strip. Under the unified medical service, this hospital was maintained until the UNEF was evacuated from the Middle East in the late 1960s.

In the early 1960s, a CFMS medical officer accompanied the Canadian communications component of the UN contingent to the Congo. Patients who could not be evacuated by air to Canada were treated in an Indian military hospital.

When the UNEF was reconstituted in 1973, the Canadian component included 52 CFMS personnel who provided medical care to Canadians and, when requested, to military personnel of other nations in a field hospital in Cairo. When a UN hospital was established, the surgical component of the Canadian component was no longer required and its strength was halved. The remaining CFMS personnel were located at Ismailia and on the Golan heights. Subsequently, in 1979, a small CFMS element provided front-line medical support to a Canadian communications detachment with the peacekeeping force in Lebanon.

From the aspect of time in being, all these pale in comparison with the truce supervisory force in Cyprus. In 1964, a force of approximately one battalion including its medical staff, with additional command, liaison and support personnel, was sent to join other UN forces in an attempt to maintain the truce between the Greek and Turkish Cypriots. From that date, Canadian battalions or equivalent formations have rotated, at six-month intervals, through their task of maintaining the "Green Line" in Nicosia between the two opposing factions. For years, the unit aid station supporting the troops on guard duty along the Line was about two city blocks from the site of potential trouble and, when fighting did erupt, a hotel across the street from the unit aid station was the target of heavy small arms fire.

Bilateral Commitments

In addition to the commitments expected to arise from formal national association with the UN and NATO, the CFMS has been charged with medical tasks as a result of agreements that Canada has made directly with one or more other countries.

Early in the 1960's, Canada provided a training team to Ghana, included in which was a CFMS medical officer who was responsible for providing first-line medical care to the members of the team, and who was appointed to the staff of the Ghanaian military hospital in Accra. This was a challenging task, the least of which was the primary task of caring for members of the Canadian team and their dependants in Accra. The greatest challenge was in his employment in the military hospital where the volume of patients, the variety of the medical problems and the difficulties in administration were the sources of much interest and much valuable experience which stimulated continued interest in Tropical Medicine.

Later, as a result of negotiations between Canada and Tanzania, a similar training team with one medical officer to provide care for the Canadian group and advice to the medical branch of the Tanzanian forces was dispatched to Dar-es-Salaam. Because medical care for the Canadians was provided in a relatively modern European-style hospital, the Canadian medical officer was largely occupied in flight surgeon duties. His assistance to the Tanzanian forces was limited in scope, as well. For these reasons, after only a year or two, the medical officer was withdrawn from this operation and service medical assistance to Tanzania was given in the form of training of their tradesmen in Canada.

Of much greater scope was the commitment to support the Canadian Forces group that was sent to join the International Control Commission (MCCD/ICCS) in South Vietnam early in 1973 to supervise the truce after the departure of the US forces. In Canada, this involved medical participation in the planning for this task and in the selection of members making up the group and their reinforcements, preparation of individual kits for First Aid and water purification, and briefing the group about potential medical problems in Vietnam, and methods of preventing them. In Vietnam, soon after arrival in Saigon, the Surgeon MCCD/ICCS established a regional system of medical care for the isolated truce-supervisory stations and set up a clinic with beds for minor medical care in the area where the Canadian group was concentrated. For more extensive care, casualties were evacuated to civilian hospitals that were operated still by US religious organizations. These arrangements worked well in both isolated and urban areas during the six months that the Canadian Forces group was in South Vietnam. The limited medical resources of HMCS TERRA NOVA, which remained in nearby waters during the period to evacuate the Canadian force if necessary, were not required.

The most recent example of bilateral medical operations was participation by the CFMS in the British Commonwealth Training Team that was sent to Uganda in 1982. This consisted of providing a medical officer and two senior medical assistants for duties in connection with the health of the members of the team, for advising the re-organized Uganda army in matters of medical organization, for teaching First Aid and, in any spare time remaining, for assisting in the medical care at the recruit training centre.

Involvement of CFMS personnel in these instances of bilateral medical commitments, particularly the smaller, short-term ones, have had a very beneficial effect on those officers and men who have had experience in them, because they were the best means of developing self-reliance and a sense of responsibility in an individual.

The Reserves

The medical elements of the Reserves, although included in the Minister's statement and the messages authorizing unification of the medical services, never came under the direct control of the Surgeon General. They have continued throughout the life of the CFMS to be under command of the sea, land and air elements of the Canadian Forces. In the early 1970's, a proposal that was made by the Surgeon General to unify the medical services of the Reserves was approved by the Vice Chief of the Defence Staff. However, the only obvious result of this proposal was the wearing of CFMS cap and collar badges by the men and women of the medical components of the naval reserves, the militia and the air reserves.

Thus, the tasks of the reserves have continued to be the medical support of their ship, militia formation, and air squadron with little exchange of personnel between the three services. This support has consisted very largely of physical examinations of personnel on joining the reserve component and for determining fitness for specific service occupations. Individual training in first aid and in medical assistant duties and participation in operational training as a reserve organization or as part of a regular unit of the Canadian Forces have been carried out when possible. Unfortunately, employment on medical tasks often took precedence over individual and unit training.

The Militia, including its medical services, has been buffeted by repeated reorganizations and reallocation of roles. In the 1959 period, the medical portions of the Militia consisted of unit aid stations and medical companies, and their roles of support to their militia organization and reinforcement of the Regular CFMS were increased by the addition of a medical role in national survival. As the hazard of nuclear attack and therefore the need for this role diminished, and as the stimulus of the Second World War and the Korean operations faded with the years, the size of the militia and of its medical components decreased. To effect economies, the establishment of the medical company was reduced, the number of companies was decreased from 24 to six and, in lieu of some of the unit medical establishments and the disbanded companies, medical sections of service battalions were formed. Recently, the number of medical companies has been increased to 12, larger and more flexible establishments for companies have been proposed, and this proposal has been implemented in part.

Although reductions had a deleterious effect on the Militia medical service, its members continued to attend weekly parade nights, week-end exercises, and summer militia concentrations when their civilian employment permitted. Members of the naval and air reserves were less affected by changes in reorganization and functions. Their members continued to provide medical support to their divisions and squadrons, to help staff ships during training missions and, on occasions, to help in aeromedical evacuation of patients. All these functions in all three elements have been devised to enable the medical elements of the Reserves to perform their most important function, to provide trained personnel to supplement the Regular Canadian Forces in time of war.

To further this aim, in the land element more control was assigned to the Militia and more practical assistance provided by the establishment of area medical staffs in the mid-1970s. In the same period, and coincidental with the increased influence at area level, increased numbers of reserve medical personnel trained with regular

medical units and were employed in peacekeeping duties in place of Regular Force personnel. Another example of the successful intermingling of individuals from the two portions of the Canadian Forces in training was the participation of a Reserve surgeon and an anaesthetist as part of a Regular surgical team that took part in an operational exercise in Norway early in the 1980's. Annually, representatives of the Reserves meet with their colleagues in the Regular CFMS and with the DMA for discussions on current problems and solutions.

Much credit has been due to the members of the medical services of the Reserves who have, throughout the last 25 years, served their units faithfully. The time they spend on reserve employment after the normal working day, on week-ends and during the summer has been truly remarkable. The performance of individuals and units of the Militia has been assessed by competitions and examinations under the auspices of the Defence Medical Association, and success in the assessments has been rewarded by the award of trophies most of which have real historical value. The contributions of the Reserves have been recognized by the appointment of senior Reserve medical officers to high offices in the international association of Reserve medical officers.

Comment

From the beginning, the CFMS has placed great emphasis on improving the capability of its members and of medical units to treat sick and injured members of the Canadian Forces in time of war. In the fortunate circumstance of the absence of actual hostilities, the CFMS has practised its operational roles by participating in exercises with its allies in NATO, by contributing to peacekeeping operations under UN, by meeting bilateral agreements and by testing its own operational readiness by medical exercises on land and in the air.

It is to be hoped that the CFMS will never be required to demonstrate the knowledge and skills of its members during hostilities. Still, the CFMS has been wise to place the emphasis that it has on the concept of preparing for war in time of peace. Otherwise, one day in the future, it might find that it could not fulfill the promise of its motto.

CHAPTER NINE

REWARDS AND AWARDS

Rewards, generally

Good work performed by members of the CFMS has been rewarded in the customary fashions of promotion in rank and advancement in profession or trade. There have been other rewards, however, that have been received over the years to which less attention has been given but that, in my opinion, have been more important than the bread-and-butter results of performance. These have been the personal satisfaction that the people of the CFMS have experienced from having done their job well, and even more, the satisfaction they have received from being part of a family or team that has worked and played together and has produced worthy results as individual medical units and, collectively, as the CFMS. This pride in the CFMS has been enhanced by the appointment of our Colonel-in-Chief, by the development and recognition of our branch insignia, and by formal recognition by the Order of St. John of Jerusalem in Canada of the contributions made by the CFMS.

Appointment of the Colonel-in-Chief

When a member of the Royal Family accepts an honorary appointment to a regiment or branch, it is both an honour to the members of the organization and a sign to others that its worth is recognized. The DMA may have had these purposes in mind when it initiated a request to Her Majesty The Queen that she name a Colonel-in-Chief of the CFMS. Regardless of what motivated the DMA, the gracious acceptance by Her Majesty Queen Elizabeth The Queen Mother, on June 11, 1977, of the appointment as Colonel-in-Chief of the CFMS was a reward of the highest order for the performance of the men and women of the medical services.

In the interval between the appointment of Her Majesty and the present time, the Colonel-in-Chief has continued to exhibit a keen interest in the activities of her CFMS. At her request periodic reports on the people and events that make up those activities have been sent to her. These have always been acknowledged graciously and, not infrequently, have resulted in requests for additional information on some aspect of the subjects of the reports. Her Majesty Queen Elizabeth The Queen Mother has, on two occasions, met with members of the CFMS in Canada. In 1979, the Colonel-in-Chief took the salute at a march-past of the Toronto Garrison in which were included 100 members of the Regular CFMS from the School and 35 members of the Reserve medical units from Hamilton and Toronto. This was followed by a garden party at which Her Majesty spoke with many members of the CFMS, Reserve, Regular and retired, and with the members of their families. In 1981, again in Toronto, the Colonel-in-Chief met with representatives of her regiments and of the CFMS at a reception. On this occasion she gave to the Surgeon General, representing the CFMS, a beautiful portrait of herself, copies of which have been distributed to all medical units as a symbol to them of her example and interest.

On the occasion of her birthday in 1980, a great celebration was held in London, England. A part of this was a special performance of the Royal Tournament at which all the regiments, corps and branches of the armed forces of the Commonwealth who are graced by having Her Majesty Queen Elizabeth the Queen Mother as their Colonel-in-Chief, paraded their colours or equivalent emblems before her. Included in this impressive display was a CFMS colour party, found from the medical units in the Canadian Forces Europe, whose members proudly carried the distinctive flag of the CFMS as they marched past our Colonel-in-Chief.

Truly, having such a gracious and renowned personage as Her Majesty Queen Elizabeth the Queen Mother as its Colonel-in-Chief has been one of the greatest possible rewards for the work of the CFMS.

Branch Insignia

A significant reward of a different type was the recognition of the CFMS as a worthy organization by NDHQ approving the branch insignia for display on the flag of the medical services and on the cap and collar badges of its members. The original symbols were the staff and serpent of Aesculapius (referring to the healing nature of the work of the CFMS), surrounded by the oval border of maple leaves (from the original badge of the Canadian Forces) surmounted by the Crown (indicating our loyalty to the Sovereign). This basic design was approved in 1971 in an open pattern so that the cloth of the service uniform formed a green background. Later the badge was made solid by the addition of a sanguine enamel background within the border of maple leaves and behind the symbol of Aesculapius. This had the advantage of adding to the badge the colour associated with medicine in heraldry, and the practical advantage of making the collar and cap badges more robust. The badges were to be worn so that, if in pairs, the serpents faced one another and if a single badge was worn, the serpent faced the right side of the wearer.

By 1973 the symbol of the CFMS was distributed to individuals and units in its original pattern as cap and collar badges, and was incorporated in the CFMS flag. That year, a handsomely embroidered replica of the badge was presented to the Royal Army Medical College in London as a gesture of appreciation for the College having hosted the combined British/Canadian Clinical Conference. Since then, shields bearing the revised badge of the CFMS have been presented to many service establishments in Canada and abroad to show the gratitude of the CFMS for the cooperation and assistance which it has received from time to time.

Thus, the CFMS has been rewarded by the development and distribution of its distinctive insignia which have been displayed with pride by members and units of the medical services and which is recognized and appreciated by the other military organizations in Canada and in allied countries.

Recognition by the Order of St. John

The Order of St. John of Jerusalem in Canada and the medical services of the armed forces have worked in close cooperation in the teaching and practice of First Aid for many years. Indeed, the Department of National Defence has become a large Special Centre of the Order. Competence in First Aid has been tested annually in competitions between the units of the Canadian Forces (Regular and Reserve), and the winning team has been rewarded by the award of the Mary Otter Trophy. The contributions of individuals to the advancement of the aims of the Order have been recognized by Priory Vote of Thanks, and by admission to, or promotion in, the Order.

The contribution of the medical services as a whole to the Order was recognized in 1972 when the Governor General, as Prior, presented a plaque commemorating 50 years of cooperation between the two organizations. The Director of Nursing Services and the Surgeon General received this token of appreciation on behalf of all in the medical services who had furthered the teaching of Home Nursing and First Aid to meet the high standards established by the Order of St. John.

Awards, generally

The rewards described previously have been earned by the CFMS mainly for its performance as a team of individuals working together. Only indirectly did they reflect credit on the separate members of the team. In addition to the general rewards, the individual contributions of many members of the CFMS have been recognized by the granting to them of honours and awards marking the excellence and length of their service, or their disregard for their own well-being while helping others under conditions of great peril.

Awards for Meritorious Service

Thousands of men and women in the CFMS, who have served their country long and faithfully, have been awarded the Canadian Forces Decoration, and hundreds have been awarded one or more bars to the decoration. This decoration, although awarded to large numbers of personnel in the Canadian Forces, has continued to be the accepted symbol of significant individual contribution over a prolonged period of service.

The Order of Military Merit was established in 1972 to provide a means of recognizing outstanding military contributions to Canada. Since the Order was founded, the following members of the CFMS have been admitted to the Order of Military Merit:

In the Grade of Commander — CMM

MGen J.W.B. Barr, CMM, CD	Jun 1973
MGen W.G. Leach, CMM, CD	Dec 1978

In the Grade of Officer — OMM

Col(W) A.M. Bélanger, OMM, CD	Jun 1973
Col G.J.L. Berubé, OMM, CD	Dec 1981
Maj (W) P.M. Betts, OMM, CD	Dec 1983
*LCol A.R. Butson, GC, OMM, CD	Jun 1982
*Maj D.W. Einarson, OMM, CD	Dec 1982
Col(W) M.J. Fitzgerald, OMM, CD	Jun 1975
*LCol G.M. FitzGibbon, OMM, CD	Dec 1974
LCol(W) D.J. Gogan, OMM, CD	Dec 1978
LCol D.R. Gowdy, OMM, CD	Dec 1981
Capt(N) D.J. Kidd, DSC, OMM, CD	Jan 1976
LCol C.A. Lambert, OMM, CD	Jun 1978
Col G. Letourneau, OMM, CD	Dec 1978
Cmdre D.A. MacIver, OMM, CD	Jun 1973
Col W.D. MacNamara, OMM, CD	Dec 1978
*Cdr W.N.A. McLean, OMM, CD	Jun 1983
*Col C.H. Murphy, OMM, CD	Jun 1979
LCol M.E. Pillar, OMM, CD	Dec 1981

* – Reserves

In the Grade of Member — MMM

Adjuc G.J.Y. Benard, MMM, CD	Jun 1974
Sgt D.R.J. Bernardin, MMM, CD	Dec 1983
MWO W.A. Bryski, MMM, CD	Jun 1974
Maj I.P.B. Buckingham, MMM, CD	Dec 1973
CWO F.A. Cruickshank, MMM, CD	Jun 1980
Adjuc J.G.F. Drapeau, MMM, CD	Jun 1981
CWO L.W. Duncan, MMM, CD	Dec 1979
Capt J.A.J. Fortin, MMM, CD	Dec 1977
MWO M.F.B. Fox, MMM, CD	Jun 1973
Adj J.A. Gallant, MMM, CD	Jan 1976
WO E.H. Grossek, MMM, CD	Jun 1981
MWO F.A.D. Hawboldt, MMM, CD	Dec 1983
Sgt J.J.M. Huard, MMM, CD	Dec 1979
WO D.R. Hogg, MMM, CD	Dec 1972
Adjuc P. Latulippe, MMM, CD	Jun 1973
WO J.R. MacPhee, MMM, CD	Jun 1973
Capt(W) H.P. McCallum, MMM, CD	Dec 1982
WO J.G. McConnell, MMM, CD	Jun 1975
Capt(W) O.J. McEvoy, MMM, CD	Dec 1977
Sgt M.G. McInnis, MMM, CD	Dec 1982
WO L.J. Middleton, MMM, CD	Jun 1974
Adjuc J.A.R. Roy, MMM, CD	Jun 1975
Capt D.C. Taylor, MMM, CD	Dec 1978
WO C.D. Vandine, MMM, CD	Jun 1979
MWO R.A. Waters, MMM, CD	Jun 1982
WO R. Wells, MMM	Dec 1976
Capt K.B. White, MMM, CD	Dec 1979

Awards for Bravery

Performance under hazardous conditions and disregard for personal safety on the part of members of the CFMS have been recognized by the granting of appropriate awards on several occasions. Sometimes these decorations were awarded for bravery in the performance of military duty, sometimes the person was honoured for gallant action in a civilian setting.

The members of the CFMS whose conduct and performance under conditions of extreme hazard have been recognized by the granting of a decoration for their bravery, have earned the following awards:

Member of the Most Excellent Order of the British Empire (MBE)

Capt(W) J.A. Cashin	Jun 1968

Medal of Bravery (MB)

Capt J.J.G. Connors	Oct 1976
*Sgt W.C. Hurry	Jul 1977
Cpl T.P. Griffin	Oct 1977

* – same deed

Foreign Awards

Government of Italy — Medaglia D'Argento Al Valore Civille (Silver Medal of Civil Valour)

Capt R.H. Massey	Dec 1976

Medal of Honour for Humane Deeds (Netherlands Bronze)

*Sgt W.C. Hurry	Sep 1977

Chief of the Defence Staff Commendation

The Chief of the Defence Staff Commendation may be awarded to any member of the Canadian Forces who has performed a deed or activity that is considered beyond the demands of normal duty. Among the members of the CFMS whose standard of performance has been recognized by the award of the Commendation are:

Capt J.A.G. Porlier
Capt(W) S.L. Savin
Capt(W) N.M. Shiner
Capt(W) T. Wagenaar
MWO J.J.S.C. Jeannotte
WO J.L. Cross
WO E.H. Grossek
P2 W.L. McGuire
MCpl(W) C. Pittman
Cpl J.L.G.A. Savard
Pte J. Morin

Comment

Rewards to the CFMS and personal awards to members of the medical services have been means of recognizing good service in the past and of encouraging good performance in the future. Both forms of recognition have reflected credit on the CFMS as an organization and on all its members. The rewards have been earned by the efforts of all members working as a team; awards to individuals for merit or bravery have been shared by other members of the CFMS team because all have shared in a common purpose, the provision of health care to the Canadian Forces.

The statement of that common purpose has been paraphrased in the motto of the CFMS and has been implied in the symbols that make up the badge of the CFMS which, displayed on flags of medical establishments and on our uniforms, has emphasized the common or team nature of the CFMS. The high principles behind that common purpose have been reinforced by the example of courage, dedication and kindliness set for us by the Colonel-in-Chief, Her Majesty Queen Elizabeth The Queen Mother.

In my opinion, any and all emphasis placed on the display of the approved insignia, common to all elements of the CFMS, emphasizes the importance of our common purpose and increases the rewards flowing from our efforts to achieve our goal. Conversely, deviations from the symbols now accepted, within the CFMS and elsewhere, as those identifying the medical services will detract from the significance of the achievements of the team of individuals that is the CFMS. Further, and more important, those deviations will weaken the thrust to produce a total team effort required to fulfil the motto of the CFMS in the future.

* – same deed

Foreign Awards

Government of Italy – Medaglia D'Argento Al Valore Civile (Silver Medal of Civil Valour)

Capt R.H. Massey Dec 1976

Medal of Honour for Humane Deeds (Netherlands Bronze)

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Capt J.A.G. Poirier
Capt(W) S.L. Savin
Capt(W) N.M. Shiner
Capt(W) T. Wageman
MWO J.J.S.C. Jeannotte
WO J.L. Cross
WO E.H. Grossek
P2 W.L. McGuire
MCpl(W) C. Pittman
Cpl J.L.G.A. Savard
Pte J. Morin

Comment

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* - same deed

CHAPTER TEN

CONCLUSION

In the Preface, I described this story as a summary and I apologized for having to omit accounts of people and events that, because of their significance, should have been included. As I read, wrote and revised, I found it difficult to make the story as short as I had hoped. Nine chapters after the Preface, I have to apologize for the length of this so-called summary while still apologizing for having devoted inadequate space to some very important elements of the CFMS.

One of these has been the nursing service. Nursing has been a vital part of the CFMS since its formation and nurses have made up the largest professional component of the CFMS. Military nurses have been key members at all levels of the medical services except those at the "sharp end" of the operational units of the Canadian Forces. While continuing to contribute their skills as nurses in a most professional manner, they have assumed more and more administrative roles which they have performed equally well. The variety of the tasks with which they have been charged in the CFMS is the reason that nurses have not had their separate space in this story. Anyone who has had experience in the military medical services would agree that it was not possible, in a summary however long, to describe adequately the roles and functions of the nursing service. Suffice it to say that, during the existence of the CFMS, these have been performed superbly.

Similarly, it has not been possible to do justice to the tradesmen of the CFMS because of the variety of trades, the complexity of their training and the differences in their working conditions, ranging as they do from research laboratories associated with universities to sick bays in warships. They have been the life blood of the CFMS. They have made up the bulk of the medical services, they have performed their duties efficiently and without fanfare, and from them have been commissioned many of the medical associate officers of the CFMS.

The members of the Medical Associate Officer classification have been described as the "connective tissue of the CFMS". They have done much of the detailed work in financial management, operational planning, medical intelligence, officer training, hospital and general administration at all levels, medical supply, rehabilitation medicine, social work, supervision of technicians in laboratories, X-ray departments and medical record libraries, and more. Like the nurses and tradesmen, their performance has defied adequate description.

Relatively little has been said about the work of the medical officers in the CFMS, because of the range of their employment from junior physicians in clinics and field units to senior clinicians in the CFMS. Along with the nurses, tradesmen and medical associate officers they make up the team in the CFMS and, without their professional skills and their leadership, the CFMS would not exist.

Having dwelt on some of the aspects in which the story is deficient, can conclusions be drawn from those that were included in it? In the belief that there can, let me begin by examining the five objects of unification of the medical services, as contained in the Minister's announcement of August 1958, to assess whether these have been achieved. Listed in the order in which they were announced, these objectives were: unification was to include all officers of the medical services; the unified medical service was to be under the control of the Surgeon General, assisted by one medical headquarters; there were to be subordinate regional headquarters located in Canada and abroad as required; unification was intended to result in more efficient and economical provision of medical service for the armed forces; unification was to result in improved professional development and career prospects of medical officers. These objectives should be examined separately to determine if they have been achieved during the past 25 years.

Unification of the medical services included all the officers of the Regular armed forces with the exception of the dietitians in the RCAMC. This was achieved quickly and was accepted by the vast majority of CFMS officers serving at the time of unification. Further, it was extended to include non-commissioned personnel of the separate medical services, a very necessary step towards establishing an effective team of medical personnel serving the armed forces. Unification did not extend to the officers and other ranks of the medical services of the Reserves although provision was made for this to be accomplished in the service messages outlining the procedures for implementing the unification process.

Thus, the first objective was only partly reached. Unification of the medical services formed a team of officers and men to provide high quality medical care to the Regular Canadian Forces. The lack of unification in the medical services of the Reserves prevented the Surgeon General from establishing the same team effort for the members of the Reserves generally and hindered his staff in planning the employment of Reserve medical personnel as reinforcements to the CFMS in time of need.

Control of the Regular medical services by the Surgeon General was assumed quickly after unification of those services was authorized. A single medical headquarters was formed as soon as suitable accommodation could be found. Economies were achieved in the numbers of military and civilian personnel who came from the previous separate headquarters staffs. Although the Surgeon General's staff was smaller than the total of the previous four medical headquarters, it functioned more efficiently and with better interpersonal relationships than had been the case previously. The Surgeon General developed medical policies which, when approved, applied to all three armed forces. He exercised control over the operations of all Regular medical elements of the RCN, Canadian Army and RCAF except those employed in operational duties. This control included: establishing medical trades standards common to the three services; selecting officers for training and promotion; recommending the postings of CFMS officers for employment in any of the three services; authorizing the temporary transfer of medical personnel to meet unforeseen requirements; managing funds to be used in the employment of civilian medical and nursing personnel, procurement of medical equipment and pharmaceuticals, and for the payment of costs incurred in civilian hospitals; proposing changes in the personnel establishments of medical units and, if within the limits of the total medical establishment, effecting those changes. With goodwill on the part of service authorities and hard work on the part of the Surgeon General's staff, this significant degree of control was effective beginning soon after unification of the medical services and lasting until unification applied to the Canadian Forces as a whole.

Thereafter, the Surgeon General's control was limited to the development of medical professional and technical policies, provision of medical advice to senior military authorities and the handling of NDMC, CFEME and the field hospital. Thereafter, administration and command of medical personnel and units became the responsibility of functional commanders in base areas in addition to the command function exercised historically over medical units in operational roles. Negotiations with service staffs and committees began to occupy a larger proportion of the time and efforts of the Surgeon General and his staff.

The establishment of subordinate medical headquarters, the third objective of the Minister's announcement, took several years to implement, and was only in effect for a few of the 25 years that the CFMS has been in existence. The reluctance with which operational commanders of the three separate armed forces surrendered their medical services to the CFMS organization and the eagerness with which they took them back when the functional and regional responsibilities were assigned after unification of the Canadian Forces, could be interpreted as evidence of the commanders' concerns for the medical well-being of their forces. However, the subordinate medical headquarters, co-located with operational commanders, had provided medical advice to commanders and had removed from them the responsibilities of the day-to-day preventive medicine and medical care. After unification of the Canadian Forces, the imposition of regional responsibilities on functional commanders gave them reason to have the regional surgeons as part of their headquarters' staff. This had the effect of reverting, at command headquarters level, to the system that had existed prior to 1959 except that funds for medical services were budgeted for by the CFMS and allotted to commands by the Surgeon General. It is my belief that this change to the pre-CFMS arrangement for medical representation in regions arose from the unification of the Canadian Forces and the assignment of regional responsibilities in general to functional commanders, and that it was not due to failure of the regionalization of medical services or of the subordinate regional medical headquarters to perform in the manner foreseen by CFMC and the service planners who implemented the Minister's decision.

Unification of the medical services succeeded in providing more efficient and more economical medical care. Patients from any one of the armed forces were readily accepted for treatment at any CFMS hospital whereas prior to unification of the medical services, they were generally treated in facilities of their own force or in a civilian establishment. Military specialists in medical, nursing and technical fields became available for employment in treatment, research and headquarters establishments other than their parent service. In addition to the financial advantages that flowed from this cross-servicing, it had the advantages of spreading experience gained in one medical service to other elements of the CFMS, and of exposing the individual to the problems and practices of the forces which his new CFMS unit was supporting. By avoiding duplication of facilities in the same area or city, and by reducing the numbers of people employed in headquarters, significant economies were effected while the best standard of medical care was delivered.

The last objective, that of improving the professional development and career prospects of medical officers was achieved, and the same improvements have extended to other classifications of CFMS officers and to the majority of its technicians in all trades. The availability of employment in any CFMS facility increased professional and career prospects for all. Common trades specifications, standards and programmes for medical tradesmen increased their competence and reduced the frequency of isolated tours of duty which highly skilled people had experienced previously. Improved teaching potential in the staffs at Halifax, Ottawa and Kingston, and better liaison with medical schools at Dalhousie University, Queen's University and the University of Ottawa enabled education and experience gained at the three largest CFMS hospitals to be counted toward the accredited training time required for RCP&S(C) qualifications in some specialties, with advantages accruing to both the medical officers under training and the Canadian Forces. One of the factors that enabled accreditation to be given to these particular service hospitals was improvement in the physical structure and equipment of the facilities which, along with improvements in other hospitals and clinics, was the result of pressure from the Surgeon General and of close liaison between his staff and construction authorities at NDHQ.

Probably the greatest gain achieved by unification of the medical services was the improved rapport between many people who belonged to any one of the separate medical services and who, never having served with another medical service, were unaware of the knowledge and skills of the members of the medical services other than their own. When these individuals were intermingled in CFMS facilities with medical colleagues wearing uniforms different from theirs, in the vast majority of cases they came to trust and respect

the ability of the other medical services of which, to this time, they had been ignorant. As the process expanded, and as more and more individuals were exposed to new service situations and to the practices of other services, it became very difficult to determine the basic service to which they had belonged. This long term association with members of the unified medical service compared with the short or, in some cases, lack of service with a combatant element of the Canadian Forces have combined to form stronger bonds within the CFMS than with one of the original armed forces. There were exceptions to this statement, but they are in the minority. For the most part, the people who make up the CFMS take more pride in their performance, in the performance of their colleagues and in what has been achieved by the CFMS, than they do in the combatant service which they support or which they had joined originally.

As in most situations, performance is better, achievement is easier and success is greater when the members of the organization work together, mix together socially and have common, understandable aims. I realize that it is seldom possible to succeed entirely, to mix with everyone or to have aims that all understand, always.

I believe, however, that during the 25 years of the CFMS a great deal of success has been achieved, success that exceeds what would have been possible if three separate services had continued; that there has been greater intermingling of the members of the medical services than was possible when they were separate, and that our aim, although complex in accomplishment, is expressed simply and understandably in the motto of the CFMS. If that success is to be continued into the next 25 years of the life of the CFMS, I believe that improvements must be made in the degree of team work and in the emphasis on the aim of the medical services.

In recent years, there seems to have developed a lessening of the team spirit, less emphasis on social contact with other members and their families, and a greater tendency to think that the military medical team works together but does not need to play together. There appears to have developed, especially in urban centres, the concept that the task of the serviceman is that of a civilian professional or technical expert in uniform, and that the relationship with the civilian profession or trade is closer than with the military service that the CFMS supports. These conditions need to be corrected by positive action to reinforce the cohesion of the medical services.

I believe there needs to be more emphasis and more leadership given to the development of social bonds between members of the CFMS, and therefore, between the members of their families. I believe that more emphasis and more attention should be given to the operational role of the CFMS, and to the preparation of its units and its members to provide medical support in war.

I believe that only with improved teamwork through continued training and improved social contact and only with better preparation for war will the CFMS be able to continue the progress of the first 25 years. Only then will the men and women of the medical services fulfil their motto — "Militi Succurrimus"

CANADIAN FORCES MEDICAL COUNCIL *

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Renaud Lemieux, QHP, MD, FRCP(C), FACP	Jul 66 — Jun 70
R.K.C. Thomson, CD, QHP, MD, FRCP(C), FACP	Jul 70 — Jun 74
R.C. Dickson, OC, OBE, CD, QHP, MD, LL.D, FRCP(Lond), FRCP(C) MACP	Jul 74 — Dec 83
Gustave Gingras, CC, QHP, MD, DM, LL.D, FRCP(C)	Jan 84 —

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R.K.C. Thomson, CD, MD, FRCP(C), FACP	Mar 61 — Jun 70
J.D. Hamilton, MD, FRCP(C)	Apr 62 — Mar 71
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Gustave Gingras, CC, QHP, MD, DM, LL.D, FRCP(C)	Jul 73 — Dec 83
D.R. Wilson, OC, MD, CM, FRCP(C), FACP	Jul 74 —
C.G. Drake, OC, MD, MSc, FRCS(C), FACS, MS	Jan 82 —
F.P. Patterson, MD, DABOS, FACS, FRCS(C)	Jan 84 —

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Major-General K.A. Hunter, OBE, CD, QHP, MD	Jun 53 — Dec 59
Surgeon Commodore E.H. Lee, CD, QHP, MD	Jun 53 — Sep 58
Air Commodore A.A.G. Corbet, CD, QHP, MD, CM	Jun 53 — Dec 59
Brigadier S.G.U. Shier, OBE, CD, QHP, MD	Mar 56 — Sep 58
Surgeon Commodore (later RAdm) T.B. McLean, CD, QHS, MD, CM	Sep 58 — Sep 64
Brigadier P. Tremblay, OBE, CD, QHP, BA, MD	Oct 58 — Dec 59
Surgeon Rear-Admiral W.J. Elliot, CD, QHS, MD, CM	Sep 64 — Jul 68
Major-General D.G.M. Nelson, CD, QHS, MD, DPH, FACPM	Jul 68 — Jul 70
Major-General J.W.B. BARR, CMM, CD, QHP, MD, CM, DHA	Jul 70 — Sep 73
Rear-Admiral R.H. Roberts, CD, QHP, MD, FRCP(C), FACP	Sep 73 — Mar 76
Major-General W.G. Leach, CMM, CD, QHP, BA, MD	Apr 76 — Jul 80
Major-General V.A. McPherson, CD, QHS, BA, MD, FRCS(C)	Aug 80 — Jul 82
Major-General Robert Dupuis, CD, QHP, BA, MD, CSPQ, FRCP(C)	Jul 82 —

* Current Composition CFMC: 4 Civilian (one of whom is Chairman), Surgeon General

GENERAL OFFICERS OF THE CFMS 15 JAN 59 TO PRESENT

Colonel Commandant, Medical Branch

Major-General J.W.B. Barr, CMM, CD, QHP, MD, CM, DHA	Nov 76 —

Surgeons General

Major-General K.A. Hunter, OBE, CD, QHP, MD	Jan 59 — Dec 59
Surgeon Rear Admiral T.B. McLean, CD, QHS, MD	Jan 60 — Sep 64
Surgeon Rear Admiral W.J. Elliot, CD, QHS, MD, CM	Sep 64 — Jul 68
Major-General D.G.M. Nelson, CD, QHS, MD, DPH, FACPM	Jul 68 — Jul 70
Major-General J.W.B. Barr, CMM, CD, QHP, MD, CM, DHA	Jul 70 — Sep 73
Rear-Admiral R.H. Roberts, CD, QHP, MD, FRCP(C), FACP	Sep 73 — Mar 76
Major-General W.G. Leach, CMM, CD, QHP, BA, MD	Apr 76 — Jul 80
Major-General V.A. McPherson, CD, QHS, BA, MD, FRCS(C)	Aug 80 — Jul 82
Major-General Robert Dupuis, CD, QHP, MD, FRCP(C), FACP	Jul 82 —

Deputy Surgeons General (Preventive and Environmental Medicine)*

Air Commodore A.A.G. Corbet, CD, QHP, MD, CM	Jan 59 — Feb 61
Air Commodore G.D. Caldbick, CD, QHP, MD, CM, DPH, DAB, FACPM	Feb 61 — Jul 64

Deputy Surgeons General (Administration)*

Brigadier Pierre Tremblay, OBE, CD, QHP, BA, MD	Jan 59 — Dec 59
Brigadier G.L.M. Smith, CBE, CD, QHP, MA, MD	Jan 60 — Nov 63
Brigadier J.S. McCannel, OBE, CD, QHP, MD	Nov 63 — Jan 66
Brigadier J.W.B. Barr, CD, QHP, MD, CM, DHA	Feb 66 — Jun 70
Brigadier-General W.G. Leach, CD, QHP, BA, MD	Jul 70 — Jun 71

Deputy Surgeons General

Brigadier-General W.G. Leach, CD, QHP, BA, MD	Jun 71 — Mar 76
Brigadier-General V.A. McPherson, CD, QHS, BA, MD, FRCS(C)	Apr 76 — Jul 80
Brigadier-General R.W. Fassold, CD, QHP, BSc, MD	Jul 80

Deputy Surgeons General (Professional)*

Surgeon Commodore T.B. McLean, CD, QHS, MD	Jan 59 — Dec 59
Brigadier E.H. Ainslie, CD, MD, MSc, FRCP(C)	Jan 60 — Mar 61
Surgeon Commodore W.J. Elliot, CD, QHS, MD, CM	Apr 61 — Sep 64
Air Commodore D.G.M. Nelson, CD, QHS, MD, DPH, FACPM	Sep 64 — Jul 68
Brigadier-General R.H. Roberts, CD, QHP, MD, FRCP(C), FACP	Jul 68 — Jun 71

* Latest titles only (Previous titles not shown)

ANNEX B

GENERAL OFFICERS OF THE CFMS
15 JAN 59 TO PRESENT

Commandants of NDMC and Senior Clinical Consultants to the Surgeon General

Brigadier-General R.H. Roberts, CD, QHP, MD, FRCP(C), FACP	Jun 71 — Sep 73
Brigadier-General F.R. Cullen, CD, QHP, MD, FRCP(C)	Sep 73 — Sep 77
Brigadier-General H.C. Robinson, CD, QHS, MD, MHA, FRCS(C)	Sep 77 — Nov 79
Brigadier-General Robert Dupuis, CD, QHP, MA, MD, CSPQ, FRCP(C)	Nov 79 — Jul 82
Brigadier-General C.J. Knight, CD, QHP, BA, MD	Jul 82 —