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Canadian Forces Medical Service

Introduction to its **History & Heritage**



MILITI SUCCURRIMUS

- *W*E HASTEN TO AID THE SOLDIER -

Canada 

Cover photos (alternately left to right):

*A wounded soldier being transferred from an army ambulance to an aircraft in Normandy, 17 June 1944 – From *The Official History of the Canadian Medical Services* by W.R. Feasby.*

Lance Corporal W.J. Curtis, RCAMC, attends to the burned leg of a French boy, while a young brother looks on, 19 June 1944, Colomby – Buissons, France – Sgt Ken Bell – DND.

Casualty Going Aboard Hospital Carrier – WWII by W.A. Ogilvie – Canadian War Museum.

Nursing Sister Waterman of Winnipeg lecturing at the Royal Canadian Navy hospital in St. John's, Newfoundland, 22 May 1942 – National Archives of Canada.

Canadian Forces medical assistants caring for a local child during a humanitarian mission – DND.

Jackstay transfer between ships at sea – DND.

Aeromedevacuation in support of an operational mission – DND.



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Canadian Forces Medical Service

Introduction to its History & Heritage

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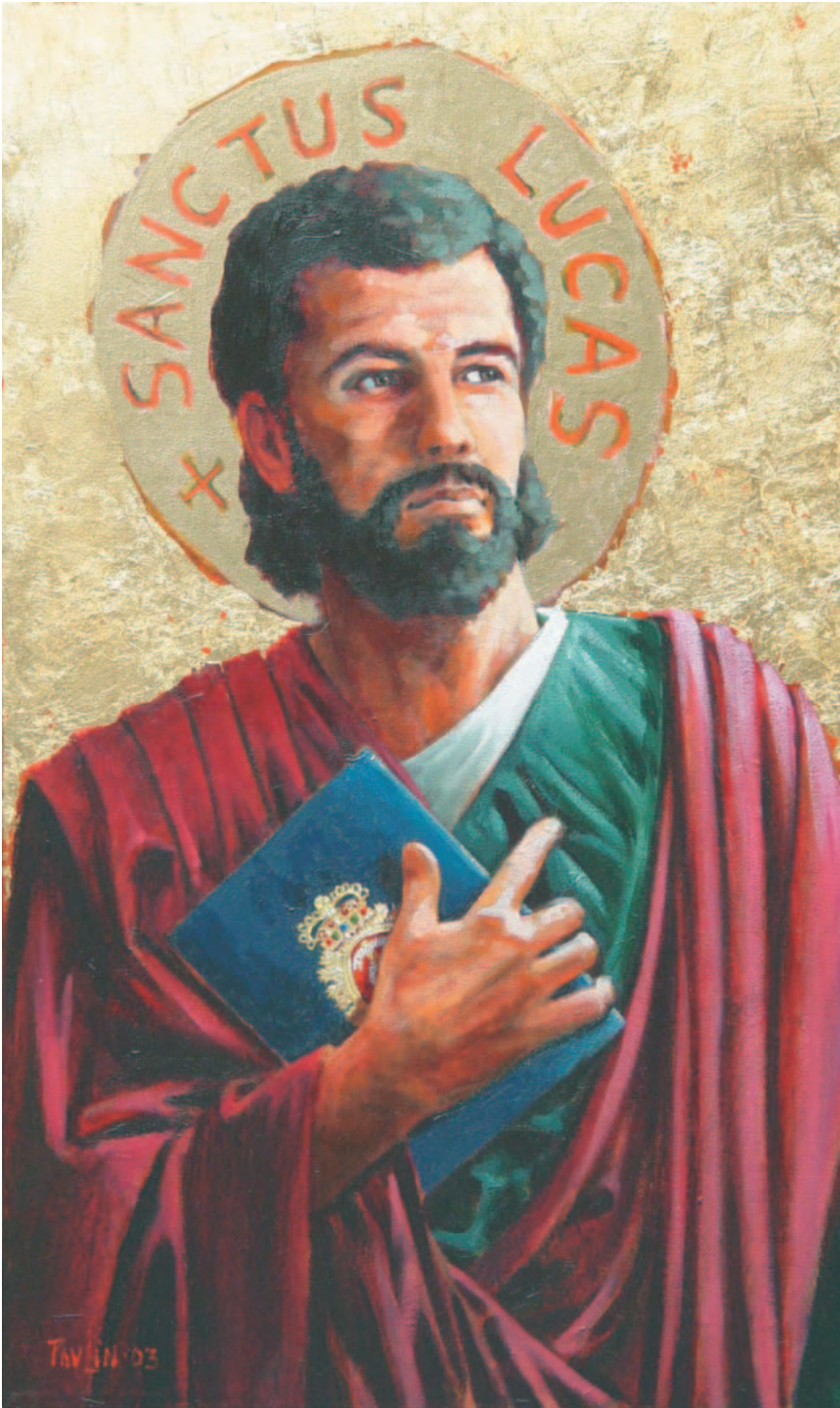
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*“There is no greater boost
to a soldier’s morale in battle
than the certain knowledge that
should he be wounded he will
receive quick and adequate medical
attention and early evacuation
from the battlefield.”*

GENERAL C. FOULKES, CB, CBE, DSO, CD
Canadian Army Journal, July 1954

*Painting of the patron saint Saint Luke
by Bernard Aimé Poulin and
presented by
Colonel Marielle S. Gagné, CD, QHNS
to the Canadian Forces Medical Service in 2003.*



Private collection

Note

This publication is intended to be informative, but neither authoritative nor exhaustive in nature. For specialized, detailed information, readers should consult the official histories and references as required.

While every effort has been made to be as accurate and, within the scope of the book, as complete as possible, errors and omissions may have occurred. Readers with corrections or additions to propose should forward them with supporting evidence to the Director General Health Services.

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Foreword

Some characterize an organization's history as its "institutional soul." Certainly, it is true that we are far more likely to understand where we are now and where we are going in the future if we know something of our past.

This book gives us a concise history of the Canadian Forces Medical Service (CFMS). It also conveys a great deal of information and one centrally important message – that members of the CFMS belong to an organization with a proud history, with high standards of conduct and with many honourable traditions.

Since 1885, when the first medical teams traveled west to support the Canadian Militia in the Northwest Territories, the medical profession has ably supported the profession of arms in this country. This book is a way to honour this long and honourable alliance between the armed services of Canada and the healing professions.

These pages capture also some individual stories of compassion and courage, outline the basic tenets of service for medical personnel in the Canadian Forces and summarize the heritage and traditions that have grown out of more than a century of service to Canada on the battlefield, in garrison and on overseas missions. Therefore, it may also serve as a handy reference for the heritage, traditions and customs of the CFMS.

Many people have worked on this publication over the past few years, but we owe a special debt of gratitude to Major-General (Retired) John W.B. Barr, CMM, CD, QHP, former Surgeon General and former Colonel Commandant of the CFMS. We must also thank Chief Petty Officer 1st Class (Retired) Elmer F. Cooper, CD for his valuable work. These are the people who summarized our customs for *Traditions of the Medical Branch*, the earlier publication on which this one is based.

I also want to acknowledge the time and effort that Colonel (Retired) Peter Green, CD, QHP spent on researching the historical part of this book. The material he collected provides a valuable glimpse into the origins and development of the CFMS.

Members of the CFMS are used to working under difficult conditions. In war and peace, they risk themselves both physically and psychologically to help the wounded and sick. On their behalf, I thank all who contributed to this work and I recommend the results of their labours, not only as a valuable reference, but also as a source of pride and inspiration.

Lise Mathieu, OMM, CD
Brigadier-General
Director General Health Services



Chapter I

H I S T O R Y



*“We are the Forces’ Medicals,
Your friends in time of woe.
When you are sick or stressed or sore
To you, we’ll always go.
On land, at sea or in the air
Fear not, for we’ll be there ...”*

*Excerpt from lyrics composed by
MAJOR-GENERAL (RETIRED) J.W.B. BARR, CMM, CD, QHP
for “The Medical Branch March”.*

Origins and Development of the Canadian Forces Medical Service



O.B. Buell/National Archives of Canada/C-001876

The York and Simcoe Rangers near Fort Qu'Appelle, N.W.T., 1885.

The Canadian Forces Medical Service (CFMS) is almost as old as Canada. One of the first requirements of the new Dominion in 1867 was to develop its Militia (and, with it, a medical service) to replace the British garrisons that were scheduled to be withdrawn. The story after that is one of gradual development from individually recruited regimental doctors and stretcher-bearers into the centralized organization that now serves the entire Canadian Forces.

1885 ✪ The Northwest Rebellion

Until the end of the 19th century, each Canadian regiment recruited its own medical practitioners, and the Canadian Militia had no over-arching medical service. In 1885, when a rebellion broke out in Canada's Northwest Territories, the Dominion government responded with a full-scale military expedition. Recognizing that the "Northwest Field Force" would require professional medical and surgical support, the Minister of Militia and Defence appointed Doctor Darby Bergin of Cornwall, Ontario, to be Canada's first Surgeon General, not only for his medical expertise but also for his influential contacts: he was also a Member of Parliament and a Lieutenant-Colonel in the Militia.

To supplement the medical personnel who accompanied each unit of the Northwest Field Force, Doctor Bergin mobilized two field hospitals and recruited four professional nurses from the Winnipeg General Hospital. All medical personnel with the expedition were under the supervision of the “Chief of the Medical Staff in the Field,” Doctor Thomas Roddick of McGill University. After the battle of Batoche, which ended the rebellion, Doctor Roddick set up a general hospital near the battlefield to treat all the wounded and sick of both sides. To staff it, Doctor Bergin despatched seven volunteer nurses from Ontario, under the leadership of Sister Hannah Grier Combe, a professional nurse and the Mother Superior of the Sisterhood of St. John the Divine.

1899-1902 🌸 The South African War

In 1899, when Britain went to war with the Boers of the Orange Free State, South Africa, the “Imperial defence” aspect of the conflict caused Canada to send troops overseas for the first time.

Although regiments were still recruiting their own medical personnel, the Canadian Army took its first step toward a permanent medical service in June 1899, with the formation of the Army Medical Department. A Canadian Army Nursing Service was also contemplated, but military planning was quickly overtaken by world events. On October 30, 1899, when the First Contingent (comprising the 2nd Battalion (Special Service Force), The Royal Canadian Regiment of Infantry) departed for South Africa, it was accompanied not only by two battalion medical officers – Surgeon Major C.W. Wilson, of whom little is known, and Surgeon Captain Eugène Fiset, who was noted for courage and efficiency under fire at Paardeberg – but also by four professionally trained Canadian nurses, dressed in khaki military uniforms and (as of 25 January 1900) accorded the status of junior officers.

Unlike the medical officers, the Canadian nurses were not permitted to go to the field with the troops. Instead, they were employed in British Army general hospitals, where at first they were not allowed to touch the patients, but restricted to instructing RAMC hospital orderlies. As casualties mounted, especially from disease, these constraints gave way to need, and the nurses were soon fully employed. Under the leadership of Georgina Fane Pope of Prince Edward Island, the Canadian nurses of the First Contingent proved valuable, so four more nurses were sent out with the Second Contingent, which departed Halifax in the late winter of 1900. On 1 August 1901, the Canadian Army Nursing Service was formally organized with a regular component comprising the nurses who had served or were serving in South Africa, and a reserve component of qualified nurses working in Canada and available for military service.

The fall of Pretoria in 1900 marked the end of the beginning of the South African War. Shortly after, the Boers took to guerrilla attacks and raiding, and the British Army responded. The demand for Canadian troops continued and, with it, the high casualty rate caused by lack of hygiene and poor management of contagious disease. In January 1902, the 10th Canadian

Field Hospital was formed and deployed to South Africa with the Third Contingent to improve the standard of care Canadian soldiers received, provide sustained case management, and consolidate medical staff so they could work together in teams. This was the first step in a long process of centralization and coordination of resources that continues today.

1904 🌸 The Canadian Army Medical Corps

The Canadian Army Medical Corps (CAMC) was formed under General Order No 98 of July 1904, to bring military health care providers together under unified command and control. Its regular component comprised only eight officers (all doctors) and 36 non-commissioned orderlies and storemen. As well as the medical officers attached to the regiments of the Non-Permanent Active Militia, the reserve component of the CAMC included dental officers, the members of the Canadian Army Nursing Service (who bore officers' rank but were never permitted to exercise military authority), and non-commissioned orderlies and logistics personnel such as storemen and drivers.

In 1906, the year Colonel Eugène Fiset was promoted from Director General Medical Services to Surgeon General, he organized the CAMC into field-deployable units. In 1914, the regular CAMC numbered 127 all ranks, namely 20 medical officers, five nursing sisters and 102 non-commissioned members. The reserve component was organized as an Army Hospital Corps with eight Cavalry Field Ambulances, fifteen Field Ambulances and two Clearing Hospitals.

1914-1918 🌸 The First World War

The First World War began in 1914 and ground on in Europe until 11 November 1918; in other theatres (such as north Russia and Siberia), Canadian involvement in hostilities lasted well into 1919. In October 1914, when the first contingent of the Canadian Expeditionary Force went overseas, the 1st Canadian General Hospital (raised from the CAMC reserve) deployed to France. On 21 October 1914, as Canada's combatant units were training in England, 1 CGH began receiving patients; four months later, when the 1st Canadian Division arrived in the Ypres area, the hospital had already treated nearly 3,000 patients.

Of necessity, the CAMC expanded exponentially, not only in size but also in complexity and professional expertise. By 1918, Canada's overseas military medical establishment included, as well as dozens of Field Ambulance units, four Casualty Clearing Stations, ten Stationary Hospitals, sixteen General Hospitals, five Special Hospitals and three Convalescent Hospitals. Canadian doctors, nurses and auxiliary medical staff also served in many British units.

The principal medical challenges were shock and infection: the troops lived and fought in mud, and the majority of wounds were inflicted by high-explosive artillery shells, which meant flesh torn by blast and shrapnel, and contaminated by the filth of the battlefield. The sick were legion, suffering

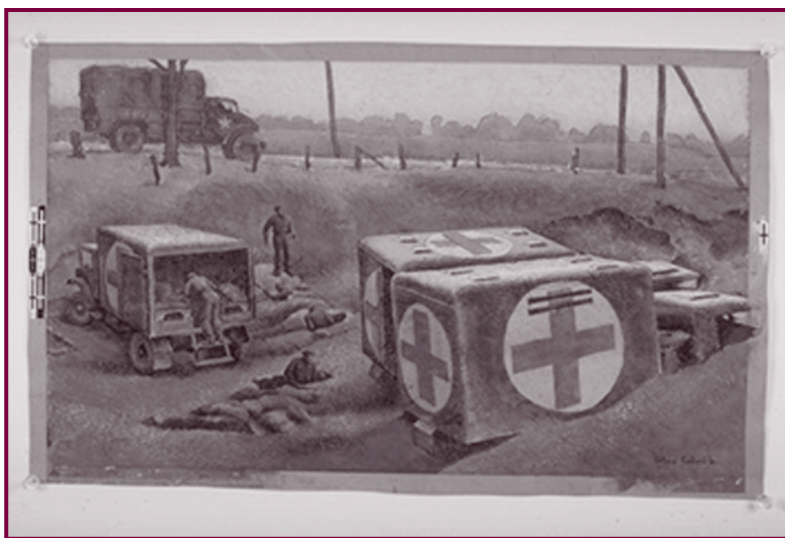
from respiratory diseases of all kinds, water- and food-borne diseases, old scourges such as typhus and new afflictions such as “trench foot,” a destructive skin infection caused by living for weeks on end in soaking footwear. The conditions were just as hard for medical personnel as they were for combatant troops.

On 3 November 1919, the CAMC was redesignated the Royal Canadian Army Medical Corps (RCAMC) in recognition of its fine service.

Did you know?



Between 4 August 1914 and 11 November 1918, the Canadian Army Medical Corps (CAMC) enrolled 21,453 personnel, including 3,141 nursing sisters. Of the CAMC's 1,325 casualties, 504 were killed in action or died of wounds, and 127 died of disease. Three Canadian medical officers and two Canadian stretcher-bearers earned the Victoria Cross, the British Empire's highest award for valour, and many earned lesser decorations: for example, a medical officer serving with the 22nd Battalion received two awards of the Military Cross.



Capt. David (Alex) Alexander Colville/Canadian War Museum/
Catalogue No.12133

Casualty Clearing Post, ca. 1944.

1939-1945 ✪ The Second World War

Canadian Army

The face of battle had changed, but only to a degree. There were static periods, with entrenched positions and raiding across “no-man’s-land”, but Canadian troops also experienced phases of greater mobility and extended lines of communication when the time came to advance or retreat. Field Ambulances began to play a much greater role, delivering the Army’s wounded to battlefield medical stations, and then to the rear echelons for more sophisticated medical care. Again, the RCAMC grew to meet the need, and by 1945 was operating five Casualty Clearing Stations, twenty-eight General Hospitals, three Convalescent Hospitals, and one General Hospital specializing in neurology and plastic surgery.

This period saw the introduction of antibiotic drugs, revolutionary improvements in surgical techniques and trauma care, and, for the first time, truly systematic case management. Of particular interest is the RCAMC’s novel approach to “battle exhaustion”, the psychological injury suffered by those overcome by a combination of combat stress and physical fatigue. Beginning in 1943, during the Italian campaign, Canadian psychological casualties were identified, taken out of the line for immediate therapy, and often returned promptly to duty. This practice was adopted to reduce guilt and other conflicts within the individual soldier in the hope that temporary trauma would not develop into a permanent disability.



Did you know?

During the Second World War, 34,786 men and women (including 3,656 nursing sisters) served in the Royal Canadian Army Medical Corps (RCAMC). Of this number, 107 died as a result of enemy action and 491 were wounded. Major RCAMC installations received about 84,000 patients, and achieved a recovery rate of 93 percent for wounded casualties and 99.91 percent for victims of disease.

Royal Canadian Navy

In 1939, the Royal Canadian Navy (RCN) had no medical capability; it was supported in Canada by the RCAMC and elsewhere by the Royal Navy. Surgeon Commodore A.A. McCallum, the senior serving medical officer in the Royal Canadian Navy Volunteer Reserve, was appointed Director of Naval Medical Services in February 1940, but the medical establishment grew slowly at first. In late 1941, the first RCN hospitals opened at HMCS *Naden* in Esquimalt, British Columbia, and HMCS *Stadacona* in Halifax, Nova Scotia; during the course of the war, the RCN opened seven more, including one at HMCS *Avalon* in Newfoundland and one at HMCS *Niobe* in Greenock, Scotland. RCN medical personnel included medical officers (who bore the title “Surgeon” in Royal Navy style and generally went to sea only in large ships), nursing sisters (all employed in hospitals), and lower-deck personnel called “sick berth attendants” (SBAs) (or “sick bay tiffies” in the fleet), who delivered almost all routine health care received by the crews of the RCN’s hundreds of small ships. In 1942, the RCN ceased its practice of having its SBAs trained in England by the Royal Navy and opened a Medical Division at the Fleet School at *Naden*.

As well as trauma care, RCN medical personnel became expert in the health problems of men required to perform hard labour in cold, damp, crowded conditions with poor food, little rest and constant fear: respiratory diseases, skin conditions, “immersion foot” (a condition similar to trench foot), hypothermia, exhaustion. They also learned to treat those who survived when their ships did not: men plucked from the frigid waters of the North Atlantic after hours or even days in a lifeboat or clinging to a Carley float, often with blast injuries and burns, and coated with oil.

During the Second World War, the Royal Canadian Navy lost nine medical officers, one nursing sister and 16 SBAs who were killed in action or died as a result of enemy action.

Royal Canadian Air Force

The Royal Canadian Air Force (RCAF), too, began the war with no medical capability, and was entirely dependant on the RCAMC for health care services. In late 1940, when the Medical Branch of the RCAF was established by Order in Council, RCAMC medical officers employed with RCAF units were transferred to form the nucleus of the new service, and recruitment of nursing sisters began. To serve the operational needs of the RCAF, the Medical Branch developed a network of small airfield hospitals that extended across Canada through the Home War Establishment and the flying schools of the British Commonwealth Air Training Plan (BCATP); by the end of 1944, there were 100 station hospitals in Canada and Newfoundland. A particular concern on BCATP stations was immunization, and large-scale programs were conducted throughout the war. The RCAF did not open its own hospitals overseas, but RCAF medical staff served at Royal Air Force (RAF) hospitals supporting Canadian units, especially (after the formation of No 6 (RCAF) Group in 1943) the RAF hospital at Northallerton, Yorkshire.

As aviation was still novel in 1939, little was known about the physiological effects of flight, or how best to identify potential aviators. For operational reasons, therefore, the RCAF was particularly interested in physiological research: not only the effects on humans of altitude, acceleration and extreme heat and cold, but also the physical and psychological characteristics most essential to aircrew. Throughout the war, the RCAF conducted a sophisticated aviation medicine research program using BCATP aircrew candidates as experimental subjects. This program also focussed on equipment, such as the Franks Flying Suit (a precursor to today's G-suit) and extreme cold weather clothing for bomber crews.

Operationally deployed RCAF medical officers, nursing sisters and medical assistants became expert in trauma care, particularly with victims of crashes on land and at sea; hypothermia and related conditions; and the health problems of ground crews, who worked long hours out of doors in all weathers – industrial accidents, exposure to toxic materials, exhaustion. Of particular interest is the development by RCAF medical staff serving in East Grinstead, Sussex, of plastic surgery techniques, supported by innovative psychotherapy methods, to treat severely maimed burn patients, many of whom were aircrew who had survived being shot down in flames. These patients became famous as the “Guinea Pig Club.”

1959 ✱ The Canadian Forces Medical Service

The post-war period was not peaceful, and Canada played an active role in many parts of the world as the Allies reorganized to form the United Nations (U.N.) and the North Atlantic Treaty Organization (NATO). As time passed, the maintenance of separate Army, Navy and Air Force medical services became less and less practical and, on 15 January 1959, after 12 years of cooperation at varying levels of formality, the Canadian Forces Medical Service (CFMS) was established to centralize the administration of all medical operations, and to permit the development and application of common policies.

On 2 May 1969, a year after the Royal Canadian Navy, the Canadian Army and the Royal Canadian Air Force were integrated to form the Canadian Armed Forces, the CFMS was authorized as a personnel branch of the CF, completing the administrative process of amalgamation that began in 1947. On 27 August 1971, the designation Medical Branch was introduced. In 1995, the Canadian Forces Medical and Dental Service were united under the Surgeon General who later became the Chief Health Services (CHS).

In 1999, with the establishment of the Director General Health Services as head of the Canadian Forces Health Services (medical and dental) the Surgeon General became responsible for medical clinical issues while the Deputy Chief of Staff, Dental Services, retained his responsibilities for dental issues.

The Cold War

In 1945, in the immediate wake of the Second World War, Canada became a founding member of the U.N. In 1949, after many clear indications that the Soviet Union had hostile intentions toward its erstwhile allies in the West. Belgium, Canada, Denmark, France, Iceland, Italy, Luxembourg, the Netherlands, Norway, Portugal, the United Kingdom and the United States, therefore, founded the North Atlantic Treaty Organization, a mutual-defence military alliance.

Membership in the U.N. and NATO was to have almost immediate consequences for the armed services of Canada and their medical personnel. During the Korean War, which broke out in 1950, Canada contributed a brigade group, a naval task force of three destroyers, and a strategic airlift squadron to the U.N. effort to halt the Communist invasion of South Korea. In 1951, also in reaction to the situation in Korea, Canada despatched a brigade group and an air group to Germany as part of an integrated NATO force designed to prevent a Soviet invasion of western Europe.

Canada's involvement in the Korean War, which ended in 1953, involved 26,791 Canadian soldiers, sailors and Air Force personnel, of whom 516 were killed and 1,072 wounded or taken prisoner.

In Germany, Canada's commitment increased and decreased in size over more than 40 years, depending on the strategic situation and Canadian government priorities. More than 100,000 Canadian Forces personnel served there, most of them soldiers and Air Force personnel. Unlike other operational deployments, however, NATO service in Germany meant a multi-year posting and, after the strategic situation stabilized about 1952, Canadian service personnel began taking their families overseas with them. Almost all social support services delivered to these Canadian communities in exile were either delivered by or obtained through their military health care providers. A British general, Sir John Hackett, wrote of the Canadian contingent, as he knew it in the early years of NATO, that, "[of] all the brigades I have known in my thirty years under arms, they were more closely knit than almost any other, and their equipment in supporting arms and services ... endowed them with an unusual breadth of experience."

Membership in the U.N. also kept Canada's military health care providers busy in post-war years, as Canada participated in dozens of peacekeeping missions around the world. In 1949, the Canadian Army began contributing personnel to the United Nations Military Observer Group in India and Pakistan (UNMOGIP), created in 1948 to monitor compliance with the agreements that ended military operations in the Kashmir region. In 1956, the Suez Crisis, which developed at a particularly dangerous period of the Cold War, prompted Lester B. Pearson (Canada's ambassador to the U.N.) to propose that, once a cease-fire was established, the U.N. should send professional troops armed only with light defensive weapons to patrol the contested areas and ensure that the belligerent armies complied with the terms of the truce. The United Nations Emergency Force (UNEF) peaked in 1957 at 6,000 troops from Brazil, Canada (with a contingent of about 1,000), Colombia, Denmark, Finland, India, Indonesia, Norway, Sweden and Yugoslavia. In 1964, Canadian troops were among the first to arrive in Cyprus when the United Nations Force in Cyprus (UNFICYP) was formed, a commitment they sustained until 1995. In 1991, when the former Republic of Yugoslavia began to break up, Canada became involved in U.N. operations in the Balkan region – a commitment that continues today with Operation *Palladium* in Bosnia-Herzegovina.

The 1990s

In 1989 – the year that marked the opening of the Berlin Wall and the beginning of the end of the Cold War – an era of budget cuts began. Over the years, the CFMS had evolved to focus more and more on the peacetime needs of the Canadian Forces, to the point (claimed the Auditor General's Report of 1990) that its ability to respond to operational demands was compromised. In 1993, a government laden with debt after years of recession addressed itself to deficit reduction, and it seemed to many that the Canadian Forces – including the CFMS – was ripe for pruning. Within two years, three of the six Canadian Forces Hospitals closed, and the number of military health care providers was cut from 3,000 to 2,400 all ranks. Before the cuts, CFMS personnel provided the full range of health care services at specialized facilities; in 1995, the CFMS began to draw on civilian facilities for services delivered in garrison, and to restructure itself into units designed primarily to support Canadian operational deployments. This reform process continues today.

Today and Tomorrow

The end of the Cold War altered the operational emphasis for the Canadian Forces in general and the CFMS in particular. There is no guarantee, however, that the experiences of the 1990s will continue to be the norm; indeed, the events of 11 September 2001, and the operations that followed, show that the Canadian Forces are likely to see great changes in the years to come. As always, the CFMS will adapt and recreate itself to meet new needs and overcome new challenges.

The process of reform that began in 1959 with the creation of the CFMS continues today with programs such as Operation *Phoenix* and Rx2000. Though they vary in detail, the central thrust of these programs is consistent with more than 40 years of CFMS development: centralization of medical resources to ensure optimal efficiency and excellence in the delivery of health care to Canadian Forces personnel.

As the 21st century starts, not only military organizations have changed: the battlefield, too, is different. The “revolution in military affairs” is the current popular phrase that refers to the effect of modern technology (especially computers) to strategy, tactics and most basic elements of war-fighting. As in every great military development since the dawn of history, the current changes arise from equipment and techniques (e.g., night-vision devices, stand-off weapons systems, advanced intelligence-gathering methods). War has become much more lethal than it was in previous generations, and it has extended its reach to areas once considered safe. Despite budgets that are still constrained, Canadian Forces operational activities have grown in scope and complexity. The nature of military medicine has also changed. As more medical personnel participate in increasingly difficult missions, they

find themselves treating a wider variety of injuries and illnesses. At the same time, environmental and occupational issues have arisen, increasing the demand for specialist care.

Future conflicts that involve the Canadian Forces as well as medical support will probably conform to one of three models.

High-and mid-intensity operations

This is the kind of action that took place in southwest Asia in 2002 (Operation *Apollo*) and during the Gulf War of 1991 (Operation *Friction*). Each Canadian Forces unit involved in Operation *Apollo* deployed with its integral medical support; during the Gulf War, however, 1 Canadian Field Hospital was deployed to Saudi Arabia to support British land forces.

THE ARMY On land, as in the First and Second World Wars, operations will likely cover great expanses of territory, reach high levels of intensity and produce high numbers of casualties. Depending on the location of operations, disease and environmental factors could also lead to high death rates.

THE NAVY Enhanced medical services may be required aboard naval vessels to support established treatment facilities. Here, too, missile or torpedo attacks could produce high numbers of casualties, and especially burn victims, in very short periods of time.

THE AIR FORCE Though the level of involvement will vary in future according to the number of troops engaged, fixed medical facilities at overseas air bases are extremely vulnerable to attack, and there is considerable risk from chemical and biological weapons. The CFMS will have to decide on a case-by-case basis whether to provide close support or to move medical facilities away from fixed air bases to more secure locations.



National Capital Commission

The Peacekeeping Monument – Ottawa.

Peace-support operations

The basic task in a traditional peacekeeping operation is to monitor the compliance of belligerent parties to a cease-fire agreement or a truce. Therefore, these missions involve extensive patrolling and observation of contested areas, which can be quiet and low-key but sometimes means dealing with fire-fights and, in rare cases, outright war. In 1988, when Canada deployed a large contingent of communications troops under Operation *Vagabond* to the Iran-Iraq border area, the Canadian Forces entered an era of complex operations in places where there might be little, if any, peace to keep. Such operations are referred to as “peace-support” or even “peace-enforcement” missions.

In a quiet peacekeeping mission, CFMS personnel concentrate on preventive measures, especially hygiene and disease prophylaxis, and the delivery of emergency care to peacekeeping forces and to local people. Examples of such missions (at time of writing) are Operation *Danaca* on the Golan Heights between Israel and Syria, and Operation *Palladium* in Bosnia-Herzegovina.

In a peace-support or peace-enforcement mission in a very troubled area, however, medical personnel face much greater challenges. Working in landscapes sown with anti-tank and anti-personnel mines, surrounded by local people scraping an existence in the wreckage of their society, CFMS personnel are primarily concerned with keeping peacekeeping forces healthy and fit for their very demanding duties. In regions lacking public institutions such as police and health authorities, and essential infrastructure such as roads, buildings, communications systems, and reliable supplies of electricity and potable water, disease prevention and the delivery of humanitarian aid to local people are particularly important. Examples of such missions are Operation *Relief* in Somalia, Operation *Toucan* in East Timor, and Operation *Eclipse* on the border between Ethiopia and Eritrea.

When peacekeeping forces are caught in open warfare, as happened to the Canadian Airborne Regiment in Cyprus (1974) and to Princess Patricia's Canadian Light Infantry in Croatia (1993), the mission has the potential to become a mid- to high-intensity operation, with the priorities there of: triage, immediate treatment of those who can return to duty, and immediate evacuation of those who require extensive treatment. It is, of course, an essential task of the medical services supporting a mission in such a volatile situation to be prepared for the worst.

To ensure the highest standard of care and the best use of medical resources, large Canadian contingents (1,000 or more Canadian Forces personnel) are supported by a surgical team with critical care resources and diagnostic equipment. Wherever possible, Canadian medical teams share facilities with allied medical teams that have similar professional standards.



Dept. of National Defence

Canadian Forces medical assistants caring for a local child during a humanitarian mission.

Humanitarian operations

Canada is capable of deploying a Disaster Assistance Response Team (DART) either in Canada or overseas, and the Canadian Forces can render assistance wherever catastrophe strikes, most such disasters being natural in origin (earthquakes, floods, ice storms). Refugee support also falls under the broad category of humanitarian operations, although it is somewhat different in character. Disaster response calls for very special qualities, including considerable medical skill and outstanding openness of mind. Medical solutions that come from individual, high-tech practices in the developed world are often inappropriate and even harmful at the site of an overseas disaster. Canadian involvement there is almost always of short duration and, when foreign troops withdraw, it is local resources that must take up the slack. It follows that Canadians must learn how to live within the boundaries of local medical practice. The implementation of public health measures is almost always of first importance.



Did you know?

The St. John Ambulance and Canada's military medical services have a relationship that goes back more than 100 years. The link between the St. John Ambulance (a descendant of the Knights Hospitaller, a religious order founded around 1070) and the Canadian Army goes back to 1884, when the first St. John Ambulance First Aid Course was held at the Royal Military College in Kingston, Ontario. In 1922, a St. John Ambulance Special Centre for First Aid was established at National Defence Headquarters in Ottawa, where it operates today under the auspices of the Director General Health Services. Since 1948, members of Canada's armed services have received appointments to the Most Venerable Order of the Hospital of St. John of Jerusalem for services rendered in support of the Order.

Medicine on the Battlefield



Benjamin West (artist)/Augustin Le Grand (engraver)/
National Archives of Canada/C-012248

The Death of General Wolfe, by Benjamin West (National Gallery of Canada).

War is a constantly recurring theme in human history, but the shape of war has changed over time. For most of European history, nations did not keep standing armies; rather, when war was declared, feudal levies were gathered, mercenaries were hired, and civilian entrepreneurs – armourers, provision suppliers, surgeons, apothecaries – attached themselves to the army. When the emergency passed and the campaign ended, both soldiers and civilian service providers returned home.

The French Revolution brought a new organization to war that was as significant in its way as the development of firearms: for the first time, mass armies were raised through volunteer recruitment when possible and, when the supply of volunteers was exhausted, by conscription. Throughout the Napoleonic Wars (1796–1815), huge forces waged campaigns that continued for years, extended the length and breadth of Europe and around the world at sea, and swept whole populations into the conflict.

Medical teams have been present on the battlefield from very early times. Though not formally organized as they are today, doctors accompanied the Roman legions in their conquest of the known world. During the Renaissance, when newly translated Arab texts brought the knowledge of ancient Greece to Europe, doctors took their rediscovered skills to war. As science continued to transform the medical profession in the 17th and 18th centuries, medical practitioners applied new knowledge to healing the wounds and illnesses of the battlefield. Eventually, specially trained medical teams made up of physicians, surgeons, surgeons' mates and apothecaries (or pharmacists)

were organized to accompany military forces, carrying with them their drugs, dressings and instruments. Often, these teams were organized not to serve the army as a whole, but specific regiments.

Military medicine has changed over the years. For countless centuries, soldiers on the field of battle have been the first to render assistance to the injured. In the past, first aid was also delivered by women, many of them the wives or followers of soldiers. When more difficult or prolonged treatment was required, it was often religious foundations that acted as hospitals. In medieval Europe, for example, many monasteries included an infirmary to which injured soldiers could be carried.

Until the arrival of gunpowder in Europe in the 14th century, the weapons used in war (arrows, swords, spears, clubs and variations thereon) were limited in the damage they could inflict. Firearms began to increase the number of casualties and the variety of wounds inflicted. Today, the range and kind of weapons deployed in war continues to increase with the development of chemical and biological weapons.

At the same time that weapons have been increasing their capacity for damage, medical sciences have undergone major changes. The age of modern medicine dawned with the era of western scientific enquiry and technical advances in the 18th century. By the middle of the 19th century, a huge increase in the understanding of disease was giving rise to general improvements in surgery and the management of illness. Improvements in public health, including both disease prevention and the provision of nursing care, began to transform the field of medicine.

In that context, armies also began to change the way they dealt with disease and injury. Gradually, throughout the 19th century, they brought a more structured approach to the practice of medicine. From the early 1800s onward, “field” or “flying” hospitals were established just behind the front lines while “general” hospitals, with as many as 6,000 beds, were set up well to the rear.

Over the past 200 years, military health care providers have pushed steadily forward, struggling to organize themselves and sharpen their skills so they can provide optimal patient care, both on the battlefield and in garrison. Health care professionals joining the CFMS in the 21st century are part of that continuing tradition.

The Achievements of Military Medicine

Modern medicine owes much to the discoveries and innovations of military health care providers. For example:

Evacuation

Napoleon's surgeon, Baron Dominique-Jean Larrey, pioneered the modern concept of evacuation with the development of specially fitted wagons that came to be known as "Napoleon's flying ambulances." The ambulance was more than an improvement in medical efficacy: it was also a potent symbol of the army's concern for soldiers' welfare and, as such, it did much to boost morale. Half a century later, the Civil War in the United States produced vast numbers of casualties in a unique set of social and political circumstances that impelled military medical personnel to perfect evacuation techniques to the fullest extent that the technology available to them would allow, and that trend continued through the great wars of the 20th century. During the Korean War (1950-53), for example, the U.S. Army adapted helicopters (then brand-new technology) to transport casualties over rough terrain and to hospital ships at sea.

Intensive care

In 1936, Doctor Norman Bethune of Gravenhurst, Ontario, provided a mobile blood transfusion service for use on the battlefields of the Spanish Civil War, thus improving battlefield medical care. In 1938, he went to China and joined the Communist forces as Chief Medical Officer of the Eighth Route Army for which he set up a mobile medical unit. During the Vietnam War, the concept of intensive care in the field developed even further. Now Field Ambulance staff routinely perform procedures that were once delivered only in the best-equipped hospitals.

Public health and immunization

Military health care providers have played a huge role in the identification of disease vectors and the eradication of disease through hygiene and immunization. During the Spanish-American War (1899-1900), for example, yellow fever (then endemic in the southern United States, Central America and the Caribbean) killed more American soldiers in Cuba than the enemy did, and Major Walter Reed, a U.S. Army surgeon and bacteriologist, determined that eradication of the mosquitoes that carried it would control the disease. During the 20th century, public health authorities adopted immunization techniques developed by the armed services for processing recruits to conduct the massive national immunization programs that are now part of normal family life in Canada.

Nursing

Modern nursing began in military hospitals during the 19th century, through the efforts of determined women using practices developed in European religious communities. Perhaps the best-known pioneer of military nursing is Florence Nightingale, a European-trained English nurse who, in 1854, took 38 hand-picked female nurses to Scutari in the Crimea and, through discipline and sanitation,

drastically reduced the mortality rate in the barracks hospital there. After two years in the Crimea, Florence Nightingale returned to England to found the first nursing school in the English-speaking world, and write the first English-language textbook on nursing.

The armies of Britain, the United States, France and Canada were among the first organizations to give nurses a professional place in the management of patient care. The Canadian nurses who served in the South African War (1899-1902) were the first Canadian women to serve in military uniform.

Humanitarian efforts

In 1859, a 31-year-old Swiss named Henri Dunant witnessed the Battle of Solferino and was so appalled by the lack of care for casualties on the field, and the resulting loss of life, that he proposed the establishment of a neutral health service to care for the wounded in conflict and catastrophe. His idea ultimately gave rise to the Red Cross (and later, in the Muslim world, the Red Crescent), the symbols of which are worn by military medical personnel around the world. Dunant's ideas also contributed to the Geneva Convention of 1864. In 1901, Henri Dunant was awarded the first Nobel Prize for Peace.



Chapter II

T E N E T S



Vision, Mission, Values Director General Health Services

Our VISION

We are a professional military health service trusted for our expertise. We understand and respect the unique needs of those who serve anytime, anywhere. The excellence of our care makes us proud to serve.

Our MISSION

To promote health protection and deliver quality care to the Canadian Forces.

Our VALUES

Caring: We have empathy for our patients, whose welfare is our foremost concern. Compassion is always evident as we share with them the responsibility for their health.

Our People: We support, promote and encourage the professional and personal development of our people.

Teamwork: We are a multi-disciplinary team that works together, guided by the best interests of those we serve.

Professional Excellence: We master the skills of our disciplines, learn continuously and base our judgements on scientific evidence and the best interests of those we serve.

Communication: We listen to, understand and inform our patients, our people, the Canadian Forces and the public.

Accountability: We take responsibility for our actions, decisions and behaviour.

Military Ethos: Our uniformed personnel continuously develop and excel as loyal and dedicated members of the Canadian Forces.

Military Medical Ethics



Ken Bell/Dept. of National Defence/
National Archives of Canada/PA-141703

Lance Corporal W.J. Curtis, RCAMC, attends to the burned leg of a French boy while a young brother looks on, 19 June 1944, Colomby/Buissons, France. (Sgt Ken Bell, DND).

Absolute Criteria

There are certain vital questions associated with the ethics of military medicine, and issues – many of them difficult to predict or foresee – that are bound to arise during any term of service. Fortunately, health care providers have a set of absolute criteria to apply whenever an ethical decision is required.

Duty to the group

The health care provider has a clear duty to render assistance to the patient, but circumstances may prevent complete fulfilment of that duty. In situations with mass casualties, for example, triage is practised, and in many cases the health care provider may be able to offer little more than pain relief and reassurance to some of the injured. It is the military health care provider's ethical duty to balance the needs of the individual against the needs of the group. As well as management problems associated with triage on the battlefield, medical resources (including transport, supplies and accommodation) may be restricted. Decision-making authority with respect to the use of resources lies with the senior medical authority on site; however, all members of the medical team must advise that authority regarding the availability of resources and their distribution in relation to needs in their respective areas of expertise.

Duty to authority

Services provided and decisions taken by military health care providers must always be guided by the needs of the Canadian Forces. Health care providers may be called upon to defend certain decisions in that light. If they find it difficult to explain or defend a decision, they are ethically required to refer it to a more senior medical authority. They may not ethically ignore concerns; however, when referring them to a higher level, they must communicate the problem openly and honestly to the patient.

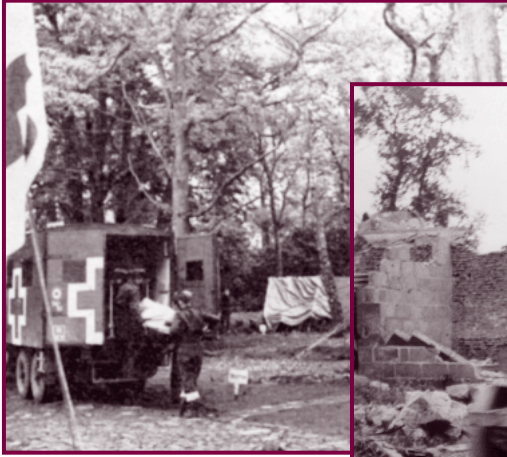
Duty to the Canadian Forces

Resolving clashes between patient advocacy and the needs of the Canadian Forces sometimes requires fine judgment. Usually, the needs of the individual and the community coincide in the long term; however, occasionally patients believe they can realize some short-term benefit by concealing or minimizing a disability. Such concealments can increase risk, not only for the patient, but for others as well.

Duty to medicine

Often working in less-than-ideal circumstances and in isolation, military health care providers may be faced with eroding standards of care. This erosion may occur slowly and almost unnoticeably, and it must be prevented. Though conditions may not meet standards to which Canadian health care providers are accustomed, they must make every effort to improve those conditions and maintain their standards. If they need help to do this, they must ask for it. If their requests for support are rejected, they have an ethical duty to persist, with more and better evidence regarding the need. One particular problem, especially with long deployments, has to do with the continuous effort that is required to maintain competence. Requests to improve competence are sympathetically received by senior medical staff. Whatever the occupation, the medical health care provider's level of skill and knowledge must be known and accepted: where appropriate alternatives exist, it is unethical to treat a patient whose condition requires skills and knowledge beyond that level. With modern communications technology, health care providers almost always have access to advice from more experienced or more highly qualified personnel. Whenever there is any doubt about patient management, they should seek advice.

From *Official History of the Canadian Medical Services*,
Vol 1, W.R. FEASBY, Queen's Printer 1956



Harold G. Aikman/Dept. of National Defence/
National Archives of Canada/PA-132862

Left: On arrival at No. 52 Mobile Field Hospital, a patient is carried from an ambulance to the reception tent, 29 May 1944, England.

Right: Wounded soldiers of the 7th Canadian Infantry Brigade are evacuated by jeep ambulance, 9 July 1944, Authie, France.

Duty to humanity

Military health care providers may be required to treat civilians or prisoners of war, and the treatment must be as good as circumstances permit. Where decisions have to be made regarding the saving of life and limb, it is unethical to allow race, creed, nationality or combatant status to affect those decisions in any way.

Military Doctrine

Structure for Action

The word “doctrine” – meaning the body of thought and knowledge taught in any particular field – applies in both civilian and military life. “Military doctrine” covers the nature of conflict, how a force is prepared for conflict, and the way in which military success is achieved. Military doctrine exists to impart knowledge and to guide the organization of the armed forces and the conduct of operations. History has shown that armies lacking military doctrine or failing to adhere to it are seldom victorious.

Doctrine arises from many sources, however, and is constantly evolving. In the way it develops and is applied, it reflects historical experience, professional insight and the particular culture of the nation it serves. The development and writing of military doctrine is, therefore, a continuous process. Every aspect of the military doctrine must be regularly checked and validated to ensure its continuing relevance, especially with regard to incorporating and applying new technologies and making sure that changes in national policy are mirrored within it. Every detail of training, tactics and operational procedures is worked out within the broad outlines of military doctrine, which thus plays a central role in determining the structure of Canada’s armed forces.

Civilian personnel may not think in terms of doctrine, but in fact they recognize its existence and routinely apply it to professional situations. For example, procedures applied by paramedics outside a hospital are defined by a series of algorithms covering all aspects of permitted procedures. Less formally, all medical decision-making is based on a “best practice” approach that constitutes an unwritten, constantly evolving doctrine governing how things are done.

Military doctrine as it applies to health services covers every aspect of caring for the sick and wounded all the way from the field of battle to restorative services. It is laid out in a series of publications, including *Health Services Support* (B-GL-343-001/FP-000) and the *Canadian Forces Medical Orders*.

Levels of Support

Continuity of care, as defined by military doctrine, is generally considered to cover four levels of support, as follows:

Role 1: Integral support

Integral support refers to the health care that is immediately available as part of any operational unit. A wounded soldier will probably receive first aid from a comrade; however, this assistance is likely to be limited by knowledge, available equipment and conditions on the battlefield. Therefore, a wounded soldier must be transported as quickly as possible to the nearest medical facility. The method of transport may be by armoured or standard ambulance (on land) or by hand-carried litter (in places inaccessible by vehicles, especially at sea). The medical facility – usually called the “Unit Medical Station” (UMS) – may be staffed by a physician, a physician assistant and medical technicians. It will have the equipment necessary to establish an airway, control haemorrhage and commence intravenous infusions. It may also be able to apply a number of other specialized treatments, depending on the nature of the injury. Integral support is equivalent to the level of health care available in any small and isolated Canadian town.

Role 2: Close support

Close support refers to the evacuation of the patient, usually to a Role 3 facility. In the Army, Field Ambulance units usually provide transport. Rearward transportation may be extremely difficult in the dangerous and erratic context of the battlefield, and it is not unusual for field ambulances to be delayed in transit; therefore, ambulances must include facilities to keep the patient stable and, if necessary, resuscitate the patient. Helicopter transport is preferable, whenever the weather or tactical situation permits, and it is the usual method of transfer in the Navy. Both land and air transport are used for the Air Force. However, neither the Navy nor the Air Force has dedicated close-support units, as the nature of casualties in these services and their locations result in fewer demands for transport.

Role 3: General support

General support is usually delivered from a Field Hospital. In some cases, however, it is provided by a field surgical team working in an Advanced Surgical Centre (ASC) deployed with the Field Ambulance or a non-medical unit. In any case, it is here that the first definitive surgical procedures can be undertaken. The decision to deploy a Field Hospital or ASC will be made in light of the anticipated casualty rates and the nature of the battlefield. General support does not usually encompass all kinds of specialized care, instead restricting itself to life-and-limb-saving measures, together with all necessary diagnostic and nursing support. General support corresponds to the level of health care available in a small community hospital with basic surgical resources.

Role 4: Operational and strategic support

Operational and strategic support delivers all kinds of specialized care, including multi-disciplinary activities and, possibly, prolonged rehabilitation. At time of writing, the Canadian Forces obtains this level of health care in allied military facilities or civilian hospitals where all or most specialties and sub-specialties are available.

Principles of Health Services Support

Principle 1: Conformity

Health Services Support (HSS) must conform to the constraints imposed by the physiology and pathology of the sick and injured, and be governed by the highest standards of medical and dental practice and ethics. In addition, HSS must conform to operations plans and requirements. Early involvement of HSS planners helps to ensure conformity.

Principle 2: Control

To ensure that all HSS requirements are considered and that resources are used effectively and economically, control and coordination of HSS resources are exercised at the highest possible level. Effective control of HSS resources depends on the exchange of accurate and timely information between operations commanders and HSS staffs.

Principle 3: Continuity

Since interruption of treatment results in increased mortality and morbidity, treatment must be continuous and progressive to the level necessary for definitive treatment of a patient's condition. Patients are evacuated through a series of HSS facilities, each with an increasing capability for treatment. Sorting of patients to reflect priorities for treatment and return to duty or evacuation, as far forward and as soon as possible, is a critical function of every HSS treatment facility.

Principle 4: Flexibility

Detailed and carefully planned HSS plans help to ensure minimum reaction time by the medical and dental services. During an operation, flexibility essential for rapid response is maintained by initially committing only the HSS resources that are required for current or imminent tasks.

Principle 5: Mobility

The HSS elements must maintain close contact with and be as mobile as the supported force.

Principle 6: Proximity

HSS facilities should be located as far forward as possible without interfering with operations or unnecessarily subjecting patients to enemy action. Medical resources should be positioned so that initial surgery can be performed within six hours of wounding, taking into account the available evacuation means. Initial surgery, carried out as soon as possible after wounding, is the most important factor in reducing mortality rates and is the focal point of operational medical support.

The Challenges of Service

For the patient

Military patients are uniquely placed in relation to health care providers. Often, they have little or no choice in who provides medical care. Deprived of the ability, where incompatibilities exist, to seek out an alternative health care provider, the patient may allow small concerns to mushroom into major complaints. By listening with a welcoming ear to patient concerns, the health care provider can prevent this from happening.

The patient may also perceive the provider of care as a possible threat to a career or posting. The health care professional must be cognizant of such anxieties and, at the same time, frank and assiduous in explaining potential problems and risks that may be associated with certain kinds of service.

Finally and most importantly, military patients – especially during or after returning from an overseas operation – are likely to have suffered stress far outside the experiences of the average Canadian civilian. Health care providers, especially if they have not taken part in similar operations, must approach such patients with sympathy, understanding and an open mind. This, and a refusal to deny possibilities, will allow for the delivery of optimal health care.

For the health care provider

Military health care providers have challenges of their own. They must always remember that the good of the community transcends the good of the individual. Military medical personnel, in duty to their employer, may have to make difficult decisions relating to a patient's fitness to serve. These determinations may run counter to the individual's wishes, which must always be balanced against the needs of the service as a whole.

The demands of active duty are also onerous, and the health care provider must understand and conform to operational objectives even if that means limiting or preventing care. For example, the requirements of an operation may mean transporting patients when this is deemed medically inadvisable. In military medicine, workload and circumstances may make triage or sorting essential. While health care providers must always maintain the highest standards and do their best for every patient, it is axiomatic that difficult ethical decisions will have to be made at some time in any military career.

The Geneva Conventions: The Laws of Armed Conflicts

*T*hroughout history, the conduct of war has been subject to complex (and often unwritten) codes of conduct, although these have varied over time and from culture to culture. The modern Laws of Armed Conflicts were first defined in the 17th century. It was not until the 19th century, however, when the first Geneva Convention was signed, that those codes had any particular relevance to medical services. In 1864, the founder of the Red Cross – Henri Dunant – organized a conference in Geneva, Switzerland. The result was an international convention concerning the treatment of those wounded in war and the protection of medical personnel.

The Geneva Convention has been amended and added to over time. As a result, four Conventions have been completed, encompassing not only the treatment of wounded and sick in the field and at sea, but also the treatment of prisoners of war, and the protection of civilian persons in time of war. The Geneva Conventions prohibit torture, hostage-taking, reprisals, and the use of chemical and biological weapons. The Geneva Conventions of 1949 (when the fourth Convention was added) have been accepted in whole or in part by most of the world's nations and by certain non-state organizations such as the Palestine Liberation Organization. The 1949 Geneva Conventions include codes for the following:

1. wounded and sick in the field (first promulgated in 1864);
2. wounded and sick at sea (1907);
3. prisoners of war (1929); and
4. the protection of the civilian population in times of war (1949).

Persons to whom the Geneva Conventions apply

The first two conventions are particularly relevant to services provided by the CFMS. They refer to the following persons:

1. members of the armed forces of a party to the conflict, including volunteer militia;
2. members of a resistance force (providing that they are properly commanded and controlled, that they carry arms openly, that they wear distinctive insignia recognizable at a distance, and that they conduct operations according to the Laws of Armed Conflicts);
3. members of regular armed forces who profess allegiance to a government not recognized by the Detaining Power;
4. accompanying civilians such as reporters, photographers and technicians provided with proper documentation;
5. members of the merchant marine or civil air crew; and
6. inhabitants of non-occupied territory who, on the approach of the enemy, rise *en masse* (provided that they carry arms openly and respect the Laws of Armed Conflicts).

In fact, unless there are very good reasons to deny it, all casualties in the field of war can expect to receive treatment.

Treatment of the sick and wounded

1. After any conflict, medical teams must seek out and collect the wounded and sick. This must be done immediately after the battle, but without reckless risk.
2. Medical teams must give adequate care to the wounded and sick, and protect them from pillage.
3. A record of care given to prisoners of war must be forwarded to the Prisoner of War Information Office (or its equivalent) as soon as possible. When a prisoner has died, a certificate of death must be sent to that office, along with property of intrinsic and sentimental value and half of the prisoner's identity discs.
4. All burials, whether on land or at sea, will be performed with honour and, when the deceased's religion is known, according to the appropriate rite.

Protection of the medical unit

The Geneva Conventions offer protected status to medical personnel and facilities, defining the conditions under which medical units and personnel will be allowed to operate on or near the battlefield.

1. Fixed establishments and mobile medical units may not be attacked or intentionally destroyed and, to that end, should not be located in proximity to military objectives.
2. If medical units are captured, medical personnel must be allowed to continue treating the sick and wounded for as long as necessary.
3. Medical personnel may be armed to protect themselves and the sick and wounded under their care, and non-medical personnel may be assigned to guard medical facilities.
4. Though the wounded may not be pillaged, they may be searched for ammunition and weapons, which items may be taken from them.
5. Military medical units may extend humanitarian aid to civilians without losing their protected status.
6. Hospital ships are protected, but they may be searched to confirm the validity of their medical activities. They may not possess or use codes to transmit information.
7. Aircraft used solely for the purpose of evacuation are protected if they fly at the heights and times and on the routes agreed to by parties to the conflict. When ordered to land, they must obey when it is safe to do so but, after inspection, they must be set free to continue the evacuation.
8. Medical personnel, chaplains, and administrative personnel attached to medical units are protected. If captured, they are considered to be retained personnel and are entitled to minimum protection as prisoners of war; however, when circumstances permit and if their professional services are not required, they must be returned to their own forces.

Though they may continue to care for their fellow prisoners of war, they must not be required to work outside the bounds of their medical or religious duties. Auxiliary personnel – for example, litter-bearers, communicators, logisticians and drivers – may be retained as prisoners of war but should be employed in delivering medical services as required. Members of this group should carry documents identifying the medical nature of their employment and wear a medical armband of modified design (e.g., with a Red Cross smaller than that worn by medical personnel).

9. Medical facilities and hospital ships should be painted white and marked with the Red Cross or Red Crescent. The national flag may be flown along with the medical symbol, unless the facility or ship has been captured, in which case only the medical symbol will be displayed.

Military Life: Standards of Conduct

The cohesion and effectiveness of the CFMS depend on high standards of conduct. Members of the service are expected to conduct themselves at all times in a manner that is conducive to the fulfilment of duty, to excellence in performance, and to respect for those in authority.

Leadership

Respect for those in authority is the Golden Rule of conduct and the basis of success in the CFMS. However, leadership means more than accepting the respect of junior ranks. If the unit is to deliver first-class medical care in a military setting, those in authority need to respect their junior ranks as well. For over a hundred years, the central principle of leadership in the Canadian military medical services has been to be “fair, firm and friendly.” All members of the medical team, whatever their rank or profession, are called upon to play a leadership role in treating the sick and injured. To do that, they must be aware of and respect the following guidelines:

1. maintain absolute integrity and honesty;
2. maintain competence and skill at whatever level has been achieved;
3. declare expectations and intentions to subordinates;
4. demonstrate commitment;
5. expect positive results and avoid negativity;
6. take responsibility for patients;
7. put duty before self and realize that taking risks is part of military life; and
8. be a team player.

Operational assignments

Military health care providers may be required to go to sea or to serve with field units, and such postings should be understood as uniquely valuable opportunities to share in the life and working conditions of patients. These opportunities allow for better, more insightful patient care and make the recommendations and advice of health care providers more likely to be accepted.

Postings

The CFMS strives to develop the careers of its medical personnel by moving them from posting to posting, thus building the individual's experience while filling vacancies in units. In particular, personnel serving in units assigned to high-stress operations are regularly rotated to units involved in less-stressful activities and replaced by fresh personnel. It follows that at some times in any military career, difficult or unpleasant postings will arise. Such postings may interfere with personal life, but they are part of military service. If an individual is not flexible enough, for personal reasons, to accept a posting, he or she should honestly evaluate the feasibility of a military career. Also, given this fact – that medical personnel are not permanently deployed, but are instead part of a chain of medical personnel coming and going to a variety of assignments – it is part of the duty of health care providers to assemble and pass on medically relevant information to those who come after. Thus, each new arrival will be better prepared for the situations he or she will encounter.

Physical fitness

All CFMS members must meet the physical fitness standards of the Canadian Forces unit or formation they support.

Continuous learning

All health care providers, both civilian and military, dedicate themselves to a career-long process of continuous learning. The body of medical knowledge is continually expanding and changing in the modern world. Maturing professionals must learn from their environment and from experience. They must also seek opportunities for retraining whenever possible and accept those opportunities in order to fulfil their duty both to the patient and to themselves.

Attitudes

Health care providers find themselves in almost constant contact with patients. It is important that they deal with them in a positive, pleasant and orderly way. When a hospital is untidy, patients will be doubtful, even if they receive first-class service. If the reception is surly, that negative impression will be remembered more than the good treatment. Those who are unable to prevent personal problems from interfering with their treatment of patients should ask for a temporary transfer to a post with less patient contact.

Teaching

Even as CFMS health care providers engage in continuous learning, so must they also teach. Whatever their occupational group, all CFMS members are expected to share what they know, either by example or through formal or informal instruction. Other activities will be periodically reduced to accommodate teaching responsibilities.

Complaints

Occasions arise when health care providers feel obliged to take the difficult step of lodging a complaint about an ethical matter or negligence of duty. Such complaints should be carefully considered and, if they are deemed necessary, should be addressed to the immediate superior. If no response is received in a reasonable period of time, the complaint can move on to the next level. Finally, if no satisfactory answer has been furnished, the senior medical authority should be advised.



Chapter III

HERITAGE AND
TRADITIONS



“The discipline of the parade square, the traditions of the mess, would work their magic and Esprit de Corps would fall like a blessed unction from above.”

EVELYN WAUGH,
Men at Arms



Harold G. Aikman/Dept. of National Defence/
National Archives of Canada/PA-140192

Chaplains work closely with medical personnel and aid in the evacuation of wounded. This unidentified chaplain is helping to load a stretcher patient onto a jeep, 15 July 1944, Caen, France.

By definition, a tradition is an “opinion or belief or custom handed down... from ancestors to posterity, especially orally or by practice.” The traditions that underlie the CFMS are its lifeblood. They embody certain ideals of service and provide a framework for members to work together as part of a highly disciplined and cohesive team. The continuing observance of military and medical traditions handed down by earlier generations will empower the CFMS to live up to its longstanding reputation for excellence.

Within the Canadian Forces, each service, branch and regiment has traditions peculiar to it. When it was formed in 1959, the CFMS adopted many Navy, Army and Air Force traditions. Since then, some customs have been found inappropriate or excessive and have been let fall. Those that remain – both medical and military traditions – draw members together within the service and provide uniformity at military and social functions. They also help to build *esprit de corps* and allow new members of the CFMS to integrate comfortably and confidently into their new military family.

It all comes down to *esprit de corps*. Canadian medical personnel rarely drill (“the discipline of the parade square”). However, the disciplines of the ward, the operating room and the laboratory are just as binding and these, together with our traditions, contribute strongly to building *esprit de corps*.

Medical Heritage

Hippocrates

*H*ippocrates, a Greek physician and teacher who flourished around 400 B.C., is called the “Father of Medicine” for the collection of 72 works on medicine written by his followers. Hippocrates distanced himself from earlier, largely magical practices and looked for a scientific and natural basis for treatment of the sick and injured. Many of the theories he advanced have long since been discredited, but the principles of medical treatment he put forward still prevail. For example, he insisted that medical practitioners have an obligation to teach their skills to those that follow them, that they should protect the confidence of patients, and that they should not assist their patients to harm themselves. Finally, and most importantly, they themselves should do no harm and, if not skilful enough to treat an injury or illness, they should refer the patient to someone more qualified. These teachings are reflected in the Hippocratic Oath, which is still sworn by modern doctors on graduation day in some countries. Its principles apply to the work of health care providers in the CFMS to this day.

Religion and the healing arts



Dept. of National Defence

*Saint Luke**

From the earliest days of Christian monasteries and convents, many religious communities have considered it part of their mission to accept the sick and injured (including soldiers), and to care for them, soul and body, until they either recover or die. This practice continues to this day.

For religious reasons, medieval monks and nuns did not perform surgery, but many orders developed expertise in nursing, physical therapy and the use of drugs. Religious healers were as concerned for their patients’ spiritual welfare as for their physical recovery, a matter of particular importance before the development of the effective drugs and techniques that are the basis of modern medicine. The association of medicine and religion survives in the close relationship between the CFMS with the Canadian Forces chaplaincy, and in the forms of address associated with registered nurses (especially in the armed forces) who, until very recently, were called “nursing sisters.”

* *Saint Luke, the patron saint: This stained glass window, now displayed at CFB Trenton, belonged to St-Paul chapel of the CF Base in Lahr (Germany) that has closed in 1993.*

The patron saint

In 1984, the CFMS chose Saint Luke, the author of one of the four gospels in the New Testament (the one that includes the parable of the Good Samaritan), as patron saint. Identified in one of Saint Paul's epistles as a physician, Luke is believed to have been a painter as well, and he is therefore the patron saint of doctors and artists. Today, medical units of the Canadian Forces celebrate the Feast Day of Saint Luke on the Sunday nearest to 18 October.

Military Traditions

Bearing Arms

*A*lthough CFMS personnel are not combatants, they bear arms to protect their patients and themselves. Medical officers on parade may carry swords, but they do not draw them; non-commissioned CFMS members on parade in a formed unit may carry personal weapons, but they do not fix bayonets. On operations, however, all CFMS personnel carry the personal weapons suitable to their situation and, when not engaged in their primary duties, perform defensive tasks such as taking their turn at guard duties.

The Order of March

The order of march has not changed substantially since the Napoleonic Wars. Before armies were motorized, the medical officer always marched near the head of the column, where he could scout for a location for the field hospital or aid post. The rest of the medical staff followed the column in the wagons that carried their equipment, picking up soldiers who fell out on the march. Today, when troops move, the medical officer (or his or her representative) still accompanies the advance party to make sure that medical arrangements are in place by the time the main body arrives. The rest of the medical unit follows with the main body and the rear party, as it is responsible for caring for the soldiers while they are in transit.

Honorary Appointments

Like many branches of the armed forces, the CFMS has a system of honorary appointments in addition to its command structure. This dual system gives the service an opportunity to recognize respected individuals, and allows those holding honorary appointments to help build *esprit de corps*. Honorary appointments are conferred on retired officers and distinguished civilians for specified periods. The following are the CFMS's honorary appointments:

The Colonel Commandant

The Colonel Commandant, an honorary appointment at National Defence Headquarters, is traditionally selected from among officers who retired at the rank of colonel or higher. The appointment is normally for three years, but it may be extended. The Colonel Commandant maintains communications with the Colonel-in-Chief and may be a source of information and experience for the staff of the Surgeon General, and a source of inspiration and *esprit de corps* for all ranks.



Did you know?

Dr. Peter Vaughan was selected as the Colonel Commandant of the Canadian Forces Medical Service (CFMS) on 6 September 2001. Dr. Vaughan served in the Regular Force as a Medical Officer and Flight Surgeon (1983-1986) and as member of the Supplementary Reserve (1986 and 1996). In 1994 he was deployed to Sarajevo in support of OP AIRBRIDGE. Dr. Vaughan distinguished record of volunteerism, humanitarian medical service, and leadership makes him an ideal role model for the CFMS health care team.



Dept. of National Defence

Colonel Peter W. Vaughan,
MA, MD, MPH.

Honorary Colonels and Honorary Lieutenant-Colonels

Honorary Colonels and Honorary Lieutenant-Colonels are appointed to CFMS units from among distinguished Canadian Forces members and civilians who live near the unit's home station. The appointment is normally for three years, but it may be extended. Honorary Colonels and Honorary Lieutenant-Colonels are expected to act as ready sources of advice on military medical traditions and other matters relating to the morale of the unit. They are also expected to be a source of inspiration and *esprit de corps*.

Royal Appointment

When a member of the Royal family is appointed, subject to Her Majesty's pleasure, as colonel-in-chief to a regiment, corps or other military organization, it is called a "Royal appointment," and it is conferred for life. The first Royal appointment to the CFMS was made in 1977, when Her Majesty Queen Elizabeth the Queen Mother, the former Colonel-in-Chief of the Royal Canadian Army Medical Corps, accepted the equivalent appointment in the CFMS, a position she held for 25 years; she died in 2002. The CFMS reports to its Colonel-in-Chief routinely and on special occasions through the Colonel Commandant, and communicates operational matters deemed to be of interest.



Did you know?

The appointment of Her Majesty Queen Elizabeth the Queen Mother as Colonel-in-Chief of the CFMS was only one of nearly two dozen such appointments she held. Among them were appointments to the Royal Army Medical Corps, the Royal Australian Army Medical Corps and the Royal New Zealand Army Medical Corps.

The Mess Dinner

Messes are integral to military life and serve a vital role in fostering morale and building *esprit de corps* among Canadian Forces personnel. A Mess Dinner is a formal military dinner held on special occasions, and it is a central event in the life of the Mess; it is here that members of a unit and their guests meet for fellowship and hospitality. It is important that those entering the Mess or enjoying its hospitality should know and comply with its traditions and customs, which centre on courtesy and respect.

An invitation to dine in the Mess is an invitation to enter the home and share in the life of the organization. Though Mess Dinner procedures vary from unit to unit, they are fundamental to any unit's traditions. Those invited to attend a Mess Dinner are expected to accept or send regrets in the same form in which the invitation was tendered and as promptly as possible. They are also expected to arrive a few minutes before the time specified on the invitation.

A CFMS Mess Dinner includes some (if not all) of the following elements:

Receiving line

If there is a receiving line, those attending the dinner proceed through it without delay, exchanging friendly greetings.

Socializing before dinner

The company will assemble for a short while in the anteroom for conversation and an aperitif or pre-dinner drink. Sherry is traditional, but no one is under any obligation to drink alcohol. At fifteen minutes and again at five minutes before dinner, a bugle call or other musical signal will remind the assembly that the meal is about to begin. During this period, all members and their guests should consult the seating plan in the lobby to find out where they will sit and who their companions at table will be. It is also wise to use this time to make any personal arrangements that are necessary to ensure that one does not have to leave the dining room during the program.

Procession to dinner

When it is time to go in to dinner, a procession forms behind those seated at the head table and their guests, and moves into the dining room. When everyone has found his or her place, all stand behind their chairs.

Grace

As soon as all are in place, the President of the Mess Committee (PMC) taps for order; the PMC, a chaplain or a member then says Grace. The company is then seated.

Dinner

A Mess Dinner comprises several courses, each with its own wine, which no one is required to drink; those who do not drink alcohol may drink water, which will be on the table, or ask the server for a suitable non-alcoholic beverage. While dining, everyone engages his or her neighbours at the table in quiet, pleasant conversation on subjects of general interest. Argument, loud talk and rowdiness are disliked in the Mess, where the company is expected to behave in a mannerly way. Those who wish to leave the table for any reason must ask the PMC for permission.

Clearing the table

After the dessert course, the table is cleared of all dishes, cutlery, glasses and napkins, leaving only a port glass for use during the toasts.

Serving the port

A decanter of port is presented to the person at the foot of each table, who fills the port glass and, without setting the decanter down, passes it immediately to the left. Each person repeats the procedure, filling the port glass and passing the bottle to the left and never across the table. A non-alcoholic drink may be substituted for port. The contents of the glass are left untouched until the Loyal Toast is proposed.

The Loyal Toast

When all the glasses have been filled, the PMC rises, taps for order and, in one of Canada's official languages, asks the Vice President of the Mess Committee (VPMC) to propose the Loyal Toast. The VPMC rises and, in the other official language, says: "Ladies and gentlemen, the Queen of Canada." All rise and, if a band is present, leave their glasses on the table and stand at attention while the Royal Anthem ("God Save the Queen") is played. Then all lift their glasses, saying, "the Queen of Canada," and drink to the health of Her Majesty. Then all resume their seats and return to quiet conversation. If no band is present, when the VPMC proposes the Loyal Toast, all rise and immediately lift their glasses to toast the health of Her Majesty. Because there are several toasts still to be made, the wise person sips only a little at each toast.

Toast to the Colonel-in-Chief

After a short pause, the PMC rises again, taps for order and, in one of the official languages, asks the VPMC to propose the toast to the Colonel-in-Chief. The VPMC rises and, in the other official language, says, “Ladies and gentlemen, our Colonel-in-Chief,” followed by the appropriate name. All rise and, if a band is present, leave their glasses on the table and stand at attention while the Colonel-in-Chief’s music is played; then all lift their glasses, saying “the Colonel-in-Chief” followed by the appropriate name, take a sip of port, resume their seats, and return to quiet conversation. If no band is present, when the VPMC proposes the toast, all rise and immediately lift their glasses to toast the health of the Colonel-in-Chief.

Toasts to foreign heads of state

If guests from foreign countries are present at dinner, the PMC proposes a toast to the Head of State of each country represented. Again, if a band is present, all stand while the national anthem of that country is played, then offer a suitable phrase of good wishes, take a sip of port, sit down, and resume

Recognition of Environmental Commands, Branches and Regiments

After the official toasts, coffee is served and, if a band is present, the marches of the Environmental Commands, branches and regiments represented at the dinner are played in order of precedence. (The PMC will have arranged the repertoire with the band director.) The non-medical members of each formation or regiment being honoured will stand at their places during the playing of their march. CFMS members, even though affiliated with an Environmental Command, are not obliged to stand during the playing of that command’s march; despite their Army, Navy and Air Force uniforms, they traditionally emphasize their medical team identity by standing only for “The Medical Branch March”. (This practice is evolving, as many medical personnel now choose to stand when their Environmental Commands are honoured.) In order to be ready to stand at the right moment, members should be aware of the order of precedence (see *Honours, Flags and Heritage Structure of the Canadian Forces* [A-AD-200-000 / AG-000]). Contrary to the practice in many other messes, only chaplains are expected to stand during the playing of “Onward Christian Soldiers”, the Chaplain Branch march. There is general applause at the conclusion of each march.

Concluding remarks and adjournment

The Commanding Officer or senior non-commissioned officer who is hosting the Mess Dinner may wish to make some remarks or invite a member or guest to do so. All comments should be brief, however, as the conclusion of the dinner approaches. The PMC signals the end of dinner by tapping the gavel and announcing the adjournment. All rise and stand at their places while the hosting Commanding Officer or senior non-commissioned officer departs with the head table guests. All the other diners follow. The PMC and the VPMC remain until everyone else has left the dining room.

Socializing after dinner

Members and guests adjourn to the anteroom after dinner to enjoy general conversation until the departure of the senior member of the Mess (i.e., the hosting Commanding Officer or senior non-commissioned officer). If any member or guest must depart early, good manners require him or her to take leave of the host and make proper apologies.

Dress and Deportment

Uniform

Military medical tradition says,
“Keep your clothes as clean as your hands.”

All military personnel wear uniforms, varying only in accordance with the season, climate and particular employment. In the CFMS, as well as orders of dress for the office and ceremonial occasions, the uniform includes “clinical whites”, “surgical greens” and various kinds of operational clothing. Uniforms must be worn according to the dress regulations, correct in every detail and as clean as possible – even in the field – both to prevent contamination and to inspire confidence. On occasion, medical personnel will be dressed in civilian clothing when they are called to treat patients, and military standards of order and cleanliness must apply to that dress also.

Deportment

Personnel in the CFMS must adhere to the high standards of conduct and respect that are followed throughout the Canadian Forces. These standards are most visibly expressed by what is called the “paying of compliments” – specifically, the salute.

The salute is a formal reciprocal gesture that expresses mutual respect and trust between non-commissioned members and commissioned officers, and between officers of different ranks. It is always initiated by the subordinate and completed by the superior. The salute under arms acknowledges the superior officer’s right to control the weapon. The hand salute, used when unarmed or when carrying a small weapon such as a pistol, indicates that the hand is empty. When not on parade, it is correct also to exchange greetings.

The elements of the salute, delivered either while standing and on the march, are:

1. erect bearing;
2. eyes directed to the person or persons being saluted; and
3. correct movement of the hands.

The hand salute

Canadian Forces members traditionally salute with the open hand only when in uniform and wearing headgear. When in uniform but without cap, the junior member merely stands or walks at attention while looking the superior officer in the eye. In civilian dress, the salute consists of raising the hat or cap; if no headgear is worn, or if removing the headgear would be awkward, it is customary to look the superior officer in the eye with head erect and exchange greetings. A junior member in uniform who recognizes a superior in civilian dress should give the hand salute, which will be returned in the manner appropriate to one in civilian dress.

The salute under arms

When carrying a “long arm” (rifle or sword), the salute normally consists of a gesture in which the weapon is proffered to the recipient of the salute. The full “present arms” is performed by Canadian Forces personnel on formal occasions (guard or parade), and the lack of a bayonet does not prevent medical personnel carrying rifles from doing this, so they do. Likewise, medical personnel armed with rifles when on guard duty give the “short salute”, in which the left hand is brought across to strike the forestock of the shouldered weapon, just as other Canadian Forces members do. The practice varies with respect to medical officers carrying swords, however; on parade, medical officers do not draw their swords, but salute with the open hand.

Saluting passengers in flag-bearing vehicles

Vehicles flying a general or flag officer’s pennant or displaying the uncovered plate of a general or flag officer (these plates are marked with one or more maple leaves) must be saluted appropriately. The occupant of the vehicle must return the salute.

Saluting the fallen

Canadian Forces members traditionally indicate respect for their fallen comrades by giving cenotaphs and war memorials the same signs of respect that they accord to superior officers. Likewise, when a military or civilian funeral procession passes, military personnel should halt, face the cortège, and salute as a sign of respect for the deceased and sympathy for the bereaved.

Symbols of Service

Every military organization has its own motto, badge, flag and march to symbolize its identity, and the CFMS is no exception. The motto succinctly defines the ideal of a group united by a common purpose. The badge, flags and march are the motto's visual and musical equivalents. Before the formation of the CFMS, the RCAMC and the medical branches of the Royal Canadian Navy and the Royal Canadian Air Force had their own insignia. For motto and march, the RCAMC used those of its British antecedent, the Royal Army Medical Corps: its motto was *In Arduis Fidelis* (Faithful in adversity), and its march was “Here's a Health Unto Her Majesty.” The medical branches of the Royal Canadian Navy and the Royal Canadian Air Force used their parent services' mottos (*Ready, Aye, Ready and Per Ardua Ad Astra*) and marches (“Heart of Oak” and “The RCAF March Past”). When the CFMS was formed, it received the following motto, badge, flag and march.

The Motto

Lieutenant-Colonel Anthony V. Grasset, a former commanding officer of 12 (Vancouver) Medical Company, proposed *Militi Succurrimus* [We hasten to aid the soldiers] as the motto of the CFMS in 1976. Taken into informal use shortly thereafter, it was formally approved on 10 August 1988.

The Badge

Within a wreath of stylized gold maple leaves, an oval annulus of dull cherry edged in gold, charged with a Rod of Æsculapius in gold, the whole ensigned by the Royal Crown proper.

The crown symbolizes loyalty to the Sovereign. Æsculapius represented healing in Greco-Roman mythology (considered a minor god by some, a demi-god or mortal by others). His emblem was a snake, whose regenerative power was symbolized by its ability to shed its skin. Today, the staff and serpent of Æsculapius are widely recognized symbols of medicine. The “sanguine” (blood-coloured) background of the badge also refers to Greek medicine, which was founded on the idea of four bodily “humours” (blood, phlegm, yellow bile and black bile), each with its own nature. The sanguine humour was associated with all that was hopeful, confident and optimistic.

When worn singly (e.g., as a cap badge), the snake faces the wearer's right. When worn as pairs (e.g., as collar badges), the snakes face each other. In print, the snake faces left.

The Flag

A flag divided diagonally from the lower hoist to the upper fly, dull cherry red above and dark green below. In the canton, the CFMS badge is presented in full colour.



Dept. of National Defence

The Badge of Canadian Forces Medical Service.



Richard Desmarais Photographer

The Flag of Canadian Forces Medical Service.

The March

“The Medical Branch March” (arrangement by Lieutenant(N) Brian Gossip) is a blend of two traditional English songs: “The Farmer’s Boy”, associated with the Duke of Edinburgh’s Royal Regiment, and “Here’s a Health Unto Her Majesty”, the march of the RCAMC. “The Medical Branch March” was selected in 1975 as the quick march of the Medical Branch by a committee chaired by the then Surgeon General, Rear-Admiral Richard Roberts; official approval followed on 2 September 1977. During a ceremonial parade, “The Medical Branch March” is played when the CFMS contingent is passing the saluting point. It is also played at Mess Dinners.

Did you know?

Brian Gossip was born in Kingston-upon-Hull in northeast England. He was conscripted into the British Army in 1952 under the National Service Act and selected for training as a musician with the Band of the Royal Highland Regiment (the Black Watch), with which he served in Germany and British Guiana. His National Service completed, Brian emigrated to Canada in 1955, and joined the Royal Canadian Navy Reserve at HMCS Hunter in Windsor, Ontario, where he served as a musician. In 1958, he decided on a full-time military career and joined the band of The Royal Canadian Regiment at Wolseley Barracks in London, Ontario.

In 1971, Brian Gossip was accepted in competition for training as a bandmaster at the Canadian Forces School of Music and, on graduation, he was commissioned and posted to the Central Band of the Canadian Forces, based at Ottawa. Between 1974 and 1988, Lieutenant(N) Gossip composed or arranged many Canadian Forces marches, including “The Medical Branch March”, an arrangement of “Greensleeves” as a slow march for the Canadian Forces Dental Service, a new arrangement of “The Princess Patricia’s Canadian Light Infantry March Past”, and “The Thunderbird March”, an original composition adopted by the Canadian Forces Security Branch as its official march. In 1988, Lieutenant(N) Gossip transferred from the Regular Force to the Cadet Instructor List, and he retired from the Canadian Forces in 1999. Brian Gossip is now a member of the Comox District Concert Band, and still writing music for military bands. He has several compositions in various stages of completion.



Private collection

*Lieutenant (Navy) (retired)
Brian Gossip.*

Medical Branch March

(The Farmer's Boy)

Arr. B. Gossip



Her Majesty the Queen Mother's Music

An Eriskay Love Lilt

Gradh Geal mo chridh

English Adaptation by
Marjory Kennedy-Fraser

With tender passion



The Queen Mother's Banner

A Banner of sanguine silk, fringed in gold and dull cherry with the Medical Branch Badge at its centre above a scroll displaying the Medical Branch Motto, Militi Succurimus, with the dates 1885-1985 embroidered below the scroll. In the canton, the Queen Mother's cipher, a stylized monogram in silver, is embroidered below a coronet. The staff head is a crowned lion in gold. The Banner is constructed of two layers of cloth, with an identical image on either side.

In 1984, when the CFMS celebrated its 25th anniversary, the Surgeon General requested that a Banner be made to honour the service's contribution to the Canadian Forces. In 1985, a century after the first operational deployment of a medical unit in support of Canadian troops, Her Majesty Queen Elizabeth the Queen Mother, Colonel-in-Chief of the CFMS, presented the Banner at a ceremonial parade held in the grounds of Queen's Park, the Ontario legislature. Her Majesty's remarks on this occasion referred to the origins of the CFMS, its splendid record in war, and the value of its contribution in peacekeeping missions.

The Banner is ensconced at the CFMS School at CFB Borden, Ontario. It is used locally and is available for display by Regular and Reserve medical units, provided that it can be safely transported to and from the place of display and protected while in the custody of the requesting unit. Normally, an officer accompanies the Banner while it is in transit.

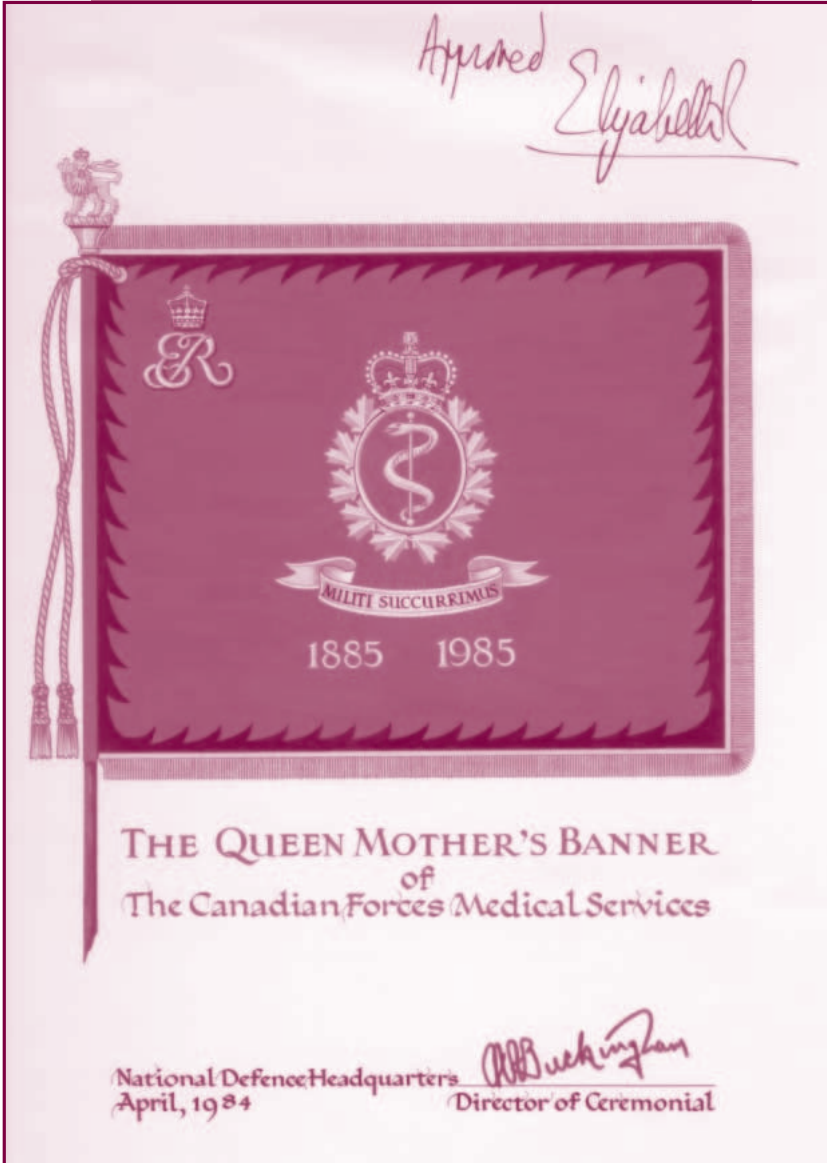
When on parade, the Banner is borne immediately behind and to the right of the Canadian national flag. In 1990, a CFMS detachment trooped the Banner in London as part of a celebration of the 90th birthday of its Colonel-in-Chief.

INTEREST AND ENCOURAGEMENT

From the Colonel-in-Chief



Her Majesty Queen Elizabeth the Queen Mother served as Colonel-in-Chief of the Royal Canadian Army Medical Corps from July 1952 until the unification of Canada's armed services in 1968. In 1977, she graciously accepted the same role with the CFMS, which then became one of the 23 Commonwealth military organizations in which Her Majesty held appointments. In regular communication with the Colonel Commandant during her years as Colonel-in-Chief, Her Majesty always responded readily to reports and, from time to time, sent messages of interest, encouragement and support to the service. She also made a point, when touring Canada, of visiting CFMS units and meeting as many members as possible. Her Majesty Queen Elizabeth the Queen Mother passed away in 2002, at the age of 101.



Battle Honours

Battle honours are badges awarded to military and naval units for participation in particular actions or, more rarely, campaigns. They are most often seen on the Colours of a regiment or the Standard of an Air Force squadron. The CFMS, though it is present wherever Canadians are serving, is not a combatant service and therefore does not receive battle honours. Our honour lies in supporting our comrades when they are well and caring for them as skilfully as possible when they are sick or wounded.

Home Station

*I*n a very real sense, the CFMS School is the “home station” of the Medical Branch. Located at CFB Borden, Ontario, since 1941, the school is the one place all CFMS members have in common, wherever they come from and wherever they serve.

The RCAMC School was established in late 1939, shortly after Canada declared war, at Lansdowne Park in Ottawa. In February 1941, it moved to Camp Borden, where it trained RCAMC personnel for nearly 20 years.

When the CFMS was formed in 1959, it faced the problem of bringing a wide variety of medical professionals and auxiliary staff with very different kinds of training and experience into a unified service. The formation of the CFMS Training Centre at Camp Borden was spurred, therefore, by the need for common standards and a way to disseminate those standards. The new school brought together and built on the earlier work of the RCAMC School, the RCAF Medical Assistant School in Aylmer, Ontario, and the medical training facilities of the Royal Canadian Navy, especially RCNH Naden in Esquimalt. The facility was renamed the CFMS School in 1968.

On 17 June 1994, the CFMS celebrated the opening of a new main building for the CFMS School, named the Private Richard Rowland Thompson Building for the Canadian recipient of the Queen’s Scarf, one of eight awarded throughout the British Empire during the South African War. Private Thompson was honoured for repeated acts of heroism in rendering aid to fallen soldiers and, as he represents the values and traditions of the CFMS, it is fitting that his name should be attached in perpetuity to its school.

The CFMS has a relationship with the Royal Army Medical Corps that dates back more than a century. Each has an exchange officer working at the other’s school.



Chapter IV

HEROES AND
HONOURS





Militi Succurrimus

Since 1885, Canada's medical personnel have shown great dedication to their patients, even when serving in conditions of great hardship and difficulty. Many have been honoured for their courage under fire; however, those with medals and awards are just a handful of the most notable of heroes in a service that routinely calls for acts of courage and self-sacrifice. Members of the CFMS should recognize and take pride in the heritage passed to them from their comrades in history, as exemplified in the stories that follow.



A Canadian postage stamp honouring Lieutenant-Colonel John McCrae.

Doctor and Poet

On 29 January 1918, a funeral was held in the military cemetery at Wimereux in France. Lieutenant-General Sir Arthur Currie, Commander of the Canadian Corps, attended with a crowd of senior medical officers. Many of those who served at two Canadian field hospitals in France also turned out, along with 75 nursing sisters in caps or veils. As the gun carriage bearing the body of Lieutenant-Colonel John McCrae moved sombrely through the cemetery, his beloved horse Bonfire was led behind.



Lieutenant-Colonel John McCrae (1872-1918).

National Archives of Canada/C-022873

John McCrae was only one of the 60,661 Canadians who died overseas during the First World War – nearly 10 percent of all who served – but he was arguably the most famous casualty, noted not for acts of war or medical brilliance but for “In Flanders Fields”, a scrap of verse he wrote in 1915, while treating casualties behind the lines at Ypres. Widely anthologized, taught to generations of schoolchildren, and now printed on the back of the ten-dollar bill, “In Flanders Fields” is one of Canada’s best-known and best-loved poems.

*In Flanders fields the poppies blow
Between the crosses, row on row,
That mark our place; and in the sky
The larks, still bravely singing, fly
Scarce heard amid the guns below.*

*We are the Dead. Short days ago
We lived, felt dawn, saw sunset glow,
Loved, and were loved, and now we lie
In Flanders fields.*

*Take up our quarrel with the foe:
To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields.*

John McCrae was born in Guelph, Ontario, in 1872, the son of an Artillery officer, and he wrote and published his first poems while still a student of medicine at the University of Toronto. Having joined his father's regiment at the age of 16, in 1900 he volunteered to go to South Africa, where he served with the left section of D Battery, Royal Canadian Artillery. On his return to Canada, McCrae embarked on a medical career in Montreal, where he lived peacefully for the next 14 years. He wrote widely on medical subjects during this period and became well known in his profession.

In 1914, war broke out in Europe, and once again McCrae joined up. In 1915, he was serving in the Ypres area as the surgeon attached to a brigade of the Canadian Field Artillery, helping out on the gun-line when necessary and occasionally performing burial services. He was there when the Germans launched a poison gas attack and, during the protracted battle that followed, he treated the wounded at an exposed medical station. He wrote later of those days: "I wish I could embody on paper some of the varied sensations of those seventeen days. ... Seventeen days of Hades! At the end of the first day, if anyone had told us we had to spend seventeen days there, we would have folded our hands and said it could not be done."

On 3 May 1915, during that period in Hell, McCrae took a few minutes to rest after burying a friend, Alexis Helmer, in a cemetery that happened to be full of wild poppies. He scribbled down a few lines of poetry on a bit of paper, then flung it away and went back to work. A fellow soldier retrieved the poem and gave it to their commanding officer, Lieutenant-Colonel E.W.B. Morrison (a newspaper editor in civil life), who sent it to the popular magazine *Punch* in London. And that is when John McCrae ceased to be just another soldier, another doctor, and walked into lasting fame.

"In Flanders Fields" made its first appearance in the 8 December 1915 issue of *Punch*, untitled and without attribution. It struck a chord, and soon the poem was being picked up and republished by newspapers and magazines everywhere in the English-speaking world. Suddenly everyone knew the name of John McCrae.

Meanwhile, McCrae continued to work. Promoted to the rank of Lieutenant-Colonel just before the battle of Ypres, he was posted shortly afterwards as second-in-command of the 3rd Canadian General Hospital at Boulogne. In 1918, he was appointed Consulting Physician to the British Armies in France. It was a post that he never took up.

McCrae was a chronic asthmatic, and his lungs had been badly damaged by the chlorine gas at Ypres. On 25 January 1918, he fell ill with pneumonia, and in three days he was dead.

On the Battlefields of Spain and China

Although most of his career was spent outside the formal boundaries of military service, Norman Bethune's name is forever synonymous with medical service on the battlefield. Born in Gravenhurst, Ontario, in 1890, Bethune studied to become a surgeon at the University of Toronto. He interrupted his studies in 1915 to enlist as a private and served as a stretcher-bearer through the First World War. After a brief stint in the Royal Navy and a period of post-graduate study in Britain, Bethune settled down to a career in Detroit, Michigan, where he made a name for himself as an inventor of surgical instruments.

It may have been a life-threatening crisis with tuberculosis in 1926 that changed the course of Bethune's life and awakened his social conscience, for from then on he began increasingly to challenge the medical profession in Canada and the United States. After a visit to the Soviet Union in 1935, Bethune joined the Communist Party. The following year, he went to Spain, where a civil war was raging between nationalists and republicans. While there, he made medical history by organizing the world's first battlefield blood transfusion service.

In 1938, Bethune turned his attention to China, where the Communists were fighting a bitter revolutionary war, and he went to volunteer his services. For a year, he worked tirelessly with the Eighth Route Army, and he died of septicaemia contracted by performing battlefield surgery without gloves. To this day, Norman Bethune is remembered as a hero in China and as a source of pride in Canada.



Geza Karpathi/National Archives of Canada/C-067451

Doctor Norman Bethune (right) performing a blood transfusion during the Spanish Civil War, ca 1937.

The Father of Aviation Medicine

Frederick Banting (1891-1941) is best known as the co-discoverer of insulin. A lesser-known fact is that he began his career during the First World War as a medical officer in France. While overseas, he was wounded in action and awarded the Military Cross, a significant decoration for valour. The official citation read:

“Captain Frederick Grant Banting, 13 Fld. Amb., C.A.M.C., near Haynecourt on 28 September 1918, when the Medical Officer of the 46th Canadian Battalion was wounded, he (Banting) immediately proceeded forward through intense shell fire to reach the Battalion. Several of his men were wounded and he, neglecting his own safety, stopped to attend to them. While doing this, he was wounded himself. His energy and pluck were of a very high order.”



Major Sir Frederick G. Banting, RCAMC, ca. 1941.

Born in Alliston, Ontario, Banting was an indifferent student in his youth, actually failing in his first year at the University of Toronto. After transferring to medicine, however, he blossomed, graduating in 1916 with above-average marks. Almost immediately, he enrolled in the Canadian Expeditionary Force and went overseas with the 13th Field Ambulance. After the war, Banting trained as an orthopaedic surgeon and began to practise in London, Ontario. During the 1920s, he worked with a team that discovered insulin, which made it possible at last to treat the previously fatal disease of diabetes. In 1923, Banting and Doctor J.J.R. Macleod received the Nobel Prize for Medicine, which they immediately shared with the other members of their team, Professor C.H. Best and Doctor J.B. Collip. In 1934, Banting was knighted by King George V.

In 1939, Sir Frederick Banting – who had remained in the Non-Permanent Active Militia (the army reserve) during the inter-war period – was mobilized, at the age of 48, with the Royal Canadian Army Medical Corps. Appointed Director of Medical Research with the rank of Major, Banting headed a group of scientists doing pioneer work in aviation medicine at the University of Toronto. In 1941, he was on his way by air to London to demonstrate their first major achievement, the Franks Flying Suit, at the Air Ministry when his plane went down near Musgrave Harbour on the north coast of Newfoundland. He died in the crash, and was buried in Toronto with full military honours.

The Inventor of the Anti-Gravity Flight Suit

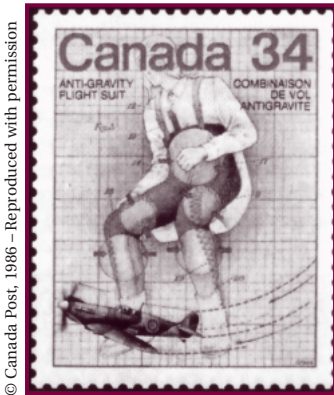
Toronto-born physiologist Wilbur Franks was a graduate of the University of Toronto Medical School and one of the experts recruited for the Department of Medical Research by Sir Frederick Banting, who had trained him as a cancer researcher before the war. As a medical officer with the Royal Canadian Air Force, Franks was directly responsible for the work that led to the development of the fluid-filled “anti-gravity flying suit” for pilots.

The purpose of the anti-gravity flying suit was to counter the blackout experienced by pilots in aircraft traveling at very high speeds and subjected to intense centrifugal pressure – called “G” (for gravitational) force. The idea came from cancer-related studies that Franks had carried out with mice, which caused him to wonder whether water could be used – in the form of a water-filled suit – to provide improved “G” protection. Franks invented the “human centrifuge” to test his idea, and it had to be powered by the same grid that supplied electricity to Toronto’s electric streetcars. Whenever Franks conducted a test, therefore, the streetcars on Eglinton Hill ground to a halt.



National Archives of Canada/PA-063923

Wing Commander Wilbur Franks modelling version D of the Franks Flying Suit on 18 February 1941.



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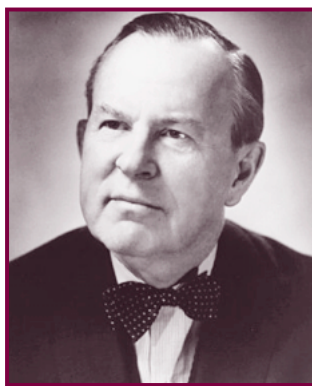
The Franks Flying Suit illustrated on a 1986 commemorative postage stamp, one of a series of four on Canadian technical achievements.

In 1940, a Spitfire fighter aircraft was brought to Canada to test the prototype of the Franks Flying Suit. Doctor Franks himself donned the gear, which was filled with water to the level of the heart. The trial was a success: with the plane achieving pressures of 6G, he remained fully conscious. In 1942, the Franks Flying Suit was first used in combat, and later became part of the standard gear of Allied pilots. The G-suits worn by pilots of high-performance aircraft, and the space suits worn by astronauts, are based on the principles first identified by Franks.

After the death of Sir Frederick Banting in 1941, Franks was promoted Wing Commander and took over the directorship of the Department of Medical Research. The part of the original research institution that specialized in aviation medicine was later re-organized as the Institute for Aviation Medicine, which became the Defence and Civil Institute of Environmental Medicine in 1968 and, in 2002, Defence Research Development Canada Toronto.

The Hospital Orderly

Lester Bowles Pearson was born in 1897, the youngest son of a Methodist minister. When war broke out in 1914, Pearson was an 18-year-old student; both his elder brothers joined the Royal Canadian Artillery, so he enrolled as a private in the Canadian Army Medical Corps. In 1915, he was sent to Salonika in northern Greece to serve as an orderly in a Canadian field hospital supporting the 10th Division, which was fighting the Bulgarians. In 1916, he transferred to the Royal Flying Corps, and was training as a pilot at Hendon, England, when he was run over by a London bus in the blackout; as a result, he was invalided home to Canada. Pearson's brief experience as a soldier left him with two important legacies: personal experience with the horrors of war, and his nickname, Mike, bestowed by an RFC squadron commander who thought the name Lester unsuitable for a pilot.



National Archives of Canada/PA-165516

*The Rt. Hon. Lester B. Pearson,
Prime Minister of Canada,
ca. 1963.*

After the war, Pearson completed his education at the University of Toronto and, on receiving a Rhodes Scholarship, at Oxford. He then tried out the law and business as careers and even taught history for a while at the University of Toronto, but he found his true calling in 1928, when he was recruited for the Department of External Affairs (then being formed) and embarked on a diplomatic career. In 1945, he was a member of the Canadian delegation to the historic conference in San Francisco where the U.N. was created, and in 1948, he was present at the negotiations that led to the formation of NATO in 1949. In 1948, with a fine record of service behind him, he left the Civil Service and entered politics.

The high point of Pearson's political career was his rise to the position of Prime Minister, which he held from 1963 to 1968. An even greater honour, however, was the Nobel Prize for Peace, which he received in 1957 for his role in urging the U.N. to establish a neutral peacekeeping armed force to help avert war during the Suez Crisis of 1956. Peace-support is now an important part of U.N. operations. Since 1948, Canada has participated in almost every U.N. peacekeeping mission, earning a proud reputation around the world.

A Colonel Commandant's Story

John Barr belonged to the armed forces of Canada for nearly 70 years. He was a medical student in 1934 when he joined the Canadian Officers' Training Corps and, in 1939, when the war broke out, he resumed his military training in breaks between spells of duty at the Ontario Hospital in Kingston.

In 1940, after graduating from Queen's University, John Barr worked briefly at the Ottawa Civic Hospital, where he was run off his feet, the pay was bad, and the food was terrible. Looking for better conditions, he joined the Royal Canadian Army Medical Corps as a lieutenant and was posted to the 23rd Field Ambulance.

In the summer of 1941, Captain Barr sailed for England where, after a number of assignments, he was deployed in 1943 to the Highland Light Infantry.

Having landed in Normandy on 11 June 1944, he was posted to 22 Field Ambulance as a company commander during the advance on Caen (France). Casualties were heavy. On one night, John Barr remembers, more than 160 patients moved through the station, which had only two medical officers to care for them. It was his job to stabilize patients so they could survive the two- to three-hour trip by ambulance to the nearest field hospital.

Many of the casualties that John Barr helped to save went to the hospital near Bruges. Early in 1945, John Barr himself was sent to that hospital for treatment. Major Barr remained with the Royal Canadian Army Medical Corps after the war, and in 1970, he attained the rank of Major-General and was appointed Surgeon General of the Canadian Forces. In 1973, he retired from the Regular component of the Canadian Forces to become Registrar of the Medical Council of Canada, where he remained until 1981. On 18 November 1976, Major-General (retired) Barr took up the honorary appointment of Colonel Commandant of the Medical Branch, a position he held until 1998.



Did you know?

During his appointment as the Colonel Commandant of the Medical Branch, Major-General (Retired) John Barr, a native of England, developed a real friendship with the Queen Mother, the Commander in Chief of the Canadian Forces Medical Service (CFMS) from 1977 until her death in 2002. The Queen Mother's continued interest in and commitment to the CFMS, which Major-General Barr deeply appreciated, combined with various opportunities that arose to keep her informed of the Service's activities and progress transformed a formal professional relationship into a lasting friendship that brought prestige and recognition to the Medical Branch.



Dept. of National Defence

*Her Majesty Queen Elizabeth the Queen Mother (4 August 1900-30 March 2002)
and Major-General (Retired) John W.B. Barr CMM, CD, QHP (7 December 1916-).*

Did you know?



Major-General (retired) John Barr, CMM, CD, QHP, former Surgeon General of the Canadian Forces and former Colonel Commandant of the Medical Branch, who devoted almost 70 years of his life to the health and well-being of Canadian military, was married to Marion Crawford, who was also involved in medical care for Canadian soldiers. Matron of the 12 Canadian General Hospital, Royal Canadian Army Medical Corps, during WWII, Marion Crawford met John Barr while they were both serving at the Ontario Hospital in Kingston.

Later, they met on different occasions while on service in Europe during the war. They married on 10 May 1945 in Bruges (Belgium) two days exactly after the victory in Europe. John Barr and Marion Crawford returned to Canada together in 1946. Marion Crawford Barr passed away in 1992, at the age of 85.



Private collection

Wedding of John Barr and Marion Crawford, 10 May 1945, Bruges (Belgium).

Prisoners of War in Hong Kong

*I*n 1940, Lieutenant Kathryn (Kay) Christie, a Toronto nurse with seven years' experience, enrolled as a lieutenant in the Royal Canadian Army Medical Corps. Late in 1941, she was sent to Hong Kong with the two Canadian infantry battalions (a deployment of 1,975 people) requested by the British to help bolster defences in the island colony. Lieutenant Christie was accompanied by another nurse, Lieutenant Ann May Waters of Winnipeg, whom she met on the train on their way to the ship that took them to Hong Kong. Also with the contingent were four medical officers (Major John Crawford, Captain S.M. Banfill, Captain J.A.G. Reid and Captain G.C. Gray), and two dental officers (Captain W.R. Cunningham and Captain J.C.M. Spence). On Christmas Day 1941, only weeks after their arrival, Hong Kong fell to the Japanese.

The British military hospital, where the two Canadian nurses worked, came under fierce shelling during the Japanese attack. On Christmas Day, when the British surrendered the colony, a period of horror began: 287 Canadians died during the fall of Hong Kong, and 266 more succumbed to hunger, disease and abuse during the next three and a half years, which the survivors of the invasion spent in brutal captivity. Four Canadians were executed for attempting to escape from Japanese prison camps.

Captain Banfill, who was serving with a Royal Army Medical Corps unit, had an especially terrible experience. He was captured early in the battle, and saw his RAMC orderlies killed before his eyes before he was taken to the Argyle Street Camp in Kowloon, where he was imprisoned with 900 Indian soldiers. Lieutenant Christie and Lieutenant Waters were incarcerated first at the Bowen Road Hospital, transformed into a prison by the addition of barbed wire, where they worked without proper food or supplies and in the face of spreading disease. After eight months at Bowen Road, they were shifted to the Stanley Civilian Internment Camp in the south-eastern sector of the island, where they remained for 13 months with 2,400 other men, women and children. At Stanley, they lived in rooms that measured nine by twelve feet and, in the beginning at least, were completely bare of furniture. "Our constant but unwelcome companions were large flying cockroaches," Lieutenant Christie recalled, "which sailed in through the windows, where there was very little glass; bedbugs that came out of the walls where the plaster had been damaged during the fighting; and large centipedes that seemed to fall from nowhere." The prisoners' other companions were boredom and hunger.

On New Year's Eve 1942, the prisoners decided to defy their captors. Ignoring the 10:30 p.m. curfew, they crept out of their rooms at midnight and assembled in the dark, all along the staircase. Linking arms along the railing from one floor to another, they sang a brave and tearful "Auld Land Syne."

In September 1943, Lieutenant Christie, Lieutenant Waters and the other Canadians at Stanley were repatriated through the efforts of the International Red Cross. They were taken by ship to the small Portuguese colony of Goa, where they were officially exchanged. Six weeks later, they were back at home.

Left behind in the prison camps of Hong Kong, the remaining Canadian military medical personnel continued to work heroically under the direction of Major John Crawford. When the bulk of the Canadians were assembled at North Point Camp, Major Crawford and the other three doctors found themselves responsible for the health of more than 1,200 Canadian prisoners.

Captain Reid was later transferred to Japan with the 500 Canadian prisoners who were shipped there to be used as forced labour. Thanks to this doctor's success in wringing concessions from their captors and making the best possible use of limited medical resources, only 25 prisoners died during their captivity in Japan, many fewer than in other, similar, contingents of prisoners.

An historian later wrote that the skill and resourcefulness that the Canadian military doctors brought to the care of prisoners in such appalling conditions "must surely be without parallel in the story of the RCAMC in the Second World War." Resourceful and dedicated though they were, they could not stem the rising tide of death over the 44 months of their captivity, and sometimes they came near to despair. Nevertheless, the fact that 1,400 Canadians ultimately returned home is largely due to the care they received from these military doctors.

Lieutenant Kay Christie's war did not end with her return to Canada; she served at a military hospital in Toronto until October 1945. After the war, she worked as a medical secretary until her retirement in 1980. Lieutenant May Waters died on 18 December 1987, exactly 46 years to the day after the Japanese attack on Hong Kong.



Sarajevo, 1995

For more than half a Century, Canadian troops have served with distinction around the world on dozens of peace-support missions. During these deployments, Canadian medical personnel have often been called on to help rescue civilians caught in the crossfire.

Canada has contributed troops to U.N., European Union and NATO peace-support operations in the Balkan region since 1992. In January 1995, fierce fighting between the Muslim, Serb and Croatian residents of Gorazde, a town in eastern Bosnia, put the community's most vulnerable members at great risk. On 31 January 1995, medical personnel of the Canadian and Norwegian contingents of the United Nations Protection Force (UNPROFOR) organized a convoy of 18 armoured ambulances to bring the sick, injured and frail elderly of Gorazde to safety.

The convoy formed up in Sarajevo and, between noon and midnight, made the 90-km journey to and from Gorazde by way of Pale and Rogatica, a route chosen to avoid contested areas. In Gorazde, where they arrived at last light, the ambulances collected 138 Muslim, Serb and Croat civilians representing the full spectrum of severe health problems from extreme old age and terminal cancer to recent gunshot wounds. The journey was painfully slow and very dangerous; a blinding snowstorm was blowing, the verges of the roads were sown with mines and screened to facilitate sniping, and the convoy was halted at least six times for "positive identification checks" at roadblocks manned by heavily armed soldiers hostile to at least some of the patients. At midnight, the convoy arrived safely at the Sarajevo hospital with all its patients in stable condition.



Photo by Chris Helgren

31 January 1995, Sarajevo, Bosnia-Herzegovina: As physician assistant, Warrant Officer Mike McBride (far left) checks patients inside, medical assistant Corporal Angie Cassel and armoured crewman Corporal Dan Worrall help an elderly blind woman out of their Bison armoured ambulance. Their passenger is wearing every garment she owns because her hometown of Gorazde is the focus of a fierce battle from which she and 137 others have been brought to safety by a U.N. ambulance convoy.

Recipients of the Victoria Cross

The Victoria Cross was instituted in 1856, at the end of the Crimean War, at Queen Victoria's personal initiative. She chose the design – a cross pattée with the Royal crest and a very simple inscription: “For Valour.” She also decided that it should be awarded purely for gallantry, with neither rank nor length of service being considered. It has always been a most democratic decoration.

The cross is cast from bronze salvaged from a Russian field gun captured in the Crimea. Originally, the medal was presented with a dark red ribbon for Army recipients and a blue ribbon for Navy recipients but, since 1920, only one colour of ribbon has been used: crimson. Of the 94 Canadians who have earned the Victoria Cross, nine were medical personnel: six doctors, two stretcher-bearers and one medical orderly.

Herbert Taylor Reade

By Helmuth Rath from a newspaper photo/
National Archives of Canada



During the siege of Delhi, and on the 14 September 1857, while Surgeon Reade was attending to the wounded at the end of one of the streets of the city, a party of rebels advanced from the direction of the Bank, and, having established themselves in the houses of the street, commenced firing from the roofs. The wounded were thus in very great danger and would have fallen into the hands of the enemy, had not Surgeon Reade drawn his sword and, calling upon the few soldiers who were near to follow, succeeded, after a very heavy fire, in dislodging the rebels from the position.

Action: *Delhi, India, 14 September 1857*
Born: *Perth, Upper Canada,
2 September 1828*
Service: *61st (South Gloucestershire) Regiment of Foot
(British Army)*
Died: *Bath, England, 23 June 1897*

Campbell Mellis Douglas

National Archives of Canada



For the very gallant and daring manner in which they risked their lives in manning a boat proceeding through a dangerous surf to the rescue of some of their comrades who formed part of an expedition which had been sent to the Island of Andaman. ... with a view to ascertaining the fate of the commander and seven of the crew of the ship *Assam Valley*, who had landed there, and were supposed to have been murdered by the natives. ... It is reported that seventeen officers and men were thus saved from what must have been a fearful risk if not certain death.

Action: *Little Andaman Island, 7 May 1867*

Born: *Québec City, Canada East, 5 August 1840*

Service: *24th (2nd Warwickshire) Regiment of Foot, British Army*

Died: *Wells, England, 31 December 1909*

William Henry Snyder Nickerson

Victoria Cross Medal



At Wakkerstroom on the evening of the 20th April 1900, during the advance of infantry to support the mounted troops, Lieut. Nickerson went in a most gallant manner, under heavy shell and rifle fire, to attend a wounded man, dressed his wounds, and remained with him until he had him conveyed to a place of safety.

Action: *Wakkerstroom, Natal, 20 April 1900*

Born: *Saint John, New Brunswick, 27 March 1875*

Service: *Royal Army Medical Corps*

Died: *Cour, Kintyre, Scotland, 10 April 1954*

Francis Alexander Caron Scrimger



National Archives of Canada

On the afternoon of 25 April 1915 in the neighbourhood of YPRES, when in charge of an advanced dressing station in some farm buildings which were being heavily shelled by the enemy, he directed under heavy fire the removal of the wounded and he himself carried a severely wounded officer out of a stable in search of a place of greater safety.

Action: *St-Julien, Belgium, 25 April 1915*

Born: *Montreal, Quebec, 10 February 1881*

Service: *Canadian Army Medical Corps, attached to the 14th Battalion, Canadian Expeditionary Force*

Died: *Montreal, Quebec, 13 February 1937*

John Alexander Sinton



Victoria Cross Medal

For the most conspicuous bravery and devotion to duty during the action at Sheikh Sa'ed on 21 January 1916. Although shot through both arms and through the side, he refused to go to hospital and remained as long as daylight lasted attending to his duties under very heavy fire. In three previous actions he had displayed the utmost bravery.

Action: *Sheikh Sa'ed, Mesopotamia, 21 January 1916*

Born: *Cranbrook, British Columbia, 2 December 1884*

Service: *Indian Medical Service*

Died: *County Tyrone, Ireland, 25 March 1956*

Michael James O'Rourke

Portrait by Ernest Fosbery (Canadian War Museum)



Seeing a comrade who had been blinded stumbling around ahead of our trench, in full view of the enemy who were sniping him, Pte. O'Rourke jumped out of the trench and brought the man back, being himself heavily sniped at while doing so. Again he went forward about 50 yards in front of our barrage under very heavy and accurate fire ... and brought in a comrade. On a subsequent occasion, when the line of advanced posts was retired ... he went forward under very heavy enemy fire of every description and brought back a wounded man who had been left behind. He showed throughout an absolutely disregard for his own safety, going wherever there were wounded to succour.

Action: *Hill 70, near Lens, France, 15–18 August 1917*
Born: *Limerick, Ireland, 19 March 1878*
Service: *7th Battalion, Canadian Expeditionary Force*
Died: *Vancouver, British Columbia, 6 December 1957*

Bellenden Seymour Hutcheson

Victoria Cross Medal



For the most conspicuous bravery and devotion to duty on 2 September 1918, when under the intense shell, machine-gun and rifle fire, he went through the Drocourt-Quéant Support Line with the battalion. Without hesitation and with utter disregard of personal safety he remained on the field until every wounded man had been attended to.

Action: *Drocourt-Quéant Support Line, near Douai, France, 2 September 1918*
Born: *Mount Carmel, Illinois, U.S.A., 16 December 1883*
Service: *Canadian Army Medical Corps, attached to the 75th Battalion, Canadian Expeditionary Force*
Died: *Cairo, Illinois, U.S.A., 9 April 1954*

John Francis Young



Victoria Cross Medal

Acting as a stretcher-bearer attached to 'D' Company of the 87th Bn., Quebec Regiment ... Pte. Young, in spite of the complete absence of cover, without the least hesitation went out, and in the open fire-swept ground dressed the wounded. Having exhausted his stock of dressings, on more than one occasion he returned, under intense fire, to his company headquarters for a further supply. This work he continued for over an hour, displaying throughout the most absolute fearlessness.... Later, when the fire had somewhat slackened, he organised and led stretcher parties to bring in the wounded whom he had dressed.

Action: *Dury-Arras Sector, France, 2 September 1918*

Born: *Kidderminster, England, 14 January 1893*

Service: *87th Battalion, Canadian*

Died: *Ste-Agathe-des-Monts, Quebec, 7 November 1929*

Frederick George Topham



Dept. of National Defence/
National Archives of Canada/PA-131823

Corporal Topham ... parachuted with his battalion on to a strongly defended area east of the Rhine. As he treated casualties after the drop, he heard a cry for help from a wounded man in the open. Two medical orderlies from a field ambulance went out to this man in succession but both were killed as they knelt beside the casualty. Without hesitation and on his own initiative, Cpl Topham then went forward through intense fire to replace the orderlies ... he was himself shot through the nose but never faltered in his task. Having completed first aid, he carried the wounded man steadily and slowly back through continuous fire to the shelter of the woods. For two hours, still refusing assistance for his own

wound, he continued to perform his duties until all casualties were evacuated. Toward the end of the day, he rescued three men from a burning Bren-gun carrier at great risk of exploding ammunition.

Action: *East bank of the Rhine River, Germany, 24 March 1945*

Born: *Toronto, Ontario, 10 August 1917*

Service: *1st Canadian Parachute Battalion*

Died: *Toronto, Ontario, 31 March 1974*

IN THE SERVICE OF EMPIRE:

Brigadier John Alexander Sinton



Canadians have a tradition of internationalism in military medicine as in other fields. One of the outstanding proponents of this tradition is certainly John Alexander Sinton, who received the Victoria Cross in 1916 and went on to a career of high medical distinction in India.

Born in British Columbia in 1884, Sinton was educated at Queen's University in Belfast and at the Liverpool School of Tropical Medicine, entering the Indian Medical Service in 1911. With the outbreak of war in 1914, he was commissioned into an Indian cavalry regiment, thereafter serving on the northwest frontier of India and later in Mesopotamia, Afghanistan and Waziristan. Repeatedly mentioned in dispatches, he was awarded not only the Victoria Cross, but also the Russian Order of St. George, and he was appointed to the Order of the British Empire in 1921.

Retiring from the Army that same year, Brigadier Sinton entered the Medical Research Branch of the Indian Medical Service. Over the years, he became a world authority on malaria and the recipient of many honours. He also acted as adviser to the Malaria Commission of the League of Nations and to the Ministry of Health in London.

At the beginning of the Second World War, Sinton was re-commissioned and served as a consulting malariologist in Africa and the Middle East. Retiring in 1945 with the rank of Brigadier, he returned to Ireland where in the last years of his life he served as a Justice of the Peace, Deputy Lieutenant of Ireland and the High Sheriff of Tyrone. He died in 1956 at the age of 71.

For the Bravest: The Queen's Scarf

The Queen's Scarf is an honour peculiar to the South African War, and most intimately associated with Queen Victoria. With her own hands, she crocheted eight scarves to be awarded to private soldiers or NCOs; of the eight, four were presented to British soldiers, and one each to a South African, an Australian, a New Zealander and a Canadian. The Canadian recipient was Private Richard Rowland Thompson, who was nominated for the award by his commanding officer and may also have been elected by his fellow soldiers.

Private Thompson was born in Ireland and emigrated to Ottawa with his family as a young man. He travelled extensively during the 1890s and studied medicine briefly, but did not qualify. In October 1899, when the South African War broke out, he enrolled in the 43rd Ottawa and Carleton Rifles and volunteered for service in the Eastern Ontario company of the 2nd Battalion (Special Service Force), The Royal Canadian Regiment of Infantry, which departed for South Africa on 30 October 1899.



Canadian War Museum

*Queen Victoria's Scarf as presented
to Private Richard Rowland Thompson.*

Private Thompson distinguished himself repeatedly in combat. On 18 February 1900, during the first phase of the battle of Paardeberg, his company was pinned down by Boer marksmen for hours in open ground. Keenly aware that to move was to draw fire, Private Thompson ran across the beaten ground to help Private James Bradshaw of Picton, Ontario, whose jugular vein had been severed by a shot through the neck. For more than seven hours, Private Thompson lay in the open beside Private Bradshaw, compressing the jugular vein with his fingers. Though Private Thompson's helmet was shot off his head, both men miraculously survived until stretcher-bearers could reach them about midnight.

Private Thompson continued to perform heroic acts, and was recommended twice for the Victoria Cross. In July 1900, he was selected as the Canadian recipient of a Queen's Scarf, an honour quite separate from all other awards for gallantry and good conduct. Richard Rowland Thompson is buried in Old Chelsea, Quebec, in the Gatineau Hills north of Ottawa. His Queen's Scarf is now on permanent display at the Canadian War Museum.

What's In a Name?

The history of the CFMS and the people who have served it is commemorated through the naming of buildings associated with the service. The sources of these names should be recognized and remembered.

Canadian Forces Base (CFB) Borden, Ontario

Founded as Camp Borden in 1916, it was named for Sir Frederick Borden, Minister of Militia and Defence from 1896 to 1911, whose career began as a New Brunswick country doctor who served 28 years as a medical officer with a Militia regiment, never missing a summer training camp. The base's original 60 square kilometres of sandy plain offered a prime venue for military training during both world wars. The construction of permanent facilities after the Second World War and the enlargement of the reserve to 80 square kilometres gradually transformed Borden into a modern military training centre. The name was changed to Canadian Forces Base Borden after the amalgamation of the Canadian Forces, and it is now the site of almost all the Canadian Forces' technical schools, including the Canadian Forces Medical Service School.

Bergin Building

This accommodation block for officers was named for Doctor (and Lieutenant-Colonel) Darby Bergin, Canada's first Surgeon General, who served in that capacity from 1885 to 1896. Doctor Bergin began his military career in 1862 with the 1st Rifle Company in Cornwall, Ontario, and was in command of the 59th Stormont and Glengarry Battalion when he was appointed Surgeon General. As well as practising medicine and holding a Militia commission, Doctor Bergin was prominent in the ruling Conservative Party and represented his constituency in the House of Commons.

Fiset Hall

The CFMS non-commissioned officers' mess hall, since demolished, was named for Major-General Sir Stephen Eugène Fiset, KCMG, DSO. A decorated veteran of the South African War, he served as Director General Medical Services from 1903 to 1906, and as Deputy Minister of Militia and Defence and Surgeon General from 1906 to 1924.

MacDonald House

This accommodation block was originally built for nursing officers and is now used for senior officers. It is named in honour of Major Margaret C. MacDonald, RRC, who went out to South Africa with the Second Contingent (1900) and served as Matron-in-Chief of the Canadian Nursing Service, Canadian Army Medical Corps from 1914 to 1917.

Banting Block

This office building originally functioned as quarters for CFMS non-commissioned members. It is named for Sir Frederick Banting, co-discoverer of insulin and a pioneer in aviation medicine.

Andy Anderson Arena

CFB Borden's arena is named for Major C.A. Anderson, DSO, a long-serving medical officer in the RCAMC and a former Chief Instructor at the CFMS School.

Private Richard Rowland Thompson Building – Canadian Forces Medical Service School

The main building of the CFMS School is named for Private Richard Rowland Thompson, recipient of the Queen's Scarf for heroic service during the South African War.

Barr Library

The CFMS School library is named for Major-General John Barr and his wife Captain Marion Crawford-Barr. Major-General Barr was Surgeon General from 1970 to 1973 and Colonel Commandant of the CFMS from 1976 to 1998. Captain Marion Barr served in England, France and Belgium during WWII.

Cooper Hall

This building commemorates Chief Warrant Officer H. Edward Cooper, MiD, CD, a long-serving member of the RCAMC and the CFMS, and a former CFMS School Chief Warrant Officer.

Pillar Hall

This building is named for Lieutenant-Colonel Mike Pillar, CD, a health care administrator with many years of service in the RCAMC and the CFMS, and a former Chief Instructor at the CFMS School.

Canadian Forces Base (CFB) Petawawa, Ontario

Lieutenant-Colonel John McCrae Building

The Petawawa garrison clinic is named in honour of the author of "In Flanders Fields".

Marion Barr Building

The 1 Canadian Field Hospital building is named for Captain Marion Barr, Matron of 12 Canadian General Hospital, Royal Canadian Army Medical Corps.

Warrant Officer Joseph Keith Arsenault Building

The 2 Field Ambulance headquarters building is named for Warrant Officer Joseph Arsenault, CD, a physician assistant who was killed in 1989, while serving with the Canadian Airborne Regiment, in the crash of a CC-130 Hercules transport aircraft at Fort Wainwright, Alaska.

Other Bases

Archie McCallum Hospital

The building that accommodates the Navy hospital in Halifax, Nova Scotia, formally known as Formation Health Services Unit (Atlantic), is named for Surgeon Commodore Archibald McCallum, OBE,VRD, CD, the Medical Director General of the Royal Canadian Navy from 1944 to 1952.

Blair McLean Hospital

The building that accommodates the Navy hospital in Esquimalt, British Columbia, formally known as Formation Health Services Unit (Pacific), is named for Surgeon Rear-Admiral T. Blair McLean, CD, QHS, who held the appointment of Surgeon General from 1960 to 1964.

Corporal Frederick George Topham Building

The Gagetown garrison clinic is named in honour of Corporal Frederick Topham, who earned the Victoria Cross for valour on 24 March 1945, during the crossing of the Rhine.



*A*nnexes



Annex I: Chronological Highlights

Year

- 1864** Henri Dunant, founder of the Red Cross, organizes a conference in Geneva, Switzerland that results in the first Geneva Convention concerning the treatment of those wounded in war and the protection of medical personnel. The Geneva Convention of 1864 was later amended and revised by the Conventions of 1907, 1929 and 1949.
-
- 1867** The *British North America Act* takes effect on 1 July, uniting the colonies of Nova Scotia and New Brunswick with the United Provinces of Canada East and Canada West to form the Dominion of Canada.
-
- 1868** The *Militia Act* creates the Department of Militia and Defence, with Georges-Étienne Cartier as Minister, and authorizes an Active Militia of 40,000 volunteers and a Reserve Militia comprising every able-bodied male between the ages of 16 and 60 years old, except those specially exempted.
-
- 1874** The Royal Military College of Canada opens in Kingston, Ontario.
-
- 1884** The first St. John Ambulance first aid course is held at the Royal Military College of Canada.
-
- 1885** The Northwest Rebellion breaks out, and the Dominion government authorizes a full-scale military expedition to quell it. To provide the Northwest Field Force with medical support, two field hospitals are mobilized and Doctor Thomas Roddick of McGill University is appointed Chief of the Medical Staff in the Field. Doctor (Lieutenant-Colonel) Darby Bergin of Cornwall, Ontario is appointed Surgeon General.
-
- 1899-1902** **The South African War:** Canada deploys troops overseas for the first time; several contingents are sent, totalling 8,372 all ranks, of whom 244 are killed in action or die of disease, and 252 are wounded. The professional nurses who accompany each overseas contingent are the first Canadian women to serve in military uniform.
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- 1901** The Canadian Army Nursing Service is formed, with a regular component of professional nurses who had served South Africa, and a reserve component of professional nurses working in Canada.

Year

- 1904** The Canadian Army Medical Corps is founded, integrating medical officers (who were attached to Canadian Army units), members of the Canadian Army Nursing Service, and medical orderlies in a unified command and control structure.
-
- 1910** The Royal Canadian Navy is created by the *Naval Service Act*.
-
- 1914-1918** **The First World War:** the British Empire (including Canada) declares war on 4 August 1914. The Canadian Expeditionary Force is raised from the Active Militia, and begins deploying overseas in October 1914; by 11 November 1918, when the Armistice takes effect, 619,636 men have been enrolled in the CEF, and 424,589 officers, men and nursing sisters have served overseas. The CEF casualty roll amounts to 59,544 dead and 172,785 wounded; Canadians serving in British and other allied forces bring the true total much higher. The population of Canada at this time is less than 10 million.
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- 1916** Camp Borden opens in south-central Ontario.
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- 1922** The St. John Ambulance Special Centre for First Aid established at National Defence Headquarters in Ottawa.
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- 1923** Doctor Frederick Banting receives the Nobel Prize for Medicine as a member of the team that discovers insulin. Banting began his medical career during the First World War as a medical officer with the Canadian Expeditionary Force.
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- 1924** The Royal Canadian Air Force is authorized on 1 April; the *National Defence Act* creates the Department of National Defence and brings the Canadian Army, the Royal Canadian Navy and the Royal Canadian Air Force together under unified administration.
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- 1936** Doctor Norman Bethune develops a mobile blood transfusion service for use on the battlefield during the Spanish Civil War.
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- 1939-1945** **The Second World War:** Canada raises and deploys massive naval and military forces, becoming a major power in its own right and developing its international standing and domestic industrial capacity beyond all pre-war expectations.
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- 1939** The Royal Canadian Army Medical Corps School is established at Lansdowne Park in Ottawa; it moves to Camp Borden in 1941.
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Year

- 1941** Doctor Wilbur Franks, serving as a medical officer in the Royal Canadian Air Force, leads the team that develops the anti-gravity speed manoeuvres.
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- 1949** The North Atlantic Treaty Organization (NATO) is formed by Belgium, Canada, Denmark, France, Iceland, Italy, Luxembourg, the Netherlands, Norway, Portugal, the United Kingdom and the United States as a mutual-defence military alliance to counter the increasingly hostile Soviet bloc.
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- 1950-1953** **The Korean War:** Canada deploys a brigade group, a naval task force of three destroyers, and a strategic airlift squadron to take part in the United Nations effort to prevent a Communist invasion of South Korea. This commitment is sustained for two and a half years.
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- 1951** As relations chill between the Soviet Union and the West, Canada deploys an infantry brigade and an air group to Germany to serve as part of an integrated NATO force. The NATO commitment in Germany lasts more than 40 years, increasing and decreasing in size according to the strategic situation in Europe and the priorities of the Canadian government.
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- 1952** Her Majesty Queen Elizabeth the Queen Mother becomes Colonel-in-Chief of the Royal Canadian Army Medical Corps.
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- 1956** **The Suez Crisis:** Canada deploys its first peacekeeping contingent to Egypt, to serve with the United Nations Emergency Force in the Sinai Peninsula and the Canal Zone. Peacekeeping quickly becomes integral to Canadian military operations.
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- 1959** The Canadian Forces Medical Service (CFMS) is established to centralize administration of medical support to the Royal Canadian Navy, the Canadian Army and the Royal Canadian Air Force.
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- 1968** The Royal Canadian Navy, the Canadian Army and the Royal Canadian Air Force are unified to form the Canadian Armed Forces.
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- 1975** The Surgeon General selects “The Medical Branch March”, an arrangement of “The Farmer’s Boy” and “Here’s a Health Unto Her Majesty” by Lieutenant (N) Brian Gossip, as the official march of the Medical Branch.

Year

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| 1977 | Her Majesty Queen Elizabeth the Queen Mother becomes Colonel-in-Chief of the CFMS. |
| 1984 | The CFMS celebrates its 25 th anniversary and chooses Saint Luke as its patron saint. |
| 1985 | Her Majesty, Queen Elizabeth the Queen Mother presents the CFMS with its Banner. |
| 1988 | <i>Militi Succurrimus</i> [We hasten to aid the soldiers] is approved as the CFMS motto. |
| 1989 | The demolition of the Berlin Wall signals the end of the Cold War. |
| 1990 | A CFMS detachment troops the Banner in London during a celebration of the 90 th birthday of its Colonel-in-Chief, Her Majesty, Queen Elizabeth the Queen Mother. |
| 1991 | The Gulf War: Canada deploys 1 Canadian Field Hospital to Saudi Arabia to support British land forces. |
| 1994 | The CFMS School opens the Private Richard Rowland Thompson Building at CFB Borden. |
| 1995 | In 1995, the Canadian Forces Medical and Dental Service were united under the Surgeon General who later became the Chief Health Services (CHS). |
| 1999 | With the establishment of the Director General Health Services as head of the Canadian Forces Health Services (medical and dental), the Surgeon General became responsible for medical clinical issues while the Deputy Chief of Staff, Dental Service, retained his responsibilities for dental issues. |
| 2001 | After terrorist attacks in the United States on 11 September, Canada mounts Operation <i>Apollo</i> as its contribution to the international campaign against terrorism. The Navy and Air Force deployments involved in this operation are the largest since the 1950s. In February 2002, the 3 rd Battalion, Princess Patricia's Canadian Light Infantry (3 PPCLI) Battle Group becomes the first Canadian unit deployed on a combat operation since the Korean War. |

Annex 2: CFMS Military Occupations

The delivery of health care services to Canadian Forces members demands a wide range of skills and knowledge. At time of writing, the CFMS comprised 16 military occupations, a number that is likely to expand along with health care knowledge and technology.

Non-Commissioned Members

Aero-Medical Technician
Bio-Medical Electronic Technician
Medical Technician
Medical Laboratory Technician
Operating Room Technician
Physician Assistant
Preventive Medicine Technician
X-Ray Technician

Officers

Bio-Science Officer
Health Care Administrator
Health Services Operations Officer
Medical Officer
Nursing Officer
Pharmacist
Physiotherapist
Social Work Officer

Annex 3: Decorations and Degrees

CB	Companion of the Order of the Bath
CBE	Commander of the Order of the British Empire
CD	Canadian Forces Decoration
CMM	Commander of the Order of Military Merit
DSO	Distinguished Service Order
KCMG	Knight Commander of the Order of St. Michael and St. George
MA	Master of Arts
MD	Doctor of Medicine
MMM	Member of the Order of Military Merit
MPH	Master of Public Health
OBE	Officer of the Order of the British Empire
OMM	Officer of the Order of Military Merit
QHP	Queen's Honorary Physician
QHS	Queen's Honorary Surgeon
QHNS	Queen's Honorary Nursing Sister
RRC	Member of the Royal Red Cross
VC	Victoria Cross
VRD	Volunteer Reserve Decoration (naval)

Annex 4: Suggested Reading and Websites

Print Materials

Feasby, W.R., *Official History of the Canadian Medical Services*, Queen's Printer, Ottawa, Ontario, 1956

Maloney, Sean M., *War Without Battles: Canada's NATO Brigade in Germany, 1951-1993*, McGraw-Hill Ryerson Ltd., Whitby, Ontario, 1997

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Richards, S.T., *Operation Sick Bay: The Story of the Sick Berth and Medical Assistant Branch of the Royal Canadian Navy 1910-1965*, Cantaur Publishing, Vancouver, British Columbia, 1994

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Swettenham, John, *Valiant Men: Canada's Victoria Cross and George Cross Winners*, A.M. Hakkert Ltd. for the Canadian War Museum, Toronto, Ontario, 1973

Wright, Harold M., *Salute to the Air Force Medical Branch on the 75th Anniversary of the Royal Canadian Air Force*, privately published, Ottawa, Ontario, 1999

Websites

Canadian Forces Medical Service

www.forces.gc.ca/health

Canadian Museum of Civilization

www.civilization.ca

Canadian War Museum

www.warmuseum.ca

Department of National Defence

www.forces.gc.ca

Directorate of History and Heritage

www.forces.gc.ca/hr/dhh

National Archives of Canada

www.archives.ca

Veterans Affairs Canada

www.vac-acc.gc.ca