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Chair

Mr. Rick Casson

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● (1530)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): I call the meeting to order.

As we continue our hearings on the issue of Afghanistan, I would like to welcome this morning, from DND, Commodore Kavanagh, commander of Canadian Forces health services group and director general of health services; and General Hilary Jaeger, Canadian Forces surgeon general.

Welcome. We appreciate your being here. I know there's been some interest in your visit, so after your presentations I'm sure we'll have some pretty interesting questions from some of the members of the committee.

The floor is yours for your opening statements, and then we'll turn it over to questions from the members.

Welcome.

Cmdre M. F. Kavanagh (Commander of Canadian Forces Health Services Group and Director General of Health Services, Department of National Defence): Thank you, Mr. Chair.

Thank you for the opportunity to explain a little about the Canadian Forces health care system, and more specifically how we provide health service support to the troops in Afghanistan.

My name is Commodore Margaret Kavanagh. I am the director general of health services and commander of the Canadian Forces health services group. Joining me, as you have said, is Brigadier-General Jaeger, the surgeon general.

I'd like to preface my comments by providing a brief explanation of why there is a separate military health care system in Canada. The Constitution Act of 1867 assigned sole responsibility for all military matters, including military health care, to the federal authority. The National Defence Act gives the Minister of National Defence the management and direction of the Canadian Forces, who in turn gives management and direction of the medical and dental services to the Canadian Forces.

In addition, the 1984 Canada Health Act specifically excludes Canadian Forces members from the definition of “insured persons”. We are also excluded from insurance coverage under the public service medical and dental care plans. Accordingly, the Canadian Forces leadership has a strong legal and moral obligation to provide comprehensive health care to Canadian Forces members, whether in Canada or abroad. In return for the commitment and unlimited liability to serve their country, Canadian Forces members must be provided with health care comparable to that which is provided to all Canadians, yet tailored to meet their unique needs.

The Canadian Forces health care system has many facets. In today's construct, it is inextricably linked with the Canadian health care system, both federally and provincially. You may want to understand more about how we provide health care in Afghanistan. To do so, it is important to first understand what we do at home.

Our activities in Canada, medically and dentally, prepare personnel for deployment and provide care to those who need it upon their return. We carry out public health and health protection functions; acquire medical equipment and pharmaceuticals in conjunction with the civilian sector; train health care professions; and provide direct patient care, predominately in the primary care setting. Almost all specialty care, in-patient, and rehabilitative services are now acquired from the civilian system, through a variety of arrangements.

Health care in general in the 21st century is very complex. It requires appropriate professional oversight. As the director general of health services, I am responsible and accountable to the CDS, through the chief of military personnel, for the leadership, management, and administration of the health system. As the commander of the Canadian Forces health services group, my job is to generate and sustain combat-ready health services units, subunits, and individuals who are capable of supporting the navy, the army, and the air force in operations. This includes the professional development, training, and preparation of health care personnel in order to meet their operational roles. Within the Canadian Forces health services, there are 19 different occupations, ranging from specialist medical and dental officers, to a variety of medical and dental technicians, all of whom have unique training and professional development requirements.

The surgeon general, as the senior Canadian Forces physician, focuses on the professional oversight of the clinical practice of medicine in the Canadian Forces. Likewise, I have a counterpart to the surgeon general, the director general of dental services, who has professional oversight of the practice of dentistry.

Brigadier-General Jaeger's main duties include the setting of clinical policies; the delineation of clinical scopes of practice, which in layman's terms means deciding what health care providers should be authorized to undertake what types of tasks; the determination of clinical and professional content for both formal CF courses, such as those offered at our school in Borden and what we call the "maintenance of clinical skills programs"; and the final review of complaints pertaining to clinical care or the occupational health aspects of CF practice. The surgeon general sets the CF's priorities for medically related research, acts as the interface between the CF health services group and the various provincial licensing bodies, and is the guardian of the clinical professional ethics of the suitable practice of medicine in the CF context.

An approximate civilian comparison to the two of us would be that of a hospital CEO with his or her respective chief of medical staff. I say approximate, because the health system aspects of a military health care organization makes the duties far more complex than those experienced by a single institution. I myself, my command team, along with the medical and dental professional leaders, work together to provide a continuum of health care to military members at home and on overseas missions.

● (1535)

To do so, the Canadian Forces health care system carries out many of the policy functions of Health Canada and the Public Health Agency, the health care delivery functions of the provincial health systems, the occupational health functions of the workmen's health and safety system, plus the equipment and pharmaceutical acquisition and distribution of the civilian sector. We also work closely with several other federal government departments, especially Veterans Affairs Canada, to ensure the most appropriate service for Canadian Forces members while still serving or as they transition to civilian life.

When the Canadian Forces health services group is directed to deploy on operations, we commence an operational planning process to determine what health services are required for each and every operation. First and foremost, we assess the risks based on the mission, the tasks assigned to the Canadian Forces personnel, and the geographical location of the mission. Through our medical intelligence, we know what naturally occurring health risks exist in the area of operation—for example, malaria—and we recommend the appropriate countermeasures.

Likewise, our intelligence gives us information about the state of the host nation's health care, so we can determine exactly what Canada, or Canada in conjunction with its allies, needs to provide to the mission. We must include everything from preventative measures to routine care, both medical and dental, to full specialist and surgical capability. We must have a robust chain of evacuation on the ground and/or in the air to meet the tactical need, but we must also have strategic air evacuation to bring patients back to Canada.

All of these aspects of health care are currently being met in Afghanistan through robust multinational arrangements and our facility located on the Kandahar airfield. We also have arrangements with our coalition partners that in the event of a mass casualty that overwhelms our facility they will take our patients.

In conclusion, providing effective health service support to the troops in Afghanistan requires not only a robust capability on the ground, but also the appropriate pre-deployment preparation and post-deployment rehabilitation. To accomplish all of these tasks, the Canadian Forces requires health care personnel who meet a high level of excellence as military and health care professionals, supported by an effective civilian health care system.

Finally, we are providing this level of support at a time when all western nations are struggling to meet the personnel demands of their health care systems. Nonetheless, the military and civilian health personnel working within the Canadian Forces health care system are dedicated to the health and welfare of the men and women serving in the Canadian Forces.

This concludes my opening remarks. I'll ask the surgeon general to address some of the clinical issues relevant to the current operational tempo.

● (1540)

The Chair: General Jaeger.

[*Translation*]

BGen Hilary Jaeger (Canadian Forces Surgeon General, Department of National Defence): Thank you, Commodore Kavanagh.

Mr. Chairman and members of the committee, I appreciate the opportunity to address you about topics that may be of interest in light of the CFs recent operational experiences.

I would like to begin with some general observations about injuries sustained on modern operations. I should preface these remarks by making it clear that most of the data underlying these observations comes out of the U.S. military's experiences in both Irak and Afghanistan, but our own data appears to be consistent with this trends.

The most important trend to notice is that soldiers are surviving incidents that they would not have survived in previous conflicts. This probably cannot be attributed to a single development, but to a combination of efforts. Better intelligence, better tactics, better vehicles and most certainly better body armour all play a role.

[*English*]

But we in the health services also think that improvements in battlefield health care have played a role in this success, and these improvements start right down at the individual soldier level, with each and every one having completed additional first-aid training, including being taught how to apply a tourniquet and use our new pressure bandage and hemostatic agents, all of which are carried by individual soldiers.

Reinforcing the individual soldiers are a cadre of soldiers trained in combat casualty care, a two-week course that gives them some additional skills. Our medical technicians are trained initially as primary-care paramedics, and at the corporal rank level also have advanced emergent care skills and can perform useful screening for ambulatory care issues. A medical technician accompanies virtually every patrol that goes out in Afghanistan.

Backing up the medical technicians will be a physician assistant or a military physician, and of course we have our small but quite capable hospital at Kandahar airfield. It may interest the committee to know that this hospital is the first Canadian military facility to utilize a CT scanner in operations.

Our health care providers are more confident in their skills than was the case a few years ago, as a result of the maintenance of clinical skills program, which takes CF uniformed providers out of our clinics and employs them, anywhere from 20% of their time for a general practitioner to almost 100% of their time for a clinical specialist, in busy, full-service health care settings where a much broader range of skills is needed.

Giving soldiers a better chance to come home from operations alive is certainly something to be proud of, but for many of these soldiers, it can be a mixed blessing in that they may face significant disabilities. The effectiveness of our personal protective equipment, added to the current adversary's preference for attacking with improvised explosive devices, produces a different pattern of wounds than previously experienced. We are seeing fewer wounds to the thorax and abdomen and more to the extremities, including more traumatic amputations. We are seeing more closed-head trauma than in previous conflicts. What this means for us when planning health care in theatre is that the orthopedic surgeon is just as much a must-have in an operational theatre as the general surgeon, whereas in previous conflicts it was the general surgeon who was at the centre of the action, and orthopedics considered something of a “nice to have”.

[*Translation*]

What this type of injuries mean, once the casualties arrive back in Canada, is multiple surgical procedures and a long period of specialized rehabilitation.

I believe the committee is aware that the CF does not provide the services directly, but works in cooperation with civilian institutions and providers. The dispersion of the CF across this vast country, coupled with the provincial responsibility for health care, makes ensuring a uniformly high level of care to all our personal a challenge, but one that we believe we are meeting.

It is important to emphasize that the CF, unlike our US counterparts, could not operate its own tertiary care hospital, or rehabilitation centre. We do not currently employ the correct types of health care providers, and even if we were to concentrate all CF casualities in a single facility—which has obvious drawbacks from the point of view of the member's family and social support networks —we would not have enough patients to develop or maintain an acceptable level of expertise.

● (1545)

[*English*]

The committee may also have concerns about how we approach mental health care for deployed soldiers and may worry whether we are doing enough to prevent, detect, and treat mental illness. Perhaps it will be clearer to you if I describe all the mental health related activities that occur around the deployment cycle. Not all of these are primarily health services activities. Of primary importance is the pre-deployment training that the member received, for at least two reasons: one, the more confident the member feels in his or her skills, the better they will be able to react when challenged; and two, the more the member feels part of a cohesive group, the better for mental health, and collective training is extremely important to building that cohesive team.

All soldiers are given a thorough but general psychosocial screening before deploying. Spouses are normally invited and encouraged to attend with the member. The intent is to discuss any personal concerns or complicating circumstances the member may have, anything from their own health status to an ailing parent to pending legal action, and to assess the impact that the deployment would have on these kinds of stressors. The member will also have a general medical screening done prior to being cleared for the mission.

[*Translation*]

While in theatre a member can access the mental health team, which currently includes a psychiatrist, mental health nurse and a social worker, or can discuss concerns with a Chaplain or general duty medical officer.

We believe that the current generation of combat arms leaders is very aware of the crucial role they play in looking out for the mental health of their personnel, and they do consider the possible emotional reactions to each incident, encourage peer support, and they do not hesitate to ask for advice.

At the discretion of the Task Force Commander, a process known as “third-location decompression” is initiated. For the current mission this involves a few days' stopover in Cyprus on their way back home, with the intention of minimizing this stress associated with coming back home. While much of the value of this activity is in the rest and recreation it affords the soldiers, there is a educational component that we hope allows members to recognize, understand, and in some cases control their emotional reactions to certain situations.

[*English*]

Four to six months after returning home, all deployed members undergo what we call the enhanced post-deployment screening, which consists of a standardized, fairly extensive questionnaire followed by a semi-structured, one-on-one interview with a mental health professional. We believe this is an excellent tool for early detection of mental health and coping concerns. Further, we believe four to six months is about the right point at which to do this testing, because at this point, many people who may have had symptoms initially will have seen them resolve spontaneously, and some others may have either had delayed onset of symptoms or may be more willing to admit to symptoms that have been there all along. Of course, a member who has any concerns about their mental health at any time can seek help from a variety of sources without waiting for this particular screening to be scheduled.

[*Translation*]

If a member is felt to need further assessment or treatment then he or she will be referred to the most appropriate provider. While we believe our members enjoy better access to mental health care than does the average Canadian, we also know that the faster we can implement appropriate treatment, the better the chance of recovery will be. Therefore, we are in the process of greatly increasing our mental health provider resources across the country, and working with the VAC and the RCMP to establish a joint network of mental health clinics.

[*English*]

Mr. Chairman, members of the committee, there is much more that I could say about health care in the Canadian Forces, but I do not want to take any more time away from the committee members. Commodore Kavanagh and I thank you for your interest and your attention, and we look forward to your questions.

The Chair: Thank you very much.

We'll get right to the questions. I believe opening round is seven minutes.

Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much for that complete overview, and thank you also for the specific questions around the mental health screening.

I'm going to surprise you by talking about feet. I think that we've heard a couple times that the soldiers are upset about their footwear. I come from the Women's College Hospital in Toronto, where we set up the first foot store and shoe store. In the February 2003 newsletter about how smart training techniques reduce injury, there were some recommendations about how the Canadian Forces can't afford to lose personnel through preventable injuries. There was also discussion of some of the issues around training and cross-training and about some of those science feedback loops that we need. One of those recommendations was to adopt a high-quality cross-trainer shoe after you'd stopped letting people run in their combat boots. Better shoes and scientifically based training guidelines and methods for female and aging warriors were to be used, including a bridging physical training program to keep people fit while they're recovering from an injury. There were also guidelines on how to train safely in the cold and how to stay fit on deployment.

I would like to use that as an example. I understand there are some very serious shoes that are now being deployed by the Navy Seals and that are NATO-approved. Other forces have them, and there are even ones that are sandproof for Afghanistan. I just want to know how you get the feedback from your clinicians. How do you use patterns? How do you use clinical research, the epidemiology of what you're seeing in the office, and get that fed back into policy and changes in training so that you actually can see that you're reducing these kinds of recurrent themes within your clinical practice?

● (1550)

BGen Hilary Jaeger: I'm going to leave the specific question of footwear aside for a moment, if I may, ma'am, and we'll come back to it.

On the general question of how we take observations from theatre and feed them into policy, the main part of the tool is a NATO epidemiological data collection system known as EPINATO, an obvious acronym that stands for epidemiology for NATO. It's a viciously detailed spreadsheet that the folks in theatre have to fill out on a weekly basis and send back through the medical chain. Our director of force health protection collects those results and analyzes them to see if there are trends.

The tool is imperfect. The tool requires a skilled person on the front end to decide how to codify everything that happens so that the data make sense on the far end. Theoretically, things should be able to be identified through the EPINATO tool, analyzed by our epidemiologists and our occupational health specialists and our sports medicine specialists and the director of force health protection, and that would form a link back into policy.

I would have to get back to you on specific questions of initiatives that have been taken on footwear. I'm perfectly aware that we stopped training in combat boots, and that was a very good step forward. I'll say anecdotally that in my career I have seen what is probably the fifth iteration of different kinds of combat boots people have tried in order to get it right. I think that's in the grey area between the practice of medicine and the acquisition of equipment for the Canadian Forces.

Hon. Carolyn Bennett: So you can influence equipment acquisition if you start seeing trends?

BGen Hilary Jaeger: I believe we can. Certainly for individuals we have a very wide latitude to provide them with special footwear to address problems—individual orthotics and foot architectures for people whose feet are different sizes. We can provide special footwear on an individual basis and always have had that ability.

Hon. Carolyn Bennett: In relation to the screening four to six months later, as chair of the women's caucus I learned at both the Edmonton base and when meeting with military spouses in Fredericton that they're concerned that the guys sometimes don't self-identify mental illness. Most people know what the right answer is, but you have to feel pretty safe to be able to admit you're not feeling okay.

There was some concern that people who were already a little bit in trouble could be redeployed when indicators like domestic violence and those kinds of other things were obviously there. You're saying that at the four- to six-month screening, the spouse is sometimes included; as you know, and as you've heard me say before, I'm really concerned that families aren't treated as families and that the spouses would have to go out of their way to tattle on their spouse before that screening, or to call the physician they're seeing, as opposed to the regular way the rest of Canadians are treated, which is that the same physician looks after the whole family. If it's optional for the spouse to participate in that four- to six-month screening, do you think we're missing some? Is there something more we should be doing?

● (1555)

BGen Hilary Jaeger: I want to clarify, Dr. Bennett, that it's the pre-deployment screening to which the spouse is invited. At the post-deployment screening, a different tool is used. In that case the spouse is not involved; it's a one-on-one interview with the mental health professional. I brought along a copy of the screening tool we use, *dans les deux langues officielles*, if you're interested in having a look.

I know what you're saying about people being reluctant to self-identify, and that, of course, is why we interview everybody. We score the standardized instrument to give the mental health professionals some idea, when they speak to somebody, of what areas to focus on, but it doesn't matter if you answer “no” to everything; you're still going to get interviewed, because we think it helps to break down stigma. Otherwise, if you only get interviewed if you score above a certain threshold, then obviously if somebody gets called in for an interview, his buddies may say, “Oh, look, Corporal Boggins got called for an interview.” We didn't want any of that, so everybody goes for an interview.

They're well-respected, standardized instruments. I'm sure you'll recognize many of them. It would be hard to snow without blatantly lying.

Hon. Carolyn Bennett: Some of the spouses think so.

At four to six months, is it possible to screen the family unit?

The Chair: Just a short response, please.

BGen Hilary Jaeger: We have to be a bit careful here. We can't compel families to do anything. We can compel behaviour of the member but not of the spouse or the family.

We have restrictions in terms of providing health care directly to spouses, but they have full access to the social work services on the base. They have full access to the 1-800 Canadian Forces member assistance program. They have access to the family resource centre. They have access to the operational stress injury social support project and peer counsellor network.

So they do have avenues to raise their concerns. We really hope these give them enough resources.

The Chair: Thank you.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Thank you, Mr. Chairman.

I would like to begin by thanking you for being here and by offering you my congratulations. I do not think that the Canadian army boasts many female generals. There are two of you here today — how many of you are there altogether?

BGen Hilary Jaeger: Four, I believe. The two of us, and General Colwell and Commodore Siew.

Mr. Claude Bachand: Congratulations. I think that we can think of you somewhat as precursors. It is difficult for women to reach the highest echelons of the armed forces and I am delighted that you have managed to reach this rank. Indeed, I hope that you will one day become the Canadian army's Chief of Staff — we would all like that a lot.

Do medical personnel accompany combat units into the combat zone of a theatre of operations? Do medical personnel go with combat units?

BGen Hilary Jaeger: In theatres of operations, armed personnel are divided into two major groups. Half stay with the combat unit, the infantry, which at the moment is the Royal Canadian Regiment. I believe the group comprises two doctors, a physician assistant and several paramedics. They accompany any soldier leaving the camp; they have armoured ambulances and stay close by the soldiers.

● (1600)

Mr. Claude Bachand: Are the ambulances and paramedics clearly identified?

BGen Hilary Jaeger: The physicians' assistants and paramedics are known to the combat unit, but they do not display the Red Cross insignia outside of the Kandahar camp.

Mr. Claude Bachand: Why?

BGen Hilary Jaeger: It was a decision made by the chain of command after having evaluated the risks and benefits of doing so.

Mr. Claude Bachand: Would you or the Chief of Staff be able to tell me whether the decision not to display the Red Cross insignia in a theatre of operations is compatible with the Geneva Convention?

BGen Hilary Jaeger: We studied the question carefully, along with our lawyers, in order to be able to advise the chain of command in its decision.

Mr. Claude Bachand: Very well.

BGen Hilary Jaeger: We discussed the matter extensively.

Mr. Claude Bachand: You concluded that, in a theatre of operations, it was preferable that our paramedics and ambulances did not bear the sign of the Red Cross.

BGen Hilary Jaeger: Outside of the camp. In the centre, the sign is used.

Mr. Claude Bachand: Very well.

[*English*]

Cmdre M. F. Kavanagh: That's for this mission. Each mission is considered independently, so the decision was taken for this one at this time.

The chain of command assesses the risks for the mission at that time, at that place, and whether or not the Red Cross symbol should be flown or worn. Should the risks change, the chain of command might change its mind. That's where we're at right now.

Mr. Claude Bachand: Is it the first time?

Cmdre M. F. Kavanagh: In my recollection, yes, but—

Mr. Claude Bachand: Brigadier-General Jaeger says no.

BGen Hilary Jaeger: No. We had a period of reversing decisions in the mid-1990s. Certainly through all of my training it has always been a valid decision to be taken by the Canadian command that in certain circumstances the risk-benefit analysis may lead you to not display the Geneva symbols. You have to understand that by doing so you forfeit your protection under the Geneva Convention. It's not a war crime, but the medical personnel forfeit their ability to be treated differently if they are captured during operations.

[*Translation*]

Mr. Claude Bachand: Fine.

I do not know whether you noticed, but some people are wearing a red ribbon today as it is the Canadian Aid Awareness Week.

On the matter of soldiers practising safe sex while in theatres of operations, I think I recall reading in a number of articles that the Canadian Forces supplied condoms.

Do you believe condoms to be important in a theatre of operations? I know it is an awkward question.

BGen Hilary Jaeger: Yes.

[*English*]

I think safe sexual practices are always important. People who understand human behaviour and who deal in realities when it comes to prevention of sexually transmitted diseases should in fact be happy that condoms are readily available to members of the Canadian Forces. I'd also point out that some of them are used, in fact, to keep dust out of weapons. There are other uses for them.

[*Translation*]

Mr. Claude Bachand: They are very important.

Do I have any time remaining?

[*English*]

The Chair: Half a minute.

[*Translation*]

Mr. Claude Bachand: When somebody who has been injured has to be transferred from Kandahar to a hospital in Germany, who makes the decision? Are there a lot of transfers? Do you only transfer those who have been very seriously injured?

BGen Hilary Jaeger: The injured who are sent from Kandahar to Landstuhl—an American hospital in Germany—are people who need to be sent back to Canada. They have serious injuries and need to be sent home. Doctors in Kandahar make the decision. They send those requiring specialists' treatment that is not available in the theatre of operations. They might need to see a urologist, for example, or another specialist that we do not have in Kandahar.

Some other injured personnel are sent to Landstuhl and then return to the theatre of operations. However, for the majority of them, it is a stage in their journey back to Canada.

● (1605)

[*English*]

The Chair: Thank you, Mr. Bachand.

Mr. Christopherson.

Mr. David Christopherson (Hamilton Centre, NDP): Thank you, Chair.

Thank you both for your presentation. It's certainly an extremely important part of the support services provided to our troops.

How many injured soldiers have there been so far? Pick a date and then give me a number, if you would.

Cmdre M. F. Kavanagh: I was told that as of today, there have been 171.

Mr. David Christopherson: And of them, how many ultimately would return back to active duty?

Cmdre M. F. Kavanagh: That's a difficult question. I'll let the surgeon general answer from a clinical perspective, but we need time to assess that. I'm not being evasive, but until someone is given absolutely every opportunity to recover and rehabilitate to the maximum extent possible, we don't make that decision.

Surgeon General—

BGen Hilary Jaeger: I would just echo that. In order to give you an accurate answer I'd have to go back and comb through those 170 and see what kinds of injuries there were there. Commodore Kavanagh is quite right; we're not in a hurry to make that final decision.

Mr. David Christopherson: There must be some number, somewhere, because I've heard different reports.

Let me leave it with you this way. If you can find a number, if you could forward it, it would be much appreciated. I'll leave it at that.

BGen Hilary Jaeger: I can do some crystal ball gazing for you and say that my best guess is that *x* percent of that 170 represent people who are likely to have a significant permanent disability and *y* percent—

Mr. David Christopherson: I was thinking of traumatic amputations. It's not very likely they're going to be returning to active duty if they've just lost a leg.

BGen Hilary Jaeger: I would be a bit cautious on that. Some amputees have gone on to full careers in the Canadian Forces, but it's true that—

Mr. David Christopherson: It should be a while.

BGen Hilary Jaeger: It's a very difficult rehabilitation, and the more you lose, the more challenges you have to overcome.

Mr. David Christopherson: Thank you for that.

I will move on. We know there are some allies that are using depleted uranium as part of their munitions delivery, and I'm wondering if you have an opinion on how that may affect our troops.

BGen Hilary Jaeger: First of all, I'm not sure that any of our allies in that particular theatre are in fact using depleted uranium, but I'd have to leave that aside for the operators to confirm, should that be an issue.

Other than the devastating impact of a depleted uranium penetrator, in terms of its physical effectiveness as a weapon, I personally have no particular concerns with the use of depleted uranium. What's depleted out of the depleted uranium is radioactivity. It's less radioactive than natural uranium, and all of the studies done to date—and there have been extensive reviews of soil contamination in Iraq, of soil contamination in the Balkans—have not concluded that it represents a significant health hazard going forward.

Mr. David Christopherson: Would you be kind enough to forward even just the latest report that speaks directly to this issue? Perhaps you would take that under advisement.

BGen Hilary Jaeger: Yes.

Mr. David Christopherson: Thank you.

My colleague Ms. Black raised here at this committee the issue of whether or not this mission is of an international character so that it falls under common article 3 of the Geneva Conventions. Apparently that's different from if it had been worded differently. If it were of an international character—and I'm talking about detainees now—then they would be treated as a prisoner of war under article 5.

What's the difference in terms of any medical services that they may be given under one declaration versus the other? Would you know that?

● (1610)

BGen Hilary Jaeger: I think you're asking a legal question that's beyond my scope. I do know we treat detainees as we would any of our members. In fact, if you speak to the people who are at the hospital in Kandahar, there is essentially nowhere else for these patients to go; there is no Afghan hospital to transfer them to, and the people we have kept the longest at the hospital in Kandahar have been detainees.

Mr. David Christopherson: Again, I'd be comfortable if you take this under advisement. Perhaps you would take a look and see whether there is a difference in the medical service that would be provided, and if so, perhaps you could provide the distinction. And if it's not applicable, then it's a moot point.

The Chair: That's a good point. We have legal people coming to talk to us about the detainees and how they're treated, so if it doesn't fall under their—

Mr. David Christopherson: I understand. That would be whether or not it is. You can even take it as a generic question. If you had one declaration versus the other, what would be the difference in the medical treatment that's afforded to detainees? The question of whether or not it falls under which article I grant you would be a legal question, but this would be the difference between medical services between the two.

Cmdre M. F. Kavanagh: We practise a standard of health care, and it doesn't matter whether you're a coalition member or whether you're a detainee, we give you the same standard.

BGen Hilary Jaeger: The difference is, do we have any place to transfer them to when—?

Mr. David Christopherson: Right. Will you check that for me to see if there is a difference? If there isn't, then it's just a simple no. A word back would be fine. If there is, I would like to know what the difference is in the medical.... Obviously, I have a reason for asking the question. You'll give me the expert answer as to whether that has merit or not.

Cmdre M. F. Kavanagh: I said we can't give you the answer on the legal part because we're not lawyers.

Mr. David Christopherson: No, I'm not asking—

Cmdre M. F. Kavanagh: Medically speaking, there's one standard. It doesn't matter whether—

Mr. David Christopherson: Okay, I am not asking you, though, to make a legal determination which it is. Is there a difference—it's just a generic question—in the health services provided to detainees, depending on whether it's a declaration under article 3 or under article 5?

I'll just leave it with you.

Cmdre M. F. Kavanagh: I thought I already said no.

The Chair: I believe you answered the question that you have one standard of treatment. The other question would be legal, and hopefully we can get that answer from the other folks. Thanks.

Go ahead. You still have a minute.

Mr. David Christopherson: Recruitment...we've had this come up in the public accounts committee. We've dealt with the general recruitment. The issues around recruitment for medical personnel...?

Cmdre M. F. Kavanagh: We are actively recruiting medical personnel from just about every occupation of the 19 that I mentioned. We have shortages in almost every occupation we have in the Canadian Forces health services. On the medical side, the dental part of the health services is in a little better shape with personnel than we are on the medical side. Some of them are relatively significant. We're significantly short of physicians. Pharmacists are actually the worst of all. They're small numbers, but on a percentage basis, they are in the worst shape. We're short of nurses, we're short of medical technicians, we're short of just about everything, and we're actively recruiting all the time.

Mr. David Christopherson: Under previous questions to a former officer, we asked about the ability to take on another commitment like Darfur. There's a point where a lot of people would like to see it, but we're told that one of the greatest limiting factors to us being able to go anywhere else is medical services. Would you like to comment on that?

Cmdre M. F. Kavanagh: Our limitations in personnel make it difficult for us to meet all of our demands, whether it's the current one or another mission, whichever the case may be. We are strapped for personnel at home and overseas and we're always looking for creative ways to meet all our commitments with our personnel demand.

The Chair: Thank you very much.

Mr. David Christopherson: Thank you again for today.

The Chair: Ms. Gallant.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman, and through you to the witnesses.

Equally important to battlefield medical services is proper attention to soldiers in training, and upon returning from deployment the psychological services are needed to deal with PTSD, which has been mentioned. With successive back-to-back deployments in the order of 2,500 troops per rotation, how prepared is the CFHS to properly treat soldiers in need of care?

Cmdre M. F. Kavanagh: We are certainly better off today than we were five years ago. Five-plus years ago, in 2000, we began a project called Rx2000, and part of that project involved a massive undertaking of refurbishing and improving the services we deliver at home.

To give you some examples, in the past on many of our bases all there would be would be uniformed personnel. There might be a base surgeon and two or three physicians and uniformed technicians. The vast majority of our facilities now have over 50% civilians in them, and there are two to three times as many personnel in there, nurses, nurse practitioners, physicians, psycho-social supports, whether it's psychologists, social workers, etc., to meet the needs of our personnel. That's all a direct result of the project that we've been putting in place in the last five and half years.

I say putting in place—it's still actively engaged, still ongoing, and we're enhancing the improvements to it all the time. It still has a few more years to go before it's completely in place. But just like the competition for uniformed health care providers, the competition for civilian health care providers in many of our locations is just as difficult. However, it's vastly improved from where it was in the days when the general and I here were actually seeing patients.

● (1615)

Mrs. Cheryl Gallant: You stated that the Constitution Act of 1867 assigned sole responsibility for all military health matters to the federal authority. As you know, one of the first actions the current Ontario premier took upon gaining office was the implementation of health premiums. Now both B.C. and Alberta also have health premiums, but soldiers are exempted from paying them. Yet the Ontario Liberals are deducting health premiums from our soldiers' paycheques. What steps has the CFHS taken to recoup these inappropriately collected premiums in order to apply them to funding at your priorities?

Cmdre M. F. Kavanagh: We actually haven't done anything about it because it's a pay and benefits issue. It's not in my lane.

I'm sorry, I can't answer the question, because that's the chief of military personnel. It's under compensation and benefits requirement to resolve, and they would have to give you the answer. I don't know the answer.

Mrs. Cheryl Gallant: CFHS could use more funding, though?

Cmdre M. F. Kavanagh: Everybody could use more money. Couldn't you?

Mrs. Cheryl Gallant: During the course of this committee's study on the mission in Afghanistan, we listened to the stories of soldiers injured in theatre. We were told that despite doctors' orders of lighter duties until injuries are healed, soldiers are forced to return to full duty prematurely. Are mechanisms or safeguards in place to prevent doctors' orders from being disregarded?

BGen Hilary Jaeger: Doctors' orders ought not to be disregarded. In fact, there was a shift made, and I'm sorry I can't tell you the exact year. It was somewhere around 1998, 1999, or 2000—my memory is failing—but before that, physicians used to make recommendations to the chain of command on employment limitations or on the awarding of sick leave, which the chain of command was at liberty to either accept or ignore.

A policy shift occurred in either the late 1990s or very early 2000s, whereupon the chain of command did not have the latitude to make those distinctions any more, but what was written by the physician would in fact be followed. If the chain of command wanted to discuss something or had any difficulty with the limitations, they were to take that up with the physician or the base surgeon and not play that little tension out through the member.

This doesn't, of course, mean there aren't instances across the country, because we can't be everywhere all the time, where things don't get either misinterpreted or forgotten about, or the employment limitation of people is not respected in some way. But if this were brought to the attention of the treating physician or the base surgeon, there would be intervention from the base surgeon to the unit commanding officer, saying, “We heard that you've been making Corporal Bloggins go out on morning PT, and he's not supposed to be running and not supposed to be lifting weights for another two months.”

It's certainly very easy for us to intervene if we know about these instances, but we're not the secret police going out to look at units.

Mrs. Cheryl Gallant: So the onus is on the injured member to tell the doctor that they're being forced not to comply with doctor's orders.

BGen Hilary Jaeger: The onus is first of all that we communicate directly with the unit to tell them what employment limitations to impose. But then the best arbiter of whether those employment limitations are being respected is the member themselves.

Mrs. Cheryl Gallant: Thank you.

Do the Canadian Forces hire foreign doctors to treat soldiers in theatre?

● (1620)

BGen Hilary Jaeger: We do not hire foreign doctors to treat soldiers in theatre; we have collaborative arrangements with some of our major allies—particularly our NATO allies and the Australians—to use their uniformed physicians in a collaborative way.

Mrs. Cheryl Gallant: So civilians are not hired from nearby countries where our soldiers are deployed to treat them, then?

Cmdre M. F. Kavanagh: No, they are not. The facility in Kandahar is a multinational unit of which we are the lead nation, with the command of it. There are Danes, there are Dutch, there are Aussies and Brits and Americans working there, who are uniformed, but we do not hire.... If we hire civilians, they will be hired meeting Canadian standards.

Mrs. Cheryl Gallant: And do wounded enlisted soldiers receive as high a quality of care as officers, if they're injured either in training or in theatre?

Cmdre M. F. Kavanagh: Absolutely.

Mrs. Cheryl Gallant: Thank you.

The Chair: Mr. McGuire is next, and then it's back over to the government.

Hon. Joe McGuire (Egmont, Lib.): Thank you very much, Mr. Chair.

There is a lot of data coming out of Petawawa about the impact of soldiers coming back to this country and to the base they left, concerning domestic violence, divorce, drug addictions, alcohol addictions, and so on. Why are we so slow off the mark in getting ready...? We had to know this was going to happen, from people coming from a theatre of war. In Petawawa, which is where most of our soldiers leave from and come back to, why aren't we better prepared for the human dimension when they come back from a theatre?

BGen Hilary Jaeger: Sir, you have me at a bit of a disadvantage, because I haven't seen the statistics you're referring to. If they pertain to a psychosocial issue, I can research them through my social work staff and perhaps I can be as well-informed as you are.

I don't want to dispute the challenges people face in Petawawa, because amongst our army bases it is the largest concentration of troops you'll find in a relatively small centre. Of the other big army bases, Gagetown is a little bit in the same boat, but Valcartier's in close proximity to Quebec City, and Edmonton of course is in Edmonton. Those are the other large army bases, and social support services and a variety of mental health referral services are all more readily available in that kind of place.

Hon. Joe McGuire: Why isn't the facility there? If most of the people who are in the theatre of war come back to Petawawa, why aren't there more people there to take care of them?

Cmdre M. F. Kavanagh: Well, they don't all come back to Petawawa. It depends on the brigade that's being deployed. When there are 2 Brigade soldiers, they come out of Petawawa. The most recent rotation were 1 Brigade soldiers, and they all came predominantly out of Edmonton or Shilo, Manitoba. As the surgeon general said, the resources are a little better when you're in an urban centre than when you're in rural Canada. It's the same in the civilian sector.

The project I alluded to earlier, Rx2000, has a very large mental health component to it. It's going to expand the number of personnel to look after mental health issues. The reality is that Petawawa is lagging behind in the implementation of that project, for a number of reasons. There are infrastructure challenges, there are challenges of recruiting professionals to work in the Ottawa Valley. That's simply a reality of today. It's considered underserviced in the civilian sector. It's difficult to attract professionals to more remote areas, and only two hours up the river is considered remote.

We're not neglecting it. We are trying to address it, and we have a very robust plan in place to do that. They are also supported by everything we have here in Ottawa. I know that's not in Petawawa, and it does not meet their wishes. We have a plan to fix that, but there are fairly significant resources here in Ottawa that do address and can be deployed to meet them—and/or the patients come to Ottawa—to assist with their requirements.

Again, the data that you have, I don't believe I've seen either. As they say, there are statistics and then there are damned statistics, so it depends on how you interpret the statistics. We have a very robust electronic health record that's in the process of being implemented, which will also be able to give us better analysis of all the epidemiological data on all sorts of health care issues when it's fully implemented. Again, it's not there yet, but it's under way. Until we have a chance to kind of analyze all the stats, I would be hesitant to draw too many conclusions from them.

● (1625)

BGen Hilary Jaeger: May I offer you some specifics, sir?

Hon. Joe McGuire: I would like to point out that as far as mental health staff is concerned, in Edmonton there are 27, in Valcartier there are 35, in Petawawa there are nine, and that's where the soldiers are coming back. How many are in Ottawa now to offset the nine?

BGen Hilary Jaeger: The number is about 30, sir.

I was the brigade surgeon in Petawawa in the late 1990s, the senior physician on that base, and we had three mental health care providers then. We've tripled that number to nine, and the mental health care project seeks to triple it again, to roughly 31.

The reason there is such a large number in Edmonton, and some other bases you've mentioned, is that those bases host operational traumas at stress support centres. We have five of these centres, a network of five across the country. When those centres were set up in the late 1990s, the decision was made that the regional centre for Ontario would be in Ottawa, because it serves not only Ottawa, but Kingston, Trenton, Toronto, Borden, and Petawawa.

Hon. Joe McGuire: So those soldiers come here, rather than to their families in Petawawa, because doctors won't go there?

BGen Hilary Jaeger: Well, we are doing the best we can to entice doctors to come and work for us. We're not going to give up, but it's very, very hard work.

The Chair: Thank you very much.

Mr. Hawn.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

Thank you, Commodore and General, for joining us.

I met a lot of soldiers who were coming to Edmonton, of course, in the most recent rotation, and I met a lot of those folks coming back in the Airbus. Given the challenge, the care they are given, in their own words, was spectacular. I simply want to commend the CFHS for that. I spent a fair bit of time with people like Paul Franklin, the double amputee above the knee, and talking about getting back to activity duty, he is probably a double amputee who will be back to active duty. Obviously it will not be combat-related. He was a medical technician, of course.

On the medical technician side, how are you doing with numbers of medical technicians relative to your manning levels? How are you doing with recruitment? How are you doing with retention? Are the ones that have been trained as physician assistants being tempted away to civvy street in any significant numbers?

Cmdre M. F. Kavanagh: We're doing reasonably well on the recruitment front with bringing people in to become medical technicians. I'm not as happy as I'd like to be with the retention piece. Some of that is demographics. We have physician assistants in the same demographic bulge as I am, who are looking for other opportunities.

The civilian sector has finally discovered physician assistants, so we now have a competitor. We are working very actively and aggressively with the civilian sector to make this a win-win for us and them. We think it can help the civilian health care system, as well as ourselves, if we approach it the right way.

The medical technicians are better trained. Again this is a direct result of the Rx2000 project that was put in place five years ago. We enhanced the training. They are very skilled PCP-trained medical technicians, which then again makes this competitive. Some of them have chosen to pursue employment opportunities outside of the uniform after their basic engagement.

I'm not as happy with the retention numbers as I would like; that is a challenge. Recently I was informed of what they actually are from the junior ranks, and I think we have some work to do to encourage them to stay and to challenge them with clinical activities, because that's what they joined to do. They joined our organization to be around patients, because that's their interest.

● (1630)

Mr. Laurie Hawn: What kind of a reception are you getting from the civilian health care organizations that would like to hire them, with respect to making it a win-win, with respect to having them release them back for reserve duty for six months at a time, for example? Are you getting a decent reception, or is it pretty tough?

Cmdre M. F. Kavanagh: The surgeon general has worked more with the University of Manitoba and the province of Manitoba, which were the first ones off the mark, and she can comment specifically. Those who have taken the time to understand this and realize what it is we have to offer are very willing to become engaged. They want to participate with us, and see this as an opportunity we can both benefit from.

This is such a novel concept in this country. Physician assistants are common in the U.S., but they're relatively new here, and there's still this fear of the unknown in many places as well. So some of it's really good, and some of it is just not understanding the issue yet.

BGen Hilary Jaeger: I'll speak to the physician assistant piece, which I know well. There are opportunities and threats out there. We have seized the opportunity because we believe we have a valuable tool or resource that can have applicability across the Canadian health care landscape. We're very enthusiastic about teaching our colleagues on the civilian side about what the potential might be.

On the other hand, if they understand it too well, we are the only provider of physician assistants in Canada at the moment, and on our small training capacity, if you spread it across ten hungry provinces and three territories, isn't going to go very far.

Mr. Laurie Hawn: How many physician assistants do you train a year?

BGen Hilary Jaeger: We train a graduating class of 24 a year, and that takes every ounce of instructional capability we can muster.

I call the difficulties we run into sort of turf sensitivities. There are nurse practitioners also seeking more recognition and broader opportunities across Canada. We certainly have no heartache with that, as we employ both of them, but some people can't see that there's room for both. Some people see it as if one side gains, the other must lose. We don't see it that way.

The Chair: Thank you.

I'll go to Mr. Bouchard, and then back to the government.

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chairman.

Thank you for being here this afternoon. I would like to ask you some questions about your personnel, and more specifically, about recruitment.

We know that the Canadian Forces have recruited 20,000 members over the past four years, bringing numbers up by 700. You yourself recognized that recruitment had been a challenge.

I had the opportunity to visit the Petawawa military base, where doctors told me that they were under a lot of pressure and had to work a lot of overtime. They even said that there was a shortage of staff.

Can you tell me whether all of your medical units have a full complement of staff? If not, why?

BGen Hilary Jaeger: Regarding doctors, allow me to give you the example of general practitioners. Thirty per cent of our GP positions at the captain and major levels are unfilled. As these are the people who provide medical care on our bases, we have a problem.

The situation is even worse for francophones. There is an even greater shortage of French-speaking doctors.

We are trying to address this problem by employing civilian doctors, but it requires a sustained effort.

The shortage of pharmacists stands at around 50% across the country. Again, we are trying to recruit civilian pharmacists.

It remains, however, that members of the armed forces can do certain tasks that civilians cannot. There's a difference between a civilian and a member of the armed forces. Having too many civilian medical personnel undermines our flexibility, particularly when a large number of troops are deployed. The work becomes increasingly difficult for those left behind.

● (1635)

[*English*]

They are, I think, committed. They can take pride in doing a job well. They know that what they're doing is important, and they are all very, very keen to make sure that, particularly when wounded people come back to Canada.... I have never had anybody say "I'm going away for the weekend; I can't possibly be there to meet the plane coming back." I've never heard any feedback like that.

[*Translation*]

Mr. Robert Bouchard: The Canadian Forces have recognized the mission in Afghanistan as being a priority.

What have been the repercussions of this mission on your staffing levels?

BGen Hilary Jaeger: The repercussions—

[*English*]

I think I'll answer in English, because I can explain it better.

There's the direct arithmetic. We have a certain number of physicians deployed in Afghanistan. We have a certain number of nurses. We have a certain number of medical technicians. Of course, those people are not available to us to provide care back here in Canada.

Not only are they not available, but their replacements, who are already on pre-deployment training to go, are not available. In some cases, those people they replaced, because they're on post-deployment leave, take some time to come back to work. So for every one person who's deployed, there are really two to two and a half people who are not available to do the work back in Canada that needs to be done.

On the other hand, it's a kind of work that is very motivating for people. Actually, in some respects, and for many respects, it's what they joined to do. It's the most real expression of what it means to be a health care provider in the military, so it can be a big motivating factor—for the families, perhaps, not so much of a motivating factor.

The Chair: Thank you.

Mr. Blaney.

[*Translation*]

Mr. Steven Blaney (Lévis—Bellechasse, CPC): Good afternoon, and thank you for having come to meet with us today.

I very much enjoyed your presentation. You spoke about the post-deployment screening that all deployed members undergo four to six months after returning home in order to ensure an early detection of any problems.

Could you give us some details on this? Each conflict leaves some soldiers with scars. How would you evaluate the general mental and psychological state of the soldiers who have returned from Afghanistan thus far?

[*English*]

BGen Hilary Jaeger: We began using this specific screening instrument in 2003 for the first time. We now have almost three years of experience and data using this particular instrument. Before that it was much less structured. There was always an evaluation, but not using the same questionnaire.

For the current mission, since we've moved to Kandahar and undertaken more active patrolling and more contact with the enemy that's been characteristic of this current mission, we do not have any data yet from anybody who has returned from that mission. The vast majority of the battle group that returned in August, who are centred in Edmonton and Shilo, will undergo these assessments after Christmas, so the data collection will run through January and February. After we have a chance to process that information, we'll have a better sense as to what the different stressors and the different nature of this deployment mean compared to the previous deployments in Kabul, or even to some other experiences we've had.

We don't know. You've probably heard lots of people say that because the mission is so active and there've been so many incidents that it must produce more mental health problems. There are some schools of thought on the psychiatric side that that's not necessarily the case, that because they have a mission, because they're pursuing their goals, and because they're out there allowed to engage the enemy, for some people and in some circumstances that might be less stressful than the enforced passivity of the classic UN peacekeeping mission. We just don't know. We're going to collect the data and see.

● (1640)

[*Translation*]

Mr. Steven Blaney: The fact that this is an active mission could have a positive effect on the mental health of our troops. At any rate, this is something that you are going to be assessing.

You mentioned earlier that the shortage of general practitioners stood at around 30%.

What are the issues and challenges you are facing in Afghanistan? Are you expecting to face problems over the upcoming months, in terms of equipment, for example? Are you expecting to face problems over the course of the upcoming months?

[*English*]

BGen Hilary Jaeger: We wall off the mission in Afghanistan. That's priority one, job one. So if we only had five physicians left in the Canadian Forces they'd be deployed to Afghanistan. So the shortages we face back here don't translate and have an effect over there.

[*Translation*]

Mr. Steven Blaney: You are saying that the situation does not carry any consequences for the mission in Afghanistan.

[*English*]

BGen Hilary Jaeger: The pain is felt back here and the backfill is done back here.

As to the equipment question—

Cmdre M. F. Kavanagh: Anything we have requested we have received. We have ongoing acquisitions through our specialists in operational medicine who are constantly reviewing the literature and looking for new things. The surgeon general made her comment about the one-hand tourniquets and the special dressings. That all came about by constantly reviewing the literature, looking for things we learn ourselves, looking and learning from our allies, and going out and acquiring it if we need it.

In the health services, we're not equipment heavy. We don't buy airplanes and tanks and things. We're relatively equipment light. Our key piece is personnel, but anything we've needed has been provided.

As the surgeon general also said, we acquired and deployed a CT scanner for the first time in our history on this mission. It's better than the ones the Americans have in Bagram. For the first time in our history, we had teleradiology capability, so the images are transmitted back to Canada for review. That was provided to us specifically for this mission. So we've received what we've asked for.

The Chair: Mr. Cannis, and then back to the government.

Mr. John Cannis (Scarborough Centre, Lib.): Thank you, Mr. Chairman.

Commander Kavanagh and General Jaeger, welcome, and thank you for sharing all this information with us.

As you've probably observed, there are many important questions, but one question that keeps coming up is the recruitment and retention of medical professionals, and it is a great concern. I have heard the military family is a unique family. And as much as it's important to address the needs and concerns, from equipment to everything with the men and women who go to theatre, we all believe it's just as important that the peripheral family, the partner, the spouse, etc., also has services available to them. How is the family treated that is left behind here in Canada, the children, the mother, etc.? Because we've heard that sometimes there's been some difficulty in offering, and I assume part of the medical services for a military family includes the family as well. Am I correct in that?

Cmdre M. F. Kavanagh: Actually not.

Mr. John Cannis: I needed to know that, because we're confronted with that.

Cmdre M. F. Kavanagh: As I read in the minister's testimony when he was here, I believe he was asked this question. We do not provide health care on a regular basis to the family members of the Canadian Forces.

● (1645)

Mr. John Cannis: Why would you say “regular basis”?

Cmdre M. F. Kavanagh: That is the purview of the provinces in this country. That's the way our health system is designed, and it is our responsibility to look after members.

There is a caveat to that, which is isolated posts. We do it overseas, but there are very few isolated posts left in this country any more. There was a time when Cold Lake was deemed isolated for medical services, but no longer. When we used to have bases in Masset and in Holberg on Vancouver Island and the Queen Charlotte Islands, and so on, those places were deemed isolated, but they are no longer. So it is the responsibility of the Canadian Forces health services to provide health care to uniformed personnel only.

That said, there is, as General Jaeger has already alluded to, a member assistance program that we established—as a matter of fact, I established it myself—that's open to family members. The family resource centres have resources that are put in place, not by us, not by the Canadian Forces health services, but by the Canadian Forces, which have access to specific counselling services, and so on.

Mr. John Cannis: Commander Kavanagh, I have to interrupt, because I know the chairman is very strict on time.

What you are really saying to us is that it varies from province to province. Is that what I'm led to believe?

Cmdre M. F. Kavanagh: It doesn't vary, in the sense that we don't provide health care in Canada to dependants unless the place is deemed isolated. I can't think of anywhere in Canada.... Goose Bay is the only place I can think of at the moment.

Mr. John Cannis: Maybe given that the military serves the country as a whole, we should look at standardizing something like that.

Cmdre M. F. Kavanagh: But, sir, health care in this country is a provincial responsibility.

Mr. Claude Bachand: That's a good response.

Mr. John Cannis: I know; I'm simply saying that it is provincial, but the soldier who's serving Canada doesn't cross borders, in my humble opinion.

We're obviously finding it difficult, because as our military is expanding and recruiting to address our domestic and international obligation, we're obviously, as you clearly indicated earlier, going to run into problems with the shortages that we have.

What is the tenure if somebody is recruited and brought on board from the outside? How long is their stay, on average?

Cmdre M. F. Kavanagh: There are many ways you can be recruited, but if you're already a qualified physician, we call that a direct-entry officer. You can enroll, and we even have a signing bonus. You can enroll for as little as two years and decide to give it a try, to see if you like it or don't.

You can even work for us as a civilian. We've actually had people come to work for us on contract as civilians, who've liked it so much that they put the uniform on. There's one in Germany right now, as a matter of fact.

Or if you take a larger signing bonus, you are obliged to provide us four years of service in uniform. If you go through our education programs, the medical officer training plan, they have a four-year commitment of obligatory service as well, after we train you in the school. And we have opportunities to train people as specialist physicians. There is a variety of ways we can enroll you or train you and turn out a physician.

Mr. John Cannis: Lastly, because I know my time is going to be up in a minute, when our men and women who have served in theatre return due to injury and what have you, and they need special attention that for whatever reason you cannot provide, would you then contract it out or would you send the person outside for proper treatment?

That's it, Mr. Chairman. I got my question in. So would you give her a second to respond?

Cmdre M. F. Kavanagh: First and foremost, the right treatment for the person is job one, as General Jaeger said. We use a variety of mechanisms. We will engage the local health care sector where they are, if it's the appropriate care. Because of the nature of the fact that where they are is too remote to provide what they need, we will move them to where they can get it. There is a variety of mechanisms.

The Chair: Good. Thank you.

We'll go over to Mr. Hiebert, and then back to the official opposition.

Mr. Russ Hiebert (South Surrey—White Rock—Cloverdale, CPC): Thank you, Mr. Chair, and thank you both for being here today.

I really only have one question, and I'll share the balance of my time with my colleague Mr. Hawn. It has to do with the work we're doing in Afghanistan.

You talked about the use of advanced technologies, a CT scanner in theatre, which I think is fantastic. I'd like you to elaborate further on the types of wounds that are being experienced and how they're unique from other theatres that we've been involved in. And secondly, what else would you need? Is there anything that's lacking in terms of technology or requirement of personnel to do the job in Afghanistan?

BGen Hilary Jaeger: I have a wish list now.

I'm afraid I lost track of the first part of the question. What would I like? What's lacking?

A voice: What types of wounds.

BGen Hilary Jaeger: Oh, the types of wounds. I'm sorry.

Before everybody got very good at wearing body armour and before we bought good stuff that covers more of your body with ceramic plates and things, typical war wounds from conflicts like Vietnam, Korea, and the Second World War were a combination of shrapnel wounds and ballistic projectiles or aimed rifle rounds. We see very few rifle rounds now. There are some shrapnel wounds, but because of the protection that's offered to the trunk, they almost all involve the extremities.

The typical gut shot wound that was very messy and very difficult to deal with in the Second World War and Korea and Vietnam is not commonly seen and is certainly not one that is associated with other things that are more of a problem. Those were commonly fatal wounds. Different chest wounds and getting a bullet through the heart are not likely to lead to your survival.

Because we have fewer of those, proportionately we have far more of the extremity wounds and the head traumas. We have been amazed at the ability of some of our people to bounce back from serious closed head trauma. Dr. Bennett will tell you that a Glasgow coma scale of three can be awarded to a dead person. We have had people who have arrived at our treatment facility with a Glasgow coma scale score of three who walked out of hospital two and half to three months later, and none of us would have predicted such an outcome. So we're learning a lot from these new injury patterns.

What would I want in theatre? I don't really want anything more in the way of medical equipment. What I would like is to have twice as many general surgeons and orthopedic surgeons, so that we can keep the rotation going indefinitely. I need well-trained, experienced, highly motivated specialists.

Do you want anything else?

● (1650)

Cmdre M. F. Kavanagh: No, that would be on the top of my wish list.

As I said earlier, we aren't equipment-heavy. We have our basic needs. The key piece that makes us effective is what's between our ears, along with some technical skills and the hand skills of the surgeons. We need people. That's what we need.

The Chair: You have a minute and a half.

Mr. Laurie Hawn: We've heard before how the military does not provide medical care for dependants. I certainly have lived that, and I understand why, but there seems to be a bit of add-to that maybe we should. Setting aside the fact that that's not the way health care in Canada is set up at the moment, can you give us just an assessment for general edification? I know you can't give me a number, but I'm going to make a wag and suggest there are probably 200,000 dependants for the 60,000 or so military. In terms of small, medium, large, or “you've got to be kidding me”, what's the amount of money, infrastructure, and personnel it would take if the CF were to ever embark on providing medical care for dependants?

Cmdre M. F. Kavanagh: The health care expenditure in this country runs about $3,000 a head, so it would be 3,000 times however many dependants there are.

Mr. Laurie Hawn: Plus the infrastructure, plus the personnel.

Cmdre M. F. Kavanagh: Plus the infrastructure, plus the personnel, yes.

Mr. Laurie Hawn: What I'm getting at is that it's really very unrealistic to suggest that the Canadian Forces would ever be in a position to provide medical care for dependants.

Cmdre M. F. Kavanagh: Anything's possible.

There's another part to it. Our American allies do this, and yes, as Dr. Bennett will tell you, as a family practitioner, it broadens your practice of medicine. We experienced that in Germany. But it does have a downside on the military piece as well. There's another pressure. On top of providing the operational readiness care we do at home now—the pre- and post-deployment—and what we do overseas, now you're adding another demand on the organization, but you can't leave the families without that person. So it would just increase the pressure and increase the stresses of meeting the deployment requirements.

The Chair: The last spot in the second round goes to the official opposition. Pass?

Then we start the third round by going back to official opposition, and then back over to the government.

Laurie, if you have something more that you want to go on with, you have some time here.

Mr. Laurie Hawn: How about something feel-good?

Commodore, you and I were at an event in Edmonton not long ago, and the aim was to raise money for something called Fisher House. Can you tell us a little bit about what Fisher House is?

● (1655)

Cmdre M. F. Kavanagh: I had the opportunity to visit Kandahar in May, and also Landstuhl, Germany, so I've seen the facilities in both places. The surgeon general will be going in the new year.

At the beginning of the evacuation chain, our facility in Kandahar may be a plywood hospital, but I can tell you that it's providing absolutely first-rate care. They are doing amazing things there. Likewise, there's the evacuation chain the Americans provide for us. There are flying intensive care units. That's what's in the back of those airplanes. And when they get to Landstuhl they're also provided with superb care. If the patient is in Landstuhl long enough or is serious enough—and mainly it's long because they're serious enough—we bring the families over to Landstuhl.

Fisher House is like Ronald McDonald House, if you are familiar with that in Canada. They provide a place to stay, give them the support they need, and make sure they get something to eat. It's on an American base, so it's culturally friendly, which decreases the stress on the members, particularly if they're coming from this country, have never been to Germany, don't speak the language, and don't understand the culture. And it's within walking distance of the hospital. Our personnel are treated exactly the same as the American people who use this facility, and they provide the creature comforts and help look after them.

There's a whole series of these on various U.S. bases. They were originally started by a man and wife named Fisher. They were wealthy Americans who started this as part of their charity work. They subsequently passed away, but they left an endowment that keeps these houses going, and the network is actually expanding. But now the money is raised through fundraising.

My old unit in Edmonton, 1 Field Ambulance—I was the commanding officer under General Cox—

The Chair: This General Cox?

Cmdre M. F. Kavanagh: That General Cox.

Mr. Laurie Hawn: I told you it was feel-good.

Cmdre M. F. Kavanagh: Master Corporal Franklin, who you've also seen, is a solider in that unit, a medic, and the unit took it upon themselves to have a fundraising event to raise some money for this. I was told the other day that the unofficial total is $80,000 that they've raised for that organization. The Chief of Defence Staff, along with a few of the casualties and their families, are going to go back early next month sometime to award the money to the organization and also to give commendations to Fisher House and the Landstuhl Regional Medical Center.

The Chair: Thank you.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand: Thank you, Mr. Chairman.

You would probably be the best person to answer my question, Ms. Jaeger. I see that you are in charge of liaison for discussions with other NATO countries. I imagine that you examine treatment protocols and so forth before developing policies. What is of particular interest to me is the relationship between you, the Department of National Defence, and the Department of Veterans Affairs. I am thinking in particular of those soldiers who find themselves withdrawn from active service. Some soldiers have to leave the armed forces because of physical or mental health problems. As I understand it, the Department of National Defence ceases to have anything to do with these soldiers from the moment that they are withdrawn. Their files are handed over to the Department of Veterans Affairs.

BGen Hilary Jaeger: That is correct, but the process begins before the soldier is withdrawn from service.

We operate on a case-by-case basis. We have a case management system for people who suffer from chronic physical or mental health problems. As soon as it becomes apparent that the person cannot remain in the Canadian Forces, our case management officers begin discussions with the Department of Veterans Affairs to organize follow-up and ensure that the veteran understands all the benefits to which he is entitled. The process begins at least six months before the member leaves the Canadian Forces, and sometimes as early as a year or a year and a half prior to discharge.

Mr. Claude Bachand: Fine. I understand that the process begins a year before the soldier is discharged. Nevertheless, am I right in thinking that, from the moment the Canadian Forces sign the discharge, your legal responsibility ends and the matter is passed over to Veterans Affairs. Is that correct?

● (1700)

BGen Hilary Jaeger: That is correct, but we run a joint mental health care project with the Department of Veterans Affairs.

[*English*]

I'll speak in English again for clarity's sake and so that I don't sound too disjointed.

The project seeks to create a system of clinics across the country, some of which are run by the Canadian Forces and some of which are run by Veterans Affairs Canada. Regardless of whether they're currently serving members or Veterans Affairs Canada clients—or, for that matter, members of the RCMP or retired members of the RCMP—they all have access to these clinics, to whichever one is best placed to meet their needs. If a member of the CF retired but stayed in Ottawa, where we run the clinic, they would continue to come to the same clinic. If they retire and move to Montreal, they have the Ste. Anne's Hospital; they will have their care through Ste. Anne's Hospital.

[*Translation*]

Mr. Claude Bachand: Yes, but the joint project with the Department of Veterans Affairs is only for those suffering from mental illness. What happens to those who have a permanent physical disability that precludes them from returning to the armed forces? Are they solely the responsibility of Veterans Affairs?

BGen Hilary Jaeger: After they have been discharged, yes.

Mr. Claude Bachand: That is the situation after they have been discharged.

Why did you pay particular attention to mental health care? We often hear complaints of poor treatment at the hands of Veterans Affairs by members of the Canadian Forces who have been discharged due to physical disability. The department does not take care of them. From a jurisdictional point of view, although they are the responsibility of the Department of Veterans Affairs, it is often provincial institutions that provide care for them. The provinces are left to deal with the problems.

Would it not be possible to set up a committee on physical disability, similar to the one that deals with mental health care issues?

BGen Hilary Jaeger: We chose to focus on mental health issues because continuity of care is very important in such cases.

Mr. Claude Bachand: Yes, it is a real problem.

BGen Hilary Jaeger: It is preferable that the same institutions continue to provide care to these people after they have been discharged.

Thus far, nobody has asked us to do anything on the other matters to which you refer.

[*English*]

From a point of view of jurisdiction, at the moment we have no responsibility remaining after the member is retired. They leave with a provincial health care card. Perhaps depending on why they leave, they leave as entitled people under Veterans Affairs Canada and the primary responsibility for what happens to them shifts from us first to the provincial health care system, but frequently there is supplementary health care or payment from Veterans Affairs Canada.

The Chair: Thank you.

Mr. Blaney is next.

[*Translation*]

Mr. Steven Blaney: A lot of questions have already been asked and I will try to ensure that mine are not redundant.

I would just like you to clarify something for me. Where exactly is Fisher House located?

[*English*]

Cmdre M. F. Kavanagh: The one our soldiers have accessed is in Landstuhl, Germany, but they have them on many of their large army bases, large navy bases, air force bases, and their Veterans Affairs Canada administration. Basically it depends on the size of the location where they have them. I saw a map of them plotted all over the place. There are 24, but the one we've used most is in Landstuhl, Germany.

[*Translation*]

Mr. Steven Blaney: Resource centres are available for the family members of those in the military. I imagine there is one such centre in Valcartier.

There are currently almost 2,500 soldiers preparing to go on mission. Do you have activities planned to help families prepare for a long separation? Do you have a program accessible to everybody or do you tend to work with families on an individual basis?

BGen Hilary Jaeger: I imagine that activities are organized. We also have a system called the rear party. All groups on rotation have a rear party—a group of soldiers who remain on the base and who are responsible for liaising with the families.

On-base programs for families are the responsibility of the family resource centre and the chain of command. They are not our responsibility.

● (1705)

Mr. Steven Blaney: Are these services offered as part of your services?

Cmdre M. F. Kavanagh: No, not directly.

Mr. Steven Blaney: Okay, I understand—your responsibilities are more in the area of auxiliary health care services.

Do you have specific measures or programs in place to address addiction—perhaps this is something you have already mentioned—and, secondly, do you struggle to reduce or eliminate addiction problems in the armed forces?

BGen Hilary Jaeger: Are you asking a general question or are you referring specifically to the testing that we carried out recently?

Mr. Steven Blaney: I want to know what the situation is like in general.

BGen Hilary Jaeger: We have a comprehensive addiction program. Previously, we almost solely relied on a 28-day treatment. People were hospitalized and went cold turkey for 28 days. Nowadays, we have a more personalized approach.

[*English*]

It's more personalized, with more hierarchical, lower-level educative interventions and steps before we resort to a 28-day in-patient program for addictions treatment. All of the bases have addictions counsellors.

[*Translation*]

Mr. Steven Blaney: Do you carry out testing? How do you detect addiction problems?

BGen Hilary Jaeger: It depends. The questionnaire I referred to a little earlier includes questions on addiction; however, it could also be that people are sent to us following an incident such as, for example, drunk driving. The chain of command sends them to us to be—

Mr. Steven Blaney: Do you run testing or prevention programs for the regular troops, when they are not preparing to go on a mission?

BGen Hilary Jaeger: I am not quite sure that I understood your question.

Mr. Steven Blaney: I was just wondering whether you run general testing and prevention programs, other than those related to preparing a mission.

BGen Hilary Jaeger: Related to missions—

Mr. Steven Blaney: It could well be that there are none. You would know better than I would.

[*English*]

BGen Hilary Jaeger: We educate members at a variety of points. Every unit is supposed to give its members a drug and alcohol prevention lecture annually....

General Cox is rolling his eyes; he's probably sat through way too many of those in his career.

There has been an ongoing sensitization and educational component. I think there's been a certain amount of success in that regard, because the messes are all dying and the base gyms are full. Mess life in the Canadian Forces is much more quiet than it used to be, and non-public funds illustrate that.

So we have made some headway, to the point where our levels of substance abuse are roughly the same as those for the civilian component of Canada.

[*Translation*]

Mr. Steven Blaney: Thank you.

[*English*]

The Chair: Just before we move on, one question.

When we were talking to the spouses in CFB Edmonton, there was a comment that most of their returning partners came back with high blood pressure. Is that a common thing?

BGen Hilary Jaeger: That's actually the first I've heard of it. I'll go back and ask Edmonton why they might have seen this. I can't think of any good physiological reason why that would be.

The Chair: This was a comment that came from more than one of the wives. I thought it was an issue you'd be aware of.

Okay, the official opposition passes, the government checks, and now to the New Democratic Party.

● (1710)

Mr. David Christopherson: It must be near Christmas.

Thank you very much, Mr. Chair.

Is potable water a serious ongoing issue? If so, could you describe some of the challenges you're facing and how you're overcoming them?

BGen Hilary Jaeger: I'll have to get back to you on the details, but it is a serious issue everywhere we go, on every mission. There's a huge priority placed on potable water. You can't do anything operationally without it.

For instance, Afghanistan's climate is very dry in the summer, very hot, and people are carrying a lot of equipment. If you're not well hydrated, you're going to end up in difficulty very soon. If your water is not safe, that will manifest itself as well.

As to exactly what steps we've taken in Afghanistan, whether we're using our own reverse osmosis systems or relying on imported bottled water, I couldn't actually tell you that, sir.

Mr. David Christopherson: It hasn't been a debilitating issue so far.

BGen Hilary Jaeger: It has not caused us casualties.

Mr. David Christopherson: Not yet.

Cmdre M. F. Kavanagh: We deploy preventative medicine technicians on all of our missions. Other than looking out for mosquitoes, they check the water and watch out for sanitation issues, and all those things. They look for any place where we might have trouble on a regular basis.

Mr. David Christopherson: I heard you say earlier that if you had any backfilling to do you'd do it on the Canadian side and make sure the front-line health services were there in Afghanistan. But if there were another mission, would you have the ability to maintain adequate medical services in Afghanistan and back here, and open up another front? Are you in a position where you would have to say the risks were too high and you would recommend no, from a medical services point of view? If not, how would you go about sort of cobbling something together? What steps would you take?

Cmdre M. F. Kavanagh: As I said in my opening comments, we would first need to know what the mission was: where is it, what are we being asked to do, how big is it, and all of those kinds of things. So it depends. Are our allies there? Do they have resources there? On each and every one would we have to know all of the answers to all those questions before we could answer.

Could we do another Afghanistan-type mission with the same capability? No. Could we do something else? Yes. It just depends on where it is, what we're being asked to do, and who else is coming to the party with us.

Mr. David Christopherson: How does it work if you're told there is a mission coming, or if you're being asked for input on what your abilities are? What are the steps you take to go about this, given that you're already strained? Where do you begin?

Cmdre M. F. Kavanagh: It isn't just us. There's always an operational planning process that goes on. It's the same for the combat arms. The army, navy, and air force go through the same planning process. The support logistics community goes through the same process. These missions are all analyzed by the senior staff, and we add our input on whatever we're asked to do. Others make the decisions as to whether we're going or not. They don't take these decisions lightly. All of the input is factored in.

We have both been in the position of providing operational advice to the senior staff from a medical perspective, and we give them exactly what we can or can't do at that particular moment.

Mr. David Christopherson: You said you were pulling out all the stops to attract doctors, including having contracts with civilians and signing bonuses. How much is the signing bonus, by the way?

Cmdre M. F. Kavanagh: It is $80,000 for two years, and $225,000 for four years for physicians.

Mr. David Christopherson: That's the bonus. What's the pay?

Cmdre M. F. Kavanagh: It varies.

BGen Hilary Jaeger: It starts at $135,000 for captains and goes up fairly sharply from there.

Cmdre M. F. Kavanagh: It depends on whether you come in as an experienced general practitioner or a specialist. That is the base pay if you're coming right out of medical school or residency with no experience.

Mr. David Christopherson: I gather you're scouring Canada. You're probably scouring the world.

This isn't a trap question at all, but in my home town of Hamilton we have a group working with city hall, the chamber of commerce, and the local academy to do everything we can to encourage.... We need family doctors, just like probably every other community around this table.

If you can't comment, I'll accept that too. This is not meant to be anything other than the fact that I'm curious.

Given the means of the armed forces versus Hamilton, it leaves us with a bit of a dilemma. While we're trying to attract family doctors and other doctors to our communities, and the Canadian armed forces are also using all the tools they have available to attract those same doctors. That creates a bit of a conundrum here in Canada, doesn't it? We're having one between communities and we don't like it, but that's the way it is. Now I'm becoming more aware that there's also this major attraction to the armed forces.

● (1715)

BGen Hilary Jaeger: I hate the fact that in Canada you seem to have to rob Peter to pay Paul on health care human resources. We wish it were not so, but we have our distinct responsibility.

The Canadian Medical Association has about 60,000 members, so that's roughly how many physicians there are in Canada. We have 180 physicians, so in terms of the greater Canadian health care landscape we're a fairly small player. We have been in a position sometimes, oddly enough, of competing with ourselves. In order to hire the civilians we need we've had to offer salaries that are so attractive that in some cases some people have taken off their uniforms and become civilians. That was also not helpful.

We are a bit sensitive to those kinds of problems, but I think we provide a valuable service to Canadians. Certainly when people leave us after their minimum engagement, or if they get a pension after 15 or 20 years of service, we return a very valuable resource to the Canadian health care system.

Mr. David Christopherson: No question. I know a nurse in her late thirties who joined the navy, I believe. She is now a doctor in Hamilton. She did her service and now is providing family service.

Are you doing anything with foreign-trained professionals within the armed forces to acknowledge credentials from Canadians who otherwise are seen to be doctors around the world but haven't quite got through our credentials system? Do you have an independent process within the armed forces for that?

Cmdre M. F. Kavanagh: We are always looking out for physicians who meet the qualifications. We take foreign graduates, but we have an evaluation process, which, again, is the civilian evaluation process. We don't do it ourselves. Most of what we do in the realm of health professionals is always partnering with some institution in this country, whether it's a particular university or a particular program. We have used the McMaster's program. We have also used the University of Alberta and the University of British Columbia. We use a lot of them to assess those people to see if they are suitable, or, if they need extra training, how much training and where we can place them.

BGen Hilary Jaeger: The bottom line is we need licensed physicians and we don't control the licensing processes.

The Chair: Does anybody have one short question?

Mr. Bachand, and then we'll wrap up.

[*Translation*]

Mr. Claude Bachand: In any conflict, death toll statistics always attract attention. As of this morning, the total stood at 44. Injuries, however, are rarely mentioned. I would like to ask you three brief questions on this subject.

Firstly, how do you define an injury? If somebody were to cut himself with a kitchen knife while cooking on a mission, would he be considered injured personnel?

Secondly, how many people have been registered injured in Afghanistan thus far?

Finally, I imagine you have a scale to classify the severity of injuries and to allow you to differentiate between minor, relatively serious and serious injuries.

Could you please provide us with some information on these three points?

[*English*]

BGen Hilary Jaeger: Thank you, sir.

I will again answer in English for the sake of my sanity and clarity.

When we look at the statistics of what happens in a theatre of operations, there are several categories you put members in once they've been exposed to trauma. They can be killed in action, and, by definition, killed in action means essentially that from the point at which any medical person touched them, vital signs were absent. They were dead from the first point of contact with the medical system.

They can be classified as died of wounds, which is a statistic you don't hear very much any more. Those are people who have succumbed to their injuries but after they started being treated by the health care system.

You can be wounded in action, and that means almost what it says: as a result of being in direct contact with an adversary, you sustained a wound. It's not necessary that it be a rifle bullet, a piece of shrapnel, or a blast. It could mean that your vehicle veered off the road, rolled over, and you had a motor vehicle accident—you're still wounded in action.

The other big category is disease and non-battle injury. Again, it's as it sounds. Either you became ill, rather than injured, or you had an injury but that injury was sustained while walking, falling in the shower, or cutting yourself with a knife in the kitchen. That would be a non-battle injury. The statistics we have are 171 wounded in action, and I don't believe that includes disease and non-battle injury.

● (1720)

Cmdre M. F. Kavanagh: No, it does not.

BGen Hilary Jaeger: Disease and non-battle numbers are much, much higher.

Mr. Claude Bachand: Much higher?

BGen Hilary Jaeger: They can be mostly minor things, where they've stayed in theatre and have gone back to work. Perhaps they had a cold.

Cmdre M. F. Kavanagh: Ever since we've collected statistics, I think the average runs about 80%.

BGen Hilary Jaeger: I wouldn't hesitate to say at least that.

Cmdre M. F. Kavanagh: At least 80% disease and non-battle injury compared to battle injury. People still get flu, they still get colds, or sprain their ankle when playing floor hockey. They do those kinds of things, even in war zones, but that's disease and non-battle injury. Yes, we would have a lot more than the 171; that's natural and to be expected.

BGen Hilary Jaeger: As an example, the exact figures.... We've just received our first half of the statistics for the current rotation, and they had over 2,500 sick parade visits. Those would be the disease and non-battle injury kinds of visits, as compared to performing some 220 surgical procedures and, as we mentioned, 171 wounded in action. There's a lot of not all that sexy work taking place on a day-to-day basis at the clinic as well as the more public things.

The Chair: Thank you very much. We appreciate your being here.

Before we suspend and move in camera for our next witness, I want to explain to the committee that the next witness was scheduled for Wednesday, but something happened to his schedule and he wasn't able to make it. So we thought we'd add him to this evening. I apologize that we have to run for another hour, but that frees up Wednesday. There will not be a meeting on Wednesday.

Thank you both very much. It was very interesting, and we looked forward to your being here. I can tell by the questions that there was a lot of interest in this aspect. Certainly the welfare of our men and women in uniform, whether they're in Afghanistan or at home here, is of critical interest to us.

We thank you very much for your input.

We'll suspend for a few minutes.

[*Proceedings continue in camera*]

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