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Chair

Mr. James Bezan

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● (1535)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone. We'll get our meeting 74 under way as we continue our study on the care of ill and injured members of the Canadian armed forces.

Joining us for the first hour is Colonel Homer Tien, a Canadian military trauma surgeon and military trauma research chair at Sunnybrook Hospital with the Department of National Defence.

Colonel Tien has been with the Canadian Forces since 1990. He has an undergraduate degree in biochemistry from Queen's, and received a medical degree from McMaster in 1992. He then posted with the 2 Field Ambulance at CFB Petawawa, and served as the unit medical officer for the 1st Battalion of the Royal Canadian Regiment. While at 1 RCR, he deployed to Croatia on Operation Harmony. He then deployed to Bosnia with IFOR on Operation Alliance. He then served with Canadian special forces at Dwyer Hill Training Centre as their first unit medical officer.

He has also deployed to Vancouver and to the Golan Heights, and has worked with Veterans Affairs in the recovery of RCAF airmen missing from World War II, in the Burma recovery mission.

He went to the University of Toronto to complete his general surgery training, his fellowship training in trauma surgery, and his master's degree in clinical epidemiology. He is now posted at Sunnybrook Health Sciences Centre as a trauma surgeon. He is the medical director for the Tory Regional Trauma Centre at Sunnybrook, and is co-chair of the U of T's trauma program. He is an assistant professor of surgery at the University of Toronto.

We welcome you, Colonel, to committee, and look forward to your opening comments.

Colonel Homer Tien (Canadian Military Trauma Surgeon and Military Trauma Research Chair at Sunnybrook Hospital, Department of National Defence): Thank you very much, Mr. Chairman, and members of the committee. I'd like to thank you for the opportunity to appear at this important committee and to participate in the study you're conducting on the care of ill and injured military personnel.

As you can understand, this is a subject very close to me and I hope to be able to assist your deliberations in any way that I can. You've been provided with my biography so I'll try to avoid duplicating some of the talk on that. I did want to say that with my experiences as a general duty medical officer there were incredible experiences that helped to shape my career in the medical profession and during these deployments I treated injured Canadian Forces members in the pre-hospital and in the Role 1 setting. What I mean by that is I was attached to small operational units and provided capabilities in first aid, immediate life-saving measures, and triage.

You heard about my background in trauma surgery after that. As a Canadian Forces surgeon, I've also deployed to the NATO-led multinational stabilization force in Bosnia in 2003, to Kabul with ISAF in 2004, and multiple times to the Role 3 Multinational Medical Unit in Kandahar.

Role 3 refers to providing capabilities in specialist diagnostic resources, specialist surgical and medical capabilities, preventive medicine, and operational stress management teams. In my position as the national practice leader in trauma for the Canadian Forces, I'm the Surgeon General's adviser regarding hospital-based acute trauma care on deployed operations. I also provide advice to the Surgeon General regarding pre-hospital trauma care on deployed operations.

Based on my training and experience in Afghanistan, I'd like to inform the committee that I rate the acute trauma care provided to Canadian Forces members who are injured on deployment in southern Afghanistan as outstanding. I'd like to shed a little light on the process that injured military personnel go through when they become injured in Afghanistan. From January 2006 to July 2011, Canadian Forces members injured in southern Afghanistan were first treated in a pre-hospital setting by themselves, by their buddies, and by Canadian Forces Health Services combat medical technicians using the principles of tactical combat casualty care. Casualties were then transferred by either a road ambulance or by helicopter to the Role 3 medical unit.

Once there, Canadian Forces surgeons, anesthesiologists, and physicians would resuscitate and conduct life- and limb-saving surgery on injured members. When stabilized, the injured members would then be evacuated by the U.S. Air Force to the Landstuhl Regional Medical Center in Germany, a U.S. Army and Air Force institution. After ongoing treatment at the Landstuhl Regional Medical Center, Canadian armed forces medical teams would then transfer Canadian Forces members back to university-based trauma centres in Canada to receive quaternary-level care.

As I previously mentioned, our pre-hospital trauma care was outstanding and compares either similarly or more favourably to our allies. The Canadian Forces take the health care of our military personnel seriously and we published a study in 2011 looking at Canadian Forces members who died on deployment in southern Afghanistan. Of those who died, we classified only 2 of 63 as potentially preventable pre-hospital deaths. It's important to clarify that these were only potentially preventable as our methodology could not evaluate the tactical situation, which may have actually rendered the death non-preventable.

In a similar study of U.S. special operations deaths published in 2007, investigators rated 12 of 77 pre-hospital deaths as potentially survivable. In a larger U.S. study published in 2012, U.S. investigators using a slightly different methodology rated 24.3% of 4,596 pre-hospital U.S. military deaths as potentially survivable.

If a Canadian Forces member was injured and arrived with vital signs at the Role 3, an internal Canadian Forces Health Services study showed that a Canadian Forces member had a 97% chance of making it back to Canada alive. This represents a significant achievement in acute hospital level trauma care and, again, compares favourably to the experiences of our allies.

One reason why the level of CF trauma care is high is that many Canadian Forces clinicians are embedded within civilian hospitals. Research suggests that trauma care is better if centralized at regional trauma centres. Clinicians are more experienced with severe trauma cases and as a result, their patients have better outcomes. Of seven active duty Canadian Forces general surgeons, five are posted to university trauma centres. One is posted to a large community hospital and one works as a transplant surgeon at a university hospital.

● (1540)

With that, Mr. Chairman, I'd be happy to explore any of these areas, or any others, if you wish. I hope my opening remarks have provided you with a little background on the role of a Canadian Forces surgeon, and what it takes to provide care to these patients.

Thank you very much.

The Chair: Thank you very much, Colonel.

In the interests of time, we're going to do five-minute rounds with the hour we have with Colonel Tien.

Mr. Harris, you have the floor.

Mr. Jack Harris (St. John's East, NDP): Thank you, Colonel, for joining us.

Do you get called Colonel or Doctor? Can we call you Doctor? Is that all right?

Col Homer Tien: You can call me Homer, if you'd like.

Mr. Jack Harris: Either way? We'll call you Homer.

Well, Homer, Doctor, Colonel, thank you for joining us. I appreciate your opening remarks. I'm pleased to hear your statistic on the success rate of avoiding preventable pre-hospital deaths, which has been demonstrated by this one comparison you've used.

When we're talking about trauma here in the medical term, we're talking about physical injury primarily, whether it be a wound or another type of physical injury mostly, not the kind of trauma when we're talking about post-traumatic stress disorder. That could be part of the trauma too, I suppose, but they're two different concepts, are they not?

Col Homer Tien: Because I'm a surgeon, I'm speaking of trauma in the physical sense.

Mr. Jack Harris: Okay.

I'm interested in the fact that you also have quite impressive medical training, part of which is clinical epidemiology. Have you made use of that in your military work? One of the areas we're obviously looking at is the kind of care injured soldiers receive, and I think you've outlined very well the success we've had with that.

Have you participated in any studies, or are you aware of any studies linking PTSD experience in a military frame and suicides that may have occurred at a later date? Is that part of any of the work you do or any work that's being done within the military medical system?

Col Homer Tien: First of all, I do clinical research within the Canadian Forces Health Services, but my research tends to focus on pre-hospital physical trauma care and in-hospital trauma care, and how we stop bleeding.

I did one study that looked at the causes of death within the Canadian Forces over a 20-year period. Of that, suicide was in the top four.

In terms of linking it to....

I'm sorry, what were you asking?

Mr. Jack Harris: I'm looking for the linkage between the experience of post-traumatic stress disorder or trauma in the field and a later suicide.

Col Homer Tien: No, I have not done a study on that.

Mr. Jack Harris: In Afghanistan, for example—and perhaps you can tell us about the other operations you have been party to—the medical treatment experience is obviously not just limited to Canadian surgeons or Canadian medical personnel treating Canadian casualties. Can you tell us how that would have worked with allied forces? How was that organized, and were there any issues or difficulties with that?

Col Homer Tien: We work very closely with our allies, to the point where, let's say—because you can't be on call every night—perhaps if there were two of us, we'd be on call every second night, as the primary surgeon or the primary person to resuscitate the trauma patient.

● (1545)

Mr. Jack Harris: This would be in a joint medical facility.

Col Homer Tien: Yes, Role 3 was a joint medical, multinational facility. Each nation would work as part of a team, and we would take our turn on the rotation.

Obviously, if we weren't on one night but heard that a Canadian Forces member had been injured, we would always come in, because we obviously felt a special attachment. If a Canadian surgeon were on, we would notify the U.S. surgeon as a courtesy if a U.S. member were injured, and the U.S. surgeon would always come in.

Mr. Jack Harris: You talked about a special arrangement that might have been made. If you had an injured solider who was given emergency treatment, what was the normal course of follow-up? Where would that soldier then go? How long would he or she stay on base, and where would the soldier be transferred? What's the procedure?

Col Homer Tien: It would depend on the severity of the injuries. If they were severely injured, we would usually stabilize them; we would have to stabilize them within the first 24 hours. The pattern then would be an air evacuation to Germany within 24 hours after a request for an air evac. They would stay at the Role 3 for a very short period of time.

Mr. Jack Harris: Then they would be looked after in Germany by...? Was there an American facility in Germany?

Col Homer Tien: It was a U.S. Army and Air Force tertiary-level hospital in Germany. They'd be cared for there until they were again deemed to be stable for transport, and then a Canadian Forces medical specialist team would come and bring them back to Canada.

The Chair: Thank you.

Time has expired. Five minutes goes quickly.

Ms. Gallant, you have the floor.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman.

Dr. Tien, would you describe how the trauma treatment at the Role 3 in Kandahar evolved from when we first stood up there to 2011? For example, was there an improvement in diagnostic equipment, an increase in numbers of caregivers?

Col Homer Tien: It was improved in many different ways. Purely from the actual structure of the building.... I was the first to arrive in 2006, so I took over from the U.S. combat support hospital that it was. At the time it was a small plywood shack, which I'm sure you've seen pictures of, with one OR. I was the last to leave in December 2011, and at that time it was a modern brick building, manned by the U.S. Navy, and there were three ORs. It was quite a facility. The diagnostic capabilities had improved by that time, we had new equipment. So there was quite an evolution of capability in that time.

Mrs. Cheryl Gallant: You obtained a CT scan there. What about an MRI machine, was that ever put in there?

Col Homer Tien: There was always a CT scan machine, as far back as early 2006, the difference was in the type of scanner. There was a two-slice scanner in 2006 that evolved to a two-slice and a sixteen-slice—that refers to the speed at which it can scan. An MRI machine showed up in 2011 from the U.S. Navy, but it was purely for research, strictly for research in mild traumatic brain injury.

Mrs. Cheryl Gallant: Did you see an improvement in the survivability of the trauma patients over time as a consequence of implementing certain procedures in the field for when the buddies first came upon them? If you did, can you tell us what those procedures were?

Col Homer Tien: The study that I quoted, about two deaths out of 63, was actually in the first 20 months of the war. In fact, it's important to realize that almost all the deaths that occurred from Kandahar occurred in the pre-hospital setting. The tactical combat casualty care that we had implemented, which is a pre-hospital way of caring for patients, was actually well entrenched at that time already. The use of tourniquets was probably the most life-saving. So for that reason I think there wasn't a huge change in the potentially preventable death rate. I think it was quite low right at the outset; that's what our study showed. There was little room for improvement in the pre-hospital death rate.

● (1550)

Mrs. Cheryl Gallant: In addition to the Department of National Defence physicians and doctors, there were also civilian doctors, as you mentioned. How did you find the integration of the civilian doctors into theatre at the Role 3?

Col Homer Tien: I can speak only to my own experience on that. I thought it was very smooth. It helped that the trauma and the specialist community in Canada is actually fairly small. The people I deployed with were people I knew from the academic environment in Canada anyway, so it was very easy to integrate them. They realized that they did not know the military environment and would obviously take guidance in that part, but what they did know was how to look after critically injured patients.

Mrs. Cheryl Gallant: The chair mentioned that you were posted to base Petawawa. When you were there, how did you keep up your skills? Did you work at a local hospital?

Col Homer Tien: Yes. While I was there I did shifts in the emergency departments at various hospitals in the Ottawa Valley.

Mrs. Cheryl Gallant: How did you find the difference in injuries from the time you were posted to Bosnia versus what you saw in Afghanistan?

Col Homer Tien: There was very little comparison in terms of the sheer number of injuries. Obviously, in Bosnia, thank goodness, there weren't too many Canadian casualties. Also, in terms of the mechanism, there were no blast injuries—at least when I was deployed there. It was mostly road traffic accidents and the occasional gunshot wound, whereas the norm in Kandahar was severe blast injuries and gunshot wounds.

Mrs. Cheryl Gallant: In your opinion, do you feel there is enough treatment and care, and are there enough programs, to take care of our ill and injured?

Col Homer Tien: If you're referring to programs or care for the ill and injured acutely, I think so. And this is what I do.

I can compare to a level one trauma standard in Toronto, where I work; you have to understand that when you're at Sunnybrook, it's Canada's largest and first trauma centre, but we do other things, including cancer care, so the resources are divided.

At the Role 3, the whole focus was on providing trauma care to injured Canadian soldiers, so everything happened quickly. We had very quick access to resources that I sometimes wish I could have on the civilian side.

The Chair: Thank you, Ms. Gallant. Your time has expired.

Mr. McKay, you have five minutes.

Hon. John McKay (Scarborough—Guildwood, Lib.): Okay. Thanks very much. I apologize for not being here earlier.

When we were at Downsview, we were exposed to some interesting research, particularly with respect to a computer system that would give you an in-the-field diagnosis. I frankly don't know how far advanced the research is or was, and I don't know whether they are going to be affected by the budget cuts.

I wonder whether you've had any exposure to that research, because it does seem to me that it fits directly within your field of interest and expertise.

Col Homer Tien: It does, and I've actually been involved with that project, if it's the same project that I'm thinking about. This is a project on automated ultrasound diagnosis in the field. The researcher is trying to come up with an algorithm for looking for specific diagnoses in the field.

It can take years to train a radiologist to interpret an ultrasound. You don't have that luxury with a combat medical technician. If we can deploy an automated diagnosis system to the field, that might help that combat medic.

Hon. John McKay: It seems to me to fit within the conversation that has been going on as to, "Do you still need doctors?"

Voices: Oh, oh!

Hon. John McKay: I think it's in New York, but I'm not absolutely certain, that they're working on loading Watson—that's the name of the computer—with a whole range of potential diagnoses so that the diagnosis is far more accurate and done far more quickly.

It seemed to me that what they were doing at Downsview was kind of a precursor of that. Am I correct about that?

● (1555)

Col Homer Tien: I can't say. I'm not aware of the U.S. program that you're referring to. The Canadian program has a very specific focus. It's really to diagnose bleeding in the abdomen in the field.

That is helpful in terms of improving the triage of that patient. If we knew they were bleeding in their abdomen, we might prioritize them in an evacuation scheme more quickly.

Hon. John McKay: How far along has that research gone? It obviously has civilian applications. Have you maintained contact with that program?

Col Homer Tien: It's not at the clinical trials level yet. It's still at the preclinical trials level.

Hon. John McKay: What does it take to move that up from "this is a really good idea for a field hospital or for a unit operating in the field" to that stage?

Col Homer Tien: I don't know. The current problem is that it's really an issue at the level of mathematics and physics, in terms of how you use sonar.

So I really don't know. I'm sort of waiting for it at the clinical level. I would then be involved with the clinical trials.

Hon. John McKay: I'm assuming that the army in particular would say that would really be a leap forward in battlefield trauma.

Col Homer Tien: We're very interested in it. I am very interested, and I think health services is interested in it. We're following it along, but obviously certain aspects of science are difficult to push along.

Hon. John McKay: Okay. Thanks very much.

The Chair: Thank you.

Mr. McKay, I'm glad you brought up our trip to Downsview and the research we saw there. I was interested to hear how that research has been progressing as well.

Let's continue on with Mr. Alexander.

Mr. Chris Alexander (Ajax—Pickering, CPC): Thanks, Chair.

It's great to have you here, Colonel Tien. Congratulations on your achievements, especially in Afghanistan, but all through your career. You've broken a lot of ground in the most critical fields of trauma and advancing our knowledge and our practice on behalf of the Canadian Forces.

It says in your biography that you're the medical director for the Tory Regional Trauma Centre. I just want to point out to members opposite that there's no partisanship associated with that.

Voices: Oh, oh!

Mr. Chris Alexander: It's a surname.

You're also co-chair of the trauma program at the University of Toronto, and a professor. One position that I know you hold because we were there together when you took up this position—and it's not mentioned here—is that you are the Major Sir Frederick Banting Term chair in military trauma research, at Sunnybrook. That is a unique and new position that really fits into the drive that I think all Canadians are trying to see strengthened, and certainly this government is trying to see strengthened, to ensure there's innovation in this field. And what better place to do it than Sunnybrook, which I think was the first dedicated trauma unit in Canada.

Could you tell us how that position is allowing you to take some of your military experiences and bring them to clinical trials, or pursue research in a civilian setting?

Col Homer Tien: The Major Sir Frederick Banting chair is a research chair. What it allows me to do as the chairholder is to make connections with the U.S. military, our allies, with the Australians, to do collaborative research, and to fund, say, some young Canadian Forces medical officer who's interested in research that's relevant to the military. Not all trauma research is directly relevant to the military. For example, treating someone at Sunnybrook who is 65, had a drink and got into a car accident, is a completely different proposition than treating an injured Canadian Forces soldier who was blown up by an IED.

The only people who tend to be interested in that type of research are in military organizations. The chair allows me to facilitate that research, conduct the research, and help organize that research. In fact, we are conducting several large trials with the U.S., our allies, on how to better treat patients who are bleeding to death.

Mr. Chris Alexander: Thank you.

Tell us a bit about a case that became very public, which is somewhere between the two that you described. Last summer, many of us who are MPs in the GTA, and I think across Canada, followed with concern the shooting on Danzig Street, which I believe is in John McKay's riding, which led to multiple wounded and a need for triage.

I understand you were on hand at the receiving end for many of these casualties. Tell us what it looked like, as a professional, and how it compared to your military experience. It was obviously different, obviously rare, in this country, but a shooting nonetheless.

● (1600)

Col Homer Tien: And thank goodness it's rare.

It presented as a phone call about multiple casualties. As you know, information can sometimes be very scant at the very beginning. It was that anywhere from 10 to 30 patients with possible gunshot wounds might arrive at Sunnybrook. As the trauma surgeon on call that night, I drove in right away. The helpful thing, I think, is that it was actually similar to an experience in Kandahar. When you get the warning of multiple casualties, what you have to do is organize your teams and call in people. I have to say that I found my experiences in the Canadian Forces very useful, in terms of how to organize teams, how to prepare for mass casualties.

At Sunnybrook, our first priority is trauma care. All the team members were very enthusiastic. Everyone wanted to stay. Everyone wanted to participate. I like to think our teams did a very good job in moving these patients through and treating them.

Mr. Chris Alexander: No doubt. And it was no doubt thanks to your leadership.

Could you say briefly what you think lies ahead for Canada and our allies when we are looking at how to prevent and then treat blast injuries, which obviously were so central to the challenge in Afghanistan, and may well be in other conflicts?

Col Homer Tien: There are huge efforts in terms of doing research on this. What you really need is better detection, better prevention. Once you're in the blast, if you're right on the blast, there's very little that medical care can do.

From the medical side, a lot of the research focuses on the mild traumatic brain injury—what does that shock wave actually do to people?—and the rehabilitation and the chronic pain issues. Those are at the forefront now in research priorities in Canada, in the Canadian Forces Health Services, as well as for our allies.

The Chair: Thank you.

[*Translation*]

Ms. Moore, go ahead.

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you very much.

I would like to come back to the education and training of trauma health care professionals. I was a medical assistant in the armed forces, but I am also a critical care and emergency nurse. We know that not much training is provided on military bases for trauma situations. Such training is provided occasionally, but not very often.

How do you ensure that those nurses are able to react quickly and that they possess the knowledge and skills they need when they're part of a mission on the ground? We could be talking about something as simple as initiating an IV line. If nurses don't do that often or don't do it under stressful circumstances, problems may arise when they find themselves in this kind of a situation. Starting an IV should not take 15 minutes. However, if the nurses never do that kind of work, or don't do it often, it's more difficult in those conditions.

How do you ensure that health care professionals are able to react quickly in trauma situations?

[*English*]

Col Homer Tien: Thank you very much for that excellent question. I'll speak both about the medical technicians and about nursing.

You've probably heard of this thing called tactical combat casualty care. This is a system of pre-hospital care that focuses directly on what injures soldiers on the battlefield. The Canadian Forces have run several large courses to prepare medical technicians to deploy. This paradigm came out in 1996, but it was really adopted probably in 2001-2002 with the beginning of Operation Apollo.

It focuses on simple manoeuvres, such as providing a tourniquet or providing a needle decompression for a collapsed lung. In fact, IV training in the pre-hospital setting is actually frowned upon now. It's less important, because there have been some studies to suggest that giving fluid early on in the field may actually be detrimental to patients.

The medics now are trained within this new paradigm called tactical combat casualty care. Having served in the Balkans in the nineties and in Afghanistan in this decade, I have to say the medical technicians have really come into their own. They have a defined mission. They have a defined specialty. No one provides better pre-hospital trauma care than they do. We have a pretty good way of providing pre-hospital care training for the medical technicians.

The nursing staff are now using the same model the physicians are using, which is the realization that if you're going to prepare for treatment for critically injured patients, you need to see critically injured patients in your normal day-to-day activity. Nursing staff are more and more embedded in hospitals, or they're sent for what we call “maintenance of competence”. There is a program under which we send nursing staff, particularly emergency medicine nurses, critical care nurses, and OR nurses to work in civilian hospitals to provide these skills so that when they deploy, they're able to treat our soldiers.

● (1605)

[*Translation*]

Ms. Christine Moore: Thank you.

Do most nurses who are already working for the Canadian Forces have previous clinical experience in the field? Are most of them new nurses who are recent graduates? How do you balance all that?

[*English*]

Col Homer Tien: Actually I don't know the answer to that; I can get back to you. I don't know the breakdown of how many are new nurses or experienced nurses.

[*Translation*]

Ms. Christine Moore: Thank you.

We have been asked to raise the following question. Why do physicians who work for the Canadian Forces opt to leave that organization and practise in the civilian world? Have any of your colleagues left the forces and decided to go back to being civilian doctors? What reasons have you heard the most often to justify that kind of a departure?

[*English*]

Col Homer Tien: Like anything, I guess, when anyone changes their career, there are probably multiple reasons. I think the biggest cohort who leave after their obligatory service, after their training.... For example, when I joined, my goal actually was just to pay for medical school. My intention was to serve my three years. My full intention at that time was to leave the military. I actually really enjoyed my experiences, both with the units in Petawawa and then with the Canadian special forces, and I elected to stay.

It's like anything. I think some people just find that the military is not for them. Like any other job, they may find that it's not for them. Most people, I think, leave after their obligatory service if they were funded through medical school.

The Chair: Thank you. Your time has expired.

Mr. Norlock, it's your turn.

Mr. Rick Norlock (Northumberland—Quinte West, CPC): Thank you very much, Mr. Chair. Through you to the witnesses, I say thank you to them for appearing today.

I have just a few quick comments. I was watching the news some time ago when of course there was a breakthrough with regard to a double amputee from the Iraq war. You saw him walk towards the cameras on stage, as it were.

It reminded me of our trip to Downsview and the facility there. I don't know if it was there or here, but we were told that some of the great advances in medicine, particularly with regard to transplants and those types of issues, were as a result of our experience in war. It reminds me of my wife saying "*un mal pour un bien*", which means that out of something bad comes something good. Would you say that's a fairly accurate statement and that what we've learned in trauma on the battlefield can sometimes, as bad as it sounds, yield good outcomes to medical science?

Col Homer Tien: Throughout the course of a war, I think trauma care is usually advanced, because what happens is that all the trauma clinicians see a problem and they try their best to improve the care on the battlefield or at the combat support hospitals or the field hospitals. For that reason, care is usually improved during the conflict.

Mr. Rick Norlock: If I can move along to what I call cyber-medicine or something like that, I was watching a television program, and I've gone to the Minister of Health with this: there are now apps for iPhones, and in these apps, you can take an ECG at home on your iPhone and ship it to your doctor. The particular cardiologist who did that also has another app, a little device that he puts on his abdomen, and it tells him by the minute what his blood glucose is.

But surprisingly in that same interview, and I don't know if you've seen it, he says that his group is very close to commercializing it. I think there might be some application here for apps in the battlefield. That's why I'm suggesting it. It's actually being developed like a tri-corder—we've seen *Star Wars*—and they're actually developing those that take your heart rate, etc. He says that he's developing an app that will tell your iPhone when you're going to have a heart attack. A nano smaller than a grain of sand is put into the bloodstream and can detect the beginning of cells coming off the cell wall and send a signal to your iPhone, thereby sending an alarm. Then you call the doctor.

Are you aware of any studies being done by any nation—usually it's our neighbour to the south, in collaboration—that might be looking at apps that can be used in the field and that will greatly assist the medical personnel there in being able to transmit from the scene of the injury to the hospital, let's say, so they can better prepare for it? Is that being looked at?

● (1610)

Col Homer Tien: I'm not aware that it's being looked at in terms of an app. The device that we were talking about previously, the ultrasound, is a device that, if developed and if it works out in clinical trials, would be given to the medics to provide information about their clinical status that might be important in our treatment.

Mr. Rick Norlock: Thank you very much.

Do I have any time left?

The Chair: You have a minute.

Mr. Rick Norlock: We had a witness before us, Dr. Alice Aiken, who spoke about research being done to draw a relationship between mild traumatic brain injuries or concussion injuries and post-traumatic stress. Has your experience or work found any similar correlations? What do you think are some of the main contributors to developing PTSD?

Col Homer Tien: My work doesn't focus on mild traumatic brain injury or post-traumatic stress, so I can't say. It's not my area of expertise.

Mr. Rick Norlock: I know you haven't studied it, but you might be able to comment on to what degree you believe the effectiveness of the Canadian Forces' current array of PTSDs and other operational stress injury treatments...? Do you think it's important that resources be contributed to the research and institutionalization of new forms of treatment?

Col Homer Tien: In attending general NATO medical meetings my sense is that our allies greatly respect our current programs, and we're considered leaders in the world on how we manage post-traumatic stress disorder, the degree of our inclusiveness and the size of our programs.

As a researcher myself I'd always say research is great because you never have enough answers. Every time you answer something you will always come up with a new question because you can always improve care. I think research funding is always important.

My understanding of where the priorities are for Canadian Forces Health Services is that during 2006 there was a tremendous focus on acute trauma care. Certainly now in the aftermath, I believe and I see in the amount of funding—$50 million a year for mental health and an additional $11.4 million for mental health—that the focus now, rightly so, is on mental health.

The Chair: Thank you.

Monsieur Larose, s'il vous plaît.

Mr. Jean-François Larose (Repentigny, NDP): Thank you, Mr. Chair.

Being a *Star Trek* fan myself, I remember Dr. McCoy saying that we were butchers in our era. Hopefully technology can come quickly so we stop being such people.

Mr. Tarik Brahmi (Saint-Jean, NDP): That's off the record.

[*Translation*]

Mr. Jean-François Larose: Colonel Tien, congratulations on being appointed Major Banting Military Trauma Research Chair, in June 2012.

What do you hope to achieve as Major Banting Military Trauma Research Chair?

● (1615)

[*English*]

Col Homer Tien: I'm hoping to promote military trauma research. In the terms of reference for the chair, it would be to stimulate research, to conduct the research myself, and to develop collaboration with other Canadian academic centres and with our allies in conducting research important to the care of the injured in the military.

[*Translation*]

Mr. Jean-François Larose: What are the main issues you would like to address? What are the most urgent problems?

[*English*]

Col Homer Tien: Because of my background in general surgery and trauma, I know the leading cause of preventable death on the battlefield remains bleeding. My personal research interests lie in how we best treat massive bleeding, how we resuscitate, and how we stop that.

[*Translation*]

Mr. Jean-François Larose: What do you think are the advantages of a military trauma research chair?

[*English*]

Col Homer Tien: For example, if you look at civilian funding, CIHR funding in Canada, the big pillars tend to be things like cardiovascular health and cancer. Mostly because this is what kills Canadians. There's no separate pillar at CIHR in terms of trauma care or care to the injured. Because trauma is a disease that affects young people—and thank goodness, as a relative proportion of causes of death in Canada, it's not in the top three leading causes of death—it is the leading cause of young people dying.

The advantage of a military chair is that I can spend my time focusing on what injures and kills Canadian Forces members in conflict, and that justifiably is not a big priority for CIHR because that's not what kills the majority of Canadians, but for the military, trauma is what kills most soldiers.

[*Translation*]

Mr. Jean-François Larose: Exactly.

In what specific way do you think your research will be implemented in the Canadian Forces?

[*English*]

Col Homer Tien: There are two types of work that I do. I do database research and I do clinical trials. We're now actually doing a study in collaboration with the U.S. It's called the PROPPR trial. We're looking at how we can best transfuse patients who are massively bleeding. There are a lot of different ideas on the best way to transfuse patients, so we're studying those in a clinical trial.

From database research you can ask different questions, and there are lots of different databases we can use to help answer military-related questions, including the Joint Theatre Trauma Registry, and so forth.

[*Translation*]

Mr. Jean-François Larose: I am down to my last question. Earlier, you were asked if the programs in place were adequate when it came to trauma. I think you said that they were. Could certain programs be abolished if cuts were made in the Department of National Defence? I am talking about areas that are doing okay now but could not handle any additional cuts.

[*English*]

Col Homer Tien: In terms of budget cuts, it's hard for me to answer because I don't have an overview. What I will say is that during the war years, so 2006 and so forth.... It's very expensive to care for acutely injured patients. We did a study on how much it costs to look after injured Canadian soldiers in the field. It was probably threefold what it costs to treat an injured Canadian civilian here. There are budgetary savings in switching from a combat role, where we have lots of casualties, to a system now where we're really dealing with the aftermath of the war. I would assume there are some budgetary savings in terms of the money we used to spend on providing care, which was very expensive for the battlefield injured.

[*Translation*]

The Chair: Thank you very much. Your time is up.

[*English*]

Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you, Mr. Chair.

I read a couple of books, thanks to John. He brought us Dr. Ray Wiss' *FOB Doc* and *A Line in the Sand*. It's my first exposure, really, to the challenges faced by foreign operating bases, and how they would transfer patients to the Role 3.

He mentioned in his book as well, and maybe you can just expand on it a bit if it's your research, that in the first rotation he went through, when there was blood loss there was a powder that was applied to stop the bleeding that caused a lot of damage to the skin and muscle. Then there was a major change in how that was done. Maybe you could just walk us through how that happened.

It's medical research. I've been on the health committee before as well. These things take years to develop. Maybe you can just describe how that problem was identified and how you were able to come up with a better solution in such a short period of time.

● (1620)

Col Homer Tien: In fact as a disclaimer, it wasn't my research. I wish it were, but it wasn't. This was a product that was developed by the U.S. military called QuikClot. When tactical combat casualty care came about there was the development of tourniquets. If you had a traumatic injury to an extremity, to a leg or an arm, you would put on a tourniquet that would stop the blood loss. However, as you got closer to the body, to the torso, it became harder and harder to apply a tourniquet to that. So what we had was a good solution for amputations to the hand, or to the foot, or to the lower leg, but we didn't have a good solution to proximal amputations because you couldn't get a tourniquet on that. So the U.S. Army Institute for Surgical Research came up with this product called QuikClot. If you apply it to proximal bleeding where you can't put a tourniquet on, it promotes clotting.

This product was put out with the Canadian Forces as well as a method for dealing with bleeding that you couldn't stop with a tourniquet because it was too close to the body. But then problems were identified with it. When you applied it you would put it in water and it would give off heat and it would cause some mild skin burns. As a surgeon who had to clean it out I didn't find it a big problem, and personally I was much happier that a patient came in with an amputation that stopped bleeding than I was worried about a few superficial skin burns. It's always about trying to improve care to the next level. Then the next generation of product that came out was called—I forget the trade name—but it was based on a shellfish product that you would put on and it would stop bleeding as well.

The problem with that is the way it was designed: if you were bleeding a lot the product would wash out. So then a lot of U.S. companies focused a lot of effort on coming up with products that would work that would try to deal with these problems.

Obviously, because it's the U.S. military there was a huge financial incentive for these companies to do the research because if it was adopted by the U.S. Army they would order millions of these things. So there was quite a lot of progression in terms of the development of hemostatic dressings. In my role as national practice leader for trauma, we would often be asked to evaluate the product in terms of reading the studies and seeing whether we should adopt them for Canadian Forces soldiers. I wasn't involved in the actual research, in their development.

Mr. Mark Strahl: Obviously, the almighty dollar was the motivator, it sounds like, there for private companies to make that improvement.

The other thing that the doctor talked about in his book was the use of ultrasound. Has that become more common? In the ten years we were in combat mission there, did it become something that was given to the medics so that they were able to diagnose? He said there were cases where someone might look like they were the most injured, but an ultrasound would reveal they were going to be okay for a half hour whereas this other guy was bleeding out internally.

Were those upgrades made throughout the course of the mission in Afghanistan?

Col Homer Tien: They weren't. The ultrasound was given to physicians and Dr. Wiss, who I know well, is an expert and a teacher of trauma ultrasound. The reason it's not given to medics at the moment is that it requires a fair amount of training and exposure to real patients with different pathology. You can imagine the problems if someone is not familiar and they read it as having blood and there's not blood. Then it actually causes more problems. Or if you read it as a false negative when it was a positive it causes more problems. Hence, that's one of the reasons why Downsview is trying to develop an automated diagnosis program for the finding of blood.

So it was never deployed in the field for medics because of the training burden that it would imply for the med techs.

● (1625)

The Chair: Thank you, time has expired.

Just so members know, we did extend an invitation to Dr. Wiss to come and appear before committee. Unfortunately his wife passed away in December so he needs to make child care arrangements for his two kids if he's going to visit us and talk about his experience. Most of us have read *FOB Doc* and *A Line in the Sand* that he wrote while in Afghanistan.

We have time for one more question.

Monsieur Brahmi, s'il vous plaît.

[*Translation*]

Mr. Tarik Brahmi: Thank you, Mr. Chair.

Colonel Tien, thank you for your testimony. I have a question that's somewhat similar to the one my colleague asked about nurses. Nurses have to provide such assistance to injured soldiers on a daily basis. I am wondering the same thing about surgeons. You are a surgeon. I assume that, in a civilian hospital, you don't have to deal with any cases similar to those following a bomb explosion in Afghanistan.

As part of continued training for surgeons, are you sent to any other theatres of operation where Canada is not involved, but where you may come across similar types of injuries? Are there any joint programs with the American army, for instance, that would allow surgeons to come in contact with similar injuries?

[*English*]

Col Homer Tien: I wrote a paper with the U.S. and the British on how you prepare a surgeon for war. We surveyed what our allies were doing with regard to preparation for surgeons. It's very difficult to send surgeons, for training purposes, to conflicts that we're not involved in.

With regard to all of our allies, we have arrangements with civilian trauma centres. The U.S. has arrangements with Baltimore, Miami, and L.A. County. We have arrangements with various trauma centres in Canada where we work.

You're absolutely right, in that there are some differences in how you treat blast versus how you treat car accident, but the principles of some of the trauma management—how you have to stop the bleeding, how you resuscitate—are very similar.

In that same context, all the major trials that the military are interested in with regard to trauma resuscitation are actually carried out in the civilian setting. We realize that it's impossible to do these things in the military setting. The principles of bleeding and bleeding control are still the same.

[*Translation*]

Mr. Tarik Brahmi: If my understanding is correct, that would cause problems. If Canadian surgeons were sent to a country where Canada was not involved, a problem of a diplomatic, rather than medical, nature would arise .

[*English*]

Col Homer Tien: Yes, I would believe so.

[*Translation*]

Mr. Tarik Brahmi: Thank you.

Let's talk about the fact that some physicians are leaving the armed forces. You said that you were bound to serve out a three-year term. Your contract obligates you to stay with Canadian Forces for three years following your training. I have done some research, and I know that, for instance, a specialist has to stay in the French army for 12 months.

How does Canada compare with other countries?

[*English*]

Col Homer Tien: The three years actually wasn't for surgery. That was just after my medical school, as a general duty medical officer. My obligatory service for general surgery was five years.

I'm not aware of what the obligation is for different countries. We can find out for you and get back to you on that.

[*Translation*]

Mr. Tarik Brahmi: Would that be a potential solution? I know that civilian doctors frown upon the obligation to serve in a specific province.

However, could that be a solution to the problem in the armed forces? Do you feel that there is no problem in terms of retaining surgeons or physicians?

● (1630)

[*English*]

Col Homer Tien: I'm sorry, I don't understand the question.

[*Translation*]

Mr. Tarik Brahmi: In the civilian world, physicians leave certain provinces for others—and Quebec is one such example. Imposing minimum timeframes for retaining doctors is frowned upon.

Do you think there is a retention problem in the military world? Could increasing or changing the time constraints help resolve that issue, if you think there is a problem?

[*English*]

Col Homer Tien: I'm not sure if there's absolutely a retention problem. What I can speak to is that in terms of the size, if there is a retention problem, I believe it's actually improving.

I would use as a metric for that the fact that perhaps ten years ago there were huge signing bonuses for civilian physicians to join the Canadian Forces. We had an obvious problem of retention, and people were getting out. To my understanding, this has now gone by the wayside.

To me, then, that would be an indication that if there is a retention problem, it's much improved compared with ten years ago.

The Chair: Thank you. Time has expired.

Colonel Tien, I understand that the Canadian team at the Role 3 multinational medical unit in Afghanistan, which you were a part of, was recognized internationally by NATO. Could you just fill us in a little bit about the award you received and why the Canadian team was recognized?

Col Homer Tien: I'm actually a little embarrassed—I know we did receive an award—perhaps I could speak to my backbencher here, in terms of the name of the award. I know that General Bernier went to receive this, and it was in recognition of the great care that was provided at the Role 3 by the Canadian Forces Health Services. I'm embarrassed to say that I don't remember the name of it.

A voice: It was the Larrey award.

Col Homer Tien: It was the Larrey award, named for a French surgeon from Napoleonic times.

The Chair: Perfect.

On behalf of the committee, I want to thank you for your service to Canada and your service to your fellow soldiers in making sure they receive the proper care and attention in the line of duty, and for all the great work you have done and continue to do for the Canadian armed forces.

With that, we're going to suspend and invite our other witnesses up. Again, we'll try to do that as quickly as possible.

Col Homer Tien: Thank you.

The Chair: We're suspended.

● (1630)

(Pause)

● (1635)

The Chair: I'm going to bring this back to order. We're going to continue moving along.

We're joined now by Colonel Fletcher. Colonel John Fletcher is the acting chaplain general. He's joined by Major Shaun Yaskiw, who is the reserve chaplain at the directorate of chaplain operations.

I'll give you a quick background on Padre Fletcher. He first enrolled in the Canadian Forces in 1980. He got his Bachelor of Science degree from the RMC back in 1984, and was commissioned to the rank of second lieutenant. After RMC he went on, in 1987, to get a Master of Divinity degree at Trinity College at the University of Toronto, and was ordained as an Anglican deacon in the diocese of Fredericton. He went into full-time service in the Canadian Forces chaplaincy in 1989. He's been posted to Halifax and Calgary, and was promoted in November to archdeacon of the Anglican Military Ordinariate of Canada, and serves as honorary assistant in the Anglican parish of All Saints' Anglican Church Westboro in the diocese of Ottawa.

Welcome, Padre.

Welcome, Major Yaskiw.

We're looking forward to your opening comments.

Colonel John Fletcher (Acting Chaplain General, Department of National Defence)s: Thank you.

[*Translation*]

Mr. Chair and members of the committee, as it was mentioned, I am Colonel Fletcher. I currently serve as Director of Chaplaincy Strategic Support, which is essentially a chief of staff role within the Office of the Chaplain General.

[*English*]

I'm humbled to have been selected for promotion this summer, and God willing, I will assume the duties and responsibilities of chaplain general in September.

It's an honour and privilege for me to be at this hearing today as a representative of the chaplain general and of our chaplain branch. I want to thank the members of the committee for all the work you have done to study the many issues related to the care of our ill and our injured personnel. This is very important work, and your faithfulness and commitment to it, and your faithfulness and commitment to our men and women in uniform, are deeply appreciated. I sincerely hope that our presence here today will be of some assistance to you in that work.

All of our chaplains are qualified religious professionals who have been endorsed by their faith groups, recruited by the Canadian Forces, and mandated by the chaplain general to provide comprehensive religious and spiritual support, advice, and care to our men and women in uniform and to their families, and to thereby contribute to their spiritual well-being and readiness, which in turn enhance the effectiveness of the Canadian armed forces.

[*Translation*]

The chaplaincy has approximately 220 Regular Force members, and about 120 Reserve personnel. We come from over 20 different Christian denominations and represent the Jewish and Muslim faith groups, as well. Together, we are committed to providing religious and spiritual services in both official languages, and in all military settings.

[*English*]

The majority of our chaplains work at the unit level and in deploy operations. The relationship that's developed between a chaplain and the members of his or her unit can be profound, spiritually intense, and from our perspective, always deeply privileged.

● (1640)

[*Translation*]

Our reserve chaplains provide a critical connection between our reservists and the diverse support programs available to them. As trusted faith group leaders within their local communities, and as trained military chaplains, reserve chaplains act as advocates and helping professionals in times of joy and sorrow alike.

[*English*]

Our chaplaincy is recognized internationally for its leadership in multi-faith approaches to military chaplaincy, and we're committed to developing and expanding this expertise.

All of our chaplains are expected to provide a comprehensive ministry by facilitating and accommodating the religious beliefs and spirituality of those entrusted to their care, without compromising our own theological beliefs and without imposing our own religious doctrine or practice on others.

[*Translation*]

All of our chaplains are professionally trained to the master's degree level, and in some cases of specialization, beyond that level. We are experienced in spiritual leadership within our own faith groups, and we remain professionally accountable to those faith groups, throughout our military service.

[*English*]

In addition to providing ministry on our unit lines, duty chaplains respond to after-hours emergency calls and provide vital spiritual support and referrals, 24 hours a day, seven days a week. Reserve chaplains provide pastoral care and support to military personnel and their families in parts of our country where there are no regular force assets.

Over the past decade, our military has expanded and enriched its programs aimed at preventing, identifying, and treating mental health issues, and supporting those who face them. Strategically, the chaplaincy supports these programs by employing chaplains in key areas, such as the Landstuhl Regional Medical Center, in Germany, and as part of our third location decompression teams.

Selected chaplains pursue advanced studies in pastoral counselling, equipping them for work as chaplain clinicians within the multidisciplinary care teams serving our operational trauma stress support centres. At the tactical level, chaplains have also been assigned to work closely with the new joint personnel support units and integrated personnel support centres in order to provide care to our injured personnel, and to support the staff of these units in an effort to help mitigate the effects of compassion fatigue and caregiver burnout.

When any one member of our community is hurt, all of us share in the pain. When one member of our community is able to find healing, our entire community finds healing. Part of the woundedness experienced by our soldiers, sailors, and air force personnel is spiritual in nature, and part of their healing is also spiritual.

Working alongside our partners in the mental health community under the direction and leadership of a caring and committed chain of command, and with your support and engagement, we are making a profound difference in the lives of those who have been injured while serving our nation in uniform.

I am grateful for this opportunity to speak with you about the important work that we, as chaplains, do each and every day to support our ill and injured personnel and their families.

If I may beg your indulgence to take just another moment, I would like to acknowledge the other chaplains who are with us today. At the table with me, of course, is Major Shaun Yaskiw. Shaun is a reserve chaplain, an ordained minister in the United Church of Canada. Shaun is the member of our staff who is responsible for reserve and cadet chaplaincy. He has a very unique experience and perspective to share.

Also with us today in a supporting role, we have Lieutenant-Colonel Barbara Putnam, who is a Baptist pastor and the deputy director of chaplaincy services, responsible for chaplain recruiting, education, training, and policy. And last, but not least, is Lieutenant-Colonel Andre Gauthier, who is a Roman Catholic pastoral associate and our deputy director of chaplain operations. Andre is also a trained specialist in pastoral counselling. Prior to joining our staff just last month, he was employed in the trauma stress clinic in Valcartier.

All three of these chaplains are veterans of our mission in Afghanistan. They are extremely experienced and capable chaplain leaders. I'm blessed to have them as part of my staff, and grateful for their presence with us today.

Thank you.

● (1645)

The Chair: Thank you very much, Colonel.

I think it is important that we have you here as witnesses. We've talked about the physical injuries, and we're talking about the mental health stresses, the operational stress injuries that have occurred in the field, and of course there is the spiritual healing that has to occur as well. It's great to have you here as witnesses.

Mr. Harris, you can kick us off with five minutes.

Mr. Jack Harris: Thank you, Chair.

Thanks to both of you for joining us and to your colleagues who have joined as support in identifying the range of services provided. Of course, ill and injured soldiers need spiritual care, as well as physical and mental health care, and thank you for that.

I know that part of your role is that of advocate, and I know that in many cases the chaplain is the first point of call. We've heard a number of times that particularly the people suffering psychological injury are afraid to come forward. They're concerned about their career, about it being a career-ending move, etc., so you and your colleagues are the first point of call. I understand that it would be a difficult situation for you to be in, so I'd like you to comment on that, your role there, and how you get them to get the help they need.

Second, we just heard from Colonel Tien that in studies of deaths in the military over the past 20 years, suicide is I think in the top four. It's very obviously a concern as the cause of death for anyone, and it would be particularly so for faith-based professionals such as yourselves in terms of understanding the despair involved. I'm just wondering whether you share the same concern about the level of suicide amongst our forces.

Also, what needs to be done to improve the situation? What more care do they need? What more attention do they need? What more help do they need?

Col John Fletcher: Thank you.

It is my understanding, even though as indicated the number of suicides is one of the leading causes of death within the Canadian Forces, that statistically the number of suicides in our population isn't drastically different from that across the country. That said—

Mr. Jack Harris: If I may interrupt, we have heard of cases where people have tried three, four, and five times and then have succeeded, so they do identify sometimes pretty early.

Col John Fletcher: Absolutely, and every instance in which someone is experiencing that level of despair, cannot see another way out, and opts for that as the solution to end their pain is tragic. Across the nation and across our Canadian Forces, anything that we can do to take away the stigma of mental pain, mental anguish, needs to be done.

Certainly, our chaplains, our front-line workers in dealing with military personnel who are suffering any kind of trauma or family crisis, ask how we can assist them in accessing the care that might be available to them, that they might need to mitigate those circumstances, and that they might find to be a more healthy outcome and a more positive outcome to their problems.

Mr. Jack Harris: Are you satisfied with the help they get?

Col John Fletcher: I'm very satisfied that the help is there for them. What troubles me is that, despite very strong efforts on the leadership's part and on the part of peer support, there still remains stigma.

People are afraid to acknowledge their hurt and their need for assistance, so anything that we can do to help encourage them.... We do that primarily by establishing a relationship with them first. Our chaplains are deployed at the unit level, so they're working with these personnel day in and day out. They try to get to know them and to be known by them.

When they're struggling with an issue, it's very difficult for them to leave unit lines, walk across, go into a mental health clinic or a doctor's office, and acknowledge that they have those challenges. That first step is challenging for them. Coming to their chaplain in the unit, whom they know and they work with, is an easier first step. That chaplain often is doing some triage work. You're helping them to see that sharing that concern with the chaplain didn't make it worse and that sharing it with the other caregiving professionals won't make it worse either.

We accompany them. We help to bridge them in their need, to meet them in their need, and we bridge them to the resources that are available to them. Sadly, we are not successful in every instance. Sadly, there are cases where that doesn't happen. We have to continue to strive to make people aware of the resources that are there, to help them find the ability to acknowledge their pain, to seek out the care that is there for them, and to journey with them through that.

● (1650)

The Chair: Thank you.

Mr. Opitz, it's your turn.

Mr. Ted Opitz (Etobicoke Centre, CPC): Thank you, Chair.

Padre, it's delightful to have you here today. Padre and I served in LFCA headquarters together back in the day. I know the challenges you faced there, including some of those godless, soulless people we refer to as engineers.

Some hon. members: Oh, oh!

Mr. Ted Opitz: They're best treated with holy water and a cross.

Thank you so much for being here. I truly know the challenges you face. On a serious note, I know how hard it is to deal with a lot of the troops, especially through all the deployments you've been on, and through the early years especially, as we got into Bosnia, which were some of the more challenging years.

Padre, for the sake of the committee, what is the role of the chaplain? How do you support our men and women in uniform? You might want to describe the chaplaincy on each base—because there's a lot of work to do on each base—whether you're deployed, and especially for the rear party. Speaking of the rear party, what are some of the challenges you face, being among those first approaching the families and notifying them of a fatality? Can you talk about some of those issues?

Col John Fletcher: We're structured as teams—that's key—and not just chaplain teams that are multi-confessional, multi-faith ecumenical teams, but interdisciplinary teams. We work hand in hand with the chain of command, which has the responsibility to care for our men and women in uniform, and all aspects of that care, including their spiritual well-being. We're a primary resource for assisting commanders to do that. We work alongside the medical care professionals, the family resource centres, etc. There is a thorough team approach to how chaplain services are structured at the tactical level on our bases and in deployed settings.

You touch on a really significant issue. Obviously, when chaplains prepare and deploy into theatre with our troops, there's a focus on the unique aspects of that deployed ministry we train them for, equip them for, and support them in.

Another whole side of this equation stays on the home front, and those are the families who worry day and night. Every time there's a story on the news or a death or an injury in theatre, that happens to every one of those families, in a sense. They're all caught up in that. I've often felt that, as challenging as the work is for the chaplains who are deployed in theatre, those who are accompanying the families and supporting them on the home front are sometimes even more challenged.

You are absolutely right that chaplains have an integral role to play in one of the most awful parts of this occupation, and that's joining an officer to go to the door, to the home of a family who has lost a son or daughter, husband or wife. To be with the notification officer at that point, as well as with the family, as we begin to deal with the terrible grief and pain and loss is sacred work, demanding work. We wish we didn't ever have to do it, but we know that our presence there can make a difference, and we seek to do that well.

Mr. Ted Opitz: What are your goals, what do you want to accomplish when you take command of the branch?

Col John Fletcher: We have a chaplain strategy that was signed off, approved by Armed Forces Council in 2008, and the follow-on campaign plan was approved in 2010. Our goal is laid out to prosecute that plan moving forward. It's about ensuring that we have an operationally effective chaplaincy, a learning chaplaincy, and a calling of choice.

There are about 22 different projects in that campaign plan. As parting gifts, we brought each of you a copy of our road map for how we want to continue to make our chaplaincy one that is noted for excellence in multi-faith work and in operational effectiveness.

As chaplain general, it will be my intent to continue to resource and prosecute that plan to make a strong chaplaincy for our Canadian Forces.

● (1655)

The Chair: Thank you. The time is up.

Mr. McKay.

Hon. John McKay: Thank you, Chair.

I learned something from Mr. Opitz' question. I thought that godlessness and soullessness were limited to the legal profession.

The Chair: You have company now.

Hon. John McKay: It's frequently said, or at least it used to be said, that there are no atheists in foxholes, yet our society is coming to have a far greater percentage of non-believers or of those simply not interested in matters religious.

I'll ask this question in a provocative way in a sense. Is there a percentage of our soldiers who see you as a chaplain, a religious person, as a barrier as opposed to assistance?

Col John Fletcher: I would think that there probably is a percentage of folks who might see that as a barrier.

Anecdotally, when I was a seagoing chaplain there was a tradition in the Canadian navy and in the Royal Navy where chaplains didn't wear rank at sea because it was seen that the rank itself might become a barrier for the sailors to seek the chaplain out as somebody who could be of support to them. I never felt any concern about taking the rank down because in our professional military there is a great rapport and working relationship among all ranks. There is a team approach.

There are obviously differences in responsibility, and job, and so forth, but I never saw the rank as the barrier. I saw the cross that I wore and the collar that I wore.... Because, you're right, there are a good number of folks in our culture and society for whom religious leaders, people who have a leadership role within organized religion, are seen somehow as distant or out of touch or even worse. There might be pain or injury that was caused in an individual's life by organized religion, judgment felt, and so forth.

Trying to overcome those barriers is an important part of what every chaplain needs to do when they're assigned to a unit, and it really does start by meeting them on their turf, journeying with them, getting to know them, and developing a relationship. I can honestly say that while not every soldier, sailor, airman, or airwoman in the forces.... In fact, the vast majority of them do not go to church or synagogue or mosque on any kind of regular basis, but they know who their padre is. They know how their padre can be a source of help to them, an encouragement to them, and the issues that they might identify they would never identify as being religious issues. They might not even use the term “spiritual issues”, but there is a spiritual dimension to those concerns.

Hon. John McKay: I noticed the warmth with which Mr. Opitz greeted you. It is true that everybody knows the padre even if they think he's from some wacko religious place.

In some respects, you transcend rank, whether it's taking off the rank and mixing with sailors on a ship, which is probably the most obvious way, but I would imagine, though I don't know, that from time to time that creates its own level of difficulties. You see the chain of command ordering so-and-so to do whatever so-and-so is supposed to do and you know the story behind so-and-so. How do you handle that? To me, that seems a unique challenge of a military chaplain.

● (1700)

Col John Fletcher: Command is a lonely place. The CO of a unit is often the loneliest person in the unit because they're the one at the top of that pyramid making the decisions. They have a strong team of advisers around them and usually a senior NCM who is very close in that command team relationship, but it can be a lonely place.

A chaplain needs to figure out a way to establish a relationship with the commander as well as with the lowest rank. One of the difficult things that new chaplains in a unit sometimes fall into the trap of doing is believing that the job is somehow to save the poor soldier from the evil chain of command, and they will try to convince us that's our role, but what you learn as you begin to work with the leadership at every level, from the master corporal right on up to the colonel, is that they actually do care about the well-being of those they are leading and you're one of the resources who helps them to do that even more effectively because you become a barometer, in some senses, for how the unit is doing. You can become a trusted confidante of people at different rank levels, but it takes work and it takes time, and everyone will stumble and fall once or twice.

The Chair: Thank you. Time has expired.

Mr. Chisu, I'll give you a chance to defend yourself from Mr. Opitz.

Voices: Oh, oh!

Mr. Corneliu Chisu (Pickering—Scarborough East, CPC): Thank you very much.

I will not use the same kind of qualification. As an infantry officer, he's doing his job very well. We are opening the way for him to be able to fight.

Thank you very much, Padre, for coming to our committee. I appreciate it.

First of all, I would like to commend you on the work you are doing in the forces. From my experience in setting up Meaford base, I saw that for a lot of young soldiers, if they had a problem they went first to the padre. That is a very important thing. Before going to anybody else, they went with their problems, with their issues, to the padre. So I think the padre has a very important role in serving the men and women in uniform.

With respect to your providing spiritual and multi-faith religious support to Canadian Forces personnel and their families, what would you say are the main needs of forces personnel and their families? I am putting this in two contexts. First, on the base, young military members go through the training phase, and they can have familial problems, etc., on the base. As well, what are the problems they can face when they are deployed overseas?

I note that especially Kandahar, in Afghanistan, was giving a specific new dimension to the conflict and also to your role in terms of the loss of soldiers' lives. The soldiers were losing their buddies, the families were losing people, and so on.

Here I just want to commend somebody from your branch, someone I know very well, and that's Captain Phil Ralph. He is one of the founders of Wounded Warriors. I need to mention this, because he didn't stop only at one side in providing counselling; he went a step forward in providing assistance after injuries, taking care of the wounded warriors.

Col John Fletcher: Thank you very much.

One of the things I think we need most, in order to tackle the challenges that are before us as a military community, is a sense of community. It's hard to achieve that. It's harder today, perhaps, than when we had bases where everybody was posted. There were some downsides to that, too. You had no privacy, in a sense.

I think the biggest risk, whether you're a soldier who's deployed or a family member on the home front, is isolation, isolating yourself from resources that are there to support you. I think it needs to be the full suite—the family, other members of the unit, the family resource centre, faith communities, etc. I think whatever problem we're facing becomes less daunting when we engage with others to tackle it together.

How do you build community when people are naturally separating themselves from one another and living in a more isolated and perhaps more virtual context? Maybe we need to focus on how to leverage virtual technology to bind people together even more powerfully than we've done in the past.

Community—togetherness—is the most essential element, I believe, to tackling the challenges that the military will face moving forward.

● (1705)

Mr. Corneliu Chisu: Do chaplains have a mandate to assist family members who are suffering mostly from mental illness and so on? Perhaps you can elaborate on that.

Col John Fletcher: Yes, we do. We're the only military occupation that actually has a mandated role to provide services to family members. There are some unique differences with families who are posted to Europe or outside of the country, where other occupations also have a mandate to provide services, but universally it is a dimension of the chaplain's role to provide services to family members.

It's a big percentage of the effort that we bring, both in terms of the rear party work during a deployment and in terms of our chapel communities, participating in supporting programs of the family resource centres, etc. It's an important part of what we do, and a part of our calling that we value and believe is part of strengthening the Canadian Forces as a whole.

The Chair: Thank you. Time has expired.

[*Translation*]

Ms. Moore, you're up.

Ms. Christine Moore: I would like to begin with a question about recruitment. We know that it's generally very difficult to recruit priests, even in the civilian world. They are aging. We had to resort to immigration in my riding. Oddly enough, the Congo helped us out by sending us priests for a three-year period.

How is recruitment done? Generally, it's difficult to recruit new blood in that profession.

Could you tell us more specifically about the role women play in the Canadian Forces chaplaincy? In some religious faiths, women cannot play the same role as men. What specific role do they play? Are they limited? How are they perceived in those services?

[*English*]

Col John Fletcher: Thank you very much.

[*Translation*]

Recruitment remains one of our biggest challenges. It's not necessarily a matter of available candidates in Canada; it's a matter of age.

[*English*]

We are finding that in most of the seminaries, for example, across Canada, the average age of theological students is much higher today than it was two decades ago. So having folks who would be available and able to come and have a career as a military chaplain is a challenge.

There are certainly difficulties when it comes to finding Roman Catholic priests. You're absolutely right: we have a real shortage everywhere in Canada. One of the things our chaplaincy has done to address that is to employ Roman Catholic pastoral associates. Padre Gauthier who is with us here today is now ordained as a deacon. He started as a pastoral associate and is now a deacon. We employ lay chaplains in the Roman Catholic chaplaincy, and a good number of our lay chaplains in the Roman Catholic chaplaincy are women.

We have women chaplains from many different denominations, and we even had a female rabbi serving with us for a period of time. She's reached retirement age and is no longer in the service. There are no limitations to their employment. Our female chaplains can serve in any unit, in any place, and at any rank level, just as the other chaplains.

● (1710)

[*Translation*]

Ms. Christine Moore: Are their limitations only those imposed by their religion?

[*English*]

Col John Fletcher: That's correct. Certainly every one of our chaplains belongs to a faith group and we are accountable to that faith group for our mandate and our licence to exercise ministry. So while a female chaplain from the Roman Catholic church can exercise the military role of a chaplain in providing care and counsel, and in deploying and providing spiritual support to military members, the church does not permit a female member of the Roman Catholic church to be ordained or to exercise the sacraments of the church. So any limitation that would be imposed upon them by virtue of their gender is imposed by the limitations of their faith community and not by the chaplaincy.

[*Translation*]

Ms. Christine Moore: If my understanding is correct, chaplains are supposed to follow the rules imposed by the Canadian Forces and those imposed by their faith.

[*English*]

Col John Fletcher: That's correct. It's written somewhere in a holy book that you can't serve two masters, but every one of our chaplains needs to. They belong to a religious tradition that has licensed them to serve in this capacity, and they remain accountable to that religious authority. But they also belong in the military. The vast majority of the work that chaplains do can be done by any chaplain. It's about accompaniment and care and counsel.

We do perform sacramental ministries and those sorts of things for the families who wish to have those, but the lion's share, the largest part of what the role of a chaplain is, can be done by any one of our chaplains.

The Chair: Thank you.

Before I give the last question to Mr. Alexander, I want to ask one question myself.

Can you talk a little, Colonel, about the grief counselling and the bereavement services offered by the chaplains in theatre and also back in the units? Often parts of units are deployed. If a fatality has occurred, what happens with the members of that unit in theatre and in offering chaplaincy services, and also what happens back home for the families but also for all the other members in the unit?

Col John Fletcher: Certainly in theatre a multidisciplinary care team is deployed. In addition to chaplain counsel there would be other resources as well, mental health nurses, etc. We do have resources in theatre that can be brought to bear to address whatever counselling needs might present themselves for the peers, for soldiers who have lost their mates.

On the home front, clearly the chaplain assigned to a family at the time will remain with that family and journey with them for weeks and maybe even months and get them to a point where we can bridge that care maybe to a civilian parish and other long-term counselling services that may be available in their community or through the Family Resource Centre.

One of the initiatives the Canadian Forces have adopted is something called Shoulder to Shoulder, which is about our enduring commitment to provide ongoing grief counselling to the families of our fallen. That involves the director of quality of life, and the military family services program. There is a 1-800 number. Essentially we want to ensure that none of those families is left without someone to call and to care and to respond to their need. You'll never take away the pain from that loss, but ideally you get them to a point where they can bear that pain with the support that's around them, and move forward.

The Chair: Thank you.

Mr. Alexander, the last question is for you.

● (1715)

Mr. Chris Alexander: Thank you, Chair.

I was just told that the vote may be deferred.

The Chair: The bells are not ringing yet, so keep talking.

Might it be deferred?

Mr. Chris Alexander: It's deferred for 30 minutes so we might have a few more minutes, if you permit, Chair.

The Chair: We're supposed to be here until 5:30, so keep going.

Mr. Chris Alexander: Okay.

Colonel, thanks to you and your team for this session. It really is hugely important to our study.

You have a unique take on the recovery process of the ill and the injured. I'm going to give you a double- or a triple-barrelled question here, but you mentioned that the woundedness of those who are injured is partly spiritual. Tell us about the spiritual side of healing in your experience. This would be subjective, I'm sure. Is it a leading indicator, a lagging indicator? Is it something that goes alongside physical recovery? Give us a bit of perspective on that.

Second, our Canadian Forces go into operations, deployments, with excellent morale rooted in their values, rooted in their faith in many cases. How do they come back with those values and that faith when they are ill and injured?

I've certainly heard stories, which tend to be the ones that come to the fore, where the spiritual side of the person who is a victim of an attack has been deepened, but you have a much broader experience. I'd love to hear your perspective.

Finally, you mentioned the commitment to diversity. We all celebrate it in your service and your branch. I come from a very diverse riding. Many of us around the table do. Do we have Orthodox priests? Are we looking at Hindu pandits, Buddhist monks? Do we have diversity among the Muslim representatives of the chaplaincy at the moment, Shia, Sunni etc.?

I know that wasn't one question, Chair, but I think we might have a little more time.

Col John Fletcher: We might have to stay after school.

Voices: Oh, oh!

Col John Fletcher: You may need to refresh my memory on these three points, but I want to go back to the first one you mentioned about a lagging or leading indicator for physical healing and spiritual healing. I think you see both.

In some instances, you will see people whose physical scars and wounds heal quickly, while the spiritual, emotional, and psychological pain will rest with them for years. Others will seem to come to a peace with things spiritually and psychologically sooner, and that actually often affects how they address their physical wounds. You see some of the courage of our amputees, and that comes from a deep place. I don't think they can get there until they've dealt with some of those spiritual questions. I think it's a bit of both.

Mr. Chris Alexander: Values, then...?

Col John Fletcher: Yes, values.

Mr. Chris Alexander: And faith among them...?

Col John Fletcher: I agree with you. I think that for a number of people their faith becomes shattered by these experiences. Other people come back deepened, deepened in a belief and commitment that what they were engaged in was of incredible value and that they made a significant difference. Others will come back having lost their sense of God. On that spectrum, it's pretty tough to know what might have caused that divergence of opinion. The important piece, from our perspective, is to meet them wherever they're at on that spectrum and to help them wrestle with the consequences and the questions involved in where they're at.

I've always said that for a chaplain the spiritual agenda is never ours. It is that of the soldier, the sailor, the airman, or the airwoman who we're dealing with, or the family member, and our job is to meet them where they're at and to journey with them on a spiritual journey that is properly their own, giving them all the support and resources we can to accomplish that.

Regarding the question of diversity, yes, we do have an Orthodox chaplain in the chaplaincy, and I believe we're recruiting another one this year. We have I think three Muslim chaplains at the moment; they're all Sunni. The Muslim member of the interfaith committee, which is a civilian credentialing committee that has a statement of understanding with the minister, is able to endorse Shiite Muslims as well, if one were to apply and be accepted for service.

Essentially, there are 11 members on that body, that interfaith committee, and collectively they represent some 60 different faith groups and denominations in Canada. That, according to the 2001 statistics from Statistics Canada, would represent about 74% of the Canadian population. There are groups that don't have representation there yet, but we have not had applications from those groups.

I don't know where the diversity will go in the future. We certainly have policies and protocols by which we would handle applications for endorsement and potential recruitment from other faith groups. I expect that some of that increasing diversity may manifest itself more quickly within our reserve communities than in the regular force, because we have a greater level of diversity in our reserve community as well.

● (1720)

The Chair: Thank you.

Just to follow up a little, what about first nations and other aboriginal groups? Do they have spiritual leaders, elders, who are serving in the chaplaincy?

Col John Fletcher: They don't.

We have aboriginal chaplains within the chaplaincy, but they're Christian clergy. A fair bit of time was spent with aboriginal elders to sort out how we would address traditional aboriginal spiritual needs. The determination was that to pursue having uniformed spiritual elders was not the option that was preferred.

What was created was an organization or a body that is in effect similar to the interfaith committee. It's called the Elders Council of Fire. Essentially, it becomes a body through which we would be able to source spiritual elders across the country. The policy framework for the Elders Council of Fire is there. We have not operationalized that as yet. How it works right now is that the chaplain becomes the point of contact for enabling aboriginal members to identify a desire or a requirement for elders services. We seek to provide those services in a way that's appropriate, because one size doesn't fit all, and the traditions are quite distinct. We journey with the aboriginal members to seek to identify those resources and facilitate access to them as best we can.

The Chair: Thank you.

Monsieur Larose.

Mr. Jack Harris: May I ask one question?

The Chair: If Monsieur Larose wants you to go first, he can pass it on.

Mr. Jean-François Larose: Sure. I can share my time. That's fine.

Mr. Jack Harris: Chair, there is one question has occurred to me.

Who looks after you folks? You have a tough job. It has to be very challenging. You deal with trauma. You deal with all of this pain and suffering. Who looks after the chaplaincy and members? You are soldiers too.

Col John Fletcher: Thank you very much.

What I identified earlier as what I think is crucial to our successful management of the challenges before us, being rooted in community, is true for us as well. Chaplains need to remain well rooted and grounded within their own faith tradition. They need to maintain a healthy prayer and spiritual life. They need to be part of multiple teams. There's a fair bit of support that we can get from our colleague chaplains and our colleagues in the other disciplines we work alongside.

It's easy for us to say to a soldier that they shouldn't be reticent to ask for help, but sometimes we're the last ones to ask for help ourselves. We need to work at fostering a sense amongst our own profession that seeking help is the right thing when we need it. Many of our chaplains have spiritual directors. Members of the ICCMC, these civilian faith group leaders, who are endorsing representatives and are our links back to our faith groups, provide a fair bit of care and counsel to us as well.

We have a whole suite of possibilities. One of the projects in the campaign plan I was mentioning a while back is to develop policies and procedures for providing specialized chaplain care. I don't actually have to turn to another military chaplain to get counsel that I ought to have, there's maybe a civilian chaplain I can go to. We're trying to nail down how best to meet the needs in ways that would be faith-group specific and appropriate, and to ensure our chaplains are not falling through the cracks and are receiving the care that they so ably provide.

● (1725)

The Chair: Monsieur Larose.

[*Translation*]

Mr. Jean-François Larose: I had the same question as Mr. Harris.

I will use this opportunity to conclude by saying that I was also a reservist. We see that faith is being questioned in our society. Our military members—reservists and regular members of the Canadian Forces—are going through extremely difficult times. I want to thank you for the work you are doing. We often talk about physical and mental illnesses, but I think that, spiritually, questioning must occur in very critical situations. Your work is more than necessary.

I am glad to see changes in the support you provide to men and women, and your interest in considering all faiths and spiritual denominations.

Do you have anything to add?

[*English*]

Col John Fletcher: I will turn the question to Padre Yaskiw to answer that. As I mentioned, he's the only member of our staff in the headquarters who is a reservist. He brings a unique perspective to some of the challenges reservists often face that we regular force people take for granted.

I appreciate your comments, and I'll turn the mike over to Shaun.

Major Shaun Yaskiw (Reserve Chaplain, Directorate of Chaplain Operations, Department of National Defence): Thank you, Padre.

Certainly one of our ongoing roles and ongoing challenges is how we help foster community. Padre Fletcher mentioned that earlier.

Establishing, maintaining, and nurturing community within the reserve has its own unique dimension. Certainly reserve chaplains are themselves situated within their own civilian communities. They have a unique role as that intersection point within many of our smaller communities, which may have limited resources, whether those are health care resources, mental health resources, social support networks. Often it's the local parish priest, or in many places in Quebec right now, it's the school chaplain or school counsellor, who may also be a reserve chaplain. They are that focal point, around which they intentionally try to build community.

It's something we are intentionally trying to do within the reserve. How do we give reserve chaplains the tools, the resources, necessary to be able to do, in that context, what they do quite naturally in their civilian lives? That is, again, to help establish and nurture community, to meet the specific needs of those reservists and their families who may feel isolated. When isolation grows, along with isolation grows despair. It's that loss of hope that we're continually trying to work against, to help people, wherever they are in their spiritual journey, find places of hope and meaning where that's been damaged.

The Chair: Thank you. Your time has expired.

We have time for one question from Mr. Norlock.

Mr. Rick Norlock: Thank you very much, Mr. Chair.

Through you to the witnesses, thank you for attending today.

Exposure, for most people, to what chaplains do comes from *M*A*S*H*. I can remember Father Mulcahy and a lot of the things he did.

Hon. John McKay: You're dating yourself.

Mr. Rick Norlock: They are reruns.

The question was whether you are serving other faiths. If I remember correctly, having spoken to some of the chaplains in Trenton, you are fully capable of conducting.... A Roman Catholic priest might perhaps know, because it's so close, the Anglican faith. And the United Church minister would know a Lutheran service or have a connection. So I want to thank you for that. I know you answered that partly.

I have a couple of really quick questions, because time is running short.

In times of need, even people who really don't believe in God sometimes—I'm told—go to see a chaplain because they just need a shoulder in order to express their isolation and despair, or they just need somebody to talk to who they know won't rebuff them because they don't believe. They know they will receive a welcoming ear. I wonder if you could talk about that as well as about your methodology in dealing with the isolation, loneliness, and despair, and talk about some of the mechanics.

By the way, I understand fully, having done 30 years of police work, how terrible it is when you have to tell somebody that someone really close—a son, daughter, or father—has died in a traffic accident, and when you're a young officer it really does help when you have the local priest or minister there to do that.

● (1730)

Col John Fletcher: You are absolutely right. A good chunk of folks who come to see us aren't coming because they have what they would identify in any way as being a religious question or a spiritual question. They're coming because they see the chaplain as an easy resource to access, because the chaplain is where they are. They don't actually have to go to a medical clinic or to the chapel even to find the chaplain, because the chaplain is in their unit lines. Seeking the chaplain out and having that first conversation there is just easier for people to do, and we hope to then make it easier to get them to a resource that might be more appropriate.

One of the important things for every chaplain to know is the limit of their competency and ability to care. I have to know when somebody needs something that I can't provide, and my job is to not just send them there but to actually take them there and to journey with them. That's vital.

We also do some of what Father Mulcahy did. We might call a bingo game or do that sort of thing as well.

With regard to isolation, I've often said that I get paid to have coffee. Chaplains wander around. We spend a lot of time, kind of like a beat cop, in a sense. We wander. We loiter with intent.

Some hon. members: Oh, oh!

Col John Fletcher: That could be dangerous. But we seek people out and we ask them those questions. You might have to ask them two or three times, “How are you doing?” Because the first time you'll just get the answer. You look them in the eye, and you spend time connecting with them. You will identify folks who have retreated into themselves, who have maybe just got something on their heart or their mind that has shut them down a bit or cut them off a bit. We encourage buddy care—to go out and do that among themselves.

Asking tough questions or heartfelt questions can be tough, but it's better than not asking the question, even if it's, “Are you thinking of killing yourself or doing harm to yourself?” We're afraid to ask that question, because we think we might give somebody the idea to do it. You never will, but you might give them permission to really say what's going on.

It's old-fashioned wandering around and meeting people and spending time with them that will overcome a good deal of that sense of isolation and will build community. I don't think there's any shortcut to that.

The Chair: Thank you.

Our time has expired. It's been a very interesting meeting.

I want to thank all of you, as padres, for the service you are providing to the members of the Canadian Forces and to their families. You are a blessing to everyone who serves this nation as members of our military. I want to thank you for that as you continue on with your good works.

Col John Fletcher: Thank you very much.

The Chair: With that, I'll entertain a motion to adjourn.

An hon. member: I so move.

The Chair: The meeting is adjourned. We're out of here.