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Chair

Mr. James Bezan

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● (1530)

[*English*]

The Chair (Mr. James Bezan (Selkirk—Interlake, CPC)): Good afternoon, everyone. We're going to call this meeting to order. We're at meeting number 77. We're going to continue with our study of the care of ill and injured Canadian Forces members.

Joining us for the first hour is Major Ray Wiss from the Canadian Forces Health Services. I think a lot of us are familiar with Major Wiss as an author, but he's also an emergency medicine specialist from Sudbury and a member of the Reserve Force.

In 2008, he was awarded the YMCA Peace Medal and the Ontario Medical Association Distinguished Service Award. In 2010 he received the Rotary Club's Paul Harris Award. He has been selected as the keynote speaker at the North York General Hospital Emergency Medicine Update. He's been one of our premier emergency medicine physicians and has been at a number of conferences speaking about his books, *FOB DOC* and *A Line in the Sand*, which I know a number of you have already read.

I want to welcome you, Major Wiss, to committee and extend to you our gratitude for your service to Canada. We also want to thank you for sharing the stories you have put in your books. One of the reasons we wanted to have you here today is to talk about your experience in Afghanistan and, more important, how we deal with a trauma at the front lines.

With that, I welcome you to bring your opening remarks.

Major Ray Wiss (Canadian Forces Health Services, As an Individual): Thank you very much.

Mr. Chair, members of the committee, thank you very much for having me. It is truly an honour to be here.

I'm going to talk to you about my time as a forward operating base doctor in Afghanistan. My time there, as you know, was very atypical medicine. I spent almost all my time in the combat area, a place where physicians almost never go.

I worked at the forward operating bases where living conditions could be fairly spartan and somewhat hazardous. Our FOBs were quite heavily attacked—including this one, which was the most heavily attacked in all of Afghanistan, setting a record one day with 19 rocket attacks in 24 hours.

This is the army's equivalent of an 18-wheeler. You get an idea of the size of blast that these rockets create when they hit. The shrapnel, the metal fragments thrown off from the blast, are lethal to a much greater distance.

Down in this corner, we had what's called a shower can. That's a sea container that has a hot water heater and some shower stalls inside. When that rocket hit, two of the shrapnel fragments tore through the multiple layers of metal around this shower and decapitated an Afghan soldier who'd been showering there, killing him pretty much instantly.

Because of that, a lot of Canadian soldiers who served at this FOB would refuse to shower in that stall. I made it a point to always shower there, because I figured that the odds of somebody else getting killed in exactly the same place had to be very low.

These are the people who did the shooting. These are Taliban soldiers with their favoured weapons. First there's the AK-47 rifle.

I should warn you, at this point, that I am showing you what it's like to be a doctor at war, so some of these images are fairly graphic.

This is an entry wound where an AK-47 bullet has gone into the body. These high-powered rounds create exit wounds that are much bigger, where the bullet comes out with a great amount of damage, probably lethal in the chest or abdomen.

This is an exit wound in an arm, an explosion of bone and tissue out the arm. If you look inside, you can see that the bones and probably the nerves and blood vessels are shattered. It would be very difficult to salvage this limb.

The other favoured weapon of the Taliban is the rocket-propelled grenade, or RPG. This is a small missile. It has a range of about 800 metres, with a little rocket motor there. It has pretty good punch, and will fill the air with small shrapnel fragments, like the ones that hit this Canadian soldier here. He was serving at this FOB right on the edge of the desert in this guard tower, standing pretty much exactly where I'm standing, manning the light machine gun that we all took turns manning to guard the approaches to the FOB. There used to be a beam here. The RPG round came in, detonated here, and showered him with fragments.

The first step to good patient care is not getting hurt. If you look at his chest, and especially here, in the death box—the heart and the great blood vessels where you will bleed out within a minute if you're hit—he has no marks, because he's wearing not just his kevlar vest, but also, right here, there's a metal bulletproof plate, front and back, that will stop an AK-47 round.

You also notice that he has no wounds from his eyes on up, because he's wearing not only his helmet but also his ballistic glasses. These are hardened plastic that will stop these shrapnel fragments from damaging the very vulnerable eye.

Now, you have to understand that these are direct-fire weapons. You have to see the person you're trying to kill to use them. So it's a gunfight, and Canadians do not die in gunfights. We're much better soldiers than the Taliban. If you look at the months of heavy fighting in Afghanistan, in Kandahar, with over 120 combat deaths, only eight of them were from direct fire by the Taliban.

So what killed us? Well, this killed us: this is what's left of a motorcycle after a suicide bomber blew himself up beside an Afghan army vehicle. You can see the shrapnel fragments that went through the vehicle like a hail of lethal bullets.

Even scarier is the suicide vehicle packed with explosives. This is on a testing range here in Canada. You can see on this test vehicle the mannequin representing the crew commander and the sentry. When something like this happens—this explosion—as you can imagine, anybody with their chest and head outside the vehicle is not going to do well.

This is the scariest thing you could do in Afghanistan—not getting shot at but going down the roads of Kandahar province. This is what killed us, the IED or roadside bomb—low-tech warfare at its best.

Sometimes we got lucky, but sometimes we didn't. This is, again, on a testing range in Canada. As you can imagine, if the breach into our armour is complete, as you can see here, nobody would survive this kind of an explosion. Even if the breach is only partial, our soldiers are in big trouble.

Paradoxically, the armour that protected them so well a second before now works against them by containing the force of the explosion inside the vehicle. This causes an overpressure to build up, which can be lethal all by itself. That can lead to some unsettling situations, because soldiers killed by overpressure have no marks on them.

● (1535)

It can be very hard to explain to young soldiers that their friend is really gone, that behind the faces that look so peaceful, the internal organs have been turned to mush.

Even if the armour is not breached but only buckles, we're still going to have serious injuries. The floor of the armoured vehicle comes up into the crew compartment so fast; it's as if the soldier had jumped off a third- or fourth-storey balcony. So even though the wounds on the surface won't look that bad, you look inside with X-rays and the bones are just shattered; the nerves and blood vessels are ripped up. It's very hard to salvage this limb. Often, amputation is the only option we have.

Limb wounds are bad to look at, but easily the most horrifying wounds are facial wounds, because even for well-trained medical personnel, these are very hard to take. They're not all that lethal, actually. All mortality from head and neck trauma is only about 5% if the patient is still breathing. If the windpipe is disrupted, that mortality goes up sevenfold.

The reason this guy is still alive is that he has benefited from a procedure where we actually cut into the neck and put a tube directly into the lungs, to push air into the lungs, bypassing the damaged face.

In 20 years of emergency medicine in Canada I've done this procedure three times. One of my medics on my first tour did this three times in six months, and did them so well that Colonel Tien, whom you heard from a few weeks ago, actually wrote an article about him in *The Journal of Trauma*, and about the quality of training that our medics receive.

Some people have expressed surprise and even criticism that as a doctor I'm heavily armed, but in the combat area I am a soldier first. Our job, for my medics and for me, is that once the shooting starts, we help win the fight. It makes no sense to take our weapons offline and open up a gap in our defences.

Once we're pushing the enemy back, we're in a good position to cover, and then we can attend to the wounded, especially at the base of one of these mud brick walls. They're like concrete and can stop a bullet. It can be difficult to do when something like this is going on right above your head. I would encourage you to focus on the top right-hand corner here.

[*Video Presentation*]

Maj Ray Wiss: So yes, that bright red light is what it looks like when an RPG goes flying right over your head.

It's difficult to deliver medical care here. It's dusty, it's noisy, it's dirty, and it's scary. It's also a little disconcerting, because once you finish patching up the wounded man, the young medic with you immediately turns and wants to videotape the firefight to post on his Facebook page. That's a generational thing that I could never really understand.

I would much prefer it if I could deliver care in my armoured ambulance, the Bison, which has everything I have in my level one ambulance here in Canada. Even better was delivering care at the FOB, where I have everything I need for that first half hour of trauma care. That's all I need to do, because in half an hour my ambulance comes to take them back to the Role 3 Hospital and outstanding care.

Just to give you an idea, this is not a helicopter crashing. This is a helicopter landing under fire to bring our wounded back directly from the battlefield. That's how good these pilots and machines are these days.

You heard a bit about the role I played in delivering ultrasound to Canadian emergency medicine. I did bring my machine along with me for my first tour. On my second tour, I actually convinced an ultrasound company to lend, for free, ultrasound machines to all of our FOBs for use on that tour.

I have to disagree a little bit with Colonel Tien here. I did teach this to my front-line medics, and I became convinced that with some brief and focused but intensive training, they could develop quite a facility with this technique.

That's the key message I want to leave with you from this oral presentation. These young medics, 28, 26, 24, and 22 years old, are extraordinarily competent. The training delivered to Canadian Forces combat medics these days is superlative.

I want to show you something here. This is what happens when three badly wounded Canadians land in the FOB all at once. Even if you don't have a medical eye and you don't speak French, I think you will all agree that this is a doctor and a half a dozen medics going about their work in a calm and professional manner.

[*Video Presentation*]

● (1540)

Maj Ray Wiss: For the trauma indications we dealt with, I felt as well surrounded by these young medics as I do by my vastly more experienced trauma nurses here in Canada in my level-one trauma centre.

The only thing more impressive than their competence was their courage.

This is an incident I described in my second book, where a medic ran forward under fire to reach a wounded soldier, got there and realized the solider had lost his helmet, and immediately removed his own to protect the casualty's head. That kind of courage came at a price. We lost eight combat medics in Afghanistan, and we were a small group to start with. Compared to the size of our group, we had the highest casualties of any of the elements in the battle group.

This individual and the one just before him were medics who served at my FOBs and on my tours. They were more than just my colleagues and comrades-in-arms; they were my friends. Two more of these individuals were from my hometown of Sudbury, in northern Ontario, including this young man, who was the last medic to die. He was the son of a very good friend of mine. I was having dinner with the father when the son was killed.

So when you tell the story of the Canadian Forces Health Services in Afghanistan, you tell them that the medics got to their patients or they died trying. For that, we will remember them. I hope Canada does as well.

Thank you.

[*Applause*]

The Chair: Thank you so much, Major. That type of reality is what we sometimes need to hear about to really form our attitudes when we are dealing with such a serious topic.

In the interest of time, since we only have an hour with Major Wiss, I would suggest we stick to five-minute questions and answers. With that, Mr. Harris, you have the floor.

Mr. Jack Harris (St. John's East, NDP): Thank you, Chair.

Thank you, Major Doctor Wiss—we have to call you both. That was a very moving presentation. Some of us have been there and recognize the terrain; however, we didn't experience the kind of trauma you did. It's news to me, I think, and it surprises me to hear the number of medics who actually lost their lives. I don't think that's well known. We think of medical personnel as being there when the trauma patients come in, not as those who actually suffer and die themselves. Thank you for letting us know that. It's certainly well worth remembering that those who served as medics also risked and lost their lives in the service of their country. And thank you for your service.

Most of our information, of course, about wartime trauma service comes from watching *M*A*S*H** on TV in the seventies or thereabouts, so it's good to see the realities of that in a different context.

I have to admire the presence of mind you showed with the group dealing with three trauma patients at once. As you say, it was a very professional attitude. Thank you again for showing us all of that.

I want to compliment you and your group, of course, for having received the very special NATO award for the Role 3 Multinational Medical Unit at Kandahar. I've looked at your book, and thank you for writing it and for informing Canadians in a very special way what it was really like.

I think most committee members are satisfied—we haven't heard any evidence to the contrary—that the kind of trauma service that was provided in combat or in theatre in Afghanistan was second to none, and the awards, of course, speak for that.

We're looking at the care of ill and injured soldiers. Obviously, the first response was very good. Unfortunately, we're hearing stories about post-trauma, whether it be post-traumatic stress injury or other details. We had one individual talking about something else come to see us. He told us he was diagnosed at Kandahar air force base with post-traumatic stress disorder. Incomprehensibly, he was told he had two months' leave and was given a ticket home. He came home on a civilian aircraft, without support or decompression or anything like that, which was surprising.

We have also heard, of course, as everyone has, about the concern around what's happening afterwards with post-traumatic stress disorder and the level of treatment we offer. We sometimes also hear concerns about the level of financial support under the new Veterans Charter and such issues.

Maybe it's not your field, but you're still working in a civilian hospital. You still come across veterans and people who have served. Would you have any comment, suggestions, or offerings on what happened after Afghanistan for our soldiers?

● (1545)

Maj Ray Wiss: Yes, I sure do.

As you say, I'm still quite intimately involved with our wounded afterwards. For any one of them who comes into my area, I tend to become their personal physician, including Bill Kerr, who is our only triple amputee of the mission, and a number of other severely emotionally and physically wounded.

There are two important messages I want to pass on to your committee. The first is that every other nation in NATO, and I think by extension on earth, recognizes that the work we do with mental health is the best in the world. You have to be very careful when you talk about the disasters that happen in any system. There's a real danger when you are talking about people with PTSD who have fallen through the cracks—and there's no question some people have, that's inevitable in any large system. But there has to be some balance there, because the danger is that other people with the same problem will not seek the care. There are a tremendous number of resources out there and some very competent and caring people working in that field, but these people have to declare that they're having difficulty. That's a really important message we need to pass along. There has to be the balance in the reporting of how we manage PTSD that reflects that, and it can't just be the horror stories that are out there that, yes, we must address. There has to be the balance. Every other nation, including the United States, with vastly more resources, is looking at us to try to copy what we do in mental health.

As for the charter itself, I have offered a written submission about that, and I imagine the government feels quite bruised about this issue, with some fair justification. The charter was implemented to deal with a great number of veterans' concerns, and it did so pretty admirably. But the people working on the charter had been looking to the past, as they had been for 50 years. They had the great mass of aging veterans in mind and they served them well.

As I believe the committee is aware, my life has been somewhat chaotic recently, so it was only in the last few days that I was able to pull this presentation together. I realize now, as I hand out my written submission to you, that I've left out the key point I wanted to make. When the legislation was enacted, as I stated, it did a good job of addressing the needs of most veterans. But when the charter was written, no one could have anticipated how effective the Canadian Forces Health Services would be. Had the war in Afghanistan been fought 10 years earlier, we would have had three times as many fatalities and not nearly as many severely wounded individuals. But precisely because of the exceptional training our medics received, many soldiers who would have died in earlier conflicts are being dragged through the valley of the shadow. They survived, but they are horribly mangled, and there are more of them than anyone expected. For this small group, the charter's benefit restrictions can adversely affect their long-term health and welfare.

In my written submission I outlined why additional benefits might be considered for these individuals, but I omitted to mention that this compensation will lead to a great benefit for the government.

As a medical officer, I am a force multiplier. That means our soldiers fight harder when I'm around because they know they'll be well cared for when they get hit. All the combat team commanders I served with told me I had a great impact on morale. The reality is that you too can be force multipliers. To quote Napoleon, the morale of the troops is three times more important than their equipment. What you want from your armed forces is operational effectiveness. Back them up when they get hurt and you'll get a tenfold return on your investment.

● (1550)

The Chair: Thank you.

Mr. Strahl, you have the floor.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): Thank you, Doctor, for your presentation, as well as for writing your book. I've read both of your books, and they did the best job, from anything I've seen, in explaining not only what you did, but why we were there and why each of the individuals who went over there played an important role, much like in the other, perhaps more famous wars. Canadians know a lot more about what we did in World War I and World War II, and I appreciated even your bringing people up to speed on things that happened in Bosnia, for instance. And thank you also for going there when you didn't have to. It reminds me of the greatest generation who felt called to go. We all thank you for that.

I want to talk about a specific incident you mentioned in your book, and I'm not sure if it's been resolved yet. You mentioned that some of the medics were paying up to $600 out of their own pockets to get better backpacks so they could better serve the fallen on the field. What was provided for free to them was inadequate, so they were spending their own after-tax dollars to supplement their kit.

Was that ever resolved, to your knowledge, or is that an ongoing concern?

Maj Ray Wiss: There was a huge step taken forward on that, because after that book came out, actually, it came to the attention of General Natynczyk. He actually put a lot of those guys together and said, “Okay, that's fine, guys, but you have to agree, we can't buy a different one for each one of you because then the next guy is going to come in and want something else.” But they did come up with something that was much closer to what they all wanted. These guys are all individualists. They probably want a little tweak here, a little tweak there. But what's operational now is much closer to what we need.

Mr. Mark Strahl: Congratulations on that real-world improvement that you helped bring.

You also brought your ultrasound expertise. When we travelled to Downsview last year we saw the goal of bringing the ultrasound technology to the battlefield.

I've asked this question before, and you mentioned it briefly. How close should we be to getting that tool to our medics on the ground, without someone like yourself, who is obviously an international expert on it? You said you felt this could be a battlefield tool. Can you maybe just expand on that a little bit?

Maj Ray Wiss: Yes, absolutely.

The thing I'm an international expert on is teaching ultrasound to rank beginners. I've taught 8,000 Canadian physicians how to use ultrasound; they had never picked up an ultrasound probe, ever, in their lives. At this point in Canadian emergency medicine, I would say if you're not using ultrasound daily, you're a dinosaur looking for a tar pit to fall into.

So yes, it can be done. Among those 8,000 doctors, I guarantee you there were some who were pretty slow and much less sharp than my medics. Yes, we can be using it.

The other thing I would tell you is that I went to see the operation at Downsview. To be honest with you, what we need is off the shelf right now. There is an ultrasound unit on the market right now that's half the size of a pitcher of water, and it will tell me if the lung has dropped, if there's bleeding in the chest, bleeding in the abdomen, around the heart, very effectively, within seconds. And I can teach a medic how to do that in about 10 hours. So that's out there.

Mr. Mark Strahl: What do you think is holding back the military from adopting that?

Maj Ray Wiss: They're not being held back that much. I've taught all the special forces medics how to use ultrasound, and I know that CANSOFCOM bought 16 or 17 units just recently. It's getting out there, definitely. Emergency medicine is still evolving in this area, and I think the army is following that quite closely.

Mr. Mark Strahl: You deployed twice to Afghanistan. Can you speak to the lessons learned that were applied right away? Were there marked improvements between your two deployments in terms of the front-line medical care?

● (1555)

Maj Ray Wiss: It was huge. When I got there on my first tour, the FOB I was at was really oriented to a non-physician, so there weren't very many other options for me, other than what was available to the medics. I made a number of recommendations at the end of my first tour, all of which were implemented. When I got there on my second tour, I might as well have been working in my level-one trauma centre. There was nothing I couldn't do on that second tour that I do at home.

Mr. Mark Strahl: That's great. Thank you.

The Chair: Thank you.

Mr. McKay, it's your turn.

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Chair.

Thank you, Dr. Wiss, for your service.

You mentioned in your presentation that there are not that many doctors who go to the forward operating base. Why is that?

Maj Ray Wiss: The fact that I did will I think explain the question a bit better. It was really an accident of circumstance. I got there on a francophone rotation. I'm French Canadian. I'm an ex-infantry officer. For the five years immediately prior to my deployment, I had been the doctor for our SWAT team, or tactical unit, of our police department. A lot of my infantry reflexes had come back. I could shoot straight, I could move tactically—I was an unusual mix as a doctor. When there was a gap in the coverage at one of the FOBs that is normally covered by a senior medic, what's called a physician assistant, they asked me to take that place. Again, a big part of the reason for that was precisely because I was francophone. A lot of francophone senior medics will serve on anglophone rotations because they speak English; the converse is not true. It was harder for the francophone rotations to fill all those spots.

Hon. John McKay: Is it therefore because the doctors are not soldiers, in the sense of fighting soldiers?

Maj Ray Wiss: Well, I could shoot straight, yes, and they asked me if I would do this job and I said that I would.

Hon. John McKay: Do you feel that the presence of a physician at a forward operating base—and I'm assuming the answer is yes—is a significant upgrade to the outcomes of the casualties?

Maj Ray Wiss: It's not significant, no. The training offered by the Canadian Forces to all level of medics, including physician assistants, is extraordinary. Someone like me, an emergency medicine specialist, brings it up a notch, but just a notch. Most of what I would do in that situation can be ably done by the Canadian Forces senior medics, with the level of training they had. So somebody like me would bring it up a notch, but not a phenomenal notch at all.

Hon. John McKay: I want to explore the irony of the Veterans Charter, which actuarially was premised upon a World War II model of a lot more dead soldiers and a lot fewer injured soldiers. But with your efforts and the efforts of your colleagues, it's kind of flipped now. We have way more injured soldiers and fewer dead soldiers, and yet the charter has not been responsive, because you're offering payouts to soldiers that are pretty modest under the circumstances.

Talk to me a bit about how that could be remedied so that the compensation packages bear some relation to the advances in medical science.

Maj Ray Wiss: The first thing I would need to do is tweak what you said a little, because all the wars of the 20th century have generated way more wounded than dead. The one thing that's changed now is that we're bringing people back out of the dead group. There's a group of severely wounded people, and it's quite a small group—just a couple of hundred people coming out of Afghanistan are ill-served by the charter. That's it.

The irony is that the folks who got hit before the charter have access to a pension that's quite adequate. As I say in my written submission, that's probably the way to look at it—just go back to the way things were when the combat mission started.

Hon. John McKay: With respect to PTSD, we're going to get a presentation after you that says that the suicides among soldiers are actually at the Canadian average, if not below the Canadian average. The argument is that people who potentially would commit suicide get weeded out in advance. It seems counterintuitive.

What is your experience with the post-discharge soldier? PTSD and suicidal ideation, all that sort of stuff, may actually be exaggerated after discharge. I would be interested in either your anecdotal or statistical observations.

● (1600)

Maj Ray Wiss: I'm not sure I get what you're—

Hon. John McKay: Well, you are in a unique position to observe soldiers post-discharge, so I'd be interested in your observations on how both suicidal ideation and PTSD manifests itself in, say, a five-year window.

Maj Ray Wiss: Okay, got you.

We're just getting up on that five-year window now. Let me start with a really basic fact about PTSD and that whole constellation of illnesses. We know that of everyone we send to Afghanistan, 6% are going to have mental health issues. We know that 2% of these, one-third, are going to get better on their own; 2% are going to get better with treatment; and 2% are probably going to have long-term issues. I want to re-emphasize the importance of making people understand that we have the best mental health care post-deployment system in the world, and we really need to access that middle 2% who are going to get better with treatment. We need to access them quickly. We also need to access, equally quickly, the 2% who are probably going to have long-term issues, so that we can minimize the effects of their illness.

The reality is that 94% of us come through it, and that's what I'm seeing, anecdotally. Here in Sudbury, where I am, I have a reserve unit that sends dozens of people every year to Afghanistan. I talk to these guys all the time, and the vast majority are doing just great. That's the reality.

The Chair: Thank you. Your time has expired.

Mr. Opitz, please.

Mr. Ted Opitz (Etobicoke Centre, CPC): Thank you, Mr. Chair, and through you, Doc, thanks for being here.

I think your time as an infanteer has probably given you some tremendous insights.

Always, we're the Queen of Battle, not the engineers.

I'm sorry, I had to get that in. It's a running battle.

Maj Ray Wiss: Yes, Colonel. I'm aware of the Lincoln and Welland.

Mr. Ted Opitz: You talked in your book about combat stress reaction, or CSR, as you put it. I'm interested in that. You said that the best way to treat that is at the front, which sounds counter-intuitive to what we have been told by previous witnesses, in terms of PTSD and other things.

Can you elaborate on that and give us some clarity there?

Maj Ray Wiss: Sure.

Consider who a solder is—a young person in the prime of life; they've been training for a significant part of their professional life, maybe their entire professional life, for this job. Then something happens and they have difficulty completing a mission. The loss of self-esteem that entails is devastating. The longer they feel that loss of self-esteem, the harder it is to bring them back, and the closer they are to depression and then to suicidal ideation.

We know this from long-standing experience, going back a couple of wars now. If you want the guy to come back emotionally, you have to treat him as close as possible to the front line. Again, the Canadian Forces is the world leader in that.

We had social workers, psychologists, go out to the FOBs. It was quite the thing. These people had no real combat training experience, and they were getting helicoptered out to the FOB to talk to these guys who had just been in a vehicle where two of their buddies had been killed and they were having a tough time dealing with it. Here you have a mental health professional, out there getting rocketed at the same time we were, talking to them about what's going on.

That's the way to do it. If you bring them back for two months, the only thing they're going to think about for those two months is that they let their buddies down. Remember, that is the deepest motivation a soldier has—much more than distant ideals like democracy, than hatred of the enemy, and more than self-esteem. The most important motivation a combat soldier has is his buddies and not letting them down. All he's going to think about for those two months back in Canada, or wherever, is that his buddies are out there still fighting and he's not. That's devastating to a psyche. The only way to improve that is to deal with it early and quickly.

● (1605)

Mr. Ted Opitz: I'm glad for your perspective. You fight for the man, and you fight for the man on your left and on your right—that kind of deal.

I'm delighted you said that, because we've had a lot of negative stories. But as you've just pointed out in some of your statistics and things like that, there are a lot of positive results that have happened with our treatment.

I'm delighted to hear you say that Canada is one of the leaders.

Maj Ray Wiss: The leader.

Mr. Ted Opitz: *The* leader in looking after our soldiers.

You've treated all kinds of injuries in your two different tours of Afghanistan. What effect does the protective equipment have now? It protects the core, and the ballistic helmet and ballistic glasses and things like that protect the head and the eyes.

There are some horrific injuries, obviously, to the extremities. You said the “kill boxes”, as you called them, are well protected because you also have that ceramic plate in behind the tac vest.

Can you talk about some of the injuries you've treated over your two tours?

Maj Ray Wiss: Hippocrates, the father of medicine, said that if you want to be a surgeon, go to war. He said that 2000 years ago, and it's just as true now. If you want to learn how to do this job, go to war, because the panoply of injuries is pretty much infinite, especially now with what modern weapons will do.

To address your question about the protective equipment, there is always a balance between firepower, mobility, and protection. You choose a mix of that and then you go into action. You might choose it right for that particular mission, or maybe you choose it wrong; there's no way of knowing ahead of time.

I can tell you that having slogged it out on patrols with that frag vest on me and the tac vest over top, I wouldn't want that thing to be any heavier. That would be about the limit.

It is very effective, and that's part of what we're seeing. We're seeing the effects of that in terms of the casualties.

Bill Kerr, in my hometown, is a guy I've been personally looking after for the past five years now. He is Canada's only triple amputee. He'd be dead as a doornail if it hadn't been for all the stuff he was wearing. So it's very effective armour, for sure.

Mr. Ted Opitz: That's great to hear.

Do you think overall that we have the services for physical injuries, mental injuries, psychological injuries, that the troops generally need in this system—the services that Canada provides for our wounded and our mentally wounded?

You alluded to it earlier. You said we're a world leader. Do you think we have the right mix of things to treat our people the best that we can?

Maj Ray Wiss: Yes, and again, that's a really important message I want to leave with the committee. We have this outstanding system. The way it has been for the past several years, it has really been doing a tremendous job, and yes, when disasters happen and people fall through the cracks, you want to be nimble in how you pick them up.

Mr. Ted Opitz: Is there anything we can do better?

Maj Ray Wiss: I suppose we could be more nimble in how we pick them up, but more importantly, get the message out there that the vast majority of people who are having mental and physical health problems are getting good care. If that's your problem, don't be dismayed. Come and see us.

The biggest obstacle to our getting to the PTSD crowd is that they're not coming. That hurts more than anything else.

The Chair: Thank you.

[*Translation*]

Ms. Moore, you have the floor.

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you kindly, Mr. Chair.

Let's use the example of someone who works as an emergency room nurse in a small community. In that sort of setting, the nurse could quite easily come across someone they know well, if not very well, and have to treat that person. That is the reality they have to live with. Regardless of what is going on in members' lives, the Canadian Forces is still something of a small family, and the likelihood of having to treat someone you know is pretty high.

Earlier, you showed a picture of Corporal Nicolas Beauchamp and of his spouse, Corporal Dolores Crampton, who was also a medical assistant and went to Afghanistan. In fact, she was one of the people in my NQ4 medical course; we spent a lot of time together. She is someone whose spouse died and who is a care provider. What would you say about those situations? How do you deal with health care providers and help them face the reality that, one day, they will probably have to treat someone they know very well?

It, is after all, not uncommon in the Canadian Forces to have spouses who are both members of the military. How do you support members who have suffered the loss of a spouse?

● (1610)

Maj Ray Wiss: I was at the repatriation ceremony for Corporal Beauchamp, as was Corporal Crampton. After that, you live with the grief, as I am doing now. You get through it in the same way.

There is another perhaps lesser known problem. How do you react to comrades who come back wounded? That was our day to day at the FOB, or forward operating base. We took care of our people. On a combat team, medical personnel are not seen as separate. They are truly part of the combat team. Those people weren't part of the medical team, but they were part of the infantry, armoured personnel. When something happened to one of us, it was extremely tough.

Something I can recall vividly, and I describe it in my first book, is the agonizing feeling I had when I knew that a major operation would result in our members' incurring severe injuries in a few minutes. It was my first mass call, my first event with a large number of wounded. At first, I was very rattled, but I can tell you that my training kicked in and I went into automatic pilot. And the same goes for my young nurses, even though their training was shorter than mine but excellent regardless. When a wounded member arrives, your training kicks in and you respond almost automatically, a reflex that is absolutely vital in those situations.

Ms. Christine Moore: Yes, when you are trained to treat a patient, you are usually able to do what needs to be done in the middle of the action. When the patient isn't doing well, when the heart monitor goes off, you can handle it. But what about afterwards, when the pressure subsides, how can you be sure that those people will be able to provide care for six months? Those are tough situations, but those people have to be able to continue providing treatment and doing their job. They build a shell around themselves. There is a shortage of medical personnel. So it's crucial that we make sure the personnel we do have remains healthy. The textbooks don't teach them how to react and cope with the fact that they are treating people they know personally. How are those individuals supported?

Maj Ray Wiss: I can't tell you what it was like in other combat teams, but when I went to Afghanistan, it was my third war. I took part in two others with Doctors Without Borders. I was 48 the first time. I was always very careful.

The benefit of the medical system in periods of war is that there isn't always an operation going on. There are times when you have a lot of wounded. Then things calm down for a good while. Whether we had 10 people wounded or only 1, I would always have a meeting with my medical team to debrief so they could vent and talk about what had happened. It certainly had an educational dimension. I was very helpful as an educator in emergency medicine. I had a lot to teach them and I made sure that we talked about situations they had had a hard time with, even in the educational context.

Let's use the example of facial injuries. Those are incredibly difficult to deal with because our face defines us to other human beings. It is staggering just how emotionally difficult facial injuries are. When we were dealing with those injuries, I made sure to talk to the personnel and acknowledge how hard those situations were. It was an opportunity for them to process and for their emotions to stabilize, to use a medical term.

That's what you do in those situations. I would even say you have much more time for that kind of thing in the field than you do in an emergency room, where you move from one patient right to the next.

[*English*]

The Chair: Merci.

Mr. Chisu, it's your turn.

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

First of all, thank you very much, Major Wiss, for your service in Afghanistan. And thank you for your innovative service in Afghanistan and for bringing the ultrasound machine. At that time, in 2007, they were learning. They were not really expecting what was happening. In 2006 we didn't have too many casualties, but 2007 was actually a year I will never forget in my life. If you remember, in the week of Easter we lost six, and after, three of our comrades.

Your presentation brought back memories from Sperwan Ghar and Masum Ghar and so on, and the work you are doing to be able to supply engineers this time...your generators and all the infrastructure. We didn't have too much.

● (1615)

Maj Ray Wiss: We appreciated that, sir.

Mr. Corneliu Chisu: I know it was very hard on us because we were very few.

What I would like to ask you—and in the Role 3 Hospital we have had two slides, the CT scanner, which was very rudimentary....

Tell me, how were you able to work with coalition forces? The Canadians didn't have helicopters. How did this work, between getting all the wounded in the FOB and transporting them to Kandahar, to the hospital? I am asking you in this context. What was the big difference between 2007 and 2009?

Maj Ray Wiss: Interoperability, in terms of how we worked with our allied nations...I wouldn't tell you there was a lot of difference between 2007 and 2009 because it was pretty seamless. The Role 3, the whole time I was there, was a Canadian-commanded, Canadian-dominated operation, so maybe that helped.

In terms of evacuations from the FOB, that was always run by the Americans on their choppers, with their medics, or almost exclusively their medics. These are people, medically, we were very close to already.

I spent a few days at Kandahar, and even there, working with a British neurosurgeon and a Danish anesthetist, it went pretty smoothly, again because trauma work is not rocket science: "There's a hole here. There's a hole there. There is damage in between. You know what to fix." There is not a whole lot of room for intellectual argument, as there might be over cancer or diabetes.

It was pretty smooth, and we didn't have any trouble with our allies.

Mr. Corneliu Chisu: Did they appreciate your ultrasound machines there?

Maj Ray Wiss: Yes.

Mr. Corneliu Chisu: I'm just asking because it was an innovation.

Maj Ray Wiss: It was, yes.

Mr. Corneliu Chisu: We had the Israeli tourniquet. It just seemed the....

Maj Ray Wiss: No, they absolutely did. I brought it out and used it on one of the first days I was in Kandahar, much to the amazement of these U.S. surgeons who were there, who couldn't believe it. I was doing a procedure where I was sticking this big catheter pretty deeply into this guy, and they said, "What are you doing?" I said, "Well, trust me, this is exactly where we need to go." It worked, and they were duly impressed.

But I think even more to the case, further on in my tour...I guess my reputation had preceded me. I was able to call for evacuations for patients who looked fine but who were bleeding to death inside. That's the enormous advantage of ultrasound. You have two patients. One of them has both his legs ripped off, but he has tourniquets on his legs and he's not bleeding anymore. He's actually going to live for several hours. The other guy beside him looks pretty good, but his belly's full of blood; there's no way you can push on that and stop the bleeding. He's the guy who goes in the chopper first and the other guy waits. That's how you end up with two living soldiers at the end. That's the huge advantage.

I was able to call for these evacuations for people who normally wouldn't have warranted one, and I got them into the operating room in time.

Mr. Corneliu Chisu: Thank you very much for your explanation about the ultrasound, because it was an innovation for everybody in the field.

Can you tell me a little bit more about what was happening with the soldiers after coming back to Canada? Did they continue to have the care that was necessary?

Maj Ray Wiss: I would say so, sir. The vast majority do. That's really the message. I know I sound a bit like a broken record, but you have to get the message out there that the care is there for the guys. If you're having trouble, if you're aware of a soldier who's maybe disappointed, he's heard these horror stories and he's heard of a buddy of his who's had a bad result from an interaction, tell him to try anyway, because the system is working for the vast majority of people. Their care is there and it's doing a good job.

● (1620)

Mr. Corneliu Chisu: Thank you very much.

The Chair: Thank you.

[*Translation*]

Mr. Larose, your turn. Go ahead.

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

I want to thank our witness for being with us today.

I want to make a brief comment.

When I was three years old, I was fortunate enough to travel to Afghanistan before the Russians invaded. The people I saw were incredible. What they're going through now is horrifying.

My hats off to you for the work you did. The conditions are extremely dry and very tough. Despite that, your morale is high and you've done an excellent job maintaining your ties. You're doing a good thing, and we can say that with pride because the civilians there need that.

Maj Ray Wiss: Thank you.

Mr. Jean-François Larose: When I was a reservist, I had instructors who had been in Bosnia and were still suffering from post-traumatic stress syndrome, and yet they were still instructors. You've had the privilege of experiencing operations. Oftentimes, the people here are clinicians. They do a tremendous amount of research, and that's important. You didn't make a contribution just there, you also made a contribution to the frontlines. You've experienced battles and you've been with comrades in arms.

From what you said, I gather a certain culture exists. If I understood correctly, you said the problem is they won't come forward and say they're grieving and having trouble coping.

Is it possible they're worried about turning their backs on the people they're with every day? Is it possible they're worried about losing the job they spent their entire life training for? Are there improvements that can be made in the field? It can't be easy when a rocket lands on the camp.

Maj Ray Wiss: No.

Mr. Jean-François Larose: It can't be easy; it must be hell, in fact. Morale must drop. No doubt you experienced that in the field.

Maj Ray Wiss: You asked a number of questions. Is there a worry? There is always the worry of not being able to be there for our comrades. The first time I was shot at, strangely enough, the feeling I remember most is relief: I had faced it head on and not run the other way. I found that strange at the time. The logical thing to do is run the other way, but I felt relieved because I wasn't going to desert my comrades on the battlefield. That shows you how strong the ties we have to our comrades are.

Do those who feel like they're losing their way worry about losing their job? The answer is no. We won't be turning our backs on anyone anytime soon for a reason like that. I would say it's the same as with any other injury. Naturally, an injury changes what you do in life. Some of our snipers have lost a leg. They won't be snipers anymore, but the Canadian Forces can find them a position in teaching or administration. The same applies to an emotional wound. It changes what you do. The army can always find you another position. Whether it's as a cadet instructor or something else, the army will find something.

Mr. Jean-François Larose: Did you make any recommendations to the Canadian Forces based on your observations and experience in the field, anything pertaining to the device you mentioned earlier that could be useful in the field? Based on what you observed from the psychological and operational standpoint, did you make any recommendations on other ways of responding? It might involve modified missions or more frequent rotations. I'm not sure what solutions you might be able to propose to the committee. As far as equipment goes, I would think you prepared a number of reports.

Maj Ray Wiss: Yes, quite a few.

The ultrasound is my pet project. It's what I know the most about. So my recommendations are based on that.

I would point out that after my first mission in the field, I made multiple recommendations. All of them were implemented before my second trip. The medications, devices and instruments we had at the FOB during my second mission were exactly what I wanted. I couldn't have asked for anything more.

Mr. Jean-François Larose: With respect to post-traumatic stress syndrome, did you make any recommendations based on your observations in terms of tools and training?

Maj Ray Wiss: In the field of post-traumatic stress syndrome, we're the best in the world. Bring us people, tell them to come and see us. Even though the front pages of *The Gazette* in Montreal and the *Journal de Québec* claim that the Canadian Forces mistreated Sergeant Tremblay, tell people to come forward anyways, because the vast majority will receive excellent care from the Canadian Forces.

[*English*]

The Chair: Mr. Alexander, the last round of questions goes to you.

● (1625)

Mr. Chris Alexander (Ajax—Pickering, CPC): Thank you so much for being here, Major Wiss.

Thank you for reminding us of the heroism of our medics in the Canadian Forces. We have all known and heard about the talent, the sheer knowledge, and the medical experience that you and your colleagues bring to the table, but sometimes we forget how important that operational dimension has always been.

You showed us eight faces here that speak louder and more truthfully to that valour than any of our voices could, but you also remind us it has deep roots in the Canadian Forces, whether it's Canadian medics who've won the Victoria Cross—and there are many—in different conflicts in different services....

I was reminded of Private Richard Rowland Thompson, who was given The Queen's Scarf, some say a higher honour than the Victoria Cross, though—

Maj Ray Wiss: There are only six of them.

Mr. Chris Alexander: Exactly. It was certainly a rarer honour, way back in the Boer War.

I think this is one of the keys to the excellence of the Canadian Forces, that you are the force multipliers that you are, and the incredible spur to morale. It's an honour to have you here.

Maj Ray Wiss: Thank you.

Mr. Chris Alexander: Thank you also for your literary contribution in telling this story, because without the books you've written, it simply wouldn't be known to as broad an audience, and you've done it with great talent and gusto.

Maj Ray Wiss: Thank you again.

Mr. Chris Alexander: We are all in your debt in that respect, and really, around this table, we've shared stories from your books and benefited from the insights.

I want to ask you about the bigger picture, though. I was just looking at the book again. I remember reading at the time the beginning of your first book, in which you talk about your commitment to the mission in Afghanistan—and I certainly share it—a moral war, a just war, an authorized military operation with our allies, the sort of thing we've always prepared for and have been prepared for. But then you talked about how we were a nation divided in spite of all those advantages, and that there were some on one side of the issue saying we were peacekeepers and we should never again be in shooting wars, and then some on the other side were saying that we should just go there and do damage, again, in a very superficial and unhelpful characterization of the conflict.

You said we were a nation divided in 2007, and I certainly think we remained that in the subsequent years we were in combat.

What kind of impact does that division in public opinion and in public support have on the ability we as a country have to motivate soldiers, to care for them in the field, and to care for them when they come home?

Maj Ray Wiss: We're soldiers. We don't practice democracy; we protect it.

I think the overarching message that I want to pass to you is that we have absolutely no problems with people who oppose the missions that we're sent to go on. In fact, several of my very best friends, to this day, oppose the mission. They have read both my books and they agree that when we debate, I win the debate, but they still oppose the mission. I think they're great people, and I went to Afghanistan to defend them and to defend their right to disagree with me.

The thing that I can't stand is the person who came up to me in 2008, when I came back from my first mission, and said, “Hey, I heard you were in Iraq.” That's hard to take. There's the person who came up to me in 2009, when I am about to deploy for a second time —this is a physician in Toronto, someone with access to as much information as anyone on the planet—who said to me, “So, Afghanistan. Are we peacekeepers over there?” That hurts.

I speak a lot about Afghanistan. Even now I still get an invitation or two a month to speak to somebody, and I'll go and speak to anybody. It could be six people in a grade school; I'll go. The most common comment I get from adults at my public presentations is, “I had no idea.” After 158 dead and 10 years of war, I have a hard time with that. That hurts veterans.

If I can ask you to do one thing, it's to just tell people what we did. It doesn't have to be partisan; it doesn't have to be to make a point; it doesn't even have to be pro-mission. People who oppose the mission have enjoyed reading my books because I call it like it is. Make sure people know why we were there, what we did, and what we suffered and what we lost.

To go there and to realize that so many Canadians just didn't know, that hurts us, and that will decrease our operational effectiveness, if you want to couch it in those terms. People have to know. People have to remember them.

● (1630)

The Chair: Thank you.

I have one question for you, Major.

I was going to give you an opportunity to say what that final message was that you wanted to leave with the committee. I think Mr. Alexander gave you that opportunity to do it.

One thing we're trying to do in this study is lessons learned. How do we get better at what we do? From your perspective, how do we get better in the field with regard to traumatic injury and dealing with that? You were already asked about some things that we've resolved —backpacks, body armour, what we're carrying in our kits. We know for a fact that your ultrasound equipment is now being developed more by DRDC for more advanced operations right in the field by our medics.

You mentioned, and you showed, how traumatic improvised explosive devices, IEDs, are on our LAVs. We know we've cut them all down, we're putting in V-hulls, and we're reinforcing them so they're more blast-proof, which hopefully increases the survivability and decreases the injuries of our brave men and women who have to ride around in them.

In your mind, what else could we be doing better in the field to protect our troops, either at the FOB or even right with the medics who are dealing with those very first injuries?

Don't feel pressured that you have to answer it today. You can always write back to us.

Maj Ray Wiss: I'm very much going to take you up on that, because I'd have a tough time formulating a brief answer right now. Let me leave you with a concept.

Right now, the Canadian Forces Health Services is an extraordinarily effective construct. It has a 98% survival rate in modern warfare. That's higher than what the major trauma centres in Canada are achieving. It's higher than any army that has deployed into the field in war has achieved. It's phenomenally effective. It is, however, a house of cards. Don't think for a second that you can change one part of it without it rippling through the entire edifice. You have to keep all these aspects going; you have to especially keep training and research going.

We know what we could have done better last year because we've worked on it. If you keep the training going at the intensity it is at right now, and if you keep the research going at the intensity it is at right now, we'll figure out what to do better next year. That's a question we don't have the answer to right now.

We've kept studying what's been going on. Every one of our guys who was killed had an autopsy. We analysed whether his protective equipment did well or not—every single one. That's why the Highway of Heroes ends in Toronto. Did everybody know that? That's why it ends there, because the Chief Coroner for Ontario looks at every one of our dead, does that study, and sends a report back. We've studied the past.

Right now, keep the machine going so that we can try as much as possible to anticipate the future.

The Chair: Thank you so much.

Maj Ray Wiss: But I will write you back on that, with a wish list.

The Chair: Yes, please do, anything from logistics to equipment to how we train.

Maj Ray Wiss: There will be a picture of an ultrasound machine in there.

The Chair: All those things are important in what we're doing here in our study.

On behalf of the committee, I want to thank you for taking the time to appear, and for bringing your family with you. It's nice to meet them as well. Thank you for your passion to your country and your fellow soldiers, and for really bringing a unique perspective that we hadn't heard around this table yet.

Maj Ray Wiss: If you meet these young soldiers, sir, it's easy to be passionate about them.

Thank you very much.

The Chair: Yes, I agree.

With that, we'll suspend and clear the table in preparation for our next witness.

● (1630)

(Pause)

● (1640)

The Chair: We'll continue. We have most of the members back at the table.

Joining us for the next hour, from the Department of National Defence, we have Major Lisa Compton. She is the manager of the maintenance of clinical readiness program. She is accompanied by Dr. Mark Zamorski, who is the head of the deployment health section.

With that, Major, I'll let you offer your opening comments.

Major Lisa Compton (Manager, Maintenance of Clinical Readiness Program, Department of National Defence): Thank you, Mr. Chair and members of the committee.

Ladies and gentlemen, I want to thank you for your interest and support for the care of Canadian Forces members. I'm a Canadian soldier and I'm a nurse. I have been privileged to work in the Role 3 Multinational Medical Unit, the hospital shack built of plywood and miracles, and as the only Canadian at the Craig Joint Theater Hospital in Bagram Airfield, Afghanistan. Given your interest in the care of the ill and injured, my role and experiences as the Role 3 trauma nurse coordinator, Bagram trauma nurse coordinator, Canadian liaison nursing officer, and Canadian Forces national trauma nurse coordinator are likely of most interest to you.

The Canadian Forces has been part of the joint theatre trauma system since 2007. It was during that time that the CF began using the joint theatre trauma registry, a robust trauma registry that not only enabled life-saving research, but real-time performance improvement in a combat zone. It provides the ability to perform data-driven, battlefield-level process improvement of trauma care that drives morbidity and mortality to the lowest possible levels.

The mission of JTTS is to improve trauma care delivery and patient outcomes across the continuum of care, utilizing continuous performance improvement and evidence-based medicine driven by the concurrent collection and analysis of data maintained in the joint theatre trauma registry. Ultimately, it means the right patient, the right place, the right time, and the right care. One of the most valuable resources from JTTS is the clinical practice guidelines, as they are the backbone of the theatre performance improvement system. Historically, since the early outset of the in-theatre trauma system, these guidelines have been developed and implemented by clinical subject matter experts in response to needs identified in the area of operations. To the greatest extent possible, JTTS CPGs are evidenced-based. As one can imagine, for many reasons, trauma care needs to be delivered differently in a war zone than back home in a large trauma centre. These CPGs not only address how to improve care in a combat zone, they also provide clinical guidance on dealing with injuries that are unique to the combat environment.

During my time at the Role 3, I not only witnessed the unbelievable bravery of CF members, but I was proud to be a part of a medical team that provided the best care anywhere. Last year, Canada was the recipient of the Larrey Award from NATO for excellence at the Role 3.

CF members accept extreme risks and are asked to make the greatest of sacrifices. Whether it be in a plywood shack or a pristine medical clinic, they deserve the very best care anywhere. The CF Health Services are committed to excellence.

I would be pleased to answer questions to the best of my ability, and any information I cannot immediately provide I will provide at a later time.

Thank you.

The Vice-Chair (Mr. Jack Harris): Thank you, Major Compton.

Dr. Zamorski, we'll hear from both of you first, and then we'll have a round of questions.

Dr. Mark Zamorski (Head, Deployment Health Section, Department of National Defence): Thank you, Mr. Chairman and ladies and gentlemen of the committee, for the opportunity to appear before you today.

I am Mark Zamorski, and I am the head of the deployment health section of the Canadian Forces Health Services group. My section mainly does research in the domain of mental health and related problems, such as suicide and family violence. We have also developed and actually support the enhanced post-deployment screening program for mental health. In addition to research, we participate in other scientific activities, notably three recent expert panels on traumatic brain injury, suicide prevention, and the prevention of family violence. Over the past year alone, our three scientific staff have been authors or co-authors of 10 peer-reviewed publications and have presented 15 abstracts at national and international scientific meetings.

We currently have three major active research protocols, two of which deal with understanding the effects of mental disorders and traumatic brain injury, respectively, on occupational fitness. I am also the principal investigator of the 2013 Canadian Forces mental health survey. This study, done by Statistics Canada on behalf of DND, involved interviewing 9,000 currently serving personnel to explore, first, how the mission in Afghanistan and, second, how the renewal of our mental health system have influenced the need for mental health care in the CF.

By training, I am a family doctor, with additional training in public health. Before joining DND, I was on the faculty of the Department of Family Medicine at the University of Michigan Medical School for nine years.

I am prepared to answer questions on the research and other scientific activities of my section. I can also comment generally on the science that lies behind the prevention and control of mental health problems and related phenomena in military organizations.

Thank you again for the opportunity to appear here before you today.

● (1645)

The Chair: Thank you very much.

With that, again, I think we'll stick with five-minute rounds.

Mr. Harris you have the floor.

Mr. Jack Harris: Thank you, Chair, and my thanks to both of you for your presentations.

Dr. Zamorski, I understand you're the director of research. You talked about this mental health survey, which I think is very positive. I want to read you something, though, that I'd like your response to. We heard Dr. Wiss and others talk about what a great system we have, and I know the things that we do, we do well. Dr. Wiss talked about the Trident trauma services and the direct response in the field to post-traumatic stress disorder. That's probably ahead of the curve across the world. But I will read you what we were told on March 20 by the Canadian Forces ombudsman, Pierre Daigle, who said:

> I am troubled that the Canadian Forces still does not have an appropriate system in place to provide a current and consistent portrait of the number of members affected by post-traumatic stress disorder and other operational stress injuries.
>
> How can the institution know if it has in place the most appropriate priorities and resource levels to manage its broader operational stress injury initiative when their data is incomplete and their research is not focused on measuring performance?

He talked earlier about performance. Perhaps you've read that testimony. Would you care to comment on it? This survey that you're part of, is that the answer to this, or is there more that needs to be done?

Dr. Mark Zamorski: The survey is a very important part of the answer. There are two criticisms in there, and they're sort of related and sort of different. One is the ability to understand the magnitude of the problem, who has it and who doesn't, and whether problems are increasing or decreasing. That's an important public health surveillance function that we need to have, and we have pieces of that in place. We also need to understand how CF operations are affecting the mental health of CF members if we're going to appropriately manage our program and take care of our people. We absolutely get that, and we agree with that 100%.

A second functionality is also very important, and we agree 100% with the ombudsman that we need to do a better job of documenting, in detail, what kind of care we're providing and how the quality of it compares with our aspirations. We also need to document better the outcomes of that care. Where we disagree with the ombudsman is in the best strategy for doing that. The ombudsman's office has been fixated for quite some time on this idea of having some kind of a database that lists all the people with operational stress injuries, so that at any given time we can press a button and say, “As of today the magic number is 3,722”, or whatever it happens to be.

As a public health expert, as someone who's supposed to keep on track with this, I can tell you this is not very helpful to me. Instead, the path that we've chosen is to use a bunch of different ways of answering these fundamental demands—to understand the care we're delivering, the effect it's having, and how the mission is affecting health.

● (1650)

Mr. Jack Harris: He says he's been asking for this for almost 10 years. He says we're not really measuring performance, in the sense of what treatments work when it comes to OSI. Where are we on that? I understand the database that Stats Canada is doing will be helpful, but what about measuring for which treatments work and which don't? I think that's pretty key to determining whether we're doing a proper job to help people. This is not a criticism of people's intentions. But we're still hearing these stories about people who aren't being helped, who think they could be helped. We don't have a handle on it. We hear, for example, that measuring the length of waiting lists is a good way to measure whether we're providing the service, but I'm not sure that's accurate.

Dr. Mark Zamorski: This problem is an international one and it is a Canadian one, which is to say that if you were to go to any outpatient mental health care setting in Canada and ask, what treatments are you providing, how well are you providing them, what outcomes are you seeing, and how do those outcomes compare to the guy next door, the answer you would get is the blankest of stares.

This is a problem we're facing, and it's a problem the nation is facing, in terms of understanding what it is delivering and what kind of outcome it's seeing.

We face these same challenges. If this were an easy problem, we would have fixed it long ago and my life would be a lot easier. I'd be happily analyzing all this wonderful data, as opposed to trying to build the kind of system we need to answer these questions. Specifically, what we need are systems that capture in detail the exact content of care, in particular the exact content of the psychotherapy, and then what the outcomes are.

If you're looking at cardiac disease, you can count how many days people stayed in the hospital. You can count whether they had a second heart attack within a year. You can count whether they died or they didn't die, and all these sorts of things, relatively easily, and those are clear markers of quality of care. It is much more difficult in mental health.

We have three initiatives in the CF. The first is that the mental health survey will provide us with important insight into some of these questions. We'll be asking people in a very careful way if they were satisfied with the care. We'll be asking people who know if they had a mental disorder or not. We'll know whether they sought care or not. That reflects on the quality of our institutions. We'll be looking at if they did seek care, how are they functioning now. How much better has that care gotten them, and we'll be asking them the perceived value of that care.

That survey will get at a bunch of other things that will help us understand how the quality of our care compares to what we aspire to.

The second thing we are doing is reinforcing our health information system in ways that will make it much more functional in terms of understanding mental health care.

Then the last initiative is institutional, what's called a mental health outcomes management system. This is a computerized system whereby patients complete a questionnaire on their symptoms at each visit, on their well-being and on their functioning. The computer compares this against the expected treatment response of similar people and it informs the clinician that this person is or is not making expected progress. Where it finds that the person is not making expected progress, it provides feedback to the person about things they could do to perhaps better help the person.

Those are the three primary initiatives we're working on.

The Chair: Thank you.

Mr. Harris, your time has expired.

Ms. Gallant, you have the floor.

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

First, to Major Compton, how did you train for the JTTS before insertion into theatre?

Maj Lisa Compton: That's an interesting question because it has an interesting answer. I was deployed as part of Roto 4, in 2007 and I was in theatre at the time when I was told I was going to become part of the trauma system. Initially, I didn't know what it was about.

So I left theatre, and within 24 hours I left Kandahar and was in San Antonio, Texas. I went there on a three-week course, where we were taught about performance improvement and the trauma registry. Then I was delivered back to theatre, where I continued for a nine-month tour.

● (1655)

Mrs. Cheryl Gallant: What would be the most challenging situation you encountered at Role 3?

Maj Lisa Compton: I think we've already talked about that with Dr. Wiss's presentation. It was the night we lost a med tech and that med tech's spouse was at Role 3 that night. That was one that probably hit home.

Also, I'm a mom, so any time we had little kids come in it was very difficult, and any time we had Canadians it was difficult.

It's really hard to put a finger on it. I was deployed six times. I spent a lot of my life in that plywood shack, so I think we've had a few.

Mrs. Cheryl Gallant: Dr. Zamorski, we've made some giant strides since 2000, when we were just getting out of Bosnia, in terms of mental health and how we look at it. Certainly, General Natynczyk ensured that the military took on a new attitude toward that.

I remember when the support systems on bases were not highly regarded by the psychiatrist. Now, for example, at Petawawa we have over five psychiatrists to take care of a population on base of about 5,000, whereas the rest of the civilian population, around 90,000, have two psychiatrists. So we are taking much better care, and we're taking it far more seriously.

The stats we hear are that the number of suicides in the military are really about the same across the board in the rest of society; however, it seems there are so many more. There seems to be a skew in what we read and what the statisticians from DND are telling us. Are there more attempts that we don't know about? Can you shed some light on the apparent discrepancy?

Dr. Mark Zamorski: The issue is that suicide is an important public health problem in Canada, obviously, and we're part of Canada. It's also a particularly important public health problem in the demographic that tends to form the bulk of the military, which is largely young and middle-aged men.

These things attract public attention, so they seem very salient, and it seems that every time we turn around we hear another story about another suicide. Unfortunately—I have the same feeling myself when I pick up the paper, so I don't want this to sound dismissive—it's not a reliable way to understand the magnitude of a public health problem.

We have a system where we know when people in the regular force pass away; we have a registry that keeps track of them and it captures the cause of death. Once a year we count up all the suicides, and we calculate rates every five years and report them.

It's also difficult because we're so close to the United States, where they have absolutely had a precipitous increase in the rates of suicide, specifically in the army and the marine corps. It's hard not to think that this somehow must be occurring in Canada as well, facing operational challenges and demands. That's just not what we've seen, for whatever reason.

Mrs. Cheryl Gallant: What are some of the common factors that may contribute to suicide, and what suicide prevention initiatives are currently in place with the Canadian Armed Forces?

Dr. Mark Zamorski: Suicide is a very complicated phenomenon, as you know. In any given case, there is a particular pattern of things that play together.

The things that are of the essence are stressful life events. Usually there is one or more stressful life event. Usually at some point there is an acute stressor that contributes as a trigger. That often intersects with mental disorders, notably depression and other related disorders. That then combines to form suicidal thoughts in people. Many people have suicidal thoughts, but then certain things that occur later on down the line actually condition to whether those suicidal thoughts turn into suicidal acts.

Those things that tend to tip someone one way or another include impulsivity. People who tend to be impulsive and have a suicidal thought may commit suicide, whereas other people who are just by nature not impulsive don't. Hopelessness, pessimism—all these psychological factors play roles.

The other factor that is underappreciated is the role that access to lethal means plays in suicide. There is abundant evidence that availability of handguns in particular is a strong risk factor for suicide.

There have been studies that have looked at the composition of household cooking gas. You hear the stories from the past of people sticking their heads in the oven and committing suicide. It doesn't work anymore because cooking gas no longer contains carbon monoxide. In the United Kingdom and elsewhere, where they've decreased the amount of carbon monoxide in cooking gas, they've seen significant decreases in the overall suicide rate.

Imitation of suicide events also plays a role. When people hear about suicide in the media, there is some evidence that it can trigger susceptible people to commit suicide.

Those are some of the factors that come into play.

● (1700)

The Chair: Thank you. The time has expired.

Mr. McKay, you have the floor.

Hon. John McKay: Thank you, Chair.

I just want to continue on that line of questioning, Dr. Zamorski.

Recently a reporter generated some information out of access to information. He showed me five years' worth of stats on suicides, and it wasn't clear to me that there was a pattern. The pattern seemed to be that there was no pattern, or there was such a steady state among all categories of demographics, and it didn't seem to be whether it was in theatre or out of theatre, etc.

When I looked at it for a little longer, two things did seem to start to tease out. The first was that there seemed to be a bump in January and September, and there may be some explanation for that. I'm not quite sure.

The second thing was the clearance rate, if you will. Suicides going back three years actually didn't seem to have had reports attached to them. So there was not a final determination on...I don't know if it was causes or whatever, but it was quite noticeable that they weren't cleared for three years.

You mentioned the U.S. There does seem to be a discrepancy between U.S. numbers and our numbers. I don't know whether it's just the way they count as opposed to the way we count. There may be something...it may be attributable to good care. If there are five shrinks per 5,000 people, that's a pretty good number, and maybe that's where the payoff is. I don't really know.

There's another thing that I was curious about. You say in your paper that in some respects it's a self-selecting group, that you weed out the risk folks prior to their getting into the military, so they're almost below the national average, which is an interesting observation in and of itself. But in some respects they're misleading because they're only tracking the folks who are not discharged.

I've thrown at you three or four or five issues. I'd be interested in your observations on each and every one, if you will.

Dr. Mark Zamorski: I admit that I may have lost track of one or more of them, but to work backwards, no, I'm convinced that the differences between our own suicide experience and that of the U.S. military are not due to differences in technical ways of counting the events. We do them slightly differently, but that's not accounting for that. That's easy, I think, to dismiss.

I also share your perspective, which other people have pointed out, which is that you might expect that the suicide rate in the military would be lower than that of civilians because it's a selected population and it has access to care. We don't have the numbers that we would be able to start teasing all that apart in trying to understand that, unfortunately. We're really going to have to rely upon other people, in the States, for example, where they have enough numbers that they could actually start to sort that out.

I'm sorry, that's two out of your five questions and I've lost track.

Hon. John McKay: The clearance rate.

Dr. Mark Zamorski: I'm not exactly sure what you're referring to. I'm not actually the one who is responsible for maintaining those statistics. What I can say, though, is that about two and a half years ago, in response to the expert panel on suicide prevention, one of the recommendations we made was that the CF initiate what we call a professional technical military suicide review. Where we have a suicide, the medical people go in and try to figure out exactly what happened. The purpose of this is, first and foremost, to understand opportunities for prevention. They produce a report, and we have much greater detail in the immediate aftermath of a suicide than we used to. That happened about two and a half years ago.

● (1705)

Hon. John McKay: Why would it be three years behind? The numbers all seem to line up, and then the clearance rate basically ends at the end of 2010.

Dr. Mark Zamorski: I'm not exactly sure what you're referring to. Probably—

Hon. John McKay: Unfortunately, I don't have those stats in front of me, so I can't....

Dr. Mark Zamorski: Yes. I'm not sure what "clearance rate" means.

Hon. John McKay: What about a bump in January and September? Any observation with respect to that?

Dr. Mark Zamorski: Well, I know that people have looked at temporal effects on suicide, including seasons and days of the week and proximity to holidays, and I know that people have found some patterns there. In our own data, with an average of maybe 12 or 13 reg force suicides a year, it would be really difficult for us to come up with any kind of meaningful pattern.

Hon. John McKay: What's red force?

Dr. Mark Zamorski: It's reg force. Sorry.

Hon. John McKay: Oh, regular force.

Dr. Mark Zamorski: Regular force. Sorry.

It would be really hard for us to make much of that, and to be honest, even if we found that suicides were 27% higher in December than November, I'm not exactly sure what one would do with that, other than to try to do all the things we're already doing in suicide prevention, which are laid out in our report.

Hon. John McKay: I didn't realize that this was limited to—

The Chair: Your time has expired.

Hon. John McKay: Oh, gosh. Okay.

The Chair: Thank you.

Time flies when you're having fun.

Mr. Strahl, you have the floor.

Mr. Mark Strahl: Mr. Chair, thank you very much.

I believe you were both here for Dr. Wiss's presentation, or part of it. Is that right?

Dr. Mark Zamorski: Only the last five minutes.

Mr. Mark Strahl: He spoke about one of the questions Mr. Opitz asked about combat stress reaction and his belief that those soldiers who are having a reaction to something that happened in combat should stay in theatre, if possible, and get back to doing the role, rather than being treated or removed from that situation, because of their desire to be there for their buddies, as he put it. Has there been a protocol developed on that? If so, has it led to improved mental health outcomes for those cases? Do you have any data that would show that as soon someone who shows signs of combat stress is removed, or for those who are rehabilitated in theatre...? Is there anything you can say on that?

Dr. Mark Zamorski: This is a practice that dates back to at least the Second World War. It's not anything new. It's something that we've done, and, honestly, the philosophy hasn't changed much. But it emanated from the experience in the First World War, when they really asked much more of human beings than they ever could do, until they finally couldn't take it any more. Then they took them out of this intolerable horror, and for some reason they didn't want to go back. In response to that, what was driving this at the time was not a concern about their long-term mental health, in part because we really didn't think in those terms; what drove it was an operational necessity, which was an unsustainable practice. In World War II, first of all, they started rotating people out of the front so that they didn't have to go crazy first, before they could be excused, if you will.

That's what has been going on, and I don't know if there's any research on it, but it's generally accepted in military organizations that this is the right way to do it when the goal is operational effectiveness.

There is very little research on what the mental health effects are of that practice. There's one little study in Israel that seemed to suggest that, if anything, it was more good than bad. But that's about it. It would be a very difficult study to do.

Mr. Mark Strahl: Right. Thank you.

Maj Lisa Compton: And it's very much common practice. It would really be the exception, not the rule, that somebody would leave theatre for any medical reason, and even with large groups we've set up, outside of the various Role 3's throughout theatre, you'll see what gets called a "heroes' hotel". Basically, because people really don't need actual medical care at that time, but they need a break, they need to be checked on, they'll have kind of a cozier shack outside the hospital. Medical personnel will be assigned to look after those folks, and they get a chance to rest up and get back to duty as soon as they're medically fit to do so.

● (1710)

Mr. Mark Strahl: Okay. I appreciate that. Thank you.

Major, I did want to ask you about the maintenance of clinical readiness program. How often do forces' clinicians go through that program?

Maj Lisa Compton: It's an ongoing program. It's actually been revamped this September—a new manual came out—and it basically has now aligned with the strategy of operations.

There are three various levels of clinical readiness. There's a standard clinical readiness that everybody must maintain. For example, as a nurse, I'm in an administrative position right now, and basically I would go from a desk job to seeing the sickest patients that you'll ever see anywhere in the world when I deploy.

I do a minimum of 40 shifts in a civilian acute care facility a year. That's what's required for my trade. For each particular MOSID—so med tech, PA, doctor, nurse, dentist, physiotherapist—all of us, each one, have a table and we look at it. Now, if I were selected to do something on the DART, for example, if I were to be at a little more of a high-readiness level, I'd need to have more days. And some of my courses would also change a bit. We identify basically on what the demands are.

Mr. Mark Strahl: Who does the evaluating as to whether or not forces clinicians are up to par? You're doing those 40 shifts, and I'm sure you do very well. Is there a way to identify someone who's not meeting those standards? What is the success rate, I guess, is another way to put it, of the evaluation of forces clinicians' who are in those tracks?

Maj Lisa Compton: There's no formal evaluation as such, like a test. There is a tool that junior personnel would take with them when they go out. For example, if a medical technician was to go out, their supervisor would fill out a report on their progress over the year. But for the most part, when we go into practice, we've—

Mr. Mark Strahl: You've earned your stripes.

Maj Lisa Compton: Yes, sir.

Mr. Mark Strahl: Excellent.

The Chair: I believe your time has expired.

Monsieur Larose.

[*Translation*]

Mr. Jean-François Larose: Thank you, Mr. Chair.

Dr. Zamorski, before becoming a member of Parliament, I worked as a correctional officer. I worked in prevention in a prison. In the past few years, three of my colleagues, two I was friends with, committed suicide, and those events were traumatic for all the workers.

People had to stop working because it was so devastating. The workers were seriously affected. They managed to get social workers in to speak to people. And in the course of talking to people, they realized that many people were quite depressed and that some had suicidal tendencies themselves. As a result, they called for a study, but of course the request met with resistance. Because they never got an answer, the assumption was that it had to do with cost.

I see everything you've done so far and I see how difficult it is to be a member of the military. The conditions can be absolutely appalling. You need great strength of character. The spirit and morale of these individuals can end up broken.

We see all kinds of reports. Some say things are going well and others say the opposite. You raise an important point. You say we need to delve deeper, not simplify things; we need to do more research. According to you, we need more specific data in order to do a more in-depth evaluation.

Could you comment on how it could be dangerous to claim that everything is fine and that we should stay on the same course we're on now?

[*English*]

Dr. Mark Zamorski: Are you speaking in general, in terms of being complacent about the problem of suicide in particular?

Mr. Jean-François Larose: I'm talking about any mental health problem or issue that's on the table with the CF.

Dr. Mark Zamorski: In my position, I get only a superficial portrait of many people. That is the nature of what I do, and that is the nature of somebody who's trying to do research on the mental health of some 60,000 people. That kind of an in-depth understanding I think needs to be something our clinicians do, and I think they do. These people understand, above all others, exactly how complicated and difficult things are, exactly how individual and complex and connected they are with what's going on in people's lives.

I accept my own portrayal of things as always an oversimplification, but it's the best we have scientifically.

● (1715)

[*Translation*]

Mr. Jean-François Larose: You said we needed to gather more data.

Do you feel that progress is being made and that data is being collected? We have been in Afghanistan since 2001, after all.

[*English*]

Dr. Mark Zamorski: Certainly the more research we do, and the higher-quality research we do, the better. The upcoming mental health survey is a good example. It is basically the very best way anyone can do a mental health survey, which is to say the best possible response rate.

Statistics Canada is an amazing, capable group of people who can get great response rates. It does beautiful surveys; they are done as carefully as they can be done and they are analyzed as carefully as anyone can do it. It will provide us with a very rich picture for a mental health survey. But it always is an approximation; it's never a crystal clear picture. Whatever research we do, it always raises additional questions about things we need to do, other things to do.

Mr. Jean-François Larose: In a comparison to civilian life, where there's a lack of research on that, especially when it comes to people in uniform, do you see a correlation where one can help the other?

Dr. Mark Zamorski: If I may, I think the general population has a lot to learn by looking at our mental health survey. We have eliminated in the military almost all of these terrific structural barriers that make it very hard for many Canadians to access care—not enough mental health providers, wait times are exceedingly long, people can't get services in the language they're most comfortable in, people can't pay for care, they can't get transportation to care. All these things are problems that we have fixed.

For that reason, when we looked at mental health seeking in the CF, even in 2002, our members with mental disorders were more likely than their civilian counterparts to have sought care for the same kinds of problems. So despite these special barriers that we're concerned about, our members also have special access to care. I think civilians can learn an awful lot from us.

In addition, if you look at us and contrast what we know about our employees with what the average civilian employer anywhere in Canada knows about the mental health of its workforce, we know so much more. However imperfect the picture I have, through my lens of research, about what's going on in terms of mental health in the CF, it far exceeds what Ford knows about its employees, or BlackBerry, or whomever.

The Chair: Go ahead, Mr. Opitz.

Mr. Ted Opitz: Thank you, Mr. Chair.

Thank you to our witnesses.

Dr. Zamorski, let me start with you, sir. Towards the end of your written presentation, you mentioned that you do additional research. Recently there have been three expert panels—on brain injuries, suicide prevention, and the prevention of family violence.

I'd like to go into this question a little deeper: what is the correlation between OSIs and domestic violence? Perhaps you can elaborate on that.

Dr. Mark Zamorski: There's a fair bit of research on this. The most consistent observation is that being a victim of family violence is a risk factor for mental disorders, including PTSD. That is the primary linkage between family violence and traumatic stress disorders.

That being said, there are a number of studies, including research that we have done ourselves, that do show a correlation between having post-traumatic stress disorder and incidentally depression as being both a perpetrator of family violence and a victim of family violence. I think most people in the field who've looked at this acknowledge that there is likely a linkage there.

That said, it is only one factor of many that influences family violence. The average person with PTSD hasn't hurt anybody. They're minding their own business, trying to go about their business in the best way they can. I worry, when we talk about these things, that people get the picture that our service members with PTSD are homicidal, suicidal maniacs, which is profoundly unfair and very unhelpful for them as they reintegrate back into society.

So there is a linkage there, but let's not take it out of context.

● (1720)

Mr. Ted Opitz: You make a good point, because it's those cases that are well publicized, and then all of a sudden people take them out of context and think they're more prevalent than they are.

If you were to make a prediction, what do you think you will see 10 years on in terms of our soldiers who have experienced OSIs, taking into account your U.S. data?

Dr. Mark Zamorski: Unfortunately, I think the gains that we have made in the prevention of physical casualties and the treatment of combat casualties to prevent death and serious disabilities have not been matched by gains in the prevention of operational stress injuries.

Arguably we've made no progress, or if progress has been made, we don't have any evidence of it. For every conflict, we look back and we say, “Aha. We figured it out.” And every time, we still see lots and lots of people with PTSD after the conflict.

We may one day make gains in terms of prevention. I don't see anything coming down the recent pipeline that's going to have a transformative effect. Above all else, then, we'll continue to see OSIs. Similarly, in terms of treatments, our treatments get incrementally better year by year by year. I don't see any magic bullets coming down the pipe.

Most people with an OSI will be okay. Some will recover completely. Many will recover substantially, to the point where they can live full and rich lives doing many things, but they will still not meet our military fitness requirements, which are extraordinary. And some, despite our very best efforts, will struggle for the rest of their lives. That will be the minority.

I think that's true today, and unfortunately, I think it will remain true for the next decade.

Mr. Ted Opitz: Do you think we can ever prevent operational stress injuries? These are unpredictable events—an IED, a combat occurrence, where several of your buddies might be killed, a variety of other events. Do you think we could ever prevent it?

Dr. Mark Zamorski: I think there will be preventive measures that are effective, but I think they will be, at most, of modest efficacy. That is my guess. I don't think I will see the reliable prevention of PTSD in my lifetime, unfortunately. It's just too big of a task.

Mr. Ted Opitz: So the main effort will be on the treatment?

Dr. Mark Zamorski: I think the main efforts will be to get people into treatment sooner, so as to provide better treatments that work more reliably and more completely, better tolerated treatments. Those are achievable things. Above all else, we have to make sure that, given the treatments we have, which we accept aren't perfect, we're doing the very best way we can.

Mr. Ted Opitz: Am I done?

The Chair: Yes, pretty much. There are only a couple of seconds left.

[*Translation*]

Ms. Moore, please go ahead.

Ms. Christine Moore: Thank you, Mr. Chair.

On the subject of medical evacuations and urgent cases, in other words, when someone's life is truly in danger, I would like to know something. I am wondering whether there are clear procedures indicating how the evacuation is supposed to be done, who is supposed to accompany the patient, what actions are supposed to be taken and whether there is a decompression period.

According to the scientific research we have, how can we make sure that these evacuations produce the least amount of stress possible for members who have to be evacuated and brought back home?

[*English*]

Dr. Mark Zamorski: Lisa, do you want to answer the first part of that?

Maj Lisa Compton: Typically, these soldiers would go from the point of injury in the field—they would be picked up and taken to Role 3, when we were in Kandahar. Then they would go from Kandahar to Bagram, which is another Role 3 facility. That one is American-led. Then they would go to Landstuhl, and from Landstuhl to home. Sometimes that would take 48 to 72 hours. Starting in 2010, we established a liaison position in Bagram, and from then on we've always had a casualty support team in Landstuhl.

[*Translation*]

Ms. Christine Moore: Before going further, I'd like to know whether there's a decompression period between those two steps or whether, within that 72 hours, the member goes from the battlefield directly home.

Does the person accompanying the patient have the same rank or higher? That might not matter. How do you choose the person who goes with them?

● (1725)

[*English*]

Maj Lisa Compton: Typically, there wouldn't be anybody who would go with that person, other than the medical team. Somebody leaving Kandahar would get on an American CCATT, critical care in the air. They would come and pick them up. Until 2010, we had the first liaison position in Bagram, but there was no Canadian with them until they arrived in Landstuhl.

As to decompression, depending on their injury sometimes they wouldn't even wake up in Bagram. I've been from point of injury all the way to Landstuhl and home. I've been fortunate enough to work throughout that continuum. I think in Bagram was the first time. Sometimes they would wake up and they'd think they were in Germany or they wouldn't know where they were. After my first tour in Bagram, the biggest thing was later I would get e-mails telling me that all they remember seeing was my maple leaf and they were so relieved to see my uniform. There was no real decompression.

TBI screening is done for anybody who's capable of answering questions and being assessed properly, that is, if they're not intubated or heavily medicated. Everybody who goes through Landstuhl has a traumatic brain injury screening done before they leave. When they arrive home, where they go depends on where their care needs to be given, according to what is the best medical care available in the area closest to where their family lives.

[*Translation*]

Ms. Christine Moore: I am not talking about urgent cases where the patients are unconscious. I am referring more so to individuals suffering from post-traumatic stress syndrome, for example, who cannot remain in combat and must be evacuated. You said that only medical personnel is there and that there isn't any decompression time, as when other military members leave the field. So those people end up at home within 72 hours or so.

Is that more or less what you are saying?

[*English*]

Dr. Mark Zamorski: If I understand your question, it sounds as if you're concerned about whether people who are medically evacuated are receiving some kind of psychological decompression as part of their repatriation.

Is that where your concern is?

[*Translation*]

Ms. Christine Moore: I am just trying to compare two situations: what happens when a member experiences traumatic events during their mission but completes that mission, versus what happens when a member is evacuated for post-traumatic stress syndrome. I'd like to get a handle on that.

Is that procedure better to control the symptoms? It's the first steps taken following an incident that have a major impact on how the person will cope with the problem or get through it later on.

Does the scientific research show that medical evacuations are most effective in helping members deal with their symptoms down the road? If not, is it possible to take a different approach?

[*English*]

Dr. Mark Zamorski: I'm not familiar with any research that specifically gets at that aspect of the repatriation or evacuation procedure. The general approach is that these are people who have identified medical needs. They're in medical care and their psychosocial state is under consideration by the whole team that is taking care of them, from the nurse to the doctor. There are specialists available if they need specialty care. And to be honest, that aspect of what's going on is probably not highest on everyone's level of concern. If people have life-threatening injuries, no one's overly worried about the shock of the repatriation procedure. They're often focused very much on making sure these patients are safe and that their complicated medical needs are taken care of. It's at the other end, as they start to stabilize, that any good trauma team starts factoring in their psychological needs.

● (1730)

Maj Lisa Compton: And for a person who would be sent home, who is completely free of physical injury.... Often the whole PTSD diagnosis isn't really confirmed in theatre; there's another diagnosis. But they're basically not mentally healthy to be there any longer.

We get them home to medical care. The actual decompression that we get is very different from the care the person receives. The priority would be getting the person home to the mental health workers who need to care for them immediately.

So the importance would be not so much the decompression, but getting them to the care back home that they need right away, because we can't have them in an environment like theatre where they wouldn't be safe.

The Chair: Thank you. We've gone over our time. It is the bottom of the hour.

Do you have a comment, Mr. Larose?

Mr. Jean-François Larose: It's a point of order. The witnesses don't have to stay. It's just for the committee.

It's just a small question. I don't know if you'll take it into consideration, but I realize that when we wait for translation, it can be longer. Let's say we have a French witness. If anglophones have a hard time, they have to wait. I was just wondering if the chair would take into consideration giving maybe an extra 30 seconds, just to give that time for everybody to have that chance.

Ms. Moore was also waiting for translation.

The Chair: I do, and we only had one question that was actually on the five-minute mark; everything else has been over by quite a bit.

Mr. Jean-François Larose: Okay, great. Merci.

The Chair: I want to thank our witnesses for appearing. Major Compton, Dr. Zamorski, thank you very much for coming in and sharing your expertise with us today, and thank you for helping us with our study on the care of our ill and injured.

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

A voice: So moved.

The Chair: We're out of here.