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FUTURE WAR PAPER

*What Color are the Podiatrist's Boots:
Creating a Joint Medical Corps*

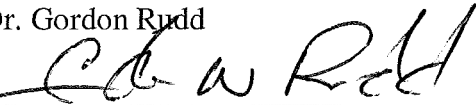
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Executive Summary

Title: What Color are the Podiatrist's Boots: Creating a Joint Medical Corps

Author: Major Alexandra V. Gerbracht, United States Marine Corps

Thesis: Developing a single medical service in the Department of Defense could reduce redundant capabilities and provide efficiencies in a deployed environment.

Discussion: The U.S. Army, Navy, and Air Force each maintain a separate medical corps and medical treatment facilities, and deploy with different structures while providing the same capabilities. For example, a medical officer in the Air Force does not provide different care than a Navy medical officer. The color of a podiatrist's boots does not matter as long as they take care of a service member's feet. Opportunities exist to make the US military medical field more flexible and efficient. Canada or France are case studies of countries with a single medical service. While there is a difference in how the services medically deploy, there remain overlapping capabilities. What are the benefits, efficiencies, and possible structure of a joint medical corps in the United States military?

Conclusion: The Department of Defense is already moving toward a joint medical capability and, a scalable and task organized medical capability will benefit the future forces of the United States military and give JTF and combatant commanders considerable flexibility regarding medical requirements. Creation of a Defense Health Service would bring standardization of equipment; and coordination supply, logistics, and available capabilities. A single medical service could pave the way for other capabilities to fall under a joint service.

Introduction

Each U.S. military department maintains a separate medical corps and medical treatment facilities (MTF). As Department of Defense budgets decline, the military services must identify cost-saving measures while still maintaining an effective and efficient fighting force. One specialty already beginning to develop a joint structure is the defense medical system. Opportunities exist to make the medical field more flexible and efficient. For example, a medical officer in the Air Force does not provide different care than a Navy medical officer. The color of a podiatrist's boots does not matter as long as they take care of a service member's feet. There are vast differences in the additional skills required by the services, including Coast Guard medical professionals. While there is a difference in how the services medically deploy, there remain overlapping capabilities. What are the benefits, efficiencies, and possible structure of a joint medical corps in the United States military? Developing a single medical service in the Department of Defense could reduce redundant capabilities and provide efficiencies in a deployed environment.¹

Creating a single medical service requires exploring active duty deployable medical resources as a component of the military health system. The Defense Health Agency (DHA) stood up in 2013 to "exercise management responsibility for shared services, functions, and activities in the Military Health System (MHS) and its common business and clinical processes. The DHA manages the TRICARE and inactive personnel care components at a joint level. DHA also supports the effective execution of the DoD medical mission"² This was the first step toward medical jointness. However, as Figure 1 shows, the services still have significant autonomy. Differences in training and deployment between medical units between the services suggest there is room for efficiency, and a single medical force would provide those improvements.

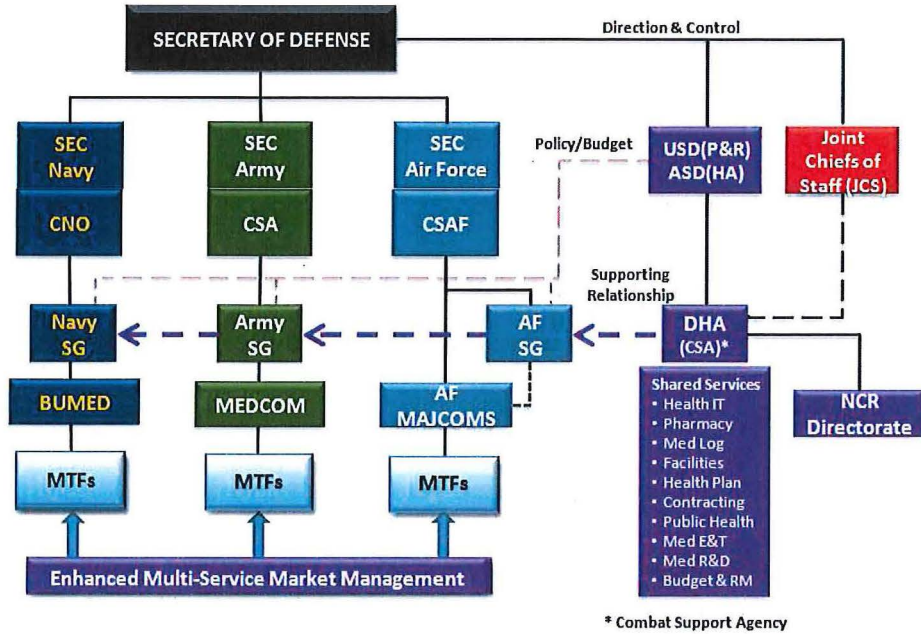


Figure 1: Organizational Chart for DoD Medical Health System³

A key assumption is the continued development of the DHA as a joint structure. DHA currently links numerous medical requirements, such as medical logistics, medical education and training, health information technology, and pharmacy operations. Although DHA is equalizing operations in the local MTFs the individual services still operate differently from each other. There are two examples here: the Navy has Medical Officers at the battalion level in the Marine Corps, but the Army keeps their doctors at the brigade level until deployment. By outlining how the current American military deploys its medical services and exploring a case study that has demonstrated efficiencies in current deployment models, a single medical service will emerge as the alternative to better meet operational requirements.

How Medical Services Deploy Today

The Army, Navy, and Air Force all have many similar capabilities, like medical planners, as part of the medical service infrastructure. Medical Planners are administrators who manage combat health support by planning the locations, logistics, and resourcing for deployed medical treatment capabilities. Medical personnel plan for medical facilities on a forward operating base, the rotation of personnel in and out of a deployed environment, logistics and supply of blood and medical supplies, and the appropriate coverage area for medical evacuation. Often, major subordinate level command and higher-level headquarters will have medical doctors on staff as advisors to ensure appropriate coverage but will also have medical service personnel working for them. For example, a division-level surgeon is always a physician; however, medical planners are also on the same staff. The physicians provide the care, while the planners on a higher staff ensure the doctors have everything they need to get the job done.

Each service provides first echelon casualty management capabilities, which are broken down into Role 1-4. Role 1 is the first medical care service members receive; it is also referred to as unit-level medical care or point of injury care.⁴ For the Army and Marine Corps, this is the individual corpsman or medic assigned through a battalion aid station. The Navy provides a shock trauma platoon at this level, but this capability exists at the Marine Expeditionary Force (MEF) level.

Role 2 offers advanced trauma management and emergency medical treatment.⁵ This can include optometry, operational stress control, dental, laboratory, radiographic, behavioral health, and surgical capabilities. The Army provides this capability with medical companies, which deploy with brigade-sized formations, or as the medical troop in the armored cavalry regiment. An Army Forward Surgical Team (FST), assigned to a medical command or medical brigade, also provides Role 2 capability. The Air Force Mobile Field Surgical Team (MFST), Small

Portable Expeditionary Aeromedical Rapid Response (SPEARARR) Team, and Expeditionary Medical Support (EMEDS) Basic are all different sized units which provide the Role 2 capability, but with various requirements for equipment and space that are not organic to the medical units. The Navy Casualty Receiving and Treatment Ship (CRTS), part of an amphibious ready group, and an Aircraft Carrier Battle Group have Role 2 capability. In the Marine Corps, the Navy creates a Forward Resuscitative Surgical System (FRSS) or Shock Trauma Platoon (STP) out of the Medical Battalions. The Navy also provides a surgical company to the Marine Corps with Role 2 capability, which is available at the MEF level.⁶

Role 3 treats patients in a medical treatment facility staffed and equipped to provide care to all categories of patients. The deployed Role 3 capability for the Army is the Combat Support Hospital (CSH), which deploys based on theater requirements from a medical brigade or medical command and can have up to 284 bed spaces. The Air Force can expand the EMEDS to provide Role 3 capability. The Navy provides Role 3 capability through an expeditionary medical facility or a hospital ship, the USNS Mercy or USNS Comfort.⁷ Medical Battalions stationed with the Marine Corps can reinforce with additional assets to create a ROLE 3 capability. Each military service has limited Role 3 capabilities and when deployed are tailored to the needs of the formations supported.

Permanent U.S. military base hospitals, like Ramstein or Camp Pendleton hospital, and robust overseas facilities provide Role 4 medical care.⁸ The Walter Reed Hospital, the Pentagon medical clinic, and Fort Belvoir medical facilities operate the DHA's National Capitol Region Directorate. These facilities are already joint, in that they have medical professionals from each service. There are additional joint medical facilities around the country that service both active duty and veteran patients.

	Role 1	Role 2	Role 3	Role 4
Army	Medics/Bn Aid Station	Medical Companies/ troops, FST	CSH	Joint Facilities, post hospitals
Navy	Corpsmen/ BN Aid Station	CRTS, Surgical Company, FRSS, STP	USNS Mercy, USNS Comfort, Medical Battalion (reinforced)	Joint facilities, base hospitals
Air Force	Medics/Aid Station	MFST, SPEARR, EMEDS Basic	EMEDS	Joint facilities, base hospitals

There is vast deployable capacity within the military health system, because each service retains the resources for all levels of coverage. Even the medical units that provide these capabilities may not have all the organic logistical equipment to operate expeditionary facilities, such as an STP with inadequate tents and generators. These numerous teams and units offer basic medical care in a deployed environment. This begs the questions, do both the Air Force and Army deployed medical facilities need x-ray technology? Could one service of medical professionals provide all medical requirements? There are obvious redundant resources and capabilities and many personnel already train jointly.

Active duty medical professionals are still required to maintain service specific skills even at joint- level units and joint medical facilities, such as Fort Belvoir. The Army has a large medical corps where the individual providers must maintain both "soldier skills", such as rifle marksmanship and the PFT, along with their medical skills.⁹ The Navy requires medical doctors have a warfare classification pin, such as the Fleet Marine Force qualification, which requires observation of a Marine Corps combat operations center and other military skills. These

requirements for medical specialists take time away from practicing medicine. The medics embedded in military units, especially special operations, need those additional skills but they are not required for all providers. Service specific training requirements reduce focus on patients or other specialized medical training.

There is already a significant amount of joint medical training for medical officers and enlisted personnel. The Uniformed Services University of the Health Sciences (USUHS), in Bethesda, Maryland, is an accredited medical, dental, and nursing school that offers commission into the Army, Navy, or Air Force. The Defense Medical Readiness Training Institute (DMRTI) at Fort Sam Houston, Texas offers joint professional military education for military medical providers in areas such as the Joint Operations Medical Manager's Course, CBRN specific education, MOOTW medical planning, and numerous others to enhance medical readiness. Systems such as the Joint Trauma System incorporate all the services in recording data as patients move through the defense medical system.¹⁰ These joint training environments and courses enhance the flexibility and interoperability of all defense medical personnel.

There are also many joint aspects of the medical health services, from DHA to Medical Logistics (MEDLOG) to the Joint Medical Operations Centers, but there are still capability overlaps. Other countries are significantly more efficient and joint in the structure and employment of their medical corps. Canada currently employs an effective joint medical capability.

Case Study: Canadian Military Health Services

The Canadian Forces (CF) are a unified military organization with three service components of maritime, land, and air. The Canadian Joint Operations Command (CJOC)

employs regional specific task forces with the Canadian Forces Joint Operational Support Group (CFJOSG) as a capability provider. This logistics unit provides forces to deploy for numerous tasks including military police, engineers, movement control, material support, and health services.¹¹ This formation provides task-specific support to the CF when deployed. “The CFJOSG is the high-readiness formation that generates task-tailored operational and support capabilities for employment in Canadian, continental, and world-wide theatres of operations and across strategic lines of communications”.¹² These task-specific elements work for the Vice Chief of Defense Staff when not deployed but are associated with a specific service. The Joint Requirements Center serves as a force provider. The Canadian Operational Support Command (CANOSCOM) controls these support forces in garrison and is a separate entity from the three service components.¹³(Appendix A is Canadian Armed Force Structure)

When Canadian Forces form a Joint Task Force (JTF) for deployment, the commander determines the personnel requirements and allocations. Based on the mission, the Canadian JTF sources personnel from the three service-specific components and the CANOSCOM. In addition to operational elements, special staff officers are tasked for medical planning and work directly for the Joint Force Commander. These planning officers may be either administrators or doctors.¹⁴ Figure 2 below shows the generic organizational structure with the medical elements highlighted.

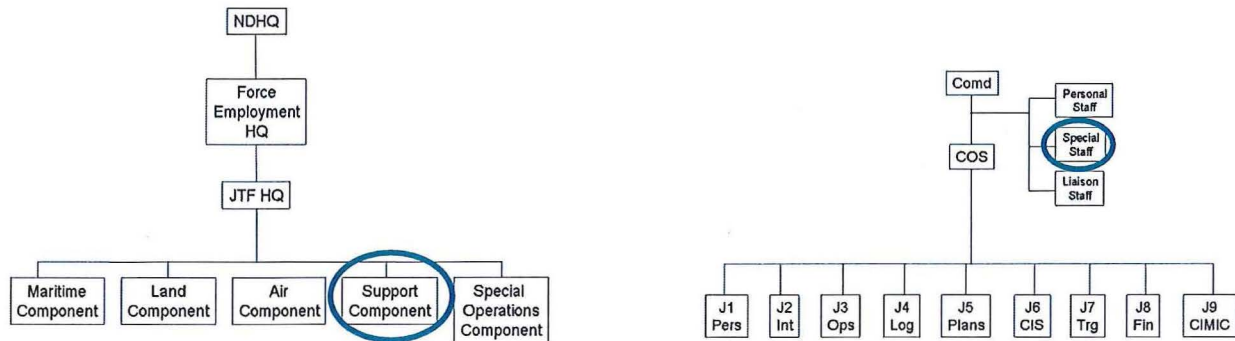


Figure 2 Generic Canadian Joint Task Force¹⁵

This structure allows for flexibility in deployment and allows the JTF to task organize based on the specific mission set, without losing specialization of medical capabilities. This system works for the Canadian military, a small force of 67,000 active duty personnel and 31,000 reserves.¹⁶ The Canadian medical and dental professionals fall under the Canadian Forces Health Services Group and operate out of regional clinics and health centers supporting active duty members. They have the capacity for one field hospital and can cover Role 1-3 in a deployed environment.¹⁷ The small size of the force allows for appropriate resource management but means many specialties are very shallow.¹⁸

The concept of a single unit supporting each of the services is not unique. The Canadian military has a Joint Military Police Services Group and also has groups within that organization tailored to the needs of each service, like the Naval Military Police Group.¹⁹ The French and German militaries also have a single medical service separate from the other services that support all operations and tailors to the mission. The United States military could implement a similar system by creating a single medical service, while still maintaining the same capabilities that exist today.

Proposed Defense Health Service

Based on the existing joint medical entities and the continued development of the DHA toward a more joint force, an even more flexible medical deployment capability could be 7-15 years away. Creating a single medical service to treat all military forces is the next step in developing efficiency of joint medical support. Garrison health care will continue to be a significant requirement however; deployable medical capabilities can and should continue to develop a joint nature. Future United States military actions will primarily use joint task forces, rather than single service deployments. The DoD could develop a scalable, flexible, and deployable independent medical capability to allow JTFs to select which medical capability best suits a mission. There must be a surge mechanism built in that does not detract from garrison medical support. A joint medical force would mean more flexibility to tailor medical assets to specific mission requirements. A joint medical capability would alter existing command and control relationships, maintain certain specializations, require enhanced joint training and further joint logistics development, retain service specific medical planners, and deploy Role 1-4 capabilities and physicians differently. Dental capabilities incorporate into a Defense Health Service the same way they pair with medical units now. Dental focus would primarily be in garrison but the deployment requirement remains.

Force Structure and Command and Control

The DHA would assume much greater responsibility for a joint medical corps by transforming into a Defense Health Service. This would include manning, training, and equipping the medical force. Joint training already in existence would continue. Specialized medical recruiters could efficiently canvas and sign up medical professionals. The medical

community would handle promotions and performance evaluations internally to ensure professional competence is the priority for advancement. For deployment purposes, the deploying unit would take administrative responsibility for the medical enablers. This type of force would require standardized training across the board.

Standing medical battalions and brigades would continue to support the individual services in garrison but in a supporting- supported relationship as opposed to operational control; similar to how the Navy's medical units support the Marine Corps but still report to the Navy. However, instead of having a medical detachment associated with units at the battalion level, the way the Navy and Marine Corps operate, a joint medical corps would operate similar to the Army²⁰ and have a larger medical unit supporting an entire MEF or Army Division. For example, a joint Medical Service Corps officer would command medical units and deploying units would coordinate support with that element. This medical unit would also be responsible for all garrison medical responsibilities and the coverage of both deployments and garrison requirements could be coordinated by the Defense Health Service level or cover gaps. A joint medical corps would support all of the services but report to through a Defense Health Service chain of command, similar to the Canadian example of CANOSCOM. A JTF or combatant commander would own all the forces and have the flexibility and scalability to move the medical capabilities around based on support required as they would any ground forces rather than based on the service medical capability.

Joint Training

DHA and joint medical training would continue to develop along the current track. There should be an emphasis on common equipment and capability sets across the force. There are

already a number of Joint medical planning courses offered at DMRTI in addition to basic training for all the services medical personnel and consolidated specialist courses. The continued development of courses at the Medical Education and Training Campus at Fort Sam Houston and USUHS offers a significant opportunity to develop joint medical courses and facilitate joint capability development.²¹

Standardization of medical equipment is required across the board. However, there is value in training how to use all types of equipment available. For example, a junior medic should be able to take a patient's blood pressure with any blood pressure equipment, not just the Army or Navy equipment. Individual personnel deploying will be able to use whatever equipment is available. The standardization of equipment and training in garrison will enable standardization of deployable equipment and reduce facilities cost and maintenance. Thus, if the mission requires a surge of equipment or personnel, those resources would be the same no matter where they came from. In addition to continued joint training, significant importance would be placed on common understanding and availability of equipment.

Medical Logistics

Medical Logistics (MEDLOG) currently falls under the Business Support Directorate of the Defense Health Agency, but that does not mean that supply and logistics of medical supplies are managed the same in all services. Often sourcing of medical supplies depends on the location of the facility (CONUS or OCONUS).²² MEDLOG should become more standard across the services and equipment should be less service specific. Medical units deployed in Afghanistan for Operation Enduring Freedom used different levels of medical supply and logistics. For instance, the Naval Surgical Company serving with the Marines in Helmand province used Marine and Naval logistics at the major subordinate command level and went through logistics

and supply hubs in California. However, the Army medical units based in Kandahar and elsewhere used the Army Medical Material Agency.²³ The Air Force Medical Operations Agency, The Army Medical Material Agency, and the Navy Medical Logistics Command all conduct the same types of operations in different ways to serve the respective services. The efforts of those agencies could combine under a joint Defense Health Service to achieve a more efficient force.

A JTF commander should be able to choose the capabilities required based on the theater and mission. A joint medical unit must have equipment sets capable of deploying for all Role levels. This means medical battalions and brigades would continue to maintain their current equipment while standardizing the equipment across all medical units. This should include all the tentage and medical equipment. In a deployed environment, the JTF should designate additional logistics and supply resources to medical enablers since they would not have the depth of capability. Marines conduct this type of support by having vehicle and utilities operators stationed with the naval medical battalions. The unit receiving support will supply utilities equipment, such as generators, lights, and water purification (and the operators to go with it).

As noted above, each service has Role 1-4 capabilities with significant overlap. A more efficient joint medical corps would have a menu of medical options with levels of service for deploying units. Standing medical units would be capable of task organizing based on the amount of triage to specialization care required. Similar to the Canadian forces which have developed deployed force based on the specific JTF operational requirements. This flexibility would still allow deployment of all four Role levels based on the mission. Instead of having an MFST, FST, or a FRSS the JTF commander could request a surgical Role 2 capability and the

medical personnel could build exactly what the commander needs and pull personnel and equipment from a standardized force to meet the needs.

Physician Employment

The preponderance of medical capabilities rely upon board certified physicians. The requirement for a significant number of medical providers in garrison will not go away when a JTF deploys. A joint medical corps must have the flexibility to reallocate doctors from all specialties with the ability to replace as needed; if all the doctors are wearing the same uniform that scalability should be easier to provide on an individual augment basis.

Physicians should have limited service-specific training requirements outside of basic health requirements to operate in a deployed environment.²⁴ They should focus primarily on their medical specialties. They should be administratively associated with the service with which they support, continuing the supporting-supported relationship.²⁵ The Defense Health Service should control physician promotions and should prioritize medical expertise and experience at the junior officer levels, and additional administrative and minor advising at the senior levels. Doctors should promote other doctors based on proficiency.

Taking surgeons and medical doctors out of the planning and operational chain of command completely is not the answer. Rather, they could be employed more efficiently at higher levels for advising while still ensuring they maintain experience in their chosen field. For example, instead of having a physician on the division or wing staff, a medical planner or medical unit commander could act as the primary advisor to the commander. Advising physicians would remain at the MEF and Corps levels. Physicians should be associated with deploying units for work-up training and actual deployment instead of serving as standing

battalion physicians. This would allow doctors to serve in a medical treatment facility for the majority of their careers and not sitting in military staff meetings and away from their patients.

Specializations

There are certain medical specializations that must remain in place, specifically, special operations medical training and aeromedical requirements. Special operations medics receive specialized medical training in the form of the Special Operations Combat Medical (SOCM) course and Advanced-SOCM course. These are currently attended only by the Army and Navy SOF communities and by the Air Force only until 2006.²⁶ These courses should continue because of the advanced nature of special operations but all three services (Army Navy and Air Force) could attend the same courses. Medical professionals associated with Special operations receive additional training as required by their individual missions; this should continue, but SOCM should remain the primary basic course attended by all services. Once a medic specializes with SOF, they should remain with that community because of the sunk cost in specialized training; the way an operator remains in the community because of an established skill set.

Similar requirements should apply to the aeromedical community. Additional training is required for in-route care physicians and nurses, and all three services have this capability. Flight surgeons receive additional training to understand the physical demands on pilots. The current medical requirements for pilot flight physicals are the same across the services. A Marine Corps pilot can go to an Air Force flight surgeon, and an Air Force pilot can see a Navy flight surgeon. Once a physician trains as a flight surgeon they should remain in support of flying units regardless of service they are supporting.

Medical personnel will need unit and service-specific training once designated to deploy. Medics deploying with infantry can earn a specialization with additional training. The

specialization training is career enhancing similar to the way unrestricted naval officers receive specialization pins as junior officers. Specialization is important in the medical field but a joint medical corps must also cultivate general medical physicians as well as general medical planners.

Medical Service Corps and Planning

There would be two types of medical service corps planners, both service-specific and joint. Medical Service Corps must remain service-specific to ensure specific requirements are met for deployments and to act as advisors to lower level commanders. This means the Army, Navy, and Air Force retain the medical planners who are responsible for determining those respective mission-specific requirements, and who understand what deploying units would bring organically to the flight. These planners would be liaisons between the specific services or deploying units and Defense Health Service units. Joint medical service corps members working directly for a Defense Health Service would be the administrators and commanders for the medical units in addition to advising at the JTF and combatant command level. The junior medical corps officers would maintain a specialization or choose a command track, similar to the breakout of first sergeants and master sergeants in the Marine Corps. Multiple tracks for medical planners mean both the needs of services and the DoD are met.

Medics, Corpsman, Physician's Assistants, and Independent Duty Corpsmen

All enlisted medical personnel should be jointly trained, and based on duty station, receive additional specialized training as needed. For example, an enlisted member stationed at a garrison hospital will not need service specific training until assigned to a deploying unit. An enlisted medic assigned to a medical brigade supporting an infantry division may require

specialized infantry training. This provides the same basic capabilities across services, which would allow for flexibility and ability to surge based on mission sets and allow lower unit commanders flexibility with their enablers.

Individual medics or independent duty corpsmen often cover the lower levels of care and everyday preventive medicine. Medical professionals who are not doctors often attend to basic medical care and sick call; these nurses and providers are the first line of medical defense and are integral to any deployment. The services differ on how they employ non-physician medical personnel. Physician's assistants (PAs) with the Army associate with a specific medical doctor for certification and oversight purposes.²⁷ The Navy has independent duty corpsmen (IDC) that can operate independent of a certified physician but have fewer capabilities than a PA. Smaller deploying units will have requirements for these independent providers but are not large enough for a full time physician. Command and control relationships with the supporting medical unit will remain to support those individual nurses, PAs, and IDCs out on deployment. Similar to the way State Department or contracted enablers work with deployed units; there will always be a connection to the parent medical command. This structure allows for conceptual planning to remain at the high levels and medical planners at the lower levels to continue the detailed planning.

Drawbacks

A command and control relationship of supported-supporting removes some control by field commanders, especially at the battalion level, which may lose a physician within its command. Ultimately, a Defense Health Service would give more flexibility to combatant and JTF commanders. Standardization of equipment and practices would be difficult and costly, but garrison medical facilities could benefit. This suggests the Navy and Air Force may lose some

service specific character to their medical support. It may take 7-15 years to implement this type of force and would take numerous exercises and war games to iron out the details and fill in gaps.

Conclusion

The Department of Defense is already moving toward a joint medical capability and there is significant opportunity to continue the evolution to a more flexible and efficient medical service. There are redundant capabilities in the existing medical services that a joint corps would reduce. A scalable and task organized medical capability will benefit the future forces of the United States military and give JTF and combatant commanders considerable flexibility regarding medical requirements. The Canadian model shows the efficiency of a scalable and flexible medical force. Creation of a Defense Health Service would bring standardization of equipment; and coordination supply, logistics, and available capabilities.

The defense medical capability is a great example of creating a more efficient national defense structure. A single medical service could pave the way for other capabilities to fall under a joint service. Do the military police, judge advocates, and chaplains differ between the services in the types of missions they conduct? Could a joint agency also provide those capabilities? A defense health service is just one step in creating a more joint military and efficient fighting force.

¹ This paper addresses only the medical personnel serving with the U.S Army, Navy and Air Force and does not recommend that the Marine Corps gain medical personnel.

² Secretary of Defense. *Defense Health Agency(DHA)*. Department of Defense Directive 5136.13, September 30, 2013.

³ Plummer, Jeff, CAPT USN. "Primer on DHA." PowerPoint Presentation. Advanced Medical Department Officer's Course (AMDOC), Navy Bureau of Medicine & Surgery, 10 September 2014. Medical Treatment Facilities (MTFs) are operating in garrison but staffed by deployable medical personal from active duty units. These facilities are the day to day operations for the deployable medical units.

⁴Office of the Surgeon General United States Army. *Emergency War Surgery*, Fourth United States Revision. Borden Institute US Army Medical Department and School, Fort Sam Houston, TX 2013. <http://www.cs.amedd.army.mil/borden/FileDownloadpublic.aspx?docid=80035d1a-f208-473d-993b-6debfb17db91> p18

⁵Chairman Joint Chiefs of Staff. *Joint Publication 4-02 Health Service Support*. Washington, DC. 26 July 2002 p xii

⁶Emergency War Surgery p21-23

⁷Emergency War Surgery p 25-28

⁸JP 4-02 pxii

⁹MAJ Tiffany Bilderback, USA (Medical Services Officer), interview by author, 8 October 2015.

¹⁰Headquarters US Army. *Casualty Care*. Army Techniques Publication (ATP) No 4-02.5 Washington, DC: Headquarters US Army, 10 May 2013 http://armypubs.army.mil/doctrine/DR_pubs/dr_a/pdf/atp4_02x5.pdf

¹¹*Jane's Sentinel Security Assessment*. North America: Armed Forces, Canada. posted 31 Jul 2015 <https://janes-ihs-com.lomc.idm.oclc.org/CustomPages/Janes/DisplayPage.aspx?DocType=Reference&ItemId=+++1303962&Pubabbrev=NAM>

¹²Government of Canada. *National Defence and the Canadian Armed Forces: Operational Support in Canada*. Accessed 21 December 2015. <http://www.forces.gc.ca/en/operations-support/cfjosg.page>

¹³*Ibid.*

¹⁴Barbara Sibbald, *Military medical service no longer has MD at helm*. Canadian Medical Association Journal. Vol 561. Feb 22, 2002

¹⁵Chief of the Defense Staff, *Canadian Forces Joint Publication. CFJP 3.0 Operation*. 2010- 07 Accessed 21 December 2015. http://publications.gc.ca/collections/collection_2011/dn-nd/D2-252-300-2010-eng.pdf

¹⁶*Jane's Sentinel Security Assessment*

¹⁷Brigadier General Jean-Robert S. Bernie. "The Canadian Forces Health Service". *Medical Corps International Forum* March 2012. <http://www.mci-forum.com/the-canadian-forces-health-service/>

¹⁸Canada is an interesting medical case study because they also have a socialized medical system for civilians. There is no additional need for the medical system to support dependents and inactive personnel as only regular force personnel (and reserves when activated) are eligible for care. There is a strain on the American DHA because of those additional requirements on defense medical facilities.

¹⁹Military Police Services, National Defense and the Canadian Armed Forces, accessed 21 February 2016. <http://www.forces.gc.ca/en/caf-community-support-services-military-police/index.page>

²⁰Bilderback interview

²¹L.A. Shively. "Transforming enlisted medical education and training for the 21st century". Fort Sam Houston Joint Base San Antonio. April 22, 2010.

²²Schoonover, Ronald, CMDR USN (Navy Medical Planner, XO 1st Medical Battalion). Interview conducted by author 8 October 2015.

²³Schoonover interview, Bilderback interview

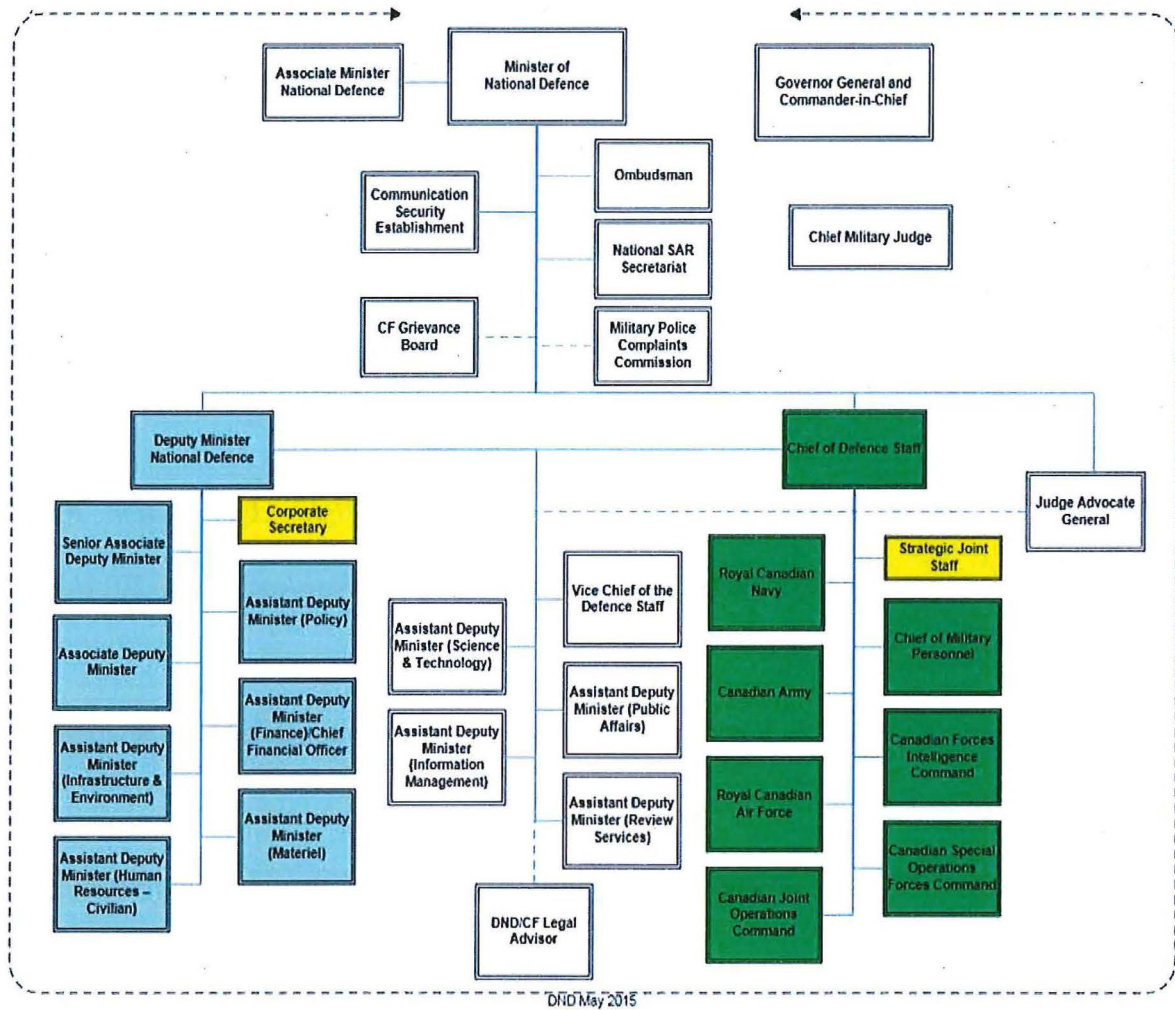
²⁴Individuals must still be capable of working in a deployed operating environment, this would still include basic height and weight and minimal physical readiness standards. Enlisted personnel would be required to conduct regular rifle training when stationed with a deployable rifle unit, officers would have one time rifle training and regular pistol training.

²⁵Navy Chaplains wear the uniform of and are administratively associated with the unit they serve.

²⁶Schwartz, Aaron SFC (ret) (Army Special Operations medic and special operations medic instructor), interview conducted by the author 27 December 2015.

²⁷Schwartz interview. Bilderback interview.

Appendix A: Canadian Armed Forces Organizational Chart



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