

No Task Fit for a Soldier? Canadian Forces Medical Personnel and Humanitarian Relief Missions since the Second World War

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[Aller au sommaire du numéro](#)

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Résumé de l'article

Les armées modernes du monde industrialisé exécutent leurs opérations selon une doctrine, c'est-à-dire une philosophie à laquelle est liée toute une série de procédures elles-mêmes déterminées par la situation tactique et stratégique. Ces mêmes armées, cependant, répondent aux besoins de gouvernements civils qui ne limitent pas leurs demandes ou leurs instructions aux types d'opérations qu'une armée pourrait énoncer dans sa doctrine. Pour les services armées du Canada, tel semble être le cas dans le domaine des opérations humanitaires, qui, même si elles ne faisaient pas partie de la philosophie opérationnelle de ces services, ont tout de même été d'une certaine importance dans l'histoire de l'aviation, de la marine, et de l'armée de terre depuis la fin de la Deuxième Guerre mondiale. Cette étude vise à explorer les opérations humanitaires dans la période débutant dans la deuxième moitié des années 1940 et prenant fin dans les années 1990, lors de la formation et les premières opérations d'une unité spécialisant dans le domaine humanitaire. L'article se penchera surtout sur la pratique de la médecine lors de ces missions, pour tenter de déterminer si les praticiens et praticiennes des forces armées devaient changer leur approche de base pour accomplir leurs tâches, ou si il suffisait tout simplement d'adapter leurs procédures selon la situation opérationnelle.

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Abstract: Modern armies of the industrialized world operate in accordance with a doctrine, that is to say a philosophy linked to a series of procedures themselves determined by the tactical and strategic environment. These same armies, however, answer to civilian governments that do not limit their demands or instructions to the types of operations an army might list in its doctrine. For Canada's armed services, such seems to have been the case in regards to humanitarian operations which, even if they were not part of these services' operational philosophies, have nonetheless been of no little importance in the history of the air force, the navy, and the army since the end of the Second World War. This study will explore humanitarian operations from the second half of the 1940s to the formation and first missions of a unit specializing in such work in the 1990s. It will focus mainly on medical practice during these missions and attempt to determine whether medical practitioners had to change their basic approach to accomplish their tasks, or whether it sufficed to adapt procedures in accordance with the operational situation.

At the battle of Batoche on 12 May 1885, at the end of the war between the Canadian government and the western Métis, the government's militia units that had fought Louis Riel's forces were accompanied by medical personnel. Military doctors were not only responsible for ministering to their own soldiers (among whom there were over a hundred injuries); they were also under orders to treat wounded and sick opponents, especially after the last battle had been fought. One unnamed field surgeon, hearing that many Métis were "lying ill and unattended

about the districts of Fish Creek and Batoche,” set out to find them. Near the first battlefield, he and two colleagues treated a patient with a lung infection, then moved on to where the climactic engagement had taken place. There, the parish priest told them that there were about ten wounded men in the area, “mostly convalescent.” One, however, named Gardapuy, “had been wounded through the lung.” The surgeon recollected: “After some trouble I found him, because he feared arrest, and on examination discovered that he had a chest filled with fluid. I did not feel justified in operating under the circumstances, but gave him a letter to the police surgeon at Prince Albert, assuring him that every attention would be paid him.”¹ Medical practitioners also left a stock of dressings, bandages and other supplies.

The episode is interesting in that, even before the formation of the Canadian Army Medical Corps in 1904, practitioners were being ordered to use their skills for other than purely military purposes—in this case seeking to convince Métis of the government’s good intentions after a bloody military campaign. Such would continue to be the case in the century and more that followed, even though the Medical Corps’ own doctrine (and later, that of the Royal Canadian Navy, Royal Canadian Air Force, and Canadian Forces Medical Service, or CFMS) clearly limited the roles of doctors, nurses and assistants. The 1910 *Regulations for the Canadian Medical Service* stated unequivocally that its officers were to focus on “the preservation of the health or comfort of the troops, and to the mitigation or prevention of disease in the army.”² There was no mention of missionary, outreach or public relations work, nor would there be in subsequent statements of doctrine. The 1959 *Manual of the Canadian Forces Medical Service in the Field* stated just as clearly that “The role of the Canadian Forces Medical Service in a theatre of operations is to conserve manpower,”³ while almost two decades later a *Canadian Forces Medical Services Information Booklet* insisted that “The Mission of the CFMS is the conservation of personnel to support the military operation through the prevention and treatment of disease and injury.”⁴

The reader will note the operative words in these statements of the military medical practitioner’s role. The “health or comfort of the troops,”

1 *Medical and Surgical History of the Canadian North-west Rebellion*, (Montreal: Printed by J. Lovell and Sons, 1886), 42.

2 Canada, Department of Militia and Defence, *Regulations for the Canadian Medical Service, 1910* (Ottawa: Government Printing Bureau, 1910), 7.

3 Canada, Department of National Defence, *Manual of the Canadian Forces Medical Service in the Field, 1959* (Ottawa: [Queen’s Printer, 1959]), 1.

4 Surgeon General, *Canadian Forces Medical Services Information Booklet* (Ottawa: National Defence Headquarters, 1977), 4.

“to conserve manpower,” and “to support the military operation,” obviously limit what doctors, nurses and medical assistants were expected to do. But health care work following Batoche just as clearly exemplifies the fact that that policy was not carved in stone, and is not a reliable reflection of historical events. Still, army official histories have focused on that institution’s purely military role in the two world conflicts and Korea; naval official histories published to date have followed a similar path. The official history of the Royal Canadian Air Force (RCAF) provides something of an exception, dedicating a substantial amount of space in its second volume to surveying and similar cartographic missions of the interwar period. More popular histories have studied, in the main, institutional development and the types of military operation those institutions considered to be of primary interest.⁵ For a comprehensive treatment of humanitarian relief operations, one needs to look to more specialized accounts, such as *In the Line of Duty*, an anthology of articles on operations in Somalia, many of which were humanitarian in nature, and Larry Milberry’s *Air Transport in Canada*, which devotes one of fifty-three chapters to the issue. These two works are, however, exceptions to a general rule. Historians and other researchers have focused on what policy makers and the armed services themselves have considered to be, perhaps understandably, their main role: national defence.

Still, there is much those who are interested in the history of medical practice can learn from studying lower priority missions. To come to grips with this area of activity it is necessary to study in some detail what medical practitioners actually did—to reach some understanding of events as they occurred and not how policy makers wished them to occur. The result, a look at what we could call “non-doctrinal operations,” can help us understand how the role of armed forces is not limited to the military sphere, and how medical practitioners sometimes adapt and alter procedures to fit that reality.

The Early Cold War

This paper focuses on the decades following the Second World War, since it was in that period that humanitarian relief operations took on a noted international flavour. In the decades following Batoche, medical practitioners overseas did indeed focus on supporting wartime military

⁵ Such works include John Martenson’s *We Stand on Guard: An Illustrated History of the Canadian Army* (though there is passing reference to humanitarian relief on p.391), J. L. Granatstein’s *Canada’s Army: Waging War and Keeping the Peace*, Marc Milner’s *Canada’s Navy: The First Century*, and a variety of general air force histories, notably Larry Milberry’s multi-volume *Canada’s Air Force at War and Peace* (though there is some mention of medical evacuations in the first two volumes, and a promise to discuss humanitarian relief in more detail in the two volumes yet to come).

operations, for instance in the South African War of 1899–1902 and the two world wars. In the peace that followed, however, Canada's armed services were, for the first time in appreciable numbers, deployed overseas in the absence of military conflict. After a few years of demobilization following victory in Europe and the Pacific, Canada's armed services began once again to prepare for war. Though much has been claimed for the importance of Igor Gouzenko's 1945 defection in raising Canadian apprehensions concerning the international designs of communist countries, the 1948 coup in Czechoslovakia had far more impact on Canadian policy making. Defence budgets began to increase that very year, and expanded dramatically after North Korea's invasion of its southern neighbour in 1950. By the time the 1953 armistice was signed, Canada's spending on things military had increased nine-fold.

In a simultaneous development, Canada also sought to play a role in ensuring Cold War protagonists did not enter into a major conflict as the result of an escalation of some smaller war. Also, as a country that never had been—and never would be—a major power, it attempted to work through international organizations such as the United Nations and NATO to see that its national interests were not overwhelmed by the world's most powerful nations. Linked with this move to get a seat at the table of international discussion was a willingness to finance various international agencies. Another result of these varied stimuli was Canada's peacekeeping operations, such as the force sent to observe the ceasefire between Israel and some of its Arab neighbours in 1948, or the group sent to help manage the ceasefire between India and Pakistan the following year.

Department of National Defence (DND) documents relating to medical issues of the time therefore focus on the support provided to these peacekeeping and similar operations following various conflicts in such places as the Middle East, South Asia, Indochina, and Cyprus. Somewhat unexpectedly, however, overseas commitments were not all the result of war; many missions were straightforward assistance operations. One of the first humanitarian operations of the post-war era to enter the documentary record was the provision of aid to the Netherlands during severe flooding in February 1953. Though no medical personnel were sent, it nonetheless demonstrates how the military chain of command could react to a humanitarian crisis. When the issue came up of involving 27th Canadian Infantry Brigade Group, which was posted to Germany as part of Canada's NATO contribution, the Canadian Ambassador to the Hague noted that "We are naturally in dark" as to how to proceed.⁶ Red tape proved not to be a problem, however, as

⁶ National Archives of Canada (NA), RG 24, 83–84/167, Box 6548, 2-13-3, Cdn Ambassador The Hague to S/State External Affairs, 2 Feb 53.

the ambassador announced the very next day that a troop of 30 men from the brigade's engineer squadron had left for Holland to "act as emergency boatcrew."⁷ Given that the operation did not involve the use of force, it was in effect the equivalent of a training exercise and was thus well within a commander's sphere of authority to launch.

The turnaround for providing support in an emergency was not always so quick. When in November 1955 the Under-Secretary of State for External Affairs requested one or two RCAF aircraft to airlift supplies to flood-ravaged parts of Pakistan and India, it took almost two weeks for the air force to rearrange its schedules in order to comply.⁸ Still, the issue was more one of making the necessary logistical arrangements than sorting out lines of authority and policy. When in 1960 Chile was struck by an earthquake, an RCAF North Star aircraft left Trenton soon after with, among other things, 2000 vials of tetanus antitoxin, 500 vials of anti-gangrene serum, and 28 000 vials of penicillin.⁹ In each of the above cases the mission was of short duration and required little in the way of personnel.

As for the medical branches, some of the requests they received were of the type that might have been more familiar to missionary societies. For example, in 1962 the Surgeon-General reported to the Canadian Forces Medical Council that "because of the attrition in the United Kingdom Medical Services they could not meet certain overseas commitments and requested that Canada provide one internist, one surgeon, one obstetrician/gynaecologist and one anaesthetist for the military hospital at Accra, Ghana," which served civilian as well as military needs. The Canadian Forces Medical Service already had a medical officer (or MO) serving there, but expanding that contribution was unlikely. "As there is a shortage of medical officers and specialists in the Canadian Forces Medical Service, any additional commitments of this nature will be extremely difficult to meet. Accordingly, authority has been requested from the Chairman, Chiefs of Staff to promulgate information to Reserve medical officers and ask for names of volunteers. Authority has also been requested to advise the Deans of Medical Schools in Canada of the potential requirement, in order that they may circulate their medical staffs and advise any interested individuals to apply." Willing volunteers could take courses in tropical medicine at either Sainte-Anne-de-Bellevue, in Quebec, or the London School of Tropical Medicine.¹⁰ Significantly, no member of the Canadian

7 NA, RG 24, 83-84/167, Box 6548, 2-13-3, Cdn Ambassador The Hague to FRG, 3 Feb 53.

8 NA, RG 24, 83-84/167, Box 6548, 2-13-3, Jules Léger to F. R. Miller, DM DND, 15 Nov 55; W/C G. Broadley for CAS, to Under S/State for External Affairs, 28 Nov 55.

9 Department of National Defence, Directorate of History and Heritage (DHH) 75/351, Canadian Red Cross News Service, 28 May 60.

10 NA, RG 24, 83-84/167, Box 7789, 2-6030-110/M1-1, pt 7, 24th Meeting CFMC, 11 May 62.

Forces Medical Council noted why they were entertaining such requests, but hints at an explanation would surface in the years that followed.

The CFMS officer already in Ghana serves as an excellent example of how the military could operate in a wider campaign of westernization. He reported in May 1962 how he had arrived in December 1961 "to find a completely new and very well equipped Laboratory." Perhaps typically, however, simply importing equipment without implementing a local training program proved counter-productive. "Much of the equipment was beyond the comprehension of even the most experienced technician," Captain R. W. W. Kay related, "and during the re-organization period preceeding this date there had been very little training and upgrading of Laboratory Technicians. In addition, reorganization of administration and the large inventory resulting from the equipment expansion required that for the first time since the Hospital started an administrative side had to be formed in the Laboratory." Certain forms of aid might therefore be more complicated than they were worth, and Kay found that though eight technicians operated the laboratory, and though "their zeal for work was high," there was no reserve to allow for some sort of rotation, so they could not be taken away from the benches for training. Furthermore, in a circular phenomenon that would become common in medical humanitarian aid, providing medical services increased demand for those same services. According to Kay, "the Hospital commitments were increasing due to the accepting of civilians as entitled patients, to the expansion of the Ghana Armed Forces to include Air Force and Naval personnel. Most of all however, the expansion was due to the fact that 'European Medicine' had at last been 'sold' to the Army personnel."¹¹ Missionary zeal had paid off in the form of acceptance, at the cost of severely straining the services being provided, as was the case in the laboratory described above.

Across the continent from Ghana was Tanzania, where Canada maintained a military aid mission in the 1960s, complete with a medical officer to look after the health needs of Canadian troops. A few months after deployment, however, Flight Lieutenant W. J. O'Hara was reporting that his mornings were mostly taken up accompanying a Tanzanian medical officer, Captain Chuwa, on sick parade. The ailments he encountered among Tanzanian soldiers included some quite common among Canadian troops, such as venereal disease, others only seen in overseas deployments, such as malaria, and some unheard of in Canadian soldiers, such as leprosy. Part of the programme he supported

¹¹ NA, RG 24, 83-84/167, Box 7849, 2-6160-034/121, Capt R. W. W. Kay, RAMC, Annual Report and End of Tour Report, 1962, 23 May 63.

consisted of sending candidates to Canada to train as pilots, but conducting medicals for these men often proved frustratingly different from the same process back home when those with the necessary educational qualifications had to be turned away on medical grounds. Fifty to eighty per cent of these potential recruits had heart murmurs, probably due to childhood bouts of rheumatic fever.¹² Attempting to apply the health standards of an industrialized state to an African nation in transition would lead to many such discoveries.

One difficulty encountered in Tanzania, also seen in the deployment to Ghana, was that demands could be limitless. The responsibilities of medical practitioners did not end when they had dealt with military needs, but were extended to families as well. In one five-day visit to the 5th Battalion, for instance, “two cases of paralytic polio had just turned up. Also several children had died from whooping cough since our last visit. I was quite surprised to find that Capt Chuwa had neglected to immunize the dependent children because ‘there is no polio here’. Immediate action was taken to get adequate polio vaccine to Tabora so that all dependents could be immunized.”¹³

In fact, this expansion of medical services provided by the military was not limited to aid missions. A similar expansion was occurring in Canada, where soldiers, sailors, and air personnel no longer joined up for the duration of a conflict but foresaw, in many cases, making a decades-long career in one of the country’s fighting services. They would not do so if the impact on their families was too harsh, so as early as the late 1940s many military medical practitioners had to apply knowledge in such specialties as obstetrics. In some communities, such as Fort Nelson, British Columbia,¹⁴ and Churchill, Manitoba,¹⁵ medical detachments treated residents of the area as well as service personnel and their families. For O’Hara to work among civilians in Tanzania was thus not unusual, and in one of his reports he presented an excellent example of the relationship between soldiers’ health and the community in which they lived. “My own efforts to launch a cleanup campaign for the serious VD problem in TPDF [Tanzanian People’s Defence Forces] has met failure. Social pressures, moral lethargy and ignorance are all contributing factors.”¹⁶ (Medical practitioners engaged in the fight against AIDS three decades later would report in like fashion.)

12 NA, RG 24, 83–84/167, Box 7849, 2-6160-034/311, F/L W. J. O’Hara, Med/MO, to SG, 6 Apr 66.

13 NA, RG 24, 83–84/167, Box 7849, 2-6160-034/311, F/L W. J. O’Hara to SG, 16 Jul 66.

14 R. G. Foulkes, “Medics in the North,” *Medical Services Journal Canada* (July–August 1962): 524, 538; (October 1962): 676; (November 1962): 750.

15 NA, RG 24, 83–84/167, Box 7789, 2-6030-110/M1-1, pt 7, Minutes of a Meeting Held in the Office of the Minister of National Defence, 24 Mar 60.

16 NA, RG 24, 83–84/167, Box 7849, 2-6160-034/311, F/L W. J. O’Hara to SG, 16 Jul 66.

Other attempts to apply Canadian procedures and products in Tanzania also met with disappointment. For instance, O'Hara noted the inadequacy of the vitamins: "The inter-service vitamins found in all first aid kits sent here cannot be used. The heat and humidity must be responsible for giving the pills such an offensive odour and taste that they cannot be consumed. As well they are all melted together and it is almost impossible to get the empty plastic container free of the stains and odour."¹⁷

O'Hara's deployment was thus a mix of challenges both familiar and new. One problem the Tanzanian People's Defence Forces faced that was identical with one within the Canadian armed services was a shortage of medical personnel, mainly because in the latter case better opportunities—and better remuneration—were available elsewhere. In spite of a wide variety of schemes which paid for medical education in return for a period of service later on or put members of the military through school, Canada's army, navy, and air force were perpetually short of qualified people.¹⁸ Similarly, the Tanzanian People's Defence Forces were having little luck recruiting doctors. "For the next two years it does not appear that there will be any additional MOs in the army. Medical students interviewed recently in Uganda by Dr Chuwa, were not interested in army life at all, and secondarily were not impressed with the salary." Further, "In general, our present small group of Army 'medical assistants' are very poorly trained, inadequate and incompetent but not because of lack of potential, interest or ability but because good medical training facilities are almost impossible to come by." O'Hara suggested that Canada take on responsibility for such education, making sure to align his plan with the priorities of the Cold War by reporting that "The Chinese have built and equipped an army medical centre in Zanzibar recently, as well as staffing it with at least three medical specialists."¹⁹

Canada thus had a competitor for the gratitude of the Tanzanian people, and therein lies an explanation for such missionary work. In the same way that religious organizations used Western medicine as a means of making contact with people in Asia and Africa so as to convert them to Christianity, so did the liberal democracies send medical practitioners to convince those who had recently gained political independence to join forces with their erstwhile masters in the Cold War against communism. As military historian Andrew Godefroy explains,

¹⁷ NA, RG 24, 83-84/167, Box 7849, 2-6160-034/311, F/L W. J. O'Hara to SG, Oct 66.

¹⁸ For example: NA, RG 24, 83-84/167, Box 7717, 20-1-1, pt 3, A/C F. G. Wait, Chair Ad Hoc Ctee, to Sec PMC, 9 May 51; NA, RG 24, 83-84/167, Box 7719, 20-1-1, pt 18, Surg RAdm T. B. McLean, SG, Supporting Data for PMC, 23 Mar 60.

¹⁹ NA, RG 24, 83-84/167, Box 7849, 2-6160-034/311, F/L W. J. O'Hara to SG, Oct 66.

“Canadian Participation in military assistance programs began in the late 1950s as officials in the Department of External Affairs (DEA) realized the increasing value of such aid in contribution towards the pro-democratic evolution of the developing world,”²⁰ or at least towards the anti-communist evolution of those recently independent nations. As for Ghana and Tanzania more specifically, Canadian missions there (both civilian and military) were to help encourage those governments to “firmly support a pro-Western rather than communist regime in the two countries.”²¹

Although competing political ideologies may have motivated the military medical aid missions, the good doctor in Tanzania seemed more concerned with competing medical ideologies. He wrote, “The witchdoctors still lead an active role here. Recently I had a TPDF pilot, trained in Canada, request to see his ‘local doctor.’ He had been sick with undulant [or fluctuating] fever for about one week, when he wrote a letter to me from his hospital bed. He stated that he was suffering from a disease unknown to modern medicine and that only ‘local doctors’ could successfully treat it. He wanted me to authorize two weeks sick leave in order to go home and get this treatment.” Within twenty-four hours of writing the letter, however, a combination of three antibiotics prescribed to treat Brucellosis “had finally worked, and he was discharged from hospital, ‘cured by modern medicine’ ... he still sheepishly smiles whenever I mention the letter.”²² Such gloating may seem rather inappropriate today, but we can perhaps consider the medical officer’s isolation, distance from home, and frustration in attempting to inaugurate public health procedures as mitigating factors. Even in the midst of the Cold War, a doctor trained in Western medicine might find a local medical practitioner to be a more tangible threat than that posed by a Chinese hospital.

By the mid-1960s, therefore, Canada’s armed services had a decade’s worth of experience engaging in non-doctrinal operations, while various civilian agencies at home, one of them the Emergency Measures Organization, also learned much about humanitarian relief. Through such work within Canada, such as following a tidal wave at Alberni in 1961, a forest fire in Prince Edward Island in 1964, an explosion in La Salle in 1965, and a Red River flood, also in 1965, civilian agencies learned a lesson that would have important implications for Canada’s armed services. This lesson was the advantage of “the use of trained

20 Andrew Godefroy, “The Canadian Armed Forces Advisory and Training Team Tanzania 1965–1970,” *Canadian Military History* (Summer 2002): 32.

21 *Ibid.*, 31.

22 NA, RG 24, 83–84/167, Box 7849, 2-6160-034/311, F/L W. J. O’Hara to SG, 19 May 67.

personnel over benevolent volunteers, who had, in fact, hindered rescue operations.”²³ “Trained personnel” could well include members of the army, navy, and air force, and when in 1966 the Emergency Measures Organization met for the first time as a committee, two of its eighteen members were from the services.²⁴ Although the Department of National Defence was clearly willing to help out in humanitarian relief on an ad hoc basis, it did not want such a role institutionalized. Its view was encapsulated in a report of November 1966: “In view of the DND position not to expend funds making special preparations for assistance to the civil authorities, the results of disaster research will have little effect on DND plans.”²⁵ Similarly, that same month E. B. Armstrong, the department’s deputy minister, stated that “In a peacetime disaster situation the Canadian Forces are prepared to provide their resources in any type of disaster where civil capability clearly requires augmentation to alleviate human suffering or property damage... The ability to carry out the above assistance to civil authorities is based on military trained personnel and the employment of available DND equipment and vehicles. No special training is carried out nor is expenditure of defence funds made for special equipment to carry out this task.”²⁶

One example of how the Armed Forces expected to apply such a doctrine was in the wake of the Peruvian earthquake of late spring, 1970. By mid-June about seventy members of the forces were in the disaster zone, and by the end of the month 424 (City of Hamilton) Squadron would fly ninety-seven relief missions for a total of 382 hours “over difficult and treacherous mountain passes.” It also evacuated 1903 injured and homeless Peruvians.²⁷ One member of the team was Captain Ben Pasicov, a medical officer whose role was to see to the health and tend the injuries of the other members of the squadron, but in a development now well-familiar, he did not limit his work to what may have been written down in terms of reference. When on 17 June he was asked to treat a Peruvian who had been injured in the mountains, he accepted. “The journey began with a flight by American helicopter,” a public relations officer reported, though the doctor was aware that three such aircraft had been lost in the previous three days in the canyon’s treacherous downdrafts. Deposited safely on a grassy knoll ten miles

23 NA, RG 24, 83–84/232, Box 41, 1150-110/J25, Summary Record of EMO Study Group on Peacetime Disasters, 13–14 Oct 65.

24 NA, RG 24, 83–84/232, Box 41, 1150-110/J25, Canada Emergency Measures Organization, Summary Record of First Meeting, 8 Jul 66.

25 NA, RG 24, 83–84/232, Box 41, 1150-110/J25, Col T. R. McCoy, DSEO, to DC Res, 22 Nov 66.

26 NA, RG 24, 83–84/232, Box 41, 1150-110/J25, E. B. Armstrong, DM, to Canadian Emergency Measures Organization, 30 Nov 66.

27 DHH 72/293, Department of National Defence, Information Services, 29 Jun 70.

further up the valley—and another thousand feet up in the mountain air—two guides were waiting “and together the foursome trudged along for about an hour climbing steadily all the way. ‘A little further up,’ the guides kept repeating as sister Guadalupe Zabaco of Madonna House, Cambermere, Ontario patiently translated... The light fails fast in the Huaylas Canyon when the sun goes down at 4.30 p.m. Unless they got there soon—and it was now almost noon—the doctor would be stranded without blankets and with no warm clothes in the subfreezing night of the mountains.”²⁸ Arriving at a village, he requested a horse for himself and a burro for the sister, though “It was then I learned the meaning of fear,” when he realized that “my life depended upon an aging nag feeling its unsteady way along a ledge where a fall meant certain death.” He was honest enough to report, however, that he seemed to be the only member of the party to be so concerned. Locating their patient, an elderly man who had been injured in a fall, they found that his left ankle and thigh had been broken, as were some ribs which had punctured and collapsed his lung. Treatment consisted of bamboo splints and pain relievers, and the small group then made its way back to the helicopter. Though RCAF medical officers, especially those who had worked in Canada’s northern areas, were well-versed in treating civilian patients, Pasicov’s experience was in a league of its own.

The Latter Cold War

By the early 1970s the Canadian Armed Forces were relying on whatever resources were available at the time—and on the initiative of those on the ground—to answer requests for humanitarian relief and similar operations. After providing aid in the aftermath of the Peruvian earthquake, other such missions included support to victims of flooding in Pakistan in 1970, of the war in Bangladesh in 1971, of an earthquake in Nicaragua in 1972, of famine in Niger in 1973, of hurricane and flooding in Haiti in 1974, and of an earthquake in Honduras, also in 1974.²⁹ Then came Operation Dolomite. In the early days of May 1976, an earthquake struck Italy, and Canadian Forces Europe was directed to send an assistance team to aid that country in earthquake relief operations. A task force formed from units of 4 Canadian Mechanized Brigade Group in Germany would establish a self-sufficient base within the damaged area to provide medical and other aid “as requested.” The directive stated that although “The task force mission should in no way degrade” the operational capacity of Canadian Forces Europe, “The

²⁸ DHH 72/293, Fry to Gen Bourgeois, 23 Jun 70.

²⁹ DHH 79/461, Maj Mackay, Request for Information, 7 Apr 74.

task force must be highly visible and indicative of CAF [Canadian Armed Forces] expertise and humanitarian concerns.” Italy being a fellow member of NATO, relief operations would help remind its people whose side they were on in the Cold War. Unlike the deployment to Peru six years before, Dolomite was underpinned by clear geopolitical considerations.

Orders having been issued on 7 May, medical practitioners were on the ground in Italy by the 10th. Clearly this type of operation was new to NATO: the situation on the ground was somewhat chaotic, not only because of the recent earthquake but due to the variety and number of organizations providing help. A question that came up at one briefing was, “As a large quantity of typhoid vaccine was sent to op[erational] area is an immunization program being carried out?” There was no immediate answer. Still, by the 11th it could be reported that, for the village of Pioverno, “A tented camp has been erected to provide food preparation, water, shelter, and med[ical] assistance.” Also, Canadian personnel had finished “deploying tents, beds and kitchens in San Daniele” in support of a local hospital.³⁰ The latter would be an important focus for medical work for the remainder of the mission.

Though by the 12th, “Generally it would appear that the initial emergency situation is over,” that merely meant that the task force had a better idea of just what would be required. Medical assistance would continue to be a priority, as would engineer support to fire brigades and the provision of food and shelter. Five patients arrived at San Daniele that day, and a request went out for a medical officer, four medical assistants and two ambulances; it was accepted. At nearby Venzone a medical officer, three medical assistants and two ambulances transported patients to facilities undamaged by the quake. With the local health situation now clearer, the Command Surgeon advised that personnel joining the task force would need booster shots for typhus and other diseases. Operations were, therefore, settling into a routine, including the report that “Mrs Margarita Perisano, the first patient in the San Daniele hospital Operating Room which had just been set up by Cdn personnel, gave birth to her seventh child, a 7.2 lb girl.” She was one of thirty-three patients treated that day by an organization at San Daniele that included a medical officer, four medical assistants and forty-eight other personnel from various armed forces trades, on site “to assist Italian Medical Authorities.”³¹

³⁰ DHH, 77/216, Annex B, Commander CFE, 7 May 76; Annex D, Minutes of Briefing in CFE Ops Centre, 10 May 76; Annex E, Minutes of Briefing in CFE Ops Centre, 11 May 76.

³¹ DHH, 77/216, Annex G, Minutes of Briefing in CFE Ops Centre, 12 May 76; Annex H, Minutes of Briefing in CFE Ops Centre, 13 May 76.

One should note, however, that the confusion that had accompanied the initial deployment did not entirely disappear as operations normalized. On the 14th the Command Surgeon noted that he had received an indent “for special drugs.” Not knowing exactly what they were for, he could only provide an educated guess that “this must be for hospital patients.” Similarly, the Chief of Staff to the Base Commander asked: “Could we get some clarification on French use of vaccines in Venzone,” since “French officer has requested inoculation for 120,” though the location and function of that contingent was something of a mystery. Information like “Some med persons seen” was not particularly helpful in that regard. Also, “The US have formed a special medical evaluation team under the authority of the Vice-President prepared ‘to recommend provision of med supplies to national contingents’,” though that was not much clearer than French intentions. The Canadians, therefore, though part of a NATO deployment, quite rationally focused on their own operations, which that day saw patients treated in the aid station in Venzone while three ambulances provided medical support to engineering operations in that area. At San Daniele, a section transported furniture and hospital equipment while another assisted in the erection of a field hospital.³²

In keeping with the fact that Operation Dolomite was a NATO deployment, instructions had been issued that it was not to degrade the capabilities of Canadian Forces Europe, whose primary responsibility was to defend against a Warsaw Pact invasion. The contingent’s commander, therefore, “questioned the use of Canadian medical supplies and vaccine in the area. He then gave direction to have Italian authorities contacted and requested to supply appropriate medical supplies...” There seemed to be no objections, and by the 18th, a week after arrival, the Commander Canadian Forces Europe could advise Lieutenant Colonel R. E. Moore, the commander of the Canadians in Italy, that “The situation is stabilizing and the time is approaching when the Italian authorities will begin to implement long term reconstruction plans. Your Task Force therefore can be withdrawn as your assistance is replaced by that provided by the local authorities.” Furthermore, “A great deal of the consultation with the Italian authorities was completed by the Comd Surg and the SSO CE earlier this week,”³³ the latter two being the Command Surgeon and the Senior Staff Officer Construction Engineering.

Ongoing tasks included providing hospital tentage and non-medical hospital support services at San Daniele, while the main body at Ven-

³² DHH, 77/216, Annex J, Minutes of Briefing in CFE Ops Centre, 14 May 76.

³³ DHH, 77/216, Annex K, Minutes of Briefing in CFE Ops Centre, 15 May 76; Annex M, SDO Briefing, 16 May 76; Annex P, Operation Instruction 02, 18 May 76.

zone focused, medically, on immunization, providing essential pharmaceutical supplies not otherwise available, and giving advice on hygiene and sanitation. Looking to the future at San Daniele, “the medical superintendent of this hospital was emphatic that the Canadian contribution of men and tentage was and will be essential to his continuing operation, until his patients can be otherwise housed.” The surgeon and engineer agreed, at least in part, recommending that “Canadian tentage should remain in use by the San Daniele hospital until replaced in two to three weeks. A small Canadian supervisory Detachment will continue to be required after the gradual reduction of the present strength. There is no viable task for Canadian medical personnel at San Daniele.” There was, therefore, little left to do medically, especially since “The mayor of Venzone states that almost all required civilian immunization is now complete.”³⁴ It was time to leave, the main body heading for Germany on 31 May. Brigadier General Belzile, the Acting Commander for Canadian Forces Europe, commented on “the professional manner in which the CFE/BASE staff have handled Op Dolomite. It has given a further opportunity for a real test for the operations centres and sections to do the very thing they are designed to perform.”³⁵

Not exactly: though all Canadians involved, including members of 4 Canadian Mechanized Brigade Group as well as Base units and Canadian Forces Europe, had performed effectively, Dolomite had not been “the very thing” they had been designed for. The Brigade Group especially had a more martial purpose, which was to help defend NATO’s central area against an invasion by the Warsaw Pact; more specifically, it was a reserve force for either VII (US) or II (German) Corps, most likely the latter. Furthermore, the brigade was in something of a logistical limbo at the time of Dolomite. It had moved away from the northern area of Germany, where it had been part of the British Army of the Rhine’s supply line, further south to where US forces were responsible for its materiel.³⁶ Though launched with a political objective in mind—matériel solidarity—Dolomite nonetheless had an important altruistic dimension to it, as Canadian medical practitioners doled out vaccines and other supplies they could replace only with difficulty.

A similar operation, called Abalone, was conducted a few years later. In the early part of April 1979, the Caribbean nation of St. Vincent

³⁴ DHH, 77/216, Annex P, LCol H. R. Bohne, SSO CE, Report on Visit to Udine Area 16/17 May 76 by Surg CFE and SSO CE, 18 May 76.

³⁵ DHH, 77/216, Annex T, Minutes of Briefing in CFE Ops Centre, 22 May 76; Annex V, SDO Briefing, 24 May 76; SDO Briefing, 25 May 76; SDO Briefing, 27 May 76; Minutes of Briefing in CFE Ops Centre, 31 May 76.

³⁶ Sean Maloney, *War Without Battles: Canada's NATO Brigade in Germany, 1951–1993* (Toronto: McGraw-Hill Ryerson, 1997), 291, 294–95.

experienced several volcanic eruptions necessitating the evacuation of upwards of fifteen thousand people to some sixty or seventy refugee camps in the southern part of the island. A thirteen-member medical team from 2 Field Ambulance, SSF, or Special Service Force, was dispatched to render aid,³⁷ though in contrast with Dolomite it was not encapsulated within the framework of a military alliance or similar organization. Perhaps for that reason, the detachment's commander, Captain D. Tyrrell, had to "obtain verbal authority to practice medicine in St. Vincent on emergency basis," since neither he nor any member of his team was licensed in that country. Similar to the instructions given for Dolomite, he was to "avoid committal of further aid from Canada without permission of Ottawa," as military medical resources were somewhat limited.³⁸

A key player in the work that followed was Master Corporal Naylor, a Preventive Medicine Technician, who "was extremely useful in inspecting and advising on health measures within the evacuation centres, namely, over sixty centres providing food and shelter for 15 to 20 000 people. These reports dealt essentially with sewage disposal, food handling, and garbage disposal. These recommendations were passed on to the Central Medical Committee for further action." However, as Kay discovered in Ghana and O'Hara found in Tanzania, deployments to other parts of the world provided lessons that had to be learned the hard way, such as the inappropriateness of the food (called an Individual Ration Pack, or IRP) the medical team brought for its own consumption. "These menus were found to be similar in make-up and were felt to supply too heavy a meal for tropical climates. In the tropics, the calorie intake required per day/per man is approximately 2 000 calories, the menus supplied a minimum of 5 000 calories." One can speculate that the rations were a consequence of Canada's focus on defending western Europe against a Warsaw Pact invasion, rather than on deployments to areas closer to the equator. Similarly, "It was quite evident that a careful and supervised period of climatization had to be carried out in this type of climate. Sunburn, to the extent of incapacitating a soldier, is a definite risk as well as heat stroke and heat exhaustion."³⁹

Humanitarian relief could thus present health challenges similar to those of the peacekeeping operations of the time or large-scale training exercises, and that the Canadian Forces Medical Service was learning from its experiences was, institutionally, all to the good. Abalone differed, however, from operations in Ghana, Tanzania, and Italy—like the

37 DHH, Annual Historical Reports, 2104, Operation Abalone, Post Operation Report.

38 DHH, Annual Historical Reports, 2104, Operation Abalone, Post Operation Report.

39 DHH, Annual Historical Reports, 2104, Operation Abalone, Post Operation Report.

operations in Peru it seemed to have no direct link with the Cold War. Still, Department of National Defence policy remained generally consistent. "While we do not maintain specialist personnel designated specifically for humanitarian relief, we do provide support where possible. Depending upon the degree of urgency and nature of support requested, armed forces personnel can be expected to move within 48 hours of receipt of a request."⁴⁰ After the 1991 break-up of the Soviet Union, however, such "requests" would be far from uncommon, and for a brief period, until it was disbanded in 1993, 4 Canadian Mechanized Brigade Group in Germany served as a base and a pool to respond to them. Whereas in the period spanning from the end of the Second World War to the attempted coup against Gorbachev Canadian operations overseas focused mainly on supporting NATO or peacekeeping/observer missions in such places as Kashmir, the Middle East and Cyprus, in the 1990s there was more emphasis than previously on humanitarian issues in such areas as the Balkans, central Africa and Kurdish parts of Turkey. Following the Gulf War, operations in Turkey were especially exemplary of how hazardous such missions had become. In some instances, Turkish troops, no doubt confused as to why foreigners were helping the Kurdish minority as well as unwanted refugees from Iraq, harassed Canadian medical practitioners by pointing cocked weapons at them.⁴¹

Perhaps even more dangerous was the mission to Somalia in 1992–93. Though the deployment became prominent in the public eye because of the murder of a Somali teenager by Canadian troops, it is the more routine medical aspect of operations which is of greater interest to the present study. Unlike deployments to Ghana, Tanzania, Peru, Italy, St. Vincent and other regions in previous decades, the troops sent to Somalia were not soldiers engaged in humanitarian relief operations, but involved in a military deployment of which aid was merely a component. Orders were that "the Canadian Joint Forces Somalia will provide, as part of the multinational United Task Force, the secure environment for the distribution of relief supplies in Somalia," the word "secure" explicitly referring to the use of armed force. HMCS *Pre-server*, for example, a 20 000-ton replenishment vessel with, among other things, the capability to perform surgery, not only used its helicopters to evacuate victims of snake bite, vehicle accidents and gunshot wounds, but on one occasion to prevent a Red Cross coastal vessel from being attacked by Somali clansmen. Furthermore, medical and health operations were provided further depth by the presence of engineering

40 DHH 79/461, Briefing Notes on CF Participation in International Relief Operations, May 79.

41 Sean Maloney, *War Without Battles*, 460–61.

teams who could, in one instance, install generators, air conditioners, X-ray facilities and various surgical equipment in the Medina hospital in the south end of Mogadishu.

As in Ghana and Tanzania decades before, there was a missionary aspect to the provision of health care, though at the tactical rather than the strategic level. As Colonel J. L. Labbé, the Canadian contingent's commander, explained, in order to establish the "secure environment" called for in his orders, "first we had to earn the trust and confidence of the local population and their leaders." One means of achieving this was by having a large proportion of the fifty medical practitioners of the Canadian Airborne Regiment performing several days of volunteer work every week in the hospital at Belet Uen.⁴² Some of the lessons of previous deployments needed to be relearned, however, and the rations the Canadians had brought were not always appropriate in an Islamic society. According to one of the medical practitioners deployed to Somalia, "Food for all people in the camp took the form of IMPs or hard rations 'boil in a bag.' The Somalis ate what we did but we had to be careful about anything with pork products. Ever think how many I(ndividual) M(eal) P(ackage)s have possible pork products in them?—wieners and beans, sausage and hash browns, ham omelette."⁴³ In regards to rations, at least, Canada was still focused on NATO and western Europe rather than on other organizations working in other parts of the world.

To the mundane could be added hazards that had been unheard of in previous missions. Canadians were operating in the midst of clan warfare where almost everyone was under arms, something Corporal Mario Charette could certainly attest to. "A medical assistant with the Canadian Airborne Regiment in Somalia, Cpl Charette defused a violent demonstration of armed townspeople at the entrance to the Belet-[U]en Hospital on February 17, 1993," a citation for a decoration later stated. While surgeons were operating inside the building, "Cpl Charette was working alone when a crowd advanced towards the gates of the hospital. Shots were fired and a grenade exploded while Cpl Charette called for back-up. Despite the growing chaos, Cpl Charette continued to transmit situation reports while he screened and disarmed the demonstrators. His efforts prevented further destruction of the hospital and the possible deaths of many people." He received the Medal of Bravery in June 1994.

⁴² *In the Line of Duty: Canadian Joint Forces Somalia, 1992–1993* (Ottawa: National Defence, 1994), 60, 104, 115, 266.

⁴³ E. A. Landells, *The Military Nurses of Canada: Recollections of Canadian Military Nurses* (White Rock, B.C.: Co-Publishing, 1995), 526, 528.

Humanitarianism Institutionalized

As we have seen, up to the time of the deployment to Somalia the Canadian Armed Forces had considered humanitarian relief to be somewhat exceptional to the Medical Service's main role, which was to support military operations. The exceptional became institutionalized in 1994 with a Defence White Paper mandating a humanitarian assistance mission for the Canadian Armed Forces as a whole. Whereas the 1987 version had had headings for "Strategic Deterrence," "Conventional Defence," "Sovereignty," "Peacekeeping," and "Arms Control," with no mention of humanitarian relief,⁴⁴ seven years later there was a noticeable change in emphasis: "UN peacekeeping and humanitarian operations are playing a critical role in responding to the immediate consequences, both direct and indirect, of global population and resource pressures. Armed forces are being called upon increasingly to ensure a safe environment for the protection of refugees, the delivery of food and medical supplies, and the provision of essential services in countries where civil society has collapsed."⁴⁵ Justification, though unsupported by evidence in the paper, was that "Canadians have a strong sense of responsibility to alleviate suffering and respond, where their efforts can make a difference."⁴⁶

The change in emphasis can be traced back to the early 1990s, the break-up of the Soviet Union, and the Progressive Conservative government of Brian Mulroney. The Prime Minister suggested in 1991 that nation-states "rethink the limits of national sovereignty in a world where problems respect no borders," and the concept was adhered to with some consistency. Foreign Minister Barbara McDougall suggested in 1993 that "we have to re-consider the UN's traditional definition of state sovereignty." Individual rights, including to basics such as food and shelter, were beginning to rise in importance in comparison with the rights of state governments. The Liberal government of Jean Chrétien that was elected in 1993 maintained a similar focus, identifying mass migration, epidemics, and other humanitarian tragedies as possible threats to Canadian security.⁴⁷

Another influence on policy may have been the fact that the country's fighting services had already carried out humanitarian relief work—and for some time. Within Canada, the 1994 White Paper noted, "The

44 Department of National Defence, *Challenge and Commitment: A Defence Policy for Canada* (Ottawa: National Defence, 1987).

45 Department of National Defence, *1994 Defence White Paper* (Ottawa: National Defence, 1994), 5.

46 *Ibid.*, 12.

47 Greg Donaghy, "All God's Children: Lloyd Axworthy, Human Security and Canadian Foreign Policy," *Canadian Foreign Policy* (Winter 2003): 39–56.

Canadian Forces play a key role in responding to natural and manmade disasters. Not only is the Minister of National Defence also the Minister Responsible for Emergency Preparedness, but, as part of a broader initiative to reduce the size of government, the administration of emergency preparedness planning—once carried out by a separate agency—has been absorbed by the Department of National Defence,” which was tasked to “make an immediate and effective contribution to disaster relief.”⁴⁸ No longer would the armed forces occasionally answer the call for help—they would be the ones organizing assistance. Thus, in a list of six objectives for National Defence, the third was to “be prepared to contribute to humanitarian assistance and disaster relief within 24 hours, and sustain this effort for as long as necessary.”⁴⁹ Though presented under the rubric of “Protecting Canadians,” and referring to disaster relief activities in Canada, the policy could just as easily apply to overseas deployments—and it was.

The Disaster Assistance Response Team, or DART, was created in the mid-1990s. Its role was “to conduct international emergency humanitarian assistance operations,” and as such was expected “to deploy anywhere in the world within 48 hours.” A typical mission was expected to last about ninety days. The response team would rely on personnel from other units to make up its establishment, Petawawa’s 2 Field Ambulance, for example, tasked to provide a platoon-plus of about thirty people to the organization.⁵⁰

Like the units sent to Somalia, the DART would be a full-fledged military organization complete with logistical support provided by the Central Medical Equipment Depot (CMED) in Petawawa. In 1998, for instance, CMED reported that it was maintaining seven days’ worth of DART medical supplies, “in order to meet a 12-hour notice to move,” with a second seven days’ worth of medical materiel assembled and retained in its warehouse. When in November 1998 the devastation caused in Central America by Hurricane Mitch resulted in the first deployment of the DART (Operation Central), at CMED, “within four hours of receiving the request for this materiel, all stores were strapped to 80 pallets and loaded onto two tractor trailers, ready for shipment to awaiting aircraft at 8 Wing Trenton.” Over the next few days CMED also ordered, received and loaded perishable medical supplies required for the deployment’s second seven days. “During the remainder of Op Central CMED provided numerous IOR [Immediate Operational Requirement] shipments of medical supplies to meet the unique, on-the-

48 DND, *1994 Defence White Paper*, 18.

49 *Ibid.*, 19.

50 DHH, *Annual Historical Reports*, 2104, For Year 1996.

ground requirements of the DART Medical Platoon.”⁵¹ As far as the Depot was concerned, such stores were in good hands, since Master Seaman Johnston, Op Central’s Primary Medical Storesperson, was one of the augmentees it relied upon to deploy—and he was normally a member of CMED.⁵² In August 1999 the DART was sent in similar fashion to Turkey to give humanitarian assistance to the victims of an earthquake, with CMED providing seven days’ worth of medical stores immediately, then at intervals in the thirty-eight days the operation (called Torrent) lasted.⁵³

As for the members of the DART proper, one example of their field operations is worth describing in some detail, since it demonstrates the state of the art of humanitarian relief operations at that time. On 3 November 1998, Lieutenant-Colonel Wayne Douglas, the unit’s CO, received a call advising of the possibility that the DART would deploy to Central America. Later, word came that he would be part of a reconnaissance team led by the Department of Foreign Affairs and International Trade, which would consider the feasibility of such a mission. The military element of the team would consist of Douglas, a medical liaison officer, a logistics liaison officer, and an engineer liaison officer. On 4 November these officers drew their personal weapons, among other preparations, only to be told by National Defence Headquarters that though fire-arms would be carried on the deployment, they would not be allowed on the reconnaissance. (The issue of weapons as a matter of routine is evidence that DART operations were not ad hoc affairs—they were military missions conducted according to pre-established Standing Operating Procedures, or SOPs. We have already seen examples of this in Somalia, a mission which predated the 1994 White Paper.) Next day their aircraft landed in Managua, and on the 10th the first five chawks (or loads) of the DART arrived, with five more next day, another five on the 12th, the total personnel in theatre numbering 286 on the 14th.⁵⁴

Events developed quickly thereafter, and the next day the medical facility saw its first patient, a young woman with a gunshot wound to the hip and hand. “Apparently they were the result of an argument with a neighbour over a chicken.” The next patient was evidence that members of the DART could themselves become casualties; a soldier, seriously ill, was evacuated on the Minister of Defence’s airbus, as the Minister happened to be touring the site at the time. The following day

51 DHH 1326-1910, Central Medical Equipment Depot, Annual Historical Report, 3 May 99.

52 DHH 1326-1910, Central Medical Equipment Depot, Annual Historical Report, 3 May 99.

53 DHH 1326-1910, Central Medical Equipment Depot, Annual Historical Report, 27 Mar 00.

54 DHH, Op Central War Diary, 3914.

was busier as medical assistance operations began in the Aguan Valley; they consisted of running a main clinic while sending Joint Medical Teams (JMTs) to more remote villages. The teams were made up of Canadian military personnel and anyone else, whether local medical practitioner or member of a non-governmental international organization (NGO), with useful skills. They saw about one hundred patients at the main clinic and twice that number in one of the villages. They also began distributing water and medical supplies.⁵⁵

On the 17th, the DART's commander toured the clinic, located a half kilometre from a nearby village. Fifty or sixty people waited at the gate, where "Intake was on a modified number system. The clients were given a quick triage and any in immediate need were taken straight to the clinic. The rest were provided with numbers and were told to wait until called." Those in the latter group remained in a tent waiting area where an interpreter asked them basic questions about what was ailing them. From there they then went through an initial screening area where medical staff and an interpreter started a patient record and asked for yet more information. A third phase in the proceedings consisted of an examination area where they were seen by medical assistants and/or nurses. Finally, a doctor might conduct an examination and diagnosis, and if necessary issue a prescription, which could be filled by an onsite pharmacy. The clinic was soon looking at about one hundred patients a day, though these tended to be people from local communities suffering from chronic illnesses rather than those affected by the floods. To look after the latter, the medical company worked in concert with local medical personnel and others from the Standard Foods corporation, which owned and operated large swathes of farmland in the region. Medical teams were trucked out to outlying villages where they conducted daily clinics, while helicopters were used to move Honduran medical teams to remote locations so they could conduct two-day clinics, each of which saw 300 to 400 patients.⁵⁶

The organization was thus up and running, but three days later it became clear that the DART was approaching the limits of its capacity. Conversations with Ottawa solicited the reminder that "The normal DART mandate consists of the provision of water and medical aid. The DART can exploit excess capacity to assist in local improvements and to work through local initiatives. However, it should not take on projects that will require the long-term commitment of resources... Local people and NGOs...will be around long after we leave" and be in a position to deal with longer-term problems. (The reader will note that

⁵⁵ DHH, Op Central War Diary, 3914.

⁵⁶ DHH, Op Central War Diary, 3914.

there were similar policies in place at the time of Operation Dolomite in Italy.) A difficulty related to the above was that the unit had received no medical supplies from Canada, beyond its initial seven day allocation.⁵⁷ The reason for this is something of a mystery since, as we have seen, the medical equipment depots had been able to package and ship the listed materials; either the latter were insufficient to the task or, more likely, there was not enough air transport to move it to Honduras. If such was indeed the case, it might have posed a serious limit on the DART's capabilities, though through no fault of its own.

Regardless of the cause, "Honduran and foreign aid workers have all expressed surprise at the small quantity of medicine which DART has contributed to its own operations. *There is potential for Canada to be embarrassed by this situation*, as supplies have been provided to DART JMTs by NGOs and by Standard Fruit Company of Honduras, the International Hospital for Children and the Robinson Foundation. These organizations are actively seeking sources of medicine for the DART... At the very least, we must bring back up Canadian supplies into theatre before our contribution is compared to that of our benefactors." The CO suggested, however, that "one might point out to the media and the NGOs that if the DART Co[mpan]y was not providing the additional medical personnel and the transport to get the JMTs into remote areas, the demand for medicine would not be as high."⁵⁸

The next day, however, though there was still concern over the lack of medicines, in general operations had settled into a routine involving the delivery of food aid, employment of Joint Medical Teams and running the medical clinic. When on the 22nd Minister of Defence Art Eggleton toured the facility, "The party was impressed with the medical set up and found it interesting that it had been described by local officials and by NGOs as the best-equipped hospital in Honduras." Mind you, "The lab is having difficulty functioning, as most of the equipment does not like the temperature or the humidity."⁵⁹

At the village of Ceibita, The clinic was set up in front of a "soil" house, a two family dwelling with "no electricity, no water, and no sanitation of any kind." Even the tented hospitals the Canadian medical practitioners were used to had such amenities, so this particular humanitarian relief operation forced them to rely on first principles. And there was more, as "The flood line was about five feet up the outside wall and it had started to crumble. Apparently, these walls become in[f]ested with insects and rodents that spread disease and infections to the people

⁵⁷ DHH, Op Central War Diary, 3914.

⁵⁸ DHH, Op Central War Diary, 3914.

⁵⁹ DHH, Op Central War Diary, 3914.

living inside.” The clinic’s personnel consisted of two Canadian doctors, a nurse and a military medical assistant, along with security people, as well as a couple of Honduran doctors and a pharmacy run by two of their compatriots. Furniture consisted of a few three-foot tables, some chairs and benches, patients being interviewed and examined in the open. “It was primitive but impressive at the same time, especially when you consider the number of people seen (upwards of 200).”⁶⁰ It proved to be the peak of the DART’s deployment.

On 26 November the unit’s commanding officer reported that the standing clinic was being used “less and less.” Plans were to close it down within days, though Joint Medical Teams would continue to work in the more isolated valley villages, concentrating on disease prevention and inoculation under the auspices of the Honduran Ministry of Health. In fact, four days later such teams were in La Paz and El Olivido to begin immunizing local people, noting “a substantial improvement in the health of the population, in general,” a sign that the immediate crisis was ebbing.⁶¹ The DART returned to Canada soon after.

Conclusion

What had been a secondary duty for over a hundred years thus became a high priority for the Canadian Forces Medical Service as the twentieth century neared its end. There is some question, however, as to whether such a change in policy made a noticeable difference in regard to the scope and pace of humanitarian relief operations. Of a score or so missions examined for this paper, only one was refused, and though there may have been other unrecorded occasions when Canadian forces declined to provide support, the trend for the period since the end of the Second World War is clear. Regardless of where policymakers placed such operations in their list of priorities, and even if they chose to leave them off the table entirely, they were always part of the military’s repertoire. One clear motivation was national interest, as humanitarian relief overseas showed Canada in a favourable light among people the country sought as allies, Tanzania and Italy being prime examples, or among potential trade partners, as may well have been the case in Latin American countries.

Furthermore, in regard to training, if one is to prepare medical practitioners for war while the country is at peace, policy makers might have come to consider humanitarian relief to be an effective forum for such

60 DHH, Op Central War Diary, 3914.

61 DHH, Op Central War Diary, 3914.

indoctrination. As Bernard Tardif noted in the afterword of a biography of a First World War surgeon,

Alors que pendant des décennies l'oto-rhino-laryngologie, l'ophtalmologie, la neurochirurgie et l'orthopédie s'étaient seules séparées de la chirurgie générale, cette dernière est en voie de disparition par éclatement en chirurgie digestive, gynécologique, urologique, cardiothoracique, plastique, pédiatrique, etc, et ne voit-on pas les orthopédistes eux-mêmes s'orienter qui vers la hanche, qui vers le pied ou le genou, l'épaule ou la main."

In fact, "Seuls, peut-être, les chirurgiens qui s'engagent dans les actions humanitaires sont-ils encore capables de donner autant dans un grand dénuement des moyens."⁶²

What for decades had not been worthy of any "special training" may have become, in the 1990s, a form of combat training in itself.

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62 Albert Martin, *Souvenirs d'un chirurgien de la grande guerre* (Lunery: Bertout, 1996), 236–37.