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STUDY PROJECT

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THE REQUIREMENT FOR MEDICAL CORPS OFFICERS (PHYSICIANS) TO BE MEDICAL FACILITY COMMANDERS AND MAJOR MEDICAL STAFF OFFICERS IN NATO AND HSC

by

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PREFACE

This Individual Study Project was produced under the aegis of the US Army War College, Department of Military Studies. It is designed to verify the requirement for Medical Corps Officers (Physicians) to be major medical facility commanders and major medical staff officers in NATO and HSC. The author elected to complete the study based on his prior experience as a commander and staff officer concerned with both aspects investigated. An analysis based on historical experience, current testimony of United States and foreign medical authorities, current trends in civilian executive medicine, and NATO medical services are used to support my position.

Chapter 1

THE ISSUE

The issue is to demonstrate, through expert testimony and historical precedent, that the physician (MC) is the only medical professional who can assure that the Army Medical Department fulfills its mission "To Conserve the Fighting Strength." Inherent in this issue is the principle that the physician must command medical treatment facilities and must fill the key roles on the staffs of organizations which deliver health care in the Army.

The Medical Corps Officer, the Army Physician, is the team leader, the quarterback. The role of the physician as leader is accepted by other physicians, by other health care professionals, by line commanders, and by patients.

THE THESIS

It is the position of the writer that Medical Corps officers (physicians) be the only health professionals to fill positions as commanders of major medical facilities and senior medical staff officers within the Army Medical Department. The study will demonstrate that this thesis is subscribed to by physicians and nonphysicians alike, not only in the United States, but also by our North Atlantic Treaty Organization (NATO) Allies, Israel, and the Union of the Soviet Socialist Republic (USSR).

GENERAL SUPPORT

Historical Experience

Writings dating back to ancient times (200 B.C.) attest to the fact that the physician historically has been the leader of the medical team, be it civilian or military. This will be expanded upon in Chapter 3. Under such leadership, advances in medical technology continue unabated.

Current Testimony of United States, NATO, and Foreign Physicians and Nonphysicians

The Surgeon General of the United States, the NATO countries, Israel, and the USSR, along with many line general officers and other senior officers, have expressed their full commitment to the leadership role of the military physician. Civilian physicians and nonphysicians, American and foreign, have also supported this thesis.

Current Trends in Civilian Executive Medicine

A review of the literature indicates that, contrary to widely held beliefs, the physician has assumed an expanded role in executive medicine. Chapter 5 will illustrate, conclusively, that the physician continues to be the team leader and controls the delivery of health care. The Joint Commission Accreditation of Hospitals (JCAH), the American Medical Association (AMA), the American College of Surgeons (ACS), and other medical specialty boards have supported this expanded role of the physician in executive medicine.

METHODOLOGY

Developing through historical evidence to the present, May 1978, the facts will be presented that demonstrate physicians have consistently commanded in an outstanding manner and that their management abilities are currently in demand.

Through personal correspondence, interviews (see Appendix A), and congressional testimony, the views of the present and former Surgeons General of the US, NATO, and foreign countries, evidence will be presented to support the thesis. General officers and senior grade officers of the line, from the US and other countries, were also interviewed by the writer.

The counter-arguments presented in Congressional testimony and elsewhere will be presented so that the reader may obtain a balanced view of the problem.

Chapter 2

RECENT ISSUE

The dearth of physicians in the Army Medical Corps will become most acute prior to the end of Fiscal Year 1978. This fact has generated the following questions, relative to the Army physician:

1. Is it necessary to have Medical Corps Officers (Physicians) in command and staff positions?

2. If the civilian medical community and the Veterans Administration do not have physicians "running" hospitals, why is it necessary that the Army do so?

3. Younger physicians are adversely disposed to the prospect of being forced into nonclinical assignments in the later stages of their military career. What can be done to make this voluntary assignment, so important to the Army Medical Department (AMEDD), more attractive?

4. Medical Service Corps officers are well trained and eager to assume command of hospitals. Why haven't they been allowed to do so?

Are these questions new and generated because of the acute shortage of Army physicians in 1978? Hardly!! In one form or another, these questions were asked during the Civil War, World War I, and World War II.[1]

On 1 May 1973 the Deputy Secretary of Defense sent a Memorandum to the Secretaries of the military departments, subject: Staff and Command Assignments of Health Professional.[2] The memorandum

addressed the replacement of physicians in varied executive medical positions. On 22 May 1973[3] the Army Surgeon General, LTG Hal B. Jennings, Jr., MD, assured the Deputy Chief of Staff for Personnel that physicians were being conserved, relative to command and staff positions. On 29 May 1973 Major General Eugene P. Forrester, Director of Plans, Programs and Budget, responding to the Assistant Secretary of the Army (Manpower and Reserve Affairs-MRA) relative to 1 above, stated,

> The best qualified health care professional may command or exercise administrative direction regardless of the officer's health profession, subject only to the availability of qualified personnel and contingent upon the size and mission of the health facility.

On 1 June 1973 Mr. Carl S. Wallace, the Assistant Secretary of the Army for M&RA[4] responded to the Assistant Secretary of Defense (Health and Environment-H&E) re: same subject as 1 stating,

> Each projected physician or dentist assignment will continue to be evaluated by The Surgeon General to determine if the duties can in fact be performed by another qualified health professional.

The Deputy Surgeon General, Major General (MC) Robert W. Green, MD,[5] in a memorandum to the ASA MRA dated 10 April 1974, stated that the Army had implemented seven positive actions to comply with DOD policies concerning the optimum use of available health care professionals (see Appendix B).

In October 1974[6] the Office of Management and Budget entered the effort to eliminate physicians as commanders and staff officers when Director Ray L. Ash directed DOD to establish criteria for individual billets if such individual billets were to receive

Special Pay as physicians. An information memorandum for the Secretary of the Army from the Surgeon General, Lieutenant General Richard R. Taylor, MD,[7] dated 19 June 1975, recommended adherence to the Army policy that physicians be retained in hospital command positions and those staff positions which unequivocally require the professional expertise of a physician. This letter memorandum by General Taylor was in answer to questions generated by a letter from the new Director of the OMB, James T. Lynn,[8] to the Secretary of Defense, dated 11 April 1975, in which Mr. Lynn asked that the position of "Commanding Officer" be eliminated from the "criteria" for special pay.

The Surgeon General of the Army, LTG Richard R. Taylor, MC, appeared before the Subcommittee on Appropriations (Medical Operations) House of Representatives,[9] and addressed questions asked previously by the Subcommittee No. 2 (Military Personnel) HR[10] relative to the need for physicians being assigned to positions not dealing entirely with patients. The Surgeon General answered "that the best qualified health professional without regard to officers' basic health branch or profession" was utilized to administratively direct small clinics under the direction of a physician at the regional hospital. General Taylor stated further, "In the Army all commanders of all hospitals that have patient beds at this time are physicians."[11] Field hospitals, <u>not</u> engaged in providing health care, would be and are commanded by carefully selected Medical Service Corps Officers.

A letter to the ASD(H&E) from the Secretary of the Army,[12] Howard H. Callaway, in July 1975, stated, "the physician in a staff position provides the expertise for contingency planning, staffing, and medical support, which may result in reduced requirements and improved care at various levels."

The arbitrary decisions made by the ASD/H&E are further evidenced in a Memorandum for Record, dated 21 May 1975.[13] This MFR stated that OSD would certify a position as requiring a physician only if the incumbent were engaged in the delivery of personal health care for:

50% of his time in command positions,

25% of his time in staff positions.

The ASD/H&E stated that physicians assigned to command or staff billets were a waste of critically needed doctors. Mr. McKenzie in the same memorandum stated, "the Army had not moved out to eliminate physicians from hospital command." (Mr. McKenzie is the Deputy ASD/H&E and a retired colonel in the Medical Service Corps.) In the same memorandum it was stated that the concept (elimination of physicians as commanders) forwarded by Dr. Cowan and Mr. McKenzie was contrary to the intent of Congress.

On 26 August 1975[14] the Deputy Secretary of Defense, William Clements, in a letter to James T. Lynn, the Director of OMB, stated: "the physician commander and staff medical officer are essential." This was the final DOD decision on the subject in 1976.

STATEMENT OF THE PROBLEM

The problem is to "verify" the requirement that Medical Treatment Facilities (MTF) commanders and senior medical staff officers must be physicians, to meet DOD and Army requirements that the best qualified hold these positions.

If this requirement is valid, why is it necessary to repeatedly defend a validated physician requirement in order to have the physician fill the position? Can someone else do the physician's job adequately? What does history tell us? What is the position of the military services of other countries (pertaining to physicians in command and staff positions)? Will AMEDD be able to meet its mission under law if the requirement is not met?

INVESTIGATIVE PROCEDURES

Through personal interviews, direct correspondence, and research into the current literature and historical books and records, in the United States and several NATO countries, Israel, and Russia, the writer has proposed the logical procedure for the Army is the assignment of MCs (physicians) to command and staff positions. General officers of the line and Medical Department, corps and division commanders, staff physicians and Medical Service Corps officers, and civilian medical executives were among the individuals contacted and interviewed. The problem was addressed and comments recorded.

SUMMATION OF PAST TESTIMONY ON THE PROBLEM

The contention that to remove the physician from command and senior staff positions will increase the quantity and quality of direct patient care is without foundation. The nonphysician commander would not eliminate the medical professional responsibility which would have to be assumed by a physician at the hospital level. The Chief of Professional Services (CPS) is essentially a full-time position in most Army Medical Centers (MEDCEN) and some larger Medical Activities (MEDDAC). Where the CPS position is additional duty to that of being a Department Chief (i.e., Surgery), it requires the incumbent to work far more than 50 hours a week. The consensus of the interviewees was that such a person could not also be the medical adviser to the nonphysician commander. Another physician would be required for the mission of any such Army hospital to be adequately accomplished.

The authority, responsibility, and accountability of a medical officer commander are unique to military operations and, as demonstrated by JCAH regulations,[15] have no equivalent in civilian or VA hospitals.[16] Military "Command" gives absolute authority and responsibility to one individual for the <u>total</u> management of the medical facility.

With the possible exception of war time, the Army Medical Department does not force physicians to assume command and staff positions. The Surgeon General has specifically stated, in worldwide communications to all physicians, anyone may refuse

such positions without consequence. Career tracks permit a medical officer to reach flag rank whether or not he serves in command positions.

To be certain it is understood clearly and in context why the questions addressed at the beginning of this chapter and the issue raised is not a valid one, the following is reinforced:

The clinical, executive medical and operational experience acquired by the physician through appropriate training and experience make him the best qualified person to make those judgments and decisions required by command on clinical, administrative and executive medical matters. He may or may not treat patients, but, as a physician commander, he is ultimately responsible for the quality of health care delivered by his organization. The line commander is provided technical advice regarding field medicine, and the physician commander is the final authority on the medical disposition of personnel. Every moral, ethical and legal aspect of this requirement to deliver health care mitigates against any person other than the physician as the commander.

Chapter 2

FOOTNOTES

1. Paul E. Steiner, Ph.D., MD, Physician-Generals in the Civil War. A Study of Nineteenth Mid-Century American Medicine (Springfield, Illinois: Charles C. Thomas Publisher, 1966), pp. 1-386; Captain Louis Casper Duncan, MC, US Army, The Medical Department of the United States Army in the Civil War (Washington, D.C.: Office of The Surgeon General, US Army, 1896), pp. 10-11; Major General M. W. Ireland, MC, Colonel Charles Lynch, MC, Lieutenant Colonel Frank W. Weed, MC, The Medical Department of the United States in the World War (I), Volume I (Washington, D.C.: Government Printing Office, 1923), p. 763; and Lieutenant General Leonard D. Weston, MC, Colonel John B. Coates, MC, Personnel in World War II (Washington, D.C.: Office of The Surgeon General, 1963), pp. 464-469.

2. Deputy Secretary of Defense William Clements, "Memorandum for the Secretaries of the Military Services, Subject: Staff and Command Assignments of Health Professionals," dated 1 May 1973.

3. Lieutenant General Hal B. Jennings, MC, The Surgeon General US Army, "Memorandum for: Deputy Chief of Staff for Personnel: Subject: Staff and Command Assignments of Health Professionals," dated 22 May 1973.

4. Major General Eugene P. Forrester, Director of Plans, Programs and Budget, DA, "Memorandum for: Assistant Secretary of the Army (Manpower and Reserve Affairs), Subject: Staff and Command Assignments of Health Professionals," dated 29 May 1973.

5. Mr. Carl S. Wallace, Assistant Secretary of the Army for M&RA: "Memorandum for: Assistant Secretary of Defense (Health and Environment), Subject: Staff and Command Assignments of Health Professionals," dated 1 June 1973.

6. Major General Robert W. Green, MC, Deputy Surgeon General, US Army: "Memorandum for: Assistant Secretary of the Army M&RA; Subject: Staff and Command Assignments of Health Professionals," dated 10 April 1974.

7. Roy L. Ash, Director of the Office of Management and Budget, Letter to Secretary of Defense, dated 9 October 1974.

8. Lieutenant General Richard R. Taylor, MC, Surgeon General, US Army: "Memorandum for the Secretary of the Army; Subject: Physicians in Command and Staff Positions," dated 19 June 1975.

9. James T. Lynn, Director of the Office of Management and Budget, Letter to the Secretary of Defense, dated 11 April 1975.

10. Lieutenant General Richard R. Taylor, US Army, The Surgeon General, Statement of the Surgeon General, United States Army, before Subcommittee of the Committee on Appropriations, House of Representatives (Washington, D.C.: US Department of Defense, 29 May 1974), p. 342.

11. Lieutenant General Richard R. Taylor, US Army, The Surgeon General, Responses to Questioning by Mr. Cook and Mr. Holt, Committee on Armed Services, Hearings on Military Posture, Subcommittee No. 2, 25 February 1974, p. 1795.

12. Howard B. Calloway, Secretary of the Army, Letter to the Assistant Secretary of Defense (H&E), dated 11 July 1975.

13. Assistant Secretary of Defense (H&E) Dr. Cowan, Memorandum for SOD with Letter for Signature of SOD, Subject: Physicians in Command and Staff Positions, dated 21 May 1975.

14. William Clements, Deputy Secretary of Defense to James T. Lynn, Director of Management and Budget, dated 26 August 1975.

15. HSC Pamphlet No. 20-1, Accreditation Guide for Army Hospitals, Section II (Fort Sam Houston, Texas: US Army Health Services Command, October 1976).

16. Taylor, Statement of The Surgeon General, pp. 342, 343, and 344; Admiral Custis, USN, Surgeon General, US Navy, Testimony given Committee on Armed Services, Hearings on Military Posture (Washington, D.C.: Government Printing Office, 25 February 1974), p. 1800; and John Lee, Executive Assistant, Office of the Associate Chief Medical Director for Operations, Veterans Administration, Testimony before Subcommittee on Appropriations, House of Representatives, Medical Operations (Washington, D.C.: Government Printing Office, 29 May 1974), p. 1797.

Chapter 3

HISTORICAL EXPERIENCE

In History of Medicine, Castiglioni[1] goes back to the pre-Christian era to demonstrate the status of the physician. To jump over this period (the reader may cover this period if interested in the above book) to the somewhat remarkable development of Military Medicine in Imperial Rome, Celsus refers to the extraction of missiles from the body (Book VII, Ch. 5). The concept of a separate medical service first surfaced with the formation of stationary armies. Claudius Aelianus (AD 100-400) in his book on Tactics classified physicians among the noncombatants, and as shown in Castiglioni's book, physicians of the legions are cited in more than forty-six Latin Inscriptions of the time of the Empire. In the time of Hadrian every legion and every warship had a physician. Physicians took their orders directly from commanders of the camp or in his absence from the tribune of the legions. The Justinian Code notes that the physician of the legion is exempt from every civil obligation during his period of military service.

The discovery of Roman military hospitals ruins near Vienna, at Bonn in Germany, and at Baden in Switzerland, shows that the medical service was well provided for even in the provinces. As early as the year 200 A.D., the physician was the commandant of medical services and hospitals. From that time until the formation of a medical service for the Continental Armies in 1775 in America, there is a wealth of evidence to further document the role of the

physician within military organizations. There is also ample testimony to the role of the physician in the military life of the United States.[2]

The Revolutionary War brought many physicians into the Continental Army who used their personal funds to establish dispensaries and hospitals. A world-famous surgeon, John Jones, accepted a commission as a Surgeon in the Continental Army in 1778. Jones wrote the first textbook on Surgery in the United States and its appendix is the first American work on public health and hygiene. He noted repeatedly the necessity for a physician to be responsible for and direct medical facilities.[3]

The Historical Register,[4] Volume III, Palmer 1896, states that Army hospitals were directed by Army surgeons during the period 1775-1861. These physicians not only cared for patients, but also either bought all items needed by hospitals, from food to medicines and bedding, or officially received such items and managed their distribution. (See appendix C as an example; the summary of duties of the Medical Department Staff in 1814.)

The Report of the Surgeon General, 28 December 1826,[5] indicates that the military surgeon in the Army incurred expenses which were barely met by his pay. The surgeon was commander, supply officer, pharmacist, physician, and many other things in this period, with ever-increasing responsibilities and ever-declining support.

The Report of the Surgeon General, 1 February 1829,[6] stated "the Medical Staff should always consist of a sufficient number to

ensure at all times a Surgeon at every post consisting of one company or more." He addressed the efficiency of his physicians at that time when resources were negligible.

Prior to the Civil War during the continuing Indian War, further evidence of physicians' ability to command was brought forth. The first man (or woman) to perform a deed which won a Medal of Honor was an Army Surgeon, Colonel Bernard J. D. Irwin, on 14 February 1861.[7] Irwin was assistant surgeon at Fort Breckenridge and volunteered to take a relief party in a snowstorm to support a Cavalry unit under attack. He arrived in time to save the unit, treat the wounded and then find and destroy Cochise's village.

The Civil War brought physicians to the fore, medically and militarily. There were 33 physicians in the Union and Confederate forces who attained General Officer rank. This included six Confederate and 27 Federal generals. While acting as a physician in some cases, most of these physicians actually commanded brigades.[8] Only two surgeons attained General Officer rank in the two medical corps during the Civil War. The fact that 33 physicians became general officers should not be surprising. During this period of American history physicians were community leaders and businessmen, and amongst the best educated.

In the Medical Department of the United States Army in the Civil War it is stated, "the Brigadier himself cannot take one ambulance for a moment so exclusively are they under the Medical Commander's control."[9] A statement from this same book is significant relative to today's Medical Corps. "The Medical Director

(always a physician) has entire control and the Ambulance Corps is as distinct a body as the artillery."[10] This was written in 1866!

In Doctors in Blue, the Medical History of the Union Army in the Civil War,[11] it is stated, "Certain features of the administration of general hospitals alienated the surgeons in the field." This referred to the general (nonmedical) commanding the Military District who gave orders in opposition to the Surgeon General's orders, thereby breaking clear lines of control. This problem was overcome when the hospital was considered an Army post and the Surgeon-in-Charge was the military commander over his staff and his patients. Even at this juncture, the Surgeon-in-Charge had an "Executive Officer," another surgeon, who took charge of records, distribution of patients, and control of clerks and orderlies, thus allowing the commander general supervisory freedom.

Medico-Surgical Aspects of the Spanish American War[12] addresses the military surgeon of that period. As in the Civil War, the following statement relative to physicians in this war is made: "Their education and training are of a nature to ensure qualities necessary to citizenship of the highest type." Many surgeons during this period attended the Army Medical School, and the Surgeon-General of the Army, Sternberg, had taken great pains to stimulate the younger members of his department to improve themselves, clinically and militarily. "The professional military surgeon is well-versed in the executive part of his duties, which is sadly lacking in the less favored volunteer surgeon," so states this history.[13] This did not detract from the volunteer's professionalism but

referred only to his ability to provide executive direction related to the military.

Leonard Wood, who later became the Chief of Staff of the Army, treated President McKinley as a patient and was a good friend of Theodore Roosevelt. His command of the "Rough Riders" with Roosevelt as his lieutenant colonel brought him public recognition. He was military governor of Santiago, then the Philippines. Stepping beyond the usual Army Surgeon's role, he rose to the highest position in the US Army: Chief of Staff.[14]

World War I found physicians as Surgeon-in-Charge and later in the war as hospital commanders.[15] Brigades, battalions, and some companies had surgeons assigned. Army physicians then were often double-hatted. They were both a Medical Battalion commander and the Division Surgeon. This occurred in World War II, Korea, and Vietnam as well. World War II showed politics to be an important part of the whole rank scheme, with Medical Officers restricted in their promotions until 1943.[16] Had the Health Services Command (HSC) concept been in existence during this period, much waste of medical resources would have not occurred. With less resources (1000 fewer personnel) in 1978, the HSC provides service to 850,000, more personnel than in 1973.

In the Korean War physicians still were commanders and major medical staff officers, and were most effective in command and staff. This has been verified by division and corps commanders in Korea during the war. (See appendix A-1, 20.)

The Vietnam War further proved that physicians were most competent commanders and staff officers. It is not the intent of this study to extol extraordinary medical care provided by the AMEDD in Vietnam, but the lowered morbidity and mortality rates of the Vietnam conflict are valid evidence that physicians as commanders and staff officers did a job that no nonmedical officer could. As stated in Vietnam Studies: Medical Support of the U.S. Army in Vietnam 1965-1970,[17]

> . . . no nonmedical commanders should be interposed between the medical commander and the line commander actually responsible for the health of the command. The well-being and care of the individual soldier must not be submerged in, or subordinated . . . .

While it will occasionally be necessary to allude to historical fact in the chapters that follow, it is difficult not to profit from history. Vietnam, our latest conflict, demonstrated that with physicians as commanders of medical units and as major staff medical officers, American soldiers were given the best medical care in the history of warfare. Line commanders in Vietnam have verified that superb medical support was of the utmost importance to them and their troops. This support was provided by medical units commanded by physicians. But we apparently have not profitted from history as evidenced by the continuing need to defend this requirement. To support the contention that the requirement is valid, we will proceed to current testimony of medical authorities throughout the world.

Chapter 3

FOOTNOTES

1. Arturo Castiglioni, A History of Medicine (Bullock, 1923), p. 237.

2. P. M. Ashburn, A History of the Medical Department of the United States Army (Government Printing Office, 1942).

3. Leonard F. Peltier, MD, "John Jones, An Extraordinary America," Bulletin, American College of Surgeons, Vol. 63, No. 3 (March 1978), pp. 24-25.

4. J. Palmer, The Historical Register, Vol. III (1896).

5. Surgeon General's Office (US Army), Report of the Surgeon General, December 28, 1826, pp. 1-6.

6. Surgeon General's Office (US Army), Report of the Surgeon General, February 1, 1929, p. 3.

7. The Medal of Honor, US Army War College Military History Institute Reference Collection, p. 6.

8. Paul E. Steiner, Ph.D., MD, Physician-Generals in the Civil War, p. 116.

9. Captain Louis Casper Duncan, The Medical Department of the United States Army in the Civil War, p. 39.

10. Ibid.

11. George Worthington Adams, Doctors in Blue (Allen and Short, 1898), p. 157.

12. Dr. Nicholas Senn, Medico-Surgical Aspects of the Spanish American War, p. 82.

13. Ibid., p. 84.

14. Archives of US Military History Institute, Colonel Donald Shaw, Director.

15. Charles Lynch, Frank Weed and Loy McAfee, The Medical Department of the United States Army in the World War (I), Volume I, p. 157.

16. John Boyd Coates, Personnel in World War II (US Government Printing Office, 1952), pp. 452, 454, and 464.

17. MG Spurgeon Neel, Vietnam Studies - Medical Support, p. 169.

Chapter 4

CURRENT TESTIMONY

The categories of testimonies supporting the thesis are based on the experiences, past and present, studies, reports, and outcomes of other than the physician commander and major staff officers.

Under the North Atlantic Treaty Organization (NATO), Denmark (RDF), the Federal Republic of Germany (FRG), the Royal Army Medical Corps (RAMC-UK), the Supreme Headquarters Allied Powers Europe, Italy, and Turkey will be addressed. Israel and the Union of Soviet Socialist Republic (USSR) will be under Foreign. The Health Services Command (HSC) will be considered, along with US Army Medical Command Europe, under HSC, and the US Surgeon General.

Each of these sectors will be examined under four subheadings:

A. Use the physician as commander in the Medical Forces.

B. Nonphysicians in the Medical Forces.

C. Physicians in major medical staff positions.

D. The physician executive in the civilian medical heirarchy.

I. NATO.

A. Royal Danish Medical Forces (RDMF). The present structure of the Royal Danish Medical Forces is found in appendix D.[1] The Director General Medical Service (DGMS) (Medical Corps, Major General) is now under the Chief of Defense Staff. Formerly, the DGMS was on a substaff level (i.e., under Logistics) but the Surgeon General (DGMS) Major General Svend Trier demonstrated to the Chief

of Defense that such a staff structure diminishes the Medical Forces' ability to meet its mission.[2] The Chief of Defense restored the DGMS to its present position in an effort to assure that the Royal Danish Forces received the best in medical care.

1. Use of Physicians as Commanders.

The Royal Danish Medical Forces utilize only Medical Corps Officers (Physicians) as commanders and major medical staff officers. No serious consideration has been or is being given to the assignment of other than a physician.[3] All personnel interviewed, including Surgeon General of the Royal Danish Medical Forces, other physicians, both military and nonmilitary, and line generals in the Royal Danish Forces stated categorically that none other than a physician *should be the commander.*[4] Physicians in the Royal Danish Medical Forces will not accept or tolerate the nonphysician commander.[5]

The Cyprus experiences with the UN-Danish Hospital verified that a physician was necessary to command and supervise his staff physicians and support personnel, but just as importantly to deal with staffs of other hospitals in Cyprus supporting UN troops. The military physician commander coordinated closely with civilian hospitals on Cyprus, since the civilian physicians would not deal with other than the physician commanders.[6]

Military physicians in the lower grades and younger age group were also interviewed, including lieutenants, captains, and majors (and their counterparts in the Navy and Air Force). They were questioned closely about their opinion on the question of physician

Forces, a program that begins at the earliest stages of a physician's career and progresses upward, assures the necessary administrative and managerial training that makes it a certainty that the physician is the best qualified to command.

2. Nonphysicians in the RDMF.

There exists no equivalent to the US AMEDD MSC officer in the RDMF.[12] Line officers are assigned to provide administrative support in those areas where a physician is not required. Assignments of line officers to medical forces are for varying lengths of time, but there is no career pattern. There is no intent to develop a corps similar to the AMEDD MSC.

3. Physicians in Major Medical Staff Positions RDMF and RDDF.

The Chief of Defense Staff (RDDF) and Commanding General of Eastern Land Command explicitly and implicitly stated that they relied totally on their physician staff officer for medical advice. These medical staff officers, such as Colonel Munt-Madsen, Surgeon Land Forces Jutland, not only must plan and guarantee the medical support for Royal Danish Forces but also must integrate and coordinate such support with NATO allies. This requirement, in the opinion of all concerned, physician and nonphysician, can only be met with physicians in such major medical staff positions.[13,14,15]

4. The Physician Executive in the Danish Civilian Medical Hierarchy.

Health care operations and medical facilities in the civilian sector of Denmark are controlled by physicians, whether it be committees, boards, or directors.[16,17]

and nonphysician commanders. These physicians were and are equivalent to what we termed "obligated tour physicians"; each and every one stated they could see no one but the physician as their "boss," nor would they accept any nonphysician in such a position.[7]

The Director of the Danish Society of Emergency Medicine stated, unequivocally, that other physicians and nonphysicians would deal with no one in the military medical forces but the "physician commander."[8] The reasons for this prevalency of the same attitude are virtually identical to those listed and elaborated in Chapter 2, pages 8, 9, and 10 of this paper. The Director, Surgical Research Unit, Copenhagen University Medical School, an experienced consultant to the Royal Danish Medical Forces, stated that a physician must be the commander of any medical unit or its professional reliability is very doubtful.[9]

The Chief of Staff, Royal Danish Defense Forces, and the Commanding General Eastern Land Command RDDF, were both clear, concise and to the point: their confidence and reliance could only be placed in the physician commander of medical units. They both deal with artillery officers on artillery questions, signal officers on communications, etc., and it would be irrational to deal with other than a physician commander on medical questions, professional or administrative.[10,11]

The development of the military physician as a commander in the Danish Forces would be a study in itself. Under the personal interest of the Surgeon General, MG Trier, and coupled with his tremendous drive to maintain and improve the Royal Danish Medical

Summary: Royal Danish Medical Forces.

The Royal Danish Defense Forces have reestablished the position of Director, Royal Danish Medical Forces, to a position equivalent to the US Army Surgeon General when it became apparent that Medical Services were deteriorating when the Directorate was controlled by other than a physician director. Whether young and relatively inexperienced, or older and with much experience, physicians (a) would not accept other than a physician as a commander and (b) could not rely on medical operations developed by a nonphysician.

Line generals in the RDDF[18,19] were firmly convinced that the return of the Director of Danish Medical Forces to the equivalency of the USATSG has had, and continued to have, a positive impact. These experienced general officers accept physicians as the experts in medical care, medical command and staff, and no other.

B. Federal Republic of Germany.

The Medical and Health Services of the Federal Republic of Germany (FRGMF) Armed Forces have a far greater importance in the military services than does the US Army Medical Department relative to the Army as a whole. This is revealed by the fact that the Director of Medical and Health Services of the Federal Armed Forces has equal status with the chiefs of the military service staffs.[20] The directors are physicians.

While six percent of the total forces in peacetime are medical, this figure rises to 12 percent of the total personnel strength of the Armed Forces in wartime. At 50 percent strength, it will be

demonstrated that physicians are utilized exclusively for command of medical units and medical staff positions, after training and experience.[21] Evidence will be presented to demonstrate the FRGMF is extending the utilization of physicians to the point that it closely resembles the present AMEDD structure for hospitals and medical staff positions.[22]

1. Physicians as Commanders.

The philosophy of the Ministry of Defense FRG and FRGMF can be summed up by a statement made in my interviews with the Deputy Surgeon General MG Krawietz and the general officer directing personnel, BG Schober: "It was, is now and will be the policy of the German forces to have physicians in command and major medical staff positions. No one will command buy physicians."[23,24] In 1916 nonphysicians were assigned as medical commanders and "terrible mistakes were made";[25] the German General Staff and Ministers resolved then that never again would any officer other than a physician be a medical commander. This is the current and obvious future policy of the FRG: the physician will command all physicians and health services.[26]

2. Nonphysicians in the FRG Medical Forces.

Line officers are assigned to the Medical Forces to provide administrative support. This is done on a rotating basis and the tour length varies. These officers provide only administrative and logistic support, and are not directing, commanding, or supervising physicians in any way. There are no plans to form an administrative corps similar to our Medical Service Corps.[27]

3. Physicians in Major Medical Staff Positions in the FRG Medical Forces.

The training and education a physician receives in medical school, internship, residency and/or fellowship trains him to identify problems completely, before arriving at a solution. The FRG MF uses the physicians' training and professional experience to expand his capabilities as a commander and staff officer through incremental training throughout the physician's career (appendix F).

While line officers are utilized in varied assignments, for varying periods, it is not a career pattern. The major medical staff officers are physicians.[28]

The senior officers of the German Medical Forces are deeply concerned with the almost total dissolution of the Allied Command Europe (ACE) Medical Adviser.[29,30,31] The Federal Minister of Defense Herr Georg Leber wrote to General Alexander Haig, Supreme Commander, Allied Powers Europe (SACEUR), telling him of the many weaknesses that had developed since the ACE Surgeon was reduced from a Major General to a Lieutenant Colonel "too far removed from your office."[32] This concern is shared by all.[33,34,35,36]

C. Royal Army Medical Corps (United Kingdom).

The Royal Army Medical Corps (RAMC) has a greater shortage of physicians than the AMEDD. In September of 1974 the "Report of the Working Party to Consider Officer Manning in the Royal Army

Medical Corps"[37] was completed. Major General de C Martin CBE was the chairman, and a nonphysician as were four of the five members of the committee. The recommendations of this committee, made after almost two years of study, will be addressed in the appropriate section below. The most important recommendation appears to be that "Medical units be commanded by doctors, supported by sufficient additional doctors to train individuals and units for war."[38]

1. Physicians as Commanders in the RAMC.

Lieutenant-General Sir Richard Bradshaw, the Director General of Army Medical Services (DGAMS), stated that his objective is "to provide the best medical service to the Army." To do so, the DGMAS stated, "You must have a Medical Corps Officer (physician) who knows the Army as well as his profession."[39]

The RAMC has physicians who have attended both the Junior and Senior division of Camberly, equivalent to the US Army Command and General Staff College. Senior officers of the RAMC attend, when selected, the National Defense College and those RAMC officers with general officer potential attend the Royal College of Defence.[40]

The command and staff progression furnishes, to the RAMC, a group of physicians who know administration, management, leadership techniques, in addition to their professional knowledge. Those physicians following this career track spend one to three years as a regimental physician. From the third to the fifth year, they are assigned as Deputy Commander of a Field Ambulance, with

a hospital and medical units in its structure. After this phase, the physician attends the Junior division of Camberly, the Staff College, then is assigned to a division staff. He may then attend the Senior division of Camberly, or possibly the National Defence College. The final step in this progression is to command a Field Ambulance. At this point in the physician's career, he is an officer who (a) knows the Army and the line, and (b) recognizes the requirements to be met.

The DGAMS noted that line general officers in the Royal Army were and are adamant that medical units be commanded by RAMC physicians.[41] The Martin Study reinforced this throughout its recommendations and conclusions. As paragraph 25 of Chapter 3 of this report states, "Almost every commander was adamant that medical units of any type in peace or in war must be commanded by doctors."[42] As one commander (nonphysician) pointed out to the committee, there might be a marginal increase in military expertise in a medical unit commanded by a nonphysician, but he had no doubt that there would be a serious loss of medical efficiency.[43]

2. Nonphysicians in the RAMC.

The Medical Support officers are assigned throughout the RAMC in a multitude of positions, but are supervised by a RAMC physician from the Command and Staff career track.

In the period approximating 1967-1970, the RAMC experimented with the nonphysician commander.[44] Two junior field grade physicians described the experiment as "turning into a disaster,"[45] and "it

turned out to be a disaster." A senior RAMC physician described it in a less emotional way. "Despite experience with the line (the non-physician acting as a commander), they were unable to give sound and adequate advice to the line Commander, and did not utilize the RAMC physicians properly."[46] While the semantics were a little different, this was the conclusion of four other senior officers also.

The return to the physician commander, reinforced by the Martin report, prevented a mass exodus of physicians from the RAMC. The uniform response from physicians in the RAMC when asked if they would work for a nonphysician was no. These physicians in staff positions will resign if nonphysicians take over the major medical staff positions and simply go to the National Health Service as civilians. This attitude prevails throughout the RAMC, and has produced, when coupled with the MC's training, superior staff medical officers in the physician ranks. Line confidence is high, as the expertise of the physician expands.

3. Physician as a Major Medical Staff Officer.

The DGAMS of the RAMC has established the Command and Staff career track, and the major medical staff officers attend schools and gain experience with the Army, the same as listed in 1 above.[47] The Martin Study reinforced the fact that line officers will deal with a physician in a staff position and, almost unanimously, only a physician.[48] The study recommended "the Staff stream be untouched, as it functioned so well."[49]

4. The Physician Executive in the Civilian Medical Hierarchy (UK).

Sir Bruce Fraser gave the fourteenth Winchester Address in New Winchester College on 23 May 1972.[50] In this address he sums up the general consensus of opinion in the civilian medical hierarchy: Cooperation can work, but the administration must always be led by a physician.

D. Supreme Headquarters Allied Power Europe (SHAPE).

There is no functional medical command in ACE or NATO per se. Likewise, civilian medical expertise is not present. The only area in NATO possible to address is the Medical Staff Officer, who is a physician.[51]

With the exception of Standardization, there has been little command emphasis on staff medical work at ACE, NATO, or SHAPE. There is an ACE Medical Adviser who is a LTC (FRG), physician, and he alone. In 1962 the SHAPE Surgeon was reduced from a Major General Medical Corps with a complete staff. The reduction continued and it has reached the present stage of a LTC physician and no staff. To further complicate the situation, the ACE medical adviser must proceed through five staff sections before reaching the Chief of Staff.[52]

The Minister of Defense (FRG) and the Assistant Secretary of Defense for Health and Environment (US) were so concerned they wrote General Haig, the Supreme Commander Allied Powers Europe (SACEUR). Minister Leber wrote for the Eurogroup, Directors of

Military Medical Services of NATO countries, stating:

> It is the unanimous opinion of these experts that you should have on your staff a medical adviser whose experience and expertise would enable him to report to <u>you</u> the medical preparations and the weaknesses and strengths involved, and to make suggestions for improving multinational cooperation in the medical field.[53]

Dr. Smith's (ASD/H&E) comments to General Haig included: "The picture is not bright when those requirements are measured against capability." Continuing, the ASD/H&E stated: "I should like to once again urge you to consider the importance of adding a surgeon and staff to your headquarters in order to aid in creating such mutual reliance between NATO countries as may be possible."[54]

The duties of the ACE Medical Adviser would overwhelm any responsible physician. Some are "restricted" in classification, but a five-page job description will give any reasonable person enough knowledge of what is meant by "overwhelm." The effort on the part of military and civilian medical authorities, from virtually every NATO country, to show the importance of this position in establishing host-nation support and expanding interoperability and rationalization, have not been fruitful.[55] This effort represents over four years of multiple attempts to accomplish this goal.

The present and past USAEUR Surgeons have made strong attempts to expand, complement, and coordinate the host-nation support concept.[56] The Directors of Medical Services and Surgeon Generals of NATO have been most cooperative, but the lack of personnel (with

further reductions envisioned) have not permitted the plan to be formulated let alone established.

The lack of such a planning and advisory staff element in SHAPE led to the formation of Eurogroup, a group of Directors of Medical Services and Surgeon Generals of NATO, excluding the US and Canada.[57] The Eurogroup continues to make plans of its own for mutual support.[58] Why should this be? Very simply because there exists no such planning and advisory staff of any import within SHAPE. The consensus of opinion amongst the senior medical officers in virtually every NATO country is that medical planning is of low priority in SHAPE. This is an opinion shared by the last Assistant Secretary of Defense for Health and Environment (US). Dr. Robert N. Smith, MD, stated when testifying before the House Select Committee that military medical problems had a low priority in the Department of Defense.[59] The Chairman of the Joint Chiefs of Staff (USA) General George Brown agreed with Dr. Smith's statement.[60]

The reduction of personnel at SHAPE caused the reduction of the medical advisory staff. Priorities were established, and were no doubt done so with valid reasons.[61] It would appear that it is necessary, now, to act to assure that <u>all</u> NATO countries have an integrated, coordinated plan, that can be implemented when the SACEUR orders. This will not occur without changes in the SHAPE medical staffing.[62]

E. Italy.

The Italian Army Medical Forces, and of course the Army, has military physician shortages more severe than AMEDD. The Centralized Health Headquarters, in the Italian Ministry of Defense, is responsible to the Chief of Staff for medical support to the Army.[63] It is staffed mainly by physicians.[64]

1. Physicians as Commanders in the Italian Medical Forces.

Military hospitals are assigned to each Military Territorial Region (MTR) and each is commanded by a Medical Corps officer (physician).[65] Mobile Field Hospitals are activated upon mobilization and attached to each corps/division/independent brigade, and each is commanded by a physician.

The Italian Health Headquarters considered using other than physicians as commanders, but, after looking carefully into the issue, the Italian view is that it is far better for a qualified physician to command a medical facility and deal properly with medical staff matters in a major headquarters.[66]

The Italian government has accepted the disadvantage of drawing medical corps officers as commanders and staff officers out of an already inadequate number of military physicians.[67]

2. Nonphysicians in the Italian Medical Forces.

Nonphysicians are assigned in a manner very similar to the Medical Service Corps Officer in AMEDD. As stated in 1 above, only the physician is a commander or major medical staff officer, and receives administrative support from the nonphysician.

3. Physicians in Major Medical Staff Positions.

These positions, in Army, corps, division, brigade, and battalion are filled by physicians; there are no plans to change this.

4. The Physician Executive in the Italian Civilian Medical Hierarchy.

Since January 1971 when Dr. Veterl, general inspector of health at the Italian Ministry of Health wrote: "Physicians must be persuaded to take a wider interest beyond their purely professional activities,"[68] such has been the case. Italian civilian physicians continue to have more and more control of medical activities, boards, and committees.

The Italian Centralized Health Headquarters, and line officers, are concerned, as are all the European NATO countries, that there is "not a centralized integrated medical body such as the Health Services Command (USA)."[69] They too feel that "standardization" is the only effort being made. Also, integrated medical information and concepts are relegated to a few "low rank officers."[70] Further concern is that senior physicians are not involved in plans, operations, and advising on medical matters.

F. Turkey.

Turkish Army medical commanders are supposed to be physicians. The Trukish medical commander and medical staff officers must be graduated from an approved Medical College (physician), and must have experience on a medical staff of a field army or

higher headquarters. There is no equivalent to the MSC in AMEDD.[71]

II. FOREIGN.

A. Israel.

The physician in the Israeli Armed Forces is the commander of medical units in peace or war. The physician is the major medical staff officer also.[72] Civilian medicine in Israel is controlled by the physician.[73]

B. Union of the Soviet Socialist Republic (USSR).

The USSR has physicians, military and civilian, throughout its political and military structure.[74]

1. Physician as Commander in the Medical Force of the USSR.

The USSR provides its Army and other forces with an effective medical service. The Medical Service of the Army (as all other forces) is subordinate to the Minister of Health of the USSR, as are all medical services.[75] The Soviet Military Medical Service is the most important branch of this ministry.[76] Physicians always hold the rank equivalent to our commissioned officers. Physicians do their basic military training in addition to their professional studies.

The Regimental Medical Post is commanded by a medical officer, usually a major. He is responsible for the medical care in the battalion and company. The physician is in total command, professionally, logistically, and administratively in the Soviet Union.

2. Nonphysicians in the Medical Forces of the USSR.

Nonphysicians are assigned to positions that are completely disassociated from patients and medicine and do not require physician expertise.

3. Physicians in Major Medical Staff Positions in the USSR.

The Army physician in a command position (i.e., Regimental Surgeon) also acts as the Medical Adviser. The nonphysician does not act as a Medical Staff Officer.[77]

4. The Physician Executive in the Civilian Hierarchy of the Soviet Union.

From the Council of Ministers of the USSR to the Rayon Health Department, in the administrative structure of health services in the USSR,[78] from the Ministry of Health of the USSR to the City Health Department,[79] to the International Health Education Section of the Central Institute for Scientific Research in Health Education,[80] the physician is the leader.

C. The United States Army Health Services Command (HSC). (To include the views of The Surgeon General; Deputy Surgeon General, US Army; and other medical and nonmedical general officers.)

The HSC was established in 1973 and was responsible for providing health care to 2.4 million eligible personnel. In 1978, HSC provides health care for 3.25 million eligible personnel, with 1000 less personnel to accomplish the mission.[81]

The five years of HSC's existence have provided ample proof to the health care providers that "it is the best thing to happen to Army medicine since we became a Corps."[82] Conversation with eight senior Medical Corps officers who worked under the old concept of medical support (i.e., Post, Army, CONARC, OTSG) and HSC universally brought the response that HSC was not only more effective and efficient, but also more concerned.[83]

These same senior medical officers share the concern of the junior Army medical officers interviewed--that Army medicine is being degraded, downgraded, and ignored.[84] Both groups were aware that (1) HSC now had one general officer, the Commanding General (CG) where it had three; the CG, Deputy CG, and Chief of Staff. (HSC is a major command; Training and Doctrine Command (TRADOC) has eleven (11) general officers in its headquarters, and Forces Command (FC) twelve (12).) This reduction in general officers was made despite increased population served,[85] and an expanded area of responsibility with the addition of Alaska, Hawaii, and Panama.[86] (2) That AMEDD had lost one general slot completely; (3) that the most recent Assistant Secretary of Defense (no replacement named since his resignation in January 1978) Robert N. Smith, MD, testified in May 1978 before the House of Representatives Select Committee (a) the Secretary of Defense gave military medical problems a low priority, (b) resources, personnel resources in particular, allocated to health care by DOD are not adequate for peacetime and are woefully inadequate to meet a wartime situation.[87] To "put it in a nutshell," as the saying

goes, all AMEDD officers contacted felt that health care in the Army was "low man on the totem pole."

With the acute shortage of physicians within the Army, the focus will be on this resource.[88]

1. Physicians as Commanders in AMEDD.

The Surgeon General and Commanding General, Health Services Command have consistently sought to place only qualified physicians in command of Army Medical Treatment Facilities. The General Officer Board for Selection of Medical Corps Officers (Physicians) for command and staff positions has further reinforced their goals. This is all well and good, but why is it necessary for a physician to be the commander? As one medical corps officer stated, "To explain why would require a volume."[89] I have attempted, with difficulty, to keep them (the reasons why) to a bit less.

The question that is asked in Congressional hearings, DOD, or the like, whether first or last, is "MSC officers are ready and eager to command; why aren't you letting them?"[90] This is an interesting question when you consider that MSCs who have been Executive Officers in Medical Treatment Facilities (MTF), or in other positions in a MTF, are not those asking the question. Each MSC officer interviewed or corresponded with thought the physician should be the Medical Facility Commander.[91]

The Chief of the Medical Service Corps (MSC) Brigadier General James Young, MSC, Ph.D., stated: "Unequivocally, Medical Corps officers, that is physicians, are required to command major

medical facilities and occupy major medical staff positions."[92] General Young gave reasons for his position, amongst which were: a. Physicians have the educational base that no other officer has to receive training and experience that will allow them to be the best of all possible commanders and staff officers; b. Physicians perform in their primary discipline, then grow in experience and knowledge professionally, to accomplish what is necessary in the position as commander or staff officer; c. The physician, with a modicum of experience and managerial training, can do the job better than any other member of the Health Care Team; d. The Army physician must be placed in circumstances early in his career that develop the required abilities that enable him to be the medical commander and staff officer of the future; e. The decimation of the command structure of HSC is not consistent with the survival of the command as a viable entity. A nonphysician, the Chief of the Medical Services Corps, has summed it up in one word--"unequivocally."

Unaware that the Chief of the Medical Service Corps had so supported the requirement for physicians to be commanders and medical staff officers, six out of seven MSC senior officers concurred with their chief.[93] (The seventh had never held a position in a hospital that had patients.) As the Executive Officer to the Director of Health Care Operations-TSG said: "Anyone who has ever held a position in a functional, operating hospital in the Army, and thinks anyone other than a physician can be the commander must have missed the boat."[94] The Executive Officer of a MEDDAC and

Army hospital in Europe said, "The heart of the question lies in the fundamental one and that is--What kinds of decisions have to be made?" The same officer stated, "I believe for the Army, the way it is (MC commanders) is best."[95]

The Chief, Health Care Administration Academy of Health Sciences, an MSC colonel, agreed that Medical Corps Officers (physicians) with the proper background, experience, and training (i.e., Masters, Health Care, AMEDD Executive Management Course), are the best commanders.

The Chief of Patient Administration Division, US Army Hospital Frankfurt, reflected the thoughts of seven other majors (MSC)--all have Masters Degree in Health Care Administration (Army physicians who are developed through experience and training to be commanders and major medical staff officers have no counterpart in any other branch. As one expands his experience as an MSC officer in hospital positions, he realizes more and more a physician has to be the commander).[96]

What is the attitude of line general and senior officers toward the physician as a commander?

The Chief of Staff of the Allied Staff Berlin (UK, France, and US) stated, "I don't believe that MSCs or any other line officer should command medical facilities."[97] (Colonel John L. Insani, Infantry, has had previous, extensive command and staff experience in his 30 years in the Army.) Colonel Insani observed that there is an urgent need to educate, through training and/or experience,

the MC in areas such as management tools, resource management, and personnel management.

General Sam S. Walker, Commander Allied Land Forces SE, stated:

> My personal view is that major medical commanders (the question addressed) who have treatment facilities under their command and control, should be qualified physicians as their functions are more closely aligned to the care of patients.[98]

Major General Joseph C. McDonough, US Commander Berlin, whose military experiences include command from platoon to division, and staff positions with the Department of the Army, stated, "All major medical facilities should be commanded by a physician." General McDonough stated further: "The physicians by training are the best equipped to make medical judgments on policy concerning patient care and general policy, as on the specific treatment of individual patients. They are key elements in the operation of a well-run medical facility."[99]

Other general officers and senior officers of the line have provided the same basic information in response to the premise of this thesis: Medical Corps officers are the best qualified by education and professional expertise to be the commanders of military medical facilities and no one else.[100]

This next section will deal with the attitude of Medical Corps officers, regardless of rank, toward the physician as a commander. The logic, reasoning, and facts presented will make it clear that the responses are not tendentious, but honest and forthright.

The Surgeon General of the Army stated that he, like his three predecessors, is firm in the conviction that the physician must be the medical commander. General Pixley, as others, noted physicians have the experiential base and medical background that enables them to make valid judgments and be the best of possible commanders.[101] The Deputy Surgeon General stated that physicians must develop abilities early in their career that complement their basic expertise in medicine to assure the best commanders for AMEDD facilities.[102]

The Commanding General of the Health Services Command made a statement[103] that was reinforced by all other medical generals and colonels, "You don't take your most skilled person and use him to do your most basic jobs. If there were five physicians left in the US Army, I would divide the responsibility for Army medicine in five parts for health care and put one physician in charge of each."[104] General McCabe's contention, that the fewer medical officers you have, the stronger the requirement for them to command, is shared by physician and nonphysician alike. With the increased use of nonphysicians in support of semi-clinical roles (i.e., Physician Assistant, Nurse Clinician, etc.), it is an absolute that a physician be in command.[105] The physician is the only professional who knows the limitations and capabilities of these support personnel, no other.

The comment was made to the writer on three separate occasions "that physicians aren't good managers." While it's true <u>all</u> physicians are not good managers, it is patently absurd for such a

statement to be made--"physicians aren't good managers." Physicians begin in medical school and internship to manage time, the care of their patients, laboratory tests, special tests. They learn, by doing, how to organize, categorize, and use time efficiently to get things done. As the physician progresses into residency, he learns more about administration each year. He advances to Ward Officer (physician in charge of a ward of patients), then, later, to assistant chief of service, etc., with each step adding to his management tools. By the time the Army physician becomes a chief of service or Chief of Professional Services, he has learned what financial management is, how personnel are utilized, supplies utilized, and has contributed to organizational decisions that require physician expertise. The demand for Medical Corps officers (physicians) upon retirement has continued unabated. Virtually every position filled on retirement requires management expertise, in addition to an MD,[106] expertise that had to be acquired while serving in AMEDD.

The obvious fact that the physician commander is not fresh out of medical school escapes those questioning the thesis. The physicial commander is a senior physician, usually a board-certified specialist, with experience in the area he commands.

> This physician is not the front-line clinic physician; this is the chief of service, chief of professional services, consultant-type physician. In a system that would require this physician to do general clinic work, to cover the emergency room, to be on a professional par with physicians straight out of training, would certainly lead to the loss of this type of physician and an even further aggravation of an already serious physician shortage.[107]

This statement by LTC James James, MC, the epidemialogy consultant in Medical Command Europe, is shared by every hospital commander contacted as well as by nonphysicians.[108]

It must be born in mind that this thesis does not state "all physicians can command." To do so would be untenable. That the physician is required to be the medical facility commander is evident to any military medical person who has worked in a hospital. The Army hospital is a military unit and a deliverer of health care. It must function as an effective component of the Army and provide patient care. The Army hospital must have a commander who is able to efficiently and effectively operate a health delivery system with reduced resources in peace, and be a military commander in time of war. The physician is the only military professional who, with a modicum of management training and experience, should be considered or allowed to command military medical facilities.[109]

"The military system allows the physician who has executive ability to develop both clinical and leadership skills needed to fulfill his role as a commander."[110] MG McDonough in commenting on the need for more management tools for the hospital commander stated:

> The physician in all likelihood will encounter many management problems earlier than the line officer because of the nature of a hospital. The line officer first encounters them as a Brigadier General or Major General when he becomes a post or community commander, whereas the physician (colonel) is confronted with them as soon as he assumes command of a hospital.

"We must prepare ourselves in executive, administrative, and management techniques."[111] General Neel, in making this statement,

echoes what military physicians, nonphysicians, and civilians have said: "It is necessary to give the physician that modicum of management training that assures he is the best commander possible."[112]

It is not my intent to write a book, but a thesis. However, I should emphasize that the interviews, letters, and testimony received could easily comprise a book. The positive response, the requirement for physicians to be medical facility commanders, was from sources expected and unexpected. The fact is, whether medical or nonmedical, virtually 100% of the respondents were positive that a physician must be the medical facility commander.

2. Nonphysicians in HSC and AMEDD.

The Medical Service Corps provides the expertise to support the physician, nurse, dentist, veterinarian, and all others in logistics and personnel support.

Medical Service Corps officers have been assigned as commanders of medical battalions in the field, where patients are not hospitalized. This is necessary because of the acute shortage of physicians. It has had the adverse impact of eliminating a position that was important in the development of physician leadership.

Positions formerly held by Medical Corps officers have been reassigned to MSCs.[113] While some on the list of converted spaces did not require physician expertise, there are those, converted, that did in fact provide an excellent training ground for physicians and fully developed their professionalism (i.e., Director, OCHAMPUS; Commander, 30th Medical Group, Theatre Army Support Command, Staff Surgeon, USAREUR, etc.).

The Medical Service Corps has the trained officers to support the medical team. Since 1951 the US Army-Baylor University master's program in Health Care Administration to May 1978 has graduated 826 officers.[114] Obviously, all branches within AMEDD will receive such graduates, and logistics, personnel, management will benefit. The other master's programs, such as the Syracuse University Program for Comptrollers, will continue to supply MSCs specialized in areas needed for support.

Nonphysicians in command positions of major medical facilities and major medical staff positions are neither contemplated, desired, nor considered by any of the Army AMEDD hierarchy.

3. Physicians in Major Medical Staff Positions.

The number of physicians in major medical staff positions has been reduced since 1969 to date. As of February 1978 thirty-eight physicians were assigned to what is called nonpatient care positions. This means approximately 0.85% of all MCs; this is in opposition to civilian medicine which has over 3.6% of the physicians delegated to executive administration and management.[115] Appendix P clearly demonstrates that these positions, administration, and management, impact on patient care and medical operations within the Army. The Director of the Plans, Operations and Training Division, HSC DCS-OPS, an MSC colonel, said, "A physician has to be DCS-OPS because there is patient care and medical treatment involved in virtually all aspects of our division. He's the only one who can really do it."[116]

General Young, Chief of MSCs, stated, "The training base for development of Medical Corps officers (physicians) has been and continues to be eroded; not by choice but necessity."[117] The "necessity" is of course the acute shortage of physicians in the present time frame. Certain jobs withdrawn as staff positions for physicians have removed a large portion of AMEDD's training base. As General McCabe put it, "You've got to continue to train people to be division, corps, or theater surgeons, and the only way to do this is to have them do the jobs in peacetime."[118]

The elimination of staff officers over the past five years from major Allied commands, to include joint commands, has caused serious concern amongst all of our NATO Allies as well as the Army Surgeon General and Deputy Surgeon General, the Commanding General, HSC and the last ASD/H&E).[119] There is virtually no medical input into medical plans, or plans of other staff activities in SHAPE that have an impact on health or require information on preventive medicine, local disease problems, or problems associated with chemical or environmental stresses.[120] The medical plans and operations will be called for in the event of war, and SHAPE will find there aren't any. Why? There is no one or group at SHAPE doing them.[121]

Reducing and eliminating the Surgeon from major commands in Europe has led to a group being formed called "Euromed" (or Eurogroup).[122] It is a totally nonmilitary group set up by the Allied medical services (excluding US and Canada) to have some device to do a little medical international planning. While nonmilitary, virtually every NATO Surgeon General (excluding US/Canada) is a

member of Euromed. These senior medical officers as well as our own, the Minister of Defense (FRG) and the last ASD/H&E have all recommended the reinstatement of a SHAPE surgeon with the two star rank he held in 1965. This action is needed to assure proper motivation of the staff in medical plans for war as well as expanding peacetime cooperative efforts and host nation integrated support.[123]

The need for physicians in staff medical positions was verified by the Vth Corps Chief of Staff and Surgeon. Senior staff officers within Vth Corps in conversations with their Surgeon stated MCs were needed for senior staff positions. Line commanders repeatedly indicate they rely on the MC Surgeon/Hospital Commander for complete professional advice. Anyone but a physician in this capacity is not acceptable, nor totally reliable, as they do not have professional ability nor educational background or expertise to give an acceptable medical judgment.[124]

The VIIth Corp Commander in a letter to the CINC-USAEUR, stated: "It is especially important that officers in the Medical Corps attend C&GSC level schools because much of their earlier years of service are spent in their technical field."[125] General Ott stated further, "and senior service colleges if they are to more effectively serve as Medical Corps commanders and staff officers at division level or higher."

> I am absolutely convinced of the need for Medical Corps officers as commanders of our health care facilities and for them to be major medical staff officers in NATO and HSC. Only with a thorough medical education and a background of medical practice can one in these important positions make proper analyses, recommendations and decisions.

MG Dirks, Superintendent of the Academy of Health Science, also wrote, "the physician must be the primary decision maker."[126]

"Division Surgeons, Corps Surgeons, the staff officers at Army level must be physicians. There is no question that the physician is the most qualified and skilled to perform this task (provided he understands the Army and has at least a modicum of field experience)."[127] MG Bishop pointed out that these staff officers have a very direct influence on the young physician and that "they are not satisfied, nor would I be, with a non-physician having the capability of exerting influence on care provided."[127]

The Italian MOD summed it all up: "We are so short of physicians in the Army we cannot afford to have anyone but a physician as commander or major staff officer."[128] This concept is very similar to that advanced by General McCabe earlier in this chapter.

Medical Corps officers need to be placed in more staff positions, not fewer, to assure AMEDD can meet its mission. Positions, no longer filled, can and will have a serious impact on medical support and operations. This has been amply testified to above. Physicians must be major medical staff officers, and must be developed early on. This is an AMEDD inherent responsibility that must be met.

D. <u>The Physician Executive in the Civilian Medical Hierarchy</u>.

This subject will be the topic of the next chapter, where it will be shown that the physician is becoming more and more involved in executive medicine.

Chapter 4

FOOTNOTES

1. See Appendix D: Structure of Royal Danish Medical Forces, 1977.

2. Interviews with MG Svend Trier, MC, Surgeon General, Danish Forces, 19, 20 March 1978 (see Appendix A-14).

3. Interview with LTG G. K. Kristensed, Chief of Staff, Danish Defense Forces, 20 March 1978.

4. See Appendix A-14, 15, 16, 17, 18, 19, 20, 21, 22.

5. Interview, MG Trier.

6. Interview with Major S. A. Jøegersen, ROMC, Commander, Field Army Hospital, former Commander, UN-Danish Hospital Cyprus, 19 March 1978.

7. Interviews held with either (8) Medical Officers of Junior grades, from the Army, Navy and Air Force of the Danish Forces on 19-20 March 1978.

8. Interview with Prof. Dr. B. Ebskov, Director, Danish Society of Emergency Medicine, 19 March 1978.

9. Interview with Dr. Hans H. Wandall, Director Surgical Research Unit, Copenhagen, University Medical School, 19 March 1978.

10. Interview, LTG Kristensed.

11. Interview with MG O. K. Lind, Commanding General, Eastern Land Command, Danish Forces, 20 March 1978.

12. Interviews, Trier and Kristensed.

13. Interview, Kristensed.

14. Interview, Lind.

15. Interview with Colonel Munt-Madsen, Surgeon, Land Forces, Jutland, 20 March 1978.

16. Interviews, Trier, Ebskov, and Wandall.

17. Review of organizational charts of Four Danish Civilian Hospitals, 19-20 March 1978.

18. Interview, Kristensed.

19. Interview, Lind.

20. See Appendix E: Organization of German Medical Forces, March 1978.

21. Interview with B. G. Artz Schoberg, MC, Director of Personnel, Surgeon General German Defense Force, Bonn, 16 March 1978.

22. See Appendix.

23. Interview, Schoberg.

24. Interview with MG Krawietz, Deputy Surgeon General, German Defense Forces, 16 March 1978.

25. Interviews, Schoberg and Krawietz.

26. Interview with Dr. Peter Brown, German Medical Association, 16 March 1978.

27. Interviews, Schoberg and Krawietz.

28. Interview, Schoberg.

29. Interviews, Schoberg, Krawietz, and Brown.

30. Interview with SG-RDMF, 20 March 1978.

31. Interview with Director General of Army Medical Services, United Kingdom, LTC Sir Richard Bradshaw, 22 March 1978.

32. Letter from His Excellency Herr Georg Leber, Federal Minister of Defense, FRG, to General Haig, SACEUR, 21 December 1976.

33. Interview with MG Spence Reid, MC, USAEUR Surgeon, 15 March 1978.

34. Interview with MG Marshall E. McCabe, MC, CG Health Services Command (former USAEUR Surgeon), 8 March 1978.

35. Interviews, Trier, Kristensed, Schoberg and Krawietz.

36. Interview with Colonel D. Toulous, MC, Vth US Corps Surgeon, 13 March 1978.

37. "Report of the Working Party to Consider Officer Manning in the Royal Army Medical Copies," Chairman, MG P. L. de C. Martin CBE, September 1974 (Appendix G).

38. Ibid., para 150, p. 31.

39. Interview, Sir Bradshaw.

40. Interview with Colonel A. C. Ticehurst, MB MRCS LPCP MFCV, Deputy Director, Royal Army Medical Services, 21 March 1978.

41. Interview, Sir Bradshaw.

42. "Report of the Working Party. . . ," Ch. III, para 25.

43. Ibid.

44. Interview with Colonel R. S. Blewett, OBERCOG, Royal Army Medical Directorate, 21 March 1978.

45. Interview with two junior field grade Medical Officers (RAMC), 20-21 March 1978.

46. Interview, Ticehurst.

47. Interview, Sir Bradshaw.

48. "Report of the Working Party. . . ."

49. Ibid., Conclusions.

50. Sir Bruce Fraser presenting the Winchester Address in New Winchester College on 23 May 1972.

51. Interview with LTC Tegtmyer, MC (FRG), Allied Command Europe (ACE), Medical Adviser, 18 March 1978.

52. Briefing on ACE Medical Adviser's position within SHAPE, LTC Tegtmyer, 18 March 1978.

53. Letter, Leber to Haig, 21 December 1976.

54. Letter: Robert N. Smith, MD, Assistant Secretary of Defense, Health and Environment (USA) to General Alexander M. Haig, Jr., Supreme Commander Allied Powers Europe, 8 September 1977.

55. Personal contact with Representatives of nine NATO countries; all nine concurred; other NATO countries were not contacted.

56. Interviews, Reid and McCabe.

57. Interviews, Trier, Schoberg, and Sir Bradshaw.

58. Interview, Trier.

59. "DOD Boss Never Met with Health Chief," Army Times, 15 May 1978, p. 31.

60. Ibid.

61. Interview with BG Charles W. Dyke, Executive to the Supreme Allied Commander Europe, SHAPE, 18 March 1978.

62. Interviews, Trier, Kristensed, Lind, Munt-Madsen, Schoberg, Krawietz, Brown, Sir Bradshaw, Leber (Letter), Reid, McCabe, Toulous, Ticehurst, Blewett, Tegtmyer, Smith (Letter), and nine Representatives from NATO countries.

63. Memorandum to LTC F. Antonacci, Senior Italian Representative COMLAND South East to Chief of Staff COMLAND South East, 20 March 1973.

64. Ibid.

65. Ibid.

66. Ibid.

67. Ibid.

68. Carlos Vetere, MD, "Doctors and Hospital Management," World Hospitals, (January 1971), p. 160.

69. Memorandum to LTC F. Antonacci, 20 March 1973.

70. Ibid.

71. Letter, MG D. Kromors, Deputy to the Commander, to Chief Staff, Southeast, 20 March 1978.

72. Interview with Colonel William Winkler, MC, designated Commander, US Army Hospital, Fort Hood, Texas, 1 May 1978.

73. Interview with M. Dyan, Ministry of Defense, Israel, 17 April 1972.

74. "Structure of the Health Education Services in the USSR," (1977) (see Appendix H).

75. "Administrative Structure of Health Services in USSR," (1971) (see Appendix I).

76. "The Soviet Military Medical Services," C. N. Donnelly, RUSI/RMAS Research Centre, December 1974, p. 74.

77. Personal conversations with two USSR Lieutenant Colonels, Medical Corps, in 1976 and 1977, Berlin.

78. "Structure of the Health Education Services in the USSR."

79. "Administrative Structure of Health Services in USSR."

80. "Structure of Central Institute for Scientific Research in Health Education, USSR," World Health Organization, "Health-Education in the USSR," (1963), Appendix J.

81. Report of the Patient Administration Division, Deputy Chief of Staff Operations, Health Services Command, San Antonio, Texas, 1 May 1978.

82. Interviews with MG Spencer Reid, MC (see appendix A1).

83. Interviews/Letters, Army Hospital Commanders, 1978 (see appendix A1, 4, 13, 15, 16, 18, 19, 27).

84. Personal and telephone interviews, and letters from Medical Corps officers throughout AMEDD, in the rank of Major or LTC, 1 December 1977 to 10 May 1978.

85. Report of the Patient Administration Division, 1 May 1978.

86. Location of HSC units (see appendix K).

87. "DOD Boss Never Met with Health Chief," p. 31.

88. Requirements within AMEDD (see appendix L).

89. Letter from COL Robert E. Neimes, MC, 3 March 1978.

90. ASD(H&E), Dr. Cowan, Memorandum for SOD, Subject: Physicians in Command and Staff Positions, 21 May 1975.

91. Appendix A-11, 14, 37, 56.

92. Interview with BG James Young, Chief of the Medical Service Corps, US Army, 22 April 1978.

93. Interviews, letters, confidential conversations with MSC officers, 4 December 1977-12 May 1978 (see appendix A-11, 14, 37, 56).

94. Personal conversation with Executive Officer, Health Care Operations OTSG, 22 April 1978.

95. Letter, LTC Leland Stone, MSC, dated 28 February 1978 (see appendix A-14).

96. Interview with Major Joseph Ribboto, MSC, Frankfurt, 17 March 1978 (see appendix A-37).

97. Letter, COL John L. Insani, USA, Berlin (see appendix A-7), 17 February 1978.

98. Letter, General Sam S. Walker, USA, 23 March 1978.

99. Letter, MG Joseph C. McDonough, 25 February 1978.

100. See appendix A-7, 24, 29, 30, 39, 46, 48.

101. Interview with the Surgeon General, USA, LTG Pixley, 22 April 1978 (see appendix A-54).

102. Interview with the Deputy Surgeon General, MG Mendez, 22 April 1978 (see appendix A-55).

103. Interview with Commanding General HSC, MG Marshall E. McCabe, 8 March 1978 (see appendix A-28).

104. Appendix A-1, 2, 3, 4, 8, 9, 12, 13, 15, 16, 17, 18, 19, 21, 23, 24, 25, 27, 29, 36, 40, 54, 55.

105. Appendix 4, 12, 13, 21, 24, 25, 27, 29, 36, 54, 55.

106. Retired US Army Medical Corps Officers Positions: Post Retirement (see appendix M).

107. Letter LTC James James, MC, USAMEDCOM Europe, 17 February 1978.

108. Appendix A-1, 2, 3, 4, 8, 9, 12, 13, 15, 16, 17, 18, 19, 21, 23, 24, 25, 27, 29, 36, 40, 54, 55, 56.

109. Interviews, letters, confidential conversations with MSC officers, 4 December 1977-12 May 1978 (see appendix A-11, 14, 37, 56).

110. Letter, MG McDonough, 25 February 1978.

111. Letter MG (R) Spurgeon Neel, MC, 27 February 1978 (see appendix A-9).

112. Appendix A-4, 12, 13, 21, 24, 25, 27, 29, 35, 36, 43, 54, 55.

113. Medical Corps Chronology: Space Conversions (see appendix N).

114. American College of Hospital Administrators Listing of Graduates from Masters Program, February 1978 (see appendix O).

115. Medical Corps Officers in Nonpatient Care Position (see appendix P).

116. Personal conversation with Director, Plans, Operations, Training, DCS-OPS HSC, 2 May 1978.

117. Interview with BG Young, 22 April 1978.

118. Interview with Commanding General HSC, 8 March 1978.

119. ASD(H&E), Dr. Cowan, Memorandum for SOD, 21 May 1975; interview with Commanding General HSC, 8 March 1978; and appendix A-29, 31, 32, 33, 34, 35, 38, 40, 41, 42, 46, 48, 49, 50, 51, 52, 53.

120. Interview with Commanding General HSC, 8 March 1978.

121. Ibid., and appendix A-33, 34, 35, 38, 41, 42, 45, 46, 48, 49, 50, 51, 52, 54, 55, 56.

122. Ibid., and appendix A-33, 34, 41, 52.

123. Interview with Commanding General HSC, 8 March 1978, and appendix A-32, 54, 55, 63.

124. Interview with Colonel Tsulous, MC, Vth Corps Surgeon and BG Ballyntyne, C/A, Vth Corps, 13 March 1978 (see appendix A-29, 30).

125. Interview/letter, COL G. Sieter, MC, VIIth Corps Surgeon, 15 March 1978 (see A-24).

126. Letter, MG Kenneth Dirks, AHS, 19 December 1977 (see A-3).

127. Letter, MG Raymond Bishop, 23 February 1978.

128. Letter, LTC Antonacci, I-A to CG Southland, 20 March 1978 (see A-8).

Chapter 5

CIVILIAN TRENDS IN EXECUTIVE MEDICINE

"There is no counterpart whatsoever to the military commanding officer of a large hospital," stated Admiral Custis, the Surgeon General of the US Navy in 1974.[1] Military "Command" vests in the physician commander the absolute authority and responsibility for the total management of the medical facility. He is responsible for both clinical and administrative activities. As the "Guidelines for Field Representatives to Use in Surveying Hospitals of the Federal System" states, "the commanding officer sets local rules and regulations for the governing board and medical staff that are in accordance with federal regulations."[2] The Joint Commission on Accreditation of Hospitals manual stated in Standard III, IV, VII, and VIII of the Section on "Governing Body" that the Commanding Officer represents the governing body.[3] "The Army Medical Department is, and operates in, an authoritarian mode where discipline and professional, moral, legal and ethical considerations are essential."[4] General Taylor and The Surgeon General of the Navy agreed that a physician was the only officer who could fill this position that does not exist in civilian medicine. Mr. Lee, an Administrative Executive of the VA Medical Directorate, testified that he did not feel qualified to command a military hospital. He had no problem directing VA hospitals however.[5]

The caveat is thus established that military medical commanders have no counterpart in the civilian medical community. What has

the trend been in civilian executive medicine?

In 1910 there were essentially three members of the health care team--physician, nurse, and aide. In 1975 the figure rose to well over 450 individual health care occupations. The most current estimate puts the figure at 600.[6] The number of graduates of Master's programs in Health Care Administration since the first program began (in the late 1940s) was 13,545 in 1977.[7]

The additional thousands of personnel in health care has led to nonphysician administration of hospitals in many cases. As more educated personnel arrived on the medical scene, more and more the physician left administration of hospitals to others. It was and continues to be to the physician's economic advantage to allow others to administer the hospital.

In 1974 physicians became acutely aware (in the civilian world) that they needed more "say" in the operation of the hospital. The American Medical Association (AMA), having already approved MDs for hospital boards, influenced the American Hospital Association to advocate that hospitals put physicians on their governing bodies.[8]

"Historically, the habits and attitude of the industry are derived from physicians."[9] This quote from the Industrial Relations Research Association goes on to state that "Whenever a physician is close at hand, he becomes the decisionmaker for administrative questions."

Since 1973 when the AMA approved and advocated physicians on boards of hospitals, the literature has abounded with the how to do it, why it should or should not be done, etc. As any civilian

nonphysician or physician will testify, the physician is becoming more involved each year in the "running" of things.

The American Academy of Medical Directors was founded in 1973. Its purpose has been and continues to be to establish physician managers, by training them as medical directors in hospitals. Their success is evident by the marked increase in medical directors throughout the United States, reporting to the Board of Directors, no one else.[10]

Peter F. Drucker said, "In any community (voluntary) hospital, the medicos (physician) can force out any administrator. It is very easy to do."[11] His article implies that anyone in hospital administration today, 1978, who does not know that physicians are the boss will not last long.

Dr. Thomas Benner, a management consultant, verified Admiral Custis' previous statement: "There is nothing in civilian medicine that has any comparability to a hospital commander, or the responsibility that rests on him."[12]

In other words, despite any protestations to the contrary, the physician in 1978 is the leader in civilian care. To date, however, he does not approach the legal, ethical, moral, professional, and military responsibility that the Army Hospital Commander accepts and meets, because no such position exists in civilian medicine.

Chapter 5

FOOTNOTES

1. Testimony of Admiral Custis, MC, Surgeon General, US Navy, before H.R. Committee on Armed Services, Subcommittee No. 2, Military Personnel, March 1974 (Washington, D.C.: Government Printing Office, 1975), p. 1800.

2. Joint Commission on Accreditation of Hospitals, Field Surveyors Manual on Federal Hospitals; Guidelines: Governing Body and Management Standard I.

3. Ibid., Standards III, IV, VII, VIII and Medical Staff Standards I-VII.

4. Testimony LTG Richard R. Taylor, MC, Hearings before Subcommittee on Medical Operations, H.R. Committee on Appropriations, April 1974 (Washington, D.C.: Government Printing Office, 1974), p. 342.

5. Ibid., p. 343.

6. Harold Goldstien and Morris Horowitz, Health Personnel (Germantown, MD: Aspen Systems Corporation, 1977), p. 10.

7. Listing of Graduates of Health Care Programs Leading to a Masters Degree and Programs Granting these Degrees (1977) (appendix O).

8. Medical World News, (March 1974), p. 18.

9. Anthony Robbins, "The Physician's Role in Hospital Management," Monthly Labor Review, (April 1971), p. 60.

10. Medical Director, Vol. 2, No. 2 (May/June 1977).

11. "An Interview with Peter F. Drucker on the Dynamics of Health Care Administration," Review Federation of American Hospitals, (February 1978), p. 14.

12. Personal conversation with the President of Medias Inc., Thomas Bennet, Ph.D., in Berlin, 1976.

Chapter 6

CONCLUSIONS

The Army Medical Department is second to none. Army residents have the best records for passing Board examinations.[1] Appendix Q indicates results on Board examinations in all specialties offered within the Army training program.[2]

The AMEDD has the same inherent responsibility to develop and train medical officers for command and staff. The training base cannot be further reduced in these two areas if AMEDD is to survive. The testimony presented in the previous chapters indicates that line and medical officers acknowledge the requirement. We in AMEDD cannot be accused of "looking out for No. 1" as the article in the Washington Star, Comment/Editorial section, stated in Section C, Sunday, 23 April 1978.[3] AMEDD has to meet the requirement of duty-honor-country not equally but better than those we serve. The soldier who is prepared to die for his/her country is entitled to every chance for survival. Regardless of your views on Vietnam, one view is universally held; medical support was the highest factor in maintaining morale.

As an Army physician (and I consider the two words inseparable) and reviewing the months of interviews, correspondence, etc., the only conclusion I am able to arrive at is (1) physicians must be medical facility commanders and (2) major medical staff officers. They must be given the opportunity to develop their managerial and leadership talents, and it is our responsibility to provide

the opportunities. The thesis demonstrates support of these conclusions.

We, in the AMEDD, must educate those within the political and military hierarchy who would degrade our capabilities. The time has long passed when we can "made do." The time has arrived when it must be told exactly as it is.

This thesis has been cursory in addressing these most important requirements. A book could be written on the affirmative aspects. It must be recognized that unless these requirements become doctrine, the future of AMEDD is in serious doubt, as would be the future of HSC. It is our duty to work toward the achievement of our mission to "Conserve the Fighting Strength." Failure to do so has consequences that could lead to dissolution of our medical support structure, in such serious peril right now.

Chapter 6

FOOTNOTES

1. BG Robert M. Hardaway, MC, USA (Ret), "Why a Career in Army Medicine," Military Medicine, Vol. 143 (April 1978), p. 288.

2. Success Rates of Trainees on Relevant Examinations, OTSG, 29 November 1977 (appendix Q).

3. Richard A. Gabriel and Paul L. Savage, Editorial, "As Officers Forget Duty-Honor-Country and Learn to 'Look out for No. 1,' the Military Loses Its Fight. It's Happening in the U.S. Army!" Washington Star, Section C, Sunday, 23 April 1978.

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APPENDIX A

LISTING OF INTERVIEWS AND LETTERS:

SUBJECT: REQUIREMENT FOR MEDICAL CORPS OFFICERS (PHYSICIANS) TO BE MEDICAL FACILITY COMMANDERS AND MAJOR MEDICAL STAFF OFFICERS IN NATO AND HSC

APPENDIX A

LETTERS

1. Colonel Mims Aultman, MC, Commander, USA MEDDAC, Fort Jackson, North Carolina, 8 March 1978.

2. Brigadier General Floyd W. Baker, MC, Commander, Brooke Army Medical Center, Fort Sam Houston, Texas 78234, 24 March 1978.

3. Major General George I. Baker, MC, CG, Walter Reed Army Medical Center, Washington, D.C. 20012, 19 January 1978.

4. Brigadier General Raymond H. Bishop, Jr., MC, Commander, William Beaumont Army Medical Center, El Paso, Texas 79920, 23 February 1978.

5. Brigadier General Philip A. Deffer, MC, Commander, Fitzsimons Army Medical Center, 1 March 1978.

6. Major General Kenneth R. Dirks, MC, Superintendent, Academy of Health Sciences, USA, Fort Sam Houston, Texas 78234, 19 December 1977.

7. Colonel Max Goldschmidt, MC, Commander, USA MEDDAC, Fort Monmouth, New Jersey, 7 March 1978.

8. LTG(R) Leonard D. Heaton, MC, Surgeon General US Army 1962-1973, Linden Road, Pinehurst, North Carolina 28374, 2 March 1978.

9. Colonel John Insani, Infantry, Chief of Staff, Allied Staff Berlin, 17 February 1978.

10. Lieutenant Colonel James J. James, MC, FASPH, Ph.D., Public Health Administration, 17 February 1978.

11. Colonel Frank Ledford, MC, Commander, Irwin Army Hospital, Fort Riley, Kansas 66442, 27 February 1978.

12. Colonel Llewely Leggters, MC, Commander, Womack Army Hospital, Fort Bragg MEDDAC, Fort Bragg, North Carolina, 21 February 1978.

13. Colonel Robert McClean, MC, Commander, US Army Medical Department Activity, Redstone Arsenal, Alabama 35809, 4 January 1978.

14. Major General Joseph C. McDonough, US Commander Berlin, 25 February 1978 and 14 March 1978.

15. MG(R) Spurgeon Neel, MD, (former CG, Health Services Command), Occupational Health Associates, 215 M&S Tower, 730 North Main Avenue, San Antonio, Texas 78205, 27 February 1978.

16. Colonel Robert E. Neimes, MC, Commander, USA Medical Department Activity, Fort Knox, Kentucky, 3 March 1978.

17. Colonel Jack Ransone, MC, USA Health Services Command, Fort Sam Houston, Texas 78234, 16 March 1978.

18. Major General Spencer Reid, MC, Commanding General, Medical Command Europe, 17 January 1978.

19. Colonel Girard Seitter, III, VII Corps Surgeon, APO 09107 27 March 1978.

20. Colonel Donald P. Shaw, Director, USA Military History Institute, Carlisle Barracks, Pennsylvania 17013, 3 April 1978.

21. Lieutenant Colonel Lleland Stone, MSC, Executive Officer, US Army Hospital Berlin, dated 28 February 1978.

22. Colonel Tracey Strevey, MC, Designated Chief of Surgery, Walter Reed Army Medical Center, Washington, D.C., 6 April 1978.

23. Colonel James B. Stubbelfield, MSC, Chief, Health Care Administration, Academy of Health Sciences, Fort Sam Houston, Texas 78234, 24 February 1978.

24. LTG(R) Richard R. Taylor, MD, Surgeon General 1973-1977, 3 March 1978.

25. General Sam S. Walker, Commander, Allied Land Forces, SE Europe, 23 March 1978.

26. Colonel William Winkler, MC, Designated Commander, US Army Hospital, Fort Hood, Texas, 20 April 1978.

INTERVIEWS

27. Brigadier General Ballyntyne, Chief of Staff, Vth Corps, 13 March 1978.

28. Colonel R. S. Blewett, OBE MB MFCM RCOG, Royal Army Medical Directorate, London, 21 March 1978.

29. Lieutenant General Richard Bradshaw, KBE, QHP, MRCS, LRCP, FRC PATU, FFCM, Director General, Royal Army Medical Service, London, England, 22 March 1978.

30. Dr. Peter Brauer, German Medical Association, Bonn, 16 March 1978.

31. Colonel John Canby, MC, Commander, US Army Hospital, Frankfurt, 17 March 1978.

32. Brigadier General Dyke, Chief of Staff, SHAPE, 18 March 1978.

33. Professor Dr. B. Ebskov, Director, Danish Society of Emergency Medicine, 19 March 1978.

34. Colonel John Fichtner, MC, Commander, SHAPE Medical Center, 18 March 1978.

35. Dr. Hyldahl, Deputy Surgeon General, Danish Forces, 19-20 March 1978.

36. Major S. A. Jøegersen, MC, Commander, Field Army Hospital, Royal Danish Medical Corps, 19 March 1978.

37. Major General Krawietz, Deputy Surgeon General, Bonn, 16 March 1978.

38. Lieutenant General G. K. Kristensed, Chief of Staff, Danish Defense Forces, Vaedbeck, Denmark, 20 March 1978.

39. Major General O. K. Lind, Commander, Eastern Land Command, Vaedbeck, Denmark, 20 March 1978.

40. Major General Marshall E. McCabe, MC, CG, Health Services Command, 8 March 1978.

41. Major General Enrique Mendez, MC, The Deputy Surgeon General, Washington, D.C.

42. Colonel Munk-Madsen, Surgeon Land Forces Jutland, Vaedbeck, Denmark, 20 March 1978.

43. Lieutenant General Charles C. Pixley, MC, The Surgeon General, US Army, Washington, D.C.

44. Major General Spencer Reid, MC, CG, USA Medical Command Europe, 15 March 1978.

45. Major Joseph Ribboto, MSC, Chief PAD, US Army Hospital, Frankfurt, 17 March 1978.

46. Brigadier General Artz Schober, Director of Personnel, Surgeon General FRG, Bonn, 16 March 1978.

47. Colonel Girard Sieter, MC, VIIth Corps Surgeon, 15 March 1978.

48. Lieutenant Colonel Tegtmyer, MC (FRG), Allied Command Europe Medical Advisor, SHAPE Belgium, 18 March 1978.

49. Colonel Merle Thomas, MC, Medical Liaison, Ministry of Defense, London, 21, 22 March 1978.

50. Colonel Thorsteinson, Surgeon, Eastern Land Command, 20 March 1978.

51. Colonel A. C. Ticehurst, MB MRCS LPCP MFCN, Deputy Director, Army Medical Services, London, 21 March 1978.

52. Major General Svend Trier, MC, Surgeon General, Danish Forces, 19-20 March 1978.

53. Colonel D. Tsulous, MC, Vth Corps Surgeon, 13 March 1978.

54. Dr. Hans H. Wandall, Director Surgical Research Unit, Copenhagen University Medical School, Copenhagen, Denmark, 19 March 1978.

55. Brigadier General James Young, MSC, Chief, Medical Service Corps, US Army Medical Department, 22 April 1978 (telephone interview).

APPENDIX B

POSITIVE ACTIONS IMPLEMENTED BY THE SURGEON GENERAL OF THE ARMY TO ASSURE PROPER UTILIZATION OF HEALTH CARE PERSONNEL

APPENDIX B

POSITIVE ACTIONS THE ARMY IMPLEMENTED SINCE JUNE 1, 1973
(Per MG Green DSG-USA) and dated 10 April 1974

1. Fifty-two physician's assistants (PAs) were assigned to positions previously identified as Medical Corps spaces. Thirty-six of that number are in divisional units while the remainder are assigned to Medical Department Activities (MEDDAC). The physician's assistant, supervised by a physician, is performing duties in troop health clinics, ambulatory care clinics, and emergency rooms. Reports to date indicate that the PA is well received by commanders and by the patients.

2. In collaboration with a physician, nurse clinicians are being utilized in the delivery of comprehensive health care in the areas of pediatrics, ambulatory care, obstetrics and gynecology, midwifery, intensive care and anesthesiology. The nurse clinician provides patient assessment, treatment, education, and follow-up care in less complicated cases under a program of medical management. The utilization of the nurse clinician enables the physician to devote more time to diagnostic and therapeutic services for the urgent medical cases.

3. To improve the effectiveness of health care professionals and the administrative support to ambulatory care programs, forty-eight Medical Service Corps (MSC) officers who are qualified health care administrators were assigned to major Army treatment facilities at Department of Clinics level.

4. At several installations, Army health nurses are currently occupying positions in the preventive medicine functional area which were previously held by MC officers. Similarly, Veterinary Corps officers are performing preventive medicine functions at four installations due to the nonavailability of physicians in the preventive medicine specialty.

5. The professional capabilities of Dental Corps (DC) officers are being extended by the employment of dental therapy assistants, oral health managers (for preventive dentistry and community health care programs), and administrative assistants. The utilization of dental therapy assistants, which will reach a projected employment level of approximately 907 by 1978, will greatly increase the productivity of the individual dentist.

6. Physical therapists are being utilized at fourteen MEDDACs in the role of a physician extender to evaluate patients with musculo-skeletal disorders. Such utilization is projected to increase in view of the anticipated physician shortages.

7. In keeping with its mission of supporting the training of USAR medical units and individual AMEDD reservists, the US Army Health Services Command (HSC) is in close coordination with the US Army Forces Command (FORSCOM) to effect maximum utilization in HSC facilities during the annual training periods.

The programs outlined above reflect the thrust of Army action to make maximum use of our dentists and physicians. These and comparable programs are evolutionary in nature and are contingent on the availability of qualified personnel.

APPENDIX C

SUMMARY OF DUTIES OF MEDICAL DEPARTMENT STAFF (PHYSICIANS)--1814

APPENDIX C

DUTIES OF MEMBERS OF THE MEDICAL DEPARTMENT, 1814

Physician and Surgeon General

1. Establish rules for management of Army hospitals and see that they are enforced.
2. Appoint stewards and nurses.
3. Request and receive returns of medicines, surgical instruments, hospital stores.
4. Authorize, regulate supply of regimental medicine chests.
5. Report twice a year on regimental medicine chests, sick in hospitals to War Department.
6. Report yearly to War Department on estimated supply needs.

Apothecary General

1. Assist Physician and Surgeon General in his duties.
2. Obey orders of Physician and Surgeon General.

Apothecary General and His Assistants

1. Receive and manage all hospital stores, medicines, surgical instruments, dressings, bought by commissary general of purchases or his deputies.
2. Account to superintendent general of military supplies for all disbursement of items under 1 above.
3. Pay monthly wages of stewards, ward masters, nurses of hospital.
4. Compound, prepare, and issue medicines under direction of Physician and Surgeon General or on estimates and requisitions of senior hospital surgeons and regimental surgeons.
5. Regulate, under supervision of superintendent general of military supplies, forms of returns made quarterly to apothecary general's office by deputy apothecaries, surgeons, mates, or those having charge of instruments, medicine, hospital stores, hospital equipment of any kind.

Senior Hospital Surgeons

1. Direct medical staff in army or districts to which he is attached.

2. Live at or near headquarters.

3. Countersign all requisitions of regimental surgeons or mates made on apothecary general or his assistants.

4. Inspect hospitals under him, correcting abuses and reporting delinquencies.

5. Make quarterly reports to Physician and Surgeon General on sick and wounded in his hospital and on medicines, instruments, hospital stores received, expended, on hand, and wanted.

6. Keep diary of weather, medical topography of country where he is serving.

7. Report to commanding officer concerning anything concerning the health of the troops.

Hospital Surgeons

1. Superintend everything relating to hospital.

2. Order steward to furnish whatever is needed by the sick.

3. Visit sick and wounded in hospital every morning.

4. Require from resident mate report on all changes since morning.

5. Instruct mate in writing on care of patients.

6. Have police rules of hospital displayed in each ward.

7. Assign appropriate wards to patients.

8. Keep register of all patients admitted.

9. Keep case book of every important or interesting case of disease and report on it monthly.

Mates

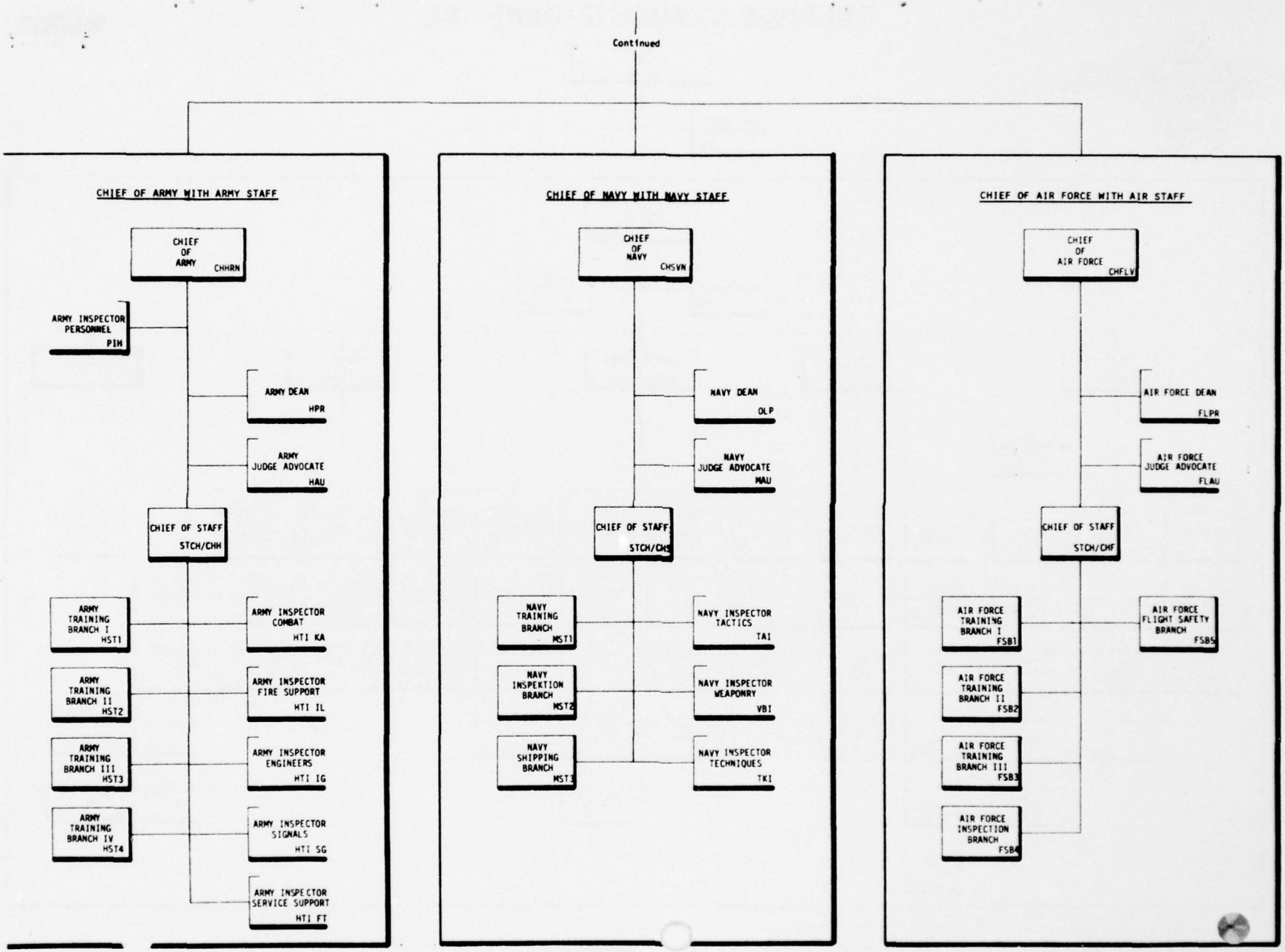
1. Visit patients with surgeon: take note of his prescriptions.

2. Keep case book.

3. Attend to carrying out of surgeon's prescriptions.

APPENDIX D

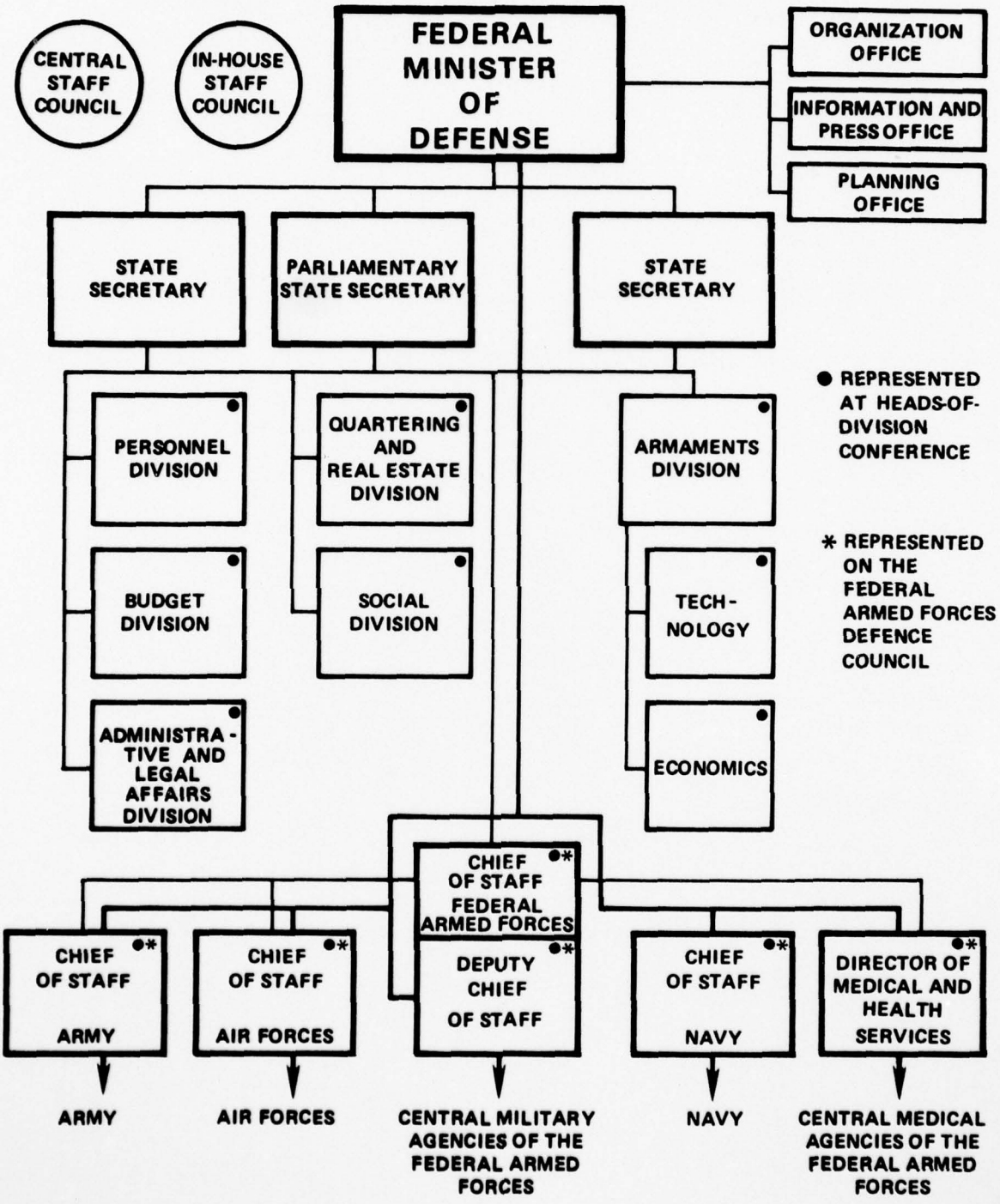
SCHEMATIC OF THE STRUCTURE OF THE ROYAL DANISH FORCES


Continued
CHIEF OF ARMY WITH ARMY STAFF
CHIEF OF ARMY CHHRN
ARMY INSPECTOR PERSONNEL PIH
ARMY DEAN HPR
ARMY JUDGE ADVOCATE HAU
CHIEF OF STAFF STCH/CHH
ARMY TRAINING BRANCH I HST1
ARMY TRAINING BRANCH II HST2
ARMY TRAINING BRANCH III HST3
ARMY TRAINING BRANCH IV HST4
ARMY INSPECTOR COMBAT HTI KA
ARMY INSPECTOR FIRE SUPPORT HTI IL
ARMY INSPECTOR ENGINEERS HTI IG
ARMY INSPECTOR SIGNALS HTI SG
ARMY INSPECTOR SERVICE SUPPORT HTI FT
CHIEF OF NAVY WITH NAVY STAFF
CHIEF OF NAVY CHSVN
NAVY DEAN OLP
NAVY JUDGE ADVOCATE NAU
CHIEF OF STAFF STCH/CHS
NAVY TRAINING BRANCH MST1
NAVY INSPEKTION BRANCH MST2
NAVY SHIPPING BRANCH MST3
NAVY INSPECTOR TACTICS TAI
NAVY INSPECTOR WEAPONRY VBI
NAVY INSPECTOR TECHNIQUES TKI
CHIEF OF AIR FORCE WITH AIR STAFF
CHIEF OF AIR FORCE CHFLV
AIR FORCE DEAN FLPR
AIR FORCE JUDGE ADVOCATE FLAU
CHIEF OF STAFF STCH/CHF
AIR FORCE TRAINING BRANCH I FSB1
AIR FORCE TRAINING BRANCH II FSB2
AIR FORCE TRAINING BRANCH III FSB3
AIR FORCE INSPECTION BRANCH FSB4
AIR FORCE FLIGHT SAFETY BRANCH FSB5

APPENDIX E

SCHEMATIC OF STRUCTURE OF FEDERAL MINISTRY OF DEFENSE

ORGANIZATION OF THE FEDERAL MINISTRY OF DEFENCE



APPENDIX F

TRAINING AND PROFESSIONAL CAREER OF MEDICAL OFFICERS IN THE FEDERAL ARMED FORCES, FEDERAL REPUBLIC OF GERMANY, MARCH 1978

TRAINING AND PROFESSIONAL CAREER OF MEDICAL OFFICERS IN THE FEDERAL ARMED FORCES AND PREPARATION OF MEDICAL OFFICERS FOR HIGHER-LEVEL ASSIGNMENTS AS SENIOR OR CHIEF MEDICAL OFFICER/COMMANDER

1. The young candidate officer headed for a career in the medical service of the Federal Armed Forces is given his scientific training in public universities of the Federal Republic of Germany.

Before he commences his studies, and in the course of his studies, he is given his military officer training, which takes four months and a half at present. In the future, however, this will be extended to nine months.

This first phase of training takes place at the Federal Armed Forces Medical College, a joint services institution, and comprises

-- military basic training
-- instruction in fundamental subjects related to the medical service (first aid, nursing)
-- the officer training course.

This is followed by an on-the-job training stage in medical installations of the Federal Armed Forces.

The candidate officer must pass this initial phase of his training successfully in order to be allowed to continue his training.

During their studies at their respective universities the future medical officers are regularly inducted for activities in the medical services during lecture-free periods; furthermore, they are instructed in specific subjects of military medicine/military pharmacy and take part in military and medical service courses and in military exercises.

Their military and scientific training takes between six and seven years in all.

2. After his "approbation" (i.e., after having received his license to practice medicine) as physician, dentist, pharmacist or veterinarian, the candidate medical officer is appointed medical officer and promoted to the rank of Stabsarzt, Stabsapotheker or Stabsveterinar, the captain's ranks in the German medical service for physicians/dentists, pharmacists, and veterinarians, respectively.

In a 3 months' familiarization course held at the Federal Armed Forces Medical College, he is prepared for his initial assignment (basic function) in the Federal Armed Forces Medical Service.

After one year of clinical instruction the physician and the dentist will be given assignments as unit medical officer and unit dental officer, respectively. Pharmacists and veterinarians will also be given assignments related to their respective "approbation."

This phase will generally take four years. During that period the medical officer is to become acquainted with the Federal Armed Forces Medical Service and is expected to gather his first experience in medical practice so as to permit him to take a decision in favor of one specific assignment or the other and to have a say in his professional career as a medical officer. His career will also be determined by the requirements of the armed forces and the personal aptitude and leanings of the individual medical officer.

In this phase the medical officers are given supplementary instruction in military medicine/military pharmacy related to their respective "approbation." This instruction takes place either in training courses or in the form of on-the-job training.

It includes, inter alia,

-- Medical CBR protection
-- Emergency medicine and lifesaving measures
-- Military psychiatry
-- Radiological protection
-- Management of supplies.

All courses are held centrally at the Federal Armed Forces Medical College; the on-the-job training periods take place in Federal Armed Forces Station Hospitals.

3. The initial assignment is followed by advanced training or specialization. This phase is devoted to the extension of professional training of the medical officers with the aim of teaching them the special knowledge and capabilities required for assignment to specific positions in the Federal Armed Medical Service. In four to six years medical officers will qualify for positions in installations within and outside the Federal Armed Forces.

The types of advanced training offered in this phase include:

(a) For <u>physicians</u> advanced training

-- as specialists in the various branches of medicine
-- as flight surgeon
-- doctor for diving medicine
-- hygienist and doctor of industrial medicine
-- doctor of public health
-- "works doctor" attached to a plant or other installation
-- doctor of sports medicine.

(b) Dentists and veterinarians may be given advanced training in special branches of dental medicine and veterinary medicine, respectively.

(c) Pharmacists are eligible for advanced training in special branches of pharmacy and food chemistry.

4. Medical officers are, however, not confined to medical functions but have to discharge command functions as well.

To give them specific preparation for assignments of this kind, a system of six types of command assignment-oriented courses has been developed. A selection of these courses has to be passed by each medical officer depending on the command assignment envisaged for him.

(a) In Course I every junior medical officer will become acquainted with command terminology and will study the fundamentals of the concept of operations of the medical service. He will attend this course during his initial assignment. The course is held at the Federal Armed Forces Medical College and takes two weeks.

Subsequent training for command assignments is given step by step depending on the aptitude of the individual medical officer. This subsequent training is given to medical officers of all types of "approbation."

(b) Attendance at Course II serves to acquire the knowledge and capabilities needed for staff assignments. This course takes six weeks and is held at the Federal Armed Forces Medical College.

The students are medical officers earmarked for their first staff assignment to military agencies, command authorities, etc.

(c) Course III prepares medical officers for their assignment to positions as unit commander/superior exercising disciplinary powers. The student will acquire the knowledge needed for medical unit commanders enabling him to exercise his disciplinary powers.

This course will be attended in particular by medical unit commanders and medical officers earmarked for higher-level assignments as senior or chief medical officer. Course III takes six weeks and is held at the Federal Armed Forces Medical College.

(d) Course IV is attended by medical officers who will be assigned to command functions in Federal Armed Forces Medical Centers, Medical Groups, Medical Commands and other command authorities, and in the Federal Ministry of Defense. This course, too, is held at the Federal Armed Forces Medical College and takes two weeks.

(e) Course V is designed to convey to the students information on the fundamentals and missions of, and the state of progress of preparations for, overall defense (both military and civil defense) with particular emphasis on medical and health matters.

The course takes three weeks and is held jointly by the Federal Armed Forces Command and General Staff College and the Civil Defense College.

The students are the senior and chief medical officers of the Federal Armed Forces and field-grade officers of the medical service assigned to comparable positions whose area of responsibility includes civil-military cooperation in the field of the medical and health services.

(f) Course VI prepares field-grade officers of the medical service for assignments as commander, director of medical installations, and comparable positions. This course is held at the Federal Armed Forces Medical College and takes two weeks.

5. Depending on their specific assignments, medical officers are trained in other assignment-oriented, function-oriented and special courses.

These include, inter alia, courses

-- for staff officers assigned to higher command authorities
-- on modern management methods
-- cataloging and preparation of the basic documentation for items of supply
-- logistic management
-- management of supplies
-- didactics/methods of instruction
-- general staff principal functional areas
-- overall defense
-- civil-military cooperation.

The duration of these courses varies (between two weeks and three months).

Field-grade officers of the medical service earmarked for key and top-level assignments will attend the highest advanced training course of the Federal Armed Forces, Advanced Training Stage D. This is a three months' course at the future Federal Armed Forces Defense College.

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THE REQUIREMENT FOR MEDICAL CORPS OFFICERS (PHYSICIANS) TO BE M--ETC(U)
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APPENDIX G

"REPORT OF THE WORKING PARTY TO CONSIDER OFFICER MANNING IN THE ROYAL ARMY MEDICAL CORPS"

Committee Chairman M.G. P. L. de C Martin GBE, etc.

London, England, 1974

REPORT OF THE WORKING PARTY TO CONSIDER OFFICER MANNING IN THE ROYAL ARMY MEDICAL CORPS

September 1974

MINISTRY OF DEFENCE
OFFICE MEMORANDA (ARMY)
Nos 24-25 of 1974 18 April 1974
(Must be seen by all Staff)

OM(ARMY) 24/74

WORKING PARTY TO EXAMINE THE OFFICER MANNING IN THE ROYAL ARMY MEDICAL CORPS

1. A Working Party has been set up under the sponsorship of the Adjutant General to examine the officer manning in the RAMC in the light of the serious shortage of doctors and in particular to review:

a. The organisation of medical support for the field force with a view to providing a more stable environment for Army doctors to work in, with increased opportunities for post graduate training.

b. All administrative, command and staff posts filled by doctors with the aim of releasing more doctors for clinical duties.

2. The Working Party is to take account of:

a. The views of Commanders as to the medical support they feel necessary in peace and war.

b. The effect of any proposal they make on the career prospects and earnings in the RAMC.

3. The Working Party will consist of the following:

Chairman - Major General P L de C Martin, CBE

Members - Colonel T S Hart, MB, DPH
Colonel R M Brennan
Lieutenant Colonel N Maclean, MB, DTM&H, RAMC

Secretary Lieutenant Colonel J A Castley, RAPC.

CHAPTER THREE

COMMANDERS' VIEWS ON THE ARMY REQUIREMENT

23. Commanders everywhere agreed with us that the role of the RAMC should be:

a. In peace to provide a National Health Service for the soldier and his family wherever they were serving.

b. In war to provide a medical service across the whole spectrum of possible operations.

24. Since in its current state of under-manning the RAMC is in no position to carry out either task with full efficiency we examined with commanders possible ways of making more medical officers available for doctoring by either:

a. Giving command of medical units and hospitals to non-medical officers, or

b. Altering the structure of the whole casualty organisation for war to reflect, for example, modern advances in air transport, and helicopters in particular.

25. Almost every commander was adamant that medical units of any type in peace or in war must be commanded by doctors. They felt that in certain circumstances medical priorities would dictate over the movement, deployment, or internal organisation of the medical unit, and conflict could well arise between a non-medical commanding officer and his Senior Medical Officer (SMO). When advice was required commanders wished to consult one officer only on all medical matters. They were not prepared to accept a situation in which they would have to consult the non-medical commanding officer on one aspect and the SMO on another. One commander expressed the view that there might be a marginal increase in military expertise in a medical unit commanded by a non-medical officer, but he had no doubt that there would be a serious loss of medical efficiency.

26. C in C BAOR felt very strongly, and his view was supported elsewhere, that ADMs of Divisions should be young men with "fire in their bellies", but that they were usually old in comparison with other Colonels of the Divisional Staffs and Services.

27. We examined and discussed the draft paper "Operational Medical Support of British Forces in Europe", (2) and agreed with commanders that the basic medical requirements for the field force were:

a. A casualty collection and first aid organisation within the battle group area.

b. A flexible casualty collecting, treatment, and evacuation unit within the brigade area.

c. Field hospitals sited sufficiently far forward in the Corps area to deal with those cases requiring urgent surgery, e.g., Priority 1 cases.

d. General hospitals in the RCZ to deal with those cases requiring less urgent surgery and those Priority 1 cases evacuated from field hospitals.

28. We considered whether the introduction of helicopters would produce any major effect on the chain of evacuation and the number and types of medical units involved. We concluded that the helicopter, although providing the means for the more rapid evacuation of Priority 1 cases, did not alter the basic requirement. . . . .

(2) Annex A to DAPS 6/72

CHAPTER SEVEN

SUMMARY OF RECOMMENDATIONS

THE ARMY REQUIREMENT

150. We recommend that:

a. The RAMC be required to provide:

(1) Operational medical support on the existing lines.

(2) Families medical support through the Group Practice concept.

(3) A hospital service.

b. Medical units be commanded by doctors, supported by sufficient additional doctors to train individuals and units for war.

c. Group Practices be established separately but with doctors shadow posted to operational medical units, and

d. An establishment review be carried out urgently into the numbers of doctors required, for the three roles of the RAMC, on this basis. (23-33)

TRI-SERVICE COOPERATION

151. We recommend that PPOs, or CPL on their behalf, examine urgently ways of improving tri-Service cooperation to ensure efficiency and economy. (58-66)

PAY

152. The only way to break "the vicious spiral" is to pay medical officers in the RAMC what they would actually earn in the NHS. This will mean major increases. In particular we recommend that:

a. The Service doctor should be paid, at his 7 or 8 year point of service, a rate assessed . . . as being realistic for a partner in general practice in the NHS. (We estimate that in mid-1974 this amounted to . . . per annum.)

b. Service doctors should receive the same 'X' factor as that paid to other officers.

c. Provided that a. and b. are fully implemented service doctors of equal rank and service should be paid the same amount, regardless of their career stream. (67-79)

STEPS TO REDUCE TURBULENCE

153. We recommend that:

a. The introduction of commissioned SRNs RAMC to some battalions in Northern Ireland should be effected with the least possible delay and, if successful, be extended to BAOR and elsewhere.

b. The present Army Health and Command and Staff streams should be rationalized and more extensive use made of Army Health Inspectors.

c. In addition to the detailed establishment savings already made by DGAMS, both permanent and short-term, those outlined in paras 87 and 88 of this report should be effected as soon as possible.

d. The liaison, exchange and secondment posts presently held by doctors should continue to be filled.

e. MOD should advertise for civilian GPs to act as "locums", particularly in BAOR. (80-98)

GROUP PRACTICES

154. We recommend that:

a. The re-organisation of Army general practice should proceed as a matter of urgency.

b. Support be given at all levels for the Group Practice concept and all that is implied in increases to establishments, provision of adequate supporting staff and transport and the necessary works services. (99-105)

POST GRADUATE TRAINING

155. We recommend that:

a. The careers of officers in the Command and Staff stream should not be disrupted by having to provide local GP cover.

b. The careers of GP officers should follow the programme set out in para 109. (106-110)

CAREER STRUCTURES

156. We recommend that:

a. The "blue-prints" at Annexures C to I should be brought into use.

b. Promotion zones should be broadened.

c. No Command and Staff Officer should be posted to a field-force appointment over the age of 50. (111-126)

POSTINGS AND CAREER PLANNING

157. We confirm the recommendation in our Interim Report[6] that DM(A) set up a Working Party to investigate whether his Directorate and the Military Secretary's Branch could and should handle the postings and career planning of medical officers. We also recommend that:

a. No movement of doctors should be permitted either inter-theatre or in-theatre without the prior approval of the Ministry of Defence at 2-Star level.

b. A complete review of career plans be made for every officer, and interviews be held to discuss their career plans and prospects.

c. With immediate effect the tied vacancy at the Staff College Camberley should be reintroduced. In addition, compulsory attendance at the Junior Division of the Staff College should be introduced for officers of the Command and Staff stream and Administrative Officers RAMC, under conditions applicable to the rest of the Army. (127-130)

MEDICAL CADETSHIPS

158. We recommend that:

a. Medical Cadets should be made to feel that they belong to the RAMC from the day they are first commissioned.

b. University Medical Scholarships should be introduced at the age of 18, leading to Medical Cadetships. (131-134)

RANK TITLES

159. We recommend that:

a. The RAMC should consider prefixing the medical officer's rank by the title "Surgeon" and the suffix "non-medical" for other officers of the RAMC should be dropped.

b. The suffix "QM" should be used for all officers holding Quartermaster commissions. (135-138)

LADY DOCTORS

160. We recommend that:

a. Lady doctors, who so wish, should be employed as RMOs and go on exercises and operations with their units.

b. Lady doctors should have their uniform designed as fashionably and femininely as the WRAC and QARANC. (139-141)

TAVR

161. We recommend:

a. The introduction of Regular Training Officers who may, where necessary, be of any arm. They should be backed by a nucleus of RAMC PSIs and administrative NCOs who must accompany their unit to war.

b. Within the inevitable financial limitations individual TAVR doctors should be permitted to undertake their annual training overseas. (142-149)

CHAPTER EIGHT

FINAL THOUGHTS

162. A study of the history of the Army Medical Services since the end of the Crimean War shows that they have been subjected to a Working Party, on average, every two years. Some of these Working Parties have been concerned with organisation, some with equipment, some with careers, and some with pay. The findings of some have been turned down because they were too ambitious or too expensive, while others have resulted in promises which were subsequently broken when the situation had remedied sufficiently. It is not surprising therefore that this latest Working Party, while always treated with the greatest kindness, was also met with considerable cynicism by doctors everywhere. One young man summed up the general reaction with engaging frankness when he said: "What makes you think that your Committee is so special that it will be any different to all the rest?"

163. It was difficult at the time to think of any convincing answer, but the DGAMS has since pointed out to us that we are unique in being the first Working Party to be composed entirely of professional soldiers and to consider both the requirements of the Army and the needs of the Corps.

164. This Report is lengthy enough, but omits any mention of the many proposals and ideas that we have considered and discarded. While we have attempted to meet the terms of reference given to us by the Adjutant-General, we have not been in any way inhibited by these terms of reference, and have felt entirely free to consider ideas and proposals however radical, and from wherever they have come.

165. In the event, we have not made any major proposals for the reorganization of the RAMC, but have sought to find solutions to the immediate causes of dissatisfaction and disillusionment within the Corps, and to set guidelines for the future which, if implemented, will, we believe, provide for the doctor in the RAMC a rewarding and stable career with full job satisfaction, and eliminate the need for any further Working Parties for many years to come.

166. In Chapter 2 we listed the shortages of medical officers against the current establishment and in Chapter 5 we gave our recommendations for ecoomies in medical officer manpower. It may be wondered why we have not attempted to carry out a reconciliation to show how our proposed savings affect the shortage. The answer is quite simple. We have stated that adequate medical support for families in BAOR is top priority. We have said that in our opinion the current establishment of doctors in BAOR is inadequate to provide this medical support for families and should be reviewed immediately, and we have recommended that group practices should be set up as rapidly as possible, worldwide, with their own establishments. Until both these steps have been taken, it will be impossible to assess the final medical officer manpower requirements for the RAMC.

167. We are under no illusions that our proposals for improving pay will be greeted with acclaim in the Army Department, which is already faced with such heavy and high priority demands on the Defence Vote. Doctors should realise, too, that before any proposal to improve pay can be put to the Armed Forces Pay Review Body and Treasury, it will be necessary for the Army Department to secure tri-Service agreement. Although the Royal Navy and RAF doctors, whom we have met, feel just as strongly as do the RAMC that they are underpaid, they have not suffered the same degree of turbulence, overwork and loss of job satisfaction as have Army doctors. Their manning problems are very much less, and their Service Boards are not under the same pressure to improve their conditions of service.

168. We are under no illusions either that this Report will remove, at a stroke, the existing cynicism of Army doctors. This cynicism will only disappear when they can see results, and when, over the course of

time, they can see that improvements, introduced to meet a crisis, are continued in good times as well as bad.

169. Even if all our recommendations are accepted without undue delay, the RAMC will not solve its problems overnight. Indeed, it may take as long as 10 years to achieve a fully-officered Corps with complete job satisfaction.

170. In the meantime everyone can help. As this Report has shown, there is plenty of scope for the RAMC to help itself. We have suggested how the Ministry of Defence can help, and commanders and staffs can help by reading this Report, understanding the problems facing the RAMC, being less demanding in their requirements, accepting that commissioned SRNs must often take the place of doctors, ensuring that hospitals and MRSs are given high priority for works services, and by doing all in their power to see that doctors get more fun out of life than at present.

171. Families too can help. They expect a far higher standard of care and service from the RAMC than they would dream of demanding from the NHS. It is entirely right and proper that the Army should maintain this high standard of care for its sick, but even the one wife who decides that little Johnny's spots can await attention until the next morning, can make a contribution.

172. In the course of the past five months we have been given great assistance by commanders and staffs, and by very many officers in the RAMC, from the DGAMS downwards. We, who have seen the RAMC at close quarters, have been immensely impressed by the real dedication and professionalism of the Corps. We doubt whether many soldiers and their families realise how fortunate they are in the care and devotion given to them by the RAMC, despite all its difficulties.

173. In conclusion, we cannot emphasise too strongly that the basic problem is that the RAMC has not got enough doctors. Unless it can recruit more doctors and retain them, none of the long-term improvements proposed in this Report will be possible. The Army knows full well that the "satisfied soldier" is the best recruiter. The dissatisfied doctor is certainly no example to the young man considering a career in the RAMC, nor is the dissatisfied senior doctor an encouragement to young men on Short Service Commissions to stay on as Regulars. The "vicious spiral" has got to be broken, and quickly. To us it appears that an improvement in pay is the only way for this to be done. We have got to buy time for other measures to take effect.

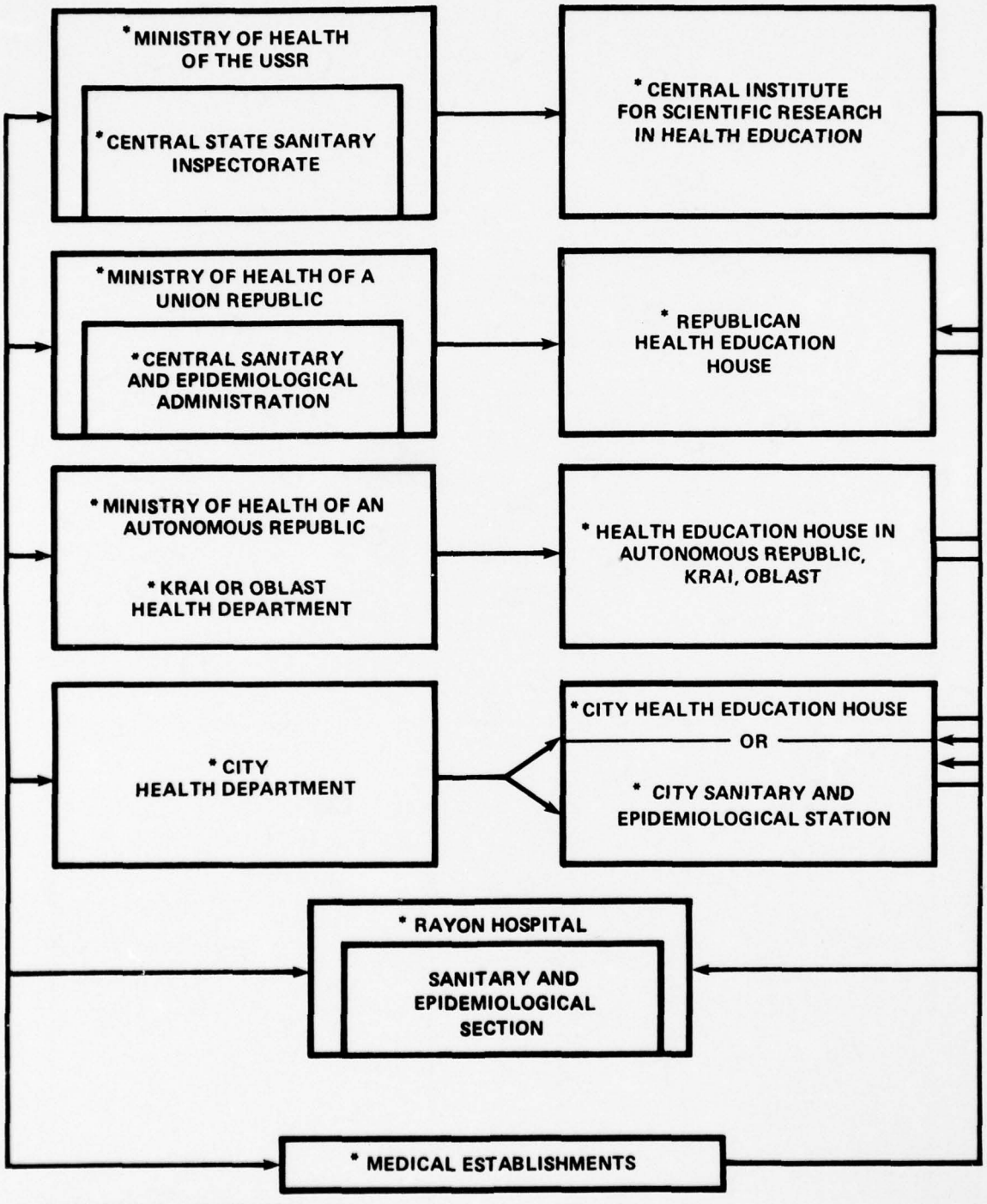
(Signatures of Chairman, Members (3), and Secretary follow.)

30 September 1974

APPENDIX H

STRUCTURE OF HEALTH EDUCATION SERVICES IN USSR

THE STRUCTURE OF THE HEALTH EDUCATION SERVICES IN THE USSR



* = DIRECTOR IS A PHYSICIAN

4. Dress all wounds.

5. Enforce discipline.

6. One mate, at least, to remain on call.

7. Responsible for medicines and instruments.

Steward

1. Receive and take charge of all hospital stores, furniture, utensils, under surgeon's direction.

2. Keep accurate account of all issues.

3. Responsible to Apothecary General or his assistant.

Ward master: under Steward's Direction

1. Receive arms, accoutrements, clothing of every patient admitted.

2. Have clothes immediately washed, numbered, labelled with name, regiment, company of patient and properly stored.

3. Responsible for cleanliness of wards and patients.

4. Call roll every morning and evening.

5. Supervise handling of close-stools, seeing that they are cleaned at least three times a day and always have proper quantity of water or charcoal in them.

6. See that beds and bedding are properly aired and exposed to sun, weather permitting.

7. See that straw in each bed-sack changed at least once a month.

8. See that each patient washed and has hair combed every morning.

9. See that bed and bedding of patient who has been discharged or has died is cleaned and straw burned.

10. See that nurses and attendants are kind and attentive to patients.

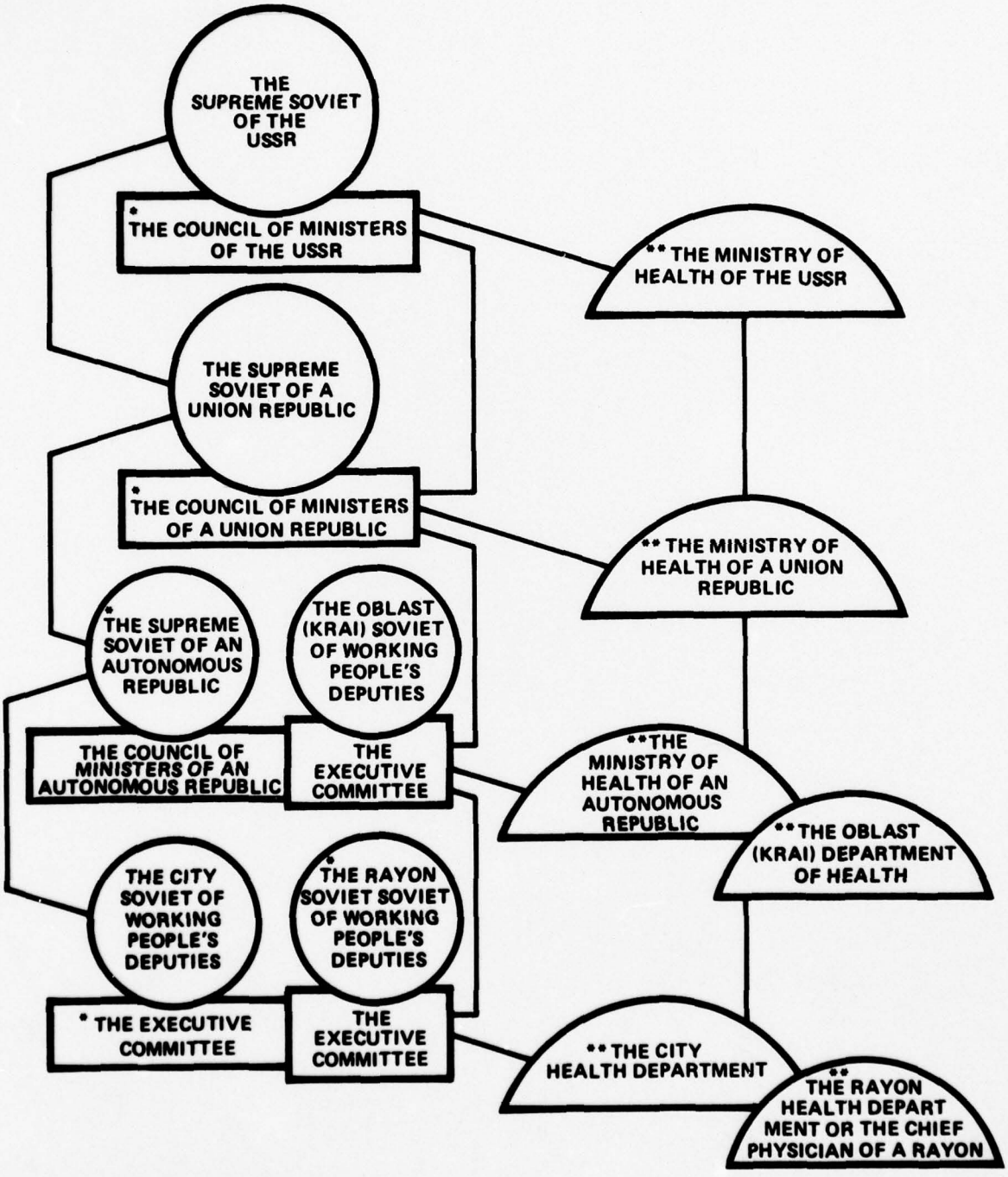
11. Supervise all attendants.

Source: Palmer, Historical Register, III, 7-9.

APPENDIX I

"ADMINISTRATIVE STRUCTURE OF HEALTH SERVICES IN USSR"

THE ADMINISTRATIVE STRUCTURE OF THE HEALTH SERVICES IN THE USSR



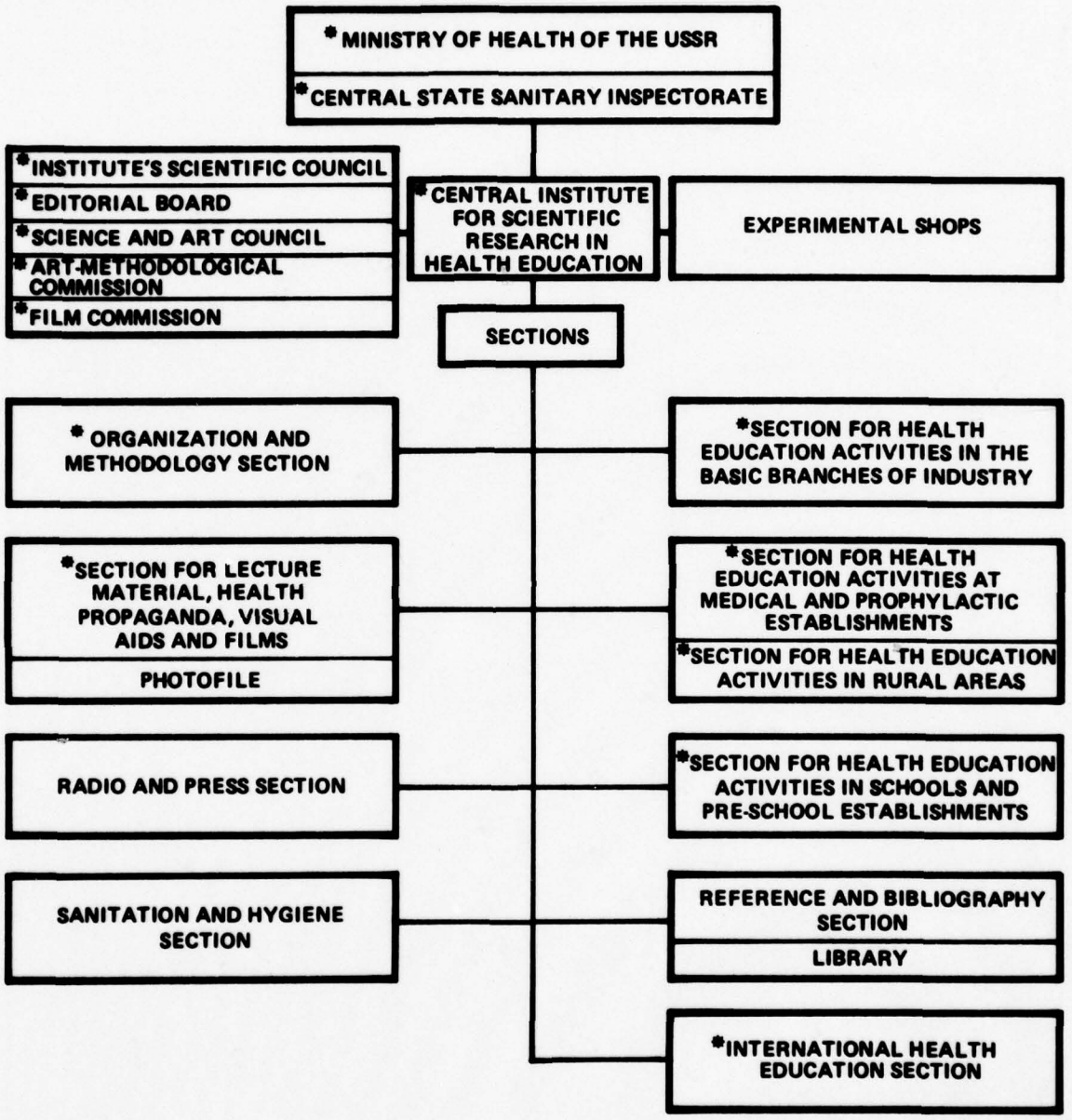
* = PHYSICIAN MEMBER
** = PHYSICIAN DIRECTOR

APPENDIX J

"STRUCTURE OF CENTRAL INSTITUTE OF SCIENTIFIC RESEARCH IN HEALTH EDUCATION, USSR,"

HEALTH EDUCATION IN THE USSR

THE STRUCTURE OF THE CENTRAL INSTITUTE FOR SCIENTIFIC RESEARCH IN HEALTH EDUCATION

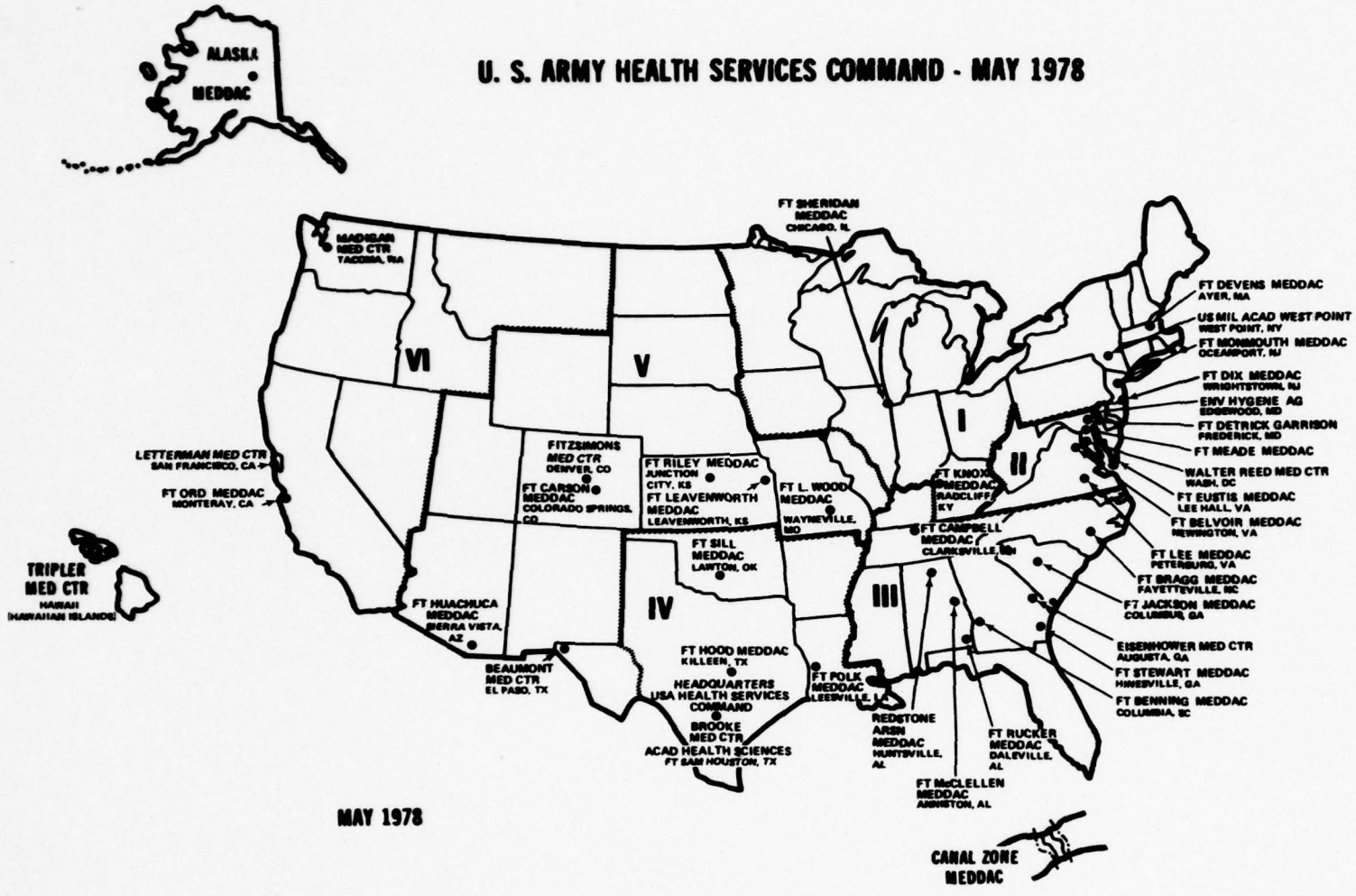


*DIRECTOR IS A PHYSICIAN

APPENDIX K

HEALTH SERVICES COMMAND MEDICAL TREATMENT FACILITIES, INCLUDING ALASKA, HAWAII, AND PANAMA, MAY 1978

U. S. ARMY HEALTH SERVICES COMMAND - MAY 1978



MAY 1978

APPENDIX L

AMEDD: AUTHORIZATIONS, REQUIREMENTS AND ALLOCATIONS OF MEDICAL CORPS OFFICERS, 1978-1982

CURRENT POM AUTHORIZATIONS FOR ALL AMEDD CORPS ARE AS FOLLOWS:

	FY 78	FY 79	FY 80	FY 81	FY 82
AMSC	450	436	432	428	428
ANC	3886	4086	3997	3886	3886
DC	1873	1873	1805	1737	1737
MC	4009	4173	4328	4539	4539
MSC	4618	4571	4571	4543	4543
VC	400	430	430	430	430
	15,236	15,563	15,563	15,563	15,563

ANC/ MC DIRECT PROCUREMENT OBJECTIVES FOR FY 78-82 ARE:

	FY 78	FY 79	FY 80	FY 81	FY 82
ANC	917	350	425	334	213
MC	336*	300*	300*	222	102

*Objective only, not sufficient to meet end strength.

REQUIREMENTS AND AUTHORIZATIONS/ PROJECTED ACTUAL

	FY 78	FY 79	FY 80	FY 81	FY 82
Constrained Readiness Requirement (Non-Mobilization)	5273	5273	5273	5273	5273
Original 78-82 POM MC End Strength Authorizations	4539	4539	4539	4539	4539
Interim E/S Authorizations to Accommodate MC Shortfall	4009	4173	4328	4539	4539
Projected Actual	3897	4080	4193	4213	4344

APPENDIX M

POSITIONS NOW HELD BY RETIRED ARMY MEDICAL CORPS OFFICERS (PHYSICIANS) POST-RETIREMENT, 1974

RETIRED UNITED STATES ARMY MEDICAL CORPS OFFICERS

February 1972

(Only 20% of all retired Colonels, MC, responded to questionnaire. This represents all respondees.)

COL William Allerton, MC (Ret)	Commissioner of Mental Health State of Virginia
COL William Anderson, MC (Ret)	Director of Mental Hygiene State of Michigan
COL Glen K. Arney, MC (Ret)	Associate Professor Department of Physiology and Medicine University of Texas Medical School
COL Elmore Aronstom, MC (Ret)	Chief, Thoracic Surgery Kaiser Hospital Los Angeles, California
COL Curtis P. Artz, MC (Ret)	Professor and Chairman Department of Surgery University of South Carolina School of Medicine
COL Kevin Barry, MC (Ret)	Professor of Medicine Georgetown University Medical School
COL Prince Beach, MC (Ret)	Chief of Urology Houston VA Hospital Associate Professor of Urology University of Texas School of Medicine
COL Philip Beckjord, MC (Ret)	Professor and Head Department of Health Education Tulane School of Public Health
COL Abram Benenson, MC (Ret)	Professor and Chairman Department of Community Medicine University of Kentucky Medical School
COL T. D. Boaz, Jr, MC (Ret)	Executive Director Committee on Biologic Effects of Atmospheric Polutants National Research Council
COL Nicholas Bottiglieri, MC (Ret)	Associate Professor of Medicine Baylor University Medical School Houston, Texas

COL Paul W. Brown, MC (Ret)	Professor of Orthopedic Surgery University of Colorado Medical School
COL George Carpenter, MC (Ret)	Deputy Commissioner of Health State of Pennsylvania
COL Joseph Cooch, MC (Ret)	Clinical Assistant Professor Preventive Medicine University of Connecticut
COL William H. Crosby, MC (Ret)	Professor of Medicine Tufts University Medical School
COL Ernst Dehne, MC (Ret)	Chief Department of Orthopedic Surgery VA Hospital, Memphis, Tennessee
COL Claude M. Eberhart, MC (Ret)	Assistant Medical Director Metropolitan Life Insurance Company
COL Henry Fancy, MC (Ret)	Deputy Director State Department of Health/Medicine Florida
COL Ralph Forrester, MC (Ret)	Associate Professor of Medicine South Western Medical School San Antonio, Texas
COL William Froemming, MC (Ret)	Director, Occupational Medicine Seeley Clinic, Houston, Texas
COL Samuel Gallup, MC (Ret)	Regional Medical Director United Mine Workers Headquarters, West Virginia
COL Albert Glass, MC (Ret)	Commissioner of Mental Health State of Illinois
COL Don Glow, MC (Ret)	Associate Professor of Surgery Georgetown University Medical School
COL Lester Graft, MC (Ret)	Professor of Radiology University of Hawaii Medical School
COL Herschel E. Griffin, MC (Ret)	Dean Graduate School of Public Health University of Pittsburgh
COL Robert J. Hall, MC (Ret)	Director Texas Heart Institute

COL George Hamill, MC (Ret)	Associate Professor of Psychiatry New York University Medical School
COL Harold Hamitt, MC (Ret)	Professor of Surgery University of South Carolina Medical School
COL James Hammill, MC (Ret)	Professor of Neurology Columbia University College of Physicians and Surgeons
COL William Hausman, MC (Ret)	Professor of Psychiatry University of Hawaii School of Medicine
COL Robert Hoagland, MC (Ret)	Professor of Medicine Emory University Medical School
COL Alan R. Hopeman, MC (Ret)	Professor and Chairman Department of Thoracic Surgery University of Missouri Medical School
COL Eugene Inwood, MC (Ret)	Professor of Psychiatry Georgetown Medical School
COL Winston Jesseman, MC (Ret)	Professor of Surgery University of Colorado School of Medicine
COL Robert Jones, MC (Ret)	Associate Professor of Cardiology University of Colorado School of Medicine
COL Donald Joseph, MC (Ret)	Professor of Otolaryngology University of Missouri School of Medicine
COL Edward Kamish, MC (Ret)	Director American College of Surgeons
COL M. Ralph Kaufman, MC (Ret)	Medical Director Mount Sinai Hospital and Medical School, New York
COL Paul Kiehl, MC (Ret)	Director of Surgical Education Chief of Department of Surgery Bethlehem, Pennsylvania
COL Theodore Kiersch, MC (Ret)	Professor of Psychiatry University of Illinois School of Medicine

COL Morton Klineman, MC (Ret)	Director State Hospital State of Pennsylvania
COL Charles Kraul, MC (Ret)	Medical Director Western Electric Company Omaha, Nebraska
COL Lewis Kurke, MC (Ret)	Psychiatry Professor University of Illinois Medical School
COL Eugene Lam, MC (Ret)	Professor of Anesthesiology University of Washington School of Medicine
COL Bruce Livingston, MC (Ret)	Professor of Psychiatry University of Washington Medical School
COL Arthur P. Long, MC (Ret)	Co-Director of Hooper Foundation Clinical Professor of Medicine University of California Medical School Commissioner of Health, Iowa Consultant, American Hospital Associatio
COL J. McCurdy, MC (Ret)	Executive Director American Society of Otolaryngologists
COL Paul Miller, MC (Ret)	Chief, Pulmonary Disease School University of Hawaii Medical School
COL Henry Modrak, MC (Ret)	Professor of Surgery University of Oklahoma School of Medicine
COL John Moncrief, MC (Ret)	Professor of Surgery University of South Carolina Medical School
COL Charles Moseley, MC (Ret)	Staff of American Medical Association
COL Robert H. Moser, MC (Ret)	Professor of Medicine University of Hawaii Medical School
LTC Jules Myers, MC (Ret)	Medical Director General Motors Corporation
COL George E. Omer, Jr, MC (Ret)	Professor and Chairman Department of Orthopedic Surgery University of New Mexico

COL William Orbison, MC (Ret)	Professor of Medicine University of Hawaii Medical School
COL Edwin Overholt, MC (Ret)	Director of Education Gunderson Clinic, Wisconsin
COL John Painter, MC (Ret)	Regional Medical Director United Mine Workers Headquarters, Tennessee
COL Eddy Palmer, MC (Ret)	Professor of Medicine New Jersey College of Medicine
COL James Pappas, MC (Ret)	Director, Regional Medical Program National Institutes of Health
COL Loren F. Parmley, MC (Ret)	Professor of Medicine University of South Carolina Medical School
COL Jack Pearson, MC (Ret)	Professor and Chairman Department of Ob/Gyn University of Indiana School of Medicine
COL Donald Peterson, MC (Ret)	Director, State Hospital Joplin, Missouri
COL Forest W. Pitts, MC (Ret)	Director of Blue Ridge Sanatorium Charlottesville, Virginia
COL Gennady Platoff, MC (Ret)	Director, Fairfax County Health Association
COL Martin Putnoi, MC (Ret)	Assistant Director Division of Graduate Medical Education AMA
COL Arnold Reeve, MC (Ret)	Commissioner of Health, Iowa
COL Richard Rink, MC (Ret)	Professor of Anesthesiology University of Missouri School of Medicine
COL Humbert Riva, MC (Ret)	Professor and Chairman Department of Obstetrics & Gynecology New Jersey State School of Medicine
COL Louis Saylor, MC (Ret)	Commissioner of Health State of California

COL Lee Serfas, MC (Ret)	Director of Surgical Education Chief, Department of General/ Thoracic Surgery Altoona, Pennsylvania
COL Frank Shannon, MC (Ret)	Director, Bureau of Health State of Delaware
COL Thomas Sheehy, MC (Ret)	Professor of Medicine University of Alabama Medical School
COL Paul E. Siebert, MC (Ret)	Associate Professor of Radiology University of Colorado Medical School
COL Ingalls Simmons, MC (Ret)	Consultant ARA Services District Director, Florida Regional Medical Program
COL Ralph C. Singer, MC (Ret)	Commissioner of Health, Indianapolis Clinical Professor of Public Health University of Indiana Medical School
COL Bruce Storrs, MC (Ret)	Director, Medical Care Service New Mexico State Health Department
COL James Syner, MC (Ret)	Professor of Pulmonary Disease University of Colorado School of Medicine
COL Paul Teschan, MC (Ret)	Associate Professor of Urology Meharry Medical College and Associate Professor of Medicine Vanderbilt University Medical School
COL Carl Tessmer, MC (Ret)	Associate Professor of Pathology Baylor University School of Medicine
COL Edward Tomsovic, MC (Ret)	Professor of Pediatrics UCLA Medical School
COL David M. Torme, MC (Ret)	Assistant Dean University of Vermont Medical School
COL Harry Umlauf, MC (Ret)	Professor of Pediatrics University of Colorado School of Medicine
COL Stefano Vivona, MC (Ret)	Assistant Medical Director American Cancer Society
COL Thomas Whayne, MC (Ret)	Vice President for Medical Affairs University of Kentucky Medical School

COL John Zelenik, MC (Ret)	Professor of Obstetrics & Gynecology University of Illinois Medical School
COL Edward Zimmerman, MC (Ret) (deceased)	Professor of Obstetrics & Gynecology University of New Mexico Medical School

APPENDIX N

"CHRONOLOGY OF CONVERSION OF MEDICAL CORPS POSITIONS TO OTHER BRANCHES"

MEDICAL CORPS CHRONOLOGICAL

SPACE CONVERSIONS

1969

Position	Grade	From	To	Number Spaces
Class II Hospital Executive Officer	COL	MC	MSC	8
Commander, US Army Aeromedical Research Lab	COL	MC	MSC	1
Chief, Plans and Operations, Surgeon's Office, CONUS Army Headquarters	COL	MC	MSC	5
Director, US AMEDD Historical Unit	COL	MC	MSC	1

1970

Office of The Surgeon General, Executive Officer	COL	MC	MSC	1
Director, Office for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	GO	MC	MSC	1
Director, Military Science, US Army Academy of Health Science	COL	MC	MSC	1
Commander, USAREUR Nuclear Research Unit	COL	MC	MSC	1

1971

Commander, 30th Medical Group (USAREUR)	COL	MC	MSC	1
Inspector General, Office of The Surgeon General	COL	MC	MSC	1
Regional ARADCOM Command Surgeon	LTC	MC	MSC	1
Chief, Research Planning, HQ, US Army Medical Research and Development Command	COL	MC	MSC	1

1972

Position	Grade	From	To	Number Spaces
US Army Physical Disability Agency Staff Officer	LTC	MC	MSC	1
HQ EUCOM Staff Surgeon	COL	MC	MSC	1
Special Assistant to The Surgeon General for Reserve Affairs	BG (USAR)	MC	MSC	1
Theatre Army Support Command Staff Surgeon (USAREUR)	COL	MC	MSC	1
Commander, US Army Environmental Hygiene Agency	COL	MC	MSC	1
Commander, 31st Medical Group (USAREUR)	COL	MC	MSC	1
Commander, US Army Medical Training Center	COL	MC	MSC	1
Director, Pathology and Laboratory Sciences, Academy of Health Sciences	COL	MC	MSC	1
Commander, US Army Medical Research Laboratory, Fort Knox	COL	MC	MSC	1
Deseret Test Center, Medical Staff Officer	COL	MC	MSC	1

1973

US Army Combat Developments Command, Staff Officer	COL	MC	MSC	2
Chief, Operations: Plans, Supply and Operations Directorate, Office of The Surgeon General	LTC	MC	MSC	1
Deputy Director, Personnel, Health & Environment, Operations, Directorate, Office of The Surgeon General	COL	MC	MSC	3
Director, Military Blood Program Office	COL	MC	MSC	1
TOTAL				40

APPENDIX O

LIST OF GRADUATES AND GRADUATE PROGRAMS IN HEALTH CARE ADMINISTRATION

Year Master's Program Established		Master's Degrees Awarded
1966	University of Alabama-Birmingham	154
1968	University of Alberta	58
1974	Arizona State University	16
1951	Baylor University/U.S. Army (MILITARY OFFICERS ONLY)	826
1972	Boston University	73
1948	University of California-Berkeley	330
1960	University of California-Los Angeles	251
1934	University of Chicago	472
1967	University of Cincinnati	103
1969	City University of New York	101
1968	University of Colorado	119
1945	Columbia University	759
1955	Cornell University	411
1962	Duke University	218
1964	University of Florida	133
1972	Florida International University	33
1959	The George Washington University	1,043
1965	Georgia State University	166
1971	Governors State University	57
1975	University of Houston-Clearlake	--
1972	Howard University	12
1969	Indiana University	110
1950	University of Iowa	389
1967	Johns Hopkins University	19
1974	University of Kansas	10

APPENDIX P

MEDICAL CORPS NONPATIENT CARE POSITIONS,

8 FEBRUARY 1978

DASG-RMM

MEDICAL CORPS OFFICERS IN NONPATIENT CARE POSITIONS

FACTS:

1. Professional medical training and expertise is required in the following nonpatient care related functions or positions.

a. Principal designated medical staff officers at various headquarters including Corps divisions and separate brigades.

b. Direction and management of medical and paramedical education and training programs.

c. Selection and assignment of Army physicians.

2. Relatively few Army physicians are assigned to nonpatient care functions:

a. Thirty-eight of 4,522 Medical Corps officers authorized for FY 1978, or 0.85 percent (not including General Officers), are assigned to positions where a predominance of their duties involve nonpatient care related functions (see inclosure 1).

b. There are seventeen (17) Medical Corps General Officers. Of these, nine (9) are assigned to patient care positions as Commander/Deputy Commander of Army Medical Centers.

1 Incl
as

MEDICAL CORPS OFFICERS IN EXECUTIVE MEDICINE POSITIONS

Activity	Number
Department of the Army/Department of Defense, & Joint Activities	6
Headquarters, Office of The Surgeon General	5
Training and Doctrine Command (John F. Kennedy Center)	1
Headquarters, Forces Command	1
Forces Command, Division/Corps Surgeon	12
Headquarters, Health Services Command	2
Academy of Health Sciences	6
Health Director, Canal Zone	1
Alaska	1
United States Army, Europe	8
United States Army, Pacific (Division/Army Surgeon)	4
TOTAL	47

Incl 1

Q&A(1/94)TSG-5 B
DATE: 28 Mar 77

MEDICAL CORPS NONPATIENT CARE POSITIONS

as of 8 February 1978

HQ Office of The Surgeon General and Army Medical Department Personnel Support Agency	Ch, Graduate Med Educ Branch Ch, AMEDD Officer Procurement
FORSCOM	FORSCOM Surgeon 10th SF Gp Surgeon, Ft Devens 5/1 SF Gp Surgeon, Ft Bragg 7/1 SF Gp Surgeon, Ft Bragg 1st Cav Div Surgeon, Ft Hood 1st Inf Div Surgeon, Ft Riley 2d Armd Div Surgeon, Ft Hood 4th Inf Div Surgeon, Ft Carson 9th Inf Div Surgeon, Ft Lewis 82d Abn Div Surgeon, Ft Bragg 101 Ambl Div Surgeon, Ft Campbell 5th Mech Div Surgeon, Ft Polk 7th Inf Div Surgeon, Ft Ord 24th Inf Div Surgeon, Ft Stewart 25th Inf Div Surgeon, Hawaii 193d Inf Bde Surgeon, Canal Zone 172d Inf Bde Surgeon, Alaska Surgeon, John F. Kennedy Center
US Army, Europe	V Corps Surgeon VII Corps Surgeon 1st Armd Div Surgeon 3d Armd Div Surgeon 3d Inf Div Surgeon 8th Inf Div Surgeon Med Liaison Officer, London
Canal Zone	Health Director, CZ
Department of Army, Department of Defense and Joint Activities	Surgeon, Nat'l Guard Bureau HQ Readiness Cmd, McDill AFB Surgeon, USA Recruiting Cmd TRIMIS Program Office
Academy of Health Sciences	Ch, Health Care Studies Division Member, Health Care Studies Division
HQ TRADOC	TRADOC Surgeon
WESTPAC	Surgeon, 2d Inf Div Dep Surgeon, Korea
HQ HSC	Dep CofS, Operations

TOTAL: 38

NOTE: Above does not include 17 MC Gen Off, 9 of which are assigned to patient care positions as Cdr/DCdr of Army Medical Centers.

APPENDIX Q

SUCCESS RATES OF ARMY RESIDENTS ON BOARD EXAMINATIONS (UNTIL JANUARY 1978)

29 Nov 77

SUCCESS RATES OF TRAINEES ON RELEVANT EXAMINATIONS

The success rate of military residents/fellows on board examinations for the past five years is as follows:

(1)	Allergy	- 100%	(15)	Nuclear Medicine	- 100%
(2)	Anesthesiology	- 93%	(16)	OB/GYN	- 100%
(3)	Cardiology	- 98%	(17)	Ophthalmology	- 100%
(4)	Dermatology	- 100%	(18)	Orthopedics	- 90-95%
(5)	Endocrinology	- 100%	(19)	Otolaryngology	- 100%
(6)	Family Practice	- 92%	(20)	Pathology	- 90%
(7)	Gastroenterology	- 80%	(21)	Pediatrics	- 95%
(8)	General Surgery	- 95%	(22)	Physical Medicine	- 100%
(9)	Hematology/Oncology	- 100%	(23)	Plastic Surgery	- 90%
(10)	Infectious Disease	- 100%	(24)	Psychiatry	- 97%
(11)	Internal Medicine	- 85-90%	(25)	Pulmonary Disease	- 80%
(12)	Nephrology	- 100%	(26)	Radiology	- 95%
(13)	Neurology	- 100%	(27)	Thoracic Surgery	- 97%
(14)	Neurosurgery	- 100%	(28)	Urology	- 100%

OTSG-HCD

Year Master's Program Established		Master's Degrees Awarded
1955	University of Michigan	344
1946	University of Minnesota	883
1972	University of Missippi	35
1966	University of Missouri-Columbia	110
1956	Universite de Montreal	198
1970	New York University	600
1943	Northwestern University	843
1969	Ohio State University	98
1964	University of Ottawa	129
1970	University of Pennsylvania	111
1973	Pennsylvania State University	3
1950	University of Pittsburgh	516
1966	University of Puerto Rico	190
1948	Saint Louis University	657
1971	State University of New York-Stony Brook	76
1968	Temple University	114
1947	University of Toronto	323
1965	Trinity University	430
1969	Tulane University	84
1949	Virginia Commonwealth University	437
1966	Wagner College	128
1946	Washington University	533
1970	University of Washington	63
1972	University of Wisconsin-Madison	34
1958	Xavier University	473
1947	Yale University	270
	Total	13,545