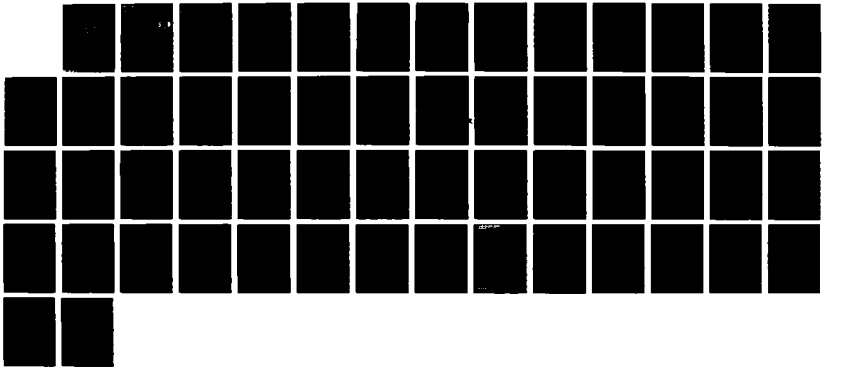
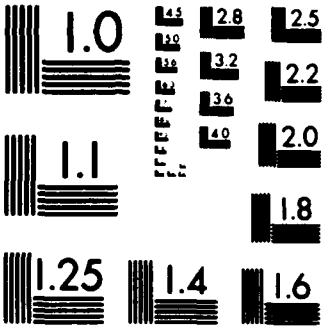
AD-A184 946 A STUDY OF NON-NORMAL DUTY HOUR PHYSICIAN HOSPITAL TIME AT MEDDAC FORT POLK LOUISIANA(U) ARMY HOSPITAL FORT POLK LA W J LANGONE AUG 79 1/1

UNCLASSIFIED F/G 5/1 NL





A STUDY OF NON-NORMAL DUTY HOUR PHYSICIAN HOSPITAL TIME AT MEDDAC, FORT POLK, LOUISIANA

A Problem Solving Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

By

Captain William J Langone, MSC

August 1979

SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION Unclassified	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION/AVAILABILITY OF REPORT Approved for public release; Distribution Unlimited
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S)	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION U.S. Army-Baylor University Graduate Program in Health Care Admin 6b. OFFICE SYMBOL (If applicable) HSHA-IHC	7a. NAME OF MONITORING ORGANIZATION
6c. ADDRESS (City, State, and ZIP Code) Ft Sam Houston TX 78234-6100	7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING/SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
A STUDY OF NON-NORMAL DUTY HOUR PHYSICIAN HOSPITAL TIME AT MEDDAC, FORT POLK, LOUISIANA.

12. PERSONAL AUTHOR(S)
William. J. Langone, Author

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Thesis	FROM July 78 TO Aug 79	August 1979	114

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	Health Services; Physician Staffing; Manpower Management

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

The assignment of non-normal duty (on-call) hour duties to physicians is often a source of dissatisfaction and conflict among the physicians. Without a comprehensive policy on non-normal duty hour duties, there exists potential for staff dissatisfaction. This paper studies the issue of non-normal duty hour duties at an Army Community Hospital and develops a methodology for determining an equitable method of allocating non-normal duty hour assignments among physicians.

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT ☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS	21. ABSTRACT SECURITY CLASSIFICATION
22a. NAME OF RESPONSIBLE INDIVIDUAL Lawrence M. Leahy, MAJ, MS	22b. TELEPHONE (Include Area Code) (512) 221-6443/6136 22c. OFFICE SYMBOL HSHA-IHC

DD Form 1473, JUN 86 *Previous editions are obsolete.* SECURITY CLASSIFICATION OF THIS PAGE

TABLE OF CONTENTS

APPENDIX

LIST OF TABLES

I. INTRODUCTION

Development of the Problem

The assignment of non-normal duty hour duties to all physicians on the staff of the U S Army Hospital Fort Polk, Louisiana, had for several months prior to the commencement of this problem-solving project in October, 1978, surfaced as a source of considerable dissatisfaction and conflict among the physicians.

Non-normal duty hour duties at USAH Fort Polk consist of on-call duties, which require physicians of various specialties to be available for emergencies and consults within one-half hour after being called, and Physician of the Day (POD) duty, which requires the physician to remain in the hospital. Normal tour of duty for weekday POD is 16 hours, and 24 hours for weekend or holiday duty. Some physicians, as chiefs of one-man services, were on call every night, while others, as members of services with multiple operators, were on call much less frequently, some as little as once every twelfth night. Indiscriminate assignment of Physician of the Day duty was regarded as equally unjust by the one and two-man services (See Appendix A, Incidence of POD Assigned Against Eligible Medical Staff).

Evidence of dissatisfaction became apparent from discussions at various departmental and professional staff conferences which often degenerated into aimless vocal conflict, with physicians of various specialties accusing others of not carrying their fair share of the workload. Additionally, comments voicing dissatisfaction with the assignment of non-normal duty hour duties were directed at the hospital Commander and the Chief of Professional Services.[1]

Existing policy established by the Commander provided that because orthopods and OB-GYN physicians were subject to more frequent emergency calls than other specialists, they were exempted from the POD roster. Specialists in other disciplines challenged the belief that the two exempted groups were called up more frequently than others and called attention to the fact that the very physicians who were exempted from POD on the grounds that they were constantly in demand somehow found time to obtain off-duty employment in civilian health-care institutions, some as much as a one-hour drive from Fort Polk (See Appendix B, USAH Fort Polk Physicians Engaging in Off-Duty Employment). Since the Commander was himself an obstetrician, rumors circulated that favoritism was being shown.

Physicians also complained that although it was the responsibility of the administration to equate duty-hour workloads with assignment of non-duty hour duties, no attempt had been made to do so. It was charged that physicians who were exempted from POD habitually reported late for duty, were observed engaging in sports during duty hours, and typically left work prior to termination of the normal duty day.

In the interest of maintaining morale and resolving the sources of conflict, the Administrative Resident was directed by the hospital Commander to develop a comprehensive profile of all official duties borne by the medical staff both during and after normal duty hours, and to provide him with problem-solving options upon which he might act in order to resolve burgeoning conflicts.

Statement of the Problem

The problem was to determine the best and most equitable method of allocating non-normal duty hour assignments to physicians at U S Army Hospital, Fort Polk, Louisiana.

Limitations Narrowing Problem-Solving Options

Because Medical Care Composite Units had been declining, resources already present would have to be utilized in devising problem-solving options. Limited funds were

available to obtain the services of civilian contract physicians to provide emergency room coverage on weekends and holidays, but due to an austere budget, expansion of this option was not feasible. Additionally, due to the remote location of Fort Polk, the availability of such physicians had been proven by recruiting efforts to be virtually nil, even had monies been available.

Likewise, the possibility of having additional Medical Corps officers assigned to USAH Fort Polk in order to diffuse the non-normal duty hour duties was not a viable option even though such physicians were authorized (See Appendix C), due once again to declining MCCUs and a shortage of military physicians.

Obstacles to Optimum Research

While on-call rosters and POD rosters were readily available, there were no records kept relating to the actual number of times physicians were called in to the hospital, or the amount of time spent in the hospital on each call. Therefore a reporting system had to be devised which would document physician time spent on non-normal duty hour duties, and as such its validity would be dependent upon the accuracy of input data.

The Setting

The U S Army Hospital, Fort Polk, Louisiana, is the only Army hospital in the state of Louisiana, and is the largest military medical treatment facility in the state. The hospital is established to provide health care support and medical services to the Fort Polk installation, housing the 5th Infantry Division(Mechanized), and to the surrounding Fort Polk military community. The hospital operates within the Army region headed by Brooke Army Medical Center, Fort Sam Houston, Texas. Professional support, to include outpatient consultation services, is provided by that facility.

The hospital was originally constructed in 1941 for the purpose of providing health care to troops in training for action in World War II and for those troops medically evacuated from overseas combat areas. The physical structure consists of over 70 wooden, one-story temporary buildings built in the cantonement style, and housing over 300,000 square feet. The buildings are connected by over 4 miles of enclosed ramps. The hospital contains 232 operating inpatient beds. A new, modern 169-bed hospital is presently under construction and has an anticipated occupancy date of October, 1982.

The mission of the U S Army Hospital, Fort Polk, is to provide both inpatient and outpatient medical services to all authorized beneficiaries in the catchment area. As of this writing, the categories of beneficiaries are as follows: active duty members of the uniformed services, 13,000; dependents of active duty members, 20,200; retired members of the uniformed services, 4,000; dependents of retired and deceased service members, 6,000.

The extent of services and capabilities available fluctuates according to the availability of physicians, specialists and other staff members. The medical staff mix provides a good cross-section of physician specialties; there are, however, serious physician shortages in some specialties at USAH Fort Polk, as there are in the military services at large. The specialty mix is an essential factor bearing on the development of the problem at hand, and may be seen at Appendix C, USAH Fort Polk Medical Staff Specialty Mix, October thru December 1978.

A Review of the Literature

Having established that the medical care setting provides some unique opportunities for disagreement escalating into open conflict among the medical staff, a survey of the literature reveals a veritable gamut of methods recommended to deal with such situations. Schulz and Detmer [2] point out that the traditional labor-management relationships found in hospitals is typically characterized by conflict and an adversary relationship, rather than by teamwork; this is attributed in large part to the cosmopolitan orientation of physicians, which is largely external to the hospital, and directed toward professional specialties and individual patients, as opposed to the local orientation of administrators toward the hospital. Schulz and Detmer posit a team approach as the only solution to problem solving and conflict resolution.

The American Hospital Association, addressing this same problem, takes on a more moderate, middle-of-the road approach by cautioning that every member of the administration, to include physicians, should recognize that his leadership must be directed toward providing the health care services needed by the community that the institution serves.[3] Martin and Mittelstaedt likewise adopt a

moderate viewpoint when they recognize that physicians, as highly trained professionals, do not take well to an autocratic environment. They view the health care manager as typically a mediator, facilitator and negotiator, all in the interest of enhancing the motivation of physicians.[4]

At the other end of the spectrum, Hume posits the belief that there can be no power vacuum within a hospital organization whose objectives are better patient care, and advocates the need for more tough-minded, task-oriented hospital administrators who will maintain the mission of the organization.[5]

Because the ultimate reason for being of the Army hospital is the provision of high-quality medical care in all areas of responsibility, it is reasonable to inquire whether the organizational environment influences physicians in the performance of their non-duty hour functions. Rhee, in a study of 454 physicians in 18 different specialties, found that external characteristics such as type of hospital and type of ambulatory care setting, tend to exercise more influence on the quality of care than do physicians' internal characteristics, such as former medical training. Further, the positive influence of a highly organized setting enhan-

ces the level of performance of younger, less-trained physicians,[6] which comprise the bulk of the USAH Fort Polk medical staff. The indication here is that the hospital administration, by instituting an equitable, well-organized system of allocating non-duty hour tasks, may conceivably not only maximize the absolute level of physician performance, but also minimize relative variations in physician performance of these duties.

But the administration, in order to capitalize upon and exploit the positive aspect of the organized setting, must walk a thin line. Stray too far to one side, and the atmosphere may take on what may be regarded as oppressive, authoritarian overtones; stray too far the other way, and an overly-relaxed atmosphere may provide an environment conducive to slacking off in the area of professional duties.

Where the former perception prevails, what is regarded as an authoritarian atmosphere may create a conflict situation which sets the stage for a collective effort akin to unionization. The unionization of physicians is a phenomenon which is likely familiar to Army physicians at Fort Polk; a bulletin published by the Louisiana Hospital Association [7] cautions administrators

that physicians on the staffs of Louisiana hospitals are currently being encouraged to unionize. As may be seen from Appendix B, a high percentage of the Fort Polk hospital medical staff engage in off-duty employment at civilian hospitals in the region. Although the Defense Manpower Commission in 1975 recommended that officers, as an essential part of command and management be prohibited from joining military unions, [8] the tendency to seek collective action must be reckoned with. An example from the civilian sector will illustrate this factor: in 1976, interns and residents at three hospitals in metropolitan New York conducted a short-lived strike for the recognition of their union. Interviews with the physicians indicated two major issues evolving from their self-images as professionals, stating that they wanted to end the paternalism which hospital administrators used in dealing with them, and they wanted more of a say on their working conditions.[9]

Krendel states that a recurring theme among professionals in the U S Armed Forces is the desire for some form of "fate control" and participation in the management system of which they are a part.[10] The implication here is that command perogatives may have to be re-evalua-

ted so that service aspects and personal aspects of military life are made more distinct. This is congruent with current philosophical thought which holds that the effective management of a hospital is the function of the administration and medical staff working together for a common goal.[11]

Conversely, where the opposite perception exists, namely that the administration is lax, the tendency to place personal goals above institutional goals may have to be reckoned with. The results of a survey of work attitudes and values from a sample of 2,522 Navy officers and enlisted personnel provides a telling example: in a rank ordering of fourteen characteristics of a job, the highest preference was given to "opportunity to control personal life;" among the least important characteristics was "opportunity to serve my country," which ranked tenth.[12]

Nelson notes that for most individuals, adaptation to the varied demands of military service represent a significant set of obstacles to be hurdled in the track-of-life experience.[13] Institutional parallels can certainly be drawn with school years, marriage and civilian employment, but the military organizational environment

is perhaps more restrictive in behavioral degrees of freedom tolerated within its institutional prescriptions of discipline and 24-hour readiness in the performance of duty. The entire experience of military life is characterized by a multitude of often stressful transitions with which the physician must struggle, and which demand frequent utilization of coping methods to adapt or adjust to new environments. During the socialization process, the physician must cope, for example, with certain pervasive changes which differentiate military from civilian life, such as changes in his basic constitutional and civil rights; a decrease in his ability to control his life; and the generalized demand for his effective and immediate adjustment to a variety of both extreme and mundane environments. It is of significance to note, at this juncture, that since the vast majority of physicians at USAH Fort Polk have reported to this assignment directly from civilian life, their socialization process into the Army has not given them the benefit of attending the AMEDD Basic Officer Orientation Course (C-21) as a rite of passage. While this does not constitute an indictment, there are several factors which, upon reflection, the absence of this common experience may be seen to indicate, such as some initial disparage-

ment of civilian status as illustrated by the requirement for unflattering haircuts; isolation from family, as dependents are not authorized to accompany C-21 students at Government expense; and the evaluation of much performance as accomplished at platoon and company level, rather than on an individual level. In toto, then, the physician arriving directly from civilian life is left more likely than not to devise his own acculturation into military life, with predictable results.

The motivation-hygiene theory of job attitudes, developed by Herzberg, would appear to offer insight into possible means of resolving the problem.[14] This theory holds that individuals have two sets of needs: the need to grow psychologically and the need to avoid pain. Satisfaction of the need to grow psychologically is related to job content; it is important to ask, therefore, whether physicians can find a sense of achievement, recognition, and opportunity for growth while performing non-normal duty hour duties in the Emergency Room. These factors are motivators or satisfiers. The need to avoid pain, however, relates to job context, and satisfaction of this need is affected by such factors as hospital policy, pay, working conditions, and quality of supervision. These factors are dissatisfiers, or hygiene factors.

Within the framework of this theory, several observations may be made. Even when hygiene factors are met, they still fail to provide long-term satisfaction because they do not relate to task or growth. When motivators are lacking, physicians would focus on working conditions even though this provides only short-term satisfaction. And when and if physicians are motivated, they would not be as likely to be dissatisfied with unmet hygiene factors. Job enrichment is indicated in the literature where the administration is willing to make a commitment to enhancing motivation.[15]

Problem-Solving Methodology

The objectives of the Non-Normal Duty Hour Physician Hospital Time project at USAH Fort Polk are as follows:

A. To obtain a composite profile of the daily professional activities of Army physicians assigned to USAH Fort Polk.

B. To increase inter-physician knowledge and understanding of the type, volume, and sometimes unique requirements of fellow physicians of various specialties.

C. To provide a data base upon which to have meaningful staff discussions concerning equitable allocation of extra duties.

D. To provide for transference of problem-solving medical staff dynamics.

Research Design

A participatory data collection method was devised which would capture the amount of time spent on all non-duty hour official business by each physician on the medical staff and subject to such duties. A local survey form, MEDDAC Fort Polk Form 129, Daily Report of Non-Normal Duty Hour Physician Hospital Time, Appendix D, was fabricated by the Administrative Resident and approved by the hospital Commander. These forms were dis-

tributed to the 25 physicians subject to non-normal duty hour duties; each form provided for documenting up to four separate episodes. The form provided for documenting on a daily basis each episode of non-normal duty hour duties upon which they spent time other than during the normal weekday duty hours of 0730-1600, but excluding Physician of the Day (POD), since these hours would be obtained by name from the POD roster. Extra duties would include but not be limited to, making early morning or late afternoon rounds, responding to emergency calls requiring their presence in the hospital, telephone consults, administrative work such as completing medical records or in the case of service/department chiefs, making policy, etc.

Because of the volume of responses anticipated, MEDDAC Forms 129 were reproduced on colored paper stock for ease of identification. To further guard against the vagaries of the distribution system, readily identifiable color-coded envelopes were utilized. The Administrative Resident received the completed forms on a daily basis and personally attended to their further processing. A Disposition Form, AFZX-MED-CO, dated 20 October 1978, Subject: Non-Duty Hours Workload Study, which

inaugurated the study and provided specific instructions for completion of the MEDDAC Forms 129, was distributed to each physician and may be seen at Appendix E.

In order to insure the credibility of the survey results, a peer review schema was formulated which provided for validation of each episode documented on the MEDDAC Form 129. A copy of the schema may be seen at Appendix F. Every effort was made to list chiefs of services/departments as reviewers who would have direct or indirect knowledge of the activities of the reporting physicians. Each reviewer would annotate whether the reason for the extraordinary time seemed appropriate and whether the total time spent on each episode appeared reasonable. After review, the MEDDAC Forms 129 were turned-in to the Administrative Resident for tabulation.

A 60-day sample test period was devised which would commence at 0001 hours, 21 October 1978, and terminate at 2400 hours, 19 December 1978. Sixty days was felt by the Commander to provide an adequate time period for obtaining a representative profile; additionally, because of the tedious nature of detailing and reviewing each individual episode, it was felt that extending the sample period any longer would yield diminishing returns in terms of cooperation by physicians. The sample period selected

had the advantage of avoiding the holiday scheduling period.

Local hospital records were utilized to obtain actual workload data of each medical specialty during the normal workday week in order to provide a complete profile of the daily activities of the physicians during the sample period.

FOOTNOTES

[1] Minutes of Professional Staff Conferences, U S Army Hospital, Fort Polk, Louisiana, 8 August & 12 September, 1978.

[2] Rockwell Schulz PhD and Don Detmer MD, "Physician/Hospital Teams: How to Get Them Going," Trustee 30, September 1977, p 38.

[3] American Hospital Association, Committee on Hospital Governing Boards. "On Involving Physicians in Hospital Governance." Trustee 31, April 1978, p 38.

[4] Samuel Martin MD, and Robert E Mittelstaedt Jr, "Management in the Health Field Part II: More Carrot, Less Stick," Health Services Manager, Volume 10 Number 12, December 1977, p 3.

[5] Edward C Hume Jr, "Organizational Dynamics Plays Important Role in Hospital Management," Cross-Reference Vol 7 September-October 1977, p3.

[6] Sang-O Rhee, "Relative Importance of Physicians' Personal and Situational Characteristics for the Quality of Patient Care," Journal of Health and Social Behavior 18, March 1977, p 15.

[7] Labor Bulletin furnished by Kullman, Lang, Inman & Bee, Labor Attorneys for the Louisiana Hospital Association, 19 March 1979.

[8] Ezra S Krendel, "The United States Armed Forces," Unionizing the Armed Forces, ed. Ezra S Krendel and Bernard L Samoff (University of Pennsylvania Press, Inc, 1977) p 166.

[9] David Bird, "Interns and Residents at 3 Hospitals Start Picketing to Gain Recognition," New York Times, October 6 1976, p 20.

[10] Krendel, p 171.

[11] Lewis E Weeks, "The Administrator, the Physician, the Trustee: the Triad in the Management of Today's Hospital," Inquiry XIV, December 1977, p 319.

[12] David G Bowers, "Work-Related Attitudes of Military Personnel," The Social Psychology of Military Service, ed. Nancy L Goldman and David R Segal (Beverly Hills: Sage Publications, 1976) p 93.

[13] Paul D Nelson, "Biographical Constructs as Predictors of Adjustment to Organizational Environments," The Social Psychology of Military Service, ed. Nancy L Goldman and David R Segal (Beverly Hills: Sage Publications, 1976) p 82.

[14] Frederick Herzberg, "The Motivation-Hygiene Concept and Problems of Manpower," Organization Development: Managing Change in the Public Sector, ed. Robert A Zawacki and D D Warrick (Chicago: International Personnel Management Association, 1976) p 179.

[15] Roy W Walters, "Job Enrichment Isn't Easy," Organization Development: Managing Change in the Public Sector," ed. Robert A Zawacki and D D Warrick (Chicago: International Personnel Management Association, 1976) p 182.

II. DISCUSSION

Data collection began on 21 October 1978, and reflected good cooperation from the medical staff. The flurries of survey sheets printed on pink paper stock were an unaccustomed sight as they circulated through the hospital, and the research project came to be humorously known as "the pink slip study" by the medical staff.

The total time frame of 60 days included 40 weekdays, and 20 weekend and/or holiday days over a sample period of 8.5 weeks. Incoming raw data on actual non-normal duty hour time spent by physicians in the accomplishment of official duties were reduced by the Administrative Resident to the following temporal categories: Weekday Evenings (1600-2400 hours); Weekday Nights (0001-0730 hours); and Weekend/Holiday Days. Both actual hours spent and the number of episodes reported in each of the above categories were tabulated.

A total of 736 non-POD episodes were reported; these episodes, in temporal categories, may be seen at Table 1. The highest frequency of evening episodes per physician occurred in Pediatric Service, with a total of 42 episodes reported by two physicians. OB-GYN, a 3-man

TABLE 1

TEMPORAL ANALYSIS OF
NON-POD
EPISODES REPORTED

Service	Total Non-POD Episodes Reported	EVENING		NIGHT		WEEKEND/ HOLIDAY*	
		Hours	# Non-POD Episodes	Hours	#Non-POD Episodes	Hours	#Non-POD Episodes
ENT	18	4.0	7	7.5	4	6.5	7
FAMILY PRACTICE	323	188.25	138	40.5	61	166.12	124
INTERNAL MEDICINE	43	12.75	7	1.0	3	57.0	33
OB-GYN	148	41.25	24	62.75	53	144.50	70
OPTHALMOLOGY	4	1.5	1	0	0	4.25	3
ORTHOPEDICS	16	18.5	7	4.0	2	9.5	7
PATHOLOGY	5	3.5	2	0	0	12.5	3
PEDIATRICS	73	113.5	42	29.5	5	84.5	26
PSYCHIATRY	6	2.5	3	0	0	8.25	3
GENERAL SURGERY	77	63.25	26	8.75	5	100.25	46
UROLOGY	23	12.50	10	0	0	17.00	13

* Holidays counted: 10 Nov, 23 Nov 78

service, claims the highest frequency of both night and weekend/holiday episodes. Further analysis of non-POD episodes is provided at Table 2, Temporal Analysis of Non-POD Duties by Category. Only one service, Family Practice, claimed administrative time. The highest frequency of telephone consults was reported by the 3-man OB-GYN Service. The two pediatricians devoted more non-normal duty time to ward rounds than did any other service. Likewise, emergency requirements took up more of their time than that of any other service. The least amount of non-POD time was spent by the opthalmologist.

When average non-POD hours per week spent by each physician are considered, it may be seen at Table 3, that the pediatricians with 13.38 hours per week, once again take first place, with each obstetrician, averaging 9.75 hours per week, taking second place. The opthalmologist, with less than 1 hour per week, spends the least amount of time.

Physician of the Day (POD) duties as experienced during the 60-day sample period, are detailed at Table 4. Although previously exempted from POD duties, the hospital Commander directed that the two orthopedic surg-

TABLE 2

TEMPORAL ANALYSIS OF
NON-POD DUTIES BY CATEGORY

	Administration	Telephone Consults	Ward Rounds	Emergency Calls	Total
	(Hours)	(Hours)	(Hours)	(Hours)	(Hours)
ENT	0	.50	12.50	9.00	22.00
FAMILY PRACTICE	18.75	22.00	146.0	208.12	394.87
INTERNAL MEDICINE	0	3.75	44.25	22.75	70.75
OB-GYN	0	9.25	83.25	156.00	248.50
OPHTHALMOLOGY	0	0	4.25	1.50	5.75
ORTHOPEDICS	0	.50	6.00	25.50	32.00
PATHOLOGY	0	0	0	16.00	16.00
PEDIATRICS	0	0	69.50	158.00	227.50
PSYCHIATRY	0	1.50	1.00	8.25	10.75
GENERAL SURGERY	0	.75	58.50	113.50	172.75
UROLOGY	0	.50	16.50	8.0	25.00

TABLE 3

NON-POD HOURS
PER PHYSICIAN PER WEEK

	Total Non-POD Hours Per Service	Number of Operator	Average Non-POD Hours Per Physician	Average Non-POD Hours Per Physician Per Week
ENT	22.00	1	22.00	2.58
FAMILY PRACTICE	394.87	12	32.92	3.87
INTERNAL MEDICINE	70.75	2	35.38	4.16
OB-GYN	248.50	3	82.83	9.75
OPHTHALMOLOGY	5.75	1	5.75	.676
ORTHOPEDICS	32.00	2	16.00	1.88
PATHOLOGY	16.00	1	16.00	1.88
PEDIATRICS	227.50	2	113.75	13.38
PSYCHIATRY	10.75	1	10.75	1.26
GENERAL SURGERY	172.75	3	57.42	6.76
UROLOGY	29.50	1	29.50	3.47

eons be placed on the duty roster just prior to the commencement of this project. The OB-GYN staff and the pathologist were the only physicians exempted from duty. Although the averages range from a low of 3.30 hours per week to a high of 6.59 hours per week, a mean of 4.83 hours is as representative an estimate as is possible, since leave and TDY absences affect the statistics more drastically in a 60-day study than they would in an extended period. In Table 5, the average non-normal duty hour duties engaged in by each physician are computed by summing both average weekly POD and non-POD hours. What results is a composite picture of how much time over and above the normal workweek, each physician typically devotes to official duties. Pediatricians unquestionably devote the most time to non-normal duty hour duties, with an average of nearly 19 hours per week; general surgeons devote nearly 11 hours per week. The pathologist, exempt from POD, spends the least amount of time with under 2 hours per week.

In order to study the activity of the medical staff it is also necessary to inquire as to what constitutes an average normal-duty workweek. In Table 6 this is accomplished, using the total 8.5 week sample period. From

TABLE 4

PHYSICIAN OF THE DAY
(POD) DUTIES

	PER SERVICE					
	# Instances					
	Weekday	Weekend/ Holiday	Actual POD Hours	Avg Wkly Hours Per Service	Number of Operators	Avg Wkly Hours Per Physician
ENT	2	1	56	6.59	1	6.59
FAMILY PRACTICE	19	7	472	55.53	12	4.63
INTERNAL MEDICINE	3	1	76	8.94	2	4.47
OB-GYN	N/A	N/A	N/A	N/A	3	N/A
OPHTHALMOLOGY	2	1	56	6.59	1	6.59
ORTHOPEDICS	2	1	56	6.59	2	3.30
PATHOLOGY	N/A	N/A	N/A	N/A	1	N/A
PEDIATRICS	2	2	92	10.82	2	5.41
PSYCHIATRY	1	1	40	4.71	1	4.71
GENERAL SURGERY	5	1	104	12.24	3	4.08
UROLOGY	2	0	32	3.76	1	3.76

the normal 40-hour workweek is deducted the 4 hours per week which the Commander has extended to all military physicians on the staff in compensation for the unsettled schedules they are required to keep; also deducted are TDY and leave time, which represent a loss of productive time to the service/department. Compensatory time is also routinely granted after each episode of POD on the following basis: 4 hours for weekday POD, and 8 hours for weekend/holiday POD. After the deduction of these nonproductive time factors, the average normal workweek is revealed. The normal duty workweeks of various specialists on the medical staff range from a low of 29.18 hours in Internal Medicine to a high of 36 hours for the pathologist. The psychiatrist, with the next highest ranking, like the pathologist did not use any TDY or leave time during the sample period.

Using the average normal duty workweek for each service/department as detailed above, and adding to it the average non-normal duty hours per week contributed by the various specialties(Table 5), there emerges an interesting profile. Four of the eleven services/departments worked less-than 40-hour workweeks, even when non-normal duty hour duties were included. The remain-

TABLE 5

AVERAGE NON-NORMAL DUTY HOUR DUTIES
PER PHYSICIAN PER WEEK

	Wkly Avg POD Hours Per Physician	Wkly Avg Non-POD Hours Per Physician	Avg Total Non-Normal Duty Hour Duties Per Week
ENT	6.59	2.58	9.16 hr
FAMILY PRACTICE	4.63	3.87	8.50 hr
INTERNAL MEDICINE	4.47	4.16	8.63 hr
OB-GYN	N/A	9.75	9.75 hr
OPHTHALMOLOGY	6.59	.68	7.27
ORTHOPEDICS	3.30	1.88	5.18
PATHOLOGY	N/A	1.88	1.88
PEDIATRICS	5.41	13.38	18.79
PSYCHIATRY	4.71	1.26	5.96
GENERAL SURGERY	4.08	6.76	10.84
UROLOGY	3.76	3.47	7.23

TABLE 6

AVERAGE NORMAL-DUTY WORKWEEK
PER PHYSICIAN
(21 October-19 December 1978)

	Number of Operators	Basic Workweek Hours (8.5 wks)	Universal Comp Time Hours* (-)	TDY & Leave** (Hours) (-)	POD Comp Time (Hours) (-)	Total Productive Hours =	Avg Normal Duty Workweek (8.5wks)
ENT	1	340	34	0	16	290	34.12hrs
FAMILY PRACTICE	12	4080	408	176	140	3356	32.90hrs
INTERNAL MEDICINE	2	680	68	96	20	491	29.18hrs
OB-GYN	3	1020	102	40	N/A	878	34.43hrs
OPHTHALMOLOGY	1	340	34	0	16	290	34.12hrs
ORTHOPEDICS	2	680	68	24	12	576	33.38hrs
PATHOLOGY	1	340	34	0	N/A	306	36.00hrs
PEDIATRICS	2	680	68	72	24	516	30.35hrs
PSYCHIATRY	1	340	34	0	12	294	34.59hrs
GENERAL SURGERY	3	1020	102	96	24	798	31.29hrs
UROLOGY	1	340	34	24	8	274	32.23hrs

* Based upon 4 hours per physician per week
** Converted to Hours

ing services/departments log in no more than 4.18 extra hours with the notable exception of Pediatrics Service, which is unqualifiedly the highest with 49.14 hours per week(Table 7).

An interesting reference point to relate to normal workweek is the number of clinic visits accomplished by the physicians during the sample period. The number of clinic visits was chosen as an indicator of workload which, while it does not reflect the number of live births, number of surgeries and other procedures, does yield a measurement of productivity which all services/ departments have in common. The daily average ranges from a low of 4 patients in Psychiatry, where the visit is necessarily longer, to a high of 17 patients per day in Ophthalmology. Five of the eleven specialties, it will be noted, see less than ten patients per physician per day (Table 8).

TABLE 7

DERIVATION OF
TOTAL WORK WEEK
PER PHYSICIAN
(21 October - 19 December 1978)

Service	Average Normal Duty-hour Work Week	Add: Avg Tot Non-Normal Duty Hour Duties per Week	Total Work Week Per Physician
ENT	34.12 hr	9.16 hr	43.28 hr
FAMILY PRACTICE	32.90 hr	8.50 hr	41.40 hr
INTERNAL MED	29.18 hr	8.63 hr	37.81 hr
OB-GYN	34.43 hr	9.75 hr	44.18 hr
OPHTHALMOLOGY	34.12 hr	7.27 hr	41.39 hr
ORTHOPEDICS	33.88 hr	5.18 hr	39.05 hr
PATHOLOGY	36.00 hr	1.88 hr	37.88 hr
PEDIATRICS	30.35 hr	18.79 hr	49.14 hr
PSYCHIATRY	34.59 hr	5.96 hr	40.55 hr
GEN SURGERY	31.29 hr	10.84 hr	42.13 hr
UROLOGY	32.23 hr	4.70 hr	36.93 hr

TABLE 8

NUMBER OF CLINIC VISITS*
DURING SAMPLE PERIOD 21 OCTOBER - 19 DECEMBER 1978

	PER SERVICE						PER PHYSICIAN		
Service	21 - 31 October	1 - 30 November	1 - 19 December	Total For 60-Day Period	Daily Average (- 40)	Weekly Average (-8.5)	Number of Operators	Daily Average	Weekly Average
ENT	43	292	218	553	13.8	65.0	1	13.8	65.0
FAMILY PRACTICE	559	1845	1029	3433	85.8	403.9	12	7.2	33.7
INTERNAL MED	56	120	332	508	12.7	59.8	2	6.4	29.9
OB-GYN	411	351	676	1438	35.9	169.2	3	12.0	56.4
OPHTHALMOLOGY	88	403	190	681	17.0	80.1	1	17.0	80.1
ORTHOPEDICS	186	704	370	1260	31.5	148.2	2	15.8	74.1
PATHOLOGY	N/A	N/A	N/A	N/A	N/A	N/A	1	N/A	N/A
PEDIATRICS	127	480	665	1272	31.8	149.7	2	15.9	74.9
PSYCHIATRY	24	84	52	160	4.0	18.8	1	4.0	18.8
GEN SURGERY	89	346	219	654	16.3	77.0	3	5.4	25.7
UROLOGY	20	178	129	327	8.2	38.5	1	8.2	38.5

*Excludes visits seen by ancillary personnel

III. CONCLUSION

Conclusions

The following conclusions are noted:

1. That there exists within the US Army Hospital Fort Polk an individual-organizational goal conflict between the medical staff and the administration which is dysfunctional for both. Defensive adaptive behaviors on the part of the medical staff are evident in dissident reactions and a lack of interest in increasing performance factors such as MCCUs. Although it cannot be determined at this writing whether or not certain segments of the medical staff are restricting their output, certain facts clearly emerge: the medical staff is for the most part not committed to Army medicine as a career, as may be seen at Appendix G; certainly physicians are capable of seeing more outpatient clinic visits than are reflected in Table 8; with an average workweek (including all non-normal duty hour duties) of 41.25 hours and a 53% moonlighting rate, it appears that the medical staff, with certain exceptions, is not overworked by any means, and there is no merit to exempting specialties from POD on the basis of heavy patient load. The extent to which the hospital succeeds at its mission of delivering quality

health care to authorized beneficiaries clearly depends in large part on physician productivity and the satisfaction which they derive from their association with the hospital. Thus the importance of isolating problem-causing factors and dealing with them cannot be underestimated.

2. That the non-normal duty time physician hospital duty assignment system is in need of revision.

Problem-Solving Options

1. That Physician of the Day assignments be revised immediately, as follows:

a. Include all physicians on POD with no specialty receiving exemption.

b. Reward the Pediatric Service physicians by excusing them from weekend/holiday duty, but retaining them on weekday rosters.

2. That the administration utilize management techniques which would provide for participation by the medical staff and increase motivation and job satisfaction before dysfunctional behaviors as are currently being experienced become firmly entrenched in emergent work norms.

3. That a study of physician productivity and potential be conducted.

APPENDIX A

INCIDENCE OF POD
ASSIGNED AGAINST
TOTAL ELIGIBLE
MEDICAL STAFF
(25 Physicians)

INCIDENCE OF POD
ASSIGNED AGAINST
TOTAL ELIGIBLE
MEDICAL STAFF
(25 Physicians)

ENT	1 Physician	.04%
Family Practice	12 Physicians	.48%
Internal Medicine	2 Physicians	.08%
OB-GYN	3 Physicians	N/A
Ophthalmology	1 Physician	.04%
Orthopedics	2 Physicians	.08%
Pathology	1 Physician	N/A
Pediatrics	2 Physicians	.08%
Psychiatry	1 Physician	.04%
General Surgery	3 Physicians	.12%
Urology	1 Physician	.04%
	25 Physicians	1.00%

APPENDIX B

USAH FORT POLK PHYSICIANS ENGAGING IN OFF-DUTY EMPLOYMENT

USAH Fort Polk Physicians Engaging in Off-Duty Employment

Service	Physicians assigned	Employed in Civilian Hospitals	Percent of Service Employed
ENT	1	1	100%
Family Practice	12	4	33%
Internal Medicine	2	1	50%
OB-GYN	3	1	33%
Opthalmology	1	1	100%
Orthopedics	2	2	100%
Pathology	1	0	0
Pediatrics	2	0	0
Psychology	1	1	100%
General Surgery	3	3	100%
Urology	1	1	100%
Totals	28	15 (53%)	

APPENDIX C

USAH FORT POLK
MEDICAL STAFF SPECIALTY MIX
OCTOBER THRU DECEMBER 1978

USAH FORT POLK
MEDICAL STAFF SPECIALTY MIX
October thru December 1978

SSI	TITLE	REQUIRED	AUTHORIZED	ASSIGNED
60 A	Executive Medicine Ofcr	2	2	2
60 E	General Medicine Ofcr	6	2	1
60 F	Pulmonary Disease Med	1	1	0
60 G	Gastroenterologist	1	1	0
60 H	Cardiologist	1	1	0
60 J	OB-GYN	5	4	3
60 K	Urologist	1	1	1
60 L	Dermatologist	1	1	0
60 N	Anesthesiologist	1	1	0
60 P	Pediatrician	4	4	2
60 S	Opthalmologist	1	1	1
60 T	Otorhinolaryngologist	1	1	1
60 V	Neurologist	1	1	0
60 W	Psychiatrist	2	2	1
61 F	Internist	1	1	2
61 H	Family Physician	12	12	12
61 J	General Surgeon	4	3	3
61 M	Orthopedic Surgeon	3	4	2
61 S	Radiologist	2	2	0*
61 U	Pathologist	2	2	1
		53	41	32

*Civilian Radiologist under contract

APPENDIX D

MEDDAC FORM 129
DAILY REPORT OF NON-NORMAL DUTY HOUR
PHYSICIAN HOSPITAL TIME

APPENDIX E

INSTRUCTION SHEET TO PHYSICIANS

DISPOSITION FORM

For use of this form, see AR 340-15, the proponent agency is TAGCEN.

REFERENCE OR OFFICE SYMBOL	SUBJECT
AFZX-MED-CO	Non-Duty Hours Workload Study

TO ALL PHYSICIANS FROM CDR, MEDDAC DATE 20 Oct 78 CMT 1

CPT Langone/so/2272

1. General.

a. A two-month sample of non-duty hour time in the hospital for all physicians in various specialties will be done. This study is expected to be useful in a number of ways.

(1) Through multidisciplinary review it will increase inter-physician knowledge and understanding of the type, volume and sometimes unique requirements of fellow physicians.

(2) It will provide a data base upon which to have meaningful staff discussions concerning equitable allocations of certain extra duties.

(3) It could result in some problem solving professional staff dynamics that, either negative or positive, may be of significance to the Army Medical Department.

b. In any study the data must be validatible or the study results can never be considered valid for any purpose. Accordingly, your attention to details required on the data collection sheet is necessary to insure credibility of any study results.

2. Specific Instructions.

a. Each physician will fill out a data collection sheet (or sheets) any time he/she must come to the hospital during non-duty hours. This includes rounds before 0730 or after 1600 hours, and on weekends; individual patient care situations, etc.

b. POD duty need not be reported since these hours will be obtained by name off the roster.

c. Telephonic consultations from home should be reported on data collection sheets and identified as such.

d. Sheet Collection Procedure:

(1) The form which has been devised to record your extraordinary time requirements is MEDDAC Form 129, Daily Report of Non-Normal Duty Hour Physician Hospital Time. You will be supplied with these forms as required. Use as many sheets per day as needed.

(2) These forms are to be turned in daily to CPT Langone, Administrative Resident, Headquarters MEDDAC, who will coordinate the peer review process.

AFZX-MED-CO 24 October 1978
SUBJECT: Non-Duty Hours Workload Study

(3) Attached is a copy of the reviewing schema. Each reviewer will annotate whether the reason for the extraordinary time seems appropriate, and whether the total time spent on each episode seems reasonable. The forms are once again to be turned in to the Administrative Resident, who will tabulate and maintain the data. You will be provided with periodic updates.

for Willard B. Winnett Col MC
WILLIAM G. PEARD, MD
Colonel, MC
Commanidng

2 Incl
as

APPENDIX F

REVIEWING SCHEMA

APPENDIX G

TIME REMAINING IN SERVICE, MEDICAL CORPS OFFICERS ASSIGNED

TIME REMAINING IN SERVICE, MEDICAL CORPS OFFICERS ASSIGNED

Physician Specialty	ESTIMATED TERMINATION OF SERVICE					
	1979	1980	1981	1982	Indef	Total
Executive Medicine					2	2
ENT(Otolaryngology)		1				1
Family Practice	3	5			4	12
General Medicine				1		1
Internal Medicine	2					2
OB-GYN	1				2	3
Ophthalmology	1					1
Orthopedics	2					2
Pathology				1		1
Pediatrics		2				2
Psychiatry		1				1
General Surgery	1	1			1	3
Urology		1				1
	9	11	0	2	9	32

BIBLIOGRAPHY

Books

Argyle, Michael. The Social Psychology of Work. New York: Taplinger Publishing Company, 1972.

Basil, Douglas C and Curtis W Cook. The Management of Change. London: McGraw-Hill Book Company (UK) Limited, 1974.

Donabedian, Avedis, MD, MPH. Aspects of Medical Care Administration. Cambridge: Harvard University Press, 1973.

Drucker, Peter F. Management: Tasks, Responsibilities, and Procedures. New York: Harper & Row, Publishers, 1974.

Goldman, Nancy L, and David R Segal, ed. The Social Psychology of Military Service. Beverly Hills: Sage Publications, 1976.

Krendel, Ezra S, and Bernard L Samoff, ed. Unionizing the Armed Forces. University of Pennsylvania Press, Inc, 1977.

Skibbins, Gerald J. Organizational Evolution: A Program For Managing Radical Change. New York: AMACOM, A Division of American Management Associations, 1974.

Somers, Anne R. Health Care In Transition: Directions For The Future. Chicago: Hospital Research and Educational Trust, 1971.

Zawacki, Robert A and D D Warrick, ed. Organization Development: Managing Change in the Public Sector. Chicago: International Personnel Management Association, 1976.

Periodicals

American Hospital Association, Committee on Hospital Governing Boards. "On Involving Physicians in Hospital Governance." Trustee 31, April 1978, 38-40.

Bird, David. "Interns and Residents at 3 Hospitals Start Picketing to Gain Recognition." New York Times, October 6, 1976.

Hume, Edward C. "Organizational Dynamics Plays Important Role in Hospital Management." Cross-Reference Vol 7, September-October 1977, 1-4.

Martin, Samuel, and Robert E Mittelstaedt Jr. "Management in the Health Field Part II: More Carrot, Less Stick." Health Services Manager, Volume 10 Number 12, December 1977, 1-4.

Rhee, Sang-O. "Relative Importance of Physicians' Personal and Situational Characteristics for the Quality of Patient Care." Journal of Health and Social Behavior 18, March 1977, 10-15.

Schulz, Rockwell, PhD, and Don Detmer, MD. "Physician/Hospital Teams: How to Get Them Going." Trustee 30, September 1977, 38-41.

Weeks, Lewis E. "The Administrator, The Physician, The Trustee: The Triad in the Management of Today's Hospital." Inquiry XIV, December 1977, 319-320.

Public Document

U.S. Department of the Army. Manpower Procedures Handbook. Department of the Army Pamphlet 570-4. Washington, DC: Government Printing Office, March 1970.

END

11-87

DTIC