STUDY PROJECT

PERCEPTIONS OF ARMY HEALTH CARE: A BLUEPRINT FOR THE FUTURE

BY

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cases are used to illustrate how the use of public affairs techniques can have a positive or negative impact on the perception of the military public. The purpose of this study is to recommend a number of innovative and conventional public affairs techniques to correct the negative perceptions of the Army health care program.

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PERCEPTIONS OF ARMY HEALTH CARE: A BLUEPRINT FOR THE FUTURE

AN INDIVIDUAL STUDY PROJECT

by

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ABSTRACT

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Army health care is considered a major factor in maintaining troop morale. Army leaders, soldiers and their family members have been given the opportunity to scrutinize the Army health care program mainly through investigative media reporting. The media has had a dynamic effect on the perception of quality of care provided by Army medicine. This study takes a look at how current perceptions concerning quality of care may have been formed. Two cases are used to illustrate how the use of public affairs techniques can have a positive or negative impact on the perception of the military public. The purpose of this study is to recommend a number of innovative and conventional public affairs techniques to correct the negative perceptions of the Army health care program. Keywords: health care; medical services; military medicine; (AF)

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CHAPTER I

INTRODUCTION

The Army Medical Department has undergone a complete review over the past 10 years. Army leaders, soldiers and their families have witnessed an increasing crescendo of negative publicity about the Army health care program. The "Problem Doctors" series written by the Army Times during the early 1980s and an independent Reader's Digest investigation titled "The Mess in Military Medicine" are just two examples.[1,2] The media clearly played an important role in focusing our attention on the Army health care system. Has this intense dissection of the Army Medical Department brought about a positive improvement in the Army health care program? LTG Frank F. Ledford, The Army Surgeon General, would answer with a strong "yes."[3] Are current perceptions of the Army health care program by Army leaders, soldiers and family members a positive one? This question is not as easy to answer. Perceptions vary. Some perceptions of the Army health care program are positive, but many are negative.

This paper will take a look at the Army Medical Department since 1980 and examine how current perceptions concerning quality of care may have been formed. Interviews, articles and case studies will be used as references. I have picked two cases that focus on untoward incidents since 1980. These two cases were chosen to illustrate how the use of public affairs techniques and interactions with the media can have either a positive or negative effect on the perception of the military public. After

establishing how current perceptions might have been acquired, I will recommend a number of innovative and conventional public affairs techniques to correct the negative perceptions of the Army health care program. One key point is that the Army's health care program is probably the best in the world. Unless the Army Medical Department can envision a "system" to tell its story, no one will ever know and the misperceptions will continue.

BACKGROUND

The science of medicine is an evolving discipline. Army physicians and other health care providers spend a lifetime training and continuing their medical education to provide the best care available. Technology and rapid advances in research make today's health care provider a "full time" student. For example, who would have thought in 1980 that today we would have a major health care problem like AIDs?

The Army stresses continuing medical education, and all health care providers are required to maintain an up-to-date working knowledge of new advances in health care. The quality of service military medicine provides far exceeds that of civilian medicine. Dr. William E. Mayer, Assistant Secretary of Defense for Health Affairs, said "We're (military medicine) ahead of the private sector" after studying an independent peer review of military medicine by civilian doctors.[4] The military public should be made aware of this report and other recent reports.

No one would deny the important role of the media in all aspects of our lives. Americans thrive on the sensationalism of the media. The Army Medical Department must give Army leaders, soldiers and family members a true perspective of the Army health care program as it is today. The Public Affairs Offices located at The Office of the Surgeon General, at local military posts, and at Army hospitals are a poorly used resource in projecting the Army health care program's blueprint for the future.

If we go back to the early 1970s, records indicate that the Army Medical Department had approximately 10,000 physicians on active duty. The draft was still an option to obtain medical professionals. However, the draft ended, and during the latter part of the 1970s the number fell to approximately 4,000 physicians on active duty.[5] The stage was set; the Army had to begin an expanded recruiting program.

The Army Medical Department began receiving applications from physicians who were in private practice in the civilian sector, and applications were also received from foreign medical graduates (US citizens who attended foreign medical schools). A number of these physicians were accepted on active duty without an adequate background check of their qualifications. The current system of quality assurance and credentials verification, referred to later, was not in effect during that recruitment period. Hence, the Army Medical Department picked up a few "bad apples."

The Media

The very essence of the negative publicity about the quality of the military health care program was rooted in the 1970s system of recruitment. The Army Medical Department paid the price in the early 1980s with headlines like "Army Accepts Psychiatrist with Revoked License," and "Man Found to be Bogus Doctor Allowed in Army."[6,7] These articles were all written by the Army Times. We all know the majority of Army Times' readers are Army leaders, soldiers and many family members.

It takes only one or two articles like the above to give an impression that the Army health care program may be out of control. The system of personnel acquisition was broken in the 1970s as stated earlier. Yet, no articles have been written since then indicating that procedures have been reviewed and necessary changes have been made to insure our current acquisition of health care providers are qualified and properly credentialed. Bad news seems to linger in the public's mind for a long time. The Army Medical Department will have to turn this image around, and the best way to do that is to discuss what changes have been made to "fix" the acquisition program. The appropriate initiatives have to be taken through the proper use of public affairs personnel. BG (Dr) Michael Scotti, Director of Professional Services and Chief of Medical Corps Officers, emphasized this during a recent interview. He said, "We don't toot our horn very much. When we do, we do it in our own trade magazines."[8] The Army Medical Department has to tell its story to the military public.

In addition to problems with personnel acquisition, the Army Medical Department had problems with policing their own ranks to insure proper medical care was given to patients by health care personnel. Two articles in the Army Times illustrated this point. One article, "Authorities Failed to Relieve Surgeon Accused of Drinking," revealed that Army medical authorities allowed a brain surgeon with a known drinking problem to continue his practice of surgery. This inaction on the part of medical authorities resulted in two deaths and two brain damaged patients.[9] Another article, "Poor Care Blamed in Boy's Death at Madigan," points out the poor judgment and inexperience of an unsupervised physician who improperly gave a dose of pain-killers and tranquilizers to Scott Johnson, a six year old. Scott died after receiving that injection.[10] He was initially brought to the emergency room for treatment of a cut on his lip. Both of these cases presented to military readers additional questions of quality care.

In the early 1980s there were many other articles that presented the same theme to the military public. At one time it appeared as though there was a media blitz to undermine the entire Army Medical Department. Television news reports, the Washington Post, and the New York Times were all adding to the overall perception that quality of care was lacking. So, Army leaders, soldiers and family members had plenty of evidence to conclude and establish in their minds that the Army health care program was riddled with problems.

The media coverage had a dynamic effect on the Army Medical Department. All of the department's "dirty laundry" was made available for public scrutiny. However, this was not an unjust attack on the military medical system. There were problems that needed solutions and without the media's attention perhaps the problems would still be unsolved. The point is the media events clearly helped the Army Medical Department to get on the "right track." Still, the perceptions of the Army leaders, soldiers and family members are derived from previous events. Since these perceptions were caused in large part by the media, the Army Medical Department should use the media to turn its public image around. In other words, if the media helped to foster negative perceptions in the past then use the media actively now to project positive perceptions. A strong, proactive public affairs program is needed to accomplish this task.

ENDNOTES

1. Neil Roland, "Problem Doctors," Army Times, 25 February 1985, p. 1.

2. Donald Robinson, "The Mess in Military Medicine," Reader's Digest, February 1985, p. 49.

3. Interview with Frank F. Ledford, LTG, Surgeon General of the Army, Washington, 3 February 1989.

4. P.J. Budahn, "Mayer: Study of Military Care Reveals 'Success Story'," Army Times, 2 November 1987, p. 3.

5. "From the Ferment, Profound Changes," Army, March 1986, p. 31.

6. Neil Roland, "Army Accepts Psychiatrist with Revoked License," Army Times, 18 March 1985, p. 8.

7. Neil Roland, "Man found to be Bogus Doctor Allowed in Army," Army Times, 25 March 1985, p. 4.

8. Interview with Michael Scotti, BG, Office of the Surgeon General of the Army, Washington, 13 October 1988.

9. Neil Roland, "Authorities failed to Relieve Surgeon Accused of Drinking," Army Times, 11 March 1985, p. 2.

10. Neil Roland, "Poor Care Blamed in Boy's Death at Madigan," Army Times, 20 May 1985, p. 4.

CHAPTER II

CASE 1: THE PEDIATRICIAN

To stress the point of the critical need for a proactive public affairs program, I will discuss two cases that show how interactions with Army medical authorities, Army public affairs offices, and media personnel had a definite impact on public perceptions of quality of care.

The first case involved an investigation of an Army pediatrician who was accused of sodomy and indecent acts with a minor child.

THE REPORTED INCIDENT

LTC (Dr) Arthur C. Andreasen was a pediatrician who specialized in adolescent medicine. He served at a US Army hospital during the early 1980s in the hospital's teen clinic. The reported incident occurred while Andreasen was performing an examination of a 14 year old male. The youth visited Andreasen's office complaining of a sore throat. During the course of the examination, Dr. Andreasen was alleged to have manually and orally manipulated the minor's genitals.[1]

The 14 year old commented that he was very confused during and after the episode and did not know what to do about Andreasen's actions. He did, however, tell his mother. The hospital commander was notified on the day of the incident. CID was also notified, and an investigation was initiated immediately.

Andreasen was interviewed the day of the alleged incident, and he made several suspicious comments according to the CID investigating agent. In a sworn statement one week later, however, he denied engaging in any form of sexual activity with the 14 year old.[2]

The details of this case are provided to give the reader a feel for the serious and potentially explosive nature of the allegations. The hospital commander was presented with information of a very sensitive nature, and he had to act immediately. The courses of action taken involved a CID investigation, SJA advice, post commander notification, and discussions with Health Services Command and the Office of the Surgeon General of the Army.

After all was said and done, Dr. Andreasen received a letter of reprimand from the hospital commander and post commander approximately three weeks after the incident. The letter reprimanded Andreasen for the conduct of a "...physical examination of this patient's genitalia, considered by this patient to be overtly sexual in conduct, apparently left [sic] him in a state of emotional distress. It was your professional duty as a physician, especially considering the patient's minor age, to evaluate and deal with his distress, whether real or perceived, by attending to your patient. Despite the opportunity to render professional assistance personally...you chose to allow the patient to depart without proper assistance."[3] Four weeks

after the incident Dr. Andreasen submitted a letter of unqualified resignation and received an honorable discharge. He was discharged seven weeks after the incident.

THE MISTAKE

From the time the hospital commander was notified of Dr. Andreasen's alleged sexual acts until his discharge from the Army, Andreasen was not decredentialed nor did he have his credentials restricted or limited. This means that he was still fully credentialed as a staff pediatrician at the Army hospital and as such was approved to provide a full range of clinical privileges.

Just three months after Andreasen's discharge, he was involved in another alleged sexual act with a 15 year old male patient while working in a civilian health care clinic. Andreasen was subsequently convicted of sexual abuse. During his trial proceedings Andreasen introduced evidence indicating he had sexually assaulted 23 teen-age male patients while on active duty at the Army hospital where he was previously assigned.

Records do not indicate the exact date when the media became interested in this case, but the hospital commander was questioned as to why he failed to initiate a peer review of Andreasen's clinical practice privileges by the hospital credentials committee. The immediate response was to stonewall and say nothing.

The following year the case was brought to the attention of the Department of Defense, Office of the Inspector General. Mr. Howard W. Cox, Deputy Assistant Inspector General for Criminal Investigations for Policy, expressed his concern for the apparent disturbing nature "of cases of criminal and other professional misconduct involving physicians."[4] Mr. Cox requested the hospital authorities to provide files on Andreasen's case and specifically requested "...credentials file, to include the minutes or any other documents generated as a result of the credentials committee's considerations as to whether [Dr. Andreasen] should be decredentialed."[5]

This request prompted the hospital authorities to finally reveal that they did not decredential Dr. Andreasen since the allegations against him were neither proven nor disproven. The fact is no formal credentials committee meeting was ever convened.[6] This indeed was a mistake on the part of the hospital commander. If a formal meeting had been held and if by chance Dr. Andreasen did have his privileges limited or if he were decredentialed then Department of Defense Directive 6000.7, Dissemination of Information on Medical Officers, and Office of the Surgeon General Regulation 635-1, Personnel Separations--Officer Personnel require that civilian authorities be notified.[7,8] Perhaps this action would have prevented the sexual assault that occurred three months after Dr. Andreasen was discharged from the Army.

This case, of course, continued in the press and three years later, the Washington Times printed an article entitled "Pediatrician pleads guilty to sex abuse" in which the first sentence reads "A former Army pediatrician yesterday pleaded guilty..."[9] Again, hospital authorities and the Office of the Surgeon General were attempting to avoid the media's attempts to present the facts. This was the wrong approach, and Ms. Tansill Johnson, former PAO at the Office of the Surgeon General, recalled that this particular case kept snowballing in the press because Army medical authorities were not making themselves accessible to the press. She stated, "If medial authorities were accessible, straight forward, and honest in the beginning, this case probably would have been a closed issue for the media a year or two earlier."[10] BG Scotti confirmed this view when he indicated that medical authorities should have admitted it the first day a mistake was made. He added, "We have to dispell the idea that talking to the press is bad. Telling the story kills the story."[11]

ENDNOTES

1. Quality Assurance Division, Personal Actions Branch, Office of the Surgeon General of the Army, Office Files - Andreasen.

2. Ibid.

3. Ibid.

4. Howard W. Cox, Office of the Inspector General, DOD, Letter to the hospital commander, 5 November 1984.

5. Ibid.

6. Quality Assurance Division, Office Files - Andreasen.

7. Department of Defense, DOD Directive 6000.7, p. 2.

8. U.S. Department of the Army, Office of the Surgeon General Regulation 635-1, p. 2.

9. Pam McClintock, "Pediatrician pleads guilty to sex abuse," Washington Times, 28 March 1986, p. B9.

10. Interview with Ms. Tansill Johnson, former PAO, Office of the Surgeon General of the Army, Washington, 28 September 1988.

11. Interview with Michael Scotti, BG, Office of the Surgeon General of the Army, Washington, 13 October 1988.

CHAPTER III

CASE 2: THE ANESTHESIOLOGIST

This case involves LTC (Dr) M. Carolyn Moore who was an Army anesthesiologist. She was assigned as Chief of Anesthesiology at a US Army hospital in the early 1980s. Her performance was described as excellent. Dr. Moore was responsible, and the quality of care she provided to her patients was outstanding.

THE THEFT

Approximately seven months after assuming her duties as Chief of Anesthesiology, another anesthesiologist on the hospital staff voiced his concern to the hospital deputy commander for clinical services (DCCS) that Dr. Moore checked out more Demerol (a narcotic) than her patients appeared to have received. The DCCS began monitoring Moore. A week later Dr. Moore appeared ill after completing two cases in the operating room. She was admitted to the hospital, and urine toxicology screens revealed a positive finding for Demerol. A CID investigation was initiated. When questioned, Dr. Moore freely admitted to the theft and use of Demerol because of the "pressures of her job."[1]

The DCCS convened a special meeting of the hospital credentials committee and Dr. Moore's credentials were immediately suspended.[2] Dr. Moore consented to seek inpatient rehabilitation therapy and was treated for six weeks. She was

discharged from the rehabilitation program with a recommendation to continue clinical medicine in an area where access to narcotics was not necessary for job performance.

UCMJ actions were also initiated against Dr. Moore, but she requested resignation under Chapter 5, AR 635-120. Her resignation was approved under other than honorable conditions eight months after the incident.

Prior to her discharge, however, she was given limited privileges to perform physical examinations. This was done in an attempt to give her "something to do" pending her discharge. No prescription privileges were granted. She was closely supervised during this time period and performed acceptably.

THE REEMPLOYMENT

Following her discharge from the Army, Dr. Moore requested employment in the physical examination section of the same hospital from which she was discharged. Appropriate consultations were made, and she was hired as a temporary GS-12 with the same limited privileges as prior to her discharge. As you can imagine, it did not take long for this information to reach the media. Neil Roland, former staff writer for the Army Times, broke the story in an issue of the Army Times titled, "Doctor hired after discharge for drug theft."[3] Needless to say, a headline like that did not go a long way in promoting the image of the Army Medical Department in the eyes of Army leaders, soldiers and family members. But, medical authorities and the PAO handled this case much differently from the previous case.

First, the commander was accessible to the media, according to Ms. Johnson. He worked closely with the PAO to provide timely responses in an attempt to try to "shape the story," stated Ms. Johnson.[4] Second, the hospital commander did all the right things--CID investigation, revoked credentials, rehabilitation therapy, and he provided supervision. Nothing was hidden, and he was honest and straight forward with the media. The hospital commander immediately gave his reasons for hiring Dr. Moore and stressed, "I was trying to strike a balance among the requirements of justice, the needs of the patients, and the rehabilitation of the doctor. The Army has a system set up to help the impaired physician, and someone has got to have faith in that system."[5] The same article also points out that "civilian doctors recovering from drug or alcohol abuse are permitted to practice in many states if they are closely supervised, [and] are barred from prescribing...These restrictions often are dropped once the doctor appears to have been rehabilitated.[6] As a result of the efforts of the hospital commander and the PAO this was no longer a "newsworthy" story. BG Scotti emphasized this when he said, "Remember a story is there only if there is a cover-up. The truth is only a one day story."[7] Over two years later, Dr. Moore was still working in the physical examination section and doing an outstanding job. She has continued to remain drug free.

These cases point out the consequences of what can happen if an untoward event is not dealt with properly. In the first case, the pediatrician, authorities made many errors. Interactions

with hospital authorities, the PAO, and the media were stymied. If authorities had admitted an error in judgment and had been up front with the facts perhaps that story too would have been declared not "newsworthy" much sooner.

ENDNOTES

1. Quality Assurance Division, Personal Actions Branch, Office of the Surgeon General of the Army, Office Files - Moore.

2. Ibid.

3. Neil Roland, "Doctor Hired After Discharge for Drug Theft," Army Times, 16 September 1985, p. 12.

4. Interview with Ms. Tansill Johnson, former PAO, Office of the Surgeon General of the Army, Washington, 28 September 1988.

5. Neil Roland, p. 12.

6. Ibid.

7. Interview with Michael Scotti, BG, Office of the Surgeon General of the Army, Washington, 13 October 1988.

CHAPTER IV

CONCLUSIONS

The Army Medical Department should be basking in considerable glory when we think of the many success stories and the advances of Army medical research. Our efforts in the research, counselling, and treatment of AIDs patients have been fantastic. The recent injuries at the Ramstein Air Show crash in Germany were triaged and treated by Army medical personnel. All health care personnel reported to the hospital immediately to help and even spouses of Army medical personnel showed up to help, where appropriate. However, these and many other successes are not publicized except in our own medical circles. The few success stories that are made public are overshadowed by headlines and cases such as those referred to in this paper. The perception of the Army health care program could certainly be improved.

This paper discussed the fundamental basis of how perceptions of Army medicine are acquired and suggests that the media is at the root of the perception process. Two cases were used to show how interactions with the media can have a dynamic effect on the public's perceptions of Army health care. Finally, I will offer recommendations to medical authorities for a proactive public affairs approach to foster positive perceptions.

CHAPTER V

RECOMMENDATIONS

So far in this paper, I have tried to present a small sample of how current perceptions of the Army health care program were acquired. The media played a major role. Medical authorities' interactions with the media in most instances were not professional. Many more examples are available.

Now with all of that behind us, the Army Medical Department needs a blueprint for the future. We need to develop innovative, proactive techniques to correct the misperceptions that Army leaders, soldiers and family members currently have about Army health care. The communication barriers among Army leaders, medical authorities, and the PAO must be replaced with open channels. We have to tell our success stories and how good we really are at providing quality care or no one will ever know. If we do not put forth the effort to tell our story then the misperceptions will continue.

What can we do? To begin this process we need a proactive Army public affairs effort. As stated earlier the media is one of the main sources of the current perceptions, and I believe the media can help clear up the misperceptions and tell the Army Medical Department's success story. The commander is the most important component of the process, and he must allow a proactive public affairs effort. LTG (ret) Quinn H. Becker, former Army

Surgeon General, made this emphatically clear in his letter to the Army Chief of Public Affairs when he expressed his concern for a permanent PAO position at the Office of the Surgeon General to galvanize the entire public affairs efforts down to the local post level. LTG Becker wrote "...the requirement for aggressively marketing the positive aspects of the Army's health care system has not changed. The most significant contribution that an 'in-house' public affairs officer provides to our staff is the ability to be proactive on controversial issues rather than simply reactive to inquiries from the media, the Congress, or other representatives of the beneficiaries of military health care."[1] This proactive PAO is not only important at the Surgeon General's level, but a significant contribution can be made at the local post level.

All of the CONUS Army Medical Centers (eight in total) have civilian PAOs except William Beaumont Medical Center, where an active duty Army officer is assigned as the PAO. None of the other 30 medical hospitals in CONUS are authorized a public affairs specialist. These medical hospitals depend on assigned individuals to handle public affairs as an additional duty.[2] Hospital and clinic commanders have to accept the fact that they must train their own PAO.

First, we must stop giving PAO responsibilities to inexperienced personnel. We can not continue to do this and expect our good deeds to be known. A selectee should be someone who can express himself orally as well as write effectively. When possible, this individual should be given the opportunity to

attend seminars or courses in public affairs techniques. The bottom line is we have to put the right personality in this important job. This is the first step in our blueprint for the future.

Second, hospital commanders need to elevate the position of PAO to the hospital executive committee. Current executive committee members are the commander, the deputy commander for clinical services, the executive officer, the chief of nursing, and the hospital command sergeant major.[3]

Third, the hospital PAO should be charged with developing a tactical plan for his or her local post. The plan should include ideas to foster better communications between medical authorities, post commanders, media, and the local community. In developing this plan, the PAO should seek general guidance from the hospital commander.

The plan should focus on some of the hospital's unfavorable past events to identify topics or issues that need special attention. This approach will give the PAO ideas as to possible misperceptions that could be an area of interest as the plan is developed. The local hospital PAOs tactical plan must be coordinated through the PAO at the Office of the Surgeon General to insure the Army Medical Department's strategic concerns are executed.

Additionally, the tactical plan should include arrangements for frequent meetings between the hospital commander, the hospital PAO, the local PAO, the local post commander, and community authorities. These meetings should have a planned

agenda to discuss local medical issues as well as a focus on long term proposals to promote health care initiatives. LTG Ledford believes that it is time to break down the communication barriers. He said "we have to teach the post commanders that the hospital is very important to his image as the local commander," and added "as a point of fact, the hospital is more important than any other type of post services. We need to get post commanders to visit our hospitals frequently and not just once a year for his or her physical examination. The once a year visit has to change. Let's plan for better communications, and maybe it will happen."[4]

Another aspect of the PAOs tactical plan should be to keep Army medicine in the public's eye through every available channel--local news letters, magazines, newspapers, and where possible television. Army leaders, soldiers, family members, and the local community need to "see us." Do no make the mistake that happened recently, according to BG Scotti, when an NBC nightly news reporter was told the Department of Defense (DOD) did not want footage of Army hospitals on a program about military medicine. The DOD spokesman's attitude was that we were probably not going to be quoted correctly, so, don't say anything.[5] This is not the way to interact with the media. Invite the local television stations to come into the hospital and do a story. These contacts have to be as often as possible and should tell of our successes. The perception that only

medical mishaps are newsworthy is a trap we have fallen into in the Army Medical Department. We have to make our successes newsworthy, and that is our challenge.

Last, the PAO's tactical plan should conclude with a section devoted to topics of current interest and suggestions for stories to project a positive perception to Army leaders, soldiers and family members about the Army health care program. The list of topics will change as events occur, but we can begin with three basic themes--the personnel, the hospital, and the Quality Assurance process.

Start by writing articles about the quality of the physicians and other health care personnel assigned to your hospital. Highlight some of their training, qualifications, and community activities.

Next, tell about the significant progress in improving quality of health care found during the recent Government Accounting Office's and the External Review Committee's surveys of military hospitals.

Finally, give the public information about the current physician credentials process and the tremendous amount of time and effort The Army Medical Department has put into patient care assessment, utilization review, and risk management. Tell them about our Quality Assurance program to assure high quality patient care.

A proactive PAOs tactical plan in coordination with the Surgeon General's strategic plan should set in motion the Army Medical Department's blueprint for the future. A tactical plan,

however, is no good if it is not followed. Nor will it be effective if certain principles are not adhered to after the plan has been prepared.

First, we have to be accessible to the media. A reporter should only have to make one call to the hospital. The next call should be from the PAO or the hospital commander to arrange for necessary meetings with the reporter. Mr. Courtney Welton, PAO, Office of the Surgeon General, advises the right attitude for hospital commanders is to "be accessible, and let the reporter walk in your shoes."[6] Another form of accessibility has to do with release of information. If the information sought by the reporter can be obtained under the freedom of information act then Department of Defense's policy is to give it to the reporter up front.

Second, we have to be honest and straight forward with the media. Admit mistakes. Do not give the media the impression that we are "circling our wagons." This approach gives the appearance we are trying to cover up something. LTC F.A. Barth, Quality Assurance Division of the Office of the Surgeon General, indicated his files are "full of cases where the principles of being honest and straight forward were not followed."[7]

Finally, we have to be timely with our comments to the media. No PAO or hospital commander should make the statement, "I have no comment," when questioned by a reporter. This error is "so bad as to be horrible," declared BG Scotti.[8]

We can no longer afford to just sit and do nothing. A recent quote from Dr. Hugh Upton, Chairman of Public Relation and Marketing Committee of American Academy of Family Physicians, stressed this point when he said, "The American public's consciousness is like a pond. You throw a pebble in and it disappears but creates waves. Soon there's nothing. You have to keep throwing the pebbles in to make an impression on the public consciousness."[9] This statement is indeed relevant, and it should apply to the Army's health care program. Now that we have our blueprint, let's get busy.

ENDNOTES

1. Quinn H. Becker, Office of the Surgeon General of the Army, Letter to Chief of Public Affairs of the Army, 7 April 1988.

2. Michael P. Kehoe, Office of Public Affairs Army Health Services Command, Letter to LTC Thomas Anderson, USAWC, 26 January 1989.

3. U.S. Department of the Army, Army Regulation 40-66, p. 37.

4. Interview with Frank F. Ledford, LTG, Surgeon General of the Army, Washington, 3 February 1989.

5. Interview with Michael Scotti, BG, Office of the Surgeon General of the Army, Washington, 13 October 1988.

6. Interview with Courtney Welton, PAO, Office of the Surgeon General of the Army, Washington, 14 October 1988.

7. Interview with F.A. Barth, LTC, Office of the Surgeon General of the Army, Washington, 13 October 1988.

8. Scotti, Interview.

9. AAFP Flies Solo on New Campaign, AAFP Reporter, December 1988, p. 1.

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4. Budahn, P.J. "Mayer: Study of Military Care Reveals 'Success Story'." Army Times, 2 November 1987, p. 3.

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