STUDY PROJECT

PERCEPTIONS OF ARMY MEDICINE-- SHOULD WE FOCUS ON A BETTER PRODUCT OR ON MORE INNOVATIVE PUBLIC RELATIONS?

BY

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Army medicine and the Army Medical Department (AMEDD) have been subject to considerable scrutiny since early 1986. There is a growing consensus that military medicine has failed in its dual mission--the AMEDD is not ready to go to war, and it is unable to provide medical care to its authorized beneficiaries. Additionally, criticism and negative publicity have significantly tarnished the AMEDD's image and devastated the morale of its members. Some feel

that Army medicine has been unfairly and inappropriately victimized by misperceptions and bad press. That school would have you believe that the overall national medical system is broken, that the civilian sector has greater problems, and that a major part of the solution requires more innovative public relations. This author does not agree. Good products sell themselves. The major focus of effective public relations has always been to give good products better visibility. This study will analyze the AMEDD "product"--specifically focusing on three critical areas: first, "go to war" issues from the perspective of a division medical officer; i.e.--AMEDD "ambassadors" and aeromedical evacuation in Airland Battle; second, on peacetime medical care of our soldiers and their family members; third, and most important, on leadership. In the spirit of "glasnost" and "perestroika," the author will identify problems, draw conclusions, and then make recommendations on how the AMEDD can best improve perceptions of Army medicine.

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USAWC MILITARY STUDIES PROGRAM PAPER

PERCEPTIONS OF ARMY MEDICINE--SHOULD WE FOCUS ON A BETTER PRODUCT OR ON MORE INNOVATIVE PUBLIC RELATIONS?

AN INDIVIDUAL STUDY PROJECT

by

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cont pg 1

TABLE OF CONTENTS

PERCEPTIONS OF ARMY MEDICINE--SHOULD WE FOCUS ON A BETTER PRODUCT OR ON MORE INNOVATIVE PUBLIC RELATIONS?

CHAPTER I

INTRODUCTION

The essential question being asked in this study is whether or not the Army Medical Department (AMEDD) can perform its dual mission--wartime medical readiness and peacetime medical care. Obviously, if the AMEDD can perform both missions, then it needs a better public relations program to clear up misperceptions. Conversely, if the AMEDD cannot perform both missions, then it needs to listen to critics and make appropriate corrections. To answer the question, this author will analyze three critical areas: "go to war" issues, peacetime medical care problems, and leadership.

"GO TO WAR" MEDICINE

The Secretary of Defense has made it clear that the primary responsibility of the military health care system is "to be medically ready in time of war to meet all requirements for lifesaving care."[1]

Background.

Despite this definitive guidance, the AMEDD is clearly more concerned with providing peacetime care to its authorized beneficiaries, and "go to war" medicine has not been emphasized. At any rate, that is the signal that the AMEDD leadership is sending to the field. On the battlefield, most lives are saved at the foxhole level by soldiers, combat lifesavers, and medics applying the basic "ABCs" to casualties--providing airways, controlling bleeding, and maintaining circulation. In the author's opinion, the AMEDD has done very little to facilitate this critical process, and little emphasis has been placed on division level "go to war" issues as illustrated by the following.

1. Organization. Unlike the rest of the Army, the AMEDD does not train the way it intends to fight. In peacetime, medical companies and battalions are overwhelmingly commanded by Medical Service Corps officers. In wartime, these units are commanded by Medical Corps officers. Unfortunately, MC officers are not formally trained for this role.

2. Professional Officer Filler System (PROFIS). This system "predesignates Active Component health professionals serving in MTDA units, to fill Active Component FORSCOM early deploying units and forward deployed units in Europe

and Korea during mobilization or upon execution of a contingency operation. The objective of PROFIS is to bring MTOE units to their required authorized level of organization of AMEDD officer strength in accord with Army Mobilization and Deployment Planning Guidance."[2] Unfortunately, this system is unresponsive in execution and illogical in planning--the system requires 90 days advance notice and little or no attempt has been made to fill division positions from the supporting installation hospital.

3. Shortage of Physician Assistants (PAs). PAs are warrant officers and are the only medical officers assigned to "line" battalions in peacetime. As such, they are the backbone of division medical readiness. In FY88, the AMEDD had to eliminate 80 warrant officers in FORSCOM and was forced to choose between 80 hospital-based medical equipment repair technicians or 80 "line" PAs. The AMEDD opted to eliminate the "line" PAs which further degraded division "go to war" medical readiness.

4. General Medical Officers (GMOs). In peacetime, the AMEDD sends one physician to an infantry brigade. This physician is a GMO who was non-competitive in the formal AMEDD graduate medical education system. Unfortunately, this officer receives no formal AMEDD training in military medicine and must learn his crucial role on the job.

5. Aeromedical Evacuation in Airland Battle. Critical shortfalls have been identified in this area. Unfortunately, they have not been seriously addressed or resolved.

Focus.

All of these are serious issues. In fact, this author feels they are serious enough to claim that the AMEDD is not prepared for war at the division level. In Chapters II and III respectively, the author will dicuss the last two issues--the GMO: the AMEDD's ambassador to the "line;" and Aeromedical Evacuation in Airland Battle: an unrecognized war stopper.

PEACETIME MEDICAL CARE

The stated peacetime mission of the Army Medical Department (AMEDD) is "to provide a training and skill-maintenance base where military health care personnel maintain proficiency by providing care to authorized beneficiaries."3

Background.

Historically, the AMEDD appears to have failed in this arena for two reasons. First, as will be shown in Chapter

II, the AMEDD training base does not prepare military physicians for their wartime roles. Second, the AMEDD freely admits that it cannot provide care for all its beneficiaries.

Significantly, the AMEDD is looking for alternate solutions to the latter problem. A quick fix was civilian referral--the CHAMPUS system.[4] Unfortunately, this has been too costly, and it diverts resources needed for readiness. Discussion now focuses on additional options, and in a recent article, two AMEDD officers stated the following:

> "The AMEDD has three options to best provide primary care to its beneficiaries: 1) increase the capabilities of its own hospital's primary care clinics, 2) increase the capabilities of its own free-standing health clinics, or 3) establish PRIMUS free-standing primary care clinics."[5]

Significantly, these authors recommended the PRIMUS option as "the best way for the AMEDD to provide primary care to its beneficiaries."[6] Of note, the current Army position is stated as follows:

> "Peacetime health care effort must focus on improving access through initiatives that expand services and recapture CHAMPUS workload. This can be achieved by: improving health care provider staffing; expanding primary care support; funding the Army Medical Enhancement Program; educating beneficiaries; and creatively managing CHAMPUS funding to optimize its use."[7]

Focus.

Obviously, the AMEDD needs to improve patient access to direct Army care, and it needs to recapture CHAMPUS workload; however, this author does not agree with the currently stated methodologies. Ultimately, they may be required; however, before the AMEDD requests increased budget allocations, it needs to focus on better leadership. In the opinion of this author, poor leadership has characteristically resulted in inefficient use of existing facilities and manpower. Together, these have reduced patient access to direct Army care. In support of this, the author will offer personal observations from three Army medical facilities--Tripler, Martin, and Blanchfield--in Chapters IV, V, and VI respectively.

LEADERSHIP

Leadership is the common thread throughout this study. In the author's opinion, the AMEDD has strong clinical leadership; however, it has weak military leadership. This will be discussed in Chapter VII.

ENDNOTES

1. Frank Carlucci, Report of the Secretary of Defense to the Congress, FY 1989, p. 283.

2. U.S. Department of the Army, Army Regulation 601-142, p. 1.

3. "Medical Support," Army Focus, p. 15.

4. CHAMPUS--Civilian Health and Medical Program for the Uniformed Services.

5. LTC Ronald P. Hudak and MAJ Paul B. Mouritsen, "Improving the Army's Primary Care Delivery System," Military Medicine, Vol. 153, June 1988, pp. 282-286.

6. PRIMUS-Primary Care for the Uniformed Services. PRIMUS clinics are "owned and operated by a private contractor,and the AMEDD reimburses the contractor on a per clinic visit basis." The Army currently has PRIMUS clinics at six installations.

7. "Medical Support," Army Focus, p. 15.

CHAPTER II

GENERAL MEDICAL OFFICERS AMBASSADORS OF THE AMEDD

BACKGROUND

Military physicians are unique. Unlike their civilian counterparts who perform in clinical or hospital settings, military physicians are often required to perform in field environments as unit medical officers or as medical staff officers for "line" commanders. Unfortunately, the AMEDD has paid very little attention to these unique aspects of military medicine and to the general medical officers (GMOs) it sends to be its ambassadors with the "line." In not sending its best physicians to the "line," the AMEDD has clearly ignored the primary focus of Secretary Carlucci. To make matters worse, those that are sent to the "line" are not trained for their assignment. Unfortunately, this forces a "line" commander to base his perception of Army medicine on how well or how poorly the GMO executes a "line" mission that he has been forced to learn on the job.

FOCUS

This chapter will examine general medical officers (GMOs) at division level and their role as brigade surgeons and officers in charge (OICs) of Troop Medical Clinics

(TMCs). The author will discuss problems with the current AMEDD selection process and offer recommendations on how the AMEDD can do a better job of serving tne "line."

THE CURRENT SELECTION PROCESS

According to the AMEDD's Graduate Medical Education Office and Career Activities Office, 355 interns will graduate 30 June 1989--230 will immediately begin a residency on 1 July 1989, and the remaining 125 will become GMOs. In essence, the GMOs were not competitive and were rejected from the formal academic/clinical environment. To fulfill their remaining service obligation, 75% of these GMOs will be required to fill TOE positions overseas, and 25% will be required to fill TOE/TDA positions in the United States. Those going to TOE positions will be brigade surgeons, and they will be the AMEDD's ambassador to a brigade commander, three battalion commanders, and approximately 2000 soldiers and their families. Those going to TDA positions will be general ambulatory patient care physicians and will work in walk-in clinics or function as OICs of TMCs together with some Family Practice physicians.

POINTS FOR DISCUSSION

Several factors merit specific comment.

First, the Medical Corps has no career planning document per se; however, initial success is equated with the following progression: internship, residency, a MEDDAC utilization assignment, board certification, and then either a teaching assignment or an assignment as a service/department chief or deputy commander for clinical services (DCCS). Significantly, all of this is hospital oriented. Consequently, GMO assignments are not in the mainstream, and are not career enhancing. To the AMEDD, GMOs are second class citizens, or as this author heard one assignment officer say, "the chaff of the Corps." In essence, the AMEDD is sending its "chaff" to the "line" to function as its ambassadors, and "line" commanders will base their perceptions of Army medicine on the performance of the AMEDD's formal rejects. Equally disturbing, the AMEDD is entrusting the medical readiness and combat medical care of approximately 2000 soldiers to a physician who came up short in the stressful intern environment. The author vividly remembers being called by the commander of a major medical center who said that one of his graduating interns was immature and unreliable: therefore, he was not suitable for residency training. Instead, he was going to send him to

the author's division for assignment as a brigade surgeon. The author would like to think that "go to war" medicine and responsibility for the medical care of 2000 soldiers in combat would require a physician with maturity and reliability.

Second, the AMEDD does not teach interns or residents to perform as GMOs. This is illustrated below.

7th Medical Command-Europe. Commander comments and analysis of 61 clinic commander profiles indicated that the overwhelming majority of commanders were not prepared by the AMEDD for their role as clinic OICs, and they had to learn their roles through on the job training.[1] Additionally, these GMOs lacked "training and experience in essential leadership and administrative skills." Furthermore,

> "Military internship and residency training programs did not appear to provide a statistically significant greater level of clinical, administrative, or leadership training than civilian programs. This observation strikes at the heart of AMEDD Graduate Medical Education programs whose purpose is to develop Army officers as well as competent clinicians."

Fort Benning, Georgia. "Family Practice (FP) physicians train in their specialty during a three-year residency program. While this training is very successful in graduating FP physicians who are highly competent in providing patient care, it is deficient in addressing the unique roles and responsibilities of these doctors in the U.S. Army."[2]

To correct this deficiency and prepare their residents to assume roles as TMC OICs, the FP program directors established a modular training program: i.e.-- 12 modules

for garrison medicine and 4 modules for deployment medicine. Significantly, this was the work of the Fort Benning MEDDAC. It did not involve the entire AMEDD, and it did not involve the identical deficiencies present in other Army residency programs: i.e.-- surgery, internal medicine, pediatrics, etc.

Third, military training programs do not prepare its graduates for wartime medicine. This is illustrated by the following.

> "The present training of military surgeons does not equip them for handling the types of trauma they will encounter in a combat situation."[3]

> "This letter in no way implies that the military training programs are inadequate-they are not. They are turning out excellent general surgeons. Unfortunately, these programs are not training general surgeons to manage combat casualties."[4]

This does not specifically relate to GMOs; however, it does illustrate that AMEDD training programs do not focus on the primary wartime mission.

Fourth, the young GMO brigade surgeon has a harder time acquiring on the job training because he has fewer mentors-- as shown in Chapter I, the AMEDD elected to sacrifice the backbone of division medical readiness and eliminate 80 "line" PAs in order to retain 80 repair technicians.

CONCLUSIONS

The AMEDD does not send its best physicians to the "line." The GMOs that are sent are neither trained for their assignments nor adequately equipped to appropriately represent the AMEDD as its ambassadors to the "line."

RECOMMENDATIONS

First, the AMEDD needs to comply with Secretary Carlucci's guidance--wartime medical readiness must be the primary mission of the AMEDD.

Second, the AMEDD must change its attitudes and concentrate on sending its best to the "line" to function as its ambassadors. The AMEDD must change the "mainstream flow" and develop an appropriate balance between clinical and troop medicine for everyone: i.e.- the "mecca" image of the major medical center must be deglamorized, and the AMEDD must emphasize to all that it is looking for military physicians.

Third, the AMEDD must endorse and institute the Fort Benning modular training program and fully train its general medical officers to perform as unit medical officers.

Fourth, the AMEDD must emphasize military education during internship and residency training. The AMEDD must ensure that its general medical officers (captains) have the same military education as "line" company commanders--basic and advanced course training.

ENDNOTES

1. COL Tinsley W. Rucker and MAJ (P) John Richards, "The Challenge of Leadership Within Army Medicine," Medical Bulletin, November/December 1988, pp. 9-15.

2. MAJ Thomas Goodell and MAJ Ronald Jones, "Curriculum Design: Operational Medicine," Military Medicine, January 1989, p. 36.

3. COL Ronald Bellamy, "How Shall We Train For Combat Casualty Care," Military Medicine, December 1987, pp. 12:617-621.

4. DR Morris Kerstein, Letter to the Editor, Military Medicine, October 1988, p. 537.

CHAPTER III

AEROMEDICAL EVACUATION AND AIRLAND BATTLE

BACKGROUND

Airland Battle doctrine and its four basic tenets-initiative, agility, depth, and synchronization--underscore the vital importance of sustainment. As GEN Carl E. Vuono stated, "There is nothing clearer in the study of war than the need for adequate force sustainment."[1] The role of health service support (HSS) in sustainment is clear. "The thrust of HSS is to maximize the return to duty (RTD) rate in order to conserve the human component of the combat commander's weapon system."[2] Additionally, "it serves as a primary source of trained replacements during the early stages of a major conflict."[3] The consequences of HSS failure, particularly in casualty evacuation, are equally clear. Patients will accumulate within the battle area, wounded soldiers will become dead soldiers, commanders will lose combat power, morale will deteriorate, and soldiers will lose confidence and their will to fight.[4] In short, failure of HSS will be a "war stopper."

FOCUS

This chapter will analyze aeromedical evacuation in the Airland Battle--particularly focusing on the critical link between division and corps. Specifically, it will accomplish three things. First, it will identify a "war stopper." Second, it will itemize key causative factors. Third, it will propose a "real world" solution.

THE "WAR STOPPER"

There are many problems associated with casualty evacuation in support of Airland Battle. For openers, the Commander, US Army Combat Arms Center at Ft. Leavenworth says, "emerging casualty evacuation procedures are still being defined and are untested."[5] Additionally, the HSS doctrinal area of responsibility needs updating. Deep operations of Airland Battle are characterized by cross-FLOT operations;[6] however, TRADOC says, "the medical system to support the U.S. Army at war is a continuum from the FLOT through the CONUS base."[7] It is bad enough to have "limited doctrinal guidance and spotty unit training in how to conduct the casualty evacuation procedures dictated by far forward care,"[8] but the significant problem of aeromedical evacuation in Airland Battle--the "war stopper"--is that

neither division nor corps can perform their doctrinal mission. Division cannot adequately evacuate casualties from the foxhole or battalion aid station (BAS), and corps cannot adequately evacuate casualties from division forward support medical companies (FSMC). In short, the Army Medical Department (AMEDD) cannot sustain the Airland Battle at the tactical level of war.

This statement is not a matter for debate. The division failure is well documented by the Center for Army Lessons Learned (CALL). CALL makes it clear that "casualty treatment and evacuation is the weak link in battalion level CSS," and further states that "casualty evacuation forward of the brigade support area (BSA) in a mid to high intensity environment is not adequate to meet the operational requirements of Airland Battle."[9] The corps failure is harder to formally document; however, in the author's experience, it can be inferred from the following. First, XVIII Airborne Corps did not have sufficient organic assets: therefore, it could not evacuate casualties from FSMCs of the 101st Airborne Division (Air Assault) in recent major computer exercises.[10] Second, corps' recognition of this "shortfall" was reflected in the habitual "TBA" by "medevac" in its planning documents (OPLANs) for major contingency missions.[11]

CAUSATIVE FACTORS

Many factors contribute to this critical problem. This author feels four merit discussion.

First, HSS planners do not fully appreciate the increased lethality of the modern battlefield. Planning for health service support is still based on historical patient admission rates from WW II, Korea, and Vietnam.[12] In this author's experience with computer wargaming, contemporary casualties were considerably higher than those projected by the historical data base.[13]

Second, division and corps do not have sufficient organic assets. "The standard for evacuation is to have casualties treated by a physician or physician's assistant within thirty minutes of injury."[14] By multiple accounts, this is not happening at the National Training Center (NTC) or Joint Readiness Training Center (JRTC), and limited medical assets have been cited as contributing factors--particularly in mechanized and armored units.[15] Current DOD policy directs that "in both peace and war, the movement of patients of the Armed Forces will be accomplished by airlift when airlift is available and conditions are suitable for aeromedical evacuation, unless

medically contraindicated."[16] With emphasis on timely treatment and evacuation by air, two points are disturbing.

1. The air assault division is the only division with an organic air ambulance company.

2. One air ambulance company (fifteen UH-60 Blackhawk helicopters) is expected to support an entire corps.

Third, "line" commanders do not give casualty evacuation appropriate consideration. In "graded" exercises, commanders are hesitant to "jeopardize" tactical mission performance: therefore, casualty evacuation tends to be "administrative" with limited opportunity for "hands on" play. This was made clear to the author on multiple occasions. Two are noteworthy.

1. In August 1986, the 101st was in California to participate in a large joint training exercise (JTX)--Gallant Eagle 86. Casualty and replacement flow was inadequate and was challenged by both the division surgeon and the division personnel officer (G1). The assistant division commander for operations (ADC (O)) acknowledged their concerns; however, he said the division was in California to exercise tactical concepts, and that casualty/replacement flow could be adequately evaluated at home.

2. In February-March 1987, the division conducted a local field training exercise (FTX)--Golden Eagle 87, Remembering the ADC(O)'s guidance, the surgeon and G1 planned extensive casualty and replacement flow. Unfortunately, only about 30% of the programmed 1000 casualties made it through the system.

Clearly, "line" commanders are reluctant to "play the game." Consequently, the division evacuation chain is rarely exercised: i.e.- foxhole to BAS to FSMC, and the critical link between division and corps is "never" exercised: i.e.- FSMC to either a combat support hospital (CSH) or an evacuation hospital (EVAC). Particularly distressing to this author is realization of the following. If battalion commanders of the Vietnam era have not given casualty evacuation appropriate consideration, then it is highly probable that the new generation will give casualty play even less consideration.

Fourth, and most distressing, medical planners have an inappropriate "mind set." In the opinion of this author, they do not espouse the sustainment imperatives of FM 100-5, Operations, they are extremely parochial, and they are trying to apply peacetime standards to wartime medicine. In short, they are so fixated and so determined to preserve antiquated, non-viable doctrine that they have forgotten the thrust of HSS and the basic tenets of combat

medicine--immediate far-forward stabilization followed by expeditious transport. This is well illustrated by the following comment from a member of the 75th Ranger Regiment concerned about prompt casualty evacuation following a forced entry (airborne drop) to secure an airhead.

"Fixed wing evacuation from an airhead is accomplished by USAF aircraft once a mobile aeromedical staging facility (MASF) is established. A MASF will not arrive until several hours or days after the initial airborne assault. Surgical capable medical units will probably not arrive for several hours or days after the initial assault. Patients injured in the early phases of an airborne assault will have to wait potentially a day to receive either evacuation or surgery. During that day, several fixed wing aircraft (logistical) would have departed, empty, for an airfield, that in most parts of the world, would have surgical capability."[17]

The ranger wants to know why he cannot use the obvious--logistical aircraft--to expedite evacuation and follow-on surgical care for his stabilized casualties. Remembering the tenets--stabilization and transport, the ranger asks a good question. Unfortunately, in the author's experience, use of logistical aircraft for evacuation has been denied for two reasons.

1. It is non-doctrinal.

2. It is not centrally controlled and centrally executed by the AMEDD through a medical regulating officer (MRO).

SOLUTION

In the experience of this author, a division surgeon of a rapid deployment unit looking at "TBA" under "medevac" in the corps OPLAN has limited options--particularly in the "18 hour sequence" of an emergency deployment readiness exercise (EDRE) or "real world" deployment. He cannot debate doctrinal inadequacies with HSS planners, and he cannot advise the division commander that corps has no plan for evacuating division casualties from the division's FSMCs. To avoid the critical bottleneck between division and corps, the surgeon has one option--he must augment (even replace) corps' inadequate evacuation assets with logistical assets, deliberately integrate evacuation plans with logistical resupply plans, and plan to use logistical backhaul to evacuate stable casualties from divisional FSMCs.

DISCUSSION

Significantly, this proposal is not new. Prior Army field manuals state, "Coordination of evacuation plans with those involving the flow of tactical and logistical traffic to and from the main battle area is essential to sound patient evacuation operations."[18] Additionally, the current

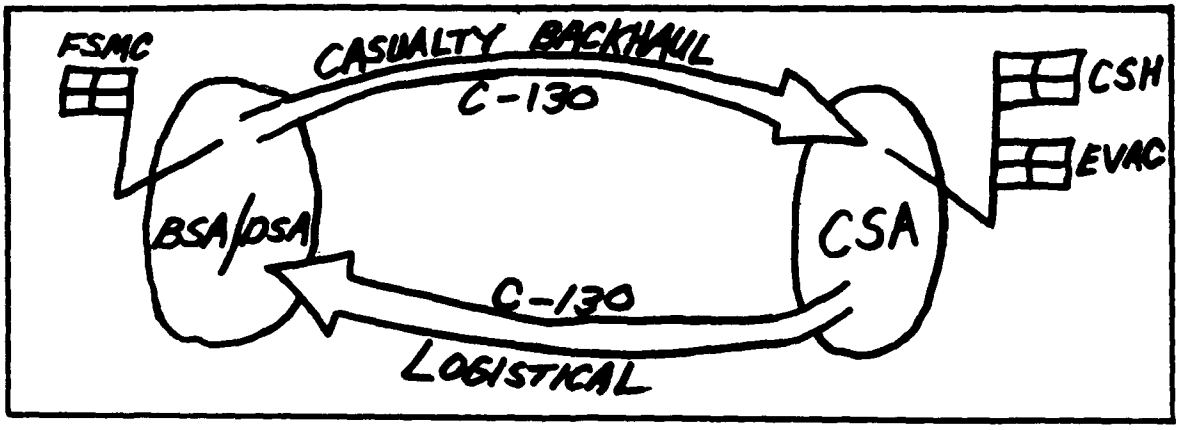
NATO handbook on emergency war surgery states that "fixed-wing aircraft of the nonmedical variety are utilized to transport personnel and supplies into the theater of operations. After offloading, these same aircraft can be quickly converted and internally reconfigured to accommodate both litter and ambulatory patients."[19] Those with traditional "mind sets" should review this "history" and then challenge the following tenets of outdated doctrine: first, medical evacuation in the combat zone (CZ) must be via AMEDD means; second, it must procede sequentially through different levels of care--from the foxhole, BAS (level I), FSMC (level II), and then to corps (level III); and third, it must be centrally controlled and centrally executed to insure optimal medical regulating. These need further discussion.

First, "except under unique circumstances, the AMEDD controls no transportation means for evacuation of patients from the CZ to the communications zone (COMMZ) or from the COMMZ to CONUS."[20] In essence, the primary means of evacuation above corps is by USAF medical air evacuation.[21] Given these facts, this author questions the sanctity of only using AMEDD assets within the CZ--particularly considering the following.

1. In the author's personal Vietnam experience, most casualty evacuations were performed by logistical assets--"log birds"--and not medical assets--"dust offs."[22]

2. Use of logistical aircraft is clearly advantageous.

a. It is logical. Logistical and medical facilities are co-located. Division FSMCs are found in the brigade/division support areas (BSA/DSA), and corps CSH and EVAC hospitals are found in the corps support area (CSA). This permits the following airflow.



This airflow maximizes use of existing assets. Instead of returning empty to the CSA, logistical assets can backhaul stable casualties. Additionally, this airflow saves aviation fuel. Use of logistical assets for casualty backhaul will decrease medical mission requirements which will save fuel in what will be a "fuel scarce" environment.

b. It is readily available. In the experience of this author, logistical planners had more C-130 aircraft available for casualty backhaul than the division needed for level II evacuation. In fact, logistical backhaul capability (in the cited CPXs) exceeded 3700 litter patients per day.[23]

c. As the ranger showed above, it is expedient.

Second, while it is desirable for medical evacuation to proceed sequentially "rearward through facilities providing increasing levels of care," this is not required. "If the patient's condition warrants, and the evacuation means are available, any medical treatment facility can be bypassed. The term for this procedure is direct evacuation."[24]

Given this fact and the availability of evacuation assets, this author would encourage the expeditious transport of a stable casualty--a WIA with an abdominal gunshot wound--direct from the foxhole to the operating room because it benefits the patient. All penetrating abdominal wounds require surgical exploration which is only available at level III (corps) in the CZ. Therefore, direct evacuation from the foxhole to level III (bypassing level I and II) is the most expedient route to an operating table. Of note, this type of direct evacuation was the norm in Vietnam.

Third, this author appreciates the importance of medical regulating. "Through the medical regulating system, patients are moved to medical treatment facilities commensurate with the treatment or care required, medical or surgical backlogs are reduced, maximum utilization of bed spaces is effected, and facilities are cleared of patients preparatory to movement."[25] However, the focus of CSS in sustaining the Airland Battle is on centralized control and decentralized execution. This should also apply to medical regulating--it must be decentralized in order to be expeditious and opportunistic. Noting the above diagram and the co-location of medical and logistical assets, it should not be difficult for logistical planners to coordinate with HSS planners. Needed is a serious effort to practically "link" FSMC commanders and logistical forward area support coordinators to corps MROs. This would optimize medical regulation and still permit decentralized execution. In addition, MROs need to coordinate more often with the USAF. In the author's experience, the USAF Tactical Aeromedical Evacuation System (TAES) is grossly underutilized, and its potential is not appreciated. It has a ground-to-air communication link, and it is designed "to evacuate patients between points of treatment within and from the combat zone to points outside the combat zone utilizing backhaul aircraft capability."[26] Significantly, the TAES worked

well for the author in "real world" exercise play and computer driven scenarios.[27]

Some final points require discussion:

First, this author is not advocating that health care providers should throw unstable patients on logistical aircraft and transport them as cargo. "It must be constantly borne in mind that the availability of rapid transportation by air does not alter, in any way, the necessity for correct application of surgical principles."[28] Additionally, the USAF operates DOD's long range air ambulance system and their motto towards patients is appropriate-- "patients are not cargo, patients are not passengers, patients are patients."

The author is saying that in the cited exercises, if the casualties had not gone as logistical backhaul, then they would not have gone at all because corps did not have the required medical assets. They would have died of wounds, infection, etc. in the division FSMCs, and the AMEDD would have failed to sustain the force. Airland Battle will not afford us many luxuries. HSS planners must refocus on the key principle of triage--"achieving the greatest good for the greatest number of casualties"--and quit throwing up roadblocks to the use of nonmedical assets for casualty evacuation. They should also think about the following:

1. For the record, there are remarkably few contraindications to aeromedical evacuation, and "the risks of transporting patients by air have at times been overstated."[29]

2. Given an option, the author believes that most casualties would opt for expeditious evacuation to an operating room via an available aircraft (properly configured or not) rather than wait for an asset that is not available, but which would be properly configured for medical evacuation if it were available.

Second, the focus of this chapter has been on the critical link between division and corps; however, as documented above, another critical link in the evacuation chain is between the foxhole and the FSMC. The solution to this problem will also require augmentation of inadequate medical assets; however, this will require the use of tactical assets since logistical ones will rarely be this far forward. Tactical augmentation is easily visualized if one considers the air assault division and the air flow from pickup zone (PZ) to landing zone (LZ) in a typical air assault operation. PZs have a mini BAS and LZs have a casualty collecting point (CCP). Tactical (lift) helicopters carry soldiers from the PZ to the LZ, and then return (empty) to the PZ for another lift. Casualties at the LZ's CCP could easily be backhauled to the PZ's BAS

where the medical assets could then concentrate on further evacuating the casualties over shorter distances to the FSMC.

Third, the US Army has benefitted from the finest medical evacuation system in the world. Unfortunately, the excellence of that system is at the operational and strategic level. As the author has shown, this system cannot sustain the Airland Battle at the tactical level of war. For more insight, medical planners must--

1. Continue to push for increased casualty play in all training exercises. "Tactical leader training on the doctrinal principles of battlefield medical support is critical. Formal classroom and field training coupled with realistic integration of medical/casualty play in FTX/CPX scenarios will greatly advance the awareness and concern for medical treatment/evacuation during combat."[30]

2. Continue to develop the concept of far forward care--"an operational concept spawned from the anticipated demands of Airland Battle."[31]

CONCLUSION

In conclusion, the AMEDD needs to reassess how it plans to do business in the Airland Battle. Austerity will require innovative support concepts. Clearly, business can not be as usual. The author has identified a "war stopper," itemized contributing factors, and proposed a viable solution. HSS planners must change some "mind sets," focus on logistical imperatives, and get on with the vital sustainment function of "manning the force" during combat. To do otherwise will court disaster.

ENDNOTES

1. GEN Carl E. Vuono, "Sustaining Combat Power," Army Logistician, July/August, 1988.

2. U.S. Department of the Army, Field Manual FM 100-10, p. 3-3.

3. Ibid., p. 3-1.

4. Center for Army Lessons Learned (CALL), "Priority Issue: Casualty Evacuation," Bulletin 1-86, July 1986.

5. CDR, USACAC, "SUBJ: Center for Army Lessons Learned (CALL) Priority Issue: Casualty Evacuation," Message, 151818Z Jul 86, p. 4.

6. MAJ Brian C. Baldwin, U.S. Army Medical Evacuation Conference, Issue # 87-1.

7. U.S. Training and Doctrine Command, TRADOC Pamphlet 525-50, p. 2.

8. CDR, USACAC, p. 4.

9. Ibid.

10. 101st Airborne Division (AASLT) participation in XVIII ABN CORPS Command Post Exercises (CPXs): Caber Dragon 86, Caber Dragon 87, and Eagle Talon VII. Hereafter, referred to as CPXs.

11. Classified XVIII ABN CORPS OPLANs detailing HSS requirements for "real world" contingency missions.

12. U.S. Department of the Army, Field Manual FM 8-55, pp. 5-1 to 5-35.

13. CPXs.

14. CDR, USACAC, p. 4.

15. Ibid.

16. U.S. Department of the Army, Army Regulation 40-535 p. 1.

17. MAJ Connor, U.S. Army Medical Evacuation Conference, Issue # 88-12.

18. U.S. Department of the Army, Field Manual 8-10, pp. 4-1 to 4-4 and U.S. Department of the Army, Field Manual 63-5, pp. 10-4 to 10-5.

19. Thomas E. Bowen, ed., Emergency War Surgery, p. 196.

20. FM 8-55, p. 4-5.

21. U.S. Department of the Army, Field Manual FM 100-16, p. 8-6.

22. Infantry platoon leader and company commander, 1BDE, 101st Airborne Division, Republic of Vietnam, May 1967-December 1968. AH-1G (cobra) pilot and aviation battalion S3, 158 AVN BN, 101st Airborne Division, Republic of Vietnam, January 1971-December 1971.

23. Assuming maximum fill of all four division FSMCs and a 100% evacuation requirement, 160 patients would need evacuation (4 companies times 40 patients per company equals 160 patients). Available logistical backhaul capability exceeded 3700 per day (over 50 C-130 aircraft times 74 litter patients per C-130 equals 3700 patients).

24. FM 100-16, p. 8-6.

25. Academy of Health Sciences, Field Circular FC 8-15-1, p. B-35.

26. USAF Handout: Utilization of the Tactical Aeromedical Evacuation System.

27. CPXs and FTX--Golden Eagle, February-March 1987.

28. Bowen, p. 195.

29. MAJ David M. Lam, MD., Aeromedical Evacuation, A Handbook for Physicians, p. 54.

30. CDR, XVIII ABN CORPS, "SUBJ: Priority Issue: Casualty Evacuation," Message, 142100Z Aug 86, p. 1.

31. CDR, USACAC, p. 4.

CHAPTER IV

TRIPLER ARMY MEDICAL CENTER

BACKGROUND

The author spent four years at Tripler as an obstetrics and gynecology (OB/GYN) intern and resident. This was significant for three reasons. First, LTG Frank F. Ledford, the Army Surgeon General, says that "OB/GYN is the most expensive category of service in CHAMPUS."[1] Second, Tripler has the largest OB/GYN training program in the Army. Third, it was the author's introduction to the AMEDD and to Army medical centers (MEDCENs).

FOCUS

This chapter will examine peacetime medical care at a MEDCEN from the perspective of a physician in training. The author will cite three examples where poor leadership resulted in poor use of existing facilities and physicians. Ultimately, these resulted in reduced patient access to the Army direct care system with unnecessary CHAMPUS referral and cost.

PHYSICIAN WORKLOAD

A typical analysis of monthly productivity in the OB/GYN department was as follows:

Experience Level	Physicians	% of Patients Seen
Intern	6	15%
1st Year Resident	6	21%
2nd Year Resident	6	26%
3rd Year Resident	4	36%
Staff	6	2%
TOTALS.....	28	100%

As one would expect, productivity increased as the physicians gained more experience and confidence--the 3rd year resident predictably saw more patients than the intern just out of medical school. The obvious question is what happened to the staff physicians? One must ask why six highly trained OB/GYN staff physicians only generated 2% of the OB/GYN workload, while four less experienced 3rd year residents generated 36% of the workload? The staff would like for analysts to believe that they were busy administering the OB/GYN training program: therefore, they did not have time for direct patient care. However, in the author's experience, that was not the case. Civilians did most of the administration, and the residents taught themselves: i.e.- 3rd year residents taught 2nd year residents, 2nd year residents taught 1st year residents, and 1st year residents taught interns. Problems were handled in reverse. Interns went to 1st year residents, and so on. As one would expect, very few problems made it to the staff level. Additionally, residents even presented the majority of the department's educational lecture series.

Remembering that a primary objective of peacetime medical care is to reduce CHAMPUS costs by recapturing workload and getting our beneficiaries back into the Army direct patient care system, then this inequitable distribution of workload is unacceptable for two reasons.

First, the staff physicians did not provide appropriate role models for the residents. Staff physicians have vital roles in residency training programs. They are required for program accreditation, they are expected to "mentor" the senior residents, and they are expected to demonstrate a level of clinical expertise. Universally, the residents perceived the failure of the OB/GYN staff, and they sent a "petition of grievances" to the Surgeon General's OB/GYN consultant requesting a formal review.

Second, it reduced patient access to the Army direct patient care system. To put this in CHAMPUS perspective, one needs to consider some patient numbers. Each 3rd year resident saw approximately 600 patients per month. This meant that the four 3rd year residents collectively saw about 2400 patients per month or around 28,800 patients per year. As indicated, this represented 36% of the department's workload.

The six staff officers saw 2% of the department workload which mathematically amounted to 22 patients per month per

staff physician. Collectively, the staff saw 1,600 patients per year.

Given the responsibilities of staff physicians, their contributions cannot be accurately assessed by clinic workload alone; however, there is a considerable difference between 600 patients per month per 3rd year resident and 22 patients per month per fully trained staff physician. In the opinion of this author, this disparity was inexcusable.

This is greatly simplified. One cannot bring more OB/GYN patients back into the Army system if other elements cannot support it--nursing, pediatrics, bed space, etc. On the other hand, it does unequivocally show that existing staff physicians at a major medical center were grossly underutilized. As a result, the AMEDD lost a considerable number of potential patients to the CHAMPUS system.

ELECTIVE STERILIZATION

The second example of how poor leadership within the Tripler OB/GYN department resulted in suboptimal use of existing manpower and reduced patient access to the Army direct care system concerned the waiting time for elective sterilization. As an intern and junior resident, the author observed that the waiting time for these surgical procedures was conservatively four to six months--not an unreasonable

period for this type of elective surgery; however, many patients did not want to wait that long. Accordingly, they got statements of "nonavailability," and the OB/GYN department lost them to the CHAMPUS system. Senior residents scheduled these surgical cases under the supervision of staff physiciansd; however, the system was not "hungry" for this case type: therefore, the waiting time persisted.

A subsequent group of 3rd year residents viewed this patient waiting list for elective sterilization as an opportunity for more surgical training time--particularly during the predictable time periods when patients did not want to have major surgery--summer time, vacations, etc. They also found that careful history and physical examinations in this patient population group often revealed significant GYN problems with indications for more "desirable" surgery--hysterectomies or repairs for urinary stress incontinence. Accordingly, they got very aggressive with the standing list. They centralized it, purified it, and got these patients to accept short notice surgery. This allowed them to capitalize on unforseen surgical cancellations.

Their efforts were noteworthy. They improved access to the system and eliminated the waiting list for elective sterilization. Significantly, this had four major impacts.

First, it satisfied the patient population. Second, it recaptured a portion of the CHAMPUS workload, since it brought patients back into the Army direct care system who would not have waited the previous four to six months for an elective procedure. Third, it helped maximize use of the operating room. Fourth, it gave the residents more surgical experience.

Clearly, everyone benefitted from the resident initiative; however, it should have come from the staff and leadership of the OB/GYN department.

NEW OB APPOINTMENTS

The third example of how poor leadership resulted in suboptimal use of existing manpower and reduced patient access to the system concerned the waiting time for new OB appointments. Historically, these appointments were time consuming. They entailed complete history and physical examinations together with special OB examinations, special laboratory work, and special patient education. This information was then examined for risk factors and the patients were then categorized as "routine OB" or "complicated OB" for subsequent prenatal visits. Typically, these exams were performed by the least experienced physicians. Consequently, productivity was low, waiting

lists were long, and CHAMPUS referral for "nonavailability" was high.

Again, a group of 3rd year residents recognized this waiting list as a chronic problem, and they resolved to eliminate it. They chose to mobilize their assets during the Christmas period where several factors worked in their favor. First, operating room (OR) time was reduced to give the OR staff a holiday break. In essence, only emergency surgery was authorized. Second, as a consequence, the OB/GYN department had a lot more residents available to work in the clinic. Recognizing the opportunity, the senior residents placed emphasis on new OB oppointments during the holidays, and they assigned every resident a daily "quota" based on year level of experience.

In so doing, they quickly eliminated the new OB waiting list. Again, four things were significant. First, it satisfied the patient population. Second, it recaptured a portion of the CHAMPUS workload utilizing existing manpower assets. Third, it was done using the traditional holiday half-day schedule: therefore, residents also got to enjoy the holidays. Fourth, it was done while still maintaining the "status quo" in all other patient areas.

Again, everyone benefitted. Again, the initiative should have come from the staff and leadership of the OB/GYN

department. Additionally, this approach should have been used during other periods of predictable low OR use.

CONCLUSION

In summary, poor leadership within the Tripler OB/GYN department resulted in inequitable workload distribution and reduced patient access to the Army direct care system. This lead to unnecessary CHAMPUS referral and cost.

ENDNOTES

1. Margaret Roth, "New Surgeon General Finds Little Time, Money For New Projects," Army Times, 14 November 1988, p. 6.

CHAPTER V

MARTIN ARMY COMMUNITY HOSPITAL

BACKGROUND

The author spent four years at Martin as a staff OB/GYN physician where he completed formal OB/GYN certification and was introduced to regional community hospitals (MEDDACs).

FOCUS

This chapter will examine peacetime medical care at a MEDDAC from the perspective of a junior staff physician. The focus will again be on leadership. Specifically, the author will cite three examples where poor leadership again resulted in suboptimal use of existing physicians. Again, this resulted in reduced patient access to the Army direct care system.

MOONLIGHTING

The OB/GYN service had four active duty physicians. Significantly, the service chief was constantly curtailing professional OB/GYN services because he allegedly needed a

larger physician staff; however, he permitted three of his physicians to "moonlight."[1]

LOSS OF MISSION ORIENTATION

The OB/GYN service chief manipulated the clinic schedule to allow one of his physicians to attend law school while assigned to the clinic. This same physician, a lieutenant colonel, was also allowed to attend the resident AMEDD Officer Advanced Course (AOAC) for five months.

POOR WORKLOAD DISTRIBUTION

The OB/GYN service had no performance yardsticks, and the workload was skewed. The inexperienced staff physicians typically saw two to three times more patients per month than the more experienced staff physicians.

DISCUSSION

All three of these examples illustrate poor leadership. Curtailment of clinical services is certainly justified if clinic chiefs do not have adequate resources to see the patient volume, within a reasonable duty day, while maintaining appropriate standards of care. However, this should be a last resort, and it must be done in a manner

that maintains credibility with the "line" that predominately "wears the uniform" 24 hours a day.

Prior to curtailment of professional services, clinic chiefs must ensure that they are getting maximum use of their physicians. The ADAC was not designed for senior field grade officers. The correspondence option would have achieved the same goal for the individual without costing the OB/GYN service the professional services of a staff physician for five months. Similarly, performance yardsticks (patient quotas) would have ensured an equitable distribution of clinic workload, and they would have provided the clinic chief with a management tool that would have allowed him to document when the capabilities of his clinic were about to be exceeded.

Curtailment of professional services for the reasons stated is credible. Curtailment concurrent with allowing moonlighting is not, and such practices will not enhance the AMEDD's image. Significantly, in a formal survey of Army officers of the U.S. Army War College Class of 1989, 73.4% of the respondents felt that Army physicians should not moonlight.2

CUSTOMER RELATIONS

At Tripler, the author frequently heard physicians in training making statements that conveyed negative attitudes towards the "line." At Martin, these negative attitudes were again evident; however, unlike the Tripler experience where impressionable young residents were echoing "in vogue" colloquialisms, the perpetrators at Martin were those who were expected to provide role models for developing AMEDD physicians. Two comments were noteworthy. First, during the pomp and pageantry of the annual Infantry ball, the MEDDAC commander remarked that, we (the Medical Corps) are a "cut above all this." Second, when asked to explain why he was not participating in the care of soldiers on the "flu" ward, the chief of medicine remarked that he did not go to medical school and residency to "look after soldiers with runny noses." These are anecdotal; however, in the opinion of this author, these make for bad customer relations and imply that the AMEDD does not respect the population it strives to serve.

CONCLUSION

Again, poor leadership resulted in suboptimal use of assigned physicians. Better focus on the OB/GYN mission and

application of basic management tools would have significantly increased patient access to the system and reduced CHAMPUS referrals and cost.

ENDNOTES

1. Moonlighting - The practice of working in the civilian sector for financial gain. Requirements are outlined in Army regulations.

2. Warren A. Todd, COL, Army Medicine--Current Perceptions and Its Use of Public Relations.

CHAPTER VI

FORT CAMPBELL, KENTUCKY

BLANCHFIELD ARMY COMMUNITY HOSPITAL

BACKGROUND

The author spent two years at Fort Campbell as Division Surgeon of the 101st Airborne Division (Air Assault). The assignment was significant for two reasons. First, it was the author's introduction to "go to war" medicine and to the field of "operational medicine." Second, it allowed the author to perceive the AMEDD from the eyes of "line" officers.

FOCUS

This chapter will examine peacetime medical care at the installation/division level from the perspective of a division surgeon accountable to a major general for the medical readiness of his division. The author will again show how poor leadership resulted in suboptimal use of existing assets and decreased patient access to the Army direct care system. This chapter will analyze Campbell's access problems and discuss how the division solved them.

THE PROBLEMS

Courtesy calls with the major unit commanders painted a dismal picture of installation medical support. Two things were clear. First, commanders were not satisfied with their medical support. Second, the installation MEDDAC was not respected by the military community it sought to support. Particularly frustrating to commanders were the following: sick call in three brigade-sized units lasted all day, medical taskings deprived many medics of refresher training, too many soldiers were on temporary profile, medical PORs took too long, and there were not enough division medical officers.

The only bright spot was the division's "Eagle Clinic"--a clinic in the main hospital staffed by division medical officers who saw adult division family members in the afternoon. The commanders felt that this provided the most reliable access to the hospital for their soldier's dependents. Unfortunately, non-divisional units did not have a similar clinic. Understandably, these commanders felt slighted, and they wanted similar access for their family members.

SICK CALL

Background.

Inefficient garrison sick call is chiefly a function of two factors--ignorance and parochialism. Ignorance, because as discussed in Chapter II, general medical officers are not taught to perform as unit medical officers. Parochialism, because MEDDACs control TMC operations but are not responsive to the line commanders or unit medical officers.

In artillery, aviation, and CSS units, inefficient sick call is also a function of personnel authorizations. These units are supposed to receive medical support on an area basis: therefore, they do not have the same number of medical personnel authorizations that you would find in an infantry unit which is expected to be "self-sustaining."

The Basics.

Effective sick call involves appropriate "triage" and patient flow procedures. It must be decentralized and use the Algorithm Directed Troop Medical Care (ADTMC) model.1 Essentially, this model requires that soldiers are first seen in battalion aid stations (BASs) by unit medics,

trained in ADTMC, under the supervision of their battalion physician assistants (PAs). Theoretically, 85% of the soldiers reporting for sick call can be treated and returned to duty from the BAS. The remaining 15% are referred to the brigade troop medical clinic (TMC) where they are evaluated by battalion PAs under the supervision of their brigade surgeon. Most of these referred soldiers can be treated and returned to duty from the TMC; however, a small percentage may require further referral to the supporting MEDDAC for more definitive evaluation by a specialist.

The Problem.

The ADTMC model was not in use. Sick call was centralized--everyone went directly to the brigade TMC. There was no rational flow from medic to PA to physician. As a result, the system was quickly flooded and abused. Unit medics rarely participated in the basic evaluation, their skills logically deteriorated, and the utility of medical platoons was lost. The division medical officers (brigade surgeons and battalion PAs) were inundated with more patient volume than they could reasonably handle. As a result, sick call was not efficient. Moreover, some soldiers took advantage of the situation and malingered. This "secondary gain" compounded the problem, and it was difficult for medical officers to sort out and treat the

sick. Tempers frequently flared, frustration levels were high, health care provider morale was low, and sick call lasted all day--from 0600 to 1600 hours.

The Solution.

The solution was to institute the ADTMC model. Medics were appropriately trained, BASs were set up, and soldiers were seen by medics under battalion PA supervision. As predicted by the model, about 85% of the soldiers reporting for sick call were treated and rapidly returned to duty from the BAS. The remaining 15% were referred to the TMC where they were evaluated by the battalion PAs under the supervision of their brigade surgeon. These were also quickly treated and either returned to duty or further referred to the hospital for more definitive evaluation.

Significance.

A chronic problem was solved, and sick call in divisional units was completed by 0930 hours. Unit commanders and first sergeants were satisfied. Sick call was responsive, and return to duty was rapid. Malingering decreased, and more soldiers were available for training and unit mission requirements. In addition, the increased efficiency "freed up" a sizeable number of medics, PAs, and physicians that the division could then use in other areas

for the remainder of the day--from 0930-1600 hours. Specifically, availability of these assets allowed the division to develop a coordinated sick call plan for the entire installation and to provide the installation MEDDAC with additional division medical officers which resulted in improved family member access to the Army direct care system.

INADEQUATE MEDICAL PROFICIENCY TRAINING

The Problem.

Increased efficiency of sick call operations via the ADTMC model freed up a significant number of medics; however, medical tasking requirements still limited the availability of these medics for medical MOS proficiency training. Simply stated, after the division provided medics for range support, Air Assault School coverage, etc., there were not enough medics left to support a medical MOS proficiency training program. Consequently, medics were not receiving adequate annual refresher training.

The Solution.

The solution was to satisfy medical tasking requirements with "combat lifesavers" and then send the untasked medics for needed proficiency training.

History.

The Center for Army Lessons Learned has stated that--

> "Medical personnel and evacuation capabilities will not always be available to treat and evacuate the wounded on the next battlefield. The life saving medical aid administered to casualties will be the responsibility of the individual soldier and his buddies."[2]

This was true in the Falklands, and the lesson learned was that "each field SOP should include a plan for treatment of wounded by non-medical personnel." To facilitate this process of providing medical multipliers, Health Services Command (HSC) designed a formal course of instruction for "combat lifesavers." Ideally, every squad or crew served weapon would have one soldier trained as a combat lifesaver.

Campbell Application.

The division viewed the combat lifesaver as a genuine medical multiplier that would enhance unit medical readiness and survivability. With the blessing and backing of the chain of command, the division established a formal one week "Combat Lifesaver Course" using HSC's formal syllabus. The division taught two classes per month with 40 soldiers per class. Unit quotas were coordinated through the Division G3. In particular, the division trained combat lifesavers for its biggest medical taskers--the Air Assault School.

Next, the division performed a retrospective study on training accidents at Fort Campbell. Several factors were considered including the close proximity of the MEDDAC, the immediate availability/accessibility of medevac or ambulance, and the actual expectations of a medic during an emergency.

The division concluded that combat lifesavers were safe alternatives to medics at Fort Campbell, and that the use of combat lifesavers was in the spirit of the "train the way you fight" philosophy. This was presented to the MEDDAC commander who gave the division official authorization to use combat lifesavers in lieu of medics for all medic tasking requirements on the installation. This was implemented immediately, and the results were obvious.

Significance.

The use of combat lifesavers virtually eliminated unit taskings for combat medics at Fort Campbell. For example, the Air Assault School stopped asking for medics because it now used its own cadre that the division had cross-trained as combat lifesavers. Similarly, units didn't ask for range medics because they already had sufficient combat lifesavers for the task. Significantly, the use of combat lifesavers made medics available for other things. In particular, more medics were now available for an increased role in sick call

operations and for increased participation in medical MOS proficiency training.

TEMPORARY PROFILES

Background.

In December 1987, the division commander attended the FORSCOM Commander's Conference. When he returned, he indicated that the FORSCOM Commander was disappointed with the medical community's inability to resolve the temporary profile situation in FORSCOM. On any given day, the equivalent of one division was on temporary profile, and a tremendous amount of training time was being lost. Clearly, this was not acceptable, and the commander wanted a definitive solution. Significantly, he turned to his command surgeons for a solution.

The Problem.

Analysis of temporary profiles issued at Fort Campbell indicated that the heart of the problem was the medical station at the installation's centralized inprocessing facility. This station was staffed by a medical NCO and three medical specialists. It was designed to give all incoming installation personnel a thorough medical record screen, necessary immunizations, and an HIV test as needed.

It was not designed or staffed to correct detected deficiences. Consequently, if major deficiencies were noted, the medical NCO was required to give the incoming soldier a temporary profile which restricted the soldier's activities until the deficiencies were corrected. This was necessary to protect the soldier, protect the command, and comply with existing regulations.

Historically, 60% of these profiles were issued for overdue physical examinations, and one third of the division's replacements required a temporary profile. In essence, the equivalent of a battalion (minus) was being profiled "up front" every two weeks, and to make matters worse, legitimate factors prevented resolution of the profiling deficiencies within the 30 day limit of the temporary profile. The FORSCOM Commander was right. Compliance with multiple DA medical requirements was not "Conserving the Fighting Strength." Training and other mission requirements were being unacceptably decremented. The system was clearly broken, and it needed an immediate fix.

The Solution.

The solution was readily apparent--the division needed an adequately staffed centralized medical processing station (CMPS) that could correct all detected medical deficiencies

"on the spot" during inprocessing. This would essentially eliminate the temporary profile problem "up front," and put soldiers back in the foxhole for the commander. Clearly, this would satisfy the FORSCOM Commander and "Conserve the Fighting Strength."

Discussion.

The sense of urgency and stated resolve of the FORSCOM Commander put the division in a position of strength in dealing with the MEDDAC for increased medical support of the soldier. Clearly, the division commander was going to support an obvious solution to the temporary profile problem, and this gave the division both the clout to attack the MEDDAC's "we can't possibly do any more" attitude and the opportunity to strike some definitive blows for improving division medical readiness. The solution also had some compelling additional advantages. The CMPS operation only needed the morning hours to solve the temporary profile problem: therefore, the CMPS would be available in the afternoon for other purposes. If it was used to accomplish annual birth month medical requirements for soldiers already assigned to the division, then six of the division's TMCs would no longer have an afternoon mission, and they could be closed--an action which would benefit both the division and the MEDDAC. The division

would gain since freed up division medical officers would be available to see more division family members. The MEDDAC would gain since unnecessary TMC ancillary support personnel--lab, pharmacy, x-ray, and nursing--would be returned to the MEDDAC where shortfalls existed in all four areas. The potential advantages of such a CMPS operation with its associated TMC closures were clearly staggering. Unfortunately, they were not perceived by the MEDDAC's leadership.

In preliminary coordination, these leaders indicated that the proposal would hurt the MEDDAC for two reasons--decreased patient visits and increased immunization requirements. They felt that the CMPS operation with its "one stop" philosophy and increased efficiency would result in a decrease of patient visits to the medical system, and that this loss of patient visits, when converted to medical care composite units, would ultimately reduce the hospital's operating budget. Additionally, they felt that centralization with 100% compliance would mean that the MEDDAC would be required to administer more immunizations than it was budgeted for.

The division did not agree with either assessment. The division logically pointed out that the overall number of patient visits would increase for several reasons. First, the existing workload was not being captured--a deficiency

that centralization would correct. Second, the closure of the six TMCs would free up division medical officers who would then be able to see more family members. Additionally, the division pointed out that the MEDDAC's inferrence--it was better to have soldiers inefficiently enter the system multiple times, than it was to have them efficiently enter the system one time--was unacceptable. On the immunization issue, the division agreed that more immunizations would be required; however, the division pointed out two facts. First, administered shots were required by regulations and could not be denied the soldier. Second, after one year, the MEDDAC would save immunization funds through more efficient central dispensing and by eliminating the existing system where poor documentation in emergency deployment readiness exercise (EDRE) lines resulted in inappropriate and excessive immunization.

In subsequent coordination, it became increasingly clear that the MEDDAC opposed the proposal, and for reasons unknown to the author, the MEDDAC's position was guided by parochialism instead of the appropriate need for increased medical support. In particular, a tremendous conflict concerned the location of the proposed CMPS. The division recommended that the CMPS operation be located in the area currently used by the division's Eagle Clinic. This would require relocation of the division's clinic; however the

division felt this was justified for three reasons. First, Eagle Clinic was only used in the afternoon; however, the CMFS operation would last all day. Therefore, relocation of Eagle Clinic would result in more efficient space utilization. Second, the family member care provided by Eagle Clinic would still be provided within the hospital using empty examination rooms that were available in the Family Practice and Outpatient Clinics. Use of these rooms would also gave the division medical officers better access to specialists for consultation which would result in improved quality assurance. Third, and most significant, the area being used for Eagle Clinic was originally designed to be a medical examination station. Therefore, locating the CMFS operation in this area would utilize the space for its intended purpose, would mean negligible relocation costs, and it would permit immediate implementation.

Additionally, the MEDDAC's leadership had several other concerns. They said the CMFS operation could not be staffed. The division countered with special duty (SD) medics authorized by the assistant division commander for support. They said the relocation required more rooms than were available in the hospital. The division countered by moving Division Mental Health out of the Family Practice area which provided more rooms than the proposal required. (Division Mental Health was already scheduled to move

pending renovation of a division building.) Finally, they said they were not satisfied with the proposed patient flow. Again, the Division countered by reminding them that the proposed location was designed to be an examination facility: therefore, the flow was built into the design. Additionally, the division presented flow diagrams that clearly showed that the proposed site could easily handle the projected flow of 20-25 soldiers per hour. Ultimately, the MEDDAC leadership conceded that the proposal had merit; however, for reasons unknown to the author, they still did not want the CMPS within the hospital. Instead, they wanted a professional study, complete with pert diagrams, and so on, to support a formal recommendation that the old hospital complex be upgraded to house the CMPS operation. Obviously, this would require years for fruition and a multimillion dollar price tag. The division pointed out that every concern and disadvantage presented by the MEDDAC had been definitively addressed. The proposed solution would work, could be implemented now, and it did not cost any money. Additionally, "line" commanders were satisfied with the coordinated issues, and the division commander wanted the profile issue resolved now. Reluctantly, the MEDDAC was obliged to approve the Division proposal. That was done on 14 January 1988, and the proposal was implemented on 25 January 1988.

Implementation.

To minimize confusion and efficiently bring the propsal on line, the CMPS operation was implemented in two phases. Phase I was implemented 25 January 1988. This was a morning operation that medically inprocessed all incoming soldiers. Between 0700-1100 hours, Monday through Friday, the replacement company transported (and returned) 25 soldiers each hour to the CMPS for medical inprocessing. Noted deficiencies--immunizations, periodic exams, over-40 physical exams, aviation exams, and so on--were corrected.

1100-1230 hours was a deliberately programmed "buffer" which allowed the CMPS to respond to contigencies--seasonal peaks in replacement flow; particular unit POR requirements; and other medical physical examination requirements--retirement, administrative discharge, separation, airborne, special forces, medical/physical evaluation board, and dependent school physicals.

Phase II was implemented 1 March 1988. This was an afternoon operation that completed annual medical requirements for soldiers already assigned to the division or installation. Between 1230-1530 hours, Monday through Friday, unit personnel transported (and returned) 25 soldiers per hour to the CMPS for completion of annual birth month medical requirements. Also during Phase II, division

medical officers continued to provide family member care; however, it was provided utilizing space in the Family Practice and Outpatient Clinics.

Significance.

As the division predicted, the CMPS operation was highly successful. Medical record flow and screening were very efficient, and patient volume and flow were appropriate. To fully appreciate the impact of the successful CMPS operation, three perspectives should be considered.

From the division's point of view, Phase I of the CMPS operation clearly accomplished its objective--it reduced and essentially eliminated the temporary profile problem. Significantly, this was immediately apparent as shown by the following statistics from the first week of operation.

Day	In-Processed	Profiles Given	Old System Profiles
1	111	6	40
2	59	0	11
3	74	1	23
4	78	0	18
5	70	0	19
Totals	392	7	111

"Up front," at a cost of seven SD medics, the division put 104 soldiers back in the foxhole. More impressive were the statistics following the second week. In two weeks, a total of 894 soldiers had been inprocessed, and only 11 required profiles. Under the old system, 278 would have required profiles on the basis of overdue physicals alone. This significantly improved the attendance and completion of "upfront" division schools, and the division command sergeant major was particularly pleased with graduation statistics from the division's Primary Leadership and Development Course (PLDC). Before the CMFS operation, approximately 33% of the students had temporary profiles and could not participate in or complete all the training.

"Line" commanders were also happy, because they got soldiers from the replacement company that were fully FOR qualified. Additionally, if incoming soldiers did not meet the weight and body fat requirements of AR 600-9, this had already been noted, and these soldiers had already received the required medical evaluations and clearances: therefore, commanders could safely initiate remedial programs the moment these soldiers reported to their first sergeant.

Phase II CMFS operations were also successful--all annual medical requirements were accomplished with "one stop shopping" during the soldier's birth month. This resulted

in convenience for the soldier and more training time for commanders. Additionally, it significantly decreased administrative requirements since all birth month requirements--medical, dental, and personnel--could now be tracked using one computer driven roster.

Centralization of immunizations via the CMPS eliminated the historical immunization bottleneck at subsequent medical POR stations during emergency deployment readiness exercises (EDREs). Additionally, the immunization station of the CMPS finally gave the division a reliable and responsive location for administration of the heptavax immunization program for soldiers on overseas levy to Korea.

Centralization of physical examinations at the CMPS and the afternoon closure of six TMCs allowed the division to use its medical officers more efficiently. Staffing the CMPS and the relocated Eagle Clinic required less manpower than was previously required to staff the six afternoon TMC operations plus Eagle Clinic. Consequently, medical officers were available for other purposes--increased family member care, increased medical platoon training time, and increased refresher training. Additionally, this increased efficiency allowed the division to maintain medical readiness despite continued loss of medical officers through external taskings and reassignments.

Overall, the division solved the temporary profile problem and greatly enhanced its medical readiness. In addition, the division demonstrated to the MEDDAC how increased efficiency and better utilization of existing assets could result in increased productivity and improved patient access to the Army direct care system.

From the family member's perspective, the CMPS operation, relocation of Eagle Clinic, and the TMC closures meant the following. First, more division medical officers were available to see family members: therefore, dependent access to the system was significantly increased. Second, division medical officers saw dependents in the Family Practice and Outpatient Clinics. This gave the medical officers and the family members better access to specialty consultation than was previously available in Eagle Clinic.

From the MEDDAC's perspective, the following were evident. Centralization of physical examinations at the CMPS provided increased efficiency and economy for the medical system since the overlap and duplication inherent in previous decentralized annual testing had been eliminated: i.e.- physical examinations, vision testing, hearing tests, HIV testing, x-rays, immunizations, and other lab work/tests were done one time and carefully documented at a single location. Previously, for example, soldiers had given fasting blood specimens for periodic/over-40 physical exams

and had then been required to have the same specimens drawn again for health risk assessment, or they had been required to go somewhere else and submit another blood specimen for HIV testing, and so on. Additionally, centralization of physical examinations and the programmed "buffer/contingency time" allowed the MEDDAC to expedite physical exams for its own physicians. Significantly, this further reduced the time required to complete physical/medical evaluation boards. Centralization also gave the MEDDAC significant control over immunizations which resulted in better supply economy--particularly with the expensive heptavax. Also, centralization established a base where, theoretically, it would be possible to conduct a computerized medical POR. Additionally, it increased opportunities for the MEDDAC to develop data bases for multiple studies--such as tracking permanent profiles, and to correct chronic administrative and annual inspection deficiencies--such as Master Problem Lists.

The closure of six TMCs allowed the MEDDAC to integrate additional divisional medical officers into the hospital's operation as "free" professional assets. Additionally, the closure returned lab, pharmacy, x-ray, and nursing personnel to the MEDDAC to work against shortfalls. Together, these resulted in increased productivity for the MEDDAC.

This increase in productivity deserves additional comment. First, the CMFS operation significantly increased the average number of daily clinic visits for the installation MEDDAC. Statistically, that is evident from the following quarterly analysis.

Average Daily Clinic Visits-Ft Campbell[3]

	FY 86	FY 87	FY 88	FY 89
10	1444.2	1432.3	1448.8	1529.5
20	1581.2	1544.2	1733.6*	
30	1511.3	1524.5	1665.7	
40	1574.0	1506.6	1659.3	

* CMFS operation started 25 January 1988.

Other clinics in the MEDDAC contributed to the average daily clinic visit total; however, two things should be noted. First, the general quarterly trend was decreasing prior to initiation of the CMFS operation. Second, gains in other areas--Family Practice and Out Patient Clinics--were largely due to the contributions of infused division medical officers. Regardless, a review of the MEDDAC's monthly and annual "Review and Analysis of Hospital Services," clearly shows that gains in other clinics were negligible when compared to the "quantum leaps" in patient visits in areas

directly influenced by the CMFS operation. For example, in FY 87, physical exam and audiology respectively averaged 777 and 737 patients per month; however, after one year of the CMFS operation, they averaged 2,770 and 2,101 patient visits per month respectively.

Second, the CMFS operation significantly increased the MEDDAC's supply dollars. In one year, the above increase in average daily clinic visits was worth $245,738.[4]

Third, the infusion of "free" division medical officer contributions into the MEDDAC's numbers resulted in an obvious increase in productivity per assigned MEDDAC physician. Ironically, Health Services Command praised the MEDDAC's leadership for "their" accomplishment..

Fourth, the increase in productivity helped the MEDDAC regain the respect of the military community.

EAGLE SUPPORT BRIGADE

In the background for this chapter, the author wrote of initial courtesy calls with the major unit commanders and noted that the Eagle Support Brigade (ESB) Commander was upset for two reasons. First, his sick call lasted all day. Second, his family members did not have an "Eagle Clinic:" therefore, they had no reliable direct access to the MEDDAC.

ESB was a garrison unit, and the MEDDAC was responsible for its medical support; however, when the ESB Commander saw what the division had done to help itself, he filed a formal complaint through command channels and directly requested the division's assistance to improve medical support for his unit. The division approach was as follows.

Sick Call Problem.

ESB's inefficient sick call was a function of the two factors mentioned earlier--ignorance and parochialism. Manpower was not a factor--ESB had an assigned physician, a PA, and an organic evacuation hospital with assigned medics. Significantly, the ADTMC model was not in use. Sick call was centralized. Everyone went directly to the TMC which caused the problems previously noted.

The solution was obvious--institute the ADTMC model. Appropriate coordination was made, medics from the organic evacuation hospital unit were trained in the ADTMC model, BASs were set up, and decentralized sick call was started in the BASs using medics under the supervision of the MEDDAC physician and PA. Problems were referred to the TMC for resolution by the physician and PA or for further referral to the MEDDAC for specialty consultation.

Using this approach, the division again solved a chronic problem. Sick call was completed by 0930 hours, and a physician and PA were freed up for use elsewhere in the medical system during the remainder of the day. ESB commanders, first sergeants, and medics were extremely satisfied with the result and roundly praised the "new" system.

Dependent Care Problem.

The division recommended that the MEDDAC use the two freed up medical officers to see ESB family members in the afternoon in the same manner that the division medical officers saw dependents in "Eagle Clinic." The MEDDAC nonconcurred citing a lack of space within the hospital. The division found space in the Outpatient Clinic. The MEDDAC then concurred, and ESB dependents were given direct access to their "Eagle Clinic" on 1 March 1988.

Again, a chronic problem was solved. Again, increased efficiency and better use of existing assets increased patient access to the Army direct care system. Again, commanders, soldiers, and family members praised the new system.

CONCLUSION

In this chapter, the author showed how an installation MEDDAC was not attuned to the needs of "line" commanders and how it was not responsive to the medical readiness needs of a division. The author identified long-standing medical support problems that caused "line" commander frustration and caused the MEDDAC to lose the respect of the community it sought to support. The author then showed how the division helped itself. Without question, resolution of the temporary profile problem and establishment of the CMPS were division success stories.

Unequivocally, the Fort Campbell experience again showed how poor leadership resulted in suboptimal use of existing assets and reduced patient access to the Army direct care system. From the myriad of presented examples, it is also clear that a division and a supporting MEDDAC should be able to work together for mutual benefit--improved patient access for the MEDDAC and improved medical readiness for the division. In the author's opinion, that lesson is worthy of export.

ENDNOTES

1. ADTMC Model-Specifics are covered in Health Services Command Pamphlet, HSC PAM 40-7-21.

2. Center for Army Lessons Learned, Bulletin No. 1-88, pp. 22-23.

3. Health Services Command, Command Performance Summary, A Review and Analysis of 4th Quarter FY88 and 1st Quarter FY89 Command Operations.

4. Computed by a special HSC formula. Application and mathematics verified by COL Joseph A. Thornton, Chief, Department Resourse Management, Walter Reed Army Medical Center, 3 March 1989.

CHAPTER VII

LEADERSHIP

BACKGROUND

The Army Medical Department is at a critical crossroads.[1] Indeed, it is faced with considerable challenges: projected budget and manpower cuts, a growing patient population, unaffordable and rising CHAMPUS costs, low morale, a tarnished image, and critics who question its ability to accomplish its dual missions--maintaining wartime medical readiness and providing peacetime medical care. In fact, the former Army Surgeon General, LTG Quinn H. Becker, said that two of his primary challenges were "to improve the image of the Army Medical Department" and to "uplift the morale of its members."[2] To meet these challenges, the AMEDD needs better leadership.

FOCUS

This chapter will examine AMEDD leadership--focusing primarily on the classic triad of the leader, the mission, and the people. The author will present problems, draw conclusions, and then offer recommendations on how the AMEDD might better address the challenges outlined by LTG Becker.

THE LEADER

Good leaders lead by example. Unfortunately, the AMEDD does not understand positive leadership, the spirit of which is succinctly captured in the Infantry's motto--"Follow Me." In the author's experience, it is very difficult to find a senior lieutenant colonel and above in the Infantry who does not have either a Combat Infantryman Badge or the Expert Infantryman Badge. On the other hand, it is very difficult to find a comparably ranked Medical Corps officer who does have a Combat Medical Badge or the Expert Field Medical Badge. To this author, this shows a continuing de-emphasis on the "go to war" mission of the Medical Corps and a lack of expertise among the AMEDD's leadership.

In Chapter II, the GMO, the author showed that the GMO and TMC OIC could not lead because the formal AMEDD educational system did not train them to do their jobs. Also in Chapter II, the author cited an article by COL Rucker and MAJ (P) Richards called "The Challenge of Leadership Within Army Medicine." The authors had some excellent points, one of which is relevant here; however, this author would broaden their focus--clinic commanders should be clinic/hospital commanders.

"A surgeon must demonstrate appropriate training and current competence before being permitted to perform surgical procedures. It is illogical to have a different

standard for clinic commanders. The AMEDD has approximately 1,300 active duty military physicians at the rank of LTC or COL. This means that over 20% of all Medical Corps officers are in the senior ranks. It should be easy to select residency-trained military physicians with demonstrated clinical, administrataive, and leadership competence to be clinic commanders. If this is not possible one would have to ask why the Army has such a large number of senior ranking physicians on active duty. One would also have to question the purpose of GME (graduate medical education) training programs. Throughout the Army, the raison d'etre for a commissioned officer is the need to provide leadership. This should be true for AMEDD Medical Corps officers."

In Chapters IV, V, and VI, the author used examples from experiences at Tripler, Martin, and Campbell to show that AMEDD leaders did not lead by example and did not demonstrate initiative, innovation, or vision.

Two additional comments should be made on "The Leader." First, the Army realized in 1985 that local initiative and innovation could lead to increased efficiency. Out of this realization came the "model installation program." From that perspective, this author would like to ask the AMEDD leadership why it took until 1988 to decentralize some of the controls on CHAMPUS. Second in 1982, the author and a group of third year OB/GYN residents recommended that a junior resident be eliminated from the Tripler program because that resident could not handle the patient volume that was expected of him. The chief of the OB/GYN department did not agree. He said the problem was unique to Tripler, and the resident in question would never again be exposed to that much stress. In 1986, the author observed

that same individual--now a staff physician and chief of the OB/GYN service at Fort Campbell. This physician was still unable to handle his own patient volume, and now he was expected to manage the service's volume. This physician could not lead by example, and he created significant problems within the OB/GYN service. Ultimately, three frustrated OB/GYN physicians left the Army as a direct result of this officer's inability to lead, or should one say as a direct result of the failure of AMEDD leadership to recognize the problem in 1982. Additionally noteworthy, this chief was a major, and he was not board certified. Under him was a LTC who was board certified; however, this LTC did not elect to be the chief of the OB/GYN service. When this is allowed to happen, one must again ask for the logical purpose of rank in the Medical Corps. In the "line," rank is equated with leadership ability. It should not be any different in the AMEDD.

As a final comment on "The Leader," it is interesting to look at a survey--Current Perceptions of the Army Medical Department by the USAWC Class of 1989.[3] Significantly, 189 surveys were distributed to the Army members of the class and 143 (76%) responded. Officers were asked to comment on various aspects of the AMEDD leadership at their last duty station. Some of the observations are noteworthy. First, only 51.8% were satisfied with the military appearance of

Army doctors, and only 72% were satisfied with the military appearance of of hospital/clinic commanders. Second, 31.5% felt the Army medical facility was not responsive. Third, 35% did not see the hospital/clinic commander at installation social functions, 32.9% did not see the hospital/clinic commander at installation military functions, and only 67.1% felt that the hospital/clinic commander was a member of the "Army team." Fourth, only 62% were satisfied with the leadership ability of the hospital/clinic commander, and only 49% would promote the hospital/clinic commander to the next highest grade. In the author's opinion, this does not speak well for AMEDD leadership--particularly the last observation.

THE MISSION

Good leaders accomplish the mission. The AMEDD is not ready for its wartime mission, and it cannot perform its peacetime mission. In the opinion of this author, this failure is a direct result of poor leadership. For review, one should reconsider the following. First, as pointed out in Chapter II, The General Medical Officer, the AMEDD does not train its physicians for their wartime roles. Second, in Chapter III, it was pointed out that the AMEDD cannot sustain the Airland Battle at the tactical level of war.

Third, it was evident from Chapters IV and V, the Tripler and Martin experiences, that poor leadership resulted in suboptimal use of existing facilities and physicians. Ultimately, this resulted in reduced patient access to the Army direct care system and unnecessary CHAMPUS referral and cost. Fourth, it was grossly evident in Chapter VI, the Campbell experience, that the AMEDD leadership was unresponsive to divisional medical readiness requirements and the medical needs of the community. Unequivocally, this leadership lacked vision and failed to see the inherent advantages of the CMFS operation to both wartime medical readiness and access to peacetime medical care. Additionally, the MEDDAC had no credibility; however, in spite of the AMEDD's standard line, "we cannot possibly do any more," a lot more was done. Significantly, it was done within the normal duty day with existing assets.

THE PEOPLE

Good leaders look after their people. In The One Minute Manager, Doctors Blanchard and Johnson wrote, "The best minute I spend is the one I invest in people."4 Essentially, that is the message of "leadership 101" which is learned by "line" officers in ROTC, etc. The key point is that when you look after your people, they will look

after you, and the mission will be accomplished. Unfortunately, the AMEDD does not look after its people as shown by the following.

Rewards.

In the experience of this author, the "line" does an excellent job of rewarding its officers and formally recognizing their service. In fact, most "line" officers have been awarded several Army Commendation Medals (ACM) before promotion to Major. The AMEDD does not do this well and does not recognize the motivating potential of a timely service award. Two examples are noteworthy. First, an ophthalmologist currently serving at Walter Reed is a lieutenant colonel with 16 years of outstanding service in the AMEDD. His highest decoration is the National Defense Service Medal. Second, the current OB/GYN consultant to the Army Surgeon General is a colonel with over 20 years of service. He is also currently assigned to Walter Reed, and his highest decoration is one ACM. In the author's experience, the most common reward a military physician can expect to receive for dedicated service is another patient from the endless line. Ultimately, this experience leads to burnout or suboptimal performance--especially in the absence of clinical yardsticks as shown in Chapters IV and V. In the author's opinion, this may also contribute to

"moonlighting" where the physician perceives the additional pay as "recognition."

Officer Record Brief (ORB) and Official FICHE.

These are key documents for all military officers. Unfortunately, the AMEDD does not take care of its physicians as shown by the following. First, consider state licensure. This is as important to a physician as "Ranger" status is to an infantry officer. Appropriately, the ORB and FICHE provide the infantry officer ample opportunity to document his "Ranger" status. Unfortunately, similar documentation of state licensure is not authorized. For reasons unkown to the author, the AMEDD feels it more important to use available space in the remarks section of the ORB to document affiliation with the AMEDD Regiment. Second, look at the ORB's civilian education level. It takes four years of dedicated effort to become an MD. Masters degrees can be acquired "on the side" in one year. This disparity of effort is not reflected under the civilian education level (CEL) of the ORB. MDs's are classified as professional degrees and are awarded a "3." Masters degrees are awarded a "2" and other doctoral degrees are awarded "1"--the highest code. This disparity gets even worse in the board certification process. In varies among the specialties, but board certification in OB/GYN requires the

following after the MD degree--a one year internship, a three year residency program, a two year apprenticeship, and successful completion of written and oral examinations--each of which last four hours. It takes approximately four years to acquire "other doctoral degrees" and a CEL "1." It takes ten years to acquire OB/GYN board certification which remains as a CEL "3." This is not right, and the AMEDD should have recognized it long ago. Third, reflect on professional memberships. Specialty board certification and "fellowship" status within that specialty are the culminating endpoints of the formal medical education system much like the senior service college is for the military. In the civilian world, "fellowship" status is a momentous professional milestone--not only does that physician's name appear in national registries for professional referral, but that physician is authorized to indicate that status as a part of the formal signature block after the "MD." In the military, "fellowship" status is ignored. "Fellowship" status is not an authorized entry on the ORB or FICHE. The rationale for this is not understood by this author especially when medical officers can enter one week courses on both the ORB and FICHE--like the Combat Casualty Care Course and the Medical Effects of Nuclear Weapons Course.

Physician Acquisition Programs.

The AMEDD acquires physicians from multiple sources--ROTC, the Health Professions Scholarship Program (HPSP), the Uniformed Services University of the Health Sciences (USUHS), and direct civilian entry. In the author's experience, the AMEDD has done very little to eliminate frictions and ensure equitability among these physicians with respect to rank, obligation, and pay. This has resulted in multiple ABCMR (Army Board for Correction of Military Records) actions where the focus has been on legal positions and not the obvious inequities. Remembering that AMEDD physicians are supposed to be *military* physicians one must ask what purpose is served when the AMEDD brings 40 year old civilians in "off the street" and starts them off with the rank of colonel.

Wartime Essential Skills.

In the author's opinion, the biggest and most recent disservice the AMEDD leadership has done to its people was to convey the message that only certain specialties were important in wartime. In essence, the AMEDD has stated that only the surgical subspecialists, anesthesiologists, and radiologists have critical wartime skills. To recognize these skills and to improve their retention in the Army,

these physicians have been awarded additional bonuses--Incentive Specialty Pay (ISP) and Medical Officer Rentention Bonus (MORB). These bonuses have varied, but the least paid recipient received $28,000 per year if he/she elected for the total option. Unfortunately, family practice physicians and pediatricians did not get these bonuses. Their only reward is still another patient. To this author, the bonus issue is creating unhealthy dissension in the ranks. To start with, all military physicians have a wartime mission. Secondly, if bonus pay was allocated on the basis of peacetime patient volume, hours worked, and direct benefit to the soldier and his family members, then family practitioners and pediatricians would be among the leaders.

General.

In the traditional sense, this author feels the AMEDD has been weak in the following. First, showing interest and visiting their people in the workplace--especially after hours or during weekends and holidays. Second, keeping their subordinates informed. Third, outlining logical career patterns. Fourth, demonstrating consistency. The AMEDD demonstrated support of the Army's weight control and PT programs by eliminating overweight OB/GYN physicians who

could not pass the PT test; however, it then allowed a grossly overweight physician to assume command of a MEDDAC.

THE ARMY ETHIC

Good leaders and individual physicians must be committed to the professional Army ethic--loyalty, duty, selfless service, and integrity. These are not negotiable. Of particular concern to this author is "selfless service." Physicians must put the needs of the service above themselves--there is no place for "careerism," "ticket punching," or "homesteading."

As previously discussed, OB/GYN is the highest category of CHAMPUS referral and payment. To recapture this workload, OB/GYN physicians need to be redistributed on the basis of Army need; however, the OB/GYN consultant to the Surgeon General says this can not be done because the "homesteaders" will leave the service. For example, Fort Ord has five OB/GYN physicians. Four of them are board certified, and three of them have been there since 1977. Other MEDDACs have demonstrated a higher workload and clearly deserve more physicians; however, the OB/GYN consultant is reluctant to move the Fort Ord physicians for the reason stated.

The following also shows that the needs of the service are not being meet--physicians and expertise are inappropriately distributed. There are 169 practicing OB/GYN physicians in the Army. 49 are in 7 major medical centers. Of these, 45 are board certified. 120 are in 36 MEDDACs scattered throughout CONUS and OCONUS. Of these, only 36 are board certified.[5]

CONTRIBUTING FACTORS

In the author's opinion, two things contribute to poor leadership in the AMEDD. First, the AMEDD equates clinical proficiency with competent military leadership. This is a myth. They are not synonymous. Where does the "military" physician who spends his career homesteading in the pure clinical and academic environment of the major medical centers or the "off the street" civilian "colonel" acquire military or leadership training? Military physicians are excellent clinicians, but without appropriate training, they are totally unprepared for their wartime roles as commanders of medical companies, medical battalions, combat support hospitals, etc. Additionally, as shown in Chapter II, The GMO, they are not prepared for their peacetime roles as brigade surgeons, TMC OICs, division surgeons, etc. The AMEDD does have a command selection board, but it does not

adhere to its own standards. For example, the prior Army Surgeon General said that prerequisites for command of a medium/large-sized MEDDAC were DCCS experience, board certification, and military education level "1"; however, a commander of one of the two MEDDACs discussed in Chapters V and VI did not meet two of these requirements.

Second, the AMEDD does not place emphasis on military education in the promotion process, and it does not stress leadership development in its training programs. This was well illustrated in Chapter II, The GMO. Additionally, it was well shown in the military education statistics from the May 1988 Medical Corps 06 promotion board. Of the 50 selected, 0% had senior service college credit, 4% had command and staff college credit, and only 28% had advanced course credit. Significantly, in the survey cited above, 83.9% of the Army officers from the US Army War College Class of 1989 felt that intermediate level Army school (CGSC) should be required for all those who wished to command Army hospitals/clinics.

CONCLUSION

Without question, the AMEDD is faced with tremendous challenges. In the experiences of this author, AMEDD leadership problems cross the spectrum--from the major

medical centers, to the MEDDACs, to the TMCs, to the BASs, and to the foxhole. From nurses complaining of soldiers tracking mud on the emergency room floor, from MEDDAC commanders saying "we can not possibly do any more," and from the system that tolerates it, it is clear that the AMEDD has lost its focus. Now, more than ever, the AMEDD needs strong leadership. The AMEDD leaders that come forward must lead by example, accomplish the mission, look after their people, and espouse the professional Army ethic.

RECOMMENDATIONS

This is a complex problem, and it is made more difficult by the following: bickering within the AMEDD family especially among nurses, physicians, and Medical Service Corps officers; resistance to change; and hostility to critical evaluation. The solution will not evolve easily or rapidly; however, this author feels it should include the following recommendations. First, the AMEDD must kill the myth that clinical proficiency is synonymous with competent military leadership. Second, the AMEDD must tie military education to the promotion process, and emphasize to its people that they are expected to be military physicians. Third, the AMEDD must develop criteria for command and apply them in a consistent manner. Fourth, the AMEDD must

emphasize leader development in all of its training programs.

ENDNOTES

1. "Medical Service at the Crossroads," ARMY, March 1986, p. 22.

2. Ibid., p. 24.

3. Warren A. Todd, COL, Perceptions of the Army Medical Department by the USAWC Class of 1989, Questions: 24, 59, 61, 63, 64, 70, 71, 74, 99, 100.

4. Kenneth Blanchard and Spencer Johnson, The One Minute Manager, p. 63.

5. OB/GYN Consultant to the Surgeon General, Roster of OB/GYN Physicians, July 1988.

CHAPTER VIII

CONCLUSIONS

The fundamental conclusion of this individual study project is that the AMEDD product is flawed. The author focused on three critical areas--"go to war" medicine, peacetime medical care, and leadership. Conclusions in each area are as follows.

"GO TO WAR" MEDICINE

Chapter I-General Medical Officers.

1. Contrary to Secretary Carlucci's guidance, wartime medical readiness is not the AMEDD's number one priority, and the AMEDD has placed very little emphasis on division level "go to war" issues.

2. The AMEDD has paid very little attention to the unique aspects of military medicine and to the general medical officers (GMOs) it sends to be its ambassadors with the "line." "Line" assignments are not career enhancing for Medical Corps officers: therefore, they are reserved for GMOs--rejects from the formal academic environment who are not in the mainstream.

3. The AMEDD does not train its interns or residents to function as unit medical officers: therefore, graduates

of AMEDD postgraduate medical training programs are not prepared for wartime medicine. In particular, graduating interns who are assigned as GMOs are not trained to function as unit medical officers.

Chapter II-Aeromedical Evacuation and the Airland Battle.

1. Neither division nor corps can perform their doctrinal mission--division cannot evacuate casualties from the foxhole or battalion aid station, and corps cannot evacuate casualties from division forward support medical companies.

2. As a result, the AMEDD can not sustain the Airland Battle at the tactical level of war.

3. This will be a war stopper.

PEACETIME MEDICAL CARE

1. The AMEDD standard line "we can't possibly do any more" is misleading and false.

2. Poor AMEDD leadership has resulted in inefficient use of existing facilities and manpower. Together, these have reduced patient access to the Army direct care system leading to unnecessary CHAMPUS referral and cost.

3. The AMEDD can significantly increase productivity and patient access to the Army system of direct care via better utilization of existing facilities and manpower.

LEADERSHIP

1. From multiple perspectives--a physician at a medical center and at a MEDDAC, "line" officers at Fort Campbell, and senior Army officers at the U.S. Army War College Class of 1989--, it is clear that the AMEDD needs better leadership.

2. The AMEDD lacks leaders with initiative, innovation, and vision.

3. Leaders that come forward must lead by example, accomplish the mission, look after their people, and espouse the professional Army ethic.

CHAPTER IX

RECOMMENDATIONS

A fundamental premise of this individual study project was that public relations cannot sell a bad product. The author's conclusions show that the AMEDD product is flawed: therefore, innovative public relations are not the solution. If the AMEDD wants to improve how it is perceived in the eyes of its customers, then it needs to focus on a better product. Recommendations in each area of focus are as follows.

"GO TO WAR" MEDICINE

Chapter I-General Medical Officers.

1. The AMEDD must comply with Secretary Carlucci's guidance. Wartime medical readiness must be the number one priority.

2. The AMEDD must change its attitudes and concentrate on sending its best to the "line" to function as its ambassadors.

3. The AMEDD must change the mainstream flow and develop an appropriate balance between clinical and troop medicine for all physicians. The "mecca" image of the major

medical center must be de-glamorized, and the AMEDD must emphasize to all that it is looking for military physicians.

4. The AMEDD must endorse and institute modular training programs for unit medical officers.

5. The AMEDD must emphasize military education and wartime medicine during internship and residency training.

Chapter II-Aeromedical Evacuation and the Airland Battle.

1. HSS planners must augment (even replace) corps' inadequate evacuation assets with logistical assets, deliberately integrate evacuation plans with logistical resupply plans, and plan to use logistical backhaul to evacuate stable casualties from divisional FSMCs.

2. The AMEDD must reassess how it plans to do business in the Airland Battle. HSS planners must change some "mind sets," focus on sustainment imperatives, and get on with the vital sustainment function of "manning the force" during combat.

3. HSS planners must continue to push for increased casualty play in all training exercises.

4. HSS planners must continue to develop the concept of "far forward care."

PEACETIME MEDICAL CARE

1. The AMEDD needs to reassess how it does business. In particular, it must focus on the peacetime mission and remember that it is a CSS unit that must be responsive to the command it supports.

2. The AMEDD must not ask for more facilities and manpower until it maximizes the potential of what is already available. The AMEDD must cultivate initiative, innovation, and vision. It must export local MEDDAC successes.

3. The AMEDD must ensure a more equitable distribution of the workload among its physicians. Performance yardsticks are clearly needed.

4. The AMEDD must take another look at its permissive moonlighting policy--particularly in those specialties that do not meet the acceptible appointment waiting times.

LEADERSHIP

1. The AMEDD must kill the myth that equates clinical proficiency with competent military leadership.

2. The AMEDD must tie military education to the promotion process, and emphasize to its people that they are expected to be <u>military</u> physicians.

3. The AMEDD must develop criteria for command selection boards and apply them in a consistent manner.

4. The AMEDD must emphasize leader development in all of its training programs.

BIBLIOGRAPHY

1. Academy of Health Sciences. Field Circular FC 8-15-1: Health Service Support Operations: Light Infantry, Airborne, and Air Assault Divisions. Fort Sam Houston: 1 August 1986. P. B-35.

2. Arner, Mark C., COL. OB/GYN Consultant to the Surgeon General. Personal Interview. Washington: 3 March 1989.

3. Baldwin, Brian C., MAJ. U.S. Army Medical Evacuation Conference. Issue No. 87-1. Fort Rucker: 1987.

4. Bellamy, Ronald, COL. "How Shall We Train For Combat Casualty Care." Military Medicine, Vol. 152, December 1987, pp. 617-621.

5. Blanchard, Kenneth, and Johnson, Spencer. The One Minute Manager. New York: Berkley, 1983. P. 63.

6. Bowen, Thomas E., ed. Emergency War Surgery. Washington: Government Printing Office, 1988. Pp. 195-196.

7. Carlucci, Frank. Report of the Secretary of Defense to the Congress on the Amended FY 1988/FY 1989 Biennial Budget. Washington: U.S. Department of Defense, presented 18 February 1988. P. 283.

8. Center for Army Lessons Learned (CALL). "Priority Issue: Casualty Evacuation." Bulletin 1-86, July 1986.

9. Center for Army Lessons Learned (CALL). Bulletin 1-88, April 1988. Pp. 22-23.

10. Commander, XVIII Airborne Corps, AFZA-MD. "Subject: Priority Issue: Casualty Evacuation." Message. 142100Z August 1986. P. 1.

11. Commander, USACAC, ATZL-TAL. "Subject: Center for Army Lessons Learned (CALL) Priority Issue: Casualty Evacuation." Message. 151818Z July 1986. P. 4.

12. Connor, MAJ. U.S. Army Medical Evacuation Conference. Issue No. 88-12. Fort Rucker: 1988.

13. Consultant Roster. Obstetrician-Gynecologists in the U.S. Army. Walter Reed: 1 July 1988.

14. Goodell, Thomas, MAJ, and Jones, Ronald, MAJ. "Curriculum Design: Operational Medicine." Military Medicine, Vol. 154, January 1989, pp. 36-37.

15. Health Services Command. Command Performance Summary. A Review and Analysis of 4th Quarter FY 88 and 1st Quarter FY 89 Command Operations. Fort Sam Houston: 1988 and 1989.

16. Health Services Command. HSC PAM 40-7-21: Ambulatory Patient Care, Algorithm Directed Troop Medical Care. Fort Sam Houston: 26 June 1985.

17. Hudak, Ronald P., LTC, and Mouritsen. "Improving the Army's Primary Care Delivery System." Military Medicine, Vol. 153, June 1988, pp. 282-286.

18. Kerstein, Morris, DR. "Letter to the Editor." Military Medicine, Vol. 153, October 1988, p. 537.

19. Lam, David M., MAJ, Aeromedical Evacuation, A Handbook for Physicians. Fort Rucker: August 1980. P. 54.

20. "Medical Service at the Crossroads." ARMY, Vol. 36, No. 3, March 1986, pp. 22-24.

21. Medical Support. Army Focus, November 1988, p. 15.

22. Roth, Margaret. "New Surgeon General Finds Little Time, Money For New Projects." Army Times, 14 November 1988, p. 6.

23. Rucker, Tinsley W., COL, and Richards, John, MAJ (P). "The Challenge of Leadership Within Army Medicine." Medical Bulletin, November/December 1988, pp. 9-15.

24. Thomassen, Thomas S., LTC. Ophthalmologist, Walter Reed. Personal Interview. Washington: 3 January 1989.

25. Thornton, Joseph A., COL. Chief, Department of Resource Management, Walter Reed. Personal Interview. Washington: 3 March 1989.

26. Todd, Warren A., COL. Army Medicine--Current Perceptions and Its Use of Public Relations. Thesis. Carlisle Barracks: U.S. Army War College, 31 March 1989.

27. U.S. Department of the Army. Field Manual FM 8-10: Health Service Support in a Theater of Operations. Washington: 2 October 1978. Pp. 4-1 to 4-4.

28. U.S. Department of the Army. Field Manual FM 8-55: Planning for Health Service Support. Washington: 15 February 1985. Pp. 4-5 and 5-1 to 5-35.

29. U.S. Department of the Army. Army Regulation 40-501: Standards of Medical Fitness. Washington: 1 July 1987. Pp. 43-46.

30. U.S. Department of the Army. Army Regulation 40-535: Worldwide Aeromedical Evacuation. Washington: 1 December 1975. P. 1.

31. U.S. Department of the Army. Field Manual FM 63-3: Combat Service Support Operations-Theater Army. Washington: 22 February 1985. Pp. 10-4 to 10-5.

32. U.S. Department of the Army. Field Manual FM 100-10: Combat Service Support. Washington: 18 February 1988. Pp. 3-1 to 3-3.

33. U.S. Department of the Army. Field Manual FM 100-16: Support Operations, Echelons Above Corps. Washington: 16 April 1985. P. 8-6.

34. U.S. Department of the Army. Army Regulation 601-142: Army Medical Department Professional Officer Filler System. Washington: 15 August 1986. P. 1.

35. U.S. Training and Doctrine Command. TRADOC Pamphlet 525-50: U.S. Army Operational Concept for Health Service Support, Airland Battle. Fort Monroe: 11 April 1986. P. 2.

36. Vuono, Carl E., GEN. "Sustaining Combat Power." Army Logistician, July/August 1988.