STRATEGY RESEARCH PROJECT

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LEADERSHIP OPPORTUNITIES FOR USAR NURSES: DO WE NEED TO CHANGE THE REGULATIONS?

BY

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ABSTRACT

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This research project reviews the United States Army Reserves (USAR) Army Medical Department (AMEDD) command leadership opportunities for the Army Nurse Corps. The study presents a historical synopsis of the ANC. The study compares USAR AMEDD command positions. It describes what systemic problems that cause AMEDD delays in considering Army nurses for command and selected command-designated positions. It reviews AMEDD's compliance with the following regulations to determine if regulatory changes should include Army nurses in selected command positions: 1983 Army Regulation 40-1, Composition, Mission, and Function of the Army Medical Department; Army Regulation 40-2, Army Medical Treatment Facilities; Army Regulation 600-20, Army Command Policy; Department of the Army Pamphlet 600-80, Executive Leadership; DA Pam 600-4, AMEDD Officer Development and Career Management. The study considers regulations that address leadership competencies appropriate for the future force. Policy changes are recommended for selected AMEDD command positions.

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Many aspiring and successful nurses serve as professionals in the Army Medical Department's (AMEDD) Army Nurse Corps branch (ANC). These professionals are skilled in their specialties and possess excellent leadership qualities developed throughout their careers. The Army nurse (AN) progresses through four phases including both nursing and military milestones of career development: initial, intermediate, advanced, and senior executive phases. When the AN officers reach the advanced and senior executive phases of their careers, they are skilled leaders with the relative rank of lieutenant colonel and colonel.[1] Department of the Army Pamphlet (DA) 600-4 outlines the professional development, qualifications criteria, career management programs, leader development policies, and initiatives for AN officers.[2]

The USAR ANs,[3] in contrast with active Army nurses, receive nursing skills development and early initial leadership development experiences but they are not presented with sufficient opportunities for senior command development. Such development opportunities are necessary for preparation for senior leader positions. The historical and current conditions underlying this discrepancy are complex. This study seeks to elucidate the problem and address the following questions: Are sufficient senior leader opportunities available to members of ANC? Likewise, are such positions equally available to members of ANC-USAR?

This study takes three approaches to explore whether senior and executive leadership positions are limited for ANC officers. First, it reviews the history of ANC. Second, it examines Army regulations specific to leadership and command at senior levels, as well as regulations that address command and leadership competencies

appropriate for the ANC branch. Third, it reviews current data pertaining to ANC leader development.

The study examines the senior leadership opportunities that exist for the ANC. A review of the ANC history is useful in understanding current leadership structure in the ANC. Several senior leaders concurred in interviews that the past, both good and bad, has contributed to current opportunities in the ANC.

Secondly, the study examines Army regulations (AR) specific to leadership and command at senior levels, as well as regulations that address command and leadership competencies for the AMEDD. Several Army regulations promote leadership and command opportunities within specific branches. But the question remains: Are there sufficient opportunities for senior executive and command positions for the ANC officer?

Third, the study reviews current data pertaining to ANC leader development. It examines prior studies on AN leader development to determine whether senior leader opportunities are available to the USAR AN, and what critical leadership competencies are necessary for senior executive and command positions. In essence, a comparison is made of the leadership skills and critical competencies expounded in regulations that govern the selection of nurses for leadership positions in AMEDD. Further, the study describes how the current Leader Development Decision Network Study (LDDN) is used as a forum for addressing current AMEDD senior leadership development issues, and concludes with recommendations for policy changes.

Army Nurse Corps Historical Highlights

Since the focus of this study is the Army Nurse Corps (ANC) officers' leadership opportunities, it is interesting to note from an historical perspective what milestones have been significant in the development and leadership of the ANC. These milestones have served as the benchmarks for the successes, as well as the shortcomings, that are relevant to challenges that the Corps faces today. In spite of limitations and restrictions, ANC officers, although often in small numbers, continue to excel beyond their members to gain opportunities for the entire Corps. In Highlights in the History of the Army Nurse Corps, (1995), BG Nancy R. Adams, Chief, Army Nurse Corps, eloquently states in the foreword that:

> Throughout its history, the Army Nurse Corps has evolved as a world-class center of excellence for military nursing and a benchmark for caring for the entire nursing community. Army nurses have remained at the forefront of change, providing leadership in integrating nursing education into clinical practice. Today, we continue the legacy of a proud heritage by maintaining the highest standards of professionalism in nursing and in military service. Our professional evolution reflects not only the changing requirements of a progressive Army, but also our expanding roles in supporting the health care needs of our nation. While endeavoring to meet the contemporary challenges posed by changes in the military mission, organizational structures, technological advances, and increased services, we have kept our commitment to support the health care needs of the soldier, the family, and other beneficiaries. Our past has prepared us to meet the challenges of today and validates our potential for meeting the health care challenges of the future.[4]

A brief history will give the reader a clearer perspective of the evolution of leadership responsibilities in the ANC. Two months after the Civil War began, nurses were welcomed into the military - on 10 June 1861. The Secretary of War appointed Dorothea Lynde Dix, famed for her work on behalf of the mentally ill, as Superintendent

of Women Nurses for the Union Army. Despite the impressive title, Miss Dix's authority was vague and limited: "to select and assign women nurses to general or permanent military hospitals. But they were not to be employed in such hospitals without her sanction and approval except in cases of urgent need." [5]

Two months later, in August 1861, Congress authorized The Surgeon General to employ women as nurses for Army hospitals at a salary of $12 per month plus one ration. Thirty-seven years later, in April 1898 at the onset of the Spanish-American War, the Surgeon General requested and promptly received Congressional authority to appoint women nurses under contract at the rate of $30 per month and a daily ration. Only four months later, in August 1898 the Surgeon General established a Nurse Corps Division to direct and coordinate the efforts of military nursing.[6]

The first Army regulations governing the Nurse Corps were published in 1899 (G.O. No 133 July 21, 1899).[7] This regulation was published as a circular, approved by the Secretary of War and issued from the Surgeon General's Office. It governed the appointment of nurses and defined their duties, pay, and privileges. The pay was increased to $40 a month in the United States and to $50 in overseas areas. The regulations were reissued on 9 March 1900, with two important changes: appointments were limited to citizens of the United States; and the annual leave was changed to thirty days authorized in each calendar year, regardless of length of service.[8]

In 1901, nurses were appointed in the Regular Army, and the Nurse Corps (female) became a permanent corps of the Medical Department (31 Stat 753 Army Reorganization Act).[9] The Army thus demonstrated a recognized need for women

nurses. A permanent Nurse Corps made it imperative that the status of the Army nurse be clarified and officially regulated. Nurses were appointed in the Regular Army for a three-year period[10], although they were not actually commissioned as officers in the Regular Army until 46 years later, on 16 April 1947.[11]

At this time, Congress directed the Surgeon General to maintain a list of qualified nurses who were willing to serve in an emergency. Therefore, provision was made to appoint a certain number of nurses with at least six months of satisfactory service in the Army on a reserve status. This was the first Reserve Corps authorized in the Army Medical Department. The Army Medical Reserve Corps for medical officers only was established by Congress on 23 April 1908 (35 Stat. 66) and is the forerunner of today's reserve component.[12]

The Army Reorganization Act, June 1920, authorized rank for Army nurses in the grades of 2LT to MAJ. Although the Army Reorganization Act of 1920 allowed Army nurses to wear the insignia of the relative officer rank, the Secretary of War did not prescribe full rights and privileges for nurses equal to that of an officer of comparable grade. It should be noted that the highest rank authorized was Major. In June 1921, demobilization reduced the ANC to 851 nurses with the following relative ranks: 1 Major, 4 Captains, 74 First Lieutenants, and 772 Second Lieutenants.[13] These numbers and ranks were constant through the interwar years.

In March 1942, Major Julia O. Flikke, Superintendent of the Army Nurse Corps, received a temporary commission as a colonel in the Army of the United States (AUS). Her assistant, Capt. Florence A. Blanchfield, received a temporary commission in the

grade of lieutenant colonel, AUS. Although they wore the insignia of their grade, they were denied the pay of that grade. This was the result of a decision by the Comptroller General that these women were not "persons" in the sense of the law under which they were promoted.[14] The nurses were viewed as helpers rather than professionals.

In the early twentieth century, female nurses were not treated as professionals. They faced many obstacles before they were recognized as workers worthy of receiving wages. They struggled against the status quo in an effort to gain wages, status, and respect commensurate with their education, dedication, and professional contributions. As the struggle for relative officer rank was gaining momentum, the nurses were expanding the scope of their roles. As new practices required new or additional skills, nurses saw the need for training and continuing education. In June 1946, a 26 week course in psychiatric nursing was introduced at Brooke Army Medical Center, Fort Sam Houston, Texas. This course marked the beginning of Army-wide education in clinical nursing practice.[15]

A critical milestone was passed when the Army Nurse Corps was established as part of the Medical Department of the Regular Army in 1947, only 50 years ago. The establishment of the ANC in the Medical Department strengthened the need for nurses' training and continuing education. In July 1947, a 56 week course in anesthesiology for nurses was started at four hospitals: Brooke General Hospital, Fort Sam Houston, Texas; Fitzsimons General Hospital, Denver, Colorado; Letterman General Hospital, San Francisco, California; and Walter Reed General Hospital, Washington, D.C.[16]

At the same time, in July 1947, the first course in operating room techniques and management for nurses to prepare for Army certification as operating room specialists was introduced at two hospitals: Letterman General Hospital, San Francisco, California, and Walter Reed General Hospital, Washington, D.C.[17] For the first time, in November 1947, Army nurses attended the hospital administration course at the Army Medical Field Service School. This became a graduate level program in 1951 through an affiliation with Baylor University. The first master of hospital administration degrees were awarded to Army Medical Department officers in 1953. The program has since become the US Army-Baylor University graduate program in Health Care Administration.[18]

Many would note that change was terribly slow. Indeed the Army Nurse Corps and women in the military advanced slowly, amidst much effort and constant struggle. In August 1951, the Defense Advisory Committee on Women in the Services (DACOWITS) was established by the Secretary of Defense to interpret to the public the role of women in the services and to promote acceptance of military service as a career for women.[19]

Sixteen years later, Public Law 90-130, passed by the 90th Congress, in 1967, removed restrictions on the careers of female officers in the US Armed Forces. This legislation granted equal promotion opportunities to men and women. The same legislation removed restrictions on promotions of Medical Specialist Corps and Army Nurse Corps officers. This law provided that the Secretary of the Army could prescribe the strength in permanent grades for AMSC and ANC officers and that the same criteria for promotion and retirement would apply to all Corps in the Army.[20]

An all female Corps during its early years of development, accepted this milestone of the mixed gender Corps, of male and female officers, as a major success. Integrating males who were often seen as "combatant" increased the acceptability of the Nurse Corps as an integral member of the fighting force. However, legislation to accept males in the Nurse Corps had to be introduced several times before becoming Public Law 89-609. The first bill H.R. 8135 was introduced in 1961, and reintroduced as H.R. 1034, in January 1963, as H.R. 420, in January 1965, and as H.R. 8158, in May 1965. Finally, the 89th Congress authorized commissions for male nurses in the Regular Army in September 1966.[21]

This historical review of regulations and milestones reveals how laws serve as a mechanism to translate intentions into realities, however slowly. Clearly, legislation and a succession of Army regulations have been needed to make positive changes and to redress historical or cultural biases against Army nurses. For example, as noted above, nurses were commissioned in 1920, but were not allowed to wear their rank until 1942. Another example, is the introduction of bills to accept male nurses in the ANC which began in 1961 but was not accepted or authorized until 1966. Making laws and passing legislation can open doors to emerging realities or close gates to opportunities.

Army Regulations A Framework For Change

Review of Army Regulations for Army Medical Department. This section of the study has a twofold purpose. First, it describes the composition of the Army Medical Department (AMEDD) and the ANC to better understand the specialty components. Secondly, it reviews AR 600-20 to determine whether there are established mechanisms

within the AMEDD organization to provide opportunities for nurses at senior levels to compete for senior executive and command positions.

Army Medical Department. The mission of the AMEDD is to maintain the health of members of the Army; conserve the Army's fighting strength; prepare for health support to members of the Army in time of war, international conflict, or natural disaster; and provide health care for eligible personnel in peacetime. The AMEDD encompasses special branches that are under the supervision and management of the Surgeon General. The AMEDD provides health services for members of the Army and other agencies and organizations under AR 10-5. Each branch component contributes to accomplishing the mission and functions of the AMEDD in its particular sphere of responsibility. Specifically, these branches are the Medical Corps (MC), Dental Corps (DC), Veterinary Corps (VC), Medical Service Corps (MSC), Army Nurse Corps (ANC), and Army Medical Specialist Corps (AMSC).[22]

The Army Nurse Corps. In the US Army Medical Centers (MEDCEN) and Medical Department Activity Centers (MEDDAC), the Department of Nursing is the administrative unit that provides the organizational framework for nursing activities - to include forecasting and planning for requirements in money, materials, and personnel resources. The Army Nurse Corps (ANC) consists exclusively of the Chief, Assistant Chief, and commissioned officers who are qualified, and registered professional nurses.

Nursing care is based on recognized professional standards of practice. It provides certain functions for which its practitioners accept responsibility. These include both independent nursing functions and delegated medical functions. ANC officers are

assigned to nurse-related professional, administrative, and staff duties that directly contribute to the accomplishment of the AMEDD mission.[23]

Although technical specialty skills are very important in performing the nursing practice mission, other types of leadership skills are needed to function at the administrative level. As noted in AR 40-1, the Department of Nursing is the administrative unit that provides flexibility and modification of practice in response to technological advances and social changes. Nurses are professionally trained to work in many different areas from primary care to specialized nursing. As trained military officers, nurses have management skills that when effectively combined to their nursing skills produce successful leaders. Even so, there is a perceived idea that officers' area of concentration (AOC) limit their capability of successfully commanding at senior levels.

Army Regulation 600-20.

An examination of Army Regulation 600-20, the Army Command Policy and Procedure, establishes a baseline for general command policy and leader competencies. Command policy and actions taken to promote command positions are laid out in Chapter 2, "Command Policies," Army Regulation 600-20, Army Command Policy.[24] This regulation states that command is exercised by virtue of office and by the special assignment of members of the Armed Forces holding military rank who are eligible to exercise command. The privilege to command is not limited solely by branch of Service except as set forth in Army Regulations. This regulation later lists specified and inherent responsibilities of command. Provisions of command are clearly documented for all

Army command positions, except for AMEDD command positions for which this regulation referenced AR 40-1.

Army Regulation 40-1.

Since AR 600-20 specifies that the AMEDD command policies AR 40-1 are an exception to the general command policy, we must review this regulation to determine if the definition of command is different from the definition of command in AR 600-20. In AR 40-1, Chapters 1-9, explains the modification of Command positions of health clinics and dental clinics. Any qualified health care professional officer can provide administrative direction for a health clinic. Such assignments may be made without regard to the officer's basic health care profession. These clinics are integral parts of the Army Medical Center (MEDCEN) or Medical Department Activity (MEDDAC) organization.

This regulation does not restrict administrative, senior, and executive leadership opportunities to a specific branch. In fact, it states that for any small outpatient health clinic any qualified health care professional officer can provide administrative direction. Further, in implementing this policy, due consideration is given to the availability of qualified officers and the size and mission of these outpatient facilities. In certain Army health clinics, the senior position is designated as commander.[25]

Department of the Army Pamphlet (DA PAM) 600-4.

In accordance with DA PAM 600-4, Active Army nurses' operational assignments include a wide variety of executive leadership positions for colonels including: Major Army Command (MACOM) Chief Nurse (for example US Army

Forces Command (FORSCOM) or 18th Medical Command (MEDCOM); Chief, Department of Nursing at large Medical Department activity (MEDDAC) and Medical Center (MEDCEN); Medical Brigade Chief Nurse; Table of Organization and Equipment (TOE) unit Chief Nurse; Chief, Army Community Health Nursing Section; Chief, Preventive Medicine Service at a MEDCEN; Chief, AN Branch at US Total Army Personnel Command (PERSCOM); Chief, Nursing Education Branch: Chief, Department of Nursing Science, AMEDDC&S; Chief Nurse, Clinical Operations Integration, USAMEDCOM; Assistant Chief, ANC.[26] Here again, we address the question: Are senior and executive level leader opportunities available to officers of the ANC?

By comparison, the career development opportunities for the USAR AN in the executive phase are not as extensive as for the Active Army nurse. Although the overall goals and AN officer responsibilities for career development in the Reserve Components (RC) parallel the Active Army, examples of operational assignment opportunities are limited for the RC AN. They include: Chief Nurse and Consultant in Hospital Centers, Medical Brigades, General Officer Commands and a very specific and limited number of positions in the IMA program at the colonel level.[27]

In addition, I further examined whether senior leadership opportunities in AMEDD are available to AN officers. In DA PAM 600-4, it is clearly noted that immaterial positions are available for career development in the AMEDD. Immaterial positions are duty positions which are not identified with or limited to one specific area of concentration(except Medical Service Corps) or medical functional area (Medical Service Corps only), but indicate that any commissioned officer in a particular Corps or area of

concentration (Medical Service Corps only) may fill the position.[28] Guidance for immaterial positions to include officers' life development cycle and career management are available for the Dental Corps, Medical Corps, Medical Service Corps, Army Medical Specialist Corps, and Veterinary Corps. Unlike, the other branches in AMEDD, the ANC is excluded from immaterial positions in the career development life cycle models.[29]

This is inconsistent with current Army policy. The Army has made a total commitment to the development of its future leaders by providing opportunities for them to develop skills, knowledge, and attitudes (SKAs) required to meet the challenges of an increasingly complex, volatile, and unpredictable world. This commitment is realized through a process known as leader development. Leader development is the process the Army uses to develop in its leaders the SKAs needed to be successful leaders, trainers, role models, and standard bearers both today and in the future. Simply put, good leaders are the result of the education, training, and experience they receive throughout their entire careers.[30]

Yet, immaterial positions are not included in the ANC leader development models as outlined in DA PAM 600-4. If all potential senior leaders are to be developed to like standards, shouldn't all AMEDD branches be given the opportunity to gain experiences for a complete career life cycle? With the significant investment the Army has made in its USAR nurse-officers, we can no longer overlook limited AN leader development opportunities and the exclusion of ANs for immaterial positions.

The Leader Development Decision Network (LDDN) is committed to addressing these issues and making recommendation for change[31]. Because of the efforts of the

LDDN, today the AMEDD is changing its executive skills training program to include command competencies for Medical Treatment Facilities (MTF) commanders. The changes introduced by the leader development study group are arguably greater than any other proposed command competencies introduced in the past. The executive skills training program, although still in its draft format, will be offered to all AMEDD branches. This program will obviate the current unwritten policy of excluding some AMEDD Corps from senior leadership positions due to the lack of leader development training. The competencies taught in this program will be incorporated in the criteria for leader selection. Therefore, future selection of the best qualified officers promise to be more equable. At the very least, there will be greater opportunities to prepare for such positions.

Senior Leadership

As we previously discussed, the ANC's struggle for leadership opportunities is not over. One additional aspect of AMEDD branch that differs from other branches is the gender mix. Unlike other Corps with a greater mix of male and female officers, the ANC, still consists of predominately female officers. It is believed that because of the predominance of females in the ANC, the struggles for leadership opportunities and role expansion continue to be slow.

Many researchers relate that progression is slow in organizations that were established predominantly by females. In Gender Power, Leader and Governance, Lahti and Kelly, state that in their review of literature on power and leadership, the words **women** and **feminine** were rarely associated with **power** and **leadership**. **Men** and

masculinity heavily saturated the understanding of **power** and **leadership**.[32] In the Army, the concept of "nurse commanders", even in outpatient clinical settings, is still not an accepted concept in the USAR.

There is a historical linkage of nurses caring for soldiers, a traditionally nurturing, feminine role, and soldiers fighting, an aggressive, masculine role. This is an example of gender bias associated with the nature of duty. The concept of a female leader in the military is not accepted by most combat officers. In the military, the emphasis is on gender-roles rather than gender-free fulfillment of duty and responsibility. The fact is, soldiers, both male and female are all fighters - whether fighting to win the war or fighting to save capabilities and lives of other soldiers - who can then continue to fight to win the war.

Examples from the historical review illustrate how gender biases have impacted on the ANC. When the Nurse Corps became a permanent corps in 1901, the Army demonstrated a need for women nurses. Although recognized as valuable and necessary for support of the armed services, nurses (women) were not recognized as officers. The only officers were males with ranks comparable to their duties and responsibilities. Twenty years later, in 1920, Congress passed legislation authorizing nurses (women) in the ranks of 2LT to Major, although they were not allowed to wear the insignia of their rank. The Secretary of War did not give full rights and privileges (such as base pay) for nurses equal to that of a male officer of comparable grade. When it recognized the need for nurses, the military reaffirmed the need for combat support and combat service support officers with duties and responsibilities other than fighting. Army nurses should

therefore be valued for their unique contributions to the Total Force, and treated as any combat or combat support corps officer. In the past, however, Army nurses were treated differently: they could not wear rank insignia, they did not get the same pay, and promotions were limited to MAJ rank.

Based on the historical record, as well as data on gender and leadership (Lahti & Kelly), in my opinion, this is due to the difference in the composition of the Corps. The ANC, composed primarily of women, was less valued and therefore offered less advancement opportunities and was less rewarded. It was a common perception in previous years that officers, in other corps, especially corps that consisted predominately of male officers, escalated to senior leadership positions and advanced rapidly in various positions of power. This perception is supported by informal communication with members of previous promotion boards. As in corporate world, people tend to select those who are similar (Kanter).[33] In the ANC, which consisted of only women until 1966, the struggle for recognition and power in the form of wages, comparable rank structure, and leadership roles move painfully slowly.

The question again is thus inescapable: Are leadership opportunities limited in the ANC because of gender related issues of the past? AMEDD immaterial command is not considered by the AMEDD to be a gender fairness issue, as the Medical Corps does have and has had female commanders. However, the DACOWITS Committee has requested that AMEDD Study its methods and policies for selecting the most qualified officer to command medical treatment facilities and to develop appropriate training programs and opportunities for all individuals seeking command.[34]

Another way to gain insight is to compare leadership opportunities of females in other Army branches and other Armed services with the female AN officers to determine if they too have had limited leadership opportunities. This was accomplished from a sample group of female officers in the Army War College class of 1997. These are women who have been board selected by their branches as those with senior leadership.

Comparison of Branch and Leadership Positions held by Female Officers

Branch [35]	Position of Commander Chief/XO	Number of Times in Position
AN	Chief	3
AN	Chief	2
AC	CDR	2
	XO	1
	Chief	2
AV	CDR	3
	Chief	1
AV	Dir	1
	XO	1
CM	CDR	2
	Chief	2
MI	CDR	3
	XO	1
	Chief	1
MP	CDR	3
	Chief	1
	XO	1
SP	Chief	2
	Asst Chief	1
	Dir	1
TC	CDR	3
	XO	1
TC	CDR	3
	XO	1
	Chief	1
USAF	CDR	1
	Chief	2
	Dir	1
USAF	CDR	1
	Chief	2
	Dir	1
USAFR	CDR	1
USN	XO	2
	OIC	2

Fig. 1. Representation of positions held by female officers in the AWC class of 1997

potential. Using their biographical summaries as background data and information obtained from personal interviews, a study was conducted to determine leadership opportunities and positions held as senior leaders. Fifteen female officers participated in the study.

This group is an excellent sample for a comparison of career leadership opportunities. These officers are high achievers, LTC and COL selected from the best in their respective Corps. Acceptance in the Army War College sends a message that these officers have sought out many challenges in their careers. Figure 1 illustrates positions held by these female officers while they served in a Combat Support Service Corps. It is noted that most officers other than nurses have had three to four types of senior leadership positions, including executive officer and command. The AN officers have had only one type of senior level position. This survey reveals that AN officers receive only limited opportunities, compared with their cohorts in other branches and services, for preparing for senior leadership positions.

AMEDD Reorganization

The reorganization of the AMEDD into one central medical command with eight Health Services Support Areas (HSSAs) has highlighted the AMEDD's need for development of immaterial senior commanders at the General Officer level. The HSSAs are major subordinate commands of the MEDCOM, responsible for assessing and assisting in total AMEDD training, readiness, and operational control of Army facilities within their respective geographic areas of responsibility. At the highest level, AMEDD

officers are limited to 17 General Officer billets in Medical Service (MS), Army Nurse (AN), Dental (DE), and Medical Corps (MC), Figure 2.

AMEDD General Officers

	MS	AN	DC	MAC
Brigadier General	1	2		5
Major General			1	5
Lieutenant General				1

Figure 2 AMEDD General Officer Billets

It is the Surgeon General's expressed desire to provide the opportunity for the best qualified AMEDD officers to seek and be selected for command and for the AMEDD to have the opportunity to utilize its General Officers in immaterial positions. The present pathway for most General Officers within the AMEDD is through senior command. Experience gained through senior command would facilitate the utilization of AMEDD General Officers in other senior immaterial positions within AMEDD.[36]

Current Research

Research on AMEDD issues is being conducted through the Leadership Development Decision Network (LDDN). Leader Development Decision Network (LDDN) per DA Pamphlet 350-58, Leader Development for the America's Army is an informal action network. For each leader development issue a separate LDDN is established. Members of LDDN consist of those individuals and organizations with the need, expertise, and resources to participate in issue development, resolution, and

execution. Permanent members include the offices of the Deputy Chief of Staff for Personnel (DCSPER), Headquarters Training and Doctrine Command (TRADOC), and the Deputy Commandant, Command and General Staff College. Major Commands (MACOMs), HQDA staff agencies, and other organizations and activities, as appropriate, may join or be invited. Issues and recommendations developed by the LDDN are incorporated in an appropriate Leader Development Action Plan (LAP) for approval and implementation. LAPs are "living documents" that establish objectives, milestones, resources; and assign agencies responsible to oversee execution of the plan.[37]

The Army Leadership Development Decision Network (LDDN) mission is to examine current leader development policies that support development of AMEDD "immaterial Commands and Commanders." The issue of how and whom the AMEDD selects to command its TOE and TAD units became an LDDN issue in September, 1993. As a result, the AMEDD LDDN was charged with developing the concept of an immaterial command policy, resolving the related issues, and designing an implementation plan. From February to October 1994, a series of action officer conferences were held to define and resolve the obstacles, concerns, and issues, and to develop an action plan to implement an AMEDD immaterial command policy.[38]

Current Army Regulation states that Medical Centers, Medical Department Activities, Army Community Hospitals and specific health clinics will be commanded by a Medical Corps (MC) officer and that Dental Activities will be commanded by a Dental Corps (DC) officer. The senior MC or DC will command, even though an officer of another Corps may be the senior officer assigned. An immaterial command would allow

the senior, or most qualified officer to command certain facilities regardless of Corps affiliation.

Leader Development Decision Network (LDDN) commenced a study in 1994 at the direction of the Army Chief of Staff. It was launched to determine whether the Army regulations that restrict MTF command to physicians should be changed. The first Council of Colonels (COC) presented a draft action plan with specific issues to be addressed; COC subsequently approved the revised plan in February 1995. The study was completed in February 1995. The study recommended changes to the regulation that the best-qualified AMEDD officer would be selected to MTF command (COL Hammerbacher, Office of the Surgeon General).[39]

A decision brief was scheduled for the CSA on 21 April 1995, then postponed to September 1995. In September 1995, the CSA directed The Surgeon General to brief the Commanders in Chief (CINCs) on implications and outcomes of the LDDN process, which was completed in April 1996. A second decision briefing was presented to the CSA in May 1996. A decision has not been published at this time. Additionally, The Surgeon General requested from the Chief of Staff of the Army that future Brigadier General and Major General promotion selection boards consider all AMEDD officers for selection to those grades (as branch immaterial officers-not restricted to a single corps of the AMEDD). This decision is awaiting Army Chief of Staff approval.[40]

Recommendations

The findings that senior leadership development opportunities are few for Active Army nurses, and especially limited for USAR AN officers are confirmed through current

studies of LDDN. The recommendations for policy changes offered by the network are clear and succinct for each issue. This study concurs with the following issues and recommendations set forth by LDDN in 1996:

Issue 1: Army regulatory guidance and Army Medical Department (AMEDD) policy do not allow or facilitate implementation of AMEDD Immaterial (AI) commands.

Recommendations: (a) Revise Army Command Policy, AR 600-20, Chapter 2 (2-3 (f-h)), to establish AMEDD Corps Immaterial commands for AMEDD table of organization and equipment (TOE) hospital units. **(b)** Revise Composition, Mission, and Function of the Army Medical Department, AR 40-1, to establish AMEDD Corps Immaterial commands for table of distribution and allowances (TDA) medical treatment organizations (MTOs). **(c)** Revise AMEDD Officer Development & Career Management, DA PAM 600-4 to incorporate AMEDD Corps immaterial commands as outlined in **APPENDIX A,** "Proposed AMEDD Immaterial Commands." **(d)** Develop a marketing plan to facilitate and build consensus for implementation of the AMEDD's command policy change.[41]

New Policy Changes

As I am completing this study, it is clear that the Secretary of the Army, Togo West, Jr., Deputy Chief of Staff For Personnel (DCSPER), Deputy Chief Of Staff For Operations and Plans (DCSOPS), and the Judge Advocate General (TJAG) have all recognized that there are limited senior and command opportunities for Army nurses. The sub-headlines on the front page of the Army Times, April 14, 1997 issue reads, **"NURSES NOW ELIGIBLE TO COMMAND HOSPITALS."** The Army Times

further elaborates in two articles in this issue about new policy changes: The first article addresses how the new policy will end a system under which Medical Corps and Medical Service Corps officers would command hospitals:

> Policy changes open medical commands. Hospital commanders don't have to be doctors anymore. That's what Army Secretary Togo West decided recently when he approved opening hospital and many other Colonel and Lieutenant Colonel-level commands to best-qualified officers of any Army Medical Department Corps. The biggest winners will be Nurse Corps and Medical Specialist Corps officers, who had virtually no command opportunities at these levels until now.[42]

The second article addresses Army Medical Command Billets:

> A new policy open certain Army Medical Department commands to best-qualified officers of any AMEDD Corps. These billets are called "corps-immaterial." Other commands will remain limited to officers of specific AMEDD corps. These billets are called "corps-specific." The policy will apply to 1998 command selection boards as they slate officers for 1999 commands. The Army will issue implementing regulations and letters of instruction to the boards in the coming months. Some commands are centrally selected by Department of the Army boards and placed on the Command Designated Position List (CDPL), while others are selected by AMEDD.[43]

Conclusion

When I started this paper, the Leader Development Decision Network (LDDN) was in the process of reviewing Army Regulations (AR) 600-20, Army Command Policy, and AR 40-1, Composition, Mission, and Functions of the Army Medical Department, and Department of the Army (DA) Pamphlet 600-4 to specifically identify who may command (AMEDD) units. That review has been completed and the findings published (as noted above). Because of these findings the LDDN recommended revision of: AR 600-20, Chapter 2 (2-3 (f-h)), to establish AMEDD Corps Immaterial commands for AMEDD table of organization and equipment (TOE) hospital units; AR 40-1, to

establish AMEDD Corps Immaterial commands for table of distribution and allowances (TDA) medical treatment organization (MTOs); and DA PAM 600-4, to incorporate AMEDD Corps immaterial commands as outlined in Appendix A, "Proposed AMEDD Immaterial Commands."

These policy changes will require associated revisions to the Reserve Component Leader Development Action Plan integrating the immaterial command policy, and realizing the ONE ARMY concept[44] (seamlessly integrating the Reserve and Active components). The LDDN recommended these revisions be incorporated into the Reserve Component Leader Development Action Plan. Just as legislation and a succession of current Army regulations were needed to make the past positive changes in AMEDD and to redress historical and cultural biases against Army nurses, passing this legislation proposed by LDDN can open doors to the emerging realities of senior leadership opportunities for both USAR ANs and Active Army nurses.

The findings of my independent strategy research project agree with the recommendations asserted by LDDN and concludes with an understanding that USAR ANs are still faced with limited senior leadership opportunities. The three approaches taken in this study to explore the availability of senior and executive leadership positions for Army nurses (historical overview, examination of Army regulations, and an analysis of current ANC leader development data) provide additional support to the findings articulated in the LDDN Action Plan.

ENDNOTES

[1] Department of the Army Pamphlet 600-4. Headquarters Department of the Army, Washington, DC, 9 June 1995.

[2] AN is a professional registered nurse, commissioned officer serving in the active Army or the United States Army Reserves (USAR).

[3] USAR AN is a registered professional nurse serving in the Army Reserves.

[4] Carolyn M. Feller and Constance J. Moore, eds., U.S. Army Center of Military History, Highlights in the History of the Army Nurse Corps. Washington U.S. Army Center of Military History, 1995.

[5] Ibid.

[6] Ibid.

[7] HR 11,770 55th Congress. Congressional Record. National Achives: Record Group 112, No. 103. February 6, 1899, 1646. G. O. No 133 July, 1899.

[8] Feller and Moore, 6..

[9] Ibid.,. 7.

[10] The application for continuance of service every three years was discontinued in 1934.

[11] Ibid., 19.

[12]Ibid., 7.

[13]Ibid., 11.

[14]Ibid., 13.

[15]Ibid., 19.

[16]Ibid., 20.

[17]Ibid.

[18]Ibid.

[19]Ibid., 26.

[20]Ibid., 40.

[21]Ibid.

[22]Army Regulation 40-1, Medical Services Composition, Mission, and Functions of the Army Medical Department Headquarters Department of the Army. Washington, DC, 1 July 1983.

[23]Ibid.

[24]Army Regulation 600-20. Headquarters Department of the Army, Washington, DC, 30 March 1988.

[25]Army Regulation 40-1, Chapters 1-9. Medical Services Composition, Mission, and Functions of the Army Medical Department. Headquarters Department of the Army. Washington, D.C. 1 July 1983.

[26]DA PAM 600-4, (3), 75.

[27]Ibid., 77.

[28]Ibid., 98.

[29]Ibid.

[30]Ibid., 2-1a.

[31]AMEDD Leader Development Decision Network.n.p., n.d.

[32]Georgia Duerst-Lahti and Rita Mae Kelly, Editors, Gender Power, Leadership, and Governance, The University of Michigan Press, 1995.

[33]Rosabeth M. Kanter, Men and Women of the Corporation, Basic Books, 1977.

[34] Theodore G. Stroup, Jr., LTG, Deputy Chief of Staff for Personnel and Honorable Sara E. Lister, Assistant Secretary of the Army, Manpower and Reserves Affairs. Forces Development & Utilization RFI #2, Leadership Opportunities & Career Positions. U.S. Army Response (Fall 1996 Conference).

[35]Armed Services branches and corps

[36] AMEDD Command Leader Development Action Plan. AMEDD Center and School. 1996.

[37] Theodore G. Stroup, Jr., LTG, Deputy Chief of Staff for Personnel and Honorable Sara E. Lister, Assistant Secretary of the Army, Manpower and Reserves Affairs. Forces Development & Utilization RFI #2, Leadership Opportunities & Career Positions. U.S. Army Response (Fall 1996 Conference),

[38] Ibid.

[39] Colonel Hammerbacher, Surgeon General Office, AMEDD, interview by author, 18 February 1997, Falls Church, Va.

[40] Ibid.

[41] Ibid.

[42] Army Times, 14 April 1997.

[43] Ibid.

[44] AMEDD Command Leader Development Action Plan

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A

Leadership Opportunities & Career Positions

QUESTION

5. SCOPE AND RECOMMENDATIONSt OF THE ARMY LEADERSHIP DEVELOPMENT DECISION NETWORK (LDDN) STUDY AND THE CHIEF OF STAFF OF THE ARMY'S DECISION.

a. What is an LDDN. Per DA Pamphlet 350-58, Leader Development for America's Army, the LDDN is an informal action network. Its composition varies for each leader developmént issue under consideration. Membership in the LDDN consists of those individuals and organizations with the need, expertise, and resources to participate in issue development, resolution, and exexcution. Permanent members include the offices of the Deputy Chief of Staff for Personnel (DCSPER), Headquarters Training and Doctrine Command (TRADOC), and the Deputy Commandant, Command and General Staff College. Additional members for a given issue could for example, include branch proponents, Major Commands{MACOMs), HQDA staff agencies, and other organizations an activties, as appropriate. Issues and recommendations developed by the LDDN are incorporated in an appropriate Leader Development Action Plan (LDAP) for approval and implementation. LDAPs are `living documents' that establish objectives, milestones, resources, and aSSign responsible agencies to oversee execution ot the plan.

b. The AMEDD LDDN - The issue of how and whom the AMEDD selects to command its TOE and TDA units became an LDDN issue in September of 1993. The mission of the AMEDD LDDN is to examine current leader development policies that support development of AMEDD "immaterial Commands and Commanders."

c. What is an Immaterial1 Command? Current Army Regulations states that Medical Centers, Medical Department Activities. Army Comnmunity hospitals and specific health clinics <u>will be</u> commanded by a Medical Corps {MC) officer and that Dental Activities will <u>be</u> commanded by a Dental Corps (DE) officer. 'The senior MC or DE officers will command, even though an officer of another Corps may be the senior Officer assigned. An immaterial command will allow the senior or most qualified officer to command certain medical facilities regardless of Corps Affliliation. The AMEDD LDDN is charged with developing the concept of an imnmaterial command policy, resolving the related issues, and designing an implementation plan.

d. Synopsis of the AMEDD LDDN progress: In September 1993, the Chief of Staff of the Army (CSA)directed the initiation of the AMEDD LDDN. From February to October 1994, a series of action Officer conferences were held to define and refine the obstacles, concerns, and issues; and to develop an action plan to implement an AMEDD immaterial command policy. The first Council of Colonels (COC) presented a draft Action plan to a General Officer Steering Committee (GOSC) in December 1994. The GOSC retuned the plan with specific issues to be addressed and subsequently approved the revised plan in February 1995. A decision brief was scheduled for the CSA on 21 April 1995, and postponed to September 1995. In September 1995, the CSA directed the Surgeon General to brief the Commanders in Chief (ClNCs) on implications and outcomes of the LDDN proccess, which was completed in April 96. A second decision briefing was presented to the CSA in May 96. A decision has not been published at this time. Additionally, the Surgeon General requésted from the Chief of Staff of the Army that future Brigader General (BG) and Májor General (MG) promotion selection boards consider all AMEDD offiers for selection to those grades (as branch immateriial officers - not restricted to a single corps of the AMEDD). This decision is also awaitíng Army Chief of Staff approval.

e. Previous DACOWITS interest: The fall 1992 conference recommended the Aimy open opportunities for career enhancing assignments. including command of medical facilities and units involved in the delivery of health care, to Armny Nurse Corps (AN) ofiìcers, as well as other AMEDD ofìficers. The committee's concern centered on the fact that, unlike the Army, the Air Force and the Navy allow all rttedical department officers, in addition to Medical Corps {MC), to comtnand medical facilities. The DACOWITS felt this constraint unnecessarily limits career opportunities for the AN corps and other AMEDD officers.

f. AMEDD immaterial command is not considered by the AMEDD to be a gender fairness issue, as the MC does have and has had female cornmanders. However, the DACOWIT Committee has requested that the AMEDD sTudy its methods and poiicies for selecting the most qualified officer to command medical treatment facilities and to develop appropriate training progrsms and ópportunities for àll individuals seeking command, assuring that the necessary skills to qualify are acquired.

g. The AMEDD immaterial command LDDN action plan addresses the emótional and controversial issues that such a major policy decision demand. The implementation of an immaterial command policy will not assure or guarantee a change to the present mix of AMEDD officers who are selected to command, but will ensure that all qualified AMEDD ofiicers will have the opportunity to compete and the best qualified are selected for command.

LIEUTENANT GENERAL THEODORE G. STROUP, JR.
For DEPUTY CHIEF OF STAFF FOR PERSONNEL

27 AUG 1996

HONORABLE SARA E. LISTER
ASSISTANT SECRETARY OF THE ARMY, MANPOWER AND RESERVE AFFAIRS
February 6, 1995 FAx (8□8) 961-5163

B

THE CHIEF OF STAFF

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Army Medical Department (AMEDD) Immaterial Command Leader Development Action,Plan

1. As the Army of the 21 st century prepares to fight and win our nation's wars and to support the nation's interest in operations such as peace keeping, the AMEDD must provide our Army the highest quality health care system, readily available to soldiers and their families. Therefore, developing and selecting leaders to command health care organizations within this system is a vital Army issue. The enclosed AMEDD Immaterial Command Leader Development Action Plan provides the opportunity to select the best qualified AMEDD officers to command, and offers those opportunities to officers previously excluded.

2. This action plan provides the road map to policies needed to broaden AMEDD command opportunities. With appropriate training programs, self-development, and sequential leadership assignments, AMEDD officers seeking command will have the opportunity to achieve that goal.

3. Leader development remains the primary focus for streamlining the Army's AMEDD command and control structure. The goal being world-class quality, cost effective and accessible health care for our Army. The AMEDD Immaterial Command Leader Development Action Plan meets these organizational and doctrinal challenges.

Encl

DENNIS J. REIMER
General, United States Army
Chief of Staff

DISTRIBUTION:
VICE CHIEF OF STAFF, ARMY
ASSISTANT SECRETARY OF THE ARMY (M&RA)
THE INSPECTOR GENERAL CHIEF OF PUBLIC ÅFFAIRS
DEPUTY CHIEF OF STAFF FOR OPERATIONS AND PLANS .
DEPUTY CHIEF OF STAFF FOR PERSONNEL .
DEPUTY CHIEF OF STAFF FOR LOGISTICS
THE JUDGE ADVOCATE GENERAL
CHIEF, NATIONAL GUARD BUREAU

(2) Command of active duty TDA clinics and Medical Department Activity (MEDDAC) facilities will be incrementally opened to members of the same four AMEDD Corps. Smaller clinics will be opened first, providing a training and proving ground for . future MEDDAC commanders. This is the same leader development process that the AMEDD used regarding command by MC officers in the past.

c. Upon approval of the new policy, the following actions will be accomplished:

(1) The AMEDD will develop, in coordination with U.S. Total Army Personnel Command, an AMEDD, immaterial code to enable documentation of immaterial positions in both T O Es and T D As.

(2) The AMEDD, incoordination with the Deputy Chief of Staff for Personnel, will prepare interim regulation changes to accommodate this policy and allow command selection boards scheduled for FY 97 to consider AMEDD officers for immaterial command.

d. This recommended change of policy represents a major policy shift for the AMEDD. The AMEDD is fully committed to ensuring that this paradigm shift will in no way affect the quality of health care provided, nor decrease leadership access to clinical personnel at any level.

e. The following Army Staff agencies concur with these policy changes:

(1) Office of the Deputy Chief of Staff for Personnel.

(2) Office of the Deputy Chief of Staff for Operations and Plans.

(3) Office of the Judge Advocate General.

3. Recommendation. That the Secretary of the Army approve the medical unit command policy change as outlined in paragraph 2b(1) and 2b(2) above, and grant publication authority of interim changes to Army Regulations 600-20 and 40-1.

RONALD R. BLANCK
Lieutenant General
The Surgeon General

APPROVED/ :

Togo D West, Jr. ·
Secretary of the Army

C

General Gordon R. Sullivan
Chief of Staff, United States Army
Room 3E668
The Pentagon
Washington, D.C. 20301-0200

Dear General Sullivan:

I have recently been made aware of the decision to deny Army Medical Department (AMEDD) officers who are not physicians or dentists the opportunity to compete on select AMEDD general officer promotion boards. This decision causes me great concern.

The Fiscal Year 1995 Senate Defense Appropriations Committee report stated the Committee's belief that AMEDD officers other than physicians and dentists should be given the privilege and equity of competing on AMEDD general officer boards. Similarly, during the Defense Appropriations Subcommittee hearings these past several years, the desire of the Gommittee to expand the general officer opportunities for nurses and Medical Service Gorps (MSC) officers was clearly articulated.

I am aware that the AMEDD has been pursuing the Leader Development Decision Network, however this is neither responsive nor timely in addressing these issues. I am particularly concerned about the Nurse Corps officers. These highly educated and experienced officers are systematically being shut out of opportunities for general officer promotion based on very limited or nonexistent opportunities for (1) attending service schools such as the War College; (2) command of Table of Organization and Equipment (TO&E)' and Table of Distribution and Allowances (TDA) medical units; (3) leadership and staff development positions at major command, Army, and joint levels; and (4) decreasing end strengths that do not allow the flexibility to provide leadership development assignments. Without Area of Concentration (AOC) immaterial general officer promotion boards, there is little incentive for the Army or the AMEDD to expand the traditional leadership development opportunities that would make nurses and other AMEDD officers competitive regardless of their otherwise equal or even superior credentials and expertise.

I understand that you have some concerns about the qualifications of nurses and other AMEDD officers for general officer, but I

think this is very important. I urge you to reconsider the Army's decision to deny nurses and other qualified AMEDD officers the same opportunities that the physicians and dentists currently enj oy.

Thank you for your consideration. I look forward to your early response.

Aloha,

DANIEL K.INOUYE
United States Senator

. DKI : bjs

cc: LTG Alcide M. LaNoue, Surgeon General

D

THE CHIEF OF STAFF
March 6, 1995

Honorable Daniel K. Inouye
United States Senate
Washington, DC 20510

Dear Senator Inouye:

This letter responds to your concems about the opportunity for Army Medical Department (AMEDD) officers other than physicians and dentists to compete for AMEDD general officer promotion selection. Along the same lines of your letter, the Senate Appropriations Committee Report 103-321 to the National Defense Appropriations Act for Fiscal Year 1995 asked for the Defense Department to delineate a plan detailing methods to make the currently excluded (AMEDD) offcers more competitive in order to achieve the rank of a one- or two-star flag offcer.

I'm not opposed to your suggestion and am cognizant of the fact that quality medical professionals serve throughout the Army Medical Department. We are now beginning to develop AMEDD officers for possible expanded roles in the future. I have directed the Center for Army Leadership to develop an AMEDD Immaterial Command Leader Development Network (LDDN). Activated in February 1994, the LDDN is continuing to formulate recommendations for inclusion into an AMEDD Leader Development Action Plan. The mission of the LDDN is to identify and formalize leader development policies that support development of branch immaterial AMEDD commands and commanders as we move toward the 21st Century.

I tasked The Surgeon General to designate a chairman, establish milestones for completion, and to ensure all recommendations address the three pillars of leader development~institutional training, operational assignments, and self-development in a format used in the Army Officer Leader Development Action Plan. All AMEDD branches are represented on the General Officer Steering Committee. An initial framework has been developed and I am to personally receive the next milestone briefing on April 21.

My decision to continue with Medical Corps/Dental Corps Competitive Promotion Categories this year was based on continuing Army requirements. The general officer selection boards, composed of medical and line offcers, select the best quality officers for promotion. To make AMEDD offcers other than physicians and dentists more competitive takes time. The steps to do this have started.

Like you, I also want to increase the promotion and assignment opportunities for AMEDD officers other than physicians and dentists. This effort, however, must be tempered by my greater responsibility to man, equip, train, and field an Army that can fight and win the

Nation's wars. Doctors in our AMEDD have been a great strength to the Army throughout our history and substantive change in the qualifications and make-up of the senior AMEDD leadership must be taken carefully and deliberately. We both want this to be a success story and the offcers involved must have every chance to succeed by being properly trained and professionally developed. I continue to believe LDDN is the most prudent approach and will keep you informed of our progress.

Sincerely,

Gordon R.Sullivan
General, United States Army
Chief of Staff