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ALTERNATIVES TO ADDRESS ROLE CLARIFICATION AT THE

U.S. ARMY COMMUNITY HOSPITAL, FORT POLK

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By

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A Problem Solving Project
Submitted in Partial Fulfillment of the Residency Requirements
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During late 1980, an Organizational Effectiveness team visited the Army hospital at Ft Polk. It found that a major institutional problem existed with regard to role clarification at all levels. The team noted that there was a lack of understanding as to who does what, the Commander was doing the staff's work, the weekly admin meeting was not working, physicians were difficult to deal with, laboratory and medical record services were poor, and MEDDAC civilians were not being treated as well as others employed on post. This study examines the abovementioned areas of concern and recommends an effective manner in which to deal with the existing role ambiguity and conflict.

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CHAPTER I

INTRODUCTION

Background Information

Fort Polk is a military reservation in rural west central Louisiana. Its U. S. Army Community Hospital (USACH) is a 159-bed facility accredited by the Joint Commission on Accreditation of Hospitals (JCAH). As the largest military medical treatment facility in the state of Louisiana, the catchment area geographically covers the entire state and 44,000 health care beneficiaries consisting of approximately 14,000 active duty members, 20,000 dependents of active duty personnel, 4,000 retired members, and 6,000 dependents of deceased or retired military personnel.

The immediate surrounding medical community includes three small hospitals within one-half hour's drive, containing 28 beds, 54 beds and 88 beds. The nearest medical facilities with any degree of sophistication are in Alexandria and Lake Charles, Louisiana. They are, respectively, one and one-and-a-half hour drives from Fort Polk.

The current facility is contained in over 100 buildings spread over 105 acres. It is a French-style cantonment complex, originally built within four months in 1941 as a 600-bed hospital.

The resulting structure, which was then considered temporary, has just recently celebrated its 40th year of operation. A new hospital building is currently being constructed with anticipated occupancy in 1982.

Identification Of The Problem

The impetus for this problem solving project evolved primarily from an Organizational Effectiveness (OE) operation conducted during the period 6 November 1980 through 2 December 1980.

The results of the OE assessment produced six themes/ areas of concern. These areas of concern were 1) concern about understanding who does what; 2) commander does too much of his own staff work; 3) weekly administrative meeting not working well; 4) physicians difficult to deal with; 5) laboratory and medical record services are poor; and 6) concern that MEDDAC civilians are not being treated as well as others elsewhere on post. It should be noted that three of the themes possessed the common element of role uncertainty at varying levels and degrees of impact.

Upon the departure of the OE team, they restated that a major problem area uncovered by their visit was one of role clarification at all levels. Their evaluation served to

reinforce the views of the Commander and his Executive Officer that there did exist an institutional problem of role clarification. Subsequently, the administrative resident set out to develop alternatives, including the OE team's clarification program, to address the perceived need of role clarification at all levels and to determine the most feasible alternative.

Conditions Which Prompted The Study

Despite the rigid organizational structure, regulatory guidelines, chain of command, and rank structure in which military hospitals are imbedded, there is still much of the same misinformation, misunderstanding, and disagreement that their civilian counterparts reportedly have. In fact, besides the organizational disruptive influences attributed to complex organizations like hospitals, the dual role of military/professional health care personnel within a federally run and budgeted bureaucracy is an additional variable that, contrary to popular belief, may in fact increase the potential for role conflict and ambiguity.

Such conflict can and does impact upon the delivery of quality care to patients. Some studies have concluded that in hospitals where the staff had a greater understanding of each others work, problems, and needs, there was found higher quality

care.[1] While conflict might foster institutional innovation and progress, the welfare of the patient may be better served with institutional stability and harmony.

There are many underlying causes for conflict within an organization. The OE intervention mentioned previously surfaced concern with respect to role ambiguity and conflict. Consequently, this project was prompted by the recognized need to develop a program to address role clarification at all levels within the U. S. Army Community Hospital, Fort Polk.

Statement of the Problem

The problem was to determine an effective manner in which to deal with the role ambiguity and conflict that exists within the U. S. Army Community Hospital, Fort Polk.

Purpose of the Study

The purpose of this study is to develop, implement and evaluate a Pilot Role Clarification Program for the U. S. Army Community Hospital, Fort Polk. As part of the evaluation, other alternatives which address role ambiguity and conflict will be discussed and a final determination will be made on the best method for implementation.

Assumptions

In the development of a Role Clarification Program it is fully understood that role clarity is just one mitigating factor in minimizing role conflict and role ambiguity. There are countless factors, formal and informal, that contribute to such organizational dysfunctions. Consequently, the various interventions as prescribed in this paper, as well as others in the field of Organizational Development and Organizational Effectiveness, will not result in a problem-free institution. Additionally, there is one basic assumption made by this paper which is that better communication equals less conflict and better patient care. It should be noted also that conflict is not always dysfunctional to the organization.

Limitations

There are several factors which place limitations on the results and implications of this problem solving project and are identified in this section. While these limitations do not nullify the findings or value of this project, the understanding of them aids in placement of this project in proper perspective. Three specific limitations are discussed which include Limitations due to 1) this particular setting, 2) the reliance on personal interviews, and 3) additional resource requirements are generally accepted as a limiting factor with a new or increased mission.

The Hospital Setting

The application of these findings is limited specifically to this hospital in which the research was accomplished. The procedures utilized in this research assessed conditions as they existed at this hospital. However, there are several factors which indicate that these results may be generalizable to other settings.

This hospital is typical of many Army hospitals in several ways. First, obviously, the hospital is a federally budgeted facility. Second, the hospital provides health care to all entitled beneficiaries. Third, its personnel turbulence is characteristic of other Army facilities. Fourth, it is associated with a medical center for tertiary care referral and consultation.

Given these similarities between this hospital and other Army military treatment facilities, the findings may be generalizable to other Army facilities. However, caution should be exercised and investigation of working conditions in other settings should be accomplished before these results are used for prescriptive recommendations.

Reliance on Personal Interviews

The primary means of data collection in this problem solving project was by personal interviews conducted by the Administrative Resident and interviews by OESOs. These

particular inquiry techniques were generally subjective in
nature and consequently must be carefully analyzed to avoid
misrepresentation of the situation. Such nonquantitative,
solicited feedback is nevertheless very important as it is
useful to gather fresh input for the resolution of the problem.

The limitations presented by use of a survey method
such as an interview may be overcome by the development of
more objective measures. However, even objective measures may
be subject to bias and inaccuracies, due to improper design or
utilization of the measurement techniques. Ultimately, multiple
measures and methods should be used to develop valid instruments
to assess working conditions in organizations.

Staffing

Additional resource requirements are generally accepted
as a limiting factor toward the initiation of new programs.
Any new personnel requirements must be supported from within
current manpower authorizations. Should a program require
additional authorizations and requirements to support a hospital-
generated mission requirement, it would be expected to meet with
minimal success.

Scope

The thrust of this project is directed toward the Commander and his key personnel following an OE tenant of working from the top to bottom. Key personnel are defined as those who can "stop, let, help or make" a change occur. This macro role clarification program is intended to serve as a pilot program for this institution, clarify actual roles of individuals at top levels within the hospital, and promote understanding of the value of the program. Upon its completion it will be evaluated as to whether the needs of this organization can be met by this OE intervention method or by other alternatives developed further within this project.

Factors Bearing Upon The Problem

The complexity of the hospital and its multiple power structures, as a result of essentially independent sub-systems and lateralization of power, reinforce the need for support emanating from top to bottom. In a complex organization no single individual has all the power for significant, planned long term change to be effected; all sources of power must be motivated and incorporated into the action.

Previous efforts by the OE consultants to demonstrate the need for a role clarification effort to key personnel were,

on the surface, successful. However, subsequent interviews have revealed several essential key personnel as either being generally disinterested or having an extreme disdain for behavioral interventions. The pilot role clarification program was part of the effort to gain support from key personnel.

Any role clarification program that is developed must recognize and account for the unique problems that will surface with the transition to the new hospital. The change in social density that will occur with the move to the new hospital surfaces a popular held belief that work force social density increases will have dysfunctional effects on individual behavior and attitudes. Consequently, any long-range plan should take the social density increase and its organizational impact into consideration.

Additionally, with the upcoming move to the new hospital and its concurrent tasks, the additional planning and administrative requirements necessitated by a role clarification program will have to be carefully monitored to ensure that appropriate time is being devoted to the program.

Finally, it is recognized that the ultimate success of this program is dependent upon a long range effort with continuous feedback. Any program to address role clarity

within an organization such as this hospital, which is constantly undergoing changes and personnel turbulance, must not be a one shot phenomena.

Objectives

An initial objective of this study was to develop a data base which would be useful in the development and evaluation of the alternatives. Secondly, from the recommendations of the OE consultants, literature research and personal insights gained from the administrative residency, a pilot role clarification program is to be developed, implemented and evaluated for future use. Finally, the third objective is to select and make recommendations as to the specific course of action to reduce the role ambiguity and conflict that exists within the U. S. Army Community Hospital, Fort Polk.

Literature Review

The Hospital as a Complex Organization

Many, if not most, of the problems experienced in hospitals are shaped by their uniqueness as organizations. The organizational makeup of a hospital deviates considerably from the Weberian (classical) model of bureaucracy and, as such, is often categorized as a complex organization. Complex organizations are defined as those organizations which have

1) essentially independent subsystems within them, 2) multiple simultaneous missions, 3) many permeable boundries necessitated by the complex environments to which they must respond, 4) sophisticated technologies requiring highly skilled internal efforts, 5) low structural clarity between subsystems and 6) multiple power structures as a result of essentially independent subsystems and the lateralization of power.[2]

The last characteristic of multiple authority is one frequently mentioned in the literature and is attributed to position power, supported by formal sanctions and professional expertise which is enforced by collegian authority. Several studies have shown that 1) multiple authority disrupts the individual's orientation to his organization or to his profession by requiring him to choose between the two; 2) individuals oriented primarily toward their professional norms are more critical of their organization and more likely to ignore administrative details; and 3) professionals in such organizations frequently experience stress as a result of being caught in the middle.[3]

Thus, the literature suggests that multiple lines of authority are accompanied by role conflict and dissatisfaction for the members and loss of organizational efficiency and effectiveness. Further, it is implied that these dysfunctions

may be necessary concommitants and costs of providing
professional control over the technical aspects of the
organization's activities.[4]

In any event, an enumeration of important charac-
teristics of a complex organization can only give the outline,
the boundaries within which social interaction takes place.
However, those organizational characteristics previously
mentioned as well as others commonly referred to in the
literature, such as the extreme division of labor and
authoritarian nature of the hospital, do affect the role
relationships that develop in a hospital.

Role Relationships

There are numerous examples within the literature
which try to provide a model for studying role behavior by
identifying the relevant social system and locating the
recurring events which fit together in converting some input
into an output. The models that develop range from the very
complex to simple. One of the more simpler and easier role
relationships to understand is the model presented by
Ivancevich, et. al.[5] Role relationships are divided into
expected, perceived, and enacted roles. The expected role
is the behavior that subordinates, superiors and peers expect
an individual in a group to have and can be specified by job

descriptions, position title, or by other directions from the organization. The perceived role concerns what behavior an individual feels he/she should exhibit subject to their perceptions. The enacted role is the way an individual actually behaves.[6]

To the extent that there are differences among the expected, perceived and enacted roles, the likelihood of role stress, conflict and negative conflict on group performance increases. Role ambiguity and role conflict are two terms that have developed that reflect the differences among the three activities. The following model depicts these activities and the outcome of their differences:

Expected Role ⟶ Perceived Role ⟶ Enacted Role

Role Ambiguity   Role Conflict

Lack of clarity with re-   Multiple demands and conflicting
spect to duties, responsi-   directions from two or more
bilities, and activities   individuals in performance of
associated with one's role,   one's role, resulting in increased
resulting in uncertainty,   tension, stress, and anxiety.
and dissatisfaction.

Figure 1. Role relationships. Source: Ivancevich, John M., Szilagyi, Andrew D., and Wallace, Marc J., Organizational Behavior and Performance (Santa Monica: Goodyear Publishing Company, 1977): Page 214.

Role Conflict and Role Ambiguity

The literature on role theory, as mentioned supra, suggests two constructs describing role perceptions: role conflict and role ambiguity. Role ambiguity describes a situation in which there is a lack of the necessary information available to a given organizational position. Essentially, it is a condition in which information is lacking or not communicated. Role conflict is a simultaneous occurrence of two more sets of pressures such that compliance with one would make compliance with the other more difficult. Role theory hypothesizes both role conflict and ambiguity to be negatively related to job satisfaction and performance.

The relationships between employee role conflict and role ambiguity and job satisfaction, propensity to leave the organization, and perceived threat and anxiety are well documented.[7-8] More recent research indicates however that the employee's level in the organization may cause a deviation in previous expected negative correlation between role conflict and job satisfaction. Hammer and Tosi indicated that the nature of positions at higher levels of an organization is primarily one of solving unstructured tasks and problems, thereby making role ambiguity a more crucial source of stress and dissatisfaction than role conflict.[9] Kahn added that the

presence of role conflict should be of less concern to higher
level employees than should role ambiguity because they have
less influence than the sources of role ambiguity.[10]

Research in Role Ambiguity and Role Conflict in Hospitals

A number of research efforts with respect to role
ambiguity and role conflict have been conducted in a hospital
setting. In a study conducted by Alpander on role clarity and
performance effectiveness, it was of interest to note that no
superior/subordinate pairs had a disagreement on the tasks to
be performed. What was disagreed on was the importance of
each task that had to be performed. Prioritization appeared
to be the primary difficulty. The study concluded that there
was a lot of perceptual gap between superiors and subordinates
in what constitutes the subordinate's important task. The
study also found the highest degree of role ambiguity among
administrative as opposed to professional and technical
groups.[11]

Another study by Szilagyi and Sims postulated the
existence of a role ambiguity continuum which revealed that
role ambiguity increased as changes in occupational skill level
reflected increasing managerial responsibilities.[12]

An additional study reinforced previous findings
concerning occupational level and the ambiguity of the job.

In this particular study the administrative group reported the highest level of role ambiguity. Several conclusions were reached: 1) recognition must be given by administration and supervisors alike that an individual's leadership style is not unidimensional, but rather a multidimensional behavioral pattern, emphasizing at least two separate styles: task orientation and employee orientation; 2) the particular leadership style utilized by a supervisor to improve the levels of employee job satisfaction may be dependent, to a large degree, on the nature and requirement of the employee's task, and 3) supervisors at all levels in the hospital must realize that the less well-defined the job, the more the employee will seek task-oriented leadership; and conversely, the more defined the job the less the subordinate will seek task-oriented leadership as adding to job satisfaction.[13]

Methodology

For the analysis, a data base was developed through three general analytical techniques: direct site analysis, inquiry techniques and direct research. The direct site analysis was directed towards overall work flow of the hospital and observation of interdisciplinary interface.

Additionally, an in depth review was conducted of a General Organization Questionnaire, Annual General Inspection

Reports, documented patient complaints, and departmental and

committee minutes.   Inquiry techniques were subjective in

nature and involved non-quantative solicited feedback from

the many personnel that make up the hospital complex.   Direct

research was evaluated research conducted on techniques

employed within the hospital setting to improve organizational

efficiency.

Footnotes

[1]Harry A. Washing, "Communication: A Study on Conflict in Two Hospitals," Health Services Manager, 11 (December 1978): 1-9.

[2]Richard Beckhard, Explorations on the Teaching and Learning of the Managing of Large System Change, unpublished manuscript.

[3]John R. Rizzo, Robert J. House, and Sidney I. Lirtzman, "Role Conflict and Ambiguity in Complex Organizations," Administrative Science Quarterly, 15 (1970): 150-163.

[4]Ibid., p. 153.

[5]John M. Ivancevick, Andrew D. Szilagyi and Marc J. Wallace, Organizational Behavior and Performance, Santa Monica, CA: Goodyear Publishing Company, 1977.

[6]Ibid., p. 214

[7]R. J. House and J. R. Rizzo, "Role Conflict and Ambiguity as Critical Variables in a Model of Organizational Behavior," Organizational Behavior and Human Performance, 7 (1972): 467-505.

[8]R. L. Kahn, D. M. Wolfe, R. P. Quinn, J. D. Snoek, and R. A. Rosenthal, Organizational Stress: Studies in Role Conflict and Ambiguity, New York: Wiley, 1964.

[9]C. Hammer and H. Toni, "Relationship of Role Conflict and Role Ambiguity to Job Involvement Measures," Journal of Applied Psychology, 4 (1974): 497-499.

[10]Kahn, et al.

[11]Guvence G. Alpander, "Role Clarity and Performance Effectiveness," Hospital and Health Services Administration, (Winter 1979): 11-24.

[12]Andrew D. Szilagyi and Henry P. Sims, "An Explotsyion of the Path-Goal Theory of Leadership in a Health Care Environment," Academy of Management Journal, 17 (December 1974): 622-633.

[13]Andrew D. Szilagyi, Henry P. Sims, and Robert C. Terrill, "The Relationship of Leadership Style to Employee Job Satisfaction," Hospital and Health Services Administration, (Winter 1977): 8-21.

CHAPTER II

DISCUSSION

As noted previously, the literature is replete with discussions on the complexity of hospital organization, the relationship between hospital staff and between hospital staff and physicians. Employee job satisfaction, management styles, performance effectiveness, role ambiguity and role conflict are examples of the topics surfaced. Unfortunately, however, the vast majority of these studies have occurred in a civilian setting, thereby not allowing for the addition of the unique variable of a military environment to the already complexing matrix of hospital organization.

The following discussion concerning the current situation, future environment, pilot role clarification program, and alternatives for problem resolution will reflect the impact of operating a hospital within the military environment, and reinforce the need to tailor programs in consideration of institutional unique characteristics.

The Existing Situation

Organization

The U. S. Army Community Hospital (USACH) is one element of the U. S. Army Medical Department Activity (MEDDAC), which, in comparison to other Army MEDDACs, is a large facility considering such performance indicators as medical care composite units, inpatient census, and outpatient visits. The USACH's organization (See Appendix A) is based on MEDDAC Regulation 10-1, Organization and Function Policy, and unlike its civilian counterparts, has a primary mission of the delivery of outpatient care. This ambulatory care orientation is partly responsible for the approximately 700 people that it takes to run the hospital. The staff/inpatient ratio that results is often an issue with civilian administrators until the magnitude of outpatient visits (30,000 per month) is surfaced. Operating a hospital with a dual mission of inpatient and outpatient care in a military environment makes the administration of such an organization most challenging.

Since 1977 the US Army Community Hospital has become increasingly a hospital with family practice as the primary source of ambulatory care. Relatively new to Fort Polk and further as a specialty, the increasing staff of family practice has resulted in gradual staff decreases in such specialties as obstetrics/gynecology, orthopedics and internal

medicine. Growing pains are evident within family practice
and its interface with such specialties as obstetrics/
gynecology and internal medicine. These difficulties are
exacerbated by real imbalances of professional personnel,
shortages of support personnel, and physical plant inadequacy.
Appendix B presents the results of interviews with six family
physicians and 15 nurses, NCOICs and receptionists. The
purpose of the interview was to identify strengths and weak-
nesses in the organization, functions and staffing of family
practice. The organizational turbulence within Family Practice
and its interface with the remainder of the hospital was plainly
evident.[14]

Besides Family Practice, there are nine other separate
organizational entities which provide for ambulatory care in
a clinical setting. They are the Community Mental Health
Activity, Division Mental Health Activity, Preventive Medicine
Activity, Departments of Medicine, Surgery, Psychiatry, Primary
Care and Community Medicine, Nursing and Dentistry, Ambulatory
Nursing Service and Social Work Service. As separate organiza-
tional entities, the chiefs report directly to the Chief of
Professional Services. This departmental rather than functional
chain of command is conducive to organizational dysfunction as
the following discussion will indicate.

As an example of the organizational complexity of the hospital, the noncommissioned officers in charge (NCOIC) of various clinics throughout the hospital offer a graphic example of the multiple authority channels that exist (See Fig. 2).

Organizational Element	Individuals by Position
Nursing	Clinic Head Nurse NCOIC Ambulatory Nursing C, Ambulatory Nursing Service
Departmental/Clinic Chief	Individual physician responsible for treatment
Department of Primary Care and Community Medicine (DPC&CM)	Chief, DPC&CM
Clinical Support Division (CSD)	C, Outpatient Support Branch C, CSD
Medical Company	CDR; 1SG
Headquarters	CDR, XO, CSM

Fig. 2. Multiple authority channels that NCOICs of clinics face.

It is not uncommon to find a clinic NCOIC who must divide his/her loyalty between four or more organizational elements and up to 13 individuals. It doesn't take much imagination to realize by the current organizational structure it is difficult to affix responsibility. Without clear cut lines of authority and responsibility, anyone can claim credit, but no one has to accept the blame. The existence of such an organizational structure is not surprising when considering

the organization, its setting, and its departmental rather
than functional chain of command. Additionally, the multiple
channels of authority are particularly sensitive in a military
environment that has a rank structure, chain of command and a
supporting judicial system.

In addition to the existence of multiple authority,
there is also a stratification system which has consequences
for patient care and is particularly evident in Department of
Nursing. In addition to the Chief (Colonel) and Assistant
Chief (Lieutenant Colonel), there is a Chief, Ambulatory
Nursing Section (Lieutenant Colonel), and two nurses (Lieutenant
Colonel and Major) who have responsibility for four wards
apiece. Additionally, the last three individuals have master
sergeants as assistants, not including the Chief Wardmaster.
The wards each have a clinical head nurse and additional military
and civilian staff nurses. Such stratification of nursing
organizations has been demonstrated in some hospitals to be an
influential factor in contributing to less than optimum patient
care through interrupting communication necessary for adequate
teamwork and inhibiting the amount of psychological support
given the patient.[15] While the latter may not be applicable
to this facility, the interruption of vertical and horizontal
communication may have merit based on general observation and
personal interviews.

Staffing

To complicate the aforementioned organizational problems are the shortages, imbalances and inexperience of the hospital staff that exist. The physician staffing irregularities are perhaps the most publicized. Two and three physician services such as orthopedics, general surgery and obstetrics/gynecology often experience staffing problems simply due to their few numbers. For example, general surgery has, on numerous occasions during the past year, had only one general surgeon to cover periods up to six weeks in duration. The physician staff also has a high degree of personnel turbulence. To date, only four of the 34 assigned physicians have been stationed a Fort Polk for more than two years. Such personnel turbulence is not conducive to smooth functioning of the hospital, and unfortunately is more the rule than the exception. Additionally, the majority of physicians who arrive at Fort Polk come directly from their residency, which is normally at a large MEDDAC or MEDCEN having accompanying ancillary services necessary for intensive training programs. Consequently, they have little knowledge of the Army, let alone experiencing direct interface with a division post. When confronted with less than optimal conditions that the individual cannot easily correct, such as inadequate ancillary support, a 40 year old cantonment hospital and finite health care resources, there results an imbalance

between demand and capacity. Should the individual view this
failure to meet demands as being serious, stress occurs.
Appelbaum advocates that resulting stressful events trigger
the "fight or flight" syndrome - a primitive physiological
response characterized by increases in metabolic, heart, and
respiration rates, blood pressure, and muscle responsiveness.[16]
While this syndrome was useful in fighting or fleeing an enemy
in prehistoric times, its usefulness is limited in resolving
the conflicts imposed by modern organizational life, and at
its extreme may pose a health hazard to the individual.

It should be mentioned that the aforementioned personnel
turbulence, shortages and inexperience are evident throughout
the organization. However, the degree and combination varies
to a lesser degree with the other staff - Medical Service Corps,
Army Medical Sepcialist Corps, Army Nurse Corps and enlisted
members.

A Common Theme

As previously mentioned, the OE operation conducted
in November and December surfaced a number of issues. Twenty-
one individual interviews of personnel from the Commander to
clinic NCOICs were conducted. These interviews, coupled with
general observation, review of recent AGI report and patient
complaints produced six themes. The six themes and supporting
quotes were:

(1) Concern about understanding who does what.

"Responsibilities on wards and in clinics are unclear."

"No written guidelines for staffing procedures."

"As Chief, I have no control over my people."

"Need delineation of responsibilities."

(2) Commander does too much of his own staff work.

"Commander should not be secretary for the doctors- he should direct them to appropriate staff agency."

"Commander micro-manages. Memos should go to about five key persons."

"Commander is doing CPS's job."

(3) Weekly administrative meeting not working well.

"Meeting is non-productive with commander there."

"People don't talk freely (at meeting) with commander present."

"Everyone passes with commander there which makes it difficult for COL Barber to know what's going on."

(4) Physicians difficult to deal with.

"Some physicians flat refuse to do things. You can't put them in jail for 30 days or you'd lose a physician for 30 days."

"Quit treating doctors as prima donnas in the name of recruiting and retention."

"Physicians go right to commander instead of appropriate staff officer."

(5) Laboratory and Medical Records services are poor.

"Terrible! The wait is too long." (Ref Lab)

"Records are a problem. Family practice should keep the records of patients they serve."

(6) Concern that MEDDAC civilians are not being treated as well as others on post.

"Downgrading of slots really hurts - people move to better jobs on post."

"Nothing is happening with regard to hiring civilians."

"No money for off-post civilian training."[17]

As can be seen, three of the themes possessed the common element of role uncertainty at varying levels and degrees of impact.

The OESO's conclusion regarding the degree and level of role uncertainty within the hospital comes as no great surprise. In fact, if anything, considering that they had very little interface with the Department of Nursing, the problem may be of greater magnitude than they envisioned. Their recommendation to conduct a role clarification program is certainly a valid one, however, their emphasis on a long range program, 18 months, would be extremely difficult to

maintain in view of the personnel turbulence that is inherent
to military organizations. As the following discussion will
reveal, there is little, if any, effective role clarification
that occurs on a formal basis, hence reinforcing the need to
address some effective means to reduce the degree and level
of role uncertainty.

Present Orientation Efforts

There are a number of installation and hospital
programs that provide individuals with an orientation to the
post, hospital and respective jobs. The Commanding General of
Fort Polk provides an enlightening introduction to all assigned
personnel as to the mission of the Army and the soldier's role.
An additional effort to orient hospital personnel to the post
is the revamped program formerly known as "Operation Get
Acquainted" just recently implemented to provide newly assigned
doctors an appreciation of the 5th Infantry Division (Mechanized)
and Fort Polk mission. (See Appendix C)

The hospital efforts with respect to orientating
newly assigned personnel are prescribed in MEDDAC Regulation
40-38, Inprocessing Military Personnel. Sponsors are assigned
to assist the new personnel (E-6 and above) with inprocessing
and familiarization with hospital, post and surrounding area.
A new personnel orientation is conducted once a month and
represents the only formalized interdisciplinary approach to

hospital orientation. Appendix C contains the Letter of
Instruction (LOI) for New Personnel Orientation. Unfortunately,
the program has not generally been well received by old and new
staff alike. The staff who have responsibility to partake in
the briefing have, over a period of time, begun to take short-
cuts to minimize their time from the office. Originally, all
the briefers were at the orientation for the entire time
(generally more than two hours) which, in some cases, was
disproportional to the time they briefed (five minutes).
Consequently, the briefers try to guess when their turn comes
up. The end result is that they are either just in time, or
late, or at the extreme forget to show up. The fact that
there is not an established, written agenda with specific times
delineated for the briefers may be partly to blame. As to the
newly assigned civilian and military personnel, it would seem
that civilian attendance is much greater than military.
Additionally, there appears to be no mechanism to ensure that
personnel attend. Comments which have been made by individuals
who have attended the program are summarized as follows: 1)
No handouts describing sequence of events and speakers, 2)
Appears to be more a lecture than an orientation (little chance
to ask questions), 3) Too long, 4) Some speakers appear to be
poorly organized, or take fifteen minutes to say five minutes
worth of comments, 5) Details of subject matter vary from

speaker to speaker, 6) A waste of time, 7) The intent is good, 8) Better than nothing, 9) The Commander's presence is appreciated, 10) Where are the doctors? The last comment prompted a review of the available signature sheets. Since July 1980, eleven ANCs, five MCs and five MSCs have attended. As to total numbers, it was plainly evident that many new personnel were not attending the newcomers briefing. Besides the centralized briefing, the following occurs: 1) Chief of Professional Services will be responsible for the professional orientation of all Medical Corps officers, 2) Chief, Department of Nursing, is responsible for orientation of all Army Nurse Corps officers, 3) The Executive Officer is responsible for the orientation of all Medical Service Corps, Army Medical Specialist Corps and Army Chaplain Corps officers and 4) The Command Sergeant Major will contact the senior NCOs' sponsor to assist the individuals in processing. Of all these orientations, there is only one formalized program which is conducted by Nursing Education and Training (See Appendix C). The program itself appears to be an excellent one. However it, along with the informal orientations of the other Corps, is missing an integrative approach to address the roles of others outside their work space and how to interface with them. Orientations, in summary, appear to be of singular purpose with little regard for the"health care team" perspective.

Besides the orientations that occur upon arrival at the hospital, there are intermittent opportunities to receive continuing education offered by Civilian Personnel, Nursing Education and Training and other professional staff meetings. Subject matter may range from short briefings to physicians on medical air evacuation, to a recently held role clarification workshop for head nurses. However, there is little coordination involved and little initiative taken from within the hospital to develop programs addressing such institutional needs as role clarification. However, again these efforts, with the exception of the hospital's concerned patient care class, involve only one discipline. There appears to be no guiding force to ensure an interdisciplinary approach to training.

PILOT ROLE CLARIFICATION WORKSHOP

Initiation

The initial efforts that were involved with the development of a role clarification program were: 1) To determine who were the key staff members (those individuals within the organization who could stop, make or let things happen); 2) Establish the need for role clarification and obtain the key personnel understanding of the need; 3) Conduct actual role clarification workshop for key personnel which will clarify actual roles of individuals at top level within MEDDAC, provide personal insight/ experience basis for

decision making and planning, and finally promote understanding of the value of the program.

Preparation

With guidance provided by the Commander and Executive Officer, key personnel were decided upon. To assist in the conduct of the macro role clarification program, the Post OE staff was contacted. The Post OE staff had the previous year conducted a General Organization Questionnaire (GOQ) and, therefore, had some prior contact with the hospital.

The Post OE staff officers agreed to facilitate the seminar at a subsequent meeting with the Administrative Resident and Executive Officer. At this time specific guidance was provided and agreed upon as to date, location, participants, and a general outline of the seminar. It was decided the seminar would be held at a local motel to provide for a neutral setting, away from the hospital, on a Saturday to preclude work related interruptions.

The participants were officially notified by a letter from the Commander (Appendix C). As can be seen in the sample letter, it outlined the purpose of the conference, the general manner in which it would be conducted, the other participants, and the preparation which would be demanded of the participants. The letter was very carefully designed to properly prepare the participants in order to provide for a productive outcome.

Execution.

Appendix D contains a copy of the after action report of the Role Clarification Workshop conducted on 21 March 1981. The document presents a general accounting of what occurred during the workshop and provides a summary of the participants' assessment of the workshop.

Evaluation.

As previously alluded and as part of the role clarification workshop, a questionnaire was provided to the participants to obtain feedback on the workshop and on the key personnel's perception as to the value of incorporating the program as a MEDDAC program.

The participants were first asked to rate the effectiveness of the workshop on a scale of 1 - 10 with 10 being the most effective. The responses ranged from ratings of 7 to as low as 3. It was interesting to note that two of the three persons responding at the lowest level were individuals who were involved in the initiation of the project and were fully cognizant of the intended purpose of the program. The third person from the onset was opposed to unneeded behavioral exercise to promote organizational efficiency.

Examining the response to "What didn't you like about?" the personal conflict which was mentioned was the by-product

of personal difficulties between participants developed prior
to the workshop. The workshop provided a medium to further
surface these tensions. Unfortunately, side discussions of
little bearing on the subject resulted.

Spontaneous ligitimate concerns that developed during
the exercise did not receive adequate attention as time began
to play a role. The emphasis on MEDDAC Regulation 10-1 often
was drawn upon as the panacea, thereby addressing only roles
from an expected perspective and not one of enacted or perceived
roles. With respect to utilization of the workshop within the
participants respective areas of responsibility, the responses
were mostly noncommittal. Of those that were affirmative,
there was a redirection of the role clarification effort
towards someone else.

Throughout the questionnaire the responses were
centered around the disappointment that the goals of the
conference were simply not realized. Admittedly, some of the
expectations that were developed were unrealistic, given the
time constraints, but nevertheless they were still problems
which were not properly addressed to someone's satisfaction.

From the questionnaire and personal observation there
were several conclusions reached. The conduct of the role
clarification workshop was less than optimum for a number of
reasons. First, the three OE facilitators failed to maintain

control and did not exercise proper supervision in the initial phases of the workshop so critical to the final outcome of the workshop. Besides the General Organization Questionnaire (GOQ) survey the previous year, the OE facilitators had no previous experience with OE interventions within medical organizations. Their lack of understanding of the medical complex was immediately evident when they addressed the participants as "doctors." Following this major faux pas, it was further evident that they, having military backgrounds of combat arms, were unaccustomed to the fiery discussions that ensued. Clearly out of their element they were unable to determine what expectations were reasonable and attainable, unable to retain control and steer the discussions in the right direction.

The Strength Development Inventory, while being interesting, was of little value in relation to the amount of time expended. The inventory went beyond the scheduled time and effectively consumed the morning. As a result, the primary purpose of role clarification was given less time to be developed.

Finally, it was apparent from the workshop that there was, in fact, a great deal of role ambiguity and role conflict in evidence among the key personnel, which was not adequately addressed. The degree of ambiguity did appear to reinforce

previous findings which suggested that it increased as
individuals' managerial level increased. On the other hand,
a subjective opinion is that at least in this gathering the
professional group, as opposed to the administrative group,
had the highest degree of role ambiguity which is counter to
Alpander's findings. However, the degree of ambiguity
demonstrated must be couched in terms of the participants'
personalities and experience which, in turn, would place
the problem of role ambiguity in proper perspective.

Lessons Learned.

The following are lessons learned from this particular
workshop and general comments which should be considered in
any future role clarification endeavors:

1. It is imperative that the participants be
cognizant of the intended purpose of the workshop.

2. With that in mind, participants' expectations/
goals should be established. Careful attention must be paid
to this effort to preclude the establishment of milestones
impossible to achieve. Some negotiation (combining, eliminating
or fragmenting) may be necessary.

3. Expectations/goals should be expressed in such
terms that there are some tangible means to measure their
accomplishment.

4. Location of the workshop is a significant factor. A neutral setting away from telephone calls or visitors is important.

5. Keep the workshop simple and to the point.

6. The facilitators must be medically experienced. The organizational relationships (informal and formal) found within a hospital are too diverse and complex for the uninitiated.

7. To sustain the program and yield self-sufficiency, the facilitators should come from within the organization.

8. The number and mix of personnel within the workshop should be carefully selected and restricted to as few as possible.

9. Role clarification efforts are particularly important upon arrival to the unit or change in jobs. (Transition workshops)

10. With respect to role clarification efforts, it is the opinion of this author that first priority should be given to one's own role in an organization and that of his/ her superiors and subordinates. Following that, an effective role clarification on an interdisciplinary level may be attempted.

11. Continual feedback is essential.

12. Such OE interventions as role clarification workshops will not result in a problem-free institution.

FUTURE ENVIRONMENT

All of the technical complexities of a large hospital of the 1980's are present, to include the added dimension of construction of a new physical facility scheduled for beneficial occupancy in the fall of 1982. With the move to the new hospital the dimensions of job characteristics, role stress, work satisfaction and functional interaction will be affected. A number of new concepts will be instituted with the move to the new hospital. Modular clinic, materiel distribution system, surgical case cart system, and new communications system are examples. These particular changes have been identified by the New Hospital Project Group and are in the process of being addressed. Besides institution of new concepts of operation, the move will result in a significant decrease in office space and distances between offices, departments and wards. The actual square footage will be reduced from that in excess of 400,000 square feet to that of 350,000 square feet. The resulting social density increase has the potential for dysfunctional effects on individual behavior and attitudes. However, as has been pointed out, the nature of the work performed by employees must be

considered in investigating social density changes. One such
study suggested that, when moving from one facility to another,
the nature of the work, the needed interactions for effective-
ness, and the potential impact on job characteristics of social
density changes should be carefully considered in planning
efforts.[18] It may be surmised from these studies that role
relationships may be modified in some manner, consequently any
programs to address role relationships should be cognizant of
the potential for role changes with any moves, such as will be
experienced by this hospital in the very near future.

Criteria

The criteria used to compare and contrast the alterna-
tives are: 1) Role ambiguity and conflict There should be
in evidence in the system (alternative) formal mechanisms to
address role ambiguity and conflict as it exists between
supervisors/subordinates and co-workers; 2) Employee satis-
faction There should be some indication of an actual or
potential impact upon employee satisfaction (job, organization)
as measured by personal interviews, periodic employee
questionnaires, personnel complaints, and personnel turnover
and absenteeism; 3) Timeliness The system should have
provisions for initial application within the first few months
of an individual's arrival so both the individual and organization

can benefit from an individual's orientation to his/her work
environment and to avoid undue trauma resulting in "flight or
fight" syndrome from lack of information; 4) Interdisciplinary
Information exchange between professional and administrative
elements of the hospital; 5) Manpower   The personnel require-
ments and efficient utilization; and 6) Complimentary of the
new hospital   onsideration of the upcoming move to the new
hospital should be present.

Alternatives

The following are three suggested alternatives to address
the role ambiguity and role conflict that exists within the U.S.
Army Community Hospital, Fort Polk:

1. Maintain status quo.

2. Implement the OESO's Role Clarification Program.

3. Heuristically improve the existing system by
confronting the current problems, making modifications of the
system, and improving upon it until it optimizes within the
limits of its components.

A simple comparison of the alternatives is presented
in Figure 3. The criteria measurements use the current situation
as a base. It must be emphasized that, as well as having visible
support from the top of the organization for any one of the
alternatives, its success is also dependent upon the support
and the cooperation of the staff.

CRITERIA	Alternative One (Status Quo)		Alternative Two (Role Clarification Program)		Alternative Three (Heuristically Improve the System)	
	PRO	CON	PRO	CON	PRO	CON
Role Ambiguity and Conflict		There is no evidence of formal programs to reduce.	Offers formal mechanism; decrease		Offers formal mechanism; decrease	
Employee Satisfaction		There is evidence of low employee satisfaction.	Improve		Improve	
Timeliness	Orientation programs are early.	Low participation preventing timely approach.		Personnel turbulence (PCS) diminishes returns; Program would not reach personnel soon enough.	More responsive (within two months)	
Interdisciplinary		No hospital formal program.	Provides for multiple channels of info exchange.		Provides multiple channels of info exchange.	
Manpower		Staff feels current orientations misuse of their time.		Training requirements for facilitators.	Utilize in-house consultation.	Greater demands on professional and administrative time.
New Hospital	New Hospital Project Group (NHPG)	No evidence of transition for new personnel.	Reinforce NHPG		Reinforce NHPG	
Acceptance		Mediocracy			More likely to receive support.	

FIG. 3. Comparison of Alternatives by Criteria

Alternative one, maintaining status quo, represents acceptance of the role ambiguity and employee dissatisfaction that have been evident within the organization. The only advantages to alternative one are namely that it does provide some orientation to the hospital within two months after one's arrival (although many do not take the opportunity), the New Hospital Project Group does provide a great deal of interchange about the hospital, and attempts to foresee and resolve problem areas in the transition to the new hospital. Additionally, no additional manpower is needed. The disadvantages to accepting this position are numerous. Role ambiguity and conflict as identified within this project will not have programs addressed to reduce their negative impact. Employee satisfaction, which is in need of improvement, will not do so if there are no steps taken to resolve some of the problems. There are no formal programs exclusive of "committees" that allow for interchange between disciplines, thereby reducing the effectiveness of the "health care team," i.e., professionals do not know who to approach to resolve administrative problems, and administrators fail to understand the professionals' problems. The staff will continue to be inefficiently utilized in orientation efforts. Finally, there does not exist a firm transition plan for up-dating newly assigned personnel to the new hospital which will be cause for disruption in the future.

Considering the deficiencies outlined above, the first
alternative is not acceptable.

Initially, alternative two would appear to be a good
selection as it is a program tailored specifically to address
role ambiguity and conflict as they exist within the hospital.
The advantages include a formal program to reduce role ambiguity
and conflict, theoretical potential to improve employee satis-
faction, provides for multiple channels of exchange of infor-
mation to facilitate interdiscipline understanding, and provides
additional reinforcement, if necessary, for clarifying individual
responsibilities with respect to transition to the new hospital.
The primary disadvantage is one of timeliness. The projected
18-months required for the program provides a long-term change
to the hospital, and could have a positive organizational impact
in contrast to past short-term fixes with only local subsystems'
impact. As previously mentioned, however, the time that is
envisioned to conduct the program is too long in view of
personnel turbulence, and not conducive to heading off initial
perceptions created by confrontation with the system before
role clarification begins. Besides the lack of timeliness,
the manpower requirements would involve extensive training of
personnel to be facilitators which would have to be accomplished
first, representing a significant delay in instituting the

program. Finally, there is still considerable resistance to
programs that give even the hint of past "sensitivity training."
Despite even the most carefully structured program, the poten-
tial exists for the staff to perceive the program in light of
past failures,such as equal opportunity and race relations
classes, diminishing their support and cooperation so necessary
for success. Considering the inherent difficulties to such a
long-term program mentioned previously, initiating such a program,
in reality, may cause more harm than good, should it fail.
Consequently, the second alternative is not acceptable.

As with the alternative outlined above, alternative
three (heuristically improve the existing system) offers a
number of advantages that include formal and timely (unlike
alternative two) programs to address role ambiguity and conflict;
has a high potential to improve employee satisfaction; provides
for interdiscipline approach; utilizes MEDDAC personnel assets
more effectively; and provides a mechanism (transition workshop)
to reinforce New Hospital Project Group activities. The
principle disadvantage is that certain professional staff may
be required to devote a portion of their day to command
consultation.

The modifications required would impact upon the
organization's new personnel orientations and the current
organizational human relations program. Such a tact would

represent considerable involvement by hospital staff, however, man-hours expended could be done within current authorizations. The programs recommended are essentially reduction/expansion of current efforts with a corresponding emphasis on effectiveness/efficiency. Role clarification efforts may be utilized, but on a reduced scale and time frame. Most of all, the programs would be tailored to meet specific needs in a timely fashion to help new personnel adapt to the environment of Fort Polk and its hospital. As in alternative two, the realities of the situation must be contended with. In particular, getting the cooperation of the professional staff and/or necessary motivation by the command group are prerequisites to the success of any organizational efforts. By approaching the problem of role ambiguity and conflict via a combination of established and new avenues (personnel orientations and upgrading human relations programs) there will be a greater potential to minimize staff alienation. Additionally, by not using an intensive Role Clarification Program alone, it will be much more difficult to stereotype.

Optimal Feasible Solution

Alternative three, heuristically improving the existing system by confronting the current specific problems, is the

optimal feasible solution. In the long run, the rejuvenation
of orientation programs, and expansion of human relation
efforts will prove of benefit to the hospital in general, its
patients and staff. By drawing upon current mechanisms and
staff feedback, programs may be developed that will provide
definitive assistance to the hospital in minimizing role
ambiguity and role conflict.

FOOTNOTES

[14]"An Assessment of Family Practice," Fort Polk's
Organization Effectiveness Staff Assessment document, no date.

[15]Melvin Seeman and John W. Evans, "Stratification in
Hospital Care: I, The performance of the Medical Intern,"
American Sociological Review, 26 (February, 1961): 67-80.

[16]Steven H. Appelbaum, "Healthful Health Management,"
Health Services Manager, 13 (December 1980): 1-2.

[17]Memorandum For Record, Subject: After Action Report
of OE Operation with Fort Polk Community Hospital/MEDDAC,
Headquarters 5th Infantry Division, Fort Polk, 2 December 1980.

[18]Andrew D. Szilagyi and Winford E. Holland, "Changes
in Social Density: Relationships with Functional and Interaction
and Perceptions of Job Characteristics, Role Stress, and Work
Satisfaction," Journal of Applied Psychology, 65 (1980): 28-33.

[19]Marvin R. Weisbord, "Why Organization Development
Hasn't Worked (So Far) in Medical Centers," Health Care
Management Review, 1 (1975): p. 19.

CHAPTER III

CONCLUSIONS

It is concluded from this problem solving project that there does, in fact, exist an unnecessary amount of role ambiguity and role conflict within the U. S. Army Community Hospital, Fort Polk, Louisiana. Additionally, there would indeed appear, as evidenced by interviews and the Pilot Role Clarification Program, an inordinate amount of role ambiguity and conflict at higher levels of the organization and with the professional staff, in particular, physicians. The need for role clarity would also appear to exist from a supervisor-subordinate perspective as well as interdisciplinary perspective. Role clarity, as referred to here, is the extent to which required information is communicated and understood by members of the organization, both vertically and horizontally. Additionally, much of the role ambiguity and role conflict experienced by physicians would appear to be related to their inexperience and turnover. It must be borne in mind that many of the physician staff of Fort Polk are in a period of transition, from a learning environment to the real world of two and three physician services in a medically isolated community, and interface with a division post and the Army. Finally, it may be concluded that there is currently no organizational program that, as is, permits a viable approach to reducing role ambiguity and role conflict.

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There are numerous methods of reducing role ambiguity and role conflict which are summarized in the Fig. 3.

GOOD PRINCIPLES OF ORGANIZATION

```
┌────────────────────────────────────────┐
│ Clear lines of authority               │
│ Extensive delegation of authority      │
│ Clearly defines roles                  │
│ Clear goals and share goal setting     │
└────────────────────────────────────────┘
```

Bring about a reduction in

```
                              ┌──────────────────┐
                              │ Role Ambiguity   │
                              │ Role Conflict    │
                              └──────────────────┘
```

SUPPORTIVE LEADERSHIP PRACTICES

Bring about a reduction in

```
┌────────────────────────────────────────┐
│ Staff training and development         │
│ Friendliness and attention             │
│ Team building                          │
└────────────────────────────────────────┘
```
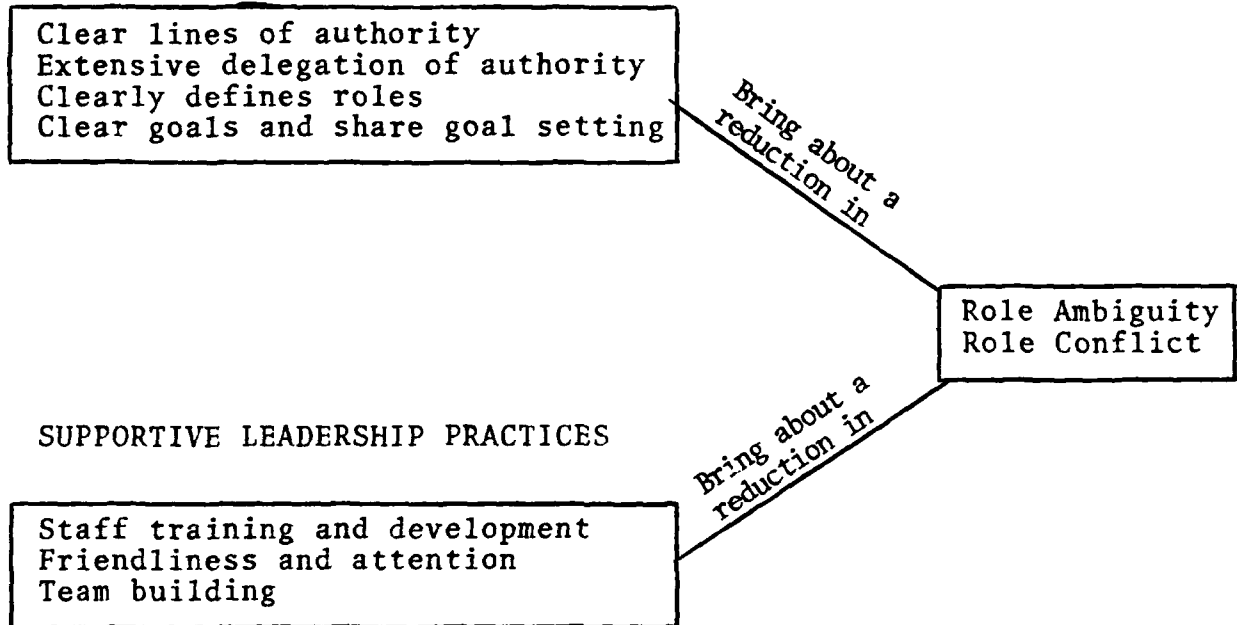
SOURCE: Modified and adapted from Gene Milbourn, Jr. "Finding the causes of job stress and learning to control them" Health Services Manager, 13 (August 1980): 6, 11 - 12

Fig. 3. Methods of Reducing Role Ambiguity and Role Conflict

This particular study focused on the development of a Role Clarification Program as one method to reduce role ambiguity and role conflict at all levels within the hospital. It was concluded that, due primarily to the severe personnel turbulence present in this hospital, in particular that of

physicians and their corresponding absence of a cadre of
physicians having in depth military experience outside of a
learning environment, a long-term, organization-wide attempt
of role clarification would ultimately fail. However, there
is seen some benefit to continuing role clarification efforts
at the upper levels of the organization where personnel have
greater tenure and experience, not to mention a definitive
need for such an intervention as expressed earlier. Addition-
ally, it was felt that improvement and expansion of current
supportive leadership practices would result in optimum
benefits in the reduction of role ambiguity and conflict.
In consideration of the preceding, there would appear to be
no reason not to reiterate the analysis finding that heuris-
tically improving the existing system would be the most
effective manner to deal with the role ambiguity and conflict
that exist within the U. S. Army Community Hospital, Fort Polk.

CHAPTER IV

RECOMMENDATIONS

It is recommended that the Commander accept alternative three which is to heuristically improve the existing system by confronting the problems identified within the text of this analysis. Specific recommendations are that:

1. The New Personnel Orientation should be modified taking the following into consideration:

A. Whatever action is taken should be based on input from individuals who give and/or receive the briefing.

B. Condense the current briefing by:

1) Eliminating new hospital portion as it can be covered adequately in the Commander's presentation.

2) Eliminating personnel and plans, operation and training from the briefing as new personnel must process individually through their offices anyway.

3) Eliminating logistics from the meeting.

4) Establishing written sequence of events for program.

C. Reestablish firm administrative procedures.

D. The individuals presenting should be doing so from a prepared script which has been screened by headquarters.

E. As part of the Commander's briefing,pictures of key staff should be incorporated, for example Executive Officer leading marathon medics.

F. Determine specific areas which, by regulation or JCAH, must be included in orientation, such as infection control officer and safety officer.

G. Although perhaps not practical, it would be theoretically appealing for the Commander to personally introduce his key staff to include Executive Officer; Chief of Professional Service; Chief, Department of Nursing; Command Sergeant Major; and Medical Company Commander.

H. Identify single entity responsible for orientation.

I. Produce staff booklet for things to know.

J. Presentation should include extracurricular activities.

2. As an adjunct to the orientations provided by sponsors and hospital supervisors, a periodic seminar should be provided to those officers who are new to the service or directly from training programs. Such a program would not be an easy undertaking, but it has an excellent potential for easing the transition into the sometimes all too real world of military medicine at Fort Polk. A prototype program has been instituted at Letterman Army Medical Center and may be drawn upon for a starting point. The following recommendations are made:

A. Participants: new staff, professional staff and administrative staff.

B.   Length: 2-3 days

C.   Subject matter:

1)   Expectations, concerns

2)   Professional (profiles, quarters, call schedule, and medical boards)

3)   Administration (Schedule X, workload documentation)

4)   Use of NCOICs

5)   Chain of Command

D.   Panel discussions on realities of Fort Polk

E.   Emphasis on who to see, how to get what you need, what numbers to call

F.   Seek consultation from HSC OE, CPT Troutman (471-6843/3378).

G.   Example of typical briefing:

SUBJECT: Medical Evacuation

BRIEFER: Patient Administration Division (20-30 minutes presentation)   (Supplemented by 2-3 page handout with people identified by name/position/telephone numbers - cookbook approach)

STAFF MEMBER: Examples of real life situations

H.   Above all, it must be emphasized that such an orientation briefing for physicians must receive the support of current professional staff, have respective staff members

associated with the briefing, and receive firm and visible support from the command group.

I. If such a program would be adopted, it would be a prototype for a USA MEDDAC with the potential to positively impact on patient care and physician retention.

3. The final recommendation is to develop a command consultation program which addresses human relations in patient care. Current efforts center around the Concerned Patient Care training and are in response to APC Model #6, A Study Guide for Human Relations in Ambulatory Patient Care. The primary purpose of such a program would be to improve human relations within the hospital to include staff - staff relationships as well as staff - patient, ultimately making the staff work more effectively. The expertise for such a program would come from within the hospital. The following are recommendations:

A. An ad hoc committee be established to develop this idea further.

B. BAMC currently has such a program which has been refined to a considerable degree, and has been well received (POC - LTC Blankenship, MAJ Allen, 471-4015).

C. Core group to consist of:

Social Workers

Chaplain

Psychiatric Nurse Clinician

Physician

Administrative Officer

D. Areas of responsibility are assigned to core
group members.

E. Formal classes are held once a month to address
such topics as time management, stress and anger management,
role clarification, etc.

F. Informal interface is maintained with the areas
of responsibility.

G. Problem - focused approach.

H. A Role Clarification Workshop should be continued
with upper levels of Command, particularly in view of the
upcoming departure of the CPS and C, Primary Care and Community
Medicine. Once specific individuals are in-bound it would
be fruitful to conduct additional sessions with only a few
in a session at a time. Taking small steps initially will
help avoid past mistakes previously mentioned. The facilitators
for the project should come from the care group who has
skills in conducting group sessions.

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APPENDIX A

ORGANIZATION CHART, US ARMY COMMUNITY HOSPITAL, FORT POLK

ORGANIZATIONAL CHART

US ARMY COMMUNITY HOSPITAL

FORT POLK, LOUISIANA

```
                        OFFICE OF THE COMMANDER

        CHIEF                                    CHIEF
         OF                                       OF
      PROF SVC                                 ADMIN SVC

DEPARTMENT    DEPARTMENT    DEPARTMENT    CLINICAL                  LOGISTICS
    OF            OF        OF PRIMARY    SUPPORT      ADJUTANT     DIVISION
 MEDICINE      SURGERY      CARE&COMMU    DIVISION
                            MEDICINE

DEPARTMENT    DEPARTMENT    DEPARTMENT    PATIENT     PERSONNEL      FOOD
    OF            OF            OF        ADMIN       DIVISION     SERVICE
  NURSING      RADIOLOGY     PATHOLOGY    DIVISION                 DIVISION

DEPARTMENT    DEPARTMENT    PHARMACY      PLANS, OPS   COMPTROLLER
    OF            OF         SERVICE      AND TRAINING DIVISION
 DENTISTRY      FAMILY                    DIVISION
               PRACTICE

CLINICAL       SOCIAL
PASTORAL        WORK
SERVICE        SERVICE
```

APPENDIX B

DEPARTMENT OF FAMILY PRACTICE SURVEY

PHYSICIANS

I could see double amount of patients with a full-time nurse and more
examination rooms.

Very inefficient, it is disheartening the few patients I see a day.
Should have third no-show kicked out of Family Practice.

Head nurse is always at meetings so she can't chaperon.

Need clinical support office. I worked three hours one afternoon to take
care of paperwork to get medical evacuation.

Always waiting for examination equipment. I keep a book on days we are
short of equipment, nurses, supplies (three months with no hot water).

There is not an arthroscope in the clinic working (on order since August).

All this is a waste of time. We have voiced these complaints many times.

Could use central screener and a nurse per physician.

Long wait for lab results; argue with doctors over procedures (one week
for thyroid test).

No x-ray for dependents; have to supplement out to CHAMPUS.

Too many rules and policies. All I want to do is practice medicine. I
had career intentions before I got here. I have trouble keeping up
with regulation changes, broken promises, red tape and harassment.

Unreliable lab tests.

Colonel won't listen to doctors, hardheaded.

Patients OK, only headaches from headquarters.

Need commander to talk to doctors and ask us what we need to practice
medicine.

Threats of Article 15's cause fear of courtmartial or transfer to Korea
if I say anything.

Not very good clinical support--nursing, equipment, supplies.

NCOIC has been around a lot longer than I and I can't tell him what to do.

Forget consolidation.

Doctors not represented very well by boss (he is a good guy).

We are waiting for Colonel Stuart to come down and practice so he can see
how it is.

Poor clinical support--need female nurses and more rooms. I had to
wait 20 minutes for a nurse one morning. Ten patients a morning is
a heavy load because of support problems.

RNs here very good; below that I question quality.

Doctors not represented well in headquarters.

COL Stuart doesn't communicate well; he doesn't come and ask for our input.

Nursing has more impact in headquarters.

Consolidation is garbage; no more room.

Too much red tape to get anything done; nothing will happen with this data.

Patients get trashy treatment; dirty place (roaches).

Crummy lab results--inadequate, slow, equipment breakdowns. X-ray gives
poor support.

I believe clinic functions very well.

Good relations between us and other clinics.

Some doctors have good attitudes and some negative.

Could use MSC officer to help do leg work.

Need another receptionist who can type.
A lot of the lab results don't get into records for a week and that slows
    us down.
I have a full-time assistant and we work well together.
I enjoy my work here at Fort Polk.
I don't respect the chief of Family Practice; he is very weak for a
    supervisor.
COL Stuart is out to burn a doctor; he failed his first time. We are
    waiting for his next move.
A lot of inertia around here; can't get anything done without moving
    heaven and earth.
Equipment, secretarial help, lab results, etc.
Leave me alone (don't make me do administration) and let me practice
    medicine; but we do want to run our own show.
We want to do total care and not have it fragmented to other clinics;
    this confuses the patient.
People in headquarters and nursing trying to run Family Practice and
    they don't know what is going on.
COL Stuart needs to get out and see what is happening; meeting in
    December was first exposure and that helped his rapport.
Head nurse is resource manager; needs to get more into patient care.
X-ray improving; lab is not.
I hated it when I didn't have a permanent assigned nurse.
Central Appointment is so far removed from patient care; not flexible.
    They could not cope with scheduling treatment room.

CLINICAL SUPPORT

Walk-ins are biggest problem; need to work on this; all walk-ins should
    be seen and not told "you can't be seen."
Clinic working pretty well; needs improvement but not sure how.
The big disadvantage to consolidation is there is no advantage.
We tried rotating LPNs with different doctors; but didn't like it.
Physician official chain not working.
A lot of my time spent in coordination of clinic; no time for education.
Need additional personnel (LPN).
Good relations with other clinics.
The two Family Practices really operate as separate clinics; this is
    no problem.
Could have central screening for walk-ins.
More cooperation from physicians needed; a lot of physicians did not
    understand why head nurse is here. They don't get along with
    nursing desk.
Things are really better now than a year ago. Everybody finally got
    together. I can go to head nurse with problems.
I am the last to know things.
I should not have to give medical advice over the telephone.

Clinic operating better than it ever has. We have tried many things and
have now settled on a procedure that works; let's not rock the boat.

Problem with doctors is they don't want to play Army.

Could use form letter for OB medical statement.

People other than those working here, and who don't know what is needed
(especially nursing) are trying to change things.

Doctors are not given any credit; no pat on the back.

Get a system and stay with it.

We need an LPN for each doctor; no time to develop rapport with patients
and preventive medicine.

LPN should not order supplies and medicine; that is the role of the
head nurse and NCOIC.

Head nurse duties should be to assure smooth operation and pitch in and
help. Some think they are delegators and some administrators.

I would like to do some home follow-up calls and visits.

This clinic has one receptionist and six doctors; next door at OB they
have two receptionists for three doctors.

Good that COL Stuart is working here with us.

No rapport between Fort Polk clinics; a lot of antagonism and competative
feelings.

Good relations with Emergency Room.

Lab is 200 percent better since CPT Bolton arrived.

No consolidation.

Worst thing needed is for everyone to do the job they are supposed to do
and keep others out of our hair.

Would have a nurse for every doctor if we consolidated. Other doctors
do physical examinations, work Emergency Room, take compensatory time.

More efficient to combine clinics; would free up people to education on
family health; need support from physicians to work; right now they
are against us.

Duty description not realistic for head nurse.

Let's do something and quit waiting around; either one clinic or same.

Family Practice Clinics #1 and #2 work independently. Yes, we are
functioning OK, but not performing our mission of total patient care.

Need to send schedules to Central Appointment on time; a lot of problems
making appointments.

There are no Indians and all chiefs; no one to run for things.

Receptionist and LPN should do traffic flow.

I am dismayed at attitude of physicians; everyone does their own thing.

We need a standard minimum for doctors on duty to better schedule support.
The standard for referring or doing own surgery is up to the
physician.

No justification for absence of doctor; comes in at 0900 hours and says
checking patients in hospital.

Need two exam rooms per doctor.

Doctors do not understand role of nurse.

Need to have physicians solve their own problems.

No discipline in doctors; keep them at all costs.

NCOIC should do 50 percent patient care and administration/supply, but he doesn't.

Clinical support; scheduling of workload, utilization of personnel; I don't know who does this.

Centralized screening OK.

There are things that would save doctors' time, like someone else filling out lab requests.

Young troops' care has lowest priority; dependent care more important.

Need another nurse in TMC #1.

Like to see outpatient clinic closed; patients are not receiving proper care and poor utilization of personnel.

It is really an outpatient rather than a Family Practice Clinic.

There is conflict between physicians and administrators.

The practice of assigning doctors' units so that they will see all patients regardless of how many, is resisted by deliberate slow-downs by doctors. Should schedule doctor to see as many families as he thinks he can properly care for and cut off at that point.

Hospital commander is good for Fort Polk; we have needed one like him for a long time.

I never receive information from my supervisor.

Many doctors request non-federal stock items and expect them to be purchased for their use.

Work slow-down by doctors causes many problems.

COL Stuart should be seen in the hospital from time to time.

Why LPN ratings are GS 3-5.

Percentage of awards to civilians does not compare to the Fort Polk percentage.

The appointment section needs classes.

Hospital headquarters personnel take PT at 1530 hours during duty time (why not lead by example).

I catch myself going to meeting after meeting.

OTHER COMMENTS

The support for senior EM is much better than before.

EM must stay on the same shift and ward for long periods of time. I think we should OJT on many wards.

Too much BS; just let me do my job.

I am qualified as an LPN but they will not allow me to practice my 91C MOS.

There should be some kind of education program for the staff so they are aware of the 91C duties.

SGM should meet with junior EM at least once every three months for rap sessions.

Should use chain of command coming down. Headquarters going directly to clinic and by-passing supervisor on matters that require administrative action or changes in procedures.

Good relations with clinics and wards.

Commander does not get out and see the people on a casual basis; only when problems arise.

A lot of hip shooting in decision making based on personal whims without communication with those affected, i.e., fatigues make for better relations with rest of Army.

Emphasis on other things (quarterly training, PT formation) instead of first priority on patient care.

MSC officers are not given enough recognition for keeping the hospital operating properly.

Need policy for AOD compensatory time.

OBSERVATIONS

Family Practice Clinics #1 and #2 operate as separate entities.
    Doctors sit, by clinic, on separate sides of room at meetings.
    No coordination (meetings) between clinics.
    Operate on different SOP with Central Appointments.

Physicians dismiss without analysis or suggestions from the Department of Nursing.

Physicians are very tight group with block complaints.

Anything that takes away from seeing patients (other than by own choice) is considered as an irritant.

A Schedule X (job description) does not exist.

Nobody seems to want responsibility for managing the clinics.

Visibility of hospital commander is seen as panacea (also practice in Family Practice Clinic #2).

Physicians expect instant results to their demands.

APPENDIX C

ORGANIZATION ORIENTATION EFFORTS

*MEDDAC REG 40-38

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Polk, Louisiana 71459

MEDDAC REGULATION
NUMBER   40-38   5 July 1978

MEDICAL SERVICES
INPROCESSING MILITARY PERSONNEL

The pronouns he, his, him, etc. when used in this regulation are intended
to include both the masculine and feminine gender. Any exceptions to this
will be so noted.

1. PURPOSE. To outline a procedure to assist in the proper welcoming,
inprocessing, and orientation of incoming duty personnel to the Medical
Department Activity (MEDDAC), Fort Polk, Louisiana.

2. GENERAL. To assure new personnel they are filling a definite need and
are an important part of the MEDDAC staff. To establish procedures to
promote a better understanding of the local procedures and administrative
procedures in order to avoid errors from lack of information.

3. PROCEDURES.

    a. Officers.

    (1) Letter of Welcome. As soon as an assignment instruction or order
assigning an officer to the Medical Department Activity, Fort Polk, Louisiana,
is received, the Commanding Officer will forward a letter of welcome with
informational brochures giving information about housing, schools, churches,
post facilities, transportation and other items of interest. The name and
office phone number of the sponsor will also be included.

    (2) Sponsor. A sponsor will be a commissioned officer designated to
correspond with and welcome the newly assigned officer. The sponsor will
write a personal letter to the new officer as soon as possible offering
assistance in any way possible prior to arrival. A copy of the letter will
be sent to Chief, Personnel Division to be maintained on file. When the
new officer arrives, the sponsor will assist with inprocessing and introduce
the new arrival and family to the other members of the MEDDAC staff.

    (3) Officer Report on Arrival. During duty hours the incoming officer
will report to the Adjutant in Hospital Headquarters, Building 734. After duty
hours he will report to the Administrative Officer of the Day, (AOD), Building
736, who will obtain a copy of his orders. The AOD will also assist the new
officer by directing him to the sign-in register, arrange for billeting and
messing and instruct the individual to report to the Adjutant at 0730 the
following workday morning.

    b. Senior Enlisted Personnel (E-6, E-7, E-8, and E-9).

    (1) Letter of Welcome. As soon as an assignment instruction or order
assigning an enlisted person to the USA Medical Department Activity, Fort Polk,
Louisiana, is received, the Command Sergeant Major will forward a letter of
welcome with information brochures giving information about housing, schools,
churches, post facilities, transportation and other items of interest. The
name and office phone number of the sponsor will also be included.

    (2) Sponsors. A sponsor will be designated by the USA MEDDAC Command
Sergeant Major to correspond and welcome newly assigned enlisted personnel and
assist them with inprocessing, to include familiarization with hospital, post
and surrounding area.

    (3) Enlisted personnel will report on arrival to the Medical Company Orderly
Room, Building 713, during duty hours and after duty hours to the Charge of
Quarters. The Charge of Quarters will assist in arranging for billeting and
messing and will instruct the individual to report to the first sergeant the
morning of the next duty day.

*Supersedes MEDDAC Regulation 40-38, dated 4 October 1976

c. Enlisted Personnel (E-5 and below). Enlisted personnel (E-5 and below) arriving for duty will report to the Medical Company Headquarters, Building 713. Orientation will be accomplished by the Commanding Officer of the Medical Company in accordance with the Standard Operating Procedure developed for the purpose.

4. RESPONSIBILITIES.

a. Officers.

(1) The Adjutant will assist the new officer as follows:

(a) Assist in signing in on the register, DA Form 647, at Hospital Headquarters.

(b) Welcome the arrival to the staff and answer any questions he may have. Provide copies of any written policies/procedures required, as appropriate.

(c) Arrange for an appointment to meet the MEDDAC Commander, Executive Officer and other officers as required.

(d) Coordinate with the post regarding the Ft Polk "Operation Get Acquainted" Program for incoming Medical Corps Officers.

(e) Assist the Officer as to inprocessing, if the sponsor is not with the individual. The Adjutant will call the sponsor and advise that the new officer has arrived and is at the headquarters. Direct the arrival to the Personnel Division for inprocessing.

(2) The Hospital Personnel Division will be responsible for the following:

(a) Provide the officer with the inprocessing instructions (Appendix A).

(b) Direct Officer to Installation Central In-Out Processing Activity, Building 1560.

(c) A duty appointment (DA Form 2496) will be prepared as soon as duty assignment has been determined designating primary duty assignment and any additional duties required.

(3) Orientation Briefing. The Chief, Plans, Operations and Training will provide to officers (with no prior service) a tailored orientation.

(4) Chief of Professional Services will be responsible for the professional orientation of all Medical Corps Officers.

(5) Chief, Department of Nursing will be responsible for the orientation of all Army Nurse Corps Officers.

(6) Deputy for Veterinary Activities will be responsible for the orientation of all Veterinary Officers.

(7) The Executive Officer will be responsible for the orientation of all Medical Service Corps, Army Medical Specialist Corps, Army Chaplain Corps assigned to the hospital and American Red Cross hospital personnel.

(8) The Executive Officer, Dental Activities will be responsible for the orientation of all Dental Corps Officers.

b. Senior Enlisted. The Command Sergeant Major will welcome the new NCO to the staff and will arrange an appointment for the individual to meet the USA MEDDAC Commander and Executive Officer. The Command Sergeant Major will contact the sponsor who will assist the senior NCO in processing.

c. Enlisted (E6 and below). The First Sergeant and Company Commander will welcome the E6 and below and assist them with any problems they may have.

5. INPROCESSING CHECK LIST.

a. Officer.

2

MEDDAC REG 40-38
5 July 1978

(1) An inprocessing check list is provided in Appendix A. All incoming officers or equivalent personnel will be presented a copy of Appendix A to be followed on an individual basis. The check list is designed to provide a record as well as a guide.

(2) Each officer with less than three (3) years active federal service who are sole parents or guardians of minor children, married to other service members with minor dependents (under age 18), or who are solely responsible for the care of dependents unable to care for themselves, regardless of age, will be counselled IAW procedure 4-29, Change 14, DA Pam 600-8 and AR 600-20, utilizing the checklist at Appendix B. A copy of the completed checklist will be placed in the individuals 201 file. Officers assigned to USAH and Vet Activities will be counselled by the Chief, Personnel Division/Troop Commander. Dental Officers will be counselled by the Dental Company Commander.

(3) Personnel with physically, emotionally or intellectually handicapped dependents will be identified and counselled IAW AR 614-203 and application made if desired IAW Procedure 4-28, DA Pam 600-8.

(4) A copy of the inprocessing check list will be placed in the officer's individual file maintained in the Personnel Office.

b. All Enlisted Personnel.

(1) Inprocessing check list is provided in Appendix A. All enlisted personnel will be presented a copy of Appendix A to be followed on an individual basis. The check list is designed to provide a record as well as a guide.

(2) Each enlisted service member with less than three (3) years active federal service who are sole parents or guardians of minor children, married to other service members with minor dependents unable to care for themselves, regardless of age, will be counselled IAW procedure 4-29, Change 14, DA Pam 600-8 and AR 600-20, utilizing the checklist at Appendix C. A copy of the completed checklist will be placed in the individual's 201 file. Enlisted personnel assigned to USAH and Vet Activities will be counselled by the Medical Co Cdr, or 1SG. Enlisted personnel assigned to the Dental Activities will be counselled by the Dental Co Cdr or 1SG.

(3) Enlisted personnel will be identified and counselled as specified in para 5a(3) above.

(4) A copy of the inprocessing check list will be placed in the individual's file maintained in the personnel office. (PD)

FOR THE COMMANDER:

APPENDIX
  A - MEDDAC OP 28 (Rev)
     MEDDAC Form 302
     Privacy Statement
     Map (USAH & Ft Polk)
  B - Dependent Care Counselling
     Checklist (officers)
  C - Dependent Care Counselling
     Checklist (enlisted)

DISTRIBUTION:
R plus 5

MICHAEL E. BARSZCZ
CPT, MSC
Adjutant

DISPOSITION FORM

For use of this form, see AR 340-15; the proponent agency is The Adjutant General's Office. S:

MEDDAC REG 40-38
5 July 1978

REFERENCE OR OFFICE SYMBOL	SUBJECT
AFZX-MEDH-PD	APPENDIX A Inprocessing Personnel

TO SECTION CONCERNED   FROM Personnel Division   DATE   CMT 1

The individual named below is inprocessing. Individual will proceed to activities listed below. Request you acknowledge processing at your activity by signing in the appropriate space.

NAME_____ GR_____ MOSC/SSI_____

ADJUTANT (Bldg 734, All Officers)   _____

OUTPATIENT CLINIC (Bldg 733)
Shots and Weight Control Program Weigh-In (FP Form 1174)   _____

OUTPATIENT RECORDS (Bldg 731)   _____

PLANS, OPERATIONS & TRAINING DIVISION (Bldg 509)   _____

EDUCATION & TRAINING (Bldg 508) (ANC Officers)   _____

AG OFFICER RECORDS (Bldg 317)   _____

CENTRAL PROCESSING (Bldg 1560)   _____

CHESSER DENTAL CLINIC (Bldg 1561)   _____

DENTAL COMPANY ORDERLY ROOM (Bldg 1734, All Den Co Pers)   _____

MEDICAL COMPANY ORDERLY ROOM (Bldg 713, Med Co Enl only)   _____

REENLISTMENT NCO (E6 & below, Bldg 721)   _____

DUTY SECTION_____   _____

SERGEANT MAJOR (Bldg 734, Enlisted only, E6 & above)   _____

RED CROSS (Bldg 637)   _____

MAILROOM (Bldg 640)   _____

LABORATORY (Bldg 649)   _____

SUPPLY ROOM (Med Co-Bldg 715/Den Co-Bldg 1561)   _____

DEPENDENCY/SOLE PARENT COUNSELLING (if applicable)   _____

PHYSICALLY, EMOTIONALLY OR INTELLECTUALLY HANDICAPPED
DEPENDENT COUNSELLING (if applicable)   _____

MEDDAC OP 28 (REV)
10 Aug 78 Ft. Polk

4

DA FORM 2496 1 FEB 66   REPLACES DD FORM 96, EXISTING SUPPLIES OF WHICH WILL BE ISSUED AND USED UNTIL 1 FEB 63 UNLESS SOONER EXHAUSTED.   GPO: 1972 769-850/1008

AFZX-MEDH-PD
SUBJECT: Inprocessing Personnel

SQT STUDY GUIDE ISSUED   YES ( )   NO ( )   _____

DEFENSIVE DRIVING CLASS (ALPHA HALL) WED & THURS
0715 to 1200 hours   _____

ALL NEWLY ASSIGNED PERSONNEL must report back to Personnel Division not later than
10 days after initial inprocessing with this form completed.

PATIENT RECORDING CARDS: The sponsor or spouse must report in person to Outpatient
Records Section, Bldg 731, to obtain patient recording cards for their dependents.
A patient recording card must be presented by both military and their dependents when
reporting for medical treatment.

DISPOSITION FORM

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

SUSPENSE:

REFERENCE OR OFFICE SYMBOL	SUBJECT
AFZX-MEDH-PD	Inprocessing Personnel

TO SECTION CONCERNED   FROM Personnel Division   DATE

The individual named below is inprocessing. Individual will proceed to activities
listed below. Request you acknowledge processing at your activity by signing in the
appropriate space.

RANK & NAME _____ MOS/SSI _____

ADJUTANT (Bldg 734, All Officers)   _____

AMIC CLINIC (Bldg 733)   _____
   Shots and Weight Control Program Weigh-In (FP Form 1174)
   (RETURN one FP FORM 1174 with Inprocessing Form)
OUTPATIENT RECORDS (Bldg 731) (Medical Records turn-in)   _____

PLANS, OPERATIONS & TRAINING DIVISION (Bldg 509)   _____

EDUCATION & TRAINING (Bldg 508) (ALL NURSING PERSONNEL)   _____

AG OFFICER RECORDS SECTION (Bldg 317) (201 File) (OFF/WO ONLY)   _____

CENTRAL PROCESSING (Eagle Hall) (Bldg 1560)   _____

DENTAL CLINIC #3 (Bldg 628) (Dental Records turn-in)   _____

MEDICAL COMPANY ORDERLY ROOM (Bldg 637, Med Co Enl only)   _____

DENTAL COMPANY ORDERLY ROOM (Bldg 2157, Den Co Pers)   _____

REENLISTMENT NCO (E-6 & Below, Bldg 638)   _____

DUTY SECTION_____.   _____

SERGEANT MAJOR (Bldg 734, all enlisted personnel)   _____

MAILROOM (Bldg 640) (ALL PERSONNEL) (After 1200 Hours)   _____

LABORATORY (Bldg 649) (ALL PERSONNEL)   _____

SUPPLY ROOM (Med Co-Bldg 507/Den Co-Bldg 2157)   _____

DEPENDENCY/SOLE PARENT COUNSELLING (if applicable)   _____

PHYSICALLY, EMOTIONAL OR INTELLECTUALLY HANDICAPPED
   DEPENDENT COUNSELLING (if applicable)   _____

ORIENTATION FOR NEWLY ASSIGNED PERSONNEL
   (0845 HOURS, 2D TUESDAY OF THE MONTH)   NOTICE RECEIVED _____
                                                              (Signature)

MEDDAC FL 52 (Rev)
1 Apr 81 Ft Polk

DA FORM 2496   REPLACES DD FORM 96, WHICH IS OBSOLETE.

AFZX-MEDH-PD
SUBJECT: Inprocessing Personnel

DEFENSIVE DRIVING CLASS (POST SAFETY OFFICE, BLDG 4705) ___ ___ ___ ___
  Monday & Tuesday (1200-1600 hours)
  DEFENSIVE DRIVING CLASS WILL BE COMPLETED WITHIN
  TWO (2) WEEKS OF ARRIVAL.

PREVENTIVE MEDICINE (Bldg 723) ___ ___ ___ ___

ALL NEWLY ASSIGNED PERSONNEL must report back to Personnel Division not later
than two (2) weeks after initial inprocessing with this form completed.

PATIENT RECORDING CARDS: The sponsor or spouse must report in person to
Outpatient Records Section, Bldg 731, to obtain patient recording cards for
their dependents. A patient recording card must be presented by both military
and their dependents when reporting for medical treatment.

DEPARTMENT OF THE ARMY
HEADQUARTERS 5TH INFANTRY DIVISION (MECHANIZED) AND FORT POLK
FORT POLK. LOUISIANA 71459

REPLY TO
ATTENTION OF:

12 MAY 1981

AF/X-DPT-PO

SUBJECT: LOI, Orientation for Newly Assigned Doctors

SEE DISTRIBUTION

1. PURPOSE: To establish procedures and responsibilities for conduct of a
newly assigned doctors orientation program.

2. GENERAL:

    a. All soldiers perform better when they understand how their personal
efforts help accomplish the unit's mission. The orientation program outlined
below will provide newly assigned doctors an appreciation of the 5th Infantry
Division (Mechanized) and Fort Polk mission. It will also allow them to
participate in tactical field training and personally experience the combat
power of the Army while seeing the living and working conditions of the
soldiers they treat.

    b. Briefings and a tour of a battalion area will be conducted during
the first day: the second day will be spent in the field observing and
participating in tactical training, see incl 1.

    c. The program will begin June 1981 with mechanized gunnery as the major
tactical event. During July - September there will be a monthly orientation
and thereafter, once a quarter for remainder of year, see incl 2.

3. RESPONSIBILITIES:

    a. G3/DPT

        (1) Provide staff supervision of orientation program.

        (2) Coordinate with Cdr, MEDDAC and DENTAC to schedule personnel attendance.

        (3) Develop itinerary based on unit training schedules and task
host units.

        (4) Coordinate helicopter support for transportation to and from
training area.

(5) Inform the major subordinate command of the number of doctors to participate on given day.

(6) Conduct Command Briefing.

b. DRM: Conduct Installation Missions and Functions Briefing.

c. Cdr, 5th Avn Bn: Provide helicopter transportation to and from field.

d. Cdr, MEDDAC and DENTAC:

(1) Provide G3/DPT standing list of personnel to participate in program annotated with preferred time frame.

(2) Provide doctors with the following minimum field equipment for field training: Helmet w/cover, LBE w/canteen, Poncho, First Aid Packet.

e. Cdr, Major Subordinate Command.

(1) Conduct tour of facilities and training per itinerary.

(2) Provide noon meal on day #2 of itinerary.

4. ADMINISTRATIVE: Point of contact for orientation program is Major Swift, D/DPT, 537 - 6112/4055.

FOR THE COMMANDER:

FOR *Edward L. Andrews*

CECIL N. NEELY
Colonel, GS
Chief of Staff
LTC, GS
DCS

DISTRIBUTION:
Cdr, 1st Bde
Cdr, 2nd Bde
Cdr, Div Arty
Cdr, DISCOM
Cdr, HQ Cmd
Cdr, 4-12 Cav
Cdr, 5th Avn Bn
Cdr, MEDDAC
Cdr, DENTAC
DRM

ITINERARY
ORIENTATION FOR NEWLY ASSIGNED DOCTORS

DAY #1

TIME	ACTIVITY	RESPONSIBLE AGENCY
1300	Arrive Bldg 2 Conference Room	Individual
1300-1320	Command briefing	G3/DPT
1325-1350	Installation Missions and Functions Briefing	DRM
1350-1415	5th Infantry Division (Mech) Organization, Mission, and Capabilities Briefing	G3/DPT
1415-1430	Enroute to Major Subordinate Command (by POV)	Individual
1430-1630	Tour Troop Barracks and Facilities	Major Subordinate Command

DAY #2

0700	Arrive Airfield	Individual
0715-0745	Enroute by Helicopter to Training Site	5th Avn Bn
0745-1800	Observe/Participate in Tactical Training	Major Subordinate Command
1800-1830	Enroute by Helicopter to Airfield	5th Avn Bn

Inclosure 1

SCHEDULE
ORIENTATION FOR NEWLY ASSIGNED DOCTORS

DATE	ACTIVITY	RESPONSIBLE AGENCY
17 Jun	Briefings	G3/DPT and DRM
	Tour	Cdr, Divarty
18 Jun	Mech Gunnery	Cdr, 1st Bde
28 July	Briefings	G3/DPT and DRM
	Tour	Cdr, HQ Cmd
29 Jul	Platoon Artep	Cdr, 2d Bde
18 Aug	Briefings	G3/DPT and DRM
	Tour	Cdr, DISCOM
19 Aug	Tank Gunnery	Cdr, 1st Bde
10 Sep	Briefings	G3/DPT and DRM
	Tour	Cdr, 4-12 Cav
11 Sep	Brigade FTX	Cdr, 2d Bde

Inclosure 2

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
FORT POLK, LOUISIANA 71459

REPLY TO
ATTENTION OF:

AFZX-MEDH-PD

23 January 1981

SUBJECT: Letter of Instructions (LOI) for New Personnel Orientation

TO: SEE DISTRIBUTION

1. REFERENCE: MEDDAC Reg 40-38.

2. PURPOSE: To prescribe the procedures and responsibilities for conducting the monthly orientation for newly assigned MEDDAC personnel.

3. GENERAL:

a. A monthly orientation will be conducted for all newly assigned military and civilian personnel on the second Tuesday of each month. This orientation is mandatory for all personnel who have inprocessed since the previous month's orientation. Newly assigned civilians should wear name tags if they have been received from the Service Branch by the date of the orientation.

b. The orientation will be conducted at 0900 hours, on the second Tuesday of each month at the PO&T classroom, Building 509.

4. RESPONSIBILITIES:

a. Commander, USAMEDDAC: Present the following:

(1) Welcoming remarks.

(2) Presentation of MEDDAC slides.

b. Hospital Project Office: Present slides of new hospital.

c. Adjutant:

(1) Arrange for remarks for other headquarters staff as may be desired.

(2) Present information on "If I were the Commander" and other subjects as desired.

AFZX-MEDH-PD
SUBJECT: Letter of Instructions (LOI) for New Personnel Orientation

      (3) Perform functions in "a" above in the absence of the Commander.

    d. Chief, Department of Nursing:

      (1) Present information on organization and functions of Department of Nursing.

      (2) Infection Control Nurse.

    e. Chief, Plans, Operations and Training:

      (1) Arrange for PO&T classroom to be available 0900-1130 hours on the second Tuesday of each month with slide projector, overhead projector, and screen.

      (2) Present information on the following:

          (a) SAEDA

          (b) Security

          (c) Alcohol and Drug Abuse, Prevention and Control Program

          (d) PT Tests

          (e) Educational Counseling

          (f) Quarterly mandatory training

    f. Chief, Clinical Support Division: Present information on the following:

      (1) Organization and function of Clinical Support Division.

      (2) Duties and responsibilities of the Patient Representative Officer.

      (3) Ambulatory Patient Care (Cdr will provide assistance if needed).

    g. Chief, Personnel Division:

      (1) Issue appointment slips for the next scheduled orientation to all military and civilian personnel during inprocessing.

      (2) Present information on the following:

          (a) Military Personnel Actions

AFZX-MEDH-PD
SUBJECT: Letter of Instructions (LOI) for New Personnel Orientation

        (b) Civilian Personnel Actions

        (c) Personnel Status Requests

        (d) Finance/Pay Inquiries

        (e) Leaves/Passes/TDY/How to sign in and sign out

        (f) Records and Record Audits

        (g) Promotions

        (h) OERs/SEERs

        (i) Miscellaneous suspense actions

        (j) Special Medical Pay Agreements (MC Officers)

        (k) Board Certification (MC Officers)

h. Chief, Logistics Division: Present information on the following:

    (1) Medical equipment maintenance

    (2) Linen exchange

    (3) Housekeeping

    (4) Materiel - How to order supplies and equipment

    (5) MEDCASE Program

i. Safety Officer: Present information on the following:

    (1) Safety briefing

    (2) Safety inspection

    (3) Fire safety

    (4) Accident/injury reports

j. Commander, Medical Company: Present information on the following:

    (1) Appearance and uniform policy.

    (2) Military courtesy.
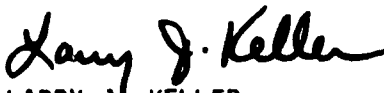
      (3)   Conduct (on and off duty).

      (4)   Indebtedness.

      (5)   DWI.

      (6)   Physical fitness and weight control.

      (7)   Change of Command (availability of CSM for assistance)

      (8)   Open door policy.

      (9)   Commander's Call.

     (10)   Monthly Inspection Formation.

     (11)   Problem assistance agencies.

     (12)   Off limits areas.

     (13)   SQT Learning Center in dayroom.

     (14)   Soldier/NCO of the Quarter/Year Program.

5.   All individuals are responsible for insuring that an alternate is available within their division/section to provide the newcomer's briefing in the event of the primary briefer's absence or unavailability on the day of the scheduled orientation.

FOR THE COMMANDER:

LARRY J. KELLER
MAJ, MSC
Assistant Adjutant

DISTRIBUTION:
A

4

Department of Nursing   US Army Community Hospital
Administrative Procedure   Fort Polk, Louisiana 71459
Number 2-1   August 1980

ORIENTATION PROCEDURE FOR PARAPROFESSIONAL PERSONNEL

1. General:

    a. Each military and civilian paraprofessional person assigned to Department
of Nursing will be given an orientation to the Department of Nursing and the Hospital.

    b. A suspense date for completion of the orientation period normally will not
exceed thirty (30) working days following initial assignment to the Department of Nursing.

2. Purpose:

    a. To acquaint the individual with organization, mission, etc. of the hospital.

    b. To assist paraprofessional personnel in familiarizing themselves with
Department of Nursing's function, policies, and procedures.

    c. To introduce paraprofessional personnel to members of the health care team.

    d. To provide paraprofessional personnel with a knowledge of the physical plan
of the hospital and a specific orientation to the working areas.

3. Responsibilities:

    a. The Chief Wardmaster, Department of Nursing, and/or an appropriate designee,
will be responsible for the orientation of each newly assigned paraprofessional person
to the mission, organization and functions of the Department of Nursing. He is also
responsible for scheduling date and time with the NCOIC, Nursing Education and Training
for hospital orientation. The Chief Wardmaster will initiate the orientation checklist.

    b. The NCOIC, Nursing Education and Training will be responsible for identifying
orientation needs, organizing an orientation program and insuring its completion.

    c. The Wardmaster of the individual's assigned unit is responsible for the
completion of the nursing unit level orientation of all newly assigned personnel.

    d. It is the responsibility of the individual and the direct supervisor/wardmaster
to return the completed orientation checklist to the Chief, Nursing Education and
Training, NLT thirty (30) days following initial assignment.

1 Attachment
Orientation Checklist   1

Department of Nursing
Administrative Procedure
Number 2-1 (Attachment)

US Army Community Hospital
Fort Polk, Louisiana 71459
August 1980

DEPARTMENT OF NURSING ORIENTATION CHECKLIST
(PARAPROFESSIONAL)

General...Paragraph 1
Purpose...Paragraph 2
Responsibilities...Paragraph 3

1. General:

    a. Each military and civilian person assigned to the Department of Nursing will be required to complete during the orientation period specific items, tasks, procedures, etc., contained in an orientation checklist.

    b. A suspense date for completion of the checklist will normally not exceed 30 working days following initial assignment to the Department of Nursing.

2. Purpose:

    a. The orientation checklist will serve as a standard guide for administrators to use in the orientation process of newly assigned personnel.

    b. The checklist will assist the individual being oriented to identify areas of specific emphasis which should be included in their orientation process.

    c. The completed checklist will be filed in the individuals education and training folder. This folder is maintained in Nursing Education and Training Section.

3. Responsibilities:

    a. It is the dual responsibility of the appropriate Nursing Department administrators and the newly assigned individual to utilize and insure completion of the orientation checklist.

    b. The individual is ultimately responsible for procuring the information and appropriate individual's initials as indicated on the checklist. The individual will sign the form upon completion and return it to Nursing Education and Training according to the suspense date listed. Space is provided above the signature block for any pertinent comments.

    c. The immediate supervisor of the orienting individual will sign the checklist in the area indicated insuring all items listed have been accomplished to his/her satisfaction. Space is provided above the signature block for any pertinent comments.

2

PARAPROFESSIONAL ORIENTATION CHECKLIST

NAME:_____ RANK:_____
Print LAST   FIRST   MI

WARD/CLINIC/UNIT:_____DATE OF ISSUE:_____

RETURN SUSPENSE DATE:_____

CHIEF WARDMASTER:
_____1. Conduct interview.
_____2. Schedule for orientation with NCOIC, Nsg Education and Training.
_____3. Ask about hospital whites, living accommodations, amount of time needed for personal matters, etc.
_____4. Read handout on DWI, types of counselling, promotions, recommendations and standards of appearance.
_____5. Describe and identify Department of Nursing organization, wards, clinics and method of supervision.
_____6. Discuss Defensive Driving Program.
_____7. Discuss Medical Company Supply.
_____8. Arrange to meet CSM.

NCOIC, NURSING EDUCATION AND TRAINING SECTION:
_____1. Interview and assess individual orientation requirements.
_____2. Establish education and training folder on individual.
_____3. Read mandatory articles on Pass Policy, Code Red, Confidentiality of Medical Information, Sick Call, Hat Wearing Policy, etc.
_____4. Discuss Education and Training programs.
_____5. Document LPN/LVN state license number and expiration date.
_____6. Discuss civilian and military educational opportunities.
_____7. Discuss off-duty college attendance.
_____8. Discuss Chain of Command.
_____9. Discuss community awareness.
_____10. Discuss recreational facilities.
_____11. Discuss drug abuse.
_____12. Arrange instruction on nursing techniques as needed such as:
    _____a. Infection Control.
    _____b. CPR.
    _____c. Surgical Technique.
    _____d. Administration of medications.
    _____e. Emergency drugs.
    _____f. Venipuncture and IV Therapy.
    _____g. Other.
_____13. Conduct tour of hospital area.

WARDMASTER/NCOIC:

_____1. Introduce to ward personnel.

_____2. Review work schedule.

_____3. Discuss Leave Policy.

_____4. Explain procedures for duty personnel sick call and reporting absence from duty.

_____5. Discuss military courtesy and personal grooming.

_____6. Discuss Enlisted Efficiency Report.

_____7. Review ward Emergency Preparedness Plan (EPP).

_____8. Review Bomb Threat Procedure.

_____9. Identify the location of the following equipment:

    _____a. Emergency drugs, Ambu-bag, Oxygen and Crash Cart.

    _____b. Emergency Power Outlet.

    _____c. Fire Extinguishers, Fire Evacuation Plan and Fire Exits.

_____10. Conduct a thorough orientation to the following ward administrative procedures:

    _____a. Personnel Time Schedule.

    _____b. The 24-Hour Nursing Report.

    _____c. Personnel Assignment Sheet.

    _____d. Utilization of Patient Identification Plate, Bed Card, and Control Card.

    _____e. Components of Patient Charts.

    _____f. Utilization of Therapeutic Documentation Forms, Nursing Notes, Doctor's Orders, Nursing Care Plan, TPR Graphic and Intake and Output Records.

    _____g. Review contents of MEDDAC Regulation Book.

    _____h. Review contents of Department of Nursing Procedure Guide.

    _____i. Review contents of Department of Nursing Administrative Procedure Book.

_____11. Supervise the administration of medications/IV Therapy to include: (Applicable to 91Cs Long Course and LPNs only and is the responsibility of the Head Nurse or designee).

    _____a. Utilization of Medication Cards.

    _____b. Location of all ward medications.

    _____c. Method of ordering Bulk Drugs and Controlled Substances.

    _____d. Management of Automatic Stop Orders for medications according to Department of Nursing Admin. Procedure #7.

    _____e. Management of drug keys.

    _____f. Utilization of the P.D.R. and the Hospital Formulary.

    _____g. Use of Unit Dose.

    _____h. Before Individual (91C/LPN) is authorized to pass medications and administer IV Therapy, ward HN must submit a DF to get the Individual certified to do above listed functions on the ward.

_____12. The Wardmaster/NCOIC will sign below after the Individual has completed the orientation to the specific areas listed.

COMMENTS: Individual Being Oriented: _____

_____

_____

_____

COMMENTS: HN, WARDMASTER/NCOIC: _____

_____

_____

_____

INDIVIDUAL'S SIGNATURE   SIGNATURE OF WARDMASTER/NCOIC

APPENDIX D

ROLE CLARIFICATION WORKSHOP'S LETTER OF INVITATION

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
FORT POLK, LOUISIANA 71459

REPLY TO
ATTENTION OF:

AFZX-MED-CO   6 March 1981

SUBJECT: Role Clarification Workshop

1. As a key member of my staff you are requested to attend a Role
Clarification Workshop to be conducted on 21 March 1981 from 0730 hours to
1400 hours at the Ross Continental Motel on Highway 171 in Leesville.

2. The purpose of this meeting is to clarify role expectations and
obligations of the top team members of MEDDAC in an effort to improve team
effectiveness in activities directly related to patient care. It is
designed to:

   a. Clarify the understanding that we have of each others' roles;

   b. Clarify our own individual roles within the MEDDAC; and

   c. Negotiate and readjust roles as necessary to best support the
patients serviced by MEDDAC at Fort Polk.

3. The workshop will focus on how the aspects of our roles are aligned
in an effort to gain clarity on each individual's job responsibilities. It
is not designed to blame others for present or past difficulties, but
rather to create a clear picture of what we are supposed to be doing so
that we avoid difficulties between or overlap of job responsibilites in the
future.

4. I have requested the Fort Polk Organizational Effectiveness Staff
Office to organize the meeting. The OESO's, Major Cole, CPT (P) Frayne,
and MSG Coleman, will be working for me and will render no report on our
activities to anyone but me.

5. The workshop will begin after a no-host breakfast at 0730 hours in
the restaurant at the Ross Continental at Leesville, LA. The Basic agenda
for the workshop is:

   a. Discussion of roles.

   b. Preparation of notes on individual roles on butcher-paper charts.

AFZX-MED-CO   6 March 1981
SUBJECT: Role Clarification Workshop

     c. Group discussion of their expections.

     d. Negotiation and readjustment of roles.

     e. Approval of roles by Commander, MEDDAC.

6. Prior to the meeting you should think through your job respon-
sibilities and positions you wish to express during the meeting. You may
want to review your portion of MEDDAC Regulation 10-1, "Organization and
Functions Policy." To expedite the conduct of the meeting, you may want to
make some notes for yourself on the following:

     a. What I think my job is.

     b. What I think the other participants responsibilities are. The
participants for this Role Clarification Workshop are: Commander;
Executive Officer; Chief, Professional Services; Chief, Department of
Nursing; Chief, Clinical Support Division; Chief and Assistant Chief,
Family Practice Department; Chief, Department of Primary Care and Community
Medicine; Chief, Emergency Medical Services/Flight Surgeon; Commander,
Medical Company; Command Sergeant Major; and Chief Wardmaster.

     c. What I actually do.

     d. What I am willing to do to assist others.

7. Finally, you should come mentally prepared to participate in the
meeting and discuss your ideas in an open and candid manner. I look for-
ward to seeing you on the 21st of March.

                            RICHARD B. STUART, M.D.
                            COL, MC
                            Commanding

APPENDIX E

AFTER ACTION REPORT ON ROLE CLARIFICATION WORKSHOP

DEPARTMENT OF THE ARMY
MEDICAL DEPARTMENT ACTIVITY
FORT POLK. LOUISIANA   71459

AFZX-MEDH

MEMORANDUM FOR RECORD

SUBJECT: After Action Report of Role Clarification Workshop Involving
Key Personnel of the US Army Community Hospital, Fort Polk

1. A Role Clarification Workshop was conducted with key personnel of
the US Army Community Hospital on Saturday, 21 March 1981. This document
presents a general accounting of what occurred during the workshop and
provides a summary of the participants' assessment of the workshop.

2. Attached as Inclosure 1 is the agenda of the Role Clarification
Workshop.

3. The participants' expectations of the workshop were:

--Individual identification of my job/your job
--What others think my job is
--Assigned job definition
--Integrate the above into new hospital
--Interpretation of HSC/MEDDAC regulations and local supplements
--Avoid conflicts by better understanding
--Change roles
--Discuss Commander's role in the functional organization
--Better day-to-day working relations
--Guidance on prioritization
--How to exercise command and control without operational control
   a. Streamline
   b. Responsive
--Have fun/job satisfaction
--Professional growth

4. Following the development of expectations, an inventory was conducted
to assist individuals to understand their own behavior. A Strength
Development Inventory (published by Personal Strengths Assessment Service,
Inc.) was employed. The inventory is based on a Relationship Awareness
Theory which holds that we act toward others as we do because we are
seeking certain gratifications in our relationships with others.

AFZX-MEDH-XO
SUBJECT: After Action Report of Role Clarification Workshop Involving
Key Personnel of the US Army COmmunity Hospital, Fort Polk

The theory espouses:

Observing how we act toward others tells us what gratifications we are
seeking from others. And, by the same token, observing how others
relate to us tells us what gratifications they are seeking from us.
The key to understanding ourselves and to understanding others is to
look behind the behavior for the underlying gratifications being sought.
When we understand what we want from others, we can often change our
behavior to more effective ways of getting what we want. When we
understand what others want, as well as understanding what will appeal
to them, what they will find rewarding and what they will find unreward-
ing or threatening, we can often change the way we relate to them so
that we achieve "win-win" relationships in which we get what we want
and they get what they want.

In sum, by understanding how we are motivated and how other people are
motivated, they become more understandable to us and we can assess more
rapidly whether or not a given relationship is likely to bring us the
gratification we seek.

5. Inclosure 2 is a compendium of role perceptions of the participants as
they view their own positions within the organization.

6. Inclosure 3 provides the participants perspective of the role of the
Commander within the organization.

7. The workshop closed with an evaluation of what was or was not achieved
with respect to the participants' expectations. The results were spread out
on a continuum from not achieved to achieved. Additionally, a questionnaire
was handed out in an effort to provide feedback on the effectiveness of the
workshop. The results of the questionnaire are summarized in Inclosure 4.

4 Incls   ROBERT J. HECKERT, JR.
as   CPT, MSC
                                     Administrative Resident

PARTICIPANTS' ROLE PERCEPTIONS

AGENDA

0730-0815	breakfast
0815-0830 (5 min)	commander's intro/reason OE intro
0830-0930 (45-60 min)	outline characteristics predict instrument align w/ charts --- change under pressure summarize app to role clar give sheet of animal characteristics
0930-1000 (30 min)	break (working) --- job/role listing on newsprint - themselves/cdr
1000-1030 (30 min)	indiv/cdr role presentation - by all (3min/person)
1030-1130 (60 min)	indiv role negotiation - 5 min ea
1130-1200 (30 min)	cdr role negotiation
1200-1215 (15 min during lunch)	question 3 (working break) --- post underneath own role
1215-1300	lunch
1300-1400 (60 min)	present and negotiate individually 5 min ea
1400-1415 (15 min)	closure and cdr cmts

NAME: COL William Bethea   DUTY: Post Flight Surgeon
                                                5ID Flight Surgeon
                                                Chief EMS
                                                Chief, Clinical Services
                                                Consultant Prev. Med.
                                                Consultant Occ. Health
                                                GMO

My role is:

   a. Flight Surgeon - - aviation physicals, Class I, IA, II, III
           Up and down slips 4156 (F/S only)
           Waiver authority for Class III flying physicals
           Maintenance of optimum state of health of flight
               crews and their families
           Obtaining waivers for senior officers who are Cat B
               aviators and maintaining currency of waivers in
               coordination with AEROMED Center, Fort Rucker
           Insuring competency of Cat B aviators to be recalled to
               Flying Duty in as short time as possible

   b. Aviation Safety - in-flight evaluations
           Classes to aviators undergoing nap of the earth flying
               training and night flights

   c. Consult to Air Amb Dept for Med Evac (MAST Mission)

   d. Consult to Division Surgeon on aviation matters, staff
       procedures

   e. Consult to Division Aviation Officer

   f. Cover for Division Surgeon when he is away

   g. Consultant to MEDDAC PAD for clearances for patients being
       med evac'ed by AF

   h. Training my Aviation P.A. - EM on loan from Division

   i. EMS - Responsible for professional ER Operations
           Working in ER during periods of patient
           Coordinating ER functions with MEDDAC physicians

NAME: COL William Bethea
Page 2

  Determining requirements for staffing of ER (3-11)
  Upgrading of physical structure of ER and replacing
   antiquated or worn out equipment
  Coordinating functions of AMOSISTS in ER setting
  Establishing ER SOPs, updating ER SOPs
  Training ER Staff - patient extractions from aircraft,
   loading med evac patients, etc.
  Putting out fires created by the ER Staff--overwork,
  Providing for advanced training for EMS physicians

j. Chief, Clinical Services - Backing Ped Nurse Practitioner
  when Peds MDs are away
  Consulting with AMICs and AMIC physicians on handling of
   problems

k. Visiting the various Support Clinics to coordinate my
  activities with their services

l. Consultant to Preventive Medicine and Occupational Health
  Provide Occ Health physicals
  Solving problems in physical conditions of civilian
   workers (Congressionals)
  Providing guidance to Preventive Medicine and Occ. Health
   on all aspects of their mission

m. GMO

NAME: LTC Thomas E. Nugent   DUTY: C, Prim Care

My role is:

    a.   Total supervision of clinics (seven)

    b.   Coordination of activities of each unit with other units

    c.   Coordination of personnel within each unit

    d.   Increase quality of care and perception of care given

    e.   Ensure training of all personnel--for the sake of both
        the personnel and the Commander

    f.   Provide physician input at Primary Care level

NAME: 1LT Michael P. Kennedy   DUTY: Cdr, Med Co

My role is;

    a.   To establish standards and policies relating to basics of
         soldiering for enlisted personnel and insure they are
         enforced. This will involve imposing appropriate disciplinary
         action when necessary.

    b.   To insure soldiers'(enlisted) welfare is being attended to.
         This involves improving living conditions of barracks and
         maintenance of barracks. Also, morale of soldiers must
         be monitored and constructive programs to improve morale
         must be developed and implemented.

    c.   To insure enlisted personnel have opportunity to get
         necessary training for career development and give them
         recognition for achievements.

    d.   To retain good soldiers

    e.   Anything else a good one foot is told to do

NAME: CSM Joe Muchen   DUTY: CSM

My role is:

    a. To keep the Commander informed on all those things that
affect the morale and the discipline of the enlisted in the
unit.

    b. Responsible for the training of all the NCOs in the unit.

    c. Keeping the enlisted informed of changes in regulations
and policies.

NAME: COL Anna M. Butcher   DUTY: C, DON

My role is:

    a. To support the Commander by maintaining a cohesive, flexible, productive nursing service and to provide expertise in all facets of nursing care.

    b. To support through staffing the physicians in their care of patients

    c. Provide managerial skills to most effectively utilize nursing staff as a whole and meet individual needs and goals for professional development

    d. Provide administrative knowledge and expertise to insure compliance with health care regulations, professional nursing practice standards as well as military regulations and requirements.

    e. Provide educational growth opportunities to increase individual short term effectiveness and long term usefullness to the Army

NAME: LTC Clark G. Hoffman   DUTY: C, Family Practice Dept.

My role is:

a. Provide leadership and supervision to Family Practice Staff

b. Be instrumental in assuring sound working relationships among the Family Practice Staff

c. Performing those duties of the chief and delegating authority to subordinates for duties which can be assigned.

d. Provide patient care as a family physician

e. Show appreciation to Family Practice Staff by my actions and let them know that their job is vital to accomplishment of mission

f. Encourage and make it possible to have regular Family Practice Staff Social functions.

g. Support both Family Practice Staff and Commander of MEDDAC

h. Maintain harmonious working relationship with all clinics, Departments, and Services

NAME: LTC L. J. Eason   DUTY: C,CSD

My role is:

a. Provide administrative management to professional staff

b. Furnish steno and typing above capabilities of clinics

c. Administrate Central Appointment System

d. Responsible for Patient Representative Program

e. Oversee the Administrative Management of an Ambulatory
   Patient Care Program

f. Assist CPS in establishing a viable CME program

g. Personnel management of clinic receptionists

h. Manage budget, assist MEDCASE planning for clinics

i. Capture and report statistical data

j. Assist CPS in admin of credentialing

k. Supervise Medical Library

l. Insure compliance with JCAH and IG Standards

m. Other duties as assigned

NAME: COL Ray A. Saintromain   DUTY: CPS

My role is:

    a. Manager of personnel who treat patients
        Balance staffing
        Arbitrate disagreements
        Develop (improve) individuals' management skills
        Present and support by personnel's ideas and needs
            to higher levels and vice versa
        Evaluate job performances

    b. Serve as commander's assistant (deputy) in all areas
        within my capability

    c. Evaluate commander's management practices, accepting or
        rejecting as I attempt to grow into a similar
        obligation (job)

NAME: COL Leroy Barber, Jr.   DUTY: Executive Officer

My role is:

    a. Act as administrative consultant to the commander

    b. Function as the leader of admin activities (PO&T, PAD, LOG, Food Services, CD, CSD, etc.)

    c. Provide admin service to the MEDDAC

    d. Prepare admin policy guidance, directives

    e. Serve as committee chairman to various committees (R.M., UR, etc.) and as a member on others

    f. Provide admin support to transition to new hospital; establish and implement transition tasks

    g. Perform other duties as assigned or RECOGNIZED

    h. Portray positive MEDDAC image

    i. Interface with higher HQ Staff

NAME: COL R. B. Stuart   DUTY: MEDDAC/Hospital Cdr

My role is:

a. Command the MEDDAC/Hospital -
    Plan
    Organize
    Staff/resource provision
    Direct
    Control

b. Insure high quality health care is provided

c. Insure that orders from higher HQs are carried out (including
    ARs, HSC Regs, FP Regs and directives, etc.)

d. Act as Director of Health Services for Fort Polk-advise
    Fort Polk Cdr

e. Responsible for security, appearance of MEDDAC area-

f. Insure MEDDAC staff is treated fairly - EO

g. Insure patients are treated fairly-with compassion, and concern-
    Pro concerned care program

h. Act as central point of contact for MEDDAC -
    internal and external publics
    ceremonies, conferences, etc.

i. Provide direct patient care

j. Conduct and supervise long-range planning for the MEDDAC-
    stationing plan impact, construction, new hospital,
    mobilization

PARTICIPANTS' PERCEPTIONS

OF

COMMANDER'S ROLE

NAME:

The Hospital Commander's role is:

    a.   To insure that major divisions are performing their
        individual missions satisfactorily

    b.   To make the decisions necessary to insure the above and
        establish internal policies

NAME: COL Leroy M. Barber, Jr.

The Hospital Commander's role is:

  a. Provide policy guidance

  b. Establish priorities

  c. Recognize capabilities and limitations

  d. Assign duties

  e. Define roles

  f. Resolve conflict

  g. Establish and enforce standards (discipline)

  h. Interface with and stand up for MEDDAC at higher
    headquarters

NAME: COL William Bethea, Jr.

The Hospital Commander's role is:

    a. Exercise command and control

    b. Arbitrate disputes

    c. Direct solutions to dispute problems

    d. Provide command guidance and insure that it is followed

    e. Know where emphasis is needed in patient care

    f. Back up the Chiefs of Departments when decisions are arrived at

    g. Provide liaison for MD's in MEDDAC with Surgeon General's Office

NAME: COL Ray A. Saintromain

The Hospital Commander's role is:

a. Manage all financial, physical plant, and personnel that
are part of the MEDDAC.

b. Resolve problems in group to group relationships

c. Develop subordinates by instruction and example

d. Represent individual and group needs to higher authority
and vice versa

NAME: LTC Clark G. Hoffman

The Hospital Commander's role is:

a.   Provide sound and wise leadership which will enable the MEDDAC to accomplish its mission

b.   Be aware of what is going on at the "grass roots" level

c.   Ensure the efficient operation of all patient care areas and supporting services

d.   Have time to listen to and counsel with hospital staff

e.   Be willing to do what he asks of his staff

f.   Be sincere, concerned, honest, and upright in all that he does

g.   Delegate authority wisely.

h.   Have sound knowledge of his job

i.   Responsible for patient care

j.   Responsible for operation of TMCs.

NAME: CSM Joe Muchen

The Hospital Commander's role is to insure that the hospital is
operated according to HSC regulations.

Name: LTC L. J. Eason

The Hospital Commander's role is:

    a.   Establish policy

    b.   Set priorities

    c.   Resolve professional conflicts

    d.   Public relations with the community

    e.   Maintain discipline

    f.   Promote socialization with view of increasing good
working relationships

    g.   Provide rewards for good work

    h.   Maintenance of quality medical service

    i.   Recruitment and retention, both of officers and enlisted
personnel

Name: LTC Thomas E. Nugent

The Hospital Commander's role is:

    a.   Maintain total perspective of the hospital's function and
        abilities

    b.   Delegate authority

    c.   Prioritize assets and services

    d.   Coordinate our activities and assets with HSC and units served

    e.   Public relations

    f.   Insure progression of personnel

    g.   Determine standards of care.

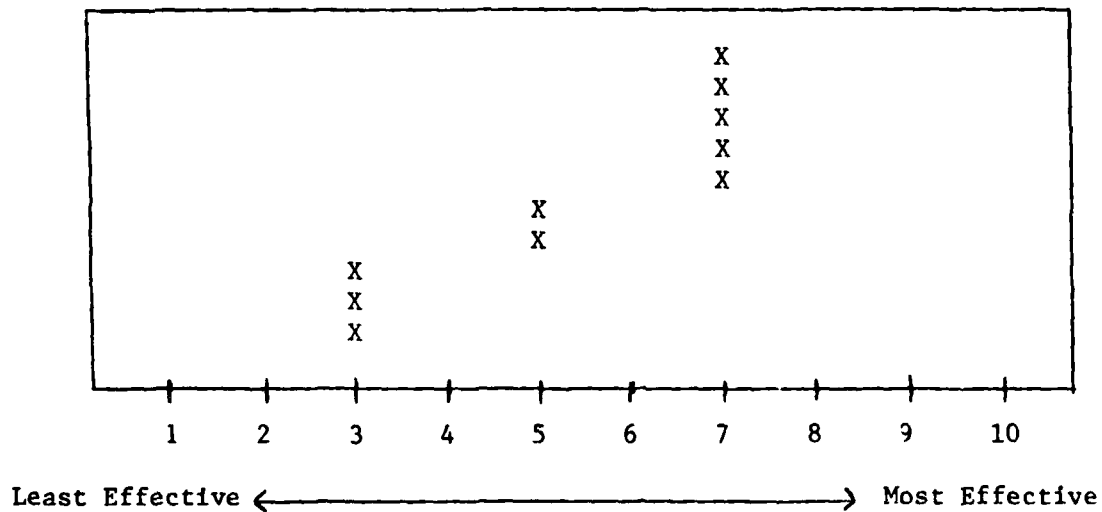NAME: COL Anna Butcher

The Hospital Commander's role is:

    a. Overall supervision and direction of activities in the
       MEDDAC

    b. To support all department chiefs in their assigned roles,
       as defined by regulations

    c. Delegate responsibilities to individual activities and
       chiefs

    d. Make policies

SUMMARY SHEET OF PARTICIPANTS' ASSESSMENT

OF ROLE CLARIFICATION WORKSHOP

1. Distribution of ratings of effectiveness of the workshop on a
    Scale of 1 - 10

```
|                                          X
|                                          X
|                                          X
|                                          X
|                              X           X
|                              X
|                  X
|                  X
|                  X
|____|____|____|____|____|____|____|____|____|____|____
     1    2    3    4    5    6    7    8    9    10
```

Least Effective ←——————————————————————————→ Most Effective

2. What did you like about it?

--The commander making his role as commander quite clear to his staff

--Got people talking openly about their relationship to others

--It was informative, particularly with roles I had little knowledge of. Secondly, information about myself and others concerning their thought processes and leadership styles in times of calm and stress was provided.

--Seeing how each person perceived his/her role

--Exchange of information

--Discovering the weakness/strengths/support, etc., of members present; observing the relationship between the Hospital Commander and Chief Nurse, the Chief Nurse and C, DPCCM, C, CSD and C, DON--all against the Chief Nurse? Interesting to observe the CPS react to supervision of C, DON spelled out by Hospital Commander

--Bringing everyone together at one time.

--Permitted 1-to-1 discussion with other participants which assisted in goal and task clarification

--Clarified roles of other key personnel in the hospital to include duties I was not aware of

--No response

3. What didn't you like about it?

--Personal conflict that arose between participants and the resulting tension

--Some didn't participate much and we didn't have enough time to explore some roles in depth, such as CPS.

--Specific problems/misconceptions of individuals' roles were not addressed particularly as they occur daily within the hospital concerning NCOs and officers

--Degenerated from role clarification to discussion on organizational structure; Didn't give participants other than Commander opportunity to see how others saw their role

--Initial goals were not met. Decisions were not made. Too much time was spent on one subject

--More discussion needed of others view of our own role

--Inability of the C, DON to clearly state the physician/nurse relationship in the total care of patients

--Waste of time

--Conducted on Saturday
  Area seemed physically uncomfortable
  Facilitators permitted Commander to take over too much

--The workshop just covered roles and I would like to have something on how effective we are at what we are doing. Really, I have no complaints about the material covered.

4. Were the proper people in attendance?

--Almost; however, the chiefs of Surgery, Medicine and Pathology should have been here.

--Yes (4)

--Add C, PO&T

--No, first time less people until key roles are clarified

--No, at this level, the Flight Surgeon/Chief EMX should
have been excluded

--No, improper mix

--Yes, but perhaps some of the chiefs of other services and
departments should have been in attendance

5. Can you make money by using this workshop in your area of
services?

--No (3)

--Yes (4)

--No, not as this workshop was conducted

--No response (2)

6. How can this be improved (location, time, date, etc.)?

--Change mix of participants, involve lower ranking individuals

--No improvement necessary (3)

--Allow more time

--No suggestions (2)

--Fewer people/proper mix

--Weekday, 0800-1600, try Holiday Inn

--Have the workshop annually

7. Is there anything else you would like to add about the workshop?

--Have available for all participants complete set of ARs,
MEDDAC and HSC Regs

--All other activities chiefs should be included in future
goals conferences

--It's a darn good excuse to have a big breakfast at the
Continental

--More control required

--Would be helpful if facilitators were familiar with MEDDAC
organization

--It would be interesting to add how each of us can become
more effective as individuals by key positions

--No response (5)

8. The top five items of support I need from other participants--

--Mission defined: Priorities set--active duty, dependents, etc:
Personnel allocations: Personal visits of DON to ER/AVN MED/OPC

--Courteous consideration: Courteous communication: Objective
decisions: Clear chain of command, upwards and down

--Information about participants, people, activities, problems,
plans (XO, C,PCCM, C, DON, C, FP, CSM, Co CDR): Technical
advice (XO, C, DON & C, EMS): Management indicators from all

--C, DON, a more rounded view of others mission with less parochialism
CSM, more involvement with NCO professionalism and discipline
(counseling); From Family Practice Department, an appreciation
for the limitation of other Divisions and a willingness to do
more with less complaint

--Respect for personal integrity; knowledge, capability, and
position: Latitude to perform my job without interference as
per AR 40-6 and MEDDAC Reg 10-1; Nonhostile, nonaggressive
communication regarding problems or needs involving DON:
Discussion of conflicting priorities and understanding or
acceptance of "unfavorable decisions", not "me first" or
nothing else will do: Understanding that the C, DON deals
with a number of priorities from different areas not just
with one section, i.e., primary care, ER, Aviation Med., etc.

--No response (3)

--Internal support once a decision is made; I need to be
informed in a more timely manner about matters that affect
my staff;

--Personnel when the workload demands extra people; Satisfactory
equipment to do the job: Adequate working conditions for all;
Minimal extra duty assignments which interfer with primary
mission: Effective, satisfactory laboratory and X-ray service.

APPENDIX F

OUTLINE FOR MEDDAC ROLE CLARIFICATION PLAN

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STEP 1. INITIATION

- Identify key personnel

    -- People who can "stop, let, help, make" change occur

- Outline benefits resulting from Role Clarification Plan

    -- Time saved

    -- Ambiguity reduced

    -- Communications improved

    -- Commander-Staff relation clarified

- Brief key personnel on concept of operation

- Conduct actual Role Clarification Workshop for key personnel.
  Which will:

    -- Clarify actual roles of individuals at top levels within
       MEDDAC

    -- Provide personal insight/experience base for decision making-
       planning.

    -- Promote understanding of value of program

- Key personnel provide guidance

- Form Ad Hoc Committee/Control Group

    -- Develop detailed plan based on guidance received from
       key personnel

    -- Supervise preparation and execution

STEP 2. PREPARATION

- Train facilitators

    -- L&MDC, observation, practical experience

    -- Will yield MEDDAC self-sufficiency

-- Provides flexibility

-- Addresses personnel turbulence

-- Emphasizes on-going nature of Plan.

- Conduct "TYPE" Role Clarification Workshop.

   -- Involves representatives from each "TYPE" role, i.e. MCs, MSCs, ANCs, EM, etc.

   -- Uses HSC Reg 10-1 as base

   -- Develops models to minimize conflicts over responsibilities and general duties between various "TYPES."

STEP 3. EXECUTION

- Role clarification at all levels

   -- Start at top - move downward

   -- Logical sequence

   -- Command Emphasis

   -- Include on-going feedback system

STEP 4. EVALUATION

- Planned renegotiation and evaluation to lend stability and flexibility

- Outside/external reassessment

RECOMMENDATIONS (In sequence)

- Key personnel attend Role Clarification Workshop

- Commander meet with key personnel to discuss their experience in terms of its appropriateness to overall MEDDAC

- Make decision whether to continue

- If "yes", key personnel work with OESO to develop GUIDANCE.

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