THE UNITED STATES ARMY MEDICAL DEPARTMENT

JOURNAL

LEADERSHIP IN THE ARMY MEDICAL DEPARTMENT

July – September 2013

THE UNITED STATES ARMY MEDICAL DEPARTMENT

A Professional Publication of the AMEDD Community

JOURNAL

Online issues of the *AMEDD Journal* are available at http://www.cs.amedd.army.mil/amedd_journal.aspx

July – September 2013 | The Army Medical Department Center & School | PB 8-13-7/8/9

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The Army Medical Department Journal [ISSN 1524-0436] is published quarterly for The Surgeon General by the US Army Medical Dept Center & School, Journal Office, AHS CDD Bldg 4011, 2377 Greeley RD STE T, Fort Sam Houston, TX 78234-7584.

Articles published in *The Army Medical Department Journal* are listed and indexed in MEDLINE, the National Library of Medicine's premier bibliographic database of life sciences and biomedical information. As such, the *Journal*'s articles are readily accessible to researchers and scholars throughout the global scientific and academic communities.

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Perspectives

Acting Commander's Introduction

COL Randall G. Anderson

Is leadership an innate talent? Is it an instinctive capability? Is it a learned skill? Is it an amalgam of all of those? Indeed, throughout the history of structured human societies, the question "are leaders born or made" has been discussed and debated. Leadership remains perhaps one of the most extensively pondered and analyzed aspects of the human condition, as both scholars and the simply curious attempt to define, dissect, and quantify it.

The intensity and persistence of interest in the essence of leadership is not simply the product of academic curiosity. The absolute necessity of effective leadership in the success and survival of societies and even civilizations has been recognized and understood for several millennia. History is replete with civilizations that rose and prospered under a series of successful leaders, only to wither and die as ineffectiveness and incompetence became the norm. Not surprisingly, such cycles are still obvious in nations of today's world. No organizational enterprise, be it societal, political, commercial, or especially military, can afford to wait for capable leadership to simply appear and lead it to success. Therefore, entities with clear historical perspective and understanding will commit significant effort and resources to the identification, development, and nurturing of skills and characteristics attributed to successful leadership.

To that end, leadership training has long been a fact of life for members of the US military services. Since most Soldiers find themselves in positions of responsibility for others early in their military experience, their formal training requirements always contain elements of leadership, which increase in sophistication in keeping with their broadening responsibilities over time. This is an important component in the mission of the AMEDD Center and School (AMEDDC&S), which is responsible for the creation and delivery of leadership training to Army medical professionals at various stages in their military careers. This issue of the *AMEDD Journal* is the result of efforts of the AMEDDC&S Leader Training Center to present the most current initiatives, internal research, and thinking in optimizing the effectiveness of leadership training within AMEDD. Although the Leader Training Center is chartered to develop and deliver leadership training to Army medical officers, the concepts, techniques, and tools discussed in this issue have universal applicability to professional military medical leadership development at all levels. Further, such training has even broader implications. It is widely acknowledged that successful leadership skills developed in the military carry over far beyond the military experience, reflected in countless success stories and major achievements by former military medical professionals in advancing medical science.

The US military is experiencing yet another tumultuous period in meeting its current evolving missions, attempting to project and define the future threats and requirements to meet them, and determining how to address the transition from one to another. It is absolutely vital that the Army Medical Department meets those same challenges in real time with the rest of the defense establishment of the United States. Indeed, there are societal, political, and financial obstacles to progress, but such has always been the case. Strong, effective leadership at all levels across the AMEDD is as important now as it has ever been. Current and future AMEDD leaders will ensure the rich, historical legacy of service, support, and extraordinary medical achievements of Army medicine will continue unabated..

EDITOR'S PERSPECTIVE

In today's world of seemingly continuous action and reaction in which everything apparently is required yesterday, there never seems to be enough time to examine and evaluate existing institutional structure and processes. After all, everything has been working for years—at least on the surface. Fortunately, within AMEDD an internal examination of "business as usual" is an integral element of each Corps transformation planning process, and leadership development is an essential area of interest. As a result of the Army Nurse Corps top-to-bottom mission analysis in 2008-2009, structural changes were implemented and significant leadership development resources were committed to ensure that effective leaders were always in place at all levels of Army nursing. In 2011, the Chief of the Army Medical Corps directed the creation of a working group to specifically address leadership development for all Army physicians throughout their careers. The result of the collaboration of 40

Medical Corps officers is a candid examination of the status quo, and a carefully constructed, detailed proposal to ensure that every Army physician receives appropriate leadership development training and support throughout his or her career. The complete report and plan, entitled *All Physicians Lead*, will soon be available from the Medical Corps. The *AMEDD Journal* is happy to present an advance look at this important work, with a collection of extracts from throughout the document.

The *AMEDD Journal* welcomes former AMEDDC&S commander MG (Ret) David Rubenstein back to these pages with his thoughts concerning a baseline for any individual faced with leadership responsibilities. His insightful article points out that a clear understanding of ourselves as leaders will simplify our task in facing the challenges of successfully leading others. It may sound simple in concept, but the reality of practice is something else entirely.

In the military, trust is elemental and essential for survival and success. Whether it is the deadly chaos of a firefight, the desperate activity of the trauma team around a critically wounded Soldier, or the directions of a unit commander to his staff, everyone must be confident that the others "have my back." This is especially true for leaders. As COL Eric Sones succinctly and clearly outlines in his article, a leader must first earn and hold the trust of those in his or her organization, otherwise they will quickly look elsewhere for guidance and inspiration. The absence of direction will eventually become obvious, ultimately reflected in mediocrity or failure in accomplishing the mission. In a medical unit, such deterioration can have serious ramifications for those whose lives may depend on the professionalism and capability of the organization.

As mentioned earlier, since 2009 the Army Nurse Corps has implemented proactive measures to ensure that leadership skills among Army nurses develop as their careers progress. In his article, COL Daniel McKay describes how the Nurse Corps approach to leadership development incorporates a values-based foundation for decisions made in both patient care situations and those choices required in leadership roles. The important aspect of this approach is the emphasis on understanding that the ability to recall a list of words (organizational values) is worthless unless those values become part of an individual's personal values. Only then will a leader truly base his or her approach to both work and leadership on the set of standards expected of all within the organization. As with trust, hypocrisy on the part of a leader with respect to personal values is usually obvious, and the organization invariably suffers as a result.

Researchers have long sought to identify and define the essence of effective leadership. The most logical approach to obtaining such information is to ask those who respect and admire a leader to quantify why they have that opinion. As data collection and statistical analysis have become increasingly more sophisticated over the last half century, lists of statistically relevant key characteristics and attributes found in successful leaders across a spectrum of organizations have been compiled. Dr Jody Rogers and Dr David Mangelsdorff of the AMEDDC&S Leader Training Center have contributed an article describing a 3-year effort to identify leadership characteristics observed in respected AMEDD leaders, and compare the results with those obtained from nonmilitary survey populations. Such data allows those responsible for the design and implementation of leadership training to address those aspects identified specifically as contributing to success and effectiveness. This article is an excellent example of the dedication, expertise, and professionalism of those charged with forming AMEDD's leaders of tomorrow.

Mentoring may be the longest-practiced approach to leadership development. It has probably existed in some form or another since human family groups evolved into tribes, and eventually into societies where it has become a recognized, formalized process. Its effectiveness is beyond dispute, else it would have long faded into history. The concept is deceptively simple, but there is much more to it than one might think. COL Mark Melanson has been a dedicated advocate and practitioner of professional mentoring throughout his military career, and has published many articles and papers on the subject, a number of which have appeared in the *AMEDD Journal*. He has contributed an article to this issue in which he calls on his many years of experience and extensive knowledge of the professional literature to derive 10 essential qualities of the ideal mentor. Although these qualities are undoubtedly applicable to mentors across the board, COL Melanson has tailored his article to specifically address mentoring within AMEDD, within which he has contributed to the development of a number of successful leaders over his 30-year career.

As discussed earlier, the Leader Training Center of the AMEDDC&S has the responsibility to develop and deliver leadership training to Army medical officers. To that end, the Center is always abreast of the latest research, thinking, and tools available in professional leadership development. Dr Jody Rogers and his coauthors have contributed an article describing the use of one such widely-used program, The Leadership Challenge, by the Leader Training Center to develop and enhance the leadership skills of AMEDD officers. This interesting article

details the philosophy and approach of the various elements of the program, and explains how it is implemented within the environment of military medicine.

One of the important changes in the ongoing transformation in the Department of Defense is the consolidation of certain elements of military healthcare into multiservice, aka joint, operations. The reality of this approach can be seen at Fort Sam Houston, where virtually all triservice medical training is now conducted at the Medical Education and Training Campus. COL William LaChance addresses the effect and differences that military medical professionals must consider in exercising leadership in this changing environment. In his article, he recognizes the potential institutional and philosophical impediments to personally accepting and embracing this new situation, especially among the more experienced military medical professionals. This is a superb, thought-provoking treatment of the new reality that should be a must-read for all military medical professionals, because the "culture shock" is definitely not limited to the Army.

COL Charles Callahan continues the discussion of the joint military medical environment with his article detailing the successful transition in what was perhaps "ground zero" of the consolidation of military medical care. Prior to 2010, each of the 3 military services had a major medical treatment facility in the national capital area, as well as an Army hospital at Fort Belvoir. Among other things, the Base Realignment and Closure Act of 1995 directed the consolidation of military healthcare in the nation's capital, which initiated a 5-year effort by a joint task force to create and implement a new organizational model for joint operation of a regional military healthcare structure. The 3 major medical centers were merged in Bethesda, Maryland, and the Fort Belvoir hospital was replaced by a larger facility by the end of 2012. COL Callahan's article clearly describes the differences in organization and staff structure philosophy among the services that had to be understood and addressed. This is a very informative article which provides excellent insight into an extremely complex process that resulted in successful, cooperative joint operation of military healthcare delivery on a wide scale.

An important caveat to any investigation into successful leadership is the environment in which it was experienced. The reigns of many legendary successful leaders throughout history were absolute, their decrees and orders established law, no matter how brutal or seemingly incoherent. Ultimately, their successes were eventually followed by decline and anarchy. Over the centuries, a number of human societies (not many by any measure) have struggled to establish the rule of law rather than the decree of man. Such structured societies must continue to produce leaders to guide and nurture them to prosperity and success, but always remain on guard against sliding back into the darkness of rule by decree. The United States is the current world history success story in living within the rule of law. All leaders in our nation must conform to a structure defined by law, and the US military is no different. MAJ Joseph Topinka returns to the *AMEDD Journal* with a team of professional military legal professionals to contribute a compendium of legal considerations that must be understood as a baseline by all US military leaders. A US military leader, including those in the AMEDD, will face many decisions throughout his or her career, and the knowledge of the boundaries and options imposed by law will be extremely important in formulating the choices. In the US Army, the Army Ethic is foremost in the foundation of leadership, and that ethic is immutably locked into the laws of our nation. The article by MAJ Topinka et al is a consolidation of the legal topics taught as part of the Leader Training Center's courses. It touches many areas, some immediately relevant to most AMEDD leaders, some that will come into play in special situations. In the tumult of today's world, a military professional never knows when he or she will become involved in such a circumstance or situation. This article is a valuable resource for both new AMEDD leaders and those with many years of experience who may benefit from a review of the legal basics of military leadership.

The US Army Medical Corps Leadership Development Program

The US Army Medical Corps Leadership
Development Program Working Group

INTRODUCTION

COL Leon E. Moores, MC, USA

This work is about culture change. At its foundation is a program of leadership development that is broader and more powerful than we in the Army Medical Corps currently consider. It is a program that has great relevance to every Army physician, not just those aspiring to senior clinical or executive leadership positions within Army Medicine.

Physicians implicitly must do 2 things: teach and lead. One form of the Latin root word of doctor, docere, means "to teach." For a modern doctor, passing knowledge to patients and trainees is a mandate. Leading is also a critical professional skill. Leading healthcare teams, leading patients, and leading trainees are all required. Leadership has been defined as the art of convincing someone to do something they do not want to do. Often this is the very essence of the physician-patient relationship—stop smoking; lose weight; take your medications.

We have noted throughout our careers that there is almost no formal education regarding teaching or leading. We have created a leadership development program to address the latter deficiency. With implementation, we will change the current paradigm of "accidental leadership training" into a structured program that is inclusive for all Army physicians in order to improve patient care delivery, improve the functioning of our healthcare teams, and enlarge and strengthen our candidate pool for senior leader positions in the Army Medical Department.

That is our task.

Currently, too few Medical Corps officers are interested in pursuing leadership positions outside of the clinical setting. Additionally, Medical Corps officers who attain clinical or command leadership positions are often unfamiliar with the principles of leadership practice and theory. The extent to which they may be prepared is usually the result of random events, focal mentorship experiences, and/or great personal effort and study rather than any leadership development program.

The standard approach to leader succession addresses only the challenges faced by those at or near the top of the leader pyramid and ignores the majority of those at the base. By failing to provide leadership education and experience from the beginning of every Medical Corps officer's career, we significantly decrease the available pool from which to select senior level leaders, and worse, we fail to prepare every physician to optimally care for patients in today's team-oriented, patient-centered environment.

Structural impediments to the acquisition of leadership training can be overcome with a well-designed, carefully implemented educational program. Unfortunately, the cultural challenge we face is significantly greater, and is based on a strong perception on the part of physicians that leadership applies only to those Army Medical Corps officers who are striving to become department chairs, commanders, or general officers.

In the summer of 2011, the Chief of the Army Medical Corps approved the creation of a working group to establish a leadership development program for all Army physicians. The initial problem statement focused on leader succession planning in the Army Medical Corps. The product of the working group's efforts is the US Army Medical Corps Leadership Development Program, presented in *All Physicians Lead*, which will soon be available from the Army Medical Corps. This article is a condensed presentation of the information contained in that publication, providing an introduction to the program and an overview of our approach to institutionalizing structured leader development as an integral part of a military physician's career from its beginning. Each of the following sections is derived from a chapter of the same name in *All Physicians Lead*. Each section ends with related observations and insights from experienced, current leaders within the Army Medical Corps.

The fundamental premise of the Army Medical Corps Leadership Development Program is that the most basic

definition of leadership, the ability of one individual to influence the behavior of other individuals, applies broadly to every physician in every aspect of professional life. A program requiring every physician to study the theory and practice of leadership will have far-reaching positive effects on the ability of those physicians to lead healthcare teams, to care for patients and their families in the daily practice of medicine, to teach the next generation of medical students and residents, and to influence population health through scientific research. Broadly applied across the entire Army Medical Department (AMEDD), this initiative could have a greater impact on the improvement of patient care over the next decades than any program in recent history.

Although the program was sponsored and developed by the Army Medical Corps, we are hopeful that other Corps within the AMEDD and our sister military services will find it appropriate to take advantage of this program and future products as they become available. Additionally, we hope that other federal and civilian institutions involved in training medical professionals at all levels will find this program helpful in their efforts to create medical leadership programs for their students and faculty.

Leadership in the broadest sense of influencing others in order to achieve desired outcomes is a core competency for all physicians. Ironically, the majority of physicians in this country receive minimal education in the theory and practice of leadership. We can and will do better, and we see the Army Medical Corps Leadership Development Program as a first step in that direction.

EVERY PHYSICIAN LEADS: RATIONALE, STRUCTURE, AND PROPONENCY

COL Leon E. Moores, MC, USA

Every system is perfectly designed to get the results it gets.

Paul Batalden[1]

While he was CEO of General Electric, Jack Welch spent 50% of his time developing people with special emphasis on developing future leaders.[2] How committed to leader development are we?

A working group was established in October 2011 to evaluate the current state of Army Medical Corps leadership development and build a comprehensive program. It quickly became clear that 2 fundamental premises would frame the working group's effort:

- Leadership is a core competency for all physicians.
- We can do better at leadership development within the Army Medical Corps.

CORE COMPETENCY

Leading is a critical professional skill for all physicians, but it is almost unrecognized as such. Whether you are in single practice or a department chair at a major academic medical center, you are required to lead a healthcare team and your patients. Leadership is often defined as the art of convincing someone to want to do something they initially do not wish to do. Although every physician must do this almost every day, "leadership" literature as it applies to physicians uniformly addresses senior executive positions and ignores the requirement for leadership knowledge, skills, and attitudes at lower levels, including the medical student and resident levels. Because of the misperception that only senior physicians aspiring to run hospital systems need leadership training, there is little to no foundational education in the theory and practice of leading. Physicians are typically left to learn this critical skill using the age-old apprenticeship model, "see one, do one, teach one." Good and bad examples of leadership are placed before the student or resident and the trainee is required to choose and develop a style based upon individual (and untrained) assessment of what seems effective. Physicians at all levels could lead much more effectively if fundamental aspects of leadership were taught beginning at the medical student level and continued throughout the medical career. This work outlines a program for full-spectrum, total career leadership development.

The Accreditation Council for Graduate Medical Education has taken some steps in the direction of leader development. A specific core competency addresses professionalism, and many medical schools are now engaged in teaching professionalism. However, professionalism can exist in a vacuum and can ignore the dynamic interaction between the individual who is attempting to be "professional" and others in the vicinity influenced by that behavior. That complex interaction is better encapsulated under the rubric of leadership. You can practice professionalism in a room all by yourself, but you cannot lead without engaging others.

Another important leadership requirement exists beyond the complex leader-to-led dynamic. Physicians do not

lead in a vacuum. They lead within complex medical systems with internal business and administrative components, as well as external forces that shape the behavior and direction of the enterprise. Leadership is less effective if the leader does not possess an awareness of all of these levels. The depth and breadth of this awareness must increase as the leader takes on more senior leadership roles. An effective leadership program must build knowledge and experience in both the "hard" or technical skills of financial management, labor-management relations, and organizational structure; and the "soft" skills, such as interpersonal communication, conflict resolution, and decision making.

Finally, it is important for all Army physicians to acknowledge that leadership performance and potential are essential parts of the military evaluation system and the merit-based promotion system. We do a disservice to our younger physician colleagues if we do not give them the tools to excel within the organizational and operational parameters of the Army in which we all serve.

WE CAN DO BETTER

Army officers are required to attend schools and courses that address professionalism and leader development throughout their careers. It is often difficult for Army physicians to access many of these excellent programs because of time constraints and the numerous external accreditation requirements of medical school, residency, fellowship, and board certification. A key to the successful execution of these programs would be the development of curricula and content delivery methods which take into consideration trainee work hour restrictions and the requirements of medical training. At the same time, the programs must provide high-quality leadership development lessons and practical tools that trainees see as useful in their current education and future practice.

Leadership training in the traditional military is heavily focused on field duty or command. While these areas do indeed represent an important subset of requirements for Army physicians at some points in their careers, it does not fully encompass all of the physician's multifaceted leadership requirements. For example, better understanding of how a brigade combat team operates in a deployed environment will certainly help a brigade surgeon communicate with the commander and staff. However that understanding may not prove beneficial to a pediatric neurosurgeon attempting to manage a challenging patient-parent-physician relationship. Basic and advanced leadership skills (as opposed to position-specific leader skills) apply broadly to all facets of physician interactions. These skills should be taught to every physician at an early level as a foundation upon which to build advanced or position-specific leader skills during later years. The ability to lead depends on both learning the craft of leadership and gaining the experience of serving in positions as the leader.

The Leadership Development Program working group could merely have created a classic succession-planning program. Such a program would be designed to develop interest at an early stage of a medical officer's career, identify promising young officers, provide structured experience and education, and offer ongoing mentorship. Such a program's objective would be to create consistently high quality, well prepared colonels to become commanders and general officers from the Army Medical Corps. Developing a robust leader succession program is a critically important endeavor outlined later in the section Building the Bench (page 21). However, in order to enhance patient care and healthcare team effectiveness, we have substantially expanded the approach to include leadership development for all physicians at all career stages by providing foundational and ongoing training in the theory and practice of leadership. The enormous secondary benefit of this broad-based education is that it creates a much more robust pool of talent from which to select midlevel and senior-level clinical and executive leadership positions (service chief, department chief, program director, deputy commander for clinical services, commander, command surgeon, etc).

Ultimately, this program should become "the way we do business."

There are both organizational and cultural impediments to physician leadership development in Army medicine. Not surprisingly, many are not significantly different from impediments encountered in the civilian sector. Extraordinary time commitments during medical school, residency, and fellowship; work hour restrictions limiting curricular additions; and funding constraints within training programs make it very difficult to add focused leadership education and training. Additional years following medical school and residency training required to achieve board certification, build a practice, and develop skills in one's specialty mean that many physicians are senior majors or lieutenant colonels before they are fully clinically competent. Understandably, preparation to lead a department or hospital is not a consideration for physicians before this career point. If we expand the definition of leadership to include the entire range of clinical interactions (interactions of medical students with technicians in the emergency department, residents with the operating room team, and

junior attendings with the staff on the inpatient ward), we then have a rationale to implement an education program that is relevant and practical.

From a cultural standpoint, military physicians often avoid leadership opportunities and training because of the perception that it will detract from their clinical practice by taking them out of the clinic or operating room for a portion of each week. Antagonism between clinicians and healthcare executives (even executives who are former clinicians) may cause young physicians to avoid leadership roles in order to avoid being perceived as "lesser" clinicians. Combined with a lack of formal training in leadership theory, these barriers create significant problems when physicians assume clinical or executive leadership roles. Without training, the physician may also avoid taking a risk to seek a leader role outside his or her comfort zone. When physicians are forced to assume a leadership position, they may experience stress, dissatisfaction, or outright failure. This stress is compounded by physicians' natural desire to perform at a high level. It is worth considering that stresses caused by being forced to lead without adequate preparation may also contribute to disruptive physician behavior.

We began by exploring several lines of effort (LOEs). Each LOE (early exposure/develop interest; provide leadership education; mentorship and coaching; and develop future senior leaders) was developed and studied by a senior physician team focusing on current state, ideal end state, gap analysis, and goals intended to close the identified gaps. Outside organizations, such as our line counterparts the Veterans Health Administration, industry, civilian healthcare systems, and professional associations, were studied for comparison. Teams were not constrained by resources or history. Divergent thinking was encouraged, and everything was on the table.

As we developed the program goals, we recognized that successful implementation must minimize any additional administrative and resource burdens at all levels. Many of the defined goals could substitute for currently existing training so that the programs are standardized across the Army Medical Command while meeting external accreditation requirements. The Accreditation Council for Graduate Medical Education Competencies, AMEDD military unique curriculum, residency review committee professionalism training, and maintenance of certification requirements can be met with elements of the proposed curriculum.

The envisioned result is a widely embraced program that teaches leadership to all physicians, while also identifying individuals to be developed for senior physician leader positions.

PROPOSED STRUCTURE

Establish a Medical Corps Leadership Consultant

The AMEDD recognizes nonclinical specialty consultants to The Surgeon General, Medical Corps history, ethics, and Medical Evaluation Board consultants, for example. We will establish a Medical Corps Leadership Consultant who will oversee implementation of the program. Ideally, this consultant will be based at Fort Sam Houston with the Corps Specific Branch Proponency Officer and will report directly to the Medical Corps Chief. The Leadership Consultant will be a senior colonel who has served the AMEDD in significant leadership roles (commander, deputy commander for clinical services, consultant to The Surgeon General, department chief, etc) and has demonstrated an interest in leadership development. The Consultant will be responsible for the implementation and maintenance of the Medical Corps Leadership Program, including the provision of guidance and oversight for the Leadership Development Committee and subcommittees. He or she will be supported by a Medical Corps lieutenant colonel as deputy consultant and a civilian assistant. Regional leadership consultants, combined with local leadership coordinators at facilities and installations with large Medical Corps populations, will assist with implementation and provide feedback for continuous program improvement.

Establish a Leadership Development Committee

The Medical Corps will create a Leadership Development Committee (LDC), the membership of which will be comprised of top-level senior executives such as commanders of medical treatment facilities, commanders, command surgeons, Medical Corps consultants, directors of medical education, Medical Corps staff officers in the Office of The Surgeon General, and other leaders as appropriate. The group will meet formally twice annually. The LDC will create an executive committee, chaired by the Medical Corps Leadership Consultant, consisting of 10 members with decision-making authority. The committee will meet monthly and will provide ongoing guidance and support for execution of the leadership program, including creating and directing subcommittees as described below.

Subcommittees will be created to take responsibility for development and execution of all major program components: develop interest, education, mentorship/coaching, leader development, strategic communication/knowledge management/website maintenance. The

subcommittees will report to the Chair of the LDC Executive Committee (Medical Corps Leadership Consultant). The LDC will develop metrics to evaluate the effectiveness of the leadership program and to drive continuous program improvement.

SUMMARY

Leadership is a core competency for all physicians, but the theory and practice of leadership are taught inconsistently. The Army Medical Corps will develop a comprehensive Leadership Development Program that will ultimately improve patient care, enhance the performance of healthcare teams and thereby improving safety and quality of care. The program will significantly enhance physicians' preparedness to assume clinical and executive leadership roles at all levels.

A QUESTION AND A LEADER'S ANSWER

Rushing out of your department on the way to the hospital pharmacy and therapeutics committee meeting, you overhear a conversation between one of the junior residents and a more senior member of your department.

"Son, don't waste your time reading any of that leadership bull#%&! You become the best doc you can be and you will find that the nurses and the bean-counters will be listening to you because you actually touch patients. They better! Otherwise they are as stupid as the so-called experts who write those leadership books but don't know anything about real medicine."

You run into the same resident at the coffee shop on your way back from the committee meeting. You were the one who recommended the leadership books to him in the first place. What do you say to him now?

Inquiring about how his reading on the leadership material I recommended is going (but reluctant to admit that I eavesdropped on his earlier discussion with the senior staff member), I would offer that there are many whom he will encounter who do not have a lofty opinion of such literature for a variety of reasons. I admit frankly in these situations that I am among those who read leadership books and articles—especially those in the business community—with a healthy dose of skepticism. Too often I have seen writers who fail to recognize the distinction between leadership competencies and managerial skills, two overlapping but different sets of learned and innate skills. In fact, I have said before that many in business and academic communities appear to think that leadership is "management on steroids." I believe the application of too many formulaic models of leadership by consumers of these materials may have led to bad leadership examples and spawned some of the resistance of these leaders' subordinates to step into important positions themselves when good leaders are needed.

But this does not explain all of the inherent resistance to seeking these opportunities or taking these important assignments. All of us share to a variable degree a fear of change and of placing ourselves into roles in which we might feel only marginally competent and, even if qualified, we lack the degree of self-confidence which is born of proven success which characterizes our professional and technical roles as physicians and caregivers. While being "the best doc you can be" has always been the foundation of the best physician-leaders, it does not provide all of the qualities and qualifications needed to be a great leader. It also does not complete the education and training necessary to develop each of us into the kind of leader our organizations require for the dynamic world in which we live and work. Being a great physician means being an effective and inspiring small unit leader. Physicians work with the most compelling and intimate aspirations of our patients, guiding them during even life-threatening moments, assisting them while in harm's way to their ultimate objective of safety and well-being.

In our best moments, we provide vision and courage, and remove obstacles in the way of our patients' achievement of health and optimal function. No image better describes a successful military, business, government, nonsecular, or community leader. But to venture further into leadership of more complex organizations, even to the highest operational and strategic levels, requires risk-taking; a knowledge of self, ethics, interpersonal skills; a knowledge of organizations and the people who populate them; strategic planning; and other areas which cannot be gained by remaining focused solely upon the medical literature, our practices, and our roles as doctors. Ultimately, we can assure this young physician that practical leadership experience and learning from errors trumps everything learned from books.

LTG (Ret) Eric B. Schoomaker
The Surgeon General of the Army, 2007-2011

DEVELOP INTEREST: EARLY EXPOSURE TO LEADERSHIP THEORY

The following US Army Medical Corps officers collaborated in the development and writing of Chapter 2 of *All Physicians Lead* from which this section is adapted:

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Leaders are made, they are not born. They are made by hard effort, which is the price which all of us must pay to achieve any goal that is worthwhile.

Vince Lombardi[3]

A critical but underappreciated skill necessary for effective physician practice is leadership. Physicians lead patients to comply with treatment regimens; they lead a surgical team through an operation; they lead complex therapeutic interventions. Unfortunately, many physicians do not possess the skills necessary to become innovative, forward thinking, team leaders, often because of a lack of exposure to leadership principles and opportunities early in their careers.

The Army has made a total commitment to the development of future leaders by providing them opportunities to develop the skills, knowledge, and attributes required to meet the challenges through a deliberate, continuous, sequential, progressive process.[4,5] This leadership development is executed through 3 domains: institutional training, operational assignments, and self-development. Institutional or "schoolhouse" training requires the officer to progress through the sequential military education levels starting with the Basic Officer Leader Course (BOLC) and subsequent courses such as the Captains Career Course (CCC) and intermediate level education.

Medical Corps officers often experience a significant gap between attendance at BOLC and CCC in order to complete medical school and graduate medical education programs. During this period, there is a great opportunity to improve junior officer leadership exposure, interest, and development. Recently graduated residents serving in positions such as clinic officer-in-charge, section chief, or an operational assignment frequently note the lack of leadership skills needed to excel in their new position. Many junior medical officers find themselves in new leadership positions unprepared and uncomfortable. A negative experience may eventually dissuade them from seeking future assignments requiring advanced leadership responsibilities and may even influence their decision to remain in the military past their initial active duty service obligation. A poorly performing Medical Corps officer also hinders the success of the organization and may result in erosion of confidence and trust in the Medical Corps to provide capable leaders.

Junior medical officers should be taught that basic physician and military-unique leadership skills are not just essential for the select few that follow an administrative track towards command or operational positions. These fundamental officership and leadership skills can be just as important for the clinician and researcher as they are for the future commander. The skills and training should be provided in small increments over an entire career, rather than in large segments followed by periods where the skills are not exercised. This does not negate the importance of a comprehensive leader succession program to identify and groom physicians for specific senior leader roles (developed in the section Building the Bench (page 21)), but stresses that the craft of leadership applies to all physicians.

CURRENT SUCCESSES AND GAPS

The Ideal State

All junior Medical Corps officers will receive programmatic, ongoing leadership education throughout medical school, residency, and early in their careers, with practical opportunities to observe and actively participate in activities designed to foster leadership development.

Successes

Available institutional training both at the AMEDD and within the Army provides a foundation in leadership training as articulated by *Army Doctrine Reference*

Publication 6-22[4] and joint professional military education. Courses such as BOLC and CCC make officership and leadership skill training available and integrate operational and deployment education training into physician development. The Medical Corps has outstanding graduate medical education (GME) programs which produce well-educated, competent military physicians. These programs focus on several core competencies that dovetail with leadership development, such as interpersonal and communication skills, professionalism, and systems-based practice.

Military graduate medical education programs are required to incorporate military unique curriculum into their standard curriculum. Many of these have successfully exposed junior medical officers to fundamental military leadership skills and engaged them in innovative curriculum activities and practical exercises.

The Joint Medical Executive Skills Institute provides military healthcare professionals with executive management and administrative skills through educational programs, products, and services. This training is accomplished primarily through distance learning and covers many of the 35 leadership competencies required by senior healthcare managers.

Gaps

There is no "off-the-shelf" formal curriculum available that incorporates physician and military leadership skills which can be used by the wide variety of existing Accreditation Council for Graduate Medical Education (ACGME) programs. Without a standardized curriculum template, each program is left to develop their own at great time and expense, and the AMEDD is not consistently producing physicians with developed leadership skills by the end of residency training.

There is no requirement for junior physicians to gain any structured leadership experience other than occasional intraresidency positions such as chief resident.

There is no easily accessible, centralized repository for practical information regarding career progression, leadership opportunities/development, and guidance for junior medical officers.

There is no proponency who clearly has the task to ensure junior officers receive excellent leadership training, especially during medical school and residency/fellowship training.

Courses offered by the AMEDD do not always match medical professional requirements such as those prescribed by the American College of Physician Executives, ACGME, and other organizations.

There is no existing centralized, formal mentoring program within which more experienced officers can help shape the interests and careers of junior Medical Corps officers.

CLOSING THE GAPS

Short Term (6-12 month) Goals

Update the Medical Corps website to provide specific information on leadership development, career progression, and career milestones. This website should be the portal by which all Medical Corps officers access leadership material and information. The website will be tailored to specific users and be modeled after university websites that have different areas for prospective students, undergraduates, postgraduate students, and faculty in addition to general information applicable to all. The Army Medical Corps website will have areas for medical students,* GME participants, junior staff, senior staff, etc. The site will have links to the core leadership curriculum, other web-based leadership modules, and leadership websites and blogsites, such as "Henry V.4.3" (http://henryv43.wordpress.com/). The site would also include a recommended reading list that is specific for different phases of the physician's career and provide information on nonmedical training programs such as those offered by the RAND Corporation, White House Fellowships, and Army-Baylor University programs. The website would proide dissemination of information about positions for midrange and senior physician leaders

Develop an Army Medical Corps leadership presence on social media sites. Current senior leadership is just becoming comfortable with email, texting, and social media, however, the next generation is fully conversant with web based portals of information exchange. This will not be limited to sites proprietary to the military (Army Knowledge Online, MilSuite.mil, etc), but to the most commonly used sites such as Facebook, and Twitter. This social media presence needs to emphasize leadership development and opportunities.

Ensure that Medical Corps officers start residency training with a sponsor/mentor. The sponsor will be selected by the resident (not assigned) from a pool of eligible faculty. Time spent with the sponsor will include modeling of leadership activities such as participating in hospital-wide committees, administrative meetings, and counseling sessions. The resident will also be involved with

*Those students in the Armed Forces Health Professions Scholarship Program or the Uniformed Services University of the Health Sciences.

military administrative activities such as writing Army Officer Evaluation Reports, Noncommissioned Officer Evaluation Reports, and awards; dealing with disciplinary actions; civilian labor disputes; property accountability; and other practical topics. Residents will maintain a meeting log similar to a procedure log in which they document hospital board, committee, or business meeting attendance each month. Residents will be given the opportunity to shadow senior leaders during some unique leadership opportunities, such as local community speaking engagements or attending a meeting with a senior mission commander and staff. This is designed to be experiential, similar to medical school rotations that expose students to various specialties to develop their interest.

Expand membership of various hospital committees to house staff members. This exposes junior officers in a project-oriented manner to processes and change management strategies used by organizational leaders within the institution. Allowing house staff members to attend these meetings should be a stated priority of training programs, with justification as meeting the systems-based practice competency.

Intermediate Term (1-2 year) Goals

Establish a Medical Corps "speakers bureau" to provide local, "just in time" leadership training. Topics could include case-based accounts related to particular leadership challenges such as resolving conflict, disruptive behavior, dealing with "toxic" leadership, and leading change. These sessions would also provide practical education on topics such as officer efficiency reports and award writing for physicians. Instructors—who should have AMEDD leadership experience—will demonstrate competence in leadership theory, organizational behavior, and facilitation of small group discussions. Regular interviews with physician-leadership at each site will also highlight the diverse talents of Medical Corps leaders. A suggested topic list could be maintained on the Medical Corps website so the local speaker's bureau will have guidelines for this training.

Strictly enforce BOLC attendance during medical school. There should be mandatory attendance after internship prior to starting any other residency training or other assignment for the infrequent outliers. It is important that this foundational training is completed on time to ensure a common fund of training for junior medical officers.

Appoint a medical treatment facility Medical Corps leadership coordinator at each hospital, who will also serve as director of military unique training within the facility. The coordinator will have time dedicated for program development and execution. The coordinator will monitor the implementation of the leadership program and will meet separately with each year group periodically throughout the year to review the schedule for the year, topics to be discussed, and available opportunities based upon year group.

Create an annual leadership day for all house staff based on residency year. Morning didactic sessions will review basic leadership skills from a variety of perspectives (military unique, physician, research, etc) and the afternoon will contain panel discussions involving senior leaders with various backgrounds to discuss leadership scenarios likely to be encountered by military physicians. Leadership day topics could also emphasize individual topics or subjects in the core leadership curriculum.

Provide ongoing leadership training for midlevel officers. These officers will assist with the leadership development of their subordinates and will therefore require development and sustainment of their leadership instruction skills. This can be accomplished in venues such as faculty development seminars or external events sponsored by military or civilian entities. Establish a supportive network of individuals that meet regularly, weekly to monthly. This would be targeted at officers that have already finished training. The establishment of regional associations (like the Silver Caduceus Society of Medical Service Corps officers) to promote Medical Corps history and develop leadership will allow for informal small-group discussions/education and will improve fellowship among Medical Corps officers. These meetings could also be developed across the different AMEDD disciplines: Medical Corps, Nurse Corps, Medical Service Corps, Dental Corps, Veterinary Corps, Enlisted Corps, and the Civilian Corps. Group members will have required readings and discussions, and would attend specific workshops and leadership symposia, as well as collaborate online. The core leadership curriculum, with its programmed reviews and changes of content, can always serve as the juncture for ongoing leadership training of these midlevel officers.

The Medical Corps will annually fund 3 company grade Medical Corps officers per region to attend leadership symposia, events, or workshops through an online application process.

Establish a physician leadership elective for all AMEDD GME programs in cooperation with GME program directors that allows residents a block of time to work alongside hospital or operational Medical Corps leaders for exposure to the unique professional challenges and opportunities of these leader positions.

Standardize residency "transition to practice" seminars at all the main GME platforms. Residents have time available between graduation and change of station that could be leveraged more effectively to provide a standardized core of "just-in-time" training that could be tailored to expected job assignments. Capitalize on the current best practices in the AMEDD and make a core curriculum available across the enterprise.

Long Term (3-5 year) Goals

Develop a tool for tracking leadership development throughout a medical officer's career. This would be modeled on the portfolio model that was described by the RAND Corporation.[6] The officer develops the leadership portfolio over time and it links to established leader development checklists which are used to monitor education and experience.

Allow the Health Professions Scholarship Program to cover dual-degree programs and have access to graduate business degrees throughout the Medical Corps officer's career. While a Master of Business Administration or Master of Healthcare Administration does not guarantee the creation of first-class leaders, those curricula provide valuable additional skills for medical executive leaders.

SUMMARY

Developing interest requires early exposure to leadership materials and opportunities. Key to this will be establishing a highly interactive and effective internet presence where material could be accessed by officers early in career development, including medical school and residency. Engaging internet materials will be followed with regularly scheduled activities within the GME curriculum as described throughout this section.

A QUESTION AND A LEADER'S ANSWER

For three years you have told your residents that their first priority when they graduate should be to pass their board examinations. The junior staff has proposed that you start a leadership breakfast or lunch session weekly. You already have challenges getting the residents and medical students to attend the didactic sessions for the training program. Starting a leadership session would take another hour out of the week for a subject that will definitely not be on the board. What's more, the Department Chief wants to know your rationale if you decide to change the curriculum. What will you do and what will you tell him?

The junior staff members are right. The military unique curriculum that was accepted by our Residency Review Committee is lacking. While our knowledge of *Army Regulation 40-501*[7] is sufficient, our ability to provide leadership knowledge is lacking. Learning to lead and developing that competency is perhaps more important than the clinical skills the residents already possess. Starting a twice-monthly leadership discussion at lunch and encouraging participation of residents (particularly during their outpatient months) is an easy first step toward leader development. One morning report or even an afternoon conference slot could also be used. We will get acceptance from the junior staff and residents by showing physician leadership has direct relevance to medical practice, not just health care administration.

Junior staff will be invited to lead the sessions. I will assume some risk by buying the lunches to show my commitment to the vision and my understanding of the residents' pressing time constraints. Beginning each session with leadership scenarios* will help the residents gain perspective, flexibility, and the mental stamina which will help them prepare for success on their board examinations. Modifying the curriculum will not only meet the needs of the junior staff and residents while serving in the military, it will also prepare them for leadership roles in the civilian world, which needs leadership presence more than ever. Ultimately we must ask the question: what are we preparing them for, their future leadership challenges or the boards?

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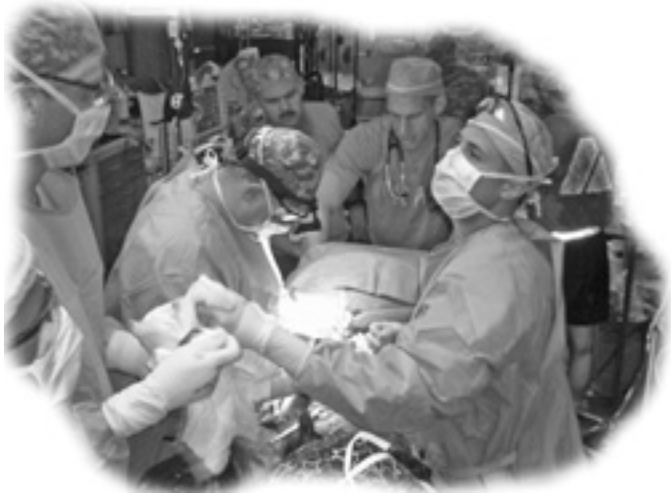
*Complete curriculum is included in *All Physicians Lead*.



THE FOUNDATION: PROVIDE LEADERSHIP EDUCATION

The following US Army Medical Corps officers collaborated in the development and writing of Chapter 3 of *All Physicians Lead* from which this section is adapted:

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The one quality that can be developed by studious reflection and practice is the leadership of men.

General of the Army Dwight David Eisenhower[8]

A sound leadership education program is the foundation upon which all other components of the Medical Corps leadership development are built. This program will adhere to several key principles:

- It must provide a broad leadership educational curriculum that is suited to contemporary working environments.
- It must provide programs focused on early exposure, ensuring all officers recognize that they are leaders.
- It must be longitudinal, and relevant throughout the continuum of the Medical Corps officer's career, and must be closely synchronized to match both grade and potential positions.

The principles of the leadership education program will include development of a core leadership curriculum, executive skills training, an introduction to strategic thinking for midgrade officers, tailored developmental programs for senior officers, and establishment of a Medical Corps Leadership Consultant and Leadership Development Committee to manage these programs and identify additional opportunities.

Development of a core leadership curriculum is essential. This curriculum, while primarily designed for current or future Medical Corps officers early in their career, can be used throughout the officer's career to either refresh or review knowledge of key leadership theory and discussion. It will be centralized and virtual, accessible to officers stationed around the globe. It will be module-based so that it can be delivered in its component parts or its entirety. Trained instructors will facilitate it, so that a standardized product will be delivered. Finally, a curriculum committee will periodically review the product to ensure it is relevant and addresses key core leadership principles important to Medical Corps officers throughout their careers.

Midgrade officers need both practical executive skills training specific to Army Medical Department (AMEDD) managerial and business practices, as well as strategic level training to prepare them to assume senior leader positions. The AMEDD and Military Health System both offer several, albeit limited, opportunities for development of practical executive skills.

Senior officers need continued development of their leadership skills through individualized leadership development programs. Coaching/mentoring and executive skills continuing medical education (CME) opportunities (through groups like the American College of Physician Executives) will be targeted at key senior leader positions. It is essential that AMEDD senior leaders complete the mentorship curriculum to ensure they have the skills necessary to serve as mentors for upcoming Medical Corps leaders. All Medical Corps officers must possess the skills and desire to coach fellow officers.

The leadership curriculum will incorporate preexisting educational venues and opportunities when possible. The core curriculum can be taught in its component parts beginning in medical school and throughout postgraduate training. Finally, a proponency office will be developed to manage these physician leadership programs. This office will be crucial in performing the continuous review and modification of this program over time to meet the evolving demands facing all Medical Corps leaders.

CURRENT SUCCESSES AND GAPS

The Ideal State

A core leadership curriculum exists for all Medical Corps officers.

Existing courses for professional development of Medical Executives are well known to all Medical Corps officers.

Mentoring and executive coaching are commonly practiced throughout the Medical Corps.

An internet-based leadership forum is available for officers throughout the Medical Corps to facilitate communication and sharing of ideas.

Successes

Several pieces of this leadership education program are already in place. A core curriculum has been in development and in use at multiple locations throughout the Army Medical Command. The basic lessons that comprise this curriculum can be found in *All Physicians Lead*.

The AMEDD-specific executive skills curriculum provides multiple opportunities for Medical Corps officers to participate both online and at specific executive skills sessions tied directly to position-specific training courses (for example, the Brigade/Division Surgeon's Course). Information is available at the AMEDD Joint Medical Executive Skills Institute (https://executiveskills.amedd.army.mil/welcome.asp).

The US military has well-designed Master of Business Administration (MBA) programs at Baylor University and the Uniformed Services University of the Health Sciences (USUHS). However, the 2-year, full-time curriculum presents a challenge for Medical Corps officers. Many universities offer executive level MBA programs which can be performed via distance learning, thus allowing Medical Corps officers to continue to practice medicine while also pursuing their degree.

For officers who are preparing to assume senior leader positions, the Pre-Command Course provides opportunity for operational level executive skills development. The Pre-Command Course also offers the Leadership Challenge Workshop, a valuable exercise for leaders at all levels to recognize their leadership strengths and weaknesses. Senior service college opportunities allow senior officers to develop strategic insight into the profession of arms. Much of this curriculum is transferable to AMEDD positions and is critical to the continued interaction of the Medical Corps with combat arms branches.

Gaps

The leadership development curriculum is not standardized and most Medical Corps officers are not aware that it exists. Because the curriculum contains clips from movies, magazine articles, and book chapters, copyright permissions may be necessary.

While the AMEDD-specific executive skills curriculum program provides standardized tactical-level AMEDD specific executive skills ideal for midcareer officers, it does not provide "strategic-level" executive skills as currently taught in civilian executive masters programs.

No formal executive coaching program exists for Medical Corps officers in, or selected for, senior leadership positions. Similarly, mentorship training is lacking throughout the medical profession. Although mentorship programs have been well described throughout the medical profession, a curriculum to train mentors does not currently exist in the Medical Corps. A formal mentor training program must be developed.

No internet-based social media products exist for the Medical Corps, and the Medical Corps website is not optimally utilized.

CLOSING THE GAPS

Short Term (6-12 month) Goals

Standardize and advertise the core leadership curriculum. Standardize the content, reading material, and video clips of the core curriculum. Obtain permissions for access to leadership reading materials in order to allow unlimited usage. Similarly, obtain permissions for the use of copyrighted video clips for education.

Advertise the executive skills course curriculum presented through Joint Medical Executive Skills Institute (http://www.cs.amedd.army.mil/jmesi.aspx). Selection boards should be instructed to consider executive skills courses as a positive discriminator in selection for promotion and command.

Develop a social media strategic communications plan and a centralized online Medical Corps leadership forum that provides access for all Medical Corps officers to the curriculum, as well as a range of leadership blogs and websites with recommended readings.

Under the leadership of the Medical Leadership Consultant, a core group of educators would be identified and certified to be the developers and initial teachers of the curriculum. Appropriate portions of the curriculum would be incorporated into the USUHS and the Armed Services Health Professions Scholarship Program undergraduate requirements. Ensure that all students rotating at military treatment facilities participate in intern leadership development opportunities.

Consider offering a 2-week or 4-week leadership elective during medical school sponsored by entities such as AMEDD Center and School, the Army Medical Command Headquarters, or the Office of The Surgeon General.

Create a leadership program within existing GME programs with a curriculum specific to the level of the individual and the flexibility to be tailored by different medical specialties to address unique skills and requirements. This curriculum would contain a mix of onsite activities with in-person teaching/coaching/mentoring in addition to web-based educational activities. Centralized training through structured distance learning cannot completely replace hands-on, personal interaction with senior leaders through spontaneous contact.

This training will meet the Accreditation Council for Graduate Medical Education program requirements for program or institutional level training, which should help in garnering acceptance from program directors and leaders within GME.

These issues could be addressed in relatively short order to allow rapid dissemination and execution of curriculum and teaching in multiple venues throughout the Medical Corps.

Intermediate Term (1-2 year) Goals

The 2 primary intermediate objectives are the establishment of a midgrade executive skills MBA-type program and executive opportunities for those senior Medical Corps officers identified for key executive positions.

Midgrade Executive Skills

Midgrade leaders will be offered opportunities to develop their executive skills, including leadership, as they prepare to enter positions of greater influence and responsibility. Physician executive MBA/MPH/MHA educational opportunities should be offered to selected Medical Corps officers. This will be done either through the current Baylor University program, or through various civilian long-term health education program opportunities. Multiple civilian institutions offer these programs with combination on-line and on-campus curricula (an example of such programs: http://www.physiciansmoneydigest.com/lifestyle/top-10-business-graduate-schools-for-physicians). A program, as well as a funding source, will require development for select midgrade officers for these opportunities. Medical Corps officers will be selected through a formal board process. The Captains Career Course will be prerequisite, and these opportunities will be available prior to or in concert with intermediate level education. Selected officers would be highly competitive for medical center department chief, deputy commander for clinical services, and division or command surgeon positions. These key Medical Corps officers will possess the foundational leadership knowledge to fill senior leadership positions and to train/mentor junior Medical Corps officers. Shorten the Captains Career Course to a length appropriate for the career development of physicians in their early years on active duty and provide content appropriate for the leadership opportunities they will face as junior and ultimately senior staff members.

Senior Level Executive Continuing Medical Education

One of the hallmarks of a successful industry senior leadership development program is targeted executive skill development opportunities. A number of civilian educational institutions offer a wide variety of opportunities spanning multiple subjects pertinent to senior executives, including leadership development. Specific opportunities to receive leadership continuing medical education would be offered to officers in specific projected senior leadership positions.

Long Term (3-5 year) Goals

Develop a thorough, system-wide, understanding of all Medical Corps job and training opportunities so that mentors can provide all protégés a complete picture of the opportunities available to them.

Develop training opportunities to allow mentors to adequately function in that role this training would include:

- Training on "critical conversations" in order to establish the ability within a mentor's repertoire to have those difficult yet "critical" discussions with protégés as they examine strategic career decision points.
- Training on how to review key personality type inventories, like Myers-Briggs, so that mentors can provide key feedback to protégés when they take such inventories.
- Training on reviewing current or future 360-degree evaluation schemes to be able to provide this critical feedback to the protégé.

SUMMARY

The Medical Corps Leadership Curriculum plan is the foundation upon which many of the other aspects of the Medical Corps Leadership Development Program are built. Defining and standardizing the primary aspects of the core curriculum is the key short-term (6-12 month) goal to accomplish in enacting this plan.

The complete development of a Medical Corps Leadership Curriculum will require further time and effort. Intrinsic and extrinsic opportunities must be leveraged to create a curriculum that addresses the longitudinal leadership needs of Medical Corps officers and mitigates

inconsistencies over an extended career spanning a wide variety of positions.

A QUESTION AND LEADERS' ANSWERS

You agree that some of the most important teaching that you can pass on to your residents and medical students involves their development as leaders. You have been meeting with a small but dedicated group each Tuesday at 0630 for breakfast. One of your students asks you what she should be reading for leadership and asked you the single most important lesson you ever learned about being a leader. What would you tell her?

The book I recommend is *Primal Leadership: Realizing the Power of Emotional Intelligence*.[9] In my opinion it is the best leadership "textbook" in existence. It gets to the heart of the key leadership skills that define success, those being encompassed by emotional intelligence, and also provides strategies to improve your individual performance in key aspects of emotional intelligence if you see yourself lacking in certain areas. While it is not an engaging narrative relating the actions (or inactions) of well-known leaders from the past, it does give a very solid and easily understood review of what personality characteristics are essential for success, and how to manifest those in your day-to-day work.

The single most important leadership lesson I learned was on rounds in the neonatal intensive care unit (NICU). That lesson is that your leadership of your small team creates the conditions for success. Your life as a leader is filled with a series of small team leadership experiences where success is defined for your organization by how well you lead that small team. In the NICU, how well you lead your small team of nurses, therapists, residents, and parents set the conditions for how well the babies healed. How well you encouraged free exchange of information, responsible disagreement, and group consensus set up the conditions for success. The same scenario has repeated itself time and again in new leadership experiences. The size and complexity of the overall organization being led increased, but there was always that small group of core individuals with which you interacted. If you successfully led that group, the overall organization, no matter what the size, responded in a positive manner. No matter what position you hold, there will always be that small team around you. If you lead that team well, the organization will perform well.

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When GEN (Ret) Hugh Shelton was Chairman of the Joint Chiefs, he required the other Chiefs of Staff to read McMaster's *Dereliction of Duty: Lyndon Johnson, Robert McNamara, the Joint Chiefs of Staff, and the Lies that Led to Vietnam*.[10] The book describes how President Johnson's decisions affected the execution of the war in Vietnam. Most significantly from a military senior leadership perspective, McMaster shows how the Joint Chiefs of Staff contributed to the failed strategies and polices by failing to provide the president with their best professional military advice. Service chiefs looked out for their own services' interests over the interests of a united recommendation to the Commander-in-Chief regarding military strategy for the deepening involvement in Vietnam. One can draw parallels to young midlevel physician leaders who must learn to address hospital-wide issues while balancing their department's interests. Recognizing a successful hospital or health system strategy requires looking through other lenses beside one's own department or professional perspective.

The late COL Brian Allgood taught me my single most important leadership lesson. We served together in the US Special Operations command back in the mid-1990s. One evening on a deployment, while I was a senior captain on my first staff physician assignment out of residency and he was a lieutenant colonel in the rare officer/physician role as medical battalion commander, I asked him, how can I be like you? Brian told me that no one could be like him. And just before I became annoyed at what initially sounded like a flippant comment, he elaborated by saying that his genes, his rearing, and his life experiences all molded him to be a unique individual with his unique strengths and weaknesses. No two people are the same. So he made the point—don't try to be like anyone else. Rather, be the best person who I could be. Know your strengths and weaknesses, improve them, and always remember the people and families we serve. That conversation remains with me to this day.

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There's one book that is a must-read for any military officer and leader, and almost universally appears on a chief of staff's or commandant's required reading list for new officers, Anton Myrer's *Once an Eagle*.[11] The novel is over 40 years old, yet simply and elegantly demonstrates the differences between a leader (the protagonist Sam

Damon) who provides a continual focus on his mission and his men and another senior officer (the antagonist Courteney Massengale) who focuses his entire career on himself and his own ambition, regardless of human cost or morale. The novel follows their fictional parallel careers from World War I to Vietnam. Myrer humanizes Sam Damon. He shows him as fallible, yet humble and professional, and demonstrates that large organizations cannot survive with a zero-defect mentality. The lessons learned throughout this book are easily generalized to any organization, medical, military, or otherwise.

The most important lesson that I have learned throughout my career is that your success as a leader is best measured by the success of your subordinates and the accomplishment of your mission. These two metrics are inseparable. Both our Army and AMEDD are full of intellectual capital and vast talent. Set the conditions for your subordinates to plan and execute, and allow them to do so without micromanagement. When the organization is a success, publicly praise, award, and recognize those who have done the hard work. When the organization inevitably falls short of expectations, you as the leader are responsible and take the blame. This will engender your subordinates with trust and confidence in you, and will inspire them to give you their absolute best. As you see sergeants become lieutenants, privates become warrant officers, and combat medics become board-certified physicians and commanders, you will also feel the pride of your efforts coming to the forefront.

A secondary corollary is a simple maxim: never ask (or direct) a subordinate to do something you will not do, cannot do, or would not be willing to learn how to do yourself. You may have never performed a complex surgical procedure yourself, but as a combat support hospital deputy commander for clinical services, you should spend time in the operating room, scrubbed in. You may not know how to perform daily preventive maintenance checks and services on a military vehicle, but as a field surgeon attached to a battalion, you should ask the vehicle operators to show you how. Small measures like these will instill Soldiers' pride in their work and establish you as a caring, concerned leader.

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APPRENTICESHIP REFINED: MENTORSHIP AND COACHING

The following US Army Medical Corps officers collaborated in the development and writing of Chapter 4 of *All Physicians Lead* from which this section is adapted:

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Mentorship is the voluntary developmental relationship that exists between a person of greater experience and a person of lesser experience. This relationship is characterized by mutual trust and respect; it develops out of a selfless bond of trust that allows for open-ended protégé guidance over a prolonged period of time. Executive coaching is about individual performance improvement or individual skills development with a specific agenda or goal in mind. It is prescriptive and intended to provide immediate results.

Medicine has always been a guild with an apprentice-based system of training. Historically, physicians and surgeons trained under more senior clinicians until the senior clinicians felt that they were ready to work independently. Even within the last century, medical students, interns, and residents learned most of their craft from more senior residents, fellows, and junior staff who served both as role models and clinical instructors. A similar model exists for junior clinical investigators whose success has relied on their ability to join a more senior scientist to learn the craft of medical research.

In addition to teaching the art and science of medicine to younger trainees, these experienced clinicians and scientists also provided insight into potential career opportunities which became available and professional and personal advice, both solicited and unsolicited. In this model, there have been opportunities for instruction and direction in the day-to-day practice of medicine and research (coaching), as well as in the pursuit of longer term ambitions and opportunities (mentoring).

A large volume of material in the business and leadership literature compares and contrasts coaching and mentoring. Executive coaching in business initially

developed as a means for correcting the poor behavior of executives. It has since evolved into a program to develop the capabilities of high-potential performers. James Hunt describes coaching as effective for executives who say "I want to get over there, but I'm not sure how to do it."[12] A study in 2004 found that 86% of companies surveyed used coaches to sharpen the skills of individuals selected as future organizational leaders. In fact in 2004, IBM had 60 coaches on staff.

Executive coaching is commonplace in business, but is a rare formal practice in medicine. Very little has been published on executive coaching in the field of medicine. In one review, 5 new departmental executive officers in the University of Iowa Carver College of Medicine were offered executive coaching at the start of their new positions.[13] The executives desired assistance in improving their skills in facilitating institutional change. After the program, the executives believed that the value of the coaching received was in their improved ability to receive external advice about specific issues, assistance with implementation of organizational change, focused career guidance, and improved time management.

The practice of medicine requires physicians to employ many clinical leadership skills on a regular basis, but it is not safe to assume these skills will translate well to organizational leadership. Physicians who leap unprepared into organizational leadership roles often experience tremendous frustration, and generate frustration in their subordinates and their superiors. Mentoring plays a valuable role in leadership development across the entire physician career spectrum. Executive coaching may play a valuable role in the transition to specific senior leadership roles. Effective application of both will lead to improved organizational performance.

CURRENT SUCCESSES AND GAPS

Ideal State

A formal leadership training program is incorporated into residency training programs. In addition, all Medical Corps officers are afforded the opportunity for formal mentorship via a regionally administered program by a mentor who has received formal education in the art of mentoring. Identified senior leaders (deputy chief of clinical services, medical treatment facility (MTF) and TOE unit* commanders, etc.) receive executive coaching via a centrally administered program.

While complementary in nature, these programs are distinct programs with different focuses. The mentoring program will focus on the strategic development of all Medical Corps officers, while the coaching program will focus on the individual development of Medical Corps officers in key leadership positions.

*A unit with structure and equipment defined by a Table of Organization and Equipment (TOE).

Current State

Many informal mentor-protégé relationships already exist across the AMEDD. In addition, the sporadic use of executive coaches exists in some MTFs where contract or civil servant organizational development practitioners are used to assist in strategic planning and executive development. The current practice of physician development is a fertile model for the application of both coaching and mentoring in physician leadership.

Gaps

Most Medical Corps officers currently serving as mentors have not received formal instruction in the art of mentoring. The availability of mentoring for junior Medical Corps officers is typically dependent on informal programs and the availability of interested senior personnel willing to serve as mentors. Time and resources are typically not allocated to facilitate mentoring relationships. There is no centralized structure to identify mentors. Executive coaching opportunities are rare and not centrally funded.

CLOSING THE GAPS

Short Term (6-12 Months) Goal: Establish a Formal Mentorship Program for the Medical Corps.

Each regional medical command will appoint, as an additional duty, a senior Medical Corps regional leadership consultant (senior colonel.) Each MTF and large installation will appoint a leadership champion (colonel or lieutenant colonel.) Ideally, the leadership champions will be volunteers with a passion for developing junior officers, and they will possess the ability to coordinate a formalized program for the MTF. Formal training opportunities will be afforded the leadership champions. Larger medical centers might consider delegating below that facility level where feasible.

The regional leadership consultant will be a senior physician well-respected by peers and well-connected within the Medical Corps in both the clinical and deployed/operational environments. Experience serving in multiple areas in previous assignments equips the leadership consultant with a wide span of knowledge to share.

Create a pool of available mentors and a method to link them to developing leaders. Understanding that it is unlikely a mentor could support multiple protégés simultaneously due to other commitments, the pool of

available, trained mentors must be expanded. The mentor will identify goals focused upon particular tasks or objectives (consider the Individual Development Action Plan from the *Army Mentorship Handbook*[14]). Individual mentoring will occur in a manner suitable for both mentor and protégé. Mentoring typically is long term, and the relationship enduring. Both the mentor and the protégé will participate in a review process and the protégé's developmental plan will be modified based on feedback from leaders.

Intermediate Term (1-2 year) Goal: Establish Mentor Training Opportunities

Mentors will be prepared to teach protégés in both general and specific terms (that is, from the potential career opportunities and nuances of leadership to the finer points and details of officer record briefs and officer evaluation reports). They will be prepared to speak to the importance and timing of the Officer Education System including the Basic Officer Leader Course (if not already completed), the Captains Career Course, intermediate level education, and senior service school.

Mentors will expose junior Medical Corps officers to career opportunities that are available after training (for example, joint medical augmentation unit, fellowships, and forward surgical team command opportunities). The basics of the promotion system will be covered with the importance of the official photo, the officer record brief, and the officer evaluation report. As both deployment and operational medicine experience are essential for developing AMEDD leaders, mentors will attempt to expose protégés to operational units during residency.

Junior Medical Corps officers need to familiarize themselves with the organization of the Department of Defense, the AMEDD, the Navy Bureau of Medicine and Surgery, and the Air Force Medical Service. It will be rare to find mentors who are well-versed in all of the topics, so mentors must be able to harness subject matter experts from other fields and other services who can share this knowledge. Finally, mentors will link protégé with senior informal mentors where potential common bonds exist.

Mentors will be provided maximum exposure to conferences and courses that will enhance their ability to develop protégés. The following list is a start and will be expanded as necessary: Association of Military Surgeons of the United States Medical Strategic Leader Program, Association of the United States Army (both Army-wide and AMEDD programs) Joint Inter-Agency Medical Executive Course, AMEDD Capstone, Military Health System conference, Human Capital Distribution Conference, and, perhaps, an off-the-shelf course that trains leaders to be mentors.

A formal mentorship training curriculum will be established. Whether embedded within other training opportunities or as a standalone course, identified mentors will receive training that covers some of the key mentorship essentials.

Long Term (3-5 year) Goal: Establish a Corporate AMEDD Executive Coaching Program

Executive coaching is a different skill than informal or formal mentorship which can be performed in-house as focused on the military specific topics. Executive coaching will require either significant investment to develop coaches from within the ranks of the AMEDD or, more likely, the hiring of experts from the organizational development or executive coaching community. Specific outcomes will be documented with the coaching investment and will be an expectation as an essential part of coaching—agreeing to reflect how practice has changed as a result of coaching and if not, why not.

If an in-house program is developed, those identified Medical Corps officers discussed in the section Building the Bench (page 21) will serve not only as potential recipients of an executive coaching program, but also as future coaches themselves for key leadership positions they have already held. The time frame for this goal will be accelerated if coaching experts from outside the AMEDD are hired to serve this function.

Every Medical Corps officer entering into senior MTF or regional leadership positions will have executive coaching available at the onset and throughout the first year in the position. Additional access to this expertise will be available as the need or requirement arises, such as, for example, the development of significant difficulties in performance or organizational challenges during the course of a leadership tour.

SUMMARY

The Medical Corps needs a formal leadership development program to enhance the development of physician leaders throughout the scope of their careers, beginning with initial training. Mentorship and executive coaching are 2 key leadership development programs that will greatly expand the effectiveness of Medical Corps officers as leaders. Mentorship will be available for all Medical Corps officers, while executive coaching will be available for senior Medical Corps officers in key leadership positions. The balance between coaching and mentoring will allow for the tactical, operational, and strategic development of senior leaders.

A QUESTION AND LEADERS' ANSWERS

The new commander of one of the regional Army hospitals is an inexperienced former department chief. You met him for the first time at the regional command conference. He admits that he does not feel particularly well-prepared for his new job, especially the subject of medical boards. He approaches you and asks for advice because he knows you were a deputy commander for clinical services and a department chief. He needs a mentor. Could it be you? What would you do next?

The first step is to look at the relationship you have with this officer, your compatibility and if having a mentor relationship is feasible. If it is not, then the best thing to do is to refer them to someone who can appropriately guide them, while also giving some initial advice. If this is someone you can mentor then the advice will not change, but there is more involved.

In both cases, my first recommendation is to read the appropriate Army regulations. For this officer, the list would include *Army Regulation (AR) 40-501: Standards of Medical Fitness*,[7] *AR 600-60: Physical Performance Evaluation System*,[15] parts of *AR 40-400: Patient Administration*,[16] and *AR 635-40: Physical Evaluation for Retention, Retirement, or Separation*.[17] Additionally, I would point the officer to the latest medical command orders related to the Integrated Disability Evaluation System. The commander must assure that the system is functioning fairly and efficiently with a focus on Soldiers, must know the individual roles and responsibilities within the process, and must be familiar with every step of the process. A close alliance with the local subject matter expert and an on-the-ground walkthrough of the system at the new command is essential.

There are few more pressing issues for a commander today than this one, and it underscores the importance of the mentor in helping the protégé to identify crucial areas of focus and encouraging him or her to develop expertise in these areas. It also reinforces the fact that there are many areas of overlap between the roles of mentor (guidance, motivation, emotional support, and career role modeling) and coach (self-discovery of key practices that result in improvements in the business as well as in the personal life of the leader). Leaders, particularly those in new roles, need both.

Finally, as a fellow officer, mentor, or friend, you must ask the hard question: "what are you really concerned about?" In this case, there is likely more to the story than simply concerns over an unfamiliar process or procedure. Our job is to look past the obvious and get to the root of the issue. The officer commented that he does not feel particularly well-prepared for the job. We should find out why; address the concerns; and provide ongoing support, advice, and an unbiased ear when needed. That is the purpose of a mentor and coach.

COL George Appenzeller
Commander, US Army Medical Activity-Alaska

I cannot imagine myself refusing to be a mentor to someone, unless I knew that we viewed the world through incompatible lenses. If that were the case, I would direct him to someone else. I would still try to help, but perhaps not as a mentor. Whether or not we "clicked" as mentor/protégé, I would reassure him not to worry about his lack of experience in medical boards. So much of his job will have nothing to do with that one aspect, and the Army and the AMEDD had the confidence to choose him. I would tell him that we are all unsure of ourselves initially. I submit that an Army career is a series of jobs for which one feels ill-prepared, often for the first 20 years.

As far as the medical board issue, I would try to put him at ease. First, the landscape is different, and much has changed with how things are done under the Physical Disability Evaluation System. In addition, *Army Regulation 40-501*[7] is under rewrite, so more will probably change. I would share my secret of success: 5 minutes lead time and an internet connection. It is amazing how smart one can seem to be given those two resources. So, given a few minutes preparation, he can gain familiarity with the issues to be discussed. I would share that another of my "secrets" is to admit that I am not an expert, and to sit down with subject matter experts and get candid opinions on process improvement.

It is also critical to know where to go for expert opinion. Often we go to the policy makers or the schoolhouse subject matter experts, when really those Soldiers in the field best understand the process. As a young doctor, I almost always tried to figure it out on my own. Not only is that approach time-consuming, but one often does not get the complete or even correct answer. We as senior folks have often learned where to go for answers, whether a local expert or the specialty leader. Asking the specialty consultant carries the weight of that person's expertise through a career in the discipline, as is the case with our consultant pool. The local clinician understands what works best at that location, so both approaches have merit.

My colleague should be reassured that his concern is very reasonable. I would be more concerned about a

commander who faked expertise and stumbled through command without asking the questions necessary to ensure he grasped the issues, and that his command was functioning as it should. The lives of Soldiers are greatly impacted by all that we do in medicine. Sometimes we need to make quick decisions with partial information, and, while it is important to have confidence despite ambiguity, it is always best not to be cavalier. As commander, he will set the tone in his unit. I would encourage him to savor the experience, command is the greatest privilege a Soldier can have.

COL Joseph F. McKeon
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BUILDING THE BENCH: IDENTIFY, RECRUIT, BUILD EXPERIENCE

The following US Army Medical Corps officers collaborated in the development and writing of Chapter 5 of *All Physicians Lead* from which this section is adapted:

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Leadership, like swimming, cannot be learned by reading about it.

Harry Mintzberg[18]

Army Medicine requires the Medical Corps successfully identify, recruit, and select top officers for future executive positions. In order to do this, we must begin to provide ongoing leadership training to all.

Early identification of physician leaders who have the potential to serve as future commanders and senior leaders can be based on (senior mentor) observation of character, presence, and intellect. These traits, from *Army Doctrine Publication 6-22: Army Leadership,*[4] are key characteristics of successful leaders. Creating the next generation of successful leaders will require a deliberative process.

The professional interest of the physician-leader in operational, clinical, academic, and hospital administration will drive the formal training courses and leadership possibilities for the midlevel physician-leader. However, the formal training and the skills required for successful senior leadership is broad. Opportunities for experience in several areas should be provided and encouraged to prepare a well-rounded, future senior leader.

CURRENT STATE AND GAPS

The Ideal State

The Medical Corps maintains a robust leader succession program which identifies future leaders that can successfully assume key developmental positions 5 to 7 years (or 1 to 2 promotions in grade) from initial identification. These officers are groomed for success with appropriate educational opportunities, assignments, mentoring, and executive coaching.

In the ideal state, all Army Medical officers will have embarked on a lifelong journey of leadership development. From that body, officers can be recruited to lead in executive positions within the Army Medical Department.

Successes

Many structured leadership programs (Basic Officer Leader Course, Captains Career Course, intermediate level education, joint professional military education, Joint Medical Executive Skills Program courses, and civilian training opportunities) are already well developed and have mature plans of instruction in place.

Military GME programs are among the best in the world as measured by board certification pass rates. In addition, GME programs teach military-unique curricula. Officers who complete these courses are clinically well-prepared to practice within their specialties.

Informal mentoring, and in some cases formal mentoring, is common in medical centers with GME programs.

Gaps

While there are many excellent physician leaders in Army Medicine, the identification of leaders is often an accidental phenomenon. An "executive leader" is chosen at the last moment when a need is identified, and those closest to the available position anoint someone to take that job—a proximity choice.

Medical Corps officers often cannot take advantage of formalized schoolhouse training opportunities because the timing is not synchronized with the AMEDD timelines due to other training realities (residency, fellowship, board certification).

The targeted experiences necessary to qualify for specific leader roles are unclear. Other Army competitive category corps have positions considered to be branch-qualifying jobs. In the AMEDD, there is no defined equivalent, and therefore no requirement to successfully complete branch qualifying jobs. Such positions exist, but incumbents are not required to progress professionally and earn promotions. Chief resident, brigade/division surgeon, service/department chief, and deputy chief of clinical services assignments are all pathways to prepare Medical Corps officers for senior executive positions.

There are currently no organized short courses scheduled around large meetings such as the Association of the US Army, Medical Health System, and GME selection boards to provide a convenient opportunity to work with a large number of physician leaders as a group. Physicians who have been identified as potential leaders based on aptitude and ability should be steered toward appropriate leadership positions by their mentors in a deliberative fashion by the Leadership Development Committee.

There are no incentives to identify promising future leaders and invest the time (and lose the clinical workload) to enroll them in a formal leadership development program.

There is no centralized support (space, funding, informatics, people) to manage a leader succession program.

CLOSING THE GAPS

Short Term (6-12 month) Goal: Identify Candidates for Future Senior Level Leader Positions.

Successful future leaders are usually individuals who succeeded in previous and varied leadership roles. These include not only leadership roles in the organization such as functional management team leaders and hospital committee chairs, but extracurricular leadership roles such as officers in parent-teacher student organizations, civic organizations, and professional societies. Documentation to support these experiences can be a CV, letters of endorsement, personal leadership philosophies, official transcripts, and service records.

When possible, identification will occur at the earliest point in the officer's career where supervisors, peers, civilians, and even patients recognize them as having the potential for service as a successful leader. In some cases this could even be done at the interview phase for the Uniformed Services University of the Health Sciences or Health Professions Scholarship Program (HPSP) students. Candidates will be formally notified that they are recognized as a potential future leader and opportunities for leadership education and experiences can be tailored to student schedules and individual enthusiasm for the program.

Leader candidates from the HPSP will be identified at the earliest point in their medical education. Typical proponents for this portion include program director, service chiefs and medical treatment facility commanders. The treatment facility GME office will provide leadership development programs with appropriate guidance on nominative guidelines.

Officers who have served as prior enlisted Soldiers, who have served in other services, have served in the Reserve Officer Training Corps programs, or who have attended a service academy will have additional skills and experiences that improve both their receptiveness to leader development and the expression of leader skills.

The annual Joint Service Graduate Medical Education Selection Board is an opportunity for program directors to identify residents, and for department chiefs to identify junior staff who have potential for long-term AMEDD leadership for the Leadership Consultant group to manage more closely.

All nominee names will be forwarded to the Leader Identification Program committee. A letter of endorsement from the first colonel or captain (US Navy) in the chain

of command as well as any supporting documents could be required. The nominee will also submit a personal leadership philosophy statement. The committee will be comprised of a combination of 15 senior AMEDD and non-AMEDD officers selected by the Commanding General, US Army Medical Command/Army Surgeon General with recommendations from the Consultants to the Office of The Surgeon General (OTSG), GME directors, commanders, and the Medical Corps Chief.

Physicians who have demonstrated interest in visiting medical schools and premedical programs to recruit for AMEDD programs have self-selected and should be recognized for their incentive with the opportunity to wear the recruiting badge.

Intermediate Term (1-3 year) Goals

The mentorship subcommittee will create and manage a database that delineates and captures individual Medical Corps officer competencies, key skills, and leadership qualifications, as well as successful assignments in key leadership development positions (clinic chief, forward surgical team commander, battalion/brigade surgeon, service or department chief, etc). This database will be regularly updated in conjunction with input by program directors, Consultants to the OTSG, promotion and command boards (below the zone promotions, command select list selections, etc). The goal of the database is to allow the mentorship subcommittee to identify high potential officers early in their careers and to work closely with the Army Human Resources Command GME program directors, and OTSG consultants to provide the career path development required to be successful senior leaders in the AMEDD.

A progressive curriculum should be developed which identifies junior officers with leadership potential, and then provides the necessary formal and informal leadership skills development and opportunities for them to develop into midlevel leaders and subsequently into successful senior leaders. Due to the differences between training requirements and the duration of training for the specialties of the Medical Corps, the delineation between a junior officer and a midlevel officer may be more accurately reflected by the physician's duties than by rank or time in grade. It is envisioned that this effort will identify and actively manage the careers of approximately 25% of Medical Corps captains, 20% of majors, 15% of lieutenant colonels, and 10% of colonels.

The Brigade/Division Surgeon Course will significantly enhance the operational capability of the physician. The AMEDD Executive Skills Course and opportunities to pursue Long Term Health Education and Training through the Army-Baylor University program or in other Army-sponsored programs should be made accessible to midlevel officers who have been identified as potential senior leaders. During this time, formal mentoring remains a critical aspect of individual development.

A centralized or regional database will be developed for tracking and monitoring officers enrolled or interested in this program. The candidates can be categorized by area of interest (operational, clinical, command, academic, etc). Data will be derived from the individual's personal statement, notes from the mentoring program, completion of the education curriculum, command input, and input from a candidate's sponsor.

Once individuals are identified, they will be provided targeted experiences to allow them to grow into the next generation of successful leaders. These experiences can be defined for many levels of junior leaders. Leadership experiences must be catalogued and translated into qualitative metrics in order that junior physician leaders who are clinically oriented can somehow be compared to other AMEDD or line officers who have been platoon leaders and company commanders. Once the physician leaders have established technical competence within their specialty, such experiences allow them to broaden their perspective and develop a better appreciation for what other AMEDD and Army professionals are contributing to the fight. This group is mentored and managed closely. Their careers are followed closely by senior Medical Corps leadership and they are given opportunities such as resident intermediate level education, early deputy commander for clinical services positions, opportunities to attend a Army-Baylor program, etc.

Identified leaders will be provided the opportunity to attend leadership training courses, such as Training with Industry, or advanced schooling such as Master of Business Administration in Health Care, Master of Hospital Administration, or Master of Medical Management. In addition, the opportunity to participate in non-AMEDD courses will allow interactions with nonphysician leaders who may identify a potential leader who may not be apparent in GME settings.

Courses that target specific jobs such as department chief will be developed. In this example, course content would include information necessary to run a service or department in a medical activity or medical center and would include such topics as managing the table of distribution and allowances, human capital distribution and labor relations, basics of Lean Six Sigma, the interaction between the medical center and TriCare, clinical operational metrics, and clinical quality measures.

The Medical Corps website will list educational opportunities linked to career maps, highlighting self-taught, local, centrally-funded and civilian opportunities for advanced training in leadership and management. A list of minimum prerequisites and expected skill sets will be developed for senior leadership positions, with an interactive "report card" demonstrating to the individual his or her progress toward self-development and requirements for senior positions in which he or she may be interested. Funding would be obtained to increase availability of Training With Industry type programs instead of senior service college for additional years of commitment or for agreement to accept a key leadership position.

A matrix cross-linking career paths (administrative, clinical, academic, research, operational) with specific required education and recommended experience will be developed for each individual and regularly updated. Officers will be able to clearly see where they are on the development timeline by printing a report summarizing their leadership development, short-term and long-term goals, and suggested leadership roles for their level of training and experience.

Long Term (3-5 year) Goals

As the Leadership Development Committee and the Leadership Development Program mature, the infrastructure required to support the program will increase. Planning should begin for space and equipment, a program manager, data managers, webmaster, etc, to allow ongoing success of the program. Some of these jobs can be additional responsibilities for some individuals, especially the various committee members, but the program will require professional management.

The implementation of an executive skill designator would allow formal recognition. An additional skill identifier similar to the "9" series (in residency, fully trained, board certified, OTSG recognition) will be developed, with various letters following the number identifying the progress toward leadership training. For example, if the leadership identifier is 7, 7D would designate initial leadership coursework completed (such as the Basic Officer Leader Course, Captains Career Course, and Joint Medical Executive Skills Institute); 7C would designate additional training and experience, including board certification, clinic leadership, intermediate level education, etc; 7B would designate further training and experience to include brigade surgeon, forward surgical team command, departmental leadership, residency program director, etc. Similar to the 9A designator, 7A would designate a fully trained, successful senior leader, award of which would be approved by OTSG based on recommendation by the Medical Corps Chief. Requirements for this designation would include completion of a successful leadership tour. The requirements for these designators will necessarily be broad so that officers on various career tracks (administrative, clinical, research, operational) can achieve recognition and designation. However, there will be enough commonality in course content and similarity in leadership experience to allow leaders in one career track to move into another area during his or her career. Key positions will require a specific level of skill identifier.

SUMMARY

Our nation's best and brightest have chosen to simultaneously serve 2 professions which embody both service and leadership: medicine and the profession of arms. Selections to medical schools, internships, residencies, and fellowships have well-defined, transparent requirements that are essentially uniform across the allopathic and osteopathic programs. Our Medical Corps has an opportunity now to develop a similar model to identify, nominate, and recruit the right officer physicians to successfully lead the health care profession in our Army.

A QUESTION AND LEADERS' ANSWERS

She is clearly the best resident you have ever known. She quickly mastered the skills of her medical discipline and now has been engaged at the department and hospital levels working with a team on performance improvement initiatives. Her interpersonal skills are as extraordinary as her clinical skills, and you know that with her Reserve Officer Training Corps college scholarship and her attendance at the Uniformed Services University of the Health Sciences, she has a long active duty commitment. She will clearly be a leader in the Medical Corps and the AMEDD. How would you recommend that her career be managed? By whom and how?

High performers often run for the exhilaration of the run, not the finish line. This resident is a high performer who will run selflessly, but perhaps to her own detriment. Occasionally, undirected energy benefits no one, not her, her patients, or the military that could eventually benefit from her leadership. The coach or teacher knows when to hold the high performers back, when to redirect, and when to release them. This is what is required of the senior leader mentoring and managing the career of a highly talented, future physician leader.

First and foremost, she must be told that we have seen her skills and understand her potential, and would like to know what she sees in herself. We cannot assume that she has the same future vision as we have, but this first step will allow the occurrence of "resonance" as described by Goleman et al,[9] and thereby an unfolding

of a magnified vision for her future success. Once a synchronous relationship is established, she can be allowed to participate in a few structured experiences (such as action officer for a new program) with very specific outcome measures and regular feedback sessions. These experiences should be tailored to core competencies of both clinical leadership and military leadership (culled from the residency review committee and Joint Medical Executive Skills Program).

Her resident advisor should manage her, but, as she progresses in skill, the program director, department chief, deputy commander for clinical services, and hospital commander will all have a requirement to manage her skill development drawing from their own experiences to expose her to progressively more complex learning experiences. The program director will necessarily have to ensure that her military education (Basic Officer Leader Course, Captains Career Course) have been mapped out and her subsequent supervisor will have to ensure intermediate level education (a strong transfer from the losing command) and further development are arranged.

COL Neil E. Page
Deputy Commander for Clinical Services
Montcrief Army Community Services
Fort Jackson, South Carolina

This is the kind of officer that we want to be the backbone of the AMEDD moving forward. It is critical that she is mentored and coached by a senior leader(s) with a clear understanding of the opportunities that exist within the AMEDD and who can articulate the pathways to help facilitate her continued progress. Depending on her specialty and location, it would seem that her program director or division/department chief would be the initial officer to coach her in career development. This may be as simple as arranging a meeting or series of meetings with the young officer to convey the fact that she has been identified as someone with a significant amount of potential, not just as a future leader in her chosen field, but also as a potential future leader within the AMEDD. Subsequently, her name would be submitted to the Leader Identification Program Committee with a letter of endorsement from the first colonel or captain [USN] in her chain of command and a personal statement from the junior officer outlining her personal leadership philosophy.

Within the construct of these early meetings, it would be imperative for the mentor to outline what options are available outside of her specific area of concentration, including administrative and operational assignments. In addition, the military education that is required to continue to progress in these specific tracts should be clearly delineated. These would include the Captains Career Course and intermediate level education. Furthermore, this would also be the time for counseling on how to write a curriculum vitae, to review her officer record brief (ORB), and instruction as to how to manage the ORB throughout her career.

Her mentor(s) and the Leader Identification Program committee will work closely with this young officer to ensure that she achieves the milestones needed to continue her career progression in the field that she has chosen. We must ensure that this junior officer is afforded every opportunity to become an outstanding, future AMEDD leader while mitigating potential pitfalls along the way.

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PHYSICIANS MUST LEAD: THE ELUSIVE "SWEET-SPOT" OF HEALTHCARE DELIVERY

COL Charles W. Callahan, MC, USA

Hospitals are the sinks of human life in an army. They robbed the United States of more citizens than the sword.

Dr Benjamin Rush[19]

Medicine used to be simple. Healthcare was delivered in the home. Providers were summoned to the patient's bedside. Diagnosis and treatment were rendered in the same room, and the family was responsible for the nursing care. The ownership of the healthcare delivery processes belonged to the patient and family. The most the doctor could offer was often palliative. The best the doctor could hope for was to separate the patient's presentation from his or her demise with enough time to avoid culpability. He often left with his fee-for-service on a leash or in a bushel.

After a several century hiatus, healthcare is returning to the home, back to the control of the patient and the family where both the authority and the responsibility to direct health and well-being must ultimately lie. The transformation will run across the grain of our delivery systems, our education platforms, and our medical business models. The changes will require professionals with the willingness and skill to lead in the face of powerful resistance.

In the history of healthcare, hospitals emerged for several reasons: to cohort the sick, to deliver more efficient care to the poor, and to quarantine the contagious from society. Hospitals also developed around the need to train more providers. In 1714, Herman Boerhaave incorporated clinical bedside teaching at St. Cecaeilia's Hospital in Leiden. His hospital-centric system for training physicians became the model for Europe and laid the foundation for American medical education. Medical students were trained to think of his system of training and practice as "perfect, complete, and sufficient."[20] Today's medical student and resident education depend on the same system.

What happened to healthcare when it moved from the home to the hospital? Hospitals of the 17th and 18th centuries were regarded with dread. The sick were usually better off at home.[21(p72)] In the hospital, the family relinquished control of the healthcare processes they owned when their loved one was at home. Providers also abdicated partnership with patient's families to the staff of large wards who before the formalization of nursing care had insufficient training and ill-defined duties.

Medicine and healthcare delivery have not become any less complex since the 18th century. And yet, 300 years later ownership and leadership of the system is no clearer. Hospitals are often places where insufficiently informed patients are exposed to highly dangerous situations inflicted by well-trained, well-meaning, but overworked professionals who are too often unaware of each other's capabilities and limitations. Each owns an individual link in the healthcare delivery chain. But no one owns it entirely. This is to say nothing of the near complete lack of continuity between inpatient and ambulatory patient care in nearly every setting. As of yet, no profession has emerged in this system of "disintegrated," desynchronized care to lead from chaos to patient safety.

The growth of cities in the United States between the 17th and 18th centuries also helped to drive medical care from the home to the hospital and to paid professionals selling their services in a competitive market. According to sociologist Paul Starr, this transition of care from the home to the market place and the evolution of medical care into as "a commodity" is one of the most significant transformations in American medicine.[21]

The delivery of healthcare today is still driven by a commodity business model that rewards office based intervention, pays a premium for technologically dependent procedures, and preferentially reimburses for inpatient stays. It undervalues prevention and low cost management of chronic disease using telecommunication or the internet, the very methods patients would prefer to use to manage their healthcare.

The military health system has also embraced the civilian business model. We use the same measures of effectiveness and productivity. Thus military and civilian medicine are trapped together in a commercial system of healthcare delivery. No profession has emerged in the context of this flawed business model to lead medical practice in the direction that patients really need and want: health rather than just the absence of disease.

While the commercial model is built around the office, the clinic, and the hospital; and patient safety efforts rightly target the dangers of inpatient care, today most healthcare happens at home. Despite a hospital-centric approach to healthcare and provider education, only a relatively small number of people enter the healthcare system at any given time.

Healthcare ecology is a model that helps to describe the health concerns of a population and the sources of care. For example, based on national surveys for a population of 1,000 people over the course of a month, 800 have medical symptoms and 327 consider seeking care. Only 217 of the 1,000 hypothetical patients will visit a physician's office, and only one is hospitalized in an academic teaching hospital.[22-24] The others ignore their symptoms, seek alternative sources of care, or seek care at home from other sources just as they did in centuries past.

In the future, our healthcare system must take the patient's life and priorities into consideration. Processes will allow for patients empowered by medical information, insight, and access to their records to decide what they themselves need. Healthcare will be convenient. Telemedicine and telehealth practices will abound. Access to care will be the window, wide open, between healthcare supply and demand. Access will include provider appointments, patient emails, text messages, nurse triage, and provider phone calls. Care will be driven by demand, not supply.

Traditionally, access has been used to describe populations with healthcare insurance or the availability of a provider visit. Future systems will redefine access. Patients and their families are busy. Healthcare is just one of the priorities they juggle. They see healthcare access differently than those who provide it. Patients desire information (general health knowledge), insight (wise interpretation and application of specific healthcare knowledge), or intervention (a system encounter that leads to a diagnostic or therapeutic action.) Only a small percentage of the patient's need and desire for access requires a traditional healthcare visit. They would rather be at home.

Healthcare leaders must be prepared and poised to shepherd the disruptive changes that loom for the American medical system. These leaders must be experienced members of the healthcare team who are familiar enough with the direct provision and practice of healthcare both within and outside of the hospital to be able to discern the needed changes from the background of commercial chaff. They must be sufficiently steeped in the study of leadership to have the range of skills necessary to lead the medical team, the community, medical education institutions, and our political systems through the most profound season of change in US healthcare history. They must be able to inspire and to teach the need for change to the remainder of the healthcare team and the American population.

An American healthcare reformation is coming. The transition will span the next generations. Physicians have the experience and technical skills to lead the change in both military and civilian medicine. The time for deliberate physician leadership training has arrived.

Will we be the leaders—or the led?

A QUESTION AND LEADERS' ANSWERS

Postretirement you find yourself consulting for an organization working with a large civilian healthcare system. Your expertise is being leveraged as you help them transition to the new, required, accountable healthcare organization guidelines. What lessons from healthcare leadership will you draw from, and how will you apply them as you become a consultant to your civilian brethren? What tools will you use to assess your strengths and weaknesses in this new leadership environment? Whom within your organization will you seek for guidance and mentorship, whom from outside your organization, and whom will you choose to mentor? How will you assess your performance as you move forward?

There are as many roles in consultancy postretirement as there are major aspects to health improvement and healthcare delivery. Consultants provide optimal prevention strategies, quality improvement methodologies, guidance in selecting and training the best employees for an effective and efficient healthcare organization, and insight into the optimal use of emerging technologies in providing patient-centered guidance on tailored health advice, medical diagnostics, and therapeutics. All are familiar to military medical leaders who have had to grapple with very similar issues over the past two to three decades, and especially during the decade of conflict through which we have navigated.

Healthcare outcome and financial accountability, improvements in population health, achieving and sustaining or restoring optimal health and function, and rapid adoption of evidence-based administrative and clinical practices have all been cornerstones of military medicine. Few large, fully integrated systems of health and healthcare have such a long record of striving to maintain optimal health, and of advancing cutting edge diagnostics and therapeutics as the US Military Health System.

Whom I shall seek for mentorship (among former coworkers and superiors or newly acquired colleagues), for improvement in my consulting skills, and in closing gaps in specific knowledge will rest entirely upon the context of the work I will seek and the clientele I will serve. Remaining open to learning; agile in thinking; receptive to constructive criticism; circumspect about my impact; and deeply values-based standards regarding honesty, integrity, trustworthiness, and the demonstration of personal courage in matters where these are challenged seem to me to be the keys to success. All of these are the attributes of the best military medical leaders as well.

LTG (Ret) Eric B. Schoomaker
The Surgeon General of the Army, 2007-2011

The successful transition of a senior medical leader following retirement from the military is an appropriate capstone thought exercise for this work. It encapsulates all we have discussed about institutional learning, self-study, and experience, and it highlights the need for lifelong learning well into the most senior level leadership positions.

The first step in answering all of the questions is to perform a needs assessment relative to your new organization and your role within. As a consultant, you are expected to bring knowledge gained from prior experience

and study, but each situation is unique. Depending upon the urgency of the situation and the timeframe required to produce appropriate consulting results, this needs assessment may take several days to several weeks.

It is important to determine if your energy is required at the strategic or operational level, keeping in mind that exploration of the tactical level will also be an important part of the needs assessment.

Once this analysis is complete, you will be able to determine which of your consulting requirements are personal strengths and which will require self-study or outreach to subject matter experts. You will not have time to become knowledgeable in every aspect of this organization's transition—you must focus your study.

At this point in your career, you have made connections with other senior leaders who may have gone through similar transitions with their organizations. Learn from their experience. Furthermore, ask them who they contacted for advice when they were going through their organizational transition. If appropriate within your organization, consider bringing some of these individuals onto your team as subject matter experts.

Many private organizations such as the American College of Healthcare Executives and the American College of Physician Executives possess a wealth of written resources and human contacts also able to assist you in everything from needs assessment through execution and performance measurement. Additionally, government organizations at the federal and state level directing this accountable care transition will have resources and consultants available. Take advantage of these, as success or failure will be measured based upon adherence to specific guidelines.

Yours will not be the first organization these government entities have shepherded through the process, and your status as a military retiree may allow you valuable access to senior civil servants with a wealth of knowledge. If there is sufficient time, focused coursework at one of the nation's business schools may complement the work you are doing. There is nothing like didactic study in the midst of hands-on work to cement knowledge into place. This is what we all accomplished during our residency programs. Finally, numerous books and periodicals are available and can be accessed based upon knowledge gaps you find initially or during subsequent feedback sessions.

Obtaining feedback on your performance in such a rapidly changing environment can be difficult, but it is essential that you continuously check with the leadership of the organization, individuals who work most closely with you, and as many external contacts as possible who have visibility of your work. While you will almost certainly be measured by objective metrics, it is also important that you consistently ask for feedback and accept that feedback with positivity and grace. Your sincerity and appreciation will ensure that you will continue to receive this essential feedback, allowing you to constantly adjust and provide the service the healthcare system needs.

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Know Yourself, in Order to Lead Others

MG David A. Rubenstein, US Army Retired

With over 35 years of healthcare leadership under my belt, and an uncountable number of paid and complimentary presentations on the subject, you would think I should have no problem penning some thoughts about leading fellow healthcare professionals. The truth is, there may be nothing more daunting than trying to stand out among the throngs of authors already writing about leadership.

In December 2012, Amazon books had over 96,000 hits for the keyword leadership, while the Harvard Business School listed 370 articles on the topic (http://hbswk.hbs.edu/topics/). Within our own healthcare profession, the wide range of options can be just as unwieldy. Amazon books listed 1,258 hits for healthcare leadership, while the American College of Healthcare Executives' own Health Administration Press listed 50 titles (http://www.ache.org/hap.cfm). On a narrower front, the American Organization of Nurse Executives, in conjunction with the American Hospital Association, offered 70 titles on its webpage (http://ams.aha.org/eweb), and the American College of Physician Executives offered a dozen (http://www.acpe.org/publications). The topics run the gamut of models as authors try to teach us the way to succeed based on the leadership traits of Attila the Hun to those of Bob Hope, based on skills learned on the golf course to those learned on the battlefield, and based on secrets from *Star Trek* and from Santa Claus.

In my opinion, most of the authors of leadership books, articles, and checklists assume that their readers have a well-formed concept of themselves as a leader. But, in the rush to lead others, it appears that many early-, middle-, and late-career leaders have yet to develop that sense of who they are relative to being a leader. Too many of us try to emulate Attila the Hun or Santa Clause before we know who we are and what we are about. Would it not be wonderful if more of us, me included, had a much more accurate understanding of ourselves as leaders so that we could better excel at the responsibility of leading others?

How do we proceed to know what we are about? The foundation for knowing about ourselves as a leader is being able, in a private conversation before a mirror, to describe what we strive for as our own personal leadership mission, vision, and values.

MISSION

Private Dwayne Turner was a combat medic in the 101st Airborne Division. In 2003, he and his unit were violently attacked by insurgents south of Baghdad, Iraq. At the onset of the attack, Turner was wounded when hit by hand grenade fragments. He saw a wounded Soldier and "checked him out, and tried to get him into a building." He then left the relative safety of the building to continue "assessing the situation, seeing who was hurt, giving them first aid and pulling them into safety." In the process, Turner, already wounded with grenade fragments, received additional fragment wounds and was further hit with gunshots that injured his left leg and broke his right arm. He remembered someone telling him he was wounded and, when seeing the blood, thinking "oh hell, if I'm not dead yet, I guess I'm not dying." Despite the realization that "it would have been really easy to just stay in that corner…. I realized I could let them continue to get hurt—and possibly die—and not come home to their families, or I could do something about it." He chose the latter and continued to leave the relative safety of the building to bring in the wounded until his injuries forced him out of action. Despite receiving multiple serious wounds himself, Private Turner repeatedly moved openly around the battlefield to care for 16 fellow Soldiers. He was credited with saving at least 2 lives. When he received the Army's Silver Star his reply was to profess that "other people may see me as a hero; I see myself as doing my job."[1]

Turner's job as a combat medic—his mission—was to keep his fellow Soldiers healthy and to care for them when they became ill, injured, or wounded. He well understood his mission and did not allow external influences to dissuade him from accomplishing it. What is instructive is that Turner's mission, though nested within his unit's mission, was unique to him. It helped accomplish the organizational mission, but was not a mirror of it. Private Turner serves as a springboard for each of us. He had the benefit of having platoon sergeants and instructors repeatedly drill into him his mission as a medic. Most of us do not have the benefit of that direct, in-your-face instruction. Instead, we have to develop our leadership mission through study, observation, and practice. Our goal should be the ability to look within ourselves and state our personal mission as a healthcare leader. What is your personal leadership mission?

VISION

Private First Class Monica Brown was awarded the Silver Star for her actions in 2007 while assigned as a combat medic to the 82nd Airborne Division's 4th Brigade and attached to 2nd Platoon, Charlie Troop, 4th Squadron, 73rd Cavalry Regiment. Brown was the only medic in a 5-vehicle convoy returning to the unit's forward operating base from a mission at a nearby village in Paktika Province, Afghanistan. One of the trail vehicles triggered a roadside bomb which was followed by an insurgent attack with mortar and machine gun fire. "They stopped the convoy. My platoon sergeant got out of the truck and said, Doc, let's go," Brown recalled. After running 300 meters with her aid bag, Brown went into immediate action to care for the 5 Soldiers injured in the attack while the battle raged around her and ammunition started exploding in the vehicle that hit the bomb. She first assessed the situation, and then rendered immediate care to the most severely injured. While she was treating the most compelling injuries, the enemy attacked with mortar rounds that endangered Brown and the casualty she was treating, so she "dove over him. [I made] sure he didn't get any shrapnel or anything from it," she recalls. With the casualties triaged and immediately treated, Brown and her fellow Soldiers loaded them into vehicles and moved out of harm's way to continue treating them and to meet a medical evacuation helicopter. After the wounded were flown away, Brown stopped to consider what had just happened. Then, she has admitted, "I threw up." Brown has also said of her actions "I wasn't scared for my life. I was scared because I was afraid I wasn't gonna be competent and able to do my job."[2]

Brown's vision of the future of her role was that of a focused, competent, and able combat medic. Her actions in the face of this combat operation certainly allow her to look back at what she did and compare it very favorably to the vision she had of herself as a combat medic. We each have a vision of what we want to see about ourselves when we look back on our career. As leaders, we work in organizations where leaders, both us and those above us, have identified a vision for the organization. From a personal perspective, though, our vision as a leader is something different. Our personal vision is one that describes what we want to have accomplished when we look back on our career or on a segment of that career—an assignment, a project, or a specific effort. What is your personal vision of yourself as a leader?

VALUES

Private First Class Stephen Tschiderer received no medal. He just did his job. PFC Tschiderer is a combat medic who, in 2005, was attached for duty to 3rd Battalion, 156th Infantry Regiment, 256th Brigade Combat Team, 3rd Infantry Division. He was with his unit on a convoy in the western part of Baghdad, Iraq, looking for someone shooting at Americans. At a stop, Tschiderer dismounted and walked around his vehicle. While engaged with his duties, an enemy sniper team in a van across the street and not more than 75 meters away, took careful aim on Tschiderer. Their aim was excellent, as a bullet from a Dragunova sniper rifle tore a hole in his jacket and embedded in his body armor directly over his heart. After being knocked to the ground by the force of the bullet, Tschiderer bounced up and ran for cover. In his words "It's not a big deal that I got shot, I'm a Soldier, and Soldiers get shot every day." He then directed his platoon's attention toward the sniper's location. During the ensuing vehicle chase, the sniper received wounds that hobbled him, but that did not prevent him from running off. Tschiderer then pursued on foot and was part of the team that caught up with the insurgent and captured him. After capturing and handcuffing the sniper, the same person who had just shot him in the chest, Tschiderer started treating his wounds. "He was hurt and I had to do my job," he said. "I'm a medic. It's my job. It doesn't matter, friend or foe, soon as he's put down his weapons, I've got to treat him."[3,4]

Stephen Tschiderer is a Soldier. As such, he's constantly bombarded with reminders about the values a Soldier is held responsible for keeping. The same is true for millions of men and women over the years who have served the Army as Soldiers or Army Civilians. Each has been held responsible for adhering to the Army Values during the conduct of their professional lives and responsibilities. But, sadly, there is a gulf between knowing one's organizational values and living them. We as leaders need to know more than the values of the organization to which we belong. We need to know what our personal values are, and we need to live those values in our dealings with others. What are your personal values as a leader?

INTERNAL EXPECTATIONS, EXTERNAL REALITIES

I am often asked if all the introspection is really necessary. Do we as leaders really need to know what we hold as important? Can we just wing it? My answer is yes, we need to know who we are, and no, we cannot just wing it. There are a host of reasons for my answers, most of which you could easily recite. Here is the most obvious one, though we may not think about it too often. Being able to describe to ourselves what we strive for as our mission, vision, and values are important because of what those around us see—our internal expectations are seen and judged as external realities. What we strive for is internal. What we actually do is external. And, as

we should realize, our people, those around us whom we are leading and affecting every day, know our mission, vision, and values very well. They make this assessment based on how we act, how we behave, how we make decisions, and how we lead.

If we know what we want to be as a leader—our mission, our vision, and our values—we will be better able to provide that leadership to our people and our organizations.

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Trust: the DNA of Leadership

COL Eric Sones, MS, USA

Trust: this small, 5-letter word can move an organization forward or stop it completely. Its powerful ability to make or break a unit has made it a top priority of Army leadership in recent years.

In a recent interview with *Army Times*,[1] Army Chief of Staff GEN Ray Odierno said "Whether you're a lieutenant, whether you're a captain, whether you're a 4-star general, you have to constantly earn [Soldiers'] trust, and they don't ask for a whole lot. What they want you to do is be true to your word. They want to know you'll fight for them when necessary. They want to know you'll make the hard, tough decisions when necessary, whether it be in combat or not. That's what they expect from you."

Trust is leading. A dictionary definition of trust is the "assured reliance on the character, ability, strength, or truth of someone or something."[2]

Successful leadership cannot exist without trust. Building it must be intentional, and requires diligence and perseverance. The respect of those you lead is earned and does not exist outside of a climate of trust. The core Army values of loyalty, duty, respect, selfless service, honor, integrity and personal courage are fostered by the presence of trust. Clearly, trust in an organization can empower a unit; the lack of trust can destroy it. If your unit has lost trust in you, you have lost the ability to lead.

While understanding the importance of trust appears straightforward, earning trust in an organization may seem like a daunting task. Depending on the command climate established by the leadership, achieving trust may either come quickly or take a substantial amount of time. In their research, Mishra and Mishra[3] noted that trust in a leader develops over time as "it is based on repeated experiences that have been validated in a variety of situations."[3(p8)]

During my recent command experience, I determined that 4 key elements are critical to building trust in any organization: confidence, reliability, empowerment, and care of others.

CONFIDENCE IN THE COMMAND

Building trust requires confidence in the command. Members of an organization must be able to place confidence in their leadership no matter the situation. When confidence is broken, the ability to trust is paralyzed. Trustworthy leaders can be "depended upon when things go well and when they do not."[3(p8)]

The team must have confidence in the leadership to ultimately make the right decision for the benefit of the organization rather than their self interests, especially in the tough times. Effective leaders understand the organization and its mission are far bigger than themselves. The leader builds confident teams who will loyally follow them and fight for the success of the mission.

Commanders also instill confidence in others when they demonstrate confidence in their own ability to lead. Confident leaders are not afraid to make decisions, and build trust when they tackle the tough issues by making the right decision rather than the easy one. Instead, toxic leaders erode trust in the organization.

As GEN Odierno explains, "A toxic leader might abuse his subordinates, or is unable to empower his subordinates. It also could be a leader who is unwilling to make decisions or makes decisions for his own benefit and not the benefit of the organization."[1]

RELIABILITY

> *People don't listen to you speak; they watch your feet.*
>
> Anonymous[4(p128)]

Trust comes when leaders are true to their word. Actions speak louder than words. When a team sees their leader putting his or her talk into action by consistently doing the right thing for the team, trust is built. Leaders establish high expectations for themselves and others by being true to their word and keeping their promises.

> Breaking your word destroys trust. You have to follow through on what you are going to say you are going to do. If you fail at this task you start to whittle away at the trust within the unit.
>
> CPT Charles Wyatt, company commander, 232nd Medical Battalion, April 23, 2013

> Trust is not just handed to you; it is earned through hard work. You earn it by being honest and truthful and not by twisting the truth around. People watch you closely and really see if you are being straight up with them.
>
> 1SG Gilberto Colon, 232nd Medical Battalion, April 24, 2013

> You can say a lot of things, but unless you actually do them, your words will not build trust; in fact, they will destroy it.
>
> Stephen Covey[4(p128)]

Effective leaders also build trust through consistency. If you say you are going to do something, do it. It's difficult to ask the team to be reliable, when you are unwilling to do the same.

Trust is also developed when a leader has the courage to take responsibility for his/her mistakes. Contrary to popular belief, apologizing is not necessarily a sign of weakness. Owning up to your mistakes illustrates honesty and transparency, and builds an environment of trust.

Mishra and Mishra point out that "We…have found that apologizing is often a necessary and even first step in fostering open and honest communication when trust has been broken." Further, "…the reality is that while trust can be robust, it quickly becomes fragile when mistakes or wrongdoing occurs without ready acknowledgment and making amends."[3(p167)]

EMPOWERING OTHERS

> *The people when rightly and fully trusted will return the trust.*
>
> Abraham Lincoln

Micromanagement stifles trust because it sends the message that the command does not trust them to do their job effectively. Team members are unable to thrive in an environment of micromanagement. Tunnel vision replaces great ideas because subordinates no longer take risks.

Leaders build trust by giving their subordinates the flexibility to do their job, take risks, and, if necessary, learn from their mistakes.

> I appreciate the trust the leadership put in me by allowing me the freedom to command and learn from my mistakes.
>
> CPT William Pitt, company commander, 232nd Medical Battalion, March 25, 2013

> If I make a mistake, the positive environment created by the command team lets us learn from a mistake. We become better leaders when we can trust our command.
>
> SFC Philip Baldwin, platoon sergeant, 232nd Medical battalion April 25, 2013

Trust goes both ways. Leadership must first establish a climate of trust in the organization by trusting their subordinates. Leaders, who see the best in their employees and demonstrate total faith in their abilities, empower them to do their job and complete the mission. They trust their subordinates unless there is a solid and founded reason not to trust them.

> I have found that by trusting people, until they prove themselves unworthy of that trust, a lot more happens.
>
> Jim Burke, former chairman and CEO of Johnson & Johnson[4(p316)]

CARE OF OTHERS

Caring for your people opens the door to trust, builds morale, and creates a positive command environment.

Commanders build trust by meeting the needs of those they lead. A selfless leader is willing to risk his or her fortune in order to do what is right for the Soldier. Self-serving, forceful leadership destroys trust while a caring, selfless leader builds it.

Effective leaders build trust through transparent and authentic relationships with their staff. Active listening is a critical component to building a team. Soliciting and valuing the opinion of every individual creates this climate of teamwork and trust.

> Good commanders have the ability to understand and listen to subordinate leaders. It gives us the confidence that our commander really trusts what we say and do.
>
> CPT Nickolas Baranello, company commander, 232nd Medical Battalion, April 6, 2013

CONCLUSION – CREATING A CLIMATE OF TRUST

How do you know when you have trust in the organization? According to Jack Welch, former CEO of General Electric, "You know it when you feel it."[4(p5)]

The best leaders treat all personnel within the organization with respect, as one team, by putting others before themselves. These actions create a positive climate of trust. Trust has strong roots in an organization. When trust is present, it has the power to allow team members to do exceptional things. However, once trust has been lost, it is difficult to restore.

It's clear that the ultimate success of any organization can be traced to the ability of its leadership to foster a team environment through a solid atmosphere of trust.

At some point in time, either in the military or in the private sector, we have all been part of a great team. What made that team so exceptional? It was trust.

The DNA in your leadership is made up of your values and these values make up your character. Ultimately, the answer of trust lies in your character.

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Inculcating Core Values Through Application of the Patient CaringTouch System

COL Daniel W. McKay, AN, USA

Ask any Soldier or Department of the Army civilian and he or she will recite the Army values,* but, as evident in each publication of the *Army Times*, recital is different from living up to these values. Where is the gap between knowledge and action? The gap may begin during the accession process, not as much because of what is taught but more in how it is taught. The Army Learning Concept 2015[2] calls for more relevant, tailored, and engaging learning experiences for our students. Based on gaps identified by a Corps Chief working group, in 2011 the Army Nurse Corps restructured their Basic Officer Leader Course Nurse Track to include a block of instruction on values in an effort to ignite a grass-roots movement to better inculcate values-based decision-making. This article describes the methodology behind the effort to provide entry-level officers self-awareness of deeper personal values and understanding of how personal and institutional values lead to values-based decisions in support of the Patient CaringTouch system of care.

PERSPECTIVE

In 2010, as part of the Army Nurse Corps (ANC) Campaign Plan,[3] the Department of Nursing Science at the Army Medical Department Center and School conducted a massive, bottom-up review and retooling of courses offered through the recently established Army Nursing Leader Academy (ANLA). The ANLA is a suite of courses designed to promote lifelong learning across the career span of ANC members. The Academy's purpose is to develop adaptive, decisive action nurse leaders through the tenets introduced by COL (Ret) Kathleen Dunemn into the Army Nursing Collaborative Learning Framework: formal schooling, professional experience, functional/technical expertise, self-development, and coaching.[4] The ANLA is grounded in the Patient CaringTouch system, guided by nursing competencies and gauged by the Nursing Leader Capabilities Map.[4(p21)] Values are one of the 10 Patient CaringTouch system components.

We all know the Army values acronym LDRSHIP,* but living the meanings/actions represented by that acronym is truly the test of individual and organizational character. Values define what individuals, organizations, institutions, and even nations consider important. In the context of this discussion, values are how we aspire to conduct ourselves, our business, our organization, or our country through thoughts and deeds. Values serve as guides to actions. The Army Values clearly define expected behaviors of Soldiers, NCOs, officers, and DA civilians from a corporate vantage point. However, the level of commitment to organizational values is less dependent upon knowing the corporate language and more dependent upon understanding and self-actualizing personal values.[5]

Kouzes and Posner[5] present over 30 years of research which answer the question:

> How much of a difference does it make in commitment to the organization for members to have a high understanding of organizational vs personal values?

Their findings revealed that people who lacked clarity of personal values but possessed high clarity of organizational values generally demonstrated a 69% commitment level to the organization. Conversely, individuals who acknowledged a high understanding of their personal values but little understanding of the corporate values demonstrated an 87% commitment to the organization. They live up to their personal values. Interestingly, when individuals are able to possess high clarity of both personal and organizational values, they demonstrated a 90% commitment to the organization.[5] It is this pivotal, incontrovertible evidence that forms the basis of the ANC Core Values instruction.

THE CLASS

The main purpose of the Core Values class is to connect personal values to behaviors. In the Patient CaringTouch system, Core Values place our patients at the center of care and guide our daily nursing practice, as well as our interactions with patients, families, and colleagues. In keeping with the Army Learning Concept 2015, the course transitions from lecture to blended presentation and discussion in which PowerPoint slides serve to keep the group focused. Small group discussions, return presentation, and open large group discussion in a nonattributional forum serve as a framework for learning.[2]

*Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, Personal Courage (LDRSHIP)[1]

During the initial part of the class, participants identify the connection between the Patient CaringTouch system and Army Values. The new Nurse Corps officers identify values, their origins, and how they know the organizational values. This interactive, large-group discussion is followed by a review of the Army Values building blocks, starting with the LDRSHIP acronym. Since these officers were introduced to the LDRSHIP concepts in the general Basic Officer Leader Course, the discussion focuses on rank ordering the Army Values. Collins[6] and Lee[7] supply the theoretical justification for a hierarchal ranking of value importance. Ranking the Army Values allows officers to make sound decisions when faced with conflicting adherence to various corporate values. If officers hold that all values are "most important," then none are important.[6] Of course there is no right answer, but integrity, honor, and duty seem to rise to the top in class after class.

Next, officers examine other Army Values supporting documents such as the "The Soldiers Creed" (page 39) where instructors make a specific point of reminding them that they are Soldiers first, officers second and Nursing is what they bring to the fight. Following the Soldiers Creed, officers are introduced to The Army Nursing Team Creed (page 39) and demonstrate the connection to this creed and the Patient CaringTouch system. Going further with the nursing-themed documents, the nurses briefly review the American Nurses Association *Standards of Practice and Professional Performance*[8] and *Code of Ethics*.[9] All these documents combine to guide our corporate and professional nursing values. This is where most Army Values classes stop. However, the evidence in mainstream media and research by Kouzes and Posner[5] have pushed the ANC to take another step.

After a brief interactive discussion of Kouzes and Posner's evidence (again linked to the Patient CaringTouch system as evidence-based), the participants are asked to conduct a practical exercise with the goal of affirming their personal values and comparing personal values to the corporate values. They are provided a list of 56 values as shown in the Figure. First they are asked to work independently by responding to the statement, "these are my values." They must limit their choices to 10 values. Then they are asked to engage in critical, introspective thinking by narrowing their first list to no more than 3 values by responding to the statement, "these are my values to which I am 100% committed and will not betray." This part of the exercise engages the learner from multiple cognitive avenues while solidifying learning, commitment, and self-actualization.

To help solidify the learning, the participants break into small groups (6 to 8 per group) and discuss their values, identify commonality, and compare the commonalties to the corporate values. After the small group discussions, each group reports their findings and, as a class, discovers the commonalties and diversity. This promotes camaraderie, cohesiveness, understanding, and trust. To round out this segment of the class, participants are asked to rate on the 1 to 10 scale their level of commitment to common values and how committed they are to demonstrating these values in the workplace. Participants use their hands to show their level of commitment (usually from 5 to 9). Those demonstrating a level less than 8 are asked: "what would it take to improve your level of commitment?"

The next practical exercise is designed to help participants envision the benefits of living their identified core values with patients and nursing staff by simply asking them to discuss 2 questions:

1. What is the benefit(s) to our patients in your living your core values?
2. What is the benefit(s) to the nursing staff in your living our core values?

Officers discuss these questions first in their small groups, then report to the large group. After receiving and consolidating the replies representing the group's values, we compare those replies to the Army Values. To date the two sets of values have been strikingly similar.

The final exercise is presented to the students as an option because by this time we have been working for about 2 hours. To date, every class has decided to conduct the exercise. The purpose of the final exercise is to actualize their personal values in their individual nursing experiences through storytelling. Stories are the richest source of identity for groups. Through our stories, we share learning, joy, sadness, mistakes, and triumphs. We see our values in action.[10] The participants are asked to share in their small groups a lived experience that demonstrated their values. Afterwards, we reassemble as a large group and ask volunteers to share a story (not their own) which demonstrated expression of uniquely nursing values-based connections with our patients. The stories are always remarkable and humbling.

To close the class we show a brief video[11] concerning how and why people and organizations drift away from their values. The best outcomes measure from this course will be 4 to 6 years in the future when these officers become eligible for separation from the ANC and choose to stay

Challenge	Simplicity	Health	Growth	Beauty	Autonomy	Happiness
Trust	Productivity	Empathy	Respect	Faith/ Spirituality	Risk-Taking	Dependability
Independence	Innovation	Competition	Variety	Power	Freedom	Decisiveness
Curiosity	Friendship	Honesty/Integrity	Security	Harmony	Humor	Achievement/ Success
Communication	Respect	Open-mindedness	Love/ Affection	Diversity	Service	Recognition
Honor	Creativity	Competence	Hope	Duty	Teamwork	Loyalty
Patience	Strength	Family	Effectiveness	Truth	Quality	Equality
Wisdom	Prosperity/ Wealth	Flexibility	Dependability	Courage	Intelligence	Discipline

From the above list, select 10 values that you consider to be your personal values.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

From the above 10 values, select 3 which fit the characterization, "these are my values to which I am 100% committed and will not betray."

1.
2.
3.

Value 1: _____is most important to me because _____
_____
_____

Value 2: _____is most important to me because _____
_____
_____

Value 3: _____ is most important to me because _____
_____
_____

Compare and contrast your personal values with Army Values.

Loyalty

Duty

Respect

Selfless Service

Honor

Integrity

Personal Courage

The Clarification of Personal Values worksheet.

Soldier's Creed

I am an American Soldier.

I am a warrior and a member of a team.

I serve the people of the United States, and live the Army Values.

I will always place the mission first.

I will never accept defeat.

I will never quit.

I will never leave a fallen comrade.

I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills.

I always maintain my arms, my equipment and myself.

I am an expert and I am a professional.

I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat.

I am a guardian of freedom and the American way of life.

I am an American Soldier

The Army Nursing Team Creed

Authored by LTC Leigh McGraw

I am a member of the Army Nursing Team

My patients depend on me and trust me to provide compassionate and proficient care always. I nurture the most helpless and vulnerable and offer courage and hope to those in despair. I protect the dignity of every individual put in my charge.

I tend to the physical and psychological wounds of our Warriors and support the health, safety, and welfare of every retired Veteran. I am an advocate for family members who support and sustain their Soldier during times of War. It is a privilege to care for each of these individuals and I will always strive to be attentive and respectful of their needs and honor their uniquely divine human spirit.

We are the Army Nursing Team

We honor our professional practice standards and live the Soldier values. We believe strength and resiliency in difficult times is the cornerstone of Army Nursing. We embrace the diversity of our team and implicitly understand that we must maintain a unified, authentically positive culture and support each other's physical, social, and environmental well-being. We have a collective responsibility to mentor and foster the professional growth of our newest Team members so they may mentor those who follow.

We remember those nursing professionals who came before us and honor their legacy, determination, and sacrifice. We are fundamentally committed to provide exceptional care to past, present, and future generations who bravely defend and protect our Nation.

The Army Nursing Team:
Courage to Care, Courage to Connect, Courage to Change

Embrace the Past, Engage the Present, Envision the Future

because they are connected to an organization aligned with their personal values. Our only current measures are the course evaluations from participants. We have an overwhelming positive response, consistently showing a greater than 80% value-added response rate.

CONCLUSION

In November 2012, a modified version of the Basic Officer Leader Course Patient CaringTouch Core Values class was presented to most of the Army Nurse Corps executive leadership during the ANC Campaign Planning Conference I. These senior nurses were asked to complete the same personal values exercise and came to consensus as a group on their shared values: integrity, loyalty, respect, and family. The challenging road ahead for the ANC is now to live up to the standards set forth by those simple, eloquent, but powerful words. Let our integrity be uncompromising, let our loyalty to the sons and daughters serving this great nation be unquestionable, let our respect be present in every interaction, and let our sense of family extend beyond bloodlines to encompass our fellow service men and women. If, from our generals to our basic privates, Army Medicine can live these values, the Army Medical Department would reach the vision and mission set forth by The Surgeon General. It all hinges on commitment to our shared values!

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Characteristics of Most-Admired Army Medical Department Leaders

Jody R. Rogers, PhD
A. David Mangelsdorff, PhD, MPH

Leadership is in the eyes of other people; it is they who proclaim you as their leader.

Carrie Gilstrap[1]

What do people look for in their leaders they admire most? What characteristics or attributes can be ascribed to those we admire more than other leaders? Studies to identify key characteristics or attributes found in leaders admired most have recently been conducted.[2-6] Kouzes and Posner[6] addressed this question for the past 30 years by surveying thousands of business and governmental executives. Many attributes were identified and, through further analysis to include content analysis by independent judges followed by additional empirical studies, the list was narrowed to 20 characteristics or attributes. Although this study falls more in line with trait theory of leadership, identification of important attributes or traits found in those we admire most could serve as a precursor to identifying the behaviors found in leaders we admire most. Studying traits alone as the sole way of becoming a better leader has been shown to be inadequate at best. Nonetheless, Ledlow and Coppola[7] indicated that identification of key traits or characteristics is an important first step in understanding what leaders in a specific business or industry do to be successful.

Respondents were asked to list the characteristics they found most common in leaders they would "willingly" follow. It is important to emphasize willingness to follow as people often must follow leaders unwillingly because their jobs or positions depend upon their ability to follow someone. These leaders may be in leadership positions but have not earned the right to be followed willingly by their colleagues.[6]

Despite broadening the surveyed population to include leaders from around the world, the characteristics found to be common in leaders admired most have remained very consistent. The top 4 characteristics have always included honest, forward-looking, competent, and inspiring. In fact, these are the only ones which routinely received more than 50% of all votes. All characteristics received votes, meaning all the characteristics are important; but the only ones receiving greater than 50% of all votes are those four.[6] Do these same characteristics apply to Army Medical Department (AMEDD) leaders? Although Kouzes and Posner did include government executives, they did not include military personnel in their surveys. Researchers from the Leader Training Center and the US Army-Baylor University Graduate Program in Business and Health Administration at the AMEDD Center and School asked this same research question to a survey population of military personnel.

METHODOLOGY

Surveys were conducted with the intent of identifying which of 20 skills AMEDD personnel deemed most important in the person they identified as their most admired leader. The survey tool chosen was based on research conducted by Kouzes and Posner.[6] The proposal for the study design and survey was examined by the Brooke Army Medical Center Institutional Review Board and considered exempt research. The research question was to determine if there was a statistically significant difference between the selected characteristics of an admired leader as chosen by AMEDD personnel and respondents from data collected by Kouzes and Posner.

Data was collected from 2009 thru 2012 from 2,530 AMEDD students attending 32 officer training courses at the AMEDD Center and School (Basic Officer Leader, Captains Career, Head Nurse, Brigade Surgeon, and AMEDD Executive Skills courses). Respondents were asked to rate each of 20 leadership attributes used by Kouzes and Posner in terms of importance in regards to the person they identified as their most admired leader using a 7-point Likert scale (1=least to 7=most important), reproduced in Figure 1. Secondary research questions included determining whether there were statistically significant differences in attributes based on age, gender, rank (company grade vs field grade*), corps (Medical, Nurse, Medical Service, Specialist, Dental, and Veterinarian), and environmental factors such as time spent in hospitals (fixed facility experience) and time spent in the field (operational unit experience). The data portion of the questionnaire is presented in Figure 2. Statistical analyses included descriptive and inferential analyses; Wilcoxon Signed Ranks test; reliability

*Company grade officers – 2nd lieutenant, 1st lieutenant, captain. Field grade officers – major, lieutenant colonel, colonel.

Attributes of an Admired Leader

We look for special attributes in our leaders. Research indicates that the attributes listed below are the ones we admire most in our leaders. From this list of 20 attributes, please indicate your opinion of each attribute in terms of importance to effective leadership using the Likert scale from 1 to 7:

Least Important → 1 2 3 4 5 6 7 ← Most Important

Ambitious 1 2 3 4 5 6 7 (aspiring, hard-working, striving)	**Honest** 1 2 3 4 5 6 7 (truthful, has integrity, trustworthy, has character)
Broad-minded 1 2 3 4 5 6 7 (open-minded, flexible, receptive tolerant)	**Imaginative** 1 2 3 4 5 6 7 (creative, innovative, curious)
Caring 1 2 3 4 5 6 7 (appreciative, compassionate, concerned, loving, nurturing)	**Independent** 1 2 3 4 5 6 7 (self-reliant, self-sufficient, self-confident)
Competent 1 2 3 4 5 6 7 (capable, proficient, effective efficient, professional)	**Inspiring** 1 2 3 4 5 6 7 (uplifting, enthusiastic, energetic, humorous, positive, cheerful)
Cooperative 1 2 3 4 5 6 7 (collaborative, team player, responsive)	**Intelligent** 1 2 3 4 5 6 7 (bright, thoughtful, intellectual, reflective, logical)
Courageous 1 2 3 4 5 6 7 (bold, daring, fearless, gutsy)	**Loyal** 1 2 3 4 5 6 7 (faithful, dutiful, unswerving in allegiance, devoted)
Dependable 1 2 3 4 5 6 7 (reliable, conscientious, responsible)	**Mature** 1 2 3 4 5 6 7 (experienced, wise, has depth)
Determined 1 2 3 4 5 6 7 (dedicated, resolute, persistent, purposeful)	**Self-controlled** 1 2 3 4 5 6 7 (restrained, self-disciplined)
Fair-minded 1 2 3 4 5 6 7 (just, unprejudiced, objective, forgiving, willing to pardon others)	**Straightforward** 1 2 3 4 5 6 7 (direct, candid, forthright),
Forward-looking 1 2 3 4 5 6 7 (visionary, foresighted, concerned)	**Supportive** 1 2 3 4 5 6 7 (helpful, offers assistance, comforting)

Figure 1. The Likert scale rating questionnaire used to collect data regarding the study participants' opinions of the importance of each of the 20 leadership attributes used in the research by Kouzes and Postner.[5]

analysis (Cronbach's alpha); analysis of variance (ANOVA) for age, gender, rank (company grade vs field grade), and environmental factors (fixed facility and operational unit experience) by corps.

RESULTS

Summary descriptive statistics (mean and standard deviation) are shown in Table 1. Comparisons were made to the attribute rankings of Kouzes and Posner.[6] Wilcoxon Signed Ranks tests (Table 2) between the Kouzes and Posner rankings vs comparison groups (officers aged 40 years or more, field grade officers, and all AMEDD Corps) showed no significant differences in rankings. The leader attribute "honest" was ranked first in Kouzes and Posner and for all comparison groups. "Competent" and "inspiring" were consistently ranked highly. There was general agreement for the attribute rankings. The Cronbach α was calculated for the 20 items (0.907; $P<.001$); the items were significantly reliable (the ratings were consistent). There were significant differences in the summary demographic statistics between the AMEDD medical officer corps (Table 3) and in the ANOVA of the leader characteristics between officer corps (Table 4).

The results of the AMEDD study closely correlates with The Leadership Challenge (TLC) study with a few important distinctions. Although there were no overall differences in the rank ordering of these attributes between

Demographic Questionnaire for Study Participants

1. Age:_____
2. Gender (circle one):
   - Male
   - Female
3. Military pay grade (circle one):
   - O1
   - O2
   - O3
   - O4
   - O5
   - O6
   - O7 and above
4. AMEDD Corps or affiliation (circle one):
   - Medical Corps
   - Army Nurse Corps
   - Medical Service Corps
   - Specialty Corps
   - Dental Corps
   - Veterinary Corps
   - Civil Service
   - Foreign officer
5. Ethnicity or Race (circle one):
   - African American
   - Asian/Pacific Islander
   - White
   - Hispanic
   - Native American
   - Other: _____
6. Years of experience serving in:
   - Operational units _____
   - Fixed facilities _____

Figure 2. Reproduction of the demographic data questionnaire completed by each study participant.

Table 1. Summary Descriptive Statistics

	Leadership Trait	n	Mean	SD
1	Ambitious	2510	5.54	1.24
2	Broad-minded	2518	5.82	1.05
3	Caring	2514	5.71	1.16
4	Competent	2520	6.48	0.86
5	Cooperative	2522	5.80	1.06
6	Courageous	2525	5.41	1.28
7	Dependable	2520	6.49	0.84
8	Determined	2503	5.87	1.09
9	Fair-minded	2521	6.04	1.05
10	Forward-looking	2512	5.88	1.06
11	Honest	2524	6.73	0.74
12	Imaginative	2517	5.13	1.24
13	Independent	2515	5.23	1.33
14	Inspiring	2517	5.98	1.08
15	Intelligent	2525	5.79	1.08
16	Loyal	2521	6.21	1.03
17	Mature	2522	5.79	1.16
18	Self-controlled	2515	5.89	1.09
19	Straightforward	2521	5.74	1.14
20	Supportive	2521	5.83	1.13
	Demographic			
Age (years)		2491	36.91	8.15
Fixed facility* experience (years)		2411	5.80	5.91
Operational unit† experience (years)		2413	4.21	5.29
		n	%n	
Age>40 years		2530	35%	
Field grade rank		2288	35%	
Male		2516	61%	

n=Number of study sample population who selected the characteristic or responded to the demographic category. Total study sample (N)=2,530.

Mean and SD are that of the cumulative Likert scale rankings (1=least to 7=most) of the characteristic by the respondents.

*Fixed facility indicates an established medical healthcare facility, such as a clinic, community hospital, or medical center.

†Operational unit indicates a deployable unit configured to provide medical services in the field in a deployed/combat environment.

the two studies, upon closer examination, noteworthy differences do occur. For example, the top 4 attributes were slightly different. Honesty remained the most important attribute in both studies, but differences started to emerge following this attribute. In the TLC study, forward-looking was the second most commonly chosen attribute, followed in order by inspiring and competent. As mentioned earlier, these 4 attributes were found to be most important in every survey conducted over the past 25 years, even when international leaders were included in the study. Honesty was always found to be the most important attribute, whereas the scores of the next 3 attributes were relatively close, with competent and loyal often switching places in terms of importance.[6] The consistency of results despite the expansion of their study to include international leaders is quite interesting. Regardless of where leaders are, the attributes most important to them remain consistent.

The attributes most important to leaders AMEDD personnel would willingly follow are slightly different. Honesty remained the most important attribute regardless of

Table 2: Comparison of rankings between Kouzes and Posner[5] and other Categories

Leadership Trait	Kouzes and Posner (n>1.5 million)	AMEDD Personnel (all) (n=2530)	Age>40 Years (n=898)	Field Grade Rank (n=800)
Ambitious	17	17	18	18
Broad-minded	8	11	16	12
Caring	14	16	10	9
Competent	4	3	2	2
Cooperative	11	12	15	15
Courageous	12	18	17	17
Dependable	10	2	3	3
Determined	13	9	12	11
Fair-minded	6	5	5	6
Forward-looking	2	8	7	7
Honest	1	1	1	1
Imaginative	15	20	19	19
Independent	20	19	20	20
Inspiring	3	6	6	5
Intelligent	5	13	14	14
Loyal	18	4	4	4
Mature	16	14	11	10
Self-controlled	19	7	8	8
Straightforward	7	15	13	15
Supportive	9	10	9	13

Table 3: Demographics of study participants who were members of an AMEDD military officer corps.

Demographic	MS n=739	MC n=471	NC n=660	DC n=236	VC n=69	SP n=177	Overall N=2352
Age>40 years	29%	30%	38%	39%	26%	38%	34%
Male	71%	76%	37%	71%	42%	68%	61%
Field grade rank	23%	71%	21%	62%	18%	18%	34%
Fixed facility* experience (yrs)	4.14	6.48	6.09	8.60	4.34	5.39	5.67
Operational unit† experience (yrs)	5.68	2.51	3.09	3.05	1.66	6.13	4.00

Acronyms:
MS - Medical Service Corps NC - Nurse Corps VC - Veterinary Corps
MC - Medical Corps DC - Dental Corps SP - Specialist Corps

*Fixed facility indicates an established medical healthcare facility, such as a clinic, community hospital, or medical center.

†Operational unit indicates a deployable unit configured to provide medical services in the field in a deployed/combat environment.

Sixty-five percent of all respondents were company grade officers. It seems quite logical that while honesty is the most important attribute to leader effectiveness, company grade officers are looking for leaders who are dependable, competent, and loyal. Inspiring and forward-looking were important attributes, ranking 6th and 8th respectively. They were not as important as dependability and loyalty, at least for company grade respondents.

Attributes most important to field grade officers differed slightly. Again, honesty was most important, followed by competent, dependable, and loyal. The same 4 attributes as identified by company grade officers but in a slightly different order. The fifth most important attribute was inspiring followed by fair-minded (ranked 8th by company grade officers).

The consistency of attributes important in the most admired leaders among field grade and company grade officers was somewhat surprising. For example, it is easy to imagine that field grade officers would place greater importance on being forward-looking and inspirational. Senior officers are expected to take a big picture approach to their units and then sell their vision of the future to those they lead. Yet, dependability and loyalty remained more important even to field grade officers.

Leadership attributes among the different Corps proved quite interesting as well. The top 4 leadership attributes most important to Medical Service, Army Nurse, and Dental Corps officers were the same: honest, dependable, competent, and loyal. For Medical Corps officers, the top 4 attributes were honest, competent, dependable, and a tie with inspiring and loyal. Specialty Corps Officers identified honest, competent, dependable, and loyal as their most admired attributes.

COMMENT

The most noteworthy finding from this study was the striking similarity in the top 4 most important attributes identified by AMEDD officers—regardless of rank, experience, age, and Corps affiliation—in leaders they admired most is honesty, dependability, competence, and loyalty. Military service places unique requirements on those who choose to serve. The inherent dangers associated with military service affects the choices of attributes most admired in military leaders. The importance of being honest is as extremely rank, age, or Corps affiliation. The importance of honesty to effective leadership cannot be understated. Honesty is as absolutely critical to leader effectiveness in the AMEDD as it is in nonmilitary settings. The second most important leader attribute for AMEDD officers was dependable, followed by competent and loyal. given our specific population, these results are understandable.

Table 4. Variables across the specific AMEDD military officer corps. All values in the officer corps columns are the means of the cumulative Likert scale rankings (1=least to 7=most) of the characteristic by the respondents. The ANOVA examined differences between the officer corps means.

	AMEDD Military Officer Corps						ANOVA		
	MS	MC	NC	DC	VC	SP			
Characteristic							*df*	F	*P*
a01 Ambitious	5.67	5.22	5.70	5.52	5.00	5.39	5, 2326	13.426	<.001
a02 Broad-minded	5.86	5.67	5.90	5.71	5.86	5.77	5, 2335	3.487	.004
a03 Caring	5.75	5.57	5.82	5.70	5.26	5.51	5, 2330	5.751	<.001
a04 Competent	6.49	6.45	6.57	6.46	6.23	6.40	5, 2336	3.157	.008
a05 Cooperative	5.88	5.59	5.95	5.71	5.65	5.69	5, 2339	8.413	<.001
a06 Courageous	5.47	5.25	5.56	5.20	4.97	5.26	5, 2341	6.920	<.001
a07 Dependable	6.50	6.38	6.59	6.49	6.48	6.35	5, 2336	4.426	.001
a08 Determined	6.01	5.66	5.96	5.73	5.51	5.80	5, 2321	9.360	<.001
a09 Fair-minded	6.04	5.85	6.19	6.00	5.99	5.92	5, 2338	6.135	<.001
a10 Forward-looking	5.98	5.82	5.89	5.72	5.59	5.86	5, 2331	3.584	.003
a11 Honest	6.72	6.63	6.81	6.73	6.54	6.75	5, 2340	4.276	.001
a12 Imaginative	5.26	5.02	5.13	5.01	4.59	5.12	5, 2334	5.482	<.001
a13 Independent	5.31	4.87	5.50	5.06	4.77	5.12	5, 2333	16.115	<.001
a14 Inspiring	6.04	5.90	6.05	6.02	5.58	5.89	5, 2334	3.711	.002
a15 Intelligent	5.81	5.67	5.92	5.80	5.36	5.64	5, 2341	6.051	<.001
a16 Loyal	6.30	5.91	6.31	6.31	5.97	6.08	5, 2337	11.849	<.001
a17 Mature	5.84	5.60	5.90	5.89	5.65	5.61	5, 2338	5.664	<.001
a18 Self-controlled	5.98	5.67	6.00	5.96	5.86	5.67	5, 2331	7.896	<.001
a19 Straightforward	5.80	5.51	5.85	5.80	5.45	5.57	5, 2337	7.435	<.001
a20 Supportive	5.81	5.55	6.10	5.83	5.68	5.58	5, 2337	15.504	<.001
Demographic									
Age	34.78	37.65	37.11	38.76	34.76	36.71	5, 2312	14.177	<.001
Fixed facility* experience (years)	4.15	6.48	6.09	8.60	4.34	5.39	5, 2261	25.086	<.001
Operational unit† experience (years)	5.68	2.51	3.09	3.05	1.66	6.13	5, 2263	42.228	<.001
	%n								
	n=739	n=471	n=660	n=236	n=69	n=177			
Age>40 years	29%	30%	38%	39%	26%	38%	5, 2346	4.414	.001
Male	71%	76%	37%	71%	42%	68%	5, 2338	56.526	<.001
Field grade rank	23%	71%	21%	62%	18%	18%	5, 2239	112.675	<.001

Acronyms:
MS - Medical Service Corps NC - Nurse Corps VC - Veterinary Corps
MC - Medical Corps DC - Dental Corps SP - Specialist Corps

*Fixed facility indicates an established medical healthcare facility, such as a clinic, community hospital, or medical center.
†Operational unit indicates a deployable unit configured to provide medical services in the field in a deployed/combat environment.
n=Number of study sample respondents who specified the AMEDD officer corps designation displayed in the column heading.

important as in the TLC study. The consistency between studies for honesty strongly indicates its importance, regardless of employment. Any successful leader must be honest. This finding is no different in the military. Leader development programs must emphasize the importance of honesty. The programs must ensure all leaders understand the meaning of this term and use case studies or discussion time to reinforce how one demonstrates this attribute as a leader. The use of case studies and open discussion can help everyone understand how difficult it can be to be honest at all times. The telling of little "white lies," for whatever the reason, can be perceived as compromising one's honesty. We tell little lies because we do not want to appear confrontational, or

because we do not want to hurt people's feelings. When we do this, we must realize we may be compromising the trust others place in us to always be honest and tell the truth. Honesty is something everyone wants to demonstrate, but which can be very difficult to always do.

Dependability is critically important in the military. If military personnel cannot depend on others to accomplish their missions, unit effectiveness can be severally compromised. Teamwork is highly emphasized in military training. Military personnel are taught to always sacrifice for the team and to ensure they are capable of performing their tasks in support of the team. As such, the team is strongest when everyone is staunchly reliable and are capable of performing their duties as well a possible. It is not surprising that dependability was selected as the second most frequent attribute found in admired leaders within the AMEDD.

Competence is closely associated with dependability. In order to be dependable, leaders must also be competent. Leaders in AMEDD must demonstrate a level of competency which shows their colleagues they have the expertise necessary to help accomplish the mission. An AMEDD officer deemed incompetent will quickly lose the respect of those they are leading. It is important to clarify what competence means to an AMEDD leader. AMEDD leaders must not only be competent in their chosen fields, but also in basic soldiering skills. Being a competent Soldier is what separates the military professionals from their civilian counterparts. Competent AMEDD leaders must not only be technically competent; they must also be competent as Soldiers.

Loyalty is an extremely important attribute to AMEDD leaders. Serving in the military is extremely challenging. Serving as a valuable team member is critical to organizational success. In addition to dependability and competence, the most effective team members are loyal to each other and to the mission. AMEDD leaders are expected to demonstrate their loyalty to organization and to always place the needs of the organization and its people above their own needs. They are expected to assist their colleagues during times of great need or stress. This loyalty is essential to unit cohesion. Without loyalty, the unit's ability to efficiently accomplish its mission may be compromised. Most importantly, without loyalty, trust will be compromised. Lack of trust definitely compromises unit effectiveness.

CONCLUSION

The attributes of the most admired leaders identified in this study of AMEDD officers did not differ in the aggregate when compared to the studies conducted by Kouzes and Posner.[6] There are slight differences in the top attributes of the most admired leaders. Whereas Kouzes and Posner identified honesty, forward-looking, competence, and inspiring as the most frequently chosen attributes in their studies, AMEDD officers identified honesty, dependability, competence, and loyalty as the top 4 attributes in their most admired leaders. The consistency of both studies concerning the importance of being honest cannot be overstated. Although dependability and loyalty were found to be significant attributes to AMEDD leaders, this difference with the Kouzes and Posner study is not surprising due to the critical nature of military service and the importance of these 2 attributes to organizational success. Leader development programs for AMEDD officers must emphasize the importance of these attributes to leadership effectiveness. All small group classes should include discussions exploring the definitions of these attributes and how they can be practiced in the work setting.

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Qualities of the Ideal Mentor

COL Mark A. Melanson, MS, USA

Mentoring has always been and remains one of the key, strategic responsibilities of all Army Medical Department (AMEDD) leaders, ensuring that future generations of Soldiers and civilians are properly groomed to one day step forward and assume the mantle of senior leadership.[1-5] Given the vital importance of leader mentorship, it is both curious and alarming to note that little to no attention has been paid to the actual qualities or attributes of successful mentors.[6,7] While it is true that each mentor will have his or her own personal style, I have come to believe that there is a core set of developable traits that make a mentor most successful. This short list of 10 qualities is based upon over a decade of scholarly research into the subject of mentoring, my career long observations of successful and unsuccessful mentors (both personal mentors, military and civilian, as well as those that I have watched mentoring others), and a critical assessment of my own strengths and weaknesses as a mentor of both military and civilian protégés. It is hoped that by outlining and presenting the attainable qualities of the ideal mentor, this article will help both aspiring and well established mentors to assess their own mentoring attributes and develop them to their fullest. Additionally, potential protégés should be on the lookout for these recognizable qualities when carefully seeking individuals to serve as their own mentors. Lastly, the AMEDD senior leadership may want to include training about these mentoring attributes as a part of leadership development programs.[8-10]

APPROACHABLE

The first quality of an ideal mentor is being approachable; it is one of the most important. This is because if a "would be" mentor is not approachable, then regardless of how much wisdom he or she has to share, it is highly unlikely that this person will be considered for mentoring. Obviously, negative traits such as arrogance and hubris do not enhance mentor approachability; instead they serve to either deter prospective protégés or eclipse a potential mentor's other positive qualities, thereby limiting his or her ability to groom others.[11] I was witness to such a situation with an Army colleague of mine who was one of the preeminent scientists in his field. His inflated ego and bravado repelled potential protégés. About a decade ago, during a workshop on mentoring that I led which was attended by both senior and junior officers, he actually said to the group, "If you want me to mentor you, you must first pass my test, and, if I deem you are worthy, then I will share my knowledge with you." Needless to say, no one ever took him up on his offer. Instead, he retired a few years ago feeling empty, frustrated, and disappointed that he was unable to pass on any of his wisdom. Unfortunately, he still remains blind to his central role in this mentoring failure and instead chooses to blame it on others (they were all undeserving, unappreciative (of his wisdom), or ungrateful). Fortunately for us, however, we can all learn from his failings as a frustrated, aspiring mentor. What my colleague failed to realize is that mentor approachability is a complex quality that is a balanced blend of affability, confidence, and humility. Some of the keys to affability are being open, upbeat, and friendly. Add the right mixture of confidence and humility, and the mentor now becomes approachable for potential protégés.

EMPATHETIC

After "approachable," the next important quality of the ideal mentor is empathy. The ideal mentor is able to relate to and appreciate the feelings of the protégé.[12,13] These feelings normally cover a wide spectrum, encompassing goals and aspirations, as well as doubts and fears.[14] Sometimes these emotions are familiar, ones that the mentor has also experienced or perhaps still feels. However, the best mentors are able to empathize with feelings that they have not personally felt. The recognition and acceptance of these protégé feelings without any judgment is one of the most powerful qualities of the ideal mentor.[15-19] It is important to note that empathy is also crucial to facilitating diversity mentoring, the guiding of individuals who are different from the mentor—diverse in race, gender, or ethnic background.[20,21] Diversity mentoring should be deliberately pursued with much vigor by all AMEDD leaders, especially those who seek to forge and cement an enduring legacy as masters of leader mentoring.[22-25]

REFLECTIVE

One of the key things that protégés seek from those that mentor them is any useful insight that mentors have gleaned from their own careers.[26,27] Therefore, the ideal mentor constantly reflects upon his or her own mentoring voyage, diving deep into past experiences in order to

harvest any pearls of wisdom that might benefit the protégé.[28] This keen introspection includes both successes and failures, for the wise mentor knows that it is often from our failures or setbacks that we learn our greatest lessons in life. Hence, self-awareness and self-reflection are critical if one is to become an effective mentor. Given that fact, an ideal mentor might even dare to quote the ancient Greek philosopher Socrates, also one of the world's most renowned historical mentors, and boldly reaffirm, "The unexamined life is not worth living."[29]

PATIENT

The next important quality of the ideal mentor is patience. While a good mentor may be able to assist a protégé to visualize his or her desired mentoring end state, the ideal mentor is able to remain patient during the mentee's often long, uphill journey towards self-discovery.[30] But this is not to say that mentor should have infinite patience.[31] Rather, the mentor should help the protégé set realistic goals and timelines and should also strive to help hold the mentee accountable to them.[32] In some extreme cases, the mentor may even have to encourage the protégé forward, step by step. Conversely, it may be necessary for the mentor to help the protégé realize and acknowledge that a certain goal is not realistic or is best deferred to a later time. I have personally done this by actually mentoring a few protégés out of the Army (which I do not say glibly). When asked if I consider these mentoring efforts as unproductive or a waste of my time, I strongly disagree. In my mind, mentoring is always focused on helping the protégé reach his or her greatest potential and, if this does not align with an Army career, then the mentee should leave and pursue career options outside the Army. When this happens, I still believe that this is a mentoring success story (recalling that the focus on mentoring should always be upon the protégé[33-36]). It is important to note that such an outcome also serves the Army well since these individuals did not, in my opinion, have the potential to become effective AMEDD leaders.

LOYAL

A mentor is always loyal to both the protégé and the realization of his or her potential.[37] This means being protective of the one being mentored (in fact, in French the word protégé literally means "the protected one") and safeguarding any shared secrets or weaknesses. Hence, the mentor must establish a safe and secure environment where the protégé can feel comfortable to learn and grow.[38] A loyal mentor also rises to the defense of his or her protégé and stands up for the mentee whenever necessary (such as in response to unfair criticism or directly confronting bullying by a senior officer, therefore making mentoring a strong and effective antidote for the poisonous venom of "toxic leadership"[39,40]). However, sometimes being loyal to the protégé also includes providing candid, critical feedback concerning any failure of the mentee to live up to his or her potential.

HONEST

One of the essential qualities of the ideal mentor which can at times be the most difficult is honesty.[41,42] Being honest means giving the protégé truthful, unvarnished feedback that may include things that the mentee may not want to hear.[43,44] Given that, a mentor may be reluctant to give such feedback, fearing that it may sour or even ruin the mentoring relationship.[45] However, the ideal mentor always remembers that effective mentoring often includes such needed criticism, along with plenty of encouragement. Usually a protégé cannot grow without first hearing and then accepting such potentially distasteful albeit important advice. Hopefully, as long as it is given in a caring manner, the message should be received in the nurturing spirit with which it was given and become profoundly appreciated by the mentee as the mentoring bond deepens with trust.[46,47]

AUTHENTIC

The ideal mentor is authentic.[48,49] There are no airs of pretense or futile efforts by the mentor to try to be someone that he or she is not. Real authenticity comes with maturity, self awareness, and a true acceptance of one's self, to include all of one's faults (not easily done, I must admit). Without it, a striving mentor is doomed to being either a hypocrite or a phony.[50] With it, the ideal mentor can comfortably share personal mistakes and setbacks without a fear of embarrassment. Interestingly enough, it is often this hard won authenticity which ultimately secures the mentor's place as an enduring and pursued counselor of protégés. As I reflect back upon my favorite leader mentors, all of them clearly share this common, even defining trait of genuine authenticity.

LOVER OF LEARNING

Ideal mentors are passionate lovers of learning.[51,52] They enjoy learning, mastering skills, and developing expertise. First and foremost, they love learning about themselves and how to improve.[28] However, this learning also extends to the noble quest of discovering potential in others and helping them realize it (or in other words, mentoring). I believe that this attribute is essential for mentors who seek to guide others who are different from themselves. This natural or acquired intellectual curiosity, coupled with sincere empathy, is what helps to make diversity mentoring most successful. I have learned the most about myself through diverse mentoring relationships which helped to challenge my assumptions about what it means to be an effective senior leader.

COMMITMENT

Commitment to the mentoring partnership is the very glue that holds the relationship together.[53] The mentor is committed to the protégé and makes sure that he or she is upholding his or her end of the mentoring pact.[54] This means always honoring promises and keeping appointments. If the mentor promises to review the protégé's officer evaluation report support form, then he or she does so and does it promptly. When the mentoring pair agrees to routine meetings, the mentor is always early (demonstrating enthusiasm) and fully prepared to do his or her part. Broken promises and missed appointments will ultimately lead to the quiet, shameful death of the mentoring relationship. Even more tragic, such a negative mentoring experience may ultimately turn off an outstanding protégé to any future mentoring opportunities just to avoid any further hurt or disappointment.[55] In extreme cases, this can directly result in the loss of a promising mentee who would have one day blossomed into a stellar senior AMEDD leader, if only someone had seriously committed to his or her mentorship. This is why leaders must not pursue mentoring lightly, and, should they decide to engage in mentoring (which I sincerely hope they do), they absolutely must make it a top priority in their busy schedules.[33] Otherwise, they are doing more harm than good.[56]

POTENTIAVOYANCE

I have never been one to casually create words (at least not since I was a very young child, so I am told). However, I have not found a single term that properly captures the essence of the most important quality of an ideal mentor. Metaphorically, it is the golden ability to envision with the mind's eye the mighty oak, cloaked and quiescent inside the tiny acorn (page 51). Or, simply put, it is a sort of clairvoyance for protégé potential. Hence, I boldly coin the term "potentiavoyance," or the ability to fully see another's latent potential and help that person attain it. First, a potentiavoyant mentor has the honed ability to quickly and accurately assess a protégé's strengths and weaknesses. Next, this gifted mentor has a special knack for recognizing clues of the hidden, dormant potential within an individual, even when others are either unable or unwilling to see it.[57,58] Further, the ideal mentor can envision the required path that ultimately leads to realizing this underlying potential. Finally, the most important ingredient of potentiavoyance is the talent of inspiring or coaxing the unseeing protégé to recognize and embrace this new vision of his or her future self (otherwise, the above discussions of the other 9 qualities are truly for naught). The rare, but achievable combination of all of these attributes is what I call potentiavoyance, the almost mystical spirit of mentoring. During my almost 30-year career, I have personally experienced potentiavoyance regarding my own protégés—it was a powerful, moving experience each and every time it happened. I am also proud of the fact that of those protégés not deemed worthy of mentoring by fellow senior officers whom I have chosen to mentor, all but one are now rising stars in their own right, thanks in part to the awesome, transforming power of potentiavoyance.

SUMMARY

An ideal mentor is first and foremost approachable so that potential protégés will become attracted and seek them for mentoring. Next, this mentor has true empathy so that he or she can feel, understand, and appreciate the fears and desires of the protégé. By living an examined life, the reflective mentor is able to extract and refine the meaningful lessons of his or her own career, sharing the needed wisdom. Measured patience is required to allow the protégé to find and pursue their individualized path to self discovery. Loyalty to the protégé and his or her mentoring quest helps the mentee to stay the course. The ideal mentor candidly tells the protégé what he or she most needs to hear. Authenticity is a must if a mentor is to attract and retain the protégé in the mentoring partnership. By being a lover of learning, the mentor maintains both personal and protégé awareness, thereby ensuring the successful conveyance of wisdom. Mentor commitment is the very glue holding the mentoring relationship together. By attaining potentiavoyance, the ideal mentor is able to visualize the diamond in the rough, nurture its own self-discovery, and guide in the mining, sculpting, and polishing of the precious gem. I sincerely hope that all AMEDD leaders will seek to identify and develop all of these achievable mentoring qualities in themselves, and that those seeking mentorship will look for them in potential mentors. Also, the senior AMEDD leadership should include teaching these attributes during all stages of leader development training..

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"POTENTIAVOYANCE"

Leader Development Within the Army Medical Department

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Leader development is a critical responsibility of the Army Medical Department (AMEDD). The current and previous Surgeons General of the Army identified leadership as a critical skill necessary to transform the AMEDD to better serve the changing mission and focus of the Army. Most organizations are challenged in the development of capable leaders who will have positive institutional effect. The Leader Training Center, AMEDD Center and School, adopted The Leadership Challenge® to help meet its mission of developing and enhancing the leadership skills of AMEDD officers.

Based on the work of Kouzes and Posner,[1] The Leadership Challenge is an industry leading, evidence-based training program designed to enhance the personal leadership skills of those attending a highly interactive, facilitator-led 2 or 3 day workshop. Kouzes and Posner use over 30 years of research and data from over 3 million leaders to identify 5 practices exemplary leaders use on a routine basis:

Model the way.

Inspire a shared vision.

Challenge the process.

Enable others to act.

Encourage the heart.

Kouzes and Posner then identified 6 specific behaviors, associated with each practice, for a total of 30. For example, one of the behaviors associated with "model the way" that highly effective leaders frequently display is "I follow through on the promises and commitments that I make."[2] The authors then created the Leadership Practices Inventory,[3] a 360 degree evaluation* of a leader's effectiveness based on how frequently a leader displays all 30 behaviors in the workplace.

This article discusses how the concepts, techniques, and practices of The Leadership Challenge have been incorporated into leadership training within AMEDD. Examples of a workshop are presented and future plans for this training are discussed.

*360-degree evaluation is also known as 360-degree feedback (among other names). In most applications, it will include direct feedback from an employee's subordinates, peers, and supervisor(s), as well as a self-evaluation. However, in some cases it can also include feedback from external sources, such as customers, suppliers, or other interested stakeholders.[4]

BACKGROUND

Faculty members of the Leader Training Center were first introduced to The Leadership Challenge in 2005. Selected faculty members attended 2-day workshops designed to teach the 5 practices of exemplary leadership discussed above, followed by a 2-day workshop learning how to facilitate this training. Courses are taught by certified facilitators, usually under the supervision of a certified master facilitator. Certification as a facilitator is granted upon completion of the 4-day training course and facilitation of a workshop while under evaluation by a master facilitator. Master facilitator certification requires years of training, including the conduct of workshops, publishing, and observing training conducted by master facilitators. The theory behind achieving master facilitator certification is the requirement to complete at least 10,000 hours required to become an expert in a chosen field.[5] Currently, the Leader Training Center has 12 certified facilitators and one master facilitator on its staff.

LEADER DEVELOPMENT USING THE LEADERSHIP CHALLENGE

The Leadership Challenge workshops are currently conducted during the AMEDD pre command courses, entry level executive nurse courses, a one semester leadership course in the US Army-Baylor University Graduate Program in Business and Health Administration, Warrior Transition Command/Para-Olympian programs, and the Civilian Life-Long Learning Program. In addition, workshops are scheduled for multiple organizations throughout the AMEDD. Feedback from all courses has been very positive with attendees often telling us they wish a course was longer. Attendees experience the following benefits when attending a workshop:

- Build trust.
- Identify their leadership strengths and weaknesses.
- Identify their values and priorities as a person and as a leader.
- Build collaboration and teamwork skills.

- Apply lessons learned to organizational challenges.
- Learn the power of encouragement/affirmation with their associates.
- Seek new ways to challenge/solve current problems.
- Create a vision for their section which supports unit vision.
- Identify ways to inspire others to accomplish their vision.
- Solve unit specific problems through enhanced teamwork and collaboration.

The power in The Leadership Challenge is that it just makes sense from a leadership standpoint. The 5 practices of exemplary leadership are not just the ideas of Kouzes and Posner, but are based on over 30 years of research and data collection. As such, it is an evidence-based model of leadership. Healthcare professionals relate well to this training because of the recent emphasis on the use of evidence-based medical practices and procedures by healthcare providers in the care of their patients.

There is a fundamental truth about leadership that also makes The Leadership Challenge a powerful training tool: leadership is everyone's responsibility. Everyone in the organization can and should enhance their leadership skills in order to help the organization accomplish its mission. The principle leadership problem within the AMEDD is not that there are no effective leaders, but that there are not enough good leaders. We simply believe that strong leadership at all levels in an organization is necessary for an organization to be truly outstanding. World-class organizations require world-class leaders, and many of them.

Workshops are designed for individuals wanting to enhance their leadership effectiveness. They are appropriate for any leader, regardless of rank, experience, age, etc, who wishes to become a better leader. We find that colonels learn as much about their leadership effectiveness and how to enhance their leadership ability as do captains and majors with far less experience. The Leadership Challenge focuses on the following core concepts:

- Leadership is everyone's business.
- Leadership is a relationship.
- The best leaders are the best learners.
- It takes deliberate practice to become a better leader.
- Leadership is an aspiration and a choice.
- Leaders make a positive difference.

Workshop attendees quickly realize that embracing these concepts can help them become better leaders, as well as help them mentor the next generation of AMEDD leaders.

TYPICAL AMEDD WORKSHOP

While we teach leadership, the workshops are primarily designed to facilitate learning. The ideal size of a workshop is 20 to 25 attendees, but we have conducted workshops for as many as 75 and as few as 15. Small group work as called for by the Army Learning Concept 2015[6] is emphasized so all attendees sit at round tables with 6 to 8 other attendees. Collaboratively sourcing knowledge from attendees is as important as providing knowledge to them. When it comes to leadership, especially more experienced leaders, they "…need to be reminded more often than they need to be instructed."* Therefore, our overarching goal is for attendees to learn as much, if not more, from each other than they do from the facilitators.

Workshops normally consist of 2 days of training involving 7 modules:

1. Introduction to importance of leadership and return of attendee's Leadership Practice Inventories (detailed in the following section).
2. Practice 1: Model the Way
3. Practice 2: Inspire a Shared Vision
4. Practice 3: Challenge the Process
5. Practice 4: Enable Others to Act
6. Practice 5: Encouraging the Heart
7. Committing

All workshops include use of movie videos, tabletop exercises, and individual activities designed to enhance discussion and foster exchange of information. As a result of these activities and the time allowed for discussions within and among tables, attendees frequently comment they wanted more time to enhance their learning, particularly among their small groups.

Attendees are asked to complete some short preworkshop exercises designed to encourage discussion and new learning. The first exercise is to write and be prepared to discuss their personal best leadership experience. The questions asked about their personal best leadership experience are intended to encourage attendees to share their leadership experiences with their tablemates. Attendees learn from what went well and what went poorly during those experiences. This exercise also enables attendees to realize that they have already enjoyed some successes as a leader, and that their development so far

*Attributed to Samuel Johnson (1709-1784), English author, critic, and lexicographer.[7]

has been fruitful. Three basic questions must be answered by each attendee:

1. What was the context of your personal best leadership experience? Describe the situation, who else was involved, and the primary challenge you faced.
2. What happened? Be specific. What actions did you take and what were your initial impressions of your successes (or failures)?
3. How did you feel after the experience concluded? What lessons did you learn?

Depending on the needs of attendees, other exercises may be used to help solve problems, develop greater collaboration and teamwork, and to build trust.

A crucial component of The Leadership Challenge is the Leadership Practices Inventory (LPI). The LPI provides a snapshot in time of observed behaviors proven to be critical in the most successful leaders across the world. Observations are gathered from the people (direct-report peers and superiors) chosen by the attendee. The central workshop focus centers on the LPI results, so it is imperative that attendees complete the evaluation before attending the workshop.

LEADERSHIP PRACTICE INVENTORY

Although it is important to know and understand the 5 practices of exemplary leadership discussed earlier, it is even more important to understand the 30 behaviors associated with those practices. Leadership is in the eye of the beholder, therefore, leaders must demonstrate certain behaviors to enhance their leadership effectiveness. Leadership is a behavior, not a title or a position. You must do something to be a leader. The LPI focuses on those behaviors that exemplary leaders demonstrate on a frequent basis. Kouzes and Posner[1] demonstrate empirically that those leaders who consistently demonstrate the 30 behaviors

- have a higher degree of personal credibility,
- are more effective in meeting job-related demands,
- are able to increase motivation levels,
- are more successful representing their group to upper management,
- have a higher performing team,
- foster greater loyalty and commitment, and
- experienced reduced absenteeism and turnover and reduced stress levels.

Approximately a month prior to a course, attendees are registered into the LPI. They receive an email with instructions directing them to the LPI website. They must complete their self-evaluation using the Likert scale across the 30 behavior statements. They are asked to rate themselves on how frequently they demonstrate the 30 behaviors. After completing their self-evaluation, leaders enter the names and email addresses of observers who will evaluate them on how frequently they see the leader demonstrate the same 30 behaviors. Observers also have the opportunity to respond to 4 narrative questions. Ideally, at least 2 supervisors, 2 colleagues, and 2 direct-report peers should be selected to complete the evaluation. A minimum of 3 and no more than 12 observers are needed for an accurate report. It is critical that observers have seen the individual in action and are willing to honestly evaluate how frequently they see him or her demonstrating those behaviors. Failure to properly select the appropriate observers will significantly bias the results and greatly minimize the value of the information in the survey. Attendees receive their LPI early during the workshop and are given sufficient time to analyze the results. The LPI is also used throughout the workshop so attendees can focus on those behaviors they deem important to them to becoming a better leader.

It is critical that attendees do not view the LPI results as "good or bad," rather that they gain an appreciation for those behaviors which are characterized as observed or not, and to what degree. Based upon this, an attendee can begin to visualize where improvements can be made in exhibiting more positive leadership behaviors and the frequency in order to improve as a leader. The areas for improvement can then form the basis for the attendee's "committing" phase at the end of the workshop.

FEEDBACK FROM WORKSHOPS

Feedback from attendees has been very positive. They enjoy getting honest feedback concerning their leadership effectiveness and learning how to demonstrate certain behaviors in the workplace so they can be seen as an even better and more authentic leader in a very short time. Attendees are also given plenty of time to develop their own specific leadership development plan so they can continue their "leadership journey" well beyond the workshop.

FUTURE PLANS FOR THE LEADERSHIP CHALLENGE

Our experience from workshops conducted during the past 3 years clearly demonstrates that attendees are learning how to enhance their leadership abilities and that they have found the workshops to be stimulating and thought-provoking. The Leader Training Center has developed a sufficient number of certified facilitators with the goal of taking this training to regional locations and to military treatment facilities. AMEDD commands and organizations wanting facilitators to conduct onsite training can

contact the AMEDD Center and School Leader Training Center at 210.221.8530 or 210.221.7480 for information.

CONCLUSION

The Leadership Challenge has proven to be a highly effective training tool in the development of AMEDD leaders. Its emphasis on the use of proven leadership tools and practices makes it a model of leadership that is definitely evidence-based. Power comes from the fact that it is highly intuitive, empirically based, and learnable. The opportunity for aspiring leaders to be given the time to focus on their leadership abilities is of particular value for all who attend. The Leadership Challenge experience adds to the ideal that leadership is truly lifelong learning and anyone can improve their leadership skills.

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Leading in the Joint Medical Environment

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Driven primarily by economic necessity, the military health system has embarked upon a historic transformation of organization, business, and culture that will forever change Army Medicine and the delivery of healthcare across the Department of Defense. Decades-old plans and concepts for the consolidation of the service medical departments are no longer the topic of idle discussion, they are the new rapidly evolving reality. Evidence of this transformation can be found at every level of the service medical departments.

The 2005 Base Realignment and Closure Commission (BRAC) set the stage for the consolidation of service medical departments by collocating the once geographically separate service medical headquarters into one location now known as the Defense Health Headquarters. The 2005 BRAC Report[1] further directed the consolidation of service medical training at Fort Sam Houston, Texas. This consolidation resulted in the establishment of the Medical Education and Training Campus, a triservice training and educational institution providing enlisted medical skill training to meet the operational needs of all services. The National Defense Authorization Act of 2012 (Pub L No 112-81, December 31, 2011)) followed to set into motion plans for the formation of a Defense Health Agency. Local consolidations, such as the Joint Task Force National Capital Medicne in the Washingtom, DC area,* the San Antonio Military Medical Center in San Antonio, and the formation of joint bases are the prototypes for service medical consolidations. If there are any doubts, one need only walk the halls of the Walter Reed National Military Medical Center, San Antonio Military Medical Center, Tripler Army Medical Center, or the Landstuhl Regional Medical Center among staff members wearing all services' uniforms to understand the reality of a joint medical environment is fast approaching. As the environment changes, so must leader skills and attributes. This article is not intended to enumerate in detail a list of technical and leadership talents. Rather, it serves to open the discussion on the challenges this new environment will present and offer insight on transforming institutional education and training and leader development of junior leaders. This article presents the case that leaders who employ the right combination of attitude, skill, courage, and vision will find the greatest success in the new reality of a joint medical environment.

It may sound simplistic, but the most important attribute required to lead in the joint medical environment is the right attitude. It is often said that attitude is everything. The joint medical environment will be no different. Success will be attained by those who believe, understand, and embrace the joint environment to look beyond the parochial and understand the tactical, operational, and strategic values of the services working in concert. In other words, leaders must have the capacity to envision "what could be" versus "the way it should be." The power of the right attitude opens the mind to different ideas and methodologies that may originate within another service, or perhaps leverages the best of all concepts to generate a completely new approach that is better than any. The joint environment must not be viewed as a threat, rather an opportunity to rethink, redesign, and renew approaches and methodologies to provide the best healthcare across all services, both deployed and at home. As powerful as this opportunity is, it will never be realized unless leaders at all levels across all services engage with the right attitude. Those who cannot escape service parochialism will not simply be ineffective, they will become irrelevant. Admittedly, there will a certain level of service parochialism that will, especially in the early years, impede progress. The reluctance to commit and to self-preserve are conditioned responses resulting from competition and rivalry between the services that bring with it an underlying sense of distrust. Understanding the historical nature of the service relationships underscores the importance the right attitude will play in joint environment. A positive attitude, rooted in the sincere desire to attain the greater good, helps break down barriers in communication and helps shape the attitudes of our service partners. Leaders who are positive and sincere in word and deed will build relationships of trust across service lines and, in the process, shape the attitudes and actions of those critical to success. It is often said that a positive attitude is a force multiplier—infectious and able to change other's attitudes and

*See related article on page 60.

environments. While a positive attitude and the relationship of trust that results will be of critical importance across services lines, it will be equally important to the success of leadership within Army Medicine. Change is never easy and not readily accepted by established organizations. Leaders must garner the trust of their organization to gain the internal commitment necessary to lead in the give and take nature of an evolving joint environment. It will take positive, well respected leaders at all levels to communicate the goodness of change, build the trust and confidence within the organization, and then move boldly towards change.

Another aspect of attitude that is critical to joint success is respect, or, in the case of the joint environment, mutual respect. Leaders must understand the simple fact that every member of other military services is deservedly proud of their culture, lineage, traditions, and history of their service. This concept is simple enough to understand but all too often ignored, not out of malice, but for lack of understanding of how simple actions, or inactions, send the wrong message. To that end, leaders must not only understand the culture, lineage, traditions, and honor of other services, but respect them as well. This means doing the little things right, such as ensuring that the appropriate service flags are at ceremonies when multiple services participate. As simple as this example may be, it can have a profound impact on the attitude of the neglected service. If a mistake is made, as occasionally happens, do not ignore it, instead correct it and be the first one to apologize personally and publicly as necessary. Attitude shapes a leader's words and actions and will ultimately shape success. The right attitude opens the mind to new possibilities beyond simple tradition, and helps building the foundation of trust essential to short- and long-term success.

Credibility is another key to leader success in the emerging joint environment as it will serve as the leader's source of influence. Senior leaders, especially in the tri-service environment, often have little or even no direct authority to unilaterally implement profound organizational and cultural change. Absent a command and control authority, leaders in these complex environments must adapt to an approach to leadership emphasizing coordination and collaboration. This places great demands upon the leader's ability to assess problems, evaluate internal and external environments, develop winning strategies, communicate effectively, and negotiate to attain consensus. While the idea of attaining consensus may be a foreign and even uncomfortable concept to those accustomed to the normal military authority and decision making, it is the reality of multi-service environments where a wide range of influences and interests must be taken into consideration. While leaders in a joint environment must possess the requisite analytical, organizational, communications, and negotiation skills, they will offer little sway if the leader espousing such talents lacks credibility. In the 1980s, the investment firm E. F. Hutton ran a series of commercials depicting 2 young urban professionals, better known at the time as "yuppies," talking about their investments at a noisy social event. As the scene played out, one yuppie leans into the other as if to pass along a secret and says "my advisor is E. F. Hutton and E. F. Hutton says…." Instantly, the noisy social scene around them becomes completely quiet, while all the partygoers lean in trying to hear the advice of E. F. Hutton as the narrator says the tag line "when E. F. Hutton talks, people listen." The commercial is clearly over-dramatized but it does make the point that credibility is a source of power and influence. If E. F. Hutton was a person, no one would care what he had to say unless they first believed that he or she was credible, not just in having the right technical skills sets, but credible in that there was a proven track record of outstanding performance. The same is true when leading in a joint environment. The ability of a leader to influence and command attention for their ideas will be a direct result of the perception of that leader's credibility. While rank and or position will, by their very nature, convey some degree of credibility, one should expect to lead in peer environments where rank offers little influence. Like E. F. Hutton, credibility in the joint environment is more than technical skill sets, it's having the leader-development experiences appropriate to the assignment and a proven record of outstanding performance. Becoming the E. F. Hutton of the joint environment requires one to become a service expert, or in the case of Soldiers, an Army expert. This means understanding and being bound to the Army's lineage, tradition, history, organization, values, culture, and role within the profession of arms. Army leaders in the joint environment cannot truly represent the interests of Soldiers if they are not first a Soldier themselves. Service expertise continues with a detailed understanding of the Army Medical Department (AMEDD), its organization, and the depth and breadth of its complex mission set. This knowledge is supported by key and progressive leadership and staff experiences that solidify mastery of leadership and technical capacities, as well as an understanding of organizational roles and missions. All of which must be supported by institutional training and education, military and civilian, to attain and develop the appropriate leadership and technical skills. One aspect of credibility that warrants special attention is emotional intelligence. Understanding your own emotions, the emotions of others, and the environment, while having the ability to self-regulate and influence others is one

aspect of credibility that cannot be overlooked. The joint environment will present many personal, professional, and organizational challenges and frustrations. Emotional outbursts, justified or not—especially at senior levels—will deal a serious blow to a leader's credibility in the assessment of service peers. A calm, professional, and consistent approach, supported by appropriate talents and experiences, will maximize credibility and the ability to build consensus and influence decisions.

While leading in the joint environment requires the right attitude and credibility, it also requires the courage to act. For all the attributes and skills discussed thus far, this may be the most difficult or perhaps unnerving for junior leaders to master. As has already been discussed, change is difficult and not always welcomed by established organizations. The Army Medical Command (MEDCOM) is comprised of many well-established organizations with proud histories of service to the Army and the United States. It is to be expected that these proud organizations will be somewhat resistant to change, especially if it means the loss of missions, facilities, and/or people. One of the great promises of the joint medical environment is the opportunity to become more efficient by eliminating duplication through consolidation. This will necessitate a give and take between the services that is certain to present very difficult choices. At the strategic level, it could mean that some MEDCOM organizations realign command authority, undergo significant restructuring, or even cease operations. At the operational and tactical levels, it could offer changes in missions and services. No matter the level, the decisions will be emotionally charged as, unfortunately, decisions are often assessed in terms of winners and losers. Leaders in this environment must possess the courage to lead, decide, and act for the greater good, even if it means ceding missions and capabilities to another service. Commanders and leaders who adopt a "not on my watch" approach may believe they are acting in the best interest of their organization, which may be true in the short-term. In the long-term, however, a parochial approach may prove detrimental as those who resist change decline in influence, while those who embrace change fill the gap to affect the final outcome. This is not to say that commanders and leaders should cede to the wishes of other services without analysis or challenge. Ideas should undergo rigorous scrutiny and be opposed when they do not serve the greater good. Those ideas that do serve the greater good, regardless of origin, should not be summarily dismissed or opposed simply to protect the proverbial "rice bowl." The leadership described here requires courage—the courage to make decisions that may have unfavorable and/or uncomfortable effects on proud organizations and people. Leaders who are entrusted to make such decisions will find that leadership is lonely and their decisions will be repeatedly questioned. Leaders facing these difficult decisions must have the courage to make tough decisions for the right reasons and follow them to completion.

The leader attributes and skill sets discussed thus far are of critical importance, but in many ways they lay the foundation for what maybe the most important talent of joint leadership: the ability to articulate a joint vision that is inclusive of all services. The consolidation of the service's medical departments into a single joint institution will be a historic first for the Department of Defense. The scope, complexity, and sheer magnitude such a change is likely to create a sense of uncertainty and confusion within organizations and personnel not accustomed to such turmoil. Clausewitz, the highly-regarded Prussian Soldier and military theorist, characterized the chaos of battle as "the fog of war."[2] Clausewitz understood that the ever-changing dynamic of battle produced a changing reality on the ground that clouded the view, the judgment, and ultimately the confidence of leadership. Absent confidence, leaders tend to hesitate in making decisions; in so doing, they create a reactionary decision-making environment that stresses the organization. The evolution of the joint medical environment will create similar uncertainty or, as Clausewitz might characterize it, "the fog of change." Penetrating that fog will require the ability to formulate and articulate a service-inclusive vision that serves as a clearly defined end-state.* A clearly articulated end-state will empower subordinate leaders to make decisions to realign efforts and resources beginning at the lowest levels that will ultimately lead to the attainment of operational and strategic end-states. Defining the end state is arguably the most important and most difficult leader task as it guides and informs every decision and every action that the organization undertakes. Leaders should understand that in defining the end state, they must be cognizant of the level of leadership at which they serve to avoid micromanaging the very leaders they must empower. At strategic levels, leaders should form a mental image of the end state while avoiding directive-level detail. Leaders at operational and tactical levels must also consider the degree of detail necessary to ensure that the right leaders possessing the right information are empowered to make the right decisions for the betterment of the organization. Developing the capacity for vision involves a level of understanding and perspective that can only come through extensive experience and

*End state is defined as "The set of required conditions that defines achievement of the commander's objectives."[3]

serious contemplation. Leaders seeking to progress in the joint medical environment must actively cultivate their capacity for building and articulating a service-inclusive vision.

The military health system has embarked upon a historic transformation of organization, business, and culture that will have profound effects upon the future of Army and military medicine and will place unprecedented demands upon leadership at all levels across all services. While the core leadership and technical competencies and talents will remain, the complexities and dynamics of the interservice environment will present challenges foreign to those developed within traditional, service-focused leader development models. The institutional, operational, and self-domains of leader development must be reassessed to ensure they support the unique demands of an evolving joint medical environment. How will leaders gain the cultural awareness, understanding, and respect of missions and capabilities of the other services? How will the AMEDD build leaders comfortable with the joint environment who are credible and have the courage to make tough decisions and follow them to conclusion for the attainment of the greater good? The concepts noted here are easily said but difficult to inculcate and develop in leaders. For the AMEDD and the other services, it means a cultural shift that breaks down historical barriers and builds mutual respect and, above all, mutual trust. Command and healthcare functions and enlisted training efforts are, at varying degrees, already moving toward cooperation and integration. On the other hand, officer education lags well behind as it remains a service-specific function with few opportunities for integration. Programs such as the AMEDD Executive Skills and the Medical Strategic Leadership programs offer opportunities for joint education, but they are focused almost exclusively on strategic level leadership. These programs offer great benefits, but in many cases come too late in the officer's career to build the skills and the long-term relationships required for joint success. Integration of all officer education and training programs should be the next step in building joint medical capacity. Army leadership education at lieutenant, captain, and major levels could meet both service-specific and joint requirements by offering a common core curriculum supported by service-specific tracks. The curriculum should focus on building both hospital and operational understanding to improve interoperability in both garrison and the deployed environment. The AMEDD Center and School (AMEDDC&S) or its joint-named successor would be the ideal location for a joint officer training school. The AMEDDC&S is a well-established training institution that offers the technical talents and capacities to assume this important mission. A joint officer training school collocated with the Medical Education and Training Campus will offer limitless potential for the continued growth and development of joint enlisted and officer leadership capacities. This type of change will require an approach to leader development that breaks the historical segregation of service training efforts and combines them to both acknowledge service-unique requirements while preparing officers for the reality of the joint medical environment.

For all the change the future may present, much will remain constant. Organizations, alignments, and missions may change, but what will not change is Army Medicine's commitment to provide the highest quality healthcare. The joint medical environment is not to be feared and resisted. It is an opportunity to work in concert with the other armed services to improve the business and provision of healthcare—not just for the Army, but for the nation. This historic change will require leaders who embrace the joint concept, possess the credibility to lead, and have the courage to make the tough decisions that lie ahead.

Are you ready?

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Moving From a Medical Anachronism: A New Approach to Military Medical Treatment Facility Organization in the National Capital Area

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An anachronism is something that belongs to another time period. The current organizational structure of the Army medical treatment facility (MTF) is an anachronism that reflects medical care delivery characteristic of the last century. The current structure is too narrow and too vertical to allow a reasonable span of control for today's complex military hospital. And it does not provide for enough organizational level leader experiences for the Army Medical Department's (AMEDD) developing leaders.

Subordinate to the MTF Commander, there is generally only one deputy commander position for each major AMEDD corps. Limited opportunities necessitate short tours. Professionals who represent smaller subsets of the corps (ie, pharmacists, physical therapists, or optometrists) are usually ineligible for these roles. The few deputies in the current system may find themselves overwhelmed with the demands of "tactical" hospital operations and unable to devote time and energy to their strategic organizational roles. Of greatest concern, because of the jobs' professional demands the most seasoned and senior leaders in the MTF are often unavailable to coach and mentor junior, developing leaders.

Fortunately, an alternative organizational structure exists and has operated successfully for the past several years at the Department of Defense's (DoD's) 2 joint facilities in the National Capital Area: Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital. As the nation's current conflicts end, the period of transition may be the ideal opportunity to review the organization of Army MTFs and to consider if it is time for change.

BACKGROUND

At the outbreak of World War I, Walter Reed General Hospital was led by a commanding officer, an executive officer, "charged, under the direction of the commanding officer, with the coordination of all departments of the hospital," and an adjutant who was "in charge of all incoming and outgoing correspondence, orders, and circulars, and had general control of all hospital records."[1] There were departments of administration, service and supply, professional services, reconstruction and education, physiotherapy, and nursing. Under professional services, the medical and surgical services were led by service chiefs. The nursing department of the hospital was administered by the principal chief nurse and the assistant principal chief nurse, the day supervisor of graduate nurses, the night supervisor of graduate nurses, and the superintendent of the Army School of Nursing.[1] It was presumably the typical organizational structure for Army garrison hospitals during the first decades of the 20th century.[2]

This structure, with a commander and executive officer typical of Army units at the company, battalion, and brigade levels, continued through World War II and the Korean conflict.[3] The hospital commander was always a physician, but, beginning with the Korean conflict, the role of the hospital executive officer, "the chief of administration and the principal adviser on management to the commander" (the chief operating officer), who had traditionally been a physician, could now also be a medical service corps officer.[4]

A chief of professional services (CPS) and chief administrative services were added to the hospital structure in the early 1970s. *Technical Manual No. 8-230*,[5] published in 1970 and now obsolete, described the positions of commander (a senior medical corps officer), executive officer (a medical corps or medical service corps officer), chief of professional services (medical corps), and chief administrative officer (medical service corps) equal in position to the chief of professional services (CPS). Under the CPS were departments of medicine, surgery, psychiatric services, and clinics. In addition, radiology, pathology, nursing, social work, and pharmacy services were positioned under the CPS.[5(pp9-1–9-4)]

"Building Two," a thousand bed patient care complex named the Heaton Pavilion in honor of Army Surgeon General MG Leonard Heaton (1959-1969), was opened

at the Walter Reed Army Medical Center (WRAMC) in 1977. There were 3 large offices in the command suite for the commander, the chief of professional services and the chief of administrative services. The role of deputy commander for nursing (DCN), equal in position to the clinical services and administrative deputies, was not suggested until 1989. Throughout the 1990s and into the next decade, the transition to organizations with the DCN and the DCN's role in hospital governance gradually occurred across the AMEDD.[6] For example, the chief of the department of nursing at WRAMC was located in another section of the hospital until the deputy commander for nursing moved to the command suite in the summer of 2006.*

This system of hospital organization persisted throughout the 1970s, while many of the functions of the executive officer and chief of administrative service were gradually combined into a single position. For example, there was a commander, executive officer, chief of professional services, and adjutant running Ireland Army Hospital at Fort Knox, KY, in 1980.[7] Increasingly complex clinical issues required a senior deputy equal in position to the executive officer with direct access to the commander. Thus the chief of professional services became the deputy commander for clinical services (DCCS).

In 1979, there was a DCCS at Brooke Army Medical Center, TX (LTG (Ret) R. Blanck, oral communication, March 19, 2013) and a DCCS at both Fort Benning, GA, and Fort Sill, OK, in 1984.[8] MG James Rumbaugh was the DCCS, WRAMC in 1986,[7] and LTG James Peake, The Surgeon General from 2000 to 2004, was DCCS, Tripler Army Medical Center, Hawaii, in 1987.[9]

In 1998, MTF commander positions were opened to other than Medical Corps officers for the first time.† This was in part a result of the experience of deploying medical units to the first Gulf War (1990-1991) commanded by Medical Service Corps officers who were replaced after arrival in the combat zone by physicians who may not always have been as qualified for command. The general model of MTF organization, with 3 deputy commanders (including the deputy commander for nursing) and a command sergeant major as senior enlisted advisor, persists with minor variation in most Army MTFs today.

The Base Realignment and Closure Act of 2005 led to development of new form of MTF organization in the National Capital Area. A joint task force was established to merge the Walter Reed Army Medical Center with the National Naval Medical Center in Bethesda, MD, and teams of leaders from Army and Navy medicine began to develop a new organizational model in the winter of 2006. The first draft was circulated in the summer of 2006, and fully 9 different versions were staffed and reviewed before the final version, shown in the Figure, was adopted in 2010, just 18 months before the merger of the hospitals.

CHALLENGES IN THE DEVELOPMENT OF THE NEW JOINT HOSPITAL ORGANIZATION

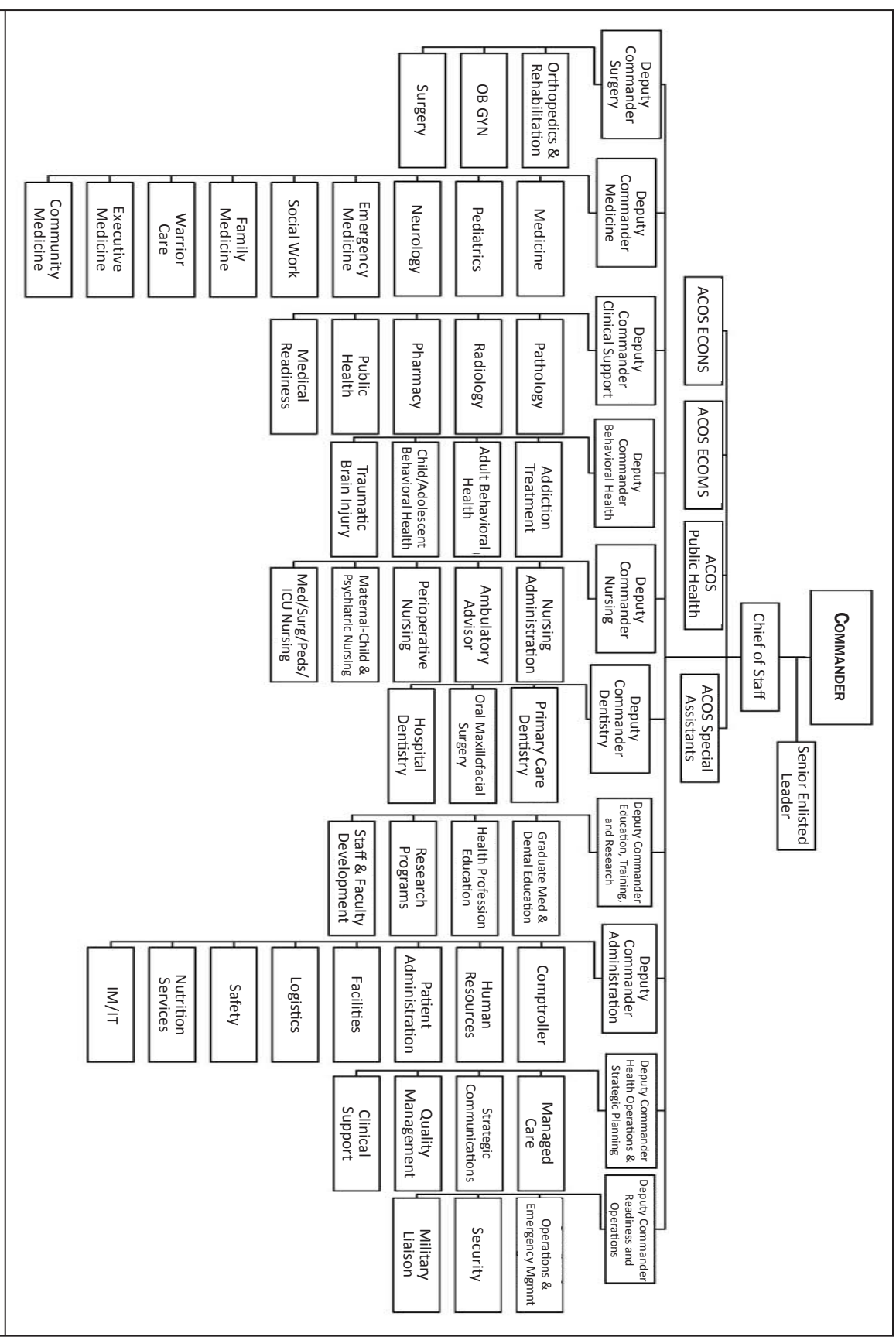
Army and Navy MTFs have significantly different organizational structures. These differences had to be identified, considered, and modified in the process of creating the joint organizational structure. For example, the older, traditional command structure of most Army hospitals resembles that of an Army division—the commander fills the equivalent role of the division commander, the deputy commander for clinical services fills the role of assistant division commander for maneuver (or operations), and the deputy commander for administration is the equivalent of the assistant division commander for support. With the addition of the senior enlisted advisor and later the deputy for nursing, the structure has been the basis for Army hospital leadership for the last several decades.

Typical of all Navy medical facilities, the National Naval Medical Center's command structure was organized more like that found on a ship. In Navy MTFs, the senior leadership team includes the commanding officer, an executive officer or deputy, the command master chief (senior enlisted), and the heads of the hospital sections or directorates (directors). The hospital commander can be from any of the corps (including the Dental Corps) and, other than at the medical centers, the deputy is generally chosen from a different corps.

Like a ship's executive officer (XO), the hospital deputy functions as the "chief operating officer" for the MTF. In the Navy culture, the commander has the responsibility for the mission and the crew, but is also specifically tasked to mentor and train the deputy to become a commander. Both of the new joint hospitals, the Walter Reed National Military Medical Center (WRNMMC) and the Fort Belvoir Community Hospital (FBCH), include this "second in command" leadership position, designated as the "chief of staff." While this position was found historically in Army hospitals and remains typical of maneuver Army battalions and brigades today,

*The author was a resident at WRAMC 1984-1987, and was the Deputy Command for Clinical Services, WRAMC from 2005 to 2008.

†The Surgeon General of the Army Action Memo of January 17, 1997; Subject: Command of Medical Units. Internal military document not readily accessible by the general public.



The organizational model for the Walter Reed National Military Medical Center, a joint military medical treatment facility created from the merger of the National Naval Medical Center and the Walter Reed Army Medical Center in 2012.

Glossary:

ACOS - assistant chief of staff
ECONS - executive committee of the nursing staff
ECOMS - executive committee of the medical staff
IM/IT - information management/information technology
Med/Surg/Peds/ICU - medical/surgical/pediatrics/intensive care unit
Mgmnt - management
OB GYN - obstetrics and gynecology

contemporary Army hospitals have no equivalent of the XO in their organizational structures.

In a Navy facility, the clinical and administrative functions of the hospital are arrayed like ship's departments (administration, deck, engineering, navigation, supply, weapons, etc). The new joint hospitals embraced the Army concept of deputy commanders as "executive vice presidents," and the Navy system of directorates or departments in its final organizational structure. Thus, there are 10 directorates, each led by a deputy commander: nursing, dentistry, surgery, medicine, behavioral health, clinical support services, administration, health care operations, training/education/research, and readiness/operations. There is the assistant chief of staff (ACOS) for public health, the elected president of the medical staff, and the ACOS for "special assistants" (chaplain, staff judge advocate, executive services). There is a fourth ACOS at FBCH, the ACOS for nursing, who serves as the assistant deputy commander for nursing as well as the chair of the executive committee of the nursing staff.

The organizational chart shown in the Figure does not necessarily dictate the hospital's system of governance. The composition of the hospital's executive committee, or "board of deputies," varies between the 2 facilities, as do some of the relationships and composition of the hospitals' major committees. For example, the comptroller is a voting member of the hospital's governing board at WRNMMC but is represented by the deputy commander for administration at FBCH. Prominent in both governance systems is the role of the assistant deputy commander for each of the major directorates. These more junior officers (majors/lieutenant commanders, lieutenant colonels/commanders) assist their directorate deputy commanders and serve important roles in hospital quality, manpower, space committees, and the awards boards. In serving as "assistant deputy commanders," they have the opportunity to gain both perspective and experience in the business of hospital operations beyond the limits of their own "tactical" or direct leadership roles.

ADVANTAGES OF THE NEW JOINT ORGANIZATIONAL STRUCTURE

In the standard Army MTF structure, there are a maximum of 2 senior strategic leadership positions per MTF that can be held by an officer from any one corps: the commander and a service specific deputy commander (ie, DCCS, DCA, DCN). In the new joint structure, the number of leadership positions is increased to include the position of chief of staff. Five different Army and Navy officers have held this position in the 2 National Capital Area hospitals since 2009: one Medical Service Corps, one Nurse Corps, and 3 Medical Corps. The chief of staff position is unlike any in the current Army model; he or she is responsible for all hospital operations and functions as the commander's right hand.

There are 10 deputy commanders in the joint MTF organization. The members generally serve 2-year terms, although the terms can be extended with consent of the Commander of the Joint Task Force (which itself will soon be transformed into the National Capital Region Directorate of the Defense Health Agency). Civilians currently serve as deputy commanders at both hospitals, representing the critical contribution of civilians to our MTF team and offering an opportunity for senior civilian leadership in the MTF organization. As of this writing 2 years since the merger, in addition to the 2 civilians, a total of 21 Medical Corps officers, 5 Nurse Corps officers, 15 Medical Service Corps officers (including pharmacist, psychologist, social worker, optometrist, and administrator specialties), and 2 Dental Corps officers have served as either chief of staff, assistant chief of staff, or deputy commander at FBCH and WRNMMC.

By one account, 70% of a leader's development comes as a result of serving in jobs that provide opportunities for growth.[10] Junior leaders consistently rank challenging leadership opportunities as the most important part of their own leader development.[11] Thus, in addition to the narrower and more focused span of control, a significant advantage of this joint system of hospital governance is an increased number of senior positions, and thus opportunities for leadership development.

There are a number of additional advantages of the joint MTF organizational structure. With this model, strategic leadership opportunities become available for some specialists who might not have the opportunity in the current structure, including, for example, pharmacists, social workers, psychologists, and optometrists. Thus, the enterprise benefits from the leadership skills of an increased pool of officers without diluting the experience and opportunity for the larger corps. Each position has a narrower span of control, allowing for more focused mastery of a specific area of hospital operations. A narrower span of control allows the clinical leader to continue to practice in his or her corps specialty, thus maintaining crucial clinical credibility while adding to MTF productivity and access. Finally, there is also a greater opportunity for mentoring and coaching subordinates in each directorate, as the narrower span of control provides the leader more time and energy to focus on the subtle but equally important aspects of leadership, including subordinate development, strategic communication, and executive rounding.

The major criticism of this flatter, more horizontal organization is that there is too great a diffusion of responsibility. However, that situation has not manifested in practice. The commander has a single point of contact for all aspects of hospital operations in the chief of staff. The chief of staff is also responsible with the commander for helping to build the executive teams and for developing the senior hospital leaders. In situations where the chief of staff is not a physician, the commander may lean more heavily on the specific clinical deputy commanders or for matters pertaining to credentialing and privileging, the president of the medical staff who also serves as the chair of credentials and the chair of the executive committee of the medical staff.

SUMMARY

Leaders develop by doing hard things—being coached and mentored while they operate in challenging positions. They also grow by observing credible leaders with whom they can relate and identify. Finally, those same credible leaders are the best source of formal leader development programs and mentoring for their subordinates. The traditional Army MTF organizational structure makes provision of these 3 means of leader development (direct mentoring, coaching, leader instruction) extremely difficult. There are too few developmental organizational-level MTF positions, and those who serve in the positions are often too taxed to provide the kind of leader development support that subordinates should have. The new joint MTF organizational structure operating at WRNMMC and FBCH allows for all of these leader development practices. It could also offer better opportunity for the future development of AMEDD leaders in the MTF, whose vocation must always be to lead, to teach, and to serve.

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Army Medical Department Leaders and the Law

MAJ Joseph B. Topinka, JAG, USA

...[T]he Army Ethic is rich and varied in its sources and its content. Parts of the Army Ethic originate from codified, legal documents, such as the Constitution and the Uniform Code of Military Justice....Army professionals conduct their individual duties according to the legal part of the Army Ethic.[1]

As of this writing, the final draft of Army Doctrine Reference Publication 1 is not yet approved doctrine and as such cannot be used for reference or citation. However, the developing draft construct[1] is a very useful tool for all of us who are part of the Army. It provides insight for Army Medical Department (AMEDD) leaders about the significance of understanding key legal subjects throughout their careers in the US Army.

Officers attending the Basic Officer Leader Course or the Captains Career Course at the AMEDD Center and School (AMEDDC&S) are exposed to specific legal topics designed to empower them throughout their careers. The courses are intended to help them develop an understanding of the framework of the Army Ethic.[1] The subjects taught within each course cannot be learned in just a few hours. This article is written to focus on those topics and should be of assistance to young, AMEDD leaders who are developing a true understanding of the importance of legal matters for success in their careers, whether military or civilian. It is also an excellent review for midlevel and senior leaders who understand that such elements must be practiced, understood, and applied along with the use of effective and knowledgeable legal counsel.

This article is organized into 4 sections:

Standards of Conduct

Military Justice

Law of Armed Conflict

Medical Negligence in the Military Setting

The Framework of the Army Ethic

	Legal Foundations	Moral Foundations
Army as a Profession Laws/values/norms for performance of collective institution	Legal-institutional US Constitution Titles 5, 10, 32 US Code Treaties to which the United States is party Status of Forces Agreements Laws of Armed Conflict	Moral-institutional US Declaration of Independence Just war tradition Trust relationships of the profession
Individual as Professional Laws/values/norms for performance of individual professionals	Legal-individual Oath of: Enlistment Commission Office US Code–Standards of Exemplary Conduct Uniform Code of Military Justice Rules of engagement Soldier's rules	Moral-individual Universal norms: Basic rights Golden Rule Values, creeds, and mottos: Duty, Honor, Country 7 Army Values Soldier's Creed, Warrior Ethos

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Standards of Conduct

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Public service is a public trust, requiring military and civilian government employees to place loyalty to the Constitution, the laws, and ethical principles above private gain. In general, the most significant matters that challenge both leaders and followers are the basics of the proper treatment of gifts, conflicts of interest and how to prevent them, and the proper use of government resources.

GIFTS

The general rule is that Department of Defense (DoD) employees shall not, directly or indirectly, solicit or accept a gift from a prohibited source or a gift given because of the employee's official position. A prohibited source is a very specific term of art and often gets confused. It specifically refers to anyone

- seeking official action from your agency;
- doing or seeking business with your agency;
- regulated by your agency; or,
- having an interest affected by the performance or nonperformance of your official duties.

Gifts include gratuities, favors, discounts, entertainment, hospitality, loan forbearance, items of monetary value, services, training, transportation, local travel, lodging and meals, purchase of tickets, and advance payments. They do not include non-meal foods such as coffee and donuts, greeting cards, plaques, trophies, discounts available to the general public or to all Soldiers, or anything for which fair market value is paid by the employee.

If something is a gift, however, there are some exceptions to the general rule which are good for all federal employees to know. The first is unsolicited gifts of $20 or less per occasion, not to exceed a total value of $50 from a single source in one calendar year. It is a very straightforward restriction, but one often violated by people who think they can accept more than $20 at one occasion and never remember the source for successive events. It should be noted that the Secretary of Defense recently waived this $20 gift limit for military personnel in the pay grades of E-6 and below when the gift is offered by charitable or veterans service tax-exempt organizations, is not in the form of cash, and does not conflict with other applicable ethics rules and regulations. The second exception involves gifts received because of personal relationship. A personal relationship is one that usually has lasted more than a few minutes. I cannot tell you how many times previous clients have referred to their good, vendor friends that they have only known for about an hour. One hour is not sufficient time to establish such a friendship. In general, there are some basic limitations on the exceptions to rules that federal employees should consider when dealing with gifts from outside sources:

- Never accept a gift for influence of an official act.
- Never solicit or coerce the offering of a gift.
- Do not accept so frequently that anyone could believe you are using your public office for private gain.
- Do not accept in violation of any statute.
- Do not accept vendor promotional training contrary to applicable regulations.

Normally, employees may not give a gift or solicit a contribution for a superior; and they may not accept a gift from an employee receiving less pay. Like all rules, there are exceptions such as gifts on an occasional basis, special infrequent occasions, minor contributions of food that will be consumed at the office, and hospitality in the home. Gifts on an occasional basis include things like office functions where a gift is traditional. Gifts must be limited to $10 or less in value. Gifts on an occasional basis also include things like food and refreshments to be shared at the office like the very common office "potluck," as well as items customarily given in connection with personal hospitality in a residence. Special, infrequent occasions are infrequently occurring occasions of personal significance or involving termination of the official relationship. Examples are transfer, marriage, birth of a child, illness, or retirement. Good solid rules for employees to follow on those special, infrequent occasions are:

- All donations must be voluntary.
- No donor may be asked to contribute more than $10. A donor may contribute more than $10, but he or she cannot be asked to contribute more than $10.
- No contribution more than $300 per donating group.
- If a donor is a member of more than one donating group, those groups will aggregate and be subject to a single $300 limit. Sometimes members of one donating group give in another without realizing it, so be careful.

Gifts of Official Travel

Federal employees can be very mobile and official travel brings its own set of ethical challenges. First, remember that all promotional benefits, such as frequent flier

miles, obtained as a result of official travel belong to the individual traveler, provided the benefit is available to the general public under the same terms and at no additional cost to the government. Second, there are specific rules to airline "bumping": If you are on official temporary duty (TDY) travel orders and you are involuntarily bumped, any benefits belong to the government, but you may remain on TDY at government expense. If you voluntarily "bump" yourself, any benefits belong to you the traveler, but you cannot charge the government for any costs associated with this on your TDY voucher. Third, never accept upgrades or benefits from bumping when based on rank or wearing your uniform. An airline operational consideration is one thing, an upgrade based on your rank or official position is another. It must be understood that as long as upgrades are not offered because of your official position, you can accept them. However, the government traveler must always understand that the more senior you are, the more likely your official position may be a consideration in the airline's decision. Finally, never voluntarily give up seating if doing so will interfere with mission accomplishment. That is not to say that you cannot exchange seats with a family that is separated by a row or two, but that is different than doing something that will not permit you to arrive on time at a designated location pursuant to official orders.

Gifts of Honoraria

There are many myths about honoraria, and I hope this article will dispel them. First, a federal employee should never accept compensation from a nonfederal source for teaching, speaking, or writing that relates to official duties. Second, a federal employee should ever wonder about official status versus personal status, he or she should answer the following questions:

- Undertaken as part of official duties?
- Invitation based on official position rather than subject matter expertise?
- Invitation extended by entity with interest in the performance of official duties?
- Draws on nonpublic information?
- Deals with ongoing operation of the agency, or any matter to which assigned in the past year?

If the answer to any of the questions is yes, then something is likely related to official duties and the employee should refuse the honorarium.

CONFLICTS OF INTEREST

As a federal employee, do not, in your official capacity, participate personally and substantially in any matter in which you have a personal financial interest. This includes interests held by your spouse and minor children. This is to avoid even the appearance of impropriety. There are some general remedies for financial conflicts of interest such as disqualification, waiver, and divestiture of the assets which are causing the conflicts. Other remedies include reassignment, transfer, or resignation from an outside position.

Outside Employment

Outside employment is a significant issue within the AMEDD, and the good common sense approach is for employees not to engage in outside employment that interferes or is incompatible with official duties, brings discredit upon the employee or the Army, or creates an actual or apparent conflict of interest. The US Army Medical Command has specific rules for outside employment in its off-duty employment regulation.[2] To ensure availability of healthcare personnel, providers must obtain command approval before obtaining outside healthcare employment, give monthly status declarations of their outside employment, and give monthly reports of the hours worked. Officer trainees may NOT hold off-duty employment. Army Medical Department personnel, however, can get compensation for teaching or speaking about their profession in general. For example, a family physician could be paid for speaking about general preventive health practices.

In addition, employees cannot represent another party before the federal government ("representing back"), which is what someone is usually doing when working off-duty in a government facility. You should be careful about conflicts of interests that result from being involved in a nonfederal entity (NFE) and representing that NFE back to the government, acting on matters in your official capacity involving the NFE in which you may be an officer, and organizing various "teambuilding" activities centered around doing charitable work with that NFE when it may also involve your official duties.

There are also some bans about which you should be aware after your departure from federal employment. First, there is a lifetime ban from working on particular matters in which you participated "personally and substantially" as a government employee. There is also a 2-year ban from working on particular matters "pending under your official responsibility" within 2 years of leaving government service. "Particular matters" is defined as something involving deliberation, decision, or action, and that is focused on the interests of specific persons, or a discrete and identifiable class of persons.

Use of Resources

Government resources include equipment, time, communications, Internet access, transportation, personnel,

and official positions. The general rule is that government resources, including personnel, equipment, and property, shall be used by federal employees for official purposes only. However, use may be authorized when it does not adversely affect official duties, is of reasonable duration, serves a legitimate public interest, does not reflect adversely on DoD, is at no significant cost to the government, and official time is dedicated to the conscientious performance of duties. Union and professional development activities may be authorized.

Equipment

Any official or personal use of communications equipment may be monitored by the government, including telephone conversations, email notes, and Internet searches. Certain communications are prohibited. These include commercial or personal business; chain letters, dirty jokes or ethnic slurs; viewing or downloading pornography; and security violations. Brief personal messages, web browsing on personal time, and professional web searches may be authorized by the appropriate supervisor.

Official Position

Employees should never reference title, position or organization to endorse a nonfederal entity. This suggests official endorsement or preferential treatment. Employees should not target subordinates or prohibited sources with personal endorsements of nonfederal entities. Official endorsements of a nonfederal entity, event, product, service, or enterprise may neither be stated nor implied except for the few authorized organizations. Federal employees shall not endorse membership drives of fundraisers except for the following:

- Combined Federal Campaign
- Army Emergency Relief (or the similar funds of the other military services)
- Organizations composed primarily of DoD employees or their dependents when fundraising among themselves.

Use of Government Vehicles

Government vehicles are for official use only. They are not to be used for transport to private social events or personal errands or transport of dependents/visitors without an escort. Transportation to after-hours official functions (which must begin and end at the duty station) is permissible when authorized. Government-owned vehicles may be used while on temporary duty assignment to go to and from lodging, restaurants, physical training, barbershop, religious services—but NOT for entertainment.

POLITICAL ACTIVITY

Federal employees must be careful about the political activities in which they may become involved.

The political activities in which Soldiers may participate are listed in Table 1. Those activities from which Soldiers are prohibited from participating are listed in Table 2. The political activities in which DoD civilian employees may and may not participate are listed in Tables 3 and 4 respectively.

Table 1. Political activities in which Soldiers MAY participate.

Register, vote, and express a personal opinion, but not as a representative of the Army.
Promote and encourage other military members to exercise their voting franchise, if such promotion does not constitute an attempt to influence or interfere with the outcome of an election.
Serve as an election official, if such service is not as a representative of a partisan political party, does not interfere with military duties, is performed while out of uniform, and has the prior approval of the Secretary of the Army or his designee.
Join a political club and attend its meetings when not in uniform.
Sign a petition for a specific legislative action or a petition to place a candidate's name on an official election ballot, if the signing does not obligate the Soldier to engage in partisan political activity, and is done as a private citizen and not as a representative of the Army.
Write a letter to the editor of a newspaper expressing the Soldier's personal views on public issues or political candidates, if such action is not part of an organized letter-writing campaign or a concerted solicitation of votes for or against a political party or candidate.
Contribute up to the statutory contribute limit to a political organization, party, or committee favoring a particular party or candidate.
Attend partisan and nonpartisan political meetings or rallies as a spectator when not in uniform.
Display a political bumper sticker on a personal vehicle.

Table 2. Political activities in which Soldiers may NOT participate.
Use official authority to influence or interfere with an election, solicit votes for a particular candidate or issue, or solicit political contributions.
Be a candidate for a civil office.
Participate in partisan political management or campaigns, or make public speeches in the course thereof.
Allow or cause to be published partisan political articles signed or written that solicit votes for or against a partisan political party or candidate.
Participate in any television, radio, or other program or group discussion as an advocate of a partisan political party or candidate.
Use contemptuous words toward the President, Vice President, etc.
March or ride in partisan parades.
Participate in organized efforts to transport voters to polls.
Promote political dinners or fundraising events.
Sponsor or serve in an official capacity of a partisan political party or club.
Attend partisan events as official representatives of the armed forces.
Display large signs/banners/posters on private vehicles.
Display banners/signs in yards of post/base housing or federal offices or buildings.
Conduct a political opinion survey.

Table 3. Political activities in which civilian DoD employees MAY participate.
Vote as you choose.
Register as a member of a political party.
Join and be an active member of a political party or club.
Express opinions about candidates and issues.
Attend and be active at political rallies, conventions, and meetings.
Contribute money to political candidates and organizations.
Attend political fund raising functions.
Give a speech at a fund raiser so long as the speech does not include an appeal for political contributions.
Hold office in political clubs or parties so long as the duties do not involve personal solicitation, acceptance, or receipt of political contributions.
Campaign for or against candidates in partisan elections.
Campaign for or against referendum questions, ballot initiatives, constitutional amendments, and municipal ordinances.
Sign nominating petitions, make nominations, or place a name in a nomination at a nominating caucus.
Assist in voter registration drives, including serving in a polling place.
Serve as a delegate, alternate, or proxy to a state or national party convention.
Distribute campaign literature in partisan elections.
Run as a candidate for public office in nonpartisan elections.
Run as an independent candidate in a partisan election in certain jurisdictions which are specified by the Office of Personnel Management (OPM).
Manage or otherwise work on a partisan political campaign of a candidate for public office, except for activities involving the direct solicitation, acceptance, or receipt of funds.
Serve as poll watcher, election judge, clerk, or similar official.
Drive voters to polling places for a partisan political candidate.

Table 4. Political activities in which civilian DoD employees may NOT participate.
Engage in political activity while on duty.
Engage in political activity while wearing an official government uniform.
Engage in political activity while using a government vehicle.
Engage in political activity in any government office.
Engage in political activity while using government property, including computers, printers, copiers, fax machines, and telephones.
Wear political buttons while on duty.
Display items (such as posters, signs, stickers) at work that indicate support of or opposition to a political party or a candidate in a partisan election
Run as a candidate for public office in any partisan election, except in jurisdictions specified by OPM.
Solicit, accept, or receive political contributions (except in limited circumstances involving certain federal labor or employee organizations).
Solicit, accept, or receive political contributions from a subordinate employee.
Allow your official title to be used in connection with fund raising activities.
Host a fund-raising function at your home.
Use your official authority or influence to interfere with an election.
Knowingly solicit or discourage the political activity of any person who has business before DoD.

Military Justice

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The military has a unique judicial process that depends heavily upon the independent judgments of commanders. The commander is engaged at every step of the system. For this reason, it is essential that Army leaders understand the military justice system and the implications of their actions. This section is intended to be a primer for understanding the system and the commander's role.

UNIFORM CODE OF MILITARY JUSTICE

The Uniform Code of Military Justice (UCMJ) (10 USC, chp 47) defines the crimes for which service members can be prosecuted at courts-martial. It contains both civilian-type offenses, such as rape, murder, and larceny, as well as strictly military offenses, such as desertion, disobedience, and disrespect. It also includes protections for service members, including the right against self-incrimination and various procedures the command must follow before disciplining a Soldier.

JURISDICTION

In order for a person to be subject to the military justice system, the commander or court involved must have jurisdiction. Jurisdiction is the authority of a commander or court to try a case and render a valid judgment. The UCMJ sets forth 2 conditions for jurisdiction: (*a*) jurisdiction over the person, and (*b*) jurisdiction over the offense. The UCMJ defines persons subject to its jurisdiction as "members of a regular component of the armed forces…and other persons lawfully called or ordered into, or to duty in or for training in, the armed forces, from the dates when they are required by the terms of the call or order to obey it" (10 USC, Article 2(a)). One consequence of this rule is that an Active Duty commander must be aware of the status of National Guard and Reserve Soldiers since they can only be prosecuted for misconduct committed while in Title 10 status.* If the Soldier is not on Title 10 status at the time of the offense, an Active Duty commander must consider alternative methods of disposing of the offense. The Supreme Court has limited the powers of courts-martial to those offenses that are "service connected." This requirement, however, is not as limiting as it may appear on its face. Generally, it is met by the offenses Congress has approved under the UCMJ. It is important to note that there is no geographic limitation for jurisdiction. So long as jurisdiction over the person and the offense exist,

*US military Reserve and National Guard personnel on active military service and paid under direct control of the US government are serving in Title 10 status.

a Soldier may be tried for misconduct that occurred in Nairobi, Kabul, or even outer space.

HANDLING DISCIPLINE AT THE LOWEST LEVEL

Commanders have a litany of available methods to respond to Soldier misconduct from simply closing the case without further action to referring the case to a General Court-Martial. The UCMJ requires that matters be disposed of at the lowest appropriate level. When considering the appropriate response, commanders should consider the

- nature and circumstances of the offense and the extent of the harm caused, including effect on morale, health, safety, welfare, and discipline;
- character and military service of the accused;
- appropriateness of the authorized punishment to the particular accused or offense;
- reluctance of the victim or others to testify;
- availability and admissibility of evidence;
- possible improper motives of the accuser; and
- cooperation of the accused in the apprehension and conviction of others.

The 3 most common command responses when faced with misconduct are nonjudicial punishment, administrative separation, and courts-martial. Administrative separations and some punishments are not technically military justice actions since they are based on regulation and not the UCMJ. This means that certain rights and procedures will differ as prescribed by regulation.

REPRIMANDS

Any commander may issue a written reprimand so long as that commander believes by a preponderance of the evidence that the Soldier committed the alleged misconduct. The real question is how the reprimand will be filed—either in the Soldier's "local" file or in the Official Military Personnel File (OMPF). Under *Army Regulation 600-37*,[3] only a general officer or the Soldier's General Court-Martial Convening Authority (GCMCA) may file a reprimand in the OMPF. Therefore, if a battalion commander issues a written reprimand and wishes to file it in the Soldier's OMPF, the reprimand must be forwarded up the chain-of-command until the proper authority can make that decision. The usual practice for issuing reprimands is that the commander will sign a reprimand and have it served upon the Soldier. The reprimand will include a recitation of the Soldier's misconduct, as well as notice that it may be filed in the OMPF and that it is not punishment under Article 15 of the UCMJ. The Soldier will sign a form acknowledging receipt and then take the reprimand, along with all supporting documentation, to a defense attorney. The reprimand will include a date by which the Soldier must provide any rebuttal matters. The issuing authority will review whatever matters are provided and then make a filing decision. If the reprimand is filed in the local file, it will remain there for 3 years or until the Soldier is transferred to a different GCMCA. If it is filed in the Soldier's OMPF, it will go in the "performance section." There is no option to file a reprimand in the "restricted section" of the OMPF.

NONJUDICIAL PUNISHMENT

Nonjudicial punishment is outlined in Article 15 of the UCMJ, and the legal process involving nonjudicial punishment is commonly referred to as simply "Article 15." Chapter 3 of *Army Regulation 27-10*[4] provides further guidance. The general rule is that Article 15s should be given for minor offenses under the UCMJ's punitive articles. An offense is considered "minor" if the maximum punishment under the UCMJ does not include a dishonorable discharge or confinement for more than one year. This is only a guideline, though, and commanders should also consider the factors discussed earlier. For example, the UCMJ authorizes 2 years confinement for failing to obey a general order. Still, not all misconduct that constitutes failure to obey a general order warrants such punishment; depending on the circumstances, it can still be considered a minor offense.

There are 2 types of Article 15 actions: summarized and formal. Summarized proceedings may be used if the Soldier is an enlisted member, and it is determined that, should punishment be appropriate, it should not exceed extra duty for 14 days, restriction for 14 days, oral reprimand or admonition, or any combination thereof. Formal proceedings will be used if the Soldier alleged to have committed the offense is an officer, or if the appropriate punishment might exceed extra duties for 14 days, restriction for 14 days, oral reprimand or admonition, or any combination thereof. The actual authorized punishments vary depending on the imposing officer's rank (company-grade, field-grade, or general officer). Since punishment under Article 15 is governed by the UCMJ, the standard of proof is the same as for courts-martial: beyond a reasonable doubt. This is higher than the preponderance of the evidence standard in place for written reprimands.

When administering an Article 15, a commander must provide notice to the Soldier of his or her intention to impose an Article 15. The notice will include the alleged misconduct and the maximum punishment that may result, should the Soldier be found guilty of the offense(s). The Soldier should be provided with a copy of Department of the Army (DA) Form 2627 (Record of

Proceedings Under Article 15, UCMJ) and the supporting documents and statements for use during the proceedings. The commander may designate an officer or noncommissioned officer (NCO) (grade E-7 or above) to deliver the DA Form 2627 and inform the Soldier of his or her rights. The NCO should ordinarily be the unit first sergeant or the senior NCO of the command concerned.

During Article 15 proceedings, a Soldier has the following rights: to remain silent; to counsel (formal proceedings only); to present evidence; to request an open hearing (formal proceedings only); to request a spokesperson (formal proceedings only); to appeal; and to demand court-martial. A commander is not limited to the Article 15 charges if the Soldier demands court-martial; additional charges may be added to the charge sheet for consideration by the court.

The Soldier may request a reasonable time to decide whether to demand a court-martial and to gather matters in defense, extenuation, and/or mitigation. The decision period will not begin until the Soldier has received actual notice and explanation of rights under Article 15. Normally, formal proceedings require at least a 48-hour decision period. Summarized proceedings normally require a 24-hour decision period. If a Soldier wishes to call witnesses on his or her behalf, those witnesses will be at no expense to the government. If the witness is located at the installation or nearby, that witness is considered available if his or her attendance would not unnecessarily delay the proceedings.

At the hearing, the commander will consider all evidence presented, including evidence of extenuating and/or mitigating factors. Such evidence is relevant to determine the appropriate punishment, if any. The formal rules of evidence do not apply, except those pertaining to privileges (attorney-client privilege, doctor-patient privilege, etc.). Therefore, the commander may consider any matter, including unsworn statements, that is reasonably relevant to the offense. Again, the commander must find that the Soldier committed the misconduct beyond a reasonable doubt in order to find him or her guilty of the charges.

As noted earlier, one of the rights available to a Soldier is the right to an appeal. An appeal not made within a reasonable period of time may be rejected by the appellate authority. An appeal made within 5 days after imposition of the punishment is considered timely. The commander may extend that time for good cause. The appellate authority may deny the appeal or alter the punishment in any way that is more lenient to the Soldier, including discarding the Article 15 altogether.

In addition to any reduction in rank, extra duty, forfeitures, or reprimands imposed as punishment under Article 15, a commander determines where the Article 15 will be filed. If the Soldier is E-4 or below, it is automatically filed in the Soldier's local file. If the Soldier is above the rank of E-4, the commander must decide whether to file it in the performance section or restricted section of the OMPF. There is no option to file an Article 15 in the local file if the Soldier is above the rank of E-4. The restricted section is "that portion of the OMPF that contains information not normally viewed by career managers or selection boards…."[4(p4)]

The commander's discretion to impose an Article 15 is personal and must not be hampered by any superior's guidelines or policies. Although a superior commander may not tell a subordinate when to impose an Article 15 or what punishment to assess, the superior commander may withhold authority to impose the Article 15 at his or her level of command. This may be done through a partial withholding of certain categories of offenses (for example, all drug offenses), certain categories of personnel (such as all officers or all noncommissioned officers), or in individual cases. The commander may also totally withhold all Article 15 authority to his or her level.

ADMINISTRATIVE SEPARATIONS

Commanders will often initiate administrative separation subsequent to a written reprimand or Article 15. However, an administrative separation may be initiated as a separate action; there is no requirement that the commander formally punish a Soldier before initiating separation. Guidelines for separating enlisted Soldiers are found in *Army Regulation 635-200,*[5] while the guidelines for officers are in *Army Regulation 600-8-24*.[6]

Enlisted separations are generally initiated by the company commander and will include a recommendation as to the characterization of service, either Honorable, General (Under Honorable Conditions), or Other Than Honorable (OTH) conditions. The available characterizations vary depending on which chapter of *Army Regulation 635-200*[5] is the authority to separate the Soldier. For example, if the Soldier is being separated under Chapter 18 (failure to meet weight control standards), only an Honorable characterization is authorized. If the Soldier is being separated under Chapter 14-12c (commission of a serious offense), an OTH characterization may be appropriate.

Once the commander initiates separation, the Soldier will take a copy of the memorandum and supporting documentation to a defense counsel. The Soldier has 7 days to respond to the allegations. Whatever material

the Soldier presents will be forwarded along the chain-of-command until it reaches the final approval authority, with each intermediate commander making a recommendation as to separation/retention and characterization of service.

If the command recommends an OTH characterization, or if the Soldier has over 6 years time-in-service, the Soldier is entitled to have an Administrative Separation Board consider the matter. The Board will hold a hearing that is basically an informal trial where it will consider evidence from both the Government and Defense. The Board will then make a determination as to (1) whether the Soldier committed the misconduct; (2) whether the misconduct warrants separation; and (3) the appropriate characterization of service. The GCMCA will consider the Board's findings and recommendations before making any final decision. If the Board recommends retaining the Soldier in the Army, the GCMCA is bound by that recommendation.

Officer eliminations must be initiated by a General Officer Show Cause Authority (GOSCA). Basically, this is any General Officer that has a legal advisor. The GOSCA will sign a memorandum informing the officer of the reasons for elimination. The officer has 30 days to respond. The officer may elect to retire (if eligible), resign, or have the matter heard by a Field Board of Inquiry (if eligible). Officers are eligible for a Board of Inquiry if the GOSCA is recommending an OTH characterization or the officer has over 5 years time-in-service as an officer. The approval authority for officer eliminations is the Army Human Resources Command (HRC). Once the officer has responded and provided the command with any rebuttal matters, the GOSCA will forward the elimination packet, including chain of command recommendations, supporting documentation, and the Board findings and recommendations (if applicable) to HRC. The Commanding General, HRC will make the final decision on retention/separation and characterization of service. This process generally takes anywhere from 2 to 5 months.

In addition, an officer who commits misconduct may have his or her file sent to the Army Grade Determination Review Board. That Board will determine the rank at which the officer last served honorably and has the authority to reduce the officer to that rank for retirement/resignation purposes.

COURTS-MARTIAL

If a Soldier's misconduct is of such a nature that some lower level of punishment is not an adequate remedy, the commander may elect to initiate court-martial proceedings. Typically, the company commander will inform the servicing trial counsel that he or she wants to proceed with a court-martial, and the trial counsel will review the case file and draft a charge sheet. Keep in mind that this is a very lengthy and serious process and must be given the consideration it is due. The charges will then be "preferred" against the accused. "Preferral of charges" is the term of art for an accuser swearing to the charges. Generally, the company commander will prefer charges, but anyone may do so. As will be discussed later, nobody may be ordered to prefer charges.

In cooperation with the trial counsel, the command will also determine the appropriate level of court-martial. There are 3 levels: summary, special, and general.

Summary Court-Martial

A summary court-martial provides for the disposition of minor offenses under simplified procedures and is generally convened by the battalion commander. This type of court can only try enlisted personnel. In addition, instead of a military judge, the presiding official is a commissioned officer, usually field-grade, who may be a lawyer, but that is not a requirement. Further, the accused is not entitled to a military defense lawyer to represent him at the summary court but is allowed to consult one before trial for legal advice. A Soldier may always hire a civilian defense lawyer to represent him or her, but he or she would have to pay for such representation. Finally, similar to an Article 15, a Soldier must consent to disciplinary action under summary court-martial. However, if a Soldier does object, the case can then be sent to a higher level court-martial. The maximum punishment available at a summary court-martial depends on the rank of the accused.

Special Court-Martial

There are 2 types of special courts-martial; one empowered to adjudge a bad-conduct discharge (BCD), known as Special-BCD, and one that is not so empowered (typically referred to as a "straight special"). A brigade commander is typically empowered to convene a straight special. The ability to convene a Special-BCD is withheld to the GCMCA. Given that the difficulty and expense of holding a straight special is the same as that for a Special-BCD, and the fact that a straight special cannot discharge a Soldier, it is becoming increasingly rare for a command to convene a straight special. A special court-martial can take one of 2 forms. It may consist of a military judge and not less than 3 panel members, or a military judge sitting alone. If the accused requests the latter, the military judge will decide guilt or innocence and, if found guilty, an appropriate punishment. If an enlisted accused requests trial before members, he or she can request at least ⅓ of the members be enlisted,

although none would be junior in rank to him. Both a trial counsel and defense counsel are detailed to represent the respective interests of the government and the accused. Just like a summary court, the accused can hire a civilian lawyer and pay for such representation using his or her resources. The maximum punishment at a Special-BCD is a bad-conduct discharge, one year confinement, reduction to E-1, hard labor without confinement for 90 days, and/or forfeiture of ⅔ pay per month for one year. Officers may not be discharged or reduced at a SPCM. While a summary court-martial may be more informal, a special court-martial is conducted just like any trial in the civilian world. The rules of evidence apply, as do numerous procedural rules.

General Court-Martial

A general court-martial is the highest military trial court and is usually convened by a general officer, typically the commanding general of a division or senior commander at an installation. It requires more formal detailed administrative procedures than either a summary or special court-martial. These procedures include conducting a pretrial investigation into the allegations, commonly referred to as an Article 32 investigation. In addition, the staff judge advocate must issue written advice to the GCMCA concerning: (1) whether there is jurisdiction to try the accused, (2) whether each specification alleges an offense under the UCMJ, and (3) whether each specification is warranted by the evidence. The general court-martial consists of a military judge and at least 5 court members, or a military judge alone. The maximum punishment available at a general court-martial is the maximum punishment listed for each offense in the Manual for Courts-Martial.[7] A general court-martial is the only court-martial able to adjudge a dishonorable discharge. It is also the only court-martial that can dismiss an officer.

The military justice system does have a system of appeals courts. Following disposition at the trial court, an accused may appeal the findings and/or sentence to a higher court. Some cases are automatically heard on appeal, such as those that adjudge a bad-conduct discharge. Ultimately, the US Supreme Court may hear military justice cases.

The UCMJ lists 5 different sentencing principles in the determination of an appropriate sentence for misconduct. Judges and panel members use these principles at court-martial, but they can also be used by commanders as they make decisions concerning the appropriate disposition of matters or as they impose punishment under Article 15. The sentencing principles include:

- rehabilitation of the wrongdoer,
- punishment of the wrongdoer,
- protection of society,
- preservation of good order and discipline in the military, and
- deterrence of the wrongdoer and those who know of his crimes.

Personnel entrusted with the responsibility of implementing the military justice system should balance these principles in consideration of an appropriate punishment.

UNLAWFUL COMMAND INFLUENCE

Unlawful command influence (UCI) has been called "the mortal enemy of military justice," and it is certainly the scourge of a system that requires commander involvement at all levels and in every disciplinary action that can be taken against a Soldier. It is defined as the unlawful assertion of authority that interferes with the fair and just administration of military justice under Article 37, UCMJ, which was written to ensure that commanders do not unlawfully influence the disposition of charges or otherwise poison the justice process. It acknowledges that commanders have a wide range of authority in the military justice sytem but requires that they act with discretion and independence when enforcing good order and discipline. Most of all, commanders must remember that they are judicial authorities and that some of the judgments and practices on which they rely in the operational setting are inappropriate or counterproductive to the fair administration of justice under the UCMJ.

There are 3 populations that commanders should keep in mind when considering whether their conduct has the potential to unlawfully influence the judicial process: subordinate commanders, court-martial panel members, and potential witnesses. When it comes to subordinate commanders, such commanders are required to make independent recommendations regarding the disposition of cases or to make the decisions to dispose of them at their levels, as the MCM requires that all cases be disposed of at the lowest appropriate level.

Law of Armed Conflict

MAJ Joseph B. Topinka, JAG, USA CPT Adam Jonasz, JAG, USA

While traveling through what is now Italy in 1859, Swiss businessman Jean-Henry Dunant stumbled upon one selfless idea: that we should help to relieve the suffering of Soldiers and civilians during a time of war. A pure concept, although perhaps not very novel in and of itself, his idea changed the world. After he witnessed the aftermath of the battle of Solferino, he recorded his experiences in the book *A Memory of Solferino*[8] in which he described the terrible battle and its bloody aftermath, at first from the sidelines and then as a volunteer and organizer of relief efforts. He recalled in great detail the horrors, suffering, and deaths of the Soldiers for whom he cared, spoke with, and consoled before they died. He also described the efforts of doctors and civilians along with the military medical personnel that cared for masses of casualties, the dead, the dying, the amputees, the disfigured, and the deaf and blind from each side of the conflict. Most notably, Dunant put forward ideas and proposals for the future, aimed at preventing a repetition of the suffering that he had witnessed at Solferino.

In 1863, only a year after he published his book, Dunant (with some help) organized a conference in Geneva, to which 16 countries sent their representatives. Since then there have been 3 additional major conventions in Geneva, and 3 protocols added to the original charter, the last in 2006. The "Geneva Conventions," as we refer to them, are really a series of treaties on the treatment of civilians, prisoners of war, and Soldiers who are otherwise rendered hors de combat, or incapable of fighting. The first convention was initiated by the International Committee for Relief to the Wounded, which became the International Committee for the Red Cross (ICRC). This convention produced a treaty designed to protect wounded and sick Soldiers during wartime. The Swiss Government agreed to hold the conventions in Geneva, and a few years later, a similar agreement to protect shipwrecked personnel was produced. Following World War II, 2 new conventions were added to the original two in 1949, and all 4 have since been ratified by 194 countries.

CONCEPT

The laws governing actions or conduct of armies, Soldiers, and combatants during hostilities although codified through the 4 conventions in Geneva, are not actually laws as we recognize the concept of a legislatively enacted law. The Geneva Conventions are a set of internationally recognized principles sanctioned by a convention. They are principles, customs, rules, and doctrine with which all nations and combatants can and should accept, recognize, and follow. However, the force of law, the ability to punish offenders who breach the principles and articles established by the conventions, and the very thing that gives them life lies within the individual signatory nation states, not Switzerland or the ICRC in Geneva. Under the Geneva Conventions and Additional Protocol I of 1977, states must prosecute people accused of war crimes before their own national courts or extradite them for trial elsewhere. It is a nation's national legislation; their military's regulations, customs, and ideology; and their government, judiciary, and military's will and readiness to police its own, that gives the law of war muscle.

Which course of action a combatant will take treating the enemy, civilians, and property during hostilities will be determined by the national character, the ideology, and the military strategy of each nation. The principles contained in the Geneva Conventions are enforced by the individual nation states through their respective judicial systems, ad hoc courts set up by the warring parties (usually the victors), or through the International Criminal Court (ICC). However, not all states recognize the jurisdiction of the ICC or have ratified the Treaty of Rome which established the court. Currently the United States is not a member of the ICC and is not legally obligated to comply with the court.

The United States conducts its military operations in accordance with the principles set forth in the Geneva Conventions, customary international law, and treaties, and recognizes the 3 additional protocols following the 1949 convention, although the US has not ratified the protocols. The Law of Armed Conflict, Law of War, or International Humanitarian Law are the terms commonly used to refer to the laws applicable to the conduct of warfare on land/sea and to relationships between belligerents and neutral states. Customary international law can best be understood as the "unwritten" rules that bind all members of the community of nations. Customary international law is the result of the general and consistent practice of states followed from a sense of legal obligation, either by treaty, regular practice over time, or excepted principles of conduct. Customary international law is binding on all nations, not just signatories of treaties. Conventional international law refers to codified rules binding on nations based on express consent, through treaty, convention, protocol, or membership within certain international organizations incurring legal obligations.

In reality, the Law of Armed Conflict is a set of laws through which individual nation states and/or belligerents regulate the conduct of their own armies, combatants, and civilians during times of hostility. Remember, under the Geneva Conventions and the Additional Protocol I of 1977, states must prosecute people accused of war crimes before their own national courts or extradite them for trial elsewhere. In effect, national legislation which attempts to prevent, limit, restrain, or control the conduct of its own armies, Soldiers, civilians, and government in a time of hostilities or war are the only true Laws of Armed Conflict for which a government, army, or Soldier is responsible. In the United States, for example, The War Crimes Act of 1996 (18 USC, §2441, amended 1997) authorizes the prosecution of individuals in federal court if the victim or the perpetrator is a US national (as defined in the Immigration and Nationality Act (Public Law 82-414, 66 stat 163 June 27, 1952)) or a member of the US armed forces, whether inside or outside the United States. Jurisdiction attaches if the accused commits any of the following:

- A grave breach of the 1949 Geneva Conventions
- Violations of certain listed articles of the Hague Conventions
- Violations of Common Article 3 of the Geneva Conventions, and of Protocol I or Protocol II of the Geneva Conventions when and if the United States becomes a party to either of the Protocols
- Violations of Protocol II to the Amended Conventional Weapons Treaty
- Violations of US national legislation (federal law/UCMJ)

CORE PRINCIPLES

Under the Geneva Conventions, there are 5 core principles governing what conduct is internationally acceptable in armed conflict. Violations of these principles constitute "grave breaches" and thus can be considered war crimes. These principles are: civilian immunity, (the prohibition against intentionally targeting civilians or otherwise treating them as combatants); distinction (the imperative to distinguish between civilians and combatants in military operations, and for combatants to distinguish themselves as such through identifiable dress and insignia and by carrying arms openly); proportionality (the requirement to use force in a manner that is proportionate to the military value of the target); necessity (the obligation to restrict targets or tactics to those necessary to achieve legitimate military goals); and humane treatment (the prohibition of torture, inhumane and degrading treatment of prisoners, and the imperative to guard the rights and interests of "protected persons," the legal term for civilians and medical/religious service members on the battlefield).

The lawful conduct of war—the bounds of lawful use of force—is defined by the concepts of military necessity, avoidance of unnecessary suffering, and proportionality. The Law of Armed Conflict allows combatants to take actions with respect to targeting and engagement that are not specifically prohibited by international law (convention law) and that are necessary and directly related to the prompt submission of the enemy. The concept of military necessity never allows for a waiver of the Law of Armed Conflict. Arms, projectiles, and material calculated to cause unnecessary suffering and/or destruction of property are prohibited. Otherwise lawful arms cannot be used to cause unnecessary suffering (for example, use of unguided munitions with the intent to extend collateral damage to surrounding civilian property or persons would be unlawful). There must be discrimination in that attacks must be directed against a specific, military target. The loss of life and damage to property incidental to an attack must not be excessive in relation to the concrete and direct military advantage gained.

LAWFUL AND UNLAWFUL TARGETS

Combatants are defined as those engaging in hostilities in an armed conflict on behalf of a party to the conflict. Combatants are lawful targets unless "out of combat." The Geneva Convention definition of "combatant" is someone under responsible command, wears distinctive signs recognizable at a distance, carries arms openly, and abides by the laws of war. Military objectives are defined as combatants, defended places, and those objects which by their nature, location, purpose, or use make an effective contribution to military action.

Incidental injury and collateral damage is unavoidable as unplanned damage to civilian personnel and property incurred while attacking a military objective. Incidental (collateral) damage is not a violation of international law. While no Law of Armed Conflict treaty defines this concept, its inherent lawfulness is implicit in treaties referencing the concept. An attack on noncombatants or protected property is illegal.

WEAPON SYSTEMS

Article 23e of Convention IV of the Hague Treaties states "In addition to the prohibitions provided by special Conventions, it is especially forbidden…(e) To employ arms, projectiles, or material calculated to cause unnecessary suffering;…"[9] This concept also extends

to unnecessary destruction of property. Arms cannot be used that are calculated to cause unnecessary suffering. Otherwise lawful arms cannot be used in a manner that causes unnecessary suffering. Weapons may be illegal per se in that they are calculated to cause unnecessary suffering determined by the "usage of states." Examples include lances with barbed heads, dumdum rounds, irregularly-shaped bullets, projectiles filled with glass.[10(p18)] They can be illegal by improper use such as using an otherwise legal weapon in a manner to cause unnecessary suffering. For example, a conventional air strike against a military objective where civilians are nearby versus use of a more precise targeting method that is equally available, if the choice is made with the intent to cause unnecessary suffering. They can be illegal by agreement or prohibited by specific treaties. For example, certain landmines, booby traps, and laser weapons are prohibited under the Protocols to the 1980 Conventional Weapons Treaty. Note that all weapons issued for use by the US armed forces have been tested for compliance with the Law of Armed Conflict and have been found to be lawful when used for their intended purpose.

THE LAW OF WAR PROTECTS CERTAIN TARGETS

Under the Law of Armed Conflict, certain persons are protected as "noncombatants." Civilians and civilian property may not be the subject or sole object of a military attack. Civilians are persons who are not members of the enemy's armed forces; and who do not take part in the hostilities.[11] Those Soldiers who have fallen by reason of sickness or wounds and who cease to fight are to be respected and protected. Civilians are included in the definition of wounded and sick (who, because of trauma, disease,…are in need of medical assistance and care and who refrain from any act of hostility).[11] Shipwrecked members of the armed forces at sea will be respected and protected.[12] Shipwrecked includes downed passengers/crews on aircraft, ships in peril, and castaways. Medical personnel are considered out of combat if they exclusively engaged in medical duties.[10(p89),12] Prisoners of war may surrender by any means that communicates the intent. There is no clear-cut rule as to what constitutes surrender. However, most agree surrender constitutes a cessation of resistance and placement of one's self at the discretion of the captor. The onus is on the person or force surrendering to communicate intent to surrender. Captors must respect (not attack) and protect (care for) those who surrender—no reprisals.[9,13] Surrender may be made by parachutists from disabled aircraft.[10(p17)] Parachutists who are crewmen of a disabled aircraft are presumed to be out of combat and may not be targeted unless it is apparent they are engaged on a hostile mission. Paratroopers are presumed to be on a military mission and therefore may be targeted. Chaplains are protected persons. Journalists are given protection as "civilians," provided they take no action adversely affecting their status as civilians.[11]

PROTECTED PROPERTY

Under the Law of Armed Conflict, there is a prohibition against attacking civilians or civilian property.[10(p98),11] A presumption of civilian property attaches to objects traditionally associated with civilian use (dwellings, school, etc).[11] There is also a prohibition against attacking cultural property. The 1954 Cultural Property Convention elaborates, but does not expand, the protections accorded cultural property found in other treaties.[9,10(p21)] The convention has not been ratified by the United States. Cultural property includes buildings dedicated to religion, art, science, charitable purposes, historic monuments, hospitals, and places where the sick and wounded are collected. Misuse will subject them to attack. The enemy has the duty to indicate presence of such buildings with visible and distinctive signs. Protected cultural property is identified through use of protective emblems.

> A shield, consisting of a royal blue square, one of the angles of which forms the point of the shield and of a royal blue triangle above the square, the space on either side being taken up by a white triangle.[14]

In addition, transports of the wounded and sick or of medical equipment shall not be attacked.[12] Medical transports may include ambulances, medical ships, and medical aircraft. Fixed or mobile medical units shall be respected and protected. They shall not be intentionally attacked. Protection shall not cease, unless they are used to commit "acts harmful to the enemy."[10(pp102,103)] Medical supplies may not be intentionally destroyed.[12] Under the Geneva Conventions of 1949, medical aircraft must have an agreement as to their route, altitude, and time of flight in order to be protected. Objects and personnel displaying emblems are presumed to be protected under the Conventions.[12] Medical emblems include the red cross, red crescent, and lion and sun. Protocol III signed in 2005 adopted the red crystal as another protected emblem. The ICRC adopted the red crystal as a compromise to countries that refused to use the red cross or red crescent because of the religious connotations those symbols hold. The red crystal is the ICRC attempt to create a non-religious symbol that all nations can agree to use.

Medical personnel may be armed for their own defense against marauders and those violating the law of war by attacking a medical unit. Medical personnel thus may carry small arms such as rifles or pistols for this purpose. In contrast, placing machine guns, mines, etc, around a medical unit would cause a loss of protection.[15]

Normally, medical units are guarded by their own personnel. It will not lose its protection, however, if a military guard, attached to a medical unit, guards it. These personnel may be regular members of the armed force, but they may only use force in the same circumstances. If possible, medical facilities should not be placed near military objectives in order to minimize collateral damage to the medical facility in the event the military objective is attacked. Medical units/establishments lose protection if committing "acts harmful to the enemy." Examples or acts harmful to the enemy are using a hospital as a shelter for combatants, as an ammunition dump, or as an observation post. Protection ceases only after a warning has been given and it remains unheeded after a reasonable time to comply. A reasonable time varies on the circumstances. For example, no time limit is required if fire is being taken from the hospital. Additionally, no warning would be necessary if a unit is taking fire from a hospital.[11,15]

IMPROPER USE OF SYMBOLS

The enemy can certainly be tricked by setting ambushes, sending false radio traffic, using enemy passwords, etc. These are not unlawful. Combatants may wear enemy uniforms (for example, to infiltrate) but cannot fight in them. Military personnel not wearing their uniform lose their prisoner of war status if captured and risk being treated as spies.[16,17] Treachery or perfidy are different matters altogether; they involve injuring the enemy by its adherence to the Law of Armed Conflict (actions are in bad faith). Perfidy degrades the protections and mutual restraints developed in the mutual interest of all parties, combatants, and civilians. In practice, combatants find it difficult to respect protected persons and objects if experience causes them to believe or suspect that the adversaries are abusing their claim to protection under the Law of Armed Conflict to gain a military advantage. Thus, the prohibition is directly related to the protection of war victims. The practice of perfidy also inhibits restoration of peace. The use of medical symbols is restricted to facilities or transport exclusively engaged in medical duties. The 1949 Geneva Convention (II)[12] requires that wounded and sick, hospitals, medical vehicles, and, in some cases, medical aircraft be respected and protected. Protection is lost if committing acts harmful to enemy. Feigning surrender or the intent to negotiate under a flag of truce is unlawful. A white flag is an indication of a desire to negotiate only and its holder has the burden to come forward.[11] Feigning protected status by using United Nations (UN), neutral, or nations not party to the conflict's signs, emblems, or uniforms is also perfidy.[11] Note, however, that this prohibition only applies if the UN force is not an actual combatant force. In fact, UN forces have been actual combatants on only one occasion in its history, the Korean War. Feigning incapacitation by wounds/sickness is also perfidy, as is feigning civilian, noncombatant status.[11,16]

RIGHTS OF PRISONERS OF WAR

Prisoners of war (POWs) have the right to receive the basic necessities to stay in good health to include reasonable accommodation of food habits. For example, one should not provide a person of the Muslim faith with pork. Shelter and clothing should be consistent with the climate in the area. Prisoners of war (POWs) have a right to retain items such as pictures of a significant other, a religious medallion, badges, and basic clothing items. Weapons or military equipment they would not need for health, protection, or shelter reasons can be taken away. What a prisoner needs depends on where he or she is on the battlefield. If money is found during a search of a POW, an officer must be notified as only an officer can seize money from a prisoner. The officer must issue a receipt to the POW stating the amount seized and the name, rank, and unit of the officer seizing the money. Once a POW reaches a camp, a copy of the Geneva Convention on POWs must be available to him or her. The ICRC will normally have copies available.

Prisoners of war have the right to make requests regarding the conditions of captivity to the camp commandant. This is normally done through the prisoner's representative, either the POW's senior ranking officer or a POW elected by the body of POWs. Complaints will be directed to the camp authorities through the senior ranking US official, be that officer or enlisted, present in the camp. All POWs have the right to practice their religion. Premises to conduct worship of their religion shall be provided. The Geneva Conventions do place certain obligations on POWs. The only information POWs must disclose to their captors is name, rank, identification number, and date of birth.[13] They must obey lawful camp rules and regulations. If a POW violates such rules and regulations, he or she can be punished, either by a court-martial or an administrative proceeding. A capturing power may use the labor of POWs who are physically fit. The labor may not be unhealthy or dangerous or directly contribute to the enemy's war effort.[13] Rank has its privileges among POWs. Retained persons may only be used in medical activities.

Retained personnel, detainees, and POWs should be provided both medical and dental care. Civilian internees must be provided medical care, but if hospitalization is required, they will, if possible, be moved to a civilian hospital where treatment must be as good as that provided to the general population. The occupying power must ensure that civilians have access to adequate medical

care, although that care does not have to be provided by the occupying power.

As a minimum, retained medical personnel shall receive the benefits and protection given to a POW and shall also be granted all facilities necessary to provide for the medical care of POW. They shall continue to exercise their medical functions for the benefit of POWs within the scope of the military laws and regulations of the US Armed forces. They shall be provided with necessary transport and allowed to periodically visit POWs situated in working detachments or in hospitals outside the POW camp. Verifications of retained status and medical proficiency will be recorded on the DA Form 4237-R (Detainee Personnel Record) of the person concerned.

RESPONSIBILITIES OF PRISONERS OF WAR

All POWs, American or otherwise, must provide their name, rank, service number, and date of birth. This is a requirement of the Code of Conduct for US personnel, and is a requirement of the Geneva Convention. Other armies allow their POWs to provide more information, but the US Code of Conduct limits Americans to providing only the 4 items listed above. Prisoners of war have an obligation to obey all rules established by their captor. This does not mean that they cannot try or attempt to escape. However, there are consequences associated with attempting to escape. It is like a contract. The captors agree not to kill or harm the POW, and in exchange, the POW promises not to commit an act harmful to its Soldiers or its cause. If the POW violates the terms of this contract, the captors can punish the POW. Because POWs are a burden on the capturing nation, that country can compel POWs to do certain work. A POW can be required to do any act within the camp that is of benefit to the entire camp. Examples would be cooking the POWs' food, digging latrines, and building their shelters. POWs can also be compelled to do work outside the camp, such as working on farms, in commercial businesses, and transporting and handling of goods which are not military in character or purpose.

INVESTIGATING VIOLATIONS OF THE LAW OF ARMED CONFLICT

The Geneva Conventions divides traditional war crimes into "grave breaches" and "simple breaches." *DoD Directive 2311.01E*[18] requires the prompt reporting and investigation of alleged war crimes, as well as appropriate disposition of resulting cases under the UCMJ. Most violations of the Law of Armed Conflict committed by persons subject to the UCMJ will constitute violations of the UCMJ. Violations that are not subject to the punitive articles of the UCMJ usually constitute violations of federal laws. *Chairman of the Joint Chiefs of Staff Instruction 5810.01*[19] establishes joint policy and guidance for the implementation of the Law of Armed Conflict. It provides that it is the policy of DoD to ensure that the Law of Armed Conflict is observed and enforced by US armed forces. It requires violations, whether committed by or against US or enemy personnel, to be promptly reported, thoroughly investigated and, where appropriate, remedied. Law of Armed Conflict violations alleged to have been committed by or against allied military or civilian personnel, will be reported through appropriate command channels for transmission to appropriate agencies or allied governments. Commanders of combatant commands are responsible for the overall execution of the DoD Law of War Program. Therefore, it is up to them to create appropriate plans, policies, and directives for reporting any violations through command channels, as well as to conduct appropriate investigations to determine if US military personnel were involved, and to ensure future enforcement of the Law of War.

COMMAND LIABILITY FOR LAW OF WAR VIOLATIONS

Commanders and other superiors are responsible for their own conduct, and can, in some cases, be responsible for the conduct of those serving under them. If a commander or superior knows or should have known of a violation of the Law of Armed Conflict either before, during, or after the violation and failed to act, the commander is responsible for his or her failure to command or lead. For example, after World War II, Japanese General Tomoyuki Yamashita was sentenced to death by a military commission for offenses committed by those under his command in the Philippines. Although the commission made no direct findings that General Yamashita ordered all of the murders and rapes of civilians and prisoners of war, it was concluded that the crimes were so widespread that General Yamashita must have known about their commission.

REPORTING LAW OF ARMED CONFLICT VIOLATIONS

Any information about the event (persons involved, location, date, time, names of witnesses, description of events, etc) as well as any existing evidence, physical or otherwise, should be communnicated to the commander, and then by the commander to others. The commander will make the effort to secure all documentation and evidence relating to the report, and higher command will appoint an investigating officer, should that be necessary.

In spite of the stated process to be used in reporting war crimes, violations have been reported to chaplains, judge advocates, inspectors general, provost marshals, military police, and the criminal investigation division.

WHY FOLLOW THE LAW OF ARMED CONFLICT?

Service members follow the Law of Armed Conflict for many reasons. Ultimately, US laws, regulations, and military custom require it. A member of the US armed forces remains responsible for his or her personal actions at all times. This is even expressed and made clear in our Code of Conduct.[20] Its 6 articles deal with chief concerns of an American in combat. Although the Code was first expressed in written form in 1955, it is based on time-honored concepts and traditions that date to the days of the American Revolution. The Code clearly states that US service members will obey only "lawful orders," even as a POW. The Code also states "…I will obey the lawful orders of those appointed over me and will back them up in every way. I will never forget that I am an American, fighting for freedom, responsible for my actions, and dedicated to the principles which made my country free."

Medical Negligence in the Military Setting

MAJ Joseph B. Topinka, JAG, USA Melissa W. Hartley, JD

As a result of "sovereign immunity," people cannot sue most governments unless they actually allow you to do it. In the United States, the vehicle for recovery of a tortuous injury is the Federal Tort Claims Act (28 USC §2679 (1946)). The Act represents the opportunity for an injured party to seek compensation and be made whole for the negligent acts of a government employee unless the injured individual is on military active duty at the time of injury. Active duty military do not have this right of recovery. There is a separate discussion concerning a case called *Feres v United States* (340 US 135 (1950)) and what it means to be "Feres Barred." Retirees, spouses, family members, and civilians being treated for emergent matters are covered by the Federal Tort Claims Act (FTCA). However, for AMEDD healthcare providers, the FTCA and the Army Tort Claims process in general can be a scary labyrinth of blame and licensure implications that may consume several years.

TORT

A tort is a wrongful act, damage or injury done to someone else.[21] It can be intentional (for example, an assault). It can also be a negligent act, such as failing to take proper care in performing a task that results in injury to another person. The tort at issue in medical malpractice claims is usually deemed to be failing to provide the care that a "reasonably prudent practitioner" would have provided. It can be a failure to act (nonfeasance) or acting carelessly without regard for the safety of others (malfeasance). In either case, if the tort causes damages, the individual patient is allowed recovery under the FTCA for the acts of providers acting within the scope of their federal duties.

SCOPE

Scope is an important concept that generally is not sufficiently analyzed when medical providers are learning about the FTCA Process. As scope determines FTCA application, the scope analysis is critical. While the Army has the opportunity to make recommendations, the authority to certify that federal employees were acting within scope of their duty lies with the Department of Justice. This scope certification must be made prior to removal of a lawsuit and the substitution of the US government as the party being sued (28 USC §2679(d)(1), (d)(2)).

Federal employees providing medical care are covered only if their conduct is within the scope of their duties (Gonzales Act, 10 USC §1089 (1988)). Thus, a federal employee in off-duty employment status would not be covered under the FTCA for any acts performed as part of that off-duty employment. Military health providers should be aware of what their scope of practice actually is for their duty. They should know the limitations of their individual licensure and the policies of their clinic or ward. If they are in a resident status, they should know the scope of their clinical duties as outlined by the program director and the department for each year of the residency. If they are staff members, the biggest issue is to maintain supervision over the residents or subordinate paraprofessionals, and to make sure that as subordinates, they know to inform their superiors of complications or changes in a patient's status. Also, they should be able to recognize when to consult another subspecialty of care and document those actions in the medical record. If they order a consult or additional medical tests, they should follow-up on those results, because that is the standard of care.

STANDARD OF CARE vs STANDARD OF PROOF

The very definition of standard of care is, in fact, a standard. This implies that health providers are acting within the big bell curve that is the standard of their profession. The legal definition is often stated as "what a reasonably prudent provider would do in the same or similar circumstances." Health providers should make sure they are practicing to professional standards cited by their clinic or hospital policies, professional organizations, Army regulations, or state licensure authorities. Standard of care is a wide gray zone. The trick to

proving that a provider is practicing within standard of care is documenting the thoughts and circumstances at the time in question. Ultimately, detailed documentation is necessary because of the legal standard of proof for medical malpractice cases. The legal standard of proof in a medical negligence case is preponderance of the evidence[22] and not beyond a reasonable doubt as in a criminal case. This generally means that when all of the evidence is heard and placed on the figurative "scales of justice," which way do the scales tip? Are they "for" or "against" the government? In FTCA cases that are not disposed of in the claims process, a federal judge is the decider of fact. There are no juries. The judge will look at the evidence and determine "on a more probable than not basis" if negligence occurred. Fifty-one percent is more probable than not. In reality, the government must prove on a "more probable than not basis" that the medical provider did not commit negligence.

Proving a negative is a challenging concept, so it helps to look at it from the plaintiff's perspective. While the government is trying to prove it did not commit malpractice, the plaintiff must actually try to prove 3 separate things. The plaintiff must first prove that the medical provider owed the plaintiff a duty of care. This is simple. If the plaintiff was the patient, the medical provider generally had a duty to care for him or her. Next, the plaintiff must show how the medical provider breached that duty. Even if the medical provider somehow failed to meet the standard of care, the plaintiff must still prove how that breach actually caused the damages the plaintiff is claiming, the third element of malpractice. Sometimes the causation of damages can be pretty simple. For example, if a medical provider failed to administer antibiotics and the patient suffered an infection that left him or her with an ugly scar, the damages are obvious. Likewise, it is easy to identify with the loss of a limb and imagine the effect on a person's daily activities. However, sometimes damages are less obvious. A delay in a diagnosis of cancer could have a loss of chance for recovery. Sometimes the percentage of chance of cure is so highly technical and speculative that even the hospital tumor board may have difficulty deciding on what chance of survival the patient had based on the date of diagnosis, or whether that percentage would have changed based on the delay. Birth injury cases that cause a developmental delay may be speculative as well. It is hard to argue how any child would have matured absent an injury.

REPORTING DATABASES

Medical providers normally believe that the government will cover them as long as they are within their scope of practice, but they should still be concerned about a claim. Any tort claim filed against the federal government for medical malpractice must be reviewed through the Army's Quality Assurance process, typically by the hospital Risk Management Committee.[23] Even if a claim is denied later, an initial review through the quality assurance process will occur. Any actual payment made "for the benefit of a health practitioner" in a medical malpractice case is reportable by the Office of the Surgeon General to the National Practitioner Databank (NPDB). The NPDB, set up under the Health Care Quality Improvement Act of 1986 (Title IV, Pub L No. 99-660 (1986)), is the central repository for information on individually credentialed medical providers. There is another lesser-known reporting databank, the Health Integrity and protection Databank (HIPDB), a national collection data program where civil judgments, convictions for healthcare fraud, and adjudicated decisions on other professions are reported. While the HIPDB and NPDB are not searchable by the general public, the information is available to all state boards of licensure for the various health professions. Medical providers who hold more than one state license may receive multiple letters about the incident from their states. Every state will likely become aware of the NPDB report and may open individual investigations. They have the authority to request records and their state licensure board may make their own independent standard of care determination. This information must also be reported to every prospective employer, as well as to insurance providers when the medical provider applies for any type of professional practice liability insurance.

PREVENTION

There is no magic in avoiding medical negligence cases—accidents do happen. However, documentation has been proven to be effective in medical malpractice cases across the country. Good documentation can provide safer communication, better informed patients, smoother transfers of care to colleagues, and improved patient outcomes. Good documentation also stands the test of time. The FTCA process is a lengthy one. The claimant has up to 2 years from the date of injury to file a claim. The supporting legal office has an additional 6 months to investigate the claim pursuant to *Army Regulation 27-20*.[24] Some claims take even longer to investigate, based on the course of treatment for a complicated injury, or the lack of reliable test data for an infant. The statute of limitation is tolled as long as the claimant files the claim before the 2-year mark of the date that they "discover" the injury (*Landreth v United States*, 850 F2d 532,533 (9th Cir 1988) citing *United States v Kubrick*, 444 US 111 (1979)). From the point the claim is denied or if settlement is offered and rejected, the claimant has the right to file suit in federal court. Once in federal court, it can take anywhere from 18 months to 3 years to actually

get a case to trial. A well written medical record holds enormous weight to the court since it was written at the time of the event. It was not something created by a paid expert or drafted under the guidance of an attorney. It was written immediately so it is obviously an accurate reflection of the events that had just occurred. The court will be looking to see if the records reflect that the medical provider met the standard of care and did "what a reasonably prudent provider would have done in the same or similar circumstances." Did they show that the medical provider was reasonably prudent by paying attention to detail? Do they explain the circumstances and what he or she were thinking at the time? Did the patient have numerous confusing symptoms that caused the medical provider to have to rule out a number of differential diagnoses? If so, there may be a valid defense regarding why a particular referral was not a delay in care that equated to malpractice. Did the medical provider consult the appropriate specialty care or senior provider for advice? If so, whom did the provider call and what did he or she said? Did the provider order appropriate tests? Were some tests not necessary in an atypical case? If so, why not? Did the provider discuss all options of care with the patient (*Howard v University of Medicine and Dentistry of New Jersey*, 172 NJ537 (2002))? Did the provider discuss risks and benefits of both having a procedure versus not having a procedure? If the patient spoke limited language, how did the provider, as a reasonably prudent provider, ensure that the patient understood what the provider was explaining/discussing? Did the provider use a language line? Did the provider rely on a family member to interpret? Did the provider ask the patient to verbalize the follow-up plan so the provider could be assured that he or she knew when to schedule the next appointment or test? If the provider ordered tests, did he or she check for results? If the provider communicated results to the patient, is there a note explaining when and how this occurred?

REALITY OF MEDICAL NEGLIGENCE CASES

The reality is a balancing act. A medical provider does not have enough time in the day to write every detail on every patient. But what is the perspective of a federal judge reading the medical provider's notes? Will he or she think that the provider was a conscientious provider who had a plan of action and addressed the patient's concerns? Or are there a number of identical notes using the copy/paste function in the medical records system with only the drop-down template boxes checked? Sometimes, even with the best documentation, claims cannot (nor should) be defended. Sometimes patients are injured and it is the fault of either the healthcare system or one particular provider. In those cases, the legal office's responsibility is to assess damages and make a fair settlement to compensate the injured party.[25] Sometimes the healthcare system should apologize to the patient or the family and restore trust in the system. Compensating an injured party when the government is truly responsible for damages is the right thing to do.[26] It is also the whole reason the federal government waived sovereign immunity in the first place. *Army Regulation 27-20*[24] specifies that the role of the claims investigator is to fully and fairly investigate the claim and adjudicate it in a way that is fair to both the injured party and the government. Ultimately, accurate records and candor with supporting legal counsel can benefit the medical provider when settling a case. First, it can help in settling the case so it does not extend it with horrible consequences to the patient, including unemployment, further damages, and lingering injuries. Second, a medical provider could find it easier to explain a payout for $50,000 for a medical error rather than a $500,000 payout for the exact same error at a later stage of the process. Third, clear and complete medical records after the injury play a large role in helping government counsel prove exactly what damages (and therefore settlement amount) can actually be substantiated.

Conclusion

MAJ Joseph B. Topinka, JAG, USA

The partnership of law and medicine is truly a noble team, but like any team, it is as only as good as the sum of its parts. In many ways, leaders in AMEDD must understand legal basics almost as well as AMEDD legal counsel must know the law within the context and culture of Army medicine where they advise and work. Together, an incredible synergy results. Together, they support the framework of the Amy Ethic. Together, they contribute to superb patient care.

ACKNOWLEDGMENTS

Mr Chandlee is Chief, Administrative Law and the ethics counselor at Office of the Staff Judge Advocate (OSJA), AMEDDC&S. CPT Crall, CPT Anderson, CPT Knodel, and CPT Woolam are the military prosecutorial team at the OSJA, AMEDDC&S. CPT Jonasz, former Administrative Law Attorney, OSJA, US Army Medical Command, is one of a group of JAG Corps officers who have deployed multiple times and have real-world experience with the laws of international armed conflict.

ACKNOWLEDGMENTS (CONTINUED)

I thank Ms Hartley, Deputy Center Judge Advocate, Madigan Army Medical Center, for mentoring and training me and many other military lawyers who have served the Army Medical Department. Since the Army JAG Corps has no formalized training program in health law for attorneys, we rely on experienced civilian attorneys such as Ms Hartley, to lead us through our experiences in military health law.

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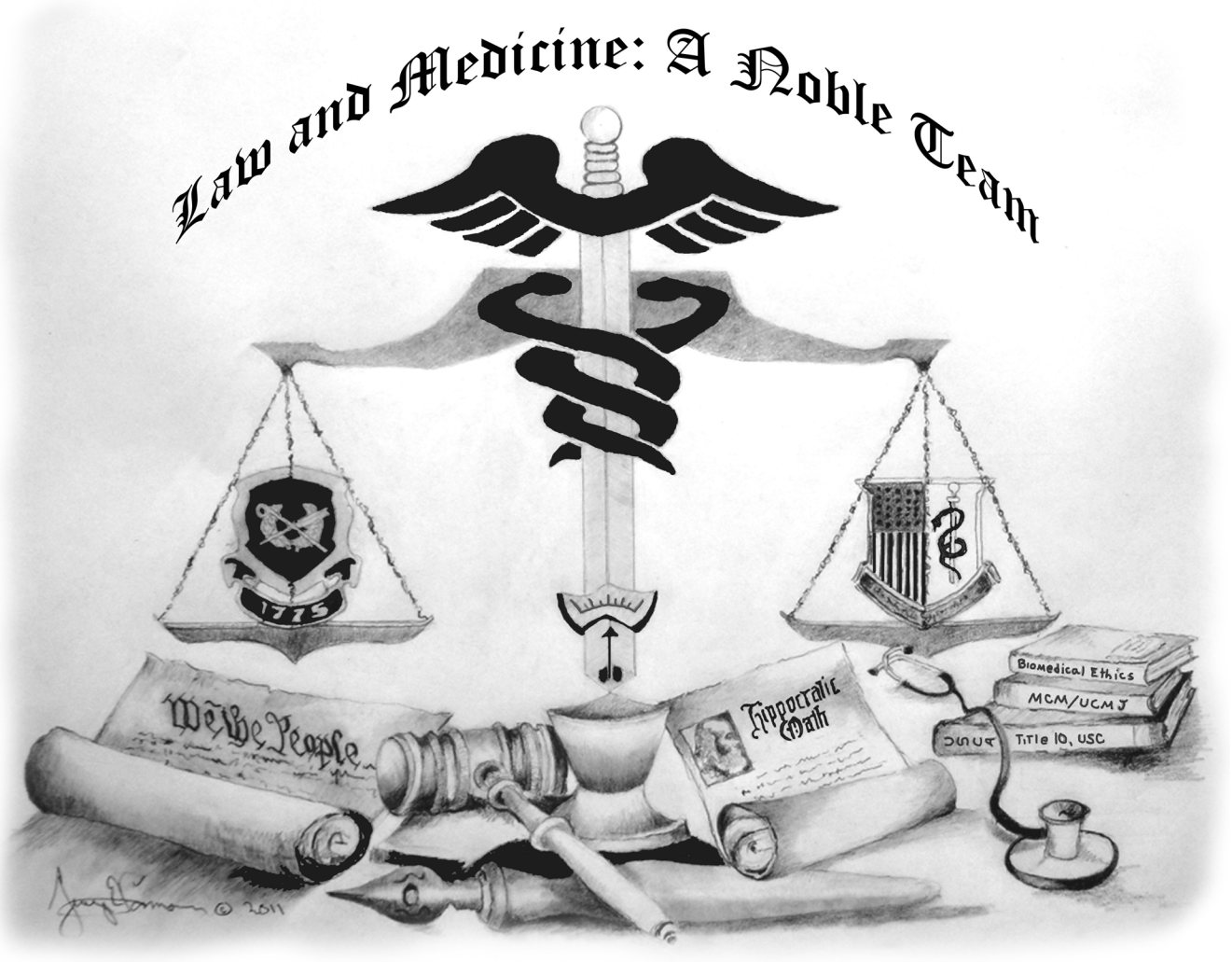

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