

All Physicians Lead

The U.S. Army Medical Corps Leadership Development Program
Expanded AMEDD Journal Version

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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 two things: teach and lead. Teaching is the root of the word doctor, and passing on knowledge to patients and trainees is a mandate. Leading is also a critical professional skill. Leading health care teams, leading patients and leading trainees are all required. Leadership has been defined as the art of convincing someone to do something they did 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 AMEDD.

That is our task.

In the summer of 2011 the Army Medical Corps Chief gave approval to assemble 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. Too few Medical Corps officers are interested in pursuing leadership positions outside of the clinical arena. The reasons are many and are covered in more detail in later chapters. Additionally, Medical Corps officers who attain clinical or command leadership positions are often unfamiliar with the principles of leadership practice and theory. If they are prepared it is usually the result of random events, focal mentorship experiences, and/or great personal effort and study rather than any standardized 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 Flag officers.

The fundamental premise of this work 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, 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 written by the Army Medical Corps, we are hopeful that other Corps within the Army Medical Department and our sister 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 little or no formal education in the theory and practice of leadership. We can and will do better, and we see this volume as a first step in that direction.

Chapter One

Every Physician Leads: Rationale, Structure, and Proponency

COL Leon E. Moores, MC, USA

“Every system is perfectly designed to give you exactly the results you are getting”
W. Edwards Deming

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

In October 2011 a working group was established to evaluate the current state of Army Medical Corps leadership development and build a comprehensive program. It quickly became clear that two 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 solo 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 even at the medical student and resident level.

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 (ACGME) 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 "hard" or technical skills of financial management, labor-management relations, and an appreciation of organizational structure in addition to "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 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 this program will 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 program 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 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.

This 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. The program's objective in this case 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 in Chapter 5. However, we have substantially widened the aperture to include leadership development for all physicians at all career stages in order to enhance patient care and healthcare team effectiveness 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 mid- 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."

In Army Medicine there are both organizational and cultural impediments to physician leadership development. 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 the 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 educational program that is relevant and practical.

From a cultural standpoint, military physicians often avoid leadership opportunities and training because of a 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 of the LOEs (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 MEDCOM while meeting external accreditation requirements. The Accreditation Council for Graduate Medical Education (ACGME) Competencies, Army Medical Department (AMEDD) Military Unique Curriculum, residency review committee (RRC) professionalism training, and maintenance of certification requirements can be met with elements of the proposed curriculum.

The envisioned end state is a widely embraced and readily utilized program that teaches leadership to all physicians while also developing physician leaders by identifying individuals to be developed for senior leader positions.

Proposed Structure

1. Establish a Medical Corps Leadership Consultant

The AMEDD recognizes non-clinical specialty consultants to the Surgeon General, e.g. Medical Corps History, Ethics, and Medical Evaluation Board consultants. We will establish a Medical Corps Leadership Consultant who will oversee implementation of the program. This Consultant will ideally be based in San Antonio 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 (DCCS, Commander, TSG Consultant, 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 to include providing 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.

2. Establish a Leadership Development Committee

The Medical Corps will create a Leadership Development Committee (LDC) whose membership will be comprised of top-level senior executives such as Medical Treatment Facility (MTF) Commanders, Command Surgeons, Medical Corps Consultants, Directors of Medical Education, Medical Corps Office of the Surgeon General (OTSG) staff officers, and other leaders as appropriate. This group will meet formally twice per year. The LDC will create an executive committee, chaired by the Medical Corps Leadership Consultant, consisting of 10 members with decision making authority. This committee will meet monthly and will provide ongoing guidance and support for execution of the leadership program, including creating and directing subcommittees as below.

Subcommittees will be created and will 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.

Conclusions

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 health care 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.

Scenario:

**Chapter One: Every Physician a Leader
Rationale, Structure, and Proponency**

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 don't 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 position themselves when good leaders are needed.

But this doesn't 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 in life; assisting them while in harm's way to their ultimate objective of safety and well-being. In our best moments, we provide vision, 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, non-secular 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.

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Surgeon General of the Army 2007-2011

Chapter Two

Early Exposure to Leadership Theory “Develop Interest”

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“Leaders are not born. Leaders are made, and they are made by effort and hard work.”
Vince Lombardi

Background

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 and progressive process (ADP 6-22, DA PAM 600-4). This leadership development is executed through three 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 Leadership Course (BOLC) and subsequent courses such as Captains’ Career Course (CCC) and Intermediate Level Education (ILE).

Medical Corps officers often experience a significant gap between attendance at BOLC and CCC in order to complete medical school and Graduate Medical Education (GME) programs. During this time 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 (OIC), Section Chief or an operational assignment frequently note the lack of leadership skills needed to excel in their new job. 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 (ADSO). 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 lead.

Junior medical officers should be taught that basic physician and military unique leadership skills are not just applicable 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, increments 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 Chapter 5) but stresses that the craft of leadership applies to all physicians.

This chapter will explore methods to provide junior medical officers leadership education, exposure to good examples (mentors/sponsors) early in their careers, and to engage them in practical opportunities to practice leadership skills. The goal is to generate excitement in junior officers regarding the lifelong process of leadership development so that they will be able to lead teams more effectively, become better followers and eventually serve as role models for the next generation of Medical Corps officers.

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 at the AMEDD and Army level provides a foundation in leadership training as articulated by Army Doctrine Publication 6-22 and Joint Professional Military Education (JPME.) 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 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 GME programs are required to incorporate military unique curriculum (MUC) 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 (JMESI) 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 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 intra-residency 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 clear proponent whose task it is 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 ACPE, ACGME, and other organizations.

There is no existing centralized, formal mentoring program, where 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 needs to 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, post-graduate students and faculty in addition to general information applicable to all. The Army Medical Corps Website will have areas for medical students (HPSP, USUHS), 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 (i.e. "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 non-medical training programs such as RAND, White House Fellowships, and Baylor programs. The website would also advertise available positions for mid-range and senior physician leaders more widely.

Develop an Army Medical Corps leadership presence on social media sites. Current senior leadership is just becoming comfortable with email and texting and social media, however the next generation is fully plugged in to web based portals of information exchange. This will not be limited to sites proprietary to the military (Army Knowledge On-line - AKO, MilSuite 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. This 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, counseling sessions as well as involving the resident with military administrative activities such as writing Army Officer Evaluation Reports (OERs) Noncommissioned Officer Evaluation Reports (NCOERs) 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 where they document attending a hospital board, committee, or business meeting 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 in order to develop interest.

Expand membership on various hospital committees to housestaff members. This exposes junior officers in a project oriented manner to processes and change management strategies used by organizational leaders within the institution. It should be a stated priority of training

programs, meeting the systems-based practice competency as the justification, to allow housestaff members to attend these meetings.

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 OER and award writing for physicians. Instructors will demonstrate competence in leadership theory, organizational behavior and facilitating small group discussions and should have AMEDD leadership experience. 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” would 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 an MTF Medical Corps leadership coordinator at each hospital. This individual will also serve as director of military unique training within the facility. The coordinator will be resourced with time dedicated for program development and execution. This individual will monitor the implementation of the leadership program and would 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 housestaff 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 mid-level officers. These officers will assist with the leadership development of their subordinates and therefore require development and sustainment of their leadership instruction skills. This can be accomplished in venues such as faculty development seminars or TDY events sponsored by the 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. Establishing regional associations (like the Silver Caduceus Society that Medical Service Corps officers have established) 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. The group will have required readings and discussions and would attend specific workshops and leadership symposia as well as collaborate on-line. The core leadership curriculum, with its programmed reviews and changes of content, can always serve as the jumping off point for ongoing leadership training of these mid-level officers.

The Medical Corps will fund three company grade Medical Corps officers per region annually 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 to learn 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 PCS 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 (see bibliography). 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 HPSP to cover dual-degree programs and for access to graduate business degrees throughout the Medical Corps officer’s career. While a Master’s in Business Administration or Master’s in Healthcare Administration does not guarantee the creation of first-class leaders, they provide valuable additional skills for medical executive leaders.

Conclusions

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 (medical school and residency). Engaging internet materials will be followed with regularly scheduled activities within the GME curriculum as described throughout chapter.

Chapter Two: Develop Interest

Early Exposure to Leadership Theory and Practice

For three years you have told your residents that their first priority when they graduate should be to pass their boards. 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 AR 40-501 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 buy in from the junior staff and residents by showing the relevance of physician leadership in medical practice and 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 (below) will help the residents gain perspective, flexibility and the mental stamina which will help them prepare for success on their Boards. 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?

"Your Critical Care attending, during an unsuccessful resuscitation for a preventable pulmonary embolus, warns everyone that "No-one is to speak of this event to anyone"! It's an order and you, as the Senior Resident need to lead your team of junior residents, medical students, and nurses during this crisis. You and your team know that a cover up seems to be occurring and the ethics of the situation are clear but the order remains. How will you lead?"

"Your Brigade Surgeon commits suicide and you have been pulled out of your "comfortable" PROFIS position into a TOE leadership role. While rounding on your team in the forward support battalion tent, some Special Forces soldiers drop off a local national with >85% third degree burns. He was discharged from a local hospital with an IV in place and a Foley. You decide that given the circumstances of your combat environment comfort care only, is the humane option. You are going to brief your team of Medics, Physicians, and administrators, not to mention your new commander, that repetitive doses of Morphine will likely result in the patient's death. How will you lead them?"

Lieutenant Colonel Neil E. Page, United States Army Medical Corps
Deputy Commander for Clinical Services, Montcrief Army Community Hospital Ft. Jackson SC

Appendix Chapter 2: Sample House staff Leadership Training Schedule and Content

(Full curriculum available with complete APL Program: <http://henryv43.wordpress.com/>)

“Leadership@Lunch” modules to be completed during the Intern Year:

Module 1-What is a Leader?

Module 2- Imperatives of Leadership

Module 3- Emotional Intelligence - Introduction

Module 4- Emotional Intelligence- Styles of Leadership I

Module 5- Emotional Intelligence – Styles of Leadership II

Module 6 – Emotional Intelligence – Styles of Leadership III

Module 7 – Servant Leadership

Module 8 – Integrity I

Module 9 – Integrity II

Module 10 - Followership

Module 11 – Narrative and Leadership

MTF Military Curriculum to be completed during the Intern Year:

1. Career Cycle, Promotion Boards
2. Army schools, GME selection process
3. Medical and Physical Evaluation Board Process, WTB
4. Capabilities and Data Solving with MEDPROS
5. Operational Medicine I: Role 1 and 2 care
6. Operational Medicine II: Role 3 care, medical evacuation, and the MED BDE
7. Managing, teaching, and evaluating subordinate learners (May) (Transition to practice capstone in lieu of this for interns stopping GME at end of the year)
8. The Army: Major Commands, Direct Reporting Units, Army Service Component Commands, Theater Enabling Commands, Corps, Divisions, Brigades, etc.
9. The AMEDD: Medical Corps, Medical Service Corps, OTSG, “One Staff”
10. The 6 Geographic Combatant Commands and the 3 Functional Ones
11. The Campaign: Phases 0 through 5

“Leadership@Lunch” modules to be completed during the PGY-2 Year:

Module 1 – The Leadership Moment

Module 2 – Vision and Getting the Big Picture

Module 3 – Crisis Resource Management

Module 4 – Toxic Leadership

Module 5 – Building a Team

Module 6 – Facing Down Conflict

Module 7 - Optimism

Module 8 – Vision: Communicating the Future

Module 9 - Motivating

Module 10 – Solving Problems

Module 11 – Teach and Develop

MTF Military Curriculum to be completed during the PGY-2 Year:

1. How to prepare and present effective academic lectures and presentations
2. Tools for Benchmarking and Improving your Clinical Performance
3. Specialty Specific Outpatient Tips for Coding and Documentation
4. Specialty Specific Tips for Inpatient Coding and Documentation
5. Anatomy of a MEDCEN (governance, committees, etc)
6. Executive Management Styles
7. How to get things done in the AMEDD: Part I – hospital, department and service budgets, differentiating P6 and P8 money
8. How to get things in the AMEDD: Part II – people and equipment
9. Commonly Tracked Outpatient and Inpatient Quality Metrics and Pitfalls in Measuring
10. Preparing a Business Oriented Decision Briefing
11. Leading Medical Teams

“Leadership@Lunch” modules to be completed during the PGY-3 Year:

Module 1 – Leading Your Peers

Module 2 – Communicating the Mission

Module 3 - Accountability

Module 4 – Resonance and Dissonance in Leadership

Module 5 – Mentoring and CEO Succession

Module 6 – Reinforce with Praise

Module 7 – Leading Change

Module 8 – Preparing for Leadership: Getting Resources

Module 9 – Leading for Loyalty

Module 10 – Enabling Others

Module 11 – Aligning Forces

MTF Military Curriculum to be completed during the PGY-3 Year:

Military education this year should be dedicated towards preparing the graduate for further professional military education and the assumption of responsibilities related to their first assignment and first deployment. Mandatory instruction includes:

1. Combat Casualty Care Course (moved from intern to senior year for more relevant “just in time” training)
2. Phase I Captains Career Course: Residents will be granted protected time that counts towards duty hours to complete Phase I. Completion of Phase I will be a requirement for graduation from residency. Exemptions approved by the program director and director of medical education could be considered on a case by case basis for learners ahead of peers.
3. Transition to Practice: Should occur within 1-2 months of graduation and consist of “capstone” training refreshing basic concepts learned earlier in the education process with immediate relevance. This should, at a minimum consist of:
 - a. Refresher didactic overview of medical evacuation and medical care at battalion, brigade, and CSH levels.

- b. Personal preparedness for deployment
- c. Panel discussions with recently deployed providers for lessons learned
- d. Management of civilian employees and NCOs
- e. Credentialing, pay, bonuses and benefits
- f. Refresher career management seminar (OER support, ORB, military schools)

Chapter Three

Provide Leadership Education

“The Foundation”

COL Mark W. Thompson, MC, USA, COL Frank L. Christopher, MC, USA, COL Bret T. Ackermann, MC, USA, MAJ Robert J Cornfeld, MC, USA, COL Telita Crosland, MC, USA, COL Thomas K Curry, MC, USA, LTC Christian Meko, MC, USA, COL Kelly A. Murray, MC, USA, COL Mary “Cathy” Nace, MC, USA, COL Peter E Nielsen, MC, USA, LTC Aaron C. Pitney, MC, USA, MAJ Timothy Switaj, MC, USA, COL Chuck Callahan, MC, USA, COL Leon E. Moores, MC, USA

“The one quality that can develop by strenuous reflection and practice is the leadership of men.”
General of the Army Dwight David Eisenhower

Background

A sound leadership education program is the foundation upon which all other components of Medical Corps leadership development are built. This program will adhere to several key principles: This program 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 and an introduction to strategic thinking for mid-grade officers, tailored developmental programs for senior officers, and establishment of a Medical Corps Leadership Consultant and Leadership Develop 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 for either catch-up or review 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 career.

Mid-grade officers need both practical executive skills training specific to AMEDD managerial and business practices as well as strategic level training to prepare them to assume

senior leader positions. The AMEDD and MHS both offer several, but 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 pre-existing 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 proponent 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 MEDCOM. The basic lessons that compose this curriculum can be found at Appendix 3.

The AMEDD-specific Executive Skills curriculum provides multiple opportunities for Medical Corps officers to participate both on-line and at specific Executive Skills sessions tied directly to position-specific training courses (e.g. the Brigade /Division Surgeon's Course). This program is found at <http://www.cs.amedd.army.mil/jmesi.aspx>.

The AMEDD has well-designed Masters in Business Administration programs at Baylor University and USUHS however its two-year, full-time curriculum presents a challenge for Medical Corps officers. Many universities offer executive level Masters in Business Administration 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 the 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 have to be sought and obtained.

While the AMEDD-specific Executive Skills curriculum program provides standardized tactical-level AMEDD specific executive skills ideal for mid-career 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 being 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 for 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. Selection boards should be instructed to consider executive skills courses 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 to 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 HPSP undergraduate requirements. Ensure that all students rotating at military treatment facilities participate in intern leadership development opportunities.

Consider offering a 2 or 4-week leadership elective during medical school sponsored by entities such as AMEDD Center and School, U.S. Army Medical Command (MEDCOM) Headquarters, or OTSG.

Create a leadership program within existing GME programs, with a curriculum specific to the level of the individual and flexible 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 distance learning cannot completely replace hands-on, personal interaction with senior leaders through structured and spontaneous interaction.

This training will meet the ACGME program requirements for program or institutional level training, which should help in garnering buy-in from program directors and leaders within GME.

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

Intermediate Term (1-2 year) Goals

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

Mid-grade Executive Skills

Mid-grade 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 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 can be found at <http://www.physiciansmoneydigest.com/lifestyle/Top-10-Business-Graduate-Schools-for-Physicians>.) A program, as well as a funding source, will need to be developed to select mid-grade officers for these opportunities. Medical corps officers will be selected through a formal board process. The CCC will be prerequisite, and these opportunities will be available prior to ILE or in concert with ILE. Selected officers would be highly competitive for MEDCEN Department Chief, DCCS, 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 more junior Medical Corps officers.

Shorten the Captain's 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 CME

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 CME 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 mentees a complete picture of the opportunities available to them.

Develop training opportunities for mentors to allow them 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 mentees 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 mentees when they take such inventories.
- Training on reviewing current or future 360-degree evaluation schemes to be able to provide this critical feedback to mentee.

Conclusions

The Medical Corps Leadership Curriculum plan is the foundation upon which many of the other aspects of the Medical Corps Leadership 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 in order 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.

Scenario:

Chapter Three: The Foundation

Provide Leadership Education

You agree that some of the most important teaching that you can pass on to your residents and medical students as to do with 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 would recommend reading is Primal Leadership: Realizing the Power of Emotional Intelligence by Daniel Goleman. 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 EI 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 easy to understand 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 NICU. That lesson is that your leadership of your small team create 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.

Colonel Mark W. Thompson, United States Army Medical Corps
Commander, Ft. Drum MEDDAC

Scenario:

Chapter Three: The Foundation

Provide Leadership Education

You agree that some of the most important teaching that you can pass on to your residents and medical students as to do with 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?

When General (Ret) Hugh Shelton was Chairman of the Joint Chiefs, he required the other Chiefs of Staff to read Dereliction of Duty: Lyndon Johnson, Robert McNamara, the Joint Chiefs of Staff, and the Lies That Led to Vietnam by H. R. McMaster. The book describes how President Lyndon 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 policies 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 Viet Nam. One can draw parallels to young mid-level 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 US Special Operations command back in the mid-nineties. 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 ticked off at what initially sounded like a flippant comment, he elaborated by saying that his genes, his rearing, his life's 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 on these, and always remember the people and families we serve. That conversation remains with me to this day.

Colonel Bret T. Ackermann, United States Army Medical Corps
Emergency Medicine Physician Tripler Army Medical Center
Former Commander, 121st Combat Support Hospital / Brian Allgood Army Community Hospital

Scenario:

Chapter Three: The Foundation

Provide Leadership Education

You agree that some of the most important teaching that you can pass on to your residents and medical students is to do with 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?

There's one book that is a must-read for any military officer and leader, and almost universally appears on the Chief of Staff's or Commandant's required reading list for new officers. Anton Myrer's work, Once an Eagle. The novel is over forty years old, yet simply and elegantly demonstrates the differences between a leader who provides a continual focus on his mission and his men (the protagonist, Sam Damon), and another senior officer (the antagonist, Courtney Massengale) who focuses his entire career on himself and his own ambition, regardless of human cost or morale. The novel follows their parallel fictional 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 and these two metrics are inseparable. Our Army, and our AMEDD, is 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 come to the forefront.

A secondary corollary is a simple maxim: never ask (or direct) a subordinate to do something you won't do, can't do, or wouldn't be willing to learn how to do yourself. You may have never performed a complex surgical procedure yourself, but as a CSH DCCS you should spend time in the OR, scrubbed in. You may not know how to perform daily Preventive Maintenance Checks and Services on a military vehicle, but as a PROFIS Field Surgeon 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.

Colonel Frank L. Christopher, United States Army Medical Corps
Deputy Commander for Clinical Services Womack Army Medical Center Fort Bragg, NC

Appendix Chapter 3: Grassroots Leadership Development Program

Leadership should be a required bullet on OERs, starting as an intern. This would inculcate and remind all officers that they are called to be leaders. Some examples of ways to facilitate leadership activities include:

Experience- give them the experience of leadership in different areas

Administrative- i.e. managing the phone calls, scheduling procedures

Clinical- i.e. being responsible for clinic, huddling with nurses

Education- i.e. planning a 10 minute chalk talk before clinic twice a week, giving weekly in-service to nurses

Research- i.e. leading a PI project, or requirement to develop a protocol

Reading from the required reading list, discussions with the mentor

Co-lead or facilitate a monthly discussion group

Work across-specialty to develop multi-disciplinary clinical teams

Develop combined conferences, or discussion groups (above) with other departments or other branches

Participating in mentoring as mentor or mentee

Ongoing Leader Development Discussion/ Resources:

These modules have been used at many military treatment facilities for the past decade to frame a one hour discussion about topics in leadership. They are presented in the general order one might use to introduce a leadership curriculum. These have worked best as informal sessions or seminars with introductory comments from a facilitator followed by the video clip and then a dialogue about the video centered around the leadership principles demonstrated in the clip. Points from the article can then be presented but in practice the participants often read the article after the session rather than before. In most organizations participation has been voluntary.

A “Leadership@Lunch” leadership development series can be started and facilitated at any level of the organization. The time of day and frequency of the sessions will depend on the organization’s battle rhythm. The sessions work best if they occur at a predictable, regular time and that means that having co-leaders of the sessions (to assure that they happen regularly) increases their success.

Since this series was started in 2000 at Tripler Army Medical Center many of these film clips can now be found on Youtube and other commercial websites in the public domain including the popular leadership website “TED.” Another popular source is “Americanrhetoric.com” for famous speeches and leadership movie clips. Several such links are included in this resource list.

Reference: Callahan C, Thompson M. AMEDD Leadership Development: From the Grass Roots Up. AMEDD Journal 2007; PB 8-07-10/11/12 p. 19-25.

What is a Leader?

Reading: Heifetz R. Laurie D. The work of leadership. Harvard Business Review January 1997

Video: Invictus (Scene 9 Invitation)

Imperatives of Leadership

Reading: Callahan, CW. Imperatives of Leadership: Henry at Agincourt. Military Review. May-Jun 1999; 88-90.

Video: Henry V (Scene: 28 For England. Speech prior to battle at Agincourt)

Emotional Intelligence- Introduction

Reading: Goleman, D. What makes a leader? Harvard Business Review. Jan 2004, pg 82-91.

Video: Gettysburg (Scenes: 8-10: Prisoner Delivery/Used by idiots/What we’re fighting for)

Emotional Intelligence – Styles of Leadership I

Reading: Goleman, D. Leadership that gets results. Harvard Business Review. March-April, 2000, pg 78-87.

Video: Miracle (Scenes 14 & 16: I am a Hockey Player / This is Your Time)

Emotional Intelligence – Styles of Leadership II

Reading: Goleman, D. Leadership that gets results. Harvard Business Review. March-April, 2000, pg 78-87.

Video Lord of the Rings: The Two Towers (Disc 1 Scene 29: The King’s Decision), Lord of the Rings: The Return of the King (Disc 2 Scene 69: The Last Debate)

Emotional Intelligence – Styles of Leadership III Mentoring and Coaching

Reading: The Army Mentor Handbook

Video: Gettysburg (Scene 5, Side B: Lee admonishes Stuart)

Mentoring and CEO Succession

Reading: “Ending the CEO Succession Crisis” Ram Charan, Harvard Business Review Feb 2005, pp72-82.

Video: Master and Commander (Scene 23 Hollom’s Weakness)

The Leadership Moment: COL Joshua Chamberlain at Little Round Top

Reading: “Joshua Lawrence Chamberlain Defends Little Round Top.” The Leadership Moment. Michael Useem. Pg 127-152.

Video: Gettysburg (Scenes 28-35, Little Round Top – Name to Remember)

Integrity – The Case of Nathan Jessup – Part 1

Reading: “Maintain absolute integrity.” The Stuff of Heroes. William A. Cohen. Longstreet Press, Atlanta, GA. 2001. Pg 9-39.

Video: A Few Good Men (Scenes 25-28, Jessup Takes the Stand – The Verdict.)

Integrity – The Case of Nathan Jessup – Part 2

Reading: “Rethinking Integrity.” Stratford Sherman. Leader to Leader, No. 28 Spring 2003.
<http://www.accompligroup.com/resources/details.php?a=1&id=13>

Video: A Few Good Men (Scene 5, COL Jessup)

Vision and Getting the Big Picture: BG John Buford at Gettysburg

Reading: John Buford and the Gettysburg Campaign.

<http://www.gdg.org/Research/People/Buford>

Video: Gettysburg (Scene 10, Side A: Bloody Moment Ahead)

Vision: Communicating the Future

Reading: Goffee R, Jones G. “Why should anyone be led by you?” Harvard Business Review Oct 2000.

Reading: Patton’s Speech to the Third Army <http://www.taphilo.com/history/Patton-speech.shtml>

Video: Patton (Scene 1: Stars and Stripes)

Leading Your Peers

Reading: Blumenson, M., Stokesbury, J.L. “Eisenhower.” Masters of the Command. Houghton Mifflin, 1975. Pages 287-303.

Video: Ike: Countdown to D-Day (Scenes 3 & 6 Patton Problem & A Plan Unveiled)

Accountability

Reading: Levinson H. Management by whose objectives? Harvard Business Review January 2003.

Video: The Thin Red Line (Scene 20 Nature’s Order) Ike Countdown to D-Day (Scene 5 Loose Lips)

Building a team: Sir Ernest Shackleton

Reading: “Epic of Survival Shackleton”. Caroline Alexander. National Geographic, November 1998, pg 83-101.

Video: Shackleton (Disc 1, Scene 8: Setting Sail)

Facing Down Conflict: Sir Ernest Shackleton

Reading: “Epic of Survival Shackleton” Caroline Alexander. National Geographic, November 1998, pg 83-101

Video: Shackleton (Disc 2, Scene 6: Breaking Point)

Optimism: Sir Ernest Shackleton

Reading: "Epic of Survival Shackleton" Caroline Alexander. National Geographic, November 1998, pg 83-101

Video: Shackleton (Disc 2, Scene 8: On the Edge)

Crisis Resource Management

Reading: "Crisis Management" Anesthesiology. Gaba DM, Fish KJ, Howard SK. New York, NY: Churchill Livingstone; 1994, pg 37-44

Video: Apollo 13 (Scene 19, Houston, We have a problem....)

Toxic Leadership

Reading: Reed GE "Toxic Leadership." Military Review, Jul-Aug 2004, pg 67-71.

Video: Band of Brothers (Disc 1 Currahee: Scene 2, Anything but Easy. Scene 5, Trial by Court Martial)

Servant Leadership

Reading: "Servant Leadership." Robert K. Greenleaf. Insights on Leadership. Pg 15-28.

Video: Gandhi (Disc 1, Scene 10)

Resonance and Dissonance in Leadership

Reading: Callahan C. Resonance and Dissonance in Leadership. AMEDD Journal 2009;PB 8-09-10/11/12 pp. 32-36.

Video: 12 O'Clock High (Scene 6 The New Commander)

Narrative and Leadership

Reading: Irving Telos, chronis and hermenia: The role of the metanarrative in leadership

http://www.ualberta.ca/~iiqm/backissues/3_3/html/irvingklenke.html

Video: Renaissance Man (Scene 4 Everyone's Got a Story)

Communicate the Mission

Reading: Senek "Start with Why" (Introduction and Chapter One)

<http://www.youtube.com/watch?v=qp0HIF3SfI4>

Video: The Thin Red Line (Scene 3 The Closer to Caesar)

Aligning Forces

Reading: Soldier, Statesman, Peacemaker – Leadership Lessons from George Marshall Chapter 3

<http://www.collegeoptionsfoundation.net/Soldier%20Statesman%20Peacemaker.pdf>

Video: Ike: Countdown to D-Day (Scenes 6 A Plan Unveiled)

Getting Resources

Reading: Soldier, Statesman, Peacemaker – Leadership Lessons from George Marshall Chapter 5

<http://www.collegeoptionsfoundation.net/Soldier%20Statesman%20Peacemaker.pdf>

Video: Glory (Scene 14 600 shoes)

Motivating

Reading: Herzberg F. Harvard Business Review How do you motivate employees? January 2003

Video: Friday Night Lights (Scene 27 Halftime)

Leading for Loyalty

Reading: Reicheld F. Leading for Loyalty. Harvard Business Review July 2001

Video: Spartacus Scene, "I'm Spartacus" http://www.youtube.com/watch?v=-8h_v_our_Q

Solving Problems

Reading: Oncken W. Wass DL. Management Time: Who 's got the monkey? Harvard Business Review November 1999.

Video: U571 (Scene 11, 12 Sailing to England, Real Sea Captain)

Transition Strategy: The Turnaround

Reading: Watkins M. Picking the right transition strategy. Harvard Business Review January 2009.

Video: Hoosiers (Scene 5 First Practice)

Transition Strategy: Sustain

Reading: Watkins M. Picking the right transition strategy. Harvard Business Review January 2009. Palmisano SJ. Leading change when business is good. Harvard Business Review December 2004.

Video: Friday Night Lights (Scene 2 Preseason)

Transition Strategy: Transform

Reading: Watkins M. Picking the right transition strategy. Harvard Business Review January 2009.

Heifetz R. Laurie D. The work of leadership. Harvard Business Review January 1997

Video: Remember the Titans (Scene 10 Lessons from the Dead)

Transition Strategy: Start-up

Reading: Watkins M. Picking the right transition strategy. Harvard Business Review January 2009.

Kotter J. What leaders really do. Harvard Business Review December 2001.

Video: Glory Road (Scene 12 Pep Talk)

Reinforce with Praise

Reading: Livingston J. Pygmalion in management. Harvard Business Review January 2003.

Video: Laura Trice http://www.ted.com/talks/laura_trice_suggests_we_all_say_thank_you.html

Leading Change

Reading: Kotter J. Why transformations fail. Harvard Business Review March 1998.

Video: Lord of the Rings, The Two Towers (Scene The Mines of Moria)

<http://www.youtube.com/watch?v=vrlTeoFcf-Q>

Teach and Develop

Reading: Prentice. Understanding leadership.

Video: Master and Commander (Scene 23 Hollom's Weakness)

Enabling Others

Reading: Reicheld F. Leading for Loyalty. Harvard Business Review July 2001

Video: Hoosiers (Scene 5 First Practice)

How Leaders Think

Reading: Martin, R. How Successful Leaders Think. Harvard Business Review, June 2007.

Groopman, Jerome. How Doctors Think. Houghton-Mifflin, 2007.

Video: Scenes from House – TV Show

The Tipping Point

Reading: Gladwell, M. The Tipping Point, Chapter 1 – The Three Rules of Epidemics, pg 15-29.

Video: Hoosiers (Scene 18 Passing to Shooter, Scene 22 Kick Me Out)

Followership

Reading: "Followership in a Leadership World. Kelley, R. Insights on Leadership. Pg 170-184.

Video: The Princess Bride (Scene 4/5/6 – Rhyming Robbers, The Shrieking Eels, Cliffs of Insanity)

Generational Sociology

Reading: Wong L. Generations Apart: Xers and Boomers in the Officer Corps.

Video: The Graduate (<http://www.youtube.com/watch?v=2EIUV1Zn-r4&feature=related>) The Fight Club <http://www.youtube.com/watch?v=gfwsfdkMoac&feature=related>

Appendix Chapter 3: Suggested Reading List

Leadership Foundations:

Covey, Stephen. Seven Habits of Highly Effective People. 1989 Simon and Schuster

A must read for everyone at some point in their adult life

Covey, Stephen. Principle-Centered Leadership. 1992. Simon and Schuster

Excellent analysis of principle-based leadership

Goleman, Daniel. Primal Leadership. 2002 Harvard Business School Press

Examining the role of emotional intelligence and leadership

Goleman, Daniel. Working with Emotional Intelligence. 2000 Bantam Books.

Foundations of the idea of work, leadership and EI.

Maxwell, John. The 21 Indispensable Qualities of a Leader. 1999 Thomas Nelson

Short summaries of leadership qualities

Maxwell, John. The 21 Irrefutable Laws of Leadership. 1996 Thomas Nelson

Short summaries of leadership laws

Green, Robert K. Servant Leadership. 1977 Paulist Press

A classic study on the servant style of leadership

Intermediate Level Leadership:

Keegan, John. The Mask of Command. 1987 Penguin Books

Excellent analysis of historical styles of leadership

Bennis, Warren On Becoming a Leader. 1989 Addison-Wesley Publishing Co.

A business world classic

Phillips, Donald T. Lincoln on Leadership. 1992 Time Warner Books

The first of the "...on leadership" biographies, and the best

Cohen, William A. The Stuff of Heros. The Eight Universal Laws of Leadership. 1998
Longstreet

A general officer survey of generals and what they think leadership means

Giuliani Rudolph. Leadership. 2002 Hyperion.

Surprisingly good survey on leadership in action.

Goleman Daniel. Social Intelligence: The New Science of Human Relationships. 2006 Bantam.

Ties together emotional intelligence with new neurobiology research.

Take Command. Leading your Organization:

Abrashoff, Michael. It's Your Ship. 2002 Business Plus.

Unique perspective on taking command

Watkins Michael. The First Ninety Days 2003 Harvard Business Press

Keys to successful leadership in a new organization

Labovitz G, Rosansky V. The Power of Alignment 1997 Wiley.

"The main thing is to make the main thing the main thing."

Buckingham M, Coffman C., First Break All the Rules: What the World's Greatest Managers do Differently. 1999 Simon and Schuster

Well researched survey of managing to talents not weaknesses

Buckingham M, Clifton D. Now Discover Your Strengths 2001 Free Press

Identifying your unique leadership talents

Buckingham M. the One Thing You Need to Know 2005 Free Press

Finding that "one thing" that is the key to everything that you do.

Collins Jim. Good to Great 2001 Harper Business

What leadership looks like in some of America's top businesses

Hofstede G, Hofstede GJ, Minkov M. Cultures and Organizations: Software of the Mind. 2010
Definitive work on intercultural cooperation provides insight into differences between military services.

Sinek, Simon. Start with Why. How Great Leaders Inspire Everyone to Take Action. 2009.
Portfolio *The key to inspiration in leadership is knowing “why.”*

Leading Health Care Organizations:

Stubblefield, Al. The Baptist Health Care System Journey to Excellence. 2004. Wiley.

How one health care system was recreated around central themes.

Studer, Quint. Hardwiring Excellence: Purpose, Worthwhile Work, Making a Difference. 2004.
Fire Starter Publishing

Creating change in health care system reformation.

Lee, Fred. If Disney Ran Your Hospital: Nine and One Half Things You Would Do Differently.
2004. Second River Healthcare

Creating a culture of customer service in health care.

Studer, Quint. Results that Last. 2007 Wiley

Insuring enduring change in health care system reformation

Berry, Leonard, Seltman Ken. Management Lessons from Mayo Clinic: Inside one of the World's Most Admired Service Organizations. 2008 McGraw Hill

Insight into the management of the world's most powerful health care brand.

Nance, John. Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care. 2008 Second River Healthcare Press.

Well written fiction story of a “burned” CEO's journey toward safety and quality.

Christensen, Clayton M. The Innovator's Prescription: A Disruptive Solution for Healthcare
2008. McGraw-Hill

The application of “disruptive technology” on healthcare innovation.

Clifton, Guy L. Flatlined: Resuscitating American Medicine. 2008 Rutgers U Prss

Hard facts and ideas on how to change American medicine.

Gawande, Atul. The Checklist Manifesto. 2009 Metropolitan Books.

Checklists, protocols and the future of medicine: reducing variance.

Leadership Lessons from History

Myrer, Anton. Once an Eagle. 1968. Berkley Publishing

Classic fiction work about two conflicting styles and motives for leadership

Ambrose, Stephen. Undaunted Courage. 1996 Simon and Schuster

How about leadership in the Lewis and Clark expedition?

Keegan, John. The Face of Battle. 1976 Penguin Books

Summary of warfare through the ages from the eyes of soldiers

Shackleton, Ernest. South. 1998 (Reprint) Carroll & Graf Publishers

Unequaled leadership example from turn of the century

Lansing, Alfred Endurance 1999. Basic Books

Ernest Shackleton's story of survival in the South Atlantic. A story every leader should know.

Goodwin, Doris R. Team of Rivals. 2005. Simon and Schuster

Lincoln's success in creating his administration.

Ambrose, Stephen. Eisenhower. 1990. Touchstone Book

One of the best biographies of this great leader...very readable.

Perret, Geoffrey. Old Soldiers Never Die: The Life of Douglas MacArthur. 1996 Adams Media

Another excellent, readable biography of a great American leader

Manchester, William. The Last Lion: Winston Churchill. 1983 Delta Publishing

Two part volume on the most influential man of the 20th Century

Ambrose, Stephen. Citizen Soldiers 1997 Simon and Schuster

Ambrose's best analysis of American soldiers in WWII

Slim, Field Marshal Viscount. Defeat into Victory

How to admit to and learn from mistakes, do much with little, never give up, and the power of a commander who believes in preventive medicine in the worst environment.

Frankl, Viktor. Man's Search for Meaning

Dr. Frankl is a psychiatrist who spent years in a concentration camp during WWII

Masters, John. The Road Past Mandalay. 1961. Bantam Books

One of the very best stories of medicine in war, set in WWII Burma

Moore, Harold G. We Were Soldiers Once and Young. 1992 HarperPerennial

Great overview of Ia Drang Battle and the naïve American Army entrance to Vietnam

Perret, Geoffrey. A Country Made by War. 1989 Random House

Excellent overview of American military history through Vietnam, very readable.

Peters, Ralph. Fighting for the Future. 1999. Stackpole Books

Thought-provoking look at the future battles of the US Military

Kitfield, James. Prodigal Soldiers. 1995 Brassey Publishing

Excellent analysis of the US Military between Vietnam and Gulf War I

Bowden, Mark. Blackhawk Down. 1999 Atlantic Monthly Press

Best analysis of urban warfare in a developing country...look at the medical challenges

Priest, Dana. The Mission. 2003. W.W. Norton

The American Military's mission in the '90's.

McCain, John. Faith of my Fathers. 1999 Random House.

Biography of an American Pilot's time as a prisoner of war.

Shay, Jonathan. Achilles in VietNam, 1994 Touchstone.

PTSD in the story of the Iliad.

Weisskoff, Michael. Blood Brothers. 2006 Henry Hunt and Company.

Story of a Time Magazine correspondent's care at Walter Reed

Heinlein, Robert. Starship Troopers. 1959. Berkley Publishing

Classic science fiction work about duty and leadership (much better than the movie!)

Pressfield, Steven. Gates of Fire. 1998. Doubleday

Tremendous historical fiction on Battle of Thermopylae and Warrior Ethics

Chapter Four

Mentorship and Coaching

“Apprenticeship Refined”

COL Erin P. Edgar, MC, USA, COL Mark W. Thompson, MC, USA, COL Bret T. Ackermann, MC, USA, COL George Appenzeller, MC, USA, MAJ Robert J Cornfeld, MC, USA, COL James R. Ficke, MC, USA, COL David K Hayes, MC, USA, COL Joseph F. McKeon, MC, USA, LTC Christian Meko, MC, USA, COL Mary “Cathy” Nace, MC, USA, COL Michael R. Nelson, MC, USA, LTC Aaron C. Pitney, MC, USA, MAJ Timothy Switaj, MC, USA, COL Chuck Callahan, MC, USA, COL Leon E. Moores, MC, USA

To a Mentor:

“Your conduct and counsel were guiding lights – beacons of sensibility. Your intensely bright spirit illuminated the unkempt areas of my life so that I might tidy them. Your leadership has served as the highest standard by which I strive to achieve. Your friendship has been a gift forever to be coveted. To be sure, I am better now for having known you.”

An Army Medical Corps graduating resident

Background:

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 mentee 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 alongside more senior clinicians until the senior clinician felt the young physicians were ready to strike out on their own. 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 has held true for junior clinical investigators whose success has been tied to 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 when needed into potential career opportunities as they 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 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, the author of *The Coaching Manager*, describes coaching as assisting executives who “want to get over there, but [are] not sure how to do it.” 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 five new departmental executive officers in the University of Iowa Carver College of Medicine were offered executive coaching at the start of their new positions (Geist.) The executives desired assistance in improving their skills in facilitating institutional change. At the conclusion of 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 (DCCS, MTF and TOE commanders, etc.) receive executive coaching via a centrally administered program.

These programs, while complementary in nature, 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.

Current State

Many informal mentor-mentee 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) Goals

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 down below the MEDCEN 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 arenas in previous assignments equips the leadership consultant with a wide breadth 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 “students” 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 Individual Development Action Plan from the Army Mentorship Handbook). 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) Goals

Establish Mentor Training Opportunities

Mentors will be prepared to teach protégés in both general and specific terms (i.e. from the potential career opportunities and nuances of leadership to the nuts and bolts of ORBs and OERs). They will be prepared to speak to the importance and timing of the Officer Education System to include Basic Officer Leadership Course, if not already completed, the Captain's Career Course, Intermediate Level Education, and Senior Service School.

Mentors will expose junior Medical Corps officers to career opportunities that are available after training (e.g. 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 mentees to operational units during residency.

Junior Medical Corps officers need to familiarize themselves with the organization of the DOD, the Army Medical Department, 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 these 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 mentees 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 mentees. The following list is a start and will be expanded as necessary: Association of Military Surgeons of the United States (AMSUS) Medical Strategic Leader Program, Association of the United States Army (AUSA, both the 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 stand-alone course, identified mentors will receive training that covers some of the key mentorship essentials.

Long Term (3-5 year) Goals:

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 Building the Bench 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, for example, should significant difficulties in performance or organizational challenges develop during the course of a leadership tour.

Conclusions:

The Medical Corps needs 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 two 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.

Scenario:

**Chapter Four: Apprenticeship Refined
Mentorship and Coaching**

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. 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 AR 40-501 (Standards of Medical Fitness) 600-60 (Physical Performance Evaluation System) parts of 40-400 (Patient Administration) and 635-40 (Physical Evaluation for Retention, Retirement, or Separation). Additionally, I would point the officer to the latest medical command orders related to the Integrated Disability Evaluation System (IDES). The Commander must assure that the system is functioning fairly, efficiently and with a Soldier-focus, 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 mentee 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 in new roles, need both.

Finally, as a fellow officer, mentor or friend, you need to ask the hard question: "What are you really concerned about?" There is likely more to the story in this case than just 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 need to find out why and address the concerns and provide ongoing support, advice and an unbiased ear when needed. That is what a mentor and a coach is for.

Colonel George Appenzeller, United States Army Medical Corps
Commander, USA MEDDAC-Alaska

Scenario:

**Chapter Four: Apprenticeship Refined
Mentorship and Coaching**

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. 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?

I can't imagine myself refusing to be a mentor to someone, unless I knew that we viewed the world through incompatible lenses, if so 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, AR 40-501 is being overhauled, so more will probably change. I would share my secret of success: five minutes 'lead time' and an internet connection. It's amazing how smart one can seem given those two. 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'm 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 SMEs, when really it's the grunts in the field who best understand the process. As a younger doc, I almost always tried to figure it out on my own. Not only is that approach time consuming, but one often doesn't 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 both 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.

Colonel Joseph F. McKeon, United States Army Medical Corps
Director, US Army Aeromedical Activity
Consultant to the Surgeon General in Aerospace

Appendix Chapter 4: Mentoring Notes and Discussion Scenarios

Excerpt from the Army Mentorship Handbook:

What is Most Important in a Mentoring Relationship?

Both the mentor and the mentee must want the relationship to work. Watch for signs of “lopsided” mentoring: both the mentor and the mentee should be committing appropriate time and energy to the process. Five things are essential:

1. Respect - established when a mentee recognizes attributes, skills, and competencies in the mentor that he or she would like to possess; and when the mentor appreciates the success of the mentee to date and the mentee’s desire to develop his or her attributes, skills, competencies, capabilities, experiences, and value to the Army.

2. Trust - is a two-way street. Mentors and mentees should work together to build trust, through communicating, and by being available, predictable, and loyal.

3. Partnership Building - The mentor and mentee are professional partners. Natural barriers that all partnerships face may include miscommunication or an uncertainty of each other’s expectations. Activities that can help you overcome these barriers include:

Maintaining communication

Fixing “obvious” problems

Forecasting how decisions could affect goals

Frequent discussion of progress

Monitoring changes

Successful partnerships develop through:

The expression of enthusiasm each has for their relationship.

Activities of idea exploration and successful problem solving which create an atmosphere of emotional acceptance of each other.

Strategies and tactics of change that move slowly enough to be monitored and adjusted to assure optimum growth and success of the mentee.

4. Realistic Expectations and Self Perception - A Mentor should encourage the mentee to have realistic expectations of:

Their own capabilities

Opportunities in terms of present and potential positions

The energies and actions the mentor will commit to the mentoring relationship

What the mentee must demonstrate to earn the mentor's support in his or her personal/professional/career development

A mentor may help define the mentee's self perception by discussing social traits, intellectual abilities, talents, and roles. It is important for the mentor to always provide **honest** feedback.

5. Time - Set aside specific time to meet; do not change times unless absolutely necessary. Meet periodically, and at mutually convenient times when you can control interruptions. Frequently "check in" with each other via informal phone calls or e-mail (it's a good idea to schedule even informal activities to assure regular contact).

Mentoring Scenarios for discussion:

This fictional pair of officers and the scenarios that follow can be used for a discussion about the challenges of mentorship, especially when the junior and senior officers are in the same "chain of command." Goals for the discussion would be to address the differences between coaching and mentoring and how the generational differences between the younger and older physician affect their ability to relate to and understand one another.

The "Mentor"

COL Chip Carron was born in 1957, putting him right at the end of the "baby-boomer" generation. His parents raised him to do his duty. He watched "Combat" and "Twelve-O'Clock High" on television. As a boy, he loved the movie "Patton." He was told that he could best serve others by being a priest or a doctor, and since he wanted to have a family, he chose the latter. He paid for medical school with a health professions scholarship and finished a medicine residency in 1986 at the age of 29, spending over one hundred hours a week in the hospital. He moved steadily through the ranks with his nose to the grindstone, working long hours caring for

patients at several different Army hospitals until he returned to the Medical Center after his pulmonology fellowship. He became department chief soon after his promotion to Colonel in 1998. He continues to work long hours in his practice, running the department and serving on several hospital committees. When he is not working, he spends time with his kids, jogs or works around his house. He has little patience for the younger staff and residents who seem so focused on the “80-hour work week.” He has told more than one person who raised concerns in meetings is that he “doesn’t want to hear about it.” And after seven years as Chief, he rarely does.

The “Mentee”

MAJ Carlos Cunningham is a recently trained pulmonologist assigned to COL Carron’s department. Carlos was born in 1973 to parents who both worked, typical of a member of “generation X.” He had more than enough of everything growing up, but rarely saw his parents except for regularly scheduled “quality times” on infrequent family vacations. Although his parents could have put him through medical school, he chose the health professions scholarship so he would not have to depend on them. His parents divorced after he started medical school. When he is not at work, he plays with the X-Box video system his girlfriend bought him last Christmas and kayaks. He is a brilliant, aggressive intensivist, passionately devoted to his patients. Last summer he became Director of the Intensive Care unit at the medical center. He has a temper and his Chief has had to intervene with nursing over allegations that he has shouted at and berated nurses in person and on the phone. The Pharmacy Chief has the same concerns. When confronted, he shrugs off the concerns, explaining to his Chief, for whom he has little respect that he was standing up for patient care and “doesn’t want to hear about it.” Unfortunately, it is something that he has to hear about often.

Questions:

- What challenges do you anticipate COL Carron to encounter in his efforts to be a mentor to MAJ Cunningham?
- Because he is in MAJ Cunningham’s chain of command, can he really be his mentor?
- What is the difference between mentoring, coaching and providing feedback? Which do MAJ Cunningham need?
- How do the generational differences (Baby Boomer vs. Generation X) affect this relationship?

Resolving Professional Conflict

COL Williams, the hospital Chief Nurse, took COL Carron aside after a department chief’s meeting.

“You have got to do something with Dr. Cunningham. He had a Lieutenant in tears last weekend, and I had her section chief in my office this morning. He has got to learn how to get along with the other members of the team.”

COL Carron had heard it before, and was not clear on what to do next. He decided to approach the Surgery Chief and ask his approach:

“Surely, this is a problem he has dealt with before.”

Career Advice

MAJ Cunningham stopped into COL Carron’s office at the end of a day for advice.

“Sir, I had a question I thought you might help me with. I like my Unit Director job fine, but the program director’s job at Walter Reed is open this summer and I was wondering what you thought about that opportunity? I was also contacted by branch about the in-residence Intermediate Level Education Course somewhere in Kansas. Do you know about that? Do you have any thoughts on what you think I should do? What would you do?”

Personal and Professional Feedback

One of COL Carron’s staff members stopped him in the hallway on his way to the unit.

“Chip, do you know about Carlos and Marsha?”

“Marsha the senior resident, that Marsha,” COL Carron answered.

“Yes. That Marsha. Did you know that they were seeing each other?”

“No...but that shouldn’t surprise anyone. I am always the last one to know anything. How long has it been going on?”

“Pretty much all year,” the staff member answered. “What are you going to do about it?”

Dr. Carron was still lost in thought. “I thought he had a girlfriend who bought him some game-box something? What happened to her?”

“Chip, Marsha bought him the Xbox. Everyone in the department knew that. Didn’t you?”

He didn’t. There was a lot about his young mentee he apparently didn’t know. He scheduled an appointment to meet with him that afternoon.

Chapter Five

Identify, Recruit, Build Experience “Building the Bench”

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“Leadership, like swimming, cannot be learned by reading about it”
Management Professor Henry Mintzber

Background:

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 (ADP) 6-22 Army Leadership, 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 the realms of Operational, Clinical, Academic, and Hospital Administration will drive the formal training courses and leadership possibilities for the mid-level 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 5-7 years (or 1-2 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 AMEDD.

Successes

Many structured leadership programs (Basic Officer Leadership 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 (POIs) in place.

Military GME programs are among the best in the world as measured by board certification pass rates and in addition already teach military-unique curricula. These officers are clinically well prepared to practice within their specialties.

Informal mentoring, and in some cases formal mentoring, is common in MEDCENs 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 "schoolhouse" formalized training opportunities because the timing is not synchronized with the AMEDD timelines due to other training realities (residency, fellowship, board certification).

It is not clear what targeted experiences are necessary to qualify for specific leader roles. Other Army Competitive Category Corps have positions which are considered 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 are not required to progress professionally and earn promotions. Chief Resident, Brigade/Division Surgeon, Service/Department Chief, and DCCS 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 AUSA, MHS, and GME selection boards may allow 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.

Incentives do not exist 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, and people) to manage a program of leader succession.

Closing the Gaps

Short Term (6-12 month) Goals

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 ones from extracurricular leadership roles such as officers in parent-teacher student organizations, civic organizations, and professional societies. Documents needed 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 Uniformed Services University or 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 Health Profession Scholarship Program will be identified at the earliest point in their medical education. Typical proponents for this portion include program director, service chiefs and MTF 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 or have served in the Reserve Officer Training Programs (ROTC,) 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 JSGMESB is an opportunity for program directors to identify residents, and Department Chiefs to identify junior staff that has 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 0-6 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 Army Medical Department (AMEDD) and non-AMEDD officers selected by the Commanding General, US Army Medical Command / Army Surgeon General with recommendations from the Consultants to the Surgeon General, GME directors, Commanders, and the Medical Corps Chief.

Physicians who have demonstrated interest in visiting medical schools and premedical programs to recruit for the 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 OTSG, promotion and command boards (below the zone promotions, Command Select List - CSL - 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 Human Resources Command (HRC) graduate medical education (GME) program directors, and OTSG consultants to provide the career path development required to be successful senior leaders in the AMEDD.

A progressive curriculum needs to be developed which identifies junior officers with leadership potential and then provides the necessary formal and informal leadership skills development and opportunities to develop into mid-level leaders and then 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 mid-level 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 approximately 25% of Medical Corps Captains, 20% of Majors, 15% of Lieutenant Colonels, and 10% of Colonels and actively manage their careers.

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 (LTHET) through the Baylor University program or

in other Army-sponsored programs should be made accessible to mid-level 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 come 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 which will 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 these 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 ILE, early DCCS positions, opportunities to attend Baylor program, etc.

Identified leaders will be provided 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 Masters of Medical Management Degrees. In addition, the opportunity to participate in non-AMEDD courses will allow interactions with non-physician leaders who may identify a potential leader that is sometimes not 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 MEDDAC or MEDCEN and would include such topics as: managing the Table of Distribution and Allowances (TDA), human capital distribution and labor relations, basics of Lean Six Sigma, the interaction between the MEDCEN 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 vice SSC for additional years of commitment or for agreeing to take 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 out a report card summarizing their leadership development, short- 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 hats” 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 ASI 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 (i.e. BOLC, CCC, and JMESI); “7C” would designate additional training and experience, including board certification, clinic leadership, ILE, etc.; “7B” would designate further training and experience to include BDE surgeon, FST command, Departmental leadership, residency program director, etc. Similar to the “9A” designator, award of “7A” would be approved by OTSG based on recommendation by the Medical Corps Chief and would designate a fully trained successful senior leader. 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 award of the ASI; 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.

Conclusions

Our Nation’s best and brightest have chosen to simultaneously serve two professions which embody servant 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 our health care profession in our Army.

Scenario:

**Chapter Five: Identify, Recruit, Build Experience
Building the Bench**

She is clearly the best resident you have ever seen. 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 ROTC scholarship in college and her USUHS medical school time 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 for the finish line. This resident is a high performer who will run selflessly and perhaps to her own detriment. Occasionally undirected energy benefits no one, not her, her patients or the service 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 do but this first step will allow “resonance” (pg 19-20 Primal leadership) to occur 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 (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 RRC and JMESP).

Her resident advisor should manage her but as she progresses in skill, the program director, department chief, DCCS 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 (BOLC, CCC) have been mapped out and her subsequent supervisor will have to ensure ILE (a strong transfer from the losing command) and further development are arranged.

Lieutenant Colonel Neil E. Page, United States Army Medical Corps
Deputy Commander for Clinical Services, Montcrief Army Community Hospital Ft. Jackson SC

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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) who has 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 O-6 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 AOC, to include 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 Captain's Career Course and Intermediate Level Education (ILE). Furthermore, this would also be the time that counseling is given on how to write a curriculum vitae, her officer record brief is scrubbed and she is taught how to manage this document along the way. 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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Brooke Army Medical Center /San Antonio Military Medical Center

Epilogue

Physicians must lead.

Hospitals are the sinks of human life in the Army. They have robbed the United States of more citizens than the sword.”

Dr. Benjamin Rush (Bayne-Jones)

Medicine used to be simple. Health care 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 health care 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, health care 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 health care, 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. Cecaelia’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” (Magner). Today’s medical student and resident education depends on the same system.

What happened to health care when it moved from the home to the hospital? Seventeenth and eighteenth century hospitals were regarded with dread. The sick were usually better off at home (Starr). In the hospital, the family relinquished control of the health care 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 health care delivery have not become any less complex since the eighteenth century. And yet three hundred 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 health care 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 "dis-integrated," desynchronized care to lead from chaos to patient safety.

The growth of cities in the United States between the seventeenth and eighteenth 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 (Starr).

The delivery of health care 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 health care.

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 health care 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 health care happens at home. Despite a hospital-centric approach to health care and provider education, only a relatively small number of people enter the health care system at any given time.

Health care ecology is a model that helps to describe the health concerns of a population as well as the sources of care. For example, based on national surveys for a population of 1000 people over the course of a month, 800 have medical symptoms and 327 consider seeking care. Only 217 of the thousand hypothetical patients will visit a physician's office. And only one is hospitalized in an academic teaching hospital (White, Green, Dovey). The others ignore their medical 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 health care 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 need themselves. Health care will be convenient. Telemedicine and telehealth practices will abound. Access to care will be the window, wide open, between health care 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 health care insurance or the availability of a provider visit. Future systems will redefine access. Patients and their families are busy. Health care is just one of the priorities they juggle. They see health care access differently than those who provide it. Patients desire *information* (general health knowledge) *insight* (wise interpretation and application of specific health care 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 health care visit. They would rather be at home.

Health care 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 health care team who are familiar enough with the direct provision and practice of health care both in 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 U.S. health care history. They must be able to inspire and to teach the need for change to the remainder of the health care team and the American population.

An American health care 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?

Colonel Chuck Callahan
United States Army Medical Corps

Scenario:

Epilogue: Physicians Must Lead

Post retirement you find yourself consulting for an organization working with a large civilian health care system. Your expertise is being leveraged as you help them transition to the new, required accountable health care organization guidelines. What lessons from health care 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? Who within your organization will you seek for guidance and mentorship, who 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 post-retirement as there are major aspects to health improvement and healthcare delivery. Among other things, 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 has the U.S. 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 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.

Lieutenant General (Retired) Eric B. Schoomaker
Surgeon General of the Army 2007-2011

Scenario:

Epilogue: Physicians Must Lead

Post retirement you find yourself consulting for an organization working with a large civilian health care system. Your expertise is being leveraged as you help them transition to the new, required accountable health care organization guidelines. What lessons from health care 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? Who within your organization will you seek for guidance and mentorship, who from outside your organization, and whom will you choose to mentor? How will you assess your performance as you move forward?

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, experience, and highlights the need for lifelong learning well into the most senior levels of 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 your health care system needs.

Colonel Leon E. Moores, United States Army Medical Corps

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Video: Invictus (Scene 9 Invitation)

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Video: Gettysburg (Scenes: 8-10: Prisoner Delivery/Used by idiots/What we're fighting for)

Video: Miracle (Scenes 14 & 16: I am a Hockey Player / This is Your Time)

Video Lord of the Rings: The Two Towers (Disc 1 Scene 29: The King's Decision), Lord of the Rings: The Return of the King (Disc 2 Scene 69: The Last Debate)

Video: Gettysburg (Scene 5, Side B: Lee admonishes Stuart)

Video: Master and Commander (Scene 23 Hollom's Weakness)

Video: Gettysburg (Scenes 28-35, Little Round Top – Name to Remember)

Video: A Few Good Men (Scenes 25-28, Jessup Takes the Stand – The Verdict.)

Video: A Few Good Men (Scene 5, COL Jessup)

Video: Gettysburg (Scene 10, Side A: Bloody Moment Ahead)

Video: Patton (Scene 1: Stars and Stripes)

Video: Ike: Countdown to D-Day (Scenes 3 & 6 Patton Problem & A Plan Unveiled)

Video: Ike Countdown to D-Day (Scene 5 Loose Lips)

Video: The Thin Red Line (Scene 20 Nature's Order)

Video: Shackleton (Disc 1, Scene 8: Setting Sail)

Video: Shackleton (Disc 2, Scene 6: Breaking Point)

Video: Shackleton (Disc 2, Scene 8: On the Edge)

Video: Apollo 13 (Scene 19, Houston, We have a problem....)

Video: Band of Brothers (Disc 1 Currahee: Scene 2, Anything but Easy. Scene 5, Trial by Court Martial)

Video: Gandhi (Disc 1, Scene 10)

Video: 12 O'Clock High (Scene 6 The New Commander)

Video: Renaissance Man (Scene 4 Everyone's Got a Story)

Video: The Thin Red Line (Scene 3 The Closer to Caesar)

Video: Ike: Countdown to D-Day (Scenes 6 A Plan Unveiled)

Video: Glory (Scene 14 600 shoes)

Video: Friday Night Lights (Scene 27 Halftime)

Video: U571 (Scene 11, 12 Sailing to England, Real Sea Captain)

Video: Hoosiers (Scene 5 First Practice)

Video: Friday Night Lights (Scene 2 Preseason)

Video: Remember the Titans (Scene 10 Lessons from the Dead)

Video: Glory Road (Scene 12 Pep Talk)

Video: Lord of the Rings, The Two Towers (Scene The Mines of Moria)

Video: Master and Commander (Scene 23 Hollom's Weakness)

Video: Hoosiers (Scene 5 First Practice)

Video: Scenes from House – TV Show

Video: Hoosiers (Scene 18 Passing to Shooter, Scene 22 Kick Me Out)

Video: The Princess Bride (Scene 4/5/6 – Rhyming Robbers, The Shrieking Eels, Cliffs of Insanity)

Appendix: Complete House staff Leadership Training Schedule and Content Curriculum

A. House staff Leadership Training Outline

The following leadership training schedule is geared towards a 3-year residency program. The schedule may be modified or the course content expanded to accommodate longer residencies as needed. The content below is considered the minimum content required and minimal time investment necessary to ensure coverage of all topics during the GME training period.

Allowances will be required for residents on away rotations or on night float rotations. Options include offering sessions twice per academic year or videotaping sessions for makeup requirements; where feasible, interactive teaching is the preferred method unless otherwise noted (eg, initial completion of the JMESI modules prior to bi-weekly conferences).

ORIENTATION

Ensure the following fundamentals are discussed during the orientation period in addition to mandatory hospital requirements and mandatory general military training requirements. The topics should be interactive where practicable. Some training should be centralized, and other training should occur at the service level. To model the principles of leadership being inculcated, the training should not be delegated solely to non-clinical subject matter experts and should include prominent roles for Medical Corps officers who demonstrate expert status in the various subject matters.

Centralized:

- a) Wear and appearance of the uniform, military conduct and military etiquette (1 hour; DCCS and MTF CSM)
- b) Fundamentals of teamwork and clinical handoffs (TeamSTEPPS; 4 hours)
- c) Provider impairment and fatigue (2 hours; DME and LCSW/LMSW)
- d) Pay, allowances, and benefits (1 hour; senior physician utilizing centrally prepared Powerpoint presentation)
- e) Joint ethics regulation; common legal pitfalls related to conduct (1 hour; DCCS and JAG)
- f) Basics of medical liability (2 hours; DCCS, JAG, physician member of MTF Risk Management committee)

Program level:

- a) Fundamentals of Outpatient Coding and Documentation (2 hours; Clinic OIC and senior outpatient coder)
- b) Basics of competent charting, including Inpatient Coding and Documentation (2 hours; Chief Resident, physician member of Records Committee, senior inpatient coder)
- c) Medical profiles, including completion of e-Profile training prerequisite (2 hours; Senior Profiling Officer; member of WTB command)
- d) Capabilities and Oversight of other Members of AMEDD Team, to include Physician Assistants, Nurse Practitioners, medics, nurses (1 hour; Chief Resident and Program Director)
- e) Fundamentals of career management, including OERs, ORBs, and Boards (1 hour; residents' senior rater)

INTERN YEAR CURRICULUM

Institute a weekly 1 hour Leadership Officer Development Program (ODP) which combines leadership development and military-unique curriculum specifically geared toward interns (11 months; 4 weeks per month). The Joint Medical Executive Skills Institute (JMESI) leadership modules will be introduced to the interns; 11 modules will be completed each year of residency. Each module requires approximately one hour to complete, has embedded questions throughout the module, and a test at the end. The modules will be completed prior to the monthly discussion; residents will present their certificate of successful completion at the first OPD of each month.

Recommended Leadership ODP schedule is:

Week 1: Discussion of that month's JMESI module

Week 2: "Leadership@Lunch" module

Week 3: Military-unique curriculum for that month

Week 4: Leadership coordinator option—rehash/expansion/follow-up of current month's Weeks 1-3 material or Journal Club article/Chapter from suggested leadership reading list

JMESI Modules to be completed during the intern year

1. Communications: Patient Relations and Communication

The first lesson describes the benefits of good patient relations/communication, Joint Commission standards on patient rights and responsibilities, methods to obtain patient feedback, and key patient satisfaction variables for surveys.

The second lesson discusses the SBAR (Situation, Background, Assessment, and Recommendation) technique as a way to standardize communication on the patient's condition, National Standards for Culturally and Linguistically Appropriate Standards (CLAS) guidelines, and effective staff-patient communication examples.

The third lesson provides ideas/ best practices to improve patient relations and communication.

2. Individual Behavior Two: Critical Thinking and Learning

The first lesson defines critical thinking, describes critical thinking attitudes and skills, and provides ways to examine one's own and another's thinking processes.

The second lesson describes the assumptions and principles of adult learning, provides a model for experiential learning, and outlines the elements of effective adult learning experiences.

The third lesson discusses the concept of the learning organization, single- versus double-loop learning, knowledge management, and communities of learning/practice.

3. Leadership Six: Stress Management

The first lesson defines stress, describes the fight-or-flight response, and lists the sources of stress (stressors).

The second lesson discusses various methods to manage stress including abdominal breathing, muscle relaxation, meditation, visualization, affirmative thinking, and time management.

The third lesson provides guidance on the management of organizational stress, including job design and stress management during disasters.

4. Leadership Seven: Service Excellence

The first lesson identifies the key characteristics, benefits, and importance of customer service, the expectations of patients, and the barriers to and facilitators of service excellence.

The second lesson discusses the four basic steps to enhance service excellence, innovative approaches to improve the patient's experience, customer service behavioral norms, and how to manage patient complaints.

The third lesson describes methods to obtain customer feedback, how to design and use customer survey data, critical patient satisfaction variables, and an organizational assessment for service excellence.

5. Leadership Eight: Coaching, Counseling, and Mentoring

The first lesson identifies basic coaching skills and how to coach super stars (high performers), middle stars (average performers), and falling stars (low performers).

The second lesson discusses organizational and managerial factors affecting performance, key considerations in counseling employees, the characteristics of “I” messages, and guidelines for a counseling/performance improvement session.

The third lesson describes the benefits of mentoring, a six-phase mentoring cycle, the caveats for mentoring, how to set up a mentoring meeting, and tips for both mentors and mentees.

6. Leadership Nine: Lifelong Learning

The first lesson provides the basic concepts and philosophy of lifelong learning, resources and suggestions for lifelong learners in healthcare management, learning methods, a model of experiential learning, and the values of different generations of learners.

The second lesson describes adult learning principles, characteristics of effective adult learning, a description of six basic levels of learning, and knowledge management.

The third lesson discusses the types, benefits, and characteristics of CoPs and the key management actions and roles for successful CoPs. CoPs (communities of practice) are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.

7. Leadership Eleven: Time Management

The first lesson discusses the importance of time management, time management principles, how to set daily priorities and develop a schedule, ideas for filling any down time, and Stephen Covey’s time management matrix, which shows the relationship between urgency and importance.

The second lesson describes common time wasters, guidelines for effective delegation, how to run more effective meetings, and ideas to overcome procrastination.

The third lesson provides techniques to deal with the large amount of telephone calls, interruptions (e.g., drop-in visitors), e-mails, and correspondence/ paperwork that face managers.

8. Public Speaking

The first lesson describes the preparation for, and organization of, a speech, how to analyze the needs of the audience, and the key elements of a speech.

The second lesson discusses ways to speak plainly and directly and the methods to effectively use voice, pace, gestures, movement, and visual aids (i.e., slide presentations).

The third lesson identifies considerations for speaking to diverse audiences, approaches to evaluate your effectiveness as a speaker, and ways to overcome the fear of speaking.

9. Personal and Professional Ethics

The first lesson describes the current level of concern about ethical practices in healthcare organizations and the distinctions among personal, professional, organizational, and biomedical ethics. It also review four basic principles: 1) Respect for autonomy (self-determination); 2)Nonmaleficence (avoidance of harm); 3)Beneficence (providing benefits and balancing risks/benefits); and, 4)Justice (equitably distributing benefits and resources)

The second lesson discusses personal integrity, virtues, and methods to resolve personal and professional conflict.

The third lesson discusses the codes of conduct for administrators, physicians, and nurses, and the methods to better ensure compliance to ethical policies, including responsibilities to patients, the community, and employees; and, guidelines for reporting medical errors and objections to unsafe or unethical clinical research.

10. Effective Communication

The first lesson describes a communication model and barriers to effective communication. In addition, the lesson identifies characteristics of open versus defensive communication.

The second lesson provides guidelines for effective communication. It also discusses various communication methods (e.g., face-to-face, telephone, etc.) and verbal and nonverbal communication.

The third lesson discusses different communication situations, characteristics of “I” messages, and how to give constructive feedback. In addition, the lesson discusses active listening.

11. Epidemiology One: Principles and Tools

The first lesson describes the role of epidemiology in population health and describes the critical determinants of disease. It also defines and distinguishes such concepts as association, causation, statistical significance, epidemiological evidence, and experimental and observational studies.

The second lesson discusses various epidemiology and surveillance tools, including measures of health and occurrence, crude and adjusted rates, and surveillance approaches for deployed forces.

“Leadership@Lunch” modules to be completed during the Intern Year

Module 1-What is a Leader?

Module 2- Imperatives of Leadership

Module 3- Emotional Intelligence - Introduction

Module 4- Emotional Intelligence- Styles of Leadership I

Module 5- Emotional Intelligence – Styles of Leadership II

Module 6 – Emotional Intelligence – Styles of Leadership III

Module 7 – Servant Leadership

Module 8 – Integrity I

Module 9 – Integrity II

Module 10 - Followership

Module 11 – Narrative and Leadership

MTF Military Curriculum to be completed during the Intern Year

1. Career Cycle, Promotion Boards
2. Army schools, GME selection process
3. Medical and Physical Evaluation Board Process, WTB
4. Capabilities and Data Solving with MEDPROS
5. Operational Medicine I: Role 1 and 2 care
6. Operational Medicine II: Role 3 care, medical evacuation, and the MED BDE
7. Managing, teaching, and evaluating subordinate learners (May) (Transition to practice capstone in lieu of this for interns stopping GME at end of the year)
8. The Army: Major Commands, Direct Reporting Units, Army Service Component Commands, Theater Enabling Commands, Corps, Divisions, Brigades, etc.
9. The AMEDD: Medical Corps, Medical Service Corps, OTSG, “One Staff”
10. The 6 Geographic Combatant Commands and the 3 Functional Ones
11. The Campaign: Phases 0 through 5

Additionally, interns would meet quarterly with their mentor to review their professional development file, discuss any leadership program concerns, review future development programs/opportunities/tracks, assist with research, contacts, etc.

PGY-2 CURRICULUM

The weekly 1 hour Leadership ODP combining leadership development and military-unique curriculum continues.

Recommended Leadership ODP schedule is:

Week 1: Discussion of that month's JMESI module

Week 2: "Leadership@Lunch" module

Week 3: Military-unique curriculum for that month

Week 4: Journal Club article/Chapter from suggested leadership reading list

JMESI Modules to be completed during the PGY-2 year

1. Individual Behavior

The first lesson lists, describes, and provides examples of leadership characteristics and various instruments available for self-assessment. In addition, the lesson identifies mentoring functions, a six-step mentoring cycle, and caveats in mentoring relationships.

The second lesson discusses methods for motivating individual and group performance.

The third lesson discusses the disciplines required for a learning organization, the components of emotional intelligence, and approaches for appreciative inquiry.

2. Leadership Three: Team Leadership

The first lesson describes the types and importance of teams in HCMOs, the characteristics of successful teams, steps in leading teams, and guidelines for effective group decision making.

The second lesson explains the use of a team charter and a responsibility matrix, provides a case study in team building, and discusses the setting of ground rules for team work.

The third lesson discusses barriers to team work, key factors in team performance, and methods to evaluate teams.

3. Leadership Twelve: Supervisory Skills

The first lesson describes the traits and functions of successful managers and guidelines in planning, problem solving, and decision making.

The second lesson discusses how to delegate tasks, run meetings, manage your time and stress, communicate with employees, and lead project teams or task forces.

The third lesson provides guidelines on disciplining, counseling, providing feedback, reducing absenteeism, retaining employees, “Management By Wandering Around” (MBWA), and motivating staff.

4. Public Law Two: Patient Rights

The first lesson describes the obligations of the HCMO and healthcare providers to protect the privacy and security of personal information and medical records. The lesson outlines the legal requirements of the Freedom of Information Act (FOIA) and the Privacy Act and reviews the national standards established in the Health Insurance Portability and Accountability Act (HIPAA).

The second lesson presents the concepts of patient rights. Beginning with a summary of the Joint Commission's position on patient rights, the lesson addresses the principles of informed consent, describes the procedures involved in complying with advanced directives, and explains the legal implications of a patient's right to refuse medical treatment.

5. Quality Management Decision-based Module

The first lesson discusses the importance of quality and patient safety in the HCMO, the underlying causes of and possible solutions to medical errors, how to analyze and report sentinel events, and the elements and leadership behaviors to implement an effective patient safety program and risk management process.

The second lesson consists of a series of scenarios in the areas of quality improvement, patient safety, and cultural change

6. Lean, Six Sigma, and Balanced Scorecards

The first lesson compares lean thinking/management and Six Sigma, describes the Six Sigma five-step process (define, measure, analyze, improve, and control), defines key Six Sigma concepts/terms/tools, shows how Six Sigma relates to problem solving, and provides guidelines to measurement and data collection.

The second lesson discusses how a lean culture differs from a traditional organizational culture, the 14 lean principles based on the Toyota Production System (TPS), areas of opportunity to reduce waste in healthcare organizations, and two case examples of the application of lean principles.

The third lesson identifies the three key steps to take in developing a balanced scorecard and suggests various measures/metrics to include on a balanced scorecard.

7. Organizational Ethics

The first lesson describes the organization's ethical responsibilities, key ethical issues, and organizational values/principles.

The second lesson discusses the structural and cultural components for an ethics program, particularly with respect to creating a positive ethical climate. In addition, the lesson will identify areas for a comprehensive ethics education plan.

The third lesson discusses the ethics consult, the roles of the Ethics Officer and the Ethics Committee, and the evaluation of an ethics program.

8. Strategic Planning Three: Population Health Improvement and Social Marketing

The first lesson defines PHI, discusses the determinants of health, provides key health indicators, and identifies various methods for community health assessments.

The second lesson describes the Precede-Proceed Model for health promotion, which shows the relationship of environmental, behavioral, and lifestyle factors of health. The lesson also provides a conceptual framework for PHI.

The third lesson discusses social marketing and perceptions of the public that must be overcome if social marketing is to be effective.

9. Conflict Management One: Principles

The first lesson describes the importance of conflict management, the consequences of disruptive and constructive conflict, stages of conflict, and the different degrees to which conflict might exist in an organization.

The second lesson identifies the levels of conflict (intrapersonal, interpersonal, and intergroup), the types of conflict (task, administrative, and emotional), areas in which conflict might occur (facts, methods, objectives, and values), sources of conflict (unclear roles, competition over resources, etc.), and third-party conflict management approaches (arbitration, mediation, facilitation, and use of outside experts).

The third lesson discusses the resolution of interpersonal conflict, a problem-solving method to deal with intergroup conflict, organizational approaches to managing conflict (decoupling, linking pins, use of a superordinate goal, and the chain of command), and conflict management styles (avoidance, accommodation, competition/authoritative command, compromise, and collaboration).

10. Conflict Management Two: Negotiation

The first lesson describes the importance of conflict management and negotiation, the methods to test for consensus, and how to manage agreement.

The second lesson identifies the key concepts and variables in negotiation as well as five negotiation styles and the three norms of fairness in a negotiation.

The third lesson discusses the two basic negotiation strategies (distributive and integrative bargaining), how to prepare for a negotiation, and the tactics for gathering information, overcoming deadlocks, and reaching agreement.

11. Diversity: Leadership Virtual Module

The virtual module is a unique learning initiative unlike any current JMESI module. It tests the use of ‘virtual content’ as a source of rich and immersive educational content. In this module, you will follow a day in the life of Major Peter Porter as he deals with issues of cultural diversity and sensitivity.

“Leadership@Lunch” modules to be completed during the PGY-2 Year

Module 1 – The Leadership Moment

Module 2 – Vision and Getting the Big Picture

Module 3 – Crisis Resource Management

Module 4 – Toxic Leadership

Module 5 – Building a Team

Module 6 – Facing Down Conflict

Module 7 - Optimism

Module 8 – Vision: Communicating the Future

Module 9 - Motivating

Module 10 – Solving Problems

Module 11 – Teach and Develop

MTF Military Curriculum to be completed during the PGY-2 Year

1. How to prepare and present effective academic lectures and presentations
2. Tools for Benchmarking and Improving your Clinical Performance
3. Specialty Specific Outpatient Tips for Coding and Documentation
4. Specialty Specific Tips for Inpatient Coding and Documentation

5. Anatomy of a MEDCEN (governance, committees, etc)
6. Executive Management Styles
7. How to get things done in the AMEDD: Part I – hospital, department and service budgets, differentiating P6 and P8 money
8. How to get things in the AMEDD: Part II – people and equipment
9. Commonly Tracked Outpatient and Inpatient Quality Metrics and Pitfalls in Measuring
10. Preparing a Business Oriented Decision Briefing
11. Leading Medical Teams

Additionally, residents would meet quarterly with their mentor to review their professional development file, discuss any leadership program concerns, review future development programs/opportunities/tracks, assist with research, contacts, etc.

PGY-3 CURRICULUM

The Leadership ODP combining leadership development and military-unique curriculum continues.

Recommended Leadership ODP schedule is:

Week 1: Discussion of that month's JMESI module

Week 2: "Leadership@Lunch" module

Week 3: Protected time for CCC Phase I completion

Week 4: Book Club from suggested leadership reading list

JMESI Modules to be completed during the PGY-3 year

1. Decision Making

The first lesson describes a problem-solving model, individual versus group decision-making, and managerial decision-making styles.

The second lesson discusses how to identify and analyze problems, including writing a problem statement and applying critical thinking to a situation. In addition, the lesson will address methods to generate and evaluate alternative solutions to a problem.

The third lesson provides methods to implement a decision, including action plans and pilot studies. In addition, the lesson discusses how to obtain commitment for a decision and ensure that the decision is implemented as planned.

2. Disaster Preparedness Decision-based Module

The first lesson lists, describes, and provides examples of a number of key characteristics of leaders including traits, skills, attitudes, and behaviors. It also reviews the concepts of emotional intelligence, transactional vs. transformational leadership, the continuum of leadership decisions, and situational leadership styles.

In the second lesson you will assume the role of as the new Commander/Chief Executive Officer (CEO) of the fictitious MHS Community Hospital. You will be faced with a number of situations during your first two weeks that require an immediate decision. (Thus, you cannot refer the decision to a committee.)

3. Financial Management One: Concepts and Regulations

The first lesson describes the financial management and controllership functions, the balance sheet and income statement, the role of the financial officer, and the various types of military funds.

The second lesson discusses the MEPRS, MEPRS reporting requirements, common financial/workload measures for MTFs, and the components of a business case analysis.

The third lesson provides checklists for the review of the balance sheet and income statement, cautions on budget preparation, guidelines for the preparation of financial reports, and criteria for quantitative measures/metrics.

4. Group Dynamics Two: Applications

The first lesson describes the roles of the team leader and facilitator, 12 core facilitation practices, how to effectively prepare for a meeting, and advanced tools for managing your meetings.

The second lesson provides the methods to create an open climate, the characteristics of open communication, and consensus-testing techniques.

The third lesson discusses how to make group process interventions, the roles of group members, how to deal with difficult personalities, advanced approaches for group self-evaluation, and documentation of group meetings.

5. Human Resources

Lesson One briefly explains the manager's role in HR and presents an overview of the main laws that guide HR management decisions.

Lesson Two describes the workforce plan and explains how it fits into the strategic planning process. The lesson continues by presenting a step-by-step review of the staffing process.

Lesson Three describes some of the trends currently influencing employee development in the healthcare industry and explains the role of the employee, manager, and the HCMO

Lesson Four outlines the importance of a good performance appraisal system, describes the advantages of reward and recognition systems, and presents appropriate methods for applying corrective discipline.

6. Human Resources Two: Staff Development

The first lesson provides an overview of HRD, adult learning theory, and training needs assessments.

The second lesson outlines considerations to be made when planning a training program and how to write learning objectives.

The third lesson explains how to evaluate a training program.

7. Human Resources Three: Cultural Competence

The first lesson provides an overview of cultural competence, diversity, and diversity management. It also discusses the major factors to enhance diversity in workgroups and the fundamentals to embrace diversity in your Health Care Management Organization (HCMO).

The second lesson discusses the need for cultural competence, the role of the HCMO, the benefits of culturally competent care, a process that leads to cultural proficiency key knowledge, skills, and abilities for managers and staff.

The third lesson describes the critical attitudes needed by providers with respect to cultural competence, cultural style differences, and the elements to consider in implementing a cultural competence plan.

8. Labor Relations One: Principles

The first lesson addresses labor-management relations. Beginning with an historical overview of unionization, the lesson takes an in-depth look at the negotiation process.

The second lesson outlines various methods for handling labor-management issues. Focusing on conflict resolution techniques, the lesson presents the grievance administration process and reviews alternative methods of dispute management.

9. Labor Relations Two: Applications

The first lesson examines the reasons that motivate employees to unionize, explores a variety of employee satisfaction issues, and identifies the factors that could affect performance and organizational climate, particularly management-union relationships if these are not addressed.

The second lesson presents a case study that incorporates many of the concepts presented in both modules. It reviews conflict resolution techniques, as well as the principles of effective labor-management relations.

10. Leadership Ten: Running Effective Meetings and Committees

The first lesson addresses when to call a meeting, the four types of meetings, how to prepare for a meeting, and the key actions in running an effective meeting.

The second lesson describes the responsibility matrix, 14 ground rules for running meetings, effective meeting behaviors (including what to say), and how to deal with difficult personalities.

The third lesson discusses how to evaluate the effectiveness of meetings.

11. Performance Improvement

The first lesson reviews the Malcolm Baldrige National Quality Award Criteria for Healthcare, the Shewhart Cycle of Plan-Do-Check-Act (PDCA), and key quality improvement tools.

The second lesson provides 17 guidelines for designing a customer feedback system, five assessment methods (surveys, interviews, focus groups, observations, and comment cards), and key questions to ask in patient and employee satisfaction assessments.

The third lesson discusses the clinical value compass as a way to track key HCMO outcomes and different methods to monitor practice patterns including clinical practice guidelines (CPG) and provider profiles.

“Leadership@Lunch” modules to be completed during the PGY-3 Year

Module 1 – Leading Your Peers

Module 2 – Communicating the Mission

Module 3 - Accountability

Module 4 – Resonance and Dissonance in Leadership

Module 5 – Mentoring and CEO Succession

Module 6 – Reinforce with Praise

Module 7 – Leading Change

Module 8 – Preparing for Leadership: Getting Resources

Module 9 – Leading for Loyalty

Module 10 – Enabling Others

Module 11 – Aligning Forces

MTF Military Curriculum to be completed during the PGY-3 Year

Military education this year should be dedicated towards preparing the graduate for further professional military education and the assumption of responsibilities related to their first assignment and first deployment. Mandatory instruction includes:

1. Combat Casualty Care Course (moved from intern to senior year for more relevant “just in time” training)
2. Phase I Captains Career Course: Residents will be granted protected time that counts towards duty hours to complete Phase I. Completion of Phase I will be a requirement for graduation from residency. Exemptions approved by the program director and director of medical education could be considered on a case by case basis for learners ahead of peers.
3. Transition to Practice: Should occur within 1-2 months of graduation and consist of “capstone” training refreshing basic concepts learned earlier in the education process with immediate relevance. This should, at a minimum consist of:
 - a. Refresher didactic overview of medical evacuation and medical care at battalion, brigade, and CSH levels.
 - b. Personal preparedness for deployment
 - c. Panel discussions with recently deployed providers for lessons learned
 - d. Management of civilian employees and NCOs
 - e. Credentialing, pay, bonuses and benefits
 - f. Refresher career management seminar (OER support, ORB, military schools)

Additionally, residents would meet quarterly with their mentor to review their professional development file, discuss any leadership program concerns, review future development programs/opportunities/tracks, assist with research, contacts, etc.

B. Sample Resident Leadership Day Schedules

Intern Year

All Physicians Lead

AM (didactic)

0800-0900: Training on public speaking tips and the best power point presentations

0900-1000: Tips on the most effective ways to lead and train students

1000-1100: How to design/develop a research protocol

1100-1200: Importance of military bearing, professionalism, PT tests, etc. in your military career

PM (panel discussions)

1300-1400: (Prior Chief residents discuss job requirements, greatest challenges, skills needed for the job, value of the job)

1400-1500: (Successful resident researchers and or IRB representative, field researcher) discuss keys to success, protocol development, lessons learned and pitfalls to avoid)

1500-1600: (Panel of Clinic chiefs (not department chiefs) who have completed their first year, job requirements, expectations, what they wish they would have known, challenges)

1600-1630: Leadership director wrap up, survey of program

PGY-2 Year

AM (didactic)

0800-0900: Preparing a professional looking curriculum vitae

0900-1000: Best ways to counsel and give valuable feedback to interns and students

1000-1100: Submitting for professional licensure

1100-1200: Best ways to prepare and achieve success for medical boards

PM (panel discussions)

1300-1400: Recently deployed 1st year staff discuss deployment experience: preparation, making the most of the deployment, needed skills, value of deployment

1400-1500: Bring in leadership team from successful multispecialty clinic to discuss key elements of a successful team, roles and responsibilities and meeting milestones

1500-1600: DCCS – discuss dashboard development, development of organizational goals, mission and vision statement, moving an organization forward

1600-1630: Leadership director wrap up, survey of program

PGY-3 Year

AM (didactic)

0800-0900: Review of timelines for board applications, discuss fellowship applications for various associations as well as medical fellowships

0900-1000: How to write effective officer evaluations reports and civilian appraisals.

1000-1100: Training on process improvement including the A-3 model, TeamSTEPPS, and team project development and completion

1100-1200: Hand out and discuss book “The Way of the Shepherd,” other books and encourage reading this year. Plan to discuss chapters at future leadership group meetings.

PM (panel discussions)

1300-1400: Panel of Department Chiefs briefly discuss their decision to become chief, challenges of position, what the job entails, what were the most challenging on the job training experiences

1400-1500: Panel of Program Directors briefly discuss their decision to become director, challenge of the position, what the job entails, what is most challenging and rewarding about the position

1500-1600: Panel of various Medical Deployment Positions to discuss job role, challenges and rewards of position, how to make the most of the deployment

1600-1630: Leadership director wrap up, survey of program

Appendix: Suggested Medical Corps Career Progression

Medical Corp Training and Achievement Recommendations by Rank and Lines of Effort
(*required) | 2012

		Operational	Clinical	Administration	Education	Research
Medical Students		Training *Complete OBC	Training *Medical School Degree/+/- PhD Masters in Public Health	Training *Participate in all MC leadership development during TDY rotations Assignments/Achievements Medical School student counsel/leadership roles	Training Assignments/Achievements Serve as class tutor/mentor	Training Assignments/Achievements Pursue summer research /publish/lab assistant

Medical Corp Training and Achievement Recommendations by Rank and Lines of Effort
(*required) | 2012

		Operational	Clinical	Administration	Education	Research
MAJ (6-12 yrs)		Training *ILE *CBRNE BN surgeons course Assignments/Achievements Utilization tour for BN surgeon	Training Fellowship Programs BN surgeons course Masters Public Health Assignments/Achievements MEDDAC/MEDCEN Staff	Training *Catch up JMESI executive training *8 hours leadership CME annually Assignments/Achievements Serve as clinic OIC Committee Chair	Training Learning assignments – 45 day rotations with educational leaders Assignments/Achievements Serve as Assistant PD, Intern Director, Transitional Director, Medical Student Director	Training Faculty Research Assistant Assist student and resident researchers
CPT (0-6 yrs)		Training * Complete CCC *Combat Casualty Care course Operation Cobra Gold Assignments/Achievements	Training *Complete Residency Assignments/Achievements *Board Certification	Training *Complete required JMESI med exec modules *Participate in all required Military Officer Leadership development training Assignments/Achievements	Training Assignments/Achievements Serve as GME representative on various committees Chief resident	Training Assignments/Achievements *Complete one research project/case report Present poster(s) at regional conferences or MTF research days

Medical Corp Training and Achievement Recommendations by Rank and Lines of Effort
(*required)

2012

	Operational	Clinical	Administration	Education	Research
LTC (12-18 yrs)	Training *ILE BDE surgeon course Assignments/Achievements BDE surgeon	Training CME and conferences Assignments/Achievements Maintain credentials, board (s) certification	Training *8 hours leadership CME annually Baylor HCA Learning assignments – 45 day rotations with leader MHS, AUSA conferences Assignments/Achievements Regional Leadership coordinator, mentor Clinic CDR/OIC, Dept. Chief 'A' designator status within specialty 'A(L)' designator leadership status	Training Assignments/Achievements Serve on National Civilian Organization Board(s) USUHS or local Medical School faculty positions	Training Assignments/Achievements Faculty Research Assistant Clinical Researcher Assist student and resident researchers

Medical Corp Training and Achievement Recommendations by Rank and Lines of Effort
(*required)

2012

	Operational	Clinical	Administration	Education	Research
COL (18-30 yrs)	Training Division Surgeons course Senior Service College Assignments/Achievements Division Surgeon, Corp Surgeon	Training Conferences/CME Assignments/Achievements Master Clinician status Maintain credentials, board(s) certification	Training *8 hours leadership CME annually Baylor HCA Assignments/Achievements 'A' designator status within specialty 'A(L)' designator leadership status Regional or MTF leadership coordinator, mentor Serve as Dept. Chief, Commander, DCCS OTSG/MEDCOM /HA/MACOM staff	Training Program Directors Course for new Program Directors Assignments/Achievements Serve on National Civilian Organization Boards USUHS or local Medical School faculty positions	Training Research techniques Assignments/Achievements Clinical Investigations Director or AD Clinical Researcher

Appendix: Summary of Objectives and their Links to Established Standards

Chapter One: Every Physician a Leader

Rationale, Structure, and Proponency

Objectives:

Establish a Leadership Consultant

Establish a Leadership Committee

Establish a Medical Corps leadership STRATCOM

Chapter Two: Develop Interest

Early Exposure to Leadership Theory and Practice

Objectives:

Short Term

Revamp the Army Medicine website to provide specific information on leadership development, career progression, and career milestones. (selected competencies from JPME (Joint Professional Military Education,) JMESP (Joint Medical Executive Skills Program -US Army), Accreditation Council for Graduate Medical Education (ACGME).)

Develop an Army Medicine leadership presence on social media sites. (ACGME E; JMESP B 2-5; JPME A 1,3-6)

Ensure that Medical Corps officers start residency training with a sponsor/mentor. (ACGME D, E; JMESP B, 1-5; E 1-3;F 1-5. JPME A 1-7; B 1-5)

Objectives:

Intermediate Term

Establish a Medical Corps “speakers bureau” to provide local, “just in time” leadership training (Novel objective)

Appoint an MTF leadership coordinator at each hospital. (Novel objective)

Create an annual leadership day for all housestaff based on residency year. (Novel objective, selected competencies from JPME, JMESP, ACGME C, D)

Provide ongoing leadership training for mid-level officers. (ACGME D,E,F; JMESP B 1-5; JPME A1-7; B 1-5)

The Medical Corps will fund three company grade Medical Corps officers per region annually to attend leadership symposiums, events or workshops through an online application process. (Novel objective)

Establish a physician leadership elective for all AMEDD GME programs (ACGME D, E, F)

Standardize residency “transition to practice” seminars at all the main GME platforms.
(Novel objective)

Objectives

Long Term

Develop a tool for tracking leadership development throughout a medical officer’s career.
(Novel objective)

Chapter Three: The Foundation

Provide Leadership Education

Objectives:

Short Term

Obtain permissions for access to leadership reading materials in order to allow for unlimited usage. (Novel objective)

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
(Novel objective)

Create a GME leadership program with a curriculum specific to the level of the individual and flexible to be tailored by different medical specialties to address unique skills and requirements (ACGME D,E,F; JPME A 1-6 B 5, JMESP B 1-5)

Objectives

Intermediate Term

Establishment of a Mid-Grade Executive skills MBA-type program and executive opportunities for those senior Medical Corps officers identified for key executive positions.
(ACGME D,E, F; JMESP A 1-5, B1-5, E 1-3, F 1-6 JPME A 1-5 B 1-5)

Objectives

Long Term

Development of a senior level coaching program and strategic mentoring curriculum for Medical Corps officers. (Selected Competencies from JPME, JMESP, ACGME)

Chapter Four: Apprenticeship Refined

Mentorship and Coaching

Objectives:

Short Term

Establish a Formal Mentorship Program for the Medical Corps. (ACGME D, E, JPME A 1-5 B 1-5; JMESP B 1-5)

Objectives

Intermediate Term

Establish Mentor Training Opportunities (Novel objective)

Objectives

Long Term

Establish Corporate AMEDD Executive Coaching Program (Selected competencies from JPME, JMESP, ACGME D, E, F)

Chapter Five: Building the Bench

Identify, Recruit, and Build Experience for Future Senior Leaders

Objectives

Short Term

Identification of candidates for future senior level leader positions. (Novel objective)

Objectives

Intermediate Term

A progressive curriculum needs to be developed which identifies junior officers with leadership potential and then provides the necessary formal and informal leadership skills development and opportunities to develop into mid-level leaders and then subsequently into successful senior leaders (ACGME D,E, JPME A1-5,B1-5, F 1-4 E 1-3)

A centralized or regional databank is necessary for tracking and monitoring officers enrolled or interested in this program (Novel objective)

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. (Novel objective)

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. (Novel objective)

Objectives

Long Term

The implementation of an executive skill designator would allow formal recognition. (Novel objective)

Appendix: Joint Professional Military Education Core Competencies

(Recreated from the Joint Leadership Primer)

A. Conceptual

1. Envisioning- anticipating the future, proactive thinking - practices critical, creative, reflective thinking
2. Frame of Reference Development- including systems understanding, scanning, pattern recognition
3. Problem Management- competing issues, no right answers, ability to recognize and ignore irrelevant issues
4. Critical Self-Examination
5. Critical, Reflective Thought
6. Effective within Environment of Complexity
7. Skillful Formulation of Ends, Ways, Means

B. Interpersonal

1. Communication- to a much broader audience; negotiations, consensusbuilding across a variety of stakeholders; systems knowledge; sophisticated persuasion skills
2. Inspires Others to Act
3. Organizational Representation- to internal and external audiences/ stakeholders
4. Skillful Coordination of Ends, Ways, Means
5. Master of Command and Peer Leadership

C. Technical

1. Systems Understanding- political, economic, cultural, logistical, force management, and joint/combined interrelationships, etc.
2. Recognizes and Understands Interdependencies - systems, decisions, organizations, etc.
3. Information-age Technological Awareness - next generation awareness, sophisticated time/space selection
4. Skillful Application of Ends, Ways, Means

ACGME Core Competencies

A .Competency in patient care

B. Competency in medical knowledge

C. Competency in practice-based learning and improvement

All Physicians Lead

- D. Competency in interpersonal and communication skills
- E. Competency in professionalism.
- F. Competency in systems-based practice

Joint Medical Executive Skills Competencies

- A. Military Medical Competencies
 - 1. Medical Doctrine
 - 2. Military Mission
 - 3. Total Force Management
 - 4. Medical Readiness Training
 - 5. Emergency Management and Contingency Planning
- B. Leadership and Organizational Management Competencies
 - 1. Strategic Planning
 - 2. Organizational Design
 - 3. Decision Making
 - 4. Change Management
 - 5. Leadership
- C. Health Law and Policy Competencies
 - 1. Public Law
 - 2. Medical Liability
 - 3. Medical Staff By-Laws
 - 4. Regulations
 - 5. Accreditation and Inspections
- D. Health Resources Allocation Competencies
 - 1. Financial Management
 - 2. Human Resource Management
 - 3. Labor-Management Relations
 - 4. Materiel Management
 - 5. Facilities Management
 - 6. Information Management and Technology
- E. Ethics in the Health Care Environment Competencies
 - 1. Personal and Professional Ethics
 - 2. Bioethics
 - 3. Organizational Ethics
- F. Individual and Organizational Behavior Competencies
 - 1. Personal and Professional Individual Behavior
 - 2. Group Dynamics
 - 3. Conflict Management
 - 4. Interpersonal Communication
 - 5. Public Speaking
 - 6. Strategic Communication
- G. Performance Measurement and Improvement Competencies

1. Population Health Improvement
2. Clinical Investigation
3. Integrated Health Care Delivery Systems
4. Quality Management and Performance Improvement

Abbreviations

ACGME	Accreditation Council for Graduate Medical Education
ADSO	Active Duty Service Obligation
AKO	Army Knowledge On-line
AMEDD	Army Medical Department
AUSA	Association of the United States Army
BOLC	Basic Officer Leadership Course
CCC	Captains Career Course
CLAS	National Standards for Culturally and Linguistically Appropriate Services
CME	Continuing Medical Education
CSH	Combat Support Hospital
CSL	Command Select List
DCCS	Deputy Commander for Clinical Services (“Chief Med. Officer”)
DME	Durable Medical Equipment
GME	Graduate Medical Education
HCMO	Health Care Management Office
HPSP	Health Professions Scholarship Program
HRC	Human Resources Command
ILE	Intermediate Level Education
JAG	Judge Advocate General (Lawyer)
JPME	Joint Professional Military Education
JMESI	Joint Medical Executive Skills Institute
JMESP	Joint Medical Executive Skills Program (US Army)

LCSW	Licensed Clinical Social Worker
LMSW	Licensed Master Social Worker
LOE	Lines of Effort
LDC	Leadership Development Committee
MED BDE	Medical Brigade
MEDCEN	Medical Center
MEDCOM	U.S. Army Medical Command
MEDDAC	Medical and Dental Activity (Community Hospital)
MEDPROS	Medical Protection System
MHS	Military Health System
MTF	Medical Treatment Facility
MUC	Military Unique Curriculum
NCOER	Noncommissioned Officer Evaluation Reports
OER	Officer Evaluation Report
OIC	Officer in Charge
ORB	Officer Record Brief
OTSG	Office of the Surgeon General
STRATCOM	Strategic Communication
TDA	Table of Distribution and Allowances
TOE	Table of Organization and Equipment
USUHS	Uniformed Services University of the Health Sciences
WTB	Warrior Transition Brigade

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