A STUDY TO DETERMINE THE BEST GENERAL METHOD OF STRENGTHENING THE SUPERVISORS' TRAINING PROGRAM AT THE U. S. PUBLIC HEALTH SERVICE HOSPITAL CARVILLE, LOUISIANA

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ABSTRACT

The problem was to determine the best general method of strengthening the supervisors' training program at the U. S. Public Health Service Hospital, Carville, Louisiana.

The methods of research utilized were, (1) non-structured private interviews, (2) structured private interviews, (3) records and reports of the public health service hospitals at Carville and New Orleans, Louisiana, (4) library research, (5) examination of literature obtained during interviews and from government agencies, and (6) observation.

Major findings brought forth the facts that no formal, controlled, identifiable, and organized supervisors' training program existed at the public health service hospital at Carville. The civil service commission was highly critical of some aspects of the total training program as stated in Appendix C. Data obtained reflected that a supervisor's training program was direly needed. The conclusion reached recommended that a supervisors' training program be established under the complete responsibility and authority of the Training Director, detailing the Personnel Officer to be his assistant for the actual operation of the program.

FOREWORD

The United States Public Health Service Hospital at Carville, Louisiana, is indeed unique. The medical facility is marked by its geographical remoteness, the presence of drooping parasitic fungus laden oak trees, a Mississippi plantation atmosphere of the old South, as well as being the only leprosarium within the United States (See Appendix A).

At the inception of the assignment of the problem, this writer was leery of a visit to a hospital better known by many as the "National Leprosarium." Culture and superstitution warns that leprosy (Hansen's Disease) is to be avoided whenever possible.

These fears were eliminated due to objective and extensive research activities that failed to support a belief that leprosy is, for the most part, infectious or contagious (See Appendix I).

Leprosy treatment and research is the hospital's primary mission. Outpatient care is provided to active members of the uniformed services for minor medical and surgical needs.

There is no charge for the treatment of Hansen's Disease at Carville. Patients are permitted to depart at will, although this is discouraged. Appropriate public health officials are notified when patients do depart against cogent medical advice.

As of May, 1968, the hospital had 357 patient beds and a census

of 303 patients, of which 75 were acutely ill and not ambulatory. Since 1921, records reveal that 43 states of the United States have sent patients there, as well as five United States' possessions, and 52 foreign countries. Languages and nationalities vary widely. Patient nationalities have included Chinese, Mexican, Indian, Taiwanese, Philippino, Okinawan, Japanese, and American.

A patient newspaper called The Star has been published by the patients for the purpose of informing others about leprosy. Its distribution has included 70 foreign nations, and one may be put on the mailing list by writing to the editor.

For patients, there has existed a movie theatre, a snack bar, television, two "ham" radio stations that have routinely communicated around the world, an industrial arts shop, workshops, tape recording facilities, a library for all categories of patients (including the blind), a chapel, a huge golf course, gardening, farming, a diversity of recreational and gaming activities, and frequent visits by nationally known figures such as "Dizzy" Dean of baseball fame.

Dr. John R. Trautman, the Medical Director of the hospital, provided additional information about the disease of leprosy, as well as permitting complete access of the physical plant and his staff. A visit for academic purposes by a student under the auspices of the United States Army and Baylor University was most certainly a "first" for the hospital.

Two members of the staff provided invaluable research assistance. These two gentlemen were Mr. Robert N. Wilner, the Assistant

Administrative Officer, and Mr. Leon M. Wells, the Personnel Officer.

For their avid interest in the U. S. Army-Baylor University Program in Health Care Administration, reminiscence gratitude goes out to all employees of the hospital at Carville. A few weeks at Carville led to the obvious conclusion that those employed there are profoundly dedicated to the most forgotten people in the world, the ostracized leprosy patients.

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CHAPTER I

INTRODUCTION

General Information

While training and education are not exactly synonymous, both should be continuous and serve as an impetus for self development of the executive, supervisor, and employee. Regardless of the mission, functions, objectives, and the location of the facility, firm, hospital or company, the people within it must be trained and educated if they are to move ahead.

Lewis E. Carroll, in Through the Looking Glass, wrote:

> "Well, in our country, said Alice, still panting a little, you'd generally get to somewhere else--if you ran very fast for a long time, as we've been doing."
>
> "A slow sort of country! said the Queen. Now here, you see, it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"[1]

To keep up with the technological advances of medicine, complicated laws and regulations that confront today's medical world, the

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[1]Carl Heyel, Management for Modern Supervisors (Chicago: American Management Association, 1962), p. ii.

era of automation and computers, and the power of collective bargaining, those participating in the management of hospitals must run twice as fast as their predecessors.

To cause efficient production, increased output, better quality output, sound employee relations, creation of an atmosphere of contentment and security, and giving due recognition to an individual for a job well done, industry, private firms, and hospitals, train supervisors.[2]

Hospital Setting and History

The U. S. Public Health Service Hospital, Carville, Louisiana, has provided rehabilitative care to the deformed, has carried out an active teaching program for physicians, conducted clinical research, and seeked to inform the outside world the true facts about the dreaded disease of leprosy (Hansen's Disease).

Located three miles from Carville, a town of about 950 people, the hospital is in Iberville Parish, adjacent to the east bank of the Mississippi River. It is within a stone's throw of the river, 24 miles south of Baton Rouge, and 76 miles northeast of New Orleans.

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[2]Office of Industrial Resources, Supervisory Development Program, Technical Bulletin No. 6 (Washington, D. C.: U. S. Government Printing Office, n. d.), p. 4.

The hospital plant occupies 337 acres of land and its present growth stems from 1894 when the treatment of leprosy patients took place in a plantation home located there. In 1894 the state of Louisiana purchased the plantation home and the 337 acres. In 1921, the U. S. Government purchased it from Louisiana and established a U. S. Public Health Service Hospital.

The two broad categories of employees have been U. S. Public Health Service Commissioned Officers, and civil service personnel. Nuns have been afforded full civil service status.

Since many patients spend their remaining lives within the fence surrounding the facility, eleven cottages for patients and their wives have been constructed. As of May, 1968, only one was vacant. Twenty-three government owned homes on the grounds were available for commissioned public health service officers and their families.

A photograph of a major portion of the physical plant is contained in Appendix A. Appendix B contains a photograph of the infirmary.

Conditions Which Prompted the Study

Two specific reasons necessitated this study. First, the Dallas, Texas Regional Civil Service Office was critical of some parts of the total training program of the hospital, as stated in the inspection report (Reference is made to Appendix C). Secondly, 'an outside unbiased study and report regarding the supervisors' training program would

hopefully culminate in objective solutions as opposed to subjective ones.

Statement of the Problem

The problem is to determine the best general method of strengthening the supervisors' training program at the United States Public Health Service Hospital, Carville, Louisiana.

Objectives

The objectives of the study are:

1. To determine who has staff responsibility and authority for the total supervisors' training program.

2. To determine if the total training system is organized, is structured along defined lines of responsibility and authority, has identifiable goals, and is planned.

3. To determine if the program is centralized or decentralized.

4. To determine if the program includes strong supervisory participation to include some method of feedback to management for purposes of evaluation.

5. To determine if professional and supervisory training programs have been developed and executed with balanced emphasis.

Criteria

The strengthened supervisors'training program:

1. Must conform to staffing and organizational requirements

of the U. S. Public Health Service (See Appendix D).

2. Must be realistic in terms of implementation, practical in terms of application, and flexible in terms of modification at each supervisory level.

3. Must consider implementation of the specific training methods commonly found within the literature (See Appendix E).

4. Should enhance the implementation of the recommendations of the U. S. Civil Service Commission's last report on training (See Appendix C).

Limitations

The study must be conducted within the following parameters:

1. The supervisors' training program will probably continue to be second to professional (clinical) training. This is because:

a. The mission of the institute is to medically treat leprosy patients.

b. About 75 percent of the key supervisors are physicians.

c. The Training Officer is a physician.

d. The Hospital Director is a physician.

2. Funds are not available to routinely send supervisors to seminars or conferences away from the hospital or to obtain outside instructional assistance from nearby Louisiana State University located in Baton Rouge, Louisiana.[3]

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[3]Leon M. Wells, private interview held at the U. S. Public Health Service Hospital, Carville, La., May, 1968.

3. There does not exist sufficient classrooms and audio-visual aids equipment to permit departmental level decentralized training at various areas throughout the physical hospital plant.

4. Because of the lack of availability of funds for overtime, the method chosen cannot establish program requirements at any time other than during normal duty hours.

5. Due to the hospital's organizational structure, as approved by the Department of Health, Education,and Welfare, the direct responsibility for the training of supervisors belongs to the training or personnel officer (See Appendix D).

Factors Bearing on the Problem

1. As of May, 1968, 297 persons were employed at the hospital, and 15 of these were utilized as branch or department supervisors.

2. The Daughters of Charity of St. Vincent de Paul have totaled 36 in number, have had full civil service status, helped establish the present hospital and have influenced the growth of the hospital in many ways.

3. In the past, supervisory training, when conducted, has been highly decentralized; and nursing supervisors have been trained and developed under a program independent from all other programs within the hospital.

4. A patient-employee ratio of 1 to 1 in the past has been somewhat misleading. Of the 300 patients, only 75 were not ambulatory. The

remaining 225 were quite ambulatory and able to care for themselves, except for daily therapy and drugs.

5. In addition to their regular pay, all employees have received a 25 percent hazardous duty pay. Because of this, few positions have remained vacant.

6. All employees have been either civil service or commissioned officers of the public health service.

7. A Training Branch, Training Officer, Personnel Section, and a Personnel Officer, depicted in Appendix D, have been authorized at the hospital.

8. Previous programs, geared to professional and technical type training, have been excellent (See Appendix C). The Training Officer in charge of these programs has been a physician (See Appendix D).

9. The employee turnover rate has been less than five percent since June 30, 1967. Programs in effect have not been interrupted by the arrival and departure of employees.

10. With the exception of nursing service and several other professional departments, no specific programs, plans, schedules, attendance records, and established goals for the training of supervisors were on file when the research was conducted.

11. Supervisors' training has been the responsibility of the Personnel Officer in the past.

12. A consolidated, formalized training program has not been

fully developed at the hospital level for all training (See Appendix C).

13. The basic document or mechanism for the training of supervisors has been a supervisors' handbook, and examinations. A sample of examination questions is contained in Appendix G.

14. Traditionalism has been inherently strong within the hospital due to large numbers of employees working in excess of 20 years, and often working together in the same department (See Appendix H).

15. Little has been done to improve the low educational level of the non-supervisory employees. Supervisors have a certain responsibility for the development of their subordinates. While Appendix H reflects that supervisors have not done a great deal about the educational level of their employees, no records were on file to indicate that supervisors have had special training in just how to aid in this unique plight at the hospital in Carville.

16. Records indicated that only three or four supervisors attended management or supervision courses offered by the U. S. Government while employed by the hospital.

17. While a training committee was established by the Medical Director, key middle managers referred to in Appendix C were not represented.

18. Physicians within the hospital have been extremely professionally and clinically oriented, which is to be expected of them. But several frankly admitted that they have not had the time to do justice to

a supervisors' training program. One physician, on commenting about this, revealed that his five subordinate supervisors, his 76 other employees, and his patients, demanded every minute he could give to them. He also has served as the Assistant Medical Director on a continuous basis.[4]

Assumptions

1. If the employee strength continues to equal or exceed the total authorization of 285, as it has for the past two years, ample time should exist for the active participation of supervisors in courses relating to their needs.

2. The length of patient stay will continue to decrease with the advent of new drugs and better treatment methods.

3. Neither the mission nor the hospital workload will change to any great degree.

4. The offices of the Training Director and the Personnel Officer will not decrease or increase in strength within the near future.

5. Physicians at the hospital will continue to view their roles of supervisors as secondary to that of the role of physician.

6. High morale, excellent working conditions, low turnover of personnel, and the 25 percent hazardous pay, will continue.

7. Except for the specialized treatment of leprosy and an

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[4]Carl V. Enna, private interview held at the U. S. Public Health Service Hospital, Carville, La., May 1968.

unusually low employee educational level, the basic things that supervisors should know at the Carville hospital are no different from those in any other hospital.

8. Traditionalism within the hospital will continue to be strong and each department will continue to be somewhat independent.

9. Higher civil service standards will cause the educational level of the hospital's employees to rise considerably as attrition takes place.

10. The federal government will continue to take an active role in seeking to develop employees to their fullest capabilities. More and broader education and training programs will be made available to civil service employees. Supervisors must be aware of what is being offered and ensure that deserving employees have the opportunity to improve themselves.

11. The Medical Director and the Dallas Regional Civil Service Office will expect a marked improvement in the total training program by the time the next inspection takes place.

Definitions

Centralized training is controlled by one responsible representative for the Medical Director, causing departments to conform to plans disseminated by the representative.

Decentralized training is controlled by department supervisors, according to some basic criteria distributed by the Medical Director

through one responsible representative.

A department supervisor is

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.[5]

Feedback is the continuous measurement of the output of a system. When measurements exceed the ranges set by management, there is an automatic or other corrective device triggered. In terms of the problem of supervisors' training in the hospital at Carville, feedback would be the same as reported evaluation to superiors by participants of the supervisors' training programs.

Operations research is the application of scientific methods to the study of alternatives in a problem situation with a view towards providing quantitative basis for arriving at an optimal solution in terms of the goals sought. Many operations researchers insist that the activities of an enterprise must be viewed as a total system, in contrast to the usual attempts to solve isolated problems.[6]

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[5]Paul Ecker, et al., Handbook for Supervisors (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1959), p. 6.

[6]Harold Koontz and Cyril O'Donnell, Principles of Management (New York: McGraw-Hill Book Co., 1964), pp. 146-47.

A sub-system is a part of the total system that influences the output or production of the total system. The sub-systems are subject to the plans and controls of the total system. Every system normally has an input, processor, control, feedback, and output.[7]

A system consists of diverse parts that serve a common purpose, this purpose having to do with planning and control.[8]

Research Methodology

Historical and descriptive methods of research were used. To meet the requirements of these methods, the following specific types of research took place:

1. Structured private interviews: Specific questions were asked of the 15 supervisors about the hospital's supervisory training program (See Appendix M).

2. Non-structured private interviews: General questions were asked about the hospital's supervisory training program. The purpose was to gain an understanding of the training of supervisors within the hospitals of the public health service.

3. Records and reports at the U. S. Public Health Service Hospitals, Carville, and New Orleans, Louisiana were analyzed. These were needed to extract current data not available elsewhere.

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[7]Robert N. Anthony, Planning and Control Systems (Division of Research Graduate School of Business Administration, Harvard University: Boston, 1965), pp. 4, 5.

[8]Ibid.

4. Library research: The object was to understand the total training system of any hospital, looking at the training of supervisors as a subsystem.

5. Literature other than library: Literature was obtained from interviewees and other sources, such as Headquarters, Fourth United States Army, and the Training Officer, Civilian Personnel Office, Brooke Army Medical Center, Ft. Sam Houston, Texas. Other agencies contacted, such as International Business Machines (IBM), were able to produce pamphlets, reports, and other records that reflected their methods of training supervisors.

6. Observation: Supervisors were observed at work to determine what they did and why they did it.

Literature Review

Much has been written on supervision and on training, but little has been written on supervisors' training per se. Almost totally absent was literature dealing with the general methods of organizing a supervisors' training program as well as program responsibility and control.

In seeking information, whether searching the reader's guide to periodical literature or the author-title card index, the bibliography listed in this paper was, for the most part, from the following headings:

1. U. S. Civil Service Commission or Public Health Service.
2. Department of Health, Education, and Welfare.
3. U. S. Government, or Federal Government.

4. Supervision.
5. Education.
6. Training.
7. Development.
8. Hospitals.
9. Health Care
10. Management.
11. Executive.
12. Foreman.

The index to publications by the U.S. Government Printing Office led to many pamphlets and books by the Civil Service Commission, the U. S. Public Health Service, and the Department of Health, Education, and Welfare.

People interviewed were able to furnish much literature bearing directly on the subject of supervisory training.

Technical Bulletins published by the Office of Industrial Resources, International Cooperation Administration, contained an abundance of valuable references, to include films and film strips, all available for a modest price.

The Defense Documentation Center, Cameron Station, Alexandria, Virginia, 22314, will upon request, furnish bibliographic information as well as summations, tabulations, listings, searches for single technical efforts, reports on current status of programs, or comparisons of

programs.[9]

Drucker is of the opinion that management must realize that the supervisor is the individual that causes the work to get done. The supervisor is expected to be the master technician or the master craftsman of his group. He is to be an expert on tools and equipment. He is to be a leader of people and is expected to perform every one of these jobs with perfection.[10]

One suggestion within the literature is that a supervisor's training program be inaugurated by the Medical Director, after conferring with the Training Director, who in turn should have previously conferred with all supervisors at all levels. Another means of bringing supervisors together on this subject would be to form a "pilot group" of 10 supervisors, and develop better programs based on their research and recommendations.[11]

One technique for self-evaluation is the use of a self-analysis questionnaire.[12]

As people are hired, their current training needs should be determined and future programs established accordingly (See Appendix J).

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[9] Defense Supply Agency, Don't Re-Invent the Wheel! Exploit the Services of the Defense Documentation Center (Washington, D.C.: U. S. Government Printing Office, n.d.).

[10] Peter F. Drucker, The Practice of Management (New York: Harper and Bros., Publisher, 1954), p. 320.

[11] Office of Industrial Resources, Supervisory Development Program, Technical Bulletin No. 6 (Washington, D.C.: U. S. Government Printing Office, n.d.), p. 16.

[12] Ibid., pp. 17-21

A common topic in the literature dealt with specific methods of instruction. Some were quite unique, and for this reason a compilation of them is seen in Appendix E.

The literature indicates that at least five essential criteria must be utilized in the development of a training program:

1. The training need must be identified with the major area in which it falls.

2. A plan must be developed around the area.

3. There should be an outline of the course content, a published time, location and the name of the instructor.

4. The method of conducting the training must be determined and classes built around it.

5. Training devices must be selected to supplement methods.[13]

A good look at the supervisor from many points of view, utilizing a diminutive word picture of the supervisor in action is seen in Appendix K.

His training and development should at least meet the minimum requirements of the guide for supervisors that is published by the U. S. Department of Health, Education, and Welfare, Washington, D. C.[14]

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[13] Office of Industrial Resources, The Responsibility of the Training Supervisor, Technical Bulletin No. 47 (Washington, D. C.: U. S. Government Printing Office, n. d.), p. 6.

[14] Department of Health, Education, and Welfare, Division of Personnel Management, Personnel Guides for Supervisors (Washington, D. C.: U. S. Government Printing Office, 1968).

The public health service hospital at Carville has also published a manual for supervisors.[15]

Principles of supervision are mentioned within the literature over and over. Twenty-five are contained in Appendix L. In putting them to use, all supervisors should know how to:

1. Begin supervising.
2. Give orders.
3. Obtain help from his people.
4. Make decisions.
5. Criticize.
6. Deal with the problem child.
7. Deal with misconduct.
8. Deal with inefficiency.
9. Handle long-distance supervision.[16]

The supervisor is responsible for developing his employees.[17] Continuously mentioned is the matter of authority and responsibility. If the supervisor is to develop his subordinates, he must be clothed with

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[15]Personnel Manual, U. S. Public Health Service Hospital, Carville, Louisiana, 1969.

[16]William R. Van Dersal, The Successful Supervisor (New York: Harper and Brothers, 1962), pp. 39-51.

[17]U. S. Department of Health, Education, and Welfare, Division of Personnel Management, Staff Development (Washington, D. C.: U. S. Government Printing Office, 1963), pp. 4-9.

the authority and responsibility. The splitting of these two often causes chaotic outcries from within the supervisory ranks.[18]

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[18]Drucker, pp. 323-24.

CHAPTER II

DISCUSSION

Within the discipline of operations research, there is a term referred to as "total systems." The total training system was initially analyzed at Carville, followed by the supervisors' training program, the sub-system. An analysis was made to determine (1) if the supervisors' training program was identifiable, structured, planned, organized, controlled in terms of authority and responsibility, and (2) if all supervisors participated in it. Van Dersal states, "Training should be planned, scheduled, executed, and evaluated systematically."[19]

The training branch of the hospital was responsible for the total training program, with the exception of supervisory training. It became apparent that this branch was primarily concerned with professional (physician) and paramedical (nurses and technicians) training. Most of this training has been in the form of seminars, conferences, and lectures for professional personnel. A review of the activities of the nursing department revealed that training was decentralized. Supervisory training that had taken place within nursing service had been conducted by the Director of Nursing, with little coordination with other departments within

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[19] Van Dersal, p. 98.

the hospital. The Training Director frankly admitted that his professional training requirements restricted his time to the degree that his branch just could not carry out a training program for supervisors.[20]

Professional training was excellent. Every criteria for the efficient operation of any training program appeared to have been met. Classes were well planned, announced in writing ahead of time, taught under ideal conditions, and well attended. For example, a leprosy seminar was held during May, 1968 for health authorities from many states. A panel was composed of patients, and questions and answers steadily went back and forth between audience and panel. Each discussion brought forth new problems and answers to old ones. It was obvious the training branch staff knew what it was doing and how to do it, regarding professional training.

The training branch was coordinating training on a decentralized basis rather than taking charge of it on a centralized basis. Excellent coordination on the use of audio-visual aids equipment, instructors, and classrooms did exist. The training staff did not instruct nor did it physically set up the classrooms. Even the literature published on forthcoming classes was published by a supporting element within the hospital. But the Training Officer and his two assistants insisted that they needed additional employees if supervisory training was to become a responsibility of the training branch. A visit to the Office of the Training Director, U. S. Public

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[20]Herbert H. Gass, private interview held at U. S. Public Health Service Hospital, Carville, La., May, 1968.

Health Service Hospital, New Orleans, La., revealed that a staff of three is responsible for all training within the hospital, which has an employee strength of 614, or about twice that of the hospital at Carville. The Director of Training at the New Orleans facility commented:

> We determine supervisory training needs by using various techniques to discover what the supervisors really want. We have application forms sent out to them to complete regarding subjects desired in the future (See Appendix J). We also have them make a written evaluation of each class after attendance. This office coordinates with the hospital personnel officer on these classes, checking with him on the material to be presented, seeing that all are notified to be there, publish a schedule and ensuring that the whole thing goes off smoothly. We keep attendance records and evaluation reports within this office.[21]

The Administrator of the Carville Hospital identified his Personnel Officer as the man totally responsible for the training of supervisors.[22] The Personnel Officer agreed that he was responsible for the program but lacked time and people to conduct it as he personally desired. His verbal approach and expressed enthusiasm towards the development of supervisors and firm programs was indeed dynamic.[23] He conducted the only supervisors' training course within the hospital from June, 1967, through May 15, 1968.

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[21] Harold George Scott, private interview held at U. S. Public Health Service Hospital, New Orleans, La., May, 1968.

[22] Flores Fernandez, private interview held at U. S. Public Health Service Hospital, Carville, La., May, 1968.

[23] Leon M. Wells, private interview held at U. S. Public Health Service Hospital, Carville, La., May, 1968.

A specific course of action was taken by the hospital to rectify the findings of the civil service commission (See Appendix C). This action was the creation of a training committee. One class was conducted under the sponsorship of that committee. But the committee was not represented at all supervisory levels. The Office of Industrial Resources states: "Every member of the supervisory group will have a part in the development of the program and in the material content."[24]

An almost universal situation, that of professional training of a technical nature versus administrative training of a supervisory nature, was also found at Carville. Chiefs of the Clinical Branch, the Rehabilitation Branch, the Medical Department, Surgical Department, and many other professional areas, have the dual roles of physician and supervisor. Several of the physicians supervised as many as 75 employees, utilizing many of them as supervisory assistants. Training attendance records that were on file regarding supervisory training conspiciously reflected the absence of physicians from the few classes that were held.

The hospital recognized the need for the further development of middle managers. A funding dilemma had existed in the past, permitting only a few of the supervisors to attend development courses at Dallas, Texas and Charlottesville, Virginia. Action was being taken to allocate more funds for the purpose of sending more middle managers to such courses.

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[24]Office of Industrial Resources, Supervisory Development Program, p. 16.

Interest in self improvement was noted. Due to a lack of government funds, one supervisor pointed out how he and his assistants attended night classes in New Orleans, driving the 130 mile round-trip three nights a week for several months at their personal expense. The course attended dealt with the further development of supervisory techniques in hospital housekeeping.[25]

Strong traditionalism, tenure, and many continuous years on the job most certainly has made some of the employees and supervisors oblivious to development needs. For example, organized classes could be given to all supervisors about federal programs that could enhance the completion of high school on the part of many employees. Several supervisors were hazy regarding responsibilities to their employee's educational opportunities.

Two-hundred and seventy-six employees and supervisor personnel records were surveyed to determine their length of continuous employment at Carville and their total years of formal education. While it is not the supervisor's job to cause every man to have a high school education, records revealed that supervisors needed training in advising their subordinates as well as improving themselves. For example, three employees never completed the <u>first</u> grade, and each has been employed in excess of 25 years (See Appendix H).

Every supervisor must be proficient in human relation skills,

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[25]Joseph L. Broussard, private interview held at U. S. Public Service Hospital, Carville, La., May, 1968.

administrative skills, company (hospital) information, technical skills, and training tools and techniques.[26] At Carville, action was being initiated to provide more information to supervisors at every level concerning such areas as job opening announcements, available courses for self improvement, persuance of high school and college degrees, etc. Human relation and technical skills appeared to be fully developed and well utilized.

The staff of the hospital at Carville is not to be indicted or criticized. It would be erroneous to state that a supervisors' training program did not exist at that facility. While the Dallas regional civil service office was critical in its report (Appendix C), credit must be given to the Director of Nursing, for example. While highly decentralized, her program was quite efficient.[27]

With the support of nearby Louisiana State University, the Dallas Regional Civil Service Office, and the Training Director of the Public Health Service Hospital in New Orleans, and with the wealth of talent and facilities to support a program at Carville, it was obvious the first step towards strengthening the program would be to positively fix staff responsibility, control and authority for this program under the leadership of one person. The following alternatives towards a solution are offered:

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[26]Office of Industrial Resources, Management Development Programs for Executives and Supervisors and a Manufacturing Division Technical Bulletin No. 24 (Washington, D. C.: U. S. Government Printing Office, October, 1956), pp. 3-11.

[27]Sister Ann Elizabeth Hughes, private interview held at U. S. Public Health Service Hospital, Carville, La., May 1968.

First Alternative

To continue with a decentralized supervisors' training program, but making the Training Director responsible for it.

The advantages are that the Medical Director can implement his training policies and procedures to supervisors through one responsible individual. Supervisors will be able to develop content according to the needs of their assistants within each department or service and the Training Director would work directly for the Medical Director. In addition, the Training Director already has control of classrooms, equipment and audio-visual aid facilities. Practices and principles now used to conduct professional training would enhance supervisory training.

A disadvantage is that Dr. Scott, one authority on the training of supervisors within the public health service, states, "Decentralized training within a hospital will succeed in part but the total program will not."[28] Another disadvantage is that since the position of Training Director has normally been occupied by a physician, programs could become clinically oriented. It is only natural that a physician exhibits his greatest interest within his chosen profession of the practice of medicine.

The physical plant has been spread out over 337 acres of ground. The average walking time to the classroom would be about eight minutes and a distance of about one-half mile, considering a centralized classroom for the use of all supervisors (See Appendix A).

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[28]Scott, private interview, May, 1968.

Second Alternative

To establish a centralized supervisors' training program under the control and responsibility of the Personnel Officer (See Appendix D).

Several advantages are that the Personnel Officer has been, to a degree, conducting supervisors' training in the past and could develop solid programs if given total authority and responsibility. The responsibility of producing and distributing the present supervisors' handbook and pertinent literature and policies from higher headquarters is routinely that of the Personnel Officer's.

In addition to being a trained personnel management specialist, records revealed that the Personnel Officer at Carville, during the past two years, has had the opportunity to attend several excellent courses dealing with the training of supervisors.

He is qualified to conduct programs to correct deficiencies in supervisory and personnel management training at the hospital. The inspection report rendered by the Dallas Regional Civil Service Office cited these two areas as needing further development.

The last advantage is that in listing all the functions of a hospital personnel department, MacEachern is of the opinion that the formation and direction of a training program for supervisors is the responsibility of the Personnel Officer.[29]

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[29]Malcolm Thomas MacEachern, Hospital Organization and Management (3d ed.: Chicago: Physicians' Record Co., 1957), pp. 963-64.

One key disadvantage is that the alternative is not consistent with the hospital's organizational and staffing chart in that the Personnel Officer is not the Hospital Training Officer (See Appendix D). In addition, the Personnel Officer is not in charge of the classrooms, instructors, and needed equipment and he does not work directly for the Medical Director. Lastly, supervisory training could easily become personnel management training, since personnel management is a key function of the personnel office.

Third Alternative

To establish a centralized supervisors' training program under complete control, responsibility and authority, of the Hospital Training Director, detailing the Personnel Officer to be his assistant for the actual operation of the program (See Appendix P).

Van Dersal states one advantage. The training officer properly has the job of helping and advising the supervisor on needs, methods, arrangements, and evaluation of results.[30]

Beckman states this advantage.

> The training director and the activities under him may be assigned to the supervision of one or another of the organization's executives. The training function should be under the immediate supervision of a high ranking official but an independent unit may not be necessary. Large organizations have established educational divisions which may or may not come within the province of the personnel department. The Personnel Officer usually occupies an

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[30]Van Dersal, p. 96.

independent position in the organization and the training program can logically be placed under his wing.[31]

A centralized supervisors' training program would fix the responsibility for this training in one office.

The Director of Training, U. S. Public Service Hospital, New Orleans, believes that a decentralized training program within a hospital will fail in comparison to the alternative of a centralized program.[32]

Of staff officers within the hospital, the Personnel Officer can logically be linked with the Training Director in carrying out a training program.[33] MacEachern is of the opinion that the Personnel Officer has definite responsibilities within the training program.[34]

There are several disadvantages to this alternative. These two staff positions are key to the success of the overall mission. The rater of the Personnel Officer is the Administrator and not the Training Director. Detailing the Personnel Officer to perform a major extra duty for an individual who is not his supervisor could lead to minor conflicts.

The organizational chart for the hospital depicts one single manager for training, the training officer (See Appendix D).

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[31]R. O. Beckman, How to Train Supervisors (New York: Harper and Brothers Publishers, 1952), p. 99.

[32]Scott, private interview.

[33]Beckman, p. 99.

[34]MacEachern, pp. 963-64

The addition of another clerk within the personnel office could be necessary in order to support training activities. The personnel office could become a personnel and training office, and involvement in broad training activities could actually interfere with the primary mission of that office.

Summary

Supervisors' training should be organized along formal, identifiable lines; structured to supervisory needs; controlled by one individual; and guided by clearly defined lines of authority and responsibility. Training within the public health service hospital at Carville has not met all of these criterion.

Any program established by these criterion should continuously be evaluated by management, and future content should be based upon the feedback obtained. It should also comply with the requirements of the civil service commission's last inspection report (See Appendix C).

CHAPTER III

CONCLUSION AND RECOMMENDATIONS

Conclusion

The best general method of strengthening the supervisors' training program at the U. S. Public Health Service Hospital, Carville, La., is to establish a centralized supervisors' training program under the complete control and responsibility of the hospital Training Director, and to detail the Personnel Officer to be his assistant for the actual operation of the program. The program should be organized along well defined lines, and planned by the Training Director; attendance should be enforced; and feedback from supervisors participating should be used to determine future needs (See Appendix P).

Recommendations

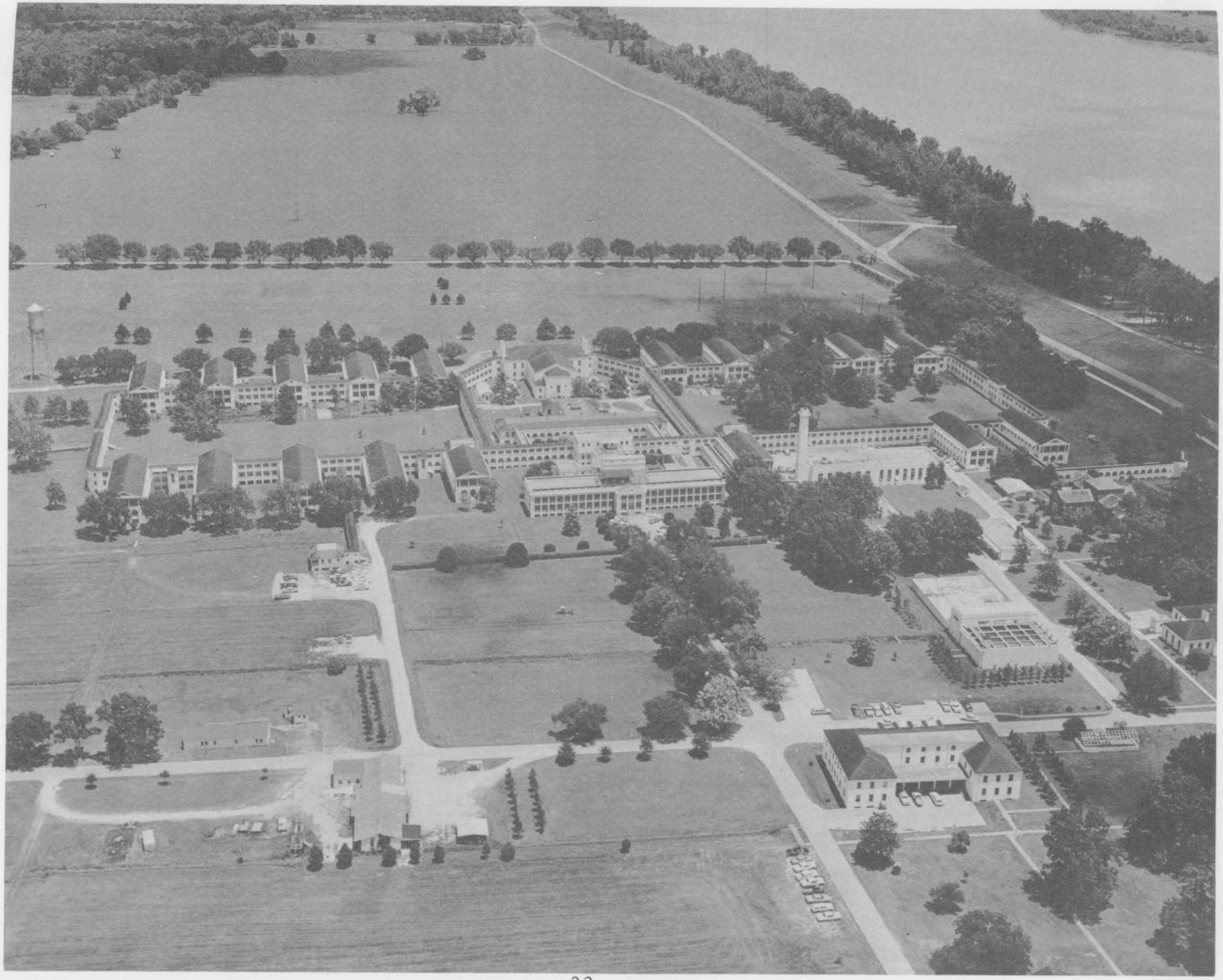
That the Medical Director of the U. S. Public Health Service Hospital, Carville, Louisiana, implement the findings in the conclusion. It is also recommended that the training committee now established within the hospital be more fully developed, to include representation by supervisors at all levels.

APPENDIX A

PHOTOGRAPH--MAJOR PORTION OF THE

U. S. PUBLIC HEALTH SERVICE

HOSPITAL, CARVILLE, LA.



APPENDIX B

PHOTOGRAPH--INFIRMARY, U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LA.

APPENDIX C

INSPECTION REPORT

INSPECTION REPORT

The following information with permission of the U. S. Public Health Service Hospital, Carville, Louisiana, was extracted from an inspection report written by the Dallas, Texas Regional Civil Service Office, after a training inspection was conducted at the U. S. Public Health Service Hospital, Carville, Louisiana, August 21-31, 1967:

> Technical training for the medical and other professional staff, generally in the form of further formal education and attendance at some professional seminars and conferences, appears to be excellent. Some of these employees are taking specialized courses at Louisiana State University; some are working toward advanced degrees; several of the top level staff hold faculty appointments at universities in the area which provide contacts important to professional growth and development. While the hospital is generally not directly involved as far as funding these activities, top management encourages this advanced training, and employee hours of work are adjusted wherever possible to accommodate participation.
>
> The above examples of skills training is typically the pattern throughout the hospital to varying degrees of intensity. In a number of areas, particularly in administrative and support organizations, the training needs are not too significant, since the activity is relatively stable and the employees are well experienced with many years of service at the hospital. Turnover at the hospital is relatively low, which has minimized training needs to a significant degree. Our contacts with managers and employees indicated that training needs to a large measure are identified through the performance evaluation process. While the inspection indicated that

management has a reasonably good record in determining requirements for training and in meeting these requirements, to a large extent the efforts seem to follow the brush "fire fighting" approach. For example, one department observes a pressing training need for the employees and proceeds to independently take care of the need.

It is recommended that a formalized program and training policy be developed. One person or a group of managers should be designated to consolidate needs, to study overall manhour and actual training expenditures, and to develop a means of evaluating training results. Training should be planned in advance, perhaps at the beginning of each fiscal year. There has not been the same degree of attention given to evaluating the results of training to be assured that it is effective and that there is good return on the training investment. Attempts should be made to improve upon this, particularly in the case of formal training. The evaluation should be in relation to the training objective or requirement, attempting to establish whether or not these were met. Where the evaluation indicates failings or deficiencies, the causative factors should be identified as a basis for improvement in the future. Obviously, line managers must assume the major responsibility to the evaluation of training.

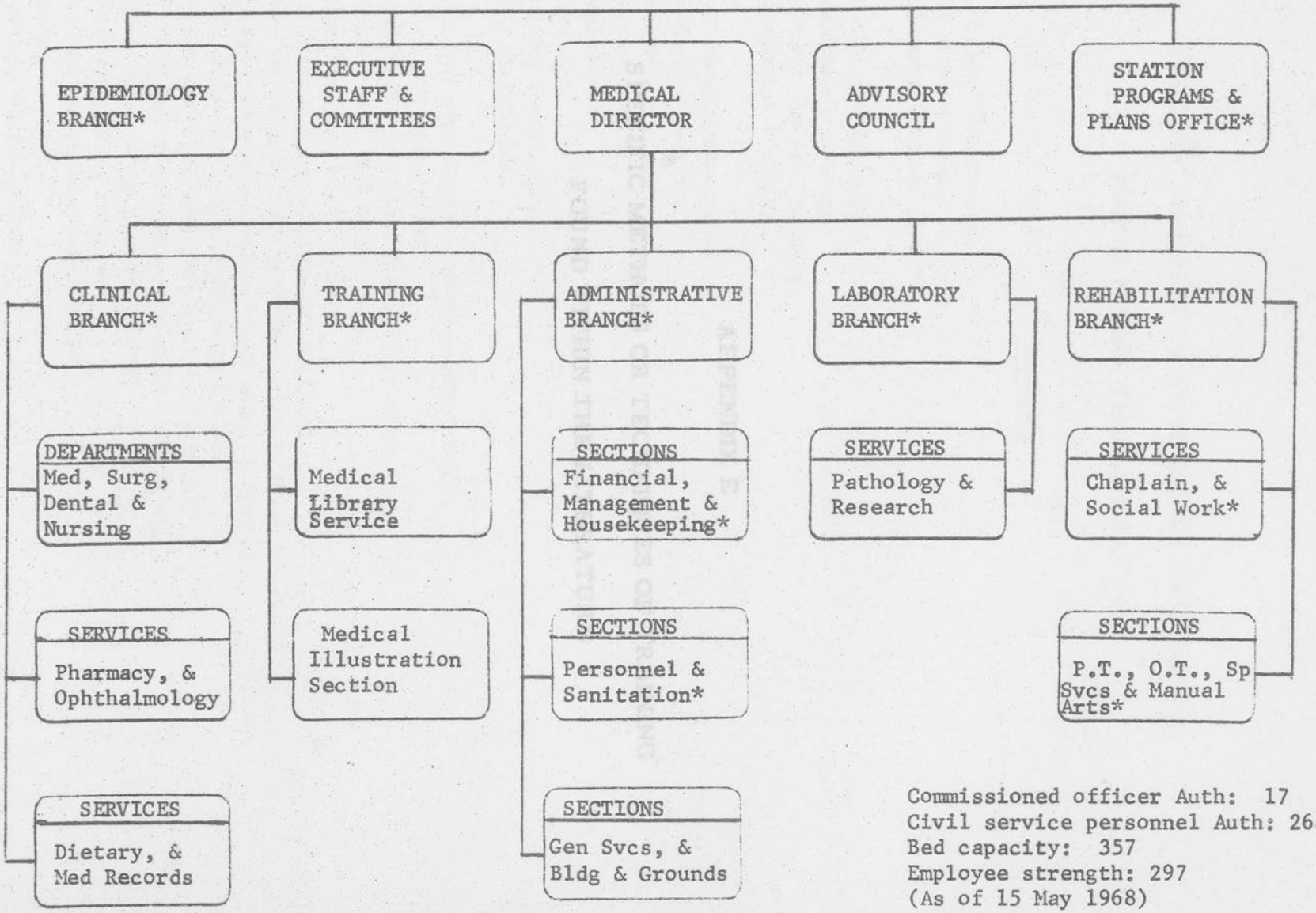
The most significant weakness in the total employee development program at the hospital concerns training supervisors and line managers in personnel management. The more significant inspection findings are directly traceable in most instances to this matter. While the personnel office has provided for such training, it has not been timely in some respects, and in a good many instances supervisors and managers have been "too busy" to take advantage of the training. This has been particularly true in regard to key middle managers.

There should be some provision during periods between the conduct of the formal course to bring new supervisors promptly abreast of their personnel management responsibilities, giving particular emphasis to special Presidential interest areas.

APPENDIX D

ORGANIZATIONAL CHART, U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LA.

ORGANIZATIONAL CHART
U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LA.



Commissioned officer Auth: 17
Civil service personnel Auth: 268
Bed capacity: 357
Employee strength: 297
(As of 15 May 1968)

*Branch, Department, Service, or Section where supervisors were interviewed.

APPENDIX E

SPECIFIC METHODS OR TECHNIQUES OF TRAINING

FOUND WITHIN THE LITERATURE

SPECIFIC METHODS OR TECHNIQUES OF TRAINING

FOUND WITHIN THE LITERATURE

Methods

[a]In-Basket Exercises.
The Action Maze.
Business Games.

[b]On-the-job-training.
Vestibule training.
Learner-helper training.
Apprentice training.

[c]Individual instruction.
Group instruction.
Lecture.
Demonstration.
Conference.
Meeting.
Written instruction.
Oral directions.

[d]Find out what learner knows--start there.
Teach easy jobs first.
Explain the job--tell the worker what to do.
Give a "pep" talk or lecture.
Experience is best teacher.
Put him to work--"pick up" method.
Show or demonstrate just how work is done.
Observe others working--visit other plants.
Place beginner with experienced man.
Assign teaching to straw boss or "pusher".
Trial under close supervision and check up.
Group discussion and questions.
Correspondence course.
Written instructions-textbooks.
Cases.
Movies, sound slides.

Critical incident considerations.
Psychological discussion.
Role playing.

Sources:

[a]Allen A. Zoll, Dynamic Management Education. A Folder of Management Games (Seattle, Washington: Management Education Associates, 1966), Sections IV, VI, IX.

[b]Ecker, et al., pp. 115-19.

[c]Beckman, p. 219.

[d]W. R. Spriegel and Edwin W. Mumma, Training Supervisors in Human Relations (Austin, Texas: The University of Texas, 1961), p. 23.

APPENDIX F

POPULATION, LABOR FORCE, EMPLOYMENT, AND UNEMPLOYMENT IN IBERVILLE PARISH, LOUISIANA

POPULATION, LABOR FORCE, EMPLOYMENT, AND UNEMPLOYMENT IN IBERVILLE PARISH, LOUISIANA

This information has been extracted from records on file at the bureau of vital statistics, Iberville Parish, Carville, La., and is used with the permission of the keeper of records:

Population Information	
Total (1967)	32,070
16 to 22 age group	3,162
45 and over age group	8,489
Work Force, Total (1966)	9,389
Employment, total	8,892
Manufacturing	1,492
Non-manufacturing	4,075
All other non-agriculture	2,254
Agriculture	1,073
Unemployment	
Total	497
Rate	5.3%
Number of families (1960)	6,523
Number of families earning less than $3,000	3,183
Percent of families earning less than $3,000	48.8%
Years of School Completed by Adults 25 years of age and Over (1969)	
Total population 25 years and over	14,401
Number that completed high school	1,732
Number that completed 1 to 3 years of high school	1,564
Number that completed 1 to 8 years of school	7,864

Aid to Dependent Children Caseload

March 1967, Total	419
White	50
Non-white	369

Other Facts (as of 1960)

Highest unemployment rate of 18 adjacent Parishes, including Iberville: 11.5%

Lowest unemployment rate of 18 adjacent Parishes, including Iberville: 2.8%

Highest rate of families earning less than $3,000 of 18 adjacent Parishes, including Iberville: 62.8%

Lowest rate of families of 18 adjacent Parishes earning less than $3,000, including Iberville: 21.9%

APPENDIX G

EXAMPLES OF EXAMINATIONS

GIVEN TO SUPERVISORS

EXAMINATION

SUPERVISORY TRAINING

NAME _____

STOP NUMBER _____

DATE _____

This is not a time test however, please complete it as fast as possible.

INSTRUCTIONS

TRUE OR FALSE

Place an X in the box under T if the statement is True or place an X in the box under F if the statement is False.

EXAMPLE:

	T	F
Baton Rouge is the capitol of Louisiana.	X	
New Orleans is the capitol of Louisiana.		X

COMPLETION

Read the questions and write the answers in the space below each question.

EXAMPLE:

The two largest cities in south Louisiana are:

1. Baton Rouge
2. New Orleans

MATCHING

On the left side enter the letter that appears next to the sentence on the right which describes the definition of the word.

EXAMPLE:

Baton Rouge __B__ A. Largest city in Louisiana

New Orleans __A__ B. Capitol of Louisiana

SUPERVISORY TRAINING

EXAMINATION

TRUE OR FALSE

Place an X in the correct box opposite each question.

		T	F
1.	A leader and a supervisor is one and the same.	☐	☐
2.	A supervisor is always a member of the group.	☐	☐
3.	Supervisory positions are all alike.	☐	☐
4.	The Public Health Service is under the jurisdiction of Health, Education, Welfare.	☐	☐
5.	The bureau of medical services is responsible for Public Health Service.	☐	☐
6.	Supervisory personnel have access to classification standards.	☐	☐
7.	Positions are subject to, or exempt from, the provisions of the classification act only by reason of congressional action.	☐	☐
8.	Standards are used for placing positions in their proper classes.	☐	☐
9.	Escalation of positions may be governed by supervisors.	☐	☐
10.	A position description is a result of an interaction between an employee and management.	☐	☐
11.	A position description is a general statement of what the employee does.	☐	☐
12.	Employee centered supervisor emphasizes the administrative and technical aspects of work processes.	☐	☐
13.	There are two major personnel systems used by the Public Health Service.	☐	☐
14.	There are 30,000 employees in the Health, Education and Welfare Department.	☐	☐
15.	The supervisor influences how the job is classified.	☐	☐
16.	Description of duties is officially recorded on an OF-52 form.	☐	☐
17.	Performance requirements are an integral part of the job description.	☐	☐
18.	Performance standards are developed by the Personnel Office.	☐	☐

		T	F
19.	The Personnel office assigns duties and responsibilities and the supervisor classifies the job.	☐	☐
20.	Implementation of personnel policies is generally the responsibility of the Personnel office.	☐	☐
21.	The supervisor is the person who has the most to do with seeing that the classification process works.	☐	☐
22.	The personnel office sets duties and responsibilities which makes up the job.	☐	☐
23.	Jobs in the General Schedule include "blue collar" occupations.	☐	☐
24.	Wage Board jobs include those paid on an hourly rate.	☐	☐
25.	Wage Board positions are classified under the General Schedule.	☐	☐
26.	Wage Board wage setting is done by the Civil Service Commission.	☐	☐
27.	The employee is responsible for preparing the job sheet.	☐	☐
28.	Performance requirements are set by the supervisor.	☐	☐
29.	Supervisors and employees are responsible for seeing that job descriptions are kept current.	☐	☐
30.	It is the supervisors responsibility to keep the Personnel office advised on anticipated staffing needs.	☐	☐
31.	Performance evaluation is not used to identify unsatisfactory workers.	☐	☐
32.	The Personnel office is the primary group responsible for motivating all employees.	☐	☐
33.	It is lawful for Federal employees to engage in political activities	☐	☐
34.	Career promotion may be made on employee whose job is reallocated.	☐	☐
35.	A detail is when you assign an employee to a job with the same grade level.	☐	☐
36.	Details may be between offices or within the same office.	☐	☐
37.	A detail changes an employee's Civil Service status.	☐	☐
38.	An employee may be detailed for 9 months without Civil Service approval.	☐	☐
39.	An employee detailed to a sensitive job doesn't need security clearance.	☐	☐
40.	Salary scale for General Schedule grades is set by Congress.	☐	☐
41.	Wage Board salary scale is set by Congress	☐	☐

		T	F
42.	Women under 18 years of age are not permitted to work at all from 7 p.m. to 7 a.m.	☐	☐
43.	Overtime work must be offically ordered or approved.	☐	☐
44.	All General Schedule employees are paid overtime pay.	☐	☐
45.	Wage employees must be paid for irregular or occasional overtime.	☐	☐
46.	Overtime worked on a holiday is paid at the rate of one and one-half times.	☐	☐
47.	The minimum charge for leave is 1 (one) hour.	☐	☐
48.	Employees may carry over to the next leave year a maximum of 45 days of accrued leave.	☐	☐
49.	An employee may be granted advance annual leave.	☐	☐
50.	An employee is required to complete a 90 day period of current continuous employment in order to be entitled to sick leave.	☐	☐
51.	Leave without pay may be demanded as a right of the employee.	☐	☐
52.	Court leave is changed to annual leave and not to compensatory leave.	☐	☐
53.	No excused leave may be granted for voting and registration.	☐	☐
54.	Safety may be defined as that condition or state of being free from danger or hazard.	☐	☐
55.	All accidents are caused. They simply don't happen.	☐	☐
56.	In a good safety program, it is important to discover and eliminate the hazards after an accident occurs.	☐	☐
57.	Safety at our hospital or at any other hospital is the sole responsibility of the safety committee or safety engineer.	☐	☐
58.	Many of the methods used to control quantity, quality, and production costs can be used with equal effectiveness to control accidents.	☐	☐
59.	Every institution should employ a full-time safety engineer that devotes all of his time in programming safety.	☐	☐

		T	F
60.	Causes of injuries are more important than causes of accidents.	☐	☐
61.	Direct costs ratio of each accident as opposed to indirect costs is approximately 10 to 1.	☐	☐
62.	Safety is often referred to as a built-in feature of a good supervisor.	☐	☐
63.	Repetition in safety is boring and monotonous and should be avoided.	☐	☐
64.	An accident can be defined as an unplanned event - a sudden interruption in an orderly procedure.	☐	☐
65.	A good supervisor recognizes that it is necessary to train all employees to understand that it is to their advantage as well as the company's to work safely, and that they are expected to cooperate in doing so.	☐	☐

COMPLETION

1. The two most improtant elements which guide us in assembling positions into classes are:

2. Give two ways in which a supervisor may orient new employees.

3. List three ways in which management is responsible to the supervisor.

4. List two ways in which supervisors are responsible to management.

5. List two ways in which supervisors are responsible to employees.

6. List three physiological needs of man.

7. List three basic needs for the ego.

8. List three ways in which the supervisor is responsible to the public.

9. List five desirable characteristics of supervisors.

10. List two means of communications.

11. List three signs of poor communications.

12. List three factors which prevent cooperation.

13. List three effects of absenteeism on the person being absent.

14. List three effects of absenteeism on other employees.

MATCHING

Demotion	_____	A. Separated from service
Promotion	_____	B. Take off duty & pay status by department for specific time.
Suspension	_____	C. Changed to lower grade or to a job with the lower minimum salary.
Admonishment	_____	D. Formal letter of adverse action.
Reassignment	_____	E. Change in the same grade on to a job with the same minimum salary.
Separation	_____	F. Formal interview with employee of his failure to live up to conduct standards.
Reprimand	_____	G. Changed to position of a higher grade.
Resignation	_____	H. Separated at request of employee.

APPENDIX H

CONTINUOUS YEARS OF EMPLOYMENT AND TOTAL YEARS OF FORMAL EDUCATION OF ALL EMPLOYEES, (MINUS 15 DEPARTMENT OR SECTION SUPERVISORS), AT THE U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LOUISIANA

CONTINUOUS YEARS OF EMPLOYMENT AND TOTAL YEARS OF FORMAL EDUCATION OF ALL EMPLOYEES, (MINUS 15 DEPARTMENT OR SECTION SUPERVISORS), AT THE U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LOUISIANA

Education within the hospital employee ranks has most certainly been affected by supervisory training, or a lack of it. Traditionalism has been prevalent within the hospital. For example, some employees and supervisors have been at the same jobs for so many years that mild complacency seemed to exist in several areas visited. More could be done by management to improve the educational plight of some of the employees. It is true that several employees were quite contented to remain "status quo" and seemed to care little for advancement and more education. One question to be answered is should top management establish a firm program to ensure that every employee is fully aware of the state and federal funds, facilities, and programs that are available to him for the purpose of self improvement? Supervisors most certainly have a responsibility for aiding the man or woman who cannot read or write. In order to do this the supervisor must first have formal guidance and training. The following listed statistics not only

informs the reader of the poor educational background of some of the employees, they illustrate a monumental challenge for the supervisors of these employees, a challenge to aid the employees in obtaining more formal education under civil service sponsorship. While records were not on file to show what has been done in this area, most certainly on file were records showing when, how, where, and under what circumstances supervisors counseled employees on letters of indebtedness received at the hospital. There did exist a defined system to handle personal matters of this nature. Therefore, an argument that "We should not involve ourselves in the personal business," is not valid. The top 15 supervisors of the hospital are not included in these statistics, although 18 of those in the list are assistant supervisors. The top 15 supervisors all have at least a high school education and 12 of them have at least four years of formal college, receiving B. S. or B. A. Degrees. Six records were not available.

Year of Initial Employment	Total Years of Formal Education	High School Graduate?	Years of Initial Employment	Total Years of Formal Education	High School Graduate?
1958	11	No	1963	7	No
1954	4	No	1966	11	No
1960	12	No	1952	8	No

1961	12	Yes	1966	12	Yes
1966	12	Yes	1961	11	No
1959	12	Yes	1965	12	Yes
1955	8	No	1966	11	Yes
1966	11	No	1961	12	Yes
1944	2	No	1945	11	Yes
1958	12	Yes	1937	11	No
1968	16	Yes	1954	10	No
1954	13	Yes	1946	10	No
1967	15	Yes	1946	15	Yes
1967	13	Yes	1966	12	Yes
1957	12	Yes	1951	12	Yes
1956	12	Yes	1966	12	Yes
1965	12	Yes	1963	18	Yes
1945	7	No	1965	10	No
1943	7	No	1958	11	Yes
1949	15	Yes	1946	5	No
1946	8	No	1963	16	Yes
1964	11	Yes	1964	12	Yes
1949	14	Yes	1946	8	No
1954	11	Yes	1966	20[b]	Yes
1959	12	Yes[a]	1945	5	No
1965	12	Yes	1942	7	No
1952	7	No	1929	0[c]	No
1944	5	No	1930	0[c]	No
1948	13	Yes	1949	8	No
1966	12	Yes	1955	10	No
1941	3	No	1938	7	No
1961	10	No	1941	3	No
1959	16	Yes	1943	6	No
1947	3	No	1964	13[d]	No
1948	4	No	1957	16	Yes
1967	12	Yes	1957	13[d]	No
1960	8	No	1945	12	Yes[a]
1946	7	No	1956	13	No
1959	13	No[d]	1964	14	Yes
1947	5	No	1968	16	Yes
1946	12	Yes	1924	8	No
1965	12	Yes	1961	11	Yes
1958	14	Yes	1947	11	Yes
1968	11	No	1967	12	Yes
1957	18	Yes	1945	11	Yes
1930	11	Yes	1963	20[b]	Yes

1959	8	No	1946	16	Yes
1952	5	No	1938	2	No
1944	3	No	1944	5	No
1964	16	Yes	1967	18	Yes
1967	12	Yes	1964	12	Yes
1952	7	No	1967	12	Yes
1963	16	Yes	1954	8	No
1963	12	Yes	1945	6	No
1962	12	Yes	1967	16	Yes
1961	14	Yes	1960	16	Yes
1965	16	Yes	1955	11	Yes
1956	11	Yes	1946	12	Yes[a]
1933	8	No	1947	4	No
1925	7	No	1945	7	No
1940	4	No	1965	16	Yes
1937	4	No	1966	11	Yes
1959	14	Yes	1963	16	Yes
1947	16	Yes	1944	11	Yes
1964	12	Yes	1945	6	No
1966	12	Yes	1948	4	No
1966	16	Yes	1954	10	No
1966	12	Yes	1964	12	Yes
1967	12	Yes	1968	12	Yes
1948	14	No[d]	1961	16	Yes
1958	12	Yes	1954	10	No
1958	12	Yes	1945	11	Yes
1946	13	Yes	1947	11	Yes
1941	8	No	1960	12	Yes
1962	12	Yes	1966	8	No
1957	12	Yes	1957	9	No
1946	7	No	1957	11	Yes
1957	11	Yes	1967	16	Yes
1954	9	No	1953	16	Yes
1942	7	No	1967	16	Yes
1967	11	Yes	1967	12	Yes
1959	12	Yes	1942	7	No
1952	7	No	1965	16	Yes
1942	5	No	1942	7	No
1941	8	No	1967	20[b]	Yes
1967	16	Yes	1952	16	Yes
1944	6	No	1968	10	No
1967	11	No	1960	16	Yes
1967	11	No	1957	12	Yes

1959	12	Yes	1966	7	No
1968	12	Yes	1968	13	Yes
1964	14	Yes	1967	10	No
1955	12	Yes	1955	11	Yes
1958	13	Yes	1949	8	No
1966	11	Yes	1946	4	No
1966	18	Yes	1956	10	No
1946	12	Yes	1937	4	No
1962	16	Yes	1947	7	No
1938	7	No	1957	13	Yes
1966	12	Yes	1966	12	Yes
1959	12	Yes	1940	4	No
1951	16	Yes	1968	12	Yes
1936	14	Yes	1966	12	Yes
1958	11	Yes	1968	10	No
1965	11	Yes	1960	12	Yes
1947	8	No	1949	10	No
1941	3	No	1967	11	Yes
1960	11	No	1952	12	Yes
1954	6	No	1968	14	Yes
1952	7	No	1945	8	No
1951	8	No	1967	16	Yes
1963	16	Yes	1947	2	No
1925	16	Yes	1960	11	Yes
1966	11	Yes	1937	0[c]	No
1941	5	No	1938	5	No
1962	10	No	1942	4	No
1954	8	No	1952	16	Yes
1945	5	No	1963	16	Yes
1968	12	Yes	1948	10	No
1963	12	Yes[a]	1966	10	No
1961	12	Yes	1965	12	Yes
1962	10	No	1945	5	Yes
1959	14	Yes	1945	0[c]	No
1960	9	No	1945	6	No
1946	10	No	1945	3	No
1959	12	Yes	1948	11	Yes
1946	6	No	1967	12	Yes
1940	4	No	1956	6	No
1945	9	No	1966	16	Yes
1966	20[b]	Yes	1967	20[b]	Yes
1966	20[b]	Yes	1966	20[b]	Yes
1966	20[b]	Yes	1967	18	Yes
1966	18	Yes	1968	20[b]	Yes

1967	20[b]	Yes	1967	18	Yes
1961	18	Yes	1967	20[b]	Yes
1960	12	Yes	1962	10	No
1948	11	Yes	1949	9	No
1951	11	Yes	1957	10	No

[a]Passed General Educational Development (GED) test and received high school diploma from the State of Louisiana.

[b]Physician.

[c]Either never started or finished the first grade.

[d]Repeated last year of high school over once or twice but never never graduated.

Range for formal years of education: 0 to 20

Range for years of initial employment: 1925 to 1968

Mean for years of initial employment: 1960 or 8 years

Mean for years of formal education: 9 years

Source: Personnel Office, U. S. Public Health Service Hospital, Carville, Louisiana, May 17, 1968.

APPENDIX I

FACTS ABOUT LEPROSY

Clinical Aspects of Leprosy*

JOHN R. TRAUTMAN, M.D.,† *Carville, La.*

This is a disease to be suspected under certain circumstances as outlined by the author. It is endemic in certain parts of the country, and in some areas of the South this is a fact to be kept in mind.

Definition. Leprosy is a chronic infectious disease involving primarily the skin, mucous membranes and peripheral nerves.

Etiology. The *Mycobacterium leprae* is accepted as the direct cause of the disease. The organism was initially described as being associated with leprosy by Dr. G. Armauer Hansen in 1874. *M. leprae* is an acid-fast bacillus similar in appearance to *M. tuberculosis* but, unlike the latter, has not definitely produced disease in animals and has not been cultured *in vitro.*

Epidemiology

Estimates of the number of cases of leprosy in the world vary considerably, but it is probable that at least 20,000,000 exist. The disease is extremely common in central Africa; high prevalences have been reported for China, India, and South America and significant numbers in many other areas. The number of cases in the United States is estimated to be about 2,500, but because of problems in diagnosis and the tendency for patients to conceal their identity, it is probable that the actual number is considerably higher. Of the known cases in the United States the majority are in California, Texas, Louisiana, Florida and Hawaii, but every section of the country has some.

The mode of transmission is not known with certainty. Many experts in leprosy believe that skin to skin contact with a bacteriologically positive patient is necessary; others believe that transmission via the respiratory tract is a distinct possibility. It is reasonable to assume that the degree of intimacy of the contact and its duration, are important factors contributing to transmission of the disease. Of probable significance, however, is the fact that about 50% of the patients who have been admitted to the U. S. Public Health Service Hospital, Carville, Louisiana, gave no history of contact with leprosy. We believe, as do many investigators in other areas of the world, that a genetic factor exists which produces susceptibility to leprosy in a given person, but unfortunately no test exists to determine susceptibility. We can and do, however, concentrate our epidemiologic efforts on members of the patient's family who have been exposed to the disease. The attack rate in these persons is thought to average about 5% in the United States. Figures from other areas of the world vary considerably.

The "incubation" or "latent" period of leprosy is quite variable, ranging from less than a year to many years, averaging probably three to five years. Because this interval is often prolonged, it is difficult to examine adequately the known contacts over periods of time necessary to determine the attack rates. In addition, the disease is erroneously considered by many persons, including medical personnel, to be an insignificant problem in the United States. This has resulted, not infrequently, in physicians not considering leprosy when such consideration was indicated.

Clinical Characteristics

Classification of Leprosy. The recommended classification is as follows:

- Indeterminate leprosy.
- Tuberculoid leprosy.
  - Minor tuberculoid
  - Major tuberculoid
- Dimorphous leprosy.
- Lepromatous leprosy.
  - Diffuse lepromatous
  - Infiltrated lepromatous
  - Nodular lepromatous

Signs and Symptoms. The presenting complaint of the patient will vary considerably depending on the type and duration of the disease. He will generally seek medical aid once

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skin lesions have appeared, but if a careful history and physical examination are not obtained the lesions may be misdiagnosed because leprosy can be confused with numerous other diseases. Among those most commonly causing diagnostic difficulty are the various dermatophytoses (especially ringworm), sarcoidosis, lupus erythematosus, seborrheic dermatitis, psoriasis, granuloma annulare and acne.

Anesthesia, or "numbness," as it is often referred to by the patient, frequently precedes by months or years the onset of visible lesions. Any area of the body may develop anesthesia, but one or more extremities are most likely to be involved. Decreased sensation is not diagnostic of leprosy but when present should arouse suspicion. Enlargement of peripheral nerves is common in leprosy and, as with anesthesia, may be an early manifestation. Enlargement of numbers of nerves is more commonly associated with lepromatous and dimorphous leprosy than with tuberculoid leprosy. Enlargement of nerves, such as the ulnar (above the elbow), the radial (at the wrist), the peroneal and the posterior auricular, should be sought for on physical examination. Nerve involvement frequently results in weakness and atrophy of muscles supplied by the nerve. Claw-hand, foot-drop and facial paralysis may result, especially in untreated or mismanaged cases. Nerve pain and tenderness is common.

Erythema nodosum, the lesions of which are not those of leprosy but which are associated with lepromatous leprosy, may occur at any time during the course of the disease. The lesions of erythema nodosum are discrete, firm, erythematous and painful; they may be accompanied by temperatures up to 105° F. The lesions may be located anywhere on the body but are most common over the extremities. Individual lesions tend to regress within 72 hours, but the overall course may be prolonged.

Nasal congestion, epistaxis, and inflammatory changes of the eyes may also cause the patient to seek medical aid. Later in the course of lepromatous leprosy the patient may complain of loss of eyebrows, loss of eyelashes and, less frequently, loss of body hair. The scalp hair is usually unaffected.

Characteristics of Skin Lesions. Leprosy can mimic almost every type of skin disease, though the lesions of the various types of leprosy have certain characteristics which, although not diagnostic of the disease, do give clues as to its classification.

Indeterminate leprosy is thought to be an early form of leprosy; it is diagnosed infrequently in the continental United States. The lesions may appear as single or multiple wheal-like papules or vague hypopigmented or pinkish macules. No definite statement can be made as to the probable course the disease may follow, and at times the diagnosis of leprosy is difficult. It is thought that the majority of persons with this type of disease recover spontaneously.

Tuberculoid leprosy affects primarily the peripheral nervous system, though skin lesions are common. These can be classified as major or minor tuberculoid lesions, with the main differential points being that the major lesions are larger and more indurated than are minor lesions. Tuberculoid lesions are usually single or few in number. They tend to occur chiefly on the face, extremities, back and buttocks. Characteristically they are asymmetrical in their location, e.g., if a lesion is present on one arm or on the face there will generally not be a similar lesion on the other arm or opposite side of the face. The lesions usually have a clear-cut margin which is often more elevated and may be darker than the center of the lesion. The surface tends to be scaly and the entire lesion is anesthetic or hypesthetic. Macular lesions occur frequently in tuberculoid leprosy. Characteristically they are hypopigmented (but hyperpigmentation may be present) and have a sharply defined margin; anesthesia in these lesions is usually present.

Lepromatous leprosy is characterized by generalized involvement of the skin and mucous membranes. Peripheral nerves are also involved, but serious involvement leading to deformity is usually seen in the later stages of the disease. In the *diffuse* type there is generalized involvement of the skin without obvious individual lesions. In the *infiltrated* type there are present areas of obvious infiltration superimposed on generalized, slight thickening of the skin. The *nodular* type is characterized by small to moderately large nodules which may appear anywhere on the body. Lesions of the latter two types of lepromatous leprosy tend to be widely and symmetrically distributed. Macular lesions can occur in any type of lepromatous leprosy, and vary in size, number and

degree of pigmentation. Most lepromatous lesions, regardless of type, have a smooth surface except when undergoing resolution, when the surface may become wrinkled. Characteristically lepromatous lesions have an ill-defined margin. The individual lesions may or may not be anesthetic, but associated glove or stocking type anesthesia is common.

Dimorphous leprosy, which has also been called "borderline" or "intermediate" leprosy, reveals mixed features. Many cases show individual lesions compatible with tuberculoid leprosy and other lesions consistent with lepromatous leprosy, but these changes may be present in the same lesion. The degree to which dimorphous leprosy resembles each type varies considerably from patient to patient and may be quite variable during the course of a given case. The lesions tend to have an elevated center and a sharply defined border; not infrequently, however, the border is vague. Macular lesions are common and, as might be expected, can resemble either tuberculoid or lepromatous macules.

Diagnosis

The importance of a careful history and physical examination is obvious. A history of or *the presence of anesthesia should be considered with suspicion*. Nerves should be palpated for enlargement and tenderness and muscular weakness or trophic changes sought. Deep tendon reflexes are usually not affected in leprosy. Since the skin lesions of leprosy may be mistaken for other dermatologic conditions, the routine examination of biopsy material is strongly recommended. Biopsy should be made of visible lesions, but if none are present biopsy of an anesthetic area may yield the diagnosis. Smears of the skin for acid-fast bacilli are at times a helpful screening procedure, though the presence or absence of these organisms is not justification for making or excluding a diagnosis,—*this procedure should not be substituted for the biopsy*. It should also be emphasized that the presence of acid-fast bacilli in nasal smears only is not of particular significance; conversely, the absence of bacilli on nasal scrapings does not rule out the diagnosis. Furthermore, it is extremely unlikely that *M. leprae* can be present in the nasal smears without obvious signs of the disease being present elsewhere. The lepromin test is not a diagnostic test for leprosy. A strongly positive response to lepromin is found, characteristically, in tuberculoid leprosy; a negative response is the rule in lepromatous leprosy. It is variable in dimorphous leprosy but usually is not strongly positive or negative and in normal controls ranges from negative to strongly positive. The factors which govern these responses are unknown.

Biologically false positive serologic tests for syphilis frequently are caused by leprosy, particularly by lepromatous leprosy. Cognizance of this fact and that the T.P. is negative in leprosy may prevent later embarrassment to the physician whose responsibility it is to determine the etiology of a positive S.T.S. It should be remembered, however, that syphilis and leprosy can occur in the same patient.

Treatment

Prior to 1941 the treatment of choice was chaulmoogra oil. Improvement was noted in many cases, but the relapse rate, especially in Caucasians, was found to be extremely high; serious complications were frequent. It became increasingly obvious that a more effective chemotherapeutic agent was needed.

With the introduction of sulfanilamide in 1937 many related drugs were investigated for antibacterial activity. Among these was DDS (4:4′-diaminodiphenyl sulfone), originally synthesized in 1908. In using this drug for the treatment of human infections other than leprosy during the years 1937-1940, it was found to be highly toxic. Later investigations revealed that smaller dosages were well tolerated. In searching for less toxic drugs, glucosulfone sodium (Promin) was synthesized. It showed some activity against guinea pigs infected with human tubercle bacilli, and since *M. leprae* has certain morphologic and staining characteristics similar to *M. tuberculosis*, it was a natural step to study its effect on leprosy. In 1941, under the direction of Dr. Guy Faget, Promin was first tried and during subsequent years found to be more effective in most respects than chaulmoogra oil.

Other sulfones were investigated, including the parent compound DDS, acetosulfone (Promacetin), and Sulphetrone and found to be equally effective. At present the sulfones most frequently used at Carville are Diasone, DDS and Sulphetrone. Diasone and DDS are administered orally and Sulphetrone intramuscularly. Antituberculosis drugs are relatively ineffective in leprosy when compared to sulfones, but

the former drugs are of some value in the treatment of patients who cannot tolerate sulfones.

Sulfone therapy can be expected to result in various degrees of improvement in most instances, but extremely good results are noted in less than 25% of our lepromatous cases. This is perhaps partially attributable to late diagnosis. The incidence of severe complications has been reduced, however, since the advent of sulfone therapy. Other drugs are being investigated, but at this time no definite statement can be made regarding their overall effects.

In addition to specific chemotherapy, other treatment programs are of great importance in the total management of the patient. Physical therapy can be of great benefit in preventing complications such as contractures and footdrop. Orthopedic consultation is indicated in every case. In patients with nerve involvement, especially of the ulnar and peroneal nerves, surgical procedures can be performed that often result in a lessened incidence of muscle weakness, deformity and trophic changes. One such procedure is transposition of the ulnar nerve. Close attention to eye problems has produced excellent results, and a reduction, if not complete eradication, of blindness in treated cases. An important adjunct to the treatment of the eye lesions in leprosy was the introduction of corticosteroids. These are most effective when used locally.

Supervised recreational activities, occupational therapy and manual arts programs are important rehabilitative measures as is spiritual guidance and the assistance offered by social service workers. An accredited school should be available for patients who need to continue their education.

It is impossible to outline a drug and treatment regimen which can be followed in every case of leprosy. Much depends on the type and duration of the disease and the response to therapy. It is important that sulfone therapy be started in low dosages (e.g., DDS 25 mg. weekly) and gradually increased over a period of at least six months to optimum levels (e.g., DDS 100 mg. four to five days weekly). In the event of "reactive" episodes of tuberculoid and dimorphous leprosy or increasing nerve involvement with resultant muscular weakness in any type of leprosy, or severe erythema nodosum, which occurs only in lepromatous leprosy, sulfone therapy should be discontinued and parenteral or oral corticosteroid therapy instituted. More specific recommendations about treatment will be outlined in a subsequent paper.

It is recommended that patients of newly diagnosed cases of leprosy and problem cases be hospitalized when feasible until such time that a satisfactory program of treatment can be maintained on an outpatient basis. Complete facilities for treatment are available at the U. S. Public Health Service Hospital, Carville, Louisiana. This hospital will accept any patient with leprosy or contact thereof who presents himself for treatment or examination. Any patient suspected of having leprosy may also be admitted for evaluation. Admission is on a voluntary basis only.

Biopsy specimens may be mailed at any time to the Laboratory Branch, U. S. Public Health Service Hospital, Carville, Louisiana, either in the form of slides or as uncut sections in 10% formalin.

APPENDIX J

TRAINING DESIRES OF SUPERVISORS

U.S. PUBLIC HEALTH SERVICE HOSPITAL
New Orleans, Louisiana

TRAINING APPLICATION

(Please print)

A. Name (Dr. Mr. Mrs. Miss _____)
Last First Middle Initial

Field Eb

B. Sex (Circle) 1. Male 2. Female

D. Present Mail Address

(_____)
Street

_____)
City State Zip Code

E. Profession or Occupation (Circle One)

1. Administrative
2. Clerical (Secretarial)
3. Dentist
4. Food Service
5. Laboratory
6. Medical Records
7. Nurse
8. Physician
9. Other (_____)

F. Present Employment:

1. Work Location (_____)
Street City State
2. Position Title and Grade (_____)

3. Employing Agency (_____)

G. Formal Education

A. High School
1. Yes
2. No

B. College Degrees
(_____)
_____)

H. Training Received

1. Indicate Title of Training, Sponsor, Location, Dates

DDHS-280
PHS (NO) 6/67

APPENDIX K

WORD PICTURE OF A POOR SUPERVISOR

WORD PICTURE OF A POOR SUPERVISOR

1. Loudly reprimands subordinates in the presence of other people.
2. Shows favoritism toward certain individuals in the unit.
3. Has insufficient knowledge of the work.
4. Gives poor instruction--either too general or not complete.
5. Deadlines not explained in advance.
6. Using employees as scapegoats for the supervisor's errors.
7. Refusal to admit mistakes.
8. Failure to support (and fight for) his people.
9. "Picky"--finds fault with everything his people do.
10. "Snoopervision"--always poking his nose into personal matters (usually explained as different from being asked for advice on personal matters).
11. Oversupervision, that is, too close watching of everything his people are doing.
12. Failure to delegate authority to his people, where needed.
13. Does not trust his people fully.
14. Gossips about one of his people with another in the same group.
15. Never gives credit where credit is due.
16. Failure to provide adequate materials or facilities for his people.
17. Clear-cut, prompt decisions almost impossible to get.
18. Treats his people as inferiors, not as associates.
19. Displays too much "brass"; never lets anyone forget he is the boss.

20. Never gives his people a chance (i. e., to get credit, to win promotions, to use their own initiative, etc.).

Source: Van Dersal, pp. 19-20.

APPENDIX L

TWENTY-FIVE PRINCIPLES OF SUPERVISION

CHOSEN AT RANDOM FROM THE LITERATURE

TWENTY-FIVE PRINCIPLES OF SUPERVISION

CHOSEN AT RANDOM FROM THE LITERATURE

[a]1. Final responsibility cannot be divided.
2. Responsibility must be accepted fully or not at all.
3. Responsibility may be delegated but not relinquished.
4. Responsibility should always be accompanied by full authority.
5. The man who assumes responsibility should know what is expected and is alone accountable for results.
6. In delegating responsibility give it in terms of expected results.
7. Leave the method of carrying responsibility out to the person who assumes it, if he knows how.
8. Assume no authority over work for which you have not been made responsible--stick to your own job.

[b]9. People must always understand clearly what is expected of them.
10. People must have guidance in doing their work.
11. Good work should always be recognized.
12. Poor work deserves constructive criticism.
13. People should have opportunities to show that they can accept greater responsibility.
14. People should be encouraged to improve themselves.
15. People should work in a safe and healthful environment.

[c]16. Work must be divided.
17. There must be authority and responsibility.
18. There must be discipline.
19. There must be unity of command and direction.
20. A scalar chain must exist.
21. There must be esprit de corps.
22. There must be initiative.
23. There must be stability of tenure.
24. There must be centralization and order.
25. There must be renumeration and subordination.

Sources:

[a]Beckman, p. 299.
[b]Van Dersal, pp. 25-38.
[c]Koontz and O'Donnell, pp. 18-19.

APPENDIX M

QUESTIONS ASKED AND ANSWERS RECEIVED DURING NON-STRUCTURED INTERVIEWS WITH 15 DEPARTMENT, BRANCH OR SECTION SUPERVISORS, U.S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LOUISIANA

QUESTIONS ASKED AND ANSWERS RECEIVED DURING NON-STRUCTURED INTERVIEWS WITH 15 DEPARTMENT, BRANCH OR SECTION SUPERVISORS, U. S. PUBLIC HEALTH SERVICE HOSPITAL CARVILLE, LOUISIANA

	Questions	Answers
1.	How many people do you supervise?	3, 6, 26, 56, 76, 14, 6, 5, 11, 60, 4, 7, 5, 5, 50
2.	Do you believe that too many minor administrative requirements are brought to your attention that could be resolved in a classroom type situation?	Yes: 8, No: 6, Don't know: 1
3.	There are three broad methods to use in training supervisors. The first is decentralized training as it is now conducted, but more formal and under the control of one person in regards to maintaining attendance records for all, publishing a master schedule, enforcing attendance, etc. A second method would be a decentralized supervisors' training program as stated above, but naming the Personnel Officer as the responsible individual. One other method is a centralized program under complete control of the Training Officer, well planned, organized, executed and controlled. Which of these methods do you prefer?	For First method: 6 For Second method: 0 For Third method: 9 No comment on any of the three methods: 0

4.	Please rate your present supervisors' training program as follows: unsatisfactory, satisfactory, good, excellent, or outstanding.	Unsatisfactory: 5 Satisfactory: 6 Good: 2 Excellent: 2 Outstanding: 0
5.	In response to the statement, "supervisory training programs are weak at this hospital," I ask that you comment yes, no, or don't know.	Yes: 3 No: 10 Don't know: 2
6.	Do you feel attendance should be mandatory at supervisory training classes? Please respond with yes, no, or don't know?	Yes: 9 No: 1 Don't know: 5
7.	How many weeks ago did you last attend a supervisory training class or related class that contributed to your development as a supervisor?	8, 12, 18, 18, 24, 16, 16, 16, 8, 16, 16, 16, 16, 16, 16
8.	Is your immediate superior supporting you in regards to training and ensuring that you and your people do go to classes held? Please answer yes, no, or don't know.	Yes: 10 No: 2 Don't know: 3
9.	Please choose one of the three statements offered regarding supervisors' training at this hospital. If you don't like any of the three, please state so. A. We need new methods and techniques. B. We are doing fine now. C. We are in a rut. D. No comment.	A: 8 B: 3 C: 3 D: 1

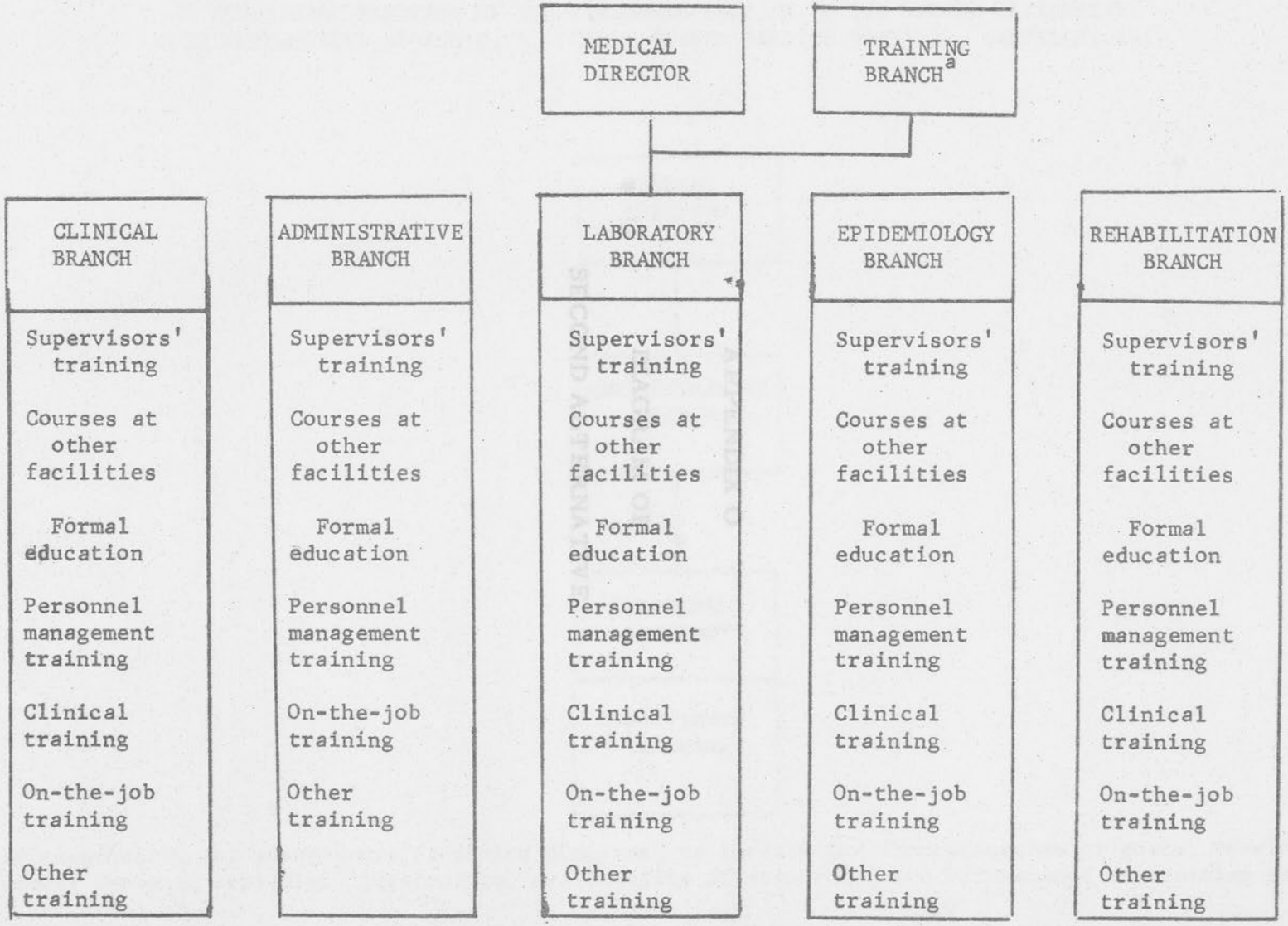
10.	I wish for you to define a supervisor as one who has been rating subordinates in writing. Please tell me in months or years how long you have been a supervisor at this hospital?	9 months 2 years 2 years 2 years 4 years 6 years 8 years 9 years 10 years 11 years 12 years 15 years 21 years 22 years 31 years

APPENDIX N

DIAGRAM OF

FIRST ALTERNATIVE

MAJOR FUNCTIONS OF THE TRAINING BRANCH IF THE FIRST ALTERNATIVE IS IMPLEMENTED AT THE U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LA.



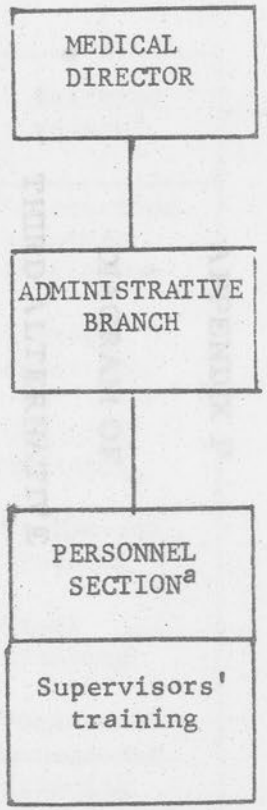
[a]Coordinates with all branches and the Medical Director to ensure that each branch identifies needs, develops schedules, provides instructions, coordinates use of resources, and maintains training records.

APPENDIX O

DIAGRAM OF

SECOND ALTERNATIVE

ADDITIONAL FUNCTION OF THE PERSONNEL SECTION IF THE SECOND ALTERNATIVE IS IMPLEMENTED AT THE U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LA.



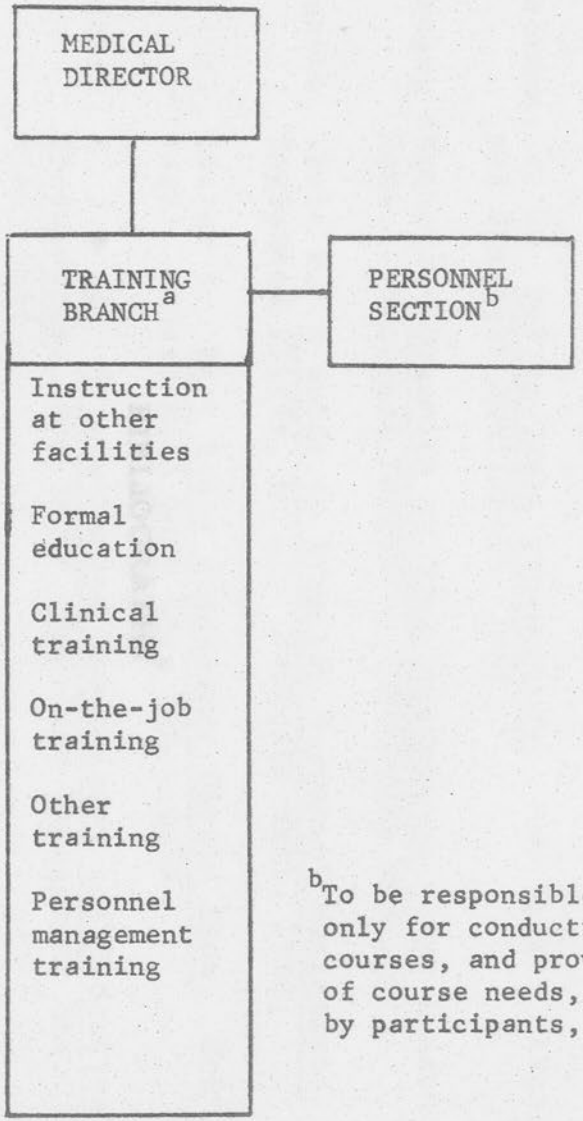
[a]To be responsible for supervisors' training programs, to include the identification of goals, development of course content, schedules, instructors, availability of resources, and maintenance of training records.

APPENDIX P

DIAGRAM OF

THIRD ALTERNATIVE

MAJOR FUNCTIONS OF THE TRAINING BRANCH IF THE THIRD ALTERNATIVE IS IMPLEMENTED AT THE U. S. PUBLIC HEALTH SERVICE HOSPITAL, CARVILLE, LA.



[a] To be responsible for all training programs to include the identification of goals, development of course content, schedules, instructors, availability of resources, and the maintenance of training records.

[b] To be responsible to the Training Branch only for conducting supervisors' training courses, and providing feed-back in terms of course needs, attendance, suggestions by participants, etc.

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BIOGRAPHICAL SKETCH

Major William M. Boyd, Jr., Service Number OF101203, Medical Service Corps, U. S. Army, [redacted]. After graduating from high school in 1952, he served three years in the U. S. Air Force. He subsequently was awarded a B. S. Degree in Physical Education and an M. A. Degree in Education and Administration from East Carolina University, Greenville, N. C.

He entered active duty as a second lieutenant in July, 1959. After a twelve week basic course for officers at Fort Sam Houston, Texas, he was assigned to the U. S. Army Hospital, Fort Lee, Va.

From November, 1962, until October, 1964, he was assigned as the Registrar of the U. S. Army Hospital, Ryukyu (Okinawa) Islands. After airborne training in 1964 he was assigned to the 173d Airborne Brigade, going with that unit to Viet Nam in 1965.

He attended the advanced course for medical service officers of the Army in 1966 at Fort Sam Houston, Texas, returning to Viet Nam in that year for a twelve month tour with the 1st Air Cavalry Division. Major Boyd was assigned to the Health Care Administration Course in July, 1967.

He is presently assigned to the U. S. Army Hospital Specialized Treatment Center, Fort Gordon, Ga. He has a wife and three children.