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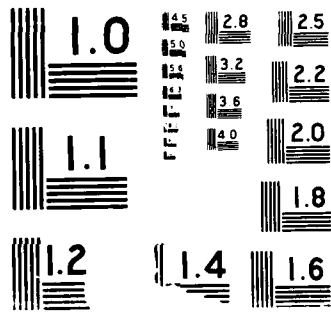
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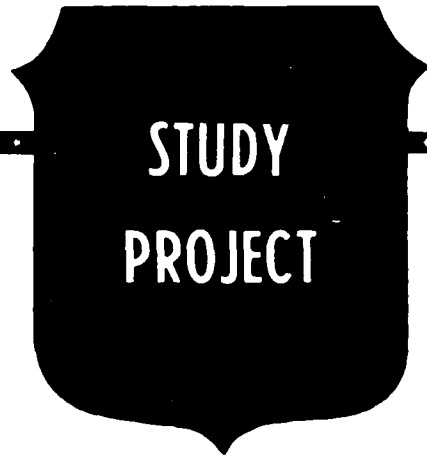
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ORAL HISTORY
BRIGADIER GENERAL (RETIRED) CONNIE L. SLEWITZKE

BY

LIEUTENANT COLONEL BEVERLY A. GREENLEE, AN

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ORAL HISTORY, BRIGADIER GENERAL (RETIRED) CONNIE L. SLEWITZKE

AN INDIVIDUAL STUDY PROJECT

by

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INTRODUCTION

This paper is an analysis based on taped oral history interviews with Brigadier General (BG), Retired Connie L. Slewitzke, an untaped interview with Colonel John Hudock and official documents from the Office of the Surgeon General.

Brigadier General Slewitzke was interviewed on three separate occasions, November 30, 1987, December 1, 1987, and January 25, 1988, at her home in Annandale, Virginia. BG Slewitzke retired as Chief, Army Nurse Corps on August 31, 1987, after having served for four years in that position. Prior to her assumption of the duties as Chief, Army Nurse Corps on September 1, 1983, she had served as Assistant Chief, Army Nurse Corps from September 1, 1979, to August 31, 1983.

The purpose of interviewing BG Slewitzke was to provide a historical record of her reflections on the issues she dealt with during her tenure as Chief, Army Nurse Corps and to reflect on lessons learned for future generations of Nurse Corps officers and leaders. During the eight years she served as Assistant Chief and Chief of the Nurse Corps, she faced more critical issues directly impacting on the long term future of the Corps than any of her predecessors.

Brigadier General Slewitzke occupied these positions

during a turbulent period for the Nurse Corps and the Army as a whole. From this turbulence came many of the issues which were addressed in the interviews with BG Siewitzke. The two issues which were most critical to the Nurse Corps were the Army Medical Officer Structure Study (AMOSS I) and the Health Services Support to AirLand Battle (HSSALB) Study. These issues are the focus of this paper.

ARMY MEDICAL OFFICER STRUCTURE STUDY

The Army Medical Officer Structure Study (AMOSS I) was activated in January 1985 to examine three interrelated problems: structure of all Army Medical Department (AMEDD) Corps except Medical and Dental, current inventory and promotion timing. (1) Of these problems, the timing of promotions was clearly the most critical issue. The problem as presented to the Deputy Surgeon General on November 6, 1984, by ODCSPER (DAPE-MPM), was that the AMEDD had "too many officers in year groups 4-20." This bulge was extending time in service (TIS) for field grade promotions to longer than officers managed by the Officer Personnel Management Directorate (OPMD). Future projections did not look any brighter. (2) The Vice Chief of Staff, Army (VCSA) responded that the medical promotion problem reflected a larger problem and that the AMEDD must develop a solution that would effectively realign the AMEDD structure and officer inventory more within Army goals. (3)

In January 1985, BG Siewitzke appointed two Army Nurse Corps officers to represent the Nurse Corps in all aspects of the study. Colonel John Hudock was the Senior Corps Representative and Major Dena Norton was the AMOSS Action Officer.

The study revealed several major facts affecting the Army Nurse Corps. First, the ANC was understructured. There were too few Lieutenant Colonel (LTC) and Colonel (COL) authorizations to facilitate promotions. Second, some degree of lateral entry (non-due course officers) was needed to maintain the Nurse Corps. Third, Field Grade Distribution (FGD) to the AMEDD does not contain enough Lieutenant Colonel (LTC) and Colonel (COL) allocations to properly manage the force. Lastly, requirements, authorizations, command grade ceilings and the Defense Officer Personnel Management Act (DOPMA) ceiling in the Nurse Corps were not properly coordinated to meet Army and Corps needs. The FGD is the number of field grade officer allocations given to the AMEDD by the Army. This number is then reallocated by the Surgeon General's Office to each of the individual Corps.

All of the facts but lateral entry were interrelated. Figure 1 shows the relationship between authorizations, inventory, DOPMA and Command Grade Ceiling for the Nurse Corps from year end FY 84.

FIGURE 1

<u>GRADE</u>	<u>REQ</u>	<u>AUTH</u>	<u>INV</u>	<u>CGC</u>	<u>DOPMA</u>
06 (COL)	93	90	75	74	201
05 (LTC)	441	384	325	329	497
04 (MAJ)	1341	982	951	961	758
03 (CPT)	3139	1862	1741	NA	NA
02 (1LT)	2094	678	1150	NA	NA

(Source: Section IV C ANC Annex, AMEDD Officer Structure Study (undated), Office of the Surgeon General, Washington, D.C., p. 3-172.)

This chart showed there was a structure problem, particularly at the 05 (Lieutenant Colonel) and 06 (Colonel) level that adversely affected promotions. Part of this problem was a result of inaccurate documentation of field grade requirements by the Nurse Corps. (4) The inaccuracies in documentation were partly due to the antiquated staffing guides used to determine requirements for both the Table of Distribution and Allowance (TDA) and Table of Organization and Equipment (TOE). (5) It is recognized that authorizations are always less than requirements, usually by about 20 percent, but inventory should match the authorizations. As the chart at Figure 1 shows, this does not occur because of the command grade ceiling imposed on the

Nurse Corps. It further showed that requirements, authorizations, inventory and command grade ceiling were significantly below the DOPMA straight slice field grade percentage allowed by law.

On January 25, 1988, I interviewed Colonel Hudock about the effects of this chart on the Nurse Corps in the future. He stated that this chart had been discussed with staff officers at the Deputy Chief of Staff, Personnel (DCSPER). He further stated that he ran the data against the DCSPER model which was based on continuation rates for each year group and the objective force. His results showed what the structure for the Nurse Corps should be at the 04, 05 and 06 level. When this data was compared to the data in Figure 1, it showed a significantly different picture.

<u>GRADE</u>	<u>REQUIRED</u>	<u>HAVE</u>
06	118	82
05	427	330
04	970	1000

When the same data was compared against the educational and experience requirements for similar administrative and clinical positions in civilian hospitals it resulted in the following configuration.

<u>GRADE</u>	<u>REQUIRED</u>
--------------	-----------------

06	220
05	520
04	970

The data was compared to civilian hospitals for validation of the methods used to determine what positions should be at the 05 and 06 level only, and was not intended to be utilized to seek additional field grade positions.

Colonel Hudock stated that after these calculations had been completed, he began discussions with officials at the DCSPER about how to resolve the differences between what the models showed was required and what the Nurse Corps actually had. Part of this procedure included significant time spent by members of the Nurse Corps in documenting what positions were actually required at the 05 and 06 level to perform the mission of the Corps. DCSPER concurred that the requirements at the 05 and 06 levels were inadequate. Colonel Hudock stated that he and DCSPER staffers were working to determine more accurate figures. The issue of Nurse Corps field grade requirements and authorizations was included in the program of issues that are regularly briefed to the VCSA by the DCSPER. Colonel Hudock stated that inclusion of the issue in this program made it likely that documentation of the new figures would become a reality within the next two years. Documentation of more accurate figures in The Army Authorization Documents System (TAADS) was determined to be

essential as the TAADS is the official document for distributing requirements and authorizations. Much progress has been made in accurately documenting the requirements for positions at the 05 and 06 level, making a stronger case for changes in the numbers at the DCSPER level.

Discussion of requirements, authorizations, command grade ceilings, field grade distribution and DOPMA constituted much of the discussion in the interviews with BG Slewitzke. BG Slewitzke strongly stated that she felt that the Nurse Corps had never received their proportionate share of the field grade distributions received by the AMEDD. (6) As an example, she stated that the Dental and Veterinary Corps, while smaller than the Nurse Corps, had almost triple the number of field grade authorizations as the Nurse Corps, while the Medical Service Corps, slightly larger than the Nurse Corps, had almost double the number of field grade authorizations as the Nurse Corps. Part of this was caused by the recruitment of lateral entry (non-due course) officers by the AMEDD, especially in the Veterinary Corps. There, one hundred percent of Veterinary officers are non-due course, causing further problems in the allocation of command grade ceilings within the AMEDD. To increase the ceiling of any one of the Corps required that the ceiling in one or more of the other Corps had to be decreased. It was important to ask to exempt the Veterinary Corps from the DOPMA field grade ceilings to free field-grade authorizations for other medical

Corps.

DOPMA did not recognize the need for recruiting lateral entry officers. Under DOPMA, all officers entered the Army as second lieutenants, proceeding at specific intervals through successive grades. The AMOSS I study recognized the need for lateral entry (non-due course) officers by all of the AMEDD corps. BG Slewitzke talked at length during the interviews about the need for such officers and the possible consequences of not being able to recruit these officers. The DCSPER wanted to eliminate recruitment of all non-due course officers from all corps, but doing so would have adversely affected the Nurse Corps in several areas. First, the quality of patient care would have immediately declined if all accessions were brand new graduates from nursing school with minimal nursing experience. Second, the cost involved in training new graduates in special skills such as anesthesia, intensive care or advanced clinical practice would have been prohibitive. It is difficult to recruit a second lieutenant with advanced specialty skills. The DCSPER solution was to bring all officers in as second lieutenants and then train them for the Corps specialty needs. BG Slewitzke astutely questioned why the Army should spend the time and money to train a nurse anesthetist or other specialty officer when the Army can bring them in as a non-due course officer and use them immediately. She noted that the Nurse Corps in looking at potential non-due course

officers assured that they could be utilized in a role equivalent to their preparation. This restriction precluded bringing several individuals with Ph.D.s into the service because they could not be effectively utilized. (8) The documents utilized to award constructive credit for non-due course officers were the standard Army and DOD regulations. When it does permit accession, the Nurse Corps awards maximum constructive credit permitted under existing regulations. (9)

Another issue recognized in the AMOSS I study and the follow-on study AMOSS II, was the substitutability of non-wartime areas of concentration (AOC). The Nurse Corps had several non-wartime AOCs: Community Health (66B), Pediatrics (66D), and Obstetrics (66G). Because all of the officers in these AOCs could substitute for officers holding other AOCs Medical-Surgical (66H), Nursing Administration (66A), or General Duty (66J) during wartime diversity of AOCs was not considered a problem. A potential problem, however, arose from the possible civilianization of all non-wartime AOCs as well as all Nursing Education and Staff Development positions. This possibility could significantly affect the CONUS rotational base which needed to balance the number of slots for every overseas tour. (10). BG Slewitzke stated that not only would civilianization affect the CONUS rotational base but the Nurse Corps mobilization posture by further decreasing the available number of officers which is already below what would be needed for mobilization.

Finally, civilianization would affect grade structure and career progression for junior officers because many beginning and middle-management positions would be lost.

HEALTH SERVICES SUPPORT FOR AIRLAND BATTLE STUDY

The second set of issues BG Slewitzke worked during her tenure was the nursing section that evolved from the Health Services Support for AirLand Battle (HSSALB) Study. This initiative began at the Academy of Health Sciences around 1982 or 1983 and sought to determine how the AMEDD could support the Army in the AirLand Battle concept, or support far forward. It was also tied into the Army of Excellence by creating new units and delaying deployment of some others. Another aspect of the study was the Carve Concept. The idea involved carving new hospitals out of existing TDA facilities, like Walter Reed Army Medical Center. To compensate for the losses the Army would backfill the TDA hospital with retirees and Individual Ready Reserve (IRR) personnel, deploy Reserve Component units, and restructure the mobilization station medical support using support battalions and medical holding companies. (11) As a hospital was carved into smaller hospitals, the grade structure changed, for example, the Chief Nurse at Walter Reed would no longer be a Colonel, but would be a Captain or Major. This change could possibly negate all the gains that had been achieved in upgrading grade structure in the Nurse Corps.

The study provided for up to eighteen additional Active Component deployable hospitals and eliminated the need for forty-two mobilization station hospitals. This change drastically affected the Reserve Component because the mobilization station hospital is the primary reserve medical unit. (12) This change would cause major restructuring in Reserve Component medical units, possibly downgrading grade structure as in the Active Component.

The primary idea that evolved out of the study was the two-hospital system. The concept increased the care provided far forward with better prepared people such as physicians, physicians assistants (PAs) and combat medics (91Bs) prepared at the paramedic level. (13) Casualties would be brought to the clearing station, the starting point in the chain of care. There, the patient would be physically assessed and classified according to treatment needs, and sent to one of two hospital streams. The return-to-duty patient would go to a combat support hospital and the more seriously ill patients would go to the evacuation hospital.

Several questions surfaced from this concept. First, would the sorting system work under the heat of battle? Second, what would happen to the non-surgical patients with medical illnesses which constitute the largest percentage of patients? Third, what impact would this have on the care

providers at each hospital? There was concern that casualties would be mixed up or that one hospital would be overloaded at the expense of the other. This concern influenced the consequences on the patient care providers. The combat support hospitals would essentially be caring for less seriously ill patients, requiring a lesser level of skilled nursing care, while the evacuation hospitals would have only seriously-ill or badly injured patients requiring a high level of skilled nursing care. The severity of illness and injury could severely strain the health care providers at the evacuation hospitals who would be working at least twelve-hour shifts, seven days a week, with little chance for relief. Under the old system, where the mix of patients ranged from minimally to seriously ill patients, staff could rotate from treating one type to the other to lessen the stress. This rotation would be lost under the proposed system. Adding to this was the fact that staffing in all of the hospitals was decreased, causing a higher patient to staff ratio. (14)

In wartime planning, medical casualties are frequently forgotten, because surgical casualties are the easiest to visualize. In reality, medical casualties constitute the bulk of the patient load and in many cases may be sicker than their surgical counterparts. It was unclear in the study how the medical patients would be triaged and into which hospital stream they would be sent.

The combat support hospitals were reduced to 252 beds with minimal nursing staff authorized. Under the HSSALB concept, all extra teams such as orthopedic teams, neurological and other specialty surgical teams were taken out of the combat support hospitals. This meant that these capabilities for treatment would no longer be available in the first line hospitals. These specialty practitioners would have to be flown in from general hospitals in the rear area or patients would have to be evacuated to the general hospitals. Without U.S. and Allied air superiority, this would constitute a major problem since the patients requiring this care would be seriously injured. The general hospitals were reduced from 1000 to 500 beds and the Mobile Army Surgical Hospital (MASH) went out all together in this concept. With the reduction of the general hospitals, concern was voiced that specialty care might further be reduced in the theater of operations. While beds in all of the hospitals were reduced, the clearing company, the cornerstone in the concept, did not grow. BG Slewitzke argued that reduction in beds, nursing staffs, and specialty care could severely compromise care in the theater of operations in wartime. The HSSALB concept did not recognize the need for registered nurses or licensed practical nurses (91Cs) in the clearing company even though the care that would be provided would be more sophisticated.

A related issue was how the new 91B "Super Medic" would function. This MOS evolved with the HSSALB study to be used in the clearing companies. The 91Bs were taught high level wartime skills such as cut downs and endotracheal tube insertion. With the large number of patients expected in the clearing company and the austere staffing that was proposed, it was doubtful that the 91B would be performing at that sophisticated skill level. A further question was raised as to the competency of the 91B to perform these skills during wartime. During the period of training at the Academy of Health Sciences in the 91B course, soldiers are taught the skills with no opportunity to perform the skills on a recurring basis to maintain proficiency. The Academy of Health Sciences developed a program for proficiency training; however, because of legal constraints in the TDA hospital, the 91B would still not be allowed to perform these tasks. In peacetime, licensed personnel with additional training in Advanced Cardiac Life Support or Advanced Trauma Life Support provide these services. Quality assurance standards in the TDA facilities prohibited the 91B from performing these procedures to maintain competency and proficiency. Further, even if the 91Bs could practice these procedures in the TDA facilities, many of these procedures are used so rarely that other members of the staff would compete with the 91Bs to develop and maintain their familiarity and proficiency. Because of these issues, many people in the AMEDD questioned why 91Bs were trained at all in sophisticated treatment

skills.

The HSSALB did produce some useful concepts. One was the Unit Life Saver Program that has been implemented in many of the units in the Army. This program provides non-medical combat soldiers with extra first aid skills to assist the medic in the unit when the fighting was finished. The program has proven itself over and over on training exercises and other instances in peacetime units. While seen as a good program by the medical community, initially it was not supported by the combat arms commanders who saw it as a diversion of their resources. As the program was implemented, however, resistance decreased as the benefits of the program became apparent.

Because of the many questions the HSSALB study raised and the radical changes it proposed, the study is not currently active. Some ideas, such as the Unit Life Saver Program and the use of the 91Bs, continue to be utilized or addressed. The issue of support far forward will continue to be addressed as well as medical support for the AirLand Battle but not in the terms of the HSSALB study.

CONCLUSION

The interview with BG Slewitzke did show that there are important issues being worked that have long range

implications for the Army Nurse Corps. My initial, negative perceptions of the AMOSS I study improved somewhat after I talked to Colonel Hudock. He said his conclusion was that the Nurse Corps will begin to get better over the next six to seven years as the problems with promotion timing decrease. Recruiting is now better regulated, based on the numbers needed to maintain the year groups and based on known and documented attrition rates at established gates in a military career. Some improvement has been made in the concerns voiced by BG Slewitzke during my interviews with her, since her retirement last year. It now appears that promotion timing will improve and grade structure changes will be made which will increase the requirements and authorizations for field grade officers in the Nurse Corps.

ENDNOTES

1. AMEDD Officer Structure Study Executive Summary (undated), Office of the Surgeon General, Washington, D.C., p. 1-1.
2. Ibid., p. 1-1.
3. Ibid., p. 1-1.
4. Section IV C ANC Annex, AMEDD Officer Structure Study Executive Summary (undated), Office of the Surgeon General, Washington, D.C., p. 3-172.
5. Ibid., p. 3-172.
6. Transcription of taped conversation with Brigadier General (Ret) Connie L. Slewitzke, Annandale, Virginia, 1987, p. 150.
7. Ibid., p. 184.
8. Ibid., p. 184.
9. Section IV C ANC Annex, AMEDD Officer Structure Study Executive Summary (undated), Office of the Surgeon General, Washington, D.C., p. 3-177.
10. Ibid., p. 3-167.
11. Transcription of taped conversation with Brigadier General (Ret) Connie L. Slewitzke, Annandale, Virginia, 1987, p. 272.
12. Ibid., p. 273.
13. Ibid., p. 342.
14. Ibid., p. 347.
15. Ibid., p. 350.

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1. AMEDD Officer Structure Study Executive Summary (undated), Office of the Surgeon General, Washington, D.C.
2. Section IV C ANC Annex, AMEDD Officer Structure Study Executive Summary (undated), Office of the Surgeon General, Washington, D.C.
3. Transcription of taped conversation with Brigadier General (Ret) Connie L. Slewitzke, Annandale, Virginia, 1987, 1988. Maintained at the Military History Institute, Carlisle Barracks, Pennsylvania.
4. Taped conversations with Brigadier General (Ret) Connie L. Slewitzke, Annandale, Virginia, November 30, 1987, December 1, 1987, January 25, 1988.
5. Untaped conversation with Colonel John M. Hudock, Assistant Chief, Army Nurse Corps, Falls Church, Virginia, January 25, 1988.

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