

Command In A Field Hospital

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ABSTRACT

This paper examines the challenges involved in commanding a field hospital. There are frequent, dynamic tensions between the military culture that is based on a task-focussed, hierarchical structure and the clinical culture that is based on flat, process-focussed, multidisciplinary teams. The paper outlines the cultural environment of the field hospital and then examines the deployment sequence whereby a functioning clinical facility may be created from a group of disparate individuals. There are a number of tools that may assist with this including the personality of the Commanding Officer, individual skills, the creation of an organizational identity and the choice of command structure.

Introduction

Creating the command climate within a field hospital represents a leadership challenge that has not been exposed to wide debate. This paper will describe the issues that apply to Regular field hospitals but much of the debate is relevant to TA field hospitals. Clinical staff have a command and leadership responsibility that is easily overlooked in peace. The following excerpt from the Journal of the Royal Army Medical Corps describes the requirement (1).

“The success of the surgeon depends in no small degree upon the devotion with which he inspires the remainder of his team. Hence much of the importance of the example which he should be able to set in enduring the stress and strain of long hours in the theatre. Hence the importance of an equable temperament or, at all events, a temperament whose variations are of an endearing variety. Hence, in short, the importance of his character and personality, as distinct from his professional ability, in developing that team spirit which will overcome the difficulties of improvised accommodation, long spells of heavy work, relatively frequent changes of location, the tedium and discomfort of road movement, and the other trials that are incidental to life with a CCS (Casualty Clearing Station). It is not suggested that these trials are overwhelming by comparison with other branches of the Service but that they undoubtedly militate against good surgical results unless met and overcome in the right spirit. That spirit is present if the surgeon is a good officer and leader. It

should be added that mutual confidence and respect must exist between the surgeon and his anaesthetist. If not, then one or other had better go elsewhere. Although the physical strain may be rather less in the case of the anaesthetist, he requires the same degree of resiliency and adaptability as his colleague, and certainly his professional skill will nowhere be more highly tested than in meeting the requirements in a forward area.”

Military field hospitals are complex, dynamic establishments that have organisational features that are unique within the Army. There are frequent, dynamic tensions between the military culture that is based on a task-focussed, hierarchical structure and the clinical culture that is based on flat, process-focussed, multidisciplinary teams. The manpower of a military hospital is based on an in-barracks cadre (105 personnel) who form the nucleus of the unit on deployment. These personnel are primarily non-professional paramedics who manage the equipment and train to establish the hospital infrastructure. On deployment, the cadre staff is reinforced by a large number of professional reinforcements (doctors, dentists, nurses, physiotherapists, laboratory technicians etc). The psycho-logical turbulence associated with this organisational change can disrupt the fragile internal dynamics of a military hospital.

Much has been said and written about the equipment for a field hospital, but above all else it is the people that make field hospitals work. This paper will present my view of the challenges of command in a Role 3 environment. Whilst many aspects of command and leadership are a personal issue, this paper will attempt to identify themes and tactics that might assist future Commanding Officers to achieve success within such a complex organisation.

Cultural Environment

This section will examine the various cultural environments of a field hospital. It is a system that undergoes considerable organisational change from the moment of being warned for deployment, through the mobilisation process, setting up in a Theatre of Operations, receiving and managing casualties, drawing down and recovering to the home base and finally returning to the peacetime routine. This is in marked contrast to the NHS hospital environment that is

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characterised by relative stability with a slow pace of change.

Military Command. ADP Command (2) places great emphasis on the role of the military commander on the battlefield. Command is defined as “identifying what needs to be done and why”. Leadership is the human process of getting sub-ordinates to implement the commander’s plan. The entire decision-making process within the Armed Forces is concerned with providing the commander with the information and communications architecture to make and implement decisions faster than the enemy. ADP Command makes a clear distinction between Command (that has an implied authority, responsibility and duty) and Management which is a more functional activity involving the allocation and control of resources to achieve objectives. On operations, the military command environment is very task-focussed, hierarchical and directive to cope with a rapidly changing external situation. Cadre staff, particularly military paramedics, will expect this style of management within a military field hospital. However, this may be an alien environment for clinical personnel used to a slower decision cycle that is more inclusive and discursive.

Hospital Cultures. The internal organisation of hospitals has been subject to considerable research by sociologists. The management structure of hospitals has been through a number of reorganisations during the history of the NHS. The most recent has been the creation of NHS Trusts run by a single Chief Executive. A harmonious relationship between the hospital management and the medical profession is often considered to be the key to the success of a NHS hospital. Medical staff are accustomed to the concept of clinical independence whereby each “consultant” has independent responsibility and accountability. Thus a group of consultants is managed on the basis of peer equality, even if one member of a department has taken on the responsibility of Medical Director. Sociologists describe a tension between the medical professions and all other professions responsible for the delivery of healthcare. This is often considered to be a “*power struggle*” when each profession may have its own functional hierarchies that lie outside the formal management chain. The evolving concept of “clinical governance” lies superimposed on these issues whereby accountability will be increasingly considered to be a team responsibility, not that of a single clinician. Thus clinical staff are used to a more consensual approach to decision-making that may be alien to the cadre staff within a field hospital. Indeed military rank may not

reflect the professional status of individual members of the clinical staff.

Expectations. Clinical staff for military Role 3 units are nominated from the pool of clinical specialists within the Defence Medical Education and Training Agency (DMETA) or from the Territorial Army. Each will arrive with their own expectations based upon their professional background, prior military experience and the post that they have been nominated to fill. Whilst they may have prior knowledge of their colleagues, it is unlikely that they will have worked together as a clinical team prior to deployment. This contrasts markedly with the expectations of the cadre staff of the field hospital. They will have trained together and established their own internal psychodynamics. Their role in establishing the hospital infrastructure is driven by a tight hierarchical structure that ensures strong task-focus at the expense of individual autonomy. This contribution is often overlooked by external visitors who concentrate on the clinical staff.

The Stress of the Military Environment. Clinical reinforcements may be unaccustomed to the personal challenges associated with living in a military environment. Accommodation, feeding, washing and using toilet facilities add considerable friction to daily living. Superimposed on this are the threats and demands of military operations. There may well be a direct threat of military action against the logistic area within which the field hospital is placed. Although the Geneva convention may provide some legal protection, many participants in a non-conventional conflict may consider targeting medical units as a means of attacking the morale component of our fighting power. Thus there are considerable personal stresses for hospital personnel in addition to the psychological stresses associated with being part of an organisation going through considerable change.

Deployment Sequence

The preceding paragraphs have examined the cultural environment that is likely to influence the psychology of each individual within the field hospital. This section will examine the sociological challenges during each stage of the field hospital deployment.

Personal Skills. The key to success in any organisation is the basic collection of personal skills inherent in every member of the workforce. At the most basic level, every individual needs to be able to meet their basic needs of eating, sleeping, washing and elimination. This can be a significant challenge in the military environment where eating might involve cooking your own food;

sleeping might involve putting up your own shelter in the rain and getting into a damp sleeping bag; washing might be limited to what can be achieved with 1 pint of water; and elimination might involve digging your own latrine. Successful communal living is likely to involve considerably more shared tasks than normal, including erecting tents, laying out of equipment, sharing sleeping accommodation and using common washing, feeding and sanitation facilities.

“Populating the Orbat”. Once warned for an exercise or operation, the field hospital command team creates an Order of Battle (Orbat). This is a blank nominal roll that lists the reinforcements required by rank and professional qualification. Names are provided to fill the Orbat from the DMETA and/or HQ 2 Medical Brigade (on behalf of the TA). These individuals are then provided with joining instructions and a time and place to arrive for mobilisation. It is important that background and professional currency of all reinforcements is considered at this stage. The social structure of TA units increases the likelihood of retaining senior staff in managerial appointments against relatively junior posts. The number of these individuals nominated must be carefully balanced so as not to inadvertently create psychological power struggles within clinical departments after deployment.

Deployment. Deployment on exercises or operations poses little threat for cadre personnel who have been formed as a team and trained for this activity. It can be a very unsettling experience for reinforcements who are likely to have been nominated as individuals and therefore may not have peer support until they have established themselves within the deployed hospital. The deployment of a field hospital is usually done in a sequence starting with the cadre staff followed by clinical reinforcements in one or more tranches. Each group will be going through its own teambuilding cycle of “forming, storming, norming, conforming, performing”. The arrival of a new group of people may disrupt this process and lead to the cycle being restarted.

Establishment and Sustainment. A field hospital has been described above as a complex network of interrelated power groupings. Each individual will have their clinical groupings and professional groupings. The process of establishing the facility is orientated towards individual training within clinical groupings in order to achieve team and collective clinical performance. Ideally each clinical department will be led by an individual with a clear vision of their teams’ requirements. However, it can be more difficult to create a culture where departmental needs are sublimated to

those of the hospital in order to ensure the correct sequence of collective performance. For instance nurses may be reluctant to delay fitting out their ward whilst their personnel are used to build sanitation facilities for the staff.

The time needed to establish a symbiotic relationship between all hospital departments in order to create a collective clinical capability should not be underestimated. A NHS hospital usually has a long history of collective working that has evolved over a considerable period of time. A field hospital has to establish all these working practices with an untrained team in a very short period of time. This period, however short, must be built into the deployment sequence of the hospital or important collective activities, such as the response to a major incident, will not work.

Drawdown, Recovery and Return to Work. The field hospital undergoes a further organisational transformation on completion of the military task. This involves the drawdown and loading of the field hospital, return to UK, return of reinforcements to their place of work and finally the receipt and reconstitution of the field hospital equipment in the home location. Clinical personal may be resented by their colleagues in the NHS hospitals when they return to work because rotas and shift patterns may have been disrupted. Their colleagues will have little or no cultural appreciation of what the deployment has involved even if they have some intellectual knowledge. The cadre staff may feel some resentment towards the reinforcements who may leave the operational theatre before them and are unlikely to be involved in the hard labour involved in cleaning, reorganising and restocking the field hospital equipment.

Tools

The Commanding Officer. The appointment of Commanding Officer (CO) within the field hospital should not be tied to any professional group but based on the selection of the best individual with the most appropriate experience base. This must include a combination of general clinical experience, military experience and specific experience of management within a field hospital. The CO must possess the ability to establish communication, rapport and affiliation with all professional groups within the personnel deployed with his unit. The inevitable scattering of senior ranks amongst the clinical reinforcements will lead to a command style based on consensus rather than formal direction for most eventualities. The CO must have sufficient knowledge and understanding of hospital systems across the full inventory ranging from the accident and emergency department, through the medical equipment repair shop to the process of

casualty reporting, tracking and regulation. This whole requirement is fundamentally different from that expected of the CO of an AMS Medical Regiment.

Individual. Coping in the military environment requires a much greater level of personal self discipline and self denial than in a civilian hospital. All military medical staff must be given the basic skills to cope and these should be maintained through regular military training exercises. It is vital that this is considered to be a mandatory part of personal development for all members of the Defence Medical Services. The stresses of the deployment phase can be reduced by communication (verbal and written) that provides a personal focus until the individual arrives at the mobilisation centre. The mobilisation process should be considered as a pipeline through which the reinforcements are inducted, orientated to the task, complete all G1 and G4 processes (checking of personal documents, issue of specific clothing and equipment), dispatched to Theatre, received in Theatre and orientated to the hospital. This process must be firmly “gripped” to ensure that the clinical staff “go with the flow” by having their needs met. If they start to lose confidence in the process the early stage of “forming” the team can go adrift.

Team. The command team of the field hospital will be augmented by reinforcements. Those individuals holding Senior rank must anticipate being given positions of responsibility that require leadership and management skills. They must have been trained for this role and been given an opportunity to practice their skills. This expectation must be inculcated during their time working in the DMETA or in the TA. It is the responsibility of the field hospital command team to ensure that the posts for these reinforcements are supported by an induction package and job description. This should enable the clinical teams to be formed rapidly and produce an effective collective performance. Both the cadre personnel and the reinforcements need to be taught to adjust to the possible disruption of the psychodynamics of the existing team by the arrival of a large number of new personnel. This is mentally tiring and a large number of rotations of groups of personnel can be disruptive to the collective performance of the hospital.

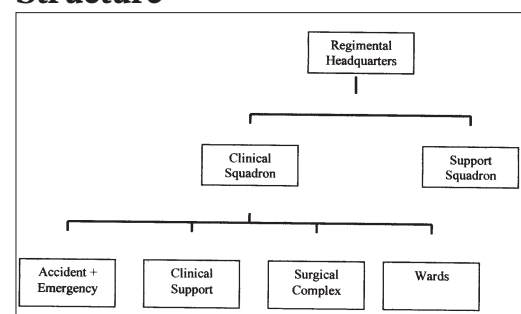
Organisation. The Commanding Officer of a field hospital will need to use a wide variety of team building tools and techniques to ensure the effective creation of a unit able to deliver a high standard clinical performance. ADP Command places the responsibility for the “command climate” squarely with the Commander(2). This may

start by the creation of a unifying task, which for a medical unit should always be clinical performance. As a last resort, Queen’s Regulations and the Manual of Military Law, provide the Commanding Officer with the authority to compel his personnel to follow his orders, in times of stress and danger it may be his duty to do so.

Unit Identity. The unifying task may then be reinforced through the creation of a single unit identity. This is simple for single units with clear command arrangements for all functions operating from within the hospital site. It may become considerably more complicated if the command arrangements are not explicit (to avoid sensitivities) or if the reinforcements have a strong, pre-existing identity (eg. reinforcements formed from sub-units of other organisations). The command environment needs to be strong enough to prevent individuals regressing to previous social groups whose boundaries may lead to a subversive challenge to the command environment. Tools to assist with the process include the creation of a single unit T shirt, the choice of name for the field hospital site or facility and the use of clinical identification markings such as the Red Cross or name badges. The team building process can be assisted by the creation of strong unit social activities such as the creation of focal points for meeting basic needs (such as washing, sleeping and sanitation), feeding and socialising.

Command Structure. Command cannot be exercised efficiently without a command structure. Military organisations are based on hierarchical structures whereas hospitals have traditionally used flat structures that often have functional networks that intersect the formal system. Ideally the field hospital command structure should reflect the strengths of both systems. I have found the organisation described in my paper in the Journal of the RAMC (3) to be a useful model for command in my unit.

Field Hospital Command Structure



It is vital to use the structure to ensure that decisions are taken at the lowest level commensurate with delegated authority. The Commanding Officer must be separated from routine clinical decision-making by

ensuring that the clinical complex is run by the Clinical Director. This controls the flow of information to the Commanding Officer allowing him to focus on unit rather than squadron level business. This boundary can be enhanced psychologically by ensuring a separate location for the Regimental Headquarters and creating a clinical squadron office within the Clinical Complex.

The Future

There are a variety of interrelated tensions that are likely to affect the creation of a command culture within field hospitals within the Army in the future. Military experience through both Regular and Territorial Army service can provide excellent leadership training. There are a multitude of opportunities for this that are being examined and indeed the NHS are looking at creating partnerships with TA field hospitals to develop their civilian staff. The creation of the 2 Medical Brigade is probably the single greatest opportunity for the Army Medical Services to develop a corporate expertise in the evaluation of the effectiveness of field hospital command teams. This should provide a depth and breadth of experience of command of field hospitals that should lead to a substantial development in AMS capability in the next few years.

The creation of the MOD Hospital Units (MDHUs) within NHS Trusts have distanced Regular clinical staff from Regular AMS units. It is vitally important that Regular clinical personnel undertake the same level of military collective training as their TA counterparts. The differences between hospital and medical command cultures need to be recognised by both military clinical staff and the general staff. This needs to be reinforced by frequent contact between both sides so that there is mutual understanding of each groups' expectations. The closure of military hospitals has reduced the range of opportunities for members of the Defence Medical Services to be closely involved in the management of hospitals. This may result in

the loss of the experience base built up from running hospitals in peacetime. This will also reduce the opportunities for DMS personnel who are being trained to command medical units to experience the cultural background of hospital-based personnel. It will also reduce their contact with developments within NHS hospitals such as clinical audit, clinical governance and the development of the role of nonprofessionally qualified healthcare personnel. These factors will need to be considered in the design of career profiles for future Commanding Officers of field hospitals.

Summary

This paper reviews the cultural experiences of the various personnel likely to be employed in a deployed field hospital. Although the paper concentrates on the Regular field hospital, many of the points raised may also apply to TA field hospitals. The sociological challenges faced by the unit command team during the phases of a military deployment are described. This leads to a description of some command tools and techniques that could assist with the creation of the appropriate "*command climate*". Finally, the impact of recent changes in the provision of hospital care for Servicemen in peace may require careful identification of key training opportunities for future Commanding Officers.

Footnote:

Lt Col Bricknell commanded 22 Field Hospital from October 1999 to January 2002. This included commanding a hospital group of two 100 bed field hospitals and one 25 bed hospital troop on Exercise SAIF SEREEA in Oman between August and November 2001.

References

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