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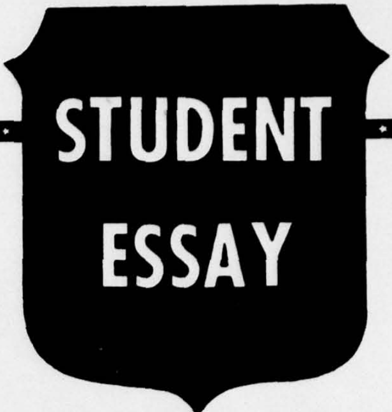

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13 December 1976

EMERGING ROLE OF THE ARMY FAMILY PHYSICIAN IN PRIMARY HEALTH CARE DELIVERY

BY

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Medical Corps

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(10) Colonel David G. Doane
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The disappearance of primary care providers and overspecialization of physicians has led to a crisis in ambulatory care. In response, an ambitious Family Practice program has been developed in the face of hostile specialists and post war resource constraints. Material was gathered from site visits to Army Programs, medical literature, Family Practice assemblies, presentations, OTSG documents and the author's four and one-half years involvement in his role as Consultant in Family Practice to the Surgeon General. Success depends upon a genuine need and a resonable solution. Success, likewise, depends upon command

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support, dedicated capable staff, talented residents, adequate resources, teaching depth, credibility with the residents and the rest of the medical team and with patients. It is essential to have long range goals and patience in achieving those goals.

". . .it must be considered that there is not anything more difficult to carry out, nor doubtful of success, nor more dangerous to handle, then to initiate a new order of things. For the reformer has enemies and all those who profit by the old order, and only lukewarm defenders and all those who would profit by the new order, this lukewarmness arising partly from fear of their adversaries, who have the laws in their favor; and partly from the incredulity of mankind, who do not truly believe in anything new until they have actual experience of it. Thus it arises that on every opportunity for attacking the reformer, his opponents do so with the zeal of partisans, the others only defend him half heartedly, so that between them he runs great danger. It is necessary, however, in order to investigate thoroughly this influence, to examine whether these innovators are independent, or whether they depend upon others, that is to say, whether in order to carry out their decisions they have to entreat or are able to compel. In the first case they invariably succeed ill, and accomplish nothing; but when they can depend on their own strength and are able to use force, they rarely fail. Thus it comes about that all armed prophets have concurred and unarmed ones failed; for beside what has already been said, the character of peoples vary and it is easy to persuade them of a thing, but difficult to keep them in that persuasion. And so it is necessary to order things so that when they no longer believe, they can be made to believe by force."

THE PRINCE by Niccolo Machiavelli,
Copyright 1952, American Library
World Literature, Signet Classics,
pp. 49, 50, Chapter 6.

INFORMATION ON FAMILY PRACTICE

Thirty years ago there were 170,000 general practitioners in this country. Today there are less than 60,000, many of whom are elderly, and most of whom are located in rural areas. The commonly cited reasons for this decline were long hours, less pay, less professional satisfaction, and low regard by one's peers. Indeed, the general practitioner considers himself a second class doctor, one who worked twice as hard for half as much. Academia was not without responsibility in this area. Medical schools did not even have departments concerned with primary care.[1] During a medical school career, a student would probably never see a primary physician but it could be guaranteed that he would see the great prestige and influence of specialists of all kinds. Emphasis was placed on research, medical education, government grants, publishing and training of super specialists. The delivery of primary medical care was ignored. The local medical doctor or "LMD", as he was disparagingly referred to, was held in low regard. Most medical school department chiefs were competitive for the best students and interns for their own fields. The decline of the general practitioner led to a crisis in ambulatory care: people jammed hospital clinics and the emergency room became the arena for primary care; the demand for continuing care; for a "family doctor" was heard from coast to coast and was reflected frequently in the lay press.[2]

The Citizen's Commission (Millis Commission Report) on Graduate Medical Education, released in Chicago in 1966, underlined the need for a primary physician.[3] It noted that no serious effort had been made to determine even in general terms the distribution of physicians within the different fields of medicine. It went on to point out that the rise in specialization accompanied the decline of numbers of physicians who were doing continuing and comprehensive primary care.

All this time, a small dedicated group of physicians were trying to lead family practice back to its rightful place as a respected member of the medical family. After many abortive attempts, the new specialty of Family Practice attained American Medical Association approval on February 8, 1969.[4] When organized medicine - The American Medical Association - spurred on by the Millis Report, got behind the American Academy of Family Practice, *daylight* was in sight. Some perceptive souls in the academic world saw the "handwriting on the wall" early and threw in their support. Other academicians were sincerely and honestly opposed to this move. An additional factor contributing to the recent renaissance in Family Practice was the young physician himself. He wished to treat a whole individual - indeed - the whole family! He wished to become involved not with a system or a disease, but with a person; and, he demanded good training programs to equip him in this endeavor.[5, 6, 7, 8]

Just what is a Family Physician? One of the best descriptions can be found in an article presented in the JAMA (JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION) June 23, 1969, entitled "A Study of Family Medicine."

> The most important concept of the family doctor is that he is one physician who provides primary and continuing care for all family members. He provides a central unifying focus from which the family can achieve adequate, complete care. In the future, he must not be the physician with the least amount of formal education, but rather one who is skillfully trained in the prevention, diagnosis, and treatment of a variety of illnesses. Training programs must be built on the principles of family care while, at the same time, allow for sufficient flexibility to prepare physicians for the larger number of potential variations in family medicine. The essence of family medicine is care of the family, something no other specialty provides. Family medicine is the family physician's job. The major problem is making this career attractive rather than changing it.[9]

The official American Academy of Family Practice definition of a Family Physician is as follows:

> The Family Physician provides health care in the discipline of family practice. His training and experience qualifies him to practice in several fields of medicine and surgery. A family physician is educated and trained to develop and bring to bear in practice unique attitudes and skills which qualify him or her to provide continuing comprehensive health maintenance and medical care to the entire family, regardless of sex, age, or type of problem, be it biological, behavioral or social. This physician serves as a patient, or family's advocate in all health related matters, including the appropriate use of consultants and community resources.[10]

In 1971 the Army embarked on an ambitious family

practice program.[11] COL Robert Parvan was appointed the first Consultant in Family Practice and Ambulatory Care to The Surgeon General. He was equipped with a mission statement that charged him to advise, represent, and act for The Surgeon General in all matters pertaining to family practice and to the staffing, operations, and design of ambulatory health care facilities in the Army. This included relationships with civilian organizations and being the point of contact for matters pertaining to the Department of Hospital Clinics, emergency rooms, troop medical clinics and separate facilities providing medical care to military personnel and their dependents. He was to advise on the staffing, operations, records and design of ambulatory care facilities. He was also to advise on the procurement, training, utilization, and assignment of general medical officers and Family Physicians; to monitor the Army physician's assistant program. His mission further included evaluating and advising on emergency services and ambulance services -- including staffing, training, equipment design, communications and cooperation with civilian agencies, as well as advising on research and development for the delivery of ambulatory care and emergency services.[12]

His first step before his untimely retirement in 1972, was to initiate a program change request (PCR) which authorized fifteen residency programs with a total of 270 residents. This PCR anticipated the production of 90 Family Physicians per year by 1979. The first program was started at Fort

Benning in 1971 with a director, a staff of three, and seven residents. The following year, 1972, programs were instituted at Madigan Army Medical Center and Fort Ord. In 1973, four more programs came into being - one each - located at Tripler Army Medical Center, Fort Belvoir, Fort Bragg, and Fort Gordon. This past year, 1976, an eighth program has been developed at Fort Sill. The eight programs include 134 residents and a staff of approximately 100 people.[13]

Many problems were encountered in developing the Family Practice program -- problems that will serve as a model for any new Army program developing within our established system, particularly an Army undergoing rapid reduction in strength and increasing constraints. These problems can be divided into three basic types according to their occurrence during the beginning, early, or present periods of the program.

The problem that first required decision was the selection of location and staff for training programs. To staff a Family Practice Residency program properly required administrators and teachers who were qualified in this new medical discipline. During this beginning period, very few such individuals actually existed in the Army. The solution lay in looking elsewhere for competent persons to fit the need. The majority of directors of new programs were people from other disciplines, usually pediatricians and internists. They were people who had been generalists in their own field and who believed strongly in the Family Practice concept. Many

were Army trained; had had the advantage of going through a military residency program; and, understood structured teaching.

Another excellent source of teachers and future program directors was private practice itself. Physicians who had been on the front-lines of family practice in the civilian community and had handled a variety of primary care problems. They volunteered to come into the Army, joined training programs, and eventually assumed positions of leadership. Approximately twenty such people have been recruited from private life and have done very well.

A third source of teachers for our training programs was the Berry Plan. Berry Plan physicians (civilian residency trained in family practice with an obligated two year service) were immediately assigned to Army training programs. It is noteworthy that a significant percentage of these physicians have elected to stay beyond their initial obligation; in contrast to the average Berry Planner in other specialties.

The second problem that surfaced immediately was the selection of program locations. This was influenced by many factors. It was essential that a hospital commander understand or at least desire a program, for without command interest, any program would fail. There had to be teaching staff at a chosen hopsital with enough depth to provide quality training in other specialties. Family Practice training is broad based; therefore, it depends upon teaching input from many disciplines such as internal medicine, pediatrics, surgery

and obstetrics, etc. There also had to be proper facilities.

The key to a Family Practice training program is the Model Family Practice Unit (MPFU). At this unit, the young doctor in training spends an increasing amount of time attending an increasing number of families during three years; thus, developing expertise in handling ambulatory patients.[13]

No sooner had the first residency program started, when it encourtered completely unanticipated problems. First, the end of the draft came and with it the reality that adequate numbers of General Medical Officers (GMO's) were no longer available. The typical GMO, a product of the draft, came into the Army at the end of his year of internship. He was usually assigned all the unpleasant and mundane duties that the specialist and career officers found unpleasant or unrewarding. The GMO was to be found in physical exam sections, troop medical clinics, emergency rooms, and general outpatient departments--usually with suboptimum help and facilities. There he saw large numbers of outpatients and had little or no inpatient responsibility. He was generally unhappy in this particular setting and his patients were generally unhappy with this particular brand of medicine. He served, however, to keep all of these unpleasant duties from the inpatient oriented specialist and, during his two years, did a creditable job.

With the end of the draft, this particular young physician phased out of the Army. The mission, however, remained. The

slack had to be taken up by someone and all that remained was the hospital based specialist who immediately looked around for somebody else to do this work. There had been an average of 1800 GMOs in the Army. Their rapid loss over a two year period of time presented a huge crisis in ambulatory care. This same crisis had slowly developed in the civilian sector as outlined in the opening paragraphs.

A second unanticipated early problem came about because of the constraints developed within the Army. During the Viet-Nam build-up no particular attention was paid to authorized spaces. If a program director wanted more trainees, he had only to ask. Suddenly a ceiling was established. It was dependent upon both the number of Medical Corps officer spaces in the total Army and the number of those spaces that could be dedicated to training. It was suddenly obvious that if Family Practice was to increase, it would increase at the expense of the other specialties. This resulted in a deep pool of antagonism in these specialties. Family Practice ceased to be just a nice thing to have -- it became a threat! The antagonism was double edged since Family Practice, of necessity, required the use of these specialists as teachers.

The third unanticipated early problem was that of developing an understanding of the basic concept of Family Practice where none existed before. The necessity for understanding just what Family Practice is and what it can do was necessitated by the crisis caused by the previous two problems. A program with a sympathetic commander would suddenly have a new commander

who did not understand Family Practice. Such lack of understanding would lead the new commander to feel Family Physicians were there to solve his GMO losses. Misutilization of this new specialty became a reality in several locations.

Department chiefs also changed. Smarting from a cutback in resources, and again lacking understanding of the basic concept, it was politic for a chief to say that he did not have the resources to teach residents. It was interesting to note that the source of such reactions varied from place to place and field to field; i.e., obstetrics at one location; pediatrics at another; and so on. It reflected either the individual chief's prejudice or the amount of resources allocated him by the hospital commander.

The third level of problems are ones that are presently with us as Family Practice continues to develop. At the present stage of development, we are living with problems which have evolved, some of which were anticipated. A major problem is the development, maintenance and philosophy of fixed patient panels for the individual Family Physicians. To best function within the scope of his specialty, the Family Physician must have a controlled number of families that he can be responsible for, develop a data base, and treat their biological, behavioral and social problems. An excessive number will cause him to provide inadequate quality care and patient satisfaction will drop. Instead of Family Practice, he will be treating episodic symptoms rather than the complete person. On the other hand, the hospital commander who only has so many physicians and an almost endless mission outside of his walls for which he

is responsible, must constantly insure that his physicians are productive.

Family Practice with its patient panel concept is constantly between a "rock and a hard place" as far as productivity is concerned, i.e., in terms of numbers of patients seen, quality of care given, and patient and doctor satisfaction. This delicate balance requires understanding of the Family Physician's role and his abilities. It should be remembered that other specialists limit their workload according to capabilities. Obstetrical departments do a specific number of deliveries per month on a first come first serve basis and refer the rest to CHAMPUS. Surgery is controlled by operating room use while other disciplines also have built in controls.

Phase I in the development of fFamily Practice was the development of training programs. Now that programs are producing graduates in significant numbers, there are definite problems in utilization. In the Army Medical Centers there tend to be conflicts as the traditional specialist feels the new member of the medical team should be the one to go to the general outpatient department to take care of the mundane, routine, episodic problems that do indeed require care. The utilization problems at the MEDDAC system really reflect the lack of supporting staff. Doctors could be more effectively utilized by having more adequate facilities and supporting staff such as receptionists, chaperones and paramedical people.

At Fort Sill, Oklahoma, enough Family Physicians have been assigned to provide family doctors for the entire military population. The traditional specialists function mainly in a consultant role. This is the only post so organized in CONUS. It is an experimental model for the development of Family Practice utilization in the Army. It has been determined that by summer of 1977, Fort Polk, Louisiana, will have a similar structure.

Another novel utilization of the family doctor is being contemplated at Carlisle Barracks where, because of low impatient census, the small Army hospital was converted to a health clinic. Isolated health clinic duty with no inpatient responsibilities is an anethema to physicians and patients alike. The proposal for credentialing Army Family Physicians to allow them to care for Army patients and dependents in the local civilian hospital is presently being staffed at The Surgeon General's Office.

Also of concern is our present system for evaluation of productivity and determination of requirements. Presently we are using a system based on past experience which does not consider prevention, efficiency or increased capabilities. Manpower surveys are based on historical evidence such as number of patient visits. The old discredited GMO system produced the largest number of visits. That patient and provider dissatisfaction were common was not addressed. Until a new system which measures population served or problems solved rather than gross number of visits is devised, there will be continued difficulties. We have developed a sophisticated, well trained provider

who is probably going to personally see fewer people; therefore, on a historical number of visits alone, he is going to compare unfavorably with the GMO.

Another problem which seems to cause concern to most physicians working in the ambulatory care area is the autonomy of nursing personnel. These people report directly to the chief nurse who is often inpatient oriented. Personnel assigned to outpatient areas by nursing service are often transitory or have been unable to effectively carry out other duties. Assignment of ambulatory care nursing personnel to an ambulatory care chief would do much to eliminate this particular problem by providing a single manager system.

Recently concern has surfaced regarding the selction of residents. The first-year residents enter the Army at the first-post graduate year level. Entrance to active duty is controlled by the Procurement Division of the Medical Department Personnel Support Agency, not the chiefs of training programs. Family Practice is one of the very few specialties in which residents are selected this way. A means must be developed to allow a satisfactory method of resident selection with increased input from teaching chiefs.

A decision was made at the October, 1976 Teaching Chiefs' conference not to allow resident losses to be refilled with residents at second year level. This caused another major problem. At the present time there is no possibility that a GMO or any Army doctor who desires Family Practice training will receive it. The only physicians eligible for Army Family Practice programs under the present rules are third-year medical students. The

lack of understanding noted under early problems continues as a major present problem today. It includes two important groups of Medical Corps officers. The first group of officers served entirely under the old system. They are the inpatient oriented specialists, usually Army trained, and are generally found in the seven teaching hospitals. Some of these individuals are now in high level or command positions. They long for a continuation of the old system based on the support of the now nonexistent GMO. It is often difficult for such individuals to put the old aside and accept the primary care physician as a full equal. The second group represents those traditional specialists whose spaces and roles are threatened by this new member.

The solution to this dilemma requires constant education and advocacy. It is interesting that the support and strength of Family Practice comes from other Medical Corps officers with the background, described above, but who are willing to work for new and improved ways of health care delivery.

Many strengths off-set the problems of the Family Practice program within the Army. The major strength has been the support of The Surgeon General and other concerned, influential people. Without such support, this program would never have developed to the point it has. A second asset is the capable and dedicated staff of physicians developed through the past few years. Many have come from other medical disciplines, and some from private practice. They all believe strongly in the Family Practice concept and have worked long, hard, frustrating hours to develop it. These people, leaders in

their new chosen field, have been offered chairmanships in many medical schools and other prestigious positions, but have preferred to remain with Family Practice in the Army.

Another positve strength for Family Practice is its highly talented residents. Family Practice is rapidly becoming the most popular specialty in the Army as well as in civilian life. In recent years, 20 to 25% of all graduating medical students in th United States have applied for Family Practice. This is reflected in the applications for Army residencies and makes Family Practice one of the more competitive residencies. Top notch students create greater credibility with residents in other fields.

Another source of strengh within the Army is that Family Practice can develop without the economic road-blocks that so often are present in civilian life. The graduate Family Physician is not only oriented to outpatient care, but has a healthy acceptance of his role. To help him do his job better, a new coding system of the ambulatory diseases is being implemented. It is called the World Organization of National Academies Code, or "WONCA" code. This allows retrieving the numbers and types of problems presented in the doctor's office. Such knowledge is needed both to audit the care of patient followup and to tailor the content of training and continuing medical education programs. No other ambulatory system within the Army, and few in civilian life, can presently accomplish this.

An innovative charting system called the Problem Oriented

Medical Record, which replaces the old disorganized source oriented records, is in use in Family Practice services. It allows the physician to see at a glance the patient's problems, state of resolution of those problems, medications, and plans of any previous physicians. It further permits the physician to follow, in a flow chart method, the progress of the patient.

Our new ambulatory systems include physician extenders of many kinds. An outstanding physician assistant program has been developed in the Army and is now being wedded to Family Practice in many areas. The AMOSIST program, which includes both patient triage and an acute minor illness clinic, utilized young hospital corpsman working from algorithms. The involvement of Family Practice residents with line units in the Army has also been invaluable. Training programs encourage their residents to go on occasional week-ends to the field with field units. In this way they begin to relate to the young soldier, they understand the stress under which he functions, they learn to respect the professionalism of the military members of the Army, and, are warmly accepted by this team.

In some areas the Family Physician serves as back-up for sick-call, using the troop medical clinic and its personnel in conducting the ambulatory care of his families. As the supervisor of the PAs and AMOSISTs, he is supervising the first level of paramedical care rendered to troops.

Various international crises have arisen since the Army family doctor came to being; i.e., Nicaragua, Guatemala, and

the South Vietnamese refugee problem -- all of which required the Army to respond with field hospitals and medical support. Family Physicians were assigned to the field hospitals in all cases and proved extremely valuable. Their versatility and competence in these TOE units made them highly respected and valued by hospital commanders.

A further source of strength in developing Family Practice and Ambulatory Care was the establishment of a consultant branch in headquarters of The Surgeon General, MEDDCOM, Europe and HSC. This placed an ombudsman at headquarters levels and has proven effective. Headquarters' concern can thus be brought to bear on various problems and a single policy can be developed. The Consultant serves as the clearing house or gathering point for information and guidance which is disseminated to the individual programs. Also, this creates valuable visibility for the development of this new program.

The civilian counterpart to the Army Family Practice program, the American Academy of Family Practice (AAFP) has been extremely helpful in developing a Family Practice within the Army. They have presented workshops for developing programs and establishing residency programs which many Army staff people have attended. They have also been supportive in the development of the Uniformed Services Military Chapter of Family Practice where problems peculiar to military medicine are addressed. Two Chapter delegates to the AAFP House of Congress have provided the Army a voice in the Academy's affairs and helped over-

come one major difficulty, the requirement that a family physician belong to the State Chapter before he could be eligible for membership in the national chapter. The American Academy has likewise underwritten a residency assistance program by providing a panel of trained consultants to visit on-going residencies in an attempt to help up-grade them. In civilian training programs this is unique to Family Practice. All of these enrichments are avilable to Army Family Practice Residencies.

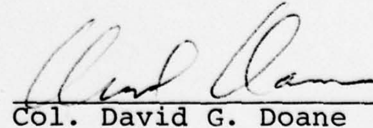
A tremendous strength to Army Family Practice is its fantastic popularity with the patients. There are long waiting lists of patients and their support has been excellent. As Family Practice spreads from one Army post to another, it is hoped that this demand will aid in an even faster expansion. The future of Army Family Practice is dependent upon continued ability of the physicians to deliver high quality care. This will alleviate recruiting problems by keeping good physicians in the Army and enhancing voluntary procurement programs.

For the time being, Family Practice chiefs favor the spread of limited resources to one post at a time. A health care delivery system whose primary care is based entirely on Family Practice is effective and efficient. On the other hand, where only enough Family Physicians are assigned to an individual medical treatment facility to provide care to "only a portion" of the base, there is a resultant competition and dissatisfaction between the two systems. The patients who are not in it wish they were. The other doctors feel that Family Physicians, with

the patient panels, are being coddled. A great deal of discomfort has evolved in these situations.

Starting any new program in the environment of an established system is not without hazard and frustration. Army Family Practice is now five years old. It has become obvious that programs of this scope must be started in Phases: Phase I was the development of Family Physicians themselves; Phase II is defining utilization; and, Phase III will be expansion and implementation. One starts with resources on hand and can anticipate the development of unexpected problems. There must be long range goals and constant striving to reach these goals. The various phases will tend to sort themselves out if problems are taken one at a time.

It is extremely important to keep a base of support. Concerned people should be kept informed of where the program is, where it is going, and problems that are evolving. It is important to attack the problems that develop within the present resources and avoid over-extension. It is of the utmost importance to believe in the program and be totally committed to it. Goals should be evaluated in the light of present realities; people must be stimulated in this direction; and, individuals must be prepared for some disappointments and setbacks. However, if the program is good, it will prevail. As Victor Hugo said, "There is nothing in the world as powerful as an idea whose time has come."



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