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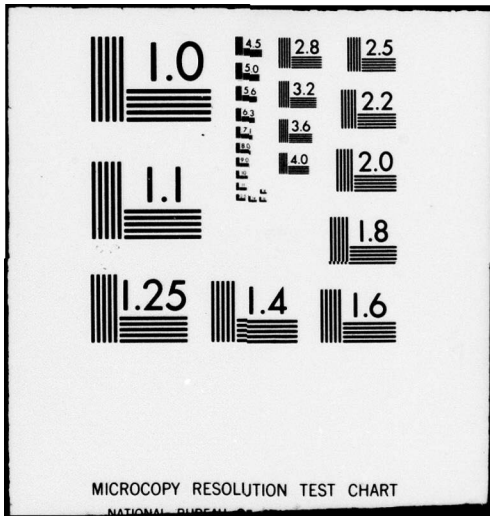
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AN EVALUATION OF THE PERFORMANCE OF THE MEDICAL EXAMINATION FOR ENTRANCE INTO THE ARMED FORCES

A thesis presented to the Faculty of the U.S.
Army Command and General Staff College
in partial fulfillment of the
requirements of the
degree

MASTER OF MILITARY ART AND SCIENCE

by

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The opinions and conclusions expressed herein are those of the individual student author and do not necessarily represent the views of either the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT APPROVAL PAGE

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THE ABSTRACT

ABSTRACT

The purposes of this study were to determine whether or not a medical examination of the form and scope prescribed by various regulations is performed on every individual processed for induction or enlistment into the armed forces, and to evaluate the professional satisfaction of the Medical Officers assigned to the Armed Forces Examining and Entrance Stations (AFEES). In February 1971, a questionnaire was sent to the 139 Medical Officers assigned to the 74 AFEES. The 90 usable questionnaires returned represented a 64.7 per cent response.

An analysis of the data obtained revealed that 60 respondents (66.7 per cent) were of the opinion that a medical examination of the form and scope prescribed by regulations was not necessary for entry into the armed forces. The items most frequently recommended for elimination were nose, sinuses, mouth and throat, ophthalmoscopy, lungs and chest, abdomen and viscera, identifying body marks, scars, tattoos, dental examination, and serology. Further analysis revealed that there was a strong negative correlation between the items recommended for elimination and the items actually performed during the examination. There was a strong positive correlation between the portions of the examination actually performed by the 60 respondents who recommended changes in the examination and the portions of the examination actually performed by the remaining 30 respondents who did not recommend any changes in the examination.

A comparison of the major categories of disqualifying medical defects responsible for Existing Prior to Service (EPTS) discharges and the items omitted from the medical examination revealed that there was not a direct relationship between these two groups.

Sixty-four of the respondents indicated some degree of dissatisfaction with their assignment at an AFEES. The most common complaints from the respondents were that they were not practicing medicine and that they had too much administrative work. In addition, the comments infer that there is friction between the Medical Officers and their Commanding Officers.

The following conclusions were made: (1) an examination of the form and scope required by various regulations is not performed on every individual processed for induction or enlistment into the armed forces, (2) an adequate screening medical examination for entrance into the armed forces is performed, (3) the Medical Officers assigned to the AFEES are of the opinion that the time required to perform a medical examination of the form and scope required by regulations exceeds the time available, (4) the Medical Officers assigned to the AFEES have determined for themselves what items of the required examination should be eliminated from the examination and have then eliminated these items from the examination as they perform it, (5) the Medical Officers assigned to the AFEES believe that the medical examination performed for induction and enlistment should be referred to as a "screening examination," and additionally, they believe the medical examination they perform is essentially a "screening examination," (6) there is not a direct relationship between the portions of the medical examination omitted by the Medical Officers and the

distribution of the disqualifying defects resulting in EPTS discharges of inductees and enlistees, and (7) the Medical Officers assigned to the AFEES are not professionally satisfied with their assignment.

Several recommendations were presented to assist in the alleviation of the problems revealed by this study.

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CHAPTER I

THE PROBLEM AND DEFINITION OF TERMS

Introduction

Since Biblical times it has been necessary for nations to raise armies to fight their wars or protect their lands. In Chapter 1 of book of Numbers, the Lord instructed Moses as follows:

> 1. On the first day of the second month, in the second year following the exodus from the land of Egypt, the Lord spoke to Moses in the wilderness of Sinai, in the Tent of Meeting, saying:
> 2. Take a census of the whole Israelite community by the clans of its ancestral houses, listing the names, every male, head by head.
> 3. You and Aaron shall record them by their groups, from the age of twenty years up, all those in Israel who are able to bear arms.[1]

This same Biblical section has been interpreted to indicate that there was also a recognition of the necessity of determining who was physically able to be in the army. Specifically, verse 3 has been interpreted to mean that the aged, infirm and maimed were exempted from the census.[2]

It would appear that there was little change between the Biblical requirement of being "able to bear arms" and the requirement of the Continental Congress in July of 1775 that "all able-bodied effective men between 16 and 50 years of age be formed into militia

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[1]Numbers 1:1-3, in The Torah: The Five Books of Moses (Philadelphia: The Jewish Publication Society of America, 1962).

[2]J. H. Hertz (ed.), The Pentateuch and Haftorahs (2d ed.; London: Soncino Press, 1965), p. 568.

companies."[3] The first specific regulation governing the physical condition of recruits was issued in 1814. This regulation specified that all "'free' able-bodied men between the ages of 18 and 35 years who were active and free from disease were welcomed into the Army, but their healthiness had to be demonstrated." A physical examination with clothing removed was required "so that it could be ascertained that they had perfect use of every joint and limb and that there were no tumors, diseased enlargement of bones or joints, sore legs, or rupture.[4]

The physical standards for entrance into the Army became more detailed in the years leading up to 1841, and in the General Regulations for the Army of the United States, issued in that year, Surgeons, Assistant Surgeons, and private physicians were directed to:

> . . . cause each recruit to be stripped of all his clothes, and to move about and exercise his limbs in their presence, in order to ascertain whether he has the free use of them; that his chest is ample; that his hearing, vision, and speech are perfect; that he has no tumors; ulcerated or extensively cicatrized (i.e., scarred) legs; rupture, chronic cutaneous affection, or other disorder or infirmity, mental or physical, which may render him unfit for the active duties of a soldier, or be the means of introducing disease into the Army; . . .[5]

The physical standards of 1841 were followed by both sides during the Civil War although examination of recruits appears to have been lax.[6]

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[3]U. S. Army, Medical Department, Physical Standards in World War II (Washington, D.C., U.S. Government Printing Office, 1967), p. xiii.

[4]Military Laws and Rules and Regulations for the Army of the United States. (Washington: Adjutant General's Office, 1814), pp. 257-258, as quoted in U.S. Army, Medical Department, op. cit., p. xv.

[5]General Regulations for the Army of the United States, 1841, as quoted in U.S. Army, Medical Department, op. cit., p. xv.

[6]U. S. Army, Medical Department, op. cit., p. xiv.

In the interim between the Civil War and World War I, the need for physical fitness in officers and enlisted men and the physical standards assuring this physical fitness both developed. Because the Army could be maintained at strength by voluntary enlistments, the physical standards of the pre-World War I period were relatively severe.[7] With the institution of the draft at the start of the First World War, there were no existing physical standards for the classification of men who were drafted into the Army. The first revision of the physical standards was applicable to registrants under the draft act only. The more stringent prewar standards were still applicable to enlistees.[8] It was not until the fourth revision of these standards, published about one year later (1918) that the same standards were fixed for draftees and for voluntary enlistees.[9]

Following World War I, the physical standards in the medical selection of personnel for the Army in peace or war were reviewed, organized, and incorporated into AR 40-105, "Standards of Physical Examination for Entrance into the Regular Army, National Guard, and Organized Reserves," which was published 29 May 1923.[10]

On 5 December 1932 MR (Mobilization Regulations) 1-5, "Standards of Physical Examinations During Those Mobilizations for Which Selective Service is Planned," was issued. This regulation listed physical defects which an individual might have and whether these defects disqualified him for military service as an enlisted man. MR 1-5 was retitled MR 1-9, "Standards of Physical Examination During

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[7] Ibid.

[8] Ibid.

[9] Ibid., p. xviii.

[10] Ibid., p. 2 and Appendix C.

Mobilization," and was reissued on 31 August 1940. Other regulations published prior to and during World War II included AR 40-100, "Standards of Miscellaneous Physical Examination," dated 16 November 1942; AR 40-110, "Standards of Physical Examination for Flying," dated 8 December 1942; and Changes No. 5 to AR 40-105, dated 17 August 1940. MR 1-9 was revised and again reissued on 19 April 1944.[11]

On 5 December 1960, AR 40-501, "Medical Service: Standards of Medical Fitness," was published. This single regulation covers the physical standards required for both officer and enlisted personnel, during peacetime and mobilization, and also the special physical requirements for service in certain geographical areas, for duties such as airborne, ranger training, diving, and flying, and for admission to the U.S. Military Academy. To date there have been 25 changes published for this regulation.[12]

Administrative Responsibilities

The Assistant Secretary of Defense (Manpower and Reserve Affairs) designates and approves the locations of the Armed Forces Examining and Entrance Stations (AFEES). Among the functions of the AFEES are (1) the examination of male applicants to determine their medical and mental qualifications for enlistment in the United States Armed Forces (regular components), (2) the examination and processing of Selective Service registrants to determine their medical and mental

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[11] Ibid., pp. 2-3 and Appendices A, B, C, D, and E.

[12] U.S. Army, AR 40-501, Medical Service: Standards of Medical Fitness, 5 December 1960 (Washington, D.C.: U.S. Government Printing Office, 1960).

qualifications and administrative eligibility for induction into the Armed Forces, and (3) the examination of other programmed personnel referred by any of the United States Armed Forces to include officer, officer candidates, and female applicants.[13]

The Department of Defense has designated the Department of the Army as Executive Agent with the overall responsibility for operation of AFEES.[14] The Commanding General of the United States Army Recruiting Command, (USAREC), a Class II activity under the general staff supervision of the Deputy Chief of Staff for Personnel, Department of the Army, has among his responsibilities that of establishing and operating the AFEES in accordance with directives from Headquarters, Department of the Army, as Executive Agent for the Department of Defense.[15]

Each of the five Army Recruiting District Commanders exercises command control of the AFEES located in his district.[16] The commanding officers of the AFEES are responsible for the "successful and efficient accomplishment of the primary functions of the AFEES."[17]

Medical Examining Procedures

The Surgeon, United States Army Recruiting Command, exercises technical supervision over all medical examination sections of the AFEES.[18]

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[13]U.S. Army, AR 601-270, Personnel Procurement: Armed Forces Examining and Entrance Stations, 18 March 1969 (Washington, D.C.: U.S. Government Printing Office, 1969), p. 1-1.

[14]Ibid.

[15]Ibid., p. 1-3.

[16]Ibid.

[17]Ibid., p. 1-4.

[18]Ibid., p. 4-12.

The senior military Medical Corps officer assigned to duty at each AFEES acts in the capacity of Chief of the Medical Examining Section. In this position he is responsible to the AFEES commander for the accomplishment of all medical examinations conducted in his section. He is instructed by regulation to insure that a "high quality of medical examination is performed in every case." He is further instructed by regulation that among his specific functions he is responsible to "insure that each examinee processed in the medical section receives a quality medical examination of the scope prescribed in chapter 10, AR 40-501."[19]

Chapter 2, AR 40-501, "Medical Fitness for Appointment, Enlistment, and Induction," contains the current general medical fitness standards for acceptance of registrants or applicants for enlistment into the military service. These medical standards are prescribed by the Department of Defense and are applicable for induction or enlistment into all military services.[20,21]

Chapter 10, AR 40-501, "Medical Examinations--Administrative Procedures," Chapter 11, AR 40-501, "Medical Examination Techniques," Appendix IX, AR 40-501, "Scope and Recording of Medical Examinations," paragraph 4-20, AR 601-270, "Complete medical examination," and USAREC Pamphlet No. 40-1, "Medical Service: Policy Guide for Medical Officers Assigned to Armed Forces Examining and Entrance Stations," describe in

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[19] Ibid., pp. 4-12 - 4-13. [20] Ibid., p. 4-15.

[21] U.S. Army, AR 40-501, op. cit., p. 2-1.

great detail the procedures and techniques to be followed during the conduct of a complete medical examination at an AFEES.[22,23,24]

Statement of the Problem

The major purpose of this study was to determine whether or not a medical examination of the form and scope prescribed by various regulations is in fact performed on every individual processed for induction or enlistment into the armed forces. A secondary purpose was to evaluate the professional satisfaction of the medical officers assigned to the AFEES.

The author was assigned to the United States Army Recruiting Command for 22 months. For the first four months he was assigned as a Medical Staff Officer in the office of the Command Surgeon. During this period he visited several of the 74 AFEES operated by the Recruiting Command. For the remaining 18 months the author was the Chief of the Medical Examining Section, AFEES, Los Angeles. As a result of this experience, the following hypotheses were developed for evaluation by the study:

1. An examination of the form and scope required by the various regulations is not performed on every individual processed for induction or enlistment into the armed forces.

2. The Medical Officers assigned to the AFEES are of the opinion that the performance of a medical examination of the form and

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[22]U.S. Army, AR 40-501, op. cit.

[23]U.S. Army, AR 601-270, op. cit.

[24]U.S. Army, USAREC Pam 40-1, Medical Service: Policy Guide for Medical Officers Assigned to Armed Forces Examining and Entrance Stations, 11 January 1968, (Hampton, VA.: Headquarters, United States Army Recruiting Command, 1968).

scope required by the various regulations requires more time than they are able to devote to each examinee.

3. The Medical Officers assigned to the AFEES are of the opinion that certain portions of the examination required by the various regulations are not necessary during the performance of an adequate medical examination to determine an individual's physical fitness for military service, and as a result of this opinion the Medical Officers omit these portions of the examination from their examination.

4. The various regulations should be changed to indicate that the medical examination performed for induction and enlistment is a "screening examination."

5. There is a direct relationship between the portions of the medical examination omitted by the Medical Officers and the distribution of disqualifying defects resulting in Existing Prior to Service (EPTS) discharges of inductees and enlistees.

6. The Medical Officers assigned to the AFEES are not professionally satisfied with their assignment.

Importance of the Study

In this era of disillusionment with the policies of the government combined with the increased draft calls required by the war in Viet Nam, many young men subject to the draft attempt to avoid being drafted by "legal" methods. Several books have been published which discuss in detail the steps a young man should go through if he desires to avoid the draft "legally." One such book counsels the potential draftee that the "younger doctors, and doctors from minority groups--Mexican-Americans, Negroes and Orientals . . . --are more likely to be

sympathetically disposed to your cause than are others."[25] The potential draftee is also instructed to see a physician for even trivial symptoms so that the visit and the ailment will be recorded on his medical records, to avoid having surgery for remediable disqualifying conditions, and by inference to exaggerate his symptoms.[26]

These books also instruct the potential draftee to appeal to the Command Surgeon of the United States Army Recruiting Command in the event he is found medically qualified for military service.[27,28] Many of these young men write to a Congressman rather than directly to the Recruiting Command Surgeon. During the first quarter of calendar year 1971, the Office of the Recruiting Command Surgeon received 4,230 Congressional Inquiries and 486 Special Interest Inquiries for a total of 4,716 inquiries.[29] Each inquiry is processed by the Office of the Command Surgeon and then forwarded to the AFEES where the examinee was processed. The AFEES has a 17 day suspense during which time it must have the examinee recalled for further processing, reexamine him with specific reference to the complaint(s) in his inquiry, determine his qualification for military service, and return the case to USAREC headquarters. Any changes in the medical examination system that would alleviate the increased workload caused by the large number of inquiries would

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[25]Frank Forster, M.D., A Doctor's Guide to the Draft (New York: Lancer Books, 1970), p. 18.

[26]Ibid., pp. 21-23. [27]Ibid., p. 159.

[28]Leslie S. Rothenberg, The Draft and You: A Handbook on the Selective Service System (Garden City, New York: Anchor Books, Doubleday and Company, Inc., 1968), p. 277.

[29]Statement by COL George W. Sgalitzer, Command Surgeon, USAREC, telephonic interview, 30 April 1971.

result in improved efficiency and allow the medical officers to devote more time to the examinees.

Another benefit arising from this study could be the identification of job dissatisfaction on the part of the Medical Officers assigned to the AFEES. In the event that an all volunteer Army becomes a reality, the Medical Corps may also be filled solely by volunteers. Even though there would no longer be the necessity of examining Selective Service registrants the regulations prescribing the form and scope of the medical examination presumably would remain the same. If the assignment is considered dissatisfying by the Medical Officers, then some changes must be made if these Medical Officers are to be persuaded to remain in the Armed Forces.

Definition of Terms

Congressional Inquiry

An inquiry received by a Congressman from one of his constituents (or constituent's parents, wife, lawyer, etc.) relative to the constituent's medical qualification for military service, and forwarded by the Congressman through the Office of Legislative Liaison to the Surgeon, USAREC.

Special Inquiry

An inquiry from an examinee, his parents, wife, lawyer, etc., relative to the examinee's medical qualification for military service, sent to the Surgeon, USAREC, or to another governmental office (Director of the Selective Service System, Chief of Physical Standards, Office of the Surgeon General, etc.,) and forwarded to the Surgeon, USAREC.

Applicant

An individual who aplies voluntarily for enlistment in the United States Armed Forces.[30,31]

Registrant

An individual forwarded by a Selective Service local board to an AFEES for preinduction processing or induction into the Armed Forces.[32,33]

Screening Examination

Mass examination of the population to detect the existence of disease (See page 15).

Limitations

The fact that the average medical rejection rate reported by 64.7 per cent of the Medical Officers assigned to the AFEES is virtually the same as the reported national average leads one to conclude that the respondents are probably representative of the total population. Therefore, the lack of response from approximately one third of the assigned Medical Officers is not considered a significant limitation.

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[30]U.S. Army, AR 601-270, op. cit., p. 2-8.

[31]U.S. Army, AR 310-25, Dictionary of United States Army Terms, 1 March 1969, (Washington, D.C.: U.S. Government Printing Office, 1969), p. 42.

[32]Ibid., p. 371.

[33]U.S. Army, AR 601-270, op. cit., p. 2-9.

CHAPTER II

MATERIALS AND METHODS

During February, 1971, a questionnaire was mailed to all military physicians assigned to the 74 Armed Forces Examining and Entrance Stations. The names of these physicians were provided by the Command Surgeon, United States Army Recruiting Command. These physicians belong to the Army, Navy and Air Force, but the service to which each individual belongs was not indicated on the list supplied by the Recruiting Command Surgeon. In addition, the list did not indicate the physicians' military ranks.

Population

There were 141 names on the list of Medical Officers assigned to the AFEES supplied by the Recruiting Command Surgeon. Since the total population was to be surveyed, it was not necessary to determine a minimum sample size.[34,35] However, it was determined that a uniform response from 50 per cent or more of the population being studied to

[34]William S. Kromer, MAJ, USA, United States Army Command and General Staff College, Fort Leavenworth, Kansas, personal interviews, May 1971.

[35]Arthur H. Schultz, LTC, USA, United States Army Command and General Staff College, Fort Leavenworth, Kansas, personal interviews, May 1971.

any individual item in the questionnaire would give adequate accuracy to that item.[36,37]

Construction of the Questionnaire

The questionnaire (Appendix A) was constructed to obtain information in six broad areas: (1) the individual AFEES to which each respondent was assigned, (2) the respondent's opinions relative to the examinee/physician ratio, (3) the respondents' opinions relative to the content and conduct of the medical examination as set forth in the various regulations and directives, (4) the actual performance of the medical examination by the respondents, (5) the respondent's opinions relative to the operation of the Medical Examining Sections of the AFEES, and (6) the satisfaction of the respondents with their assignments as physicians at the AFEES.

The Individual AFEES

In order to categorize the questionnaires as they were returned, question 1 asked for the rated capacity of the AFEES. Questions 2, 3, 6, 9, 12, 13, 15, 16, and 17 requested information relative to the work loads of the stations, to include examinee loads, consultations, rejection rates, Congressional and Special Interest inquiries, and the quality of the facilities, and adequacy of size of the medical examining sections.

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[36] Ibid.

[37] Taro Yamane. Statistics; An Introductory Analysis. (2nd. ed.; New York: Harper and Row, 1967), p. 582.

Examinee/Physician Ratio

Questions 7, 8, 10, 11, 14, 22, and 23 were included to determine whether the respondents were of the opinion that a change in the examinee/physician ratio would affect the number of consultations required, the medical rejection rate, or the number of Congressional and Special Interest inquiries. Questions 22 and 23 specifically asked if the respondent felt the requirement of 30 examinations per physician per day was realistic, and if not, what number of examinations per day he would recommend.

Opinions Relative to the Medical Examination

Question 18 asked for the respondents' opinion of whether or not a medical examination of the extent required by regulations was necessary for entrance into the armed forces. Question 19 asked those respondents who indicated that a medical examination of the extent required by regulations was not necessary for entrance into the armed forces to indicate what portions of the examination they would eliminate. In the construction of this question, Standard Form 88 (SF 88), Report of Medical Examination (Appendix D) was used as a reference. In this way individual items in the medical examination were presented to the respondent in the order and form in which he was used to seeing them, since SF 88 is completed for every individual who receives a medical examination at an AFEES. With each item presented in question 19, the instructions for the completion of that item as found in the regulations were also presented. With the exception of item 45, Urinalysis, item 46, Chest X-ray, and item 47, Serology, only those items normally requiring direct action by the medical officer (examining physician) were presented.

Question 21, in which respondents indicated what items they would include if they were responsible for setting up the medical examination for inductees and enlistees, was included as a check on the answers to both question 19 and question 20 (see below). It was anticipated that if a respondent indicated he would omit an item in question 19, he would not include this item in question 21.

Question 26 used the term "screening examination." This term was not defined since it is a relatively common medical term defined as mass examination of the population to detect the existence of disease.[38] The term is used in medical literature without definition. Question 26 asked the respondent whether or not he felt the medical examination for induction/enlistment should be referred to as a "screening examination" and formally recognized as such with an appropriate change in the regulations.

The Performance of the Medical Examination

Question 4 indicated how much time the medical officer was able to spend with each examinee. Question 5 gives the same information for the medical corpsmen and medical technicians.

Question 20 indicated what portions of the prescribed medical examination were actually performed by the medical officers. The same list of items presented in question 19 was again presented in question 20 with the exception that question 19-7, item 24, Eyes--General, was inadvertently omitted from question 20. Once again, question 21 was

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[38] W. A. Newman Dorland, The American Illustrated Medical Dictionary (22nd. ed.; Philadelphia and London: W. B. Saunders Company, 1951).

used to check the responses to question 20. It was anticipated that there would be a direct correlation between the items of the medical examination actually performed and those items recommended for inclusion in the medical examination.

Questions 24 and 25 asked the medical officers if their examinees received a medical examination of the form and scope required by regulations. The term "screening examination" was introduced in question 25, and as explained above, this term was not defined.

Questions 27 and 28 presented the respondents with the hypothetical situation of performing the medical examination on a private patient. The respondents were asked how long it would take them to perform an extensive medical examination of the form and scope prescribed in the regulations and how long it would take them to perform a screening examination to evaluate an individual's medical qualification for military service.

The Operation of the Medical Examining Sections

Question 29 asked the respondents what they would do to increase the efficiency of the Medical Examining Sections at the AFEES. They were presented with three choices, lower the examinee/physician ratio, change the examination to a "screening examination," or "other." If the respondents answered "other" they were asked for their suggestions.

Satisfaction with Assignment

Question 30 asked the respondents whether or not they were satisfied with their assignments as physicians at the AFEES. If they answered "no" they were asked why they were not satisfied.

Question 31 asked the respondents to present their recommendations to improve the tour of duty at the AFEES.

Type of Questions

With the exception of questions requiring comment by the respondents, an attempt was made in the construction of all the questions to force the respondents into making specific answers, i.e., "yes" or "no," "check for elimination," "check for inclusion," etc. This was done to reduce the necessity for judgment on the part of the author in the evaluation of the individual responses.

Response to the Questionnaire

The cover letter (Appendix B) attached to the questionnaire requested that they be returned by 17 March 1971. On that date 63 questionnaires had been returned. Therefore, on 18 March 1971, a follow up letter (Appendix C) was sent to all 141 physicians requesting an immediate return of the questionnaire.

By 9 April 1971, 30 additional questionnaires had been received, bringing the total number of questionnaires accounted for to 93 or 66.0 percent of the total mailed. Two of the returned questionnaires indicated that the physicians to whom they were addressed had separated from the armed forces and that their forwarding addresses were unknown. This brought the total population studied to 139. One additional questionnaire could not be used since the respondent stated that another medical officer at his station had already answered the questionnaire and that he had "nothing to add." Therefore, there were 90 usable questionnaires returned which represented 64.7 percent of the total population.

CHAPTER III

RESULTS AND ANALYSIS OF DATA

As each questionnaire was returned it was assigned a sequential arbitrary number for purposes of identification and retrieval. The information contained in the questionnaire was then entered on master charts according to the stated capacity shown in question 1. One respondent failed to enter the rated capacity of his station but his questionnaire nevertheless contained sufficient information to warrant inclusion in the study. A listing of the rated capacities of the 74 Armed Forces Examining and Entrance Stations for Fiscal Year 1971 is shown in Appendix E. A complete summary of all data collected is shown in Appendix F.

The Individual AFEES

The rated capacity of an AFEES refers to the number of complete medical examinations the station is expected to be able to complete on any given day. For the purposes of this study, the AFEES were grouped according to their rated capacities into the following categories:

50 or less
51 to 124
125 to 199
200 to 500

Table 3.1 shows the number of AFEES in each size grouping used in the study, the number of physicians assigned to the stations in

TABLE 3.1

RATED CAPACITIES, ASSIGNED PHYSICIANS,
NUMBER AND PER CENT OF RESPONDENTS

Rated Capacity	Number of AFEES in Group	Number of Physicians Assigned to Group	Number of Physicians Responding	Per Cent of Assigned Physicians Responding
50 or less	22	27	22	81.5
51 to 124	18	31	23	74.2
125 - 199	27	55	27	49.1
200 to 500	7	26	17	65.4

each group, and the number and per cent of respondents in each group.

Questions 2 and 3 asked for information regarding the examinee loads at the AFEES. Forty-two respondents (46.7 per cent) indicated that the average daily examinee load during calendar year 1970 was less than the rated capacity of the station while only 10 respondents (11.1 per cent) indicated that it exceeded the rated capacity. On the other hand, 86 respondents (95.6 per cent) indicated that the largest number of examinees on any one day during the same period exceeded the rated capacity of the station while only one respondent, from a station with a rated capacity of 50 or less, stated that his largest daily load was approximately equal to his station's rated capacity.

The results from question 6 indicate that 16.5 per cent of all the examinees require a consultation by a specialist. It is noted, however, that the physicians in the 200 to 500 rated capacity group indicated that 30.3 per cent of their examinees require a consultation.

The average of the responses to question 9 indicates that the medical rejection rate is 39.4 per cent. This is surprisingly close to the current national medical rejection rate of 38 per cent.[39]

Sixty-three respondents to question 12 (70.0 per cent) indicated that they handle five or fewer Congressional and Special Interest inquiries per week. No respondent at a station with a rated capacity of less than 200 indicated that he handled more than 10 such inquiries per week. However, 11 of the 17 respondents assigned to stations with capacities greater than 200 stated that they handle 11 or more inquiries per week.

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[39]Sgalitzer, telephonic interview, 30 April 1971.

During the first quarter of calendar year 1971, the office of the USAREC Command Surgeon processed 4,230 Congressional inquiries and 486 Special Interest inquiries for a total of 4,716 inquiries.[40] This averages out to about 2.6 inquiries per week for each of the 139 physicians assigned to the AFEES at the time of the study. It would appear, therefore, that the physician at the larger station must devote more of his time to the processing of Congressional and Special interest inquiries than does his fellow physician at a smaller station.

The average of the responses to question 13 indicates that the physicians uphold the originators of Congressional and Special Interest inquiries about 30.5 per cent of the time. The distribution of responses indicates that only 13 respondents uphold the originators of the inquiries more than 51 per cent of the time, and that only 14 uphold the originators from 41 to 50 per cent of the time. This is at variance with the figures from the office of the Recruiting Command Surgeon which indicate that 57 per cent of the inquiries result in a reversal of the original finding of the Medical Examining Sections, usually from qualified to disqualified, and that 60 per cent of the inquiries are justified. The 3 per cent difference represents cases in which there are no changes in the status of the originators of the inquiries but in which there were in fact errors in the performance of the medical examination (e.g., an individual may claim that an audiometric examination was not performed, but when this is performed, it reveals acceptable hearing).[41]

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[40] Ibid.

[41] Statement by COL George W. Sgalitzer, Command Surgeon, USAREC, telephonic interview, 21 May 1971.

Question 15 revealed that 22 of the respondents (24.4 per cent) rated the facilities of their Medical Examining Sections as being "Fair," and an additional 6 respondents (6.7 per cent) rated their facilities as "Inadequate." These 28 respondents presented a total of 73 individual criticisms in response to question 16. The two most frequently cited criticisms were deficiencies in heating and/or ventilation (10 respondents) and poor traffic or flow patterns within the Medical Examining Sections (10 respondents).

Question 17 revealed that 49 respondents (54.4 per cent) felt their Medical Examining Sections were too small for the largest examinee load processed during calendar year 1970, and that 9 (10.0 per cent) felt their Medical Examining Sections were too small to handle their average daily examinee load during the same period.

Examinee/Physician Ratio

Question 7 and 8 gave conflicting results. Each asked the respondents whether they felt the percentage of examinees requiring consultations would decrease if the examinee/physician ratio were decreased (i.e., fewer examinees per physician). Question 7 specified that the number of examinees would decrease, question 8 that the number of physicians would increase. The results of these questions were approximately reciprocals of each other.

Questions 10 and 11 asked the same type questions relative to the medical rejection rate. Greater than 60 per cent of the respondents indicated that they would expect no change in the medical rejection rate if either there were fewer examinees or more physicians.

Question 14 revealed that approximately half of the respondents would expect a decrease in the number of examinees instituting Congressional or Special Interest inquiries if there were fewer individuals for each physician to examine.

In response to question 22, 50 respondents (55.6 per cent) were of the opinion that the requirement of 30 examinations per physician per day was realistic. Of the 38 respondents who answered "no" to question 22, 34 indicated in question 23 the number of examinations per physician per day they felt was realistic. The average of these responses was 20 examinations per physician per day.

The results from this series of questions appear to show that the respondents to the questionnaire were of the opinion that a change in the examinee/physician ratio resulting in fewer examinees per physician would have little, if any, effect on the results of the examination, the percentage of examinees requiring consultations, or the number of examinees instituting Congressional or Special Interest inquiries. Over half of the respondents indicated that the requirement of 30 examinations per physician per day was realistic.

Opinions Relative to the Medical Examination

Sixty respondents (66.7 per cent) were of the opinion that an examination of the extent prescribed by regulations is <u>not</u> necessary for entrance of inductees and first time enlistees into the armed forces. These 60 respondents were then asked, in question 9, what items of the medical examination they felt should be eliminated from the examination.

Three items of the medical examination were recommended for elimination by 50 per cent or more of the respondents to question 19. These items were "Nose" (question 19-2), "Sinuses" (question 19-3), and "Mouth and Throat" (question 19-4). An additional 6 items were recommended for elimination by more than one third of the respondents to question 19. These were "Ophthalmoscopy" (question 19-8), "Lungs and Chest" (question 19-11), "Abdomen and Viscera" (question 19-14), "Identifying Body Marks, Scars, Tattoos" (question 19-24), "Dental Examination" (question 19-26), and "Serology" (question 19-29). The number of respondents recommending elimination of each of these items is shown on table 3.2.

No respondent recommended elimination of "Feet" (question 19-19) or "Lower Extremities" (question 19-20). Only 1 respondent each recommended elimination of the following four items: "Upper Extremities" (question 19-18), "Spine, Other Musculoskeletal: (question 19-21), "Urinalysis" (question 19-27), and "Chest X-Ray" (question 19-28).

The results of question 26 indicated that 64 respondents (71.1 per cent) were of the opinion that the medical examination for induction and enlistment should be referred to as a "screening examination" and formally recognized as such with an appropriate change in the regulations to require a much less extensive medical examination. The significance of this will be discussed in Chapter IV.

The Performance of the Medical Examination

Questions 4 and 5 revealed how much time is devoted to each examinee by the medical staffs at the AFEES. The responses to these questions indicate that the average physician at an AFEES spends 6.1

TABLE 3.2

MAJOR ITEMS RECOMMENDED FOR ELIMINATION
FROM MEDICAL EXAMINATION

Question No.	Description	Number Recommending Elimination (Total = 60)	Per Cent Recommending Elimination
19-2	Nose	34	56.7
19-3	Sinuses	53	88.3
19-4	Mouth and Throat	39	65.0
19-8	Ophthalmoscopy	23	38.3
19-11	Lungs and Chest	27	45.0
19-14	Abdomen and Viscera	29	48.3
19-24	Identifying Body Marks, Scars, Tattoos	24	40.0
19-26	Dental Examination	28	46.7
19-29	Serology	27	45.0

minutes with each examinee and that the average corpsman or medical technician spends 10.4 minutes with each examinee. Therefore, the average examinee at an AFEES is in personal contact with either a physician or a corpsman or medical technician for only 16.5 minutes during his stay in the Medical Examining Section.

Question 20 asked the respondents what items of the medical examination they actually perform at their Medical Examining Sections. The responses to this question were analysed on the basis of the total respondents to the questionnaire and additionally on the basis of the respondents to question 19 (a total of 60) (Appendix G).

Utilizing Automatic Data Processing Equipment a linear regression analysis was performed to determine the correlation between the data from question 19 recommending elimination of items from the medical examination and the data from question 20 representing the items actually performed during the examination. The coefficient of correlation (r) between the responses of these same 60 respondents to question 20 is -.766407. The coefficient of determination (r^2) is .58738. It would appear that a majority of the respondents recommending elimination of items from the medical examination have, in fact, eliminated these items from the examination they perform at their Medical Examining Sections.

A linear regression analysis was also performed between the data representing the items performed during the medical examination by the 60 respondents recommending elimination of portions of the examination and the remaining 30 respondents who did not recommend any changes to the medical examination. The coefficient of correlation (r) is .921532 and the coefficient of determination (r^2) is .849405. It would

therefore appear that most (85 per cent) of the 30 respondents who did not recommend elimination of portions of the medical examination may, none-the-less, eliminate the same items from the medical examination as were recommended for elimination, and actually eliminated, by the 60 respondents recommending changes in the medical examination.

Question 21 asked the respondents what items they would include in the medical examination for entrance into the armed forces if they were responsible for setting up the examination. Regression analyses were performed between the data from questions 19 and 21, and questions 20 and 21. The coefficient of correlation (r) between question 19 and question 21 is -.851212 and the coefficient of determination (r^2) is .724561. The coefficient of correlation (r) between question 20 (all respondents) and question 21 is .815498 and the coefficient of determination is .665038.

Looking at questions 19, 20 and 21 together (Appendix G) it appears that items recommended for elimination from the medical examination for induction and enlistment are, in fact, not performed by the medical officers at the AFEES and, in addition, are not recommended for inclusion in the medical examination by the respondents when they are placed in the position of setting up the medical examination for entrance into the armed forces.

The responses to questions 24 and 25 revealed that only 32 of the respondents (35.6 per cent) felt that the examinees at their Medical Examining Sections received an extensive medical examination as prescribed in the various regulations. An additional 42 (46.7 per cent) felt that even though the examinees at their Medical Examination Sections did not receive an extensive examination as prescribed by

regulations, they nevertheless received a good general medical examination. The remaining 16 respondents (17.8 per cent) felt that their examinees received a good "screening" examination.

Questions 27 and 28 presented the respondents with the hypothetical situation of performing the medical examination on a private patient. Only nine respondents (10.0 per cent) indicated that they could perform an extensive medical examination of the form and scope prescribed in regulations in 15 minutes. Fifty-five respondents (61.1 per cent) indicated that it would take them 30 to 45 minutes to complete such an examination, and 25 respondents (27.8 per cent) indicated that it would take them one hour or more to complete the examination. On the other hand, 64 respondents (71.1 per cent) indicated that they could perform an adequate screening examination to evaluate an individual's medical qualification for military service in 15 minutes or less.

The Operation of the Medical Examining Sections

Question 29 asked the respondents what they would recommend to increase the efficiency of the Medical Examining Sections at the AFEES. Twenty-one respondents (23.3 per cent) recommended an increase in the number of physicians assigned to the AFEES so that a more extensive medical examination can be performed (i.e., lowering the examinee/physician ratio), 28 respondents (31.1 per cent) recommended that the regulations be changed to require a "screening" examination which would be much less extensive in form and scope, and 15 respondents (16.7 per cent) offered other suggestions. In addition, 22 respondents recommended combinations of the above three possibilities, including 16 who offered other suggestions. Therefore, a total of 31 respondents (34.4 per

cent) offered suggestions to improve the efficiency of the Medical Examining Sections other than the suggestions presented in the question. Among the suggestions offered were recommendations that AR 40-501, Standards of Medical Fitness, should be revised to be much more specific and detailed, that Standard Form 89 (SF 89), Report of Medical History, should be revised (a copy of Standard Form 89 will be found at Appendix H), that the AFEES should be drastically reorganized, that trained medical corpsmen be utilized to perform more of the examination under the supervision of the physician, and that the input of examinees into the AFEES each day more closely approximate the rated capacities of the stations. A list of representative suggestions offered by respondents to question 29 will be found at Appendix I.

Satisfaction with Assignment

Question 30 asked the respondents whether or not they were satisfied with their assignments as physicians at AFEES. Only 33 respondents (36.7 per cent) stated that they were satisfied, and of these 11 entered comments relative to professional dissatisfaction with the assignment. Forty-seven respondents (52.2 per cent) indicated that they were not satisfied with their assignment, and 6 respondents (6.7 per cent) answered "yes/no" and were classified as "No Answer." The respondents answering "yes/no" entered comments relative to their reasons for professional dissatisfaction with their assignments, as did the respondents who indicated that they were dissatisfied with the assignment. In all, 64 respondents (71.1 per cent) indicated dissatisfaction with their assignments as physicians at AFEES.

Almost every comment relative to dissatisfaction indicated that the respondent did not believe he was practicing medicine. The assignment was referred to as "a professional vacuum," "boring, monotonous, demoralizing," a "Medical and Professional void," "Professionally unrewarding," and "Demeaning." A listing of the comments given in response to question 30 is presented in Appendix J.

In question 31, the respondents were asked to offer recommendations to improve the tour of duty at an AFEES. A total of 146 recommendations were received. Forty-seven respondents (52.2 per cent) recommended that the AFEES physicians be given an opportunity to attend local professional conferences during duty hours, and 24 respondents recommended that the Recruiting Command permit the physicians to engage in private practice. Paragraph 5e, AR 40-1, Medical Service: Composition, Mission, and Functions of the Army Medical Department, authorizes military physicians to engage in private practice with the approval of their commanding officer.[42] The large number of comments received relative to this subject would indicate that the Recruiting Command is exceptionally restrictive in granting permission for the physicians assigned to the AFEES to engage in private practice. A representative selection of recommendations offered in response to question 31 is presented in Appendix K.

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[42]U.S. Army, AR 40-1, Medical Service: Composition, Mission, and Functions of the Army Medical Department, 1 June 1965, (Washington, D.C.: U.S. Government Printing Office, 1965), p. 3.

CHAPTER IV

DISCUSSION

The data obtained from the survey of the military physicians assigned to the 74 Armed Forces Examining and Entrance stations would appear to indicate that a medical examination of the form and scope prescribed by regulations is not performed on every individual processed for induction or enlistment into the armed forces. Various aspects of this will be discussed in the following sections. In addition, the relationship between the portions of the medical examination apparently omitted by the Medical Officers and the distribution of disqualifying defects resulting in Existing Prior to Service (EPTS) discharges of inductees and enlistees, and the satisfaction of the medical officers assigned to the AFEES will also be discussed.

The Medical Examination

Sixty respondents (66.7 per cent) indicated that they did not feel that a medical examination of the form and scope required by regulations is required for entrance of inductees and enlistees into the armed forces. These 60 respondents represent 43.2 per cent of the total population studied. When queried as to what items they would recommend for elimination from the medical examination, the items most frequently selected by the respondents were examination of the nose, sinuses, mouth and throat, lungs and chest, abdomen and viscera, and teeth, the

performance of an ophthalmoscopic examination, and the serology determination. There were strong negative correlations between the items recommended for elimination and the items actually performed by the same group of respondents (r = -.766407), and between the items recommended for elimination by the sub-group of 60 respondents and the items recommended for inclusion by the entire group of 90 (r = -.851212). In addition, there were strong positive correlations between the items actually performed by the 60 respondents who recommended changes in the examination and the items actually performed by the remaining 30 respondents who did not recommend any changes in the examination (r = .921532), and between the items actually performed by the entire group of respondents and the items they would recommend for inclusion if they were responsible for setting up the medical examination for inductees and enlistees (r = .815498). The correlation between the items of the examination actually performed by the sub-group of 60 and those performed by the sub-group of 30 appears to indicate that even though the respondents in the sub-group of 30 did not recommend the elimination of any items from the examination, they nevertheless have eliminated the same items as were recommended and eliminated by the sub-group of 60.

The amount of time an individual examinee spends with a physician or a medical corpsman/technician appears to be significant when it is compared to the length of time it would take the physicians to perform an examination of the form and scope required by regulations on private patients. The survey indicates that the average examinee spends 16.5 minutes with a physician or medical corpsman/technician. On the other hand, 80 of the respondents (88.9 per cent) indicated that it would take them 30 minutes or longer to conduct the required examination on private

patients. Sixty-four of the respondents (71.1 per cent) however, indicated that they could perform an adequate screening examination to evaluate an individual's medical qualification for military service in 15 minutes or less. As was noted in Chapter III, 64 respondents recommended in response to question 26 on the questionnaire that the medical examination for induction/enlistment should be referred to as a "screening examination" and formally recognized as such with an appropriate change in the regulations.

In summary, the following conclusions can be made regarding the medical examinations performed at the AFEES: (1) a medical examination of the form and scope required by the regulations is not performed on every examinee, (2) the physicians assigned to the AFEES have determined for themselves what items of the required examination should be eliminated from the examination and have then, in fact, eliminated these items from the examination as they perform it, (3) the physicians assigned to the AFEES are of the opinion that the time required to perform a medical examination of the form and scope required by regulations exceeds the time they and their medical corpsmen/technicians are able to devote to each examinee, (4) the physicians assigned to the AFEES are of the opinion that the time required to perform an adequate screening examination to evaluate an individual's medical qualification for military service is approximately equal to the time they and their corpsmen/technicians are able to spend with each examinee, and (5) the physicians at the AFEES believe the required medical examination for induction/enlistment should be referred to as a "screening examination," and the assumption can be made that these physicians probably consider the medical examination as they perform it as a "screening examination."

Items Omitted from the Examination and the EPTS Rate

Approximately 1.9 per cent of all individuals who enter the armed forces are subsequently discharged because of the presence of disqualifying medical defects that existed prior to entrance on active duty.[43] When an individual is so discharged from the armed forces, a copy of his Medical Board proceedings, together with a copy of the records of his initial medical examination at the AFEES, are forwarded to the USAREC Command Surgeon.[44] These records are then evaluated by the Surgeon to determine whether or not the disqualifying defect could have, or should have, been detected prior to the individual's entrance on active duty.[45,46] Fifty-two and one-tenth per cent of the EPTS cases are classified as representing conditions that could not have been detected at the AFEES, and 34.3 per cent of the cases are conditions that possibly could have been detected if further investigation had been carried out. Nine per cent of the cases are classified as conditions that should have been detected at the AFEES, and 4.6 per cent are conditions that were overlooked "due to an inexcusable error."[47,48]

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[43]Sgalitzer, telephonic interview, 30 April 1971.

[44]George W. Sgalitzer, COL, MC, USA, "Medical Defects that Existed Prior to Entry into the Armed Forces: A Review of 10,010 Cases," Military Medicine, 134:454-456, June 1969.

[45]Ibid.

[46]U.S. Army, USAREC Pam 40-1, op. cit., p. 19.

[47]Sgalitzer, "Medical Defects," op. cit.

[48]Sgalitzer, telephonic interview, 30 April 1971.

The most common category of the conditions resulting in EPTS discharges is "Orthopedic." This category represents 36.7 per cent of all EPTS discharges.[49,50] The data from this study reveal that the orthopedic portions of the examination (Upper Extremities, Feet, Lower Extremities, Spine and Musculoskeletal) are not recommended for elimination and are actually performed during the examination. In addition, 43 respondents stated that they would give particular emphasis to the orthopedic examination if they were responsible for setting up the examination for induction/enlistment. It would appear, therefore, that the physicians at the AFEES are aware of the large percentage of EPTS discharges caused by orthopedic conditions and that they consequently devote particular attention to the orthopedic portions of the medical examination.

The second most common category of conditions resulting in EPTS discharges is "Neuropsychiatric," representing 12.3 per cent of the cases.[51,52] The data from the study reveal that 8 respondents (8.9 per cent) recommended the psychiatric examination for elimination, 60 respondents (66.7 per cent) actually perform the psychiatric examination, and 61 (67.8 per cent) recommend it for inclusion in the examination. While this represents less emphasis to the psychiatric examination than to the orthopedic examination, it should be noted that it was the opinion

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[49] Ibid.

[50] Sgalitzer, "Medical Defects," op. cit.

[51] Ibid.

[52] Sgalitzer, telephonic interview, 30 April 1971.

of the USAREC Surgeon that only 5.9 per cent of the neuropsychiatric cases should have been detected at the AFEES.[53]

The third most common category of conditions resulting in EPTS discharges is "Allergic (Asthma)," accounting for 10.7 per cent of the cases.[54,55] The data from the study reveal that 27 respondents (30.0 per cent) recommended elimination of the examination of the Lungs and Chest, 64 respondents (71.1 per cent) actually performed the examination, and 66 (73.3 per cent) recommended inclusion of the examination of the Lungs and Chest in the examination. Once again it should be noted that it was the opinion of the USAREC Surgeon that only 14.7 per cent of the cases in this category should have been detected at the AFEES. In addition, asthma is an intermittent condition that will not always be detected, even with very careful auscultation of the lungs, and if an individual wants to enlist, he may hide his history of asthma from the examining physician. This is a relatively common situation, and one in which the physician has no means of detecting the existence of asthma.

In summary, it must be concluded that there is not a direct relationship between the items omitted from the medical examination at the AFEES and the principal causes of EPTS discharges.

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[53]Sgalitzer, "Medical Defects," op. cit.

[54]Ibid.

[55]Sgalitzer, telephonic interview, 30 April 1971.

Satisfaction with Assignment

The finding that as many as 71 per cent of the physicians assigned to the AFEES are professionally dissatisfied with their assignments is disturbing. This professional dissatisfaction, however, does not appear to affect their job performance if we consider the EPTS rate as a performance indicator. It would appear that only 0.26 per cent of all individuals who enter the armed forces through the AFEES are subsequently discharged for disqualifying defects that should have been discovered during the medical examination at the AFEES.[56,57]

The dissatisfaction of the physicians at the AFEES is of perhaps more significance when we consider the possibility of retaining some of these physicians in the armed forces as career officers. A review of the comments in Appendix J reveals that many of the respondents complained that they are not practicing medicine and that they have too much administrative work. In a study by Winkler, 41 per cent of his study group of military physicians considered the possibility of command or administrative assignments to be an important or major cause for leaving military service. Winkler commented that this aversion to such assignments may be due to the physicians' fears that their knowledge and skills will be degraded by separation from the clinical practice of medicine.[58] This very complaint was voiced in several of the comments in Appendix J.

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[56] Ibid.

[57] Sgalitzer, "Medical Defects," op. cit.

[58] W. P. Winkler, MAJ, MC, USA, "A Study to Evaluate Factors Involved in Retention of Medical Officers in the Military Service" (unpublished Master's thesis, United States Army Command and General Staff College, Fort Leavenworth, Kansas, 1968), p. 97.

A subject not addressed in the questionnaire was that of the relationship of prior military experience with job satisfaction in the AFEES assignment. It is known that there was no career medical officer in the study group.[59] All of the officers were serving their 2 year service obligations. It is possible that medical officers who have been in the armed forces for several years prior to their assignment to an AFEES would have a better understanding of needs of the armed forces as they relate to the physical fitness of inductees and enlistees, and would thus feel less threatened by the assignment with its concomitant administrative responsibilities and separation from clinical medicine. If these same officers could be assured that they would be allowed to engage in private practice so long as it did not interfere with their official duties, the assignment could perhaps be still more tolerable.

Another subject mentioned in the comments both to question 30 (reasons for dissatisfaction) and question 31 (suggestions to improve the tour at the AFEES) relates to the relationship between the medical officer and the line officer. Several respondents infer that there is friction between themselves and their commanding officers, and several also suggest that the AFEES Medical Examining Sections should be under the control of the Surgeon General. Some respondents commented that it was "degrading" to be commanded by non-medical officers. It may be possible that these young physicians feel that their status as physicians is threatened when they are under the command of non-medical line officers, and that they additionally feel that they do not receive

[59]Statement by CPT Paul Wagner, Office of the Surgeon, Headquarters, USAREC, telephonic interview, 28 May 1971.

the respect and recognition they deserve as physicians. Tannenbaum states that "the responsibility, respect, and recognition . . . associated with status, contribute significantly to the satisfaction of important needs--and to a sense of self-esteem."[60] At least one respondent asked for an improvement of the attitude of non-medical military personnel toward physicians. Is he perhaps telling us that he feels his status as a physician has fallen? This certainly is a problem that must be considered if we are to retain sufficient physicians in the armed forces. If the medical officer is not professionally satisfied, there will be little incentive for him to remain a part of the military team.

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[60]Arnold S. Tannenbaum, "Social Psychology of the Work Organization" (Belmont, California: Wadsworth Publishing Company, Inc., 1966), p. 41.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary and Conclusions

The purposes of this study were to determine whether or not a medical examination of the form and scope prescribed by various regulations is performed on every individual processed for induction or enlistment into the armed forces, and to evaluate the professional satisfaction of the Medical Officers assigned to the Armed Forces Examining and Entrance Stations. The study was based on an evaluation of 90 questionnaires returned by the 139 Medical Officers assigned to the 74 AFEES. This represented responses from 64.7 per cent of the population.

Based on the analysis of the data derived from the returned questionnaires, the following conclusions are made:

1. An examination of the form and scope required by the various regulations is not performed on every individual processed for induction or enlistment into the armed forces.

2. An examination of the Existed Prior to Service (EPTS) discharge rate indicates that an adequate screening medical examination for entrance into the armed forces is performed at the AFEES.

3. The Medical Officers assigned to the AFEES are of the opinion that the time required to perform a medical examination of the form and scope required by regulations exceeds the time they and their medical corpsmen and medical technicians are able to devote to each examinee.

4. The Medical Officers assigned to the AFEES have determined for themselves what items of the required examination should be eliminated from the examination and have then eliminated these items from the examination as they perform it.

5. The Medical Officers assigned to the AFEES believe that the medical examination performed for induction and enlistment should be referred to as a "screening examination," and additionally, they believe the medical examination they perform is essentially a "screening examination."

6. There is not a direct relationship between the portions of the medical examination omitted by the Medical Officers and the distribution of the disqualifying defects resulting in EPTS discharges of inductees and enlistees.

7. The Medical Officers assigned to the AFEES are not professionally satisfied with their assignment.

Of the original hypotheses presented in Chapter I, only number 5, the relationship between portions of the medical examination omitted by the Medical Officers and the distribution of disqualifying defects resulting in EPTS discharges, is disproved by this study.

Recommendations

In order to assist in the alleviation of the problems revealed by this study, it is recommended that:

1. The regulations governing the medical examination for inductees and enlistees be changed to reflect the fact that it is essentially a "screening examination."

2. An additional study be made to evaluate the feasibility of utilizing physicians' assistants (Warrant Officer rank) as an augmentation of the AFEES medical staff.

3. An additional study of the fee-basis physicians employed at the AFEES be made to evaluate their performance of the medical examination for induction and enlistment.

4. Medical Officers be assigned to the AFEES only after they have spent at least one year on active duty. In this way, they will have a better understanding of the physical fitness requirements for inductees and enlistees.

5. The assignment of Medical Officers to the AFEES be limited to one year.

6. The Medical Officers assigned to the AFEES be allowed to engage in the practice of clinical medicine so long as it does not interfere with the performance of their duties.

APPENDICES

APPENDIX A

THE QUESTIONNAIRE

Medical Examination Questionnaire

(This questionnaire should take you about 15 to 20 minutes to complete.)

1. What is the rated capacity of your Medical Examining Section? _____per day

2. What was your average daily examinee load during calendar year 1970? _____per day

3. What was the largest number of examinees you had on any one day during calendar year 1970? _____

4. As a "gut" reaction, without taking the time to figure it out, how much time are you able to spend with each examinee? _____minutes

5. Again, as a "gut" reaction, how much time does a corpsman or medical technician spend with each examinee? _____minutes

6. What percentage of your examinees require a consultation by a specialist? _____%

7. It has been hypothesized that if you had fewer individuals to examine a smaller percentage would require a consultation. Do you agree? ____YES ____NO

8. It has been hypothesized that if there were more physicians assigned to your station (with no change in the number of examinees) a smaller percentage of the examinees would require a consultation. Do you agree? ____YES ____NO

9. What is the current medical rejection rate at your station? _____%

10. If you had fewer individuals to examine, do you think the medical rejection rate would:
_____stay the same
_____increase
_____decrease

11. If you had more physicians assigned to your station (with no change in the number of examinees) do you think the medical rejection rate would:
_____stay the same
_____increase
_____decrease

12. How many Congressional/Special Interest Inquiries do you handle weekly? _____

Medical Examination Questionnaire

13. What percentage of Congressional/Special Interest Inquiries are justified (i.e., you find the examinee disqualified)? _____%

14. If there were fewer individuals to examine, do you think there would be a lower percentage of examinees instituting Congressional/Special Interest inquiries? ____YES ____NO

15. Are the facilities in your Medical Examining Section:

_____Excellent
_____Good
_____Fair
_____Inadequate

16. If you answered Fair or Inadequate in question 15, please describe what is wrong with the physical set up of your Medical Examining Section.

_____

_____

_____

_____

_____

_____

_____

_____

17. Is your Medical Examining Section physically large enough to handle the largest examinee load you had on any one day during calendar year 1970? ____YES ____NO

Is it large enough to handle your average daily load? ____YES ____NO

18. In your opinion, is an examination of the extent prescribed by regulations necessary for the entrance of inductees and first time enlistees into the armed forces? (Chapters 2, 10, and 11 and appendix IX, AR 40-501; Section II, Chapter 4, AR 601-270; USAREC PAM 40-1; and AFEES Medical Notes prescribe the form and scope of medical examination to be given to inductees and first time enlistees entering the armed forces.) ____YES ____NO

Medical Examination Questionnaire

19. If your answer to question 18 is NO, what portions of the medical examination do you feel should be eliminated (the assumption is made that any item considered for elimination would be examined if the individual's medical history indicated a problem in that particular area)? (Item numbers refer to SF 88, Report of Medical Examination; instructions are from Section VI, USAREC PAM 40-1 and Appendix IX, AR 40-501.)

(Check for elimination)

19-1 Item 18, Head, Face, Neck, and Scalp. Note any abnormality, disfigurement or condition precluding wearing of military headgear..... _____

19-2 Item 19, Nose. Note septal deviation or perforation, obstruction to breathing..... _____

19-3 Item 20, Sinuses. Palpate for tenderness..... _____

19-4 Item 21, Mouth and Throat. Observe for hypertrophied tonsils; disease of gingiva; condition of teeth; malocclusion. If tonsils are enucleated, this is considered abnormal, thus check this item abnormal..... _____

19-5 Item 22, Ears--General..... _____

19-6 Item 23, Drums. Remove inspissated cerumen, if need be, to visualize drums..... _____

19-7 Item 24, Eyes--General..... _____

19-8 Item 25, Ophthalmoscopy..... _____

19-9 Item 26, Pupils..... _____

19-10 Item 27, Ocular Motility..... _____

19-11 Item 28, Lungs and Chest. Pectus excavatum and its physiological significance must be kept in mind. Auscultation should include apices and bases. Both front and back should be auscultated..... _____

19-12 Item 29, Heart..... _____

19-13 Item 30, Vascular System. Note varicosities, edema, swelling, ulcers, abdominal varicies, etc..... _____

Medical Examination Questionnaire

19. (continued)

(check for elimination)

19-14 Item 31, Abdomen and Viscera. At least both upper quadrants should be palpated with the abdominal wall in a relaxed position. The need for this examination can be dictated by history..... _____

19-15 Item 32, Anus and Rectum..... _____

19-16 Item 33, Endocrine System. Observe habitus, abnormalities of secondary sex characteristics, and fat distribution. Note signs of hypo- or hyper-thyroidism..... _____

19-17 Item 34, G.U. System. Cryptorchidism is disqualifying. The prepuce must be retracted to allow examination of the glans and meatus for evidence of ulceration or urethral irritation..... _____

19-18 Item 35, Upper Extremities..... _____

19-19 Item 36, Feet..... _____

19-20 Item 37, Lower Extremities..... _____

19-21 Item 38, Spine, Other Musculoskeletal..... _____

19-22 Item 39, Identifying Body Marks, Scars, Tattoos. The physician must personally check on the adequacy of descriptions, location, diagnosis and comment on significance of scars when appropriate..... _____

19-23 Item 40, Skin Lymphatics. Describe all eruptions and abnormalities..... _____

19-24 Item 41, Neurologic..... _____

19-25 Item 42, Psychiatric..... _____

19-26 Item 44, Dental Examination..... _____

19-27 Item 45, Urinalysis..... _____

19-28 Item 46, Chest X-Ray..... _____

19-29 Item 47, Serology..... _____

Medical Examination Questionnaire

20. What portions of the prescribed medical examination do you actually perform at your Medical Examining Section?

(check if performed)

20-1 Head, Face, Neck and Scalp..... ____

20-2 Nose..... ____

a. Do you perform rhinoscopy? ___YES ___NO

20-3 Sinuses..... ____

a. Do you palpate for tenderness? ___YES ___NO

20-4 Mouth and Throat..... ____

a. Do you routinely look into the mouth? ___YES ___NO

b. Do you routinely note the absence of tonsils? ___YES ___NO

20-5 Ears..... ____

a. Do you routinely look into the auditory canals? ___YES ___NO

20-6 Drums..... ____

a. Do you routinely remove inspissated cerumen? ___YES ___NO

20-7 Ophthalmoscopy..... ____

20-8 Pupils..... ____

20-9 Ocular Motility..... ____

20-10 Lungs and Chest..... ____

a. Do you routinely auscultate apices and bases, front and back (a total of eight locations)? ___YES ___NO

20-11 Heart..... ____

a. Do you routinely auscultate at least four locations? ___YES ___NO

Medical Examination Questionnaire

20. (continued) (check if performed)

20-12 Vascular System..... ____

a. Do you routinely note the presence of varicosities, even if minimal? ____YES ____NO

20-13 Abdomen and Viscera..... ____

a. As a "gut" reaction, how frequently do you palpate the abdomen?

____per 100 examinees

OR

____times per week

b. Do you routinely check for hernia? ____YES ____NO

c. Do you check for hernias with one hand or with both hands (i.e., one side at a time or both sides simultaneously)?

____One hand

____Both hands

20-14 Anus and Rectum..... ____

20-15 Endocrine System..... ____

20-16 G.U. System..... ____

a. Do you routinely retract the prepuce (or have the examinee retract it) to allow examination of the glans and meatus? ____YES ____NO

20-17 Upper Extremities..... ____

20-18 Feet..... ____

20-19 Lower Extremities..... ____

20-20 Spine, Other Musculoskeletal..... ____

a. When performing the orthopedic exercises, how many individuals do you normally observe at one time?

____6 or less
____6 to 8
____8 to 10
____10 to 12
____More than 12

Medical Examination Questionnaire

20. (continued) (check if performed)

20-21 Identifying Body Marks, Scars, Tattoos..... _____

a. Do you (or your corpsmen or technicians) routinely note and describe the presence of identifying body marks, scars or tattoos? ____YES ____NO

b. Do you personally check on the adequacy of descriptions when they have been noted by corpsmen or technicians? ____YES ____NO

20-22 Skin, Lymphatics..... _____

20-23 Neurologic..... _____

20-24 Psychiatric..... _____

20-25 Dental Examination..... _____

20-26 Urinalysis..... _____

20-27 Chest X-Ray..... _____

20-28 Serology..... _____

20-29 Do you ever complete item 76 (Physical Profile and Physical Category), item 77, (Qualification) or item 82 (Signature) before you have the results of the urinalysis, chest x-ray, or serology? ____YES ____NO

21. If you were responsible for setting up the medical examination for inductees and enlistees, what items would you include in the examination? (check for inclusion)

21-1 Head, Face, Neck, and Scalp..... _____

21-2 Nose..... _____

21-3 Sinuses..... _____

21-4 Mouth and Throat..... _____

21-5 Ears--General..... _____

21-6 Drums..... _____

21-7 Eyes--General..... _____

Medical Examination Questionnaire

21. (continued)

(check for inclusion)

21-8	Ophthalmoscopy	_____
21-9	Pupils	_____
21-10	Ocular Motility	_____
21-11	Lungs and Chest	_____
21-12	Heart	_____
21-13	Vascular System	_____
21-14	Abdomen and Viscera	_____
21-15	Anus and Rectum	_____
21-16	Endocrine System	_____
21-17	G.U. System	_____
21-18	Upper Extremities	_____
21-19	Feet	_____
21-20	Lower Extremities	_____
21-21	Spine, Other Musculoskeletal	_____
21-22	Identifying Body Marks, Scards, Tattoos	_____
21-23	Skin, Lymphatics	_____
21-24	Neurologic	_____
21-25	Psychiatric	_____
21-26	Dental Examination	_____
21-27	Urinalysis	_____
21-28	Chest X-Ray	_____
21-29	Serology	_____
21-30	Other Items:_____	

_____

_____

Medical Examination Questionnaire

21. (continued)

21-31 Are there any items in the medical examination you would particularly emphasize? ____YES ____NO If so, what ones?_____

_____ _____ _____

_____

22. Paragraph 4-17a, AR 601-270, indicates that the daily ratio of examinees to medical officers should be 30 to 1. Do you feel that this requirement of 30 examinations per physician per day is realistic? ____YES ____NO

23. If your answer to question 22 was NO, in your opinion what would be a realistic requirement of examinations per physician per day?

_____examinations per physician per day

24. In your opinion, do the examinees at your Medical Examining Section receive an extensive medical examination as prescribed in chapters 2, 10, and 11, and appendix IX, AR 40-501; Section II, Chapter 4, AR 601-270; USAREC PAM 40-1; and AFEES Medical Notes? ____YES ____NO

25. If your answer to question 24 was NO, in your opinion do the examinees at your Medical Examining Section nevertheless receive an adequate general medical examination? ____YES ____NO

If your answer was NO, do they receive a good "screening" medical examination? ____YES ____NO

26. In your opinion, should the medical examination for induction/enlistment be referred to as a "screening examination" and formally recognized as such with an appropriate change in the regulations to require a much less extensive medical examination? ____YES ____NO

27. Assuming you were examining a private patient, how long would it take you to perform an extensive medical examination of the form and scope prescribed in AR 40-501, AR 601-270, and USAREC PAM 40-1?

____15 min. ____30 min. ____45 min. ____60 min.

____1 1/2 hrs.____ 2 hrs. ____other (how long?_____min.)

Medical Examination Questionnaire

28. Assuming you were examining a private patient, how long would it take you to perform an adequate screening examination to evaluate an individual's medical qualification for military service?

____15 min. ____30 min. ____45 min. ____60 min.

____other (how long? _____min.)

29. In order to increase the efficiency of the Medical Examining Sections at the Armed Forces Examining and Entrance Stations, which of the following do you recommend be accomplished?

Increase the number of physicians assigned to the AFEES so that a more extensive medical examination can be performed (i.e., lower the examinee/physician ratio)..... _____

OR

Change the regulations so that they require a "screening" examination which would be much less extensive in form and scope..... _____

OR

Other..... _____

What do you suggest?_____

_____

_____

_____

_____

_____

30. Are you satisfied with your assignment as a physician at an AFEES? ____YES ____NO

a. If NO, why not? (Professional, not political reasons, please)_____

_____

_____

_____

Medical Examination Questionnaire

31. What are your recommendations to improve the tour of duty at an AFEES? (For example, time to attend professional conferences at local hospitals during duty hours.)_____

_____

_____

_____

_____

_____

32. Would you like to receive a copy of the statistical results of this questionnaire? ___YES ____NO

33. If you have any comments regarding the medical examination for inductees/enlistees, please write them below.

THANK YOU VERY MUCH FOR YOUR TIME

APPENDIX B

THE COVER LETTER

72 Third Infantry Road
Fort Leavenworth, Kansas 66027
24 February 1971

Dear Doctor,

As part of my course at the United States Army Command and General Staff College I am writing a thesis on the medical examination performed at the Armed Forces Examining and Entrance Stations. Having served at the Los Angeles AFEES for 18 months prior to my arrival at Fort Leavenworth I am familiar with the many problems you have. It is my hope that by bringing some of these problems to light they may be rectified.

I would appreciate it if you would take 15 to 20 minutes of your time to complete the inclosed questionnaire. Please note that the questionnaire does not have to be signed. In addition, as a colleague I can assure you that I will not divulge your identity. Any information you include on the questionnaire will appear only in tabular form. This study is not sponsored by The Office of the Surgeon General, the United States Army Recruiting Command, or any other official agency. The results, however, will be available to them when the study is finished.

When I have completed the compilation of the results I will send you a copy of them. A self-addressed, stamped envelope is inclosed for your convenience in returning the questionnaire. In order to allow adequate time for processing them, I would appreciate receiving your completed questionnaires here at Fort Leavenworth by 17 March 1971.

Thank you very much for your consideration.

Sincerely yours,

/s/David L. Siegal

DAVID L. SIEGAL, M.D.
LTC, MC

Incl: Medical Examination
Questionnaire

APPENDIX C

THE FOLLOW UP LETTER

72 Third Infantry Road
Fort Leavenworth, Kansas 66027
18 March 1971

Dear Colleague,

I NEED YOUR HELP!

I refer, of course, to my recent request to you asking for your assistance in the completion of a questionnaire relating to the operation of your Medical Examining Section. This questionnaire will assist me in writing a thesis as part of my course at the United States Army Command and General Staff College.

As I noted in my first letter, this questionnaire does not have to be signed. In addition, as I mentioned, I can assure you that I will not divulge your identity. The information you include will appear only in tabular form. Let me also restate that this study is not sponsored or supported by the Office of the Surgeon General, the United States Army Recruiting Command, or any other official agency. However, I feel this is an important subject and the results of my research will be available to the above agencies when the study is finished. An initial review of the questionnaires already received indicates that there is a considerable amount of agreement among the AFEES medical officers across the country.

If you have already completed the questionnaire, my sincere thanks for your help. If you have not done so, won't you please do so today! The results of the study may be of benefit to you or your successor.

Sincerely yours,

/s/David L. Siegal

DAVID L. SIEGAL, M.D.
LTC, MC

APPENDIX D

STANDARD FORM 88: REPORT OF MEDICAL EXAMINATION

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.800-3

REPORT OF MEDICAL EXAMINATION

88-117

1. LAST NAME—FIRST NAME—MIDDLE NAME			2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
4. HOME ADDRESS (*Number, street or RFD, city or town, State and ZIP Code*)			5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY / CIVILIAN	10. AGENCY	11. ORGANIZATION UNIT
12. DATE OF BIRTH	13. PLACE OF BIRTH		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS			16. OTHER INFORMATION	
17. RATING OR SPECIALTY			TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column, enter "NE" if not evaluated.*)	ABNORMAL
	18. HEAD, FACE, NECK AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Ext. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 58, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

(Continue in item 73)

44. DENTAL (*Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.*)

Restorable teeth (examples: 0 / 1 2 3 / 32 31 30 / 0) — *Non-restorable teeth* (examples: / 1 2 3 / 32 31 30 / /) — *Missing teeth* (examples: x / 1 2 3 / 32 31 30 / x) — *Replaced by dentures* (examples: x x x / 1 2 3 / 32 31 30 / x x x) — *Fixed Partial dentures* (examples: (x) / 1 2 3 / 32 31 30 / (x))

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY			46. CHEST X-RAY (*Place, date, film number and result*)
B. ALBUMIN	D. MICROSCOPIC		
C. SUGAR			
47. SEROLOGY (*Specify test used and result*)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	56. TEMPERATURE

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
A. SITTING	SYS / DIAS	B. RECUMBENT	SYS / DIAS	C. STANDING (3 min.)	SYS / DIAS	A. SITTING	B. AFTER EXERCISE	C. 2 MIN AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R. H. L. H. PRISM DIV. PRISM CONV. PC PD
CT

ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT			CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV	/15 SV	/15		250 *256*	500 *512*	1000 *1024*	2000 *2048*	3000 *3696*	4000 *4096*	6000 *6144*	8000 *8192*	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

77. EXAMINEE (*Check*)

A. ☐ IS QUALIFIED FOR
B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE	
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)	SIGNATURE	
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE	NUMBER OF ATTACHED SHEETS

* U.S. GOVERNMENT PRINTING OFFICE : 1960 O—330-940

APPENDIX E

ARMED FORCES EXAMINING AND ENTRANCE STATION CAPACITIES

APPENDIX E

ARMED FORCES EXAMINING AND ENTRANCE STATION CAPACITIES[61]

STATION	CAPACITY
FIRST RECRUITING DISTRICT	
Albany, New York	75
Baltimore, Maryland	175
Bandor, Maine	25
Boston, Massachusetts	150
Buffalo, New York	125
Fairmont, West Virginia	25
Ft. Hamilton, New York	300
Harrisburg, Pennsylvania	75
Manchester, New Hampshire	40
Newark, New Jersey	300
New Haven, Connecticut	125
New York, New York	150
Philadelphia, Pennsylvania	175
Pittsburgh, Pennsylvania	175
Portland, Maine	25
Providence, Rhode Island	40
Springfield, Massachusetts	50

[61]Based on information supplied by the Directorate of AFEES Operations, Headquarters, USAREC, 30 April 1971.

Syracuse, New York	100
Wilkes-Barre, Pennsylvania	50
THIRD RECRUITING DISTRICT	
Ashland, Kentucky	50
Atlanta, Georgia	175
Beckley, West Virginia	40
Charlotte, North Carolina	125
Coral Gables, Florida	100
Ft. Jackson, South Carolina	150
Jacksonville, Florida	150
Knoxville, Tennessee	75
Louisville, Kentucky	125
Montgomery, Alabama	175
Nashville, Tennessee	75
Raleigh, North Carolina	125
Richmond, Virginia	125
Roanoke, Virginia	75
San Juan, Puerto Rico	150
FOURTH RECRUITING DISTRICT	
Abilene, Texas	25
Albuquerque, New Mexico	40
Amarillo, Texas	40
Dallas, Texas	150
Denver, Colorado	100
El Paso, Texas	40
Houston, Texas	125

Jackson, Mississippi	75
Kansas City, Missouri	150
Little Rock, Arkansas	75
Memphis, Tennessee	100
New Orleans, Louisiana	125
Oklahoma City, Oklahoma	100
San Antonio, Texas	125
Shreveport, Louisiana	75

FIFTH RECRUITING DISTRICT

Chicago, Illinois	400
Cincinnati, Ohio	125
Cleveland, Ohio	225
Columbus, Ohio	125
Des Moines, Iowa	100
Detroit, Michigan	400
Fargo, North Dakota	40
Indianapolis, Indiana	125
Milwaukee, Wisconsin	175
Minneapolis, Minnesota	175
Omaha, Nebraska	75
Sioux Falls, South Dakota	40
St. Louis, Missouri	175

SIXTH RECRUITING DISTRICT

Anchorage, Alaska	25
Boise, Idaho	25
Butte, Montana	40

Fresno, California	50
Honolulu, Hawaii	40
Los Angeles, California	500
Oakland, California	300
Phoenix, Arizona	75
Portland, Oregon	100
Salt Lake City, Utah	50
Seattle, Washington	100
Spokane, Washington	40

APPENDIX F

SUMMARY OF DATA OBTAINED FROM QUESTIONNAIRE

1. What is the rated capacity of your Medical Examining Section?

Station size	DISTRIBUTION OF RESPONSES
50 or less	22
51 - 124	23
125 - 199	27
200 - 500	17
Size not stated	1
TOTAL	90

2. What was your average daily examinee load during calendar year 1970?

DISTRIBUTION OF RESPONSES

Station size	Less than Rated Capacity	Rated Capacity ± 10	Greater than Rated Capacity	No Answer
50 or less	6	14	1	1
51 - 124	12	7	4	0
125 - 199	12	7	5	3
200 - 500	12	4	0	1
Size unknown				1
TOTALS	42 (46.7%)	32 (35.6%)	10 (11.1%)	6 (6.7%)

3. What was the largest number of examinees you had on any one day during calendar year 1970?

DISTRIBUTION OF RESPONSES

Station size	Less than Rated Capacity	Rated Capacity ± 10	Greater than Rated Capacity	No Answer
50 or less	0	1	20	1
51 - 124	0	0	23	0
125 - 199	0	0	26	1
200 - 500	0	0	17	0
Size unknown				1
TOTALS	0	1 (1.1%)	86 (95.6%)	3 (3.3%)

4. As a "gut" reaction, without taking the time to figure it out, how much time are you able to spend with each examinee?

Station Size	Number of Answers	Average
50 or less	21	6.0 min
51 - 124	22	6.5 min
125 - 199	27	5.3 min
200 - 500	17	6.6 min
Size unknown	1	10 min
TOTALS	88	6.1 min

5. Again, as a "gut" reaction, how much time does a corpsman or medical technician spend with each examinee?

Station Size	Number of Answers	Average
50 or less	21	14.7 min
51 - 124	22	10.0 min
125 - 199	26	9.8 min
200 - 500	17	7.0 min
Size unknown	1	4 min
TOTALS	87	10.4 min

6. What percentage of your examinees require a consultation by a specialist?

Station Size	Number of Answers	Average
50 or less	21	10.7%
51 - 124	23	15.1%
125 - 199	26	13.9%
200 - 500	17	30.3%
Size unknown	1	5 %
TOTALS	88	16.5%

7. It has been hypothesized that if you had fewer individuals to examine a smaller percentage would require a consultation. Do you agree?

Station size	YES	NO	NO ANSWER
50 or less	7	15	0
51 - 124	10	13	0
125 - 199	16	11	0
200 - 500	7	10	0
Size unknown	0	1	0
TOTALS	40 (44.4%)	50 (55.6%)	0

8. It has been hypothesized that if there were more physicians assigned to your station (with no change in the number of examinees) a smaller percentage of the examinees would require a consultation. Do you agree?

Station size	YES	NO	NO ANSWER
50 or less	11	10	1
51 - 124	13	10	0
125 - 199	20	7	0
200 - 500	7	10	0
Size unknown	1	0	0
TOTALS	52 (57.8%)	37 (41.1%)	1 (1.1%)

9. What is the current medical rejection rate at your station?

Station Size	NUMBER OF ANSWERS	AVERAGE
50 or less	21	41.2%
51 - 124	20	38.3%
125 - 199	25	36.5%
200 - 500	14	44.0%
Size unknown	1	30 %
TOTALS	81	39.4%

10. If you had fewer individuals to examine do you think the medical rejection rate would stay the same, increase, or decrease?

Station size	STAY THE SAME	INCREASE	DECREASE	NO ANSWER
50 or less	18	3	1	0
51 - 124	16	2	5	0
125 - 199	14	6	7	0
200 - 500	13	1	3	0
Size unknown	1	0	0	0
TOTALS	62 (68.9%)	12 (13.3%)	16 (17.8%)	0

11. If you had more physicians assigned to your station (with no change in the number of examinees) do you think the medical rejection rate would stay the same, increase, or decrease?

Station size	STAY THE SAME	INCREASE	DECREASE	NO ANSWER
50 or less	17	2	3	0
51 - 124	16	2	5	0
125 - 199	13	6	8	0
200 - 500	12	3	2	0
Size unknown	0	0	1	0
TOTALS	58 (64.4%)	13 (14.4%)	19 (21.1%)	0

12. How many Congressional/Special Interest Inquiries do you handle weekly?

A total of 68 (75.6%) individuals indicated that they handle five or fewer Congressional/Special Interest Inquiries weekly. See next page for distribution of responses.

12. How many Congressional/Special Interest Inquiries do you handle weekly?

DISTRIBUTION OF RESPONSES

Station size	0	Less Than 1	1-5	6-10	11-15	16-20	21-25	26-30	31-35	--	46-50	No Answer
50 or less	3	16	3	0	0	0	0	0	0		0	0
51 - 124	0	6	14	2	0	0	0	0	0		0	1
125 - 199	1	4	16	5	0	0	0	0	0		0	1
200 - 500	0	0	4	2	3	1	1	1	1		4	0
Size unknown	1											
TOTALS	5	26	37	9	3	1	1	1	1		4	2

13. What percentage of Congressional/Special Interest Inquiries are justified (i.e., you find the examinee disqualified)?

Station size	NUMBER OF ANSWERS	AVERAGE
50 or less	21	35.7%
51 - 124	20	27.4%
125 - 199	26	24.6%
200 - 500	16	37.1%
Size unknown	0	
TOTALS	83	30.5%

13. What percentage of Congressional/Special Interest Inquiries are justified (i.e., you find the examinee disqualified)?

DISTRIBUTION OF RESPONSES

Station size	0%	1-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
50 or less	6	2	3	0	1	3	2	0	1	0	3
51 - 124	1	5	2	5	1	5	0	0	1	0	0
125 - 199	1	9	5	3	3	2	2	0	1	0	0
200 - 500	0	5	0	0	4	4	1	1	1	0	0
Size unknown	(No response)										
TOTALS	8	21	10	8	9	14	5	1	4	0	3

14. If there were fewer individuals to examine, do you think there would be a lower percentage of examinees instituting Congressional/ Special Interest inquiries?

Station size	YES	NO	NO ANSWER
50 or less	9	13	0
51 - 124	11	12	0
125 - 199	16	11	0
200 - 500	8	8	1
Size unknown	0	1	0
TOTALS	44 (48.9%)	45 (50.0%)	1 (1.1%)

15. Are the facilities in your Medical Examining Section excellent, good, fair, or inadequate?

Station size	EXCELLENT	GOOD	FAIR	INADEQUATE	NO ANSWER
50 or less	11	8	3	0	0
51 - 124	4	15	4	0	0
125 - 199	5	9	9	4	0
200 - 500	4	5	6	2	0
Size unknown	0	1	0	0	0
TOTALS	24 (26.7%)	38 (42.2%)	22 (24.4%)	6 (6.7%)	0

16. If you answered Fair or Inadequate in question 15, please describe what is wrong with the physical set up of your Medical Examining Section.

A total of 73 individual criticisms were noted by the 28 respondents who stated that the facilities of their Medical Examining Sections were Fair or Inadequate. A summary of the criticisms is listed below.

CRITICISM	FREQUENCY
Heating/ventilation deficiencies	10
Poor traffic or flow pattern	10
Inadequate size (space)	7
Poor environment (section requires painting, no area for eating lunch, general dreariness)	6
Age of building	5
Deficiency in X-ray equipment	5
Inadequate female examination facilities	5
Overall equipment deficiencies	5
Deficiency in audiometric equipment	4
Lack of privacy for examinations	3
High noise level	3
Inadequate personnel	2
Poor janitorial service	2
Poor lighting	2
Inadequate interview space	1
Insufficient waiting area for examinees	1
Location of AFEES	1
Poor laboratory facilities	1

17. Is your Medical Examining Section physically large enough to handle the largest examinee load you had on any one day during calendar year 1970?

Station size	YES	NO	NO ANSWER
50 or less	13	9	0
51 - 124	14	8	1
125 - 199	9	18	0
200 - 500	3	14	0
Size unknown	1	0	0
TOTALS	40 (44.4%)	49 (54.4%)	1 (1.1%)

17a. Is it large enough to handle your average daily load?

Station size	YES	NO	NO ANSWER
50 or less	21	1	0
51 - 124	23	0	0
125 - 199	22	5	0
200 - 500	14	3	0
Size unknown	1	0	0
TOTALS	81 (90.0%)	9 (10.0%)	0

18. In your opinion, is an examination of the extent prescribed by regulations necessary for the entrance of inductees and first time enlistees into the armed forces?

Station size	YES	NO	NO ANSWER
50 or less	6	16	0
51 - 124	6	17	0
125 - 199	12	15	0
200 - 500	5	11	1
Size unknown	0	1	0
TOTALS	29 (32.2%)	60 (66.7%)	1 (1.1%)

19. If your answer to question 18 is NO, what portions of the medical examination do you feel should be eliminated (the assumption is made that any item considered for elimination would be examined if the individual's medical history indicated a problem in that particular area)? (Item numbers refer to SF 88, Report of Medical Examination; instructions are from Section VI, USAREC PAM 40-1 and Appendix IX, AR 40-501.)

19-1. Item 18, Head, Face, Neck, and Scalp. Note any abnormality, disfigurement or condition precluding wearing of military headgear.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	3
51 - 124	4
125 - 199	1
200 - 500	1
Size unknown	0
TOTAL	9 (10.0%)

19-2. Item 19, Nose. Note septal deviation or perforation, obstruction to breathing.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	9
51 - 124	11
125 - 199	9
200 - 500	5
Size unknown	0
TOTAL	34 (37.8%)

19. (Continued)

19-3. Item 20, Sinuses. Palpate for tenderness.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	14
51 - 124	15
125 - 199	14
200 - 500	10
Size unknown	0
TOTAL	53 (58.9%)

19-4. Item 21, Mouth and Throat. Observe for hypertrophied tonsils; disease of gingiva; condition of teeth; malocclusion. If tonsils are enucleated, this is considered abnormal, thus check this item abnormal.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	8
51 - 124	12
125 - 199	10
200 - 500	9
Size unknown	0
TOTAL	39 (43.3%)

19-5. Item 22, Ears--General.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	3
51 - 124	3
125 - 199	1
200 - 500	0
Size unknown	0
TOTAL	7 (7.8%)

19. (Continued)

19-6. Item 23, Drums. Remove inspissated cerumen, if need be to visualize drums.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	3
51 - 124	2
125 - 199	3
200 - 500	4
Size unknown	0
TOTAL	12 (13.3%)

19-7. Item 24, Eyes--General.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	1
51 - 124	0
125 - 199	1
200 - 500	0
Size unknown	0
TOTAL	2 (2.2%)

19-8. Item 25, Ophthalmoscopy.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	9
51 - 124	9
125 - 199	3
200 - 500	1
Size unknown	1
TOTAL	23 (25.6%)

19. (Continued)

19-9. Item 26, Pupils.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	1
51 - 124	2
125 - 199	1
200 - 500	1
Size unknown	0
TOTAL	5 (5.6%)

19-10. Item 27, Ocular Motility

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	2
51 - 124	3
125 - 199	5
200 - 500	0
Size unknown	0
TOTAL	10 (11.1%)

19-11. Item 28, Lungs and Chest. Pectus excavatum and its physiological significance must be kept in mind. Auscultation should include apices and bases. Both front and back should be auscultated.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	4
51 - 124	12
125 - 199	7
200 - 500	4
Size unknown	0
TOTAL	27 (30.0%)

19. (Continued)

19-12. Item 29, Heart.

Station size	NUMBER RECOMMENDING ELIMINATION
125 - 199	1
All others	0
TOTAL	1 (1.1%)

19-13. Item 30, Vascular System. Note varicosities, edema, swelling, ulcers, abdominal varicies, etc.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	2
All others	0
TOTAL	2 (2.2%)

19-14. Item 31, Abdomen and Viscera. At least both upper quadrants should be palpated with the abdominal wall in a relaxed position. The need for this examination can be dictated by history.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	6
51 - 124	10
125 - 199	9
200 - 500	3
Size unknown	1
TOTAL	29 (32.2%)

19. (Continued)

19-15. Item 32, Anus and Rectum.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	0
51 - 124	2
125 - 199	3
200 - 500	1
Size unknown	1
TOTAL	7 (7.8%)

19-16. Item 33, Endocrine System. Observe habitus, abnormalities of secondary sex characteristics, and fat distribution. Note signs of hypo- or hyper-thyroidism.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	2
51 - 124	4
125 - 199	2
200 - 500	0
Size unknown	0
TOTAL	8 (8.9%)

19-17. Item 34, G.U. System. Cryptorchidism is disqualifying. The prepuce must be retracted to allow examination of the glans and meatus for evidence of ulceration or urethral irration.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	5
51 - 124	5
125 - 199	6
200 - 500	1
Size unknown	0
TOTAL	17 (18.9%)

19. (Continued)

19-18. Item 35, Upper Extremities.

Station size	NUMBER RECOMMENDING ELIMINATION
125 - 199	1
All others	0
TOTAL	1 (1.1%)

19-19. Item 36, Feet.

No medical officer recommended elimination of this item.

19-20. Item 37, Lower Extremities.

No medical officer recommended elimination of this item.

19-21. Item 38, Spine, Other Musculoskeletal.

Station size	NUMBER RECOMMENDING ELIMINATION
51 - 124	1
All others	0
TOTAL	1 (1.1%)

19-22. Item 39, Identifying Body Marks, Scars, Tattoos. The physician must personally check on the adequacy of descriptions, location, diagnosis and comment on significance of scars when appropriate.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	6
51 - 124	7
125 - 199	3
200 - 500	7
Size unknown	1
TOTAL	24 (26.7%)

AD-A067 457 ARMY COMMAND AND GENERAL STAFF COLL FORT LEAVENWORTH KANS F/G 6/5
AN EVALUATION OF THE PERFORMANCE OF THE MEDICAL EXAMINATION FOR--ETC(U)
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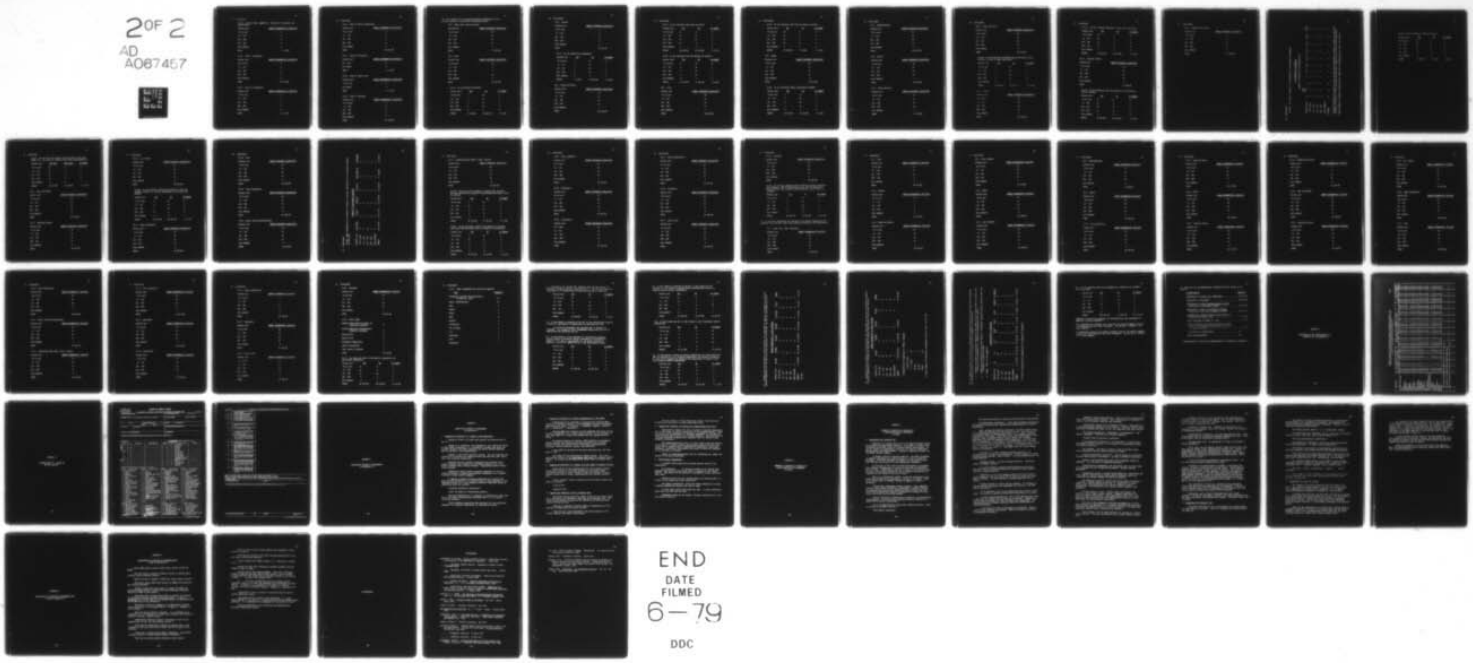

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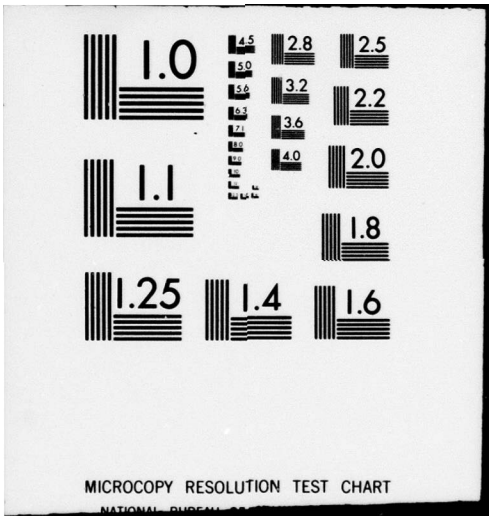
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MICROCOPY RESOLUTION TEST CHART

19. (Continued)

19-23. Item 40, Skin, Lymphatics. Describe all eruptions and abnormalities.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	1
51 - 124	0
125 - 199	4
200 - 500	2
Size unknown	0
TOTAL	7 (7.8%)

19-24. Item 41, Neurologic.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	4
51 - 124	6
125 - 199	6
200 - 500	0
Size unknown	0
TOTAL	16 (17.8%)

19-25. Item 42, Psychiatric.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	1
51 - 124	3
125 - 199	4
200 - 500	0
Size unknown	0
TOTAL	8 (8.9%)

19. (Continued)

19-26. Item 44, Dental Examination.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	5
51 - 124	9
125 - 199	9
200 - 500	4
Size unknown	1
TOTAL	28 (31.1%)

19-27. Item 45, Urinalysis.

Station size	NUMBER RECOMMENDING ELIMINATION
124 - 199	1
All others	0
TOTAL	1 (1.1%)

19-28. Item 46, Chest X-Ray

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	1
All others	0
TOTAL	1 (1.1%)

19-29. Item 47, Serology.

Station size	NUMBER RECOMMENDING ELIMINATION
50 or less	7
51 - 124	11
125 - 199	4
200 - 500	5
Size unknown	0
TOTAL	27 (30.0%)

20. What portions of the prescribed medical examination do you actually perform at your Medical Examining Section?

20-1. Head, Face, Neck and Scalp.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	17
125 - 199	22
200 - 500	17
Size unknown	1
TOTAL	77 (85.6%)

20-2. Nose.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	13
51 - 124	8
125 - 199	7
200 - 500	12
Size unknown	0
TOTAL	40 (44.4%)

20-2a. Do you perform rhinoscopy?

Station size	YES	NO	NO ANSWER
50 or less	1	20	1
51 - 124	1	21	1
125 - 199	2	24	1
200 - 500	7	10	0
Size unknown	0	1	0
TOTALS	11 (12.2%)	76 (84.4%)	3 (3.3%)

20. (Continued)

20-3. Sinuses.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	1
51 - 124	4
125 - 199	2
200 - 500	8
Size unknown	0
TOTAL	15 (16.7%)

20-3a. Do you palpate for tenderness?

Station size	YES	NO	NO ANSWER
50 or less	1	21	0
51 - 124	0	22	1
125 - 199	2	23	2
200 - 500	4	12	1
Size unknown	0	1	0
TOTALS	7 (7.8%)	79 (87.8%)	4 (4.4%)

20-4. Mouth and Throat.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	17
51 - 124	12
125 - 199	14
200 - 500	12
Size unknown	1
TOTAL	56 (62.2%)

20. (Continued)

20-4a. Do you routinely look into the mouth?

Station size	YES	NO	NO ANSWER
50 or less	17	5	0
51 - 124	12	10	1
125 - 199	15	11	1
200 - 500	11	5	1
Size unknown	1	0	0
TOTALS	56 (62.2%)	31 (34.4%)	3 (3.3%)

20-4b. Do you routinely note the absence of tonsils?

Station size	YES	NO	NO ANSWER
50 or less	4	18	0
51 - 124	3	19	1
125 - 199	2	23	2
200 - 500	4	12	1
Size unknown	0	1	0
TOTALS	13 (14.4%)	73 (81.1%)	4 (4.4%)

20-5. Ears.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	21
125 - 199	24
200 - 500	17
Size unknown	1
TOTAL	83 (92.3%)

20. (Continued)

20-5a. Do you routinely look into the auditory canals?

Station size	YES	NO	NO ANSWER
50 or less	20	2	0
51 - 124	20	2	1
125 - 199	24	3	0
200 - 500	16	0	1
Size unknown	1	0	0
TOTALS	81 (90.0%)	7 (7.8%)	2 (2.2%)

20-6. Drums.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	16
51 - 124	14
125 - 199	11
200 - 500	10
Size unknown	0
TOTAL	51 (56.7%)

20-6a. Do you routinely remove inspissated cerumen?

Station size	YES	NO	NO ANSWER
50 or less	7	15	0
51 - 124	4	18	1
125 - 199	6	20	1
200 - 500	2	13	2
Size unknown	0	1	0
TOTALS	19 (21.1%)	67 (74.4%)	4 (4.4%)

20. (Continued)

20-7. Ophthalmoscopy.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	13
51 - 124	16
125 - 199	20
200 - 500	17
Size unknown	0
TOTAL	66 (73.3%)

20-8. Pupils.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	22
125 - 199	26
200 - 500	16
Size unknown	1
TOTAL	85 (94.4%)

20-9. Ocular Motility.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	15
51 - 124	21
125 - 199	18
200 - 500	16
Size unknown	1
TOTAL	71 (78.9%)

20. (Continued)

20-10. Lungs and Chest.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	18
51 - 124	14
125 - 199	18
200 - 500	14
Size unknown	0
TOTAL	64 (71.1%)

20-10a. Do you routinely auscultate apices and bases, front and back (a total of eight locations)?

Station size	YES	NO	NO ANSWER
50 or less	3	19	0
51 - 124	2	20	1
125 - 199	5	20	2
200 - 500	6	11	0
Size unknown	0	1	0
TOTALS	16 (17.8%)	71 (78.9%)	3 (3.3%)

20 11. Heart.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	21
51 - 124	23
125 - 199	26
200 - 500	15
Size unknown	1
TOTAL	86 (95.6%)

20. (Continued)

20-11a. Do you routinely ausculate at least four locations?

Station size	YES	NO	NO ANSWER
50 or less	18	4	0
51 - 124	20	2	1
125 - 199	23	4	0
200 - 500	11	6	0
Size unknown	1	0	0
TOTALS	73 (81.1%)	16 (17.8%)	1 (1.1%)

20-12. Vascular System.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	16
51 - 124	19
125 - 199	24
200 - 500	16
Size unknown	1
TOTAL	76 (84.4%)

20-12a. Do you routinely note the presence of varicosities, even if minimal?

Station size	YES	NO	NO ANSWER
50 or less	11	11	0
51 - 124	16	6	1
125 - 199	19	8	0
200 - 500	13	4	0
Size unknown	1	0	0
TOTALS	60 (66.7%)	29 (32.2%)	1 (1.1%)

20. (Continued)

20-13. Abdomen and Viscera.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	8
51 - 124	3
125 - 199	10
200 - 500	6
Size unknown	0
TOTAL	27 (30.0%)

20. (Continued)

20-13a. As a "gut" reaction, how frequently do you palpate the abdomen?

DISTRIBUTION OF RESPONSES

(Number of times per 100 examinations)*

Station size	0	Less Than 1	1	2	3-5	6-10	11-40	41-50	51-75	76-100	No Answer
50 or less	6	0	11	3	1	0	0	1	0	0	0
51 - 124	6	7	2	2	1	1	0	0	1	0	3
125 - 199	8	5	7	2	2	1	0	0	0	0	2
200 - 500	5	3	2	0	3	0	0	0	0	2	2
Size unknown											1
**TOTALS	25	15	22	7	7	2	0	1	1	2	8

*Responses expressed as number of times per week were translated to number of times per 100 examinations on the basis of the expressed average daily examinee load of the stations concerned.

**Total number of responses indicating two times per 100 examinations or less = 69 (76.7%)

20-13b. Do you routinely check for hernia?

Station size	YES	NO	NO ANSWER
50 or less	20	1	1
51 - 124	23	0	0
125 - 199	27	0	0
200 - 500	17	0	0
Size unknown	0	0	1
TOTALS	87 (96.7%)	1 (1.1%)	2 (2.2%)

20. (Continued)

20-13c. Do you check for hernias with one hand or with both hands (i.e., one side at a time or both sides simultaneously)?

Station size	ONE HAND	BOTH HANDS	NO ANSWER
50 or less	15	5	1
51 - 124	18	5	0
125 - 199	22	4	1
200 - 500	14	3	0
Size unknown	0	0	1
TOTALS	70 (77.8%)	17 (18.9%)	3 (3.3%)

20-14. Anus and Rectum.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	22
51 - 124	22
125 - 199	27
200 - 500	15
Size unknown	0
TOTAL	86 (95.6%)

20-15. Endocrine System.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	14
51 - 124	16
125 - 199	14
200 - 500	14
Size unknown	0
TOTAL	58 (64.4%)

20. (Continued)

20-16. G.U. System.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	14
51 - 124	15
125 - 199	17
200 - 500	13
Size unknown	0
TOTAL	59 (65.6%)

20-16a. Do you routinely retract the prepuce (or have the examinee retract it) to allow examination of the glans and meatus?

Station size	YES	NO	NO ANSWER
50 or less	6	16	0
51 - 124	3	20	0
125 - 199	9	18	0
200 - 500	11	6	0
Size unknown	0	0	1
TOTALS	29 (32.2%)	60 (66.7%)	1 (1.1%)

20-17. Upper Extremities.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	18
51 - 124	23
125 - 199	27
200 - 500	16
Size unknown	0
TOTAL	84 (93.3%)

20. (Continued)

20-18. Feet.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	23
125 - 199	27
200 - 500	16
Size unknown	0
TOTAL	86 (95.5%)

20-19. Lower Extremities.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	23
125 - 199	27
200 - 500	16
Size unknown	0
TOTAL	86 (95.5%)

20-20. Spine, Other Musculoskeletal.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	21
125 - 199	22
200 - 500	13
Size unknown	0
TOTAL	76 (84.4%)

20. (Continued)

20-20a. When performing the orthopedic exercises, how many individuals do you normally observe at one time:

	NUMBER OF INDIVIDUALS OBSERVED					
Station size	6 or less	6 to 8	8 to 10	10 to 12	More than 12	No Answer
50 or less	8	2	1	5	5	1
51 - 124	7	4	6	4	2	0
125 - 199	11	1	6	2	6	1
200 - 500	7	3	0	3	4	0
Size unknown	0	0	0	0	0	1
TOTALS	33 (36.7%)	10 (11.1%)	13 (14.4%)	14 (15.6%)	17 (18.9%)	3 (3.3%)

20. (Continued)

20-21. Identifying Body Marks, Scars, Tattoos.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	23
125 - 199	25
200 - 500	15
Size unknown	0
TOTAL	83 (92.2%)

20-21a. Do you (or your corpsmen or technicians) routinely note and describe the presence of identifying body marks, scars or tattoos?

Station size	YES	NO	NO ANSWER
50 or less	6	14	1
51 - 124	15	8	1
125 - 199	9	17	0
200 - 500	8	8	0
Size unknown	0	0	1
TOTALS	38 (42.2%)	47 (52.2%)	3 (3.3%)

20-21b. Do you personally check on the adequacy of descriptions when they have been noted by corpsmen or technicians?

Station size	YES	NO	NO ANSWER
50 or less	6	14	2
51 - 124	15	8	0
125 - 199	9	17	1
200 - 500	8	8	1
Size unknown	0	0	1
TOTALS	38 (42.2%)	47 (52.2%)	5 (5.6%)

20. (Continued)

20-22. Skin, Lymphatics.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	18
51 - 124	22
125 - 199	25
200 - 500	16
Size unknown	0
TOTAL	81 (90.0%)

20-23. Neurologic.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	11
51 - 124	10
125 - 199	15
200 - 500	12
Size unknown	0
TOTAL	48 (53.3%)

20-24. Psychiatric.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	17
51 - 124	13
125 - 199	17
200 - 500	13
Size unknown	0
TOTAL	60 (66.7%)

20. (Continued)

20-25. Dental Examination.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	13
51 - 124	11
125 - 199	10
200 - 500	12
Size unknown	0
TOTAL	46 (51.1%)

20-26. Urinalysis.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	22
125 - 199	27
200 - 500	16
Size unknown	0
TOTAL	85 (94.4%)

20-27. Chest X-Ray.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	22
125 - 199	27
200 - 500	16
Size unknown	0
TOTAL	85 (94.4%)

20. (Continued)

20-28. Serology.

Station size	NUMBER PERFORMING EXAMINATION
50 or less	20
51 - 124	22
125 - 199	26
200 - 500	15
Size unknown	1
TOTAL	84 (93.3%)

20-29. Do you ever complete item 76 (Physical Profile and Physical Category), item 77 (Qualification) or item 82 (Signature) before you have the results of the urinalysis, chest x-ray, or serology?

Station size	YES	NO	NO ANSWER
50 or less	8	14	0
51 - 124	7	15	1
125 - 199	7	18	2
200 - 500	2	15	0
Size unknown	0	0	1
TOTALS	24 (26.7%)	62 (68.9%)	4 (4.4%)

21. If you were responsible for setting up the medical examination for inductees and enlistees, what items would you include in the examination?

21-1. Head, Face, Neck, and Scalp.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	19
51 - 124	17
125 - 199	22
200 - 500	16
Size unknown	1
TOTAL	75 (83.3%)

21. (Continued)

21-2. Nose.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	11
51 - 124	8
125 - 199	10
200 - 500	9
Size unknown	1
TOTAL	39 (43.3%)

21-3. Sinuses.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	0
51 - 124	1
125 - 199	7
200 - 500	3
Size unknown	0
TOTAL	11 (12.2%)

21-4. Mouth and Throat.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	15
51 - 124	10
125 - 199	14
200 - 500	10
Size unknown	1
TOTAL	50 (55.6%)

21. (Continued)

21-5. Ears--General.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	12
51 - 124	20
125 - 199	23
200 - 500	15
Size unknown	1
TOTAL	71 (78.9%)

21-6. Drums.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	19
51 - 124	21
125 - 199	23
200 - 500	17
Size unknown	0
TOTAL	80 (88.9%)

21-7. Eyes--General.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	19
51 - 124	23
125 - 199	25
200 - 500	17
Size unknown	1
TOTAL	85 (94.4%)

21. (Continued)

21-8. Ophthalmoscopy.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	9
51 - 124	13
125 - 199	17
200 - 500	14
Size unknown	0
TOTAL	53 (58.9%)

21-9. Pupils.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	18
51 - 124	20
125 - 199	23
200 - 500	15
Size unknown	0
TOTAL	76 (84.4%)

21-10. Ocular Motility.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	14
51 - 124	18
125 - 199	18
200 - 500	17
Size unknown	1
TOTAL	68 (75.6%)

21. (Continued)

21-11. Lungs and Chest.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	17
51 - 124	10
125 - 199	21
200 - 500	17
Size unknown	1
TOTAL	66 (73.3%)

21-12. Heart.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	22
51 - 124	23
125 - 199	26
200 - 500	17
Size unknown	1
TOTAL	89 (98.9%)

21-13. Vascular System.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	11
51 - 124	18
125 - 199	20
200 - 500	17
Size unknown	0
TOTAL	66 (73.3%)

21. (Continued)

21-14. Abdomen and Viscera.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	7
51 - 124	4
125 - 199	10
200 - 500	14
Size unknown	0
TOTAL	35 (38.9%)

21-15. Anus and Rectum.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	20
51 - 124	20
125 - 199	24
200 - 500	16
Size unknown	0
TOTAL	80 (88.9%)

21-16. Endocrine System.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	10
51 - 124	15
125 - 199	15
200 - 500	12
Size unknown	0
TOTAL	42 (46.7%)

21. (Continued)

21-17. G.U. System.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	19
51 - 124	21
125 - 199	24
200 - 500	17
Size unknown	1
TOTAL	82 (91.1%)

21-18. Upper Extremities.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	21
51 - 124	23
125 - 199	16
200 - 500	17
Size unknown	1
TOTAL	88 (97.8%)

21-19. Feet.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	22
51 - 124	23
125 - 199	26
200 - 500	17
Size unknown	1
TOTAL	89 (98.9%)

21. (Continued)

21-20. Lower Extremities.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	22
51 - 124	23
125 - 199	26
200 - 500	17
Size unknown	1
TOTAL	89 (98.9%)

21-21. Spine, Other Musculoskeletal.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	21
51 - 124	22
125 - 199	26
200 - 500	17
Size unknown	1
TOTAL	87 (96.7%)

21-22. Identifying Body Marks, Scars, Tattoos.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	12
51 - 124	13
125 - 199	17
200 - 500	13
Size unknown	0
TOTAL	55 (61.1%)

21. (Continued)

21-23. Skin, Lymphatics.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	19
51 - 124	22
125 - 199	23
200 - 500	17
Size unknown	1
TOTAL	82 (91.1%)

21-24. Neurologic.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	11
51 - 124	10
125 - 199	15
200 - 500	13
Size unknown	1
TOTAL	50 (55.6%)

21-25. Psychiatric.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	13
51 - 124	15
125 - 199	18
200 - 500	14
Size unknown	1
TOTAL	61 (67.8%)

21. (Continued)

21-26. Dental Examination.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	7
51 - 124	7
125 - 199	11
200 - 500	9
Size unknown	0
TOTAL	34 (37.8%)

21-27. Urinalysis.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	22
51 - 124	22
125 - 199	16
200 - 500	17
Size unknown	0
TOTAL	87 (96.7%)

21-28. Chest X-Ray.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	21
51 - 124	22
125 - 199	26
200 - 500	17
Size unknown	1
TOTAL	87 (96.7%)

21. (Continued)

21-29. Serology.

Station size	NUMBER RECOMMENDING INCLUSION
50 or less	12
51 - 124	9
125 - 199	22
200 - 500	11
Size unknown	1
TOTAL	55 (61.1%)

21-30. Other Items.

Examine other areas if history or inspection indicates	4
Perform hematocrit determination instead of serology	2
Revise SF 89	2
Revise SF 88	1
Orthopedic examination	1
Cardiac examination	1
"Pap" smears on females	1
TOTAL	12 (13.3%)

21-31. Are there any items in the medical examination you particularly emphasize?

Station size	YES	NO	NO ANSWER
50 or less	12	8	2
51 - 124	16	4	2
125 - 199	14	10	4
200 - 500	7	7	3
Size unknown	0	1	0
TOTALS	49 (54.4%)	30 (33.3%)	11 (12.2%)

21. (Continued)

21-31. Items recommended for particular emphasis.

ITEM	FREQUENCY
Orthopedic (includes musculoskeletal, extremities, gait)	43
Heart, cardiovascular	22
Eyes	9
Hernia	5
Lungs	4
Ears	3
History	3
Psychiatric	3
Use of drugs	1
G.U.	1
Neurologic	1
Skin	1
Urinalysis	1

22. Paragraph 4-17a, AR 601-270, indicates that the daily ratio of examinees to medical officers should be 30 to 1. Do you feel that this requirement of 30 examinations per physician per day is realistic?

Station size	YES	NO	NO ANSWER
50 or less	16	6	0
51 - 124	12	11	0
125 - 199	15	10	2
200 - 500	7	10	0
Size unknown	0	1	0
TOTALS	50 (55.6%)	38 (42.2%)	2 (2.2%)

23. If your answer to question 22 was NO, in your opinion what would be a realistic requirement of examinations per physician per day?

34 of the 38 individuals who answered "NO" to question 22 responded. The average of their recommended figures was 20.13 or 20 examinations per physician per day.

24. In your opinion, do the examinees at your Medical Examining Section receive an extensive medical examination as prescribed in chapters 2, 10, and 11, and appendix IX, AR 40-501; Section II, Chapter 4, AR 601-270; USAREC PAM 40-1; and AFEES Medical Notes?

Station size	YES	NO	NO ANSWER
50 or less	5	17	0
51 - 124	6	16	0
125 - 199	13	14	0
200 - 500	7	10	0
Size unknown	1	0	0
TOTALS	32 (35.6%)	58 (64.4%)	0

25. If your answer to question 24 was NO, in your opinion do the examinees at your Medical Examining Section nevertheless receive an adequate general medical examination?

Station size	YES	NO	NO ANSWER
50 or less	13	4	5
51 - 124	13	4	6
125 - 199	9	5	13
200 - 500	7	3	7
Size unknown	0	0	1
TOTALS	42 (46.7%)	16 (17.8%)	32 (34.4%)

25a. If your answer was NO, do they receive a good "screening" medical examination?

Station size	YES	NO	NO ANSWER
50 or less	4	0	18
51 - 124	4	0	19
125 - 199	5	0	22
200 - 500	3	0	14
Size unknown	0	0	1
TOTALS	16 (17.8%)	0	74 (82.2%)

26. In your opinion, should the medical examination for induction/enlistment be referred to as a "screening examination" and formally recognized as such with an appropriate change in the regulations to require a much less extensive medical examination?

Station size	YES	NO	NO ANSWER
50 or less	14	8	0
51 - 124	20	3	0
125 - 199	17	9	1
200 - 500	12	5	0
Size unknown	1	0	0
TOTALS	64 (71.1%)	25 (27.8%)	1 (1.1%)

27. Assuming you were examining a private patient, how long would it take you to perform an extensive medical examination of the form and scope prescribed in AR 40-501, AR 601-270, and USAREC PAM 40-1?

NUMBER RESPONDING IN EACH CATEGORY

Station size	15 min	30 min	45 min	60 min	1 1/2 hrs	2 hrs	Other
50 or less	4	7	6	4	1	0	0
51 - 124	1	8	8	6	0	0	0
125 - 199	3	11	4	5	1	2	*1
200 - 500	1	7	3	5	1	0	0
Size unknown	0	1	0	0	0	0	0
TOTALS	9 (10.0%)	34 (37.8%)	21 (23.3%)	20 (22.2%)	3 (3.3%)	2 (2.2%)	1 (1.1%)

*20 min

28. Assuming you were examining a private patient, how long would it take you to perform an adequate screening examination to evaluate an individual's medical qualification for military service?

NUMBER RESPONDING IN EACH CATEGORY

Station size	15 min	30 min	45 min	60 min	*Other
50 or less	11	5	0	0	6
51 - 124	12	6	1	0	4
125 - 199	13	5	1	0	8
200 - 500	11	5	1	0	0
Size unknown	1	0	0	0	0
TOTALS	**48 (53.3%)	21 (23.3%)	3 (3.3%)		18 (20.0%)

* Distribution of responses in "Other" category.

5 min or less	- 4
5 - 10 min	- 12
20 min	- 1
25 min	- 1
TOTAL	- 18

** Total number of individuals responding 15 min or less = 64 (71.1%)

29. In order to increase the efficiency of the Medical Examining Sections at the Armed Forces Examining and Entrance Stations, which of the following do you recommend be accomplished?

a. Increase the number of physicians assigned to the AFEES so that a more extensive medical examination can be performed (i.e., lower the examinee/physician ratio).

b. Change the regulations so that they require a "screening" examination which would be much less extensive in form and scope.

c. Other. What do you suggest?*

DISTRIBUTION OF RESPONSES

Station size	"a"	"b"	"c"	"a+b"	"a+c"	"b+c"	"a+b+c"	No Answer
50 or less	5	10	5	1	0	0	0	1
51 - 124	6	8	2	3	0	2	1	1
125 - 199	3	10	6	1	3	1	1	2
200 - 500	7	0	2	1	3	2	2	0
Size unknown	0	0	0	0	0	0	1	0
TOTALS	21 (23.3%)	28 (31.1%)	15 (16.7%)	6 (6.7%)	6 (6.7%)	5 (5.6%)	5 (5.6%)	4 (4.4%)

*A list of representative suggestions is presented in Appendix I

30. Are you satisfied with your assignment as a physician at an AFEES? If NO, why not?[a]

Station size	YES	NO	NO ANSWER
50 or less	9	12	1
51 - 124	6	13	4
125 - 199	12	12	3
200 - 500	6	9	2
Size unknown	0	1	0
TOTALS	[b]33 (36.7%)	47 (52.2%)	[c]10 (11.1%)

[a]Comments to Question 30 relative to dissatisfaction with assignment at AFEES are listed in APPENDIX J.

[b]11 respondents who answered "yes" none the less entered comments relative to dissatisfaction with their assignment. See Section 2, APPENDIX J for these comments.

[c]6 respondents listed as "No Answer" answered "yes/no" and entered comments relative to dissatisfaction with their assignment. See Section 3, APPENDIX J for these comments.

31. What are your recommendations to improve the tour of duty at an AFEES?*

RECOMMENDATION	FREQUENCY
Opportunity to attend local conferences	47 (52.2%)
Permission to "moonlight"	24 (26.7%)
Opportunity to attend national/regional medical conferences at government expense	13 (14.4%)
Opportunity to work at a military or federal hospital or clinic while assigned to AFEES	12 (13.3%)
Assignment of a Medical Service Corps officer to handle administrative work	7 (8.9%)
Limit Assignment to AFEES to 1 year	6 (6.7%)
Remove the Medical Examining Section from USAREC and/or AFEES control and place under control of the Surgeon General	5 (5.6%)
Miscellaneous recommendations	34
TOTAL RECOMMENDATIONS	146

*A representative selection of recommendations is presented in Appendix K.

APPENDIX G

COMPARISON OF DATA FROM QUESTION 19, QUESTION 20, AND QUESTION 21

Comparison of Question 19, Items Recommended for Elimination from Examination; Question 20, Items Actually Performed During Examination (Total Respondents and Respondents to Question 19); and Question 21, Items Recommended for Inclusion in Examination

Description	19. Items Recommended for Elimination from Examination (=60 respondents)				20. Items Actually Performed During Examination						21. Items Recommended for Inclusion in Examination		
					Total Respondents (=90)			Respondents to 19 (=60)					
	Item No.	Total	% (90)	% (60)	Item No.	Total	Percent	Item No.	Total	% (90)	% (60)	Item No.	Total	Percent
Head, Face, Neck and Scalp	19-1	9	10.0	15.0	20-1	77	85.6	20-1	50	55.6	83.3	21-1	75	83.3
Nose	19-2	34	37.8	56.7	20-2	40	44.4	20-2	22	24.4	36.7	21-2	39	43.3
Sinuses	19-3	53	58.9	88.3	20-3	15	16.7	20-3	7	7.8	11.7	21-3	11	12.2
Mouth and Throat	19-4	39	43.3	65.0	20-4	56	62.2	20-4	39	43.3	65.9	21-4	50	55.6
Ears--General	19-5	7	7.8	11.7	20-5	83	92.3	20-5	55	61.1	91.7	21-5	71	78.9
Drums	19-6	12	13.3	20.0	20-6	51	56.7	20-6	36	40.0	60.0	21-6	80	88.9
Eyes--General	19-7	2	2.2	3.3	*			*				21-7	85	94.4
Ophthalmoscopy	19-8	23	25.6	38.3	20-7	66	73.3	20-7	44	48.9	73.3	21-8	53	58.9
Pupils	19-9	5	5.6	8.3	20-8	85	94.4	20-8	57	63.3	95.0	21-9	76	84.4
Ocular Motility	19-10	10	11.1	16.7	20-9	71	78.9	20-9	47	52.2	78.3	21-10	68	75.6
Lungs and Chest	19-11	27	30.0	45.0	20-10	64	71.1	20-10	38	52.2	63.3	21-11	66	73.3
Heart	19-12	1	1.1	1.7	20-11	86	95.6	20-11	58	64.4	96.7	21-12	89	98.9
Vascular System	19-13	2	2.2	3.3	20-12	76	84.4	20-12	50	55.6	83.3	21-13	66	73.3
Abdomen and Viscera	19-14	29	32.2	48.3	20-13	27**	30.0**	20-13	17***	18.9***	28.3***	21-14	35	38.9
Anus and Rectum	19-15	7	7.8	11.7	20-14	86	95.6	20-14	57	63.3	95.0	21-15	80	88.9
Endocrine System	19-16	8	8.9	14.7	20-15	58	64.4	20-15	40	44.4	66.7	21-16	42	46.7
G.U. System	19-17	17	18.9	28.3	20-16	59	65.6	20-16	42	46.7	70.0	21-17	82	91.1
Upper Extremities	19-18	1	1.1	1.7	20-17	84	93.3	20-17	57	63.3	95.0	21-18	88	97.8
Feet	19-19	0	0	0	20-18	86	95.6	20-18	58	64.4	96.7	21-19	89	98.9
Lower Extremities	19-20	0	0	0	20-19	86	95.6	20-19	58	64.4	96.7	21-20	89	98.9
Spine, Other Musculoskeletal	19-21	1	1.1	1.7	20-20	76	84.4	20-20	52	57.8	86.7	21-21	87	96.7
Identifying Body Marks, Scars Tattoos	19-22	24	26.7	40.0	20-21	83	92.2	20-21	56	62.2	93.3	21-22	55	61.1
Skin, Lymphatics	19-23	7	7.8	11.7	20-22	81	90.0	20-22	55	61.1	91.7	21-23	82	91.1
Neurologic	19-24	16	17.8	26.7	20-23	48	53.3	20-23	31	34.4	51.7	21-24	50	55.6
Psychiatric	19-25	8	8.9	14.7	20-24	60	66.7	20-24	40	44.4	66.7	21-25	61	67.8
Dental Examination	19-26	28	31.1	46.7	20-25	46	51.1	20-25	31	34.4	51.7	21-26	34	37.8
Urinalysis	19-27	1	1.1	1.7	20-26	85	94.4	20-26	58	64.4	96.7	21-27	87	96.7
Chest X-Ray	19-28	1	1.1	1.7	20-27	85	94.4	20-27	58	64.4	96.7	21-28	87	96.7
Serology	19-29	27	30.0	45.0	20-28	84	93.3	20-28	59	65.6	98.3	21-29	55	61.1

*"Eyes--General" was inadvertantly omitted from question 20 on the questionnaire.

**87 respondents (96.7%) indicated that they routinely check for hernia.

***58 of the 60 respondents (96.7%) indicated that they routinely check for hernia.

APPENDIX H

STANDARD FORM 89: REPORT OF MEDICAL HISTORY

Standard Form 89
(Rev. March 1965)
Bureau of the Budget
Circular A-32

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

89-106-01

1. LAST NAME—FIRST NAME—MIDDLE NAME		2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
4. HOME ADDRESS *(Number, street or RFD, city or town, State and ZIP Code)*		5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY / CIVILIAN	10. AGENCY / 11. ORGANIZATION UNIT
12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS		16. OTHER INFORMATION	

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS *(Follow by description of past history, if complaint exists)*

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
SPOUSE				
BROTHERS AND SISTERS				
CHILDREN				

19. HAS ANY BLOOD RELATION *(Parent, brother, sister, other)* OR HUSBAND OR WIFE

YES	NO	*(Check each item)*	RELATION(S)
		HAD TUBERCULOSIS	
		HAD SYPHILIS	
		HAD DIABETES	
		HAD CANCER	
		HAD KIDNEY TROUBLE	
		HAD HEART TROUBLE	
		HAD STOMACH TROUBLE	
		HAD RHEUMATISM *(Arthritis)*	
		HAD ASTHMA, HAY FEVER, HIVES	
		HAD EPILEPSY *(Fits)*	
		COMMITTED SUICIDE	
		BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW *(Place check at left of each item)*

YES	NO	*(Check each item)*	YES	NO	*(Check each item)*	YES	NO	*(Check each item)*	YES	NO	*(Check each item)*
		SCARLET FEVER, ERYSIPELAS			GOITER			TUMOR, GROWTH, CYST, CANCER			"TRICK" OR LOCKED KNEE
		DIPHTHERIA			TUBERCULOSIS			RUPTURE / HERNIA			FOOT TROUBLE
		RHEUMATIC FEVER			SOAKING SWEATS *(Night sweats)*			APPENDICITIS			NEURITIS
		SWOLLEN OR PAINFUL JOINTS			ASTHMA			PILES OR RECTAL DISEASE			PARALYSIS *(Inc. infantile)*
		MUMPS			SHORTNESS OF BREATH			FREQUENT OR PAINFUL URINATION			EPILEPSY OR FITS
		COLOR BLINDNESS			PAIN OR PRESSURE IN CHEST			KIDNEY STONE OR BLOOD IN URINE			CAR, TRAIN, SEA, OR AIR SICKNESS
		FREQUENT OR SEVERE HEADACHE			CHRONIC COUGH			SUGAR OR ALBUMIN IN URINE			FREQUENT TROUBLE SLEEPING
		DIZZINESS OR FAINTING SPELLS			PALPITATION OR POUNDING HEART			BOILS			FREQUENT OR TERRIFYING NIGHTMARES
		EYE TROUBLE			HIGH OR LOW BLOOD PRESSURE			VD-SYPHILIS, GONORRHEA, ETC.			DEPRESSION OR EXCESSIVE WORRY
		EAR, NOSE OR THROAT TROUBLE			CRAMPS IN YOUR LEGS			RECENT GAIN OR LOSS OF WEIGHT			LOSS OF MEMORY OR AMNESIA
		RUNNING EARS			FREQUENT INDIGESTION			ARTHRITIS OR RHEUMATISM			BED WETTING
		HEARING LOSS			STOMACH, LIVER OR INTESTINAL TROUBLE			BONE, JOINT, OR OTHER DEFORMITY			NERVOUS TROUBLE OF ANY SORT
		CHRONIC OR FREQUENT COLDS			GALL BLADDER TROUBLE OR GALL STONES			LAMENESS			ANY DRUG OR NARCOTIC HABIT
		SEVERE TOOTH OR GUM TROUBLE			JAUNDICE			LOSS OF ARM, LEG, FINGER, OR TOE			EXCESSIVE DRINKING HABIT
		SINUSITIS			ANY REACTION TO SERUM, DRUG OR MEDICINE			PAINFUL OR "TRICK" SHOULDER OR ELBOW			HOMOSEXUAL TENDENCIES
		HAY FEVER			HISTORY OF BROKEN BONES			BACK TROUBLE OF ANY KIND			PERIODS OF UNCONSCIOUSNESS
		HISTORY OF HEAD INJURY									
		SKIN DISEASES									

21. HAVE YOU EVER *(Check each item)*						22. FEMALES ONLY: A. HAVE YOU EVER—			B. COMPLETE THE FOLLOWING:	
		WORN GLASSES—CONTACT LENS			ATTEMPTED SUICIDE			BEEN PREGNANT		AGE AT ONSET OF MENSTRUATION
		WORN AN ARTIFICIAL EYE			BEEN A SLEEP WALKER			HAD A VAGINAL DISCHARGE		INTERVAL BETWEEN PERIODS
		WORN HEARING AIDS			LIVED WITH ANYONE WHO HAD TUBERCULOSIS			BEEN TREATED FOR A FEMALE DISORDER		DURATION OF PERIODS
		STUTTERED OR STAMMERED			COUGHED UP BLOOD			HAD PAINFUL MENSTRUATION		DATE OF LAST PERIOD
		WORN A BRACE OR BACK SUPPORT			BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION			HAD IRREGULAR MENSTRUATION	QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY	

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	25. WHAT IS YOUR USUAL OCCUPATION?	26. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		27. HAVE YOU BEEN REFUSED EMPLOYMENT OR BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
		B. INABILITY TO PERFORM CERTAIN MOTIONS
		C. INABILITY TO ASSUME CERTAIN POSITIONS
		D. OTHER MEDICAL REASONS *(If yes, give reasons)*
		28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
		29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? *(If yes, give details)*
		30. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? *(If yes, state reason and give details)*
		31. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? *(If yes, describe and give age at which occurred)*
		32. HAVE YOU EVER BEEN A PATIENT *(Committed or voluntary)* IN A MENTAL HOSPITAL OR SANITORIUM? *(If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic)*
		33. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? *(If yes, specify when, where, and give details)*
		34. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? *(If yes, give complete address of doctor, hospital, clinic, and details)*
		35. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? *(If yes, which illnesses)*
		36. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date and reason for rejection)*
		37. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability)*
		38. HAVE YOU EVER RECEIVED, IS THERE PENDING, OR HAVE YOU APPLIED FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? *(If yes, specify what kind, granted by whom, and what amount, when, why)*

WARNING: A FALSE OR DISHONEST ANSWER TO ANY OF THE QUESTIONS ON THIS FORM MAY BE PUNISHED BY FINE OR IMPRISONMENT (18 U.S.C. 1001)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

39. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in items 20 thru 38)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

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APPENDIX I

SUGGESTIONS OFFERED BY RESPONDENTS TO QUESTION 29

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SUGGESTIONS OFFERED BY RESPONDENTS TO QUESTION 29

1. Suggestions referable to a change in the regulations

"Change AR 40-501 to be much more specific and detailed than it now is."

"Change to a 'screening' type examination; also rewrite AR 40-501 so that areas of ambiquity, i.e., psychiatric, allergy (hay fever and allergic rhinitis) and other conditions are better defined regarding what is and what is not disqualifying."

"Chapter 2 (AR 40-501) should be revised. Very few inductees are required to be suitable for combat and there are many desk jobs; therefore, less extensive examination."

"Workload could be reduced if applicants and inductees with physical defects were accepted for non-combat situation (e.g., mild asthma, deranged knees, missing fingers). Regulations should be extensively revised."

"Regulations should require screening examination as well as define psychiatric, allergic and neurologic (headaches, etc.) disqualifications in much clearer language."

"I suggest a general screening examination for everyone with more detailed examinations in a specific area or areas depending on the examinees history (i.e., spot checking individual complaints during or immediately after the history)."

"Eliminate psychiatric evaluations."

"Limit the number of disqualifying defects."

"Keep the examination as it presently is performed but admit that due to the number of examinations performed that it is in reality a screening procedure."

"Allow screening examination when necessary but have sufficient manpower to do complete examinations as indicated by history."

2. Suggestions Referable to a Major Reorganization of the AFEES

"Examinations to be performed in locations with Veterans Administration or military hospitals, or be performed by private corporations consisting of at least: 1 internist, 1 orthopedic surgeon, 1 psychologist, 1 optometrist, 1 radiologist."

"Abolish AFEES and establish civilian examining facilities with no military interference, e.g., public health facility; if not possible, at least take AFEES out of Recruiting Command and into Surgeon General's Office."

"To properly perform its mission, AFEES should be an autonomous medical facility with military physicians assigned both as general medical officers and specialities of cardiology, gastroenterology, neurology, internal medicine, surgery, and psychiatry."

"Leave AFEES in the hands of fee-basis physicians who like this kind of 'job'."

"Hire more civilian physicians to handle station. For a two-year period, AFEES is a very unrewarding experience for a general medical officer. He is given no training and is denied funds for medical meetings."

3. Suggestions Referable to a Change in SF 89, Report of Medical History

"Revise SF 89 so that examinee will not list a positive answer to such minor things as occasional headaches or occasional upper respiratory infections, minor soreness in legs with athletic activity, nervous trouble that is merely (representative of) everyday concerns, etc."

"Fewer 'nonsense' items in Section 20 of SF 89 which require comments or interview."

"A new SF 89."

"Improve SF 89."

4. Suggestions Referable to Daily Examinee Load

"Selective Service varies the number of men per day rather widely and I feel quality of examination goes down with increasing load. Our station should perhaps be rated at 100 instead of 125 and we do best seeing 50-60 men per day."

"Maintain a reasonably constant number of examinations per day and have all physicians be military doctors."

"Keep the daily load approximately the same according to the station capacity and number of physicians."

"Medical advisors at Draft Board level should screen obviously disqualified individuals to reduce examination load."

5. Suggestions Referable to Lowering the Examinee/Physician Ratio

"Physicians by nature will focus on areas of suspected abnormality and in turn these are usually brought out by the examinee himself. Hence the quality of the examination is somewhat independent of the formal or legal structure which serves only to impede progress. More physicians at a station diversify background and experience and will result in more adequate evaluations."

"The examinee/physician ratio, if lower, would allow more individual attention to certain possibly disqualifying defects and allow additional time to perform special comprehensive examinations (neurologic, orthopedic, psychiatric, particularly the latter 2) which are sometimes not as extensive as desired."

"Lower the examinee/physician ratio by increasing pay, number and quality of fee basis physicians."

6. Miscellaneous Suggestions

"I suggest having specialists perform specific parts of the examination."

"An alternative . . . is training of medics to do certain examinations--any deviation from normal would be reported to the medical officer. This would only be practical in evaluation of skin, exercises, feet, ears."

"Authorize use of the well trained medics and examining NCO's to do more of the examination under supervision."

"For female examinations, allow each female examination to equal 3 regular examinations because they take so long."

"I would leave things pretty much the same. A lesser examination would raise the EPTS rate too much."

"Commanders should be man enough to discuss problems face to face with medical officers."

APPENDIX J

COMMENTS TO QUESTION 30 RELATIVE TO DISSATISFACTION WITH ASSIGNMENT AT AFEES

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COMMENTS TO QUESTION 30 RELATIVE TO DISSATISFACTION WITH ASSIGNMENT AT AFEES

1. Respondents Who Answered "No"

"Medicine is a science and an art to be learned through contact with patients and experienced teachers. At an AFEES, the basic rules of medicine are broken, there is no doctor-patient relationship. We are not subject to professional rules but to a bunch of regulations dealing mostly with legal matters. Instead of learning we forget the few hardly learned lessons."

"I became a doctor to practice medicine. The AFEES assignment is complete frustration to a physician due to a lack of scientific challenge. No medical meetings, no surgery, no sick people to see, plus the fact you are part of a non-professional atmosphere."

"I feel that it has little to offer with respect to expanding one's medical knowledge and is a waste of time from a professional point of view. A physician in this job is more or less isolated from the rest of the medical profession, has no academic stimulation and stagnates for the length of his tour of duty."

"This is a professional vacuum! I have not encountered a pertinent day relating to my profession in the past 1 1/2 years. There is no patient care, no therapy, nothing to suggest or require a physician."

"Professional advancement becomes stagnant. Some commanding officers really hamper professional advancement of medical officers by being egotistic about their command positions whereby they don't allow them to attend local medical conferences but instead let them stay at the AFEES station doing nothing."

"Boring, monotonous, demoralizing, non-medical, non-professional; non-therapeutic; no provision for continuing medical education or a normal doctor-patient relationship."

"It is an administrative rather than a medical position. There is no medical treatment involved."

"Poor medical experience."

"Not practicing medicine; boring and intellectually unchallenging."

"No professional stimulation. I feel that my general knowledge of the practice of medicine has significantly deteriorated due to lack of stimulation."

"(No) because the medicine practiced is of such a narrow scope (i.e., examining basically fit males ages 18 to 26). Most of your day is devoted strictly to administrative tasks (i.e., signing your name approximately 200 times). The current tight restrictions against "moonlighting' mean a tremendous waste of time, talent, and learning opportunity for both the community and the physician. A 2-year AFEES tour is essentially a 2-year Medical and Professional void. I'm sure a great deal of medical knowledge is lost to the physician simply because he is not allowed to use what he was taught. I am definitely not as sharp a physician now, after a 2 year AFEES tour, as I was on completion of my internship."

"Virtually no clinical learning-teaching experience. No association with a group of peer-physicians. Was not allowed to attend military medical meeting--'lack of funds.' Too much administration, too little medicine."

"Extremely boring. No real challenge medically. Would much prefer a treatment facility."

"I am not allowed to practice medicine during my free time. With APC's the only authorized medicine at AFEES one cannot practice medicine on AFEES personnel."

"Medically, it is a very stagnant period of my life; there is little stimulus in the work itself and of course no chance for treatment or followup. The big advantage is having enough time for my family."

"Minimal exposure to actual medical problems. No followup on medical problems discovered and requirement for excessive 'red tape type of activities.'"

"It is completely void of any stimulation from a medical standpoint. My ability to practice medicine has deteriorated as a result."

"I am not practicing medicine! This is 95% administrative work. I have lost all contact with the practice of medicine. Compared to a tour of duty in Vietnam, it's OK, but that is not saying much. 4th Recruiting District claimed inadequate funds for professional conference attendence."

"I am losing all track of therapeutics in medicine. There is little if any stimulus for learning. There is too much nit-picking by non-medical personnel."

"Completely removed from medicine. Cater to the elite particularly those with congressional influence. Lack of permission to 'moonlight' in order to stay in medical condition upon discharge."

"Insufficient contact with a treatment situation. Nonavailability of continued medical education in this locality. Disparity between actual procedures performed and those 'put on' for inspectors that come through."

"Not practicing medicine. Unrewarding. No therapeutics. Non-medical atmosphere. Conflicts with infantry commander."

"Isolated from the practice of medicine."

"Very un-medical; difficult, if not impossible, to keep abreast; of changes inclinical medicine; little contact with professional people with similar interests."

"No treatment. Too short a period of time to evaluate people. Poor coordination between Selective Service and AFEES."

"Lack of professional activities. Lack of respect for profession. Too much administrative interference. Too much non-medical activities."

"There's nothing professional about this assignment (medically speaking). It's two years of stagnation medically."

"Professionally unrewarding--lack of patient care; no true follow-up on examinees who have disqualifying defects. Minimal learning experience."

"Professional growth is stunted during AFEES tour, regulations are vague, special interest cases receive special attention, while non-complainers are shunted through as rapidly as possible."

"No therapeutic practice, hard to retain this phase of medicine. Unpleasant to examine number of men sent in. Unpleasant to examine unruly, rude, and uncooperative nuts who are obviously lying or exaggerating. Functioning more as a quality control inspector than physician."

"No sick people to treat. Patient-doctor relationship non-existent--rather a game, contest, battle. Adequate examination but lacks real quality and dignity. High examinee/physician ratio, inadequate fee basis physicians and heavy administrative burden is tiring, depressing, and professionally unrewarding."

"It's not a bad assignment as military assignments go--we live like civilians--but medically it's a disaster and physician's graveyard. We practice no medicine nor are we allowed to practice. We become cold impersonal administrators--forgetting out medicine."

"Poor followup--lack of understanding of my problems as a Senior Medical Officer. Too much administrative work without adequate preparation."

"Clinical experience is nil, expecially since moonlighting is forbidden except to a very limited degree. Time to attend conferences at local hospitals is difficult to arrange in my schedule. Most of my time is spent in administrative work."

"Compared to Vietnam--fine. Compared to functioning as an internist at a good hospital--this job is boring, tedious, and conducive to professional atrophy."

"Professionally unrewarding. Too much administrative work. Need actual medical duties to keep my professional standards up to par. Tired of the hastle with the registrants--constant battle."

"Too much paper work. No opportunity to learn or encouraged to attend conferences."

"In my case, only one medical officer--cannot discuss cases, have free time for medical school conferences and rounds, etc. Failure (by headquarters) to convey both administrative and medical changes to medical officers adequatels--discontinuance of medical notes, surgeon making statements concerning acceptability of certain defects, then no notification in writing."

"I do not like being subordinate to non-medical lifers! I do not like doing non-medical administrative tasks."

"Attitude of non-professionals in USAREC is overbearing and hostile. Pressure is exerted daily to meet quotas. Quality medical examinations are spoken of only to give lip service. The concept of AFEES is paradoxical to quality medicine. Too much time spent with administrative paperwork. Too much interference from non-medical AFEES command personnel because of pressure brought to bear on them by USAREC, district, and Recruiting Main Station (quality medicine should transcend all of these administrative problems, i.e., either a man is or is not physically fit)."

"Was (satisfied) at first but interference from commanding officer has made work here unpleasant for all concerned. I am also a little concerned about lack of thoroughness and followup of those with serious medical problems that deserve further attention."

"Demeaning, lack of respect from registrants and station personnel. No medical challenge or contact, can't work regulations, etc., too much interference from administrative people. Efficiency report done by layman."

2. Respondents Who Answered "Yes"

"Satisfied from point of view of convenience bur professionally, it leaves much to be desired. Feel as if corpsman could surely perform the same job."

"My reasons for being satisfied are personal, not professional. Professionally, this assignment is a disaster. No opportunity to practice medicine or sharpen diagnostic techniques. Plenty of time to read but no motivation for doing so."

"For family reasons, however, it is a professional vacuum."

"No professional gain whatsoever, but it's been nice for personal reasons--no call, free time, time to pursue hobbies, etc."

"Not very professionally stimulating!!"

"No professional stimulation. We are not practicing medicine--we are being detectives. In short, Mental Masturbation."

"Only because I had access to 'moonlighting' opportunities in the local community which allowed contact with treatment of patients."

"This would be a more satisfying professional experience if (1) consults were available as teaching consults, (2) it was combined with house staff responsibilities, (3) 'moonlighting' was encouraged."

"As a general medical officer I feel AFEES is about the best assignment available--especially considering the alternatives (RVN or 'dispensary Doc'). Medically speaking, it is a relative zero."

"Too heavy a hand on moonlighting. I detest . . . (AFEES location)."

"Only because I'm not in Vietnam, I'm not responsible for sick call or night duty and I have short (relatively) duty hours with a 'civilian' evening life."

3. Respondents Who Answered "yes/No"

"Yes, because I am with my family for the first time in 3-4 years. No, because (1) professionally this job is a complete waste, (2) incompetence of military officer personnel, (3) it requires certain philosophical compromises to perform as a professional."

"I'm happy with the hours, the fact that I did not go to Vietnam and I stayed in one spot with my family for 2 years. The job itself is a medical disaster on a professional level and becomes incredibly boring after a period. Due to the constant intra- and intermural bickering amongst everyone it is also anxiety producing to an unhealthy degree."

"There are few opportunities to utilize one's training since no treatment of patients is allowed. On the other hand, one can improve diagnostic skills, weed out malingerers (which would help out later in private practice), improve one's history taking skills."

"No, because it has been a complete waste of time professionally. I have learned nothing and forgotten a lot. On the other hand, I have not been shot at nor have I had to listen to the neurotics in a general therapy clinic. I know from experience that one listens to the same complaints in an AFEES as one hears in the general therapy clinic. The advantages of the AFEES complaint is that you don't have to appear interested and pretend to treat it."

"I like the hours and the chance to see many normal men. I have enjoyed my time in the Army. However, this particular job lacks any aspects of patient care and thus very much personal satisfaction. Perhaps tours should be just 12 months."

"Present assignment is a waste of my ability and education. More civilian physicians could be employed, making each AFEES require only 1 military physician."

APPENDIX K

REPRESENTATIVE SELECTION OF RECOMMENDATIONS GIVEN IN QUESTION 31

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REPRESENTATIVE SELECTION OF RECOMMENDATIONS GIVEN IN QUESTION 31

"Place AFEES Medical Section under direct control of SGO not USAREC."

"Have MSC officer assigned to Medical Section to perform administrative tasks of Medical Section."

"Have AG or MSC in command of AFEES (not combat branch officer)."

"Physically remove AFEES from presence of USAREC and Recruiting Main Station personnel."

"Provide a regulation which makes it illegal for USAREC and Recruiting Main Station to exercise any form of pressure on medical officers in AFEES to meet quotas."

"SGO should make a concentrated effort to improve the attitude of non-medical military personnel toward physicians. It must be emphasized that neither rank nor the uniform change the responsibilities of the physician to his profession."

"The medical officer in command of the AFEES Medical Section should answer only to the Surgeon General. He must be a commander in his own right!"

"Make the Medical Section autonomous. It is degrading to be outranked and to be commanded by a high school graduate just because he happens to outrank a captain doctor."

"AFEES Medical Officers should be encouraged to work in the community and to join the local medical society."

"When possible AFEES doctors should be assigned after a tour elsewhere so that they would have a better idea of the needs of the services."

"Allow time to attend local medical conferences. Allow funds to permit doctors to attend national medical conferences."

"Have two (at least) medical officers at each station."

"Have at least a month overlap between new assignments if only one man at station."

"Have medical officers visit other stations periodically to get new ideas on processing examinees."

"Closer contact with USAREC surgeon; e.g., newsletter, personal visit."

"Assign only MD's with substantial personal integrity and commitment to duty at AFEES."

"Closer contact with Surgeon General. We're out of the mainstream of medicine (military and civilian) and not a part of either. No Army physician ever talked with me regarding staying in the Army as a career . . ., an idea I was receptive to."

"I . . . feel that moonlighting should be allowed (within reasonable limits) if it does not interfere with performance of medical officer. In general, the assignment at the AFEES is a 'medical abortion' for value for medical officers. Working in a hospital would help."

"Opportunity to work in private or military hospitals with or without additional salary."

"The medical doctors should be more autonomous, i.e., have actual command of the section on an equal footing with the administrative personnel. It is degrading to be commanded by a non-medical officer."

"Physical separation of all recruiting and administrative personnel from Medical Section."

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