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USAWC MILITARY STUDIES PROGRAM PAPER

THE MAKING OF AN ARMY PHYSICIAN

INDIVIDUAL ESSAY

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ABSTRACT

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The Army Medical Department (AMEDD) is one of the largest and most comprehensive health care systems of its kind. Its 5200 physicians, including approximately 1600 in internship, residency, and fellowship programs, work in a regionalized system composed of ten medical centers, forty-one community hospitals, and over two hundred health clinics, and provide comprehensive health services to millions of Americans across the nation and around the globe. For the army physician to maximize his effectiveness as a health care provider and director of health care services, in peace and in war, he must achieve certain milestones. These include competence in primary health care by completing a rotating internship, and in operational medicine by completing the Combat Casualty Care Course, the AMEDD Officers' Basic and Advanced Courses, and earning the Expert Field Medical Badge, in a medical specialty by completing a residency and becoming board certified, and finally in management and leadership through formal courses and diverse assignments.

Early in the morning of 23 October 1983, an explosion destroyed the Battalion Landing Team Headquarters of the 24th United States Marine Amphibious Unit in Beirut, Lebanon. Within minutes, the surviving members of the unit's service support group had sent a party forward to provide emergency care and to help evacuate the wounded, and established an aid station to sort and treat casualties. By the end of the first 1 and 1/2 hours, 65 casualties had reached the aid station, and the first patients were being evacuated by helicopter to the USS Iwo Jima. Civilian and International Red Cross health providers were on the scene. In the next several hours, patients were flown to Cyprus and to United States Army and Air Force hospitals in the Federal Republic of Germany. In all, 241 US Marines died that day, and another 126 were wounded.

The threat and reality of terrorism that hangs over the world today, unfortunately, makes this scenario one that is apt to be repeated. Is the Army Medical Department (AMEDD) prepared to react quickly and competently to such disasters, as well as to war of any magnitude? Are medical corps officers properly schooled in emergency treatment and triage? Are they trained to coordinate and participate in joint military health care efforts? Are they skilled in war surgery and educated in what has been termed "operational medicine?"

Let us take a closer look at the AMEDD, which over the years, has evolved into one of the largest and most comprehensive health care systems in the world, serving millions of Americans across the nation and around the globe. For the AMEDD to meet its worldwide commitments, health care has been regionalized, with ten medical centers supporting

forty-one community hospitals, which in turn support over two hundred health clinics. Under this concept, soldiers and their families receive their basic health care (primary care) from physicians trained in family medicine. Patients requiring hospitalization or more sophisticated care (secondary care) are referred to the community hospital, while those requiring even more specialized care (tertiary care), e. g., heart catheterization, are referred to the medical center.

To support such a structure, the medical corps is composed of two groups of mutually supporting physicians (see figure 1). First are those who provide primary health care, including general practitioners (general medical officers), and residency trained family practitioners, internists, pediatricians, and emergency medicine specialists. Physician's assistants and nurse practitioners, although not physicians, can also be included in this group. Second are the other specialists and subspecialists such as cardiologists, surgeons, psychiatrists, pathologists, etc. Health clinics are staffed mainly with primary care specialists, predominantly general practitioners, family practitioners, and physician's assistants, community hospitals with varying mixtures of primary care and other specialists, and medical centers with a predominance of non-primary care specialists.

Today's medical corps numbers some 5200 physicians, of whom approximately 1400 are engaged in primary care; as many as 1600 are in internship, residency, and fellowship programs. These latter physicians, studying clinical and basic sciences in military and civilian hospitals around the world, are among the finest in the nation.

For the young medical corps officer, there are no thoughts of command, administration, logistics, personnel, and the like. His goals, like those of all his colleagues, revolve around patients and obtaining the necessary expertise to provide outstanding health care. Unlike his military colleagues in other branches, these basic goals do not change with time. Hence, often times, the medical corps colonel, like his younger colleague, places the care of the individual patient as his number one priority. He is not systems oriented, nor does he care to be. Somehow, that same medical corps officer must be motivated to see the forest as well as the individual trees. That is not to say that his primary focus should not be the individual patient, but rather if he is to best serve that patient, he must become master of the environment he works in. The highly skilled clinician must be inspired to expand his horizons beyond the bedside so that the entire army family, and not just the individual patient, can benefit from his knowledge.

How, then, should the medical corps officer be prepared to assume the responsibilities not only of providing health care, but of directing health care services at every level, in the field as well as in the hospital, in war as well as in peace? To begin with, every army physician should possess the necessary skills to serve as a primary health care provider. Until perhaps fifteen years ago, the majority of medical school graduates entered what was called a "rotating internship," during which the young physician was exposed to several specialties to include emergency medicine, internal medicine, obstetrics-gynecology, pediatrics, and surgery. Upon completion of the



internship year, the physician had gained invaluable broad clinical experience, and was well prepared to provide primary health care as a general practitioner. It was just what the army needed. Unfortunately, increased emphasis on early specialization resulted in the rotating internship losing its appeal, such that today, only a small minority of medical school graduates opt for this program. The AMEDD, in order to compete effectively for quality medical school graduates, likewise began de-emphasizing the rotating internship program, and lost a significant portion of its much needed pool of appropriately trained general practitioners. This trend must be reversed.

There are additional medical and military medical skills that should be mastered prior to the army physician's first assignment. These are presently being taught at the AMEDD Officers' Basic Course and the Combat Casualty Care Course, both of which should be a must for all who enter the medical corps. Additionally, army physicians should be strongly encouraged to earn the Expert Field Medical Badge; the Aviation Medicine Short Course (to earn flight surgeon's wings) should be offered to many more physicians. Each of these programs will help assimilate the medical corps officer into the army as well as increase his medical skills. One further point. It is incumbent upon the AMEDD to recertify the specific skills it requires of its physicians on a cyclical basis. Refresher courses and recertification in combat casualty care and advanced trauma life support are paramount to the AMEDD's future successes. Those naval officers in Beirut might just some day be us.

Armed with this education and training, the army physician is

well prepared to enter the army community to provide family health services and emergency services. The AMEDD has, traditionally, sent the least experienced medical corps officers to the most medically isolated, and often geographically isolated, assignments as general medical officers where they are not only expected to provide health care services, but to serve as staff officers in TOE units and military communities. Rather, first assignments should be to community hospitals or large health clinics under the umbrella of more senior and experienced physicians. After 1-2 years in such a setting, the young medical corps officer will be much better equipped for an operational assignment, and in most cases, can be assigned to a co-located TOE unit without requiring a PCS move. Only those who have successfully completed a general medical officer and/or operational assignment should be considered for residency training.

During the residency period, the medical corps officer will begin to integrate his understanding of the AMEDD with the knowledge he has gained as a general practitioner, and that which he acquires during his specialty training. This is an ideal time for him to attend an abbreviated AMEDD Officers' Advanced Course for medical corps officers.

To this point, covering perhaps the first seven years of an army physician's career, the educational experiences for all army physicians should be similar. Each will have completed an internship, a general practice and/or operational assignment, and a residency, and each will have attended the Combat Casualty Care Course and the AMEDD Basic and Advanced Courses. From this point, the road splits into many

avenues, but with many interconnections. Paths in clinical medicine, academic medicine, operational medicine and command, and research are among those that may be chosen (see figure 2). While this divergence makes it impossible to dictate specific assignments, it does not preclude establishing certain milestones, the most significant of which, perhaps, is board certification. All army physicians should be required to become certified in their medical specialty. This certification should be linked to promotion at the O-5 level, and not the O-6 level. Failure to become certified should delay promotion, if not preclude it.

If board certification, as an objective measurement of medical proficiency, is the most important milestone, then becoming a skilled manager must be second. Whether a commander of a hospital or a battalion, of a clinic or a company, or serving as a department chairman or staff officer, having management skills and some knowledge of administration, personnel, logistics, and resource management are essential ingredients for success. This educational process begins in the AMEDD Basic Course, is expanded in the Advanced Course, and should be further enriched with course at the middle management and executive management levels. Many such courses, military and civilian, are available.

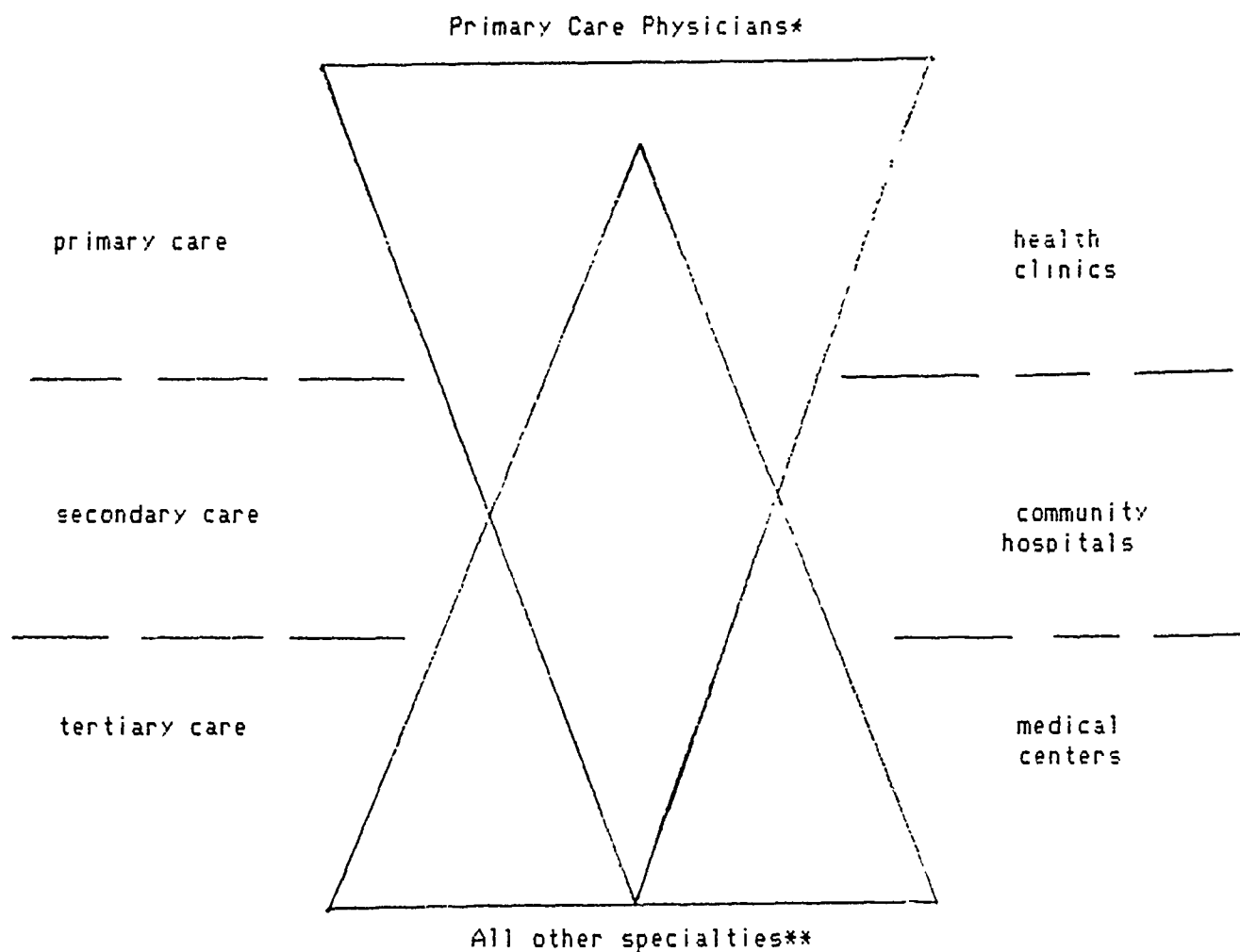
Certain jobs within the AMEDD should, and in most cases do, have prerequisites. A health clinic commander should have completed a residency, and hence, the advanced course. A hospital department chairman should have been a service chief. A division surgeon should have attended Command and General Staff College. A deputy commander for

clinical services should have served as a department chairman or major command staff officer. A hospital commander should have first been a deputy commander for clinical services. And so it goes.

As it turned out, the two surviving Naval Medical Department officers in Beirut that fateful October day were dental corps officers, who, along with eleven corpsmen, distinguished themselves by their heroic efforts. All casualties received primary and secondary body surveys; the ABC's of emergency care were given. Areas were designated to handle the various categories of patients, and corpsmen were assigned to each area. Dressings were applied, IV's started, and medications administered. They were prepared.

As we look to the future and to improve the AMEDD, let us not forget that the military medical departments of the United States have contributed significantly to giving the American soldier on the battlefield the highest survivability of any warrior in the history of mankind, and in peacetime, provide more quality, cost effective health care than any comparable system in the world. The medical corps can be justly proud of its heritage, and of its accomplishments, past and present.

Figure 1  
Physicians in the Medical Corps



\* general medical officers, flight surgeons, emergency medicine specialists, family practitioners, internists, pediatricians

\*\* obstetricians, pathologists, psychiatrists, radiologists, surgeons, etc.

Figure 2  
Medical Corps Milestones

Captain

Internship  
AMEDD Officers' Basic Course  
Combat Casualty Care Course  
Advanced Trauma Life Support Course  
Expert Field Medical Badge  
Aviation Medicine Short Course

Major

Residency  
AMEDD Officers' Advanced Course  
Board Certification  
Management Course

Fellowship

Command & General Staff College

Executive Management

Masters in Health Care Administration

Senior Service College