SECURITY CLASSIFICATION OF THIS PAGE

DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

AD-A209 608

1b. RESTRICTIVE MARKINGS
N/A

3. DISTRIBUTION/AVAILABILITY OF REPORT

2b. DECLASSIFICATION/DOWNGRADING SCHEDULE
N/A

4. PERFORMING ORGANIZATION REPORT NUMBER(S)
59-89

5. MONITORING ORGANIZATION REPORT NUMBER(S)

6a. NAME OF PERFORMING ORGANIZATION	6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION
Eisenhower Army Medical Center	HSHF-DCA/CS-R	U.S. Army-Baylor University Graduate Program in Health Care Administration

6c. ADDRESS (City, State, and ZIP Code)	7b. ADDRESS (City, State, and ZIP Code)
Fort Gordon, GA 30905-5650	AHS San Antonio, Texas 78234-6100

8a. NAME OF FUNDING/SPONSORING ORGANIZATION	8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER

8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS			
	PROGRAM ELEMENT NO.	PROJECT NO.	TASK NO.	WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
A Study to Identify the Transitional Training Needs of United States Army Medical Residents

12. PERSONAL AUTHOR(S)
RAWLS, Edward Watson

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Final	FROM 7/87 TO 7/88	88 Jul 29	86

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	

19. ABSTRACT (Continue on reverse if necessary and identify by block number)
A study to determine the transitional training needs for graduating military medical residents and recommendations for model "Transition to Practice" programs within the Army Medical Department.

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS	N/A

22a. NAME OF RESPONSIBLE INDIVIDUAL	22b. TELEPHONE (Include Area Code)	22c. OFFICE SYMBOL
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DD Form 1473, JUN 86 *Previous editions are obsolete.* SECURITY CLASSIFICATION OF THIS PAGE

89 3 04

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A STUDY TO IDENTIFY
THE TRANSITIONAL TRAINING NEEDS
FOR UNITED STATES ARMY MEDICAL RESIDENTS

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

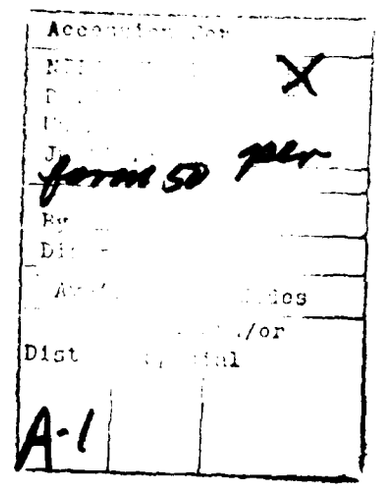
of

Master of Health Administration

by

Edward W. Rawls

Major, United States Army



July 1988

ACKNOWLEDGMENTS

To my loving

and very supportive family:

Kathy, Heather, and Ryan

Thank you.

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CHAPTER I - INTRODUCTION

Orientation

General

"Transition" is defined as passage from one state, stage, subject or place to another; a movement, development, or evolution from one form, stage, or style to another (Webster's 1254).

Each year, the Army has between four and five hundred physicians undergo developmental and maturational transitions as they graduate from their medical residency/intern programs and proceed to duty assignments. As they evolve from the role of apprentice to "solo" practitioner, they are transitioning into DIRECT responsibility for their actions--medical as well as non-medical. They have been intensely and expertly trained for the medical decisions they will make. Unfortunately, their preparation for the myriad of non-medical responsibilities has been greatly neglected.

Considering the variety of responsible roles that our newest physicians (i.e., newly graduated residents) can attain within our system, as well as the costly attrition rate of those who depart the military due to professional "frustrations" after their training obligations are fulfilled, it is surprising that so little attention has been devoted toward studying the manner in which we prepare physicians for practice within our military health delivery environment. Specifically, I know of no current effort under way to ascertain the transitional training needs for members of this most vital segment of the health care team.

The goal of this project is to design a study which can identify relevant program curricula which will be attractive to the graduating medical residents and at the same time meet important learning needs (both

institutional as well as personal). Ultimately, improved competence of physicians transitioning from residency to military "solo" practice is sought.

Problem Statement

To determine transitional training needs for graduating military medical residents and develop a model for "Transition to Practice" programs within the Army Medical Department.

Limitations

1. Due to the number of graduates involved and their diverse locations, a survey tool was developed and utilized in the research methodology. The survey population was limited to graduates from 1987 medical residency programs. The Office of Graduate Medical Education, Office of The Surgeon General, has recently automated graduate data. No centralized data base exists for year groups prior to 1987. Efforts to obtain listings from the individual Medical Centers (MEDCENs) had negative results.

2. The study was intended to identify administrative and personal learning needs as they relate to transition. Topics relating to clinical dimensions of practice were not addressed.

3. Supervisors of newly graduated residents could provide another dimension of institutional needs; however, this potential study population was too large [i.e., all Medical Department Activities (MEDDACs), MEDCENs, and separate clinics] and ill-defined (i.e., all clinical and/or administrative service chiefs) for the scope of this project. Additionally, their views would provide situational needs (based on local conditions or individuals), as opposed to systemic needs. It is felt that their concerns are adequately expressed through the design and conduct of their facilities' programs.

4. Implementation and reevaluation of a recommended model program will not be accomplished.

Literature Review

General

Within the civilian sector of medicine, the literature indicates that an interest was developing for some type of "transitional" training beginning in the early 1970s. This era corresponds to the increased involvement of physicians in health care management decisions, brought about by an intensified role of third-party payers and health-care-related litigations.

Since 1970, a variety of organizations (such as the American Academy of Family Physicians and the American Medical Association) has developed a number of one-day and week-long courses related to health care management for physicians (Detmer and Noren 641). While these seminars began to address physician management training needs through "practice management" workshops in the early 1970s, the issues continued to have only marginal interests from teaching institutions for nearly a decade.

In 1982, the hospital medical staff surveyed 28 U.S. graduate schools with programs in health care administration. They found that 10 of the 14 institutions that offered executive programs in health care management had experienced increased registration and/or interest by physicians. Usually, however, the programs continued to be of short duration (5 to 14 days in length) (Wilkinson 22).

Increasingly, health care organizations recognized the need for more effective management (Detmer and Noren 641); but unfortunately, the administrative skills which institutions needed were not being produced.

In 1983, Borus became outspokenly critical of the training deficit. "This current lack of emphasis on training in administrative areas seems out of step with the realities of practice in the 1980s" (444). Borus argued, "Administrative skills are not intrinsic and unteachable. Few are 'born administrators' and most can benefit from instruction in administrative principles and practices during residency" (444).

A focus began to turn toward residency programs to identify administrative training needs. In 1981, Breitweiser et al. conducted a survey of third-year family practice residents. They found that of the 717 responses received (a 35% response rate), none of the respondents had had high school business classes and 85% had had no undergraduate business classes; 87% had had no medical school lectures or seminars on business topics. Overall, 66% felt unprepared for independent practice in areas of employee payrolls/benefits, computers in medical offices, physician contracts, legal structures of medical practice, disability, overhead, and malpractice systems. At least one-half felt inadequately prepared in areas of hiring and firing of employees and employee staffing. (Breitweiser et al. 1063-64)

The training "needs" for medical professionals who are, as Detmer and Noren stated, ". . . capable of combining the sophisticated medical and technical knowledge of modern medicine with the administrative expertise for management of modern health delivery systems" (641) had begun to be documented.

Defining "Transition to Practice"

Terms such as "administrative medicine," "practice management," "executive skills," "transition stress," and "management development" are contemporary titles applied to transitional educational efforts offered

during residencies and through continuing medical education programs. "Practice management" is perhaps one of the most common.

Although it is recognized that a predictable transition period comes at the culmination of the prolonged formal medical educational process and helps determine the ways in which residents will use their extensive training, there has been surprisingly little attention paid to it in the professional literature (Borus 1513). Formalization of definitions and core curricula of established programs are still seen as largely a function of specialty and institution.

Opinions of Experts

Several experts in the field have offered their opinions reference transitional training requirements.

Dr. Merrill A. Anderson, from the University of South Carolina, feels that from his/her earliest experience, the resident must learn good record-keeping, efficient and effective time management, billing, and disease indexing, as well as the role played by third parties and how to make the best use of paraprofessionals and physician extenders. He further states that waiting until the last three to six months of a residency is too late. As a resident progresses through his training, experiences should be offered to him in the areas of accounting, data retrieval, budgets, personnel management, and other general aspects of operating a practice. The role of the faculty member is stressed. There must be a dedicated, enthusiastic, knowledgeable faculty. To properly prepare the residents, each program should have a faculty member responsible for a given area of curriculum. The program director and all faculty members must be strongly supportive of practice management or the resident will conclude that it is unimportant. There must also be time set aside in

the demanding residency schedule, an adequate budget, and experts in the areas where expertise is not available within the program's faculty. Again he emphasizes that the answer is not a two-day course offered in the resident's second or third year. This latter approach is used by some programs, but residents need and deserve much more during the comprehensive three-year curriculum (Anderson 1249-50).

Dr. Donald E. DeWitt, at the East Carolina University School of Medicine, recognizes that the residency program makes an excellent setting in which to teach practice management. He stresses that a resident's future practice must be concerned with fiscal health. DeWitt states that programs should include all of the administrative and financial aspects of care-giving that allow it to be medically comprehensive, to operate smoothly, and be financially sound. Other subject areas to be taught in a practice management course include fee-setting, accurate record-keeping, time management, office design, and staffing (DeWitt 160).

Dr. Jonathan F. Borus of the Harvard Medical School believes that transition sessions have often given residents their first real taste of the politics and hierarchy of institutions, the business end of practice, methods of seeking research support, and techniques for dealing with the bureaucracy of public or academic institutions or delivery systems. He feels that faculty should familiarize residents with the process of terminating their student roles, the decision-making tasks before them, the normality of associated stress, and methods used by previous students to actively cope with this transitional period. He notes that some "Transition to Practice" seminars have come to be known as "Reality Rounds" because of their focus on many real contemporary issues and problems (Borus 1513-16).

Sample Residency Training Programs

Regardless of expert opinions, survey findings show that premedical and medical students receive minimal business education, either by choice or by educational requirement. The responsibility for teaching practice management to the nation's new physicians falls to the residency programs (Breitweiser et al. 1064).

The majority of literature identified with the subject appears to be in the specialties of Family Practice and Psychiatry (although some transitional training literature can also be found in the related professions of Nursing and Dentistry).

Family Practice. In 1982, the University of Wisconsin noted that more than 60% of its Family Practice residency graduates felt unprepared in administrative and financial aspects of practice. They have subsequently included legal aspects of practice, organizational dynamics, personnel issues, business records office management, etc., into their program (Hecht and Farrell 549).

At Miami Valley Hospital, Dayton, third-year Family Practice residents are combining their medical expertise with a didactic program called "Resident Business Management" (RBM). The program is a mandatory four-week rotation during which they spend from 4 to 10 hours daily sharpening business management skills. Residents spend only one-half day per week in the clinics during this rotation. During the program, they meet one-on-one with a wide spectrum of business professionals including bankers, lawyers, management consultants, personnel directors, office managers, and physicians in solo and group practices. Topics covered include practice organization, financial management, leadership development, office communications, professional and legal obligations,

and practice marketing. Because these newly trained physicians have learned practice management basics, it is believed they often establish sound practices in less time than physicians without management instruction. The sooner they establish financially viable practices, the sooner the physicians, their patients, and the hospitals benefit (Prahl and Moore 56).

Psychiatry. Not surprisingly, Psychiatrists have looked closely at the stress factors involved with transition to practice. One report in the American Journal of Psychiatry in 1980 indicated "alarming symptoms" of stress during this period. The most effective coping mechanisms were found to be those involving the establishment of support systems with loved ones (Looney et al. 32).

Borus' review of the literature revealed only a single formal faculty program to facilitate residents' transition from training to psychiatric practice (Borus 1978, 1513). In a separate study, Borus found less than one-third of psychiatric residency programs offering any didactic instruction or seminars on quality assurance and personnel management. Less than one-fourth taught budgeting, accreditation standards, or resource allocation. As of 1983, less than one-third of residency programs required core training in administrative aspects of practice. The teaching of administration in Psychiatry, as an important aspect of residency training, has been generally overlooked and underemphasized (Borus 1983, 444).

Purpose/Objective of Transition Training

When attempting to evaluate the civilian sector's attempts at a transitional training "program," one must try to decipher the purpose or objectives of such. Again, a wide range of opinions are to be found.

Breitweiser's survey suggests that current residency efforts are inadequate and that closer scrutiny would be needed "to meet the objective of such training for all residents: adequate preparation for medical office practice in its various forms" (Breitweiser et al. 1064).

More specific goals can be found, especially with regard to fiscal awareness and resource utilization. Following a study which concluded that a sound knowledge of medical costs can lead to decreased utilization of tests (up to 30%) without adverse outcomes of care, Dresnick et al. advised that cost awareness should be included in medical school curricula and residency programs. They felt that teaching institutions have an obligation to teach not only the latest in medical knowledge, but also to teach the indications of tests and procedures with consideration to risks, benefits, and costs (Dresnick et al. 1607).

I prefer an educational goal as described by Borus, in that the new physician "should be able to work harmoniously with other professionals and rationally allocate clinical resources for effective patient care" (Borus 1983, 444). He also includes an associated goal of lessening "the confusion about, and frustration with, the administrative sides of their professional roles" (444).

Regardless of ultimate objectives, truly successful planners of any transitional program must design one which will be attractive to physicians and at the same time meet important learning needs and ultimately improve physician competence (Laxdal 827).

The Army Experience

In the Department of the Army, physicians occupy key executive management positions. Administrative educational experiences for Army Medical Corps personnel are limited. Senior ranking officers may acquire management skills

as a result of assignment experiences, executive seminars, and continuing professional education courses. Unfortunately, many physicians are placed into positions requiring administrative management skills immediately following graduation from residency programs. Colonel James J. James, Chief of the Army's Medical Corps Branch, stated in a transition seminar at Dwight David Eisenhower Army Medical Center (DDEAMC) in April of 1988 that the Army is currently experiencing a doctor shortage in middle management levels. There are not enough senior Majors and Lieutenant Colonels. Therefore, more graduating residents are assuming significant management roles immediately upon graduation. In the military, there is little evidence that a valid needs assessment has been recently conducted to evaluate the adequacy of administrative practicums offered to these persons.

Within the military, original "Transition to Practice" efforts were designed for post-Vietnam-era physicians who lacked military training and who had not attended the Officer Basic Course. Subsequent higher physician retention rates and increased recruitment of physicians with prior military experiences mandated a different program direction. A model program was designed at Letterman Army Medical Center, under (then) Brigadier General Floyd Baker, during 1980-1981. The program was developed as a three-day seminar to assist graduating medical residents in their transition from a clinically intensive training environment into the realities of practicing medicine in the Army medical system. Goals and curriculum for this seminar incorporated findings derived from two surveys. Questionnaires sent to 20 senior MEDDAC Commanders indicated the health care command structure felt that graduating residents lacked educational training in the areas of administrative skills, adjustment to limited ancillary support, the medical

profiling system, and the role responsibilities of the officer/physician. Surveys of 1979 and 1980 Letterman residency graduates indicated their perceived educational needs to be in the coordination requirements for support activities and interactions with non-medical staff. The two surveys documented a real need for better preparation of medical graduates for the myriad of administrative duties and management tasks they would face in practice. General Baker presented the findings of this research and provided an overview of the Letterman transition program to the 1981 Health Services Commander's Conference.

Subsequent to this conference, the other major teaching facilities (a total of eight Army Medical Centers) have incorporated some form of "Transition to Practice" programs. The seven-year development of these programs can be described as decentralized and reflective of the concerns of the individual Commanders and their staffs. Consequently, the context and duration of the programs, as well as presentation methodologies, vary considerably among the eight teaching centers. Collectively, the programs could be viewed as representing the Army's institutional goals, objectives, and methodologies as they relate to transitioning our physicians into the military practice environment. A review of the existing programs offers an excellent opportunity to examine the contemporary institutional training needs and concerns of our system.

Because the programs are facility-specific in design, the approximately five hundred medical residents who graduated last summer received varying degrees of exposures to a variety of transitional issues. With the exception of individual course critiques, there is no evidence that the perceived transitional needs of the medical graduates (the learner population or a consumer public) have been collectively studied. Educational literature

persistently emphasizes the need for such assessments. Houle states that, "Since men and women know what they need to learn, the task of the educator of adults is to discover what it is and provide it for them" (Kaufman et al. 17).

Collectively, the military provides one of the largest medical training establishments in the country. In order to maintain its long-standing tradition of training excellence and to continue to produce leaders in medicine, the system must continuously evaluate its educational goals, objectives, and methodologies. To that end, identification of learner needs is likely to result in more relevant program offerings with a concomitant efficient use of time and monetary and personnel resources (Smith et al. 1980, 40).

Research Methodology

General

Transitional learning needs were assessed utilizing institutional (educator) programs as well as resident graduates' (learner) perceptions.

Evaluation of Institutional Needs

Since presently there exists no standardized program within the Army for transitional training, it was felt that a collective analysis of syllabi from the major teaching facilities would provide a paradigm of institutional needs. Subsequently, "Transition to Practice" and orientation programs were requested and received from all eight United States Army Medical Centers during the fall of 1987.

In order to be considered as an educator need, and to qualify as a distinct institutional concern or training need, a functional area had to be clearly discernible in at least two of the eight MEDCEN programs.

Furthermore, since "time" is generally accepted as being an element of expense, the allocation of this resource could be considered as reflective of institutional priority. Therefore, following identification of the various functional needs areas, didactic times allocated (by topic and by facility) were discerned. A minimum of thirty minutes had to be allocated for the instructional area for inclusion into the data base.

Evaluation of Graduate Needs

Survey design. Needs of learners were assessed utilizing survey questionnaires. Following recommendations of researched literature (Smith et al. and Laxdal), survey design stressed clarity (for both respondent and data interpretation) and brevity (to assist with potential response rates).

To allow for evaluation of potential confounding variables, demographic data were requested to include institutional affiliation (MEDDAC, MEDCEN, or other), geographical assignment (overseas or CONUS), self-perceived administrative responsibilities (on a five-point Likert scale ranging from light = 1 to heavy = 5), years of military service, and medical specialty.

Questions on perceived needs were designed using topics identified from the institutional evaluations. Respondents were requested to indicate their perceived level of "need" for each given area of training. "Need" was measured on a five-point Likert scale. The Likert scale format allows for a significant discrimination of the intensity of a respondent's belief regarding an issue (Mangelsdorff 35). Responses could range from "no need" (a value of 1) to "critical need" (a value of 5). A response of "neutral" was permissible and was weighted with the median value of 3.

For responses other than "no need," respondents were requested to designate a preference as to when instruction in the particular topic should be received. Three periods of possible educational exposure were offered: instruction throughout residency, instruction just prior to graduation, or instruction upon arrival at a new duty station. At present, all MEDCENs concentrate on seminars near the close of residency. In the near future, Health Services Command intends to place transitional training responsibility and emphasis at the receiving facility level. Most medical facilities now have some form of site-specific newcomers' orientation program. The military's time preference for transitional training appears to contrast with that of civilian institutions. Literature pertaining to the civilian sector indicates a significant need to have future physicians exposed to transitional issues throughout the residency cycle (Anderson, Borus, and Breitweiser to name a few). It was hoped that the survey tool would provide indications as to the preferences of the military learner population.

An opportunity was also offered for the respondent to offer additional suggestions and/or comments which he/she felt to be relevant.

An introductory cover letter was designed for the survey. To achieve a favorable response rate, it was felt that this document had to be carefully constructed. Brevity, explanation of the need for assistance, the potential for benefit, and a personalized appreciation on the part of the surveyor were points stressed. To preclude an impression that they were receiving "just another computerized form letter," each document was signed in blue ink and a personalized "Thanks" was affixed. A sample of the survey and introductory letter is contained in Appendix A.

Target population. Assistance in identification of graduates was requested from the Office of Graduate Medical Education, Office of The Surgeon General. A list, by name and specialty, was also obtained which indicated 501 graduates completed training during 1987. This roster was matched with a Medical Corps "Alpha" roster dated 9 February 1988. Subsequent updated addresses and ranks of the graduates were obtained from this document.

Pre-testing. During the last week of March 1988, the survey was pre-tested on those 1987 graduated residents who had been subsequently assigned to DDEAMC. Pre-test assistance and advice was also obtained from the Director of Medical Education and several other senior teaching staff members. Modifications deemed necessary were minor, and the DDEAMC responses were ultimately included directly into the cumulative results.

Response rates. The final surveys were mailed out in mid-April. There were 107 addresses in overseas locations; 180 were in the eight major MEDCENs; 179 were at CONUS MEDDAC locations; 26 were in miscellaneous other CONUS sites; and 9 graduates had only "en route" listed for addresses.

Of the 492 surveys mailed, 26 were returned due to insufficient address or inability to locate. Therefore, of the 501 potential respondents, 466 may potentially have reached their destinations.

Subsequently, 232 completed responses were received prior to data compilation (n = 232). With a target population of 501 (N = 501), this represents an overall response rate of 46.3%. Overseas response rate was 52.3% (n = 56) and CONUS responses were 45.7% (n = 176).

Data compilation. Institutional needs data, resulting from program reviews, were compiled and displayed utilizing a Commodore 64 microcomputer.

The software package utilized was the "Graphics Environmental Operating System" (GEOS), version 1.2.

Responses from survey questionnaires were entered into a MacIntosh II microcomputer (with 40-megabyte hard-disk drive). Utilizing "Micro-Soft Works," version 1.1, a data base was designed for initial data array, with subsequent numerical calculations being accomplished through spreadsheet applications. Graphic displays for survey responses were obtained from the same software package.

CHAPTER II - DISCUSSION

Institutional Evaluation

General

The 1987 "Transition to Practice" programs from the eight major Army teaching facilities were evaluated in order to ascertain functional areas of transitional training offered. Additionally, the relative priorities, expressed as a function of didactic time devoted to each of the defined areas, were determined.

The eight programs varied both in terms of course duration and modalities of presentation. None of the programs exceeded a week in length. Instructional methodologies normally incorporated a mixture of lecture presentations and panel discussions.

The range of time devoted specifically to transition training was from 645 didactic hours at Fitzsimons Army Medical Center to 1185 hours at Letterman Army Medical Center (the first site to present a formalized program). The average time for all programs was 855.6 didactic hours. Times allocated for registrations, introductions, meals, and social events were not considered in the program evaluations.

Appendix B-1 through B-8 reflects a breakdown of educational areas presented by each of the eight major facilities. Functional training areas are first listed in the order in which they were presented. Functional areas are then arrayed according to the percentage of didactic time devoted to the topic. Appendix C provides a summarization of didactic times allocated by the various programs.

Seventeen functional training areas were defined. To be considered representative of an institutional area of concern, the functional area had to be clearly discernible in at least two of the eight MEDCEN programs.

Those topics which were only found in singular locations or were too ill-defined in the programs' literature to allow for classification were placed into a miscellaneous (eighteenth) category. Each of the eighteen categories will be discussed on the following pages. There is no significance as to the order in which they are presented.

Functional Training Areas Defined

1. Organization/Structure (ORG): This category of instruction evolves around topics which address institutional relationships and interactions which are internal to the Army Medical Department. Instructional periods which could be classified in this category include presentations on departmental responsibilities; ancillary support functions; MEDCEN, MEDDAC, and clinic operations and structures; and FORSCOM, TRADOC, and other medical TDA units. Fundamentally, "Organization/Structure" addresses issues of how the Army Medical Department mechanically functions within its bureaucratic design.

2. Patient Administration (PAD): These are areas which are routinely found within standard Patient Administration Divisions of fixed medical facilities. As a focal point around which a myriad of administrative patient activities revolve, they address a broad scope of issues. Presentation topics could include discussions on CHAMPUS; the physical disability and evaluation process (medical boards); profiles; release of medical information; and nonavailability statements. Emphasis on medical records management could be routinely found in the various curricula. Often, the Patient Administration presentations were considerably detailed with respect to their content.

3. Quality Assurance/Risk Management (QA/RM): It was clearly evident that institutions felt an obligation to prepare physicians for the myriad of professional and hospital committees which would face them in the near future. As residents, their participation and/or responsibilities with respect to organizational reviews were limited. Occurrence screening, credentialing, and medical-legal issues are the predominant issues covered. There is an important distinction in the latter in that it pertains to legal issues directly associated with the military litigation process. Civilian "malpractice" issues (e.g., insurance, monetary awards, legal "trickery," etc.) were often found in guest speaker presentations.

4. Resources Management (RMD): Selected presentations in this topic area could include manpower/force development, hospital finance systems overviews, comptroller responsibilities, manpower authorizations/ requirements, and Medical Care Composite Units. Even with the pending conversion to diagnostic related groups (DRGs), there was little attention given toward orienting new physicians on DRGs and their subsequent impact on facility resources. Basically, this classification covers the fiscal and personnel issues found in our health care system, demonstrating how our resources are allocated and why there is often "less than desired" support available.

5. Logistics (LOG): Classic Army medical logistics functions are found in this classification. Supply and property management, medical equipment procurements, MEDCASE, CEEP, and the Medical Benefits Program are a few examples. A basic knowledge of the medical logistics system would allow provider managers the ability to requisition and receive required materiel in a timely manner and possibly avoid many of the

frustrations commonly experienced by new physicians arriving at facilities with "less than optimal" equipment.

6. Civilian Personnel (CPO): This area is concerned with management of the civilian work force. Specific topics could be performance appraisals, awards, leaves, counselings, and hire and fire actions. With the exception of previously having the need for occasional clerical support and realizing the shortage of civilian aides and nurses on the wards, most residents have had no experience with the mechanics and responsibilities involved with civilian staffing.

7. Military Personnel (MILPO): These are topics addressing the peculiarities of managing soldiers. Officer Evaluation Reports, Enlisted Efficiency Reports, awards and decorations, and punishments are some of the potential classes. Selected areas could also include discussions on enlisted/NCO roles. Although this topic area is presented during Basic Officer training, the skills may not be of great significance during the several years of residency, thus are likely forgotten.

8. Judge Advocate (JAG): This classification includes areas of military judicial actions, medical-legal ethics, and standards of conduct. Although dedicated legal support is usually found within the major Medical Department Activities, smaller facilities often derive their support from host installation Staff Judge Advocates. As a rule, malpractice discussion was not included in this category of training.

9. Information Management (IMD): This classification deals with automation in military medicine. Tri-Service Medical Information Systems (TRIMIS), Composite Health Care System (CHCS), and automated workload management were the primary topics. Realistically, a firm understanding of medical automated support systems must be preceded by basic knowledge

of the functional areas to be supported. For example, the Defense Eligibility Enrollment Registration System (DEERS) would mean little to those who are not aware of beneficiary requirements and entitlements to care. Likewise, an understanding of workload accountability systems must be predicated on fundamental knowledge of resource management.

10. Inspector General (IG): Inspections and compliance standards, as well as grievance procedures, are covered within this category. It is worth noting that recently the Department of the Army has moved away from a centralized IG inspection system. Inspections will henceforth be major "Command Inspection Programs." The nature of this functional area will change, and the future directions of emphasis in this area are not known at this time.

11. Joint Commission on Accreditation of Healthcare Organizations (JCAHO): These are the requirements, criteria, and inspection methodologies as they relate to this voluntary national organization. A military physician's impact on organizational functions and standards could be viewed as much more direct than that of solo civilian practitioners with staff privileges. By nature of its organizational design, the Army medical staff has a much closer involvement in overall hospital functions and operations. Consequently, our physicians must receive orientation to the institutional standards they will face in the future.

12. Professional Perspectives (PRO VIEWS): These were presentations typically given by senior physicians who occupy positions of considerable administrative responsibilities. The discussions generally concerned the roles, responsibilities, and expectations of the military phvsician. Emphasis was placed on the distinctions of military medicine with its multiple opportunities to pursue dual careers as both a doctor and soldier.

13. Line Perspectives (LINE VIEWS): This topic covers the roles, relationships, and responsibilities of the military physician as viewed by other, non-medical branches of the service. Often, presentations were in panel format with both officers and enlisted. Major efforts were made to have the graduating residents understand how they fit in the overall military scheme, particularly how they realistically impact on operational aspects such as physical training and profiles, training time versus efficient sick call systems, the soldiers' morale as affected by care rendered to families, etc. Communications between the physician and unit commanders or First Sergeants were frequently stressed.

14. Graduate Perspectives (GRAD VIEWS): These presentations by recent medical resident graduates reflected views of their personal practical transition to practice. Although usually based upon particular situational environments, recent graduate perspectives provide a forum for discussions which can assist in alleviating many transitional anxieties. This category of instruction can also serve to reinforce the importance of certain areas which may presently seem irrelevant to many residents.

15. Career (CAREER): This functional classification concerns matters pertaining to military career development and progression as they relate to physicians. Topics routinely include promotions, incentive pay, rating schemes, and attendance at professional schooling. Forecasts as to rank structures of the Army Medical Corps are often included.

16. Permanent Change of Station (PCS): These presentations relate to the practical aspects of military moves. Transportation, housing, dislocation allowances, PCS orders, and preparation for overseas movement are the predominant subjects. Most institutions allocated additional time for those soldiers deploying to overseas locations. As a rule, these

periods of instruction were devoted to the details of "how to" accomplish the move. It is interesting to note that some residents have not yet received orders or may not know the location of their pending assignment at the time of the transition seminars.

17. Spouses (SPOUSES): This category of training includes courses specifically tailored to assist spouses with their peculiar transitional issues. Stress management, social expectations and obligations, potential child transition problems, etc., are some of the topics to be found in this classification. Although a number of programs invited spouses to attend part or all of the presentations, this category only includes time specifically designated for the military spouses.

18. Miscellaneous: A significant portion (10.99%) of all programs were not clearly discernible as belonging to any of the above classifications. Frequently, these were guest speakers presenting topics of contemporary medical interest. Direct correlation to military medicine and/or transitional issues was seldom recognizable in these program texts. Contemporary civilian medical issues (e.g., the future impact of AIDS, professional ethics, participation in professional organizations, etc.) and human behavioral topics related to stress management were among the popular topics addressed. In general, the "miscellaneous" presentations were inserted to assist with increasing the interest levels of the attendees.

Summary of Institutional Categories of Training

Appendix C contains information which summarizes the documentation review of the eight MEDCEN transition programs.

A collective review of the eight MEDCEN "Transition to Practice" programs clearly indicates that there are several training priorities which can be discerned. Organization/Structure, Permanent Change of Station, and Quality Assurance/Risk Management each derive greater than 10% of the cumulative time devoted (expressed in percentage of didactic time). These functional areas are also present in each MEDCEN program. There appears to be a mid-range of topics which demanded a respectful percentage of institutional attention. These were Patient Administration, Military Personnel, Professional Perspectives, and Line Perspectives. These functional areas each represented between 5% and 10% of total didactic times and were to be found in five or more facility programs. The remaining ten functional areas each represent less than 5% didactic time devoted, and consistent inclusion by all MEDCENs is generally not demonstrated.

In addition to providing some indication of an "institutional" view on transitional training requirements, analysis of the teaching facilities' programs also provided an excellent foundation for the design of a survey tool. The resultant questionnaire provided considerable insight as to the perspectives of those individuals who attended the various programs.

Training Needs as Expressed by Demographic Stratifications

General

Attempting to categorize human beings is a risky and often futile undertaking. Among physicians transitioning into practice, it was felt that five common factors might have some influence on the perceived training needs expressed by respondents. Responses for the seventeen training areas (previously identified through review of institutional programs) were stratified by the respondents' medical specialty, assignment (MEDDAC, MEDCEN, or other), location (overseas or CONUS), years of military service, and their self-perceived levels of administrative responsibilities. Each of these artificial classifications will be addressed separately in the following sections. Applicable tables and/or illustrations follow the discussions of each cohort

Needs Expressed by Specialty

Respondents could be clearly divided into eleven distinct medical specialties. Unfortunately, with a sample size of 232, stratification into eleven categories presents only limited data for evaluation. Only four contained sample sizes of greater than twenty. Only two of these specialty samples exceeded thirty, at which point the central limits theorem could be reasonably applied.

No acceptable criteria could be found in the literature review which would allow for larger categorization of these specialties. Realistic observations of deviations due to specialty should await a larger data base. Figure 1 displays the results obtained on the eleven specialties. Figure 2 compares results obtained from the four largest sample specialties.

NEEDS EXPRESSED BY MEDICAL SPECIALTY

SPECIALTY	(n)	OR6	std dev	PAD	std dev	QA/RM	std dev	RMD	std dev	LO6	std dev
Family Pract	27	3.7037	0.76	4.0741	0.60	4.1852	0.77	3.1111	0 96	3.2963	1 08
Medicine	59	3.4915	0.87	4.1525	0.99	3.8644	0.88	3.2203	1.37	3.5593	1.26
OB/GYN	12	3.6667	0.85	3.7500	1.01	4.0833	0.86	3.0833	1.11	3.6667	1.03
Pathology	12	3.6667	0.94	3.0833	1.04	4.5000	0.65	4.0000	0.91	3.8333	0.99
Pediatrics	28	3.7500	0.63	3.9286	0.70	4.2500	0.51	3.2857	0.92	3.6429	0.97
Psychiatry	13	3.9231	1.00	4.3846	0.49	4.0000	0.96	3.1538	0 95	3.2308	1.05
Radiology	6	3.6667	0.94	3.1667	1.07	3.8333	1.07	3.8333	1.21	3.8333	1.07
Surgery	49	3.3673	0.94	4.1633	0.87	4.1020	0.79	3.4694	1 20	3.8776	0 96
E.R.	14	3.6429	0.89	3.5000	0.82	4.2143	0.56	3.6429	0.89	3.1429	0 99
Prev Med	3	3.3333	0 94	2.6667	1.22	2.6667	1.57	4.0000	1 10	3.3333	1 00
Anesthesia	9	3.7778	0.92	4.0000	0.82	3.8889	1.10	3.5556		4.1111	0 57
TOTAL	232	3.5862	0 89	3.9655	0.90	4.0560	0 88	3.3621	1 12	3.6078	1.05

SPECIALTY	(n)	CPO	std dev	MILPO	std dev	JA6	std dev	IMD	std dev	I6	std dev
Family Pract	27	3 4444	1 13	3 9259	0.86	3.6667	0.86	3.1111	1 03	3.4074	1 03
Medicine	59	3.3390	1.22	3.6441	1.06	3.2542	1 11	2 7966	1 05	3.0339	0 88
OB/GYN	12	2.7500	1 42	3.4167	1.04	3.6667	0.94	3.5000	1 19	2 8333	0.90
Pathology	12	3 6667	0 85	3 8333	0 80	3 1667	0 90	3.8333	0.99	3 0833	0 76
Pediatrics	28	3.4643	1 12	3 6786	0 80	3 6786	0 97	3 0714	1 07	3 1071	1.01
Psychiatry	13	3 1538	0 86	4.2308	0 80	4 0769	0 73	3.3077	1 14	3.0769	0 92
Radiology	6	3.6667	1 25	3.6667	0 94	2 8333	1 34	3 1667	0 90	3.5000	0 96
Surgery	49	3.1429	1 01	3.6122	1.01	3 2653	1 06	2 8776	1.08	2 9592	1 01
E.R.	14	3 5000	0 82	4.0000	0 38	3.6429	0 81	3 4286	0 82	3 3571	0 89
Prev Med	3	4.0000	0 94	3.6667	1 22	3.0000	1 19	2 6667	1 23	3 0000	1 10
Anesthesia	9	3 3333	1 25	4 3333	0 67	3 8889	0 74	3 3333	0 94	3 6667	0 82
TOTAL	232	3 3276	1 11	3 7543	0 95	3 4526	1 02	3 0690	1 08	3 1207	0 97

SPECIALTY	(n)	JCAHO	std dev	PRO-VIEWS	std dev	LINE-VIEWS	std dev	GRAD-VIEWS	std dev	CAREER	std dev
Family Pract	27	3.4074	0 95	3 5769	1 12	3 6296	0 95	3 5185	1.03	3 7778	0 79
Medicine	59	3.5424	1.00	3.2542	1 04	3.0508	1.17	3 4237	0 99	3 6610	0.82
OB/GYN	12	3 4167	0 86	3.5000	1.04	3.2500	1 16	3.5000	1 04	4 0000	0 71
Pathology	12	4.1667	0 55	3.2500	0 92	2.6667	1 03	3.0000	0.82	3 5000	0 87
Pediatrics	28	3 5000	1.09	3.2857	0.99	3 4286	0.82	3 6071	0 90	3 7500	0 57
Psychiatry	13	3.8462	0.66	4 0000	0.55	3.9231	1 00	3 8462	0 66	4 0769	0 92
Radiology	6	3 5000	1 50	3.1667	1 21	3.3333	1 37	3 0000	1 15	3 6667	1 37
Surgery	49	3 5306	0 95	2 9184	1 24	3.0204	1 04	3 1837	1 10	3 5918	1 12
E.R.	14	4 0714	1.03	3 4286	0 73	3 4286	0 49	3.5000	0 91	3.7143	0 96
Prev Med	3	2.6667	1 35	2.6667	1 35	3 3333	1 30	2 0000	1 49	4 0000	1 24
Anesthesia	9	4 1111	0 74	3.8889	1 20	4.1111	0 87	4.0000	0 94	4 4444	0 68
TOTAL	232	3 6034	1.00	3 3030	1 14	3 2716	1 08	3 4095	1 03	3 7414	0 93

SPECIALTY	(n)	P.C.S.	std dev	SPOUSES	std dev	Admin	Avg Yrs Svc
Family Pract	27	4 2593	0 84	4 1111	0 87	3 1481	6 2222
Medicine	59	4.3559	0 77	3 5690	1 08	2 8136	7 1356
OB/GYN	12	4.1667	0 69	4 2500	0 60	3 0833	7 5833
Pathology	12	4.0833	1 09	3 7500	1.09	3 5833	8 2500
Pediatrics	28	4.2143	0 56	3.7857	0.86	2 8571	6 1786
Psychiatry	13	4.2308	0.70	4.0769	0 83	3.0769	9.0769
Radiology	6	4.5000	0 50	3.6667	1 37	2 8333	8 3333
Surgery	49	3.9796	0.98	3.4490	1 16	3 1429	8 1837
E.R.	14	4.0714	0.96	3.4286	1.05	3 3571	6 5000
Prev Med	3	3.0000	1.50	2.3333	1.23	3 6667	10 0000
Anesthesia	9	4.4444	1.26	3.5556	1.17	2.7778	7 0000
TOTAL	232	4.1897	0.85	3.6840	1.08	3.0388	7 3491

Fig. 1. Needs Expressed by Medical Specialty

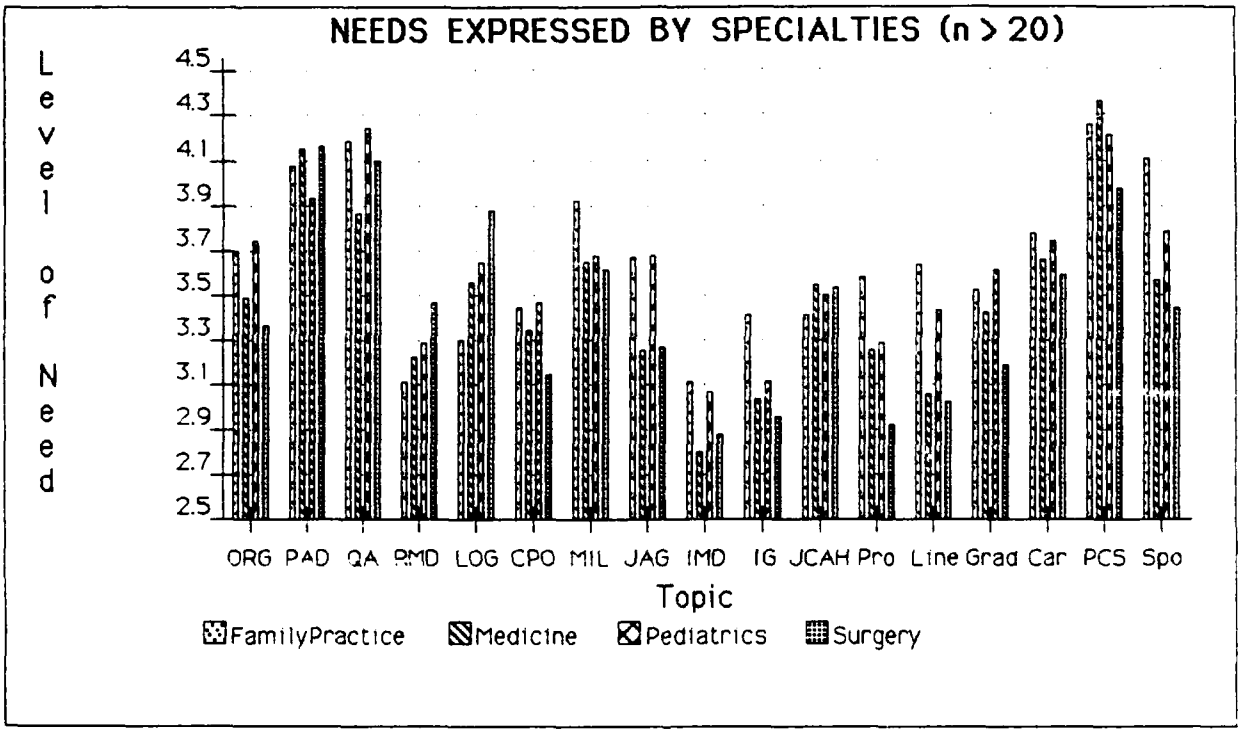


Fig. 2. Needs Expressed by Specialties

Needs Expressed by Assignment

Responses were stratified according to the assignment which followed residency training. The largest number of responses came from Medical Department Activities (MEDDACs) (n = 135). Medical Centers (MEDCENs) provided eighty responses. Seventeen responses were classified as "Other." The latter contained a mix of field TO&E assignments (e.g., Division Surgeons) as well as research/development and command staff positions.

As could be expected, the average years of service by category increased in the order previously given. MEDDACs, with average years of service at 7.06, are environments which emphasize primary care and are frequently first-assignment locations. MEDCENs represent tertiary, acute care settings and all have advanced teaching programs. Average years of service increased to 7.61. The specialized experience required by many assignments contained in the "Others" category is evidenced by average years of service at 7.35.

Of the three assignment categories, "Others" presented the highest degree of self-perceived administrative responsibilities. Those assigned to MEDCENs expressed the least degree of administrative burdens. Perhaps the latter is related to organizational size and staffing levels.

Figures 3 and 4 display data obtained from these three categories; however, the "Others" category is realistically too small and too ill-defined to merit further concerns at this time.

It appears that respondents assigned to MEDCENs and MEDDACs differ significantly in at least three areas of training needs. MEDCEN respondents demonstrate a stronger need for exposure to logistical functions and civilian personnel matters. The comparative size of a MEDCEN's bureaucracy, with its

corresponding elevation of frustration levels in these two areas, may contribute to these perceptions. Likewise, the smaller environment of a MEDDAC, where social interface may often play a more dominant role, could explain the MEDDAC respondents' higher desire for involvement of spouses in transitional training.

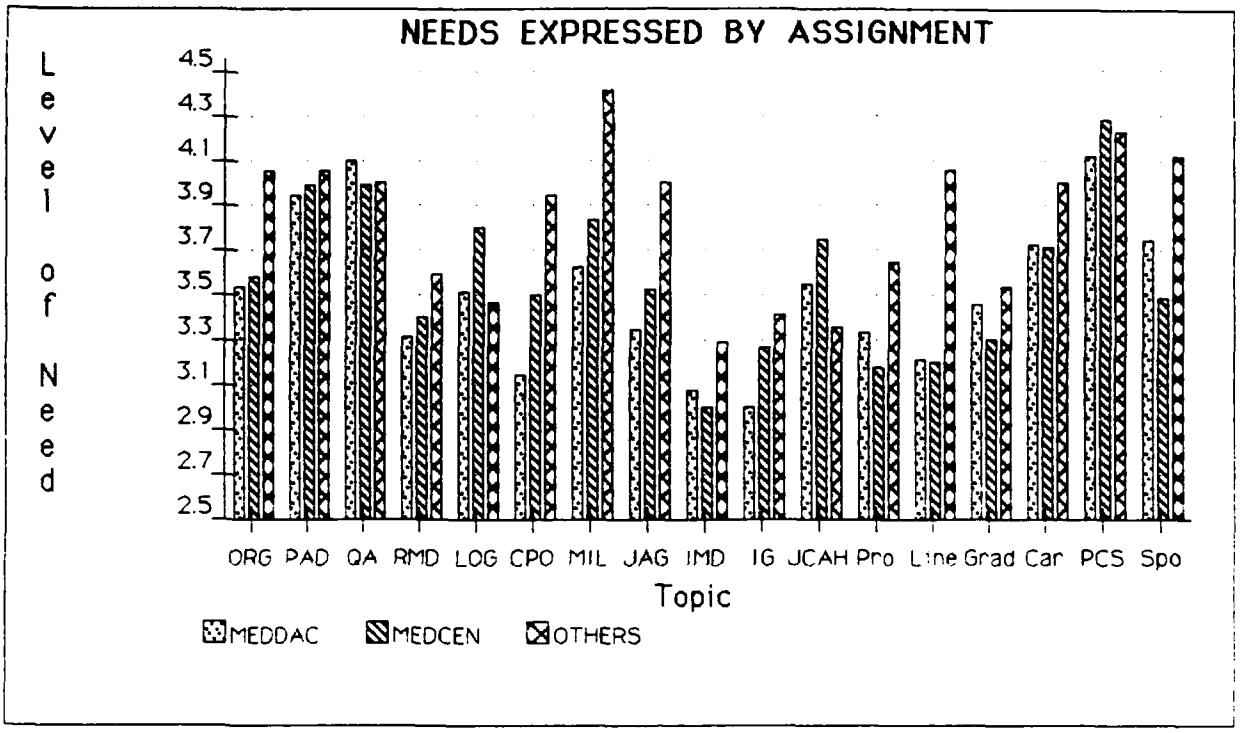


Fig. 3. Needs Expressed by Assignment

Respondent	(n)	Yrs Svc	Admin	ORG	std dev	PAD	std dev	QA Risk Man	std dev	RMD	std dev
MEDDAC	135	7.0593	3.11	3.5333	0.88	3.9407	0.88	4.1037	0.78	3.3111	1.11
MEDCEN	80	7.6125	2.75	3.5750	0.88	3.9875	0.96	3.9875	0.96	3.4000	1.17
OTHERS	17	8.4118	3.82	4.0588	0.87	4.0588	0.87	4.0000	1.19	3.5882	0.84
TOTAL	232	7.3491	3.04	3.5862	0.89	3.9655	0.90	4.0560	0.88	3.3621	1.12

Respondent	(n)	LOG	std dev	CPO	std dev	MILPO	std dev	JAG	std dev	IMD	std dev
MEDDAC	135	3.5111	1.08	3.1481	1.10	3.6222	0.94	3.3407	0.99	3.0815	1.11
MEDCEN	80	3.8000	0.99	3.5000	1.11	3.8375	0.94	3.5250	1.02	3.0000	1.07
OTHERS	17	3.4706	0.98	3.9412	0.80	4.4118	0.69	4.0000	0.97	3.2941	0.89
TOTAL	232	3.6078	1.05	3.3276	1.11	3.7543	0.95	3.4526	1.02	3.0690	1.08

Respondent	(n)	IG	std dev	JCAHO	std dev	Prof Views	std dev	Line Views	std dev	Grand Views	std dev
MEDDAC	135	3.0000	0.96	3.5481	1.00	3.3358	1.11	3.2148	1.08	3.4593	1.01
MEDCEN	80	3.2625	0.95	3.7500	0.99	3.1750	1.18	3.2000	1.05	3.3000	1.05
OTHERS	17	3.4118	0.97	3.3529	0.97	3.6471	1.08	4.0588	0.94	3.5294	1.04
TOTAL	232	3.1207	0.97	3.6034	1.00	3.3030	1.14	3.2716	1.08	3.4095	1.03

Respondent	(n)	Career	std dev	PCS	std dev	Spouses	std dev
MEDDAC	135	3.7259	0.91	4.1259	0.85	3.7407	1.03
MEDCEN	80	3.7125	0.98	4.2875	0.87	3.4937	1.16
OTHERS	17	4.0000	0.84	4.2353	0.73	4.1176	0.90
TOTAL	232	3.7414	0.93	4.1897	0.85	3.6840	1.08

Fig. 4. Summary of Data by Assignment

Needs Expressed by Location

Stratification of respondents by follow-on assignments in either the Continental United States (to include Alaska and Hawaii) or to overseas locations demonstrates some practical differences of opinions.

For the past several years, priorities have been given toward the funding and resourcing of overseas locations. Subsequently, CONUS respondents have been the primary recipients of resource constraints, thus a higher need for understanding of resource management functions. Similarly, with differences in constraints and utilization of the civilian work force, it is not surprising to see a higher interest in civilian personnel training coming from CONUS respondents.

The higher preferences expressed by CONUS doctors in the area of Joint Commission Accreditation standards likely stem from the fact that JCAHO standards are not required in overseas locations. Within CONUS, heavy command emphasis would be expected, especially in those facilities anticipating accreditation evaluations in the near future.

Considering the relative lack of advanced automation systems available in overseas locations, the higher training needs for information management systems expressed by CONUS respondents could be predictable. In their written comments, some overseas respondents mentioned they were not familiar with many of these systems. One could expect a higher need for automation training from the overseas cohort it proliferation of these support systems accelerates.

The higher need for professional perspectives demonstrated from CONUS is perplexing. It should be noted that the corresponding standard deviations for responses in this category are relatively high, so a higher dispersion of responses was experienced.

Overseas locations clearly felt stronger needs for training in two specific areas: PCS and Spouses. Although the reasons for such may be "intuitively obvious," they are certainly two points which should not be ignored in any transition program directed toward overseas-bound personnel.

Figures 5 and 6 summarize the data on needs expressed by location.

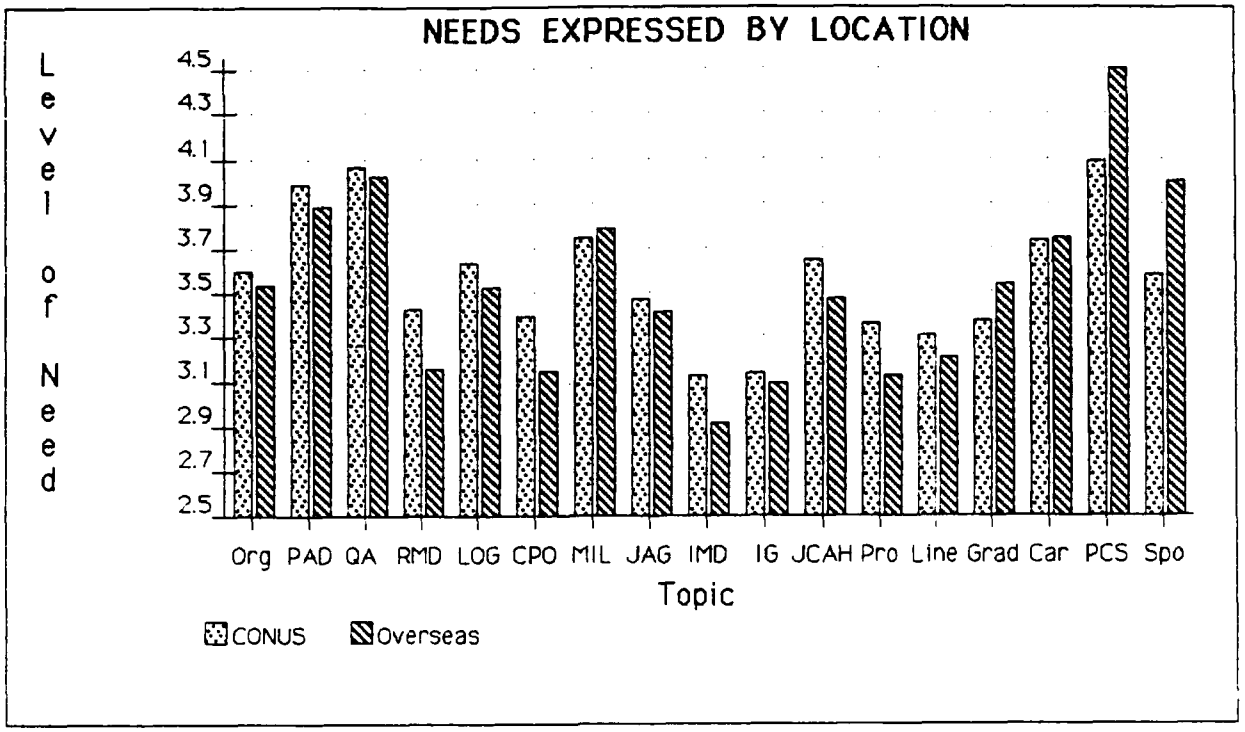


Fig. 5. Needs Expressed by Location

LOCATION	(n)	Yrs Svc	Admin I	Org	std dev	PAD	std dev	QA Risk Man	std dev	RMD	std dev
CONUS	176	7.5227	3.05	3.6023	0.88	3.9886	0.87	4.0682	0.86	3.4261	1.09
Overseas	56	6.8036	3.02	3.5357	0.94	3.8929	1.04	4.0179	0.99	3.1607	1.06
TOTAL	232	7.3491	3.04	3.5862	0.89	3.9655	0.90	4.0560	0.88	3.3621	1.12

LOCATION	(n)	Log	std dev	CPO	std dev	MILPO	std dev	JAG	std dev	IMD	std dev
CONUS	176	3.6364	1.04	3.3864	1.05	3.7443	0.91	3.4659	1.00	3.1193	1.09
Overseas	56	3.5179	1.07	3.1429	1.09	3.7857	0.94	3.4107	1.05	2.9107	1.17
TOTAL	232	3.6078	1.05	3.3276	1.11	3.7543	0.95	3.4526	1.02	3.0690	1.08

LOCATION	(n)	IG	std dev	JCAHO	std dev	Prof Views	std dev	Line Views	std dev	Grand Views	std dev
CONUS	176	3.1307	0.90	3.6477	0.99	3.3600	1.12	3.2955	1.07	3.3693	1.01
Overseas	56	3.0893	0.93	3.4643	1.00	3.1250	1.18	3.1964	1.19	3.5357	1.00
TOTAL	232	3.1207	0.97	3.6034	1.00	3.3030	1.14	3.2716	1.08	3.4095	1.03

LOCATION	(n)	Career	std dev	PCS	std dev	Spouses	std dev
CONUS	176	3.7386	0.94	4.0909	0.89	3.5829	1.11
Overseas	56	3.7500	1.00	4.5000	1.11	4.0000	1.17
TOTAL	232	3.7414	0.93	4.1897	0.85	3.6840	1.08

Fig. 6. Summary of Data by Location

Needs Expressed by Years of Service

The years of military service achieved by the respondents (as of the survey date) were broken down artifically into three groupings. It was felt that one to four years of service was indicative of junior officers with no more than one full PCS experience. The category of five to nine years clearly contained the average (at 7.35) and allowed for "some" previous military experience. Finally, true veterans of multiple transitional issues could be found in those respondents with ten or more years of service.

Training categories of Patient Administration, Quality Assurance/ Risk Management, Logistics, and Military Personnel are dominated by the needs as expressed by the ten-plus-year group. If one truly believes that wisdom is a function of time and experience, then such priorities are certainly to be considered.

Conversely, perhaps the relative inexperience of the one-to-four-year group explains the slightly higher concerns expressed by this cohort for IG and JCAHO issues. These "compliance-oriented" areas demonstrate a decreased concern on the part of the physicians as their experience level increases.

It is noteworthy that all three time frames demonstrate very similar responses for career training exposure. This category of training showed strong need with a mean of 3.74 and a stable overall standard deviation of 0.93.

Figures 7 and 8 summarize the data on needs expressed by years of service.

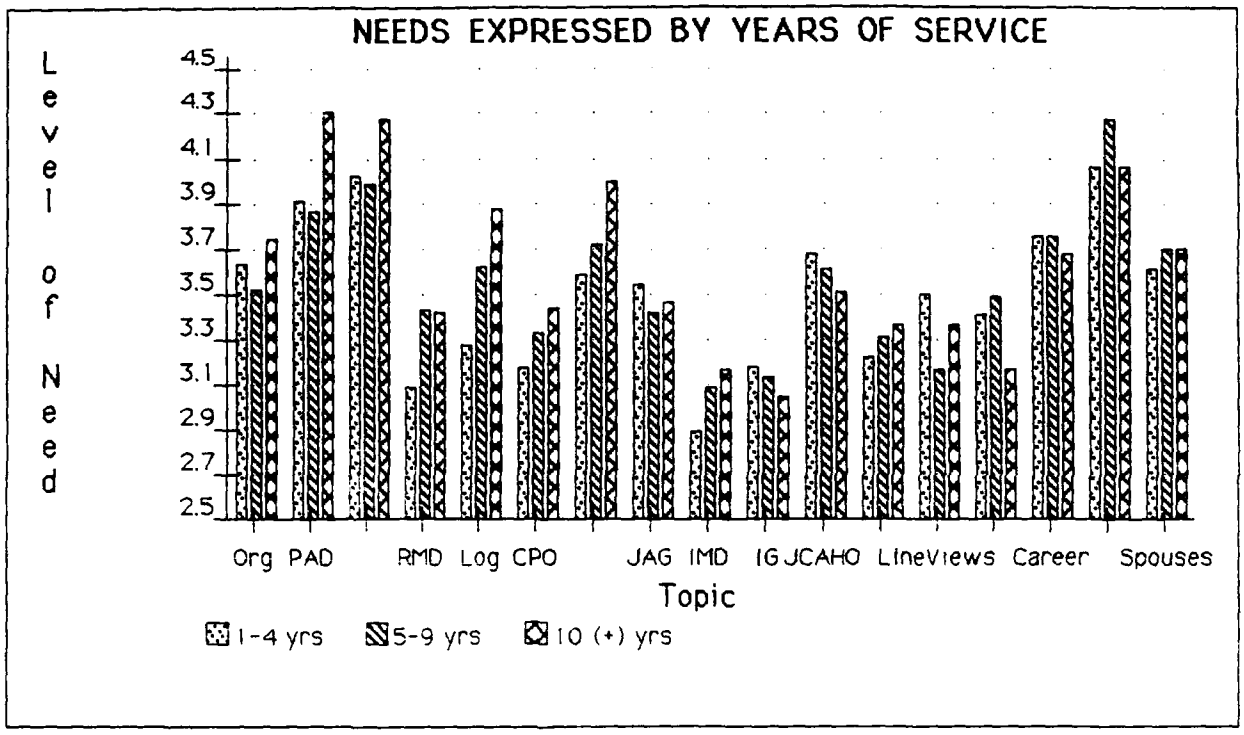


Fig. 7. Needs Expressed by Years of Service

Yrs Svc	(n)	Admin Resp		Org	std dev	PAD	std dev	QA Risk Man	std dev	RMD	std dev
1-4	47	2.9130		3.6304	0.82	3.9130	0.88	4.0217	0.82	3.0870	1.10
5-9	139	2.9928		3.5180	0.93	3.8705	0.96	3.9928	0.95	3.4317	1.13
10 (+)	46	3.2979		3.7447	0.81	4.2979	0.65	4.2766	0.67	3.4255	1.05
TOTAL	232	3.0388		3.5862	0.89	3.9655	0.90	4.0560	0.88	3.3621	1.12

Yrs Svc	(n)	Log	std dev	CPO	std dev	MILPO	std dev	JAG	std dev	IMD	std dev
1-4	47	3.2826	1.19	3.1739	1.22	3.5870	1.01	3.5435	1.02	2.8913	1.00
5-9	139	3.6259	1.01	3.3381	1.10	3.7266	0.99	3.4173	1.05	3.0935	1.11
10 (+)	46	3.8723	0.94	3.4468	0.99	4.0000	0.68	3.4681	0.90	3.1702	1.08
TOTAL	232	3.6078	1.05	3.3276	1.11	3.7543	0.95	3.4526	1.02	3.0690	1.08

Yrs Svc	(n)	IG	std dev	JCAHO	std dev	Prof Views	std dev	Line Views	std dev	Grand Views	std dev
1-4	47	3.1739	1.05	3.6739	0.89	3.2222	1.13	3.5000	0.88	3.4130	1.01
5-9	139	3.1295	0.96	3.6115	1.05	3.3094	1.16	3.1655	1.15	3.4892	1.04
10 (+)	46	3.0426	0.90	3.5106	0.96	3.3617	1.08	3.3617	1.02	3.1702	0.97
TOTAL	232	3.1207	0.97	3.6034	1.00	3.3030	1.14	3.2716	1.08	3.4095	1.03

Yrs Svc	(n)	Career	std dev	PCS	std dev	Spouses	std dev				
1-4	47	3.7609	0.56	4.0652	0.94	3.6087	0.92			Mean	7.3491
5-9	139	3.7554	0.97	4.2734	0.83	3.7029	1.14			Median	10
10 (+)	46	3.6809	1.07	4.0638	0.78	3.7021	1.03			Mode	4
TOTAL	232	3.7414	0.93	4.1897	0.85	3.6840	1.08				

Fig. 8. Summary of Data by Years of Service

Needs Expressed by Perceived

Administrative Responsibilities

Requesting a self-assessment of the physicians' level of adminstrative responsibilities resulted in a remarkably bell-shaped curve of responses as demonstrated by Figure 9. Whereas the mean response was clearly equal to 3, there were exactly 58 responses in evenly descending order on both sides of this mean/median. Figure 10 shows that the highest level of administrative responsibilities was perceived by senior physicians.

In general, it can be seen that as the level of responsibility increases, so does the need for training in the respective transitional topic area.

Frequently, a considerable increase in need can be seen between levels 1 and 2, most notably in the categories of Professional, Graduate, and Line Views. It is curious to see a converse decline in interest occur in all three of these areas between administrative levels 4 and 5.

Figure 11 gives a graphic representation of each functional area and Figure 12 provides a summary of data by administrative level.

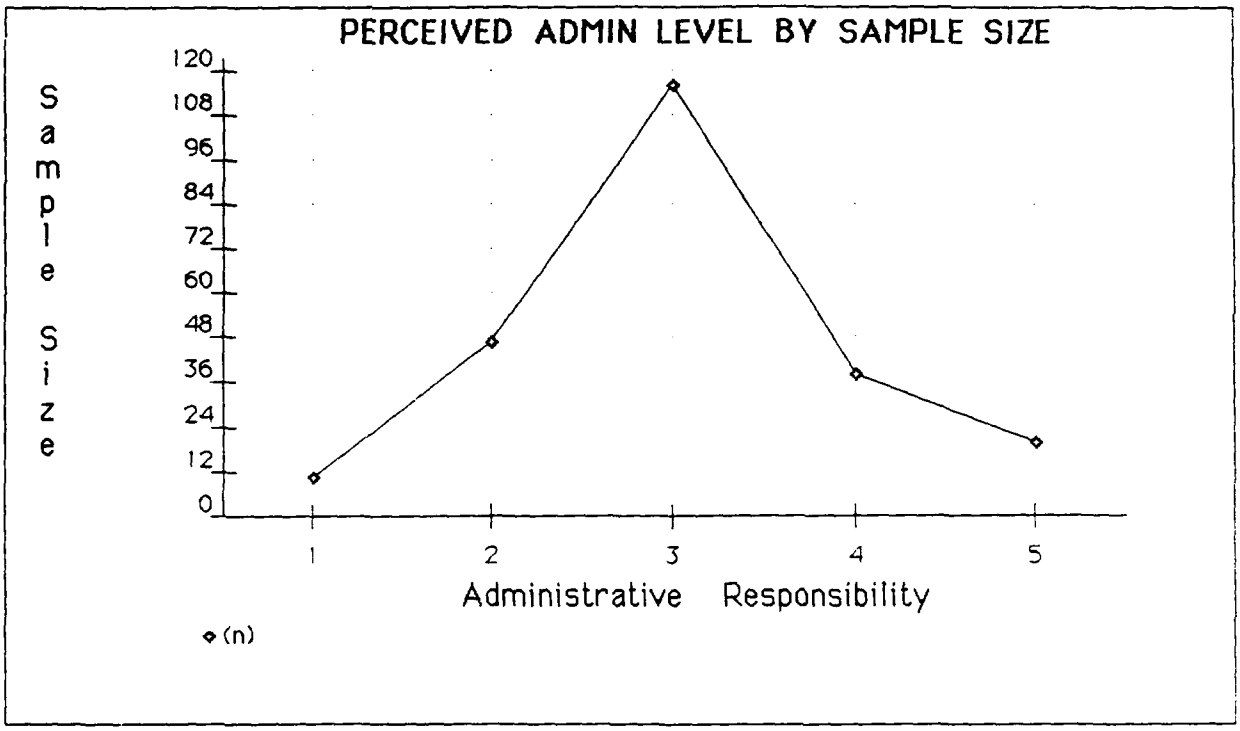


Fig. 9. Perceived Administrative Level by Sample Size

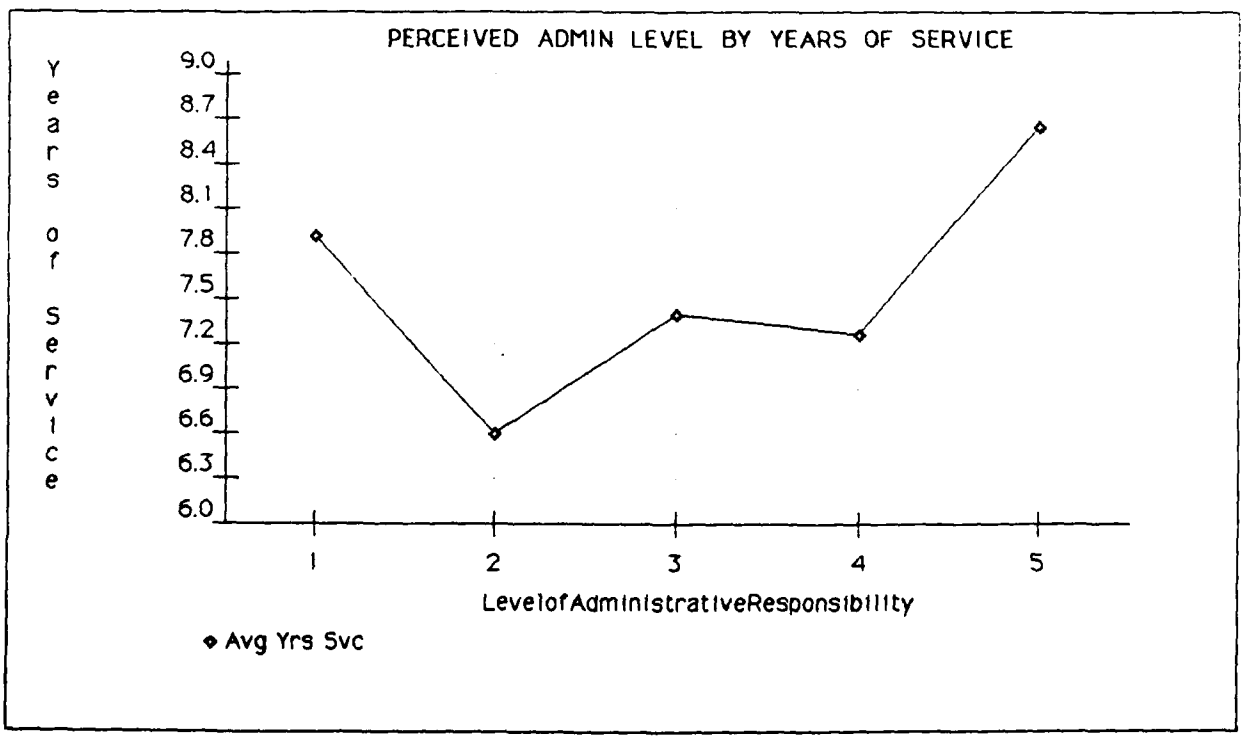


Fig. 10. Perceived Administrative Level by Years of Service

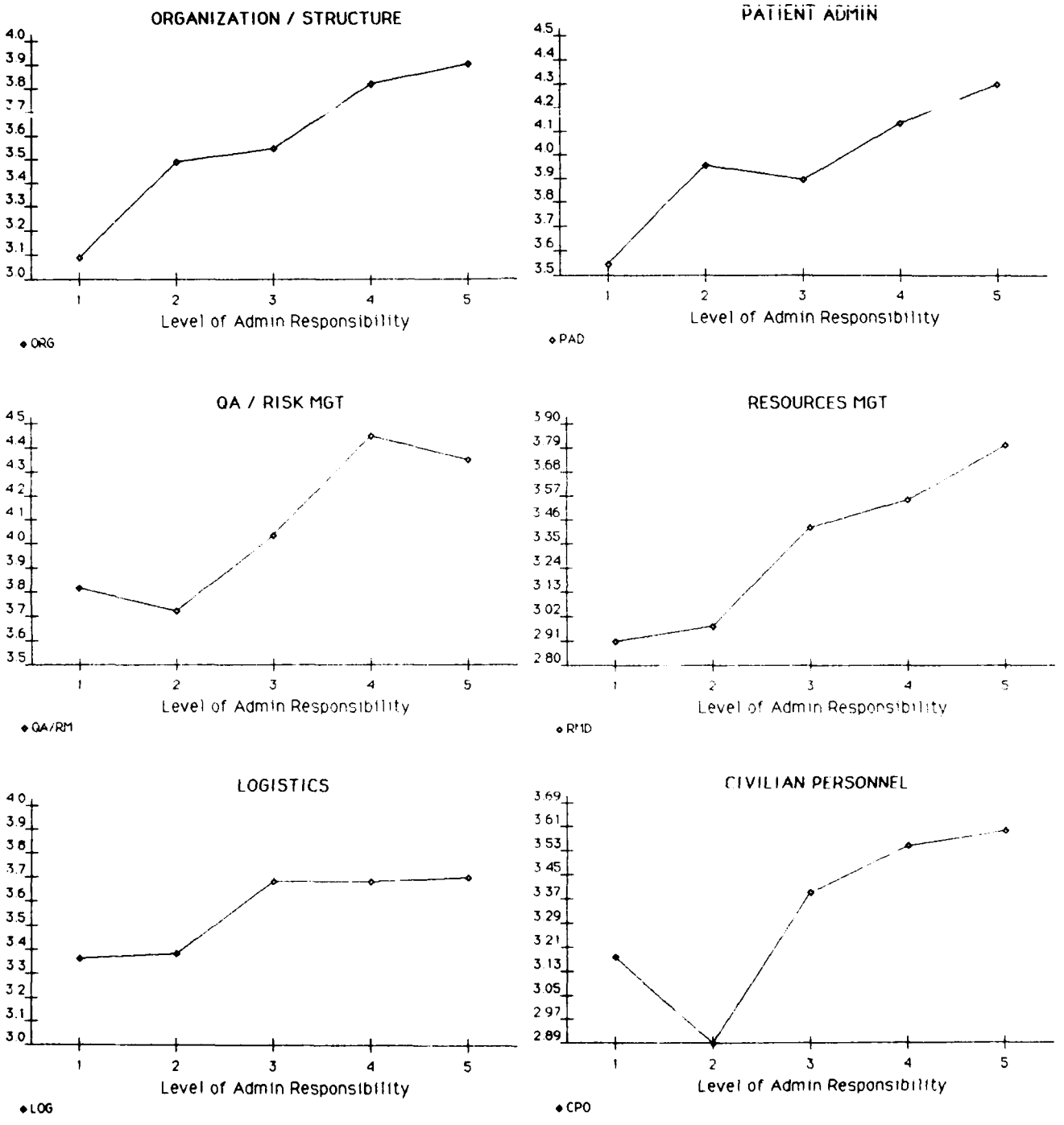


Fig. 11. Graphic Representation of Each Functional Area by Administrative Level

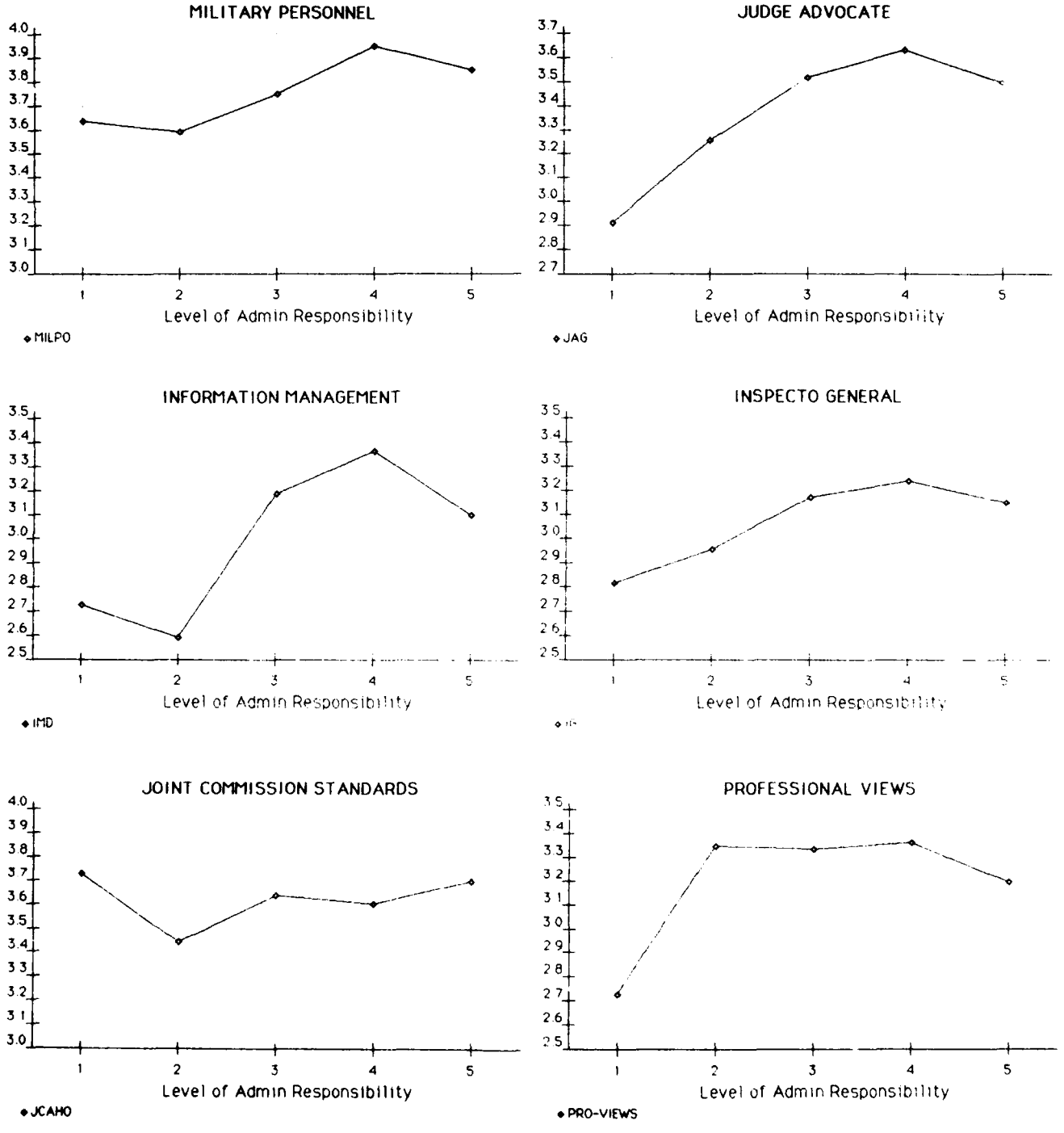
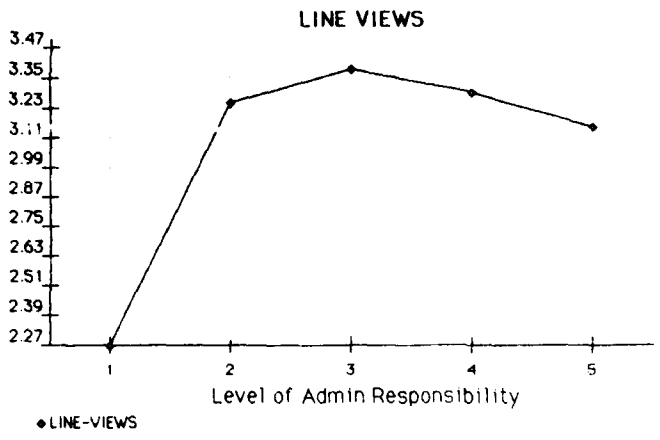
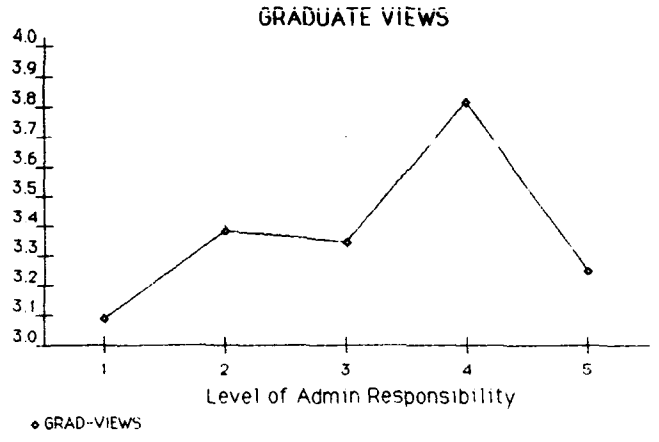
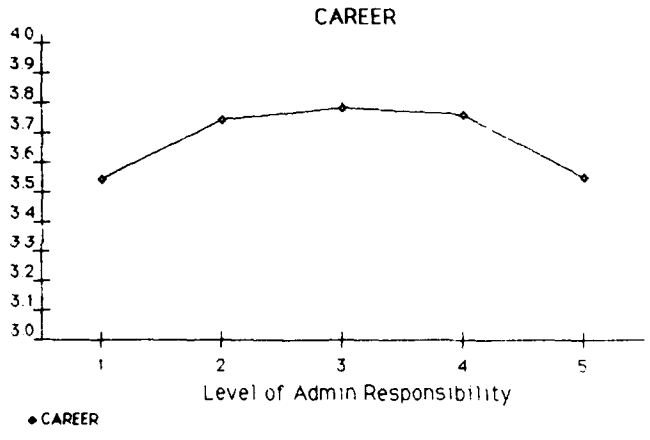
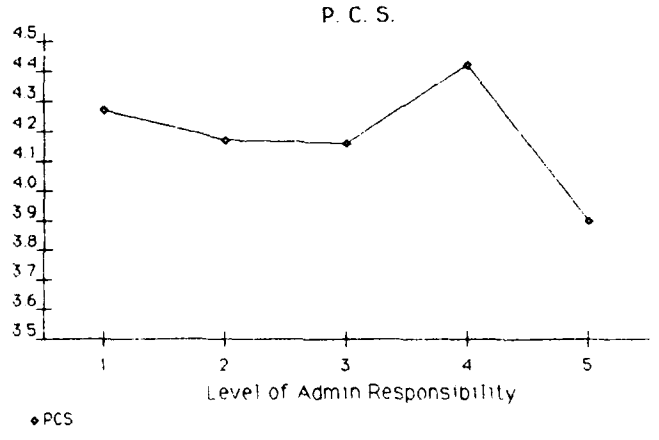


Fig. 11. (continued)









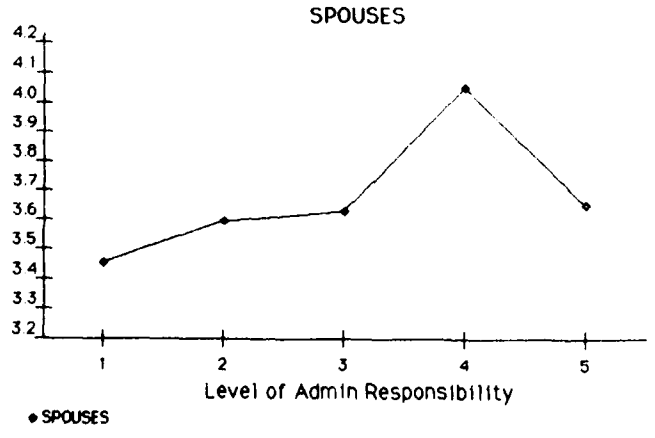


Fig. 11. (continued)

ADMIN LEVEL	(n)	Avg Yrs Svc		ORG	std dev	PAD	std dev	QA/RM	std dev	RMD	std dev
1	11	7.9091		3.0909	1.08	3.5455	1.16	3.8182	1.19	2.9091	1.24
2	47	6.5957		3.4894	0.85	3.9574	0.62	3.7234	0.92	2.9787	1.10
3	116	7.4052		3.5431	0.87	3.8966	0.97	4.0345	0.86	3.4224	1.13
4	38	7.2632		3.8158	0.79	4.1316	0.89	4.4474	0.59	3.5526	0.97
5	20	8.6500		3.9000	0.94	4.3000	0.78	4.3500	0.79	3.8000	0.93
TOTAL	232	7.3491		3.5862	0.89	3.9655	0.90	4.0560	0.88	3.3621	1.12

ADMIN LEVEL	(n)	LOG	std dev	CPO	std dev	MILPO	std dev	JAG	std dev	IMD	std dev
1	11	3.3636	1.30	3.1818	1.03	3.6364	0.88	2.9091	1.08	2.7273	1.14
2	47	3.3830	0.96	2.8936	1.06	3.5957	1.02	3.2553	1.00	2.5957	0.96
3	116	3.6810	1.07	3.3966	1.10	3.7500	0.90	3.5172	1.03	3.1897	1.07
4	38	3.6842	1.05	3.5526	1.09	3.9474	1.00	3.6316	0.87	3.3684	1.01
5	20	3.7000	0.90	3.6000	1.07	3.8500	0.91	3.5000	1.02	3.1000	1.14
TOTAL	232	3.6078	1.05	3.3276	1.11	3.7543	0.95	3.4526	1.02	3.0690	1.08

ADMIN LEVEL	(n)	IG	std dev	JCAHO	std dev	PRO-VIEWS	std dev	LINE-VIEWS	std dev	GRAD-VIEWS	std dev
1	11	2.8182	0.83	3.7273	1.14	2.7273	1.05	2.2727	0.86	3.0909	0.79
2	47	2.9574	1.01	3.4468	1.01	3.3478	1.09	3.2553	1.06	3.3830	1.02
3	116	3.1724	0.93	3.6379	0.98	3.3362	1.17	3.3879	1.07	3.3448	1.07
4	38	3.2368	0.98	3.6053	1.09	3.3684	0.98	3.2895	0.97	3.8158	0.79
5	20	3.1500	1.01	3.7000	0.84	3.2000	1.25	3.1500	1.19	3.2500	1.13
TOTAL	232	3.1207	0.97	3.6034	1.00	3.3030	1.14	3.2716	1.08	3.4095	1.03

ADMIN LEVEL	(n)	CAREER	std dev	PCS	std dev	SPOUSES	std dev
1	11	3.5455	0.66	4.2727	0.62	3.4545	0.78
2	47	3.7447	0.81	4.1702	0.83	3.5957	1.04
3	116	3.7845	0.95	4.1638	0.84	3.6261	1.13
4	38	3.7632	0.98	4.4211	0.67	4.0526	0.89
5	20	3.5500	1.07	3.9000	1.18	3.6500	1.15
TOTAL	232	3.7414	0.93	4.1897	0.85	3.6840	1.08

Fig. 12. Summary of Data by Administrative Level

Transitional Training Time Preferences

General

Graduate respondents were asked to indicate the time frame during which they felt the given educational topics should have been presented. They were allowed to indicate more than one choice. Whereas comparisons of their perceived "need" for training within the various functional areas involved evaluating the significance of decimal points, the results of this question generated some striking contrasts. Figures 13 and 14 contain the summary data for this section.

Training Throughout Residency

A significant number of respondents felt that they should have been exposed to six of the functional areas throughout their residency training. Patient Administration, Quality Assurance/Risk Management, Judge Advocate, Joint Commission on Accreditation, Professional Perspectives, and Career demonstrated this distinction. It is noteworthy that PAD (with a cumulative "need" rating of 3.96) and QA/RM (with a rating of 4.06) are two of the highest priority training areas for the graduates. These two areas, as well as JCAHO, could be viewed as highly relative to the clinical practice of medicine; therefore, inclusion in the medical training regimen appears reasonable. As residents, they were subjugated to the views of senior physicians throughout training, so the high rating for the Pro Views functional area is of no surprise. The areas of JAG and Career, however, present interesting perspectives. It appears that matters of medical-legal ethics and the military judicial system demand more than just the cursory exposure permissible in an orientation program. Career issues, likewise, is another area of considerable significance and one in which a degree of mastery is sought well before graduation.

Just Prior to Graduation

Recalling that the majority of the respondents were exposed to most of the functional areas in orientation programs just prior to graduation, only four areas stand out as being best suited for this presentation time frame. Of these, Permanent Change of Station and Spouses appear as obvious selections. Graduate Perspectives and Military Personnel presentations could well be sought to assist in alleviating some of the anxiety of the unknown. Remember that for a number of years, the resident had very limited exposure and/or no need to be concerned with military personnel issues. His/her concerns of "stepping out" into that environment are understandable. The views of previous graduates and their personal perspectives on transition issues are also a logical presentation.

Upon Arrival at New Duty Station

Four areas are shown with preferred exposure upon arrival at the graduates' new duty station. Resource Management, Logistics, Civilian Personnel, and Inspector General are all areas which the respondents have apparently recognized as being greatly influenced by local policies and peculiarities.

Additional Considerations

Three functional areas demonstrated more than one dominant preference. Information Management has split preferences between "Throughout Residency" and "Upon Arrival at New Duty Station." Line Perspectives is also split, with fairly even preferences of "Throughout Residency" and "Just Prior to Graduation." Organization/Structure was the only topical area which evenly demonstrated a need for educational exposure in each of the time periods.

While viewing high preference rates for the most desired instructional time frame, a look at the lowest figures could also be beneficial in a program design. For instance, presentations concerning PCS, Logistics, and Civilian Personnel provided throughout residency training would have little interest or support. Likewise, heavy concentrations of PAD, JAG, or IMD during pre-graduation orientation programs (as is currently the case in many of the MEDCEN programs) should be seriously questioned.

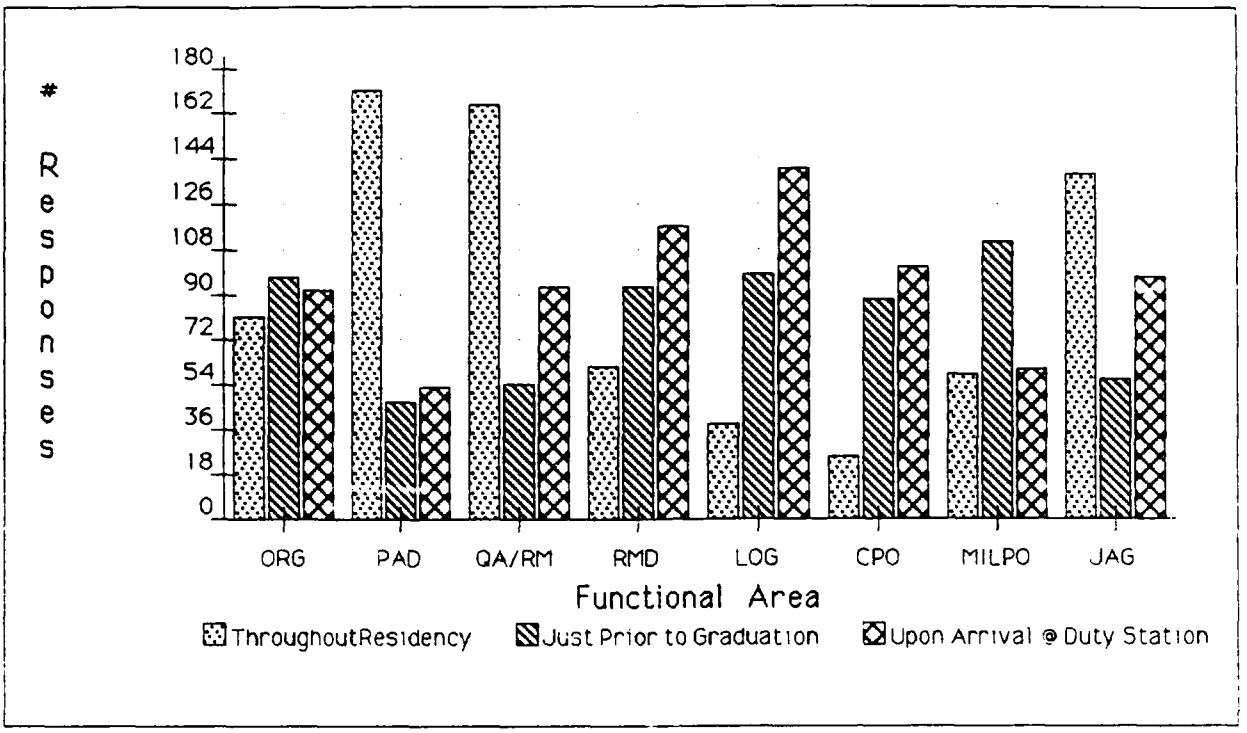


Fig. 13. Training Time Preferences by Functional Area (Part I)

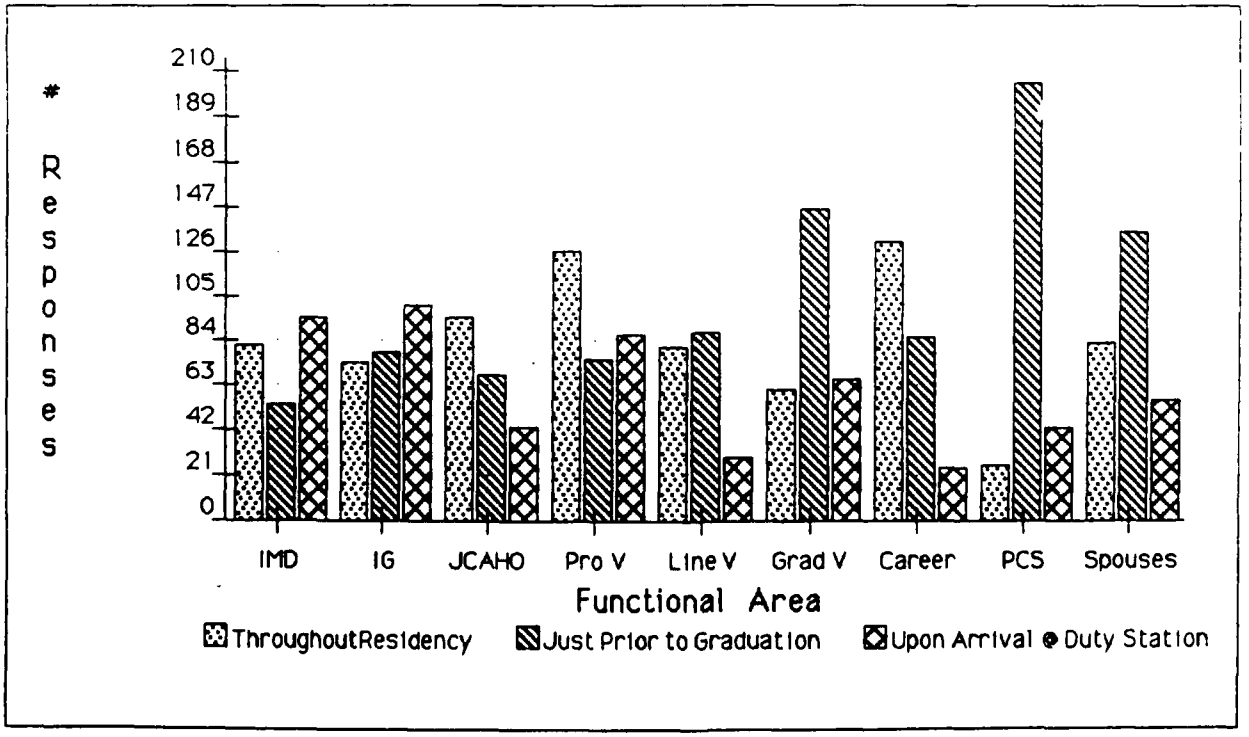


Fig. 14. Training Time Preferences by Functional Area (Part II)

CHAPTER III - CONCLUSIONS

General

The purpose of this study was to determine transitional training needs for graduating military medical residents and to develop a model for "Transition to Practice" programs within the Army Medical Department.

Review of contemporary programs from the Army's eight major teaching facilities revealed an institutional need for seventeen functional categories of transitional training. Recently graduated medical residents were then offered the opportunity to assess these training categories, both in terms of their perceived degree of need and in terms of when such training would be most beneficial.

Observations in this research effort suggest that transitional issues should be presented during three sequential phases: throughout residency, just prior to graduation, and soon upon arrival at the new duty station. Curricula and emphasis areas would vary and should (as a minimum) take into account the following confounding variables: the doctor's future institutional affiliation; the degree of administrative responsibility to be required; the geographical location of the individual's assignment; and years of military service and experience.

An attempt was made to determine training needs based on individual specialty. It is felt, though, that insufficient data were obtained on which to state such inferences. It is conceivable that psychographic techniques (as popularized by the Stanford Research Institute at Palo Alto) could be pursued to provide further insight into this variable. Such investigation would necessitate additional detailed responses from multiple-year groups. Ultimately, generalizations of this nature are still hard to make (Beckham 56).

Collectively, the responses obtained in this research present a picture of learner preferences which cannot be institutionally ignored. There are clear indications that the subject areas of PAD, QA/RM, JAG, Professional Perspectives, and Career issues must be incorporated throughout the residency training cycle. The argument of "not enough time" (during a three- to four-year training period) holds little credibility.

The present methodology of cramming multiple transitional training topics into a few hours just prior to graduation is in need of change. There are distinct indications that military personnel issues, views of recent graduates, education on PCS matters, and increased involvement by spouses would be best received, remembered, and utilized if presented during these pre-graduation orientations.

Matters which are heavily influenced by individual localities are best left for detailed orientation at the new duty station. These would include, but are not limited to: resource management, logistics, civilian personnel management, and information management systems.

Appendix D-1 through D-3 presents suggestions for core curriculum, with prioritizations, to be offered during each of the three transitional training phases.

Additional

The response rate obtained in this research endeavor was encouraging. Not only did almost 50% of last year's graduates feel the topic was worthy of their time expenditure, but over sixty responses were rendered with comments. I feel these represent a definite interest on the part of our medical professionals to be a part of the overall improvement of our health care delivery system. Appendix E contains a reproduction of the individual comments obtained. They present an array of diverse opinions,

attitudes, personal experiences, and potentially beneficial ideas. They present a unique insight into the medical graduates' environment and offer interesting possibilities for future research endeavors.

Summary

The results of this survey suggest that current transitional training efforts are inadequate and that closer scrutiny is needed to identify potential shortfalls between current and optimal competence or performance.

The question of who can best determine the transitional training needs for new physicians does not require an "either/or" answer. A number of perspectives could have relevance and value. However, as Monette has stated, "Because learning is essentially an internal process, only learners themselves can, in the end, decide to learn and to act upon their learnings" (121).

The needs assessment presented herein has offered a systematic procedure for determining important discrepancies in our present educational system and could be utilized to establish instructional modalities and levels of teaching emphasis. Subsequent allocation of valuable teaching resources could result. Ultimately, the objective of our medical education system must be to ensure our physicians are fully capable of transitioning into DIRECT professional responsibility for actions--medical as well as non-medical.

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From: Dwight David Eisenhower Army Medical Center

Letterman Army Medical Center

William Beaumont Army Medical Center

Walter Reed Army Medical Center

Madigan Army Medical Center

Tripler Army Medical Center

Fitzsimons Army Medical Center

Brooke Army Medical Center

APPENDIX A

Sample of Survey and Introductory Letter

DEPARTMENT OF THE ARMY
HEADQUARTERS DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
FORT GORDON, GEORGIA 30905-5650

Dear Doctor,

As a graduate of a medical residency program during 1987, your help is needed. I am an Administrative Resident trying to complete a Masters degree in Health Care Administration.

I have chosen physician training as an area of concentration for research. Specifically, I am concerned with the manner in which our teaching facilities prepare physicians for practice within our military health delivery environment. There are five hundred and one of you who received varying degrees of "Transitional Training" last year. I want to document the important issues which you feel are relevant to the education of our new physicians.

The seventeen transitional topics on the attached questionnaire were derived from existing programs. There is no need, or desire, to obtain individual identity. The results of this research will be provided to Health Services Command. Your input is needed back by the end of May.

I know of no other effort to capture the transitional training needs of our system, from your perspectives. I feel it is an important issue. With a full appreciation of the value of your time, I respectfully request your assistance.

Edward W Rawls

Edward W. Rawls
MAJ MS
Admin Resident

Thanks

TRANSITIONAL TRAINING SURVEY

DEMOGRAPHIC DATA :

YEARS OF MILITARY SERVICE _____ **MEDICAL SPECIALTY** _____

ADMINISTRATIVE RESPONSIBILITIES : 1 2 3 4 5 — Light Moderate Heavy

CURRENT ASSIGNMENT (circle one) :

MEDCEN MEDDAC TO&E UNIT OTHER _____

LOCATION (circle one) :

CONUS OVERSEAS

Please circle the appropriate number for your perceived need for transitional training experiences. Also indicate the desired location for such educational experience (note: more than one exposure preference may be indicated).

1. ORGANIZATIONAL STRUCTURE

Institutional relationships and interaction internal to the Army Medical Department. Departmental responsibilities. Ancillary support functions. MEDCEN, MEDDAC, and clinic operations. TDA structures. FORSCOM units.

1 — No Need; 2 — Minor Need; 3 — Neutral; 4 — Moderate Need; 5 — Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

2. PATIENT ADMINISTRATION

Medical administrative issues. CHAMPUS. Disability processing. Medical boards. Profiles. Release of medical information.. Non-availability statements. Medical Records.

1 — No Need; 2 — Minor Need; 3 — Neutral; 4 — Moderate Need; 5 — Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

3. QUALITY ASSURANCE & RISK MANAGEMENT

Professional and hospital committees. Occurence screening. Credentials. Medical-legal issues.

1 — No Need; 2 — Minor Need; 3 — Neutral; 4 — Moderate Need; 5 — Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

4. RESOURCES MANAGEMENT

Manpower/Force development. Finance/Comptroller. Authorizations/Requirements. Manpower allocations. MCCU's.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

5. LOGISTICS

Supply and property management. Medical equipment procurement. MEDCASE. CEEP. Medical Benefits Program.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

6. CIVILIAN PERSONNEL

Management of the civilian workforce. Performance appraisals, awards, leaves, counseling, hiring/firing actions.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

7. MILITARY PERSONNEL

Management of military personnel. OERs, EERs, awards, decorations. Enlisted/NCO roles.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

8. JUDGE ADVOCATE

Military judicial actions. Military medical ethics. Standards of Conduct.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

9. INFORMATION SYSTEMS

Automation in military medicine. TRIMIS, CHCS, automated workload accounting.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

I. INSPECTOR GENERAL

Inspections and compliance standards. Grievance procedures.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

11. J.C.A.H.

..spection criteria, requirements, and methodology of the Joint Commission on ..ccreditation of Healthcare Organizations.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

12. PROFESSIONAL VIEWS

..esentations by senior physicians regarding the roles, responsibilities, and expectations ..f the military physician.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

13. LINE PERSPECTIVES

Role, relationships, and responsibilities of the military physician as viewed by other ..anches of the services (Infantry, Artillery, Post Commanders, etc...)

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

14. GRADUATE VIEWS

Personal views of recent graduates on their practical experiences.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

15. CAREER PLANNING

..atters pertaining to military career development/progression. Promotions, incentive pay, rating schemes.

1	2	3	4	5
No Need	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

P.C.S. MOVES

ing to the practical aspects of military moves. Transportation, housing, dislocation vance, PCS orders. Overseas preparation.

1	2	3	4	5
lo ed	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

SPOUSES

ses specifically tailored to assist spouses with their transitional issues (ie. stress agement, social expectations, child transition problems, etc..)

1	2	3	4	5
lo eed	Minor Need	Neutral	Moderate Need	Critical Need

Exposure Preference
1 -- Throughout Residency
2 -- Just Prior to Graduation
3 -- At New Duty Station

CELLANEOUS / COMMENTS : Are there any additional areas of transitional ning needs you feel need to be addressed ?

THANK YOU VERY MUCH !

APPENDIX B-1 THROUGH B-8

MEDCEN Program Worksheets

MEDCEN PROGRAM WORKSHEET

acility: Walter Reed Army Medical Center

eneral Description: Three consecutive day program. Few presentations by panels.

EDUCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

dactic ime	Didactic Time %	Functional Classification	Remarks
0 min	3.33	MISC	Stress mgt. Adverse effects & coping
0 min	6.67	Org/Structure	AMEDD Organizations
60 min	6.67	Org/Structure	Army MEDDACs.
60 min	6.67	QA/RM	Variety of comittee structures
0 min	6.67	QA/RM	QA/RM/Credentials specifics
0 min	6.67	LOG	Procurements, MEDCASE,CEEP,Forms
60 min	6.67	RMD	Clinic funds, budgets, personnel staffing
0 min	3.33	IG	
0 min	3.33	JCAH	Plus a few other reviews
0 min	3.33	MILPO	OERs, EERs, Awards/Reprimands
30 min	3.33	CPO	Evaluations, Awards, Hire/Fire
0 min	6.67	PAD	Quarters, profiles, MEBs, PEBs, EPTS, Champus, Supplemental
0 min	6.67	ORG/Structure	Roles, responsibilities, management
30 min	3.33	Line Perspectives	Commo, protocol, leadership
60 min	6.67	PCS	Housing, travel, finance, pro-pay, orders
0 min	6.67	Career	Requirements and opportunities of an Army career
0 min	6.67	PCS	Finances, wills, car registration, power of attorney, state residency
60 min	6.67	Grad Views	
tal 900			

CONSOLIDATED EDUCATIONAL PRIORITY LISTING

dactic Time	Didactic Time %	Functional Classification	Remarks
0 min	20.01	Org/Structure	AMEDD Organizations Army MEDDACs. Roles, responsibilities, management
0 min	13.34	QA/RM	Variety of comittee structures QA/RM/Credentials specifics
0 min	13.34	PCS	Housing, travel, finance, pro-pay, orders Finances, wills, car registration, power of attorney, state residency
0 min	6.67	LOG	Procurements, MEDCASE,CEEP,Forms
0 min	6.67	RMD	Clinic funds, budgets, personnel staffing
60 min	6.67	PAD	Quarters, profiles, MEBs, PEBs, EPTS Champus, Supplemental
0 min	6.67	Career	Requirements and opportunities of an Army career
0 min	6.67	Grad Views	
0 min	3.33	MISC	Stress mgt. Adverse effects & coping
30 min	3.33	IG	
0 min	3.33	JCAH	Plus a few other reviews
0 min	3.33	MILPO	OERs, EERs, Awards/Reprimands
0 min	3.33	CPO	Evaluations, Awards, Hire/Fire
30 min	3.33	Line Perspectives	Commo, protocol, leadership
tal 900			

MEDCEN PROGRAM WORKSHEET

acility: Madigan Army Medical Center

General Description: Three consecutive day program. Current program has been used for three ears.First day is a general overview of the AMEDD and field expectations. Second day concentrates on rganization/structure and MILPO matters. Third day is for personal PCS concerns. Families are encouraged to attend third day. A "fireside lounge" workshop was provided on the secon evening for interaction with ist graduates.

EDUCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

idactic Time	Didactic Time %	Functional Classification	Remarks
5 min	7.98	Org/Structure	Overview of TO&E AMEDD environment & panel discussion
5 min	6.11	Line Perspective	Expectations of the AMEDD & panel discussion
70 min	6.57	Prof Perspective	Medicine in Community Hospitals & Clinics
70 min	6.57	QA/RM	Medical Legal Issues
70 min	6.57	JAG	Judicial Actions
90 min	8.45	Misc	Keynote Speaker (Topic not specified)
60 min	5.63	MILPO	OERs, EERs, awards, couseling statements
60 min	5.63	QA/RM	Hospital committees
30 min	2.82	MILPO	Enlisted personnel
50 min	4.69	RMD	Resources Management
55 min	5.16	LOG	MEDCASE, CEEP, supply & property management
60 min	5.63	PAD	Patient Administration, CHAMPUS
30 min	2.82	Org/Structure	Panel discussion
60 min	5.63	PCS	Transportation, household goods
60 min	5.63	PCS	Finance brief; pro-pay, direct deposit, allotments
30 min	2.82	PCS	Personnel brief; orders, leave, reporting in
60 min	5.63	PCS	Wills, Powers of attorney, claims for damage
60 min	5.63	Misc	Financial Seminar
65 total			

CONSOLIDATED EDUCATIONAL PRIORITY LISTING

idactic Time	Didactic Time %	Functional Classification	Remarks
9 min	19.71	PCS	Wills, Powers of attorney, claims for damage (60 min) Transportation, household goods (60 min) Finance brief; pro-pay, direct deposit, allotments (60 min) Personnel brief; orders, leave, reporting in (30min)
0 min	14.08	Misc	Keynote Speaker (Topic not specified) (90 min) Financial Seminar (60 min)
130 min	12.20	QA/RM	Medical Legal Issues (70 min) Hospital committees (60 min)
3 min	10.88	Org/Structure	Overview of TO&E AMEDD environment & panel discussion (85min) Panel discussion (30 min)
90 min	8.45	MILPO	OERs, EERs, awards, couseling statements (60 min) Enlisted personnel (30 min)
70 min	6.57	Prof Perspective	Medicine in Community Hospitals & Clinics
70 min	6.57	JAG	Judicial Actions
65 min	6.11	Line Perspective	Expectations of the AMEDD & panel discussion
60 min	5.63	PAD	Patient Administration, CHAMPUS
55 min	5.16	LOG	MEDCASE, CEEP, supply & property management
50 min	4.69	RMD	Resources Management
65 total			

MEDCEN PROGRAM WORKSHEET

acility: Tripler Army Medical Center

General Description: Two day program. Facility's evaluation indicates information related to PCS was ost popular. There are also indications that the hand-out books provided to residents were of benefit. 82 Transition to Practice was their first program. It was five days duration. Two days has been utilized for the last two years. Current program seems to lack information on the "mechanics" of PCS moves.

EDUCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

idactic Time	Didactic Time %	Functional Classification	Remarks
145 min	21.57	Org/Structure	MSC Officers & their functions
15 min	5.88	MILPO	Enlisted personnel management
8 min	15.69	QA/RM	JCAH, Occurrence screening, QA committees & processes, RM
45 min	5.88	Line Perspectives	Commander's & Community's Expectationns
3 min	15.69	Prof Perspectives	Department specific panel discussion
5 min	13.73	Misc	Stress & impaired physicians
90 min	11.76	Misc	Personal effectiveness
75 min	9.80	PCS	Panel Discussions specific to CONUS, Korea, & Europe
.5 total			

CONSOLIDATED EDUCATIONAL PRIORITY LISTING

.dactic Time	Didactic Time %	Functional Classification	Remarks
5 min	25.49	Misc	Stress & impaired physicians (105 min) Personal effectiveness (90 min)
165 min	21.57	Org/Structure	MSC Officers & their functions
3 min	15.69	QA/RM	JCAH, Occurrence screening, QA committees & processes, RM
3 min	15.69	Prof Perspectives	Department specific panel discussion
75 min	9.80	PCS	Panel Discussions specific to CONUS, Korea, & Europe
45 min	5.88	MILPO	Enlisted personnel management
15 min	5.88	Line Perspectives	Commander's & Community's Expectationns
.5 total			

MEDCEN PROGRAM WORKSHEET

acility: Letterman Army Medical Center

General Description: Three day program. Spouses invited to attend, but no separate sessions specifically r them. Civilian guest speakers presented on topics of malpractice issues and life transitions.

DUCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

Didactic Time	Didactic Time %	Functional Classification	Remarks
5 min	18.99	Misc	Life Orientation: Building upon strengths and weaknesses
135 min	11.39	PCS	Moving, housing, pay, physician bonuses, etc..
195 min	8.86	Org/Structure	MEDDAC Panel Discussion
5 min	8.86	Grad Perspective	Recent Graduates' Panel
3 min	7.59	Line Perspective	Line Officer/NCO panel
60 min	5.06	Misc	Medical Malpractice (civilian speaker)
3 min	5.06	QA/RM	QA
3 min	5.06	MILPO	Military Personnel issues.
45 min	3.80	JAG	Standards of Conduct
45 min	3.80	PAD	Medical Administrative Issues
min	3.80	PAD	Medical Administrative Issues
min	2.53	LOG	Medical Logistics
30 min	2.53	Misc	Pharmacy Operations
30 min	2.53	Prof Perspective	Transition to Practice: Practical Suggestions
min	2.53	Org/Structure	Medical Practice in FORSCOM
min	2.53	PAD	Disability case processing
30 min	2.53	QA/RM	RM
min	2.53	Line Perspective	A Combat Arms AView of Medical Support (BG Bickston)
35 total			

ONSOLIDATED EDUCATIONAL PRIORITY LISTING

Didactic Time	Didactic Time %	Functional Classification	Remarks
5 min	26.58	Misc	Life Orientation: Building upon strengths and weaknesses (225 min) Medical Malpractice (civilian speaker) (60 min) Pharmacy Operations (30 min)
5 min	11.39	PCS	Moving, housing, pay, physician bonuses, etc..
195 min	11.39	Org/Structure	MEDDAC Panel Discussion (165 min) Medical Practice in FORSCOM (30 min)
9 min	10.13	PAD	Medical Administrative Issues (45 min) Medical Administrative Issues (45 min) Disability case processing (30 min)
120 min	10.12	Line Perspective	Line Officer/NCO panel (90 min) A Combat Arms AView of Medical Support,BG Bickston (30 min)
5 min	8.86	Grad Perspective	Recent Graduates' Panel
90 min	7.59	QA/RM	QA (60 min) RM (30 min)
3 min	5.06	MILPO	Military Personnel issues.
45 min	3.80	JAG	Standards of Conduct
30 min	2.53	LOG	Medical Logistics
min	2.53	Prof Perspective	Transition to Practice: Practical Suggestions
35 total			

MEDCEN PROGRAM WORKSHEET

acility: William Beaumont Army Medical Center

eneral Description: Two day program. One day basically for administrative functional areas, one day r personal transition issues.

UCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

Didactic Time	Didactic Time %	Functional Classification	Remarks
3 min	13.53	Org/Structure	TDA panel discussion
60 min	9.02	Line Perspective	Line officer's questions & answers
59 min	9.02	PCS	Finance & travel
1 min	9.02	PCS	Transportation
.5 min	6.77	QA/RM	QA/RM/Credentials
30 min	4.51	PAD	PAD
min	4.51	Org/Structure	MEDDAC Orientation
min	4.51	Org/Structure	Troop Clinics
30 min	4.51	Manpower	Force development
30 min	4.51	Misc	Weight control & profiles
min	4.51	Line Perspective	Line officer's presentation
min	4.51	Misc	Spouse presentation
30 min	4.51	MILPO	Military Personnel
15 min	2.26	Misc	Dept of nursing
min	2.26	JAG	JAG
min	2.26	Misc	Nuclear Surety
15 min	2.26	Misc	Alcohol & drug abuse
min	2.26	Finance	Comptroller
min	2.26	LOG	Logistics
10 min	1.50	Misc	EEO
10 min	1.50	IG	IG
5 Total			

ONSOLIDATED EDUCATIONAL PRIORITY LISTING

Didactic Time	Didactic Time %	Functional Classification	Remarks
3 min	22.55	Org/Structure	TDA panel discussion (90 min) MEDDAC Orientation (30 min) Troop Clinics (30 min)
3 min	18.04	PCS	Finance & travel (60 min) Transportation (60 min)
90 min	13.53	Line Perspective	Line officer's questions & answers (60 min) Line officer's presentation (30 min)
min	12.79	Misc	Weight control & profiles (30 min) Dept of nursing (15 min) Nuclear Surety (15 min) Alcohol & drug abuse (15 min) EEO (10 min)
45 min	6.77	QA/RM	QA/RM/Credentials
45 min	6.77	RMD	Manpower/Force development (30 min) Finance/Comptroller (15 min)
min	4.51	PAD	PAD
30 min	4.51	Spouses	Spouse presentation
30 min	4.51	MILPO	Military Personnel
min	2.26	JAG	JAG
min	2.26	LOG	Logistics
10 min	1.50	IG	IG
5 Total			

MEDCEN PROGRAM WORKSHEET

acility: Brooke Army Medical Center

eneral Description: Two day program. Unique in that four panels gave views from their perspective eas during last afternoon. Presentations very structured by functional areas.

UCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

Didactic Time	Didactic Time %	Functional Classification	Remarks
) min	10.71	Org/Structure	MEDDAC Panel
75 min	8.93	Prof Perspective	GMO Panel
75 min	8.93	Grad Perspective	Returning resident's Panel
1 min	8.33	MILPO	Personnel admin/Troop command
60 min	7.14	Line Perspective	Line Officer's panel
45 min	5.36	Career	Assignment/career planning
min	5.36	Spouses	Wives' panel
1 min	4.76	JAG	Center Judge Advocate
30 min	3.57	IMD	Administrative services
30 min	3.57	CPO	Civilian personnel office
min	3.57	Manpower	Force development
min	3.57	Finance	Comptroller
30 min	3.57	PAD	Patient Administration
30 min	3.57	IG	IG
min	3.57	QA/RM	Risk mgt/QA
30 min	3.57	LOG	Logistics
30 min	3.57	Career	Promotions
min	3.57	PCS	personal affairs
min	2.38	Org/Structure	AMEDD Organization
20 min	2.38	Org/Structure	MEDDAC/MEDCEN
840 Total			

CONSOLIDATED EDUCATIONAL PRIORITY LISTING

dactic ime	Didactic Time %	Functional Classification	Remarks
3 min	15.47	Org/Structure	MEDDAC Panel (90 min) AMEDD Organization (20 min) MEDDAC/MEDCEN (20 min)
75 min	8.93	Prof Perspective	GMO Panel
min	8.93	Grad Perspective	Returning resident's Panel
min	8.93	Career	Assignment/career planning (45 min) Promotions (30 min)
79 min	8.33	MILPO	Personnel admin/Troop command
1 min	7.14	Line Perspective	Line Officer's panel
3 min	7.14	RMD	Manpower/Force development (30 min) Finance/Comptroller (30 min)
min	5.36	Spouses	Wives' panel
1 min	4.76	JAG	Center Judge Advocate
30 min	3.57	IMD	Administrative services
30 min	3.57	CPO	Civilian personnel office
min	3.57	PAD	Patient Administration
min	3.57	IG	IG
30 min	3.57	QA/RM	Risk mgt/QA
30 min	3.57	LOG	Logistics
min	3.57	PCS	personal affairs
40 Total			

MEDCEN PROGRAM WORKSHEET

acility: Fitzsimons Army Medical Center

eneral Description: Two day program. They feel they are presenting too much material which ysicians shoould be exposed to earlier in their careers. Shifting more material from transitiion program o newcomer's orientation. Most popular topics were those relating to personal issues.

UCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

Didactic Time	Didactic Time %	Functional Classification	Remarks
135 min	20.93	PCS	Personal transition issues: PCS orders, trans of household goods, MILPO, Personnel div, finance, housing,
3 min	13.95	QA/RM	QA, Risk Management, Medical legal issues, credentials file
5 min	11.63	Career	Customs and courtesies, career progression, mil and civ personnel mgt, Army enhancement program
3 min	9.30	PAD	Med boards, profiles, quarters, release of med info, Champus, non-availability statements, supplemental care
60 min	9.30	Prof Perspective	Specialty groups: suggestions and comments from program directors
min	6.98	Grad Perspective	Comments from recent graduates
min	6.98	Org/Structure	MEDDAC environment
25 min	3.88	Manpower	ManpowerStaffing and workload: Requirements, authorizations, allocations, MCCU's
min	3.88	Line Perspective	Line view of military physicians
min	3.10	LOG	MEDCASE, CEEP, Medical Benefits Program
20 min	3.10	IG	IG
min	3.10	MILPO	NCO roles
min	2.33	QA/RM	Professional Committees Overview
10 min	1.56	JCAH	JCAH
645 Total			

CONSOLIDATED EDUCATIONAL PRIORITY LISTING

Didactic Time	Didactic Time %	Functional Classification	Remarks
5 min	20.93	PCS	Personal transition issues: PCS orders, trans of household goods MILPO, Personnel div, finance, housing,
105 min	16.28	QA/RM	QA, Risk Management, Med-legal issues, credentials file (90 min) Professional Committees Overview (15 min)
min	11.63	Career	Customs and courtesies, career progression, mil and civ personnel mgt, Army enhancement program
60 min	9.30	PAD	Med boards, profiles, quarters, release of med info, Champus non-availability statements, supplemental care
min	9.30	Prof Perspective	Specialty groups: suggestions and comments from program directors
45 min	6.98	Grad Perspective	Comments from recent graduates
min	6.98	Org/Structure	MEDDAC environment
min	3.88	Manpower	ManpowerStaffing and workload: Requirements, authorizations allocations, MCCU's
25 min	3.88	Line Perspective	Line view of military physicians
min	3.10	LOG	MEDCASE, CEEP, Medical Benefits Program
min	3.10	IG	IG
20 min	3.10	MILPO	NCO roles
10 min	1.56	JCAH	JCAH
15 Total			

MEDCEN PROGRAM WORKSHEET

acility: Eisenhower Army Medical Center

General Description: Three, half-day program spaced over a week. Sessions began with lunch, llowed by presentations.

EDUCATIONAL AREAS LISTED IN ORDER OF PRESENTATION

idactic ime	Didactic Time %	Functional Classification	Remarks
3 min	19.23	Org/Structure	MEDDAC Panel
min	9.62	QA/RM	QA/RM
75 min	9.62	PAD	PAD: records
60 min	7.69	PAD	Med Boards, TDRLs, Profiles
min	7.69	RMD	RMD
min	7.69	LOG	Logistics
60 min	7.69	CPO	CPO: GPASs, leaves, awards, counseling
45 min	5.76	MILPO	Military personnel: OERs, EERs, Awards, actions
min	5.76	JAG	Military medical e3thics, standards of conduct
min	5.76	PCS	Transportation: personal issues
30 min	3.85	IMD	IMD: automation in military medicine
min	3.85	Career	Career development
min	3.85	IG	IG
15 min	1.92	JCAH	JCAH
780 total			

ONSOLIDATED EDUCATIONAL PRIORITY LISTING

idactic ime	Didactic Time %	Functional Classification	Remarks
150 min	19.23	Org/Structure	MEDDAC Panel
135 min	17.31	PAD	PAD: records (75 min) Med Boards, TDRLs, Profiles (60 min)
min	9.62	QA/RM	QA/RM
60 min	7.69	RMD	RMD
min	7.69	LOG	Logistics
min	7.69	CPO	CPO: GPASs, leaves, awards, counseling
45 min	5.76	MILPO	Military personnel: OERs, EERs, Awards, actions
45 min	5.76	JAG	Military medical e3thics, standards of conduct
min	5.76	PCS	Transportation: personal issues
min	3.85	IMD	IMD: automation in military medicine
30 min	3.85	Career	Career development
min	3.85	IG	IG
min	1.92	JCAH	JCAH
780 total			

APPENDIX C

Summary of MEDCEN Programs

SUMMARY OF MEDCEN PROGRAMS

(stated in % of didactic time devoted)

	EAMC	FAMC	BAMC	WBAMC	LAMC	IAMC	MAMC	WRAMC	Mean
rg/Structure	19.23	6.98	15.47	22.55	11.39	21.57	10.80	20.01	16.00
PAD	17.31	9.30	3.57	4.51	10.13		5.63	6.67	7.14
A/RM	9.62	16.28	3.57	6.77	7.59	15.69	12.20	13.34	10.64
MD	7.69	3.88	7.14	6.77			4.69	6.67	4.61
JG	7.69	3.10	3.57	2.26	2.53		5.16	6.67	3.87
PO	7.69		3.57					3.33	1.82
MILPO	5.76	3.10	8.33	4.51	5.06	5.88	8.45	3.33	5.55
JG	5.76		4.76	2.26	3.80		6.57		2.89
IMD	3.85		3.57						.93
	3.85	3.10	3.57	1.50				3.33	1.92
JCAH	1.92	1.56						3.33	.85
of Perspectives		9.30	8.93		2.53	15.69	6.57		5.38
Line Perspectives		3.88	7.14	13.53	10.13	5.88	6.11	3.33	6.25
ad Perspectives		6.98	8.93		8.86			6.67	3.93
areer	3.85	11.63	8.93					6.67	3.89
LS	5.76	20.93	3.57	18.04	11.39	9.80	19.71	13.34	12.82
ouses			5.36	4.51					1.23
Misc				12.79	26.58	25.49	19.71	3.33	10.99
TALS	99.98	100.02	99.98	100.00	99.99	100.00	99.97	100.02	100.71

APPENDIX D-1 THROUGH D-3

Training Topics for Model Programs

RECOMMENDED TRANSITIONAL TRAINING

THROUGHOUT RESIDENCY

MAJOR EMPHASIS (Selected by greater than 50% of respondents)

1. Patient Administration
2. Quality Assurance / Risk Management
3. Judge Advocate
4. Professional Views
5. Career Issues

MODERATE EMPHASIS (Selected by 25% to 50% of respondents)

6. Organization / Structure
7. Information Management
8. Inspector General
9. Joint Commission Standards
10. Line Views
11. Graduate Views
12. Spouses

MINOR EMPHASIS (Selected by less than 25% of respondents)

13. Resources Management
14. Logistics
15. Civilian Personnel
16. Military Personnel
17. Permanent Change of Station

RECOMMENDED TRANSITIONAL TRAINING

JUST PRIOR TO GRADUATION

MAJOR EMPHASIS (Selected by greater than 50% of respondents)

1. Permanent Change of Station
2. Graduate Views
3. Spouses

MODERATE EMPHASIS (Selected by 25% to 50% of respondents)

4. Organization / Structure
5. Resources Management
6. Logistics
7. Civilian Personnel
8. Military Personnel
9. Inspector General
10. Joint Commission Standards
11. Professional Views
12. Line Views
13. Career Issues

MINOR EMPHASIS (Selected by less than 25% of respondents)

14. Patient Administration
15. Quality Assurance / Risk Management
16. Judge Advocate
17. Information Management

RECOMMENDED TRANSITIONAL TRAINING

UPON ARRIVAL AT NEW DUTY STATION

MAJOR EMPHASIS (Selected by greater than 50% of respondents)

1. Logistics
2. Resources Management

MODERATE EMPHASIS (Selected by 25% to 50% of respondents)

3. Organization / Structure
4. Quality Assurance / Risk Management
5. Civilian Personnel
6. Judge Advocate
7. Information Management
8. Inspector General
9. Professional Views
10. Graduate Views
11. Spouses

MINOR EMPHASIS (Selected by less than 25% of respondents)

12. Patient Administration
13. Military Personnel
14. Joint Commission Standards
15. Line Views
16. Permanent Change of Station
17. Career Issues

APPENDIX E

Respondent Comments

Years Military Service 9
Medical Specialty Anesthesiology
Admin Responsibilities 4
Current Assignment MEDDAC/Overseas

I think you covered all the areas of importance. I wish you luck in preparing this data and look forward to seeing the end results.

Years Military Service 8
Medical Specialty Anesthesiology
Admin Responsibilities 3
Current Assignment MEDDAC/Overseas

Location specific orientation. Before I go overseas to a particular area, it would be appropriate to get an idea of the area I'm going to.

Years Military Service 8
Medical Specialty Anesthesiology
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

I would suggest that HPSP trained individuals be included in transitional training. It was quite a culture shock that the brief "Basic" course at Ft Sam didn't even come close to preparing me. I had to learn about OER's, awards, MEDCASE, IG, & JCAH, etc while OJT.

Years Military Service 9
Medical Specialty Anesthesiology
Admin Responsibilities 3
Current Assignment MEDCEN/Overseas

From the perspective of one person who has been through 4 PCS moves (including "overseas"), I think that all the aspects of the move are especially stressful. This is increased by the scheduling of written/oral boards in the same time frame. The practical side of the move should be addressed well before the transition to practice. By the time of transition, many of the steps need to be in progress to ensure a smooth move. There is also resistance to giving residents time off to handle these details until after, or close to, 30 June. At the same time, the receiving facility is screaming for as early a reporting date as possible.

Years Military Service 5
Medical Specialty Emergency Medicine
Admin Responsibilities 3
Current Assignment MEDCEN/CONUS

Administrative aspects of medicine need to be introduced very early in the physician's training. QA, Risk Management, how to manage your practice, are all extremely important. An administrative residency needs to be developed besides the already established Baylor Program.

Years Military Service 7

Medical Specialty Emergency Medicine
Admin Responsibilities 3
Current Assignment MEDCEN/Overseas

Most of what you propose as needs was not (or minimally) addressed during my residency. Now that I am staff, I wish I had a better handle on the admin "nonsense" required of me.

Years Military Service 5
Medical Specialty Emergency Medicine
Admin Responsibilities 5
Current Assignment MEDDAC/CONUS

Most programs do not allocate adequate time prior to graduation to present more than a short seminar on transition to practice. HSC should generate specific course material to be covered.

Years Military Service 6
Medical Specialty Emergency Medicine
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

This covers it very well. I feel strongly that military aspects / what the "line" guys expect, etc. should be incorporated early.

Years Military Service 4
Medical Specialty Family Practice
Admin Responsibilities 4
Current Assignment TDA/Overseas

The understanding and definition, from officers and enlisted, of the concept of "NCO business".

Years Military Service 4
Medical Specialty Family Practice
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

A focus needs to be developed throughout residency and active duty tours on retention. Adaptation to military physicians should not be left to chance. For example, my board pay (BCP) was delayed 8 months. Gradually, as these bad experiences accumulate, a career in military medicine becomes less (underlined) of an option. The time to respond to this problem is not (underlined) 1-2 months or even 6-8 months before re-enlistment time. Too much of the overall growth and training experience seems left to chance. Thanks for your review.

Years Military Service 8
Medical Specialty Family Practice
Admin Responsibilities 2
Current Assignment MEDDAC/CONUS

Most of these areas were well covered in my residency. The people with no idea are the civilian HPSP's who come into the service prior to residency and are albatrosses (underlined) on my neck!

Years Military Service 8
Medical Specialty Family Practice
Admin Responsibilities 5
Current Assignment MEDDAC/CONUS

Idea: Requiring and (underlined) facilitating either correspondence or in-residency (at the individual's choice) completion of the AMEDD Advanced Course (either prior to or just after completing residency program) might be an option. Personally, I hope to be able to take AMEDD Advanced in-residence in the near future though it may be somewhat of an overkill after learning some of these things the hard way.

Years Military Service 6
Medical Specialty FP/GMO
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

Most of the pertinent issues were addressed in this survey. I am of the opinion that there is a very very (underlined) critical need for the military to be of more help in aiding the Professional Spouses when they make PCS moves with service members.

Years Military Service 9
Medical Specialty Medicine
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

WE NEED MORE (underlined twice) DOCTORS!

Years Military Service 10
Medical Specialty Medicine
Admin Responsibilities 4
Current Assignment MEDDAC/CONUS

I strongly feel a miliyary physician's primary responsibility remains to provide the best health care he can. All other military aspects come second. Therefore, I feel that the training provided during residency in one's area of specialization provides you with about all you need to function well in a MEDDAC. All the other miscellaneous non-medical topics take a distant second and I feel are not really important. I have been able to function well in a MEDDAC simply by practicing the medicine I was taught. Absolutely nothing covered in the transition training has been needed except for a refresher course in CHAMPUS eligibility/reimbursement and profiles.

Years Military Service 4
Medical Specialty Medicine
Admin Responsibilities 3
Current Assignment MEDDAC/Overseas

I answered a lot of the questions "throughout residency". This is because any course just prior to graduation is likely to be forgotton. The things that can be taught throughout residency should be done through the individual departments with conferences, peer reviews, etc. where it is easier to speak up. rather than at an all-hospital meeting.

Years Military Service 4
Medical Specialty Medicine
Admin Responsibilities 2
Current Assignment MEDDAC/CONUS

From your introduction, I missed the meaning of "transitional training", but your questions were very clear and concise. My experience at FAMC was excellent and indeed provided an overview of all these facets. After being at Ft. Hood for nine months, it is generally true that what was conveyed was true, but very dependent upon where the individual MD is stationed.

Years Military Service 4
Medical Specialty Medicine
Admin Responsibilities 3
Current Assignment MEDDAC/Overseas

As you can tell my responses indicate a general lack of knowledge of the above issues and a feeling that they should be included as part of residency training. However as a recent graduate of residency training I know that time and energy to accomplish this is not available. The issue is a difficult problem for us, and I believe the civilian sector is little different. Some of the issues are different but admin, QA, etc. are with us for the forseeable future. One of the biggest problems is that physicians have abdicated responsibility for many of the above issues in favor of "patient care" and a traditional loathing for admin type problems but this only fuels the fire. Problems will continue until physicians regain control of the profession and work with all health care professionals to provide quality patient care.

Years Military Service 10
Medical Specialty Medicine
Admin Responsibilities 3
Current Assignment MEDCEN/Overseas

I attended a 5-day/all day "transition to practice seminar" that was way too inclusive and, as it turned out, a waste of time because I have never used that info.

Years Military Service 6
Medical Specialty Medicine
Admin Responsibilities 2
Current Assignment MEDDAC/CONUS

Training in a MEDCEN didn't prepare me for the most frequent problem of trying to determine when troops are trying to get out of duty, especially with complaints of shortness of breath, astma, then determining a profile and when to initiate MEBs!

Years Military Service 5
Medical Specialty Medicine/Pulmonary
Admin Responsibilities 2

Current Assignment MEDCEN/Overseas

I agree with a structured delivery of most of these issues. My experience has been learning it (underlined) the hard way!

Years Military Service 5
Medical Specialty Medicine
Admin Responsibilities 1
Current Assignment MEDCEN/CONUS

General information regarding the new installation and city to which the individual is anticipating PCS.

Years Military Service 8
Medical Specialty Med/Cardiology
Admin Responsibilities 3
Current Assignment MEDCEN/CONUS

I never attended a "transition to practice" either after residency or fellowship - I feel it's a waste of time while still in training. That large block of info - when it is not immediately relevant - is easily lost.

Years Military Service 7
Medical Specialty Med/Cardiology
Admin Responsibilities 4
Current Assignment MEDCEN/CONUS

There needs to be more input from recent graduates to those in training programs regarding what is important information to be obtained prior to transferring to a utilization tour. Those running seminars on transition have a different perspective on what is important in comparison to those who have actually made a recent transition.

Years Military Service 4
Medical Specialty Medicine
Admin Responsibilities 5
Current Assignment MEDCEN/CONUS

The primary deficit regards PCS & family issues. Most of us have little or no previous military experience. When we come on to active duty, our families live off-post, due to inadequate housing, so that they are not rapidly assimilated into the military system. Our first real (underlined) army experience is where we complete our residency (which is sheltered at a MEDCEN) and make our first PCS move.

Years Military Service 6
Medical Specialty Medicine/Urology
Admin Responsibilities 2
Current Assignment MEDDAC/CONUS

Most of these topics should be addressed throughout residency with increasing amounts of involvement. Waiting until graduation causes too much material to be presented too rapidly and with no basis for understanding.

Years Military Service 4

Medical Specialty Medicine
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

There is "hope" perceived by residents in training that when finally assigned to work in a MEDDAC, etc. that in fact "life" will become more structured. Often this is not true - the reality of transition is long hours, more histories and physicals, more discharge summaries, significant increase in admin time for QA programs, various committee meetings, always (underlined) a push for more admissions (MCCUs), and the never ending budget crunch curtailing pharmacy costs, reimbursement of travel, etc. Despite continued expectations to pass PT tests, there is no organized activity and you are expected (just as in residency) to do this after duty hours and weekends. This is not a degree of bitterness, just reality (underlined), of the practice (underlined) of Army medicine.

...then if you don't "behave" (underlined) there is always the threat of the OER! We must accept the fact that we are "employees" (underlined).

Years Military Service 7
Medical Specialty Med/Rheumatology
Admin Responsibilities 3
Current Assignment MEDCEN/CONUS

The senior leadership in the Armed Forces does not understand that personal/technical issues of military medicine are handled well. The lack of practical experience with troops allows lots of problems to fester (eg medical boards, profiles, sick slip problems). I have also found the MSC bureaucracy to be hidebound. It sure asks for a lot of data, reports, etc "yesterday". But when I need something I get the same old "well we'll look into it".

Years Military Service 8
Medical Specialty Occupational Medicine
Admin Responsibilities 5
Current Assignment MEDDAC/CONUS

By the time I arrived at my current location, I had been on PCS three times. Occ. Med. residency prepares physicians for the practice of military/industrial medicine, thus we have fewer needs (or have had more military experiences) upon arrival at our first duty station after training.

Years Military Service 7
Medical Specialty OB/GYN
Admin Responsibilities 4
Current Assignment MEDDAC/CONUS

The transition to practice at MAMC in 1987 was very helpful and well organized. The requirement (underlined) to attend the informal sessions was ignored by senior officers.

You may want to look at sick/maternity leave, profiles for physicians, etc. These are areas that need work and conformity.

Good luck in your studies.

Years Military Service 9
Medical Specialty OB/GYN
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

You need to be trained to deal with the absence of clinical support, equipment, secretarial support, office equipment, office space, and other basic requirements to practice medicine.

Also to deal the excessive number of patients that you have to record all their visits manually so some administrative secretary can enter them into the "automated system".

You probably cannot prepare them for transition into a system where you are doomed to supply patient dissatisfaction, patient anger, and perform on the "cutting edge" of malpractice as the physicians who are overwhelmed by numbers of patients and lack of support.

Years Military Service 5
Medical Specialty OB/GYN
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

Physicians should all be ACLS (advance cardiac life support) certified and up-to-date before moving from residency to MEDDACs.

Years Military Service 14
Medical Specialty OB/GYN
Admin Responsibilities 3
Current Assignment MEDDAC/Overseas

WBAMC - El Paso, Tx - Offers a very useful Transition to Practice seminar prior to graduation. I would recommend their program as a guide.

Years Military Service 5
Medical Specialty OB/GYN
Admin Responsibilities 4
Current Assignment MEDDAC/CONUS

In almost all cases training issues should be addressed throughout the physician's career rather than bolused immediately before a utilization tour for instance. It would be much easier for a graduating resident to manage the transition to practice if he had been exposed to issues throughout the years of training instead of being swamped in one stroke.

Years Military Service 5
Medical Specialty OB/GYN
Admin Responsibilities 3
Current Assignment MEDDAC/Overseas

The fact that each MEDDAC Commander has a great deal of latitude to augment or first rate these systems needs to be addressed. That is where recent participants in the years of transition offering practical experience would be of great help.

Years Military Service 6
Medical Specialty Pathology
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

My answers were chosen from a pathologist's view. The administrative/managerial role of a pathologist differs from that of a "clinician".

Years Military Service 8
Medical Specialty Pathology
Admin Responsibilities 5
Current Assignment MEDCEN/CONUS

The officer advance course offers a good forum for communicating much of the info I've indicated as being needed. The problem is that the OAC is too (underlined) long and too (underlined) laden with info NOT useful to M.C. Officers. A short version of this, enroute to a new assignment or as TDY during last months of residency, would be the best way to accomplish this.

Years Military Service 8
Medical Specialty Pathology
Admin Responsibilities 3
Current Assignment MEDCEN/CONUS

The continued lack of support of CME by the military - something required to maintain virtually all (underlined) state licenses. & state licenses are required by law.

Years Military Service 9
Medical Specialty Pediatrics/Neuro
Admin Responsibilities 1
Current Assignment MEDCEN/CONUS

Specific reference to MEDDAC - MEDCEN physician relationships.

Years Military Service 4
Medical Specialty Pediatrics
Admin Responsibilities 2
Current Assignment MEDDAC/Overseas

I feel more exposure to all these issues is necessary through out residency. It is generally not critical to know these things but it is hard to pick them up as you go along. More systematic teaching is required.

Years Military Service 9
Medical Specialty Pediatric/Endocrinology
Admin Responsibilities 3
Current Assignment MEDCEN/CONUS

A lot of the transitional training deals with areas that the SM may never encounter. After my first training experience, I spent three years at a MEDDAC as a Department Chief - THAT was when I needed these lectures. As a staff physician a lot of these issues (OERs, EERs, civilians, JCAH, IG) were not in my job.

Years Military Service 5
Medical Specialty Pediatrics
Admin Responsibilities 3
Current Assignment MEDDAC/Overseas

1) I have never experienced any contact with information systems.

2) What I perceive to be a critical area, JAG, was never addressed in my residency until I invited a JAG Officer to address one of my Grand Rounds when I was Chief Resident. This is a disturbingly inadequate area of traininf.

Years Military Service 5
Medical Specialty Psychiatry
Admin Responsibilities 4
Current Assignment TO&E/Overseas

All topics are very important. I feel my residency and incidental experience did cover many or most of these areas. Unfortunately, many hours of "military psychiatry" training were led by instructors with little or no recent field experience. It will be a great challenge for HSC to develope a comprehensive curriculum to address these needs. I suggest (underlined): develope a manual for Army medical officers - cover these topics & update every two to three years. Include separate chapters on each of the major specialties. Get folks at Ft Sam to help develope it.

Years Military Service 5
Medical Specialty Psy/Neuro
Admin Responsibilities 2
Current Assignment MEDDAC/CONUS

After having recently done a two week military school outside of medicine, (Air Assault) I recognize the importance of physician contact with line units/troops in a non medical context.

Years Military Service 15
Medical Specialty Surg/Otolaryngology
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

Having graduated and transitioned several times I have found the following to be the most ignored:
-Proper dictation and evaluation of MEBs and even more troublesome TDRL reevaluations.
-Local regulations on how far you can live from the hospital
-A candid discussion of social obligations and expectations
-local policies on profiles, CHAMPUS
-Relationship of physicians to other staff officers in a TO&E unit (many new officers have not gone to the advanced course.

TO&E units are generally much better than TDAs at orienting new personnel to local policies. I would recommend a packet including items such as: important DFs; SOPs; a who's who list; narrative dictation outline; comittees and schedules; etc.

Thanks for your interest in this part of our lives.

Years Military Service 8
Medical Specialty Surg/Otolaryngology
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

No mention of Continuing Medical Education needs, or Graduate Education needs.

Years Military Service 6
Medical Specialty Surg./Opthalmology
Admin Responsibilities 4
Current Assignment MEDDAC/CONUS

In one man specialties there needs to be some overlap between PCS moves. If this means TDY before the current doctor ETS's or PCS's then it should be done. This way, the incoming doctor is not at the mercy of the non medical staff when he arrives & will have an idea of how to efficiently and efectively handle medical problems no-one else is qualified to handle.

Years Military Service 8
Medical Specialty Surg/Opthalmology
Admin Responsibilities 5
Current Assignment MEDDAC/CONUS

More emphasis should be placed on communications between the different specialties and their consultants. I feel stronglyabout the consultant getting to know the needs of both the particular assignment and of that physician occupying that particular slot. I have been in my present assignment for 9 months. My consultant has not attempted to know what my needs are. I know for a fact he will call me when I am ready to PCS to see if he can do something for me. At that time it will be too late!

Years Military Service 6
Medical Specialty Surgery
Admin Responsibilities 4
Current Assignment MEDDAC/Overseas

In my 5 year residency I had little or no exposure to the logistics and mechanics of running a clinic, or to JCAHO, QA, Risk Management responsibilities. These topics were superficially covered in the transition seminar given at the end of residency. I felt (and was) totally unprepared to deal with the administrative end of business at my first duty station. The transition to practice seminar was a poor attempt to make up for what had been neeglected during my training - too little, too late.

Years Military Service 9
Medical Specialty Surgery
Admin Responsibilities 3

Current Assignment MEDCEN/CONUS

Yes - Ability to withstand stress associated with the hospital & governmental beurocracy (Underlined) in attempting to perform adequate medical care.

Years Military Service 11
Medical Specialty Surgery/Ortho
Admin Responsibilities 5
Current Assignment MEDDAC/CONUS

Some specialties have more exposure to some of the above during residency due to the nature of the medical specialty. For example, Orthopaedics does many medical board procedures throughout residency, whereas other types of training, ie Family Practice, may not do any until their new duty station. Therefore your survey would need to address each specialty separately.

Years Military Service 6
Medical Specialty Surg/ENT
Admin Responsibilities 2
Current Assignment MEDDAC/CONUS

Preparation is important and helpful, but only the actual situation (ie the new assignment) allows you the practice.

Years Military Service 10
Medical Specialty Surgery
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

The issues most needed to be covered are the things not encountered in residency: CHAMPUS, QA, acquisition of equipment & OER/EERs.

Years Military Service 8
Medical Specialty Surgery/Ortho
Admin Responsibilities 3
Current Assignment MEDDAC/CONUS

ETS - Reserve options, advance planning, timing, insurance needs, etc.

Practice management (military & civilian) - solo, group, megagroup; contracts; business management; setting up practice; malpractice; office personnel management; etc.

Comment: Universal complaint of residents in all fields of medicine in civilian and military programs. Positive benefit to military would be spillover of efficiency from civilian-run practices into military systems. Aside from pay differential (which may be insoluable problem) ongoing inefficiency of system is one of the primary causes of the military's inability to retain many of their well-trained and motivated physicians.