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for the Behavioral and Social Sciences

Research Report 1665

Analysis of Special Forces Medic (18D) Attrition

Scott E. Graham
U.S. Army Research Institute

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Research Report 1665

Analysis of Special Forces Medic (18D) Attrition

Scott E. Graham
U.S. Army Research Institute

Organization and Personnel Resources Research Unit
Paul A. Gade, Chief

Manpower and Personnel Research Division
Zita M. Simutis, Director

U.S. Army Research Institute for the Behavioral and Social Sciences
5001 Eisenhower Avenue, Alexandria, Virginia 22333-5600

Office, Deputy Chief of Staff for Personnel
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FOREWORD

As the world continues to change, the role of U.S. Army Special Forces (SF) grows in importance. This is especially true as the Army is faced with an increasing number of peacekeeping missions. In support, this research represents part of the U.S. Army Research Institute for the Behavioral and Social Sciences (ARI) program to enhance the effectiveness of Army Special Operations Forces personnel. The research investigates ways to improve the training and performance of SF medics.

The Commanding General, U.S. Army Special Operations Command (USASOC), in early FY93 asked ARI to examine the causes of 18D attrition both from training and from the force. Because of the SF training focus, the work was done under the direct leadership of Major General Shachnow, Commanding General, U.S. Army John F. Kennedy Special Warfare Center and School (USAJFKSWCS). The research was conducted by ARI's Organization and Personnel Resources Research Unit, Manpower and Personnel Research Division as specified in Annex A, "Special Operations Research," of the memorandum of agreement between USASOC and ARI dated 30 June 1991.

The results were briefed to the Commanding General, USAJFKSWCS, in July 1993 and the Commanding Generals of USASOC and the U.S. Army Medical Department Center and School in August 1993. The results are being used to improve current SF medic training at Fort Sam Houston, Texas, and Fort Bragg, North Carolina, and also in the design of the Special Operations Medical Training Center.

EDGAR M. JOHNSON
Director

ANALYSIS OF SPECIAL FORCES MEDIC (18D) ATTRITION

EXECUTIVE SUMMARY

Requirement:

In early FY93, the Commanding General (CG), U.S. Army Special Operations Command (USASOC), asked the U.S. Army Research Institute for the Behavioral and Social Sciences (ARI) to examine the causes of 18D attrition both from training and from the force. In response, the primary focus of the research looked at attrition from the 18D Special Forces (SF) Qualification Course (SFQC) or Q-Course. Because of the SF training focus, the research was conducted under the direct leadership of Major General Shachnow, Commanding General, U.S. Army John F. Kennedy Special Warfare Center and School (USAJFKSWCS). The research also looked at the reasons SF medics were considering leaving SF and the Army.

Procedure:

The majority of the report discusses the results of two questionnaires. The first questionnaire, the "Questionnaire on 18D Q-Course Attrition," was developed specifically for this project. As part of the development process, interviews were conducted with approximately 100 students, instructors, and SF medics. The questionnaire was administered to 130 individuals, including students recently relieved from the Special Operations Medical Sergeants Course (SOMED), SOMED and MedLab students, SOMED and MedLab instructors, and SF group medics.

The second questionnaire was developed by the USASOC Surgeon's Office and addressed SF medic career issues. The questionnaire contained 95 items on issues such as career progression, training, credentialing, job satisfaction, and leadership. The questionnaire was sent out in early FY92 to medics in all five active component (AC) SF groups and to a selected few reserve component (RC) medics. A total of 155 medics returned the completed questionnaire, including 135 AC medics.

Findings:

The attrition rate in SOMED rose from 38% in FY89 to 53% in FY92. On top of that, the MedLab/Fort Bragg attrition rate was around 10% for each of those years. Even though the SOMED attrition rate grew during those four years, the number of Q-Course graduates increased from 55 in FY89 to 130 in FY92. As of December 1992, there were 581 of 725

authorized 18Ds. The Special Operations Proponency Office (SOPO) estimates that 10% of the 18D force is lost each year. Once 18Ds are at 100% strength, the 10% steady state loss means that the SWCS will only need to produce approximately 75 18Ds each year. Given that there were 130 new 18Ds last year, the steady state requirement will be only 60% of the current output. Assuming a 10% annual loss and that the Q-Course can continue to produce 130 students per year, 18D should reach 100% strength in the second quarter of FY95.

Training Issues

The biggest single reason for the high attrition at SOMED is that so many tasks are trained in such a short period of time. Because of this, the course is extremely difficult. Discussion to reduce the number of tasks invariably comes around to maintaining the training of trauma skills and reducing the training of medicine skills. It would most likely, however, be a mistake to reduce the amount of medical skills training in SOMED. Medicine is what SF medics do most of the time. Adding additional study time would give the students time to actually learn the information, rather than having to just memorize the information for the next test. There are currently plans to add an additional 11 days of training to SOMED. The additional time will primarily be used to slow down the pace of instruction.

The current authorized SOMED student load is 75 students, including 60 active enlisted and 15 reserve component and foreign nationals. In addition, for the trauma portion of the course, weeks 5 to 19, there are an additional 15 students trained as part of what is now called the "Basic SOF Medic course." For the most intensive part of the course, there is a total of 90 students, not including recycles. Also, because SOMED is 31 weeks long and there are five classes per year, there are always at least three overlapping classes in session.

As of April 1993, there were 34 SOMED instructors. These included 18 active duty slots with one physician, one physician's assistant (PA), and seven 18Ds. A recent Department of Army analysis using the Training and Doctrine Command staffing requirements model determined that the instructor requirement for the course was 44, including 14 18Ds. This analysis did not include the Basic SOF Medic course, which would add 11 additional instructor requirements. Including four new SEAL instructors, SOMED has 38 to 55 (69%) instructor requirements; this is insufficient.

A number of the instructors have inappropriate backgrounds and credentials. Sixteen of the instructors are civilians who have been hired under an educational services contract. Nine of the sixteen are retired licensed practical nurses (91Cs) that, for the most part, are considered lower in the medical hierarchy than 18Ds. The lowest credentialed instructor is a Basic Emergency Medical Technician (EMT-A), which is a credential the students earn half way through SOMED. Increasing the number of instructors at SOMED with appropriate backgrounds will most likely have the biggest effect on reducing attrition.

The increase in number of students has directly increased the student/instructor ratio.

This is particularly critical for the hands-on trauma instruction, in that it limits the amount of one-on-one instructor time that each student receives. In addition, the high student/instructor ratio adds to the stress and burnout of the instructors. Also, because of the high student/instructor ratio, each instructor is the academic counselor for 11 to 12 students. This leads to greater attrition as the counselors do not have sufficient time to adequately know their students. A significant amount of academic attrition is rooted in personal problems.

Until recently, soldiers who failed the 18D Q-Course were often given the opportunity to go to other 18-series Q-Courses. The rationale was that 18Ds were the cream of the crop and that, even though the soldiers could not make it as medics, they probably would still be good in SF. Because of the large numbers in other SFQCs and the diminishing need for the other MOS, 18D Q-Course failures now are sent to a worldwide assignment in their previous MOS. Given that the attrition rate in the other 18-series MOS courses is around 10%, SF is, in effect, systematically selecting more lower aptitude soldiers than higher aptitude soldiers. This situation deserves reexamination.

Recycles are nearly twice as likely to graduate from SOMED than initial inputs. Furthermore, the quality and skills of the recycle graduates are thought to be equal to or greater than those of initial input graduates. Largely because of the addition of the SOF Basic Medic course, the number of soldiers allowed to recycle in FY92 dropped from 27 in the first class to 12 in the fifth class. Because of the pressure to give everyone as much of a chance to pass as possible, students are being allowed to stay in the course as long as there is a mathematical chance of their passing. A more efficient recycle policy would be to relieve marginal students from SOMED as early as possible. The vacated seats could then be filled with recycles who have a much higher probability of graduating.

The SOMED training facilities are in buildings that have been condemned for over a year. SOMED is being forced out of the condemned buildings into facilities that are probably worse, at least from a training perspective. Given that SOMED will be moving to the SOMTC in FY96, a reasonable alternative might be to lease a training facility off-post. This would require funding for transporting the students back and forth, but it would provide a better training facility for perhaps less cost.

The responses on the questionnaire overwhelmingly disagreed with the notion that part of the SOMED attrition comes from the Fort Sam Houston/San Antonio location being too distracting. Many stated the opposite, saying that the medical training facilities at Fort Sam Houston and surrounding San Antonio universities were vital to success in the course. When the medic training is consolidated at SOMTC, it is important SOMTC includes adequate study facilities, including a library and 24-hour study rooms.

SOMED and SOMTC should consider incorporating computer-based training into the 18D training. The PA training program at Fort Sam Houston currently includes computer-based Advanced Trauma Life Support (ATLS) training. Probably for little cost, SOMED could acquire the necessary hardware to run the training.

Selection Issues

Given that 18D students are selected from the pool of SFAS graduates, the 18D selection process appears on track. The selection process is doing a good job of only sending soldiers with the highest intellectual skills. It is recommended that those selecting 18D students continue to look for instruments that measure cognitive flexibility, motivation, and perseverance. Until recently, a considerable number of the soldiers were sent to SOMED who did not want to be medics. It appears as if only volunteers are now being sent to SOMED. Sending only volunteers is particularly important at SOMED because success is heavily determined by motivation and perseverance.

The biggest problem in the selection of the 18D soldiers is that the SFAS graduates largely lack the academic skills and science background that normally would be prerequisites for this type of training. The academic demands of SOMED are roughly equivalent to those of an upper-level undergraduate curriculum in science or perhaps to those of first year medical school. By contrast, most of the SOMED students have had little to no college experience, particularly in the sciences. Given this, the high SOMED attrition rate is to be expected. Some have suggested that a greater effort should be made to recruit soldiers for 18D training with prior medical MOS, e.g., 91B, combat medic, but this was not found to be warranted.

It was widely thought that an 18D precourse would reduce attrition. The precourse should include the basics, e.g., anatomy, physiology, math, and be as rigorous as SOMED. Recently, there was a similar effort to require future SOMED students to complete several Army medical correspondence courses before arriving at SOMED, but the program did not work largely for administrative reasons. Unlike the PA program, 18D does not have a selection board other than SFAS, which is selecting SF and not medics per se. Adding an 18D precourse would serve many of the functions of a selection board. Another possibility would be to have 18D-specific recruiters.

Evaluation and Standards Issues

One possible explanation for the rising attrition is that standards may be rising. Over two-thirds of the instructors said the opposite--that Q-Course standards were being relaxed to increase the number of graduates. For the most part, however, it does not seem that the standards have changed appreciably in one direction or the other over recent years.

Subjectivity in grading, particularly of trauma skills, was thought to be a problem at SOMED, but not at MedLab. The SOMED leadership has, however, made a number of significant changes to standardize the training and evaluation. In general, the trauma scenarios have been standardized and the grading is strictly structured around the ATLS standards. The biggest source of subjectivity is the differences between instructors/evaluators, which is amplified by the fact that they have different backgrounds and, therefore, different points of emphasis. One recommendation would be to monitor the evaluation records of each instructor to identify those who are overly lenient or strict. Similarly, disgruntled instructors should be identified, relieved, and replaced with instructors who want to be there.

It appeared that a significant number of the SOMED students failed the Trauma III field exercise because they were unable to get two full-bore IV started within the prescribed time limits. Even though the students had made 40-50 IV sticks prior to Trauma III clinic, it was the first time that many had ever stuck IVs in the mud, rain, cold, or heat. If IV sticks during Trauma III is a true bottleneck, it is recommended that the soldiers be given additional training under testing conditions, i.e., stressful, cold/hot conditions.

Career Issues

Based on the results of the USASOC Surgeon's 18D survey and the interviews, it is apparent that there is a significant disconnect between the initial Q-Course training and sustainment training. Overall, the group medics were extremely dissatisfied with their sustainment training. Much of the problem hinges on the groups' shortage of medics in that it makes it more difficult for a lone A-team medic to be released for training. Sustainment training opportunities are available, but other commitments take priority over the medics being sent to training. One way to fix this problem is to set up the medical sustainment training, e.g., hospital training programs, as primary tasking from USASOC or SF command.

One of the problems that has arisen in the past several years is that the green cycle is overburdened by certification requirements and testing. It was frequently suggested that the SF certification needed to be seriously examined, as much of the certification focus is on Infantry tactics and drills. An alternative approach would be to decentralize the battalion green cycle training, e.g., train for 3 weeks, during which time the training would be within MOS. Limited MOS sustainment training opportunities are not particular to medics.

One of the areas that needs improvement is the amount and quality of the medic sustainment training provided by the battalion and group surgeons. In general, the team medics received very little training from the unit PAs and physicians.

USASOC Reg 350-9 states that medics must achieve and maintain 210 credentialing points. While the medics understood that the purpose of the requirement was to ensure adequate medical sustainment training, they were overwhelmingly dissatisfied with the credentialing process. Half of the group medics said that they had less than 75% of the required credentialing points. Rather than helping medics receive training, the system was

seen by some as punitive, in that medics are held responsible for not having enough credentialing points.

Plans are underway to give every 18D the opportunity to become EMT-P (paramedic) certified, a credential that is highly sought after by the 18Ds. It was thought that the EMT-P certification would bolster the attractiveness of being an 18D in that there will then be civilian equivalency and recognition. While the EMT-P certification is highly desirable, there is a 48-credit-hour sustainment training requirement for maintaining the certification. Given that group medics are having a tough time getting their certification now, adding additional requirements will make it even more difficult. At some point in the future there could be 800 18Ds and SOF basic medics who need EMT-P sustainment training.

Many of the students and medics said that they thought that SF medics should receive proficiency (Pro) pay. Their rationale was they have to go through longer, more difficult training than their SF peers and that they should be given an extra incentive for maintaining the highly perishable skills. One of the most irksome aspects of Pro-pay issue is that Navy independent duty corpsmen for the most part begin receiving approximately \$275/month Pro-pay upon completion of the 18D training.

One of the reasons some medics become dissatisfied is that they develop unrealistic expectations in the Q-Course. The 18D is trained to be "special." He is given high-powered medical training and is told that he has to make spontaneous life-saving decisions. When the SF medic gets to an A-team, however, his primary responsibility is to be an SF team member, not a health care professional. There may be a need to "detune" the 18D Q-Course some, i.e., to soften the near elitist image of the SF medic. While there need not be a lot of time devoted to training non-medical SF skills, the medic should at least come out of the Q-Course with a set of realistic expectations as to what it means to be an SF medic.

A number of the medics hold misconceptions about their career opportunities. One widely held belief is that 18Ds are less likely to be promoted to MSG and 1SG than the other MOS. This is largely incorrect. The CMF 18 promotion rates to MSG and 1SG for the past three years are nearly identical for the five MOS (to include 18F).

There is some concern within the SF, particularly within the groups, that too many 18Ds are being lost to the PA program. At worst, this should only be seen as a problem until the 18Ds are at 100% of their authorized strength. Approximately 20 18Ds will be accepted into the PA program each year, which means that about 25-30% of all 18Ds eventually go into the PA program. A change was recently made to the PA selection procedures that says that soldiers must have no more than a maximum of 8 years services to be accepted into the program. One of the potential problems of the new PA requirement is that it may force 18Ds to leave SF earlier in their career. If SF is going to continue to attract quality soldiers into the 18D program, the opportunity should be there for some medics to continue their careers in the PA program.

Recommendations:

Based on the results of the research, the following are the top recommendations for reducing 18D attrition:

- Increase the number of instructors at SOMED. Ensure that the instructors have the proper background and credentials, and that they want to be there.
- Relieve marginal students earlier from SOMED. Use the vacated seats to train more recycles who are twice as likely to graduate as initial inputs.
- Identify those tasks that are most frequently failed and better focus the training on those tasks. In particular, make sure that the training on IVs is conducted under the same conditions as the field testing.
- Minimize the subjectivity in the grading of trauma skills by providing additional training and by weeding out instructors who are overly strict or lenient. Develop training materials similar to the SFAS Assessor Training Program.
- Ensure that the new SOMED training facilities are appropriate for the intensity and length of the training.
- Continue to send only those soldiers to SOMED who want to be medics.
- Investigate the feasibility of an 18D precourse.
- Develop policies to reduce instructor burnout.
- Incorporate appropriate computer-based training, beginning with the existing ATLS training.
- Provide better computer capabilities to the SOMED staff.

ANALYSIS OF SPECIAL FORCES MEDIC (18D) ATTRITION

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ANALYSIS OF SPECIAL FORCES MEDIC (18D) ATTRITION

Introduction

The Special Forces (SF) medic, military occupational specialty (MOS) 18D, is a unique Army asset. Unique in that 18Ds are both warriors and medical practitioners. SF medics treat life threatening trauma injuries to fellow soldiers and provide medical, dental, and veterinary care to indigenous forces and their families. They parachute into denied areas with sufficient medical supplies for sustained missions and deliver training to foreign forces. They remain well trained in small unit tactics and are able to bring violent force on direct action targets as part of 12 man A-detachments. They speak foreign languages and are sensitive to the culture of their area of operation. Clearly, not many people can muster the intelligence, strength, sensitivity, and medical knowledge and skills to become an SF medic.

To become an 18D, the soldier must pass a rigorous selection process and complete what is likely the most difficult training in the U.S. Army, the 18D SF Qualification Course (SFQC). Not surprisingly, the 18D SFQC, or Q-Course, has what is likely the highest attrition rate of any training in the Army. The training is extremely difficult, requiring both the academic skills to absorb tremendous amounts of medical information and the motor skills to master delicate hands-on medical procedures. The high attrition rate is not all bad, in that high selection and training standards are thought to be necessary to maintain the quality reputation and high standards of the SF medic. Nevertheless, despite the need for high standards, the 18D training attrition rate remains somewhat of an enigma.

In early FY93, the Commanding General (CG), U.S. Army Special Operations Command (USASOC), asked the U.S. Army Research Institute for the Behavioral and Social Sciences (ARI) to examine the causes of 18D attrition both from training and from the force. The primary focus of the research is on the attrition from the 18D Q-Course. Because of the SF training focus, the research was conducted under the direct leadership of Major General Shachnow, Commanding General, U.S. Army John F. Kennedy Special Warfare Center and School (USAJFKSWCS or SWCS) and in coordination with Major General Moore, Commanding General, U.S. Army Medical Department Center and School (AMEDDC&S). The research also looked at the reasons SF medics were considering leaving SF and the Army.

The negative impact of high Q-Course attrition can be seen in at least three areas. First and foremost, there continues to be a shortage of 18D medics. Currently, there are only about 80% of the authorized number of active component (AC) medics in the force. As a result, the majority of A detachments only have one of two authorized medics. Second, the high attrition rate is costly. The Army has paid for many soldiers and their families to make two permanent change of station (PCS) moves to Fort Sam Houston, TX, and to Fort Bragg, NC, with the end result being that they were relieved

from the course. In addition to the PCS costs, the salaries of the unsuccessful soldiers are, in effect, lost during the time that they are training.

The third impact of the high attrition rate is that quality soldiers are being lost from SF. In general, the best and brightest of those who pass the SF Assessment and Selection Course (SFAS) are sent to 18D training. Given the current attrition rate, the most likely outcome for these SF medic trainees is that they will be sent to a world-wide assignment in their previous MOS. Given that the attrition rate in the other 18-series MOS courses is considerably lower (around 10%), SF is, in effect, systematically selecting more lower aptitude soldiers than higher aptitude soldiers. This is not to say, however, that there are not numerous quality soldiers in each of the 18-series MOSs.

Major Factors of Attrition

Many factors potentially contribute to the attrition rate of the Q-course. These individual factors can, however, be logically organized into three major factors: (1) training, (2) selection, and (3) evaluation and standards. The crux of the report will address issues within each of these major factors of attrition, including some of the issues introduced below.

- Training - Are the curriculum, instruction, and materials adequate to train the students to pass the criteria? Factors to be discussed are student/instructor ratios, qualifications of instructors, physical facilities, and course organization.
- Selection - Are the right people being sent to the course? Do they have the prerequisite knowledge, skills, and abilities needed to succeed? Some of the critical selection factors that will be discussed are the student's background, motivation, and problem-solving ability.
- Evaluation and Standards - Are the test standards appropriate for the course objectives? Are the course objectives appropriate for the desired product? Factors here include changing standards, training under test conditions, and subjectivity in grading.

Overview of the Report

The next section of the report presents a sketch of the 18D selection and training process. Because the majority of the 18D Q-Course attrition occurs during the Special Operations Medical Sergeants Course (SOMED), particular focus is placed on the 31 week SOMED phase which takes place at Fort Sam Houston, TX. The sketch of the 18D selection and training process is followed by an analysis of 18D attrition statistics and manpower projections.

The majority of the report discusses the results of two questionnaires. The first questionnaire, the "Questionnaire on 18D Q-Course Attrition," was developed specifically for this project. As part of the development process, interviews were conducted with approximately 100 students, instructors, and medics. The method and results of the 18D Q-Course attrition questionnaire are presented at Appendix A. The second questionnaire was developed by the USASOC Surgeon's Office and addresses SF medic career issues. The methods and results of "SF Medic Annual Survey" are presented at Appendix B. The complete questionnaires, analyses, and soldiers' written comments are presented in Appendixes C through H. The body of the report attempts to synthesize the information gained in the interviews and questionnaires and is generally organized along the three major factors of attrition, i.e., training, selection, and evaluation and standards. There is also a section of career issues which discusses issues such as sustainment training, credentialing, and career paths.

Before proceeding, a caveat is necessary. Most of what is reported here comes from one of three sources. First, it comes from soldiers' opinions and perceptions as they were reflected on the questionnaire, second, it comes from soldiers' opinions and perceptions as given during the interviews, and third, it comes from what I picked up in limited observations of the training and in talking to everyone I could about 18D. Based on these sources of information, I have presented a host of ideas along with some recommendations. In some cases, the recommendations follow directly from the questionnaire data, while in other cases they may not. Also, I have included a number of quotes from those interviewed. Each of the quotes is one soldier's opinion, but one's that I think that give insight into what is happening. Lastly, I have included a few ideas which may be difficult to realize, but which were strongly held by a significant number of soldiers, e.g., the creation of SF medic PA slots.

18D Selection And Training Process

All soldiers who go into SF are volunteers. They must be males with ranks ranging from Specialist (SPC) to Sergeant First Class (SFC) and have an Armed Services Vocational Aptitude (ASVAB) General Technical (GT) score of 110 or higher. GT is a variable which is thought to correlate highly with general intelligence. Given that GT has a standard deviation of 20, SF volunteers are from the upper 30% of the GT distribution. If the SF volunteers meet these and other requirements, they are sent to the Special Forces Assessment and Selection course (SFAS).

SF Assessment and Selection Course

SFAS is designed to identify those candidates who have the highest potential to succeed in SF training. The 21 day course is held at Fort Bragg and is divided into two phases. The first phase is designed to assess individual physical fitness, effort, and the ability to cope with stress. The candidates must complete psychological tests, swim tests, obstacle courses, timed ruckmarches, and military orienteering exercises. On day 11, an

evaluation board determines whether the candidates are allowed to continue in the course. The second SFAS phase focuses on the candidates' leadership qualities and their ability to work as part of a team. The candidates are rated on factors such as motivation, teamwork, intelligence, stability, communication, and decisiveness. A final selection board then decides which candidates qualify for the SF Qualification Course. Over the past several years, approximately 50% of those in SFAS have been selected for Q-course training. For a more detailed description of the SFAS selection procedures, see Brooks, 1991.

MOS Allocation

Those candidates selected for further training are assigned to one of the four 18-series MOS, either 18B (Weapons Sergeant), 18C (Engineer Sergeant), 18D (Medical Sergeant), or 18E (Communication Sergeant). The soldiers are typically asked for their MOS preference, but at least until recently, their preference did not carry much weight in the MOS assignment process. Soldiers typically have been assigned to the 18D training if they had GT scores above 120 and/or had any medical, science, or math background. A GT of 120 or above means that the soldiers selected for 18D training are at or above the 84th percentile. To further ensure that only soldiers with the highest intellectual abilities are sent to SOMED, the Wonderlic intelligence test is also used in the MOS allocation.

18D SF Q-Course

After being selected for 18D training, the candidate returns to his unit to await a PCS move to Fort Sam Houston, TX. Until recently, the wait typically was for several months; now the wait can be up to a year or longer. SOMED is a 31 week course which is taught by Company F (Abn), Academy of Health Sciences (AHS), which is part of AMEDDC&S. The course includes 26 weeks of didactic and hands-on medical and surgical training, a one week Trauma field exercise (FTX), and concludes with four weeks of clinical proficiency training (CPT). The CPT is an on-the-job training phase with most positions being at U.S. Army Medical Activities or U.S. Public Health Service clinics. Additional details about the SOMED training are presented later.

Those soldiers who successfully complete SOMED are PCSed to Fort Bragg for the remainder of the Q-Course. They continue MOS training with 14 weeks of MedLab. MedLab primarily focuses on the development of trauma skills, including medical, surgical, clinical laboratory, veterinary medicine, and nursing skills training. Much of the MedLab training involves the use of live tissue and human role models. MedLab is followed by the eight week Field/Branch phase which is conducted near Fort Bragg at Camp MacKall. This phase includes training in land navigation, small unit tactics, mission planning, and culminates in the "Robin Sage" FTX in which the soldiers are trained and evaluated as part of an A-team. At the end of the 55 week 18D SFQC, the

soldiers are awarded their 18D MOS and SF tab. Before being assigned to an SF group, however, the medics must successfully complete up to 10 months of language school.

SOMED Snapshot

Because most of the Q-Course attrition occurs at SOMED, a more detailed description of SOMED is necessary. SOMED is designed to prepare the medic for his medical duties and responsibilities on an A-team or related element. The course incorporates intensive didactic and hands-on instruction and testing in subjects and skills related to medicine, surgery, acute trauma care, nursing, pharmacology, anatomy and physiology, psychiatry, and dentistry. (SOMED Student Evaluation Plan, 1993). The instruction is organized into seven modules of which the instruction and testing is largely interwoven. The one main exception is that most of the anatomy and physiology module is taught and tested in the first weeks of the course. The seven modules are:

1. Medical
2. Surgical
3. Nursing
4. Pharmacology
5. Anatomy and Physiology
6. Advance Trauma Management Clinics
7. General Subjects Module

Table 1 shows the instructional subjects that are included in the Medical module. The amount of instruction for each of these subjects ranges from one 45 minute period to twenty 45 minute periods with the mean amount of instruction being around four 45 minute periods. The purpose of this list is intended in part to convey the scope, complexity, and difficulty of the 18 Q-Course.

SOMED Instruction. Instruction during the first two months and last two months of SOMED is primarily lecture. By contrast, the middle twelve weeks of the course contain most of the hands-on surgical and trauma instruction. In particular, there are three trauma clinics which train and assess the hands-on treatment of trauma injuries. As a note, the SOMED and MedLab trauma training and standards are largely based on those from the nationally registered Advanced Trauma Life Support (ATLS) program.

The Trauma III clinic is the FTX and is one of several critical objectives in the course. The Trauma III clinic involves intensive one-on-one graded exercises utilizing moulaged "victims" with severe traumatic injuries, e.g., protruding projectiles, blown off body parts, severe lacerations and burns. The first portion of the exercise requires the student to respond to a field casualty and to provide pre-hospital type trauma care. The second portion of the testing evaluates the students' patient assessment and management skills in an emergency room or battalion aid station. In both portions the evaluation standards are in accordance with ATLS standards. The Trauma III clinic has become

Table 1

Instructional Subjects Included in the SOMED Medical Module

Medical Terminology	Medical Aspects of Arthropod-Borne Diseases
Fundamentals of taking a Health History	Applied Gynecological and Obstetrical Anatomy & Physiology
Introduction to Physical Examination	Pelvic and Rectal Examinations
Physical Examination of the Skin	Gynecological Infections and Abnormalities
Diseases of the Skin	Assessment of Pregnancy and Estimating Dates of Confinement
Physical Exam of Head, Eyes, Ears, Nose, and Throat	Complications of Pregnancy
Diseases of the Head, Eyes, Ears, Nose, and Throat	Pediatric Physical Examination
Physical Exam of the Respiratory System	Pediatric Diseases
Diseases of the Respiratory System	Oral Boards Briefing
Tuberculosis	Common Etiologies for Pediatric Diarrhea and Assessment
Drowning, Near Drowning	Common Pediatric Orthopedic Problems
Diseases of the Cardiovascular System	Medical Case Studies
Blood Grouping and Transfusion Reactions	Medical Ethics
Diseases of the Blood	Small Group Instruction
Physical Examination of the Abdomen and Genitalia	Clinical Proficiency Training Orientation
Appendicitis	Area Study
Differential Assessment of Abdominal Pain	Diving Medicine
Differential Assessment of Jaundice	Interpretation of Laboratory Data
Infectious GI Diseases	Malaria
Diseases of the Genitourinary System	Endoparasitic Protozoal Diseases
Oliguria	Introduction to Medical Facilities
Sexually Transmitted Diseases	Medical Supply
Physical Examination of the Neurological System	Endoparasitic Helminthic Diseases
The Unconscious Patient	Ecto-parasitic Disease
Control of Pain	SF Duties/Responsibilities
Physical Exam of the Musculoskeletal System	Leprosy
Common Arthritic Disorders	Disorders of Heart Rate and Rhythm
Endocrine Diseases	Low Back Pain
Poisoning	Sick Call Practice Exercise
	Hepatitis
	High Altitude Sickness

the "make or break" point in SOMED in that approximately 90% of the students who pass Trauma III end up graduating from SOMED.

Evaluation Criteria. The basic SOMED requirement is that a student must maintain a 75% grade point average (GPA) in each of the seven modules. This, of course, means that the overall GPA must be 75% or higher. In addition, there are several critical objectives which must be passed, e.g., the Trauma III clinic and the Emergency Medical Technician-A (EMT-A) National Registry Exam. If a student fails a critical objective/task, he is given a reteach and one retest. If the student fails the retest, he is academically relieved from the class.

Recycle Procedures. Certain students who are relieved from a class are given the opportunity to recycle. Usually this involves the student being placed in one of the next two classes that follows his original class. The recycled student's grades on tests that are not to be tested in the later class are carried forward and recorded on the student's grade card for the new class. An effort is made to recycle students far enough back so that they are retrained and retested in the entire module or modules that resulted in the academic recycle. This prevents the carry over of failing grades into the new class.

Class Sizes. The current authorized size for the full SOMED course is 75 students, which is comprised of 60 active enlisted and 15 reserve component and foreign nationals. In addition, for the trauma portion of the course, weeks 5 - 19, there are an additional 15 students trained as part of what is now called the "Basic SOF Medic course." Previously it was called the "short course" or the "Generic SOF Medic Course." The authorized fill of the Basic SOF Medic course is 10 SEALS and five SOF Medics (primarily 91Bs from the Rangers, PSYOP, Civil Affairs, or SOF Aviation units). For the most intensive part of the course then, there is a total of 90 students, not including recycles. Also, because SOMED is 31 weeks long and that there are five classes per year, there are always at least three overlapping classes in session.

In a fair number of cases, soldiers are showing up for SOMED without being on the Army Training Requirements and Resources System (ATRRS) roster, for example, soldiers show up one class too soon. It was suggested that the biggest violator was RC units. In some cases, if the soldiers are not on the ATRRS list, they are PCSed back to their previous unit. This of course is extremely costly. In other cases, soldiers are showing up with incomplete medical records. If the discrepancy is not resolved within a couple of days, these soldiers are also PCSed back. The end result of the extra soldiers showing up for SOMED is that the initial class sizes are sometimes greater than the maximum authorized class size. Several individuals interviewed questioned the procedures from which RC soldiers were selected and sent to SOMED. In some cases, tabbed RC soldiers were being sent to SOMED for 18D cross-training even though their A-detachment had as many as four qualified Medics.

Instructors. As of April 1993, there were 34 SOMED instructors including one physician, one physician's assistant (PA) and seven 18Ds. Sixteen of the 34 are contract-civilian instructors. Some of the blocks of instruction are, in addition, taught by AHS instructors. As will be discussed later, the student/instructor ratio and the background of the SOMED instructors appear to be a major contributor to the high attrition.

SF Medic Mission

One of the working assumptions made during this project was that the 18D task list was valid and that the 18D Q-Course was training what it needed to train. This assumption may not be correct. The basic question that needs to be addressed at a higher level is "What should the capabilities of an 18D be?" Should the SOF community expect all SF medics to be the best trauma medics in the world, and in addition to be able to diagnose and treat exotic diseases, sustain casualties for extended periods of time, deliver babies, and perform surgery. With little exception, however, it seems that everyone is quite satisfied, if not proud, of the SF Medics in the field today. Any discussion of lowering the standards, i.e., letting lower ability Medics graduate or graduating with fewer skills, is severely challenged.

Attrition Rate Analyses

Several analyses were conducted to look at changes in the 18D Q-Course attrition rate over the past four years (FY89-FY92). The analyses were conducted using the SFQC database which has been constructed by ARI (Zazanis, Diana, and Teplitzky, 1994). The data used for these analyses are largely cleaned-up ATRRS data, i.e., numerous discrepancies in the ATRRS database were reconciled with individual class rosters and grade sheets. Figure 1 shows the change in SOMED attrition rate over the past four years. The attrition rates were calculated using the AHS attrition formula:

$$\text{Attrition Rate} = \frac{\text{Initial Inputs} + \text{Recycles In} - \text{Recycles Out} - \text{Graduates}}{\text{Initial Inputs} + \text{Recycles In} - \text{Recycles Out}}$$

The AHS attrition formula is reasonable and straightforward; it does, however, basically disregard those students who are recycled to later classes. As can be seen in Figure 1, the SOMED attrition rate has increased a significant amount in the past several years.

Part of the increase in SOMED attrition seems to be due to a restructuring of the course. Prior to 1991, all Q-Course students received four weeks of initial field training at Fort Bragg before beginning their MOS training. Table 2 shows the attrition rates for each of the Q-Course phases. As shown, 10% of the students attrited from the initial field phase in FY89 and FY90. After that course was restructured and the initial field training was moved to the end of the course, the SOMED attrition increased by roughly that same amount. The last column shows the overall probability that a student attrited from the full Q-Course. These data appear to suggest that eliminating the initial field

phase attrition added to the SOMED attrition rate. The likely explanation is that the initial field training served to screen out unmotivated or weaker students before they arrived at SOMED.

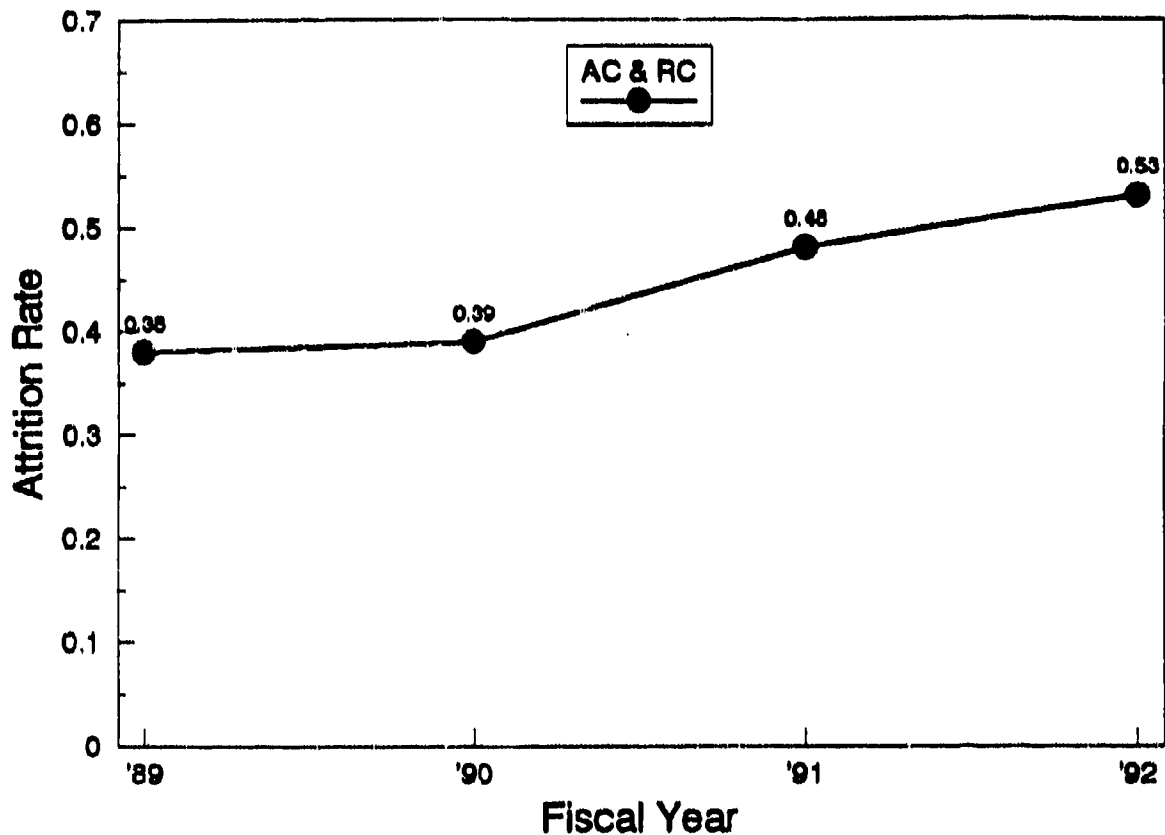


Figure 1. FY89-92 SOMED attrition rates.

Further analysis of the data, however, casts some doubt on whether the attrition from the initial field phase was passed directly onto SOMED. Because of the way the course was restructured there was not a single SOMED class in which everyone either had or had not completed the initial field phase. The midpoint was SOMED course number 3-90, which contained half who had and half who had not completed the initial field training at Fort Bragg prior to SOMED. One way to compare the effects of restructuring is to look at the attrition rate of the classes immediately preceding and following the change. The SOMED attrition rate for the three classes immediately preceding class 3-90, i.e., 2-90, 1-90, and 5-89, was 42%, while the SOMED attrition rate for the three classes immediately following 3-90, i.e., 4-90, 5-90, and 1-91, was 41%. Going out five classes before and after 3-90 found the mean SOMED attrition rate to 42% for both before and after. Based on these analyses it does not look like the restructuring of the course had much effect on the SOMED attrition rate.

Table 2

18D SFQC Attrition Rates (FY89-92)

FY	Initial Field	SOMED	MedLab & Field	Combined
'89	10%	38%	17%	54%
'90	10%	39%	5%	48%
'91	---	48%	7%	52%
'92	---	53%	10%	58%

Another possibility as to why the SOMED attrition rate has risen is that the number of students in the classes has increased. Table 3 shows the average number in each class along with the percentage of AC students. Indeed there was a 75% increase in the number of SOMED students between FY89 and FY91. As a note, there are five SOMED classes per year and until recently six MedLab classes per year. Beginning in FY93, there are only five Q-Courses classes per year for all of the MOS. Approximately 25% of the graduates have been RC soldiers, although the percentage should be stabilizing around 20%, given that the input to the course is now set at 60 AC and 15 RC soldiers. In Table 3, you can see the cohorts through the moving course. In FY90, for example, there are 69% AC graduates from SOMED and in FY91 there were 69% AC graduates from MedLab.

The basic strategy has been, "The more students in, the more graduates out." Even though the SOMED attrition rate may have increased with the larger student input, the strategy has basically worked. Table 4 clearly shows that the number of AC 18D graduates has increased dramatically over the past years.

As mentioned, some of the students who are relieved from SOMED are given the opportunity to recycle to a later class. Figure 2 shows the probability of graduating from SOMED for both the recycles and for the initial starts. The question here is: given that a student is in training, what is the probability that he will graduate from that class. Probability of graduating is not simply the inverse of attrition in that recycles are handled differently. In this analysis recycles are basically counted as failures, i.e., the soldier is in the training seat but he does not graduate. Two interesting points can be seen here. First, in the last several years there is a marked decrease in the probability of graduating for initial inputs whereas the probability of graduating for recycles is basically flat. Second, for FY91 and FY92 the probability of graduating for recycles is nearly

twice as great as the probability of graduating for initial starts. The last point has significant implications for the SOMED recycling policy and will be discussed later.

Table 3

Average Number of Students per Class

FY	SOMED		MedLab & Field	
	n	% AC	n	% AC
'89	53	85%	19	64%
'90	63	69%	20	80%
'91	93	76%	39	69%
'92	82	80%	40	77%

Table 4

Number of Active Component Graduates per Fiscal Year

FY	Number
'89	55
'90	75
'91	82
'92	130

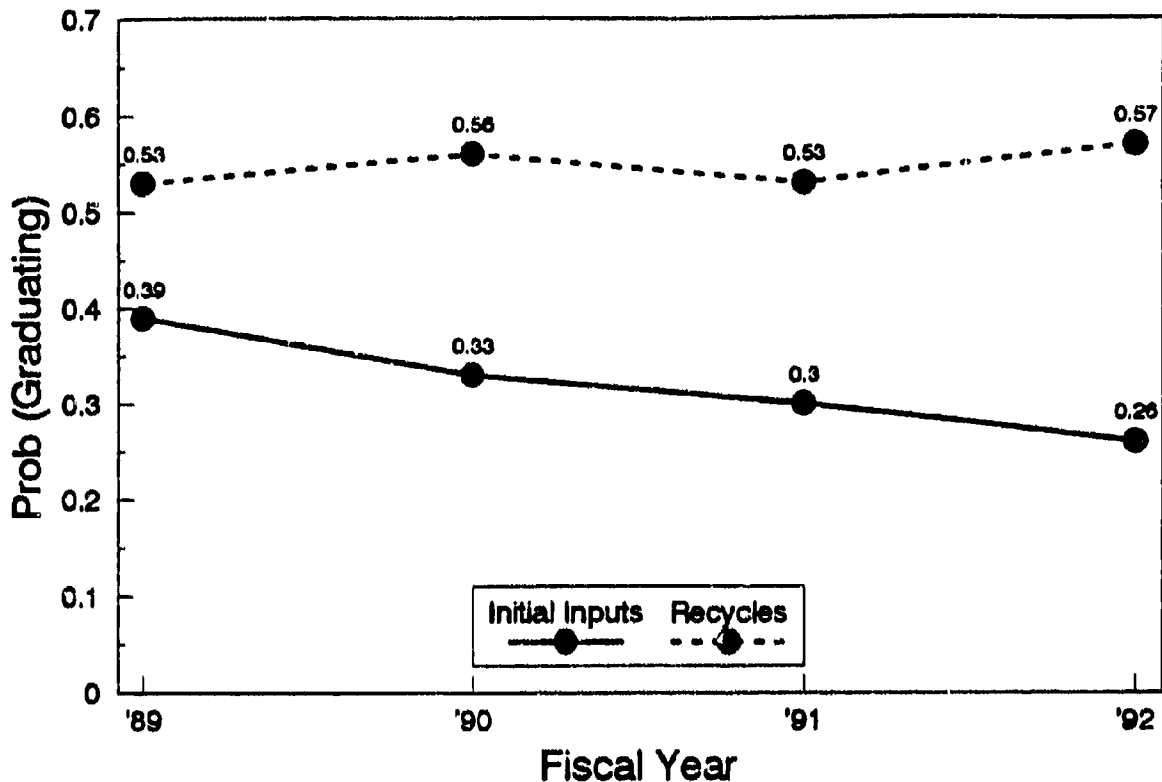


Figure 2. Probability of graduating from SOMED as a recycle or initial input.

Manpower Projections

The Special Operations Proponency Office (SOPO) estimates that 10% of the 18D force is lost each year. A small percentage of the loss is due to ETS, retirement, and reclassification to other MOS while the majority of the loss is due to migration to the PA program and to 18Z promotions. Based on the March 1993 CMF 18 laydown, there were 581 of 725 authorized 18Ds in December 1992. At that point the CMF was 144 18Ds short. Once the CMF is at 100% strength, a 10% steady state loss rate means that the school house will only need to produce approximately 75 new 18Ds each year. Given that there were 130 new 18Ds last year, the steady state requirement will be at 60% of the current output. Considering the fact that 18Ds have long been under strength, it is difficult to anticipate the need to cutback the supply, but it will happen relatively soon. The needs for 18D will almost certainly be less by the time the training moves to the SOMTC. Assuming a 10% annual loss and that the Q-Course can continue to produce 130 students per year, 18D should reach 100% strength in the second quarter of FY95.

18D Q-Course Attrition Questionnaire Summary

Most of the discussion here is based on information gained through a series of interviews and on the results and analysis of a questionnaire on 18D attrition. Approximately 100 individuals were interviewed with the majority being students and instructors from SOMED and MedLab. In addition, training directors, managers, and developers from SWCS, USASOC, and AMEDD and SF Medics were also interviewed. As mentioned, a complete description of the 18D Q-Course attrition questionnaire methods and results are presented beginning at Appendix A.

The questionnaire contained 38 objective items along with numerous opportunities for the soldier to provide written comments. The questionnaire primarily asked the respondents to agree or disagree with the ideas that had been generated during the initial interviews. Because most of the 18D Q-Course attrition occurs during SOMED, the majority of the questions focused on SOMED. The questionnaire was administered to 130 individuals including students recently relieved from SOMED, SOMED and MedLab students, SOMED and MedLab instructors, and SF group medics.

The first items on the questionnaire asked the soldiers and civilian instructors to make recommendations as to how the 18D Q-Course could be improved and as to how attrition could be reduced. Table 5 presents the top ten most frequently made recommendations along with the number of times each was mentioned. Each of these recommendations will be discussed within the sections on training, selection, or evaluation and standards.

Table 5

Top Ten Recommendations to Improve 18D Course/Reduce Attrition

Recommendation	Frequency
Lengthen SOMED/Increase amount of study time	53
Reduce student/instructor ratio at SOMED	52
Only send soldiers to SOMED who want to be Medics	52
Improve the 18D selection procedures	44
Get instructors/evaluators with proper backgrounds (SOF, Physicians, PAs)	41
Decrease subjectivity in grading	33
Provide civilian certification/equivalency (EMT-I or EMT-P)	24
Maintain the high standards as attrition rate ensures quality Medics	18
Increase the amount of hands-on training and lab work	15
Improve the SOMED physical facilities	13

Training Issues

Course Content and Structure

The most frequently mentioned recommendation for reducing attrition was to lengthen SOMED. The basic point is that too much information and skills training is condensed into too short of a period of time. There are two basic alternatives. Either change the amount of material that is trained or add additional training and study time. First let us look at what is trained.

18D Task List. The 18D task list consists of 518 18D tasks of which 512 are deemed critical. In addition, 188 tasks are, in principal, trained to standard during SOMED. Some have suggested that it is unrealistic to think that all of these tasks can be trained and then adequately sustained. While there is an on-going relook of the 18D task lists by a committee group from SWCS and AMEDDC&S, preliminary indications are that the task list is not likely to change very much. Critics have suggested that the relook of the task list over-represents the medical perspective. It has been suggested that if a significant change in the 18D task list is to be realized, then the task analysis should focus on what the SF group commanders say they really need in their medics.

Trauma vs. FID-related Tasks. The SF Medic tasks can be split into two categories. The first category involves trauma tasks which are generally performed in treating our own soldiers during direct action (DA), special reconnaissance (SR), and counter-terrorism (CT) missions. The second category involves medicine tasks which are generally performed during foreign internal defense (FID) and unconventional warfare (UW) missions.

The performance requirements and preferred instructional approach for these two types of tasks are sufficiently different. In the case of the trauma tasks, the knowledge and skills must be readily available and highly practiced such that the medic can quickly perform the tasks "off the top of his head." By contrast, the FID-related tasks, e.g., diagnosis and treatment of diseases and preventive veterinary skills, are less time-sensitive. In most cases the medic would be able to use reference information while performing the FID-related tasks.

It is recommended that the training of these FID-related tasks focus on the process of using the reference materials and generally should involve "open book" type evaluations. Relatedly, it is probably better that the medic knows how to get up-to-date area information rather than being able to remember the information. For example, the Medic should be quite familiar with how to get information from the Armed Forces Medical Intelligence Center (AFMIC). In SOMED there are currently few, if any, open book exams that were designed to test the process of locating and using reference information. Incorporating this type of exam should not be viewed as lowering the standards, but as emphasizing the appropriate, realistic career skills.

Another recently considered proposal is that of the Junior and Senior Medic. Under such a program, the Q-Course graduate would be a Junior Medic who would primarily be trained in the must-know trauma skills. He would also be given familiarization training in the medical skills. Later he would be sent back to school to receive further training in the FID-related medical skills. The downside of this plan is that deployability of A-detachments would be determined by whether they had a Junior Medic and Senior Medic or both.

Trauma vs. Medicine. In some ways it is nearly absurd that so many tasks are trained at SOMED in such a compressed time frame. On the other hand, any discussion to reduce the number of tasks invariably comes to maintaining the training of trauma skills and reducing the training of medicine skills. It would, however, most likely be a mistake to reduce the amount of medical skills training in SOMED. Medicine is what medics do most of the time. As one group medic wrote, "I can definitely say that 85-90% of what I have done has involved medicine skills. That is not to say that you don't need the trauma skills, because when that happens, it is most important." Or, "I have had one trauma in six months and 100 (medicine) patients in a day."

SOMED is where the Medics receive almost all of their medical skills training. While they do receive some training from the unit surgeons on area specific diseases, most of the unit training focuses on the sustainment of trauma skills. This is particularly true of the annual ATLS sustainment training. Given the likely increase of SF roles in peacekeeping missions, it would seem unwise to reduce the amount of training in medicine. The success of SF and of the United States foreign policy is often predicated on the ability of the 18Ds to treat indigenous personnel and their families.

A complete 18D training strategy needs to be developed. The training strategy should identify which tasks are to be trained in the schoolhouse during initial training, which tasks are to be introduced in initial training, and which are to be taught OJT and/or in the units. The current approach basically is to train all tasks to standard during the Q-Course. One partial solution would be the development of a more comprehensive distributed training program where quality training and training materials can be distributed to the field. This might include computer-based training, video teleconferencing, or specific training packages developed to train, for example, regional based diseases and treatments.

Adding Additional Study Time. While it may be possible to somewhat reduce the amount of material that is trained in the 18D Q-Course, another option is to add additional time to the course. As one student suggested, "It is not the amount of material per se that is the problem, but the pace at which the training is presented." (Tables A-8 and A-9.) Currently, students get eight to nine hours of instruction every day. They then must go home and study for several hours each night only to have to come back the next day for eight or nine hours of new instruction. There is very little time to digest the information.

Adding additional study time would give the students time to actually learn the information, rather than having to just memorize the information for the next test and then dump it. Even SOMED instructors have told the students, "Don't worry about learning the material, just get to where you can regurgitate it on the tests. You can relearn it when you get to the unit." There is so much information that students are often forced to write down information that they have no idea as to what it means. Then they are tested on it several weeks later.

The differential graduation rate between recycles and first time starts argues in favor of adding additional study time. The explanation frequently given is that if recycles had been given more time in the first place then their graduation rate would have been higher. For a variety of reasons, even the extremely sharp and motivated student may not make it through the first time. Furthermore, the instructional material is much more salient to the recycles in that they understand why the information is important. The second time around they also have a context in which to store the information. As one recycle said, "Only now do I realize how little I understood in A&P the first time around. Now I am scoring 92s to 95s on my tests." In general, the better the foundation, the easier it is to learn and recall new information. Adding additional study time to the course should help to build a better knowledge foundation the first time through.

There are currently plans underway to add an additional 11 days of training to SOMED. The additional time will primarily be used to slow down the pace of instruction by adding proctored study halls. Eleven days works out to a little over three hours of additional time per week. Responses to the questionnaire suggested that 22 additional days of study time should be added to SOMED.

There are some downsides to adding additional time to the course. At the current SOMED length of 31 weeks, it is difficult to keep the students motivated. Adding two additional weeks will likely make it even more difficult. Also, there are additional costs in lengthening the course. The per student cost will increase when the course is extended 11 days; four of the eleven days will be used for additional trauma practice and will require extra supplies. Adding eleven days to the five classes per year also means that 55 additional days of instructional time will have to be provided by the current instructors and staff, basically out of hide. As will be discussed later, there is already a problem with instructor burnout.

Adding a Mid-Term Break One idea suggested was to consider adding a mid-term break in SOMED. Only those classes which stretch over Christmas receive any break in instruction. Otherwise, the course goes for 31 solid weeks without any breaks. Furthermore, recycles usually go right back into the next class without any break. The responses on the questionnaire only moderately supported the idea that a midterm break would be effective in reducing attrition. In general, however, there are virtually no other training or education programs that go 31 weeks (soon to be 33 weeks) without a break. In

designing the class schedules for the Special Operations Medical Training Center (SOMTC), it is important that they consider including breaks.

SOMED Instructors

Two of the top five recommendations for improving the Q-Course and for reducing attrition were to reduce the student/instructor ratio at SOMED and to get more instructors with appropriate backgrounds. The basic point is that SOMED does not have enough instructors and that many of the ones that they do have lack adequate training, background, and/or credentials.

Number of Instructors. As of April 1993, there were 34 SOMED instructors. These included 18 active duty slots with one physician, one PA, and seven 18Ds. In FY94, SOMED is programmed to lose one of the 18D authorizations to Quicksilver. I was told that a recent Department of Army analysis using the TRADOC staffing requirements model determined that the instructor requirements for the course was 44 including 14 18Ds. This analysis did not include the Basic SOF Medic course which, I was told, would add 12 additional instructor requirements. Assuming that this information is correct, SOMED and the Basic SOF Medic Course currently have 34 instructors against 55 requirements. They have, however, begun to receive and train-up four Navy instructors to assist in teaching the Basic SOF Medic Course. Including the SEALS, SOMED has 38 of 55 instructor requirements which is 69%.

Inappropriate Instructor Background. Sixteen of the instructors are civilians who have been hired under an educational services contract. The credentials and, in extension, the appropriateness of the civilian instructors are generally questionable. Nine of the sixteen are retired licensed practical nurses (91Cs). For the most part, 91Cs are considered lower in the medical hierarchy than 18Ds. The lowest credentialed instructor is a Basic Emergency Medical Technician (EMT-A) which is a credential the students earn half way through SOMED. Another civilian instructor is a retired combat medic (91B).

It is generally unheard of in education and training to have instructors whose highest degrees or credentials are lower than that of the course that they are teaching. An analogy would be having a college instructor with only a high school degree. While it is certainly possible for the instructors with lesser degrees to present information that is written out in the lesson plans, it is generally difficult for them to answer questions or to integrate the information beyond that which they are specifically presenting.

By contrast, most of the course used to be taught by physicians and PAs. In the mid 70's there were four full time physician instructors; in 1979 there were two physicians. Currently there are two physicians listed on the TDA, but the second physician slot, an emergency medicine physician, has never been filled. In 1978, every medicine block and surgery block was taught by a physician. Now very little of the instruction is provided by

the SOMED physician, although some of the lessons are taught by AHS physician instructors. Even though the current civilian instructors are minimally experienced in medicine and surgery, the civilians are forced to teach those blocks because other instructors are not available. Furthermore, the SOMED training has gradually shifted over the years to a greater emphasis on trauma at the relative expense of medicine. Because of this shift, there is an increased need for instructors with trauma backgrounds, but most of the instructors lack trauma backgrounds.

Another significant problem that is caused by instructors with inappropriate credentials is that they hurt motivation and morale. This is particularly important in the grueling eight month long SOMED where sustained motivation and perseverance is a major determiner of success. It is hard for the students to remain motivated when their instructors do not hold respected credentials. Day after day, the students are taught by retired 91Cs who lack both the medical status and the SF tab that the student is working towards. One of the most poignant examples is that of an active duty 91C SOMED instructor who had himself twice failed SFAS. Now as a SOMED 91C instructor and evaluator he is flunking soldiers out of SOMED. In doing so, he has told a number of students that they were not SF material, even though the students had made it farther in the SF selection/training process than he. This particular situation was related to me a number of times. The point being that all of the students were aware of the instructor's background and history and that his presence hurt motivation, morale, and the perception of fairness.

Three of the civilian instructors are retired 18Ds and were generally regarded as being the best of the civilian instructors. Even so their medical knowledge is probably dated. Two of the instructors are certified paramedics (EMT-Ps). The 18Ds and EMT-Ps are far more appropriate backgrounds for SOMED instructors in that they have had extensive training and experience in trauma injuries and treatments. By contrast, the nurses (91Bs and 91Cs) have had much less trauma training and experience. This is not to say that there is no need for nurse instructors as SOMED does train nursing skills, but, as mentioned, the overwhelming focus of 18D training is on trauma. The problem becomes exacerbated by the instructor shortage and that so many of the instructors have nursing backgrounds. Because of instructor constraints, both active duty and retired nurses are required to train and evaluate trauma.

These points are solidly supported by the questionnaire results. The students and medics, in particular, strongly disagreed with the notion that increasing the number of either active duty non-18D instructors or civilian instructors would reduce attrition. Conversely, everyone overwhelmingly agreed that increasing the number of 18D, physician, and PA instructors would reduce attrition. Similarly, the three most common written comments about the number and background of SOMED instructors were: "Non-18D military instructors were unacceptable," "Number of 18D instructors should be increased," and "Instructors should have experience in what they are teaching," (Table A-

13). As mentioned there is currently only one physician, one PA, and seven 18Ds to teach three overlapping classes of 90 students each.

Educational Services Contract. The contract for civilian SOMED instructors was originally established as a short-term quick fix. Instead it has grown to where nearly half of the instructors are from the contract. The civilian contracting mechanism is workable, but the Army should only request and accept instructors that have backgrounds that are needed, i.e., not nine retired 91Cs. In effect what has happened is that the Army has said we need three instructors and we have some amount of money, e.g., \$150,000. What can we get for that amount of money? Included in that amount of money is both the instructors' direct costs plus the overhead of the contract, the latter of which was said to be hefty.

In an effort to keep the cost of the contract down, the minimum instructor qualification acceptable under the contract does not require any medical experience but "Previous successful instruction experience in a TRADOC/AMEDDC&S school, or similar subject matter institution for two years within the last ten. Experience should include testing, grading, and record keeping procedures." Fortunately the qualifications of all of the instructors exceed this minimum requirement, with the lowest being a Basic EMT. This is not to imply that alternative civilian instructor mixes would not be more expensive. The contract could require several physicians, several PAs, and a number of recently retired 18Ds, but the cost would likely increase significantly. For the most part, however, this is what needs to be done.

SOMED Physician. In the past year, the role of the SOMED physician has shifted away from that of delivering instruction to one of quality control and to improving standardization. One of the problems that they are trying to address is the diversity of instructor experience and their differing levels of knowledge. In some cases, for example, PAs have instructed beyond the level at which the 18D training is intended. The physician now checks to see if each instructor's level of instruction is at the appropriate level. The SOMED physician is also working to minimize the subjectivity in the grading. At Trauma III, for example, the physician will monitor all of the stations rather than being an evaluator of a single station. Having the most medical expertise, his job includes reviewing training plans and identifying where and how emerging medical knowledge can be integrated into the training.

For the most part the physician's re-defined role seems reasonable, as there is a great need to cultivate and maintain quality control. Conversely, one could argue that the physician's primary responsibility should be that of an instructor and that administrative tasks, including quality control, should be handled by others. On the whole, SOMED needs one or more additional physicians as instructors.

Instructor Selection and Train-up. The quality and dedication of the active duty SOMED instructors varies considerably. Some of the active duty instructors feel that

they are being penalized with the assignment and as a result do not want to be there. Some of the instructors have allegedly become "keepers of the tab." They, in effect, say, "I'm an 18D and you're not going to make it because you don't live up to my standard." In some cases non-18Ds are also accused of also being "keepers of the tab." The SOMED leadership knows that they have some poor instructors, but argue that the same situation exists in all Army schools. This is likely true, but probably no other school in the Army has such high attrition. The cost of PCSing an unacceptable active duty instructor to another assignment may be insignificant relative to the cost of the SOMED attrition rate.

It is likely that SOMED attrition would be reduced if the procedures for selecting SOMED instructors were improved. The disgruntled instructors should be replaced with quality SF medics who want to be there and who want to teach. In the interviews with group medics, several senior medics said that they had been trying for several years to get SWCS instructor jobs. They thought that they needed the experience to round out their careers. In addition, they thought that SWCS assignments provided certain advantages, e.g., family maintenance, civilian education at night. They also thought that it was their group leadership that was preventing them from being released for the instructor assignments. As an aside, the SF Medics Annual Survey found that SWCS instructors were considerably less satisfied with their jobs and careers than medics in the groups. The main point here is that there needs to be a better way for identifying and screening instructors. To the extent possible, the instructors at SOMED should be quality SF medics who want to be there.

One of the problems with moving instructors in and out is that it takes a long time to train them up. For non-18Ds, it takes 9 months to a year to fully train up new SOMED instructors. For 18D instructors, the train-up period is somewhat shorter. Even so, the 18Ds must become thoroughly familiar and competent in each of the skill stations and also learn how to grade to standard. During the train-up, the instructor/evaluator first becomes a "back grader" where he evaluates a student and then compares his assessments and notes to those of a more experienced "front-grader," who is grading for the record. After some time, the new instructor becomes the front-grader, but he is overwatched by an experienced back-grader. During this fairly lengthy train-up period, e.g. up to three SOMED courses, two instructors are needed at each evaluation station.

Increasing the number of instructors at SOMED will most likely have the biggest effect on reducing attrition, but it is important that the added instructors have the appropriate backgrounds. The existing civilian contracting mechanism can work, but the civilian instructors should primarily be retired 18Ds, EMT-Ps, or both. In addition, the civilian contract might provide two physicians, e.g., emergency room physician and internal medicine, and two or three PAs, preferably with SF experience. The contract should also supply someone with a medical supply background as they are currently using an instructor as the medical supply sergeant which wastes part of an instructor's time.

Lastly, to the extent possible, poor instructors should be replaced with instructors who want to be there.

Effects of High Student/Instructor Ratio

The increase in number of students has directly increased the student/instructor ratio. This is particularly critical for the hands-on trauma instruction in that it limits the amount of one-on-one instructor time that each student receives. In addition, the high student/instructor ratio adds to the stress and burnout of the instructors. At SOMED, the skill stations are often set up for 90 minute clinics. In the unconstrained case, each student should be getting dedicated instruction for three 90 minutes clinics, e.g., one time in which he is guided through the procedure, a second time in which he is given some guidance, and a third time under test conditions.

The trauma II clinic is scheduled for five days with two 90 minute clinics each morning and two 90 minute clinics each afternoon; there is an hour between clinic for prep time. At four clinics per day, it would take 15 stations to get 90 students through three repetitions in five days. This schedule requires training from early morning to late in the day with nothing going wrong.

Instead of getting three 90 minute clinics, one student, for example, said that he got only three 20 minute clinics. Because of the time constraints, the individual clinics sometimes start at different points along the procedure. One student will go part way through a procedure and then the next student will pick up there. This means that not everyone gets the same instruction. One recycle said that he had just been given feedback the previous day which cut 10 minutes off the time it took him to complete a particular procedure. He said that he had been there for eight months and had he had more personalized instruction, he would have learned the time-saving technique earlier.

Similarly, the instructors frequently tell the students that when they get back to the barracks, they should practice what they did not a chance to do during the clinic, e.g., secondary surveys. As one student asked, "How can you practice secondary surveys in the barracks without someone grading you as to what you are doing right or wrong?" Numerous students said that they had to pick up advice and rumors from other students on what they should and should not do. Several noted that this often led to picking up bad habits. One student said it was rumored that SOMED intentionally recycled some good students so that they could help train the junior class in the barracks. This is not true. Practicing in the barracks is, of course, valuable and necessary, but it is an inadequate substitute for proper training in the classroom.

Not having enough instructors for the trauma training makes the weeks of trauma instruction too intense for the instructors. Day after day, the instructors must run one trauma clinic after another. To be an effective trainer in the hands-on trauma clinics, it was suggested that the instructor should be thinking five procedural steps ahead of the

student. With such an intense schedule, the instructors said that after awhile it was difficult not to be operating "on autopilot" which means that the effectiveness of the training was suffering. In addition, a number of the instructors have come in at night and on weekends to help students complete their clinics. Putting in the overtime hours may help in the short run and but it leads to instructor burnout.

The high student/instructor ratio also has another downside in that all of the instructors are counselors. Because of the high student/instructor ratio, each instructor currently is the counselor for 11-12 students. As a counselor, their primary job is to identify problems early-on so that they can be corrected before a student irrevocably fails out. This is difficult for the counselors to do when they are responsible for so many students, plus the counselor responsibilities are on top of their normal instructional load. There are similar problems at F Company (ABN), AHS, which is responsible for administrative issues and problems. With 90 students in each platoon, the platoon sergeant barely knows his soldiers.

Course Organization

For a variety of reasons the organization and scheduling of the SOMED training is less than optimal. The reasons include the need to coordinate with AHS, lack of qualified instructors, and the incorporation of the SOF Basic Medic course. The scheduling of the three concurrent classes is a complex and tedious task which is done by hand. Consider, for example, the previous example of where 15 trauma clinic stations were required for one week. During that period of the time, those instructors would be unavailable for teaching in the other two classes. Also there are problems of integration with AHS, in that some of classes can only be taught when AHS instructors are available. The result is that the schedule varies from class to class and that the scheduling is administratively manpower intensive.

SOMED instruction will often be on a particular subject for three hours and then because of scheduling the instruction will shift to something very different. As one student said, "At SOMED the schedule is so broken up. The order is nearly random. The only thing that was good was that they taught A&P at the beginning." One student said that he had received a block of pharmacology instruction which he was tested on 2 1/2 months later. Because of the fractured class schedule, the students are forced to go to class all day and then at night study different material for an upcoming test. It would be better if their studying involved reviewing and digesting the material that was presented that day or week. Again this goes back to the comments about the pace of the course material; there never is time to understand or digest the information.

The course has also been reorganized to accommodate the SOF Basic Medic course. SOMED now trains all of the surgical and trauma skills together in a 12 week block in the middle of the course, so that the "short course" students can be there for the shortest amount of time. The reorganization is thought to have added to the lack of continuity

within the course. The course material was previously organized by physiological systems, e.g., skin system or respiratory system. Within the block of instruction on the skin, the course taught anatomy and physiology of the skin, physical examination of the skin, diseases of the skin, injury and trauma to the skin, and lastly surgery of the skin. Because all of the trauma portion of the course is now taught in weeks 5 -19 of the course, anatomy and physiology, and diseases of the skin are separated from injury, trauma, and surgery.

The trauma module drives the organization of the course and it sometimes becomes too great of a focus. Students get nervous about trauma and lose perspectives on the other things they have to do, e.g., medicine, nursing. There are tentative plans to include EMT-I (Intermediate) testing in the short course. This will add even more to the scheduling mess and will possibly result in more attrition. If the EMT-I testing is added, it would likely require that the testing of EMT-A, EMT-I, and the Patient Management Skills Tests (PMSTs) be compressed more closely together. In addition, if both the long course and the short course students are tested, testing will require a couple of additional days which will further add to the instructor burnout. The scheduling burden and the fractured schedules could likely be reduced if the appropriate computer hardware and software were added.

Instructor Burnout. One of the big problems with the current TDA is instructor burnout, particularly for the active duty instructors. The intense one-on-one trauma instruction is extremely stressful. The trauma block runs for 12 weeks beginning with Surgical Block I and ending with the Trauma III FTX. Because only some of the instructors, e.g., the 18Ds, are truly qualified to teach the Trauma portions of the course, they are particularly subject to the burn-out. Five classes per year means that five 12 week trauma blocks are taught per year. The instructors are therefore constantly teaching trauma in at least one course. In addition, the current civilian contract says that only three civilian instructors can be sent to the field for the Trauma III FTX. Therefore all of the military instructors must always go to the field. There are also several other responsibilities that only the military instructors can do, e.g., serve as jumpmaster.

Because there are always three classes in session, there is never a clear beginning or end which adds to the burnout. NCO instructors were said to have had some trouble adjusting to this organization in that there never is any closure, i.e., never an end of mission (EOM). They are used to having projects with beginning and ends and in training soldiers from start to finish. At SOMED, they teach one block of instruction to one class one day and another block of instruction to another class the next day.

One of the ways SOMED has been combating instructor burnout, at least for the 18Ds, is to move the 18Ds to F Company after about a year and a half of being an instructor. Currently there are four 18Ds (three platoon leaders and an operations sergeant) at company, plus an 18Z first sergeant. Each of them does only a little teaching. In addition to reducing burnout, these are leadership positions which are

thought to be necessary for promotion to E-8. It is probably not necessary to have 18Ds in the platoon sergeant positions, but the leadership experience and the avoidance of burnout seems to make good sense.

As mentioned before there has recently been approval to add eleven days to the length of the course with four to six days being additional hands-on trauma training. For the most part, SOMED will have to take the additional days out of hide which will place yet additional burden on the instructors and will likely lead to more burnout. Lastly, the current plans for training at the SOMTC call for teaching five classes a year with the integrated SOF Basic Medic course and the 18D course lasting 44 weeks. It is important in designing the SOMTC TDA that sufficient instructors are included so that off time can be programmed. Otherwise SOMTC is going to have extreme instructor burnout problems as well. Hopefully, SOMTC will receive enough instructors so that they will not begin behind the instructor burn-out curve.

One of the ways to reduce instructor burn-out is to reduce the administrative workload; this can be accomplished through office automation. Currently, SOMED is minimally computerized. A significant amount of workload would be reduced if the instructors and administrators were connected with a local area network (LAN). The LAN could be used to provide easier access to the programs of instruction and lesson plans. The LAN could also be the basis of an electronic mail (E-mail) system that could be used between instructors and between SOMED and AHS.

Changes in Retraining/Recycling Policy

Somewhat remarkably, if a soldier volunteers for SF, completes SFAS, and is sent to the 18D Q-Course, the most likely outcome for that soldier is he will be sent to a world-wide assignment in his previous MOS. Until recently, soldiers who failed the 18D Q-Course were often given the opportunity to go to other 18-series Q-Courses. The rationale was that you were selecting the cream of the crop for 18D and that even though the soldiers could not make it as a medic, they probably would still be good in SF. Because of the large numbers in other SFQCs and the diminishing need for the other MOS, 18D Q-Course failures now are sent to a world-wide assignment in their previous MOS. If indeed, those sent to 18D training are the best SFAS graduates, at least as measured by ASVAB, this is probably a questionable practice. There may, no doubt, be some downside in letting the 18D failures go to the other Q-Courses. Some of the 18D trainees may have intentionally failed the Q-Course so as to go to the MOS of their preference. The answer is not to send 18D reliefs to other MOS but rather to do everything possible to get each soldier to pass the 18D Q-Course.

While the focus on 18D attrition is to maximize the number of graduates from the Q-Course, it is important to remember that the system is currently producing more than enough medics to replace the steady-state 18D loss. Given that the 18D is selecting the cream of the NCO crop and that the most likely outcome for the soldier is

that he will be returned to his previous MOS, an equally important goal should be to reduce the number of reliefs. This will become even more important when 18Ds are at their authorized strength. The question should become, "What is the least number of students we need to send to the 18D Q-Course to ensure that we get the 80 or so medics we need each year?" As the 18D training and selection improves, the number should go down.

Recycles. As shown earlier, recycles are nearly twice as likely to graduate from SOMED than initial inputs. A critical question is whether the recycle graduates are as good initial input graduates. I frequently asked the instructors that question during the interviews and their answer was overwhelmingly "yes". Many even went on to suggest that the recycles are often better medics than the first time graduates in that they understand the information better. In general, this pattern supports the point that too much information is presented in too short of time. A big reason that recycles are more successful and perhaps even more skilled than the first time graduates is because only the best of the non-graduates are selected for recycling. Those students selected for recycling at SOMED generally are successful in most of the modules but may be below the standard in one or two of the modules. In a fair number of cases, the students may be doing quite well, but then fail a critical objective, in particular, the Trauma III FTX.

SOMED has analyzed five years of class data regarding the success of recycles in the course. They found that those students who were re-cycled with an overall GPA of around 83% or higher had a 65% chance of graduation whereas those who were recycled with a GPA below 83% were no more likely to graduate than initial inputs. The 65% graduation is probably an overestimate given the current situation, but the pattern is what is most important. Students who have done reasonably well in the course as represented by their GPA are considerably more likely to graduate as recycles than either initial inputs or those with lower GPAs.

Historically, the decision whether or not to recycle a student was only partially based on the student's GPA. Before a student was dropped or recycled, a SOMED board talked to the student's initial and secondary evaluators, as well as to other students. They also looked at the student's pattern of failures and homework assignments. "This process is fairly man-hour intensive, but given the relative success of the recycles, the recycle selection process apparently has been successful. Because of increased pressure for objectivity and fairness as of late, recycling decisions are now based on who has the highest GPA.

There is also currently some debate as to how far back the student should be recycled in the course and relatedly how should poor test grades from the previous class be handled. It has been suggested by some at AHS that recycled students should be given a "clean slate," that is, all of their grades from the class in which they had been recycled should be dropped from their record. The rationale for the clean slate is legalistic and designed to counter appeal criticisms that previous failures were held

against the student. The thinking is that if you are going to recycle someone they should have the same chance as everyone else. To be fair to all this would, in effect, require students to be recycled to the beginning of the course. The problem with recycling everyone to the beginning of the course is that it is extremely resource intensive. Instead, for example, of giving each recycle one and a half classes of instruction, you would be giving him two full classes of instruction.

The current approach for determining the number of students that can be recycled is to look at the number of students that can be added to the subsequent classes without exceeding a maximum cap of 90 students. Given that all of the classes are being filled at the ATRRS limit of 90, the number of recycles that can be added to a class is equal to the number of students who are relieved early on. Recycling students back to the beginning of the course will be a problem because there is no time for any of the students to attrit from the following class.

One of the biggest negative impacts of the SOF Basic Medic course is that it limits the number of recycles. For 1-92 to 5-92, the number of recycles were: 27, 27, 26, 20, and 12, respectively. The SOF Basic Medic course officially began in January 1993 so its effects are starting to show in the later classes. Given that recycles graduate roughly at twice the rate of new starts, fewer recycles in each class means fewer total graduates. It is a case of diminishing returns.

Because of the pressure to give everyone as much of a chance to pass as possible, students are being allowed to stay in the course as long as there is a mathematical chance of their passing. Recall that a student must maintain a 75% average in each of the modules to pass. Consider the anatomy and physiology (A&P) module which has four written exams and a practical exam each worth 50 points and a final exam worth 100 points. If a student scored 65% on each of the first five exams, i.e., he failed them all, he could still pass the module if he scored 100% on the final exam. In this situation the student would be carried in the course through the final exam in the A&P module. The chances of any student failing the first five exams and then getting a perfect score on the final is, however, near zero. Because of this policy, many of the students are now carried through the Trauma III FTX whereas they previously would have been relieved earlier from the course.

A more efficient recycle policy would be to relieve marginal students as early as possible. Those vacated slots could then be used to for recycles who have a much higher probability of graduating. While the overall probability of graduating for initial starts is 28%, the probability is undoubtedly less for those who have a failing GPA early in the course, e.g., after 8 weeks. SOMED should consider adding an academic review board much earlier in the course.

If the SOMED analysis is correct that recycles with a GPA of 83% are considerably more likely to pass than other, recycling all of those students should yield the lowest

attrition rate. There are at least two ways in which this can be accomplished while remaining under the 90 student maximum (60 active duty). First, as just suggested, more students should be relieved earlier in the course. Second, the ATRRS number for initial starts should be cut back. To fully minimize the attrition rate, SOMED should estimate how many students are likely to be relieved early on based on the proposed early evaluation boards. The ATRRS initial input limit should be based on the estimated number of early reliefs and the average number of recycles with GPAs greater than 83%. The equation to calculate the ATRRS class size limit would be:

$$\text{ATRRS limit} = 90 + \text{Estimated Number of Early Reliefs} - \text{Average Number of Recycles with GPA} > 83\%$$

Physical Facilities

The SOMED physical facilities at Fort Sam Houston are in very poor shape. As represented by the written comments in Table A-6, the facilities are old, run-down, and inadequate. The two main SOMED classrooms are in buildings that have been condemned for over a year. The classrooms are also not particularly well designed for large group instruction as it is hard to see and hard to hear from some of the seats. As one student said, "The classes are so big, at 0730 students run in the classroom to get the seats up front. They call them the 'learning seats'." What is almost remarkable is that SOMED is being forced out of the condemned buildings into facilities which are probably worse, at least from a training perspective.

As of April, the plan was for SOMED to move into the basement of the building that houses DOTD. The basement rooms are very long and very narrow and there are plans to add drop ceilings to cover the pipes. The result will be long and narrow 100 man classrooms with seven foot ceilings and no windows. There were also watermarks on the walls which indicate that the rooms are subject to flooding. To facilitate the training, a row of video monitors will be mounted along the walls to make it easier to see the vugraphs and demonstrations. Nevertheless, it is hard to imagine being in those rooms 40 hours a week for the majority of an eight month long course. Given that SOMED will be moving to the SOMTC in FY96, a reasonable alternative might be to lease a training facility off-post. This would require funding for transporting the students back and forth, but it would provide a better training facility for perhaps less cost.

Supplies. Some of the students complained that they were unduly restricted in the use of supplies during training, e.g., new bandages, O2 masks. During the trauma training, they said that they were not allowed to use some of the supplies so they would say, "I would then do this or that." Then during the evaluation they would have to actually unwrap the bandages and use them in the tested procedure. Based on my observation, the shortage of supplies did not seem to be much of an issue. Conversely, it seemed as if the students were allowed to use a large amount of supplies. Also, lack of supplies was not rated as a particular problem on the questionnaire. There are some

signs, however, that this may become more of a problem. One of the budget problems that SOMED currently is having is with regards to money for supplies. The cost for supplies in SOMED is estimated at \$1300 per student which totals to about \$500K per year. As of April, SOMED was running about \$40K short for the year which was attributed to them having added a greater number of students from the Navy.

San Antonio and Environs. Some have suggested that part of the SOMED attrition problem is that the Fort Sam Houston/San Antonio location is too distracting for some of the SOMED students. The likely factors would include: San Antonio's "Fiesta" atmosphere, the non-military campus like setting of AMEDDC&S, and the relatively high number of women at AMEDDC&S. Counter-arguments suggest that there are distractors everywhere, including Fort Bragg, where there are plenty of women and bars. It is further argued that if a soldier is conscientious, he should be able to find the time and place to study anywhere. The responses on the questionnaire overwhelmingly disagreed with the notion that the Fort Sam Houston/San Antonio location per se was a problem.

A number of the comments (Table A-6) indicated quite the opposite was true, that Fort Sam Houston and San Antonio was indeed a good place for SOMED. First, Fort Sam Houston/San Antonio is a medical training community which provides easy access to medical libraries. Second, it was suggested that given the intense pace of the course, San Antonio offered good opportunities to unwind and to get away from the Army. As one 7th Group Medic said, "One of the best things about Fort Sam was that you could go to UTSA (University of Texas-San Antonio) or Trinity University to get answers to your questions and to find a place to study around the clock. It is impossible to study in the barracks. There is nothing at Bragg like that. There isn't even a medical book store here at Bragg whereas there was one right on post at Fort Sam Houston." When the medic training is consolidated at SOMTC, it is important SOMTC includes adequate study facilities, including a library and 24 hour study rooms.

Personal Problems

A significant amount of the academic attrition at SOMED is rooted in personal problems. Given the intense pace of the course, if a student falls behind even for a couple of days it is often impossible for him to catch up. Some students get off to a bad start because they do not arrive at Fort Sam Houston early enough to get settled. In general, the Army gives 10 days permissive TDY to PCS which is normally a sufficient amount of time. Problems arise when soldiers arrive with their families a day or two before the beginning of the course. The result is too many distractions at the beginning of the course. Efforts should be made to ensure that students are given adequate time to get settled in before the classes begin. If possible, the SOMED academic counselors should try to more quickly become acquainted with their students and to better identify personal problems early in the course.

As shown in the questionnaire results (Table A-9), it would be useful to provide the soldiers and their families with better information about the true requirements of SOMED before they arrive. In particular, it should be stressed how hard the course is, how much time they likely will have to put in, and the stress that it will put on the family. The prospective students should also be told to take care of as many problems as possible before he and his family arrive. For example, some soldiers arrive with financial problems which can become a major distraction. As a note, it was suggested that the finance office support that the students receive at Fort Sam Houston could be improved.

When the course was 10 weeks long, personal problems and their effects could be stalled. At 31 weeks, it is almost impossible for the NCOs and their typically young families not to have some significant problems during the eight months. Anything that distracts the students, e.g., children being sick, marital squabbles, often ends up hurting the students in the course academically. As already mentioned 31 weeks is a very long course with no break. The point here is that a fair amount of the academic attrition rate may in fact be precipitated by personal problems. If the soldier is generally a good student and the specific personal problems can be resolved, then the student is a good candidate for an academic recycle.

Computer-Based Training

SOMED and SOMTC should consider incorporating computer-based training technologies into the 18D training. The shortage of instructors and limited training time is a good fit for the potential benefits of computer-based training. It has been estimated, for example, that quality computer-based training can reduce military training time by 30% with no loss in effectiveness (Orlansky and String, 1979).

The PA training program at Fort Sam Houston currently includes computer-based ATLS training. The training which was developed by the Navy runs on the Electronic Information Delivery System (EIDS). Probably for little cost, SOMED could acquire a number of EIDS terminals which are basically PCs with a videodisc player. During the trauma clinics, students who were not actively participating in the training could make better use of their time by training on the computer rather than just observing other students. The ATLS training could also be used to provide remedial and/or refresher training. SOMED and SOMTC might also identify those areas in which computer-based training would be most beneficial and request that appropriate computer-based instruction be developed for those blocks of instruction.

In the future the 18D training might attempt to take advantage of advances that are being made in the area of virtual reality. Virtual reality is a computer-generated technology which allows information to be presented in a simulated life-like environment. Virtual reality systems are being developed that can be used to train anatomy and physiology, perform surgical procedures, and simulate the outcome of surgery. At the

center of the system is a "virtual cadaver" which contains three dimensional models of the anatomy. The virtual cadaver also contains simulation software which represents various attributes of the anatomy, including biomechanics, and physiological and pathological processes (Satava, 1992).

Selection Issues

The SFAS course was designed to separate SF selection from the SF training. For the most part soldiers who graduate from SFAS are quality candidates and are expected to pass the Q-Course. This is generally true in the other three 18-series MOS Q-Courses in that they have graduation rates around 90%. It is not, however, true for the 18D as a tremendous amount of selecting out occurs at SOMED. It would, however, be much more cost-effective to identify those who are most likely to succeed before they are PCSed to SOMED and before they take up a precious training seat.

As with any selection system, the 18D selection process should identify those skills that are needed for success and then try to identify those skills early on. A more complete effort might be conducted in this area, but in general we know what skills are required for success. The successful 18D student must first possess strong academic skills to comprehend and remember the tremendous amount of information that is presented at SOMED. In addition, the student must have good psychomotor and mechanical skills so that he can execute precise medical procedures while under pressure, e.g., inserting IVs under less than ideal conditions. Successful 18D students must also be able to demonstrate cognitive flexibility, to the extent that they can learn principles and then apply those principles in somewhat different situations. Based on the observations of the SOMED instructors, it has been suggested that concrete, black-and-white, thinkers do not fare so well in the SOMED trauma clinics. Lastly, 18Ds must be highly motivated with the will to persevere.

Most of the selection has focused on selecting soldiers with high cognitive skills, e.g., high GT scores from the ASVAB. The GT composite score is composed of math and verbal subtests and generally correlates highly with measures of general intelligence. Because soldiers are allowed to retake the ASVAB to increase their scores, Wonderlic intelligence test scores are being used in addition to GT. In a fair number of cases, soldiers who were originally classified as in Mental Category IV, i.e., in the bottom 30%, were able to improve their test scores enough to qualify for SF. There are books on sale at Army bookstores which teach soldiers how to improve their ASVAB scores. The problem is that when soldiers retake the ASVAB, their test scores may improve, even though their basic intelligence has not. Taken together, the use of ASVAB and the Wonderlic is doing a good job of only sending those soldiers to SOMED that have the highest intellectual skills.

The Wonderlic, as well as most of the other tests, are ably administered and managed by the USASOC Psychologist. The USASOC Psychologist, SWCS, and ARI

have developed a longitudinal selection and training database which will be used to assess the validity of current and future selection instruments. Other selection tests are being considered. In the past few months, for example, an experimental biodata instrument which is thought to measure cognitive flexibility, motivation, and perseverance has been administered to SFAS candidates. It will take several classes worth of data before the validity of that test can be examined. Clearly it is more difficult to reliably measure the softer skills such as motivation and perseverance than it is to measure traditional intellectual traits.

One significant problem for determining the effectiveness of selection tools is that changes are nearly constantly occurring at SOMED. This year they added the SOF Basic Medic course which increased the student/instructor ratio. Later this year or early next year, they are going to add 11 days to the training. Also as will be discussed, there appears to be a significant amount of variability in the grading. All of these factors hurt traditional test validation procedures. This is not to imply that selection cannot be improved at the same time changes are made to the training and evaluation and standards, but that it is more difficult to get a firm assessment of the effects of any one intervention.

Student Background

The academic demands of SOMED are roughly equivalent to those of an upper-level undergraduate curriculum in science or perhaps to those of first year medical school. By contrast, most of the SOMED students have had little to no college experience, particularly in the sciences. It is not surprising that the SOMED attrition rate is high given that the majority of the SOMED lack the basic knowledge and background that normally would be required for such a course of instruction. Similarly, it is easy to understand why recycles have a higher graduation rate than first time starts. The first time through the course, particularly through A&P and pharmacology, the students are developing the background knowledge and skills that they need to succeed in the course.

Some have suggested that a greater effort should be made to recruit soldiers for 18D training that already have a medical MOS, e.g., 91B (combat medic). This approach is not, however, supported by the results of the questionnaire as lack of a medical background was not thought to be particularly related to attrition. In addition, during the interviews I was told that in an analysis done by SOMED, the graduation rate of students of 91Bs was not any higher than other MOS. It is likely that the medical knowledge and skills of a 91B are negligible relative to what is required in SOMED. Others have said that soldiers with combat arms backgrounds tend to make the best medics in that they were better prepared and more willing to perform the host of non-medical tasks that a SF medic must perform on the team. All told, it is not recommended that any extra effort be made to recruit soldiers with medical MOS for 18D training.

Several have commented that anybody can pass the course if they are motivated and willing to study. This is probably not true, and at best misleading. SOMED is an extremely difficult course and some of the students selected for training lack appropriate math, verbal, and problem-solving skills. For the most part, the verbal and math skills of most of the SOMED students are rather weak. Several of the SOMED instructors noted that on the one written exam that has short essay questions, most all of the students misspelled a number of words. I similarly found this in the written comments on the questionnaire. As one instructor said, "Based on their midterm exam, I'd say their language skills are ninth grade at best."

The relatively low verbal and math skills of the SOMED students in some ways reflect the general decline of math and science skills in our society. The selection board has recently begun using the Test of Adult Basic Education (TABE) to help prevent those students with exceptionally low math and verbal skills from being sent to the Q-Course. Furthermore, while the SOMED students may be the cream of the NCO crop, they simply do not possess the same academic and intellectual skills as do university pre-med students. On the other hand, not many pre-med students can ruck cross-country and assault an objective.

Some of the more senior medics and instructors noted that the goals and motivation of the students and young medics have also changed over the years. Today soldiers are more career oriented. It used to be that the goal for most everyone on an A-team, including the medics, was to become the team sergeant. Few medics today are interested in being a team sergeant but instead tend to view 18D as a stepping stone in their medical career. This trend is supported by the results of SF Medic Questionnaire (Table B-2) in which over half of the Medics said they intended to go to PA or medical school. In addition, because of downsizing the motivation and type of person who is going to SFAS is seen as having changed. Years ago it used to sometimes be, "Go into the Army or go to jail." Now it is believed by some that they must "Go to SFAS or be forced out of the Army." While these soldiers might have high GT scores, it is unlikely that they have the desire to be a medic and to persevere for eight months at SOMED.

MOS Preference

Until recently a considerable number of the soldiers were sent to SOMED who did not want to become medics. For the most part, SFAS graduates with the highest GT scores were sent for 18D regardless of their MOS preference. The rationale was that they had volunteered for SFAS to become SF, not a particular 18-series MOS. If there is a correlation between success in SOMED and GT then sending soldiers with the highest GT scores should result in the lowest attrition. The result is that there are students at SOMED who do not want to be there. I was told by the previous SOMED NCOIC that he on occasions had asked soldiers off the record to raise their hands if they had not wanted to become a medic. He said that usually between 20% and 30% said they did not want to be there. For the last several MOS assignment boards, I was told,

however, that almost everyone sent to SOMED had selected 18D as their first MOS preference. Because of the delay between SFAS and SOMED, those classes had not arrived as of March when I completed the interviews.

For the most part, only sending volunteers to SOMED is common sense. This is particularly true at SOMED where success is so much determined by motivation and perseverance. In addition, given that we are talking about soldiers at the extreme high end of the GT distribution, there will be almost no difference in the predicted success between soldiers with a GT of say 120 and 125. The point here is that if you are choosing between two soldiers where one has a GT of 120 and wants to be a medic and another has a GT of 125 and does not want to be a medic, send the soldier who wants to be a medic. The questionnaire results also strongly support the idea that only volunteers should be sent to SOMED. The item on this point had the highest agreement rating of any item on the questionnaire (Table A-5).

SOMED Pre-Course

SFAS was designed to screen out those soldiers who are unlikely to succeed in the Q-Course. Several other difficult Army courses use pre-courses as part of their screening process, e.g., there is a pre-Ranger course, a pre-Scuba course. What we know, however, is that SFAS does not do a good job of predicting success in the 18D Q-Course. One plan that has been discussed is to require selected soldiers at the end of SFAS to complete an 18D pre-course before being accepted into SOMED. The pre-course could be designed for three purposes: (1) to provide background knowledge, e.g., basic A&P and math skills, (2) to give the soldier a better understanding of the tough SOMED requirements, and (3) to screen out those soldiers who are less likely to graduate. Those soldiers who fail the pre-course could likely be able to select another 18-series MOS.

The questionnaire included several items on the likely utility of a pre-course as a means to reduce SOMED attrition. The soldiers strongly agreed that such a pre-course would significantly reduce attrition. When asked what the most efficient length of the pre-course would be, the mean estimate was 5.2 weeks. That estimate is probably unrealistically long. A more appropriate length might be two weeks. The questionnaire also asked what should be included in pre-course (Table A-11). Not surprisingly, they include the basics, e.g., anatomy and physiology, medical terminology, and math. It was suggested that the demands and requirements of the pre-course should be as rigorous as the demands and requirements of SOMED. These would include long classes and the need to study on one's own time. In addition, a number of soldiers suggested that the pre-course should train and evaluate hands-on trauma skills. While this makes sense, in that many are relieved from SOMED because they fail to develop adequate hands-on trauma skills, training and evaluating hands-on trauma skills in the pre-course would be difficult to execute.

As a first step, there has recently been an effort to require prospective SOMED students to complete several Army correspondence courses, e.g., A&P, medical terminology, prior to arriving at SOMED. In general, the correspondence course pre-requisite has not worked because of administrative reasons. It is nearly impossible for soldiers to complete their correspondence courses, send them off to be graded, and get the grades back in time to make a decision as to whether they will be accepted into SOMED. In addition, the correspondence course requirement may not be fair because soldiers who return to their units prior to PCSing to the SOMED may have very different requirements placed on them. The soldier's ability to find time to complete the correspondence course may largely be a function of what type of unit he is from and where they are in their training cycle. The correspondence course material and tests could be used as part of the pre-course.

Perhaps the biggest problem for setting up an 18D pre-course is the TDY funding. Currently DA pays for the SFAS TDY, and it is unlikely that they would pay for an additional two weeks for the pre-course. Also, you would need a few additional instructors to run the pre-course, but it might be possible to draw the instructors from D company. As discussed, plans are underway to send soldiers to the land navigation and small unit tactics training prior to going to SOMED. It is possible that this will additionally screen some of the unsuccessful SOMED students and will in effect reduce the usefulness of an additional 18D pre-course. Recall, however, that the restructuring of the Q-Course in FY91 which eliminated the initial field training did not have an effect on SOMED attrition. Another alternative would be to build the 18D pre-course into the initial training. If the soldier passed the medical phase he could go to SOMED, if not he could go to another 18-series Q-Course.

Selection and Attrition in PA Program

One frequently asked question is how does the 18D attrition rate compare to other comparable Army training courses. As mentioned, the attrition rates of the other 18 series Q-Courses are around 10%, whereas the 18D attrition rate exceeds 50%. Perhaps the most comparable Army course is the PA training. PA training is a two year program which was recently changed from being a warrant officer program to a commissioned officers program. The first year of the PA training is primarily didactic with the second year being a hands-on internship.

According to the AHS PA Branch, the attrition rate of the PA course is less than 10% with the low attrition rate thought to be due to the rigorous PA selection procedure. Soldiers applying to the PA program must have a minimum of 60 hours of college credits and have three letters of recommendation to the program from their chain of command. The soldiers and their applications are then reviewed by two selection boards. In the end only about one in four applicants is selected for the training. Currently 50 are selected per year, but the number is scheduled to increase to 60 per year. Of those selected, approximately 30% come from 18D.

Clearly the selection procedure for the PA program is much different from 18D. Applicants to the PA program must have some college background and letters of recommendation saying that they are well-suited for medical training and medical careers. By contrast, most of the 18D trainees have no college background and many, in the past, did not even necessarily want to be medics. Based on the PA application criteria alone, the pool of PA applicants is going to be better qualified for medical training than those soldiers actually selected for 18D training. The PA process then goes on to select only the top 25% of the applicants. The PA selection process is similar to those used by medical schools in that it is highly selective. As a result, both the PA program and medical schools yield low attrition rates.

18D does not have a selection board other than SFAS which is selecting SF and not medics per se. Adding an 18D pre-course would serve many of the functions of selection board. Another possibility would be to have 18D-specific recruiters. The 18D recruiter's mission should not be raw numbers of 18D applicants but a low attrition percentage from SFAS and SOMED. Like the 18D pre-course, the 18D recruiter would serve many of the same functions as the medical training selection board.

MOS Allocation Model

As mentioned ARI, SWCS, and the USASOC psychologist have been working on the development of a longitudinal SF selection and training database. The database is near completion and will be used to identify the best predictors of training success. For example, a preliminary examination has found that the Field Artillery (FA) composite score may be a better predictor of Q-Course success than the GT score which is currently used. The database links information from the enlisted master file (EMF) including scores on the Armed Forces Vocational Aptitude Battery (ASVAB) with selection and training performance data from SFAS and SFQC. The analyses will also include predictor information that has only recently been collected by SWCS, e.g., reading and math levels from TABEs, MOS preference, and the Biodata scales.

Based on the analyses of the longitudinal database, an MOS allocation model could be developed. The MOS allocation model could identify the optimal strategy for assigning SFAS graduates to one of the four MOS Q-Courses. Clearly the primary focus of the model would be on 18Ds. ARI is currently developing a computer software package that will assist SWCS in the MOS assignment process.

Evaluation and Standards Issues

The third major area to be considered concerns the 18D standards and the evaluation of those standards. One possibility for the increasing SOMED attrition is that the standards are getting more difficult. This could be true for several reasons. In general, the amount of medical information has grown significantly over the past years and the standards have changed to reflect the growth of that information. Today's medics must

learn new and in some cases more complex procedures than their predecessors. In addition they must still learn the older procedures and drugs in order to support FID missions in third world countries. Another possible reason for why the standards might be increasing is that instructors/evaluators remember the course as being more difficult than it actually was. As a result they are themselves stricter than previous instructors.

When the students, instructors, and medics were asked on the questionnaire whether they thought that the 18D Q-Course standards had been drifting higher over the years, the students and group medics, for the most part, accurately indicated that they did not know (Table A-14). As for the instructors, over two-thirds said the opposite, that SFQC standards were being relaxed to increase the number of graduates. Nearly half said that SFQC standards were being relaxed because the quality and the dedication of the students had decreased. In general, it is unlikely that the SOMED attrition rate is due to increasingly difficult standards.

Many of the SOMED and MedLab instructors noted that the quality of recent Q-Course graduates does not seem to be as high as it once was. As one MedLab instructor said, "The students aren't learning as much as they once were, but are being allowed to slide through." As discussed earlier, the verbal and math skills of the youth population has dropped significantly in the past decade. Also, the dedication of recent SFAS graduates to SF may be lacking because of the threat of downsizing. On the other hand, the interviews with the group medics and personnel from the group surgeon's office suggested quite the opposite. They thought that the quality of the recent graduates was outstanding. Several noted that they were amazed at some of the things the new medics could do right out of school. For the most part, it does not seem that the standards have changed appreciably in one direction or the other over recent years.

Subjectivity in Grading

As indicated in Table 2, the sixth most frequently made recommendation as to how to reduce attrition and improve the Q-Course was to reduce the subjectivity in the grading. As discussed in Appendix A, subjectivity in grading is thought to be a problem at SOMED but not at MedLab. For the most part, the comments regarding subjectivity in grading refer to the grading of the SOMED trauma clinics. While there no doubt is a problem with subjectivity in grading at SOMED, the SOMED leadership has made a number of significant changes in the last couple of years to standardize the training and evaluation. In general, the trauma scenarios have been standardized and the grading is strictly structured around the ATLS standards. The effort to make the training and evaluation more objective has been driven by two factors: first, to be fair to the students, and second, to avoid appeals.

The biggest source of subjectivity is the differences between instructors/evaluators. This is always going to be a problem when you have multiple instructors, but its effects can be minimized. In many cases, the soldier are evaluated by someone other than who

provided the training. The instructor differences are amplified by the fact that the instructors have different backgrounds and therefore different points of emphasis. As one student said, "Each of the instructors has his own biases based on his orientation. For example, in trauma II if you get a nurse, you had better watch your urinary catheter, whereas if it is an 18D, it is more on trauma, just keeping the guy alive."

It is good to have specialists as instructors for particular blocks of instruction, but the evaluators of the hands-on trauma blocks should be of similar backgrounds. Unfortunately, this is not usually possible because of the number and backgrounds of SOMED instructors. As mentioned earlier, nurses and combat medics are required to train and evaluate trauma even though they lack the formal background and credentials. For this situation, SOMED might improve the training of its trauma evaluators. As described, they already have a fairly elaborate system of back-graders and front-graders, but it still should be improved.

ARI in conjunction with SWCS has just completed the development of an SFAS "Assessor Training Program" which is being used to train new SFAS evaluators. The program contains videotapes that describe the performance dimensions of interest and how the evaluations should be conducted. The program also includes a series of vignettes in which the new instructor/evaluators can practice scoring. SOMED might likewise develop a set of videotapes which help train standardized scoring of the trauma clinics. The tapes could, for example, follow the ATLS-based checklists and for each step show a couple of examples of acceptable behavior and a couple of examples on unacceptable behaviors.

In an uglier vein, there were a fair number of comments that suggested that some of the SOMED instructors "...don't want anyone to pass." This is in line with the "keeper of the tab" idea previously discussed. During the student interviews, several of these alleged instructors were named. Later during the Trauma III clinic, a student commented that one of the instructors failed all six of the students that he evaluated; the instructor was one of the previous named "keepers of the tab." In all fairness, it is possible that on any one day, six of six students would deserve to fail, but it is unlikely. One recommendation would be to monitor the evaluation records of each instructor to identify those who are overly lenient or strict. As suggested before, disgruntled instructors should be relieved and replaced with instructors who want to be there.

Another source of subjectivity in grading is that different students get different scenarios. This has largely been addressed by SOMED in that they have scripted scenarios for the trauma clinics. The scripts specify the number, type, and location of injuries to the moulaged casualties. For test security reasons as well as common sense, not everyone gets the same scenario, but the scenarios have been designed to be of comparable difficulty. Some casualties will have more injuries than others, but that may not matter as much as the students think. While there are certain critical tasks/steps

which must be performed during the test, it is not imperative to make it through all of the steps during the timed test. For the most part, as long as the operator proceeds in a competent manner, in accordance with the ATLS sequence, he will pass.

Another source of subjectivity can be the position of the patient. This also has largely been standardized within the SOMED scenarios. This was not, however, always the case. It used to be that "creative" evaluators would put their casualties in a tree or in the middle of a creek. While it is generally believed by the students that finding a patient on his back is easier than finding him on his stomach, the initial position does not have much effect in the scoring.

Artificial Stress During SOMED

One of the more questionable aspects of the SOMED training is the artificial stress that is created by the instructors during the trauma clinics, particularly Trauma III. While not a formal part of the training, the general procedure is for the instructors to hassle successful students during the latter minutes of the trauma clinic. They do this by yelling, casting aspersions, and screaming questions like, "Are you sure that is right, are you sure that is right?" In one reported case, an instructor made speculations about the sexual orientation of a Navy SEAL. The rationale for such behavior is that Trauma III should be as intense as possible to help prepare the medic for the stress he will face in the field. In MedLab, the artificial stress is unnecessary because there is natural stress created by the live tissue.

One of the goals of the training is to teach the students that not every patient reacts in the same way and that there will be unanticipated events that they one must either ignore or resolve. The students need to also learn that there is a basic sequence which needs to be followed, regardless of the distractors. The artificial stress is added to help ingrain these points. Furthermore, the results of the questionnaire (Table A-15) show that soldiers strongly thought that the artificial stress created during SOMED added to the value of the training and the evaluation. For the group medics, their level of agreement with that statement was the highest of any item on the questionnaire.

Initially I was very skeptical of the value of artificial stress, but as I observed the execution and evaluation of the Trauma III clinics it did not appear as if the artificial stress altered the final outcome of the test. That is, no one passed or failed because of the way they handled the stress. In general those students who did well were given more stress and they seemed to handle it pretty well. The instructors claimed that they only "messed with" successful students in the closing minutes of the Trauma III sessions, and that no students were failed after they were being stressed. This appeared to be the case. In a few cases, the stress began much earlier than the closing minutes, but in each of these instances the student was given a GO. In a very few instances, some of the evaluators seemed to be on the fringe of acceptable stress-invoking behavior. In one case, the evaluator seemed to try to get in the operators way and physically touched the

student's equipment during the test. I was told that this had already been noted and that the Trauma NCO was going to talk to the evaluator about the practice.

The worst aspect of the artificial stress is that it is a source of subjectivity, and even more likely, it gives the appearance of subjectivity. Even though the previously mentioned SEAL had passed SOMED and could articulate what the instructor had been trying to do, he was still irritated months later that he had been treated in such a degrading manner. The degree to which subjectivity in grading is a problem may have overrepresented in the interviews and on the questionnaire. But when students see the artificial stress being doled out to themselves or to the student next to them, it is difficult for them to think that they are being treated fairly. The stories also live on from class to class. Even when extreme artificial stress has no direct effect on the outcome of the test, it can adversely affect the morale and motivation of students for classes to come.

Lastly, while I was largely unknowledgeable of the ATLS standards used in the Trauma III evaluation, it was fairly apparent which students were passing and which were not. Those that passed, were generally confident and competent despite the harassment, while those that failed appeared hesitant, confused, and sometimes lost. As I was told in an earlier interview, the bottom line goal of the Trauma III clinic is to determine which of the students will later be able to save someone's life on their own. If they do not have the skills, they will end up killing someone. It was said that in Trauma III the instructors try to apply the "Gold standard." The basic question is, "Is this guy going to save someone's life or is he going to kill someone?"

Training to Standard Under Test Conditions

Many of the SOMED students failed the Trauma III clinic because they were unable to get two full-bore IV sticks within the prescribed time. The IV stick time is a black-or-white criterion; if you miss the time, you are a NoGo. For the one Trauma III clinic that I observed, it appeared that the majority of the NoGos were due to late IV sticks. Because the Trauma III clinic is a critical objective and basically the defining event of SOMED, for a number of students the whole course boils down to what is in effect a one item test. Can they get two full-bore IVs started under the time standard?

It was suggested that while there are a large number of failures due to IV times, it is because this is the first critical event on the checklist. That is, if those students who failed the IV stick times were allowed to continue in the test they would more likely fail other tasks. This is probably true to some degree. Nevertheless, if many of the students are failing SOMED because of one event on one test, something should be done. Either the criticality of that test event should be examined and possibly reduced, or the training should be refocused toward that event, or both.

The instructors said that the students had made 40-50 IV sticks prior to Trauma III clinic. This number was confirmed by a number of reliefs whose mean estimate of the

number of IV sticks made prior to Trauma III was 45. The problem is not the number of times that the students have stuck IVs, but the conditions under which they were trained. To wit, a number of students commented that Trauma III was the first time that they ever stuck IVs in the mud, rain, cold, or heat. If IV sticks during Trauma III is a true bottleneck, I would strongly recommend that the soldiers be given additional training under the conditions that they will be tested, i.e. stressful, cold/hot conditions .

Career Issues

While the primary objective of this project was to look at attrition for the 18D Q-Course, a secondary objective was to look at the reasons medics were leaving the Army, SF, and 18D. While less comprehensive than the work on Q-Course attrition, the following information was gathered from interviews with group medics and from the analysis of the results of the SF Medic Annual Survey.

Methods and Results of the USASOC Surgeon's Survey

In mid-1991, the USASOC Surgeon' Office and the United States Army Special Forces Command began development of a survey to measure SF medic attitudes. The completed questionnaire which is included at Appendix F contained 95 items on issues such as career progression, training, credentialling, job satisfaction, and leadership. In addition, on a number of the items the medics were asked to write comments as to why they did or did not agree with a particular idea. The questionnaire was sent out in early FY92 to Medics at all five AC SF Groups and to a selected few RC Medics. A total of 155 Medics returned the completed survey including 135 AC Medics. A full description of the methods and results of the USASOC Surgeon's SF Medic Survey is provided at Appendix C.

18D Sustainment Training

Based on the results of the USASOC Surgeon's 18D survey and the interviews, it is apparent that there is a significant disconnect between the initial Q-course training and sustainment training. Overall, the group medics were extremely dissatisfied with their sustainment training (Table B-4). Much of the problem hinges on the groups being short of Medics. 7th Group, for example, only has 94 of its 125 authorized Medics which means there are typically only 8 of 13 Medics per company. It was estimated that three-fourths of the A Detachments only have one Medic. Only having one medic per team makes it more difficult for the commander to release the one Medic for training.

Lack of command support for training. The problem primarily seems to be getting command support for the sustainment training programs. The sustainment training opportunities are available, but other commitments take priority over the medics being sent to training. The USASOC Surgeon's office and the groups, for example, set up the "18D Medical Proficiency Training Program" in which four Medics would continually be

sent to Womack Army Hospital for 30 days of sustainment training. After the first rotation, no one was sent, so the program just died. Similarly, the 7th group surgeon had very recently set-up a program to teach the Pre-Hospital Trauma Life Support Course to any 18-series MOS. This would have helped alleviate some of the 18D support burden in that it would have allowed other MOSs to cover drop zones and ranges. It also would have given the Medics many of their credentialing points for the period. Letters were sent out 120 days in advance announcing the 60 training seats; only four soldiers showed up.

The majority of the sustainment training that the Medics receive is from the Advanced Trauma Life Support (ATLS) course which is offered twice a year by each Group. USASOC Reg 350-9 mandates that each 18D complete ATLS annually. At Fort Bragg ATLS is offered quarterly because it is the home of the 3rd and 7th SF Groups. ATLS is formally only three days, but it is packaged as 7 days of training. The remaining four days can include Microlab, OB/GYB, Advanced Cardiac Life Support, Advanced Burn, and most often Combat Anesthesia (CA).

Nearly all of the medics said that the ATLS was excellent training, but that it was not enough. They said that in addition they needed hospital rotations to fully sustain all of their skills. It was generally thought that the hospital training should include one week rotations through orthopedics, pediatrics, etc., as these areas are rarely covered in ATLS. As one medic said, "The fact is that if you don't see something for over a year you forget it. All of a sudden you are down south and you need to cast someone. You get out the books, but you forget the hands-on." As already described, there have been hospital rotation training programs that were established but not supported.

The primary reason that medics are not released for training is that the groups receive more taskings than they can handle. As a result the medics end up raking pine cones or doing mod demos instead of getting sustainment training. One way to fix this problem is to set up the hospital training programs such that they are primary tasking, e.g., from USASOC or SF Command. This makes them exempt from other taskings. Furthermore, if a medic is sent to a hospital rotation, it is bad business to pull the medic away one day or the next because of some other tasking. The physicians quickly lose confidence in the abilities of the medics or even in their capability to show up.

Training cycles. Group training is structured by quarterly cycles. Red cycle is for individual training and support; green cycle is for collective/unit training; amber cycle is for deployments. This year 7th Group had two Amber cycles. 18D sustainment training for the most part occurs during the red cycle, but it must compete with other taskings from SF Command. During the last red cycle the 7th Group 3rd Bn medics (which only has two CONUS companies) received 31 taskings. Many of the support requirements stem from the requirement that a medic must be present at live-fire ranges and at drop-zones. It was estimated that each of the taskings on average took a couple of days to accomplish considering the time it took to coordinate, e.g., arrange transportation.

One of the problems that has arisen in the past several years is that the green cycle is overburdened by certification requirements and testing. It was frequently suggested that the SF certification needed a serious relook as much of the certification focus is on Infantry tactics and drills. An alternative approach would be to de-centralize the battalion green cycle training, for say three weeks, during which time the training would be within MOSs. Medics could train collectively with other Medics; weapons sergeants could train collectively with other weapons sergeants.

Limited sustainment training opportunities are not particular to Medics. It is sometimes thought that the other MOS, e.g., 18B, do not have sustainment training problems because they normally get to train their MOS tasks as part of the Infantry type exercise. While there are significant sustainment training problems for Medics, there may be even greater problems for the other MOS. For example, the weapons sergeants rarely get the opportunity to fire mortars or to maintain and fire Russian weapons even though they are responsible for those tasks. If the green cycle included a block of decentralized MOS training, the other MOS would greatly benefit as well as the 18Ds.

One of the areas that needs to be improved concerns the amount and quality of the medic sustainment training provided by the battalion and group surgeons. The responses and comments on the questionnaire (Table B-4) suggest that very little training was received from the unit PAs and physicians. It should be emphasized that one of the main responsibilities of the surgeon's shop is to train the 110 Medics in the group. Each SF group includes a surgeon, dentist, veterinarian, environmental science officer, senior medic, medical operations officer, medical supply sergeant, and three battalion surgeons. Some of those interviewed thought that this group was largely a wasted resource.

Improve group surgeon and PA training. A big part of the problem is that the battalion surgeons typically are fresh out of medical school, new to the Army, and have no SF experience. While a major part of their job should be to provide sustainment training to the battalion medics, it is difficult for them to design and deliver quality SF-specific sustainment training given their limited SF and Army experience. Nevertheless, it was suggested that with more focused attention, many battalion surgeons could significantly increase the quality and frequency of their sustainment training to the medics.

While the Group physician does spend a fair amount of time at the Troop Medical Clinic (TMC), it was suggested that this also was largely a waste of resources in that most every case of consequence was referred to the hospital. One recommendation would be for the group surgeon to get 10-15 Medics assigned to him for the day at the TMC on a routine basis. Together they could run sick call in the morning and then the surgeon would have the medics as a captive audience for training in the afternoon. They might, for example, review disease processes, IV therapy, new drugs, and discuss diseases that are particular to the region of an upcoming deployment, e.g., Bolivia.

Credentiailling

USASOC Reg 350-9 states that medics must achieve and maintain 210 credentiailling points by successfully completing sustainment training on various tasks. The purpose of the requirement is to help ensure that the Medics receive adequate medical sustainment training. While this purpose was generally understood, the medics who completed the SF Medic Survey were overwhelmingly dissatisfied with the credentiailling process (Table B-7). Half of the group medics, for example, said that they had less than 75% of the required credentiailling points. Rather than helping the medics receive training, the system is seen by some as being punitive in that medics are held responsible for not having enough credentiailling points.

As shown in Appendix B, some medics called the credentiailling process a "farce and a paper-drill." They did not think that there was much of a relationship between receiving credentiailling points and receiving quality medical sustainment training. In a harsher light, some comments alleged that surgeons more or less just signed off on the credentiailling books to ensure that their medics had sufficient points. A number of medics indicated that commanders were interested in the program only to extent that failure to keep their medics credentiailled would hurt the officer's OER. In general, it was not thought that the program assisted the medic to get more medical sustainment training. USASOC Reg 350-9 has recently been revised and it is believed that it will now have more of a positive impact in that it contains more explicit threats of de-credentiailling.

EMT-P credentiailling requirements. Plans are underway to give every 18D the opportunity to become EMT-P certified. As reflected in the SF Medic Annual Survey responses, the EMT-P is highly sought after by the 18Ds (Table B-5). It is thought that the EMT-P (paramedic) certification will bolster the attractiveness of being an 18D in that there will be civilian equivalency and recognition. The EMT-P certification will also help eliminate many of the legal constraints that medics face in delivering medical and trauma treatments throughout the world.

Senior medics are currently being sent to EMT-P training. When the training moves to the SOMTC in FY96, not only will all 18Ds receive the EMT-P certification, but even those graduates of the SOF Basic Medic course. As a note, the current SOMTC plan is to send all students to New York City for four weeks where they will train with the New York City Emergency Medical Services (EMS). The New York City EMS is the busiest in the world with 1.1 million emergency ambulance responses annually. In addition to the ambulance time, the SOMTC clinical proficiency training would be conducted at 52 NYC area hospitals and three Level I trauma centers.

While the EMT-P certification for 18Ds and SOF basic medics is highly desirable, there is some additional baggage that goes along the certification, for example, there is a 48 credit hour sustainment training requirement for maintaining the certification. Given that group medics are having a tough time getting their certification now, adding

additional requirements will make it even more difficult. For example, I interviewed two 18Ds who had completed the EMT-P training. One medic's certification had already expired because he had not completed the sustainment training requirement. The second medic knew the date which was in about a month that he would lose his EMT-P certification.

At some point in the future there could be 800 18Ds and SOF basic medics who need EMT-P sustainment training. This requirement will need to be specifically addressed. An opposing position is that 48 EMT-P hours can be directly subsumed under the existing credentialing requirements such that there is no additional requirement. When asked, a number of the group medics did not see it that way. One partial solution is that the annual ATLS course should count toward the EMT-P sustainment, but it is not listed on the list of standard approved courses. It was thought that it would be added. Also, it is likely that SOMTC will offer regularly scheduled sustainment training opportunities. The problem then becomes getting the medics released for training.

18D Career Satisfaction

The responses from the SF Medic Annual Survey reflect a fair amount of discontent among the medics. A number of both the medics and the students said that becoming an 18D was a dead end, both in terms of an Army career and a medical career. These perceptions are for the most part incorrect. That a fair number of the medics and students hold these misperceptions is, however, in itself a problem.

The discontent from the medics seems to come primarily from the perceived lack of command support for sustainment training and the lack of medical status within the Army and civilian world. One medic noted that even though he was a nationally certified paramedic and ACLS instructor, he could not teach at Womack Army Hospital nor could he even use the hospital library. In general, the Army medical community fails to adequately recognize 18Ds. During a preliminary briefing of this research, MG Moore, CG, AMEDDC&S, noted that there was a marketing problem for 18D within AMEDD which should be remedied. Concerning the lack of a civilian medical status, this is being fixed with the award of EMT-P certification.

Many of the students and medics thought that they should receive proficiency (Pro) pay. Their rationale was they have to go through longer, more difficult training than their SF peers and that they should be given an extra incentive for maintaining the highly perishable skills. One of the most irksome aspects of pro-pay issue is that Navy independent duty corpsmen begin receiving approximately \$275 month pro-pay upon completion of the 18D training; there are some restrictions. It is hard for the medics to understand why their Navy counterparts should receive pro-pay for having the same training and

skills as they. This is particularly apparent at SOMED where the Navy instructors who receive pro-pay work side by side with the Army instructors who do not receive pro-pay.

One of the reasons some medics become dissatisfied is that they develop unrealistic expectations in the Q-Course as to what it means to be an SF medic. At SOMED and MedLab, they receive high powered medical training and are well aware that they are taking the toughest training in the Army. In one year they go from being grunts to skilled health care providers. As part of the clinical proficiency training they, for example, treat severe trauma injuries, deliver babies, and perform vasectomies. For most 18Ds, SOMED and MedLab is the one year in their SF career where they are fully part of the medical community. Some medics may later get to specialized training programs such as that at the Maryland Institute for Emergency Medical Services System (MIE-MSS), but those are the rare exception, not the rule.

The medic is trained and expected to be "special," in the sense that he will have to make spontaneous life-saving decisions. Sometimes this leads to an attitude of arrogance, but that arrogance is not necessarily all bad. When the SF Medic gets to an A-team, however, his primary responsibility is to be an SF team member, not a health care professional. Problems can arise if the medic fails to understand what his role is on the team and his need to satisfy all of the other SF and NCO obligations. In a sense, the Special Forces Medic can well be conceived of as half "Special Forces" team member and half "medic." It has been suggested that some medics think of themselves as 90% medic and 10% SF. Medics with such an attitude will either change or not succeed in SF.

Some have suggested that the 18D Q-course and, in particular, SOMED does not focus enough on those other NCO qualities. For example, there is little or no group PT at SOMED. The result may be that the SF medic sees himself as special, not in the sense that he has special responsibility and skills, but in the sense he may be exempt from standard NCO obligations. In response some have suggested that there is a need to "detune" the 18D Q-Course some, i.e., to soften the near elitist image that the SF medic is the "best trauma medic in the world." While there need not be a lot of time devoted to training non-medical SF skills, the medic should at least come out of the Q-Course with a set of realistic expectations as to what it means to be an SF medic.

Beyond 18D

Promotion to 18Z. As suggested above, a number of the medics hold misconceptions about their career opportunities. One widely held belief is that 18Ds are less likely to be promoted to MSG and 1SG than are the other 18-series MOS. More specifically, it is thought that 18Fs are most frequently promoted. This is largely incorrect. The SOPO CMF 18 Manager has recently prepared an information paper showing the promotion rates of the CMF 18 promotions to MSG and 1SG. The numbers shown below were taken from the information paper dated 8 Mar 1993. The FY90 to FY92

average percentages are the number who were promoted to E-8 relative to the number that were eligible. As can be seen the percentages are almost exactly the same across the five MOS. It is, however, true that the actual number of 18Fs promoted to MSG/1SG is greater than the other MOS. More 18Fs are eligible for promotion each year than the other MOS because they tend to be more senior. For example, of the 1263 who were eligible for promotion during the three years, 528 or 42% were 18Fs.

18B	23%
18C	27%
18D	26%
18E	27%
18F	22%
Total	24%

PA program. There is some concern within SF, particularly within the groups, that too many 18Ds are being lost to the PA program. At worst, this should only be seen as a problem until the 18Ds are at 100% of their authorized strength. As for the numbers, SOPO estimates that approximately 20 18Ds will be accepted into the PA program each year. Given that the steady-state loss rate will level out at around 75 per year, that means approximately 25-30% of all 18Ds will end up going into the PA program. Remember that over half of the medics in the SF Medic Annual Survey indicated that they planned on going to medical school or PA school (Table B-2).

A change was recently made to the PA selection procedures that says that only soldiers with a minimum of three years and a maximum of eight years service can be accepted into the program. The rationale is that eight years maximum service plus two years of PA training results in a total of ten years. The PA can then retire with ten years as an officer at year 20. Otherwise the Army is somewhat compelled to carry the PA past 20 years to allow him to retire as an officer. The eight year maximum is, however, a waivable limit. Many of the SF Medics interviewed believe that the 8 year maximum was imposed to prevent 18Ds from becoming PAs. If the purpose of the new restriction was to guard against situations where a PA did not have enough years to retire as an officer, it was no different than before. When the PA program was a warrant officer program, 18Ds had to sign a waiver acknowledging that they might not be able to retire with ten years as a warrant.

One of the potential problems of the new PA requirement is that it may force 18Ds to leave SF earlier in their career. One medic reported knowing a medic in the 5th Group who spent only four months in his unit before getting picked up for the PA program. This clearly is undesirable. The system might be changed to say that you have to stay in 18D for 3-5 years before you can apply for the PA program. If this were the case, the eight year time in service maximum would need to be permanently waived for 18Ds.

If SF is going to continue to attract quality soldiers into the 18D program, the opportunity should be there for some medics to continue their careers within the PA program. From the 18D perspective, it would be ideal for many if they could become PAs and remain in SF. A number of possibilities have been suggested, but there are significant problems with each. When the PA was still a warrant officer, it was suggested that the PA should become the senior A-Team Medic. The problem was that the medic would out rank the team sergeant. This is even more of a problem now that the PAs are commissioned officers.

Another possibility would be to have a special PA program for SF Medics in which the Medic would go to PA school but come out as a SFC. The difference would be that there would be a significant amount of proficiency pay roughly equating the E-7 pay to that of a 2LT, 1LT, CPT, and Major's pay based on seniority. You could add a five year obligation. Another possibility would be to give either the B-team medic or the battalion medic the choice of being either an E-8 or a PA. Once the medic was promoted to E-8, he could be given the option of going to PA school. Upon graduation he would come back with a multi-year obligation. This would enhance the career path for those SF medics who want to stay in medicine.

Closing Comments

Being able to observe the 18D training at SOMED and MedLab was truly a gratifying experience. It was remarkable to see that SF can take young soldiers from the ranks and turn many into skilled medical practitioners in one year's time. Above all, it was obvious that the 18D training was extremely difficult and that most people could not succeed in the course. Considering that most of the soldiers selected for training lack the proper academic background, there is little doubt that the attrition rate must and will remain high. Throughout this project I thought about what was said about training to the "gold standard." Are the soldiers who graduate from this course going to have skills to save someone or are they going to kill someone? Can the attrition rate be lower? Certainly. What should the attrition rate be? Responses to the questionnaire suggested that 40% is an optimum Q-Course attrition rate. All things considered, a 40% attrition rate would seem to be a reasonable target.

There are a number of changes that can be made to help lower the attrition rate. One would be to add additional instructors at SOMED that have the proper background and credentials and who want to be there. Another would be to relieve poor students earlier in SCMED and then use the vacated seats to train more recycles. As we have seen, selected recycles are twice as likely to graduate as initial inputs. A third change would be to identify those tasks which are most frequently failed and better focus the training on those tasks. In particular, make sure that the training on IVs is conducted under the same conditions as the testing. Also, SOMED should go even further to minimize the subjectivity in the grading of trauma skills.

All told, the 18D Q-Course is not badly broken. The training is impressive. The medics that are being produced are highly skilled and well-respected. With few exceptions, the instructors and staff are extremely dedicated and hard-working. Also, even with the high attrition rate, the Q-Course is producing 130 medics a year which is way more than ever before. At that rate, 18D should be at full strength in less than two years. Furthermore, once the 18Ds are at 100% authorized strength, many of the concerns of the medics in the groups, e.g., lack of sustainment training opportunities, should largely go away. It is tough to become an SF medic, but because it is, you can count on an SF medic to save your life.

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APPENDIX A

18D Q-Course Attrition Questionnaire: Methods and Results

The primary objective of this project was to identify the causes of attrition from the 18D Q-course. This was principally accomplished through a series of interviews and through the development and administration of a questionnaire on 18D attrition. Approximately 100 individuals were interviewed with the majority being students and instructors from SOMED and MedLab. In addition, I interviewed training directors, managers, and developers from SWCS, USASOC, and AMEDD, and SF Medics.

Questionnaire Development

Information gathered in the interviews was used to construct the Questionnaire on 18D Q-Course Attrition; the questionnaire is included as Appendix C. The questionnaire primarily asked the respondents to agree or disagree with the ideas that had been generated during the initial interviews. Because most of the recent 18D Q-Course attrition occurs during SOMED, the majority of the questions focused on SOMED. The questionnaire included questions about:

1. Ways to improve the quality of the Q-course
2. Ways to reduce attrition from the Q-course
3. Factors related to attrition
4. SFQC MOS assignment procedures
5. Fort Sam Houston/San Antonio environment and facilities
6. SOMED course length and amount of material presented
7. Information given prior to arriving at the course
8. SOMED Trauma clinic instruction
9. Feasibility and content of an 18D Pre-Course
10. Number and background of SOMED instructors
11. Standards and evaluation procedures
12. 18D problems in SFQC field phase
13. Additional comments and concerns

In each of these areas the soldiers were asked several specific questions about current or proposed procedures. The majority of the items ask the soldier for his level of agreement with a statement. For example, item six was:

6. Only those SFAS graduates who want to be Medics should be sent to the 18D SFQC. (Circle the number that indicates the extent of your agreement with this statement.)

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

The respondents were then given the opportunity to write comments in each of the question content areas. The last item of the questionnaire asked the soldiers to add any additional comments that they might have about the Q-course or 18D attrition. Two versions of the questionnaire were constructed, one that included questions about MedLab and one that did not. In that the SOMED students and reliefs had not attended MedLab, they received the version without the MedLab questions.

Sample

The questionnaires were administered to a total of 130 persons comprising seven groups of individuals. They were:

	Number	Percentage
Students recently relieved from SOMED	25	19%
SOMED Students - Senior Class	19	15%
SOMED Instructors (Military and Civilian)	16	12%
MedLab Students - Junior Class	24	18%
MedLab Students - Senior Class	15	12%
MedLab Instructors (Military)	13	10%
7th SF Group Medics	18	14%

Most of the students recently relieved from SOMED, i.e., the "SOMED Reliefs" were from the same class as the "SOMED Students." In most cases the SOMED Reliefs had only days before failed the final trauma field test, "Trauma III." Because most of the SOMED attrition occurs at or before Trauma III, the "SOMED Students" were ones who were likely to graduate from SOMED.

The "MedLab Students - Senior Class" had completed all of the 18D SFQC requirements including the field phase. They were awaiting graduation and, in effect, were recent Q-course graduates. The SOMED and MedLab students included active component and reserve component soldiers and several Navy SEALs. The SOMED instructors included seven civilians. The 7th Group Medics ranged from 1978 Q-Course graduates to recent graduates. They were asked to respond to the questionnaire items based on when they took the training.

The MedLab Junior and Senior classes may have been somewhat special in their perceptions of SOMED in that there had been exceedingly high attrition from their SOMED classes. In that most of the Q-course attrition occurs at SOMED, the MedLab Students, along with the SOMED instructors, had perhaps the best perspective as to what was going on at SOMED.

Analysis Procedures

For the scaled questionnaire items, the seven groups of individuals were condensed into three groups (1) "Students," which included SOMED reliefs, SOMED students, and

MedLab students, (2) "Instructors" which included SOMED and MedLab Instructors, and (3) "Medics," which were the 7th SF Group Medics. In the few cases where the sub-groups differed from each other in meaningful ways, it will be noted. Appendix D includes the Responses to the Questionnaire on 18D Q-Course Attrition for the objective items. Also included are the results of a Oneway Analysis of Variance (ANOVA) which compares the responses of the Students, Instructors, and Medics.

For the open-ended questions, the written comments were content analyzed by the author. Generally this involved counting the number of times a particular idea occurred in the written comments. The results of the content analysis of the written comments are shown below. Only those comments which occurred at least five times are included. The following sections will present the results from the major content areas of the questionnaire.

Ways to Improve the Quality of the Q-course and/or Reduce Attrition

The first substantive item on the questionnaire asked the soldiers to describe briefly up to three changes that could be made to improve the quality of the 18D Q-Course and its graduates (Item 4). The following item similarly asked the soldiers to describe briefly up to three changes that could be made to reduce attrition from the course. For the most part, the soldiers responded to the two items in the same way. Table A-1 lists the recommendations made as to improving the course or reducing attrition based on the combined responses of Items four and five.

The top recommendations on how to improve the quality of the Q-course and to reduce attrition basically reflect the major sections of the questionnaire. These responses largely validate that most of the serious concerns were identified in the interviews prior to the development of the questionnaire. Given that these items were first on the questionnaire, it is unlikely that many of the soldiers had read the remainder of the questionnaire which biased their responses.

Table A-2 shows the top-rated recommendations for the seven groups. For this analysis, those recommendations given in Items 4 and 5 that were circled indicating they were the top recommended change were weighted double. One might reasonably suspect that the top recommended changes between the groups are somewhat unreliable given the number of different responses, but it is nevertheless interesting to see what the different groups indicated.

best and most complete training that they will ever receive in medicine skills was during SOMED and that they wished they had more time to digest the information.

Table A-1

Recommendations to Improve 18D Course/Reduce Attrition

Recommendation	Frequency
Lengthen SOMED/Increase study time	53
Reduce student/instructor ratio at SOMED	52
Only send soldiers to SOMED who want to be Medics	52
Improve the 18D selection procedures	44
Get instructors/evaluators with proper backgrounds (SOF, Physicians, PAs)	41
Decrease subjectivity in grading	33
Provide civilian certification/equivalency (EMT-I or EMT-P)	24
Maintain the high standards as attrition rate ensures quality Medics	18
Increase the amount of hands-on training and lab work	15
Improve the SOMED physical facilities	13
Lengthen the Clinical Proficiency Training (CPT)	11
Give Medics proficiency (Pro) pay	11
Develop a pre-course to better select students	11
Conduct CPT after MedLab	10
Improve course organization	9
Reduce class sizes	7
Establish mandatory study halls	5
Keep the course at For. Sam Houston	5
Standardize the training between SOMED and MedLab	5
Treat SOMED students with more respect	5

Factors Related to Attrition

Item 8 asked the soldiers to rank order a set of eight factors as to how much they thought each contributed to SOMED attrition, with 1 being the factor that contributes the most and 8 being the factor that contributes the least. Table A-3 shows the factors rank ordered.

Table A-2

Most Frequent Recommendation for Change by Group

Group	Most Frequent Recommended Change
SOMED Reliefs:	Lengthen SOMED/Increase study time
SOMED Students:	Reduce Student/Instructor ratio at SOMED
SOMED Instructor:	Reduce Student/Instructor ratio at SOMED
MedLab Students: (Junior Class)	Decrease subjectivity in grading
MedLab Students: (Senior Class)	Only send soldiers to SOMED who want to be Medics
MedLab Instructor:	Improve the 18D Selection Procedures
Group Medics:	Lengthen SOMED/Amount of study time

For Students, the top three factors were subjectivity in grading (2.9), amount of course material (3.2), and student/instructor ratio (3.3). For Instructors, the top three factors were student/instructor ratio (2.7), amount of course material (3.1), and crowded classrooms (3.6). For the Medics, the top three factors were amount of course material (2.4), student/instructor ratio (3.4), and subjectivity in grading (3.8).

Table A-3

Rank Order of Factors Related to SOMED Attrition

Rank Order	Factor	Mean Rating
1	Amount of Course Material	3.0
2	Student/Instructor Ratio	3.2
3	Subjectivity in Grading	3.4
4	Crowded Classrooms	4.5
5	Instructor Experience/Background	4.7
6	Course Organization	4.9
7	Availability of Supplies	5.8
8	San Antonio/Fort Sam Houston Location	6.5

In general, the overall rankings of these factors seem to cluster into high, middle, and low with amount of course material, student/instructor ratio, and subjectivity in grading as ranked as high. This rank ordering may be misleading in that all of the eight factors were identified as being related to attrition during the interviews, i.e. the lower ranked factors may still be major contributors to SOMED attrition. The one exception possibly being the location of SOMED at Fort Sam Houston. As further evidenced by the responses to other items, the San Antonio location was not thought to be a real problem even though it is often given as a reason for the high attrition.

Item 9 similarly asked the soldiers to rank order eight student characteristics as to how much they contributed to SOMED attrition. The rank-ordered student characteristics are shown in Table A-4.

Table A-4

Rank Order of Student Characteristics Related to SOMED Attrition

Rank Order	Factor	Mean Rating
1.	Poor Study Skills	2.4
2.	Poor Motivation	3.2
3.	Personal Problems	4.4
4.	Poor Reading and Writing Skills	4.7
5.	Family Problems	4.8
6.	Poor Medical Background	4.8
7.	Poor Math and Science Background	5.0
8.	Poor Math Skills	5.5

The rankings of student characteristics show that poor study skills and poor motivation were thought to be most related to attrition with all of the other factors being considerably less so. One suggestion that has sometimes been made is that a greater effort should be to recruit more soldiers to be SF Medics from other medical MOSs, e.g., 91B. These results would indicate that lack of a medical background was not thought to be particularly related to attrition.

SFQC MOS Assignment Procedures

As for the 18D assignment procedures, the respondents overwhelmingly stated that they thought only soldiers who wanted to be Medics should be sent to the 18D SFQC. The mean rating on Item 6 was 6.4 (7 = completely agree). This item had the highest mean agreement rating of any item on the questionnaire.

The soldiers largely disagreed with the idea that soldiers relieved from 18D SFQC should be sent back to their previous MOS with an overall rating on Item 7 of 3.1. Somewhat interesting is that MedLab Instructors were the only group that agreed that they should be sent back to their previous MOS (rating = 5.8). By contrast, the SOMED Instructors disagreed with a rating of 2.9. Table A-5 presents the frequency of the comments made about MOS assignment procedures

Table A-5

Comments about SFQC MOS Assignment Procedures

Comment	Frequency
System disregards the student's MOS preference	21
Only 18D volunteers should be sent to SOMED	20
Many who fail 18D would be very good 18B's and 18C's	9
Too many good soldiers are being lost from SF	5

Fort Sam Houston/San Antonio Environment and Facilities

During the initial interviews it was suggested that the Fort Sam Houston/San Antonio environment may be adding to the SOMED attrition rate because of its "Fiesta" atmosphere, non-military campus-like setting, high number of women, and minimal SF presence. The soldiers strongly disagreed with this notion with a mean rating of 2.6 (Item 11). The comments acknowledged that the facilities were old, run-down and inadequate, but that attrition was largely due to motivation and factors other than the location.

A number of the comments (Table A-6) indicated that quite the opposite was correct, i.e., Fort Sam Houston/San Antonio is a good place for SOMED. First, Fort Sam Houston/San Antonio is a medical training community with easy access to medical libraries. Secondly, it was suggested that given the intense pace of the course, San Antonio offered good opportunities to unwind and to get away from the Army.

Table A-6

Comments about Fort Sam Houston and SOMED Facilities

Comment	Frequency
Facilities are old, run down, inadequate	28
Attrition is from motivation, not location	15
Academy and local libraries are available	13
Facilities are adequate	12
Fort Sam/San Antonio provides a place to get away for needed breaks/stress reduction	10
Classrooms are too small	10
Course should be kept at Fort Sam Houston	9
Fort Sam/AMEDD treats SOMED students less well than Fort Bragg	7

SOMED Course Length and Amount of Material Presented

Just as the written comments on ways to improve the Q-Course (Table A-1) most frequently recommended that the course be lengthened, the items shown in Table A-7 further suggest that SOMED presents too much information in too little time. The Instructors do, however, agree to a lesser extent than either the Students or the Medics that lengthening SOMED without adding more material would reduce attrition. Similarly, the Students and Medics agree that too much material is presented in SOMED while the Instructors tend to disagree with that statement. Overall it was neither felt that too much material was presented in MedLab nor would a mid-term break significantly reduce SOMED attrition.

As reflected in the written comments shown in Table A-8, the amount of material may not be so much the problem, but instead one of tempo and organization. For example, it has been suggested that course becomes too intense when all of the trauma training is held back to back, week after week. In general, lengthening the course would allow the students more time to digest and understand what they are being taught.

Another point that was frequently made was that the tests too often came weeks after the instruction on the material.

Table A-7

Items on Course Length and Content

Item	Total	Student	Instruct	Medic
13a Too much material in SOMED	4.7	5.1	3.7	4.7
13b Too much material in MedLab	3.6	3.5	3.0	4.4
14 Lengthening SOMED would reduce attrition	5.2	5.5	4.4	5.5
16 Adding mid-term break would reduce attrition	3.9	4.0	3.6	3.8

Item 15 asked the soldiers how much additional study time they thought should be added to the SOMED. It was noted that each additional week of study time that is added to the 31 week course adds approximately one and a half hours of study time that would be available each week. The mean response was 4.4 weeks with students indicating 5.1 weeks and instructors 2.4 weeks.

Information Given Prior to Arriving at the Course

Item 17 asked whether the students and their families received adequate information about the true requirements of SOMED before arriving at Fort Sam Houston. The respondents neither agreed nor disagreed with a mean rating of 3.7. In some contrast, over one third of the respondents wrote (Table A-9) that it would be helpful to stress how the hard SOMED is and the actual number of hours that the student will have to put in to succeed. They also often mentioned that this information should be given to the wives of the soldiers about to attend SOMED. It was also suggested that the students be given advance material on the course to include the course schedule and standards, and correspondence courses on anatomy and physiology and medical terminology.

Table A-8

Comments about SOMED Course Length/Amount of Training

Comment	Frequency
Course should be lengthened	29
Course organization/testing schedules need improvement	11
Do not change/decrease content	10
Tempo, not length, is not the problem	8
Course length is appropriate, if you are willing to work	8
Extend training in A&P, medical subjects	7
Add a midterm break	7

Table A-9

Comments about Information that should be Given Before SOMED

Comment	Frequency
Course is extremely demanding/Actual amount of time required	47
Training schedule/course standards	19
Information of off-post housing, cost of living	18
Prepare wives for demands of course and their need for support	17
Correspondence courses on A&P, medical terminology	11
Normal welcome packet information	9

SOMED Trauma Instruction

Table A-10 shows the written comments that were made about the SOMED Trauma Clinic instruction. The most frequent comment was that the evaluation of the trauma skills was too subjective. While many said that the instruction was good, it was also noted that there was a need for more individualized instruction and more practice time. Item 19 specifically asked whether the soldiers received a sufficient amount of one-on-one instruction in SOMED. The responses were generally neutral with an overall mean of 3.9.

Table A-10

Comments about SOMED Trauma Clinic Instruction

Comment	Frequency
Evaluation is too subjective	33
Good/excellent training	20
More individualized training is needed	17
Not enough practice time	12
Student/instructor ratio too high	11
Instructors should not be nurses	11

One of the difficult issues that is being discussed about the 18D Q-Course content concerns the relative balance between the training of trauma skills and general medicine skills, e.g., diagnosis and treatment of disease. Item 28a asks the soldiers whether there is too much of an emphasis on trauma during SOMED. Similarly, Item 28b asks whether too much trauma is trained in SOMED, given the extensive hands-on trauma in MedLab. The respondents strongly disagreed with both statements with mean ratings of 3.0 and 2.5 respectively. On both of these items the Medics most strongly disagreed with ratings of 1.8 and 1.7.

During the preliminary interviews it was suggested that part of the bigger 18D problem was that Medics received such specialized and technical training that they ended up with an attitude that they were different than the rest of the SF NCOs. It was suggested that a way to remedy this would be to place a greater emphasis on general

NCO skills and SF responsibilities in the 18D Q-Course. The responses to Item 29 suggest that this point of view is not widely held with an overall rating of disagreement being 3.1. The likely interpretation here is that it was felt that there is so much information and pressure in SOMED as it is, that it would be worse to add anything else on top.

Feasibility and Content of an 18D Pre-Course

The questionnaire also included several items on the utility of a pre-course as a means to reduce SOMED attrition. Prior to these questions the questionnaire included the statement: "One plan that is being discussed is to require selected soldiers at the end of SFAS to complete an 18D pre-course before being accepted into SOMED. The course would be designed for three purposes: (1) to provide background knowledge, e.g., basic A&P and math skills, (2) to give the soldier a better understanding of the tough SOMED requirements, and (3) to screen out those soldiers who are less likely to graduate. Those soldiers who fail the pre-course would likely be able to select another 18-series MOS."

The soldiers strongly agreed that such a pre-course would significantly reduce attrition with a mean rating of 5.6 (Item 20). When asked what the most efficient length of the pre-course would be, they gave a mean estimate of 5.2 weeks.

Table A-11 shows the most frequent written comments as to what should be included in the pre-course. Not surprisingly, they include the basics, i.e., anatomy and physiology, medical terminology, and math. It was often suggested that the demands and requirements of the pre-course should be as rigorous as that required in SOMED. This would be to include long classes and the need to study on one's own time. In addition, a number of the suggestions included the training and evaluation of hands-on trauma skills. Training and evaluating hands-on trauma skills in the pre-course would, however, be difficult to execute.

Number and Background of SOMED instructors

A series of items asked the soldiers to predict whether increasing the number of particular types of SOMED instructors would significantly decrease SOMED attrition. Table A-12 shows the responses to items which asked whether increasing the number of particular types of instructors would reduce attrition. The soldiers strongly agreed that increasing the number of 18D and Physician/PA instructors would reduce attrition. Conversely they strongly disagreed with the notion that increasing active-duty non-18D or civilian instructors would decrease attrition. Given that student/instructor ratio is one of the major factors in attrition, not thinking that more non-18D instructors would reduce attrition is taken as a strong indictment on the quality of the non-18D instruction.

Table A-11

Comments about What to Include in Pre-Course

Comment	Frequency
Anatomy & physiology (A&P)	45
Pharmacological calculations	27
Math	21
Pre-course should be as demanding as SOMED	19
EMT-Basic	16
Medical terminology	16
Study procedures/skills	11
Basic Medic tasks/first aid	9
Hands-on trauma skills	8
Nursing, IVs	8

Item 27 asked the soldiers to indicate the percentage of the course that was taught by physicians and PAs when they took the course. The students estimated 14% while the instructors estimated 45%. These figures reflect how the background of the instructors has shifted over the years away from physicians and PAs.

The written comments shown in Table A-13 reflect the same information, that the non-18D military and civilian instructors were unacceptable. For the most part these instructors are licensed practical nurses (91Cs). The comment that the instructors should have experience in the areas in which they are teaching addresses the same basic problem. Because of the high student/instructor ratio and the instructor mix, 91Cs are forced to teach and evaluate trauma skills, even though they basically lack experience in that area. They do, however, receive training and experience in preparation for being SOMED instructors.

Table A-12

Items on SOMED Instructor Background and Attrition

Item	Total	Student	Instruct	Medic
23 Increasing 18D instructors would reduce attrition	5.4	5.7	5.1	4.4
24 Increasing active-duty non-18D instructors would reduce attrition	3.0	2.7	4.1	2.7
25 Increasing civilian instructors would reduce attrition	3.0	2.9	3.4	3.1
26 Increasing Physician and PA instructors would reduce attrition	4.9	4.7	5.3	5.2

Standards and Evaluation Procedures

There are two major issues here, the standards in the course and the evaluation of performance relative to those standards. One of the questions that is often raised is whether the course standards have changed over time. Items 30 to 34 ask the soldiers about perceived changes in course standards over the years. For the most part, the students and group medics accurately indicated that they "Don't Know." As for the instructors, 68% said that SFQC standards are being relaxed to increase the number of graduates and 46% said that SFQC standards are being relaxed because the quality and the dedication of the students have decreased. If anything, the students thought the course standards were getting more difficult over time with 44% indicating that they thought that the standards were getting tougher because the amount of medical information continues to grow. Only 14% of the instructors agreed with the point that the standards were getting more difficult.

As shown in Table A-13, the most frequent comment about standards and evaluation was that the grading of hands-on skills is too subjective. An examination of the items in Table A-15 shows that the perceived subjectivity in grading primarily applies to SOMED (Item 35a) and not to MedLab (Item 35b). Not surprisingly the students viewed the grading as being more highly subjective than did the instructors. Item 36 indicates that the students thought that subjectivity in scoring was a significant factor in the high SOMED attrition rate.

Table A-13

Comments about Number and Background of SOMED Instructors

Comment	Frequency
Non-18D military instructors were unacceptable	20
Number of 18D instructors should be increased	15
Instructors should have experience in what they are teaching	14
There are too few instructors	10
Non-18D civilian instructors were unacceptable	10
Number of Physicians and PAs instructors should be increased	9
Overall the instructors were good	8
18D instructors were excellent/good	7

Table A-14

Comments about Standards and Grading

Comment	Frequency
Grading of hands-on skills was too subjective	38
Keep the standards as they are/high	10
Objective standards take out creativity/hinder good evaluation of skills	7

Item 35a is one of the few items in which the responses between the SOMED and MedLab instructors significantly varied with SOMED instructors having of mean rating of 3.6 as compared to the MedLab instructor mean rating of 4.9, $t_{(27)} = 2.25$, $p < .05$. For

the most part, the MedLab instructors were uniformly cautious in saying anything negative about the SOMED instruction as all of their information was hearsay. As reflected in these ratings, however, they apparently had heard numerous stories about lack of objective scoring. In some of the interviews and written comments there were horror stories as to the artificial stress and harassment created during the Trauma III evaluation. The responses to Item 37, however, show that all of the groups thought that the artificial stress in Trauma III was overall quite beneficial. While not statistically different from the other groups, it is interesting to note that the Medics rated the value of the artificial stress extremely high (6.3).

Table A-15

Items on Evaluation and Attrition

Item	Total	Student	Instruct	Medic
35a Evaluation of trauma skills at SOMED is highly subjective	5.3	5.8	4.2	4.9
35b Evaluation of trauma skills at MedLab is highly subjective	3.6	3.2	3.4	4.6
36 Significant amount of SOMED attrition from inconsistency in grading	4.4	5.2	2.4	3.9
37 Artificial stress created during SOMED adds to value of training/evaluation	5.6	5.5	5.4	6.3
12a Percentage of soldiers relieved from SOMED who have skills, knowledge, and abilities to become good medics	31%	35%	22%	22%
12b Percentage of soldiers relieved from MedLab who have skills, knowledge, and abilities to become good medics	33%	32%	26%	45%

Items 12a and 12b asked the soldiers to estimate the percentage of soldiers relieved from SOMED and MedLab who have the basic skills, knowledge and abilities to be good SF Medics. These items are basically asking what percentage of those who are being relieved should actually graduate. For both SOMED and MedLab, the estimated

percentage was around one-third. It is again not surprising that the students had higher estimates than the instructors. Assuming for the moment that the attrition rate in SOMED is 50%, the estimates in Item 12a would imply that another 31% of those who are relieved or another 15% of the class have the basic skills and/or potential to graduate. Similarly, assuming the MedLab attrition rate to be 10%, the estimates in 12b would imply that another 3% have the skills have the basic skills to graduate. Given these assumptions, this analysis would suggest a 35% optimum attrition rate for SOMED and a 7% attrition rate for MedLab. The overall 18D Q-Course attrition rate is therefore estimated at 40%. All things considered this seems to be a reasonable estimate.

18D Problems in SFQC Field Phase

Item 38 asked if the 18D students had any particular problem in the SFQC field phase. The vast majority said "no," with six soldiers saying that the 18D's tended to have trouble with land navigation.

Additional Comments and Concerns

The last item in the questionnaire asked the soldiers to add any additional concerns that they may have about the 18D Q-Course or attrition. These comments are organized by group and are presented at Appendix E.

APPENDIX B

Special Forces Medic Annual Survey Methods and Results

In mid-1991, the USASOC Surgeon' Office and the United States Army Special Forces Command began development of survey to measure SF medic (18D) attitudes. The stated purpose was "to investigate the trends, both negative and positive, which are influencing the 18D currently in the field relative to the following parameters: self-image, motivation and initiative, perseverance and achievements, career progression, retention in Special Forces, and future plans and goals."

The completed questionnaire contained 95 objective items and is included at Appendix F. A number of the items also asked the medics to write comments as to why they did or did not agree with a particular idea. The last item on the questionnaire asked the medics to add any additional comments or suggestions that they might have about the 18D career field or the survey. The questionnaire was sent out by the USASOC Surgeon's Office in early FY92 to medics at all five active component (AC) SF Groups and to a selected few reserve component (RC) medics. Completed questionnaires were returned to the USASOC Surgeon's office over the next six plus months. While the intent was to get responses from all AC 18Ds, it is unclear how many medics actually received the questionnaire.

A total of 155 medics returned the completed including 135 AC medics. The 155 AC respondents represent 25% of the 534 AC 18D's that were operational in December 1991. If all of the medics actually received copies of the questionnaire, the return rate is quite low. As with any low return rate, the responses may be negatively biased with an overrepresentation of unhappy or disgruntled medics who took the questionnaire as an opportunity to complain. On the other hand, 25% of the AC medics population is substantial. Because only 20 RC medics returned the questionnaire, unless otherwise noted, the analyses of the results reflect only AC medics.

The responses for all items in the questionnaire are included as Appendix G. The percentages and mean scores are presented separately for the AC medics, RC medics, as well as combined. Standard deviations are presented in parentheses. Again, the results and analyses presented in the text, unless otherwise noted, represent only the AC medics.

Background Variables

Table B-1 presents the results of items that reflect the demographics and background of those responding to the questionnaire. Because of the potentially low return rate, the numbers should not be interpreted as the actual percentages within the 18D

population, but as ballpark estimates. A number of these variables were used in later analyses to split the medics into particular groups.

Table B-1

Background of Sample

Item	Variable	Percentage
(33)	Component	
	• Active	87%
	• Reserve	13%
(2)	Rank	
	• SSG	33%
	• SFG	62%
	• Other	5%
(5)	Location	
	• SWCS	18%
	• Fort Bragg SFGs	28%
	• Fort Campbell	18%
	• Fort Devens	23%
	• Other	12%
(6)	Education	
	• High school graduate/GED	19%
	• 2 yrs college or less/no degree	41%
	• 2 yrs or more/Associates degree	32%
	• Bachelors degree or higher	9%
(19)	Marital Status	
	• Single, never married	6%
	• Married	78%
	• Divorced or Separated	16%

Table B-1 (Continued)

Background of Sample

Item	Variable	Percentage
(21)	Number of children living with you	
	• None	35%
	• One	19%
	• Two	31%
	• Three or more	20%
(3)	Years MOS 18D	
	• Three years or less	31%
	• Four to seven	36%
	• Seven or more	33%
(25)	Volunteered for 18D (25)	
	• No, was told to become 18D	12%
	• Yes	88%
(11)	Prefers new MOS (11)	
	• Yes	21%
	• No	72%
	• Not sure	7%
(31)	Medical Problems experienced in the last 12 months	
	• Hypertension	5%
	• Peptic Ulcers	4%
	• Migraine Headaches	8%
	• Emotional Problems	5%
	• Insomnia	13%
	• Increased Alcohol	8%
	• Increased Smoking	12%

Interpretation of Scale Scores

A number of the items in the questionnaire asked the medic to agree or disagree with an idea by responding on a five point scale. For example, consider item 36.

36. I believe that the implementation of a "credentialling system" for 18Ds has helped the 18D sustain his medical proficiency. Circle your response below.

1 = Strongly Disagree 5 = Strongly Agree

1 2 3 4 5

Other items asked the medics to rate their level of satisfaction with various aspects of being an 18D on a similar five point scale; the anchors of the satisfaction scale were "Very Dissatisfied" and "Very Satisfied." Analysis of these items found the standard deviation of the responses to be around 1.1 for most of the items. Assuming the responses to be normally distributed, it is possible to estimate the percentage of the level agreement with each item based on its mean rating. If an item, for example, had a mean rating of 3.3 (.3 points above the neutral rating of 3.0), the ratio of those who agree to those who disagree would be 3:2. Conversely if the rating was 2.7 (.3 points below the neutral rating of 3.0), the ratio of those who disagree to those who agree would likewise be 3:2. Other ratios are as follows:

<u>Mean Scale Rating</u>	<u>Ratio</u>
2.7 or 3.3	3:2
2.5 or 3.5	2:1
2.3 or 3.7	3:1
2.0 or 4.0	9:2

These ratios are intended to be aid the understanding of the mean scale values for the numerous items. For example, the mean rating for Active Component soldiers on Item 36 is 2.3 which means that approximately three medics disagree with the idea that credentialling has helped sustain proficiency for every one medic who agrees that credentialling has helped.

Career Progression

A number of the items asked the medics about their career intentions. The driving concern is that the number of 18Ds remains at around 80% of the authorized strength. For the most part the items were intended to determine the reasons medics plan on leaving SF or why they plan to stay. Table B-2 shows the reasons 18Ds plan to leave the MOS by rank.

One of the more interesting points here is that over half of the medics indicate that they plan to leave 18D to go to either PA or medical school with over two-thirds of the SSGs indicating such plans. The questionnaire was, however, administered prior the to changes made to the regulations for admission into PA school. Currently those accepted into PA must have less than eight years of total service. It is generally thought that this

change in policy will make it more difficult for 18Ds to go into the PA program. The regulation is, however, waiverable.

Table B-2

Reason for Leaving 18D (Item 24) by Rank

Reason	SSG	SFC
Do not plan to leave	18%	8%
Promoted to 18Z	11%	31%
SF Technician (Warrant Officer)	7%	1%
PA school	48%	39%
Medical school (Nurse or Doctor)	16%	21%

While only 31% of the SFC's intend on being promoted to 18Z, this is actually more than the personnel system needs, so there is no implied problem here. Item 84 asked the medic what was the most important determining factor for staying in the Army. The top responses were Job Satisfaction (28%) and Retirement Plans (27%). At the other end of the continuum, 5% responded on Items 84 and 85 that they were basically leaving the Army no matter what happened. This figure is consistent with the Special Operations Proponency Office migration figures which estimates a total of 10% of the medics leave 18D each year. This includes promotions, attrition, retirement, and commissioning, e.g., into PA program.

Table B-3 shows MOS preference (Item 11) by number of years as an 18D (Item 3). The basic question is whether a medic prefers to change to another MOS. This question is somewhat ambiguous since wanting to change MOS may mean wanting to be promoted to 18Z.

The basic results are that the longer you have been an 18D the more you want to get a new MOS. The big confounding in these results is the location of the medic. Nearly half (48%) of those medics who worked at SWCS indicated that they wanted a new MOS as compared to only 16% of the medics from the SF groups. For the group medics, rank was not a factor. Fifteen percent of the SSGs desired a new MOS as compared to 19% of the SFCs. The desire for SWCS medics to want to leave 18D may be due in part to the tendency to put medics who are on profile at SWCS. In some cases, these SWCS medics may know that their bodies can no longer stand the wear-and-tear of SF and therefore they want to get out. At another level, being an 18D seems to be increasingly viewed as a being a dead-end, hence the majority of the medics wanting to leave to go to PA or medical school.

Table B-3

MOS Preference by Years as an 18D

Years as an 18D	New MOS	Remain 18D
Three years or less (32%)	5%	95%
Four to seven years (33%)	25%	75%
Seven or more years (35%)	35%	65%

Two of the items asked about the impact of senior medical NCO slots on career intentions. Item 68 asked whether "Being the senior medical NCO in my command is worth striving for." The mean response was a neutral 3.0. Similarly on item 95, 56% of the medics indicated that the lack of a SOF Sergeant Major was not a strong factor in their long-term career plans. Regarding the senior battalion medic slot, many of the comments were to the effect that the job entailed too much administrative work, that it was used to hide medics with a profile, or that the job was a "whipping boy" for staff officers. On the other hand, if the slots were filled with capable individuals, they could be the most powerful medic position in the battalion. Overall, the lack of senior medic positions was not seen as much of a problem.

Selected Comments about 18D Migration. Listed below are selected comments that were made about 18D migration. All of the written comments from the questionnaire are included as Appendix H.

- "If the 18D CMF wants to retain 18Ds and not lose them to the PA/Nurse program, a good well-rounded sustainment program needs to be implemented."
- "The reason you lose 18Ds is that they: (1) want to be able to practice more medicine than they can in the groups and (2) 18D means nothing in the civilian world."
- "What forces many medics away...are fundamental problems with the groups, i.e., lack of missions, certification, the feeling that A-Tm members are scab labor."
- "People go to DEA, etc., not just for the money (it helps), but they get to work as a medic in the real world."

The selected comments about 18D migration represent several of the major themes addressed by the questionnaire, namely the lack of sustainment training and civilian

equivalency. The term "Migration" is used by the Special Operations Proponency Office (SOPO) rather than attrition in that many of the soldiers who leave the 18D MOS are being promoted out of the MOS or are accepting a commissioning as part of the PA program.

18D Training

18D SFOC. The medics were generally quite satisfied with the Q-course training, with the mean satisfaction rating on Item 72n "The 18D qualification course" being 3.5. The satisfaction rating of the Q-Course by medics who were college graduates was even higher with a rating of 4.3. It is likely that the college graduates were more satisfied than non-graduates in that they better understand that the quality of the medic training compares extremely favorably with the quality of standard college instruction. The satisfaction ratings of the Q-Course by SWCS medics was, however, somewhat lower (3.1). It may be that since the SWCS medics are much closer to the course, they see more of the problems.

Selected Comments about 18D Q-Course Training.

- "More material on third world missions."
- "Does not prepare for harsh realities of A-Tm"
- "Sick calls and physical exams are given low priorities; not all A-Tm equipment covered."
- "Great didactics, but no true application to an 18D."

Sustainment Training. The comments about the quality and frequency of medical sustainment training opportunities were generally negative, although the results are somewhat conflicting. Table B-4 presents the results of several items on sustainment training opportunities. Note the rating of satisfaction with sustainment training (Item 72o) is 2.3, which can be interpreted to mean that three medics are dissatisfied for every one medic that is satisfied.

One of the discrepancies is that 70% of the medics said that they never got the opportunity for sustainment training, yet approximately 3/4 of the group medics report having received formal sustainment training within the past 8 months. Furthermore, since many of the SWCS medics were MedLab instructors it is difficult to see how they could say that they were not receiving formal sustainment training. In response to these numbers, it was suggested by members of the USASOC Surgeon's office that medics may tend to only consider experiences as medical training when they have flown off some where TDY and are on someone else's time. Several items on the questionnaire asked

the medics what type of sustainment training they preferred. The responses tended to be any and all training, but in particular hands-on training in the hospitals.

Table B-4

Responses to Items on Sustainment Training

Item					Percentage
(42)	Are the type and number of sustainment training opportunities meeting your needs:				
	• Enough opportunities, but subjects too limited				14%
	• Never get chance to take any medical training				70%
	• Adequate number, quality not worth the time				5%
	• I participate in plenty of training				10%
(61)	How long has it been since last formal sustainment training, e.g., ATLS, formal lecture, hospital/TMC rotation				
	Within:	<u>SWCS</u>	<u>Bragg</u>	<u>Campbell</u>	<u>Devens</u>
	1 month	22%	24%	32%	36%
	3 months	4%	8%	8%	13%
	6 months	13%	13%	20%	6%
	8 months	4%	21%	16%	13%
	Year or longer	56%	34%	24%	32%
					<u>Mean Rating</u>
(72o)	Satisfaction with sustainment training				2.3
(92)	Unit Surgeon/PA provides regular and pertinent classes to 18D				2.5

Not that in item 92, the medics indicated by a 2:1 margin that they did not receive adequate and appropriate training from the unit Pas and physicians. This point is further emphasized by their written comments which strongly suggest that the medics receive little training from the unit surgeons. Designing, tailoring, and delivering sustainment training should be a major part of the unit surgeon's job.

Selected Comments about Group PA and Surgeon Training

- "Four years as a senior A-Team medic and no classes."
- "No PA. The battalion Surgeon is on the run at the TMC and hospital. The group Surgeon is stuck in meetings all of the time. It is not their fault."
- "I have never had a class with them except on deployments."
- "In three years, we have been given no classes at all."

The selected comments on medical sustainment training shown below further support the notion that there is a perceived lack of medical sustainment training which is largely thought to be due to the lack of command emphasis. The perceived lack of command support is in part due to the 18D MOS shortage. The majority of A detachments only have one medic which makes it more difficult for them to be released for sustainment training.

Selected Comments about Sustainment Training

- "Everything has priority over 18D training."
- "There is still a problem with command emphasis. The excuse that I cannot afford to go without a medic keeps popping up."
- "Medical experience pretty much comes to a standstill after graduating from the Q-Course. Medics feel stagnated and are denied opportunities to maintain and improve..."
- "More hospital rotation opportunities. Sustainment opportunities more than once a year for those who miss them due to deployments."
- "Sustainment training needs to be tailored to mission needs, not credentialing."

Civilian Certification

Several of the items on the questionnaire pertained to the issue of civilian certification or equivalency, i.e., awarding the paramedic (EMT-P) certification to SF medics. The questions asked whether medics would be interested in such a program and whether they thought having an EMT-P certification would lead to medics leaving the Army for civilian jobs. The responses to these items are shown in Table B-5.

Table B-5

Responses to Items on Civilian Certification

Item	Mean Rating
(39) Would be willing to enroll in Army sponsored EMT-P course, even if it required own time:	4.5
(44) Acquiring a civilian medical certification would encourage me to leave military for higher paying job	2.1
(93) Gaining civilian EMT-P equivalent would encourage 18D's to leave the Army	1.9

The responses to the items on civilian equivalency were some of the most extreme on the questionnaire. The medics overwhelmingly said "Yes" they would be interested in the training and "No" the EMT-P would not lead to them leave the Army. Regarding the latter question, a number of comments indicated that it was ludicrous to think that an B-6 or B-7 would quit the Army to take a paramedic job which pays around \$18,000 per year. Selected comments are shown below.

Selected Comments about EMT-P Certification

- "I enjoy being a medic but am very frustrated about my credibility on the civilian side."
- "We should be provided an opportunity to get EMT-P, so we are legally covered when working on civilians."
- "The average annual income of a paramedic is less than that of an B-5 18D."
- "Having the security of knowing that I can perform and step into a job in the civilian world would enhance my career immensely"

Schools Attended.

Table B-6 shows the percentage of medics who reported that they had attended Army schools within the last 18 months. The sum of the percentages equals 70%, because a number of the medics had attended more than one school. Forty-seven percent of the medics had not attended any Army schools within the past 18 months.

Table B-6

Schools Attended within the Past 18 Months

School	Percentage
HALO	10%
SCUBA	6%
SERE Course	3%
O&I Course	7%
Rough Terrain Parachuting	0%
Water Infiltration	0%
Jump Master	13%
Dive Medical Technician	5%
Other: (Mostly ANCOC)	26%
No Schools	47%

Credentiailling

As part of USASOC Reg 350-9 on Medical Sustainment Training, medics must achieve and maintain 210 points in their 18D credentiailling book. Several of the questionnaire items inquired about the usefulness of the program and the medic's satisfaction with it. The purpose of the program is basically to help ensure that the Medics receive adequate medical sustainment training. While this purpose was generally understood and appreciated, the application of the program was not perceived very positively. The responses to the items on credentiailling are show in Table B-7. Selected comments about the credentiailling program are also shown below.

Selected Comments about the Credentiailling Requirements

- "Continuing training is an excellent idea, but the 'points' system is a pain"
- "It's a farce and a paper drill. Commanders do not support medical training."
- "The certification/credentiailling programs have adversely affected morale... We feel that we are constantly being tested and that no one trusts us to do our jobs."
- "It backfired. Instead of medics getting released for training, they get in trouble for not having enough points"

Table B-7

Responses to Items Credentialling

Item	Mean Rating				
(70p) Satisfaction with the credentialling process:	2.0				
(38) Supervisors are aware of credentialling and show interest:	2.9				
(35) Percentage of credentialling points accumulated during this period.					
	<u>SWCS</u>	<u>Bragg</u>	<u>Campbell</u>	<u>Devens</u>	
0%-15%	61%	11%	8%	7%	
15%-30%	0%	6%	12%	17%	
30%-50%	6%	14%	16%	7%	
50%-75%	11%	22%	12%	17%	
75%-80%	22%	47%	52%	52%	

The mean rating of satisfaction with the credentialling system of 2.0 indicates an overwhelming dissatisfaction with the program. The notion that it is a "farce and a paper-drill" suggests there is not thought to be much of a relationship between receiving credentialling points and receiving quality medical sustainment training. In a harsher light, the comments refer to alleged situations where surgeons more or less just sign off on the credentialling books to ensure that their medics have enough points. A number of medics indicated that commanders were interested in the program only to extent that failure to keep their medics credentialed would hurt the officer's OER. In general, it was not thought that the program assisted the medic to get more medical sustainment training. It should be noted that the regulation has recently (3 March 1993) been revised. It is believed that the revised regulation will have more an impact because of the more explicit threat of de-credentialling.

Job Satisfaction

Table B-8 presents the results of the items dealing with SF medic job satisfaction. With the exception of income, all of the factors are rated near or above the middle of the satisfaction scale. Concerning income, many of the medics think they should receive proficiency (pro) pay because of the high level of training that they have received and the responsibility that they must bear. It is not surprising that SFCs think that their rank

more fairly represents their time and experience than do SSGs. In most cases, there is only one medic per A-team, so that the work requirements and responsibilities are nearly the same regardless of rank.

Table B-8

Responses to Items on Job Satisfaction

Item	Mean Rating	
<u>Grade Structure</u>		
(69) Rank Fairly Represents Time and Experience	<u>SSG</u> 3.0	<u>SFC</u> 3.8
<u>Intrinsic Factors</u>		
(72b) Type of Work	3.3	
(72c) Importance of Job to Unit	3.8	
(59) 18D experience has met my expectations in terms of self-satisfaction	3.0	
<u>Extrinsic Factors</u>		
(72a) Income	2.6	
(72d) Promotion Opportunities	3.6	
(72g) Recognition and Awards	2.9	
(72i) Quality of Co-workers	4.0	
(72m) Time Spent with Family	2.8	

It is especially encouraging that satisfaction with "Importance of job to unit" and "Quality of co-workers" was rated very highly. On the other hand, it is somewhat surprising that the rating of "18D experience has met my expectations in terms of self-satisfaction" was not rated more highly. The written comments on this item (see

Leadership

Table B-10 shows the responses to items dealing with satisfaction with leadership. Item 72f "Treatment by supervisors" is rated quite high which would seem to indicate that medics are quite satisfied with A-detachment leadership, particularly that of the team sergeant. The other items, e.g., "Unit morale" and "Being kept informed" by contrast, are rated fairly low. These low ratings on satisfaction with leadership may not, however, be specific to medics, but could be the same for the other 18-series MOSs. Also listed below are selected comments about SF leadership. For the most part the comments were not very positive.

Table B-10

Responses to Items on SF Leadership

Item	Mean Rating
(72f) Treatment by supervisors	3.6
(72e) Command support for medical training	2.5
(72h) Unit morale	2.6
(72r) Being kept informed	2.6
(72s) "My opinion counts"	2.5

Several themes are reflected in the comments. The first is that there is discontent with the lack of command support for appropriate medical sustainment training opportunities. There were, for example, a number of anecdotes about quality training opportunities being missed because the medics were not allowed to be released for training. A second theme was that Special Forces was becoming less special. It was suggested that SF officers were now more frequently looking for career-enhancing ticket punches rather than being truly committed to developing and maintaining quality units. A third theme was that the leadership did not understand the needs of the medics.

Selected Comments about SF Leadership.

- "18Ds are expected to be 'Medical Gods' purely through graduation from the Q-course. Ccmmanders expect this, but are unwilling to send medics to sustainment training."
- "We never receive recognition. We're told that we are just doing our job."
- "SF has the best NCOs in the Army...If you don't give the NCOs responsibility and good, loose leadership, you stifle their initiative and destroy their morale."
- "The emphasis in SF today is on quantity and not quality; SF continues to ignore the real, underlying problems."
- "Too many weapons men are in charge of SF."
- "Very little medical training is planned into missions."

Table B-11 shows the perceived organizational barriers to training for medics from SWCS and from the SF groups. Note that the medics in the groups thought that most of the barriers occurred at battalion and group while the SWCS medics thought most of the barriers were from higher up.

Table B-11

Perceived Organizational Barriers to Training

Item	SWCS	SFGs
(65) At which level do you believe is the greatest barrier to your being medically prepared. Select all that apply:		
No barriers exist, I'm prepared.	17%	20%
Company HQ	17%	19%
Battalion HQ	29%	39%
Group HQ	33%	53%
SF Command HQ	46%	29%
USASOC HQ	42%	30%

18D Reform

Table B-12 shows the responses to items asking which programs are or are not in most need of reform. Consistent with the rest of the results, the credentialling process and availability of medical sustainment training were identified as areas in most need of improvement. The curriculum of the Q-course was most frequently identified as that which should left untouched.

Table B-12

Responses to Items on 18D Reform

Item		
<hr/>		
(74/75) Which of the following should be left untouched/ Is in most need of revision:		
	<u>Do not touch</u>	<u>Revise</u>
Recruitment for 18D	22%	12%
Curriculum of SFQC	49%	5%
Credentialling process	6%	65%
Family Support Program	13%	7%
All should be changed	26%	11%
(88) If you had the power to change one of the following, what would it be?		
Medical portion of SFQC		3%
18D METL		5%
SF selection standards		7%
Availability of medical sustainment training		62%
18D credentialling process		17%
Relationship with next level of command		1%
Other		5%

Comparison of SWCS and Group Medics

Table B-13 presents the results of some of the items in which the responses of SWCS medics differed from SF Command medics. For the most part, the medics in SWCS were considerably less satisfied with their situation than those medics in the

groups. In particular, note that the rating for satisfaction with unit morale was 1.8 for the SWCS medics which is exceptionally low. The one area in which SWCS medics were more satisfied than group medics was in "Time with family."

Table B-13

Items on which SWCS and Group Medics Differed

Item	SWCS	SFGs
(72d) Promotion opportunities	2.8	3.8
(72f) Treatment by supervisors	2.7	3.8
(72h) Unit morale	1.8	2.8
(72n) 18D Q Course	3.1	3.6
(39) Willing to enroll in EMT-P even on own time	3.9	4.6
(44) Civilian certification would encourage me to leave Army	2.6	2.0
(72m) Time with family	3.3	2.7

Comparison of AC and RC Medics

Similar to the comparison of analysis comparing SWCS and group medics, Table B-14 shows a number of the items in which the responses of AC medics differed from RC medics. With the exception of this analysis, all of the other analyses only included the responses of AC medics. For the most part, the RC medics were extremely positive and satisfied. The RC medics, however, were unsatisfied with their equipment and with the training received from the unit surgeons and PAs. In a number of cases, the RC medics lacked battalion and group surgeons.

Additional Results

18D Non-volunteers. One of the issues frequently discussed relative to the 18D Q-course attrition is whether only volunteers should be allowed to become medics. In the questionnaire sample, 12% of the respondents indicated that had been made to become

18Ds (Item 25). Somewhat remarkably, the responses of the 18D Non-volunteers did not differ on any item from those who were volunteers. Of particular interest, there was no difference on Item 94, 'Regardless of critical shortages', one's personal intelligence and excellence of prior duty, no one can become an effective medic unless he enters by his own choice." Both the 18D volunteers and non-volunteers overwhelmingly agreed with this statement with means of 4.4 and 4.3 respectively.

Table B-14

Items on which AC and RC Medics Differed

Item	AC	RC
(54) Hard work for 18D was worth it	3.8	4.5
(59) Met self-satisfaction expectations	3.0	4.2
(72h) Unit morale	2.6	3.6
(83) Army experience helps civilian employment	3.2	4.0
(87) Newsletter would be helpful	3.7	4.5
(66) Properly equipped to do mission	3.1	2.4
(92) Unit surgeon/PA provides training	2.5	1.2

Satisfied vs. Unsatisfied Medics. Item 59 asked for the medics level of agreement with the statement: "My experience as an 18D, thus far has met my expectation in terms of self-satisfaction." For analysis purposes the medics were split into three groups based on their response to this item with a response of 1 or 2 being Low Satisfaction, 3 being Medium Satisfaction, and 4 or 5 being High Satisfaction. The numbers in Low, Medium, and High Satisfaction groups were 40, 47, and 46, respectively. Separate one-way analysis of variances were run to identify those items in which responses varied as a linear function of satisfaction. Selected items are presented in Table B-15.

Those medics with high levels of satisfaction were more satisfied with many of the internal and external factors of job satisfaction including type of work, importance of job, and unit morale. As reflected throughout the questionnaire, sustainment training opportunities, and the perceived command support of sustainment training, proved to be

an important factor. The least satisfied medics were least satisfied with the sustainment training. Perhaps the most interesting finding here is that those medics who are generally most satisfied with being an 18D SF medic rated the importance of tropical medicine, pediatrics, and Ob-Gyn higher than those medics who are generally least satisfied. It as if the satisfied medics are more accepting and appreciative of the FID type medicine.

Table B-15

Selected Items which Vary as a Function of 18D Satisfaction

Item	Level of Satisfaction		
	Low	Medium	High
(60) Command knows value of well-trained 18D and supports training	1.9	2.6	3.0
(72b) Type of work you do	2.7	3.2	3.9
(72c) Importance of job to mission	3.4	3.7	4.2
(72e) Unit Morale	2.2	2.8	2.9
(72o) Sustainment training opportunities	1.8	2.4	2.7
(72s) My opinion counts	2.1	2.6	2.8
(73c) Importance of tropical medicine	3.1	3.4	3.9
(73d) Importance of Pediatrics	3.1	3.3	3.7
(73e) Importance of Ob-Gyn	2.8	3.0	3.4

Discussion

While the attitudes of the 18D were not overwhelmingly positive, the questionnaire results reflect a fairly healthy SF medic force. There were several areas which were identified as in particular need of improvement. First, there continues to be a problem in getting the medics sustainment training. The sustainment training opportunities are there, but because of other obligations, too often medics are not being released for the training. In part, this is due to the shortage of medics at the A detachment level. With only one medic per team, it is thought to be difficult to find time for the medic to

receive training. The barriers to training were seen as being at battalion and above. In general, the medics did not see the leadership as being sensitive to the medical sustainment training requirements. In addition, it was suggested that very little sustainment training was received from the unit surgeons.

The medics were not pleased with the credentialing system. While it was readily understood that the purpose of the credentialing requirement was to help ensure that they received sustainment training, the system was viewed as being more punitive than helpful. The procedure was also viewed as a paper drill. The impression was that there was not much of a relationship between receiving credentialing points and receiving quality medical sustainment training.

A third major issue addressed on the questionnaire was the need for civilian certification and equivalency. The questionnaire had several items which inquired whether receiving civilian paramedic (EMT-P) equivalency would lead to medics leaving SF and the Army. The response was a strong "No." By contrast it was thought that the civilian certification would likely bolster the attractiveness of being an SF medic and would help eliminate many legal constraints that medics face when delivering medical and trauma treatment.

APPENDIX C

Questionnaire on 18D Q-Course Attrition

1. Duty Position: _____

2. Rank: _____

3. Course Number or date you graduated from 18D SFQC: _____

4. Briefly describe up to three changes that could be made to improve the quality of the 18D SFQC and its graduates. Circle the letter of the recommendation that you think is most needed.

- a. _____

- b. _____

- c. _____

5. Briefly describe up to three changes that could be made to reduce attrition from the 18D SFQC. Circle the letter of the recommendation that you think would be most effective.

- a. _____

- b. _____

- c. _____

6. Only those SFAS graduates who want to be Medics should be sent to the 18D SFQC. (Circle the number that indicates the extent of your agreement with this statement.)

1	2	3	4	5	6	7
Completely			Neither			Completely
Disagree			Agree/Disagree			Agree

7. Now that there are enough SFAS graduates to fill the SFQCs, it is reasonable to send soldiers relieved from the 18D SFQC back to conventional units with their old MOS.

1	2	3	4	5	6	7
Completely			Neither			Completely
Disagree			Agree/Disagree			Agree

Comments about the SFQC MOS assignment procedures: _____

8. Rank order the following factors as to how much they contribute to SOMED attrition. (1 = most, 8 = least)

- a. Crowded classrooms _____
- b. Availability of supplies _____
- c. Student/Instructor ratio _____
- d. Subjectivity in grading _____
- e. Instructor experience/background _____
- f. Amount of course material _____
- g. San Antonio/Fort Sam Houston location _____
- h. Course organization _____

9. Now consider the following student characteristics; rank order them according to how much they contribute to SOMED attrition. (1 = most important, 8 = least important)

- a. Poor reading/writing skills _____
- b. Poor math skills _____
- c. Poor study skills _____
- d. Poor math and science background _____
- e. Poor motivation _____
- f. Personal problems _____
- g. Family problems _____
- h. Poor medical background _____

10. The biggest problem with the physical facilities at Fort Sam Houston is:

- a. Not being able to hear in the classrooms/labs
- b. Not being able to see in the classrooms/labs
- c. Lack of space to study
- d. Availability of supplies
- e. Other: _____

11. The SOMED attrition rate is increased by the San Antonio/Fort Sam Houston environment, e.g., the "Fiesta" atmosphere, the non-military campus-like setting, the high number of women, and minimal SF presence.

1 2 3 4 5 6 7
 Completely Neither Completely
 Disagree Agree/Disagree Agree

Comments about Fort Sam Houston & facilities: _____

12a. What percentage of the soldiers who are relieved from SOMED do you think have the skills, knowledge, and aptitude to be good SF Medics? _____

12b. What percentage of soldiers who are relieved from MedLab do you think have the skills, knowledge, and aptitude to be good SF Medics? _____

13a. Too much material is presented in SOMED in the available amount of time.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

13b. Too much material is presented in MedLab in the available amount of time.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

14. Lengthening SOMED without increasing the content, i.e., increasing study time, would significantly reduce attrition.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

15. How much additional study time do you think should be added to SOMED? _____
(Note: Each additional week which is added to the 31 week course adds approximately 1 1/2 hours of study time that would be available during each week.)

16. Adding a mid-term break would significantly reduce attrition from SOMED.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

Comments about course length/amount of training: _____

17. My family and I received adequate information about the true requirements of SOMED before we arrived at Fort Sam Houston.

1 2 3 4 5 6 7
Completely Neither Completely
Disagree Agree/Disagree Agree

18. What information should be given to soldiers and their families before they arrive at SOMED? _____

19. At SOMED, I received a sufficient amount of one-on-one instruction in the trauma clinics.

1 2 3 4 5 6 7
Completely Neither Completely
Disagree Agree/Disagree Agree

Comments about the SOMED trauma clinic instruction: _____

18D Pre-Course

One plan that is being discussed is to require selected soldiers at the end of SFAS to complete an 18D pre-course before being accepted into SOMED. The course would be designed for three purposes: (1) to provide background knowledge, e.g., basic A&P and math skills, (2) to give the soldier a better understanding of the tough SOMED requirements, and (3) to screen out those soldiers who are less likely to graduate. Those soldiers who fail the pre-course would likely be able to select another 18-series MOS.

20. Do you think such a pre-course would significantly reduce attrition from the 18D SFQC?

1 2 3 4 5 6 7
Completely Neither Completely
Disagree Agree/Disagree Agree

21. What would you include in the course? e.g., content, number of tests, reading requirements: _____

22. What would be the most efficient length for the 18D pre-course? _____

23. Increasing the number of 18D instructors at SOMED should significantly decrease the SOMED attrition.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

24. Increasing the number of active duty non-18D instructors at SOMED should significantly decrease the SOMED attrition.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

25. Increasing the number of civilian instructors at SOMED should significantly decrease the SOMED attrition.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

26. Increasing the number of Physician and PA instructors at SOMED should significantly decrease the SOMED attrition.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

27. When you attended SOMED, approximately what percentage of the course was taught by physicians and PAs? _____

Comments about the number and background of SOMED instructors: _____

28a. Too much emphasis is placed on the trauma blocks during SOMED.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

28b. Given the extensive hands-on trauma training in MedLab, too much trauma is trained in SOMED.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

29. The 18D SFQC should place a greater emphasis on general NCO skills and overall SF responsibilities.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

Comments about SFQC content: _____

30. SFQC standards have been getting stricter because the evaluators remember the course as being tougher than it actually was.

True False Don't Know

31. SFQC standards have remained relatively stable over the years.

True False Don't Know

32. SFQC standards are being relaxed to increase the number of graduates.

True False Don't Know

33. SFQC standards have been getting tougher because the amount of medical information continues to grow.

True False Don't Know

34. SFQC standards are being relaxed because the quality and dedication of the students have decreased.

True False Don't Know

35a. The evaluation of skills in the SOMED trauma clinics, especially Trauma clinic III, is highly subjective.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

35b. The evaluation of hands-on trauma skills in MedLab is highly subjective.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

36. A significant amount of SOMED attrition is due to inconsistency in grading.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

37. The artificial stress and distractors created during SOMED Trauma adds to the realism and value of the training/evaluation.

1	2	3	4	5	6	7
Completely Disagree			Neither Agree/Disagree			Completely Agree

Comments about Standards and Grading: _____

38. Were there any aspects of the SFQC Field Phase that were particular problems for the 18D students? _____

Any additional comments about the 18D Q-course or attrition: _____

APPENDIX D

Responses to Questionnaire on 18D Q-Course Attrition

	<u>Number</u>	<u>Percentage</u>
1. Duty Position: Recent SOMED Reliefs	25	19%
SOMED Students	19	15%
MedLab Students - Junior Class	24	18%
MedLab Students - Senior Class	15	12%
SOMED Instructors	16	12%
MedLab Instructors	13	10%
7th SF Group Medics	18	14%

2. Rank:	<u>Number</u>
Specialist	13
Sergeant	33
Staff Sergeant	39
Sergeant First Class	34
Captain	2
Major	1
Lieutenant Colonel	1
Civilian	7

3. Course Number or date you graduated from 18D SFQC:

<u>Year</u>	<u>Number</u>	<u>Year</u>	<u>Number</u>	<u>Year</u>	<u>Number</u>
1978	3	1985	3	1990	1
1979	1	1986	3	1991	2
1980	3	1987	3	1992	3
1982	3	1988	5	1993	83
1984	1	1989	8		

4. Briefly describe up to three changes that could be made to improve the quality of the 18D SFQC and its graduates. Circle the letter of the recommendation that you think is most needed.

5. Briefly describe up to three changes that could be made to reduce attrition from the 18D SFQC. Circle the letter of the recommendation that you think would be most effective.

6. Only those SFAS graduates who want to be Medics should be sent to the 18D SFQC.
(1 = Completely Disagree 7 = Completely Agree)

<u>Total</u> <u>(n=130)</u>	<u>Students</u> <u>(n=83)</u>	<u>Instructors</u> <u>(n=29)</u>	<u>Medics</u> <u>(n=18)</u>	<u>F(2,127)</u>	<u>p value</u>
6.4 (1.4)	6.4	6.4	6.0	.81	n.s.

7. Now that there are enough SFAS graduates to fill the SFQCs, it is reasonable to send soldiers relieved from the 18D SFQC back to conventional units with their old MOS. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
3.1 (2.1)	2.6	4.2	3.3	7.16	.001

8. Rank order the following factors as to how much they contribute to SOMED attrition. (1 = most, 8 = least)

	<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>
a. Crowded classrooms	4.5	4.5	3.6	5.8
b. Availability of supplies	5.8	5.9	5.2	6.1
c. Student/Instructor ratio	3.2	3.3	2.7	3.4
d. Subjectivity in grading	3.4	2.9	4.8	3.8
e. Instructor exper/background	4.7	4.6	5.0	4.6
f. Amount of course material	3.0	3.2	3.1	2.4
g. San Antonio/Fort Sam	6.5	6.8	6.3	5.4
h. Course organization	4.9	4.8	5.2	4.9

9. Now consider the following student characteristics; rank order them according to how much they contribute to SOMED attrition. (1 = most important, 8 = least important)

	<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>
a. Poor reading/writing skills	4.7	4.7	4.8	4.5
b. Poor math skills	5.5	5.7	5.3	5.1
c. Poor study skills	2.4	2.5	2.5	2.0
d. Poor math/science background	5.0	5.3	4.8	4.5
e. Poor motivation	3.2	2.7	3.7	4.9
f. Personal problems	4.4	4.3	4.7	4.4
g. Family problems	4.8	4.7	5.2	4.9
h. Poor medical background	4.8	4.7	5.2	4.9

10. The biggest problem with the physical facilities at Fort Sam Houston is:

	<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medic</u>
a. Not being able to hear	17%	15%	20%	23%
b. Not being able to see	15%	15%	16%	8%
c. Lack of space to study	16%	16%	16%	15%
d. Availability of supplies	4%	5%	4%	0%
e. Other:	48%	48%	44%	54%

(Note: See written comments)

11. The SOMED attrition rate is increased by the San Antonio/Fort Sam Houston environment, e.g., the "Fiesta" atmosphere, the non-military campus-like setting, the high number of women, and minimal SF presence. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u> (n=130)	<u>Students</u> (n=83)	<u>Instructors</u> (n=29)	<u>Medics</u> (n=18)	<u>F(2,127)</u>	<u>p value</u>
2.6 (1.9)	2.3	2.6	4.1	7.12	.001

12a. What percentage of the soldiers who are relieved from SOMED do you think have the skills, knowledge, and aptitude to be good SF Medics?

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
31% (24)	35%	22%	22%	3.99	.02

12b. What percentage of soldiers who are relieved from MedLab do you think have the skills, knowledge, and aptitude to be good SF Medics?

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,72)</u>	<u>p value</u>
33% (35)	32%	26%	45%	1.48	n.s.

13a. Too much material is presented in SOMED in the available amount of time. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
4.7 (1.9)	5.1	3.7	4.7	6.20	.003

13b. Too much material is presented in MedLab in the available amount of time.
 (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u> (n=130)	<u>Students</u> (n=83)	<u>Instructors</u> (n=29)	<u>Medics</u> (n=18)	<u>F(2,127)</u>	<u>p value</u>
3.6 (1.9)	3.5	3.0	4.4	2.84	n.s.

14. Lengthening SOMED without increasing the content, i.e., increasing study time, would significantly reduce attrition. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
5.2 (1.8)	5.5	4.4	5.5	4.20	.02

15. How much additional study time do you think should be added to SOMED?
 (Note: Each additional week which is added to the 31 week course adds approximately 1 1/2 hours of study time that would be available during each week.)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,111)</u>	<u>p value</u>
4.4 (4.8)	5.1	2.4	4.1	3.22	.05

16. Adding a mid-term break would significantly reduce attrition from SOMED.
 (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
3.9 (2.1)	4.0	3.6	3.8	.57	n.s.

17. My family and I received adequate information about the true requirements of SOMED before we arrived at Fort Sam Houston. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
3.6 (2.1)	3.7	3.7	3.3	.23	n.s.

18. What information should be given to soldiers and their families before they arrive at SOMED?

19. At SOMED, I received a sufficient amount of one-on-one instruction in the trauma clinics. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
3.9 (2.0)	3.6	4.8	4.7	2.78	n.s.

18D Pre-Course

One plan that is being discussed is to require selected soldiers at the end of SFAS to complete an 18D pre-course before being accepted into SOMED. The course would be designed for three purposes: (1) to provide background knowledge, e.g., basic A&P and math skills, (2) to give the soldier a better understanding of the tough SOMED requirements, and (3) to screen out those soldiers who are less likely to graduate. Those soldiers who fail the pre-course would likely be able to select another 18-series MOS.

20. Do you think such a pre-course would significantly reduce attrition from the 18D SFQC? (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
5.6 (1.7)	5.8	5.1	5.5	1.61	n.s.

21. What would you include in the course? e.g., content, number of tests, reading requirements:

22. What would be the most efficient length for the 18D pre-course?

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
5.2 weeks (4.8)	5.6	4.2	4.9	.78	n.s.

23. Increasing the number of 18D instructors at SOMED should significantly decrease the SOMED attrition. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
5.4 (1.6)	5.7	5.1	4.4	5.14	.007

24. Increasing the number of active duty non-18D instructors at SOMED should significantly decrease the SOMED attrition. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
3.0 (1.8)	2.7	4.1	2.7	6.86	.002

25. Increasing the number of civilian instructors at SOMED should significantly decrease the SOMED attrition. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
3.0 (1.8)	2.9	3.4	3.1	.95	n.s.

26. Increasing the number of Physician and PA instructors at SOMED should significantly decrease the SOMED attrition. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
4.9 (1.8)	4.7	5.3	5.2	1.31	n.s.

27. When you attended SOMED, approximately what percentage of the course was taught by physicians and PAs?

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
20% (22)	14%	45%	29%	24.20	.0000

28a. Too much emphasis is placed on the trauma blocks during SOMED. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
3.0 (2.0)	3.4	2.8	1.8	5.02	.008

28b. Given the extensive hands-on trauma training in MedLab, too much trauma is trained in SOMED. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2.80)</u>	<u>p value</u>
2.5 (1.9)	2.9	2.6	1.7	2.29	n.s.

29. The 18D SFQC should place a greater emphasis on general NCO skills and overall SF responsibilities. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2.127)</u>	<u>p value</u>
3.1 (1.8)	3.1	3.1	3.4	.21	n.s.

30. SFQC standards have been getting stricter because the evaluators remember the course as being tougher than it actually was.

	<u>True</u>	<u>False</u>	<u>Don't Know</u>
Total	12%	48%	40%
Students	17%	37%	46%
Instructors	14%	86%	0%
Medics	6%	35%	59%

31. SFQC standards have remained relatively stable over the years.

	<u>True</u>	<u>False</u>	<u>Don't Know</u>
Total	17%	38%	45%
Students	17%	26%	57%
Instructors	17%	69%	14%
Medics	18%	41%	41%

32. SFQC standards are being relaxed to increase the number of graduates.

	<u>True</u>	<u>False</u>	<u>Don't Know</u>
Total	38%	40%	41%
Students	28%	26%	46%
Instructors	68%	11%	28%
Medics	38%	6%	56%

33. SFQC standards have been getting tougher because the amount of medical information continues to grow.

	<u>True</u>	<u>False</u>	<u>Don't Know</u>
Total	34%	37%	28%
Students	44%	25%	31%
Instructors	14%	75%	11%
Medics	19%	31%	50%

34. SFQC standards are being relaxed because the quality and dedication of the students have decreased.

	<u>True</u>	<u>False</u>	<u>Don't Know</u>
Total	16%	47%	37%
Students	7%	58%	34%
Instructors	46%	28%	34%
Medics	7%	20%	73%

35a. The evaluation of skills in the SOMED trauma clinics, especially Trauma clinic III, is highly subjective. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
5.3 (1.7)	5.8	4.2	4.9	11.28	.0000

35b. The evaluation of hands-on trauma skills in MedLab is highly subjective. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,71)</u>	<u>p value</u>
3.6 (1.7)	3.2	3.4	4.6	3.93	.03

36. A significant amount of SOMED attrition is due to inconsistency in grading. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
4.4 (2.0)	5.2	2.4	3.9	30.09	.0000

37. The artificial stress and distractors created during SOMED Trauma III adds to the realism and value of the training/evaluation. (1 = Completely Disagree 7 = Completely Agree)

<u>Total</u>	<u>Students</u>	<u>Instructors</u>	<u>Medics</u>	<u>F(2,127)</u>	<u>p value</u>
5.6 (1.6)	5.5	5.4	6.3	1.90	n.s.

38. Were there any aspects of the SFQC Field Phase that were particular problems for the 18D students?

Any additional comments about the 18D Q-course or attrition:

APPENDIX E

GENERAL COMMENTS FROM 18D ATTRITION QUESTIONNAIRE

Recent SOMED Reliefs

Class size with course facilities are the primary factors in attrition. Classes of 30 to 40 with more classes going through SOMED is highly recommended. Run a class of 18-series qualified students only and have them here for the course and course only. The only formation should be at the classroom and they should remain off-post and away from post politics.

Overall I have learned more than I thought I could. This course has opened my eyes to what I can do if I put my mind to it.

I wish I understood half of what I memorized.

You've got good Medic candidates at the schoolhouse. Those who have worked six months or more before biffing an exam, provided that they want to be 18D combat Medics, I would recommend that you start them ahead of newer candidates. Their experience will carry more of them to graduation.

It is senseless to spend thousands of dollars on a student to turn around and send him back to a conventional unit. With selective retraining that student can probably be a good Medic very soon.

(1) The EMT test is a joke. How do you expect to train soldiers one way of medical treatment just to give them a test in which they must regress to less knowledge to pass. It's extremely difficult. (2) There should be a standard for the instructors to limit the subjectivity in the course. (3) In all of the trauma clinics you can get everything wrong, but if you get two full-bore IV's on board you get a go. Or if you get all of the sequence down correctly, but miss your IV times you are a fatal error. Everybody misses an IV now and then including the instructors during demonstrations. They should take a good look at their grading criteria. (4) After all the time and effort put into a student all the way to Trauma III, how can you just let them go if they have a good attitude. With a good attitude, almost anyone is retrainable. (5) One way to get rid of the undesirables who doesn't want to be here is peer evaluation. (6) I've heard several times, "Some people aren't just made to be Medics." Nonsense. If a person really cares and fails the course, who can say he can't pass it the next time around with flying colors. Some of the instructors need a reality check.

I believe the proper matching of abilities and interests is the key to the production of a successful Medic. Being an NCO, I fully realize that men are motivated by their individual needs. If these needs can be met, and the individual skills of the soldier

channeled to the requirements of the SF soldier, a superior Medic will be the resultant achievement. Failure to match those needs will provide, with rare exception, a disenchanting, unmotivated soldier who will fail consistently at the Army's cost.

Research into this course would be enhanced if a researcher would become a student in the course and get objective information first hand.

The course is very good and has a lot to offer. It is highly subjective even if it is getting better. I have learned a lot and know that I know a lot more than I did when I got here. I know the material, even though I did not pass Trauma III.

Since all instructors know how hard the course is, there should be a better system for dealing with people/students and their family problems. Of the few I saw (myself included) the answer was always, "Sorry, but you can reapply in 6 months." There was no real support until the end of the course. The words, "we're here to help that were spoken at the family in-brief were not really supported by action. Adding the move here to the SOMED course and, God forbid, a child being due, is a lot of stress to handle without support. To be told that you are being sent back to the conventional Army is brutal.

If a man has the right attitude and is willing to try, let him try. If he fails, he has learned from his mistakes. Unless you make a mistake or two, you don't learn. Don't let good men go down the drain. Recycle them or send them to another 18-series MOS.

It is absurd that people who fail the course have almost no chance of getting another SF MOS. Talk about stress. How about making it through the course for 6 months without failing a test and then failing Trauma III, then having no SF career after all the blood, sweat, and tears. We're supposedly the best of the best, the cream of the crop, and then we are tossed away like a piece of trash. The students who fail here should always get another SF MOS, especially those who didn't want to be here in the first place.

In the re-evaluation of dropped students at the boards, more needs to be looked at other than just the student's GPA. That is like sending a soldier here just because he has a 120 GT score, whether he wants to be a medic or not. More should be heard from the instructors and the counselor on his potential as a medic before a final decision is made. I cannot stress enough two things: (1) the want, drive, and motivation a student has to be an SF medic, and (2) the student-instructor ratio. Just looking at a class here should strike you in the face. Common sense should tell you that if you take a good, motivated, honest student and pair him up with the ability to seek out a good instructor anytime, without restrictions, he will be able to learn anything and the attrition rate will drop like a rock.

Give students the chance to recycle if desired.

Senior SOMED Students

Most of the students had trouble with IV's (during Trauma III). I agree with the critical importance of the 22 minute two large bore IVs. However, I think strongly that if a student is just having it rough, there should be some way of recovery after the 22 minutes. If an operator is really skilled, he can recover. I would like to say that this course has been the best and most personally rewarding time in the military. The professionalism of the instructors is beyond comment and the course runs smoothly. It provides an excellent base of medical knowledge.

I believe that PT at 0545 is a distraction. There might be a PT test once a month. Students could do PT after classes to relieve stress. This is the hardest 18-series school and it is sad to know that if you should fail you are sent conventional.

Some people sent here just do not have the common sense to make it regardless of the their background and GT score.

The majority of students that don't make it would benefit from being recycled to the beginning of the course. They would then get the chance to learn the etiology rather than just memorizing it and not understanding the process involved.

There's going to be attrition from any course. This just happens to be a hard course so there's more people leaving. Most of them just couldn't hack it.

Graduating from this course has been a dream of mine for a long time. I'm a nurse and a recycle. I'm glad I had a second chance.

Take a look at the records of the individual instructors that graded Trauma III. One instructor failed six of six students. The grading is completely subjective, e.g., (1) scenarios - some are extremely easy. (2) graders - some are easy, some are hard. (3) patients - some have large veins, some do not, and (4) environment - sometimes it is cold, rains, etc.

I believe that a soldier who comes to the SOMED course and fails should be given the opportunity to be given another 18-series MOS. It is a total waste of USSOC-OM's money to send this soldier back to the conventional Army when he probably has the potential to pass a less demanding 18-series MOS.

With a little extra training most students can develop the PMST (Patient management skills test) and trauma skills needed to pass the course. As for the high failure rate in Trauma III, there was inadequate training to develop the necessary IV skills and situational awareness.

So much responsibility lies with the 18D on a team that it would be a crime to lower standards in any way. But I have seen men who would have been great medics dropped from the course. It's not only their loss, but ours too.

Soldiers who make a decent showing at the SOMED course should be afforded to an opportunity to attempt another 18-series MOS rather than being thrown away, because he certainly would have passed one of the other courses with ease. Sending someone from SFAS to another MOS is ludicrous.

I've seen operators commit 3 fatal errors, e.g., forgetting a fracture was even present, IV's far over 22 minutes, and failure to tape the patient's head during transport, and pass. Then again I've seen operator's fail because they didn't aspirate the IV catheter hub when changing an administration set which had been dry for less than 2 minutes. In other words, we've lost excellent medics and kept marginal medics mostly due to evaluator inconsistency. The instructors do the best that they can, and sometimes more, but much that is unfair continues to go on. Also I think it is a great waste to recycle students who fail early and then not recycle students who have a good GPA who fail Trauma III. So far all Trauma III failures from the previous class have continued on while many of the early recycles have failed again.

More emphasis should be placed on pertinent "important to know" information rather than General Reference (GR) trivia. A greater number of tests covering less subjects in a more timely manner would also be beneficial. Also, how many classes even have tests that require using the reference materials. As Einstein has said, "An intelligent man does not know everything, but knows where to find it."

SOMED Instructors

Over the years, course length has increased and standards have lowered having little or no effect on the number of students graduating from the course. No matter how many instructors you have or the location of training, it will still come down to student motivation, desire, and ability.

(1) Medical subjects should be taught by the best possible instructors, i.e., Physicians, PAs, and 18D's. This does not happen. Instructors still don't have a basic understanding of A&P, much less the medicine they are teaching. (2) Clean up the POI. There have been several POI revisions which consisted of additions or deletions of particular blocks without looking at the whole course. For example, 91B was taken away to reduce repetition, eliminate non-18D tasks, to make better use of the time and to decrease attrition. What happened? The EMT block is added, non-18D tasks are added, repetition is added. Time is increased yet attrition remains the same. (3) The course has lost its purpose and modular POI. The schedule is now primarily driven by the Basic SOF Medic rather than the 18D. Go to a modularized POI with breaks in

between modules. The course has been working to reduce attrition for many years. It's a continuous circle with many quick fixes and no long term follow through or evaluation.

The Trauma III was too much, too fast in one day. It should be limited to two runs per day. It appears that we rush to get the instructors back home rather than to train and test the students properly. Overall it is an excellent course. It needs to stay at Ft Sam Houston due to the cost factor and availability of additional backup medical instruction from active duty personnel. We should send students and instructors who want to be here and relieve those who do not.

I still feel that it is difficult to determine which students will make it and which will not. The question is: How badly do you want it? And what are you willing to give up for it. Although many students come in unprepared, they do well because they want it.

I think this course should be moved away from main post and go to Camp Bullis. I say this because there is too much additional BS from the company and the school. This adds additional stress which the students do not need.

Increase the number of 18D instructors. Allow instructor input for student's follow on assignments. There is too much legal concerns over students' appeals/rights. More power should be given to the senior instructor/1SG. Decrease the number of students. Do not overlap classes 3 and 4 at a time with 90 students per class. Send only those soldiers who are motivated and who want to be 18Ds. Instructors are being burned out. Instructors and 18D's should get pro-pay.

Some of the students that they send here just don't want to be here. That should be considered more.

If the individual evaluating the course has never been responsible for a human life, he has no right to judge the amount of stress applied in the course, especially in Trauma III. This is the only time that we can stress them in a controlled environment, the next time it will be with a real patient. To allow anyone to complete the course without this phase will allow numbers into the SF community. This will only destroy the SOCOM mission.

The course is hard: then and now, even if the standards are relaxed.

To remain the highest quality/trained enlisted medic in the military, the standards must remain high. Students must be able to handle stress/harassment to ensure they are able to (1) work in a stand alone environment and (2) operate in less than ideal stressful times. Only the most motivated and self-disciplined people should be allowed to try to become 18Ds/Special Ops medics. Any attempt at lessening the requirements, stan-

dards, or less stressful environment would do nothing less than degrade the quality and reputation of the SF medic.

Send us people who want to be here.

MedLab Students - Junior Class

I learned a great deal, but I forgot more.

Don't make a guy that realizes that he is not cut out for the medical field have to admit it to instructors. Fort Sam threatens to kick you out of SF altogether if you say that you cannot hang in the medical field. Why waste all the time and money training a guy that is a future 18B, C, or E type guy.

There were good students who were dropped out of the course that would have been good medics as well as other 18 series - but they were dropped period. Then there are students who could pass SOMED and become Medics that I would not work with on a team. The overall student should be looked at.

MedLab students should be allowed more mistakes. I don't know if I mean that, but I think some more slack should be cut. After all, the majority of the "weeding out" has been done.

During CPT, I was allowed as much if not more responsibility and authority as any MD or PA student. Indeed I was trained as a resident. In my opinion this is the reign of the 18D. Therefore training needs to be oriented as such, i.e., use UTSA (University of Texas-San Antonio) medical instructors, Army MD and PA instructors. The standards are high, but rightfully so. Certain people simply will not make it. There are few people capable of being SF, even fewer of being 18D's. Increase the quality of the instructors. Screen perspective students carefully and allow them to decline (if they really want it, they will be here eventually). Finally the instructors must be able to determine the adequacy of the treatment, rather than capable of checking the block. An 18D is a complicated combination of M.D. (pathology, I.M., E.R., etc.), Vet, Dentist, and Preventive Medical Specialist who is also a highly skilled military professional. Perhaps there aren't a lot of them.

The 18D course is challenging and requires a lot of determination and devotion to accomplish. The majority of students go from 0 level of medical knowledge to a high level of knowledge in a short time with a remarkable amount of information retained. Many good soldiers and potentially good Medics are terminated without a second chance because of instructor subjectivity (mainly civilian and non-SF personnel). This is a good course but there are in desperate need of remodeling of SOMED. Much too much money, time and effort was spent on good soldiers on to go to waste, because an

instructor did not like the way you performed even though you met the standards and saved a life.

(1) Subjectivity and the perceived "discussion around the campfire" should be limited at Trauma III. There is also a race to get out of the field, rather than a full blown extra training (retraining) at Trauma III. The "big egos" of SOMED need to be checked and balanced without interfering too much with the autonomy and "unconventional flavor" that SF used to have. (2) A greater "quality instructor" to "quality student" ratio should help the quality of the 18D's and also the attrition rate. (3) Classes in trauma, e.g., BTLS, ATLS, should be given once a week so that every Medic could have the opportunity to be a "Trauma God". (4) 91C's should not be allowed to test trauma.

You have to positively motivate 18D candidates. Even if you have to twist their arm and force them go through the course, their skills will just atrophy of a team. They have to want it so you have to make it attractive to them. Some suggestions: (1) 18D incentive pay. (2) More outside accreditation for the hard work they do. EMT was a great step forward, now we need EMT-I and ACLS. Maybe tie the credits in with a university program so that if a man can't get a nursing, PA, or medical degree while he is in the course, at least he will have something to build on later. (3) The promise of continuing education once he graduates. Paramedic was great. It is perfectly legal to allow students to attend college for skills related to their job during duty hours. Why aren't we doing this? Most 18D MOS guys would pay for it themselves. Rotations through Cook County Medical hospital, seminars and ANCOC style training sessions. (4) A 2 week stress leave for 18D grads (not personal leave). 18Ds work much harder and longer than other MOS and should be compensated. (5) 18D students must be allowed career progression once they graduate. The stigma of not being promoted with your peers hangs heavy among the students, You already are one step behind the guys who graduated from SFAS because they are already on a team while you are still in school. (6) Make the school more attractive for 18D instructors; attract the best. Reduce the workload by increasing the number of instructors. This has direct benefits for the course - and allows the instructors more personal and educational time.

There are too many guys that just want green berets and care nothing about medicine initially.

The course should be all in one place.

MedLab Students-Awaiting Graduation

I would never advocate dropping the standards or changing a course just to make the numbers look right for a General.

Do not move the course or attrition will increase, but standardize both phases.

I was an 11B with constant pay problems. My truck got stolen and destroyed; I went through a messy divorce; I partied every weekend; I went to Mardi Gras; I went to South Padre island. I had to handle singlehandedly a credit and money mess that my ex-wife left me with while I was in records and reports. Through all of this I didn't recycle and left SOMED with an 87% average and was honor grad from the SFQC. So I don't give a flying rat ___ about the B.S. excuses for why people fail. High attrition ensures high standards.

The women nurses should be relieved as the OICs and instructors. How can a nurse or a female nurse know what it takes to be an 18D. The course should be taught by 18D or prior 18D and that is all. As for the attrition, the standards need to be kept high. You need quality and not quantity.

The 18D course is a rough course, attrition is necessary. What is the attrition rate at Med School? We can't afford to reduce the amount of material learned or decrease the quality of graduates to inflate the number of 18D's on the books. Low quality medics are useless. Even with the high attrition rate we graduated Medics who I wouldn't want working on me.

How a student could graduate SOMED with a 92+ GPA and receive a marginal academic evaluation report is a testament to how subjective the grading standards are. It also illustrates how the personnel there are geared towards attrition as opposed to teaching and doing worthwhile counseling. Somebody needs to oversee SOMED closer because they do what they want because they are away from the flagpole.

SF Tac set is always mentioned but to this day I have never seen one or know what is in one.

There is a real problem with personality conflicts at Ft Sam. The course needs to be moved to Bragg where it can be controlled by SWCS.

A female out of touch nurse has no idea what SF needs as far as Medics are concerned.

A nurse makes the final decision! It should not be like this. The NCOIC or 1Sg are 18Ds and they should have the final say as to who makes it or not. This subjective call should not be made by a woman who has never seen it or done it.

Somebody's life may one day count on those tough standards: You can't lower them. Who knows, it may be mine. If 100 guys start and no one meets the standards, so what! At least there won't be some bumbling idiot making mistakes for real. One qualified guy can teach the right material correctly. Who knows what a poorly trained Medic could do?

Fort Sam was a totally different world and environment than MedLab. Fort Sam was very subjective and political. A total purge of instructors down there would be beneficial. Getting rid of the civilians is a must.

The attrition is a must. The main thing is that it needs to be all volunteers. Leave the course at Fort Sam but have only volunteers. If your motivation is good you can study in the environment. I enjoyed the course. The Army finally produced some tough standards and challenged me. A soldier will rise to the standards that are set.

If a man wants to be an 18D he'll sit down and study. You have to be dedicated and motivated to pass the course. It ain't no cake walk. No one needs to have his hand held or be spoon fed. How does a female nurse know what it takes to be an 18D?

MedLab Instructors

The one thing an instructor hears day and night is that we need more bodies and that anyone who passes SFAS cannot fail the course, that per se, he already has a tab. You have an almost impossible time getting rid of the dregs at Ft Bragg. I believe in giving a student a chance but let's be real. If he can't write, hold a semi-intelligent conversation, he doesn't belong here.

1. SFQC students need to be led! Good leadership and fear will motivate them to do PT and study. 2. Find students that want to be Medics. They are the ones who will complain less and study more. 3. Attract more Medics from the regular units that want to meet the challenge. I found that in my class 70% of the NCOs came from medical units and that they had the experience, knowledge, and desire to pass. 4. Go back to Phase 1-2-3, because SFAS doesn't mean hit. The students feel because they have passed SFAS they deserve to pass the Q-course. Make them understand that it is difficult, that is why it is SF school. Also that it ain't over until the fat lady sings.

As an 18D in 7th Group, the good 18Ds have always been mature and carrying soldiers, more so than the other MOS. When folks' lives are in danger, this needs to be the standard. Frequently CMF 18 soldiers work alone with little or no guidance. The chain of command and the National Command Authorities have to be able to trust the judgment of the CMF 18 soldiers to do the right thing. This is even more important for 18Ds.

This is a very difficult course. Everyone agrees with that. Standards cannot be lowered as Medics will find themselves as the only Medic on a team. They may not have a senior Medic to mentor them. I personally feel that the best Medics have come from the Infantry/Ranger, combat arms MOS. They perform the best on the team and contribute much to a team success. Once you are on a team you are Medic maybe 10% of the time, the other 90% you are just another 18B and are expected to perform as well as they are. The medical training is highly specialized and very difficult. Perhaps

offering and increased promotion/pay incentive will attract people dedicated toward completing the course.

MOS training for 18D needs to be updated, improved, contain real world certifications and needs to produce the world's best Medics.

- New POI - New facility - Qualified and competent instructors in a ration oriented towards small group instruction. - Better qualified students, both medically and morally. Yes morally in that the soldier who wants to be a Medic should want to preserve life and limb because he cares about life.

Medics from 7th Group (SFOC graduation year)

(1980) Working with the new Medics, I am impressed with the calibre and knowledge of the graduates. I feel they are better trained and superior Medics than my graduation time. We're not supposed to be doctors, just good enough to treat the routine and how to research something new. Personal opinion - more emphasis on preventative medicine and on the use of more reference materials that they student can keep and use.

(1982) The course is demanding because it needs to be to get a finished product that is highly capable. The problem is not in the course because at group level we are getting good Medics. The problem is the attrition rate once people get to the groups. Something needs to be done to keep the Medics motivated and wanting to stay in SF.

(1985) I graduated from the 18D SFQC because I prayed, studied, and partied. I wanted to be there; I was motivated. I volunteered and made it a point to follow instructions and not piss instructors off.

(1989) The attrition and the weeding out in the Q-Course is very much necessary and should not be changed.

(1990) It is a demanding course and the attrition will be high. The only way that the course can be lowered is a lowering of the standards. This is not the answer. We do not need 91B's with a little extra training. We need 18D's. I can wait for the next fully qualified soldier to come on board. I think this point is shared by a majority of my peers. If we start filling slots with bodies, think of the level of training your team members will be getting.

(1991) The claim that attrition is being increased due to the SFQC being down in San Antonio is extremely overrated. The course should not be moved to Fort Bragg. It should stay in San Antonio for the simple reason that more resources are available in Texas. Being away from Fort Bragg allows the student the time to concentrate on just medical training.

APPENDIX F
SPECIAL FORCES MEDIC ANNUAL SURVEY

The following survey is designed to collect information annually on a variety of areas which are important to the continued refinement of the training and assignment of the Special Forces Medic. You are being asked to provide your personal and candid responses and remarks so that we can continue to improve our career field.

1. What is your duty MOS and Skill Level?

- a. 18D30 e. 18D4B (Instr)
b. 18D3B (Instr) d. 18D40
c. 18D3V (Ranger) f. 18D4V (Ranger)
 g. 18Z50

2. What is your rank?

- a. SGT c. SPC
b. SSG d. MSG

3. Years you have held the MOS 18D?

- a. Less than one year d. 7 - 10 years
b. 1 - 3 years e. 11 - 20 years
c. 4 - 6 years f. 21 years or more

4. Years Active Federal Service?

- a. 4 - 6 years c. 11 - 20 years
b. 7 - 10 years d. 21 years or more

5. Where are you working?

- a. Ft Bragg, SPG e. Ft Lewis
b. Ft Bragg, SWCS f. Germany
c. Ft Campbell g. Okinawa
d. Ft Devens h. Panama
 1. Other: _____

6. Highest level of education?

- a. Didn't graduate from high school
b. GED or high school equivalency
c. High school graduate
d. 2 years or less of college (no degree)
e. Associate degree
f. 2 years or more of college (no degree)
g. Bachelor's degree
h. Some graduate work
i. Graduate degree
j. Post graduate degree

7. Length of time in current position?

- a. Less than 3 months d. 1 - 3 years
b. 3 - 6 months e. 4 - 6 years
c. 7 - 11 months f. 7 years or more

8. What race do you consider yourself ?

- a. White d. Eskimo or Aleut
b. Black e. Asian/Pac Islander
c. American Indian f. Other: _____

9. Are you of Spanish/Hispanic origin?

- a. Yes b. No

10. Duty assignment/MOS?

- a. 18D b. 18Z c. Other: _____

11. Would you prefer a different MOS?

- a. Yes b. No c. Not sure

12. If reenlisting tomorrow, which MOS would you select?

- a. 18D c. 91 series MOS
b. Other 18 series MOS d. Non-18 series MOS

13. Would you reenlist if you wanted to change your MOS but could not?

- a. Definitely d. Definitely not
b. Probably e. Don't know
c. Probably not f. Does not apply, retiring

14. If you had to change your MOS in order to reenlist, would you?

- a. Definitely d. Definitely not
b. Probably e. Don't know
c. Probably not f. Does not apply, retiring

15. The kind of work I enjoy most is:

- a. Only in the military
b. Primarily in the military
c. Equally in military and civilian world
d. Primarily in the civilian world
e. Only in the civilian world

16. Months left in your enlistment term or obligated period of active duty service?

- a. Less than 6 months d. 25 - 36 months
b. 6 - 12 months e. 37 - 48 months
c. 13 - 24 months g. 49 - 60 months
 h. More than 60 months

17. Years of active duty you expect to have completed by the time you leave the Army?

- a. 6 - 10 years c. 16 - 20 years
b. 11 - 15 years d. More than 20 years

18. At this time last year, how many years of active duty had you expected to complete by the time you left the Army?

- a. Less than 6 years d. 16 - 20 years
b. 7 - 10 years e. More than 20 years
 c. 11 - 15 years

19. What is your current marital status?
a. Single, never married d. Divorced
b. Married e. Widowed
c. Separated

20. How many dependent children do you have?
a. None b. One c. Two d. Three or more

21. Dependent children living with you?
a. None b. One c. Two d. Three or more

22. In what area is your home of record?
a. South Eastern US b. South West
c. Mid Atlantic states i. Mountain states
d. New England j. West Coast
e. Great Lakes region k. Hawaii
f. Appalachia l. Alaska
g. Mid West m. US Territories
h. Gulf Coast n. Other: _____

23. How long do you plan to be an 18D?
a. Til the end of this enlistment
b. Til I get promoted out of the MOS
c. Til I retire
d. Til I get accepted to PA school or other medical school
e. Til I get accepted to SP Warrant program

24. What is the reason you plan to leave 18D?
a. Do not plan to leave 18D
b. Promoted to 18E
c. Become an SP Technician (warrant officer)
d. Become a PA
e. Medical school to become doctor or nurse

25. Why did you become an 18D?
a. No choice, was told I would become a medic
b. Was related to civilian experience
c. Training to get a better civilian job
d. Use this as a step to PA or Med school
e. Work in third world countries
f. Chance to work on an A team
g. Recognition and awards
h. Adventure and travel
i. Chance to influence others
j. Other: _____

26. Which SP mission do you prefer?
a. DA d. SAR
b. PID e. SR
c. UW f. CT

27. If you did it over, which SP MOS would you select?
a. 18B b. 18C c. 18E d. 18D

28. Have you bought medical textbooks in:
a. Last 12 months
b. Last 24 months
c. Last 36 months

29. Subscribe to medical periodicals?
a. Yes b. No

30. Do you rely on the SP bookset for your self study resources?
a. Yes, almost exclusively d. Seldom
b. Yes, usually e. Never
c. Yes, sometimes

31. In past 12 months have you experienced:
a. Hypertension e. Insomnia
b. Peptic ulcers f. Increased alcohol
c. Migraine headaches g. Increased smoking
d. Emotional problems

32. At which level are you assigned?
a. A team b. B team c. C team
d. SPG e. USASPC

33. Which applies to you?
a. Active Component b. USAR c. NG

34. If you are USAR or NG, is your civilian job medically related?
a. Yes b. No

35. What percentage of credentialling points have you accumulated during this credentialling period?

- a. 0% to 15%
- b. 15% to 30%
- c. 30% to 50%
- d. 50% to 75%
- e. 75% to 80%

36. I believe that the implementation of a "credentialling system" for 18Ds has helped the 18D sustain his medical proficiency. Circle your response below.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

37. I make a conscious effort to keep track of my sustainment training records.

1 2 3 4 5

If not, why? _____

38. My supervisors are aware of the requirement I have to maintain a certain level of credentialling and show interest in achieving that objective.

1 2 3 4 5

If not, why? _____

39. I Would be willing to enroll in an Army sponsored course for certifying 18Ds as paramedics (EMT-P), even if it required some of my free time.

1 2 3 4 5

If not, why? _____

40. I discuss medical subjects, interesting cases etc. with colleagues as a matter of general conversation when meeting them.

- a. Frequently
- b. Occasionally
- c. I avoid medical subjects during my free time.
- d. Only if the other guy brings the subject up.

41. Have you established a personal medical reference library at your workplace or home?

- a. Yes, at my own expense.
- b. No because I cannot afford to buy books or subscribe to journals.
- c. No, because the SF Bookset meets my needs.
- d. No, because I train only when I'm told to do so.

42. Are the type and number of medical sustainment training opportunities available to you meeting your needs?

- a. Enough opportunities but subjects are too limited
- b. I never get a chance to take any medical training courses.
- c. Adequate number but their quality is not worth the time.
- d. I participate in plenty of worthwhile medical training programs.
- e. It doesn't matter because I'm getting out of the Army.

43. Do you believe that your ability to perform your duty would be enhanced by attending a tutorial in trauma management at a major civilian trauma center?
- a. Yes; trauma care is one of my weakest areas.
 - b. No because I'm in an administrative position.
 - c. Yes; any educational exposure can only make me a better medic.
 - d. No because those centers are too sophisticated for SF application.
 - e. No, for other reasons: _____
-

44. Acquiring a civilian medical certification(s) during my time on active duty would encourage me to leave the military for better a paying job.
- 1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

45. Who most closely approaches your ideal as a role model?
- a. Joe Montana
 - b. Norman Schwartzkopf
 - c. John Wayne
 - d. Walter Reed, M.D.

46. In which of the following medical skill areas do you feel most confident?
- a. Tropical Medicine
 - b. Environmental Medicine (altitude illness; cold injuries; snake bite etc.)
 - c. Trauma management
 - d. OB-Gyn.
 - e. Dental emergencies
 - f. Preventive Veterinary Medicine
 - g. I'm confident in all of the above
 - h. I'm confident in none of the above

47. In which of the following medical skill areas do you feel least confident?
- a. Tropical Medicine
 - b. Environmental Medicine (altitude illness; cold injuries; snake bite etc.)
 - c. Trauma management
 - d. OB-Gyn.
 - e. Dental emergencies
 - f. Preventive Veterinary Medicine
 - g. I'm confident in none of the above
 - h. I'm confident in all of the above

48. Which of the following do you consider the best trained medic in the military?
- a. Ranger medic, Rifle Co.
 - b. Seal Team medic
 - c. Air Force PJ
 - d. 18D on an SFODA
 - e. Aviation Medical. Tech.
 - f. None of the above

49. What is the most significant impact an 18D can have through effective performance of his duty?
- a. Awards and decorations
 - b. Career progression and satisfaction
 - c. Achievement through teamwork
 - d. "Winning hearts and minds"
 - e. Key to the team's accomplishing the mission
 - f. Other: _____

50. Which of the following can you do best?

- a. Hand to hand combat
- b. Land navigation
- c. Treat hemorrhagic shock
- d. Speak a foreign language
- e. Teach a class on basic combat lifesaver skills
- f. Evaluate and initiate treatment for acute diarrhea

52. If advising your brother, who was recently enlisted into the Army, about his career goals, which of the following would you recommend that he strive for?

- a. Ranger medic, 91A
- b. SF medic, 18D
- c. SF weapons, 18B
- d. Rifleman, 82d Abn., 11B
- e. Military policeman
- f. Chaplain's Assistant
- g. Other: _____.

53. The loss of which single team member would have the greatest detrimental effect on an A-Team?

- a. 18A
- b. 18B
- c. 18C
- d. 18D
- e. 18E
- f. 18F

54. All the hard work to become an 18D been worth it.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

55. I would welcome the opportunity to train in a hospital environment, ER etc.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

56. During an average duty week, how many hours do you spend on medically related activities? This should include patient care, training, self-education, medical equipment maintenance, etc. J

- a. None
- b. Up to 25%
- c. 25% to 50%
- d. 50% to 75%
- e. Over 75%

57. The hours I spend on medically related activities help me sustain my medical skills.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

58. How difficult is it for you to maintain your credentialing objectives?
- It's impossible; I cannot even maintain the 70% minimum standard.
 - It doesn't matter because the credentialing process is only a paper exercise.
 - It's never been easy, but I always manage to stay above the minimum requirement.
 - It's a snap; I may not learn anything, but I get the points I need.
 - There's plenty of training opportunities out there and I take advantage of them, learning all I can.

59. My experience as an 18D, thus far, has met my expectation in terms of self-satisfaction?

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

60. My command, from the Group Commander to my immediate supervisor knows the value of a well-trained 18D and supports my need for sustainment and enhancement training.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

61. How long has it been since you last participated in formal sustainment training (ATLS, formal lecture, hospital or TMC rotation etc.)?

- Within 1 months.
- Within 3 months.
- Within 6 months.
- Within 8 months.
- A year or longer.

62. What type of medical training format do you prefer?

- "Hands-on" in hospital or TMC.
- Lecture/laboratory combination, as during ATLS.
- Self paced, self programmed, as with video-tapes, audio-tapes etc.
- Reading assignments followed by quizzes.
- During deployments for FID missions (medretes).
- No preference.

63. What has been the most satisfying medical experience since you became an 18D?

- ATLS.
- Local Army hospital or TMC rotation.
- Civilian program at my own cost & on my own time.
- OCONUS deployment (peacetime).
- OCONUS deployment (wartime).
- Rendering emergency medical care on street/roadside.
- Teaching medical subjects regardless of whom the students were.
- Other: _____

64. Have you attended any of the following schools during the past 18 months?

- Halo.
- Scuba.
- Sere Course.
- O&I Course.
- Rough Terrain Parachuting.
- Water Infiltration Course.
- Jump master.
- Dive Medical Technician.
- Other, non-medical: _____

65. At which level do you believe is the greatest barrier to your being medically prepared for your mission? Circle all that apply.

- a. No great barriers exist. I'm medically prepared!
- b. Company HQ.
- c. Battalion HQ.
- d. Group HQ.
- e. Special Forces Command HQ.
- f. USASOC HQ.

66. I am properly equipped to do my medical mission.
1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

67. My supervisors have made efforts to recognize me when I've performed my duty especially well.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

68. Being the senior medical NCO in your command is worth striving for.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

69. Do you agree that your rank fairly represents your time in the Army and your experience?

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

70. Would you prefer to spend most of your SF career in one or two SFGs, or serve with several different Groups?

- a. In several Groups. It'll broaden my base of experience.
- b. In one or two Groups. I'll become more proficient in specific things.
- c. In a limited number of Groups, because I'll become better known and the opportunity for advancement will be enhanced.
- d. In several Groups, because things get stale if you hang around too long.

71. Six years from now I hope to be a:

- a. Senior 18D on an A-team.
- b. PA.
- c. A physician/other professional degree.
- d. 18Z medical position.
- e. 18Z in a non-medical position.
- f. A civilian.
- g. Senior medical NCO SF Battalion or Group.
- h. An OCS graduate.

72. Relative to your current situation in the Army, mark the block which best indicates the level of your satisfaction with the following aspects of duty as an 18D. 1= Very Dissatisfied 5= Very Satisfied

- | | | | | | |
|--------------------------------------------|---|---|---|---|---|
| a. Your income. | 1 | 2 | 3 | 4 | 5 |
| b. Type of work you do. | 1 | 2 | 3 | 4 | 5 |
| c. Importance of your job to unit mission. | 1 | 2 | 3 | 4 | 5 |
| d. Your promotion opportunities. | 1 | 2 | 3 | 4 | 5 |
| e. Command support for medical training. | 1 | 2 | 3 | 4 | 5 |
| f. Your treatment by your supervisors. | 1 | 2 | 3 | 4 | 5 |
| g. Recognition and awards. | 1 | 2 | 3 | 4 | 5 |
| h. Unit morale. | 1 | 2 | 3 | 4 | 5 |
| i. Quality of your coworkers. | 1 | 2 | 3 | 4 | 5 |
| j. Training opportunities (non-medical). | 1 | 2 | 3 | 4 | 5 |
| k. Location of current assignment. | 1 | 2 | 3 | 4 | 5 |
| l. Quality of life for your family. | 1 | 2 | 3 | 4 | 5 |
| m. Time spent with your family. | 1 | 2 | 3 | 4 | 5 |
| n. The 18D Qualification Course. | 1 | 2 | 3 | 4 | 5 |
| o. 18D sustainment training opportunities. | 1 | 2 | 3 | 4 | 5 |
| p. 18D credentialling process. | 1 | 2 | 3 | 4 | 5 |
| q. 18D Critical Task List. | 1 | 2 | 3 | 4 | 5 |
| r. Being kept informed. | 1 | 2 | 3 | 4 | 5 |
| s. "My opinion counts." | 1 | 2 | 3 | 4 | 5 |

73. Beside the following list of medical skills training experiences, mark the block which indicates the degree of importance you place on each of them as they relate to the successful performance of your job.

1 = Not at all Important 5= Extremely Important

- | | | | | | |
|-------------------------------------|---|---|---|---|---|
| a. Trauma management. | 1 | 2 | 3 | 4 | 5 |
| b. Emergency medicine. | 1 | 2 | 3 | 4 | 5 |
| c. Tropical medicine. | 1 | 2 | 3 | 4 | 5 |
| d. Pediatrics. | 1 | 2 | 3 | 4 | 5 |
| e. Ob-Gyn. | 1 | 2 | 3 | 4 | 5 |
| f. Radiology. | 1 | 2 | 3 | 4 | 5 |
| g. Nursing skills. | 1 | 2 | 3 | 4 | 5 |
| h. Medical administrative subjects. | 1 | 2 | 3 | 4 | 5 |
| i. Medical logistical subjects. | 1 | 2 | 3 | 4 | 5 |
| j. TMC rotations. | 1 | 2 | 3 | 4 | 5 |
| k. In-hospital rotations. | 1 | 2 | 3 | 4 | 5 |
| l. FID (HCA) deployments. | 1 | 2 | 3 | 4 | 5 |
| m. Veterinary skills. | 1 | 2 | 3 | 4 | 5 |
| n. Dentistry skills. | 1 | 2 | 3 | 4 | 5 |

A/F

74. Which of the following aspects of an 18D's career would be best left untouched during any "reform process"? Circle all those that apply.

- a. The way an individual is recruited for 18D.
- b. The curriculum of the medical portion of SFQC.
- c. The credentialling process for 18Ds.
- d. Your unit's Family Support Program.
- e. All the above should be changed.

75. Which of the following aspects of an 18D's career is in most need of revision?

- a. The way an individual is recruited for 18D.
- b. The curriculum of the medical portion of SFQC.
- c. The credentialling process for 18Ds.
- d. Your unit's Family Support Program.
- e. All of the above should be changed.

76. Which of the following is most attractive to you?
- "Pro Pay" for independent duty status.
 - A career progression program for 18Ds which would allow for additional duty positions for 18Ds as they mature in their careers.
 - The award of EMT-P (Paramedic) status upon completion of the 18D Course.
 - All of the above.
 - None of the above.
 - Other: _____.

77. I receive medical information it in a timely manner from my next higher HQ.
 1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

78. The medical sustainment training program for my unit is--
- Sufficient to make me confident in the performance of my duty.
 - Adequate; at least I'm able to meet biennial credentialling
 - I make the points I need, but the subjects don't cover a broad enough spectrum to meet my METL.
 - The program would be fine if I could get time (from deployments etc.) to get involved in it.
 - No one cares about medical sustainment in my unit.
 - None of the above statements adequately describe my situation.

79. Which of the following impresses you most favorably?
- Your unit's Family Support Program.
 - The type of work you're doing.
 - Your promotion opportunities.
 - Your treatment by supervisors.
 - Your relationship with Medical Officers in your unit.
 - None of the above.

80. In your opinion, is the following statement true? "The medical portion of the 18D Qualification Course was an adequate preparation for the real-world responsibilities of the A-Team Medic."

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

81. What do you think you will do after this enlistment? FP
- Reenlist.
 - Leave the Army to find civilian employment.
 - Leave the Army to attend college.
 - Leave the Army for civilian vocational/technical education.
 - I'm not sure.

82. If you reenlist, which option will be your most likely choice?
- Remain in SF; same MOS.
 - Remain in SF; pursue a new MOS (non-medical).
 - Attend PA school.
 - Seek assignment outside Special Operations.
 - Other: _____.
 - The question is not relevant to me. I'm not reenlisting.

83. My Army experiences have had a strong positive effect on the development of specific knowledge, skills and abilities that will help me obtain civilian employment?

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

If yes, how? _____

84. If you are remaining in the Army, what has been the most important determining factor in your decision?

- a. Retirement plans.
- b. Family and other domestic concerns.
- c. Money matters.
- e. Job satisfaction.
- f. Career progression.
- g. Other: _____.
- h. The question is not relevant to me. I am leaving.

85. If you plan to leave the Army now, what would it take to change your mind?

- a. Additional pay (independent duty pay or proficiency pay).
- b. Selection to PA school.
- c. An appointment through the AMEDD Commissioning Program.
- d. Guaranteed assignment of your choice.
- e. Selection for Paramedic Certification.
- f. Other: _____.
- g. Not applicable, I'm staying in.
- h. The question is not relevant to me. I am leaving for the following reasons: _____.

86. Which of the following should be the minimum prerequisite for selection to the Special Forces Medical Sergeant's training program (18D/SFQC)?

RF

- a. "Bring 'em in right off the street"
- b. Completion of Basic Training
- c. Completion of 91A Course
- d. Completion of 91B Course
- e. An E-4 with MOS 91A or 91B
- f. Rank/MOS immaterial, but at least one tour in conventional Army
- g. Other: _____

87. A regularly published newsletter from SF Group, USASFC or USASOC level would be helpful to me in my current role within the unit.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

If yes, how? _____

88. If you had the power to change one of the following, which would it be?
- The medical portion of the SFQC curriculum
 - The 18D Mission Essential Task List (METL)
 - The selection standards for SF
 - The availability of medical sustainment training programs
 - 18D credentialling process
 - My relationship with the medical authority at my next level of command.
 - Other: _____

89. Relative to your answer of question number 3, please indicate how you would change it. _____

90. Prioritize the following (1-8) regarding the emphasis each should receive in the sustainment training of an 18D within the SF Group?

- ____. Trauma management
- ____. Preventive Medicine
- ____. Infectious Disease
- ____. Dental skills
- ____. Veterinary skills
- ____. Surgical skills
- ____. Emergency Medicine
- ____. OB/GYN

91. Have/(would) computers enhanced your performance of duty in your current position?

- Yes
- Most of the time
- Occasionally
- No, even though I am somewhat knowledgeable about computers
- No, because I am not computer literate

92. My unit surgeon/PA provides regular and pertinent classes to 18Ds.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

93. Gaining the civilian equivalent of Paramedic status (EMT-P) would encourage 18Ds to leave the Army at the termination of their next tour.

1= Strongly Disagree 5= Strongly Agree

1 2 3 4 5

If not, why? _____

APPENDIX G

RESPONSES TO SPECIAL FORCES MEDIC ANNUAL SURVEY

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
1. What is your duty MOS and Skill Level?			
a. 18D30	30%	65%	34%
b. 18D3H (Instr)	2%	0%	2%
c. 18D3V (Ranger)	3%	0%	3%
d. 18D40	33%	15%	30%
e. 18D4H (Instr)	23%	10%	21%
f. 18D4V (Ranger)	3%	10%	4%
2. What is your rank?			
a. SGT	3%	6%	3%
b. SSG	33%	56%	36%
c. SFC	62%	28%	58%
d. MSG	2%	11%	3%
3. Years you have held the MOS 18D?			
a. Less than one year	4%	10%	5%
b. 1 - 3 years	27%	20%	26%
c. 4 - 6 years	36%	50%	37%
d. 7 - 10 years	22%	5%	20%
e. 11 - 20 years	11%	15%	12%
f. 21 years or more	0%	0%	0%
4. Years Active Federal Service?			
a. 4 - 6 years	10%	57%	14%
b. 7 - 10 years	39%	14%	37%
c. 11 - 20 years	50%	29%	48%
d. 21 years or more	2%	0%	1%
5. Where are you working?			
a. Ft Bragg, SFG	28%	0%	24%
b. Ft Bragg, SWCS	18%	0%	16%
c. Ft Campbell	18%	0%	16%
d. Ft Devens	23%	0%	20%
e. Ft Lewis	5%	0%	4%
f. Germany	0%	0%	0%
g. Okinawa	0%	0%	0%
h. Panama	0%	0%	0%
i. Other:	7%	100%	17%

		<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
6.	Highest level of education?			
a.	Did not graduate from high school	0%	0%	0%
b.	GED or high school equivalency	2%	0%	1%
c.	High school graduate	17%	0%	15%
d.	2 years or less college (no degree)	41%	20%	38%
e.	Associate Degree	15%	15%	15%
f.	2 years or more college (no degree)	17%	35%	19%
g.	Bachelor's degree	7%	15%	8%
h.	Some graduate work	2%	5%	2%
i.	Graduate degree	0%	5%	1%
j.	Post graduate degree	0%	5%	1%
7.	Length of time in current position?			
a.	Less than 3 months	6%	5%	6%
b.	3 - 6 months	6%	15%	7%
c.	7 - 11 months	18%	0%	16%
d.	1 - 3 years	45%	33%	44%
e.	4 - 6 years	22%	40%	24%
f.	7 or more years	3%	5%	3%
8.	What race do you consider yourself?			
a.	White	88%	100%	90%
b.	Black	2%	0%	2%
c.	American Indian	2%	0%	2%
d.	Eskimo or Aleut	0%	0%	0%
e.	Asian/Pac Islander	1%	0%	1%
f.	Other:	7%	0	6%
9.	Are you of Spanish/Hispanic origin?			
a.	Yes	8%	5%	7%
b.	No	92%	95%	93%
10.	Duty assignment/MOS?			
a.	18D	100%	100%	100%
b.	18Z	0%	0%	0%
c.	Other:			
11.	Would you prefer a different MOS?			
a.	Yes	21%	5%	18%
b.	No	72%	75%	73%
c.	Not sure	7%	20%	9%

		<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
12.	If reenlisting tomorrow, which MOS would you select?			
a.	18D	74%	90%	76%
b.	Other 18 Series MOS	12%	10%	12%
c.	91 Series MOS	6%	0%	5%
d.	Non-18 Series MOS	8%	0%	7%
13.	Would you reenlist if you wanted to change your MOS but could not?			
a.	Definitely	16%	42%	20%
b.	Probably	35%	21%	33%
c.	Probably not	15%	16%	15%
d.	Definitely not	9%	0%	8%
e.	Don't know	23%	21%	23%
f.	Does not apply, retiring	2%	0%	2%
14.	If you had to change your MOS in order to reenlist, would you?			
a.	Definitely	18%	20%	19%
b.	Probably	33%	35%	34%
c.	Probably not	16%	15%	16%
d.	Definitely not	10%	15%	10%
e.	Don't know	21%	15%	20%
f.	Does not apply, retiring	2%	0%	1%
15.	The kind of work I enjoy most is:			
a.	Only in the military	3%	0%	3%
b.	Primarily in the military	38%	35%	37%
c.	Equally in the military and civilian world	55%	55%	55%
d.	Primarily in the civilian world	4%	10%	5%
e.	Only in the civilian world	0%	0%	0%
16.	Months left in your enlisted term or obligated period of active duty service?			
a.	Less than 6 months	7%	16%	8%
b.	6 - 12 months	14%	16%	14%
c.	13 - 24 months	29%	23%	29%
d.	25 - 36 months	18%	10%	17%
e.	37 - 48 months	10%	16%	10%
f.	49 - 60 months	14%	0%	14%
g.	More than 60 months	8%	16%	7%
17.	Years of active duty you expect to have completed by the time you leave the Army?			
a.	6 - 10 years	6%	53%	11%
b.	11 - 15 years	7%	20%	8%
c.	16 - 20 years	47%	13%	44%
d.	More than 20 years	40%	13%	37%

		<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
18.	At this time last year, how many years of active duty had you expected to complete by the time you left the Army?			
a.	Less than 6 years	2%	25%	5%
b.	7 - 10 years	10%	25%	11%
c.	11 - 15 years	4%	12%	5%
d.	16 - 20 years	44%	31%	42%
e.	More than 20 years	41%	6%	37%
19.	What is your current marital status?			
a.	Single, never married	6%	25%	8%
b.	Married	78%	75%	77%
c.	Separated	3%	0%	3%
d.	Divorced	13%	5%	12%
e.	Widowed	1%	0%	1%
20.	How many dependent children do you have?			
a.	None	22%	40%	24%
b.	One	23%	25%	23%
c.	Two	34%	30%	33%
d.	Three or more	22%	5%	20%
21.	Dependent children living with you?			
a.	None	35%	45%	36%
b.	One	19%	20%	19%
c.	Two	31%	31%	31%
d.	Three or more	20%	22%	14%
22.	In what area is your home of record?			
a.	South Eastern US	18%	35%	20%
b.	Mid Atlantic states	8%	0%	7%
c.	New England	13%	0%	11%
d.	Great Lakes Region	11%	0%	10%
e.	Appalachia	3%	0%	3%
f.	Mid West	14%	20%	15%
g.	Gulf Coast	8%	0%	7%
h.	South West	10%	0%	9%
i.	Mountain States	4%	40%	8%
j.	West Coast	6%	0%	5%
k.	Hawaii	1%	0%	1%
l.	Alaska	2%	0%	1%
m.	US Territories	1%	0%	1%
n.	Other:	2%	0%	1%

		<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
23.	How long do you plan to be an 18D?			
a.	Til the end of this enlistment	13%	5%	12%
b.	Til I get promoted out of the MOS	24%	21%	24%
c.	Til I retire	10%	37%	14%
d.	Til I get accepted to PA school or other medical school	50%	21%	47%
e.	Til I get accepted to the SF Warrant Program	2%	16%	4%
24.	What is the reason you plan to leave 18D?			
a.	Do not plan to leave 18D	13%	44%	17%
b.	Promoted to 18Z	24%	6%	22%
c.	Become an SF Technician (warrant officer)	3%	17%	5%
d.	Become a PA	41%	17%	38%
e.	Medical school to become a doctor or nurse	18%	17%	18%
25.	Why did you become an 18D?			
a.	No choice, was told to become 18D	12%	15%	13%
b.	Was related to civilian experience	9%	10%	9%
c.	Training to get a better civilian job	4%	10%	5%
d.	Use this as a step to PA or medical school	13%	15%	13%
e.	Work in third world countries	17%	5%	15%
f.	Chance to work on an A-team	22%	15%	21%
g.	Recognition and awards	1%	0%	1%
h.	Adventure and travel	3%	10%	4%
i.	Chance to influence others	1%	0%	1%
j.	Other:	18%	20%	18%
26.	Which SF mission do you prefer?			
a.	DA	26%	25%	26%
b.	FD	31%	35%	31%
c.	UW	23%	35%	25%
d.	SAR	5%	5%	5%
e.	SR	3%	0%	3%
f.	CT	12%	0%	11%
27.	If you did it over again, which SF MOS would you select?			
a.	18B	7%	10%	8%
b.	18C	3%	0%	3%
c.	18E	1%	0%	1%
d.	18D	85%	90%	88%

		<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
28.	Have you bought any medical textbooks in:			
a.	Last 12 months	73%	94%	74%
b.	Last 24 months	8%	6%	8%
c.	Last 36 months	11%	0%	10%
	Missing (> 36 months)	8%	0%	8%
29.	Subscribe to medical periodicals?			
a.	Yes	33%	56%	36%
b.	No	67%	44%	64%
30.	Do you rely on the SF bookset for your self-study resources?			
a.	Yes, almost exclusively	12%	15%	12%
b.	Yes, usually	33%	30%	33%
c.	Yes, sometimes	27%	25%	27%
d.	Seldom	18%	20%	18%
e.	Never	10%	10%	10%
31.	In the past 12 months have you experienced:			
a.	Hypertension	5%	0%	5%
b.	Peptic Ulcers	4%	0%	3%
c.	Migraine headaches	8%	0%	7%
d.	Emotional problems	5%	0%	5%
e.	Insomnia	13%	22%	14%
f.	Increased alcohol	8%	6%	8%
g.	Increased smoking	12%	6%	11%
32.	At which level are you assigned?			
a.	A-Team	64%	83%	65%
b.	B-Team	2%	11%	3%
c.	C-Team	3%	3%	6%
d.	SFG	4%	0%	5%
e.	USASFC	7%	0%	7%
	Missing (mostly from SWCS)	19%	0%	17%
33.	Which applies to you?			
a.	Active Component	100%	0%	87%
b.	USAR	0%	50%	6.5%
c.	NG	0%	50%	6.5%
34.	If you are USAR or NG, is your civilian job medically related?			
a.	Yes	-	71%	71%
b.	No	-	29%	29%

35. What percentage of credentialling points have you accumulated during this credentialling period?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. 0% to 15%	18%	47%	22%
b. 15% to 30%	8%	5%	8%
c. 30% to 50%	12%	10%	19%
d. 50% to 75%	17%	16%	17%
e. 75% to 80%	46%	21%	42%

36. I believe the implementation of a "credentialling system" for 18Ds has helped the 18D sustain his medical proficiency. Circle your response below.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
2.3	2.5	2.4
(1.2)	(1.7)	(1.3)

37. I make a conscious effort to keep track of my sustainment records.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.0	3.2	3.0
(1.8)	(1.8)	(1.4)

38. My supervisors are aware of the requirement I have to maintain a certain level of credentialling and show interest in achieving that objective.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
2.9	3.3	3.0
(1.3)	(1.6)	(1.4)

39. I would be willing to enroll in an Army sponsored course for certifying 18Ds as paramedics (EMT-P), even if it required some of my free time.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
4.5	4.4	4.4
(1.2)	(1.4)	(1.2)

40. I discuss medical subjects, interesting cases, etc., with colleagues as a matter of general conversation when meeting them.

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Frequently	44%	75%	48%
b. Occasionally	30%	25%	47%
c. I avoid medical subjects during my free time.	1%	0%	1%
d. Only if the other guy brings up the subject	5%	0%	4%

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
41. Have you established a personal medical reference library at your workplace or home?			
a. Yes, at my own expense.	85%	100%	87%
b. No, because I can not afford to buy books or subscribe to journals.	9%	0%	8%
c. No, because the SF Bookset meets my needs.	5%	0%	4%
d. No, because I train only when I'm told to do so.	1%	0%	1%

42. Are the type and number of medical sustainment opportunities available to you meeting your needs?			
a. Enough opportunities but the subjects are too limited.	14%	22%	15%
b. I never get a chance to take any medical training courses.	70%	61%	69%
c. Adequate number but their quality is not worth the time.	5%	0%	4%
d. I participate in plenty of worthwhile medical training programs.	10%	17%	11%
e. It doesn't matter because I am getting out of the Army.	1%	0%	1%

43. Do you believe your ability to perform your duty would be enhanced by attending a tutorial in trauma management at a major civilian trauma center?

a. Yes; trauma care is one of my weakest areas.	11%	0%	10%
b. No, because I'm in an administrative position.	0%	5%	1%
c. Yes; any educational exposure can only make me a better medic.	85%	85%	85%
d. No, because those centers are too sophisticated for SF application.	2%	0%	2%
e. No, for other reasons:	2%	0%	2%

44. Acquiring a civilian medical certification(s) during my time on active duty would encourage me to leave the military for a better paying job.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
2.1	1.8	2.1
(1.2)	(1.2)	(1.2)

45. Who most closely approaches your ideal as a role model?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Joe Moutana	2%	5%	2%
b. Norman Schwartzkopf	19%	15%	19%
c. John Wayne	19%	30%	20%
d. Walter Reed, M.D.	11%	25%	13%
Missing	49%	25%	46%

		<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
46.	In which of the following medical skill areas do you feel most confident?			
a.	Tropical Medicine	2%	5%	3%
b.	Environmental medicine (altitude illness, cold injuries, snake bite, etc.)	12%	15%	12%
c.	Trauma management	63%	60%	62%
d.	OB-Gyn	2%	5%	3%
e.	Dental emergencies	5%	5%	5%
f.	Preventive veterinary medicine	2%	0%	1%
g.	I'm confident in all of the above	10%	5%	10%
h.	I'm confident in none of the above	4%	5%	4%
47.	In which of the following medical skill areas do you feel <u>least</u> confident?			
a.	Tropical Medicine	17%	25%	18%
b.	Environmental medicine (altitude illness, cold injuries, snake bite, etc.)	1%	0%	1%
c.	Trauma management	2%	5%	2%
d.	OB-Gyn	35%	30%	34%
e.	Dental emergencies	10%	15%	11%
f.	Preventive veterinary medicine	23%	25%	23%
g.	I'm confident in none of the above	5%	0%	4%
h.	I'm confident in all of the above	7%	0%	6%
48.	Which of the following do you consider the best trained medic in the Army?			
a.	Ranger medic, Rifle Co.	0%	0%	0%
b.	SEAL team medic	2%	0%	2%
c.	Air Force PJ	4%	0%	3%
d.	18D of SFOA	87%	100%	89%
e.	Aviation Medical Tech	1%	0%	1%
f.	None of the above	6%	0%	5%
49.	What is the most significant impact an 18D can have through effective performance of his duty?			
a.	Awards and decorations	1%	0%	1%
b.	Career Progression and satisfaction	23%	10%	21%
c.	Achievement through teamwork	13%	10%	12%
d.	"Winning hearts and minds"	21%	20%	21%
e.	Key to team's accomplishing the mission	27%	50%	30%
f.	Other:	16%	10%	15%
50.	Which of the following can you do best?			
a.	Hand to hand combat	5%	0	4%
b.	Land navigation	9%	5	9%
c.	Treat hemorrhagic shock	47%	40	46%
d.	Speak a foreign language	5%	5	5%
e.	Teach a class on basic lifesaver skills	29%	45	31%
f.	Evaluate and initiate treatment for acute diarrhea	5%	5	5%

51. (Item number skipped on questionnaire)

52. If advising your brother, who was recently enlisted into the Army, about his career goals, which of the following would you recommend that he strive for?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Ranger medic, 91A	8%	0%	7%
b. SF Medic, 18D	44%	65%	47%
c. SF weapons, 18B	7%	5%	7%
d. Rifleman, 82nd Abn., 11B	1%	5%	1%
e. Military policeman	1%	0%	1%
f. Chaplain's assistant	2%	0%	1%
g. Other:	38%	25%	36%

53. The loss of which single team member would have the greatest detrimental effect on an A-team?

a. 18A	2%	5%	2%
b. 18B	1%	0%	1%
c. 18C	1%	0%	1%
d. 18D	53%	25%	49%
e. 18E	24%	60%	28%
f. 18F	6%	5%	6%
Missing	15%	5%	14%

54. All of the hard work to become an 18D has been worth it?

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.8	4.5	3.9
(1.3)	(1.2)	(1.3)

55. I would welcome the opportunity to work to train in a hospital environment, ER, etc.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
4.5	4.8	4.6
(1.0)	(0.6)	(1.0)

56. During an average duty week, how many hours do you spend on medically related activities? This should include patient care, training, self-education, medical equipment maintenance, etc.

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. None	13%	5%	12%
b. Up to 25%	53%	45%	52%
c. 25% to 50%	13%	5%	12%
d. 50% to 75%	9%	15%	10%
e. Over 75%	12%	30%	14%

57. The hours I spend on medically related activities help me sustain my medical skills.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.2	4.0	3.4
(1.4)	(1.3)	(1.4)

How difficult is it for you to maintain your credentialing objectives?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. It's impossible; I cannot even maintain the 70% minimum standard.	17%	61%	22%
b. It doesn't matter because the credentialing process is only a paper exercise.	25%	11%	24%
c. It's never been easy, but I always manage to stay above the minimum requirement.	44%	22%	42%
d. It's a snap; I may not learn anything, but I get the points I need.	6%	0%	6%
e. There's plenty of training opportunities out there and I take advantage of them, learning all I can.	7%	6%	7%

59. My experience as an 18D, thus far, has met my expectation in terms of self-satisfaction.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.0	4.2	3.2
(1.2)	(1.1)	(1.2)

60. My command, from Group Commander to my immediate supervisor knows the value of a well-trained 18D and supports my need for sustainment and enhancement training.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
2.5	3.0	2.6
(1.3)	(1.5)	(1.3)

61. How long has it been since you last participated in formal sustainment training (ATLS, formal lecture, hospital or TMC rotation, etc.)?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Within 1 month.	30%	35%	30%
b. Within 3 months.	8%	10%	8%
c. Within 6 months.	13%	10%	12%
d. Within 8 months.	13%	0%	12%
e. A year or longer	36%	45%	37%

		<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
62.	What type of medical training do you prefer?			
a.	"Hands-on" in hospital or TMC	49%	26%	46%
b.	Lecture/laboratory combination, as during ATLS	11%	37%	14%
c.	Self-paced, self-programmed, as with video tapes, audio-tapes etc.	3%	5%	3%
d.	Reading assignments followed by quizzes.	1%	5%	1%
e.	During deployments for FID missions (medretes)	26%	16%	25%
f.	No preference	10%	10%	10%

63.	What has been the most satisfying medical experience since you became an 18D?			
a.	ATLS	7%	0%	6%
b.	Local Army hospital or TMC rotation	9%	21%	10%
c.	Civilian program at my cost and on my own time	3%	16%	4%
d.	OCONUS deployment (peacetime)	36%	37%	36%
e.	OCONUS deployment (wartime)	16%	5%	14%
f.	Rendering emergency medical care on street/roadside	7%	10%	7%
g.	Teaching medical subjects regardless of whom students were.	15%	5%	14%
h.	Other:	9%	5%	8%

64.	Have you attended any of the following schools in the past 18 months?			
a.	Halo	10%	0%	8%
b.	Scuba	6%	0%	5%
c.	Sere course	3%	5%	3%
d.	O&I course	7%	0%	6%
e.	Rough terrain parachuting	0%	5%	1%
f.	Water infiltration course	0%	5%	1%
g.	Jump master	13%	25%	15%
h.	Dive medical technician	5%	0%	4%
i.	Other:	26%	15%	24%

65. At which level do you believe is the greatest barrier to your being medically prepared for your mission? Circle all that apply.

a.	No great barriers exist; I'm medically prepared!	20%	10%	18%
b.	Company HQ	19%	10%	18%
c.	Battalion HQ	37%	68%	41%
d.	Group HQ	50%	42%	49%
e.	Special Forces Command HQ	32%	10%	30%
f.	USASOC HQ	32%	10%	30%

66. I am properly equipped to do my medical mission?
1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.1	2.4	3.0
(1.1)	(1.3)	(1.1)

67. My supervisors have made efforts to recognize me when I've performed my duty especially well.
1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.3	3.5	3.3
(1.2)	(1.1)	(1.2)

68. Being the senior medical NCO in my command is worth striving for.
1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.0	3.6	3.1
(1.3)	(1.3)	(1.3)

69. Do you agree that your rank fairly represents your time in the Army and your experience?
1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.5	3.8	3.5
(1.3)	(1.4)	(1.3)

70. Would you prefer to spend most of your SF career in one or two SFGs, or serve with several different Groups?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. In several groups. It'll broaden my base of exposure.	50%	20%	46%
b. In one or two groups. I'll become more proficient in specific things.	39%	55%	41%
c. In a limited number of groups, because I'll become better known and the opportunity for advancement will be enhanced.	6%	25%	8%
d. In several groups, because things get stale if you hang around too long.	5%	0%	5%

71. Six years from now I hope to be a:

a. Senior 18D on an A-team	6%	25%	8%
b. PA	41%	30%	40%
c. A physician/other professional degree	22%	10%	20%
d. 18Z medical position	6%	15%	7%
e. 18Z in a non-medical position	11%	5%	10%
f. A civilian	10%	10%	10%
g. Senior medical NCO in SF Bn or group	3%	5%	3%
h. An OCS graduate	1%	0%	1%

72. Relative to your current situation in the Army, mark the block which best indicates the level of satisfaction with the following aspects of duty as an 18D.

1 = Very Dissatisfied 5 = Very Satisfied

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Your income.	2.6 (1.0)	3.2 (1.2)	2.7 (1.0)
b. Type of work you do.	3.5 (1.1)	3.7 (1.0)	3.4 (1.1)
c. Importance of your job to unit	3.8 (1.0)	4.2 (1.0)	3.8 (1.0)
d. Your promotion opportunities.	3.6 (1.1)	3.2 (1.4)	3.6 (1.1)
e. Command support for medical training.	2.5 (1.1)	2.4 (1.4)	2.5 (1.2)
f. Your treatment by supervisors.	3.6 (1.1)	4.0 (0.9)	3.6 (1.1)
g. Recognition and awards.	2.9 (1.1)	3.1 (1.3)	3.0 (1.1)
h. Unit morale.	2.6 (1.2)	3.6 (1.4)	2.8 (1.3)
i. Quality of your coworkers.	4.0 (0.9)	4.6 (0.7)	4.1 (0.9)
j. Training opportunities (non-medical).	2.8 (1.2)	3.0 (1.2)	2.8 (1.2)
k. Location of current assignment.	2.9 (1.3)	4.0 (1.0)	3.1 (1.4)
l. Quality of life for your family.	3.0 (1.2)	4.1 (1.1)	3.2 (1.3)
m. Time spent with your family.	2.8 (1.2)	4.2 (0.8)	3.0 (1.2)
n. The 18D qualification course.	3.5 (1.0)	4.6 (0.7)	3.7 (1.1)
o. The 18D sustainment training opportunities.	2.3 (1.0)	2.2 (0.9)	2.3 (1.0)

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
p. The 18D credentialling process.	2.0 (1.1)	2.0 (1.1)	2.0 (1.1)
q. The 18D critical task list.	2.4 (1.1)	2.7 (1.2)	2.4 (1.2)
r. Being kept informed.	2.6 (1.1)	2.4 (1.1)	2.5 (1.1)
s. "My opinion counts."	2.5 (1.2)	3.0 (1.5)	2.6 (1.2)

73. Besides the following list of medical skills training experiences, mark the block which indicates the degree of importance you place on each of them as they relate to the successful performance of your job.

1 = Not at all Important 5 = Extremely Important

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Trauma management	4.8 (0.5)	4.9 (0.3)	4.8 (0.5)
b. Emergency medicine	4.8 (0.6)	4.8 (0.4)	4.8 (0.5)
c. Tropical medicine	3.5 (1.1)	3.2 (1.1)	3.4 (1.1)
d. Pediatrics	3.4 (1.0)	3.3 (1.1)	3.4 (1.1)
e. Ob-Gyn	3.1 (1.0)	3.0 (1.0)	3.1 (1.0)
f. Radiology	2.7 (1.2)	2.3 (1.1)	2.6 (1.2)
g. Nursing skills	3.9 (0.9)	4.2 (0.7)	4.0 (0.9)
h. Medical administrative subjects	3.0 (1.0)	3.0 (1.0)	3.0 (1.0)
i. Medical logistical subjects	3.4 (1.0)	3.4 (1.1)	3.4 (1.1)
j. TMC rotations	3.8 (1.0)	3.6 (1.4)	3.8 (1.1)

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
k. In-hospital rotations	4.3 (1.0)	4.1 (1.2)	4.2 (1.0)
l. FID (HCA) deployments	4.4 (0.9)	4.6 (0.8)	4.4 (1.0)
m. Veterinary skills	3.3 (1.0)	3.4 (1.0)	3.3 (1.1)
n. Dentistry skills	3.8 (1.0)	3.8 (0.8)	3.8 (1.0)

74. Which of the following aspects of an 18D's career would best be left untouched during any "reform process"? Circle all of those which apply.

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. The way an individual is recruited for 18D.	22%	20%	21%
b. The curriculum of the medical portion of SFQC.	49%	65%	51%
c. The credentialing process for 18Ds.	6%	0%	5%
d. Your unit's Family Support Program.	13%	15%	13%
e. All of the above should be changed.	26%	20%	25%

75. Which of the following aspects of an 18D's career is in most need of revision?

a. The way an individual is recruited for 18D.	12%	5%	11%
b. The curriculum of the medical portion of SFQC.	5%	0%	5%
c. The credentialing process for 18Ds.	65%	95%	68%
d. Your unit's Family Support Program.	7%	0%	6%
e. All of the above should be changed.	11%	0%	10%

76. Which of the following is most attractive to you?

a. "Pro Pay" for independent duty status.	13%	5%	12%
b. A career progression program for 18Ds which would allow for additional duty positions for 18Ds as their career matures.	7%	15%	8%
c. The award of EMT-P (Paramedic) status upon completion of the 18D Course.	16%	30%	17%
d. All of the above.	56%	57%	50%
e. None of the above.	3%	0%	3%
f. Other:	4%	0%	3%

77. I receive medical information in a timely manner from my next higher HQ.
1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
2.8 (1.0)	1.8 (1.0)	2.7 (1.1)

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
78. The medical sustainment for my unit is:			
a. Sufficient to make me confident in the performance of my duty.	7%	5%	6%
b. Adequate; at least I'm able to meet biennial credentialling.	16%	5%	5%
c. I make the points I need, but the subjects don't cover a broad enough spectrum to meet my METL.	8%	0%	7%
d. The program would be fine if I could get time (from deployments, etc.) to get involved in it.	19%	10%	18%
e. No one cares about medical sustainment in my unit.	16%	32%	18%
f. None of the above statements adequately describes my situation.	34%	47%	36%

79. Which of the following impressed you most favorably:

a. Your unit's Family Support Program.	2%	0%	1%
b. The type of work you are doing.	31%	25%	30%
c. Your promotion opportunities	3%	5%	3%
d. Your treatment by supervisors.	9%	20%	10%
e. Your relationship with medical officers in your unit.	18%	0%	16%
f. None of the above.	37%	50%	39%

80. In your opinion is the following statement true? "The medical portion of the 18D Qualification Course was an adequate preparation for the real-world responsibilities of the A-Team Medic."

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.6	4.4	3.7
(1.0)	(0.6)	(1.0)

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
81. What do you think you will do after enlistment?			
a. Reenlist	55%	74%	57%
b. Leave the Army to find civilian employment	6%	5%	6%
c. Leave the Army to attend college	14%	5%	13%
d. Leave the Army for civilian vocational/technical education	1%	0%	1%
e. I'm not sure	24%	16%	23%

82. If you reenlist, which options will be your most likely choice?

a. Remain in SF; same MOS.	28%	75%	34%
b. Remain in SF; pursue a new MOS (non-medical).	7%	0%	6%
c. Attend PA school.	44%	25%	42%
d. Seek assignment outside of Special Operations.	3%	0%	3%
e. Other:	11%	0%	10%
f. The question is not relevant to me, I'm not reenlisting.	6%	0%	5%

83. My Army experiences have had a positive effect on the development of specific knowledge, skills, and abilities that will help me obtain civilian employment?

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.2	4.0	3.3
(1.3)	(1.4)	(1.3)

84. If you are remaining in the Army, what has been the most important determining factor in your decision?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Retirement plans	27%	16%	26%
b. Family and other domestic concerns	14%	0%	12%
c. Money matters	5%	10%	6%
e. Job satisfaction	28%	68%	33%
f. Career progression	14%	0%	13%
g. Other:	6%	5%	6%
h. The question is not relevant to me. I am leaving.	5%	0%	5%

85. If you plan to leave the Army now, what would it take to change your mind?

a. Additional pay (independent duty pay or proficiency pay)	15%	5%	13%
b. Selection to PA school	16%	21%	17%
c. An appointment through the AMEDD commissioning program	8%	5%	7%
d. Guaranteed assignment of your choice	5%	0%	4%
e. Selection for paramedic certification	11%	21%	12%
f. Other:	8%	5%	8%
g. Not applicable, I'm staying in	32%	42%	34%
h. The question is not relevant to me. I am leaving for the following reasons:	5%	0%	5%

86. Which of the following should be the minimum prerequisite for selection to the Special Forces Medical Sergeant's training program (18D/SFQC)?

a. "Bring 'em in right off of the street"	5%	0%	4%
b. Completion of basic training	1%	0%	1%
c. Completion of 91A course	5%	10%	6%
d. Completion of 91B course	10%	15%	11%
e. An E-4 with MOS 91A or 91B	25%	40%	27%
f. Rank/MOS immaterial, but at least one tour in Army	40%	10%	36%
g. Other:	13%	25%	14%

87. A regularly published newsletter from SF Group, USASFC, or USASOC level would be helpful to me in my current role within the unit.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
3.7 (1.2)	4.5 (1.0)	3.8 (1.2)

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
88. If you had the power to change one of the following, what would it be?			
a. The medical portion of the SFQC curriculum	3%	0%	3%
b. The 18D Mission Essential Task List (METL)	5%	0%	4%
c. The selection standards for SF	7%	5%	7%
d. The availability of medical sustainment training programs	62%	55%	61%
e. 18D credentialing process	17%	40%	20%
f. My relationship with the medical authority at the next level of command%	1%	0%	1%
g. Other:	5%	0%	5%

89. Relative to your answer of question number 88, please indicate how you would change it.

90. Prioritize the following (1-8) regarding the emphasis each should receive in the sustainment training of an 18D within the SF Group.

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Trauma management	1.3 (0.6)	1.8 (1.4)	1.3 (0.8)
b. Preventive medicine	4.1 (1.6)	4.0 (1.6)	4.1 (1.6)
c. Infectious diseases	3.8 (1.3)	3.5 (1.3)	3.8 (1.3)
d. Dental skills	5.8 (1.2)	5.9 (1.2)	5.8 (1.2)
e. Veterinary skills	7.2 (0.8)	7.4 (0.5)	7.2 (0.8)
f. Surgical skills	4.7 (1.5)	4.5 (1.4)	4.6 (1.5)
g. Emergency medicine	2.2 (1.0)	2.0 (0.7)	2.2 (0.9)
h. OB/GYN	6.8 (1.2)	6.9 (1.2)	6.8 (1.3)

91. Have/(would) computers enhanced your performance of duty in your current position?

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Yes	46%	50%	47%
b. Most of the time	11%	5%	10%
c. Occasionally	20%	30%	21%
d. No, even though I am somewhat knowledgeable about computers	8%	10%	8%
e. No, because I am not computer literate	15%	5%	14%

92. My unit surgeon/PA provides regular and pertinent classes to 18Ds.
1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
2.5	1.2	2.3
(1.2)	(0.5)	(1.2)

93. Gaining the civilian equivalent of Paramedic status (EMT-P) would encourage 18Ds to leave the Army at the termination of their next tour.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
1.9	1.6	1.8
(1.1)	(1.0)	(1.1)

94. Regardless of "critical shortages", one's personal intelligence and excellence of prior duty, no one can become an effective 18D unless he enters the field by his own choice.

1 = Strongly Disagree 5 = Strongly Agree

<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
4.4	4.1	4.3
(1.0)	(1.2)	(1.0)

95. The fact that currently, no Sergeant Major (E-9) position exists for the medical MOS in Special Operations is a strong factor influencing my long-term career plans.

	<u>Active</u>	<u>Guard/Reserve</u>	<u>Total</u>
a. Yes	23%	10%	22%
b. No	56%	60%	57%
c. I'm not sure	20%	30%	22%

THANK YOU FOR YOUR PARTICIPATION IN THE SURVEY

Use the following space and reverse for any additional comments or suggestions that you may have about the 18D career field or this survey.

APPENDIX H

WRITTEN COMMENTS FROM SF MEDIC ANNUAL SURVEY

36. I believe the implementation of the "credentialling system" has helped the 18D sustain his medical proficiency.

Continuing training is an excellent idea but the "points" system is a pain.

The credentialling system creates unrealistic demands on the medic's time.

Due to deployments, I have not had the opportunity to pursue it fully.

The credentialling system is a "check-the-block" paper drill. Suggest a re-look at the system.

It's a farce and a paper drill. Commanders do not support medical training.

AR 250-9 is a regulation with no enforcement. I have never seen an 18D de-credentialled.

One week in ATLS does not maintain medical proficiency. It is a good refresher, but it falls way short of maintaining a good medic.

It is not a legitimate means of attaining proficiency. A lot of people just "pencil in" their needed points.

Credentialling is a farce. What other MOS has to go through this B.S.? It forces people to cheat and lie. It's not realistic and does not apply to everyday work experience, but it looks good on your pie chart.

It backfired. Instead of medics getting released for training, they get in trouble for not having enough points.

The system does not work. If you are on an A-Team or have a real job, the whole credentialling system is nothing but a hassle. I am sure that the people who made it have not nor do not put themselves in our shoes.

Increased proficiency requires training with more knowledgeable people, hands-on discussion, not just reading 14 lines in a paper.

It has not had much of an effect here.

The credentialling system is a ticket punch. The Bn/Grp surgeons don't have a program to teach/refresh us. We're not allowed to work in a clinical environment (other than TMC 13 in support cycles).

Although it was designed to put 18D's into clinical teaching environments, it has not worked. Command emphasis is not on sustainment training. Points are given for things like SQT, ANCOC, ATLS. One does not do "hands-on" clinical rotations for points.

The credentialling books are usually a hit/miss deal and is a paperwork drill. No book will ever replace effective personnel management, an area in which SF is a little clueless.

Most commanders say they support the program, however, in reality they don't.

I have never had the opportunity to do credentialling while in SWCS.

We never have a chance to use the system.

Strongly disagree, because command does not allow ample time to relearn subjects or just does not give the time at all.

There is still a problem with command emphasis. The excuse that I can't afford to go without a medic keeps popping up.

The program is an eyewash, a paper drill, and an insult to the 18D who truly enjoys being a medic.

(RC) There is no vehicle for medical training other than that which we arrange for ourselves.

(RC) A better system must be implemented for RC 18Ds

(RC) The credentialling system is not feasible for reservists.

(RC) I have seen no effort at my level in the group to direct the credentialling at proficiency.

(RC) It is not supported by the existing training opportunities in the military system.

(RC) What is this? Continuing education?

(RC) I am not aware of this.

37. I make a conscious effort to keep track of my sustainment records.

It becomes more of a ticket punch. Forced to hunt for points as opposed to training. A bookkeeping burden on supervisors.

I do not, as a rule, receive sustainment training.

Too busy "checking boxes" in other areas.

Sustainment training is important. Hospital relations are difficult to acquire.

Medics rarely get enough training to worry about it.

Only because I maintain records for 36 other 18Ds.

I really don't care. When it comes down to a basic deployment, I am confident that I can complete then medical portion of the mission.

It's a paper drill.

It is a low priority.

I'm lazy and I'm not concerned about it. I've done lots of things in the TMC this quarter, El Salvador and Peru, but I haven't gotten any updates. Why? No time, not high priority to me.

Why? It is obviously more important to certify and validate than to sustain medical training.

In ten years as a 18D/91B, no one has ever asked to see any sustainment records.

(RC) We get only rare opportunities to train and update procedures. We do not get the chance.

(RC) There isn't much reason to do so when there isn't any sustainment training.

38. My supervisors are aware of the requirement I have to maintain a certain level of credentialing and show interest in achieving that objective.

They have their own problems. I am supposed to be supporting the team, not them supporting me.

They are too busy checking their own boxes.

If sustainment training does not interfere with mission training, I can go.

If commanders don't support medical training, supervisors cannot.

Bn level chain of command has virtually no interest in 18D sustainment training.

No opportunities are available for Medics to train in hospitals and to work in foreign countries. Credentialling is limited to ATLS.

No one understands our needs.

It is a low priority.

A-Team level is concerned; B-Team could care less.

Only when they are reminded that it has to be done do they remember.

Most 18A's are more interested in the OER's than their personnel, and most team sergeants are generally busy with other items.

They may know, but have make no effort to send us to ATLS, ACLS

Commanders see the need, but mission requirements almost always have higher priority.

I have been of a team for 3 years and have yet to have been to A'TLS. When the team is in green cycle, we certify, red cycle is support (head count etc.)

(RC) Very little effort is made to ensure 18Ds are up to standards. We have skated by all of these years because nothing serious, e.g., accidents, have happened.

(RC) Most of the past commanders and HQ only have cared about the mission not the components of the mission.

(RC) Administrative requirements always take precedence over training.

(RC) They are not aware of credentialling.

39. I would be willing to enroll in an Army sponsored course for certifying 18Ds as paramedics (EMT-P), even if it required some of my free time.

I will accept all medical training within reason if it has a purpose.

I am already putting in 12 hour days and, quite frankly, I don't get paid enough for the hours I work.

Yes, but only 18Ds are required to give their "free time" to maintain their MOS credentialing

Yes, real hands-on training. That is what we really need.

If assigned to an ODA, those type of programs take the medics away from the detachment for too great an amount of time for "civilian stuff."

I would take leave - big time.

(RC) I would like to, but getting away from my civilian job would be very difficult. Especially if it did not interfere with my "real" civilian education. I can't believe the Army can not do this on Army time.

42. Are the type and number of sustainment training opportunities available to you meeting your needs.

Not enough opportunities

Hardly ever.

No opportunities to meet SF needs or quality.

Not enough opportunities.

Are not often enough.

44. Civilian certification would encourage leaving the Army.

I am in until retirement, but certification or a degree would help with employment after retirement.

Senior NCOs E-7/E-8 would take a severe pay cut to go a civilian Paramedic job.

No, It makes no difference what job or education you have, a soldier will leave the Army when he wants to.

I like what I am doing now. Acquiring civilian medical certification would make it easier to do my job. If a medical situation arises outside a military setting civilian certification, it would make it legal to perform and help in this situation.

I feel I would give something back after the training.

Having the security of knowing that I can perform and step into a job in the civilian world would enhance my career immensely.

Some may leave the Army early, but most will use this for job improvement and wait until they retire to use the certification.

(RC) In the ARNG, a guy can only attend drill if his civilian job is stable. Having the EMT-P would ensure that the 18D would be employable after retiring from active duty. Now if you don't get out while you are young enough to attend college, you are behind the power curve.

54. All the hard work to become an 18D has been worth it

Education/training has not been put to use.

I went to school for 18 months to get my tab. Since then I have attended at least another 12 months of schools. Other 18 series soldiers are the same; our duties and responsibilities are awesome. Yet we are paid the same as PAC NCOs and supply sergeants. Pro pay!

In the last four years I have done next to no medical skills. On an A-Team you can't keep on top of the medical skills that are needed.

When I first came to SF, it was an "NCO's" organization. Now NCOs are not given enough responsibility and as a result many of us have become lazy and apathetic. The increased paper shuffling and logistics nightmares also make life hard.

I never get to use my skills. There is no hands-on sustainment training.

Most of my skills have never been tested on a regular basis.

I had hoped to move on to PA school, but SF Cdr's won't allow me to go to school to get what I need for PA school, even after 12 years in SF.

Proficiency requires great expenditures which group is unwilling to do.

I've gained confidence in my abilities because of the work I put into the 18D course.

Biggest disappointment in my life. Jack of all trades, master of none. No time. No life, but deployments. No security. No way of maintaining skills.

Fourteen months of training, no sustainment training, no missions in 12 months, no credentialing comparable to civilians, not being able to treat my teammates even for minor illness/injuries. No, it was not worth it.

It seems like we get the short end of the stick on promotions.

Lack of career progression, lack of leadership positions.

I need an MOS change after 12 years, but I don't have any option except to get promoted to 18Z.

You're treated like a detail person, until things go to hell, then you're expected to save lives with minimal practice.

(RC) I have had many satisfying years of service.

(RC) I have not used my skills or been given the opportunity to keep my skills up to date.

(RC) Educationally yes, but other than drill and AT, my civilian medical capabilities (legally) are very limited. There is no place for an SF Medic to earn a reasonable living without a civilian education.

(RC) I enjoy the work, but don't feel very confident about my skills because of the lack of refresher training.

55. I would welcome the opportunity to train in a hospital environment, ER, etc.

It should be a requirement that each year we should spend two weeks in a hospital.

Training in a hospital is the best training available to us. However, this training should be on Army time, not on our free time after a 10-12 our day.

Yes, as long as it did not conflict with the mission and ODA needs

57. The hours I spend on medically related activities help me sustain my medical skills

I don't spend nearly enough hours to stay current and proficient.

Medical equipment maintenance in no way helps sustain medical skills. Hands on training is the key.

Medical related activities for ODA medics are virtually non-existent. The command emphasis is on language school and not medical training with the exception of ATLS.

It is not enough to be sustained.

95% of my time is spent on equipment inventory and maintenance.

I do a lot of other things, e.g., paper work, organizational required training.

I spend a lot of time reviewing records, giving immunizations, etc.

It's either maintenance or inventory or sick call stuff.

Self-study without clinical rotation is only marginally helpful.

Working in SWCS in other positions, eg., HALO instructor, you're not given the time to keep up on your 18D skills.

59. 18D has met expectation in self-satisfaction

The opportunity of work in the MOS (Medical) is rarely afforded and efforts to solicit opportunities are strongly discouraged.

I have not been recognized or rewarded for my level of training, experience, or responsibility. I am not allowed certain responsibilities because I am not civilian certified, or because doctors refuse to release certain of their responsibilities to me.

The only sustainment training worthwhile was TMC-13 rotations. Commanders do not realize how perishable medical skills are. Not allowed to attend schools because of shortage of medics.

This would vary by individual, dependent on unit assignment and location. 7th SFG(A) medics are undermanned and over worked with real world missions while 3rd SFG(A) are manned at 85% and have no real mission.

Medical experience pretty much comes to a stand still after graduating from the Q Course. Medics feel stagnated and are denied opportunities to maintain and improve their medical skills.

Yes, but job satisfaction won't pay the bills when you're retired or separated. More money is the reason that so many medics leave 18D for PA. Not much incentive to stay anymore.

I have participated in a few good medical operations but they have been few and far between.

I have only done one medical mission in four years (Provide Comfort). Everything else a 91B could have done equally well.

Yes, until I was assigned to a B-1m and only functioned as an S-1 with no opportunity to do any medical training.

But after 12 years I am ready for something bigger. Self-improvement is the key. I am at a crossroad in my career.

The team is great. I feel pretty confident concerning my medical abilities, but the group, due to poor leadership has gone to shit.

Strongly agree, however, not as much in the past few years as in prior years.

There is nothing self-satisfying about pulling support for the entire Army instead your own duty description.

Five years ago yes, now I've had enough 18D.

I need more challenge in the Medical field.

(RC) Lack of opportunity to deploy OCONUS and lack of real world missions.

(RC) I don't feel that I have actually been able to perform in my duty MOS.

(RC) Our group command down to the company level could care less.

60. Command knows value of 18D and supports training

MOS sustainment training throughout is a paper drill only. Suggest two weeks to a month that is set aside each year for sustainment of all 18 series.

Very little medical training is planned into missions. All other MOSs get training on missions except medics.

This is not evident in the actions of the command structure in support of any type of training.

Immediate supervisors are very supportive but are powerless to do anything without command support.

I recently had a Bn commander who said that SF Medics were not necessary.

A lot of lip service is paid in this area.

This is two questions. Yes they know, but the Bn Cdrs do not support the training, because they have their own requirements. Numbers before men.

The Sgt supports whole-heartedly; the group commander seems to have other self-aggrandizing ambitions.

A lot of lip service is paid and nothing seems to get done.

Sustainment training is given high priority in command training guidance. However, where the rubber meets the road, medics are receiving less than one week per year of sustainment training.

If they did, why have I not received any opportunity to get any training.

He knows the value, but due to a shortage of personnel, the time needed is not available.

(RC) You are up to your own as to maintaining your skills.

(RC) I think the commanders understand our importance but do not realize the importance of diversified and frequent sustainment training.

(RC) The command knows the value of a well-trained Medic but the support has not been adequate.

(RC) There is little knowledge or support for sustainment training for 18D in the Reserves. If there was, we would most likely be told there is a lack of funds.

66. I am properly equipped to do my medical mission

I still have rudimentary skills, they are not as sharp as they used to be.

There are severe shortages of assigned MTOE equipment. Also some of the equipment is outdated. Supply system is slow to react to real needs of detachment medics.

Lab sets are antiquated and in poor repair. Drugs within the sets need to be changed in a more timely manner to keep pace with trends in medical technology.

The SF group has tremendous medical knowledge but very rudimentary equipment.

The sets are ill equipped and contain a lot of useless equipment, e.g., bone saw without the means of developing an OR.

SF TAC set is at least 10 years out of date. It does not allow an ability to update with new drugs or lighter, more efficient equipment.

I have the equipment but need more knowledge and practice on usage.

The SF TAC set only takes up space because we very seldom have the required reagents to do the tests.

I could use a lot of refresher training. ANCOG was for the most part worthless.

I believe that I could make it work, but not without a lot of mistakes first.

We have outdated equipment; the Vietnam era is over.

(RC) Strongly disagree, mainly due to the inability to obtain supplies both durable and expendable.

(RC) The RC medics get the shaft on equipment and sustainment training for using the equipment.

(RC) We get no sustainment training nor supplies.

(RC) The supply of drugs and other essential items is almost non-existent.

(RC) No supplies due to poor funding and people at Bn HQ who can't do anything to help.

67. My supervisors have made efforts to recognize me when I've performed especially well.

We never receive recognition. We're told that we are just doing our job.

Most people don't recognize 18Ds when they do a good job, unless it is something dramatic.

Basically an 18D is only noticed when needed, but is usually not praised.

A-Team members see very few efforts to recognize their performance while the HQ people receive a lot of recognition.

Who did the most work for Provide Comfort and funny only senior NCOs and officers received MSM's, not medics.

On an 8 month OCONUS trip, in addition to my regular work, I did volunteer medical work at a refugee hospital, saved a girl's life, provided care to a multi-national contingent and got an ARCOM. I was told only so many MSM could be given and I was only an E-7.

A by product of higher's disregard for all MOS. The A-Team member is no longer important. It is just a tool for an officer to proceed through the ranks.

They give awards for B.S. and keep me from doing my job.

It's been hit or miss, much more dependent on boss's opinion's of Medics in general than my job performance.

It's a sad case when you write up an award for someone saving another person's life and then you have to force your CO to endorse it.

(RC) They don't recognize exemplary medical performance.

(RC) I usually write my own EER. My supervisor doesn't have any idea what all I do for my 18D's.

68. Being the senior Medical NCO in my command is worth striving for.

They don't practice medicine , but administration and supply.

I work in a Bn Med section and the workload and additional duties are overwhelming. A Bn Med section is understaffed.

This is the least desired position due to the lack of support at the group level by the chain of command. This also occurs at Bn level.

I agree, but that is not how it works. Battalion commanders put E-7s, E-8s with alcohol problems or other problems in that important position. That is terribly wrong.

They become a whipping boy for staff officers. They should be allowed time to be a trainer.

Slugs are usually assigned to these positions.

The position has no power to make changes in a faulty system.

More paper pushing and less patient care. Good opportunity to "book learn" and work with the PA or Bn surgeon.

This is a job for cripples and people who have limiting profiles.

This position is usually not filled by someone who wants it, but by an 18D who is recovering from injury or who is dysfunctional of an A-Team.

This means you will get promoted out of medicine and into administration.

The A-Team is the preferred place to be.

I do not want to waste my potential in a dead end job.

77. I receive medical information in a timely manner from my next higher HQ.

A-team is last to know. Company Medic is used as Admin Specialist.

Usually I get medical information/updates on my own or by talking with my peers.

We receive fair support from higher HQ, but we usually hear about things from other sources before our higher HQ does.

I rarely receive any medical information.

If info is passed from higher, you have to retrieve it yourself or you do not get it.

In 12 years, I have never seen any kind of update information come out of Ft Sam to the 18D's in the field.

In my experience, SWCS does not distribute medical related information down to companies.

(RC) I never hear anything from above. I find out my own information.

80. 18D O-Course was adequate preparation for A-Team Medic

They lean so heavily on trauma that the basic sick call and physical exam are given a low priority, even though it is a major portion of what we do after the Q-course.

The course contains too many experiences and ideas from the Vietnam era. More material should be included about third world missions. I would update so a new 18D will not be so shocked.

The course is basically a survey course which does not give adequate skills to do the job without considerable hands-on experience in the ODAs.

A lot of job responsibilities were not covered. In fact, the equipment found in a A-Tm was not covered in the course.

It does not prepare the soldier for the harsh reality of the A-Tm. Your medical skills are not important enough for you to be released to maintain them, but if someone gets hurt, you had better be able to save them.

Great didactics, but no true application as an 18D.

The way it was taught to me in '87. It was fast and long, but needed.

Nothing replaces experience which is needed in the program such as doing OJT in a third world country.

83. My Army experience had a positive effect on the development of specific knowledge, skills, and abilities that will help me obtain civilian employment

No colleges recognize the 18D Q Course.

The civilian community is almost completely unaware of an 18D's capabilities.

18D provides an excellent base in all medical subjects.

Attitude, self-discipline, hands on skills, ability to handle responsibility.

There are no civilian qualifications which are awarded from the 18D course except EMT-Basic. This won't get you very far in the civilian world.

They allow a person to know that they can handle the college course work required to become a civilian medical professional.

The experiences I have garnered and the maturing process have made me much more marketable if I choose to go out of the military.

The Army has been good to me. I have benefitted in many ways and enjoy being in the Army.

(RC) Due to my SF training, I currently work for a group of orthopedic surgeons. My duties include all nursing duties and 1st surgical assistant for all procedures from hand surgery to total hips. I have no other schooling.

(RC) My military medical education helped me tremendously in civilian courses - but my 18D MOS did nothing for me until I got civilian certification.

87. A regularly published newsletter would be helpful

Disagree, because the newsletter would probably reflect current USASFC or USASOC interest in continuing education, i.e., nil.

It could highlight medical issues, availability of training.

Letter should come from USASFC because they are familiar with the problems in all of the groups. Gp Med can attach additional info to the letter that is specific to each group.

No, personnel at group HQ are generally out-of-touch with the feelings and opinions of detachment members. Detachment members have no input.

Too often these types of publications are aimed at officers with only an article or two focused on the NCO

Being informed is being up to date.

Hopefully, this would get out some of the information which doesn't seem to get down to the troops.

It would be good to know what is happening in the upper levels of our command. We are interested in their thoughts and plans.

My Bn has a newsletter with sustainment tasks and news of medical nature. Good stuff.

There is a regular newsletter from SWCS which is of no use to anyone.

Maybe we could find out when the ATLS, ACLS etc. dates are. Also any update in the medical field.

I agree as long as the establishment of a newsletter does not require any additional input from ODA, ODB or ODC. There is enough useless reporting going on now. It might help medics stay aware of administrative and logistical requirements and changes, as well as new developments.

89. Comments on Question 88 Choices

Have sustainment training directed at DA level like ANCOC.

Mandatory hospital or TMC rotations for 1-2 months per year. EMT-P credentialling.

More courses which are timed to a unit's cycle, not just when the slots come down. When you are the team medic you can't just go to school anytime.

Sustainment training is needed by all 18 series MOS. Each Bn should set aside 2-4 weeks per year for this.

Make sustainment training more readily available at all times of the year.

I would make medical sustainment training programs available to 18Ds where there are none at this time.

Allow medics to deploy on Medretes with physicians and PAs and do Med training. Quit testing and retesting and testing again.

Why do we have credentialling when the other MOS do not.

The SF officer corp seems to get the dregs. Find more intelligent officers, people that a good NCO can respect. Don't take officers who are running away from a career mess-up in another branch or someone who really wants to be a Ranger but somehow came to SF.

With respect to the SFQC, new 18Ds don't have the common sense skills of hands-on experience nor the broad medical subject area actually dealt with by the ODAs.

Replace the credentialling system with hands-on requirements: TMC rotations, MED-RETES, medically related school requirements.

Sustainment training needs to be tailored to mission needs and not credentialling.

Why all this paper work and credentialling process/hassle just to find a couple of no good or unmotivated medics. It is hard to accomplish these requirements in the real world.

Make time and money available for 18Ds to attend training at TMCs and hospitals under guidance of PAs and MDs.

Set up block times for Medics to rotate in hospitals, clinics, and TMC. Do away with the credentialling program; it is more of a hindrance than a help.

Get rid of the credentialling process.

Mandatory classes by Doctors/professionals (not 18D's), followed by hands-on practice, followed by hands-on patient care in a medical environment and period in retraining.

Make sustainment training programs available. More ATLS slots, EMT-P, BCLS, burn treatment, Vet/dental rotations.

The Q course should include more on how to plan and prepare for a mission and more training on the everyday tasks.

If you have sustainment training let the 18D's attend. It should not be ATLS every year.

Give medics time to work in hospitals, TMCs, go to school, etc.

Allow E 3/4 in and do not allow E-6's with 2 or more years time in grade. If it took them that long to make the decision they are weak and they only will weaken SF.

Coordinate METL with what 18D's are doing, e.g., Turkey, Philippines.

There is something wrong when 18D's instructors in Med Lab train Navy corpsmen that are not at the same skill level but who get \$300-\$400 a month pro pay.

More command emphasis on the credentialling process. Make it mandatory, instead of what you can spare, to give medics ATLS or hospital rotations.

Civilian certification! Why reinvent the wheel. We work in overseas hospitals with civilians.

More hospital rotation opportunities. Sustainment opportunities more than once a year for those that miss them due to deployments.

(RC) Would not have deleted cut scores for support personnel. Would require B-Team and C-Team members to have served on A-team first.

(RC) Senior Medics must be allowed to advance along medical career lines instead of special operations if they desire, e.g., PA or nurse credentialling.

92. My unit surgeon/PA provides regular and pertinent classes to 18Ds.

Four years as Senior A-Tm medic and no classes.

Yes, when all of the medics can be assembled in one area at the same time which is very rarely.

I have yet to attend a pertinent class.

We have never really had a Bn level physician or PA who had the time to train us.

Our Dr's and PAs are great, but due to requirements placed on the Bn Cdrs, Medics and doctors are not together enough to consider this.

I haven't received any classes from PAs or Docs.

We have received no classes from our surgeon, but changes are being made.

No PA. The Bn surgeon is on the run at the TMC and hospital. The group surgeon is stuck at meetings all the time. It is not their fault.

I have not received a class in several years.

I've never had a class with them except on deployments.

In three years, we have been given no classed at all.

(RC) Surgeon has no concept of 18Ds role as medics.

(RC) There is no regular sustinment training. We get occasional classes which are optional.

(RC) We don't have a unit surgeon/PA, Bn PA, Gp PA that I can contact or who has ever contacted me. No one in my company even knew the names of the Bn or Gp surgeons.

93. Civilian equivalent of EMT-P would encourage 18Ds to leave

Pay as EMT-P is not equal, however, it would encourage moonlighting during off duty hours.

Other factors are present that keep individuals on active duty.

They would not want to get out as often if training was a realistic goal and was readily available for all 18Ds.

EMT-P certification could only make a better medic. It would also boost the morale of 18Ds.

Exactly the opposite would happen. If I was EMT-P qualified hopefully the Army would see to it that I kept sustinment at a high level, then I could enjoy the medical portion of the 18D's duties.

Negative, give them good training and recognition (by the other Med MOS so that we are allowed to work in hospitals). Give them good real world missions. Basically job fulfillment and they will not keep bugging out. Most 18D's became medics to be medics. When the job does not provide satisfaction they move out. Give them a reason to stay. In general, they don't go PA or nursing for the bucks, they go so they can do medicine.

Most 18Ds enjoy the Army. I feel we should be provided an opportunity to get EMT-P, so we are legally covered when working on the civilian population. It also would help as a form of sustinment training working in civilian hospitals.

If you encourage and promote the people who want to be here in SF, you won't have Medics leaving. But at present the Medics are so dissatisfied, they are going to leave without the Paramedic program.

I'm proud to be with SF. Team success is the most important.

(RC) The average annual income of a paramedic is less than that of a E-5 18D. In addition, the 18D is able to perform higher level tasks in the Army than an EMT-P can in the civilian world.

Most get out to civilian education.

No, most soldiers are not here so that they can leave. We are soldiers because we like soldiering. The system destroys a soldier's morale and desire to excel which leads the soldier to change his job.

94. No one can become an effective 18D unless he enters the field by his own choice

18D cannot be selected on the whim of a senior officer or NCO. They must be true volunteers.

I have known a few excellent medics who did not initially wish to be medics.

If you recruit the guy with the right values, he will perform.

Comments

- My answers on the survey reflect my strong discontent with the 18D sustainment training. There are so many requirements that are placed on the ODAs, e.g., BFA, ITC, TTKs that there is little time left for training.
- Pro-pay, bonus, and schools in a timely fashion.
- Pro Pay for all CMF 18. MOS sustainment for 18 CMF in groups. 18D civilian certification - at least EMT-P and LPN after SFQC, after ANCOC other certification, e.g. RN. 18D credentialing/sustainment is strongly supported by most NCOs (18D) and PA's throughout the chain of command. Some doctors also support it. It will not work, however, until credentialing points are more realistic, i.e., (1) they reflect the availability of medical training in SFG and (2) commanders are forced to accept the idea of sustainment training.
- 18Ds are expected to be "Medical Gods" purely through their graduation from the Q-course. Commanders expect this but are unwilling to allow medics to attend sustainment courses. Certification and validation are more important to higher commands than

having the medics develop their skills. - This survey seeks to gain insight on how to keep 18Ds and why so many leave. Too bad nothing will become of it. The problems should be obvious and not require any surveys.

- The reason you lose 18Ds as I see it is that (1) they want to be able to practice more medicine than they can in group (2) 18D means nothing in the civilian world. If an 18D stayed in group 20 years and got out he would not be able to get a civilian job in the medical field without civilian training and certification. - Pro pay would go a long way toward keeping not just 18Ds but all soldiers in SF. As an E-6 I make the same pay as an E-6 who works range control 0700-1630. Don't you think an SF soldier does more than that? The pay is not equal to the responsibility, skills or the requirements. Even after I get off, I have to spend an hour reading to keep up.

- I feel all "available" time should be spent rotating through various clinics in the hospital.

- If the 18 CMF wants to retain 18Ds and not lose them to the PA/Nurse program then a good, well-rounded sustainment program needs to be implemented. 18Ds should not become 18Zs upon promotion to E-8 .

- Our sister services attend the same trauma course we receive in MedLab and then receive Pro Pay for it. No credentialling. In service training - Medics cannot be spared because to go to ATLS because of the MOS shortage. The only form of advancement available is the PA course of other medically related schooling. I feel that after an 18D has served his time he should be given priority in these schools. In this way he could continue to serve the Army as opposed to leaving the service.

- A pyramid of programs to maintain and enhance proficiency is needed. Command needs to back these programs. The fear that we will leave because of this training is unfounded. The current low morale for 18Ds is due to the lack of job satisfaction in treating people in third world countries when emphasis is placed on DA only. Medical comes last unless SOCOM places a fire under the 1st Gp command. I have been fortunate in the opportunities that I have received, but I have seen other people who deserve the chance to receive this opportunity.

- When medics are not in the field, let them rotate through hospitals, ambulances. I have spent eight years on an A Detachment and in recent years the certification, credentialling programs have adversely affected my morale and the morale of my fellow Medics and team members. We feel we are constantly being tested and that nobody trusts us to do our jobs. The individuals that require all of this certification/validation do not participate themselves and it seems as if the leaders are not leading by example. When people speak out they are labeled as "cry-babies. Most of the men have resigned to keep it inside which therefore increases the stress and lowers the morale. If we make a mistake we get hammered; if we do well we are not recognized. We are told we are

just doing our job, that SF soldiers are supposed to do a good job. We feel helpless to control our futures. We stay hoping things will improve. ATLS for medics is always outstanding training. Medreates were outstanding but are rare nowadays. Many skill qualifiers get Pro Pay. Medics go through a long training program with no civilian equivalency and do more MOS training than the other 18 CMF but receive no pro/-incentive pay. We get reenlistment bonuses but so do the other 18 CMF. Scuba school is 3-4 weeks long and they do a monthly pay dive. The physicians get extra pay; PAs get their commission. 18Ds go to the most ungodly places in the world and provide medical care there others can not or will not go.

Now they are saying we will be 18D50s and not leaders. My point is that there is very little incentive to stay an 18D. This is why medics want to go PA or get out of the service. I stay because I think things will get better. I can say negative things because I have been there. I can't consider another job. I hold my fellow soldiers and commanders in high regard. I'm just frustrated because I feel we are being singled out and identified as incompetents who need to be trained and retrained and tested and retested. If they want PAs or physicians on teams then put them on teams (at E-6 or E-7 pay). Otherwise help us with more than rules or regulations. Go with us and train with us. Live with us, see where we go and what we do.'

- Time should be allotted for sustainment training, realistic training, not paper drills. allow rotations through TMC/hospital assigned to SF, PA, or doctor. Allow training with EMT-P ambulance training in high trauma regions. This would also establish/maintain rapport. Allow 18D who have paid dues to become team sergeants/SGM. Certain people have become prejudice in allowing 18D a fair share of the 18Z leadership positions. I for one am ready for the challenge.
- Treat us as the important assets that we are. Those of us who are 18Ds sacrificed a lot to get where we are. Don't chase us away by not offering us the incentive to stay.
- Need more sustainment training. Need to continue EMT-P course for seasoned medics. Need to revise 18D curriculum at 300FI to allow students to challenge the NREMT-P exam or Intermediate at a minimum. Need to place more emphasis on continuing education at Gp, Bn, and Tm levels. Need chain of command at Gps to allow 18D's to attend civilian education classes, TMC, and hospital rotations, and dispense with the attitude that if the medic is not here where I can see watch him he is "getting (over)". Too many weapons men in charge of SF.
- 18Ds normal career progression is to become a PA. Allow this to happen and you can always easily pull them back to group.
- My first two years in SF were very satisfying - team training, cross training, and advanced MOS skills training. Now with the thousands of gates for team certification, all we do is test and certify. SF might as well be Light Infantry.

- Enlighten commanders to the skills required to be a good, well-rounded 18D. Put 18Ds in an OCONUS setting where they can practice a variety of skills to good effect and have Cdr's pay attention. Perhaps then appreciation would follow with less resistance to continued medical training, pro pay, consideration of career goals, etc.

- The SF officers with few exceptions are more of a training distractor than anything.

- If you can't find 18D recruits outside of SF, look in the ODAs. A lot of guys in the other MOSs would like to become 18Ds. Promote the 18Ds with the other MOSs not after. Most 18's get out of the Army because they are dissatisfied with the way it is run. We spend our time doing administrative, logistical and support requirements, and "check the block" when it comes to training requirements. The current low moral is due in part to the officer corps. SF has the best NCOs in the Army, but usually has standard officers who seem to be afraid of giving responsibility to the NCOs. If you don't give NCOs responsibility and good, loose leadership, you stifle his initiative and destroy his morale.

- Stress from the highest to the lowest levels of command the need and importance of good medical training. Get old 18Ds current with new 18Ds (EMT-P). Reevaluate the credentialling program. The points system is difficult to maintain and the booklet is difficult as well. Consider a list of tasks to be performed in a specific amount of time. When it is met, re-start the tasks. The program of maintaining minimum points and constant changing and updating and calculating is confusing. Stop the threat of de-credentialling. What is so bad about refresher training? Give medics the time and support to do medic things. Get Cmds to prioritize what is important and stop overtaxing the first echelon soldiers. A lot of 18D problems are 19 Series problems. SF used to be the best. We have grown too large and claim to be capable of too much, in fear of losing a few senior officer slots. Let's get back to job dedication, not ticket punching and realistic training, not eye wash. Admit limitations and excel in our specialties; do not bite off more than the ODAs can chew.

- Let's face it. We're doing a lot more paper drills now rather than putting out the money and emphasis on long term sustainment training. Of course, this has seriously affected the morale of 18Ds.

- What is the 18D METL? I have never actually seen a printed list. The 18D skill level 3/4 manual is a worthless piece of paper, good only if someone wants a GO/-NOGO checklist. We need a study guide which will assist us in all aspects of the tasks.

- The recent suggestion to reform the 18D Course to eliminate training in disease is ludicrous. In my five years as and 18D, I have never treated a major trauma. I have, however, had many opportunities to treat infectious diseases and dental patients. To remove that part of the training would make 75% of the Medics incapable of operating

in the FID/UW and humanitarian assistance environment. I direct your attention to the many Medreces of the past and the recent experience of 10th Gp in "Provide Comfort."

- You have some of the most highly motivated individuals in the nation's military serving as 18D's. But due to shortages in the MOS, SF treats them like a bunch of bastards, step children, so afraid that they might lose one if they give them a little extra training. The biggest reason that the SF is losing Medics today is due to the B.S. associated with credentialing, no training opportunities, and ITC, instead of real missions. The SF community should be proud of the number of intelligent, highly motivated medics that get picked for PA school, or get out and go to other medical specialties or med school. If the SF used this as a recruiting tool, and actually helped the Medics get the schooling requirements to advance medically, the SF community would probably have more Medics than it needed and the Army would benefit from a large pool of talent to fill its needs in the PA and other medical fields. I strongly feel that a training program which took and in about 6 years took him to PA school would give the SF community all the 18D's it would ever need.

- The 18D MOS is great, but for example, our group turned down two 18D slots to go to Laos, our area of operation, so we can do ITC and JRTC. Not one 18D was released from these requirements. This was realistic training that was thrown away. No excuses for this management. The Bn CDR said that he would have to get an okay from a general officer to release an 18D. I really like the medical field, if I have to retire at 20 years to do it in the civilian world I will, because I am good at helping others and I enjoy it more than being a manager. Thank you for taking the time to create this survey. It feels good that someone cares about us.

- Everything has priority over 18D training. Group will not allow four hours per month to train. Presently I am the only Medic on the team serving a Team Sergeant through Green Cycle. With ranges, certification, common tasks, there is not time for anything in 18D other than basic CPR. So you have to do it on your own, then your family suffers. It is a no-win situation.

- I think more attention needs to be given to the selection of 18D candidates, possibly some type of diagnostic test. Also, some measure of personal discipline. There is much discipline required to make it through 18D training.

- We are losing 18D's because of the actual jobs we are doing in the groups. People go to DEA, etc. not just for the money (it helps), but they get to work as a medic in the real world. The amount of job satisfaction and the meaningfulness of the work varies tremendously between groups.

- Please don't get carried away with changing the 18D selection. Don't get in a hurry to fill the 18D slots with shake and bake medics. If a soldier really wants to be an 18D then he will give it his all. It is B.S. to think that a soldier is forced into a 18D

position. Because if he wanted, like all of us already know, he will go to Ft Sam and fail. get boarded and at the board he'll say "I didn't want to be an 18D; they made me". The board will then give him a choice of another MOS and send him back to Bragg.

- What forces many medics away from group are fundamental things wrong with the group (i.e., lack of missions, certification, the feeling that A-Team members are scab labor, etc..) SF Medics will continue to leave group to go to PA and Medical schools no matter what you offer, though pro-pay may keep 18D's a little longer in the groups.

- I think all 18's should receive pro pay. While attending the SFQC we had SEAL team medics with us. They said that if they completed the Phase IIA and IIB of the 18B course that they would get pro pay. It's our MOS that we do every day but we don't get pro pay.

- I've done a lot of surveys lately about being an 18D. I enjoy the work and responsibility immensely. My reasons for wanting to attend PA school are simple. I want to improve myself. I want to learn a civilian compatible skill. And I want a job that will allow me to serve after my body starts to break down.

- We need more sustainment training. We have a great didactic education, but we don't have the clinical experience consummate with the expectations of our Special Ops community.

- You've asked 95 questions pertaining to my opinion of the 18D field and its future. What an extraordinary waste of time. You know as well as I that my opinion means nothing in the final analysis. Decisions to be made concerning the future of the 18D field will be made with only economics and the needs of the Army in mind. I have been selected to the PA course in the near future. I consider it my only option. I have no intention of staying an 18D or returning to SF as a PA. SF medicine and SF , in general, is a dead end street. SF has been destroyed. It's dead and will not return. I am out of the pool.

- Overall these questions will not result in any changes that will benefit the course. Any and all of the decisions that are made will be based on economic factors and made by people who have spent limited or no time on special forces teams. The emphasis in SF today is on quantity and not quality and SF continues to ignore the real underlying problems.

- Do you want to keep Medics:

1. Allow time for them to retain proficiency.
2. Schedule classes and make-up classes by Bn PAs, surgeons and civilians.
3. Press for command support.
4. Give Pro Pay for having these time consuming responsibilities.
5. Make available educational opportunities.

6. Don't stop the paramedic course-medics need the security of having a comparable skill in case they retire or lose their jobs.
7. Consider opening alternative positions other than Tm Sgt or Bn or Group.
8. Give medics a medical chain of command to insure their continued retraining and proficiency.
9. Open Warrant Officer slot on team for senior medic with time and rank of 18D as determiner.
10. Cut out basic 91B/91A tasks from the SQT and 18D manual.
11. Add A&P retraining, clinical medicine, tropical meds, pharmacology, current drugs, and use physical, exams, tests. Cut the Lab which we never use. Tell us how to do things.
12. Time must be made available for Medics to do their jobs.

- Pulling people out of a group of trainees during the selection phase and making them 18D's is a real bad move. One should be able to choose his line of work, something he could do and want to do. If he can't make the grade then let him try something else. Recycling him over and over until he passes is no good.

- This questionnaire is too late and it completely misses the problem. Trying to retain a bunch of disillusioned 18D's is part of the symptom of a greater problem. The idea of special forces is just about dead in the water. We promote incompetence from within far too often, and we have allowed the officer corps to completely destroy the special operations mentality this unit grew from. It is a sad day as we see the "conventional Army" take over. All these medics look around and decide that there are no benefits to putting up with all of the tribulations of being SF, e.g., 6-9 month deployments, validation (certification, etc.). So why not become a PA or medic in the regular Army? Most of these medics have witnessed the slow death of SF over the past 10 years and will never go back to an A-team.

- Forget this paramedic idea, it is a waste of time. You will never be able to keep them current, even if they are able to go to Trauma centers to work. No established trauma center is going to let a "rookie" work in a life or death situation. Face it, a doctor or a PA will be doing the work. 18D's don't need to work in ER's as much as they need to ride in ambulances. What has happened is that you have half trained a bunch of talented NCOs to do medicine. All of these men are intelligent and have the intelligence to see beyond today. All SF will continue to seek medical advancement because the 18D course gave them too "good" of a taste of how good field medicine is. An 18D is not a PA, better trained than a medic, but unable to "practice medicine." This is unsuitable.

- This was probably a waste of time, because this survey carries little weight and no one listens to us any way.

- If I do not make E-8 at/or around the same time as my peers, I will do everything I can to get out of the MOS.
- Slowing promotions for 18D's is unfair and will drive senior people from the units.
- ATLS and ACLS, good courses but until they can make an x-ray machine that fits in my sack, x-rays are useless. 18D's need to return to signs, symptoms, diagnosis, and treatment (S.O.A.P). Also included should be a more comprehensive lab program. The only time any of us see any lab procedures is ATLS, and then its just two weeks of slides in a 2 hour block. With all of the thousands of other tasks an SF soldier is supposed to be proficient at, at least provide us with the tools to (what you're obviously after with this survey) the "best medics in the world."
- In my opinion it is wrong to assume a Special Operations soldier would be happy pursuing a career in the Army if he knew he would spend 20 years in the same group doing the same things year after year. I believe it broadens ones experiences by being in different groups and being in different parts of the world. I joined the Army for the broad range of experiences and the opportunity to travel to different places. To remain in one group is to be stagnated.
- I think the credentialling process stinks. Some medics for some reason always get the school and points while others might not receive any. EMT-P qualification would keep 18D in service because they earned something in the Army and can strive for more education in the service.
- I'm a discouraged 18D. I haven't had any medical training in 4 years. I am about to go to ATLS and am very thankful for the opportunity. I would like to see an active program to credential 18D's annually, perhaps a mobile team of individuals with command influence to ensure 18D's would be made to complete sustainment training objectives or be non-should.
- You cannot treat intelligent SF medics like morons and expect them to like it, or to let their skills to get rusty and then expect them to work flawlessly in a life threatening situation. Add to this that a lot of medics are forced into the job. There is no upward mobility once you reach E-7, and medics are always critically short-handed so you don't have the opportunity to work at the ER, the local hospitals or with local EMT-P's.
- As of Nov '91, the most immediate issue that needs attention by the USASOC surgeon is "fixing" the situation in TMC 13. Under current conditions, cadre and students of SWCS have to spend an unacceptable amount of time to be seen for medical needs. As a result of the way that is conducted, many men do not seek medical treatment when it is needed because they have to choose between mission/training and treatment. Keeping in mind that I am addressing the problems encountered by senior

NCOs and officers. My recommendation is that SWCS instructors (not staff and support) and students in training be given first priority behind emergencies. Regardless of other options, the specific block of individuals are not being served by the TMC. The current system is a detriment to the individuals and the SWCS system. The majority of the ash and trash that inhabits the system would not even notice. This is a problem that needs some kind of a fix.

- If you are looking to reinvent the wheel, change the 18D course so that medics graduate as EMTs. Touch on pharmacology, lab, PM emergency medicine, but a goal of EMT certification. Keep the goat lab, it's great training. This will shorten the course and get your shortages addressed. Also it is an incentive to come out EMT certified. Then after a couple of years on a team, progress to get the senior medics EMT-P certified. This will give us credit working for other agencies, OCONUS hospitals as well as CONUS. Keep ATLS. Let the groups run the dental and hospital rotations. Get rid of credentialing. Use the saved time and money to support keeping the EMT-Ps certified. I enjoy being a medic but am very frustrated about my credibility on the civilian side. Whatever you do don't try to make a military EMT-P school; the civilians have their act together. We should take advantage of this. If the 18D is not on an A-Team, then he shouldn't go these schools (EMT-P).

- (RC) Being an 18D is a very special job with lots of responsibility. One must love his position and be dedicated in order to be proficient. This can only come from personal interest and desire. The problem with 18Ds leaving for higher level medical jobs in my opinion cannot be solved because there is no civilian equivalent. The 18D course gives you a great taste of medicine but does not fulfill the craving. I love being an 18D more than anything. I enjoy the adventure, responsibility, and believe in all our missions. Although I want to stay an 18D, I still feel the desire to receive a higher medical education and have skill desirable for a civilian job. As a National Guardsman my biggest frustration is having all this training and not being able to get a civilian equivalent job which would fulfill my interest and most importantly help me maintain my skill and make me a better medic.

- (RC) I feel that for those of us in the Reserve or Guard EMT-P or at least EMT-I or LPN can enhance career longevity. Because if you don't have a civilian job, you must either spend time finding one or go to another school. Also, most 18Ds want a medically oriented job which is close to their skill level.

- (RC) (1) Training: My 18Ds receive very little medical training. We need more opportunities, training time, not testing time. MEDCAPS should be excellent opportunities to practice what we have been taught, plus a real morale booster. (2) Supplies: I order much needed medical supplies year after year with no results. It's a disgrace to the U.S. Army and certainly to the 18Ds to deprive them of necessary medicine and equipment to adequately treat their men. Some medicines do expire, they must be updated. (3) All 18D's must have at least annual training besides ATLS etc to stay

current. (4) It certainly wouldn't hurt to recognize the 18D Medic for his devotion to his training, men, mission. I feel this is certainly neglected at this time. Is it no wonder that there is a shortage of 18D's?

- (RC) Currently a well-trained amoeba could do my job. I have not been able to do my job due to lack of sustainment training. It is not hard to tape ankles, hand out Motrin, or give out Moiskin. I have never been able to acquire the proper equipment of medicine. I usually have to ask doctors for it at my own expense. That is absurd. I would be willing to give up some of my weekend time to train at facilities. However, remember two things: (1) The Army does not pay my bills, therefore do not ask me for my work time. I am employed in the medical sales area and my time literally is my money. (2) I do not intend to go to an Army facility and empty bedpans. I am not above this. I have done it before and will do it again, but I am not going there to train to be an orderly.

- (RC) The paramedic opportunity is the most encouraging program for Medics to come along. It should increase re-enlistments (for 18D's) measurably, as well as increase proficiency.

- (RC) Recently I left the active Army after 10 years as an 18D/91B. If there had been more options or career progression pathways into professional medical fields, it would have affected my decision to ETS. Currently a medic has limited progression if he desires to remain working in medicine. Gp Medic slots are usually held by medics incapable of deploying. Medical career progression outside of the SF community is very difficult. PA candidate requirements, for example, require a level of education that is very difficult for an SF medic to attain who is doing his duty on an A-Team. An alternate career path must be made available for those medics who wish to remain in the career field. If this is not the case, SF will continue to hemorrhage medics who desire to remain in medicine. After serving as an instructor at the SOMED course in Ft Sam, I would like to say that the 18D's graduating from the course today are a superior medic to the ones that graduated in my class in 81. Medical skills and medicine are equivalent, but today's medics have superior trauma management skills.