Strategy Research Project

PHYSICIAN RETENTION IN THE ARMY MEDICAL DEPARTMENT

BY

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PHYSICIAN RETENTION IN THE ARMY MEDICAL DEPARTMENT

by

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PHYSICIAN RETENTION IN THE ARMY MEDICAL DEPARTMENT

As the Long War enters into its ninth consecutive year, the United States military struggles with the task of maintaining the all-volunteer force. This challenge is daunting for leaders of the Army Medical Department (AMEDD), particularly in the arena of manning the objective force with physicians. This is accomplished through procurement and retention. Procurement is the way the Army brings doctors into the force and it's done through the Uniformed Services University of the Health Sciences (USUHS), the Health Professions Scholarship Program (HPSP), and direct commissioning of fully qualified physicians. In Fiscal Year 2005-2006, the breakdown between those sources for Army physician accessions was USUHS – 19 percent, HPSP – 71 percent, and direct commission – 10 percent.[1] Since HPSP accessions represent the overwhelming input of physicians into the Army, the fact that the Army did not meet its HPSP recruiting goals from Fiscal Year 2004 to 2007 gives reason for concern.[2] Therefore the AMEDD must develop a comprehensive focus on retention of its physicians. This is particularly difficult assuming that a protracted war is chief among reasons for both not joining and for departing at the end of one's Active Duty Service Obligation (ADSO). Although robust recruiting efforts are required, particularly in the primary care specialties given the downward national trend for them, the AMEDD must focus on its physicians already in uniform.[3] Much like a tourniquet is preferable to a blood transfusion, retaining one experienced doctor is more beneficial to the force than recruiting and training a new one. With a nation-wide primary care shortage predicted to be between 35,000 and 44,000 by the year 2025, retention is becoming even more important.[4]

The civilian physician workforce in the United States has been a growing entity over the last several years due to increased demand and increased quality of life.[5] However, the Army Medical Corps budgeted end strength is set by law and fluctuates as the size of the Army does. Unlike in the civilian workforce, where doctors often work well into their sixties and beyond, Army doctors can retire from uniform after twenty years of service. Additionally, many leave long before they are eligible for retirement. They forego the generous pension offered in return for career military service in lieu of lucrative salaries that can make early departure a fiscally superior option. Head hunters value the phenomenal training that most Army doctors receive in military Graduate Medical Education (GME) programs, and do their best to lure them out of uniform.[6]

Primary care specialty billets in the AMEDD are some of the most challenging to fill. These are specifically Family Practice, Internal Medicine, Emergency Medicine, and Pediatrics. The national trend for medical students to pursue more lucrative and less time-consuming specialties is replicated in the Army. This dearth of primary care doctors presents a challenge to the AMEDD as it tries to fill all of the Field Surgeon slots at battalion and brigade equivalent levels. Fifteen years ago, these jobs were filled by General Medical Officers (GMO) -- graduates of internships who spent some time "muddying their boots" in the field while waiting a year or two for the residency position of their choice. Today, the GMO is an endangered species. In an effort to provide the best level of care to the force, the AMEDD decided to field board certified Field Surgeons – largely from the primary care specialties. This puts further strain on the force needed to man Medical Treatment Facilities (MTFs), and the challenge is greater than ever with the Army's unprecedented number of wounded warriors. Though the

Army can provide medical care from contractors in its MTFs, uniformed physicians are needed for deploying units

The Top Three Factors Impacting Physician Retention

Several factors impact whether a doctor decides to stay in the Army or leave. Currently, the issues that are foremost include combat deployments, administrative burdens -- the onerous electronic medical record known as the Armed Forces Health Longitudinal Technology Application (AHLTA) being chief among them, and bonus pay issues.[7]

Combat deployments are a given for the force for the near future. The Long War is recognizing some gains for the U.S., particularly in Iraq; however, Afghanistan's future is uncertain. Clearly, American forces will deploy for the foreseeable future in response to Americas contingencies. Therefore, Army physicians will continue to deploy to provide the healthcare that is expected and needed by our forces. Deployment weighs heavily in the consideration of Army physicians' job satisfaction. Paramount in this consideration is deployment length – a factor for which there is great disparity among physicians. This lack of equity contributes to decreased morale.

For surgeons and other sub-specialists who deploy as part of the Professional Filler System (PROFIS) or as individual augmenters at echelons above division, the standard tour is six months. For field surgeons and operational medical specialists (60A), the standard tour now is twelve months. In the spring of 2007 when the "Surge" in Iraq was announced, all active duty Army units were extended from their twelve month tours to fifteen month tours, and the physicians serving in those units who were not surgeons or sub-specialists were extended as well. Air Force physicians typically

serve four month tours like the rest of their force, and Navy physicians, largely in support of Marine units, serve a seven month combat tour.

The “Surge” in Iraq and subsequent extension of units in Iraq and Afghanistan are of particular concern in regard to retention because the extension, for several units, was unnecessary. The purpose given for the extension was solely to increase Brigade Combat Team (BCT) dwell time.[8] Too many BCTs were returning from deployments and having to turn around in ten-to-twelve months and return to theater. This situation was untenable, and the Army desired a twelve month dwell at a minimum with twenty-four months being ideal. When medical units at echelons-above-division were given this extension, the purpose of BCT dwell time had no relevance. The time-honored tactical adage of “purpose drives task” was ignored. Neither the Army nor the AMEDD gave a purpose for medical unit extensions. Furthermore, the AMEDD was in no position to argue against the extension of units that, in the worst case, had a twenty-two month dwell given a twelve month deployment scenario. The black eye from the Walter Reed dust-up and the firing of the Walter Reed Commander and the Army Surgeon General left the AMEDD in a credibility gap. Despite the admirable work of the Army’s Acting Surgeon General who worked tirelessly to rehabilitate a tarnished AMEDD image, those medical units stayed for the fifteen month duration in order to increase BCT dwell time.[9]

Several studies have demonstrated how lengthy combat tours are demoralizing, but length is not the only factor. Equity contributes largely to how AMEDD physicians view their tours. The varying tour lengths previously mentioned demonstrate such inequity, but the populations who are more prone to deploy, such as brigade and

battalion surgeons also experience different treatment. Majors embarking on their third or fourth tour harbor disdain for the Colonels who haven't served one. Even though there are good reasons for certain ranks to be more frequently deployed, those reasons don't assuage the ill feelings.

The administrative burdens placed on AMEDD physicians drive many to leave the Army at the end of their ADSO. The staffing models for Army facilities (MTFs) often don't measure up to those of the civilian medical market. Army doctors complain that they spend too much time on tasks that should be performed by ancillary support personnel.[10] Chief among the administrative burdens is the military's electronic medical record known as the AHLTA. Army physicians have criticized AHLTA for its non-intuitive methodology, its frequent downtime, and the extra time it adds to patient visits and end-of-day documentation because of its inefficiency. Users claim that it is data-driven rather than patient care – driven. Many Army physicians regard the Veterans Administration's electronic health record, Veterans Health Information Systems and Technology Architecture (VISTA), as a superior tool and wish the Department of Defense (DOD) would just scrap AHLTA and adopt VISTA. However, debate continues over VISTA's ability to perform the combat applications available in AHLTA. Dr. S. Ward Casscells, the Assistant Secretary of Defense for Health Affairs, is planning for a converged solution in which the DOD would take the best of AHLTA and VISTA to create a functional hybrid.[11]

Pay concerns among Army physicians is a factor in retention. Many are lured out of uniform at the end of their ADSO by lucrative job offers. This is more of a temptation for surgeons and sub-specialists whose Army pay is a small fraction of what their

earning potential is in the civilian world. However, even primary care physicians can find comparable or better salaries on the outside, and often these jobs entail less work, improved ancillary support, and better family stability. Although not the predominant factor in retention, pay will always play a role.

Recommendations for the Top Three

The Army must make six month deployments universal for all PROFIS providers in order to instill more equity into the deployment process. Certainly, brigade and division surgeons will stay on deployment for as long as their units do because they belong to those units full-time. This new six month deployment does have a disadvantage in that non-physicians, both in and outside the AMEDD, will experience inequity in regard to the doctors. Additionally, battalions that rely on PROFIS physicians will have to replace their doctors during the middle of their tour, perhaps in the midst of dangerous combat operations. However, this is a risk worth taking if it will keep more doctors in uniform. Given that deployment length and inequity is the predominant force causing physicians to leave the Army, this step is necessary.

Conversely, the Army could mandate that all physicians, regardless of specialty, complete twelve month deployments. This would fix the inequity issue among specialties, but it is likely that the tour length issue has the larger impact. Six month deployments for surgical specialists came about because of alleged degradation of skills in a combat environment. Many surgeons serving on forward surgical teams would sit idle for weeks at a time while being over flown by MEDEVAC helicopters ferrying casualties to fixed facility hospitals with more advanced capabilities. Furthermore, for surgeons who did stay busy in the operating rooms, the lack of

endoscopic cases in combat guaranteed a degree of erosion in such skills which are necessary back at their MTFs. The narrow focus of damage control surgery for extended periods of time tends to dull the skills required in the myriad of surgical scenarios that our non-deployed surgeons face in MTFs. Therefore, having surgeons deploy for a year is a non-optimal solution. The exception here is for surgeons who are in command of forward surgical teams or hospitals; they should remain with their units for the entire deployment.

In addition to deployment length, physicians tend to complain about their utility on a deployment if they are not serving in their trained specialty (e.g. a dermatologist serving as a battalion surgeon and providing primary care rather than dermatology) or if they believe that they are underutilized or not needed.[12] One PROFIS family physician explains the issue thusly:

> Two years ago I nearly left the Army despite having 15 creditable years and 4 years of USU in the hole, solely due to 6-plus month deployments. After being in Iraq for a year, seeing how easy and seamless it would have been to sub me out of a battalion surgeon job at 6-9 mos yet no one even tried, I decided that's where I would draw the line. With my family consisting of four teenagers and a stressed home-schooling wife, and Army families crumbling all around me due to wartime stress, I had to put my family first. It was only a very attractive job with a low risk of long deployment that kept me in.[13]

Although it is sometimes necessary to put a square peg into a round hole, like in the case of the dermatologist serving as a battalion surgeon, the extent to which the personnel and PROFIS system can minimize this will be appreciated by the physicians who just want to practice their trade. In regard to physicians who are deployed where they are not needed, the Surgeons General of all three major services should advocate for a joint medical command wherever our forces deploy. This would streamline medical care for these theaters and eliminate the need for excessive physicians being

deployed. For instance, when the Army stood up a Combat Support Hospital in al Anbar Province, Iraq in order to provide state of the art care to the Marines in March 2007, the five Navy Forward Resuscitative Surgical Sections remained in al Anbar. The goal of economy of force was not realized, and excessive surgeons remained in theater.[14] It seems intuitive that as the Army and Navy medical systems in the National Capital Region and the Army and Air Force medical systems in San Antonio merge functions under the Base Realignment and Closure (BRAC) execution, the same kind of synergy should be applied in our combat theaters. The Assistant Secretary of Defense for Health Affairs should mandate an end to this service parochialism which results in excess deployment of low-density assets. However, a joint medical command alone will not completely solve the problem of duplicity, because it would likely reach no further down than the hospital level. Surgical teams are doctrinally allocated to brigades and regiments. Therefore, leadership and doctrinal changes are needed to prevent commanders from holding on to these teams once the theater matures.

AMEDD physicians also express disappointment with lack of deployment predictability and a tendency for short notice deployments.[15] Again, the personnel and PROFIS systems play the lead here. Specialty consultants to the Army Surgeon General also have a role. The larger the specialty population is, the harder it is to manage. For instance, a plastic surgeon (small population) will typically deploy as either a plastic or general surgeon. There are a finite number of such positions in each theater, and that number is well known by PROFIS planners. By forecasting six-month deployments longitudinally for at least three years out, the plastic surgeon consultant can fill the necessary slots with volunteers given that he knows the requirement.

Furthermore, he can do this on a voluntary basis in which surgeons can choose the time of their rotations. If a surgeon can have a predictably timed deployment with a predictable frequency of deployments, he tends not to complain. However, with large populations such as family practice, providing such predictability becomes more challenging, but the same process can be applied. Additionally, leaders down to the department level must make the hard decisions about filling necessary slots. Oftentimes, they procrastinate to avoid giving their junior doctors bad news about a deployment. However, the news is much better when there is ample planning time. It's impossible to eliminate all the short notice "hey, you" taskings, but diligent forecasting of the requirement can go a long way in securing physician loyalty and understanding. The degree of unpredictability likely peaked during the "Surge" in Iraq, so hopefully physician tolerance regarding this is past its nadir.

Finally, in the large and consequential vein of deployment-related service departures, the AMEDD must focus on its women physicians as a key constituent. Women account for fifty percent of all medical students today but only account for twenty-two percent of the Army physician ranks.[16] Deployments impact to a greater degree women's decisions to leave the military than men's decisions.[17] For those with children, deployments cause unwanted family separation. Despite the success of the feminist movement over the last few decades, mothers are still less tolerant of being separated from their children than fathers are. Their innate tendency to be nurturers struggles with their military obligation. Admittedly, this belief is a generality, but it is hardly provocative. Furthermore, women who are planning on having children struggle with the probability of getting deployment orders. They desire proper time after giving

birth to spend with their child before having to deploy. The AMEDD should, to the greatest degree possible, guarantee a generous amount of post-partum non-deployability in order for mothers to bond with and nurture their children.[18] The Army changed the policy from four months to six months in August of 2008, and that appears to be a step in the right direction.

As AHLTA complaints abound, the AMEDD must adopt a strategic communication program geared toward its physicians. Many complain about poor communication as a source of their frustration.[19] AHLTA is a leviathan and will not be idealized overnight. Its clinical data repository is the world's busiest Oracle database and handles more transactions in a second than that of any other organization.[20] In an electronic town hall meeting initiated by Dr. Cascells, the majority of military healthcare respondents had negative comments about AHLTA, and some were vitriolic.[21] Top-down updates via streaming video on the internet and e-mail messages updating physicians on AHLTA improvements are a must. This can make the difference between an informed force and a hopeless, cynical one. Additionally, the AMEDD must spare no expense in software, hardware, and intellectual capital. One promising tool is the Dragon NaturallySpeaking® Medical software from the Dicataphone Healthcare division of Nuance Communications, Inc. This voice recognition software has shown that it can speed documentation and decrease physician workload. In a survey of seventeen Army, Navy, Air Force, and Marine Corps MTFs, 79.9 percent of respondents chose Dragon as their preferred method of documentation for AHLTA.[22] However, Dragon is not universally deployed. The AMEDD must make this tool available to all its clinicians and contract for the New Equipment Training that it requires.

Financial incentives for retention of military physicians were first implemented in 1974 with the Variable Incentive Pay.[23] Since then, DOD has modified its bonus pay for physicians a few times. However, there have been no major changes since 1991. There are currently five categories of bonuses: the Medical Additional Special Pay (MASP) is a yearly bonus given to doctors who sign a contract to serve another year; the Variable Special Pay (VSP) is a monthly sum given to all doctors (including those still in specialty training); the board certification pay is another monthly sum for those who achieve and maintain certification in their specialty; the Incentive Special Pay is a yearly sum determined by the specialty; and the Multi-year Special Pay (MSP) is a yearly sum given to those who contract to stay in uniform for a certain number of years past their ADSOs. Recent increases in the MSP have improved retention, but experts question whether or not this trend will continue. Besides, the military will never match the pay that civilians can earn in comparable jobs. Some even suggest that pay is overrated as a retention factor.[24] Nevertheless, pay will continue to surface as a relevant issue, and the military must continue to reevaluate the compensation of its physicians in order to maintain an all volunteer force.

Because of the lengthy service obligations of United States Military Academy (USMA) and USUHS accessions, this special population deserves attention. In particular are the doctors who attended both USMA and USUHS. The same is true, but to a lesser extent, for USUHS graduates who owe time for an ROTC scholarship. Once many of these physicians begin to pay back an ADSO of well over a decade, they are already majors with eleven or more years of commissioned service. Initiating an MSP

contract in order to garner the accompanying financial incentives is daunting even if they are eligible for the MSP. As one surgeon explains, he's frustrated with the:

> lack of appropriate compensation-for example since I'm West Point/USUHS & did a sponsored fellowship- committing me to 22yrs of service I'm really NOT eligible for the"new" MSP bonuses-which would require me to commit myself to 26yrsof service…Thus my partners-some lesser rank than me-now make $76,000 MORE a year than me doing the same job! I should be paid for my job, not based on how much time I owe. I feel I'm being treated unfairly.[25]

The AMEDD should look at the feasibility of allowing concurrent payback for undergraduate and medical education. Doctors who are so invested in the military are highly likely to stay in for a career anyway, particularly if their eligibility for special pay is not hampered by their commissioning source.

An additional tool known as the Critical Skills Retention Bonus (CSRB) is also available. The Air Force successfully used this recently when it faced a critical shortage in its surgeon population. Like the MSP, the CSRB contracts a doctor to stay in uniform beyond their ADSOs for a certain duration, and the yearly amount paid increases as the length of the contract increases. Although historically reserved for surgeons and sub-specialists, the shortage in primary care providers might very well suggest that this under-strength population merits this bonus.

Other Corporate Inputs

The Army Medical Corps has the only branch office at U.S. Army Human Resources Command (HRC) that is not largely represented by its own officers. For several years, the only physician assigned to the branch office was the branch chief. The other officer personnel managers have been largely Medical Service Corps officers. They perform tremendously, but as non-physicians, they have potential for a lack of

empathy with their customers since they have not been similarly trained. In most all other branch offices from Armor to Signal Corps, the personnel management of Army officers is handled by same branch officers. The logic behind this staffing model for Medical Corps branch was obviously to keep as many doctors as possible available for patient care – their primary mission. However, recently the Medical Corps has added an additional physician slot at the HRC branch office in the grade of O-5 to O-6. This person is the deputy chief, and his addition has made a palpable impact. It may not be prudent to staff all positions at branch with doctors, but the addition of a senior O-4 would help. This mid-level doctor would be a peer to most of the doctors who are nearing the end of their ADSOs. He would have the most understanding of their issues and would relate to them best. Obviously, as with all other HRC officer selections, the AMEDD needs to select a truly positive and charismatic role model. This more tailored version of customer service could positively impact retention.

Schooling has been used as an incentive for continued service for many years. Professional development schools such as the Command and General Staff College and the Senior Service Colleges carry with them an active duty service commitment upon completion. The AMEDD has used this tool for physicians who have pursued masters degrees in public health and healthcare administration. The healthcare administration program is offered at the AMEDD Center and School through Baylor. There are a few programs approved by the AMEDD for doctors to pursue a masters degree in public health. However, most are tied to additional specialty training, and the choice of schools is limiting. Many physicians take classes at night and/or on weekends in order to these advanced degrees. Certainly, public health expertise

comes in handy for many physicians who manage large populations such as division and corps surgeons and hospital commanders. There are several doctors who would opt for the university of their choice and add two years to their ADSO for the one year of education and stabilization. In essence, this would be the medical corps equivalent of the Long Term Health Education program currently offered to other AMEDD branches. This type of incentive has proven its utility in extending the ADSOs of USMA and ROTC cadets upon commissioning.[26]

In addition to educational incentives, many physicians would opt for unpaid sabbaticals.[27] These breaks in service would be an opportunity for Army physicians to take a break from the deployments, maximize family time, or even start a family. Additionally, physicians could use this time to evaluate civilian healthcare. Many would find that the grass isn't necessarily greener out of uniform.[28] Upon completion of the sabbatical, the officer would return to the Army for continued service. There is precedent for this in that Mormon cadets are allowed to leave service academies for their two years of missionary work and then return to school when their religious obligations are complete.

The Less Tangible Factors

The senior AMEDD leadership is well-aware of the top three retention-related problems and will, no doubt, diligently and aggressively address them. With a good information campaign directed at Army physicians, the changes which will be implemented can cause a significant improvement up front if doctors just know that these changes are coming. However, there are additional remedies that can be applied at much lower levels. Positive actions from hospital commanders, service and

department chiefs, residency directors, attending physicians, chief residents, and the like can go a long way in making a young doctor decide that the Army is a good place to practice medicine.

The Medical Corps has made tremendous gains in its professionalism in the last two decades. As recently as 1990, during Operations Desert Shield and Desert Storm, physicians dominated the AMEDD as a result of their branch rather than their merit. With the exception of the 307th Medical Battalion, all medical units that had been commanded by non-physicians prior to deployment had their commanders replaced by physicians upon deploying.[29] In many instances these doctors were not prepared for the responsibilities of command. It was not their fault; they had just not been professionally developed for such a responsibility. Additionally, many had never spent time in deployable units, and this was their first experience outside of fixed facility hospitals. Today, command positions in the AMEDD are branch immaterial. Doctors must compete with nurses, operators, medical logisticians, physician assistants, and all the other officer categories for the privilege of command. Thanks to the AMEDD's investment in and insistence upon physician professional development, Medical Corps officers are competing very well and are now earning their positions via merit. This evolutionary improvement is likely to continue as more young Army doctors progress through the ranks and gain more influence. One byproduct of the Long War is that so many of the AMEDD's captains and majors have deployed to combat – in many cases, multiple times. Such exposure to the operational Army leads to cross-pollination, increased professionalism, and credibility with the combat arms and combat support

sides of the Army. Furthermore, these young doctors are more invested in their Army now than they would have been in a non-deployed, peacetime Army.

Good leadership is vital to any organization, and the AMEDD is no exception. It must be emphasized at all levels with as much empowerment of junior leaders as possible. In his leadership book, It's Your Ship, Captain (Ret) Michael Abrashoff details his experience as the commander of the USS *Benfold*. In this entertaining and admittedly self-aggrandizing management primer, he explains how he transformed the crew of the *Benfold* with leadership techniques that he had learned from both positive and negative examples. By empowering his sailors and implementing their good ideas to the greatest degree possible, his retention rate in his two most critical categories went from twenty-eight percent to one hundred percent.[30] Taking this concept to the extreme, Google is an entirely bottom-up innovator. The company doesn't plan what products or markets to enter; it relies on the ideas of the employees.[31] It's hard to argue against Google's success, but it's also clear that the AMEDD can't become quite that bohemian. However, Google's example illustrates the need to leverage the innovative and cognitive power of the rank and file. AMEDD leaders must value the insights of junior physicians. Given the operational tempo of our Army and AMEDD over the last seven years and the experience gained by the captains and majors, it is likely that these young officers represent some of the best and brightest. They have a tremendous amount to offer, and empowering them gives them more ownership.

Retention of enlisted soldiers in the Army is a formalized process. Career counselors are assigned at battalion level and above. Their job is to track all soldiers who are nearing the end of their enlistment windows. These counselors explain to

soldiers the benefits available to them such as re-enlistment bonuses, military occupational specialty reclassifications, assignment or stabilization options, and schooling opportunities. Every unit is given retention quotas for initial term, middle term, and career soldiers. This data is tracked and briefed to commanders routinely at command and staff meetings. Soldiers who opt not to re-enlist are usually compelled to meet one-on-one with their first sergeant, company commander, and battalion command sergeant major before the Army gives up on convincing them to re-enlist. In some units, the soldiers must go even higher.

No such human rigor is applied to Army physician retention. When an Army doctor is nearing the end of his ADSO and decides to leave the service, he is considered a loss. Sometimes, he's offered a geographical assignment of choice in return for putting in another couple years. However, the MSP and the MASP are the only formal incentives because they offer additional pay for staying in for at least another year. Furthermore, they are offered at corporate level. There needs to be a retention program down in the trenches where the AMEDD's physicians work. Hospital commanders possess adequate human resources to initiate physician retention programs that parallel those of enlisted soldiers. Every hospital has experienced, role-model physicians who can serve as mentors to young doctors who might not be aware of the myriad opportunities available in Army medicine. Physician leaders need to take ownership of physician retention rather than wait for HRC to staff their organizations when their personnel leave the Army. Commanders should sit down with those doctors contemplating departure and share their wisdom with them. Just knowing that the boss cares is a nice shot in the arm for the doctor who struggles to meet all administrative

and patient care requirements and rarely gets to see the boss. Perhaps the Office of the Surgeon General could craft a policy spearheading this initiative. In addition to the time and labor investment for the local physician retention program, commanders should formally recognize those doctors who choose to stay in uniform. On the enlisted side, the Army conducts formal re-enlistment ceremonies. However, there is no such opportunity for officers. Instead, a simple recognition at the monthly awards and promotion ceremony would suffice. A $3.95 commander's coin of excellence is not too much to spend for the continued selfless service of a seasoned clinician. Praise is the breakfast of champions.

Morale is a key component to any organization. When it is high, the hospital or clinic is more likely to perform in its band of excellence. Such performance makes the members feel like winners, and these feelings improve the likelihood of retention. Like most other highly-functioning demographics, doctors like to compete. They had to do so academically for many years to get where they are. Competition is a proven ingredient in improving morale.[32] A clinic chief can lift morale by merely forming competing teams along the lines of relative value units, customer service, chart completion, or any other metric of value. Besides bragging rights, a leader can tie other incentives to winning that are within the purview of his authority such as scheduling priorities, time off, awards, and funding for attendance at medical conferences.

Oftentimes, when a soldier leaves the Army, he does so because of family. Many soldiers would continue to serve if their families approved. However, many families cast the deciding vote, causing soldiers to pursue civilian careers. In this respect, Army doctors are no different. The social aspect of Army life is paramount to

the family's experience while their sponsor is in uniform. A robust social structure provides support, information, and emotional comfort, especially in trying times such as deployments. Family Readiness Groups (FRGs) are the Army's answer for providing this social structure. In deployable units, they are usually robust and receive support from Family Readiness Support Assistants. When the units are deployed, FRGs are the conduits for commanders to keep families informed of unit activities in the theater of operations. They also have regular social gatherings and are a source for support and information for everything from child care to medical access. Highly functioning FRGs actively embrace families and make them feel like part of the unit family. This sense of belonging gives the soldier's family more ownership of the Army.

The Army's MTFs are where most of the Army's physicians are assigned. They also serve as the source for most PROFIS doctors because the facilities are non-deployable. The AMEDD puts these PROFIS physicians on orders, and they deploy with units. In a typical scenario, Dr. Jones from Ft. Lewis, Washington receives orders to deploy with the 115th CSH out of Ft. Polk, Louisiana. His family is embraced by the 115th CSH FRG, and gets all their info via the internet and telephone. Dr. Jones' family is not unique, because scores of families from treatment facilities all over the world are in the same situation. They are connected information-wise; however, the social bonds and support aspect of the FRG system is not within their reach. Commanders of the Army's medical treatment facilities should play a more active role in promoting, and in some cases, building their own FRGs. By taking and retaining ownership of these families, the commanders will demonstrate the Army's commitment to families.

Although the deployed physician can easily bond with his new team, the family's bond is much easier with the local unit that stays home.

Conclusion

AMEDD physicians are a vital component of the Army force structure. Recruiting trends over the past few years demonstrate the need for a comprehensive and robust effort in retaining the physicians already in uniform. Since deployments top the list of grievances, an aggressive effort at optimizing the length of deployments and their equity and utility among physicians will help keep many doctors from leaving. Additionally, improving clinical efficiency and pay discrepancies will help with morale. Novel ideas from the ranks such as the allowance of breaks-in-service and educational incentives may succeed as well and deserve careful consideration by the AMEDD leadership.

However, if a retention program is to be comprehensive, it must permeate all levels of the AMEDD. Just like politics, all morale is local. Physician leaders at all levels must own this issue and incorporate aggressive local retention programs. Ignoring retention is akin to ignoring patient safety. Mentorship of the junior and mid-level AMEDD physicians will pay large dividends. Unlike the other AMEDD branches, the Medical Corps is handicapped in leader development by virtue of the four years of medical school and subsequent years of specialty training. It can ill-afford a passive stance by any leader in its ranks.

Endnotes

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