MILITARY GRADUATE MEDICAL EDUCATION: A 21ST CENTURY LOOK

"A PRO-BONO STUDY"

INITIATED AND CONDUCTED UNDER THE AUSPICES OF THE HEALTH AFFAIRS DIVISION, NATIONAL DEFENSE INDUSTRIAL ASSOCIATION (NDIA)

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Military Graduate Medical Education: a 21st Century Look

Executive Summary

Graduate Military Medical Education (GME) has been a core competency within the Armed Services for decades. The programs have remained in high esteem by the accreditation groups such as the Residency Review Committee and the individual professional specialty boards. The graduates of the programs have achieved prominence in practice and academia.

Over the recent years, the cost and value add of the GME programs has always been debated. There is no question of their value. However, the program analyst(s) of the Department of Defense (DOD) may see it as an indirect value and contemplate the removal of the program when stacked and racked against direct value needs.

The 21st Century brought war in the Middle East, September 11, 2001, the Quadrennial Defense Review (QDR) and Base Realignment and Closure (BRAC). TRICARE is now invoked for life and major portions of healthcare delivery under TRICARE are not at military facilities. The creation of "Centers of Excellence" at military healthcare facilities is diminished under TRICARE rules because of the freedom of choice to determine point of service.

At no other time have so many critical factors collided. It is a good time to analyze GME in the military. Can we sustain it? Should we sustain it? How big should the program(s) be? Where should they be? How should GME governance be constructed for the 21st Century? These are questions that are critical.

This study looks at the past studies, leaps into the milieu of the present through discussion groups, and extracts a series of assumptions and recommendations. The major recommendation is:

The Surgeons General, the Joint Chiefs of Staff and the ASD (HA) must develop a clear, unified vision on military GME for the 21st Century. A variety of options or mixture of options could weave the fabric of a flexible, reliable, sustainable infrastructure for GME in the military. We must not sacrifice quality nor exceed our capacity to support quality GME.

To accomplish this, a series of high-level participatory workshops should be directed. The time is right – the individuals in the responsible positions are the right group to tackle this – there are people who are willing to help the process work – a 21st Century vision is NECESSARY – NOW.

FORWARD

This study of Graduate Medical Education (GME) in the United States Military was conducted by the National Defense Industrial Association (NDIA) as a pro-bono project of the Health Affairs Division of the NDIA, sponsored by the Surgeons General and the Office of the Assistant Secretary of Defense for Health Affairs (ASD-HA) and authored by John S. Parker, MD.

The concept of the study was simple and meant to capture new thinking pertinent to the promulgation of GME within the construct of a transforming Department of Defense (DoD). This was accomplished by reviewing previous studies. Conducting interviews and sponsoring group seminars designed to collect thoughts and hear prepared presentations from the various sectors and players within GME. Reviewing the collected information gathered from those meetings. Circulating a rough draft and then having discussions over that draft report. Authoring a final draft of the report and delivering it to the sponsors. The NDIA will continue to assist the medical departments of the Services and OSD (HA) as needed by making the author or others available to them.

The makeup of the report is Executive Summary style. Assumptions and facts are listed. Recommendations are made. The report is developed to be easily read and serve as a major discussion stimulator for the DoD Healthcare leadership.

John S. Parker, MD, FCCP, FACS, Major General MC, USA (Ret.) was the study chair and reported to Julie Susman, Director of the Health Affairs Division. Dr. Parker was assisted by (in alphabetical order): Stewart Baker, Barry Bates, Emanuel Cassimatis, Andrew Cornell, Grace Demaio, Earl Fauver, Brian Hurley, Ray Leahy, Sherry Mills, Elizabeth Smith, and Julie Susman. Each of these individuals participated in at least one seminar, workshop, or management teleconference. Their questions presented to the principals during the seminars combined with comments and reflections were a critical part of the Study Chair's report.

LOOKING BACK TO PREVIOUS STUDIES

There are some observations that can be made from two prior studies of the military Graduate Medical Education system, excerpts of which follow. Reputable, responsible individuals authored these studies. They had national reputations within the GME community and in the Armed Forces Medical Departments. The circumstances of the reports were meant to be a "rebuttal" or academic argument for the continuance of GME with small changes in its form and regulation. They were not meant to be iconoclastic in nature.

There are some observations you can make from these study excerpts. They were both built as "defensive briefs." They have information and recommendations that are pertinent today for the sustainment of a GME system. Although they were ten years apart, the themes were the same and visionary objectivity against a changing DOD was not there – preservation and protection was the argument and clichés such as retention, quality, and recruitment that we use today were found throughout the studies. In fact, the recommendations demonstrated a strange similarity.

Times have changed. The DoD is thinking about doing things differently. Priorities, funding streams, organizational structures, healthcare infrastructure and most importantly people have changed over time. The medical leadership is willing and more than equipped at this time to TAKE THE RISK and agree that there may be a dichotomy between the cultural "lure" of GME and the reality of our times. A critical re-look at DoD-sponsored GME is needed today. The King may not be naked – but his clothing is tattered.

Consider the following excerpts from prior studies.

Study: 1987 Society of Medical Consultants for the Armed Forces (SMCAF) White Paper: "Military Graduate Medical Education Under Stress"

Introductory comments:

The quality of medical care is directly related to GME. This is considered to be axiomatic in university medical centers and throughout the civilian medical community. The quality of military medical care is equally a dependent function of GME.

GME is the keystone supporting the entire voluntary military medical structure for quality health care delivery in time of peace and war. The very existence of GME programs in the DoD is threatened by intrinsic and extrinsic forces.

These include advisory/directive actions reflecting Congressional phasing-down (right-sizing) the military budget without adjustments for the impact of inflation, the rising cost of medical care, and the cost of adding technology which is continuously coming on line.

Readiness requirements are threatened by the downsizing of military hospitals toward dispensary or outpatient facilities, with loss of clinical practice and experience with the more severely ill. Of equal importance is the impact of active duty dependents and retirees being increasingly denied access to military medical facilities due to shortages of professional personnel, ancillary manpower, supplies, equipment and funding.

Most of these events are in direct opposition to the criteria for minimal educational experience recommended and required by the Accreditation Council on Graduate Medical Education (ACGME) in the training of medical and surgical specialists. The TRICARE initiative, accelerating externalization of health care, may further compromise provision of GME.

Out-of-service graduate medical training, although a necessary and important adjunct, is no substitute for a sound and stable in-house effort. Cost accounting of military medicine should not be permitted to destroy military medical education. The latter cannot be replaced like equipment, and each cut-back may require years to recoup.

Recommendations

- Maintain full operability of Army, Navy and Air Force teaching facilities.

- Provide priority staffing with adequate ancillary support to assure the productivity of the facilities' health professional staff.

- Be attentive to ACGME staffing criteria. Every possible means should be undertaken to ensure a stable academic faculty, particularly for the position of Program Director.

- Provide the teaching staffs of those facilities with the technology and tools to practice and teach state-of-the-art medicine.

- Restrict with catchment areas of military teaching hospitals the exodus of beneficiaries to out-of-service medical care. Provide for and encourage the transfer of patients in need of tertiary care from outlying areas to military teaching facilities. Do not permit the complete disassociation of primary and non-institutional care from GME programming.

- Disavow the specious argument that pediatricians, obstetrician/gynecologists, internists and family practitioners are not valuable assets for contingency readiness.

- Promote GME specialty program balance within military teaching facilities in conformity with ACGME’s criteria for concurrent, accredited, mutually supportive training programs. Enhance opportunities for faculty and resident staff in individual research pursuit.

- Continue to develop close liaison and coordination among the military GME

programs of all Services and Uniformed Services University of the Health Sciences (USUHS) medical school.

- Seek legislative modification of 10 USC 1089 to provide protection from malpractice litigation for civilian medical consultants while providing professional service to patients in military hospitals. Although the provisions of Title 38 of the U.S. Code, treating the operation of Veterans Administration hospitals and Title 10 of USC, governing the operation of DOD facilities, are generally parallel, DOD presently has no equivalent to 38 USC 4114. This statute specifically authorizes the Veterans Administration to make temporary full time, part time, and without compensation appointments to the hospital staff. Persons so appointed enjoy immunity from tort liability for activities conducted on behalf of the VA... DOD should pursue a similar provision to Title 10.

Study: Graduate Medical Education (GME) Medical Education in the Armed Forces, by the Society of Medical Consultants to the Armed Forces, October 20, 1998

Introductory comments:

GME is the keystone supporting the entire voluntary military medical structure for quality health care delivery in time of peace and war. The very existence of GME programs in the DoD is threatened by intrinsic and extrinsic forces. These include advice contained in the report of the DoD Blue Ribbon Panel on sizing of medical facilities. Recommendation was given that readiness requirements be met by means of limiting training programs within the military services to yield only the medical manpower of specialists not readily available from the civilian sector, depending upon a presumed excess supply of civilian physicians to make up the difference (inviting the possibility of a physicians' draft). Of equal importance is the impact of active duty dependents and retirees being increasingly denied access to military medical facilities due to shortages of professional personnel, ancillary manpower, supplies, equipment and funding.

Most of these events are in direct opposition to the criteria for minimal educational experience recommended and required by the Accreditation Council on Graduate Medical Education in the training of medical and surgical specialists.

Out-of-service graduate medical training, although a needed and important adjunct, is no substitute for a sound and stable in-house effort. Cost accounting of military medicine should not be permitted to destroy military medical education. The latter cannot be replaced like equipment, and each cut-back may require years to recoup.

The personnel and dollar crunch to maintain the military's increased state of readiness is clearly appreciated, as is the need for the Military Health Services System to share in resource restraints.

Recommendations:

- Maintain full operability of Army, Navy and Air Force teaching facilities. Provide priority staffing with adequate ancillary support to assure the productivity of the facilities' health professional staff. Be attentive to ACGME staffing criteria.

- Every possible means should be under taken to ensure a stable academic faculty, particularly for the position of Program Director.

- Provide the teaching staffs of those facilities with the technology and tools to practice and teach "state-of-the-art" medicine.

- Restrict within catchment areas of military teaching hospitals the exodus of beneficiaries to out-of-service medical care. Provide for and encourage the transfer of patients in need of tertiary care from outlying areas to military teaching facilities. Assure, by diligent monitoring, the effective function of CRI's "health finder" (gatekeeper) mechanism to provide all GME programs with proper patient mix. Make better use of ambulatory care format for teaching purposes. Do not permit the complete disassociation of primary and non-institutional care from GME programming.

- Disavow the specious argument that pediatricians, obstetrician/gynecologists, internists and family practitioners are not valuable assets for contingency readiness.

- Promote GME specialty program balance within military teaching facilities in conformity with ACGME's criteria for concurrent, accredited, mutually supportive training programs.

- Enhance opportunities for faculty and resident staff in individual research pursuit.

- Optimize out-of-service training opportunities to supplement in-house GME effort, especially in subspecialty fellowship training. Seek legislative approval to implement both the Brandt Committee recommendation for a new Military Medical Reserve recruitment program as well as the Air Force proposal for a civilian GME stipend recruitment program.

- Clarify, or if need be, legislatively modify Federal law (10 USC 1089) to assure FTOS personnel and in-service military residents rotating through civilian hospital teaching programs, the benefit of protection from malpractice liability.

- Pursue House Armed Services Committee's recommendations to extend medical officer mandatory retirement age from 62 to 67 years, and remove constraints on Medical Officers' special pay and promotions to selectively compete for the retention of high pay critical specialists.

- Seek, where feasible, affiliation arrangements with neighboring civilian medical schools.

- Continue to develop close liaison and coordination between military GME programs of all Services and USUHS Medical School.

- Seek legislative modification of 10 USC 1089 to provide protection from malpractice litigation for civilian medical consultants while providing professional service to patients in military hospitals. Although the provisions of Title 38 of the U.S. Code, treating the operation of Veterans Administration hospitals and Title 10 of the USC, governing the operation of DoD facilities, are generally parallel, DoD presently has no equivalent to 38 USC 4114. This statute specifically authorizes the Veterans Administration to make temporary full-time, part-time, and without compensation appointments to the hospital staff. Persons so appointed enjoy immunity from tort liability for activities conducted on behalf of the VA DoD should pursue a similar provision to Title 10.

BACKGROUND, CONCEPT, ASSUMPTIONS AND RECOMMENDATIONS OF THE NDIA STUDY

The Health Affairs Division of the National Defense Industrial Association (NDIA) proposed a study of GME in the Armed Forces to the Defense Department. The Assistant Secretary of Health Affairs encouraged the NDIA to gain the interest and co-sponsorship of the Surgeons General. Through a gradual process, the group of co-sponsors for the study grew from the Surgeon General of the Army as an early sponsor to the current Surgeons General of the Armed Forces. John S. Parker, MD, was selected as the Study Chair and was supported by key personnel from other membership corporations of the NDIA.

The concept of the study was presented to the sponsors in a series of meetings establishing the scope of the study. Interestingly enough, the scope constantly expanded versus being constrained or restricted. The resulting scope was broad and allowed the study to be executed without an "expectant" result being a defensive paper for military GME. This study was to be iconoclastic if necessary. All sponsors agreed that Dr. John S. Parker should manage the study. The rationale was based on several factors: the sponsors knew him; he is a retired medical General Officer; he had at some point in his military career seen and functioned over the entire gamut of GME operations, to include a closure of a GME training medical center; and, he was a good balance between the unwavering advocate of military GME and the folks that execute the rigid process of defense financial program analyst. He is currently a senior vice president and technical fellow, Science Applications International Corporation.

The data collection and interpretations for the review were elucidated from the following seminars, briefings and discussions:

- 30 Nov 2004, GME Study Meeting with Surgeon General of the Army and Surgeon General of the Navy (LTG Kiley & VADM Arthur) to review the collection of thoughts and information and get some final comments from the study group. This represented an informal venting of views that were not harmonious and in no manner was meant to "negotiate" those views of GME into a single position of the Surgeons General. It did codify the universal agreement to work together and enter serious discussions about the future characterization of GME in the future.

- 20 August 2004, NDIA Meeting at USUHS with Dr. Earl Fauver & Dr. Emanuel Cassimatis.

- 29 June 2004, NDIA Meeting at VA Headquarters with Dr. Michael Kussman, DUS for Health.

- 7 July 2004, Teleconference GME Study Team.

- 3 June 2004, Teleconference GME Study Team.

- 26 May 2004, Teleconference GME Study Team.

- 18 May 2004, Teleconference GME Study Team.

- 23 July 2004, NDIA Representatives Meeting withArmy Surgeon General, MG (P) Kevin Kiley, transitioning the sponsorship from General Peake to General Kiley.

The following studies were reviewed:

- Military Graduate Medical Education (GME) Under Stress, by the Society of Medical Consultants to the Armed Forces, October 1987.

- Graduate Medical Education (GME) Medical Education in the Armed Forces, by the Society of Medical Consultants to the Armed Forces, October 20, 1998.

- DoD Graduate Medical Education (GME) Advisory Committee Report, August 1987.

- Military Medicine Future, by Michael J. Scotti, Jr., MD, Major General, USA (Ret.), July 11, 1995.

- Quick Response Analysis of Graduate Medical Education (GME) Costs, Volume 1: Annotated Briefing, 31 May 1995, by Vector Research, Inc.

- Costs of Graduate Medical Education (GME) within US Army Health Services Command, 1988 – 1990, by US Army – Baylor University Graduate Program in Health Care Administration, July 1992.

- Graduate Medical Education (GME) and Military Medicine, by the Institute of Medicine, National Academy of Sciences, July 1981.

- The Medical Corps Optimization Study, Phase II (GME) (Cornell, Andy), January 1992.

FACTS / ASSUMPTIONS

- GME as a method of retention has always been on the positive side of the column in the support of GME, but retention beyond commitment is not a proven case. The effort to truly look at this has never been executed. Data was discussed in the seminars that would neutralize this hypothesis. In some instances senior leaders are not holding on to this myth.

- Quality of care is always associated with the concept of GME but no study proves that fact. A quality medical staff and healthcare team is the key.

- GME has been an important method of "reconstituting" the force structure – true but not at no-cost. This reconstitution – sustainment has not been a one-for-one in the areas of greatest need.

- GME has been an important method of resupplying critical battlefield needs – true – but to have a GME program other "non-critical" training is also required; therefore, GME is not a highly focused resource.

- There have been several Base Realignment and Closure (BRAC) actions, and medical facilities have been included. GME will have to be readjusted to accommodate the loss of teaching facilities.

- The GME program was sometimes considered a career in itself; some physicians planned to stay in fixed facilities as permanent GME faculty at the end of residencies and fellowships. This is an academic illusion that uniformed personnel had to be in the Director, faculty and staff of the military GME system.

- There is a Program Decision Memorandum that mandates a medical command by 2008.

- The services are transforming to provide greater combat effectiveness. For example, casualty movements to CONUS are practically "overnight" - this change requires force structure and requirements.

- Positions in the DoD/military services that do not require an active duty incumbent are being converted to civil service or contract positions.

- The TRICARE system, with its choices, lack of nonavailability statements, and its freedoms to seek local care – have limited the ability of the military to create Centers of Excellence.

- GME faculty do not have to be uniformed physicians.

- GME is not different in the services – it is just promulgated through different methods. There may be cultural realities or illusions regarding the variances in quality, commitment and focus on the GME programs.

- GME is regulated by the Residency Review Committee(s) and the American Certification Boards.

- There is no reason, other than service pride, rivalry, or precedence, not to have one DoD GME program governed by the same rules and regulations.

- Residency review committees are requiring larger faculty staffs with a wide array of subspecialties. The services are stretched to support this requirement.

- The discriminating factor making military physicians more desirable than civilian physicians is their ability to DEPLOY and provide quality care in the battlespace. Therefore, programs that attract physicians for short tours (five to seven years) can be developed.

- DoD needs to decrease the retirement cost tail.

- There are barriers to making GME program changes that are generally "must do" changes:

    - Culture
    - History
    - Precedence
    - Fear of failure
    - Fear of the label "killer of uniformed GME"
    - Fear of yielding to (real) jointness

- Military GME is high quality education. Board results prove it.

- GME at its peak, before the "initial" BRACs, did sustain battlefield critical specialties. This was a time when over one half of the force played some role in GME.

- GME cannot sustain battlefield critical specialties; the infrastructure for training has changed dramatically and will continue to change. We see this today in war – high turnover in tours of duty and a tremendous dependence on the reserve force.

- All of the military Surgeons General are concerned regarding the sustainability of the existing system(s). OSD and OMB have always been concerned about the cost and value added. This creates "a critical moment" to evaluate Military GME and make strategic change.

- Alhough the Uniformed Services University of the Health Sciences (USUHS), Edward Ebert School of Medicine is part of the medical education system; it currently plays a

minimal role in DoD GME programs. Without changes in this philosophy, the school will lack sustainment and support.

- There are alternatives – the services can use many at once – it is time to capitalize on the possible consortium thinking that is good business practice today.

- You really want one quality program. Service rivalry has no place in the world of providing care to the Armed Forces of the U.S.

- Medical research (GME associated) programs and the clinical investigation program would be strengthened by being integrated into the Medical Research and Materiel Command providing a deeper research base to the Armed Forces.

RECOMMENDATIONS

Major overarching recommendation:

The Surgeons General, the Joint Chiefs of Staff and the ASD (HA) must develop a clear, unified vision on military GME for the 21st Century. A variety of options or mixture of options could weave the fabric of a flexible, reliable, sustainable infrastructure for GME in the military. We must not sacrifice quality nor exceed our capacity to support quality GME.

To accomplish this, a series of high-level participatory workshops should be directed. The time is right – the individuals in the responsible positions are the right group to tackle this – there are people who are willing to help the process work – a 21st Century vision is NECESSARY – NOW.

General Recommendations:

- Action is required now. If the Surgeons General do not engage and engineer this strategy now, someone else will.
- Create one professional medical education system.
- Consider the Uniformed Services University of the Health Sciences as an epicenter.
- Convert some military faculty positions to civilian or contract positions. A ten-year transition plan should be initiated.
- Concentrate GME at those centers that appear to be able to support the case load necessary for certified programs.
- Continue to explore programs similar to the University of Virginia and Veterans Health Administration (VHA) structure. Understand how to leverage other people's money and other Federal programs.
- Be a tough leader. Understand the time, circumstances and the real needs of the services. Do the really hard stuff so future quality is assured.
- Admit that the rhetoric of needing GME to maintain the force structure as it relates to quality, recruitment, retention and cost effectiveness may not be true.

- Start to try to understand the positions and arguments of the analysts at the DoD, OMB, and Congress. Negotiate intelligently. Make thoughtful change in the programs. Demonstrate a leadership-versus-preservation mentality. It is hard to see reality or opportunity through a lens of culture and history. The reality versus the illusion of the value of the present system must be carefully weighed.
- With Congress recommending DoD health assets being deployed more routinely in homeland disasters, along with the increasing use of military health care personnel in humanitarian missions, it is clear that a more unified, focused and balanced approach to our military GME programs will yield results that will support America's military health care delivery mission. As you discuss openly what your objective(s) are we think that you will get the support you will need from multiple sectors..
- Be a good, objective, business-oriented manger – the current program may create inequities in the availability of key personnel for deployment.
- There is no reason why a resident cannot be deployed for six months. Try to justify it. If the resident has a role at a Medical Center – deploying that resident with the appropriate faculty level personnel can only be a force multiplier and training ground much like any other trauma receiving center in the US. Seek the support of the AMA, American Boards of surgery, and the Residency Review Committees (RRCs) to support this idea. We believe it makes sense. Yes, it is a change in thinking and culture and it will not be an easy sell. It is an opportunity worthy of debate by our medical leadership military and civilian.