Family Practice in Military Medicine: A Pilot Program

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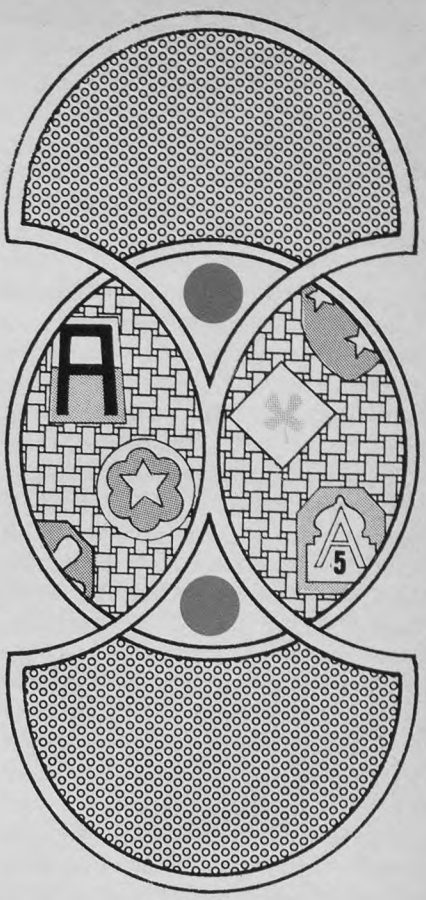

A test program to study the applicability of a family practice concept to the United States Air Force was established at the United States Air Force Hospital, Homestead Air Force Base, Florida, in 1972. This paper discusses the organization and development of this program, as well as the problems encountered and changes made in response to them.

The name "family practitioner" suggests an idealistic concept of one physician providing care to the same group of families for a duration which may span several generations. It is difficult, if not impossible, to imagine that such an ideal could succeed in military medicine. However, when one considers that in the civilian community in 1970 one of every five ambulatory patients who presented to a physician did so in a hospital setting, and that one third of those occurred in an Emergency Room,[1] it becomes apparent that even in civilian medicine a large segment of medical care may be obtained from a physician who is unfamiliar to the family. Our population in the United States has become so mobile that the ideal of longitudinal medical care from the same physician is rarely achieved.

The military family is still more nomadic than its civilian counterpart, and it is certainly true that military physicians move more frequently than do their peers in civilian life. The single most important item in insuring high quality medical care for the military family is the thorough and well-maintained medical record which should contain a complete medical data base and which moves with the patient from physician to physician. However, of almost equal importance in providing continuity of high quality family care (given that one cannot have the same physician at every assignment) is provision, in hospitals and dispensaries at all military bases, of similar family practice units staffed by the same high-caliber, well-trained family practice physicians interested in providing comprehensive family care.

The Homestead Program

A test program to study the applicability of a family practice concept in the United States Air Force was established at the United States Air Force Hospital, Homestead Air Force Base, Florida, in 1972. The initial family practice unit was staffed by four fam-

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ily practice specialists with supporting corpsmen and administrative helpers. The program was expanded in 1973 by the assignment of ten additional family practice physicians, four of whom were also trained in aerospace medicine to provide comprehensive care for the aircrew member and his family.

Four more family practice physicians were assigned during the summer of 1974 to replace those completing a two-year tour in the Air Force. This provided the first opportunity to observe the effect of changing the family doctors for the 2,000 families being cared for by the departing four physicians. The transition was relatively smooth and the new physicians had little difficulty in assuming the already established family practice of their predecessors.

A number of lessons have been learned and changes made in the administration of the family practice program. However, the program itself is still evolving. By the fall of 1973, all active duty military members and their families had been assigned to the care of a family physician. Initially, families were enrolled in the family practice of the physician of their choice. It became apparent that this led to some inequity in patient load and difficulty in determining the exact number of families under the care of each physician in the pilot program. Meanwhile, family practice flight surgeons were being assigned according to flight organization rather than individual choice. The family practice flight surgeons cared for the flyer and his family by squadron, as had been customary in the squadron flight surgeon concept for years. There were many advantages to this system. First, there was a specific doctor to attend squadron functions, give briefings on the family practice program at his squadron commander's call, and be available to provide consultation to his squadron commander on medical problems within the unit. Second, since the exact number of persons assigned to the squadron was known, the number of families under each physician's care could be easily determined. A third advantage was that as new families were assigned to the squadron, the squadron commander or his first sergeant was able to brief the newly arriving member and his family on the family practice program and identify for them the physician who would provide the care for the family unit.

Eventually, this same concept was applied to the non-flying units and organizations so that all families of military members on the base were assigned to the care of a "Unit Family Practitioner." The same responsibilities for serving his organization and attending social and official functions were given to the non-flight surgeon family practitioner as had been expected of the flight surgeon in the care of his flying squadron. The concept of the organizational family practitioner was well received and has simplified the overall administration and communication problems related to family practice in the military environment. As would be anticipated, some families have requested and been permitted to enroll in the family care panels of physicians other than those assigned for the care of their organization. Most units or organizations on the base have enthusiastically supported the program and helped a great deal in providing information to the family members.

Fully trained physician's assistants were assigned to the model family practice program in 1973. There was one for each family practitioner, and he shared the medical care responsibilities for the military unit assigned to that physician. There is a continuing effort to determine the best mix of numbers of physician's assistants and physicians to most effectively provide comprehensive family care. The optimum skill levels and Specialty Codes for supporting corpsmen, administrative technicians, and other ancillary clinic personnel are still being tested.

Each family practice doctor (and his assistants) is now providing care for approximately 700 families. This number includes many retired military families living in southern Florida who were assigned family practitioners in 1974. The family practice unit is able to provide at least 90 percent of the medical care for the families assigned. A number of other specialists are assigned to the hospital and serve primarily in a consultant capacity to the family practice physicians.

Discussion

The quality of medical care provided to the military family is certainly improved by the program described. However, a number of problems – mostly related to patient acceptance – still exist. The majority of military families have never had the opportunity to have a family physician, and many persist in using the emergency medical services for non-emergent conditions. Naturally, this interferes with the concept of continuity of care by a single physician. Some families feel that they have a right to see a physician regardless of the nature of their illness or the time of day. Many become disgruntled when they walk into the Emergency Room or hospital clinic and are unable to see the family doctor who they understand was assigned for their comprehensive care. Many of these demands have been fostered by the previous health care delivery system provided for many years. Some family members are offended when told that the physician's assistant can adequately give care for minor illnesses and medical conditions that would previously have been treated by a general medical officer. Clearly, education of the families is a continuing necessity.

The concept of family practice is one that can work in the military medicine environment. The ideals of family practice and the high quality of family care that it can provide will only reach maximum effectiveness in the care of military families when the military families are made aware of what the system has to offer and are able to find continuity in the quality and availability of the family practice unit throughout the majority of military medical facilities. The family practice test program at the USAF Hospital, Homestead Air Force Base, is still evolving. There are daily questions about better ways to provide good care for more families with the resources available. Enthusiastic physicians, administrative personnel, and nursing and corpsmen support technicians are attempting to find the answers to those questions. The prospect for improving the overall medical care available to the military family through family practice in the military environment is great.

Reference

1. Fletcher SW, Appel FA, Bourgois M: Improving emergency room patient follow-up in a metropolitan teaching hospital. N Engl J Med 291:385-388, 1974