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AMOSIST PROGRAM FIELD EVALUATION: STABILITY AND VIABILITY--A RE--ETC(U)
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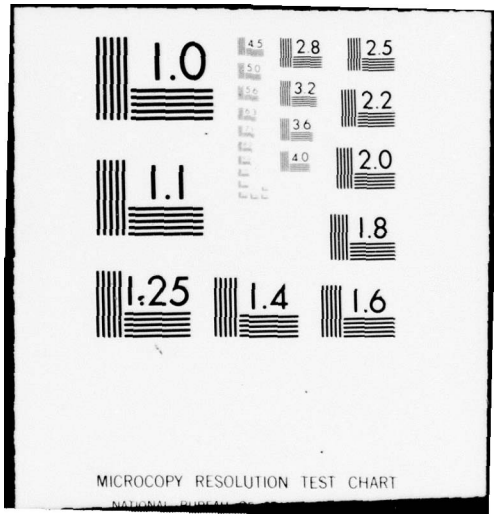
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AMOSIST PROGRAM FIELD EVALUATION: Stability and Viability--A Re-evaluation of Program Acceptance and Operational Characteristics

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February 1979

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Prepared for:

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20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

The US Army's AMOSIST Program employs physician supervised enlisted corpsmen who utilize a manual of medical algorithms to provide care to unappointed ambulatory outpatients. The present study describes a follow-up evaluation of the program's operational characteristics and acceptance. Although overall patient satisfaction increased slightly and overall staff satisfaction decreased between Phase I and the Phase II follow-up, the findings indicated that adequate levels of patient and staff satisfaction existed. Nonetheless, there existed pervasive evidence of a decrease in the perceived competence of the

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AMOSIST (the program's principal care provider) relative to Phase I on the part of not only the AMOSISTs' physician supervisors, but also the remainder of the hospital staff. The decrease was ascribed to the withdrawal from the program of the more highly trained clinical specialist (vis-a-vis the remaining medical specialist). The evaluation evidenced continuing medico-legal vulnerability as the result of significant program deficiencies in the areas of physician staffing practices and AMOSIST supervision (due to the use of roster-assigned physicians), and auditing procedures (due to the lack of an efficient means of performing same--a consequence of inadequate data recording procedures, the permission to effect local changes to the logic, and the non-utilization of the manual of algorithms).

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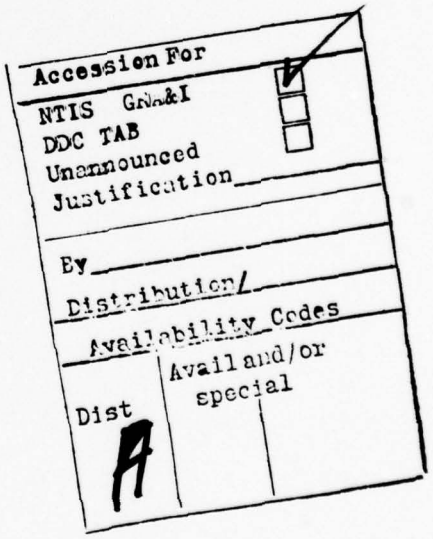

SUMMARY

The present study was undertaken for the purpose of providing the Surgeon General with an assessment of the current status of the AMOSIST* Program as it is presently employed within US Army Medical Activities (MEDDAC) in the Continental United States (CONUS). The objective of the present phase of the study was to effect a follow-up evaluation of the operation characteristics of the Acute Minor Illness Clinics (AMIC) functioning within the context of this program, and the extent of program acceptance which has been achieved.

This objective was addressed primarily through the use of a comprehensive mailed survey comprised of patient and staff satisfaction questionnaires and an AMIC Checklist. Regarding the issue of program acceptance, the findings indicated that an acceptable level of patient satisfaction exists, that the job satisfaction of both AMOSISTs and AMOSIST Physicians are equal to that of their counterparts serving in non-AMIC positions, and that a moderate level of program acceptance exists among non-AMIC medically trained personnel. A comparison of the follow-up data to the initial findings revealed a small but statistically significant increase in the satisfaction of patients and a statistically significant, larger decrease in the job satisfaction of AMOSISTs and AMOSIST Physicians. Additionally, there existed a significant decrease in the extent of perceived competence of AMOSISTs on the part of both the AMOSISTs' physician supervisors and the hospital staff in general. Both the decrease in AMIC staff satisfaction and the decrease in the perceived competence of AMOSISTs were attributed to the withdrawal of the more highly trained Clinical Specialist (MOS: 91C) from the two categories of enlisted personnel initially eligible to serve in the program as AMOSISTs.** (The other, remaining category is the Medical Specialist, MOS: 91B.)

*The term derives from Project AMOS (Automated Military Outpatient System), i.e., an AMOS-ist. As used herein, the term AMOSIST refers to the enlisted medical corpsman who works within the confines of the AMOSIST Program's health care delivery system.

**Due to fortuitous circumstance, the decision by the Office of the Surgeon General (OTSG) to delete the 91C from the AMOSIST Program occurred at approximately the time the initial, Phase I data collection was begun. The actual removal of 91Cs did not begin to occur, for the most part, until the initial phase data collection had been completed. By the time of the follow-up evaluation, the number of 91Cs remaining in the program had been halved. Hence, the timing of the study was such that it afforded an excellent opportunity to provide an assessment of the initial impact of that decision upon the program.

Comparisons of job satisfaction among various subsets of the AMOSIST sample itself showed (a) the 91C to be significantly more satisfied than the 91B, (b) those who were in the training status (or who had just completed same) to be significantly more satisfied than their more senior counterparts, and (c) those serving in AMICs wherein a substantial portion of the physician staffing was provided by roster-assigned physicians to be significantly less satisfied than those serving at AMICs wherein the physician was assigned on a full-time basis. As regards the last-cited finding, AMOSISTs also reported that roster-assigned physicians were significantly less knowledgeable of the AMOSIST concept and the operation of the AMIC than were physicians assigned there on a full-time basis. All of these findings were consistent with the findings evidenced at the time of the initial evaluation.

Operationally, the follow-up evaluation yielded findings which were not statistically more positive or more negative than the initial findings. As in the initial phase, the data indicated that most administrative requirements associated with the initial implementation of a local program had been met--particularly those aspects of the program which have been directly addressed by Army Regulation (i.e., those pertaining to the credentialing process and those pertaining to the development of a drug list which had been reviewed by the Therapeutic Agents Board and approved by the local commander.) Additionally, most physical requirements of the program were found to have been met, and the existing patient workload was found to have been reasonable at most sites. Nonetheless, as in the initial phase, the data indicated that adequate, regularly performed auditing functions were largely absent from the program, and that AMOSISTs were not constrained to the limitations of medical care implicitly existing in the algorithms contained in the AMOSIST Manual. These findings were viewed to be contrary to the content of the 1973 legal opinion rendered by the Office of The Judge Advocate General (TJAG). In this regard it is noted, however, that the program users have not been provided with, nor (in a militarily legal sense) are they bound by a set of consistent, complete guidelines which definitively describe the audit procedures to be employed. Existing program-defining documents are viewed as being either too broad to be of use or lacking the legal status to permit the program to be monitored and administered by the command in the rigourous manner required for it to be consistent with the recommendations cited in the TJAG legal opinion. The findings, in conjunction with findings of the third report which showed that an unacceptably high error rate existed among closely audited AMOSIST-completed treatment data collection sheets, strongly suggest that the program is "at risk" from the medico-legal perspective.

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1. INTRODUCTION.

In recent years the Army has suffered a marked shortage of physicians. In an effort to cope with this shortage, it has undertaken the development of several physician extender programs. One major effort in this regard was that undertaken at Fort Belvoir, Project AMOS. As an outgrowth of this research, the Health Services Command (HSC) adopted the AMOSIST concept and introduced a substantial number of physician extenders to serve in Acute Minor Illness Clinics at most US Army hospitals. Since the time of the decision to adopt the AMOSIST Program there have been no formal study efforts to evaluate the manner in which the program had been implemented and operated. A request from the US Air Force and the US Navy to The Surgeon General of the Army for such information resulted in a subsequent request by The Surgeon General for a formal evaluation of the program. The series of reports, of which this is the fourth, describes the findings of that study effort. A more detailed and comprehensive description of the relevant background pertaining to this study is provided in the initial report of this series (Schopper, 1978a).

2. OBJECTIVES.

The findings presented in this report address the issues of the AMOSIST Program's stability and viability. Herein, stability is measured by the extent to which there exists an absence of differences between the findings of the initial data collection period of October, 1976 and that of May, 1977. Viability is measured by the extent to which those changes which were evidenced are seen to be positive. As indicated in the approved study protocol for this project (Schopper, 1975), the present analyses will be limited to the data pertaining to the AMOSIST Program's operational characteristics and program acceptance.

3. METHODOLOGY.

3.1 General. The data used as a referent in making the evaluations was that collected during the initial phase of the study as described in the first report of this series (Schopper, 1978a). The data pertaining to operational characteristics was derived from responses to the AMIC Checklist (Appendix A). The data pertaining to program acceptance was derived from measures of both patient and staff satisfaction (see Appendices B, C, and D). Further descriptions of these data collection instruments are provided below. The methodology employed to distribute, collect, and evaluate these data collection instruments is the same as that employed during Phase I of the study. Such will be described in brief in the section dealing with each of the data collection instruments as they appear in the sections below.

3.2 AMIC Checklist. The AMIC Checklist is a 14-page data collection instrument containing approximately 130 items appearing in 16 separate sections within the questionnaire. It is comprehensive in scope and addresses all major operational aspects of the AMIC's functioning as described in HSC's Ambulatory Care Program No. 13 and its supplement. One copy of the checklist was included in the mailed survey package sent to each of the

MEDDACs. It was to be completed at each MEDDAC by an individual not employed in the AMIC itself. Considerable follow-up efforts in the form of both written and telephonic communications were made to obtain as complete a response as possible from each of the MEDDACs participating in this phase of study.

3.3 Patient Satisfaction Questionnaire I. The Patient Satisfaction Questionnaire I, (PSQ I), was a 25-item questionnaire (Appendix B). Two-hundred PSQ Is were sent to each site. The first six items of the questionnaire were to be completed by the patient while he was still in the patient waiting area awaiting call for treatment. These items addressed demographic variables and the patients' satisfaction with (a) military life in general and (b) previous military medical care that he had received. The remaining 19 items assessed the extent of the patient's satisfaction or dissatisfaction with both care provider related and non-care provider related aspects of the treatment he had received while in the clinic. The questionnaire also included three questions extracted from five originally included in research performed during the final, pre-implementation phase of Project AMOS.

3.4 Staff Satisfaction Questionnaire.

3.4.1 Also included in the mailed survey package were multiple copies of the Staff Satisfaction Questionnaire (SSQ) (Appendix C). One copy was provided for each physician serving in the AMIC and one copy was provided for each AMOSIST serving in the clinic. Additionally, three copies were provided for non-AMIC related physicians, and twelve copies were provided for 91Bs and 91Cs not allied with the AMIC operation. These latter documents were intended to develop data for the purpose of a comparative evaluation and assessment of job satisfaction. These questionnaires were distributed within the hospital by a locally designated action officer. Each was accompanied by a blank envelope which instructed the individual completing the questionnaire to insert the questionnaire into the envelope and seal the envelope prior to returning it for subsequent inclusion in the package of documents to be returned to the study agency. This facet, the inclusion of a blank envelope, was included in an effort to increase the candidness of the responses obtained. Additionally, for the same reason, no individual identified himself by either name or social security number.

3.4.2 Like the AMIC Checklist, the SSQ is a multipart data collection instrument. The initial section obtains demographic and identificatory information from the respondent. The second section is a longer section derived from the summary questions used in a large scale questionnaire employed by the US Air Force in their job satisfaction assessment (Gould, 1974). The third section of the SSQ is comprised of a slightly modified version of the Job Descriptive Index, a data collection instrument which is widely used in research and industry to assess job satisfaction (Smith et al, 1969). The JDI itself addresses five separate aspects of work job satisfaction: work, co-workers, immediate supervisor, pay, and promotions. The fourth part of the SSQ addressed the issues of the relative importance of various aspects of one's work. It considered the individual's perceptions of the extent of importance attached to his work by others, how well he believed himself to be performing his work, to what extent there seemed to be pressure to perform well, and the extent to which the spirit of professionalism appeared to exist within the clinic.

3.4.3 The last part of the SSQ was tailored to the specific respondent. The version prepared for AMOSISTs assessed their perspectives of the manner in which the clinic was operated, their perceptions of the knowledgeability of the physicians who staffed the clinic, several questions concerning their supervision, their perceptions regarding their job expectations and the extent to which their actual work conformed to these expectations, and their impressions of the most and least desirable aspects of being an AMOSIST. A separate Part V was also prepared for AMOSIST physicians. This section addressed the AMOSIST physicians' perceptions of the AMOSISTs' competence, the AMOSISTs' principal strengths, and their principal weaknesses. Also addressed in this section was the issue of the AMOSIST Program as a health care delivery system in and of itself, its major strengths and weaknesses. The Part V for non-AMOSISTs personnel merely asked the likelihood of their making the Army a career. This question was also asked of AMOSISTs and AMOSIST physicians.

3.5 Staff Perceptions Questionnaire

The extent of program acceptance evidenced by hospital personnel not directly associated with the AMIC was determined through the use of the Staff Perceptions Questionnaire (SPQ) (Appendix D). The SPQ was administered to the non-administrative clinic personnel serving within the hospital. Respondents were asked to indicate the extent of their knowledge regarding the AMOSIST program and to express their opinions regarding: (a) the need for an AMIC and (b) the ability of AMOSISTs to provide adequate medical care. They were also asked to render their perceptions of the professional staff's view of the AMOSISTs capabilities.

4. RESULTS AND DISCUSSION.

4.1 AMIC Checklist.

4.1.1 General.

4.1.1.1 The findings presented herein reflect an evaluation and analysis of the responses from 14 sites common to both phases of the study. Specific numbers or percentages are frequently cited within the text. When they appear in the principal portion of the text (the non-parenthetical portion), they refer to Phase II data. Data which address the same topic, but which has been obtained from Phase I of the study will generally be enclosed in parentheses within the same sentence in which the Phase II data was cited, e.g., (I=XX). Occasionally, information from both sets of data will be enclosed in parentheses, e.g., (I=XX, II=XX).

4.1.1.2 In order to correctly interpret that data cited below, it is necessary to note that some of the questions were responded to on a "conditional" basis. For instance, item 1.8 of the checklist asked whether or not "roster-assigned" physicians are used in the AMIC and; furthermore, if they were, were they rated by the same individual who rated the Chief of the AMOSIST Program? As a consequence of the use of this type of question construction, the second portion of the question is a "conditional" inquiry; hence, the percentage which is cited with regard to the second portion reflects the percentage of only those sites that indicated

that they did utilize roster-assigned physicians. For example, the results of the Phase II mailed survey for this particular item indicated only four of the 14 sites (approximately 29% of the 14 sites) used roster-assigned physicians in the clinic. Of these four sites, two (50%) of the four sites indicated that the roster-assigned physicians were rated by the same individual who rated the physician having principal responsibility for the AMIC.

4.1.2. Triage Utilization. The requirements of Annex B to the HSC Ambulatory Patient Care (APC) Model #13* clearly and emphatically indicate the need for, and the importance of, a properly run triage station. The analysis of the AMIC Checklist revealed an increased effort to improve the triage system between Phases I and II. There were only two items in Table 1 that were below 93 percent in Phase II. They both related to the availability and use of triage data collection sheets. Only 79 percent of the Phase II sites indicated that triage forms are present in the triage area (Item 1) and that triage data collection sheets are completed for every patient seen at the triage station (Item 5). Both, however, reflect a slight increase as Phase I figures for both items were at the 71 percent level. The APC Model states in paragraph IV C2 that, ". . . only those patients who go through a triage interview and who receive an AMOSIST disposition should ever reach an AMOSIST's office for diagnosis and treatment." As indicated in Item 3, there was a substantial increase in the percentage of sites that reported ALL AMOSIST-treated patients had gone through the triage process. Paragraph III E5 of the APC Model indicates that non-AMOSIST triage personnel (e.g., 91B or Red Cross volunteers) are to be trained by the Chief of the AMOSIST Program. Item 6 shows an increase in the percentage of sites wherein the triage function is performed by AMOSISTs or personnel trained by the AMOSIST MD. One of these sites indicated that the triage function was performed by either AMOSISTs or Red Cross Volunteers trained by the AMOSIST NCOIC (instead of the AMOSIST physician). In addition to AMOSISTs and Red Cross Volunteers, some sites reported the use of Civilian Health Technicians to perform the triage function.

4.1.3 AMOSIST Manual and Treatment DCS Utilization.

4.1.3.1 The two items in Table 2 that are specific requirements of the APC Model (Items 2 and 4a) reflect a continued 100% participation at all sites, i.e., a copy of the AMOSIST Manual is provided each AMOSIST, and the treatment data collection sheets are used to record the AMOSIST's work. However, not all of the AMOSIST Manuals were the current version (I = 100%; II = 88%). There was an increase in the percent of patients for which treatment data collection sheets were initiated (I = 86%; II = 93%); however, there was a slight decrease in the percent of patients treated by going step-by-step

*Hereafter, unless otherwise specified, the terms "HSC Model," "APC Model," and "APC Model #13" are all used to refer to the Implementation Packet, a lengthy annex to the basic model itself which describes the operation of the program in some detail.

Table 1

TRIAGE FUNCTIONING AND VITAL SIGNS

ITEM *	PERCENT "YES" PHASE I	PHASE II
1. Triage forms are present in the Triage area (11.1)	71%	79%
2. The patient's outpatient record is available at the time of Triage (11.2)	93%	100%
3. All AMOSIST-treated patients have gone through the triage process (10.3)	79%	93%
4. A triage data collection sheet is completed for every patient seen at the triage station (2.1)	71%	79%
5. A Triage Manual is utilized at the triage station (2.2)	86%	93%
6. The triage function is performed by AMOSISTs or personnel trained by the AMOSIST MD (2.3)	79%	93%
7. Vital signs (to include as a minimum the patient's temperature) are determined for each patient evaluated in the AMIC (3.1)	93%	93%

* Parenthetical entries denote the number of the items as they appeared in the AMIC Checklist.

Table 2

UTILIZATION OF AMOSIST MANUALS AND DCSs

ITEM *	PERCENT "YES" PHASE I	PHASE II
1. How many AMOSIST Manuals are presently in use in the AMIC? (14.1)	7.9	7.4
2. There is a copy of the AMOSIST Manual provided to each AMOSIST. (14.2)	100%	100%
3. What percent of the AMOSIST Manuals presently in use are the revised (July 1976) version? (14.3) ***	100%	88%
4. a. Data collection sheets (DCSs) are used to record the AMOSIST work. (4.3)	100%	100%
b. The percent of patients for which DCS initiated is:	86%	93%
5. Percent of patients treated by going step-by-step through the algorithms in the AMOSIST Manual. (4.1)	85%	81%
6. a. Illnesses which are not contained in the local AMOSIST Manual are treated by AMOSISTs. (4.2)	29%	29%
b. How many additional diagnoses are treated (4.2a, range) **		"None" to "too numerous to count"

* Parenthetical entries denote the number of the items as they appeared in the AMIC Checklist.

** Conditional question; the data cited are applicable only to sites which responded affirmatively to the initial item of the series.

*** Phase I percent reflects July 1975 revision, whereas Phase II percent reflects July 1976 revision. However, the revision reflected was the current revision and the one each AMIC should have been using.

through the algorithms in the AMOSIST Manual (I = 85%; II = 81%). A recommendation of the APC Model that continues to be violated is that of AMOSISTs treating illnesses that are not contained in the AMOSIST Manual (I and II = 29%). Of those sites reporting such, one indicated that the additional diagnoses were "too numerous to count." Fifty percent of those sites indicated AMOSISTs only treated one or two additional diagnoses.

4.1.3.2 It is noted that the question asked above concerning the AMOSIST Manual addressed only its availability--not the extent of its use. Observations made by study personnel while on-site indicated that the manuals are rarely consulted (and at times are not even present in the treatment rooms). Additional observations suggested that one reason for the lack of their use is that AMOSISTs feel uncomfortable in having to make obvious, continuing reference to a separate manual during the treatment of a patient. Such actions, they believe, convey a sense of ineptitude to the patient. Additionally, a more concrete finding which was believed to be contributing to the non-use of the Manual was that of the inefficiency inherent in its content. It was found (Schopper, 1979a) that nearly forty percent of the specific diagnoses cited in the Manual occurred with a frequency of less than one in every 100 patients treated. Hence, it is likely that an additional reason AMOSISTs do not employ the manual is that a substantial portion of it rarely has an impact upon the eventual treatment that they rendered.

4.1.4 Auditing Procedures.

4.1.4.1 General. The AMIC Checklist addressed three types of audits: Audits of Triage Data Collection Sheets, Audits of the Treatment DCS used by the AMOSISTs to record their work, and audits of diagnostic skills. A comparison of the mailed survey relevant to each for Phase I and Phase II is discussed below. The AMIC Checklist data pertaining to all three audits are provided in Table 3.

4.1.4.2 Triage Audits.

4.1.4.2.1 In view of the findings in the Phase I data analysis and because the APC Model #13 does not unambiguously define a formal procedure for conducting a triage audit, the survey materials mailed during Phase II of the study specified an audit to be "a formal audit." The term "Formal Audit" was defined to be ". . . an auditing procedure that is performed which (a) follows a written procedure which has been reviewed and approved by appropriate hospital administrative personnel and (b) yields a continuing record of its having been performed."

4.1.4.2.2 The decrease in the number of sites conducting or performing audits of the triage function (Item 1) may be the result of the previously mentioned more definitive explanation of the auditing procedure. Of the 14 sites reporting during the Phase II mailed survey, eight (57%) performed "formal audits" of the Triage DCSs (I = 86%). The intervals between audits were reported to range from once a month to daily, with one half of the audits conducted only one or twice a month. The response to item 1b

Table 3

AUDITING PROCEDURES

ITEM *	PERCENT "YES" PHASE I	PHASE II
1. An audit of the triage function is performed (2.4)	86%	57%
a. Performed how often (per month) **	6.0	5.9
b. Involves how many triage data collection sheets per month **	129 ***	197 ***
c. Is performed by whom (see text) **		
2. Treatment DCS audits are performed (4.4)	86%	71%
a. They are done once every ___ days **	10.6	4.7 **
b. They are performed by ___ (see Table 4)		
c. Individual(s) selecting DCSs for auditing is ___ (see text) **		
d. The average number of DCSs audited per month per AMOSIST is ___ **	89 **	104.8 **
e. DCSs are audited for completeness and accuracy **	100%	100%
f. AMOSISTs have ready access to all audits of their work **	93%	100%
g. Audit results are maintained in a continuing log **	67%	0%
3. Skill audits are performed (5.1)	64%	21%
a. They are performed once every ___ days **	10.0	3.0
b. They are performed by ___ (see text) **		
c. Results are maintained in a continuing record **	11%	-
d. AMOSISTs are permitted ready access to results of all audits of their performance **	89%	67%

* Parenthetical entries denote the number of the items as they appeared on the AMIC Checklist.

** Conditional question; the data cited reflect proportions or other statistics that are applicable only to those sites which responded affirmatively to the initial item of the series.

*** Some data were not included in the calculation of these means, see text.

resulted in a wide range of values being reported regarding the average number of triage data collection sheets audited per month. Phase II mailed survey yielded a range from 10 to 900 per month (I = 10 to 600).* In addition, 71 percent of the sites reporting showed marked changes in the average number of triage data collection sheets audited per month between Phase I and Phase II of the study. One study site reported that an average of 320 triage data collection sheets audited per month during Phase I and that an average of 10 were audited during Phase II. Another site reported that an average of 40 triage data collection sheets were audited during Phase I while an average of 320 were reported to have been audited during Phase II. Computations based upon the data as reported yields a mean value of triage data collection sheets audited per month of 297 for Phase II (I = 168). However, the value 900 appears to be excessive. A recomputation of the mean excluding the extreme values of 900 for Phase II (and 600 for Phase I) results in a mean of 197 (I = 129), a value which, in the opinion of the author, appears more realistic.** The triage data collection sheets continue to be audited at approximately six times per month (Item 1a). The Phase II findings indicate that these audits are performed by the AMIC NCOIC at 38 percent of the sites (I = 45%), by the Chief of the AMOSIST Program at 13 percent of the sites (I = 27%), by the AMOSIST physician at 13 percent of the sites (I = 9%), and by other personnel or a combination of the above individuals at 38 percent of the sites (I = 18%). Since the guidelines presented in APC Model #13 indicate that this is a function to be performed by the AMOSIST Physician, these findings do not reflect favorably upon the program.

4.1.4.3 Treatment DCS Audits.

4.1.4.3.1 The implementation packet contained in APC Model #13 is much more explicit regarding the auditing procedures of the treatment data collection sheets used by the AMOSISTs. However, there is still a great deal of latitude left to the local user to alter the auditing procedure to fit the peculiarities of each facility.

4.1.4.3.2 In response to the question asked as to whether or not audits of the treatment DCSs were peformed (Item 2), approximately three-fourths of the sites reported that a "formal audit" was performed at the time of the Phase II survey (I = 86%). This decrease, too, can probably be explained by the specificity of the phrase "formal audit." Of those Phase II sites performing an audit, it was reportedly performed more frequently, once every 4.7 days, than it had been at the time of the Phase I evaluation (I = every 10.6 days). The individuals who performed the audits are indicated in Table 4. Clearly, a substantial number of sites continue to utilize non-physician personnel to perform the audits--a practice which is

*The site reporting 900 during Phase II was not the same site reporting 600 for Phase I.

**The value 900 was more than twice as large as the next highest value reported.

Table 4

PERSONNEL PERFORMING AUDITS OF TREATMENT DATA COLLECTION SHEETS

AUDITOR	PHASE I NO. OF SITES *	%	PHASE II NO. OF SITES *	%
C, AMOSIST Program	5	42	5	50
AMOSIST Physician	1	8	1	10
C, AMOSIST Program and/or AMIC NCOIC			1	10
C, AMOSIST Program and/or AMIC NCOIC and/or Other AMOSIST Personnel	1	8	1	10
AMIC NCOIC and/or Other AMOSIST Personnel			1	10
Other AMOSIST Personnel	3	25	1	10
Roster-assigned Physician	1	8		
AMIC NCOIC Only	1	8		

* This is a conditional response; i.e., Phase I=12 sites; Phase II=10 sites.

contrary to the guidance provided in APC Model #13.

4.1.4.3.3 One of the recommendations contained in the APC Model is that the audit should include 10 DCSs per AMOSIST per week. Item 2d findings indicate the average number of DCSs audited per AMOSIST per month is 105, a finding which is higher than the recommended value. However, of the ten sites (I = 12 sites) performing formal audits, 50 percent (I = 67%) were below the recommended quantity. All of the sites that reported that DCS audits were performed indicated that the treatment DCSs were audited for both completeness and accuracy (I = 100%) and that AMOSISTs have ready access to the results of the audits performed on his work (I = 92%). However, none of the Phase II sites which indicated that audits were performed reported that the results of these audits were recorded and maintained in a continuing record. This absence of documentation is contrary to APC Model #13 guidance and is viewed as a serious shortcoming. In view of Phase I findings which indicated a marked discrepancy between the adequacy of audits performed as reported by the sites themselves (more than 80%) and the adequacy of audits reported by personnel making on-site visits (less than 50%--with none meeting all requirements for a satisfactorily implemented audit program), this finding is viewed as being particularly acute.

4.1.4.3.4 The findings cited above represent, from the writer's point of view, the major shortcoming of the AMOSIST Program--an adequate means of appropriately auditing the work of the AMOSISTs. Such personnel (AMOSISTs) are not professionally trained. Hence, from the medico-legal point of view, as specifically cited in the legal opinion rendered by the Judge Advocate General (1973) at the time the program was recommended for implementation, AMOSISTs must be subjected to closed supervision and monitorship. Nonetheless, as was pointed out in both the first and third reports of this series, the principal reason for the present status is the lack of a manageable, efficient means of accomplishing the audits recommended in the APC Model. To demand that a physician spend his time attempting to manually perform and document (in a usable, meaningful fashion) the audits of treatment DCSs of all his AMOSISTs in the quantity recommended by the APC Model would be inappropriate. What is needed (and what has been recommended in the previous reports) is a data collection/utilization system which can be efficiently and accurately audited by non-physicians at both the local and Command levels, and the generation and establishment of some normative data against which both individual AMOSISTs and individual AMICs can make comparisons.

4.1.4.4 Skill Audits

4.1.4.4.1 In general, there is very little guidance provided regarding the performance of skill audits in the APC Model. It does, however, indicate that the skill audits should be performed by physicians.

4.1.4.4.2 Item 3 of Table 3 addressed the matter of skill audits. The data indicate that a majority (79%) of the sites did not perform skill audits. Among the three sites that indicated skill audits were employed, the data reported indicated that such audits occurred more frequently during Phase II than during Phase I (I = 10 day interval, II = 3 day interval). They were performed at two-thirds of the sites by an AMOSIST MD who works in the AMIC

on the full-time basis. A decrease in the percentage of AMOSISTs who were provided ready access to the results of any and all audits performed was reported between Phase I and II (I = 89%, II = 67%). No sites reported during the second phase evaluations that the results of these audits were maintained in a continuing record (I = 11%). Hence, the attention given the skill audit on site appears to mirror the minimal amount of concrete direction provided in the program guidance.

4.1.5 Physician Staffing.

4.1.5.1 The APC Model #13 guidelines indicate that two categories of physicians are possible: a Chief, AMOSIST Program, and one or more AMOSIST Physicians who may supplement the Chief or work in lieu of him in the AMIC. Also, it highly recommends (paragraph III D3) that either the Chief or one of the staff AMOSIST Physicians attend a formal orientation to the AMOSIST concept at the Academy of Health Sciences (AHS). The APC Model also indicates that it is "most desirable" but "not mandatory" that physician positions be filled with full-time personnel. Furthermore, it states that the Chief of the AMOSIST Program should work a minimum of one full day per week in the AMIC. As regards the AMOSIST Physician, it is stated (paragraph III E2) that when full-time personnel are not available, "It is preferable to keep the number of physicians in a rotational staffing as small as possible and the frequency of AMIC duty often enough to insure that the physician remains well oriented to the AMOSIST program concepts, to the clinic algorithms, and to the strengths and weaknesses of the AMOSIST(s) they will be supervising."

4.1.5.2 The data reported in Table 5 indicate that all sites had designated a physician as the Chief, AMOSIST Program (Item 1). Nonetheless, at only 57% (I = 50%) of the sites, had the Chief of the AMOSIST Program been formally oriented to the AMOSIST concept at AHS by personnel of the AMOSIST Branch. While the APC Model states that the Chief should be present "for at least one full day per week," the data indicated that, on the average, the Chiefs spend between 20 and 47.5 hours (I = 19 and 27 hours) per week in the AMIC (Item 3). However, one site reported that the Chief did not spend any time in the AMIC, and one site reported data that did not meet an 8-hour per week minimum.

4.1.5.3 Ninety-three percent of the sites in both phases reported that a physician was in the AMIC during the entirety of its operating hours (Item 4). However, a lesser percentage, seventy-nine percent of all sites in each phase, indicated that a physician charged with the responsibility of providing requested consultation to the AMOSIST was present in the AMIC during all operating hours (Item 6). The number of physician man-hours supplied to the AMIC shows that on the average the equivalent of 1.7 physicians (I = 1.5) were assigned to work in the AMIC each week (Item 7). The mean ratio of AMOSISTs to AMOSIST physicians (Item 5) increased from 4.7 to 1 to 5.3 to 1 between Phases I and II. Both are within the guidelines set forth in the APC Model (paragraph III C4).

4.1.5.4 The findings relating to the use of roster-assigned physicians (RAPs) appear in items 8a through 8h. Based on the data received from the

Table 5

PHYSICIAN STAFFING

ITEM *	MAILED SURVEY PHASE I	MAILED SURVEY PHASE II
1. Physician has been designated as Chief, AMOSIST Program (1.2)	100%	100%
2. The Chief, AMOSIST Program has been formally oriented to the AMOSIST concept at AHS by personnel of the AMOSIST Branch (9.2)	50%	57%
3. The Chief, AMOSIST Program spends ___ hours per week providing patient care and/or providing consultation to or supervision of AMOSIST (6.1)	25.9	32.9
4. A physician is present in the AMIC during all times during its hours of operation (6.2)	93%	93%
5. During a typical week, the maximum ratio of AMOSISTs to physicians who serve in direct support of AMOSISTs at any one time is ___ (6.3)	4.7/1	5.3/1
6. There is a physician on duty in the AMIC at all operating hours whose principal duty is to provide consultation to AMOSISTs (6.4)	79%	79%
7. The total number of physician man-hours in direct support of the AMIC each week is ___ (6.5)	61	66
8. a. Roster-assigned physicians are used to meet some portion of the physician staffing requirements of the AMIC (1.8)	36%	29%
b. Each roster-assigned physician works in the AMIC an average of ___ man-days per month (6.7) **	5.9	14.3
c. Each roster-assigned physician spends approximately ___ hours per day each day he works in the AMIC (6.8) **	5.3	7.6
d. The number of consecutive work days that a roster-assigned physician typically works when assigned to the AMIC is ___ (6.9) **	3.2	4.3
e. The total number of man-hours per week provided to the AMIC by roster-assigned physicians is ___ (6.10) **	29.5	36.0
f. The principal duties of roster-assigned physicians are ___ (see text) (6.11) **		
g. Roster-assigned physicians are rated by the same individual who rates the Chief, AMOSIST Program (1.8) **	40%	0%
h. Each roster-assigned physician receives a formal briefing on the AMOSIST concept from the Chief, AMOSIST Program prior to beginning work in the AMIC (9.3) **	67%	75%

* Parenthetical entries denote the number of the items as they appeared in the AMIC Checklist.

** Conditional question; see footnote, Table 1. Additionally, data are excluded for the site at which roster-assigned physicians are assigned as the prinicpal physician (for ½ day each) for 90-180 day periods.

surveyed sites, it was apparent the phrase "roster-assigned physician" held a different meaning at each of the sites. As a result, verbal contact was made with those individuals responsible for the completion of the AMIC Checklist to acquire appropriate data. It was determined that one-third of the sites responding to the mailed survey (I = 43%; II = 36%) indicated that RAPs were being utilized. However, one of those sites qualified their use of RAP by saying that the roster-assigned physicians were used only to fill in when the full-time AMOSIST MD was pulled for physical exams, was on leave, etc. This condition also existed at the time of their response to the Phase I survey. The data reflected in Table 5 do not include this site among those employing RAPs in either phase of the study. At the four Phase II sites which did employ RAPS, the number of RAP man-hours reported accounted for 54 percent of the physician man-hours worked at the clinic each week.

4.1.5.5 Of related interest is the manner in which the RAPs are employed within the AMIC. At three of the four sites reporting the use of RAPs, the principal duty was described as being equally divided between providing patient care and providing consultation to AMOSISTs. The remaining site indicated the RAPs served mostly in consultation with AMOSISTs, but provided some direct patient care.

4.1.5.6 In comparing the Phase I and Phase II findings regarding roster-assigned physicians, the findings are mixed. Whereas one less site reports the use of RAPs in Phase II than did in Phase I, the data relating to the manner in which they are utilized reflects a negative change. Phase I data indicated that each roster-assigned physician works in the AMIC an average of only 5.9 man-days per month (Item 8b); however, Phase II data indicated an average of 14.3 man-days per month, a figure which is reasonably consistent with the average of 12.0 man-days per month encountered during the Phase I on-site visits as cited in the initial report of this series. Similarly, increases were also observed in the number of hours per day worked by RAPS and the total number of man-hours per week provided by RAPs. As regards the issue of managerial control, it is noted that there was a substantial decrease in the reported number of RAPs who were rated by the same individual who rated the Chief of the AMIC (I = 33%, II = 0%). There was, however, a slight increase in the percentage of sites reporting that RAPs were given formal briefings regarding the AMOSIST Program prior to their beginning to work there (I = 67%, II = 75%).

4.1.5.7 In view of the findings to be subsequently elaborated upon (paragraph 4.3.2.2.3.4) it is apparent the supervisory environment provided by RAPs is unsatisfactory to the AMOSISTs themselves. A clear need for greater continuity and stability of physician supervision is indicated.

4.1.6 Supervision of AMOSISTs.

4.1.6.1 The APC Model emphasizes the supervision of an AMOSIST by a physician as the most significant quality control measure and states that the physician must periodically spot check AMOSIST performance, daily review AMOSIST records, and provide continuing education functions (paragraph IV C). (This procedure will be hereinafter referred to as "feedback/supervisory sessions.")

4.1.6.2 Data contained in Table 6 indicates a slight increase in the percentage of sites that provided feedback/supervisory sessions to AMOSISTs (I = 79%; II = 93%). The sessions were, however, provided less often (I = once every 5.4 days; II = once every 7.5 days) (Item 1), and the average total time per AMOSIST each month decreased. The total number of hours of such activity reported during Phase II for each AMOSIST (Item 2) ranged from less than one hour per month to a maximum of 12 hours per month with an average value of 4.0 hours per month. The number of hours per month per AMOSIST for Phase I ranged from less than one hour to a maximum of 27 hours with an average of 6.7 hours (Item 2). Thirteen of the fourteen sites (93%) (I = 100%) indicated they based their sessions, at least in part, upon data from DCS or skill audits. Additionally, the data evidenced a decrease in the number of sites indicating that the majority of these sessions were provided by the Chief of the AMOSIST Branch (I = 62%; II = 46%) or by an AMOSIST Physician other than the Chief (I = 31%; II = 8%). Correspondingly, there was an increase in the number of sites reporting that the supervisory sessions were provided by the AMIC NCOIC (I = 8%; II = 23%), or by the AMIC NCOIC in combination with either the Chief of the AMOSIST Program or another AMOSIST Physician (I = 0%; II =15%. On an average, the Chief of the AMOSIST program conducted 66% (I = 56%) of the feedback/supervisory sessions (Item 1e). A lower professional level of supervision than that considered to this point is the AMIC staff meeting. It is noted that the frequency with which staff meetings were held decreased substantially between Phases I and II. Whereas staff meetings occurred approximately once every 0.9 days in Phase I, the interval lengthened to an average of 11.5 days when reported in Phase II.

4.1.6.3 In contrast to Phase I, the findings for Phase II indicate that some improvement has occurred in the overall rating scheme for AMOSISTs. More AMOSIST physicians have become directly involved in the rating of their AMOSISTs. Fifty-seven percent of the sites responding in Phase II indicated that they were rated by the AMOSIST Physician (I = 43%). The remainder of the sites (43%) reported that AMOSISTs were rated by the AMIC NCOIC. During Phase I, approximately 14 percent of the sites reported an AMOSIST physician (not the Chief of the AMOSIST Program) rendered the AMOSIST Enlisted Efficiency Report (EER). No site reported that this was so during Phase II.

4.1.7 Procedural Documentation.

4.1.7.1 General. The documents required by the AMOSIST Program, and the extent to which individual sites and their commanders supplemented and/or "tailored" existing HSC guidelines with written descriptions of their own is discussed in the following text. Relevant data is presented in Table 7.

4.1.7.2 Required Documents.

4.1.7.2.1 The two documents that are actual requirements of the AMOSIST Program are those which address the credentialing of AMOSISTs and the medications which AMOSISTs are permitted to prescribe (AR 40-48).

Table 6

SUPERVISION OF AMOSISTS

ITEM *	MAILED SURVEY PHASE I	PHASE II
1. Feedback/supervisory sessions are provided for each AMOSIST (7.1)	79%	93%
2. a. A feedback/supervisory session is provided for each AMOSIST (on the average) once every ___ working days **	5.4	7.5
b. There are ___ hours of feedback/supervisory sessions provided each AMOSIST each month **	6.7	4.0
c. The majority of the feedback sessions are provided by ___ (see text) **		
d. Feedback/supervisory sessions are based, at least in part, upon DCS or skill audits performed within the past two weeks **	100%	93%
e. The percent of the feedback/supervisory sessions provided by the Chief, AMOSIST Program is ___ **	56%	66%
3. AMIC staff meetings are held once every ___ days (9.1)	6.9	11.5
4. EERs are rendered on each AMOSIST annually (7.2)	100%	100%
5. The AMOSISTs' rater is ___ (see text) (7.3)		

* Parenthetical entries denote the number of the items as they appeared within the AMIC Checklist.

** Conditional question; data cited pertain only to those sites responding affirmatively to the initial item of the series.

Table 7

PROCEDURAL DOCUMENTATION

ITEM *	MAILED SURVEY PHASE I	MAILED SURVEY PHASE II
1. Scope and limits of clinical practice (1.1)		
a. Have been delineated in writing for all AMOSISTs	93%	93%
b. By the MTF's credentials committee **	71%	86%
c. Approved by MTF commander **	86%	86%
2. AMIC druglist has been reviewed and approved by MTF's Therapeutic Agents Board and Commander (1.3)	93%	93%
3. Written guidelines which delineate a specific review procedure for introducing changes to the Triage Manual (1.5)		
a. Do exist	36%	43%
b. Receive separate (i.e., extra-AMIC) review **	60%	83%
c. Reviewers are: (see text) **		
4. In the Triage Manual, specific source of health care (1.4)		
a. Have been designated in writing	71%	57%
b. These designations have received external review (i.e., reviewed by individuals separate from the AMIC) **	20%	38%
c. Those participating in this review are (see text) **		
5. A written description of the procedures to be employed in performing Triage Audits does exist (8.3)	50%	29%
6. A standardized written procedure for entering changes to the AMOSIST Manual does exist (8.1)	21%	36%
7. Written instructions which delineate a specific review procedure for locally proposed changes to the AMOSIST Manual (1.6)		
a. Do exist	21%	43%
b. Reviewers are: (see text) **		
8. A consolicated file or list of all formally reviewed and approved changes to the AMOSIST Manual does exist (1.7)	14%	29%
9. A written description of the procedures to be employed in performing the continuing audit of treatment DCSs does exist (8.5)	50%	57%
10. A written description of the procedures employed in performing skill audits of AMOSISTs does exist (8.8)	21%	14%
11. A written description of the procedures to be employed in the supervision of AMOSISTs by AMOSIST MDs does exist (8.2)	64%	29%
12. A record of the training status (i.e., that required for AHS certification) of all AMOSISTs in the clinic does exist (8.6)	50%	79%
13. A written description of the procedures to be followed in handling medical emergencies which may occur in the AMIC does exist (8.7)	50%	50%
14. Workload related data is recorded and maintained in the AMIC (8.9)	100%	100%
15. A patient log is maintained within the AMIC (8.10)	71%	93%

* Parenthetical entries denote the number of the items as they appeared in the AMIC Checklist.

** Conditional question; data reflect only those sites responding affirmatively to the initial items of the series.

4.1.7.2.2 In both phases, all but one site (93%) reported that the credentialing requirements had been delineated in writing for all AMOSISTs.* Such documents were indicated to have been written by the facility's Credentialing Committee (I = 71%; II = 86%) and approved by the MTF Commander (I = 86%; II = 86%) in most instances.

4.1.7.2.3 Ninety-three percent of the sites in both phases indicated the AMIC drug list had been formally reviewed by the MTF Therapeutic Agents Board (TAB) and approved by the Commander (Item 2). As regards this item, one of the requirements of the AMIC Checklist was that each site provide the study agency a "copy of the locally approved Drug List that is currently in effect." One site that indicated that their drug list had not been formally reviewed and approved by the MTF Therapeutic Agents Board, but the MTF Commander explained that their TAB meeting's minutes commented under "Old Business" that ". . . HSC drug list is still in use and cannot be modified unless we have an algorithm to go along with it. This tabled . . ." Hence, it is likely that all sites (100%) now have approved drug lists.

4.1.7.3 Locally Developed Guidance. While the APC Model does not provide consistent, adequate guidance as to the possible modification of the Triage Manual and the AMOSIST Manuals, it permits and encourages local modification designed to tailor the AMOSIST Program to fit the local situation and needs. Items 3 through 15 of Table 7 address the extent to which local guidance has been developed in several functional areas.

4.1.7.3.1 Triage Manual.

4.1.7.3.1.1 A review of the data revealed that there was a slight increase (7%) in the existence of written guidelines which delineated a specific review procedure for introducing changes to the Triage Manual and a 23 percent increase in the extra-AMIC review of these changes. Of the five Phase II sites reporting that someone who is separate from the AMIC reviewed these locally proposed changes, 60 percent stated the Chief, Department of Clinics, in combination with the Chief, Professional Service (two sites) and the MTF Commander (one site) conducted the review. (One of the sites that indicated the Chief, Department of Clinics and the Chief, Professional Services reviewed the changes qualified their response by stating these individuals were one and the same). Two sites (40%) indicated that the MTF Commander, either alone, or in combination with the Chief of Professional Services reviewed the changes.

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*During the Phase I on-site survey, one MTF had reported that the credentialing documents requirement had not been met. A search made during Phase II located the credentialing documents. The data cited in Table 7 reflect this correction.

4.1.7.3.1.2 Almost one-half of the Phase II survey sites (43%) reported that the Triage Manual had not been supplemented in writing by replacing the generic names of clinics and services with the names of the local clinics and services to which patients should be referred within the hospital. Although there is no HSC guidance, the "Disposition Level Summary" portion of the Triage Manual (Annex B to the 5th edition) recognizes the need for such guidance, and the Phase I Report (Schopper, 1978a) suggests several reasons why it should be done. Nevertheless, of those sites reporting that individual clinics/services had been specified, only three indicated these instructions had been reviewed by anyone outside the AMIC. One site reported the review was made by the Chief of the Department of Clinics, the Chief of Professional Services and the Chiefs of each clinic; one site indicated their review was by a single individual who served as both the Chief of the Department of Clinics and the Chief of Professional Services; and one site reported there was a review but did not specify who conducted it.

4.1.7.3.2 Triage Auditing Procedures. The auditing of the triage function has been discussed previously. Therein, it was indicated that the APC Model does not require the performance of triage audits nor provide guidelines as to how they might be performed. It is noted in item 5 that the percentage of sites reporting that a written description of triage audit procedures exists declined from 50 percent in Phase I to 29 percent in Phase II. Again, it may be that the decline is the result of the more rigorous definition of the term "audit." (It is interesting to note that one site reported that they had a written description of the procedures for performing a triage audit; however, they did not perform a formal audit of the triage data collection sheets.)

4.1.7.3.3 AMOSIST Manual.

4.1.7.3.3.1 The APC Model #13 does not describe a procedure to be followed in order to review and make changes to the AMOSIST Manual, but it does suggest that the Chief of the AMOSIST Program review the AMOSIST Manual at least annually to insure the logic in the treatment protocols reflect current medical practice (paragraph IV C7). A substantially greater proportion of the Phase II sites (43%) reported they had written instructions which outlined a specific procedure for reviewing locally proposed changes to the AMOSIST Manual than were reported during Phase I (29%). Of the Phase II sites indicating such, 50 percent were reviewed by the Chief of the Department of Clinics and the Chief of the Professional Service; 33% were reviewed by the Chief of the Department of Clinics, Chief of the Professional Services, and the MTF Commander; and 17% were reviewed by the MTF Commander only. There was also an increase in the number of sites indicating that a standardized written procedure now exists for entering changes to the AMOSIST Manual (I = 21%; II = 36%). Nevertheless, of those sites indicating the existence of this document, not one furnished a copy of it for review as requested. The lack of a response on the part of these sites does, therefore, create some doubt regarding the existence of such guidance at the local level.

4.1.7.3.3.2 The percentage of sites reporting the existence of a consolidated file or list of formally reviewed changes to the AMOSIST Manual

doubled between Phases I and II, (I = 14%; II = 29%). However, one-half of the second phase sites indicated that there were no changes existing to the AMOSIST Manual.

4.1.7.3.3.3 Eight sites (57%) indicated the existence of a written description of the procedures to be employed in performing the continuing audit of treatment DCSs; however, one site qualified its reply and stated that the procedure used is as prescribed in the "APC package." Even though the APC Model gives more definitive guidance pertaining to treatment DCS auditing procedures than it does for other types of audits, it still leaves many of the specifics of the audit operation up to local personnel.

4.1.7.3.4 Skill Audits. The only guidance given in the APC Model regarding the procedure for the AMOSIST skill audit is that the audit be conducted periodically by the AMOSIST physician, that it be documented, and that the frequency and methodology is a local decision (paragraph IV C3). Only two of the 14 sites (14%) indicated that a written description of the procedures employed in performing skill audits of AMOSISTs existed in their AMIC organization (I = 21%).

4.1.7.3.5 AMOSIST Supervision and Training.

4.1.7.3.5.1 There existed a very substantial decrease in the number of sites reporting the existence of a written description of the procedures employed by AMOSIST Physicians in supervising AMOSISTs (I = 64%; II = 29%).

4.1.7.3.5.2 There seemed to be considerable confusion regarding what documents were necessary for AHS certification of an AMOSIST. Only after repeated telephone conversations outlining specific documents required to verify the various training levels of each AMOSIST was it determined that 79 percent (I = 50%) of the sites had in their files records indicating the AMOSISTs training status. This information was obviously neither well organized nor readily available. Similar confusion was reported by the personnel making the on-site visits during Phase I of the study.

4.1.7.3.6 Other Documentation. Regarding the existence of a written description of procedures for handling medical emergencies, a number of sites indicated that their AMIC was physically located next to the emergency room and that all emergencies were triaged to the Emergency Room or Emergency Room personnel could come to the patient in the AMIC. Hence, the 50 percent figure reported may reflect the absence of a perceived need to have such a description in a clinic manual of standing operating procedures (SOP).

4.1.8 Pharmaceutical Considerations. The data reflected in Table 8 shows very little change from Phase I to Phase II. The exception is a marked decrease between Phases I and II for item 5 (I = 29%; II = 7%) which pertains to the identification of both AMOSIST and the responsible physician on the labels of AMOSIST prescribed medication. It is acknowledged, however, that this dual form of identification is not a requirement of the APC Model or any related regulation.

4.1.9 Other Characteristics and Parameters.

Table 8

PHARMACEUTICAL CONSIDERATIONS

ITEM *	PERCENT "YES" PHASE I	PERCENT "YES" PHASE II
1. The pharmacy <u>does</u> have a copy of the current TAB/CDR approved AMOSIST drug list (15.1)	100%	100%
2. The pharmacy <u>does</u> have signature cards for all AMOSISTs presently serving in the AMIC (15.2)	93%	100%
3. The pharmacy <u>does</u> prominently display the TAB/CDR approved drug list (15.3)	93%	93%
4. Prescription slips are overstamped with the statement: "To be filled only at (name of MTF) Pharmacy" or its equivalent (15.4)	100%	93%
5. Labels appearing on AMOSIST-prescribed medication do identify both the AMOSIST and the responsible physician (15.5)	29%	7%
6. There have been ___ instances during the past six months wherein the pharmacy has encountered AMOSIST-originated prescriptions for drugs not appearing on the TAB/CDR approved drug list (15.6)	2.2	1.5

* Parenthetical entries denote the number of the items as they appear on the AMIC Checklist.

4.1.9.1 Screening and Examination Room Characteristics. The Phase II data describing the rooms and the equipment which AMIC personnel utilize is described in Table 9 and reflects very little change from the Phase I data for most items. However, the item (Item 2) pertaining to the availability of office and examination rooms for all personnel declined sharply from 72 percent in Phase I to 29 percent in Phase II. Albeit little change was observed between phases, the items relating to patient privacy in both the triage areas and in the treatment rooms (Items 5 and 7) are not as satisfactory as desired. Regarding the medical examining instruments available in the examination rooms (Item 10), the most commonly missing item was the temperature measuring device. However, at all sites this instrument was available in the screening section.

4.1.9.2 General Characteristics of AMIC Area.

4.1.9.2.1 As previously mentioned in the Phase I Report (Schopper, 1978a) all items in Table 10, except items 5 and 6, are applicable to most outpatient clinics or services. These items pertain to the wearing of an AMOSIST jacket which identifies their status as AMOSISTs (item 5) and the availability of AMOSIST patient education handouts (item 6). For both items, there was a substantial decrease between Phases I and II. Even though the APC Model #13, paragraph III 14, recommends the AMOSIST wear the short, white "PA jacket" over their authorized military uniform and a badge or nameplate which clearly identified them as AMOSISTs, just over one-half of the sites (57%) reported that this was being done (I = 79%). Clearly, this decrement lends further credence to the medico-legal concern (patient informedness) voiced in the initial report (Schopper, 1978a).

4.1.9.2.2 The findings pertaining to the AMOSIST Program educational handouts indicate that they are not available for distribution to patients at 29 percent fewer sites (I = 100%). Observations made on-site during both Phases I and II indicated although they were physically present, they are rarely utilized.

4.1.10 AMOSIST Workload and Assignment.

4.1.10.1 The data presented in Table 11 relate to a comparison of the reported workload of AMOSISTs and the clinics/services to which AMOSISTs were assigned. AMOSISTs were reported to be seeing approximately 19 patients per day in both phases. This is close to the APC Model's suggested workload of 20 patients per day. The range of the number of patients seen per day was 12 to 25. Only four sites exceeded the APC Model guidelines (i.e., 3 sites reported 25 patients per day and one site reported 24 patients per day). The average number of patients seen per hour by an AMOSIST during periods of peak workload decreased by approximately one patient (I = 4.8; II = 4.1); again, a figure which is closer to the APC Model's suggested number of 2.5 patients per hour than that reported during Phase I.

4.1.10.2 The sites surveyed were asked to identify the department/service against which the AMOSISTs were assigned. At the time of the second phase data collection, one-half of the Phase II sites (50%) indicated the AMOSISTs were assigned against the TDA of the Department of Primary Care,

Table 9

SCREENING AND EXAMINATION ROOM CHARACTERISTICS

ITEM *	PERCENT "YES" PHASE I	PERCENT "YES" PHASE II
1. The physician's office/examination rooms are located in the same area as the AMOSIST's office/examination rooms (13.1)	100%	100%
2. The number of fully enclosed office/examination rooms is equal to or more than the maximum number of AMOSISTs and physicians on duty in the AMIC at any one time (13.2)	72%	29%
3. The Triage area is at least semi-enclosed (i.e., enclosed on at least 3 sides) (11.3)	93%	93%
4. The Triage areas do permit patients to be individually screened (11.4)	93%	100%
5. Triage facilities do prevent the overhearing of Triage conversations by individuals who are awaiting Triage or treatment (11.5)	64%	71%
6. All office/examination rooms are fully enclosed with solid walls and doors (13.3)	93%	100%
7. Conversations in the office/examination rooms are intelligible to individuals in adjacent areas (13.4)	29%	29%
8. The area where vital signs are recorded is equipped with all of the following materials: (1) stethoscope, (2) temperature measuring device, (3) sphygmomanometer (11.6)	100%	100%
9. Each office/examination room does have all of the following items: (1) examination table with disposable paper sheets, (2) two chairs, (3) desk, (4) waste receptacle, (5) shelves or other container for blank forms (13.5)	100%	100%
10. Office/examination rooms do have all of the following medical equipment: (1) Otoscope set, (2) sphygmomanometer, (3) stethoscope, (4) reflex hammer, (5) temperature measuring device, (6) tongue depressors (13.6)	57%	50%

* Parenthetical entries denote the number of the items as they appear in the AMIC Checklist.

Table 10

GENERAL CHARACTERISTICS OF AMIC AREA

ITEM *	PERCENT "YES" PHASE I	PERCENT "YES" PHASE II
1. The ER's telephone number prominently displayed in the clinic (12.1)	64%	64%
2. A litter is readily available (12.2)	79%	86%
3. An emergency cart is readily available (12.3)	64%	86%
4. The following medical references are present in the AMIC area: (1) Medical dictionary, (2) reference book on Physical Diagnosis, (3) Physicians Desk Reference (PDR) (12.4)	93%	93%
5. All AMOSISTs do wear a hospital jacket which clearly identifies their status as AMOSISTs (12.5)	79%	57%
6. The patient education sheets included as Appendix L in the revised AMOSIST Manual are available as handouts to the patient (12.6)	100%	71%
7. Patient education materials of a general nature are readily available in the patient waiting areas (12.7)	71%	64%
8. Information pertaining to how and where a patient may register a complaint is prominently displayed in the hospital (12.8)	71%	79%

* Parenthetical entries denote the number of the items as they appear in the AMIC Checklist.

Table 11

AMOSIST WORKLOAD AND ASSIGNMENT

ITEM	PERCENT "YES" PHASE I	PERCENT "YES" PHASE II
1. The average number of patients seen per AMOSIST per day is ___ (10.1)	18.3	18.9
2. The average number of patients-per-hour seen by AMOSISTs during hours of peak workload is ___ (10.2)	4.8	4.1
3. AMOSISTs are assigned against the TDA of ___ (see text) (1.9)		

21% of the sites reported they were assigned against the TDA of the Nursing Service, and the rest reportedly were assigned against various other departments and services. This represents little change from that evidenced in the initial phase.

4.1.11 Summary of AMIC Checklist Findings.

4.1.11.1 To assist in attempting an overall assessment of the changes encountered between Phases I and II of the present study regarding the operational characteristics of the AMICs, a summary table, Table 12, is provided. Therein, for each of the ten areas addressed in the AMIC Checklist, a total is given for the number of items for which there existed positive change, negative change, or no change (or mixed results between Phase I and Phase II).

4.1.11.2 A total of 101 individual items were evaluated in the principal areas contained in the AMIC Checklist. As indicated in Table 12, 36 percent of the items evidenced a change which is considered to be positive in nature, and 25 percent of them evidenced a change which is considered to be negative in nature. The remaining 41 percent yielded findings which reflected no change or change which was equivocal in nature. Overall, the mean change is not significantly different form zero ($t = 1.29$, $df = 1/100$, $p = .2$).

4.1.11.3 While the above findings indicate that, from a global perspective, there occurred no significant change in the manner in which the AMOSIST Program functioned between Phases I and II, it is emphasized that the level of functioning in several important areas is low and in need of considerable improvement. The most critical of these are, in the writer's opinion, those dealing with auditing procedures, supervision of AMOSISTs, and physician staffing procedures. From the vantage point of medico-legal vulnerability, the present findings suggest no change in the conclusion cited in the initial report (Schopper, 1978a) that the AMOSIST Program is quite vulnerable to medico-legal suit due to its inability to assess and document the adequacy of performance of this least-of-all-formally-trained direct care provider.

4.2 Program Acceptance.

4.2.1 Patient Satisfaction

4.2.1.1 Interphase Comparisons: Demographic Characteristics. The demographic characteristics of the respondents to the PSQ I Questionnaire are depicted in Table 13 for Phases I and II. As is apparent from the data in Table 13, the characteristics of the respondents are quite comparable between the two phases. For both phases there are approximately equal number of respondents above and below the age of 29. Female respondents outnumbered male respondents by more than 60 percent, and enlisted personnel or their dependents made up more than 75 percent of the respondents in both phases. Active duty personnel and their dependents made up more than 60 percent of the respondents in each phase of the study. Chi-square analyses performed on each of the demographic characteristics yielded no significant difference existed between Phase I and Phase II for any of the demographic characteristics considered.

Table 12

SUMMARY OF AMIC CHECKLIST INTERPHASE CHANGES

AREA (No. ITEMS)	POSITIVE CHANGE	NEGATIVE CHANGE	NONE OR MIXED
Triage Functioning (7)	6	0	1
AMOSIST Manual and DCS Utilization (7)	1	3	3
Auditing Procedures (15)	3	8	9
Physician Staffing (9)	5	2	8
Supervision of AMOSISTs (9)	2	4	3
Procedural Documentation (22)	11	4	9
Pharmaceutical Considerations (6)	2	2	2
Screening and Exam Room Characteristics (10)	3	2	5
AMOSIST Workload (2)	1	0	1
General Characteristics of AMIC (8)	3	3	2
TOTAL: (101)	35	25	41
PERCENT OF TOTAL:	34.7	24.8	40.6

Table 13

COMPARISON OF DEMOGRAPHIC CHARACTERISTICS OF PSQ I SURVEY RESPONDENTS: PHASE I VERSUS PHASE II

CHARACTERISTIC *		PHASE I	PHASE II
Age	19 or less	21%	20%
	20-29	33%	33%
	30-39	16%	17%
	40-49	15%	16%
	50 or more	14%	14%
Sex	Male	37%	37%
	Female	63%	63%
Rank (self or sponsor)			
	E1-E3	13%	11%
	E4-E5	26%	27%
	E6-E7	27%	30%
	E8-E9	11%	10%
	WO (all)	3%	3%
	O1-O2	3%	3%
	O3	5%	4%
	O4	4%	4%
	O5	6%	5%
	O6 or higher	3%	3%
Medical Eligibility			
	Active (AD)	34%	35%
	AD Dependent (ADEP)	27%	28%
	Retired (RET)	20%	19%
	Dependent of retired or deceased (DRET)	19%	18%

* Total number of respondents = 1908. Forty-eight and six-tenths percent of these were Phase I respondents. None of the chi-square analyses reflected statistically significant differences at $p > .65$. Failures to total 100% in the Phase I column for RANK is due to rounding errors.

4.2.1.2 Interphase Comparison: Care-Related Items. The Phase I versus Phase II comparison of PSQ I responses to each item on the questionnaire is shown in Table 14. Among all 25 items shown in Table 14, only four showed a statistically significant difference at the $p \leq .05$ level. Significantly increased satisfaction was observed for the amount of time respondents had to wait for care, the amount of time spent in their examination, and the manner in which they were treated by the receptionists. Significantly increased positive feelings about having to complete the questionnaire itself also existed. There were no statistically significant decreases among any of the items in the questionnaire. The results of a multivariate analysis of variance involving items 8 through 18 collectively showed an increase in patient satisfaction between Phases I and II ($p = .03218$).* The results of a multivariate analysis of variance involving only those five items which pertain to the behavior of the care providers themselves (item 11, Completeness of examination; item 12, Amount of information received; item 14, Amount of interest shown by examiner; item 15, Amount of time spent in examination; and item 17, Courtesy, friendliness of examiner) also showed a significant difference ($p = .05323$). An additional analysis using only those variables which were not readily subject to change (item 19, Parking facilities; item 20, Appearance of clinic; item 23, Degree of privacy; and item 28, Convenience of clinic) revealed, as should be the case, no statistically significant interphase change ($p = .52559$).

4.2.1.3 Demographic-Related Response Patterns. In the initial report of the study (Schopper, 1978a), there was clear documentation for differences in levels of satisfaction according to the age and medical eligibility status of the respondent. With relatively few exceptions, the same pattern was evidenced for both characteristics on each item included in the questionnaire. The effects attributable to the respondents sex or rank were less clearly defined and frequently not statistically significant. Since all demographic findings were, in general, replicated in the Phase II data, they are exampled in the present report in Table 15 for only the item addressing the respondent's perceptions of the overall treatment he received in the clinic. The same general patterns were observed among the other items in the questionnaire. As observed in Table 15, there was a significant difference present among the respondents when categorized according to both age and medical eligibility status. The results of a Duncan's aposteriori test applied to the data indicated that the respondents in the oldest two groups (those age 40 and over) were all significantly higher in their rated satisfaction with the care received than were those in the youngest three groups. The results of a similar aposteriori analysis conducted on the medical eligibility status characteristic showed that retired personnel were significantly more satisfied than any other group of respondents (which were, collectively, not significantly different from one another). As shown in the table, neither sex nor rank (when dichotomized into enlisted and officer personnel) evidenced a statistically significant difference.

*Item 29, that pertaining to laboratory and x-ray services, was deleted in order to increase the sample size. The computer program employed (SPSS, Nie et al, 1975) deletes all cases for which all data is not complete. Since patients who did not receive either laboratory tests or x-rays were instructed by the questionnaire to leave item 29 blank, the inclusion of that item would have decreased the sample size by more than one-half.

Table 14

PHASE I VERSUS PHASE II COMPARISON OF PSQ I RESPONSES

ITEM		PHASE I	PHASE II	SIG. * (p=)
6.	Military life in general	6.37	6.28	.3747
7.	Previous military medical care	6.36	6.43	.5116
8.	Waiting time	5.99	6.28	.0193
9.	Parking facilities	5.78	5.75	.8204
10.	Appearance of clinic	7.06	7.11	.5524
11.	Completeness of examination	6.79	6.88	.4543
12.	Amount of information received	6.87	6.93	.5819
13.	Degree of privacy	7.63	7.62	.9741
14.	Amount of interest shown by examiner	7.07	7.17	.3521
15.	Amount of time spent in the examination	6.76	6.98	.0513
16.	Manner treated by receptionist	7.37	7.57	.0373
17.	Courtesy, friendliness of examiner	7.55	7.66	.2547
18.	Convenience of clinic	7.27	7.25	.7856
19.	Laboratory and x-ray services	6.68	6.58	.5344
20.	Overall treatment of this clinic	7.03	7.15	.2433
21.	Adequacy of people in this clinic **	3.52	3.50	.6604
22.	Evaluation of medical treatment received **	3.47	3.54	.1256
23.	Examiner's understanding of problem **	3.91	3.95	.4284
24.	Comparison with prior care in this clinic ***	3.25	3.26	.8628
25.	Feelings about completing questionnaire	7.60	7.92	.0020

* One-way ANOVAs on 5-point scale: 1=Extremely Dissatisfied to 9=Extremely Satisfied (see Appendix D). No. respondents: Phase I = 927, Phase II = 981.

** 5-point scale: 1=Least Satisfied evaluation to 5=Most Satisfied evaluation (see Appendix D).

*** 7-point balanced scale: 1=Very Much Better Today Than Before to 7=Very Much Worse Today Than Before.

Table 15

EFFECTS OF DEMOGRAPHIC CHARACTERISTICS OF PHASE II PSQ I RESPONDENTS WITH PERCEPTIONS OF OVERALL TREATMENT IN CLINIC

CHARACTERISTIC	CATEGORY	MEAN RESPONSE	SIGNIFICANCE (p=)
Age	19 or less	6.96	
	20-29	6.86	
	30-39	7.08	
	40-49	7.59	
	50 or more	7.95	.0000
Sex	Male	7.10	
	Female	7.23	.3326
Rank (Self or Sponsor)	Enlisted Personnel	7.11	
	Officer Personnel	7.33	.1216
Medical Eligibility Status	Active Duty (AD)	6.97	
	Dependent of AD	7.11	
	Retired (Ret)	7.73	
	Dependent of Ret or Deceased	7.05	.0003

Total number of respondents = 785

4.2.2 AMOSISTs versus Physicians

4.2.2.1 General. During the course of the evaluations conducted for the purpose of evaluating the cost effectiveness and physician savings aspects for the AMOSIST Program (Schopper, 1978b), on-site visits were made for periods of two weeks each at three of the better-run AMICs and three General Outpatient Clinics (GOCs). Data pertaining to patient satisfaction was obtained at each facility using the two-page, two-part questionnaire inclosed at Appendix E. The items pertaining to patient satisfaction on this questionnaire (PSQ IV) were identical to those utilized on the questionnaire, PSQ I, just discussed. The principal differences in the content of the questionnaires was the increased amount of demographic information contained in the first part of the questionnaire. A second difference between the questionnaires was the manner in which the data was gathered. Instead of providing the entire list of questions to the patient at the time he arrived at the clinic and asking him not to complete the satisfaction-related items until after he had completed his care, the questionnaire employed in the on-site visits was distributed in two parts. They received the first part (that addressing the demographic items) at the time they arrived at the clinic and were not given the second part (containing the satisfaction-related item) until after they had received their care. Hence, while comparison between the data from the on-site visits and those from the survey data might be contaminated to some unknown degree by the differences in the methodology employed in distributing the questionnaires, comparisons between the AMICs and the GOCs are not so affected and may be made directly. The results of the comparison are presented in brief in the following paragraphs.

4.2.2.2 Demographic Characteristics. Overall, the patients treated in the GOCs were significantly different ($p < .05$) from those in the AMIC on nearly all characteristics evaluated. In particular, as relates to those considered in the PSQ I sample, the patients treated in the GOC (a) were significantly older, (b) evidenced slightly (but significantly) fewer females (4 percent less), (c) were higher in rank (self or sponsor) and (d) more often from the retired or dependent-of-retired population. The GOC-treated group also expressed significantly greater general satisfaction with the military life. They also reported greater satisfaction with previously rendered care received; however, the magnitude of this difference was not statistically significant ($p = .2191$). The differences between these two samples (GOC vs AMIC) was also mirrored for the subsamples of AMOSIST-treated and GOC-physician treated patients. It is noted that the differences cited above are all in the directions which have been previously reported to have been associated with greater satisfaction (see paragraph 4.2.1.3 herein and Tables 15-19, Schopper, 1978a).

4.2.2.3 Satisfaction-Related Findings.

4.2.2.3.1 The comparison of most interest to the present study is that between the amount of patient satisfaction reported by patients treated by AMOSISTs and that reported by patients treated by physicians serving in GOCs. However, due to the discrepancies reported above between these types of clinics on demographic variables and attitudinal variables which have been found to

be related to patient satisfaction it is necessary to report the results of analyses which minimize the effects of such differences upon the comparisons through the use of covariates rather than report the results of analyses performed upon the raw data, per se.

4.2.2.3.2 Table 16 depicts the results of one-way analyses of covariance (ANCOVA). The analyses effect statistical control for the aforecited differences in the patient's ages, expressed satisfaction with the military life, and expressed satisfaction with previous medical care received. They also similarly control for (a) differences observed in the initial, raw-data analyses pertaining to patient-noted differences in the extent to which the clinic seemed to be operating in a manner which was better than it had been in previous visits ("Hawthorne effect") and (b) differences noted between the patient samples regarding the extent to which the requirement to fill out the questionnaire constituted a "bother" or "annoyance" to them. (The differences in both instances significantly favored the GOC sample; i.e., they reported a significantly larger "Hawthorne" effect and significantly less irritation at having to complete the questionnaire.)

4.2.2.3.3 The results of the analyses of covariance are shown in Table 16. All but three items favor AMIC delivered care. The results of a multivariate analysis of variance using collectively all similarly scaled items (except that pertaining to laboratory and x-ray services) showed that, statistically, there existed a highly significant difference in the amount of satisfaction reported by patients treated by AMOSISTs and those treated by GOC physicians ($p = .00001$).* This difference was retained ($p = .00001$) when variance attributable to the factors cited previously was accounted for by employing them as covariates in the multivariate analyses of variance.

4.2.2.3.4 In order to focus more sharply upon the care providers themselves, a second multivariate analysis of variance with covariates was performed using again, as was done in the interphase comparisons, only those items which pertained directly to the behaviors of the care providers, per se (i.e., Completeness of examination, Amount of information received, Amount of interest showed by examiner, Amount of time spent in the examination, and Courtesy, friendliness of examiner). The results of this analysis also showed that AMOSIST-treated patients were significantly more satisfied with their care than were patients who were treated by GOC physicians ($p = .00158$).

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*The rationale for deleting the laboratory x-ray item is the same as that cited previously, i.e., to increase sample size (see footnote referenced from paragraph 4.2.1.2).

Table 16

PATIENT SATISFACTION COMPARISON: PATIENTS TREATED BY AMOSISTS VERSUS PATIENTS TREATED BY GOC PHYSICIANS

ITEM	AMOSISTs	GOC Physicians	Sig.* (p=)
1. Waiting time	6.69	6.63	.033
2. Parking facilities	6.83	6.35	.002
3. Appearance of clinic	7.75	7.67	.458
4. Completeness of examination	7.61	7.38	.080
5. Amount of information received	7.74	7.33	.003
6. Degree of privacy	8.17	7.76	.001
7. Amount of interest shown by examiner	7.97	7.47	.001
8. Amount of time spent in the examination	7.71	7.09	.001
9. Manner treated by receptionist	7.52	7.41	.558
10. Courtesy, friendliness of examiner	7.83	7.78	.794
11. Convenience of clinic	7.40	7.58	.349
12. Laboratory and X-ray services	6.79	7.15	.115
13. Overall treatment of this clinic	7.36	7.49	.474
14. Adequacy of people in this clinic **	3.81	3.61	.004
15. Evaluation of medical treatment received**	3.79	3.61	.002
16. Examiner's understanding of problem **	4.18	4.14	.596

* One-way ANCOVAs on 9-point scale: 1=Extremely Dissatisfied to 9=Extremely Satisfied (see Appendix D). Covariates for items 1 through 16 were: Age, Satisfaction with military life in general, Satisfaction with previous military medical care, Comparison with care received in prior visits, and Feelings about completing the questionnaire.

** 5-point scale: 1=Least Satisfied evaluation to 5=Most Satisfied evaluation (see Appendix D).

4.2.2.3.5 Some caution is warranted regarding the last statment made in the preceding paragraph, however. Since the three AMIC sites involved were among the best-operated of those visited during Phase I of the study, it may be that the AMOSISTs serving therein also deliver care in a manner which is more positive and/or appropriate than do AMOSISTs serving at most other clinics. (Such is not necessarily so; however, since the fact that an AMIC appears to run somewhat more efficiently and in somewhat greater accord with existing guidelines than do other AMICs does not guarantee that the AMOSISTs themselves evidence corresponding differences in the manner in which they provide care.) Hence, a summary statement which is more appropriate to the AMOSIST Program as a whole is that there exists the "potential" for AMOSISTs to provide care in a manner which is equally as acceptable to the patient as that provided by a physician.

4.2.3 Summary of Program Acceptance. The principal findings pertaining to patient satisfaction were that (a) care-provider-related patient satisfaction increased significantly between Phases I and II, (b) care-provider-related patient satisfaction was significantly greater for patients treated by AMOSISTs than for patients treated by GOC physicians, and (c) the pattern of satisfaction related to demographic variables was largely the same for both Phase I and Phase II respondents; i.e., patients over 40 and retired sponsors were significantly more satisfied with their care than were younger patients, active duty patients, or dependent patients of any category.

4.3 Program Acceptance: Staff Satisfaction/Perceptions.

4.3.1 General. The acceptance of the AMOSIST Program on the part of hospital staff was viewed from two separate perspectives. From an internal perspective, this was assessed by determining the level of job satisfaction existing among those serving within the AMICs at the various MEDDACs. This assessment included not only perceptions of the AMOSISTs and the AMOSIST physicians toward their job, but also some appreciation of their perceptions of one another. From an external perspective, the evaluation focussed upon determing the extent of apparent acceptance of the AMOSISTs and the AMOSIST Program on the part of those comprising the sociomedical environment within which the AMOSIST Program functioned. The evaluation addressed the opinions of both physicians and non-physician personnel serving in other clinics within the hospital.

4.3.2 AMIC Staff Job Satisfaction.

4.3.2.1 General. The assessment of satisfaction among those personnel serving within the AMOSIST Program was multifaceted. The data were examined in both a comparative and a non-comparative fashion to determine, respectively, whether or not those personnel working within the AMIC were more or less satisfied than comparable personnel serving elsewhere in the hospital and to determine the most and least liked aspects of the program.

4.3.2.2 AMOSIST Job Satisfaction.

4.3.2.2.1 Comparative Findings: Phase I versus Phase II.

4.3.2.2.1.1 Demographic Characteristics. Prior to undertaking an analysis of the possible differences in job satisfaction between Phase I and Phase II among AMOSISTs regarding their work, it is necessary to first examine the demographic characteristics of each sample to assure that the two samples are comparable. This comparison is reported in Table 17. Therein, it is apparent that there exists no significant difference among AMOSISTs between Phase I and Phase II of the study as regards their age, pay grade, sex distribution, years of active duty, or months at the facility where they were presently working. There was, however, a very substantial and statistically significant difference in the relative proportion of 91Bs serving during Phase I and Phase II of the study. In the initial phase of this study, AMOSISTs were made up in equal parts of 91Bs and 91Cs. However, between the time data was collected during Phase I and the time data was collected during Phase II, a decision was made to withdraw the 91C from the AMOSIST Program. Hence, by the time of the Phase II evaluation, the proportion of 91Cs within the AMOSIST Program had been halved.* The impact of the deletion of the 91C is to eliminate personnel who have had substantially more formal medical education from the program. Findings cited later in the report will relate to this reduction in the proportion of 91Cs in the program.

4.3.2.2.1.2 SSQ Parts II

4.3.2.2.1.2.1 The stability of the program as reflected in the staff satisfaction questionnaire data was examined by determining the extent to which statistically significant differences were observed between the two data collection phases among the individual items comprising the questionnaire. In general, it is noted that for the attitudinal items contained in Part II-IV of the questionnaire there were relatively few significant differences observed. Among all items included in Part II of the SSQ there were only two items which evidenced a significant difference between the phases at the level of statistical significance normally cited, $p \leq .05$. Both of these items related to renumerative considerations. On the 9 point scale used in Part II, the findings indicated that Phase II AMOSISTs were significantly less satisfied with the amount of pay they received (I = 5.01, II = 4.30, p = .0282), and that they were significantly less satisfied with the benefits that the Army provides to them (I = 6.54, II = 5.61, p = .0020).

*The principal difference between personnel with a 91B MOS versus a 91C MOS is that the latter have received considerably more formal military medical education. The 91B is the US Army's basic corpsman MOS. The 91C MOS identifies the individual as a Clinical Specialist. The medical education provided the 91B is approximately eight weeks in length. The medical education for the 91C consists of an additional 14 weeks of formal didactic training plus six more months in a supervised, hands-on clinical training environment.

Table 17

AMOSIST PHASE I VERSUS PHASE II COMPARISON:

DEMOGRAPHIC VARIABLES

ITEM	PHASE I [a]	PHASE II [b]	Sig.[c] (p =)
Age	26.4	25.8	.3611
Pay Grade (E-)	5.1	4.9	.1276
Sex (% Male)	59.5	58.1	.8173
Years of Active Duty	6.18	5.60	.3350
Months at Present Facility	14.0	13.8	.9027
MOS (% 91B)	49.7	73.8	.0000

a. N = 141

b. N = 130

c. Two-tailed tests

The latter is reflected in the same direction to a lesser, nonsignificant degree regarding their opportunities to participate in the Army's educational support program (item 25, p = .0728) and their perceptions of the availability of support personnel (item 42, p = .0643). Nonetheless, 77 percent of the similarly scaled items of Part II (items 1 through 44) showed a decrease in satisfaction between Phases I and II. The statistical significance of this finding was evaluated by collectively examining the difference scores for each of the 44 items in order to determine if the mean, overall difference evidenced was significantly different from zero. The results of that analysis showed that there did exist a very reliable statistical difference between Phases I and II ($t = 4.03$, $df = 1/43$, $p = .0005$) indicating the existence of less overall satisfaction among Phase II AMOSISTs.

4.3.2.2.1.2.2 As cited previously, the construction of the initial part of the test was such that 44 items therein were answered using a common 9-point Likert scale. Hence, it was possible to determine among those 44 items which were rated as being most satisfactory and which were rated as being least satisfactory. These data appear in Tables 18 and 19, respectively. The eight items which appear in each correspond roughly to those which constitute items falling in excess of one standard deviation from the central point of the distribution of mean scores evidenced for each of the 44 items.

4.3.2.2.1.2.3 The items rated highest by AMOSISTs (Table 18) show marked consistency with those similarly ranked during the initial phase of the study. Among the eight items appearing in Table 18, the six rated highest by AMOSISTs were precisely those included in the uppermost six items during the initial phase of the study. The two items which differ from the corresponding table in the initial report on the study are those appearing in the bottom two lines of the table. These two items, satisfaction with one's immediate supervisor and satisfaction with the extent of work autonomy existing in the program, displaced, respectively, items indicating satisfaction with the extent of interest and pleasure in their work and the amount of variety in their work.

4.3.2.2.1.2.4 As indicated from the present analysis, the items rated highest by the AMOSISTs appear to convey a sense of altruism in that they appear to obtain satisfaction with the extent of accomplishment from work which they perceive as benefiting others and effecting a contribution to the military community. Another theme running through these items is the apparent satisfaction with their social environment, i.e., satisfaction with their co-workers and their immediate supervisor. The third theme which appears relates to the work itself and the schedule for same. They indicate that there is clearly enough work to do, that they have some say about what and, perhaps, how they do their work. Also, the number of hours that they have to put in and when they have to put them in appear to be satisfactory.

4.3.2.2.1.2.5 The items rated lowest among the same Part II items appear in Table 19. In this instance, the degree of sameness evidenced by the AMOSISTs between Phases I and II is even more marked than it was in Table 18. In the table presently considered (Table 19) all eight items

Table 18

ITEMS RATED HIGHEST BY AMOSISTS DURING PHASE II

(PART II ITEMS ONLY) *

ITEM	CONTENT	MEAN
38	Work benefits others **	7.52
7	Co-workers **	7.38
5	Opportunity to remain busy **	7.32
37	Work schedule **	7.26
4	Feeling of accomplishment **	7.24
39	Contribution to military community **	7.23
3	Immediate supervisor	7.22
10	Work autonomy	7.17

* The values shown for each item are based upon computations performed on data from 128-130 AMOSISTs. All items responded to on 9-point scale: 1=Extremely Dissatisfied to 9=Extremely Satisfied; the mid-point of the scale was labeled "neutral/?."

** Appeared among eight highest ranked during Phase I evaluation, also.

Table 19

ITEMS RATED LOWEST BY AMOSISTS DURING PHASE II

(PART II ITEMS ONLY) *

ITEM	CONTENT	MEAN
20	Physical characteristics of work area	5.73
21	Opportunity for recognition	5.69
17	Freedom to choose co-workers	5.62
42	Availability of support personnel	5.55
2	Military installation to which assigned	5.54
25	Opportunity for continuing education	5.45
15	Promotion system	5.44
18	Amount of pay	4.67

* The values shown for each item are based upon computations performed on data from 142-145 AMOSISTs. All items responded to on 9-point scale: 1=Extremely Dissatisfied to 9=Extremely Satisfied; the mid-point of the scale was labelled "neutral/?." All items appeared among the eight lowest ranked items in Phase I, also.

are the same as those which appeared during the initial phase of the study. The only difference is that item 21, Opportunity for Recognition, has been elevated to the seventh ranked item in the table, whereas item 42, Availability of Support Personnel (erroneously labeled as item 22 in the initial report), has been advanced to the fifth ranked position among the items rated lowest by AMOSISTs. It is noted that the items appear in what may be considered to be reverse order within Table 19. In other words, the item rated lowest by AMOSISTs appears at the bottom of the table with the item rated eighth lowest by AMOSISTs appearing at the top of the table.

4.3.2.2.1.2.6 In considering these findings, it is apparent that the AMOSISTs' perceptions of the best and least liked aspects of the program are reasonably stable, at least insofar as their perceptions are confined to the items appearing in Part II of the questionnaire.

4.3.2.2.1.3 SSQ Part III. Part III of the questionnaire was comprised of the JDI (Smith et al, 1969). Among the five scales addressed on the JDI, only that addressing the individual's satisfaction with his co-workers evidenced a statistically significant difference. On that scale, it was determined that Phase II AMOSISTs were significantly less satisfied with their co-workers than were Phase I AMOSISTs (I = 6.87; II = 6.25; $p = .0359$).*

4.3.2.2.1.4 SSQ Part IV. Among the items included in Part IV of the questionnaire there were no items which evidenced a difference which was statistically significant at the $p \leq .05$ level. The only item to yield even suggestive findings was item 10, that pertaining to the AMOSISTs perceptions of how he believed the hospital commander would rank the extent of professional requirements that existed in the AMIC. For this item, the AMOSISTs in Phase I perceived the requirements to be higher than those responding during the second phase of the evaluation ($p = .0804$). This finding may be related to the training difference which exist between 91Bs and 91Cs; i.e., given the same actual level of "professional requirements," those who are less well trained (91Bs) may perceive the extant requirement to be greater than those who are better trained (91Cs).**

*The scoring and scaling of the JDI is a matter which has evidenced considerable variability in the published literature (e.g., Breslau et al, 1978; Schneider and Snyder, 1975; Wanous, 1973). The scoring used herein is suggested by the originator of the instrument (Smith et al, 1969); however, the scaling has been linearly expanded to assume the same range of possible values for each subscale (1 through 9) as is employed in most of the other items in the questionnaire.

**In Part II of the questionnaire, another "suggestive" finding (item 45) was that Phase II AMOSISTs reported that their training was more adequate than that reported during Phase I ($p = .0939$).

4.3.2.2.1.5 Part V Comparison.

4.3.2.2.1.5.1 Part V of the Staff Satisfaction Questionnaire deals more specifically with the operation and management of the AMIC, per se, than do most of the previous parts of the questionnaire. The results of the comparison between the responses obtained during Phase I and Phase II of the study for these data are depicted in Table 20.

The data presented therein reveal very few items for which statistically significant differences exist between the Phase I and Phase II. In fact, there exists only one item in Table 19 which evidences a difference which is statistically significant at the $p \leq .05$ value. This item, item 14B, indicates that, relative to the perceptions of the AMOSISTs during the initial phase of the study, Phase II AMOSISTs found their work to be somewhat more complicated than expected ($p = .0328$). Among the remaining items included in Part V for the AMOSISTs there were only two others which yielded suggestive findings, items 12 and 14a. The first cited indicates that the majority of supervisory sessions which pertain to the results of data collection sheet audits decreased from 38.2 percent to 25.3 percent during the interim between Phase I and Phase II ($p = .0557$). The second item suggests that the Phase II AMOSISTs, in contrast to the Phase I AMOSISTs, found that the difficulty of their work was greater than initially anticipated ($p = .0679$). While the writer does not have an hypothesis to account for the decrement in the percent of supervisory sessions which related to the results of data collection sheet audits between Phases I and II, it is likely that the previously cited rationale linking the increase in the proportion of 91Bs in the sample with their relative deficiency in basic medical education (vis-a-vis the 91C) accounts in some measure for the increase between Phases I and II in the perceived extent of difficulty and complicatedness involved in the work of the AMOSIST.

4.3.2.2.1.5.2 One block of data appearing in Table 20 which was subjected to further analyses are those subitems appearing in item 7. These sub-items pertain to the perceptions of the AMOSISTs regarding the apparent extent of knowledge concerning the AMOSIST Program and the AMIC procedures which has been evidenced by the various categories of physicians which work in the AMIC. As there existed no significant differences between Phases I and II for any of the sub-items appearing in item 7, the overall mean was computed for each of them. These means are depicted in Table 20. From the data appearing therein, it is clear that there is no inversion of the rank order of the physicians regarding their perceived extent of knowledge concerning the program. The Chief of the AMIC is viewed as being the most knowledgeable of all the categories of physicians evaluated and the least knowledgeable roster-assigned physician is viewed as being clearly the least

TABLE 20

PHASE I VERSUS PHASE II COMPARISON:

AMOSISTs' Perceptions of AMIC Operation (Part V Data)

Item	PHASE I	PHASE II	Sig. * (p =)
1. Months since AHS training	14.8	15.1	.8272
2. All post-AHS assignment as AMOSIST (%)	1.06	1.11	.2686
3. Months at present AMIC	13.9	14.1	.8950
4. Percent of time physician available (%)	80.9%	81.8%	.8769
5. Time to wait for physician consultation (minutes)	11.03	11.77	.5327
6. Percent of consults where MD sees patient himself (%)	43.8	38.4	.1859
7. Knowledgeability of AMIC procedures (6-pt scale: 1 = Hi to 6 = Low)			
a. Regularly assigned physicians:			
(1) Chief, AMOSIST program	1.63	1.83	.1296
(2) AMOSIST physician	1.81	2.03	.1337
(3) Additional AMOSIST physician	2.79	2.87	.7083
b. Roster-assigned physicians (RAP)			
(1) Most knowledgeable RAP	2.90	3.06	.4673
(2) Least knowledgeable RAP	4.20	4.03	.4992
(3) Typical RAP	3.65	3.60	.8387
c. Tendency to use RAPs versus regularly assigned physicians for consults (8-point scale: 1 = Very much less to 8 = Very much more)	3.00	3.10	.7582
8. MD rating of importance of AMOSISTs work (7-point scale: 1 = Extremely important to 7 = No importance)	2.26	2.48	.2446
9. Hours of training per month	10.1	8.8	.4005
10. No. MD supervisory sessions per month **	3.53	4.35	.3882
11. Length of supervisory sessions (minutes) **	12.8	12.49	.9013
12. Majority of supervisory sessions pertained to DCS audits (%) **	38.2	25.3	.0557
13. Ready access to audits is permitted (%)	83.6	79.4	.5364
14. Work as AMOSIST versus expectations regarding: (8-point scale: 1 = Very much more to 8 = Very much less)			
a. Extent of difficulty	4.37	3.88	.0679
b. "Complicatedness"	4.59	4.05	.0328
c. Amount of time required	3.90	3.67	.3456
d. Degree of interest in work	3.02	3.20	.5078
e. Amount of individual responsibility	2.79	2.92	.5878
15. Self-performance versus other AMOSIST (1=Very much better, 8=Very much worse)	2.81	2.74	.6921
16. C, AMIC compares performance with others (1=Very much better, 8=Very much worse)	3.11	2.97	.4716
17. Apparent levels of satisfaction of other AMOSISTs: (8-point scale: 1 = Extremely dissatisfied to 8 = Extremely satisfied)			
a. Most satisfied AMOSIST	6.24	6.60	.1414
b. Least satisfied AMOSIST	3.96	3.95	.9703
c. Typical AMOSIST	5.59	5.68	.6618
18. See Table 36			
19. See Table 37			
20. Project years as AMOSIST for career motivated individuals	1.99		

*Total number of AMOSISTs is 268; number of respondents for each non-conditional item ranged from 132 to 136.

**Data reflect those respondents who reported the existence of MD supervisory sessions.

knowledgeable physician.* The data appearing in the last column in the table cite the statistical level of confidence for the difference between the mean for which the p-value is provided and the mean for the item appearing immediately above it. The results of these pair-wise analyses are very comparable to the results obtained on similar analyses performed for the Phase I data (Schopper, 1978a, p. 97). As in the Phase I data, the difference between each mean and the mean appearing immediately below it is statistically significant, or very nearly so, for all comparisons except that between the third AMOSIST physician and that of the most knowledgeable roster-assigned physician. As regards the mean reported for the most knowledgeable assigned physician, it is noted that the extent of difference between it and the value given for the "other AMOSIST physician" is also a highly significant difference. In sum, then, it is apparent that with the exception of the difference in perceived knowledge between the most knowledgeable roster-assigned physician and the occasional third AMOSIST physician which may regularly appear in a clinic, all regularly assigned physicians are rated as having significantly greater knowledge of the AMOSIST program than any of the roster-assigned physicians.**

4.3.2.2.1.5.3 The version of Part V prepared for AMOSIST respondents also requested them to list the three most desirable and the three least desirable aspects of being an AMOSIST. The categories employed to summarize their comments appear in Table 22. The findings are presented in the next two tables.

4.3.2.2.1.5.4 The items which the AMOSISTs themselves cited in Part V of the SSQ as being most desirable are depicted in Table 23 for both Phase I and Phase II. As can readily be discerned from the last column in the table, that which depicts the differences encountered between Phases I and II, there exists relatively little change. The largest difference encountered

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*The actual numerical values appearing under the column AMOSIST Ratings in Table 20 do not reflect the mean which could be computed directly from the figures appearing in Table 20. The reason for this is that pair wise t-tests were employed to derive the data appearing in Table 21. As a result, the only data that appears is that for the AMOSISTs which supplied responses to each of the items being contrasted. The total number of such responses is therefore, slightly less than that used to compute the figures appearing in Table 20.

**The data pertaining to items 18 and 19 of the questionnaire are depicted subsequently in Tables 22 and 23. There were no statistical differences observed as regards the remaining three items in Part V, i.e., those items pertaining to the length of time of which the AMOSISTs perceive themselves as remaining as AMOSISTs in the future, their likelihood of remaining in the service, or their reactions to completing the questionnaire.

Table 21

AMOSISTS' PERCEPTIONS OF THE KNOWLEDGEABILITY OF PHYSICIANS

CONCERNING THE AMOSIST PROGRAM AND THE AMIC's OPERATION

PHYSICIAN'S POSITION/STAFFING STATUS[a]	AMOSIST'S RATINGS	COMPARISON WITH NEXT HIGHER RATED[b]
Chief of the AMIC	1.85	
Other AMOSIST Physician	2.03	.054
Third AMOSIST Physician	2.89	.000
Most Knowledgeable Roster Assigned Physician	3.04	.275
Typical Roster Assigned Physician	3.57	.000
Least Knowledgeable Roster Assigned Physician	3.99	.002

a. The upper three physicians are for those physicians who are regularly assigned to the AMIC for at least some period of duty each week. The lower three are for physicians who are not regularly assigned, but work in the AMIC on a rotational, roster-assigned basis.

b. The levels of confidence cited (p-values) are based upon two-tailed pair-wise comparisons between the rating for the physician for which the p-value is cited and the rating for the physician appearing immediately above in the table.

Table 22

CATEGORIES OF RESPONSES FOR QUESTIONS 18 & 19 WITHIN PART V OF AMOSIST COMPLETED QUESTIONNAIRES *

1. PATIENT CARE: Satisfaction or personal fulfillment felt by one for treating, taking care of, expressing concern for the needs of mankind and the alleviation of human suffering; experience of providing timely, appropriate and needed direct patient care; engaging in the type of work that is challenging, demanding, and requiring considerable knowledge; receiving feedback or an appreciation of one's performance and efforts through follow-up visits or lab results; and experiencing a variety of tasks.

2. JOB SATISFACTION (UNAMPLIFIED): Unamplified expression of satisfaction.

3. STATUS: Satisfaction felt by one concerning the expressed attitude toward, respect and appreciation for, confidence in, prestige and recognition of an AMOSIST (as a health care provider) and/or the AMOSIST Program by Non-AMIC hospital staff, (to include specifically the Hospital Commander and the Nursing Service).

4. LOCAL SUPPORT FOR PROGRAM: References to the extent of understanding of and/or support provided by other personnel and elements of the hospital; extent of command interest, knowledge and/or emphasis.

5. DUTY HOURS/WORK SCHEDULE: Desirability of duty hours and work schedule.

6. PERSONNEL STAFFING/WORKLOAD: Shortage of support personnel and equipment to handle patient load, personnel turbulence.

7. WORK AUTONOMY: Freedom from undesired supervision; opportunity to assume responsibility or concern over amount of responsibility one has to assume; opportunity to use one's own initiative, and exercise a degree of independence in performing assigned duties.

8. SUPERVISION/CONSULTATION: Amount, effectiveness, timeliness, availability, demands and support of and conflicts with supervisors and consulting physicians; attitudes of supervisory personnel (i.e., AMIC NCOIC and/or physicians working in AMIC) toward AMOSISTS; satisfaction felt with leadership.

9. CO-WORKERS: References to conflict, compatibility, or nature of the association with one's co-workers; references to the degree of competence, dedication, maturity and/or amount of teamwork shown by co-workers within the AMIC.

10. PROFESSIONAL GROWTH AND TRAINING/EDUCATION: Amount and effectiveness of on-the-job and AMOSIST qualification training, ability to develop a marketable skill; opportunity to learn or gain worthwhile experience or training while working.

11. CAREER MANAGEMENT: Advancement of individual potential, career progression, MOS-related considerations (e.g., skill identifier problems, deletion of MOSs from eligibility, ability to continue to work as AMOSIST when transferred); stability of AMOSIST Program; and inability to work in career area/field for which trained

12. AMOSIST/PATIENT RELATIONSHIPS AND ATTITUDES: Negative or unaccepting attitudes on the part of both the AMOSIST and the patients toward each other; references to abuse by the patient, continually complaining or dissatisfied "repeaters," difficult patients.

13. PAY MATTERS: Being afforded the opportunity to collect superior performance pay; being paid according to level of responsibility given and difficulty of tasks performed.

14. PHYSICAL SURROUNDINGS/ENVIRONMENT: Attitude toward installation assigned to; physical arrangement and setting of and appropriateness of equipment in work area; (generally speaking "working conditions"); toward building, room(s) or physical structure in which work is performed, provision for privacy.

15. LOCAL ORGANIZATION/OPERATIONAL MANAGEMENT: Maintaining effective line of communication (including reference to AMOSIST Bulletins); being utilized in job trained for; experiencing stability in job assignment, being inundated with excessive paperwork; organizing clinic so there is an expeditious and efficient flow of patients; misuse of various areas of the clinic (example: triage desk); concern for lost time from clinic for soldiering purposes, non-medical or additional duties, and for interruptions on busy days.

16. PROGRAM LIMITATIONS/RESTRICTIONS: Limitations imposed upon type of patients seen and/or type of treatment rendered or drugs prescribed.

17. OTHER/MISSING RESPONSES: Desire for more opportunity for formal or advanced education outside of job related training; feeling that one is being placed in compromising situations; being harrassed; being exposed to prejudiced persons; having to go on sick call when one knows how to treat minor illnesses, and all other comments not identified above.

* It listed as a negative characteristic, responses denote the absence or the reverse of the description provided.

Table 23

INTERPHASE COMPARISON OF AMOSIST-CITED DESIRED ASPECTS OF BEING AN AMOSIST

RESPONSE CATEGORY	PHASE I (% TOT I)	PHASE II (% TOT II)	DIFFERENCE (% II-% I)
1. Patient Care	33.6	27.1	- 6.5
2. General Job Satisfaction	3.9	6.5	2.6
3. Status	4.3	4.3	0
4. Local Support of Program	.3	0	- .3
5. Duty Hours/Work Schedule	9.2	9.4	.2
6. Personnel Staffing/Workload	0	0	0
7. Work Autonomy	12.2	11.2	- 1.0
8. Supervision/Consultation	2.0	2.5	.5
9. Co-Worker	3.6	4.0	.4
10. Professional Growth, Training/Educ.	22.4	20.6	- 1.8
11. Career Management	1.0	1.8	.8
12. AMOSIST-Patient Relationships/ Attitudes	1.0	2.2	1.2
13. Pay Considerations	0	.7	.7
14. Physical Surroundings/Environment	.7	2.5	1.8
15. Local Organization/Operational Management	2.3	1.8	- .5
16. Program Limitations/Restrictions	.3	0	- .3
17. Other	3.3	5.4	2.1
TOTAL NUMBER RESPONSES[a]	304	277	

a. The data described for each response category reflect the sum of all responses in each of the three possible hierarchical categories used in the questionnaire: Most desirable, second most desirable, and third most desirable. There were 119 (Phase I) and 113 (Phase II) additional responses possible which were either left blank or evidenced inappropriate, irrelevant responses (e.g., facetious responses). Chi-square = 11.021, $p > 170$ (X^2 excludes "other").

was that of a decrease in the frequency with which patient care considerations was cited as being a desirable aspect of being an AMOSIST. The magnitude of this change, a 6.5 percent decrease, was more than twice as large as any other change observed in the data. Among the specific codable responses, only one other category, that of an unamplified statment of job satisfaction, exceeded a change of more than 2 percent between Phases I and II. The results of the chi-square analysis (exclusive of the comments coded as "other") indicates that no statistically significant change occurred between the phases ($X^2 = 11.021$, $p > .70$).

4.3.2.2.1.5.5 The four items cited most frequently are the same for Phases I and II. Additionally, their rank order is identical in both Phases. These four items, satisfaction with patient care, satisfaction with the extent of professional growth, training and education they receive, satisfaction with the extent of work autonomy permitted, and satisfaction with their work schedule and duty hours, comprise 77 percent of all codable comments rendered during the initial phase of the study, and account for 68.3 percent of all of the comments offered during the second phase assessment.

4.3.2.2.1.5.6 The findings concerning the AMOSIST cited undesirable aspects of being an AMOSIST appear in Table 24 in a similar format. As was noted in the initial, Phase I, findings the categories cited as being representative of undesirable aspects of being an AMOSIST are less well delineated than are the categories utilized to describe the desirable aspects of being an AMOSIST. Such is reflected in the relative evenness of the distribution of reponses among the possible response categories. An examination of the data portrayed in Table 24 does suggest, however, that some degree of focus has evolved between Phases I and II, and that there has occurred a statistically significant amount of change ($X^2 = 23.847$, $.02 > p > .01$). If one excludes the miscellaneous or uncodable responses labeled as other (17), one observes that at least one item in Phase II, item 12, AMOSIST-patient relationships and attitudes, now has been identified more clearly as the major undesirable aspect of being an AMOSIST. This category of response was evidenced in slightly more than 20 percent of all responses to this item in part V. This represents an absolute increase of nearly 10 percent between Phases I and II. This magnitude of increase reflects nearly a doubling of the frequency with which it was cited in Phase I. The item which is next most frequently identified as being an undesirable aspect of being an AMOSIST is item 8, that of the apparent quality of supervision and consultation provided to AMOSISTs. This 6.2 percent increase over the 6.8 percent which occurred during Phase I also represents nearly a doubling in the frequency with which a response category occurred between Phases I and II. The item cited third most frequently as being undesirable is item 3, the status which the AMOSISTs feel they have. This suggests that many AMOSISTs perceive themselves to be unaccepted and unrecognized as direct health care providers. In contrast to the previous two items, there exists little difference between Phase I and Phase II in the frequency with which this item was cited. In the rank ordering of these items, items 11 (career management) and 15 (local organization/management) appear next. Both items reflect some small decrease in the relative proportion of times in which they were cited between Phases I and II. The perceived improvement in the area of career management is likely to be due to the decrease in the number

Table 24

INTERPHASE COMPARISON OF AMOSIST-CITED UNDESIRABLE ASPECTS OF BEING AN AMOSIST

RESPONSE CATEGORY	PHASE I (% TOT I)	PHASE II (% TOT II)	DIFFERENCE (% II - %I)
1. Patient Care	5.5	4.1	-1.4
2. General Job Satisfaction	0	.8	.8
3. Status	8.9	8.5	- .4
4. Local Support of Program	5.5	6.1	.6
5. Duty Hours/Work Schedule	1.3	4.5	3.2
6. Personnel Staffing/Workload	9.3	5.7	-3.6
7. Work Autonomy	4.2	2.4	-1.8
8. Supervision/Consultation	6.8	13.0	6.2
9. Co-Workers	3.0	4.1	1.1
10. Professional Growth, Training/Education	3.4	3.7	.3
11. Career Management	11.0	6.9	-4.1
12. AMOSIST-Patient Relationships/Attitudes	10.6	20.3	9.7
13. Pay Considerations	2.5	2.0	- .5
14. Physical Surroundings/Environment	3.4	2.4	-1.0
15. Local Organization/Operational Management	9.7	6.9	-2.8
16. Program Limitations/Restrictions	1.7	4.9	3.2
17. Other	13.1	3.7	-9.4
TOTAL NUMBER RESPONSES [a]	236	246	

a. The data described for each response category reflect the sum of all responses in each of the three possible hierarchical categories used in the questionnaire; Lease desirable, Next-to-least desirable, and third least desirable. There existed 236 (Phase I) and 246 (Phase II) additional possible responses which were either left blank or evidenced inappropriate, irrelevant responses (e.g., facetious responses). Chi-square = 28.947, $.02 > p > .01$ (X^2 excludes "other").

of 91Cs in the sample between Phases I and II. The 9 July 1976 change to AR 611-201 authorized the awarding of a skill identifier, V1, to AMOSISTs for the first time in the history of the program. While this authorization was perceived to be a positive action for the program in general, it resulted in considerable ill feelings on the part of 91C AMOSISTs and 91B AMOSISTs in grade E-6 and above, since the change authorized the skill identifier to be awarded only to 91B AMOSISTs in the grades E-3 through E-5. Hence, the decrease in the frequency with which "career management" was cited as an undesirable feature of being an AMOSIST is apt to be the result, in part, of the substantial reduction in the number of 91Cs participating in the Phase II evaluation.

4.3.2.2.2 AMOSISTs vs Non-AMOSISTs

4.3.2.2.2.1 In the initial, Phase I report analyses were conducted to determine whether or not AMOSISTs were more or less satisfied than their peers. The results of that analysis (paragraph 4.3.4.2.2.4.6 and Table 33, Schopper, 1978a) indicated that no significant difference existed between these two groups.

4.3.2.2.2.2 Comparable analyses were performed for the present study on Phase II respondents. The specific items for which differences were significant at the $p \leq .10$ level are presented in Table 25. As observed therein, relatively few items evidenced a difference of this magnitude. Among those cited, AMOSISTs were generally more satisfied than non-AMOSISTs regarding the rules governing their work, the use made of their skills, and the opportunity to obtain additional skills--items which are all job-related. On the other hand, AMOSISTs were less satisfied than their non-AMOSIST counterparts regarding factors which are much less directly related to the work activities they actually perform: amount of pay, organizational benefits, and physical characteristics of their work area. The last item appearing in the table, one relating to perceptions of training preparedness, was not scored with the 9-point satisfaction-related scale used with the other items. The responses to this item show that AMOSISTs reported the level of training provided for them to have been less than adequate (in an absolute sense) and significantly less adequate than that reported by non-AMOSISTs. This finding, when coupled with the previously cited finding that better use is being made of their skills, suggests that the demands of their work are apt to be placing them considerably closer to the limits of their skills than is the case for their counterparts working in other areas of the hospital.

4.3.2.2.2.3 The results of an analyses of Part II items undertaken to determine whether or not, from a more global perspective, there existed a difference between AMOSISTs and non-AMOSISTs yielded a negative finding. The results of a t-test considering the mean difference score for each of the 44 similarly scaled items in Part II as an independent data point showed the overall mean difference to be not significantly different from zero ($t = 1.30$, $df = 1/43$, $p = .14$).

4.3.2.2.2.4 Among all of the remaining items in the questionnaire, there were none which evidenced a statistically significant difference between AMOSIST and non-AMOSIST enlisted respondents. The results of the

Table 25

PHASE II COMPARISON: AMOSISTS VERSUS NON-AMOSISTS

ITEM		AMOSISTs	NON-AMOSISTs	SIG. * (p=)
14	Satisfaction with rules governing work	6.11	5.62	.0930
18	Amount of Pay	4.28	4.83	.0912
19	Organizational Benefits	5.58	6.20	.0520
20	Physical Characteristics of Work Area	5.50	6.24	.0207
33	Use of Abilities, Experience, Training	6.74	6.07	.0184
34	Opportunity to Obtain Additional Skills	6.36	5.72	.0422
46	Extent of Training (5-point scale: (1=Very Overtrained, 5=Very Undertrained)	3.57	3.21	.0166

* All values are the results of two-tailed, one-way ANOVAs (t-tests).
Number of respondents: AMOSISTs = 131, Non-AMOSISTs = 137.
Unless otherwise indicated, all scales are balanced, 9-point scales with labelled end points (1=Extremely Dissatisfied, 9=Extremely Satisfied) and a labelled midpoint (5=Neutral/?).

Phase II comparisons are, therefore, clearly in conflict with the Phase I results which had shown that AMOSISTs' perceptions of and attitudes toward their work was significantly higher than non-AMOSISTs.

4.3.2.2.3 Intra-AMOSIST Sample Comparisons.

4.3.2.2.3.1 General. The data which have been presented to this point reflect the major considerations to be addressed in assessing the stability of the program from the vantage point of the AMOSIST himself. Nonetheless, as in the initial, Phase I report (Schopper, 1978a) a series of additional analyses were conducted to address issues which lie within the AMOSIST sample itself. These analyses included comparisons of the extent of job satisfaction between (a) the 91B AMOSISTs and the 91C AMOSISTs, (b) AMOSISTs in training status and AMOSISTs who had completed their training, and (c) AMOSISTs serving at sites wherein the principal physician staffing was accomplished by the use of roster-assigned physicians and AMOSISTs serving at sites wherein the principal staffing was accomplished by physicians who were regularly assigned to the AMIC. Although these analyses are acknowledged not to be germane to the purpose of the present report, per se, they have been repeated in the interest of completeness.

4.3.2.2.3.2 Job Satisfaction Comparison Among AMOSISTs: 91B vs 91C.

4.3.2.2.3.2.1 One of the intra-AMOSIST comparisons described in the initial report examined the differences between AMOSISTs in the MOS 91B and those in the MOS 91C. The items evidencing significant differences from the same analysis performed on the Phase II data are depicted in Table 26. In general, the findings are similar to those previously reported.

4.3.2.2.3.2.2 The findings pertaining to Part I and items 1 and 3 of Part V, clearly show the 91C AMOSIST to be senior to his 91B counterpart. He is significantly older, holds a higher rank, has more years of active duty, and has been at the facility a significantly longer time than the 91B AMOSIST. As was pointed out in the initial report, it is likely that these differences reflect, in part, the additional time (and subsequent obligation) required to obtain the advanced education possessed by the 91C.

4.3.2.2.3.2.3 The findings reported for Parts II and III of the SSQ suggest that the 91C AMOSIST is more satisfied with his work than is the 91B AMOSIST. This is strongly reflected among Part II findings wherein 41 (93.2%) of the 44 similarly scaled items evidenced a higher rating by the 91C AMOSIST. The results of a t-test using, as before, all 44 similarly scaled items of Part II showed the overall mean difference favoring 91Cs to be highly significant ($t = 4.13$, $DF = 1/43$, $p \leq .0005$). The JDI overall sum and the "Faces" scale of Part III also evidenced significantly greater job satisfaction on the part of the 91C ($p = .0097$ and $p = .0471$ respectively).

4.3.2.2.3.2.4 The findings shown relevant to Parts IV and V are consistent with observations cited elsewhere pertaining to the educational differences between the two types of care providers. In contrast to the

Table 26

PHASE II AMOSIST COMPARISON: 91Bs VERSUS 91Cs

ITEM	AMOSIST 91B	AMOSIST 91C	SIGNIFICANCE (p=) *
PART I			
1. Age (years)	24.30	29.90	.0000
2. Pay Grade (E-)	4.54	6.00	.0000
3. Years of Active Duty	4.44	9.20	.0000
4. Months at Present Facility	10.74	22.31	.0000
PART II (Nine-point scale: 1=Extremely Dissatisfied, 9=Extremely Satisfied)			
2. Military Installation to which Assigned)	4.98	6.31	.0131
6. Control over Others	6.00	6.80	.0698
15. Promotion Criteria	5.28	6.26	.0614
17. Control of Social Interaction in Clinic	5.20	6.00	.0973
18. Amount of Pay	3.98	5.12	.0394
20. Physical Characteristics of Work Area	5.23	6.24	.0579
24. Job Security	6.09	7.21	.0121
31. Time Required to Remain Current in Field	6.18	6.85	.0857
39. Contribution to the Community	6.96	7.82	.0386
PART III			
Composite Total Score of all JDI Scales	5.24	5.87	.0471
"Faces" Scale (reverse scoring, 1-6, 6=Dislike)	3.09	2.48	.0097
PART IV			
2. Rated Importance of Own Work (7-point scale: 1=Extremely Important, 7=No Importance)	2.55	2.03	.0727
4. Importance of Work (perceptions of commander's opinion using same 7-pt scale as item 2)	3.70	2.91	.0321
6. Extent of Patient Appreciation (6-point scale: 1=Extremely Appreciative, 6=Mostly Nonappreciative)	3.56	3.12	.0883
7. Extent of Pressure to Perform Well (5-point scale: 1=No Pressure, 5=Much too much Pressure)	3.12	2.50	.0040
11. Job-related Satisfaction (9-point scale: 1=Extremely Dissatisfied, 9=Extremely Satisfied)	5.98	7.17	.0159
12. Non-job Related Satisfaction with Army Life (same 9-point scale as item 11)	4.76	6.03	.0151
PART V			
1. Months Since Training	11.72	29.90	.0000
3. Months of AMIC	11.01	23.86	.0000
15. Self-performance versus other AMOSISTs (8-point scale: 1=Very Much Better, 8=Very Much Worse)	2.88	2.36	.0444
16. Self-performance versus other AMOSISTs (perceived rating by AMOSIST Physician, same 8-point scale as item 15)	3.14	2.48	.0408
21. Likelihood of Career in Army (6-point scale: (1=Definitely Will Not, 6=Definitely Will)	3.13	4.53	.0003

* One-way ANOVAs with 131 respondents; all are two-tailed tests.

91C, the less educated and less highly trained 91B perceived significantly more pressure to perform well (item IV) and perceived his performance on the job to be significantly worse than other AMOSISTs with which he works, a perception which he believed to be shared by the hospital commander (items V-15 and V-16). The 91B also perceived his work to be less important than the work of other AMOSISTs and attributes the same less favorable evaluation to the hospital commander (items IV-2 and IV-4). The global evaluation of the 91Bs was also observed to be less satisfactory than that of the 91C regarding both job-related and non-job-related aspects of his military life.

4.3.2.2.3.2.5 In sum, the perceptions and reported job satisfaction of the 91B AMOSIST are less positive than those of his better educated and better trained 91C co-workers.

4.3.2.2.3.3 AMOSIST Job Satisfaction: Trainees vs Non-Trainees.

4.3.2.2.3.3.1 Another intra-AMOSIST comparison made in the initial report was that between AMOSISTs who were still in (or had just completed) their entire training program and their more experienced counterparts. The rationale for performing such an analysis was that there would likely exist a substantial difference in the job perceptions of these two groups due to a number of factors, e.g., the additional exhileration and tension associated with being in a new job and the fact that they should be receiving considerably more supervision and attention than the more experienced AMOSIST receives. The results of the Phase I analyses clearly indicated that this was true; those labelled as trainees reported significantly more job satisfaction than did their more experienced peers. The results of the present Phase II analyses (discussed below) yielded similar findings. The same criterion (less than four months since time of AHS training) was employed in both phases to "define" a trainee.

4.3.2.2.3.3.2 The findings pertaining to parts I-IV of the SSQ are presented in Table 27. As cited in the footnote to the table, the proportion of trainees in the sample is rather substantial (32.8% of the entire sample). It may be that this circumstance is due to the increased personnel turnover associated with the deletion of the 91C from the program; nevertheless, it is pointed out that the percentage of trainees was similarly high (29.8%) at the time of the Phase I evaluation. While the interval is clearly too small (vis-a-vis the nearness in time to the date at which the 91C had been withdrawn) to permit any justifiable concern to be expressed, it is believed that the continued existence of such a high rate of turnover cannot be considered desirable--at least in terms of the implications regarding training costs associated with the program. However, for other reasons (such as the need to be able to present the opportunity for such experience to as many personnel as desire it in order to enhance the likelihood that they would remain in

Table 27

PHASE II AMOSIST COMPARISON: TRAINEES VERSUS NON-TRAINEES

(PARTS I-IV)

Item		Trainees	Non-Trainees	Sig.* (p=)
I-	Sex (percent male)	75 %	51 %	.0109
I	Months at present facility	8.9	13.7	.0029
II-13	New skills acquisition	7.19	6.20	.0281
II-20	Physical characteristics of area	6.32	5.11	.0158
II-32	Space and equipment	6.32	5.45	.0750
II-38	Amount of pay	7.86	7.19	.0851
II-42	Amount of social interaction	6.52	5.61	.0453
III-JDI	Sum - Work	6.19	5.25	.0222
III-JDI	Sum - Total	5.76	5.24	.0804
IV-6	Expressed appraciation by patients (6-pt scale: 1=Extremely appreciative, 6=Mostly non-Appreciative)	3.00	3.65	.0075
IV-7	Amount of pressure to perform well (5-pt scale: 1=No pressure at all, 5=Much too much pressure)	2.68	3.08	.0521

* Two-tailed tests. N=43 for Trainees; N=88 for Non-Trainees.

the Army) it may be considered desirable to maintain a rather substantial personnel turnover.*

4.3.2.2.3.3.3 The findings in Table 27 also indicate that there was a significant increase in the number of females entering the program. Although this was not an area of substantial concern, when the issue of the AMOSIST's sex was mentioned by AMOSIST physicians during on-site visits the preference was generally for that of a female. (Chaperon-related needs were often cited as one of the reasons for the preference.) The finding that the more experienced individual has spent significantly more time at the facility is expected in view of the criterion employed to differentiate trainees from non-trainees.**

4.3.2.2.3.3.4 The four items from Part II of the questionnaire which showed statistically significant differences all evidenced greater job satisfaction on the part of AMOSIST trainees. Greater trainee satisfaction was also present in 88.7 percent of the remaining 44 similarly scaled items contained in Part II. The overall mean difference observed between trainees and non-trainees among all 44 similarly scaled items was significantly different from zero and indicated that trainees were more satisfied with their work than were their more senior co-workers ($t = 6.19$, $df = 1/43$, $p < .0001$).

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*Should the recommendations made within this series of reports be accepted and acted upon, another reason for not objecting to a rather high turnover rate among AMOSISTs at the present time is related to the possibility of increased voluntary and involuntary attrition due to a dislike of the requirement to evidence increased levels of adherence to the algorithms. This change in the program might prove to be positive for some AMOSISTs in that a continuing objective record of their performance could stimulate some degree of competitiveness and, as such, constitute a personal and/or interpersonal (or inter-AMIC) challenge to evidence a continuing high level of performance. However, for others, such additional structure and pressure may prove aversive. Albeit individual reactions would likely show considerable variance, it is also probable that the manner in which the additional, stricter requirements were reacted to, and subsequently implemented by the AMIC's supervisory personnel, would constitute an equal, if not greater, influence on the AMOSISTs' reactions.

**It is not illogical that the mean time at the facility be as large (8.9 months) for AMOSIST trainees since those selected as candidates and schooling are those who have been chosen from a pool of individuals who have already worked at that facility for some period of time. The mean time since AHS training (the criterion employed) yielded mean values of 1.7 months and 19.4 months for trainees respectively ($p = .0000$).

4.3.2.2.3.3.5 As depicted in Table 26, items IV-6 and 7 of the SSQ also showed significant differences between trainees and non-trainees. The trainee reported a significantly lower perception of patient appreciativeness (item IV-6) and, rather paradoxically, a significantly smaller amount of pressure to perform well on the job. As regards the latter item, however, the non-trainee rated it as essentially neutral. Hence, it appears that trainees perceive that the extent of pressure to perform well could be increased without exceeding their perceptions of what is an appropriate amount. This finding is in agreement with the findings related to the contrast between their expectations regarding their work and the realities of their work as reported in paragraph 4.2.2.3.3.7 below concerning item 14, Table 28.

4.3.2.2.3.3.6 The data depicted in Table 28 describe the results of a comparative analysis of Part V of the questionnaire. In general, the findings depicted in the table evidence relatively few items for which differences were statistically significant at the usual .05 level of significance. The table shows only five items which were significantly different at less than the $p = .05$ level of significance. The existence of only five statistically significant items is in contrast to the findings presented in Table 38 of the initial Phase I report wherein nearly twice that number of items reached or exceeded that same level of statistical significance. In the present table, item 6, the percent of time for which the AMOSIST physician himself sees the patient, and item 11, the length of supervisory sessions, both yield statistically significant differences which reflect improvements in the program. Item 6 showed that when AMOSISTs requested a consultation, the AMOSIST physician saw the patient himself nearly 50 percent of the time when the request for consultation came from a trainee as opposed to 35 percent of the time when the request for consultation came from a non-trainee AMOSIST. Item 11 indicates that the length of the supervisory sessions provided to trainee AMOSISTs is more than double the amount of time provided in supervisory sessions for non-trainee AMOSISTs. While not reaching the .05 level of confidence, the data reported for item 10 indicates that much closer supervision is provided for the AMOSIST trainee. The data cited there indicates that the number of supervisory sessions provided for AMOSIST trainees is more than double that provided for non-trainee AMOSISTs ($p = .0825$). If the data for items 10 and 11 are multiplied together to determine the total amount of physician supervisory time provided per month, it is the case that trainees reported more than 4-1/2 times as much physician supervision than non-trainees. This finding is in sharp and positive contrast to corresponding data provided in Table 38 of the initial report (Schopper, 1978a). The Phase I data showed that AMOSIST trainees received somewhat less physician supervision time per month than the non-trainee AMOSISTs.

4.3.2.2.3.3.7 The findings pertaining to the knowledgeability of physician supervisors are included in item 7 of Table 28. They show that for all categories of physicians, save that of the Chief of the AMOSIST Program, AMOSIST trainees rated the extent of knowledgeability concerning the local AMOSIST procedures and knowledgeability of the AMOSIST Program to be somewhat higher than the ratings rendered by non-trainee AMOSISTs. For one of these items, that addressing the extent of knowledge evidenced

Table 28

PHASE II AMOSIST DESCRITPION OF AMIC OPERATION: TRAINEE VERSUS NON-TRAINEE *

(PART V DATA)

ITEM	CONTENT	NON-TRAINEE	TRAINEES	SIG. ** (p=)
4.	Percent of time physician available (%)	80.9	84.5	.5888
5.	Time to wait for physician consultation (minutes)	12.3	10.2	.2898
6.	Percent of consult where MD sees patient himself (%)	35.0	49.7	.0276
7.	Knowledgeability of AMIC procedures (6-point scale: 1=Hi to 6=Low)			
	a. Regularly assigned physicians:			
	(1) Chief, AMOSIST program	1.80	1.93	.5905
	(2) AMOSIST physician	2.14	1.73	.0583
	(3) Additional AMOSIST physician	3.02	2.52	.1257
	b. Roster-assigned physician (RAP)			
	(1) Most knowledgable RAP	3.13	2.83	.3940
	(2) Least knowledgable RAP	4.26	3.36	.0262
	(3) Typical RAP	3.76	3.17	.0786
	c. Tendency to use RAPs versus regularly assigned physicians for consults (5-point scale: 1=Very much less, 7=Very much more)	2.97	3.43	.3913
8.	MD rating of importance of AMOSISTs work (7-point scale: 1=Extremely important, 7=No importance)	2.67	1.89	.0307
9.	Hours of training per month	8.26	10.48	.2186
10.	No. MD supervisory sessions per month	3.5	7.1	.0825
11.	Length of supervisory sessions (minutes) ***	9.6	21.9	.0071
12.	Majority of supervisory sessions pertained to DCS - audits (%) ***	1.75	1.75	.9782
13.	Ready access to audits is permitted (%)	79.8	78.3	.8782
14.	Work as AMOSIST versus expectations regarding: (8-point scale: 1=Very much more, 8=Very much less)			
	a. Extent of difficulty	3.95	3.67	.5164
	b. "Complicatedness"	4.13	3.81	.4599
	c. Amount of time required	3.78	3.33	.2467
	d. Degree of interest in work	3.33	2.78	.2356
	e. Amount of individual responsibility	2.95	2.81	.7236
15.	Self-performance versus other AMOSISTs (1=Very much better, 8=Very much worse)	2.49	3.63	.0000
16.	C, AMIC compare performance with others (same as 15)	2.68	4.05	.0001
17.	Apparent level of satisfaction of other AMOSIST: (8-point scale: 1=Extremely dissatisfied, 8=Extremely satisfied)			
	a. Most satisfied AMOSIST	6.58	6.68	.7943
	b. Least satisfied AMOSIST	3.72	4.61	.0951
	c. Typical AMOSIST	5.56	6.07	.1936

* Total number of respondents was 125; number of respondents for each non-conditional item ranged from 117 to 125.

** One-way ANOVAs.

*** Data reflect only those respondents who reported the existence of MD supervisory sessions. (One-third of respondents indicated that such sessions were not helf.)

by the least knowledgeable roster-assigned physician (item 7b2) this difference is statistically significant ($p = .0262$). For two other categories of physicians, the principal assistant AMOSIST physician and the typical roster-assigned physician, the levels of statistical significance are observed to be suggestive rather than definitive in terms of the level of confidence evidenced, ($.10 < p < .05$). For the remaining parts of item 7 the differences were not statistically significant. The absence of statistically significant differences cited is in contrast to the findings evidenced in the initial report. Therein, the differences between non-trainee AMOSISTs and AMOSIST trainees were all statistically significant at the $p \leq .05$ level of confidence. As a whole, the present findings concerning physician knowledge of the program suggest that AMOSIST trainees continue to be somewhat more laudatory than non-trainees in their evaluations of the physicians who staff their clinics; however, it is apparent that the magnitude of the differences between these two categories of AMOSISTs has decreased between Phases I and II of the present study.

4.3.2.2.3.3.8 Another block of data to be considered is that contained in item 14 of Table 28; i.e., that pertaining to the discrepancy between training engendered job expectations and the realities of an AMOSISTs work. In the Phase I evaluation, items 14a, 14b, and 14c evidenced differences which were statistically significant at or near the accepted (.05) level of significance. In the present table, it is observed that none of the five items contained within item 14 evidenced a statistically significant difference. Nonetheless, the direction of the differences evidenced was that of greater perceived demands and interest on the part of trainees for all five items in the present table, a condition which is identical to that existing within the Phase I data. Items 15 and 16 of the present table indicate that the AMOSIST trainee perceives his own performance to be less adequate than that of his fellow AMOSISTs and that the Chief of the local AMOSIST Program shares this impression. The magnitudes of the differences existing in these two items are highly significant statistically and are consistent with those encountered in the Phase I evaluation.

4.3.2.2.3.3.9 In general, the present comparisons show the AMOSIST trainee to feel greater satisfaction in his job and less competence in his work than those who have been in the program for some time. As is appropriate, the trainees also reported receiving more supervision than did non-trainees. It is likely that these findings are related; i.e., that the individual attention which is associated with increased supervision and monitorship contributed substantially to trainees' aforecited greater expression of job satisfaction. This difference in the amount of individual time spent with the supervisory physician may also have contributed to the more positive rating given by trainees regarding their supervising physicians. Nonetheless, this rating of supervisors may also have been affected by the fact that more senior, experienced personnel have accrued more knowledge and have become more sure of themselves and, as a result, stand less in awe of the physician than do trainees. The differences between trainees and non-trainees in the amount of individual attention provided and in the extent of experience and knowledge possessed appear to be consistent with differences in the extent to which trainees differ from

non-trainees regarding the amount of job satisfaction expressed, the competence reported, and the ratings of physician supervisors. The finding which is most disconcerting to the writer is that trainees reported significantly less pressure to perform well than did non-trainees. From the most positive perspective, this finding suggests that their supervisors possessed considerable expertise and tact in providing the guidance and monitorship required. However, the absolute value of the rating is less than the midpoint of the scale, a point labelled "about the right amount of pressure." Ratings of this magnitude suggest that there exist some room for "tightening up" the program--a need which, according to data presented elsewhere in the present report, clearly exists if the program is to be run in a manner which is in greater accord with existing guidelines.

4.3.2.2.3.4 *Job Satisfaction at RAP and Non-RAP Staffed Sites.*

4.3.2.2.3.4.1 General. The impressions rendered for item 7 in the previously cited table clearly suggest that AMOSISTs perceive roster-assigned physicians to have a less adequate knowledge of the AMOSIST Program and local AMIC procedures than do regularly assigned physicians. As a consequence of these findings, a comparison was made of the impact of roster-assigned and regularly assigned physicians upon the job satisfaction evidenced by AMOSISTs serving under them. The data pertaining to this issue is addressed in Tables 29 and 30.

4.3.2.2.3.4.2 Demographic Characteristics. The results of this analysis evidenced a large number of items for which statistically significant differences existed in spite of the lack of such discrepancies according to age, sex, rank, years of active duty or number of months at the facility.

4.3.2.2.3.4.3 SSQ Part II. Among the items appearing in Table 29, only one (item 3, Satisfaction with immediate supervisor) favored the AMOSISTs serving at RAP-staffed sites. All of the remaining items appearing within Table 28 showed greater satisfaction for those serving at non-RAP staffed AMICs. The overall prevalence of greater satisfaction for AMOSISTs at non-RAP staffed sites was consistent with the results of the application of a t-test to all 44 similarly sealed items in Part II of the SSQ ($t = 8.32$, $df = 1/43$, $p \leq .0001$).

4.3.2.2.3.4.4 SSQ Part III. The results of analyses performed on the JDI scales were consistent with those cited above from Part II of the questionnaire. Two of the subscales, SUM WORK and SUM CO-WORKERS, as well as the overall sum of all items showed AMOSISTs serving at AMICs staffed principally by physicians who were regularly assigned to the AMIC to be significantly ($p < .05$) more satisfied than their counterparts at RAP-staffed AMICs.

4.3.2.2.3.4.5 Table 30 presents the data pertaining more directly to the operation of the AMICs at these two types of facilities. The majority of the findings cited therein indicate that there is little difference

Table 29

PHASE II AMOSISTS: DIFFERENCES IN JOB SATISFACTION BETWEEN THOSE SERVING AT RAP-STAFFED AND NON-RAP STAFFED SITES (SSQ PART II)

ITEM		RAP	NON-RAP	SIG. * (p=)
2	Satisfaction with installation	4.44	5.65	.0290
3	Satisfaction with immediate supervisor	7.90	7.08	.0561
4	Feelings of accomplishment	6.44	7.51	.0129
6	Control over others	5.67	6.52	.0784
7	Satisfaction with co-workers	6.18	7.78	.0001
8	Creative opportunities	5.59	7.06	.0015
10	Extent of autonomy	6.56	7.53	.0387
11	Amount of interest in work	6.33	7.44	.0178
12	Opportunity to assess impact of work	6.18	7.30	.0135
13	Acquisition of new skills	5.69	6.61	.0735
16	Efficiency present in job	5.49	6.78	.0038
17	Control of social interactions	4.49	5.73	.0147
18	Amount of pay	3.64	4.58	.0933
22	Amount of social interaction required	6.15	6.91	.0658
23	Amount of responsibility	5.92	7.45	.0008
28	Supervisor's interest in evaluating you	5.97	6.91	.0933
29	Amount of supervision provided	5.38	6.42	.0685
30	Fairness of supervisor's evaluation	6.03	6.91	.0989
31	Time required to remain up-to-date	5.56	6.69	.0062
33	Utilization of skills and knowledge	5.87	6.97	.0280
34	Opportunity for development of new skills	5.56	6.46	.0983
36	Satisfaction with variety in work	6.23	7.09	.0685
37	Work schedule	6.33	7.28	.0612
38	Contributions to others	6.59	7.69	.0134
39	Community contributions	6.72	7.47	.0917

* One-way ANOVAs. Number of respondents: RAP Staffed = 39, Non-RAP Staffed = 65.

Table 30

AMOSISTS' PERCEPTIONS OF AMIC OPERATION AT RAP vs NON-RAP SITES (PART V DATA) *

ITEM	CONTENT	RAP SITE	NON-RAP SITE	SIG.** (p=)
1.	Months since AHS training	15.5	14.6	.7926
2.	All post-AHS assignments as AMOSIST (%)	83.8	77.5	.7394
3.	Months at present AMIC	13.5	14.1	.8230
4.	Percent of time physician available (%)	81.3	80.4	.8915
5.	Time to wait for physician consultation (Minutes)	9.9	13.2	.1109
6.	Percent of consults where MD sees patient himself (%)	39.9	39.4	.9447
7.	Knowledgeability of AMIC procedures (6-point scale: 1=High, 6=Low)			
	a. Regularly assigned physicians:			
	(1) Chief, AMOSIST Program	1.83	1.82	.9686
	(2) AMOSIST physician	2.56	1.73	.0011
	(3) Additional AMOSIST physician	3.14	2.63	.1426
	b. Roster-assigned physicians (RAP):			
	(1) Most knowledgeable RAP	2.72	3.37	.0888
	(2) Least knowledgeable RAP	3.97	4.03	.8889
	(3) Rypical RAP	3.28	3.95	.0880
	c. Tendency to use RAPs versus regularly assigned physicians for consults (8-point scale: 1=Very much less, 8=Very much more)	3.26	3.21	.9326
8.	MD rating of importance of AMOSISTs work (7-point scale: 1=Extremely important, 7=No importance)	2.51	2.60	.4689
9.	Hours of training per month	8.94	8.79	.9355
10.	No. MD supervisory per month	4.32	5.11	.7208
11.	Length of supervisory sessions (minutes) ***	13.4	11.7	.7191
12.	Majority of supervisory sessions pertained to DCS audits (%) ***	16.2	35.0	.1971
13.	Ready access to audits is permitted (%)	84.4	79.2	.5645
14.	Work as AMOSIST versus expectations regarding: (8-point scale: 1=Very much more, 8=Very much less)			
	a. Extent of difficulty	4.23	3.76	.2985
	b. "Complicatedness"	4.40	3.96	.3183
	c. Amount of time required	3.97	3.38	.1494
	d. Degree of interest in work	3.89	3.02	.0720
	e. Amount of individual responsibility	3.29	2.71	.1657
15.	Self-performance versus other AMOSIST (8-point scale: (1=Very much better, 8=Very much worse)	2.43	2.90	.0606
16.	C, AMIC compares performance with others (same as 15)	2.71	3.02	.3437
17.	Apparent levels of satisfaction of other AMOSISTs: (8-point scale: 1=Extremely dissatisfied, 8=Extremely satisfied)			
	a. Most satisfied AMOSIST	6.54	6.58	.9214
	b. Least satisfied AMOSIST	3.29	4.50	.0241
	c. Typical AMOSIST	4.74	6.22	.0002
	d. Career Liklihood (6-point scale: 1=Definitely will not, 6=Definitely will)	2.76	3.86	.0060

* Total number of respondents was 104, of which 39 were from RAP-staffed sites.

** One-way ANOVAs.

*** These data reflect only those respondents who reported the existence of MD supervisory sessions.

between them. Both indicate that a physician is available approximately 80% of the time and that the number of times wherein a physician sees the patient himself when a consultation is requested is approximately the same for each, roughly 35%. It is also of interest to note that there was no significant difference between these two types of operations as regards the AMOSISTs' perceptions of the physicians' rated importance of their work, the hours of training provided each month, the number of physician supervisory sessions provided each month, or the length of the supervisory sessions.

4.3.2.2.3.4.6 Item 14 in Table 30 addressed the differences between the AMOSISTs expectations regarding their work (as developed during the time of their training) and the realities of their work. For each of the five topics addressed, those serving at non-RAP staffed sites, more than those serving at RAP staffed sites, found the realities of their work experiences to be more demanding than their expectations. While none of these differences were individually significant, the mean difference averaged over all five items is significantly different from zero ($t = 6.94$, $df = 1/4$, $p < .001$).

4.3.2.2.3.4.7 Item 17 in Table 30 addresses the issue of perceived satisfaction among AMOSISTs serving at RAP staffed and non-RAP staffed sites. While there is no statistically significant difference between the perceived satisfaction for the most satisfied AMOSIST serving at these facilities, there is a very significant difference between the extent of perceived job satisfaction between RAP and non-RAP facilities for the typical AMOSIST serving in each. The difference is in favor of AMOSISTs serving at AMICs staffed by regularly assigned physicians. A significant difference in the same direction also exists for the preceived job satisfaction of the least satisfied AMOSIST.

4.3.2.2.3.4.8 Overall the comparisons presented indicate that AMOSISTs working at RAP staffed AMICs perceive their working situation to be clearly less desirable than that which is reported by AMOSISTs serving at AMICs staffed by regularly assigned physicians. Further support for this contention is provided by the last item of Table 29. As indicated therein, the reported likelihood of making a career out of the Army is significantly lower ($p = .0060$) for AMOSISTs serving at RAP staffed AMICs than it is for their counterparts serving in non-RAP staffed AMICs.

4.3.2.2.4 Summary of AMOSIST Job Satisfaction

4.3.2.2.4.1 The principal AMOSIST-related interphase comparative findings are that (a) the level of satisfaction among AMOSISTs responding during Phase II of the study is lower than that found during Phase I, and (b) the ratio of 91B AMOSISTs to 91C AMOSISTs went from 1:1 to approximately 3:1 between Phases I and II. Since the result of both Phase I and Phase II analyses showed the 91C to be significantly more satisfied with his work than the 91B, the interphase difference in the overall decrease in satisfaction cited above is viewed as stemming primarily from the disappearance of a substantial portion of the 91Cs from the program between the two periods of evaluation. This same rationale, the reduction in the proportion of the more medically

educated 91C, is believed to account for the Phase II AMOSIST's data indicating that there existed a greater amount of professionalism required within the AMIC and that (vis-a-vis Phase I) the work was more complicated and difficult. While the items rated highest and lowest among all items appearing in Part II of the SSQ remained largely stable between Phases I and II, their solicited comments pertaining to the three least desirable aspects of being an AMOSIST evidenced significant change. Comments indicating poor, unsatisfactory, and/or unsatisfying relationships with their patients nearly doubled in frequency and constituted the category of response most frequently rendered. The category cited next most frequently and evidencing a similar magnitude of increase pertained to discontent with the nature, quantity, and/or quality of the supervision and consultation provided to them. While evidencing no interphase change, a substantial portion of AMOSTISTs cited their lack of acceptance and recognition as primary, direct care providers as a major undesirable aspect of being an AMOSIST.

4.3.2.2.4.2 Using only Phase II respondents, contrasts performed between AMOSISTs and non-AMOSIST 91Bs and 91Cs showed no significant differences between these groups regarding their attitudes toward their work, a result which is not consistent with that of Phase I wherein AMOSIST satisfaction had been significantly higher than non-AMOSIST satisfaction.

4.3.2.2.4.3 Comparisons performed among subpopulations of the Phase II AMOSIST sample showed that (a) AMOSISTs serving at AMICs wherein roster assigned physicians did not comprise a significant portion of the physician staffing requirement were significantly more satisfied in their work than those serving at AMICs where this was not the case, (b) 91C AMOSISTs were significantly more satisfied than 91B AMOSISTs, and (c) AMOSIST trainees were more satisfied with their work than were those AMOSISTs who had completed their training requirements.

4.3.2.3 AMOSIST Physician Job Satisfaction.

4.3.2.3.1 Interphase Comparisons.

4.3.2.3.1.1 Part I, of the SSQ addresses largely the demographic characteristics of the respondents. The interphase comparison of the data for AMOSIST physicians yielded no significant differences for any of the characteristics examined: age, sex, race, pay grade, years of service, months working at facility and regularity of work at clinic.

4.3.2.3.1.2 Among all of the 44 similarly scaled items contained in Part II of the SSQ, there was only one item which evidenced a difference whose magnitude was large enough to be statistically significant at the $p \leq .05$ level.* This item, item 40 ($p = .0135$), indicated that AMOSIST

*Nonetheless, the mean difference score overall of these items showed Phase I respondents to be more satisfied than Phase II respondents with the magnitude of this difference being significantly different from zero ($t = 3.24$, $df = 1/43$, $p < .005$).

physicians were considerbly less satisfied with the physical facility they were working in at the time of the second-phase evaluation than they were at the initial phase of the evaluation.

4.3.2.3.1.3 SSQ Part III. The third part of the SSQ was comprised of a slightly modified version of the JDI. (The modification consisted of the elimination of one item believed to be irrelevant to US Army and US Government employed personnel, that pertaining to profit sharing.) The Phase I versus Phase II analysis yielded but one statistically significant difference, a decrease in the satisfaction with one's co-workers ($p = .0359$). In view of this finding, a further analyses of the individual items comprising the JDI co-worker scale was undertaken. The results of this analyses are presented in Table 31. Seven of the 18 items (nearly 40 percent) evidenced changes which approached ($p < .10$) or exceeded the usual level of statistical significance, $p \leq .05$. All except one, that addressing the tendency toward laziness, reflected adversely upon the AMOSIST physicians co-workers. The changes indicate that in contrast to Phase I, the co-workers evaluated in Phase II were perceived to be more "boring," "slower" (as well as less "fast"), less "intelligent" and less "smart," and more prone to make enemies. Albeit the referent is not stipulated in the questionnaire, it is believed logical to assert that these evaluations reflect to a substantial extent the AMOSIST physicians' perceptions of the AMOSISTs assigned to them. As such, these findings are consistent with others encountered in the study in reflecting degradation of the characteristics of the individuals serving as AMOSISTs between Phases I and II.

4.3.2.3.1.4 SSQ Part IV Data. There were no statistically significant interphase differences found among any of the 20 items included in this portion of the questionnaire.

4.3.2.3.1.5 SSQ Part V Data.

4.3.2.3.1.5.1 General. Part V of the Staff Satisfaction Questionnaire for AMOSIST physicians solicited their perceptions regarding the competence of AMOSISTs, the strengths and weaknesses of AMOSISTs, the need for the AMOSIST Program, and the strengths and weaknesses of the AMOSIST Program itself. The findings relevant to each of these areas are presented in Tables 32 through 35.

4.3.2.3.1.5.2 AMOSISTs' Competence. The first question in Part V asked AMOSIST physicians to rate the AMOSISTs' competence on a scale of 1 to 8. A rating of 1 corresponded to the label "Extremely Incompetent"; a rating of 8 corresponded to the label "Extremely Competent." AMOSIST physicians were to use this scale to evaluate the most competent AMOSISTs, their least competent AMOSIST, and the group or average of all AMOSISTs in the AMIC. As shown in Table 32, there were no statistically significant differences between Phases I and II for any of these items, although each item showed a decrement between the phases. Also appearing in Table 32 is the item pertaining to the perceived need for an AMIC. The increase

Table 31

INTERPHASE COMPARISON OF AMOSIST PHYSICIAN'S RESPONSES TO INDIVIDUAL ADJECTIVES COMPRISING THE JDI CO-WORKERS SCALE

ITEM	Phase I	Phase II	Significance* (p >)
Stimulating	1.91	1.22	.1371
Boring **	2.68	2.06	.0837
Slow **	2.55	1.67	.0277
Ambitious	1.77	1.33	.3340
Stupid **	2.82	2.44	.1766
Responsible	2.64	2.50	.6600
Fast	2.45	1.39	.0087
Intelligent	2.45	1.78	.0781
East to Make Enemies **	2.77	2.11	.0380
Talks Too Much **	2.41	2.50	.7914
Smart	2.14	1.39	.0753
Lazy **	2.82	2.17	.0360
Unpleasant **	2.68	2.67	.9580
No privacy **	2.32	2.22	.7975
Active	2.68	2.33	.2720
Narrow Interests **	2.36	1.94	.2668
Loyal	2.50	2.50	1.0000
Hard to Meet **	2.68	2.44	.4427

* Two-tailed test on three item scale: Yes, No, ?

** "NO" responses were given a value of 3, "YES" responses a value of 0 (zero), and "?" responses a value of 1. The unmarked adjectives (those with positive connotations) were given values of 3, 0, and 1, respectively, for responses of "YES", "NO", and "?" (see Smith et al, 1969). For all items, therefore, the higher the magnitude of the mean response, the more positive the evaluation.

Table 32

INTERPHASE COMPARISON OF AMOSIST PHYSICIANS' JUDGEMENT OF AMOSIST COMPETENCE AND THE NEED FOR AN AMOSIST PROGRAM

ITEM	PHASE I	PHASE II	SIG. (p=)
1. AMOSIST physician's judgement of the competence of his: *			
a. Most competent AMOSIST	7.47	7.35	.5849
b. Least competent AMOSIST	4.63	4.24	.4054
c. Typical (average) AMOSIST	6.21	6.06	.5376
3. Need for an AMOSIST program **	2.35	1.56	.0891

* Eight-point scale: 1=Extremely incompetent, 8=Extremely competent.

** Six-point scale: 1=Virtual necessity, 6=No need.

evidenced between Phases I and II is substantial, albeit not of such magnitude to have reached the generally accepted level of statistical significance ($p = .0891$).

4.3.2.3.1.5.3 Principal Strengths of AMOSISTs. The AMOSIST physicians' responses to the request for their comments (Table 33) regarding their perceptions of the principal strengths of AMOSISTs are provided in Table 34 for both Phases I and II. As cited at the bottom of the table, the chi-square analysis among the categories of responses by phase was nearly statistically significant ($p \leq .08$). An examination of the responses to the questionnaire indicates that the strongest contributions to the statistical significance of the chi-square analysis were due to relative decreases in the number of favorable Phase II comments regarding the AMOSISTs intelligence, his willingness to work, and his adaptability and relative increases in the number favorable responses concerning his ability to perform triage and screening functions. In general, then, the principal change between Phases I and II reflected some decrease in the attribution of positive capabilities of AMOSISTs. However, it is also noted that these changes did not occur in the categories which were most often cited. The categories most frequently cited remained largely unchanged. These cite the ability of AMOSISTs to get along well with patients, their willingness to adhere to algorithms, and their competence in general.

4.3.2.3.1.5.4 Principal Weaknesses of AMOSISTs. Item 2B of Part V of the SSQ asked AMOSIST physicians to list what they perceived to be the AMOSISTs principal weaknesses. As shown in Table 35, there existed no significant difference between Phases I and II among the various categories of weaknesses cited by AMOSIST physicians. It is somewhat striking to note that the two items cited most frequently in the table are items which are in direct opposition to two of the three items just cited in the previous paragraph as being those most frequently reported to have been AMOSISTs' strengths (i.e., those items concerning the AMOSISTs' competence and his willingness to adhere to the algorithms). Comments concerning the AMOSISTs' competence and willingness to adhere to the algorithms accounted for nearly 70 percent of all of the responses cited as being principal weaknesses of AMOSISTs. Competence was cited as one of the AMOSISTs principal weaknesses for more than 45% of all responses rendered in Phase II. Among Phase I data, competence was cited as a weakness for only 31% of all responses rendered.

4.3.2.3.1.5.5 Principal Strengths of AMOSIST Program. In item 4a in Part V of the SSQ, AMOSIST physicians entered their perceptions of the major strengths of the AMOSIST Program. Their responses are summarized by category of response for Phases I and II in Table 36. There was no significant change in the distribution of the responses between Phases I and II. In both Phases I and II, more than 75% of the responses were clustered among three response categories. These responses indicated that the major strengths perceived by AMOSIST physicians regarding the program were those of the ability of the program to achieve a physician's savings, the ability of the program to provide high patient volume care, and the program's ability

Table 33

CATEGORIES OF AMOSIST PHYSICIAN COMMENTS REGARDING AMOSISTS AND AMOSIST PROGRAM

1. AMOSIST--Patient Relationship: Positive or negative comments concerning (a) the ability of the AMOSIST to relate to the patient, to establish rapport with the patient; (b) the extent of desire to help or relate to the patient; (c) the nature of the AMOSIST-Patient relationship (e.g., "courteous," "concerned") or (d) the skill shown in establishing that relationship. (Includes references to related training requirements and/or existence of such problems even though they are acknowledged to be of rather short-term duration.)

2. AMOSIST Adherence to Algorithms: As an AMOSIST's characteristic, refers to an AMOSIST's ability or inability to adhere to algorithms, to recognize his own limitations, to keep from overextending himself or overstepping his capabilities and/or knowledge, to keep from becoming overconfident in his work; as a delivery system characteristic, refers to the local system's use of AMOSISTs, i.e., the degree to which AMOSISTs are required to (or for whatever reason, are not required to) function within the limitations and constraints of the existing system of algorithms. Comments which refer to existing limitations (i.e., number of diagnoses treated or drugs prescribed by AMOSISTs.)

3. AMOSIST's Competence: Statements (positive or negative) concerning the AMOSISTs medical competence and/or level of medical knowledge, training, experience, background, or education; to include comments relating to the AMOSISTs ability (or inability) to perform specified medical tasks, e.g., (physical) examination skills, ability to interpret laboratory test results, general accuracy/adequacy of his work.

4. AMOSISTs' Desire to Learn: References to the AMOSISTs desire to increase his knowledge; his willingness and/or capacity to learn.

5. AMOSISTs' Intelligence: References to the intelligence of AMOSISTs.

6. AMOSISTs' Willingness to Work: References concerning the motivation of AMOSISTs; comments on their persistence, thoroughness, industriousness, and/or enthusiasm (or lack of same).

7. AMOSISTs' Adaptability: References to the AMOSISTs adaptability, his compatability, flexibility, cooperativeness and/or ability to work with (get along with) staff personnel.

8. Professional, Mature Attitude of AMOSIST: References to the AMOSISTs integrity, maturity, honesty, professional attitude, and/or judgemental capacities.

9. Cumbersome "Paperwork" Requirements of Program: References to excessive paperwork and/or documentation requirements inherent in the AMOSIST Program; comments indicating that too much time and/or emphasis is placed upon completing the paperwork/forms required by the system.

10. AMOSIST Supervision: Comments which pertain to the supervision provided by the AMOSIST MDs (e.g., unspecified references or references to amount and/or quality of same); comments which pertain to the training and/or selection of AMOSIST MDs; comments relating to the amount of responsibility that is placed on the AMOSIST, or comments pertaining to the audit procedure(s) employed.

11. Triage/Screening System: References to or comments concerning the AMOSIST Program's screening/triage capabilities.

12. "Fast" Care/Excessive Patient Workload: Comments which reflect some protest concerning the existence of (or the resultant ill or negative effects of) a "heavy" or overly large patient workload; comments indicating a desire by AMOSISTs to treat too quickly or an (over) emphasis by the system on providing fast medical care; comments indicating a lack of sufficient time to provide (adequate) medical care for patients or training for AMOSISTs.

13. High Patient Volume: A comment which asserts (as an advantage) that the AMOSIST program can provide treatment to a large number of patients; provide a rapid, fast means of delivering medical care; shortens waiting time, provides rapid care for patients with minor illness.

14. Low Cost Medical Care: A comment that indicates that the cost of medical care provided by the AMOSIST program is low.

15. Physician Savings: Comments which indicate that the AMOSIST program saves (or "frees") the physicians' time, reduces the amount of physician-patient contact time required, enables medical care to be provided in spite of the physician shortage, and/or reduces the patient load at other treatment clinics.

16. Lack of Staff Knowledge/Support: Comments which indicate that (non-AMIC) administrative/medical staff are insufficiently informed regarding the AMOSIST Program (e.g., its purpose, functional capabilities/limitations, manner of operation, etc.) and/or do not provide adequate support for the program; comments pertaining to type of (characteristic of) support provided by other staff, clinics, services.

17. Lack of Patient Knowledge/Acceptance: Comments which indicate that patients lack adequate information regarding the AMOSIST program (e.g., its purpose, functional capabilities/limitations, manner of operation) and/or do not accept (or are dissatisfied with) the program.

18. Continuity of Care/Follow-up: Comments pertaining to need for/adequacy of follow-up performed by AMOSISTs or AMOSIST MDs; comments pertaining to the need/desire for patients to see the same care provider or subsequent visits.

19. AMOSIST Job Satisfaction/Status: Comments which indicate that the AMOSIST is satisfied or dissatisfied with his job/work (e.g., references to interest, boredom, status, liking of job).

20. Other:

Table 34

PHASE I VERSUS PHASE II COMPARISON OF AMOSISTS' PRINCIPAL STRENGTH AS PERCEIVED BY AMOSIST PHYSICIANS

	CATEGORY OF RESPONSE	PHASE I NO.	PHASE I (% of TOTAL)	PHASE II NO.	PHASE II (% of TOTAL)
1	AMOSIST-patient Relationship	7	(13.5)	7	(17.1)
2	Adherence to Algorithms	9	(17.3)	7	(17.1)
3	Competence	9	(17.3)	9	(22.0)
4	Desire to Learn	3	(5.8)	4	(9.8)
5	Intelligence	3	(5.8)	-	
6	Willingness to Work	8	(15.4)	1	(2.4)
7	Adaptability	3	(5.8)	-	
8	Professional, Mature Attitude	3	(5.8)	2	(4.9)
10	Responsiveness to Supervision	-		1	(2.4)
11	Triage/Screening Capabilities	-		4	(9.8)
13	High Patient Volume	-		1	(2.4)
15	Physician Savings	1	(1.9)	2	(4.9)
20	Other	6	(11.5)	3	(7.3)
	TOTAL	52	(100.1)*	41	(100.1) *

$X^2 = 19.599$, $.10 > p > .05$

* Discrepancy from 100.0 is due to rounding.

Table 35

PHASE I VERSUS PHASE II COMPARISON OF AMOSISTS' PRINCIPAL WEAKNESSES AS PERCEIVED BY AMOSIST PHYSICIANS

	CATEGORY OF RESPONSE	TOTAL NUMBER OF RESPONSES PHASE I		PHASE II	
1	AMOSIST-patient Relationship	3	(7.1)	2	(4.5)
2	Adherence to Algorithms	6	(14.3)	10	(22.7)
3	Competence	16	(38.1)	20	(45.4)
5	Intelligence	1	(2.4)	2	(4.5)
6	Willingness to Work	3	(7.1)	-	
7	Adaptability	1	(2.4)	1	(2.3)
8	Professional, Mature Attitude	3	(7.1)	3	(6.8)
10	Responsiveness to Supervision	2	(4.8)	1	(2.3)
12	"Fast" Care	1	(2.4)	-	
15	Physician Savings	1	(2.4)	1	(2.3)
20	Other	5	(11.9)	4	(9.1)
	TOTAL	42	(100.0)	44	(99.9)*

$X^2 = 7.550$, $p > .50$

* Discrepancy from 100.0 due to rounding.

Table 36

PHASE I VERSUS PHASE II COMPARISON OF THE STRENGTHS

OF THE AMOSIST PROGRAM AS JUDGED BY AMOSIST PHYSICIANS

CATEGORY *		TOTAL NUMBER OF RESPONSES PHASE I		PHASE II	
1	AMOSIST - patient Relationship	2	(5.3)	-	
2	Algorithms: Adherence to/constraints resulting from	2	(5.3)	4	(12.1)
3	AMOSISTs' Competence	1	(2.6)	1	(3.0)
10	Physician supervision	1	(2.6)	-	
11	Triage/Screening System	6	(15.8)	7	(21.2)
12	Fast Care/Excessive Workload	-		1	(3.0)
13	High Patient Volume	12	(31.6)	7	(21.2)
14	Low Cost Medical Care	1	(2.6)	-	
15	Physician Savings	11	(28.9)	11	(33.3)
18	Continuity of Care/Follow-up	1	(2.6)	-	
20	Other	1	(2.6)	2	(6.1)
	TOTAL:	38	(99.9)**	33	(99.9)**

$X^2 = 8.077$, $p > .50$

* Descriptions of all categories employed are found in Table 33.

** Discrepancy from 100.0 due to rounding.

to serve as an effective triage and screening system for the hospital. It is noted that these perceptions are generally in accord with the findings cited in the third report of the series of reports rendered on this study.

4.3.2.3.1.5.6 Weaknesses of AMOSIST Program. Table 37, provides the AMOSIST physicians' perceptions of the major weaknesses of the AMOSIST Program. As noted at the bottom of the table, the change in the distribution of responses between Phases I and II was not at a level of significance that is normally considered acceptable ($p = .13$). In examining the calculations, it was clear that the strongest contributor to the chi-square value was the relative increase from Phase I to Phase II in the frequency with which AMOSISTs' competence was cited as a weakness of the AMOSIST Program.

4.3.2.3.2 Intraphase Findings and Comparisons.

4.3.2.3.2.1 SSQ Part II Items Rated Highest and Lowest.

4.3.2.3.2.1.1 Table 38 presents the eight items for which the AMOSIST physician's expressed the greatest amount of satisfaction.* Only four of the items included in the table are common to the table (Table 41) dealing with the same topic in Phase I (Schopper, 1978a). One-half of the items cited pertain to the AMOSIST physician's supervisor. Two items relate to satisfaction with the belief that a contribution is being made to others and to the military community. The remaining two items indicate relatively high satisfaction with the opportunity to remain busy and with their co-workers. The last listed item is of some additional interest due to the substantial change in its rank-order position between Phases I and II. In the initial, Phase I analysis, satisfaction with co-workers was very clearly the highest ranked item among all 45 with a mean response of 7.77 on the nine-point scale utilized. Its fall to the eight-ranked item with a value of 6.94 is substantial. The magnitude of the difference is nearly statistically significant at the .05 level ($p = .0783$).

4.3.2.3.2.1.2 Table 39 lists the ten items with which the AMOSIST physicians reported the least amount of satisfaction.** In consonance with the findings of Table 38 (but in contrast to the considerably greater extent of agreement evidenced by AMOSISTs), only one-half of the items appearing in the table are the same as those appearing in the corresponding table (Table 42; Schopper, 1978a) for Phase I data. Clearly the item for

*The eight uppermost related and lowermost related items comprise those which are beyond $\pm$ 1 standard deviation of the mean of the distribution of means for all similarly scaled items in Part II.

**Ten are included instead of eight due to the "ties" encountered.

Table 37

PHASE I VERSUS PHASE II COMPARISON OF WEAKNESSES

OF THE AMOSIST PROGRAM AS JUDGED BY AMOSIST PHYSICIANS

CATEGORY *		TOTAL NUMBER OF RESPONSES			
		PHASE I		PHASE II	
1	AMOSIST - Patient Relationship	-		2	(6.7)
2	Algorithms: Adherence to/ Constraints Resulting from	3	(7.1)	4	(13.3)
3	AMOSISTs' Competence	4	(9.5)	10	(33.3)
6	AMOSISTs' Willingness to Work	1	(2.4)	1	(3.3)
9	Cumbersome Paperwork Requirements	3	(7.1)	-	
10	Physician Supervision	6	(14.3)	3	(10.0)
12	Fast Care/Excessive Workload	3	(7.1)	-	
13	High Patient Volume	-		1	(3.3)
16	Hospital Knowledge/Support	8	(19.0)	4	(13.3)
17	Patient Knowledge/Acceptance	4	(9.5)	1	(3.3)
18	Continuity of Care/Follow-up	2	(4.8)	-	
19	AMOSIST Job Satisfaction	7	(16.7)	4	(13.3)
	TOTAL:	42	(99.9)**	30	(99.8)**

$X^2 = 15.832$, $.20 > p > .10$.

* Descriptions of all categories employed are found in Table 33.

** Discrepancy from 100.0 due to rounding.

Table 38

SSQ PART II ITEMS RATED HIGHEST IN SATISFACTION

BY AMOSIST PHYSICIANS

ITEM		MEAN RESPONSE *
30	Fairness of Supervisor's Evaluations	7.36
3	General Satisfaction with Supervision **	7.11
38	Work Contributes To/Benefits Others **	7.11
5	Opportunity to Remain Busy **	7.06
26	Interpersonal Manner of Supervisor	7.06
39	Work Contributes to Military Community	7.06
27	Work-related Knowledge, Skill of Supervisor	7.00
7	Coworkers **	6.94

* Nine-point, balanced Likkert scale: 1=Extremely Dissatisfied, 9=Extremely Satisfied.

** Appeared in the same list in Phase I.

Table 39

SSQ PART II ITEMS RATED LOWEST IN SATISFACTION

BY AMOSIST PHYSICIANS

ITEM		MEAN RESPONSE *
21	Responsibility for own actions and consequences in clinic	7.89
29	Amount of time spent by supervisor in reviewing your work **	4.89
35	Adequacy of clerical support and supplies available	4.89
41	This particular outpatient facility (in general)	4.89
33	Extent to which work makes use of your abilities, training **	4.83
42	Availability of personnel to support you	4.78
13	Opportunity for professional growth **	4.50
34	Opportunity to obtain additional skills of future value **	4.33
15	Operation of organization's promotion system **	4.12
20	Physical characteristics of immediate work area	3.61

* Nine-point balanced Likkert scale: 1=Extremely Dissatisfied, 9=Extremely Satisfied.

** Appeared in this same list in Phase I.

which the greatest dissatisfaction was reported is item 20, that pertaining to the physical characteristics of the immediate work area. Among the remaining items in the table, two (items 35 and 42) indicated a lack of support for the clinic, and three (items 13, 33, and 34) expressed the belief that their skills were being underutilized and that there was little opportunity for professional growth. The remaining four indicated dissatisfaction with the degree of responsibility they had for their own actions, decisions and the consequences of same within the clinic, the amount of time spent by the supervisors in reviewing their work, the promotion system, and the AMIC in general.

4.3.2.3.2.2 AMOSIST Physicians versus Non-AMOSIST Physicians. A comparison between the Phase II AMOSIST Physician respondents and Non-AMOSIST Physicians is presented in Table 40. The results pertaining to Part I indicate that AMOSIST physicians were significantly older than their counterparts and had been at the facility significantly longer. There were also significantly more females among the AMOSIST physicians than among the Non-AMOSIST physicians. As regards their attitudes toward their work, only four items in Part II yielded a statistically significant difference. Three favored satisfaction by AMOSIST physicians and one by Non-AMOSIST physicians. As before, in an effort to obtain an appreciation of whether or not an overall, global difference existed between AMOSIST physicians and non-AMOSIST physicians, the difference scores for each of the 44 similarly scaled items in Part II were examined to determine if the mean difference was significantly discrepant from zero. This analysis did evidence a statistically significant result ($t = 2.19$, $df = 1/43$, $p < .05$) indicating the existence of greater job satisfaction among AMOSIST physicians.

4.3.2.3.3 Summary of AMOSIST Physician Job Satisfaction.

4.3.2.3.3.1 The principal findings of the factors pertaining to the job satisfaction of AMOSIST physicians, per se, were that (a) they were significantly less satisfied with their work in Phase II than they were in Phase I, and (b) they were significantly more satisfied with their work than non-AMOSIST physicians participating in the Phase II evaluations.

4.3.2.3.3.2 In general, the AMOSIST physicians' perceptions of their AMOSISTs evidenced a substantial deterioration between Phases I and II. To the extent that their responses to items pertaining to their co-workers reflect their perceptions of the AMOSISTs assigned to them, AMOSIST physicians viewed AMOSISTs as being significantly slower and less intelligent in Phase II than they were in Phase I. When requested to address the issue of their AMOSISTs' competence, a decrement was observed for all categories evaluated (i.e., least competent AMOSIST, most competent AMOSIST, and typical AMOSIST) although none of the differences were of sufficient magnitude to be statistically significant.

4.3.2.3.3.3 In contrast to the just-cited absence of a statistically significant finding regarding the decrease in the rating of competence given AMOSISTs between Phases I and II, the Phase II comments rendered by AMOSIST

Table 40

PHASE II COMPARISON: AMOSIST PHYSICIAN VERSUS

NON-AMOSIST PHYSICIAN (SSQ PARTS I-IV)

ITEM		AMOSIST Physician	Other Physician	Sig.* (p=)
I- 1	Age (years)	43.7	32.6	.0000
I- 3	Sex (percent male)	68.7	95.5	.0128
I- 5	Months at present facility	22.9	13.2	.0485
II-14	Job constraints	5.83	4.42	.0226
II-17	Control of social interactions	5.11	3.98	.0696
II-18	Amount of pay	4.94	3.58	.0665
II-19	Benefits	6.41	5.04	.0352
II-20	Physical characteristics of work area	3.61	5.44	.0106
II-30	Fair supervisor	7.35	6.26	.0562
III	JDI Sum-Pay	5.65	4.88	.0304
IV- 2	Amount of interest in work (8-pt scale: 1=Extremely boring, 8=Extremely interesting)	4.41	5.51	.0754
IV-10	Perceptions of hospital commander's rating of professional requirements (6-pt scale: 1=Extremely professional, 6=Totally non-professional)	3.56	2.07	.0045

* Two-tailed tests; AMOSIST Physicians = 18, Other = 45.

physicians regarding the principal strengths and weaknesses of AMOSISTs and the AMOSIST Program focussed rather sharply on the issue of the AMOSISTs' abilities and found them to be lacking (vis-a-vis Phase I findings). The most prominent change in the comments made regarding the principal strengths of AMOSISTs was a relative decrease in the number of times the AMOSISTs' competence was cited in the second phase evaluation. In complementary fashion, there was a marked Phase II increase in the frequency with which competence was cited as being a principal weakness of AMOSISTs. ("Competence" as a principal weakness of AMOSISTs comprised slightly more than 45 percent of all weakness-related comments rendered in Phase II.) "Adherence to algorithms" was another weakness-related category that showed a substantial increase between Phase I and Phase II.

4.3.2.3.3.4 No significant interphase changes among the categories of comments were found between Phases I and II regarding the AMOSIST physician's perceptions of the strengths of the AMOSIST Program itself. The capability to effect a physician saving, to render high volume care, and to function effectively as the hospital's triage/screening system remained as the most frequently cited strengths of the program. While the extent of change from Phase I and Phase II pertaining to weakness of the program was only of marginal or suggestive statistical significance ($p \lesssim .13$), it is noted that it was the response category dealing with the AMOSISTs' competence that evidenced the largest change (an increase of 250%) and was cited most frequently (33 percent of all weakness-related comments).

4.3.2.4 Staff Perception Questionnaire.

4.3.2.4.1 General. The extent of program acceptance evidenced by hospital personnel not directly associated with the AMIC was determined through the use of the Staff Perceptions Questionnaire (SPQ). This questionnaire was administered to the non-administrative personnel serving within the hospital. They were first asked to indicate the extent of their knowledge regarding the AMOSIST Program and then were asked their opinions regarding: (a) the need for an AMIC and (b) the ability of AMOSISTs to provide adequate medical care. They were also asked to render their perceptions of the professional staff's view of the AMOSISTs capabilities.

4.3.2.4.2 Distribution of Respondents by Phase of Job Category. The distribution of the SPQ respondents among four general job categories for each of the phases is provided in Table 41. As indicated at the bottom of the table, there was a statistically significant shift of the types of respondents between the two phases. The largest change (60%) was the decrease in the number of 91Bs responding during Phase II. Smaller changes in the opposite direction occurred for the two professional categories employed (physician, 22%; nurses, 29%).

4.3.2.4.3 Preliminary Analyses. Two way analyses of variance (phase of category of respondents) using a regression model (Nie et al, 1975) to minimize the effects of interphase inequities among the categories of respondents were performed. The results indicated that there were highly

Table 41

DISTRIBUTION OF STAFF PERCEPTION'S QUESTIONNAIRE RESPONDENTS BY CATEGORY OF RESPONDENT AND PHASE OF STUDY *

CATEGORY OF RESPONDENT	PHASE I	PHASE II
Physician	73	89
Nurse	59	76
Corpsman (91 B)	156	93
Other Enlisted Personnel	171	199

* Chi-square = 21.616, $p \leq .0001$

Table 41

DISTRIBUTION OF STAFF PERCEPTION'S QUESTIONNAIRE RESPONDENTS BY CATEGORY OF RESPONDENT AND PHASE OF STUDY *

CATEGORY OF RESPONDENT	PHASE I	PHASE II
Physician	73	89
Nurse	59	76
Corpsman (91 B)	156	93
Other Enlisted Personnel	171	199

* Chi-square = 21.616, $p \leq .0001$

significant differences among categories of respondents for all of the questions asked. Conversely, all but one of the items (item 4, $p = .049$) showed no significant difference between the phases. In all analyses, the phase by category-of-respondent interaction was not statistically significant ($p \geq .33$ for all analyses). As a result of these analyses the findings for each of these variables, phase and category-of-respondent, are described separately.

4.3.2.4.4 Interphase Comparison. Table 42 depicts the results of the interphase comparison for each of the items. As cited above, there exists no statistically significant difference between the phases for any item except item 4, that which pertains to the impression held by individual staff members regarding the apparent opinion of the professional staff concerning the ability of AMOSISTs to perform their work adequately. On this item, there was a statistically significant worsening.* This finding is consistent with that of the data cited elsewhere (re: comments of AMOSIST physicians regarding competence of AMOSISTs) which suggest that there has been a decrement in the perceived capabilities of AMOSISTs between Phase I and II of the study. Such may be in part, attributable to the deletion of the more medically education 91C from the program.

4.3.2.4.5 Differences Associated With Phase II Respondent's Categories. The differential effects upon the responses for each item among the categories utilized to classify Phase II respondents are shown in Table 43. Aposteriori analyses using Duncan's multiple range test at the $p = .05$ level of confidence (Nie et al, 1975) were employed to identify the nature of the statistically significant differences which did exist among the categories of respondents for 2, 3, and 5. The clearest differences were evidenced for items 2 and 5. As regards the former, the physicians, nurses, and 91Cs all reported similarly greater degrees of knowledge of the AMOSIST Program than did the 91Bs and "Other" enlisted personnel. In contrast to the overall lack of a statistically significant difference among respondents regarding the apparent perception of the professional

*Note that larger numbers indicate lower, more negative opinions. Additionally, while the level of statistical shown in Table 41, $p = .0530$, is not quite at the commonly employed $p \leq .05$ criterion, the results of the aforecited two-way ANOVA showed the difference to be statistically significant at $p = .049$. The difference in the magnitude of the probabilities cited (.004) is due to differences in the sample size. Since the two-way ANOVA involves only those data from respondents who provided information regarding both position and perceived opinion of professional staff, the sample is smaller (by 4%) than that employed in the one-way analyses depicted in the table, (i.e., the data for those who did not indicate their position is not included in the one-way ANOVA).

Table 42

STAFF PERCEPTION'S QUESTIONNAIRE: INTERPHASE COMPARISON

ITEM		Phase I	Phase II	Sig (p=)*
2	Extent of Knowledge about AMIC (7 pt scale: 1=High, 7=None)	3.19	3.16	.7797
3	Need for AMIC (6 pt scale: 1=High, 6=None)	2.44	2.45	.8465
4	Perceived Opinion of Professional Staff Regarding AMOSISTs	3.04	3.24	.0530
5	Own Opinion of AMOSISTs (8 pt scale: 1=High, 8=Low)	3.67	3.55	.3326

* One-way ANOVAs with 2-tailed tests. There were 463 respondents in Phase I and 462 in Phase II. At least 451 respondents answered item 2-4 in each phase. For item 5, there were 423 Phase I and 420 Phase II respondents who answered. The statistical significance derived from the two-way ANOVA using the regression-model approach (Nie et al, 1975) were as follows for item 2 through 5, respectively: 0.635, 0.359, 0.049, and 0.561 (see text).

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AMOSIST PROGRAM FIELD EVALUATION: STABILITY AND VIABILITY--A RE--ETC(U)
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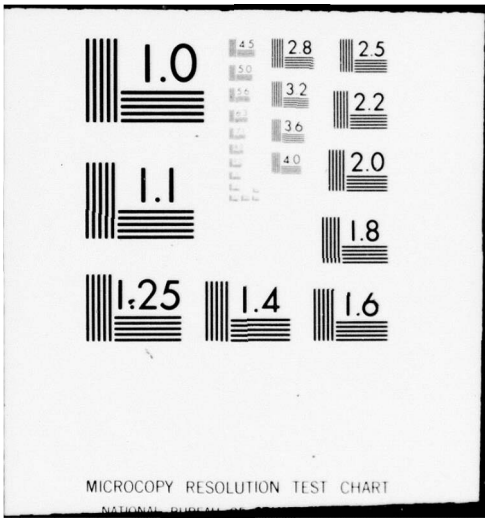
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MICROCOPY RESOLUTION TEST CHART

Table 43

Phase II Staff Perceptions Questionnaire

Broken Down by Job Title

ITEM		Job Title MD	RN	91 B	91 C	Other	Sig. * (p=)
2	Knowledge about AMIC (7 pt scale: 1=High, 7=None)	2.75	2.75	3.51	2.82	3.52	.0000
3	Need for an AMIC (6 pt scale: 1= High, 6=Low)	2.13	2.72	2.33	2.34	2.66	.0158
4	Perceived Opinion of Professional Staff Regarding AMOSISTs (8 pt scale: 1=High, 8=Low)	2.88	3.57	3.16	3.30	3.27	.1303
5	Own Opinion of AMOSISTs (8 pt scale: 1=High, 8=Low)	2.95	3.68	3.84	3.59	3.59	.0204

* Statistical significance shown is that based on a one-way ANOVA with N's $\geq$ 837 in each analysis. The statistical significance derived from two-way ANOVAs using a regression-model approach (Nie et al, 1975) were as follows: for items 2 through 5, respectively, 0.001, 0.001, 0.027, and 0.003 (see text).

staff concerning AMOSISTs (item 4), the aposteriori analyses of relating to their own opinions of AMOSISTs (item 5) revealed that all non-physician personnel held a similar and significantly poorer opinion than did physicians. The aposteriori analyses of responses concerning the need for an AMIC were less clear cut and indicated substantial overlap among categories indicated to be homogeneous in the range of values indicated. One homogeneous group included those with the three mean values indicating the highest perceived need (physicians, 91Bs, and 91Cs) while another grouped together all categories but physicians, who had the highest perceptions of need for an AMIC.

4.3.2.4.6 Correlational Findings. The results of a correlational analysis of the data from all respondents indicates that one's perceptions regarding the need for an AMIC are substantially correlated with one's perceptions of the staff's evaluations of AMOSISTs ($r = .51$, $p < .001$) and one's own evaluation ($r = .42$, $p < .001$). There was also considerable congruence between one's own evaluation of AMOSISTs and one's impression of the staff's evaluation of AMOSISTs ($r = .64$, $p < .001$). The extent of knowledge that an individual purported to have regarding the AMOSIST Program was considerably less to either his own evaluation of AMOSISTs ($r = .0741$) or his impression regarding one's staff's evaluation of AMOSISTs ($r = .0536$) and was only marginally related to one's own belief regarding the need for an AMIC ($r = .1523$). The correlations between the extent of knowledge and the remaining variables were statistically significant ($p \leq .05$) but quite small, less than .075 in each instance.

4.3.2.4.7 Analysis of Additional Comments Rendered.

4.3.2.4.7.1 General. The SPQ also permitted each respondent to write-out whatever additional written comments he may have wished to make. These comments were initially dichotomized into those which were either positive or supportive of the program and those which were either negative or derogatory regarding the program. Categories were then developed to reflect the content of comments rendered (Table 44). The results of the interphase comparison of the comments made in each phase of the study are presented in Table 45.

4.3.2.4.7.2 Positive, Supportive Comments. Very clearly, the most frequently given positive response in both phases was one which reflected a general need for an AMIC and/or a rather general positive statement regarding the merit of the program. Nearly three-quarters of the comments provided in both halves of the study reflected one or the other of these. Content areas which contributed substantially to the statistical difference which is cited were the initial appearance of complimentary comments pertaining (a) to professional attitudes and/or behaviors of AMOSISTs, and (b) to suggestions that the AMOSIST Program be enhanced or expanded. The largest change, however, was in the relative decrease in the number of responses praising the AMOSISTs' training, abilities, and/or extent of education. While other factors may be relevant it is again likely that this decrease is associated with the withdrawal of the 91C from the program.

Table 44

STAFF PERCEPTIONS QUESTIONNAIRE COMMENT CATEGORIES

1. AMOSIST PERSONNEL TRAINING/ABILITY/EDUCATION: References to the AMOSIST's experience, education, candidate selection criteria, MOS'S; their level and/or adequacy of training, and perceived competence and/or ability (to include references pertaining to dissatisfaction or disappointment by some staff at being unable to be treated by a physician).

2. PATIENT CARE/PATIENT CARE LIMITATIONS: Comments regarding direct patient care. Perceptions and/or recommendations pertaining to limitations and/or expansion of the type (level) care provided. References to treatment policy limitations imposed on the AMOSIST, recommendations as to how patient care could be (expanded) and still be within the scope of AMOSIST ability. Also references to proposed limitations or overexpansion of clinical practices and procedures utilized by AMOSIST's.

3. AMOSIST Supervision: References to need for/or adequacy of AMIC Supervisors.

4. AMOSIST CONSULTATIONS/REFERRALS: Adequacy and appropriateness in judgement of AMOSIST referrals, consultations to proper specialty clinic (screening), complete and accurate preparation of medical history, and general knowledge of specialty clinic functions so as to make a better judgement to which clinic to refer the patient. Also references to Physician's/Clinicians acceptance (or non-acceptance) of the AMOSIST consults.

5. GENERAL WORTH OF NEED FOR AMIC: Reference to amount of perceived worth/need for a AMIC, it's potential and general adequacy. References to the Program being needed by the hospital (serving a specific need) and being a part of the overall health care service. Reference to clinic "underutilization" or "abuse."

6. HOURS OF OPERATION: References to hours and weekend operation. Also comments regarding combining AMIC with Emergency Room to effect extended hours.

7. STAFFING: Availability of sufficient and appropriate personnel (not supervisors) to accomplish the workload. (Understaffed)

8. WORKLOAD SCHEDULING: References to appointment systems and patient waiting times, and workload management.

9. PROFESSIONALISM: Professional attitude of AMOSIST. References to the personal integrity, ethics, manner or maturity of judgement evidenced by AMOSISTs in their treatment of patients. Also references to AMOSIST's deliberately giving the patient the impression they are the physician.

10. OTHERS: Specific remarks not covered above.

Table 45

STAFF COMMENTS REGARDING THE AMOSIST PROGRAM

CATEGORY OF COMMENT	NATURE OF COMMENT: POSITIVE [a] Phase I No.	Phase I %	Phase II No.	Phase II %	NEGATIVE [b] Phase I No.	Phase I %	Phase II No.	Phase II %
1 AMOSIST Training, Ability, Education	15	19.7	5	8.6	96	38.6	85	35.3
2 Patient Care and Care Limitations		-	4	5.7	12	4.8	19	7.9
3 AMOSIST Supervision	-	-	-	-	15	6.0	27	11.2
4 AMOSIST Consultations/Referrals	-	-	1	1.7	20	8.0	17	7.1
5 General Worth of/Need for AMIC	58	76.3	42	72.4	25	10.0	22	9.1
6 Hours of Operation	-	-	-	-	14	5.6	8	3.3
7 Staffing	-	-	-	-	10	4.0	5	2.1
8 Workload Scheduling	-	-	-	-	14	5.6	20	8.3
9 Professionalism	-	-	3	5.2	10	4.0	16	6.6
10 Other	3	3.9	3	5.2	33	13.5	22	9.1
TOTAL	76	99.9 [c]	58	100.0	249	100.1 [c]	241	100.0

a. Chi-square = 11.59, $p < .025$
b. Chi-square = 14.24, $p > .10$
c. Total ≠ 100.0 due to rounding

4.3.2.4.7.3 Negative, Critical Comments. There were no statistically significant changes between Phases I and II regarding the nature of the criticisms and/or derogative responses rendered. As in the first phase, the absolute quantity of negative comments vastly outnumbered the quantity of positive comments. The largest number of negative comments made in each phase were those which were critical of the AMOSISTs' training, ability, and education--in short his competence.

4.3.2.4.8 SPQ Summary. The findings of the SPQ indicate that there has been little statistically significant change in the perceptions of the hospital staff regarding the AMIC and AMOSISTs. Physicians tended to perceive the program more positively than any other group. While the need for a AMIC or a related type of service is commonly perceived to be its principal merit, the data suggest that negative perceptions of the AMOSISTs' competence remain the most prominent criticism of the program.

5. SUMMARY OF FINDINGS.

5.1 AMIC Checklist. The operations of the AMICs evaluated evidenced considerable change between Phases I and II although there existed no statistically significant change in either a positive or negative direction. The area evidencing the most positive change was that pertaining to the triage function. The most negative changes were evidenced in the areas of AMOSIST supervision and auditing functions. (The latter is believed to be due largely to the use of terminology which unambiguously defined "audit" to mean a "formal," recorded audit.) Aside from the extent of change, per se, the findings continued to evidence low levels of functioning in the critical areas of AMOSIST supervision, auditing procedures, and physician staffing practices.

5.2 Patient Satisfaction. Among the sites included in the mailed surveys, there was a statistically significant increase between Phase I and Phase II findings regarding the level of patient satisfaction evidenced. The comparison between patient satisfaction present at the three AMICs and the three General Outpatient Clinics (GOCs) included in the Phase II evaluation of Cost Effectiveness and Physician Savings (Schopper, 1978b) showed patients treated at AMICs were significantly more satisfied with the treatment received than were those treated at GOCs.

5.3 Staff Satisfaction.

5.3.1 AMOSISTs. The interphase comparisons showed AMOSISTs in Phase II to be significantly less satisfied with their work than were AMOSISTs in Phase I. Additionally there were significantly more 91Bs and significantly fewer 91Cs in Phase II than were in Phase I. Since the 91B in Phase II was also significantly less satisfied with his job than his 91C counterpart (a finding consistent with Phase I results), the interphase decrement was hypothesized to be due to the prevalence of the 91B in the Phase II sample. In contrast to the Phase I finding of greater job satisfaction among AMOSISTs than non-AMOSISTs, the job satisfaction of Phase II AMOSISTs was found not to be significantly different from their non-AMOSIST counterparts. As in

Phase I, however, AMOSISTs in training status at the time of the Phase II evaluation were found to be more satisfied than their more experienced co-workers. A similar interphase consistency was found regarding the RAP versus non-RAP evaluation. AMOSISTs serving at AMICs wherein roster-assigned-physicians provided a significant portion of the physician man-hours supplied to the clinic were significantly less satisfied with their work than those serving at AMICs staffed by regularly assigned physicians.

5.3.2 AMOSIST Physicians. AMOSIST Physicians responding in Phase II were significantly less satisfied with their work than were those who responded in Phase I. They were, however, significantly more satisfied than Phase II physicians serving in other outpatient clinics. Their evaluations of AMOSISTs and the AMOSIST Program evidenced a significant decrease between Phases I and II. Issues pertaining to the AMOSISTs' competence were prominent, and it is believed that the decrements shown were due, in large measure, to the substantially increased proportion of the less formally educated 91B (vis-a-vis the 91C) working in the AMOSIST Program at the time of the Phase II evaluation.

5.3.3 Non-AMIC Staff Perceptions. Statistically significant interphase changes were observed in the comments rendered regarding the Program. In consonance with the perceptions of the AMOSIST MD cited above, these changes evidenced a lack of confidence in the competence of AMOSISTs and, too, are believed to reflect the increase in the relative percentage of 91Bs (versus 91Cs) in the AMOSIST Program at the time of the second phase evaluation.

6. CONCLUSIONS.

6.1 Operational Characteristics.

6.1.1 There occurred no overall statistically significant directional change in the operational characteristics of the AMOSIST Program between Phase I and Phase II.

6.1.2 The program continues to remain acutely deficient as regards the performance of adequate, documented audits of the AMOSIST's performance--a function which is believed (in view of the small amount of formal medical education provided the AMOSISTs) to be a critical, core requirement of the program.

6.1.3 Inadequate physician staffing and supervision practices continue to exist. Checklist data indicate that physicians who are not regularly assigned to the AMIC continue to provide a substantial portion of the physician man-hours provided to some clinics (a practice which, according to AMOSISTs' responses on the job satisfaction questionnaire, is deleterious to their morale and their stated likelihood of remaining in the Army). Data from both the AMIC Checklist and from the AMOSISTs' responses to the questionnaire addressing their work satisfaction indicate that physician supervision is not available to AMOSISTs at some sites during the entirety of their working hours.

6.1.4 Overall, the operational characteristics of the program are such that it is considered to remain "at risk" from a medico-legal perspective.

6.2 Program Acceptance

6.2.1 Patient Satisfaction. The manner in which medical care is delivered by AMOSIST Program care providers is acceptable to the recipients of such care.

6.2.2 Staff Satisfaction. As the apparent result of the replacement of the better-educated 91C AMOSIST with the lesser-educated 91B AMOSIST (a) the job satisfaction of both AMOSIST physicians and AMOSISTs themselves decreased between Phases I and II, and (b) the ratings given by both the AMOSIST physicians and the hospital staff in general regarding the perceived competence of AMOSISTs decreased during the interim between Phase I and Phase II.

7. RECOMMENDATION.

The findings and conclusions rendered in the present report are in consonance with, and reinforce the findings and conclusions of the initial report of this study (Schopper, 1978a). As a result of the present replication, the recommendations of that report remain relevant and receive added emphasis. The exception pertains to the issue of physician staffing. Rather than recommending at least a one-half time regularly assigned physician to each AMIC as was initially advocated (para 6.5, Schopper, 1978a) it is now recommended that (a) each AMOSIST-staffed clinic have a minimum of one regularly assigned physician present in the clinic during the entirety of its hours of operation, and (b) the roster assignment of physicians not be permitted as principal physician supervisor to AMOSISTs.*

*No recommendation is made for remedial action concerning the decrement observed between Phases I and II regarding the perceived competence of AMOSISTs. The perceived degradation-of-competence was cited by both AMOSIST Physicians and non-AMIC hospital staff. This is concomitant with the withdrawal of 91C from the program and appears to be an expression of anticipation rather than of actual observation. The other observer group, the patients, did not share their loss of faith but actually expressed a slight increase in patient satisfaction. It is also the opinion of the study personnel that implementation of a better controlled and operated program will increase confidence in the program.

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APPENDICES

APPENDIX A

AMIC CHECKLIST

AMIC CHECKLIST

INSTRUCTIONS FOR COMPLETION OF AMIC CHECKLIST

1. Attached is an AMIC Checklist, a checklist which is being utilized to obtain an appreciation for the manner in which Acute Minor Illness Clinics (AMICs) are being operated in CONUS. On the basis of past experience, it is anticipated that there will exist considerable diversity among AMICs insofar as their specific operational procedures are concerned.

2. The Checklist has been arranged in such a manner as to facilitate the collection of the data being requested. The items have been arranged in sections according to the source which is likely to be able to provide the information requested. At the beginning of each source-defined section there appears a list of the sources of information which are believed to be the ones which are most likely to be able to provide the information which is being requested. Within each of these sections the items are further subgrouped according to their content.

3. While it may be the case that the response to some of the items will have to be rendered on the basis of a professional opinion, it is desired that, to the extent possible, the responses be predicated upon objective data. As indicated below, the source providing the information upon which each response is based is to be identified for each item.

4. Checklist Entries.

a. The majority of the items on the Checklist require a selection from among numbered alternatives. For these items, circle the number corresponding to the alternative which correctly describes the situation in your AMIC. (NOTE: Some numbered items involve a series of questions wherein an affirmative response leads to a succeeding question (e.g., item 1.5.) For these items continue to make responses (i.e., circle the appropriate choice) until a negative response is given. At that time, discontinue that numbered item-series and proceed to the next numbered item.) A second principal category of response required is that of entering some number that reflects some quantifiable dimension pertaining to the AMIC's operation, e.g., the number of patients seen per month. The number to be entered is to be written in the space which is provided immediately following the question.

b. For each of the two categories of responses noted above, however, the person completing the checklist is to provide two additional items of information in the column labelled "Type/Source of Data" appearing near the right-hand side of the sheet. The two items of information required are:

(1) The nature of the data upon which the response is based (i.e., "E" for direct Examination--as in directly examining an SOP or log,

etc.; and "O" for professional Opinion--for use in instances wherein actual data cannot be located upon which to base a response); and

(2) An abbreviated designation of the location of the area or the office having the documents which were examined, or the position of the individual who provided the information (or opinion) which served as the basis for the response (i.e., ADJ for Adjutant; CPS for Chief, Professional Services, etc.). An example of the response required for an opinion rendered by the Chief, Professional Services would be O/CPS; an example of a response indicating that something was directly examined or observed in the Triage area would be E/TA. (The entire list of abbreviations to be employed appears at the bottom of each page of the Checklist.)

c. The information requested in the final major subsection of the Checklist involves requirements for copies of certain rosters, lists of changes, etc., which are to be met by obtaining duplicate copies of each of the items requested and attaching them to the Checklist.

d. The last column appearing on the right-hand side of the Checklist is not to be used by the individual who completes the Checklist. This is reserved for the use of research personnel to code the responses made.

AMIC CHECKLIST

		TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
	EXPECTED SOURCES OF INFORMATION FOR THIS SECTION ARE: ADJUTANT; C, PROFESSIONAL SERVICES; C, DEPT OF CLINICS.		_____ (1-3)
1.1	The scope and limits of clinical practice, including the designation of the supervising physician(s) (1) have/(2) have not been delineated in writing for each AMOSIST by the (1) MTF's credentials committee/(2) Other (specify:_____ _____) and (1) have/(2) have not been approved by the MTF Commander.	/	_____ (4-7) _____ (8-11) _____ (12-15)
1.2	There (1) is/(2) is not a physician who has been designated as the Chief, AMOSIST Program. If there is, indicate name, rank, and MOS:_____	/	_____ (16-19) _____ (20-23) _____ (24-27)
1.3	An AMIC drug list (1) has/(2) has not been formally reviewed and approved by the MTF's Therapeutic Agents Board and Commander.	/	_____ (28-31)
1.4	Sources of health care (i.e., the places to which patients are to be sent) (1) are/(2) are not specified in writing for each disposition level required by the Triage Manual. If they are specified, the list of places where patients are to be sent (1) is/(2) is not reviewed by an individual(s) who is separate from the AMIC. If the list is reviewed, circle those who participate in the review process: (1) C, Department of Clinics (2) C, Professional Services (3) MTF Commander (4) Other, specify:_____	/	_____ (32-35) _____ (36-39) _____ (40-43)
1.5	Written guidelines (1) do/(2) do not exist which delineate a specific review procedure for introducing changes to the Triage Manual. If the guidelines exist, they indicate that locally proposed changes (1) are/(2) are not reviewed and approved by an individual(s) who is separate from the AMIC. If they are reviewed, circle those who are designated to participate in the review process: (1) C, Department of Clinics (2) C, Professional Services (3) MTF Commander (4) Other, specify:_____	/	_____ (44-47) _____ (48-51) _____ (52-55)
1.6	Written instructions (1) do/(2) do not exist which delineate a specific review procedure for locally proposed changes to the AMOSIST Manual. If such instructions exist, circle those who are designated to participate in the review process: (1) C, Department of Clinics (2) C, Professional Services (3) MTF Commander (4) Other, specify:_____	/	_____ (56-59) _____ (60-63)

A. TYPE OF DATA: E = direct Examination O = professional Opinion

B. SOURCES OF DATA: (Position, Office, or Location):

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CPS = C, Professional Services	LOG = AMIC Logs	AM = AMOSIST	HA = Hospital Area
CDC = C, Dept of Clinics	CAP = C, AMOSIST Program	TA = Triage Area	Other = Other

		TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
1.7	A consolidated file or list of all formally reviewed and approved changes to the AMOSIST Manual (1) does/(2) does not exist.	/	(64-67)
1.8	Roster-assigned physicians (1) are/(2) are not utilized to meet some part of the physician staffing requirement of the AMIC. If they are, they (1) are/(2) are not rated by the same individual who rates the Chief, AMOSIST Program.	/	(68-71) (72-75)
1.9	AMOSISTs are assigned against the TDA of_____.	/	(76-79)
			1 (80)
	EXPECTED SOURCES OF INFORMATION FOR THE FOLLOWING SECTION ARE: AMIC SOPs; C, AMOSIST PROGRAM; AMIC NCOIC, AMOSISTs.		(1-3)
	TRIAGE FUNCTIONING		
2.1	The Triage Data Collection Sheet (1) is/(2) is not completed for every patient seen at the Triage station	/	(4-7)
2.2	The Triage Manual (1) is/(2) is not utilized at the Triage station.	/	(8-11)
2.3	The Triage function (1) is/(2) is not being performed by AMOSISTs and/or personnel trained by the AMOSIST MD (If performed by others, specify:_____	/	(12-15) (16-19)
2.4	An audit of the Triage function (1) is/(2) is not performed. If a Triage audit function is performed, answer a, b, and c below. Otherwise, proceed to item 3.1	/	(20-23)
	a. On the average, how frequently is the audit function performed?_____times per month	/	(24-28)
	b. On the average, how many Triage Data Collection Sheets (DCSs) are audited each month?_____. . . .	/	(29-34)
	c. Which of the following performs the majority of Triage audits? (1) Chief, AMOSIST Program (2) AMOSIST MD (3) roster-assigned physician (4) AMIC NCOIC (5) Other, specify:_____	/	(35-38)

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		TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
	VITAL SIGNS RECORDING PROCEDURES		
3.1	Vital signs (to include as a minimum the patient's temperature) (1) are/(2) are not determined and recorded for each patient evaluated in the AMIC.	/	(39-42)
	AMOSIST MANUAL AND DATA COLLECTION SHEETS		
4.1	Among the patients seen initially by AMOSISTs, approximately what percent are treated by going step-by-step through the algorithm(s) provided in the AMOSIST Manual?_____	/	(43-47)
4.2	AMOSISTs (1) do/(2) do not treat illnesses which are not contained in the local AMOSIST Manual.		(48-51)
	If they do, approximately how many additional diagnoses do they treat?_____	/	(52-56)
4.3	Data Collection Sheets (DCSs) (1) are/(2) are not used to record the AMOSISTs work.		(57-60)
	If they are used, for approximately what percent of the patients treated by AMOSISTs are DCSs initiated?_____	/	(61-65)
4.4	DCS audits (1) are/(2) are not performed. If they are, answer a thru g below. Otherwise, proceed to item 5.1 . . .	/	(66-69)
	a. On the average, how frequently are they performed? Once every _____working days.	/	(70-74)
	b. Who performs the majority of the audits? (1) C, AMOSIST Program (2) Other AMOSIST MD (3) roster-assigned physician (4) AMIC NCOIC (5) Other, specify: _____	/	(75-78)
		2	(80)
			(1-3)
	c. Who selects the DCSs to be audited? (1) Auditor (2) AMOSIST (3) Other, specify:_____	/	(4-7)
	d. The average number of DCSs audited per AMOSIST each month is_____	/	(8-13)
	e. DCS audits are for (1) DCS completeness only (2) logic accuracy only (3) both completeness and accuracy. . . .	/	(14-17)
	f. The results of these DCS audits (1) are/(2) are not maintained in a continuing record or log	/	(18-21)
	g. The AMOSISTs (1) have/(2) have not ready access to the results of any and all audits performed on their own work	/	(22-25)

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		TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN	
	AMOSIST PHYSICAL DIAGNOSTIC SKILL AUDITS			
5.1	Skill audits (1) are/(2) are not performed. If they are, answer a thru d below. Otherwise, proceed to item 6.1. . .	/		(26-29)
	a. Skill audits are performed (on the average) once every _____ working days.	/		(30-34)
	b. Skill audits are performed by the (1) Chief, AMOSIST Branch, (2) an AMOSIST MD who works in the AMIC on a full time basis, (3) Other, specify: _____	/		(35-38)
	c. The results of the skill audits (1) are/(2) are not maintained in a continuing record	/		(39-42)
	d. AMOSISTs (1) are/(2) are not provided ready access to the results of any and all skill audits which have been performed.	/		(43-46)
	PHYSICIAN STAFFING			
6.1	The Chief, AMOSIST Program spends _____ hours per week in the AMIC providing patient care and/or consultation to/ supervision of AMOSISTs	/		(47-51)
6.2	A physician (1) is/(2) is not present in the AMIC at all times during its hours of operation	/		(52-55)
6.3	On the average, what is the maximum ratio of AMOSISTs to physicians who serve in direct support of AMOSISTs at any one time in the AMIC during a typical week? _____ . . .	/		(56-60)
6.4	There (1) is/(2) is not a physician in the AMIC during all operating hours whose principal duty is to provide requested consultation to the AMOSISTs.	/		(61-64)
6.5	What is the total number of physician man-hours (roster-assigned and regularly assigned, full or part-time physicians) spent in the AMIC each week by physicians who are actively engaged in providing patient care, providing consultation to AMOSISTs, or providing supervision or training of AMOSISTs? _____	/		(65-70)

Answer the remaining questions of this section only if the response to the previous question indicated that some portion of the physician staffing of the AMIC is provided by physicians who are assigned from a roster to work in the AMIC for brief periods at a time. Otherwise, proceed to item 7.1.

6.7	On the average, each individual roster-assigned physician works in the clinic approximately _____ man-days per month	/		(71-75)

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		TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
6.8	Each roster-assigned physician spends approximately _____ hours per day in the AMIC each day he is assigned to work there.	/___	_____(76-79)
			3 (80)
			_____(1-3)
6.9	What is the number of consecutive work days at a time that each roster-assigned physician works each time he is scheduled to work in the AMIC?_____.	/___	_____(4-8)
6.10	What is the total number of man-hours per week provided to the AMIC by roster-assigned physicians?_____	/___	_____(9-14)
6.11	What are the principal duties of the roster-assigned physicians? (1) Almost exclusively direct patient care, (2) Mostly direct patient care (some consultation to AMOSISTs), (3) Equally divided between patient care and consultation to AMOSISTs, (4) Mostly consultation to AMOSISTs (some direct patient care), (5) Almost exclusively consultation to AMOSISTs	/___	_____(15-18)

SUPERVISION OF AMOSISTs

(NOTE: The term "feedback/supervisory session" which is used below denotes a supervisory counseling session or similar type meeting between an AMOSIST and a qualified supervisor for the purpose of maintaining, developing, and/or enhancing the AMOSIST's skills.)

7.1	Feedback/supervisory sessions (1) are/(2) are not provided for each AMOSIST. If they are, answer a thru e below. Otherwise, proceed to item 7.2.	/___	_____(19-22)
	a. A feedback/supervisory session is provided for each AMOSIST (on the average) once every_____work days. .	/___	_____(23-27)
	b. There are _____hours of individual feedback/supervisory sessions provided, on the average, each AMOSIST each month.	/___	_____(28-32)
	c. The majority of the feedback/supervisory sessions are provided by (1) the Chief, AMOSIST Program, (2) an AMOSIST MD, (3) roster-assigned MD, (4) AMIC NCOIC, (5) Other, specify:_____	/___	_____(33-36)
	d. Feedback/supervisory sessions (1) are/(2) are not based, at least in part, upon Data Collection Sheets (DCSs) or skill audits performed within the past two weeks	/___	_____(37-40)
	e. Approximately what percent of the feedback/supervisory sessions are provided by the Chief, AMOSIST Program? _____.	/___	_____(41-45)

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		TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
7.2	EERs (1) are/(2) are not rendered on each AMOSIST annually.	/	(46-49)
7.3	The AMOSIST's rater is (1) Chief, AMOSIST Program, (2) AMOSIST MD, (3) AMIC NCOIC, (4) Other, specify:_____	/	(50-53)
	PROCEDURAL DOCUMENTATION (Examine AMIC SOPs and AMIC Logs)		
8.1	A standardized written procedure for entering changes to the AMOSIST Manual (1) does/(2) does not exist.	/	(54-57)
8.2	A written description of the procedures to be employed in the supervision of AMOSISTs by AMOSIST MDs (1) does/(2) does not exist	/	(58-61)
8.3	A written description of the procedures employed in performing Triage Audits (1) does/(2) does not exist	/	(62-65)
8.4	How many enlisted personnel are there working in the AMIC as AMOSISTS?_____ Of these, how many have been fully certified by the AMOSIST Branch, Academy of Health Sciences? _____.	/	(66-70) (71-75)
8.5	A written description of the procedures employed in performing the continuing audit of treatment DCSs (1) does/(2) does not exist	/	(76-79)
			4 (80) (1-3)
8.6	A record of the training status (i.e., that required for AHS certification) of all AMOSISTs in the clinic (1) does/(2) does not exist.	/	(4-7)
8.7	A written description of the procedures to be followed in handling medical emergencies which may occur in the AMIC (1) does/(2) does not exist	/	(8-11)
8.8	A written description of the procedures employed in performing skill audits of AMOSISTs (1) does/(2) does not exist. .	/	(12-15)
8.9	Workload related data (1) is/(2) is not recorded and maintained in the clinic.	/	(16-19)
8.10	A patient log (1) is/(2) is not maintained within the clinic	/	(20-23)
	GENERAL		
9.1	AMIC Staff meetings are held once every _____ days . .	/	(24-28)

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		TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN	
9.2	The Chief, AMOSIST Program (1) has/(2) has not been formally oriented to the AMOSIST Concept at AHS by personnel of the AMOSIST Branch.	/		(29-32)
9.3	Each physician who serves as an AMOSIST MD on a roster-assigned basis (1) does/(2) does not receive a formal briefing on the AMOSIST Concept from the Chief, AMOSIST Program, prior to beginning such work.	/		(33-36)

AMOSIST WORKLOAD

10.1	The average number of patients seen per AMOSIST per day is _____	/		(37-41)
10.2	The average number of patients per hour seen by the average AMOSIST during the period of peak workload is estimated to be _____.	/		(42-45)
10.3	All AMOSIST patients (1) have/(2) have not been initially through the Triage process	/		(46-49)

DIRECTLY OBSERVE AND/OR EXAMINE THE CONTENTS AND/OR OPERATIONS OF THE AREAS INDICATED BELOW TO PROVIDE THE INFORMATION REQUESTED IN THIS SECTION.

TRIAGE/SCREENING AREA

11.1	Triage forms (1) are/(2) are not present in the Triage area.	/		(50-53)
11.2	The patient's outpatient record (1) is/(2) is not available at the time of Triage.	/		(54-57)
11.3	The Triage area (1) is/(2) is not at least semi-enclosed (i.e., enclosed on at least 3 sides)	/		(58-61)
11.4	The Triage areas (1) do/(2) do not permit patients to be individually screened.	/		(62-65)
11.5	Triage facilities (1) do/(2) do not prevent the overhearing of Triage conversations by individuals who are awaiting Triage or treatment.	/		(66-69)
11.6	The area where vital signs are recorded (1) is/(2) is not equipped with all of the following materials: (1) stethoscope, (2) temperature measuring device, (3) sphygmomanometer. (Circle missing items.).	/		(70-73)

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	AMIC AREA: GENERAL	TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
12.1	The ER's telephone number (1) is/(2) is not prominently displayed in the clinic.	/____	_____(74-77)
			_____(80)
			_____(1-3)
12.2	A litter (1) is/(2) is not readily available	/____	_____(4-7)
12.3	An emergency cart (1) is/(2) is not readily available. . . .	/____	_____(8-11)
12.4	The following medical references (1) are/(2) are not present in the AMIC area: (1) Medical dictionary, (2) reference book on Physical Diagnosis, (3) Physicians Desk Reference (PDR). (Circle missing items.).	/____	_____(12-15)
12.5	All AMOSISTs (1) do/(2) do not wear a hospital jacket which clearly identifies their status as AMOSISTs.	/____	_____(16-19)
12.6	The patient education sheets included as Appendix L in the revised AMOSIST Manual (1) are/(2) are not available as handouts to the patients	/____	_____(20-23)
12.7	Patient education materials of a general nature (1) are/ (2) are not readily available in the patient waiting areas .	/____	_____(24-27)
12.8	Information pertaining to how and where a patient may register a complaint (1) is/(2) is not prominently displayed in the hospital.	/____	_____(28-31)
	OFFICE/EXAMINATION ROOM		
13.1	The physician's office/examination rooms (1) are/(2) are not located in the same area as the AMOSIST's office/examination rooms.	/____	_____(32-35)
13.2	The number of fully enclosed office/examination rooms is (1) less than/(2) equal to or more than the maximum number of AMOSISTs and physicians on duty in the AMIC at any one time	/____	_____(36-39)
13.3	All office/examination rooms (1) are/(2) are not fully enclosed with solid walls and doors.	/____	_____(40-43)
13.4	Conversations in the office/examination rooms (1) are/ (2) are not intelligible to individuals in adjacent areas. .	/____	_____(44-47)

A. TYPE OF DATA: E = direct Examination O = professional Opinion

B. SOURCES OF DATA: (Position, Office, or Location):

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	TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN	
13.5 Each office/examination room (1) does/(2) does not have all of the following items: (1) examination table with disposable paper sheets, (2) two chairs, (3) desk, (4) waste receptacle, (5) shelves or other container for blank forms. (Circle missing items.)	/		(48-51)
13.6 Office/examination rooms (1) do/(2) do not have all of the following medical equipment: (1) Otoscope set, (2) sphygmomanometer, (3) stethoscope, (4) reflex hammer, (5) temperature measuring device, (6) tongue depressors. (Circle missing items.)	/		(52-55)

AMOSIST MANUALS AND DCSs

14.1 How many AMOSIST Manuals are presently in use in the AMIC? _____	/		(56-60)
14.2 There (1) is/(2) is not a copy of the AMOSIST Manual provided to each AMOSIST.	/		(61-64)
If there is not, a copy of the AMOSIST Manual (1) is/(2) is not present in each of the examination rooms utilized by AMOSISTs	/		(65-68)
14.3 What percent of the AMOSIST Manuals presently in use are the revised (July 1975) version?_____	/		(69-73)

NOTE: In order to complete the following items it will be necessary to have a consolidated listing or file of all changes to the AMOSIST Manual which are presently in effect. If such information is not available, check here _____ and proceed to subsection 15, below.

14.4 The AMIC itself (1) does/(2) does not have in its files a "master list" of all changes which are in effect to the manuals which are presently in use (i.e., an actual consolidated list of changes, a file folder reflecting all changes, or a reference "master copy" of the manual which reflects all changes).	/		(74-77)
		6	(80)
			(1-3)
a. If an AMIC "master list" does exist, what is the total number of changes presently indicated to be in effect in the AMOSIST Manuals (exclusive of changes to the drug list)._____	/		(4-8)

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	TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
b. If the AMIC "master list" exists, it (1) is/(2) is not consistent with those changes which have been reviewed and approved elsewhere (see item 1.7) in the MTF. If it is not consistent, how many items does it contain* that are not on the extra-AMIC list?_____ How many items is it missing?_____ (Again, exclude from consideration changes to the drug list).	/____	_____(9-12) _____(13-17) _____(18-22)
14.5 If both an extra-AMIC approved list of changes (see items 1.6, 1.7) as well as a local AMIC master list of changes exist, use the extra-AMIC approved list as a criterion in performing the following review of AMOSIST Manuals. If only the local AMIC's "master list" is available and is used as the criterion, check here _____. It is required that (1) at least one-third (but not less than 3) of the AMOSIST Manuals presently in use in the AMIC be reviewed and (2) that these manuals be randomly selected from those currently in use. (To example these requirements; if there are 12 AMOSIST Manuals in use, assign the numbers 1-12 to the manuals, write the numbers 1-12 on 12 small squares of paper, place the pieces of paper in a small container and blindly draw 4 pieces of paper, i.e., 1/3 of 12. The four manuals whose numbers correspond to those which were drawn would be the four to be reviewed.) Indicate here the number of manuals reviewed _____.	/____	_____(23-27)
a. Exclusive of drug list related errors, what is the total number of inaccuracies or inconsistencies noted in the way in which the indicated changes have been entered in the AMOSIST Manuals reviewed? ("Inaccuracies" or "inconsistencies" are defined as referenced, required changes which were (a) entered in the wrong location, (b) entered using terminology which is not equivalent to that cited in the reference, and/or (c) omitted. The appearance of extraneous changes to a manual (i.e., any changes which do not appear on the criterion list) is also to be counted as an "inaccuracy.") Total (for all manuals reviewed) _____.	/____	_____(28-32)
b. Changes to the AMOSIST Manual (1) are/(2) are not entered in a "permanent" manner (i.e., via "pen and ink" entries or the use of page-for-page substitutions of revised and printed material).	/____	_____(33-36)

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	TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN	
14.6 Estimate the number of DCSs (revised version, Fall 1975) on hand for each of the algorithms: (1" = 250 sheets) Eye_____ Respiratory_____ Gastrointestinal_____ Genitourinary_____ Musculo-Skeletal Spine_____ Musculo-Skeletal Extremity_____ Skin-Regional_____ Skin-General_____	/____	_____	(37-40)
PHARMACY			
15.1 The pharmacy (1) does/(2) does not have a copy of the current TAB/CDR approved AMOSIST drug list.	/____	_____	(41-44)
15.2 The pharmacy (1) does/(2) does not have signature cards for all AMOSISTs presently serving in the AMIC.	/____	_____	(45-48)
15.3 The pharmacy (1) does/(2) does not prominently display the TAB/CDR approved drug list.	/____	_____	(49-52)
15.4 Prescription slips (1) are/(2) are not overstamped with the statement: "To be filled only at (name of MTF) Pharmacy" or its equivalent.	/____	_____	(53-56)
15.5 Labels appearing on AMOSIST-prescribed medication (1) do/ (2) do not identify both the AMOSIST and the responsible physician	/____	_____	(57-60)
15.6 There have been _____ instances during the past six months wherein the pharmacy has encountered AMOSIST-originated prescriptions for drugs not appearing on the TAB/CDR approved drug list.	_____	_____	(61-65)
ADDITIONAL REQUIREMENTS			
16.1 Obtain copies of all locally approved changes to the Triage and AMOSIST Manuals (If some changes to these manuals exist which have not been reviewed and approved by an extra-AMIC authority, include them also, but clearly label each such change as being "non-reviewed"). Place a check mark in the space to the right when this requirement has been met . . .	_____		
16.2 Obtain a copy of the locally approved Drug List which is currently in effect. Place a check mark in the space to the right when this requirement has been met.	_____		
16.3 Obtain two copies of each of the eight Data Collection Sheets (DCSs) which are presently in use in the AMIC. (If additional, locally developed DCSs, are employed, obtain 2 copies of each of these also). Place a check mark in the space to the right when this requirement has been met . . .	_____		

A. TYPE OF DATA: E = direct Examination O = professional Opinion

B. SOURCES OF DATA: (Position, Office, or Location):

ADJ = Adjutant	SOP = AMIC SOPs	ANCO = AMIC NCOIC	AA = AMIC Area
CPS = C, Professional Services	LOG = AMIC Logs	AM = AMOSIST	HA = Hospital Area
CDC = C, Dept of Clinics	CAP = C, AMOSIST Program	TA = Triage Area	Other = Other

	TYPE/ SOURCE OF DATA	DO NOT USE THIS COLUMN
16.4 From the C, AMOSIST Program (or the AMIC NCOIC), obtain a list of those presently serving in the AMIC by name and SSN. Place a check mark in the space to the right when this requirement has been met.	_____	
16.5 If the physicians utilized to staff the AMIC are supplied in whole or in part from a roster of physicians who periodically are assigned to the AMIC for some (brief) period of duty on a rotating basis, obtain from the MTF Adjutant, or Chief, Professional Services, a copy of the roster for as far in advance as it is presently scheduled. Place a check mark in the space to the right when this requirement has been met	_____	
16.6 From the C, AMOSIST Program (or the AMIC NCOIC) obtain a copy of the AMICs' duty roster. Place a check mark in the space to the right when this requirement has been met. . . .	_____	
16.7 What is the average number of patients treated per month in each of the following patient categories? (If data is not available, write N/A; if data is available and/or estimates are made, cite the source of information used. Utilize the past 12 months data as the reference. If the AMIC hasn't been in operation for 12 months, indicate here the number of full months it has been in operation and use those months as the reference for supplying the information requested: _____ months.).	/____	
a. Average total per month _____		_____(66-71)
b. Average number of Active Duty _____		_____(72-77)
		7 (80)
		_____(1-3)
c. Average number Active Duty Dependents _____		_____(4-9)
d. Average number retired _____		_____(10-15)
e. Average number of Dependents of Retired and Deceased _____		_____(16-21)
f. Other _____		_____(22-27)
16.8 Determine the hours of operation of the AMIC, and determine whatever hours, if any, are specified to provide care to particular categories of patients (i.e., AD, Dependent of AD, Retired, Dependent or Retired or Deceased, Other). Enter the information on the following page. (If there is a printed handout which provides a description of the AMICs' hours of operation, include one copy as part of the response to this question. If there is no such handout, check here _____).	/____	8 (80)

A. TYPE OF DATA: E = direct Examination O = professional Opinion

B. SOURCES OF DATA: (Position, Office, or Location):

ADJ = Adjutant	SOP = AMIC SOPs	ANCO = AMIC NCOIC	AA = AMIC Area	
CPS = C, Professional Services	LOG = AMIC Logs	AM = AMOSIST	HA = Hospital Area	
CDC = C, Dept of Clinics	CAP = C, AMOSIST Program	TA = Triage Area	Other = Other	

16.9 By entering the number of each type of individual working in the AMIC during each of its hours of operation, indicate below the typical staffing pattern for the AMIC for an average week. If there is an individual who simultaneously assists in two clinics, e.g., AMIC and Emergency Room, estimate the proportion of time that individual spends in the AMIC each hour (e.g., 0.3, 0.5, etc.) and include that on the appropriate hourly total. (AM-MD = regularly assigned physician serving as C, AMOSIST Program or as an AMOSIST MD; nAM-MD = nonAMOSIST MD, i.e., a "roster assigned physician;" AM = AMOSIST):

HOUR	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
*07__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
08__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
09__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
10__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
11__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
12__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
13__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
14__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
15__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
16__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____
17__	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____	AM-MD ____ nAM-MD ____ AM ____

* Person completing the form is to enter 0700 or 0730 depending upon the nature of the AMIC staffing procedures employed; use whichever most effectively depicts the AMICs' staffing.

DESCRIPTION OF AMIC HOURS OF OPERATION

HOUR	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
0700					
0800					
0900					
1000					
1100					
1200					
1300					
1400					
1500					
1600					
1700					
1800					

APPENDIX B

PATIENT SATISFACTION QUESTIONNAIRE I

_____(1-10)

PATIENT SATISFACTION QUESTIONNAIRE I

In our efforts to provide the best medical care possible we are asking you to take a few moments to answer the following questions. The questionnaire is anonymous: you are not to identify yourself. We ask, therefore, that you state your honest opinions on all questions regardless of how positive or negative they may be. The information provided will be held in the strictest confidence.

1. What is your age (in years)? _____(11,12) 2. What is your sex? (1=male, 2=female). . . . _____(13)
3. What is your pay grade (e.g., E1, E2,...O1, O2,...W1, W2, etc.) or if a dependent, the pay grade of your military sponsor?. . . . . _____(14,15)
4. What is your present eligibility status? 1. Active Duty 2. Dependent of Active Duty 3. Retired 4. Dependent of Retired or Deceased 5. Other. . . . . _____(16)

Please read each item below, then indicate in the space provided to the right of each item "how satisfied" or "how dissatisfied" you are with it. Use the 9-point scale below to indicate your feeling. (5 = undecided or neutral)

EXTREMELY DISSATISFIED	1	2	3	4	neutral 5 ?	6	7	8	9	EXTREMELY SATISFIED

NOTE: There are no "right" or "wrong" answers. Please do not struggle or "work" to make your answers exact. Your "general" impression is satisfactory.

HOW SATISFIED OR DISSATISFIED ARE YOU WITH.....

5. Military life in general?. . . . . _____(25)
6. The overall treatment and care you have previously received in most other military medical treatment facilities (If you've had none, leave blank) . . . . . _____(26)

♦ ♦ STOP ♦ ♦ PLEASE READ THE BOX BELOW ♦ ♦ STOP ♦ ♦

AFTER you have received your care in this clinic, complete the following items using the same 9-point scale provided above. (NOTE: Please be discriminating in your responses; although it may be easier to use the same number for all items, it won't help us find out how we are doing on each item. Thank you for your assistance.

HOW SATISFIED OR DISSATISFIED ARE YOU WITH.....

7. The amount of time you had to wait to obtain medical care here today?. . . . . _____(27)
8. The parking facilities provided? (Consider both the number of spaces provided and the distance from the clinic: If you're not familiar with the parking facilities, leave blank) . . . . . _____(28)
9. The general appearance of this clinic? . . . . . _____(29)
10. The thoroughness (completeness) of the medical examination you received? . . . . . _____(30)
11. The amount of information given to you concerning your illness by person(s) who examined and treated you? . . . . . _____(31)
12. The degree of privacy you had when you discussed your problem with the person(s) who treated you? . . . . . _____(32)
13. The amount of interest shown concerning you as an individual by the person(s) who examined and treated you? . . . . . _____(33)
14. The amount of time spent with you during your actual evaluation and treatment? . . . . . _____(34)
15. The manner in which you were treated by the receptionist?. . . . . _____(35)
16. The degree of courtesy and friendliness shown to you by the person(s) who treated you? . . . _____(36)
17. The convenience of the location of this clinic?. . . . . _____(37)
18. The way in which laboratory and/or X-ray services are provided? (If not used, leave blank) . _____(38)
19. The overall total treatment and care you have received at this clinic? . . . . . _____(39)

Please complete the following statements:

20. I feel the people working in this clinic: 1. Could have done a better job in all areas. 2. Were adequate in some areas but could have done better in other areas. 3. Did an adequate job. 4. Did most of their work efficiently. 5. Were outstanding in all areas . . . . . _____(40)
21. I feel the medical treatment I received today was: 1. Unacceptable 2. Less than adequate 3. Adequate 4. More than adequate 5. Outstanding . . . . . _____(41)
22. I feel the examiner's understanding of my medical problem was: 1. Very poor 2. Poor 3. Average 4. Good 5. Very good. . . . . _____(42)
24. How would you rate the treatment you received in this clinic today compared to the treatment you have received previously in this clinic? (If you have had no previous care here, leave blank.) 1. Very much better today than before 2. Much better today 3. A little better today 4. About the same as before 5. A little worse today 6. Much worse today 7. Very much worse today than before. . . . . _____(46)
25. How did you feel about filling out this questionnaire? Answer using a number from 1 (Strongly disliked or resented doing it) to 9 (No dislike, didn't mind doing it at all). . . . . _____(47)

_____1_____(80)

APPENDIX C

STAFF SATISFACTION QUESTIONNAIRE

_____(1-3)

STAFF SATISFACTION QUESTIONNAIRE

This portion of our research requires that you complete the following questionnaire. It deals with several aspects of your own work and work involvement. We request that you be entirely honest and candid in your responses and we emphasize the confidentiality involved. The questionnaire is an anonymous one. Your responses will be transferred to computer cards as soon as the research team returns to its base of operations. Immediately thereafter your questionnaire will be destroyed. There will be no way in which the results of this research can be associated with any individual respondent.

PART I

1. Age (in years). . . . . _____(6,7)
2. Pay grade (ie., E2, E3, E4 .. or 03, 04, ... etc.). . . . . _____(8,9)
3. Sex (1=male; 2=female) . . . . . _____(10)

4. Years of active military service. (Use two digits, i.e., if 9 or less, precede by a zero. For example: 4 years service would be written as 04. If less then 1, count as 01.). . . . . _____(11,12)

5. How many months have you been working in the present facility? (Use two digits, i.e., precede numbers of 9 or less with a zero. If you are a military physician who works in this facility only on a rotating, roster basis, leave blank.) . . . . . _____(13,14)

6. Indicate one of the following: 1. I am regularly assigned to this clinic. 2. I work here only occasionally on a rotating, roster basis. . . . . _____(15)

7. What is your race or ethnic group? 1. Black. 2. White. 3. Mexican-American. 4. Chinese-American. 5. Japanese-American 6. American Indian. 7. Filipino-American 8. Other . . . . . _____(16)

8. Please indicate to which of the following general medical occupations you belong. 1. 91B, AMOSIST 2. 91C, AMOSIST 3. 91B, nonAMOSIST 4. 91C, nonAMOSIST 5. AMOSIST Physician(MC) 6. nonAMOSIST Physician(MC) 7. Other. . . . . _____(17)

PART II

During this portion of the questionnaire you are to examine the following statements which concern your work and the working conditions in this particular outpatient clinic. Examine each statement and then decide whether or not you are satisfied or dissatisfied with the consideration it describes. Then, using the numbered scale shown below, indicate "how satisfied" or "how dissatisfied" you are by writing the appropriate number in the column provided to the right. Make a response to each item, omit none of them. Express your honest opinion or feeling.

EXTREMELY DISSATISFIED	1	2	3	4	neutral 5 ?	6	7	8	9	EXTREMELY SATISFIED

NOTE: There are no "right" or "wrong" answers. Please do not struggle or "work" to make your answers exact. Your "general" impression is satisfactory.

HOW SATISFIED ARE YOU WITH. . . .

1. Your job (in general)? . . . . . _____(25)

2. The military installation to which you are assigned? . . . . . _____(26)

3. Your immediate supervisor (in general)?. . . . . _____(27)

4. The feeling of accomplishment you generally obtain from doing your job in this clinic: the feeling of pride and pleasure you get from your work?. . . . . _____(28)

5. The opportunity to remain busy at your job?. . . . . _____(29)

6. Your opportunity and authority to control or influence the activities of others? (Such power may result from responsibilities which are a part of your position, title, or rank and/or as a result of your own technical or professional knowledge of expertise.). . . . . _____(30)

EXTREMELY DISSATISFIED	1	2	3	4	neutral 5 ?	6	7	8	9	EXTREMELY SATISFIED

HOW SATISFIED ARE YOU WITH. . . .

7. Your co-workers in this clinic; their friendliness, cooperativeness, and competence? . . . . . _____(31)

8. Your opportunities to be creative, to show initiative and ingenuity in the performance of your work; to suggest and develop new ideas and solutions to problems which occur?. . . . . _____(32)

9. The extent to which you feel you contribute positively and constructively to your organization's work effort, to feel that your work is valuable and would be missed if not performed as you do it?. . . . . _____(33)

10. The chance you have to organize your own work activities, to work with minimal supervision, to plan and do your own work, to be autonomous?. . . . . _____(34)

11. The degree to which you perform work which interests you and gives you pleasure? _____(35)

12. The degree to which your work permits you to determine the impact it has, to appreciate the results achieved, or to assess whatever contribution is made?.. . . _____(36)

13. The opportunity for developing new or additional skills, for "Growth" in your profession, for self-fulfillment?... . . . . _____(37)

14. The number and types of rules and regulations which exist to govern your behavior on the job in this clinic? . . . . . _____(38)

15. The operation of your organization's promotion system, your feelings that promotions are rewards for good work; that adequate and proper regulations and guidelines are utilized to determine who should be promoted? . . . . . _____(39)

16. The amount or efficiency present in your job in this clinic; the extent the various tasks to be done seem to work together smoothly, to mesh well?. . . . . _____(40)

17. The freedom you have to choose your co-workers and to control the time, place, and frequency of on-the-job social interactions you have in this clinic?. . . . . _____(41)

18. The amount of pay you receive?. . . . . _____(42)

19. The number of organizational benefits you have, their types, and the amount of each (such as retirement, medical care, etc.)? . . . . . _____(43)

20. The physical characteristics of your immediate work area in the clinic (such as lighting, noise level, attractiveness, cleanliness, amount of space, temperature, etc.)?. . . . . _____(44)

21. The opportunity to obtain clear recognition or appreciation for your work?. . . . . _____(45)

22. The degree of face-to-face interaction with other staff members required of you to perform your work satisfactorily? . . . . . _____(46)

23. The degree of responsibility given to you for your actions, decisions, and their consequences in the clinic? . . . . . _____(47)

24. The degree of job security present in your work, feeling that your basic security needs will be met regardless of changes in the general economy? . . . . . _____(48)

25. The opportunities to participate in Army-sponsored continuing education programs (consider both local and TDY-related educational and training programs)? _____(49)

26. The interpersonal manner in which your immediate supervisor(s) works with you?. _____(50)

27. The degree of work-related knowledge and skill shown by your immediate supervisor(s) in his job; his competency? . . . . . _____(51)

EXTREMELY DISSATISFIED	1	2	3	4	neutral 5 ?	6	7	8	9	EXTREMELY SATISFIED

28. The degree of interest shown by your supervisor in evaluating you (consider both formal and informal evaluations, i.e., EER's and OER's, as well as other feedback, comments, criticisms, etc. offered by your supervisor during your day-to-day work?) . . . . . _____(52)

29. The amount of time spent by your supervisor in teaching or training you, or reviewing your work with you?. . . . . _____(53)

30. The fairness shown by your supervisor in evaluating you (consider the accuracy, timeliness, lack of ambiguity involved)? . . . . . _____(54)

31. The extent to which you must spend time and effort in keeping up with new techniques, information, etc., in order to do your job satisfactorily? . . . . . _____(55)

32. The adequacy of office/working space provided and professional equipment provided to do your job? . . . . . _____(56)

33. The extent to which your work makes use of your abilities, training, and experience?. . . . . _____(57)

34. Opportunity to obtain additional skills which will be of future value to you?. _____(58)

35. The adequacy of the clerical support and supplies available to you?. . . . . _____(59)

36. The opportunity to have variety in the content of your work, i.e., work with different people, problems, or tasks?. . . . . _____(60)

37. Your work schedule, the hours or times at which you work each week?. . . . . _____(61)

38. The extent you can feel the work you do is of benefit to others; contributes to satisfaction, health, ease-of-life of others?. . . . . _____(62)

39. The degree to which your work contributes to your military community? . . . . . _____(63)

40. The amount of free time you have?. . . . . _____(64)

41. This particular outpatient facility (in general)?. . . . . _____(65)

42. The availability of personnel to support you in your work? . . . . . _____(66)

43. The quality of the medical equipment and facilities available to support you in your work?. . . . . _____(67)

44. The availability of medical equipment and facilities to support you in your work?. . . . . _____(68)

45. Using a number from 1 through 9 indicate how your present work or job compares to the best possible job, military or civilian, that you could presently obtain in view of your present level of education and training. (The number 1 would indicate that your present job ranks among the <u>best</u> possible that you could obtain; the number 9 would indicate that your present job ranks among the <u>worst</u> possible that you could obtain.). . . . . _____(69)

46. Complete the following statement: Considering what I have to know to do my work, my previous schooling and training was 1. Much more than I need (very overtrained). 2. Somewhat more than I need (somewhat overtrained). 3. About right. 4. Somewhat less than I need (somewhat undertrained), 5. Much less than I need (very undertrained). . . . . _____(70)

_1_(80)

_____(1-3)

PART III

Below are five groups of items. Each group represents some aspect of your present job. We would like you to indicate your feelings about these aspects by circling "Y" (Yes) if the item is descriptive of your present job. "N" (No) if it is not descriptive, and "?" if you can't decide.

WORK

Fascinating	Y	N	?	(06)
Routine	Y	N	?	(07)
Satisfying	Y	N	?	(08)
Boring	Y	N	?	(09)
Good	Y	N	?	(10)
Creative	Y	N	?	(11)
Respected	Y	N	?	(12)
Hot	Y	N	?	(13)
Pleasant	Y	N	?	(14)
Useful	Y	N	?	(15)
Tiresome	Y	N	?	(16)
Healthful	Y	N	?	(17)
Challenging	Y	N	?	(18)
On your feet	Y	N	?	(19)
Frustrating	Y	N	?	(20)
Simple	Y	N	?	(21)
Endless	Y	N	?	(22)
Gives Sense of Accomplishment	Y	N	?	(23)

CO-WORKERS

Stimulating	Y	N	?	(24)
Boring	Y	N	?	(25)
Slow	Y	N	?	(26)
Ambitious	Y	N	?	(27)
Stupid	Y	N	?	(28)
Responsible	Y	N	?	(29)
Fast	Y	N	?	(30)
Intelligent	Y	N	?	(31)
Easy to make enemies	Y	N	?	(32)
Talk too much	Y	N	?	(33)
Smart	Y	N	?	(34)
Lazy	Y	N	?	(35)
Unpleasant	Y	N	?	(36)
No Privacy	Y	N	?	(37)
Active	Y	N	?	(38)
Narrow interests	Y	N	?	(39)
Loyal	Y	N	?	(40)
Hard to meet	Y	N	?	(41)

IMMEDIATE SUPERVISOR

Asks my advice	Y	N	?	(42)
Hard to please	Y	N	?	(43)
Impolite	Y	N	?	(44)
Praises good work	Y	N	?	(45)
Tactful	Y	N	?	(46)
Influential	Y	N	?	(47)
Up-to-date	Y	N	?	(48)
Doesn't supervise enough	Y	N	?	(49)
Quick-tempered	Y	N	?	(50)
Tells me where I stand	Y	N	?	(51)
Annoying	Y	N	?	(52)
Stubborn	Y	N	?	(53)
Knows job well	Y	N	?	(54)
Bad	Y	N	?	(55)
Intelligent	Y	N	?	(56)
Leaves me on my own	Y	N	?	(57)
Around when needed	Y	N	?	(58)
Lazy	Y	N	?	(59)

PAY

Income adequate for normal expenses	Y	N	?	(60)
Barely live on income	Y	N	?	(61)
Bad	Y	N	?	(62)
Income provides luxuries	Y	N	?	(63)
Insecure	Y	N	?	(64)
Less than I deserve	Y	N	?	(65)
Highly paid	Y	N	?	(66)
Underpaid	Y	N	?	(67)

PROMOTIONS

Good opportunity for advancement	Y	N	?	(69)
Opportunity somewhat limited	Y	N	?	(70)
Promotion on ability	Y	N	?	(71)
Dead-end-job	Y	N	?	(72)
Good chance for promotion	Y	N	?	(73)
Unfair promotion policy	Y	N	?	(74)
Infrequent promotions	Y	N	?	(75)
Regular promotions	Y	N	?	(76)
Fairly good chance for promotion	Y	N	?	(77)

Indicate in the space to the right, the number of the face below which expresses <u>how, in general, you feel about your job in this clinic,</u> (including the work, pay, the supervision, the opportunities for promotion and the people you work with). . . . . _____(78)

2 (80)

_____(1-3)

PART IV

1. If your employer could somehow offer to you a guarantee that some aspects of your job (those listed below) would become and remain highly acceptable to you, in what order (sequence) would you choose to have them guaranteed? Indicate your sequence by writing the numbers 1 (first to be guaranteed) to 9 (last to be guaranteed) in the spaces provided. (Answer as if your employer indicated that he might not be able to guarantee all of them, but that if that were to be the circumstance, he would guarantee those that he could in the sequence you had indicated, i.e., if he could only guarantee your satisfaction on 5 of the 9 items he would guarantee those you listed as 1 through 5 and ignore those you had indicated as 6, 7, 8, and 9.)

a. Good pay. . . . . _____(06)
b. Interesting, satisfying work . . . . . _____(07)
c. Good opportunity for promotion . . . . . _____(08)
d. Competent, fair, understanding supervisor . . . . . _____(09)
e. Good equipment and work environment . . . . . _____(10)
f. Good co-workers . . . . . _____(11)
g. Good opportunity for recognition . . . . . _____(12)
h. Good geographical location. . . . . _____(13)
i. Considerable independence of work effort. . . . . _____(14)

2. In you own eyes, how important do you feel the work is that you do? 1. Extremely important. 2. Very important. 3. Moderately important. 4. Slightly important. 5. Little importance. 6. Very little importance. 7. No importance at all. . . . . _____(15)

3. How interesting or boring do you find your work? 1. Extremely boring. 2. Very boring. 3. Moderately boring. 4. Slightly boring. 5. Slightly interesting. 6. Moderately interesting. 7. Very interesting. 8. Extremely interesting. . . . . _____(16)

4. How much importance do you believe the hospital commander attached to the work you do in this clinic? 1. Extremely important. 2. Very important. 3. Moderately important. 4. Slightly important. 5. Little importance. 6. Very little importance. 7. No importance at all. . . . . _____(17)

5. In your opinion, how well is this clinic presently operating? (Answer using a number from 1 to 9 with 1 = condition in which both the clinic staff and the patients are <u>very dissatisfied</u> and 9 = condition in which both the clinic staff and the patients were <u>very satisfied</u>.). . . . . _____(18)

6. As regards the average patient seen in this clinic, how appreciative does he or she seem of your work? 1. Extremely appreciative. 2. Very appreciative. 3. Moderately appreciative. 4. Slightly appreciative. 5. Generally nonappreciative 6. Mostly nonappreciative . . . . . _____(19)

7. To what extent do you feel there is "pressure" to perform well in your job at this clinic? 1. No pressure at all. 2. Very slight pressure. 3. Some pressure, about the right amount. 4. A little too much pressure. 5. Much too much pressure. . . . . _____(20)

8. How well do you feel you do your work? (Answer using a number from 1 to 9: 1=Extremely well, 9=Extremely poorly) . . . . . _____(21)

9. As regards the concept of "professionalism", how would you rank the requirements of your work in this clinic? 1. Extremely professional 2. Very professional. 3. Moderately professional. 4. Slightly professional. 5. Mostly nonprofessional 6. Totally nonprofessional. . . . . _____(22)

10. Using the rankings provided in the previous question, how do you believe your hospital commander would rank the requirements of your work in this clinic? . . . _____(23)

11. Considering only job-related factors, how satisfied or dissatisfied are you with your present military occupation. (Answer using a number from 1 to 9 as in Part II: 1 = extremely dissatisfied, 9 = extremely satisfied.). . . . . _____(24)

12. Considering only the non-job-related factors, how satisfied are you with the Army's way of life? (Answer using a number from 1 to 9 as above) . . . . . _____(25)

3 (80)

_____than the "regularly assigned" full- or part-time physicians:

1. Very much less
2. Substantially less
3. Slightly less
4. Just barely less
5. Just barely more
6. Slightly more
7. Substantially more
8. Very much more . . . . . _____(23)

8. How much importance do you believe the physicians of your clinic attach to your work? 1. Extremely important 2. Very important 3. Moderately important 4. Slightly important 5. Little importance 6. Very little importance 7. No importance at all. . . . . _____(24)

9. On the average, during the previous three months, approximately how much time was scheduled <u>each</u> month for the purpose of training? Consider training for either the purpose of keeping present skills at a high level or to learn new or different skills. (Answer in hours, precede the number by a zero if less than 10) . . . . . _____(25,26)

10. On the average, how many times per month during the past three months did you receive individual supervisory sessions with a physician wherein he discussed your performance with you? (If less than 10, precede the number by a zero, i.e., if your response is 8, write "08").. . . . . _____(27,28)

11. On the average, how long did each session last? (Answer in minutes. If less than 10, precede the number by a zero).. . . . . _____(29,30)

12. Did at least the majority of these supervisory sessions involve a discussion of recent physician audits of your completed Data Collection Sheets? (1=YES, 2=NO). . . . . _____(31)

13. Are you permitted ready access to the results of any audit performed on your work? (1=YES, 2=NO) . . . . . _____(32)

14. Complete the statement below. Answer in the space to the right of each item by using the following 8-point scale:

1. Very much more
2. Substantially more
3. Slightly more
4. Just barely more
5. Just barely less
6. Slightly less
7. Substantially less
8. Very much less

My work as an AMOSIST in this clinic:

a. is _____ difficult than I originally expected . . . . . _____(33)

b. is _____ complicated than I originally expected . . . . . _____(34)

c. requires _____ time than I originally expected. . . . . _____(35)

d. is _____ interesting than I originally expected . . . . . _____(36)

e. involves _____individual responsibility than originally expected. . . . . _____(37)

15. In comparing yourself to other AMOSISTs in general, how well do you feel you do your job?

1. Very much better
2. Substantially better
3. Slightly better
4. Just barely better
5. Just barely worse
6. Slightly worse
7. Substantially worse
8. Very much worse _____(38)

16. How do you think the Chief of your AMIC would have answered the previous question concerning your performance? . . . . . _____(39)

17. On the basis of conversations you have had with the other AMOSISTs in this AMIC what is your impression of the degree to which they (other AMOSISTs) are satisfied or dissatisfied with their work as an AMOSIST? Answer using the same 8-point scale used in previous portions of this questionnaire (i.e., 1 = extremely DISSATISFIED to 9 = extremely SATISFIED) to complete the following statements:

The apparent level of satisfaction or dissatisfaction of:

a. The most satisfied AMOSIST in the clinic is. . . . . _____(40)

b. The least satisfied AMOSIST in the clinic is . . . . . _____(41)

c. All AMOSISTs in the clinic is (i.e., the group average). . . . . _____(42)

18. What, to you, are the three most desirable aspects of being an AMOSIST?

a. (most desirable)_____

_____ _____(43)

b. (second most desirable)_____

_____ _____(44)

c. (third most desirable)_____

_____ _____(45)

19. What, to you, are the three most undesirable aspects of being an AMOSIST?

a. (least desirable)_____

_____ _____(46)

b. (next to least desirable)_____

_____ _____(47)

c. (next to above)_____

_____ _____(48)

20. If you are considering the Army as a career, how long do you envision yourself remaining an AMOSIST before you seek a different field of work? (Answer in years; if one year or less, enter 1. If you are not considering the Army as a career, enter "0".) . . . . . _____(49)

21. At the present time, how likely is it that you will make the Army a career?

1. Definitely <u>will not</u>. 2. Probably will not, conditions seem unfavorable. 3. Undecided, but slightly more against it than for it. 4. Undecided, but slightly more for it than against it. 5. Probably will, conditions seem favorable. 6. Definitely <u>will</u>. . _____(77)

22. How did you feel about filling out this questionnaire? Answer using a number from 1 (Strongly disliked or resented doing it) to 5 (No dislike, didn't mind doing it at all). . . _____(78)

23. If you have any further comments you would like to make concerning your satisfaction with your present work, please enter them here._____

_____

_____

_____

_____ _____(79)

4 (80)

_____(1-3)

PART V

AMOSIST MDs ONLY

1. Considering only the AMOSISTs in this MTF's AMIC, what is your perception of their ability to provide appropriate medical care to patients with acute minor illness. Respond with a number from the following scale:

1. Extremely incompetent	5. Just barely competent
2. Very incompetent	6. Sufficiently competent
3. Somewhat incompetent	7. Very competent
4. Just barely incompetent	8. Extremely competent

a. The most competent AMOSIST's rating. . . . . ____(50)

b. The least competent AMOSIST's rating . . . . . ____(51)

c. The (group) average of all AMOSISTs in the AMIC. . . . . ____(52)

2. As regards the typical AMOSISTs ability to provide medical care to patients with minor illnesses:

a. What are his principal strengths (list in order from the most significant to those of lesser significance).

1._____

_____ ____(53)

2._____

_____ ____(54)

3._____

_____ ____(55)

4._____

_____ ____(56)

b. What are his principal weaknesses? (List in order from the most significant to those of lesser significance).

1._____

_____ ____(57)

2._____

_____ ____(58)

3._____

_____ ____(59)

4._____

_____ ____(60)

3. What is your overall opinion concerning the need for an AMOSIST Program?. . . . . _____(61)

1. Virtual necessity
2. Very high need
3. Moderately high need
4. Slight need
5. Very slight need
6. No need

4. As a health care delivery system, what do you consider to be the AMOSIST Program's...

a. Major strengths:

1._____

_____ _____(62)

2._____

_____ _____(63)

3._____

_____ _____(64)

b. Major weaknesses:

1._____

_____ _____(65)

2._____

_____ _____(66)

3._____

_____ _____(67)

5. At the present time, how likely is it that you will make the Army a career?
1. Definitely will not. 2. Probably will not, conditions seem unfavorable.
3. Undecided, but slightly more against it than for it. 4. Undecided, but slightly more for it than against it. 5. Probably will, conditions seem favorable.
6. Definitely will. . . . . _____(77)

6. How did you feel about filling out this questionnaire? Answer using a number from 1 (Strongly disliked or resented doing it) to 5 (No dislike, didn't mind doing it at all) . . . . . _____(78)

7. If you have any further comments you would like to make concerning your satisfaction with your present work, please enter them here._____

_____

_____

_____

_____

_____

_____ _____(79)

4 (80)

_____(1-3)

PART V

nonAMOSIST MC OR nonAMOSIST 91B OR 91C

1. At the present time, how likely is it that you will make the Army a career? 1. Definitely will not. 2. Probably will not, conditions seem unfavorable. 3. Undecided, but slightly more against it than for it. 4. Undecided, but slightly more for it than against it. 5. Probably will, conditions seem favorable. 6. Definitely will. . . . . _____(77)

2. How did you feel about filling out this questionnaire? Answer using a number from 1 (Strongly disliked or resented doing it) to 5 (No dislike, didn't mind doing it at all) . . . . . _____(78)

3. If you have any further comments you would like to make concerning your satisfaction with your present work, please enter them here._____

_____

_____

_____

_____

_____

_____

_____

_____(79)

4 (80)

APPENDIX D

STAFF PERCEPTIONS QUESTIONNAIRE

_____ (1)

STAFF PERCEPTIONS QUESTIONNAIRE

Among the outpatient clinics in your medical treatment facility is the Acute Minor Illness Clinic (AMIC), a clinic which employs trained, physician-supervised enlisted personnel (AMOSISTs) to utilize a series of algorithms (i.e., Step-by-step, decision-regulated procedures) to provide direct medical care to patients suffering acute minor illnesses. You are requested to respond anonymously to the following items which pertain to that clinic:

1. Please indicate to which of the following general medical occupations you belong:
   1. Physician 2. Registered Nurse 3. 91B 4. 91C 5. Other medical MOS, specify_____
   _____. . . . . _____ (6)

2. What is the extent of your knowledge concerning the operation of an AMIC and the work of AMOSISTs? 1. Complete 2. Very substantial 3. Substantial 4. Some 5. Slight 6. Nearly none 7. None (except that provided by the above statement). . . . . _____ (7)

3. What is your opinion concerning the need for a clinic of this type? 1. Absolute necessity 2. Very high need 3. Moderately high need 4. Slight need 5. Very slight need 6. No need . . . . . _____ (8)

4. What do you think is the general opinion of the professional staff in your MTF concerning the ability of AMOSISTs to provide adequate and appropriate medical care to the patient population they treat (i.e., those with acute minor illness)? 1. Extremely competent 2. Very competent 3. Somewhat competent 4. Just barely competent 5. Just barely incompetent 6. Somewhat incompetent 7. Very incompetent 8. Extremely incompetent. . . . . _____ (9)

5. Based upon your own knowledge of the medical care received by patients who have been treated in an AMIC, how would you, yourself, answer the previous question (Respond using the same 8-point scale listed in item 4)?. . . . . _____ (10)

6. If you have any further comments or opinions concerning the AMOSIST Program, please provide them below:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ (11)

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APPENDIX E

PATIENT SATISFACTION QUESTIONNAIRE IV

PATIENT SATISFACTION QUESTIONNAIRE IV

Clinic_____ (1-10)

In our efforts to provide the best medical care possible we are asking you to take a few moments to answer the following questions. The questionnaire is anonymous: you are not to identify yourself. We ask, therefore, that you state your honest opinions on all questions regardless of how positive or negative they may be. The information provided will be held in the strictest confidence.

1. What is your age (in years)?. . . . . _____ (11,12)

2. What is your sex? (1-male, 2-female) . . . . . _____ (13)

3. What is your pay grade (e.g., E1, E2,...O1, O2,...,W1, W2,...etc.), or if a dependent, the pay grade of your military sponsor? . . . . . _____ (14,15)

4. What is your present eligibility status? 1. Active Duty 2. Dependent of active duty 3. Retired 4. Dependent of retired or deceased 5. Other. . . . . _____ (16)

5. What is your marital status? 1. Married 2. Single 3. Divorced 4. Separated 5. Widow 6. Widower . . . . . _____ (17)

6. What is your race or ethnic group? 1. Black 2. White 3. Mexican-American 4. Oriental 5. Other . . . . . _____ (18)

7. Approximately how many times have you been treated in this or any other medical clinic/ hospital in the past 12 months? (if 9 or less, precede the number with a zero.). . . . . _____ (19,20)

8. Did you have an appointment for today's visit? (1=YES, 2=NO) . . . . . _____ (21)

9. How many years of formal education have you completed? (Answer in years, count GED as 12; if 9 or less, precede the number by a zero. For example, if you have 8 years of education, write 08). . . . . _____ (22,23)

10. Rate the severity of the pain or discomfort you are now feeling from 1 to 9 (1= no pain or discomfort, 9= extreme pain or discomfort). If you are here simply to obtain a prescription refill and are suffering no pain, write 0) . . . . . _____ (24)

Please read each item, then indicate in the space provided to the right of each item (how satisfied" or "how dissatisfied" are you with it. Use the 9-point scale below to indicate your feelings. (5= undecided or neutral)

EXTREMELY										EXTREMELY
DISSATISFIED	1	2	3	4	neutral 5	6	7	8	9	SATISFIED

NOTE: There are no "right" or "wrong" answers. Please do not "struggle" or "work" to make your answers exact. Your "general" impression is satisfactory.

HOW SATISFIED OR DISSATISFIED ARE YOU WITH. . . .

11. Military life in general?. . . . . _____ (25)

12. The overall treatment and care you have previously received in most other military medical treatment facilities? (If you've had none, leave blank) . . . . . _____ (26)

1 (80)

PLEASE RETURN TO RECEPTIONIST AT THE TIME YOU ARE CALLED FOR TREATMENT.

CLINIC_____(1-10)

PATIENT SATISFACTION QUESTIONNAIRE IV

In our efforts to provide the best medical care possible we are asking you to take a few moments to answer the following questions. The questionnaire is anonymous: you are not to identify yourself. We ask, therefore, that you state your honest opinions on all questions regardless of how positive or negative they may be. The information provided will be held in the strictest confidence.

Please read each item below, then indicate in the space provided to the right of each item "how satisfied" or "how dissatisfied" you are with it. Use the 9-point scale below to indicate your feeling. (5 = undecided or neutral)

EXTREMELY DISSATISFIED	1	2	3	4	neutral 5 ?	6	7	8	9	EXTREMELY SATISFIED

NOTE: There are no "right" or "wrong" answers. Please do not struggle or "work" to make your answers exact. Your "general" impression is satisfactory.

HOW SATISFIED OR DISSATISFIED ARE YOU WITH.....

1. The amount of time you had to wait to obtain medical care here today?. . . . . _____(27)
2. The parking facilities provided? (Consider both the number of spaces provided and the distance from the clinic; if you're not familiar with the parking facilities, leave blank) . _____(28)
3. The general appearance of this Clinic? . . . . . _____(29)
4. The thoroughness (completeness) of the medical examination you received. . . . . _____(30)
5. The amount of information given to you concerning your illness by person(s) who examined and treated you? . . . . . _____(31)
6. The degree of privacy you had when you discussed your problem with the person(s) who treated you? . . . . . _____(32)
7. The amount of interest shown concerning you as an individual by the person(s) who examined and treated you? . . . . . _____(33)
8. The amount of time spent with you during your actual evaluation and treatment? . . . . . _____(34)
9. The manner in which you were treated by the receptionist?. . . . . _____(35)
10. The degree of courtesy and friendliness shown to you by the person(s) who treated you? . . . _____(36)
11. The convenience of the location of this clinic?. . . . . _____(37)
12. The way in which laboratory and/or X-ray services are provided? (If not used, leave blank) . _____(38)
13. The overall total treatment and care you have received at this clinic? . . . . . _____(39)

Please complete the following statements:

14. I feel the people working in this clinic: 1. Could have done a better job in all areas 2. Were adequate in some areas but could have done better in other areas 3. Did an adequate job 4. Did most of their work efficiently 5. Were outstanding in all areas . . . . . _____(40)
15. I feel the medical treatment I received today was: 1. Unacceptable 2. Less than adequate 3. Adequate 4. More than adequate 5. Outstanding . . . . . _____(41)
16. I feel that the examiner's understanding of my medical problem was: 1. Very poor 2. Poor 3. Average 4. Good 5. Very good. . . . . _____(42)
17. Estimate the amount of time (in minutes) that you had to wait, after arriving at this clinic, before you first received treatment here today . . . . . _____(43-45)
18. How would you rate the treatment you received in this clinic today compared to the treatment you have received previously in this clinic? (If you have had no previous care here, leave blank.) 1. Very much better today than before 2. Much better today 3. A little better today 4. About the same as before 5. A little worse today 6. Much worse today 7. Very much worse today than before. . . . . _____ (46)
19. How did you feel about filling out this questionnaire? Answer using a number from 1 (Strongly disliked or resented doing it) to 9 (No dislike, didn't mind doing it at all). . . _____ (47)

_2_ (80)

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