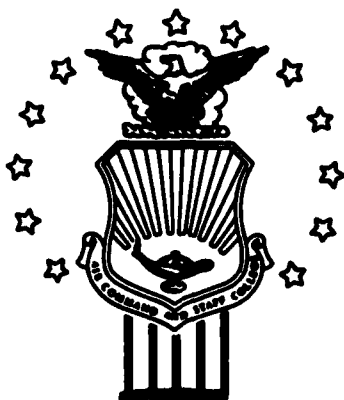


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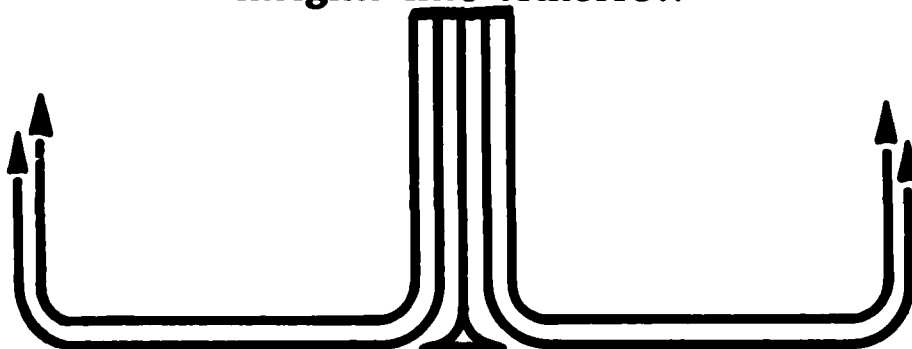
STUDENT REPORT

RETENTION OF
USAF OBSTETRICIANS/GYNECOLOGISTS

MAJOR STEVEN P. HELLMANN

881180

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PREFACE

The training, utilization and retention of skilled medical professionals is vitally important to the force sustainment and morale of the United States Air Force (USAF). In order to sustain USAF forces during combat contingencies, the USAF must have trained medical professionals in uniform, who are mobile, deployable, resourceful, durable, and capable of providing continuous high quality and compassionate medical care anywhere in the world, and across the spectrum of conflicts. USAF physicians must be capable of rapidly treating USAF casualties and returning the maximum number of personnel to duty so they can resume their wartime tasks. For the more seriously injured casualties, USAF physicians provide the treatment necessary to prevent undue pain, suffering, and loss of life and limb; as well as restore them to maximum wellness. A desirable, and quite visible byproduct of the USAF medical capability is the health and morale of it's forces during peacetime. This is achieved through timely and appropriate medical treatment of, not only active duty members, but also their dependents, retirees, and their dependents.

Although the entire USAF Medical Corps is vital to both the wartime and peacetime missions of the United States Air Force, one specific segment of the corps, Obstetrics/Gynecology specialists (OB/GYN), is the focus of this report. Their value in the wartime contingency mission of the USAF is not fully acknowledged, and their extreme value in the peacetime setting of the typical small USAF medical facility is appreciated even less. This undervaluation of OB/GYN contributions to the mission of the Air Force, along with several other factors, is creating extraordinary problems in the retention of these particular medical professionals

Sincere appreciation is extended to the following agencies for their support in the development and preparation of this project:

HQ AFMPC, Medical Career Division
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HQ USAF, Health Policy & Programs Division
HQ USAFOMS, Medical Logistics Contracting Division
HQ USAFOMS, Biometrics Division
AU Regional Hospital, Medical Library
AU Regional Hospital, OB/GYN Clinic
Maxwell AFB, Data Automation

ABOUT THE AUTHOR

Major Hellmann was born in Belleville Illinois in 1953 and commissioned through AFROTC in 1975. Trained as a Combat Rescue helicopter pilot, he flew UH-1Ns at Vandenberg AFB, CA from 1977 to 1980. From 1980 to 1982, he was a Flight Safety Officer for the 76 ALD at Andrews AFB, and was attached to the First Helicopter Squadron to fly the UH-1N. During 1983 he flew HH-3s at Osan AB, ROK. From 1984 to 1986, he was the Chief of Combat Rescue Exercises and Tactics for the 41 RWRW at McClellan AFB, CA. As a helicopter pilot he flew over 1600 hours. When medically grounded in 1986, he was selected to the Medical Service Corps and assigned to the 833d Medical Group, Holloman AFB, NM. During that assignment, he served as the Director of Medical Logistics, Director of Medical Readiness, and the Director of Patient Affairs. During 1987-88, Major Hellmann attended the Air Command and Staff College.

He has been awarded the Meritorious Service Medal and the Air Force Commendation Medal with three oak leaf clusters. He has a Bachelor of Science Degree from the University of Iowa, and a Master of Arts degree in Management and Supervision from Central Michigan University. He has completed Squadron Officers School by correspondence and in residence, and completed Air Command and Staff College by seminar. He is a nominee to the American College of Healthcare Executives (ACHE).

Major Hellmann and his wife Terri have three children; Jessica and Steven, and Sara.

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REPORT NUMBER

881180

AUTHOR(S)

Steven P. Hellmann

TITLE

Retention of USAF Obstetricians/Gynecologists (OB/GYN)

PROBLEM: Persistent low retention of USAF OB/GYNs has degraded the OB/GYN capability of several USAF medical treatment facilities. In response to manning shortfalls, several USAF hospitals are now establishing very costly local contracts for OB/GYN services.

PURPOSE: This report uses information from several sources to identify the factors which cause low retention among OB/GYNs. It then recommends courses of action which focus on these factors. This report also analyzes trends in healthcare which affect staffing and funding for medical operations and thus affect future OB/GYN retention programs.

DATA: USAF manpower statistics support the notion that the Air Force has a serious problem in retaining OB/GYNs. Various medical journals, and a survey of USAF OB/GYNs show that each of the eight retention factors considered in this report should have predictable effects on OB/GYN retention. Of the factors considered, four should influence OB/GYNs to separate: lack of esteem/control over their medical practice, workload, and compensation. Four factors, which are unique to the private sector, should influence the OB/GYN

to remain in the Air Force. These include: malpractice premiums, malpractice claims, uncertain demand for their services, and the stress of dealing with business aspects of private practice. On balance, it appears that influences favoring separation equal those favoring retention. As this report will show however, each factor does not have equal weight or effect, and that a factor such as workload has an extreme effect on the decision to separate. Statistical information from the US Department of Commerce and USAF Biometrics sources show that the cost of healthcare has increased drastically since 1970, that medical treatment has shifted toward outpatient care, and that the military retiree population has grown rapidly. This information must guide the staffing and funding for future medical operations.

CONCLUSIONS: The battle for retention of OB/GYNs is winnable if senior leadership acknowledges that the challenge comes from within the USAF medical system, as well as from outside. Workload is the primary reason USAF OB/GYNs separate and are willing to endure the risks of the private sector. Inadequate compensation also affects retention, but seems to be partially linked to OB/GYN complaints about workload. Lack of esteem from leadership at all levels, and lack of control over several aspects of the medical practice are also strong incentives for the OB/GYN to separate. The emotions generated by these four factors are so strong that the OB/GYN has little concern for the risks of the private sector. Decreasing workload and increasing OB/GYN staff levels will have positive effects on retention. Incentive payments must also be considered as a possible way to raise retention. Support staffing must be adjusted to outpatient clinics to reduce the OB/GYN workload and make maximum use of the limited OB/GYN staff. Logistics support to OB/GYN must become an item of special interest to hospital commanders. Decisions on ISP payments should not only be based on the "wartime criticality" of certain specialists, but should consider that shortages among OB/GYNs are now leading to expensive commercial contracts that drain off O&M dollars.

RECOMMENDATIONS: The USAF must pay the real cost of running a medical system by increasing staffing and compensation for OB/GYNs. Where staffing is not increased, the USAF needs to set maximum work limits for OB/GYNs with which hospital commanders will be required to comply. The USAF must direct hospital commanders to adjust their staffs to make maximum use of the OB/GYN. (This may mean taking support from other less productive clinics or inpatient areas.) The USAF should develop a "hotline" to enable OB/GYNs to elevate their frustrations to a level where resolution can occur. The USAF must make logistics support to OB/GYN staffs a high interest item requiring interface between senior leadership in each medical facility and supervision by the hospital commander.

LIMITATIONS

Due to the breadth and complexity of the physician retention problem in the USAF, senior leadership must ultimately direct an analysis of the problem leading to corrective actions which deal directly with fundamental causes. Such a detailed analysis should be conducted by several disciplines within the Medical Corps. This research project will not provide such a detailed analysis. Due to time constraints involved with conducting this analysis and preparing this report, the focus and depth of analysis were intentionally limited. This analysis focuses specifically on the retention of OB/GYN specialists (AFSC 9496). This is appropriate since the Air Force is preparing to spend millions of dollars of its critical operating funds to maintain an obstetrics capability in spite of major shortfalls in OB/GYN manning. The depth of this project is limited to an initial analysis of a variety of outside source material on the following subjects: OB/GYN retention data, USAF policies toward physician incentive pay, workload, and retention, competition from the private sector, the current work environment of USAF OB/GYNs as documented by an attitude survey, the changing trends in healthcare delivery and payment, the expanding DOD patient population, and deficiencies in locally contracted OB/GYN care. This initial analysis will lead to recommended future actions. As earlier stated, this analysis will not make a multi-disciplined staff analysis unnecessary, but it will indicate the need for such an analysis, and identify the factors which have caused this problem.

This research project does not discuss specific staffing levels, or recruitment goals, and does not evaluate whether the AF receives adequate benefit from OB/GYN service for the cost of their education.

This research project also does not explore alternate methods of providing medical care to dependents and retirees.

Chapter One

INTRODUCTION

For the past several years, the United States Air Force has found it difficult to retain Obstetricians/Gynecologists (OB/GYN). This persistent low retention has led to manning shortfalls which have degraded the OB/GYN capability at several USAF medical treatment facilities. In response, several USAF hospitals are now establishing very costly local contracts to have civilian physicians work in their facilities.

If senior USAF leadership hopes to correct this problem, it must understand the factors which cause it, plan a course of action which addresses the causes, and have the resolve to carry out the plan. This report systematically presents information from several sources in order to assist senior leadership in this effort.

Analysis begins in Chapter Two with a brief background discussion of the OB/GYN retention problem, using specific retention statistics. Chapter Three describes a survey of USAF OB/GYNs that was conducted by the author of this report, and summarizes the significant results of the survey. Much of the information from the survey will be used later in the report when studying factors in retention. Chapter Four, entitled "Decision Factors," examines eight factors which can influence a USAF OB/GYN's decision to stay in the Air Force. The author will consider these factors in terms of both USAF medical practice and private practice, and then make conclusions about the affect each one should have on a USAF OB/GYNs decision to separate. Chapter Five then discusses several other considerations which senior leadership must be aware of as it tries to raise OB/GYN retention. These additional considerations are most significant because they affect funding and staffing for future medical operations and thus will affect OB/GYN retention programs. Chapter Six provides information about an actual commercial OB/GYN contract to help the reader see further that something must be done about OB/GYN retention. Chapter Seven will summarize the main points of the report and Chapter Eight makes recommendations which will guide future plans regarding this problem.

Ultimately, this report will do two things. It will leave the reader convinced that something must be done about OB/GYN retention, and convince the reader that things can be done to correct the OB/GYN retention problem.

Chapter Two

BACKGROUND OF THE PROBLEM

To fully understand the OB/GYN retention problem, it is necessary to first become aware of its scope and seriousness. This can be accomplished by reviewing some basic statistics on retention, and on numbers of assigned vs authorized OB/GYNs.

Retention rates for OB/GYNs are among the lowest of all USAF physicians. In FY 86, the USAF only retained 20% of its OB/GYNs one year past initial obligation. This is significantly lower than the USAF average of 50% for all physicians that year. In FY 86, the only medical specialty with a population greater than 20 that had lower retention was diagnostic radiology, which only retained 3% of its physicians one year past initial obligation. This low retention rate in FY 86 reflects a downward trend, as the average for OB/GYN retention for the past five years is 32%. (13:--)

In spite of an aggressive recruiting effort, which has accessed 233 OB/GYNs between FY 82 and FY 87, the USAF Medical Corps only had 164 assigned (non-resident) OB/GYNs against an authorization of 185 as of 30 September 1987. (13:--) Although increased authorizations from 167 to 185 during the period contributed to this shortfall, low retention must be considered a major cause.

In summary, low retention is a major cause of the OB/GYN shortage. Therefore, it is necessary to identify those factors which cause low retention, and take long-term, effective action to deal with these factors. The next several chapters of this report discuss these factors and provide appropriate recommendations.

Chapter Three

SURVEY OF USAF OB/GYNS

Throughout the rest of this report, the writer will frequently refer to a survey of USAF OB/GYNs, and use statistics derived from it. To help the reader use the information later in the report, this chapter describes the purpose of the survey and explains the types of questions asked. It also discusses confidence levels, processing methods, and statistical results. A limited number of narrative responses, which the author felt accurately represented the entire group of responses, is also provided.

While developing the survey, the author established three fundamental purposes. These are:

1. Establish and understand what OB/GYNs feel about several aspects of their Air Force medical practice.
2. Establish and understand the work environment of the USAF OB/GYN. This includes work hours, on-call, division of workload, and numbers of OB/GYNs on staff.
3. Establish and understand what it would take to convince these people to stay in the Air Force.

The survey (Appendix A) was comprised of 63 questions. Survey recipients were asked to answer 59 multiple choice questions on an optical character reader answer sheet, and answer 4 open-ended questions on the survey questionnaire. Respondents remained anonymous. The 59 multiple choice questions were divided into three types: 10 demographic variable questions, 6 environmental variable questions, and 43 attitude questions. The remaining 4 open-ended questions were used to expand the information in the multiple choice questions and support survey conclusions. Between 23-25 November 87, the survey was sent to 225 USAF OB/GYNs worldwide, including those in USAF residency training programs. A total of 134 surveys were returned complete, and 130 of those processed through the Statistical Program of the Social Sciences (SPSS). This achieved a confidence level above 90% and a precision of 5%. Processing was accomplished in two phases. First, the results were tabulated to provide

the frequency of answers for each question. Those attitudes and factors that were statistically significant were used in the second phase where the results of the questions were crosstabulated. Typically, environmental and demographic questions were compared to attitude questions. The survey produced the following results:

Grade distribution of respondents was as follows:

0-6-----	13
0-5-----	10
0-4-----	65
0-3-----	41

Time on active duty of respondents was as follows:

less than 2 years----	34
2-3 years-----	25
4-7 years-----	24
more than 7 years----	45

Time remaining on commitment was as follows:

less than 1 year----	45
1-2 years-----	44
3-4 years-----	31
over 4 years-----	9

Break in service after commissioned as a physician?

yes	22
no	106

NOTE: When the number of respondents doesn't total 130 or percentages don't total 100% it is because some respondents either chose not to answer these questions, or didn't answer them correctly.

What are your current intentions toward remaining in the Air Force beyond your current commitment?

- 6.2% Not applicable, I have no commitment
- 10.0% Will probably remain beyond commitment
- 6.9% Undecided, leaning toward remaining
- 12.3% Undecided, leaning toward separating
- 64.6% Probably will separate at the end of commitment

It is interesting to note that 23.1% of the respondents either don't have a commitment, probably will remain beyond commitment, or are leaning that way. That is nearly the 20% retention rate of FY 86 and indicates that the respondents intentions closely mirror those of earlier OB/GYNs.

What were your original intentions in regards to making the Air Force a career?

- 20.0% Definitely would make the Air Force a career
- 25.4% Probably would make the Air Force a career
- 15.4% Probably would not make the Air Force a career
- 6.9% Definitely would not make the Air Force a career
- 32.3% Undecided about making the Air Force a career

The last two questions show clearly that most USAF OB/GYNs do not come into the Air Force predisposed to getting out. Something causes attitudes toward the Air Force to change during the course of their military service.

Recipients were asked to rate their level of satisfaction with 34 specific factors. The following factors were the most negative, based on the percentage of respondents who indicated they were "very dissatisfied":

Quantity of Support Staff	58.5%
Quantity of Medical Staff	55.4%
Compensation	50.0%
On-Call	46.2%
Administrative Tasks	41.5%
Job Effects on Family	39.2%
Workload	38.5%

It's important to note that these percentages reflect those who answered "most dissatisfied." Most of the above factors also had a large percentage of respondents who answered "somewhat dissatisfied."

Results indicate that staffing is the greatest dissatisfier. However, since medical and support staffing directly affect workload, the author believes that workload is actually the greatest dissatisfier for USAF OB/GYNs.

The most satisfying factors (termed "very satisfied"):

Immediate supervisor	37.7%
Medical Benefits	30.0%
Quality of Medical Staff	27.7%

When asked to comment on this statement, "Senior leaders in the Air Force are well aware of the depth and seriousness of the obstetrician retention problem," respondents answered:

Strongly Agree	6.2%
Agree	9.2%
Neither	6.2%
Disagree	30.8%
Strongly Disagree	46.2%

When asked if increasing annual Incentive Special Pay (ISP) to \$30,000 would convince them to stay in the Air Force:

Not applicable, compensation not a factor	13.8%
Undoubtedly yes	12.3%
Probably yes	44.6%
Undoubtedly no	7.7%
No, but it may have convinced me in the past	20.0%

NOTE: The respondents were not asked to pick the dollar amount that would convince them to stay, because the author believed that most respondents would automatically pick the highest amount listed. Instead, \$30,000 was chosen because it was large enough to clearly make a difference in the attitude of those USAF OB/GYNs who could be influenced by compensation.

When asked if adding one OB/GYN to his/her staff would convince him/her to stay in the Air Force:

Not applicable, workload not a factor	19.2%
Undoubtedly yes	6.9%
Probably yes	40.8%
Undoubtedly no	8.5%
No, but it may have convinced me in the past	23.1%

When asked if imposing mandatory maximum work standards for OB/GYNs would convince them to stay in the Air Force:

Not applicable, workload not a factor	17.7%
Undoubtedly yes	12.3%
Probably yes	42.3%
Undoubtedly no	5.4%
No, but it may have convinced me in the past	20.8%

The responses to the three previous questions show that there are some things that can be done to make USAF medical practice appealing enough to convince more OB/GYNs to continue. Later on, these results will be crosstabulated to provide more detailed information.

When asked what impact decreasing ISP had on the overall Medical Corps, 51.5% felt it had a negative impact. 20.0% felt it had a very negative impact.

When asked how many OB/GYNs are on staff at their facilities:

1	.8%
2	46.2%
3-5	30.8%
more than 5	19.2%

When asked how many hours, on average they spend in their facilities each week:

40-50	3.1%
50-60	16.9%
60-70	36.2%
More than 70	42.3%

When asked, on average, how many days per month they are on-call:

Less than 5	3.8%
6-10	29.2%
11-15	28.5%
16-20	33.8%
More than 20	1.5%

Significant crosstabulated data are as follows:

Of those persons who have indicated they would probably separate at the end of their commitment:

14.3% originally had planned to make the Air Force a career

20.2% originally felt they would probably make the Air Force a career

We see here that over 34% of those separating had originally planned to stay in the Air Force for a career.

When comparing the numbers of OB/GYNs on staff with numbers of hours worked each week:

In hospitals with 2 OB/GYNs, 51.7% work over 70 hours per week

In hospitals with 3-5 OB/GYNs, 27.5% work over 70 hours per week

In hospitals with more than 5 OB/GYNs, 52.0% work over 70 hours per week

When comparing the numbers of OB/GYNs on staff with the numbers of days each month on-call:

In hospitals with 2 OB/GYNs, 96.6% were on-call 11-20 days/month

In hospitals with 3-5 OB/GYNs, 45.0% were on-call 11-20 days/month

In hospitals with more than 5 OB/GYNs, 21.7% were on-call 11-20 days/month

This clearly shows that physicians in 2 OB shops work the most hours and have the most on-call duty.

Comparing the offer of an increase in ISP to \$30,000 with those planning to separate:

7.2% planning to separate would definitely stay in the Air Force

34.9% planning to separate would probably stay in the Air Force

Major increases in ISP not only have an effect on the total OB/GYN population. 42.1% of those planning to separate (a pessimistic segment of the population) would probably stay in the Air Force if ISP were increased to \$30,000.

Comparing the offer of adding an OB/GYN to the staff with those planning to separate:

2.4% planning to separate would definitely stay in the Air Force

37.3% planning to separate would probably stay in the Air Force

Again, making tangible improvements, this time with staffing, can induce OB/GYNs to stay in the Air Force.

Comparing the offer of maximum work standards with those planning to separate:

9.6% planning to separate would definitely stay in the Air Force

38.6% planning to separate would probably stay in the Air Force

Comparing those planning to separate to numbers of OB/GYN on staff:

Of those with 2 OBs on staff.....73.3% will separate

Of those with 3-5 OBs on staff.....60.2% will separate

Of those with more than 5 OBs on staff.....56.0% will separate

The smaller the OB staff, the greater likelihood the OB/GYN will separate.

Comparing those planning to separate to numbers of hours worked per week:

Of those working 50-60 hours per week.....63.6% will separate
Of those working 60-70 hours per week.....68.1% will separate
Of those working over 70 hours per week...67.3% will separate

Comparing those planning to separate to numbers of days per month on-call:

Of those on-call 6-10 days per month.....55.3% will separate
Of those on-call 11-15 days per month.....62.2% will separate
Of those on-call 16-20 days per month.....79.5% will separate

Size of OB staff, and days per month on-call have the strongest correlation in these comparisons and also have the greatest effects on the decision to separate. (73.3% of those in 2 OB shops, and 79.5% who are on call 16-20 days per month are planning to separate.)

Open-ended questions asked survey recipients to list the three most positive factors and three most negative factors in their Air Force medical practices. They were also asked how they would recommend solving the OB/GYN retention problem.

When the answers were tabulated, the author attempted to quantify the results, in order to compare them with the multiple choice questions on the survey. This was not possible since open-ended questions give the respondent considerable latitude in explaining his/her feelings. Because it is often difficult to know the basis for some answers, it is impractical to assign frequency values to the answers provided.

It is useful however to point out that the tone and focus of the OB/GYN's narrative responses generally coincided with the multiple choice questions from the survey. Prevalent throughout the answers were the following themes: OB/GYN workload is severe and greater than any other group of physicians (often 90-100 hours per week), administrative/technical support is not adequate to make maximum use of the limited number of OB/GYNs (which lead to longer hours), two-man OB/GYN shops are devastating, they are not paid according to their productivity or private sector standards, an unresponsive supply system forces many OBs to

practice with 1950s technology, OB/GYNs are not trained for Emergency Room duty (MOD) and already work too many hours to also have that duty. They also feel that MAJCOMs and local commanders are unresponsive to the point of belligerence, the OB/GYN contribution is undervalued, and nobody is listening to their concerns.

Another message which carries throughout the responses is that many of these OB/GYNs clearly see many positive reasons for staying in the Air Force. Many are very pleased with the high quality of Air Force physicians and love treating such a wide variety of young patients without being concerned about their ability to pay. Many more stated that service to their country and the esprit de corps within the Medical Corps is immensely satisfying. The balanced answers, especially in the narrative comments indicate that USAF OB/GYNs are not vindictive or self-serving. Most are simply overwhelmed by the negative aspects of their practices and are separating for their own professional and personal survival. To further expand on these themes, several comments have been extracted from the survey:

Senior DOD leadership thinks of gynecologists as well-trained midwives and does not know that, save for general surgeons, no other specialty offers such a rich resource of well-trained abdominal surgeons. Would anyone seriously argue that an orthoped or a neurosurgeon would be better trained to deal with, for example, a gunshot wound to the abdomen?...Many obstetricians would be motivated to stay in the Air Force if hospital commanders began to understand that obstetricians are the most severely tasked specialists at virtually every MTF in the Air Force.

(An example of a commander's lack of concern for his assigned physicians), I'll crush anyone who stands in my way of making General.

My senior partner says that this is the only place in the world that you can make less money for more experience and greater output, and I'm beginning to agree.

Pay providers competitively with the civilian community, and do not force workloads that are unmanageable. Many Air Force OB/GYNs have been in positions where, if standard Blue Cross/Blue Shield and Medicare/Medicaid payments were made, they would easily net before taxes, \$600,000 to \$800,000 per year. Few private OB/GYNs would work that hard even if paid that much. How in the world can

anyone think that quality physicians want to do it for \$50,000 per year?

It is easy in theory. Find a way to make the obstetrician proud to be an Air Force physician, pay them a competitive salary, provide support that allows them to be both efficient and innovative, and give them "strokes" due any group of highly-motivated and highly-trained professionals. Lee Iacocca could do it!

Prolonged episodes of "solo duty" are the most devastating forces to career plans for many physicians.

I love this country. I joined the USAF partially because I want to preserve freedom and to fight against communism. However, after six months of being an Air Force OB/GYN, spending an average of 12-14 hours a day in the hospital and being on-call every second night, I feel like I am an indentured servant and not a physician. I'd like to stay with the Air Force, however, I must leave after I have fulfilled my obligation for my health's sake, (mentally and physically.) I believe that our leaders do not understand the reality and seriousness of the problem that we OB/GYNs are facing. They do not understand how one feels to be working for a straight 72 hours without sleep; and is expected to function normally and competently.

I would be crazy to continue to work an average of twice the hours for 1/2 the pay (even with overhead and malpractice) than my civilian counterparts.

Doctors with an active duty commitment (HPSP students) are sacrificed at the small, remote, & undesirable locations. While this may be in the best interests of the Air Force, you shouldn't expect physicians offered up on this altar to extend their time on active duty. This then leaves you with a permanent two tier corp of OB/GYNs. Those in larger facilities, and those in the trenches. Perhaps the last two years of every HPSP physician's initial tour should be someplace desirable.

My goals are to survive until I can get out with my family, health and credentials intact. I go to work knowing that exhaustion, poor staffing, poor supply, and an overwhelming patient load make all but the most cursory patient care impossible.

Consider eliminating incentive pays and special pays in exchange for a percapita bonus: \$5/outpatient visit, \$100/major surgery, \$75/delivery etc.

We are now so short-staffed that the GYN surgery patients are sent to the general surgery floor: we have only 2 RNs and one tech to cover the PP floor, LDR and nursery. Then base security takes techs out of the hospital to act as flightline security. In short, I end up doing tech and RN tasks instead of seeing patients. Very inefficient!

Pay of course is always an issue. I generate more than \$1 million in care for the AF, but am paid less than 5% of the gross. I get offers every week for 125-200 thousand, first year guaranteed. I have never worked less than 60 hours per week and usually spend 70-80 hours per week. When my partner goes on leave, the workload does not decrease and the hours are 100-130 per week.

The Air Force has 35+ hospitals with two-man services, with 90-120 hour work weeks routine. With retention of OB/GYNs so low, each year there are 15-20 one-man services for 4-5 months. This is a disgrace.

Phasing out ISP for the OB in favor of the more "critical" surgeons, orthopods, and anesthesiologists shows what some really think of our role and importance. There is a lot to be said for providing good dependent care so that the soldier is ready to fight and doesn't have to worry about his family. Although I am not on active duty for the money, the messages being sent are that I am a commodity, and am not as important as others in the glamorous world of warmaking.

The workload on a day-to-day basis is the main problem. The average week is 90-100 hours, with enough work for double the physicians at the facility. Our support staff/nurses are also understaffed.

My goal was to stay on active duty as a practical obstetrician for a full AF career. Even after I completed a fellowship I planned on an AF career when I first arrived at my facility. I cannot now in good conscience stay on active duty since I am forced to use substandard equipment and feel an unmistakable decay in the quality of the force

across the board (equipment, supply, RNs). I work for senior people who don't respect or recognize me, and whom I in-turn do not respect or trust. I can almost guarantee that the more important/expensive a needed piece of equipment is, the more likely it will be to cause confusion or mistakes along its procurement journey. I suggest that an advisory group of civilian with no military experience, civilians with military experience, and active duty obstetricians be formed to look at this problem in great depth.

There needs to be a hotline for OB/GYNs who feel that they are at the end of their rope--forget going through the chain of command because frankly, many people in the chain do not want problems to leave the hospital.

(From a hospital commander); Two physicians to cover an active OB/GYN service is not enough. Minimum is three. Failure to address this flaw only drives these specialists out of the military. Manning standards must change if we intend to keep these specialists. They separate not for the money but for health and sanity.

NOTE: These are only a small portion of the narrative responses to the survey. These specific responses were chosen because they represent the most dominant themes raised by the entire body of responses.

Chapter Four

DECISION FACTORS

When deciding to remain in the Air Force or to separate, the USAF OB/GYN must consider literally dozens of factors which can affect his/her personal values, needs, and concerns. This chapter will identify eight of those factors, assess their role in USAF and private medical practice, and suggest how each influences the USAF OB/GYN's decision to separate. These factors include: self esteem/control over practice, compensation, workload, malpractice premiums, malpractice claims, physician demand and business stress.

SELF ESTEEM/CONTROL OVER PRACTICE: Elements of these two factors are interrelated, so the author chose to handle them together.

In the Air Force, the OB/GYN suffers from repeated assaults on his/her self esteem, primarily because they have little control over decisions in their medical practice. As indicated in the survey of USAF OB/GYNs, they have little input to the number of hours they work, or how those hours are used. They are unable to appreciably influence decisions on availability or quantity of support staff or on many clinical policies. They see hospital commanders and headquarters staffs as unresponsive and generally hostile to their suggestions. The perceived lack of value attached to the OB/GYN is even more frustrating for the OB/GYN because of the hours they work compared to other USAF physicians. OB/GYNs universally declare that they routinely work more hours than any other category of physician. With that contribution, they feel should come more opportunity to control one's environment.

OB/GYN esteem is also degraded by the recent change in DOD policy toward Incentive Special Pay (ISP). According to the AF Times, 5 Oct 87, DOD, beginning in FY 88 has identified a group of three "most critical" specialties (orthopedic surgeons, general surgeons, and anesthesiologists). In a graduated process during FY 88 and 89, DOD will increase Incentive Special Pay (ISP) for those three specialties from \$4,000 annually (before FY 88), to \$8,000 annually in FY 89. Also, medical residency program directors, regardless of specialty, will receive either

\$2,000 or \$4,000 annually in ISP. Also competing for ISP is a larger list of "critical" specialists which, prior to FY 88 also received \$4,000 annually in ISP. These include radiologists, psychiatrists, urologists, ear/nose and throat specialists, ophthalmologists, OB/GYNs, and emergency medical specialists. (8:3)

The doubling in ISP for the newly designated "most critical" specialties has resulted in a decrease in ISP for those specialties only designated as "critical." This is because ISP is paid to "critical" specialties from funds left over after the "most critical" specialties are paid. As a result, the "critical" specialties are seeing their ISP drop in FY 88 from \$4,000 to \$3,250. Once the full weight of increased ISP for the "most critical" specialties is felt in FY 89, there will be even less ISP for those specialties only designated as "critical." For several of these specialties, ISP will totally disappear. (8:3)

In considering allocation of ISP, DOD does not acknowledge the important role the OB/GYN plays in the medical readiness mission, or the day-to-day operation of the USAF medical facility. In a deployment situation, OB/GYNs can be used as substitutes for general surgeons (AFSC 9416), which is one of the "most critical" specialties. If they don't deploy, OB/GYNs will either be used to staff receiving hospitals in the CONUS or continue to provide treatment at their hospitals where most of the staff has deployed to a contingency. OB/GYNs are also pivotal players in the Air Force's peacetime medical mission as they typically work more hours, and treat more patients than any other class of physician. The survey of USAF OB/GYNs bears this out as it indicated that 78% of OB/GYNs work more than 60 hours per week, and 42% work more than 70 hours per week on a sustained basis. Furthermore, nearly every respondent to the survey stated that OB/GYNs are the most heavily tasked physicians. In the opinion of the author, the nature of OB/GYN care also adds to the value of the OB/GYN. By nature, because OB/GYNs deliver babies and treat the spouses of military members for their "female-related" problems, they are providing "high emotion/high interest" care which can have a major impact on the overall patient population's level of satisfaction with their medical care.

The cut in ISP at a time when OB/GYNs feel they play a major role in the USAF medical mission is very frustrating and raises doubts in their mind about the real value of their contribution.

While USAF OB/GYNs have little control over their practices, and their compensation is not tied to their productivity, private sector OB/GYNs have a vastly different

experience. The private practice OB/GYN has considerable freedom to build his/her staff, decide who to treat, what hours to work and how much he will be paid for his services. Such freedoms are constitutionally based. OB/GYNs also have similar prestige and influence in dealing with hospitals. They sit on boards of directors, and participate directly in various forms of decision making to include: expectation setting, operating procedures and policies, long range planning, pricing and promotion, capital programs budgeting, disputes, recruitment etc. (2:180, 425) They also have several compensation options which can be tied directly to their productivity. (2:502-504)

By comparison, the private sector OB/GYN is able to see himself as much more important and influential in his environment than the USAF OB/GYN. The desire for "self esteem/control of practice" is a strong incentive for separating from the Air Force.

COMPENSATION: The disparity between USAF and private OB/GYN practice is also evident in compensation. The USAF OB/GYN receives two categories of compensation. As an Air Force Officer, he/she receives the same basic entitlements (base pay, BAQ, VHA, and subsistence pay) as other officers. (12:--) Additionally, the USAF OB/GYN can receive several forms of incentive pay depending on his/her professional status. These include Variable Special Pay, Additional Special Pay, Board Certified Pay, and Incentive Special Pay. (11:2-4) As stated earlier, current DOD policy will decrease, and probably eliminate, Incentive Special Pay for OB/GYNs by FY 89. The current compensation system for OB/GYNs was enacted in FY 81. As of 15 December 87, a board certified OB/GYN, in the grade of O-4 with five years in the Air Force received the following annual pay prior to taxes: (12:--)

Base Pay	27,698.40
BAQ w/dep	6,420.00
VHA (estimate)	600.00
Subsistence	1,351.80
Variable Special Pay	5,000.00
Additional Special Pay	9,000.00
Board Certified Pay	2,000.00
Incentive Special Pay	3,250.00

	\$55,320.20

Average compensation for private sector OB/GYNs looks quite different. According to the American Medical Association, the average net income (net income after expenses, before taxes) for OB/GYNs in 1985 was as follows:(1:104)

All OB/GYNs	\$122,700
Location	
--non-metropolitan	\$100,100
--metropolitan	
---below 1,000,000	\$127,100
---above 1,000,000	\$121,600
Age	
--below 36	\$ 84,300
--36-45	\$132,000
--46-55	\$138,800
--56-65	\$130,000
--over 65	\$ 76,000

As indicated, average compensation is affected by location and age of the OB/GYN. The lower compensation for non-metropolitan OB/GYNs, and those under 36 years old may make compensation less of a factor for USAF OB/GYNs who are considering separation. This is because many USAF OB/GYNs are under 36 when they separate and will have to establish themselves in non-metropolitan areas where the physician/patient ratio is lower. The distribution of OB/GYNs, and physicians in general, will be discussed later.

In comparing the compensation levels between the USAF and private sector, it is easy to see there is a significant difference. Even when using AMA data that are two years old (but the best available), there is nearly a \$30,000 per year discrepancy between USAF and private sector compensation. (\$84,300 vs \$55,320.20) The author presumes that the gap is larger now since OB/GYN net income has probably increased somewhat since 1985. In real terms however, the gap may be somewhat less because USAF OB/GYNs are compensated in other ways because they are Air Force physicians. They don't have to pay malpractice premiums, some of their income is not taxable, they have some measure of job security, they have a generous retirement plan, continuing medical education is free, medical care is essentially free, and BX/Commissary costs are lower than at off-base outlets. It appears that compensation by itself may be a powerful factor in making a USAF OB/GYN separate. The writer proposes however that complaints about compensation stem mostly from OB/GYN frustration over workload because most comments about compensation in the survey also mention the overwhelming workload, and many respondents said that if given the choice, they wouldn't work such hours for any amount of money.

WORKLOAD: Workload is clearly a major issue for USAF OB/GYNs. Of the seven most dissatisfying factors in their medical practices, which were cited in the survey of USAF OB/GYNs, five factors were closely tied to workload. The greatest dissatisfier was "Quantity of Support Staff" where 58.5% of the respondents were "very dissatisfied." "Quantity of Medical Staff" was second with 55.4% of the OB/GYNs very dissatisfied. "On-call" had a 46.2%, while "Administrative tasks" and "Workload" had 41.5% and 38.5% respectively. These statistics become more meaningful when remembering that 36.2% of the respondents said they work between 60-70 hours per week and 42.3% work more than 70 hours per week on a sustained basis. It's also important to note that survey respondents who work longer than 70 hours per week could not actually specify how many hours they actually work. They could only answer "more than 70." The author believes that many OB/GYNs actually work far beyond 70 hours per week because many narrative responses in the OB/GYN survey claimed 90-100 hour work weeks.

American Medical Association (AMA) statistics from 1985 indicate that the private sector OB/GYN has a vastly different work week. During 1985, private sector OB/GYNs spent the following number of hours in professional activities in an average work week: (1:36)

All OB/GYNs	60.2
Location	
--non-metropolitan	62.9
--metropolitan	
---less than 1,000,000	60.1
---more than 1,000,000	59.8
Age	
--less than 36	64.5
--36-45	65.9
--46-55	62.0
--56-65	57.4
--over 65	42.0

As indicated, physician age determines the number of hours worked, and physicians below age 45 work longer hours than those above 45 years of age. The writer believes that this is because as OB/GYNs get older and more established, their private practice enterprises also mature. This means the private sector OB/GYN must spend less time developing his/her medical practice and has enough clientele to warrant taking on partners in the business.

When comparing the workload of USAF OB/GYNs to the private sector, it is easy to see that a sizeable portion of

the USAF OB/GYN population works 10 to 20 hours per week more than the average private practice OB/GYN. This disparity is magnified by USAF OB/GYN's staunch belief that they work more hours than all other USAF physicians. This "mismatch" with other USAF physicians and private sector OB/GYNs is very real to the average USAF OB/GYN and is the biggest reason they separate as soon as their commitment is met.

MALPRACTICE PREMIUMS: In the absence of any equivalent burden in the USAF, and other factors being equal, the threat of malpractice premiums in the private sector should encourage USAF OB/GYNs to remain in the Armed Forces.

According to Martin L. Gonzalez, AMA Department of Medical Practice Economics, Center for Health Policy Research, "Professional liability insurance premiums averaged \$10,500 in 1985. Among OB/GYNs, the average was \$23,300." (1:12) "Since 1982, premiums have increased at an average annual rate of 21.9% for all physicians and 28.8% for OB/GYNs." (1:12) (See Table 1) It is clear that OB/GYNs entering private practice from the USAF will pay higher malpractice premiums than other physicians, and their premiums are growing at a faster rate.

	Average Premiums in thousands of dollars		Annual Percent Increase
	1982	1985	
ALL PHYSICIANS*	\$5.8	\$10.5	21.9%
Specialty			
General/Family Practice	3.5	6.7	24.2
Internal Medicine	3.7	5.8	16.2
Surgery	9.9	16.6	18.8
Pediatrics	2.9	4.7	17.4
OB/GYN	10.9	23.3	28.8
Radiology	4.9	9.1	22.9
Psychiatry	1.7	2.6	14.1
Anesthesiology	10.1	18.0	21.2

*Includes physicians in specialties not listed separately
Source: (1:13)

Table 1
Average Annual Professional Liability Insurance
Premiums of Self-Employed Physicians
by Specialty, 1982 and 1985

MALPRACTICE CLAIMS: As in the case of malpractice premiums, malpractice lawsuits are not a factor in USAF OB/GYN medical practice. They should however, influence a USAF OB/GYN to separate because of the effect they can have in the private sector on the cost of malpractice premiums and because of the psychological effects they can have on the physician.

According to Jack McCue, Associate Professor of Medicine and Chief of General Medicine and Geriatrics, Bowman Gray School of Medicine, Wake Forest University, "Fear of malpractice suits has become a nearly obsessive concern to physicians that influences their behavior out of proportion to the actual economic impact of such suits." (7:8)

As in the case of malpractice premiums, OB/GYNs are also in a category of their own regarding the frequency of malpractice claims. "Physicians were over three times more likely to incur a claim in 1985 than in years prior to 1981. The average annual rate of claims increased from 3.2 per 100 physicians before 1981 to 8.2 during 1981-1984, and 10.1 claims per 100 physicians in 1985." (See Table 2) Before 1981, OB/GYNs experienced claims at a rate of 7.1 per 100 physicians. Between 1981-1984, the rate increased to 20.6 per 100 physicians and was 26.6 by 1985. (1:12-13)

	Annual Claims Per 100 Physicians		
	1985	1981-1984	Prior to 1981
ALL PHYSICIANS*	10.1	8.2	3.2
Specialty			
General/Family Practice	5.5	6.1	3.3
Internal Medicine	6.3	6.4	1.9
Surgery	16.5	11.9	4.1
Pediatrics	7.6	4.4	2.3
OB/GYN	26.6	20.6	7.1
Radiology	12.9	7.1	2.4
Psychiatry	2.4	3.1	0.6
Anesthesiology	6.5	7.2	3.0

*Includes physicians in specialties not listed separately
Source: (1:14)

Table 2
Average Incidence of Malpractice Claims
by Specialty

PHYSICIAN DEMAND: This is also a factor which is felt primarily in the private sector, but must be considered by USAF OB/GYNs who are thinking about leaving the Air Force.

Due to continuing increases in the number of physicians, and the emergence of Health Maintenance Organizations (HMOs), the volume and location of future demand for OB/GYNs in the private sector is uncertain. Between 1970 and 1983, the number of OB/GYNs in the US grew from 18,900 to 29,300. (See Figure 1) This is a 55% increase. During the same period, the number of all physicians in the United States also increased from 334,000 to 519,000. (10:91) (See Figure 2) This is a 55.5% increase and is nearly identical to the growth rate of OB/GYNs.

The growth of the physician population has outstripped the growth of the patient population. In 1970, there were 348 physicians per 100,000. By 1983 there were 542 physicians per 100,000 people. (10:90)

There are various interpretations of these figures. The most pessimistic view is presented by the Graduate Medical Education National Advisory Committee (GMENAC). The 1980 GMENAC report is the standard work on which US policy makers rely when searching for data on future medical needs. According to the report, there will be a significant excess of physicians (70,000) by 1990 and 145,000 unneeded physicians by the year 2,000. (5:861-2) A more conservative estimate of the excess is presented by the Department of Health and Human Services. It projects a 35,300 surplus by 1990 and a 51,800 physician surplus by 2,000. (5:861) The American Medical Association is less inclined to admit to a current or projected near term surplus as stated by Dr James H. Sammons, executive vice-president of the AMA in 1985. He stated, "The AMA position-always subject to change-is that we do not believe there is a surplus of physicians, nor are we in favor of artificial efforts to manipulate the system." (4:862)

Other experts feel the geographic movement of physicians is an indicator of the surplus. Nancy E. Gary, M.D. writes about two of them in the July 1986 issue of the Journal of Medical Education:

According to William Schwartz's 30 Oct 1980 New England Journal of Medicine paper, "The Changing Geographic Distribution of Board Certified Physicians," the migration of specialists to less densely populated areas is documented. These data would support the notion that we are training too many specialists....Furthermore, as Robert Petersdorf pointed out in the 27 Oct 1983 issue of

Source: (10:91)

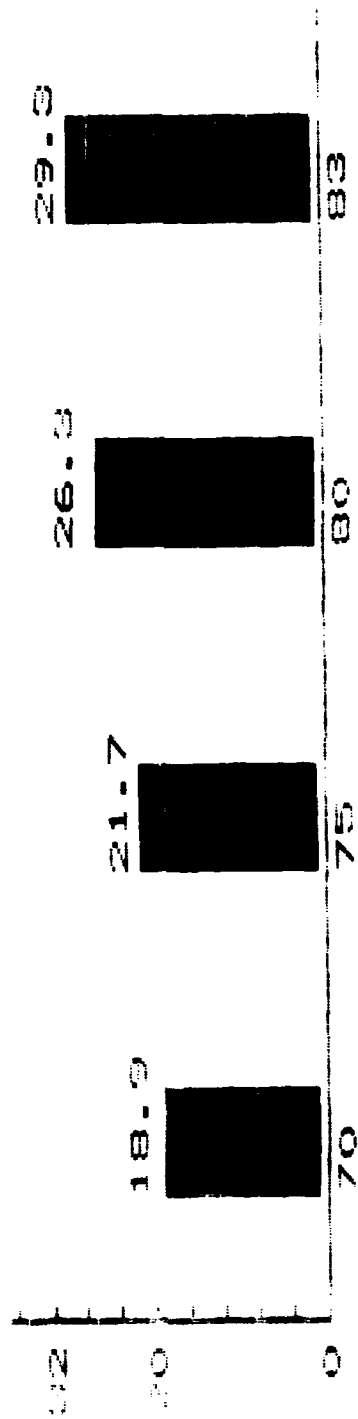


FIGURE 1
GROWTH OF OB/GYNS (X 1,000)

Source: (10:91)

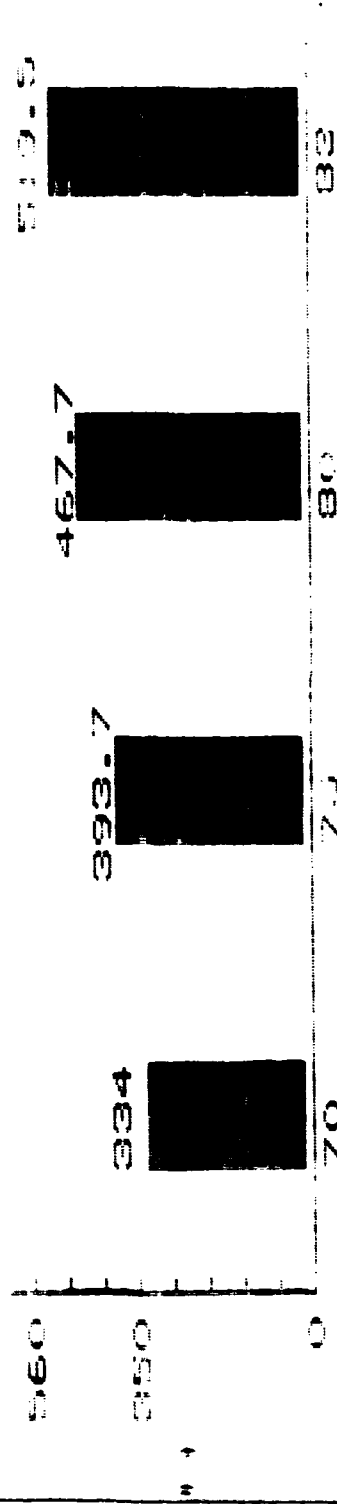


FIGURE 2
GROWTH OF PHYSICIANS (X 1,000)

the New England Journal of Medicine, there probably is not a need for more than 50 percent of the graduates to enter specialty and subspecialty training. (3:615)

Although there may be an oversupply of physicians, some experts suggest we may only be seeing a distribution problem. According to Richard L. Jackson, president of one of the nation's largest physician search teams:

Fifty percent of all physicians practice in only eight states, and over 1,500 counties continue to be designated by the Federal Register as "health manpower shortage areas." Moreover, in our recent survey of 1,000 hospitals, over 58 percent of the hospitals polled were looking for physicians. Particularly hard hit are small hospitals—80 percent of small hospitals in the south, with fewer than 50 beds are, in fact, recruiting physicians. (6:104)

The concentration of physicians in certain "most desirable" areas is further explained by the California Medical Association in a "White Paper on Physician Oversupply." It said:

California's supply of physicians in 1982 exceeded by 12%, or more than 5,800 physicians, the number required to serve the state's population...nearly every specialty in California is oversupplied....Gastroenterology and general internal medicine are the only major specialties in which supply falls short of the number deemed necessary. (5:862)

As these experts suggest, future demand for additional physicians is uncertain. It appears the volume of physicians either has, or soon, will saturate the demands of the American population. Regardless of which position is taken, the long-term future may force many physicians to settle in rural areas, or at least smaller cities where the patient/physician ratio presents a greater demand for their services. This may present a problem for OB/GYNs who may find lower salaries in non-metropolitan areas, yet have the same malpractice premiums as their counterparts in the large metropolitan cities.

The growth of Health Maintenance Organizations (HMOs) also clouds the picture for private sector opportunities for OB/GYNs. Between 1976 and 1985, enrollment in HMOs increased from 6,016,000 to 18,894,000. (10:90) (See Figure 3)

Source: (10:90)

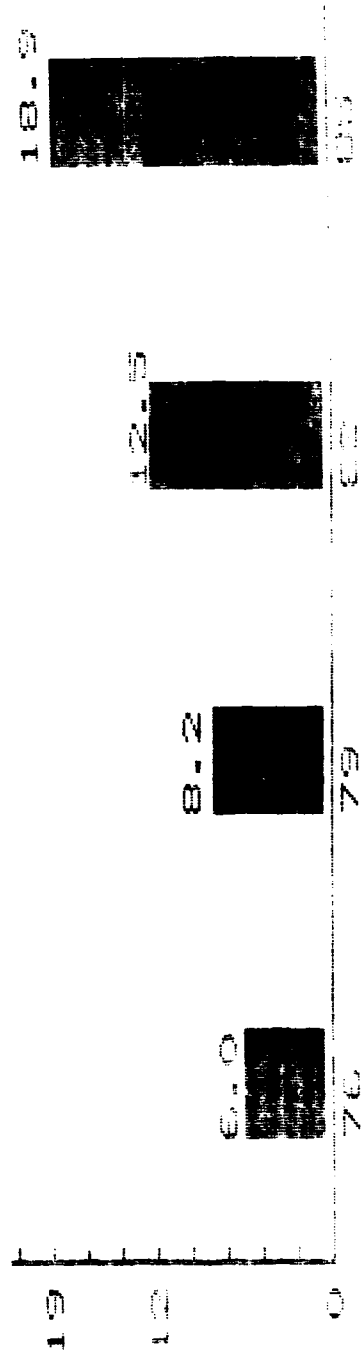


FIGURE 3
HIV ENROLLMENT (X 1 MILLION)

An article by Michie Hunt, "Managed Care in the 1990s," in the December 85 issue of "Health Care Strategies Management" indicates that...by 1990 over 65 percent of the US population will belong to HMOs. This projection isn't far off the mark since 25 percent of the population of Minneapolis/St Paul belonged to an HMO in 1983, and one year later, 35 percent were enrolled. (3:615)

This growth of HMOs indicates the trend of the future for delivery and payment for medical care. These structures are highly motivated by cost containment, and reward physicians financially for cost containment measures that include not requesting consultations. Dr Nancy E. Gary, M.D. accurately describes the situation:

In these operations, the Primary Care physicians have the ability (and motivation) to control dollars that will be spent for care rendered by specialists. The specialties of surgery and subspecialties of medicine, if not now, will soon have a supply of physicians that exceeds projected need....There appears to be a trend in managed health care systems that financially favors the general practitioner and ultimately may control and reduce the flow of dollars to specialists. (3:616)

It is clear from these experts that the rapid growth of the physician population, and the emergence of HMOs as the healthcare delivery scheme of the 1990s raise serious doubts about future demands for OB/GYNs. Therefore, Physician Demand, as a decision factor for USAF OB/GYNs, should convince many of them to stay in the Air Force, or at least lower their expectations for private sector compensation.

BUSINESS STRESSES: Several respondents to the survey of USAF OB/GYNs said they were pleased that they did not have to endure many of the business-related stresses as their private sector counterparts. This report previously showed that private sector physicians have to face the national tendency toward malpractice. Private sector physicians also must pay the cost of starting their medical practices. They must also manage the business aspects of their practice to include budget, personnel, marketing, billing, collection, purchasing, and patient administration. For the sake of profitability and viability of their practice, physicians are also forced to balance quality medical treatment with the patient's ability to pay. Respondents to the OB/GYN survey repeatedly stated that they were pleased with not having to worry about whether or not patients could pay for the treatment they need. This concern is further described by

Jack D. McCue, Associate Professor of Medicine and Chief of General Medicine and Geriatrics at Wake Forest University:

Business and legal stresses are, to some degree, encountered by anyone who owns a small business. There is in medicine, however, a profound conflict between the ordinary profit motive and our universally professed altruism that is not found in most professions. Even the simplest setting of a price for service is something most of us feel uncomfortable doing. Ironically, a "big sale" in the business world, one that would bring recognition and financial reward to a businessman, is equivalent to a catastrophic illness in medicine because the physician's reimbursement is generally related to the severity of the patient's illness. (7:11)

As the reader has seen, private sector OB/GYNs face several forms of business-related stresses. The prospect of encountering these stresses should cause the USAF OB/GYN to lean toward remaining in the military.

Chapter Five

OTHER CONSIDERATIONS

As senior leaders deal with the causes of the OB/GYN retention problem, they must also be aware of trends during the past 15-20 years in the private healthcare industry, the USAF medical system, and the patient population of the USAF. These trends will drive requirements for staffing and funding future medical operations, and will consequently influence the course of programs designed to retain more OB/GYNs. These trends specifically involve the following: total expenditures for healthcare and physician services, the method of treatment (inpatient vs outpatient), life expectancy, and the growth of the retiree population.

Between 1970 and 1985, the annual bill the United States paid for medical care grew from 75 billion dollars to 425 billion dollars. (See Figure 4) This is an increase of 466%. (10:84) Some of this increase can be discounted due to inflation which totaled 112.5% between 1970-85. (10:465)

Although the increase in "Total Expenditures" for healthcare in the United States is significant, the figure includes all costs including such things as costs for research, construction, drugs, dental services, hospital care and nursing home care. More germane to the study of OB/GYN retention however, is the growth of expenditures for physician's services. Between 1970 and 1985, spending for physician's services in the United States increased from 14.3 billion dollars to 82.8 billion dollars. (See Figure 5) This represents an increase of 479%. (10:85) This is important because it means that the cost of physician's services actually climbed at a faster rate than overall healthcare costs.

Primarily as a cost containment measure, Americans have changed one of the circumstances of their medical treatment. For the past five years, they have been less likely to be actually admitted to a hospital (inpatient), and more likely to be treated at a walk-in clinic (outpatient). In 1980, there were 159 admissions per 1,000 people. By 1984, admissions per 1,000 people had decreased to 149. (10:96) This downward trend has continued as admissions fell 4% in 1986. (4:102) Between 1980 and 1984, outpatient visits

Source: (10:84)

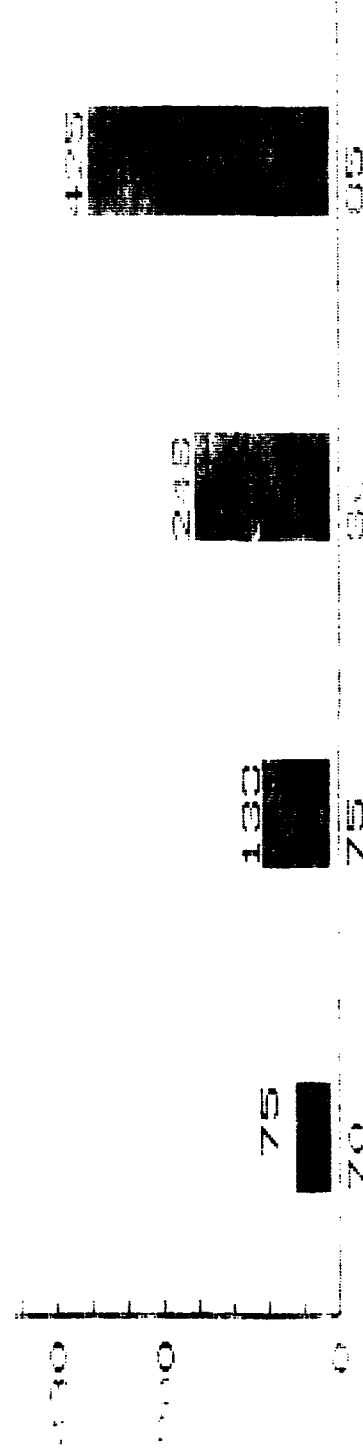


FIGURE 4
EXPENDITURES FOR HEALTH CARE (BILL)

Source: (10:85)

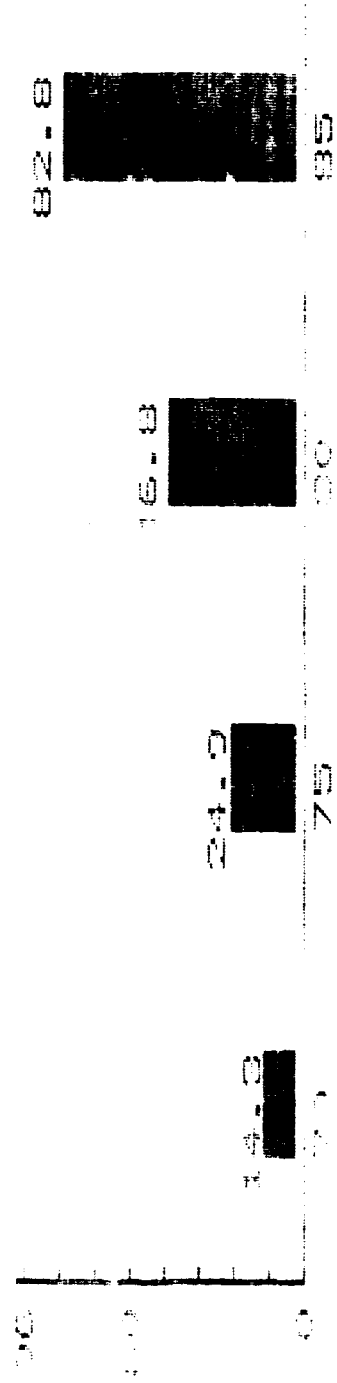


FIGURE 5
EXPENDITURES FOR PHYSICIAN SERVICES

increased slightly from 913 per 1,000 people, to 917 per 1,000 people. (10:96) So there appears to be a noticeable shift from inpatient treatment to outpatient treatment.

The Air Force experienced a similar trend between FY 83 and FY 87. (See Table 3) Total inpatient admissions dropped sharply from 284,000 in FY 83 to 256,000 in FY 87. During the same period, outpatient clinic visits climbed from 16,719,000 to 16,813,000. (14:--) OB/GYN clinic visits have also followed this trend by growing from 565,000 in FY 83 to 576,000 visits in FY 87. The writer believes that in both total outpatient clinic visits and OB/GYN clinic visits, the number of visits would have probably climbed higher if the clinics had the excess capacity to meet the demand. Instead, he believes, the increased demand was most likely met through CHAMPUS. A study of CHAMPUS utilization for the last few years would probably bear that out.

	FY83	FY84	FY85	FY86	FY87
Total Visits	16,719	16,811	16,821	16,896	16,813
Total Admissions	284	282	275	267	256
OB/GYN Visits	565	575	577	595	576
Source: (14:--)					

Table 3
 USAF Hospital Utilization
 Inpatient Admissions and Clinic Visits
 FY 83 thru FY 87
 (x 1,000)

As shown, the USAF trend toward outpatient treatment reflects the national trend.

The military retiree population, as a group, has a significant need for medical services which must be considered by USAF leadership. Not only is the retiree population large, but it has been growing constantly. (See Table 4) In 1950, there were only 132,000 retirees of the Armed Forces. By 1980, the retiree population reached 1,479,000. (10:326) In the opinion of the author, massive enlistments in the mid and late 1960s will continue to fuel

the growth of the retiree population, as the Vietnam-era veterans become eligible to retire.

Year	Military Retirees x 1,000
1950	132
1960	256
1970	773
1975	1,073
1980	1,330
1985	1,479

Source: (10:326)

Table 4
US Armed Forces Retiree Population
1950-1985

The rapid growth in retirees clearly shows that the demands for healthcare in the USAF will continue to grow and that senior leadership must prepare for this as they decide what they are willing to do to recruit and retain OB/GYNs.

Further increasing the burden placed on the USAF medical system by retirees is the steady increase in longevity. (See Table 5) As of 1985, the average life expectancy for residents of the United States was 74.7 years, compared to 69.7 years in 1960. (10:69)

Year	Life Expectancy (years)
1960	69.7
1970	70.8
1975	72.6
1980	73.7
1985	74.7

Source: (10:69)

Table 5
Life Expectancy in the United States
1960-1985

In summary, if the Air Force is going to continue to maintain a complete "bluesuit" OB/GYN capability, it must begin to accept and act upon three basic facts. First, medical care and physicians services in the late 1980s are expensive. Therefore, USAF leadership needs to look at the growth in its spending for physician recruitment and retention and see if it even vaguely resembles the growth in costs for physician's services in the private sector. Ultimately, incentive payments must be increased to aid in retention, and staffing increased to meet increasing demand. Secondly, utilization trends in the healthcare system indicate that hospital staffs should be adjusted to deal with the shift to outpatient medical treatment. This means that technical and administrative support staffs should be moved to OB/GYN clinics and support functions to make the OB/GYN more efficient. Finally, the explosion of the retiree population, magnified by longer life expectancy, guarantees that the demand for all physicians will continue to grow for several more years. As a result, physician staff levels from as recently as 1983 are not suitable for the continuous growth of the patient population. The Air Force needs more OB/GYNs now, and even more in the future.

Chapter Six

COMMERCIAL OB/GYN CONTRACTS

As a result of the shortage of USF OB/GYNs, approximately ten USAF medical facilities are establishing local contracts for commercial OB/GYN services. Two of these are already operating under contract arrangement. These contracts have been necessary because the shortage of OB/GYNs has either left these facilities without any OB/GYNs at all, or left them with a seriously degraded OB/GYN capability. In some cases, OB/GYNs in one and two man shops were consolidated, leaving some facilities without OB/GYNs. (15:--)

While local contracts are often the only way to continue to provide OB/GYN care, they can only be considered suitable in the short-term. They are by no means an acceptable long-term response to the OB/GYN shortage for the following reasons:

a. Locally established commercial contracts are expensive. The reasons why they are expensive are not important. It's just important to realize that they require huge sums of money. The simplest way to illustrate this is to use one of the new contracts as a sample. (15:--) The hospital which secured the sample contract was authorized two OB/GYNs, but had none on staff. To fill it's shortfall of two OB/GYNs, and meet it's wide range of surgical and clinical OB/GYN requirements, the hospital secured a nine month local commercial contract to have contract OB/GYNs treat USAF patients within the USAF medical treatment facility. The nine month contract which expires at the end of FY 88 cost \$441,338.20. Since cost accounting is normally conducted on a twelve month basis (fiscal year), it is useful to consider what such a contract would cost for twelve months. For the sake of this illustration, it's not necessary to consider the effects of fixed and variable costs when converting from a nine month to a twelve month contract. It's only important to realize that a considerable sum of money is being paid by the sample hospital to compensate for its lack of two OB/GYNs. When considering a twelve month contract, the cost increases to about \$588,000. At this cost, the hospital is spending about \$294,000 to fill each of it's OB/GYN vacancies. Considering that ten

hospitals could soon have these contracts, at about \$600,000 per facility, the total cost of these contracts could reach \$6,000,000. Consider that if each facility is compensating for a shortfall of two OB/GYNs, they are spending about \$6 million to replace 20 OB/GYNs. (10 hospitals x 2 OB/GYNs per hospital) Additional funding has not been appropriated to meet this expense, so these contracts must be paid out of hospital operating funds. This is a major concern at a time when budgets are shrinking.

b. Although contracted OB/GYNs will provide basic OB/GYN services, they will not perform several other functions normally provided by USAF OB/GYNs. They will not work in the Emergency Room. Although they will supervise nurse practitioners and midwives in the role of a "preceptor", they will not be supervisors in the organizational sense as raters, evaluators, and policy makers. Although one of the contracted physicians will be designated as Chief of OB/GYN Services, he/she will only have direct supervisory authority over the other contracted physicians. They will also not be available for after-hours disaster response activities, and will not be tasked to extend their hours during actual wartime contingencies. (15:-
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c. In the opinion of the author, the short duration and nature of these contracts can degrade the continuity and harmony of the organization. In many cases, as a contract employee, the contracted OB/GYN is not responsible to the hospital commander or chief of hospital services. In matters of contract performance, the hospital commander has recourse, if he/she is willing to use the process described in the contract. In more subtle areas such as policies within the OB/GYN clinic, the hospital commander may find it difficult to direct the activities of the contracted OB/GYNs. It can be done but will be more difficult than if the OB/GYNs were "bluesuiters." As a contract employee, the OB/GYN can also appear to be an outsider. This can affect the contracted OB/GYNs willingness to make any long-term improvements in the performance or capabilities of the OB/GYN clinic. The presence of these high-priced outsiders can also affect the morale of the USAF personnel on the staff.

Locally contracted OB/GYN care is expensive and has limitations. The USAF needs to find a more effective and long-term way to deal with the OB/GYN retention problem.

Chapter Seven

CONCLUSIONS

The battle for retention of OB/GYNs is winnable if senior leadership would recognize that the challenge comes not only from outside the military but from inside as well. USAF medical policy makers must now acknowledge that, although there are attractive opportunities for the OB/GYN in the private sector, most USAF OB/GYNs separate due to the situations they face within the military medical system. Simply stated, they are driven out of the Air Force, not lured out.

Workload is the overwhelming reason that OB/GYNs separate. USAF OB/GYNs typically work many more hours than their private sector counterparts, and usually work longer hours than any other physicians in the Air Force. This is caused by inadequate OB/GYN staffing, lack of medical and administrative support staffing, Emergency Room duty, and on-call. The situation is at it's worst in the two-man OB shops. Their plight seems even more intolerable because they feel senior leadership doesn't accept that there is a problem, and local commanders aren't willing to make the tough decisions that would reduce the burden on their OB/GYN staffs. Emotions about workload are so strong that OB/GYNs are willing to endure the risks of private practice in order to get relief. As stated earlier, private sector OB/GYNs have massive malpractice payments, and are sued more than any other class of physician. They also must endure the stresses of managing their medical practices. Furthermore, the demand for OB/GYNs is uncertain and many who leave the Air Force may have to practice in undesirable areas. Several USAF OB/GYNs seem concerned about these negative factors of private practice, but are more concerned about how their USAF medical practice affects their mental and physical health. Most USAF OB/GYNs see private practice as the only way to regain any control over the amount of time they work. If the Air Force would take concrete action to moderate OB/GYN workload, many of these people would remain in the Air Force. Survey results showed that over 37% of those planning to separate would probably stay in the Air Force if specific workload standards were implemented.

Although compensation is a concern for most USAF

OB/GYNs, it appears to be partially linked to their dissatisfaction with workload. Therefore, if workload is moderated, compensation should become less of an issue. It's important to acknowledge however, that there are costs associated with decreasing OB/GYN workload to quell their complaints about compensation. Although workload can be lessened by such in-house actions as giving the USAF OB/GYN better medical and administrative support and relieving them of such additional duties as Emergency Room rotation, the Air Force still must do two things to completely solve the workload issue. In the short-term, USAF will have to send more patients out to CHAMPUS, which is already over its budget. In the long-term it will have to increase OB/GYN staffing, which will be costly. As these steps succeed in increasing retention, many of the cases sent out to CHAMPUS can be brought back into the USAF medical facilities.

If moderating workload is not seen as the sole means of dealing with the compensation issue, then enhanced incentive payments should be considered. Although increasing ISP to \$30,000 for OB/GYNs is very expensive, it does more about the OB/GYN retention problem than expensive commercial contracts. Consider that the approximate costs of these contracts should reach \$6 million per year when all ten hospitals, which are currently pursuing such contracts, finish their work. The Air Force receives no marginal benefit in the area of retention from these contracts. Now consider that \$30,000 ISP for 164 OB/GYNs will cost \$4.39 million the first year. ($\$30,000 - \$3,250$ [current ISP] = $\$26,750$ [increased cost for ISP]; then $164 \times \$26,750 = \4.39 million) For that cost, the Air Force could expect to retain 14 additional OB/GYNs. This is derived by: $(35$ [separations per year] $\times 42.1\%$ [in the OB/GYN survey who are separating but would stay if ISP were raised] = 14.73 more OB/GYNs. Retaining 14 extra OB/GYNs would reduce the need for contract OB/GYNs by the same amount. This is a contract savings of \$4.11 million. ($14 \times \$294,000$ per OB/GYN covered by contract.)

A less expensive and perhaps equally effective alternative to this plan involves keeping annual ISP at \$3,250, but offering \$30,000 bonuses to those OB/GYNs who are willing to sign extended contracts. That would spread the cost of these payments over several years and still convince many USAF OB/GYNs to stay in the Air Force. It is the author's belief, based on survey results, that such a large cash payment captures the attention of the average USAF OB/GYN.

The potential cost of decreasing workload, or increasing staffing or compensation, suggests that perhaps it would be

cheaper to just ignore the retention problem altogether and just recruit more OB/GYNs. Although this issue is not within the scope of this report, it deserves comment. Admittedly, for the \$4.39 million it would cost to raise ISP to \$30,000, the Air Force could put several more OB/GYNs through medical school. This may be easier said than done since the Air Force is already struggling to meet its FY 88 recruiting objectives. (IC:--) It's not likely, under the current system of compensation and obligation that the USAF could succeed in recruiting a significantly larger number of OB/GYNs per year.

USAF leadership is now at the point where it must decide whether or not it wants to continue to provide OB/GYN care in its medical facilities. It would appear that it does, if a willingness to pay \$6 million in OB/GYN contracts is an indication. If it's in the best interests of the Air Force to maintain a full OB/GYN capability, then its leadership must accept and act on certain facts. Due to massive increases since 1970, physician's services are extremely expensive. Therefore, senior leadership must be willing to accept that the cost of physicians services in the Air Force will also be expensive. Once they are willing to bear the costs of maintaining an OB/GYN capability, they must understand that proactive efforts such as increasing staffing and compensation are more promising than reactive measures such as commercial contracts. Failure to build an OB/GYN capability which is large enough to deal with the growing patient population places the burden on the local OB/GYNs, whose only ethical response is to work as hard as they can for as long as they can...until they burn out. In the absence of any staffing increases, or compensation enhancements, leadership must at least specify workload limitations for OB/GYNs and provide for some method of enforcement of these standards. Hospital commanders must also adjust their medical and administrative support staffs, (RNs, med techs, admin techs) to deal with shifts in hospital utilization. Due to the growth in demand for outpatient treatment, and decrease in demand for inpatient admissions, the support staffs must be adjusted to make maximum use of limited OB/GYN physicians. Most OB/GYNs feel they could see more patients in less time if they had adequate support staff.

As long as the Air Force continues to have an OB/GYN capability in its medical facilities, the USAF OB/GYN is a valuable resource. Consequently, leadership at all levels must act to retain them. These actions must target the causes of low retention which are: workload, lack of esteem/control over their medical practices, and lack of sufficient compensation. Actions must also reflect the realities of conducting medical operations in the 1990s.

Chapter Eight

RECOMMENDATIONS

HQ USAF must decide whether or not it is really in its best interests to maintain an Air Force-wide military OB/GYN capability. A well-considered position on this matter will give the Air Force sufficient resolve to do what is necessary to carry out this policy. Policies must address the factors currently causing low retention, and must consider the high cost of stopgap commercial contracts.

HQ USAF must review the growth in spending for recruiting and retaining their physicians to see if growth in this area realistically reflects the cost of these activities in the 1990s.

HQ USAF must impose maximum work limits for its OB/GYNs to align them closer to private sector OB/GYNs. This will also help to correct the disparity in workload between USAF OB/GYNs and other Air Force physicians. Work limits must be developed at HQ USAF and be sufficiently coordinated to ensure the support of line commanders. Directives must include specific instructions for hospital commanders to follow to avoid exceeding these work limits. Instructions could include use of emergency rooms, acute care clinics, or CHAMPUS.

HQ USAF must consider the value of increasing financial incentives for OB/GYNs. Compensation could range from drastically increasing annual ISP, to paying large bonuses to OB/GYNs willing to commit to long-term contracts.

HQ USAF should consider changing the whole incentive program, tying it directly to productivity. For instance, the OB/GYN would be paid a specific bonus for each birth, each major surgical procedure, each minor surgical procedure, and each outpatient visit.

HQ USAF should review growth in the retiree population and increase overall OB/GYN manning appropriately. Particular emphasis should be given to eliminating two-man OB shops.

HQ USAF should direct hospital commanders to adjust

their medical and administrative support staffs to maximize OB/GYN productivity in outpatient clinics. Direct commanders to report actions they have taken.

HQ USAF should develop a hot line, staffed by a motivated and aggressive OB/GYN who is interested in defusing the frustration and helplessness felt by most OB/GYNs. This hot line would allow OB/GYNs to bypass the "chain of command," which most feel stifles their attempts to solve their problems. This OB/GYN must have access to AF/SG in order to effectively deal with situations that arise.

HQ USAF should direct its medical facilities to have local programs which closely track the acquisition of supplies and equipment for OB/GYNs, and require an ongoing dialogue between the Director of Medical Logistics and the senior OB/GYN on staff. Current customer education and physician orientation programs don't require detailed contact between the senior logistician and senior OB/GYN on matters of supply support.

HQ USAF should consider moving those HPSP physicians (who want to), to a medium or large facility for the last two years of initial commitment.

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APPENDIX

Appendix A

USAF OB/GYN SURVEY QUESTIONNAIRE



DEPARTMENT OF THE AIR FORCE
AIR UNIVERSITY
AIR COMMAND AND STAFF COLLEGE
MAXWELL AIR FORCE BASE, AL 36112-5542

3824 STUS/41

1 Dec 87

Obstetrician Retention Survey, SCN 87-127, Exp 31 Jan 88

Survey Recipient

1. In conjunction with Air University, I am studying obstetrician retention in the United States Air Force. The loss of highly skilled specialty practitioners has major implications concerning the quality and range of medical care the Air Force can provide. It also significantly affects the cost of that care.
2. We've been concerned about low obstetrician retention for several years, but have never gotten beyond acknowledging that it's a problem. In order to correct this situation, it is first essential that we establish, and document, the attitudes and perceptions of Air Force obstetricians. I have developed the attached survey to obtain that information.
3. Please answer the questions as candidly as possible, so our information is accurate. Your participation is voluntary, and no attempt will be made to attribute answers to specific people. As a service to you, we intend to send the results of this survey to you as soon as they are available. I solicit and thank you for your prompt cooperation in this important effort. Your inputs will assist us in making authoritative recommendations to correct this situation.

STEVEN P. HELLMANN, Major, USAF, MSC
Survey Project Officer

1 Atch
Retention Survey

UNITED STATES AIR FORCE



SEPTEMBER 18, 1947

SURVEY INSTRUCTIONS

1. Do not write your name or social security number on the answer sheet.
2. Select the single best answer to each question.
3. Use a no. 2 pencil when marking your answers on the answer sheet.
4. Please mark your answers on the computer answer sheet provided.
NOTE: Please mark your written answers on the survey sheet.
5. Be sure your answer marks blacken the entire rectangle on the computerized answer sheet.
6. Be sure to mark your answers carefully so that you enter them opposite the same answer sheet number as survey question number.
7. Upon completion, please place your answer sheet and the survey in the attached envelope and forward to your administration section for mailing.
8. Please try to return the answer sheet by 20 December 1987, so that we may submit our recommendations by 1 February 1988.
9. Thank you for your cooperation.

1. What is your present age?
 - a. 30 or less
 - b. 31-33
 - c. 34-36
 - d. 37-40
 - e. Greater than 40

2. What is your current rank?
 - a. Captain
 - b. Major
 - c. Lieutenant Colonel
 - d. Colonel

3. How many years have you been on active duty?
 - a. Less than 2 years
 - b. 2-3 years
 - c. 4-7 years
 - d. Over 7 years

4. In which Major Command have you been primarily assigned? (Please answer in question 4 or 5.)
 - a. SAC
 - b. TAC
 - c. ATC
 - d. MAC

5.
 - a. USAFE
 - b. PACAF
 - c. AAC
 - d. Other (Please state)

6. How much civilian practice did you have prior to coming on active duty?
 - a. Less than one year
 - b. 1-3 years
 - c. 4-6 years
 - d. 7-10 years
 - e. More than 10 years

7. How much time do you have left from your original commitment?
 - a. Less than one year
 - b. 1-2 years
 - c. 3-4 years
 - d. More than 4 years

8. Have you had a break in service since you were commissioned as a military physician?
- a. Yes
 - b. No
9. What is your marital status?
- a. Married
 - b. Unmarried
10. How many children do you have?
- a. None
 - b. 1-2
 - c. 3-4
 - d. More than 4
11. How many PCS moves have you had in your career?
- a. 1
 - b. 2-3
 - c. 4-5
 - d. More than 5
12. How long have you been at your current base?
- a. Less than 6 months
 - b. More than 6 months, less than 2 years
 - c. More than 2 years, less than 3 years
 - d. More than 3 years, less than 4 years
 - e. More than 4 years
13. What are your current intentions toward remaining in the Air Force beyond your current commitment?
- a. Not applicable; I have no commitment
 - b. Probably will remain beyond my commitment
 - c. Undecided, leaning toward remaining
 - d. Undecided, leaning toward separating
 - e. Probably will separate at the end of my commitment
14. Think back to when you were commissioned and began active duty. What was your intent in regard to making the Air Force a career?
- a. Definitely would make the Air Force a career.
 - b. Probably would make the Air Force a career.
 - c. Probably would not make the Air Force a career.
 - d. Definitely would not make the Air Force a career.
 - e. Undecided about making the Air Force a career

Using the following scale, please rate your level of satisfaction or dissatisfaction with the following factors:

	Very Dissatisfied	Somewhat Dissatisfied	Neither Opinion	Somewhat Satisfied	Very Satisfied
15. Base Housing	(a)	(b)	(c)	(d)	(e)
16. Quality of AF Leadership	(a)	(b)	(c)	(d)	(e)
17. Work schedule	(a)	(b)	(c)	(d)	(e)
18. Promotion Opportunities	(a)	(b)	(c)	(d)	(e)
19. Evaluation System	(a)	(b)	(c)	(d)	(e)
20. Job effects on the family morale (free time, leave, PCS moves)	(a)	(b)	(c)	(d)	(e)
21. Medical Benefits	(a)	(b)	(c)	(d)	(e)
22. Financial Compensation	(a)	(b)	(c)	(d)	(e)
23. Freedom to make independent decisions	(a)	(b)	(c)	(d)	(e)
24. Opportunity for spouse to have a career	(a)	(b)	(c)	(d)	(e)
25. Training Opportunities (CME)	(a)	(b)	(c)	(d)	(e)
26. BX/Commissary	(a)	(b)	(c)	(d)	(e)
27. Retirement plan	(a)	(b)	(c)	(d)	(e)
28. Ability to stay proficient in the range of OB/GYN procedures	(a)	(b)	(c)	(d)	(e)
29. Quality of Medical Staff	(a)	(b)	(c)	(d)	(e)
30. Quantity of Medical Staff	(a)	(b)	(c)	(d)	(e)
31. Quality of Medical Equipment	(a)	(b)	(c)	(d)	(e)

	Very Dissatisfied	Somewhat Dissatisfied	No Opinion	Somewhat Satisfied	Very Satisfied
32. Quality of support staff	(a)	(b)	(c)	(d)	(e)
33. Quantity of support staff	(a)	(b)	(c)	(d)	(e)
34. Respect from Commander and staff	(a)	(b)	(c)	(d)	(e)
35. Ancillary training (Readiness)	(a)	(b)	(c)	(d)	(e)
36. Medical Library	(a)	(b)	(c)	(d)	(e)
37. Office space	(a)	(b)	(c)	(d)	(e)
38. Peer review	(a)	(b)	(c)	(d)	(e)
39. Authority that is commensurate with training and ability	(a)	(b)	(c)	(d)	(e)
40. Immediate supervisor	(a)	(b)	(c)	(d)	(e)
41. Administrative tasks (record reviews, meetings, forms)	(a)	(b)	(c)	(d)	(e)
42. Amount of "on call"	(a)	(b)	(c)	(d)	(e)
43. Amount of TDY	(a)	(b)	(c)	(d)	(e)
44. Hospital formulary	(a)	(b)	(c)	(d)	(e)
45. Supply support	(a)	(b)	(c)	(d)	(e)
46. Recognition programs	(a)	(b)	(c)	(d)	(e)
47. Hospital Organization	(a)	(b)	(c)	(d)	(e)
48. Opportunity to make suggestions and improvements	(a)	(b)	(c)	(d)	(e)

49. Senior leaders in the Air Force are well aware of the depth and seriousness of the obstetrician retention problem.

- a. Strongly Agree
- b. Agree
- c. Neither agree or disagree
- d. Disagree
- e. Strongly Disagree

50. There is adequate compensation, in terms of total pay and benefits, for the inherent hardships of an Air Force career.

- a. Strongly Agree
- b. Agree
- c. Neither agree or disagree
- d. Disagree
- e. Strongly Disagree

51. If you decide to separate and money is a factor, would increasing annual incentive specialty pay to \$30,000 induce you to remain in the Air Force?

- a. Not applicable; compensation is not a factor in my decision
- b. Undoubtedly Yes
- c. Probably Yes
- d. Undoubtedly No
- e. No, but it may have convinced me in the past

52. If you decide to separate and workload is a factor, would addition of one more obstetrician to your staff convince you to stay in the Air Force?

- a. Not applicable; workload is not a factor in my decision
- b. Undoubtedly Yes
- c. Probably Yes
- d. Undoubtedly No
- e. No, but it may have convinced me in the past

53. If you decide to separate and workload is a factor, would you consider staying in the Air Force if the USAF developed mandatory maximum workload standards for obstetricians? (These standards would force hospital commanders to refer patients to other sources of care to avoid overwhelming their OB/GYN capability.)

- a. Not applicable; workload is not a factor in my decision
- b. Undoubtedly Yes
- c. Probably Yes
- d. Undoubtedly No
- e. No, but it may have convinced me in the past

54. Certain USAF physician specialties receive more incentive specialty pay than others because they are termed "most critical". What impact to you feel this has on the Medical Corps as a whole?

- a. Very Positive
- b. Somewhat Positive
- c. No Impact
- d. Somewhat Negative
- e. Very Negative

55. How many obstetricians are on staff at your hospital?

- a. 1
- b. 2
- c. 3-5
- d. More than 5

56. On the average, how many hours do you spend at work each week?

- a. Less than 40 hours
- b. More than 40 hours, less than 50 hours
- c. More than 50 hours, less than 60 hours
- d. More than 60 hours, less than 70 hours
- e. More than 70 hours

57. What percentage of your hours in the hospital are devoted to inpatient care?

- a. Less than 20%
- b. More than 20%, less than 40%
- c. More than 40%, less than 60%
- d. More than 60%, less than 80%
- e. More than 80%

58. What percentage of your hours in the hospital are devoted to outpatient care? (Includes emergency room)

- a. Less than 20%
- b. More than 20%, less than 40%
- c. More than 40%, less than 60%
- d. More than 60%, less than 80%
- e. More than 80%

59. On the average, how many days per month are you "on call"?

- a. Less than 5
- b. 6-10
- c. 11-15
- d. 16-20
- e. More than 20

60. What, for you, are the three most positive factors in your Air Force career?

a.-----

b.-----

c.-----

61. What, for you, are the three most negative factors in your Air Force career?

a.-----

b.-----

c.-----

62. Please tell us in your own words, what steps the Air Force must take to solve the obstetrician retention problem.

63. Are there any other comments you would like to make regarding obstetrician retention?

END

DATED

FILM

8-88

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