

# **The Health Professions Scholarship Program Is Not Meeting the Military's Requirements for Physicians**

Harold M. Koenig, M.D.  
Vice Admiral, Medical Corps  
United States Navy, Retired

## ***Introduction***

The military services face a rapidly growing problem – a declining number of medical students applying for the Armed Services' Health Professions Scholarship Program (HPSP). Two branches, the Army and Navy, failed to fill their quotas in 2005 and the Air Force barely had enough applicants to fill theirs.

Failure to fill this essential military medical pipeline means insufficient numbers of physicians to meet operational requirements not to mention military residency positions beginning as early as 2009. Failure to correct this soon may require activation of the Health Care Personnel Delivery System (HCPDS) authorized as part of the Military Selective Service Act (50 U.S.C. App. 451) in just a few years.

This document provides an historical review of the nation's effort to meet its requirements for physicians' service in the military. The history begins with the end of WW II, on through the end of the draft in 1973 and then through the period of the all volunteer force. This review also looks at early signs of problems and tracks them to the present. It reveals the system may collapse in only three years unless swift and effective action is taken to change course. Action must begin now.

This review concludes by offering four prioritized specific recommendations that, if promptly implemented, would prevent system collapse. System collapse will mean resorting again to a "Doctor Draft," which will not set well with America's public.

## ***History Of Meeting The Military's Needs For Physicians***

### **The Doctor Draft**

In 1940, before the United States entered WW II, President Roosevelt instituted the nation's first peace-time draft. Until 1946 the United States manned its armed forces with both volunteers and conscripts. The draft law was allowed to expire after the war, but was reenacted less than two years later to maintain required military manpower levels. From 1948 until 1973, during both peacetime and periods of conflict, men were drafted to fill vacancies in the armed forces which were not being filled through recruitment. All men 18-35 years old were eligible for the draft unless:

- They had already fulfilled their service obligation,
- were exempt for health reasons,
- were in college and maintaining good grades,
- were in an occupation deemed vital to national security, or,
- claimed exemption as a conscientious objector.

If drafted, a man's choices were to report for service, risk going to prison or move to another country that would not extradite him back to the USA.

Male medical students (nearly all medical students prior to the end of the draft in 1973 were male) were not exempt from the draft. However, men enrolled in medical school were not drafted until they graduated and completed one year of Graduate Medical Education (GME). This first year of GME was called an “internship” and nearly all new physicians did a rotating internship – where they spent two to three months on surgical, medical, pediatric and obstetric services and had a few months for electives. If drafted directly out of internship these physicians filled the military’s need for GMO’s (General Medical Officers). They functioned essentially like their civilian counterpart - GP’s (General Practitioners).

The Korean War armistice was signed in 1953 and in the civilian world medical specialization was increasing. The days of GP’s being able to meet an improving community standard of care was ending. A controversy developed over the needs of the armed services for medical officers and the needs of hospitals for physicians to fill their rapidly expanding residency programs.

In 1954, a noted thoracic surgeon, Dr. Frank Berry, was appointed assistant secretary of defense (health affairs). Upon assuming office one of his first acts was to propose a plan for physicians to follow one of three pathways after completing their internship:

1. Enter the armed services immediately and return to their residencies after fulfilling their obligated service;
2. Enter the armed services two years after medical school and complete their residencies after service;
3. Enter the service after the completion of residency training.

Physicians were not guaranteed their preferred choice; the military’s needs were always met first. Those who did not elect option 1 or who were not needed immediately were “deferred.” Some were allowed option 3, to complete their residency training and then entered active duty as a fully trained specialist. Those who were deferred for only one year of residency were called “partially trained specialists” and were usually given military assignments that allowed them to work within their specialty. Many residency programs would give a year’s credit toward completion of residency for their time in military service to physicians who served under option 2. Known as the Berry Plan, this triple option program continued for 19 years until the draft ended in 1973.

### **The All-Volunteer Force**

Conscription ended in 1973 and many predicted the “All Volunteer Force” would soon fail. They believed the services would not be able to meet their manpower needs and involuntary conscription, even in peace time, would have to be reinstated. As a hedge against that possibility, the Selective Service System was continued as an independent federal agency operating with permanent authorization under the Military Selective Service Act (50 U.S.C. App. 451). The Selective Service System is not part of the Department of Defense; it exists to serve the emergency manpower needs of the military by conscripting untrained manpower, or personnel with professional health care skills, if directed by Congress and the President in a national crisis.

Skeptics of the All Volunteer Force warned the first area to fail would be health care manpower. Therefore Congress established a standby Health Care Personnel Delivery System (HCPDS) within the Selective Service System. It allows drafting health care personnel during a crisis. Designed to be implemented in connection with a national mobilization in an emergency, it can be activated only if Congress and the President approve the plan and pass and sign legislation to enact it. No portion of the plan is designed for implementation in peacetime. If implemented, HCPDS would:

- Provide a fair and equitable draft of doctors, nurses, medical technicians and those with certain other health care skills if, in some future emergency, the military’s existing medical capability proved insufficient and there is a shortage of volunteers.
- Include women, unless directed otherwise by Congress and the President.

- Draft a very small percentage of America's health care providers into military service. Impact on the availability of civilian health care would be minimal. Those health-care workers whose absence would seriously hurt their communities would be deferred on the basis of community essentiality.
- Begin a mass registration of male and female health care workers between the ages of 20 and 45 at local post offices. HCPDS would provide medical personnel from a pool of 3.4 million doctors, nurses, specialists and allied health professionals in more than 60 fields of medicine.
- Require minimal training for HCPDS draftees, because they are already skilled personnel.

Before conscription ended in 1973, the military services had programs similar to the college- and university-based Reserve Officer Training Corps (ROTC) programs for medical students. These programs recruited medical students to the various service branches and commissioned them as Ensigns in the Navy or 2<sup>nd</sup> Lieutenants in the Army or Air Force. Upon graduation they were promoted to Lieutenant in the Navy or Captain in the Army or Air Force. During their fourth year of medical school they were on active duty and received all the pay and allowances of their pay grade. One great advantage of those programs was that officers were given four years of credit for longevity for the years they were in medical school. When they completed medical school most had the same rank and years of service credit for pay purposes as their high school peers who went either to a service academy or a ROTC program.

In 1980 the Defense Officer Personnel Management Act (DOPMA) was enacted. DOPMA sets guidelines governing the promotion opportunity of officers--the proportion of those competing for a higher grade who are in fact promoted. It also sets guidelines governing promotion points--the number of years and months of service at which officers may typically expect promotions. An apparent unintended consequence of DOPMA affected medical students: the four years of longevity credit previously received for the four years in medical school was lost. Following DOPMA enactment, new medical officers entering the service directly from medical school came as Lieutenants (Navy) or Captains (Army/Air Force) with zero years' longevity. The consequence was a significant pay disparity between officers in the old system and those in the new.

To avoid reinstating a "Doctor Draft" Congress took steps encouraging medical students to enter the military as physicians. The Uniformed Services University (USU) of the Health Sciences was established by Congress in 1972, graduating its first class in 1980. Now it graduates about 164 physicians each year. Today USU graduates make up about 25% of all doctors in the military. About 90% of all USU's graduates remain on active duty until reaching retirement eligibility. Unless the number of military doctors on active duty decreases or the USU class size is increased, this is the highest possible end state for USU alumni as a proportion of total medical officer end strength.

USU can not meet all of the military's requirements for physicians, so other programs were established to help "fill the gap." The principal program for medical students (and dentists and optometrists as well) was the Health Professions Scholarship Program (HPSP). Each service branch is responsible for recruiting and administering its own program; much like each service has its own ROTC program and undergraduate service academy. The Armed Forces Health Professions Scholarship Program (AFHPSP) provides tuition assistance for up to four years of school and currently a monthly stipend of at least \$1,235. All required fees and expenses, books and equipment are paid for by the program. The value of this program is estimated to be \$200,000 or more over the course of a four year medical school curriculum. The program still does not provide longevity credit. The consequence remains: medical students entering the service directly from medical school enter as Lieutenants/Captains with zero years of creditable service, rather than the four as in pre-DOPMA years. Practically speaking for pay purposes, they are at least four years behind their high school classmates who went to a service academy or through an ROTC program.

### *Early Signs of Trouble*

The exodus of experienced medical officers became the next difficulty for military medicine. Medical officer end strength chronically fell short of authorized end strength during the years following the draft. By the late 1980's the problem had become so acute it attracted congressional attention.

Recruiting medical students to come into the military was not the problem; there were plenty of applicants for USU, far exceeding available seats. Similarly there were more applicants for HPSP than there were scholarships. The problem was retention of trained physicians; those completing their accrued obligated service for medical school and residency training.

The shortage of experienced medical officers was due in part to the pay disparity for military physicians compared to their civilian counterparts. Congress attempted to stem the losses by enacting a new medical special pays program for physicians. Retention of fully trained specialists improved and consequently authorized end strengths for physicians were met and in some cases exceeded.

Retention was so good that during the manpower drawdown following the end of the Cold War, the early to mid 1990's, the Air Force and Army had Selective Early Retirement Boards (SERB) for medical officers. Many fully trained, board certified physicians planning on a 30 year career in military medicine were involuntarily separated if they had served twenty or more years on active duty. The services had all the physicians they were authorized, though not the ideal specialty mix their tables of organization called for. This situation continued after the Cold War, through the Persian Gulf War and even into the immediate post 9-11 years. The combination of USU graduates, the HPSP program and recruiting fully trained physicians from the civilian sector was adequate to meet the military's active component requirements.

In the Fall of 2002, a year after 9/11, the first indications of problems with accessions became apparent. Decreased numbers of applicants were applying for both USU and HPSP. USU still received enough highly qualified applicants to fill all of its seats, but there were fewer applying. In contrast, the services were finding it increasingly difficult to fill all of their HPSP scholarships. In addition, the Medical College Admission Test (MCAT) scores of those students accepted into the HPSP were lower than in previous years. The number of students in the HPSP program attending osteopathic medical schools began to exceed those attending allopathic schools, despite the fact that there are only 23 osteopathic schools and 125 allopathic medical schools.

In 2005 for the first time the Navy and the Army were unable to fill their HPSP scholarships, while the Air Force barely filled theirs. In contrast, the Public Health Service (PHS) which also has an HPSP had over 700 applicants for its 100 scholarships. Thus the concern, prompting this review.

With the HPSP shortfall in 2005 the Army and Navy will be unable to meet their requirements for medical officers to serve with the operating forces and fill their GME positions in 2009-2010. This management conundrum is only three years away. Beyond support for the operating forces, this will in a few more years cause shortfalls of fully trained specialists as well.

In the past the HPSP students the services attracted were of the highest caliber and therefore the physicians in the military were amongst the very best in the country. The GME programs attracted some of the world's best teachers and that is reflected by many former military physicians now holding leadership positions in many of the nation's leading civilian training programs. An analogy would be if there weren't enough babies born this year to fill all the kindergarten classrooms in five years; there is no going back and making more babies this year. Likewise, there is no going back and making more service obligated 1<sup>st</sup> and 2<sup>nd</sup> year medical students this year.

The rest of this paper examines factors possibly contributing to this HPSP recruiting shortfall and suggests possible remedies.

### ***Why is HPSP recruiting falling short of quotas?***

#### **The War**

Students may not be applying because of the war in the Middle East but if so medical recruiting is unique. Applications to the service academies, ROTC programs and enlistments into the armed services did not fall in the immediate post 9-11 environment. There was a surge of patriotism post 9-11 and all recruiting quotas were met until FY 2005 when the Army missed its enlisted recruiting goal by about 9,000 (9%). The first sign of problems in the HPSP programs came in 2002, immediately after 9-11 but before major combat in Iraq had begun.

### **HPSP Recruiting and Advertising**

Each military service administers its own HPSP recruiting and program. All of the services have HPSP web sites that provide good information about the program and how to apply for it. No medical schools ban military recruiters as occurs at some law schools, an issue the Supreme Court is now addressing. As noted above in the section, **Early Signs of Trouble**, the services acknowledged a decrease in HPSP applicants in 2002. But that was not the first indication of problems. Two articles published by COL Kenneth Swan, MC USAR in the journal, *Military Medicine* gave early warning that trouble was just over the horizon. The first article, appearing in December 1997, appropriately titled *Don't Know, Don't Care: Medical Students' Knowledge of and Attitudes toward Military Medical Career Opportunities and Medical Education Cost Reimbursement* reported on students enrolled at New Jersey's medical schools who were graduating in 1996. Despite 80% of the students having educational indebtedness averaging \$75,000, 57% of them were unaware of any programs that would repay a portion of their medical educational loans in return for military service. Of those who were aware of such programs less than 10% could correctly identify any program. Most alarming was that when queried if they would consider serving their country as a military physician, only 16% answered yes.

Swan followed up his first article with another in *Military Medicine* in November 1999 titled *Don't Know, Don't Care III* in which he enlisted the support of some colleagues from other medical schools. (*Don't know Don't Care II* appeared later as a letter in *Academic Medicine* in May 2000. It contained little information that wasn't included in the second *Military Medicine* article.) This second *Military Medicine* article tried to determine if the attitudes of the New Jersey medical students "might reflect regional bias, recognizing the well-known moderate philosophy attributed generally to metropolitan New York and New Jersey." Four additional classes (1997 – 2000) of graduates from the New Jersey medical school were included along with graduates from the University of Missouri in Kansas City and the University of Utah in Salt Lake City. Again, the majority of students at all three schools were not aware of federal financial aid programs available in return for military service. When asked about their willingness to serve in the military as a physician in any capacity; active, reserve, in time of war, in peace keeping operations or continuing in the reserves; the most popular response overall was "I would not consider serving in the military in any capacity" (37%). The Utah students were the most willing to serve in some capacity (74%), the Missouri students the least (52%) and the New Jersey students intermediate (37%). Swan and his colleagues lifted the cover off the attitudes of medical students about serving in the military: ignorance, apathy and refusal.

They went on to boldly suggest a possible "better way to go" focusing primarily on how to recruit graduating medical students to serve in the Army Reserves, a problem at that time which was seen as more critical than getting medical students to join the HPSP. They suggested assuming up to \$100,000 of educational debt plus whatever interest had accrued for a graduating senior willing to enroll in and complete a residency leading to board certification in a specialty needed in the reserves. All a student would have to do is agree to participate in one week of drilling each year for ten years at the Academy of Health Sciences, Fort Sam Houston where he or she would be updated on current concepts in military science, military medicine, combat casualty care, and his or her own specialty. Pay and allowances, transportation and lodging would be provided during the week at temporary duty or annual training rates. If the individual liked it, after ten years they could convert to regular reserve status, if not, they would be free to go with no further obligation. If at any time during the ten years of obligation a national need for the individual's specialty arose, he or she would agree to mobilization. No action was ever taken on this recommendation.

The Society of Medical Consultants to the Armed Services (SMCAF) became concerned about the HPSP recruiting problems upon hearing about the problems in 2002. In response SMCAF put together a network of concerned physicians, many of them retired medical corps officers and some medical school faculty to assist the services in their recruiting efforts. The service Surgeons General and the recruiting commands are aware of this group of volunteers. The services have recently increased their recruiting efforts. The Army is beginning a program where active duty physicians will visit medical schools in person. Recruiters, even though dedicated to medical recruiting, are not necessarily fluent in the practice of medicine while in uniform.

### **DoD Policy Changes**

PBD 712 was released in early 2005. It called for some major future restructuring of the military medical departments. Some of what is contained in PBD 712 is controversial and disturbing to those serving now. It had a demoralizing impact on some physicians involved in military GME programs. The decline in HPSP candidates started years before PBD 712 was released so it had no impact on HPSP recruiting.

### **Customer Service**

One retired medical corps flag officer related a conversation he had with a current HPSP student. The 2<sup>nd</sup> year student said he really wished now he had not joined the HPSP. It is not that he does not want to serve or risk having to go to war; his problem is the hassle factor. The rules for submitting the paper work for reimbursement for expenses is cumbersome and he finds communication with his service's HPSP office extremely difficult. He says his phone calls and email messages are seldom returned and he finds the regulations over-burdening.

### **The Services' continued reliance on GMO's**

As noted in the introductory section of this paper, **The Doctor Draft**, the services for many years have relied on GMO's. The GP, the GMO's civilian counterpart, has virtually disappeared from the medical scene. General practice is no longer the community standard of care. The Air Force and Army have essentially done away with GMO's; any HPSP student offered a GME position in these services is allowed to continue their training to completion without interruption. The Navy still has requirements for GMO's serving with the Marines and some operational requirements with Navy line units.

As noted above, there are a lot more osteopathic than allopathic medical students entering the HPSP now than is proportional to their total numbers. Historically osteopaths have preferred primary care medicine. Until recently some still did only one year of general practice GME training before entering practice. This may account for why the HPSP was more attractive to Osteopathic than Allopathic students. But that too is changing. Osteopathic medicine now encourages longer and more specialized training before entering practice.

Most physicians who have done a GMO tour before completing residency training have found it a very valuable experience, the author of this paper included. But today this no longer the community standard and it may be that medical students are being told that by their civilian mentors. Another anecdotal comment made by some medical students is that they are being told by civilian mentors that if they enter the military they may be "directed" to do a residency in a specialty other than their first choice.

### **Publicity**

Military medicine gets media exposure as all of medicine does. Some of it is very good, like the humanitarian work it is called on to provide following national and international natural disasters. Within the last year military medicine has provided aid and received positive media exposure about providing help to the victims of the Indonesian tsunami, both U.S. Gulf Coast hurricanes and the Pakistan earthquakes. The reports provide a message that only the U.S. military can respond rapidly on the scale required to these cataclysmic events.

The flip side of publicity is that military medicine also gets negative press, some of it deserved and some of it not. Perhaps the most damaging in recent times was the Pulitzer Prize winning series published in the Dayton Daily News in the Fall of 1997. The series ran on the front page of the newspaper for seven days and was picked up and reprinted in many other dailies throughout the nation. The series told of malpractice events and the resultant tragedies and suffering of military personnel and their families, of licensure problems with some physicians and of bureaucratic attempts to cover up these problems.

More recently the issue of physicians possibly participating in the interrogation of prisoners in the war on terrorism has been raised and articles on the subject have appeared in prestigious medical journals such as the New England Journal of Medicine and the Journal of the American Medical Association. Though no proof has been offered that physicians have actually participated in torture, the failure of the top levels of the Department to respond openly to queries has led to a suspicion that this is going on. Academics who oppose the current war or the use of torture to extract information find this useful fodder to create doubt in the minds of medical students considering the military HPSP.

A near continuous stream of medical “horror stories” appears in the military “Times” weekly newspapers, a group of four privately owned tabloid style newspapers providing stories and information of interest to each of the four military services and the Coast Guard. Recently a request was printed in these publications asking people to submit their personal stories with health care problems for publication. Even prestigious academic publications like the *U.S. Naval Institute Proceedings* get into the act, publishing in the December 2005 issue an article titled *Navy Medicine in Critical Condition* by the current Chairman of the Department of Surgery at the Naval Regional Medical Center, San Diego. The title itself is enough to scare a medical student away from joining the Navy’s HPSP. The article contains nothing new. It re-hashes several ongoing difficult issues the Navy has been dealing with for years, despite significant progress on several fronts. One not intimately familiar with Navy Medicine over time has difficulty understanding that this is a single snapshot in time. Its author is a worried and unhappy officer whose concern should not be dismissed out of hand.

In summary, military medicine gets a lot of media exposure. All that can be done is to be open and honest with the 4<sup>th</sup> estate. This lessens the negative impact of the “bad” stories, making sure its people are informed about the issues. In turn, they can address them with potential candidates for HPSP and those who will influence them.

## **Pay**

Pay is again a problem. The incentive special pays program instituted in 1991 served well; retention went up. Now the problem is not retention; it is at the accession end of the career ladder. One problem is that young doctors joining the military directly from medical school find themselves lagging four years on the pay scales behind their high school classmates who went to a service academy or through an ROTC program. This pay inequity is significant.

A third-year medical student addressing the SMCAF committee on Recruitment and Retention told the members about recruiting from a student’s perspective. He said that money alone isn’t enough any more. He said little towns across the USA are competing with the military for physicians. They offer as much as HPSP in return for practicing in their communities after graduation, “and the only shooting done in Michigan’s Upper Peninsula is by hunters.”

Even with the financial advantages HPSP students have with the program paying their tuition, fees and books many still incur significant debt. Many military physicians would like to stay for a thirty year career but cannot afford to because they have significant educational debt. The PHS has a program to pay off financial debt that the military services do not. Perhaps that is a contributing factor to why the PHS is not having trouble attracting HPSP candidates while the services are.

## ***Conclusions and Recommendations***

In just three years, the Navy and Army face significant problems in meeting their requirements for physicians. The Air Force may face the same problem just one year later if present trends continue.

The preceding section, **Possible reasons why HPSP recruiting has fallen off**, offers some testable hypotheses to turn this growing problem around. The military must attract enough medical students to meet requirements or resort to the doctor draft.

In 1954 Dr. Frank Berry proposed a plan reviewed above in the section, **The Doctor Draft**, balancing the military's need for doctors and the civilian sectors need for physicians to complete specialty training. During Dr. Berry's time the draft was available to fulfill the military's requirements; today it is not.

**How can the military services attract enough medical students** to meet military requirements without the draft? Prioritized, the answers are readily apparent:

1. **Establish a program to eliminate educational debt for HPSP students** who agree to remain on active duty beyond completion of their initial obligated service similar to the current PHS program.
2. **Modify the current recruiting programs.**
  - Have all services participate and involve active duty physicians with presentations at medical schools as the Army is now beginning to do.
  - Use the SMCAF organized group of senior volunteers in recruiting HPSP students.
  - Assign a SMCAF volunteer "ombudsman" to each student.
  - Make application to HPSP similar to USU.
    - a. The student applies for HPSP and prioritizes his/her choice of services.
    - b. The program office then assigns students to a service branch, trying, but not guaranteeing, they will get their first choice.
3. **Consolidate all HPSP management and administration (the three military services plus PHS) under a single office.**
  - Eliminate administrative "hassle factors" for HPSP students.
  - Be immediately responsive to their questions and needs.
  - Consider outsourcing this function, this is not something uniformed people or government employees need to do.
4. **Eliminate GMO's to the fullest extent possible in all services.**

*Failing to quickly correct the HPSP program accessions problem will likely result in only one remaining choice for the nation: resume the doctor draft as authorized in the Military Selective Service Act (50 U.S.C. App. 451).*