Soldiers' Experiences with Military Health Care

Guarantor: COL Bonnie M. Jennings, AN USA (Ret.)
Contributors: COL Bonnie M. Jennings, AN USA (Ret.)*; Lori A. Loan, PhD RNC†; Stacy L. Heiner, RN BSN‡; COL Eileen A. Hemman, AN USA (Ret.)³; Kristen M. Swanson, RN PhD FAAN⁴

Patient satisfaction can be enhanced by narrowing gaps between what health care consumers experience and what they expect. A study was therefore conducted to better understand health care experiences and expectations among Army beneficiaries. Data collected using focus groups were analyzed by using qualitative research methods. A concept was identified and labeled “Soldier Care.” It involves first-line care delivered at the unit level as well as the interface between first-line care and military treatment facilities. There are four features of Soldier Care, i.e., provider competence, the sick call cycle, getting appointments, and unit leadership. Together, these features affect soldiers' time from injury to recovery. Insights about Soldier Care can provide decision-makers with direction about Soldier Care can provide decision-makers with direction.

Study Design

Methods

Introduction

Throughout the United States, health care is in turmoil. Part of the turmoil is created by the tension between infinite health care needs and finite health care resources. The tension involves difficult tradeoffs among cost, quality, and access. The military health system (MHS) is not immune from this turmoil. Just as the rising cost of health care was the catalyst for change in civilian health systems, increasing health care costs within the Department of Defense prompted a move to a military managed-care system known as TRICARE. The MHS has a mandate to provide comprehensive health coverage to >8 million beneficiaries worldwide. The shift to TRICARE thus created a profound change for a large beneficiary population.

Although the MHS strives for excellence, quantitative assessments of TRICARE suggest that beneficiaries are not satisfied with certain aspects of their care. Moreover, compared with all other beneficiaries, active duty (AD) personnel report the least overall satisfaction with the health care system. Satisfaction, which is a key component of health care quality and an important health care outcome, is related to differences between patients' experiences and their expectations. Logical steps to enhance military patient satisfaction are to examine MHS beneficiary experiences and what beneficiaries expect and then to take action to reduce the gaps. Therefore, a qualitative study was conducted to better understand satisfaction among Army health care beneficiaries. The study was guided by three broad questions. Quite separate from those questions, and not expected by the investigators, was the identification of a concept labeled “Soldier Care.” The findings about Soldier Care are reported here.

Sample

Although stratified random sampling is unusual in qualitative studies, it was used to recruit soldiers and family members (i.e., health care consumers) by considering region, site where care was given, rank, gender, and ethnicity. In addition, purposive sampling was used to recruit a variety of HCP ranging from providers to administrators.

Procedure

After acquiring approval from appropriate Institutional Review Boards, lists of potential participants were created based on data in the MHS data repository. These lists were compiled to

999 Military Medicine, Vol. 170, December 2005
ensure that individuals meeting the inclusion criteria would be
given the opportunity to participate. Therefore, the lists were
based on region, site of care, rank, gender, and ethnicity. The
names on the lists were sorted with a random number generator
and supplied to the research assistants (RAs) in increments of
100 names. The RAs used the lists to contact potential partici-
pants, with the goal of locating 20 individuals who verbally
agreed to participate in the focus group being recruited. A stan-
dard script was used to inform individuals about the study.
Those who agreed to participate were sent a letter restating
information discussed during the telephone conversation. Ad-
ditionally, a few days before each focus group meeting, the RAs
called each person who had agreed to participate, to remind
them about the focus group.

Before the start of each focus group, written informed consent
was obtained. The moderator used a scripted dialogue at the
beginning and end of each focus group. A list of possible probes
was available to stimulate the discussion, but the probes were
not used. The groups were eager to talk based on two general
queries posed by the moderator, as follows. (1) What do you
expect from the MHS? (2) Give me some ideas of what happens
to you when you go to get health care. The moderator was
diligent in soliciting both positive and negative experiences from
the participants.

All focus groups were recorded verbatim by a court reporter
and converted into Word (Microsoft, Redmond, Washington)
documents. The transcripts were assessed by all members of
the research team using the iterative analytic process described by
Colavizza.2-18 Specifically, each transcript was read by each in-
vestigator independently. As a group, the investigators extracted
phrases pertinent to the questions being investigated. These
phrases were the unit of analysis in this study. The phrases
were then formulated into categories and themes. The rigor of
the analysis was maintained by attending to tenets of trustwor-
thiness applicable to qualitative research.20 The findings re-
ported here are based on 564 pages of transcripts from which
the Soldier Care concept emerged.

Results

Sample Characteristics

AD Army personnel (n = 15) and AD family members (n = 11)
ranged in age from 21 to 55 years. The AD consumers included
eight commissioned officers, three warrant officers, and four
enlisted soldiers. All enlisted participants were men. All family
members were women; 4 of the 11 AD officers were also women.
The group included 13 Caucasian participants, 6 African Amer-
ican participants, 4 Hispanic participants, and 1 each of Pacific
Islander, Asian, and other participants. Participants discussed
their experiences with care at both military treatment facilities
(MTFs) and troop medical clinics (TMCs). TMCs are medical
clinics designed for sick call. They also provide limited treat-
ment, immunization services, medical examinations, physical
profiling, and limited pharmacy dispensing services.

HCP ranged in age from 29 to 56 years based on data for the
27 individuals for whom age data were available. Of the 31 HCP,
14 were men and 17 were women. Most of the HCP participants
were AD commissioned officers (n = 23), seven were MHS civil-
ian workers, and one was an enlisted member. There were 12
physician participants (39%), 8 registered nurses (26%), 4 phy-
sician assistants (PAs) (13%), 4 physical therapists (13%), 1
administrator, 1 social worker, and 1 licensed practical nurse.
Although medics were invited to the focus groups, none at-
tenied. Therefore, the perspective of the medic is absent from
these data. Ethnically, 25 HCP were Caucasian, 3 were African
American, 2 were Asian, and 1 was Hispanic. HCP practiced in
both MTFs and TMCs. All of the HCP were also MHS beneficia-
ries and therefore could address care from both consumer and
provider perspectives.

Features of Soldier Care

The investigators were not aware of the features of Soldier
Care, as explained here, before this study. However, early in the
analysis it became clear that health care for soldiers was quite
different from health care for family members. This led the
investigators to identify the Soldier Care concept. Soldier Care
can be defined as a spectrum of health care that starts
with unit-level care, spans the interface between unit and MTF care,
and continues until injured soldiers are fully recovered and able
to return to duty. In the Army, soldiers are initially treated at
battalion aid stations and TMCs. This care is provided by flight
surgeons and other physicians, as well as field medics and PAs.

Overall, participants were not impressed with their initial treat-
ment.

There are four features of Soldier Care that may increase the
time from injury to recovery, thereby exerting an effect on units' readiness posture. These features include gaps between what
soldiers expect and what they experience regarding health care
provider competencies, sick call cycle inefficiencies, appoint-
ment challenges, and lack of support from unit leaders. The
features of Soldier Care, the experiences that render them prob-
lamatic, and the expectations that provide direction for improve-
ments are listed in Table I.

Provider Competence

The importance of accurately and swiftly diagnosing problems
is illustrated by a 24-year-old enlisted soldier who had a foot
problem.

They [the medics] kept pretty much blowing me off at the
aid station, telling me it was something totally different.
... When I went to [the MTF] ... the podiatry section ... told me . . . "If you had come here to begin with, we could
have taken care of this 5 or 6 months ago, instead of you
continuing to be on profile and not getting well."

This soldier’s recommendation for improving care was to place
more qualified providers in the aid stations. He was not confi-
dent in the skills of medics who were "looking into books" for the
answers.

Female soldiers expressed some gender-specific concerns
about provider competence. A 34-year-old female warrant officer
summarizes these concerns.

All the guys in the aid station are guys. And females go in
there . . . complaining of a headache or stomachache, first
thing they do is they give you a pregnancy test.

Provider competence, however, has less to do with degrees
than it does with understanding soldiering. Being a superb
surgeon is not enough. Participants expected HCP to understand soldiers’ jobs and to initiate treatment that is more specific to their jobs and their injuries. This expectation was well stated by a 30-year-old male officer.

I don’t want to say doctors do not believe people, but knowing what certain jobs require . . . that maybe somebody is coming in [whose job has them] wearing a heavy pack, maybe three times a week or for a couple weeks at a time, jumping out of airplanes, jumping off vehicles, and maybe understanding these injuries.

Special Forces medics, in contrast, were viewed as being quite competent. Because they train with other soldiers, they have a good grasp of how injuries happen as well as how to treat them. A 26-year-old AD officer recounted how Special Forces medics have a good grasp of how injuries happen as well as how to treat them.

The Sick Call Cycle

Sick call is the means by which most soldiers initially access care. Both HCP and soldiers see sick call similarly, referring to it as “cattle call medicine” because of the large volume of patients rapidly triaged. A 39-year-old civilian PA conveyed a common sentiment, i.e., that sick call was about moving the numbers.

I don’t think soldiers feel that they were actually listened to or cared for as much as if you were able to spend a little bit more time with them.

The need for a quick disposition so that soldiers can get back to work contributes to sick call being regarded as depersonalized. More importantly, sick call often sets in motion a repetitious sequence involving profiles and Motrin (ibuprofen, McNeil Consumer & Specialty Pharmaceuticals, Fort Washington, Pennsylvania). Profiles provide an index of functional capacity; they are governed by Army Regulation 40-501. Profiles are used to modify physical activity for a specified time and they do not address what soldiers can do along with what they cannot do.

Profiles are also a source of concern among both soldiers and family members. Special Forces medics, in contrast, were viewed as being quite competent. Because they train with other soldiers, they have a good grasp of how injuries happen as well as how to treat them. A 26-year-old AD officer recounted how Special Forces medics have a good grasp of how injuries happen as well as how to treat them.

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soldiers regarding the expectation that profiles should be written and used to protect soldiers from further injury. Several of the HCP were aware of the need to tailor profiles specific to the individual's job and the injury. However, the HCP also observed that frequently this specificity was not achieved, as noted in remarks by a 44-year-old, male, civilian PA.

Most docs at our clinic don't know to ask what the person's job is. So they're [the soldiers] going to get a generic answer [profile] whether they're a finance clerk or an infantryman.

The Appointment Obstacle Course

When unit-level care fails to return soldiers to a healthy status so they are "fit to fight," soldiers need to access care at the MTF. Although other beneficiaries face challenges in getting appointments, these challenges are compounded for soldiers because of their training schedules. This may initiate the appointment obstacle course, i.e., telephone calls, no appointments available, and then out for training, which may repeat itself for several months before a soldier succeeds in scheduling an appointment.

The experience of a 30-year-old male officer who tried to coordinate an appointment with his unit's training schedule typifies the situation.

I would call for an appointment with the MRI [magnetic resonance imaging] folks. And they're, like, . . . "I have one appointment available a month from now." "Okay, well, I'm deployed then. I can't take that one. Can you . . . put me in 2 months from now?" "Well, we don't book out that far." So then I get back from the deployment [and] call again. "No, we're all booked up but you can have this date." "Well, I'm gone again, and I get back on this date." "Well, we can't book out that far." It was just . . . it was infuriating, absolutely infuriating. So I think the appointment system they have is designed for like we work 9-to-5 jobs, and we don't.

The incompatibility of the current health care appointment structure with soldiers' work schedules was mentioned frequently. The essence of the problem is illustrated in the words of a 39-year-old male officer.

I've got to go in for orthopedic surgery because I've been putting it off for about a year now, just because of the nature of my loving job. I couldn't go in the daytime. . . . My job, you know, starts at 0600, and I did not normally get out until approximately 1930.

The Role of Unit Leadership in Soldier Care

The interface between the soldier's unit (its leadership and philosophy regarding health care) and the health care system was threaded throughout the data. Commanders regulate soldiers' whereabouts, including whether they are released from duty for medical appointments. They also have the final say in whether the parameters of a profile are followed. The power of the command structure in supporting or thwarting health care was recognized by soldiers, family members, and HCP. As noted by a 51-year-old PA.

The commander can do whatever he wants to do. If I put somebody on quarters [but] the commander says, "No, you're going to work today," you work.

Unit leaders, for the most part, were portrayed as having a low tolerance for soldiers who are not fully functional. Soldiers quickly learn they may need to "suck it up," or carry on with their mission despite health problems. A 44-year-old PA summarized the situation by noting.

I have more problems with commanders and supervisors . . . they push the troops until they are broken and figure, "I'll just get a new one," . . . rather than give the person time to get better . . . They want them to get in formation and just run until they drop out.

Both soldiers and HCP were well aware of the stigma of being labeled a "broken soldier." An AD physician who was married to a soldier noted, "Anything medical is a sign of weakness."

Similarly, the will of the commander with respect to appointments was illustrated by a 30-year-old female physician.

Some commanders sort of think [soldiers'] personal health care time is before 0900 and after 1700, so they won't let [soldiers] go for physical therapy or occupational therapy. I've had [soldiers] miss CT [computed tomography] scans, MRI [magnetic resonance imaging] scans, consults to consultants who are really hard to get appointments with . . . and it's just the commanders thinking that's not important.

This perspective was consistent with the view of AD soldiers and family members. In the words of a 26-year-old male officer.

For me to be able to get an hour out of my time to go down there [to the MTF], I think the hardest part is going through the unit . . . trying to get the time or trying to be able to do it.

Other unit leaders may also create obstacles to getting care. Platoon sergeants and squad, team, or platoon leaders may decide who gets to leave work to get care. A 37-year-old female physician thought the age of the leader was an important factor. Younger leaders are still learning their jobs and might view health care as a nuisance because it interferes with work and training of the troops. Conversely, efficiently delivered health care could be seen as supporting the mission because it keeps soldiers fit to fight.

Soldier Care is enhanced when solid relationships are established between HCP and unit leaders. Good two-way communication creates a strong bridge between the unit and the health care system. When unit leaders know the HCP, it is possible to negotiate times for soldiers to get care that fit best into the unit's schedule. Additionally, as commanders grow to trust the HCP, they are more likely to initiate calls to the HCP regarding soldiers whose health concerns them.

It's a Long Road from Injury to Recovery

Soldiers experience a long road from injury to recovery, in part because of the features of Soldier Care. All too often, the recovery process is prolonged because of issues such as those described by a 26-year-old enlisted participant.

We've got a soldier . . . [who] got hurt in May, and they finally got notice it was going to be like October before he gets in there to get the surgery. And then he's going to be out. And to the Army, that's almost a whole year . . . be-
cause he's got to go through all the rehab from it, and that's another 6 months. . . . So we've pretty much lost a soldier for a whole year there.

The consequences of delays in recovery are experienced by soldiers, their military units, and the Army. Morale may be diminished among injured soldiers who feel stigmatized and unchallenged when assigned to administrative duties in lieu of their usual jobs. These become quality of life and retention issues, as reflected in the comments of a 30-year-old male officer.

Health care has an enormous impact upon morale, and that just cascades down into so many other things: productivity, reenlistment, retention. It plays a huge role.

Unit cohesion may be reduced when injured soldiers cannot perform mission-related training. This creates vacancies that may jeopardize units' readiness status. A 26-year-old male enlisted soldier noted,

They [soldiers on profile] are held on our battle rosters. And they take up a space, so we can't get a fully functional soldier in because he's there.

Discussion

Although AD soldiers are covered by the preferred TRICARE option (Prime), their initial access to care remains outside the TRICARE system itself. These data provide a view of factors, collectively referred to as Soldier Care, that may contribute to dissatisfaction with care among AD soldiers. Along with lengthening the time from injury to recovery, Soldier Care issues may have an impact on readiness.

Concerns about provider competence suggest that training for all individuals providing care to soldiers needs to address the military culture. Being a good surgeon, for instance, is necessary but not sufficient. Taking good care of soldiers requires that HCP understand what each soldier's job entails, the role of unit leadership, and the military culture.

Despite sick call being a longstanding military tradition, it may be overdue for a major overhaul. The dissatisfaction with sick call was confirmed in findings from a separate study. Along with improving interactions so that soldiers feel respected and valued, the seemingly automatic reliance on Motrin and Tylenol may need to be reconsidered.

Possible strategies to improve profiles can be found in the regulation governing them, namely, Army Regulation 40-501. Profilling officers, who are to be designated by MTF commanders, are expected to be thoroughly familiar with the contents of the regulation. Educating providers about how to tailor profiles to soldiers' jobs and monitoring the thoroughness of profiles could enhance satisfaction among AD personnel. This education needs to be ongoing, because individuals in the early stages of their medical training are likely to be more focused on acquiring technical proficiency and less focused on military aspects of care.

Although a goal of TRICARE is to improve access, evidence from this study suggests that the goal is not being met for AD soldiers. For example, appointment times do not occur when soldiers can easily access the system. Although extended hours would put additional stress on clinical systems that may be understaffed, soldiers greatly appreciated after-hours clinics. Additionally, altering the appointment system to allow scheduling into the future would better accommodate soldiers as well as other MHS consumers.

Finally, the tension between training and getting care was strongly conveyed in these data. The soldiers are caught in a tug-of-war. They expressed a fierce loyalty to their units, a strong desire to be kept fit to do their jobs, and a struggle to get the care they need. Unit leaders need to develop a better appreciation of how health care sustains soldiers' fitness and directly supports readiness. There is an interesting irony in the "mission first" norm within the military culture. Soldiers are essential to doing the mission, so which ought to come first, the mission or the "men"?

The discrepancies between what soldiers experience and what they expect indicate possible sources of dissatisfaction with military health care. These sources of dissatisfaction represent opportunities for improvement. They are also dimensions of care not typically assessed by satisfaction surveys. Therefore, they represent a set of factors that may be pivotal to soldier satisfaction. With intervention to better align experiences and expectations, AD satisfaction with Soldier Care might be improved.

Acknowledgment

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References

Letters to the Editor (cont.)

including the spring/summer of 2003. The findings of this study were presented at the American Association for the Surgery of Trauma meeting in September 2003, and full manuscript was submitted for publication on October 30, 2003. The dates of submission and acceptance are clearly mentioned in the published manuscript. Thus, the delivery date of the product matches the period of active experimentation, and was many months prior to the completion of this project.

I am sure that FastAct is a wonderful product that works very well. The efficacy of any hemostatic dressing in a pre-clinical study depends upon a variety of factors such as; the animal size and species, source of bleeding, nature of injuries, rate and pressure of hemorrhage, resuscitation strategies, just to name a few. It is fairly common for a hemostatic agent to work well in certain models, but not in others. Unfortunately, in our animal model, FastAct failed to stop the bleeding. For full details please refer to the published data in the Journal of Trauma (56:974-983. 2004).

I am very grateful that Mr. Wortham decided to help us with this study, which was designed to improve the care of our troops in the battlefield.

Husan B. Alam, MD, FACS
Div of Trauma, Emergency Surgery
Massachusetts General Hospital
Boston, MA