Military Colon and Rectal Surgery Practice

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ABSTRACT

Military medicine is a unique type of group practice. It can be very rewarding because of the quality of appreciative patients and fellow providers. The lifestyle has challenges, especially in time of war. This article describes many of the advantages and challenges of military medicine.

KEYWORDS: Military practice, armed services, deployment

Objectives: Upon completion of this article, the reader should be familiar with the characteristics of a military colon and rectal surgery practice.

The purpose of this article is to describe the practice of colorectal surgery within the military. I would like to beg the reader's permission to write in the first-person tense and to use personal anecdotes to communicate better my ideas about this topic, one that is near and dear to me. Perhaps a few words to establish my credibility: I spent 30 years on active duty in the U.S. Air Force, the last 15 of those years as a colorectal surgeon, and for many years I was Chief Consultant to the Air Force Surgeon General for colorectal surgery. I retired from active duty in 2003. Beyond retirement, I continue to practice colorectal surgery in a military medical center. I presently serve on the faculty of our only federally sponsored training program for medical students, Uniformed Services University of the Health Sciences (USUHS). Incidentally, all of what I write is my own opinion and does not reflect federal doctrine or thinking or policy.

HISTORY OF MILITARY COLORECTAL SURGERY

Colorectal disease has been a very important concern of the military ever since the beginning of warfare. Battles have been won or lost because of colorectal disease. One example is the Battle of Valmy, in 1792, which happened

soon after the beginning of the French Revolution; it should have been easily won by the combined armies of the enemy, but their soldiers were overcome by infectious, bloody diarrhea, and the victory was won by the French. This particular battle was especially significant in the early history of the French Republic, perhaps won because of diarrhea. (At least, that has been the speculation of some.) Another example was what happened at Waterloo, in 1815, when Napoleon apparently was severely hampered by a nasty case of acute hemorrhoids. His condition did not permit him to lead his troops in battle on his horse, which could well have made the difference in the outcome. In more modern times, some famous operations have been done in military hospitals by military physicians for colorectal disease. For instance, President Eisenhower had obstructive ileal Crohn's disease and underwent a bypass of the obstruction at Walter Reed USA Medical Center by Dr. Leonard Heaton in July 1956. Dr. Heaton was later to become Surgeon General of the Army and was a powerful advocate of military medicine. He was an excellent general surgeon and the first to become board certified in general surgery in the U.S. Army. President Reagan had a right colectomy for cecal cancer, done at the National Naval Medical Center in July 1985 by a team of military and civilian surgeons, including Drs. Hutton,

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Oller, and Smith (Lee Smith, later to become president of the American Society of Colon and Rectal Surgeons (ASCRS)).

Simple conditions, such as pilonidal cysts, have always been a frequent complaint in the military and have caused major loss of work and been a source of debility. Pilonidal cysts became known as “Jeep rider’s disease” because they were so often seen among troops who were bounced around on the seats of the Jeep in World War II. Hemorrhoids are a common source of complaint among fighter pilots, who are subjected to G forces. Colorectal disease continues to this day to be a very common and often debilitating complaint, and colorectal surgery clinics in the military generally are well frequented by patients.

SUPPORT FOR MILITARY COLORECTAL SURGERY

Over the years, many of us in the military have benefited by having been trained in superb colorectal surgery centers throughout the United States. The invitation to train at these centers has been, at times, an act of faith for the various program directors. The time spent interacting with the faculties of these centers, the training received, the papers written—this total fellowship experience has been a huge influence for good and has substantially improved the delivery of colorectal surgery care to the military community. At the risk of leaving out some names, I might mention a few centers where military surgeons have been able to get great colorectal training: Mayo Clinic, Cleveland Clinic, University of Minnesota, Lahey Clinic, Ferguson Clinic, University of Texas at Houston, Northwest Colon and Rectal Clinic, Carle Clinic, and Ochsner Clinic. My personal list of mentors includes absolute superstars such as Dozois, Pemberton, Wolff, Beart, Nivatvongs, Beahrs, Spencer, DeVine, Schoetz, Goldberg, Oommen, Billingham, Chiu, Bailey, and Abcarian. I cannot say enough about the profound influence of these teachers on military medicine. And there are many others, beyond my personal sphere, including Fazio, Marks, Sullivan, Ray, and Gathright. The military truly owes all of these great teachers a hearty “thank you” for their profound contributions. In particular, Dr. Stan Goldberg has been a stalwart supporter of military medicine and has trained several excellent colorectal surgeons for the military. Dr. Goldberg continues to go out of his way to seek out military physicians and to continue to train and mentor them, wherever they are throughout the world.

MILITARY SURGEONS WHO HAVE CONTRIBUTED TO THE SPECIALTY

There have been literally dozens of excellent military colorectal surgeons who have been trained in fellowship

programs, have finished their military careers (either by separating from the service after completing their obligations or by retirement), and have gone on to make major contributions to our field. It is perhaps risky even to attempt to make a list of these physicians, knowing that I will forget to include many who are worthy of mention. Some of the names that come to mind include Beck, Karulf, Otchey, Fry, Smith, Roe, Simmang, Harford, Oommen, Dawson, Rosenthal, Browning, Sweeney, and Robertson. Several former military members have been elected to high office in the ASCRS. In the recent past, Dr. Lee Smith and Dr. Robert Fry have both been honored to have been elected president of ASCRS. Given the proven track record of many military colon and rectal surgeons, it is somewhat surprising that we seldom see our military allowed into higher councils and leadership positions in the ASCRS while still on active duty. At the present time, I know of no member of the Executive Council of ASCRS, the Members-at-Large of ASCRS, the officers or board members of the American Board of Colon and Rectal Surgery, or any of the colorectal surgeons who sit on the Advisory Council for Colon and Rectal Surgery of the American College of Surgeons—no one who is an active-duty member of the U.S. Armed Forces.

ACTIVE-DUTY MILITARY COLORECTAL SURGEONS WHO HAVE ACHIEVED HIGH MILITARY OFFICE OR DISTINCTION

Each of the three services (Army, Navy, and Air Force) has a medical corps that is led by a surgeon general, the highest ranking physician of that corps. For instance, the only three-star general in the Air Force Medical Corps is the surgeon general. It is unusual to have a colorectal surgeon so honored. To my knowledge, the only time any service has chosen a colorectal surgeon to be surgeon general was in 1982, when Dr. Max Bralliar was chosen by the Air Force. Dr. Bralliar is now a retired fellow of ASCRS. Other rising stars of military medicine, currently on active duty, deserve mention: Dr. Adam Robinson is serving as Commander of the National Naval Medical Center in Bethesda, Maryland. Dr. Robinson is a long-time fellow of ASCRS and is at the helm of the flagship of Navy medicine, the NNMC. Dr. Robinson has had a long and distinguished career and is always mentioned as a leader of Navy medicine, and as someone who has a promising career yet ahead. The NNMC is a primary source of care for casualties, fresh from the fighting in Afghanistan and Iraq, and is where President George W. Bush gets much of his medical care. Another well-known and highly respected colorectal surgeon-leader in the Navy is Dr. H.R. Bohman. Dr. Bohman has volunteered time and time again to go into the most difficult and dangerous battlefields and to give care to our

wounded. He has really been an example of courage and service before self throughout the military, and we can all be proud of his many accomplishments. Soldiers in Somalia, Afghanistan, Iraq, and elsewhere throughout the world can count themselves lucky to have had a surgeon like H.R. Bohman on hand to give them care. H.R. Bohman is a fine colorectal surgeon, but his lasting legacy will be the trauma care he has given on the front lines in the current conflicts. Colonel Ron Place is presently serving at Landstuhl, in Germany, where he has been chief of surgery and a leader of that important medical center as well as the colorectal surgeon there. Dr. Place has been deployed on several occasions to difficult battlefield situations and continues to represent our colorectal community with distinction.

CURRENT PRACTICE PATTERNS IN MILITARY COLORECTAL SURGERY

Many of the current military physicians joined as part of scholarship programs such as the Reserve Officer Training Corps (ROTC), the Health Professions Scholarship Program (HPSP), or attendance at a military academy, or attendance at the Uniformed Services University (our military medical school in Bethesda, MD). These funded educational programs usually require some subsequent period of service in the military.

The practice of colon and rectal surgery in the military most closely resembles a large multispecialty group practice. The provider has clinic to see patients and a hospital service. At most facilities, the general surgery demands exceed those of the colorectal-specific patients, and most military colon and rectal surgeons do some general surgery. The call schedule varies with the number and specialty of assigned providers.

The practice locations include medical centers (200 to 800 beds), large or regional hospitals (75 to 100 beds), small hospitals (25 to 0 beds), and stand-alone clinics (no inpatient capability). Each service (Army, Air Force, or Navy) has such facilities, and they are located on military bases or posts throughout the United States and the world. The number and specialty of providers assigned to each type of facility vary. In general, a specialty-trained surgeon (such as colon and rectal surgeon) is usually assigned to a regional hospital or a medical center. The military residency programs are located at the medical centers. If the physicians have no commitment to the military (as from ROTC or other scholarship program), they have a great deal of choice in their assignment. Subsequent assignments take into account the physicians' desires, but the needs of the service take priority. Most assignments are for an average of 3 years.

Most facilities have a standard range of military uniforms, which are service specific: blue for the Air

Force, green for the Army, and white or tan for the Navy. As a result, you do not have to decide which tie to wear, and matching with your shirt or pants and clothing is not an option to express your individuality.

As a military officer, you are subject to the Uniform Code of Military Justice. This is a federal legal system and set of rules. It somewhat mirrors the civilian system, but there are some additional rules. For instance, fraternization with enlisted personnel in your chain of command, adultery, substance abuse, or "conduct unbecoming of an officer" can be punished administratively or criminally.

The past several years have been a huge challenge for all surgeons in the military. Colorectal surgeons have not been immune from the deployments, the time away from home, the loss of operating room skills, the dust, the heat, and the loneliness. Our colorectal surgeons have often been sent off to battle, taking advantage of the fact that they are also trained general surgeons. In battle, they are used as trauma surgeons. Many of them have become polished in handling trauma and have distinguished themselves on the battlefield, working in the most austere and difficult of circumstances. The typical military colorectal surgeon is sent off for 3 to 6 months and then comes back to resume practice, almost always in a medical center or larger hospital. Obviously, a routine colorectal surgery practice is not something that is possible in a forward hospital in a tent in Iraq. Our surgeons have become skilled at "damage-control surgery" and at transport of the critically injured back to the larger hospitals. The overriding concern today is the ongoing war in Iraq and Afghanistan. The conflict continues to drain our people and our supplies and has been a huge, expensive, challenging strain on our system of care.

However, when back at the medical centers, our colorectal surgeons have a steady demand for their services. Our patients range from newborns to elderly people. Our diseases include everything that one would expect in a university practice, including inflammatory bowel disease, cancer, anorectal disease, polyposis, and incontinence. We do a huge volume of typical colorectal surgery, and we also do many colonoscopies and much outpatient surgery. Whereas other surgical subspecialties seem to be withering on the vine (cardiovascular surgery, for instance), the need for colorectal surgery in the military has never been greater. The current list of active military colorectal surgeons is not extensive but includes some superb surgeons such as Nelson, DeNobile, Erchinger, Scherrer, and Perry.

ADVANTAGES OF MILITARY MEDICINE

In many respects, I believe that military medicine can be the very best place to be a doctor in 2006. Imagine a

system full of well-informed, appreciative patients who are striving hard to keep fit and healthy and who almost always do exactly what you tell them to do. This system provides all administrative support, including a full complement of legal assistance. All overhead expenses are paid, even malpractice premiums. The physician never has to worry about paying the rent, heat, lights, and salaries or buying equipment. And there is never a worry about whether the patient can afford needed tests or treatment. Most of the offices and operating rooms are really well appointed, with modern, expensive equipment. The salary for a senior military physician can be as high as about \$200,000 per year, with a portion of the salary tax free. After 20 years, one can retire with a guaranteed income of over \$50,000 per year and can then pursue a second career. But all of these positive features of military medicine are less important to me than one other: the feeling of camaraderie and fellowship that I have always sensed in the military system. In my 30 years of active duty, I never once felt that a colleague was out to undermine or denigrate my efforts. I always had total support from others, whenever I needed advice about a patient, or a friendly, helping hand in the operating room. Only when I retired from the military did I really begin to appreciate and miss this aspect of military medicine, namely the feeling of being on a team. I have great respect for the surgeons who have served in the desert. They come back with incredible memories and a pride in their accomplishments that is really noteworthy. There is not much complaining among our military surgeons, despite the challenges they face. Many of them continue to volunteer to return to battle. But the grind of frequent deployments is wearing them down.

CHALLENGES OF MILITARY MEDICINE IN 2006

For all its good features, military medicine is not a perfect system. Here are, in my view, a few of the challenges of our day:

1. Managed care has crept into military medicine. The military version of managed care is called TRICARE. In this system, the medical care for each region of the United States is under the direction of a private contractor. TRICARE has a mixed reputation among private physicians because of its variable reimbursement rates, delays in payments, lack of compassion, and so forth. Like Medicare, TRICARE has not had a method to measure excellence and does not limit care to the better providers. Even more important, the use of TRICARE has resulted in a drain of the population of military patients away from the military treatment facilities. This lack of patients has turned several of the military medical centers into

glorified clinics, closed down graduate medical education centers, and generally had a corrosive, negative impact on military medicine. As with many federal program, TRICARE has become bloated and self-serving. The Department of Defense (DoD) is now having difficulties funding this expensive program. Many military providers and patients feel that TRICARE is a poor excuse for what it has replaced, namely uniformed care given in military hospitals.

2. Inefficiencies of military medicine: Like many large systems, the military medical system has always needed more secretarial help, more clinic help, more nurses, a better dictation system, and a better computer system. Patients are often inconvenienced and are required to wait unnecessarily. There remains a maze of redundant paperwork that is begging to be streamlined. For years, we have lived with a very poor computer system, CHCS, which could have been replaced with any of several excellent and proven systems. More recently, we have been given CHCSII, which is actually making us less efficient and slowing us down. Flexibility has never been a key component of DoD thinking. I am convinced that all colorectal surgeons of the military could be much more productive if somehow we could allow them to practice in a large system like the Mayo or Ochsner Clinic system.
3. Frequent deployments: The so-called "ops tempo" of current military life can be stifling. Some of the older surgeons are feeling the strain as they have had multiple trips to the desert. Early in the conflict, we had large numbers of Reservists who were helping. Almost all of them have given up their military connections and have returned to private life. The active-duty physicians who remain are members of a much smaller personnel pool, making each member liable to go to the battlefield more and more often. Eventually, this sort of a system becomes unmanageable and implodes. We have been outsourced, privatized, "right-sized," and downsized to the point that we are seeing serious strains among our few remaining surgeons. It remains to be seen whether this present system will continue to be sustainable.

A military colon and rectal practice can be very fulfilling if it is approached with the appropriate mind set and realistic expectations. It offers the ability to practice medicine with an intelligent, appreciative population of patients without the usual financial constraints of other practice patterns. One has the opportunity to serve one's country while seeing varied parts of the world and participating in unique activities. These advantages must be balanced by the challenges of occasional resource limitations and

deployments. Military colorectal surgeons are a national resource and their contributions should be celebrated. (See Editorial, this issue.)

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The author has no conflict of interest to disclose with respect to this article.