
UNIFYING THE TRAINING CURRICULUM

The Congressional request that led to this report inquired about a joint training curriculum and a unified chain of command and budgeting authority. Our research focused on managed-care management approaches and the special considerations for coordination arising from the readiness mission. Much of this report focuses on the chain of command and resource management authority, but we have not examined in detail the DoD's vast and complex medical training programs.

Drawing on research on military training programs in general, we can offer some tentative conclusions about the feasibility and desirability of further unifying the training programs. Although the FY 2000 defense authorization act, discussed in Chapter 1, specifically mentions training curriculum, we also consider unified delivery of the curriculum.

Two goals exist for unifying training: (1) enhancing the ability to integrate peacetime and wartime care across the three service systems through cross-service integration of training and (2) cost savings associated with economies of scale in training. The first goal may be attained through common curricula. Realizing economies of scale in training would require consolidating training programs, and not just common curricula.

Military medical training programs fall into three categories: (1) programs that provide standard medical training (for example, undergraduate and graduate medical education for physicians or radiology technicians); (2) programs that train personnel in military-unique skills; and (3) unit training programs.

Some of the programs in the first category are already joint activities; the most obvious example is the Uniformed Services University of Health Sciences (the military medical school). The curricula for the programs run by the individual services differ only to the extent allowed by the relevant accrediting body. Further, the Defense Medical Readiness Training and Education Council (DMRTEC) is directed to “emphasize training for interoperability, by conducting joint and multi-service training” and to ensure the training is provided efficiently.

Despite this oversight by the DMRTEC and the various accrediting bodies, there may remain some differences in the curricula. Even more important differences may arise in the implementation of the curricula in what are typically hands-on training programs. Further differences are introduced in some medical occupations by the considerable number of personnel trained in civilian programs prior to or during their active service. It is not obvious that a further effort to standardize curricula in the individual skills training programs would be productive.

We discuss medical readiness training at the individual and unit levels in Chapter Four. To the extent that personnel and units from the three medical departments might operate jointly, the training curricula must have the common elements that lead to interoperability. However, legitimate differences exist in the operational requirements of the services that require differences in the curricula.

The health-care committee of the Inter-Service Training Review Organization was directed by the Chairman of the Joint Chiefs of Staff in 1992 to review readiness medical training, subject to the oversight of the DMRTEC. As described in Chapter Four, the highest priority is on ensuring that personnel and units receive sufficient readiness training. However, ensuring interoperability is also an important objective of these reviews. Interoperability of active and reserve medical units within a service is at least as important as interoperability of units from different services.

Joint-service review of the training programs does not guarantee that the curricula are appropriately unified, merely that coordinated curriculum changes may be considered. Joint training programs do provide this guarantee. Training programs that involve significant

patient care cannot be combined because the patients are distributed throughout the medical system. The only alternative for these programs is joint oversight, as is currently provided for physician residency training by the Flag Officer Executive Committee on Graduate Medical Education.

Many medical training programs do not require access to a population of patients. Even if these programs include service-specific instructional components, joint training may increase efficiency and generate cost savings. The analysis appropriate for determining which training programs to combine is complicated and requires extensive and detailed data (Schank et al., 1999; Shanley et al., 1997). The biggest potential source of savings is in the fixed support for a training program—for example, administrative personnel and curriculum developers—and in improved utilization of the training facilities. If these savings are small, there may be little point in combining programs.

Outsourcing the training to the civilian sector or employing distance learning may be more-efficient approaches, especially if they avoid the costs of moving personnel to a distant training location. In many instances, it is not possible to determine the most cost-effective approach without a pilot test (Shanley et al., 1997).

The rapid pace of technological development in both medicine and training puts a premium on having an organization capable of designing cost-effective training approaches well into the future. Therefore, the most important question about training may not be how to do it best today, but whether the cross-service working groups the DoD currently uses to coordinate training can provide this organizational capability. If not, strong central leadership in the form of a joint command may be required.