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Veteran-centred content in medical education

Authors:

Paula T Ross [1] and Monica L. Lypson [1,2]

[1]University of Michigan Medical School, Ann Arbor, Michigan, USA

[2]Office of Academic Affiliations, Department of Veterans Affairs Central Office, Washington, District of Columbia, USA

ABSTRACT

Background

Veterans have unique experiences that warrant special consideration in health care. Unfortunately, training in veteran-centred care has not been a clear focus of medical education and only a very small proportion of medical schools include military cultural competency in their curricula.

Methods

We conducted an 80-minute focus group with six U.S. veterans. Open-ended questions were used to elicit their perceptions of the health care they receive and how it can be improved. The audio-recording was transcribed verbatim and coded for thematic content. A phenomenological analytic approach was used to analyse the 31-page transcript and arrive at the final themes.

Results

Former service members from various periods of conflict (e.g. World War II, Vietnam, Persian Gulf) offered several insights about how to improve veterans' health care experiences. Veterans suggested that consideration of their previous military service would improve care. They lamented that the lack of military consciousness is a barrier to care. Finally, they suggested that clinicians pay close attention to the transition from service member to civilian, as reintegration to civilian life is a critical life experience.

Discussion

Veteran-centred care ensures optimal health care through ease of access to services, and positive patient-provider interactions. Being aware of military culture can help providers contextualise veterans' experiences and beliefs about health care seeking and illness management, particularly invisible wounds of war including Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD).

Keywords: veteran, health care, military, patient-centred

Introduction

"To care for him who shall have borne the battle and for his widow and his orphan."[1] President Abraham Lincoln's immortal words became the enduring promise of the U.S. Veteran Health Administration (VHA) to service members. An outgrowth of that promise was the partnership established between the VHA and U.S. Academic Health Centers to address the shortage of physicians, limited capacity of VHA hospitals to accommodate World War II veterans and support patient care, education and research. This partnership continues and has grown to include 124 VHA centers, 135 allopathic medical schools and 30 osteopathic medical schools.

Despite this partnership, veteran-centred care (VCC) has not been a clear focus of medical education and only 31% of U.S. medical schools include military cultural competency in their curricula.[2] As of 2016, this VCC as curricular content is taught with 83 of 135 medical schools, mostly in lectures[3], however the specific content is unknown.

With the number of military personnel reintegrating into civilian life[4] each year it is essential that providers in both veteran focused and civilian health facilities are aware of veteran-centred care (VCC). VCC ensures optimal health care through provider attentiveness to the specific implications of previous military service on patients' life circumstances and needs.[5] Below we suggest that VCC must be directed toward exposing trainees to the unique needs of service members through educational content in military culture, communication, and patient-centred care.

Methods

As a U.S. Army veteran (PTR) and a primary care physician at a VHA (MLL) for over 15 years, we launched this study to identify ways to improve care. Veterans were recruited from flyers at the local VA in clinics and lobby, e-mails to military support programmes and networks, and snowball sampling. In 2015, we (PTR and MLL) conducted an 80-minute focus group with six veterans from various periods of conflict (e.g. World War II, Korea, Vietnam, Persian Gulf); ages ranged from 49 to 95 (average 76.3); gender (10 males, one female); serving in the U.S. Army, U.S. Air Force and U.S. Marines.

Open-ended questions were used to explore veterans' perspectives on their care. For example, participants were asked "What do you want your doctor to know about your health care and life experiences that have affected your feelings about the health care system? What do you think doctors miss when caring for veterans?" All veterans fully engaged in this rich discussion. Using a phenomenological analysis approach[6] the authors independently read the 31-page transcript to become familiar with the transcript and extract significant phrases and statements that pertained to veteran-centred care. Final themes were reached through several discussions and comparison between authors. All veterans provided informed consent. The Institutional Review Board at the University of Michigan approved this study.

Findings and Discussion

Our discussion with former service members about how to improve veterans' health care experiences offered several insights. Perhaps most importantly, veterans voiced how consideration to previous military service would improve present patient care to veterans.

> Get as much information as they can from the individual's military experience, their post military time, and what they experienced [during] that time. This gives a little better understanding of what the individual could be going through as far as what happened in the military versus what's going on now.

Cultural consciousness in health care combines patient-centred care with understanding the social and cultural influences that affect the quality of medical services and treatment.[7] Military cultural consciousness is an essential part of VCC as it recognises the cultural aspects of being a member of the armed forces.[8,9] The military's distinct vocabulary, hierarchy, norms of behaviour, and code of conduct are key aspects of its culture. The socialisation process (e.g., basic training), facilitates the transition from civilian to service member and the adoption of the military's customs and has the potential to impact health seeking behaviours. Participants acknowledged how the lack of military consciousness can be a specific barrier to care.

> …[M]ost of the doctors [have] never been in war. They don't relate because they don't have that experience of being in the same shoes that you've been in. When you have individuals who are young coming from medical school where the only thing he knows about is being at home, having fun, and going to school, it's not related to the aspect of being in the military, the distance you have from family and friends, and things that you go through while you're in the military.

Traditionally, civilian providers care for veterans and reservists at VHAs and civilian facilities, while military physicians care for service members who are on active-duty. Compared to entering the military, the transition from service member to civilian is

generally less targeted and lengthy, which can make reintegration difficult. Another veteran stated,

> [M]ost physicians don't understand that people in the military are guarded about the information they give because in the military you're constantly told not to give up any information about yourself or anything else. So you have to bring this person to the point to where it's okay for you to let some guard down.

Being aware of military culture can help providers contextualise veterans' experiences and beliefs about health care seeking, self-care, illness management as well as symptoms, particularly invisible wounds of war including mental illness, Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD).[10] In the context of VCC, patient-centred communication may help elicit how a patient's military affiliation may influence their attitude and behaviour toward their health care and uncover service-related medical concerns.

Veterans expressed clear opinions about the type of questions physicians should be asking about their life experiences in order to provide the best care. One veteran suggested they ask, "Has he been in combat experience, number one." Another veteran suggested,

> Ask about his transition from coming to the military to a civilian life. That's the main thing. Because a lot of people's transition is terrible. Some people have some good transitions. Some people have it bad. Some people can't cope being out of the military.

Beyond deployment to combat environments, veterans may have service-related conditions that affect them physically, emotionally, or psychologically, even after they have departed from service.[11] Military service can affect various aspects of the patient's history (e.g., medical, social, family, occupational, and psychiatric) and impact clinical diagnosis and treatment recommendations. As military affiliation may not be visible (e.g., wearing service insignia) and only 30% of veterans seek care within the VHA, we would argue that all patients should be asked about their service to ensure better insight into existing symptoms.

Conclusions

Many countries (Australia, Canada, France, Germany, United Kingdom, United States, etc.), have been involved in the long conflicts in Iraq and Afghanistan[4] causing the increased numbers of veterans across the globe.[4] (Table 1) Many of these countries expend significant federal resources to provide crucial services to assist in veterans' reintegration into civilian society[4], yet not all veterans seek their care via government sponsored agencies.

While these findings are limited by small numbers, the quotes make a strong case for veteran-centred care training for medical trainees and practicing physicians. We recommend incorporating VCC principles into existing curricula to expose trainees to military culture and veteran health needs to improve assessment and triage skills.[3,12] Acknowledging veterans as a distinct population, incorporating a differential diagnosis related to military service exposures, and including clinical rotations at military health centers are some examples of how to integrate VCC into existing curricular content.[3,12] VCC is also relevant for practicing providers. For example, asking patients about military service[13], especially in civilian settings, to ensure they receive appropriate care and military-service related benefits (through official government agencies, e.g. VHA or NHS (National Health Service)). A military history includes four critical questions: Did you, or someone close to you, serve in the military? When did you serve? Where did you serve? What did you do in the military?[13] These questions can affect their medical history, social and family history, occupational history, psychiatric history, and preventative medical screening. Surprisingly, military service is often overlooked as part of the patient's medical history.[13]

VCC also emphasises partnership and collaboration across professional disciplines to facilitate efficient patient handoffs (handovers and referrals). Veterans can present with combat or environmental-related concerns such as, chronic pain (primary care), PTSD and TBI (psychiatry/mental health), substance use disorders (specialty treatment centers), homelessness (social work) and chronic medical problems (primary care). Excellence in health care is the result of a comprehensive team including patients, family members, and health care staff working together.

We suggest using various pedagogical approaches (e.g., small group learning, photo-elicitation, unannounced standardised patient) to develop these skills.[14,15] For example, we used reflective writing to stimulate critical thinking about the complexities of humanism in their role as physicians, and cross-cultural patient-provider interactions (e.g., military veterans, elderly, racial minorities).[14] At our institution we have begun to expose medical students, residents, and faculty to VCC. Some of these activities include a Veterans' Day panel, second-year medical student elective course, unannounced standardised patient for residents, faculty development workshop, and massive open online course (MOOC) (Service Transformed: Lessons in U.S. Veteran Centered Care). Teaching and implementing the principles of VCC throughout the education continuum may ensure veterans receive appropriate and necessary care.

References

1. Lincoln, A. Second Presidential Inaugural Address March 4, 1865. Washington, D.C., United States. Accessed from: http://libertyonline.hypermall.com/Lincoln/lincoln-2.html. December 17, 2017
2. Serving those who serve America. Joining Forces: Results of an AAMC Survey.2012. Association of American Medical Colleges, Washington, DC. Available at: https://members.aamc.org/eweb/upload/ServingThoseWhoServeAmerica.pdf. Accessed January 4, 2018.
3. Lypson ML, Ross, PT. 2016. Curriculum Inventory in Context. Integrating Veteran Centered Care into Your Existing Curricula. [database on the Internet] 2016;3. Available at: https://www.aamc.org/download/471208/data/ciic03-9sep2016.pdf.
4. Veterans Affairs Canada: Comparison to Other Countries Comparison to Other Countries. 2009. Available at http://www.veterans.gc.ca/eng/about-us/reports/departmental-audit-evaluation/2009-12-nvc/4-4.) Accessed October 18, 2017.

5. Hamm WG, Betts VT, Duffy DM, Fairbanks FA, Garthwaite TL, Kell DF, et al. After Yellow Ribbons: Providing Veteran Centered Services. Washington, D.C.: A Report of a Panel of the National Academy of Public Administration for the U.S. Congress and the U.S. Department of Veterans Affairs 2008.
6. Colaizzi PF. Psychological research as the phenomenologist views it. In: Valle RS, King M, eds. Existential-Phenomenological Alternatives for Psychology. New York: Oxford University Press; 1978:48-71.
7. Kumagai AK, Lypson ML. Beyond cultural competence: Critical consciousness, social justice and multicultural education. *Acad Med* 2009;**84**:782-7
8. Convoy S, Westphal RJ. The importance of developing military cultural competence. J *Emerg Nurs* 2013;39:591-4.
9. Meyer E. Case Report: Military Subcultural Competency. *Military Med* 2013;**178**:e848-E50.
10. Ramchand R, Karney BR, Osilla KC, Burns RM, Caldarone LB. Prevelance of PTSD, Depression, and TBI Among Returning Servicemembers. In: Tanielian TL, Jaycox LH, eds. Invisible wounds of war: psychological and cognitive injuries, their consequences, and swrvices to assist recovery. Santa Monica, CA: RAND Corporation; 2008:35-85.
11. Lee J, Sanders KM, Cox M. Honoring those who have served: How can health professionals provide optimal care for members of the military, veterans, and their families? *Acad Med* 2014;**89**:1198-200.
12. Ross PT, Ravindranath D, Clay M, Lypson ML. A greater mission: Understanding military culture as a tool for serving those who have served. *J Grad Med Educ* 2015;7:519-22.
13. Brown JL. A piece of my mind: The unasked question. *JAMA* 2012;**308**:1869-70
14. Lypson ML, Ross PT, Zimmerman N, Goldrath KE, Ravindranath D. Where Do Soldiers Really Come From? A Faculty Development Workshop on Veteran Centered Care. *Acad Med* 2016;**91**:1379-83.
15. Lypson M, Ravindranath D, Ross P, Pfeiffer P, Griggs J, Buckler S, Whitman, L, Tremblay A, Weiner S, Fitzgerald JT. Veteran Interactive Cases to Reinforce Service (VICTORS):

Standardized Patient Assessment of Veteran-Centered Care. 2016. MedEdPORTAL Publications. Available at: https://www.mededportal.org/publication/10326.

16. Veteran Affairs Canada Report 2014. http://www.veterans.gc.ca/eng/about-us/reports/departmental-audit-evaluation/2009-12-nvc/4-4
17. Austrialian Government Department of Veteran Affairs Pensioner Summary 2017. https://www.dva.gov.au/sites/default/files/files/about%20dva/stat/PenSumm_Sep2017.pdf
18. Veteran Affairs Canada. War Service and Canadian Armed Forces Veteran Population as of March 2017. http://www.veterans.gc.ca/eng/about-us/statistics/1-0
19. Annual population survey: United Kingdom Armed Forces Veterans Residing in Great Britain, 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/654734/20171023_-_APS_2016_Bulletin.pdf
20. Profile of Veterans 2015. Data from the U.S. Census Bureau, American Community Survey PUMS, 2017: U.S. Department of Veterans Affairs: National Center for Veterans Analysis and Statistics. 2017. https://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Veterans_2015.pdf

Corresponding author's contact details: Paula T. Ross, PhD, Office of Medical Student Education, University of Michigan Medical School, 5100-C3 Taubman Health Sciences Library, 1135 E. Catherine, Ann Arbor, Michigan 48109, USA. E-mail: paulat@umich.edu

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Ethical approval: Our study was approved by the Institutional Review Board at the University of Michigan Medical School.

Table 1. Veteran Population and Reintegration Services

Country	Australia	Canada	United Kingdom of Great Britain	United States of America
Government Agency[16]	Department of Veteran Affairs	Veteran Affairs Canada	Service Personnel and Veterans Agency	Department of Veteran Affairs
Country Population	24,450,56	36,624,199	66,181,585	324,459,463
Veteran Population	54,600[17]	658,400[18]	2,500,000[19]	18,831,3005[20]
Veterans' Reintegration into Civilian Society Annually[16]	Approximately 5,000 annually	Approximately 4,000 annually	Approximately 24,000 annually	Approximately 200,000 annually
Programmes Supported During Military to Civilian Transition[16]	• Military and Compensation Act • Rehabilitation • Permanent impairment • Incapacity payments • Special rate	• New Veterans Charter • Disability awards • Rehabilitation • Financial benefits • Health benefits • Job placement	• Armed forces compensation scheme • Lump-sum payment • Guaranteed income payment • Career transition partnership	• VA disability compensation • VA disability pension • VA health care system • Independent living programme • Vocational rehabilitation and employment programme