A Greater Mission: Understanding Military Culture as a Tool for Serving Those Who Have Served

Paula T. Ross, PhD
Divy Ravindranath, MD, MS
Michael Clay, MD
Monica L. Lypson, MD, MHPE

The number of veterans who have served in Iraq and Afghanistan has grown over the past decade, and it is important to provide high-quality health care for this population. Unlike previous generations of veterans, contemporary veterans often have been deployed in multiple conflicts, have been exposed to close proximity explosions, and have had longer tours of duty, making their military histories and medical needs more complex.[1] To address this issue at the national level, the White House's Joining Forces initiative pledged its commitment to meet the needs of veterans and their families. Shortly after the announcement of this initiative, the Association of American Medical Colleges (AAMC) initiated a nationwide survey of more than 100 medical schools and health systems to determine the extent to which future physicians were being trained to care for military personnel.[2] Nearly all medical schools indicated that their curriculum included training in posttraumatic stress disorder (PTSD) and traumatic brain injury; however, only 31% indicated that their curriculum provided training in military cultural competency.[2]

Many veterans affairs (VA) health care centers serve as clinical training sites for physician trainees (medical students, residents, and fellows) through affiliations with medical education programs.[3] Recent legislation calling for additional funding for graduate-level training positions through the Veterans Access, Choice, and Accountability Act of 2014 will likely increase the number of residents in the VA.[4] Surprisingly, however, only about 9 million of the 22 million veterans receive care at the VA.[5] With increasing numbers of veterans reintegrating into civilian life, and strict eligibility criteria for receiving care at the VA, it is equally important to prepare trainees to care for the veterans in VA institutions as well as in civilian health care centers.

For the past 2 years, as the University of Michigan Health System readies new residents for their role in providing patient care, we have asked 378 incoming interns 5 questions about their exposure to, or experience with, the military (provided as online supplemental material). All incoming trainees participate in a postgraduate assessment as part of orientation and complete a survey on various topics (patient handoffs, sterile technique, pain assessment, and informed consent, among others). In our incoming resident cohort, 71 US and 3 international medical schools were represented. The results did not indicate a lack of exposure to the military, as 67% of new interns had rotated at a VA medical center during medical school. In contrast, only 1% identified as a veteran. In response to 2 questions about PTSD and military sexual trauma (MST), 2 afflictions at the forefront of contemporary veterans' health issues, 71% of respondents indicated feeling confident to successfully work with veteran patients, yet only 32% recognized MST as a VA acronym for military sexual trauma, and only 21% recognized avoidance as the necessary symptom for a diagnosis of PTSD (using DSM-IV criteria).

These findings suggest that many residents have shortcomings in their knowledge of conditions affecting a large number of veterans. PTSD exists within 11% to 20% of veterans of Iraq and Afghanistan combat, 10% of veterans of the Gulf War, and 30% of veterans of the Vietnam War.[6] Undoubtedly, combat is not the only source of trauma for veterans, as MST was found to have increased by 50% between fiscal years 2012 and 2013 in all 4 military services.[7] Although MST is perhaps stereotypically expected to be more common among female veterans, 54% of all VA patients who screen positive for MST are men.[7]

DOI: http://dx.doi.org/10.4300/JGME-D-14-00568.1

Editor's Note: The online version of this article contains the survey questions used in the study.

TABLE
Suggested Topics for Veteran-Centered Care Curriculum for Veterans Affairs and Civilian-Based Trainees

Topic	Instruction Focus	Teaching Methods	Teaching Resources
VHA utilization	Share patterns of veteran usage of VHA health care facilities	Focused didactics/ lecture Self-paced learning	US Department of Veterans Affairs. VA Health Care Utilization by Recent Veterans. http://www.publichealth.va.gov/epidemiology/reports/oefoifond/health-care-utilization.
			US Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. http://www.va.gov/vetdata/index.asp.
Military cultural competence/ consciousness	Provide trainees with an overview of the structure of the US military and military conflicts, and demographic background of US veterans, as well as military socialization processes, traditions, values, and behavioral norms	Focused didactics/ lecture Self-paced learning	Goldenberg MN, Hamaoka D, Santiago P, McCarroll J. Basic training: a primer on military life and culture for health care providers and trainees. MedEdPORTAL. 2012. https://www.mededportal.org/icollaborative/resource/192.
			Reger MA, Etherage JR, Reger GM, Gahm GA. Civilian psychologists in the Army culture: the ethnical challenge of cultural competence. *Mil Psychol*. 2008;20:21–35.
			Center for Deployment Psychology. Learn About Military Culture Course. http://deploymentpsych.org/military-culture.
Military health history	Demonstrate how to obtain a focused military history, elicit service-related health concerns, and assess life stressors	Vignettes/trigger tapes Medical encounter videos	Association of American Medical Colleges. Taking a military health history: four critical questions. 2013. https://www.aamc.org/advocacy/campaigns_and_coalitions/360908/takingamilitaryhealthhistory.html.
			Brown JL. A piece of my mind: the unasked question. *JAMA*. 2012;308(18):1869–1870.
			Pankow SH, Dill MJ, Navarro AM, Jones KC, Prescott JE. Health care provider awareness of the military status of patients: asking the question. *Analysis in Brief*. Association of American Medical Colleges. 2013;13(5). https://www.aamc.org/download/358546/data/oct2013analysisinbrief-awarenessofmilitarystatusofpatients.pdf.
Health care disparities	Identify causes of health disparities for US veterans, highlighting the social determinants of health and the ways in which social location creates challenges in optimal health care	Problem-based learning cases Individual case-based discussion	National Ethics Committee of the Veterans Health Administration. An ethical analysis of ethnic disparities in health care. National Center for Ethics, Veterans Health Administration, Department of Veterans Affairs. 2001. http://www.ethics.va.gov/docs/necrpts/NEC_Report_20010801_Ethnic_Disparities_in_Health_Care.pdf.
Empathetic communication	Instruct trainees to provide care that is concordant with the patient's values and preferences that promotes active participation in decision making regarding their health and health care	Faculty role models/ mentors Medical encounter videos	Lypson ML, Page A, Bernat CK, Haftel HM. Patient-doctor communication: the fundamental skill of medical practice. iCollaborative. 2012. https://www.mededportal.org/icollaborative/resource/595.
			Bellet PS, Maloney MJ. The importance of empathy as an interviewing skill in medicine. *JAMA*. 1991;266(13):1831–1832.

TABLE
Suggested Topics for Veteran-Centered Care Curriculum for Veterans Affairs and Civilian-Based Trainees (continued)

Topic	Instruction Focus	Teaching Methods	Teaching Resources
Common diagnoses in veterans	Summarize conditions particularly prevalent in veterans (eg, PTSD, TBI, anxiety, depression, etc) and instruct trainees on how to identify these conditions within this population	Individual case-based discussion Workshops Problem-based learning cases	Lypson ML, Ravindranath D, Ross PT. Developing skills in veteran-centered care: understanding where soldiers really come from. MedEdPORTAL. 2014. http://www.mededportal.org/publication/9818.
			PTSD: National Center for PTSD. http://www.ptsd.va.gov/index.asp.
			Krakower J, Navarro AM, Prescott JE. Training for the treatment of PTSD and TBI in US medical schools. In: Analysis in Brief. Association of American Medical Colleges. 2012;12(5). https://www.aamc.org/download/313126/data/november2012anaysisinbrief-trainingforthetreatmentofptsdandtbii.pdf.
			Spelman JF, Hunt SC, Seal KH, Burgo-Black AL. Post deployment care for returning combat veterans. *J Gen Intern Med*. 2012;27(9):1200–1209.

Abbreviations: VHA, Veterans Health Administration; PTSD, posttraumatic stress disorder; TBI, traumatic brain injury.

Based on data from the AAMC survey, as well as our own, we suggest that medical education programs at all levels direct attention toward helping trainees develop improved awareness of military culture and the health issues facing veterans. Grasping the complexities of military culture with its distinct traditions, socialization, values, vocabulary, behavioral norms, and branch distinctions can be a challenge.[8–10] Understanding military culture is further complicated by the fact that service members also occupy other cultures (race/ethnicity, socioeconomic status, religion, sexual orientation) that need to be considered in the delivery of health care. Nonetheless, the consideration of military culture and experiences (eg, indoctrination process, combat zones, war-related trauma, and the stigma of help-seeking) can help contextualize patient symptoms, help treatment planning, and ultimately improve health outcomes.

Others have suggested that probable methods to learning about military culture as related to medical education specifically include how to obtain a focused military history, how to elicit service-related health concerns, and how to identify and assess stressors.[11] In addition to these, we recommend that trainees receive a meaningful introduction to military culture to improve their knowledge, enhance their awareness of the needs of veterans, and identify and address any assumptions, biases, and prejudices that could arise in their interactions with veteran patients (TABLE).[12–14] Furthermore, while structural and patient-level causes of health disparities have received much attention, provider-related causes of health disparities also contribute to poor outcomes through stigma, lack of cultural consciousness, and unconscious provider bias.[14,15] A provider's use of effective communication skills and the ability to elicit pertinent details about a patient's military experience can directly influence the patient's health and health outcomes.[16]

Education programs will also need to assess whether their faculty possess sufficient knowledge and experience to serve as good role models to prepare trainees for working with veterans. Along these lines, the authors created an active learning faculty development workshop to help address certain faculty assumptions and biases about contemporary veterans, recognize the value of patient-centered communication skills, and identify causes of health disparities for veterans, particularly patients with PTSD and traumatic brain injury.[17]

Educating trainees in military culture will hopefully improve their ability to recognize and diagnose symptoms, which is expected to reduce the problem of service members "slipping through the cracks" and not receiving proper care. Through these efforts, we hope to address the larger mission, which is to train physicians to serve those who have served us.

References

1. Coll JE, Weiss EL, Yarvis JS. No one leaves unchanged: insights for civilian mental health care professionals

into the military experience and culture. *Soc Work Health Care*. 2011;50(7):487–500.
2. Association of American Medical Colleges. Serving those who serve America: joining forces: results of an AAMC survey. https://members.aamc.org/eweb/upload/ServingThoseWhoServeAmerica.pdf. Accessed July 9, 2015.
3. US Department of Veterans Affairs Office of Academic Affiliations. Medical and Dental Education Program. http://www.va.gov/oaa/gme_default.asp. Accessed July 9, 2015.
4. Veteran Access, Choice, and Accountability Act of 2014, HR 3230. Pub L No. 113–146. https://www.congress.gov/bill/113th-congress/house-bill/3230. Accessed July 9, 2015.
5. 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(9):1198–1200.
6. US Department of Veterans Affairs, PTSD: National Center for PTSD. How common is PTSD? http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp. Accessed July 9, 2015.
7. US Department of Defense Sexual Assault Prevention and Response. Department of Defense annual report on sexual assault in the military: fiscal year 2013. http://www.sapr.mil/public/docs/reports/FY13_DoD_SAPRO_Annual_Report_on_Sexual_Assault.pdf. Accessed July 9, 2015.
8. Reger MA, Etherage JR, Reger GM, Gahm GA. Civilian psychologists in the Army culture: the ethnical challenge of cultural competence. *Mil Psychol*. 2008;20(1):21–35.
9. Hobbs K. Reflections on the culture of veterans. *AAOHN J*. 2008;56(8):337–341.
10. Hall LK. The importance of understanding military culture. *Soc Work Health Care*. 2011;50(1):4–18.
11. Chretien JP, Chretien KC. Coming home from war. *J Gen Intern Med*. 2013;28(7):953–956.
12. Goode TD. Promoting cultural diversity and cultural competency: self-assessment checklist for personnel providing primary health care services. Georgetown University Child Development Center National Center for Cultural Competence. http://nccc.georgetown.edu/documents/checklistbehavioralhealth.pdf. Accessed September 24, 2015.
13. Kumagai AK, Lypson ML. Beyond cultural competence: critical consciousness, social justice, and multicultural education. *Acad Med*. 2009;84(6):782–787.
14. Burgess DJ, Fu SS, van Ryn M. Why do providers contribute to disparities and what can be done about it? *J Gen Intern Med*. 2004;19(11):1154–1159.
15. Atkins D, Kilbourne A, Lipson L. Health equity research in the Veterans Health Administration: we've come far but aren't there yet. *Am J Public Health*. 2014;104(suppl 4):525–526.
16. King A, Hoppe RB. "Best practice" for patient-centered communication: a narrative review. *J Grad Med Educ*. 2013;5(3):385–393.
17. Lypson ML, Ravindranath D, Ross PT. Developing skills in veteran-centered care: understanding where soldiers really come from. http://www.mededportal.org/publication/9818. Accessed July 9, 2015.

Paula T. Ross, PhD, is Educational Research Specialist, Office of Medical Student Education, University of Michigan Medical School, and a Desert Storm Veteran; **Divy Ravindranath, MD, MS,** is Director, Mental Health Evaluation Clinic and Consultation Service, Veterans Affairs Palo Alto Healthcare System; **Michael Clay, MD,** is Deputy Associate Chief of Staff for Education, Veterans Affairs Ann Arbor Healthcare System, and Clinical Assistant Professor, Department of Internal Medicine, University of Michigan; and **Monica L. Lypson, MD, MHPE,** is Associate Chief of Staff for Education, Veterans Affairs Ann Arbor Healthcare System, Professor, Departments of Internal Medicine and Learning Health Sciences, and Assistant Dean for Graduate Medical Education, University of Michigan Medical School.

The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the US government.

Corresponding author: Monica L. Lypson, MD, MHPE, Associate Chief of Staff for Education, VA Ann Arbor Healthcare System, Professor of Internal Medicine and Learning Health Sciences, University of Michigan Medical School, #11J, 2215 Fuller Road, Ann Arbor, MI 48105, 734.845.3400, mlypson@umich.edu