

The Unasked Question

MY FIRST POSTGRADUATE YEAR AFTER MEDICAL SCHOOL was routine. The second year was not. Seven weeks after induction into the Army, I was sent to Vietnam, issued combat gear, an M-16, and a .45-caliber pistol, and then embedded with 900 infantry troops and 30 medics as the only physician.¹ At first I felt like an imposter—a civilian dressed up to look like a soldier—but this feeling evaporated when I began treating wounded troops while under fire, drenched by monsoon rains, or kneeling in a minefield. The learning curve for medical improvisation is steep when there is no suction, oxygen, blood products, or most of the equipment I had previously taken for granted.² Unlike recent wars where soldiers are meticulous about wearing body armor, we often wore baseball caps and cotton shirts in the tropical heat—one of the reasons there were 57 000 dead soldiers by the war's end.³ When I was hospitalized with severe headaches and fever, I self-diagnosed meningitis, but was relieved to learn it was only dengue fever.

It required a machine gun–mounted jeep and a squad of men to ensure security, but I still looked forward to treating smiling Vietnamese children in the local villages as a diversion from my regular workday. So when I returned to civilian life, I trained to become a pediatrician. By that time, an improbable transformation had somehow taken place. Now I felt like an Army doctor who was dressed up to look like a civilian. As a resident physician at a teaching hospital, I was irreverent when asked to perform tasks I thought were unnecessary; after all, I was used to taking charge and carrying a weapon. I forced myself to order x-ray films and laboratory tests instead of relying on instinct alone, and if I treated an injured adolescent male patient, the unwelcome smell of mud mixed with blood might suddenly appear in my nostrils. I noted the location of windows and doors when I entered public places, and when I went fishing, I found it necessary to check the tree line of our local lake before baiting my hook.

I married, started a family, and settled into a rewarding career as a community pediatrician. During the four decades that followed, I developed an assortment of medical ailments. A few were of uncertain etiology, but most seemed consistent with my age. It is only recently that I realized that although there had been dozens of medical encounters, without my prompt I had *never* been asked by a medical student, resident, or attending physician if I had served in the military, or if my deployment might be responsible for my medical symptoms. In fact, I am embarrassed to say, I had not given it much thought either. Like most physicians, I was never trained to *routinely* ask

patients if they were veterans or taught how to take a military health history. I believed that the likelihood of seeing patients who were veterans was small and that those with service-related conditions were already receiving attention at the Veterans Health Administration. Both assumptions were wrong.

I am quite certain that I would seem like an ordinary patient to most physicians. But I also know that I carry the psychological imprint of my Vietnam experience and that I am at increased risk for developing medical complications from constant exposure to the dioxin-containing defoliant known as Agent Orange. We were told that it was non-toxic. Toxicity is now measured in parts per billion, and Agent Orange has been shown to cause cancers, neurological disease, leukemia, type 2 diabetes, ischemic heart disease, and many other conditions.⁴ In retrospect, regardless of my unremarkable appearance, questions that every physician should have asked me at every age were: Did you ever serve in the military. (Yes.) When and where were you stationed? What was your job description? Were you physically injured? (No.) Did you ever receive a blood transfusion before routine screening for hepatitis C? (No.) Were you ever exposed to Agent Orange? (Yes.) Were you ever treated for parasitic or tropical diseases? (Yes. Yes.) Have you ever been treated for a service-related condition? (Yes.) Were you affected psychologically by your military experiences? (Yes.)

When I reviewed the most recent US census data that pertained to veterans, I could not have been more surprised by the results: The 19.4 million male and 1.8 million female veterans who live in the United States comprise about 10% of the population 18 years and older. Of these, one of every six men (16.5%) between the ages of 35 and 64 years is a veteran; the percentages are higher for those older than 64 years and lower for those younger than 35 years.⁵ Only 40% receive some portion of their medical care from the Veterans Health Administration.⁶ And, like me, the majority use traditional health care resources that are covered by Medicare, Medicaid, or private insurance.

The public health implications are important: Large numbers of veterans who might have sequelae from their military service are receiving medical care from civilian physicians who have no awareness that they are veterans. The 63-year-old man who presents with multiple myeloma and Parkinson disease, the 41-year-old woman with chronic fatigue and myalgia, and the 30-year-old patient with memory loss and panic attacks might all have symptoms related to

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deployments in Vietnam, Iraq, or Afghanistan. And because no one ever asked if they served in the military, no one would know that their symptoms might be service related. As good medical practice, a factory worker with a two-year history of exposure to low-grade radiation or chemical and smoke inhalation would have his or her occupational history noted and flagged for long-term follow-up; medical conditions like cancer and emphysema might not become evident until many years later. But if these same health risks occurred during a Gulf War deployment, this information might never find its way into the patient's health record.

When a patient answers no to a single question, "Have you ever served in the military?" his or her service history has been completed. But the 21 million patients who answer yes will benefit because possible service-related causes will now be included in the differential diagnosis of their medical complaints, and statistical correlations between a risk like dioxin exposure and medical illness might be made years earlier. (Some Vietnam-era veterans might have received treatment and disability benefits 20 or 30 years sooner, and others might not have died in the interim.) If every adult patient is asked this single question, pooled electronic health data could be used to detect associations between illness and deployment. This will be especially important for female soldiers who require ongoing monitoring for possible complications of pregnancy and birth defects. And physicians might now refer eligible underinsured veterans to Veterans Affairs health facilities for treatment they could not otherwise afford.

Teaching how and why to take a military health history should be added to medical school curricula along with other medical history questions. And military veterans could be considered a "cultural group" when teaching about cultural diversity. This would allow for discussions about common issues like unemployment, marital and psychological stresses, substance abuse, suicide, and the potential for occupational disability. Thousands of medical students, residents, and fellows currently receive some of their training at Veterans Affairs facilities every year, and requiring enhanced courses before their rotations would provide an excellent opportunity for learning this material. The VA's Department of Academic Affiliations has developed useful teaching tools that include a pocket card that is updated an-

nually.⁷ Few of the veterans who visit their physician have the stereotyped appearance of young amputees, older men wearing gold-embroidered "I Am a Veteran" caps, or anxious patients taking tranquilizers. They represent one of every six average-looking adult male (and an increasing number of female) patients. And because they served their country, many are at risk for potentially serious problems that are not being addressed by our medical community. This is not because of indifference, but because of an oversight in training. Until the question "Have you ever served in the military?" becomes part of routine medical history, patients who have been wearing their "I Am a Veteran" caps when visiting the physician will have good reason to continue doing so.

Jeffrey L. Brown, MD

Author Affiliations: Department of Pediatrics, New York Medical College; and Department of Psychiatry, Weill Cornell Medical College; New York, New York (jlbrown100@msn.com).

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1. Medical personnel carried weapons and did not wear Red Cross insignia because the Viet Cong treated them as valued targets. For the same reason, troops were taught to call for medics by name rather than yell "Medic!" I had no meaningful weapons training before my arrival. When I was issued an M-16 and the .45-caliber pistol, I returned the M-16 because I thought it was more likely that I would injure myself than any of the enemy. A medic taught me how to fire the pistol.
2. The practice of placing physicians in front-line battalion aide stations was vestigial from wars when the aide station was "behind the lines." In Vietnam, the perimeter machine guns might be located just a few hundred yards behind the aide station. By the end of my tour, most physicians were rotated out of the field into higher-level medical facilities. Medevac helicopters picked up many patients at their point of injury, and battalion surgeons could only function like well-trained medics, so the added danger did not seem justified.
3. Pre-Kevlar flak vests were heavy and thick as ski vests. Our "steel pot" helmets were also heavy and hot. Both were impractical for use in wet tropical climates. They were often worn at the discretion of individual soldiers and only when absolutely necessary.
4. US Dept of Veterans Affairs. Veterans' diseases associated with agent orange. <http://www.publichealth.va.gov/exposures/agentorange/diseases.asp>. Accessed October 8, 2012.
5. US Census Bureau American Fact Finder. Table B21001: Sex by age by veteran status for civilian population 18 years and over. 2010 American Community Survey 1—Year Estimates. <http://www.census.gov/acs/www/>. Accessed August 20, 2012.
6. US Dept of Veterans Affairs, Veterans Health Administration 2011 survey of veteran enrollees' health and reliance upon VA, March 2012. http://www.va.gov/healthpolicyplanning/soe2011/soe2011_report.pdf. Accessed August 23, 2012.
7. The pocket card can be accessed at <http://www.va.gov/oaa/pocketcard/military-health-history-card-for-print.pdf>.