TIPS WHEN CARING FOR SOLDIERS WITH DEPLOYMENT-RELATED HEALTH CONCERNS

CPT Doctor has been the brigade surgeon for the ten months following his medicine residency at Military Medical Center. It is late in the afternoon walk-in clinic, and CPT Doctor hurries into the exam room to find a 37-year-old airborne ranger with 18 years in service including Gulf War service and other deployments, SFC Soldier, sitting on the exam table with his shirt off. Doctor glances through the short medical record that consists mainly of a series of standard forms with no complaints and the usual *"I'm in excellent health"* penned onto each of them. He noticed that SFC Soldier had visited the troop medical clinic about ten times over the past three or four months.

"What can I do for you today SFC?" asks Dr. Doctor. "Doc, I've got a couple years left to retirement, and, well, for the past three years or so, I've been feeling more and more run down – tired all the time. My knees hurt worse every day. I'm real worried. The last year my shoulders started hurting too. I've known other soldiers from the Gulf War unit I was in that came down with this kind of thing… What do you think is going on doc?

Previous exams for the same symptoms were all negative, knee films and shoulder films were normal, and a pretty complete set of screening labs including electrolytes, complete blood count, liver function tests, and sedimentation rate were also normal. Sounds like chronic fatigue syndrome, fibromyalgia, or one of those sorts of 'conditions', thought CPT Doctor. He had recently read some news articles about Gulf War Syndrome – seemed like just another medical myth to him. Deep down it upset and puzzled CPT Doctor that there were no medical answers for so many of these veterans. Over a hundred thousand veterans were ill, he had read, and they can't all be making something out of nothing…could they? Then again, CPT Doctor had a tough time getting past his personal experiences involving the few troops he had seen that were worried about Gulf War Syndrome. They were pretty frustrating and difficult.

"Why does stuff like this always come up right at the end of the day when there's a bunch of people in the waiting room, and I'm supposed to meet with the brigade XO at 1700?" Doctor thought to himself.

How should CPT Doctor handle this visit? The following is a list of FIRST LINE and SECOND LINE CONSIDERATIONS regarding how to constructively assist Gulf War veterans like SFC Soldier with related health concerns.

The **FIVE FIRST LINE CONSIDERATIONS** are the most important ones. These are:

1. Emphasize compassion, empathy, and concern. CPT Doctor must set aside his preconceptions regarding whether or not the Gulf War is a "legitimate" cause of SFC Soldier's symptoms and emphasize respect and gratitude for his service to country. Validating SFC Soldier's health concerns will help CPT Doctor gain the soldier's confidence and enhance trust and rapport. Particularly if SFC Soldier has concerns about the relationship of his symptoms to past deployments, there may be many factors that can make trust-building an uphill task. Doctor and patient are worlds apart – the doctor is an officer: white collar, management, educated, and an expert. The patient is an NCO: blue collar, labor, and a layperson. If SFC Soldier connects his symptoms to a deployment, he may not trust the doctor to diagnose a problem that he views as implicating the military. SFC Soldier, like other soldiers, knows there are limits to the doctor-patient privilege, and he may fear the implications his health care visit will have for his future in the military. In contrast, CPT Doctor has the upper hand; he is in his element, the troop medical clinic, in control of the outcome of the visit, and personally has little on the line. Under these circumstances, SFC Soldier may wonder whose interests CPT Doctor has at heart.

2. Encourage SFC Soldier to offer his concerns about deployment-related illness. Given the potential for mistrust, SFC Soldier may not share the links he has made between his symptoms and the Gulf War unless CPT Doctor asks about them directly. Soldier may feel that Doctor will judge him to be a troublemaker if he says anything more about it. If deployment-related illness is not a concern for Soldier,

then Doctor's inquiry will do no harm. If it is a concern, then broaching the issue will leave SFC Soldier feeling validated and understood.

Many clinicians feel uneasy validating, asking about, or legitimizing "ill-defined" or subjective illnesses for fear they will reinforce or sanction inappropriate illness and disability. There is no scientific evidence to support this view. SFC Soldier's symptoms are already chronic. Pretending his symptoms are "minor" or that they don't exist will not help him or reassure him. At best, it will convince him that his doctor is patronizing and falsely reassuring. At worst it will leave him thinking his doctor is incompetent and unworthy of his trust. Soldier knows what he or she feels, and simplistic reassurances are destined to fail.

3. Acknowledge reasonable clinical uncertainty. *A recent National Academy of Sciences Institute of Medicine expert panel recently noted during a review of force health protection procedures that, "The acknowledgement of uncertainty does not erode trust and confidence in leaders; rather, it fosters confidence in the reliability of information deemed to be more certain and valid."*

Clinicians are taught to act decisively, even though uncertainty is substantial in nearly all clinical encounters. How can clinicians possibly know whether common symptoms like fatigue and chronic pain are related or unrelated to a particular low-level deployment exposure? Even the finest clinicians simply cannot. Often reasonable uncertainty exists as to whether a given exposure occurred. Other times, uncertainty exists as to whether a given low-dose exposure can lead to illness. Uncertainty may also exist as to what the symptoms of low-dose exposure would be if they were to occur. Just like simplistic reassurances, clinicians expressing exaggerated levels of certainty are virtually guaranteed to shatter the patient's trust and confidence. Demeaning expressions of exaggerated certainty often take the form of the following clinician statements:

- "Your symptoms do not have a physiological cause."
- "Exposure x could not have occurred during deployment y."
- "Illness z doesn't have anything to do with exposure x or deployment y."

Clinical Uncertainty
Example of Illness after the Gulf War

The Gulf War health issue can serve as an example of the high level of uncertainty inherent to these situations. Population-based studies of Gulf War veterans versus different comparison groups have consistently shown that, even though Gulf War veterans do not have elevated rates of hospitalization or illness-related mortality due to illness, they report an increased prevalence of nearly every symptom, both physical and emotional. Gulf War veterans also report a lower than expected health-related quality of life. Consider the results of one CDC study: 15% of non-deployed Gulf War era veterans suffered from a mild chronic fatiguing illness they called, "chronic multisymptom illness". By comparison, 45% of Gulf War deployed veterans met criteria for the same illness. Taken literally, that suggests an ill Gulf War veteran has a one-third chance (15% / 45%) their health would have declined even had they not gone to the Gulf, and a two-thirds (30% / 45%) chance are somehow related to Gulf War service. If you are CPT Doctor, you have no way of knowing whether SFC Soldier fits in the one-third who would have gotten it no matter what or the two-thirds with Gulf War-related illness.

Therefore, CPT Doctor is best advised to acknowledge uncertainty rather than rely on bias or preconception. Similarly, the temptation is often great to diagnose a somatoform disorder (i.e., a psychological explanation for what are essentially medically unexplained physical symptoms). It is honest and sensible to acknowledge that large proportions of the symptoms causing patients to seek care ultimately lack clinical explanations.

4. See SFC Soldier and his significant other(s) back in a week or two for an extended visit. This is prudent if SFC Soldier relates his symptoms to a military or deployment-related exposure. The invitation to come back for an extended visit with a significant other will allow CPT Doctor to learn more about SFC Soldier's specific concerns and the deployments he has participated in. Often it is a worried spouse or significant other that observes subtle declines in the soldier's health and pushes the soldier to seek care. Inviting the significant other into the evaluation can prevent them from feeling excluded, and it may demystify the symptoms as well as the medical evaluation process.

The Department of Defense Deployment Health Clinical Center has assembled a tri-service website for clinicians, for soldiers, airman, seamen, marines, and their loved ones. A key objective of the site is to provide "CPT Doctors" everywhere with a centralized site for dissemination of health information found in the media and the medical literature about the health effects of various deployments. The site is at http://www.deploymenthealth.mil.

5. Collaborate with SFC Soldier in his care. Often clinicians see it as their job to "find it" (the source of the patient's problem) and then "fix it". In this way of thinking the clinician must "tell" the patient the treatment, "prescribe" it to him, and hope he will "comply" with it. A more **soldier-centered approach** to care acknowledges that different people with the same illness may have completely different care-related goals. The clinician's job in this model is to elicit the soldier's concerns, his or her explanation for symptoms, and his or her goals for the visit. The clinician and the patient-soldier must then collaboratively negotiate treatment goals as well as the indices that will be used to monitor whether or not progress is occurring toward those goals. Appropriate improvement indices may or may not involve laboratory measures of disease status. Often patient-reported progress toward behavioral ability or capacity to fill family-related, duty-related, or other roles is the final or only available indicator of treatment success or failure.

Military clinicians may find soldier-centered approaches to care problematic. These clinicians may feel strongly that this approach denies the military reality that the clinician is an officer and the patient is usually enlisted and sometimes in need of old style military "guidance". An order to "suck it up and drive on" is a poor substitute for a show of leadership on the part of the clinician. Good military leaders acknowledge that they cannot simply boss troops around. They must respect their intellect and their need to know. Good military leaders must motivate the men and women in their charge to continuously seek higher ability and functioning. The same is exactly true of the military clinician.

The first line considerations outlined above are the most important ones. It may also help to use the following **FIVE SECOND LINE CONSIDERATIONS** when providing care for SFC Soldier:

1. Ensure that SFC Soldier has sound primary care for deployment-related health concerns. Clinicians often become anxious over the possibility of deployment-related exposure syndromes and assume that the management of these concerns necessarily requires specialized training of some sort. Most deployment-related symptoms and syndromes are best managed in primary care settings. Referring the concerned soldier to a specialist for sophisticated evaluation and testing sends an important message. The soldier may wonder, "Why is the doctor sending me to a specialist?" In the absence of a lengthy explanation, the soldier is likely to answer his or her own question: "The doctor must be worried. Maybe I have a serious undiagnosed condition…?"

2. Military health records document service suitability and medical treatment. It is best to avoid challenging SFC Soldier's health concerns on the basis of documents in the military medical record. CPT Doctor should not assume that the "clean bill of health" often found in the medical records of good soldiers are a reliable indication of their actual state of health. Many soldiers with "clean" medical histories report many medical problems on their separation physicals. Probably the best estimate of the soldier's health is somewhere in between these best- and worst-case data gathering scenarios.

3. Keep the medical evaluation focused on suspected diseases. Most times clinicians can tell when they are faced with a low-yield diagnostic evaluation. However, perhaps the most common error of diagnostic reasoning is to suspect a low-yield and then embark on an extensive evaluation to "rule out" every possibility no matter how improbable. If deployment-related health concerns are at issue, clinicians may often feel compelled to run the gamut of low yield medical tests in a duty-bound effort to "leave no stone unturned".

The better strategy is to see the soldier for a series of scheduled return visits and engage in "watchful waiting" to see if symptoms progress into a more recognizable pattern. Extended diagnostic evaluation in low-yield clinical situations typically leads to a higher than acceptable rate of false positive test results. These false positive results provide fertile soil for sowing diagnostic and therapeutic misadventures. As with unjustified specialist referrals, unnecessary or inappropriate diagnostic testing can also send unintended and potentially harmful messages to the soldier-patient.

4. Diffuse the potential for clinician-patient "contests" before they occur. The famous back pain specialist Nortin Hadler has said, "You cannot get better if you must prove you are ill." Clinicians should

avoid the temptation to tell SFC Soldier, "There is no Gulf War Syndrome," no matter how strong one thinks the evidence is. Such a statement is as ill advised as looking SFC Soldier in the eye and saying, "Gulf War Syndrome exists, and you have it!"

Telling the patient there is no such thing as what they think they have is akin to throwing down a challenge. Consider, for example, what happened after the Gulf War. After a spirited US victory there were regular proclamations that no chemical exposures occurred during the Gulf War. Many veterans and their advocates intuitively understood that positive evidence of even minor chemical exposures could damage military credibility.

Clinicians must avoid the same mistake! Challenging the validity of a soldier's deployment-related health concerns will cause them to worsen more often than not. A pattern of challenging soldier's concerns may well lead to a clinical miscue and accompanying loss of CPT Doctor's professional credibility. Ultimately, debating the legitimacy of Gulf War Syndrome overlooks the main reason for SFC Soldier's visit. Whether or not Gulf War Syndrome exists, SFC Soldier doesn't feel well, and CPT Doctor's first duty and obligation is to help SFC Soldier.

5. Destigmatize "stress" before diagnosing it or making a mental health referral. CPT Doctor knows full well of course that "stress" can lead to physiological changes, physical symptoms, and sometimes illness, disease, and disability. There is an excellent chance that SFC Soldier knows that too. Why not just "give it to SFC Soldier straight"? *Because people are not computers.* People often misunderstand or may react to news in ways it was not intended. When clinicians invoke stress as a possible explanation for illness, it is taken by many people to indicate a personal problem as opposed to a health problem. Many will view it as an accusation: "The doctor just told me that I'm crazy!" [or, "…that I'm just imagining my symptoms!"] Some soldiers, particularly those with a history of excellent service and who take pride in their reputation, may mistakenly infer that the doctor thinks he or she should never have sought care in the first place: "This doc thinks I'm riding sick call!" Others may fear the career or security clearance repercussions of even a single mental health visit.

Hopefully, after a few visits to see CPT Doctor, SFC Soldier will have come to view him as an advocate. Until such time as a positive rapport is established, "the stress explanation" is best set aside. Instead, clinicians should simply address the symptoms as "medically unexplained" and engage in conservative diagnostic testing, scheduled follow-up, and watchful waiting. Rather than making an immediate psychiatric referral, start first with a trial statement to destigmatize referral (e.g., "chronic symptoms are often distressing, especially if they are causing limitations; I often think a counseling visit helps. What do you think?"). Clinicians should *always* see the patient back after referral so they don't feel you have rejected or abandoned them as "a head case".

Military clinicians are well trained and equipped to address the technical aspects of caring for military personnel and their loved ones. These are the top priority. Keep firmly in mind, however, that technical failures are seldom the source of complaints among those with deployment-related concerns. Soldiers want advocacy, explanations, and compassion. They want clinicians they can trust and who trust them. Fostering superior relationships with our soldier-patients will ultimately bolster the credibility of all of military medicine and improve the health of troops.