Reproductive Health Management for the Care of Women Veterans

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Question 1:

How do you feel about the new maternity leave policy in branches such as the Navy? Do you think that this policy should be standardized across all branches? Do you think that this policy, while put in place to hopefully help assist in retention of women in the military, will act to further separate men and women in the military? For instance, do you have any concerns that a policy that would allow women to take a year off for maternity leave would lead to lack of respect or discrimination by male coworkers?

Response from Dr. Zephyrin:

The policy being referred to is available here: http://www.navy.mil/submit/display.asp?story_id=87987. The new maternity leave policies will provide much needed support for military families. This can possibly enhance retention and allow women to continue to have careers in the military with children. Active duty women and men are often away from their families for months at a time. This new policy shows support for creating strong families and healthy children. Maternity and paternity leave in the military is weighed against the need for readiness; therefore, system supports must be in place to ensure any gaps are filled adequately. In some ways this issue of readiness is unique to the military and is likely different from private sector organizations. Whenever maternity leave policies are discussed, modified, or implemented, there is a concern that rather than helping women stay in the workforce and improving the health of families, such policies will create further gender divisions and exacerbate existing inequalities. However, there are limited data to support such assertions. Parental leave policies have been increasingly discussed and available in corporate America. Rather than reducing or limiting maternity leave, it has been suggested that a more positive trend is to provide paternity leave in addition to maternity leave, and to encourage men to take advantage of paternity leave.
Many developed nations have progressive maternity and paternity leave policies. Women and families should not have to choose between having a child or having a career or a constant means of financial support while caring for newborn children. This new policy is forward thinking and will hopefully be extended to paternity leave and include other branches of the military. Interestingly, both the U.S. Air Force and U.S. Army offer up to 10 days of consecutive paternity leave (see http://www.bamc.amedd.army.mil/departments/obgyn/peri-natal/docs/Paternity%20Leave%20Policies.pdf). I am unaware of statistics indicating what percentage of active duty fathers chose to take such leave.

Question 2:

As opposed to the “healthy soldier effect,” do you think that there may be a large portion of active duty military women who hide certain medical conditions so as not to seem weak among their peers or “different” from their male counterparts?

Response from Dr. Zephyrin:

The “healthy soldier effect” refers to the fact that to join the military one has to meet some minimum educational and physical fitness requirements, which by definition makes those in the active duty military on average healthier in many ways than civilians. There is ongoing debate in the scientific literature as to whether, or for how long, this effect persists among veterans.

I am not aware of any data addressing the hiding of medical conditions. The development of qualitative studies addressing this potential issue may be needed. It is possible that women AND men may have concerns of how a medical condition affects their job or eligibility for benefits. Nevertheless, the most severe conditions would be difficult to hide and there would be no incentive to hide them once an individual separates from the military.

Question 3:

With the ever-increasing awareness of sexual harassment, sexual assault, and sexual trauma in the military, active duty military members are briefed on a regular basis on how to handle these situations and how to report interpersonal violence and sexual assault. How effectively does this translate to the care of veterans, considering that they often are being cared for by civilian personnel who may not have been exposed to this information or training?

Response from Dr. Zephyrin:

It is critical that all health care providers are aware of the demographics of their population. Asking a woman if she has served in the military is an important first step. This allows for acknowledgement of military service and the ability to start a conversation about her military service and what she may have experienced. Women veterans are able to receive care at a local Veterans Affairs (VA) health care system for any issues related to military sexual trauma. There is a need for translation of information about military sexual trauma to health care providers who may not have familiarity with this population. However, it is worth noting that many providers outside the VA, particularly those in mental health and emergency medicine, are trained to be aware of and manage patients with a history of sexual trauma or who seek medical care as a result of sexual assault. Nevertheless, one recent assessment found that less than 20% of U.S. hospitals provided comprehensive services to sexual assault patients (see Int J Gynaecol Obstet 2013;123:24–8). To date there are no data as to whether the increased awareness within the military and the VA has influenced providers caring for veterans in the community.

Given that many women veterans are seen by non-VA personnel, it is important to increase awareness among non-VA and non–Department of Defense clinical providers regarding this issue. The continued development of innovative linkages between veteran and non-veteran organizations that serve women are needed and organizations that advocate and enhance care delivery for women must include veterans as part of their agenda.
Question 4:

Because sexual assault is such a charged topic, asking questions about this topic on a screening questionnaire may not result in candid answers. What do you think is the best way to approach these questions during a medical office visit? Should this topic be addressed by the medical assistant rooming the patient, or should it be left for the provider to discuss?

Response from Dr. Zephyrin:

Questions addressing sexual assault must to be part of routine screening. Screening for interpersonal violence should be asked, as all medical questions, in a private environment. An untrained medical assistant may not be comfortable addressing these questions with patients. Screening for a history of sexual assault can be asked initially by a nurse, or other trained provider, who screens the patient before the visit and by the primary health care provider. In my experience, the best way to approach these questions is to build a rapport with the patient. Sometimes it can take several visits before she feels comfortable sharing this information with her health care provider. It is important not to rush the patient through her disclosure, to listen to what she is sharing, and to ask open-ended questions. I focus all my attention on the patient and truly listen. It is also important to understand that the gynecologic exam can be a difficult experience for those with a history of sexual trauma. If it is a new patient, and she has experienced this trauma, I often provide her the option of deferring the pelvic exam to another visit. In my experience, this allows the patient to feel more in control of the visit. In the Clinical Expert Series article, I provide some tips on how to approach the gynecologic exam in patients with a history of sexual trauma.

Question 5:

There has been an increasing interest in medicine to “center” patient care during office visits. Centering groups of pregnancy, parenting, and even hypertension and diabetes have been created leading to group medical care of people with similar diagnoses. Are there any unique features of women veterans that would increase or reduce the likelihood of success with a centering approach?

Response from Dr. Zephyrin:

Centering groups can provide a support network for women undergoing similar experiences in pregnancy and has been shown to increase knowledge and empower women to be active in their own care. The Centering Pregnancy model has been implemented in several medical treatment facilities, including Madigan Hospital in Washington State and the Naval Medical Center in San Diego. While these groups have largely been successful and well received, it is important to note that these medical centers care for both active duty members and their spouses, and thus are serving a very different population than the VA. There are several unique factors that need to be taken into account when considering the likelihood of success of a centering approach for pregnancy care among women veterans. These include:

- Prevalence of medical or mental health conditions that can make women veterans’ pregnancies high risk.
- Geographic distribution of women veterans and access to peer groups of other pregnant women veterans.
- Reliance of the VA on care purchased from community clinicians for providing pregnancy care.

Importantly, Centering Pregnancy was primarily developed for use among women with low-risk pregnancies. While many women veterans may in fact fall into this category, a growing body of literature indicates that those who seek pregnancy care through the VA do not.

Another issue to consider is the geographic distribution of women veterans, particularly those relying on the VA for pregnancy care. While the number of women veterans is increasing along with the number using VA
health care, women veterans still comprise only 2% of the overall U.S. population and approximately 10% of the veterans using VA health care. A major component of Centering Pregnancy is the focus on the group and building peer support. Studies in other veteran populations and anecdotal experience indicate that veterans appreciate support of other veterans and that this one factor can make VA health care attractive to veterans. While I am currently unaware of any publications or data related to mobile or telehealth adaptations of the Centering Pregnancy approach, uses of such technology to enhance care for pregnant patients with conditions such as diabetes or substance use are increasingly popular and some promising results have been published.