Prejudging the problems of Canada's military families

I was delighted to read in "Caring for Canadian military families" in the January issue of *Canadian Family Physician* that research is under way to identify medical concerns specific to Canada's military families.[1] My interest is personal. I am the son of a career officer and World War II veteran, I was raised on military bases around Canada, and later I served as a Canadian Armed Forces (CAF) General Duty Medical Officer and raised my children on and near military bases.

I am concerned that the authors are pre-empting the research.[1] Their article begins with the usual vignette, in this case a military family in crisis. The infant son is not progressing, the daughter is regressing, the infantryman-father's behaviour has changed, the mother is struggling. The vignette is a list of red flags, a picture of incipient failure.

The authors state that "this is not an uncommon situation for military families."[1] Later they say that currently "there are no Canadian data comparing commonly experienced health problems by CAF spouses or children."[1]

You cannot say the problem is common and then say that you have no epidemiologic data.

The data in the article are essentially United States (US) data. Extrapolating these data would be unwise. United States military personnel start from different socioeconomic backgrounds; they are deployed abroad more frequently and for longer periods than Canadian personnel are; their families are uprooted more often; and the US military is embedded in American society and culture in a way that is foreign to this country.

Contrary to the article's suggestion, the triad of mobility, separation, and risk is not unique to military life. I suggest that families of Canadian workers involved in resource extraction industries would be as close a comparator as US military personnel. Many miners spend more time away from their families than military personnel do. Thousands of oil field workers have moved their families to other provinces, often more than once. When mines close or logging is no longer profitable, miners and loggers pack up and move, with attendant discontinuity of care. Unlike military families their spouses and kids do not have a military family resource centre to turn to.

As for the risks of military service, this is a myth. Miners, loggers, fishermen, and oil field workers have a substantially higher risk of morbidity and mortality than soldiers, sailors, or air force personnel. In 2018 the CAF Directorate of Force Health Protection published an analysis of overall mortality in CAF personnel enrolled between 1976 and 2012.[2] They concluded that all-cause mortality was statistically significantly lower than in the general population, for both sexes. Rather than increasing risk of death, military service might have a protective effect.

Finally, I think it is worth mentioning that Calian is a for-profit company, with strong ties to the Department of National Defence.

—Marc Clark MD CCFP
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Competing interests
None declared

References

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Response

We thank Dr Clark for his letter[1] and we appreciate the opportunity to discuss the issues that military families endure. We are always working to find the balance between recognizing the real effects of high mobility and relocation on the Canadian health care experience for military families without perpetuating the perception that military families are damaged.

Dr Clark raises some valid issues related to differences between the military operational demands and experiences across nations; however, he fails to consider the unique health care experiences of Canadian military families. In the United States (US), the military provides continuous health care for the families regardless of their location. For Canadian military families, 50% of whom move every 2 to 4 years, this is not the case. They must access civilian health care services across jurisdictions, starting from scratch every time. The issues raised in the vignette in our commentary,[2] when present, are amplified under these conditions.

We agree with Dr Clark that we cannot state that the issues highlighted in our vignette are common without supporting Canadian data. Recently published survey data from Canadian Forces Morale and Wellness Services suggest that, while this might be a common scenario for military families in the US or Canadian military families in need, most Canadian military families are doing well at any point in time.[3] Military families in crisis are not the norm for the average family physician; however, when in need, these are commonly cited concerns and issues to look for, investigate, and ask about.

We also agree with Dr Clark that fly-in–fly-out resource extraction types of jobs are a close comparator for occupations that require protracted absences from the family unit. What this comparison does not account for is the interaction between separation and mobility that military families face. Many families of individuals employed in resource extraction remain in their communities and connected to their social, community, and health services in a stable and persistent manner. The workers often deploy on cycles of weeks, so relocation is not as frequent for those families. We also agree that more research needs to be done to understand the effect of occupation on health and social well-being at the family level to better

understand how occupational mobility might affect continuity of care for other mobile Canadian families.

Dr Clark has also raised the point that many other occupations come with risks and that Canadian Armed Forces members experience lower mortality than the general population does.[4] Individuals who join the military and stay in the military are by definition healthier than individuals in the general population, given occupational eligibility and operational requirements. Health effects of service and acquired morbidity continue after the period of employment, with an effect on families. While it is true that the risk of mortality might be lower in particular employed subsets who do not deploy to conflict zones, no other occupation requires the employee to legally sign off on the risk of death and injury.

Five years ago, there were virtually no Canadian data on military families. Since our commentary was submitted some 14 months ago,[2] the field of military family health research has surged forward.[3,5-10] We now know through the analysis of routinely collected health administrative data more and more about the differences between the children and spouses in military families and those in civilian families, and how they access and use the publicly funded health care system. This information, along with discussions with families themselves, can help direct thinking about the barriers military families face in accessing health care.

Dr Clark has also pointed out that we have highlighted programs run by for-profit companies for military families. Calian Canada is a company with strong ties to the Department of National Defence. They also have an active program to create primary health care access for military families; we also mentioned Operation Family Doc, which has a similar mandate. Rather than endorsing a single organization, we are outlining available supports for military families that family physicians can access while facilitating access to primary health care, so the issues described in the vignette do not evolve.

Most military families do well. Yet, like any population of patients, there is a small proportion who do not. We would like to ensure that the military lifestyle factors are recognized and addressed within the family physician relationship so that the concern that families are paying a price for the serving member's service can be dampened.

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Competing interests
Dr Birtwhistle has received research funding from Calian Canada through the Canadian Institute for Military and Veteran Health Research. This funded project is unrelated to this letter to the editor.

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Correction

In the article "Caring for Canadian military families" that appeared in the January issue of *Canadian Family Physician*,[1] one of the authors omitted to declare a competing interest. Dr Birtwhistle received a research award from the Canadian Institute for Military and Veteran Health Research funded by Calian Canada for 3 years starting in 2015. This research project has provided 1 progress report to Calian Canada through Queen's University in Kingston, Ont, but Calian Canada has had no involvement with the project other than to connect researchers to Primacy medical clinics in several provinces.

Reference

1. Cramm H, Mahar A, MacLean C, Birtwhistle R. Caring for Canadian military families. *Can Fam Physician* 2019;65:9-11 (Eng), e1-4 (Fr).

Correction

Dans l'article intitulé « Soigner les familles de militaires canadiens » publié dans le numéro de janvier du *Médecin de famille canadien*[1], l'un des auteurs a omis de déclarer un intérêt concurrent. Le Dr Birtwhistle a reçu une bourse de recherche de l'Institut canadien de recherche sur la santé des militaires et des vétérans, financée par Calian Canada, pendant 3 ans à compter de 2015. Ce projet de recherche a produit 1 rapport d'étape qui a été remis à Calian Canada par l'intermédiaire de l'Université Queen à Kingston (Ontario), mais Calian Canada n'a eu aucune implication dans le projet, sauf celle d'avoir établi un contact entre les chercheurs et des cliniques médicales Primacy dans différentes provinces.

Référence

1. Cramm H, Mahar A, MacLean C, Birtwhistle R. Soigner les familles de militaires canadiens. *Can Fam Physician* 2019;65:9-11 (ang), e1-4 (fr).