Army families and the general practitioner

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SUMMARY. The military component of a rural general practice is described with details of increased workload and morbidity for conditions associated with emotional stress.

Introduction

There is, apparently, no way of estimating accurately the number of civilian general practitioners who care for service families in Britain, both because of the high mobility of army staff and the inability to identify them as the families move in and out of the National Health Service. A figure of 50 practitioners has been suggested, but this is surely an underestimate. Some doctors may deal with only one or two families while others find that a considerable proportion of their practice is orientated to the work. Often family medical care is fragmented when the serviceman has to consult the service medical officer while his wife and children are registered with a local general practitioner.

The army family lives in a more controlled and paternalistic environment than its civilian counterpart and in return gives up a considerable degree of responsibility for itself. It is subject to great stresses of transience and separation which lead to a multitude of medical and social problems (McGhie, 1953; Fanning and McConvell, 1967; Densham-Booth, 1970).

The military environment has also altered considerably in the last 20 years. The soldier's role has become blurred, less heroic, and concerned more with peacekeeping, security operations, and civil disorders than with open warfare (Wawman, 1968). The army has contracted in size, but increased in professionalism and skill. This is reflected in the greater intelligence and stability of the men. The proportion of married soldiers has risen from 20 per cent in 1965 to about 50 per cent.

Army

The purpose of this paper is to describe the military component of a rural civilian practice and describe some organisational and medicosocial problems which seem to be specific to army families.

Method

The practice

Three doctors serve 5,212 patients in a rural setting covering 100 square miles. Within this area lie two military establishments, one five miles and the other three miles from our main purpose-built surgery. Almost no public transport links them to the surgery, so branch surgeries are held in each camp two to three times a week. All the soldiers and officers are cared for by semi-retired army doctors, while their wives and children are registered with the practice. Drugs are dispensed at the main surgery and delivered twice weekly to a collecting point in each camp.

Results

Analysis of the military component of the practice (1974).

Number of patients:	1,101	i.e. 20·1 per cent of total practice population.
Annual turnover:	400	women and children, i.e. 36 per cent of the military population, 7·8 per cent of total practice.

Morbidity

There have been some studies of morbidity in army families (Fanning, 1967; Hoyte, 1971; Neild *et al.*, 1972). These were mostly concerned with overseas communities. The recording of

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morbidity in the families in this study has been hampered by the transience of the patients and the slow transfer of their medical files from overseas. Another difficulty has been the maintenance of adequate duplicate records in the military branch surgeries. It has been possible to obtain data only on severe, chronic, or recurrent problems, thus excluding much minor illness. Because of the cultural background of the military families and urban style of the married quarters, the population under study was regarded as urban in nature.

TABLE 1
ANALYSIS BY AGE AND SEX

Age range	*Male*	*Female*	*Total*	*Per cent of total practice population in age group*
Under 5	194	141	335	*62*
5–14	155	156	311	*31*
15–44	34	381	415	*20·3*
45–64	—	36	36	*3·5*
65+	—	3	3	*0·5*

TABLE 2
MORBIDITY OVER 12 MONTHS

Disease or problem (Royal College of General Practitioners code)	*This study incidence/1000 patients*	*Hodgkin (1973) incidence/1000 patients*
Reactive depression	53	20
Insomnia	33	10–18
Eczema	31	29–35·7
Vaginitis	24	2·4+
Lumbar disc lesion	22	17·7–36·4
Endogenous depression	20	19
Severe marital problems	20	
Hayfever	20	3·1+
Anxiety neurosis	14	
Asthma	14	8·6+
Enuresis	12	9·5
Migraine	12	4·8–16·0
Pyelonephritis	11	10·3–15·9
Acne vulgaris	11	8·8+
Sterilisation	10	–
Epilepsy (Grand mal)	9	2·8–5·7
Cystitis	9	14·5–22·4
Dysmenorrhoea	8	5·7+
Squint	8	1·5–4·3
Infertility	7	3·0+
Hysterectomy	6	–
Rhinitis	6	9
Chronic otitis media	5	2·2–2·8
Psoriasis	5	5
Gallstones	3	1·9–4·8
Uterovaginal prolapse	3	2·0–6·4
Schizophrenia	2	1·1–1·7
Duodenal ulcer	1	6·5

Discussion

Workload

The departure and arrival of about 36 per cent of the military component of the practice population each year creates considerable administrative work in the practice. There is often difficulty in obtaining medical records from overseas. Medical care is often unsatisfactory for those families

who arrive from overseas with their problems only half solved. Similarly they may be posted away from England in the middle of medical investigations or while waiting for hospital admission. For instance, several patients have been submitted to repeated and unnecessary hospital tests for infertility owing to postings and lack of medical records.

Morbidity analysis (table 1) shows a high incidence of several problems which may be associated with emotional stress. This is particularly clear with asthma, hayfever, and the various neurotic disorders.

The high incidence of allergic, respiratory, mental, and genital disorders in army families has been confirmed in other studies. (Hoyte, 1971; Neild *et al.*, 1972). Depressive illness and marital problems prove to be most time-consuming, requiring co-ordination with the attached health visitor, general practitioner, the army medical officer, the unit families officer, and the unit commanding officer. A Soldiers, Sailors, Airmens, Families Association (SSAFA) sister was not available in the practice. SSAFA now provide support services only overseas.

A visiting community psychiatric social worker organised counselling groups in a town nearby, which included army wives who were under specialist psychiatric care.

The constant movement of army families in and out of the practice assured a never-ending supply of medicosocial problems similar to those reported by general practitioners serving transient urban populations (Lefever, 1975).

Organisational problems

Medical care to army families overseas is provided mainlv by military staff. Attention is paid to housing and social support with the assistance of SSAFA sisters, unit families officers, and army wives' groups. In Britain, only the larger camps warrant these services, while the smaller establishments rely more heavily on the National Health Service. The latter are often sited in rural or semi-rural areas with inadequate transport to urban and medical facilities. This stimulates the need for on-site branch surgeries and arrangements for the delivery of drugs. The often demanding and dependent attitude of the patients (Hoyte, 1971; Neild *et al.*, 1972) ensures a high workload exacerbated in a rural setting by the distances travelled for home visits.

The army family

The soldier's repeated absence on training courses or unaccompanied postings often produces symptoms of anxiety and depression in his family. The frequent uprooting of the home and repeated packing and unpacking, often at short notice, lead to instability of married life, particularly in young families living far from supporting relatives. Children's schooling can be disrupted. The soldier has the rewards of an active mobile life, but his family may suffer for it.

Conclusion

The medical care of army families is time-consuming and provides a disproportionately high workload for the civilian general practitioner. Further efforts should be made by the Ministry of Defence and the National Health Service to provide social support for these families.

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