



Guest editorial

I'm not strange, I'm just like you

I'm not strange I'm just like you;

I like to do what the normal people do.

Comb my hair and wash my face

And keep my neck tie in its place.¹

Growing up in the land of blues and barbeque in Memphis, I had the opportunity to go to high school with the son of musician and song writer Keith Sykes, who penned the words to the above opening stanza of his song, “I’m Not Strange, I’m Just Like You.” As I completed high school and continued my undergraduate studies there in Memphis with future plans of medical school, I began to research financial options to avoid incurring debt for medical school. My search ended when I discovered the military’s Health Professions Scholarship Program (HPSP). This competitive scholarship program pays for all medical school tuition, fees, and provides a financial stipend, which currently is in the neighborhood of \$28,000 each year. The Air Force (AF) HPSP recipient currently also receives a \$20,000 bonus when entering into the program at the start of medical school. In exchange for this attractive financial package, the HPSP recipient incurs a year-for-year active duty service commitment, which begins after residency training. I completed both my residency and fellowship training in AF graduate medical education programs. Having no military background in my family, my intent on entering the HPSP was to pay my 4 years back and return to Memphis to practice. Well, here I am 20 years later—still active duty and now serving as the Chief of Graduate Medical Education for the AF, which includes providing oversight to our 2,500 medical students, residents, and fellows training around the country.

As an active duty military physician for the last 20 years, I have encountered the perception of practicing in a “strange” medical setting, that is, the perception that the patient population and practice setting we have in the military is somehow different from that of our civilian counterparts. The logical extension of this mindset by some is that our clinical research findings may not be applicable to our civilian colleagues. A common misperception supporting such a position is the thought that our patient population consists solely of young, active duty military members. Although we do care for relatively young active duty members, most of our patient population consists of the spouses and children of these members and also military retirees and their spouses and

children. Thus, our patient population is from cradle to grave. In fact, only 333,000 of the 2.6 million beneficiaries the AF Medical Service cared for at the 75 AF medical facilities around the world are active duty. Thus, only 12.8% of our AF medical beneficiaries are active duty. The AF Medical Service comprises a \$7.1 billion, 43,000-person integrated health care delivery system. In San Antonio alone, 1 in 4 in our city of 1 million citizens is eligible for military medical benefits. When our beneficiaries do not have access to a military medical facility, they are seen by civilian providers and use their TRICARE insurance benefits. Many readers of *Annals* are familiar with TRICARE, as they care for these patients in their practices.

In this issue of *Annals*, my Air Force colleagues from the fellowship program at Wilford Hall in San Antonio publish the adherence findings from their study of patients with imported fire ant (IFA) hypersensitivity.² They prospectively followed 76 IFA hypersensitive patients and report a 71% (54/76) adherence rate with initiation of immunotherapy. Practically speaking, 3 of 10 patients evaluated, tested, counseled, and recommended for life-saving therapy never showed up for their first visit. In addition, they obtained 1-year data on 97% (74/76) of their patients, with only 35% (26/74) adherent after 1 year. San Antonio, we have a problem. We have a problem with IFA immunotherapy adherence.

Some of the *Annals* readers will ask whether this adherence problem is applicable to their own practice. Is there a reason to be concerned or is this just reflective of a “strange” military paradigm? Are the findings applicable to all of the *Annals* readers? As mentioned here and as described by the authors in their discussion, military patients and practice are no different from what is experienced in the civilian allergy practice. The Wilford Hall program has provided our community with a wealth of IFA data over the years, with 8 IFA papers published since 2007.^{3–9} More specifically, in 2002 they published a retrospective study evaluating adherence with allergen immunotherapy and reported a 64% adherence rate within the subgroup of IFA immunotherapy patients.¹⁰ This rate may have been an overestimate, because the retrospective nature of the study only allowed the evaluation of active patient charts in their clinic and defined adherence as an immunotherapy injection within the last 3 months.

The findings of these studies are applicable and are a reason for concern. Hopefully, this report will motivate our allergy community to evaluate innovative ways to enhance patient adherence with this life-saving therapy. As the authors conclude in this issue of *Annals*, “additional studies are needed to compare IFA immunotherapy adherence rates between centers and to identify best practice procedures to maximize adherence.”

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Disclaimer: The opinions or assertions herein are the private views of the author and are not to be construed as reflecting the views of the Department of the Air Force or the Department of Defense.

I am certain if I had a chance to sit down with Keith Sykes and share my military medical career experiences these last 2 decades, he would probably add a final stanza to his song:

I'm not strange I'm just like you,

I take care of the same patients as you.

Code the visit and sign the note,

And got my name on my white coat.

I'm not strange I'm just like you.

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