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PERSPECTIVE: PART I

WHY I BECAME OPEN WITH MY OBSESSIVE-COMPULSIVE DISORDER (OCD)

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Medical school in Peru is a seven-year program during which the last (seventh) year of medical school is called the *internship year*, similar to the first year of residency in the United States. Interns are expected to work every single day of the year, despite having 24-hour shifts during the week. In January 2020, I began my internship in a pediatric service center. As the only intern on that service, I worked alongside five residents. Unfortunately, the paperwork to start the internship was delayed so I had to bring some of my documents with me during the first week of the internship. The documents included my transcripts and health certificate, both of which I kept in a folder. One day, I forgot my folder in the service center. I was so busy starting the night shift that I overlooked that I had left it behind until I found it the following morning. I was busy and tired. I did not think much of it.

Less than a week later, I was discussing a case with a resident after rounds. He asked me directly if I had obsessive-compulsive disorder (OCD). I felt my mouth getting super dry, and I began to sweat profusely, an intense sharp pain starting to form in my chest. I got flustered and did not know how to answer. At that time, only my mother, husband, and two close friends knew about my OCD. Later that week, another resident confessed (without me asking about it) that they had found my folder and read through it. I laughed nervously in response and changed the topic immediately. I tried not to make a big deal about it, but it only got worse. The residents picked on me a lot. I finally had the courage to talk with the attending physician about what happened, but it did not go well. He concluded that I brought the papers with me because I unconsciously wanted others to discover that I had OCD. It felt like I was being blamed for what happened to me. This was probably one of the saddest points of my internship. I was despondent and thought about resigning for some time. I decided to stay and complete my rotation on that service and put it behind me when I was finished. And that is what I did, I was busy in my third rotation when the novel coronavirus arrived in Peru, and all the medical students were sent back home. My internship was put on hold indefinitely. During the following weeks, I reflected on what had happened.

Neurodiversity is the variation and differences in neurological structure, viewing these differences as normal and natural rather than pathological. Several recognized types of neurodiversity exist, including autism, Asperger's syndrome, dyslexia, dyscalculia, epilepsy, hyperlexia, dyspraxia, attention deficit and hyperactivity disorder, OCD, and Tourette syndrome.[1] I was first diagnosed with depression in late 2018 but was later confirmed to have OCD. I remember asking twice if I had the disorder, not the personality. A person with OCPD (obsessive-compulsive personality disorder) has some rigid behaviors, but does not engage in the overwhelming need for repetition linked to OCD compulsions. OCD affects all aspects of life, making work, school, or healthy relationships impossible if untreated. In contrast, OCPD could relate to improved performance at work or school,

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WELL-BEING FOR ALL

Tiffany I. Leung, MD, MPH, FACP, FAMIA,
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As fall begins, marking the end of September (also Suicide Prevention and Awareness Month), SGIM *Forum* almost imperceptibly shifts from last month's "Physician and Patient Well-being and Mental Health" theme issue. Observant readers might have noticed that last month's articles offered a prismatic view of experiences and perspectives focusing on physician well-being. An abundance of submissions means this issue is an ad hoc Part Two along the theme, reflecting the unforgettable imprints of the recent past on our hearts and minds. They resonate in our social, political, and especially our local work and learning environments that continue to experience the polarizing and painful mortal consequences of the COVID-19 pandemic. In this issue, the well-being dialogue continues to explore additional facets of physician mental health and well-being while also beginning to shift to what can be done to address *both* physician *and* patient mental health and well-being as two parts of a common issue.

Despite or because of the pandemic, some readers, colleagues, and friends might also have recognized and even commemorated National Physician Suicide Awareness Day (#NPSADay) on September 17th. NPSA Day echoes annually as a reminder of the tragic and perhaps ultimate never event among our distressed physician and healthcare communities. Intentional and open conversation, with grace and non-judgment, and linked tightly with advocacy and action can enable meaningful change.

For example, the *Journal of General Internal Medicine* published a policy paper from the American College of Physicians Ethics Committee on physician suicide prevention in June 2021.[1] The paper offers thorough and thoughtful ethical considerations on physician suicide prevention, appropriately shifting the paradigm from individual failure and need for helpseeking towards shared responsibility and systemic change. Aligned with this, but altogether a separate effort, was the U.S. Senate passage of the Dr. Lorna Breen Health Care Provider Protection Act (S. 610) on August 6, 2021 that "aims to reduce and prevent suicide, burnout, and mental and behavioral health conditions among health care professionals."[2] Passing with bipartisan support and the backing of numerous organizations, including the American Foundation for Suicide Prevention and the American Association for Suicidology, as of this writing,

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HOW SGIM CAN USE OUR HISTORY TO CREATE A BETTER FUTURE: COVID-19 & VACCINE HESITANCY

Monica L. Lypson, MD, MHPE, FACP, President, SGIM

". . . we are witnessing increasing cases of the Delta variant of SARS-CoV-2. The surge is uneven, likely attributable to low vaccination rates and vaccine hesitancy. With the academic year is in full swing, we again work overtime to keep hospitals, schools, and the economy open. Given this, I am rethinking the fall and look to the past for answers. I return to the aphorism 'Those who cannot remember the past are condemned to repeat it' as stated by Spanish philosopher George Santayana and later paraphrased by PM Winston Churchill. This phrase helps us examine history to understand the future."

I spent the early part of this summer considering how we would work together to readapt our lives, practices, trainees, peers, and society from the disheartening reality of the COVID-19 pandemic to the "new normal." There were many glimmers of hope of normalcy as we proceeded into the summer solstice. Many of us were excited to pursue time for respite in old and familiar vacation locations despite varying levels of restriction. Our practices were transitioning back to face-to-face visits with telemedicine as adjunctive and hopefully as a tool to enable our focus on equity. Our academic hospitalists were making systemic changes in their environments to rejuvenate and combat burnout given they often bore the brunt of high-intensity clinical care over the past year. Those involved in research were excited to learn of the new federal research priorities focused on eliminating structural racism within the NIH as well efforts dedicated to enhancing primary care research. We read the *Forum* last month seeking strength, renewal, and lessons learned to improve mental health. The SGIM's Council, Board of Regional Leaders, ACLGIM, as well as the Program Committee were reviewing budgets, executing a new program year, and planning for face-to-face meetings. With a new wave of hope, SGIM had set the date of December 2021 to transition back to face-to-face meetings.

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Q & A WITH SGIM'S CEO AND THE CHAIR OF THE PHILANTHROPY COMMITTEE ABOUT EARLY SUCCESS OF THE FORGING OUR FUTURE PROGRAM

Eric B. Bass, MD, MPH; Martha Gerrity, MD, MPH

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What are highlights of the Forging Our Future Program to date?

SGIM launched the Forging Our Future Program in November 2020 with the goal of instilling a culture of giving among all members of the organization.[1] We set targets of raising $200,000 by December 31, 2020, and another $300,000 in 2021. SGIM's Council and Philanthropy Committee set great examples by achieving 100% participation in the program within the first two months. By the end of December 2020, we had received donations and pledges totaling more than $200,000. By the end of June 2021, we had received a cumulative total of $303,495 in donations and pledges. So far, the program has succeeded in engaging more than 300 members,[2] including 83% of the chairs of the committees and commissions, and 70% or more of the Finance Committee, Health Policy Executive Committee, and ACLGIM Executive Committee. In addition, five of JGIM's past editors have joined Thomas and Nancy Inui in making a commitment to our Legacy Program for Bequests and Planned Giving.[2] We want to take this opportunity to thank all members of the Philanthropy Committee for their tremendous work in launching the program so successfully.

What has support from donors allowed SGIM to accomplish?

The extra support from the Forging Our Future Program enabled SGIM to invest in high priority initiatives despite the extreme fiscal challenge imposed by the COVID-19 pandemic which prevented us from having an in-person Annual Meeting in 2020 or 2021. Thanks to this philanthropic program, SGIM was able to invest in new member-centric infrastructure including virtual meeting platforms for the national and regional meetings, a new mentoring platform (Mentor Match),[3] and a learning management system (GIMLearn).[4-5] In the last year, donations to the Future Leaders of GIM Fund enabled SGIM to give complimentary memberships to 60 fellows and to give scholarships to 43 medical student and resident members to cover their registration for the 2021 Annual Meeting. Thus, SGIM is already benefitting from the additional income, with the Forging Our Future Program moving the organization's financial support from a three-legged stool (based on membership dues, meeting registration fees, and JGIM royalties) to a four-pillared fortress of revenue (see figure).

What are SGIM's philanthropy priorities in the coming year?

The Philanthropy Committee is committed to achieving the cumulative target of $500,000 by the end of 2021. Continued donations will help us expand use of the technologies needed to adapt to the post-COVID-19 world, as mentioned above, and will enable us to continue increasing the number of scholarships to trainees interested in academic GIM. Our long-term goal is to offer free memberships to all fellows and residents pursuing a career in academic GIM. We also have challenged the past presidents of SGIM and ACLGIM to help raise $200,000 to expand support for the Unified Leadership Training in Diversity (UNLTD) Program. By expanding the UNLTD Program, we can do more to diversify the leadership of institutions where our members work, and thereby promote a climate that will lead to greater diversity and inclusion within institutions.

How can members participate in the Forging Our Future Program?

We encourage members to consider three options for participating in the Forging Our Future Program:

1) Make a donation this year, using our online portal;[2]
2) Make a pledge to future annual giving; and
3) Make a commitment to join our Legacy Circle by including SGIM in a bequest or planned giving.

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Several of SGIM's longstanding dedicated members have done all three!

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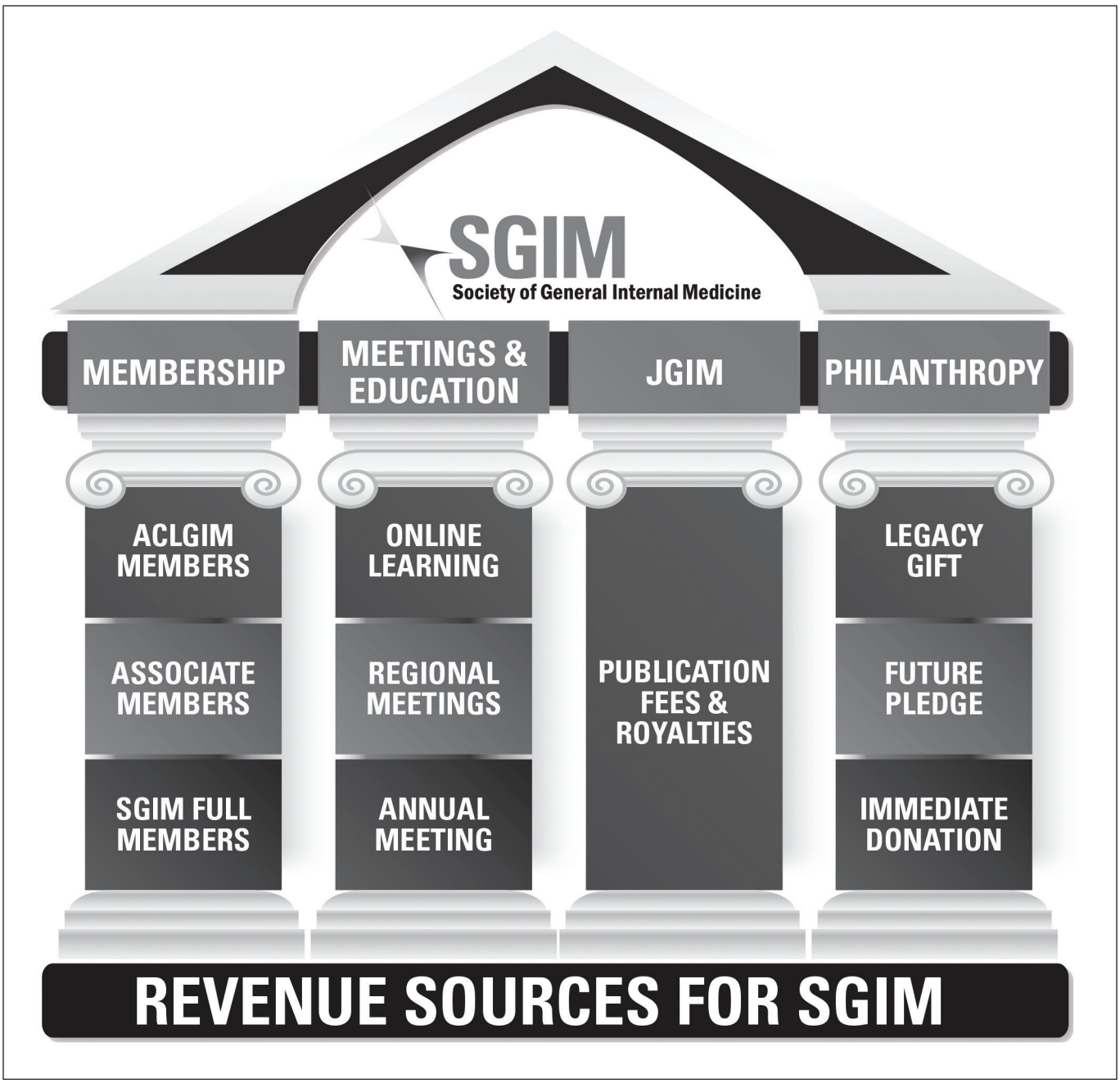

SGIM's four main pillars of support.

A LASTING LEGACY: WHY INTERNISTS SHOULD KNOW ABOUT ADVERSE CHILDHOOD EXPERIENCES

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Every day in internal medicine, we see the pain and enduring consequences of mental illness; we are taught early in training about mental health screenings and treatment, critical to addressing our patients' needs. While mental illness is at least partially genetic, we are learning that many environmental factors also play a role in the development of mental health. Exploring and understanding these environmental factors, such as childhood events that increase the risk of mental health problems, can provide important context to ongoing and future mental illness, yet clinicians, including physicians and advanced practice providers, rarely discuss them with their patients.

Adverse childhood experiences (ACEs) are defined as potentially traumatic events that occur in childhood, such as experiencing violence, living with adults with substance use or mental illness, parental incarceration, or food insecurity.[1] These events are unfortunately commonplace—in one study, 61% of adults reported experiencing at least one ACE, and 1 in 6 reported experiencing four or more types of ACEs, classifying them as "high risk" for toxic stress.[2] Data shows that being exposed to four or more ACEs increases the risk of chronic disease development compared to exposure to one ACE, suggesting a direct correlation between number of ACEs and toxic stress. Women and minorities are more likely to have exposure to four or more ACEs,[1] leading to further inequity. These events can affect whole communities, and with the significant economic and health impacts of the COVID-19 pandemic, the current generation of children are likely to have even more exposure to adverse events.

ACEs have a significant impact on long-term health, likely related to altered gene expression, as well as changes in immune and organ function,[3] and place patients at high risk of chronic medical co-morbidities, including pregnancy complications, heart disease, COPD, mental illness, and substance use in adulthood.[2] Studies have shown that those with four or more ACEs have five-fold increased odds of depression and were at increased risk of heavy alcohol use, obesity, COPD, unemployment,[2] and violence victimization and perpetration.[1] Traumatic exposures as a child are hypothesized to affect brain development, decision-making, and ability to cope with stress. A lack of stability and healthy relationships in childhood can cause difficulty establishing secure relationships in the future; ACEs may subsequently become intergenerational, with the lasting impact of trauma extending from parents to their children. By increasing the risk of mental illness in adulthood, it can also generate new adverse experiences for the next generation of children. Additionally, ACEs deepen socioeconomic barriers for survivors and consequently affect their social determinants of health, such as resources for food, jobs and income, and education.

Due to their significant prevalence and role in future health, ACEs have become an important topic of discussion within Pediatrics, with a focus on both preventing adverse experiences and mitigating their effects. In our experiences as Internal Medicine-Pediatrics physicians, however, these conversations have not frequently extended to include adult clinicians. While the childhood events a patient experienced are obviously not preventable once a patient is an adult, ACEs can still affect ongoing mental and physical well-being, and screening for ACEs can shape ongoing care. Screening tools (typically 10 ques-

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tions) for adults and recommended clinical workflow are available to clinicians through the Center for Health Care Strategies and ACEs Aware (https://www.acesaware.org/resources/). Exposure to one of the ten surveyed ACEs results in a positive screen. Patients with exposure to 1-3 ACEs are considered at "intermediate risk" for toxic stress, and should be provided with anticipatory guidance regarding ACEs and their possible consequences. Also, protective factors against toxic stress (e.g., developing supportive interpersonal relationships, stable employment, completion of education, and connection to their community) should be discussed. Patients with exposure to four or more ACEs are at "high risk" for toxic stress, and the patient should be linked to supportive services if amenable and evaluated for health conditions associated with toxic stress.

The most common concerns regarding screening are time commitment, patient and clinician discomfort, and how to best implement this into a busy clinical practice. Most research shows that patients are comfortable with self-administered surveys and that positive ACEs screening usually takes less than five minutes to discuss.[4] ACEs screening can be used in conjunction with more commonly used screens for mental health illness such as the Patient Health Questionnaire (PHQ-2 or PHQ-9). Studies have also shown that most patients felt discussing ACEs improved their relationship with their clinician, and clinicians reported increased empathy for their patients after discussion of ACEs.[4] Providing trauma-informed care education using the 4C (Calm, Contain, Care, and Cope) framework[5] to all staff and clinicians may serve as a guide to improve comfort in acknowledging and responding to ACEs during screening. Trauma-informed care recognizes the impact of trauma on ongoing functioning and helps the provider to respond in an empathetic way without causing ongoing trauma. This includes helping providers to address distorted beliefs related to a history of trauma, discussion of available resources for those with a history of trauma, and avoidance of re-traumatization.

Given their significant impact on adult health, it is critical for clinicians to screen for ACEs and intervene in those at increased risk. As Med-Peds physicians, we have often seen the intergenerational effects of trauma, and how surviving ACEs can shape a patient's experience. ACEs can normalize substance use, cause difficulty handling new stressors, and devalue the benefits of stable interpersonal relationships. But helping a patient acknowledge these traumas and critically analyze how they affect their response, can create an open dialogue between the patient and provider to discuss ways to move forward with healthier lifestyles. From our practice, for example, an adult patient who presents with multiple chronic conditions that were poorly controlled (related to medication non-adherence) engaged with us in a discussion of how growing up, she had no stable relationships with adults due to being raised mostly in foster homes. This provided context for previous encounters: her distrust of authority figures had carried into her adult life, affecting her relationships with her physicians. Upon discussing this openly with her, she reframed her relationships with her physicians to be about self-empowerment – rather than authority — and we were then able to form a truly therapeutic relationship.

Identification of risk factors for substance use or mental health disorders can help clinicians connect their patients to resources earlier and prevent propagating trauma through multiple generations. Through screening, we can connect patients with mental health resources earlier to benefit whole families, not just individuals. It is important that clinicians who choose to implement ACEs screening feel prepared to address these conversations in a trauma-informed manner and refer patients to appropriate mental health resources. Much like a thorough family history or review of systems, identification of ACEs can provide important context for understanding our patients' and their families' perspectives on their mental health, medical co-morbidities, and the socioeconomic implications of these conditions—and assist clinicians in halting the cycle of this long-lasting inequity.

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WHAT PRIMARY CARE PHYSICIANS SHOULD CONSIDER WHEN HIRING MENTAL HEALTH CLINICIANS

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Bringing mental health and substance use disorder (SUD) services into primary care practices is something that both physicians and their patients have long needed—and even more now that COVID-19 has taken its toll on our collective mental health and well-being. This article makes the case for why that is, explains briefly what mental health integration looks like in primary care, and offers advice to primary care physicians on the type of skillset a mental health clinician should have to work in primary care.

Background

To better keep up with the demand for mental health and addiction services, one of our biggest untapped opportunities is to meet people where they are, starting with the first place most people go when they aren't feeling well: primary care.

Primary care physicians are no stranger to mental health. In addition to the day-to-day stressors that naturally come with being a frontline clinician when there isn't a public health emergency, primary care physicians often see patients presenting with mental health and SUD needs in their offices, even if those needs aren't the primary reason for the visit. With 50% of counties in the United States having no psychiatrist and half of the people in those counties needing to drive more than one hour round-trip for services, paying their local primary care doctor a visit to discuss their mental health is one of the best-possible options considering the relationship they likely have with their primary care physician. Visiting a primary care physician is a much better alternative to a patient showing up in an emergency department (ED) when there's no place else to go. EDs are often ill-equipped to manage mental health concerns, and in some instances, EDs are actually "boarding" mental health and SUD patients in hallways for days at a time. During the pandemic, each month, boarding increased between 200%-400% in Massachusetts hospitals alone.[1]

Boarding in EDs is something that should never be occurring, let alone be increasing. However, part of the reason why boarding is occurring and increasing is that people of all ages are struggling with their mental well-being at alarming rates and having difficulty accessing care. This has major downstream implications. In 2019, more than 156,000 Americans died from alcohol, drugs, and suicide[2]—yet another year-over-year increase that is likely to increase again when 2020 data becomes available.

We need to bring care to where people are—beginning with primary care—and clearly establish an understanding of what integration is, what mechanisms are needed to support it, and the type of workforce primary care clinicians should be recruiting to join them in care delivery.

Defining and Enabling Behavioral Health Integration

To bring mental health and SUD services into primary care without disrupting too much of the clinical workflow, we must first come to understand exactly what integration is and is not. While any definition should allow for local adaptation and flexibility so that practices have the freedom to implement the integrated model of care that works best for them, there needs to be a shared understanding and standard for integration. This operational definition by the Department of Health and Human Services' Agency for Healthcare Research and Quality[3] hits on a few key points, and therefore acts as a good definition for the purposes of this article:

> "The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

Medical and mental health clinicians working together under one roof is a fundamentally different approach to frontline care delivery that will require a few policy fixes before we see broader widespread adoption. Our healthcare system's predominant payment mechanisms reinforce a siloed delivery model rather than support an integrated one. While there are some examples of broader scale implementation using federal funding in

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the Veterans Administration and Federally Qualified Health Centers, how we pay for care is a major barrier for integrated models. There have been some changes to support integration, such as the addition of the Collaborative Care Codes, and while their adoption has been slowly increasing, they're still very limited.

Rather than continue this way, a better approach would be to fix existing payment structures so that they support and enable integration. Medicaid Managed Care Organizations, Medicare Accountable Care Organizations, and Medicare Advantage Plans all could be potent vehicles for scaling integrated efforts—should they allow for flexible spending that enables a practice to onboard properly and deliver truly team-based care without the limitations of fee for service.[4]

Core Competencies Mental Health Clinicians Should Possess

When able to begin hiring and onboarding mental health clinicians, primary care physicians should know what to look for in a mental health clinician. The following eight competencies can help ensure that their new team members have the appropriate knowledge, skills, and attitudes:

1. **Identify and assess behavioral health needs as part of a primary care team** so that they can get a whole-person view of the patient's well-being and work with the primary care physician to collaboratively and accurately identify, screen, assess, and diagnose the patient.
2. **Engage and activate patients in their care** so that patients can start to clearly see how mental health and physical health are connected and why they must work to take care of both.
3. **Work as a primary care team member to create and implement care plans that address behavioral health factors,** to ensure that primary care physician efforts and mental health clinician efforts aren't duplicative or contradictory.
4. **Help observe and improve care team function and relationships** so that the strengths and expertise of both the primary care physician(s) and mental health clinician(s) are fully leveraged to produce a positive patient outcome.
5. **Communicate effectively with other clinicians, staff, and patients,** as communication is key to preserving a team willingness to initiate patient or family contact outside routine face-to-face clinical work.
6. **Provide efficient and effective care delivery that meets the needs of the population seen in the primary care setting.** This means setting agendas with roles and goals for the patients and their care team, balancing length of patient encounters effectively, and identifying when immediate intervention and follow-up care is necessary.
7. **Provide culturally responsive, whole-person, and family-oriented care** that takes into account all of the lifestyle factors influencing a patient's well-being, biologically, psychologically, socially, spiritually, and culturally via patient and family beliefs, values, culture, and preferences.
8. **Understand, value, and adapt to the diverse professional cultures of an integrated care team** to prevent internal conflict and best meet patients' unique needs.

Primary care physicians should note that these core competencies are specifically designed for licensed mental health clinicians working on a team in primary care and are written in such a way that they should hold true no matter which integration approach a clinician takes. These competencies were originally synthesized from seminal articles on the topic of integration and highlight what skills mental health clinicians need to possess to work in primary care.[5]

Conclusion

Primary care physicians equipping their clinics with staff capable of helping of meet their patients', and potentially their own, escalating mental health and addiction needs is key to addressing out nation's mental health and addiction crisis. Primary care and mental health care have always been inseparable, and now, it's time we make integration the standard of care.

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DOES PHYSICIAN MENTAL HEALTH AND WELL-BEING AFFECT PATIENT MENTAL HEALTH AND WELL-BEING?

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Few studies focus on the ways in which physician mental health and well-being closely relate to patient mental health and substance abuse disorders (MHSUD). In this perspective, we describe how the COVID-19 pandemic impacts the mental health of physicians and highlight the bidirectional effects of physician and patient well-being.

The Impact of the Pandemic on Physician Mental Health

Even prior to the pandemic, there were reports of physician burnout, depression, and death by suicide, spanning medical students to physician leaders in medicine. The COVID-19 pandemic further highlighted the need for an increased focus on physician mental health and well-being. In a survey of more than 12,300 physicians across 29+ specialties in the United States from August–November 2020, 42% reported burnout, 20% depressive symptoms, 60% colloquial depression, 13% suicidal ideation, and 1% attempted suicide.[1] Many factors have been posited for worsening mental health outcomes among physicians.

First, many likened the COVID-19 pandemic to a medical "war." Physicians did not receive training in trauma or preparation for war as many soldiers do. This was not residency or a typical workday. They were trained to gather histories, examine, heal, intubate, break bad news to families, and even pronounce deaths, but not at the extraordinary physical, emotional, and mental demands from the pandemic. Physicians encountered mass causalities, limited access to resources, fear of becoming sick or dying, fear of infecting their loved ones, moral injury due to resource allocation decisions, and emotional support needs of patients. They even lived in isolation from their families to avoid infecting them. Ongoing COVID-19 surges and related upheavals in physician roles and responsibilities further affected their sense of well-being.

Multi-level Factors Contributing to Physician Mental Health and Well-being

Besides the direct effects of the pandemic on mental health, many have remarked on the unique stressors attributed to training and working in the medical field. Physicians often sacrifice time away from family, including significant life events, to complete their training and care for patients. Despite higher rates of MHSUDs among physicians compared to the general population, marked stigma in the medical field hinders adoption of effective treatments. At the healthcare system level, physicians also face scheduling demands, the ongoing need to adapt to technological and medical innovations (e.g., telemedicine, medical devices), documentation pressures, uncertainty of new normal of medical care delivery and work-life balance, to name a few challenges. All these factors were magnified by the pandemic and resulted in a mass exodus of physicians who provide direct patient care, as evidenced by increased rates of office closures, early retirement, and/or transitions to non-medical careers.

Interaction between Physician and Patient Mental Health

Elucidating the determinants of physician mental health not only has the potential to impact physician quality of life but also to mitigate the negative effects of physician well-being on patient mental health. Multiple studies have demonstrated increased rates of MHSUD over the last year, including among patients receiving the diagnosis of COVID-19 and who required hospitalization, intensive care admission, or who suffered from encephalopathy.[2]

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Few, if any, prior work has examined the ways in which physician and patient mental health may be related, however.

First, we are human! Physicians and patients faced and still are facing similar stressors and triggers (both due to the pandemic but also to changing industries/technology) contributing to parallel mental health pandemics. Increasing rates of MHSUD in the face of limited time and mental health training and the degree of emotional support required likely negatively impacted the mental health and well-being of physicians. While understudied, physician mental health also has the potential to impact patient mental health in several ways. These may include decreased empathy during clinical encounters, suboptimal patient-physician communication, and an inability to concentrate during visits. There is well-documented mental health stigma among physicians, and it is unknown whether physician stigma influences how comfortable patients feel in disclosing MHSUD symptoms. On the other hand, physicians may avoid discussing MHSUD symptoms that remind them of their own. In a 15-minute encounter that requires reviewing chronic medical conditions, preventative health maintenance, and quality measures, physicians often lack the time to assess for MHSUD.

Meanwhile, physicians are needed now more than ever to care for the MHSUD needs of our patients and communities. Even prior to the pandemic, physician shortages and lack of training contributed to limited mental healthcare access and suboptimal patient outcomes. Shortages spurred the proliferation of task-shifting and multidisciplinary team-based care to meet patient needs. If the physician exodus from direct patient care continues, there will be a lack of physicians from "soldiers to generals" to lead the interdisciplinary care teams in managing patients with chronic, complex mental and physical health needs and leading initiatives to quell this war. Thus, physician mental health and well-being must be at the forefront of local and national government, healthcare organization, and professional associations' agendas and policies to prevent a parallel mental health pandemic. If they are not prioritized, we run the risk of clinics, emergency rooms and hospital halls overflowing with patients who are suffering and dying from MHSUD and other comorbidities, and fewer physicians to care for them through this pandemic and beyond.

Where Should We Start?

Impacting patient well-being will require that physicians be vigilant and inquire of MHSUD symptoms, work against the already existing stigma of MHSUD in our communities, find safe treatment interventions in an already scarce pool of MHSUD programs, and advocate for, participate in and innovate/adapt team-based care models shown to be effective in reducing mental health disparities. Answering these calls however requires physicians to prioritize their own mental health needs. First, medical school and residency training programs will need to integrate mental health treatments like mindfulness into the fabric of their programs. This has the potential to reduce stigma, improve the well-being of future physicians, and teach skills to physicians that they can impart during patient encounters. Second, healthcare systems will need to allocate time and funding to improve physician and patient mental health and well-being alike (e.g., allocating time during multidisciplinary rounds for mindfulness exercises, disseminating mental health toolkits to patients in the waiting rooms).

In addition, more data is needed on whether and the mechanisms by which physician burnout and well-being affects patient mental health and physical outcomes; the bidirectional effects of MHSUD on both physician and their patients may be a novel area for research. Medical educators and investigators should consider adapting the Stanford Model of Professional Fulfillment, which focuses on the triad of a culture of wellness, efficiency of practice, and personal resilience[3] to address both patient and physician mental health and well-being.

Finally, at the national level, government agencies, like the National Institutes of Health, will need to fund centers, similar to the World Trade Center Health Program developed for 9/11 first responders.[4] Programs like these can be essential in screening, monitoring, treating, and investigating long-term effects of the COVID-19 pandemic, particularly given the onslaught of COVID-19 variants despite vaccination efforts.

Conclusion

Advancing mental health and well-being are here to stay for our patients, our communities, and physicians! We need to acknowledge it, feel comfortable about it, discuss it, reduce stigma, and advocate for mental health and well-being for physicians and patients alike. COVID-19 variants have spurred ongoing surges despite vaccination initiatives, which has the potential to create a mental health domino effect. Making an impact on physician and patient mental health care is essential and will require further research on the bidirectional effects of patient and physician mental health and well-being as well as national and local policies and innovations at the government, healthcare system, and organizational levels.

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ASSOCIATION BETWEEN ELECTRONIC CIGARETTE USE AND SAFETY BELIEFS AMONG PHYSICIANS AND MEDICAL STUDENTS

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Background

Electronic cigarettes (e-cigarettes) have gained global popularity in the past decade, especially among adolescents. However, little is known about them and no current evidence-based guidelines exist surrounding their use. A 2020 Cochrane review found moderate evidence that e-cigarettes are superior to nicotine replacement for smoking cessation, but limited evidence exists comparing them to pharmacotherapies.[1] One study showed that misperceptions about e-cigarette use are especially common among pregnant patients.[2] Because nicotine has known toxic effects on developing fetuses and the amount of nicotine consumed when using e-cigarettes is similar to that when smoking cigarettes, the American College of Obstetricians and Gynecologists advises against e-cigarette use during pregnancy and recommends extensive counseling about risks and benefits before any sort of nicotine replacement is used by pregnant patients.

Physicians report lacking knowledge of health impacts of e-cigarettes and discomfort providing counseling on their use, yet patients look to them for guidance.[3,4] Age-related trends suggest e-cigarette use is more prevalent among medical students than attending physicians. In one study, 14.7% of medical students had used e-cigarettes, 39% considered them safer than combustible cigarettes and 28% considered them useful smoking cessation tools.[5] Personal experience with e-cigarettes may influence physicians' beliefs about safety and patient recommendations.

The purpose of this pilot study was to identify associations between demographics, role (medical student, trainee, and attending), and personal use of e-cigarettes with beliefs about their safety, utility for smoking cessation, and recommendation for use by pregnant patients.

Methods

Literature review revealed no pre-existing validated survey instrument. We created a questionnaire querying demographics, e-cigarette, use, and beliefs about e-cigarettes using a four-point Likert scale with no neutral option (Strongly Disagree, Disagree, Agree, Strongly Agree). All 1,672 medical students, trainees, and attendings at one academic medical center were invited to participate in the anonymous online survey (*Qualtrics*, Provo, UT). Invitations were e-mailed via institutional listservs to students in January 2020 with two reminders two weeks apart. Invitations were emailed to trainees and attendings once in February 2020 without reminders out of respect for COVID-19 pandemic-related demands. The George Washington University's Institutional Review Board determined this study exempt (#NCR191674).

Likert responses were converted to numerical scale (1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree) for analysis. We examined associations between age, gender, role, prior e-cigarette use, and use in the past month with responses to each of the following statements:

- "E-cigarettes are safe"
- "E-cigarettes are safer than traditional cigarettes"
- "E-cigarettes are useful for smoking cessation"
- "If she could not quit smoking, I would recommend my pregnant patient use e-cigarettes."

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We used analysis of variance to examine associations of item scores with categorical variables and Pearson *r* for associations with age (*SAS*, version 9.4, Cary, NC). We considered p<0.05 statistically significant.

Results

We received 343 responses (20.5% response rate): 65% were medical students, 13% trainees and 21% attendings, 59% were female, 40% were male and 1% were other gender. Eighty-two respondents had used e-cigarettes (23.9%). Eighteen respondents used e-cigarettes in the past month (5.2%). Rates of "ever" use were higher among medical students (27.7%) and trainees (37.0%) than attendings (4.1%). Those who previously used e-cigarettes, or used in the past month, had significantly higher mean scores on safety perception (p=0.011, p<0.001) and deemed e-cigarettes safer than traditional cigarettes (p<0.001, p<0.001). Age, gender, and role were not significantly associated with perception of safety. Age and role were not significantly associated with perception that e-cigarettes are safer than traditional cigarettes, but male gender was associated with stronger perception of their safety relative to traditional cigarettes (p=0.002).

Being a medical student (p<0.001), younger age (p=0.002), previous e-cigarette use (p<0.001), or use in the past month (p<0.001) were all associated with higher mean scores on perception that e-cigarettes are useful smoking cessation aids. Prior use was associated with higher scores on recommending them to pregnant patients (p=0.003). Students "would recommend e-cigarettes" to pregnant patients to quit smoking more frequently than trainees and attendings (p=0.047). This recommendation nadired among physicians 36-50 years of age, with higher scores given by physicians outside the 36-50 years of age range. (p=0.022).

Discussion

Overall, we found that physicians and medical students who had ever used or currently use e-cigarettes have stronger beliefs regarding their safety and "would recommend e-cigarettes" as a smoking cessation tool, including to pregnant patients. Among all-comers, students and respondents under age 25 years more strongly agreed that e-cigarettes are useful smoking cessation aids and would recommend them to pregnant patients for such use. Our pilot study is the first to investigate this association that may impact recommendations to patients. Nearly one-quarter of respondents had ever used e-cigarettes, with rates seven times higher among medical students and nine times higher among trainees than among attendings. These preliminary findings suggest the coming generation of physicians, who are more likely to have used e-cigarettes, may regard them as safer.

Prior studies have demonstrated substantial knowledge deficits about e-cigarettes among physicians and medical students.[4] Taken together, increasing e-cigarette use by patients, lack of knowledge and misperceptions of their safety by patients and physicians, and the potential association between physicians' personal use and recommendations given to patients as illustrated by our data, support the need to incorporate e-cigarette education into undergraduate and graduate medical curricula.

This single-institution study has limitations. Because we used a non-validated questionnaire, our results are hypothesis-generating. The low response rate from a convenience sample may cause selection bias, although it is unlikely that e-cigarette users would participate differentially, as anonymity should have mitigated social desirability bias. Given our preliminary findings, next steps should include designing and rigorously validating a survey tool. Subsequent multi-institutional research using such a tool should explore this possible association between personal use of e-cigarettes and smoking cessation recommendations given to patients, including whether current or former users may recommend e-cigarettes over proven pharmacotherapies.

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And then, two national holidays—Juneteenth and July 4th—arrived. Since those landmark days, we have witnessed increasing cases of the Delta variant of SARS-CoV-2 nationally. The surge has been uneven and likely attributable to low vaccination rates and vaccine hesitancy.

Now that the academic year is in full swing, we are all again working overtime to keep the hospitals, schools, and the economy open. Given the current situation, I am now rethinking the fall and looking to the past for answers. I keep returning to the aphorism "Those who cannot remember the past are condemned to repeat it" as stated by Spanish philosopher George Santayana and later paraphrased by Prime Minister Winston Churchill. This phrase helps us examine history to understand the future.

Those who know the history of the Spanish Influenza (1918-20)[1] pandemic might have thought our technological advancements, most notably the rapid development of the vaccines, would have allowed us to short cycle the natural history of another pandemic. Nonetheless, we must ask ourselves: *What can we do to mitigate this lingering public health dilemma, confront vaccine hesitancy, and prepare for difficult conversations about the vaccine?*

As general internists and those in training we must heed the following:

- Arm ourselves with evidence-based information. Read the literature, locate, and, at times, develop the evidence; consult with both basic science and subspecialty colleagues. Dr. Robert Centor (@medrants, SGIM president 2005-06) would remind us that as generalists we must do this in our daily clinical practice.
- Use effective communication skills to articulate the benefits and risks of the vaccine with our patients and the public in ways that encourage understanding. Dr. Michael Barry (SGIM president 2004-05) also demonstrated this expertise in the field of medical decision making.
- Listen to our patients empathetically and remain open to their questions. Dr. Thomas Inui (SGIM president 1987-88) reminded us to excel at the social context of medicine and the humanities.
- Separate public health from politics as Dr. JudyAnn Bigby (SGIM president 2003-04) reminded us so eloquently almost 20 years ago.[2]
- Work with communities both collectively and individually to strengthen our trustworthiness as physicians and health care institutions, as clearly articulated by Dr. Bigby.[3] Bigby and former SGIM presidents Dr. Marshall Chin (@MarshallChinMD, SGIM president 2015-16) and Dr. Giselle Corbie-Smith (@gcsmd, SGIM president 2018-19), have long role-modeled ways to work both as trusted brokers and with trusted brokers within our communities.
- Continue to advocate at the federal level as Dr. William Moran (SGIM president 2014-15) has long demonstrated on health policy to ensure that COVID-19 vaccines remain 100% free for every individual living in the United States and that COVID-19 services for the uninsured or undocumented are billed to the federal government.
- Demand that our local leaders make access to the vaccine easy in the outpatient and inpatient settings as well as in the community.
- Amplify the voices of our patients and support the institutional structures needed to improve health not only regarding COVID-19 but also those related to the underlying structural inequalities and racism. These are necessary steps to realize "a just system of care in which all people can achieve optimal health." Dr. Karen DeSalvo (@KBDeSalvo, SGIM president 2019-20) called this to our attention.[4]
- Use social media to collectively amplify each other and the public health message needed to combat this virus on the big screen of the world wide web (see @medrants). Accept that it is here and can serve as a tool to combat misinformation.

As fall transitions into winter, the SGIM community must continue to learn from history, especially the wisdom of our former presidents so that we can change our future for the better.

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but relationships with other people are not likely to suffer. The media's depiction of people with OCD is overwhelmingly dramatic and miserable. I remembered searching on the internet to read about famous people with OCD. When I read about actor Leonardo DiCaprio's OCD diagnosis, I admired him as a successful actor and environmental activist. At that time, I did not find anybody in health care who had it.

The lockdown and uncertainty about my future worsened my OCD symptoms. I decided to write about my feelings. I have previously written a little about my struggle with mental health for the American Society of Clinical Oncology.[2] However, my story during the Medical Student Story Slam of the American College of Physicians[3] was the first time I was open to the public with my OCD diagnosis and debilitating symptoms. I dreaded the day when the video was going to go live, but, once it did, I felt relieved. Everybody was very supportive. I cannot count how many direct messages I received on Twitter from people in health care with OCD. They were no longer alone because they could identify with my journey. Being open about my OCD diagnoses was my way to regain some power after being outed against my will. Not everybody has to be open with their diagnosis. However, I opened up after my terrible experience because I refused to be ashamed of my condition. I found a great community on social media and learned about neurodiversity. People with neurocognitive disabilities have talents, perspectives, and skills that can be distinctly beneficial in many work environments, including medicine. I am proud to represent and advocate for a more inclusive and neurodiverse medical force.

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a companion bill (H.R. 1667) awaits consideration in the U.S. House of Representatives.[3]

In this issue, Lypson, SGIM President, reflects on SGIM history to address COVID-19 vaccination hesitancy and plans for the future, while Bass, SGIM CEO, and Gerrity, chair of SGIM's Philanthropy Committee, also look ahead on bolstering SGIM's community through the Forging Our Future program. Anampa-Guzmán, a medical student, courageously shares her experiences as a physician mental health and neurodiversity advocate. Torres-Deas and Moise call for greater attention to the link between physician well-being and patient well-being in their perspective. As one example, Malik, et al, share preliminary findings linking physician perceptions of e-cigarette use and advice given about using them as tobacco cessation tools. Miller offers a guide for primary care physicians to seek key competencies in a behavioral health clinician who can be a part of an integrated primary care team, while D'Amico, et al, describe the importance of screening for and addressing adverse childhood experiences among patients.

SGIM members excel at directly and deftly disrupting stigma-perpetuating barriers to well-being, including social and workplace injustices, using the tools of our trade: scientific evidence, expertise, and professionalism, weaved together by our shared human experiences and commonalities. Although 2022 is just around the corner, there is still so much more to be done to advance physician and patient mental health and well-being. Let's be sure to keep going forward together, with and for each other and for our patients!

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