**Transcript**

Addressing and Supporting Physician Mental Health during Challenging Times

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**ACP Leadership Academy and ACP Well-being and Professional Fulfillment**

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**Susan Koger:** Good afternoon. My name is Susan Koger and on behalf of the American College of Physicians I'd like to thank all of you for joining today's webinar “Addressing and Supporting Physician Mental Health during Challenging Times.” This webinar is a co-presentation of the ACP Leadership Academy and the ACP Well-being and Professional Fulfillment program.

Our speakers today are Drs. Kerri Palamara and Joshua Morganstein. Dr. Palamara is an Assistant Professor of Medicine at Harvard Medical School and practices as a primary care general internist at Massachusetts General Hospital. She leads ACP’s physician coach training program, which focuses on training physicians to integrate coaching techniques into their quality improvement and well-being initiatives.

Dr. Morganstein is Associate Professor and Assistant Chair at the Department of Psychiatry and Assistant Director at the Center for the Study of Traumatic Stress at Uniformed Services University of the Health Sciences. He is a Captain in the Commissioned Corps of the US Public Health Service. We welcome our speakers and thank you all for joining us today.

Throughout the webinar, you may submit your questions by typing them into the Q and A box. Please use the Q and A box, rather than the chat, for all of your questions, which will be answered at the end of the webinar.

Before we begin, please note that the American College of Physicians is accredited by ACCME to provide continuing medical education for a maximum of 1 *AMA PRA Category 1 Credit* for this webinar. You may claim credit on ACP’s website, and we will email you that link following the webinar. Please also note that the individuals in control of this content for this activity have nothing to disclose, and now Dr. Morganstein has a disclosure to share, as well.

**Joshua C. Morganstein, MD:** Thank you. These are my ideas and attitudes and this slide reflects the rest of my disclaimer.

**Susan Koger**: Thank you. Now we'll turn things over to Dr. Palamara.

**Kerri Palamara, MD, FACP:** What Josh and I had planned as we were talking about what we could do that would best reach this audience and both provide you with some experiential insight from Josh, as well as from the current front lines here and around the country, but also how we can really make that applicable and useful to you all, but not in a way where we're just lecturing at you, but really talking with you and learning together. We prepared an interview where I'm going to be asking Josh some questions and through that drawing from my experience here in Boston on those front lines, as well as from what I've heard from others around the country and the work in well-being, and then Josh will share his experience. Then, if there are questions that we haven't answered, or as we go through if there are things that you really want to know, please do share those in the Q and A, and we'll have time at the end to go through all those.

I want to start off first with a question about a phrase I hear a lot, which is this is a marathon, not a sprint. We use this as we think about health care workers and really preparing ourselves and not overdoing it and taking time to rest. What do we really know, Josh, about crisis response and prior pandemics that can help us really understand what this what this phrase means?

**Joshua C. Morganstein, MD:** Well, first of all, it's good to be with you. I think a couple of things. One thing that's probably important to be thinking about right now is that we really have three disasters that are happening simultaneously. We have a pandemic, and we also have an economic disaster in this country that has really affected, as many disasters do, very disproportionately certain populations, but perhaps the most significant economic disaster in this country in generations. We also much more recently are experiencing disaster really within the fabric of our society and experiences that are pulling on and pulling back at the at the very fabric of sort of the core of our values. So there's really a lot that's happening, and that is converging at one time.

Most of what we know about the effects of, for instance, trauma come from our study of disasters; and historically, what we have found is that the mental health effects of disasters, a psychological and behavioral phenomenon for people, are experienced really by more people over a much broader geography, across a much longer period of time, really, all other medical effects combined, and that goes for virtually all types of disasters. If history is any predictor, we should expect a relatively significant tail of mental health effects.

There's a lot that we don't know right now as far as risk and exposure and mitigating factors, but that certainly has been the history around disasters.

I think one of the other aspects that's really important to think about is the range of these psychological and behavioral responses to pandemics and other types of disasters. I think as health care providers, many of us think a lot about things like psychological disorders and we're often looking for disorders, and certainly disorders occur: depression, anxiety, post-traumatic stress are all very real phenomenon that happened for people after disaster events, but earlier than that, and with much greater frequency, people experience distress reactions like having trouble sleeping and feeling unsafe. Physical symptoms in their body. Things like feeling unsafe actually have significant adverse health effects associated with them. For instance, we know that feeling unsafe—people who just perceive themselves to be unsafe—have more difficulty with sleep, are more likely to use alcohol, have higher rates of depressive symptoms, and post-traumatic symptoms. These distress reactions can confer significant public mental health burden.

People also experience things like health risk behaviors. That would be things like the use of alcohol, tobacco, or other substances to cope. Family distress, and, in some cases, interpersonal conflict or violence, and then real disruptions to work life balance, perhaps throwing ourselves so much into our work or spending so much time at work that things like our underlying health care and other needs go unaddressed and those sort of stressors mount.

It's really important to think about things like health risk behavior because whether or not someone has alcohol use disorder, the increased frequency and intensity of use of alcohol—just increasing our use of alcohol—is associated with accidents, violence, medical errors, presenteeism in the workplace, and other adverse mental health effects that really affect populations. Our ability to be effective and to really broadly address the range of challenges that emerge after a disaster really necessitate looking at this full spectrum of adverse mental health effects.

The other thing that's really important is, and I think about this from my background as a family physician and psychiatrist, and when I think about this, many of these things—difficulties with sleep, people feeling irritable and distracted, people having increased use of alcohol or other substances—these things don't usually show up necessarily in a mental health clinic. Many of these things show up in primary care and emergency care and even other sectors of society like social services, law enforcement, and other places. Our ability to effectively manage and respond to population mental health effects means that it's really important for us to collaborate with one another, cross-disciplinary collaboration becomes really essential. I think another important message that probably needs to kind of blanket this whole thing is a reminder to all of us about the fact that the vast majority of people, including people who have difficulties along the way, will ultimately be okay. I think that's an important message that we need to be transmitting right now as well.

**Kerri Palamara, MD, FACP:** That's a nice way to leave that with we're ultimately going to be okay.

**Joshua C. Morganstein, MD:** If there’s one other thing I might mention, I think, just about the specifics that just came to mind for me, I think, to talk about. One particular aspect of pandemics, for instance, and other disasters that involve things that we talk about as exposure and contamination—so, things that involve chemical, biological, radiologic, and nuclear types of material—is the fact that what really guides people's behaviors, including health behaviors and willingness to engage in health behaviors is people's perception of risk. It's the perception of risk, rather than actual risk, that determines whether people practice physical distancing, wash their hands, wear a mask, come to work or not. All of those things are significantly impacted by how people perceive risk. The ability to influence people's perceptions of risk becomes essential in terms of shaping health behaviors for individuals, organizations, communities, and the broader public.

I appreciate that you just brought this slide up, as well, because one of the things that we have found over many years of studying disasters is—and this really is largely informed by expert consensus, rather than what someone might think of as a traditional evidence-based randomized control trial, but people who have hundreds of years collectively in the field of disaster mental health have developed a model for how we look at phases, through which communities, and that would include organizations, because there are many types of communities, go through and progress through disaster events—and this model is perhaps most characteristic of extreme community-based natural types of disasters. Many of the people that were sitting around in a back room somewhere, literally, the person who is the kind of lead architect for that is a colleague at our Center for the Study of Traumatic Stress—this was developed almost 20 years ago—will tell you that this really was about understanding the natural disaster, the progression through natural disasters.

Now what we're seeing often is that even within other communities, like a health care organization or community around the country, many of these phases are playing out. Honeymoon phase, for instance, is characterized by increased cohesion of community members, collaboration of focus on getting the job done rebuilding and repairing and the general sense of, at a minimum, cautious optimism about the future; and it's followed predictably by this sort of disillusionment phase, which also has things like anniversary reactions. This is a period of time where stressors mount, underlying health and mental health issues go unaddressed, financial challenges mount, and people kind of find themselves in this more disillusioned place. These kinds of stages or phases are relatively predictable when it comes to natural disasters.

When we have things like exposure and contamination events, whether that was the anthrax attacks that happened in the mail using the Postal Service to deliver those as a vehicle in 2002, right after 9/11, the Aum Shinrikyo sarin gas attacks in Tokyo a decade or so back, these kinds of events disrupt these phases to varying degrees, and the ability for people to come together in a way that a community might becomes disrupted, for instance. A traditional honeymoon phase may not play out in the same way, but it is likely that these phases will occur, to some degree, and in some form or fashion. One of the real benefits to understanding that these phases occur is that it really can assist with health care resource planning, as well as helping our patients, ourselves, our coworkers, our families, our communities, our neighborhoods to anticipate and plan for subsequent phases that are going to happen.

**Kerri Palamara, MD, FACP:** I think that's really helpful. What's interesting is I think we can see right now, how many of us are probably starting to either enter or are in this disillusionment phase, and there's so many different triggers and events going on right now, as you mentioned, as the concurrent pandemics that we're dealing with.

One thing that you had mentioned: risk and our ability to assess risk, which I think most people are actually pretty poor at, but also influencing other people's risk, which I personally have found as a great frustration of my own. I've certainly gone out for a run wearing my mask seeing people on the beach with no mask or crowding all around and saying, ‘What the heck am I doing this for if none of you people are going to do it?’ As we think about influencing other people's risks and assessing our own as we get a little bit further out from that really scary first parts of the surge, do you have any suggestions about how we can influence other people's perception of risk?

**Joshua C. Morganstein, MD:** Well, I mean, risk in general with disaster events is a complex issue. We may have another slide that sort of talks to some issues of risk as a kind of graphic that presents a little bit of a framework in terms of how we might think about risk, but risk is a complex issue, and understanding risk is an important part of managing the well-being, as you're getting at, for health care workers, patients, the general public during the pandemic. What people face, what they're exposed to, how it impacts them. One of the things that are, and certainly for us to be thinking about in our health care worker community, is that the duration and the severity of exposure to various traumatic aspects of this pandemic are an important aspect of understanding risk. Health care workers involved in direct and prolonged patient care, and other responders and emergency workers that have been exposed to extremes of suffering, as well as human remains and mass death, maybe it increased risk. I recall a news article, maybe a month or so back, that quoted a health care provider who said that when they were intubating a patient with COVID-19 it felt as though we're standing right next to a nuclear reactor.

That's really a reminder that this event will bring unique aspects of exposure for different health care workers and that, in turn, may alter experience of risk. It's also important to remember that in this disaster everyone's been affected in some way. In fact, those *not* involved in direct patient care may experience unique stresses that are related to things like increased work demands in the place where they’re at. They may receive the less organizational and community recognition of their work, and the ever reduced sense of meaning and the work that they are doing, and may experience feelings of guilt for not being on the “frontlines.”

Part of understanding risk involves collecting data through surveillance, and we really need to be developing measures and implementing surveillance now, in order to plan for the future. I think the issue of influencing risk involves a couple of things, but one important thing that I want to highlight has to do with issues of communication and messaging. The words that we choose in terms of how we talk about this event will convey certain things to patients, to the public, to other communities in which we work. The language that we choose and some important facets of communication that have really emerged over a number of years of work in this area, and one of the leading sources in this is The Center for Disease Control and Prevention. They have an entire manual in crisis, emergency, and risk communication; and their very first chapter talks a lot about the psychology of a crisis and what happens for communities and then what are the aspects of how one communicates that really influence risk.

I think in this way, one of the things I would comment on is that many of us might appreciate the fact that communication is a vehicle for delivering interventions. If your training was anything like mine, even in medical school, for instance, as far back as that, there was this awareness that our verbal and nonverbal communication might influence how people perceived, how patients would perceive, and experience our interaction, and this, in turn, would ultimately impact for instance, the building a therapeutic report. Well, I would I would actually argue, and I think a lot of data would suggest that communication isn't just a vehicle for delivering interventions, but it is, in and of itself, an intervention. Because the behaviors that people choose to engage in, whether it's to shelter in place or to wear a mask or not, they really have serious, serious health consequences, and in some disasters, they’re life and death consequences.

Again, we know that how we choose words and messages influence people. A couple of important considerations that I think are worthwhile because physicians really are de facto public health leaders. We may not see ourselves that way, but we really are public health leaders and our patients and others look to us for information. They look to us for guidance, and in an era where science is being challenged, perhaps, now more than it has been a long time, it's important for us to understand how we can best influence people. Things like information that is timely, that is updated, and that is delivered by credible messengers—and credible messengers are different for different populations. Understanding that different populations will experience certain messengers a certain way becomes very important.

Other facets of communication that have been found to be particularly useful are, in fact, avoiding the use of medical jargon. There's a real emerging body of literature; Baruch Fischhoff and others, and Peter Sandman have looked at things like the science of science communication and there's all there is an emerging body of literature on the issue of the use of medical jargon. When people use medical jargon, what we find is that not only do we confuse a considerable number of our patients, but for more and more of them it actually causes an increase mistrust. This is paradoxical for us as physicians, because we see science and our medical terms as being a stabilizing force. We kind of count on that, and for us that lends credibility. When I use a quarter word instead of a nickel word with a physician coworker that makes me sound more credible. For patients, it is better for us to use nickel words when they can do. Because for many of, and an increasing number of, our patients, they will find that kind of language—language that is down to earth, that is relatable to them—to be something that is even more persuasive and less likely to undermine trust.

Those are a couple of principles to think about as people consider how to talk to any given individual or have a conversation; or, whether you are in a leadership position in your organization or are part of helping think about community messaging in your community association, or want to be involved in those things. Certainly we are ideal messengers for these things and understanding some of these principles can really aid in our ability to more effectively communicate, influence risk, and ultimately impact health behavior.

**Kerri Palamara, MD, FACP:** Speaking of jargon, I have a question about that, because there's a lot of military jargon used as we communicate with each other, and communication within the media. Terms like front line, redeployment, shelter in place, disasters; these words that we use to think about the work that we're doing. What are your thoughts about that?

**Joshua C. Morganstein, MD:** Well, analogies to terminology that's often reserved for the military, such as the ones that you've mentioned, this being a battle, for some people, this can really help to articulate their experience of working in a place that feels unsafe, under extremes of stress, with sometimes very limited resources. Although it's also important to remember that in combat or war we don't usually fight on our own home soil. We can see our enemy, we know when we've been injured, and we don't worry the enemy will follow us home and hurt our family. While there are some useful sorts of parallels there that can be helpful, there are also important distinctions between these different types of experiences.

I also think that for some people, because their experiences or perceptions of the military or war, for them it will be such that the comparison to battle or the use of other military terminology, maybe won’t work as well for them. I also think one of our most recent disasters, that's happening within our society right now and that’s playing out in the setting of protests and other various activities around the country, people have quickly seen a shift from people within our military helping out in cities to help manage the COVID crisis—whether that's aiding people in providing health care to them or doing health screening or involved in other very difficult and highly stressful aspects of support to the community—now, being part of managing or responding to some of the protests and other things, as causes sort of dichotomy in terms of how people think about or maybe see the military. I think that to the degree that it helps people to capture or to articulate or validate in some way the extremes of some of the experiences people have gone through, that it can be useful; but there are also important distinctions and it's important to remember that for some people that language simply will not work.

There are always unique cultural and contextual factors for any given community in which messaging is used and language and words are used, and to the degree that we stay aware of and attuned to the unique cultural variables and contextual factors of a community, I think we can most effectively choose messaging language that aids and supports people rather than leave people feeling perhaps alienated, confused or offended.

**Kerri Palamara, MD, FACP:** It strikes me with the alienation, I think about people who aren't on the roles that people consider the front line, who are feeling like they're working really hard, or even wishing they could do more who feel somewhat alienated by that language.

**Joshua C. Morganstein, MD:** Yes, absolutely. I think the issue is whose experiences are we capturing when we use those? I think you're getting at the idea of sort of inclusivity and recognizing and acknowledging the contributions that different people play. In an event like this, as I mentioned earlier, there are very few of us who are not impacted in some way. So many of us have been impacted and many people in many ways, some very devastating ways, that to recognize and acknowledge the contributions that different people have had will probably be important for not only developing and maintaining community cohesion, but also really bringing a community together and enhancing a sense of hope moving forward.

**Kerri Palamara, MD, FACP:** Thinking about how to understand and how to support each other as health care workers during this time, is there a particular framework that you would recommend that would help really guide how to think about the best ways to support each other?

**Joshua C. Morganstein, MD:** Well, research has shown us that the essential elements of interventions that help people recover following disasters include enhancing a sense of safety, calming, social connectedness, self and community efficacy, as well as hope or optimism. These elements form the basis of what has been termed Psychological First Aid, which is really a resilience-focused and population-based framework for supporting individuals, communities, and organizations, both during and after disasters to help reduce the stress, enhance well-being, and improve people's functioning. And again, it's also helpful to remember that any given intervention that is delivered is going to be most effective when it's done so within the unique cultural and contextual factors of a given community. When people make suggestions or ‘we should try this’ or ‘we should try that’ as a way of helping and supporting, a reasonable lens to put some of those things through are the degree to which they serve to enhance any one or more of those essential elements.

**Kerri Palamara, MD, FACP:** Are there some examples that you have of things that we can do as individuals, as peers, or as leaders to support each other during this time.

**Joshua C. Morganstein, MD:** Well, for individuals, something that is going to be so essential—it's not exciting, but it's, it is perhaps one of the most significant things that we can be doing for ourselves—is self-care; and that involves getting adequate sleep, eating regular meals as best we can, engaging in exercise and other health promoting activities for ourselves, but also involves family care, so things that help us care for our families better because when our families are well we are able to focus more on the things that we need to take care of and understanding.

This also is going to involve managing things like our media exposure and using media wisely, taking care of our underlying health care issues, avoiding, the use of substances and other harmful coping mechanisms .One thing you could think about or what people can think about is PMVC. P is for phone. Put down your phone. Get away from it. M is for media, turn it off. It's important to remind ourselves that we can take the media break. V is for vision, and that's literally our physical vision. Get away from the computer or the thing that is right in front of us and step outside, look down the hallway, get out of your house, look down the street, look under the horizon, see things beyond and away from the immediate moment. This place that's right in front of us, where all our problems seem to be and where seeing into the future can become more difficult or more murky. C is for connection. Reach out and connect with somebody, text someone, call someone, whatever it is, or phone them, whatever it is. PMVC can help any one of us in any given time.

A really helpful thing peers can do is encouraging one another to practice good self-care, but also to speak up when concerns arise. It's really important for us to tell ourselves and remind each other that our voices matter, particularly during crisis events when things seem so out of control.

The other thing we can do is help by dispelling myths and avoiding spreading rumors, because these things often undermine organizational well-being. It can seem innocuous in the moment, but as they spread and fester, those types of things really tend to bring an organization down.

The other thing people can do is recognize each other for their service. This doesn't have to be fancy; even small acts of recognition can be incredibly meaningful. ‘I saw what you did for that patient; I saw you went the extra mile; I know you are doing your best, with that, or how you talked to that person who was really stressed out.’ These very small acts with one another are things people—we are often surprised at how much people remember us reaching out to them during difficult times. It can surprise us how five, 10, 15 years later we can't remember anything about what happened during very challenging experience but will remember those small—what seemed to us like a small thing to do. Will remember so-and-so looking us in the face and saying, ‘you know, I saw you handle that really difficult situation, nicely done. Way to go.’ Or ‘I know you were really trying your best there. I saw how hard you worked for that.’ Those kinds of things are meaningful. Buddy systems can also be very helpful for strengthening work community.

For leaders, it's important to understand the range of supports that are important for people, and this is sort of things like instrumental or practical support needs, as well as emotional support, and the fact that these needs evolve and change throughout a disaster. Instrumental support has to do with things like food and shelter, child care; and certainly earlier on people didn't need counseling. They didn't need therapy. They needed to know where am I going to park, who's going to take care of my child, how am I going to eat, how will I pay the bills. It is the case that sometimes providing emotional support can help some people engage with instrumental supports, but the reality is that it's often hard to talk about feeling sad when you're feeling hungry in your stomach and you don't know whether you can pay the rent. I think it's important for leaders to understand this and keep a pulse on their organization and the people within it and what those needs are and what's evolving over time, because they certainly do change.

Leaders can also ensure that people have training and resources that they need. Communicating consistently and effectively with personnel, as it is a very important thing throughout the duration. Some of that's going to be sort of face-to-face, or mask-to-mask, whatever you want to call it, but staying connected with people, with your personnel.

It's important when we talk about leaders, Kerri, that we remember leaders exist at all levels of an organization. We're not just talking about the CEO. There are team leaders in the ICU and on the medical wards; there are charge nurses; there are service chiefs; there are medical directors. So many people exert leadership influence, and all of these people have the capacity to have profoundly positive effects and supportive effects on the people that they lead. There will also be people who emerge, as is almost always the case during disasters, that will exert leadership influence regardless of their position or title. Often those people resume their kind of more routine work activities after the disaster but we all probably know people around us who are exerting influence during these times of crisis, whether they have an official title or not. The last thing that becomes really important for leaders that will be an enduring necessity is effective grief leadership.

**Kerri Palamara, MD, FACP:** Now, when I hear you talk about these suggestions for individuals and the suggestions for peers, I can see all the ways that my peers have been supporting each other. When I think about the individual ones I think of all the times where I knew I needed some time or I knew I needed some self-care but hesitated, knowing that if I was asking for help somebody else was going to have to be working, taking my work on for me, when they were tired, too. That was something I really struggled with during the time where, man, could I have just used a few hours, let alone a day off, but felt like it was too much to ask of anyone else. Can you talk a little bit about how we can enable each other to take care of ourselves and how we can’t do what I did?

**Joshua C. Morganstein, MD:** Well, it's certainly the case that in helping professions: physicians, other health care workers, people like law enforcement, struggle with this same thing, emergency services folks. Many careers or professions where people's primary job is providing help for others. There is this sort of this unspoken ethos of service before self that sometimes turns into service of everyone else except for myself. These are barriers, they can be barriers to care. There are many barriers to care. Stigma as a barrier to care, economics are barriers to care, a service-before-self ethos can also serve as a barrier to care. One of the things that becomes a very powerful tool is modeling to the degree that leaders at all levels, that peers, can model self-help behaviors and encourage one another gently. Sometimes this doesn't have to be with sort of an epic policy or procedure. Sometimes we just need to nudge people.

You may be familiar with the idea of nudge theory. This has to do with the fact that sometimes it's not about a big intervention that we do at some point in time, but it's more about encouraging a little here and checking in a little there and sort of nudging someone to care a little bit at a time here and there. I think that to some degree that can take the pressure off of us to feel like we have to come up with something big, something grand in order for it to be useful in terms of being helpful to people around us, or to the people that we’re in a leadership position to support. Certainly for leaders, modeling self-care and ensuring that people are made aware that it is not only an acceptable thing but a good thing to speak up and to get the help that we need becomes really important in an organization, because people get the message quickly if what they're seen as is a commodity and that taking care of yourself is frowned upon, or that barriers are thrown up and put in people's way.

I think for us as physicians, sometimes it's that we really need to couch some of this in terms of thinking about our not only our well-being, but our family's well-being, and remembering that our self-care will serve to care for the people that, if we have a family at home or people who we help provide support or care to in any way, that those people—their care is dependent on our own well-being. Sometimes kind of keeping that picture in mind can also be helpful in terms of how we frame things, but it surely is a challenge when we're used to taking care of other people and where we sense a difficulty or a hesitancy in speaking up and asking for help. Remembering that you are not only taking care of yourself, but other people who see it and who benefit from it can be one way of helping move that along.

**Kerri Palamara, MD, FACP:** Another thing that you mentioned that I found really intriguing is this concept of the battle buddy, and I was wondering if you might be able to share a little bit about that with us?

**Joshua C. Morganstein, MD:** I think it's important to think about, or be aware of, the idea of buddy systems are not new. The concept of buddies has been used in many different communities to promote a sense of safety, efficacy, social support; which are all protective during crisis events, as we've talked about. The idea of sort of a battle buddy, which is a term that the military coined, again may or may not work for people. Any variation on the word buddy, or to create a buddy system is perfectly fine. It's really the ideas, more so than, than the exact terminology, but that's actually been adopted in some health care settings to support the safety and well-being of health care workers. This is a form of peer support that's done in a more formal way rather than on an ad hoc basis, because just as you mentioned, It is difficult sometimes for people to reach out and ask for assistance. When we have a buddy that's established, knowing that our responsibility or role is to kind of check in with each other every day at least once. ‘How are you? Have you done something to take care of yourself? Have you had something to eat? Did you get some rest last night?’ Or just a word of encouragement to somebody, whether it's a text or phone call or whatever it is that works.

Or maybe it's somebody on your team. It's often good to have a buddy that understands the work culture that you are in. Having someone close to you who shares some of those same experiences as a buddy is often ideal, but particularly for there are many professions, as I mentioned, that have been exposed to extremes of stress and whose job is to protect and care for other people. When it's difficult for folks to ask for assistance, having this formalized system in place can be extremely helpful for people because it really is a way of staying safe and connected to one another and also a reminder that there's somebody looking out for me and there's somebody that I can be looking out for, as well. Somebody that I can help on a regular basis, just by touching base with them. I think we often undervalue the things we do, and overvalue what other people do, and we sort of forget that our assistance and support to other people can be so critical and valuable and appreciated. Building that sense of efficacy and a reminder that we're in this together, which can sometimes combat feelings of isolation that become more common when we're operating under extremes of stress.

**Kerri Palamara, MD, FACP**: You really get the benefits of community, you get the benefits of helping someone else, you get the benefits of being helped by others and experiencing the gratitude for that, and also just knowing that there’s a touch point on everybody. You’re not worrying about how people are doing on a leadership level.

**Joshua C. Morganstein, MD:** Yeah, I mean there are a lot of different ways for groups, whether they are two people in a buddy system… one of the other things that a lot of organizations find helpful are sort of post-shift huddles, for instance, and some of you may do this already, people may do it already, but to stop and take even five minutes after a shift where the group gets together and says a lot of times we do this shift change on inpatient settings right so we're talking about what we're doing is we're largely talking about patient care issues. A post-shift huddle has to do with our own team and how the team functioned. What happened today; what went well; what do we have challenges with; are there things you might want to do different tomorrow. It's not attributional; it's not about assigning blame. It's all about learning together. Those are really also opportunities, as we think about the concerns around the term moral injury is being used a lot to talk about experiences that people have had during this event, and the things that people have seen or things that they think they should have done but didn't, or did but thought they should not, that have emerged.

A post-shift huddle is often a time to kind of check in with one another and also dispel misunderstandings or correct distortions of thought. Someone might say, ‘well I clearly blew whatever,’ and other person might say, ‘No, you actually totally did the right thing because X, Y, and Z,’ and, so, that person who had that distorted thought has an opportunity to ‘oh, I didn't realize that,’ and rather than going home and holding on to that and allowing that to fester in their mind, this sort of negative belief that they maybe did something to hurt a person or failed in some way, they get a chance to kind of have open more corrective experience about it and leave with hopefully a more balanced perception of the overall experience.

It’s also an opportunity for buddies to see one another or a team leader to see how people are doing on a regular basis. That makes appreciating if there are changes for someone even easier because you've had that sort of dedicated daily kind of check in with one another. A post-shift huddle for just a few minutes can serve a number of really valuable purposes for the entire team as well as the leader.

**Kerri Palamara, MD, FACP:** That strikes me as so important right now when we are in such uncertain times: we're dealing with a disease that we know very little about and are learning as we go, and what we did one day might not be what we would do another day later. Not carrying the weight and the burden of those decisions and those outcomes with us. So important.

Now, one thing that I've heard a lot about is, myself and others who do this well-being work and establishing programs for people to get support and you feel really good, you created this resource, and then nobody shows up or nobody accesses it. You alluded to part of it, which is if you're worried about when you're going to eat or how you're going to take your kids, you're not going to want to talk about your feelings, but what about now, when people perhaps are not so worried about how they're going to eat and how they're going to take care of their children or anything else, and they still don't seem to be showing up. How do we help people access resources and really normalize that?

**Joshua C. Morganstein, MD:** Well, the normalizing of experiences, and, in many ways, like other interventions can be a peer-to-peer thing and it will definitely be leadership thing. I think we have to be aware that when we make resources available and accessible it's important, first of all, to understand if we're kind of firing at the… if we got the right target, if I can use that analogy, because it really is important, as I mentioned earlier, to sort of measure things. When we're building programs and trainings and other things one of the important questions is, are we really building and training to the things that people need; and the only way to know that is through surveillance and assessments, and those can be informal. I mean, that can be a leader walking around and talking to people or supervisor talking to people. That's a really important way of getting information. I mean, it's absolutely critical. There's information that you will never capture in a survey, for instance, if people fill it out, that you will hear about and find out about when you're walking around and talking to people. When you're kind of in the mix with them, when you're part of what's going on, and people sort of open up and it will share during those experiences.

That's one way of getting information. I mean, people do other formal ways of gathering information, like maybe a focus group or a key informant interview or, again, a post-shift huddle where the group is kind of sharing things and patterns might be emerging around what are consistent ongoing challenges for people. Really effectively targeting or providing interventions and support often involve some sort of synergy of a variety of different mechanisms of surveillance of a group or an organization.

Important questions we always have to ask ourselves are do people know about these resources. Do they see those resources as things that are useful or necessary to them? The earlier one about whether it's really addressing the things that are relevant to them. Do they have the time to do them? Does our organizational culture encourage the use of those things? I think you might have had up a slide earlier that sort of talked about organizational interventions and providing training and resources and making sure that those are accessible to people. That people can actually do them because, for sure, people aren’t going to want to go home and have the limited time that they have with their family or their loved ones be consumed with doing something to do feel-well-at-work kind of things. I think when we really understand kind of what's going on and a system is set up to facilitate people engaging with it that we really optimize those kinds of things for people.

There are two things that are really important for us to be thinking about right now, and those are reintegration and recovery time; and I'm not sure the degree to which we're giving attention to reintegration. This really happens, inevitably, when we transition from a focused kind of intense period of extremes of stress back to more day-to-day operations and we may not be going back to what feels like normal. The exposures to extremes of stress, death and dying, having to work within crisis standards of care, this ongoing uncertainty and disruption that's happened for people that have really characterized this event, create challenges for people when they go from these extreme circumstances back to, kind of, quote, daily life. How we people interact with coworkers, communicate with family, a sense that people don't understand…. The world around us can really feel altered. When once we've been around death and dying and shortages of resources, people may find themselves sort of feeling short-tempered about the person in front of them at the grocery store that's arguing about a coupon or a spouse that's concerned about getting the grass cut. Both of those are very reasonable things, but sometimes when our mindset is really back in this place of ‘what did I just see?’ we can sort of think to ourselves, ‘how can you care about something so unimportant? Don't you know people are suffering in this world?’

Reintegration processes are designed to help people who've been in these extreme circumstances and the people that are close to them to understand some of these challenges, to provide healthy ways of managing them when they emerge, as well as when to get additional help and resources that are available to them.

There are many professions that have learned this over time. Certainly that when people are in these extremes for periods of time. Some people have been away from their family, whether it's sleeping in the garage or an Airbnb or a hotel room or their office at the hospital coming back together. Coming back together with coworkers at a unit where you were moved from your area of specialty to help others. You have all these people who don't understand, and that lack of their understanding, their ability to appreciate these things and understand, can feel isolating and frustrating. Anticipating this and sort of helping everyone involved negotiate that together is important. I think it's something that will be important for us to be thinking about now.

The other piece is recovery time. Recovery time can be: how long did it take you to get your inbox back to a manageable state? Or, how many days was it after you went back to sort of your normal work duties before you stop feeling distracted most of the time thinking about what happened during the COVID surge and wave? These are ways of measuring, sort of, recovery time and how long does that does that take?

An important piece of sustaining people and preparing for what are likely the next waves is ensuring that people have adequate recovery time. Encouraging people to take vacations or to take time off or to just be away from the office that may not be a trip in the traditional sense, but it may be being away so that one can transition one's thoughts.

PMVC. One can transition one's vision and connect with people that we need to connect with and do those things that are restoring; that allow people to replenish, rejuvenate, and kind of be effective when they come back to the work environment so that we don't have high rates of presenteeism where people are… they're physically in place, but they're distracted, emotionally, psychologically, mentally from the tasks at hand.

**Kerri Palamara, MD, FACP:** One last question, maybe two minutes on thinking about, we had some relief after the surges were over, but now we're starting to see cases rise around the country. I think there are people getting nervous again and worrying about another surge, and there's a lot of talk about the fall. As we think about that, suggestions for us as individuals and/or leaders about what we can do to prepare to handle this in an even better way next time, if there were a next time.

**Joshua C. Morganstein, MD:** Yeah, I mean I think the issues that I just mentioned about reintegration and recovery are probably both going to be really central to this, and I think leaders have to be… it will be really important for leaders to be thinking about recovery time and just understanding that it is really essential. We've studied this and other high risk occupations that are exposed to extremes of stress. The military is probably one of the best studied at this point, particularly because of decades of being a war and trying to understand how long do people need off, how much time can people be away, sort of, how does that influence things. Elements of recovery time for people and this process of reintegration are going to be really important.

I think things that an organization that really wanted to strengthen their community would be looking for ways to capitalize on opportunities. What are things that changed during this pandemic or changes to processes and procedures that serve patients and providers and all the health care workers? Helped everyone do what they needed to do and care for themselves better. One could do a sort of lessons learned or an after-action review where they pulled together all of the things that happened and figure out what worked and what didn't, and find ways to sustain those things. I think for people feeling like all of the difficulties that they went through meant something. In other words, we learn some difficult things here. We're going to figure out how to incorporate some of these lessons as we go forward so that when this comes again, whether it's the next wave of this or the next crisis, our organization is in a better place to respond. Those kinds of things from an organization at a leadership perspective really help increase and foster a sense of hope and a sense of well-being and a this-wasn't-all-for-nothing kind of feeling and response from people.

I think to the degree that organizations use this time to get things that they need—training, equipment, educating people, putting resources in place, using lessons learned, and capitalizing on those for opportunities. Those things will really strengthen health care organizations and the communities within them during this period of time that's more quiescent.

**Kerri Palamara, MD, FACP:** Now, there was a question in the Q & A about going back to the post-shift huddles and how when people are going off shift at different times, it's not as easy to do this all at the same time. Do you think that group chats or apps or things where people can check in with each other is a reasonable way to do that?

**Joshua C. Morganstein, MD:** I think people have to use whatever works. If your team will do it and engage with that, great. We find what works for us. If part of the team leaves at one time and part of the team leaves at another, a face-to-face can bring some benefits that are sometimes more difficult as we all appreciate face-to-face encounters in general, bring things that communication through text messaging or other things, we may miss certain things through that or they may not offer the richness in terms of an interaction, but if the team is able to benefit from it and it's the only option, for instance, if everyone is dispersing one at a time and people got to go, then we do the best we can.

**Kerri Palamara, MD, FACP:** There was a question in thinking about how we communicate with each other to support our own well-being. We talked about language in the media, we talked about military jargon; but, in just thinking about the language of support for each other, do you have any suggestions as far as what what's helpful or the most helpful?

**Joshua C. Morganstein, MD:** Well, one of the things that is often most helpful, is most well received, is self-disclosure to someone else. ‘Boy, I'm having a hard day today’ or ‘this has been a really tough day for me, how are you?’

The other thing that often goes over well for many people is when we listen, rather than try to fix things. We are a very solution-oriented, problem-focused society. It is also difficult for us to see other people in distress. As health care providers, I think it’s particularly difficult and it's easy for us to go into fix it mode, solving mode. It's perfectly okay when somebody shares all of the difficulties that they're going through, to say to them, ‘I don't know what to say right now, but I'm just really glad that you shared.’ That is an okay thing to do.

We can also sort of think about reach and touch. Reach is reaching out to people. If you see someone who's having a hard time and you're thinking, I'm not sure I'm going to say the right thing. I'm not sure I know exactly what to do. Reach out anyway. People will remember that you reached out to them when we see someone drifting away. People will remember that you reached out to them years later, when all else is forgotten. People are often surprised to find out how impactful that their reaching out was. Whether you consider yourself an expert at reaching out or not, do it. Touch is physical touch, and that's putting a hand on someone, which when people are kind of zoning out or going inward sometimes in a—I wouldn't want to use the word dissociative way, but in a way where they're sort of drifting away, but almost inward sense—putting a hand on someone has a very powerful way of activating them and bringing them back. Now we're in a circumstance right now where we have to be cautious about touching, physical touch, and that will change as these curves come up and down and recommendation shift and altar and things like that, but it is important to think about and good to be aware of in general when we're trying to think about how to engage with other people. To the degree that we can do one or both of those things, they can be very powerful ways of interacting with and connecting with people.

**Kerri Palamara, MD, FACP:** There was one last question. I know we're just at time, but many people right now are balancing the stressors of just everything you've mentioned and the pandemic, but also balancing family stressors at home and in helping and supporting people in this situation. Are there takeaways, in particular, that that you can share with us?

**Joshua C. Morganstein, MD:** Well, what people have told me, and we are seeing happen, is that the issue of family safety and well-being and that balance is very challenging, and a huge part of that has to do with disrupted routines. One of the things to the degree that it can be done, is the creation of routines. Dedicated time for X, Y, and Z and reestablishing. If your home is anything like mine, our routines have just been completely thrown up in the air like whatever the pick-up sticks game is. When our routines are really disrupted, and particularly for children, the establishment of routines can be very powerful and huge buffer against some of the other challenges that people are dealing with right now.

**Kerri Palamara, MD, FACP:** Well, thank you so much, Josh, for sharing your expertise. Thank you everyone for your questions and your presence today, and we really appreciate this opportunity from ACP to share these insights with everyone and we recognize that this is just getting started. There's a lot of resources that are within these slides, which will be available with the webinar that people can people can reference afterward. We also plan to put this all together in some sort of written form so that people can access it later on. Thank you all so much for this time together. We greatly appreciate it.

**Joshua C. Morganstein, MD:** Good to be with you.

**Susan Koger:** Thank you. Thank you all for joining us today. Before we conclude, we just wanted to share some additional resources. I'm going to turn it over to my colleague Clare Sipler now to run through these quickly.

**Clare Sipler:** Yes, thanks Susan. Very quickly, we have a lot of really great well-being resources featured in our ACP Physician’s Guide. We have a whole well-being section. We've also produced some really great CME-eligible well-being webinars, besides this one, including one featuring two physicians—one on the front lines in Seattle and another former Ebola doctor so they gave really good well-being tips for crisis situations.

I also wanted to just highlight some of the regulatory relief and other advocacy work ACP has been doing advocating for administrative and regulatory relief during the pandemic and also asking HHS to make targeted allocation from the Provider Relief Fund to primary care physicians and other clinicians to just help them weather this storm and help primary care practices survive. Thanks, I'll turn it over to you.

**Susan Koger:** Thanks, Clare. We invite you all to visit ACP’s COVID-19 resource hub, which has a wealth of information. We also invite you to register for next week's webinar on innovations in the care of patients with COVID. That will be on Wednesday, June 24, at 5 p.m. Eastern Time.

Once again, thank you. Thank you to Kerri and Josh for joining us today for this wonderful presentation. Thank you all for being here and thank you for your membership in the College. Have a great day.