

LETTERS TO THE EDITOR

Primary Care Challenges in Addressing Veterans' Postdeployment Mental Health

TO THE EDITOR:

We agree with the article by authors Koonce and colleagues, who highlight the importance of incorporating veteran-specific occupational and health questions through case discussions during first-year medical education.¹ As health professionals who have served in the military and/or cared for veterans at US Veterans Health Administration (VHA) and non-VHA health facilities, we understand firsthand that military service and deployments embody a significant part of veterans' identity.² Following the deployments since 9/11, many veterans have received physical and mental health diagnoses as a result of environmental and occupational exposures.³ The postdeployment reintegration period is defined as 3 to 6 months or longer following a veteran's return home from deployment. With limited veteran-specific content on mental health topics in health professions education,⁴⁻⁵ family medicine educators can lead efforts to develop short-term learning experiences for medical students and residents that offer guidance on the prompt diagnosis and management of veterans' mental health during their postdeployment transitions.

The VHA has prioritized veterans' mental health services for postdeployment needs with increased annual funding to \$8.9 billion, expanded telehealth visits for veterans, and other

actions to enhance access to mental health services.⁶ Alarming statistics highlight the reported suicide rate of 17.2 veterans per day,⁷ and link combat deployment to increased risk of mental health diagnoses like posttraumatic stress disorder (PTSD), suicide, and depression.⁸ Although emotional disturbances may result from combat stressors as reported by the Millenium Cohort Study⁸ (eg, repeated post-9/11 deployments, postdeployment reintegration challenges), rapidly withdrawing service members from Afghanistan and leaving some Afghan translators in the country⁹ may have exacerbated feelings of anxiety, powerlessness, shame, or regret. These combined stressors can significantly impact veterans' and family members' mental health and well-being needs during the postdeployment transition period.

To address this mental health burden, family medicine educators can streamline clinical questioning to elicit veterans' specific, postdeployment health concerns. First questions should always include: Are you a veteran? What was your service and specialty? Were you deployed overseas? When did you return from deployment? These questions should be followed by recognition of their selfless service.² Service members are a heterogenous population, with differences in biological (eg, age, ethnicity, gender), sociodemographic (eg, economic status, education, residence), and military (eg, service branches, service components, service era) information. Service members may represent active duty (full-time) or Reserve and National Guard (part-time) forces, with

Table 1: Selected Resources for Medical Students and Residents to Understand Veterans' Health Needs

Category	Key Resources	Description
Eliciting a military health history	Military Health History: Pocket Card for Health Professions Trainees and Clinicians: https://www.va.gov/oaa/military-health-history-pocket-card.asp	A pocket card for clinicians to ask veterans about physical and psychosocial health challenges and understand their unique experiences during transition home
Understanding military culture	Uniformed Services University's Center for Deployment Psychology: https://deploymentpsych.org/content/self-paced-elearning-courses	A list of self-paced eLearning courses to provide health professionals with an overview of the military culture
Offering virtual platforms for clinical support	US Department of Veterans Affairs' App Store: https://mobile.va.gov/appstore	A list of smartphone apps for clinical management, including databases and telehealth (iOS, Android, web)

distinct postdeployment transition needs that can influence health-seeking behaviors at VHA and non-VHA health facilities.² Understanding these individual veterans' health needs can ultimately enhance doctor-veteran rapport and build trust in shared decision-making activities for optimal mental health service delivery. Short-term courses and workshops that incorporate role-playing exercises, case studies, invited lectures with veterans, and roundtable discussions offer practical opportunities for medical trainees to utilize innovative tools and master clinical skills addressing postdeployment reintegration needs (Table 1).³

As primary care practitioners, serving our nation's veterans at VHA and non-VHA health facilities is our utmost duty. By better understanding veterans' invisible wounds, we can identify relevant resources that support their mental health needs as they transition from deployment to civilian life.

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Military Family Medicine Readiness for National Pandemic Hospital Support

TO THE EDITOR:

We read with great interest the article "Family Medicine and Emergency Redeployment: Unrealized Potential"¹ by Drs Byun and Westfall from the Graham Center in the January issue of *Family Medicine*. In this article, the authors highlight the versatility of family medicine training to cover the diverse needs of medical resource deficient populations, while demonstrating that physicians working in multiple care settings maintain a broader scope of practice and as a result are better prepared to support personal shortages secondary to the COVID-19 pandemic.

We explored this concept early in the COVID-19 pandemic for family medicine in the military services. Military family physicians are expected to maintain a broad scope of practice with readiness to provide medical support in global armed conflicts, humanitarian missions, and national emergencies, yet the majority of military family physicians primarily work in outpatient clinics. While the scope of practice varies within military family medicine, inpatient and obstetric care is primarily limited to those in academic medicine and smaller hospitals that are overseas or geographically remote. Although military family physicians regularly change positions, only a minority ever serve in these positions during their career. In early 2020, almost all military family physicians had experience in the post-9/11 wars but no previous experience with national pandemic hospital support. We asked members of the Uniformed Services chapter of the American Academy of Family Physicians (USAFP) to assess their own immediate readiness to provide effective medical care in the inpatient or intensive care settings. A total of 253 participants (11% response rate) were included in the analysis. USAFP members are primarily active-duty family physicians with a small number of retired or civilian physicians who work with the military health system. Survey respondents differ from USAFP membership with a higher proportion working in academic medicine and who are female but are similar in distribution of postresidency experience. This study was approved by the Uniformed Services University Institutional Review Board.

Fifty-one percent of the 253 survey respondents reported being clinically ready to perform inpatient care, either requiring no preparation or only minimal literature review. The other half of respondents felt they required refresher training with an experienced provider for up to 2 weeks or more before being able to work independently. For intensive care unit (ICU) care readiness, 14% of respondents felt they were ready, while 86% felt they required more expansive training. A multivariate logistic regression demonstrates that two factors are associated with increased readiness for both environments: having inpatient experience of at least 14 days in the last year (OR for ward readiness=8.6, 95% CI 3.8-19.3, and OR for ICU readiness=7.9, 95% CI 2.2-28.1) and being residency faculty (OR for ward readiness=3.8, 95% CI 1.5-9.4, and OR for ICU readiness=6.3, 95% CI 1.3-31.2).

These results support Drs Byun and Westfall's findings of the capacity of family physicians to fill diverse roles and provide complex care across many medical settings and demonstrate the importance of maintaining this broad skill base. The breadth of family medicine training develops uniquely qualified physicians whose skills are largely underutilized in both the civilian and military communities. Our survey results also demonstrate the important reserve of broad scope physicians represented by residency faculty. The military services have since mobilized hundreds of family physicians to support pandemic relief, both from residency programs and outpatient clinics. Partially in response to this experience, the services are starting to require family physicians to maintain minimum levels of experience in inpatient, urgent, and obstetric care to maintain a broad scope of practice. With the current Accreditation Council for Graduate Medical Education family medicine residency guidelines under active review, we also advocate and believe our results add to the Graham Center argument for maintaining comprehensive, coordinated, and complex training within our graduate medical education programs. Family physicians are uniquely qualified to meet the health care needs of our communities. doi: 10.22454/FamMed.2022.361811

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Prioritize Comprehensive Women's Health Training, Protect Our Communities

TO THE EDITOR:

As family physicians with maternity care experience in both rural and urban academic settings, we have witnessed multiple threats to the women's health competency of the graduating family physicians. "Comparison of Maternity Care Training in Family Medicine Residencies 2013 and 2019: A CERA Program Directors Study" uncovered the core of what is actively dismantling the practice of women's health amongst family physicians. This well-performed study compared provisions of maternity care by resident graduates after the 2014 change in Accreditation Council for Graduate Medical Education (ACGME) requirements—a shift from quantitative targets to competency-based learning in perinatal care. The data predictably illustrates a significant decline in the volume of maternity patients cared for by residents during their training.¹ The adjusted ACGME requirements created a deficit within resident education that threatens the well-being of our patients. The byproduct challenges family medicine's delivery of perinatal care and, inescapably, women's health primary care to our most vulnerable populations.

When we dilute maternal health training for residents, we invariably leave voids in the totality of our women's health primary care curricula. In a short 6-year span, we have seen far less time devoted to teaching maternity skills, and the precious time needed to become proficient physicians for the care of women was reallocated elsewhere in our programs. This monumental shift will exacerbate the known gap of residency preparedness and practice

implementation in women's health primary care previously attributed to health systems.² Now, family medicine graduates are at great risk of feeling ill-prepared and failing to deliver health care for women in all phases of their lives.

Threats to resident competency are multifactorial, extending beyond ACGME maternity care requirements. Nearly one-quarter of family medicine in-training examination questions stem from women's health, with a predominant reproductive and perinatal care footprint.³ Unfortunately, we neglect to test on preventative and longitudinal care of women, which are a cornerstone of primary care. Clinical exposure is further challenged by reproductive-age women choosing Ob-Gyn for preventative visits.⁴ Primary prevention and chronic disease management are core to family medicine and instrumental in reducing severe maternal morbidity.⁵ Enhancement of and adherence to comprehensive women's health and perinatal training are fundamental to maintaining our unique ability to deliver evidence-based and family-centered interconception care.

A broadened competency requirement for family medicine residents will support the necessary skills to comprehensively care for women at all stages of life. Neglecting gaps in women's health curricula only contributes to the grim mortality affecting women today,⁶ especially Black and poorly resourced communities largely cared for by our family medicine colleagues. It is now vital for us to push the ACGME and the American Board of Family Medicine to reprioritize comprehensive women's health care by reinstating more rigorous and quantitative gynecological and perinatal care curricula requirements centered on the care and protection of women. By taking bold and necessary action, we answer the beckoning call from our learners and the communities we serve, some of whom are grieving immeasurable losses from this preventable maternal health crisis.

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Address Structural Racism First!

TO THE EDITOR:

Drs Jabbarpour and Westfall have provided an excellent commentary on the importance of the future family medicine workforce in addressing racial inequalities by promoting diversity and inclusion in residency training.¹ We agree with many of the recommendations suggested by the authors. Individual, intentional education on diversity, equity, and inclusion (DEI) issues is a good starting point. We encourage leaders to use this education to produce meaningful changes. However, in order to progress, academic family medicine leaders must deliberately dismantle structural racism, which is embedded in culture, practices, and policies of academic medical institutions²; otherwise, our diversity and inclusion efforts are rendered futile. This differs from the traditional approach where institutions have often sought out diversity without first implementing equitable policies and practices.

Structural racism is not only evident in residency recruiting processes but also part of how underrepresented in medicine (URIM) residents are treated once they join residency programs. Underrepresented minority residents have been the target of bias and discrimination in patient interactions as well as from fellow residents, attendings, program leadership, and other health care team members.³ URIM residents' experiences and opinions need to be understood and valued. They should be equitably evaluated, and they should not be subject to the minority taxes that are commonplace in academic medicine.⁴

Leaders, educators, trainees, and staff must be involved in the work, altering policies to ensure that changes become permanent. Dr Foster and her coauthors in the article “Dear White People” provide meaningful solutions to address these inequities.⁵ Among them: exploring individual biases, uprooting them, dismantling them, taking on the responsibility of learning about the roots of structural racism, and actively educating others about this history. White privilege can also be used to increase equity and eliminate structural racism by channeling this influence into critically examining and abolishing racist structures, practices, embedded norms, and values that sustain inequities.⁶

An additional step to dismantling systemic racism lies in rigorous policy review and revision. Leaders can recognize that “every system is perfectly designed to get the results it gets.”⁷ Therefore, if we are not satisfied with the diversity of our profession, we must admit that our systems are perpetuating that lack of diversity. We then can examine the systems of hiring, admissions, or residency recruitment and make modifications to ensure that we are recruiting a diverse workforce. At least two residency programs have taken this approach, and the changes in policy have resulted in increased compositional diversity.^{8,9}

The recommendations by Dr Foster and colleagues in addition to our collective resolve can encourage many in our field looking to make sustainable collaborative change in their institutions, with the goals of addressing racial inequities, eliminating structural racism, and ensuring our institutions are truly inclusive environments where those we recruit and care for can thrive.

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