

# Stigma Compounds the Consequences of Clinician Burnout During COVID-19: A Call to Action to Break the Culture of Silence

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My sister, Dr. Lorna Breen, of New York, NY, died by suicide on April 26, 2020. My sister was head of the Emergency Department at New York-Presbyterian Allen Hospital. Within a period of just 3 weeks, she had treated confirmed COVID-19 patients, contracted COVID-19 herself, and returned to an overwhelming, relentless number of incredibly sick patients. My sister and her colleagues worked around the clock during peak levels of the COVID-19 outbreak in New York, with limited personal protective equipment, insufficient supplies, not enough oxygen, not enough beds, not enough help. They saw patients dying in the waiting room and in the hallways.

After twelve-hour shifts, my sister would stay (as would her co-workers) because the onslaught didn't slow throughout the day or night. When Lorna left the Emergency Department, she had to take the train home. As the trains were largely empty due to distancing measures, she was afraid of being mugged. She tried to take cabs home, but some of the cabs that stopped wouldn't pick up someone leaving the hospital for fear of being exposed to the virus. In spite of all of that, she kept going back until she literally could no longer stand.

On April 9, 2020, Lorna called me from her home in Manhattan to tell me she couldn't get out of her chair. She was nearly catatonic. She had not slept in over a week. During one shift she covered two emergency rooms in Manhattan at the same time, at locations that are five miles apart. My sister had answered the call for her city and for her country. And when she became so overworked and despondent that she was unable to move, her biggest fear? Her job.

Lorna was worried that she would lose her medical license or be ostracized by her colleagues, because she was suffering due to her work on the front lines of the COVID-19 public health crisis. Lorna had no prior history of mental health issues, either known or suspected. But when she experienced a mental health crisis for the first time during the pandemic, she was afraid to get help. She was worried it would end the career that she had spent her entire life working for.

At the time, I thought Lorna's fears were unfounded. What I learned after her death is that medical licensing boards throughout the country require physicians to disclose current or past mental health care (in some cases at any level); hospitals require disclosure for credentialing; and seeking mental health care is considered a sign of weakness among many medical professionals. This paradigm must change.

—Jennifer B. Feist

Our nation's health care professionals are currently working in the midst of a "pandemic within a pandemic." The extreme stress and isolation of the COVID-19 pandemic, with its associated patient load, suffering, and death, as well as limited supplies and incomplete understanding of this disease, is a significant burden on its own. However, the pandemic has been layered on top of already dangerously high levels of clinician burnout throughout the health care system. In other words, we are experiencing concurrent public health emergencies.

Even before COVID-19, more than 50 percent of clinicians treating patients reported that they had experienced symptoms of burnout, "a syndrome characterized by high emotional exhaustion, high depersonalization (i.e., cynicism), and a low sense of personal accomplishment from work"[12]. Burnout has been shown to reduce job performance, increase turnover, and, in its most extreme instances, increase incidence of medical error or lead to mental illness or death by suicide [1]. It is estimated that at least one physician dies by suicide each day, an alarming statistic that is likely still underreported [10]. Dr. Lorna Breen's story is, tragically, one of many, and it is part of a crisis that has been further exacerbated by both COVID-19 and a pervasive culture of silence.

Despite the prevalence of burnout, speaking up or seeking help to deal with work-related stress continues to be seen, especially within the culture of health care, as a sign of weakness or inability to "make it" as a clinician [2]. Research shows that physicians are fearful about the consequences of disclosing any mental health condition or treatment [11]. As Hengerer and Kishore, commenting on the role of State Medical Boards, observed, "there is often great stigma surrounding mental health issues ... as a result, physicians experiencing depression or any mental health challenge do not feel their confidentiality would be protected if they were honest about what they are experiencing." [5]

The culture of silence was a stifling burden before COVID-19 [3]. Now, coupled with the isolating effect of the pandemic, the consequences of stigma are ever more dangerous. While the media congratulates the courage and resilience of health care workers, their day-to-day experience continues to reflect the pre-pandemic reality – that expressing pain or struggle with their work could be perceived as a weakness and a potential impediment to career success.

Clinicians are struggling to stay afloat as rates of COVID-19 continue to surge. Therefore, health care leaders must step up. Leaders must be present, recognize

and address sources of concern for clinicians, respond to requests for help to care for patients or for themselves, and express gratitude for delivering extraordinary care under very stressful circumstances. There has never been as important a time to say thank you to teams who put themselves in harm's way, potentially putting their lives in danger, for the greater good. However, as Shanafelt et al. caution, "gratitude from leaders rings hollow if not coupled with efforts to hear, protect, prepare, support, and care for health care professionals in this challenging time." [4] The stigma against speaking out or requesting help and the resulting culture of silence has been well documented – it is beyond time to act.

There has been some progress in addressing the culture of silence by ensuring that clinicians can safely seek help without fear of retribution. For example, in 2018, the Federation of State Medical Boards issued a set of recommendations supporting less intrusive interview questions and "safe haven" reporting that would not penalize clinicians for seeking mental health support [6]. The Joint Commission, in May 2020 and in response to COVID-19, issued a statement urging health care organizations not to inquire about clinicians' past history of mental health conditions or treatment, noting that "it is critical that we ensure health care workers can feel free to access mental health resources." [8] The American College of Emergency Physicians also recently released a joint statement with 45 peer association signatories noting that "a provider's history of mental illness or substance use disorder should not be used as any indication of their current or future ability to practice competently and without impairment." [9]

But this progress is not enough. Clinicians are struggling, suffering, and, in some cases, dying while their needs are not being met by employers, educational institutions, professional organizations, and other authorities that shape the culture of health care.

Peer support for clinicians has been shown to be effective in helping to move away from "a culture of invulnerability, isolation, and shame and toward a culture that truly values a sense of shared organizational responsibility for clinician well-being and patient safety" and could be a method to prevent the isolation that Dr. Breen felt. [7] Additional progress can be made if state medical boards and accrediting and licensing bodies add further leniency when evaluating past or current mental health diagnoses, so that other clinicians do not view seeking help with the same fear that Dr. Breen did. The same leniency could and should be extended to professional and membership organizations, so that clinicians can take time off to care for

their mental health without fear of being barred from membership. A variety of other systems-level changes have been shown to be efficacious as well [12]. The time has come for health care systems and health care leaders – including C-suite executives and boards of directors of health care organizations – to demand such changes be put into place to protect the health care workforce.

We are sharing the experiences of Dr. Lorna Breen and others as part of a call to action – action that was overdue before the pandemic, and has only become more urgent now. We must break the culture of silence surrounding clinician burnout and mental health issues.

The systemic factors driving burnout and its dangerous consequences have brought the health care workforce to a breaking point. Clinicians across the career and specialty spectrum, along with leaders in health care, accrediting and licensing, educational institutions, and membership and professional organizations, must speak out now for culture and systems change. Only by fundamentally addressing the culture of silence can we ensure that the clinicians who care for us can, in turn, ask for and receive the care they need without fear of consequences that could jeopardize their careers and well-being.

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None to disclose.

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