The NEW ENGLAND JOURNAL of MEDICINE

Perspective

DECEMBER 31, 2020

Supporting Clinicians during Covid-19 and Beyond — Learning from Past Failures and Envisioning New Strategies

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Clinicians are facing important emotional stressors during the Covid-19 pandemic, including grief from seeing so many patients die, fears of contracting the virus and infecting their family members, and anger over health care disparities and other systems failures. For some, these stressors have caused or exacerbated burnout, depression, or post-traumatic stress disorder, and they have been implicated in suicides. Even before the pandemic, there were unacceptably high rates of burnout and suicide among clinicians, especially among physicians.

There is a strong consensus that immediate action is needed to bolster the emotional health of clinicians. A recent article argued for enhanced organizational resources for efforts supporting clinician well-being.[1] Clinician well-being has multiple components, and limited progress has been made in addressing some important drivers of well-being, including improvements in workplace efficiency and workflow, increased supplies of personal protective equipment, and strengthening of communication with organizational leaders. Other efforts often fail, however, when it comes to supporting clinicians' emotional well-being. The design of initiatives to bolster emotional well-being, which has been rooted in mental health models, leads to low utilization because of barriers related to deeply entrenched, counterproductive views about what is expected of clinicians.

One barrier is that these expectations are often unrealistic. Clinicians have been taught that self-care is selfish. The culture of medicine reinforces the belief that physical and emotional exhaustion is part of the job. Although meant to be appreciative, messages depicting clinicians as heroes imply an expectation of personal sacrifice at all costs. Well-being efforts have overemphasized personal resilience, thereby placing the burden of handling emotional distress solely on individual clinicians. Research has found, however, that organizational approaches to improving clinician well-being are more effective than strategies focusing on personal resilience.[2] Stigma and isolation are also important barriers to the success of well-being efforts. The ethos that vulnerability is a sign of weakness is reinforced regularly. Programs relying on self-referral often fail because they require clinicians to admit that they need help. Moreover, clinicians tend to feel alone in their vulnerability and suffering; this feeling is reinforced by a culture of silence, which convinces clinicians that others are successfully handling these stresses.

Because of the nature of health

care workplace stressors, clinicians often want to confide in and receive support from peers rather than from mental health professionals,[3] so the current mental-illness framework generally isn't useful. Mental health programs are often reactive, waiting for clinicians to exhibit distress rather than anticipating that compassionate clinicians will experience emotional pain associated with their challenging work. Mistrust in organizations also keeps some clinicians from seeking help. Medical institutions have historically punished clinicians who have mental health issues. Other factors have further eroded clinicians' trust that their organizations will support them, such as a pattern of valuing productivity over well-being and a failure to address health care disparities that have been highlighted during the pandemic. Finally, there has been a lack of accountability when it comes to fostering well-being. Despite declarations that clinician well-being is an organizational priority, support programs are often poorly resourced and leaders are rarely held accountable for outcomes related to well-being. Although perpetuating the status quo and ignoring these barriers may appear to serve an organization's short-term financial interests, lack of attention to well-being is ultimately extremely costly.[4]

We believe there are several important strategies that medical institutions could use to design emotional-support programs that clinicians will embrace. First, institutions can create and provide funding for peer-support programs. Emotional stressors are often occupational hazards rather than mental health problems. Programs built solely on a mental health model — in which the need for support is portrayed as applying to people with mental health disorders and treatment is provided by mental health professionals — aren't used by many people who might benefit from them. Clinicians are more likely to accept support from colleagues who understand their specific stressors.[3] The peer-support model frames emotional fallout as an occupational hazard, thereby reducing the stigma associated with receiving support.

Peer support also fosters a sense of camaraderie that is crucial to sustaining joy at work. Seeing that colleagues understand one's emotional responses and have had similar experiences reduces the feelings of isolation and self-recrimination associated with distress. Peer-support programs should involve adequate training, marketing, and personnel, including program leaders. The American Medical Association provides practical tools for developing peer-support programs.

Second, institutions can prioritize reaching out to employees who may benefit from receiving help by developing systems for offering support to clinicians rather than relying on self-referral. Even when emotional-support programs exist, physicians rarely seek them out because of barriers including concerns about confidentiality, stigma, and access.[3] Programs should therefore have a robust component that involves proactively reaching out to clinicians and that destigmatizes receiving support and facilitates access. We have found that stressful events such as the occurrence of medical errors can be successfully used as triggers for peer-support outreach.[5] Outreach triggers specific to Covid-19 could include clinical service on a coronavirus ward or the death of a patient with Covid-19, especially if the patient was the clinician's colleague.

Third, institutions can provide easily accessible and psychologically safe "reach-in" services for clinicians requesting help. Although some emotional stress can be mitigated by means of preventive approaches such as peer-support programs, some clinicians will need professional mental health services. These supplemental services must be confidential, affordable, and accessible at any time. In these cases, having peer supporters make initial contact with clinicians has the advantage of normalizing and facilitating connections to professional mental health resources.

Finally, institutional leadership should be accountable for clinician well-being. Leaders should empower clinicians to speak up about unsafe, highly stressful, or morally challenging workplace conditions and ensure that concerns are listened to and, whenever possible, acted on. We have found while providing peer support to hundreds of clinicians that their emotional stress often comes from workplace issues that should be mitigated, such as inadequate resources; unsustainable clinical volume and hours; other clinicians' unprofessional and problematic behavior, including racist and sexist behavior; and persistent health care disparities. Statements from organizational leaders about their desire to reduce burnout, in the absence of efforts to address its underlying causes, erode trust. Organizations have an obligation to assess and address concerns in order to treat the causes of emotional stress rather than merely the symptoms.

As part of this effort, there should be processes in place for

leaders to actively solicit feedback and suggestions for improvement from clinicians on the front lines, as well as channels through which clinicians can safely and anonymously report concerns.[1] Accountability among organizational leaders for support initiatives is vital and should include sufficient investment of resources, elimination of access barriers, articulation of this accountability among executives in particular, and development of measures to track progress. National accrediting organizations should continue to establish mandates and metrics that support the health of the workforce, such as the Joint Commission's recent recommendation to remove barriers that inhibit clinicians' access to mental health services.

The Covid-19 pandemic has highlighted the urgent need to address the emotional well-being of clinicians and has laid bare the cultural and structural barriers that cause many programs to fail. Programs should be designed to overcome these barriers using a range of strategies, including peer support as a way of framing emotional stress as an occupational hazard; processes that involve reaching out to clinicians and proactively offering support; "reach-in" components that allow clinicians seeking help to easily obtain access to professional resources; and leadership accountability for mitigating workplace stressors and for financially supporting and assessing program outcomes.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on October 14, 2020, at NEJM.org.

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DOI: 10.1056/NEJMp2024834