Turning Medical Tragedy into a National Movement | The Lorna Breen Legacy Transcript

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Introduction to physician wellness and systemic barriers

We all heard the platitudes. Just focus on your sleep hygiene, get a balanced meal, go for a walk. When we talk about physician wellness, it's far too often framed as an individual resilience problem.

But the reality? We are working within a system that has historically punished the very clinicians who need support the most. Today, we're cutting through the noise and tackling systemic Today, we're cutting through the noise and tackling the systemic barriers to mental health and medicine.

I'm joined by Dr. Stephanie Simmons, Chief Medical Officer of the Dr Launer Breen Foundation. And here we are discussing her journey through trauma, the tragic legacy of Dr Laura Brien, and the massive historic shifts we were finally seeing in state licensing and credentialing across the country.

This isn't just about burnout. It's about dismantling the stigma that has kept us silent for far too long. If you're a clinician, this is the most important conversation you'll hear this year.

And it's not isolated, just physicians only. Nurses, you need to hear this too. I'm Dr. Mark Papadakis, nobody particularly special, Just another frickin' ER doctor.

And this is the Jafford Cast. Let's get on with it. All right, so I'm here with Dr. Stephanie Simmons. Thank you very much for joining me. Hello. Thanks, Mark.

I am happy to be here today. So the Dr Lorna Breen Foundation, this is something I've wanted to talk about for a little while now. And I have brought up and invoked her name, actually, in a wellness talk I give to my residents.

As an attending in 2019 and then, of course, 2020, COVID hit. Yes. Wellness was a bit of a talk that I gave since then because ER, especially, we're all pretty heavily affected.

Tell me a little bit about you, first of all. What's your background, where you come from, things like that. Yeah. I mean, it started when I was a small girl up in Northern Michigan.

We can go that far back. And I actually am going to start my story there because I'm somewhat joking, but I really loved animals and I spent a lot of time out in nature and thought I would be a vet, Mark.

Wow. Okay, it would be like the kid who would literally dissect the roadkill to see how it how It worked and my dad was a hunter so I would also section the lungs of the that he harvested and like look I'm now a vegetarian maybe related you just You must have gotten A's in anatomy, man, because that's pretty impressive.

Well, I'll tell you, it was really interesting and I loved it. And then I went to school to be a history major because it turns out that I had this other great love, which was why things happen the way they do.

And in animals, that was the anatomy and physiology, but in history is how societies change, how people change how decisions are made. And so I thought I was going to be a history professor and I went to school to do that.

There was this sort of alchemy that happened throughout the course of undergrad where I realized that these two loves that I had of knowing how things work sort visceral, literally, level in animals and people.

Dr. Simmonsu2019 background and path into emergency medicine

And then knowing how things worked on this societal and human level kind of came to a head together in medicine because we're dealing with people often in very momentous times for themselves and sometimes for society.

We're having to bring to bear knowing in order to intervene and to help that individual in that moment and tell them to go on and make the difference that they're going to make in their lives and as people.

So I did end up going into medical school. I'm a lifer at University of Michigan, so undergrad medical-school residency matched originally in anesthesiology and then switched and also did a residency in emergency medicine.

Nice. And that's where I started my career after my training. Awesome. You know, it's always interesting to hear people answer why they went into medicine, because there are people who, like you, pivoted later in their professional career and their undergraduate career, and there're people, who is like, well, I'm going to do it in medicine.

That's what I am going do no matter what. I was one of those people. It took me longer to get there than others, but I always have no offense to some of my listeners out there because I know who you are.

I always have better conversations with people who decide to pivot to medicine later after certain experiences, after a certain different exposures. And I feel like, um, if you're an undergraduate listening to this, If you are a history major or sociology major, you honestly, in some ways and a better chance to get into medical school than some other, than somebody going to just be biology, because In many ways, those humanistic, the gen eds, as we used to call them in college, help you become a better doctor.

That's my opinion. Well, I think I would always come to my patients with that sort of social science lens of the why. Like, why are you here? Not just what is your diagnosis and what's is my treatment plan, but why did you end up in the emergency department?

because there's also a different story for the patient who comes to the emergency department with their abdominal pain than the person who goes to their primary care doctor with abdominal pains.

Part of that is acuity and intensity of symptoms, but part of it is social and sociologic. I actually love emergency medicine for that. Like, I love the procedures.

I loved the team dynamic. That's what drew me to emergency medicines and to anesthesiology was the procedure and the birth to death and critical care.

But the reason I ended up in emergency medicine instead of anesthesiology was the social science aspects of emergency medicines. So I was doing my residency.

I had actually decided I would do a Robert Wood Johnson clinical scholars program and had gotten into that. Maybe my internship year. Wow. That's tough.

It's really good that I had my kids when I was like ignorant of the impact. Right. I had my first being in my internship year and then I got a second child actually as a fourth year resident.

And that was a really pivotal point for me because of two things that happened right around the time I was finishing residency. So the first thing was that I caught the worst case of my career.

It happens for everybody at some point. You have the case that's going to be the worse case in your career, For me, it just happened really early. It happened at the end of residency training when I was about to exit residency and go into this fellowship and my career.

And this case is public record, so I can talk about it. I'm not violating confidentiality. But it was the middle of the night. The ambulance comes in with a resuscitating a three-year-old.

And if you do the math, you will know that I had a three-year-old at home at that point. And we did everything we could to try to get this kiddo back and we failed.

We could not resuscitate this child, which happens, right? And it's always bad. nobody is unaffected by a pediatric death. But I wouldn't be telling you the story if that had been it.

What happened is that like about six weeks later, I got a summons to go testify in court because this child had been murdered. And so after I had cared for her, right, and couldn't get her back, I pivoted to take care of the patient that was left, which was her mother, And I comforted her and I explained what had happened.

I was also the mother of a three-year-old, so I really identified with this woman. The defendant in this murder trial was that woman, was this mother.

As you might imagine, that And we have no way of knowing these things, right? Unless they come in with police or something like that, you know, we assume things happen.

We don't really see the cause of this through the emergency department lens here. So, wow. I mean, I was filled with rage, Mark, on behalf of my patient, this child, but also for me and for all the children out there in the world and all of the parents who lost their children, and what weren't the agents of that.

And it sort of, at around the same time, I developed peripartum depression. I was pregnant with a second child. We know now that what is happening in your world outside of the pregnancy impacts your mood, and then that sort takes on a life of its own and gets accelerated.

100%. All of pregnancy hormones and everything. Throughout that year, I was moonlighting to pay for daycare for two kids, right?

Trauma, postpartum depression, and early career struggles

Like working spouse, but it's hard when you're a young couple to make ends meet with two children in day care. And residency doesn't pay much. I'm just going to throw that out there.

That's right. Like, working extra shifts while pregnant, while having postpartum depression, While having a three-year-old at home and trying to reconcile all of these things together.

and I chose wrongly at that point in my career, not to seek help. Not to get mental health care, not even to tell anyone outside of my spouse, my husband, that I was experiencing this.

Because I knew I about to finish training. I going to be applying for my first permanent license. I was going to be getting my first job and everything that I had been told as a student, as our resident was like, you don't want a mental health history on your record.

You're going be asked all kinds of places. It's going impact your ability to get insurance to, get credentialed, right? So I didn't see care. I, didn' get a diagnosis.

So when I tell you- It can even impact to your, ability get medical license depending on the state you're in. For sure. So, so that was the narrative that I had been told and that wasn't the belief that i had at the time part of our conversation.

actually, at that point in time, the decision was the wrong decision. And now, even more so, it is much safer. There has been a change, not only in the culture and medicine and how mental health care is viewed, but actually in these structure of licensing and credentialing.

I'm giving you the bottom line up front here of this discussion in case anybody leaves before they get to that. But at the time… They don't leave. They listen to the entire conversation.

That's right. You know, sometimes they're in their car, they are listening, Mark, and there's a car accident, right? Like that's the only possible reason I could think like.

So I made that decision at that point. And let me tell you that first five years of my career, were rocky, rocky rocky. I dropped out of my fellowship.

So I started it and I drop out it. And for people who don't know this fellowship, like, it's kind of a big deal, fellowship is very prestigious. It's hard to get into.

community setting for our residency, which was a great hospital, great community hospital great group, but not really the like academic hot chat trajectory that I had been on.

You're not going to become the Dean of Medicine or something like that by going Probably not. And what I would say is my opportunities were really awesome.

It turns out it's just a different path. So what did right out of residency is I worked part time. I work 10 shifts a month, which is not quite full time, didn't have any protected time outside of that.

My income was lower than it would have been, but I decided to to decide what, you know, to try what my hobbies were going to be at work, I sort of volunteered for a bunch of different parts of the hospital operations because I knew I wanted to do something, right?

That wasn't clinical work. I loved clinical, but I needed more. So while I was dealing with the sequelae of this postpartum depression and, uh, everything that was part of that.

I was also volunteering to be on the Culture of Safety Committee, ironically, since I had this safe-to-seek care. Mm-hmm. Yeah. So, I, you know, was spinning up a therapeutic hypothermia program for the hospital.

You can see how like a lot of this is kind of relating back. these interests. So I did end up digging myself out of that pit. This did not end being a long, like lifelong mood disorder, but definitely led to a rocky first five years to the extent that I even thought about leaving medicine altogether, right?

Like after 12 years of training and like Yeah. Yeah, and not for nothing, you know, people think about how can you throw all that away? How can he throw that education and training and money out the window?

I mean, he sacrificed 12 years of your life to get to this point here. And now all of a sudden it's going to start from scratch and people underestimate the psychological impact that medicine, especially this type of medicine can have on the individual.

So it's pain, right? You're not leaving medicine because you don't want to work hard or it is too hard. It's actually too painful. And so I was still coming to working every day and showing up with a smile on my face and taking great care of patients.

Of course. Yeah, somebody said the unhappiest people, the most oppressed people are the ones who have a smiling on their face. Right, and I will say like sort of doing a really great job.

Sure. Absolutely. And so, but it was very, very painful because I had not developed the skillset to manage the traumas in what I was doing other than partitioning.

I Like, trauma, take it, put it in the backpack. Next trauma. Take it. Put it into the back pack. You know, like, I could go from a bad case to the next room and just like be there for the patient, do a great job, but I wasn't dealing with any of that.

I was not processing it I, wasn t talking to anybody about it there was no a culture of doing that and so eventually that backpack gets just too heavy.

You know, and you're like a bug on your back with your hands and your feet. Yeah. Right. And so I was given an offer by our chief medical officer of our medical group, the medical that staffed that emergency department had about 900 doctors and staff about 30 hospitals across the Midwest.

Wow. So I given offer to be the director of quality and safety for the Medical Group based on the work that I And I respectfully refused and said, there's nobody doing the work of patient and clinician experience for this group.

I would like that job. And the CMO at the time said I don't think that's a job I've never I don't know that like what like, can you write a job description about what that would entail?

And so, you know, I had people point it out to me since then that, why don t you right the job decription and we'll see could have been interpreted as a blow off.

But that is not how I interpreted actually, this was a very sincere mentor, a wonderful doctor. And took him at his word and wrote a job description with a.3 FTE, like a third of a jobs, right?

That they would pay me for and I would do patient experience training and coach people who were struggling with some task around communication or burnout.

It was some of the leadership development for the group and and i was given that job. So this was just a couple years out of residency. I have a job as a director of patient clinician experience for 900 docs.

And it's very typical of physicians to experience something awful themselves and say, even before they've dealt with their own stuff, right? Even before their fully through it, say I want to take this experience and figure out how to help other people.

That's exactly what I was doing. Cause that's, well, that what we're trained to. That's what want to do. We want help other people. that why we go into this.

So of course we are going to take our own personal experiences and say, Oh, good. How can I make this better for somebody else? And then forget about the person in the mirror.

Right. so that is what I was doing. And I had a very hard one skill set over the next 10 years. I did not do coach training. It was like, I'm good at stuff.

Like I could do this, right? So, and there really wasn't like there wasn' a big group of chief well being officers. Physician coaching was not the industry that it is today.

There was patient experience stuff out there, but it was very formulaic. You sit down, you shake hands, and you tell people how long it's going to be.

That's not what I was interested in doing. I wasn't interested talking to doctors and NPAs and MPs about why they wanted to take care of people and help them be a thought partner with them about getting back to a place where that's really what they wanted to do.

And they want to put energy into that and do a great job. To me, that is how you have a good patient experience, not following some formula. Yeah. That's why I call it cookbook medicine.

Yeah, customer service, right? And like customer services is important.

Building patient and clinician experience support

If I called and make an appointment with my doctor, I want to get in to see them quickly. I wanted somebody who's polite and nice and like you want all of those parts to be smooth.

You don't have to wait for an ultrasound 36 hours in the ER, you know, because the whole process is gross. But customer service is different than patient experience, because there's like, I've had customers.

I waited tables for eight years. Oh, great, Chris. That'd be great tips. Like, i'm friendly. I could do all of the customer-service stuff. i will do things for a patient that I would never do for customer, right?

I'm going to take care of a patients with an empty stomach and a full bladder and put their needs before mine, and it's a very privileged relationship.

where they are telling me things, they're only telling that they may not have told their spouse. And I am holding that sacred in that relationship. It's a very intimate relationship, I'm touching their body in a physical relationship to help them as their physician.

That is not something I would do for a customer. Right, exactly. But that's not the relationship so it's very It has to be both. You have to have the customer service side of things, but you also need to really be connected to why you're a physician or a PA or nurse practitioner caring for our patient.

And it's rough because as emergency physicians, we only have maybe five minutes to make that connection and get a patient to trust us and tell us, okay, why are you here?

No, no, you told the nurse why we're here. Why are we really here and sometimes it manifests that they sell the triage team one thing, they tell something completely different.

We come out and say, well, here's a workup. And the nurse is like, what are you talking about? What are we doing? And he said, Well, they're actually here for this.

Well they didn't tell me that. I'm like I know. And sometimes that is the way it goes, you know, because the people who can establish that bond quickly are going to get to the root of the problem and figure out how to hopefully solve this.

But it's tricky. And it is a real skill set. So that's what I was helping people with in that role. The history of my group over the next 10 years was the history of a lot of areas of emergency medicine, which was mergers and acquisitions, right?

So that group that I was working with acquired some other groups and then, so there was just some merger and some acquisition and got bought out by a very big group and that merged with another group, and bada bing, bata bang, over the course of 10 years, now I'm doing that role as the vice president of patient and clinician experience for 26,000 docs.

It was a big national medical group. And I was trying to grow that support for clinicians in their journey as clinicians and as physicians, support them, build resources.

and do that sort of in a very diffuse model where there was a lot of ability to influence, but really not a lots of authority over their environments, right?

Because there's staffing, an emergency department, and a hospital has its own structures and its' own processes and decisions. And so it was really like a lesson in how to lead without authority, how do influence environments, How to provide support where you don't necessarily even employ the person, right?

But you're trying to build these structures. So that's what I was doing in in 2020. That was my role. Along the way in 19, I stopped seeing patients. So I saw patients for about 15 years and this role had grown and was very big and involved a lot of travel.

three kids at home, an executive level position with travel responsibilities and something had to give. It was a process of, it was an agonizing process, of self-discovery and talking to my mentors and others who had sort of

made that transition out of clinical practice.

But I decided that whatever happened, the thing that gave could not be excellent patient care. and I was seeing few enough patients, working few-enough shifts as I juggled all of these other priorities, that it felt to me like that was becoming a risk.

Like it was a becoming risk that I wasn't going to be the person you wanted to see at the foot of the bed when you came in with a trauma. anymore because I was doing it so part-time.

And so I made the hard decision to step away at that point from clinical medicine and to focus entirely on this sort of leadership of patient and clinician experience at this organization.

Now it turns out that October 2019 was a really weird time to leave emergency medicine because like three years later, it's the pandemic. Right. And at first I thought we were going, I was going to step back in to practice clinically because we weren't going have enough ER docs.

But if like, you remember back at that time, it's not that there weren t enough er docs, like the work was really hard. There was a lot of death. It was a lot of risk, but it wasn't because there weren't enough people.

We actually had decreased volumes across departments across the country. So instead of stepping back into clinical medicine, I doubled down on mental health support, working with the clinicians who were dealing with all of that death and trauma and risk and societal upheaval and really building out those supports.

And then of course, in 2020, that was when Lorna died and the foundation started. So you asked me to tell me a little bit about yourself, myself, and you just got like a double handful, but that's, that the best.

Well, here's the thing, because ultimately you're the face of this foundation. So for disclosure purposes, you came to my hospital site, talked about the foundation, talk about those services you have.

And I thought it was important enough to get you onto this show because I felt more people needed to see it. Yes, you talk about the fact that we deal with death a lot in the year 2020 because of the pandemic.

One of my friends who I graduated residency with went to work in a New York City hospital and he, our doc, he would work overnights and all he heard was the code blue alarm go off all night long, constant.

And it was at the time, March and April and May. Even to June of that year, that he knew what was happening. He knew that those patients were going to cardiac arrest and they weren't getting better.

They were, they were dying. And he would walk into work and he saw, and I saw too, refrigerated, you know, basically trucks to house. It says by the more couldn't house, the public saw it briefly and then.

Lorna Breenu2019s story and the foundationu2019s mission

Later on, forgot about it. We went from healthcare heroes to healthcare zeros. That's pretty much the sentiment among frontline acute care staff, as still is to this day, and many of the people that I work with.

And when I talk to the residents about wellness, you know, the mantra of wellness is, Get a good rest. Get good night's sleep. Drink water on ship. Make sure you get a balanced meal.

Go exercise. Tell that to a resident who's working 60 plus, 80 hours plus a week to do all that. Wellness is a lot of things, but it's not just taking care of yourself.

You talk about taking of care yourself, how do you do that? Well, I like to go on bike rides. Great. What are you going to do in the winter time? Well I, uh, don't know.

Or like, for example, you. I have many residents, co-worker and otherwise, who started a family in residency, started family medical school. And now they're juggling the career as a parent and a resident and all the responsibility that comes with it.

Where's your downtime? So there's a lot of nuance to this conversation. The biggest one we'll focus on obviously is with Dr. Lorna Breen and the fact that, you know, of all the things that happened, she committed suicide.

That's where this whole discussion really stems from. So can you tell her story? I mean, obviously, like I said, I'm going to have you to tell the story because you're going tell it better than I ever could.

Sure. Thank you. So, when you introduced me at the beginning of our conversation, as you mentioned, I'm the chief medical officer for the Dr. Lorna Breen Heroes Foundation.

LORNA, Dr Lorne Brene, was also an emergency medicine physician. She was practicing emergency medicines at New York Presbyterian Allen Hospital in Manhattan, which is what she'd always wanted to do was practice emergency medication in Manhatten, own a fast car and a black cat, and she had the check.

She came back from vacation with her sister and brother-in-law and their kids to take care of patients in the first days of the pandemic. And she was taking care patients, but she also taking of her community of clinicians because she is the medical director of their emergency department.

So the people who were running those departments back then, you know, were trying to figure out PPE for everybody, how to protect people, How to reduce risk, help cover the department when there were people whose kids were home from school who didn't have daycare.

There was no way to get them care, right? all of these issues and patient care. And so just day after day of not eight, these aren't eight hour days, right?

Like these are 18 hour, days of trying to problem solve and take care of patients who are almost all dying and being at great personal risk yourself. So, really tough situation.

Now, I will tell you, a lot of people, when you ask them about those first few weeks of the pandemic, there's some horror about the experiences and certainly trauma, but also a real sense of like, this is what I trained for.

And they were caring for people and doing what they could. And yes, there was a lot of human tragedies of people dying without their families there. A lot that was really awful.

Some of the bureaucracy and the administrative burden and like the BS around patient care went away. And so, it wasn't all awful. There was a lot that was very satisfying, right?

So, that is the milieu that Dr. Lorna Breen was in. And she got COVID, and she get real sick with it. But like many people did, 24 hours after her fever broke, she came back to that.

She went right back those day after day, but she became exhausted. So physically, mentally, emotionally exhausted, unable to get up off of her chair in her apartment.

called on her physician colleagues, her residency friends, or medical school friends and they evacuated her by car to Virginia, which is where she grew up.

And she received mental health care and she was discharged and was explaining to her family that she like I had been worried at the beginning of my career, that because she had received mental health care, she was at risk of losing her license, her hospital credentials, certainly her leadership position and her role at hospital.

And that was one of the conversations that she have with her family before she died. She did die by suicide. Twelve hours after her death, the New York Times published an article about her.

Her family had media trying to talk to them when all they wanted to do was grieve. But it's what happened next that really sparked the formation of the foundation and the work that we do now.

So what happens next is that people started to reach out to her sister and brother-in-law, her family as well. And it was dozens at first and then hundreds and ultimately thousands.

Lorna's little sister and her brother-in-law started the Dr. Lorna Breen Heroes Foundation to take them and to carry it into a movement where there is a place for conversations around professional well-being for healthcare workers.

There is way to address the barriers to mental healthcare that people seek. organizations and individuals that are passionate and interested in this topic to gather and to have a community and collaborate, and that there is a group that's advocating for healthcare workers.

And so that is the Dr. Lorna Breen Heroes Foundation and I'm so privileged to be able to work with them and for them, for this foundation. And in addition to obviously being a resource for physicians who need mental health resources, your foundation has actually scored legislative victories.

So really, quite early on, in March of 2022, there was the passage of the Dr. Lorna Breen Health Care Provider Protection Act. And if you look at the picture of signing ceremony, Lorne's sister and brother-in-law and mom and niece are there.

The Lorna Breen Act was first of its kind federal legislation funding programs around professional well-being for healthcare workers. And that included direct grants to organizations and then also the Impact Well-Being campaign, which was an action guide for healthcare leaders on how to start the work of professional well-being in hospitals and health systems.

We also had the opportunity to partner with the CDC and NIOSH on the creation of that guide to be able to sort of spread the word. So the Lorna Breen Act was reauthorized this year, 2026, for five years for those life-saving programs to continue to receive funding and provide programmatic support for organizations around the country.

Now I'm going to show what you're talking about for the signing ceremony here. Yeah. So that is March 18th, 2022. And behind President Biden, you'll see Corey and Jennifer Feist, Lorna's sister and brother-in-law.

in the blue dresses, Lorna's mom, Rosemary, and to Corey's left is Charlotte, Lorena is niece. And to her left, is Senator Tim Kaine. So he was one of the co-sponsors of this bill.

The bill was bicameral, bipartisan. It was Democrat and Republican sponsored in both the House and the Senate. And so was the reauthorization. So it was and remains deeply bipartisan, deeply human issue.

The original bill was signed into law by President Biden and the Reauthorisation was sign into the law President Trump. And we're currently going through the appropriations process right now.

Throughout the process of the original bill and the reauthorization, it has been essential for health workers to raise their voices and share that this is important to them.

And so there's been a grassroots effort as well as organizations from across healthcare really lending their push to this work. And for your listeners, if they're interested in raising their voices in the appropriations process, we do have a link which I can give you for the show notes.

Yeah. The link is going to be in the description for both. If you're listening in a car, if you go onto the podcast website, it's going be on there. It's also going on the YouTube description, so check down below.

Great. So that was, I think, one of the first sort of legislative actions and successes that came about. We also, that day, March 18th, now is Healthcare Workforce Well-being Day.

Every year we commemorate the signing of that act into law and celebrate healthcare workforce at large. act on their well-being. So we've also been working at the state level across the states to address licensing and credentialing.

Federal advocacy and licensing reform

And that's really been one of the key areas of impact for the foundation. This caught my attention because you spoke about this. Please, this is something that every health care worker should applaud here because not just physicians, you're also working with nursing as well with this?

nurses, dentists, pharmacists. And in a lot of states, we've been able to impact all licensed health workers. So I want everybody to know about this because I think if you aren't in healthcare, you may not know.

About this part of things. As licensed healthcare workers, and then for physicians and PAs and NPs as credentialed healthcare workers who care for patients in hospitals and health systems.

As people who get malpractice insurance, who have to enroll for payers, meaning insurance companies, to be able to reimburse for our work, we get asked the same set of questions multiple times throughout our career.

And in the past, these used to called the moral fitness questions. like, are you an upstanding moral human being? Okay. And, you know, depending on how you define that in your belief system, You may agree that some of these questions are indeed about moral fitness, like you have you been convicted of a felony, right?

Like, or are You a pedophile? We want to know that. Yeah, good information to have. Good information for somebody who's a health worker. Then there's the question, that says, have you ever been diagnosed or treated for a mental health condition?

And that stems back to a point in the medical understanding of mental and the societal understanding that there was a belief that this was moral failing, that if you had a medical condition, this is a moral not a health condition, not something like my peripartum depression that is the combination of your internal biochemistry and your external events, right, but something that says something about you as a person.

in a word, these were outdated. In a bunch more words, there had been a lot of people who had pointed out that they were out dated. The American Medical Association, the Federation of State Medical Boards, and the federation of state physician health programs had all said these questions are doing more harm than good.

They are actually preventing people from receiving care that helps them be excellent health workers. And everything we know is that having a mental health condition actually does not.

Having a treated mental condition does NOT prevent you from being an excellent healthcare worker. In fact, more people need to be treated for their mental conditions that they have.

And so there had already been a movement underway to educate the medical boards and to encourage them to change their questions. And the first year that we did a survey of the Medical Boards, we really said, yes, no.

Are they asking these questions about mental health and substance use disorder, about diagnosis and treatment? Yes, No. Or are they only asking a single question about impairment for any reason?

And if anybody ever wants to make a point of like, well, it's important to know about people's history so that we know if they're impaired now, I'll make this point about stigma.

Nowhere were people asking, have you ever been diagnosed or treated for any medical condition? Because there are many chronic medical conditions that are potentially impairing.

So I will give you, for example, diabetes, right? When it is diagnosed and treated, typically there is no impairment.

You may have to check your blood sugars, watch your food intake.

Maybe you would want the people around you to be aware of what high blood sugar looks like or low blood so they could help you if that happened. But we're not asking everybody what their hemoglobin A1c is.

That's a measurement of your Blood Sugar over three months, right? And we are not ask people if they've ever been diagnosed with diabetes. Substance use disorder and mental health conditions are no different.

They are chronic conditions that have the potential, if untreated or poorly treated, to become impairing. But we are asking about that. So what we're recommending with these questions is either you don't ask or you ask one question, which is, are you currently impaired for any reason?

Or we asking people to proactively attest to the fact that they're taking care of their business. Right, exactly. They're getting care, right? And so the first time we did this survey of the medical licensing boards, there were 17 boards that were consistent with best practices.

This was the reason, at the beginning of my career, why I didn't seek help, because I knew I was going to be asked that question. I am not somebody who would misrepresent on an application and say no, even if the answer was yes.

So I don't want to have to answer yes, so I just didn' get care. Cause that could come back to burn you. If somebody does some digging all of a sudden, they want to ruin you, here we are.

Right. And so like you're faced with the choice, do I not get care? Which was my choice. Because by the way, the question isn't, are you seriously concerned that you might have a serious mental health condition that is impacting your life and happiness and choice?

Like, no, it's have you ever been diagnosed or treated for a mental condition? So I'm like, oh, well I could just brute force this and suffer. Yeah. Because at that point in my life, I was really well trained to suffer.

I just got through it. But okay, so I'm going to tangent for one second because there is also this belief too that the people who need these resources are just not resilient.

You know, like we need to build like more resilient doctors, more resilience nurses. And that belief is not just outdated. Outdated is probably the best way to put it, barbaric is another.

The idea that the people who are burning out right now, we're not talking mental illness. We're talking about burnout and people are leaving the healthcare profession.

The view that, well, you know, there's a lack of resilience. Okay. And to tell people have been caring for patients or in their worst moments of their lives that well you're just not resilient enough is.

I don't even think I can think of the word, the appropriate word right now is bullshit. That's a great word. It's an appropriate. I mean, I agree, right?

I am a, I'm a very resilient person. I, am an athlete, a physician, an excellent, scholar, researcher, parent. Like I was doing all of this care, caring for an infant pregnant and doing great.

Operating really at a super high level. That was at my own expense and we don't give people, dealing with the traumatic experiences of of caring for patients, it has to be an aerobic process.

It needs like light and air and time. And what we do is we make it an anaerobic processes. We try to do it in the dark, you know, like under pressure, and that's when it explodes.

So we don't build systems that allow people to what they need to to resilient. This is really a systems issue and we

need address the systems. And so that's what we started to do with the licensing is we said, OK, like there are 17 states that are best practice for physicians.

Let's recognize them. So we made a badge, Wellbeing First Champions Challenge badge with our All in Coalition, which is made from organizations across health care.

and celebrated them. And with the badge, we made a map and we colored in the map with states that were consistent with best practices. So that became a change management strategy for education.

If your state has the Badge, communicate about the badge. Make sure people know the rules. Here's the amended changes, which by the way, we didn't make up the best practices.

We took those from the AMA, from The Federation of State Medical Boards, From The federation of state PHPs, the researchers in this area over the years who had focused on this and had asked people what were the, what would the questions that would both protect patients and also allow healthcare workers to get healthcare.

Yeah. It's not coming out of vacuum. This stuff is actually researched and quantified and everything. That's right. So this wasn't like a de novo sort of discussion.

But what we did is we used the change management techniques of measurement, recognition, celebration, education, made a toolkit on how to change, and then offered free of charge review of any licensing application, any credentialing application any malpractice application with recommendations on how to become consistent with those best practices and then we have a badge we, have certificate we'll put you on the map right like once once you've gone through that process we will do the recognition part of things.

We now have map for physicians for nurses for pharmacists for dentists in terms of their licensing and also a map of the states where you can click on your state and see all of entities, the hospitals, health systems, clinics in that state that have also done the work for credentialing and peer reference forms.

So when we started, there were 17 states for physician licensing. There are now over 43. Wow. physician board, licensing boards that have made these changes.

And we're about to update our maps in May, so I'm not sure when this is coming out, but May 2026 we'll have our newest updates.

Stigma, seeking help, and closing thoughts

We update them about three times a year, almost the same week, usually the week that we update then they're out of date because we are consistently churning on these applications and we have new sets of applications all the time.

from hospitals and states. So this is the hospital that I was applying to for my first job and the state where I getting licensed for first my job. I would now not be asked about my mental health history in either of those settings.

When I said at the top of our conversation that this landscape is changed, it is changing too and it has changed. So the person in my position today does not have to be worried about getting asked those questions for their license or their hospital credentialing.

I think the way I want to end this show is obviously on that good note, but also a call for people to seek help. Cause it's one thing if you can say, Hey, you are now no longer going to be afraid of losing your job, of loosing your career.

I'm not going into this career if have a mental health issue, substance abuse, whatever depression, Whatever it is, You can now do this job. The key now is.

Can you and can we change the culture of acknowledging this is not a resilience problem, that this something that can be treated, what you are feeling if you work in healthcare is normal and I need you to seek help now.

You can seek health, there are pathways to do this now and to add your voice now into this mix too. I got to tell you, I was talking to Mel Herbert, who I know you know who Dr.

Herbert is, but just like one of our superstar educators and leaders in emergency medicine. And I having this conversation with him and he said, you what else would solve this problem for people if everyone checked the box?

Yes, because we were all getting the help we needed. I love it. That is brilliant. In the way that only he could have been brilliant and put that, he's absolutely right.

So I want to share one other finding that I think will put some of this into perspective too. Please. We partnered with the Heart of Safety Coalition, a nonprofit that looks at sort of all things safety.

in healthcare. And we surveyed groups of physicians, nurses, PAs, and NPs about perceived barriers to mental healthcare, And one question that we asked them was, are you worried that you'll be judged?

Do you believe that, you will be judge negatively if you receive mental health care? Like 70% of people said yes. I'm worried I would be judges negatively, if I received mental care.

And then we asked, if you had a colleague that received mental health care, would you judge them negatively for that? Only 10% of physicians would. And by the way, it's only 5% percent of nurses, gays, and NPs.

So there's this mismatch between what we think is out there and how we believe. Here's my takeaway. For people who are in that 10%, you're the problem.

Do some work on yourself. You actually need to understand that your colleagues, that people in healthcare, deserve the right to receive healthcare. And that includes mental healthcare and it is not an indicator that they are not a good physician, just like having diabetes would not be an indicated that there are no good physicians.

So for those people who may hold that belief, I think it's worth examining that believe critically. And if you are in the group that is positive towards your colleagues that would receive mental health care, they're worried about you.

They don't know what you believe. they are assuming the worst because we are little c conservative beings who have a lot invested in being able to do our jobs.

You need to declare yourself. And that could be declaring yourself by telling your story, by wearing a pin, and by letting people know just as plainly as you can.

I think that all healthcare workers should have access to mental health care. And if somebody I knew received mental healthcare, I would think it was a really great decision they made.

So it's like anything you need to declare your allyship. If you hold the view that's holding people back and hurting people, you have to examine that.

In those data, the stigma around mental health care is much more in the perception of the stigmas than the actual beliefs. And so I think there's a lot of hope, too, for where we're headed as a profession and as society in years to come.

I agree. I think there's a lot of change happening right now for the positive. And we talk about COVID-19, but COVID 19 was a huge inflection point in healthcare for a number of reasons.

We are starting to recognize it now. To that 10%, to your point, I'll put even more bluntly, which is I'm pretty sure you have problems too. that I'm pretty sure that 10%, if you've used somebody like that negatively, it's probably

because you have a problem in your own personal life that you don't want to actually seek out and evaluate and have treated as well.

So it is projection. Okay. But I am not as political as Stephanie is here, so take that for what it. Well, and really, I mean, what we want is for everybody to be healthy, right?

And so, if your beliefs are causing a problem for someone else, chances are they're causing the problem to you too. And maybe even for your family, so we wanna, we people to healthy.

We want people live an examined life and a healthy life. Ideally, this is never a situation where we have to oppositional with each other, but to say, hey, how do we all get to a spot where people can be healthy and happy and heal others as well?

Exactly. Dr. Stephanie Simmons, thank you so much for coming on to talk about this. It was a pleasure. And for you listening, again, there are going to be resources and links in the description below.

Check them out. And if you find that your state is not on her beautiful map, contact your representatives, your State nursing, pharmacists, boards everywhere and make them aware of this.

A lot of times it's an awareness issue. It's not a true, we don't want to do this type of issue So education and empowerment is going to go a long way for something like this.

And if you feel that you need to seek help, don't hesitate. If you don' want to reach out to one of these links and these resources that we have here, talk to somebody about it.

I think you'll be surprised at the response that get from a colleague or a friend. if You admit, hey, I'm depressed, i have a substance abuse issue. i think that case went really wrong and i feel terrible about.

There's a range here. Okay. Don't ignore those feelings, talk about them and please seek help if you do think that you really truly need help because your patients, yes, they're counting on you, but so are your family and friends too.

Dr. Simmons, thank you again. Yeah. Thanks, Mark. It's been a great conversation. Thanks again to Dr. Stephanie Simmons for joining me. If you liked what you heard, please support this show by subscribing and giving a positive review wherever you manage to find us, either on Apple, YouTube, or Spotify.

We're moving from a culture out of silence and into support, but it requires each and every one of us to raise our voices. Please take a look at the resources linked in the description below.

Educate yourself, check your state's licensing policies, and if you or a colleague need help, reach out to them. The system is changing because we are demanding it to change.

Thanks for listening, we'll see you next time.