Preventing Clinician Suicide: A Call to Action During the COVID-19 Pandemic and Beyond

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Abstract

In this commentary, the authors offer a call to action in the long-standing fight to prevent clinicians from dying by suicide. In April 2020, the nation was shocked by the suicide of New York City emergency physician Dr. Lorna Breen, who died while recovering from COVID-19. She joins an unknown number of clinicians who have taken their lives over the past year. The authors introduce Dr. Breen, a highly talented physician working on the frontlines of the COVID-19 pandemic, and examine how pervasive distress and suicide are in clinicians. Then, they explain the lived experience movement and highlight how clinicians speaking openly about their mental illness and treatment are making it easier for their colleagues to seek lifesaving help, despite the stigma still surrounding mental illness and treatment in medicine.

The authors sort through the science of clinician distress; critique how the COVID-19 pandemic is affecting the lives of clinicians; and describe existing national initiatives to address clinician stress, burnout, and suicide. Finally, they recommend evidence-based actions to prevent clinician suicide that multiple stakeholder groups can take, including regulatory agencies, licensing boards, and hospital privileging boards; specialty boards, professional associations, and continuing education organizations; medical educators; and individual clinicians. Suicide is a complex but generally preventable cause of death. Those in medicine must forge ahead with collective momentum. Dr. Breen, so many other clinicians, and those they have left behind deserve nothing less.

Dr. Lorna Breen graduated from medical school on a steamy day in May 1999 in Richmond, Virginia. Her father, a trauma surgeon, and her brother, a radiologist, had the honor of hooding Lorna that day. Her family sat proudly in the audience as they fumbled to properly place the hood so the green color denoting medicine could be seen clearly, while Lorna rolled her eyes in embarrassment. Lorna's parents taught their children that education was the key to success. In their family, it was an unspoken understanding that medicine was a gift. It was a high honor to those who were able to give and, to those who received, it was the most noble of professions.

Lorna practiced medicine for 21 years, first as a resident in a dual internal medicine–emergency medicine program, then as a faculty physician in the Department of Emergency Medicine at Columbia University. Like her name, she was unique. Tall and thin with dark hair and dark eyes, she cherished adventure, action, and taking care of people. She loved the 24/7 lifestyle of Manhattan and embraced it fully. Always with friends, always on the way to dinner, to the airport, to yoga, to work. Always on the move. But in the best possible way. She was in the prime of her life and her career.

How is it possible then that she died by suicide on April 26, 2020? As is often the case, there are many factors to consider. Lorna was working at the epicenter of the COVID-19 pandemic as an emergency medicine physician at NewYork-Presbyterian Hospital in Manhattan. She contracted COVID-19, falling ill after only a handful of days treating patients during the pandemic. Then, she returned to work after 10 days at home. Soon thereafter, her family began to question whether the coronavirus had affected her brain, as her behavior and speech were dramatically different after her apparent recovery. In the days and weeks following her death, her family tried to make sense of what could have brought her to this final act.

Almost as shocking as her suicide itself was her family’s realization that the risk of suicide among physicians is higher than that among the general population.1 That burnout is a well-known and almost accepted occupational hazard in medicine.2 Worse yet, the stigma of seeking help is pervasive1 and reinforced by regulations in many states mandating disclosure of mental health treatment.4 Lorna's family learned of this culture of silence from the hundreds of clinicians who reached out to share their stories. Lorna’s death made her family wonder if they were the only ones who were unaware how dangerous it is to be a physician.

In response, her family began the Dr. Lorna Breen Heroes’ Foundation, and they have partnered with organizations across health care, raising awareness of burnout, depression, and suicide in clinicians and championing change. The current centerpiece of their work is federal legislation sponsored by Senator Tim Kaine of Virginia entitled the Dr. Lorna Breen Health Care Provider Protection Act,5 aimed at supporting the well-being of clinicians and reducing burnout and suicide.

Postvention: What Else Can Be Learned?

Despite research on stressors, psychiatric illness, psychological vulnerabilities, and
personality variables that drive suicide risk in physicians, the literature contains little from those close to physicians who die by suicide. Postvention refers to communal activities in the aftermath of a suicide that are meant to reduce the risk of suicide in a decedent’s loved ones and to promote their healing. What follows are our findings from a narrative research project, a postvention of sorts, for which we interviewed the family members, colleagues, friends, patients, and therapists of physicians who died by suicide (unpublished).

We found that the arc of impact after a physician suicide extends beyond their family to their peers, classmates, deans, and designated institutional officials. The psychological reactions of these individuals to the suicide included shock, anxiety, sorrow, guilt and blame, and fears that suicide contagion may occur, all known reactions among suicide loss survivors. A smaller cohort of those we interviewed reacted with coolness or cynicism, employing the not uncommon character armor of physicians under duress. For decedents in training, institutional responses to suicide were increasingly informed and aided by readily available postvention toolkits. For decedents who had completed their training, the community response ranged from negligible to robust; our interviewees decried how stigma impeded symptomatic physicians from receiving lifesaving treatment. What is salutary and gratifying is that survivors of physician suicide loss have become allies in prevention, presenting at conferences, conducting research, and advocating for change.

The Lived Experience Movement

A recent study of medical students’ exposure to physicians speaking out about their experience with mental illness illustrated that those students exposed to such discussions were more likely to access care themselves should they become symptomatic. This form of role modeling, taking a humanistic and professional responsibility for oneself and others, is a facet of the lived experience movement. One physician who attempted suicide when he was a resident described the movement in this way:

Following my spinal cord injury, I encountered frequent relapses of depression … old familiar faces reminded me what I could have been. It was painful because all seemed lost, my dreams destroyed. I used to cry almost every day wishing I were not alive. But it is amazing that today I have transformed from that earlier state…. I feel strangely lucky to be alive. I no longer am consumed by self-hatred or the feeling that I am defective. It is a remarkable transformation, one that should give hope to others who are suffering.

My hope is that through the telling of my story, it will encourage others battling depression to realize that relief and success [are] possible for them as [they were] for me despite the direst of circumstances and the most recalcitrant of depressions. The core belief that you are defective is one of the hardest to overcome, but it is possible and there is hope through intensive work with a clinical psychologist and optimization of anti-depressant therapy by an experienced psychiatrist.

Other physicians are also speaking out and calling for change. For example, medical students are questioning why they cannot talk about their human experiences including vulnerabilities:

We need open-forum discussions about depression and suicide that include personal testimonials from students and physicians. We need to share our experiences—in person, in writing, and … over social media. Collectively, we must accept our human vulnerability and thereby foster connection….. Openness is our liberation. Let us speak.

In addition, trainees are publishing their personal narratives of mental illness, and physicians throughout their careers are sharing their stories of burnout, substance use disorders, and other mental illnesses. These personal disclosures are having a ripple effect in the medical community, providing a hopeful arc to mental health experiences, shattering stigma, modeling help seeking, and contributing to a new culture where mental health can be viewed and addressed openly and without shame.

The Scourge of Stigma in 2021

Despite these advances, stigma continues to impede progress and healing. Many suicides remain shrouded in secrecy and mystery, and it is too early to know whether clinician suicide rates have changed since the beginning of the COVID-19 pandemic.

Over the last year, one of us (M.F.M.) has learned of 3 physicians who died by suicide in New York. Upon notification of the first death by 2 residents, he contacted the graduate medical education office of the deceased resident’s institution to offer services. His call was not returned. Reddit chronicled the shock and heartbreak of this resident’s peers. M.F.M. learned of the second suicide, classified as an “accident,” from a psychiatrist colleague requesting guidance about offering support to colleagues of the deceased when the actual cause of death had been only selectively shared. Regarding the third suicide, M.F.M. was contacted by a resident of an attending physician who had taken his life a few days earlier. He set up a Zoom support session with the resident and her peers that was held 3 days later. Fearing any misunderstanding of intent, he sent an email to the training director of the program. It was not acknowledged or returned.

Many have argued for transparency regarding medical student suicide. Concern about institutional reputation has been a barrier: What might knowledge of a suicide do to a school’s recruitment, reputation, and ranking? Three years ago, one of us (M.F.M.) was invited to give a grand rounds on physician suicide after a physician at the institution took his life, only to be disinvited because of the “optics” when the title of the talk, “Stress, Depression, and Suicide in Physicians: Strategies for Prevention and Psychological Growth” was “leaked” to the general public.

Risk Factors for Clinician Suicide

The 3 of us who are physicians (C.Y.M., M.F.M., S.Z.) each went into medicine as a calling. Our mothers could not have been prouder when we applied to and were accepted at top medical schools. And so were we. Physician burnout, depression, and suicide were not part of our formal curriculum, nor were they subjects of hallway discussions. Yet soon after starting medical school, we learned firsthand that these were unspoken occupational hazards. It is disheartening that many physicians regret their career choice and no longer recommend a career in medicine to their children. Most concerning is that each of us has known trainees and colleagues who have tragically ended their lives.
List 1
Recommended Evidence-Based Actions to Prevent Clinician Suicide

Regulatory agencies, licensing boards, and hospital privileging boards
- Follow the recommendations of the Federation of State Medical Boards, American Medical Association, American Psychiatric Association, American College of Emergency Physicians, and others to refrain from asking questions about clinicians' mental health. This practice of asking intrusive questions about diagnoses and treatment history has been shown to be an ineffective way to detect impairment and protect public safety; it is also at odds with the Americans with Disabilities Act in many instances. Moreover, it has driven clinicians to hide their treatable mental health issues and prevented scores of providers from accessing effective treatment that can protect both patient safety and their own health and careers. This change may be the "lynch pin" to dismantling a toxic infrastructure that has perpetuated fear of getting help for too long.
- Launch communication strategies so clinicians in each organization’s jurisdiction are aware of the protections afforded to them should they seek therapy, psychiatric treatment, and addiction recovery. Policies and procedures related to matters of health must be transparent and effectively communicated.
- Develop initiatives that help clinicians safely address their own suicide risk factors and health concerns (e.g., the American Foundation for Suicide Prevention’s Interactive Screening Program, which many academic institutions, health systems, and state associations have already implemented).
- Pass the Dr. Lorna Breen Health Care Provider Protection Act early in 2021, as it encompasses many of these recommendations.

Specialty boards, professional associations, and continuing education organizations
- Within each discipline, identify and address specific barriers to seeking treatment. Workgroups with members at all levels of seniority and from all settings can optimally accomplish this goal.
- Incorporate questions related to self-care into board certification and continuing education to emphasize that, alongside medical knowledge, technical skills, and empathy for others, the ability to optimize one’s own mental health, including availing oneself of mental health care, is an essential component of professional responsibility.

Medical educators
- Ensure policies at the undergraduate and graduate medical education levels provide trainees with the greatest access to mentors, support, and mental health care without punitive consequences (e.g., build in debriefs following critical incidents, encourage therapy to optimize resilience, allow for access to treatment within and outside the institution when feasible).
- Be transparent. Communicate clearly about how trainees’ mental health challenges are handled by the institution.
- Prioritize and promote a growth mindset (e.g., “Every clinician struggles at times. It’s a sign of strength to address challenges. It’s commendable not to wait until the point of crisis to get help.”).
- Continuously provide information about how trainees can access support, guidance, and mental health treatment. List resources on the back of I.D. cards, on program websites, etc.
- Introduce self-care early in the curriculum as a practice linked to professionalism that can be cultivated throughout one’s career.
- Model mental health self-care by disclosing personal struggles when appropriate and explaining that everyone needs to lean on others for support or treatment.
- Provide opportunities for storytelling to set new norms with hopeful narratives for addressing struggles.
- Enhance peer support by teaching trainees how to reach out and respond to distressed peers, cultivate active listening skills, and use available resources for support.

Individual clinicians
- Cultivate daily self-care habits by being curious about “how you tick” (i.e., take note of and practice the activities that lead to positive outcomes).
- Realize that mental health is a dynamic part of human health, which means individuals can have some influence over their own mental health outcomes (e.g., staying on effective treatment for a recurrent pattern of depression or anxiety to positively affect mental health).
- Look out for colleagues. Realize that subtle changes in behavior can be the “tip of the iceberg” indicating more significant struggles.
- Do not assume that accomplished peers have it together and never struggle (i.e., check in on strong friends).
- Learn how to have caring conversations, colleague to colleague, that invite deeper disclosure.
- When dialoguing with a distressed colleague, remember that with distress comes negative cognitive distortions, so it is critically important to state the obvious—that you respect them, think well of them for getting help, are willing to help them connect with treatment, and will continue to be there for them. If you have struggled previously, you may have special empathy that you can marshal to help them understand they are not alone.

Clinician distress is recognized as a serious threat to health systems and to the optimal delivery of health care. Alarmingly high rates of burnout and depressive symptoms have been well documented across clinicians’ training and careers, including among students, residents, physicians, and nurses. Consequences of burnout and depression include not only personal misery but also compassion fatigue, medical errors, patient care devoid of optimal empathy, absenteeism, and early retirement, leading to high and costly turnover. Depression presents potent risk for suicide, and although burnout is not a specific risk factor, one distinguishing feature of suicide among physicians and nurses compared with other groups is the predominance of work-related issues. Indeed, the leading cause of death among male residents and the second leading cause among female residents is suicide. The risk of suicide likely only increases throughout a physician’s career, especially for female physicians. Additionally, both male and female nurses have higher rates of suicide than age-matched males and females in the general population.
A logical question from this rapid transformation of medicine as a calling to medicine as a source of overwhelming distress and despair for so many is, “Why?” What could possibly cause this dramatic shift? A number of internal and external factors contribute to the problem. Long hours, heavy workloads, onerous health care system changes, lack of autonomy, and increased time spent on computers instead of with patients are obvious setups for burnout and cynicism. Added to these workplace factors are a stoic culture of self-sufficiency and real and/or perceived barriers to help seeking, which allow deterioration in well-being to go unaddressed and potentially spiral into more severe, entrenched mental health problems. 5,23–25 One well-established effective method to prevent suicide is the treatment of depression, yet the majority of physicians and nurses with depression do not seek professional care. 27

Adding to the already daunting list of workplace stressors is the unprecedented level of emotional stress caused by the COVID-19 pandemic. Hailed as the “perfect storm for suicide,” COVID-19 has generated a host of concerning problems for the general population: elevated levels of anxiety, depression, and substance use; uncertainty; social isolation; unemployment and economic contraction; and a surge in firearms sales. 28–31 The mental health toll is particularly intense for frontline clinicians who have the additional burdens of working with infected patients in the absence of adequate personal protective equipment, fear of exposing themselves and family members to the coronavirus, the trauma of working in a high-stress environment, overwhelmed facilities, mounting illness and the deaths of patients and colleagues, and additional barriers to seeking mental health care. 31 A 2020 Medscape survey of more than 5,000 physician respondents in the United States found that 23% had treated COVID-19 patients without appropriate personal protective equipment; 5% had contracted COVID-19; 64% had experienced increased burnout symptoms; 31% had “coped” with COVID-19 stress by decreasing exercise, 29% by eating, and 19% by increasing alcohol intake; 44% felt their relationships at home were more stressful; and 46% were lonelier. 32

**A Way Forward**

Since suicide is a complex health outcome with many drivers of risk, preventing suicide requires a strategic, multipronged, longitudinal, evidence-based plan. Reducing the risk of clinician suicide requires changes in regulatory policies, changes in curricula and role modeling in medical education, increased access to mental health care, and transformation of an entrenched culture. In List 1, we recommend those actions that have the most evidence for suicide risk reduction, organized by role and type of organization within health care.

Despite numerous organizations making suicide prevention a priority, change has been slow. Perhaps now medicine is finally reaching a tipping point. Several national initiatives to address the issues of physician and nurse well-being, burnout, and suicide had emerged even before the pandemic. 3 What these programs have in common is attention to evidence-based practices, safe and accessible avenues for physicians and nurses to address mental health concerns, confidential and timely follow-up, and stigma reduction.

During the COVID-19 pandemic, the realization that the mental health of clinicians must be protected has been front and center. The tragic loss of Dr. Lorna Breen further energized this movement to better support clinicians’ well-being. Medical educators, professional associations, insurers, state medical boards, suicide loss survivors, and clinicians with lived experience have all come to the table. It is time to reject the myths and stigma that so many discriminatory policies are based on and to allow mental health challenges to be addressed as the health issues they truly are. We urge all in medicine to follow the science, which shines a light on suicide as a complex but generally preventable cause of death and on mental health as a legitimate and impactful part of human health. We urge all to take action to transform this science into practice to prevent clinician suicide.

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