Ruth Adewuya, MD (host):

Hello, you are listening to Stanford Medcast, Stanford CME's podcast where we bring you insights from the world's leading physicians and scientists. If you're new here, consider subscribing to listen to more free episodes coming your way. I am your host, Dr. Ruth Adewuya. This episode is part of our Physician Distress mini series, and today's podcast guest is Dr. Ariel Brown. Dr. Brown is board president and founder of the Emotional PPE Project, a platform that connects healthcare workers in need with licensed mental health professionals who can help at no cost. Dr. Brown is a neuroscientist who has conducted research in the brain in ADHD and bipolar disorder and helped develop the first drug approved for postpartum depression. She started the Emotional PPE project merely by asking a friend, how can I help? And by tapping into the goodwill of her personal and professional network. Thank you, Dr. Brown, for chatting with me today.

Ariel Brown, PhD (guest speaker):

Thanks so much for having me, Ruth.

Ruth Adewuya, MD (host):

Tell us a little bit more about the Emotional PPE project and how it came together.

Ariel Brown, PhD (guest speaker):

It is a non-profit organization that my physician friend Dan and I started in March of 2020. So the whole project came together very organically and it was sparked by a conversation that the two of us had. We were talking about ways for Dan to help support the wellness of the residents in his program. Dan is a program director in anesthesiology at Mass General Hospital, and what I was trying to do was to provide for these trainees what I knew had worked for me in times of overwhelming stress, which is access to professional mental health care. So obviously March of 2020 first wave of COVID on the East Coast, giant stressors being introduced, particularly for these young physicians who were just coming into the workforce.

So what I did is I put out a call to the therapists in my network to see if any of them would be willing to provide some pro bono care for the residents in Dan's programs. And what happened was we got this massive response from a community of therapists, and really what we realized is that this is a community that really wanted to give back and used their skill sets to help support the folks that were on the front lines of the pandemic. So what I did was I gave the contact information for the therapist that responded to Dan to give to his residents to see if his residents would want to pick up the phone and say, "Hey, I could use a little extra emotional support."

And what happened was that within a couple of weeks, the therapists were getting lots of calls. We started to get contacted by other hospitals that were interested in our list of volunteer therapists. More therapists were hearing about it through the grapevine, more therapists wanted to sign up, and then we started to get media attention. And that sort of really kicked off this snowball effect where before we knew it, we said, all right, let's answer this call and address this need that is obviously very big right now. And so we put together a team, we registered as 501(c)(3) and quickly we went nationwide.

So that's an origin story. The board, myself, the founders, we are all staunchly committed to keeping as much anonymity as possible for anyone who uses the directory. So what that means is that no one at the project, except for the volunteer therapist that's contacted, knows that a physician is using the service. So if a physician goes on to emotionalppe.org and contacts the therapist from the list, it's done directly by text, by phone and by emails. But I think as we all know at this point, there are so many

systemic barriers that need to be addressed in order for physicians to feel comfortable seeking treatment for their emotional distress. And so in addition to this micro approach of connecting individuals with help, we are also taking a macro approach to lifting barriers. And so really that looks like advocating for systemic change and awareness raising to these barriers. And that's what brings me here today.

Ruth Adewuya, MD (host):

I was reflecting on your story and how this project started. And first of all, I just want to say thank you to you and to your colleague, Dan, for seeing a need taking action on the need. And I can just imagine the countless clinicians that have been supported because of an idea, and it's a call to action for all of us that we can all do something on this issue and it can start small and you never know the impact that it can have. And so just want to say that. Thank you.

Ariel Brown, PhD (guest speaker):

Thanks so much for saying that.

Ruth Adewuya, MD (host):

The other thing that I was reflecting on as you were talking was you mentioned something that teed up my next question, which is the barriers for clinician to seek help. So it sounds like this is a directory, it's available, but just recognizing that not all clinicians, not all physicians would seek help. And especially when we think about burned out physicians who are unlikely to seek professional help navigating this alone. In your experience with the Emotional PPE Project, what prevents physicians from seeking professional treatment?

Ariel Brown, PhD (guest speaker):

Yeah, that's such a great question. March 2020, when we started the project, I just had no idea what was happening. And these barriers that existed in the culture prior to COVID have nothing to do with COVID. They started before they went through COVID and then now they still exist. And I think that the mental health of physicians and healthcare workers more generally has been spotlighted during COVID and oh my gosh, these new stressors, these new traumas so important and the suicide rates in the community, the rates of diagnosable mental health conditions are really being featured. But the barriers are really the reasons why these inflated rates of suicide and mental health conditions exist. And the way we usually talk about barriers at Emotional PPE, what we define as a barrier is what stops a clinician from getting the help that they need?

We typically break those barriers down into four categories. And the first one is the concern that receiving mental health care could have an impact on their career. So sometimes this is just a perception, it's a fear, but very much in reality there are very real actual consequences to career that can happen when a physician seeks mental health care. So most of the reporting to date on this topic relates to questions about mental health on state board licensing applications. What these medical board licensing application questions represent, however, is really just the tip of the iceberg.

So what we know is that questions on these applications, and it could be state board licensing, it could be credentialing, it could be malpractice insurance applications that these questions that exist propagate stigma. And also the responses that indicate a mental health history may mean that physicians have to provide the committees with a whole host of private health information. So again, it's

a barrier because physicians know that these questions are coming and so they think, I can't do this. I can't seek the help I need because I'm going to be asked about it.

Now, the second barrier is time, cost, access to care. A physician may work 50 to 70 hours in a week. And in addition to this, contributing to exhaustion and contributing to burnout, the lack of time itself is a barrier to help seeking any of us who are looking at popular media at all. We know that access to mental health services across the board is really challenging right now, not just for physicians. During the pandemic, the demand for mental health services has increased dramatically, but the supply is still the same. And this challenge is compounded for physicians because of these concerns for confidentiality, and it leads many physicians to prefer providers outside their home institution. And that decreases access to care. It increases the time associated with finding a provider. And it can also increase cost because many physicians may connect with providers who are not in network. So logistical is a third group of barriers. So this is the resistance that physicians seem to have to being in the patient role.

So in medicine we know that poor self care is normalized and this is even more pronounced for emotional health. And I think particularly because good emotional self care is almost never role modeled by leaders in medicine. That's something that we're trying to change and that we think is a really important part of battling stigma. But in medicine, help is only encouraged and people are really depleted and close to fully burning out. I just read the other day this study that really struck me was this survey study where 10% of physician respondents said that they self prescribed antidepressants. So if they're treating themselves, it's just built into this culture that being a patient is not preferred.

So just to go full circle, the fourth bucket is really the umbrella bucket, which is the stigma that mental healthcare receives in the context of medical culture. And I do believe that the stigma's really at the root of all the other barriers. To me, I think the umbrella idea that defines this stigma is that having and admitting that one needs emotional support is equal to being impaired as a doctor. And we know this is not true. And in fact there's so much research out there that gives strong support to the association between getting professional emotional support for a physician and increased patient safety. So your patients are safer if you are treating your emotional health. Again, together, these are the four buckets and what we typically understand to lead physicians to hesitate to get professional support.

Ruth Adewuya, MD (host):

I appreciate that framework. You broke it down into this large bucket and repeating the four buckets. There's the foundation of the stigma which impacts all of these things, whether perception about their impact on career, the physician culture, what people are overworked and don't have time, don't have access, and just the fact that a lot of people that go into the career of being clinician are usually performance driven. And so there's this perception of you're not performing if you are seeking help. You briefly talked about data and what data is available, and you talked about the 10% of physicians that are self prescribing. I want to continue to talk about data and just talking about the fact that it's my understanding that there's no specialty specific data that exists around physicians who experience suicidal ideation or have attempted suicide. And so I'm just curious, as you look at the Emotional PPE Project and you look maybe aggregately at your data, have you identified any trends when providing mental health healthcare to clinicians that can potentially inform preventative initiatives?

Ariel Brown, PhD (guest speaker):

Yeah, there's quite a big lack in the data in terms of telling this story. And if you look back at the literature, the effective initiatives for increasing mental health in physicians, there are so many holes. And I do think that now because there's more of a spotlight because of the pandemic, that means there's more money put into the research. And I think we're starting to fill in some of these holes. In

terms of what we've learned from Emotional PPE, in service of confidentiality, first of all, we don't collect any data on specialty, so we don't have any answers to that special question. But the other thing too, in terms of trends that we're seeing is that because the content of the sessions between the physician and the therapist are completely confidential, we as an organization don't actually have any information on the nature of the presenting issue. So in other words, we don't actually know if a physician is suicidal or not when they contact one of our therapists. And in terms of trends, really what we're understanding is just from the research that's out there.

Ruth Adewuya, MD (host):

I appreciate the fact that there's this dedication that the Emotional PPE Project has to confidentiality and protecting that because clearly you have identified that fear as a barrier for seeking help. I want to switch gears and talk about how colleagues can be part of the solution. When physicians experience emotional triggers in their careers due to clinical pressures, litigation errors, what we see is that they may begin isolating themselves because they perceive that their colleagues are coping better. What are some of the warning signs that we can identify when a colleague becomes withdrawn and when do you think it's appropriate to intervene?

Ariel Brown, PhD (guest speaker):

I am not a clinician. I am not somebody that sees patients. I am a scientist that works in psychiatry and I know a little bit from being in the medical field and also in the mental health field, but I hesitate to give any specific advice. But what I will do is I'm going to repeat what my co-founder Dr. Dan Saddawi says. And he always says, "Looking for signs is like waiting until a patient is floridly septic." So instead of waiting for stressors and issues to make themselves known, take the approach of assuming distress when there are stressors. We want to normalize discussing it and we want to systematize checking in.

So if we think about what the risk of waiting until a colleague is showing signs of distress, that sometimes can be a fatal risk. If we say, I think she's okay, I'm just going to let her do her thing, but she's withdrawing, the outcome of that can be disastrous. And then if you think about what checking into early, what the risk of that is, it's really such a low risk. But I also want to mention that there are really great toolkits out there for physicians who are peers, who are leaders, program directors that can help guide conversations and help guide looking for these warning signs. And specifically, I recommend just this week AMA published a toolkit on preparation for NPSA for the National Physician Suicide Awareness Day. So AMA, if you check out their website, also the Learn and Brain Foundation has a great toolkit that can be used to help guide these conversations for helping support physicians who are having these triggering events.

Ruth Adewuya, MD (host):

Well said. And an important point was made there. I spoke to Corey Feist just recently and Chrissy Motea as well. And they have also echoed the fact that there are resources there, and we will be linking some of those resources in the podcast notes as well. One of the things that has happened is that we have this new 988 mental health hotline. It's now live. And for those who don't know, this newly established phone number connects people who are suicidal or in any other mental health crisis to a trained mental health professional. Do you anticipate that the Emotional Health PPE Project would integrate in any way with this hotline, or do you even foresee any local or on the ground support networks emerging for physicians who are experiencing suicidal ideation?

Ariel Brown, PhD (guest speaker):

Yeah, I'm so glad you brought up 988 and I want to talk about it in every conversation. Like in the supermarket line, I'm like, "Do you know about 988?" Anyways, I can't tell you how thrilled I am that it is out there and I feel like we have needed it forever. So many lives are going to be improved by the existence of 988. So many lives will be saved because of it. But in terms of Emotional PPE, I do see these two programs as complimentary. So we don't have plans to integrate. 988 is really for an acute mental health crisis where there are respondents available 24 hours a day. The Emotional PPE Project seems as a directory of therapists that can be contacted to arrange an appointment. It's not designed as an acute crisis response service. It's really about therapists that are there. They are available and they want to help. But for somebody who is feeling acutely suicidal, you need to be reaching out to somebody that can respond immediately. And 988 is there for you and use it, that's what I say.

Ruth Adewuya, MD (host):

I want to also talk about the fact that this crisis, although we're talking about it in the context of physicians and clinicians, it's clearly an issue just across any profession, which means that there is a role for non-clinician, for the general public, to play in being a part of the solution. How can the general public help spread awareness or be a part of the solution around this mental health crisis?

Ariel Brown, PhD (guest speaker):

One of the main things that I've learned from starting this project is that we all have something to give. As I said, I'm not a physician, I'm not a therapist, I just am an entrepreneur and really interested in trying to provide innovative solutions to mental health problems. And so I happen to be in the right place at the right time asking Dan the right questions. One thing that the general public can do is to obtain curiosity about how we can all use our skill sets to help out. And that may be just asking a friend, "Are you okay? How can I help?" Or it could be starting a non-profit, you never know. But as I mentioned before, don't wait to offer support. Giving space is important of course, in all of our interactions, but the risk of giving too much space is so much more of a risk than giving not enough space. So don't wait to check in to see how your peers are doing, ask them how you can help introduce them to resources so we can all be of help.

Ruth Adewuya, MD (host):

I agree. Thank you for sharing those practical tips for all of us to get involved. A personal anecdote, I recall going into my general practitioner's office at the height of the pandemic and it took a while to get in, but I needed to get in. And I just recall sitting there and I just asked her the question, I said, "How are you?" And she says, "Oh, it's busy." And I'm like, "No, no, no, no. How are you doing? It must be crazy." And it spiraled into this five, 10 minute conversation just about the things that she's doing, the things that she's enjoying, the things that she has started to do to manage the stress of working in a hospital in the height of the pandemic.

And I don't know if she even recalls that conversation, she probably moved on, but it felt that our conversation was a little lighter afterwards. It wasn't just another routine appointment for her. She was able to pause and take a breath because she was probably back to back appointments that time. And I would just say that as patients taking a moment to just turn the tables a little bit and surprise them and just say, "Hey, how are you actually doing?"

Ariel Brown, PhD (guest speaker):

Kudos to you for doing that. And I think when it comes down to skill sets, I know some people are really good at baking, so maybe you just want to bake something for your local healthcare worker. It sounds cheesy, but it's like we all have something that we can give back.

Ruth Adewuya, MD (host):

Yeah, I agree. As we wrap up our conversation, I want to circle back to where we started with Emotional PPE Project and you can just give us a little bit more information about what you're doing, what's in store for the future of the project.

Ariel Brown, PhD (guest speaker):

Yeah, absolutely. We do currently have over 700 therapists volunteering enlisted in our directory. They hail from all over the country that are cumulatively licensed to provide care in all 50 states. So any healthcare worker that's out there in the US, we are available to serve. So the way it works is that if you're in need, you just go to emotionalppe.org, you choose the state you live in, and a list of volunteer therapists that are licensed to practice in your state will pop up. So you can browse that list, which includes all the bios of the therapists and contact any one of them. So I just looked this morning at California, there are a dozen, so 12 volunteer therapists available right now, and any of which for listeners if you live in California can contact. But to date across the country, we've had about 2,200 healthcare workers get connected to free therapy through the project, and they're from all over the country. So specifically 48 states and DC. So we're working on those two final states.

So where we are going next, I think one, we do want to maintain and grow that directory so that any healthcare worker anywhere in the country can connect with no cost, no insurance, confidential emotional support when they need it, and we're going to continue to make that bandaid exist while we work on the other side of the project, which as I've mentioned is lifting the institutionalized barriers. And what that looks like is raising awareness to the problem, battling stigmas through storytelling, publishing research, and trying to change policy at the institutional and state level. Through all of that, we are continuing to exist to try and build this awareness, build the organization. We are by design, not associated with any institution that employs healthcare workers, that trains healthcare workers.

Ruth Adewuya, MD (host):

A small but mighty nonprofit. Last question for you is if we have therapists that are listening that want to volunteer, do they go to the same website as well and can get connected?

Ariel Brown, PhD (guest speaker):

They do. So you'll see there's basically three buttons. One is if you're therapist and you want to volunteer, push this button. If you are a healthcare worker in need, push the other button. Emotionalppe.org is the place.

Ruth Adewuya, MD (host):

Thank you so much for chatting with me. I've learned a lot. And thank you for the work that you do and the work that your organization has done and continues to do to elevate this issue and to create some solutions for our healthcare workers.

Ariel Brown, PhD (guest speaker):

Thank you so much for having me.

Ruth Adewuya, MD (host):

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