Barriers to Help-Seeking for Health Care Workers

The 14 questions you submitted are grouped into seven themes, with a short answer for each. Two scope flags up front: workplace violence is not my area of expertise, and duty-hour and schedule design is a systems problem I will name but do not claim to solve.

One other note. The barriers below cut across physicians, nurses, advanced practice clinicians, techs, other healthcare workers, and the therapists who care for us.

Theme 1: Mapping the barriers

- *What barriers (personal, professional, organizational) most prevent healthcare workers from seeking support?*

The barriers sort into three layers. The first is a culture that has normalized inadequate self-care, plus the perfectionism and the tendency to overestimate our own ability to self-manage that the culture rewards. The second is the fear of consequences: stigma, and real or perceived risk in licensing, credentialing, and career advancement. The final layer is logistical: lack of time (the single most cited barrier), difficulty accessing care (which is compounded by a profound desire for confidentiality, and cost.

These cut across every role. The culture is shared; what differs by profession is the consequence machinery, since physicians, nurses, and other clinicians answer to different boards and different monitoring pathways.

Theme 2: The self-reliance culture and how to unwind it

- *How do you "normalize" asking for help when our identity is to care for others?*
- *Why isn't asking for support part of training in medical school?*
- *How do you overcome a lifetime of "needing to do it yourself"?*

The honest starting point is that this is a taught cultural legacy, not a personal failing. Training has long rewarded stoicism through a kind of shadow contract, where you work through illness to protect colleagues and patients, and that ethos was taught implicitly far more than it was ever written down. Unwinding a career's worth of conditioning is hard work, and it takes time.

What actually moves it is changing the defaults and the examples. Role modeling is the single most powerful lever: respected people talking openly about their own care does more to loosen the reflex than any amount of being told it is okay.

The reframe I would push hardest is this. Self-care is a professional skill. It is not just *compatible* with clinical excellence, it is reinforcing of it and necessary to optimize it. The clinician who tends to their own well-being sustains sharper judgment, steadier presence, and a longer career.

Theme 3: Confidentiality and the licensure/monitoring fear

- *How do you address confidentiality, when "it's a small community and word always gets out"?*
- *(Therapist) How can providers work with patients' real anxiety about licensure and monitoring program involvement?*

While there is much work to be done, I want to lead with how much progress there has been, because the fear is often anchored to rules that no longer apply. A national reform effort has led most state medical boards to remove intrusive mental health questions from licensing applications and shift to current-impairment standards. The communication about that change has badly lagged the change itself, so one practical step is to look up your own state's actual application language rather than assume the worst (https://drlornabreen.org/removebarriers/). It is also worth separating two things people conflate: a licensing-application question is not the same as monitoring-program involvement, which is generally tied to impairment or substance-use pathways, not routine outpatient therapy for depression or anxiety.

The instinct to protect privacy is rational, and I am not against confidentiality. But it is culturally self-reinforcing: every time we route around the system quietly, we communicate to one another that it is not safe. So I will add, because modeling matters, that I see a mental health professional myself. So do many of us, far more than we likely realize. Quelling the fear probably depends less on argument than on enough of us saying that out loud so that it stops being the exception.

Theme 4: Building the conditions for help inside a stressful system

- *How do you create space/time for in-person colleague connection that actually helps?*
- *How do you create safe spaces and a culture of help-seeking in a system that adds stress?*

- *How do you sustain your health across a career as you are spread thinner and workplace violence rises?*

Connection works best when the schedule itself leaves room for it, rather than asking people to carve out time that isn't there. The formats that hold up are concrete and recurring, like Schwartz Rounds and structured peer support. The Betsy Lehman Center's Virtual Peer Support Network and this collaborative are good examples. And measuring psychological safety, rather than assuming it, helps keep it on the radar and resourced.

Sustaining your own health over a long career works the same way: it depends on the schedule leaving real room for recovery and time with colleagues, not just whatever is left after everything else. And some of what wears people down is not personal at all. Being spread thinner is a staffing problem, and the worst response is to treat it as a personal failure to cope. The better one is to name it for what it is and put it in front of the people who can actually change it.

Workplace violence is a real and growing problem, but it is not one of my areas of expertise, so I will not pretend to have good answers. The little I would say is that it is a safety and systems problem, not something individuals should have to just put up with, and it needs to be handled at the institutional level. For anything specific, I would defer to the people who work on it directly.

Theme 5: Adverse events, cumulative toll, and peer support as the on-ramp

- *How do you manage the cumulative effect of poor outcomes over a long career?*
- *How can peer support bridge the gulf between daily practice and more formal help?*

My best advice is to not carry outcomes alone, and do not assume time heals all of them. Adverse events are one of the clearest indications for peer support, which exists precisely for this. Major medical errors are associated with a roughly threefold increase in suicidal ideation. Massachusetts has a strong program in the Betsy Lehman Center's Virtual Peer Support Network, which pairs you with a trained colleague soon after an event, before isolation sets in. Two distinctions matter over a career: grief after a bad outcome is normal and often improves with processing and connection, while other conditions like depression and PTSD are different, do not reliably resolve on their own, and deserve connection with professional caregivers.

Peer support is uniquely valuable because it is a smaller step than formal care. It is a trained colleague, not a clinician on record, who normalizes the struggle and meets you in the context of the work. That is its power as an on-ramp: it lowers the threshold to the first conversation and routes people onward when they need more. Good programs train their peers to recognize that moment and make a warm hand-off rather than leave someone to navigate it alone. It should connect to formal care, not substitute for it.

Theme 6: Going upstream: students and trainees

- *How do we build agency early in careers, even at the student level, more upstream?*
- *Why are physician trainees taught to become inured to self-harm, in schedules that prevent healthy sleep?*

Build agency upstream the way you build any durable behavior, by changing the default rather than adding a lecture. The highest-leverage move is opt-out: make a check-in with a mental health professional a scheduled part of being a student or trainee, the way USC's Keck Checks does, so the first contact is routine instead of an act of courage. Pair that with early, repeated normalization from respected faculty, and with teaching help-seeking as a clinical skill we expect of any competent professional. Students who experience care as ordinary carry that expectation forward, which is the whole point of working upstream.

On the second question, it deserves a straight answer. The cultural piece is real: a hidden curriculum has long rewarded pushing through illness and exhaustion. But I do not think self-neglect is necessarily what anyone set out to teach, and as we push for well-being, we need to be mindful of competing priorities. Training has to balance real competing demands like patient care and education. Patients get sick at night and someone has to be there, and a lot of really important learning happens in those same hard hours. That's not to say that we don't optimize where we can, just that as we optimize we have to balance and be mindful of what we're balancing. A clear goal should be to cut the harm that serves no alternative purpose and protect the work that does. I do not think we should pretend healthcare is an easy career, or that any schedule can make it one. What we can do is remove the needless harm and make help easier to reach.

Theme 7: Real, local resources

- *Can you provide a list of real, accessible, local resources?*

Yes. Local options first, then ones available anywhere:

1. **Betsy Lehman Center Virtual Peer Support Network (617-701-8101 or request support here).** Free for all healthcare workers in Massachusetts.
2. **Massachusetts Medical Society Physician Health Services.** Confidential support for physicians and medical students in Massachusetts.
3. **Unified Recovery and Monitoring Program (URAMP)** - Confidential, voluntary recovery and monitoring program for all 22 boards and professions overseen by the MA Bureau of Health Professions Licensure.

4. **Massachusetts Nurses Association Peer Assistance** - Free, confidential network of nurses who are in recovery helping other nurses whose life, health and/or profession are impacted by alcohol and/or other drugs

5. **988 Suicide and Crisis Lifeline.** For anyone in crisis, anytime.

6. **Physician Support Line (1-888-409-0141).** Free and confidential, staffed by volunteer psychiatrists for physicians and trainees, 8 a.m. to 1 a.m. ET, seven days a week.

7. **The Emotional PPE Project.** Free, confidential therapy from volunteer clinicians. Not for crisis care. (Disclosure: I co-founded it.)

8. **Dr. Lorna Breen Heroes' Foundation.** Information on licensing and credentialing.

9. **Employee Assistance Program (EAP).** Most hospitals and employers offer one, with a few free, confidential counseling sessions.

10. **Your own primary care doctor.** A reasonable starting point for screening, a referral, or treatment.