HOD ACTION: Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-16)
Access to Confidential Health Services for Medical Students and Physicians
(Resolution 901-I-15, Resolution 913-I-15, Resolution 304-A-16)
(Reference Committee C)

EXECUTIVE SUMMARY

This report is in response to AMA Policy D-405.983, "Medical Students and Residents as Patients," and to Resolution 901-I-15, "Access to Mental Health Care for Medical Trainees"; Resolution 913-I-15, "Mental Health Services for Medical Staff"; and Resolution 304-A-16, "Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance."

To ensure a holistic approach to this issue, the scope of this report has been expanded beyond access to mental health care services to encompass confidential access to all health services. That said, it should be emphasized that the provision of mental health services, and the confidentiality of this care, is a critical need throughout medical education training and practice and presents some challenges in the inherently imbalanced relationship(s) between and among teachers and learners.

This report provides an overview of the issue and its challenges vis-à-vis the culture of medicine writ large and then examines potential solutions by a number of key stakeholders, including: 1) accrediting agencies, 2) medical institutions, including medical schools, residency/fellowship programs, employers, hospitals, and 3) professional associations, particularly the AMA.

Issues cited include 1) The mental and physical toll that medical education exacts on medical students and physicians, as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the needed skills to practice medicine; 2) The "hidden curriculum" of medical education, which can expose students/learners to an unhealthy emotional environment and contribute to burnout; 3) The long-standing and deeply ingrained stigma against physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications; 4) Issues with confidentiality of care, particularly in training or practice settings in more isolated, rural areas or small towns, as a significant barrier to seeking needed services; and 5) Acculturation during medical education and training to ignore one's own personal health needs rather than expose colleagues and team members to an even more onerous work load.

Through the work of two of its strategic focus areas, 1) Accelerating Change in Medical Education and 2) Professional Satisfaction and Practice Sustainability, the AMA can play a key role, alongside other stakeholders, in addressing these systemic issues in medical education and practice and ensuring a healthier health care environment, to the ultimate benefit not only of medical students and physicians but patients as well.

The report's recommendations include revisions to existing AMA policy on medical student and physician health, to streamline and consolidate this policy into a more cohesive, coherent body. These recommendations do not reflect new policy directives for the AMA.

HOD ACTION: Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-16

Subject: Access to Confidential Health Services for Medical Students and Physicians (Resolution 901-I-15, Resolution 913-I-15, Resolution 304-A-16)

Presented by: Patricia L. Turner, MD, Chair

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

INTRODUCTION

This report of the Council on Medical Education is in response to the following American Medical Association (AMA) Policy and to the three resolutions noted below, which were referred by the House of Delegates:

- Policy D-405.983, "Medical Students and Residents as Patients," which directs the American Medical Association (AMA) to study ways to address the power dichotomy between physicians and medical students, residents and fellows as it relates to these trainees' care as patients.

- Resolution 901-I-15, "Access to Mental Health Care for Medical Trainees" (introduced by the Indiana Delegation), which asks that the AMA: 1) Support the provision of on-campus mental health care in medical schools and residency programs that goes beyond supportive counseling; and 2) Encourage ongoing and future initiatives by medical schools and residency programs to provide urgent and emergent access for all medical trainees to psychiatrists that could include an in-house board-certified psychiatrist.

- Resolution 913-I-15, "Mental Health Services for Medical Staff" (introduced by the Resident and Fellow Section), which asks that the AMA encourage health systems, hospitals, and medical schools to offer physicians and medical students access to confidential and comprehensive mental health services not affiliated with their place of employment.

- Resolution 304-A-16, "Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance" (introduced by the Resident and Fellow Section), which asks that the AMA study ways to improve access and reduce barriers to seeking preventive and routine physical and mental health care for trainees in graduate medical education programs.

For Resolutions 901-I-15 and 913-I-15, testimony before Reference Committee K at the 2015 Interim Meeting emphasized the importance of making confidential and comprehensive mental health services available to medical students and resident/fellow physicians. It was noted that Liaison Committee on Medical Education (LCME) accreditation standards require medical schools to provide medical services at sites in reasonable proximity to the locations of their required

educational experiences, and that the LCME collects data on access to psychiatric services and student satisfaction with mental health services. It was also noted that this item is consistent with the work being done by the Accreditation Council for Graduate Medical Education (ACGME) to support trainee well-being, through such efforts as the ACGME Clinical Learning Environment Review process. There was concern expressed during testimony about providing students and residents access to in-house psychiatrists for urgent and emergent care. It was noted that a psychiatrist located in reasonable proximity to training sites would be the most appropriate caregiver so that students and residents would not be obligated to receive care from a physician who is involved in their academic assessment and advancement. Other factors related to Occupational Safety and Health Administration (OSHA) standards and occupational health care regulations also need to be considered, as well as the health of physicians beyond training years.

For Resolution 304-A-16, significant testimony was provided to Reference Committee C at the 2016 Annual Meeting, reflecting the importance of this timely issue, as the epidemic of physician burnout and suicide continues unabated. Testimony noted the work of the AMA in exploring and disseminating solutions, through its Professional Satisfaction and Practice Sustainability strategic focus area, for example, and educational sessions on the topic during the 2016 Annual Meeting. It was also noted that the Accreditation Council for Graduate Medical Education, through its Physician Well-Being initiative (as described further below), is actively addressing the issues of physician burnout, wellness and resiliency. Additional testimony noted issues of confidentiality in accessing needed care, especially in smaller cities and towns; the reluctance among trainees to seek care due to fear of burdening their residency colleagues with having to cover for their absence; and the need to change the culture of medicine to enhance physician well-being and work-life balance.

BACKGROUND

To ensure a holistic approach to this issue (and in light of the need to respond to Resolution 304-A-16), the scope of this report has been expanded beyond access to mental health care services to encompass confidential access to all health services. That said, it is important to emphasize that the provision of mental health services, and the confidentiality of this care, is a critical need throughout medical education training and practice and presents some challenges in the inherently imbalanced relationship(s) between and among teachers and learners. Although Policy D-405.983 calls for studying this imbalance, the real priority (and the objective for this report) is how to address this imbalance so that medical students and resident/fellow physicians can receive appropriate care without fear of stigma or repercussions.

This report provides an overview of the issue and its challenges vis-à-vis the culture of medicine writ large and then examines potential solutions by a number of key stakeholders, including: 1) accrediting agencies; 2) medical institutions, including medical schools, residency/fellowship programs, employers, hospitals; and 3) professional associations, particularly the AMA.

THE NEED FOR MEDICAL STUDENT AND PHYSICIAN ACCESS TO CARE

Interest in physician health and wellness has increased significantly over the last few years, as stressors in medical education and practice exact a mental and physical toll on medical students and physicians. Those at the early stages of their careers—medical students and resident/fellow physicians—are undergoing the challenges of balancing their personal lives with the need to master a growing body of knowledge and develop the needed skills to practice in a changing health care environment. What is often called the “hidden curriculum” of medical education can expose students/learners to an unhealthy emotional environment and can contribute to burnout. Residency training, in particular, can be a daunting endeavor for many, despite the implementation of duty

hour limits. For some, the personal and professional stresses become too great, leading to emotional distress, burnout, major depression, and, in extreme cases, suicide. Indeed, a study in the Dec. 8, 2015 issue of *JAMA* found that nearly one-third of interns and residents experience depressive symptoms or full-blown depression at some point during their training. The prevalence of depression among trainees is significantly higher among medical residents than the general population (about 7 percent of all U.S. adults had at least one major depressive episode during the previous year, according to the National Institute of Mental Health).

Similarly, more than half of U.S. physicians "experienced at least one symptom of burnout in 2014, compared to about 46 percent of doctors in 2011," notes coverage of a *Mayo Clinic Proceedings* study released on Dec. 1, 2015. These data point to the need for interventions for all physicians and physicians-in-training to learn techniques for ensuring wellness, managing burnout when symptoms arise, and improving emotional resiliency to professional and personal challenges.

Without serious attention to physician wellness, physicians may retire earlier or leave medicine for another field, further exacerbating medical workforce shortages and reducing access to needed care among patients. Even for those who remain in practice, burnout can have substantial professional and patient safety implications. An extensive body of research has demonstrated a strong link between physicians' personal well-being and the quality of care they provide patients, as well as a positive relation between physicians' and patients' preventive health practices.[1] Finally, as role models and mentors to those who will serve as the nation's future physicians, academic physicians must develop a better understanding of the importance of and need for wellness so that they can help their mentees succeed.

From a systemic perspective, the stigma against physicians seeking care for either physical or mental health issues is long-standing and deeply ingrained. Generalizations about generational differences come into play as well, with a commonly held stereotype in medicine that today's "kids" (the Millennials, for example) are not as committed to medicine and their patients as their predecessors and lack the requisite work ethic to be physicians. Long hours and commitment to patients are praised, and attention to self-care or healthy lifestyles/prevention may be seen as self-indulgent or indicative of a lack of dedication. Little or no confidentiality, particularly in training or practice settings in more isolated, rural areas or small towns, can be a barrier to seeking needed services. During training, many resident/fellow physicians are acculturated to ignore their own personal health needs (sleep, for example) and are loath to miss a shift and expose colleagues and team members to an even more onerous work load. Many physicians develop a "survival" mentality during medical school and training, which extends throughout their careers, with unfortunate consequences for personal health and well-being as well as work-life balance and interpersonal and family relationships.

Physicians who continue to work when sick and who routinely ignore their own health needs to provide care to their patients may be unintentionally endangering those very patients—e.g., by exposing them to contagions or infection if they come to work while sick, or to unintentional injury if they are not well-rested. As noted in the AMA *Code of Medical Ethics* 9.3.1, "Physician Health & Wellness" (included in the appendix of this report), "When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress." The policy also notes that physicians should take "appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease."

These attitudes and behaviors may be gradually shifting—particularly as more physicians enter into employment versus solo practice—but the enduring power of the "medical-institutional complex" and the attitudes of attending physicians and faculty (upon whose approval/satisfaction one's career rests) may ensure the perpetuation of an ultimately unhealthy hidden curriculum and culture. For example, one medical student, who decided to be outspoken about her own personal mental health struggles, wrote, "Dealing with academic administration is an awful part of med school. It's a medieval-like process of judgment and punishment to ask for help or find yourself struggling with all the exams."[2]

In addition, a significant number of mental health professionals do not accept insurance. A recent news report notes, "[N]early half of therapists in California don't take insurance, according to a recent survey from the California Association of Marriage and Family Therapists. The same is true of psychiatrists."[3] This widespread lack of insurance coverage presents another barrier to medical students and resident/fellow physicians seeking mental care services and counseling.

The extent of these pernicious issues and challenges throughout medical education and practice call for a variety of individual, institutional, and systemic (cultural) solutions. When learners/ employees access medical/behavioral services from teachers/employers, the potential exists for troublesome conflicts of interest, confidentiality concerns, and related issues. As noted in the following sections, key stakeholders in this process include: 1) accrediting agencies; 2) medical institutions, including medical schools, residency/fellowship programs, employers, hospitals; and 3) the AMA and other professional associations and related bodies.

THE WORK OF ACCREDITING AGENCIES

Liaison Committee on Medical Education (LCME)

Relevant LCME standards (now called "Elements") are included below (note that the LCME defines personal counseling to include psychiatric and psychological services):

> 12.5 Non-Involvement of Providers of Student Health Services in Student Assessment/ Location of Student Health Records
> The health professionals who provide health services, including psychiatric/psychological counseling, to a medical student have no involvement in the academic assessment or promotion of the medical student receiving those services. A medical school ensures that medical student health records are maintained in accordance with legal requirements for security, privacy, confidentiality, and accessibility.
>
> 12.4 Student Access to Health Care Services
> A medical school provides its medical students with timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required educational experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care.
>
> 12.3 Personal Counseling/Well-Being Programs
> A medical school has in place an effective system of personal counseling for its medical students that includes programs to promote their well-being and to facilitate their adjustment to the physical and emotional demands of medical education.

Commission on Osteopathic College Accreditation (COCA)

Relevant standards from the COCA are as follows:

> 5.5.7 The COM [College of Medicine] and/or its parent institution must make available to students confidential resources for physical healthcare services.
>
> 5.5.8 The COM and/or its parent must make available to students on a 24 hour per day 7 days a week ("24/7") basis, confidential resources for behavioral healthcare services.[4]

Accreditation Council for Graduate Medical Education (ACGME)

Through its Physician Well-Being initiative, the ACGME is engaging in a national dialogue on this issue to ensure positive, transformational change in the learning environment. Beginning with a symposium in November 2015, medical education organizations representing accreditation, assessment, and certification, along with the AMA, have joined the ACGME in prioritizing this issue. As noted on the initiative's website, the following areas of focus have been identified:

- Physician well-being is an individual and a system issue, and needs to be addressed on both levels.
- Alignment between institutional leadership and faculty members in the learning environment is necessary to create a culture of respect and accountability for physician well-being.
- The well-being of physicians as caregivers is crucial to their ability to deliver the safest, best possible care to patients.

Although the ACGME does not have specific accreditation standards on resident wellness and confidential access to health care services, certain standards are relevant to this topic. For example, its Institutional Requirements[5] state:

> Behavioral Health: The Sponsoring Institution must provide residents/fellows with access to confidential counseling and behavioral health services.
>
> Physician Impairment: The Sponsoring Institution must have a policy, not necessarily GME-specific, which addresses physician impairment.
>
> The Sponsoring Institution must ensure a healthy and safe learning and working environment that provides for:
>
> - access to food while on duty at all participating sites;
> - safe, quiet, and private sleep/rest facilities available and accessible for residents/fellows to support education and safe patient care; and
> - security and safety measures appropriate to the participating site.

Meanwhile, the ACGME Common Program Requirements,[6] in the section "Resident Duty Hours in the Learning and Working Environment," state:

> Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

> The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.

In addition, these requirements state that residents and faculty members "must demonstrate an understanding and acceptance of their personal role in the following," including "recognition of impairment, including illness and fatigue, in themselves and in their peers."

The ACGME is in the process of updating the Common Program Requirements. Revision of section VI of these requirements was in process at the time this report was written. These new Common Program Requirements are likely to include a section on resident well-being. The ACGME supports the fact that well-being is critical to the development of physicians and that self-care is an important component of a physician's professional life.

Finally, one of the six focus areas that is part of the ACGME's Clinical Learning Environment Review (CLER) program has been renamed to reflect a broader emphasis on physician well-being. The ACGME Board of Directors approved the recommendation of the Executive Committee for the CLER Evaluation Committee, such that the CLER focus area currently called "Duty Hours/Fatigue Mitigation and Management" has been renamed "Well-Being," effective July 1, 2017. This focus area will concentrate primarily on the Clinical Learning Environment's systems-based approaches to creating and maintaining an environment of well-being. It is anticipated that the new focus area will include a number of pathways and properties that address fatigue, burnout, work-life balance, and support of residents and faculty at risk or demonstrating self-harm. The other five CLER focus areas are patient safety, health care quality, care transitions, supervision, and professionalism.

The Joint Commission

Joint Commission standard MS.11.01.01 requires that medical staffs create a non-disciplinary process by which licensed independent practitioners' health issues can be identified and managed. When the standard was first created, many hospitals implemented wellness committees with the primary focus of detecting and reprimanding physicians struggling with addiction, stress, or other issues that could negatively impact patient safety. More recently, however, an increased focus on physician burnout by the medical community at large has led many of these groups to shift their thinking and proactively offer tools and resources meant to alleviate stress and promote resiliency.

THE WORK OF MEDICAL INSTITUTIONS

Academic medical centers and regional health systems, medical schools, residency/fellowship programs, teaching hospitals, and physician groups all have a role to play in addressing medical student and physician health. Each type of organization can take action on this topic in different ways.

For example, as described by the authors of a 2012 study in *Academic Medicine*,[7] one teaching hospital's graduate medical education division has sought to address obstacles to resident/fellow well-being by implementing a policy "that requires programs to assign residents four half-days off per academic year for health care and wellness (physical and mental well-being)." The study, which detailed gaps in personal health care practices of resident/fellow physicians, noted that this population may be less likely than demographically similar non-physician peers to have a primary care physician or seek routine health or dental care. Some of the concerns identified in the study include a perception of lack of time to see a physician, lack of access to an appropriate physician, and concerns about confidentiality and stigmatization (particularly as it relates to seeking mental

health services). In addition, with the introduction of the 16-hour work day requirements for first-year resident physicians, many residency programs have gone to week- or month-long night float rotations. The residents on night float, therefore, have additional time for personal well-being visits. Residents on a more traditional day-work schedule, who in the past had part of their post-call days free, now no longer take call. As a result, their post-call flexibility may be limited except when they are assigned to the night float service.

For medical students and physicians seeking care, particularly those in more remote communities, telemedicine may offer one way to supersede some of these issues—particularly the confidentiality, access, and time/scheduling concerns that an on-site, face-to-face visit might present. As reflected in Council on Medical Education Report 6-A-16, "Telemedicine in Medical Education," this modality offers multiple benefits and is growing in popularity. Indeed, a recent news article describes how telemedicine kiosks are becoming more common, with an increasing number of employers offering insurance coverage for telemedicine services and installing telemedicine kiosks at work sites so employees can receive on-the-job medical advice.[8]

Another possible solution for institutions to consider, as described in a recent article in *Academic Medicine*,[9] is to apply the principles of the patient-centered medical home to improving care for resident/fellow physicians. The authors suggest several interventions to improve access to care, including "confidential care without perceived conflicts of interest in the training environment, co-location of medical and mental health care, and accommodations for schedule constraints." These types of resources and support may be particularly useful for first-year resident physicians, who are not as familiar as their senior colleagues with seeking and obtaining health care services in the specific hospital/health system in which they are training.

Finally, as noted earlier in this report, a significant number of psychiatrists and other mental health professionals do not accept insurance, which presents another barrier to medical students and resident/fellow physicians obtaining needed care and counseling services. In Manhattan, for example, and other large cities, mental health/counseling services are prohibitively expensive for residents and fellows—$350 to $450 a session is common. To address this issue, New York-Presbyterian, a sponsoring institution for 135 residency/fellowship programs, has developed Housestaff Mental Health Services.[10] Through this program, resident/fellow physicians can access up to eight free, confidential sessions from a pool of attending psychiatrists who have been identified as having a particular interest in and aptitude for working with housestaff. The institution pays for the services; insurance is not billed. A director (who is a psychiatrist) triages the residents, manages the program, and maintains a firewall of confidentiality between the trainees and anyone in the graduate medical education enterprise. Program directors and institutional leadership (to include the designated institutional official, for example) do not know who accesses these services; the human resources department processes the billing. As for usage, currently about 10% of housestaff access these services each year. The program is offered on each of New York-Presbyterian's two GME campuses. Aside from helping individual residents access needed care, the program is also available as a resource for crisis management and promoting well-being among trainees.

THE WORK OF THE AMA

The AMA has a number of policies on this topic, as noted in the Appendix to this report:

1. H-95.955, "Physician Impairment"
2. H-225.961, "Medical Staff Development Plans"

3. H-225.966, "Medical Staff Role in the Development of Substance Abuse Policies and Procedures"
4. H-235.977, "Medical Staff Committees to Assist Impaired or Distressed Physicians"
5. H-295.872, "Expansion of Student Health Services"
6. H-295.955, "Teacher-Learner Relationship in Medical Education"
7. H-295.999, "Medical Student Support Groups"
8. H-310.907, "AMA Duty Hours Policy"
9. H-310.912, "Residents and Fellows' Bill of Rights"
10. H-310.979, "Resident Physician Working Hours and Supervision"
11. H-345.973, "Mental Health Services for Medical Students and Resident and Fellow Physicians"
12. H-345.981, "Access to Mental Health Services"
13. H-405.961, "Physician Health Programs"
14. D-405.990, Educating Physicians about Physician Health Programs"
15. D-405.992, "Physician Health and Wellness"
16. D-405.996, "Physician Well-Being and Renewal"
17. H-440.905, "Confidentiality, Counseling and Treatment in the Tuberculosis Screening of Health Care Workers"
18. E-9.0305, "Physician Health and Wellness"
19. E-8.191, "Peers as Patients"

Included in the recommendations of this report are several items to consolidate existing AMA policy on this topic. For example, a portion of AMA Policy H-345.973, "Mental Health Services for Medical Students and Resident and Fellow Physicians," is proposed for recission, as it is already reflected in LCME element 12.4, Student Access to Health Care Services (part of LCME standard 12, Medical Student Health Services, Personal Counseling, and Financial Aid Services), which reads: "A medical school provides its medical students with timely access to needed diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the locations of their required educational experiences and has policies and procedures in place that permit students to be excused from these experiences to seek needed care."

Aside from policy, the AMA has several ongoing projects/initiatives that address many aspects of medical student and physician health. One example is the biennial International Conference on Physician Health, a collaborative effort of the AMA, Canadian Medical Association, and British Medical Association. The theme for the 2016 conference was "Increasing Joy in Medicine," with a focus on research about and perspectives into physicians' health.

Similarly, the work of AMA member sections, including the Resident and Fellow Section, Young Physicians Section, Organized Medical Staff Section, and others often touches on issues of wellness, burnout, and physician health.

The AMA Academic Physicians Section (APS), for example, featured wellness/burnout throughout the medical education and practice continuum as its educational focus during the 2016 Annual Meeting. In his talk, Tait Shanafelt, MD, director of the Mayo Clinic Department of Medicine Program on Physician Well-being at the Mayo School of Medicine in Rochester, Minn., reviewed the literature on physician satisfaction and burnout and discussed the personal and professional repercussions of physician distress. He also reviewed the individual and organizational approaches to promoting physician well-being. Next, an interactive, hands-on session provided the opportunity for medical education leaders to learn how creative expression—designing and constructing a mask and drawing a comic—can mitigate the impacts of an unhealthy emotional environment, which can

lead to burnout. A third session on burnout was co-sponsored by the APS and the AMA Senior Physicians Section, featuring Richard Gunderman, MD, a professor at Indiana University.

AMA Medical Student Section

Another AMA section that is addressing wellness/burnout is the AMA Medical Student Section. The AMA-MSS works to represent the interests of medical students, improve medical education, develop leadership, and promote activism for the health of America. Related to improving accessibility to confidential health care services, the MSS can work to publicize, disseminate, and advocate for all efforts undertaken by the AMA on this topic. As reflected in MSS policy on this topic, some concrete recommendations for action at the medical school level include:

1. Creating a mental health awareness and suicide prevention screening program that would be available to all medical students on an opt-out basis; ensure anonymity, confidentiality, and protection from administration; provide proactive intervention for identified at-risk students by mental health professionals; and educate students and faculty about personal mental health and factors that may contribute to suicidal ideation.

2. Increasing or enhancing existing collaborations between university mental health specialists and local health centers to provide a larger pool of mental health resources.

3. Basing actions to improve access to confidential health services for medical students (e.g., on-campus programs, local campaigns) on the concepts of accessibility and de-stigmatization.

Accelerating Change in Medical Education

The AMA's Accelerating Change in Medical Education consortium comprises 32 medical schools working together to create the medical school of the future and transform physician training. An estimated 19,000 medical students—18% of all U.S. allopathic and osteopathic medical students—study at medical schools that are consortium members. The projects of several member schools of the consortium are focused on medical student wellness, including Eastern Virginia Medical School and Mayo Medical School. Further, the consortium has a newly formed student wellness interest group to share ideas across schools as to best practices to ensure wellness and counter burnout. Finally, several submissions to the 2015 AMA Medical Education Innovation Challenge focused on medical student wellness, including the third place winner, submitted by a team from the University of Louisville School of Medicine.

Professional Satisfaction and Practice Sustainability, Steps Forward modules

As one of the AMA's three key strategic focus areas, the Professional Satisfaction and Practice Sustainability initiative is addressing issues that practicing physicians face, including concerns with electronic health records and the rising wave of documentation requirements from insurers and regulators, by providing useful and user-friendly tools and apps to help ease the burdens of the administrative side of medicine. Indeed, for many physicians, dealing with regulatory, certification, licensure, insurer, and other rules and dictates represent a challenging and unfulfilling aspect of medicine. It is not surprising, then, that data from the AMA's Steps Forward website show that the Preventing Physician Burnout module is among the most popular modules that have been accessed via the site.

AMA Council on Ethical and Judicial Affairs (CEJA)

The AMA Council on Ethical and Judicial Affairs (CEJA) works to maintain and update the *Code of Medical Ethics*, through its policy development function, and to promote adherence to the professional ethical standards set out in the *Code*, through its judicial function. Related to the topic of this report, CEJA may wish to review its guidance so that AMA ethics policy addresses conflicts of interest involving confidential health services for medical students and resident/fellow physicians, in addition to that of physicians.

THE WORK OF PROFESSIONAL ASSOCIATIONS AND OTHER ENTITIES

Other entities involved in this issue include the Association of American Medical Colleges and American Osteopathic Association. In addition, through its role in identifying major issues in education and focusing national attention on these issues, the U.S. Department of Education should be a major stakeholder in any kind of education reform (e.g., de-stigmatization of mental health services). The Department's role might include allocating funds to research on this topic, releasing data on what successful de-stigmatization efforts would entail (and encouraging states to implement those efforts), and, more generally, informing the public on the importance of access to mental health services in post-secondary education.

Federation of State Medical Boards (FSMB) and State Medical Boards

Physician burnout is a key topic of interest for the Federation of State Medical Boards (FSMB). Currently, an FSMB workgroup, appointed by FSMB chair Art Hengerer, MD is studying burnout on behalf of the nation's state medical and osteopathic boards. In addition, the FSMB participated in a planning meeting in July at the National Academy of Medicine—at the invitation of its president, Victor Dzau, MD—to explore the issue of physician burnout and the role of the National Academies of Sciences, Engineering and Medicine in advancing a solution. The meeting was co-hosted by Darrell Kirch, MD, CEO of the Association of American Medical Colleges, and Tom Nasca, MD, CEO of the Accreditation Council for Graduate Medical Education.

Meanwhile, the state medical licensing boards can work to de-stigmatize treatment for mental illness. In this regard, the FSMB and the state boards should consider a reevaluation of the scope of boards' access to applicants' health records during the medical licensure application process, including the need for applicants to disclose treatment received by a mental health professional. This disclosure may have a chilling effect on medical students who would like to seek treatment for their mental illness; students may fear being perceived as professionally impaired and/or discriminated against by medical boards.

One example, from the Illinois Application for Physician Licensure, Question 4 of Personal History,[11] is illustrative of the scope of licensing boards' queries related to mental health; it asks for:

> A report from any and all physicians, counselors, or therapists from whom you have received treatment for any chronic disease or condition (i.e., chemical/ alcohol dependency, depression, etc.). The report must include dates of treatment, method of treatment, diagnosis, and prognosis. Attach a detailed statement advising whether you are currently under treatment. If you have been treated as an inpatient/outpatient at any time for any disease or condition, then it will be necessary for you to have the institution(s) submit, directly to this Department, copies of any and all admitting histories, physicals and discharge summaries for each inpatient/outpatient stay or treatment.

Similarly, state boards of professional regulation, in their work to ensure patient protection, may consider a less punitive approach to addressing physician impairment. For example, boards could reevaluate the factors that contribute to the suspension of a medical license and determine whether these factors: (a) relate to mental illness; and (b) could be replaced with an option for treatment, rather than or in addition to a punishment (i.e., license suspension).

Physician Health Programs

Related to state physician health programs, one potential model/best practice comes from Colorado, where the Colorado Physician Health Program (CPHP) offers a safe haven for reporting of physicians with mental health issues to the medical board.[12] That is, physicians who are applying or reapplying for a Colorado medical license can ensure, under specific conditions, that certain medical and/or psychiatric matters will remain unknown to the state medical board.

As with other state medical board licensure applications, the Colorado application includes questions pertaining to medical/psychiatric health, encompassing substance use, mental health disorders, and cognitive matters. The applicant must indicate either yes or no, to acknowledge or deny the presence of a medical or psychiatric condition, respectively.

The applicant may also answer no, and keep certain personal health matters unknown to the medical board, if: 1) the CPHP has been informed of the applicant's health matter(s); 2) the applicant has attended an initial appointment with CPHP for the behavior or condition; and 3) there is compliance with all of CPHP's requirements for evaluation, treatment, and/or monitoring.

This safe haven encourages physicians to proactively seek and receive the health care services they need, confidentially, and provides assurance to the Colorado medical board (through oversight by the CPHP) that patient safety is not jeopardized.

SUMMARY AND RECOMMENDATIONS

Ensuring access to confidential health services for medical students and physicians offers many ethical, logistical, educational, and systemic/cultural challenges. Fortunately, a variety of programs/initiatives/requirements are currently in place, from accrediting agencies and medical institutions, along with the AMA and other professional associations, to ensure more attention and holistic solutions to this issue. The Council on Medical Education believes that this report and its recommendations will help raise awareness of and action on this important issue as it relates to the medical education needs of medical students and physicians throughout the continuum.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolutions 901-I-15, 913-I-15, and 304-A-16, and the remainder of the report be filed.

1. That our American Medical Association (AMA) ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

   1) Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: a) include appropriate follow-up; b) are outside the trainees' grading and evaluation pathways; and c) are available (based on patient preference and

need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

2) Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

3) Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

4) Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle. (New HOD Policy).

2. That our AMA urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. (New HOD Policy).

3. That Policy H-345.973, "Mental Health Services for Medical Students and Resident and Fellow Physicians," be amended by addition and deletion, as follows.

   <u>Medical and</u> Mental Health Services for Medical Students and Resident and Fellow Physicians

   Our AMA promotes <u>the availability of timely,</u> confidential, accessible, and affordable <u>medical and</u> mental health services for medical students and resident and fellow physicians<u>, to include needed diagnostic, preventive, and therapeutic services</u>. <u>Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place.</u> (Modify Current HOD Policy).

4. That Policy H-295.872, "Expansion of Student Health Services," be rescinded, as it is (in part) already reflected in current LCME standards and (in part) now incorporated into Policy H-345.973, Mental Health Services for Medical Students and Resident and Fellow Physicians. (Rescind HOD Policy).

5. That Policy D-405.992, "Physician Health and Wellness," and D-405.996, "Physician Well-Being and Renewal," be rescinded, as these directives have been accomplished, are superseded by other policy, or are no longer relevant. (Rescind HOD Policy).

6. That Policy D-405.983, "Medical Students and Residents as Patients," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy).

7. That the AMA encourage medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administrative action, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RELEVANT AMA POLICY

H-95.955, "Physician Impairment"

(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.

H-225.961, "Medical Staff Development Plans"

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care.

H-225.966, "Medical Staff Role in the Development of Substance Abuse Policies and Procedures"

1. Our AMA establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation.2. Policy of the AMA states that medical staff must be involved in the development of the institution's substance abuse policy, including: (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for-cause post-incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members. 3. The AMA believes all drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place.

H-235.977, "Medical Staff Committees to Assist Impaired or Distressed Physicians"

Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members.

H-295.872, "Expansion of Student Health Services"

1. It is AMA policy that medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring. 2. Out AMA will encourage the LCME to develop an annotation to its standard on medical student access to preventive and therapeutic health services that includes a specification of the following: a. Medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring. b. Medical students should have information about where and how to access health services at all locations where training occurs. c. Medical schools should have policies that permit students to be excused from class or clinical activities to seek needed care.

H-295.955, "Teacher-Learner Relationship in Medical Education"

CODE OF BEHAVIOR: The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct… Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students, which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication…

H-295.999, "Medical Student Support Groups"

(1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.(2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

H-310.907, "AMA Duty Hours Policy"

Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training: 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.

H-310.912, "Residents and Fellows' Bill of Rights"

…E. Adequate compensation and benefits that provide for resident well-being and health. (3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.

H-310.979, "Resident Physician Working Hours and Supervision"

(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services."

H-345.973, "Mental Health Services for Medical Students and Resident and Fellow Physicians"

Our AMA promotes confidential, accessible, and affordable mental health services for medical students and resident and fellow physicians.

H-345.981, "Access to Mental Health Services"

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

H-405.961, "Physician Health Programs"

Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.

D-405.990, "Educating Physicians about Physician Health Programs"

1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.

D-405.992, "Physician Health and Wellness"

Our AMA: (1) supports programs related to physician health and wellness, including those offered in conjunction with the Federation of State Physician Health Programs; (2) will convene those interested in medical education in an effort to bring the dialogue about healthy lifestyle and balance early in the careers of medical students and residents; and (3) considers the concept of physician wellness as an element of the AMA Strategic Plan.

D-405.996, "Physician Well-Being and Renewal"

Our AMA will work with the Federation of State Physician Health Programs to establish and promulgate a networking resource/database and web site clearinghouse for Medical Staff Physician Health Committees or their equivalents in physician groups throughout the country, and to provide resources that will allow such committees to proactively initiate programs of wellness and illness prevention for physicians.

H-440.905, "Confidentiality, Counseling and Treatment in the Tuberculosis Screening of Health Care Workers"

The AMA encourages all health care organizations that require Tuberculosis screening tests to adopt standards which guarantee health care workers and medical students the right to confidentiality, appropriate counseling, and treatment following the positive results of a tuberculosis skin test; and encourages all health care organizations that require Tuberculosis screening tests to adopt standards which guarantee prospective health care workers and volunteers confidentiality and education about treatment options following the positive results of a tuberculosis skin test.

9.3.1, "Physician Health & Wellness"

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

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10.3, "Peers as Patients"

The opportunity to care for a fellow physician is a privilege or physician-in-training and may represent a gratifying experience and serve as a show of respect or competence. However, physicians must recognize that providing medical care for a fellow professional can pose special challenges for objectivity, open exchange of information, privacy and confidentiality, and informed consent.

In emergencies or isolated rural settings when options for care by other physicians are limited or where there is no other qualified physician available, physicians should not hesitate to treat colleagues.

Physicians must make the same fundamental ethical commitments when treating peers as when treating any other patient. Physicians who provide medical care to a colleague should:

(a) Exercise objective professional judgment and make unbiased treatment recommendations despite the personal or professional relationship they may have with the patient.

(b) Be sensitive to the potential psychological discomfort of the physician-patient, especially when eliciting sensitive information or conducting an intimate examination.

(c) Respect the physical and informational privacy of physician-patients. Discuss how to respond to inquiries about the physician-patient's medical care from colleagues. Recognize that special measures may be needed to ensure privacy.

(d) Provide information to enable the physician-patient to make voluntary, well-informed decisions about care. The treating physician should not assume that the physician-patient is knowledgeable about his or her medical condition.

Physicians-in-training and medical students (when they provide care as part of their supervised training) face unique challenges when asked to provide or participate in care for peers, given the circumstances of their roles in residency programs and medical schools. Except in emergency situations or when other care is not available, physicians-in-training should not be required to provide medical care for fellow trainees, faculty members, or attending physicians if they are reluctant to do so.

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REFERENCES

[1] Frank E, Dresner Y, Shani M, Vinker S. The association between physicians' and patients' preventive health practices. *CMAJ* April 8, 2013. Available at: http://www.cmaj.ca/content/early/2013/04/08/cmaj.121028#cited-by. Accessed June 23, 2016.

[2] Aroncyzk A. A Med Student Decides To Be Upfront About Her Mental Issues. All Things Considered. Available at: http://www.npr.org/sections/health-shots/2016/06/01/480173677/a-med-student-decides-to-be-upfront-about-her-mental-issues. Accessed September 28, 2016.

[3] Demboskey A. Frustrated You Can't Find A Therapist? They're Frustrated, Too. NPR Morning Edition. July 14, 2016. Available at: http://www.npr.org/sections/health-shots/2016/07/14/481762357/frustrated-you-can-t-find-a-therapist-they-re-frustrated-too?sc=tw. Accessed July 14, 2016.

[4] Accreditation of Colleges of Osteopathic Medicine: COM Accreditation Standards and Procedures (Effective: July 1, 2016). Commission on Osteopathic College Accreditation. Available at: https://www.osteopathic.org/inside-aoa/accreditation/COM-accreditation/Documents/com-accreditation-standards-7-1-16.pdf. Accessed August 6, 2016.

[5] ACGME Institutional Requirements, effective July 1, 2015. Available at: http://www.acgme.org/Portals/0/PDFs/FAQ/InstitutionalRequirements_07012015.pdf. Accessed June 23, 2016.

[6] ACGME Common Program Requirements, effective July 1, 2015. Available at: http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_07012015.pdf. Accessed June 23, 2016.

[7] Cedfeldt AS, Bower EA, Grady-Weliky TA, Flores C, Girard DE, Choi D. A comparison between physicians and demographically similar peers in accessing personal health care. *Acad Med*. 2012;87(3):327-331. Available at: http://journals.lww.com/academicmedicine/Fulltext/2012/03010/A_Comparison_Between_Physicians_and.19.aspx. Accessed June 22, 2016.

[8] Galewitz P. Office Chatter: Your Doctor Will See You In This Telemedicine Kiosk. Kaiser Health News, June 21, 2016. Available at: http://khn.org/news/office-chatter-your-doctor-will-see-you-in-this-telemedicine-kiosk/. Accessed June 23, 2016.

[9] Carvour ML, Ayyar BK, Chien KS, Kelly S, Ramirez NC, Yamamoto H. A Patient-Centered Approach to Postgraduate Trainee Health and Wellness: An Applied Review and Health Care Delivery Model. Acad Med. July 12, 2016. Abstract at: http://journals.lww.com/academicmedicine/Abstract/publishahead/A_Patient_Centered_Approach_to_Postgraduate.98445.aspx. Accessed July 25, 2016.

[10] Lyuba Konopasek, MD, designated institutional official, graduate medical education, New York-Presbyterian Hospital. Personal communication, July 15, 2016.

[11] Instruction Sheet: Physician – Licensure by Acceptance of Examination; Physician – Licensure by Endorsement. Illinois Department of Financial and Professional Regulation. Available at: idfpr.com/renewals/apply/forms/md-ac-end.pdf. Accessed June 30, 2016.

[12] Colorado Physician Health Program, FAQs. Available at: http://cphp.org/faqs/. Accessed July 6, 2016.