Whereas, The rate of suicide completion among medical professionals exceeds that of the combined U.S. population; and

Whereas, Suicides among physicians are perceived as isolated events; and

Whereas, Job stress is an independent risk factor for physician suicide; and

Whereas, More understanding is needed about what systemic factors lead physicians to suicide; and

Whereas, Current AMA policy addresses a physician’s or student’s responsibility to seek mental health care, and encourages confidential reporting of risk factors by medical students, but does not include consequences for institutions that do not work to prevent suicide; and

Whereas, Work conditions beyond resident work hours, such as bullying, can contribute to suicide; and

Whereas, Media coverage of physician suicide has increased dramatically in the past year; therefore be it

RESOLVED, That our AMA request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events. (Directive to Take Action)

RELEVANT AMA POLICY:
Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will 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:
A. 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: (1) include appropriate follow-up; (2) are outside the trainees’ grading and evaluation pathways; and (3) 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;
B. 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;
C. 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
D. 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.
2. Our AMA will 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.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and
suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction
professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk
factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b)
encourages state medical boards to recognize that the presence of a mental health condition does not
necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical
societies to advocate that state medical boards not sanction physicians based solely on the presence of a
psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and
risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and
release information regarding reporting rates of depression/suicide on an opt-out basis from its students;
and (c) will work with other interested parties to encourage research into identifying and addressing
modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. 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. Our AMA supports
making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational
resources and training related to suicide risk of patients, medical students, residents/fellows, practicing
physicians, and other health care professionals, using an evidence-based multidisciplinary approach.
Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep.
01, A-18; Appended: Res. 312, A-18