

## AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1  
(I-20)

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Subject: Resident and Fellow Physician Work-Life Balance

Referred to: Reference Committee

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1 Whereas, physician burnout, a precursor to the spectrum of depression and suicide, is widely  
2 prevalent in the practicing physician population (29-54% across various specialties from a 2020  
3 Medscape survey<sup>1</sup> (previously documented at 45.5% in another study);<sup>2</sup> attributed to increasing  
4 clinical and administrative demands, and lack of practice autonomy and challenges to achieving  
5 acceptable work-life-balance.<sup>3</sup>

6  
7 Whereas, work-life-balance, in particular, has been the subject of study via the AMA Physician  
8 Masterfile,<sup>4</sup> and an increase in hours worked was related to increased rates of burnout (for each  
9 1 additional hour worked per week, correlation with burnout was OR 1.021 (1.017-1.026), p<  
10 0.01).<sup>5</sup>

11  
12 Whereas, hours worked during residency and fellowship are among the greatest number in a  
13 physician's career, with the average attending physicians working an average of 50 hours per  
14 week<sup>5</sup> and first year residents reporting an average of 66 hours per week, with 43% violating the  
15 80-hour rule when averaged over 4 weeks;<sup>6</sup> . Moreover, these hours may be falsified and the  
16 true number of hours worked could be higher;<sup>7</sup>

17  
18 Whereas, formal wellness programs have been implemented at various residency programs in  
19 an attempt to give residents the tools needed to maintain good work-life balance. Among these  
20 programs include Wellness Wednesdays at Cleveland Clinic (offering a selection of snacks on  
21 Wednesdays along with suggestions of activities around the city); and the Balance in Life  
22 program at Stanford University,<sup>8</sup> which involves detailed plans for resident wellness divided  
23 across major areas of (1) Professional well-being (pairing of senior and junior residents for  
24 quarterly complimentary lunch meetings), (2) Physical well-being (ensuring residents have  
25 complimentary access to refrigerator stocked weekly with healthy snacks and beverages), (3)  
26 Psychological well-being (scheduling routine group counseling appointments every 6 weeks  
27 during protected educational time), (4) Social well-being (monthly informal social gatherings  
28 sponsored by the program);

29  
30 Whereas, the Federation of State Medical Boards encourages accrediting bodies (including the  
31 ACGME) to "include standards related to required resources and policies aimed at  
32 protecting...resident...physician health;"<sup>8</sup> and with the COVID-19 pandemic, a report published  
33 on the CDC website found that rates of mental health outcomes, substance use, and suicidal  
34 ideation have been increasing, especially among younger adults and essential workers;<sup>9</sup>

35  
36 Whereas, there are many general policies to study mental health and educate physicians and  
37 stakeholders about burnout, but not yet a targeted AMA policy to lend increased support,  
38 specifically, towards resident and fellow physicians, who are at increased risk of burnout  
39 compared to attending physicians; therefore, be it

1 RESOLVED, that our AMA advocates for resident and fellow trainees to be regularly given  
2 separately allotted protected time dedicated for mental health, rather than the current practice of  
3 sharing “personal days” with illness, other health-related appointments, family emergencies, and  
4 interviews; so that trainees can participate in elective stigma-free mental health and substance  
5 use disorder services, in order to maximize work-life-balance; and be it further  
6  
7 RESOLVED, that our AMA supports governing bodies, including ACGME, in developing and  
8 expanding on formal policy and standards aimed at protecting resident and fellow trainees’ well-  
9 being, including professionally, physically, psychologically, and socially, during the course of  
10 their training.

Fiscal Note:

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**References:**

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9. Czeisler MÉ, Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69(32):1049-1057. doi:10.15585/mmwr.mm6932a1

**Relevant RFS Position Statements:**

291.015R Intern and Resident Burnout: That our AMA-RFS work with the ACGME to study resident burnout and determine if (1) recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) it relates to the professionalism core competency for residents; and (3) recognizing, treating and possibly preventing burnout could be included in the program requirements for residency program directors. (Resolution 3, A-06) (Reaffirmed Report D, I-16)

420.009R Prevention of Physician and Medical Student Suicide: That our AMA request that the Liaison Committee on Medical Education and Accreditation Council of Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events. (Resolution 2, I-17)

**Relevant AMA Policy:**

**D-310.968 Physician and Medical Student Burnout**

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

*CME Rep. 8, A-07, Modified: Res. 919, I-11, Modified: BOT Rep. 15, A-19*

**H-405.957 Programs on Managing Physician Stress and Burnout**

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

*Res. 15, A-15, Appended: Res. 608, A-16, Reaffirmed: BOT Rep. 15, A-19*

**H-405.961 Physician Health Programs**

1. 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.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.

*CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Modified: BOT Rep. 15, A-19*

**H-295.858 Access to Confidential Health Services for Medical Students and Physicians**

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 re licensure 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.

*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; Reaffirmed: BOT Rep. 15, A-19*

### **H-310.907 AMA Duty Hours Policy**

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.

3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work 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.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
  - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
  - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
  - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
  - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
  - a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
  - b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
  - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
  - d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to clinical and educational work hours:
  - a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
  - b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
  - c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
  - d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
  - e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
  - f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
  - g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
  - h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.

- i) Scheduled time providing patient care services of limited or no educational value should be minimized.
- j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
- K) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
- l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
- m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
- o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

*CME Rep. 5, A-14; Modified: CME Rep. 06, I-18*

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

Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. 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.

*Res. 915, I-15; Revised: CME Rep. 01, I-16*