Whereas, Existing studies of medical trainees have shown high rates of depression and anxiety, both of which are known risk factors for suicide; and

Whereas, In one meta-analysis, the prevalence of depression or depressive symptoms among medical students was 27%, with only 16% of those who screened positive seeking psychiatric treatment; residents report depression at rates of 21-43%, with rates increasing over time; and

Whereas, Matriculating medical students have lower rates of depression and burnout compared to the general population, a trend that reverses when they begin medical school; similarly, the first year of residency is associated with a 16% increase in depressive symptoms, highlighting a need for additional support during that transition; and

Whereas, Rates of burnout - a contributor to depression, relationship problems, and substance use - are higher in all medical trainees compared to the general population; and

Whereas, Suicide rates in medical trainees are difficult to estimate due to lack of high-quality data, particularly in the medical student population; and

Whereas, A study on causes of death in residents revealed suicide to be the second leading cause (second only to cancer), and the leading cause of death for male residents; and

Whereas, There is limited data on depression, anxiety, and suicide in post-graduate physicians, much of which comes from older data and small-scale studies, although a 2020 meta-analysis subsequently found that suicide remains a leading cause of mortality for physicians when compared to other causes (i.e., cardiovascular disease, cancer), despite a general decrease in physician suicide rates since 1980; more recently, the Medscape Physician Burnout and Suicide Report has become a powerful tool to track mental health trends anonymously within our profession in real time; and

Whereas, Overall, there are limited robust studies about medical student, resident, and physician suicide, as noted in a 2015 JAMA Psychiatry viewpoint calling for a national response regarding studies of depression and suicide in medical trainees; and

Whereas, Increasing professional demands and worsening burnout related to the COVID-19 pandemic highlight the importance of collecting accurate, real-time data on our profession’s mental health to inform efforts on mitigating risks and preventing suicide; and

Whereas, For allopathic medical school accreditation, the LCME requires that institutions “include programs that promote student wellbeing;” for osteopathic medical school accreditation, COCA requires that the institution “must develop and implement policies and procedures as well
as provide the human and physical resources required to support and promote health and
wellness;” for residency, ACGME requires “Institution, must ensure healthy and safe learning
and working environments that promote resident well-being”18-20; and

Whereas, Wellness initiatives in medical schools and residency programs can vary widely in
format—usually with preventative, reactive, and cultural programming, and rarely with structural
programming—and effectiveness, and often face barriers such as insufficient financial or
administrative support21-23; and

Whereas, A public database of wellness initiatives of each medical school and residency would
allow programs to display their own initiatives as well as gather ideas and contact information to
more rapidly and effectively implement new ones; therefore be it

RESOLVED, That our AMA amend Study of Medical Student, Resident, and Physician Suicide
D-345.983 as follows:

D-345.983 – STUDY OF MEDICAL STUDENT, RESIDENT, AND
PHYSICIAN SUICIDE
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting
National Death Index (NDI) data and confidentially maintaining manner of death
information for physicians, residents, and medical students listed as deceased in the
AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association
of American Medical Colleges, the American Association of Colleges of Osteopathic
Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to
collect data on medical student and resident/fellow suicides to identify patterns that
could predict such events; (3) support the education of faculty members, residents and
medical students in the recognition of the signs and symptoms of burnout and
depression and supports access to free, confidential, and immediately available stigma-
free mental health and substance use disorder services; and (4) collaborate with other
stakeholders to study the incidence of and risk factors for depression, substance misuse
and addiction, and suicide among physicians, residents, and medical students--; and (5)
work with appropriate stakeholders to explore the viability of developing a standardized
reporting mechanism for the collection of current wellness initiatives that institutions
have in place, to inform and promote meaningful mental health and wellness
interventions in these populations. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: 05/11/22
References:


RELEVANT AMA POLICY

Study of Medical Student, Resident, and Physician Suicide D-345.983
Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; and (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students.

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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.

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.

AMA Principles of Medical Ethics: I,II,IV