AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 326
(A-22)

Introduced by: Medical Student Section

Subject: Standardized Wellness Initiative Reporting

Referred to: Reference Committee C

Whereas, Existing studies of medical trainees have shown high rates of depression and anxiety, both of which are known risk factors for suicide[1-4]; 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[3,5]; and

Whereas, Matriculating medical students have lower rates of depression and burnout compared to the general population, a trend that quickly 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[5-7]; 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[8,9]; and

Whereas, Suicide rates in medical trainees are difficult to estimate due to lack of high-quality data, particularly in the medical student population[7,8,10]; 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[11]; 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[12-15]; 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[16]; 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[17]; 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 support[21-23]; 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

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References:

1. Hawton K, Casañas I Comabella C, Haw C, Saunders K. Risk factors for suicide in individuals with depression: A systematic review. *J Affect Disord.* 2013 May;147(1-3):17-28. doi: 10.1016/j.jad.2013.01.004.
2. Sareen J, Cox BJ, Afifi TO, et al. Anxiety disorders and risk for suicidal ideation and suicide attempts: A population-based longitudinal study of adults. *Arch Gen Psychiatry.* 2005;62(11):1249-1257. doi:10.1001/archpsyc.62.11.1249
3. Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: A systematic review and meta-analysis. *JAMA*. 2016;316(21):2214-2236. doi:10.1001/jama.2016.17324
4. Dyrbye LN, Thomas MR, Shanafelt TD. Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. *Acad Med*. 2006;81(4):354-373. doi:10.1097/00001888-200604000-00009
5. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: A systematic review and meta-analysis. *JAMA*. 2015;314(22):2373-2383. doi:10.1001/jama.2015.15845
6. Brazeau CM, Shanafelt T, Durning SJ, et al. Distress among matriculating medical students relative to the general population. *Acad Med*. 2014;89(11):1520-1525. doi:10.1097/ACM.0000000000000482
7. Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and suicidal ideation among U.S. medical students. *Ann Intern Med*. 2008;149(5):334-341. doi:10.7326/0003-4819-149-5-200809020-00008
8. Mousa OY, Dhamoon MS, Lander S, Dhamoon AS. The MD Blues: Under-Recognized Depression and Anxiety in Medical Trainees. *PLoS One*. 2016;11(6):e0156554. doi:10.1371/journal.pone.0156554
9. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med*. 2014;89(3):443-451. doi:10.1097/ACM.0000000000000134
10. Blacker CJ, Lewis CP, Swintak CC, Bostwick JM, Rackley SJ. Medical student suicide rates: A systematic review of the historical and international literature. *Acad Med.* 2019;94(2):274-280. doi:10.1097/ACM.0000000000002430
11. Yaghmour NA, Brigham TP, Richter T, et al. Causes of death of residents in ACGME-accredited programs 2000 through 2014: Implications for the learning environment. *Acad Med.* 2017;92(7):976-983. doi:10.1097/ACM.0000000000001736
12. Kane L. 'Death by 1000 cuts': Medscape national physician burnout & suicide report 2021. Medscape. https://www.medscape.com/slideshow/2021-lifestyle-burnout-6013456#1. Published January 22, 2021.
13. Näher A-F, Rummel-Kluge C and Hegerl U. Associations of Suicide Rates With Socioeconomic Status and Social Isolation: Findings From Longitudinal Register and Census Data. *Front. Psychiatry.* 2020;10:898. doi: 10.3389/fpsyt.2019.00898
14. Duarte D, El-Hagrassy MM, Couto TCE, Gurgel W, Fregni F, Correa H. Male and Female Physician Suicidality: A Systematic Review and Meta-analysis. *JAMA Psychiatry.* 2020;77(6):587–597. doi:10.1001/jamapsychiatry.2020.0011
15. Schernhammer ES, Colditz GA. Suicide rates among physicians: A quantitative and gender assessment (meta-analysis). *Am J Psychiatry.* 2004;161(12):2295-2302. doi:10.1176/appi.ajp.161.12.2295
16. Goldman ML, Shah RN, Bernstein CA. Depression and Suicide Among Physician Trainees: Recommendations for a National Response. *JAMA Psychiatry*. 2015;72(5):411–412. doi:10.1001/jamapsychiatry.2014.3050
17. Halperin SJ, Henderson MN, Prenner S, Grauer JN. Prevalence of Anxiety and Depression Among Medical Students During the Covid-19 Pandemic: A Cross-Sectional Study. *Journal of Medical Education and Curricular Development*. January 2021. doi:10.1177/2382120521991150
18. Association of American Medical Colleges (AAMC). LCME Accreditation. https://www.aamc.org/services/first-for-financial-aid-officers/lcme-accreditation Accessed May 6, 2022.
19. Commission on Osteopathic College Accreditation (COCA). Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards. Revised February 27, 2020. https://osteopathic.org/wp-content/uploads/2018/02/com-continuing-accreditation-standards.pdf Accessed May 6, 2022.

20. Accreditation Council for Graduate Medical Education (ACGME). ACGME Common Program Requirements (Residency). Revised July 1, 2021. https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency2021.pdf Accessed May 6, 2022.
21. Schutt A, Chretien KC, Woodruff JN, Press VG, Vela M, Lee WW. National Survey of Wellness Programs in U.S. and Canadian Medical Schools. Acad Med. 2021 May 1;96(5):728-735. doi: 10.1097/ACM.0000000000003953.
22. Drolet BC, Rodgers S. A comprehensive medical student wellness program–design and implementation at Vanderbilt School of Medicine. Acad Med. 2010;85:103110.
23. Slavin SJ, Schindler DL, Chibnall JT. Medical student mental health 3.0: improving student wellness through curricular changes. Acad Med. 2014;89:573577.

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.
CME Rep. 06, A-19

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.
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

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