Whereas, All human beings, including all physicians, eventually become afflicted by medical conditions meriting evaluation, management and treatment by a clinician, and

Whereas, Such medical conditions may accrue while a physician is engaged in the active practice of medicine; and

Whereas, some of these medical conditions include mental health conditions; and

Whereas, Actively practicing physicians are at higher risk for mental illness that can be treated on an outpatient basis than members of other professions, and

Whereas “burnout”, a condition believed to afflict up to 50 percent or more of physicians in some specialties, is a condition which can predispose to the mental health disease of depression, a disease that merits ongoing management and treatment; and

Whereas, Physicians who suffer untreated depression are at increased risk for suicide, with more than 300 physicians dying by suicide in a typical year, at a rate that exceeds those for most other professions and occupations; and

Whereas, Physician suicides are not only tragic but also a terrible waste of human capital; and

Whereas, Mental health conditions under outpatient medical management by another licensed professional are less likely to impair a physician’s ability to discharge their clinical duties in an ethical and competent fashion than unmanaged mental health conditions; and

Whereas, Physicians applying for relicensure or insurance, hospital organization, or medical specialty board recredentialing typically are asked to reveal mental health conditions under treatment, even if such treatments are limited to an outpatient setting, as a condition for relicensure or re-credentialing; and

Whereas, An untreated mental or psychological condition or disease should elicit more concern for the clinician’s competence and fitness to practice medicine than a condition under active outpatient management; and

Whereas, it is a form of discrimination to single out mental illness matters as a condition that must be revealed during relicensure and re-credentialing, because evidence is lacking that physicians who are receiving effective outpatient mental health counseling or medications are typically unable to competently practice medicine; and
Whereas, It is self-evident that any physician currently receiving inpatient care for any disease, including mental health diseases, is temporarily unable to discharge their clinical duties, and

Whereas, our American Medical Association has recently taken actions and adopted policies aimed at minimizing or eliminating discrimination against minoritized populations, such as African Americans, Native Americans, individuals from the LGBTQ community, and those who dress or wear hair styles or hair coverings in a manner that delineates them as a member of a particular ethnic or cultural group; and

Whereas, our American Medical Association has previously enacted policy H-295.858, “Access to Confidential Health Services for Medical Students and Physicians,” which states in part that accessing such services should not be required to be disclosed to state licensure boards (but which is silent as regards disclosure to hospital and insurer credentialing agencies and medical specialty boards); and

Whereas, Federal legislation aimed at decreasing the burdens that can result in physician suicide have been enacted by the Congress in 2022 as H.R. 1667, the Lorna Breen Health Care Provider Protection Act, an act which was subsequently signed into law, demonstrating that the American people demonstrably have a clear interest in the health of physicians that exceeds that previously demonstrated by many of the organizations involved in the licensure and credentialing of physicians; and

Whereas, The authors of a 2022 article in *Academic Medicine* recommended that state medical boards review and refine licensure applications’ health history questions regarding mental health disclosure in ways that strategically address concerns related to stigma, bias, and unwarranted scrutiny, and called for research to examine the impact of such question changes on applicant response accuracy, help-seeking behaviors, and mental health outcomes and stigma, while also recommending that medical schools offer and promote access to mental health services, encourage faculty to normalize help-seeking behaviors, and provide students with information about state licensure processes; therefore be it

RESOLVED, That our American Medical Association compile a report summarizing which states have implemented and which states have not implemented suggestions that medical boards should not require disclosure of mental health conditions as a condition for re-licensure, as listed in Policy H-275.945, “Self-Incriminating Questions on Applications for Licensure and Specialty Boards,” (Directive to Take Action); and be if further

RESOLVED, That our AMA advocate to applicable organizations that state licensure boards, hospital organizations, private and public health insurers and specialty boards stop asking whether physicians are currently receiving outpatient mental health care (Directive to Take Action); and be it further
RESOLVED, That Substance Use Disorder (SUD) conditions currently managed with the assistance of a state’s Physicians’ Health Program (PHP) (or similar entity) need not be reported on applications for re-credentialing, because participation in a PHP ensures strict accountability on the part of physicians with a history of SUD, with this accountability enabling these physicians to such successfully and safely re-engage in the practice of medicine. (New HOD Policy)

Fiscal Note: Not yet determined

Received: TBD

RELEVANT AMA POLICY

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 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.

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.