ILLINOIS STATE MEDICAL SOCIETY

Resolution 09.2021-08
(A-22)

Introduced by:	Aquilla Chase, Amanda Bjornstad, Megan Gjertsen, and Rasa Valiauga, ISMS Members
Subject:	Medical Student, Resident and Fellow Suicide Reporting
Referred to:	Council on Medical Service

Whereas, depression is a known risk factor for suicide[1-2]; and

Whereas, 27% of medical students screen positive for depression, a rate 2.2-5.2 times higher than the age-matched general population[3]; and

Whereas, a meta-analysis reported that 29% of residents screen positive for depression, a rate higher than the general population[4]; and

Whereas, there are no studies assessing fellow depressive symptoms across multiple specialties, though a single survey assessing United States (U.S.) pulmonary and critical care medicine fellows reports that 41% show depressive symptoms[5]; and

Whereas, a relationship that meets causal criteria exists between burnout and suicidal ideation in medical trainees[6]; and

Whereas, burnout is defined in the 11th Revision of the International Classification of Diseases (ICD-11) as a syndrome resulting from chronic workplace stress, that has not been successfully managed, and is characterized by feelings of exhaustion, increased cynicism related to the profession, and reduced professional efficacy[7]; and

Whereas, medical students, residents and fellows report higher rates of burnout than the general population[8]; and

Whereas, the presence of an anxiety disorder is an independent risk factor for suicidal ideation[9]; and

Whereas, medical students have significantly higher rates of anxiety than the general population[10]; and

Whereas, residents and fellows are 800% more likely to screen positive for generalized anxiety than the general population[11]; and

Whereas, over 11% of medical students report experiencing suicidal ideation[3], yet only three research articles have been published exclusively surveying and collecting data on national medical student suicide rates[12,13]; and

Whereas, the only published study investigating suicide rates among trainees in Accreditation Council for Graduate Medical Education (ACGME)-Accredited Residency Programs states that the second leading cause of death among residents is suicide[14]; and

Whereas, there are currently no studies reporting suicide rates among U.S. fellowship programs; and

Whereas, there is a general lack of published data on medical student, resident and fellow suicide rates at the time of submitting this resolution; and

Whereas, the AMA Policy D-345.983 urges the Association of American Medical Colleges (AAMC) and ACGME to privately collect data for research on the prevention of future medical trainee suicides; and

Whereas, HOD Action Report 6 of the Council on Medical Education (A-19) recognizes the limitations of National Death Index (NDI) retrospective data collection stating, "Studies have shown that suicide is likely under-reported due to a lack of systematic approaches to reporting and assessing the statistics," and further states the AMA is exploring potential new mechanisms for data collection; and

Whereas, response bias, listed as a common study design limitation, resulted in underreporting of suicides in the two most recent national medical student suicide survey reports conducted from 1989-1994 and 2006-2011[12,15,16]; and

Whereas, the data published attempting to quantify medical student, resident, and fellow suicide is inconsistent because there is no reliable, systematic reporting mechanism for medical trainee suicide[12,15,16]; and

Whereas, the lack of consistent published data on medical trainee suicide necessitates a national standardized reporting mechanism and protocol[12,15,16]; and

Whereas, centralized data registries have been found to be beneficial for epidemiologic research initiatives due to the ability to collect prospective, tailorable data that can be stratified to aid with pattern recognition[17-20], and a similar system could be beneficial for medical trainee suicides; and

Whereas, Laitman et al (2019) call for reporting of "... numbers of deaths by school, [that] should be publicly available on the AAMC and ACGME websites"; and

Whereas, the AMA has no policy regarding standardized reporting of medical student, resident and fellow suicide information to a publicly accessible database; therefore, be it

RESOLVED, that the ISMS write a resolution to the American Medical Association (AMA) to advocate for the amendment of D-345.983 as follows:

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, 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 develop a standardized reporting mechanism for the confidential collection of pertinent suicide information of trainees in medical schools, residency, and fellowship programs, along with current wellness initiatives, to inform and promote meaningful interventions at these institutions; and (6) create a publicly accessible database that stratifies medical institutions based on relative rate of trainee suicide over a period of time, in order to raise awareness and promote the implementation of initiatives to prevent medical trainee suicide, while maintaining confidentiality of the deceased.

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Relevant ISMS Policy

ISMS recognizes that there are a number of student health issues such as drug abuse, suicide risk and prevention, exposure to infectious diseases, asbestos or mold, that are public health concerns that need to be addressed and are issues into which physicians should have input. (HOD 2011; Last BOT Review 2014)

Relevant AMA and AMA-MSS 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.

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.

Physician Suicide D-345.993
Our AMA will: (1) work with the American Foundation for Suicide Prevention and the Federation of State Physician Health Programs to study, to educate physicians, and to increase awareness through medical schools, state physician health committees, the AMA Alliance, and internal publications to anticipate, mitigate and eliminate, as far as possible, the preventable endemic catastrophe of physician suicide; and (2) contact the director of the Substance Abuse and Mental Health Services Administration and the American Psychiatric Association to join with the initiative to explore ways to act now to reduce the high prevalence of suicide in the United States particularly among physicians.

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

Educating Physicians About Physician Health Programs and Advocating for Standards D- 405.990
Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.
(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non- renewal.
(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.
(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well- being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or

that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

295.058MSS Suicide Prevention Program for Medical Students
AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective. (AMA Amended Res 315, A-95 Adopted [H- 345.984]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed:MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15)

310.054MSS Preventing Resident Physician Suicide
AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities. (MSS Res 38, A-17)

345.009MSS Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15)

345.012MSS Addressing Medical Student Mental Health Through Data Collection and Screening

AMAMSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and (2) encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (MSS Res 14, I-16) (AMA Res 303, A-17 Adopted as Amended [appended to H-295.858])

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

ISMS recognizes that there are a number of student health issues such as drug abuse, suicide risk and prevention, exposure to infectious diseases, asbestos or mold, that are public health concerns that need to be addressed and are issues into which physicians should have input. (HOD 2011; Last BOT Review 2014)