ILLINOIS STATE MEDICAL SOCIETY

Resolution 09.2022-15
(A-23)

Introduced by: Cecily Negri and Connor Cole, ISMS Members

Subject: Supporting the Mental Health of Medical Students

Referred to: Council on Education & Health Workforce

Whereas, physician burnout is described as the mental and physical exhaustion related to stress and overwork, with systematic reviews of physician burnout finding significant overall physician burnout, emotional exhaustion, depersonalization, and sense of low personal accomplishment;[1] and

Whereas, burnout and decreasing job satisfaction among physicians is associated with decreased working hours and increased departure from clinical medicine, demonstrating the substantial impact that burnout has on our physician workforce;[2,3] and

Whereas, medical students have higher rates or mood disorders, anxiety disorders, suicidal ideations, and psychological distress compared to post-secondary graduates in the general population;[4] and

Whereas, up to one half of medical students are affected by burnout during their medical education, yielding concern for continuance of burnout and related symptoms into graduate medical training and beyond;[5] and

Whereas, first-generation medical students report lower measures of self-care and more sleep problems than their peers;[6] and

Whereas, the current generation of medical students self-report the highest stress involving academic workload and conflicts with work-life balance, and other stressors including performance pressure, time constraints, financial concerns, and career planning concerns; with 11.2% noting the stress to be severe and debilitating;[7] and

Whereas, the ongoing COVID pandemic has resulted in decreased medical student wellness, with students feeling less supported in their daily environments, feeling less satisfaction with their medical education, and increased anxiety;[8] and

Whereas, medical students find high satisfaction with measured mentorship programs, with findings supporting improved residency match data and increased scholarly productivity;[9,10] and

Whereas, when didactic curriculum is altered with student wellness in mind, student mental health can improve, students get more nightly sleep, spent less time studying per day, and improved Step One scores;[11] and

Whereas, specialized programming for first generation medical students can help connect students with visible faculty and peer support, mentorship, academic resources, and educational transitions to promote development of physicians from underrepresented backgrounds in medicine;[12] and

Whereas, the Indiana University School of Medicine's mental health services program, is an example of how targeted minimization to barriers of care – no session limits, no cast for care, expanded accessibility – in mental health services can improve service utilization by medical trainees at all levels;[13] and

Whereas, Illinois State Medical Society has policy specifying "The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care" in reference to mental health services in communities throughout Illinois; and

Whereas, AMA Policy H-295.858 supports access to low-cost, confidential health care services, including mental health and substance use disorder counseling services, for medical students and physicians, but whose language "include appropriate follow-up" is vague, allowing medical schools to limit mental health services by the number of visits and not the adequacy of care; therefore be it

RESOLVED, that our ISMS create policy supporting medical student access to affordable physician-led mental health services without student insurance coverage limitation on number of visits; and be it further

RESOLVED, that our Illinois delegation to the AMA draft an amendment to AMA Policy H-295.858 (Access to Confidential Health Services for Medical Students and Physicians) to add that the number or times the medical student or physician is seen in a mental health service appointment should not be the sole criterion of the necessity or adequacy of psychiatric care; and be it further

RESOLVED, that our ISMS create policy supporting development and maintenance of medical school- and/or medical student-driven wellness programs which may emphasize routes to address burnout in the education process, developing support networks between students and faculty, discussions on purpose in medicine, and sharing evidence-based and anecdotal methods for student success and wellbeing.

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Fiscal Note:

None

Existing ISMS policy related to this issue:

The Illinois State Medical Society and its individual members recognize the importance of and need to promote, support and participate in state, local and hospital activities to prevent, recognize and overcome impairment among medical students, residents and practicing physicians. (HOD 1985; Last BOT Review 2014)

Board of Trustees approved the creation of an ad hoc committee of the Council on Education and Health Workforce to address the issue of physician-trainee burnout, including how to recognize and treat it and how to prevent it. (BOT 2005-OCT)

Board of Trustees adopted Substitute Resolution 01.2020-28 (A-20), Mental Health First Aid Training, in lieu of Resolution 01.2020-28 (A-20), as follows: RESOLVED, that our ISMS encourage physicians and medical students to train in mental health crisis intervention through programs such as the Mental Health First Aid skills initiative and/or through clinical training, as appropriate. ISMS is similarly encouraged to offer in this area educational courses for physicians, fellows, residents and medical students in this area; and be it further RESOLVED, that ISMS work with other like-minded delegations to prompt our AMA to encourage physician and medical student training in mental health crisis intervention through programs such as the Mental Health First Aid initiative and/or through clinical training, as appropriate. ISMS is to similarly encourage the AMA to offer education courses in this area for physicians, fellows, residents, and medical students in this area; and be it further RESOLVED, that ISMS work to ensure that informal training in mental health crisis intervention not be construed as an expertise that would expose participating health professionals to medical liability lawsuits. (BOT - JAN 2020)

House of Delegates adopted Substitute Resolution 56 (A-05), which directed that ISMS review the subject of physician-trainee burnout from the physician-in-training perspective. (HOD 2005)

The Illinois State Medical Society encourages physicians and medical students to train in mental health crisis intervention through programs such as the Mental Health First Aid skills initiative and/or through clinical training, as appropriate. Informal training in mental health crisis intervention should not be construed as an expertise that would expose participating health professionals to medical liability lawsuits. (2020 Annual Meeting; BOT 2020-JAN; Last BOT Review 2020)

A. The Importance of Mental Health Education and Services: ISMS recognizes the importance of mental health in the quality of a person's life and the devastating impact mental illness can have for an individual and one's family. Knowing that modern medicine has much to offer, ISMS supports the training of physicians in mental health care, the education of the public in recognizing mental illness and the development of private and public services for care. B. The Physician's Role in Mental Health Services: ISMS recognizes the primacy of the physician in the diagnosis and treatment of mental illness. Involuntary psychiatric hospital certification of any patient must, without exception, involve a physician licensed to practice medicine in all its branches. The discharge of any patient from a psychiatric institution must remain the responsibility of a physician. C. Continuing Medical Education for Department of Mental Health and Developmental Disabilities Physicians: The Department of Mental Health and Developmental Disabilities (DMHDD) [Department of Human Services] should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians. D. Cooperation between County Medical Societies and DMHDD: Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage: (1) Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle; (2) Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature; (3) Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician time available; (4) Arrangements for emergency mental health care, i.e., crisis intervention, to be available area wide. E. Patient Visits: The number of times a patient is seen should not be the sole criterion of the necessity or adequacy of psychiatric care. The level of care needed by the patient must be a major factor in determining the delivery of that care. Each hospital or hospital system should establish its own standard of psychiatric care to include the level of care needed by that patient, and should monitor the adequacy of psychiatric care by means other than frequency of visits. F. Community Mental Health Services: ISMS supports and encourages the development of community options for services to the chronically mentally ill in the private and public sectors, although the Society opposes using such alternatives to inappropriately discharge these persons to inadequate services and living conditions, thereby increasing the number of homeless mentally ill. (HOD 1987; Last BOT Review 2013)

Relevant AMA Policy:

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.

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 Care Services for Physicians and Trainees D-405.978

1. Our AMA will advocate that: (a) physicians, medical students and all members of the health care team (i) maintain self-care, (ii) are supported by their institutions in their self-care efforts, and (iii) in order to maintain the confidentiality of care, have access to affordable health care, including mental and physical health care, outside of their place of work or education; and (b) employers support access to mental and physical health care including but not limited to providing access to out-of-network in person and/or via telemedicine, thereby reducing stigma, eliminating discrimination, and removing other barriers to treatment.

2. Our AMA will advocate for best practices to ensure physicians, medical students and all members of the health care teams have access to appropriate behavioral, mental, primary, and specialty health care and addiction services.

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.

Physician Health Programs H-405.961

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.