Accreditation Council for Graduate Medical Education

401 North Michigan Avenue
Suite 2000
Chicago, Illinois 60611

Phone 312.755.5000
Fax 312.755.7498
www.acgme.org

ACGME

May 30, 2017

Dear Members of the Graduate Medical Education Community,

For all of us engaged in the preparation of the next generation of physicians to serve the American Public, this time of year is bittersweet. It is the time in which we say goodbye to those we have come to know, nurtured, and seen mature into confident, emerging expert clinicians ready and eager to enter the next phase of their lives of service. We have come to know their families, and celebrate their successes. It is also a time of educational program rejuvenation, where we plan for, and welcome the next cohort of anxious new graduates into our programs. It is, in many ways, the rhythm of our professional lives.

One of the most important dimensions of our work is to constantly enhance our educational programs. We learn from what went well last year, we reaffirm our goals, and we make necessary changes in our programs based on that learning. A potential benefit of our collective effort over the past two decades is that we now have opportunities to learn collectively, in a fashion that we might never have had at an individual program or institutional level. It is in this regard that I write to you today.

We all have concerns over the working and learning environment for medical students, residents, fellows, faculty, and the entire health care team. So great is the concern, and so broad is the alarm that my colleague Dr. Darrell Kirch, president of the Association of American Medical Colleges, and I approached Dr. Victor Dzau, president of the National Academy of Medicine, to initiate a national dialogue regarding the well-being of our caregivers, and the impact it has on our ability to fulfill our mission of service to our society. That effort has begun, and we are amazed and gratified by the breadth and depth of support from other organizations in our collective efforts to address this challenge.

In my travels, I have not only been supported in this effort, but also asked for tangible suggestions to begin to approach these challenges of well-being, burnout, depression, and suicide. It is in this spirit that I offer you the following information.

Death by suicide is a tragedy of immense proportions. When death occurs in a member of the health care team, perhaps especially when it is a resident, it is devastating. To try to understand the magnitude and causes of death of residents, my colleagues and I reviewed the nearly 400,000 individual physicians who entered ACGME-accredited programs from 2000 through 2014. The results of this study are published, and available for download, in an article newly published in *Academic Medicine*.

The results are both comforting and disquieting. First, residents die during training at age and gender rates well below those in the general public for nearly all causes, including suicide, accidental death, and homicide. Second, the most prevalent cause of death of residents is neoplastic disease, which is also the leading cause of death of women residents. The second most prevalent cause of death of residents is suicide, which is also the most common cause of death of male residents.

The most prevalent causes among neoplastic diseases (80; 42 men, 38 women) was central nervous system malignancy (15; 7 men, 8 women) and breast cancer (12 women, 0 men). Breast cancer was the most prevalent malignancy resulting in death of female residents.

While there is no increase in resident death by suicide over the 15 years that we studied, the second-most-prevalent cause of resident death was suicide (66; 51 men, 15 women), with 16 residents dying using firearms, and 16 intentionally overdosing on drugs or other substances. Suicide is the leading cause of death in male residents, and the second most prevalent for female residents. An important finding is that the majority of suicides (49 of 66; 74%) occurred in years 1 and 2 of training. Perhaps even more important is that there appears to be seasonality in suicide deaths, with the first and third quarter of the academic year (July-September; January-March) demonstrating peaks in death by suicide.

Other medical illnesses (51) and accidents (51, 24% of the rate in the general age- and gender-matched population) are the third and fourth most prevalent causes of death. These occur at rates significantly below those observed in the general public.

The etiologies of the neoplastic and medical illnesses observed suggest that there is a chronic disease burden that exists or surfaces during medical school and residency that must be recognized.

While both the absolute death rate, as well as the specific causes of death of residents are lower than national comparisons, they present opportunities for improvement. First, we must provide residents with the opportunity to receive the appropriate level of medical and surgical care required to live healthy lives. This includes physical and mental health, and dental health. In addition to our efforts around the clinical learning and working environment, it may require evolution of our culture, where admitting needs or weakness has been often seen as a sign of lack of commitment. It also likely requires our willingness to permit our colleagues on the faculty to be treated in the same fashion. We must model the behaviors we wish to instill in our residents.

Second, we have some specific strategies and interventions that can begin today.

- Start at orientation/onboarding – data on death by suicide suggest added risk early in residency and during certain months of the academic year. Transitions are a critical point in residents' lives when they need reassurance and support. Promote a supportive culture and let them know you care. One way to raise awareness is by screening the suicide prevention video created by Mayo Clinic and the American Foundation for Suicide Prevention. Provide information on prevention, treatment, and emergency support services for

mental health and medical issues. Repeat this information frequently during the July through September timeframe.

- Provide reminders and added support during stressful events (e.g., after the death of a patient), especially during the first quarter and mid-year from January through March, when evidence has shown burnout peaks again.
- Enhance mentoring by senior peers and faculty. Mentors can help to destigmatize asking for help related to depression, burnout, and feelings of inadequacy. Encourage connections between peers, faculty, and within interprofessional teams to reduce social isolation and watch for signs of burnout, depression, and significant changes in performance.
- Create a resident well-being plan for your program, or assess and update your existing well-being program using a tool like Combating Burnout, Promoting Physician Well-Being. ACGME resources include tools for assessing stressors and supports, and for creating a well-being action plan.
- Review health insurance and other related elements of Human Resources policies to remove barriers to residents receiving timely health, mental health, and dental services.
- Encourage an environment for all health care providers to find meaning in work and a sense of purpose in life. Let your residents know that project funding is available from the ACGME, and support the submission of proposals for *Back to Bedside*.

The ACGME welcomes your feedback and assistance in creating the highest quality resources. We invite you to send us a description of the tools, resources, and strategies that have proved effective in your organization and GME program to wellbeing@acgme.org. You can also submit an article to the *Journal of Graduate Medical Education*, and join in the conversation on LinkedIn and Twitter: @ACGME and #PhysicianWellBeing. To address the system-wide solutions for all clinicians, the ACGME is co-sponsoring the National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience. We invite you to join us on July 14 in person in Washington, DC, or via webinar, to advance solutions to reverse the trends in clinician stress, burnout, and suicide by registering here.

These are just a few suggestions, now beginning to be informed by evidence, that provide opportunities for us to collectively make a difference in the lives of those we serve. It is our collective goal that our residents and faculty find each successive transition of graduates even happier and healthier next year than this year. Please join us in this journey.

Most sincerely,

Thomas J. Nasca, MD, MACP
Chief Executive Officer
Accreditation Council for Graduate Medical Education (ACGME)