

HOD ACTION: Recommendations in Council on Medical Education Report 5 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 05-A-23

Subject: Support for Institutional Policies for Personal Days for Undergraduate Medical Students (Resolution 314-A-22)

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 Resolution 314-A-22, “Support for Institutional Policies for Personal Days for Undergraduate
2 Medical Students,” was authored by the American Medical Association (AMA) Medical Student
3 Section and submitted to the 2022 Annual Meeting of the House of Delegates (HOD). The
4 resolution reads as follows:

5
6 RESOLVED, That our American Medical Association encourage medical schools to accept
7 flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it
8 further

9
10 RESOLVED, That our AMA support a clearly defined number of easily accessible personal
11 days for medical students per academic year, which should be explained to students at the
12 beginning of each academic year and a subset of which should be granted without requiring an
13 explanation on the part of the students. (New HOD Policy)

14
15 The resolution was subsequently referred by the HOD for a report back to the House; this report is
16 in response to the referral.

17
18 BACKGROUND

19
20 *Concerns expressed by the resolution’s author*

21
22 The resolution stresses the frequency of burnout and its impact on the professional development
23 and mental health of medical students and identifies a lack of protected time as the prominent
24 barrier preventing medical students from accessing mental health treatment. The author expresses
25 concern regarding the inconsistency and lack of standardization of institutional policies for the
26 implementation of excused absences and the level of disclosure required by the students,
27 recognizing that students may not feel comfortable sharing mental health concerns due to
28 professional stigma, shame, or fear of repercussion.

29
30 *Reference Committee C testimony on the resolution*

31
32 The Reference Committee C report at the 2022 Annual Meeting reflected mixed testimony on this
33 item of business. Some testimony indicated support for this resolution, while others recommended
34 referral for further study due to concerns that using excessive personal days during a given
35 clerkship would have significant repercussions on the quality of education. While there was
36 support for the use of personal days by medical students, it was noted that determining a defined

1 number of personal days per academic year may be difficult given the variances across medical
2 schools. For these reasons, the resolution was recommended for referral by the reference
3 committee; the HOD subsequently concurred with this recommendation.

4
5 *Council on Medical Education testimony on the resolution*

6
7 In its testimony, the AMA Council on Medical Education stated that the AMA has a large amount
8 of policy on burnout in medical students, but nothing specific to personal days or less restrictive
9 excused absences. The Council recommended that the resolution be amended by adding the
10 language of the first resolve to current policy D-310.968 (3), “Physician and Medical Student
11 Burnout,” and adding a new resolve that the AMA support a clearly defined number of easily
12 accessible personal days for medical students per academic year, which should be explained to
13 students at the beginning of each academic year and a subset of which should be granted without
14 requiring an explanation on the part of the students. The Council recognized the possibility of
15 misuse of these days but noted that providing for but limiting the number of personal days provides
16 for both greater flexibility as well as privacy for students.

17
18 DISCUSSION

19
20 The goal of undergraduate medical education and awarding of the medical degree is to ensure that
21 medical students have acquired the knowledge, skills, and professional behaviors that prepare them
22 for a spectrum of career choices in medicine. Medical schools need to create an educational
23 environment that assures that graduating medical students meet the standards for achieving the
24 medical degree with the flexibility to meet the individual needs of their students.

25
26 *Time constraints as a barrier to medical student mental health care and well-being*

27
28 Burnout among medical students and the need for initiatives to counter burnout are well-
29 documented. Approximately half of U.S. medical students report experiencing burnout, and
30 medical students are more likely than their same-age peers outside of medicine to experience
31 depression or depressive symptoms (a prevalence of 27.2 percent)¹ and suicidal ideation (overall
32 prevalence of 11.1 percent).² Until recently, studies into obtaining timely mental health care
33 treatment and obstacles to care for students have been limited. However, one of the most frequently
34 cited barriers in this earlier research is lack of time.³

35
36 To gain a more thorough understanding, the University of Michigan conducted a study in 2020 of
37 current and recently graduated medical students, including pre-clinical, core clinical, and clinical
38 elective students. The goal of the study was to identify rates of burnout, barriers to treatment, and
39 program preferences for medical students.⁴ The results demonstrated the negative impact that lack
40 of time had on medical student access to mental health services as time constraints were the most
41 commonly reported barrier to accessing care. Of the participants who identified barriers to
42 obtaining care (77 of 312 respondents), 60 percent noted lack of time. In addition, 43 percent of
43 respondents felt that their schedule did not leave them with enough time for personal or family life,
44 another aspect of well-being impacted by time constraints. Students in the study were given the
45 option to provide suggestions for improvement, with flexibility in pre-clinical and core clerkship
46 schedules the most frequently mentioned theme.

47
48 *Concerns regarding stigma and potential career impact*

49
50 Stigma and fear of professional consequences also influence whether medical students seek mental
51 health treatment. In a 1994 study of first- and second-year medical students at the University of

1 California, San Francisco, School of Medicine, approximately one third of the students identified
2 as depressed cited the stigma associated with using mental health services and lack of
3 confidentiality as reasons for not seeking treatment.³ (The questionnaire was constructed to identify
4 the medical students' severity of depression by using the 13-item Beck Depression Inventory, a
5 standardized measure of depression symptoms.) In a 2009 cross-sectional student survey at a large
6 Midwestern medical school, most students cited potential embarrassment and the adverse effects
7 that disclosing mental illness could have on their professional development.⁵

8
9 The 2020 University of Michigan study also identified similar sentiments among its medical
10 students. The aspect of mental health services that students most endorsed was the guarantee that
11 seeking mental health care would have no negative impact on a student's future career (78 percent).
12 The study noted that policies concerning the reporting of mental health treatment to residency
13 programs and questions asked by licensing boards are variable and unclear, with many students
14 avoiding treatment for fear that future employers would view such treatment unfavorably.⁴

15
16 *Medical education accreditation standards related to student mental health*

17
18 The Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic
19 College Accreditation (COCA) have assessed the need for addressing medical student mental
20 health and have issued specific requirements on standards for accreditation to allopathic and
21 osteopathic medical schools, respectively.

22
23 LCME standards (Element 12.3 – Personal Counseling/Mental Health/Well-Being Programs,
24 Element 12.4 – Student Access to Health Care Services, and Element 12.5 Non-Involvement of
25 Providers of Student Health Services in Student Assessment/Location of Student Health Records)
26 require that health professionals providing any services, including psychiatric or psychological
27 counseling, should not be involved in the academic assessment or promotion of students in a
28 medical school program. Legal requirements for security, privacy, confidentiality, and accessibility
29 should be met when maintaining medical student health records. Furthermore, these standards state
30 that diagnostic, preventive, and therapeutic health services must be accessible to medical school
31 students near the site of their required educational experiences, which may include classroom
32 facilities, rotation sites, etc. Policies should be in place that allow students to be excused to seek
33 necessary health care.⁶

34
35 COCA standards (Element 5.3 – Safety, Health, and Wellness, Element 9.8 – Mental Health
36 Services, and Element 9.9 Physical Health Services) require that medical schools publish and
37 follow policies related to student, faculty, and staff mental health and wellness and fatigue
38 mitigation; provide students with confidential access to an effective system of counseling and
39 mental health care, with a mental health representative accessible 24 hours a day, 365 days a year,
40 from all locations where students receive education from the medical school; and provide students
41 with access to diagnostic, preventive, and therapeutic health services 24 hours a day, 365 days a
42 year, accessible in all locations where students receive education from the medical school.⁷

43
44 *Medical school attendance policies and impact of absences on education*

45
46 Medical school policies regarding excused absences and the use of personal days vary as schools
47 set policy to fit their specific curriculum structure. Therefore, standardization of these policies
48 would prove difficult.

49
50 In a sampling of medical school attendance policies regarding health-related excused absences,⁸⁻¹⁵
51 acceptable reasons included: illness affecting one's ability to report to the scheduled session and

1 necessary health care services which cannot be rescheduled, such as preventive health services,
2 care for chronic illnesses, physical therapy, and counseling/psychological services. In some
3 instances, students were not required to disclose the specific type of health care being sought.
4 Students were strongly encouraged to schedule non-emergency health care appointments during
5 times that do not conflict with classroom and clinical activities.

6
7 The number and timing of absences can impact the quality of the education, and there are many
8 issues to consider, including the potential for accumulation and use of absences over one or more
9 experiences; the active participation required by some curricular and clinical experiences over a
10 limited number of days; the impact on individual vs. team learning; and student responsibility for
11 the content or experiences missed. Medical schools should recognize that some students will be
12 absent during any curricular component and should develop alternative, timely means for students
13 to achieve curricular goals affected by an absence and avoid educational delays.

14
15 School policy varied regarding the number and timing of excused absences allowed, usually
16 limiting the number of absences per course, block, or year, and with restrictions on use, such as
17 during testing, orientation, or critical learning experiences.^{8,9,10,11} Some schools allowed these
18 excused absences to be applicable equally across all phases of training (foundational and clinical),
19 while for others absence from clinical duties was more restricted because it would decrease the
20 total amount of time in clinical service and thus impact a valid assessment of clerkship
21 performance.^{12,13}

22
23 In addition to excused absences, several of the schools in the sampling had personal day policies.
24 One school had core clerkship personal days, with a personal day defined as a day during a
25 required clerkship in the third year when a medical student would be excused from the rotation and
26 not required to state the reason. This policy allowed two personal days in the third year, and no
27 more than one personal day could be taken on any individual clerkship. Personal days were
28 restricted in some instances, such as exams, orientation, and assignments in which a student has
29 responsibilities that would impact the clerkship, i.e., overnight or weekend call.¹⁴ Another school
30 allowed students up to three personal day passes during the pre-clerkship phase to attend to
31 personal business. Personal day passes were restricted in some instances, such as exams and
32 interprofessional activities, and a specific reason for using a personal day pass was not required.¹⁵

33 34 RELEVANT AMA POLICY

35
36 The AMA has policy in support of identification and management of stress and burnout in students
37 and prioritizing self-care. The most specific policies related to the topic of this report are as
38 follows:

- 39
- 40 • D-345.983, “Study of Medical Student, Resident, and Physician Suicide,” which supports
41 the education of faculty members, residents, and medical students in the recognition of the
42 signs and symptoms of burnout and depression and access to free, confidential, and
43 immediately available stigma-free mental health and substance use disorder services.
44
 - 45 • D-405.978, “Access to Confidential Health Care Services for Physicians and Trainees,”
46 which includes advocating that medical students maintain self-care and are supported by
47 their institutions in their self-care efforts.
48
 - 49 • H-295.858, “Access to Confidential Health Services for Medical Students and Physicians,”
50 which in part asks that accreditation bodies encourage medical schools to make available
51 confidential health care in reasonable proximity to the education/training site and consider

1 designating some segment of already-allocated personal time off specifically for routine
2 health screening and preventive services.

- 3
- 4 • H-405.960, “Policies for Parental, Family and Medical Necessity Leave,” which in part
5 encourages medical schools to develop written policies on parental leave, family leave, and
6 medical leave for medical students, including how time can be made up in order for
7 medical students to be eligible for graduation with minimal or no delays, and whether
8 schedule accommodations are allowed.

9
10 These policies are listed in full detail in Appendix A.

11
12 SUMMARY AND RECOMMENDATIONS

13
14 Resolution 314-A-22 requests that the AMA 1) encourage medical schools to accept flexible uses
15 for excused absences from clinical clerkships and 2) support a clearly defined number of easily
16 accessible personal days for medical students per academic year, some of which should be granted
17 without requiring an explanation on the part of the students.

18
19 Time constraints and the fear of stigma and negative professional consequences are key barriers to
20 medical student access to care. Existing AMA policy supports the identification and management
21 of medical student burnout and the prioritization of self-care by medical students and their
22 institutions, including the allocation of time and access to services. However, the impact of excused
23 absences on medical student education must be considered carefully, including their use, quantity,
24 and timing, as medical schools create and implement policy with their own curriculum structures in
25 mind.

26
27 The Council on Medical Education therefore recommends that the following recommendation be
28 adopted in lieu of Resolution 314-A-22 and the remainder of this report be filed:

- 29
- 30 1. That our AMA support a requirement that each medical school have policy defining 1) the
31 number of days a medical student may be excused from each curricular component; 2) the
32 processes for using excused absences, providing alternative, timely means of achieving
33 curricular goals when absent from a curricular component; and 3) effective mechanisms to
34 communicate these policies at appropriate times throughout the curriculum; and that
35 schools be encouraged to create a mechanism by which at least some portion of such days
36 can be used without requiring explanation. (New HOD Policy)

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APPENDIX: RELEVANT AMA POLICY

[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; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed 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.

(CME Rep. 06, A-19; Modified: Res. 326, A-22)

[D-405.978, “Access to Confidential Health Care Services for Physicians and Trainees”](#)

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.

(Res. 7, I-20)

[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.

(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; Reaffirmed: Res. 228, I-22)

[H-405.960, “Policies for Parental, Family and Medical Necessity Leave”](#)

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical student to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.

15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.

17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.

18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.

(CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22)

REFERENCES

- ¹ Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, Shanafelt TD. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med.* 2014;89:443–51.
- ² 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.
- ³ Givens, Jane L. MD; Tjia, Jennifer MD. Depressed Medical Students' Use of Mental Health Services and Barriers to Use. *Academic Medicine* 77(9):p 918-921, September 2002.
- ⁴ Collins C, Pichan C, McGee L, Siden JY, Brower K. Assessing Student Burnout, Treatment Acquisition, and Barriers to Care to Prompt Changes in a Student Mental Healthcare Program. *Acad Psychiatry.* 2022 Jul 25:1–5. doi: 10.1007/s40596-022-01685-2. Epub ahead of print. PMID: 35879597; PMCID: PMC9311347.
- ⁵ Wimsatt LA, Schwenk TL, Sen A. Predictors of Depression Stigma in Medical Students: Potential Targets for Prevention and Education. *Am J Prev Med.* 2015 Nov;49(5):703-714. doi: 10.1016/j.amepre.2015.03.021. Epub 2015 Jul 2. PMID: 26141915.
- ⁶ Liaison Committee on Medical Education. Standards for Accreditation of Medical Education Programs Leading to the MD Degree. Published March 2022. <https://lcme.org/publications/>
- ⁷ Commission on Osteopathic College Accreditation Accreditation of Colleges of Osteopathic Medicine: COM Continuing Accreditation Standards. Effective July 1, 2019. <https://osteopathic.org/wp-content/uploads/2018/02/com-continuing-accreditation-standards.pdf>.
- ⁸ Zucker School of Medicine at Hofstra/Northwell. Attendance Policy for the First 100 Weeks. <https://medicine.hofstra.edu/policy/policy-attendance-policy-fow.html> Accessed January 23, 2023.
- ⁹ Texas Tech University Health Sciences Center School of Medicine, Operating Policy and Procedure. <https://www.ttuhsc.edu/medicine/documents/policies/SOMOP40.02.pdf> Accessed January 23, 2023.
- ¹⁰ University of Illinois College of Medicine. Attendance Procedures (Phase 1). <https://chicago.medicine.uic.edu/education/educational-policies/phase-1-attendance-late-arrival-policy/> Accessed January 23, 2023.
- ¹¹ Geisinger Commonwealth School of Medicine. Student-Policy on Class Attendance and Excused Absence in Phase 1 of the MD Curriculum. <https://www.geisinger.org/-/media/OneGeisinger/pdfs/ghs/Education-GCSOM/student-life/policies/class-attendance-and-excused-absence-in-pre-clinical-years.pdf> Accessed January 23, 2023.
- ¹² University of California, Los Angeles. Curricular Policies. <https://medschool.ucla.edu/education/md-education/current-students/handbook-and-policies#AttendancePolicies>. Accessed January 23, 2023.

¹³ Emory University School of Medicine. Academic Standards, Policies, and Procedures. <https://med.emory.edu/education/programs/md/student-handbook/academics/absences.html> Accessed January 23, 2023.

¹⁴ Boston University Chobanian & Avedisian School of Medicine. Attendance and Time Off Policy. <https://www.bumc.bu.edu/busm/education/medical-education/policies/attendance-time-off-policy/> Accessed January 23, 2023.

¹⁵ The University of Arizona College of Medicine-Tucson. Attendance and Absence Policy. https://medicine.arizona.edu/sites/default/files/attendance_and_absence_policy_emergency_notification_protocol_tepc_approved_1.15.2020_0.pdf. Accessed January 23, 2023.