When a Resident or Fellow Dies

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"I am afraid I have some very bad news." In May 2016, we learned that one of our trainees had died unexpectedly. While we hope that other programs will not need to reference this, we describe below what we learned.

Beyond creating an environment of academic and clinical excellence, program directors and academic leaders need to be aware of the psychological and physical health of our trainees and coworkers.[1] We monitor trainees for signs of burnout, substance use, depression, and suicidal ideation; teach fatigue mitigation techniques; and offer mental health services,[1] all within the context of a 24/7 clinical service.

What happens when—despite our best efforts—one of our trainees or junior faculty colleagues dies?[2,3] The death of a trainee can be a crisis for a program or department. This article provides tips for managing this tragedy.

Residents, fellows, and staff expect the program director and other academic leaders to guide them through the emotional and practical aspects of the grieving process. People watch our actions and level of empathy.[4] How we manage and present ourselves in this type of crisis affects our organization's culture and our own standing in the workplace.[5] The TABLE outlines matters that may need the leader's attention. It is organized by time: immediate steps first, followed by longer-term considerations.

People will want to know what happened, but the deceased trainee retains privacy rights under the Health Insurance Portability and Accountability Act of 1996. We cannot reveal the cause of death without permission from his or her next of kin. This may require a series of discussions with the family, as they may need time to consider what to share and with whom. How the trainee died will affect how we frame the news (TABLE).[6–8] The program director may find it helpful to rehearse and review the phrasing with a trusted colleague before sharing more broadly.

This type of news is best conveyed in person with all the residents gathered.[9] Meeting as a community decreases the sense of isolation and provides a platform for sharing feelings of loss.[10] It creates a visual reminder that the trainees are part of a supportive community.

How one starts delivering the information matters. First, reassure trainees that the program is secure. This will allow them to focus on the critical information conveyed.[11] After sharing the bad news, the leader may choose to give voice to the range of emotions he or she is experiencing.[12] The program director's modeling of appropriately expressed emotions allows others to follow suit. Trainees may need permission to express anger at the deceased.[13]

Trainees may recall their last moments with the deceased, and wonder if they should have noticed something or should have acted differently. Physicians strive to protect the vulnerable and may feel unrealistic guilt about not having prevented the death.[14]

Experiencing and expressing a range of emotions and then returning to care for patients can be disorienting. In retrospect, we wish we had discussed this challenge explicitly with our residents. Physicians are expected to perform and place their patients' needs before their own. Performing dual roles—grieving and working simultaneously—can be difficult.[13]

After the initial shock, trainees may ask in various contexts, "What about me?" They may worry about the impact on the program's reputation or how much call they may need to absorb.

The more profound *What about me?* question may take the form of "If this person can die, and he or she was so accomplished, then what about me?" These thoughts may not be voiced. Again, we wish we had anticipated these questions and addressed them directly. The program director should address *What about me?* with reassurance—right after the announcement of the passing.[11]

After this acute period, how trainees feel may not be apparent. On the surface, things "return to normal." But people's grief may be "disenfranchised," meaning not freely expressed and repressed.[10,13]

We did not foresee disenfranchised grief and its consequences. Some residents craved an opportunity to share stories[14,15] and felt isolated if they kept these stories to themselves. The baseline strain of training, compounded by isolation and increased call responsibilities, may cause some trainees to suffer and

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TABLE
Tasks After the Death of a Resident or Fellow

Steps	Specific Actions
Immediate steps: garnering resources	
Inform departmental and hospital leadership	▪ Associate training director, service leaders, and chair can help activate resources.
Call home	▪ Ensure that responsibilities at home are covered. ▪ Talk with loved ones to garner courage for the tasks ahead.
Speak with legal counsel	▪ Have someone else (service chief, chair, or DIO) call. Legal counsel should hear early to guide disclosure.
Work with hospital communications staff	▪ Have someone else (service chief, chair, DIO, or legal counsel) call the hospital communications office to get ahead of the news cycle. ▪ Provide guidance to trainees and faculty to deflect news agencies back to the hospital communications office.
Mobilize grief counselors	▪ Have someone else contact and mobilize grief counselors to be available to trainees and staff.
Speak with other training director or academic leader who has gone through a similar event	▪ It can be calming to speak with another academic leader who has survived this type of tragedy.
Talking with deceased's family	
Talk with the family	▪ Seek legal advice regarding disclosure, as patients' HIPPA rights still pertain. ▪ Discuss with colleagues how to frame the news to the family. ▪ Honor the deceased's emergency contact information. While another family member may be known to the program, it is important to contact the person listed. ▪ Provide the family with a single point of contact from the institution. ▪ Provide the family with resources—including how to file legal charges—if a patient assaulted the deceased. ▪ It is appropriate to say that all the facts are not yet known and will be shared as they emerge. ▪ State that the hospital will review the situation and change practices as appropriate to safeguard future trainees. ▪ If the trainee died outside of work, the family may know more about the situation and be able to provide insight into what happened. ▪ If the trainee died by suicide, review guidance on how to talk about suicide.[16] ▪ Be open to forming a bond with the family, as this may provide a measure of comfort to the family, trainees, and oneself.
Next steps: spreading the bad news	
Inform others as quickly as reasonable	▪ Convey accurate information before rumors spread.[17]
Inform the other trainees	▪ Inform the chief residents first, as they may know information to help frame the announcement appropriately. ▪ Tell the trainees next, before informing the larger community. ▪ E-mail faculty, signaling that something serious is happening and they need to cover clinical duties for the trainees. ▪ Pull all trainees from clinical duties so they can hear the announcement together. ▪ Time the announcement at the end of the day so that the majority of trainees can leave afterward. ▪ Choose a familiar and comforting location to inform the trainees. ▪ Consider providing some food or tea. Ask someone else to gather provisions. ▪ Allow ample time to convey the news so that it can be absorbed in degrees. ▪ Model sharing emotional reactions and thoughts about the deceased to encourage trainees to share. ▪ Provide contact information for grief counselors.
Make a plan for covering clinical services	▪ Explicitly state the expectation for patient care coverage and communicate it broadly.

TABLE
Tasks After the Death of a Resident or Fellow (continued)

Steps	Specific Actions
Inform the broader community	▪ Inform the broader clinical and academic community after meeting with the trainees. Provide grief counselors' contact information.
Handling memorial services	
Family's services	▪ Consider sending a representative to the family's services. Trainees may be comforted by knowing that they are represented and their condolences conveyed.
Local services	▪ Allow sufficient time to plan a local commemoration service. ▪ Gather trainees' ideas on the deceased's preferences and ask if they would like to be involved in the planning. ▪ Contact the hospital's interfaith services to help with arrangements and provide a suitable space. ▪ Notify family of the local service and invite them to attend.
Managing practical issues	
Revise and communicate call schedule	▪ Give trainees permission to discuss issues of covering call.
Empty office (eg, keys, IDs)	▪ Ask the deceased's family to return hospital equipment (keys, identification cards, beepers, patient care kits, laptops, simulation equipment, lab coats, and scrubs). ▪ Empty the trainee's office or locker. Patient records or any patient-related materials need to be properly disposed before the family can have their loved one's personal effects.
Recruit a new trainee	▪ Recruit another resident quickly, as residents will be concerned about managing additional clinical responsibilities. ▪ Include the current trainees in the process. They do not want to be blindsided and may want a voice in the selection. ▪ Include faculty in the recruitment process.
Ease transition for the new trainee	▪ Tell the new trainee about the deceased to help him or her fit into the local culture. ▪ Anticipate a long adjustment period for the new trainee. The trainee will need to learn about the culture, clinical policies and procedures, and personnel. ▪ Support the new trainee in the transition. Fellow trainees may not include the new trainee readily if friendships are already firmly established.
Inform the deceased's patients	▪ Request that the clinical service inform the trainee's patients as appropriate. This loss may complicate some patients' care as they absorb the news and start anew with a different clinician.[16]
Inform the deceased's mentors and faculty	▪ Reach out to faculty who supervised and mentored the trainee. If the larger community can support one another, the less alone and devastated each member will feel.[18] Faculty will need to heal and attend to self-care to maximize their own sense of well-being and productivity.[19,20]

Abbreviations: DIO, designated institutional official; HIPAA, Health Insurance Portability and Accountability Act of 1996; IDs, identification cards.

become "second victims."[14] They can feel empty or experience waves of grief.[21] Some trainees' health may deteriorate such that they cannot work or take call. Absenteeism may rise,[10] placing an additional strain on the other residents. Medical errors may increase.[22]

We wish we had predicted the risk of trainees' prolonged grief and complicated bereavement. It may have been helpful to discuss this risk openly, encourage trainees to seek help, or organize an additional team-building day. Helping people "make sense" of the loss and "bearing witness" to their pain, and not just saying, "Move forward," are important to help prevent feelings of burnout.[8,14,15,22,23]

This is a fine line to navigate. Some trainees will want to move forward and will find inquiries intrusive. Other trainees may need to be asked multiple times before they feel comfortable describing their pain. Knowing who needs what can be challenging.

Best practices from the organizational leadership literature support flexible time for grieving employees

or gradual reentry into the workplace.[22] How to balance trainees' need for grieving time with the service's need to staff emergency room shifts is a challenge.[1,13]

Grief may stir as the anniversary of the death approaches.[23] Anniversaries can affect well-being and even mortality.[24] Planning to mark the anniversary can ease anxiety, yet it presents its own dilemmas. While the impulse may be to create a named seminar series, for instance, there will come a time when all of the deceased's peers have graduated. A second option is to create something permanent, such as a plaque or award given at graduation, but residents may not want the reminder. It may help to survey trainees anonymously for their preferences.

Throughout this entire experience, people will watch leadership and observe how skillfully leaders communicate decisions and how faithfully they support others. This can weigh heavily on leadership. The program director should try to connect with other leaders who have experienced a death in the program.

Another way the program director or academic leader can maintain well-being is by reaching out[3] and expressing love. We choose to be educators because we love to teach and have a desire to pass along the wisdom we have.[3] While a trainee's death is a painful tragedy, it also can be an opportunity to grow, connect, and love.

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