



After a Suicide:

A Toolkit for Physician Residency/Fellowship Programs



AMERICAN FOUNDATION FOR
Suicide Prevention

afsp.org

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At a Glance

In the event of a suicide within a physician residency or fellowship program, it is critical to have a plan of action already in place. This toolkit gives you a foundation for doing so. First and foremost, we encourage you to assemble a Crisis Response Team (pg. 5), and have provided a Suggested Communication Plan (pg. 6).

This toolkit also serves as a practical handbook to consult at the time a suicide death does occur. You will find guidance and step-by-step lists on how best to go about:

- Gathering information (pg. 7)
- Communicating with the deceased's emergency contact (pg. 8)
- Notifying the community (pg. 10)
- Helping residents, as well as faculty and staff, cope (pgs. 14-15)
- Dealing with the practical consequences on schedules and workflow (pg. 16)
- Coordinating and planning a memorial (pg. 17)

You will also find within the Appendix (pg. 20) immediately usable advice and checklists including Tips for Talking about Suicide (pg. 23); Sample Scripts to be Used in Face-to-Face Communication (pg. 25), and Sample Email Death Notifications (pg. 27); a Memorial Service Planning Checklist (pg. 30); a Sample Media Statement (pg. 32); and Key Messages for the Media Spokesperson (pgs. 33-34).

It is our hope that you will read through this toolkit before an event takes place. Whether or not you do so, this handbook can serve as a useful guide in the immediate aftermath of a suicide.

**In this document the word 'institution' is used to mean employer of the deceased resident. The word 'resident' is used in the most inclusive sense to mean residents and fellows.*

Introduction

The death of a resident by suicide is devastating, shocking, and stressful for all involved. It can feel different than the death of a patient and may be more like that of a family member or close friend. There are also aspects of suicide loss that can be traumatizing for many.

Being aware of the experiences common to suicide loss can help:

- Prevent contagion
- Allow the community to grieve and feel supported
- Raise awareness of the mental health needs of the community
- Engage in suicide prevention efforts at a later stage

It is also important to remember that the resident is a colleague or hospital employee. While physicians may have experience in dealing with patient deaths, managing the death of a resident carries with it a different set of responsibilities. Thankfully, this is not an everyday experience – but this means residency/fellowship training programs are often uncertain about how to respond and need reliable information, practical tips and tools, and guidance readily available.

Experts in graduate medical education, resident distress and wellbeing, and suicide have collaborated to make this toolkit to help residency/fellowship training programs in the aftermath of a resident death by suicide. The toolkit contains consensus recommendations endorsed by the American Foundation for Suicide Prevention (AFSP). It is designed to offer practical tips, modeled after the gold standard resource, “After a Suicide: A Toolkit for Schools,”¹ co-developed by AFSP and the Suicide Prevention Resource Center. Additional resources are provided in the Appendix. Key considerations, general guidelines for action, do’s and don’ts, templates, and sample materials are provided on strategies for notification of the event and support of the community. This toolkit may serve as a guide for the development of a local action plan.

It is important to have procedures in place that approach all resident deaths in a similar fashion. Processes for notifications, bringing residents together as a community, and creating memorials should be the same when responding to the death of a resident who dies by suicide, by car accident or from cancer. This approach minimizes stigma and reduces the risk of suicide contagion.

Proactively Developing a Suicide Response Plan

Ideally institutions will develop a suicide response plan prior to a suicide occurring. If the institution already has a protocol for death of a trainee, steps should be taken to ensure it specifically addresses suicide. Suicide death should be addressed in a similar manner as other types of death. However, there are some unique aspects of suicide loss that require consideration. Having a plan in place will facilitate a coordinated response by a team of individuals who can support each other. Development and endorsement of such a plan should involve key stakeholders, such as Designated Institutional Official (DIO), Education Committee leaders/Associate Deans, Graduate Medical Education (GME) Dean, House Staff Mental Health Service or Employee Assistance Program personnel, GME office staff, resident/fellow representative, communication office, human resources, and legal.

The plan should include details about:

- Ensuring the emergency contact list is updated yearly
- Reinforcing importance of timely arrival and notification of absences during orientation
- Addressing a missing resident
- Confirming death of a resident and how to do so
- Developing a Crisis Response Team
- Communicating with emergency contact/family
- Notifying residents and faculty
- Determining who needs to know what (program of deceased resident vs. larger medical community)
- Creating face-to-face, phone, and written notifications
- Planning a memorial service
- Managing media inquiries
- Managing social media
- Supporting wellbeing of residents, faculty, other staff, and Crisis Response Team members

Once developed, the plan should be widely disseminated to Program Directors (PDs) and Program Coordinators (PCs), along with GME office personnel. Awareness of the plan should be part of all GME staff orientations. The plan should be easily locatable after-hours and on weekends by key personnel, such as PDs and the DIO.

Checklist for After a Suicide

Day 1

- Immediate notifications (see Figure 1)
- Meeting(s) with residents
- If not already in place, develop a Crisis Response Team using the template on Page 5

Day 2

- Remaining announcements (see Figure 1)
- Check in individually with any at-risk residents
- Use noon conference to debrief with residents with mental health professional
- If Chairperson was not at earlier meetings with residents, beginning of this meeting is another opportunity for him/her to check in with residents
- Check in with deceased resident's emergency contact/family regarding funeral arrangements and next steps, plans to meet

Day 3-4

- Consider cancelling didactics and convening residents to gather
- If possible, provide meals over the weekend. Ask attending(s) covering the weekend to check in
- For residents not on call for the weekend encourage informal gatherings
- Let residents and faculty know about funeral arrangements and address for condolence cards/social media site
- Debrief with Crisis Response Team

Week 1

- Check in daily with Chief Residents (CRs) – they will be on the frontline and will know who is struggling; this is also a very difficult time for CRs
- Crisis Response Team continues to meet for debrief, monitoring of community, and carry out of communication next steps

Week 2

- Return to regularly scheduled didactics
- Make statement that this is still early in grieving process, reinforce continued availability of mental health services, caring for each other, faculty who are available to speak, etc.
- Check in with family regarding any HR issues (benefits, final paycheck, hospital apartment, returning of electronic devices, etc.) and Memorial Service
- Plan Memorial Service
- Ask faculty advisors to check in with advisees, plan group dinners, etc.
- Debrief with the Crisis Response Team
- Provide suicide loss resources to community/appropriate individuals (afsp.org/AfterALoss)

Checklist continued on next page >

Week 3-4

- Consider another noon conference to debrief with residents with mental health professional
- Continue checking in with CRs and think about best ways to support them (take them out for nice lunch or dinner)
- Continue to monitor schedules and work flow
- Monitor residents coping as described above
- Debrief with the Crisis Response Team – refine plan

Beyond the first month

- Hold memorial service if not done already
- Consider monthly process groups with mental health professional
- Attend to resident wellbeing issues
- Develop a departmental resident wellbeing plan
- If not already done, develop an institutional suicide prevention plan

Crisis Response Team

A Crisis Response Team serves an important role following any critical incident, including the loss of a trainee to suicide. The team carries out the critical aspects of crisis management in the aftermath of suicide loss: communication, support of the community, and prevention of contagion.

Selecting the team leader and members can be accomplished in a number of ways, but the team should include several key individuals such as: DIO, PDs, other key faculty, CR, mental health professionals, and other key staff such as PC and hospital staff (from nursing or other services). The team leader needs to ensure the checklist is carried out.

In some instances, the DIO may be best suited to lead the team, and in other instances, it may make more sense for the PD or other key program faculty to take the lead.

The following is a template to assist in the development and action planning of your Crisis Response Team.

Team Leader: _____

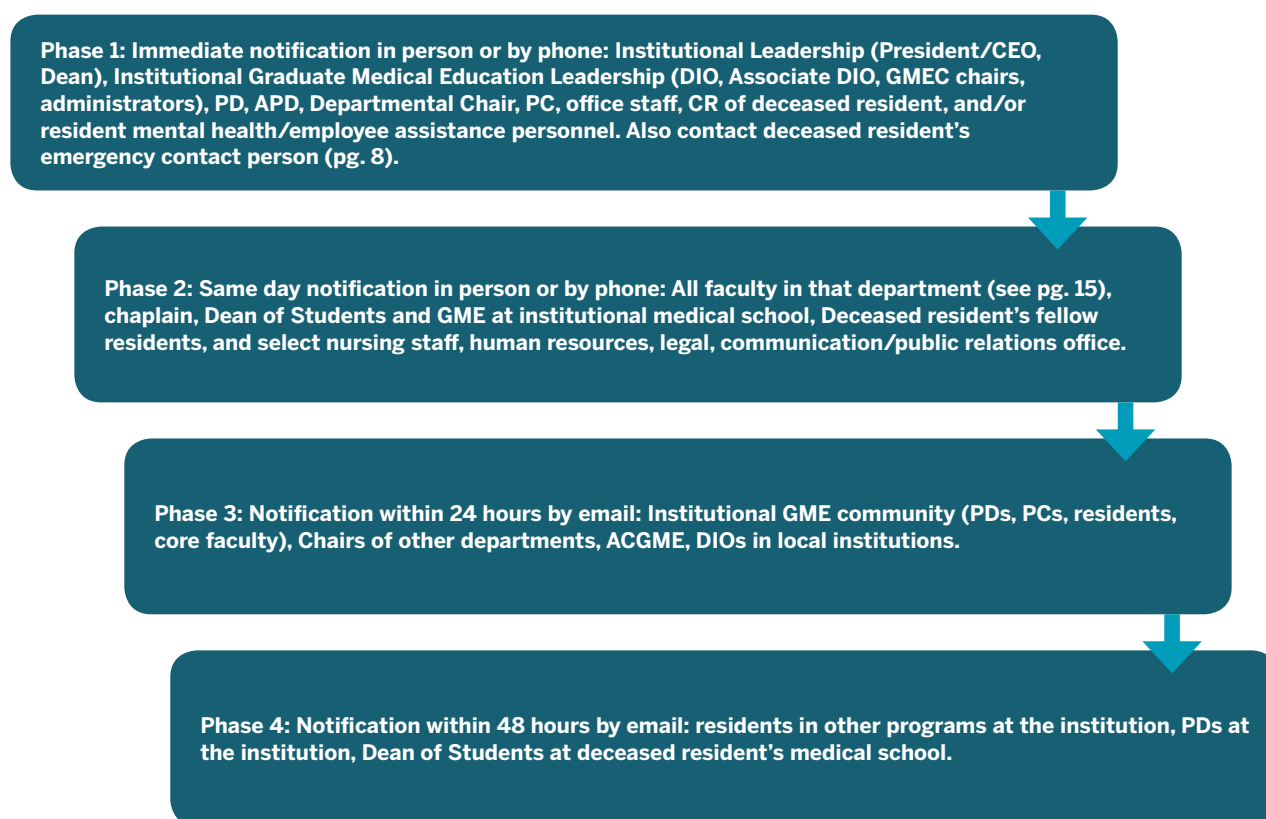
Team Member	Tasks from Checklist	Date Completed

Crisis Response Communication Plan

Once the death has been confirmed by the institution, a coordinated crisis response should be implemented to manage the situation, provide opportunities for grief support, help residents and faculty cope with their feelings, and minimize the risk of suicide contagion. (see Crisis Response Team, pg. 5)

First, a Crisis Response Team should be identified. This team should coordinate communication across the graduate training program, associated institution, and others. Keeping a list of individuals who need to be informed and a plan for who will speak to each individual along with notes of when completed is useful (see **Appendix A** for example). Whom to notify when and in what manner varies. One approach and list of potential individuals to communicate with is shown in Figure 1.

Figure 1: Communication Plan



The first people to notify are those who need to know while formal announcements are prepared and fellow residents (residents in the same program as the deceased resident) are notified (see Sharing the News, pg. 10). A suggested communication checklist can be found in **Appendix A**.

Get the Facts First

In the event of a possible death of a resident, it is imperative to obtain accurate facts. Obtaining as much information as possible helps alleviate speculation and rumors that can fuel emotional turmoil within a training program. Sometimes the family learns of the suicide first and informs someone at the institution, such as the PD; in other cases, the death of a resident comes to light after the resident does not report for duty or after a phone call from local authorities, Emergency Dept. personnel, or others. Depending on the situation, facts may be obtained or clarified by contacting the coroner, medical examiner's office, or local law enforcement.

The cause of death should not be disseminated without first speaking with the family about their preferences. Full discussion of this can be found in Sharing the News (pgs. 10-14) and Appendix D (pgs. 27-29).

Missing Resident

A resident not showing up for work may be a serious problem or a simple mistake. Now that many residents do not have a land line, or in some situations a pager, we are dependent on a charged cell phone for contact.

Residency training programs should have a process in place for how to deal with a resident who does not arrive when expected (see the box below for a suggested strategy).

Step-Wise Approach to Finding a Missing Resident

- 1. Page, text, and email the resident**
- 2. Call the resident's home or cell phone**
- 3. If there is no response, next options include:**
 - a. Calling resident's emergency contact/family**
 - b. Contacting local police or hospital security to request a welfare check**

Informing the Emergency Contact Person

Individuals within the training program may be the first to know a resident has been declared deceased. In such a situation the crisis response leader or a delegate (e.g., DIO or Residency Training PD) should contact the emergency contact person immediately. Every resident should have emergency contact information on file (phone numbers, email address, and names of parents, spouse/partner, or other emergency contact person). Such information should be updated yearly.

In other situations the police may know first, and they will have their own protocol for managing this and notifying the next of kin. If the resident was brought to the Emergency Room, it will be the physician who declares the individual deceased who would likely make the call. In situations where another individual has disclosed the death of a resident, it is still important that the Crisis Response Team Leader or a designated individual from the institution call the emergency contact person.

Prior to calling the emergency contact person it is helpful to obtain as much information as is currently available (see *Get the Facts First*, pg. 7) as well as information about what, if anything, has already been conveyed to the emergency contact person by others (e.g., police, emergency dept. physician). This initial call should focus on condolences and extending support. Ask what the residency training program can do to assist, and discuss the family's preference regarding what information is provided to the faculty and fellow residents. The family may ask what happened. Sometimes it is not clear early on if the death was by suicide or if the death was accidental. Starting by asking what they have heard or what they understand about what happened may be helpful. Be careful about sticking to the known facts and avoiding any conjecture. Ask if they have thought about funeral arrangements and if residents and faculty from the program can attend. Some families wish for the funeral to be private.

Although difficult, it is vital to discuss what information can be relayed to faculty and residents. If the death is determined to be a suicide and the family does not want it disclosed, the emergency contact person should be informed that it would be helpful for fellow residents to know the cause of death. It is important to tell the emergency contact person that faculty and fellow residents are deeply affected by the passing of their loved one and would benefit from honest disclosure of cause of death. Doing so enables peers, faculty and support staff to fully process and grieve the death of the resident, to learn more about suicide and its causes, and, importantly, is an important step to keeping the residents safe and avoiding more tragedy. That said, it should be kept in mind that the family may be in a state of shock immediately following the death, and may not be ready to accept suicide as the cause of death; it is advisable not to push too hard, with the understanding that acceptance may arise within 24-48 hours.

End the conversation by providing information about how the emergency contact person can reach one particular contact person (typically the caller) if questions arise following the initial call. If that person is not the individual making the initial call be sure that is clearly conveyed to the emergency contact person. Also, let them know to expect a follow up phone call within a few days. Suggested topics to cover with the emergency contact person can be found in the chart on Page 9. It may be relevant to inform the family of anticipated media attention surrounding the death of their loved one. Although suicides happen all over the world every day, the death of a resident may draw unwanted media attention and the caller can help prepare the emergency contact person.

Topics to cover with the emergency contact person /family

First call

- Introduction (identify who you are and your role at the institution)
- Condolences
- Ask what they have been informed of thus far, and gather any other knowledge or thoughts they may have (but be careful not to confuse this person's conjecture with fact)
- Ask permission to speak with fellow residents about cause of death
- Offer to meet
- Assistance the institution can provide to the emergency contact person or family
- Potential for media attention (they are not obligated to take interviews, and can refer media to the institution's communications team if they prefer)
- Contact information for investigating officer
- How best to contact the emergency contact person going forward and how that individual can best contact the caller (phone number, email, evening/weekend)
- Commitment to calling again the next day

Second call at 24-48 hours

- Willingness to share funeral plans, may flowers be sent, and may faculty and residents attend
- If appropriate, desire for on-campus memorial service and acceptable venue
- Assistance the institution can provide:
 - Collecting deceased resident's belongings before their arrival
 - Finding local hotel
 - Packing up belongings (if the death occurred inside the resident's housing it will likely be sealed by police during their investigation and unavailable)
- Release of home address for condolence notes
 - The program may want to collect condolence notes and send to the family in one package
- Discussion with family about the institution placing an obituary
- Assistance with administrative or human resource issues (insurance, final paycheck)
- Provide resources for suicide loss survivors (afsp.org/loss)

Subsequent call, up to several weeks later

- Coordinate with family and HR regarding found items (e.g., pagers, electronics)

Sharing the News

Following notification of key personnel and the emergency contact person, a plan must be developed and implemented for how to notify fellow residents of the deceased resident and relevant faculty. What to say and how to say it varies by the group being informed along with the family's wishes.

It is critically important for steps to be taken to ensure that suicide contagion risk is minimized to every extent possible. Contagion risk is heightened when a vulnerable individual is exposed to sensationalized communication about the suicide or when the deceased's manner of death or life is portrayed in an idealized manner.² The risk of suicide contagion is mitigated by including support and mental health resources in several communications, and ensuring that every communication following the death is vetted with the following do's and don'ts in mind:

DO'S	DON'TS
Avoid contagion	
<p>In written communications, acknowledge the tragic loss to suicide of a member of our program (and call it a suicide if emergency contact person has given permission). But do not include the suicide method in written communications.</p> <p>During in-person meetings, it's ok to mention the method of suicide, but avoid dwelling on the manner of death during in-person conversations (e.g., "_____ took his life by hanging. We probably won't ever fully know all of the factors that led to his suicide, but we recognize that there must have been overwhelming pain/struggle and we grieve his loss").</p>	<p>Don't include graphic or detailed descriptions of the suicide method, location, circumstances surrounding the death</p> <p>Don't highlight pictures of the location or sensationalized media accounts</p> <p>Even during in-person meetings, avoid providing more detail than the general method (e.g., "died by overdose, hanging, took his life using a firearm"). Going beyond this into more detail is not advisable especially in written or group settings.</p>
Don't glorify the act of suicide	
<p>Talk about the person in a balanced manner. Avoid idealizing the person and only extolling virtues. Do not be afraid to include the struggles that were known, especially during conversations.</p>	<p>Try to avoid describing the deceased resident only in terms of his/her strengths. This paints a picture of suicide being an option/solution or presents a confusing picture when the person's apparent struggles aren't mentioned or alluded to.</p>
Encourage help-seeking	
<p>Always include the list of resources and the after-hours numbers that anyone can call 24/7. Include the National Suicide Prevention Lifeline at 1-800-274-TALK (8255), and the Crisis Text Line at 741-741.</p>	<p>Don't portray suicide as a reasonable solution to the person's problems.</p>
Give accurate information about suicide	
<p>Explain that suicide is a complicated outcome of several health and life stressors that converge at one moment in a person's life to increase risk. Mention the fact that mental health is a real part of life, dynamic and changing like other aspects of health, that we all have common life struggles, and can support one another. Explain that along with risk factors, there are known protective factors that mitigate risk for suicide. Emphasize the institution's stance on help seeking as a sign of strength, a way to show the most proactive mature level of professionalism. Mention the fact that there have been times when all good leaders have sought support or healthcare to the good of their personal health/wellbeing, as well as for the betterment of their professional work.</p>	<p>Don't portray suicide as the result of one problem, event or issue.</p>

Notification should occur as soon as possible, ideally the same day of the death or before work starts in the morning. If there are residents who were very close to the deceased who are known to the institution (significant others, close friends), they should be notified first and separate from the others. Members from the Crisis Response Team should connect regularly with these individuals over the next few weeks.

Although it is permissible to disclose a resident has died, the cause of death should not be disclosed unless approved by the emergency contact person. In situations where the family does not want the cause of death shared with other residents, it is still important to acknowledge the death and follow that immediately by saying or writing about the supportive mental health resources that are available to the residents. If the cause of death has not been confirmed and there is an ongoing investigation, individuals on the Crisis Response Team should state that the cause of death is still to be determined and additional information will be forthcoming. Suggested processes and oral as well as written scripts to help convey this information are provided below and in **Appendix C and D**.

Notifying residents in the same program as the deceased resident

- Should occur in-person the same day of the death or before work starts in the morning
- If possible to divide the residents into small groups to deliver the news, this is recommended in order to encourage honest dialogue and to avoid group escalation in anxiety, which is more likely in a large group setting; if not possible, the office staff should secure a room large enough to hold all residents in the same program as the deceased resident
- The office staff should page/call every resident telling them of an emergency mandatory meeting; residents who cannot be reached by phone can be emailed with instruction to call in as soon as possible regarding “sad news”; residents who are off from work should be called and asked to come in to attend the meeting
- Program Leadership including APDs and PCs should attend this meeting
- It can be helpful to have mental health counselors/psychologist, chaplain services, and employee assistance counselors available at the meeting when possible

During the meeting, the Crisis Response Team members should introduce themselves (if not known to the residents) and other guests. Tips for how to talk about suicide and avoid contagion are provided above. Sample scripts to relay information in person about the death can be found in **Appendix C**. Share accurate information about the death of the resident, as permitted by the emergency contact person.

If the emergency contact person refuses to allow disclosure, members of the Crisis Response Team can state: “The family/emergency contact person has requested that information about the cause of death not be shared at this time.” Members of the Crisis Response Team can take the opportunity to talk with residents about suicide in general terms, and state:

“We know there has been a lot of talk about whether this was a suicide death. Since the subject of suicide has been raised, we want to take this opportunity to give you accurate information about suicide in general, ways to prevent it, and how to get help if you or someone you know is feeling depressed, struggling, or may be suicidal.”

Allow residents to express their grief, and identify those who may need additional support and resources. Explain that everyone's grief response is different — some residents will need time off and others may find solace in working. Commit to providing coverage or changing schedules as needed. Remind all residents of the importance of seeking help if they are experiencing difficulty, and how to do so.

- Remind the residents of the processes in place for accessing care:
 - Provide a list of individuals, such as attendings who are available to residents, and who the residents can reach out to talk about the loss and to debrief; this is not mental health treatment, but rather supportive debriefing with an advisor/mentor
 - Include institutional and community-based mental health providers
 - Clinical treatment may be indicated for sleep, anxiety, mood and prevention of a depressive episode (e.g., in a resident with a history of recurrent depressive episodes); explain how residents can access treatment, if indicated
- Address barriers to engaging in self care:
 - Explain the process for taking time off and how CRs or PDs will help arrange coverage; emphasize that over the course of training everything evens out and colleagues are happy to cover for them
 - Remind residents that the PDs will not know who is receiving mental health care; consider having people in the audience speak about their own experience about seeking mental health care, or stating that many people who have never sought mental health services find speaking with a trained mental health professional at times like these very helpful
 - Some residents may have heard that seeking mental health services may have negative ramifications on licensure; in fact, unaddressed mental health problems are much more likely to negatively impact safe practice or medical licensure than appropriate help-seeking behaviors
- Remind residents if they have struggled with depression themselves or are actively getting mental health care, they may want to check-in with their therapist
- Inform them of a clear mechanism to help identify anyone they are concerned about (e.g., who should they bring that information to if concerned)
- Share information about suicide bereavement groups in the community (afsp.org/SupportGroups has a list of over 800 nation-wide support groups)
- Ask if residents know if there are others (outside of the institution) who may need to be notified or sent resources; for example, the resident may have a significant other in the local area who is not known to the family but whom friends of the deceased know
- As applicable, inform the residents about the funeral and process for requesting time-off to attend the funeral
- Discuss plans for a memorial service (see **Appendix E**)

Residents may also experience guilt about not recognizing the signs of distress and suicide risk in a co-resident. As physicians, residents tend to be people who are sensitive to others, and not having “noticed” the signs of distress can induce guilt. It is important to remind everyone that residents often feel the need to appear strong as part of their identity as physicians, and may likely cloak their feelings of anxiety, worry, and/or other psychiatric symptoms in order to carry out their job. This both makes it difficult to identify those in distress so they can receive assistance and ends up making individuals feel more isolated as no one knows how they really feel. Remind residents that hindsight is 20/20; as with all health outcomes, while many suicides can be prevented, not all can.

This is really a great opportunity to highlight the importance of reaching out and the complexity of suicide — that it has multiple “causes” and that often, we do not know all of the things that the person was contending with, physically, emotionally or in terms of their life stressors/past experiences (for tips on how to talk about suicide, see the textbox on Page 10, and **Appendix B**).

There are likely to be individuals in the group who are more deeply affected by the death. It may be difficult to meet their needs during the initial meeting. It might be helpful to allow for a separate time for those who wish to discuss in more detail, particularly if the reporting is to a larger group. For example, Crisis Response Team members could offer to spend an additional 30 minutes with anyone who wants to talk further about the death. It’s best to provide several options for individuals to speak with, including one to two individuals outside the program or even home institution, since privacy is very important to some trainees and faculty.

A second meeting with the residents may also be wise to encourage them to think about how they would like to remember their comrade. Ideas include writing a personal note to the family, participating in or attending the memorial service, and/or doing something kind for another person. Other reflective activities such as writing, poetry reading, or an art project can also be very helpful. These can be done individually or as a group. It is important to acknowledge the need to express their feelings while helping them identify appropriate ways to do so.

At the end of the meeting the Crisis Response Team should gather to review the day’s challenges, debrief and share experiences and concerns, consider strategies for individuals who may need additional support, remind each other of the importance of self-care, and plan for next steps and follow up. This might also be a good time to write an email to the residents and key faculty about resources that were verbally shared during the meeting and any next steps.

Immediately after this meeting it is critical to inform attendings and staff assigned to the services with affected residents/fellows (e.g., Emergency Dept. staff, Hospitalist Services, etc.) and nursing leadership (so that they can let the nurses on the floor know) about the death and the fact that the residents have just been informed. These individuals may have known the resident and may also be affected by this news. It is also important that these individuals understand that some residents may be distraught when they return to the floor.

Fellow residents in the same program as the deceased resident who did not attend the in-person meeting should be informed as soon as possible, preferably by telephone and not email.

Written communication with others

Next, an email announcement should be sent to members of the surrounding graduate medical education community (e.g., PDs, PCs, and residents of other programs, core faculty of the deceased resident’s program), Chairs of other departments, ACGME representative, DIOs in the local community, and Dean of Students at deceased resident’s medical school. Such communication should be sent within 24-48 hours. A follow-up email can be sent later with details regarding the obituary, address of emergency contact person and if applicable, funeral/memorial service information. Sample email scripts can be found in **Appendix D**. A similar approach should be used for cases of death by any cause.

For PDs and GME leaders at other institutions/hospitals in the surrounding geographical area, particularly where residents from different programs have rotations together, a thoughtful approach to whether an announcement should be made must be considered. On the one hand, if residents at other programs have learned about the death, it can be helpful for leaders to gather them together to provide factual information and similar messages about the importance of wellbeing, support being available, and help seeking being a sign of strength. However, if most residents have not become aware, this type of messaging can create unnecessary anxiety. It is recommended to start by meeting with the CRs to determine the level of knowledge among the residents, as well as to gauge the tone and level of concern the community is experiencing.

Helping Residents Cope

In the aftermath of a suicide, residents may feel emotionally overwhelmed, and this can disrupt patient care as well as learning and overall performance. Most residents have mastered basic skills to control their emotions, but these skills can be challenged in the setting of a suicide. For some residents it will be their first experience of death of an individual they personally know, let alone by suicide. As physicians, however, the residents are likely to recognize complex feelings and physical indicators of distress, such as stomach upset, restlessness, and insomnia. Some may experience a suicide death as a psychological trauma, and will have symptoms related to that (hypervigilance, avoidant responses, intrusive memories, numbness, sleep disruption, or negative changes in mood). These symptoms should lessen in intensity over time; if they do not lessen or if they are at a level of severity that interrupts the resident's functioning, the resident should be encouraged to seek out mental health care.

It may be helpful to reach out to residents to help them deliberately process their emotions, and to better identify those who may need additional support. Counselors can meet with small groups of residents to help express feelings and discuss safe coping strategies. Residents can be encouraged to use relaxation or mindfulness skills as a way to cope with intense emotions related to the event. *Residents may need to hear permission from the PD that they should engage in activities that will help them feel better and to take their mind off the stressful situation, as well as permission to seek help.* Participating in rituals, such as attending a funeral or memorial service, may help the resident resume their daily lives and responsibilities.

Pay attention to residents who are having particular difficulty, including those who may have struggled previously, or who begin to show signs of deteriorating health/wellbeing, e.g., tardiness, sick days, short temper, trouble managing workload, or any persistent changes from baseline behavior patterns. Encourage them to talk with counselors, Chaplain, and other appropriate personnel.

The loss of a resident also has practical consequences on schedules and work flow, particularly in the residency class which has lost their colleague. Consider solutions such as providing increased physician extender coverage for that year. The one-year anniversary of the death, or other significant dates such as the deceased's birthday, may stir up emotions and can be an upsetting time for residents. Residents may also be desensitized to death in general, and may react to patient death differently. While physicians can become desensitized to patient death, the death of a peer, particularly by suicide, can evoke strong emotions. It is helpful to anticipate this, particularly for those residents who were close to the deceased resident or who are exposed to other deaths or challenges soon after the loss.

Supporting Faculty and Staff

Although the faculty and staff will have known the resident to varying degrees, the experience may still have a powerful personal impact. Taking the time to offer support in the aftermath of a traumatic event is important. Some faculty and staff deeply touched by the experience may need to discuss with their immediate supervisor whether they can take the rest of the day off and how to handle the immediate workload. These individuals may also be directed to Employee Assistance Program personnel or other in-house experts.

Staff who will likely be impacted include nursing staff, and other disciplines in the clinical settings where the resident worked. Make an effort to communicate support to this broader network of the hospital/clinical community and make sure key leaders such as Chief of Nursing, PT, OT, etc. are made aware. (see **Appendix D** for template emails)

Faculty and staff should be reminded that:

- Caring for oneself is an important part of professionalism and is critical in caring for others; residents learn from watching others model solid self-care practices
- Unattended feelings can lead to poor communication skills
- If you see something say something (speak with the resident, call the PD), e.g., if you notice changes in a resident's behavior, irritability, etc.
- Build relationships with residents deliberately
- Residents are working extremely hard — remember to acknowledge that and thank them
- Share your own experiences mindfully — it is important for residents to know that many of the difficulties are a part of training
- If you are worried about a resident, call the PD

Ideally steps should be taken so that one individual, such as a PD, does not have to tell the story of the resident's death repeatedly. Using a Crisis Response Team, as previously described, helps ease the burden.

Faculty and staff deeply affected and members of the Crisis Response Team should have debriefing meetings with in-house experts. Reaching out to these individuals two to eight weeks after the event is also a useful way to support their wellbeing and ongoing bereavement.

Working with the Community

It may become necessary in the aftermath of a suicide to communicate with community partners such as the coroner/medical examiner and police.

If warranted, the coroner or medical examiner is the best starting point for confirming that the death has in fact been declared a suicide. (In some cases, it may also be necessary to contact the police department to verify the information). However, given how quickly news and rumors spread (including through media coverage, email, texting, and social media), institutions may not be able to wait for a final determination before they need to begin communicating with the residents and faculty. There may also be cases in which there is disagreement between the authorities and the family regarding the cause of death. For example, the death may have been declared a probable suicide but the family believes it to have been an accident or possible homicide. Or the death may have been declared a suicide, but the family does not want this communicated, perhaps due to stigma, for fear of risking contagion, or because they simply do not (yet) believe or accept that it was suicide.

Institutions have a responsibility to balance the need to be truthful with the community while remaining sensitive to the family. As mentioned above, this is an opportunity to educate the community (including potentially vulnerable residents) about the causes and complexity of suicide and to identify available mental health resources. Communication scripts can be found in **Appendix C and D**.

The police will likely be an important source of information about the death, particularly if there is an ongoing investigation (for example, if it has not yet been determined whether the death was suicide or homicide). The Crisis Response Team will need to be in close communication with the police to determine (a) what they can and cannot say to the community so as not to interfere with the investigation, and (b) whether there are certain residents who must be interviewed by the police before the Crisis Response Team can debrief or counsel them in any way. In situations where law enforcement need to speak with residents to help determine the cause of death, a Crisis Response Team member may offer to accompany the residents for this discussion and notify institutional legal counsel.

Memorialization

Communities often want to memorialize a resident who has died. It can be a challenge to balance meeting the needs of distraught residents and staff while preserving the day-to-day activities of taking care of patients and learning. It is very important to treat all resident deaths in the same way to the extent possible. The approach for responding to the death of a resident from a car accident or cancer should be the same as for a resident who dies by suicide. This approach minimizes stigma and reduces the risk of suicide contagion. In the case of suicide it is very important not to inadvertently glamorize or romanticize the deceased resident or the death. It is best to emphasize the link between suicide and underlying mental health problems (such as depression, anxiety, and burnout). These conditions can cause substantial psychological pain while not being apparent to others.

The first step is to discuss with the emergency contact person if they approve of a memorial service or remembrance event, and if so what an acceptable venue would be. Particular religious beliefs may make a chaplain service inappropriate, for example.

A memorial service planning checklist can be found in **Appendix E**.

- In choosing a location, it is best that the memorial service not be held in regular meeting rooms; doing so could inextricably connect the space to the death, making it difficult for residents and faculty to return there for regular learning
- The location should not be the place of death
- It is also best if services are held outside of regular hours; involving family and the resident's close friends in planning the memorial can be helpful
- It is important to provide an opportunity for residents to be heard; it will be valuable to remind all who will be talking at the funeral the importance of emphasizing the connection between suicide and underlying mental health issues, and not romanticizing the death in any way
- When announcing the memorial be sure to include details regarding what to expect and policies for attending funerals, arranging coverage for clinical assignments, and other relevant details
- Counselors and mental health professionals should attend the memorial and be available to provide support
- Attendees should be requested, if at all possible, to turn off their phones and pagers as a sign of respect to their deceased colleague; being able to truly focus for this brief span of time means a great deal to those most intimately affected by the loss

Sometimes there is a desire to establish a permanent memorial (e.g., planting a tree, installing a bench or plaque, establishing a scholarship). Although such memorials may not increase risk of contagion they can be upsetting reminders to bereaved residents and faculty. Careful consideration should be given to whether a permanent memorial is warranted, and this should only be done if this is protocol for other resident deaths. If possible, permanent memorials should be located away from common areas of work and learning. It is also important to remember that once a permanent memorial is set up, it establishes a precedent that can be difficult to sustain over time.

Other approaches for memorialization include:

- Holding a day of community service or creating an institutional-based community service program in honor of the deceased
- Putting together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations (e.g., [outofthedarkness.org](https://www.outofthedarkness.org)), or holding a local fundraising event to support a local crisis hotline or other suicide prevention program
- Sponsoring a mental health awareness day
- Purchasing books on mental health for the local library
- Working with the administration to develop and implement a curriculum focused on effective problem-solving or other pro-mental health activities such as mindfulness
- Volunteering at a community crisis hotline
- Raising funds to help the family defray their funeral expenses
- Making a book available in a common space for several weeks in which residents and faculty can write messages to the family, share memories of the deceased, or offer condolences; the book can then be presented to the family on behalf of the community

Online Memorial Pages and Social Media

Online memorial pages and message boards have become common practice in the aftermath of a death. At times training programs/institutions may choose (with the permission and support of the deceased resident's family) to establish a memorial page on the program's website or on a social networking site. As with all memorialization following a suicide death, such pages should take care not to glamorize the death in ways that may lead other at-risk residents to identify with the person who died. It is therefore vital that memorial pages utilize safe messaging, include resources, be monitored, and be time-limited.

It is recommended that online memorial pages remain active for up to 30 to 60 days after the death, at which time they should be taken down and replaced with a statement acknowledging the caring and supportive messages that had been posted and encouraging residents who wish to further honor their friend to consider other approaches.

If the deceased residents' friends create a memorial page of their own, it is important that the Crisis Response Team communicate with the friends to ensure that the page includes safe messaging and accurate information.³ An example of recommended language for a friends and family memorial page could include: "The best way to honor your loved one is to seek help if you or someone you know is struggling." When possible, memorial pages should also contain information about where a person in a suicidal crisis can get help (e.g., National Suicide Prevention Lifeline at 1-800-273-TALK (8255), or the Crisis Text Line at 741-741). Crisis Response Team members should also join any resident-initiated memorial pages so that they can monitor and respond as appropriate.

Social media should be monitored for several weeks following the death. A member of the Crisis Response Team who is adept at social media can watch for distressed posts by other residents, and also for posts that get into graphic details about suicide, pictures of location of death, or memes that make suicide seem like a positive outcome, e.g., meme of picture from movie Aladdin: “Genie, you’re free” that unfortunately went viral after Robin Williams’ death.

Media and the Press

A member of the Crisis Response Team should be assigned to media relations. A media statement should be prepared (see **Appendix F** for example) and a designated media spokesperson identified. Identifying key messages for the media spokesperson can be helpful (see **Appendix G** for example). Typically only authorized staff or institutional communication personnel should speak with the media. It may be best to advise residents to avoid interviews with the media. The media can also be provided guidance on how best to report on suicide to minimize risk of suicide contagion (afsp.org/SafeReporting).

Moving Forward

Promoting the wellbeing of residents and, in fact, all members of the institution, requires a long-term, sustained effort. Continuing to improve the learning environment and support for trainee wellness must occur beyond the acute phase after a suicide. A few months following the suicide, institutions should consider implementing:

- Suicide awareness programs to educate residents and faculty about the symptoms of depression and the causes of suicidal behavior
- Programs to educate residents and staff about physician mental health and the risk of suicide among physicians
- The AMA has developed a set of resources to address physician mental health that is available at stepsforward.org/modules/physician-wellness
- A suicide prevention program that utilizes an educational campaign directed at all levels of the institution and specific mechanisms for help seeking to be safe and encouraged⁴
- A database of such programs that have been determined by expert peer review to reflect best practices is available at the Best Practices Registry for Suicide Prevention (BPR), available at sprc.org
- Another source is the National Registry of Evidence-Based Programs and Practices, maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services; while few of the programs are specific to suicide prevention, this database includes mental health interventions that have been scientifically tested (available at nrepp.samhsa.gov)
- Some institutions may also wish to take collective action to address the problem of suicide, such as participating as a team in an awareness or fundraising event to support a national suicide prevention organization or local community mental health center

Appendix: Crisis Response Tools

A. Suggested Internal Communication List

	Who	When	Notes/Completed
Phase 1: Immediate notification by phone or in person			
Institutional leadership (President/CEO)			
Institutional graduate medical education leadership			
DIO			
Associate DIO			
GMEC chairs			
GMEC administrators			
PD of deceased resident			
Associate PDs of deceased resident			
Departmental Chair of deceased resident			
PC and office staff of deceased resident			
CRs of deceased resident			
Resident mental health/employee assistance personnel			
Phase 2: Same day notification in person or by phone			
Deceased residents' emergency contact person/family			
Chaplain			
Deceased resident's fellow residents			
Select nursing staff and attendings			

Checklist continued on next page >

	Who	When	Notes/Completed
Human resources			
Legal			
Communication/public relations office			
Phase 3: Notification within 24 hours by email			
Institutional GME community			
Chairs of other departments at the institution			
ACGME			
DIOs in local institutions			
Dean of students at deceased resident's medical school			
Phase 4: Notification within 48 hours by email			
Residents in other training programs at institution			
PDs of other training programs at institution			
Dean of students at institutional medical school			

B. Tips for Talking about Suicide

<p>Give accurate information about suicide.</p>	<p>By saying....</p>
<p>Suicide is a complicated behavior. It is not caused by a single event.</p> <p>Research is very clear that in most cases, underlying mental health conditions like depression, substance abuse, bipolar disorder, PTSD, or psychosis (and often comorbid occurrence of more than one) were present and active leading up to a suicide. Mental health conditions affect brain functioning, impacting cognition, problem solving, and the way people feel. Having a mental health problem is actually very common and is nothing to be ashamed of, and help is available.</p> <p>Talking about suicide in a calm, straightforward manner does not put ideas into residents' minds.</p>	<p>"The cause of ____'s death was suicide. Suicide most often occurs when several life and health factors converge leading to overwhelming mental and/or physical pain, anguish, and hopelessness."</p> <p>"There are treatments to help people with mental health struggles who are at risk for suicide or having suicidal thoughts."</p> <p>"Since 90 percent of people who die by suicide have a mental health condition at the time of their death, it is likely that ____ suffered from a mental health problem that affected [his/her] feelings, thoughts, and ability to think clearly and solve problems in a better way."</p> <p>"Mental health problems are not something to be ashamed of — they are a type of health issue like any other kind, and there are very good treatments to help manage them and alleviate the distress."</p>
<p>Address blaming and scapegoating.</p>	<p>By saying....</p>
<p>It is common to try to answer the question "why?" after a suicide death. Sometimes this turns into blaming others for the death.</p>	<p>"The reasons that someone dies by suicide are not simple, and are related to mental anguish that gets in the way of the person thinking clearly. Blaming others — or blaming the person who died — does not acknowledge the reality that the person was battling a kind of intense suffering that is difficult for many of us to relate to during normal health."</p>
<p>Do not focus on the method or graphic details.</p>	<p>By saying....</p>
<p>Talking in graphic detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable individuals.</p> <p>If asked, it is okay to give basic facts about the method, but don't give graphic details or talk at length about it. The focus should not be on <i>how</i> someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc.</p>	<p>"It is tragic that he died by hanging. Let's talk about how ____'s death has affected you and ways for you to handle it."</p> <p>"How can we figure out the best ways to deal with our loss and grief?"</p>
<p>Address anger.</p>	<p>By saying....</p>
<p>Accept expressions of anger at the deceased and explain that these feelings are normal.</p>	<p>"It is not uncommon to feel angry. These feelings are normal and it doesn't mean that you didn't care about _____. You can be angry at someone's behavior and still care deeply about that person."</p>

List continued on next page >

Address feelings of responsibility.	By saying....
<p>Reassure those who feel responsible or think they could have done something to save the deceased. Many physicians have exceedingly high expectations of themselves, and along with medical training, they may feel that they should have detected signs of suicide risk. The reality is that many cloak their internal distress (to their detriment) so that it can be challenging for even the closest people in their lives to observe the change in their mental state. This highlights the importance of asking and caring when you notice even subtle changes in others' usual way of behaving and approaching problems.</p>	<p>" ____ was a colleague, a friend, and not your patient. No one has the ability to predict imminent suicide. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident's behavior, just engage in a conversation with them, and if you are concerned encourage them to seek help and consider letting <insert name of appropriate local person> know."</p> <p>"This death is not your fault. This is an outcome we all would have wanted to prevent, and no one action, conversation or interaction is what caused this."</p> <p>"We can't always predict someone else's behavior. Especially when many of us are able to hide distress."</p>
Promote help-seeking.	By saying....
<p>Advise residents to seek help from a trusted mentor or mental health professional if they or a friend are feeling depressed.</p> <p>Communicate that we don't need to wait for a crisis — early help seeking is a sign of strength. If residents have thoughts of self-harm, encourage them to call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), text HELLO to the Crisis Text Line at 741-741, go to the emergency room, or call 911.</p>	<p>"We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried or depressed or had thoughts of suicide?"</p> <p>"There are effective treatments to help people who have mental health struggles or substance use problems. Suicide is never an answer."</p> <p>"This is an important time for all in our community to support and look out for one another. If you are concerned about a friend or colleague, you need to be sure to tell someone."</p> <p>"Whether you get help from recommended resources or others, the important thing is to get help when you need it."</p>

C. Sample Scripts to be Used in Face-to-Face Communication

Death ruled a suicide

It is with great sadness that I have to tell you that one of our residents, ____, has died by suicide. All of us want you to know that we are here to help you in any way we can.

A suicide death presents us with many questions that we may not be able to answer right away. Rumors may begin to circulate, and we ask that you not spread rumors you may hear. We'll do our best to give you accurate information as it becomes known to us.

Suicide is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors are not identified or noticed; in other cases, a person with a disorder will show obvious changes or warning signs. One thing is certain: there are treatments that can help. Suicide should never be an option.

Each of us will react to ____'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known ____ very well and may not be as affected, while others may experience a great deal of sadness whether you knew him/her well or not. Some of you may find you're having difficulty concentrating, and others may find that diving into your work is a good distraction.

We have counselors available to help our program deal with this sad loss and to enable us to understand more about suicide. If you'd like to talk to a counselor, these are the contacts [Insert contacts here.]

Sometimes physicians, when confronted by the death of a colleague, feel responsible. They wonder if there was "something that they missed." First, remember, that ____ was a colleague, a friend, and that ____ was not your patient. No one has the ability to predict imminent suicide. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident's behavior, just engage in a caring conversation and listen to their thoughts; if you are concerned encourage them to seek help and consider letting <insert name of appropriate local person> know.

This is a time to take a moment to be together, to remember ____ in our grief, and to support one another. Please remember that we are all here for you.

Cause of death is unconfirmed

It is with great sadness that I have to tell you that one of our residents, ____, has died. All of us want you to know that we are here to help you in any way we can.

The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask you only share information known to be factual since inaccurate information can be hurtful to those coping with this loss. Please also be mindful of the use of social media in discussing this event. We'll do our best to give you accurate information as it becomes known to us.

Each of us will react to ____'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known ____ very well and may not be as affected, while others may experience a great deal of sadness whether you knew him/her or not. All types of emotions are common following the loss of someone you know — sadness, confusion, guilt,

anger, numbness. Some of you may find you're having difficulty concentrating, and others may find that diving into your work is a good distraction.

We have counselors available to help our community deal with this sad loss and to enable us to understand more about suicide. If you'd like to talk to a counselor, just let us know.

Sometimes physicians, when confronted by the death of a colleague, feel responsible. They wonder if there was "something that they missed." First, remember, that ____ was a colleague, a friend, and that ____ was not your patient. No one has the ability to predict death. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident's behavior, have a conversation with them. If you are concerned, encourage them to seek help and consider letting <insert name of appropriate local person> know.

This is a time to take a moment to be together, to remember ____ in our grief, and to support one another. Please remember that we are all here for you.

Cause of death may not be disclosed

It is with great sadness that I have to tell you that one of our residents, ____, has died. All of us want you to know that we are here to help you in any way we can.

The family has requested that information about the cause of death not be shared at this time.

We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask you only share information known to be factual since inaccurate information can be hurtful to those coping with this loss. We'll do our best to give you accurate information as it becomes known to us.

Since the subject has been raised, we do want to take this opportunity to remind you that suicide, when it does occur, is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors are not identified or noticed; in other cases a person with a disorder will show obvious changes or warning signs. One thing is certain: there are treatments that can help. Suicide should never be an option.

Each of us will react to ____'s death in our own way, and we need to be respectful of each other. Feeling sad, upset, confused, angry, or numb are normal responses to loss. Some of you may not have known ____ very well and may not be as affected, while others may experience a great deal of sadness whether you knew him/her or not. Some of you may find you're having difficulty concentrating, and others may find that diving into your work is a good distraction. We have counselors available to help us deal with this sad loss. If you'd like to talk to a counselor, just let us know.

Sometimes physicians, when confronted by the death of a colleague, feel responsible. They wonder if there was "something that they missed." First, remember, that ____ was a colleague, a friend, and that ____ was not your patient. No one has the ability to predict death. We do know that talk saves lives. If your gut instinct tells you something is different about a fellow resident's behavior, have a conversation and listen to them, and if you are concerned encourage them to seek help and consider letting <insert name of appropriate local person> know.

This is a time to take a moment to be together, to remember ____ in our grief, and to support one another. Please remember that we are all here for you.

D. Sample Email Death Notifications

To be sent by email with subject "Sad News".

An email announcement should be sent to members of the institutional GME community (e.g., PDs, PCs, core faculty and residents of other programs), Chairs of other departments, ACGME representative, DIOs in the local community, and Dean of Students at deceased resident's medical school. A follow-up email can be sent later with details regarding the obituary, address of emergency contact person (if released, see above) and if applicable, funeral/memorial service information. Remember that the same approach should be used in other types of death.

Death ruled a suicide

I am writing with great sadness to inform you that one of our residents, _____, a PGY _____ in the _____ residency program, has died. Dr. _____ was a graduate of _____ Medical School. Our thoughts and sympathies are with [his/her] family and friends and the Department of _____.

All available residents were given the news of the death today. The cause of death was suicide. We want to take this opportunity to remind our community that suicide is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors and warning signs are not identified or noticed; other times, a person who is struggling will show more obvious symptoms or signs.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other.

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available.

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[Crisis Response Team Leader or DIO]

Cause of death is unconfirmed

I am writing with great sadness to inform you that one of our residents, _____, a PGY _____ in the _____ residency program, has died. Dr. _____ was a graduate of _____ Medical School. Our thoughts and sympathies are with [his/her] family and friends and the Department of _____.

All available residents were given the news of the death today. The cause of death has not yet been determined by the authorities. We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask you to respond to any speculations as to the cause of death with a reminder that this is not yet clear. We'll do our best to give you accurate information as it becomes known to us.

Since the subject has been raised, we want to take this opportunity to remind our community that suicide, when it does occur, is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors are not identified or noticed; other times, a person who is struggling will show more obvious symptoms or signs.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other.

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available.

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[Crisis Response Team Leader or DIO]

Cause of death may not be disclosed

I am writing with great sadness to inform you that one of our residents, _____, a PGY _____ in the _____ residency program, has died. Dr. _____ was a graduate of _____ Medical School. Our thoughts and sympathies are with [his/her] family and friends and the Department of _____. Our thoughts and sympathies are with [his/her] family and friends.

All available residents/fellows were given the news of the death today. The family has requested that information about the cause of death not be shared at this time. We are aware that there have been rumors that this was a suicide death. Since the subject has been raised, we want to take this opportunity to remind our community that suicide, when it does occur, is a very complicated act. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors are not identified or noticed; other times, a person who is struggling will show more obvious symptoms or signs.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other.

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[Crisis Response Team Leader or DIO]

D.2. Alternative Sample Email Death Notification for PDs in other Residency Programs

Refer to the emails above in addressing whether the cause of death is known and if the family wishes it to be shared. The email to the rest of the programs should come from the DIO.

I am writing with great sadness to inform you that one of our residents, ____, a PGY ____ in the ____ residency program, has died. Dr. ____ was a graduate of ____ Medical School. Our thoughts and sympathies are with [his/her] family and friends and the Department of ____.

All available residents/fellows in Dr. ____'s residency program were given the news of the death today. The cause of death was suicide. It is usually the culmination of several health and life factors that converge in a person's life during the same period of time, including mental health conditions such as depression, which lead to overwhelming mental and/or physical pain, anguish, and hopelessness. Sometimes these risk factors and warning signs are not identified or noticed; other times, a person who is struggling will show obvious symptoms or signs.

Please speak with your residents about this sad news and the supports which are available to them. Consider if you have any residents who may be at risk and reach out to them individually.

Resources for support and mental health care are listed below. We encourage any community members to seek the help they need. It is a time to come together, to grieve, and to support each other. [Insert contacts here.]

(As applicable depending on emergency contact person preference) Information about a remembrance service will be shared as it becomes available.

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[DIO]

E. Memorial Service Planning Checklist

In consultation with the family, the following details may be considered:

	Who	When	Notes/Completed
Name and date of remembrance			
Location			
Order flowers			
Obtain a sign-in book for family to keep			
Framed picture of resident to place on easel			
Furniture needs			
How many chairs are needed			
Tables to display pictures and belongings			
Coat racks			
Tissues			
Basket to collect cards			
Catering and room reserved			
Organization: How will the program run?			
Will there be a master of ceremonies?			
Will any faculty speak?			
Which resident will speak? Open microphone?			
Does the family want/feel comfortable speaking?			
Music and/or slideshow			

Checklist continued on next page >

	Who	When	Notes/Completed
What music will be playing when guests arrive? Are residents/staff able to play piano at opening, during service, and after?			
Will a slide show be put together to run with pictures while people are arriving or as part of the memorial?			
Video – Does the family want it videotaped?			
What AV is needed?			
Program: Who will design program for memorial?			
Support: Will counselors be on hand to support guests?			

F. Sample Media Statement

It may be necessary to proactively or upon request provide a statement to local media outlets. Such statements will likely need to be reviewed by an institution's communication and legal team. In some states there may be a state law regarding discussing cause of death. A sample script is below:

We were informed by the coroner's office that a ____ -year-old resident at ____ has died. The cause of death was suicide.

OR

We were informed by the coroner's office that name ____ -year-old resident at ____ has died unexpectedly. Dr. ____ was a ____ year resident in the ____ residency program at [Name of Hospital]. He was graduate of [College in year] and [Medical school in year].

Our thoughts and support go out to [his/her] family and friends at this difficult time.

Trained crisis counselors will be available to meet with residents, faculty, and staff starting tomorrow and continuing over the next few weeks as needed.

Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can increase the risk of suicide contagion ("copycat" suicides), particularly among youth. Media are strongly encouraged to refer to the document "Reporting on Suicide: Recommendations for the Media," which is available at afsp.org/media.

Media Contact

NAME:

TITLE:

SCHOOL:

PHONE:

EMAIL ADDRESS:

G. Key Messages for Media Spokesperson

For use when fielding media inquiries.

Suicide/Mental Illness

- Suicide is one of our nation's leading, yet preventable, causes of death
- Among the top ten leading causes of death in our nation, suicide continues to be on the rise; we must invest in research and prevention at a level commensurate with suicide's toll on our nation
- The risk of suicide increases when several health factors and life stressors converge at the same time in a person's life
- Multiple risk factors and protective factors interact in a dynamic way over time, affecting a person's risk for suicide; this means there are ways to decrease a person's risk, once you learn which modifiable risk factors are pertinent in a particular person's life (getting depression treated and well managed, limiting use of alcohol particularly during times of crisis, developing healthy boundaries in relationships, limiting exposure to toxic people, developing healthy self-expectations and accepting imperfection as a part of life, etc.)
- We are learning how to connect the dots and notice warning signs, to detect when people are at increased risk — suicide is preventable
- Depression and other mental health problems are the leading risk factors for suicide
- Depression is among the most treatable of all mood disorders; more than three-fourths of people with depression respond positively to treatment
- The best way to prevent suicide is through early detection, diagnosis, and vigorous treatment of depression and other mental health conditions, including substance use problems
- Physicians are more likely to die from suicide than many other occupations

Medical School/Hospital Response Messages

- We are saddened by the death of one of our residents; our hearts, thoughts, and prayers go out to [his/her] family and friends, and the entire community
- We will be offering grief counseling for residents, faculty and staff starting on [date] through [date]

Medical School/Hospital Response to Media

- Media are strongly encouraged to refer to the document "Reporting on Suicide: Recommendations for the Media," which is available at afsp.org/media
- Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion ("copycat" suicides)
- Media coverage that details the location and manner of suicide with photos or video increases risk of contagion
- Media should avoid oversimplifying the cause of suicide (e.g., don't say "resident took his/her own life after breakup with their significant other"); this gives people a simplistic understanding of a very complicated issue, and doesn't allow for learning about the many risk factors that can be points for intervention

- Instead, remind the public that more than 90 percent of people who die by suicide have an underlying mental health condition such as depression and that mental health can be treated and optimized like any other aspect of health
- Media should include links to or information about helpful resources such as local mental health resources, the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), and the Crisis Text Line at 741-741

H. Facts about Physician Suicide and Mental Health

Suicide is more common in physicians than in the general population. Accessing appropriate mental health treatment at key times is a critically important part of reducing suicide risk.

General

- Suicide is generally caused by the convergence of multiple risk factors, the most common being untreated or inadequately managed mental health conditions
- An estimated 400 physicians die by suicide in the U.S. per year⁶
- In cases where physicians died by suicide, depression is found to be a significant risk factor leading to their death at approximately the same rate as among non-physician suicide deaths; but physicians who took their lives were less likely to be receiving mental health treatment compared with non-physicians who took their lives⁷
- The suicide rate among male physicians is approximately 1.41x higher than the general male population; and among female physicians the relative risk is even more pronounced — 2.27x greater than the general female population⁸
- Suicide is the second leading cause of death in the 24-34 age range (accidents are the first)⁹
- Although suicide is the second leading cause of death among young Americans age 15-34, suicide has a low base-rate (about 13/100,000 in the U.S.) so the numbers are still low
- The prevalence of depression among residents is higher than in similarly aged individuals in the general U.S. population — 28 percent of residents experience a major depressive episode during training versus the general population rate of 7-8 percent¹⁰
- Culture and beliefs play a role in suicide risk; regional variations in culture are linked with suicide risk: the populations that have lower stigma related to mental health problems and help-seeking behaviors, have lower rates of suicide than those populations with higher stigma¹¹
- Among physicians, risk for suicide may be particularly elevated when mental health conditions go unaddressed and when self-medication occurs as a way to address anxiety, insomnia, or other distressing symptoms; although self-medicating may reduce some symptoms, the underlying health problem is not effectively treated and this can lead to a tragic outcome⁷
- Access to (and knowledge regarding) lethal means elevates risk of suicide
- A higher proportion of physician suicide deaths are by overdose compared with the general population suicide methods⁷
- Fears about the potential for seeking mental health care to negatively impact one's professional reputation, ability to get or maintain licensure, or malpractice insurance are largely unfounded; what is more likely to harm a physician's reputation, licensure and insurance, are unaddressed and worsening mental health conditions
- Successful suicide prevention programs utilize stigma reduction, education, and policy to increase healthy behaviors and access to mental health services⁴

Suicidal Ideation

- In surveys of students, house staff and faculty 10-12 percent report suicidal ideation^{12, 13}
- In one prospective study, 23 percent of interns had suicidal thoughts, but among those interns who completed four sessions of web-based Cognitive Behavior Therapy nearly 50 percent fewer had SI¹⁴
- Burnout has been found to be an independent risk factor for suicidal ideation¹²

Alcohol Use

- Alcohol misuse is a common response to unmanageable stress
- Alcohol increases impulsivity and the risk of a suicide attempt

Stressors

- The experience of becoming depressed is in itself tremendously stressful; while fewer than 25 percent will suffer from depression or significant depressive symptoms during their intern year; interns are under tremendous stress and have little time to rest^{15, 16}
- Drivers of burnout include work load, work inefficiency, lack of autonomy and meaning in work, and work-home conflict
- Feeling like a failure or making a medical mistake often leads to severe distress¹⁷
- Impostor syndrome: despite countless successes, when confronted with their internship, residents may start feeling like they don't really belong here; the worry about being "exposed" or "failing" may be intolerable

Stigma

- Perfectionism, self-perceived identity as a caregiver to others, and lack of practice seeking help for oneself are all common among physicians, making it hard for residents to recognize and accept their need for mental health care; there is also concern about being "found out" by their peers or supervisors
- Residents often mask symptoms of depression or other mental health problems, leading at least some suicides to appear shocking or seem to come out of the blue

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