**After Suicide:**
*A Toolkit for USF GME Residency and Fellowship Programs*

**This document was developed based on ACGME’s “After a Suicide: A Toolkit for Physician Residency/ Fellowship Programs,” created by the following workgroup:**

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# Overview: Suicide Response Plan

This Suicide Response Plan will serve as a protocol to guide the institutional response to the death of a trainee (resident, fellow) by suicide.

## Advance Planning

Emergency contact information will be maintained for every trainee. Advance planning will include development of a Crisis Response Team (CRT), identification of individual tasks to be accomplished in the designated period of time following a trainee’s death by suicide, and development of standardized communication guidelines for dissemination of necessary information to the appropriate parties.

## Response Planning

Standardized communication protocols will be established, as guidance when accepting or relaying information to a deceased trainee’s emergency contact(s), family members, and members of the GME community. The scope of information to be provided will be outlined and disseminated to recipients who have been identified in advance. Planning a memorial service will also be considered in addition to managing media inquiries and social media.

## Guidelines for review

Both advance planning objectives and response planning objectives will be reviewed annually.

# Crisis Response Team

The Crisis Response Team (CRT) carries out the critical aspects of crisis management in the aftermath of a loss by suicide, including facilitating communication, supporting the community, and preventing contagion. This team should include several key individuals, typically the GME DIO, PD, key faculty, mental health professionals, and other key staff as indicated. The identified Team Leader is responsible for ensuring that the tasks from the checklist are completed.

|  |  |  |
| --- | --- | --- |
| **Team Member** | **Tasks** | **Date completed** |
| PD | Reviews the toolkitCall emergency contact w/ DIOSet up meetings with CRT and other residents |  |
| APD | Reviews the toolkitBe present at CRT meetings with residentsHelp PD with planning for needs for family of deceased, memorialization of deceased, and other resident support |  |
| DIO | Reviews the toolkitCall emergency contact w/PDContact Vice Dean/Dean/Dean for Student Affairs/GME DirectorHelp PD with planning for needs for family of deceased, memorialization of deceased such as flowers/attending services, and other resident support |  |
| GME Director | Reviews the toolkitContact affiliatesEnsure additional resources are obtainedAddress HR issues |  |
| Program Coordinator | Reviews the toolkitBe present at CRT meetings with residentsSet up meetings with CRT and other residents Adjust work schedulesMonitor other resident’s well being |  |
| Chief Resident | Reviews the toolkitAdjust work schedules where neededMonitor other resident’s well beingHelp PD with planning for needs for family of deceased, memorialization of deceased, and other resident support |  |
| Department Chair | Reviews the toolkitEnsure additional resources are obtainedMonitor faculty and PD’s well being |  |
| Mental Health Services/RAP | Provide support to residents |  |
| GMEC Wellness Subcommittee chair  | Reviews the toolkitEnsure additional resources are obtainedProvide additional help for residents, coordinators, and faculty where needed |  |

## SHARING INFORMATION

## Communication with emergency contact person or family

Individuals within the training program may be the first to know a resident has been declared deceased. In such a situation the CRT leader or a delegate (DIO, DC, PD) should call the emergency contact immediately.

Prior to calling the emergency contact, it is helpful to gain as much information as is available as well as determine information the emergency contact may have already been provided.

|  |
| --- |
| **Initial call to the emergency contact should focus on-** |
| * Introduction (*Self-identification of the caller and the caller’s role at the institution*)
* Offering condolences and extending support
* Ask what they are aware of or have been told so far
* Offer an in-person meeting
* Gather any other information they may have (*Be careful not to confuse this person’s conjecture with facts*)
* ***Identifying the family’s preference regarding what information may be provided to faculty and fellow trainees***. *It is vital to discuss this topic. If the death is determined to be a suicide and the family does not want it disclosed, it is our responsibility to explain how deeply affected faculty and fellow trainees are by the passing of their loved one and the importance of honest disclosure, allowing peers, faculty, and support staff to fully process and grieve the death of the trainee, to learn more about suicide and its causes, and as an important step to keeping the residents safe and avoiding more tragedy. However it is important to be mindful 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; this may be an ongoing conversation over the subsequent days.*
* Finding out what the residency program can do to assist the family
* It may be helpful to inform the family of anticipated media attention surrounding the death of their loved one*(Families may not be prepared for the unwanted media attention their loved one’s death may bring, and it can be supportive to remind them that they are not obligated to take interviews. Caller may extend an offer for the family to refer media personnel to an institutional official*)
* End the conversation by providing information about how the family member may contact a single identified person (usually the caller) if any questions arise following the initial call. They should be told to expect a follow up phone call the next day.
 |
| **Second call to the emergency contact the next day should focus on-** |
| * Continued condolences and support
* Willingness to share funeral arrangements, whether flowers or other honoraria may be sent, and whether faculty and other trainees may attend
* If appropriate, discuss possibility of on-campus memorial service and acceptable venue
* Assistance the institution can provide:
	+ Collecting deceased resident’s belongings from clinical or educational sites before family’s arrival
	+ Finding local hotel
* Release of home address for condolence notes (*program may want to collect condolence notes and send to the family in one package*)
* Discussion with family about the institution releasing an obituary
* Assistance with administrative or human resource issues (*insurance, final paycheck*)
* Provide resources for suicide loss survivors (*afsp.org/loss*)
 |

## DOs and DONTs when sharing the news

It is **critically important for steps to be taken to ensure that suicide contagion risk is minimized** to every extent possible, and this risk is heightened when a vulnerable individual is exposed to sensationalized communication or when the deceased’s life or manner of death is portrayed in an idealized manner.

|  |  |
| --- | --- |
| **DOs** | **DONTs** |
| **Avoid contagion** |
| Acknowledge the loss, using the word “suicide” if the emergency contact or family has given permission.Do not include the method of suicide in written communication.During in-person meetings it is okay to mention the method, but avoid dwelling on the manner of death. | Don’t include detailed descriptions of the suicide method, location, or circumstances of the death.Don’t highlight pictures of the location or sensationalized media accounts.Even during in-person meetings, avoid providing more detail than the general method. |
| **Don’t glorify the act of suicide** |
| Talk about the person in a balanced manner, avoiding idealization or only extolling virtues. Do not be afraid to include the struggles that were known and which have been permitted in communication, especially during personal conversations. | Avoid, when possible, describing the deceased person only in terms of his or her strengths, as this may paint a picture of suicide being a solution; this may present a confusing picture and make it more challenging to process the loss if the person’s apparent struggles aren’t alluded to. |
| **Encourage help-seeking** |
| 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. | Don’t portray suicide as a reasonable solution to the person’s problems. |
| **Give accurate information about suicide** |
| 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. Emphasize the institution’s stance on help-seeking as a sign of strength, a way to show the most proactively mature level of professionalism. | Don’t portray suicide as the result of one problem, event, or issue. |

## Notifying residents in the same program as the deceased resident

Generally the notification for residents within the same program of the deceased should include the following:

* **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.**
* **The office staff or program leadership should seek to contact every resident individually (typically via pager or phone call), telling them of an emergency mandatory meeting; residents who cannot be reached by phone can be emailed with instructions to call in as soon as possible regarding “sad news.” Residents who are on scheduled leave should be called and asked to come in to attend the meeting if possible.**
* **Program leadership should be present, including the PD, APD, and program coordinators.**
* **Mental health counselors, psychologists, chaplain services, or employee assistance counselors may be helpful to have available at the meeting when possible; however the meeting should be led by program leadership with whom the residents have a previous professional relationship or a designated CRT representative.**

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 emergency contact person refuses to allow disclosure of a suicide, members of the Crisis Response Team can state**, “*The family has requested that information about the cause of death not be shared at this time. We know that 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 while 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.

The following resources should be reinforced

* Remind the residents of the processes in place for accessing care:
	+ Provide a list of individuals, including program faculty 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 a trusted advisor and 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:
	+ Remind residents of 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
	+ Remind residents that the PDs will not know who is receiving mental health care
	+ 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 residents 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 are aware of
* As applicable, inform the residents about the funeral and process for requesting time-off to attend the funeral
* Discuss plans for a memorial service, if appropriate

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 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.

This is an 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. There are likely to be individuals in the group who are more deeply affected by the death, and 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.

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 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.

## Internal Communication List

The following staged approach to internal communication establishes individual responsibilities for the notification cascade, reducing the potential risk of mischaracterization of the individual circumstances while appropriately distributing responsibility.

### *Immediate notification*

|  |  |  |  |
| --- | --- | --- | --- |
| **Phone or in person** | **Responsible** | **Notes** | **Completed** |
| **Emergency Contact** | DIO and/or PD |  |  |
| **Senior Associate Dean USF Health** | PD |  |  |
| *Associate Program Director* | PD |  |  |
| *Program Coordinator* | PD |  |  |
| Chief Resident(s) | PD |  |  |
| RAP | DIO and/or PD |  |  |
| Other members of Crisis Response Team (Faculty, Other Mental Health Providers at Site) | DIO and/or PD |  |  |
| Vice Dean Medical Education | DIO |  |  |
| Dean of USF Health | DIO or Vice Dean |  |  |
| Dean for Student Affairs | DIO or Vice Dean |  |  |
| Department Chair | DIO or PD |  |  |

### Same-day notification

|  |  |  |  |
| --- | --- | --- | --- |
| **Phone or in person** | **Responsible** | **Notes** | **Completed** |
| GME Director | DIO |  |  |
| Affiliate Sites | GME Director |  |  |
| Residents who were close or working with resident | PD |  |  |

### Notification within 24 hour

|  |  |  |  |
| --- | --- | --- | --- |
| **Email** | **Responsible** | **Notes** | **Completed** |
| Residents in the program | PD |  |  |
| Faculty in the program | PD |  |  |
|  |  |  |  |

### Notification within 48 hours

|  |  |  |  |
| --- | --- | --- | --- |
| **Email** | **Responsible** | **Notes** | **Completed** |
| All GME residents and fellows | DIO |  |  |
| PDs of other training programs | DIO |  |  |
| All medical students | Student Affairs Dean |  |  |
| All coordinators | DIO |  |  |

# Sample Communications

## Identifying Information

An institution’s coordinated response to tragedy carries potential risk for innocent oversights which may interfere with the message of condolence, support, and solidarity. This is particularly true following a tragic event such as a trainee’s death by suicide. By completing the following fields, the sample communication texts will be consistently and accurately updated in an efficient, effective, and comprehensive manner.

* First Name:
* Last Name:
* PGY       (ex. 1, 2, 3)
* PGY       (ex. first, second, third)
* Age (years)
* Specialty:
* College:
* College (year):
* Medical School:
* MS (year):
* CRT Leader:

## Face-to-face communications

### ***Cause of death: 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 one another 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 contacts here] 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: 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 contacts here] 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: undisclosed***

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 contacts here] 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.

## Electronic communication

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; to this end the subject of the email should simply be “Sad News.”

### ***Cause of death: 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 the . Our thoughts and sympathies are with ’s 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. This 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: 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 the . Our thoughts and sympathies are with ’s 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,

### ***Cause of death: undisclosed***

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 the . Our thoughts and sympathies are with ’s family and friends and the Department of .

All available residents 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,

### ***Alternative sample email death notification to PDs of 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 the . Our thoughts and sympathies are with ’s family and friends and the Department of .

All available residents 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,

## Sample Media Statement

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

OR

We were informed by the coroner’s office that , a -year-old resident at the University of South Florida has died unexpectedly. A graduate of in and the in , Dr. was a year resident in the residency program.

Our thoughts and support go out to Dr. ’s 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.

**Message to receiving media personnel, not for distribution:***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:

# Appendices

## Tips for Talking about Suicide

|  |  |
| --- | --- |
| **Give accurate information about suicide** | **By saying…** |
| Suicide is a complicated behavior that is not caused by any single event; research clearly indicates that in the vast majority of cases, underlying mental health conditions were present and active in the period of time leading up to a suicide.Using the word “suicide” and talking about suicide in a calm, straightforward manner does not “put ideas” into residents’ minds.  | “The cause of \_\_\_\_\_’s death was suicide. Suicide most often occurs when several factors converge, leading to overwhelming mental or physical pain, anguish, and hopelessness.” “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.” |
| **Address blaming and scapegoating** | **By saying…** |
| It is common to try to answer the question “why?” after a death by suicide. Sometimes this may turn into blaming others for the death.  | “The reasons that someone dies by suicide are not simple, and these are often 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.” |
| **Do not focus on the method or graphic details** | **By saying…** |
| Talking in graphic detail about the method may be upsetting for some and can increase the risk of imitative behavior by vulnerable individuals. If asked, give basic facts about the method, but don’t give graphic details or talk at length about it. The focus should not be on how someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc. | “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. How figure out the best ways to deal with our loss and grief?” |
| **Address Anger** | **By saying…** |
| Accept expressions of anger at the deceased and explain that these feelings are normal. | “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.” |
| **Address feelings of responsibility** | **By saying…** |
| Reassure those who feel responsible or think they could have done something to save the deceased. Many cloak their internal distress 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. | “\_\_\_\_\_ 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.” “We can’t always predict someone else’s behavior. Especially when many of us are able to hide distress.” |
| **Promote Help-seeking** | **By saying…** |
| Advise residents to seek help from a trusted mentor or mental health professional if they or a friend are feeling depressed. Communicate that we don’t need to wait for a crisis — early help seeking is a sign of strength.  | “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 depressed or had thoughts of suicide?” “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.” |

## Resources

No person should ever have to wait for a crisis to reach out for assistance; seeking help early is a sign of strength. If residents have thoughts of self-harm, they are encouraged to consider use one of the following resources:

* GME Wellness and Wellbeing, “Coping with Tragedy”
[health.usf.edu/medicine/gme/wellness/tragedy-resources](https://health.usf.edu/medicine/gme/wellness/tragedy-resources)
* Resident Assistance Program
813-870-3344, 727-576-5164, 800-343-4670
[health.usf.edu/medicine/gme/current/resident-assistance-program](https://health.usf.edu/medicine/gme/current/resident-assistance-program)
[www.woodassociates.net/](http://www.woodassociates.net/)
* American Foundation for Suicide Prevention
www.afsp.org/loss
* National Suicide Prevention Lifeline
1-800-273-TALK (8255)
* Text HELLO to the Crisis Text Line
741-741
* Crisis Center of Tampa Bay
[www.crisiscenter.com/get-help/](http://www.crisiscenter.com/get-help/) or by calling 2-1-1
* Hospice support groups
Bereavement and loss support groups are available for all those suffering from loss, and services are not confined to those who have lost a loved one or friend through Hospice services
www.chaptershealth.org/services-chapters-health-system/grief-services-bereavement-support/
* USF Success & Wellness Coaches
www.usf.edu/student-affairs/wellness/about-us/sucessandwellnesscoaching.aspx
* National Alliance for the Mentally Ill
www.namihillsborough.org/
* Local Emergency Department or by calling 911

## Supporting Residents

In the aftermath of a suicide, residents may feel emotionally overwhelmed. 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 services, 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 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 & 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.

Faculty and staff should be reminded:

* 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.

## 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). 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.

### General approach

A memorial service planning checklist is provided her, and the following guidelines should be considered:

* Avoid using regular meeting rooms or the place of death, as doing so could inextricably connect the space to the death, making it difficult for residents and faculty to return there for work or learning
* It is best if services are held outside of regular hours, with involvement of family or close friends
* It is important to provide an opportunity for residents to be heard, reminding all who will be speaking to emphasize the connection between suicide and mental health issues without romanticizing the death
* 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 to turn off their phones and pagers as a sign of respect to their deceased colleague; being able to focus for this span of time means a great deal to those most 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.

### Alternatives to a standard memorialization

Other approaches for memorialization may be considered:

* Holding a day of community service or creating institution-based service programs 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, or holding a local fundraising event to support local resources
* Sponsoring a mental health awareness day or purchasing books on mental health for the local library
* 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 or 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.

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.

### Memorial service planning checklist

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Who** | **When** | **Notes / Completed** |
| **Advance General Planning** |
| Point of Contact |  |  |  |
| Location, Date of remembrance |  |  |  |
| Catering and room reserved |  |  |  |
| Program design |  |  |  |
| Order flowers |  |  |  |
| Obtain a sign-in book for family to keep |  |  |  |
| Framed photo of resident for easel |  |  |  |
| Furniture needs |  |  |  |
| How many chairs are needed |  |  |  |
| Table to display pictures |  |  |  |
| Coat racks |  |  |  |
| Tissues |  |  |  |
| Basket to collect cards |  |  |  |
| **Program Schedule Planning** |
| Program schedule |  |  |  |
| Will there be a facilitator (MC)? |  |  |  |
| Will a resident or residents speak? |  |  |  |
| Will any faculty speak? |  |  |  |
| Will there be an open microphone? |  |  |  |
| Does the family want/feel comfortable speaking? |  |  |  |
| Will counselors be on hand to support guests? |  |  |  |
| **Audiovisual resources** |
| What AV is needed? |  |  |  |
| Music playing when guests arrive? |  |  |  |
| Slideshow playing when guests arrive? |  |  |  |
| In Memoriam music and/or slideshow |  |  |  |
| Does the family want it videotaped? |  |  |  |

**This document was developed based on ACGME’s “After a Suicide: A Toolkit for Physician Residency/ Fellowship Programs,” created by the following workgroup:**

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