

Crisis/Disaster Management for a Training Program

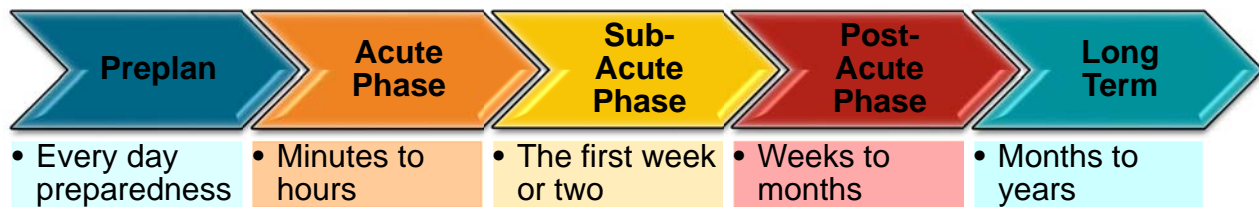
Authors: Lia S. Logio, MD, Bethany Gentilesco, MD, and Dominick Tamaro MD

Physicians are all susceptible to the modern day realities of disaster preparedness and response. We work in hospitals where we plan for the unthinkable, the natural, and the unnatural. Still we find ourselves unprepared when that disaster is a physician suicide. Collectively, the authors have experience in managing these tragedies and hope to share the lessons learned with the medical community at large.

This document outlines the basic phases and important steps to help manage crisis specifically related to physician suicide. We earnestly hope that no one needs to utilize the plan described but we understand the importance and necessity of preparing for the unimaginable. The following guideline can serve as a roadmap for response to a completed or incomplete suicide in a housestaff training program, medical school, or other medical community.

This strategic plan is divided into five parts, presented in chronological order. Together they represent our cumulative advice and best guidance. It should guide the unit (program, schools, and department) most acutely affected.

Timeline



Pre-plan: Every Day Preparedness

Updated Emergency Contact Information. For any crisis, the ability to communicate with every member of the community immediately is critical. An updated, correct phone list is crucial. Although group emails will reach most people, fast communication is key, so having multiple ways of reaching every person is important. It is also useful to have an easy way to identify any members of the community who are off site, on vacation, working nights, or otherwise apart from the group. In case of crisis, they will require individualized communication.

Keeping an accessible list of next of kin or emergency contact is also vital and should be available to the leaders day and night.

Updated Emergency Contact Procedures. Program leadership (directors, chief residents, and department leadership) should have a schedule of availability so that program staff know how to activate the chain of communication described. Such a schedule may be arranged with hospital operators or administrative staff.

Acute Phase: Minutes to Hours

First Steps. At the first recognition that an unanticipated physician death has occurred, the work unit (residency program, medical school class, and department) should create a central location for managing the crisis. Events may be fluid and details evolving over time; a central place where information is gathered, collated, and distributed allows for timely dissemination of information.

Gathering Space. A private space should be reserved indefinitely for grieving and processing. Develop a plan that will provide food and comfort 24/7 with a rotating schedule of important support team members assigned to staff the space. These leaders include chaplains, grief counselors, selected faculty, and chief residents.

Notifications. It is critically important to manage the flow of information so that family and work colleagues are notified at or around the same time. Family should be informed by a key leader or through local law enforcement. Since many trainees live far from family, it may be best to let law enforcement officials notify the family. Police departments have a protocol to reach out to the law enforcement of distant towns to locate family members for notification.

Institutional Leadership Notification. It is important to keep institutional leadership involved in the process. Their direct involvement will be determined by the local norms of the institution.

Meetings. As soon as enough information is known and verified, the work unit (residency program, medical school class, or department) should be brought together by program leadership for an emergency meeting. Key leaders, psychiatrists, and other support personnel (chaplains, social workers, etc.) should attend the meeting. At the meeting, announce that a tragedy has occurred and include whatever details are reasonable to share. The key leaders should share their own sadness at the news and encourage everyone to take time to absorb the information. Be prepared that in any such gathering, there will be varying levels of awareness regarding the event as well as varying degrees of familiarity with the individual (particularly in large, multi-institution-based programs).

For residency programs based at multiple hospitals and clinics, program leaders should be present at each site for these meetings. Being present and holding meetings when evening or overnight teams begin or end their shifts will help reach many members of the program in a timely manner.

Invite your collected group (residents or other group of colleagues) to ask questions or reflect on what this means, what worries they have, any information they want to share about the individual, the past few hours/days/weeks, and the next steps. It should be a warm environment where people feel comfortable sharing whatever they want without judgment.

Consider including nursing, office, and other ancillary staff who may also be affected by the news. Many people experience added grief during a tragedy because it triggers emotions and sadness from prior experiences. Recognize it out loud; awareness of this normal response may help recovery. It is often helpful to have members of the institutional employee assistance program (EAP) be present at these initial and perhaps subsequent meetings.

Details. It will be important to collect details from those who may contribute to the fact-finding efforts so critical in defining the nature of any such tragedy. Such detail, while important, is often best gathered via individual in-person interviews. It is important to create a timeline of what happened, when the person was last seen and by whom, and what is known about the last contact (by phone, email, social media, etc.). This information may be helpful to law enforcement, family, and colleagues who are all struggling to find meaning.

It is essential that program leadership, residents, students, and staff respect individual privacy. While it may be helpful to discuss public events and permit first responders to share their experiences, privacy for everyone involved must be the primary concern. Program leaders should be explicit in such meetings and remind those in attendance to avoid email and social media discussions. Not all information will be appropriate to disclose and the purpose of such meetings, beyond the initial dissemination of news of the event, should focus on the support of the community. However, particularly if the suicide occurs at the hospital, some disclosure of details will be necessary. Working with the hospital's crisis management team can help you to decide which information should be shared and with whom.

Reactions. Individuals most affected may need to meet with support staff in small groups or on an individual basis to debrief. They may be the team members who worked with the individual most recently or had a close

relationship with the person. A supervisor should join them for this meeting. Security personnel may also be present.

Coverage should be arranged for any and all individuals who do not feel able to work because of their personal reaction to the news. Consider enlisting others who were less affected (or not at all affected) to cover immediate patient care needs. In most situations, there will be many volunteers to provide support for their peers. Be attentive to tracking people who provide volunteer hours to avoid overloading specific individuals.

Encourage everyone to stay connected to each other by email and text messaging. Program leaders should communicate a clear plan about how much information they know, when they expect more information, and how that will be communicated. In the case of an uncompleted suicide, uncertainty can persist for days and a rigorous communication strategy is necessary. This first meeting should last as long as necessary.

Give permission to defer answering questions from other programs or other departments. Provide statement responses such as, "I appreciate your asking, but I'm not ready to talk about this yet." This permission to grieve and to be relieved of any responsibility to share information can be helpful.

Prepare a well worded announcement or statement of grief for any press inquiries. Advise individuals answering the phones to have a single sentence response to calls. For example, in cases of suicide, an appropriate response is: "At this time, we are saddened by the loss of one of our own. We thank you for your understanding."

Continue to emphasize the need for anyone feeling down or in distress to seek help with readily available providers, phone numbers, office hours, etc. An employee assistance program (EAP) may be able to provide immediate and ongoing resources both communally and individually.

Sub-Acute Phase: The First Week or Two

Ongoing Meetings and Other Modes of Contact. In the two to four days following the event, arrange follow-up meetings. Many individuals will have delayed grief reactions and will find comfort in the presence of their peers. Plan so that everyone can help facilitate freeing up the members of the core work unit or community. At this meeting, key leaders should again reflect on the sense of loss, personal grief, and general sense of needing to lean on each other for support. Psychiatry, grief counselors, and chaplains should be available at this second meeting to talk about mental illness and the resources to help all who are struggling. Written material should be distributed (as well as posted broadly) about mental health resources for anyone feeling the need to talk or seek help. These follow-up meetings are often a good place for publicizing counselor availability, office hours, contact information, etc. Expect a broad range of behavior. Your acceptance of the varied responses will be an important leadership role to shepherd your community. Keep close physical track of your group. Volunteer your own availability, and express ongoing and often concern and investment.

Daily email updates will serve the purpose of keeping individuals on distant rotations informed as well as remind all residents of the support resources available to them.

Reassurance. It should be stated and restated that suicide can NOT be predicted. Your internal conversation of "could have, should have, would have" is futile. It wasn't you. You can NOT predict suicide. Prevention of suicide occurs primarily through elimination of means (covering gorges, high railings on bridges, gun control, or limiting access to toxic chemicals).

In the case of suicide, key leaders and close friends should be encouraged to attend the funeral or memorial services; leadership should help by adjusting schedules as needed for people to attend. These events allows closure for those who need it. The work unit should plan a memorial service within four to six weeks of the event for all of the others who are unable to attend the primary funeral event.

Ask permission from the family to share the funeral card with the work place community. Posting it in key locations to share with colleagues and coworkers can be highly valued by those who were unable to attend.

Resumption of Clinical Routine. For those who stay at work, be sensitive to the particulars. Is there someone working in place of the resident who died or is injured? That person may need extra support and encouragement. Are there teams who share space that is tainted by memories of an event or situation? Awareness of and sensitivity to these kinds of local specifics can make a big difference for the community.

Ongoing Vigilance. In the emotional aftermath of suicide, there is a risk that someone who may be struggling with depression may be especially affected, resulting in withdrawal from contact with others or possibly self-injurious behavior. At group meetings, it is helpful to address this phenomenon and encourage residents or friends worried about such colleagues to alert program staff or a mental health professional.

Post-Acute Phase: Weeks to Months

In the weeks that follow the event, there will be multiple inquiries from family, friends, staff, and peers. These inquiries will need to be managed on a case-by-case basis. It is best to identify one or two individuals to serve as the point person for the unit. These central managers should limit speculation and not share details of the event; instead they should spend their time listening and reflecting what others want to talk about.

There may be an investigation by law enforcement or by the family about the details of the event. The central managers should work together to coordinate any interviews and serve as a resource to the family regarding logistics (cleaning out home; managing last pay check; returning important documents, ID badge, pagers, or phones, etc.). The organization (usually via human resources) should seek to eliminate final bills and mitigate any administrative tasks for the family. It helps the family to have a single administrative contact to manage future questions and tasks (W2, forwarding mail, etc.)

In the case of suicide, this is a reasonable time to have an onsite memorial service. The memorial service should be inclusive of any and all people who may feel a sense of loss, including staff from other departments, nursing and ancillary personnel, etc. The family should be invited and included in the memorial service but it should focus on the individual's professional accomplishments and connection to colleagues. Personalize the memorial service as much as possible; invite input from close friends and contacts of the person. The memorial service should be followed by an open reception to share condolences, stories, and words of kindness with the family.

Long Term: Months to Years

Your organization may need additional support for weeks to months after an event. When members of the work unit stop arriving to the central comfort location, consider creating a biweekly open session for anyone seeking help or solace. Everyone's "metabolism" for death and tragedy is different; some seem to get over it quickly, others are in denial for a long time and then have a late response, and still others are deeply affected for weeks to months.

Encourage grass roots solutions for the most affected work unit to connect to each other (group chat, scheduled social events, etc.) Various models include sponsoring an outdoor yoga session at a local park, preparing and sharing meals together, or sponsoring narrative medicine reflection sessions. Find activities that appropriately nourish the body and soul and will serve to reinforce the sense of community, much in the way such practices are carried out in other communities after tragic events.

Tragic events such as suicide should serve as an opportunity to inventory wellness activities and promotion as well as to reinforce the concept of the safety net function of each organization. Leaders should model self-care and be explicit about their own needs, grief process, and sadness. For physicians, the idea of caring for oneself while simultaneously caring for others is not new. In tragedy, it is all the harder, and all the more important.

IMPORTANT POINTS FOR PROGRAM LEADERSHIP

- Be open and transparent in supporting the community at large. Healing requires time, connection, and relationship. Be present.
- Suicide is NOT predictable.
- Absolve yourself and others of any guilt over any could haves or should haves or would haves.
- Copycat suicide is a real entity; make sure you say out loud that strong emotions brought out by the news should trigger people to talk to someone and make mental health support staff easily available.
- Systematic approach to talking about a physician death is an important part of the healing process.

Authors:

Lia S. Logio, MD, Vice Chair for Education and Program Director, Weill Cornell Medicine [lil9051@med.cornell.edu]

Bethany Gentileco, MD, Associate Program Director, Warren Alpert Medical School of Brown University

Dominick Tammaro, MD, Program Director, Warren Alpert Medical School of Brown University