COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE

Unexpected Resident Death

CORD Bomb Survival Packet

A playbook for program leadership from program leadership to respond to the rare but devastating events which can occur.

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www.cordem.org

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Message:

If your resident dies unexpectedly, there will be tons of grief and heartache. Perhaps even some unresolved issues and regret. Your main role at this time will be in communications, support, and scheduling logistics.

If your resident died of suicide, there will be a tremendous amount of guilt and confusion all around. The range of immediate emotions (guilt, shame, anger, sadness, etc) can be overwhelming for the program leadership and resident advisors. This is NOT your fault. You are NOT incompetent or a failure. Still, you will have to deal with the repercussions.

It is bewildering to know what to do. There are people who have gone through this. They can help you and want you to reach out for help. Focus on your other residents and faculty. Although there is nothing that you can do for the resident who died, you can support the residents, other faculty and leadership team. Ultimately, one of the most healing things may be creating meaning from the loss.

Recommendations:

- **After A Suicide: A Toolkit for Physician Residency/Fellowship programs** http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pd
  This is the go-to reference for logistics and communications in which many parts may be translatable to an unexpected resident death.

- Connect with someone who has gone through this before. There are several contacts listed in the first part of Section 1.

- Contact the ACGME- There is a strong interest in supporting institutions and leadership who are enduring these tragic circumstances.

Section I- Taking Care of Yourself

- **People Resources**
- **When a Resident Dies By Suicide- What happens to you**
    - **Missing It: Were there clues before suicide?**
    - **Missing It: When there were clues before suicide**
    - **Stages of Second Victim Syndrome**
    - **Clinician Survivor Listserv**
    - **Reaction to Future Resident Unexpected Death and Suicides**

People resources:

The most helpful thing may be connecting with people who have been through this before. Here is a list of people who are willing and ready to be contacted. If contacting by email place **'unexpected resident death' in the subject line**. These people want to help you.

PLEM- Program Leadership at the time when an EM resident unexpectedly died
PLID- Program Leadership at the time when non-EM resident died within the institution
PE- Personal Experience
IL- Institutional Leadership
Other- Other with relevant experience outside EM

Due to privacy concerns, we cannot publish private contact information. If you need guidance and/or support – there is an established team with similar experiences ready to assist. Email cord@cordem.org to be placed in contact.

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When a Resident Dies By Suicide: What Happens to You

When a resident dies unexpectedly, there is huge amount of crisis management work to be done for both the program and the institution. At the same time, this tragic event can be personally devastating for the program leadership tasked with the response. The experience may be best framed as a second victim syndrome. Program leadership shoulder an incredible sense of responsibility for residents well-being and success. A resident's death may be just as unsteadying to a sense of competence and confidence as an unexpected patient death or medical error. Perhaps even more so.

Second victims are traditionally defined as "healthcare providers who are involved in an unanticipated adverse patient event, medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event.". These events may cause the provider to feel guilty, fearful, frustrated, anxious, depressed, demoralized and sometimes suicidal. These same feelings can be invoked by the sudden unexpected death of a resident. Program leadership needs to be aware of this potential, take care of themselves and seek appropriate help if needed.

Missing It- Were there clues before suicide?

When a person dies by suicide, the reasons why tends to haunt many. It is no less true of program leadership as well as co-residents. The common literature says that about 70% of people that die by suicide gave clues in the days and weeks before death. However, this doesn't tell the full/entire story.

- That statistic comes from retrospective forensic psychological autopsies of people who died by suicide. As we all know, it is easy to see things retrospectively and the retrospectoscope can be inappropriately harsh and cruel.
- Even with that statistic, one third of those that take their own life are non-disclosers. They don't tell others and may give few to no clues of their intent. Physicians more commonly fall in this category, but we are not alone. Pilots are another group who may actually lose their license at the mention of suicidal ideation. Police and fire-fighters as well are ones who don't reveal.
- Many times the clues are vague and could be easily be interpreted as a non-risk statement. Only in hindsight canone see the context and risk.
- Some only give one or two clues to a person. Later, when a group gets together reflecting on what happen do individual tiles of a mosciac come together to form a concerning picture.
- The greater the perceived power differential the more likely that this will be hidden. It is likely that for many, the program director is the virtually the last person that one would typically reach out to on their own.

Perhaps it is helpful to think of this similar to a spinal epidural abscess, missing it is tends to be the rule rather than the exception- often until it is too late. The signs might be there but they are nonspecific and can be attributable to other things. Unless a suicidal person is going to be open about their intent, one has to be really lucky or have an incredibly high index of suspicion to uncover and help a non-discloser.

Missing It- When there were clues before death

Knowing a resident was at risk and still died by suicide is a different excruciating hell. It is not unexpected to feel shame and guilt; but when there is judgement without being able to defend oneself because of confidentiality, it becomes torture.

This is going to just be painfully difficult. Understanding the stages of second victim syndrome may be helpful. In particular, understanding emotional first aid can be healing. Here are some emotional first aid tips:

- Be gentle and compassionate with yourself.
- Distract yourself from rumination.
- Redefine your view of failure.
- Find meaning in loss.

Stages of Second Victim Syndrome-

- Chaos and accident response: This is the initial phase. It is complicated as described above by the need to organize and manage the response. You may be trying to figure out what happened and what to do about it while operating with only limited information. It is important to ensure that while you are providing resources for your team, you may also need to also reach out for yourself.
- Intrusive reflections: This phase refers to recurrent thoughts about the situation. This can begin to impair sleep, self care and cause feelings of doubt. These are generally self limited but can persist if not acknowledged as part of the normal process.
- Restoring personal integrity: This phase is where this survival resource can be very helpful. Part of restoring integrity often centers around seeking support from trusted community members. Because this is a rare occurrence in any given ACGME program, the community should be considered to include virtual support from individuals identified above. Those individuals who have survived this time of tragedy can provide a lot of hope to those currently experiencing it.
- Enduring the inquisition: Institutional responses to resident suicide can vary. This uncertainty about what questions or aspersions the program may face can be disconcerting to the program leadership as well as to residents and faculty.
- Obtaining emotional first aid: The uncertainty associated with this phase can be crippling. There are concerns about reaching out due to privacy issues. Peer support by talking to a coworker or trusted supervisor is the most helpful emotional first aid intervention.Programs should also have identified in advance psychological counseling resources for people involved in the case who can be activated quickly in the case that more advanced help is required or requested.
- Moving on: One goal of support is to minimize dropouts as a result of the crisis and to control suicide contagion. Another goal is to get as many people to move past this in a way that allows them to thrive and make something positive out of the event. There are

ideas here including memorial and graduation ideas that can help ensure that something positive comes out of this tragedy for those affected.

Why We All Need to Practice Emotional First Aid
https://www.ted.com/talks/guy_winch_the_case_for_emotional_hygiene

Emotional First Aid
https://psychcentral.com/blog/emotional-first-aid/

Clinician Survivor Listserv

- *to join the listserve for clinician survivors email Vanessa McGann at VLMcGann@aol.com*
- http://mypage.iu.edu/~jmcintos/therapists_mainpg.htm

Reaction to Future Resident Unexpected Death and Suicides

I start to feel like my skin has thickened, my heart has healed and I can tolerate the frequent reminders of her that live on in the world though her life was cut so short. And then another come along and not just the loss, but the mind bending process of the secret grief from losing one somehow still slams into me like a ton of bricks, knocking me off my feet, filling me with heartache and compassion. I imagine in my head whom I can never reach out to and whom may be thrust into an isolation that I really believe is unimaginable to most people.

Once a resident death has touched you and your program in such a deeply personal way, it is likely that the awareness of other resident deaths (even far removed from your program) will cause strong feelings and memories to resurface. Perhaps this is akin to the reaction of survivors of mass casualty shooting events when another tragedy occurs. However, with mass shooting events there seems to have been an informal established culture where the last one reaches out to the next. We still are generally a culture of silence.

Here was one program's response:
When we heard of the death of a resident at Kentucky we were all hurt knowing that this was young physician with his entire life ahead of him, but he could not see the positives and was clearly hurting badly. In an attempt to support the other residents at Kentucky ,we obtained a list of all the residents in the program from their website and our residents wrote one of their residents a sympathy card. We expressed our concern for them, our sympathy and extended a hand if they needed any help. I collected all the cards and we mailed them in bulk to the residency. The letters and cards were individualized and personalized so if one of my residents knew one of theirs they wrote the card and extended their help. I think it was helpful to discuss suicide and sudden deaths in our program and helped to show everybody that our community sticks together.

Section II- Knowledge

- **Statistics in Resident Deaths**
- **ACGME and Resident Deaths**
- **Is There Risk of Contagion?**
- **Semantics and Messaging with Suicide**

Statistics in Resident Deaths

Just the Facts:

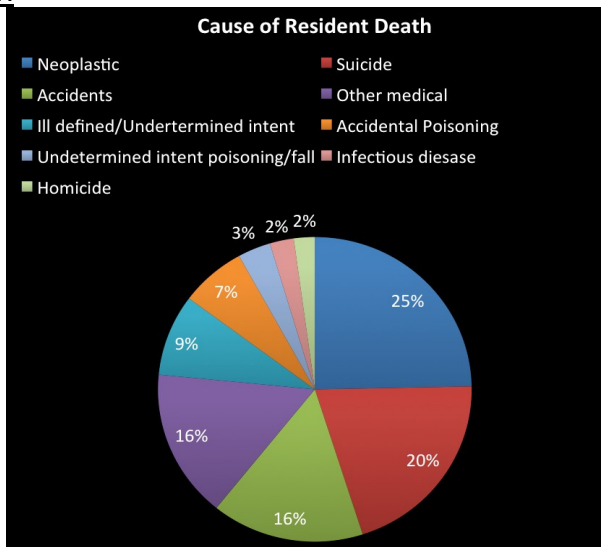
- Resident death by suicide is less frequent than the general population.
- Overall suicide is the #2 cause of resident death. It is the #1 cause of death in male residents and #2 cause of death in female residents.
- The greatest proportion of residents that died by suicide are PGY1s.
- Academic quarter 1 and 3 have the highest number of resident suicide deaths.

The ACGME Report on Resident Death from 2000-2014:

In 2017, the ACGME published an analysis of the cause of resident deaths between 2000 and 2014 and compared those to the age-matched general population by matching data from the Accreditation Data System maintained by the ACGME to the National Death Index.

- In the study period, there were 324 resident deaths. Of those, 311 causes of death were identified.
- Overall, the rates of death in resident populations are lower than the age-matched general population (19.96 deaths per 100,000 person years in residents versus 105.4 per 100,000 person years in the general population; 4.07 suicides per 100,000 person years in residents versus 13.07 per 100,000 person years in the general population).
- This data did not reflect the death rates in non-ACGME accredited programs, although the preliminary analysis showed no significant difference in the rate of resident deaths in ACGME accredited versus non-ACGME accredited programs. .
- No trend in the rate of resident deaths (either positive or negative) or common cause of death was identified.

Overall Cause of Death



1. Cancer (80 deaths total, 42 in men, 38 in women)
   Most common cancers were those of the central nervous system and the breast.

2. Suicide (66 deaths total, 51 in men, 15 in women)
   Manner of dying by suicide: most common was by firearm or by overdose on drugs or other substance, followed by leaping from height, and asphyxia by hanging, strangulation, or inhalation.

3. Accidents (51 deaths total, 34 men, 17 women)
   The majority were due to motor vehicle collisions (33 deaths total) or pedestrian or bicycle accidents (5 deaths total).

   There is no data to suggest whether resident fatigue contributed to fatal motor vehicle collisions in residents.

4. Medical or surgical illness (51 deaths total, 17 women, 34 men)
   Majority due to complications from cardiovascular disease (22 men, 8 women).

5. Accidental poisoning (22 deaths total, 19 men, 3 women)
   More than half (12) were anesthesiology residents.

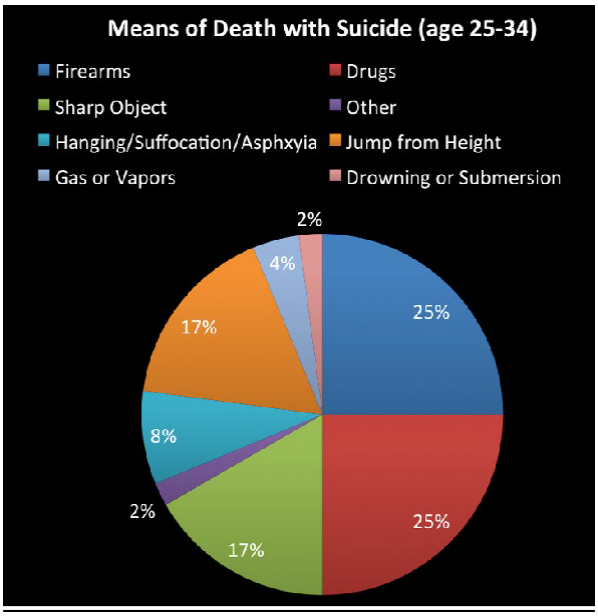
6. Unclear intent (11 deaths total, 5 by fall, 6 by poisoning).

7. Infectious Disease (8 deaths total , 3 women, 5 men)

8. Homicide (7 deaths total. 3 women, 4 men)

9. Unclear cause of death (28 deaths total, 6 women, 22 men).
   These included causes of death that were unable to be identified and causes of death that were not clear.

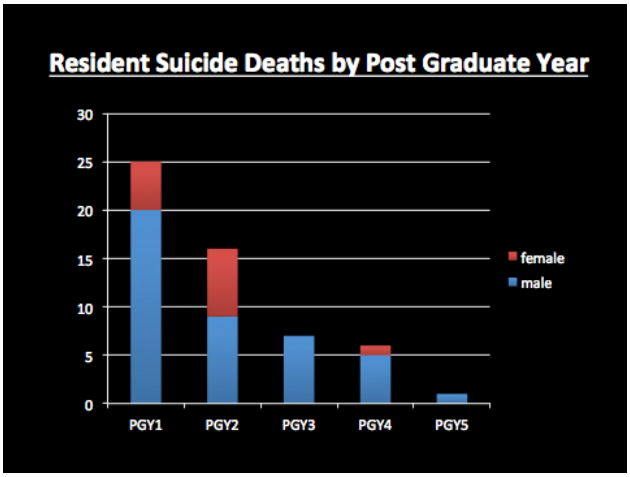
Means of Suicide



The most common means were firearms and overdose on drugs or other substance. These were followed by leaping from height, and asphyxia by hanging, strangulation, or inhalation.

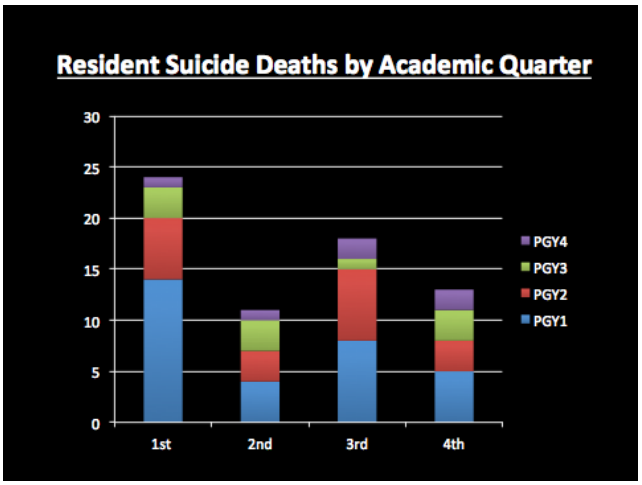
Timing of Resident Suicides By Post Graduate Year:

The majority of resident suicides occurred in the first two years of post-graduate training.



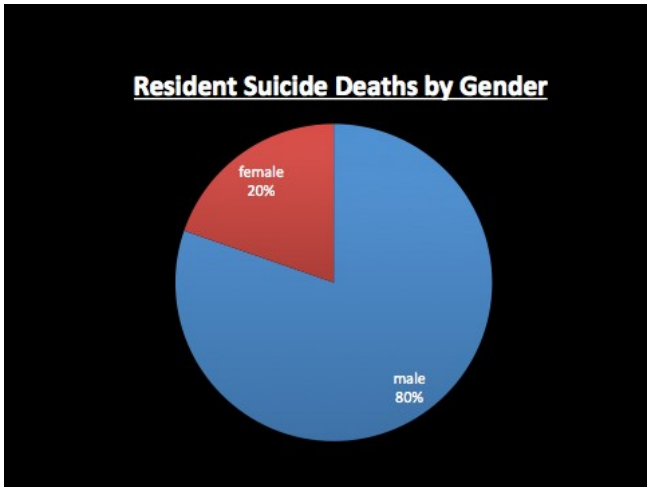
Timing of Resident Suicides By Academic Quarter:

Resident suicides occurred most frequently in the months of July through September and January through March, possibly due to role transition stressors in the early part of the academic year, and the post-holiday mid-winter period in the latter part of the academic year.



Resident Suicides By Gender:

The suicide rate for male residents is over 2.5 times higher than female residents.



Resident Suicides By Age:

Older residents (those aged 35-44 and 45-54 years old) have higher rates of suicide than younger residents (aged 25-34 years old) and higher rates of suicide in comparison to their age-matched cohort in the general population.

Resident Suicides Compared to the General Population:

The odds ratio of resident cause of death compared to the general population was less in every category.

Cause of Death	**Odd Ratio to the General Population**
Neoplastic Disease	0.44
Suicide	0.27

Accidents	0.34
Accidental Poisonings	0.10
Undetermined Cause	0.16
Undetermined Intent	0.34

In contrast to attending physicians, resident physicians were found **less likely to died by suicide** than members of the general population. It is likely that the general population's deaths are subjected to the same lack of clarity in some cases as physicians. However, even if all the deaths from accidental poisonings, undetermined causes and undetermined intent were included as suicide, the odds ratio of suicide would still be below the general population.

Yaghmour N, Brigham T, Richter T, et al. "Cause of Deaths of Residents in ACGME-Accredited Programs 2000 Through 2014: Implications for the Learning Environment. " Academic Medicine July 2017. Vol 92 (7) 976-983.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5483979/ (Full Free Text)

ACGME and Resident Deaths

We ARe All Part of the Solution: A Call to Action from ACGME CEO Thomas J Nasca, MD, MACP
http://www.acgme.org/Meetings-and-Events/Annual-Educational-Conference/Blog/Details/ArticleID/6300/We-Are-All-Part-of-the-Solution-A-Call-to-Action-from-ACGME-CEO-Thomas-J-Nasca-MD-MACP

Is there risk of contagion?

The short answer is yes. After a publicized celebrity suicide, suicide rates often increase.

- Marilyn Monroe- after her suicide, deaths by suicide rose 12% in the subsequent months per the CDC
- Robin Williams- after his death, death by suicide rose almost 10% (an additional 2000 people)

For those with suicidal ideation, publishing details about a suicide can trigger a crisis. However, it doesn't have to be a celebrity. Schools and specific populations, particularly aboriginal, have been known to have suicide clusters. Perhaps GME shares some of the exact same characteristics as these native populations:
Many native reserves consist of individuals who are closely related and share the same social predicaments, thus, the impact of a single suicide is often felt by the entire community. Because of the closeness of the residents, there is a greater risk of a cascading effect leading to a cluster of suicides ….It's devastating whenever an individual is successful. It impacts not only the immediate family, but the entire community. That's where the ripple effect seems to take place.

There are many institutions in which there have been multiple suicides over time. MIT and University of Pennsylvania have been two undergraduate schools where this has received special attention. There are also GME sites in which multiple suicides have occured.

Experts do not know how to stop suicide 'copycats'' but recommend:

- Avoid discussing details of the suicide- even the what might seem like the most trivial detail can become a focal point. With Kate Spade's death, "hanging by a scarf" was highly criticized by the suicide prevention community.
- Discuss messages and stories of hope. (Papageno Effect of Suicide)
- Encourage people to seek help.
- Check in with each other.

Terms:

- Suicide Cluster- multiple people attempting or dying of suicides in a short time frame
- Mass Cluster - clustered suicides within a short time but not close geographically and are often heavily related to media reports of celebrity suicides.
- Point clusters- suicides occur closely in time and location- often in institutional settings (hospitals, prisons, or schools, etc)
- Echo clusters- suicides at a location that happen clusters that occur well after the time initial cluster.

Olsen R. Suicide Cluster and Contagion. Info Exchange 10. 2013:1-5.
https://www.sprc.org/sites/default/files/migrate/library/OlsonSuicideContagionSuicideClusters2013.pdf

Mental Health Experts Concerned about 'Suicide Contagion' after deaths of Kate Spade and Anthony Boudain
http://www.latimes.com/local/lanow/la-me-ln-suicide-contagion-20180608-story.html

Semantics and Messaging with Suicide

The words to say-- and not to say-- about suicide
https://www.cnn.com/2018/06/09/health/suicide-language-words-matter/index.html

Section III- Logistics and Procedures

After A Suicide: A Toolkit for Physician Residency/Fellowship programs

http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pd

This extensive document was developed by the American Foundation of Suicide Prevention and the Mayo Clinic for departments and institutions to have a plan in the event of a resident or fellow suicide. This is the go-to reference for logistics and communications.

Getting the News

There is no standard or typical way to 'find out' that a resident has unexpectedly died. It could be a call from the family to the department or institution, police notification, a co-resident who found your resident dead, or the resident did not show up for work which prompted a search. In any event, if you're reading this then you probably already have passed this point.

Meetings

- **DIO-** Does your DIO know? The DIO may have experience, resources, communication plans or connections that will be helpful. The DIO may be helpful in contacting the ACGME for support.

  Resident Death by Suicide: The GME Office's Role in Response and Management
  ACGME Webinar- June 21, 2017
  http://www.acgme.org/Meetings-and-Events/Webinars

- **Residents:**

  This is an Emotional Mass Casualty Event

  One cannot overestimate how stressful and difficult this event can be. It is reasonable to assume every person in the room will have "taken a hit" in some manner. There will be a wide range of questions, emotions and reactions. In addition, there may be significant communication challenges as not all the information may be known or may be able to be shared. All of this is occurring at at time when the program leadership may also feel devastated.

  It may be worthwhile to engage others who help-especially as one or more may require individual attention. Options may include-
  - Other faculty within the department,
  - Faculty from other departments-especially those with experience,
  - Members of the institutional wellness committee,
  - Second victim program facilitators,
  - Social workers,
  - Pastoral care,

- Employee assistance program therapists and counsellors, and
- If one works with a university, there may be additional people resources available through the university for crisis management.
- A country's mobile crisis service- especially to respond to suicide or traumatic events.

Logistics:

It is a logistical feat to be able to find a time and venue to speak to all the residents and/or faculty at one time. Still make every attempt for the a group meeting.

Advice:

Here are some reflections and words of advice from people who have done this in the past:

- Just being together is important. (CD)
- Connectivity and community are critical at this moment. (CD)
- The feeling in the room doesn't need to be controlled. (CD)
- It took a long time to get people talking but once started they didn't want to stop. (LH)
- Eventually someone will fill the silence. (LH)
- Shut up and listen. (LH)
- Do it soon. We had a resident die on Friday and scheduled the meeting for Monday. It was too late. Things spread between the residents and were all over social media by that time. (JY)
- Residents want time to be together. Facilitate that quickly (DE)
- Although important, residents respond viscerally to broadcast announcements which feel impersonal about available mental health resources (DE)

Patel A. Suicide. In House. May 7, 2017
http://in-housestaff.org/suicide-769

Section IV- Program Coordinators

- Be sure to collect emergency contact information from all residents upon arrival as an intern. This will be detrimental to have so that you know who to contact in the event of a tragedy or an emergency for that matter. Update this information annually and if possible obtain two people that are not in the same location (e.g. significant other and sibling, or parent and best friend).
- Be sure all program leadership has access to emergency contact information in the event the PC is not reachable.
- Logistics that would have to be dealt with:

    - Any shifts deceased resident was scheduled for would need to be covered in some way. Without alarming residents the back up call system would need to be put in place. We have a “jeopardy call” in place at all times in the event a resident becomes suddenly ill, death in family, emergencies etc.
    - Block schedule would need to be reworked to remove this resident from all future rotations(contact off service rotations - can they do without coverage vs.expanding coverage amongst other residents.) It is unlikely that this position would be filled within the academic year.

- Contact Employee Assistance Program/Psychiatry PD - they can help to break this news to the residents. (PC’s should be sure to be included in this session. They are likely grieving too.)

Section V- Other Considerations

- We had a resident pass away in 2013 from Metastatic melanoma (diagnosed in March, she died in July).We decided to have a fund in her name that we use each year to sponsor a Palliative Care Lecture in April. We host a guest speaker and each year her family comes. We chose this over an award as we felt itwould help carry out her memory in a way she would want. Her family was invited and did attend the graduation. While we weren't allowed to give her an EM diploma as she didn't finish the program, we gave her an "Honorary Degree." Her family accepted it when we handed out the diplomas. (not a dry eye in the room, admittedly). She is included in the Photo of Graduates (on our Alumni wall within our Dept) in which she is listed a s Honorary Member. Her classmates were adamant about this (and certainly leadership was in agreement) Her family actually brought each of the graduates a gift symbolic of her life.

- If you are leaning toward an award, our Neurosurg Dept also had a resident death in 2011 for which they have an annual award - all residents on our campus are eligible. Award Criteria: resident physician who has made significant contributions to the care of patients during training and demonstrates excellence in one or more of the following areas: patient care and procedural skills, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, interpersonal skills and communication, research, education of medical students and other residents, and community service.

- We had a resident die on a family vacation during his final year of residency. We established an award that is given out each year to a senior who embodies the spirit of that resident. We send the parents a picture each year of that personand it allows them to remain a part of our residency family.

- The DIO and program director are encouraged to reach out to the family as soon as possible to determine how to include them in a memorial service, or to obtain an address to receive expressions of condolence. In cases in which the cause of death is not clearly suicide, the family may wish to withhold information about cause of death until suicide is substantiated by a coroner's report. It is helpful to have a sensitive conversation about how to respect their desire for privacy and also notify their loved one's colleagues about what happened.
- If the family is willing, they should be invited to a campus memorial service for theirloved one. The residents are able to express their condolences to the family, and the family is often warmed by the expressions of care and the positive stories about their loved one. It helps residents to hear stories about their deceased friend and widens the narrow context they may have had about that individual.

- ❖ Roommates-Making sure they have appropriate mental health resources and extra attention/check ins.

- ❖ When a co-resident finds the one who is dead.
  - ➢ Residents typically reach out to each other or their program director for support after they discover an individual who has completed a suicide. If this is a roommate, they may wish to move out of their apartment, live with a friend for a couple weeks, or take a week leave of absence to be with their family. It is very important for that individual's program director to check in with them every few days, and to encourage them to seek mental health support. It is fairly common for this individual to experience symptoms such as flashbacks, lack of appetite, and insomnia. It may be helpful to offer them time away so they do not have to continually field questions from people who may be more curious than invested in their emotional wellbeing.
  - ➢ If possible, allow this individual to return to work in a rotation that is less demanding and/or time consuming. This will allow the resident to have time to obtain ongoing mental health support, engage in self-care behaviors, and engage with supportive friends.

- Social Media- What do you do when they come for you
  - This is challenging in today's world where things spread quickly and openly.
  - Our institution often will send out the "social media policy" after any event which in the cases of suicide and death have triggered very negative responses from the resident as it is seen as impersonal and a "cover up"
  - Recognize that social media postings will take place and prepare yourself for it and the likelihood for responses.
  - Information may be inaccurate and to the best of your ability you should be transparent and ensure residents that you will provide honest, open communication.
  - Physician suicide, including medical student and physician suicide, has become a social media target by some individuals seemingly bent on accusations of exclusive responsibility and guilt of the medical system for these tragic deaths. The institution may be faulted or criticized for public responses or inaction. These outside postings may come quickly, with very limited information and without consent of release of information from the family or the institution. It is especially challenging, even painful, in your leadership role as it is likely that you should not respond on social media platforms. It may be helpful to feedback information you see to your DIO or other leadership. On the ground level, the most important thing is for your own residents to understand that you are responsive, communicative and interested in their well-being and ability to get through their grieving process.

- ❖ Institutional Responses. Organizations that experience a suicide often become hypervigilant in the immediate aftermath. It is appropriate that program directors,

department chairs and residency coordinators look carefully at their procedures and structures to see what can be improved, or to determine if the individual “fell through the cracks.” Institutional leaders may become very anxious after suicide as they hear from other institutions or oversight organizations who may conduct an investigation or examine how the institution has dealt with the suicide. Leadership often feels a sense of failure that they may have missed a clue that suicide was forthcoming. Some well-meaning faculty and local clinicians may rush forward with new program proposals and interventions that seem helpful, but that they might not be prepared to sustain for a long period of time. It is immensely helpful to have meetings across all levels of leadership aimed at offering support, increasing a sense of solidarity across the organization, and careful review of procedures and what is known about the suicide. This reduces the natural tendency to either blame one another, create unsustainable programs, or overlook important facts that contributed to suicide. Such meetings help maintain calm, assist faculty and administrators to feel supported and also helps the institution to present a united front to its own organization and outside entities.

Section VI- Resources

Second Victim Resources

https://www.cordem.org/resources/professional-development/wellness--resilience---resources-page2/wellness--resilience---resources-page/

Suicide Resources

Crisis Management Tool Kits:

AAIM Resident Suicide: Crisis Management for a Training Program
http://www.im.org/page/crisismanagement

After A Suicide: A Toolkit for Physician Residency/Fellowship programs
http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pdf

Articles:

Kathyrn- http://www.nejm.org/doi/full/10.1056/NEJMp1615141#t=article
Kathryn was 3 days into her 4th year of medical school when she killed herself jumping from a building in New York City. This is a reflection of the events from Dr. David Muller, dean of students at It Icahn School of Medicine at Mount Sinai.

Depression and Suicide Among Physician Trainees: Recommendations for a National Response Goldman ML, Shah RN, Bernstein CA. JAMA Psychiatry. 2015;72(5):411-412.

Cause of Death of Residents in ACGME Accredited Programs
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5483979/
Yaghmour N, Brigham T, Richter T, et al. "Cause of Deaths of Residents in ACGME-Accredited Programs 2000 Through 2014: Implications for the Learning Environment. " Academic Medicine July 2017. Vol 92 (7) 976-983.
(Full Free Text)

Patel A. Suicide. In House. May 7, 2017
http://in-housestaff.org/suicide-769

Websites:

Ten Facts About Physician Suicide and Mental Health
https://afsp.org/wp-content/uploads/2016/11/ten-facts-about-physician-suicide.pdf

Preventing Physician Distress and Suicide
https://www.stepsforward.org/modules/preventing-physician-suicide

Breaking the Culture of Silence on Physician Suicide (NAM Discussion Paper)
https://nam.edu/wp-content/uploads/2016/06/Breaking-the-Culture-of-Silence-on-Physician-Suicide.pdf

Podcasts

The Dark Side of EM
https://www.emrap.org/episode/burnout/burnout
A 8:11 minute EMRAP short interview with Dr. Ramin Tabatabai discussing a personal experience of a friend and colleague who died by suicide.

Suicide Risk in Physicians
https://www.emrap.org/episode/suicideriskin/suicideriskin
A 26:03 minute EMRAP discussion on physician suicide with Christine Moutier (CMO of the American Foundation of Suicide Prevention), Mel Herbert, Ramin Tabatabai and Mattieu DeClerck.

Video Resources

Make the Difference: Preventing Medical Trainee Suicide
https://www.youtube.com/watch?v=I9GRxF9qEBA&feature=youtu.be
A 3:53 minute PSA video from the American Foundation of Suicide Prevention and the Mayo Clinic explaining that everyone can be aware of the signs of depression and suicidal ideation and can make a difference in suicide prevention.

Just Ask
https://www.youtube.com/watch?v=4DUJAzA-D3c&t=5s
A 1:37 minute PSA video developed by CORD and RSA/AAEM with Dr. Christopher Doty to raisi awareness of physician suicide prevention.

I Would Call- A Suicide Prevention PSA https://www.youtube.com/watch?v=Ek-cos9gNKY&t=31s
A 2:30 minute PSA video developed by CORD and RSA/AAEM in conjunction with Dr. John Draper, the director of the national crisis hotline which explains the similarities of EM docs and crisis workers and reasons to call the hotline.

Physician Suicide: What You Can Do to Save a Life
https://www.youtube.com/watch?v=REFj5N3N8S
A 57:40 minute video with speaker Dr. Michael Myers, a psychiatrist from with particular interest and expertise in physician suicide, lecturing at the 2017 Nevada Psychiatric Association for the Suicide Prevention Series

Struggling in Silence: Physician Depression and Suicide
https://www.youtube.com/watch?v=i1Sz-3GnvGI
A 53:33 minute documentary which explores personal stories of physicians struggling with these issues.

Books

After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances
https://www.sprc.org/sites/default/files/migrate/library/aftersuicide.pdf
Online PDF by SPRC (Suicide Prevention Resource Center)

Case Discussion

ALiEM MEDiC Series: The Case of the Resident At Risk Case:
Case Discussion- February 3, 2016
https://www.aliem.com/2017/02/medic-case-resident-at-risk/
Expert Commentary-February 17, 2016
https://www.aliem.com/2017/02/medic-case-resident-risk-expert-review-curated-commentary/

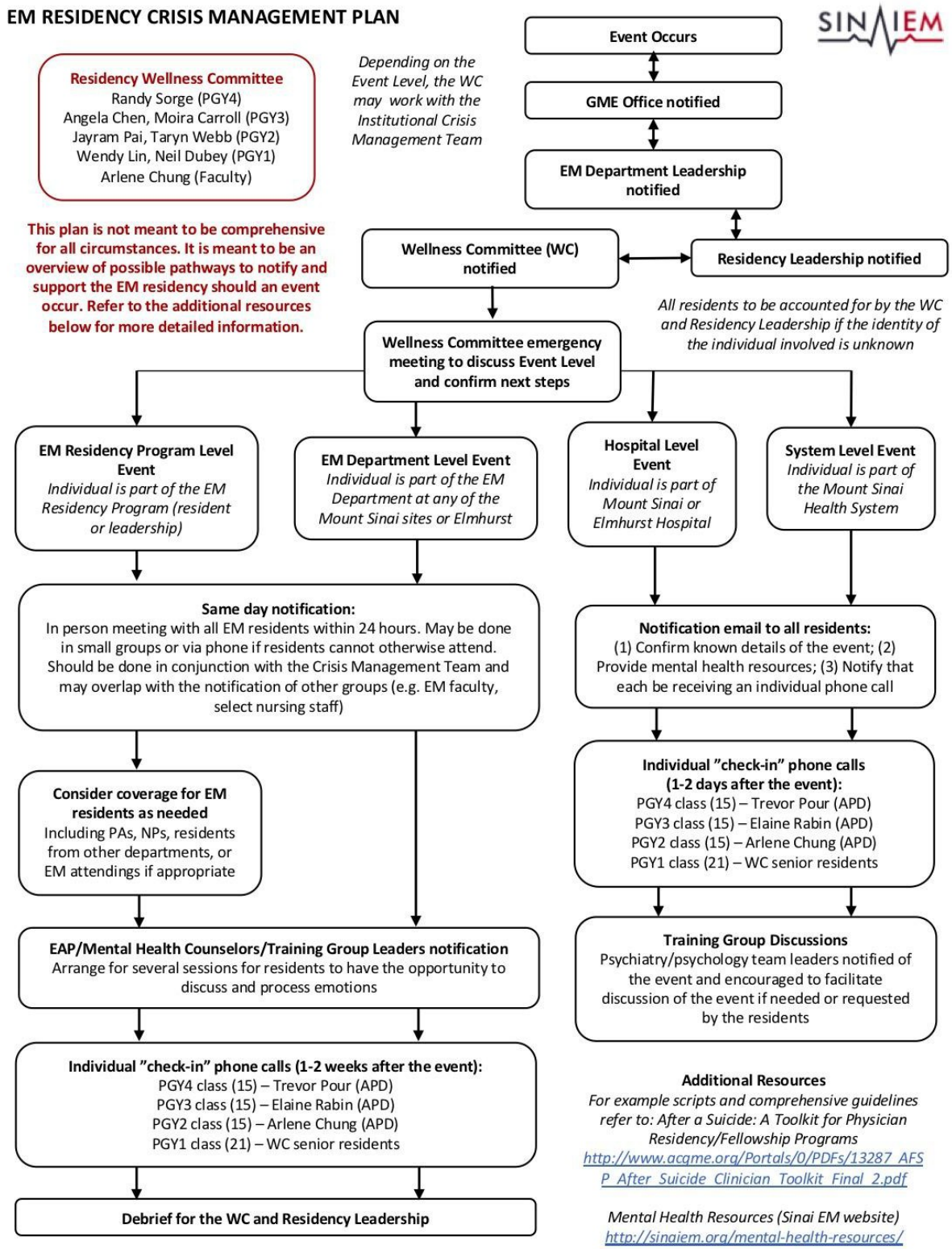
Ted Talks

The Bridge Between Life and Death
https://www.ted.com/talks/kevin_briggs_the_bridge_between_suicide_and_life

A Matter of Laugh and Death (19:11)
https://www.youtube.com/watch?v=IeMg6OFYfU0
Comedian Frank King discusses suicide and his personal struggle with suicidal ideation.

Why We All Need to Practice Emotional First Aid (17:24)
https://www.ted.com/talks/guy_winch_the_case_for_emotional_hygiene

EM RESIDENCY CRISIS MANAGEMENT PLAN



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