COUNCIL OF RESIDENCY DIRECTORS IN EMERGENCY MEDICINE

Mass Casualty Incident

CORD Program Survival Packet

A playbook for program leadership to prepare and respond to the aftermath

Sponsor: CORD Resiliency Committee

Team:
Douglas Char, MD - Washington University in St Louis
Christopher Hunter, MD - Orlando Regional Medical Center
Ross P. Berkeley, MD - University of Nevada, Las Vegas
Christopher Sampson, MD - University of Missouri-Columbia
Kerry McCabe, MD - Boston University Medical Center
Bonnie Kaplan, MD - Denver Health Medical Center
Barbara Blok, MD - Denver Health Medical Center
Loice Swisher, MD - Mercy Hospital Philadelphia, Drexel University

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Message:

A mass casualty incident (MCI) is a devastating event for the victims, families, communities, and healthcare providers. The range of emotions experienced by providers involved in MCI patient care may include anxiety or exhilaration, fear, sadness, emotional and physical exhaustion, trouble sleeping, and isolation. You may have a sense of accomplishment (you responded to what few others are called upon to do). Second-guessing after the fact (e.g., "what if I had…?") is quite common. Residents and faculty not involved in MCI patient care may also be affected with unexpected emotions including guilt and frustration – some may be disappointed they were unable to be present to assist and bond with their colleagues, having missed out on being involved in the 'big one', then feel guilty for having such thoughts, or even feel guilty about "letting the team down" by not being there. The impact starts immediately but often peaks hours and days after the event, and may last for weeks and months.

As a Program Director, you play a critical role in both the coordination of the immediate resident MCI response and the subsequent emotional recovery necessary to build resident resilience and help mitigate the development of burnout and PTSD.

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.

Section I – Timeline

Pre-plan

a) Maintain up-to-date contact information for residents, faculty, and administrative staff (emergency contact info should include: email, cell phone, pager, home address, family contact)
   i) Consider developing group chats, email distribution lists, or phone trees to rapidly reach all residents
b) Update residency emergency contact procedures and flowsheet:
   i) Identify initial points of contact (Program Coordinators, chiefs, directors, GME office) for MCI event
   ii) Identify non-clinical personnel who will communicate MCI information downstream to residents via text or email during the acute phase
c) Review hospital emergency surge capacity plan (on a regular basis so that people are familiar with it)
   i) Identify the trigger and process to bring additional resident and faculty resources to the Emergency Department
d) Engage residency program personnel in MCI drills
   i) Ensure residents at all training levels participate in department and hospital MCI drills to gain familiarity with the system
   ii) Acknowledge predictable events in the community that could become an MCI challenge (athletic events, political events, cultural events, etc) and routinely review protocols to normalize advance preparation and review of systems

Acute Phase (minutes to hours)

<u>While clinical care for MCI is ongoing in the Emergency Department:</u>

e) Prioritize support of clinical care delivery
f) Ensure the safety of trainees, staff, and loved ones
g) Follow hospital MCI protocols for operational procedures
   i) Establish a need for additional resident resources versus shelter-in-place
   ii) Remember to reserve resident resources for the next shift
   iii) Expect that there will be a strong desire by residents to drive to the hospital to assist. Consider in advance how to best communicate *'we've got enough people here already, and need you to be fresh as a member of the relief team...'*

After clinical care for MCI has transitioned from Emerg Department:

a) Contact residents who provided direct clinical care during event (debrief and support) – they will not appreciate that they need this
   i) Immediately after clinical care has been transitioned, if possible
   ii) Face-to-face, if possible
   iii) Establish availability for future needs
   iv) Reach out to residents who *did not* provide clinical care during event, and consider the psychological impact of guilt and shame in failure to assist colleagues/provide patient care during the event
   v) Faculty will benefit from analogous process, but this is not the Program Director's responsibility
b) Self-care – address personal and family needs, adequate rest and nutrition
   i) Rely upon your Associate/Assistant PDs (you must all work as a team to support each other)
c) Organize group debriefing
   i) Reserve space and time to gather the entire program
   ii) Hold initial debriefing 24-48 hours after the event
   iii) Utilize hospital, GME, or local resources for physician coach, licensed mental health practitioner, and/or grief counselors.
      (1) While it is not typically the role of the PD to coordinate, consider advocating to hire professional debriefing counselors trained in ICISF (International Critical Incident Stress Foundation) principles of critical incident stress debriefing (CISD), and critical incident stress management (CISM). Although these formal protocols may be rigid and time-consuming, they are literature proven to decrease maladaptive behaviors in response to stress. Given the constraints of continued clinical care in the aftermath of MCI, most debriefing counselors adapt heavily from these protocols and manipulate them to better align with work-flow (as yet, there is no literature on the benefit of more streamlined systems).
   iv) Establish a 'safe space' and encourage open discussion in a judgment-free environment
   v) Focus on emotional impact and mutual support (active listening more than a set agenda)

vi) *Do not* address logistical issues/systems failures at this time
vii) Discuss an approach to media and social media
(1) A specific reminder of HIPAA and privacy practices
(2) Encourage avoidance of media appearances/interviews without explicit involvement of hospital/GME public information officer (PIO) or program leadership
viii) Provide connection to employee assistance plan (EAP) resources

d) Identify individuals in need of additional support
i) Encourage the utilization of support resources – needs to be ongoing, not just mentioned once
ii) Identify close peers/mentors and encourage them to maintain open communication
iii) Consider establishing a mentorship link with residents from another program who have previously been through an MCI event
(1) Offer as a potential resource to consider
(2) May be helpful for those uncomfortable with the idea of speaking with a counselor

Sub-acute Phase (Days to Weeks)

e) The community at large
i) Undoubtedly residents and faculty will be affected in the same way as the rest of the community, in addition to their specific involvement as emergency physicians – this includes feelings of despair, fear, insecurity, violation, etc.
(1) Some residents may have personal connections to victims or their family, or share religious, ethnic, sexual or gender identity to those targeted in the event
(2) Individuals with existing mental health issues may find themselves triggered by the event regardless of their level of clinical involvement

f) Frequent check-ins with residents and staff
i) Peer-to-peer (chiefs, upper levels)
ii) Faculty-to-resident
iii) Faculty-to-faculty (if residents see faculty reaching out they are more likely to do so as well)

g) External communications

i) Expect a significant (i.e., 'overwhelming') initial outpouring of concern and support for residents, faculty, and hospital staff, which may include:
   (1) Food donations (e.g., numerous pizzas and anything else that can be delivered)
   (2) Signed posters
   (3) Cards
   (4) Emails
   (5) Text messages
   (6) Voicemail messages on office lines and personal phones
ii) Recognize it may not be feasible to personally contact and/or thank each individual/group (nor is it necessary)
iii) Consider various methods of mass communication to address any potential concerns regarding resident wellness (e.g., '*We're all OK...*'):
   (1) Program Twitter account or website, or other social media
   (2) Professional organizations (e.g., CORD, SAEM, ACEP, EMRA, AAEM) - use them to "get the word out"

h) Media
   i) Utilize hospital Public Information Officer (PIO) or media relations as intermediaries
   ii) Consider how you want to promote resident involvement (i.e., they deserve credit for their clinical response but may not want the weight of the media attention)
   iii) Involve residents in the decision to speak with media or not
      (1) Provide media training/prep prior to interviews to decrease stress
      (2) They may say "yes out of sense of obligation", make sure their desire is personal

i) Social Media
   i) Advise regarding potential regional/national spotlight on personal social media accounts
   ii) Warn those with public accounts of potential media/conspiracy theorist engagement (resist the urge to 'correct' naysayers; <u>do not engage with trolls</u>)

j) Vigils and Memorials
   i) Encourage participation as residents see fit (there is strength in groups)

k) Emotional processing of the event
   i) Consider encouraging residents to write their thoughts in a journal, which may be therapeutic

ii) If any are willing to share their experiences, it may be helpful in the creation of an anonymized experience log to benefit residents from other programs who go through a similar situation in the future
iii) A valuable role of the PD is to process or acknowledge their own emotions and reactions in the subacute phase. A role model who can process complex emotions and reveal their humanity permits others to wrestle with those feelings, which is important to moving through them constructively.

l) Post-traumatic stress disorder
   i) Monitor for signs and symptoms in residents and faculty
   ii) Consider schedule manipulation for most affected residents for time off, avoidance of trauma bay shifts, etc.
      (1) Share this decision-making with residents – they may or may not want to 'get right back on the horse.'

Post-acute Phase (Weeks to Months)

m) Wellness Activities
   i) Schedule group activities
n) Monitor for burnout
   i) Engage individually with residents that were clinically involved as well as those that were not ('survival guilt') – PTSD and burnout may only manifest significantly after the initial 'surreal-ness' of the event has subsided
   ii) Consider mandatory meetings with physician coach/counselor if available
   iii) Lean on resident peers or mentors to identify those who are struggling
   iv) Utilize confidential surveys
   v) Integrate burnout assessments into semi-annual evaluations
o) Additional resources may be offered during a limited window of time
   i) Hospital administrators, donors, various private and governmental agencies may offer capital resources to help prepare for 'the next event'
   ii) Consider potential training and capital needs of the program and department that may be relevant to an MCI response
   iii) Anticipate those resources will dry up with time as attention re-focuses onto other pressing matters
p) National speaking/Authorship
   i) Anticipate numerous invitations to speak or serve on panels
   ii) Encourage residents and faculty to participate as much or as little as desired

q) Back to normal
    i) “You’ll eventually have to buy lunch again” – attention will fade, administrators will start focusing on metrics and experience scores again, people will stop asking you questions about the event

Long Term (Months to Years)

r) Graduation – do you address the MCI or avoid it during a celebratory event?
s) The anniversary
    i) The community at large and hospital will address the anniversary in some way
    ii) This can trigger unwanted emotions
    iii) Reach out to residents or coordinate an unrelated wellness activity
t) Recruitment
    i) Consider how this event may play into recruitment
    ii) Anticipate questions from rotators, applicants, and interviewees
        (1) Have an idea of how you want to respond
        (2) Advise the residents to consider in advance how they may want to respond
u) Posters and cards of support
    i) Consider when is the ‘right time’ to start taking them down off the walls
        (1) May be viewed as a painful reminder by some vs. a symbol of togetherness by others
        (2) Consider discussing with faculty and residents whether certain ones may be posted long-term
        (3) Consider taking photos of each and creating an archive
v) PTSD
    i) Burnout and PTSD symptoms may persist or begin at any time
w) The ‘next event’
    i) The next large-scale MCI or similar event can also trigger an emotional response
    ii) May also be a good time to reach out to those in need

Section II- Taking Care of Yourself

Personal thoughts from individuals connected to MCI events in Orlando, UNLV, Boston, and Denver (Aurora)

UNLV Perspective *(Ross Berkeley):*

Although I clearly understood it was important to take some time for myself to process the emotions involved during the initial 48 hours after the MCI, there was a sense that food and rest needed to be deferred due to an overwhelming concern of potentially letting the residents down at a time they needed support and strong leadership more than ever. This may involve a very different kind of leadership than many Program Directors are accustomed to providing, especially given the scale involved. Connecting with other residency leaders who had previously been through an experience of a similar nature was enormously helpful on a personal level in those first 24 hours, not only due to the strategic advice I received, but even more due to the validation of the various concerns I had at that time.

Denver Perspective *(Barbara Blok):*

I completely underestimated the benefit of a group debrief for providers present in the ED during the event, initially thinking that I could rapidly return to "business as usual" for both life and work. Our group debriefs was, in reality, the best way I could support both myself AND the residents involved as it normalized everyone's thoughts and emotions while creating an automatic support group of amazing people who were available for a check-in, kind word, or hug in the weeks, months, and years that followed. Recovery is a process – be kind to yourself. In retrospect, I also appreciate the efforts my chair and hospital took to publicly acknowledge the ED providers who were on the front line of caring for the Aurora Theater shooting victims. Being someone who doesn't seek out the spotlight, it felt silly and unnecessary at the time ("we were just doing our jobs"), but in retrospect, I look at these acknowledgments as a positive outcome of what was otherwise a pretty terrible event.

Orlando Perspective *(Chris Hunter):*

Personally, I was in a different role at the time of the incident and was wearing several hats that kept me so busy in the immediate aftermath that I didn't really process much.

The closest thing to self-care for me was discussing things with a close colleague who was engaged in much of the same work (family reunification, EMS and hospital after-action plans, etc) at the time as me. Communicating with other EMS medical directors who had been through similar experiences helped me process it, and my feelings of inadequacy, etc. Our hospital - and the ER specifically - became a safe space, oddly enough. Everyone from faculty, residents, and nurses to hospital administrators would check-in, hug, look out for each other. Our nursing staff was dramatically affected by the incident, not just the clinical care experience but specifically because it targeted the LGBT community, which many staff members are part of. Pulse nightclub was so close geographically to the hospital that the street leading to the ED was mostly closed off as part of the investigation, which played a role in making the department noticeably slower than usual those first few days. I had previously scheduled a vacation a couple of weeks after the incident, and getting away from Orlando in general for a short time was definitely helpful.

Section III- Knowledge

Havron W, Safcsak K, Corsa J, Loudon A, Cheatham M. Psychological effect of a mass casualty event on general surgery residents. *J Surgical Education* 2017:74(6):74-80 https://www.sciencedirect.com/science/article/abs/pii/S1931720417302301?via%3Dihub

Orlando Health Disaster Response Project https://survs.com/survey/h18mv9ou79 This is an open-access, web-based book reviewing the entire account, response, and after-action plans of Orlando Regional Medical Center after the Pulse nightclub attack. You have to log in with an email address to access it.

Parrish, GA, Bondani, KJ, Bullard, TB, Stone, AM, Tarkowski, AF, Ponder, CH, Smith, TN, Weatherford, TL, Hunter, CL, Silvestri S, The Orlando Nightclub Shooting: Firsthand accounts and lessons learned. (2016) *Emergency Medicine*; 48(8):348-56. https://www.mdedge.com/emergencymedicine/article/111036/trauma/orlando-nightclub-shooting-firsthand-accounts-and-lessons

Roozendaal S, Guldner G, Abou-Zaid H, Siegal J, Berkeley RP, Davey D, Allswede M. Tragedy meets GME: the impact of the 1 October mass casualty incident on academic attending and resident physicians [abstract]. *Prehospital and Disaster Medicine* 2019; 34(S1): S72. DOI:10.1017/S1049023X19001572. https://www.cambridge.org/core/journals/prehospital-and-disaster-medicine/article/tragedy-meets-gme-the-impact-of-the-october-1st-mass-casualty-incident-on-academic-attending-and-resident-physicians/D00EE6D07780A4E1DC3EC69A23CCCE27

Group critical incident stress debriefing with emergency services personnel: a randomized controlled trial MCI MR Tuckey, JE Scott - Anxiety, Stress & Coping, 2014 - Taylor & Francis Abstract indicates evidence of improvement in stress/alcohol use outcomes in a group that had coordinated CISD compared to screening or education alone.

Debriefing: An Expert Panel's How-to Guide Brian Chinnock MD, Paul C.Mullan MD, MPH, Lauren E.Zinns MD, Stuart Rose MD, Fawn Brown RN, David Kessler MD, Andrew Grock MD, Jessica Mason MD https://doi.org/10.1016/j.annemergmed.2017.07.005--This article (from 2017) is EM focused on post-resuscitation debriefing (PRD) after difficult cases or interactions, in real-time, to lead to short term and long term individual and team-based care. Not so much about CISD.

Interventions Following a Critical Incident: Developing a Critical Incident Stress Management Team EddieBlacklock https://doi.org/10.1016/j.apnu.2011.04.006--This article (from 2012) gives statistics regarding economic impact of stress related issues, is a brief review of the original CISM (critical incident stress management) concepts from 1983 with additional brief references

to more recent work making suggestions to modifications of the 1983 paper concepts. Also outlines an occupational health approach to developing a CISM team.
The debriefing" controversy" and crisis intervention: A review of lexical and substantive issues MCI GS Everly, JT Mitchell - International journal of emergency mental health, 2000 - ruhk.pw -- This article looks at the controversy regarding whether CISM/D is beneficial or harmful head on, redefines terms, and concludes that CISM and CISD are effective if done by a trained person following prescribed practices, including voluntary participation by those who experienced the event.

Scott SD, Hirschinger LE, Cox KR*, et. al.* The natural history of recovery for the healthcare provider “second victim” after adverse patient events. BMJ Quality & Safety 2009;18:325-330. The MCI provider often experiences “second victim” effects of guilt and shame regarding their performance, similar to that of an adverse patient event. This article discusses the natural history of this recovery, leading to provider Thriving, Surviving, or Dropping Out.

Section IV- Logistics and Procedures

Donations

Expect a massive outpouring of support from individuals, businesses, community and national organizations, and potentially other training programs and facilities across the country. Any donations, financial or otherwise, may represent an avenue for others to be able to assist by addressing the wellness and recovery of the healthcare personnel involved. Some may choose to send food deliveries for those working in the hospital – at one point after the Las Vegas MCI, the hospital had started to refuse any further pizza deliveries due to the stacks of pizzas that were piling up (there were more than 40 pizzas in one Emergency Department breakroom, estimated to represent ~10% of the donations received by the hospital within the first 24 hours). It may become necessary to find tactful ways of declining further food donations or requests to send money, such as recommending donating instead to the American Red Cross or a GoFundMe campaign for victims, if one has been set up.

Posters & Cards of Support

Other hospitals and programs will likely show their support by sending posters, signs, and cards that may be displayed around the hospital, the resident conference room, etc. A common theme noted was that leaders tended to struggle a little regarding how to approach eventually removing these in a respectful manner. At one site, they decided to hold a small ceremony during which the posters were removed and unveiled a permanent plaque hung outside the trauma bay. Consider discussing with faculty and residents whether certain items should be posted long-term, and consider taking photos of each and creating an archive.

Section V- Program Coordinators

Program Coordinators have an essential role during and after the event, however, its important to remember that they lack a clinical background so their response to trauma will be that of a layperson.

During event

1. Be ready to help - there is no job description for this time frame
2. Help to operate phone tree for residency in seeing who is available to work and serve as a communication intermediary for the residency program
3. Coordinate with all involved and be available to do what is needed.
4. Remember that the Coordinators will have emotions regarding the situation too. Have an ALL IN IT TOGETHER approach**
    a) Be careful that they don't become overburdened - they will not have any training to deal with this type of trauma

Post-event

1. Can assist Program Director in follow-ups with residents to assess well-being
    a) Watch for signs of stress in the residents, faculty, and the office staff and communicate that with those who can help if you feel you cannot.

2. May serve a key role as a 'sounding board' to listen to residents and provide emotional support

    a) Keep Kleenex handy & comfort modalities – crunchy snacks, chocolate, stress ball, soft music

    b) Program Coordinators often act as "den mothers" in many programs. Residents may feel more comfortable opening up to them more than faculty about personal issues

3. Be a 'sounding board' to listen to the PD / Program Leadership and provide emotional support to them (not just the residents)
4. Make sure that all people involved, even peripherally, are supported.
    a. Help arrange public time for residency to debrief in large and small groups.
    b. Be ready with a list of resources for all involved. Keep a database of support networks of peers or other experts in your department who could serve as mentors for people affected.

c. Write out a basic script for FAQ as you will receive numerous calls - it is helpful to have answers right next to the phone in case you get bombarded. Hand that list out to anyone who answers the phones in your office, so answers are consistent. You can also use the Word doc to copy and paste into emails- as you will get questions from all angles
    i. Coordinate can follow up on emails, thank you notes, etc. as needed
d. After the immediate issues are addressed, have a group office lunch to break up the day and allow for some psychological down time. While the ER may get donations of food the office staff is often in an outbuilding and may not benefit from the outpouring of support.

Section VI- Lessons Learned, Other Considerations

Debriefing

University Nevada Las Vegas (Ross Berkley)

Absolutely nobody had any difficulty stating that they were 'proud of what everyone accomplished' and all believed the team as a whole did a great job in its response to caring for the multiple victims. However, when asked about their thoughts about their role *on an individual level,* things were quite different. When those who had been present in the Emergency Department described their thoughts, many reported feelings of inadequacy with a common theme that they 'didn't really think they did all that much' on an individual level, accompanied by a general sense of uselessness and the perception that 'everyone else was doing so much more'. Comments like these came even from several who had significant experience with mass casualty incident training. Emotions described by faculty and residents who were home at the time of the MCI ranged from guilt to frustration to even anger at others (for not having awakened them to come to the hospital that evening, since they were scheduled to work in the morning). A valuable insight gained during the debriefing was the importance of helping both residents and faculty recognize that each individual plays an essential role in an MCI response, including those not present in the hospital at the time – those on the next shift (the 'relief team') are a critical element of a successful response to an MCI, though they may not initially believe that to be the case.

There were some faculty who initially thought that the psychological impact of the MCI event would have been akin to a 'really bad shift', since as emergency physicians we routinely take care of tragically injured patients every day without need to debrief or cry – however, an MCI by its very nature differs because of the sheer magnitude of the event itself, and the lasting community and/or societal change that will likely result. Depending on the weapon or device utilized in the event, the injury patterns and severities may also differ from the ballistic or explosive injuries with which emergency physicians are more familiar, and may instead be more akin to battlefield injuries. One faculty member described experiencing images of the multiple injured bodies whenever they closed their eyes, despite having had extensive leadership experience in coordinating MCI responses. Program Directors should, therefore anticipate that their residents and faculty may be victims of the MCI from a psychological perspective.

Boston Medical Center (Kerry McCabe)

Had a discussion with our EAP Social Worker who coordinates debriefings for our institution and has extensive training in the ICISF (International Critical Incident Stress Foundation, created by the founder of this work, Jeffrey T Mitchell, PhD, Clinical Professor of Emergency Health Services at UMaryland) model, which has been studied, improves stress-related outcomes, and actually can only be facilitated by specifically trained people in the model.

This model is time consuming and does not realistically mesh with clinical work-flow. This doesn't mean that nothing can or should be done immediately after the incident or in the days to weeks after, just that there is no model currently in the literature that has been studied and proven effective that meets the constraints of the clinical arena. Because of the multidisciplinary nature of the MCI response, and the reverberations through not only those folks who are present in the ED or the field but also those who were not involved in the immediate response but came in to relieve their colleagues, the logistics for a response need to be substantially adapted from the ICISF model.

Having said that, many places are using home-grown adaptations of the ICISF model, keeping in mind the best practices that are available in the literature around critical incident stress debriefing. Some of the literature addressing these practices and controversies are included in the Knowledge section above.

Orlando Health (Chris Hunter)

We secured a room in the hospital in order to meet as an entire program the day after the incident. Initially, a group of faculty described the event as it unfolded to clear up confusion among the group, and then individuals discussed their experiences. If I remember correctly, we discussed as a group the clinical care, the barriers to care providers felt, and had a broader discussion about what we, as a group, felt we should do next. Looking back, I wish we had focused less on the clinical aspect of the event and had a more structured debriefing but at the time the emphasis from the residents seemed to be more about knowing what, exactly, happened. This is also when it became clear that some of our faculty (and I'm sure some residents that were less vocal) were upset about not being called in. Orlando Health has a "physician coach" available for the

concerns/wellbeing of the residents and physicians. Everyone was encouraged to reach out to her. Many of our trauma surgeons were open about meeting with her after the event, which I believe helped reduce the stigma that individuals may have felt.

Denver Health - Univ of Colorado (Barbara Blok) Boston University Medical Center *(Kerry McCabe)*

We held a group debrief for those who provided care in the ED at a faculty member's home a week or so after the event. Since we had an unsophisticated disaster call-down process for ED providers at that time, our actual number of providers was quite small making a smaller venue possible. A psychiatrist specializing in PTSD helped facilitate the discussion (we now have a Critical Incident Stress Debrief team). We focused on each provider's experience and emotions, letting each talk in turn. I was particularly impressed by the emotional toll the experience had on the 2 off-service providers (an internal medicine resident and a neurology resident) who were in-house and responded to the event making it important to include them in the debrief. The psychiatrist then discussed strategies to mitigate the post-traumatic stress symptoms all were experiencing. The University of Colorado Hospital established a process for providers/hospital personnel to access free one-on-one counseling sessions and sent out frequent email reminders to all hospital staff encouraging participation. I have come
to believe that scheduling opt-out counseling appointments for providers/personnel is the correct approach – many of us were simply too emotionally overwhelmed to do this on our own but would likely have gone if scheduled.

Recruitment

Years later we still struggle a bit with how to approach this. Currently, it is acknowledged as a brief talking point, but nothing expansive. Applicants that ask seem to do so more out of curiosity or from the angle that the experience is a strength, of sorts.

For several years after the marathon bombing, we still got questions about it during the interview season. I agree with the writer above, most candidates asking questions had a bit of a movie-screen remove from the events, really seeing the experience more as a badge of EM badassery rather than as the complex emotional event that it was. This juxtaposition brought an additional closeness to the resident group, as it outlined just how

different it is to experience this kind of event than it is to see it on the news. In the end, the candidate questions offered the opportunity to reflect on the kind of teamwork that we value and experience in our department, and the attention that we pay to each others' emotional well-being.

Public Relations

Orlando Health scheduled a press conference at the hospital two days after the event, including physicians and one of the victims. Dr. Silvestri encouraged the hospital PIOs to include the EM residents who provided care. The other specialties did not involve their residents. Speaking with our residents after the fact, it seems that they were glad to have been acknowledged for their role, but felt unprepared to actually speak to national and international media on live TV. It was a very intense experience - dozens and dozens of cameras and microphones, at least a hundred reporters, many different languages being spoken. Having a little bit of media training or at least prep of what they were walking into may have been helpful. Encouraging that all communication with the media go through the PIOs is extremely important in these settings, as we discovered the media can be shockingly aggressive and callous.

Social Media

Our EM residents largely policed themselves with social media. One of the surgical residents posted a photo and comment soon after the attack that went viral, and it became clear how much attention - much of it unwanted - he endured online afterward. This is probably a larger issue now, as most of our current and future residents have grown up completely online and what's considered acceptable seems to have blurred. I imagine an immediate reminder of hospital privacy rules should be shared with everyone at the least.

Our Department of Public Relations & Communication handled all media requests in the immediate aftermath of the event and reached out to the ED providers with requests to participate in interviews. One ED provider in particular chose to interact with the media and did the majority of the interviews in the immediate aftermath of the event. If asked to participate in a media event, I would suggest a group interview with several providers participating. For me, this was emotionally less stressful than a one-on-one interview and allowed me to better support any resident involved. I would also make it clear that interviews are not required but can be a positive experience when viewed in hindsight.

Graduation

The program created a special award for the residents that worked the night of the incident, as well as our hospital Chief Operating Officer, who played a major role that night and beyond. Due to a scheduling fluke, all of the residents working that night were seniors, graduating just a couple weeks after the attack. Our graduation event was only about a week after the incident so it was all very fresh. I'm not sure how it would've been handled had graduation not occurred so close to the incident and if non-graduates had been working that night

Section VII- Resources

guidelines, scorecards, links to educational videos

First Person healthcare provider reflections from MCI

1) Trauma Surgeon – Dallas Police shooting; https://www.medpagetoday.com/surgery/generalsurgery/83279
2) ED Nurse – San Bernardino shooting; https://www.medpagetoday.com/nursing/nursing/83278
3) EMS Physician – Sandy Hook;

a) https://www.medpagetoday.com/emergencymedicine/emergencymedicine/83282d0

4) Volunteer Physician (orthopedist) – 9-11 New York City;

b) https://www.medpagetoday.com/emergencymedicine/emergencymedicine/83282

NIMS - PTSD brochure https://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/index.shtml

Psychological First Aid - World Health Organization 2011
https://www.who.int/mental_health/publications/guide_field_workers/en/

Trauma, Resilience and Recovery - Self Care white Paper (Vituity sponsored) - attempting to get permission to share the monograph (Char has pdf)

A Horrific Privilege - The Untold Story Behind the Officers at The Aurora Theater Shooting. https://www.9news.com/article/news/local/aurora-theater-shooting/a-horrific-privilege-the-untold-story-behind-the-officers-at-the-aurora-theater-shooting/73-457670031 A powerful interview with the Aurora Theater Shooting first responders. This interview taken in 2017, five years after the MCI event, demonstrates the lasting emotional effects of an MCI event. Watch if you have not experienced a MCI event in person.

Employee Assistance Program (EAP)- Most healthcare institutions have this resource for employees (including residents). EAP has multiple services which can include a limited number of individual counselling sessions and can also help with disaster response with larger groups.