Abstract
This article was migrated. The article was marked as recommended.
Caring for the dying patient can have significant impact on physicians in training, and if unaddressed, can lead to burnout and potentially compromised patient care. The literature suggests didactics and real time supportive interventions such as "post code debriefs" may be most effective in addressing the impact of death on physicians. In this paper, we highlight and discuss a reflection that is conducted several days after the event, when resident physicians are more self-aware of their mental hygiene and the residual impact of challenging event on their personal and professional well-being.

Keywords
Resident well being, wellness, medical education, burnout, well-being
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Competing interests: No competing interests were disclosed.

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Introduction

“I am unable to go on vacation because I am sad and torn about a recent patient death,” lamented a resident during routine patient care. Facing an unexpected mortality can be bewildering for trainees with little preparedness or coping skills. Processing such experiences in small reflection groups is important for resident resilience, well-being and professional identity development. Many residency programs have some structured well-being or wellness curricula in the form of didactics, and some may have an immediate post-resuscitation “debrief the grief” meeting that at least allows residents to minimally acknowledge the human side of such losses with a few minutes pause before rushing on to the next patient (Eng et al. 2015). However, residents may carry unresolved emotional burdens from challenging losses that are hidden underneath the thin veneer of everyday equanimity. These burdens, including self-guilt for a serious medical error, can have adverse emotional consequences long term. Thus, there is a need for an on-demand substantive crisis intervention that we describe below as the Day Seven Reflection Circle (Day7RC).

Healthcare settings may very rarely utilize a formalized mechanism to address the psychological impact of traumatic events known as Critical Incident Stress Debriefing (CISD). CISD usually occurs immediately in the aftermath of a major disaster, and is designed to support overwhelmed disaster responders. They are heavily structured, time intensive, and are conducted by trained facilitators (True 1999). Such a mechanism does not transpose to the resident in a clinical setting who is struggling to process a difficult clinical experience. We urge residency programs to develop their own unique intervention occurring about one week after such an experience occurs, especially to address “self-blame.” Therefore, we utilize what we now term the Day Seven Reflection Circle, a mechanism available as residents are more self-aware of their mental hygiene and the residual impact of challenging event on their personal and professional well-being. The seventh day is not designated based on scientific analysis about the optimal timing for such an intervention, but rather because it likely represents the temporal window when residents may have become clearly aware that they need an opportunity for emotional expression, discussion and guidance. Our anecdotal experience strongly supports this chronology.

Methods

Despite holding well-being and resilience retreats, establishing a formalized wellness curriculum and conducting post resuscitation debriefs, we were surprised by our resident’s comment. His comment and feelings inspired us to start the Day7RC to enhance resident resilience, formation, and well-being. This is best described as a lightly facilitated opportunity for the residents to share their personal narrative about a critical event with several respected members of the healthcare team in confidentiality and trust. The Circle creates a safe forum for resident expression of thoughts and emotions, to normalize group member’s reactions to critical incidents, and to facilitate emotional recovery through perspective gaining and reframing. Additionally, it allows for follow up and suggestions for counseling as needed.

A week after the aforementioned patient death, an attending physician came to hear of the impact this adverse event had on the residents. The residents revealed their elevated self-awareness of how affected they really were. Therefore, a Circle session was convened with the three residents involved in the case and internal medicine attending physicians who serve as their mentors. The Circle session lasted for slightly more than one hour, allowing for meaningful and ample conversation.

Based on an evaluation of debriefing developed by Redinbaugh et al. (2003) at Memorial Sloan Kettering Cancer Center in a pilot study, the involved residents gave feedback on the Circle session. Unanimously, they found the Circle to be very helpful, and especially valued the opportunity to express how they felt with those who were also involved in the case and shared similar feelings. Residents noted that they came to better accept the fact that all physicians make mistakes for which self-forgiveness and self-compassion are needed, and that they were able to achieve these resilience assets through the attentive listening and renewed affirmation on the part of their mentors. Further, it was helpful for residents to hear attending physicians share narratives of their own experiences involving patient loss with self-doubt and resilience when they felt that their own performance was suboptimal and blameworthy. Residents came to understand that even the most experienced physicians have patients who have affected them and carry these emotions and lessons with them over the years. Residents reported poor coping skills before the session; all of them reported perseverating on the minutia of the case and feeling “incompetent.” They appreciated the invite to participate in the Circle as an opportunity to move forward with perspective and greater resilience. They reported having gained peace of mind and reassurance that they are still skilled resident physicians, and recommended the Circle for their co-residents as needed.

Discussion

The Day7RC is not focused on the patient or the case, and is thus very different in content and tone from a Morbidity & Mortality session. Neither is it focused on an analysis of the case, although residents asked to go through the case analytically at a different time to learn from an academic standpoint. It is focused on the human side of the resident experience, examining feelings and enabling cognitive perspective and emotional resilience. Having a Day7RC in the
hospital setting means that these feelings and responses are not left outside the building in the parking lot never to be resolved, or brought home to surprised spouses and friends who generally are unprepared to respond insightfully.

Ideally, a residency program might have a Circle of Trust series of debriefing processes to address the emotional reactions following each event (Table 1), within which the Day7RC is embedded. We are convinced anecdotally that having such an interventional structure established within the culture of our residency can be protective and enhancing of professional identity formation and wellness.

### Take Home Messages

- Careful Debriefs interventions after patient death should not only focus on immediate debrief but should ideally entail some form of reflection a few days after the event to address emotional impact.

- Establishment of an interventional structure within the culture of our residency can be protective and enhancing of professional identity formation and wellness.

- Trainees found it helpful to hear attending physicians share narratives of their own experiences involving patient loss.

### Notes On Contributors

Dr. Nirvani Goolsarran (NG) is an Associate Professor of Clinical Medicine, Associate Program Director of Internal Medicine Residency, Director of Quality and Safety Education, Department of Medicine, Stony Brook University Hospital, Stony Brook, NY.

NG wrote the original draft of the paper.

Dr. Aditi Bhagat (AB) is a third year resident, Department of Medicine, Stony Brook University Hospital, Stony Brook, NY.

AB conducted the resident surveys, analyzed the data and added to the manuscript.

Dr. Stephen G. Post (SGP) is a Professor of Family, Population and Preventive Medicine, Director of the Center for Humanities, Compassionate Care and Bioethics, Stony Brook University Hospital, Stony Brook, NY.

SGP provided final revision and edits to the manuscript.

### Declarations

The author has declared that there are no conflicts of interest.

### Ethics Statement

This study was deemed IRB exempt.

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**Table 1. Outline of the Circle of Trust Chronology**

| Circle of Trust process                                                                 | Time Frame process should occur        |
|----------------------------------------------------------------------------------------|----------------------------------------|
| Immediate informal “debrief the grief” session right at the temporal node of loss      | Within minutes of the event            |
| simply to acknowledge the human side of the event                                      |                                        |
| A small Day Seven Reflection Circle (Day7RC) comprised of no more than five or six     | Seven days following the event         |
| people including the resident(s) about one week after said event as requested by the   |                                        |
| resident                                                                               |                                        |
| A one-on-one “check in” follow-up between the residency director/chief resident and    | 14-21 days after the event             |
| the requesting resident within 14 to 21 days.                                          |                                        |
| Schwartz Rounds (Goodrich, 2012), which focuses on the human side of clinician         | Several months to a year from the event|
| experience with difficult clinical experiences and cases                                |                                        |
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This article has not had any External Funding

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Migrated Content

**Version 1**

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BALAJI ARUMUGAM
TAGORE MEDICAL COLLEGE AND HOSPITAL

This review has been migrated. The reviewer awarded 4 stars out of 5

This is the very interesting and useful opinion on "The residents sharing their personal narrative about a critical event with several respected members of the healthcare team in confidentiality and trust. The circle session was well conducted I guess so that the physicians and the residents were freely exchanging their views on the seventh of the event. The physicians shared narratives of their own experiences involving patient loss and they felt that their own performance was suboptimal and blameworthy. This is the very important aspect wherein the residents should learn and to carry over message for their future practice. Similarly, the residents reported poor coping skills before the session; all of them reported perseverating on the minutia of the case and feeling “incompetent.” Such sort of the circle team can really help the physician and residents who deal with dying patients to cope up with the mental well being and can be a part of the circle team in future. I would suggest such long term programme involving the psychiatrist in the tertiary care institutes to maintain the confidentiality and the mental health of the intensive care team who mainly deal with these terminally ill patients and dying patients. This is the really a well written personal opinion on Day 7 Reflection circle and I felt the need to include such in the Hospital system.

**Competing Interests:** No conflicts of interest were disclosed.

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Gerard Flaherty  
National University of Ireland Galway

This review has been migrated. The reviewer awarded 3 stars out of 5

This is an interesting opinion piece which describes a single institution's experience with a novel reflective exercise to support physician residents whose patients have died under their care. The article is well written with relevant supporting literature and a clear description of the format of the “day 7 reflection circle”, referred to in Table 1 as being part of a longitudinal “circle of trust”. The title suggests an intervention designed to enhance resident resilience but the article does not provide any objective measure of increased resilience. Qualitative feedback from participants is summarised, however, which points to the perceived effectiveness of the debriefing process. How would you evaluate its impact further? Is it envisaged that participation in this process would be voluntary or do the authors suggest that it should be a mandatory part of the debriefing procedures already in place? Why was a one week interval selected as the optimum time point for this intervention? Is this an arbitrary temporal window? Brief reference is made to “anecdotal experience” but this should be expanded upon. There is no demographic information provided on the participating residents – age, gender, residency grade, experience of bereavement, for example. Did the experienced physician facilitators receive any special training to enable them to conduct these sessions? You mention Schwartz Rounds in Table 1. How frequently are these held at your institution and what additional value is derived from an earlier Day7RC? Perhaps the authors could elaborate briefly on this. Overall, this is an interesting manuscript which addresses an important issue in medical professional training. It may be difficult for other institutions to replicate the intervention, however, without providing some additional detail as suggested in this review.

Competing Interests: No conflicts of interest were disclosed.

Johnny Lyon Maris  
Southampton GP Education Unit

This review has been migrated. The reviewer awarded 3 stars out of 5

Thankyou for this descriptive intervention. It is a topical issue and one close to many physician's hearts. The description of the circle is clear, the text well written and the purpose very necessary. It would be good to see if your institution can sustain this intervention as an hour of 5-6 clinicians time, although for
a very valuable reason, is increasingly scarce. It would be good to hear who decides that a death is a 'Difficult Patient Loss', with resource ramifications. It would also be useful to hear what the evaluation results are from all the participants - you suggest the more experienced clinicians would be helping the less experienced. It is my personal feeling that the support can be mutually supportive rather than one-way. Thank you for opening up the discussion and I look forward to hearing more about the practicalities and evaluation.

**Competing Interests:** No conflicts of interest were disclosed.

**Reviewer Report 19 March 2019**

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**Susmita Reddy Karri**
Topiwala national medical college and BYL nair charitable hospital, mumbai. India

This review has been migrated. The reviewer awarded 3 stars out of 5

Touched upon an important topic that every physician encounters at some point in his/her career. I personally believe that the new/junior doctors are more affected by this. While I agree that the senior physicians can help the juniors on how to deal with it, I do think that we should look at having a small team/committee in every hospital where doctors can go and share their grief.

**Competing Interests:** No conflicts of interest were disclosed.