When a Doctor Dies:

Responding after an Unexpected Death or Suicide

Doctors' Health NSW

Introduction

“As doctors, we deal with death and grief as part of our job. We help others navigate through it, prepare them for it. But when it’s one of us, it hits differently. You’d think we’d be able to handle it, but it’s just not that simple. There’s something profound about losing a medical colleague; it shakes us to our core.”

This guide supports NSW hospital managers and leaders in responding to the unexpected death of a doctor, including by suicide. Preparing the organisation is essential to ensure a compassionate and effective response. Doctors may be profoundly affected by the loss of a colleague, and require targeted support owing to the unique pressures they face and their higher suicide risk. Developed specifically to address these needs, this guide is based on insights from doctors who have experienced the unexpected death of a colleague. While focused on supporting doctors, the guide is also relevant for all staff, and organisations are encouraged to use it as a framework to consider the needs of everyone in the hospital community.

This resource was initiated by the Doctors-in-Training Committee of the Australian Medical Association (NSW), funded by NSW Health, and developed by Doctors’ Health NSW. It draws on national and international research to provide a structured response. Doctors’ Health NSW thanks the many experts who have generously assisted in the development of this document.

In particular, Doctors’ Health NSW consulted many people directly impacted by the unexpected death of a colleague, incorporating real experiences to highlight the challenges medical professionals face. Quotes are paraphrased and anonymised for confidentiality. Doctors’ Health NSW thanks everyone who shared their stories.

Supporting doctors’ well-being is essential, and employers have a responsibility to create safe, inclusive environments that reduce suicide risks and support all staff. A compassionate, coordinated approach can help the entire hospital community navigate in the aftermath of a tragic event.

When a Doctor Dies: Responding after an Unexpected Death or Suicide addresses the sudden death of a doctor from suicide and other causes. The term Postvention is used to describe specific interventions designed to support individuals and communities after a suicide has occurred. The goal is to address the emotional and psychological needs of those left behind, to mitigate distress, facilitate the grieving process, and prevent additional mental health issues, including further suicides.

This guide follows the principles for postvention in providing advice for an organisation following the unexpected death of a doctor for any reason. A personalised approach is recommended, ensuring no one is overlooked. Hospitals are encouraged to integrate it with their critical incident plans, using available resources and training staff regularly.

Grief literacy refers to our understanding of grief and putting this knowledge into practice to support others. This includes being able to have supportive conversations about loss experiences and normalising the many ways of grieving. In a grief-literate workplace, shared knowledge about loss can help to establish supportive norms and practical ways to support one another effectively.

PRIORITISING PREVENTION

> **"It's not just about providing support after something happens; it's about looking into why it happened, and making change to stop it from happening again and causing more harm."**

Doctors' health is a priority, and preventing loss of life starts with proactive measures to support well-being. It is acknowledged that many organisations may already be implementing strategies to address workforce shortages and workload, and are responsive to doctors' feedback on workplace issues. Immediate and ongoing actions are needed to create a positive workplace culture that reduces suicide risk and prioritises doctors' welfare. A response strategy for an unexpected death complements, but does not replace, a comprehensive organisational approach to supporting doctors and minimising risk.

THIS MATERIAL MAY BRING UP STRONG EMOTIONS. WHILE SUPPORTING OTHERS, PLEASE PAY ATTENTION TO YOUR OWN FEELINGS AND ENSURE THAT YOU HAVE SUPPORT AS WELL.

Contents

HOW TO USE THIS GUIDE

> **"I wanted to do something but didn't know what to do."**

- **The strategy outlined in this guide is intended to be in place prior to an unexpected death of a doctor occurring. Advice on planning, training staff and policy development is provided in Appendix 1.**
- **After an unexpected death of a doctor, managers will find advice on immediate actions in section 4. This section outlines essential knowledge, and the immediate, short term and longer term actions recommended.**

Key messages

The risk of suicide is significantly higher for doctors than for the general population

Individuals will be very distressed – but this may not be obvious

Compassion is key

Plan rather than React - preparation is vital

Communication matters most

There is lots of support available

No One-Size-Fits-All

Options not orders

Care must be taken to avoid additional distress and suicide contagion

Non-critical clinical services can often wait

Allowing time for colleagues to attend the funeral is important

Grieving takes time - immediate, short term, and long-term strategies are necessary

Section 1

Overview - providing support after a traumatic loss

> **"An organised approach to support can make a real difference—reaching out to colleagues, arranging gatherings for reflection, offering time off, and providing additional workplace support."**

The risk of suicide is significantly higher for doctors than for the general population. Support after a traumatic event, such as a suicide, is essential. Research has shown that such an event can deeply impact around 135 people, from direct witnesses to those indirectly affected. In high-stress environments like hospitals, professional relationships are crucial, and the loss of a colleague can have a profound impact. Immediate support helps individuals access coping mechanisms and resources, reducing the long-term negative effects.

> **"I felt stunned, alone and disconnected."**

Tailored support is crucial as people are impacted differently by a colleague's death, depending on their unique experiences and coping abilities. Adjusting support to individual needs ensures everyone receives appropriate help in their grief and recovery.

> **"I was shocked and deeply shaken. I found it difficult to function normally and often became emotional and teary when explaining to patients why I was stepping in for my colleague."**

WHY IS ORGANISATIONAL SUPPORT ESSENTIAL?

> **"I started to feel like suicide was becoming an option for me too."**

In the case of suicide, losing someone increases the risk of distress and suicide among those left behind. A coordinated support plan can help reduce further harm, promote healing and support recovery within the community.

An effective response supports staff to feel comfortable continuing in their professional role, as otherwise staff may eventually step back to focus on their own recovery. If doctors are well supported, in whatever way they grieve, this will reduce personal stress and ease workplace pressures in the longer term.

> **"The workload didn't allow me to take any time to breathe, let alone care for myself."**

THE NEED FOR A DOCTOR-SPECIFIC GUIDE

Doctors face unique pressures - long hours, high-stakes work often with ultimate responsibility, and mental health stigma. These challenges, along with additional stressors for doctors-in-training and international medical graduates, can increase mental health risks. Many doctors feel they should manage alone, and factors like lack of time, confidentiality concerns, and self-reliance often prevent them from seeking help. Doctors are often reluctant to use generic support services, preferring to connect with other doctors for support, as they frequently feel the need to maintain a professional front around other staff. Profession-specific support that allows doctors to connect and be open with their peers can create a safe, supportive environment for them.

ADDRESSING SUICIDE AND STIGMA

Suicidal thoughts and behaviours are difficult to talk about and are often surrounded by stigma that can prevent open conversations. For doctors, this stigma may be a barrier to seeking help or expressing vulnerability. Normalising discussions about mental health and providing a supportive environment can reduce shame and fear associated with seeking support. By addressing these issues openly, hospitals can foster a culture where doctors feel safe to reach out, ultimately supporting well-being and reducing isolation during times of crisis.

LEARNING FROM EXPERIENCE

In 2024, Doctors' Health NSW, in collaboration with The University of Notre Dame Australia, conducted a research study to explore doctors' experiences following the unexpected death of a medical colleague due to suicide, misadventure, or other causes. The study aimed to understand the personal and occupational impact of such losses, identify available support structures, and determine what participating doctors found helpful or unhelpful.

Further information about this research is available at https://doctorshealth.org.au/when-a-doctor-dies

Table A: *Summary of the findings from the research study and relevance to an organisational response*

	HELPFUL	UNHELPFUL	ADVICE
SUPPORT	Meaningful support from family, friends and colleagues, and from the workplace	A generic email and/ or generic offer of an "open door" from Executive/ Manager Only being provided the number for a generic Employee Assistance Program A perceived lack of support from the workplace	• That workplace communication is written with care and compassion, reflects genuine concern and outlines the organisational response • Whenever possible, personal contact is appreciated and will be remembered • Time created for workers to interact with colleagues, friends and family
GATHERING	Discussing suicide and loss Gathering to share stories	Isolation Feeling alone Inability to find support (despite looking for it)	• Opportunities to meet informally at work to discuss loss
WORKPLACE	Access to leave Knowing support is available	Increased workload Not getting enough time off work (not ready to go back but had to)	• Leave available for those who want it • Close or pause services and bring in other workers to help • Ensure support for colleagues who take on an extra load
FUNERALS AND MEMORIALS	Attending the funeral Supporting the doctor's family Memorial at workplace	Missing the funeral	• Allow time to attend the funeral • Consult staff and family about possible memorial events
PROFESSIONAL SUPPORT	Their own GP Their own Psychologist	Impersonal support - such as only being provided with the number for a generic Employee Assistance Program	• Offer a range of support options including personal, social and medical network and employee-based support • Involve specialised and independent doctor support services
EXTERNAL FACTORS	Self-care (sleep, exercise) The passage of time Religion/ faith/ spirituality/philosophy		• Acknowledge that the grief experience is individual and unique • Encourage self-care and allow time for it

Section 2

Planning Ahead

> **"It would be really helpful to have a "road map" for departments and hospitals to follow. Rather than just directing people to Employee Assistance Programs (EAP) and then moving on, there should be practical and respectful ways to remember and honour a colleague's life."**

PREPARING THE ORGANISATION FOR THE UNEXPECTED LOSS OF A DOCTOR

Rather than responding in an unplanned manner after an event, hospitals should be prepared in advance for the unexpected loss of a doctor.

The capacity to implement a local response will vary by hospital size, but every site should consider how they will prepare for such an event, based on their local resources. Hospitals are often under pressure, and while these guidelines outline the ideal response, each hospital can adapt them to suit what is feasible within their local constraints.

Integrated into the hospital's crisis management strategy, a planned response ensures smooth implementation and reduces confusion during a crisis. A trained response team, guided by a regularly-reviewed plan, can minimise further harm, helping to reduce prolonged grief and secondary trauma. This approach offers essential support to staff, mitigates long-term trauma, and maintains stability through clear communication protocols with staff, patients, and the public, while ensuring continuity of patient care.

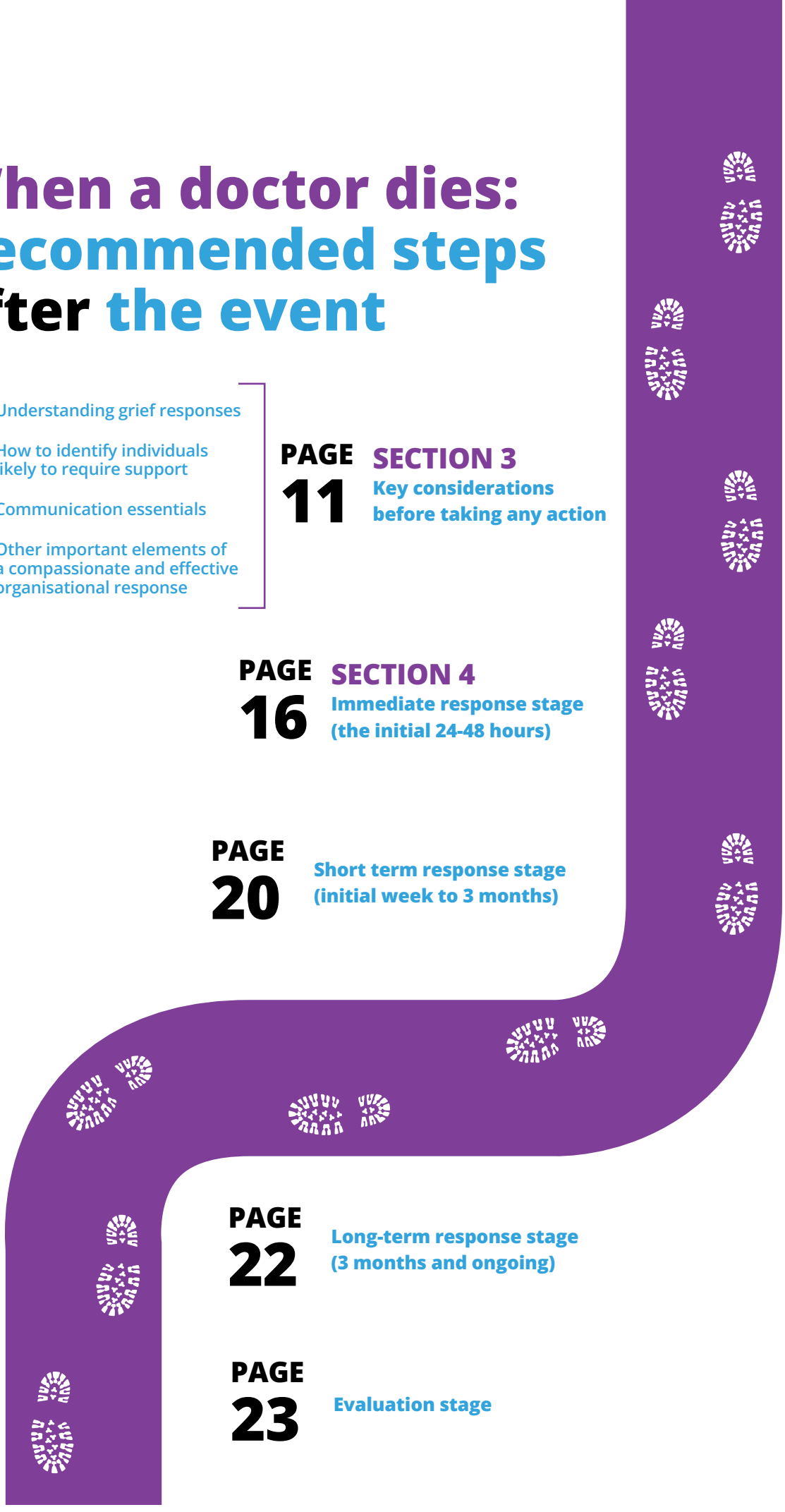
Planning ahead for clinical service management in a crisis, including strategies for staffing when regular teams are unavailable, helps ensure a thoughtful and coordinated response if an unexpected death affects a large group of medical and clinical staff.

FORMING A RESPONSE TEAM AND DEVELOPING AN ACTION PLAN

Refer to Appendix 1 for guidance on preparing for a doctor's unexpected death, including advice on forming a response team, and a checklist for managers including considerations around memorials, emergency staffing and clinical service adjustments.

When a doctor dies: Recommended steps after the event

1. Understanding grief responses
2. How to identify individuals likely to require support
3. Communication essentials
4. Other important elements of a compassionate and effective organisational response



Section 3

Key considerations before taking any action

> **"A deep sense of shock and loss completely overwhelmed me. I ultimately had to leave the job I had loved, the place I envisioned spending my career."**

1. UNDERSTANDING GRIEF RESPONSES

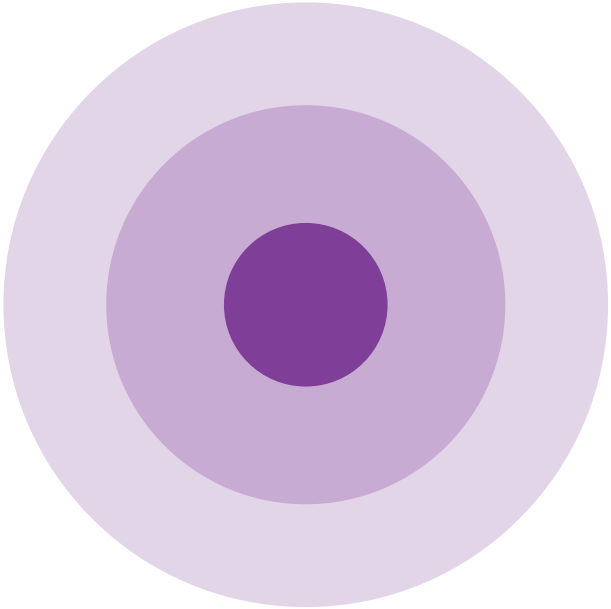
An unexpected death often brings shock and confusion, which can be even more intense after a suicide. Initial disbelief may soon be followed by feelings of guilt, anger, or responsibility. For staff who have worked with or treated a doctor who has unexpectedly died, particularly within the same hospital, this loss can feel particularly distressing. The hospital may serve as a constant reminder of the loss. Grief can affect not only individuals but the entire team, making it difficult to maintain normal work routines.

Appendix 2 provides further detail about common responses after an unexpected death or suicide.

2. HOW TO IDENTIFY INDIVIDUALS LIKELY TO REQUIRE SUPPORT

Circles of vulnerability describe the groups affected by a traumatic event based on proximity to it:

- **Innermost Circle:** Those directly involved, such as immediate colleagues or family members.
- **Second Circle:** Friends or professional peers of those in the innermost circle.
- **Third Circle:** Broader community members or colleagues indirectly affected.



Identifying individuals in these circles helps tailor support. Some people may feel a deep impact even if they are further from the event, so no one should be excluded from support.

Careful consideration should be given to:

» Discussions with family members

» Informing and briefing medical colleagues and other staff

» Informing patients

Appendix 3 provides specific advice on managing communication with these three cohorts.

Special care must be taken to identify and support all staff involved in the clinical care of a doctor who has died. This experience can be highly traumatic, impacting those involved in any aspect of care during this critical time, including resuscitation attempts, certification of death, and postmortem procedures. Regardless of their role, such situations often bring intense feelings of shock, grief and sometimes guilt over the inability to save a colleague, amplified by a sense of professional empathy, even among those without a personal connection to the doctor.

3. COMMUNICATION ESSENTIALS

Effectively supporting staff after a doctor's death requires timely, clear, and compassionate communication. This includes sharing relevant details about the death, workplace and funeral arrangements, and available support to foster community and understanding. Consistent updates and open channels of communication help grieving individuals feel connected and supported.

> **"I was stunned and in disbelief, constantly thinking about the loss, struggling with sleep and concentration, and feeling angry towards the medical system."**

HOW YOU SHARE THE NEWS, WHAT YOU SAY, AND HOW YOU SAY IT WILL GREATLY IMPACT HOW PEOPLE RECEIVE AND REMEMBER IT.

• Involving key personnel

In sensitive situations, involving the right people is essential. Senior staff with training and experience in handling such circumstances play a critical role. Clinicians skilled in delivering difficult news bring a gentle, effective approach, managing the impact of the message with care.

• Safe communication about suicide

> **"Acknowledging the hard truth that it was a suicide was actually really important."**

Using respectful, clear language when discussing suicide is crucial to reducing stigma and helping people feel comfortable about seeking help. Thoughtful communication fosters understanding, supports those affected, and encourages open mental health discussions. Sensitive conversations about suicide, though challenging, are key to creating a supportive environment.

» Share only confirmed information.

» The news of the death can be shared without family consent, but the cause of death should not be disclosed without their permission.

» If the family has not consented to release details such as the cause of death, terms like "sudden" or "tragic" death can be used. Communications can indicate that out of respect for the family, further details are not being made available.

» Always avoid mentioning the method and location of death.

» Provide information on organisational support as well as other resources for seeking help.

Table B: *National communications charter language guide - suicide*
https://mindframe.org.au/guidelines#Reporting-suicide

Do say / don't say

Preferred	Problematic	Why?
✓ 'died by suicide'; 'took their own life'	✗ 'successful suicide'; 'completed suicide'	Suggests suicide is a desired outcome
✓ 'took their own life'; 'suicide death'	✗ 'committed suicide'; 'commit suicide'	Associates suicide with crime or sin
✓ 'increasing rates'; 'higher rates'	✗ 'suicide epidemic'	Sensationalises suicide
✓ 'suicide attempt'; 'non-fatal attempt'	✗ 'failed suicide'; 'suicide bid'	Glamourises a suicide attempt
✓ Refrain from using the term suicide out of context	✗ 'political suicide'; 'suicide mission'	Is an inaccurate use of the term 'suicide'

"Someone from the hospital called me personally while I was on holiday. It was helpful to know sooner rather than later."

» It's important to have a system to identify individuals who need to be informed and ensure they receive messages directly. Notify people as soon as possible, even if they are on leave. For doctors-in-training and medical students who frequently move between hospitals, this may involve contacting specialist colleges and universities to ensure the news can be conveyed sensitively.

"I found the sense of secrecy surrounding the circumstances of my friend's death to be very difficult."

» Without timely communication and appropriate updates, miscommunication can easily spread. The vacuum will soon be filled with unhelpful rumours, potentially perpetuating stigma and increasing distress. It's important for people to know where to find reliable information.

» Having a single point of contact is helpful, but delivering this information can be stressful, so it's often better for two or more people to share this role.

MINIMISING RUMOUR AND GOSSIP

> **"The gossip going around made everything so much harder."**

Prompt, Compassionate Updates	**Share accurate, respectful information quickly to prevent speculation.**
Unified Messaging	**Ensure all leaders provide consistent information.**
Clear Information Channels	**Direct staff to a designated source for updates and questions.**
Confidential Support Spaces	**Offer safe places for staff to express feelings to reduce corridor speculation.**
Privacy Reminder	**Reinforce respect for privacy and professionalism, and remind about the impact of gossip.**
Address Rumours	**Correct misinformation directly and calmly if specific rumours emerge.**

To ensure inclusive support, depending on the target audience, communications could consider the advice provided in the NSW Health Accessibility Guidelines. See Appendix 3.

4. OTHER IMPORTANT ELEMENTS OF A COMPASSIONATE AND EFFECTIVE ORGANISATIONAL RESPONSE

> **"Most of my colleagues were also impacted by the death but the lack of staff and ongoing workload made it impossible for us to take time out to talk about it, let alone take any leave."**

4.1 Trauma-informed care

Applying trauma-informed principles is essential in response to an unexpected death, recognising that colleagues may be dealing with trauma and need empathetic, personalised support. Avoid language or actions that could unintentionally cause harm. Trauma-informed care provides flexible, compassionate assistance, fostering an environment where healing and support are prioritised.

4.2 Considering cultural sensitivity

Australia's diverse health workforce brings varied cultural responses to grief. Recognise and respect individual mourning practices and beliefs, creating inclusive memorials that honour diverse traditions. For Aboriginal and Torres Strait Islander communities, acknowledge communal grieving practices such as Sorry Business and consider involving community leaders and Indigenous health workers as appropriate.

4.3 Creating a supportive environment

A supportive atmosphere involves workplace flexibility, safe spaces, and accessible group sessions:

> **"It would really have helped if the hospital could have cancelled some clinics."**

» **Flexible scheduling:** While essential care must continue, offer time off and consider scaling back non-urgent services if possible. Having a pre-arranged plan for staffing support, such as pre-approval for engaging locum doctors or accessing additional funds, helps managers to balance clinical service provision with the needs of individuals.

> **"The hospital admin let me leave work right away, so I didn't even need to ask."**

» **Access to memorials:** Ensure staff who wish to attend the funeral or memorial occasion are able to do so, as this is essential for many in their grieving process.

> **"Speaking at his funeral was important."**

4.4 Dedicated support spaces

Designating a private support space for doctors offers a place to process emotions together or individually:

» **Location:** Choose a private, accessible location within the hospital.

» **Environment:** Create a comfortable, welcoming setting with food/ refreshments to encourage informal conversations.

» **Support On-Site:** Where possible, consider having a trained support person with expertise in doctors' health available for guidance and support.

4.5 Organised group sessions

> **"Arranging a support session, or even a memorial service as a group, could have opened the door to discussions and ongoing support."**

Hospitals may choose to offer opt-in group sessions led by trained facilitators. These sessions provide a safe, informal setting for people to share thoughts, remember their colleague and encourage help-seeking behaviours. Participation should be voluntary to respect individual preferences for support.

> **"I found it helpful to meet with the other doctors and talk about our friendship and share memories."**

4.6 External support access

It is essential to facilitate access to external support services, enabling doctors to take time to visit their GP or psychologist. Provide easy access to information on relevant organisations and local GP contacts.

Section 4
Action Plans

Immediate response stage (the initial 24-48 hours)

> **"It was absolutely devastating. That's the best way to describe it. Utterly devastating."**

In the immediate aftermath of news of the unexpected death of a doctor, the first 24 to 48 hours are crucial for initiating a compassionate and structured response. No matter how much time has passed since the incident itself, the news will still have a significant impact on the hospital community.

Checklist: *Immediate response - the inital 24-48 hours*

			Person responsible	Check
1	Enact the response plan	This should occur immediately on receiving the news, even if it is unconfirmed.		☐
2	Deploy the response team	The response team should coordinate rapidly to decide on the best course of action, keeping in mind the sensitivities involved. The response team, coordinating with the senior management of the organisation, are responsible for the operation of the response plan. All information, decisions and actions should be documented for transparency and future reference.		☐
3	Gather information	Confirming the details of the incident is essential, preferably with local authorities or through sensitive enquiries. It is necessary to understand the role of the doctor in the organisation, including the work of their department. It is also important to consider that the doctor may have worked in other hospitals, requiring liaison with those institutions as well. Confirm the facts before any response or communication. Verify information with local authorities or through sensitive enquiries with the bereaved family. Do not release details about the method or location of death. Only release details about the cause of death (such as suicide) with the consent of the family.		☐

			Person responsible	Check
4	Rapid environmental scan	Consider current pressures on the organisation and staff—whether routine or extraordinary—and gather further details. Examples of other relevant factors might include: • existing workforce shortages • increased clinical load (such as the winter respiratory illness season) • a recent natural disaster or environmental challenge • Specialist college examinations – candidates may need assistance liaising with the college • medical staff or students having recently rotated, unfamiliar with the organisation or support networks • medical staff or students on rotation away from home, with reduced access to personal support • whether there is an accreditation process underway • budgetary or performance pressures – end of financial year, compliance reporting etc.		☐
5	Notify senior management / NSW Health	Follow the pre-planned communication strategy using emergency communication channels if required. Ensure relevant managers are notified, including the Local Health District Executive and NSW Ministry of Health.		☐
6	Activate specialist support	Notify and coordinate with local and external mental health services to arrange immediate specialised support. Confirm timely, on-site confidential support arrangements to ensure these details are available when informing staff. Contact EAP to notify them of the death and to enable them to organise appropriately qualified staff to provide support.		☐
7	Identify impacts	Ensure the physical and emotional safety of first responders (if the death occurred on site, or the doctor was brought to the Emergency Department). Identify the people who may be affected – consider circles of vulnerability. Pay special attention to the needs of managers and leaders involved in the response who may also be grieving and require support.		☐
8	Discussion with the family	Communicate respectfully and sensitively with the doctor's family (when appropriate). Determine an appropriate single point of contact – this may be a senior doctor who knew the doctor who died. Ensure this doctor is supported by the member of the response team with responsibility for liaison with the family.		☐
9	Manage communications	Managing communications, including potential media or social media interest, with appropriate discretion and sensitivity. Monitor the messaging that is circulating informally in the hospital environment to ensure unhelpful messaging is addressed in a timely and effective manner. Quickly investigate any rumours, emails, messages, and social media posts.		☐

			Person responsible	Check
10	Notify colleagues and other staff	See Appendix 3 Communicate respectfully and sensitively with impacted individuals – recognising the breadth of people who may be affected. Individualised, personal approaches are preferred. Avoid generic emails. Ensure all team members, including those absent or on leave, are informed in a compassionate manner. Review rotations of medical students and doctors-in-training to ensure that individuals who have recently left the organisation can also be informed. Provide clear information on available support and encourage engagement. Provide advice about the availability of opt-in group and individual support sessions over the following days to weeks, understanding that needs may vary and some may require more intensive support. Offer immediate leave, and ensure a single point of contact is in place for additional support (such as requests for leave at a later point).		☐
11	Create safe time and space for doctors	Facilitate reduced workload and time off work to allow doctors to gather, or access personal support. Advertise the availability of the designated support space to all doctors and medical students.		☐
12	Facilitate leave arrangements	Offer individuals immediate leave from work. Ensure each doctor has a single point of contact (with People and Culture Department support) to negotiate their return to work or to extend their leave if required.		☐
13	Review and manage clinical services	Consult the emergency clinical services plan. Monitor the situation for any evolving needs or risks, including the impact on patient care. Proactively identify the key role of the individual, their workload and imminent commitments and determine the safest and best way to address that person's patient load and ensure safe care. It is likely that the very people with the skills required to address the patient need will be those who are grieving so implement mechanisms for cancelling lists and outpatient clinics as well as diverting patients requiring acute care to another hospital (if possible). Essential patient care will need to continue, but it may be necessary to pause non-critical services, if possible, to focus on essential needs, supporting both staff and patients during this challenging time.		☐

			Person responsible	Check
14	Deploy alternative workforce if required	Deploy alternative medical workforce to provide assistance where required. This may include mobilising doctors from other teams within the hospital, or bringing them in from elsewhere (if possible). This may require utilisation of an emergency medical staffing strategy to bring in locum medical staff or doctors or clinical teams from other organisations (if possible). Additional doctors may be required for some time – including to provide cover for the funeral.		☐
15	Notify patients	See Appendix 3. Identify patients requiring notification. Support clinicians in providing the necessary communication with patients.		☐
16	Respond to impacts	Monitor the well-being of staff and any others impacted, with a focus on mental health and coping mechanisms. Be proactive in checking in and providing support to individuals known to have been working with the doctor who died, as well as those who self-identify as being close to the individual.		☐

Short term response – Initial week to 3 months

This phase is crucial for starting the recovery process and supporting the hospital community after a doctor's death. It assumes that the elements of the immediate response have been completed, although some of these, such as the notification of staff and patients, may be ongoing.

> **"Being required to continue working at the place where we worked together was tough. Trying to maintain focus and work safely as a doctor while grappling with grief was challenging. Having to conceal the grief in order to carry out work duties only added to the strain."**

Checklist: *Short term response – Initial week to 3 months*

			Person responsible	Check
1	Ongoing monitoring and support of staff	Implement structured support mechanisms for staff, including access to counselling services, peer support groups, and self-care resources. Monitor staff absences and mental health (remembering that doctors are less likely to be absent from work and more likely to over-work). Gradually guide the hospital back to its regular operational routine while being mindful of the emotional state of the staff. Avoid over-stressing the unit that is affected. Provide training and resources to help staff understand grief and loss, recognise signs that colleagues may need additional support, to manage their own feelings of grief. Provide further opportunities for people to grieve together – just to gather and share a meal can be helpful.		☐
2	Managing clinical services	Continuing review of capacity. Monitor essential patient care services and ensure adequate workforce. Consider capacity and ability to provide non-critical services as the workforce returns. Enable a reduced load initially as staff return to usual duties so that there is some time for conversations and adjustment within the clinical team.		☐

			Person responsible	Check
3	Managing workforce	Ongoing management of the organisation's internal medical workforce to ensure an appropriate workload and scope of practice for all doctors and adequate clinical cover for services. Proactive recognition and support of medical staff and other colleagues taking on additional workload. May require ongoing utilisation of external doctors or clinical team or locum medical staff. Monitor for team distress or disharmony that may require supportive solutions.		☐
4	Ongoing notification of patients	Ongoing support for clinicians and other staff providing the necessary communication with patients.		☐
5	Managing return to work	Assist doctors with return-to-work arrangements which do not put them under pressure to return before they feel ready to do so. Ensure a single point of contact is in place to assist them to make these arrangements. Recognise that some staff may require longer periods of leave or may need support to work in a different role. Allow additional leave once individuals have returned to work as required, including for medical or psychology appointments and to attend the funeral.		☐
6	Funerals and memorials	Facilitate the participation of staff to attend funeral services, acknowledging the importance of saying goodbye and offering their respects. If there is no funeral in the the local area, then consider whether a local memorial service (e.g. at the hospital chapel) is appropriate. Decisions about memorials, if staff are considering this, should be approached with compassion, involving discussion with bereaved families to understand their wishes and managing their expectations.		☐
7	Operational debriefing	Ensure regular check-ins with the response team and senior management. Allow time for individuals to debrief about their experiences, remembering that anger can be a part of a grief response. Ensure an overall review of the management of the situation is arranged to identify how to better develop the response to the future and to inform the next phase of the response plan.		☐

Longer-term response stage (3 months and ongoing)

This stage is important for helping the hospital recover and supporting the mental health of all individuals. With timely and appropriate support after a suicide, communities can largely return to normal functioning.

When doctors lose a colleague unexpectedly or to suicide, their grief can build up, especially if they've faced similar losses before. Long-term, comprehensive support is essential.

> **"His loss continues to affect me deeply, and I think of him often – even after all this time"**

Checklist: *Longer-term response (3 months and ongoing)*

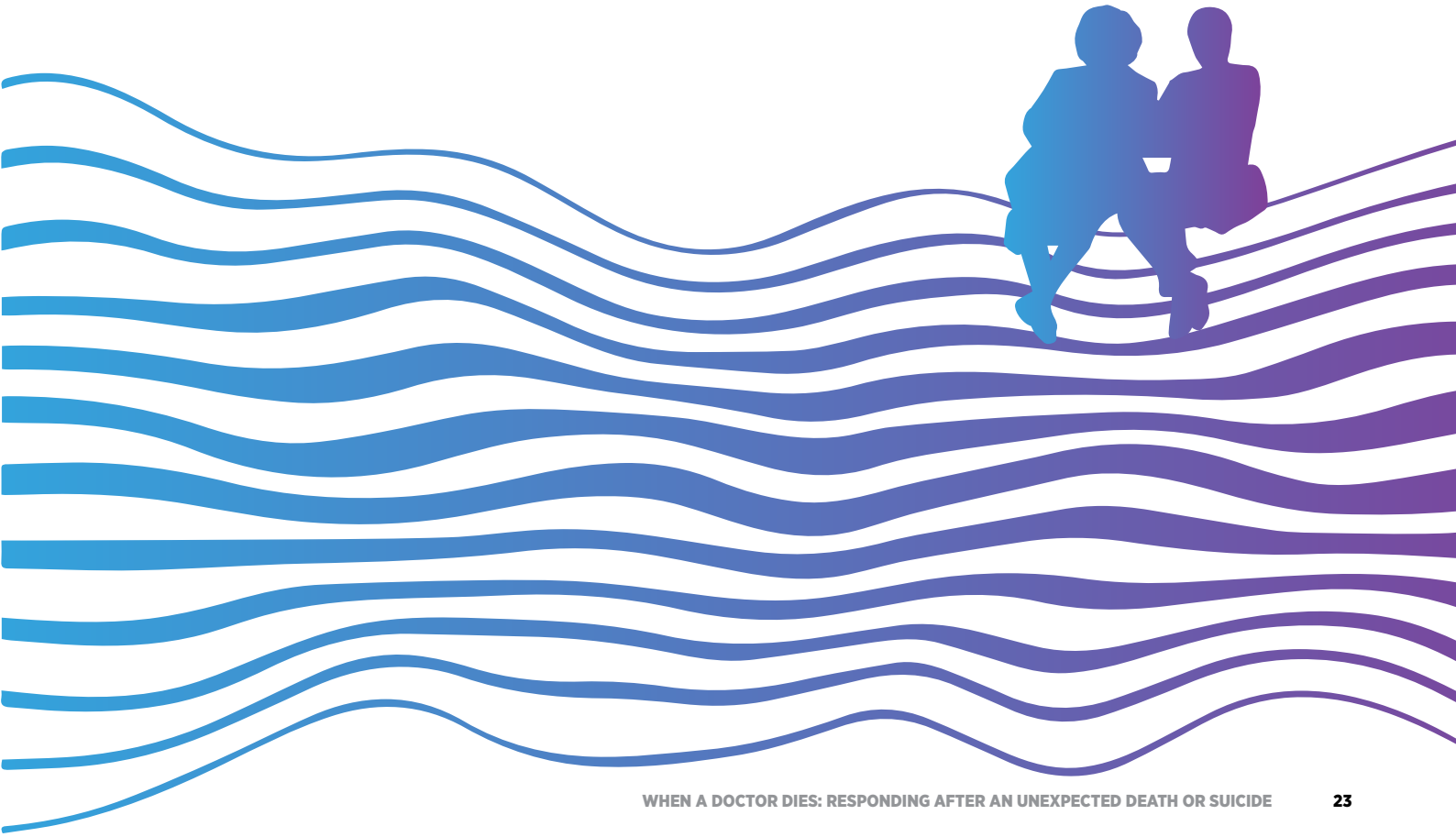
			Person responsible	Check
1	Ongoing monitoring and support	Promote grief literacy, mutual care, and support to normalise grief and loss. Enable additional support for individuals who are struggling with their grief. Ensure ongoing visibility of the response team and supportive leadership from senior management. Regular review of the response and the well-being of individuals during the first 12 months is necessary to determine the best ongoing response and support.		☐
2	Support mental health and promote a positive culture	Education sessions can improve grief literacy by focusing on grief, self-care, and supporting others. Tailor these sessions to the audience's readiness. Adopt and promote a trauma informed approach to individuals seeking support. Hold conversations in small groups to manage distress effectively.		☐
3	Anniversaries and significant dates	Anniversaries and significant dates require sensitivity, recognising that such occasions can elicit varied emotional responses. Planning should aim to minimise distress, with activities tailored to meet the diverse needs of the community. It's important to consult with support services for guidance on managing these responses appropriately.		☐

Evaluation stage

It's important to reflect on the incident, evaluate strategies, and identify areas for improvement to prepare for future incidents.

Checklist: *Evaluation stage*

			Person responsible	Check
1	Reviewing the response	There should be regular and ongoing reflection by the response team and senior management about the response throughout the process. A formal review of the response should be undertaken, but not before 6 months have passed since the incident.		☐
2	Updating the response plan	The response team and senior management of the organisation should meet to determine any necessary changes to the plan, based on the lessons learned from the response. Documenting the response and identifying key challenges and successes enables additional strengthening of the planning for the future.		☐



Section 5 Appendices

Appendix 1

PLANNING AHEAD

Essential elements of the organisational response to the unexpected death of a doctor:

- A **communication strategy** for efficient and compassionate communication. This should include communication within the organisation as well as a crisis communication channel with relevant senior executives of the organisation/NSW Health.
- **Emergency clinical services strategy:** to enable rapid approval of variations to the delivery of clinical services (if required) following the death of a doctor.
- **Emergency medical staffing strategy:** ensures protocols are in place for the emergency credentialing and temporary appointment of additional clinical staff (e.g., locums or teams from other healthcare organisations) when several members of the existing medical workforce are unavailable without notice.
- **Pre-planned on-site and external specialist support** which can be activated immediately.
- Consideration of a consistent approach to memorials to allow flexibility but manage expectations.
- An **action plan,** with **checklists for the immediate, short term and ongoing phases** of a response
- An **evaluation process** to review the organisation's response and update the plan if required.

A STAFF SUPPORT RESPONSE TEAM

A pre-established, trained response team ensures that individuals with the necessary skills can manage the organisation's immediate response to the unexpected death of any staff member.

A response team needs to be flexible enough to respond rapidly to an unfolding situation. Most organisations should link the initiation of this response to other crisis responses. However, the skills required for members of the response team are different from those needed for other environmental crisis responses.

SECURE SUPPORT

- Gain commitment from hospital leadership for the establishment of a response team and ensure ongoing support and resources will be available
- Ensure that the team is recognised and represented at the organisation's existing crisis response planning activities.

NOMINATE AND TRAIN TEAM MEMBERS

» Ensure the team includes individuals from various departments to offer diverse perspectives and expertise. Include grief literacy as part of workforce training where possible.

» Choose team members who have experience, skill and compassion.

» Team members need to have an understanding of the local environment (the organisation and the local community) and have the seniority and capacity to engage with other senior people within the organisation as required.

» The following roles are suggested (some individuals may be able to fulfil dual roles):

- **Team leader:** Responsible for coordinating the overall response, chairing meetings, and ensuring all actions are aligned with the plan.
- **Senior executive:** A senior member of the organisation with authority. This may be the Director of Medical Services or equivalent. This individual must be able to coordinate with NSW Health and the senior executive of the organisation to facilitate the authorisation of additional resources or variations to staffing or clinical services if required.
- **People and culture team:** Responsible for addressing staff-related issues and ensuring all legal requirements are met. This individual provides access to staff contact details to enable rapid communication, and facilitates approvals for immediate and extended leave, and the appointment of extra workers (such as locum doctors).
- **Mental health professional:** Understands grief and grief in the workplace, provides psychological advice and support and understands the barriers experienced by doctors accessing health care.
- **Communications:** Manages internal and external communications. This individual will nominate and assist those leaders responsible for communication with other staff.
- **Family liaison:** Ensures consistent and compassionate communication is provided to the family. In the event of an organisational response, this individual may be nominated as the single point of contact for the family or can provide support to another person who knew the doctor and feels able to take on this role.
- **Administration:** Provides general administrative support, particularly to the Team Leader, including documenting all actions and decisions. Maintains the database of contact details for individuals at relevant organisations such as other hospitals, specialist colleges, and universities.

» Ensure all team members understand their roles and responsibilities and are willing to participate.

» Members need to be readily available to attend in the event a response is required. Individuals may need to nominate and brief an alternate to ensure there is cover for periods of leave.

» Provide training on response strategies, trauma-informed care, and effective communication.

CREATE A COMPREHENSIVE AND LOCALLY RELEVANT RESPONSE PLAN

» Create a response plan including a communication strategy

» Ensure the response plan is signed off by the relevant members of the organisation (senior management and crisis planning team), with an agreed review cycle.

MEET REGULARLY

» Create a schedule of meetings

» Refresh team membership if required and ensure that all members are aware of the plan and are supported in their roles with active succession planning when members expect to leave the organisation or retire.

» Review and update the response plan

INTEGRATE WITH THE ORGANISATION'S CRISIS MANAGEMENT PLAN

» Ensure ongoing representation in the organisation's crisis response management planning activities

» Attend meetings and drills, to maintain awareness of the response team.

Checklist: *Planning a response*

			Person responsible	Check
1	Promote a healthy organisational culture	Outline planned activities: (e.g. Institute an organisation-wide education program incorporating: suicide awareness; the impact of bullying and blame culture; harm of mental health stigma; harm of invulnerability among health workers).		☐
2	Establish a response team	List roles, membership and availability: (e.g. Team Leader, Dr XXX, Director of Medical Services). Determine a schedule of meetings. Describe how the response team fits within the organisation's wider crisis management planning.		☐
3	Communication strategy	Outline (with responsibilities) the communication strategy for notifying senior executives at the Local Health Districts and NSW Ministry of Health. Outline (with responsibilities) the communication strategy for efficient and compassionate communication about the death of a doctor (including updates as required) with families and staff. List (with contact details for relevant individuals) the organisations responsible for doctors-in-training and medical students (colleges and universities) affiliated with the organisation, in case it is necessary to contact individuals on previous rotations or assist students due to sit an examination. Consider and approve sample email and phone scripts. See Appendix 4.		☐
4	Emergency communication channel	List (with contact details) relevant organisational and Local Health District senior management requiring notification. Relevant contact/s at NSW Health, contact details and designate person with responsibility for this contact.		☐
5	Emergency clinical services plan	Develop/ outline the protocol for arranging a variation in clinical services in an emergency situation (e.g. cancelling outpatient clinics or theatre lists or diverting patients requiring acute care), including relevant approvals required and contact details.		☐
6	Emergency medical staffing strategy	Develop/ outline the protocol for arranging additional medical staff in an emergency situation (including the recruitment, credentialling, approval and appointment process). This may include pre-arrangements with other hospitals or locum agencies. Include relevant approvals required and contact details.		☐
7	Consider relevant leave policies and arrangements	Ensure there is an approved and consistent approach for managing leave requests from all staff in these circumstances, including for attending a funeral or memorial for a colleague.		☐

			Person responsible	Check
8	On-site and external specialist support	Arrange and list (with contact details) specialist on-site and external support after an incident (e.g. local counselling service, Doctors' Health Service, list of local GPs). Ensure access to pre-arranged on-site, confidential support can be implemented rapidly.		☐
9	Be thoughtful about memorials	Consider how the organisation would like to approach memorials, remembering that families and colleagues might have various expectations and some flexibility will be required. Any decision about one individual will set a precedent and expectations for similar memorials. Develop a thoughtful organisational position – so that requests from family and colleagues can be considered with compassion but expectations can be managed in a timely manner. Avoid prohibiting a memorial as this may be stigmatising. However, setting some limits around the material, the content, the location and the length of time it remains in place can reduce potential distress and reduce risk to vulnerable people. • Ensure the memorial does not disrupt hospital operations or patient care and offers staff the choice to engage with it or not. • Respond in a way that respects the diverse cultural backgrounds of the hospital staff and family. • Set a clear timeframe for the memorial, explaining how and when it will be sensitively concluded. • Encourage staff to engage in activities that honour the memory of their colleague in a healthy and constructive manner, potentially including initiatives that promote mental health awareness and suicide prevention within the medical community. Permanent memorials have the potential for re-triggering trauma, setting unsustainable precedents, and risking suicide contagion (in the case of deaths by suicide).		☐
10	Educate relevant staff about the response	Ensure all staff are aware of the response and how it can be activated. It may not be a member of the management team who first becomes aware of the death of a doctor, so it is important that all staff know how to escalate this news to ensure an immediate response.		☐
11	Review	Ensure there is an allocated and active team leader role for the review stage. Check these activities have been completed and are reviewed regularly. Describe the process of review and allocate responsibilities.		☐

Appendix 2

UNDERSTANDING GRIEF RESPONSES

> **"Nobody really understood how much her death affected me... it all hit me very hard."**

When someone dies unexpectedly, it's common to feel shocked and confused. People can often experience complex grief reactions, including intense feelings of guilt and/or anger.

> **"It deeply impacted me, making me feel like I should have been able to do something to help."**

When a death is by suicide, the shock may be even more intense. People may feel that the death could have been predicted or prevented, which can lead to strong feelings of personal responsibility or frustration.

> **"I felt like it was taking over my thoughts. I found myself thinking about it all the time."**

Grief can arise at any time after an event, sometimes unexpectedly and without clear cause. Individuals who may have rationalised how they would respond to this kind of hypothetical situation can still be shocked and overwhelmed by their actual emotional response.

COMMON RESPONSES AFTER A SUICIDE

Guilt or responsibility

Individuals often feel guilty or responsible for not recognising the signs of distress. This can lead to self-blame and intense regret.

> **"It left me questioning what more I could or should have done to provide support."**

> **"I felt deeply guilty that I had not spent more time with him."**

Anger

There may be feelings of anger towards the doctor for leaving them or for taking their own life. This can be compounded by feelings of abandonment and betrayal.

Intense anger may also be directed towards organisations, such as an employer or regulatory authority, that may be seen as contributing to the circumstances surrounding the death.

> **"I felt regret and some anger that she hadn't asked for help."**

> **"I experienced feelings of shock, sorrow, and frustration towards the healthcare system, particularly in relation to surgical training and the treatment of junior doctors."**

Unresolved questions

The abruptness of suicide often leaves many questions unanswered, leading to a sense of things being "left up in the air." These unresolved questions can hinder the grieving process.

> **"Not being able to attend her funeral was tough. I really missed not having the chance to say goodbye to her."**

Deep sadness and despair

Close friends and family members experience profound sadness and despair, struggling with the intense grief of losing someone to suicide.

> **"I felt an overwhelming emptiness and deep sadness, as if I were completely lost and adrift."**

Impact on spiritual beliefs

The death can disrupt spiritual beliefs, leading to a crisis of faith or a loss of hope. This spiritual turmoil adds another layer of emotional complexity to the grief.

> **"The sense of loss persists. Despite my Faith, she is no longer here, or anywhere."**

Existential crisis

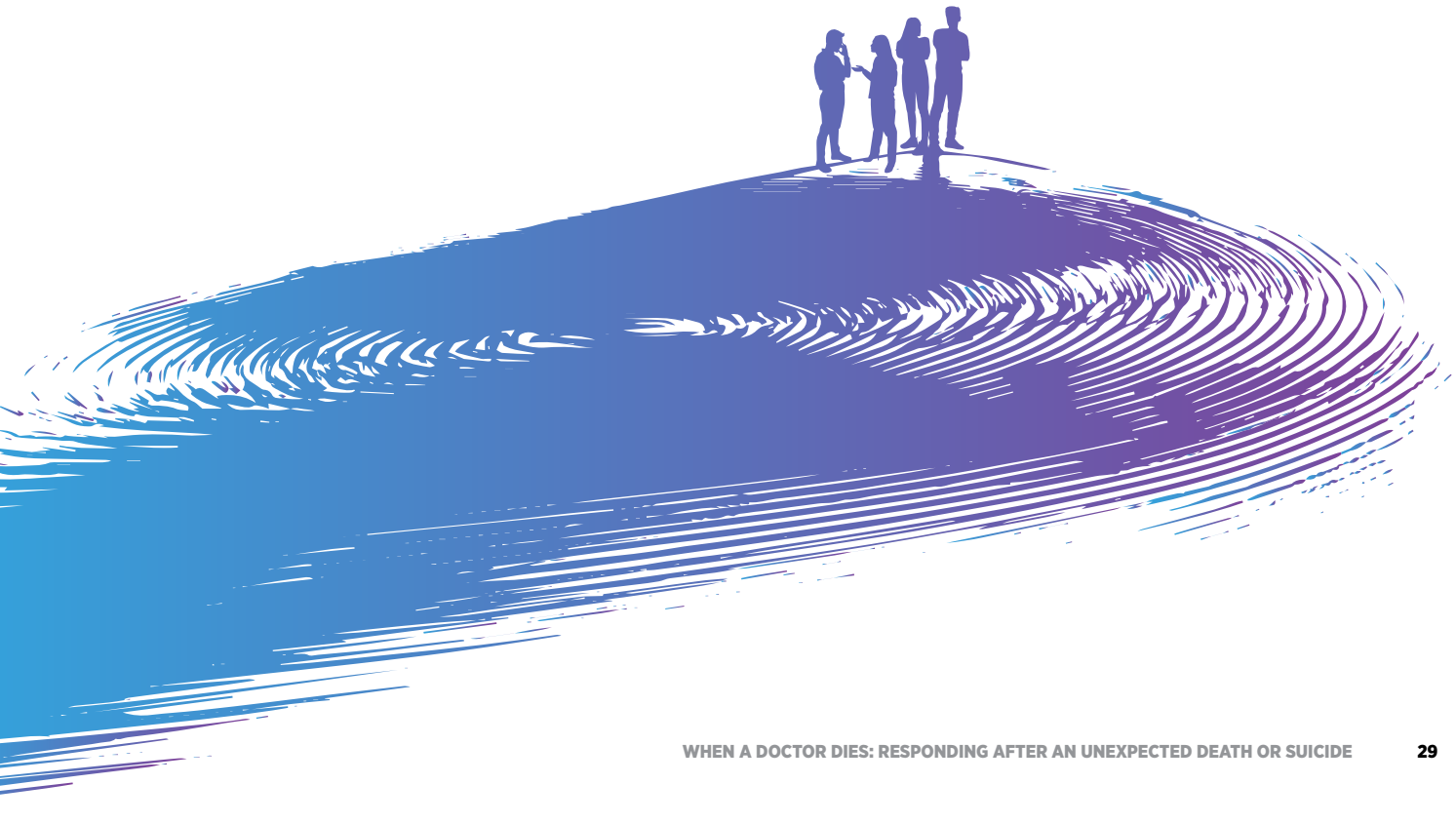
Individuals might experience deep confusion and existential questioning, wondering "why did this happen?" This existential crisis can challenge their understanding of life and death, causing profound emotional distress.

> **"It was disturbing, confronting and deeply saddening... and made me reassess my own life priorities."**

Re-traumatisation

Individuals who have experienced previous trauma may find that the suicide reactivates these past traumas, intensifying their emotional response and complicating their grieving process. This can lead to a recurrence of previous symptoms of trauma, such as anxiety, depression, or post-traumatic stress disorder (PTSD).

> **"The memories came flooding back, overwhelming me..."**



SPECIFIC CHALLENGES FOR DOCTORS

Some doctors may feel they "missed" the signs of their colleague's distress. As healthcare professionals, they might feel extra grief and remorse for not seeing warning signs or for not being able to help their colleague. It's important to educate and reassure them that suicide and unexpected death cannot be predicted, even by doctors.

> **"Through it all, I had to continue to handle everyone else's problems as well as my own. Patients were devastated after losing their doctor, staff members were struggling, his overwhelmed wife blamed herself, and colleagues were having a very difficult time - both angry and sad that he hadn't reached out to anyone."**

Doctors are trained to hide their emotions while caring for others, so their distress might not be obvious to colleagues or managers. They may seem to be coping well on the outside but struggle inside. It's important for colleagues and managers to regularly check in on their well-being, as their true feelings might be hidden.

> **"I felt a huge wave of sadness, shock, and confusion. I worried about my colleagues. It took a toll on our workload, supervision, morale, patient care, and trust in the hospital's management."**

The aftermath of an unexpected death is a deeply challenging time for those left behind. Unexpected deaths, including suicides, can greatly affect the emotional, physical, and spiritual well-being of the bereaved.

> **"There was very little support available for the doctors. I found some help through a private grief psychologist, which was reassuring because it helped me realise that there was nothing I could have done to prevent the situation. Without that support, I think I would've felt much worse."**

Media attention can add to the burden in cases of unexpected death, intruding on private moments of grief. The involvement of police and coroners can also affect the grieving process. Colleagues might feel they don't have the "right" to grieve or seek support. Feelings of anger might also arise, causing confusion and further complicating grief. These reactions aren't necessarily tied to the type or closeness of the relationship with the doctor; many factors contribute to grief reactions.

> **"Sometimes it is best to be able to process the events by yourself and in your own way. Then there may be a time when it is appropriate to seek out others who have also experienced the same."**

Coping mechanisms vary widely. Some people find comfort in shared memories, while others seek professional help to navigate their grief. The grieving process is unique to each person and often requires time and patience.

Appendix 3

Communication With Family Members, Colleagues And Other Staff And Patients

INCLUSIVE COMMUNICATION

To ensure inclusive support, depending on the target audience, communications could consider the advice provided in the NSW Health Accessibility Guidelines, particularly with regards to:

- **Audience Sensitivity:** Adapt messages to meet the diverse needs of all staff, including those from culturally and linguistically diverse backgrounds and individuals with disabilities.
- **Plain Language:** Use clear, simple language to ensure understanding across different literacy levels.
- **Alternative Formats:** Provide materials in accessible formats, like Easy Read, translated versions, and audio, as needed.
- **Digital Accessibility:** Ensure digital documents follow Web Content Accessibility Guidelines (WCAG) for compatibility with assistive technology.
- **Event Accessibility:** Use the NSW Health Event Accessibility Checklist to make memorials and gatherings accessible to all.

DISCUSSIONS WITH FAMILY MEMBERS

Talking to family members after a suicide requires sensitivity, compassion, and careful thought.

Here are some key points to keep in mind:

- **Show empathy:** Be genuine and compassionate. Acknowledge their pain and loss and offer your condolences.
- **Listen:** Let them share their feelings and thoughts without interrupting. Sometimes, just listening is more helpful than speaking.
- **Be honest and clear:** Use simple and straightforward language. Avoid using vague terms or euphemisms. Be honest about what happened, but deliver the information gently.
- **Ease guilt:** Reassure them that suicide is complex and they should not blame themselves. Emphasise that many factors contribute to such a tragic outcome.
- **Acknowledge anger:** Understand that anger is a normal part of grieving. It may be directed at others or the workplace, especially if the doctor was under stress. Avoid being defensive and show understanding, taking their concerns seriously.
- **Offer support:** Let them know that help is available. Provide information about grief counselling, support groups, and other resources.
- **Respect their wishes:** Follow their lead in the conversation. If they don't want to discuss certain details, respect their boundaries.
- **Share information carefully:** Provide necessary information about hospital arrangements, memorial services, or other updates sensitively.
- **Follow up:** Check in with them periodically to offer continued support. Grieving is a long process, and ongoing support can be very meaningful.
- **Cultural sensitivity:** Be aware of and respectful towards cultural differences in how grief and suicide are viewed. Adapt your approach to honour their cultural practices and beliefs. For some cultures this may involve consultation with community leaders and respect for traditional practices.

- **Encourage professional help:** Suggest they seek professional help if needed. Sometimes, talking to a mental health professional can provide additional support and guidance.

Each family is different, so it's important to adjust your approach to meet their specific needs and preferences during this difficult time.

INFORMING AND BRIEFING COLLEAGUES AND OTHER STAFF

- **Timely and personal communication:** Share the news promptly to prevent rumours and misinformation. There may be a chain of communication, often from police, to management and then to a senior member of the relevant department, who will possibly then be responsible to tell members of the team. Anyone involved needs to be supported in their role.
- **Use compassionate language:** Communicate with empathy and authenticity. Acknowledge the impact of the loss and express condolences. Both the content and tone of written or email correspondence are important.
- **Personalised communication:** Avoid generic emails. Personal phone calls or individual approaches are often more appreciated and less distressing.
- **Provide clear information:** Be honest and straightforward about what happened, but avoid unnecessary details. Make sure staff have accurate information to prevent speculation. Acknowledge that some questions may remain unanswered.
- **Acknowledge grief:** Learning about a death, especially a suicide, can be very distressing. It is important to understand that everyone grieves differently and there is no right or wrong way to feel. Encourage staff to take the time they need to process their feelings. For some, the death of a colleague can trigger memories of previous loss. People may react in unexpected ways, which can sometimes feel uncomfortable.
- **Avoid speculation:** Do not discuss personal opinions about the suicide, blame, or guilt. Focus on support and healing.
- **Respect privacy:** Respect the privacy of the doctor and their family. Avoid sharing personal details that are not necessary for staff to know, even if they want to know. This can be challenging as it is natural for people to ask more questions - but respect is vital.
- **Encourage open discussion:** Encourage talking about feelings and thoughts, including suicidal thoughts, to help prevent future tragedies. Understand that some people might be uncomfortable with these talks because of their personal, cultural, or religious beliefs. Remain sensitive to individual's needs, as different people like different kinds of conversations.
- **Create a supportive environment:** Foster an open and supportive atmosphere where staff can express their feelings and support each other. Inform staff about planned support measures like safe spaces and group or individual support sessions.
- **Offer professional support:** Provide access to mental health resources, including specific doctors' health services and counselling. Ensure that Employee Assistance Programs are aware of the death and have qualified staff available. Make sure all staff know how to access these services.
- **Provide a variety of options:** Have workplace policies to support staff during crises, including mental health leave, flexible working arrangements, and access to support services.
- **Follow up:** Periodically check in with staff to offer ongoing support. Grief can have long-term effects, and continued support is important.

The doctor's colleagues may feel very angry about the situation, especially if they believe workplace issues contributed to the death. They might also have ongoing concerns for themselves or their colleagues. It's important to listen carefully, act quickly on any urgent safety issues, and provide a clear way for ongoing, meaningful discussions to address their concerns.

INFORMING PATIENTS

When a doctor dies unexpectedly or by suicide, healthcare settings need to give clear guidelines and support for patients and the staff tasked with informing them. Here are some important points to consider:

1. Coordination and preparation

- **Team approach:** Create a small team, preferably senior doctors experienced in delivering sensitive news. They should receive a briefing on the facts, focusing on conveying the information with compassion and sensitivity. This briefing should happen soon after the event to prepare and support the doctors.
- **Opt-out option:** Give doctors the option to opt out of delivering the news, recognising the emotional toll. Discuss this option personally with each doctor.
- **Briefing session:** Hold a session to ensure all involved doctors understand what to share and how to communicate it. Inform them about the range of reactions they might face and the support available for those distressed by the news. Ensure there is time for the doctors to discuss how they might personally deliver these messages.
- **Workload distribution:** Share the responsibility among several doctors. Repeating the same message multiple times can be more traumatic for an individual than they realise. Responding to different patients, each with unique reactions, can be exhausting.
- **Consistent messaging:** Ensure these messages are consistent with messages that other staff such as nursing staff will be providing.

2. Deciding who should inform which patients

- **Involve senior medical staff:** Patients should be informed by a senior doctor who knows them, or the senior doctor taking over their care. Do not give this task to doctors-in-training.
- **Identifying the patients who need to be informed, and when they should be told:** Consideration will need to be given to outpatients who may not be returning for review for some time.
- **Identifying patients needing extra support:** Consider the impact on patients who had a close relationship with the doctor and plan a more personalised approach for them.
- **Determine when patients should be told**

3. Crafting the message

- **Essential information only:** Share only the necessary information, without going into detail about the death unless it directly affects the patient's care.
- **Sensitive language:** Use compassionate and clear language, avoiding medical jargon or euphemisms that might confuse or upset the patient.
- **Use of a script:** Provide doctors with a script to ensure the message is consistent and accurate. Avoid unnecessary details about the death and respect the privacy of the doctor and their family. Review the script in advance and allow doctors to ask questions or express concerns.

4. Delivering the news

- **Private setting:** Inform patients in a private and comfortable setting to give them space to process the information.
- **Calm and reassuring demeanour:** Stay calm and reassuring to help the patient feel supported.
- **Allow time for reaction:** Give patients time to react and process the news. Be ready to offer emotional support or referrals to mental health resources if needed.
- **Follow-up support:**
  - **Availability for questions:** Be available to answer any questions the patient may have after the initial conversation.
  - **Referral to support services:** Offer information about support services, such as counselling, if the patient needs more help coping with the news.

5. Institutional support

- **Debriefing for staff:** Provide opportunities for the doctors who delivered the news to talk about their experience and get support, whether through peer support groups or professional counselling.

Appendix 4

Suggested email response and phone script

SAMPLE EMAIL/ LETTER

Dear [recipient's name]

It is with great sadness that I am writing to share news that will likely come as a shock. I wanted to ensure you heard about it directly.

We were informed yesterday (morning / afternoon / evening) of the unexpected death of Dr [full name] on [day].

Dr [surname] has been a valued member of our team for [many years], and (his/her/their) loss will deeply affect many of us. [Add more relevant details here about where Dr X was working, including unit, department and any committees or other roles].

Our thoughts are with (his/her/their) family at this time. With respect for their privacy, additional details regarding Dr [last name]'s death are not available.

Hearing such tragic news is very upsetting and I want to reassure you that we are committed to supporting you and your colleagues. While the work of the hospital continues, we will do all we can to ensure that everyone can access the time and support they need.

- Specialised support services are immediately available, including the 24/7 Doctors' Health Service (02 9437 6552 for Doctors' Health NSW) and our Employee Assistance Program (details).
- I encourage you to make use of your own supports, such as family, friends and your own doctor. If you would like to talk to your GP or other professional supports, then we will do our best to make sure you have time for this.
- If you need to take some leave, [name of responsible officer] is available at [contact details] to assist with these arrangements.
- We will support colleagues choosing to remain at work, and [name of responsible officer eg DMS] is available at [contact details] to assist with any difficulties managing workload or rosters.
- A private space will be set up in the hospital [state location and times if known – if not, state details will be provided] for colleagues to gather and support one another.
- I will keep you informed about other support and memorial arrangements as they arise.

I am very sorry to share this sad news and understand that the coming weeks and months will be challenging for us all, so please take care of yourself and your colleagues.

[Manager's full name]
[Manager's position]

Preparing to make the phone call

Phone calls may be preferred or needed to reach team members of the unit where the doctor had been working. Colleagues who regularly worked with the doctor who has died may be away on leave and may not receive the email.

Working with those who know the local situation is important, as some doctors are likely to require a personal phone call. Some phone calls may be made by the person leading the response team, while other calls may be better coming from someone senior leading the unit where the doctor had been working.

This phone script is intended as a guide for these phone calls, recognising the importance of being sensitive to the unfolding conversation and that the recipient is likely to have other questions.

Allow time during the conversation for the information to settle, and be prepared for questions, some of which you may not have the answers to. The person is likely to want to know who else on their team has been told and what other communication is planned. Remember to make a note after each phone call if there are specific details that need to be followed up.

Suggestions for breaking the news of a colleague's death by phone

SAMPLE PHONE SCRIPT

Greeting: "Hello, [recipient's name]. This is [your name], [your position] from [hospital/organisation name]. Do you have a moment to talk? Are you somewhere private at the moment?" [Make an arrangement to call back or to be available later, if the recipient is unable to talk.]

News preparation: "I'm afraid I have some very sad news to share, and I wanted to tell you personally."

Breaking the news: "We received word that Dr [full name] died unexpectedly on [day]. I know this will come as a shock, and I am very sorry to share such difficult news."

Managing requests for further information: "We are respecting the family's privacy, so there are no specific details at this point - other than that this was a very unexpected and tragic event."

Acknowledge their reaction: "I know this is hard to hear, and it's a lot to take in."

Check in on well-being: "Are you okay? Do you have someone nearby for support?"

Offer support: "I also want you to know that specialised support is available if you or any of your colleagues need it. You can call [Doctors' Health Service/Employee Assistance Program/Other Service] anytime. We are also setting up a space at [location if applicable - or details to be provided and confirm where to send these details] where colleagues can gather privately to talk."

Provide information on leave or additional support: "We know some people may need some additional support, such as time off. [Name of responsible officer] can assist with leave arrangements or anything else you might need."

Conclude compassionately: "I can keep you informed about arrangements as they are made. What's the best way for me to get in touch with you?"

End of call: "I'm really sorry [recipient's name] that I had to phone you with this sad news. Please take care of yourself".

SAMPLE TEXT MESSAGE

In some circumstances, it may help to give notice to the recipient that a phone call is planned by sending a text message:

"Dear Dr X. This is [your name] from [your position, your hospital]. May I speak to you as soon as possible about some difficult news I need to share with you. Please let me know when I can give you a call? Thank you [your name].

IN CONCLUSION

Preparing every organisation for the unexpected death of a doctor is essential for ensuring a compassionate and effective response. While implementing these measures may seem challenging in an already pressured system, many of the steps outlined in this guide can also support responses to other crises and apply to all staff.

Doctors' health remains a priority, and preventing such tragedies begins with proactive support for their wellbeing and mental health. This resource, specifically developed for doctors in the NSW Health System, is informed by new research and insights from those who have experienced the unexpected death of a colleague. Targeted support for doctors is vital, as they face unique pressures and are at a higher risk of suicide. However, organisations are encouraged to use this guide as a framework to address the needs of all staff.

Responding with empathy and care, while maintaining a focus on staff wellbeing and support, honours the memory of colleagues and supports those who continue their essential work.

RESOURCES

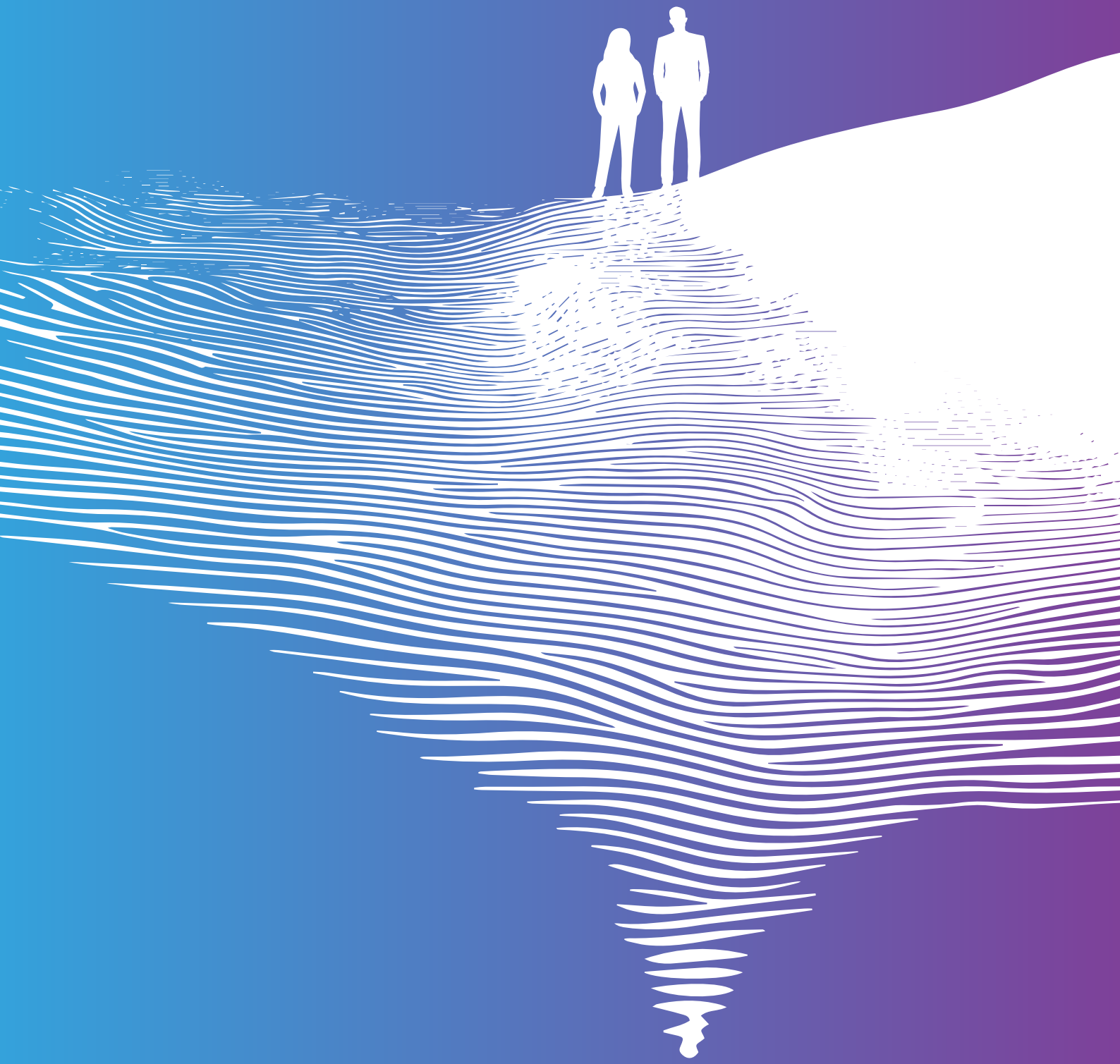
For additional resources go to:

https://doctorshealth.org.au/when-a-doctor-dies

"The workplace response was really helpful. The culture led by the CEO meant we were well supported. I think we all did the best we could."

REFERENCES

1. Abbate L, Chopra J, Poole H, Saini P. Evaluating Postvention Services and the Acceptability of Models of Postvention: A Systematic Review. Omega (Westport). 2024 Dec;90(2):865-905.
2. Agrawal A, Gitlin M, Melancon SNT, Booth BI, Ghandhi J, DeBonis K. Responding to a Tragedy: Evaluation of a Postvention Protocol Among Adult Psychiatry Residents. Acad Psychiatry. 2021 Jun;45(3):262-271.
3. Andriessen K, Krysinska K. Essential questions on suicide bereavement and postvention. Int J Environ Res Public Health. 2012; 9(1):24-32.
4. Australian Institute for Suicide Research and Prevention & Postvention Australia. Postvention Australia Guidelines: A resource for organisations and individuals providing services to people bereaved by suicide. Brisbane: Australian Institute for Suicide Research and Prevention. 2017
5. Causer H, Spiers J, Efstathiou N, Aston S, Chew-Graham CA, Gopfert A, Grayling K, Maben J, van Hove M, Riley R. The Impact of Colleague Suicide and the Current State of Postvention Guidance for Affected Co-Workers: A Critical Integrative Review. Int J Environ Res Public Health. 2022; 19(18):11565.
6. Cazares PT, Santiago P, Moulton D, Moran S, Tsai A. Suicide Response Guidelines for Residency Trainees: A Novel Postvention Response for the Care and Teaching of Psychiatry Residents who Encounter Suicide in Their Patients. Acad Psychiatry. 2015 ; 39(4):393-7.
7. Duarte D, El-Hagrassy MM, Couto TCE, Gurgel W, Fregni F, Correa H. Male and Female Physician Suicidality: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2020; 77(6):587-597.
8. Dutheil F, Aubert C, Pereira B, Dambrun M, Moustafa F, Mermillod M, Baker JS, Trousselard M, Lesage FX, Navel V. Suicide among physicians and health-care workers: A systematic review and meta-analysis. PLoS One. 2019; 14(12):e0226361.
9. Gehrmann M, Dixon SD, Visser VS, Griffin M. Evaluating the Outcomes for Bereaved People Supported by a Community-Based Suicide Bereavement Service. Crisis. 2020; 41(6):437-444.
10. Gold KJ, Schwenk TL, Sen A. Physician Suicide in the United States:Updated Estimates from the National Violent Death Reporting System. Psychol Health Med. 2022; 27(7):1563-1575.
11. 11. Harvey SB, Epstein RM, Glozier N, Petrie K, Strudwick J, Gayed A, Dean K, Henderson M. Mental illness and suicide among physicians. Lancet. 2021; 398(10303):920-930.
12. Kõlves K, De Leo D. Suicide in medical doctors and nurses: an analysis of the Queensland Suicide Register. J Nerv Ment Dis. 2013; 201(11):987-90.
13. Kõlves K, Zhao Q, Ross V, Hawgood J, Spence SH, de Leo D. Suicide and sudden death bereavement in Australia: A longitudinal study of family members over 2 years after death. Aust N Z J Psychiatry. 2020; 54(1):89-98.
14. Milner AJ, Maheen H, Bismark MM, Spittal MJ. Suicide by health professionals: a retrospective mortality study in Australia, 2001-2012. Med J Aust. 2016; 205(6):260-5.
15. Petrie K, Zeritis S, Phillips M, Chen N, Shand F, Spittal MJ, Harvey SB. Suicide among health professionals in Australia: A retrospective mortality study of trends over the last two decades. Aust N Z J Psychiatry. 2023; 57(7):983-993.
16. Pilgrim JL, Dorward R, Drummer OH. Drug-caused deaths in Australian medical practitioners and health-care professionals. Addiction. 2017; 112(3):486-493.
17. Pitman AL, Osborn DP, Rantell K, King MB. The stigma perceived by people bereaved by suicide and other sudden deaths: A cross-sectional UK study of 3432 bereaved adults. J Psychosom Res. 2016; 87:22-9.
18. Sansone RA, Sansone LA. Physician suicide: a fleeting moment of despair. Psychiatry (Edgmont). 2009; 6(1):18-22.
19. Spiers J, Causer H, Efstathiou N, Chew-Graham CA, Gopfert A, Grayling K, Maben J, van Hove M, Riley R. Negotiating the postvention situation: A grounded theory of NHS staff experiences when supporting their coworkers following a colleague's suicide. Death Stud. 2024; 48(9):937-947.
20. Visser V, Tretheway R. A Longitudinal Study of the Impact of a Suicide Bereavement Service on People Bereaved by Suicide. Omega (Westport). 2023 Jul 9:302228231188751.



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