ACGME Resources for Promoting Well-Being during the COVID-19 Pandemic

Foreword

Timothy P. Brigham, MDiv, PhD
ACGME Chief of Staff and Chief Education and Organizational Development Officer

A "Thin Place" is an ancient Celtic concept that describes a locale where the distance between this world and the eternal world narrows. These are mesmerizing places that can inspire and stir us but also disorient us and confuse us. Thin places can be amazingly beautiful and shockingly scary at the same time. We often lose our bearings in such places. Time seems altered and we become transformed within the place and often we are forever changed once we leave it. "Thin Places" can be found in cathedrals, mosques, synagogues, temples and the like, and also through nature and in the arms of a loved one. In our society, the thin place is often encountered within the halls of healing; a hospital; a clinic; in the spoken words between patients and physicians. This is where the magic of birth, life, care, and cure happen. This thin place is also where people stare into the face of death and disease, as well as despair. It takes a special person to exist within the thin space, to care for and through care, to minister to patients in such an environment. This is where our residents and fellows learn, teach, and work.

In the world of today, the crush of the thin place is heavier than ever before in our lifetime. Residents and fellows not only find themselves in a thin place, but they also find themselves in a thin time. This makes the line between the world and the eternal even thinner. Our learners are asking questions we never thought they would ask, as they strive to realize their sacred mission to patients and to society. "We don't know what to do." "What if I go to work and get infected?" "What if I get sick?" "What if I die?" "Will I really be safe?" Will my family be safe?" "What happens to my future?" "Will anyone protect me?" "Does anyone care?" These are but a few of the questions current residents and fellows are asking.

To address the challenges of a global pandemic on residents and fellows and their teachers, the Accreditation Council for Graduate Medical Education (ACGME) has assembled and engaged some of the nation's experts to create this monograph to help guide institutions and programs through this unprecedented crisis. This resource is designed to assist you to connect deeply with your faculty members and learners as we all negotiate uncertain terrain in these uncertain times. We hope this will help you move forward through this thin space and time into a better future.

Guidance for Promoting Well-Being during the COVID-19 Pandemic

This ACGME guidance for promoting resident/fellow well-being during the COVID-19 pandemic was written by a group of experts in graduate medical education (GME) and well-being and reviewed by leaders in these fields. The list of authors and reviewers can be found at the end of the document.

Section I discusses *Strategies for Coping and Preserving Well-Being during the COVID-19 Pandemic*; and Section II outlines *Responses to Resident/Fellow and Colleague Illness and Death from COVID-19*. Recommendations are evidence-informed and drawn from existing guidance and already available well-being resources. Recommendations reflect what was known in late spring 2020. The authors and reviewers recognize that information on COVID-19 overall, and its impact on GME is "rapidly evolving and fluid" and were mindful of this as they developed this guidance. The intent is to offer readers recommendations in a framework that can be applied across a range of specific local contexts and changing situations.

The authors appreciate that much is not yet known. This includes the progression of COVID-19, and how education and patient care will be provided in a post-pandemic world. Institutions across the nation experienced different levels of the pandemic, with various degrees of impact on their health and education systems. The authors and the ACGME trust in the ingenuity of the medical education community, and its ability for continuous improvement, and hope that this guidance can serve as a foundation for future adaptation.

Section I: Strategies for Promoting Well-Being during the COVID-19 Pandemic

COVID-19 has placed a significant strain on the nation's health care system and on health professionals, including residents and fellows. Fortunately, most Sponsoring Institutions and programs already developed a solid foundation of well-being programming prior to the pandemic. Rather than attempting to create new well-being resources mid-crisis, the optimal approach involves taking an inventory of existing resources to determine what is useful in its current form and what can be re-tooled to address the demands of the current situation. It may be helpful to expand the use of trauma-informed resources to support the well-being of residents and fellows in the face of unprecedented stressors and emotionally challenging experiences during the pandemic. This guidance also addresses sources of health care professionals' anxiety during the early phases of the pandemic identified by Shanafelt and colleagues, including access to appropriate personal protective equipment (PPE) and COVID-19 testing, being able to provide competent care if deployed to a new patient care unit, and being provided accurate and up-to-date information, among others.[1]

The ACGME's initial three stages of GME during the COVID-19 pandemic are described in **Table 1**. Local and institutional responses to the pandemic may not proceed in a linear fashion, as incidence and prevalence of COVID-19 in communities may wax and wane. Stages may recur with an additional resurgence of the pandemic. In addition, residents and fellows may experience different stages and levels of patient care volume, depending on the sites and clinical units to which they are assigned. The ACGME's and the GME community's response to the COVID-19 pandemic continue to evolve. This includes a planned update to the ACGME's guidance to the GME community related to pandemic preparedness and response.

Stage 1. Pandemic Crisis Planning and Preparation

During Stage 1, institutions are largely functioning in a "Business as Usual" mode, while actively planning and preparing for a surge of pandemic patients and the associated impact on operations and resident/fellow well-being. The focus should be on shoring up well-being-related "universal precautions," including strategies to proactively promote enhanced resilience, stress reduction, and adaptive coping at the level of the individual, and to nurture supportive communities at the program and institutional levels. Stage 1 describes the time to create an inventory of well-being resources and pathways to mental health care, determine if increased staffing or capacity increases may be needed as patient care pressures mount, and develop a virtual mode of care delivery if telehealth platforms are not yet in place. This is also the time to ensure that education leadership is represented in various departmental and institutional pandemic crisis management teams. Any plans for re-deployment of residents and fellows must be accompanied by a plan for education and just-in-time-training to meet any new clinical demands.

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[1] Shanafelt T, Ripp J, Trockel M. Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic. JAMA. 2020 Apr 7.

Table 1: Three Stages of GME during the COVID-19 Pandemic		
Stage 1 "Business as Usual" (Surge Planning Phase)	**Stage 2** "Increased Clinical Demands" (Implement Surge Plan)	**Stage 3** "Pandemic Emergency Status" (Surge Plan Fully Implemented)
Key considerations: 1. Ensure communication systems for each stage, including communicating what is known and not known. 2. Establish resident/fellow Rules of Clinical Engagement for each phase. 3. Develop/update sick call and crisis management plans. 4. Provide training in Psychological First Aid (PFA) to residents/fellows, staff members, and supervisors. 5. Scan for signs and symptoms of emotional distress, burnout, and mental health conditions. 6. Ensure ready access to telemedicine and tele-mental health for residents/fellows. 7. Staff institutional Crisis Line. 8. Establish communication plans between designated institutional official (DIO), program directors, program coordinators, chief residents, and the Chief Medical Officer/Chief Operating Officer. 9. Communicate personal protective equipment (PPE) availability, appropriate use and post-exposure protocols.	Key considerations: 1. Review Rules of Clinical Engagement and GME protocols, as needed, to ensure adequate work hour compliance, supervision, proper PPE, and training. 2. Maintain daily communications from leadership to residents/fellows and frontline staff members to reinforce connectedness and help manage uncertainty. 3. Encourage and provide access to self-screening. 4. Continue to scan for emotional distress and mental health conditions. 5. Maintain ready access to telemedicine and tele-mental health for residents/fellows. 6. Set-up virtual support program for quarantined/ self-isolated residents/ fellows and faculty members, including delivery of care packages for residents/fellows in self-isolation. 7. Deliver just-in-time clinical training as a refresher and for re-deployment.	Key considerations: 1. Maintain all elements instituted in Stage 2. 2. Daily communications at an established time, with a consistent, clear message to update residents/fellows on hospital status, PPE supply, and other critical updates, recorded for individuals unable to attend. 3. Ensure work hour compliance and disseminate concise guidance for fatigue mitigation. 4. Encourage and provide access to self-screening. 5. Continue to scan for emotional distress and mental health conditions. 6. Maintain ready access to telemedicine and tele-mental health for residents/fellows. 7. Ensure adequate training, supervision, and connectedness for re-deployed residents/fellows. 8. Provide PFA and brief resident/fellow peer group support sessions. 9. Provide leadership presence to engage with residents/ fellows and faculty and staff members.

Stage 1 is the time to begin scanning for signs and symptoms of emotional distress, burnout, clinical anxiety, unhealthy alcohol and substance use, new mental health conditions, and exacerbation of pre-existing mental health conditions. Professionalism lapses, changes in appearance, behavior (e.g., irritability), level of performance, or absenteeism may be early indicators.

Stage 1 is also the time to train residents and fellows, frontline staff members, and supervisors in the concepts of Psychological First Aid (PFA). PFA is an evidence-informed approach to reducing stress symptoms and assisting a healthy recovery for persons affected directly or vicariously by trauma or disasters, including patients and family members, first responders, and relief workers. It requires relatively limited training and the skills can be applied immediately. PFA principles include a focus on safety, calming, connectedness, empowerment, and instilling hope. PFA may help residents

and fellows address stress in patients and their families and help deal with stress resulting from clinical challenges during the pandemic. Institutional leaders should consult with their psychiatry/psychology departments for resources on PFA and/or other evidence-informed practices for managing traumatic and stressful situations.

Studies have shown that some models of psychological debriefing to encourage residents and fellows to process their stressful experiences may actually increase the risk of developing post-traumatic stress disorder (PTSD). A definition of PTSD can be found on the [Department of Veterans Affairs National Center for PTSD website](). In contrast, PFA focuses on promoting a sense of physical safety, reducing emotional and physiological arousal, and connecting individuals with a social support network empowering them to take positive steps to support their recovery and well-being.

Consult the ACGME guidance entitled [Administering Psychological First Aid](). PFA training resources also are available from the Department of Veterans Affairs National Center for PTSD, which provides a [variety of resources on PFA](), including a [mobile app](), a field operations guide, [a series of videos, a one-hour primer,]() and a [six-hour training course](). Other resources include [PFA guidance]() from the American Red Cross and a [summary guide]() and [brief video]()from the Minnesota Department of Health.

PFA may be provided to individuals or in group settings. A key focus of training is for individuals providing PFA to be aware of their limits and to follow defined procedures to facilitate access to mental health care when residents/fellows, staff members, and supervisors are concerned that someone may need additional services.

Stage 2. Increased Clinical Demands Call for the Implementation of the Institution's Pandemic Crisis Management Plan

Stage 2 describes the circumstances in which patient demands are rapidly increasing due to the influx of COVID-19-positive patients, and the institution and programs are beginning to implement their Crisis Plan.

Stage 2 can be marked by widely divergent clinical demands, with some units and clinicians experiencing a surge and others with a dramatic reduction in patient volume and clinical responsibilities. Proactive communication and a focus on teamwork are crucial, and programs and institutions must ensure adequate supervision, proper infection control protocols and access to PPE, maintaining compliance with work hour requirements, and just-in-time training of residents and fellows, especially if they are redeployed to other services and units.

Stage 2 is also the time to implement expanded proactive well-being support, including preparing care packages to distribute to residents and fellows in self-isolation, and ensuring all residents and fellows have access to their institution's online network. This includes access to online well-being resources that should be provided to all residents and fellows to support their mental health during the COVID-19 pandemic. This should recognize that residents and fellows may have face external stressors, such as a partner, parent, or other relative losing a job, or loved ones with illness from COVID-19. Selected examples of personal well-being resources for residents and fellows are provided in Item 3. Build Skills and Mindsets in the Strategies section of this document.

Institutions in Stages 2 and 3 may offer temporary sleeping/living accommodations for residents, fellows, faculty members, and other health professionals caring for patients with COVID-19 so that they have a safe and restful space between shifts and to reduce the risk of infection for family members, significant others, or housemates.

Resident/fellow counseling/mental health professionals may consider increasing the frequency of check-ins by phone or text for past or current resident/fellow clients to make sure they are handling the stressors appropriately and to provide support.

Stage 3. "Pandemic Emergency Status" with Full Implementation of Pandemic Crisis Management Plan

Institutions in Stage 3 can declare Pandemic Emergency Status. The priorities implemented in Stage 2 are continued, supplemented with regular check-ins and communication among key clinical and education leadership and updates for residents and fellows. Concurrently, clear communication with residents and fellows about well-being support and available resources is key.

Residents and fellows may be confronted with anticipatory grief, moral distress/injury, a conflict between closely held values and realities that may arise if there are shortages of resources and difficult allocation decisions that need to be made, and other challenging experiences that could benefit from additional support. Support may be provided via virtual or one-on-one meetings or virtual peer group sessions that offer individuals an opportunity to share concerns. These sessions should be facilitated by a mental health professional or someone trained in PFA; departments of psychiatry and psychology may be important allies in developing and scaling up these resources. An added resource is the video on moral distress with Joshi Jane Halifax, Abbot and Head Teacher of Upaya Institute and Zen Center in Santa Fe, and Cynthia Rushton from the Johns Hopkins Berman Institute of Bioethics and the School of Nursing.

In this phase, as clinicians are entirely focused on the care of their patients, residents and fellows are less likely to access mental health resources for themselves. Explore approaches to reduce barriers and promote use of counseling and mental health resources. Some institutions have found that embedding counseling/mental health specialists in high acuity/risk units may increase utilization. Others have used resident/fellow peer groups (*CopeColumbia*) or virtual mental health appointments.

During peak volume or surge periods, in addition to ensuring work hour compliance, alertness management strategies will be important to ensuring resident/fellow and patient safety. Strategies include strategic napping, strategic use of caffeine, and institutional systems to ensure safe transportation for residents and fellows or the ability to remain at the institution to sleep after or between shifts. Attention to sleep hygiene is also important (see guidance for improving sleep in hospital workers from the Uniformed Health Services University's Center for the Study of Traumatic Stress). Sleep in the home setting may be challenging for some residents and fellows due to other family members who are in self-isolation.

In Stage 3, there may significant absenteeism due to illness of residents, fellows, and staff members. Ensure frequent outreach is extended to residents and fellows who are

still working and to re-deployed physicians. This should include regular check-ins on their well-being. Outreach to residents and fellows who are COVID-positive can include distribution of care packages of food and supplies, as well as brief virtual check-ins. Remind program leaders, faculty mentors, and peers of the importance of reaching out. All residents, fellows, and staff members should be familiar with and scan for signs and symptoms of acute stress reaction and acute stress disorder in their colleagues. Additional resources may be needed to help residents and fellows experiencing acute reaction (ASR) and acute stress disorder (ASD). See the ACGME resource for ASR and ASD in the face of COVID-19, and the definitions for ASD and PTSD provided by the Department of Veterans Affairs National Center for PTSD. ASD can be a predecessor to PTSD. Another resource is the "Recognize, Respond, and Refer" protocol in Item 5, Identify and Assist Trainees in Distress, in the Strategies section of this document.

Considerations for the Period Following the Peak of the Pandemic

After the peak of the local epidemic has subsided, and the number of patients with COVID-19 has declined, institutions may experience high patient care volumes due to "pent-up demand" from patients needing care, including surgical and diagnostic procedures that could not be safely performed while the hospital focused on preparing for and addressing the anticipated or actual surge of patients with COVID-19. Program and institutional leaders should continue regular communications and updates, acknowledging the challenges that were faced and trying to voice realistic optimism and hope.

This period is a crucial time to continue to monitor for resident/fellow distress and caregiver fatigue, including compassion fatigue. Continue to offer virtual or in-person PFA and group counseling activities as personal safety measures permit. In the wake of a pandemic surge, this is also a time of increased risk for onset or recurrence of mental illness, such as depression, anxiety, substance use disorders, and acute stress disorder. Suicidal ideation and suicide attempts may occur and should be responded to immediately and compassionately. Ready access to virtual mental health resources for residents and fellows is important. This could include the Interactive Screening Program (ISP) developed by the American Foundation for Suicide Prevention and Skills for Psychological Recovery (SPR), a VA-designed program to follow PFA to promote healing in the weeks and months following traumatic events.

Remind residents, fellows, peers, and faculty members to scan for signs and symptoms of psychological stress and mental health disorders in themselves and their colleagues and be ready to respond with compassion, assistance and, as needed, a referral to a counseling/mental health evaluation. Faculty members and program leaders should consider that professional lapses may suggest a clinician is in distress and encourage the individual to seek help.

Considerations for the period of added volume after the peak of the pandemic include:

1. Communicate with a positive message and emphasize connectedness and signs that the rate of new infections is declining.

2. Encourage and provide access to self-screening.

3. Continue to scan for emotional distress and mental health conditions.

4. Maintain ready access to telemedicine and tele-mental health for residents and fellows.

5. Ensure ongoing work hour compliance given the potential high volume of COVID-negative patients for elective and preventive procedures.

6. Engage residents and fellows in exploring opportunities to improve workflow.

7. Monitor COVID-19 levels to prepare for potential future spikes in infections.

Following the period of added patient volume unrelated to COVID-19 there will be a gradual return to more normal levels of patient care and learning activities. Health systems will remain vigilant in anticipation of potential additional surges of COVID-19. New approaches to patient care and learning developed during the pandemic, such as telemedicine and distance learning, likely will become accepted features of the learning and working environment.

Regular communication will continue to be essential, with leadership focusing on instilling hope while acknowledging that some aspects of care provision and learning may have permanently changed. The transition back to a more regular work life may be a time for the emergence of delayed emotional reactions to the crisis in residents and fellows, including PTSD. Continued support and provision of screening and self-screening tools, with ready access to medical and mental health care, are crucial in this period. One available self-screening tool is the Well-Being Index developed by Mayo Clinic.

Considerations for the period of when patient volumes return to more normal levels include:

1. Debrief with residents, fellows, and faculty members to harvest and apply learnings from the crisis.

2. Aim for post-traumatic growth.

3. Continue to communicate and check in with residents, fellows, and faculty members.

4. Continue to scan for emotional distress and mental health conditions.

5. Empower programs and individuals to work on well-being initiatives.

6. Fully resume educational programming, using new approaches that have proven effective.

7. Plan for combined education/team building/celebration events (face to face or virtual).

8. Schedule DIO visits to offer a post-crisis update, share learnings, and collect input.

9. Continue to monitor COVID-19 levels to prepare for potential future spikes in infections.

Six Strategies for Promoting Well-Being

Strategies for promoting resident and fellow well-being throughout the pandemic and the period that follows is provided in **Figure 1** and is discussed in detail in the text below. A worksheet for programs and institutions to assess their offerings is provided as **Table 2** in the appendices to this document.

Figure 1. Strategies for Promoting Well-Being during the COVID-19 Pandemic

- Crisis Management Plan
- Leadership Strategies
- COVID-19 Illness Plan
- Bereavement Response Plan

- Regular Communication
- Rules of Clinical Engagement Defined
- Personal Protective Equipment
- Post-Exposure Management
- Work Hour, Supervision Reinforcement

- Scan for Signs and Symptoms of Clinician Distress
- Offer Screening Tools
- Promote Use of Counseling/ Mental Health Resources
- Institute "Recognize, Respond, Refer"

- Resident/Fellow Forum
- Buddy/Pod System
- Mentoring
- Support for Self-Isolated Residents/Fellows and Faculty Members
- Virtual Social Events

- Mental Health Resources
- Peer Support (Group and One-on-One)
- Departmental Well-Being Liaison
- Institutional Crisis Hotline

- Well-Being Website/Emails with Self-Management Tips
- Self-Care Expectations
- Psychological First Aid
- Just-In-Time Clinical Training

Deliver Coordinated Crisis Planning and Management

Optimize a Challenging Working and Learning Environment

Identify and Assist Trainees in Distress

Promote Connectedness

Provide Virtual Resources for Well-Being Support

Build Skills and Mindsets

Adapted from Goldman ML, Bernstein CA, Konopasek L, Arbuckle M, Mayer LES. An Intervention Framework for Institutions to Meet New ACGME Common Program Requirements for Physician Well-Being. Acad Psychiatry 2018;1-6.

1. Optimize a Challenging Working and Learning Environment

Crisis situations highlight the commitment that Sponsoring Institutions and programs have to their residents, patients, and the public. This requires GME to be conducted in an environment where residents and fellows are provided with appropriate resources to do their work, receive appropriate supervision for the tasks they perform, and not independently provide patient care for which they lack the appropriate experience and competence.

- Provide adequate **PPE**, as well as training in its appropriate use. Health care institutions have a moral responsibility to ensure adequate PPE is available to all in the clinical learning environment. Institutions and programs should communicate regularly with residents and fellows on current guidance about appropriate PPE for different circumstances, where to access PPE, and proper donning and doffing procedures. See guidance for optimizing the supply of PPE and equipment from the Centers for Disease Control.

- Ensure compliance with the ACGME **work hour requirements** to promote patient and resident/fellow safety. Violations of the work hour requirements increase risk of medical errors, needlesticks, and potential lapses in infection control, and have a negative impact on resident/fellow well-being.

- Build a **culture of self-care** as mission-critical for resident/fellow, workforce, patient, and community safety. Working while ill has been a common practice in the medical profession, often expected and even applauded. This has led to "presenteeism," defined as employees present at work but not being able to work effectively. In medicine, especially during a pandemic, the risks of presenteeism are amplified with members of the work force potentially spreading infection by working while ill.

- **Communicate regularly** with brevity, clarity, and transparency. This is essential for mitigating the uncertainty that has marked every phase of the COVID-19 pandemic and has been felt by everyone from the medical student to the most seasoned clinician. Clear communication on the status of PPE, new workflows, new therapies, and updates on the health of the workforce helps residents and fellows understand what is known and what is not known. See Item 6 (Coordinated Crisis Planning and Management) in the Strategies section for added guidance about communicating during a crisis.

- Continue to reinforce the message that **each of us is our "brother's and sister's keeper**." Encourage residents and fellows to keep an eye on their peers, and if they see something concerning, to say something and offer support.

- Encourage residents and fellows to develop a personal "Distress Go-Kit." See **Figure 2** for guidance that can be shared with residents, fellows, and others.

- Deliberately **create opportunities for people to express their needs, worries, and fears** without risk of retaliation or stigma. Facilitated resident/fellow peer support groups such as *CopeColumbia* (a guide for virtual peer support groups to address stress and emotional consequences of COVID-19) are one approach for discussing challenges and coping strategies. These are neither psychotherapy nor psychological debriefing sessions. The groups do not involve program leadership or individuals involved in resident/fellow evaluation to increase psychological safety. Consider providing similar opportunities for faculty members.

- **Respect diversity and protect all members of the team from discrimination**. News accounts suggest some individuals have been targeted out of fear they may infect others on the basis of their race or ethnicity or country of origin, and some residents and fellows may be fearful for themselves and loved ones. Others may have difficulty finding PPE that is compatible with religious or cultural practices around dress or facial hair. Discrimination towards health care workers in general may also be directed at residents and fellows. Residents and fellows need to be protected in the workplace, and they need to hear this message clearly from leadership.

Figure 2: Your Distress Go-Kit

> 1. Your coping strategies
> 2. Your soothing strategies
> 3. Awareness of your "stress scale"
> 4. Emergency psychological contact list

Just as you might pack a "go-kit" when planning to enter or exit a disaster zone, it is useful to pack a psychological go-kit in preparation for managing stress.

1. *Your coping strategies: Consider strategies that you have used to cope effectively in the past. What can you do deliberately to manage stress? What new thing are you willing to try?*

2. *Your soothing strategies: Consider strategies you use to manage your emotions and to calm yourself in the moment. How do you recover from an anger storm, fear, or anxiety? How do you calm yourself before sleep?*

3. *Awareness of your "stress scale": If a "one is no stress at all, and a 10 is the worst stress you have ever felt" monitor yourself throughout the day. Where are you on the stress scale? Catch yourself in the mid-range and use calming and coping strategies deliberately.*

4. *Your psychological emergency contact list: Create a list of people who you can call on for emotional support. Ideally this should not be just the one person you use for your usual emergency contact. Expand your list to include colleagues, friends and family members.*

- **Consider existing baseline (pre-COVID-19) data for resident/fellow burnout, well-being, and engagement** and other locally available and relevant data to allow an assessment of the impact of the pandemic, and the effect of a subsequent gradual restoration of more regular work and learning in programs. Another approach could include surveying residents and fellows about how well their needs are being met during the pandemic with suggestions around opportunities for improvement.

- Continue to **focus on learning**. Residents and fellows provide a crucial component of the clinical workforce in a public health emergency, and this provides both new challenges and new opportunities for learning. Strategies include using telecommunication technology for attending supervision of patient encounters, online self-study curriculum focused on COVID-19, disaster medicine, or other relevant topics, "just-in-time" curricula for residents and fellows being redeployed to other clinical areas, and cueing attendings and residents and fellows to focus on the lessons being learned and modeled in real time about the community's professional values.

2. Promote Connectedness

Increase the emphasis on social connectedness, with messages that emphasize the ongoing importance of social connections and "looking out for each other." During a time of "social distancing," residents and fellows are particularly vulnerable to isolation as they are often geographically separated from their loved ones and may lack social support networks outside of work. When residents and fellows can no longer casually interact with each other in person, they can also miss the camaraderie that bolsters coping with stress. Just as during the normal stresses of training, promoting teamwork, shared values, and a sense that "we are all in this together" can buoy residents, fellows, and faculty members. Sharing virtually during the pandemic can have a positive impact on residents', fellows', and faculty members' lives. Programs have successfully built intentional social connection in a variety of ways:

- Buddy programs, in which residents/fellows regularly check in with one or two others also help build camaraderie and support, or creation of small "pods" of five or six residents/fellows with leads selected for their emotional intelligence, with residents/fellows regularly checking in with one or two others

- Intentional brief group "check-ins," potentially at the beginning of virtual didactics and/or during shift changes

- Shifting established team-oriented activities, such as retreats, fitness challenges, or social gatherings to a virtual format

- Arranging for group "Zoom meals" and other virtual social activities

- Partnering with medical students or other mutual aid volunteers who can serve as "runners" to obtain groceries or other needed supplies for residents/fellows who are working or are in isolation/quarantine

- Engaging "sidelined" residents and fellows by finding opportunities for them to work together supporting other institutional or local needs (e.g., tracing, calling positive COVID results, screening, homeless outreach clinics)

3. Build Skills and Mindsets

A "growth mindset" does not shy away from struggles but recognizes opportunities for learning and forward progress in facing new challenges. This can contribute to self-empowerment and increased resilience. The ACGME AWARE podcasts and other resources teach self-awareness and empowerment skills and promote a growth mindset in the midst of the challenges of GME; these resources have expanded to include pandemic-specific content and may be useful to distribute.

In the midst of highly emotionally charged situations, skills for decreasing emotional and physiological arousal are helpful in transitioning from work to home and may reduce the risk of developing PTSD. Mind-body strategies, such as progressive muscle relaxation (Anxiety Canada), diaphragmatic breathing (Blanchfield Army Medical Center), and tactical breathing (Navy and Marine Core Public Health Center), are easy to learn and practice, and the ritual of doing so at the end of a work day can also ease transitions. Mindfulness and spiritual practices also can help residents and fellows center

themselves, focus their attention and remain calm. Many institutions and programs have offered access to additional online resources that promote physical exercise, yoga, cognitive reframing/restructuring, guided meditation, and mindfulness practices. Consider pulling these resources together in a central website that can be accessed when residents and fellows are off site. A range of resources to support emotional well-being and coping during the pandemic can be found on the website of the University of California at San Francisco (UCSF) Department of Psychiatry. Additional examples include psychologist Russ Harris's FACE COVID video suitable for learners, faculty members, and others, and a video on cognitive restructuring developed by the UCSF Weill Institute for Neurosciences in the Department of Psychiatry.

4. Provide Virtual Resources for Well-Being Support

Assess existing well-being resources to ensure they cover all ACGME well-being requirements and are available in a virtual format, and consider if any need to be enhanced. Most institutions already have some form of triage available 24/7, in compliance with the ACGME requirements. This may be provided through an Employee Assistance Program (EAP), an institution's workforce health and safety center, or a dedicated counselling program for residents and fellows.

- The COVID-19 pandemic has prompted growth in innovative approaches to support medical professionals. Many institutions' mental health departments, counseling and coaching staffs, social workers, or spiritual care providers provide additional in-person or virtual support to residents, fellows, and faculty members on the front lines. Routine mental health care at the institution or in the community has transitioned to virtual care provision in many circumstances – which may make routine care even more accessible for residents and fellows with limited time to travel to appointments.

- The Substance Abuse and Mental Health Services Administration (SAMHSA) has crisis counseling available 24/7 through the Disaster Distress Hotline accessed by calling 800.985.5990 or texting TalkWithUs to 66746. Many states, physician societies, and others are developing additional resources for clinicians, including residents and fellows, who experience distress in the setting of the pandemic.

- Offer facilitated virtual peer support groups, such as *CopeColumbia*, for residents and fellows to discuss stressors, challenges, and coping strategies together.

- Staff and widely communicate access information for the institution's crisis hotline.

- Appoint a departmental "Well-Being Liaison" to connect residents, fellows, and faculty members with available resources.

- The ACGME website offers an array of well-being tools and resources.

- Mental health crises can and do occur, and emergency mental health care, including hospitalization, continues to be available even during the pandemic crisis.

- If a resident, fellow, or faculty member is struggling with thoughts of self-harm, stay with that person and get additional help. Call the National Suicide Prevention Lifeline at 800.273.TALK, text the Crisis Text Line at 741741, or call 911. Also see added

information in Item 5 below on identifying residents or fellows who may be suffering or in distress.

5. Identify and Assist Residents and Fellows in Distress

To help build a program to identify and assist learners in distress, programs and institutions can focus on three levels of support for physician well-being relevant to addressing resident/fellow stress during this pandemic.[2] The first tier is *Primary Prevention* and entails "universal precaution" strategies that promote resilience, stress reduction, adaptive coping, and nurturing a supportive community at the individual, program, and institutional levels. The next tier is *Secondary Prevention* and encompasses strategies that direct additional resources and interventions to higher-risk groups, and that promote early identification of residents and fellows in distress. If residents and fellows continue to experience distress, they should be referred to the third tier, which is *Tertiary Prevention*. This includes strategies for providing rapid access to appropriate clinical care for residents and fellows who begin to experience more serious distress that may be due to new onset or recurrence of a mental health disorder.

Educate residents, fellows, and faculty members on **common emotional responses to crisis** and strategies for self-care and stress reduction. Common stress reactions include confusion, fear, anxiety, anger, grief, shock, guilt, sadness, withdrawal, irritability, sleep problems, distractibility, or obsessive thinking about the distressing event. Individuals may also lose confidence in themselves, others, or even deeply held religious or spiritual beliefs. These reactions are often temporary, and the institution's or program's well-being resources, including training supervisors and trainees in the principles of PFA can assist residents and fellows adaptively manage their reactions to stress.

Offer screening instruments so that residents and fellows can recognize symptoms of their own distress that may not be apparent to others. Screening programs with links to mental health professionals, such as the [Interactive Screening Program (ISP)](#) by the American Foundation for Suicide Prevention and the tools provided by [Mental Health America](#), can assist residents and fellows in self-identification of mental health concerns and appropriate help-seeking resources. Mental health screening programs for residents and fellows should link to institutional resources or to national confidential resources and services, such as the [ISP](#).

Additionally, ask residents and fellows to consider signs of other distress, including irritability with family members, increased alcohol or drug intake, and self-prescribing medication.

On the institution's resident/fellow resource site, consider providing a link to the video [Make the Difference: Preventing Medical trainee Suicide](#), developed by Mayo Clinic and the American Foundation for Suicide Prevention (AFSP). Consider a virtual, facilitated session using the ["Time to Talk About It: Physician Depression and Suicide"](#)

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[2] Chaukos D, Vestal HS, Bernstein CA, et al. An Ounce of Prevention: A Public Health Approach to Improving Physician Well-Being. Acad Psychiatry 2017;1–5.

video/discussion session for residents and fellows to raise awareness and engagement as their "brothers' and sisters' keepers."

For residents and fellows who require more than basic emotional supports, consider a three-step approach: Recognize, Respond, and Refer, adapted from the Substance Abuse and Mental Health Services Administration's Concept of Trauma and Guidance for a Trauma-Informed Approach.[3]

Recognize the signs of residents and fellows who are or may be suffering from a mental health condition. This can happen to anyone, not just residents and fellows who are in one of the high-risk groups described below. Check in regularly with residents and fellows, paying particular attention to those demonstrating:

- changes in appearance, affect, level of attention, or engagement
- irritability or impulsivity
- threats to abandon their position or tasks
- professional lapses
- appearance of sleep deprivation, inability to eat, or inability to relax
- statements about hopelessness or overt mentions of self-harm or suicide

Residents and fellows who may be at particular risk include those who:

- have a pre-existing medical or mental health condition
- are caregivers for children, older adults, or ill family members
- have been deployed to clinical areas outside of their usual rotations or peer group
- are working in clinical areas with high volumes
- are caring for critically ill or dying patients
- are part of care teams facing ethical dilemmas in the face of limited care resources

Respond to those who may be in distress. Language consistent with PFA is useful for providing support. Strategies that employ frontline support from peers and direct supervisors may be a first step in responding to residents and fellows in need. If symptoms persist despite peer support, mentorship, and self-help resources, consultation with a mental health professional is recommended.

Refer residents and fellows to additional resources when needed. Programs should ensure that existing pathways to mental health care are still available during the pandemic. Residents and fellows may be reluctant to utilize mental health resources as they do not see themselves as ill or they fear stigma or professional repercussions. A program's policies should include information for residents and fellows about the risks

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[3] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Monograph prepared by Prepared by SAMHSA's Trauma and Justice Strategic Initiative. July 2014. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

and benefits of seeking mental health care to both normalize and demystify the process and explicitly address licensure reporting requirements. Leaders sharing their own experiences of mental illness and/or use of mental health services can also serve to destigmatize this choice for residents and fellows.

6. Deliver Coordinated Crisis Planning and Management

The coordinated crisis management plan should include the following:

- **A communication plan** – Anxiety and uncertainty are high, and rumors and misinformation abound. Timely communication of essential information is vital. Principles of clear communication in a crisis include:

  - Promote visibility of leadership to reestablish a sense of safety and enhance trust in the leadership team.

  - Provide accurate, timely information on what is known, what is not known, and when more information will be communicated.

  - Understand that people process information differently in a crisis, so keep messages simple, repeat frequently, and emphasize positive messaging.

  - Use multiple channels of communication, as typical ways of receiving information (in-person, flyers, sites behind institutional firewalls) may not be consistently available. Back up important information communicated verbally with an email.

  - Communicate calmly and encourage working together.

  - Consider having GME programs distill institutional messages into a brief weekly email and/or holding weekly brief check-in meetings with program leadership via Zoom or a similar secure platform to provide pragmatic updates.

  - Identify institutional resources and sources of accurate information, both about clinical/work needs and about personal health and emotional support of residents/fellows and their families. An example of a graphic showing the institutional resources available to support residents and fellows at the University of Texas (UT) Health San Antonio is shown as **Figure 3**.

- When health care allocation decisions need to be made in the face of **resource limitations**, these should be decided and communicated by a team rather than placing this burden on individuals. A resident or fellow should not be in the position of making allocation decisions independently. Well-being supports should be routinely offered to the team making these decisions, as well as to the care teams affected, if these are different.

- Deliberate leadership strategies to employ include Relational Leadership and strategies for Grief Leadership from the Center for the Study of Traumatic Stress.

Figure 3. UT Health San Antonio Resident and Fellow Support
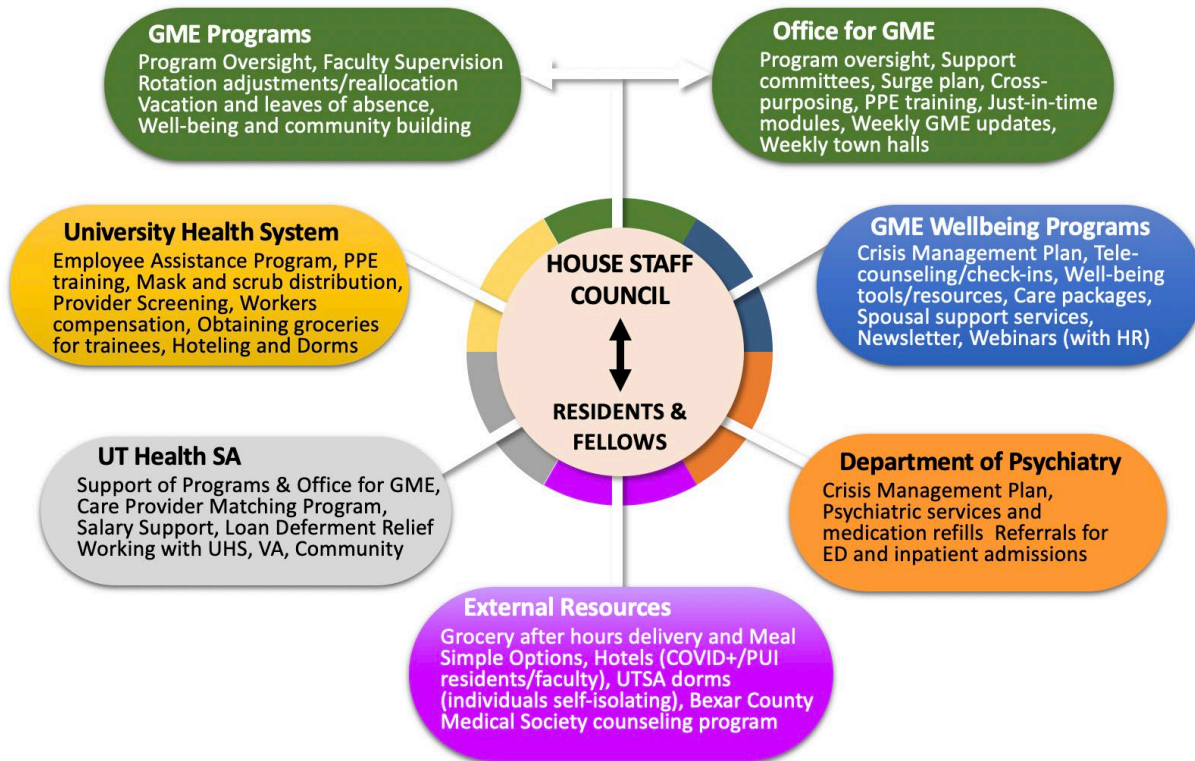
- Additional strategies may also be found in a series of published resources for leaders, health care workers, and patients from Center for the Study of Traumatic Stress, and Considerations for a Trauma Informed Response for Work Settings aggregated by Portland State University in Oregon.

- Illness and bereavement response plans must be organized in advance in case a resident or fellow or other care team member is **hospitalized or dies**. The fear, anger, and grief surrounding such an event are likely difficult for program directors and/or clinical supervisors to manage on their own. Having readily available plans and resources, suggested scripts for communication, and timelines for these difficult tasks can provide a roadmap for a leader and ensure that communication is thoughtful, considerate, and complete. Plans and added resources for resident and fellow illness and death from COVID-19 are described in Section II of this document.

Section II: Responding to Illness and Death due to COVID-19

The particular vulnerability of the health care workforce during the COVID-19 pandemic demands thoughtful planning and a systematic response to the illness and death of a resident, fellow, or other colleague. This section focuses primarily on residents and fellows and provides general considerations, as well as considerations for five sets of circumstances in which residents and fellows are deeply affected by COVID-19. They are shown in an infographic (**Figure 4**) and described in detail in the remainder of the section.

Figure 4. Responding to Resident/Fellow or Colleague Illness or Death due to COVID-19

General Considerations
1. Clarify coverage plans for absent residents/fellows
2. Discourage "presenteeism"
3. Communicate testing protocols and access
5. Secure access to medical/mental health care
6. Clarify stipend and benefits policies for ill residents/fellows
7. Address impact of illness on training requirements
8. Guidance on family member illness and associated concerns
9. Clarify protocols for personal travel and training implications

Resident/Fellow Illness and Self-Isolation due to COVID-19
1. Encourage self-isolation self-care and virtual care
2. Protocols for check ins and access to food/necessities
3. Communicate expectations for the duration of isolation and return to work

Resident/Fellow Hospitalization due to COVID-19
1. Elicit resident's/fellow's preferences for communicating status
2. Reinforce privacy considerations and the resident's/fellow's communication preferences with colleagues

Death of a Resident/Fellow due to COVID-19
1. Follow the protocol for notifying peers, colleagues and the resident's/fellow's family
2. Guidance regarding social media and media inquiries
3. Multiple strategies to support peers and colleagues
4. Communicate information about memorial service/celebration of life
5. Connect resident's/fellow's family with Human Resources

Illness/Death of Resident's/Fellow's Family Member from COVID-19
1. Ensure connecting with family for updates and problem-solving
2. After a family members' death, follow institution's bereavement protocol
3. Offer compassion, support, grief counseling resources
4. Elicit resident's/fellow's preference for disseminating information
5. Be attuned to the impact on other residents/fellows

Resident/Fellow Distress due to a Colleague's Hospitalization or Death
1. Information about self-identification and referral and to identify, respond to and refer a colleague in distress
2. Ensure access to virtual mental health appointments
3. Multiple strategies for support residents/fellows, particularly those in high-stress areas

General Considerations for Responding to Resident/Fellow Illness or Death due to COVID-19 and Associated Distress in Peers

The following general considerations will help education leaders to proactively manage the challenging situations of a resident's or fellow's illness or death due to COVID-19, and their impact on the decedent's colleagues.

Clearly describe where and how residents and fellows can access testing and treatment for any health concerns related to COVID-19, including symptoms and possible exposure. Communicate the importance of seeking this care rather than self-treatment or consulting a colleague or faculty members.

1. Ensure coverage plans for absences are developed and communicated with residents, fellows, and faculty members (ideally *prior to* reports of COVID-19-related illness among residents and fellows).

2. Develop and communicate travel guidance for both personal and work-related activities and discuss implications of unadvised travel on training status (e.g., missing required shifts as a result of border closures, needing to be quarantined, and/or becoming ill).

3. Reinforce the protocol for residents and fellows who have tested positive for COVID-19 or have COVID-19 symptoms without laboratory confirmation. Strongly advise against "presenteeism" for symptomatic residents and fellows and emphasize the importance of protecting colleagues and patients, recognizing that for many groups this would be a culture change. Ensure that this message is delivered to chief residents and that they embrace it.

4. Use multi-channel communication to inform residents and fellows of the institution's protocols and plans for COVID-19 testing and care and where to access this information. Communicate with employee health services to ensure alignment of institutional protocols for testing and follow-up for ill residents and fellows and other health care workers.

5. Ensure residents and fellows have access to virtual medical care, communicate how and where to access to it.

6. Work with counseling staff/psychiatry and/or the institution's EAP to identify ready pathways for residents and fellows to access virtual mental health care and address real and perceived barriers to access (health insurance, fears about repercussions on credentialing or licensure, etc.).

7. Proactively address sick leave policies, sick call coverage, and protocols for workers' compensation, use of health insurance, and waving sick-day usage for hospital-acquired COVID-19 exposure.

8. Communicate testing data for the community as a whole, patient testing data in the facility, and aggregate resident/fellow and staff member data.

9. Clarify the potential impact of extended leave on stipend support and meeting education and training requirements.

In addition to the general considerations above, specific guidance for five areas of impact of COVID-19 are summarized below and checklists and communication guides are provided as supplemental materials.

Resident/Fellow Illness and Self-Isolation due to COVID-19

Key Considerations:

1. Mandate any resident or fellow with symptoms to commit to self-isolation, self-care, and virtual care by a personal physician through telehealth rather than relying on unofficial consults with peers or supervisors.

2. Initiate sick leave and coverage processes and convey clear reassurance to the residents/fellows that this period will not adversely affect their education and training.

3. Establish and disseminate a protocol for check-ins (i.e., with whom, how frequently), how to ensure access to food and other necessities, and who residents/fellows should contact if their condition worsens.

4. Communicate expectations for the duration of isolation and the timing and process for returning to work.

5. If self-isolation is secondary to an exposure and a resident/fellow is not ill, communicate regarding the ability to work from home and implications for licensure requirements (length of the educational program, etc.).

6. Inform residents/fellows of the protocol for testing if they may have had exposure to another infected resident or fellow. Engage with contact tracing protocol in accordance with institutional policies.

Hospitalization of a Resident/Fellow due to COVID-19

Some residents/fellows infected with the virus will be hospitalized at their home institution. In these situations, protecting the individual's right to privacy (compliance with the Health Insurance Protection and Accountability Act [HIPAA]) is critical. See **Box 1** in the appendices to this document for a list of suggested actions for program directors to respond to the needs of a hospitalized resident/fellow and peers in the program. Also see the section below for suggestions for how manage distress in the affected resident's/fellow's peers.

Considerations:

For the hospitalized resident/fellow

1. Elicit the individual's:
   a. preferences for sharing information regarding health status with peers, faculty members, and the department.

   b. desire for virtual visits from colleagues.

   c. the name of an individual who could serve as the liaison between the hospitalized resident/fellow and the department.
2. Plan for well-being check-ins and ensure access to self-screening and mental health care if needed.

For the other residents/fellows in the program

1. Reinforce the importance of the hospitalized resident's/fellow's privacy.

2. Communicate to colleagues the hospitalized resident's/fellow's preferences for virtual visits (or no visits).

3. Communicate to colleagues how updates will be provided.

4. Proactively offer multiple strategies to support the hospitalized resident's/fellow's colleagues, such as *CopeColumbia*, PFA and access to referrals to virtual mental health appointments.

Death of a Resident/Fellow due to COVID-19

If a resident/fellow dies of COVID-19, the process for notifications and follow-up should follow the institution's response plan for the death of any member of the health care team. If the institution currently does not have a plan, relevant stakeholders (education leaders, resident/fellow representatives, Communication Office, Human Resources, Legal, chaplains, counseling/mental health) should develop a bereavement response plan and vet it through leadership. The plan should include the designation of a Bereavement Response Team (see guidance for the composition of the Bereavement Response Team in **Table 3** in the appendices to this document).

At the program level it is important to engage residents/fellows in the response. The plan may include scripts for face-to-face/synchronous or asynchronous video, phone, and written notifications and should be shared proactively with institutional and department leaders at all participating sites used by the program.

Sharing the news, including what to say and how to say it, will vary in accordance with the deceased resident's/fellow's family's wishes for disclosure of the cause of death. Additionally, the connectivity of residents/fellows through group chats and social media means that news travels quickly and program leaders need to be prepared to manage the rapid spread of information that may have variable accuracy.

If a resident or fellow dies by suicide, resources can be found in the AFSP's After a Suicide Tool Kit.

Considerations for the program/institution:
1. Determine the approach to notifying the deceased's resident/fellow peers and other colleagues.
2. Determine the approach to contacting the deceased resident's/fellow's family.
3. Offer guidance to the deceased resident's/fellow's peers and faculty members regarding respecting privacy in social media communications.
4. Provide help with media inquiries (e.g., suggest reporters be directed to the institution's Communications Office).
5. Offer multiple strategies to support peers and colleagues, including virtual peer support groups (such as *CopeColumbia*), PFA, and access to referrals to virtual mental health appointments.
6. Communicate information about a memorial service or celebration of life, even if delayed or virtual, once that information becomes available.
7. Connect the deceased resident's/fellow's family with an assigned individual in Human Resources for matters related to benefits, life insurance, etc.

Added suggestions for a bereavement response include:
1. See **Box 2** in the appendices to this document for a detailed program director's communication checklist, including a timeline of activities, after the death of a resident/fellow).
2. For communication strategies see:
   a. the Communication Plan shown as **Table 4** in the appendices to this document.
   b. Dos and Don'ts for Communication provided as **Table 5** in the appendices to this document.

c. communication suggestions for a bereavement response (see **Box 4** in the appendices to this document).

d. an example of a script for an email communication of the death of a resident or fellow from COVID-19 (see **Box 5** in the appendices to this document).

Serious Illness or Death of a Resident's/Fellow's Family Member due to COVID-19

When a family member is seriously ill, physicians often serve as a liaison between their own family and the health care system, interpreting information, connecting with the health care team, and supporting their family. In the pandemic, this type of involvement is much more difficult and residents and fellows in this position may have feelings of helplessness, feel overloaded by their own clinical requirements, and find it challenging to navigate the health care system to advocate for or even connect with a loved one. For physicians and other health care workers, feelings of responsibility for the care of their family member and/or guilt for any adverse outcome will likely compound the usual stress and anxiety anyone would feel when a family member is seriously ill.

Considerations for residents and fellows with ill family members:

1. Proactively address the possibility of family member illness and associated anxieties and concerns openly in check-in sessions with residents/fellows before anyone has an ill family member.

2. Provide one-on-one check-ins to listen compassionately, problem solve, and plan for contingencies.

3. Proactively encourage residents/fellows to make time in the day to connect with family members.

4. For residents and fellows living with family members who are ill from COVID-19, discuss strategies to minimize transmission to family members by developing a hygiene routine and possibly self-isolating from high-risk family members.

Considerations after the death of a resident's or fellow's family member:

1. Follow the institution's bereavement protocol for time away from work.

2. Check in regularly to show compassion and offer support.

3. Proactively provide resources for grief counselling and any other mental health support.

4. Anticipate that some residents and fellows will want to continue in their clinical duties. Consider if they are safe to do so. Engage Employee Health for fitness for duty evaluations if concerns arise.

5. Connect with the resident or fellow on their preference to disseminate information, including cause of death and opportunities for donations to honor the deceased.

6. Stay attuned to impact of the death of a family member on other residents/fellows who may have family members who are ill.

Resident/Fellow Distress due to a Peer's, Family Member's, or Colleague's Hospitalization or Death due to COVID-19

If a peer, family member, or colleague becomes seriously ill or dies, feelings may include survivor guilt, a sense of increased vulnerability, and anger at the system that may be directed at program or institutional leaders. These events may exacerbate existing risks for depression, substance use, and suicide. They may also precipitate strong memories or symptoms related to prior traumatic experiences. These events may also amplify prior traumatic experiences. Leaders should find ways to elicit, discuss, and validate residents'/fellows' feelings.

Considerations:

Ensure access to current systems for self-identification and self-referral and for identifying, responding to, and referring residents/fellows in distress. A resource is the "Recognize, Respond, Refer" protocol, in the Item 5, *Identify and Assist Residents/Fellows in Distress* from the Strategies section in Section I of this document.

1. Remind residents, fellows, and faculty members to refer for active mental health care if distress persists despite peer and faculty member support, or if safety concerns arise.

2. Distinguish between residents and fellows who need support and those who need active mental health care.

3. Ensure access to virtual mental health appointments for residents and fellows, as defined prior or developed/expanded due to the COVID-19 pandemic.

4. Provide support through virtual peer support groups (*CopeColumbia*), PFA, and online self-care resources.

Closing Statement

In this period marked by rapid change and learning for the nation, the health care system, and the graduate medical education community, this guidance was based on the best available evidence at the time of its writing. While some disasters share similar characteristics, others, including the COVID-19 pandemic, require new approaches and can lead to new insights through study and evidence-informed practice. Added evidence and pragmatic learning likely will result from the use of the strategies and resources in this document by programs and institutions across the nation. Members of the GME community will contribute to this learning and continue to expand the resources available to Sponsoring Institutions and programs though the ACGME's COVID-19 Well-Being Idea Exchange.

In the care of residents, fellows, and faculty members during the global COVID-19 pandemic, it is essential that programs and leaders are deliberate about caring for their personal physical, mental, and emotional health. The concept of "securing your own oxygen mask before assisting others" applies more than ever. The authors hope readers will find some of the suggestions in this guidance useful for attending to their own well-being.

Authors:
Lyuba Konopasek, MD; Sandra J. Rackley, MD, MAEdHD; Woodson "Scott" Jones, MD; Liselotte N. Dyrbye, MD, MHPE; Timothy P. Brigham, MDiv, PhD; Jon A. Courand, MD, FAAP; Matthew L. Goldman, MD, MS; Laurel E. S. Mayer, MD; Stuart Slavin, MD, MEd; Ingrid Philibert, PhD, MA, MBA

Institutional Affiliations

Lyuba Konopasek is Senior Associate Dean for Education and Professor of Medical Sciences, Frank H. Netter MD School of Medicine at Quinnipiac University.

Sandra J. Rackley is Assistant Dean for Trainee Well-Being and Consultant in Child and Adolescent Psychiatry at Mayo Clinic, Rochester.

Woodson (Scott) Jones is Vice Dean for Graduate Medical Education and Designated Institutional Official, Long School of Medicine, UT Health San Antonio.

Liselotte (Lotte) N. Dyrbye is a burnout and well-being researcher and Assistant Dean, Faculty Development, Mayo School of Graduate Medical Education, and Consultant in the Division of Community Internal Medicine, Department of Medicine at Mayo Clinic, Rochester.

Timothy P. Brigham is Chief of Staff and Chief Education and Organizational Development Officer, ACGME

Jon A. Courand is the Assistant Dean for GME, Wellbeing, and Professor and Vice Chair, Education and Training Chair, Department of Pediatrics, Long School of Medicine, UT Health San Antonio.

Matthew L. Goldman is a Public Psychiatry Fellow and Clinical Instructor in the Department of Psychiatry at the University of California San Francisco.

Laurel E. S. Mayer is Associate Professor of Psychiatry, *CopeColumbia*, Columbia University Irving Medical Center and Director, NewYork-Presbyterian (NYP) Housestaff Mental Health Service - Columbia Campus.

Stuart Slavin is Senior Scholar for Well-being, ACGME.

Ingrid Philibert is Visiting Faculty, Frank H. Netter MD School of Medicine at Quinnipiac University.

Reviewers

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Carol A. Bernstein, MD; John Patrick T. Co, MD, MPH; Dinchen A. Jardine, MD; Sharon C. Kiely, MD, MPM, FACP; Catherine M. Kuhn, MD; Christine Moutier, MD

Carol A. Bernstein is Professor and Vice Chair Faculty Development and Wellbeing, Departments of Psychiatry and Behavioral Science and Obstetrics and Gynecology and Women's Health, Montefiore Medical Center/Albert Einstein College of Medicine.

John Patrick T. Co is Director, Graduate Medical Education, Massachusetts General Hospital and Brigham and Women's Hospital Designated Institutional Official, Director, Ambulatory Quality and Safety, MassGeneral Hospital for Children, Associate Professor of Pediatrics, Harvard Medical School.

Dinchen A. Jardine is Assistant Designated Institutional Official, Navy Medicine Readiness and Training Command, Portsmouth, Virginia.

Sharon C. Kiely is Vice President, Chief Wellness Officer and Associate Chief Medical Officer, Hartford HealthCare, Hartford, Connecticut.

Catherine M. Kuhn is Associate Dean and Director, Graduate Medical Education and ACGME Designated Institutional Official, and Professor of Anesthesiology, Duke University Hospital and Health System.

Christine Moutier is Chief Medical Officer, American Foundation for Suicide Prevention.

Aggregated Online Resources for Promoting Resident/Fellow Well-Being during the COVID-19 Pandemic

Leadership Strategies and Resources

COVID-19 Pandemic Response Resources, Uniformed Health Services University's Center for the Study of Traumatic Stress

Considerations for a Trauma Informed Response for Work Settings, Portland State University

Grief Leadership, Center for the Study of Traumatic Stress

Relational Leadership, Center for the Study of Traumatic Stress

Optimizing the supply of PPE and equipment, Centers for Disease Control

Illness and Death of a Trainee due to COVID-19

*Bereavement Response Team Composition (see **Table 3** in the appendices to this document*)

Program Director's Checklist for a Resident/Fellow Hospitalized with COVID-19 (***see Box 1** in the appendices to this document*)

Communication Plan for a Resident/Fellow Death (*see **Table 4** in the appendices to this document*)

Communicating the Death of a Resident/Fellow (*see **Box 2** in the appendices to this document*)

Communication Suggestions for the Bereavement Response Team (see ***Box 3** in the appendices to this document*)

Dos and Don'ts for Communication about a Resident's/Fellow's Death (see ***Table 5** in the appendices to this document*)

Sample Email for Communicating a Resident's/Fellow's Death due to COVID-19 *(see **Box 4** in the appendices to this document*)

After a Suicide Tool Kit, American Foundation for Suicide Prevention

Individual Resources

ACGME AWARE podcasts, ACGME

Cognitive restructuring video, Weill Institute for Neurosciences, Department of Psychiatry, UCSF

Diaphragmatic breathing, Blanchfield Army Medical Center

Emotional well-being and coping strategies, Department of Psychiatry, UCSF

FACE COVID video, Russ Harris

Fight COVID-19 With Better Sleep Health, Center for the Study of Traumatic Stress

Guided meditation, UCLA Mindful Awareness Research Center

Make the Difference: Preventing Medical trainee Suicide, video developed by the Mayo Clinic and the American Foundation for Suicide Prevention

Mental health screening tools, available from Mental Health America

Moral distress video, Joshi Jane Halifax, Abbot and Head Teacher of Upaya Institute and Zen Center, Santa Fe and Cynthia Rushton, Johns Hopkins Berman Institute of Bioethics and the School of Nursing

Progressive muscle relaxation, Anxiety Canada

Your Distress Go Kit, see Figure 2 in Section I

Tactical breathing (Navy and Marine Core Public Health)

Institutional and Program Well-Being Resources

ACGME Well-Being Tools and Resources, ACGME

Acute Stress Disorder (ASD), definition, Department of Veterans Affairs National Center for PTSD

[Addressing Acute Stress Reaction and Disorder in Health Care Workers in the Face of COVID-19, ACGME](#)

[Administering Psychological First Aid](#), ACGME

[CopeColumbia](#) Guide for Virtual Peer Support Groups to address the impact of COVID-19

COVID-19 Institutional Trainee Well-Being Worksheet

[Interactive Screening Program](#)(ISP), American Foundation for Suicide Prevention

[Post-traumatic Stress Disorder](#) (PTSD), definition, National Center for PTSD

Psychological First Aid (PFA) [mobile app](#), VA National Center for PTSD

PFA [Field Operations Guide](#), VA National Center for PTSD

PFA [video series](#), VA National Center for PTSD

PFA [one-hour primer](#), VA National Center for PTSD

PFA [6six-hour training course](#), VA National Center for PTSD

PFA [Summary Guide](#), Minnesota Department of Health

PFA [video](#), Minnesota Department of Health

[Psychological Recovery (SPR) resources](#), VA National Center for PTSD

[“Time to Talk About It: Physician Depression and Suicide”](#) video/discussion, Nagy et al., MedEdPortal, 2016.

Appendices

Table 2. COVID-19 Program/Institutional Well-Being Worksheet

Resource/ Intervention	Check-In Question	Yes/No (circle)	Action Plans
1. **Optimize a Challenging Working and Learning Environment**	Are you addressing: • COVID-19 impact locally (in department, hospital, community? • Rules of clinical engagement? • Personal protective equipment (PPE) supply and training? • Post-exposure management? • Work hour/supervision policies? • Counseling/mental health support, Psychological First Aid, virtual peer support groups? • Just-in-time clinical training for redeployed residents/fellows? • Do you regularly communicate with residents/fellows to provide updates?	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No	
2. **Promote Connectedness**	Institution: Have you engaged your Resident/Fellow Forum in planning? Program: Have you engaged your resident/fellow well-being committee or similar group? • Do you have a resident/fellow buddy system/or group support system in place? • Have you engaged your mentoring program? • Is support available for self-isolated residents/fellows and faculty members? • Are there regularly scheduled virtual events? • Are virtual platforms available (i.e., program-level Instagram)?	Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No	
3. **Build Skills and Mindsets**	• Is there a well-being/wellness website with resources and self-management tips? • Are you promoting access with emails/texts? • Have you addressed self-care expectations for residents/fellows?	Yes/No Yes/No Yes/No	
4. **Provide Virtual Resources for Support**	• Do you have virtual mental health resources available? • Do you have one-to-one peer support available? • Do you have virtual peer support groups? • Is there a departmental well-being liaison? • Is there an institutional crisis hotline?	Yes/No Yes/No Yes/No Yes/No Yes/No	
5. **Identify and Assist Residents/Fellows in Distress**	• Do you have a multi-modal mental health scanning strategy? • Education on signs and symptoms of mental health disorders? • Do you provide access to screening tools linked with resources/services? • Do you make virtual counseling/mental health services readily accessible to residents/fellows?	Yes/No Yes/No Yes/No Yes/No	
6. **Deliver Coordinated Crisis Planning and Management**	• Do you have a Crisis Management Plan? • Have you defined leadership strategies for the managing of graduate medical education during the pandemic? • Do you have a COVID-19 illness plan for residents/fellows? • Do you have a bereavement response plan?	Yes/No Yes/No Yes/No Yes/No	

Box 1. Program Director's Checklist for Resident/Fellow Hospitalized with COVID-19

Day 1

- For the hospitalized resident/fellow, elicit:
  - Preferences for communicating health status and providing updates to the department
  - Desire for virtual visits from colleagues
  - The name of an individual who could serve as the liaison between the hospitalized resident/fellow and the department and desire for providing updates to the department
- Provide timely notifications to peers, faculty members, and other team members if permitted by the hospitalized resident/fellow
- Communicate with the department regarding privacy (including a reminder not to look in the chart or ask care team members)
- Share the hospitalized resident's/fellow's preference for communication
- Indicate how updates will be provided (include frequency of updates and method of communication)
- Reinforce counseling/mental health support resources which are available to all residents/fellows
- Check in again on residents'/fellows' perception of adequacy of PPE (supply and training)
- If permitted by the hospitalized resident/fellow, connect with the hospitalized resident's/fellow's family or designee to offer support

Week 1

- Check in daily with the Chief Residents and/or the program coordinator for the "pulse" of the program (anxiety, coverage issues) and any individuals who may require increased support
- Check in with the designated institutional official (DIO) and/or Employee Health/Human Resources for resources available to the hospitalized resident/fellow post-discharge
- Communicate the hospitalized resident's/fellow's health status following the plan made on Day 1

Week 2 and Beyond

- Continue to provide updates and check in with the Chief Residents

Table 3. Bereavement Response Team Composition

Educational Program Leadership (DIO, Program Director)	Name(s)
Counseling/Mental Health/EAP/ Resident/Fellow Mental Health Program	
Spiritual Care	
Social Work	
Human Resources	
Institutional Public Affairs/Media relations	
Resident/Fellow Representative	
Others (as determined by leadership)	

Box 2. Program Director's Checklist for Communicating the Death of a Resident or Fellow from COVID-19

Day 1
• Ensure timely notification of individuals/groups (see **Table 4** for a communication plan, **Table 5** for communication dos and don'ts, and **Box 3** for communication suggestions after the death of a resident or fellow) • Schedule virtual meetings with deceased resident's/fellow's program and work unit where the death occurred (if on campus) • Connect with the deceased resident's/fellow's family/designee to offer support

Day 2
• Complete any remaining notifications • Check in with individuals deeply impacted by the loss (program and work unit where the death occurred), remembering program leadership and chief residents • Offer peers the opportunity for a virtual meeting counseling/mental health professionals or chaplains • Encourage leaders to be sensitive to needs to modify work schedule of residents/fellows/employees deeply affected by the loss, if at all possible • Consider activating virtual group peer support • Check in with the deceased resident's/fellow's family regarding questions, memorial service planning, and any other remaining issues • Consider providing meals or other support to the deceased resident's/fellow's program and unit where the death occurred if this is permitted given contagion concerns

Day 3
• Encourage virtual gatherings of affected individuals within the program • Encourage core faculty members and current clinical supervisors to check in with residents and fellows

Week 1
• Check in daily with the deceased resident's/fellow's program leadership team to provide support and identify individuals who may need additional support • Ensure the Bereavement Response Team meets daily to debrief and communicate about next steps

Week 2
• Communicate with deceased resident's/fellow's program about grief, available mental health and well-being resources, the need to care for each other, staff members available to speak with, etc. • Connect with the deceased resident's/fellow's family regarding any Human Resources issues (benefits, paycheck, returning electronic devices, etc.) • Advise leaders to check in with residents/fellows and core faculty members to monitor for coping • Debrief with the Bereavement Response Team and check in on well-being of members

Week 3-4
• Check in with the deceased resident's/fellow's program leadership team and offer a group session to debrief. • Hold a memorial service, if not already done, or plan a later celebration of life ceremony

Table 4. Communication Plan After the Death of a Resident or Fellow

Individuals/Groups to be Notified	Communication Lead
Resident's/fellow's family	
Peer residents/fellows	
Employee Assistance Program, resident/fellow mental health	
Spiritual care	
Health care team members who work with the program's resident/fellows	
Health care team members who worked with the deceased resident/fellow	

Institutional Public Relations/Media Relations staff members/Office	
Institutional GME community	
Human Resources	
Affiliated medical school	
Medical school from which the resident/fellow graduated	
ACGME	

Table 5. Dos and Don'ts for Communication about the Death of a Resident or Fellow

Dos	Don'ts
Communicate as soon as practicable.	Do not wait to see if others pick up the story.
Provide simple messaging and recognize it may need to be repeated frequently.	Do not include graphic or detailed descriptions of the deceased resident's/fellow's hospital course.
Highlight the courage, commitment, and teamwork of all staff members, including the individual who died.	Do not glorify self-sacrifice.
Provide information about COVID-19 and resources for residents/fellows worried about their health and safety, including information on how to access PPE and testing, as well as the institution's ongoing efforts to address staff health and safety.	Do not make unrealistic promises, such as that no other trainees or staff members will die. Do not imply that there are simple solutions or that the individual who died or their care team did something wrong.
Acknowledge difficult emotions, including anger, sadness, blame, fear, and guilt. Encourage channeling these reactions into supporting each other, solving problems, and moving forward.	Do not minimize difficult emotions or try to tell people to cheer up or feel gratitude. Do not allow blame directed toward individuals, groups, or the institution to stand unaddressed.
Acknowledge that everyone grieves differently and on different timelines.	Do not limit resources to those who worked with the deceased resident/fellow – a death will reverberate throughout the organization.
Communicate about how to access site-specific grief support resources.	Do not equate sadness or worry with mental illness such as depression
Acknowledge stress and grief may increase risk for development of new physical and mental health disorders, and exacerbation of existing illness. Provide site-specific for care access, including after hours.	Do not suggest that needing health care is a sign of lack of strength or poor coping.
Pay particular attention and encouragement to leadership to engage in their own self-care.	Do not imply that leaders do not experience suffering.
Be alert to ongoing needs for communication – anger or blame or worries about safety.	Do not expect communication to be "one and done."
Express hope for the time when the situation will return to normal, though it may be a "new normal." Acknowledging this may take time and some things may be changed forever.	Do not make unrealistic promises about timelines or what things will be like in the future.

Box 3. Communication Suggestions for the Bereavement Response Team

1. Allow residents, fellows, and other colleagues to **express their grief** and identify those who may need additional support and resources. Explain that everyone's grief response is different — some residents and fellows will need time off and others may find solace in working. Some individuals may experience grief right away, others may notice it comes later. Commit to providing coverage or changing schedules as needed and is practically possible. Remind residents and fellows of the importance of seeking help if they are experiencing difficulty, and how to do so.

2. Remind residents and fellows of the processes in place for **accessing care**: provide a list of individuals, ranging from supervisors and peer supporters (who the individual can reach out to talk to about the loss and to have support); virtual peer support groups, such as *CopeColumbia*; the institution's Employee Assistance Program; and institutional and community-based mental health professionals.

3. Address **barriers to engaging in self-care**. Explain the process for taking time off and how coverage will be arranged (as applicable); consider having individuals who provide this information speak about their own experience about seeking mental health care, or stating that many people who have never sought mental health services find speaking with a trained mental health professional at times like these helpful. Reassure residents and fellows that seeking mental health services should not have negative ramifications on credentialing or licensure; and that unaddressed mental health problems are more likely to negatively impact safe practice or medical licensure than appropriate help-seeking behaviors.

4. Remind residents and fellows that if they **have experienced mental illness** themselves or are actively getting mental health care, they may want to check in with their regular source of care.

5. Provide information on whom residents and fellows should contact if they are **concerned about the emotional/mental health** of a colleague.

6. Notify **peers and others who work with peers of the deceased resident/fellow** (e.g., the nurse managers on floors where residents/fellows will be working). This coordination is critical for allowing these individuals to a) provide compassionate support; b) help identify residents/fellows who may be in need of assistance and help refer them for support; and c) address situations in which distressed residents/fellows may not be able to safely provide care.

7. Inform **peer residents/fellows and others about a memorial service or celebration of life** (virtual or in-person) and the process for requesting time-off to attend.

8. The Bereavement Response Team members may offer **virtual sessions with individuals who want to talk further about the death**. This could entail encouraging residents/fellows and colleagues to reflect about how they would like to remember the deceased individual (e.g., writing a personal note to the family, a memorial donation or voluntary service, or doing something kind for another person).

Box 4. Sample Email for Communicating a Resident's/Fellow's Death due to COVID-19

To be sent by email with subject "Sad News" or a similar appropriate title.

An email announcement should be sent to peers, faculty members, and department staff members. A follow-up email can be sent later with details regarding the obituary, address of emergency contact person (if released, see above), and when available, memorial service or celebration of life information.

I am writing with great sadness to inform you that one of our residents/fellows, _____(Name), a PGY-X in the Department of _____, has died. Dr. _____ was a graduate of _____ Medical School. Our thoughts and sympathies are with Dr. [Name]'s family and friends and the Department of _____.

All residents, fellows, and staff members in the Department/Division were given the news of the death today. The cause of death was COVID-19. [OR: The family has requested that information about the cause of death not be shared at this time.]

Resources for support and mental health care are listed below. If you need support, please contact these resources. We care about every one of you and your well-being is important. This is a time to come together and to support one another.

Information about a memorial service will be shared as soon as it becomes available.

Please do not hesitate to contact me with any questions or concerns.

Sincerely,

[Bereavement Response Team Leader or institutional leader]

[Include a list emotional, counseling, and mental health support resources available to residents and fellows]

- Crisis Management Plan
- Leadership strategies
- COVID-19 Illness Plan
- Bereavement Response Plan

- Regular Communication
- Rules of Clinical Engagement defined
- Personal Protective Equipment
- Post-Exposure Management
- Work Hour, Supervision reinforcement

- Scan for Signs and Symptoms of Clinician Distress
- Offer Screening Tools
- Promote use of counseling/ mental health resources
- Institute "Recognize, Respond, Refer"

- Resident/Fellow Forum
- Buddy/Pod System
- Mentoring
- Support for Self-Isolated Trainees and Faculty
- Virtual Social Events

- Mental Health Resources
- Peer Support (Group and One-on-One)
- Departmental Well-being Liaison
- Institutional Crisis Hot Line

- Well-Being Website/Emails with Self-management Tips
- Self-Care Expectations
- Psychological First Aid
- Just-In-Time Clinical Training

Pie chart segments:
- Deliver Coordinated Crisis Planning and Management
- Optimize a Challenging Working and Learning Environment
- Promote Connectedness
- Build Skills and Mindsets
- Provide Virtual Resources for Well-Being Support
- Identify and Assist Trainees in Distress

Figure 1. **Strategies for Promoting Well-Being During the COVID-19 Pandemic**

Adapted from Goldman ML, Bernstein CA, Konopasek L, Arbuckle M, Mayer LES. An Intervention Framework for Institutions to Meet New ACGME Common Program Requirements for Physician Well-Being. Acad Psychiatry 2018;1–6.

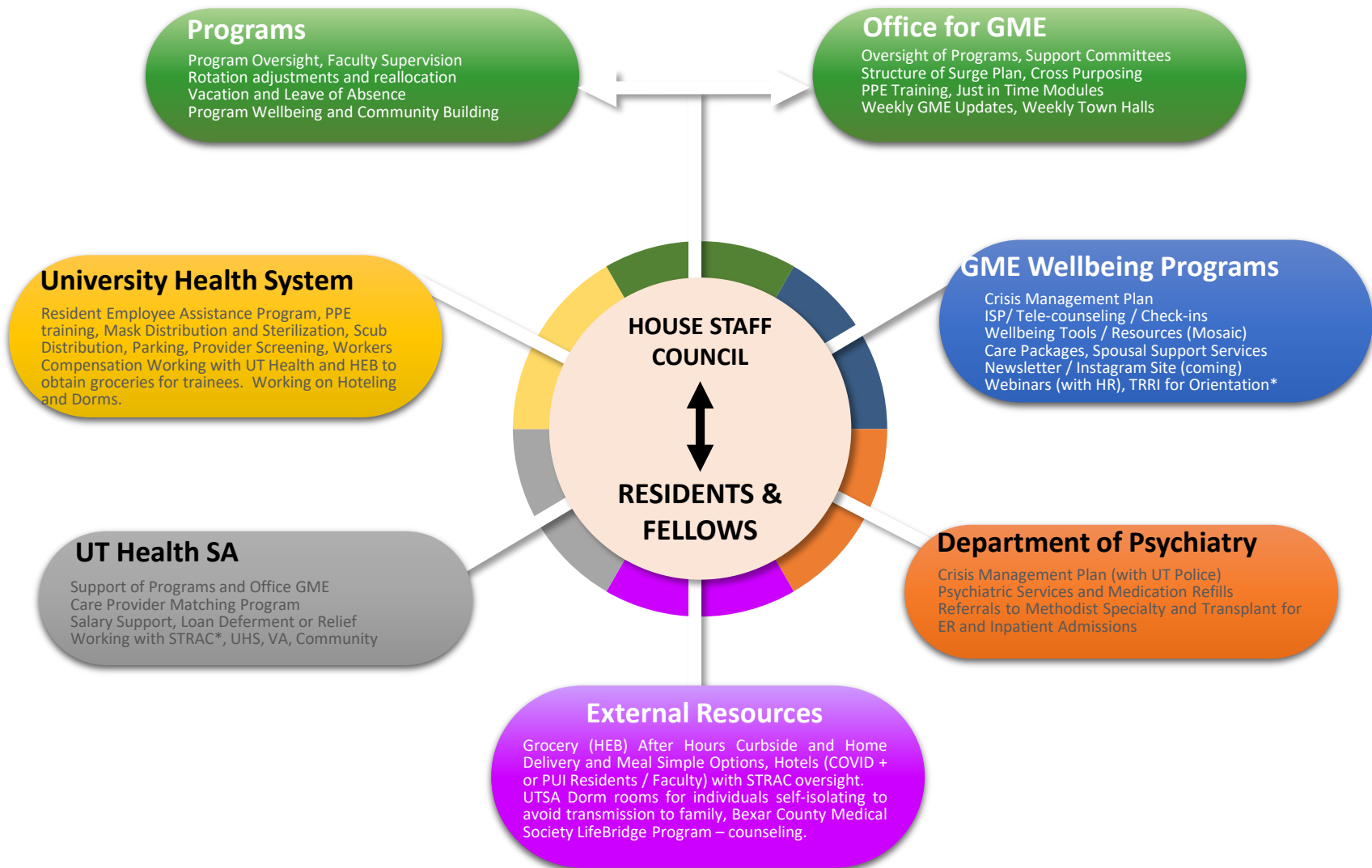# Your Distress Tool Kit

1. Your coping strategies

2. Your soothing strategies

3. Awareness of your "stress scale"

4. Emergency psychological contact list

Programs
Program Oversight, Faculty Supervision
Rotation adjustments and reallocation
Vacation and Leave of Absence
Program Wellbeing and Community Building

Office for GME
Oversight of Programs, Support Committees
Structure of Surge Plan, Cross Purposing
PPE Training, Just in Time Modules
Weekly GME Updates, Weekly Town Halls

University Health System
Resident Employee Assistance Program, PPE training, Mask Distribution and Sterilization, Scub Distribution, Parking, Provider Screening, Workers Compensation Working with UT Health and HEB to obtain groceries for trainees. Working on Hoteling and Dorms.

GME Wellbeing Programs
Crisis Management Plan
ISP/ Tele-counseling / Check-ins
Wellbeing Tools / Resources (Mosaic)
Care Packages, Spousal Support Services
Newsletter / Instagram Site (coming)
Webinars (with HR), TRRI for Orientation*

HOUSE STAFF COUNCIL

RESIDENTS & FELLOWS

UT Health SA
Support of Programs and Office GME
Care Provider Matching Program
Salary Support, Loan Deferment or Relief
Working with STRAC*, UHS, VA, Community

Department of Psychiatry
Crisis Management Plan (with UT Police)
Psychiatric Services and Medication Refills
Referrals to Methodist Specialty and Transplant for ER and Inpatient Admissions

External Resources
Grocery (HEB) After Hours Curbside and Home Delivery and Meal Simple Options, Hotels (COVID + or PUI Residents / Faculty) with STRAC oversight. UTSA Dorm rooms for individuals self-isolating to avoid transmission to family, Bexar County Medical Society LifeBridge Program – counseling.

*STRAC: South Texas Regional Advisory Council – develops, implements and maintains the regional trauma and emergency healthcare system for the 22 counties it serves including Bexar County and San Antonio.

*TRRI: Transition for Residency Risk Index is a 9-item questionnaire given to all PGY-1 residents during new resident orientation to help identify those residents at highest risk for a difficult transition or isolation and intervene with enhanced engagement and mental health resources.

Figure 3. **UT Health San Antonio Resident & Fellow Support**

Provider Screening

COVID-19 Hotline/Testing:

IF SICK or HAVE ALLERGIES … AND SYMPTOMS CHANGE … DO NOT COME TO WORK

- Call UHS Hotline FIRST …210-358-9999. Need for COVID testing will be determined at that time.

IF you are screened entering a hospital and are found to have a fever, do NOT enter the hospital, contact the UHS Hotline at …210-358-9999 and then notify your Program Director.

Never bypass a screening site and enter the hospital.

Return to Work Guidance (UHS Employee Health, 210-358-2277)

Care Provider Matching Program

Program Framework

YOU are our Focus: UT Health San Antonio Childcare Matching Program

The framework for the childcare matching program will consist of one webpage (UT Health SA Coronavirus Update → Human Resources Continuity → HR Services → Childcare Matching Program) with the following:

- Description of the program and its objectives
- Instructions for utilizing the program, to include a statement that the childcare recipient and childcare provider are required to negotiate the terms, conditions, and location of childcare services without intervention from UT Health San Antonio
- Links for childcare seekers
  - Sign up if you need childcare
  - Review a list of childcare providers available
- Links for childcare providers
  - Sign up if you are able to provide childcare
  - Review a list of childcare seekers
- A disclaimer or link to a disclaimer (drafted by Legal Affairs)

Care Package Process

If a resident indicates POSITIVE for COVID-19:

A. Ms Garcia calls the resident's Program to see if the Program is able to deliver the care package and any other support to the resident during their self-isolation period.

   1. If yes, Program personnel visit GME to pick up the package and deliver to the resident. **No consent form is required**.

   2. If no, Program will request that the resident provide written consent to disclose COVID-19 status, phone number, address, etc. for GME or other UT Health personnel to deliver to the resident.

      a. Ms Garcia provides the consent form to the Program

      b. Program sends the consent form to the resident

      c. Resident completes the form and returns to Ms Garcia

      d. GME arranges delivery to the resident

General Considerations
1. Clarify coverage plans for absent trainees
2. Discourage "presenteeism"
3. Communicate testing protocols and access
5. Secure access to medical/mental health care
6. Clarify stipend and benefits policies for ill trainees
7. Address impact of illness on training requirements
8. Guidance on family member illness and associated concerns
9. Clarify protocols for personal travel and training implications

Trainee Illness and Self-Isolation due to COVID-19
1. Encourage self-isolation self-care and virtual care
2. Protocols for check ins and access to food/necessities
3. Communicate expectations for the duration of isolation and return to work

Trainee Hospitalization due to COVID-19
1. Elicit trainee's preferences for communicating status
2. Reinforce privacy considerations and the trainee's communication preferences with colleagues

Death of a Trainee due to COVID-19
1. Follow the protocol for notifying peers, colleagues and the trainee's family
2. Guidance regarding social media and media inquiries
3. Multiple strategies to support peers and colleagues
4. Communicate information about memorial service/celebration of life
5. Connect trainee's family with Human Resources

Illness/Death of Trainee's Family Member from COVID-19
1. Ensure connecting with family for updates and problem-solving
2. After a family members' death, follow institution's bereavement protocol
3. Offer compassion, support , grief counseling resources
4. Elicit trainee's preference for disseminating information
5. Be attuned to the impact on other trainees

Trainee Distress due to a Colleague's Hospitalization or Death
1. Information about self-identification and referral and to identify, respond to and refer a colleague in distress
2. Ensure access to virtual mental health appointments
3. Multiple strategies for support trainees, particularly those in high-stress areas
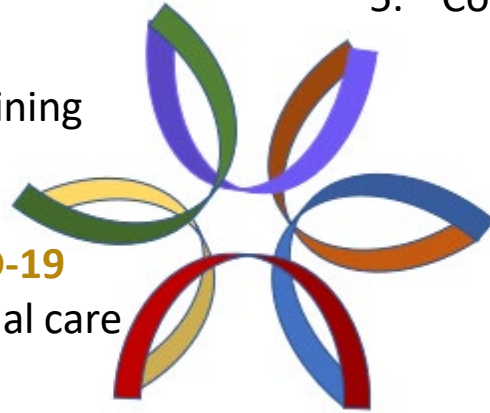
Figure 4. **Responding to Trainee and Colleague Illness or Death Due to COVID-19**