Received: 30 November 2023 | Revised: 6 June 2024 | Accepted: 12 June 2024
DOI: 10.1002/aet2.11009

ORIGINAL CONTRIBUTION

Bereavement scheduling policy for emergency medicine residents: A descriptive pilot study

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Abstract

Background: The Accreditation Council for Graduate Medical Education has tasked residency programs to prioritize resident wellness, reduce trainee stress, and prevent burnout. Grief and bereavement can significantly impact residents' wellness during difficult clinical training schedules. There are no best practices on how to support residents during this time.

Methods: In a split academic county emergency medicine (EM) residency, this pilot study documents a resident-driven change to scheduling practices for bereavement leave. An advisory group of residents, chief residents, and program directors informally polled peer institutions to develop bereavement leave guidelines. Considerations were made to balance resident wellness, education, and patient care in developing a bereavement scheduling policy.

Results: The bereavement policy was adopted in January 2023, aiming to "support the resident during a difficult time and reduce concerns around shift coverage" following the death of a family member without impacting sick call. The number of covered days depended on the relationship of the resident to the deceased. Residents covering bereavement days for their peers were financially compensated. During the first 7 months following implementation, five residents utilized the policy. These residents noted this to be the most positive impact on the residency during the past year. Based on resident feedback, the scope was expanded to include grave medical illness of a family member as an implementation criterion.

Conclusions: This article outlines the creation, implementation, and benefits of a bereavement scheduling policy within an EM residency. Describing this approach will provide guidance for other residencies to adopt similar wellness-focused strategies.

INTRODUCTION

The demands of specialized residency training are arduous and inflexible.[1] As a result, medical training has been consistently associated with increased rates of professional burnout, clinical depression, and suicidal ideations amongst trainees.[2–4]

Due to the extensive demands of medical training and the associated personal costs, the Accreditation Council for Graduate

Supervising Editor: Ambrose H Wong

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Medical Education (ACGME) and residency programs across medical and surgical disciplines have mandated that residency programs address resident wellness.[5–8] This focus is especially relevant to emergency medicine (EM) where burnout rates are the highest compared to all other specialties.[9,10] EM residency programs have championed the exploration of factors relating to resident wellness.[11–13] Multiple published interventions ranging from the creation of a residency wellness committee[14] to flexible scheduling policies for pregnant and new parent residents exist.[15] Recognizing the importance of addressing burnout early, the Council of Residency Directors in Emergency Medicine (CORD-EM) has published evidence-based policies to foster resident wellness.[16] Efforts to address burnout among resident trainees are needed now more than ever given the negative impact of the COVID-19 pandemic on resident mental health and wellness.[17–19] In fact, one survey of residents and medical students training during the COVID-19 pandemic found that more than 50% experienced significant mood changes.[20]

Physician grief is an established risk factor for depression and professional burnout.[21–24] Academic explorations of physician grief often focus on the burden of suffering that is witnessed during residency and clinical practice.[25,26] This is understandable given that residents of all specialties are frequently exposed to patient death and suffering.[27] One investigation of physician grief and burnout among oncologists found that "negative work events" (such as patient death) was the most commonly cited stressor of professional burnout.[28] Less attention and critical focus has been directed toward the impact of personal grief and bereavement (i.e., the death of a grandparent, parent, sibling, child) during residency. The rigorous clinical demands of residency can make it difficult for residents to personally grieve and, in some cases, attend end-of-life events and services. Resident wellness and mental health may suffer when residents are unable to adequately attend to individual bereavement needs.

Consideration for workplace bereavement policies is not unique to medicine. To this end, multiple corporate leaders have argued for more comprehensive approaches to corporate bereavement leave.[29,30] Since the COVID-19 pandemic, the American Medical Association (AMA) and Emergency Medicine Residents' Association (EMRA) have both adopted resolutions encouraging residency programs to develop resident bereavement policies.[31,32] Furthermore, the American Board of Emergency Medicine (ABEM) recently published guidelines that afford more flexibility to residents who pursue personal leave during residency.[33] To our knowledge, though, no residency has published their experiences or suggested formal guidelines for implementing a resident bereavement leave policy.

The purpose of this narrative investigation is to describe the creation, implementation, and impact of a novel resident bereavement scheduling policy at an academic EM residency program. We hope that sharing our experience will empower other residency programs to address their residents' bereavement needs more comprehensively.

METHODS

Development

Beginning in September 2022, the Indiana University School of Medicine Emergency Medicine Residency explored the creation of a new resident bereavement policy providing residents protected time during periods of personal bereavement. The Indiana Emergency Medicine Residency is a split academic county residency made up of 73 residents (63 EM and 10 EM/pediatrics residents) who primarily train at three Level I trauma centers in Indianapolis, IN. The impetus behind this initiative was informed by individual resident experiences. The initiative was proposed and led by residents.

The Indiana Emergency Medicine Residency convened an advisory group made up of residents, chief residents, and program directors. Given the lack of existing literature specific to residents' bereavement needs, the advisory group informally solicited information from a small number of near-peer EM residency programs regarding bereavement support to residents. These other EM residencies were chosen by a convenience sample of programs where the authors' have personal and professional contacts. In total, we discussed with five other programs, three of which are county-based and two of which are academic-based. The five programs ranged from 12 to 17 residents per class. Multiple residency programs offered monetary incentives for ED coverage.

The advisory group considered institutional, logistic, and financial factors during the development of the resident bereavement policy. It was critical that the policy operate separately from the sick-call system to preserve sick call for that specific purpose, address the question of which personnel would cover affected shifts, and clarify if/how personnel would be compensated.

Adoption

After discussing findings with departmental leadership, the novel resident bereavement scheduling policy was approved. The policy delineated time for residents to attend to personal bereavement needs following the death of a loved one. The study was exempted by our institutional review board. Included resident quotes were approved by the individual for inclusion in this article.

RESULTS

Description of bereavement policy

The bereavement policy for EM residents was approved by Indiana University Department of Emergency Medicine leadership in January 2023. The explicitly stated goal of this policy is "to support the resident during a difficult time and reduce concerns around shift coverage while also ensuring the ability of our ED clinical sites to

provide adequate coverage including sick call coverage." The resident bereavement policy is provided in full in the Appendix.

According to the policy, residents who experience the death of a loved one are eligible to have a certain number of shifts covered during the week of the death and/or services. The program arranges for coverage without any requirements to make up the missed shifts. The number of shifts covered is based on relationship of the deceased to the resident, as illustrated in Table 1. These associations are modeled upon existing school and practice plan bereavement policies that are available to our faculty and are intended to promote equity and unburden program directors from difficult and subjective decisions. According to the policy, the Department of Emergency Medicine provides financial compensation ($500 per shift) for a resident who works the missed shifts without sick call being activated. Financial reimbursement is covered by the Department of Emergency Medicine.

This policy was discussed with and approved by graduate medical education oversight within our institution, specifically those responsible for overseeing policies and procedures. Additionally, this policy does not jeopardize the minimum of 46 weeks of training per year as required by the ABEM.

In July 2023 a second version of the policy was approved by the department based on feedback from one of the residents, who shared that "the calculus of a shift trade was the last thing I wanted to have to consider before leaving town to see my grandfather before he passed." The resident advocated for the policy to include utilization for residents to be with loved ones with limited life expectancy. The resident shared that "it was disheartening that my grandfather had to pass to open up shift flexibility." This version changed eligibility from the death of a loved one to additionally include a loved one who "has significant traumatic or medical illness resulting in suspected limited life expectancy or is enrolled in hospice care."

Policy implementation and feedback

In the first year following the implementation of the new bereavement policy, it was utilized by five residents who suffered personal losses. In total, 10 shifts were affected with 10 different residents each covering one missed shift.

Since inception of the policy, residents have indicated that the bereavement policy was one of the most important positive changes made by the residency program over the corresponding year. One resident who experienced a personal loss before the implementation of our policy spontaneously sent the following statement regarding the implementation of the new scheduling policy: "Thank you for making this happen. I remember working together on one of my first shifts back after the passing of my brother, and I could tell [that] I shouldn't be there ... It took all my energy and concentration to focus on breathing and not to break down crying. I'm really not sure how I got through seeing patients. I knew I needed more time but didn't know how to ask for it or what my options were and definitely didn't want to burden my coresidents. This is huge step forward for resident wellness and I just wanted to say thank you." One resident sent a thank you note indicating "this was incredibly important to me and made possible by [this new policy.]" Another resident who utilized the policy added that "it was a relief to know I could just leave to be with family and not have an extra task of finding shift coverage."

TABLE 1 Number of shifts covered by policy based on relationship of deceased family member.

Number of shifts	Relationship to resident
Three	Spouse/registered domestic partner
	Parent
	Child
	Sibling
Two	Grandparent
	Grandchild
	Father-in-law/mother-in-law
	Daughter-in-law/son-in-law
	Brother-in-law/sister-in-law

DISCUSSION

Implementation

Through a resident-led initiative, our program successfully implemented a bereavement policy for residents. During times of bereavement, alleviating the mental and emotional burden of finding shift coverage to allow time to grieve is important. The bereavement policy also facilitates departmental coverage without utilizing the already existing "sick-call" policy. This is important additional back-up in the event it is needed, especially for such a large program. Our policy has been met with much appreciation from our residents. Importantly, we also modified our policy based on feedback to further support the needs of our residents.

Support of resident wellness and wellness

Literature has shown that physician grief is linked to depression and burnout[21] and that medical training is the peak time of distress for physicians.[2] The implementation of the bereavement policy in a large EM and EM/pediatrics residency program is one example of how a residency program can support its residents in times of need. We believe this directly relates to resident wellness. While the ACGME does mandate these considerations in residency programs, they do not provide detailed recommendations.[5] Despite CORD-EM evidence-based policies and best practices that lay the foundation for residency programs to support resident wellness,[16] the needs of each individual residency program are somewhat unique, limiting the ability to provide specific policies for implementation. This

policy is one example that can be added to a residency program's armamentarium when considering how to support residents during their medical training.

This policy, while by no means an all-encompassing solution to the grief experienced during the bereavement process, does take a small burden away from residents during this difficult time. This policy gives residents time away from patient care to work through the initial phase of this process privately, instead of trying to both care for patients and grieve at the same time. Depending on circumstances, residents need more time away than allowed with this policy. When needed, the program director and chief residents work to address these individual circumstances with other coverage alternatives including a formal leave of absence.

Implications of resident-led work

Implementing strategies and best practices to support resident wellness is particularly challenging as the definition of wellness and what improves a resident's wellness is unique and individualized. However, residents themselves are best situated to identify target areas that could benefit the collective. Our residents previously showed success with implementation of a flexible scheduling policy for pregnant and new parent residents[15] and were able to show additional success with this work developing the bereavement policy. One of the keys to their success was to identify the groups of people (namely the residents, the program, the department, and the leadership) affected by these policies and to involve them early in the process to identify barriers. This approach was fundamental to the success of this new scheduling policy.

LIMITATIONS

Our study has several limitations. First, this policy was implemented at one residency program and might not be applicable as written to other residency programs. Regardless, we believe that the importance of our study is not the details of our specific policy and more in the provision of resident bereavement support—successful bereavement programs at various residencies may look and operate differently. Second, we have a larger residency program and the presented implementations might be more easily achieved in a program of our size. For smaller EM programs, we suspect that creative staffing solutions including utilizing EM residents on well-staffed off-service rotations and/or allowing senior residents to flex into junior resident roles may help with operational success. Additionally, our institution allows flexibility for programs to administer policies such as this at a program level. Other institutions may not provide the same flexibility. Finally, the implementation outcomes are thus far limited to only five residents. Moving forward, we will continue to track these outcomes and modify the policy as needed to increase support for our residents.

CONCLUSIONS

This work describes the successful development, adoption, and implementation of a bereavement scheduling policy to support our residents in times of need. Our hope is that this policy can serve as an example to other residency programs to support resident wellness during periods of personal grief and bereavement.

AUTHOR CONTRIBUTIONS

Timothy D. Kelly—study concept and design, analysis of data, drafting of manuscript. Bryce T. de Venecia—acquisition of data, drafting of manuscript. Peter S. Pang—study concept and design, analysis of data, drafting of manuscript, critical revision, admin support. Joseph S. Turner—study concept and design, analysis of data, drafting of manuscript. Kyra D. Reed—acquisition of data, analysis of data, drafting of manuscript. Katie E. Pettit—study concept and design, analysis of data, drafting of manuscript, study supervision.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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How to cite this article: Kelly TD, de Venecia BT, Pang PS, Turner JS, Reed KD, Pettit KE. Bereavement scheduling policy for emergency medicine residents: A descriptive pilot study. *AEM Educ Train*. 2024;8:e11009. doi:10.1002/aet2.11009