## Introduction

During COVID, many trainees (resident physicians) have experienced an insurmountable exposure to patient mortality. Prior to the pandemic, residents reported inadequate training in end-of-life care[1,2]. The COVID pandemic only compounded this as trainees experienced more responsibilities with potentially less oversight caring for a potentially lethal virus without curative therapy. While the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine recommend curricula cover end-of-life topics, residents still feel unprepared[3]. Patient debrief sessions present an opportunity for trainees to process their feelings, emotions, and insecurities as a group while learning from the dying process[4].

At this time in our residency program and others that we are familiar with, there is no mandated or suggested approach to discussing patient death with trainees. When a patient death occurs some attendings may choose to lead a debrief session, however, this is not the standard. Debrief sessions provide the opportunity to facilitate discussion about patient death and can be helpful for all stakeholders. However, for debrief sessions to be effective there needs to be a supportive environment and opportunities for trainees to share their experiences, ask questions, and reflect[1].

There is a need to enhance awareness and attention to resident grief and coping, especially during the busy times of COVID. This may in part be due to a lack of faculty training on how to facilitate a debrief session, time constraints, and/or comfort level. This case illustrates a scenario in which a trainee finds a lack of support and inattention to their feelings when a patient is transitioned to comfort care and passes away the following day.

**Case: Captain Geringer**

My first year as a staff physician was during the start of the COVID pandemic. The staff role was new to me, and although my residency training prepared me to care for patients, I felt less equipped to help trainees cope with patient death. My first week on the service, I was focused on the logistics and paperwork surrounding patient death. Was the death certificate signed and the appropriate discharge paperwork completed? The following month, a few more patients passed. This time I checked in to see how trainees were doing. However, these check-ins were brief, a yes-no answer sufficed, and the time allotted for this was minimal. The week of Christmas 2020 we saw a surge in the number of patient deaths. It was becoming all too common and I found that I could no longer ignore the effects this was having on my trainees. I tried to navigate the overwhelming role of supervising my trainees while also providing mental support, however, I lacked any formal training to do this. Through many failed attempts, I stumbled through leading patient death debriefing sessions. It wasn't until my second year when I matriculated into a degree program that I learned about the situational leadership theory that I now apply to help trainees cope with patient death.

**Commentary: Captain Geringer & Dr. Durning**

Situational leadership theory appreciates that different situations demand different styles of leadership. Instead of a one size fits all approach, the leader analyzes and identifies the developmental level of the trainee and offers the appropriate level of support and direction. For this scenario, the developmental level is determined by *competence,* which refers to knowledge and skills to cope with patient death, and *commitment,* which refers to confidence and motivation to accept and deal with patient death. Appreciating that learners can and do regress, is one of the benefits of this approach[5].

To address the scenario, let's start by elucidating what each developmental stage may look like with respect to this specific case

Determine developmental level (assess trainee competence and commitment)

- D1: low competence, high commitment
    - First patient death and/or unexpected death. Ill-equipped with coping skills. Eager to debrief.
- D2: some competence, low commitment
    - Few experiences with patient death. Reluctant or uninterested in sharing the experience or discussing impact.
- D3: moderate to high competence, but variable commitment
    - Many experiences with patient death. Desire to debrief is conditional. May shy away from sharing at times and be willing to participate and lead other times.
- D4: highest in development and high degree of commitment
    - Many experiences with patient death. Actively involved in debriefs, often leading.

Once the developmental level is determined, one can address each in the following manner modeled off of Blanchard's situational leadership theory approach[5] (Table 1):

D1: First, we would acknowledge the death event and surrounding emotions. Next, we would set aside protected time for the medical team to grieve and debrief the event. We would lead the debrief session, calling on trainees to share their stories, teach coping strategies, and inform them about mental health resources.

D2: We would discuss with the team when they would like to set aside time to debrief and ask trainees for input about opportunities for remembrance. We would help lead the debrief session based on the needs expressed by the trainees, whether that be time for them to share stories, discuss coping mechanisms, etc.

D3: We would listen to trainees' concerns, assuring residents that they are capable of leading or participating in a debrief session, and supporting their efforts to debrief in a manner they find fit. While residents are given the ability to lead a debrief session, we are still present to facilitate problem-solving.

D4: We would delegate to a senior resident and have them determine the objectives for the debrief session. We would have interns come prepared with individual stories to share and let the senior resident determine how to facilitate the session. The attending would still be present to observe.

**Potential Challenges:**

This leadership theory approach offers a practical and prescriptive approach that is fairly easy to understand, apply and accommodate for varying trainee developmental levels. However, there are potential challenges using situational leadership theory approach. First, there is ambiguity about determining followers' developmental levels based on competence and commitment. Also, situational theory fails to account for how certain demographic characteristics influence the leader-follower prescriptions. One solution is to carefully consider each trainee individually. What is their level of experience, age, gender, previous work experience and how may these influence the type of leadership desired and needed? Another challenge is addressing the individual as well as the group. Trying to match leadership style to both can be demanding and at times not feasible. If group members are approximately at the

same developmental level, then it is easier to adapt the leadership style to the group. However, if individuals exist on a spectrum, pairing those with similar abilities and using those more advanced to assist with those at lower stages is one way to integrate all members of the team and focus time and resources on those who need more direction.

In medicine, physicians write prescriptions for patients based on their initial impressions with a personalized goal based on the patient's needs. Prescriptions may be ineffective or have undesired side effects. When this occurs, we stop the medicine and try a new prescription. Similarly, situational leadership may begin with one prescription, but later require a new one based on observations and intended outcomes. Continuously reviewing the needs of trainees and adopting a flexible approach to leadership style is key to overcoming these barriers.

Disclaimer: The views expressed herein are those of the authors and do not reflect the official views or policy of the Department of Defense or its components.

**References**:

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