**NHS Education for Scotland**

**Transcript of ‘Responding to the Sudden Death of a Doctor in Training - Case Study: Foundation School Director’ Film**

It was a good few years ago when I was the Foundation School Director that I got a call telling me a junior doctor had suddenly died. It was thought likely to be suicide. It was my department where I was also a consultant. I just wasn't in any way prepared to deal with something like that.  
   
I found out that she was well liked, that there was just nothing to indicate that this was a doctor who was in any kind of difficulty at all.

I was expected to deal with her death as part of my job and also on behalf of the hospital. People were ringing and emailing me, the foundation doctors, consultants, nurses who had worked with her. Literally dozens of individuals all asking me what had happened. I made myself available on that first day for anyone who wanted to talk. That was difficult because you were going through the same discussion again and again. There were two or three of us trying to do it. But many of the staff were quite upset. You had to really rely on all your training about how to break bad news in that situation. We got the Chaplain involved and arranged drop-in sessions so that the other junior doctors could either go to the chapel or come and speak to us. And then in the middle of all of this, her parents requested to come and get her belongings. I just thought, that's so quick, you know?

I went and spoke to them to say I'm deeply sorry and it was awful. Her parents just sat there with all her belongings in one box. You could see they were completely shell shocked. Then I had a difficult couple of weeks in organising and supporting staff. There was a lot of anger from her peers and her colleagues. Rota management became a priority because some staff were just too upset to stay at work.

We had similar issues when it was her funeral. Who was going, who wasn't going? But we dealt with it as best we could. About a year later, I was just sat in the office and the phone rang, and it was her family. They shouted at me and said, “So what have you done? We told you there were things that you needed to do, and you just, you haven't done anything, and you've all let us down”. I came away from that conversation thinking…I wasn't there when it happened. I haven't done anything wrong. It’s not my fault. I still don’t really know what it is that they, they wanted, except probably just to shout at me, to vent.

I don't know what else I could have done. I honestly did my best. Subsequently, we've done a load of work about how to manage sudden death incidents. We've put processes in place, done an annual review and looked at causes of death amongst doctors in training. I'm still in two minds of whether or not I should write to her family and say I've done this, this and this. I’ve thought about it quite a lot, got the address out a couple of times. But what do I actually say? I don't know if it will make things worse or better. I thought about it quite a few times, if it might reopen wounds? So I haven't written, but I think at some point I'll have to. It might provide some closure.

Nobody asked me if I was okay and, and that was really difficult. I think that's come through quite strongly about the care and support that you need is well, that you need as well. Also, for me, that first time, it was about my guilt, that I couldn't make it better for her parents. But then how could I have, you know?

Sadly since then we have had a few sudden trainee deaths while I’ve been Postgraduate Dean. It's something that you don't think you will see. Before I think there wasn't a responsibility for us to train our colleagues about how to manage these instances as professionally as possible and also how to take care of yourself and others. Now I would do things differently from that first time when I was dealing with it from all angles at once. In response, we've created checklists, with things like ensuring the GMC don't ask for the doctor’s registration fee as it really upsets their families. We've also developed a list of everyone that needs to be informed and that's in order to provide emotional support. We've involved the Chaplains in the work.

We also considered press inquiries and who's going to deal with these? Like if it gets out on Facebook, what do we do? So, we now have a structure and a process of how we manage sudden death. When it does happen, staff know where they can get some information. Whereas I was working completely blind. It's like all you want to do is sit and cry.

This is about faculty development. Planning how you handle such difficult circumstances. We might not want to talk about it, but if a sudden death happens, you're ready to deal with it. And at times like these, it's our humanity that helps us to deliver on our professional responsibilities.

The film was produced in May 2022 and can be found at [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk) or <https://vimeo.com/711668681>

For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk) or contact [supportarounddeath@nes.scot.nhs.uk](mailto:supportarounddeath@nes.scot.nhs.uk)

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