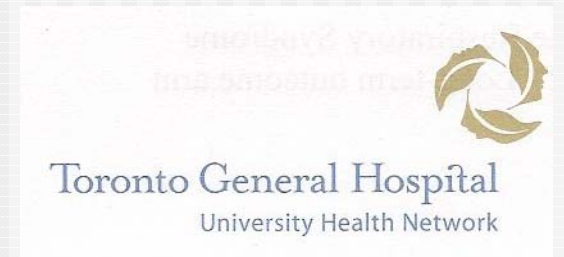


Bereavement Programs after Critical Illness

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**Canadian Critical Care
Trials Group**



Objectives

- Define Complicated Grief
- Adverse Health Consequences of Bereavement
- Review of NEJM Communication and Brochure Intervention
- Bereavement Follow-up Programs
- Bereavement counselling as part of our ICU continuum of care

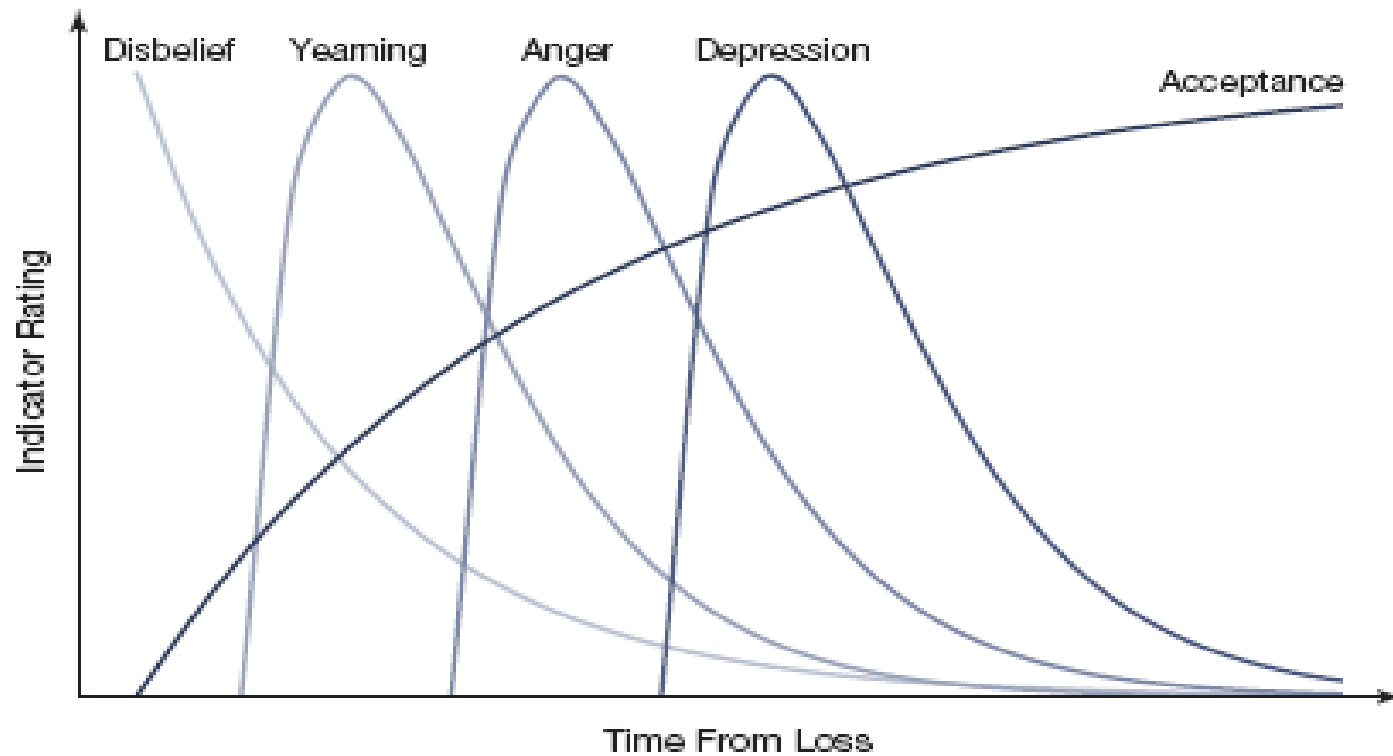
Bereavement

- The experience of losing to death a person to whom one is closely emotionally attached
- 80-90% of bereaved individuals experience normal or uncomplicated grief and have limited signs of impairment 6 months after the loss
- A minority experience adjustment difficulties including: suicidal thoughts and gestures, Major Depressive Disorder, PTSD, those with symptoms of Complicated Grief Disorder

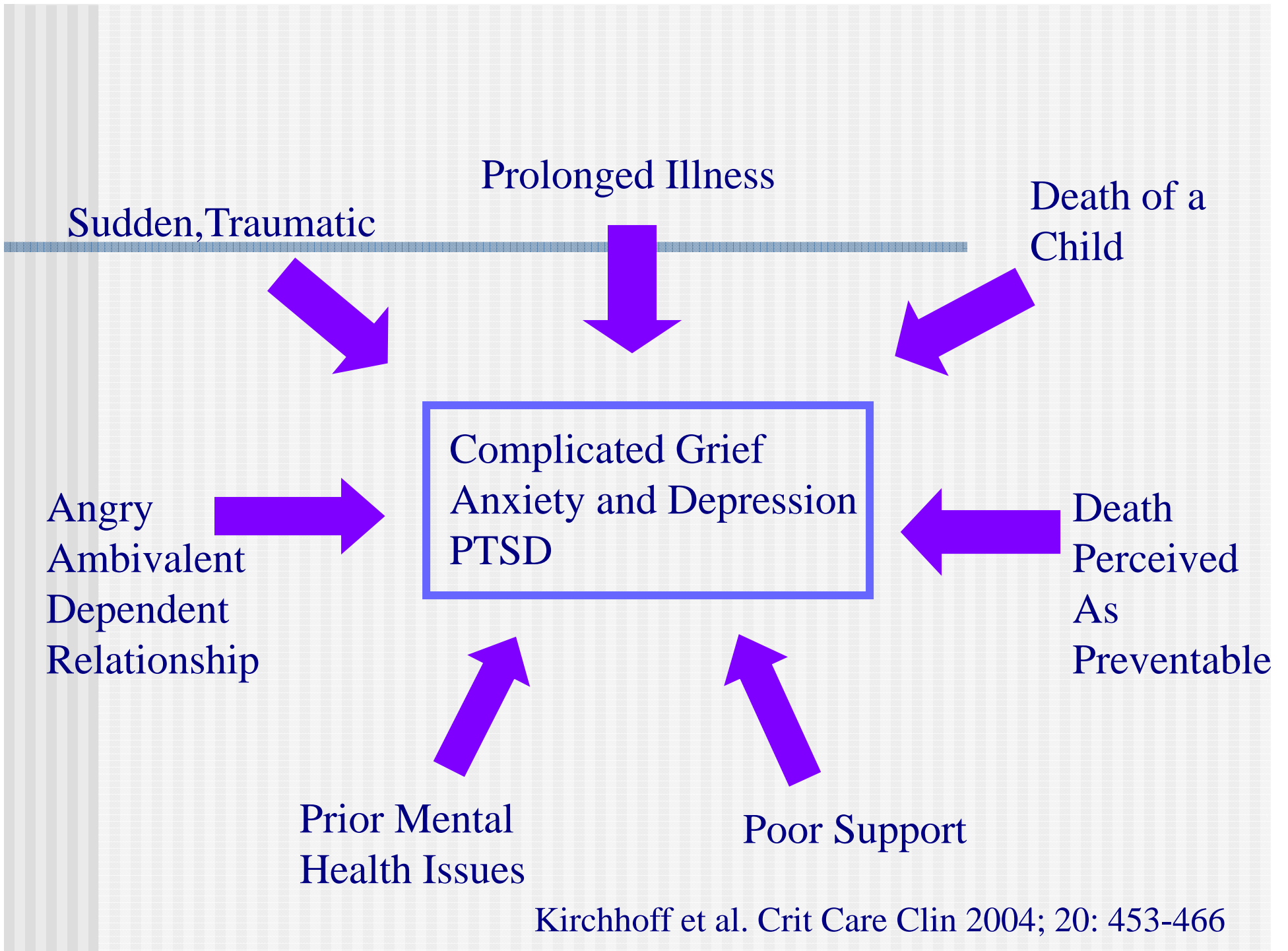
Zhang et al. J Palliative Med 2006; 9:1188

Prigerson . Bereavement Care 2004;23:38

Figure 1. Hypothesized Stage Theory of Grief



JAMA. 2007;297:716-723



Health Consequences of Bereavement

- Increase in fatigue, eating and sleeping disorders, MD visits, medication use, disability, hospitalizations, death
- High risk of PTSD in family members of patients dying in ICU (50%-82%) and risk increased by poor communication at end-of-life
- Severe PTSD associated with anxiety, depression and decreased HRQOL

Curtis et al. Crit Care Med 2001;29 (Suppl):N26-N-33; McDonagh et al. Crit Care Med 2004; 32:1484-1488; Azoulay et al. Am J Respir Crit Care Med 2005; 171: 987-994; Curtis et al. Am J Respir Crit Care Med 2005; 171:844-849; Schut and Stroebe. J Palliative Med 2005;8:S-140-147

Impact of Bereavement

Cuthbertson and colleagues CCM 2000;28:1196-1201.

- Cross-sectional study with telephone interview
- Single centre, tertiary ICU
- Persistent sleep disturbances, financial difficulty were common
- 25% of family members requested and were referred for grief counselling

The NEW ENGLAND JOURNAL *of* MEDICINE

ORIGINAL ARTICLE

A Communication Strategy and Brochure for Relatives of Patients Dying in the ICU

Alexandre Lautrette, M.D., Michael Darmon, M.D., Bruno Megarbane, M.D., Ph.D.,
Luc Marie Joly, M.D., Sylvie Chevret, M.D., Ph.D., Christophe Adrie, M.D., Ph.D.,
Didier Barnoud, M.D., Gérard Bleichner, M.D., Cédric Bruel, M.D.,
Gérald Choukroun, M.D., J. Randall Curtis, M.D., M.P.H., Fabienne Fieux, M.D.,
Richard Galliot, M.D., Maité Garrouste-Orgeas, M.D., Hugues Georges, M.D.,
Dany Goldgran-Toledano, M.D., Mercé Jourdain, M.D., Ph.D., Georges Loubert, M.D.,
Jean Reignier, M.D., Fayçal Saidi, M.D., Bertrand Souweine, M.D., Ph.D.,
François Vincent, M.D., Nancy Kentish Barnes, Ph.D., Frédéric Pochard, M.D., Ph.D.,
Benoit Schlemmer, M.D., and Elie Azoulay, M.D., Ph.D.

Lautrette et al. *N Engl J Med* 2007;356:469-78

Study Question

Can the content and structure of the end-of-life family conference, with the addition of a brochure on bereavement, decrease adverse psychological outcomes in family members after a patients death

Participant Selection

Inclusion Criterion

- Belief by the physician in charge that patient would die within a few days

Exclusion Criteria

- Patients younger than 18
- Family members with insufficient knowledge of French for a telephone interview

Intervention

VALUE

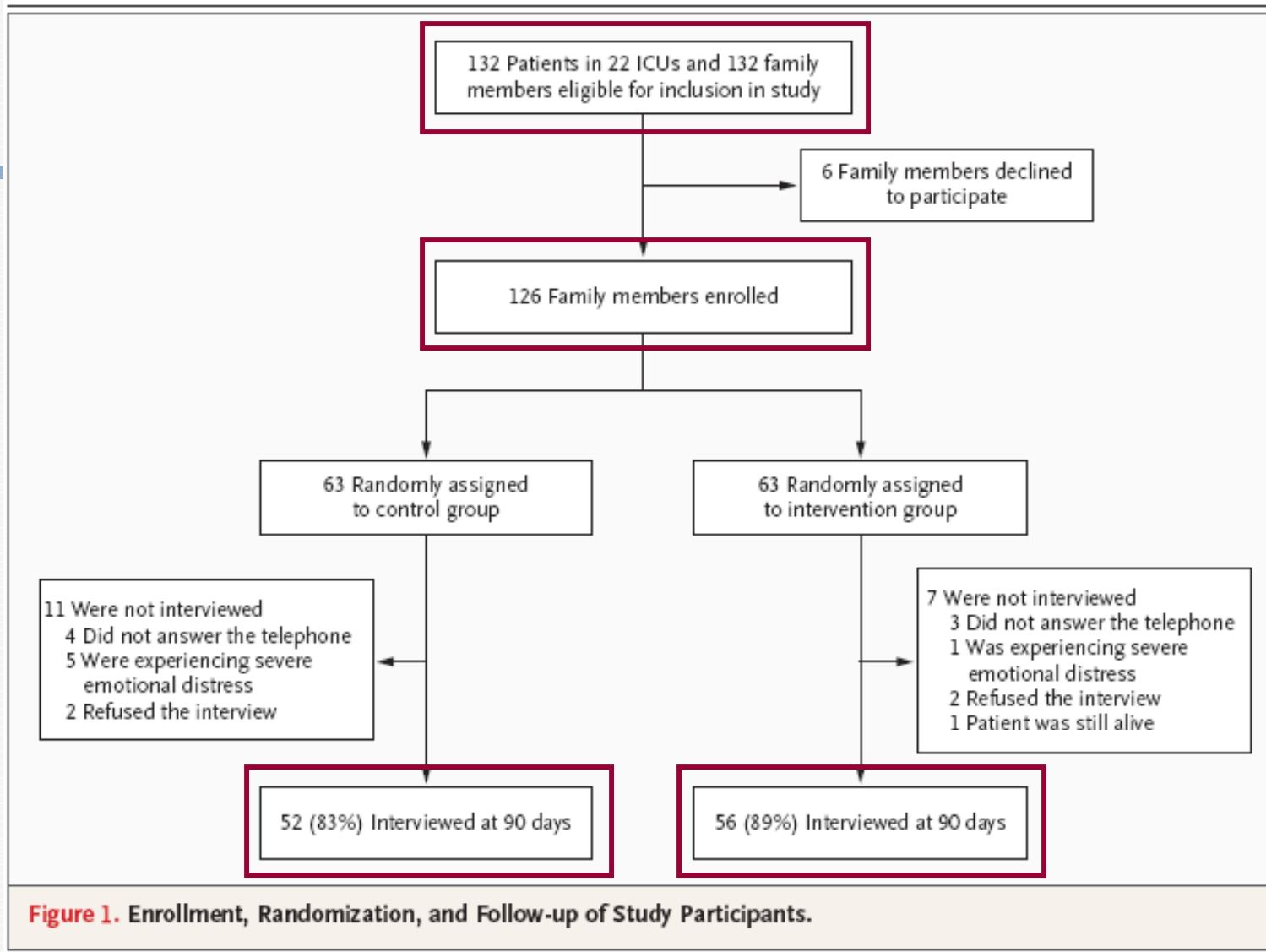
Value and appreciate what the family members said, **A**cknowledge the family members emotions, **L**isten, ask questions that allow the caregiver to **U**nderstand who the patient was as a person, **E**licit questions from family members

+

Bereavement Brochure

Bereavement Brochure

- Practical information- paperwork, disposition of the body, funeral planning etc.
- Landmarks on your journey through grief, the moment of death, the funeral, working through the grieving process etc.



Lautrette et al. N Engl J Med 2007;356:469-78

Table 4. Outcomes Assessed on Day 90.

Variable	Control Group (N=52)	Intervention Group (N=56)	P Value
IES score			0.02
Median	39	27	
Interquartile range	25–48	18–42	
Presence of PTSD-related symptoms (IES score >30) — no. (%)	36 (69)	25 (45)	0.01
HADS score			0.004
Median	17	11	
Interquartile range	11–25	8–18	
Symptoms of anxiety — no. (%)	35 (67)	25 (45)	0.02
Symptoms of depression — no. (%)	29 (56)	16 (29)	0.003
Saw a psychologist after death of patient — no. (%)	6 (12)	4 (7)	0.41
Received newly prescribed psychotropic drugs after death of patient — no. (%)	12 (23)	6 (11)	0.05
Effectiveness of overall information provided — no. (%)			
Time allotted to provide information was sufficient	45 (87)	51 (91)	0.45
Information was clear	45 (87)	52 (93)	0.34
Additional information requested	24 (46)	17 (30)	0.05

Lautrette et al. N Engl J Med 2007; 356:469-78

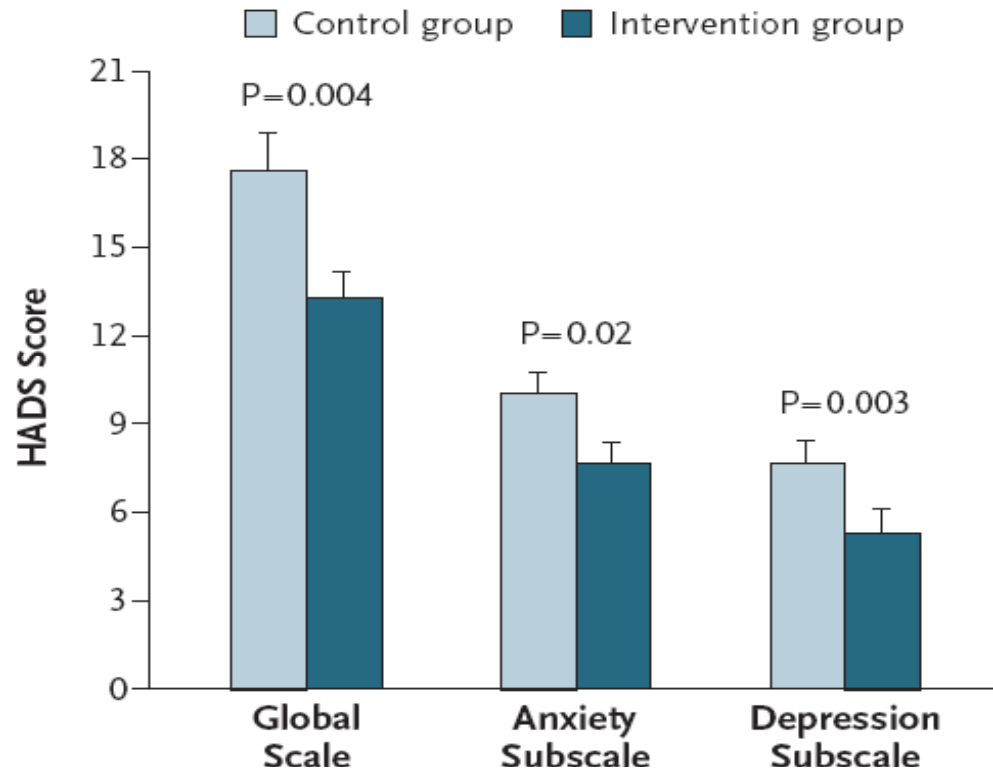


Figure 2. HADS Scores in the Two Randomized Groups.

The median HADS score was 11 (range, 8 to 18) in the intervention group versus 17 (range, 11 to 25) in the control group (P=0.004). With a cutoff of 8 for each of the subscales, symptoms of anxiety and depression were less common in the intervention group (anxiety, 25 patients [45%], vs. 35 [67%] in the control group; P=0.02; depression, 16 [29%] vs. 29 [56%]; P=0.003).

Summary of Results

Family members in the intervention arm had longer conference times, spent more time talking, were able to better express guilt and those who received the bereavement brochure intervention, had significantly fewer symptoms of depression, anxiety and PTSD compared to the control arm at 90 days after the patients death.

Limitations

- Generalizability-possible cultural bias
- Independent contribution of bereavement brochure unclear
- Duration of benefit unclear beyond 90 day follow-up

Clinical Practice Guidelines for Support of the family in the patient-centred ICU: ACCM Task Force 2004-2005 Davidson et al. CCM 2007; 35: 605-622.

- Staff Stress Related to Family Interactions
- Cultural Support of the Family
- Spiritual and Religious Support
- Family Visitation
- Family Environment of Care
- Family Presence on Round and at Resuscitation
- Palliative Care

Recommendations for end-of-life care in the intensive care unit: A consensus statement by the American College of Critical Care Medicine

- Embracing family-centred care
- Clinician competence in end-of-life care
- End-of-life care continues after the death of the patient and ICUs should consider comprehensive bereavement programs for families and clinical staff
- Comprehensive agenda to guide research, quality improvement and education

Truog et al. Crit Care Med 2008; 36: 953-963

Experience with Formal and Informal Bereavement Programs

Bereavement Follow-up (New Zealand)

Cuthbertson SJ et al. Crit Care Med 2000; 28: 1196-1201

- Single centre follow-up (33 days) of 99 family members of patients who died in ICU
- Persistent sleep disturbances, financial difficulties, many referred to grief counsellors

Audit of Bereavement Programs in Australia

Valks et al. Aust Crit Care 2005; 18: 146- 151

- Surveys sent to 117 adult ICUs (85% response rate)
- 1/3 units provide follow-up as phone calls / sympathy cards or referrals for counselling

Borasino et al. Pediatrics 2008; 122: 1174-8

High proportion of pediatric CCM have contacted bereaved families and attended funerals after the death of a child patient

SO...

Are Issues of Bereavement
our responsibility ...

Think Longitudinally...

Bereavement Follow-up as Part of the ICU Continuum of Care

- Hospice providers routinely provide follow-up to families after death
- Specified in Joint Commission on Accreditation of Hospitals and Organizations, National Hospice Organization, Tax Equity and Fiscal Responsibility Act
- Level I evidence and support in guidelines
- Important family-centred interventions should be considered as part of delivery of quality ICU care

Campbell and Thill CCM 2000;28:1252-53