Informing Critical Care Patients of a Loved One’s Death

The Rev. Lisa A. P. Watson, MDiv, BCC

Much has been written about how to break bad news to patients regarding their own illness and diagnoses and about making death notifications in the community. Little, however, has been written about informing critical care patients of bad news regarding the death of a loved one. Aspects of previously published literature and protocols can be adapted for situations in which a critical care patient must be informed of such a death.1-4

In this article, the critical care patients are adult patients in any intensive care unit (ICU; surgical, medical, cardiac, burn) who in the course of a hospitalization have had a loved one die either in a related incident or because of other injury or health issues. The approach recommended focuses on the importance of the timing of the news, provides patients with a safe and healthy beginning for their grieving, considers the needs of the other grieving family members and the hospital staff caring for the grieving patients, and identifies the hospital chaplain, with his or her experience and training, as the one to be the giver of the news.

Grieving Patients and Families

Statistics on how often critical care patients must be informed of the death of a loved one are not generally tracked. However, at Regions Hospital in St. Paul, Minnesota, a level I trauma center, the Trauma Registry does track the number of patients with trauma due to motor vehicle accidents (ranging from minor injuries to critical injuries) in which a fatality has occurred in the same vehicle. The other person or persons who died may or may not be a relative of the surviving patient; nonetheless, the patient must be informed of the death. In a 24-month period, from October 1, 2004, to September 20, 2006, the Trauma Registry recorded 55 trauma patients who survived an accident in which a fatality occurred in the same vehicle. The other person or persons who died may or may not be a relative of the surviving patient; nonetheless, the patient must be informed of the death. In a 24-month period, from October 1, 2004, to September 20, 2006, the Trauma Registry recorded 55 trauma patients who survived an accident in which a fatality occurred in the same vehicle. These fatalities are often relatives or friends of the
surviving patient but sometimes may be mere acquaintances. In any case, the patient still must be informed of the fatality and be given the time and space to grieve as needed.

Some examples of critical care patients who might need to be informed of a loved one’s death include the following:

- A medical ICU patient who is sedated and receiving mechanical ventilation because of pneumonia whose mother-in-law died of cancer during the patient’s hospitalization.
- A surgical ICU patient involved in a motor vehicle accident whose husband and daughter died in the same accident.
- A burn unit patient whose other family members were in the same house fire and died at the scene or maybe even made it to the hospital but did not survive.

These situations affect not only patients and their family members who are present to support them but also the hospital staff caring for the patients. The family members who are already concerned about the surviving patient are also grieving the death of another family member. With this added stress, they are concerned about their loved one’s ability to cope with the news and worry that the news will cause a medical setback or, even more so, that their loved one may lose the will to live.

Hospital staff, especially the nursing staff providing day-to-day care for the patient, struggle because they tend to know the news before the patient does, and when family members try to keep the news from the patient, the nursing staff are often caught in the middle. Other interdisciplinary team members, such as chaplains and social workers, can provide a framework in which they work with a patient’s family members and hospital staff to prepare the way for the news to be shared with the patient. Preparation for these situations provides the patient with the best possible environment in which to hear this bad news, provides for the care of other grieving family members, and honors and attends to the needs of the hospital staff caring for the grieving patient.

**Current Research on Informing Someone of Bad News**

Although the verbal component of actually giving bad news is important, other skills are also needed. These skills include responding to a patient’s emotional reactions, involving the patient’s family members, and moving members of the patient’s family toward a sense of hope for the future. “The task of breaking bad news can be improved by understanding the process involved and approaching it as a step-wise procedure, applying well-established principles of communication and counseling.”

To improve the future quality of care at Harborview Medical Center in Seattle, Washington, Jurkovich et al’ conducted an 18-month survey to “identify the most important characteristics and methods of delivering the bad news of death.” The survey included 48 families whose loved one died of a trauma-related event in either the emergency department or the ICU. The families were asked to rate 14 elements (Table 1) on the level of importance when receiving bad news.

After families ranked the importance of each element, they were asked to rate how the hospital actually did in paying attention to 12 of the 14 elements (attire and seniority of news giver were not included). Respondents thought the hospital did poorly at informing surviving family members of the likelihood of an autopsy; at having clergy available; and in the timing, location, and privacy of the conversation. The results of this survey show that the way in which families are informed of a death has lifelong implications for the survivors. The behaviors that families perceived as most
comforting and helpful can be summarized as “a caring attitude of a well-informed, sympathetic caregiver who gives families a clear message and is able to answer their questions.”3 The survey also indicates that the news giver should be someone who can spend whatever time is needed with the family, provided he or she has or can obtain adequate information about the loved one’s death.3

Research2,5,7,8 indicates that most patients want to be informed of their own medical condition. The percentages vary; in some cultural and religious traditions, patients do not want to know this information.7 Although this research is specific to patients receiving information about their own condition, the findings often apply to any patient and family members who want to know the truth about a loved one so that they can begin to accept the news and move forward.

Existing Models for Communicating Bad News

Several models exist for delivering bad news. Bad news is defined as any news that adversely affects a person’s view of his or her future.1,2,4,5 In this article, the person receiving the news is a critical care patient, and the bad news is the death of a loved one, whether a member of the patient’s family or a dear friend of the patient. The models are the PEWTER model,1 a mental health clinician’s guide to death notification,4 and the SPIKES model.2

The PEWTER Model (Table 2) was developed specifically for use by community emergency mental health workers who may be delivering news of a death, a violent crime, a school shooting, a natural disaster or one created by humans, or a terrorist attack.1 The Eberwein model (Table 3) for the mental health clinician’s guide to death notification is similar to the PEWTER model but includes a time for viewing the body.4 Eberwein developed this guide to provide a systematic delivery of the information so that mental health professionals might feel a better sense of control and awareness of what to anticipate when delivering the news of a death. Although viewing the body can be an important part of acceptance and closure, sometimes it is not an option because of various factors related to the body itself (eg, dismemberment, the body was not recovered or was already buried or cremated).4 Offering other meaningful ways to say good-bye and providing counseling services can help move the recipient of the bad news toward acceptance of the death.

The SPIKES model (Table 4) is a protocol for delivering unfavorable information to cancer patients about their illness.7 It was developed after the 1998 annual meeting of the American Society of Clinical Oncology in which an informal survey was conducted on participants’ experiences in breaking bad news to cancer patients. After the development of the SPIKES model and subsequent training of physicians, residents, and medical students at the University of

### Table 1

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<thead>
<tr>
<th>Fourteen elements for patients’ families to rank on the basis of the level of importance when receiving bad news</th>
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<tr>
<td>Ability/knowledge to answer questionsb</td>
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<tr>
<td>Attire: how the news giver is dressedc</td>
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<tr>
<td>Attitude of the news giverb</td>
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<tr>
<td>Autopsy information</td>
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<td>Clarity of the messageb</td>
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<td>Clergy available</td>
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<td>Directions after death</td>
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<tr>
<td>Family given time to ask questions</td>
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<tr>
<td>Follow-up call</td>
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<tr>
<td>Location of conversation</td>
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<tr>
<td>Privacy of conversationb</td>
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<tr>
<td>Seniority: rank of news giver</td>
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<tr>
<td>Sympathy of the news giver</td>
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<tr>
<td>Timing of conversation</td>
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*Based on Jurkovich et al.3

*b Among the 4 most important elements.

*c Not rated by respondents in actual discussions.

### Table 2

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<tr>
<th>Components of the PEWTER modela</th>
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<tr>
<td>Preparing the one giving the news through education and training and preparing the setting and the approach for giving the news</td>
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<tr>
<td>Evaluating what the listener already knows</td>
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<tr>
<td>Warning by making a brief statement followed by a moment of silence to prepare the listener for the bad news that comes next</td>
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<tr>
<td>Telling the news</td>
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<tr>
<td>Emotional response: paying attention to and responding appropriately to the listener’s emotional responses</td>
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<tr>
<td>Regrouping by helping the listener move forward with the next steps</td>
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*Based on Nardi and Keefe-Cooperman.1

### Table 3

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<thead>
<tr>
<th>Six steps included in the Eberwein model of death notification by mental health staffa</th>
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<tr>
<td>1. Gathering information</td>
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<td>2. Initiating contact with the survivors</td>
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<td>3. Delivering the notice</td>
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<tr>
<td>4. Responding to the survivors’ reactions</td>
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<tr>
<td>5. Viewing the body</td>
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<tr>
<td>6. Providing information and follow-up referrals</td>
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*a Based on Eberwein.4
Aspects Unique to the Critical Care Setting

Compared with reporting a diagnosis or death in the community setting, informing critical care patients of a loved one’s death has its own unique aspects and dynamics (Table 5). These dynamics require teamwork with patients’ family members, nurses, social workers, and chaplains and careful attention and planning.

In work with patients and their families in the critical care setting, the relationship with a patient’s family often starts before the patient knows of the death and then continues after the news is shared. Nurses are an integral part of the patient’s ongoing emotional assessment and support because they are the hospital staff who spend the most time directly with the patient. This time together provides nurses opportunities to support the patient in accepting the information and in grieving. Hospital staff must also attend to the emotional needs of the patient’s family and friends who continue to grieve while also supporting the critically ill or injured patient. All staff members (nurses, social workers, chaplains, therapists, physicians, etc) have ongoing relationships with the patient and family throughout the hospitalization.

To Tell or Not to Tell

Most patients want the truth about their own condition, options, and prognosis. The experience of chaplains and social workers reveals that most people want to be told the truth about the death of a loved one. In addition, people have a right to know the truth. Often, even though they have not actually been told about the death, patients later share that they already knew. They report that they knew because their loved one had not come to see them in the hospital, because they have some hazy memory of the accident, or because no one else would talk about that person or would change the subject when the patient asked about that person.

Sudden death is totally abrupt, giving no time for preparation or to say goodbye, which can be extremely difficult for those left behind. The sudden death of a loved one has the capacity to leave people damaged or to result in a prolonged and painful grieving process that is made worse by the lack of time or preparation for the death, leading to a “double grief”—for what is lost and for what might have been.

Although the intention to withhold news of a loved one’s death is most often due to compassion for a patient, the patient’s grief and suffering will not be diminished by withholding the news. And, if the patient finds out later that family members withheld the information, relationships could be unnecessarily strained at a time when family members should be comforting one another. This strain can also occur between

<table>
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<th>Table 4 SPIKES model for delivering bad news to patients</th>
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<tbody>
<tr>
<td><strong>Setting up the interview</strong></td>
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<tr>
<td>Assesing the Patient’s Perceptions</td>
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<tr>
<td>Obtaining the patient’s Invitation by asking him or her how much he or she wants to know now</td>
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<tr>
<td>Giving Knowledge by first warning the patient of the bad news and then sharing the news</td>
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<tr>
<td>Addressing the patient’s Emotions</td>
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<tr>
<td>Strategy and Summary in which those present determine the next steps</td>
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2 Based on Baile et al.

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<tr>
<th>Table 5 Dynamics unique to the critical care setting in relating the death of a loved one to a patient</th>
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<tbody>
<tr>
<td>The person giving the news is not necessarily a physician or a mental health worker</td>
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<tr>
<td>The information is not about the patient’s own condition but rather about a loved one</td>
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<tr>
<td>The setting is in a hospital (a critical care unit)</td>
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<td>The patient’s own condition dictates the timing of sharing the information</td>
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<tr>
<td>The patient’s family members worry that the news will cause the patient’s condition to deteriorate</td>
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<tr>
<td>The patient’s family and friends know about the death and are grieving while at the hospital</td>
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<tr>
<td>The hospital staff are aware of the death and know the patient will need to be told</td>
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<tr>
<td>Hospital staff are providing spiritual and emotional support to the patient’s family and friends as well as to the patient</td>
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<tr>
<td>The patient may be, or is perceived to be, responsible for the death</td>
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the nursing staff and a patient if the patient feels he or she can no longer trust the nurses because they withheld this information.7,10-12

Whether the withholding of information is a form of lying or deception is a constant topic of debate among ethicists.12 Most important, hospital staff should consider the ongoing relationship between the patient, the patient’s family, and staff when discussing the overall value and intent in withholding this information from a patient. Truth-telling sets up a sense of trust and safety not only among the grieving family but also between the patient, family, and hospital staff. Family members and staff who do attempt to withhold information from a patient find themselves paying a high emotional cost; they are always in fear of the patient’s asking questions, of having to lie, and of the consequences when the patient eventually discovers the truth.10,12

A survey8 of trauma patients showed that in general they were frightened; they wanted to know what happened in the accident, what was happening now, and what would be happening. Trauma patients find themselves thrust into the unknown and chaotic hospital environment with no sense of safety or control. The respondents to the survey8 reported that they regained some sense of control by acquiring knowledge: knowledge about the accident, about their own injuries, and about anyone else involved in the event.

Families’ Concerns

During discussions with a patient’s family about when and how to tell the patient of a death, family members may focus on the following concerns:

- The patient will be adversely affected by the news, causing a medical setback, or, even worse, the patient may give up the will to recover and live on without the loved one.
- The family members do not want to be the bearer of the bad news.
- The family members worry that if they are the bearer of the news, the patient will always remember them as being “the ones” who told the patient about the death.
- The family members want to know when is the “right time” to tell the patient of the death.

These concerns are all very real and should be addressed with the family members before talking with the patient. It is best to address the concerns as soon as the family knows of the death so that the hospital team of nurses, social workers, and chaplains can be working with the family to make a plan sooner rather than later. The inner resources of the patient should not be underestimated when discussing when and how to share the news of a loved one’s death.10

While they are concerned about adverse effects on the patient, the family should be assured that the patient is in a safe place. Patients are under the care of physicians and nurses to address health care needs, and social workers, chaplains, and, possibly, psychiatrists or psychologists are available to address psychosocial, spiritual, and psychological needs.

In a study13 of the stress of bereavement on the endocrine and immune systems of bereaved widows, mortality and physical illness increased during the first 2 years of bereavement. Of note, the changes in the endocrine and immune parameters were significantly marked in the early weeks of bereavement and were still present in some widows even 6 months after the death of their spouse. Sometimes, what is not being said or talked about can also add stress and anxiety, and the delay in telling the news may be adversely affecting the patient.

Nurses’ Concerns

When a family wants to delay telling a patient about the death of a loved one, the family’s wish affects the entire staff caring for the patient, especially critical care nurses, because

With specialized skills and training, the hospital chaplain is often the appropriate person to guide the patient, the patient’s family, and hospital staff through the process and offer grief support throughout the hospitalization.

The critical care model of assessment and consultation, information gathering, preparation, discussion, ongoing support, and resources provides a safe and healthy environment for patients to learn of a loved one’s death.
the nurses are the ones providing the most direct care.\textsuperscript{11,14} In these situations, if the patient is alert enough to ask questions either verbally or in writing, nurses are under moral distress as they try to avoid answering the questions.\textsuperscript{12,15} These situations also strain the nurses’ relationship with those family members who have requested the withholding of the information. The nurses may resent the family members for causing the nurses to lie or deceive the patient. If a patient learns that a nurse knew about the patient’s loved one and was avoiding or even lying to the patient, the patient may lose trust in that nurse.\textsuperscript{11,12,15}

Another factor to address includes the nurses’ own feelings when working with bereaved patients and patients’ family members. Working in such an environment causes nurses to face their own mortality and the reality that everyone will one day die.\textsuperscript{30,15} Kendrick\textsuperscript{15} found that nurses often use defense mechanisms to avoid bereaved patients and the patients’ family members. Caring for bereaved patients and their bereaved family members at such an acutely painful time is a difficult aspect of the nursing role.\textsuperscript{15}

Patients’ Concerns

Patients probably will want to know the details of what happened.\textsuperscript{8} They may ask where is their loved one’s body, can they view the body, will they be a part of the funeral planning or even be able to attend the funeral. They may also begin to have concerns about medical bills, finances, housing and job issues, legal issues, possible child care problems, and so on. A chaplain and social worker can help patients and patients’ families with some of these issues. For the period of the discussion about the death, acknowledging that a patient has these concerns and that over time these issues can be addressed will be helpful. Trying to keep the patient in the present moment and allowing for the beginning acceptance and grieving will be the priority of this conversation. Subsequent visits with the chaplain and social worker can be arranged to discuss the other concerns.

At times, patients may avoid asking about their noticeably absent loved one. They themselves are trying to avoid the pain and suffering by not talking about the missing person.\textsuperscript{15} Again, this avoidance will not diminish their suffering, because they probably are suffering anyway; they are just not talking about their concern openly.

Who Should Tell . . . and When

Patients’ family members are not trained to share bad news or facilitate the processing of emotions. A patient’s family members are also grieving themselves and should not be put in the position of trying to be the news giver. With the hospital chaplain as the leader in telling the bad news, family members and other hospital staff are comforted in knowing that they will not need to be the one to tell the patient of a death. Family members then are relieved of the burden of thinking they might always be thought of as the ones who shared the news. Having a chaplain be the news giver also allows the family members to support the patient when the patient is being told of the death; providing support is the appropriate role for family members in this situation.

The stress that comes from the family members’ worries is typically relieved once a plan has been made with the hospital staff and the family members are assured that the staff will participate in the news sharing so that the family members feel supported. The relationship that the family members develop with the chaplain and social worker allows for ongoing comfort and support so that the family members do not have to “go it alone.”\textsuperscript{16}

Because a patient’s nurses work so closely with the patient, they are often the first ones to notice that the patient is more alert and may be wondering or even sometimes asking directly about one of his or her family members. Even patients receiving ventilatory support can be alert enough to hear the information and can begin to grieve. If a patient is receiving ventilatory support, those present with the patient should try to anticipate the questions the patient might have. Once the patient is more awake, he or she is likely beginning to look around the room and take notice of who is and is not present. The patient’s nurses should be working closely with the social worker and chaplain in preparing for the time when the patient will be told of the loved one’s death. The social worker and chaplain will also meet with the various family members involved to assure them of the best timing and provide support and resources for the family members during the members’ grieving.

A Sense of Relief

Once the information about the death has been shared with the
Assessment and Consultation

Assessment and consultation begin with a patient’s family, chaplain, social worker, nurse, and physician working together to assess when the patient will be alert and able to participate in the conversation and a plan for the shape of that discussion. If the patient is affiliated with a faith community, the faith leader may be able to provide helpful insights and be a supportive presence for the patient and the family throughout the hospitalization. Family members are encouraged to include their community leaders and faith leaders as appropriate. Cultural and religious rituals and practices may need to be addressed in the planning and the discussion. For example, in some cultural and religious traditions, using the words “died” or “death,” speaking the name of the deceased, making eye contact, or touching a member of the opposite sex is considered offensive. Chaplains often know and can address these needs. In some situations, the community or religious leader may be the most appropriate person to inform the patient about the death.

Information Gathering

Information should be gathered about the circumstances of the death, where the body is, if the patient will be able to see the body, and possible funeral plans. If the deceased is an immediate family member, such as the spouse, child, sibling, or parent, it is helpful to counsel families on the possibility of postponing the funeral until the patient is able to attend. In some religious traditions such as Islam and Judaism, burial must happen within a certain time frame. Knowing the patient’s faith tradition and its practices will be important for knowing if timing is an issue and for including faith leaders in the arrangements as needed.

Preparation

Preparation includes the following:

- Determining who will be the discussion leader
- Determining who will be present in the room (a smaller group of support persons will be less overwhelming to the patient)
- Coordinating with the hospital staff to provide a calm environment and privacy for the discussion
- Working with nursing and medical staff to determine the timing of the discussion, and informing the staff of the plan by documenting the plan in the patient’s medical record
- Informing oncoming nursing staff during report times
- Discussing an alternative plan

(It only takes a quick word of “I’m sorry about [deceased’s name]” from a well-intentioned visitor, family member, or staff member to erase all the best planning and preparation. The team should discuss what to do when the news about the death is revealed inadvertently.)

Because the team has spent a great deal of time in preparing a plan, even if the patient is told unknowingly by
another person, most of the plan can still be followed. If the patient hears from someone prematurely, the nurse should confirm that the patient’s loved one has died and that the nurse will contact the person (chaplain or otherwise) who will be able to provide more details about what happened. The person who unknowingly informed the patient of the death may benefit from reassurances from the staff that a well-prepared plan is in place for such a situation.

If making the patient wait more than a few minutes would cause the patient undue stress, the nurse may decide to move forward with the discussion that had been planned. In those situations, notifying the chaplain and social worker that the discussion has already taken place will prompt them to come and offer additional spiritual and emotional support to the patient and the patient’s family.

Discussion

The conversation with the patient about a loved one’s death typically proceeds best when only one person leads the discussion. Others present may offer helpful information as needed or requested by the leader of the discussion. The chaplain is one of the few hospital staff persons who is not providing hands-on nursing care or therapies to the patient or performing medical procedures. Thus, the chaplain can develop a relationship with the patient that is based on supportive listening and presence. The chaplain may also be providing support to the patient’s family and so may have a good sense of the family dynamics involved. Family members may be in the midst of their own grieving and concern for the patient and therefore unable to provide an objective approach to the discussion or to assess and manage the emotional needs of the patient during the discussion. Although each discussion will be unique to the situation, the following provides a general idea of how a discussion might proceed:

• The discussion leader introduces all persons present in the room. If the patient and the deceased loved one were together in a trauma accident, the discussion leader asks the patient what he or she remembers about the accident and who was with him or her.

• Offering clarity to the patient about actual events is helpful because the patient’s memory may be very hazy. If the death was due to a separate traumatic event or illness, a brief summary of that situation is shared.

• Once the facts are confirmed (in a brief conversation), the discussion leader prepares the patient for bad news about the loved one. The leader might say, I have some sad news to tell you about . . . At this point, the patient may already be guessing what is about to be said, but the preparation provides a moment for the patient to catch a breath.

• The statement informing the patient of the death can be brief, with any cultural or religious practices about the use of certain language kept in mind. Sometimes using the relationship (ie, brother, sister, mom, dad) rather than the name of the person is more acceptable. The leader might say, I’m sorry to tell you that (name) died.

• The leader asks the patient for permission to share more details. This step is important to give the patient some sense of control at a time when he or she is feeling that he or she has none. A simple question gives the patient an opportunity to think about how much information he or she wants at that moment. The leader might say, Do you want me to tell you what I know?

• If the patient wants the details, simple language and brief statements are best. Too much information, especially medical jargon, is confusing, particularly when a patient is taking a variety of medications or has a brain injury.

• Euphemisms can cause confusion, especially if someone is already Guilt is a natural reaction any time one person survives and others do not. Patients who are medically ill and were not present when a loved one died may have feelings of guilt for not being with the loved one or may still somehow feel they could have prevented the death.
sick, injured, and taking medications. Assessing the patient’s ability to understand what is being said and understanding his or her cultural and religious practices help the discussion leader know what words are most appropriate. In general, avoiding euphemisms such as passed on, passed away, and expired is the best practice.

- Silence from the patient does not necessarily mean lack of understanding. Some moments of silence allow the patient to process the information and to think about any questions he or she may want to ask.
- The calm, soothing, and compassionate presence of the discussion leader provides a sense of trust and safety in a moment when the patient feels as if things are about to spiral out of control.
- The patient responds in his or her own way to the information being shared. He or she may openly weep and wail, not believe the news, be quietly tearful, or be angry.
- The patient’s emotional reactions during this time are assessed, and appropriate responses are made. His or her emotions and grief statements are normalized. Comforting statements might include the following: This must feel like a bad dream right now, but your family and friends are here to support you. It’s understandable that you are angry right now. It’s not unusual for you to feel . . .
- The patient may be spiritually distressed and ask questions such as these: Why did this happen? Did I do something wrong? How will I go on? These questions are acknowledged, but, if possible, discussion continues to focus on the information and on allowing the family some time together. An appropriate response from the discussion leader to these questions would be as follows: I know you have a lot of questions right now and I want you to know I’m available to talk with you more about them. Right now I’d like to let you have some time with your family and then we can talk again later.

The chaplain may explore these questions with the patient in future conversations around the patient’s faith practices and beliefs. It is always helpful for the patient’s family and staff to let to the chaplain know if those types of questions are coming up in other conversations.

- If the patient does not have any more questions or does not wish to have any more information, the hospital staff leaves the room so that the family can be together and provide support to the newly grieving family member.
- Letting the patient know that the staff members will continue to be available and will return later to check on the patient is often a comfort to the patient and the family members present: The leader might say, I’m going to leave the room now so that you can have some private time with your family. I will come back and see you later. If you have any other questions or want more information, I am available to assist you however I can.

Ongoing Support of the Patient and the Patient’s Family

Although all hospital staff may be providing some level of spiritual, emotional, and psychosocial support to the patient and the patient’s family, it is the primary role of chaplains and social workers to attend to these needs. The patient’s ongoing needs will vary, depending on his or her medical condition. Because of the medications they are taking and their own injuries or illness, patients may not remember what they have been told. Having to tell a patient repeatedly about the death of a loved one can be difficult for the patient’s family members and staff, but continuing that open dialogue with the patient will aid in healing. A patient who has been in an accident may need help in processing memories of the accident or even the frustration felt if he or she cannot remember anything about the accident. Helping patients process those memories is helpful for the patients’ grieving.

Survivor’s Guilt Patients who survive an accident in which others have died may experience survivor’s guilt. Survivor’s guilt is common and is defined as “a uniquely deep sense of guilt, often combined with feelings of numbness and loss of interest in life, felt by those who have survived some catastrophe.”

Survivor’s guilt is often detected through a patient’s statements about feeling that he or she did not do enough to save those who died, is in some way responsible for the death, or is not worthy to be the one who survived. Sometimes these statements are not based in reality, but other times they contain a lot of truth. If a patient (ie, survivor) had been intoxicated and was in an accident while driving in which another person died, the patient’s statements of feeling responsible are based in reality and should be addressed.

Sometimes the feelings are more related to the absence of the patient because of other circumstances. For example, a patient was late in picking up his or her loved one from work...
because of heavy traffic, and the loved one decided to walk home and was hit by a car and died. The patient feels guilty and thinks that he or she could have prevented the death if he or she had been on time. These feelings are also real, and talking with the patient about the nature of accidents and circumstances that are indeed out of a person’s control will be important. Sometimes these guilty feelings are manifested more by the patient’s behaviors, such as responding inappropriately with humor or even displaced anger.16

It is vital to not automatically dismiss a patient’s guilt and sense of responsibility without knowing the circumstances of the events. Asking questions to clarify why the patient feels guilty and addressing the realities of what happened are important ways to help the patient process feelings of guilt and responsibility. Guilt is a natural reaction any time one person survives and others do not. Whether or not the survivor is directly involved or possibly responsible for the death affects the level of guilt the survivor might be feeling. Patients who are medically ill and were not present when a loved one died may have feelings of guilt for not being with the loved one or may still somehow feel they could have prevented the death.

Early intervention, helpful referrals, and follow-up can help survivors overcome this emotional wound.16 Critical care nurses have a unique opportunity to begin this early intervention because they are the ones who provide the most direct patient care. Nurses can be a listening ear, but they can also notify social workers and chaplains when a patient’s comments indicate the patient’s sense of guilt. Ways in which critical care nurses can help survivors who have an overwhelming sense of guilt are listed in Table 7.18

**Depression** Sometimes family members are worried that the patient is depressed after learning about the death of the loved one. They ask the nurses and physicians about prescribing antianxiety or antidepression medications for the patient. Although some patients may become depressed because of the stressors they are experiencing and may need medication for short- or long-term use, such a situation should not be assumed automatically. A patient’s family and staff should not be afraid of the patient’s grieving process. Sometimes medications can cloud the ability to process thoughts, feelings, and emotions. Monitoring the patient’s emotions and behaviors and making appropriate referrals for consultation with the psychiatry service when needed should be addressed within the interdisciplinary team caring for the patient.

**Ongoing Support to Staff**

Staff members may also continue offering support to one another; the emotions of patients and patients’ families can also be stressful for the caregivers. Sometimes the circumstances of one case or the impact of several stressful cases in a unit might necessitate more formal support. One formal support model is critical incident stress management (CISM).19 CISM is an intervention used for sudden unexpected critical events or for cumulative stressful events. CISM includes critical incident stress debriefings in which attendees can express their thoughts and feelings in a safe, nonthreatening environment with

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**Table 7** Ways critical care nurses can help survivors deal with a sense of guilt

<table>
<thead>
<tr>
<th>Provide a safe place with privacy for conversations to take place.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a trusting relationship with the patient through calming interventions and naming the guilt. Use statements such as the following:</td>
</tr>
<tr>
<td>- I understand that you feel responsible for your loved one’s death.</td>
</tr>
<tr>
<td>- I know you are feeling so many different emotions right now.</td>
</tr>
<tr>
<td>- You must feel overwhelmed right now.</td>
</tr>
<tr>
<td>Actualize the loss by allowing the patient to share the events as they happened, ask about the patient’s feelings during that time, and evaluate the patient’s reactions in the midst of the event.</td>
</tr>
<tr>
<td>Help the patient recognize his or her own strengths and support systems to draw on in these times of distress</td>
</tr>
<tr>
<td>Clarify a real sense of responsibility from a more irrational sense of guilt; allow the patient to process the reality of his or her involvement in the death and acknowledge the involvement without being judgmental. When the guilt is more irrationally based, use nursing expertise to offer another view of the situation. Statements such as the following may be comforting:</td>
</tr>
<tr>
<td>- It sounds like you did everything you could to help your loved one.</td>
</tr>
<tr>
<td>- Your own injuries would have prevented you from being able to help your loved one.</td>
</tr>
<tr>
<td>- From what you are telling me about your loved one’s injuries, there was nothing you could have done to save her.</td>
</tr>
</tbody>
</table>
trained debriefing leaders. A critical incident is a situation or event that evokes unusually strong emotional responses that may interfere with a staff member’s ability to function. The purpose of CISM is to promote healthy recovery after such a traumatic event. Debriefings are usually offered within 24 to 72 hours of an event and may last 1 1/2 to 2 hours. Debriefings are not case reviews and are not designed to evaluate the medical care a patient received.

A shorter, less structured, and less formal CISM intervention is a defusing. A defusing is used to stabilize the working crew so that they can return to normal service or go home without unusual stress if they are at the end of their shift. A defusing is often offered within a few hours of an event and may last 30 to 45 minutes. CISM interventions are not an operational critique of the event or a form of therapy. Many hospitals and communities have CISM teams who can provide support as needed or requested.

**Resources**

Chaplains and social workers provide the appropriate community resources for ongoing support in the community for patients and patients’ families once discharge from the hospital has occurred. Such resources might include connecting the patient and family with an appropriate faith community; counseling services through support groups, counseling centers, or employee assistance programs; community financial resources; bibliographies on grief and loss; and funeral assistance information.

Because grief and loss are spiritual crises, the chaplain should have a variety of information and resources available for patients and their family members. As the nurses, chaplains, and social workers continue working with a patient and the patient’s family, they provide an ongoing assessment of spiritual and mental health needs.

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### Table 8: Comparison of 4 models for communicating bad news to patients

<table>
<thead>
<tr>
<th>Model</th>
<th>PEWTER&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Eberwein&lt;sup&gt;c&lt;/sup&gt;</th>
<th>SPIKES&lt;sup&gt;d&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and consultation: determining when the patient is medically ready to be told</td>
<td>Preparing the news giver with information and setting up a plan</td>
<td>Gathering information</td>
<td>Setting up the interview</td>
</tr>
<tr>
<td>Information gathering: collecting data on the death, relationships, and support systems</td>
<td>Evaluating what the listener already knows</td>
<td>Delivering the notice</td>
<td>Assessing the patient’s perceptions</td>
</tr>
<tr>
<td>Preparation: Determining who, when, and how the patient will be told of the death</td>
<td>Warning the listener of the bad news</td>
<td>Responding to the survivor’s reactions</td>
<td>Obtaining the patient’s invitation by asking how much the patient wants to know for now</td>
</tr>
<tr>
<td>Discussion: talking with the patient, including warning of the news, telling the news, and attending to the patient’s emotional needs, and discussing the possibility of viewing the body</td>
<td>Telling the news</td>
<td>View the body</td>
<td>Giving knowledge by first warning the patient of the bad news and then sharing</td>
</tr>
<tr>
<td></td>
<td>Emotional response</td>
<td>Providing information and follow-up resources</td>
<td></td>
</tr>
<tr>
<td>Ongoing support for the patient and the patient’s family while the patient is still hospitalized and support for staff as needed</td>
<td>Regrouping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources in the community for when patient is discharged</td>
<td></td>
<td></td>
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</table>

<sup>a</sup> In the PEWTER and Eberwein models, once the discussion is over, there is generally no further contact with survivors; information on community resources may be provided during the discussion. In the SPIKES model, the patient generally has ongoing contact with the physician caring for him or her and may receive information on community resources as appropriate during ongoing care.

<sup>b</sup> Based on Nardi and Keefe-Cooperman.1

<sup>c</sup> Based on Eberwein.4

<sup>d</sup> Based on Baile et al.2
emotional needs. They attend to those needs throughout the hospitalization and offer resources for continued counseling and support in the community after discharge from the hospital.

For a patient recovering from a trauma-related injury, educating the patient and the patient’s family about signs and symptoms of posttraumatic stress disorder before the patient’s discharge from the hospital will help them be aware of issues that may arise later on. Signs and symptoms of this disorder include vivid thoughts of the accident or injury; inability to return to the scene or to the activity (e.g., driving if the patient was injured in a car accident); problems with concentration; changes in sleep patterns, mood, or appetite; and increased irritability. Early diagnosis and timely referrals can markedly reduce medical expenses, disability payments, and lost wages. Simple screening questions help detect signs and symptoms such as nightmares or hyperarousal, and increased startle responses. This screening alerts health care professionals to the need for various treatment options such as exposure-based interventions, cognitive restructuring, and cognitive behavior therapy.

Whether a critical care patient is recovering from a trauma or a medical event, regular visits with the patient’s primary physician should be encouraged so the patient receives ongoing monitoring for indications of posttraumatic stress disorder or depression.

Summary

Informing a critical care patient of a loved one’s death is a common event. Teamwork among hospital staff and the patient’s family members, a well-thought out plan, and ongoing spiritual and emotional support promote a healthy and safe environment for the patient to receive this news and to begin grieving. Because no current models take into account the unique aspects of the critical care setting, the proposed critical care model for communicating the death of a loved one borrows from other models designed for communicating bad news to cancer patients and delivering death notifications in the community. Table 8 is a side-by-side comparison of these 4 models and gives the distinct elements of the critical care model. The critical care model includes assessment and consultation with the chaplain, social worker, nurse, and family members; gathering information about the circumstances of the loved one’s death; having the discussion with the patient; ongoing support throughout the hospitalization; and resources upon discharge for support within the community. Along with providing ongoing support while the patient is hospitalized, health care personnel provide ongoing assessment of the patient’s coping, monitor the need for antianxiety or antidepressant medications, and, if needed, educate the patient and the patient’s family about the signs and symptoms of posttraumatic stress disorder. CCN

Financial Disclosures

None reported.

References

CE Test  Test ID C0833: Informing Critical Care Patients of a Loved One’s Death

Learning objectives:  1. Review research on informing someone of bad news  2. Identify role of the critical care nurse in the process of informing and supporting the patient and family  3. Describe patient and family aspects of grieving unique to the critical care area

1. Who is best prepared with experience and training to give news to a critically ill patient of the death of a loved one?
   a. Physician
   b. Critical care nurse
   c. Family members
   d. Hospital chaplain

2. Which statement describes the most comforting and helpful way to inform a patient of a loved one’s death?
   a. A caring attitude of a well-informed, sympathetic caregiver who gives a clear message and is able to answer their questions
   b. A straightforward explanation of the loved one’s death with details of medical information pertaining to the death
   c. An informed caregiver who briefly discusses the death and then mediates the patient to prevent any adverse effects on the patients health
   d. A sympathetic caregiver who clearly delineates information and refers all questions to the family physician

3. What is the difference between the Pewter Model and Eberwein Model of delivering bad news?
   a. Eberwein Model refers to physicians delivering the news in a hospital setting
   b. The Pewter Model includes a time for viewing the body
   c. The Pewter Model refers to physicians delivering the news in a hospital setting
   d. The Eberwein Model includes a time for viewing the body

4. Which model was developed for protocol of delivering unfavorable news to cancer patients?
   a. Pewter Model
   b. Eberwein Model
   c. Spikes Model
   d. Cancer Info Model

5. Which statement does not reflect the fact the patient maybe aware of the death of a loved one?
   a. I haven’t seen my spouse since I have been here.
   b. Why did you change the subject when I was talking about my spouse?
   c. Spikes Model
   d. I don’t remember a thing about the accident.

6. What does truth telling help establish?
   a. Sense of trust
   b. Friendship
   c. Companionship
   d. Reality

7. What is not a family concern when dealing with the death of a loved one?
   a. The patient will be adversely affected by the news
   b. Family members do not want to be the bearers of bad news
   c. Families prefer that physicians give information to the patient
   d. Family members want to know when it is the right time to tell the patient

8. What nursing concern develops when a patient is not told immediately of the death of a loved one at the request of family?
   a. Social
   b. Moral
   c. Private
   d. Defensive

9. When the news is given to the patient about the loved one’s death, what is the appropriate role of the family?
   a. News giver
   b. Providing support
   c. Presenting solidarity
   d. Grieving

10. What does the family experience once information is shared with the patient regarding the death of a loved one?
    a. News giver
    b. Definition
    c. Presenting solidarity
    d. Defensive

11. What should a critical care nurse do if the patient is told inadvertently of a loved one’s death and is caused undue stress?
    a. Confirm the death simply and contact the physician who can give more information
    b. Deny any knowledge of this and refer to physician
    c. Delay response and call contact person to give more information
    d. Answer the patients questions and then notify the contact person

Test answers: Mark only one box for your answer to each question. You may photocopy this form.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
   a   a   a   a   a   b   a   a   a   a
   b   b   b   b   b   b   b   b   b   b
   c   c   c   c   c   c   c   c   c   c
   d   d   d   d   d   d   d   d   d   d

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