Care of the Family in the Surgical Intensive Care Unit

Leslie Steele Tyrie, MD[a], Anne Charlotte Mosenthal, MD[b,*]

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• Surgical intensive care unit • Palliative care • Family support
• Surrogate decision maker • Communication

One of the subtle but important shifts in surgical palliative care from usual surgical care is the treatment of the family and patient as the unit of care. Nowhere is this more apparent than in the surgical intensive care unit (SICU), where the stress of having a critically ill loved one creates significant bereavement and emotional needs for family members. Multiple studies have now demonstrated that families of patients in the ICU are themselves in crisis, with high levels of stress, anxiety, and depression regardless of whether the patient lives or dies.[1–4] Family perception of the patient's distress and suffering can also contribute to this. Families are usually called on to be surrogate decision makers for the patient in the ICU, further adding to their burden and emotional needs. The availability of emotional support, information, and appropriate communication for family not only affects their level of distress while in the ICU, but can predict their long-term bereavement and psychosocial outcome and whether or not they develop posttraumatic stress disorder (PTSD), anxiety, or depression.[5,6] How this affects the surviving patient's long-term outcome in turn is not clear, but one can speculate that patient and family distress are interrelated. Standard surgical ICU care must include both interdisciplinary teams and processes of care that specifically address the needs of patients' families with respect to communication, emotional support, information, and decision making.[7,8] If the ICU stay results in the death of the patient, appropriate end-of-life care should also include further support for families in bereavement, decision making, cultural observances, and ample access and time to be at the patient's bedside.

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[a] Department of Surgery, New Jersey Medical School, University of Medicine and Dentistry of New Jersey, 185 South Orange Avenue, MSB G506, Newark, NJ 07103, USA
[b] Trauma/Critical Care Division, University Hospital - New Jersey Medical School, 150 Bergen Street, Mezz 233, Newark, NJ 07103, USA
* Corresponding author.
E-mail address: mosentac@umdnj.edu

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THE FAMILY EXPERIENCE IN THE SICU: GRIEF AND BEREAVEMENT

Grief is a normal but profound emotional reaction to the loss of a loved one. Grief includes diverse emotional, behavioral, cognitive, and physiologic manifestations (**Box 1**). Families may manifest grief in some or all of these ways, at different times, and with different intensity. How families cope with grief will affect their behavior and interactions with the ICU team and the patient. More importantly, how the SICU team supports and interacts with families will have a profound impact on both their acute and long-term bereavement. Grief occurs not only after death, but after any major loss. Even if the patient survives the SICU stay, but has permanent disability, grief may complicate both the patient's and family's recovery. Medical events such as anoxic brain injury, stroke, amputation, or spinal cord injury leading to permanent loss of function mean loss of hopes, expectations, and life as previously known. Such a situation can be devastating—families and patients will experience the same sequence of grief and coping mechanisms as is apparent after a death.

Box 1
Manifestations of grief

Emotional

- Despair
- Anxiety
- Guilt
- Anger
- Hostility
- Loneliness

Behavioral

- Agitation
- Fatigue
- Crying
- Social withdrawal

Cognitive

- Decreased self-esteem
- Preoccupation with the image of deceased
- Helplessness
- Hopelessness
- Self-blame
- Problems with concentration

Physiologic

- Anorexia
- Sleep disturbances
- Energy loss and exhaustion
- Somatic complaints
- Susceptibility to illness/disease

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