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Aligning intention and effect: What can we learn from family members' responses to condolence letters?

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Even when bolstered by good intentions, unforeseen and occasionally harmful consequences may arise from our actions as healthcare providers. An example of this phenomenon was recently provided by a randomized trial assessing the effect of a condolence letter on grief symptoms among relatives of patients who died in the ICU.(1) It is surprising that a condolence letter, a gesture which seems intuitively helpful, was linked to increased symptoms of psychological distress among bereaved family members.(1) This left many of us asking questions about our own practice of sending condolence letters, while also wondering how we might better understand these findings. In this issue of *Critical Care Medicine*, Kentish-Barnes and colleagues(2) use rigorous qualitative methods to explore the experiences of family members receiving condolence letters as part of their randomized trial. By allowing us to understand more about the impact of the intervention, this study highlights one of the important ways qualitative research can be used to improve the conduct of randomized trials. Qualitative research is frequently used to develop and implement interventions before a trial,(3) but this study shows how qualitative methods can also provide key insights *after* the trial is complete.

In this qualitative analysis, the authors evaluated transcribed statements obtained during follow-up interviews with bereaved relatives.(2) During the randomized trial, interviewers were appropriately blinded to group allocation, so statements about condolence letters had to come spontaneously from family members and could then be followed by an in-depth interview. In addition to transcribed statements from interviews, the authors also analyzed written feedback sent from relatives to clinicians during a fourmonth period following the patient's death. Using thematic analysis, the investigators identified six themes related to the

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receipt of condolence letters: 1) a feeling of support; 2) humanization of the medical system; 3) an opportunity for reflection; 4) an opportunity to describe their loved-one; 5) continuity and closure; and 6) doubts and ambivalence. Although several of these themes suggest the potential for condolence letters to foster positive experiences among relatives of patients who died in the ICU, there were negative reactions that cannot be ignored.

Several of the identified themes have direct appeal to critical care clinicians striving to provide family-centered care. The goals of supporting family members during a difficult time, acknowledging the humanity of their loved one, and ensuring family members that the medical team provided high-quality care, are all important.(4) In many instances, statements from family members demonstrate the ability of the condolence letter to help achieve these goals even after the patient's death. However, for some, the statements reveal a mixture of emotions. In addition to feelings of support and gratitude, family members note sadness as they relive the death of their loved one, grapple with grief, or express regret related to the patient's hospital stay. The bereavement process differs for each individual.(5–7) so it is possible that for some, feelings of support associated with the letter may be overshadowed by a renewed sense of loss. It is also possible that an intervention providing psychological support could cause a temporary increase in symptoms associated with remembering the death and yet enhance long-term recovery from grief. However, since this trial followed family members for 6 months, it seems unlikely the findings represent a temporary increase in symptoms followed by a later reduction.(1) Other reactions to the letter highlight unintended consequences that may have resulted from the format of the letter. For some family members, the letter created a sense of obligation to reply, resulting in additional stress. In what was hopefully an isolated example, one family member had a negative experience when efforts to contact the medical team for additional information, a courtesy offered in the condolence letter, did not result in the promised communication. Taking all of the identified themes into consideration, it seems that this relatively straightforward intervention opened the door to the outpouring of a complicated array of emotions from family members.

The complexity of the emotional reaction experienced by family members could explain the relationship between the letter and increased symptoms of psychological distress. This insight may inform additional research related to the utilization of condolence letters, but should it influence clinician behavior now? On one hand, the results from this study, along with those from the associated randomized trial, suggest against the routine mailing of condolence letters. However, both studies have important limitations. First, the randomized trial only included participants from France where the culture of medical care has been noted to be more paternalistic than many other countries.(8) This may limit the generalizability of the trial and thus this qualitative study. Second, although clinicians followed a guideline for the letter, they wrote the letters independently. Clinicians who did not routinely write condolence letters before this trial may have had little experience with this type of correspondence, potentially influencing the quality of the letters. Also, the required nature of the letter may have detracted from the sincerity that corresponds with a letter written of one's own accord. Finally, in this qualitative analysis, only family members who made spontaneous declarations about the condolence letters or provided unsolicited written feedback to clinicians about the letters were included. This leaves a lingering

question about family members who did not provide such statements, and how their experiences may have differed from those who discussed the condolence letter during follow-up interviews or correspondence. These limitations suggest it would be premature to advocate that clinicians cease sending condolence cards altogether. However, this study does suggest that such letters should not be routinely sent to all families of patients who die in the ICU. It also calls into question the appropriate content for a condolence letter, including what types of information may or may not be helpful to grieving family members. Certainly, letters should avoid making commitments that cannot be met, and further evaluation of condolence letters should explore ways to reduce any sense of obligation to respond on the part of family members. Importantly, this qualitative study provides key insights into the results of the randomized trial and offers a foundation for future research to help ICU clinicians support family members even after they have left the ICU.

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