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Original Article

Meaningful Communication Before Death, but Not Present at the Time of Death Itself, Is Associated With Better Outcomes on Measures of Depression and Complicated Grief Among Bereaved Family Members of Cancer Patients

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Abstract

Context. Few studies have explored the clinical significance of the family's presence or absence at the moment of a patient's death and meaningful communication (saying "goodbye") in terms of post-bereavement outcomes.

Objectives. To explore the potential association between the family's depression/complicated grief and their presence at the moment of a patient's death and the patient's communication with the family.

Methods. A nationwide questionnaire survey was conducted on 965 family members of cancer patients who had died at palliative care units.

Results. More than 90% of family members wished to have been present at the moment of death (agree: 40%, $n = 217$; strongly agree: 51%, $n = 280$); 79% ($n = 393$) thereof were present. Families' presence at death was not significantly associated with the occurrence of depression and complicated grief, but the dying patient's ability to say "goodbye" to the family beforehand was (depression: adjusted odds rate, 0.42; 95% CI, 0.26−0.69 adjusted $P = 0.001$; complicated grief: adjusted odds rate, 0.53; 95% CI, 0.29−0.94 adjusted $P = 0.009$).

Conclusion. Many families wished to be present at the moment of the patient's death; however, meaningful communication (saying "goodbye") between the patient and family members, and not their presence or absence itself, was associated with better outcomes on measures of depression or complicated grief. Health care professionals could consider promoting both mutual communication (relating to preparation for death) between family members and patients before imminent death, as well as the family's presence at the moment of death. J Pain Symptom Manage 2017;54:273−279. © *2017 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Family's presence, death, cancer patients, communication

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Introduction

Empirical studies indicate that, after a patient's death, 25%–45% of bereaved family members experience depression and 7%–20% experience complicated grief.[1–3] Health care professionals should make maximal efforts to avoid worsening bereaved families' depression and complicated grief through their actions. Risk factors for complicated grief include the following: social background (economic condition, sex, and age), relationship and closeness with the patient, social support, and previous experiences of loss. The environmental setting before and after the patient's death is also one of the risk factors for complicated grief and depression, and can be modified by health care professionals. For example, health care professionals often ask family members if they would like to spend time with the patient until the patient's death as a part of daily practice, as they believe that it is important for family members to be present at the moment of death. In previous studies, many families explicitly required notification of a patient's impending death, so they could prepare and also call other family members who might wish to be present. If death occurs suddenly, unexpectedly, or in their absence, family members may experience guilt, anger, or regret.[4,5] On the other hand, meaningful communication (saying "goodbye") between the family and the patient before death has been reported to be a component of good death.[6,7]

Nonetheless, to date, few studies have explored the clinical significance of the family's presence or absence at the moment of a patient's death and meaningful communication (saying "goodbye") in terms of post-bereavement outcomes.[8] The primary aim of this study was to explore the potential associations between psychological outcomes on measures of depression and complicated grief on the one hand, and presence at the moment of death and meaningful communication between the patient and bereaved family members on the other.

Methods

Participants and Methods

This was a nationwide survey (the Japan Hospice and Palliative Care Evaluation Study: J-HOPE3) of bereaved family members of cancer patients, aimed at evaluating the quality of end-of-life care across Japan.[9] A multicenter questionnaire survey targeted bereaved family members of cancer patients who had died at palliative care units. We mailed questionnaires to bereaved families in May 2014 and again in June 2014 to non-responding families. Completion and return of the questionnaire was regarded as consent to participate in this study, and families who did not want to participate were asked to return the questionnaire with "no reply." Ethical and scientific validity were confirmed by the institutional review boards of all participating institutions.

Setting and Participants

Primarily responsible physicians identified potential participants with the following inclusion criteria: 1) bereaved family members of an adult cancer patient (one family member was selected for each patient), 2) aged 20 years or older, 3) capable of completing a self-reported questionnaire, and 4) aware of the diagnosis of malignancy. Exclusion criteria were as follows: 1) inability to complete the questionnaire (dementia, cognitive failure, psychiatric illness, language difficulty, or visual loss), 2) treatment-associated death or death in intensive care units, 3) unavailability of family member, 4) the patient having received palliative care services in less than three days, and 5) no recognition of serious psychological distress by the primary physician. The final criterion, as in our previous studies,[10,11] was adopted on the assumption that primary physicians could identify families who might experience a serious psychological impact, given the aim of the present study; no formal criteria or psychiatric screening were applied. According to our previous research,[9] families were surveyed six to 12 months after the patients' deaths.

Measurements

The questionnaire was developed by the authors on the basis of a literature review[1–7] and discussion among the authors. The face validity of the questionnaire was confirmed through a pilot test with five bereaved family members and eight physicians.

Primary End Points

We measured depression and complicated grief among the bereaved family members. We used the Patient Health Questionnaire-9 (PHQ-9) to assess depression. The reliability and validity of the Japanese version of the scale were confirmed, and we classified a score of 10 as indicative of clinical depression.[12,13] We used the Brief Grief Questionnaire (BGQ) to assess complicated grief. The BGQ was developed by Shear et al.,[14] and the reliability and validity of the Japanese version have been confirmed.[15] Fujisawa et al.[16] used the questionnaire with the general Japanese population, including bereaved individuals who had lost a loved one to cancer. Responses were rated as follows: 0 = not at all, 1 = somewhat, and 2 = a lot. A total score of 8 or higher indicates that the respondent is likely to develop complicated grief, scores of 5–7 indicate sub-threshold complicated grief, and scores of <5 indicate that the respondent is unlikely to develop complicated grief.

Primary Predictors

The Family's Wish to be Present at the Moment of the Patient's Death and Their Actual Presence. We asked whether the family was actually present at the moment of the patient's death, and the family-perceived degree of the wish to be present at the moment of death was rated on a five-point Likert-type scale from 1 = strongly agree to 5 = disagree.

Meaningful Communication (Saying "Goodbye") Between the Family and the Patient Before Death. We asked about the dying patient's communication with the family, using the Good Death Inventory.[6,7] We asked the family-perceived degree to which the patient was able to tell the family what he or she wanted (say "goodbye" to the family), which was rated on a seven-point Likert-type scale from 7 = strongly agree to 1 = disagree.

Other Covariates

As covariates, we asked family members to report the following demographic data: patient age, sex, and tumor sites; family member's age, sex, and relationship with the patient; duration of hospice stays; and the availability of another person who could stay with the patient. Furthermore, we asked family members who were actually present at the moment of the patient's death about the family-perceived level of the following, on a five-point Likert-type scale from 1 = strongly agree to 5 = disagree: "I was relieved not to make the patient feel lonely and alone at the final moment," "I was able to prepare by seeing and noticing changes in the patient's body," "I was able to say words of appreciation and farewell to the patient for the last time," and "I had the burdensome feeling that I must be on time for the death of the patient." We also asked family members who were not actually present at the moment of the patient's death about the family-perceived level of the following, on a five-point Likert-type scale from 1 = strongly agree to 5 = disagree: "I regret and blame myself for not being present at the moment of the patient's death."

Statistical Analyses

We calculated the proportion of family members who were actually present at the moment of the patient's death, and determined the relationship between the actual presence and the family-perceived level of the wish (strongly wish or wish, unsure, and do not wish) to be present. We examined the psychological outcomes of the family associated with their presence at the moment of the patient's death and whether the dying patient could communicate what he or she wished to say ("goodbye" to the family) with the family before death. The psychological outcomes of family's presence were assessed by comparing the prevalence of depression (a PHQ-9 score of 10 or more) and complicated grief (a BGQ score of 8 or more). Comparisons were performed using Student *t*-test, and adjusted for the following potential confounding factors through regression analyses: patient's age, sex, and tumor sites; family member's age, sex, and relationship with the patient; periods spent by family members with the patients during the last week; and the availability of another person who could stay with the patient. A *P*-value of 0.050 was regarded as significant. All analyses were performed using the Statistical Package for the Social Sciences (ver. 11.0).

Results

Of the 965 questionnaires sent to bereaved family members, 727 were returned (response rate 75.3%). Of the 727 respondents, 69 declined participation in the study. For the present study, 114 responses were subsequently excluded because of missing data on the primary end-points. Thus, we analyzed a total of 544 responses (82.6% of the obtained data). Background characteristics are summarized in Table 1.

The Proportion of Family Members Who Wished to be Present at the Moment of the Patient's Death, and of Those Who Were Actually Present or Absent

More than 90% of family members wished to be present at the moment of the patient's death (agree: 40%, $n = 217$; strongly agree: 51%; $n = 280$). Among family members who wished to be present at the moment of the patient's death, 79% ($n = 393$) were actually present (Fig. 1).

Psychological Outcomes of the Family Associated with Their Presence at the Moment of the Patient's Death and Meaningful Communication (Saying "Goodbye") Between the Family and the Patient Before Death

The prevalences of depression (a PHQ-9 score of 10 or more) and complicated grief (a BGQ score of 8 or more) were 18.3% (100/544) and 11.9% (65/544), respectively. Figure 2 shows the psychological outcomes of the family associated with their presence at the moment of the patient's death and whether the dying patient could say "goodbye" to the family. Not being present at the time of the patient's death was not significantly associated with depression and complicated grief, but the dying patient's ability to say "goodbye" to the family before death was.

Comparisons were conducted using Student *t*-test, and adjusted for the following potential confounding factors through regression analyses: patient's age, sex, and tumor sites; family member's age, sex, and relationship with the patient; duration of hospice stays;

Table 1
Respondents' Characteristics ($n = 544$)

Characteristic	*n*	%
Patients		
Age (average, SD), yrs	73.5	11.6
Sex		
Male	287	52.6
Female	253	46.3
Original cancer site		
Lung	132	24.2
Pancreas	49	9.0
Gall bladder	20	3.7
Liver	19	3.5
Colon and rectum	70	12.9
Esophagus and stomach	70	12.8
Uterus and ovary	37	6.8
Brain, head, and neck	33	6.1
Kidney and bladder	25	4.6
Breast	22	4
Prostate	19	3.5
Blood and lymphoma	12	2.2
Others	36	6.6
Duration of hospice stays		
Less than seven days	85	15.6
Seven days or more	459	84.4
Family caregiver		
Age (average, SD), yrs	60.0	12.3
Sex		
Male	193	35.3
Female	341	62.5
Relationship with patient		
Spouse	229	41.9
Child	223	40.8
Sibling	29	5.3
Parent	11	2.0
Others	44	8.1
Someone else who can care for the patient		
Yes	412	75.5
No	124	22.7

Some data do not add up to 100% because of missing values.

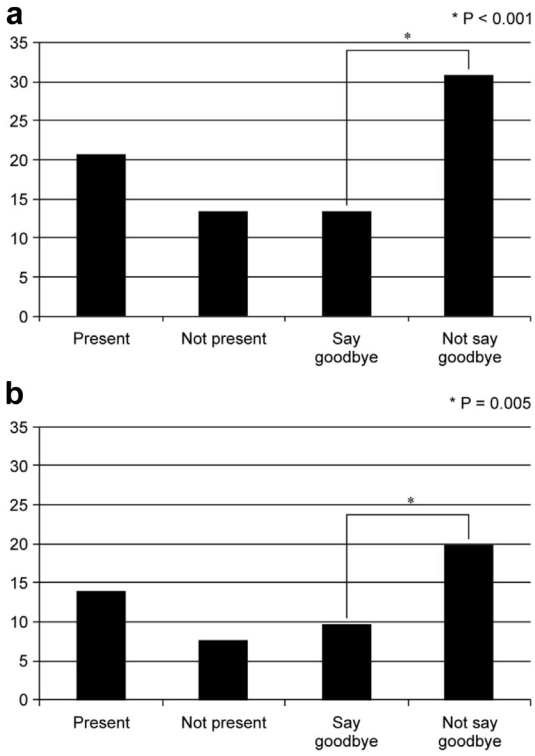

Fig. 2. Psychological impact on family of presence at the moment of the patient's death and meaningful communication (saying "goodbye") between the patient and family members before death. a) The bereaved family members showed depression (indicated clinical depression [PHQ-9 ≥ 10]). b) The bereaved family members showed complicated grief (indicated clinical complicated grief [BGQ ≥ 8]). BGQ = Brief Grief Questionnaire; PHQ-9 = Patient Health Questionnaire-9.

and the availability of another person to stay with the patient (Table 2). The dying patient's ability to say "goodbye" to the family before death was only significantly associated with depression and complicated grief (depression: adjusted odds rate, 0.42; 95% CI, 0.26–0.69 adjusted $P = 0.001$; complicated grief: adjusted odds rate, 0.53; 95% CI, 0.29–0.94 adjusted $P = 0.009$). The family's presence or absence at the moment of the patient's death was not significantly associated with depression and complicated grief. In addition, even when analysis was limited to families who wished to be present beside the patient at the moment of death, family's presence or absence at the moment of death was not significantly associated with depression and complicated grief. Among potential confounding factors, relationship with the patient was significantly associated with depression and complicated grief, and duration of hospice stays was significantly associated with complicated grief.

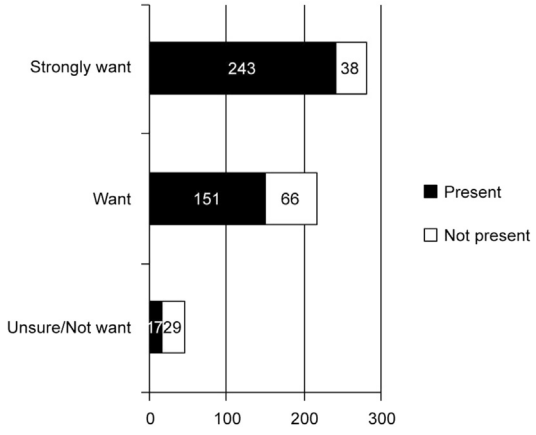

Fig. 1. The actually present and the level of the family-perceived wish to be present at the moment of the patient's death.

Experiences of Family Members Who Were Present or Absent at the Moment of the Patient's Death

Table 3 shows the percentage of family members who responded, "agree" and "strongly agree" regarding the experiences of family members who were present or absent at the end of the patient's life. Of family members who were present at the

Table 2
Relationship Between Depression and Grief

	Depression (PHQ ≧ 10), $n = 100$					Complicated Grief (BGQ ≧ 8), $n = 65$				
Variables	*n*	%	95% CI	*P*	Adj *P*	*n*	%	95% CI	*P*	Adj *P*
Patients										
Age				0.007	0.427				0.001	0.054
Less than 75 yrs	60	22.7	17.6−27.8			44	16.7	12.2−21.2		
75 yrs or more	40	14.3	10.2−18.4			21	7.5	4.4−10.6		
Sex				0.034	0.374				0.755	0.369
Male	64	22.3	17.5−27.1			35	12.2	8.4−16.0		
Female	36	14.2	9.9−18.5			30	11.9	7.9−15.9		
Original cancer site				0.426	0.423				0.005	0.068
Lung	22	16.7				9	6.8			
Stomach	11	19.0				5	8.6			
Colon	10	20.0				9	18.0			
Rectum	3	15.0				1	5.0			
Liver	3	15.8				0	0.0			
Gall bladder	3	15.0				5	25.0			
Pancreas	11	22.4				9	18.4			
Esophagus	1	8.3				1	8.3			
Breast	1	4.5				1	4.5			
Prostate	6	31.6				2	10.5			
Kidney	1	8.3				1	8.3			
Bladder	2	15.4				1	7.7			
Head and neck	3	12.5				3	12.5			
Uterus	2	10.5				2	10.5			
Ovary	3	16.7				0	0.0			
Blood	0	0.0				0	0.0			
Lymphoma	2	20.0				4	40.0			
Soft tissue	1	25.0				0	0.0			
Brain	4	44.4				3	33.3			
Other	11	34.4				9	28.1			
Duration of hospice stays				0.072	0.165				0.014	0.046
Less than seven days	21	24.7	15.5−33.9			17	20.0	11.5−28.5		
Seven days and more	79	17.2	13.7−20.7			48	10.5	7.7−13.3		
Family caregiver										
Age				0.015	0.844				0.001	0.024
Less than 75 yrs	76	16.2	12.9−19.5			45	9.6	6.9−12.3		
75 yrs or more	19	28.4	17.6−39.2			17	25.4	15.0−35.8		
Sex				0.168	0.157				0.648	0.418
Male	32	16.6	11.4−21.8			21	10.9	6.5−15.3		
Female	64	18.8	14.7−22.9			42	12.3	8.8−15.8		
Relationship to patient				0.000	0.023				0.000	0.005
Spouse	62	27.1	21.3−32.9			44	19.2	14.1−24.3		
Others	33	10.7	7.2−14.2			18	5.9	3.3−8.5		
Someone else who can care the patient				0.126	0.225				0.147	0.161
Yes	69	16.7	13.1−20.3			43	10.4	7.5−13.3		
No	28	22.6	15.2−30.0			21	16.9	10.3−23.5		
Preference				0.008	0.265				0.114	0.827
Strongly want	65	23.2	18.3−28.1			40	14.3	10.2−18.4		
Want	31	14.3	9.6−19.0			23	10.6	6.5−14.7		
Uncertain/Not want	4	8.7	0.6−16.8			2	4.3	−1.6−10.2		
Preference and presence				0.093	0.566				0.088	0.424
Want and present/Not want	86	19.6	15.9−23.3			57	13.0	9.9−16.1		
Want and not present	14	13.5	6.9−20.1			8	7.7	2.6−12.8		
Say goodbye				0.000	0.002				0.004	0.009
Yes	58	14.5	11.0−18.0			38	9.5	6.6−12.4		
No	42	29.0	21.6−36.4			27	18.6	12.3−24.9		

The bereaved family members showed clinical depression (PHQ-9 ≥ 10) and clinical complicated grief (BGQ ≥ 8). BGQ = Brief Grief Questionnaire. PHQ-9 = Patient Health Questionnaire-9

moment of the patient's death, 370 (90%; 87%−93% [95% CI]) reported, "I was relieved not to make the patient feel lonely and alone at the final moment." On the other hand, of family members who were not present at the moment of the patient's death, 36 (27%; 20%−35% [95% CI]) reported, "I regret and blame myself for not being present at the moment of the patient's death."

Discussion

This is, to our knowledge, the first large-scale study on bereaved family members to systemically investigate the potential association between psychological outcomes of the family and their presence at the moment of the patient's death and patients' meaningful communication (saying "goodbye") between the

Table 3
Bereaved Families' Experiences at the Moment of the Patient's Death

Items	*n*	%	95% CI
Family members who were actually present at the moment of the patient's death ($n = 411$)			
I was relieved not to make the patient feel lonely and alone at the final moment.	370	90.0	87.1–92.9
I was able to prepare by seeing and realizing changes in the patient's body.	320	77.9	73.9–81.9
I was able to say words of appreciation and farewell to the patient for the last time.	291	70.8	66.4–75.2
I had a burdensome feeling that I must be on time for the death of the patient.	57	13.9	10.6–17.2
Family members who were actually not present at the moment of the patient's death ($n = 133$)			
I regret and blame myself for not being present at the moment of the patient's death.	36	27.1	19.5–34.7

family and the patient before death. The strengths of this study were its large sample, which was drawn from a nationwide population of inpatients at hospices. Two important findings became obvious. First, many families wished to have been present at the moment of patients' death. Second, absence at the moment of the patient's death itself was not significantly associated with family grief, but meaningful communication (say "goodbye") between the patient and family members before death was.

More than 90% of family members wished to have been present at the moment of the patient's death; more than half strongly wished for this. This result suggests that it was important to ask whether family members wished to have been present at the moment of patients' death when death was imminent. This study further revealed that 90% of family members who were present at the moment of the patient's death reported, "I was relieved not to make the patient feel lonely and alone at the final moment," and 27% of those who were not present at the moment of the patient's death reported, "I regret and blame myself for not being present at the moment of the patient's death." Unlike in the present study, in a French study, only 24% of patients had loved ones present at the time of death.[17] Health care professionals should consider the role of family and the environment in end-of-life care, based on cultural background.[18]

Furthermore, in this study, not being present at the time of a patient's death was not significantly associated with depression and complicated grief, but the dying patient's ability to say "goodbye" to the family before death was. This suggests that, although many family members wish to be present at the moment of the patient's death, presence itself was not associated with psychological morbidity. It is important for health care professionals to consider promoting mutual communication (communication relating to preparation for death) between family members and patients before the patient's death, as well as family members' presence.[19–21]

This study has several limitations. Firstly, because of its retrospective nature and because we chose the interval from patient death to questionnaire completion to be within six to 12 months, similar to our previous study,[9] there may be recall bias. Secondly, all patients received specialized palliative care and the findings of the present study may not be automatically generalizable to other situations. Thirdly, the present study had a moderate response rate, and the opinions of family members who did not respond are not known. Fourthly, we could not eliminate the potential influence of unmeasured factors such as history of psychiatric comorbidity associated with family's depression and complicated grief. Finally, this study was conducted in Japan; the results are likely to have been influenced by factors relating to the Japanese culture and, therefore, may not be applicable to other countries.

In conclusion, many families wished to be present at the moment of the patient's death. Moreover, meaningful communication (saying "goodbye") between a patient and family members before the former's death, but not presence or absence at the moment of death, was associated with better outcomes on measures of depression or complicated grief. It is important for health care professionals to consider promoting both mutual communication (communication relating to preparation for death) between family members and patients before patients' death, as well as family members' presence at the time of death.

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References

1. Lobb EA, Kristjanson LJ, Aoun SM, et al. Predictors of complicated grief: a systematic review of empirical studies. Death Stud 2010;34:673–698.

2. Simon NM. Treating complicated grief. JAMA 2013;310:416–423.

3. Stroebe M, Schut H, Stroebe W. Health outcomes of bereavement. Lancet 2007;370:1960–1973.

4. Kristjanson L, Hudson P, Oldham L. Working with families in palliative care. In: Aranda S, O'Connor M, eds. Palliative Care Nursing: A Guide to Practice, ed 2. Melbourne, Australia: AUSMED Publications, 2003:271–283.

5. Heyland DK, Dodek P, Rocker G, et al. What matters most in end-of-life care: perceptions of seriously ill patients and their family members. CMAJ 2006;174:627–633.

6. Miyashita M, Sanjo M, Morita T, et al. Good death in cancer care: a nationwide quantitative study. Ann Oncol 2007; 18:1090–1097.

7. Miyashita M, Morita T, Sato K, et al. Good death inventory: a measure for evaluating good death from the bereaved family member's perspective. J Pain Symptom Manage 2008; 355:486–498.

8. Witkamp FE, van Zuylen L, Borsboom G, et al. Dying in the hospital: what happens and what matters, according to bereaved relatives. J Pain Symptom Manage 2015;492: 203–213.

9. Miyashita M, Morita T, Hirai K. Evaluation of end-of-life cancer care from the perspective of bereaved family members: the Japanese experience. J Clin Oncol 2008;26: 3845–3852.

10. Morita T, Miyashita M, Yamagishi A, et al. Effects of a programme of interventions on regional comprehensive palliative care for patients with cancer: a mixed-methods study. Lancet Oncol 2013;14:638–646.

11. Shinjo T, Morita T, Hirai K, et al. Care for imminently dying cancer patients: family members' experiences and recommendations. J Clin Oncol 2010;28:142–148.

12. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med 2001;16:606–613.

13. Muramatsu K, Miyaoka H, Kamijima K, et al. The patient health questionnaire, Japanese version: validity according to the mini-international neuropsychiatric interview-plus. Psychol Rep 2007;101(3 Pt 1):952–960.

14. Shear KM, Jackson CT, Essock SM, et al. Screening for complicated grief among Project Liberty service recipients 18 months after September 11, 2001. Psychiatr Serv 2006; 57:1291–1297.

15. Ito M, Nakajima S, Fujisawa D, et al. Wall MM: brief measure for screening complicated grief: reliability and discriminant validity. PLoS One 2012;7:e31209.

16. Fujisawa D, Miyashita M, Nakajima S, et al. Prevalence and determinants of complicated grief in general population. J Affect Disord 2010;127:352–358.

17. Ferrand E, Jabre P, Vincent-Genod C, et al. Circumstances of death in hospitalized patients and nurses' perceptions: French multicenter Mort-a-l'Hôpital survey. Arch Intern Med 2008;168:867–875.

18. Mazanec P, Tyler MK. Cultural considerations in end-of-life care: how ethnicity, age, and spirituality affect decisions when death is imminent. Am J Nurs 2003;103:50–58.

19. Hebert RS, Prigerson HG, Schulz R, et al. Preparing caregivers for the death of a loved one: a theoretical framework and suggestions for future research. J Palliat Med 2006; 9:1164–1171.

20. Schulz R, Boerner K, Klinger J, et al. Preparedness for death and adjustment to bereavement among caregivers of recently placed nursing home residents. J Palliat Med 2015;18:127–133.

21. Hebert RS, Schulz R, Copeland V, et al. What questions do family caregivers want to discuss with health care providers in order to prepare for the death of a loved one? An ethnographic study of caregivers of patients at end of life. J Palliat Med 2008;11:476–483.