Should family members be present during cardiopulmonary resuscitation? A discussion paper.

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Summary

- Traditionally, in Hong Kong, family members are not allowed to witness the cardiopulmonary resuscitation procedure.
- Family members are not encouraged to witness resuscitation events due to concerns about the potential traumatic and distressing impact of resuscitation on the family, the possibility that a family member might hinder the resuscitation process, the limited space at the bedside, and the possibility for a breach of patient confidentiality.
- The benefits of having family members present during resuscitation include imparting loving and caring feelings to the dying patient, establishing an empathic and compassionate atmosphere for the patient and family, meeting their emotional needs, and promoting their grieving process.
- When making a clinical ethical decision, the patient's medical indications, their preferences, and quality-of-life should normally exert a more powerful influence in the clinical ethical analysis.
- Based on the concept that nurses are obligated to advocate for the primacy of the patient's interests by meeting the comprehensive needs of patients and their families, healthcare workers should balance the needs of the patient and family and the preferences of medical staff that carry out the resuscitation by allowing family members to witness the procedure.

Introduction

Decades ago, sick individuals were cared for at home especially those who had terminal illness. They were cared by their family doctors and died with their families surrounding them. With the advancement of medical technology, disease and illness was medicalised, and the process of caring was removed away from communities into the hospital environment. Admitting patients into ward areas and in particular critical care settings to receive treatment and other lifesaving interventions means that they are potentially isolated from their families.

Traditionally, the exclusion of family members (FM) from witnessing the resuscitation of a loved one has been justified on a number of grounds (Osuagwu, 1991; Mitchell & Lynch, 1997; Van der Woning, 1999). However, on the basis of a small study conducted in early eighties, this practice has aroused extensive debates in many western countries (Hanson & Strawer, 1992; Robinson et al., 1998; Van der Woning, 1997; Meyers et al., 2000; Eichhorn et al., 2001). Research evidence has shown that many family members want to remain with their loved ones during their final moments of life (Barratt & Wallis,1998; Meyers et al., 1998; Eichhorn et al., 2001). In Hong Kong as well as in many other countries, educational standards have risen and the public has access to news and information to an unprecedented level. Consequently, families are increasingly challenging hospital staff for not allowing FM to be with the patient during resuscitation (Meyers et al., 2000; MacClean et al., 2003). This issue challenges the current routine practice in many hospitals regarding cardiopulmonary resuscitation (CPR) and exposes the conflict between needs of the patients and their family members and the preferences of the medical staff that carry out the resuscitation measures.

To address whether or not to allow FM to observe the resuscitation of a loved one, this paper investigates the arguments for keeping families away during resuscitation and the justification for allowing them to be present. After reviewing the controversial perspectives, healthcare workers may make a reasonable judgment based on developed knowledge and the balance between the needs and preference between patients, families, and healthcare workers.

Reasons of preventing family members witnessing CPR

There are apparently many reasons for keeping relatives away during CPR of a loved one. Healthcare workers have concerns on the immediate and long-term impact of witnessing resuscitation on families, especially a failed one (Weslien & Nilstun, 2003). Many healthcare workers believe that FM may find resuscitation attempts traumatic and distressing (Mitchell & Lynch, 1997; Weslien & Nilstun, 2003; Grice et al., 2003). In a study of 50 nurses, medical staff and paramedic staff, only eight respondents would invite a relative to be with the patient during resuscitation (Chalk, 1995). In fact, as observed in clinical practice, it will not be easy for families to watch a team of strangers shoving tubes down the throat of a relative, piercing each arm of their relative with large-gauge needles or, in extreme situations, even cracking open the patient's chest. Therefore, among the study sample of 80 doctors and nurses, the majority of them (86%) commented that

CPR procedures were too distressing to FM, 79% believed that FM would impede CPR, and 68% expressed that FM would find it more difficult to make a decision to withdraw treatment if they witness the CPR (Mitchell & Lynch, 1997). Moreover, a survey exploring healthcare professionals beliefs concluded that 43 (100%) of doctors and 32 (91%) of nurses agreed that families might be traumatised by the resuscitation procedures (Blundell & Watson 2004). Van der Woning (1999) described the traumatic effect of sounds of resuscitation as FM imagined that the patient was hurting during CPR; in addition, the visual appearance of the patient during CPR was dreadful as described by FM. Families experienced the whole situation as frightening, offensive and had flashbacks and negative feelings for a long time. Therefore, watching these undignified procedures may not only be traumatic to families but may also possibly leave the families with a horrifying final memory.

Apart from the believed impacts on families, healthcare workers are also concerned about the possible hindrance on nurses and doctors associated with allowing FM witnessing the CPR procedure. Studies have shown that healthcare workers often expressed the fear that the presence of FM would increase the stress of the medical team and possibly disrupt medical procedures (Redley & Hood, 1997; Helmer et al., 2000). According to Blundell et al. (2004), around 95% of doctors and 88% of nursing staff expressed that they would find having FM present emotionally stressful. Similar findings have been reported with junior medical doctors (Morgan & Westmoreland, 2002). In addition, some believed that allowing families to witness CPR would inhibit staff's performance (Chalk, 1995; Meyers et al., 2000), and would induce one or more acute stress reaction symptom among the staff (Boyd & White, 2000). According to Schilling (1994), presence of relatives may interfere with treatment as families may impair the staff's ability to remain focused; families may also have the potential to intervene physically during the resuscitation. As a result, the level of stress among staff during the resuscitative process might be increased. A less tense atmosphere can help people to concentrate on the priorities of the job in hand and avoid being distracted by unimportant details because of increased anxiety (Schilling, 1994). Studies also found that both medical staff and families agreed that allowing families to witness would prolong the resuscitation, making the decision to stop resuscitation difficult (Blundell et al., 2004; Rosenczweig, 1998).

The available space in many units is also an issue to be considered. During resuscitation, space is at a premium. If families are allowed to stay at the bedside, it will leave no room for doctors and nurses to carry out the resuscitation measures. Moreover, when a highly invasive procedure is needed, such as thoracotomy, there will be no room for families to stand nearby or to hold the patient's hand (Rosenczweig, 1998). There is also the potential that family observers could come to harm or be injured by hospital equipment, those granting permission may be liable in claims of compensation (Albarran & Stafford 1999).

One more factor for excluding FM from staying at bedside during CPR is related to maintaining patient confidentiality. Fulbrook et al. (2005) stated that 78 (62.9%) of the studied nurses expressed concerns that breaches of confidence could occur during witnessed CPR. The assurance of confidentiality ensures a good rapport so that patients are willing to disclose their personal information to healthcare workers (Steward & Bowker, 1997). A patient's permission is required in order to disclose their medical information to other parties. Without the patient's permission, healthcare workers are not sure to what extent they can allow the families to know. Breaching this confidentiality could damage the trusting relationship between patient and healthcare workers. It was suggested that patients who are unconscious or gravely ill have the same rights to confidentiality as conscious patients. Healthcare workers could not assume unconscious patients would normally consent to have relatives witness their treatment (Steward & Bowker, 1997) although there were a number of authors who stated that this confidentiality for witnessed CPR was a theoretical discussion rather then a reality (Boyd, 2000; Mason, 2003; Fulbrook et al., 2005).

Should presence of relatives be prohibited?

The disadvantages of having families around during resuscitation are discussed above, however, the advantages of family presence are also discussed by many authors. Recent studies indicate that both relatives and patients may actually benefit from the presence of family members during resuscitation (Hanson & Strawer, 1992; Chalk, 1995; Resuscitation Council, 1996; Robinson et al., 1998; Meyers et al., 2000; Eichhorn et al., 2001). Vanezis and McGee (1999) stated that if the grieving process is hindered during the early phase of accidents or sudden death, it can result in psychiatric problems of the FM in the future. Allowing family members to be present during resuscitation will assist the grieving process of the family (Robinson et al., 1998; Eichhorn et al., 2001). Hanson and Strawer (1992) suggested a practical way for FM to be with the patient during CPR. Families could be briefed by hospital staff and given the choice of being present during resuscitation. When the resuscitation team was ready, families might be led into the room, where they would be were supervised closely. During invasive procedures families could be escorted out but permitted to re-enter later if they wished.

Doyle et al. (1987) studied the effects of family presence during resuscitation. They found that 76% (n = 36) of the studied families believed that their adjustment to the death of the patient became easier and their recovery from the grieving process was quicker, and 94% (n = 44) of studied families (indicated that they would participate again if they would ever come across a similar situation. In addition, 64% (n = 30) of relatives believed their presence were beneficial to the dying family member. Some participants believed a dying relative might still be able to hear them and was comforted by their last words of "good-bye" and "I love you" (Hanson & Strawer, 1992). MacClean et al. (2003) also agreed that family presence can provide "a sense of closure on a life shared together."

Apart from the view of the families, Eichhorn et al. (2001) and Robinson et al. (1998) interviewed patients who had undergone invasive procedures or survived from CPR. The majority of them described being comforted and supported, and the presence of the FM led to an atmosphere of greater empathy and compassion. All of the nine patients from Eichhorn et al.'s (2001) study viewed FM presence as a right. In the study by Meyers et al. (2000), the views of staff members were obtained. Healthcare workers felt that family presence was important for the family and for the patient's emotional and spiritual needs. All staff members were convinced that family members had a unique role in providing help to the patient and the team members, such as acting as a family spokesperson. Staff perceived that family presence made them more aware of the patient's dignity, privacy and need for pain management.

Professional behaviour as well as modifying conversations at the bedside were encouraged while families were around.

As mentioned previously, relatives' emotions may distract doctors and nurses during resuscitation. Although an emotionally unstable relative could pose an increased risk of interfering with or disrupting the resuscitation attempt, this fear might be overstated. Many studies indicated that family members were rarely disruptive, and family members were led to the bedside and encouraged to touch and speak to their loved one with no obvious disruption to the resuscitation process (Doyle et al., 1987; Hanson & Strawer, 1992). However, it is hard to predict everyone's reaction to a traumatic event and death of a family member, so a dedicated member of the resuscitation team is encouraged to escort FM throughout the experience (Fulbrook et al., 2005).

Concerning the family's reaction to invasive procedures, the thought of a bloody scene such as the cracking open the chest and performing cardiac massage may horrify many family members. However, Robinson et al. (1998) showed that for all the eight relatives who witnessed defibrillation, tracheal intubation, cannulation of the femoral or subclavian vein, tube thoracocentesis, and pericardocentesis, none of them was frightened by the procedures or had to leave the resuscitation room due to distress. However, not all resuscitations are as extreme as these and most resuscitations are not excessively invasive and may therefore be less traumatic for families. In fact, if accompanied by a social worker, a chaplain or a nurse who can provide emotional support, explanations and interpretation of technical procedures and decision (Albarran & Stafford, 1999), a willing and emotionally stable family member could stay at the bedside without interfering with patient care (Hanson & Strawer, 1992). By allowing the families to stay during the resuscitation, they are well informed of the patient's condition and know that the healthcare workers have made every effort to save their family member's life. As found by Meyer et al. (2000), nearly all of the 39 FM in their study described that being present had helped them to understand the patient's condition, to feel certain that every possible intervention had been performed and also helped them to face the reality.

It is true that a patient's right to confidentiality is breached by allowing families to witness without permission of the patient. However, confidentiality is already violated when a police officer or hospital staff member phones a family member to let them know that their loved one has become gravely ill or has been in a serious accident (Rosenczweig, 1998). Of course, medical staff should consider the views of the patient, and patients who have expressed advance directives on CPR about restricting people during resuscitation should have their wishes respected. However, when there is no advance directive, a decision to balance the consequences of breaching, as opposed to preserving, a patient's confidentiality must be made. If breaching confidentiality offers no obvious benefit to the patient, then the advantages of informing family members should outweigh any justifications. For instance, if the patient is unable to communicate, families are very helpful in providing additional medical information to the resuscitation team (Rosenczweig, 1998; Hanson & Strawer, 1992).

Clinical ethical analysis on family presence during CPR

There is no definitive answer about whether to allow families to witness resuscitation or not. However, it is reasonable to make a judgement based on developed knowledge. A conflict may exist between the family members and healthcare providers when the family member has a desire to be present with the loved one during CPR but the healthcare providers prefer not to have families witness the resuscitation measures. To resolve such a dilemma, the clinical ethical analysis described by Jonsen et al. (1998), which defines social, economic, and health policy issues, provides a practical and understandable approach. According to Jonsen et al. (1998), restrictive practice constitutes a contextual feature that would normally decrease its overall importance in ethical decision making. Instead, the medical indications, the patient's preferences, and quality-of-life issues would normally exert a more powerful influence in the final clinical ethical analysis, thus overweighing the contextual features. The following case example illustrates the dilemma.

Mr. A suffered from liver cancer and was admitted to the intensive care unit. However, he developed sudden cardiac arrest on his second day of hospitalisation. The resuscitation team rushed in and started the resuscitation measures. The family members were escorted out to a waiting room. Unfortunately, the resuscitation was unsuccessful. Mr. A passed away, and the family was informed later by the doctors. In this case, the patient did not survive and therefore his preference for having relatives present was unknown. As a result of the family members' exclusion the quality of life of the patient during his last moments may have been affected adversely, as may have been the family's emotions because they were not given the opportunity to say "goodbye" to their loved one.

Death of a family member is a personal event. Arguably, every individual needs companionship, even if they are unconscious. If Mr. A's family had requested to remain present and witness the resuscitation process, ethically, they should be allowed to stay. This dilemma was referred to by Blair (2004). In the USA, nurses should enable FM to be present with the patient during CPR, based on the Code of Ethics for Nurses (American Nurses Association, 2001), which emphasises that they are obligated to advocate for the primacy of the patient's interests by meeting the comprehensive needs of patients and their families across the care continuum. Blair (2004) also suggested that whenever a decision is made, the duty of care to the patient is of primary importance. On the other hand, as suggested by many other authors (Moreland, 2004; Fulbrook et al., 2005), nurses may collaborate with the multidisciplinary teams consisting of physicians, social workers, chaplains, and other health care providers to develop written guidelines to guide and support the needs of staff and relatives.

Conclusion

There is still much debate about whether healthcare workers should abolish the traditional restriction of family presence during CPR. So far, the Emergency Nurses Association of the United States is the only health-related organisation that has published a position paper promoting family presence during CPR. Although the issue remains controversial, it is agreed that, in general, family presence can be beneficial for both patients and the patients' family members. Besides, there are increasing numbers of western countries allowing family members to be present during CPR if they wish.

In Hong Kong, healthcare workers are still routinely practising the 'no presence of patient's family' during CPR. Perhaps it is now time for us to rethink about our routines and change our practice!

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