

Should relatives witness resuscitation? Ethical issues and practical considerations



Education

Éducation

Carolyn Rosenczweig

In brief

IN WINNING SECOND PRIZE in the Logie Medical Ethics Essay Contest in 1997, Carolyn Rosenczweig raised questions about the role patients' family members should be allowed to play during resuscitative efforts by medical staff. She concluded that even though their presence might complicate resuscitation attempts, "blanket policies that exclude all relatives from being present seem a knee-jerk reaction."

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En bref

DANS LA DISSERTATION QUI LUI A VALU LE DEUXIÈME PRIX au Concours Logie de dissertation en éthique médicale du 1997, Carolyn Rosenczweig a soulevé des questions au sujet du rôle que les membres de la famille des patients devraient être autorisés à jouer au cours des tentatives de réanimation faites par le personnel médical. Elle conclut que même si leur présence pourrait compliquer les tentatives de réanimation, «les politiques qui interdisent d'emblée la présence des membres de la famille ressemblent à une réaction irréfléchie».

We were catching up on charting during a brief lull on a busy night when the hot line rang. A cardiac-arrest patient was 5 minutes away, so the trauma-team members assumed their positions. Mine was bedside, on a small bench, ready to do compressions. The lines were ready, monitors turned on, intubation tray set up for use. The paramedics burst through the door, bagging a heavysset man in his 50s. Trailing the stretcher, hanging on to his left ankle, was his wife.

Mr. B, his wife and some family friends had been having dinner at the marina. Later, Mr. B started complaining of not feeling well, collapsed, and went into full arrest. CPR was initiated immediately by a bystander with training. Mrs. B rode in the ambulance, with the resuscitation in progress. More than 25 minutes elapsed between his collapse and arrival at the ER.

We moved him on to a trauma bed and I began cardiac compressions while the team leader began the intubation and team nurses put lines into each arm. Mrs. B remained at the foot of the bed, tears streaming down her face, calling out: "Come on Bill. Come on Bill, we need you!"

I had never been part of a resuscitation where a relative was present. Mr. B was ashen grey, his skin cold. There was an uneasiness among team members. This was not the usual clinical exercise; this time we were working to bring back Mrs. B's husband. Ten minutes went by. "Oh my God, please God, don't let Bill die," Mrs. B pleaded.

Having switched off with a nurse, it was my turn to do compressions again. Our rescue attempt was failing. Neither the drugs nor defibrillation helped. We looked at each other as we continued working, silently communicating that we could not call this with Mrs. B present. One of the nurses put an arm around Mrs. B and escorted her out. We continued for another minute and then called the effort.



Carolyn Rosenczweig



Should relatives be present?

In the early 1980s, the routine exclusion of relatives from resuscitation procedures in emergency departments was called into question.^{1,2} An increasing number of relatives began expressing the need to be present during the death of a family member.^{3,4} Most respondents to an informal survey of emergency physicians at the Vancouver General Hospital, which asked if relatives should be allowed to witness resuscitation, were against the idea. There was a common concern about the immediate and long-term impact of witnessing such an event.

Many physicians felt that watching a resuscitation attempt, especially following a traumatic event, would be horrifying for an untrained person. However, recent research indicates that relatives may actually benefit by being present. The question, then, is whether the emergency physician's instinct to "protect" the relative is truly justified, especially in light of recent evidence. The issue also raises ethical considerations about patient confidentiality and relatives' rights.

Keeping relatives away

When discussing arguments against the presence of relatives, 3 issues are raised, the first involving patients and their right to confidentiality. A letter in the *British Medical Journal* argued that doctors cannot assume that unconscious patients would normally consent to having relatives witness their treatment because "patients who are unconscious or gravely ill have the same rights to confidentiality as conscious patients."⁵

Traditionally, a patient's permission is required before medical information is disclosed to outside parties. The assurance of confidentiality creates a bond of trust whereby patients readily disclose personal information to their physician. Breaching this confidentiality can have several repercussions, beginning with damage to the fiduciary patient-physician relationship. The dissemination of private information about a patient also gives rise to the utilitarian prediction of diminished public faith in the integrity of the medical profession. Finally, in this age of litigation, breaching patient confidentiality can result in legal action.

The second reason for keeping relatives away is their potential impact on the resuscitation team. Relatives could impede staff performance in several ways. Their presence may influence the decision to prolong a futile resuscitation effort, as was the case with Mr. B. Conversely, a relative may pressure the team to stop a resuscitation effort prematurely. In either scenario, the locus of control drifts away from the team leader, possibly impairing her ability to remain focused. More dramatic is the potential

for hysterical relatives to intervene physically during a resuscitation.^{6,7} In one case, a mother tried to drag a physician off her daughter during cardiac massage.⁶ Also, it is not uncommon during a resuscitation for team members to make gestures or comments that might appear inappropriate to a relative. To preserve calm, a "slightly relaxed atmosphere helps people concentrate on the priorities of the job in hand and avoid being distracted by unimportant details because of anxiety."⁶ The presence of a relative might prohibit the coping mechanisms of remaining detached and imparting dark humour in the face of a seemingly hopeless situation. As a result, there might be an increased level of stress among staff during the resuscitative effort and perhaps even afterwards.

There is also the issue of space. During extreme resuscitative efforts space is always at a premium. In some cases, highly invasive procedures such as thoracotomies are performed. Amid such chaos there is no room for a relative to stand bedside and hold the patient's hand.

Finally, errors may occur during a resuscitation. The presence of a relative may increase staff self-consciousness due to the potential litigation and public awareness that may result when a mistake is witnessed.

The remaining consideration involves the relative of the patient being resuscitated. As one emergency physician stated in the Vancouver survey mentioned earlier: "To watch a team of strangers frantically shove tubes down the throat of a relative, pierce each arm with large-gauge needles or, in extreme situations, crack open the chest, would not only be traumatic to observe but could also leave the relative with a horrifying final memory."

On the other hand . . .

Allowing relatives to witness a resuscitation would indeed violate the patient's right to confidentiality. However, is confidentiality not also breached when a police officer or hospital social worker phones a relative to say that a loved one has become gravely ill or been in a serious accident? Emergency departments routinely phone the relatives of victims rendered unconscious by illness or accident. Also, what of those instances when the relative is already aware of the condition that led to the patient's cardiac arrest? This is often the case when the relative has been the longtime caregiver for an ailing spouse. Here, "confidentiality" seems but a weak and invalid excuse to keep the family out.

No matter the situation, a decision must be made that weighs the consequences of breaching as opposed to preserving a patient's confidentiality. If breaching confidentiality offers no obvious benefit to the patient, then the consequences of informing family members should outweigh any justification underlying such a violation. How-



ever, in dire circumstances that have rendered the patient unable to communicate, relatives often become invaluable in providing additional medical information. Here, breaking confidentiality rules would appear justified. As the concept of "witnessed resuscitation" becomes more widely accepted, there may be a future need to obtain consent for relatives to be present. At present, however, this option remains theoretical.⁸

Relatives frequently become even further involved in the care of family members via their responsibilities as "next of kin." Because being unconscious obviously renders a person incompetent to participate in treatment decisions, the relative must become the surrogate, act on the patient's behalf, participate in critical decisions and become the patient's voice. The sense of responsibility this role bestows is enormous and surely deepens any pre-existing need to be close by, even during the most critical moment of all — death. What justification exists to then deny a relative a chance to meet this need?

Perhaps there is no justification per se, other than a paternalistic instinct to try and protect the relative from death. However, is the medical profession really "protecting" anyone by routinely excluding relatives from the resuscitation of family members? As one nurse observed: "We devalue the importance of any particular death as a profoundly unique human event that touches the lives of others, and we ignore the significance of death as a passage, as a mystery. In doing so, we protect and perpetuate our own myth of control."⁹

Others have argued that "the paternalistic desire to protect relatives misunderstands the human response to death," adding: "There is no preparation for sudden death and witnessing the event may reduce the disbelief that hinders grieving."³ This, then, begs the question: Might relatives actually benefit from, rather than be harmed by, witnessing resuscitation?

A hospital responds

A study by emergency department staff at the Foote Hospital in Jackson, Michigan, concluded that allowing family members to be present assisted the grieving process in most cases.^{1,2} There, relatives were briefed by hospital staff and given the choice of being present during the resuscitation. The manner in which the option was posed eliminated any guilt among those who declined to be present. When the resuscitation team was ready relatives were led into the room, where they were closely supervised at all times. They were escorted out during invasive procedures but permitted to re-enter later if they wished. Several months later participating relatives completed a survey; 76% believed that their adjustment to the death of their relative, as well as their grieving process,

had been made easier; 94% indicated they would participate again. Moreover, 64% of relatives believed their presence was beneficial to the dying family member. The possibility that the patient, although unconscious, may actually benefit from this process should also be recognized. Some people believe a dying relative might still be able to hear them and have the comfort of feeling that their last "good-bye" and "I love you" was heard.¹⁻⁴

Finally, physicians must appreciate that television dramas such as *ER*, medical features in the media and the seemingly infinite access to medical information via the World Wide Web have all contributed to rudimentary public awareness of the resuscitation process. Further, widespread public campaigns promoting training in basic first aid and CPR have further added to public awareness. Lastly, there is a very real possibility that the relative in the ER will have been present during paramedics' initial resuscitation efforts or, in some cases, was the first person to perform CPR. Therefore, the scene in the trauma room may be less shocking than previously expected.

Resolving the problem

In resolving this issue, the concerns of emergency department staff must be addressed. Although an emotionally overwrought relative may appear to pose an increased risk for directly interfering with or disrupting the smooth running of a resuscitation attempt, this fear may be overstated. At the Foote Hospital, family members were rarely disruptive.^{1,2} In fact, family members "frequently had to be led to the bedside and encouraged to touch and speak to their loved one." However, since one cannot predict another's reaction to pending death, close supervision is warranted.

A resuscitation effort must run as smoothly as possible in order to have a realistic chance of defeating death. This is especially true when the effort entails resuscitation of the victim of a traumatic accident. The dramatic extremes of cracking the chest and performing open cardiac massage are often the scenarios that spring to mind when deciding whether relatives should be permitted to witness the resuscitation of a family member. However, not all resuscitations are as extreme as those for a traumatic arrest. Yet, even the most exhaustive resuscitative efforts can reach a lull after all procedures have been performed and only test results are being awaited. During these times a willing and emotionally stable relative, accompanied by a social worker or nurse, can be accommodated without interfering with patient care. This is even more true during less invasive resuscitations, such as cardiac arrest protocols. The potential long-term benefits for grieving relatives have been proven. Further discussion needs to be encouraged and a means of accommodating both the needs



of relatives and emergency department staff must be explored, thereby inviting an attitude that death is no longer a phenomenon that occurs within a sterile clinical vacuum.

Conclusion

Although there are different degrees of resuscitation, blanket policies that exclude all relatives from resuscitation attempts are a knee-jerk reaction taken because the worst possible scenario has been envisioned. Not all resuscitations are forums of blood and chaos. Although it is true that resuscitations can become very crowded events, even the care of the most severely injured victim can afford a moment when a willing and composed relative can enter and hold the patient's hand. Relatives must not be viewed as an added complication but as a direct extension and reflection of the patient's life. The need to say good-bye before it is too late should be regarded as an innate response to the death of a family member.

Resuscitation teams seem to take for granted that they are often the last people to be in the presence of a dying person. Being present during these final moments is a privilege, not a side effect of an arrest protocol. Sharing this privilege may be the greatest comfort the medical profession can offer a grieving relative.

References

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This photo, sent to us by Dr. J.A. Webster of Yarmouth, NS, was taken by his father, Dr. Charles Webster, in 1897 while on a voyage from New York to Yokohama, Japan. Another picture taken on the same voyage appeared in the Feb. 10 issue (*CMAJ* 1998;158:355). On the back of the photo Dr. Charles Webster, who would later be named a senior member of the CMA, wrote: "Old Cameron at the wheel in fair weather in ship *Iranian*."