Family opinion regarding their presence with the physicians during active cardio-pulmonary resuscitation of their relatives

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ABSTRACT

Background: Family presence during resuscitation has been a controversial topic ever since it was first introduced. Despite claims that it may exaggerate the burden on health care workers, this practice is widely gaining attention and a lot of evidence refutes these claims. In fact, a number of international organizations have supported this practice as being useful and with a positive impact on family members. There is not a lot of research in this area in Saudi Arabia and we conducted this research with this aim.

Methods: This was a cross-sectional study conducted in the Southern Region of Saudi Arabia and 1185 subjects were enrolled. After attaining formal consent, a pre-formulated questionnaire, formulated on themes from the literature review, was given to the subjects which addressed some basic questions about their opinions regarding family presence during cardiopulmonary resuscitation.

Results: Out of the 1,185 respondents, 174 (14.6%) had witnessed Cardiopulmonary Resuscitation (CPR) of their relatives while 85.3% had never done so. This study demonstrated that more than half of the family members (58.9%) expressed a desire to be with their loved ones during resuscitation. While 587 (49.5%) people were concerned their presence in the treatment room may interfere in the medical help being provided to their relative, a slight majority i.e. 598 (50.3%) did not agree with this statement. When asked about the psychological impact of witnessing the CPR of their relative, 54.6% (650) people said it might affect them negatively in the long run while 45% (535) did not feel the same. Moreover, 609 (51.4%) did not feel their presence in the Emergency Room (ER) would help the patient in any way while 48.6% agreed that it may indeed do so. 69.8 % of attendants disagreed that they would interfere with the medical process if they were allowed to be present.

Conclusion: This study supports that FPDR has shown promising benefits . Therefore, family members must be offered an option to witness the efforts of the medical team and their wishes must be respected and it is the duty of the health care institutions to facilitate this process .

Key words: FPDR, family presence, Cardiopulmonary resuscitation, CPR

Introduction

Cardiopulmonary resuscitation or CPR is a lifesaving maneuver employed all over the world in hospital emergency rooms (and sometimes general wards) to maintain cerebral blood flow in case a patient develops a cardiac arrest. It is a difficult and distressing time both for the family and the health care providers. A lot of discussion has ensued about whether family members should be allowed to stay in the resuscitation room during CPR. This controversial topic first made its formal appearance in literature in the early 1980s at the Foote Hospital in America where several family members requested permission to be present in the resuscitation room (1). Consequently, Doyle et al conducted a study in the emergency department at the Foote Hospital in 1985 amongst the attendees and the health care workers (2). Ever since, this subject has gained a lot of attention and the pros and cons of allowing relatives in the treatment room have been argued.

Family presence during resuscitation (FPDR) has been defined as "the presence of family in the patient care area, in a location that affords visual or physical contact with the patient during resuscitation events" (3). Some authors like Helmer et al argue that witnessing the CPR may put an additional emotional and physical burden on the relatives and thus, impair the coping process and may also interfere with the quality of medical care decisions (4). FPDR may also result in increased levels of stress amongst the health care team and sometimes, even disrupt the communication necessary during resuscitation (5,6). One study demonstrated that the presence of a disruptive family member led to a delay in delivering the first shock and fewer total shocks delivered (5). However, proponents of this practice believe that being present during cardiopulmonary resuscitation (CPR) may help the family member understand that everything possible to bring the patient back to life has been done. Moreover, the relative's presence in the ER may offer the opportunity for a last goodbye and help that person grasp the reality of the patient's imminent death, in addition to quashing suspicion about what happened behind closed doors (7,8,). Some also suggest that it may eventually help them cope with the grief and the bereavement will not be prolonged along with a decreased incidence of PTSD (post traumatic stress disorder) (9,10). For instance, in a trial in UK families that were randomized to be present during resuscitation and who were followed up it was found that they had lower bereavement scores, using the Texas Inventory of Grief at both 3 and 9 months after the resuscitation event. This was considered strong evidence in favour of FPDR so the trial was stopped and the practice adopted (11). However, there is a need for analyzing further the potential benefits to family members against the stress induced in health care providers as well as the risk of legal claims. Despite these debates about benefits and harms, major international guidelines for CPR state that there is evidence based positive aspects of family-witnessed resuscitation, and this action is considered reasonable and generally useful (12). Furthermore, it has been adopted as a standard by the Emergency Nurses Association (13) the American Academy of Pediatrics (14), and the American Heart Association (15).

Keeping in view that the social and moral values differ among different parts of the world, we formulated this cross sectional study to assess the psychological effects of family attendance in the resuscitation room. In our study, our principal aim was to determine the response of family members to their presence in the resuscitation room and how likely it was to affect their ability to cope with their loss. We also assessed the effect of family presence on medical efforts at resuscitation, the well-being of the health care workers and their response to a witnessed CPR.

Aims and Objectives

To study, assess and form evidence based conclusions on the practice of allowing family members to be present at the time of resuscitation.

Materials and Methods

This was a cross-sectional study conducted in the southern region of Saudi Arabia and 1185 subjects were enrolled. After attaining formal consent, a pre-formulated questionnaire, formulated on themes from the literature review, was given to the subjects, which addressed some basic questiona about their opinions regarding family presence during cardiopulmonary resuscitation.

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Study Participants

Inclusion Criteria:

Regular Community members

Visitors to Aseer Central Hospital (ACH)

Attendants of Inpatients at ACH

ER Visitors.

Exclusion Criteria:

1- Physicians

2-Nurses and nurses' assistants

3-Respiratory therapists.

Ethical clearance was obtained from the Human Research Ethics Committee of the King Khalid University (KKU), and permission was obtained from the administration of the hospital. The total study group canvassed, comprised 1,185 respondents.

After attaining formal consent, a pre-formulated questionnaire formulated on themes from the literature review was given to the subjects which addressed some basic questions about their opinions regarding family presence during cardiopulmonary resuscitation. The questionnaire was divided into 2 sections comprising a total of 13 questions. Section 1 consisted of four demographic queries. Section 2 consisted of 9 survey questions relating to the attitude, desires and any concerns regarding family presence in the resuscitation room. These questions were formulated after careful and detailed literature review and keeping in view the religious and ethical sentiments of people.

This was then collected and the data assessed by standard statistical analysis.

Statistical Analysis:

Qualitative and quantitative data were analyzed using IBM SPSS ver. 22. Responses were tabulated and compared. Data analysis was conducted using descriptive statistics

Results

Of the 1,185 subjects, the maximum (52%) were aged between 21 – 32 years, 23% were 32- 42 years, 15% were aged less than 20 years and 0.34% were above 53 years (Figure 1). The occupation of the respondents is given in Figure 2.

The response of family members to each query is given in Table 1.

Out of the 1,185 respondents, 174 (14.6%) had witnessed the CPR of their relatives while 85.3% had never done so. When asked , 91.4% (1,083) attendants were not allowed by the attending physicians to witness the CPR. 698 (58.9 %) subjects wished to be present with the medical team as they performed CPR. However, 487 (40.7%) attendants did not wish to do so. While 587 (49.5%) people were concerned their presence in the treatment room may interfere in the medical help being provided to their relative, a slight majority i.e. 598 (50.3%) did not agree with this statement. When asked, in general terms, about the psychological impact of witnessing the CPR of their relative, 54.6% (650) people said it might affect them negatively in the long run while 45% (535) did not feel the same. Moreover, 609 (51.4%) did not feel their presence in the ER would help the patient in any way while 48.6% agreed that it may indeed do so. 69.8 % attendants disagreed that they would interfere with the medical process if they were allowed to be present .

Further, respondents were also asked about the physicians' practices during an active CPR. Which usually lasts 30 minutes. While 55.6% (659) wanted someone from the medical team to inform them about what is happening during the process, 31.55 % (376) would rather wait till the end. 12.7% (150) people said it did not matter.

Table 1

QUESTIONS	RESPONSE YES	FREQUENCY NO
1. Did you witness active CPR for anyone from your family?	14.6%	85.3%
2. Did the physician allow you to be present during CPR?	8.6%	91.4%
3. Would you prefer to be with the medical team in the resuscitation room?	58.9%	40.7%
4. Do you think your presence in the Resuscitation room will interfere with the medical help being provided to your relative?	49.5%	50.3%
5. Do you think your presence during CPR will affect you negatively psychologically in the long term?	54.6%	45%
6. Do you think your presence during CPR will affect you positively psychologically in the long term?	42%	58%
7. Do you think you might interfere with the resuscitation if you are allowed in the treatment room?	30.2%	69.8%
8. Do you think your presence with your relative during CPR will be beneficial to him/her?	48.6%	51.4%

Figure 1: Age distribution

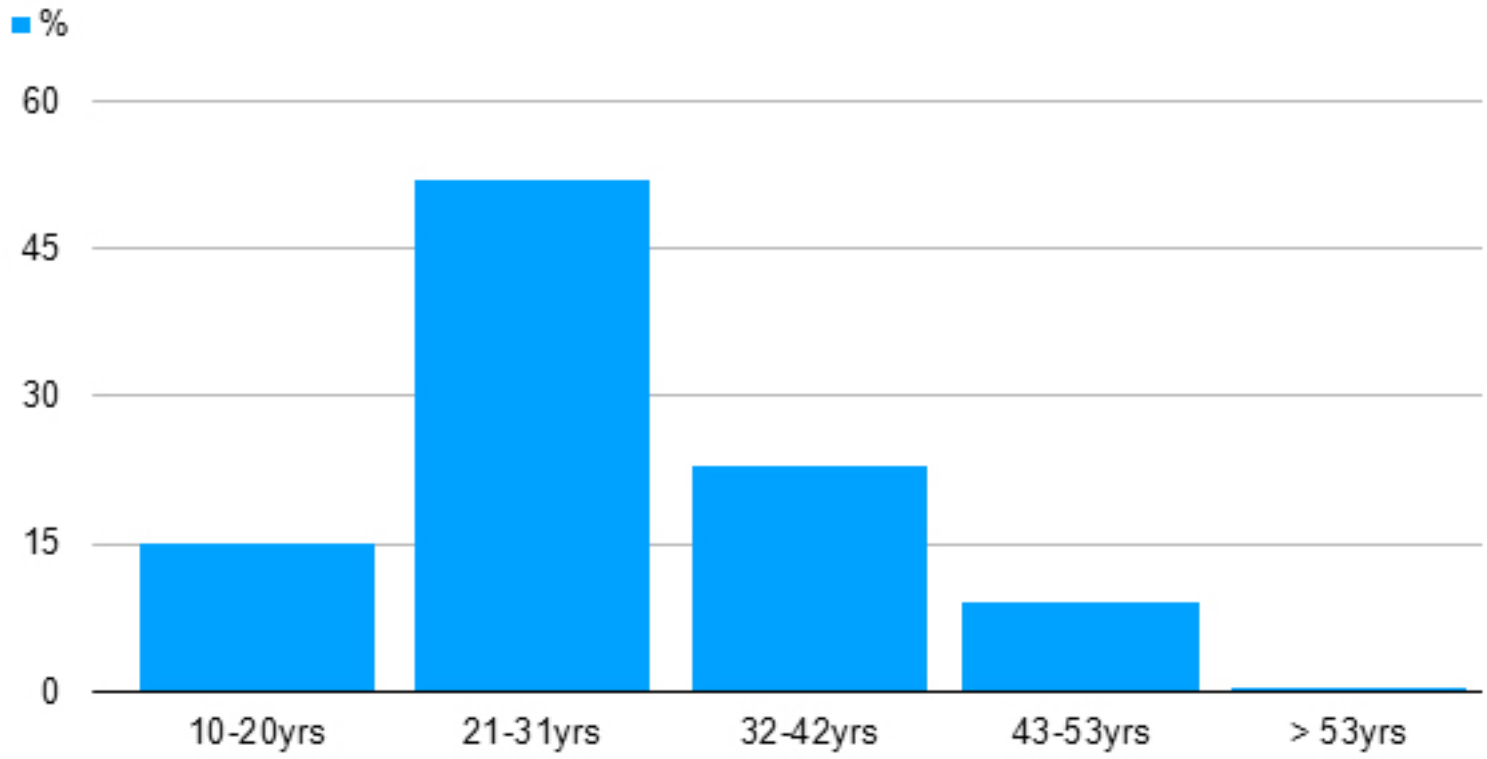
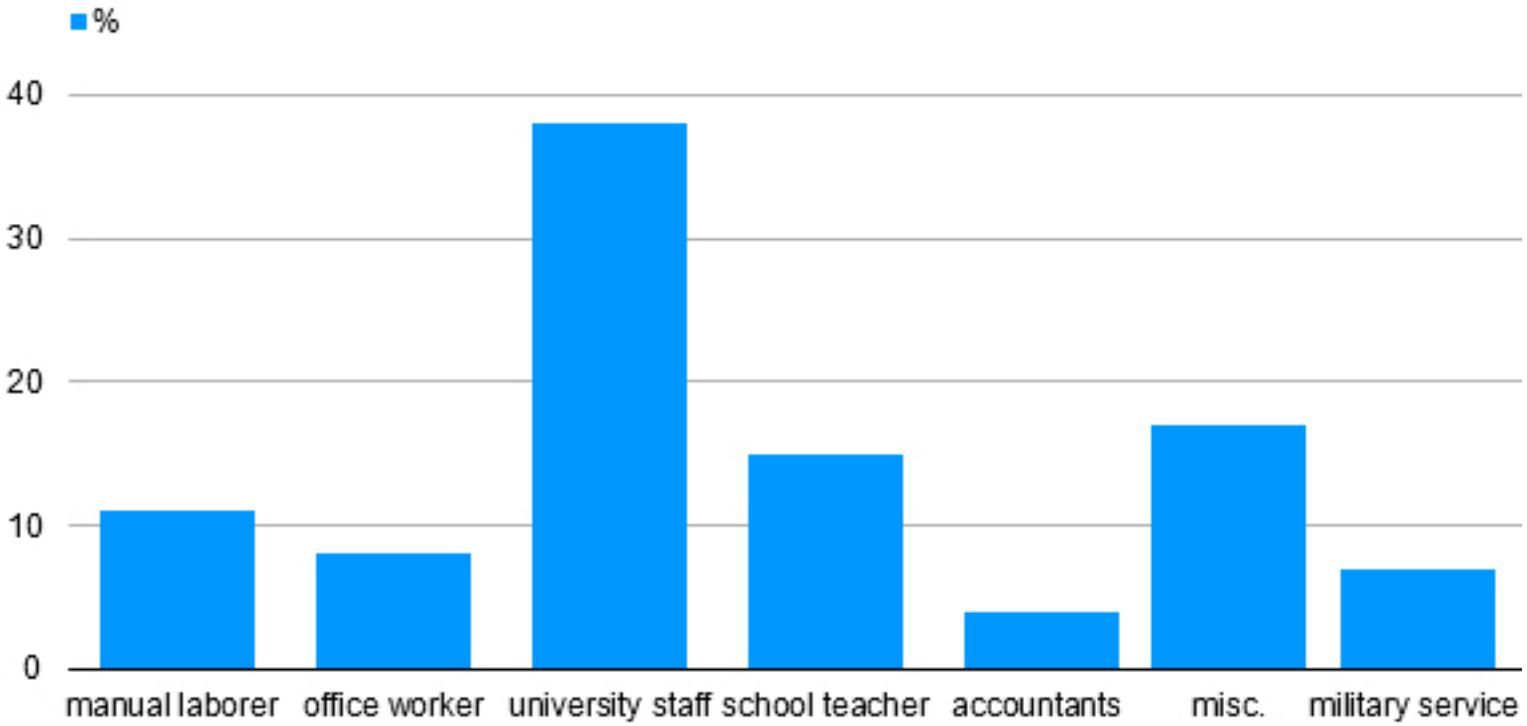


Figure 2: Occupation of respondents



Discussion

This study demonstrated that more than half of the family members (58.9%) expressed a desire to be with their loved ones during resuscitation. However, only less than 15% had actually witnessed an ongoing CPR. The majority (91.4%) of relatives stated this was because the physicians did not allow them to do so. Similar responses have been documented in the past literature conducted by Zakaria et al, [16] Doyle et al.,[2] and Meyers and Eichhorn (7,8). In the Kingdom of Saudi Arabia, Abdul aziz Alshaer et al (18) recently conducted a similar study and found that the majority of patients would like to be offered the option of staying with their relatives during CPR.

The most important and possibly, the most controversial aspect of FPDR is the long term psychological effect on the relatives willing to attend CPR. In our study, less than 50% of people thought it would affect them negatively in the long run. Moreover, around 51.4% of attendants did not feel their presence in the ER would help their relative in any way. This is in contrast to some earlier studies. For example Abdulaziz Alshaer et al (18) found that more than half, i.e., 141 (60.0%) of the respondents believed that their presence might have eased the suffering of the deceased. One hundred and fifty-seven (66.8%) of the family members thought that their presence with the deceased in their last moments could have helped their sorrows and sadness. Meyers et al, (5,6) also suggested relatives would have wanted to be present if they had been given a choice. In fact, his research team continued to examine the relatives' behavior prospectively after they had been present during resuscitation. This research provided compelling evidence that most of the family members would wish to be present at the time of attempted resuscitation and it may in fact, be beneficial in the long term and help them cope better with the stress. More recently, a randomized control trial was conducted by Jabre et al in which family members were randomized into groups allowing Family Presence(FP) and the standard practice. Both the groups were followed and administered a structured questionnaire by a trained psychologist telephonically. His research team found that the FP group had significantly fewer symptoms of PTSD (37 vs 27%, $p=0.01$) and anxiety (23 vs 15%, $p<0.001$) than the control (standard practice) group (9). Follow-up at one year demonstrated that the control group had a higher rate of complicated grief (36 vs 21%, $p = 0.005$) and more major depressive episodes (31 vs 23%, $p = 0.02$) (9).

Another important aspect of FPDR is possibly the physician's attitude and beliefs. In a previous study conducted by us, we found that the majority of the physicians opposed FP during CPR (19). Several concerns were cited by the treating physicians such as that FP might decrease bedside space available for the CPR team, produce staff distraction and performance anxiety, interfere with patient care, jeopardize privacy, and make the decision to discontinue futile CPR difficult. So in our study we enquired from the relatives if they would interfere in the medical aid being provided and majority (69.8%) said no.

There are several important points to consider in this. First and foremost is the process of educating health care providers about the importance of FPDR and alleviate their fears about family interruption during an ongoing CPR. Also successful implementation of this practice will require designated staff which should be available with the designated hospital resuscitation/code teams at all times. These may be someone from the nursing staff or a social worker but these must first be trained on how to provide all the necessary information to the families in the resuscitation room such as explain the interventions, describe in simple terms the meaning of medical terms/jargon, provide information about expected outcomes, supply comfort measures, give an opportunity to ask questions, and if possible, allow them to see, touch, and speak to the patient. These support staff also have an important role to play after the unsuccessful CPR has been completed, to explain or debrief in lay terms the outcome to the family and help them cope with it and if necessary, guide them to a grief counsellor.

Conclusion

This study supports that FPDR has shown promising benefits. Therefore, family members must be offered an option to witness the efforts of the medical team and their wishes must be respected and it is the duty of the health care institutions to facilitate this process.

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