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Predictors of public support for family presence during cardiopulmonary resuscitation: A population based study

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ABSTRACT

Background: The debate on whether individuals want their family to be present during cardiopulmonary resuscitation continues to be a contentious issue, but there is little analysis of the predictors of the general public's opinion. The aim of this population based study was to identify factors that predict public support for having family present during cardiopulmonary resuscitation.

Design: Data for this cross-sectional population based study were collected via computer-assisted-telephone-interviews of people ($n = 1208$) residing in Central Queensland, Australia.

Results: Participants supported family members being present should their child (75%), an adult relative (52%) or they themselves (51%) require cardiopulmonary resuscitation. Reasons cited for not wanting to be present were; distraction for the medical team (30.4%), too distressing (30%) or not known/not considered the option (19%). Sex and prior exposure to being present during the resuscitation of adults and children were both predictors of support ($p < 0.05$). Reasons for not wanting to be present differed significantly for males and females ($p = 0.001$).

Conclusion: Individual support for being present during cardiopulmonary resuscitation varies according to; sex, prior exposure and if the family member who is being resuscitated is a family member, their child or the person themselves. A considerable proportion of the public have not considered nor planned for the option of being present during a cardiac arrest of an adult relative. Clinicians may find it useful to explain the experiences of other people who have been present when supporting families to make informed decisions about their involvement in emergency interventions.

What is already known about the topic?

- Professional bodies support family presence during resuscitation.
- Staff attitudes may impede family presence during cardiopulmonary resuscitation.
- Family want to be present if it was their child requiring resuscitation.
- Population based studies report lower levels of support for family presence during resuscitation when compared to studies conducted in the hospital environment.

What this paper adds

- This study adds information on the beliefs of the general public towards family presence during cardiopulmonary resuscitation.
- Levels of acceptance vary according to the relationship between the family member and the person being resuscitated.

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- Younger adults are more likely to want to be present and want a family member present.

1. Introduction

In the context of emergency care, there is a growing body of literature and practical interest in, examining the benefits for family involvement and presence when emergency measures are being initiated (Ganz and Yoffe, 2012; Lowry, 2012; Porter et al., 2013). This family involvement sometimes extends to family being present if cardiopulmonary resuscitation (CPR) is initiated (hereafter the term 'resuscitation' refers only to CPR). Patients, family members and professional groups report positively on the benefits of family presence during CPR (Axelsson et al., 2010; Hung and Pang, 2011; Porter et al., 2013). Relatives explain that being with their loved one during their last moments of life was meaningful as they believed they were able to provide comfort, appreciate that a life was over and commence grieving (Fulbrook et al., 2007; Holzhauser and Finucane, 2008; MacLean et al., 2003; Meyers et al., 2000). Some studies indicate that witnessing this intervention was not always a positive experience with some families reporting regret at having witnessed the event and ongoing stress recalling the experience (Fulbrook et al., 2005; Mian et al., 2007; Van der Woning, 1999).

Of the few studies examining the experiences of patients who have survived CPR (described in this paper as survivors), individuals express feelings of being safe, supported and comforted, and less afraid when family were present (Eichhorn et al., 2001; McMahon-Parkes et al., 2009; Robinson et al., 1998). Further, patients believed that family acted as an advocate and their presence served to remind the staff of their personhood and promote quality care. Families who were not present, tended to report more intrusive images, depression, anxiety and reduced acceptance that the death had occurred (Clarke and Carter, 2002; Doyle et al., 1987; Eichhorn et al., 2001; Hansen and Strawser, 1998; MacLean et al., 2003; Meyers et al., 2000; Oman and Duran, 2010; Robinson et al., 1998). A recent experimental study conducted in the pre-hospital environment randomised assigned family member to either family presence during CPR ($n = 211$) or standard practice ($n = 131$) groups (Jabre et al., 2013). Families in the intervention group reported less post-traumatic stress disorder. Having the family present does not interfere with the health teams' delivery of care (Dwyer, 2009; Jabre et al., 2013). Further, being together is evidently important for family members in this crisis with family members expressing relief at *just being with them [patients]* to offer emotional support, to know that everything was done or to make sense of the situation (Maxton, 2008; McGahey-Oakland et al., 2007).

Studies of family members' level of support for being present during resuscitation varies from 49 to 73 per cent (Berger et al., 2004; Ersoy and Yanturali, 2006; Mazer et al., 2006; Ong et al., 2007). This variation in the levels of support may reflect unique aspects about the cohort and the use of the term 'resuscitation'. For example, families report higher levels of support for being present during invasive procedures (Anantha et al., 2014), when compared to being present specifically during CPR. Clarification of the term when reporting family preference is important as families' perception of the severity of the illness and whether the intervention is 'life-saving' could influence the individual's desire to be present (Schmidt, 2010).

Studies of patients and relatives presenting to hospitals generally report high levels of support for family presence. Ong et al. (2007), approached the family support person ($n = 155$) of patients presenting to the emergency department, reported high levels of support (73.1%) for witnessing resuscitation (Ong et al., 2007). These participants believed that being present aided the grieving process (68.8%; $n = 99$) and offered them a measure of assurance that everything possible was being done for their family member (85.3%; $n = 122$) (Ong et al., 2007). These findings mirror the high levels of support observed when participants are recruited as they present to emergency departments (Duran et al., 2007; Meyers et al., 2004; Wagner, 2004). Where the benefits for survivors and families are becoming clear, attitudes and opinions of the general public about their involvement, and the decisions they may make should it happen to them, have not been widely reported. Knowledge about public opinion is largely limited to family in emergency departments and there is need for more diverse studies of the views of the general public attitudes towards being present when a family member requires CPR. Greater knowledge about public perceptions is imperative to inform the development of culturally appropriate policy and guidelines to support this practice.

1.1. Aim of the study

The aim of this population based study was to identify factors that predict general public support for having family present during CPR. Secondary aims were to: determine if individual attitudes vary for family presence during CPR of; an adult, child or the individual themselves and identify factors that influence and individuals preference for wanting to be present.

2. Methods

2.1. Study design

This cross-sectional population-based study used an omnibus survey, administered by telephone interview, to explore the general public's perception of family presence during CPR. The omnibus survey was designed to create a population based representative estimate of the attitudes of the adult individual responding to the survey and the household where they live (Evans et al., 2007; Thomas and Coleman, 2004). The survey received approval from University Human Research Ethics Committee and informed consent obtained by all participants prior to data collection (number: H05/08-10).

2.2. Sampling

Recruitment involved a two-stage process to randomly select individuals from a population of adults over the age