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Review

Family presence during resuscitation: A concise narrative review

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ABSTRACT

Background: The involvement of family members in end-of-life discussion is generally considered critical. Family members want to be present during the last moments of their beloved, even during resuscitation. Family presence during resuscitation (FPDR) is on the one side an opportunity for the family members to give a last farewell and may help them to understand the gravity of the situation. The aim of the present narrative review is to provide an overview of the current discussions on FPDR.
Material and methods: Narrative review of recently published papers on FPDR.
Results: and Discussion: FPDR has been proposed since 1987. Mostly, family members want to be present during CPR. Studies have shown that nursing staff are more supportive of FPDR than physicians are. Physicians, who do not often support FPDR, believe that FPDR may interfere with resuscitation, may induce psychological trauma, or be the object of legal repercussions. The presence of family members may also alter the performance of resuscitation. Surveys have shown that the majority of persons interviewed wanted their beloved to be present during resuscitation.
Conclusions: Currently, several international organizations have published statements and guidelines supporting FPDR. There is no clear response if FPDR is always a safe procedure. Moreover, studies investigating FPDR contain various methodological flaws meaning it is difficult to make any definite conclusions.

Contents

1. Introduction

In a society dominated by consumerism, there is no space for the death. The arrogance of some physicians and of a part of the pharmaceutical industry has roused public expectations of perfect health and strong longevity. Media talk about "preventable" deaths

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as if death could be prevented or "treated" rather than postponed. Despite these promises, death remains the inevitable conclusion of life and is often unpredictable, arbitrary, and rarely a simple failure of medicine or doctors faults.

A recent cross-national comparison study [1] has shown that hospitals are frequently the place where many people die, whilst home deaths have been decreasing [2]. Medical emergency teams (METs) are often involved in such end-of-life (EOL) decisions. An observational study [3] found that METs was involved in EOL discussions and limitations of medical therapy in approximately one-third of calls.

The emergency room is a highly stressful and crowded environment, with rapid clinical deterioration as a rule. METs have to take rapid decisions without having a lot of information available when called in the shock room. In such a context, EOL decisions during emergencies are extremely complex and require sound balancing of pros and cons. METs have to identify patients who may benefit from invasive and aggressive treatments, from those who cannot tolerate them. METs should, furthermore, avoid aggressive, futile or even harmful therapies that are unlikely to be beneficial, whilst providing palliative and comfort care. However, under the pressure of the unwillingness of the kin and the possible liability, METs may be prone to ignore the EOL and, instead of limiting to palliative care only, focus on the outcomes.

The involvement of family members in EOL discussion is generally considered critical. Often excluded and neglected, family members usually want to be present during the last moments of their beloved, even during resuscitation. Family presence during resuscitation (FPDR) is on the one side an opportunity for the family members to give a last farewell and may help them to understand the gravity of the situation. However, the need to be present during resuscitation may pose psychological risks for the kin on the other side and also carries the risk of interfere with CPR attempts.

Nonetheless, FPDR is an ethical issue beyond the wish of the family and beyond the clinical decision of the METs. Following the principle of non-maleficence, FPDR must not cause any harm to the patient, either by the interference of the family with cardiopulmonary resuscitation (CPR), or by ignoring the patient's wishes and breaking his/her confidentiality. On the other hand, not allowing family members to be present for the last moments of the life of their beloved could be a violation of the principle of autonomy, which states that families and the patient have the right to make voluntary decisions with understanding, and without undue influences.

FPDR has been proposed since 1987, when in a US survey [4], 94% of the family members who had been present during resuscitation would have made the same choice again. This survey was carried out after two separate incidents happened in 1983 at the Foote Hospital in Michigan [5]. In one, a person who was in the ambulance refused to leave his relative during resuscitation. The second involved the wife of a police officer who had been shot. She wanted to see and stay with her husband during CPR. A chaplain escorted her in the shock room. Consequently, a program of FPDR was adopted at the Foote Hospital. The report of nine-year experience about FPDR has been published in 1992 [5]. Since then, more than 40 studies have been published from 1987 to 2016 about FPDR, mostly surveys, with the focus on families and clinicians and less interest to the patient's wishes.

Even though there is some evidence showing the beneficial effects of FPDR [6], a recent survey [7] has shown that in 16/31 countries (52%) of Europe, FPDR was not routinely performed. A previous survey [8] showed that 8/20 countries (40%) of Europe routinely allowed FPDR. Moreover, in cases of pediatric resuscitation, the proportion of FPDR increased to 11/20 (55%) [8]. Also a web-based poll published in the New England Journal of Medicine [9] has shown that the majority of the readers (69%) in 62 countries and territories were not in favor of FPDR.

The debate is still open. However, the promotion of FPDR is only possible through adequate formation, communication, respect and comprehension [10].

The present review wants to critically analyze the scientific literature by giving brief but dense messages about Family Presence During Resuscitation (FPDR) in different situations (ward, ICU, ED). We have raised the following questions: what are the pros and cons, is it widely practiced, what are the opinions of the figures involved, what do the authors thinks about this ethical dilemma?

2. Search methods and structure of the review

An electronic search strategy was adopted using Medline, EMBASE, PsychLit, CINAHL databases. Search terms included: family, presence, resuscitation, ICU, trauma, emergency department, pediatric invasive procedures, relatives, witnessed. We included studies published between 1970 and 2017. Considering the search literature, we have tried to synthesize the current evidence and underline the different points of view of the figures involved during FPDR: physicians, family members, nurse staff and the patient.

3. The point of view of physicians

Physicians, who do not support FPDR, believe that FPDR may interfere with resuscitation, may induce psychological trauma, or be the object of medico-legal repercussions [11,12]. Furthermore, physicians fear that families can request continuance of a futile resuscitation, or stop a CPR prematurely [13,14].

Moreover, some think that CPR may be too traumatic for the family members and can be interpreted as cruelty by those who are unfamiliar with performing chest compressions and invasive techniques, and that during CPR confidentiality and privacy of the patient may be violated [15,16].

The presence of family members may also alter the performance of the healthcare providers. Some persons may witness errors or misunderstand what they see or hear, and this may be a cause of litigation, especially if the patient dies. Lack of space or dedicated personnel is another reason for physicians to avoid FPDR [16].

As cultural beliefs may play an important role between physicians in supporting FPDR [17,18], senior physicians, past experience with FPDR and the presence of specific protocols, are strong factors that favor the presence of family to witness the resuscitation [19–21]. Training is essential. One way to implement FPDR may be adding the presence of relatives in a CPR scenario during Advanced Life Support training [6].

A randomized study involving 570 relatives of patients suffering from out-of-hospital cardiac arrest (OHCA) conducted by Jabre et al. [22], have shown that FPDR lowered the rate of post-traumatic stress disorder (PTSD), without interfering with resuscitation or causing medico-legal conflicts. The benefits of FPDR were persistent even after 1 year from the resuscitation [23].

However, as some have pointed out [24], in-hospital cardiac arrest situations may be quite different from OHCA, in as much as the relatives do not witness directly the occurrence of the cardiac arrest, but rather, they are informed by the health personnel of the sudden deterioration of their beloved, when CPR has already started. Consequentially, a cardiac arrest in the ward and ICU may be more traumatic and invasive for family members [10].

In the study by Jabre et al. [22], there were 5 suicides only between family members who witnessed cardiac arrest (not statistically significant different from controls), which may suggest that there is a proportion of family members who are not suited to be

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