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How Do Healthcare Providers Feel About Family Presence During Cardiopulmonary Resuscitation?

Alicia Pérez Blanco

ABSTRACT

The presence of patients' families during cardiopulmonary resuscitation (CPR) is a controversial topic, due to its repercussions for clinical practice. While family members' presence may help them to overcome their grief, it could be detrimental, as it may case posttraumatic stress disorder (PTSD), and there is the possibility that family members may interfere with the procedure. For these reasons, families' presence during CPR has rejected by some healthcare providers.

To research concerns about families' presence among providers dealing with CPR in the Fundación Hospital Alcorcón (Madrid), I performed this study. Of the 190 providers surveyed, 115 submitted a complete questionnaire. The most frequently reported concerns were interference (78.3 percent of respondents), and PTSD (69.6 percent of respondents). Fewer pediatric providers were concerned about PTSD than other providers (41.2% percent versus 74.5 percent, $p = 0.01$). Providers were reluctant to offer families the option of being present unless they had requested it, and would only permit it under certain conditions. Having a staff member to support the family was of great value to most respondents. The author believes families have a negative right to be present during CPR and so should be invited to stay.

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INTRODUCTION

Less than 10 percent of individuals who receive out-of-hospital cardiopulmonary resuscitation (CPR) survive,[1] and the families of the other 90 percent must face the death of their loved one. One potential way to alleviate the pain resulting from this experience would be to allow families to be present during CPR. This hypothesis has been held by several authors, based on information on the bereavement process reported by psychologists and psychiatrists, which I will review here. I have observed during my own professional experience as an intensivist and as transplant coordinator that families' presence can be a valuable aid in helping to get over the death of a loved one.

Family presence is defined as "the presence of family in the patient care area, in a location that affords visual or physical contact with the patient during invasive procedures or resuscitation events."[2] *Family members* are defined as "individuals who are relatives or significant others with whom the patient shares an established relationship."[3]

The possible consequences of allowing family members to be present during CPR are controversial. On the one hand, its supporters argue that being present facilitates the process of bereavement for family members by allowing them to witness hospital staff dutifully trying to save the life of their

loved one.[4] On the other hand, its opponents argue that families may experience posttraumatic stress disorder (PTSD) as a result of being present,[5] and that family members may interfere with, and, therefore jeopardize, medical procedures.[6]

Historically, family members, rather than healthcare providers, were the first to request to be present during emergency room CPR. Cheryl Hanson, a staff nurse at Foote Hospital in Jackson, Michigan, began a program in 1982 that allowed families to stay in the emergency room while healthcare providers were performing CPR.[7] This new policy did not come from the staff members of the emergency department; on the contrary, it was the request of two families that constituted the first step to changing the policy on families' presence. This new policy was developed and later evaluated by a survey, and, in a 1985 follow-up survey of 47 family members, 76 percent of the respondents felt that witnessing CPR made their adjustment to the death easier, and 64 percent of the respondents felt that being present was beneficial for the patient.[8] This data suggest that the majority of family members considered their experience—witnessing the CPR—to be positive. The above-mentioned study did not give any information about the reasons that 24 percent of the respondents did not feel that their presence during CPR was helpful in easing their grieving. No one responded that the interests of the patients, or even their posthumous interests, might be harmed as a result of a family member witnessing them during CPR. Among the fears voiced by respondents to another study, performed by Sanford and colleagues, were concerns about being overwhelmed by the situation and being disillusioned because what they saw during CPR did not match their expectation.[9]

Hanson and colleagues recall that, after 30 years of following this new policy, no lawsuits had been brought because of family members' presence during CPR, as of publication in 2002.[10]

Some studies report that patients also desire the presence of family members during CPR. Eichhorn and colleagues interviewed a survivor of CPR; the patient later learned that his family had observed him while healthcare providers performed CPR, and he expressed his gratitude for the emotional support provided by his wife, including the ability to reframe the stressful event, once recovered.[11] Robinson and colleagues carried out a 1998 randomized study comparing family members' presence during CPR to no presence by family members during CPR; three patients who survived were in the families' presence "treatment" group.[12] Advocacy for their care and the provision of useful information to the physicians were positive experiences that survivors reported. None of them complained of a violation of their privacy.

One of the largest surveys of patients' preferences, by Benjamin, Holder, and Carr, regarding family members' presence during CPR, interviewed a convenience sample of 200 stable patients and their family members who were recruited while waiting to be attended in the emergency trauma department. Of the 200 patients, 72 percent said that they wanted family members to be with them during CPR. Interestingly, of the patients who said that they wanted family with them, 56 percent indicated they wanted to limit the presence of family members to family members of their choice.[13] To respect patients' preferences, this information should be recorded in an advance directive document or in the clinical chart when patients are admitted to the hospital. Knowing that the majority of patients do not complete an advance directive and that physicians do not usually ask patients about this issue while treating them in the ward or in the ICU, these questions will most often have to be addressed without this information. If a healthcare provider believes there will be long-term benefits for the family, and no severe negative consequences, the healthcare provider might invite family members to stay during CPR. This assumes that the benefits to family members outweigh any potential disagreement by the patient—the patient's preferences can only be taken into consideration when they are known. Conversely, if a healthcare provider does not consider the presence of family members during CPR to be of help for their grieving process, the healthcare provider probably will not invite anyone to be present, even if that person asks to be present.

I propose that a healthcare provider should ask family members if they want to be present during CPR, and, if the answer is positive, then the provider can ask who they think the patient would have chosen to be there. In my daily clinical practice, I ask patients, at any stage when they are conscious, an open question: "In the case of your life being acutely compromised, whom would you wish me to invite to come to the hospital to be with you?" I assume that the chosen person is someone who has the utmost confidence of the patient, and should be invited to be present should CPR take place.

The most important benefits, however, are for the family. Jabre and colleagues report that families who were present during CPR that was performed at home exhibited a statistically significant smaller incidence of PTSD and anxiety symptoms than their counterparts who did not witness the CPR.[14] These

authors report that being present during CPR at home resulted in a more positive psychological evaluation 90 days after witnessing CPR, based on the Impact of Event Scale (IES) and the Hospital Anxiety and Depression Scale (HADS).

Being present during CPR eases bereavement in terms of its duration and complications.[15] Merlevede and colleagues studied "the mourning reactions of bereaved relatives confronted with a sudden unexpected death" and observed that it was common for relatives to later raise questions related to their feelings of guilt and to their impulse to blame either themselves or others, most likely the physicians.[16] These feelings generally subsided when family members were allowed to be present during CPR and were therefore able to see for themselves that everything necessary had been done for the patient. Their presence reduced anxiety and fear, produced a feeling of being supportive and helpful to the patient, and seemed to alleviate feelings of self-blame.[17]

Healthcare providers also reported benefits from the presence of family members during CPR. Critchell and Marick wrote that family members' presence during CPR "increases professional behavior among staff by the humanization of the patient."[18] Robinson and colleagues stopped the randomization of their pilot study because physicians concluded that the benefits of family members' presence were so obvious.[19]

The first guidelines in the United Kingdom regarding family members' presence during CPR were published in 1996 and emphasized that the views of healthcare providers often differed from those of the patient's relatives. Whereas most family members preferred to remain with the patient, healthcare providers often saw family members' presence as an impediment.[20]

In general, nurses have been more positive about families' presence than physicians. McClenathan and colleagues surveyed healthcare providers who had experienced families' presence during CPR and found that almost 75 percent of physicians in the survey characterized their experience as negative, compared to 47 percent of nurses.[21] York reported that nurses, but not physicians, considered families' presence to be a right of the patient and of the family members.[22] Duran and colleagues also affirmed that nurses have more positive attitudes towards family members' presence than attending or resident physicians.[23] Jarvis reported the opinion of physicians in a pediatric ICU: "The team leader should be able to say no to parental presence, depending on the staff's confidence and ability"; the nurses, in the ICU, however, "were very much concerned about feelings of parents . . . asking if they wanted to be present."[24] In the discussion section, I will put forward an hypothesis that may explain this difference in attitude between nurses and physicians.

In 2007, a group of 20 ICU healthcare providers convened in Washington, D.C., to create a guideline for the presence of family during CPR. The Presence of Family Members during CPR Working Group concluded:

> All patients have the right to have family members present during resuscitation. When the person who is being resuscitated is not able to communicate his or her wishes, or who has not previously expressed their wishes in an advance directive, the decision about who should be present during resuscitation should be made jointly by the members of the resuscitation team and family members. The patient's family members should be offered the opportunity to be present during CPR. . . . In some occasions, it may not be possible to provide a health care professional to support the family. . . . An experienced member of the team, who is not the team leader, should be a family facilitator for the family's emotional well-being during and after the CPR."[25]

Later, in 2010, new guidelines launched by the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care made the same recommendation:

> Most family members would like to be present during resuscitation. . . . Family members with no medical background report that being at the side of a loved one and saying good-bye during the final moments of life is comforting and helps in their adjustment, and most would participate again. Standardized psychological examinations suggest that, compared with those not present, family members who were present during attempted resuscitation have less anxiety and depression and more constructive grieving behavior. Parents or family members often fail to ask, but providers should offer the opportunity whenever possible. If the presence of family members proves detrimental to the resuscitation, they should be gently asked to leave. Members of the resuscitation team must be sensitive to the presence of family members, and one person should be assigned to comfort, answer questions, and discuss the needs of the family.[26]

Nonetheless, the presence of family during CPR remains a rare occurrence, in large part due to con-

cerns about the negative repercussions, such as the possibly harmful emotional impact on family members or their possible interference with the medical team's procedures.

One of the most common arguments against the presence of family during CPR is that witnessing frightening and aggressive procedures, including defibrillation and chest compressions, will result in PTSD. Family members, however, tend to see it quite differently. One study reports that 95 percent of families who were present during CPR found the experience less stressful than they would have imagined if the healthcare provider had banned them being there.[27] This is what Robinson and colleagues observed in their randomized study: the group of families who were allowed to be present during CPR found "the reality of the resuscitation room less distressing than anything they might have imagined if they had been in the waiting room."[28] That is, witnessing CPR can prevent family members from being tormented by dreadful thoughts.

Interference is the second most commonly reported argument against the presence of family members. Healthcare providers are especially concerned that family members might interfere in either of the two following moments of CPR—when a physician administers defibrillation shocks or when the medical team decides to stop CPR. Fernandez and colleagues, in a small pilot study, examined the negative impact of family members' presence during CPR using actors and residents in three simulated scenarios.[29] They observed a significant delay in the time taken to deliver the first defibrillation shock, and that physicians administered fewer defibrillation shocks in total in "the overt reaction witness" group versus "the quiet" group and the "no family witness" group. The 2010 European Resuscitation Council Guidelines for Resuscitation increased the emphasis on delivering successive shocks and minimizing pre- and post-shock pauses for ventricular fibrillation or pulseless tachycardia to improve the chances the patient would recover spontaneous circulation.[30] Therefore, if Fernandez and colleagues' findings are confirmed by other studies, family members' presence during CPR could be considered a serious threat to a successful patient outcome.

Another possible time that family members may interfere is when the medical team decides to stop CPR. At that point, the family may lose all hope that their loved one will survive. Healthcare providers worry that if a family member were to lose emotional control and interfere with the decision to stop CPR, it could lead to futile medical treatment. The aforementioned virtual study by Fernandez and colleagues found no difference in the length of the CPR performed for the three groups.[31]

These results were not reproduced, however, in a recently published, multicenter, randomized trial conducted by Jabre and colleagues, which enrolled 570 relatives of actual patients who received CPR in their own home by 15 prehospital emergency medical service units.[32] Jabre and colleagues found that neither the number of defibrillation shocks nor the duration of CPR were significantly changed in the intervention group (systematically offered to family to witness CPR, 47 percent, $n = 266$) compared to the control group (usual practice regarding the presence of family members during CPR: family members were not invited to stay, 53 percent, $n = 304$). The overall effectiveness of the resuscitation (the percentage of patients who returned to spontaneous circulation) was not statistically different when comparing both groups. In this setting, healthcare providers administered the defibrillation shocks without delay while being observed by the family. The authors did not find significant differences in the stress levels of the healthcare providers—measured by the visual-analogue scale of stress—depending on the presence of family members or their absence. Less than 1 percent of family members (from a total of 342) who did finally witness CPR interfered with the medical team. Therefore, in real-life scenarios, healthcare providers' decision making during CPR did not alter in the presence of family members. Another explanation for the lower level of anxiety reported by Jabre and colleagues is that trained professionals are less vulnerable to it than residents are.

One of the largest studies, performed by O'Conell and colleagues, reports that there were no cases of physical interference by the 197 family members who were present during CPR in the emergency department of an urban trauma center.[33] In addition, 97 percent of the 136 healthcare providers who responded to the survey said that the family's presence during CPR had improved or had no effect on the providers' medical decision making.

In their daily clinical practice, the healthcare providers at the Intensive Care Unit of the Fundación Hospital Alcorcón, Madrid, do not currently invite family members to be present during CPR. This study aims to determine the positions and factors that influence the attitudes of healthcare providers (physicians and nurses) in the hospital's Intensive Care Unit, Emergency Department, Post Anesthesia Care Unit, Internal Medicine Department, Neonatal Unit, and Pediatric Department regarding family members' presence during CPR.

MATERIALS AND METHODS

Objectives

The objectives of this study were to do the following:

1. Identify the attitudes of providers in the Emergency Department, Intensive Care Unit, Internal Medicine Department, Post Anesthesia Care Unit, Pediatric Department, and Neonatal Unit at the Fundación Hospital Alcorcón, Madrid, towards family members' presence during CPR;
2. Determine whether pediatric providers have different opinions regarding a family's presence during CPR than adult healthcare providers;
3. Determine whether nurses' attitudes toward a family's presence during CPR are different from physicians' attitudes;
4. Determine which conditions might facilitate a more positive attitude toward a family's presence during CPR.

Subjects

The subjects of this study were healthcare providers (physicians and nurses) in the Emergency Department, Intensive Care Unit, Internal Medicine Department, Post Anesthesia Care Unit, Pediatric Department, and Neonatal Unit of the Fundación Hospital Alcorcón, Madrid. The healthcare providers who participated in the survey consented to the publication of questionnaire results.

Setting

The hospital has 566 beds: the Intensive Care Unit has 12 beds; the Post Anesthesia Care Unit has 13 beds; the Emergency Department has 20 beds, and the Neonatal Unit has 10 beds.

Study Design

This study utilized a structured questionnaire following three phases. The study was started in February 2012 and finished in July 2012.

First Phase

Nurses and physicians from the above-mentioned departments attended separate educational seminars about the potential conflicts of a family's presence during CPR and its known benefits, based on the information published on the topic. The seminars lasted 45 minutes.

Second Phase

After the seminars, a questionnaire was distributed. The questionnaire was anonymous and featured two questions, each with five possible answers from which a maximum of two answers could be chosen (see table 1). A circled answer was considered a positive response. An answer that was not circled was considered a negative response.

Third Phase

The questionnaires were collected the same day the seminar was held. Data were transcribed using Microsoft Excel. I evaluated two hypotheses:

1. Pediatric healthcare providers would be more supportive of a family's presence than adult healthcare providers.
2. Nurses would be more in favor a of family's presence than physicians.

RESULTS

A total of 115 out of 190 surveyed healthcare providers submitted a complete questionnaire (60.5

TABLE 1. Study questionnaire

Question 1: What concerns you most about family presence during CPR?

- Answer 1.1: Witnessing CPR can be very traumatic for the family; it can produce PTSD.
- Answer 1.2: The family may lose control of their emotions and interfere with CPR.
- Answer 1.3: Family presence can influence the decision making of the medical team; important decisions could be delayed.
- Answer 1.4: Family presence can induce futility, and prolonged CPR could lead to a permanent vegetative state for the patient.
- Answer 1.5: Family presence might increase litigation.

Question 2: What conditions might influence your decision about family presence during CPR?

- Answer 2.1: I would agree to family presence if a professional healthcare supporter stays with the family during and after CPR.
- Answer 2.2: I would agree to family presence if the family can be asked to leave the room if they interfere.
- Answer 2.3: I agree with family presence if the family stays calm and out of the way.
- Answer 2.4: I would consider allowing family presence only if the family requests it, but I will not offer it to them.
- Answer 2.5: I believe family presence can be positive only if a professional healthcare supporter is available for the family during and after CPR.

percent response rate), including 98 healthcare providers who care for adult patients and 17 healthcare providers from the Pediatric Department and the Neonatal Unit; 70 healthcare providers did not respond to the questionnaire, and five healthcare providers submitted an incomplete questionnaire.

First, I examined the responses to Question 1, "What concerns you most about families' presence during CPR?". The most frequently reported concern was family members' interference, with 78.3 percent of all surveyed healthcare providers choosing Answer 1.2. In particular, 79.7 percent of physicians versus 76.1 percent of nurses (see figure 1), and 77.6 percent of healthcare providers working with adults versus 82.4 percent of healthcare providers working with pediatric patients (see figure 2), were concerned about the possibility of interference by family members. These data suggest that regardless of specialty or profession, the majority of healthcare providers consider interference by family members to be the most important concern.

In total, 69.6 percent of all healthcare providers surveyed were concerned that family members might develop PTSD, responding positively to Answer 1.1.

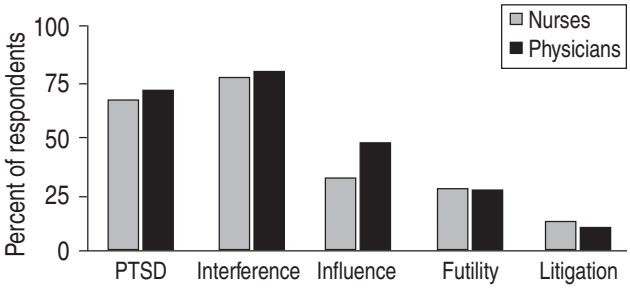

FIGURE 1. Physicians' versus nurses' concerns about family presence during CPR.

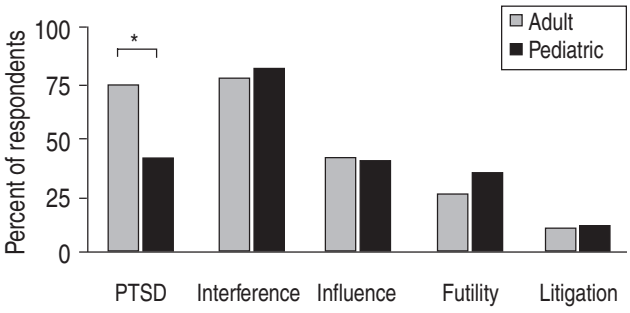

FIGURE 2. Pediatricians' versus adult healthcare providers' attitudes towards family presence during CPR.
*$p = 0.01$

Specifically, 71 percent of physicians versus 67.4 percent of nurses believed that family members might experience PTSD (see figure 1). I found a surprising disparity between the adult and pediatric healthcare providers. Significantly fewer pediatric healthcare providers voiced being concerned about PTSD than their counterparts who care for adult patients (41.2 percent versus 74.5 percent, $p = 0.01$; see figure 2).

Fewer than half of the healthcare providers surveyed were primarily concerned that the presence of family members during CPR would influence the decision-making process of the medical team (41.7 percent of all providers; see figure 1). Although the difference was not significant, the greater percentage of positive answers among physicians (47.8 percent, compared to 32.6 percent of nurses) might represent a heightened awareness of physicians' role in making a final decision to end or start CPR.

Of all of the healthcare providers surveyed, 27.8 percent were primarily concerned about futility. Concern about increased litigation was not frequently reported, with only 11.3 percent of all healthcare providers surveyed answering positively to Answer 1.5.

Secondly, I examined the responses to Question 2, "What conditions could change your mind about the presence of the family during CPR?". Consistent with the finding that interference was a common concern among healthcare providers, many healthcare providers were more likely to consider allowing family members to be present during CPR if the family could be asked to leave the room if they interfered (in total, 46.1 percent of all healthcare providers surveyed responded positively to answer 2.2). Fewer adult healthcare providers (42.9 percent) than pediatric healthcare providers (64.7 percent) responded positively to this question (see figure 3), although this difference did not demonstrate statistical significance. Physicians and nurses were similarly willing to consider family members' presence during CPR if the family could be asked to leave the room in cases of interference (49.3 percent versus 41.3 percent; see figure 4).

The presence of a supportive staff member might alleviate concerns about the possible negative impact of the CPR on family members, particularly for pediatric healthcare providers. Questionnaire responses indicate that 52.9 percent of the pediatric healthcare providers surveyed would approve the presence of family during CPR if the family was with a family professional health supporter, compared to just 32.7 percent of healthcare providers who care for adult patients (see figure 3). Interestingly, only

19.1 percent of all of the healthcare providers surveyed responded that a family's presence during CPR might be positive for the family, only if a healthcare supporter was with them during the CPR. A greater number of pediatric healthcare providers agreed with this condition than adult healthcare providers did (35.3 percent versus 16.3 percent; see figure 3). Overall, 27 percent of the healthcare providers reported that they would not offer the option of a family's presence during CPR, but would agree to it if the family requested it (29 percent of physicians versus 23.9 percent of nurses; see figure 4).

The results indicate that most of the providers who participated in the study had significant concerns about a family's presence during CPR, primarily interference and PTSD. A small percentage of respondents might agree to a family's presence during CPR if another healthcare professional assumed the task of helping the family to cope with the emotional stress that CPR could produce for them.

DISCUSSION

Why Do Healthcare Providers Not Offer Family's Presence During CPR?

The results of my study confirm that the most frequently reported reasons for not offering families presence during CPR were the possibility of interference and the possibility of PTSD. The vast majority of healthcare providers were seriously concerned about interference, regardless of their profession or specialty (79.7 percent of physicians, 76.1 percent of nurses, 82.4 percent of healthcare providers caring for adults, and 82.4 percent of healthcare providers caring for children). Interestingly, 49 percent of physicians and 41 percent of nurses chose Answer 2.2: "I would agree to family's presence if the family is requested to leave the room should they interfere." I believe that this position may be related to healthcare providers' desire to exercise control over all possible events that might occur during CPR.

In addition, these results confirm the data reported in the literature: healthcare providers are not offering family the opportunity to be present during CPR due to concerns that family members may suffer from PTSD as a result of witnessing CPR (71 percent of physicians versus 67.4 percent of nurses).[34]

Interestingly, the healthcare providers surveyed said that they felt they would feel differently should CPR be performed on a member of their own family or on themselves. These questions were addressed by Basol and colleagues, who surveyed 625 healthcare providers and asked if they themselves would like to be present during the CPR of a family member, or to have their own family present if they were the patient.[35] Of the 625 respondents, 543 answered the question, "If your family member was critically ill/injured, would you as a healthcare provider want the option to be present during resuscitation?"; 37.6 percent (n = 32) of physicians and 58 percent (n = 270) of nurses responded positively. The rationales included "It is my right," and wanting "to see that everything was tried." Among the negative comments from providers who said that they would not want their family members to be present were: "discomfort," "emotional trauma to observer," "it would take focus from the patient," and "staff might not make good clinical judgments." When the question was, "If you were critically ill/injured would you want the option to have your family present at your bedside?" of the 543 providers who answered, 83.1 percent (n = 69) of the physicians and 92 percent (n = 441) of the nurses responded positively.

Summing up, the vast majority of these physicians and nurses said that they wanted to be surrounded by their family while being resuscitated

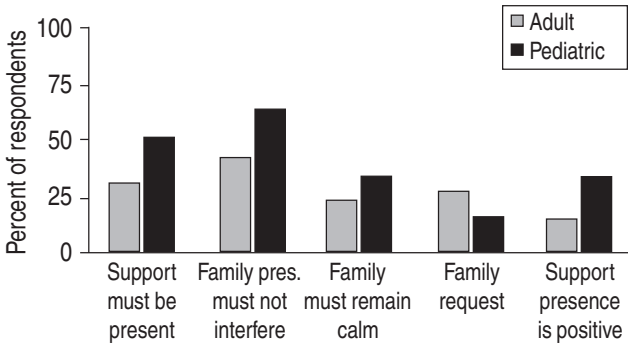

FIGURE 3. Pediatricians' versus adult healthcare providers' concerns about family presence during CPR.

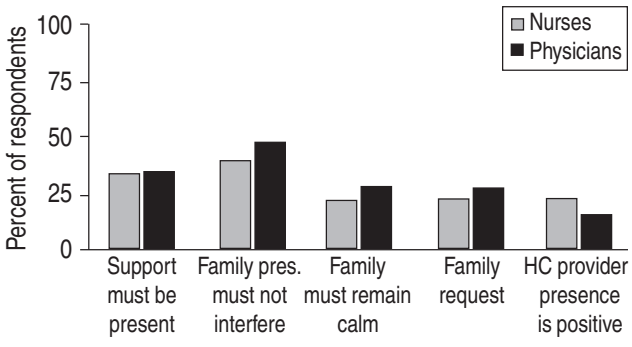

FIGURE 4. Physicians' versus nurses' attitudes toward family presence during CPR.

and, on average, nearly 50 percent wanted to be invited to stay with their loved one during CPR. This changed when healthcare providers were asked about allowing a patient's family members to witness CPR, as McClenathan and colleagues reported in one of the largest published studies: among the 592 healthcare providers surveyed, a small percentage of physicians (20 percent) and nurses and allied healthcare workers (39 percent) would allow a patient's family members to be present during CPR.[36]

The results of the above-mentioned studies remind me of one of the most common idiosyncrasies that we physicians usually acquire over our clinical practice. We do not put ourselves in the role of patients. We tend to focus only on the skills required to perform difficult technical tasks such as placing a central catheter or intubating in emergency circumstances. Rarely do we give time to thinking what we ourselves would like if we were a patient, as a way to understand what our patients want for themselves. There are occasions when the feelings of patients and their family members should be of especially great consideration, and the last moments of life are one of these. If we would like to have our family members present when we are the patient, or if we would like to be close to a loved one while the person is resuscitated by our colleagues, then we must offer the same choice to our patients' family members. Being consistent is of the utmost importance when intimate feelings are at stake, otherwise we may fall into a double standard of behavior. Following the Kantian categorical imperative, also known as the golden rule, one should treat others in the same way one would like to be treated.[37]

In addition to concerns regarding interference and PTSD during CPR, there is a further issue that a small-scale study like mine cannot address. I believe that healthcare providers, while involved in CPR, dislike being observed, especially during the performance of invasive procedures, for fear of failure. Families, unknowingly, may increase anxiety in the healthcare team (especially in residents), thus decreasing the likelihood of success. Elements of being observed that increase anxiety include being misunderstood by the family during their communication with team members, and fears about attention being diverted from the patient in order to attend to the family.

Do Pediatric Providers and Adult Providers Feel Differently about the Presence of Family?

Compared to adult healthcare providers, pediatric providers were more likely to support a family's presence during CPR if a family support person were available, or if the family could be asked to leave if they interfered. In addition, healthcare providers treating pediatric patients indicated that they were less concerned about PTSD ($p = 0.01$) than their counterparts caring for adults. Intuitively, one might expect that healthcare providers treating pediatric patients would be more concerned about the occurrence of PTSD. Since many pediatric healthcare providers maintain a closer relationship with the parents of their patients than healthcare providers do with the family of their adult patients, however, at the end of the day, pediatric providers may be more closely aligned with the actual worries and fears of parents, and are able to evaluate more accurately whether their presence during CPR would present a real risk of PTSD.

Another factor that should be taken into account is previous experience with family members witnessing invasive procedures. As Duran and colleagues observed, healthcare providers' attitudes were different if they had previous knowledge about the presence of family members during CPR or other invasive procedures witnessed by family members.[38] When healthcare providers gain experience with family members' presence during invasive procedures, they usually become comfortable with it. Some of the pediatricians surveyed in my study were familiar with accounts of family-witnessed invasive procedures, although our institution has no written policies on the issue. Drawing on this knowledge may serve to diminish providers' fears about PTSD.

Do Nurses and Physicians Feel Differently about the Presence of Family Members?

Previous studies have suggested that, by comparison, nurses were more favorably inclined toward the presence of family than were physicians.[39] I believe that nurses may hold a different view as a consequence of their work during CPR. They do not make the decision when to finish CPR, and they are not concerned about litigation. Physicians feel very much responsible for the technical aspects of CPR and decision making during CPR; if defibrillation shocks are not properly delivered and ventricular fibrillation persists, a patient's chances for survival diminishes. As Kudenchuck and colleagues report, there is a significant inverse relationship between the duration of ventricular fibrillation, or pulseless ventricular tachycardia, and the outcome of resuscitation.[40] Meanwhile, nurses generally focus their attention on the patient and are more liable than physicians are to support family members while they are facing the overwhelming emotions surrounding death. I believe that, because nurses see themselves

primarily as caregivers, they have been, as I alluded to in the introduction, historically the first to consider a change in the policy of the presence of patients' family members during CPR.

In this study, I failed to find support for these conclusions. My analyses suggest that the nurses and physicians working in the Fundación Hospital Alcorcón shared similar attitudes towards PTSD and interference, and that they were equally disinclined toward the presence of family during CPR. One explanation for this discrepancy might be that nurses and physicians at this hospital work in cohesive teams, and collaborate closely on all decisions related to relatives' visiting schedule. Sharing in making decisions may lead to a sharing of attitudes. It is also important to note that, at the time of my study, the nurses and physicians caring for adults had no prior knowledge of the presence of family during CPR. Some studies such as the one performed by Sacchetti and colleagues, conducted in an emergency department during CPR for pediatric patients, reported that healthcare providers who had experience with the presence of family during CPR strongly advocated it.[41] In my study, neither nurses nor physicians had such experience, therefore it should not be considered as a reason for their similar attitudes.

Whom Are Healthcare Providers Protecting, and from What?

Healthcare providers are unintentionally engaged in paternalism, defined as "overriding another's autonomy for the sake of achieving greater beneficial value, identified as such by those who perform the act suppressing another's autonomy."[42] Assuming that CPR can be a stressful experience for family members, healthcare providers conclude that family should not witness the procedure. And yet, paternalism can be viewed as an asset to cultural ethics. Although one study of Spanish parents reported that a majority wanted to be present during invasive procedures, the parents also confessed that they would rely on the physician's judgment to decide the best option—to stay or to leave.[43] My study did not specifically address the presence of family members during CPR, but describes the general preferences of the Spanish parents who were surveyed. When comparing the beliefs of Americans and Spaniards around the paradigm of autonomy, the cultural roots of self-determination are stronger in Americans.[44] Healthcare decisions can be influenced by cultural background, making it even more difficult to accurately gauge a family's preferences. Salmond and colleagues found that cultural roots had a great impact on decisions regarding the presence of family during CPR, internationally.[45] The authors looked at the results of studies in Belgium, Germany, Singapore, and Turkey, and found a general disapproval of the presence of family during CPR; studies from the U.K., Ireland, Australia, and the U.S. found general favor for it.

Healthcare providers try to resolve their concerns about PTSD by emphasizing the need for a family supporter. In my study, around 35 percent of respondents chose Answer 2.1, "I would agree to the presence of family if a professional healthcare supporter stays with the family during and after the CPR." Currently, the administration of CPR does not allow healthcare providers to simultaneously perform CPR and attend to family members' emotional needs during the procedure. Thus, ideally, a supporter would be there to aid family members. Traditionally, the role of supporter has been performed by nurses, chaplains, and clinical psychologists who are trained in dealing with emotionally overwhelmed family members. There are no guidelines that recommend that a specific group of healthcare providers support family members, and this is an open question that every institution must resolve, following its organizational framework. Whatever group is designated by the institution to provide support, it must be trained to acquire the skills to see to the needs of a grieving family, in a compassionate way. In daily clinical practice, when CPR is begun in the emergency room or on the ward, a large group of healthcare providers gather, but only a few are directly involved; in most hospitals, these are intensivists or anesthesiologists. The attending physician, nurses, and the residents are on hand to help, however, and I believe they could act as supporters once they have been trained to do so.

Above all, the ideas of family-centered care and end-of-life care include providing care for family members as they are an extension of the patient.[46] This aligns with the principle of beneficence. In optimal practice, healthcare providers should promote therapeutic and compassionate communication to help relatives overcome their grief.

My study has several limitations: the population surveyed is limited, especially the subpopulation of pediatric healthcare providers. There was no current knowledge about families' presence during CPR in any of the hospital departments. Perhaps respondents might have had different opinions if they had had any previous experience on this topic.

Families Have a Right to Be Present During CPR

"In the absence of data documenting harm and in light of data suggesting that it may be helpful,

offering select family members the opportunity to be present during a resuscitation is reasonable and desirable." This quotation, from the American Heart Association, recommends that families should be invited to be present; relatives should be asked whom, if anyone, the patient would prefer to be present during what may well be the last moments of the patient's life.[47]

In this section I will discuss why the presence of family during CPR is positive not only for the patient, but also for his or her relatives and for healthcare providers. Arguments will be framed following the principles of bioethics: autonomy, beneficence, and nonmaleficence, with the conclusion that the presence of family members is a negative right held by patients.

Autonomy

To respect the principle of autonomy for a dying and unconscious patient, a surrogate decision maker must be found. Lederman and colleagues propose that an integrated model of surrogate decision making can be used: assuming that the patient did not express prior contrary wishes, and no advance directive was written, the patient's family members should be informed about what they might see during CPR, and be asked about the preferences of their loved one in this regard.[48] Decisions should rely on what all of the parties involved (relatives and physicians) consider to be in the best interest of the patient and his or her family. This model is in accordance with the guidelines published in 2007 by the Presence of Family Members during CPR Working Group, mentioned in the introduction.[49] In the daily life of hospital clinical practice, I propose that family members be invited to stay. An invitation to stay must not come from the healthcare provider who will be directly responsible for CPR, as this team member will be too focused on the procedure. The attending physician, the resident who has been in charge of the patient, or the nurse, once trained, can take on the role of supporter and invite the family to stay. If the family wishes to be present, the supporter should ask whom the patient would have preferred to stay. It is crucial to ask for the voice of the patient, establishing the criterion for being present.

In the case of pediatric patients, there is no doubt about whom to ask for consent. Guidelines for the care of pediatric and neonatal patients from the American Heart Association and the American Academy of Pediatrics recommend, "In pediatric decision making, as a general rule, minors are considered incompetent to provide legally binding consent about their healthcare. Parents or guardians are generally empowered to make healthcare decisions on their behalf."[50]

Beneficence

Families' presence during CPR is of benefit to patients, healthcare providers, and family members.

First, benefits to patients: although there is no conclusive evidence that suggests that the presence of family members increases patients' survival, most patients, on reflection, state a desire for relatives to be present, suggesting that patients may well derive some benefit from having close family present.[51] As stated in the introduction, whenever patients learn that their family was with them during CPR, they express gratitude for family members' advocacy, for the useful information family can provide to physicians during CPR, and for their presence, which patients found to be of great help when they were fighting to survive.[52]

Second, benefits to healthcare providers: research indicates that the presence of family members facilitated greater communication between healthcare providers and families, especially when healthcare providers informed family members of the patient's death. Critchell and colleagues wrote that families' presence "increases professional behavior among staff by the humanization of the patient."[53] These authors report healthcare providers said that seeing patients with their loving families in the sometimes rough situation of providing CPR helped providers view patients as "more human," made providers more aware of the dignity of patients, and improved professionalism by reducing dark humor. In short, providers saw patients as real people rather than as a clinical challenge.

Finally, benefit to family members: the core argument for the presence of family members during CPR, as an element of beneficence, concerns the psychological benefits for family members in helping them face a new life without their loved one. Accepting the death of a relative is the necessary first step in a healthy bereavement. As Robert Truog notes, "Actions surrounding the death are highly symbolic and often of great significance to the surviving family. . . . Family members may live for years with the psychological effects and regrets of end-of-life decisions. In these situations, the interests of the surviving family members may take priority."[54]

Several authors agree that "viewing the body seemed to help in the grieving process because the relatives could fully realize that their beloved one was dead."[55] Being present also permits the family of patients who are dying to say a last good-bye, although, in daily clinical practice, families might

need to wait until CPR has ended to make their farewells.

Nonmaleficence

There are no published studies reporting that family members who were present during CPR suffered significantly more from PTSD than family members who did not witness CPR (the standard of care).[56] Concern for PTSD should no longer be an argument against the presence of family members during CPR.

Interference by family members who are present during CPR remains a common worry for healthcare providers. Several studies examined the feelings of healthcare providers when a patient's family was present during CPR, and none reported any cases of aggressive behavior.[57] Most healthcare providers report that their initial caution receded when they became involved in having a patient's family present during CPR. Most providers said that they had experienced no detrimental effect on medical decision making, on communication among healthcare providers, or on communication between healthcare providers and family members.

While the benefits to communication when families are present during CPR have been reported, the effect of being observed while performing defibrillation shocks, chest compressions, and intubation in front of a patient's family is still up for debate. There are no published studies that have been conducted specifically in the ICU setting that test the hypothesis that offering families the option to be present during CPR can be helpful in confronting the process of bereavement without hindering medical efforts or increasing stress on intensivists and nurses. The majority of published studies were conducted in open settings: emergency departments and in prehospital emergency medical services. Conversely, the ICU is a closed setting where families are allowed to be at bedside only during visiting hours—normally two hours, and six hours occasionally, in Spanish ICUs per day, every day. Thus, healthcare providers working in ICUs are used to working away from the view of patients' relatives. Considering this trend, it could be even more stressful for intensivists and nurses to accept family members at the patient's bedside while doing CPR. Future studies should test the above-mention hypotheses in the ICU.

To summarize: the main concerns of healthcare providers—interference and PTSD—do not align with the actual behavior of family members and the testimony of healthcare providers who have experienced the presence of family members during CPR.

What Is a Right, and Why Are Rights Invoked for Healthcare Providers?

A right can be defined as a justified claim on others.[58] The justification of a claim is dependent on standard knowledge and must be accepted, not only by the claimant, but also by society. Moral rights come from Immanuel Kant's assertion that every individual's self-worth must be respected.[59] According to this view, human dignity is based on one's self-governing capacity. Thus, we must be granted the liberty to act freely, to the extent that this freedom does not preclude others' freedom. Kant's principle supports a fundamental right—the right to freely choose for oneself—and rights related to this fundamental right are conventionally called *negative rights,* following the writings of Joel Feinberg.[60] Negative rights are individuals' protection from the actions of others, and give rise to the negative duties of non-interference. These duties are *erga omnes* (toward everyone), in the sense that everyone should refrain from interfering in the exercise of the correlated right.[61]

Family members have the right to be present while CPR is performed because they are direct extensions of the patient. Hence, the family's *prima facie* right to be present in the last moments of a patient's life can only be restricted if healthcare providers provide specific reasons for doing so. Nevertheless, difficult questions about rights arise when the interests of one person are in conflict with the interests of another. In such situations, should the interests of healthcare providers or the interests of patients' families take precedence? If family members are accepted because they are direct extensions of the patient, their right to be present takes precedence. The rationale of this assumption comes from the meta-ethical problem of the justification of rights. According to Feinberg, "To make a claim is to exercise rights one already has by presenting a title."[62] That they are direct extensions of the patient is the title for family members. As Feinberg notes, "The title is the evidence that established the claim as valid."[63]

The *prima facie* duty of healthcare providers is to not exclude family members during CPR. The onus to provide reasons to prevent a family's presence is on the medical team. To do otherwise is to violate familial rights.

As with most rights, the right of a family to be present is not an absolute right. There may be exceptions, for example a patient who expresses her or his desire to hide a clinical condition from family members. In this case, it would be prudent to not invite family members to witness CPR.

From Ethics to Clinical Practice: The Need for a New Policy

Laskowski-Jones states, "Some clinicians firmly believe that allowing family members to be present during resuscitation efforts—very possibly the last moments of a patient's life—is the ethically correct thing to do."[64] Duran and colleagues postulate that most healthcare providers who have experienced families' presence during CPR would support a policy to implement families' presence.[65] However, McLean and colleagues[66] and other authors[67] report that, of the 45 to 51 percent of nurses who worked in departments that permit families' presence during CPR, only 5 percent said that they worked in a department that has a written policy about families' presence during CPR. A written protocol that allows families' presence during CPR may change healthcare providers' attitudes, as Basol and colleagues observed.[68] Policy changes at their facility led to a 26 percent increase in families' presence during CPR. Members of the CPR team described various unexpected benefits of the new policy, including the families' ability to come to terms with the decision to stop resuscitation even before the resuscitation team came to that conclusion.

Dooling and colleagues report that physicians made decisions related to families' presence during CPR 87 percent of the time, whereas hospital or departmental policy guided a decision 9 percent of the time.[69] The authors state that during CPR is not an appropriate time to discuss the presence or exclusion of family members. Many professional organizations, including the Emergency Nurses Association, the American Heart Association, the American Association of Critical Care Nurses, the Society of Critical Care Medicine, and the American Academy of Pediatrics, recommend that healthcare facilities create policies to permit families' presence during CPR as a way to ensure family-centered care, which is considered the paradigm of good clinical practice.[70]

Such a lack of written policy is remarkable not only in the U.S., but also in Spain. Clark and colleagues found that only 5 percent of critical care units in the U.S. have a written policy.[71] Similarly, Gamell-Fulla and colleagues surveyed the heads of pediatric emergency departments at 32 Spanish hospitals and found that only one department had a written protocol on families' presence during CPR, and 11 departments never allow families' presence during invasive procedures or CPR.[72] Gamell-Fulla concluded that families' presence during CPR was not offered due to a perceived risk of parental anxiety and a fear that parents' anxiety might be detrimental to the success of the procedure. In the same study, parents affirmed that they did not want physicians to make decisions for them, as they believed that they had the right to decide whether to stay or leave their child. These two different approaches, parents who defend their right to decide, versus healthcare providers who worry that families' presence during CPR could be detrimental, could create an abrupt increase in tension that would not be helpful during CPR. An established policy would prevent such tension. It is of crucial importance that every institution develop a protocol concerning families' presence during CPR that is most suitable for the sociocultural profile of its catchment area.

Although not all the published studies on families' presence during CPR are in favor of it, there are enough consistent data from all of the parties involved and from both fields of expertise—medicine and ethics—to warrant further investigation. It is imperative that those intensivists who are interested in patient-family-centered care design studies that address the incidence of PTSD caused by families' presence during CPR, the number and type of documented cases of interference by family members during CPR; and healthcare providers' accounts of any detrimental effects on the provision of CPR.

Looking to the future, an over arching policy regarding families' presence during CPR in ICUs is desirable. To achieve this aim, institutions should educate healthcare providers who work with critically ill patients. Once implemented, the clear benefits of families' presence during CPR will be evident enough for it to be embraced by most healthcare providers.

CONCLUSIONS

Healthcare providers report that they are most concerned about the possibility of interference by family members who are present during CPR or that the family members who witness CPR will experience PTSD as a result. Pediatric healthcare providers are less concerned about PTSD resulting from families' presence during CPR than adult healthcare providers, perhaps because they have a more intimate relationship with family members as they provide care, and, therefore, have a more accurate understanding of the emotions of family members.

This study found no significant difference in the attitudes toward families' presence during CPR among nurses versus physicians, possibly because nurses and physicians work closely as a team and because neither party has previous knowledge of the topic.

Healthcare providers are reluctant to offer families' presence during CPR unless it is expressly requested by the family. Upon request, some healthcare providers would generally authorize a family's presence under certain conditions. This may be due to an ingrained disbelief in the benefits of families' presence, or to a lack of desire to become involved in a practice that, to the healthcare providers, is unjustified.

Healthcare providers consider the presence of a family supporter to be extremely important, possibly because they have a justifiable concern for the risk of emotional distress to family members. It is also possible that healthcare providers would be concerned about how to manage the situation if family members exhibited signs of overwhelming distress.

Patients' family members have a negative right to be present during CPR, and thus relatives should be invited to stay with their loved one. If family members are not invited, healthcare providers should provide sufficient justification to the family for that decision.

Healthcare providers find it easier to make a decision to invite relatives to be present during CPR when institutional policies are in place.

CONFLICTS OF INTEREST

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