Family Presence During Resuscitation: An Ethical Analysis

Introduction

Though first described in 1874, the widespread adoption of cardiopulmonary resuscitation (CPR) only occurred with the publication of the first life-support guidelines in 1966 (1). Initially, CPR was only performed by trained health care providers (HCPs), however the development of Advanced Cardiac Life Support courses in 1976 led to the development of bystander-administered CPR outside of the hospital setting. Bystander CPR was soon followed by the first reports of family presence during resuscitation (FPDR), published in 1987 (1, 2). Family members reported a preference for being present during the resuscitation of loved ones, while at the same time HCPs voiced concerns that family members could interfere with resuscitation efforts (2).

The question of whether families should be present during resuscitation is neither a simple matter of patient and family preference, nor a purely clinical decision to be made by HCPs, but rather it is a complex ethical dilemma with many competing interests at stake. The dominant issue is whether the autonomous rights of family members wishing to be present during resuscitation outweigh the potential risks to the patient undergoing CPR and the psychological risks to the family members themselves. In this paper, I argue that the systematic offering of FPDR is an ethically sound practice. By “systematic offering,” I refer to the practice of offering almost all family members the opportunity to be present during resuscitation, as opposed to passively allowing family to be present. I begin by identifying the stakeholders and their general perspectives on FPDR. I then describe the ethical framework described by Beauchamps and Childress (3) and use it to analyze the general arguments for and against FPDR. Throughout, I reference clinical trials which have evaluated FPDR, in particular the recent large randomized controlled trial (RCT) published by Jabre et al (4).

Identification of Stakeholders

Families
Families are central to any debate about FPDR, and studies have found them to be overwhelmingly supportive of the practice, with even those who would not want to be present believing that they should at least be offered the opportunity (5-9). Not all family members may wish to witness resuscitation if offered, with a rate of 80% acceptance in the most recent study (4). General surveys of the public are similarly supportive (10).

**Health Care Providers**

Despite endorsement by many organizations, including the Emergency Nurses Association (11), American Association of Critical Care Nurses (12), American College of Critical Care Medicine (13), American Heart Association (14), European Society of Cardiology (15), and the Canadian Association of Critical Care Nurses (16), and the American Academy of Pediatrics (17), FPDR has remained a contested issue within the medical community. Physicians tend to be more reluctant to support FPDR than nurses, citing concerns about interference of family members with the resuscitation, fear of psychological trauma to family members, and medico-legal repercussions (18-22). A recent international poll found less than 40% of physicians favoured the practice (23).

**Patients**

It is difficult to elucidate the perspective of patients regarding FPDR, as patients are unlikely to recall the events surrounding their resuscitation. A number of surveys and qualitative studies have asked survivors of resuscitation what their preferences regarding FPDR would be, all of which were supportive of the practice (19, 24-29). One study found elderly inpatients who had not undergone resuscitation to also be supportive (28). Patients were also aware that health care teams may need to exercise discretion in which, if any, family members may be present (29).

**Ethical Framework**

In order to evaluate the ethical implications of FPDR, I will adopt the framework described by Beauchamps and Childress (3), which uses four principles to describe the morally relevant features of a problem. Nonmaleficence refers to the avoidance of actions which would cause harm; beneficence to the duty to provide benefit for others; respect for persons/autonomy to the right to make meaningful choices; and justice to the provision of fair treatment. I will examine each principle from the point of view of the patient, family, and health care team, where applicable. Principlism does not proscribe an explicit hierarchy or ranking of the four principles, and they often come into conflict. In the North American context, concerns about respect for
persons (autonomy) will generally outweigh those regarding beneficence, nonmaleficence, and justice, but I will endeavour to justify why any one principle should outweigh any other, and under what conditions. I also emphasize the nature of the fiduciary responsibility physicians have towards their patients, and argue that such a relationship implies greater obligations towards patients than other individuals who physicians may encounter, including families (30).

**Ethical Analysis**

*Nonmaleficence*

Given the high morbidity and mortality of patients undergoing resuscitation, and the fiduciary responsibility of the physician towards the patient, a prerequisite for FPDR is that it cause no harm to the patient. Any significant benefits to the family, the care providers, or the institutions as a result of FPDR must be secondary to any risks it poses to the patient undergoing resuscitation, either by early termination of resuscitation due to family member distress, or direct interference by the family with the health care team’s resuscitation efforts. These are the usual concerns voiced by health-care providers who are wary of introducing a family member to an already chaotic environment (18, 20-22). Although one RCT of simulated cardiac arrest showed increase time until the first shock is delivered with family member presence (31), data from multiple RCTs in both medical and trauma resuscitations show that family interference is an uncommon event, with no evidence of harm to the patient undergoing resuscitation (4, 32-34). There are instances where nonmaleficence indicates that the health care team should exercise discretion in allowing family presence, for instance if family members are intoxicated, abuse is suspected, or there are other signs that their presence will be harmful to the patient (35). However, such exceptions are not sufficient to justify exclusion of family members as the default option during resuscitation.

Similarly, some HCPs are concerned that exposure to the often graphic and chaotic resuscitation environment may result in psychological harm to family members. Although undesirable, a competent family member should be allowed to weigh the risks of such potential harms against the importance of being with their loved ones during what may be their final moments. Because there is no direct fiduciary relationship between HCPs and the members of a patient’s family, there is a weaker obligation to mitigate potential harms. Therefore, though nonmaleficence trumps autonomy when patient welfare is at stake, autonomy can override nonmaleficence concerns for family member welfare. To minimize harms, institutional policies for FPDR should include provisions for a chaperone, to brief family members about what they are experiencing, to monitor for any signs of emotional shock.
**Beneficence**

Unconscious patients undergoing resuscitation are unlikely to benefit from FPDR. However, FDPR has the potential to help family members by providing them with the reassurance that “everything is being done,” by giving an opportunity for closure, and by allowing a final goodbye so as to orchestrate the best death possible, when death cannot be reversed by CPR(36). Traditionally, a physician’s fiduciary responsibility is to the patient, but beneficence suggests that a HCP’s goal should be do the most good possible, including towards the families of patients. However, such duties to beneficence of the family are weaker than to the patients with whom they have direct fiduciary responsibility. Thus, any potential benefits to family members must be weighed against any potential harms to patients, and in general, are of lower priority. However, it has been argued that the chances of survival during CPR are so low that a priority during the resuscitation should be the well-being of the family (37).

**Respect for persons (autonomy)**

Birth and death are poignant and personal life events. Patients and families should therefore have as much autonomy as possible in matters concerning them. Denying a family member the right to see their loved one in the moments prior to death, or allowing a patient to die without a loved one nearby if that would be their wish, contravenes the right to autonomy. The debate over FPDR has been compared to debates in the past about paternal presence during childbirth, now a common, accepted practice (38). The emotions and behaviours people demonstrate when confronted with critical illness varies within and between communities and cultures (19, 39). The consequences of introducing family members to the complex, confusing, and potentially traumatic environment of a resuscitation can vary, and there are anecdotes of family members experiencing traumatic recollections (40). Therefore, as with many other medical interventions where there are potential risks and benefits, the autonomy of those affected -in this case, the patient’s family- should be respected. In the North American context, the right to autonomy often outweighs concerns of beneficence and non-maleficence, especially in such cases where risks and benefits are closely matched. Similarly, the principle of autonomy suggests that if offered, FDPR should always be optional and never mandated or otherwise forced upon families irrespective of any demonstrated benefits.

**Justice**

The principle of justice encourages equal, reasonable access to health care and social resources, including interventions such as FPDR. Multiple RCTs that have evaluated FPDR have demonstrated that more family members would accept the offer to be present than request it if
not offered (4, 32, 33, 41). This implies that without the systematic offering of FPDR to all families, only those family members who have the confidence and authority to specifically request to be present will have the opportunity to do so. Thus, by systematically offering family presence to all available family members, health care providers could mitigate this inequity. Thus, offering is a matter of both procedural justice (ensuring fair process) as well as distributive justice (ensuring equal access to loved ones undergoing resuscitation).

**From Ethics to Evidence**

The debate in medical communities focuses on the relative weights of each of the principles I have outlined above—does the autonomous decision of family members to be present during resuscitation outweigh any potential harms to the patient receiving CPR? Based on the analysis above, I argue that the systematic offering of FPDR is ethical if the following criteria are met:

- no pre-existing wishes to the contrary from the patient exist
- absence of demonstrable harm to the patient undergoing resuscitation
- potential benefits for family members (chance to say goodbye, opportunity for closure, etc.) outweigh, or are comparable to, psychological harms of witnessing resuscitation
- family members have capacity to make an informed decision about being present
- family members who wish to be present during resuscitation are accompanied so as to minimize any potential interference or psychological harm
- the offering of FPDR is done systematically so as to minimize inequity of opportunity to be present during resuscitation

Can the above criteria be met? A large cluster-randomized controlled trial published by Jabre et al in 2013 investigated the effect of systematically offering FPDR to family members of adult patients undergoing CPR (4). The trial included 570 families of patients undergoing resuscitation. 79% of family members in the group which was systematically offered FPDR witnessed resuscitation, while only 43% in the group offered usual care witnessed resuscitation. Those who witnessed were accompanied by a trained support person who monitored the family member for signs of distress and used a standardized communication guide to explain the events during the resuscitation. Family members who were visibly intoxicated, in distress, or otherwise thought to pose a risk to the patient were not offered FPDR.

No significant differences in mortality or duration of resuscitation were seen between groups. Only 4% of patients survived until 30 days. Interestingly, lower rates of post-traumatic stress disorder (PTSD)-related symptoms and anxiety-related symptoms were seen at 90 days
for family members randomized to FPDR. Five family members committed suicide, all of whom had witnessed resuscitation, though there were no statistical differences between the group which was systematically offered resuscitation and the usual care group (4). This suggests that the suicide of family members may not be related to the systematic offering of FPDR. It is uncertain whether it is directly due to the witnessing of resuscitation, or whether witnessing resuscitation and suicide are associated for other reasons (eg. both are indicators of a close relationship between the family member and the patient).

A major concern of some practitioners is that FPDR could potentially lead to increased litigation as families could misinterpret resuscitation efforts as being substandard. However, this has not been seen in the largest RCT to date (4), in which no legal actions were undertaken in the year following study completion. The legal risks to health care providers of FPDR, though a regular source of worry, seem to be small.

Objections to FPDR

I will now address some of the objections to FPDR. Firstly is the concern that FPDR may result in interference with resuscitation. Evidence from Jabre et al suggests that this is rare, occurring in less than 1% of resuscitations, and there is no evidence that such interference results in adverse outcomes for the patient, probably because chances of survival are so poor to begin with (less than 5%) (4, 42).

Secondly is the concern that family members may experience psychological harm by witnessing resuscitation. If properly accompanied, long-term follow-up reveals fewer symptoms of PTSD and anxiety in family members who were offered FPDR. Of concern is the fact that of the small number of family members who committed suicide, all had witnessed resuscitation. However, there is no evidence of a causal association, and this may simply be a marker of attachment to the patient. There was no difference in the number of suicides between groups systematically offered FPDR compared to the group who was not offered, suggesting that such family members will seek to be present during resuscitation even if not offered, and may potentially be at risk for suicide even if they do not witness resuscitation. Even if there was a causal link for some people between witnessing resuscitation and suicide, barring all family members from the resuscitation area, including those who may potentially benefit from the practice, is neither a practical nor proportional solution. Competent family members should be allowed to weigh potential risks and benefits to themselves, and HCPs should aim to maximize the ability of families to be together at the end-of-life. Furthermore, the systematic offering of FPDR with an assigned support person may actually provide opportunities to identify distressed family members and arrange psychological follow-up, and thereby reduce harms. The three
RCTs which have evaluated FPDR in adults have used existing members of the health care team to act as support personnel, including MDs, nurses, and social workers, thereby minimizing any resource costs of the implementation of FPDR (4, 32, 41).

**Conclusions**

FPDR is an issue at the intersection of medical evidence and ethics. In light of current evidence, the systematic offering of FPDR is an ethically sound practice, with minimal demonstrable harms to patients and family members, and it is supportive of patient and family autonomy and reduction of inequalities. When offered, family members witnessing resuscitation should be accompanied by a trained support person to explain the events during resuscitation and monitor for signs of distress. FPDR has the potential to be used safely and effectively by clinicians to provide beneficent, family-centered care.

**References**


35. Ardley C: Should relatives be denied access to the resuscitation room? *Intensive and Critical Care Nursing* 2003; 19:1–10


