EPERC End of Life / Palliative Education Resource Center

FAST FACTS AND CONCEPTS #232 (PDF)

Authors: Ciarán Bradley MD, MA, Melech Lensky BCC, JD, and Karen Brasel MD, MPH <!--[endif]-->

Background Cardiopulmonary resuscitations are abrupt and traumatic clinical events that frequently result in a patient's death or permanent change in health status *(Fast Fact #179)*. Not only can the time period of the resuscitation be the only chance family members have to see a patient before death, but families are sometimes called upon to make end-of-life or other critical medical decisions during this highly emotional event. Allowing family presence during resuscitation (FPDR) has been proposed as a way to better support the emotional needs of family members and facilitate improved decision-making. This *Fast Fact* discusses the potential benefits and pitfalls of FPDR. *Fast Fact* #233 discusses key elements of an institutional policy to effectively implement and maximize the benefits of FPDR.

Description of FPDR FPDR 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…resuscitation events' (1)**.** FPDR involves the selective, monitored admission of one or two family members into the care area while their loved one is undergoing resuscitation. Trained facilitators screen the family members prior to their entrance into the care area, provide constant supervision and emotional support for the family members while observing the resuscitation, and arrange grief counseling or continued spiritual support after the conclusion of the resuscitation. Venues where FPDR can occur include the emergency department or trauma resuscitation room, intensive care units, pre-and post-procedure recovery areas, and inpatient units.

History Historically, many practitioners thought that FPDR was inappropriate and injurious to families, as well as bothersome or dangerously distracting to clinicians. It was seldom practiced, and only on an ad hoc basis. Recently, however, many institutions have developed formal policies and protocols to support the practice, and FPDR has been the subject of intense research. Based on this research, multiple professional societies have endorsed FPDR (2-6), and FPDR has gradually become more accepted by clinicians. The majority of critical care nurses support FPDR (7), and after real-life exposure to an FPDR protocol, 79% of attending physicians supported it as well (8). Resident physicians, however, tend to be the most uncomfortable with FPDR, often feeling watched and evaluated by family members (8).

Potential Benefits of FPDR

Patients: For patients with some awareness of their surroundings (such as when a patient awakens shortly after a successful resuscitation), FPDR can provide comfort through the presence of loved ones (9).

Families: FPDR can help families understand the gravity of their loved one's condition and recognize that the medical staff is doing everything possible (8). It may be that witnessing the trauma of unsuccessful resuscitative efforts can facilitate surrogate decision-makers' comfort with suspending further resuscitation attempts. FPDR can also promote closure and assist with grieving for family members after unsuccessful resuscitations (8).

Medical Team: FPDR provides an opportunity to educate family members about the patient's condition, while family members help practitioners by providing information or acting as spokespersons. FPDR also reminds clinicians of the patient's personhood, and is thought to encourage more professional behavior at the bedside (8,9).

Concerns Associated with FPDR

Traumatized Families: Some practitioners believe that trauma to families can be worsened by watching invasive procedures performed on their loved ones. Evidence shows, however, that family members who are present experience neither prolonged distress nor greater anxiety than those in matched control groups. Furthermore, they may experience fewer symptoms associated with a complicated grief response.

In one prospective trial, 100% of family members who had agreed to participate in FPDR said they would do so again if given the opportunity (8).

Increased Litigation: Concerns persist that FPDR will increase malpractice litigation. These concerns are contradicted by the mounting evidence demonstrating that improved patient and family communication decreases lawsuits/ Additionally, hospitals with longstanding FPDR policies have not reported increase litigation (12).

Hampered Medical Team: Some clinicians worry that FPDR can distract the medical team from the task at hand or lead clinicians to themselves. One study showed the detrimental effect of FPDR on trainee physicians performance in a simulated setting, particularly with 'disrurptive families'(13). However, there are no data from real-life situations to support that FPDR worsens the quality of resuscitative efforts, and many institutions specifically have addressed these concerns in their FPDR protocols (see *Fast Fact* #233).

References

1. Clark AP, Aldridge MD, Guzzetta CE, et al. Family presence during cardiopulmonary resuscitation. *Crit Care Nurse Clin N Am.* 2005; 17:23-32.
2. Emergency Nurses Association. Position Statement: Family presence at the bedside during invasive procedures and cardiopulmonary resuscitation. Revised 2005. Available at: http://www.ena.org/SiteCollectionDocuments/Position%20Statements/Family_Presence_-_ENA_PS.pdf. Accessed Oct 16, 2009.
3. American Association of Critical-Care Nurses. Practice Alert: Family presence during CPR and invasive procedures. 2004. Available at www.aacn.org/wd/practice/docs/family_presence_during_CPR_11-2004.pdf. Accessed Oct 16, 2009.
4. Walsh K. End of Life Care Practice Update: Family presence in resuscitative and treatment procedures. National Association of Social Workers. 2004. Available at www.socialworkers.org/practice/behavioral_health/mbh0904.pdf. Accessed Oct 16, 2009.
5. Cummins RO, Hasinski MF. The most important changes in the international ECC and CPR guidelines 2000. Circulation. 2000; 102:I371-I376. American Academy of Pediatrics Committee on Hospital Care. Family-centered care and the pediatrician's role. Pediatrics. 2003; 112:691-696.
6. Maclean SL, Guzetta CE, White C, et al. Family presence during cardiopulmonary resuscitation and invasive procedures: Practice of critical care and emergency nurses. Am J Crit Care. 2003; 12:246-257.
7. Meyers TA, Eichhorn DJ, Guzzetta CE, at al. Family presence during invasive procedures and resuscitation: the experiences of family members, nurses, and physicians. Am J Nurs. 2000; 100:32-42.
8. Eichhorn DJ, Meyers TA, Guzetta CE, et al. Family presence during invasive procedures and resuscitation: hearing the voice of the patient. Am J Nurs. 2001; 101:26-33.
9. Robnison SM, Mackenzie-Ross S, Campbell Hewson GK, et al. Psychological effect of witnessed resuscitation on bereaved relatives. Lancet. 1998; 352:614-617.

.0. SS, Hamm G. Risk management: extreme honesty may be the best policy. Ann Intern Med. 1999; 131:963-967.
.1. Mason DJ. Family presence: Evidence versus tradition. Am J Crit Care. 2003; 12:190-192.
.2. Fernandez R, Compton S, Jones KA, et al. The presence of a family witness impacts physician performance during simulated medical codes. Crit Care Med. 2009; 37:1956-1960.

ACGME Categories: Systems based practice, professionalism

Author Affiliations: Medical College of Wisconsin, Milwaukee, WI (CB, KB); FroedtertHospital, Milwaukee, WI (ML).

Fast Facts and Concepts are edited by Drew A. Rosielle MD, Palliative Care Program, University of Minnesota Medical Center – Fairview Health Services, and are published by the End of Life/Palliative Education Resource Center at the Medical College of Wisconsin. For more information write to: rosi0011@umn.edu. More information, as well as the complete set of *Fast Facts*, are available at EPERC: http://www.mcw.edu/eperc. Readers can comment on this publication at the *Fast Facts and Concepts Discussion Blog* (http://epercfastfacts.blogspot.com).