VIEWPOINT

Should we allow relatives into the cardiopulmonary resuscitation room?

¿Debemos dejar entrar a los familiares a la sala de reanimación?

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In 2010, the European Cardiopulmonary Resuscitation Council recognized the right of family members to witness resuscitation maneuvers on a patient. Despite institutional recommendations, professionals are generally skeptical of this practice.

A study from the Basque Country in 2019 showed the hesitation of professionals, but also of patients, to witness an invasive maneuver in which the patient could be in pain. In France, family visits began to be allowed, and the impact on families was positive when resuscitation maneuvers were witnessed especially if the outcome was not positive, since it improved grief processing. However, it increased the stress of the professionals and sometimes led to medicolegal problems. In fact, a study also carried out in the Basque Country showed that the presence of the family could indeed influence medical practice.

In the resuscitation room of our hospital, not only cardiorespiratory arrests are attended, but all those patients who have an emergency or resuscitation triage level or who require more intense care in the face of hemodynamic instability or the possibility of worsening in a short space of time. In May 2019, we conducted a survey of the patients we cared for in the resuscitation room. Of the 239 patients, 112 responded, of which 80% were the patient himself or herself and on other occasions a family member. Of all the patients attended, 4 died. The majority (71.4%) would have liked to have had a companion, they understood that this could be a hindrance or distraction to the team. Relatives of patients are overwhelmingly inclined to accept to witness the resuscitation. Unawareness of the patient state, especially when in a serious condition, may cause concern among family members since sometimes the patient remains in the resuscitation room for more than an hour.

Given these results, the question arises whether emergency professionals are prepared to allow family members to witness the resuscitation performance. A study carried out in Spain in 2015 gave this query a negative answer, showing that hospital emergency department professionals face more risks than benefits.

However, out-of-hospital care professionals were more open to this practice, as their resuscitation maneuvers are often performed at the address of the patient or in the street.

Perhaps a space from where family members can observe the process instead would be more appropriate than letting them in the resuscitation room? There is still no clear evidence on this. A review in 2008 was not able to tip the balance towards the benefits nor the risks of the presence of relatives. A 2017 study showed that, if during resuscitation a liaison person could accompany the family, explaining what was being done and answering questions, it could compensate for the need to watch invasive procedures or resuscitation on site. A publication in Plos One showed that the presence of the family could lessen the pain of death and help the patient at a decisive moment. Once again, communication between the family and the care team is shown to be a fundamental element.

The fear that the family may interfere with resuscitation and the fear of legal consequences if resuscitation does not work are 2 of the main obstacles for professionals. One of the main problems is the Slow Code or the simulation of resuscitation. This is when maneuvers are performed in a simulated manner to avoid informing the family that the patient has no chance or in the face of very demanding relatives and with the risk of a complaint. On some occasions this is done precisely so that the family can grieve correctly in the face of an unexpected death that is imminent.

As long as the care process remains transparent there is no need to keep family members from witnessing the performance. In the face of resuscitation, perhaps one of the most relevant medical operations where professionals give their very best, why is there any inconvenience of being observed? Is it because of a paternalistic point of view trying to protect the family from what they should or should not see? As previously mentioned, it is a matter of allowing rather than forcing. There is less hesita-
tion in the case of a patient in whom resuscitation is successful. But if resuscitation does not succeed in saving the patient's life or in recovering the patient's situation, why is there a rejection to show the family that all efforts have been made? The focus of this topic could go as far as perceiving the witness as part of a quality control to ensure the excellence of EPs resuscitation performance. Still, it remains an unresolved debate that should possibly be raised again.

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