# Should relatives be allowed to watch resuscitation?

*The sudden death of someone after an accident at a public event can be difficult for relatives to cope with. Doctors' attention is focused on the patient, and the needs of relatives are often unheard. Sarah Adams describes her feelings when her brother died after falling from his horse at the Windsor international three day event, and a doctor who was on duty at the event gives his view. We asked an anaesthetist who was a member of the Resuscitation Council, a cardiologist who runs a resusucitation training course, and a general practitioner with a special interest in ethics to comment on Sarah Adams's wish to be present during attempts to resuscitate her brother.*

## A sister's experience

Sarah Adams

My younger brother, Richard Adams, had spent the best part of his life riding and competing horses, the last four years professionally. On the day of the cross country phase of last year's Windsor International three day event, he was happy and confident, laughing and chatting with friends. He said goodbye as he mounted. I cannot explain why, but I went back, held his hand, kissed him, and told him to enjoy his ride. He successfully completed 13 fences and the table fence loomed. I have since learnt of five other deaths at this type of fence in the past six years. As they took off the horse did not get enough height over the fence. It went head over heels, catapulting Richard over the fence head first, and landed on top of him. Moments later the horse stood up and I knew that something was very wrong.

I was not very far away from where Richard was lying. When I reached him he had been put in the recovery position and was lying still and extremely white in a pool of blood. Someone had taken his hat off, and it was sitting beside him—covered in blood. My mind was racing: "This couldn't be happening to Richard. What would we all do if he was dead? I must make sure my mother does not witness this." A team of doctors were quickly by his side and thankfully somone started to screen off the area to hide us from onlookers and the press. The riding had been stopped, and apart from the activity around me it had gone very quiet.

They started to resuscitate him: a woman gave him compressions to his chest: someone on the other side was bagging him with oxygen connected to a tube inside his mouth. There was another tube in his mouth, which seemed to contain large volumes of blood.

My parents arrived. My mother stayed outside the screens and my father stood beside me, holding my hand and praying. He kept rushing from Richard's side to my mother's. People kept asking me to leave but I chose to stay. I wanted him to know that I was close to him in his time of need and would have liked to have held his hand but didn't dare ask. I just sat down quietly on the fence. Time seemed endless, but after about 40 minutes we were told we had to leave. I left the enclosure to face the masses of people standing there wanting to know what was going on inside. A friend called to me, and as a family we stood in full view of everyone waiting for news and not being told anything. After about five minutes we moved into a St John ambulance and a doctor came to tell us that they were taking him to Wexham Park Hospital.

We were taken to the hospital, feeling disbelief that this could be happening. We were thinking of unimportant facts that seemed vitally important at the time—cancelling appointments for that evening. How would we get home from the hospital? Would the dogs be all right at home, and who would feed them? Richard was proclaimed dead shortly after arrival at hospital.

Since Richard's death I have discussed the advantages and disadvantages of watching the resuscitation process with nurses and doctors. It seems that most professionals would prefer relatives not to be present, but I would not have been anywhere else at that time. You have to make a split second decision and whatever your decision you will cope with it later. Insisting on staying with Richard has helped me to come to terms with his death, although it did upset me that people constantly tried to remove me. I am sure that if I had allowed myself to be ushered out, it would have been impossible to return.

People in these circumstances should be encouraged to follow their instincts. They should be made welcome if they wish to stay and be kept updated. It is a very frightening experience to someone who does not understand what is going on in front of them, but the overwhelming desire is to stay close to the injured person. This overrode any fears that I experienced.

## The doctors' perspective

Michael Whitlock

There were seven doctors covering the event and the Royal London helicopter was also present. Some of us had international reputations in immediate care and resuscitation. Screens appeared from nowhere to provide privacy but I was always aware of the presence of members of the Royal family, the world press, and many spectators. I took Richard's sister to sit on the jump—to comfort her and allow her to watch from a distance. Doctors kept coming to the family to ensure they were coping, but later Sarah said she could not remember this.

There is no reason why relatives should not watch the resuscitation and I believe that they should not be discouraged. It may help them to come to terms with the death and realise that everything possible had been done. This should apply not only to sporting events but also at home or in hospital.

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My role as doctor was not finished after Richard Adams had been certified dead. The equestrian world is small, and memories of many deaths and tragedies came back. There were five deaths in eventing in 1993 alone. One woman told me that the family never discussed her sister's death from a riding accident. What does one say to the starter who was the last person to speak to several of the dead riders last year? There have been several deaths over this particular type of fence, and the person who built two of them was also distraught. This fence has now been modified to reduce the possibilities of death. Because of my involvement it was easier for people to talk to me about their feelings and hopefully come to terms with this and other tragedies.

Richard Adams's family has raised nearly £50 000 to provide an ambulance so that all the necessary resuscitation equipment is present at horse trials. This will complement the existing ambulance. The medical profession has a responsibility to ensure that if a doctor agrees to cover an event he or she has the necessary skills and practical experience to do so.

## Relatives' wishes should be accommodated

Roger Higgs

Doctors are often accused of being more concerned with the outcome of their work than with the processes involved, but in resuscitation this approach seems at first sight amply justified. Successful resuscitation continues a life; failure compounds the tragedy. Thus anything that might reduce the chance of success requires a strong counter argument. Health professionals must concentrate their attention on preventing the death, and some people worry that they might not do their best in front of spectators who are emotionally involved and might interfere physically. The patient's body is being treated as an object, and the physical details of the procedure—electric shock or opening the chest, for instance—might look like a horrifying assault. In addition, there is concern that memories of resuscitation might plague relatives later in bereavement. How do we know the person could cope? Thoughtfulness suggests the risk is too great. Even Sarah wanted to make sure her mother did not see what happened.

Yet the paternalistic desire to protect relatives misunderstands the human response to possible death. Sarah Adams's brave account offers all the evidence. Death is a personal, private, or family event, and we may feel strongly that we should be there to support, hold, or talk to someone we love—that the dying person, even if unconscious, needs companionship. Professionals, however kind, are strangers. Likewise, there is no preparation for a sudden death; and witnessing the event may reduce the disbelief that hinders grieving. These concerns alone suggest that if members of the family decide that they can cope they should be allowed to stay. But there is more. Many people reproach themselves in grief for not having done enough. If it does not hinder the medical work, this account suggests that allowing someone from the family to touch or hold a hand would be important later.

There have been campaigns to train the public in resuscitation, and television has made the process more familiar. People who have a claim to be there and feel they can cope should be allowed to stay. Doctors who act at public events ought to be able to cope with at least this minimal addition of openness to their work. And others who usually work in a less public environment should also prepare themselves for this request.

Someone from the family has a role in several senses. Professionals not needed for the immediate resuscitation work should care for the needs of the family: for their privacy, for appropriate companionship and comfort, for information and explanation, and if necessary help with their reasonable claims to be properly heard, and appropriately involved.

## Good information and time with the body are more important

Peter Bloomfield

Most people would want to have their close relatives with them when they die. Relatives also want to be present when a family member is seriously ill. But what if there is a sudden catastrophe such as trauma or cardiac arrest when prompt and expert medical attention can save a life? The instant reaction is that of "please do something". Will the attempt at resuscitation be hampered or hindered by the continued presence of the relatives?

Most doctors' instinctive reaction is to ask the relatives to leave when they are attempting a resuscitation. They may have a number of fears: that the relatives might become hysterical and distract them from or interfere with their efforts; that their resuscitation skills are inadequate and they will be seen to be incompetent; that it will be hard to stop when continued resuscitation seems futile if the relatives are present; that the sight of intubation, defibrillation, or dealing with the consequences of major trauma will be too distressing. Some relatives may wish to protect others from this experience, as Sarah Adams did.

The decision whether to allow a relative to stay has to be instantaneous—there is no time to interview or counsel. Undoubtedly many will be distressed if they stay (colleagues have recounted occasions where relatives have wished that they had not been present) and others will be distressed if they were not allowed to stay. It can be hard to believe that a sudden death has occurred.

Ambulance staff are the people who most commonly have to attempt resuscitation in the presence of relatives. Those I spoke to said that witnessing resuscitation is a terrible experience for relatives and that it seems less distressing if someone can take the relative to another room. If this is not possible the crew usually asks relatives to do something such as write down details of name, address, and drugs so that they feel they are doing something useful. One of the most distressing feeling for relatives is guilt that they should have done something more to help.

I believe that most doctors' instincts are right and that relatives should be asked to leave, but in a way that will allow those to stay who feel they must. "It is probably best that you leave. We will keep you fully informed of what is happening. You may stay if you feel you need to." If relatives do stay there should be an experienced nurse or doctor with them to explain what is happening and why. If the relatives leave they must be kept fully informed, and promptly, on the progress of resuscitation.

It is essential that relatives are allowed to return after the patient has died. They may feel guilty that they allowed themselves to be taken away, and they must be counselled that if the patient was unconscious he or she

would not have known of their presence or absence. Whether the relatives stayed or left during resuscitation they must be allowed time with the body of the deceased to start to come to terms with the death.

## Doctors need to be trained to work in public

Peter J F Baskett

Sarah Adams's account of her emotions at witnessing her brother's violent and untimely death will touch all in the medical profession. It makes us reflect on our policy of preventing relatives from watching undignified procedures such as resuscitation.

This was not an isolated incident. As Dr Whitlock points out, several deaths occurred during equestrian events last year and they also occur in other dangerous sports such as motor cycle, motor, and power boat racing, although thankfully less often than previously. The problem arises much more commonly, however, with people who have heart attacks. The relative either attempts resuscitation or watches helplessly as a sole bystander performs chest compressions and mouth to mouth ventilation.

Lay people as well as paramedical and medical professionals will attempt to exclude relatives from the scene. The action is based on genuine compassion for the feelings of the relative. Those performing resuscitation may also fear that the relative will become overdistressed and interfere or that they will be put off by excessively critical scrutiny.

Increasingly, doctors are expected to perform in front of the public. Mothers watch their children being anaesthetised, fathers are present during childbirth, and there are even reports of relatives observing organ harvesting after death. Doctors attending popular events must be trained and prepared to exercise their skills in front of a grandstand full of onlookers and under the scrutiny of the press and television cameras. Thankfully, the British media are nearly always discreet on such occasions.

We must reconsider our knee jerk reaction that it is psychologically harmful for relatives to watch resuscitation attempts. A degree of emotional scarring will inevitably follow if the resuscitation is unsuccessful, but, as Sarah Adams points out, watching will help some people come to terms with the anguish of bereavement.

Clearly, relatives have only a few seconds in which to decide whether they want to stay during resuscitation. Whatever decision they make it should be immediately respected. Either way they should be comforted and honestly informed of progress at regular intervals. Miss Adams has given us food for thought. The food is certainly not indigestible, and the profession should react with understanding and compassion.

## Withholding and withdrawing life sustaining treatment from elderly people: towards formal guidelines

Len Doyal, Daniel Wilsher

**Clinicians often decide either to withhold or to withdraw lifesaving treatment in elderly patients. Considerable disagreement exists about the circumstances in which such actions can be defended. Debates about the scarcity of resources in the NHS add urgency to the need to resolve this disagreement. Competent elderly patients have a legal and moral right to decide whether to receive life sustaining treatment. Such treatment should not be withheld or withdrawn on the basis of a patient's age alone. Principles for making decisions about life sustaining treatment in incompetent elderly patients can be defended and should exist as written guidelines.**

Clinicians working with elderly patients often face difficult decisions about withholding or withdrawing life sustaining treatment. They must balance the sometimes uncertain benefits of active intervention against the potential burdens. Despite the frequency of such dilemmas little clear guidance exists on the moral and legal status of "non-treatment."

The lack of such guidance is unsatisfactory for several reasons. Firstly, clinicians often disagree about what is morally and legally required of them. Secondly, this disagreement leads to arbitrary differences in the treatment that elderly patients receive; indeed, on occasion, non-treatment on the basis of old age is used unacceptably as a mechanism for rationing scarce resources.[1,2] Finally, when disagreements arise within clinical teams or with patients or relatives no agreed policy exists to help to resolve these disagreements.

In recent years the extent of the legal duty to provide life sustaining treatment has been substantially clarified. Allowing elderly patients to die is now without doubt lawful in certain circumstances. Furthermore, developments in moral theory have reinforced the acceptability of such actions. In this paper we build on these results to defend specific principles for non-treatment which can be applied to characteristic dilemmas in geriatric medicine. While many of our arguments are applicable to all adult patients regardless of age, our focus remains firmly on elderly people.

### Informed consent and non-treatment

Irrespective of their age all adult patients who are competent to consent to life prolonging treatment are also competent to refuse it. In general, therefore, they have the legal and moral right to know that they are being considered for non-treatment on whatever grounds unless they specifically delegate decision making to their clinician.

Only two exceptions to this legal and moral right exist. The first arises when clinical evidence exists that a discussion of non-treatment may endanger the patient's health. In such a case doctors should seek permission to discuss the patient's care with close relatives. The second exception arises in cases in which treatment would be futile in that it would not achieve its physiological objective. Clinicians are not obliged to offer useless interventions, and these do not need to be discussed with patients.[3]

Given that consent to non-treatment should normally be sought, we have argued elsewhere that it does not need to be explicit. Elderly patients who are competent

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