

## Should relatives watch resuscitation?

### No room for spectators

EDITOR,—The article discussing whether relatives should be allowed to watch resuscitation raised some interesting points.<sup>1</sup> As a medical registrar I have several objections to relatives being allowed to watch resuscitation.

The atmosphere of a resuscitation in hospital is very different from that described by the authors. Far from being a calm, controlled environment, it often comprises five scared junior members of staff crowded around a hospital bed.

It is the job of the person leading the arrest team to instil confidence and prevent panic. I have found that one of the most effective ways of doing this is to appear detached about what is going on around me, and even to make occasional lighthearted comments. I believe that this slightly relaxed atmosphere helps people to concentrate on the priorities of the job in hand and avoid being distracted by unimportant details because of anxiety. The presence of a relative would inhibit this kind of reassurance. I also believe that many relatives would find it upsetting to see hospital staff working in this impersonal fashion.

Secondly, the resuscitation of patients in hospital is often much more invasive than that described by Michael Whitlock. I am sure that seeing defibrillation or a pericardial drainage would be unreasonably distressing for most people.

It is often difficult to fit even the most essential staff or equipment into the spaces around beds when resuscitating. This cramped environment would certainly not allow the presence of spectators.

It could be argued that relatives should be allowed to stay until one of the above situations arises and should then be taken away, but it is often the case that there is simply not time to monitor the condition of both the patient and relative.

I have witnessed a relative present during resuscitation only once. A mother, distressed at the sight of cardiac massage, tried to drag the doctor off her daughter. It took three nurses to remove and comfort her and delayed defibrillation by at least three minutes.

It is not always possible for relatives to know how they will react in such stressful and upsetting circumstances. It is the unpleasant task of doctors to sometimes call on greater experience to make decisions which go against the wishes of intelligent people. We should not shirk this duty, especially if it is to the detriment of the patient.

R J SCHILLING  
Cardiology registrar

Hull Royal Infirmary,  
Hull HU3 2JZ

<sup>1</sup> Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF. Should relatives be allowed to watch resuscitation? *BMJ* 1994;308:1687-9. (25 June.)

### Local factors may influence decision

EDITOR,—The debate on allowing relatives to watch resuscitation<sup>1</sup> has extensively addressed all the main points and leaves the impression of a consensus that relatives' wishes should be accommodated. This attitude is based on the idea that people will let doctors do their job and will cooperate with them. Unfortunately it is extremely

We prefer short letters that relate to a recently published article and are we unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

rare, in my experience at least in southern Italy, to obtain a minimum of self control or cooperation from the relatives of a patient to be resuscitated.

The emotional distress and despair are always expressed by an aggressive attitude, even towards the doctors and the paramedics who are trying to reach the patient through a crowd of screaming or fainting relatives and spectators. Some colleagues have even been wounded as they tried to put a patient in the ambulance or to make some space to start resuscitation procedures. This is not just a matter of education, since this attitude is found in every social class.

In a country like Italy, in which charges of malpractice and misconduct have landed ministers and vice ministers for public health in jail, people prefer to rely on "magic thinking." This stems from the cultural attitude of the "Latin soul" towards tragedy and a deep mistrust of doctors who, while trying to resuscitate a patient, are often physically assaulted by relatives who get the feeling that "something" is going wrong. It may even happen that a dying patient would be carried into a church, rather than into a nearby hospital.

CLAUDIO CRISCI

Centro Medico di Campoli,  
Via N Bixio 10,  
82030 Campoli,  
Italy

<sup>1</sup> Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF. Should relatives be allowed to watch resuscitation? *BMJ* 1994;308:1687-9. (25 June.)

### Relatives can be helpful

EDITOR,—The question of whether relatives should be allowed to watch resuscitation was posed for me two weeks before I read Sarah Adams's article and the commentaries,<sup>1</sup> when a 3 year old child with a thermal injury to 55% of his body had a cardiac arrest while on a ventilator for treatment of a deteriorating pneumonia. I am happy to report that the resuscitation was successful, although the period of hypoxia was prolonged and brain damage was feared until his successful weaning 10 days later.

There is little time to think in such circumstances; reintubation (the tracheal tube was displaced more than once in this crisis) and giving drugs were the only thoughts in my mind. The man at the end of the bed was helpfulness itself, responding intelligently to my (fortunately calm) requests to hold this, hang on to that; my eyes were meanwhile fixed on the child and the monitors. It

was not until the heart rate was restored and there was time to relax a little that I realised that my helper had been the child's father. Furthermore, the nurses had sized up the situation a little more quickly than I, had instantly decided that any "damage" was already done, and had allowed him to continue his excellent work.

I asked him later, when his shock and worry had faded somewhat, how he had felt at the time. Like those mentioned in this series of papers, he had found it helpful to be involved. He had not considered it unusual, and had just reacted instinctively, knowing he was contributing to his son's welfare.

I am, however, left with one concern: what might I have said to him, in the heat of the moment, if, still mistaking him for a professional helper, I had found him less helpful? Would I have berated him for incompetence, and would he have understood or been deeply hurt? I am sure that, though like the authors I favour allowing relatives the choice of whether to remain for a resuscitation, I will henceforth always spare just two seconds to make myself aware whether they are present and think with just a small part of my brain of their wishes. I am also left with a strong feeling that asking this man to leave would have been a greater distraction to my work than allowing him to remain.

KEITH C JUDKINS  
Medical director

Yorkshire Regional Burn Centre,  
Pinderfields Hospitals NHS Trust,  
Wakefield WF1 4DG

<sup>1</sup> Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF. Should relatives be allowed to watch resuscitation? *BMJ* 1994;308:1687-9. (25 June.)

### May affect doctors' performance

EDITOR,—The major discussion about whether relatives should be allowed to watch resuscitation seemed to be in relation to a death in a public area.<sup>1</sup> We would like to report our experience of a hospital setting.

The philosophy of our department has facilitated exposure of relatives to the care being given to their family members in the resuscitation room. The relatives have been briefed by a senior member of nursing staff and then are brought into the resuscitation room by the nurse and given a continuous explanation of the procedures going on.

Records are not kept, but our impression is that some part of one in 20 adult resuscitations are watched by a relative, but over half of children's resuscitations are witnessed by the parents. All relatives are offered the opportunity to view the body after unsuccessful resuscitation.

The effect of observing relatives on the confidence of doctors is constantly borne in mind. We never allow relatives to stay unless all the staff present are comfortable with their presence.

Follow up of relatives, particularly parents, who have witnessed resuscitation attempts shows 100% to be appreciative of the experience, and they report benefits in terms of grieving and coming to terms with an unsuccessful resuscitation.

This is a routine service that we offer in our department, and we commend it to all other accident and emergency departments, although it must be recognised that it requires time and experience for everyone involved in the resuscitation team to become comfortable with the concept

and to be prepared to put the necessary effort into looking after the relatives.

NIGEL ZOLTIE  
Consultant  
JP SLOAN  
Consultant  
BOB WRIGHT  
Clinical nurse specialist

Accident and Emergency Department,  
General Infirmary,  
Leeds LS1 3EX

1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF.  
Should relatives be allowed to watch resuscitation? *BMJ*  
1994;308:1687-9. (25 June.)

## Effect on relatives needs study

EDITOR,—Most of the writers considering whether relatives should be allowed to watch resuscitation were in favour, using Sarah Adams's account as strong evidence.<sup>1</sup> We should keep in mind, however, that her account is the account of only one relative. It is noteworthy that her mother chose to remain outside the screens while her son was being resuscitated. Had she given her account of that tragic incident, it may very well have given us a completely different perspective.

Peter Bloomfield notes that ambulance staff report that "witnessing resuscitation is a terrible experience for relatives." Before we start advocating that relatives might be present during resuscitation procedures we should have more formal studies of the short term and long term effects of such an experience on relatives who have attended such procedures previously—mainly those relatives present when ambulance staff carry out resuscitation procedures at home.

I feel that Bloomfield's view was the most practical of those presented—ask the relatives to leave in a way that allows those who feel they must remain to do so; keep the relatives fully informed; and allow sufficient time for the relatives to remain with the body immediately after death. Simple counselling should be given to the relatives immediately after that, emphasising that they could not have done anything more had they stayed and that the patient was unconscious and would not have been aware of their presence. This would aid in preventing or alleviating feelings of guilt.

HISHAM MEHANNA  
Medical student

University of Glasgow,  
Glasgow G12 8QQ

1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF.  
Should relatives be allowed to watch resuscitation? *BMJ*  
1994;308:1687-92. (25 June.)

## A successful American programme

EDITOR,—Sarah Adams's account of her brother's death at an equestrian event raised several issues regarding the rights of relatives to be present during resuscitation.<sup>1</sup> The account and the subsequent viewpoints of eminent doctors, who mostly supported the rights of the relatives, mirrored a debate among American emergency room nurses that began with a letter in their official journal in 1991 supporting the rights of relatives to be present during resuscitation.<sup>2</sup>

The Foote Hospital in Jackson, Michigan, USA, has operated a planned programme of family member presence during resuscitation since 1982.<sup>3</sup> This programme stemmed from two incidents in which relatives demanded the right to be present: in the first case the relative had been in the ambulance during the initial resuscitation attempts, and in the second case the relative belonged to the family of a police officer who had been shot. The staff of the emergency room at the Foote Hospital questioned whether it was ethically correct to exclude relatives and close friends during resuscitation, as had previously been the norm. Since the hospital's programme began, no resuscitation

attempts have been interfered with. Relatives or close friends have occasionally fainted or become hysterical but they have quickly been escorted from the room.

The key to the programme's success stems from several factors, which were suggested by Peter Bloomfield.<sup>1</sup> Chief among these is the need for a trained person, in addition to those in the resuscitation team, who can discuss the procedure with relatives or close friends and offer to stay with them during resuscitation. They should be able to enter and leave as they wish; in fact, most relatives and close friends stay for only a short time. The resuscitation team allows them to hold the patient's hand or just to sit close by.

Malone suggests that it is ethically questionable to exclude relatives or close friends from such a procedure.<sup>4</sup> Exclusion may devalue the death to a clinical procedure or a failure of treatment rather than a unique human event that touches the lives of others. But if close friends or relatives are admitted to an event that is traditionally the reserve of health care professionals then loose talk and black humour, occasionally used to defuse a tragic situation, may have to be carefully monitored. Of major concern is the grieving relative or friend holding the patient's hand, who may be unfamiliar with terminology such as "Everyone clear!"

RICHARD HATCHETT  
Lecturer in critical care

St Bartholomew and Princess Alexandra  
and Newham College of Nursing and Midwifery,  
Royal London Hospital,  
London E1 2EA

- 1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF.  
Should relatives be allowed to watch resuscitation? *BMJ*  
1994;308:1687-9. (25 June.)
- 2 Martin J. Rethinking traditional thoughts. *Journal of Emergency Nursing* 1991;17:67-8.
- 3 Hanson C, Strawser D. Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine-year perspective. *Journal of Emergency Nursing* 1992;18:104-6.
- 4 Malone R. The ethics of exclusion and the myth of control. *Journal of Emergency Nursing* 1993;19:33-34A.

## Elderly patients and resuscitation

### Advanced age is not a factor

EDITOR,—Marguerite E Hill and colleagues and R Morgan and colleagues have highlighted the difference between doctors and patients regarding resuscitation decision making.<sup>1,2</sup> We sought the opinions of doctors and nurses regarding 100 elderly patients admitted through casualty in a district general hospital. All patients were over 70 (mean age 80 years); 59 were admitted under the care of a general physician and 41 a geriatrician. There was no formal resuscitation policy.

A questionnaire was completed by the junior doctor (senior house officer or registrar) and senior ward nurse in all cases and by the consultant in 88 cases. Each was asked whether the patient should be resuscitated, the degree of discussion that had taken place, and the importance of various factors (graded on a scale of 1-5) in making a decision.

There was no significant difference, by matched analysis, between junior and senior doctors in the likelihood of making a decision for resuscitation; consultants felt that 55/88 (63%) should be resuscitated and juniors 63/100 (63%). In 23/88 (26%) cases there was disagreement between junior and senior doctors. Nurses felt that 51/100 (51%) should be resuscitated. In only 53/88 (60%) cases was there agreement among all three groups. There was no difference between general physicians and geriatricians.

In only 7/33 (21%) cases, when the consultant felt that resuscitation was not appropriate, had there been any discussion of resuscitation with either the patient or a relative. Junior doctors

reported discussion in only 8/37 (22%) such cases. Even if discussion had taken place, in only one case did either the consultant or junior doctor feel that the opinion of patient or relative was of major importance (graded 4-5) in making a resuscitation decision.

"Agism" did not seem to be practised by either doctors or nurses. The mean age of those for resuscitation was 79 years and those not for resuscitation 81 years. In only 5/88 (7%) and 8/100 (8%) cases did consultants and junior doctors respectively feel that age was a major factor (graded 4-5) in deciding resuscitation status.

Do not resuscitate orders are poorly recorded in hospital notes.<sup>3</sup> In only 13/33 (39%) cases when the consultant felt that resuscitation should not be performed was there a record of "not for resuscitation" in the notes.

In summary, despite a *BMJ* editorial in 1982 which stated, "No longer should the choice [regarding resuscitation] be left unspoken, undiscussed, and less important, unrecorded"<sup>4</sup> doctors and nurses continue to exclude patients and their relatives from the decisionmaking process of resuscitation.

NICK P THOMPSON  
Senior house officer  
GILLIAN H JENNER  
Consultant

Department of Medicine for the Elderly,  
Orsett Hospital,  
Near Grays,  
Essex RM16 3EU

- 1 Hill ME, MacQuillan G, Forsyth M, Heath DA. Cardiopulmonary resuscitation: who makes the decision? *BMJ*  
1994;308:1677. (25 June.)
- 2 Morgan R, King D, Prajapati C, Rowe J. Views of elderly patients and their relatives on cardiopulmonary resuscitation. *BMJ* 1994;308:1677-8. (25 June.)
- 3 Stewart K, Abel A, Rai GS. Resuscitation decisions in a general hospital. *BMJ* 1990;300:785.
- 4 Bayliss RS. Thou shalt not strive officiously. *BMJ* 1982;285:1373-5.

## Some patients can benefit

EDITOR,—Marguerite E Hill and colleagues<sup>1</sup> and R Morgan and colleagues<sup>2</sup> advocate that patients should be more involved in decisions about whether they should be given cardiopulmonary resuscitation. The information given to patients about cardiopulmonary resuscitation, however, strongly influences their opinions. Murphy *et al* showed that patients' preferences for cardiopulmonary resuscitation were reduced when they were given accurate estimates of survival.<sup>3</sup> We have found that British and American doctors and nurses overestimate the potential for survival after cardiopulmonary resuscitation, and they will probably convey this overoptimistic view to their patients. Perhaps attention should be given to educating health professionals about cardiopulmonary resuscitation before patients are educated.

We have surveyed health professionals, in both Britain and the United States, about their attitudes to decisions on whether to resuscitate patients and their current practice (unpublished data). In Britain 73 of 114 doctors and nurses stated that patients were infrequently or never involved in decisions on cardiopulmonary resuscitation and 69 thought that they should be more involved. More surprisingly, in the United States, where patients are legally required to consent to "do not resuscitate" orders, 50 of 208 doctors and nurses stated that patients were infrequently or never involved in the decisions. Perhaps this shows the difficulties that arise when policy in such sensitive matters is dictated by law. We have used audit methods to agree and subsequently initiate a policy for making decisions on cardiopulmonary resuscitation, and this has resulted in a considerable improvement in the documentation of do not resuscitate orders. This policy is being updated to include discussion with patients when appropriate.