Attitudes of Emergency Department Staff toward Family Presence during Resuscitation

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ABSTRACT: **Background:** While family presence during resuscitation has been researched extensively in the international and especially American medical literature, in Israel this subject has rarely been researched. Because such policies have become common practice in many countries, it is important to investigate the attitudes of health care staff in Israeli emergency departments to better understand the potential implication of adopting such policies.

Objectives: To examine the attitudes of the physicians and nurses in the ED of Soroka Medical Center to FPDR.

Methods: The methods we used were both qualitative (partly structured open interviews of 10 ED staff members from various medical professions) and quantitative (an anonymous questionnaire that collected sociodemographic, professional, and attitude data).

Results: The qualitative and quantitative results showed that most staff members opposed FPDR. The main reasons for objecting to FPDR were concern about family criticism, the added pressure that would be put on the staff members, fear of lawsuits, fear of hurting the feelings of the families, and the danger of losing one's "objectivity" while treating patients. Physicians objected more strongly to FPDR than did nurses.

Conclusions: More research is needed on FPDR in Israel, including an examination of its medical, ethical, legal and logistic aspects. In addition to the views of the medical staff, the attitudes of patients and their families should also be examined.

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KEY WORDS: family presence during resuscitation, attitudes, cardiopulmonary resuscitation, family-centered care, emergency room practices

Traditionally, family members were not allowed to be present during resuscitation. Not only is it a potentially traumatic experience for the family, but they could interfere with the resuscitation procedure itself [1] However, the attitude toward family presence during resuscitation has changed in recent years and today there is a tendency to allow it.

Experiencing the death of a family member is an understandably difficult experience, especially when uncertainty and unrealistic expectations about survival are added. Nevertheless, if asked, most patients say they would like family members to be present during resuscitation [2]. Furthermore, most people express a desire to be present during a family member's resuscitation, and those who experienced such an event say they would do it again should the situation arise [3]. Opinions among medical staff, however, are divided. Research conducted mainly in the United States showed that some staff members believed FPDR would traumatize family members and lead to an increase in lawsuits, and that, ultimately, it was detrimental to patient care. On the other hand, some staff members believed that FPDR benefits not only the patient and his/her family, but also the staff [4].

The major findings to emerge from recent FPDR research show that support for FPDR is influenced by several factors: a) profession (nurses more supportive than physicians), b) length of professional experience, c) staff training, and d) previous experience with FPDR [4]. Although an extensive body of research shows that FPDR benefits the family, only a limited number of hospitals in the U.S. actually have a protocol that allows FPDR [5].

No research on the attitude of medical staff to FPDR has been done in Israel. In 2001, the Israel Ministry of Health published guidelines stating that each patient can be accompanied by a family member (or other person of his/her choosing) during medical examinations. However, these guidelines do not identify specific medical situations like resuscitation. The Ministry of Health has no official guidelines regarding FPDR, and the decision of whether to allow it is left to the attending medical staff. Although no survey has been done, there is anecdotal evidence that FPDR does occur in Israel, in most cases when a staff's family member or someone under the age of 18 is involved.

The aim of the present study was to examine the attitudes of the physicians and nurses in the emergency department of Soroka Medical Center, Beer Sheva, toward FPDR.

FPDR = family presence during resuscitation

SUBJECTS AND METHODS

This research combines qualitative and quantitative methods.

QUALITATIVE RESEARCH

The research tool was a partly structured open interview of ED staff members from various medical professions. The interviews, conducted in the ED of Soroka during morning hours, were recorded with the consent of the interviewees. All the interviews were transcribed and analyzed, and their main themes compared. The themes and insights that emerged from the interviews were taken into consideration when planning the quantitative part of the research.

QUANTITATIVE RESEARCH

During a 2 week period, an anonymous, computerized questionnaire built on Microsoft Access software was distributed to all ED personnel at Soroka Medical Center. The questionnaire was adapted and translated from Badir and Sepit [6]. We distributed a pilot questionnaire to 10 physicians, nurses and paramedics who work outside Soroka, and we used their feedback to adjust the questionnaire interface. The internal consistency of the questionnaire was assessed using Cronbach's alpha coefficient and found to be 0.82. The questionnaire was divided into four parts:

- Nine sociodemographic questions: age, gender, religion, country of birth, profession, country where medical training was acquired, years of experience in the ER, medical and academic education
- Three questions that explored each employee's objective experience with FPDR
- Twenty questions based on a Likert scale of 1 to 7 that examined employee opinions on FPDR. These questions were divided into three dimensions – the effect of FPDR on the staff, the effect of FPDR on the family, and the effect of FPDR on the patients – whose values were calculated using the average scores for the answers of each employee. Scale range was 1 (most negative views of FPDR) to 7 (most positive views of FPDR)
- Two yes/no questions on employee opinions of FPDR in terms of the employee's own family in circumstances of either the employee or a family member being ill.

Soroka's Helsinki Committee gave the necessary authorizations to conduct the research. SPSS 15 software was used for data analysis. Differences between the groups were examined by *t*-tests and one-way ANOVA. Relations between variables were examined using Pearson's correlations.

ED = emergency department

RESULTS

QUALITATIVE RESEARCH FINDINGS

The in-depth interview was conducted with 10 personnel from Soroka's ED: 3 physicians (ED manager, senior physician, and intern), 5 nurses (head nurse, nurse in charge of the resuscitation room, a senior nurse, a relatively new nurse, and a male nurse), and two social workers. Three interviewees were men and seven were women.

Most staff members who were interviewed mentioned that patients and families are more knowledgeable of their rights today than ever before. Some perceived this change as a potential problem. Interviewed staff members were typically not positive about this change: "The involvement of families makes our job more difficult," "The patients' rights law harms the patients and the physicians eventually." Most of the staff members interviewed objected to FPDR; indeed, only the ER manager and the social workers supported it completely.

Several issues elicited staff resistance to FPDR. First, the staff is not used to criticism from family members during a resuscitation attempt: "It interferes," "The family puts the doctor under pressure," "It's a resuscitation attempt not childbirth." The ER manager, however, thought FPDR can raise the quality of care over time. Hospital staff was also concerned about the additional pressure that they would be under, and about medico-legal aspects that were perceived as real issues for the staff members: "The staff is afraid of lawsuits, and of being portrayed in an unprofessional way."

The staff was also concerned about the effect of FPDR on the family: "It's a traumatic event for the family, and even if it's done in a skillful way, for lay persons it is a traumatic experience."

Some of the interviewees expressed logistic concerns: "We need to consider protection for the staff members," "FPDR requires that the doctor notice things beyond the resuscitation itself," "Reinforcement of the team with a security guard and an extra nurse is needed."

Finally, staff members exhibited a variety of reactions when asked how they would feel about being present during the resuscitation of a family member: "I would want to be present; when this issue relates to me its totally different," "Without doubt I would not want to be present during a family member's resuscitation," "I would lose my objectivity." In contrast, some staff members thought of their membership in the medical profession as an advantage: "I would like to be present because of my professional experience," "If I saw a mistake I would interfere."

QUANTITATIVE RESEARCH FINDINGS

The population characteristics are summarized in Table 1.The population of physicians (n=43, 51.2%) comprised mainly men (70%), aged 30–40 (63%), with up to 10 years experience in the ER (81%). Half of the physicians were born in Israel

Table 1. Population characteristics (n=84)

	Profession	N	%
Age (yrs)			
20–30	Physicians	9	20.9
31–40		27	62.8
41+		7	16.3
20–30	Nurses	4	9.8
31–40		15	36.6
41+		22	53.7
Gender			
Male	Physicians	30	69.9
Female		13	30.1
Male	Nurses	9	21.9
Female		32	78.1
Country of birth			
Israel	Physicians	22	51.2
Former Soviet Union		18	41.9
Other		3	6.9
Israel	Nurses	13	31.7
Former Soviet Union		16	39
Other		12	29.3
Country where profession was acquired			
Israel	Physicians	10	23.3
Former Soviet Union		25	58.1
Other		8	18.6
Israel	Nurses	33	80.5
Former Soviet Union		8	19.5
Other		0	0
Years of experience			
‹ 5	Physicians	25	58.1
5–10		10	23.3
› 10		8	18.6
‹ 5	Nurses	5	12.2
5–10		8	19.5
› 10		28	68.3

(51%) and 42% were born in the former Soviet Union [Table 1]. Women (78%) constituted most of the nursing population (n=41, 48.8%), the majority of which was distributed between the age groups 30–40 years (37%) and 50–60 years (32%). About a third of the nursing personnel were born in Israel (32%), and 39% were born in the former Soviet Union.

No differences were found according to age and gender categories regarding attitudes toward FPDR, although trends toward greater support for FPDR with increased age and by females were observed [Table 2]. Nurses had a more positive view of FPDR than physicians (respective means of 3.62 versus 3.24, $P < 0.05$, $t_{(84)} = 2.15$). No correlation was found between years of experience in the ED and attitudes toward FPDR. No significant differences were found between the attitudes of Israeli-born staff members to FPDR and those born in the former Soviet Union [Table 2]. Yet in all dimensions (effect of FPDR on the staff, family, and patients), a trend of less favorable attitudes toward FPDR was found among staff born in the former Soviet Union compared to Israeli-born staff members.

Table 2. Comparison of attitudes to FPDR by demographic variables (n=84)

	Mean values (Likert scale)¶ (N)	SD	t/F	df	*P*
Age (yrs)					
20–30	2.73 (13)	0.63	F = 1.16	83	0.320
31–40	2.98 (42)	0.76			
41+	3.11 (29)	0.77			
Gender					
Male	2.90 (39)	0.71	*t* = -0.98	82	0.330
Female	3.06 (45)	0.78			
Profession					
Physician	3.24 (43)	0.81	*t* = -2.15*	82	0.035
Nurse	3.62 (41)	0.80			
Experience in ER (yrs)					
0–5	3.00 (30)	0.76	F = 0.67	83	0.515
6–10	2.81 (18)	0.67			
11+	3.06 (36)	0.78			
Country of birth					
Israel	3.02 (35)	0.75	*t* = 1.28	67	0.205
Former Soviet Union	2.79 (34)	0.74			

FPDR = family presence during resuscitation

¶Likert scale range: 1 (more negative views) to 7 (more positive views)

*$P < 0.05$

No significant differences were found between staff members who were exposed and those who were not exposed to a situation in which family members were present. Staff members who wanted to be present during the resuscitation of their family member tended to express more favorable attitudes to FPDR than their colleagues who did not want to be present (respective means 3.49 vs. 2.83, $P < 0.001$, $t_{(84)} = 3.68$). Similar results were evident in all three dimensions, with the greatest differences in the dimension that measured the effect of FPDR on the patient (4.15 vs. 2.51, $P < 0.001$, $t_{(84)} = 4.18$) [Table 3].

LOGISTIC ASPECTS

No difference was found between the attitudes of physicians and nurses on logistic issues. A more positive attitude to

Table 3. Comparison between staff member attitudes to FPDR and their views on being present during the resuscitation of a family member (n=84)

	Does subject want to be present?	Mean values (Likert scale)¶ (N)	SD	t	df	*P*
Attitude to FPDR	Yes	3.49 (20)	0.88	*t* = 3.68***	82	0.000
	No	2.83 (64)	0.63			
Effect of FPDR on the staff	Yes	3.30 (20)	1.20	*t* = 2.52*	82	0.014
	No	2.68 (64)	0.88			
Effect of FPDR on the family	Yes	3.93 (20)	0.99	*t* = 3.38**	82	0.001
	No	3.26 (64)	0.70			
Effect of FPDR on the patient	Yes	4.15 (20)	1.78	*t* = 4.18***	82	0.000
	No	2.51 (64)	1.43			

¶Likert scale range: 1 (more negative views) to 7 (more positive views)
*$P < 0.05$, **$P < 0.01$, ***$P < 0.001$

Table 4. Pearson's correlation examining the relationship between attitudes to FPDR and views on logistic issues (n=84)

Attitude toward FPDR	Logistic element	r	*P*
Effect of FPDR	Enough staff	*0.20	0.047
	Enough room	***0.40	0.000
Effect of FPDR on the staff	Enough staff	0.02	0.831
	Enough room	*0.25	0.015
Effect of FPDR on the family	Enough staff	**0.33	0.001
	Enough room	**0.27	0.008
Effect of FPDR on the patient	Enough staff	0.14	0.175
	Enough room	*0.23	0.026

*$P < 0.05$, ** $P < 0.01$, *** P

FPDR correlated with perceiving logistic problems as less of an obstacle [Table 4].

DISCUSSION

Our study shows that most ED personnel at Soroka Medical Center objected to the practice of family presence during resuscitation. This opposition is despite the fact that more than half of the staff members reported past experience with FPDR or were asked by family members to participate in a relative's resuscitation.

The main staff objections to FPDR derived from anticipated family criticism, added pressure on staff members, fear of lawsuits, fear of hurting the feelings of the families, and loss of "objectivity" in treating patients. Furthermore, most staff members felt that the ED is logistically ill equipped to safely allow FPDR, namely, insufficient numbers of staff to support the family during resuscitation and a lack of physical space near the resuscitation bed. All reasons concur with what is known from the literature review [4]. Based on the in-depth interviews conducted, staff member opinions were widely distributed along the spectrum between an approach that views the patient and his/her family as a whole, and a more "technical" approach that places the patient's illness at the center. The family-centered approach was emphasized more by the nursing staff, while the more "technical" approach was prevalent in interviews with the physicians. The "technical" approach does not encourage routine participation of the family in patient treatment in the ED; instead, it advocates a more traditional paternalistic approach, where the doctor decides for the patient in the ED setting. It is possible that the high percentage of former Soviet Union-educated physicians [7], and the physicians' greater influence (versus that of the nurses) on treatment in the ER setting are the reasons for the dominance of the "technical" approach in our interviews. These considerations are part of a broader ethical debate that should inform the question of whether FPDR should be part of common practice in Israel and elsewhere [8].

Currently, one of the only instances when a family member can be present during resuscitation is when the patient is part of the same family as a staff member. There is no official policy on this issue, but it is customary to permit those staff members who want to be present to witness the resuscitation attempt. Pragmatism, however, may be the driving force behind this practice, as it is simply not possible to prevent a staff member from entering the resuscitation room, and in any case, the prevailing assumption of medical staff is that it is less likely that a lawsuit will follow such a resuscitation attempt.

STUDY LIMITATIONS

The research was conducted in the ER of only one hospital. The uniqueness of Soroka Medical Center, a large teaching hospital that serves a significant proportion of the Israeli public distributed over a large territory, must be emphasized. Soroka serves a heterogeneous population that comprises people representing a variety of dispersions, religions and cultures. Each population has its own grieving customs, and the staff must adjust its behavior accordingly, especially under the stress of a resuscitation attempt.

The study population included all ED health care personnel, yet their total number (n=84) was relatively small. In addition, only medical staff members were included (no technical, security, or emergency medical services personnel), family members and patients were not interviewed, and the subject of trauma and children was not included. Nevertheless, the first step in generating professional discussion on FPDR and garnering this important subject more public exposure is to examine the opinions of medical staff.

RECOMMENDATIONS

A transformation in FPDR policy at any medical center, including Soroka, entails implementing a few measures. First, a multidisciplinary team (physicians, nurses, social workers, and psychologists) should be established to discuss the issue and examine all the ethical, legal and logistic aspects of FPDR. Next, if they agree that allowing FPDR is advisable, a protocol for its enablement, similar to existing protocols at medical centers around the world, should be established. Once a protocol is decided upon, it should be tested on a limited number of cases and then revised and finalized accordingly for daily use. Implementation of the protocol will be possible only if all staff members are included in the decision-making process. Alternatively, the discussion on FPDR feasibility can take place at the national level, both in relevant professional organizations and within the Ministry of Health.

CONCLUSIONS

The issue of FPDR is an intrinsic part of patient- and family-centered care. More research is needed to understand why FPDR is not a currently viable option in Israel and to elucidate whether certain characteristics peculiar to the Israeli health system prevent this change. We recommend further research in this field that will examine the views of patients and their families on this subject and examine the social, logistic, ethical and legal aspects of FPDR.

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