The attitudes of Emergency Department consultants toward family presence during resuscitation

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Abstract: Objectives: We assessed the attitudes of emergency department (ED) consultants toward family presence during resuscitation (FPDR), to elucidate and provide proof of the benefits of allowing FPDR in Kingdom of Saudi Arabia.

Methods: A cross-sectional descriptive study using a questionnaire electronically sent to all ED consultants from five major government hospitals in Riyadh, Saudi Arabia. The survey examined the consultants' beliefs and perception of FPDR, legalities, policies and the effects and outcomes of FPDR on the patient, family, and themselves.

Results: The survey received 172 responses, 55.0% were 36–45 years old and 144 (83.7%) were men. Most respondents (91.36%) had experienced FPDR. Less than half (40.1%) believed that FPDR is beneficial to the patient, and 58.7% believed that FPDR could cause difficulties for the resuscitation team. A written policy for FPDR was preferred by 42% of respondents. Significantly more respondents 36-45 years old recommend allowing FPDR compared to other age groups, and significantly more male consultants in this age group believe there is a positive outcome of FPDR.

Conclusion: The attitude and perception of emergency consultants towards the practice of FPDR was less positive than expected. Many consultants did not favor the advantages of FPDR, and were worried about negative outcomes, potential medico-legal repercussions, and the unpleasant experience for the family members, especially female consultants. However, a larger proportion of consultants nevertheless recommend FPDR. The ability of ED doctors to manage FPDR and their understanding of the benefits of FPDR needs to be strengthened.

Keywords: Emergency room, consultants, attitudes, family members, resuscitation.

Introduction

Several studies have been conducted on the attitudes of health care staff toward family presence during resuscitation (FPDR). Emergency healthcare staff perceive both positive and negative effects as a consequence of family presence during adult resuscitation and their opinions suggest that there are more risks than benefit [1].

In Saudi Arabia, a study revealed that nurses had negative attitudes toward FPDR. A high percentage (77·2%) agreed that witnessing resuscitation is a traumatic experience for family members. Almost all participants (92·3%) disagreed with the statement that the practice of allowing family members to be present during the resuscitation of a loved one would benefit the patient and (78%) disagreed with the statement that it would benefit families. The majority of the participants (65%) felt that the presence of family would negatively affect the performance of the resuscitation team [2]. A study conducted in the US showed that (77%) of staff members favored allowing the option of FPDR, and recommended drafting and implementing a protocol for allowing FPDR [3]. A Hong Kong study showed that healthcare staff support FPDR [4]. In France, a study revealed that a majority of emergency room physicians and nurses were hesitant to have parents present during child cardio-pulmonary resuscitation (CPR), although the physicians were in favor of FPDR more often than nurses [5].

It was shown that an existing family presence policy during resuscitation alters physicians' and nurses' knowledge, attitudes, and compliance with FPDR, and the policy changed their behaviors toward FPDR [6]. It was also shown that FPDR allows communication between the family and the emergency care team in facilitating the acceptance of the reality of death [7]. In Brazil, the majority of ER personnel provide health care in the presence of the family, and similarly, the medical staff had a more favorable view of the presence of the family in contrast to the nursing staff [8]. In contrast, there were also studies that suggested disapproval of FPDR, particularly studies conducted among physicians in Vienna and Tabriz [9], and also among medical professionals in the occupied Palestinian territory [10].

There remains controversy surrounding the real effect of FPDR on the family members and the health care staff. One study showed that FPDR was associated with positive results on psychological variables and did not interfere with medical efforts, increase stress in the healthcare team, or result in medico-legal conflicts [11], and FPDR did not prolong time to imaging or resuscitation completion for pediatric trauma patients or negatively affect the time efficiency of the pediatric trauma resuscitation [12]. In fact, it was found that FPDR is useful in facilitating uninterrupted patient care [13] and fostering positive attitudes during episodes of patient deterioration [14]. The disparity in staff views has been identified as a major obstacle to FPDR citation [15]. If given the chance, family members usually prefer to be present during resuscitation [16].

Because of the persisting controversy surrounding allowing family members to be present during resuscitation, and the existing debates particularly in an emergency room set-up, we conducted this study to assess the attitudes of the emergency room healthcare consultants toward FPDR, to shed light and tangible proof of claims of the benefits and outcomes of allowing FPDR in our institution.

Methods

This cross-sectional descriptive study was conducted using a questionnaire to all Emergency Department (ED) consultants from five major government hospitals in Riyadh, Saudi Arabia (King Saud University Medical City, King Abdulaziz Medical City, Prince Sultan Medical City, King Fahad Medical City, and King Saud Medical City) from May 1 to June 1, 2017 initially, then another phase of data collection from May 1 to June 8, 2022. Registrars, residents, interns and nursing staff were excluded from the study.

The questionnaire was developed using questionnaires from previous literature and was suited to our target population under the guidance of an ED consultant. A pilot study was conducted prior to the field work to enhance the questionnaire. The questionnaire was sent and collected electronically using Survey Monkey. Sample size was calculated using the formula: a= N /(1+n*e2) where n is the sample size, N is the population size, and e as the 5% margin of error. The calculated required sample size was 80.

Data was analyzed using the Statistical Package for Social Sciences (SPSS) version 22.0 (IBM SPSS, Armonk, New York, USA). Results are expressed as numbers and percentages for categorical variables, and as mean and standard deviation for continuous variables. Chi-square tests were used to determine the significant difference in between two groups. A p value of <0.05 was considered statistically significant.

Ethical approval was granted by the Institutional Review Board of the College of Medicibe, King Saud University Medical City, Saudi Arabia. Individual consent was given by returning the survey.

Results

In total, 172 ED consultants responded to the survey; 55% (n=96) were 36–45 years old, and 144 (83.7%) were males. The majority of respondents (n=157, 91.3%) claimed to have experienced FPDR.

Beliefs on the benefit of having a family member present during resuscitation

There were 69 respondents (40.1%) who believed that FPDR is beneficial to the patient, whereas 59 (34.3%) did not and 44 (25.6%) claimed that the presence of a FPDR "may be" beneficial to the patient. One hundred and one respondents (58.7%) believed that FPDR will help convince the family that doctors did everything they could to save the patient. Whereas 101 (58.7%) believed that family members should not be present during CPR because it could cause a very difficult atmosphere among the resuscitation team.

Policies and procedures, and legalities allowing family members to be present during resuscitation

There were 73 (42.4%) respondents who preferred to have a written policy in Saudi Arabia that will allow family members to be present during resuscitation. Fifty-four respondents (31.4%) believed that allowing family members during resuscitation will be in conflict with patient's privacy and confidentiality. Also, 70 (40.7%) respondents believed that the presence of a family member during resuscitation will not cause medico-legal litigation.

Effect and outcomes of FPDR

There were 88 (51.2%) respondents who believed that FPDR will result in a better understanding of the complications following resuscitation. Whereas 132 (76.7%) believed that FPDR would not influence treatment decisions. In contrast, 76 (44.2%) thought that FPDR among relatives who have medical knowledge will reassure their decision and comfort during treatment, 79 (45.9%) believed that family members would not be traumatized by witnessing resuscitation. Sixty-four respondents (37.2%) believed that the family will be able to control their emotions during resuscitation. There were 84 (48.8%) respondents who thought that FPDR will influence the resuscitation outcomes positively, and 116 (67.4%) would recommend allowing FPDR for other physicians.

Responses according to age groups

The frequency of a previous experience with FPDR was significantly higher in those >35 years old (p=0.002). Respondents in the age groups 36-45 and >56 believed that FPDR is beneficial to the patient (p<0.001), whereas more respondents in the age groups 25-35 and 46-55 years believe that witnessing resuscitation will traumatize family members (p=0.002). There were no other significant differences in the proportion of respondents on the other questions. (Fig. 1)

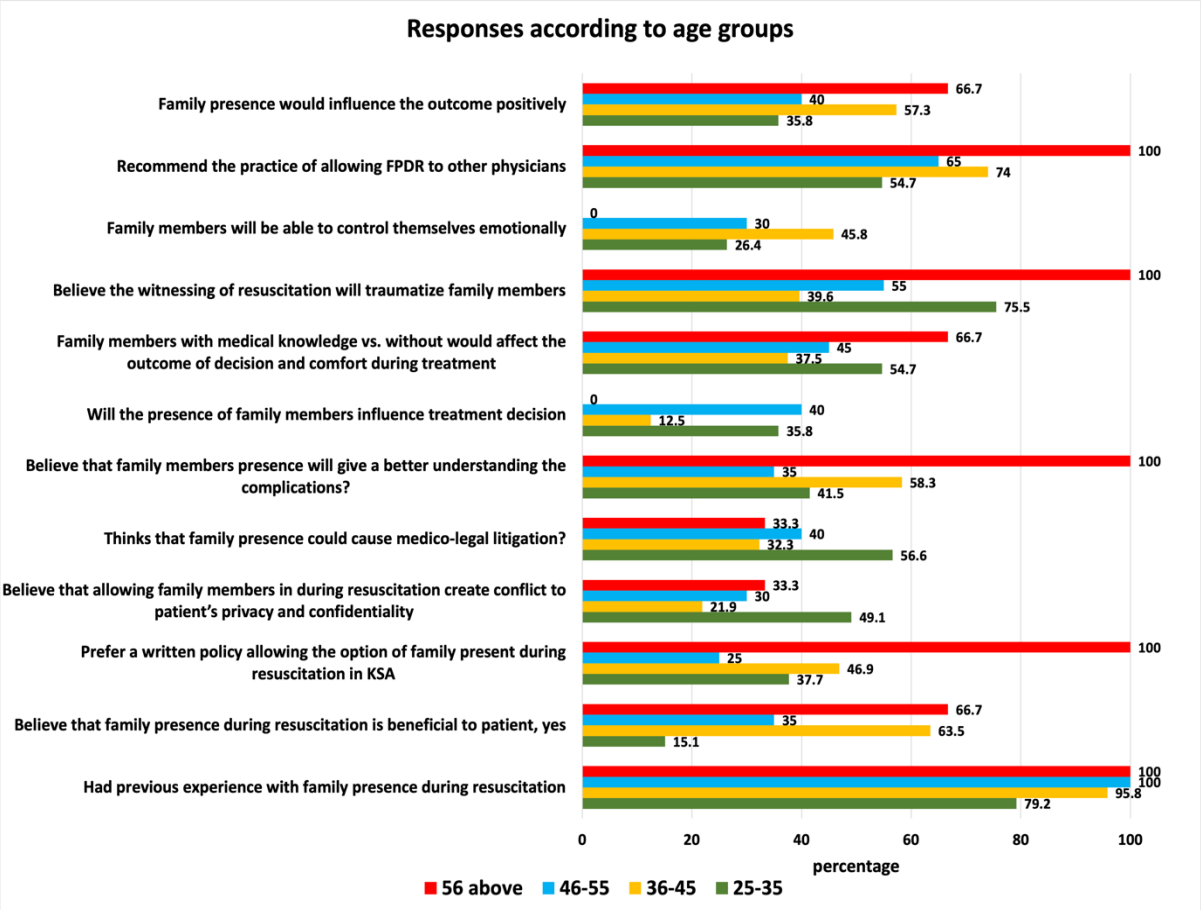

Fig.1 Responses according to age groups

Responses according to gender

A significantly greater proportion of male respondents had previous experience with FPDR (n=138/144, 95.8% versus 19/28, 67.9%, p<0.001). In contrast, a greater proportion of female respondents believed that witnessing resuscitation will traumatize family members (82.1% versus 47.9%, p=0.004). There were no significant gender differences in the responses to other questions. (Fig. 2)

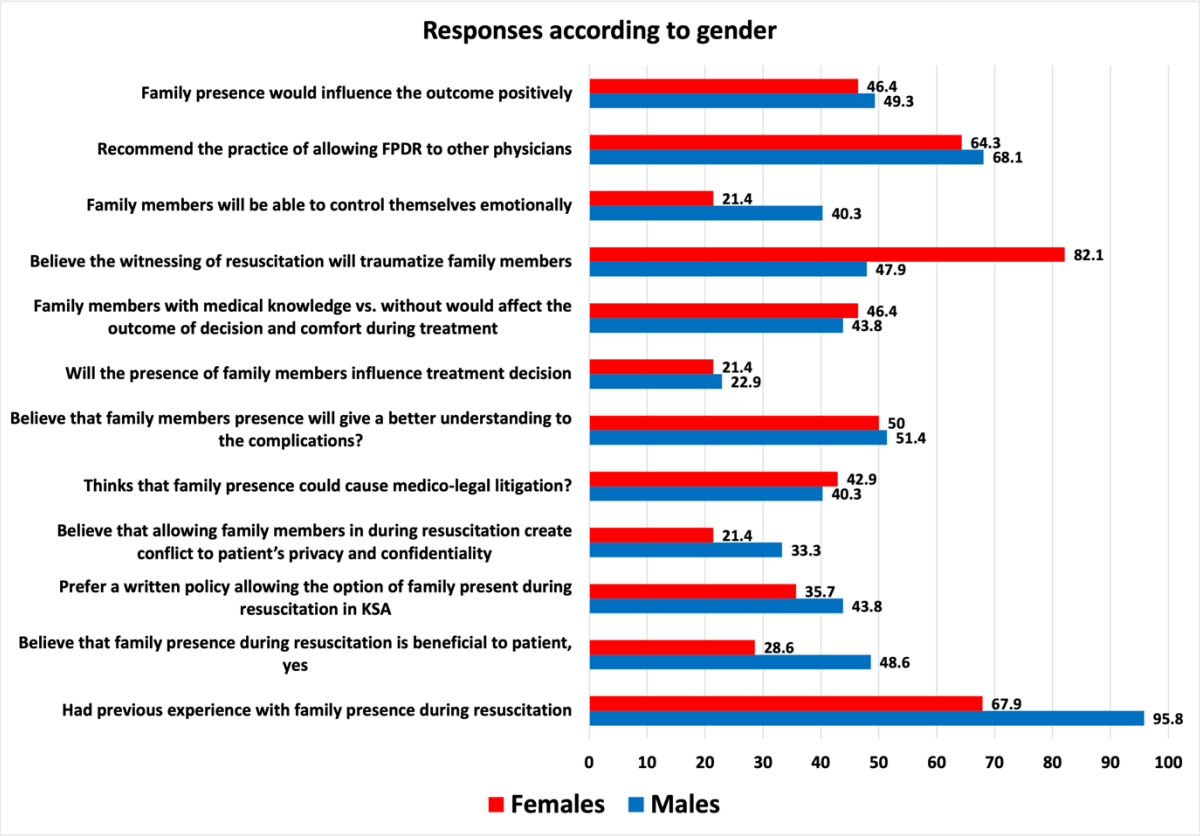

Fig.2 Responses according to gender

Discussion

Healthcare workers always try to balance their ethical and professional responsibilities towards patients' families and their comfort in performing resuscitation. However, this dilemma is still unresolved [17]. This study aimed to explore the beliefs of ED consultants in Riyadh, Saudi Arabia toward FPDR and whether it is advantageous or not, and to assess their perceptions of current practices surrounding family presence during episodes of acute deterioration in adult ED patients.

Generally speaking, in the current study, the perception of the ED consultants regarding current practices surrounding family presence during episodes of acute deterioration in adult ED patients was less than satisfactory. Only 40.1% of the respondents believed that the FPDR would be beneficial to the patient, and 58.7% of the respondents believe that family members should not be present during CPR. Despite this, 67.4% of the respondents would recommend allowing family members to be present during resuscitationfor other physicians. Conflicting results have been observed in other studies as ED staff perceive both positive and negative effects of FPDR and their opinions generally suggested that there are more risks than benefits [1]. According to the American Association of Critical Care Nurses 50–96 % of healthcare consumers in the acute care setting believe that family should be allowed to be present during emergency procedures and resuscitation [18].

In the present study, the main reason mentioned by the participants for their acceptance of FPDR was to convince them that everything possible was done to save the patient. Jabre et al., 2014 [11] and Meyers et al., 2000 [19] revealed that FPDR removes doubt about the patient's condition and can help in decreasing anxiety. Also, in

accordance with our finding, a study conducted on ED health care professionals in the Yale-New Haven Hospital (USA) observed that 77% favored allowing the option of FPDR [3]. The same was documented in a study conducted in Hong Kong [4]. Two Australian studies [14, 15] concluded that FPDR was both important to and beneficial for families, and ER clinicians had positive attitudes towards including family during episodes of patient deterioration. A recent study found that spending time with family members during CPR required nearly a quarter of the time allotted for CPR. The research also discovered that while there was no apparent detrimental impact on the standard of CPR, FPDR was linked to an increase in frustration and perceived temporal and mental demands [20]. Another recent study revealed that, especially in pediatric situations, parents and family members desire the opportunity to be present [21].

However, in another study conducted among nurses in Saudi Arabia by Al-Mutair et al. [2], most nurses (77·2%) agreed that witnessing resuscitation is a traumatic experience for the family members. A vast majority (92·3%) disagreed with the statement that the practice of allowing FPDR would benefit the patient and 78% disagreed with the statement that it would benefit families. Almost two-thirds of the participants (65%) revealed that the presence of family would negatively affect the performance of the resuscitation team. In reality, it was discovered that the attitudes of healthcare professionals varied greatly with between 15-85% in favor of FPDR [21]. The difference between the present study and that conducted by Al-Mutair et al. could be attributed to variation in the demographic characteristics of the participants; we included consultants, the majority of whom were men whereas the Al-Mutair study included nurses, mostly women. A French study including both emergency physicians and nurses revealed that the majority of nurses were hesitant to have parents present during child CPR where the physicians were more favorable to FPDR [5]. Another study of 252 nurses in Korea showed a mean score of 3.47 out of 5.0 with regards to their intention to allow FPDR [22]. Researchers showed that physicians and nurses attitudes towards FPDR was not affected by educational intervention, however it changed their behaviors [6].

In the present survey, 42% of ED consultants preferred a written policy allowing the option for FPDR. The same has been reported by Al-Mutair et al. in a recent Saudi study conducted among ED nursing staff where 43.8% of the nurses agreed [2]. In a recent study, Jordanian nurses showed a mean positive attitude of 3.71 of 5.0 maximum towards FPDR, however, their positive attitude was positively associated with age and health beliefs, and negatively associated with self-efficacy and experience [23].

Consultants in the middle-aged group (36–45 years old), and the more experienced ED consultants believed more strongly than others that FPDR is beneficial to the patient, will not be in conflict with the patient's privacy and confidentiality, will give the family members a better understanding to the complications of the patient's condition, and will not traumatize family members. A more positive attitude towards FPDR was also observed among male consultants who had more experience with FPDR. They believe that FPDR is beneficial to the patient. In contrast, female consultants tended to believe otherwise including the possibility of medico-legal litigation, FPDR affecting their decision, and that FPDR might traumatize the family members. More experienced nurses in an African study disagreed that FPDR negatively affects patient care compared to less experienced nurses [24]. More experienced physicians tend to rely more on experience and gamble less or take fewer risks [25]. With regards to gender variation in the attitude and practice towards FPDR, male physicians tend to take risks more than female physicians where women were more concerned with litigation/legal issues, affecting the outcome of treatment, and traumatizing the patient. This risk taking may be associated with experience, age, environmental influences, and other factors that need to be explored.

Additionally, they would recommend the practice of allowing FPDR and they thought more positively of the positive outcome of FPDR. However, further study is recommended to investigate this factor and others that could affect the healthcare providers` preference in towards FPDR.

Limitations

The inclusion of only consultants is a significant limitation of this study that may have an impact on the generalizability of the findings. However, they were affiliated with five of Riyadh's main hospitals. The study's cross-sectional design, which only allows for association and not causality between the independent variables and the outcome variable, is another drawback. The discussion of this critical topic in our society benefits public health despite these two major limitations of the study.

Conclusion

The attitude and perception of emergency consultants towards the practice of FPDR was less positive than expected. Many consultants, especially female consultants, tended not to favor the advantages of FPDR, and more were worried about a negative outcome, potential medico-legal repercussions, and the unpleasant experience for the family members. However, a larger proportion of consultants nevertheless recommend FPDR. The ability of ED doctors to manage FPDR and their understanding of the benefits of FPDR needs to be strengthened. A written policy written policy allowing the option for FPDR, could help the ED consultant to have more acceptance and better understanding of FPDR.

Abbreviations

CPR cardio-pulmonary resuscitation
ED Emergency Department
FPDR family presence during resuscitation

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