

Family presence in the trauma setting: A case study

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Abstract

The topic of family presence during resuscitation (FPDR) has been in the medical literature for several decades. However, these discussions have largely failed to delineate a difference between resuscitation of patients in cardiac arrest and the resuscitation and stabilisation of trauma victims before a necessary procedure. Through a case-based scenario, this primer aims to explore the ethical considerations of FPDR in emergent trauma care – particularly in the case of a motor vehicle collision. In doing so, consideration is given to the relevant aspects of patient dignity and privacy; as well as to the benefits of exposing family to clinician efforts, including how FPDR can aid in the grieving process.

Case report

On a Tuesday evening, 43-year old Mr Smith is brought to the emergency room by ambulance after suffering a serious motor vehicle crash (MVC). He is in critical condition. Upon completion of an emergent thoracentesis, the care team decides to prep their patient for an emergency laparotomy given his level of bleeding and organ damage. Mr Smith's wife is contacted, and she arrives at the emergency room before her husband is taken to the operation room (OR). Shortly thereafter, Mr Smith codes (ie falls into cardiac arrest). As the senior resident runs the code, the hospital chaplain asks to meet with Dr Reynolds, the attending physician: Mrs Smith has asked to see her husband before he is taken into surgery. Dr Reynolds takes a look behind the curtain at Mr Smith—intubated and covered in blood—with the care team working around him. She wonders what to do.

Discussion

Medicine in the trauma bay—despite its intensity and immediacy—has room for compassion. If feasible, medical teams can be encouraged to allow family members to see a patient in an acute setting, as this act of compassion is

consistent with an ideal of patient and family-centred care. Feasibility should be determined by the current status of Mr Smith and by the presence of other patients in the trauma bay, with consideration given to the privacy and dignity of both parties.

This encouraged accommodation of family presence during resuscitation (FPDR) can be further elevated to the level of an ethical obligation should Dr Reynolds interpret her “duty to care” as one that extends beyond an immediate patient to his/her family. Either way—as compassionate care or ethical obligation—Dr Reynolds ought to allow Mrs Smith an opportunity to see her husband preoperatively, as this will likely do more good than harm in the overall caregiving experience.

This normative claim is supported by two key assumptions. First, exposure to a trauma team's action and effort will help to improve the family-provider relationship. Second, FPDR can help improve the grieving process for family members. Aesthetics in this case must be carefully weighed; proper communication can do a great deal to prepare Mrs Smith for what she will see – but it may undermine Mr. Smith's dignity. Variables such as Mrs Smith's current mental state and the presence of other patients in the vicinity have additional relevance in the calculus of this case. If, after considering these factors, Dr Reynolds feels that Mrs Smith's presence will not adversely affect patient care, then she should allow Mrs Smith to see her husband briefly before surgery.

How FPDR highlights medical efforts

Allowing Mrs Smith to see her husband before surgery can help her appreciate the effort that the medical team is putting into her partner's care. This can help to build a family member's trust and respect for the medical team. In a policy recommendation, the American College of Emergency Physicians (ACEP) has encouraged the collaboration of providers with family members in the acute setting, recognising the importance of family as decision makers and cultural liaisons (1). This acknowledges that the needs of family members should be respected in emergency care and that a medical team ought to build a working relationship with their patient's family.

Research points to the benefits of FPDR in acute care settings, particularly in the way it improves the family-provider relationship. At Foote Hospital in Jackson, Michigan, physicians implemented a programme whereby chaplains gave family

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members the option to be present during cardiopulmonary resuscitation (CPR). In a follow-up study six months after the experience, 94% of respondents present at the time of CPR believed they would make the same decision again (2). Retrospective analysis nine years after the program's implementation found that family members described several benefits to being present at the time of CPR, including increased appreciation of both the patient's condition and the effort of the medical team in providing care (3). A similar study that included a convenience sample of 39 family members and 96 medical providers at Parkland Health and Hospital System in Dallas, Texas, found that 95% of family members believed that their presence had helped improve their understanding of a patient's condition; 89% of providers concurred with this view, and 93% believed that FPDR also helped family members appreciate the effort that the medical team had put into the patient's care (4).

Two counterarguments to this claim are that FPDR in an acute care setting will: (i) distract the medical team and hinder outcomes, and (ii) put providers at an increased risk for litigation. Neither of these positions has been empirically proven. A French study on FPDR in acute care involved 570 relatives of patients who had received CPR, comparing outcomes between an intervention group given the opportunity to witness resuscitation and a control group that was not given that opportunity. The study found that FPDR did not impact duration of CPR, selection of drugs, or patient survival rates; moreover, FPDR did not impact stress levels of the healthcare team (5). Similarly, both the Parkland and Foote Hospital studies reported no disruptions by or interference from family members in the medical team's efforts (2, 4). These findings suggest that the potential for FPDR to distract the medical team and hinder outcomes could be overstated.

The medico-legal reservations against FPDR during acute care may similarly be overstated. This view may be rooted in an assumption that family members may feel that not enough was done to save the patient. Some scholars suggest that FPDR could lessen the risk for litigation given that such an opportunity would both improve the bond between family and providers and also satisfy questions family may have on the level of care provided to a patient (6-8). The French study supports this position; given that no claims for damages were reported in the months after FPDR, family presence is unlikely to do harm to the medical team or hospital system (5).

The basis for most litigation in medicine—aside from explicit tort injuries in medical error—is a lack of communication between patient and provider. If Dr Reynolds allows Mrs Smith to see her husband before surgery, it displays a level of transparency and understanding that can mitigate the potential for formal or legal complaints. Moreover, it will help Mrs Smith to appreciate the intensity of her husband's medical condition and the level of effort that the medical team is exerting in his care.

Unique aspects of the trauma setting

While the aforementioned data supports FPDR, neither the Parkland nor Foote Hospital studies were conducted in a trauma care setting. This raises questions of whether family presence during CPR is comparable to family presence during an acute trauma. Some, particularly those who work in the trauma setting, are adamant that these two scenarios are not similar.

An overwhelming majority (97.8%) of respondents to a survey study of the American Association for the Surgery of Trauma (AAST) stated that FPDR in the trauma setting was inappropriate across all stages of resuscitation (9). Members of AAST found that FPDR crowded the trauma bay and increased stress amongst care providers. One can imagine that stress is particularly increased in instances where teams include trainees and/or where the presence of family nudges medical teams to attempt resuscitation longer. The responses by members of AAST stand in opposition to the recommendation by ACEP, further supporting the idea that witnessing CPR is not analogous to witnessing trauma resuscitation.

Early studies suggest that AAST's position may be partly true. In particular, the benefits of FPDR in terms of family-provider relationships and family satisfaction with care may be difficult to achieve in the trauma setting. A study at a Level 1 trauma center in Wisconsin surveying family members of 140 trauma patients of MVC or gunshot wounds found that FPDR did not have a statistically significant impact on satisfaction with critical care (10). It is possible that the sheer intensity of a trauma setting— including the severity of a patient's condition— may overshadow the hard work of a care team from the perspective of a family member.

Patient privacy is an additional factor that distinguishes trauma resuscitation from the intensive care or ward medicine setting. Urgency of care coupled with a patient's inability to communicate can jeopardise patient privacy if a medical team hastily agrees to allow FPDR. In this case example, Mr. Smith is clearly incapacitated and cannot communicate his desires regarding his family's presence during resuscitation. In such instances, medical teams cannot fully know a patient's explicit wishes regarding FPDR, let alone their relationship with the family member (eg, in cases of domestic violence or estrangement).

An opportunity to facilitate grieving

Visiting a patient in an acute setting can help improve the grieving process for family members. In this case, seeing first-hand how Mr Smith is "intubated and covered in blood" can help Mrs. Smith appreciate the immensity of his trauma. More importantly, refusing Mrs Smith's request to see her husband can exacerbate her grief and increase the likelihood of mental distress (11). Several studies show that the presence of family in an acute setting or during resuscitation attempts helps to initiate the grieving process, reduces anger at being kept from loved ones, and alleviates anxiety (12-14). The Wisconsin survey study found that these findings are consistent with FPDR in the trauma setting (10).

The benefits of family involvement in the emergency room are compounded when the grieving process has evolved into bereavement. For example, this may be the last opportunity that Mrs Smith has to see her husband alive. Published personal accounts of family members at the bedside of dying patients suggest that some individuals feel a sense of closure in speaking to the patient (conscious or otherwise), to remind them that they are loved and/or to say goodbye (13, 15-16). Physical touch is also encouraged as a means to facilitate grief and to convey support to a dying patient (17). Mrs Smith would benefit from seeing her husband before he is taken away for surgery; depending on Dr Reynolds' judgement, it may even be appropriate to allow Mrs. Smith to briefly hold her husband's hand if desired. As long as Mrs. Smith is comfortable in this acute setting, she should have the opportunity to "speak" with her husband, which might facilitate her grieving.

The counterargument to this claim is that exposure to a patient's suffering will worsen family members' mental health and lead to symptoms of post-traumatic stress disorder (PTSD). But empirical findings suggest that family members offered the opportunity to be present during resuscitation or before an invasive procedure are more likely to choose that option again. The French study on family presence during CPR also compared PTSD-related symptoms in intervention and control groups 90 days after the experience. Fewer family members in the intervention group reported symptoms of anxiety compared to the control group (5). In short, if Dr Reynolds interprets her professional ethic of "doing no harm" to include her patient's family, then she is ethically obligated to allow her patient's wife an opportunity to be present given the aforementioned benefits discussed earlier. If Dr Reynolds does not include family in the fold of this professional ethic, she may still choose to allow family to be present as it is an act of patient and family-centered care that displays a level of compassion and has overall psychological benefit.

Applying family presence in practice

The benefits mentioned earlier of family presence should encourage medical teams to let family members see patients in the acute care setting. As discussed, depending on how we interpret the medical "duty to care," encouraging family presence can either be an act of compassion or an ethical obligation. If Dr Reynolds and her medical team include a patient's family in their professional "duty to care," then allowing a family member to visit the patient should become institutional policy, as it improves family understanding of a patient's medical condition, improves trust between provider and family, and addresses the family member's grief and anxiety.

In this case, Dr Reynolds should first use medical judgement to ensure that family presence does not jeopardise her patient's medical care or the wife's health. This includes both medical precautions (eg, contact with bodily fluids) and a brief assessment of Mrs Smith's mental state. However, as the referenced studies have found, a family member is unlikely to cause disruption in medical care and will likely be less

anxious and angry if her need for a visit is met. This "landscape analysis" should also consider the presence of other patients in the trauma bay. Patient privacy must be respected as much as possible, and if other patients are not behind a separate curtain, it should be ensured that the wife's visit does not impact them negatively.

Dr Reynolds should then thoroughly communicate to Mrs Smith the expectations of the visit and her husband's medical condition. This includes:

- impressing the need for the visit to be brief in order to not delay surgery;
- a clear statement on how the patient is bloody, intubated, and in physical distress;
- providing the option of being accompanied by the hospital chaplain or other support staff. Being accompanied by a hospital employee, other than the attending, should not be obligatory.

During and after the visit, Dr Reynolds should balance a level of confidence with compassion, assuring Mrs Smith that all efforts are underway to ensure her husband's treatment and survival. If possible, Mrs Smith should be given the opportunity to ask questions and seek clarification on her husband's pending procedure from an available medical team member after seeing him.

Conclusion

Permitting family presence is a decision that must be considered carefully by providers. It can be viewed as a compassionate act that promotes a sense of patient and family-centred medical care. Depending on one's professional ethics, FPDR can be seen as an ethical obligation, improving the family-provider relationship through transparency and lessening the risks of anxiety and depression in the family. However, providers must weigh the impact of FPDR on the care a patient is receiving, particularly as it relates to patient privacy and the potential stress it places on medical teams. Ultimately, the absence of adequate communication can fuel insecurity on both sides and increase tension. As such—regardless of whether or not she chooses to allow FPDR— Dr Reynolds must ensure that Mrs Smith is clearly aware of her decision and the reasoning behind it.

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