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Practitioner's blog

Witnessed resuscitation and diversity in death

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It is well recognised that individuals' responses to death and dying are infinitely variable even in a homogeneous society. In a multicultural society such as London this variability will be influenced further by the cultural, religious and traditional belief systems of the person and their family. This can pose moral and ethical challenges in the emergency department, where sudden and unexpected death is not an uncommon occurrence. It is increasingly accepted that witnessing the resuscitation of a loved one can have a positive effect, with much of the evidence suggesting that patients and relatives want to have a family presence in the resuscitation room (Ersoy *et al*, 2009; Mortelmans *et al*, 2010). A more recent study in France found that family presence during resuscitation was associated with positive psychological results and did not interfere with medical efforts, increase stress in the healthcare team, or result in conflict or complaints from the family (Jabre *et al*, 2013).

Despite this evidence, some clinicians still feel very uncomfortable about having relatives in the resuscitation room, and therefore witnessed resuscitation continues to be controversial. Proposing it in some circumstances can pose practical dilemmas depending on the context and background of the situation (Colbert *et al*, 2013). Even in settings where staff have become accustomed to witnessed resuscitation, and where it is almost considered a patient and relative prerogative, problems can arise that have the potential to seriously jeopardise successful resuscitation or impede a dignified and peaceful death. The resuscitation room in any emergency department is an area where the extremes of human emotions are played out. The relief, gratitude and joy engendered by a life saved often sit uncomfortably alongside the grief and anguish of a life lost, and such emotional outpourings need to be addressed in the most sensitive way possible.

Best practice advocates that relatives should only be allowed in the resuscitation room when there is a nurse available to stay with them to explain the proceedings. Generally speaking, this works well. However, difficulties can arise when there are language barriers and cultural differences that are not immediately obvious or readily understood. The very nature of resuscitation means that the medical imperative takes precedence over the need for interpreters and cultural considerations, but this is the very area where conflict and moral disputes have the potential to cause great distress and affect the grieving process.

Such was the case recently when a 50-year-old Arab man was brought to the emergency department by ambulance after he had sustained a cardiac arrest in the street. The paramedic team had already performed resuscitation for nearly an hour at the scene, and the prognosis was poor. The resuscitation room was already full, so space had to be made to accommodate the patient. The police brought the patient's family, a very large group, to the relatives' room. As the team tried to resuscitate the man they could hear crying and screaming from the distressed family, who desperately wanted to be present with their relative in the already overcrowded resuscitation room.

A doctor and a nurse went to speak to the family to explain the gravity of the situation. A young man who said he was the patient's son said he wanted to be with his dad and so did his uncle. The patient's wife and daughter also wanted to be there, but were told by the son that they were too mentally fragile, that they would not cope with the situation, and that they were not allowed to be there during the resuscitation. The girl's distress at being excluded was evident to the nurse, but it was also clear that she was not going to question her brother's and uncle's decision. The nurse intervened and advocated for the daughter and her mother, the patient's wife, explaining to the male relatives the importance of them being there, if that was what they most desired.

Once in the room, the family stood back respectfully, obviously wanting to be close to the patient. They were told that they could touch him if they wanted, so long as they did not get in the way of the resuscitation attempt. Acknowledging this request they all knelt on the floor at the foot of the bed, touching his feet and holding his legs, while the resuscitation attempt went on around them. The family prayed quietly, chanting softly. The team worked quietly, respecting the family presence.

Outside the resuscitation room more family members and relatives arrived, possibly in excess of 50 people, and it was necessary for the police who were already in the department to ask them to wait outside in the ambulance bay, as the noise from the group, many of whom were distraught, was clearly audible inside the department.

The resuscitation attempt went on for some time, the family were present throughout, and they were given water and the events were explained to them as they happened. When all efforts and attempts had been exhausted, the team leader indicated to the nursing staff that it was time to stop and allow the man to die with dignity. This decision was explained to the family, who found it hard to accept and wanted the attempt to continue. The son and uncle pleaded with the team leader, while the daughter and wife dropped to the floor and began to scream and cry. They were comforted by the nursing staff. The son and uncle then ran outside, and screams and cries of disbelief were heard from the ambulance bay. The daughter and wife then also ran outside. By this stage, additional police had arrived to assist with crowd control, as emotions were running high, particularly among those who did not speak English.

When the team leader asked to speak to the relatives in order to explain what had happened and debrief them about the events that they had witnessed, it was discovered that the wife and daughter were no longer at the hospital. The police reported that the brother of the patient and the son had insisted that they should go home in a taxi, despite their protests that they wished to stay. As a result, they could not be debriefed and were unable to take part in the discussion. The team, who were used to debriefing and answering the questions that relatives might have, were dismayed that they were unable to reassure the wife and daughter and ensure that they knew where to access further help and counselling if required. The brother and son attended the debriefing on the family's behalf and were given bereavement advice. Staff were unable to contact the patient's daughter or wife subsequently, as the male family members had not included them in the next-of-kin details.

Death and dying are inevitably understood and experienced within a complex mosaic of cultural and religious meanings, and in patriarchal societies women may be excluded from some rituals. Whilst it is important to recognise and respect the fact that each society characterises and, as a result, treats death and dying in its own individual way, such diversity needs to be borne in mind when considering the effects and ramifications of witnessed resuscitation.

This was a sad situation which was managed well, but nonetheless left staff feeling that they had somehow failed the female members of this family and possibly caused unknown consequences for them. The concept of doing no harm must always govern our practice, and this case highlighted an unanticipated outcome that needs to be taken into consideration in future witnessed resuscitations

Obtaining the contact details of all those attending may be a necessary prequisite not just for diverse groups but for all those in our care, so that we can ensure not only the highest quality care for our patients, but also appropriate access to their families.

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