Challenge of Change
Incorporating Family Members in Hospital Care

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Culture is difficult to change, particularly when created and maintained within formal institutions. The culture of the hospital, as reflected in its specific practices, rules, and policies, seems particularly resistant to change. From its historical roots as a hierarchical structure focused on maintaining patient safety, hospitals have a long history of limiting information about the patient (eg, minimizing access to the medical record and even the diagnosis) and restricting visitors. Today, however, the hospital is slowly evolving to a structure that supports patient-centered care and open communication among patients, families, and caregivers.1

The article by Goldberger et al2 in this issue of Circulation: Cardiovascular Quality and Outcomes focuses on a policy adopted by some hospitals that allows family presence during resuscitation (FPDR). The focus of their study provides an interesting insight into the traditions and culture that underlie many hospital practices, as well as the resistance that some physicians and nurses feel about having families participate in the care of acutely ill patients, particularly during a cardiac arrest. The authors compared the clinical outcomes of patients who had an in-hospital cardiac arrest in institutions that allowed FPDR compared with those that did not allow FPDR to address the concern expressed by clinicians and hospital administrators that FPDR is detrimental to patient care. Goldberger et al2 compared the 2 categories of hospitals (those who allowed FPDR versus those who did not) on the proportion of patients who experienced a resuscitation event and had a return of spontaneous circulation, the neurological status of survivors, and the proportion of patients who lived to hospital discharge.

The study is strengthened by the large number of cases included and the number of clinical outcomes included, but has the limitations of all secondary analyses. The data were gathered for purposes other than to determine the result of FPDR on patient outcomes, and the investigators could not verify whether family members were actually present during a resuscitation event regardless of hospital policy about FPDR. The inability to analyze the data based on actual family presence is a major limitation of the study. Also, it must be noted that a finding of no difference between 2 groups is always less compelling scientifically than the finding of a difference.

Despite these limitations, the results of this study answer an important question about the safety of FPDR. The questions surrounding FPDR are not new and, in fact, were posed almost 3 decades ago.3 Many clinicians and family members began to ask why relatives were excluded from witnessing the resuscitation when being present could help them to process the potential loss of a loved one and might be their last opportunity to say good-bye if the resuscitation was not successful. Moreover, witnessing all the efforts of the medical team during cardiopulmonary resuscitation could be a source of reassurance to family members that everything possible was done, thereby facilitating the bereavement process and even reducing the incidence of post-traumatic stress disorder. Critics of changing the policy countered that family members might interfere with the resuscitation effort and cause a decrease in its quality. Their presence might even increase malpractice claims.4 Finally, critics suggested that witnessing resuscitation would have detrimental psychological effects on the family.

After several small studies were published supporting the benefit of FPDR,5 a large multicenter, randomized controlled trial was conducted in France to test the hypothesis that witnessing resuscitation would reduce the likelihood of post-traumatic stress disorder in family members.6 When interviewed at 90 days, family members in the intervention group had significantly fewer symptoms of post-traumatic stress disorder, were less depressed and had less complicated grief reactions than family members who did not witness resuscitation. Thus, concerns that inviting family members to witness resuscitation might be deleterious to them seem unfounded. Still, the issue remains contentious. This study by Goldberger et al2 extends the findings about FPDR to issues around the safety of the practice by answering the question whether the clinical outcomes of patients would be negative if their families were allowed to witness the resuscitation. The results once again support the policy of FPDR by documenting no difference in the quality of care given when a policy exits allowing family members to be in the room compared with a policy of exclusion.

Is it surprising that the policy supporting FPDR has been controversial? We just have to look at how long it took to change visitation policies in hospitals to understand why policies that do not support family-centered care, and that have no scientific support, continue to be upheld. Pediatric, maternity, and intensive care units (ICUs) all provide poignant historical examples.

The first example is provided by pediatric units. As late as the 1950s, the majority of hospitals in the United States
maintained policies that severely restricted parents visiting their hospitalized children. Visiting was allowed twice a week for 1 hour each time. When the visitation rule was challenged by parents or staff, hospital administrators and nurses countered with concern about minimizing infection risk and avoiding children’s distress when parents had to leave their child’s bedside. As researchers discovered the importance of parental presence,2–4 hospital staff slowly changed the visitation policy to allow more frequent visits, although it was still a far cry from the unrestricted visiting policies of most pediatric and neonatal ICUs today. Still as late as 1978, 38% of hospitals from the unrestricted visiting policies of most pediatric and neonatal ICUs today. Still as late as 1978, 38% of hospitals restricted awaiting the birth of their babies. With the advent of free-standing maternity units that provided family-focused care and competed with the much more restrictive setting of the hospital, maternity wards began programs to prepare fathers to participate in labor and birth and to create a more home-like atmosphere in labor and delivery. However, the evolution was slow to de-emphasize an illness model and incorporate increasing respect for individual choice and family presence. It took decades to arrive at today’s practice of having fathers participate at every level of labor and delivery.10

The final example of reluctance to include family members in the hospital setting is the adult ICU. Policies related to visiting, combined with the physical architecture of the hospital, have been the slowest to change in adult ICUs compared with other specialty units. Unfortunately, staff-centered philosophies and approaches to care that limit family presence can still be found in the majority of adult ICUs.11 In a guideline published by the American Association of Critical-Care Nurses in 2011, the authors estimated that 70% of hospitals still restricted family visiting in the ICU,12 despite overwhelming evidence that unrestricted visitation benefits both critically ill patients and family members.13–15 Restricted visiting rules minimize staff burden and eliminate the need for architectural changes necessary to include family members in the physical setting; both of these issues can serve as powerful forces against change.16 Relaxing visitation policy in the adult ICU has been slow in coming.

Given the history of hospital policy related to visitation, it is not surprising that witnessing the resuscitation of a family member would serve as the last bastion of resistance to family-centered care. Thus, the study by Goldberger et al2 is an important addition to the literature supporting family-centered care in general and FPDR in particular. It is time to change.

**Disclosures**

None.

**References**


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