LETTERS TO THE EDITOR

Should relatives be allowed in the resuscitation room?

EDITOR,—I welcome the paper by Mitchell and Lynch¹ and the sentiments behind it but as a specialist in the psychology of trauma I feel compelled to comment upon it.

The only way of preventing post-traumatic stress reactions or mental illness is by not exposing individuals to traumatic events. Once exposed there is little evidence that it is possible to prevent them as their genesis is complex.

Society today does indeed have a view about what we get up to, which is informed by such excellent TV "dramamen-taries" such as *Casualty* or *ER*. We must however recognise that relatives will not see resuscitation as we do. They have no training and will be highly emotionally charged or even "dissociated". We must be aware that individual's reactions to trauma are very different, many may cope well, but others will decompensate, but all are affected to a greater or lesser degree. Every relative deserves and has a right to access to compassionate holding and caring, but care must be taken not to brutalise them at a time of intense vulnerability.

I broadly welcome this initiative but question our responsibility to potentially bereaved individuals. As the only certainly in life is death and grief and bereavement are painful, we must be careful in assuming that watching resuscitation will be beneficial; it may equally be damaging. We must look at our motives in proposing this: will it make us look better or enhance our prestige, will it prevent litigation, and will we be acting, turning our casualty into the "Casualty" of the television?

I feel that perhaps being able to see from a distance through the doors may help, but to be intimately involved in the thick of organised chaos may be damaging, indeed callous. For if we are to care for individuals we must prevent post-traumatic mental illness and the only preventive measure is non-exposure.

Exposure may help grief, but it may not. It may create traumatic neurosis and delay the grieving process, or require more medicalisation to deal with not only the loss, but the traumatic images related to that loss. The key seems to be aiding bereavement without medicalising it.

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1 Mitchell MH, Lynch MB. Should relatives be allowed in the resuscitation room? *J Accid Emerg Med* 1997;14:366-9.

Should relatives be allowed in the resuscitation room?

EDITOR,—Mitchell and Lynch reported that accident and emergency (A&E) "staff with the least experience in dealing with resuscitations and distressed relatives were likely to be

opposed to relatives being present in the resuscitation room".¹ Concerns about the design of this study led us to question their results.

The small sample size (n=81) may be sufficient to estimate the overall proportion in favour of permitting relatives in the resuscitation room. However subgroup analyses based on such small numbers in each subgroup (for example 10 nurses and eight house officers) must be interpreted with caution. The statistical test used is not specified.

The validity of grouping all nurses together ignoring grade or experience must be questioned.

We also believed the questionnaire to be a source of bias as it stated the authors' belief, their interpretation of the evidence, and was not anonymous. To test the questionnaire we repeated the study using two questionnaire wordings randomly allocated to nurses in five A&E departments. Our first questionnaire used Mitchell and Lynch's wording; the second simply stated "I would like to know your opinion on relatives being present in the resuscitation room during cardiopulmonary resuscitation. This is an anonymous questionnaire".

A total of 196 questionnaires were distributed, 99 (50.6%) were of the first type. An overall response rate of 54.1% was achieved. The response rate of 63.9% for the second questionnaire was higher than that for the first questionnaire (44.4%) ($\chi^2=7.48$, $p<0.01$).

Although a greater proportion of respondents to the first questionnaire were in favour of allowing relatives to be present than for the second questionnaire this difference was not significant (table 1).

Table 1 Nurses in favour of relatives being present in resuscitation room; results are number (%)

	Yes	No	Total
Questionnaire			
First	37 (84.1)	7 (15.9)	44
Second	48 (77.4)	14 (22.6)	62
Total	85	21	106

Overall 85 (80.2%, 95% confidence interval 71.1% to 87.1%) of the 106 nurses who responded reported that they felt relatives should be present. This more robust estimate, than the 90% previously reported, confirms that the majority of nurses are in favour of relatives being allowed in the resuscitation room.

We believe the results of our small study demonstrate the design of Mitchell and Lynch's questionnaire is unlikely to have had a significant influence; however, their sample size is insufficient to enable recommendations to be made. Future analyses should have sufficient respondents by subgroup and should collect information on confounding factors such as age, sex, and years since qualification. These factors are necessary to determine whether the observed differences are real or artefactual. The presence of relatives in the resuscitation room is not a simple issue. Anecdotal reports² and the impressions of family members³ are insufficient evidence of benefits to relatives. It is possible that the adverse effects for some

individuals may be extreme and new recommendations should be supported by evidence.

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The authors reply

We welcome the responses to our paper and welcome the opportunity to correct some misunderstandings regarding our research on the matter.

The letter from Dr Matthew Cooke *et al* involves a restrictive study involving A&E nurses only and not all members of hospital staff likely to be involved in resuscitation in the A&E department. The number of respondents in their study was no greater than in ours but I agree that because ours was a more heterogeneous group, each subgroup was relatively small. We did not ignore grade or experience of our A&E nurses. They were all E grade or above with at least four years of A&E experience and all had extensive experience in resuscitation management, training, and management of distressed relatives. That our forms were not anonymous helped in chasing up unreturned forms. I note that there was no significant difference in responses to either of their differently worded questionnaires and that both these figures mirrored ours. Whether 80.2% is more "robust" than 90% is debatable.

We are disappointed by the perception that we based our recommendations on hearsay and other soft evidence. As we stated in our paper, it is our strong belief that before recommendations could be put into place, important measures must be undertaken:

- Rigorous analysis of opinions of staff and relatives, both before and after the resuscitation (ongoing for some months afterwards)
- Weekly resuscitation training sessions with moulage including one person taking the role of the relative and one the nurse accompanying the patient.

Dr Palmer in his letter adopts a paternalistic approach. Post-traumatic stress can be avoided by preventing exposure to both natural and unnatural disasters but they happen and this is unavoidable. Once the disaster has happened it may be too late but even then bereavement counselling has been standard in many hospitals for some years. It is in the context of the evolving disaster that if appropriate guidance and support are given, that the grieving process may be alleviated somewhat. When a child is dying in hospital would we as carers have the nerve to prevent the parent from being present during the final resuscitation in the name of preventing post-traumatic stress? I think not. Preventing distress is laudable but assisting people's grieving by offering them the opportunity of witnessing the resuscitation may be beneficial.³ The suggestion that we would be wishing to enhance our prestige by carrying out this work is distasteful, offensive, and untrue.