Teaching Clinical Ethics Using a Case Study
Family Presence During Cardiopulmonary Resuscitation

Ainslie T. Nibert, RN, PhD

Critical care nurses often find themselves in the midst of challenging ethical situations that involve conflict between the needs of critically ill patients and the patients’ family members and the preferences of physicians and other healthcare providers who initiate and manage resuscitation measures. Yet, many critical care nurses have reported that they received little preparation in their basic education programs to deal with these sensitive issues. Because new graduate nurses often choose to specialize in critical care, nurse educators who design and teach undergraduate critical care nursing courses are obligated to address ethical decision making as part of the curriculum. In this article, I present a case study of an ethical issue in critical care and describe a method of clinical ethical analysis that nurse educators can use when teaching students about making ethical decisions in clinical practice.

The presence of patients’ family members during cardiopulmonary resuscitation (CPR) is an ethical issue debated among healthcare professionals who routinely face life-threatening situations. Presentation of a case study involving a family’s presence during CPR provides students in a critical care nursing course valuable experience in making ethical decisions that will prepare the students for the inevitable dilemmas faced by professional nurses.

Case Study
A 40-year-old man lost control of his vehicle and struck a guardrail in a single-car collision. He was not wearing a seat belt and was thrown through the windshield, sustaining a traumatic, closed-head injury. He was brought to the trauma center via helicopter and was admitted to the surgical intensive care unit. The night staff provided support to the patient’s wife during her first visit to see her husband, who was receiving mechanical ventilation and was unresponsive and surrounded by multiple invasive catheters and equipment. The trauma team briefly met with her soon after admission to explain her husband’s grave prognosis.

The next day, a senior student in an undergraduate critical care nursing course assisted the nurse preceptor in managing the patient’s complex care. The patient’s wife came into the unit for her second visit just as the nurse preceptor and the student were preparing the patient for the morning visit. As the patient’s wife approached the bedside, the alarms of the monitors for the cardiac and arterial catheters sounded, indicating a cardiac arrest, and CPR was initiated. The healthcare personnel
handling the code situation pulled the privacy curtains around the bed in an attempt to screen the situation from view by the patient’s wife and the other patients and their visitors within the unit. At that moment, the student took the stunned wife into the hallway, and a nursing supervisor arrived to lead the woman into a private waiting room.

The student later reported the events of the morning to her peers at a clinical conference, including the fact that the patient’s wife had arrived just as the code started. The student explained that the patient did not survive despite the team’s efforts and that the patient’s wife did not have the opportunity to see him again before he died. The student’s statement caused the instructor to question the policy in almost all adult critical care units that family members’ access to loved ones during CPR should be restricted. The ethical dilemma that arose in this situation involved the conflict between the desire of the patient’s wife to be present during CPR and the desire of the trauma team to exclude her.

**What Constitutes an Ethical Dilemma?**

A moral conflict exists because two opposing obligations collide: an obligation to the family members who desire to be present with their loved one during CPR and an obligation to the healthcare providers who do not want patients’ family members to witness resuscitation efforts. The focus of the ethical questions that stem from this clash of desires is determining which obligation deserves to be fulfilled while the opposing obligation is ignored or compromised. Resolution of the ethical dilemma involves initiating a change in accepted policy that would allow patients’ families to be present, reinforcing the existing policy that prohibits their presence, or selectively permitting them to be present on the basis of screening according to predetermined criteria.

**Using a Clinical Approach to Resolve Ethical Dilemmas**

Nurse educators teaching critical care courses can increase students’ understanding of ethical dilemmas by having the students participate in a clinical analysis of a case study. The debate about whether to offer family presence during CPR is an example of an ethical dilemma that arises within critical care nursing practice. In small groups, students can begin their analysis of the issue by reviewing the current literature on family presence. Discussion of findings with their peers helps students identify key issues within the ethical dilemma. Once the issues defining the dilemma are exposed and described, students can search for relevant practice guidelines endorsed by medical, nursing, and other health-related organizations. After the review of the literature and the search for current practice guidelines are completed, students will be ready to further define the opposing arguments inherent in the ethical conflict. During the discussion of these issues, the instructor should function as both facilitator and moderator and should be responsible for ensuring that all points of view are equally represented and discussed as the ethical analysis unfolds.

The clinical analysis of the case study is designed to answer the question, Does an overriding obligation exist to honor the desires of the family or the desires of the healthcare providers? Once students formulate an answer to this question, they can advance recommendations that reaffirm the traditional policies that restrict family presence or that promote the adoption of new policies that lift restrictions on family presence in the critical care setting.

**Step 1: Reviewing the Literature**

Family presence during CPR is a relatively new issue in healthcare. Students conducting a review of the literature may be surprised to discover that most of the available information has been published within just the past 2 decades. No ethical dilemmas of this type existed before the development of CPR in the late 1950s because family members were present at almost all deaths. A dying person’s last moments were most often controlled by his or her family in the home rather than by medical personnel in a hospital.

The advent of high-tech medical practices moved patients out of homes and into hospital beds. When patients were too sick to be treated on general nursing units, they were moved to critical care units. Even though such a move offered greater proximity to lifesaving equipment, it removed patients from their families. Molter published a landmark study that was the first to acknowledge the needs of families of critically ill patients. Once critical care nurses began to actively question the enforcement of restrictions on visiting hours, access of patients’ families to critically ill patients gradually increased during a 20-year period.

Hanson and Stawser published the experiences of the emergency
department staff at Foote Hospital in Michigan, attributed as being the first hospital to allow family presence during CPR. As early as 1982, the staff at Foote Hospital began questioning the merit of restricting access of patients’ family members to the patients during CPR. The issue came to the attention of the Emergency Nurses Association in 1993, and a resolution was passed encouraging health professionals to offer patients’ families the chance to be present during CPR. Guidelines to assist staff in creating these policies were published by the association in 1995, and an educational booklet for families on the subject was developed.

Articles and letters to editors continued to be published through the late 1990s in many medical and nursing journals that supported either retaining traditional restrictions on family presence or adopting more lenient policies that allowed family presence in selected situations. However, few articles offered research-based findings on the issue until Meyers et al published the results of the first formal research study in which the responses of family members who had participated in family presence at Parkland Hospital in Dallas, Tex, were examined. Subsequent studies resulted in the publication of the first evidence-based guidelines, which recommended that hospital personnel remove restrictions on family presence. The guidelines were based on reports of perceived advantages and disadvantages of family presence given by patients’ family members, healthcare providers, and patients. The articles were published in the *American Journal of Nursing*, and findings were widely disseminated to the public through the mass media.

Advantages and disadvantages of family presence during CPR from the perspectives of patients’ family members and healthcare providers (Table 1) varied slightly. Family members viewed family presence

<table>
<thead>
<tr>
<th>Table 1 Perspectives of patients’ family members and healthcare providers on family presence during cardiopulmonary resuscitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family members</strong></td>
</tr>
<tr>
<td>Perceived benefits 5,8,12,14,15</td>
</tr>
<tr>
<td>Fosters greater appreciation for efforts of code team to ensure that “everything possible” was done to save the patient</td>
</tr>
<tr>
<td>Enhances feeling of usefulness by offering medical history and actively supporting the patient</td>
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<tr>
<td>Gives opportunity for patient’s values to be expressed to staff</td>
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<tr>
<td>Increases spiritual connectedness felt with the patient</td>
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<tr>
<td>Reduces guilt and anxiety about leaving the patient in crisis</td>
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<tr>
<td>Allows closure with the patient, facilitating grief process; offers the chance to say goodbye</td>
</tr>
<tr>
<td>Fears that staff might be distracted by a patient’s distraught family members</td>
</tr>
<tr>
<td>Unease about the potential for litigation brought by patients’ family members who view the code</td>
</tr>
<tr>
<td>Authoritative report of research based on evidence from multiple hospitals and healthcare providers</td>
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Advantages and disadvantages of family presence during CPR from the perspectives of patients’ family members and healthcare providers (Table 1) varied slightly. Family members viewed family presence
not only as a fundamental right but also as a way of offering support to their loved ones in crisis. However, they also expressed concern about feeling emotionally traumatized and obligated to witness CPR when they might prefer to decline. Interestingly, all parties thought they had a right to have their families present. Some patients said that they felt safer and less afraid with family members present. However, other patients reported that they preferred to face death alone and did not want estranged relatives allowed to invade their privacy. Healthcare providers viewed family presence as an opportunity to maintain the dignity and personhood of patients but feared physical assault by distraught family members, increased threats of liability and subsequent litigation, and loss of control over the code situation. Interestingly, all parties involved agreed that family presence during CPR could result in subjecting patients to prolonged resuscitations in medically futile situations because the trauma team might be reluctant to “call” the code in the presence of a patient’s family member.

Step 2: Reviewing Practice Guidelines

Position papers and codes of ethics from various medical and nursing professional organizations can be scrutinized to determine which groups have identified standards of practice for family presence. Some organizations have offered broad statements that reflect the importance of service to patients and patients’ family members as a primary goal of healthcare and have designated all other actions as subordinate to this obligation. However, only the Emergency Nurses Association and the American Heart Association have publicly acknowledged the benefits of family presence and advocated that family presence be an option for hospital staff.

Step 3: Defining the Opposing Arguments

The method of clinical ethical analysis described by Jonsen et al (Table 2) provides students a practical and understandable approach to resolving ethical dilemmas in critical care nursing practice. The focus of this method is an analysis of 4 distinct issues that have a bearing on the ethical dilemma under examination: (1) medical indications; (2) patients’ preferences; (3) quality of life; and (4) social, economic, and health policy issues, defined by Jonsen et al as contextual features. By examining family presence during CPR within the context of these 4 categories, students can gain experience in building arguments that support or reject this practice.

Medical Indications for Offering Family Presence During CPR

Analysis begins with a review of the medical indications that would markedly affect a patient’s chances of being benefitted or harmed by offering or denying family presence. Medical indications typically focus on treatment goals and the impact the ethical problem has on the achievement of these goals. The review of the literature provides evidence indicating that family presence does not usually interfere with medical interventions with a focus on patients’ survival. Furthermore, results of research studies indicate that providing family presence can be of great comfort to both patients and the patients’ families. The American Heart Association estimated that less than 15% of all hospitalized patients receiving CPR survive to discharge from the institution where they were resuscitated. Therefore, because of this high mortality rate and patients’ wishes to be close to their family members at the moment of death, medical indications favor offering family presence.

Patients’ Preferences

Patients’ preferences are key components within the clinical ethical analysis and should be evaluated next. A patient may express certain preferences about medical care directly to his or her family members and/or healthcare providers. If a patient’s preferences are not specifically known, they may be construed from a review of the patient’s consents for treatment and advanced directives or determined from the statements of the patient’s surrogate decision maker. General evidence about patients’ preferences can also be obtained from the literature. The research indicates that patients and their families prefer having family presence offered as an option and that virtually all patients and families who are offered the opportunity for family presence will accept it. Regarding family presence, patients and their families have expressed a desire to be in close contact when facing a life-threatening situation.

Quality-of-Life Issues

The nursing literature describes several quality-of-life concerns expressed by patients and patients’ families who have experienced family presence during CPR. For many years, healthcare providers have restricted family presence because of concerns...
about the emotional trauma that witnessing CPR might cause a patient’s family members. However, patients thought that family presence elevated the patients’ dignity and status as persons in the eyes of the healthcare team. Likewise, family members of patients reported that family presence provided an opportunity for closure and a chance to say goodbye. Although the potential danger of emotional trauma resulting from family presence has been described, most family members indicated that their experiences with family presence did not adversely affect their quality of life. 

**Contextual Features** The tradition of restricting family presence in hospitals is a significant social and health policy issue that is a contextual feature in the ethical debate associated with this practice. Long-standing opposition to family presence during CPR is a well-known, social phenomenon within the medical community. Physicians in particular have expressed covert concerns about experiencing increased emotional distress due to the presence of a family member during the code. These concerns stem from an intentional depersonalization of patients by physicians that allows the physicians to remain focused on the required medical interventions and to main-

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**Table 2** Method of clinical ethics analysis

<table>
<thead>
<tr>
<th>Medical indications</th>
<th>Patient preferences</th>
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<tbody>
<tr>
<td>3. What are goals of treatment?</td>
<td>3. Is patient mentally capable and legally competent? What is evidence of incapacity?</td>
</tr>
<tr>
<td>5. What are plans in case of therapeutic failure?</td>
<td>5. If incapacitated, who is appropriate surrogate? Is surrogate using appropriate standards?</td>
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<tr>
<td>6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?</td>
<td>6. Is patient unwilling or unable to cooperate with medical treatment? If so, why?</td>
</tr>
<tr>
<td></td>
<td>7. In sum, is patient’s right to choose being respected to extent possible in ethics and law?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality of life</th>
<th>Contextual features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the prospects, with or without treatment, for a return to patient’s normal life?</td>
<td>1. Are there family issues that might influence treatment decisions?</td>
</tr>
<tr>
<td>2. Are there biases that might prejudice provider’s evaluation of patient’s quality of life?</td>
<td>2. Are there provider (physicians and nurses) issues that might influence treatment decisions?</td>
</tr>
<tr>
<td>3. What physical, mental, and social deficits is patient likely to experience if treatment succeeds?</td>
<td>3. Are there financial and economic factors?</td>
</tr>
<tr>
<td>4. Is patient’s present or future condition such that continued life might be judged undesirable by them?</td>
<td>4. Are there religious, cultural factors?</td>
</tr>
<tr>
<td>5. Any plan and rationale to forgo treatment?</td>
<td>5. Is there any justification to breach confidentiality?</td>
</tr>
<tr>
<td>6. What plans for comfort and palliative care?</td>
<td>6. Are there problems with allocation of resources?</td>
</tr>
<tr>
<td></td>
<td>7. What are legal implications of treatment decisions?</td>
</tr>
<tr>
<td></td>
<td>8. Is clinical research or teaching involved?</td>
</tr>
<tr>
<td></td>
<td>9. Any provider or institutional conflict of interest?</td>
</tr>
</tbody>
</table>

tain an objective perspective while directing a code situation. Their distress is compounded by anxiety over possible litigation and even physical assault. The underlying issue appears to be one of control, with nurses more likely than physicians to favor allowing family presence during CPR.

Healthcare personnel have a fiduciary duty to their patients that requires the personnel to promote their patients’ interests above their own preferences. Physicians have traditionally recognized the interest that patients’ family members have in the welfare of the families’ loved ones, and physicians are therefore obligated to support and shield these patients from harm. Thus, the contextual features of the family presence issue support subjugating the desires of healthcare providers in deference to the obligation owed to patients and patients’ family members.

Making Ethical Decisions About Family Presence During CPR

The culmination of the clinical ethical analysis occurs when the student group reaches a decision about the merits of restricting or permitting family presence during CPR in critical care units. The tradition of restricting family presence in hospitals was identified in the clinical ethical analysis as a social and health policy issue, or contextual feature, within this ethical dilemma. According to Jonsen et al., the fact that this restrictive practice constitutes a contextual feature would normally exert a more powerful influence in the final analysis provide little guidance in the case study involving family presence during CPR. In this case study, the key medical indication, the provision of CPR, did not extend the patient’s survival, the patient’s preferences about family presence were unknown, and the spouse’s quality of life could have been affected because she lost the opportunity for closure and the chance to say goodbye to her husband. Thus, the contextual feature, the tradition of restricting family presence during CPR in this hospital, was a pivotal factor in the clinical ethical analysis. In order to effectively resolve the ethical dilemma, a change in policy to remove traditional restrictions on family presence during CPR was needed. In other words, the argument for keeping a restrictive policy because “that is the way it has always been done” at a particular hospital is not necessarily valid for restricting family presence. Perpetuating restrictions on family presence simply because these restrictions have traditionally been upheld by hospitals (the contextual feature of the family presence debate) is not supported by the clinical ethical analysis. Therefore, from an ethical perspective, hospital policies that globally restrict family presence during CPR should be abolished, and healthcare professionals should develop procedures that at least selectively, or even unconditionally, allow family presence.

Conclusion

During the past decade, nurses have increasingly advocated for family presence. In fact, nurses have been the most frequent authors of studies on family presence. The Emergency Nurses Association is the only professional, health-related organization that has published a position paper promoting family presence during CPR. As a result of the American Journal of Nursing’s publication of 2 landmark studies on family presence and the subsequent publicity about these studies within the popular media, the family presence issue and nurses who support family presence during CPR have gained national attention. Although the issue remains controversial, nurses generally agree that family presence can be beneficial for both patients and patients’ family members, if patients and their families desire it. Because of this belief, nurses continue to advocate for their patients by attempting to revise policies that restrict family presence in their hospitals.

What can nursing students learn from analyzing this case study on family presence? They may realize that situations involving ethical dilemmas in the critical care environment can be resolved in many different ways. Student groups using the case study may gain additional insight by discussing what might have happened if the patient’s wife had been allowed to stay with her husband during CPR. Students may gain a deeper appreciation for the complexity of ethical issues they will face in the critical care environment. They may even begin to question hospital policies that are based on tradition rather than on specific evidence. Providing the opportunity to discuss and debate an ethical issue and to work through a clinical ethical analysis under the guidance of an informed instructor offers students a valuable experience in dealing with the issues they will undoubtedly face as novices in professional nursing practice.
Acknowledgments

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References

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