CHAPTER 2

Hidden in Plain Sight: Family Presence During Resuscitation on Prime-Time Media

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The first episode of the third season of *Heroes* begins when Peter Petrelli is excluded from the hospital room where his brother, Nathan Petrelli, is undergoing cardiopulmonary resuscitation (CPR).[1] The doctor who escorts him out does not even reply to the question, 'is he going to make it?' and closes the doors to the room without a word. The background music expresses urgency. In the next scene, Peter watches helplessly as the disappointed doctor comes out of the room and utters, 'I'm sorry.'

Family presence during cardiopulmonary resuscitation remains a much contested topic in clinical ethics. Even though professional guidelines support it, healthcare professionals commonly oppose it and decline to implement the guidelines. The reasons for this opposition include the perception that CPR is chaotic, bloody, and that relatives might become obstructive and/or faint. Interestingly, the author's personal experience suggests that even students of the medical professions or medical professionals who have minimal or no experience with CPR share this negative

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attitude towards family presence during CPR. This chapter explores the origins of this attitude. Specifically, it empirically examines one plausible origin for the predominant negative attitude among students of the health professions or junior medical professionals towards family presence during CPR—prime-time media.

For the purpose of this chapter, the following definitions will be used:

- CPR in the media: Any situation in which chest compressions or emergency intubation were performed on a patient; a patient was said to be having 'an arrest' or be 'crashing'; an unconscious patient was treated for a life-threatening arrhythmia; or a physician declares a patient dead.
- FPDR (Family Presence During Resuscitation): The ability of any family member (blood related or not), friend, spouse or anyone who shares some form of intimate relationship with the patient to watch, talk and/or touch the patient.

Importantly, this chapter focuses on adult CPR, excluding paediatric CPR from the discussion. While the differences between the two populations are not necessarily morally significant, most studies implicitly distinguish the two.[2] Therefore, to prevent any potential biases and circumvent potential objections, only adult CPR will be discussed.

Family Presence During Resuscitation

Guidelines recommending parameters for allowing families to be present during adult CPR were published in the USA as early as 1994.[3–5] Currently, both European and American nursing and medical guidelines recommend allowing FPDR.[6–10] A recent report by the Institute of Medicine also advocates for FPDR.[11] Two recent large studies demonstrated the lack of negative effects of FPDR on in-hospital CPR outcome and the benefits FPDR holds for relatives.[12–14] However, FPDR is still not widely endorsed by healthcare professionals around the world.[15] In fact, in 2003 only 5% of 984 American nurses who participated in a survey worked in critical care/emergency units that had protocols allowing FPDR.[16] The literature suggests that while the majority of nurses oppose FPDR, they favour it more than physicians. Further, less experienced physicians are less likely to favour FPDR.[17–24]

Healthcare providers commonly raise a variety of reasons against FPDR, including: concern for the family experiencing a traumatic event;

concern for the privacy and care of patients; increased law suits against healthcare staff; lack of physical space at the bedside; or concern for professional staff that might experience performance anxiety or be subjected to acts of violence by relatives.[20,25–27]

While empirical evidence and ethical deliberation have debunked the majority of these concerns, this chapter will not attempt to engage with them directly.[28] Rather, the questions that concern us here are the following: How do healthcare professionals form these (mis)conceptions? Particularly, the author's personal experience suggests that medical students, who never participated in CPRs, tend to instinctively oppose FPDR. But whence do they learn this 'intuition'? This chapter does not presume to answer these questions completely, but rather seeks to discuss one medium, which may create and fuel oft-misguided perceptions of and attitudes towards FPDR. In short, I suggest in this chapter that television may influence the attitudes of laypeople as well as medical professionals and students towards FPDR.

Medical Dramas and Medical Socialisation

Medical dramas have long been considered a major vector of medical information which shape and contribute to the social appearance and cultural influence of the medical institution.[29] As early as 1996, Diem et al. suggested that the false portrayal of CPR on television instils upon the public an unrealistic notion of its success rates and hence gives a false sense of hope.[30] Other observational studies that examined different television shows, both American and foreign, have demonstrated that the success rates of CPR were in fact realistic but suggested other concerns, such as: the psychological qualitative (rather than quantitative) effects of dramatic CPR scenes,[31] unrealistic reasons for CPR and type of population undergoing resuscitation,[32,33] and failure to depict long-term effects rather than short term ones.[34] Specifically, laypersons' perceptions of FPDR and CPR in general might also be affected by television, as might be inferred from Grice et al.[35]

Moreover, many have discussed the specific effects that medical dramas have on medical students, such as causing more students to choose a specific residency,[36] or shaping their medical conduct in general.[37] One study calls to change the way in which the healthcare system is depicted in medical dramas, for fear that viewers might have false expectations from their healthcare providers.[38] Another study congratulates the scriptwriters of *House*, *M.D.* for their realistic depiction of chronic-pain

management.[39] Even Baer, a physician and co-producer of *ER*, who, in reply to Diem et al. warned against blaming television rather than the physicians themselves, still affirms that television affects viewers' knowledge, at least to some extent.[40]

Study Description

I sought to analyse how FPDR is depicted in prime-time medical dramas, the reasoning being that these dramas often provide students of medical professions with their first encounter with CPR. For this purpose, I watched and analysed the first season of *House, M.D.* (22 episodes),[41] and *Grey's Anatomy* (nine episodes).[42] For comparison, I also analysed 16 episodes of *Medic*. *Medic* was the first hit prime-time medical drama aired in the USA, between 1954 and 1956, while *House* (2004–2012) and *Grey's Anatomy* (2005–present) are among the most popular prime-time medical dramas to date.[29] I identified CPR cases according to the definition stated above and for each case recorded seven items: name, age and sex of patient, cause of CPR, underlying illness, location of CPR and details of family presence. A second academic observer reviewed five episodes of *House, M.D.* in order to increase internal validity. I reviewed the results a second time to further increase internal validity. CPRs in the operating room (OR) were excluded, on the assumption that family could not be present under those circumstances.

The results were as follows (see Table 2.1):

House: M.D: 14 CPRs were recorded, of which one was performed in a pre-hospital setting. In four of the CPRs there is no family at the bedside. In one of these cases, the family member (business agent) appears right after intubation and complains that it was done despite a do not resuscitate (DNR) order. In four cases family members are excluded, either by escorting them out of the room or by shutting the blinds. In six cases family members are present, one of which occurred in a pre-hospital setting. In one case out of these six cases, relatives (nuns) are not present in the room but allowed to watch from the outside with open blinds. Family members are never invited to be present during CPR. In none of the six cases where family is present are they accompanied by a member of the staff.

Grey's Anatomy: 12 CPRs were recorded (two CPRs which took place in the OR were not considered). In ten cases there are no family members at the bedside during CPR. In one case the family member (wife) is

Table 2.1 Characteristics of CPR cases

CPR	*Episode*	*Name*	*Age*	*Sex*	*Cause*	*Underlying illness at the time of CPR*	*Location*	*Details of family presence*
House 1	Pilot	Rebecca Adler	Young adult	F	Seizure	Unknown	Hospital	None
House 2	'Occam's razor'	Brandon	16	M	Ventricular tachycardia during heart catheterisation	Unknown	Hospital clean room	Parents are watching from outside and seem confused/ frightened after the physician shuts the blinds
House 3	'Maternity'	Hartig	Neonate	F	Seizure	Unknown	Hospital	Parents are present and are not excluded
House 4	'Maternity'	Chen-Lupino	Neonate	F	Infection	Unknown	Hospital clean room	Family member waits outside and blinds get shut
House 5	'Damned if you do'	Sister Augustine	Adult	F	Tachycardia	Unknown	Hospital	Other nuns are present and House does not exclude them
House 6	'Damned if you do'	Sister Augustine	Adult	F	Anaphylactic reaction	Unknown	Hospital clean room	Other nuns watch from outside

(continued)

Table 2.1 (continued)

CPR	*Episode*	*Name*	*Age*	*Sex*	*Cause*	*Underlying illness at the time of CPR*	*Location*	*Details of family presence*
House 7	'Poison'	Matt	Adolescent	M	Bradycardia	Unknown	Hospital	Mother is in the room, asked to move aside by the physician but is not excluded
House 8	'Poison'	Chi	Adolescent	M	Unknown	Unknown	Hospital	Parents are escorted out
House 9	'DNR'	John Henry	Old	M	Iatrogenic	ALS?	Hospital	Agent comes in after intubation and resents CPR despite of 'DNR' order
House 10	'Cursed'	Gabe Reilich	12	M	Laryngospasm	Anthrax?	Hospital	Parents are in the room, father doubts the physicians while the mother calms him down ('Let them do their job')

(continued)

Table 2.1 (continued)

CPR	*Episode*	*Name*	*Age*	*Sex*	*Cause*	*Underlying illness at the time of CPR*	*Location*	*Details of family presence*
House 11	'Control'	Carly	Young	F	Respiratory arrest during angiography	Unknown	Hospital	None
House 12	'Heavy'	Jessica	10	F	Myocardial infarction	Unknown	School	Other students are present
House13	'Babies and bath water'	Naomi	Young adult	F	Pulmonary embolism	Small cell carcinoma	Hospital	Husband is escorted out
House 14	'Three stories'	Unknown	Middle age	M	Allergic reaction to antivenom	Snake bite	Hospital	None
Medic 1	'General practitioner'	Unknown	Old	M	Unknown	Strokes	Home	Rabbi and daughter are present
Grey's 1	'A hard day's night'	Katie Bryce	Young adult	F	Seizure	Epilepsy	Hospital	None
Grey's 2	'The first cut is the deepest'	Allison	Young adult	F	Rape	Unknown	Hospital	None
Grey's 3	'The first cut is the deepest'	Unknown	57	M	Asystole	Unknown	Hospital	None
Grey's 4	'The first cut is the deepest'	Unknown	Unknown	?	Unknown	Unknown	Hospital	None
Grey's 5	'The first cut is the deepest'	Unknown	Unknown	?	Unknown	Unknown	Hospital	None

(continued)

Table 2.1 (continued)

CPR	*Episode*	*Name*	*Age*	*Sex*	*Cause*	*Underlying illness at the time of CPR*	*Location*	*Details of family presence*
Grey's 6	'Winning a battle, losing the war'	Kevin Davidson	Middle age	M	Trauma	Bike race	Hospital	Wife comes in while patient is in a coma after CPR
Grey's 7	'No man's land'	Liz	55	F	Pancreatic cancer	Pancreatic cancer	Hospital	None
Grey's 8	'Shake your groove on'	Mrs. Patterson	Old	F	Post-coronary artery bypass graft	Unknown	Hospital	Husband is asked to leave by the physician ('Get him out of here') but does not
Grey's 9	'If tomorrow never comes'	Jimmie Harper	Late middle age	M	Thrombo-embolism	Post-chest tube placement	Hospital	Wife is present during the collapse but is escorted out during CPR
Grey's 10	'The self destruct button'	'Digby' Owens	Young adult	M	Septic shock	A tattoo	Hospital	None
Grey's 11	'Save me'	Unknown	Young	F	Unknown	Unknown	Hospital	None
Grey's 12	'Who's zoomin' who'	Mr. Franklin	Old	M	Complication of paracentesis	Hepatic failure	Hospital	None

present, but is escorted out of the room. In one case, the family member is asked by the physician to leave the room, but does not comply. Family is never invited to be present during CPR. In the one case in which one family member is present (husband), there is no staff member to accompany him.

Medic: One CPR was recorded, in which the physician comes to the patient's home and declares him dead, with no intervention. The patient's daughter is sitting at the bedside; a rabbi is present as well.

Discussion

Two conclusions can be drawn from the results. The first is that current prime-time medical dramas do not portray the option of FPDR as recommended by current guidelines. However, these medical dramas are realistic insofar as they present a negative stance towards FPDR, which is the prevailing medical practice worldwide.[16–22] In both dramas, no family members were ever invited to be present during CPR. On *Grey's Anatomy*, in one case family members were asked to leave the room during CPR. In all other ten cases of CPR no family members were present. FPDR is only allowed in one out of 12 CPRs, and only because of the family member's insistence. In *House*, family members were present in six out of 14 CPRs, and were not present in four other cases. In four cases the family was excluded. In those five in-hospital CPRs where family was present in the room or allowed to watch from outside, there was no staff member to support them, as recommended by professional guidelines.[6,7] As mentioned earlier, in one case the family member (business agent) enters the room after an emergency intubation is performed on a patient who signed a DNR order. The agent is clearly (and rightly) upset.

A second conclusion, albeit anecdotal at most owing to low statistical power ($n = 1$), is that CPR in *Medic* is portrayed in a very different manner than it is in *House* and *Grey's Anatomy*.[43–46] The patient lies in his bed, in his home, with his daughter and a rabbi who prays while the patient is dying. Once he dies, the physician does not attempt any heroic measures, but simply covers the patient's face with a blanket and turns immediately to console the daughter, affirming that they have discussed the issue before and that it was 'bound to happen.'[47] The grieving process of the family begins in the same room where death was announced, and at the same time, together with the body of the loved one, the physician and a supporting figure (in this case, a rabbi). The background

music is quiet and soothing, unlike the hectic music that appears in most of the CPRs that occur in the more modern shows (this, of course, could not have been quantified objectively).

Drawing from these two conclusions, one may assume the effects these modern medical dramas might have on patients, their families and medical professionals, especially those with less real-life experience, such as medical students and interns. Family members are rarely present, and if they are present they are escorted out of the room in a dramatic manner: music is hectic, blinds are shut and the stressed physician uses an assertive tone and strong language, for example exclaiming 'Get him out of here!' The DNR case in *House* further emphasises this point: the family member realises that the physician disobeyed the law (as well as ignored the patient's autonomy) and is therefore legally liable. The viewer might conclude that family members are either almost never present at the bedside or that they are (and ought to be) excluded from their loved one's CPR by escorting them out of the room and/or by shutting the blinds. Moreover, the viewer might wrongly deduce that FPDR would increase the risk of a legal lawsuit and that family members might lose their calm and interfere with the patient's care (see Gabe Reilich case in *House*, where the father publicly and vocally doubts and threatens the physicians).[12,48,49]

Of course, the aforementioned is far from proving a causative effect. Similar to the argument presented by Baer,[40] there is no evidence that the way FPDR is depicted in prime-time television actually affects either the public's or healthcare professionals' attitudes towards the issue, so no real causal correlation can be established at the moment.

Two more general points should be noted. First, 16 episodes of *Medic* depict only one case of CPR, while the current medical dramas depict many more. Second, in *Medic* the dying takes place at home and no intervention is made by the physician, while in the current medical dramas dying usually happens inside the hospital and rigorous CPR is performed. As many have suggested, it seems reasonable to assume that this modern over-medicalisation of death and dying originates both from advancements in technology and, to a larger extent, a change in the modern cultural notion of death and medicine's role in coping with it.[50] Modern society has become afraid of death (subconsciously or consciously), and instead of facing this fear it turns to the comforting image of the hospital and the white coat. In the hospital, death can take place behind the curtain, meaning out of sight. Relatives often bring their

loved ones to the hospital with no clear expectations or, worse yet, with false expectations as to treatment options and prognosis. Furthermore, relatives often believe that by taking their loved ones to the hospital they will have maximised the patient's well-being.[46,51–55] Sadly, this is far from true.[56,57]

What are we then to do? From a descriptive perspective, medical dramas seem to portray the status quo realistically: relatives are commonly excluded from their loved one's CPR. From a normative perspective, however, medical dramas fail to portray what *should* be the status quo based on empirical evidence, professional guidelines and ethical deliberation.[28] Potentially, this may create, or perpetuate, misconceptions about the effects of FPDR among medical professionals as well as among laypeople.

Do the non-medical personnel responsible for these medical dramas—that is, the producers, screenwriters and so on—have a moral obligation to portray FPDR according to empirical data and professional guidelines? I believe so, but my intention is not to argue for it here. Rather, this chapter is mainly addressed to medical professionals or students who are either involved in the production of these shows or who are watching these shows. I join with Baer,[40] and Diem et al.[30] by arguing that physicians and other healthcare professionals bear a great responsibility in countering the inaccurate images portrayed on television and should educate patients, their families and themselves about the risks (or lack thereof) and benefits of FPDR. This responsibility is threefold. First, those healthcare professionals who consult with screenwriters should push toward a more accurate depiction of FPDR. Second, healthcare professionals ought to offer the option of FPDR and verify that family members are well informed and know what to expect, regardless of their decision. Third, healthcare professionals should educate their colleagues, particularly the less experienced ones, about the benefits of FPDR and refer them to current guidelines.

Conclusion

Patients and less experienced healthcare professionals have few sources from which to learn about FPDR. Even though a causal correlation between FPDR on television and its effects on FPDR in real life has not been established, it is likely to be an influencing factor. The study described here suggests that medical dramas, while realistic in this sense,

do not portray FPDR as they should, in a way that is beneficial to both staff members and families. Screenwriters should be aware of this, and perhaps consider modifying the manner in which they portray FPDR. More importantly, medical professionals should educate themselves and their colleagues about the benefits of FPDR and apply professional guidelines to their practice. Medical professionals who advise screenwriters should push for a depiction of FPDR that is more congruent with existing empirical evidence—misconceptions help no one.

After discussing an *ER* scene in which Dr Kerry Weaver dramatically excludes a patient's mother from the resuscitation of her son, Ellen Tsai argues that:

> Art imitates life. Our traditional practice during resuscitation procedures is to exclude family members, keeping them out of the room until we have ceased our efforts. Why do physicians and nurses continue to deny family member the option of staying with patients while they are dying, even though the results of numerous studies favor the family's presence? It is time for us to stop hiding behind unfounded fears.[58]

I concur, and I would add that occasionally it is life that imitates art.

Notes

1. *Heroes*, 'The Second Coming,' Episode, 1, Season 3. Directed by Allan Arkush. Written by Tim Kring. NBC, 22 September 2008.
2. Reasons for this distinction fall beyond the scope of this article.
3. R.O. Cummins and M.F. Hazinski, 'The Most Important Changes in the International ECC and CPR Guidelines 2000,' *Circulation* 102 (2000): 371–6.
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43. Two important qualifications are worth nothing here. First, while appreciating the advantages of CPR as portrayed in *Medic*, it is imperative to note that chest compressions were only developed in the 1960s and mouth-to-mouth ventilation was still not standard of care. However, other CPR methods were being used.
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