**Title: Ethical Considerations for Family Visitation in the Trauma Setting: A Case Study**

**Reviewer 1:**

1). Importance of the paper

The author has chosen an issue which is very relevant to an emergency care practice both in developing and developed countries. The study attempts to address the ethical obligations of the medical care provider towards the patient’s relative/guardian during the process of resuscitation and stabilization before a procedure in a trauma care setting.  Important benefits with counterarguments have been clearly explained, other studies provided in detail and well defined terms have been used. However, a few of the studies provided by the author to support the arguments discussed are not based in a trauma care/hospital setting. The cases of trauma always occurs sudden in onset and the resuscitative procedures are dreadful to be watched ( especially by a relative)  and more vigorous with a multidisciplinary team being involved in the care of the victim. Hence, how consistent are the findings of family visitation in cardiopulmonary resuscitation versus that of a emergency trauma setting is something to be looked into.   
  
2). Is it topical?

The issue has been discussed comparing study findings of more developed countries. Developing countries usually have lesser doctors , more sick patients who require resuscitation and lesser space available per patient in the trauma bay . The practice of approving family visitation during such times can lead to a likely chance of violating the privacy of the patient’s nearby. The issue is apt for discussion and not too specialized for this journal.  
  
3). Originality

The issue discussed is different from majority of the studies in literature which are mainly focused on cardiopulmonary resuscitation. However the arguments and justification of counterarguments  need to be more on studies done in similar settings .   
  
4). Conclusions

The author has provided two main benefits which are exposure to the efforts of the medical team and facilitating the process of grieving.

The first premise of ‘ exposure of the medical efforts’ is very relevant in this scenario. The author has provided studies supporting their statement. One is that  family members have described several benefits to being present during the resuscitation in the study mentioned in reference 3 . But this study has excluded trauma cases and hence cannot be taken as scientific evidence for the same . The author goes on to mention another study(reference 2) which shows that majority of the relatives were happy with their decision to be present during the resuscitation but this study includes only cardiac arrest cases. Two counterarguments which are family being a distraction to the team efforts and chances of malpractice litigation have been provided which are important aspects to be considered. However, results of studies based on a larger sample size and facility based studies( reference 2 and 5 respectively) would reflect the results better. To summarize , the author’s first premise and counterarguments are justified but the evidence(studies) provided in support of these statements need to be replicated in the light of a trauma setting with a sufficiently large sample size. Based on the evidence provided by the author, it is difficult to say if both are comparable.

The second premise of ‘ facilitating the process of grieving’ is also applicable in this scenario. The study in support of relatives feeling closer to their loved ones or feeling a sense of closure (reference 11) is well developed and in line with the point raised by the author. Once again studies mentioning that ‘family visitation alleviates anxiety’ are based on the health worker’s opinions( reference 12) and non trauma settings ( reference 11). It would be preferable if the author provided with studies highlighting the family’s perspective as well. The counterargument provided on ‘post traumatic stress disorder’ has been explained in detail and well supported by the study provided. Overall, the author’s argument appears satisfactory to the second premise.

The author has mentioned factors such as hysterical behavior of the relative having a possible impact on the efforts of the medical team. A few of the other factors  that can be considered to have an impact are as follows :-

1. Issue of privacy-

* Allowing the family member to be present during resuscitation violates the victim’s right to confidentiality.
* Also , the victim may have a bitter relation with the family member/guardian ( in cases of domestic violence ,the guardian being the accused ) and may not be comfortable in their presence.

1. Negative impact of presence of a family member-

* The presence of a family member may create an undue pressure on the team to continue the resuscitative efforts for longer than required since they are being observed by the victim’s loved one.
* The team may have junior doctors in training who will find it difficult to pose any questions regarding their technique considering the relative needs to be ensured that the victim is in experienced hands.
* Some relatives require medical assistance themselves while watching which can disrupt the resuscitative efforts.
* In countries where in a large proportion of the population are unexposed to basics of resuscitation and a lot of their limited knowledge on this is extracted from unreliable sources(such as media) , the expectations of successful outcomes are quite high. It is also commonly seen that relatives misinterpret certain procedures and claim that the hospital staff were negligent and hence the victim suffered a bad outcome.
* The above factors can affect the performance of the team. Also negligence reported wrongly by a family member can have a negative impact on the hospital and its staff.

5) Other comments

* I completely agree with the author that the doctor should first use medical judgement not jeopardizing medical care / wife’s health also considering the other patient’s privacy while deciding on whether or not a family member should witness the care. Moreover, the doctor should mention to the wife to have a brief consultation, explaining the victim’s current condition, providing an option for accompaniment by staff and permitting the wife to ask questions on the procedure to be done.
* A few other factors to be kept in mind while considering family visitation can be age of the victim ( especially paediatric age ) and if the victim had a prior life threatening illness( for example on palliative care). In such an instance the relative will be more prepared since they have been part of the victim’s suffering due to the previous illness.
* Similar to other resuscitation cases, a hospital policy guideline exclusively for trauma cases should be in place including aspects of family visitation.

6). Recommendation

* I appreciate the author for the efforts to present this case study. The conclusion provided is partially linked to the findings of the studies provided. I would recommend the author to provide more scientific evidence on trauma settings to justify their claims which will help to clearly distinguish between already existing literature.
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**Reviewer 2:**

1. The article, **Ethical Considerations for Family Visitation in the Trauma Setting: a Case Study,**uses a casuistry approach to justify favouring the normative claim of physician being duty bound to allow family visitation and facilitating communication in an acute trauma care setting.
2. Casuistry provides for an ideal reference for discussing ethical tensions within an acute care setting and the author uses it well to provide a very good insight into the ethical tensions from a clinician’s point of view. The author’s valiant effort to bridge the ‘*is-ought’*divide with the use of what ‘is’ (through empirical evidence) in order to reach to what ‘ought’ to be (compassionate care as an ethical obligation) needs to be complimented; but the effort will benefit from the addition of an ethical analysis of the primary competing premises in an acute care setting: the duty of veracious communication in a physician-patient relationship and a duty to save human life; which are often placed as conflicting obligatory premises.
3. An argumentative process based on a step wise process as suggested in section 2 will add to the robustness of the discussion. Also, the author can buttress the argument with description of how an absence of adequate communication of any forms fuels the insecurity on both sides and increases the ethical tension.
4. Lastly, the author can elaborate salient features of this adequate communication with verbal and non-verbal do’s and don’ts to drive home the take home message.
5. Discussion section, para 4: Here the author attempts to make a ‘modus tollens’ argument but ends up denying the antecedent fallacy. ‘If litigation, then family visit harms. No litigation, hence family visit does not harm. (if p then q; not p and hence not q)--This needs to be changed. A better way of presenting this would be ‘if family visit leads to litigation, then there may be harm. In most cases there are no litigations from family visits, hence unlikely to harm. (if p then q; not q and hence not p)

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