Journal of
Qualitative Research in Health Sciences
https://jqr1.kmu.ac.ir
10.34172/jqr.2024.01
Vol. 13, No. 1, 2024, 1-7

Original Article

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The Experience of Witnessing Resuscitation among Patients' Families: A Phenomenological Study

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Abstract
Background: Understanding the experiences of patients' family members witnessing resuscitation helps develop care plans. Accordingly, this study aimed to explore the experiences of witnessing resuscitation among the patients' family members.
Methods: A total of 15 patients' family members were interviewed over a 4-month period (from April to July 2019). The participants were recruited through purposive sampling, and they were enlisted from three educational hospitals in Tabriz. Data were analyzed using Smith's interpretative phenomenological analysis (IPA) via the MAXQDA12 software.
Results: Data analysis led to the identification of four main themes and nine subthemes. The main themes included "*the insistence on being present*", "*achieving calmness*", "*partnership and collaboration*" and "*hindrance*".
Conclusion: Although family members reported feelings of agitation towards the health professionals, there was also strong evidence of the benefits of witnessing resuscitation such as open communication, psychological support, and facilitating acceptance of the patient's prognosis. The study highlighted the importance of developing formal policies based on a family-centered care (FCC) approach to observe family presence during resuscitation while maintaining the patient's and family's rights.
Keywords: Resuscitation, Family-centered care, Qualitative study, Experiences

Citation: Hassankhani H, Haririan H, Porter JE. The experience of witnessing resuscitation among patients' families: a phenomenological study. *J Qual Res Health Sci*. 2024;13(1):1–7. doi:10.34172/jqr.2024.01

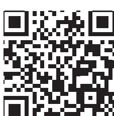
Received: May 18, 2022, **Accepted:** May 7, 2023, **ePublished:** March 28, 2024

Introduction

Cardiac arrest, as a result of cardiovascular diseases, requires immediate consideration and is an emergency and life-threatening event needing cardiopulmonary resuscitation (CPR) (1). Globally, cardiac arrest continues to be a burden on the health system with 290 000 in-hospital cardiac arrests reported in the United States, annually (2). Similarly, cardiovascular disease and heart attack are the main causes of death in Iran and continue to be an ongoing health concern and burden to the Iranian health system (3,4).

Every day, the incidence of deaths caused by cardiac arrest is increasing around the world despite the efforts of resuscitation teams with survival rates remaining low (2). Moreover, the opportunities for family members to be present in the last moments of life are limited as they are often separated from their loved ones during resuscitation (5).

There has been a worldwide movement towards family-centered care (FCC) with family members actively participating in patient care which results in increased patient, staff, and family satisfaction levels (6). In the FCC model, all needs of the patient and family members are considered. The patient and his/her family are seen as a unit and their rights, information, and supportive requirements are taken into account. Family involvement in the direct care of the patient is encouraged especially when CPR is performed (7). Families expect to be present during CPR and invasive procedures (7,8). Family presence during resuscitation (FPDR) refers to the presence of the patient's family members in the location where the CPR is being carried out which allows the family to be able to make eye contact and or touch the patient (9). With the development of the FCC approach, the Emergency Nurses Association identified the importance of FPDR and invasive procedures (7). Studies in this field support family presence highlighting the benefit to the patient, family, and healthcare providers (5,10,11). Resuscitation team members remain uncertain about the benefits of FPDR for the family members and worry that it might be traumatic for the family to be present during resuscitation (9,12). There is an increased level of satisfaction of family members towards the resuscitation staff when allowed to be present during the event (5,13,14).



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A study examined the attitude of nurses towards FPDR comparing nurses who have or have not experienced FPDR clinically. The results showed most of the participants who had experienced FPDR had positive attitudes toward it (15). It is necessary to assess the family's and CPR team's perceptions, attitudes, and experiences of family presence before the implementation of FPDR in hospitals (16,17).

Understanding the experiences of healthcare providers as well as the patient's family members helps develop guidelines and care plans during resuscitation events (18). However, FCC is a new approach to patient care in the Iranian health care system. Therefore, there is a need for further research within the sociocultural context of Iran to improve the understanding of FCC (19,20). Accordingly, this study aimed to explore the lived experiences of patients' family members when present during CPR in hospitals in Tabriz, Iran.

Methods

An interpretative phenomenological analysis (IPA) based on Smith's approach (21) was used to explore the experiences and social perceptions of the participants in this study. This approach helps to understand how people react in different situations and how they feel about their social and individual lives (21).

The study was retrospective and did not recruit participants at the time of the event. The participants were selected using a purposive sampling from among the patients who had been resuscitated in the emergency departments (EDs) and intensive care wards according to the list of patients in the hospital database. To determine the date and time of the interviews, the participants were contacted by phone. No one refused to participate in the interview. As part of the inclusion criteria adult family members directly related to the patient (first-degree) who had witnessed a family members' resuscitation event were invited to participate. First-degree family members were defined as either being a parent, spouse, offspring, or sibling of the patient. There were no specific exclusion criteria. The final dataset consisted of 15 participants in a 4-month period (from April to July 2019) in Tabriz, Iran. This study was conducted in three hospitals including one private and two public hospitals.

Semi-structured and face-to-face interviews were conducted 90 days after the resuscitation event at the place and time determined by the participants. The period of 90 days post-CPR was chosen as this interval was believed to allow people time to reflect on their experiences (22). The duration of the audio recorded interviews was between 35 and 50 minutes and the interviews were transcribed verbatim by the principal researcher. Questions on demographic data and the participant's relationship with the patient were asked followed by a series of open-ended questions exploring the families' experiences during the resuscitation event. Open-ended questions included "Would you please describe your experiences about witnessing resuscitation?", and "What were your feelings when your family member was receiving CPR?".

The transcripts were read several times by two of the researchers, and the statements related to the phenomenon were selected and placed under the theme headings. Data collection continued until the data were rich enough to clarify the phenomenon (data richness) and no new themes emerged. Finally, data richness was identified after 15 interviews.

The objectives of the study were explained to the participants, and they were assured that they could withdraw from the study at any time. Written informed consent was obtained from all participants. To ensure confidentiality, numbers were used in reports to describe the participants. If the participant became distressed, the interview was terminated or rescheduled to a time more convenient for the participant, and a counseling service was offered.

A four-step analysis process was utilized as follows: 1. Initial encounter, 2. Identification of emerging themes, 3. Grouping themes into clusters (extracting subthemes and main themes), and 4. Tabulation of themes (23,24). The principal researcher suspended his assumptions and did bracketing in the form of reflective journaling. The researcher's personal experiences and assumptions, as well as research notes, were explored as part of the reflective journaling process (20). In the second step, the researcher used three methods including abstraction, polarization, and contextualization to establish a relationship between the initial themes. To extract the sub-themes and main themes, similar data were integrated and data reduction was carried out. The sub-themes and main themes were returned to the participants for their approval and to ensure the rigor of the data. Finally, the researcher prepared a list of the emerging themes and placed them in a table. Data were analyzed using MAXQDA-12 software. The four criteria proposed by Lincoln and Guba, including credibility, dependability, confirmability, and transferability were used to ensure rigor (25).

After encoding, the sub-themes and main themes were returned to the participants for their approval and to ensure the credibility of the data. Besides, an audit trail was used to control the dependability of the data. Independent scrutiny by an external reviewer was also conducted to assess the dependability of the data. The confirmability of the findings was established through peer checking. In addition, the rich description of the themes ensured the transferability of the data. The COREQ checklist was used to determine the items to be included in the reporting of the study.

Results

A total of 15 family members who witnessed resuscitation

and were directly related to the patient participated in this study.

The age range of the family members was 24-50 years. The majority of family members were male (n = 10) and, half of them were the patient's child (n = 8). Moreover, the majority of patients (n = 12) had unsuccessful resuscitation (Table 1).

The researcher read and re-read the text of every interview separately to extract the initial codes, subthemes, and main themes. A total of 322 initial codes and 105 subcategories were identified. The themes were included if they were raised by at least three participants (21). Finally, four main themes and nine subthemes were identified following Smith and colleagues' iterative stages (21). The main themes included *insistence on being present*, *achieving calmness*, *partnership and collaboration*, and *hindrance* (Table 2).

Insistence on being present

Family members were inclined to and insisted on being present during CPR. This theme had three subthemes including distrust of staff, ambiguity and curiosity about resuscitation, and concern for the patient's condition.

Distrust of staff

The participants often asked to be present because they distrusted the emergency staff and wished to be present to ensure their relative was well cared for. During resuscitation, the staff exhibited behavior that was deemed unprofessional towards the patient. One of the participants talking about the care provided to his mother concerning the urinary catheter stated, "*There were also nurses telling the doctor that there is no urine output from the patient's foley catheter, but the doctor did not pay attention, and he reluctantly asked the nurses to shake the urinary catheter, maybe something was wrong... His tone and indifference to the patient were unpleasant to me....*" (Participant 4).

In addition, he stated another experience in this regard, *"My father-in-law was critically ill. During the transfer from the ED to the ICU, I was given a bag. I did not know what it was and how it worked. More importantly, I was paying attention to the patient and I did not know how often I was supposed to press it. Suddenly, a nurse shouted at me for not pressing. I told her it was not my responsibility, ... This treatment leads to the insistence of the family to be present."* (Participant 4).

A young man whose father survived following CPR said, *"In order for the family to be assured that their patient is well treated, it is better for nurses to follow the patient instead of asking the relatives to frequently go to the nursing station. Nurses must be sensitive to the alarms and the requests of the family members."* (Participant 6).

Ambiguity and curiosity

The participants noted there was a lot of ambiguity and curiosity related to resuscitation. One participant stated, *"I cannot see what is happening behind the curtain. After the procedure is finished, the doctor only informs the family of the survival or death of the patient. However, if we are there, we can see everything"* (Participant 6). A father whose child was resuscitated stated, *"We were told not to stay in the CPR room since we could be sad. We did not accept. We told the nurses we would like to stay and see the procedure. We were curious to see what was happening and know about our child's condition"* (Participant 2).

Concern for the patient's condition

Table 1. Participants' demographics

No.	Age	Gender	Education	Job	Relationship with patient	CPR location	CPR result	Interview location
1	32	Male	Bachelor's degree	Nurse	Brother	ED	Deceased	Hospital
2	50	Male	Elementary school	Shoemaker	Father	ICU	Deceased	Home
3	48	Female	Bachelor's degree	Nurse	Daughter	ED	Deceased	Hospital
4	48	Male	Bachelor's degree	Engineer	Son	CCU	Deceased	Office
5	46	Female	Diploma	Housewife	Wife	ED	Deceased	Home
6	24	Male	Associate degree	Worker	Son	ICU	Survived	Home
7	28	Female	Diploma	Housewife	Daughter	ED	Survived	Home
8	27	Male	Bachelor's degree	Bank teller	Son	ED	Deceased	Bank
9	41	Female	Bachelor's degree	Housewife	Daughter	ED	Deceased	Office
10	49	Male	Diploma	Worker	Wife	CCU	Deceased	Home
11	35	Male	Bachelor's degree	Employee	Son	ED	Deceased	Office
12	42	Male	Associate degree	Worker	Brother	ED	Deceased	Office
13	37	Male	Diploma	Worker	Brother	ED	Survived	Office
14	29	Female	Bachelor's degree	Nurse	Sister	ICU	Deceased	Office
15	50	Male	Diploma	Employee	Son	ICU	Deceased	Office

Table 2. Main themes and subthemes obtained from family members' experiences of witnessing resuscitation

Main themes	Subthemes
Insistence on being present	Distrust of staff
	Ambiguity and curiosity
	Concern for the patient's condition
Achieving calmness	Psychological support
	Facilitating acceptance of the patient's death
Partnership and collaboration	Collaboration with the resuscitation team
	No interference by family members
Hindrance	Colleagues' interference
	Agitation transferred to team members

The families insisted on being present in the CPR room because they were concerned about the patient's condition. A woman whose husband was resuscitated said, *"I really had stress, and it was my right to be with my husband. I was worried about what was going to happen"* (Participant 5). Another participant stated, "*Our presence in the CPR room relieved our concerns. Being present in the room was our right and gave us more comfort than being outside"* (Participant 8).

Achieving calmness

The second main theme extracted from the statements of the participants was achieving a sense of calmness with two subthemes including psychological support, and facilitating acceptance of the patient's death.

Psychological support

According to the experiences of the families, if one of the nurses or doctors responded to the family's questions respectfully and established professional and courteous verbal and non-verbal communication including showing support, it would help alleviate the concerns of the family members. One participant stated, *"The resident who resuscitated my mother in the ICU was very respectable. I appreciated her after my mom's death. I appreciated her efforts and seriousness. Simultaneously, she was helping my mother and responding to my worries. This was really important for me and led to my calmness"* (Participant 4).

Seeing the CPR efforts and being informed about what was happening was another way of providing psychological support to the family which helped to alleviate the family members' concerns. Many family members' first contact with a hospital occurs when a loved one is admitted. One participant noted, *"There are individuals who have never been in a hospital. They are not familiar with the environments. They must be allowed to be present in the CPR room so that they can see the efforts"* (Participant 15). Another participant stated, *"If you are present in the room, you can see it yourself. Which makes you feel comforted regarding the efforts made by the CPR team" (*Participant 6).

Facilitating acceptance of the patient's death

Being present in the CPR room can also help the family to accept the prognosis of the patient being resuscitated. One participant noted, *"If I did not see this and my brother died, I was always thinking that the CPR team did not try their best. But I myself saw how they tried hard, and even if the patient died, I would not blame the CPR team for my brother's death"* (Participant 13). Another participant stated, *"Since I was there and saw how hard the team tried, I can more easily accept my son's death"* (Participant 2).

Partnership and collaboration

The third identified theme was partnership and collaboration with two subthemes including collaboration with the resuscitation team and no interference by family members.

Collaboration with the resuscitation team

Some families believed that their presence was aligned with the CPR measures, with family members collaborating with the CPR team in caring for the patient while not interfering in the CRP process. A participant stated, "*I was standing on the corner of the room, responding well to the questions. I responded to questions like what happened to the patient and what medications she used to take, and I was comforting my siblings. I was fully cooperating with the CPR team"* (Participant 4).

Another participant stated. *"The relative cannot practically help in the resuscitation procedure. The help is mainly on giving information, that is beneficial to the resuscitation team"* (Participant 1).

No interference by family members

Family members not interfering in the procedure was the point three participants mentioned. The participants emphasized it was important not to interfere in the resuscitation efforts of the team. *"It was not necessary to interfere and complain since I did not know the work. Therefore, I did not interfere"* (Participant 9).

Hindrance

The statements and experiences of the participants who were also nurses showed at times, the family interfered in resuscitation hindering the team's ability to work. This theme was further divided into two subthemes including the colleagues' interference and agitation transferred to team members.

The colleagues' interference

One health professional stated, *"The paramedics arrived. I frequently asked for CPR, but they did not. I mean they could not. I asked for intubation, but they asked us to take the patient to the hospital... I have done cardiac massage*

in the ambulance. I have even done CPR on the stairs" (Participant 3).

Agitation transferred to team members

Some of the families directed their anxiety and agitation to the CPR team. A participant stated, "*Although I liked to be with my mom, I knew our anxiety and frequent questions were unpleasant and an obstacle to the team"* (Participant 12).

Discussion

The current study aimed to explore the experiences of the patients' family members who witnessed the resuscitation of a loved one in Tabriz, Iran. The analysis of the experiences showed when families are present during CPR, their trust increases, and their concerns are reduced. A study by Chew and Ghani in Malaysia examining public opinion about FPDR revealed that 76% of the participants supported FPDR. The participants believed being present during CPR enabled the family members to closely observe the activities which reduced their ambiguity and concerns (26). The results of the present study also highlighted the importance of families' insistence on being present in the resuscitation room.

Some families stated that the healthcare team's ignorance of the patient's condition did little to improve trust among the family members. The family members described conditions that led to the growing distrust of health professionals including; ignoring family members' requests by physicians and nurses, the use of family members in patient care, and assistance with specialized activities such as administration of ventilation during the transfer from emergency ward to ICU/CCU. In a study conducted in the United States, family members expressed feelings of distrust toward the healthcare system and its relationship with participation in medical care programs (27-29). In the current study, some of the participants believed that being behind the resuscitation door is similar to being in a dark room. A systematic review by Salmond et al showed family's concerns and doubts were relieved as a result of their insistence on being present in the CPR room (30).

The second main theme identified in this study was achieving calmness. The results confirmed that FPDR helps the family members to achieve a sense of calmness and most families believed being present was their right (31,32). These findings are also in line with the central concepts of the family-centered model. In the study by Basol et al, some participants believed it was their right to be present in the CPR room. They stated that families could see what was happening and were able to make better decisions regarding the patient's condition (16).

The current study showed, that if death occurred, the family members who were present were less likely to blame the health professionals and would accept that everything possible was done. The study by Leske et al describing the experience of being present during CPR for trauma patients demonstrated that family members may have a positive attitude toward the medical and CPR team members if allowed to be present. In addition to establishing trust towards the medical personnel, the FPDR provided emotional support for the patient, ensured valuable patient information was readily available, and even ensured that family members felt connected with the patient being resuscitated (13). Porter et al also indicated that the family's presence in the CPR room facilitates the grieving process, increases their awareness of the patient's condition, and makes the acceptance of the patient's death easier (11).

The third main theme was partnership and collaboration. The participants believed it was their right to be present in the CPR room and claimed that collaboration with the CPR team was beneficial to the patient and the family members alike. Some families believed their presence during resuscitation was aligned with the CPR team's measures by responding to the questions, describing the patient's condition, and trying not to interfere. The study by Leske et al pointed to the role of family members in providing support for the patient by giving information to the CPR team and working in collaboration with the health professionals (13).

The study by Miller and Stiles showed there was no interference from the family members, and the information provided by them helped the CPR (12). It seems that FPDR does not always result in the family's interference with resuscitation; instead, the family's presence was considered to be a valuable source of information contributing to providing more collaborative care.

Finally, the fourth main theme identified in the present study was hindrance. Despite exhibiting agitation and anxiety to the medical team members, families reported being allowed to witness the resuscitation and invasive procedures was important to them. However, there were times when the family interfered with resuscitation. According to the findings of the current study, the participants supported FPDR, claiming that the stress and agitation caused by the deterioration of the patient's condition were at times transferred to the medical team. On the other hand, family members who were also health professionals were more likely to interfere with resuscitation believing they had the right to comment on the team's performance. Transferring stress to the CPR team has also been noted by some studies (30,33). The study by Oman and Duran in which a nurse played a mediating role between the CPR team and family members, noted no interference from family members (34). The study by Giles et al, showed medical colleagues did not interfere in the procedures and mainly acted as the patient's supporter (31).

There were several limitations encountered in the

current study. To avoid researcher bias, the participants were asked to confirm the study themes, the findings were reviewed by peers, and two members of the research team coded the data. This study mostly reported the experiences of family members whose patients were deceased; thus, the findings may not be reflective of the experiences of family members of patients who survived after resuscitation. Resuscitations were conducted in three unique clinical settings, and the approaches adopted by the staff in implementing FPDR might have certain differences that should be taken into consideration when interpreting the findings.

Conclusion

This study provided strong evidence for the benefits of witnessed resuscitation by family members as the medical staff informed the family members of the CPR process, provided psychological support, and facilitated the acceptance of the prognosis. Although family members reported interferences in the procedure and transfer of agitation to the health professionals, the positive effects of working in collaboration with the medical staff were also noted. The findings of this study supported the development of a policy based on the FCC approach to confirm the family's right to be present in ED, ICU, and CCU in Iran. Further research is required to investigate the incidence of interference of health professionals who accompany a patient's family member in the CPR process.

Acknowledgments

The authors would like to thank the participants who gave their time to participate in the study.

Authors' Contribution

Conceptualization: Hamidreza Haririan, Hadi Hassankhani.
Data curation: Hamidreza Haririan.
Formal analysis: Hamidreza Haririan, Hadi Hassankhani, Joanne E Porter.
Funding acquisition: Hadi Hassankhani.
Investigation: Hamidreza Haririan.
Methodology: Hamidreza Haririan, Hadi Hassankhani.
Project administration: Hadi Hassankhani.
Resources: Hamidreza Haririan.
Software: Hamidreza Haririan.
Supervision: Hamidreza Haririan.
Validation: Hamidreza Haririan, Hadi Hassankhani, Joanne E Porter.
Visualization: Hamidreza Haririan.
Writing–original draft: Hamidreza Haririan.
Writing–review & editing: Joanne E Porter, Hamidreza Haririan.

Competing Interests

The authors reported no conflict of interest.

Ethical Approval

The ethical approval was obtained from the regional committee of medical research ethics at Tabriz University of Medical Sciences under the code: IR.TBZMED.REC.1397.728.

Funding

This work was supported by the deputy of research at Tabriz University of Medical Sciences [Grant number 60842].

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