

Family Witnessed Resuscitation: Through the Eyes of family Members

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Abstract: Family witnessed resuscitation (FWR) is still a debated subject. FWR was started in the Foote hospital, United State. Since then, many resuscitation councils have adopted FWR guidelines. However, family members in many occasions still denied this right. In Jordan, there is no guidelines for FWR. The aim of this study is to explore family members' attitudes, beliefs, perceptions regarding FWR in adult critical care settings. An explorative qualitative design was adopted. Face-to-face semi-structured in-depth interviews with 14 family members were done. Three major themes were produced: family members' perceptions about FWR, positive versus negative families' experiences during CPR, and what could family members do in the resuscitation room? All family members favored FWR. This study showed that family members with experience of witnessing CPR will insist to attend CPR in future. Uniquely, this study adds that many family members want to witness CPR for religious purposes. This study explained that family members focus on their loved one's life in the first degree. Family members wanted this option for religious, cultural and social reasons. There is a need to organize this issue and there is a need for more studies in this field.

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1. Introduction

The last decades included a steady change in the priority of care delivered by the critical care professionals. Until the 1970s, critical care professionals focused only on providing physical care for the critically ill patients (Damboise and Cardin, 2003). This trend came into question when researchers started to study the needs of critically ill patients' relatives (Henneman and Cardin, 2002; Obeisat and Hweidi, 2014; Smith, 2014). It was reported that critically ill patients' relatives need for information, reassurance, support, comfort and being near their loved ones (Alhassan and Hweidi, 2004; Verhaeghe et al., 2005). Damboise and Cardin (2003) explained that the findings of these studies were fundamental in the evolution of FWR.

Witnessing resuscitation was initially explored by the Foote Hospital in Michigan, US (Hanson and Strawser, 1992). During several cardiopulmonary resuscitation (CPR) attempts, family members refused to leave the room and they insisted to stay beside their patients. This led the CPR team to ask their policy makers in the hospital to produce a clear policy to exclude family members during CPR. As a result of this request, the policy makers surveyed family members and found that most of the family members wished to stay beside their loved ones during CPR (Hanson and Strawser, 1992). After three years of this survey, the hospital issued a new policy to allow and organize FWR. Family members who wanted to witness resuscitation received support

and were accompanied by special staff to explain procedures during CPR. Hanson and Strawser (1992) assessed the results of implementing this new policy. Both healthcare professionals and family members reported positive views and they encourage the continuity of this policy.

Since the success of this new policy, this trend was considered by several councils around the world. In 1993, the Emergency Nurse Association (ENA) adopted a resolution to support the option of FWR and also invasive procedures (Emergency Nurses Association (ENA), 1995). The association revised and updated the policy statement on family presence in July 2001, with support for the trend of FWR (Tsai, 2002).

FWR also was investigated by Resuscitation Council (UK) in 1996, who sought to reduce some of the controversy surrounding this practice by issuing guidelines for staff. The American Heart Association has also developed guidelines for the purpose of advocating patients' families' right to be present during CPR (American Heart Association, 2006). More recently, more comprehensive FWR guidelines were issued by the European Resuscitation Council (Baskett et al., 2005b). In 2007, a group of experienced healthcare professionals and researchers published an article that includes a position statement on FWR. This position statement is widely based on research evidences and experts' opinions (Fulbrook et al., 2007).

Family members' attitudes regarding FWR were examined in literature (Hanson and Strawser, 1992; Meyers et al., 2000; Wagner, 2004; Berger et al., 2004; Holzhauser et al., 2006; Weslien et al., 2006). According to Meyers et al. (2000), 39 family members were surveyed regarding their views towards FWR. Family members believed that it is their right to stay with the patient during invasive procedures and CPR. They also viewed themselves as active participants in the care process, providing comfort and connecting with the patient. Furthermore, all relatives believed that their presence was helpful to them and they would do it again. Finally, of those relatives surveyed, 95% believed that their presence helped the patients even when they were unconscious. Wagner (2004) suggested that families want to know what is going on during CPR and they also want to know that everything possible was done to save their loved one's life. Berger et al. (2004) surveyed 32 family members, who were sitting in a waiting room in the ED of a hospital in USA. They found that more than half of the respondents wanted to be present during their relatives' CPR. Berger et al. pointed out that witnessing CPR gives the opportunity to family members to share a loved one's last minutes of life.

The advantages of FWR has been discussed by many researchers (Weslien et al., 2006; Ong et al., 2007; Kentish-Barnes et al., 2014). Belanger and Reed (1997) conducted a survey study in Wooster Community Hospital in Ohio to ask family members whether they want to go to the resuscitation room accompanied by the staff member. Consequently, 100% of relatives believed that the FWR enabled them to better cope in their grief process. Holzhauser et al. (2006) conducted an experimental study to examine patients' relatives' views regarding FWR. They divided family members into two groups; the control and experimental group. The experimental group was given the chance to witness their loved ones' CPR with presence of special supporting staff for assistance. In comparison with 67% of the control group who preferred to be present during CPR, 100% of the experimental group felt glad they were present. Some of the experimental group said that FWR "helped with grieving process".

Holistic care is another advantage might be achieved from the FWR. Fumis et al. (2014) argued that during resuscitation, the family might suffer more stress than the patient himself, as the patient is unconscious, while his/her relatives are waiting to know what will happen to the patient. This led some authors to asserting the importance of care provided to patient's relatives at this time. Ardley (2003) stated that within a holistic framework, health providers have a duty to care of the patients as well as their

families. Weslien et al. (2006) interviewed 17 family members 5 to 34 months after the cardiac arrest of their loved ones. Those family members who were given the option to stay thought that their presence was thought to improve trust of health professionals.

Despite the advantages that were suggested for FWR, there are other possible disadvantages have been raised from relatives. Grice et al. (2003) conducted a survey in the ICU of Southampton University Hospital. Of all relatives, 33% thought it would be too distressing, 16% were concerned that their presence may impede resuscitation, and one relative felt that it was too difficult to be present while there is nothing they can do. In another study, Compton et al. (2009) aimed to compare symptoms of post-traumatic stress disorder in out-of-hospital cardiac arrest victims' relatives who did or did not witness the failed CPR attempt of their loved one. 34 witnessed and 20 non-witnessed relatives were surveyed by telephone. It was reported that witnessing a failed CPR attempt of a loved one may be associated with displaying symptoms of post-traumatic stress disorder in the early bereavement period.

According to Woning (1999), six of a surviving patient's family members had been qualitatively asked to describe their experiences during CPR of their relative in the ICU. All respondents felt discomfort during the procedure. They described it as very painful. Two participants, however, did not regret their experience, and they said that they would do it again. In contrast to these findings, Nibert (2005) was the only researcher who used the case study design to evaluate the impact of FWR on patients' relatives. This paper was started by describing a case study of woman prevented from staying with her husband during CPR. Interestingly, it was reported that FWR does not affect on the treatment process. More importantly, it was indicated that most family members did not psychologically influenced from FWR.

Any practice should be assessed by comparison of its advantages and disadvantages. Mangurten et al. (2005) argued that until new data emerges to demonstrate that the problems outweigh the benefits, there is no reason not to formalize the practice and establish family presence programs as an option for all families. The literature shows that most of the studies were conducted in the Western countries, with more than 70% of them were in USA and UK. A few studies were conducted to examine this phenomenon in Jordan (Bashayreh et al., 2013; Masa'deh et al., 2014). However, one of these papers focused only on studying healthcare professionals (Bashayreh et al., 2013) and the other one studied families' needs during CPR (Masa'deh et al., 2014).

Therefore, the aim of this study is to explore family members' attitudes, beliefs, perceptions regarding FWR in adult critical care settings.

2. Material and Methods

2.1 Design

A descriptive qualitative design was adopted to explore family members' attitudes toward FWR within the Jordanian context. This study is one of the rare studies that examining this phenomenon in Jordan. Therefore, using a qualitative approach was expected to provide deeper insights about Jordanian family members' wishes during the resuscitation efforts for their patients. An interview guide was developed derived from the literature review and the authors' experience in this field. This guide is presented in following box. The time spent in each interview ranged from 40 to 60 minutes.

2.2 Study Sample

The sample included family members of patients underwent CPR in adult critical care settings. The sample was derived from critical care units of six hospitals. Specific demographic criteria were determined before selecting the study sample. Only adult family members were selected. All Family members have been exposed to CPR effort, either CPR succeed of failed. Finally, a purposive sample of 14 family members was recruited over a period of six months. The age of the sample was between 22 and 58 years (mean 36 years). Ten male and 4 female family members were interviewed. Only five family members had the opportunity to witness their relative CPR. However, this presence was not organized and these family members were not accompanied by special staff to explain the procedures. Nine of the sample experiences ended with failed CPR. The level of education was different between the family members. Two of them had post graduate degrees (master and PhD), 6 of them had bachelor degree, 3 had diploma degree, and the rest of them had primary level of education.

2.3 Data Collection

After obtaining the ethical approval from the included hospitals, a visit to each critical care unit was done by one of the researchers. A brief information about the study aims and data collection method was presented the head nurses of these units. The head nurses were asked about patients who had been exposed to CPR attempts before. They were also asked about critical cases who may be exposed to resuscitative efforts soon. No specific or sensitive information about these patients was taken. Together one of the researchers and the head of the unit went to family members of these patients and provided brief information about the study. Family members who met the inclusion criteria and accepted to

participate in the study were asked to give permissions for future contact. Finally, family members of patients that have had CPR were contacted two to three months after CPR and an invitation letter was posted to each of them.

Each participant was received enough information about the study objectives and the method of data collection at the beginning of their interviews. It was explained to family members that their statements will be treated confidentially. Family members were also informed that ethical approval was taken before starting the process of data collection. Sampling continued until saturation point. Semi-structured, in-depth interviews were selected as the method of data collection. The interview guide was built on a reading of the available literature, and the questions that were raised when discussing this subject with our colleagues, friends, family members and supervisors. New questions emerged during the interviews. Interviews ranged from 40 to 60 minutes. All the interviews were tape recorded.

2.4 Ethical Considerations

There is no national or local ethical committee in Jordan. Therefore, ethical approval was obtained separately from each hospital. The interviewees received enough information about the study aim, objectives and data collection method before agreeing or rejecting to participate in the study. All participants were told that they are autonomous to participate or to refuse participating in the study. They also had the opportunity to withdraw from the study at any time. All participants were informed that their responses would be treated confidentially, and anonymously. Each participant was asked to fill in a consent form before each interview.

2.5 Data Analysis

Interviews were transcribed verbatim by one of the authors. The other authors helped in reading the transcriptions and making notes. Braun and Clarke's (2006) technique of thematic analysis was utilised to analyse our data. This technique contains six steps.

Familiarization: this includes listening carefully for the taped interviews and reading and re-reading the interview transcripts.

Generating initial codes: this includes reading and examining line-by-line the transcriptions. The researcher should ask "what did this person want me to understand by saying this?"

Searching for themes: all respondents' sentences, phrases, and texts were assigned one or more codes. These codes were transferred into the free nodes in NVivo.

Reviewing themes: once all the data had been entered, the codes were refined. The aim was to reduce their number, eliminate duplication, and

permit the development of more sophisticated analytical categories.

Defining and naming themes: after finishing the process of coding and collecting codes together, re-reading for all these codes and their texts was conducted.

Producing the report: this is the final phase of thematic analysis process. This phase is important for assessing the outcomes of the analysis process.

3. Results

Fourteen family members were interviewed. The interviews were conducted 3 to 6 months after the incident. The relation of the interviewees to the patients was as follows: there were six sons, 3 daughter, 2 sons, and 3 brothers. All of the relatives accompanied the patient during the whole incident. Six of the relatives had their incident in private hospitals, four had their experiences in public sector and the rest had their experiences in university hospitals. Only seven patients' relatives followed the patient to the resuscitation room. One of these relatives was prevented from witnessing prior CPR, for his mother. The other relatives were escorted from the resuscitation room. Of a total patients, 5 patients died during CPR, and one died within 5 hours of admission. As for the survivors, 5 stayed in the hospital until time of the interview, two went back home and left their job, and only one went back to his work.

The participants' remarks were analyzed and collected under three major themes. The first theme included family members' perceptions about FWR. The second theme described the positive and negative families' experiences during CPR. The last theme showed what could family members do in the resuscitation room?

3.1 Family members' perceptions about FWR:

The results of this study indicated that the majority of family members would prefer to stay beside their relative during CPR. Despite all of the relatives wishing to stay during CPR, only three of them had verbally asked health professionals to witness his father's CPR. However, they were not given this opportunity. The other relatives did not ask to enter the resuscitation room. Their decisions to enter into the resuscitation room were dependent on the circumstances and conditions surrounded CPR. Family member 3, for example, stated that he entered into the resuscitation room after seeing that other relatives had entered.

...The movement of the nurses and doctors in and out of the room, and there were other relatives entering into the resuscitation room, and my brother also had a relation with nursing job, so, his entrance and the entrance of other relatives encouraged me to

enter. (Family member 3)

The above statements may explain that FWR was not organized or supported by policies. It was also clear that family members seemed quite uncertain about their rights. They were unsure about if their presence was a right, or if they had to ask permission to stay. Several relatives were worried that their presence would affect negatively the CPR.

I like to enter, but I will follow the doctor's advice, if they say it is not allowed being there or that it will cause problems, I will follow the instructions. (Family member 13)

Family members were more confident about their rights of attending similar future incidents. They got this confidence from their experiences. Interestingly, the relatives who were given the opportunity to witness CPR stated that they would insist on witnessing CPR in the future. All relatives believed that it is one of their rights to witness their loved one's CPR. They, however, were concerned about possible negative effects on health professionals' performance during CPR.

I will insist. On the contrary, after two experiences, I really believe that I have to stay with this patient until the end, either God heal him or God take him. (Family member 6)

In this study, the relatives were united in their perceptions that close relatives should be allowed to witness CPR. Close relatives included first degree relatives such as son, wife, daughter, father and mother. Relations by blood were given the priority to stay in the resuscitation room. Friends and other relatives came in the second degree. All relatives thought that only one to two patients' relatives should be allowed to be present at the same time with the possibility of swapping between relatives.

They might be the closest persons to the patient like his or her son, wife and may be the daughter. The son might be the closest one for the patient. (Family member 3)

Relatives thought that not all family members should be given the opportunity to witness CPR. It was explained that a person, to be allowed to witness resuscitation, should be adult and stable. The presence of 'nervous' persons could increase stress on the CPR team and other relatives.

We are human, and we are changing. So, if the person present was very nervous, with presence of other relatives, this might lead to increased stress on the relatives; and may cause a hysterical effect on the person himself and on other relatives. But, if the person was quiet and was able to tolerate these situations, I will advise them, one hundred percent, to enter. (Family member 5)

3.2 Positive versus negative families' experiences during CPR

This theme discusses the benefits and disadvantages of FWR as suggested by the patients' relatives. Witnessing the last moments of a patient's life was identified as an important issue by several patients' relatives. This was thought to be a chance to say goodbye to a loved one. Listening to and looking at their relative before and during CPR was viewed as a good chance to know the last verbal or non-verbal responses of victim. Family member 5, for example, talked about this issue.

This was the last talking while she was able to breathe. Although she tired and could not speak any words at that time, she did not ask me to call my brothers or other people or the doctor, but she really raised her fingers and she said no God except Allah and Muhammad is his messenger. (Family member 5)

Family member 5 seemed to settle down when he recounted the above statement. Cultural and religious importance was attributed to the patient's movements or expression directly before death. In the above quotation, Family member 5 supposed that the movement of his mother's finger was a good signal. Despite respecting Family member 5's statement and many other persons' beliefs in this area, Family member 8, who has a PhD in Islamic studies, warned against exaggeration in judging and interpreting these signals:

It is a kind of culture and some people relate it to religious information ... I think there is something in Islam about that thing, but at the end we should not judge that this person is righteous or not, because this person is going to the grave and the God will decide if this person is a good person ... (Family member 8)

Williams (1996) suggests that, while experiencing the death of a loved one is never easy, it can help the grieving relative to know that they were present during these last few moments. In this study, the relatives were unsure about the exact benefits of their presence during CPR. They, however, insisted that their presence was beneficial for their loved ones. Going inside the room and observing what health professionals were doing was viewed as better than staying outside the room and doing nothing. The relatives who witnessed their loved one's CPR recognized the amount of skill and energy expended by the CPR team to save their relative.

I appreciated their work and efforts, and I was satisfied that they did their best and gave all medical treatment... (Family member 3)

Another advantage raised by several patients' relatives was maintaining feelings of hope. Relatives stressed the importance of hope during the procedure. Robinson (1998) explained that fantasy may often be worse than reality. This imagination was far from reality, and included the worst scenario. 'Many

thoughts were coming to my mind during that situation' was often expressed by relatives who did not witness the CPR. However, relatives who witnessed resuscitation stated that their presence added some sort of reality and improved feelings of hope.

At that time, it was impossible to control the feelings. For example, I imagined my father died and I imagined his funeral and I imagined many things. I also imagined him in the operation room and the doctor went out and told us that the operation has been successfully done. So, I imagined everything. (Family member 14)

Despite the benefits that were expected to be produced from FWR, a few disadvantages were suggested by some relatives. Increased noise was the main disadvantage. Additionally, family members admitted the need for concentration and the need for control in the situation. The presence of several persons in resuscitation room was expected to affect the health professionals' concentration and performance.

This might distract the job of the doctors. Relatives may start crying loudly, which affects the hearing of doctors. This may lead to increased stress among doctors which push the doctors to escort them outside ... (Family member 10)

3.3 What could family members do in the resuscitation room?

Mixed feelings were raised in answering this question. The relatives explained that visiting the sick is a part of social support to the patient and their relatives. Several relatives thought that staying with the loved one during CPR was to nourish some cultural and social needs. More importantly, most of the relatives believed that witnessing CPR was a part of their religious duties. Asking their relatives to say *Shahada* (saying that there is only one God) was an important role of family members. Praying beside their loved one was viewed as a source of relaxation for both patients and relatives.

Firstly, from a religious view, obedience of the parents is a duty. Secondly, we should not forget that they took care of us, they suffered for us, they spent nights without sleeping, they cried while we were kids and they emotionally suffered from troubles we exposed to. Therefore, how we ignored them when they become old. If we do that, we will not be human ... (Family member 9)

Nearly all relatives expressed that they only wanted to stay beside their loved one during CPR. Morgan (1997) supposed that allowing FWR gives the relatives a feeling of worth at a time of hopelessness. The relatives admitted that they may have nothing to do, however, they thought that their presence was very important. At least three of the

five relatives viewed themselves as advocates for their relatives. Firstly, relatives wanted to be sure that everything was done for the patient. Secondly, relatives wanted to be sure that health professionals had done their job properly. Thirdly, FWR was thought to encourage health professionals to do their best during CPR. Fourthly, some relative were concerned that health professionals may become busy with other patients.

... They might be exposed to an accident and they are seeing a lady with old age, they might say it is over; let us do the routine procedures in front of the family, but she is dead. So, it is just routine procedures; not more than that. So, my presence might lead them to work correctly ... (Family member 7).

An important role for family members was maintaining patients' privacy. All relatives admitted that patients' privacy could be invaded during CPR. They, however, preferred appropriate covering for their relatives, particularly female patients, as much as possible. The relatives thought that they could do this during CPR. They, however, recognised that this should not affect the CPR team's performance.

... I tried to enter many times into ICU because I did not like to see that her back was uncovered or something like that. There is privacy for patient ... They should give more attention about covering patients and closing curtains between patients. (Family member 4)

Specific decisions may need to be taken during CPR and FWR could help in taking these decisions. Health professionals may also need to do an emergency procedure which may cause major complications in the future. FWR would seem to be very helpful in this, as they would be part of decision-making.

... The advantage that happened with us... we wanted to enter him into the operation room for cardiac catheterization and they refused until we paid the money for them. OK, imagine if they found this person in the street. They will leave him in the resuscitation room even if he died. The important thing is to pay the money. (Family member 12)

4. Discussions

This is the first study conducted in Jordan to examine families' attitudes toward FWR. The present study is one of a few studies that utilized qualitative design to examine family members outside of the Western regions. This sheds some light on the possibility of implementing this practice out of the Western countries. More importantly, this study sheds some light on the importance of considering the cultural and religious differences when implementing FWR in a new arena. This participated

in producing rich and deep information about this practice.

Family members indicated the importance of religion in formulating other life aspects such as the interaction between people, the relationships between family members, the interaction with illnesses and crisis, and the end-of-life issues. All family members identified religious reasons for their desires to stay beside their loved ones during CPR, such as praying and supplicating for God to help and support their loved ones. These activities were thought to support patients and their relatives. No precedent in the literature examined the influence of religion on families' attitudes toward FWR.

Andrews (2008) explained that "religious beliefs may influence a client's explanations of the cause(s) of illness, perception of its severity, and choice of healer(s)" (p. 356). Andrews explained that religion may become more effective in case of serious illness, as it may become source of support for patients and family members, and it may influence the course of action believed to be appropriate. Leininger and McFarland (2002) and Halligan (2006) were aware of the role of religion in shaping the worldviews of Arab Muslim people. Being conscious of the effect of religion on Arab Muslims would make patients and their relatives cooperate with and appreciate health professionals' efforts. Therefore, health professionals need to have knowledge about the worldview of Islam as a cultural influence on the daily life of the people (Luna, 2002).

The single most important feature of the worldview of Islam is the concept of *tawhid* (Luna, 2002). *Tawhid* means that there is only one God (Allah), and Allah has the greatest power to control everything in this life and in the hereafter. A Muslim should try to remind his brother Muslim to recite the Word of Sincerity (*Shahadah*): "None has the right to be worshipped except Allah" (Al-Jaza'iry, 2001). In the present study, family members wanted to witness their loved ones' CPR to remind them of saying this *Shahadah*.

There is an important Islamic rule stated in the Holy Qur'an, that "whoever killed a person will be as the one who killed all people, and whoever saved a person will be as the one who saved all people" (Al-Jaza'iry, 2001). In Islam it is not allowed to end the life of anybody. This makes, statements like "do not resuscitate" problematic for most Muslims. These principles may explain Jordanian families' desire to be present during their loved one's CPR. Family members want to see that their relative has received the best treatment before dying. They also want to be sure that their relative's dignity has been preserved, especially if the patient is female. Furthermore, they

want to support their relative by praying, supplicating and reading from the Holy Qur'an.

Reviewing the literature on FWR shows that most of the studies were conducted in Western countries, particularly in the USA and the UK. The first guidelines for FWR were originated in USA by the ENA (ENA, 1995). In UK, guidelines for FWR were produced in 1996. FWR guidelines were also adopted by some Australian hospitals (Maurice, 2002). Recently, the European Resuscitation Council issued its guidelines for CPR (Baskett et al., 2005a). Significantly, all these guidelines were originated depending on evidences or research conducted in the Western countries. FWR was rarely studied out of the Western context (Yanturali et al., 2005; Badir and Sepit, 2007; Ong et al., 2007; Demir, 2008; Gunes and Zaybak, 2009). Interestingly, most of studies conducted outside the Western context indicated that cultural and social factors may have an impact on participants' views, but they did not exactly examine this impact.

Trust was seen as a very important in its own right because it is the attribute that gives medical relationships intrinsic value (Hall et al., 2002). Trust is critical to patients' willingness to seek care, reveal sensitive information, submit to treatment, and follow physicians' recommendations (Hall et al., 2001). Previous studies revealed that family members want to witness their loved ones' CPR because they want to be sure that everything possible was done (Hanson and Strawser, 1992; Meyers et al., 2000). The current findings, consistent with these findings, also suggest that family members want to see that their loved one receives the best level of care. The findings of this study reveal that trust is an essential part in the treatment process

The authors reviewed more than 50 different papers about FWR between the date 1987 and 2014. Interestingly, the attitude toward FWR was mainly influenced by several factors. Firstly, it was noted that the attitudes of healthcare professionals toward FWR are improved over time (Madden et al., 2007; Twibell et al., 2008; Fallis, 2008). Secondly, this improvement may be resulted from adopting FWR guidelines by several health organizations (ENA, 1995; Basket et al., 2005; Fulbrook et al., 2007). Thirdly, and more importantly, it was found that the key issue for improving the attitude toward FWR was simply education and improving awareness of this topic. Interestingly, the experimental studies or the studies that assessed well-organized FWR protocol reported positive attitudes toward FWR (Belanger and Reed, 1997; Bassler, 1999; Mian, 2007). Family members' attitudes also were significantly positive in experimental studies or in studies that depended on

implementing clear policy for FWR (Hanson and Strawser, 1992; Holzhauser et al., 2006).

5. Conclusion

This study concentrated on hearing the voice of family members regarding the option of FWR. All family members said that they would like to be in the resuscitation room with their loved ones. Family members who took the opportunity to witness a relative's CPR did not regret for their decision and they confirmed that they would do it again in future. This study explained that family members focus on their loved one's life in the first degree. Family members were worried that their presence may distract the performance of healthcare professionals. This study reported that family members who attended CPR of one of their relatives are more determined to attend CPR in future. They obtained the courage and confidence from their experiences. Uniquely, this study adds that many family members want to witness CPR for religious purposes. They wanted to pray and read from the Holy Quran at these moments.

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