Family Presence during CPR in Adult Critical Care Settings: Hearing the Voice of Jordanian Health Professionals

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Abstract: Differing views regarding family-witnessed resuscitation (FWR) have been debated. There is a growing body of research that clearly highlights the benefits of allowing FWR. However, the process of active medical resuscitation in the presence of family members remains an ethical, moral, and legal dilemma to healthcare professionals. An emotional debate has arisen among healthcare providers concerning the topic of FWR. The purpose of this study is to deepen understanding of the experience of health professionals regarding the phenomenon of family-witnessed resuscitation in adult critical care settings. 31 semi-structured interviews with critical care professionals were arranged. The critical care professionals included nurses, doctors, anaesthetists, theatre technicians and respiratory therapists. The thematic analysis was utilised to interpret the professionals' accounts. Two main themes were raised from the health professionals' views. The first theme "should family members be given the opportunity to enter the resuscitation room?" discusses the willingness of healthcare professionals to allow FWR. The second theme "suggestions and interventions" provides realistic steps to facilitate FWR and to improve professionals' attitudes. Most of the health professionals opposed FWR. In conclusion, a few professionals, however, expressed their favour for this new trend. The findings of this study uniquely suggest some interventions to organise FWR such as health education and increasing awareness about this subject, preparing family members to witness CPR and the importance of preparing the resuscitation room and increasing the staff number.
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1. Introduction

A middle-aged patient was admitted to the emergency department in a Jordanian hospital. This man had been exposed to myocardial infarction. Directly, as is the usual routine in most Jordanian hospitals, the patient was transferred to the Intensive Care Unit (ICU). At this stage, the patient was semiconscious and was asking to see his relatives. Continuously, he said "my sister", "my brother", "let me see them", and many delirious words about his family. On the other side, his relatives, one brother and sister, were inappropriately pushed out of the unit and left sitting in the waiting room. After less than ten minutes, the patient's condition became worse and the bedside monitor started to alarm. The patient's assigned nurse shouted "Patient has cardiac arrest", "call CPR team", and "evacuate visitors from the unit". Cardiopulmonary Resuscitation (CPR) began immediately to save the patient's life. Not too far away, 10 metres outside of the patient's room, the patient's family was waiting and asking to see their loved one. The relatives' request to enter the resuscitation room was strongly refused by the CPR team. Despite all efforts to save the patient's life, the patient died. After removing everything around the patient and cleaning him, the patient's relatives were invited to say goodbye to their loved one. This scenario is typical in Jordanian hospitals. It could be argued that both the patient and relatives were denied the opportunity to face death together, to resolve unfinished business, and to say goodbye (Redley and Hood, 1996; Chapple and Ziebland, 2010).

Family witnessed-resuscitation (FWR) is a relatively new trend. The literature has demonstrated a trend towards acceptance of the issue of witnessing resuscitation as a good practice (Ardley, 2003; Jones et al., 2011). This comes from the idea that FWR brings a sense of reality to the loss of a loved one, and helps avoid a long period of denial (Hung and Pang, 2011; Walker, 2013). FWR has been supported by many nursing and medical organisations such as the Royal College of Nursing, the Emergency Nursing Association (ENA), and the British Association for Accident and Emergency Medicine (Madden and Condon, 2007). Recently, the European federation of Critical Care Nursing Association, the European Society of Paediatrics and Neonatal Intensive Care, and the European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions jointly formulated a position statement on the presence of family members during CPR (Fulbrook et al., 2007).

However, allowing FWR remains debated in nursing and medicine. There are several studies reported positive views regarding this trend (Timmermans, 1997; Booth et al., 2004; Mangurten et al., 2005; Fallis et al., 2008; Walker, 2013). For example, Timmermans (1997) conducted a qualitative study to examine 57 emergency multidisciplinary healthcare providers' attitudes towards FWR. Consequently, several staff preferred involving family members as active participants in the resuscitation efforts. In a more recent study, Fallis et al. (2008) reported positive professionals' perceptions regarding FWR. By surveying 450 Canadian critical care nurses, they found that more than 90% supported the option of FWR. However, only 8% of the nurses reported that written guidelines for FWR were available in their hospitals. A multi-specialist group was developed to demonstrate a new clear protocol for allowing FWR (Mangurten et al., 2005). This protocol was followed by special education to healthcare providers about FWR, presented by panel lectures. 79% of staff believed that family members should have the option to be present at the bedside of their relative during CPR.

However, this positive response from health practitioners and specialists argued and rejected by other health care groups. In two recent studies, Twibell et al. (2008) and Gunnes and Zaybak (2009) surveyed nurses' attitudes towards FWR. Similarly, both studies reported negative nurses' attitudes. They found that the majority of nurses never invited family members to witness their loved ones' CPR. Walsh (2004) asked "how would the family react during the active phases of resuscitation or treatment with the patient?" Jones et al. (2011) raised another question about the litigation risks if something goes wrong during these stressful procedures. Ong et al. (2004) indicated that Asian healthcare professionals have stronger disapproval of FWR than their Western colleagues. Lack of experience with FWR and absence of clear guidelines were expected to explain this difference in attitudes. Indeed, the conditions in Jordan seem similar to those in Singapore in terms of lack of experience of FWR and absence of clear guidelines to support it.

Yanturali et al. (2005) and Demir (2008) quantitatively surveyed Turkish nurses and physicians' perspectives regarding FWR. Most of the respondents reported that they were not in favour for giving family members this option. Most of the above studies reported several fears and concerns not to allow FWR. These concerns include the procedure involved would offend family members, emotional stress on staff would be increased, family members would be disruptive to staff members working, family presence would interfere with the treatment, staff may offend family members, the general public are not important to deal with witnessing this procedure, the legal proceedings that may arise from family presence, and the concern there were no benefits from family presence (Redley and Hood, 1996; Howlett et al., 2011; Jones et al., 2011; Doolin et al., 2011; Walker, 2013).

Most studies in this field adopted a quantitative design. The reductionist feature of the quantitative (Strong, 1992; Hanson, 2008) design let many authors to recommend studying this phenomenon qualitatively (Halm, 2005; Walker, 2008; Howlett et al., 2011). For example, Halm (2005) reviewed 28 studies on family presence during CPR. Of these studies, only four (14%) adopted the qualitative approach. By applying a qualitative approach, this research provides a deeper insight into the critical care professionals' attitudes towards FWR, and how they perceive this practice. Walker (2008) and Doolin et al., (2011) reviewed several studies about FWR, and indicated the need for moving beyond quantitative approaches by alternatively adopting techniques that examine the impact of FWR in qualitative terms.

The literature review shows that most of the studies were conducted in the Western countries, with more than 70% of them were in USA and UK. However, some studies examined the Turkish population (Yanturali et al., 2005; Badir and Sepit, 2007; Demir, 2008; Güneş et al., 2009), and 2 studies were done in Singapore (Ong et al., 2004; Ong et al., 2007). There was no study examining FWR in Jordan. The findings of this study provide an opportunity to keep in mind some factors that might affect on examining FWR in other countries with similar conditions. As a qualitative study, its findings would facilitate understanding how other people, under similar conditions, may think. For instance, the way of selecting one or two family members from a huge number of patient's relatives would be one of the findings of this study.

In this study, FWR was defined as "offering the choice for critically ill patient's relatives to stay at bedside of their loved one in the resuscitation room from the period the patient enters the resuscitation room until discharge or death". The aim of this study was to deepen understanding of the experience of health professionals regarding the phenomenon of FWR in adult critical care settings.

2. Material and Methods

Semi-structured in-depth interview was selected as the method of data collection for this research. A descriptive survey was the main data collection method in most of these studies (Helmer et al., 2000; Leung and Chow, 2012; Ganz and Yoffe, 2012; Al-

Mutair et al., 2012). Despite the useful information that was produced from these studies, the reductionist nature of survey (Parahoo, 2006) limited the production of more details and deeper information about the topic. Therefore, qualitative research seems to be effective when there is a need for more understanding of social phenomena like FWR (Bryman, 2012). By adopting a qualitative research method, we concentrate on providing more in-depth and rich data, sharing the participants' own experience, and being part of the social phenomena (Silverman, 2011; Bryman, 2012). We developed our interview schedule depending on the literature, our experience, and reading about the different aspects that surrounding this topic.

2.1 Setting

The healthcare system in Jordan consists of three main sectors (public, private and university). The study was conducted in six hospitals in two major Jordanian cities. Two hospitals of each health sector were selected. All participants were either from intensive care units (ICUs) or from cardiac care units (CCUs). The reasons behind choosing these units are the critical conditions of the patients admitted to these units, high incidence rate of CPR and the difference in the relationship between the critical care professionals and patients and their relatives.

2.2 Sample and Data Collection

An individual semi-structured in-depth interview was utilised as the main data collection method in this study. Our aim was to interview healthcare professionals who usually have a role during CPR. This includes nurses, physicians, anaesthetists, anaesthesia technicians and respiratory technicians. There are no guidelines for FWR in Jordan. Therefore, we looked to recruit two groups of health professionals. The first group included healthcare professionals with experience in Jordan only. Each participant in this group was expected the following criteria:

- They were working within a critical care unit in one of the Jordanian hospitals.
- The nurses were registered nurses; the doctors were residential doctors or senior doctors; the respiratory therapists and the anaesthetists or the theatre technicians have a diploma or bachelor's degree in anaesthesia.
- All healthcare professionals were critical care staff within Jordanian health institutions and had previously shared in CPR for an adult patient.

The second group included Jordanian health professionals who had experience within Jordanian health institutions, as well as outside the Jordanian context. It was preferred if they had an experience in hospitals that had clear guidelines for FWR.

After getting the ethical approval from each hospital, initial contact with the head of critical care units and the educational department was made. A demographical questionnaire was then distributed to the health professionals face-to-face. A brief explanation about the study aim and data collection procedure was provided for each health professionals received one of these demographical questionnaires. The health professionals were asked kindly to leave the questionnaire in a specific box at the end of their duties. For any health professionals who met the inclusion criteria and agreed to take part in this study, an appointment for interview was arranged. Health professionals were asked about their attitudes toward FWR and if the family members should be given the opportunity to witness their loved ones' CPR. Data collection continued until the saturation point. The average of each interview extended from 45 to 60 minutes. All interviews were tape recorded and transcribed by one of the authors. Eventually, a purposive sample of 31 health professionals was recruited.

2.3 Ethical consideration:

In Jordan, there is no national ethical approval system. Therefore, we got ethical approval from each sector or hospital separately. The participants had complete freedom to participate or to refuse participation in the research. They were given the choice to participate in this study, and to terminate their participation at any time without any penalty or stress. As far as possible, the interviewees were interviewed in private places. All participants were informed that their responses would be treated confidentially, and their account would always be anonymous. All collected data are maintained in a locked file and the access to the identifying information is restricted to only one of the study authors. Participants' real names were exchanged of pseudonyms during the process of data analysis. A consent form was signed from each participant before each interview. This form was accompanied by an information sheet.

2.4 Data analysis:

The aim of qualitative data analysis is to organise and reduce the data into themes (Walker and Myrick, 2006). In qualitative research, the process of data analysis starts congruently with the process of data collection. All interviews were recorded and transcribed, directly after each interview. We decided to use a computerised thematic analysis to analyse the data that were generated by the interviews (Braun and Clarke, 2006). Braun and Clarke (2006) identified six phases for thematic analysis: familiarisation yourself with your data, generating

initial codes, searching for themes, reviewing themes, defining and naming themes and finally producing the report. The NVivo software was utilised to facilitate the process of data analysis. This eased the process of organising the data and the process of coding.

2.5 Research Rigor:

Credibility and transferability are used in qualitative research as validity is used in quantitative research (Barusch et al., 2011). Angen (2000) showed that the credibility of research depends on the skill and competence of the researcher. For the current study, all the authors have good training and preparation for doing qualitative research. Writing field notes and using a personal journal during data collection were expected to improve the credibility of the studies (Tuckett, 2005). Therefore, recording field notes was used in this study by using a specific journal to write down notes and comments about each interview. Additionally, using the tape recorder, thematic log, and auditing transcripts contribute to increasing the credibility of the research (Tuckett, 2005).

Credibility is increased as a result of selecting purposive sampling (Brink, 1991; Tuckett, 2005). This also contributes in facilitating the transferability (Lincoln et al., 2011) because purposive sampling opens the way for producing the widest possible range of information. Purposive sampling formed the basic strategy to select the participants in this study.

Guba and Lincoln (2005) indicated the importance of the constant comparison of the data that emerged from the participants' interviews. We sent samples of our interview transcripts to two external researchers. We showed them our analysis for these transcripts. Both of them were convinced that interpretations for the interviewees' accounts were consistent with their interpretations. Considering and not ignoring negative cases contributes in promoting the credibility and dependability of a qualitative study (Tuckett, 2005; Barusch et al., 2011). Negative cases were considered and widely-used in our study.

3. Results

Two main themes were raised from the health professionals' views. The first theme "should family members be given the opportunity to enter the resuscitation room?" discusses the willingness of healthcare professionals to allow FWR. The second theme "suggestions and interventions" provides realistic steps to facilitate FWR and to improve professionals' attitudes. The following table provides an idea about the two main themes and the sub-themes which were produced in this study.

Table 1. The themes and sub-themes

Themes	Sub-themes
Should family members be given the opportunity to enter the resuscitation room?	Would you want family members to enter the resuscitation room?
	Who and when to be allowed into the resuscitation room?
	Would you, as a health professional, want to enter the resuscitation room?
Suggestions and interventions	Focus on health professionals (education and training)
	Focus on patients' relatives: • Keeping families up-to-date. • Presence of supporting staff.
	Focus on the resuscitation room: • Adapting the CPR room. • Presence of clear guidelines.

3.1 Should family members be given the opportunity to enter the resuscitation room?

The aim of answering this question was not only to decide whether the health professionals were in favour of FWR or not. This question raised many contradictory opinions and views from the health professionals.

3.1.1 Would you want family members to enter the resuscitation room?

Health professionals were questioned if they would allow FWR. The question 'why do they allow or not allow FWR?' was subsequently asked. Asking this question aimed to clarify some factors that might affect health professionals' worldviews. Generally, the data suggested that health professionals were quite unsure about if the patients' relatives have the right to be with their loved one during CPR. Some health professionals rejected this right. Rasheed, for example, considered that allowing FWR is one of the health professionals' rights.

I think it is our choice as healthcare professionals. We have the right to ask them to go out, and to leave during any procedure. (Rasheed, Nurse)

Most of the professionals seemed to be predisposed against FWR. Refusing FWR was clearly indicated by many health professionals, such as Kholod, Husni, Jalal, Nada, Nancy, Nemer, Raghad and Baha. It was indicated that CPR is not the only procedure in which families are escorted out.

The CPR is not the only procedure that the patient is isolated during it. The patient who wants to do cardiac catheterisation, goes to the catheterisation room alone. The patient who does an operation is also the same … (Kholod, Nurse)

Dealing with CPR, however, seems different from dealing with surgery or cardiac catheterisation. During surgery, the issue of sterilisation and infection control is the essential issue in not allowing family presence in the operation room. During CPR, the situation is one of life and death.

Despite the tradition of excluding family members during CPR, some of the health professionals believed that family members could be given the opportunity to enter the resuscitation room. According to these professionals, there are some cases in which FWR seems quite acceptable. One of these cases was if the relatives were members of the health community, such as doctors or nurses.

Sometimes … some of the patient's relatives are from medical staff. In this case, maybe I will allow one or two to stay. (Raghad, Resident Doctor)

3.1.2 Who and when to be allowed into the resuscitation room?

This issue was about the proper people to be allowed, and the way of selecting these people. It was suggested by most of the professionals that the person who should be given this chance should be one of the closest family members.

Should be very close, first degree relatives, not other than that. (Raghad, Resident Doctor)

By saying this, Raghad seems not to be in favour of allowing a friend or other non-blood relations into the resuscitation room. In addition to selecting the closest relatives, some of the health professionals suggested selecting a calm person, the senior one, or the closest to the patient. More than two-thirds of the professionals suggested not involving female relatives in CPR, as they thought that females are highly-emotional in such circumstances.

I mean to select the command in the family… that person who supposed to control the situation and help in relaxing the other family members … (Salameh, Anaesthetist)

One man, not woman … because the man cannot cry, but woman does not tolerate. (Khalid, Resident Doctor)

This finding is a unique for our study. However, it should be also indicated that most of the interviewees were male (21 of 31). However, some female professionals indicated that they do not prefer allowing female relatives to witness CPR. Lina, for example, was a nurse working in a university hospital. She asserted not allowing female relative to witness CPR.

Always, the highly emotional people, like females, as possible, should be escorted, because they will be highly affected (Lina, Nurse)

The results showed that the number of family members to be allowed in the CPR should not exceed two persons at the same time. Hamad: *"I think it should not be more than two …"* Other professionals preferred not to allow more than one person at the same time. They tried to minimise the number of relatives in the resuscitation. They said that they do not like this phenomenon, and thus they preferred to make it as few as possible.

When you do not like something, you make it minimum. If you allow, and you have to do it, you just make it minimum. So, I would say one. (Mahmoud, Anaesthetist)

From the previous quote we can conclude that this participant will not allow family to be in and if he has to do it by law then he will do. Based on that if there is guidelines/policy, this will enhance the process and it will become more common.

Many health professionals would allow FWR after finishing the resuscitative efforts. This means that family members will wait until finishing the whole procedure, and then they will enter to see their loved one either being dead or being connected to many machines. This also does not add anything new to what was already available, as family members were given this opportunity in the past. Some professionals suggest allowing FWR if the health professionals reached to a point that there is no chance for that patient to survive.

I think in these moments when the physician and the whole team take a decision to stop, when we take everything invasive and try to clear the area. At this time we ask the family to come in; hold hands and pray, but not in the middle of CPR. (Nancy, Nurse)

However, some staff believed in allowing family members to be present during all of the CPR. Hamad said: *"Yes, during all phases in the CPR"*. It was thought that allowing FWR at some stages of CPR and not allowing them at other stages could affect the trust between family members and health professionals. Some professionals thought of either allowing them during all of the procedure or not allowing them at all.

Well, this also brings to my thinking the matter of trust. So, if you bring them to part of it and prevent them from the other parts this means that there is no trust. This means that there is something you are going to hide. It is either to be permitted for all or not to be permitted for all. (Sami, Respiratory Therapist)

3.1.3 Would you, as a health professional, want to enter the resuscitation room?

Almost two-thirds of the health professionals preferred to be with their relative during CPR, though there were differences. Some of them supposed that they would insist on staying. Nancy, for example, confirmed that she wanted to stay in the CPR of one of her relatives "*Yes, definitely*". While several of the professionals needed to be with their loved one during CPR, they stressed the importance of following the instructions of the CPR team. The rest of the health professionals would favour their presence during CPR of one of their relatives if the CPR team allowed them to stay.

Even if I am not a nurse, I prefer to be present, but my presence will be controlled by specific things. I have to accept that these people know what they are doing. (Lina, Nurse)

In contrast, there were a few health professionals who were reluctant to be present during the CPR of one of their relatives. Many reasons were raised for not favouring this presence. Firstly, they appreciate the feelings of the CPR team. They thought that the CPR team would not be able to concentrate if somebody else was watching and observing what they did. Secondly, some other professionals reported that they would not wish to enter the CPR of their relatives as they feared making any interruption to the treatment process:

I put myself in their shoes and I do not want to be there, because they will be very careful and may be nervous, especially if they know that I know what they are doing ... (Saleh, Anaesthesia Technician)

Some of the professionals linked their wishes to enter the CPR of their relatives and the incident itself. Some of them said clearly that if they trusted the CPR team and the health institution, they would not want to enter.

If I trust the team inside, definitely I would rather to stay outside. But, for some reasons, if we went for a very bad reputation hospital, no, definitely I would like to go inside ... (Husni, Nurse)

It seems difficult to assess the CPR team's abilities without getting in the room and seeing what they do. In this case, their presence seems important even for a while to assess whether they had to stay or not. It was also indicated by some of the professionals that the health professionals would play the role of patient's advocate during CPR. However, by linking trust and their wishes to witness the CPR, health professionals seem to have admitted the role of family members as advocates for their relatives during CPR.

3.2 Suggestions and interventions

3.2.1 Focus on health professionals (good education and training)

Good education and adequate training for health professionals are important before starting to allow FWR. The health professionals demonstrated that more courses and workshops should be implemented to prepare staff to work without inhibitions during CPR in presence of family members. These courses should focus on communication skills and ways to deal with the patients and their relatives. It was stated that these courses could be important in reminding the staff that they are dealing with a human being (the patient) rather than a machine.

The staff starts to deal with the patient as a machine… and after a period of time, the health professionals forget the other patient's components that they should deal with during the treatment proces. (Shadi, Nurse)

More importantly, the need for staff to practice what they have learned should be highlighted by putting the staff in real incidents of FWR. This could not be implemented without practical training for staff. Diala, for example, talked about attending a course about customer service. She thought that she could possibly manage and deal with family members. However, she seemed not to be very confident about doing that, as she had never practiced this role in a real situation. This is in agreement with Ellison (2003). Ellison stated that both educational and experimental components promote adaptation to a new situation.

For me, I took training course about customer service and we discussed this issue during this training. I think I can manage, I can deal with the family in this situation, but I did not try to do it ... (Diala, Nurse)

3.2.2 Focus on patients' relatives (keeping families up-to-date and presence of supporting staff)

Most, if not all, interviewees were supportive of keeping good communication with the family members. Several of them appreciated the conditions of the family members during CPR. They supported the idea of updating family members about the case of their relatives, and not keeping them without any information, helping them in dealing with the situation.

Updating the family about worsening of the cases will greatly help to let them absorb the death of their beloved person ... (Saleem, Nurse)

Another interesting point was raised about the type of information that should be communicated to the family during the critical situation. Some health professionals indicated that sometimes the information transferred to family members is not accurate. Therefore, they went on to suppose that if

the family received accurate information, they would have better acceptance of the results.

If the patient's family receive suitable information, they will know why the CPR was successful here and not successful in the other side ... (Zaid, Nurse)

To maintain good communication with the family members, many health professionals suggested finding a special person to deal with family members during CPR. In one way or another, this role seems being present in many cases, but without planning or organising. Some professionals indicated that, sometimes, they delegate one of the staff in the unit to tell the family about their relative's condition.

Almost always one of the nursing team will inform the family members ... (Raghad, Resident Doctor)

Raghad, however, did not explain any qualification for this presence. She also failed to define the role of this person. Therefore, it was quite important to ask some questions about the identity of this professional, their roles and qualifications. Some professionals indicated that this role should be undertaken by one of the health professionals. They did not specify whether it should be a doctor, nurse, or other professional. There were, however, other professionals who went further, to suppose that this staff should be one of the CPR team, who would be more oriented about the CPR. In some cases, nurses were expected to be the convenient people to play this role. Nancy expected that nurses would be the best to do this job:

I think a nurse can be very informative, and nurses, in my opinion, are better than physicians in communicating with families ... (Nancy, Nurse)

After indicating the importance of having this employee and trying to identify the suitable person to do this job, it was important to outline their roles and main duties. Firstly, supporting staff should stay with the family members during CPR, communicate with them, and explain all procedures to them. Secondly, supporting staff are expected to be honest with family members. Thirdly, this member is expected to be a connection between health professionals and family members. Even in the case of not allowing FWR, this employee would keep communicating with family members.

Actually, for the family themselves, somebody needs to be with them. A professional explains what is happening and reduces stress on them ... (Ghawar, Nurse)

Regarding the necessary qualifications of the supporting staff, some of the professionals suggested that supporting staff should be knowledgeable about CPR. This staff also suggested having a good understanding of the local culture. Furthermore, supporting staff should have good communication skills, and should know how to deal with the family members during CPR. Finally, supporting staff generally should have high qualifications.

I think the best person to do it in Jordan; is a Jordanian person, in India is an Indian person, because he is the best person to understand the culture and the attitude of his own people. (Saleem, Nurse)

They must have good communication skills, and they must know how to explain the procedure for this family? (Diala, Nurse)

To our knowledge, there is no instance in the literature that describes exactly the qualifications required for supporting staff. Some studies, however, pointed out that supporting staff should have knowledge about communication skills, the grieving process, and how to manage crisis situations (Doyle et al., 1987; Doolin et al., 2011).

3.2.3 Focus on organisational aspects (CPR room and guidelines)

Approximately one-third of the professionals indicated the importance of having special rooms to meet the needs of both the CPR team and the family members in the case of CPR. Some health professionals suggested preparing a special room with a glass barrier. They proposed that this would help the family members to witness the CPR, while at the same time, allowing them to work freely.

It is suggested to have a glass barrier in ICU to see what the ICU staff doing to patients ... (Awad, Nurse)

By providing this room, it was supposed that family members would appreciate the efforts of the health professionals. However, it seems that the motives for health professionals suggesting the use of this special room were egoistic. Nevertheless, seeing the resuscitative efforts was suggested as one of the main family needs during CPR.

It was indicated by many of the professionals that there was no policy to organise, allow, or even disallow FWR. However, they indicated that excluding family members is a well-known tradition.

We have not written policy, but it is well known that family will be kept out the ward, to keep silence and to prevent interruptions from the family. (Majdi, Nurse)

This empowers staff to allow family members to enter into the CPR room, if desired. Consequently, some of the professionals considered the importance of having clear, documented guidelines to organise the process during CPR. It was supposed that presence of clear policies would support the staff and clarify to them exactly what to say and what to do.

Sure, if there was something written and well-known, sure you can speak firmly as you

know that your back is supported ... (Raed, Resident Doctor)

Most of the health professionals considered the need for a clear policy in organising FWR. They also focused on the component of this policy, and they encouraged producing a comprehensive policy to organise FWR. It seems helpful to conclude with the following statement from Zinab, a registered nurse with diverse and considerable experience.

Actually, we need a very clear and comprehensive policy about including the family in ... At the same time, the policy should include how each one can help in managing the CPR? Because as I told you even the policy is very vague ... (Zinab, Nurse)

4. Discussions

To our knowledge this is the first study conducted in Jordan to examine health care professionals' attitudes toward FWR. Qualitative design is rarely utilised in literature to examine this phenomenon. The use of quantitative design in the previous studies about this topic resulted in limited information on this phenomenon. Therefore, we used the qualitative design which gives better understanding and capturing of this phenomenon. This study is one of the rare studies that examine health professionals out of the Western region which emphasize the ability of implementing this practice out of the Western countries.

There is a development in understanding of end of life and the improvement in the programs that stress on providing the best care during what is typically a very difficult period for patients and their relatives (Truog et al. 2001; Curtis et al., 2012). However, most of these programs and principles have focused on terminally ill patients. There is a paucity of information about end-of-life care in individuals with acute critical illness, and this may contribute to the existence of many barriers to end-of-life care in the ICU (Nelson 2006). CPR, even with chronic illness, is an acute incident. Lack of information about providing end-of-life care to the acute critically ill patients may explain the disagreement among most of the studies and researchers regarding the importance of allowing FWR. This produces diversities between healthcare professionals' views regarding this presence.

In keeping with the findings of previous studies (Helmer et al., 2000, Mian et al., 2007; Ong et al., 2007; Cho et al., 2013), it emerged that nurses were more willing than other professionals to give family members the option of witnessing CPR. In this study, more than two-thirds of the respondents expressed views that opposed FWR. Only five interviewees would allow FWR during CPR. Interestingly, all of these interviewees were nurses. To explain these results, it is important to understand some characteristics of nursing work. Nursing is frequently described as a caring practice (Spichiger et al., 2005). Nurses spend the longest time with patients during hospitalisation (Venning et al., 2000). Nurses also communicate with patients and their relatives more than other health professionals. Additionally, nurses are an essential link between physicians and the hospitalised patient (Tzeng, 2008). Focusing on these perspectives may explain why nurses are more sympathic with family members during CPR. Uniquely, the present study explains the possible reasons behind the difference in attitudes between nurses and their colleagues from the other healthcare professions toward FWR.

The findings of this study show that Jordanian healthcare professionals usually adopt a paternalistic perspective when dealing with patients and family members. Physicians, more than other professionals, adopt this perspective. Despite the paucity of studies in the Jordanian critical care settings, some of the researchers indicated this phenomenon (Al-Hassan and Hweidi, 2004; Alasad and Ahmad, 2005; Hweidi, 2007; Omari, 2009). All of these researchers indicated that healthcare professionals in these units used to taking control over patients' needs. It was explained that critical care professionals usually decide on what to be done for the patients and when (Al-Hassan and Hweidi, 2004; Alasad and Ahmad, 2005). This perspective and taking control on all decisions may explain the negative attitudes of most of the professionals in my study regarding FWR.

This study provides valuable information about some criteria that should be available to the person proposed to be given the option of witnessing CPR. We clarified that this person must be from the very close relatives, and should have leadership characteristics. Distinctively, the findings of this study warned against allowing highly emotional people to witness CPR. Some professionals assert not allowing female relatives to witness CPR. These might be unique findings for the Jordanian culture. Traditionally, Jordanian society is patriarchal society. Jordanians are used to the idea that men are stronger and can tolerate bad news more than women. However, this situation has been changing within the Jordanian society. Approximately, 29% of women in Jordan have higher than a diploma degree, a relatively high figure, particularly for a developing country (Department of Statistics, 2007). This may limit the transferability these findings to other countries or cultures. However, these findings should be considered when studying this phenomenon in other societies with similar characteristics.

In the present study, several health professionals stated that trust is an essential criterion that affects their desire to stay or leave the resuscitation room. Gidman et al. (2012) showed the importance of trust on patient's acceptance of healthcare services. In the current study, the private hospitals had the highest level of trust, while the public hospitals had the lowest level. This may explain the views of many health professionals that they would attend their relative's CPR if they did not trust the CPR team or the institution. Many of these professionals said that they would assess the situation first, and then they would decide whether or not to attend the CPR. Therefore, our findings stress the importance of fostering the trust between healthcare professionals and family members.

It was noted that health professionals in the public health sector were more assertive in rejecting FWR. The majority of health professionals from the public sector not only refuse FWR, but they also reject even communication with family members. We think that higher pressure on the public sector may negatively affect the attitudes of health professionals. The pressure on the public sector in terms of resources may result in providing a lower level of health services. We recommend doing more research about this subject in Jordan. This includes comparing the quality of healthcare services in both sectors and the economic results of this attitude.

A positive relationship between good education and positive attitudes towards FWR was found in the current study. In this study, all the health professionals who encouraged FWR went through specialised courses or shared in studies about communication with patients and patients' families. This is in agreement with Bassler's (1999) and Ellison's (2003) findings. An interesting finding in our study is that some of the professionals who support FWR held postgraduate nursing certificates. Zinab, for example, was a nursing PhD student; Awad and Shadi held master degrees in nursing. A relationship might be supposed between the high level of education of health professionals and positive attitudes towards FWR.

Significantly, our findings reveal that health professionals with experience in and out of Jordan, especially in one of the Western countries, were more positive. This could result from several factors. These professionals had attended different courses such as attending communication skills courses, tending to deal with family members during critical situations and stating that they were used to involve family members in the treatment process.

Our findings are in agreement with the findings of some other Jordanian research (Mrayan, 2005; Abu Alrub, 2007). These studies did not plan to study the presence or absence of policies or guidelines in Jordan. They, however, found that absence of policies and guidelines to organise the treatment process and the job description produce negative impact of the treatment process and on professionals' satisfaction. Therefore, in addition to the importance of doing more research about the influence policies on treatment in Jordan, it seems important to organise all procedures by producing clear policies. Job description is also a very important step in improving professionals' satisfaction and reducing the confusing during critical incidents. More importantly, all these procedures should be accessed by healthcare professionals, patients, and family members, and should be written in clear and understandable way for all.

5 Conclusion

In this study, we showed that most of the professionals thought that FWR is inappropriate. However, most of them would want to attend their relative's CPR. The majority of the professionals stated that they would allow FWR if the family members have a medical background, or if they are well educated about CPR. Interestingly, health professionals suggested some interventions to organise FWR such as health education and increasing awareness about this subject, preparing family members to witness CPR and the importance of preparing the resuscitation room and increasing the staff number.

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